**Care Planning: NCQA PCMH Care Plan Elements and OHIC Care Plan Elements and Health Plan Expectations**

|  |  |  |
| --- | --- | --- |
| **Element**  | **NCQA PCMH 2017**  | **OHIC (for high risk patients)**  |
| Comprehensive health assessment  |  Core: Select 6 Family/social/cultural characteristics Social Functioning Communication Needs Medical History of patient and family Advance Care planning (N/A for pediatric ) Behaviors affecting health Mental health/substance use history of patient and family Social determinants of health (new) Additional Criteria: Addresses health literacyScreening adults and adolescents: Depression, anxiety and SUD Pediatrics: Developmental screening  | Care manager completes a patient assessment based on patient’s specific symptoms, complaints or situation including the patient’s preferences and lifestyle goals, self-management abilities and socioeconomic circumstances that are contributing to elevated near-term hospitalization and/or ED risk For children and youth: A family status and environmental assessment (medical/behavioral/dental/ social supports of family/friends/financial needs, family demands /relationships and functioning; cultural beliefs and values of family; strengths/assets of child, youth, family/caregivers and current goals of child/youth and family and A growth and development assessment of developmental progress/status/child/youth strengths/assets/school performance and needs and emotional and behavioral strengths and needs  |

|  |  |  |
| --- | --- | --- |
| **Element**  | **NCQA PCMH 2017**  | **OHIC (for high risk patients)** |
| Uses comprehensive health data to implement needed interventions, tools and supports for the practice as a whole and for specific patients  | Advanced Criteria: Documents social determinants of health, monitors at population level and implements care based on this data  |  |
| Medication safety  | Core: Reviews and reconciles medications for more than 80% of population Assesses understanding of meds for more than 50% of patients/families/caregivers Assesses patient response to medications and barriers to adherence for more than 50% of patients Maintains up to date medication list (new)Additional criteria Educates on new prescriptions Documents nonprescription medications Advanced Medication reconciliation for behavioral health (new) Systematically obtains prescription claims data to assess and address medication adherence. 9new)  | Care manager completes a medication reconciliation after a high risk patient has been discharged from inpatient services; to the extent possible the medication reconciliation is conducted in person  |

|  |  |  |
| --- | --- | --- |
| **Element**  | **NCQA PCMH 2017**  | **OHIC (for high risk patients)**  |
| Care Support  | Additional criteria Provides educational materials and resources for patients including online support programs (new) Provides oral health resources (new) Provides self-management tools to record self-care results Adopts shared decision aides for preference sensitive conditions (new) Offers or refers patients to structured health education Works with community schools or urban intervention agencies 9new)  | Care manager provides health and lifestyle coaching for high –risk patients designed to enhance the patient’s caregiver’s self/condition-management skills Care management/care coordination resources have in-person or telephonic contact with each high risk patient at intervals consistent with the patient’s level of risk  |

|  |  |  |
| --- | --- | --- |
| **Element**  | **NCQA PCMH 2017**  | **OHIC (for high risk patients)** |
| Risk stratification  | Core: Selects 3 Behavioral health condition High cost/high utilization Poorly controlled or complex conditionsSocial determinants of health Referrals by outside organizationsAdvanced Comprehensive risk stratifications of entire patient panel to direct resources appropriately and provide care planning and management to patients that would most benefit  | Practice has developed and implemented a methodology for identifying patients at high risk for future avoidable use of high cost services Updates the list of high risk patients at least quarterly Practice has developed a risk assessment methodology that includes at a minimum consideration of Assessment of patients based on co-morbidity Inpatient utilization ED utilization Practice has a designated resource (RN or LPN or social worker) to provide care management focused on providing services to high risk patients Practice has a methodology of the timely assignment of levels of care management/care coordination services needed by high risk patients based on risk level, clinical information including disease severity level and other characteristics  |

|  |  |  |
| --- | --- | --- |
| **Element**  | **NCQA PCMH 2017**  | **OHIC (for high risk patients)**  |
| Care Plan development  | Core: Identifies treatment goals in individual care plans Provides written care plan to patient/family/caregiver Additional Criteria for individual care plans Incorporates patient preferences and functional /lifestyle goals iAssesses and addresses potential barriers to meeting goals in individual care plans Includes a self-management plan Collaborates with patient/family to develop/implement a written care plan for complex patients transitioning from pediatric to adult Advanced Follow s up on community referrals to determine impact on individual patients (new)  | Within 2 weeks of completing assessment, care manager completes a written care plan that includes Medical/social summary Risk factors Treatment goals Patient-generated goals Barriers to meeting goals Action plan for attaining patient’s goals Updates care plan on a regular basis based on patient needs to affect progress to meeting existing goals or to modify an existing goal but no less frequently than semi-annually  |
| **Element**  | **Health Plan Phase 2 NCM /CM reporting**  |  |
| NCM/CM status  | Open: date referral received Participating: Date of engagement when patient consents to participate Closed: date discharged Closed reason: expired, declined, unable to contact, goals met, LTC resident, Inappropriate for CM  |  |
| **Element**  | **Health Plan Phase 2 NCM/CM reporting**  |  |
| Intervention Type  | Complex: 60+ days of CM Transition of Care/Moderate: Requires 30-59 days Short term: /one time touch: Will not require CM after addressing immediate need  |  |