



Targeted
Investments

Core Component #3 Pediatric PCP Area of Concentration

Utilizing Practice Care
Managers for Members in
the High Risk Registry



Key Concepts

TI participants will utilize practice care managers to:

- assess **high risk** member needs
- play an active role in developing and implementing care plans
- collaboratively support hospital transitions of care
- coordinate **high risk** members' medical and behavioral health services
- assure optimal communication and collaboration with other MCO's and or practices
- work with **high risk** members and families to facilitate linkages to community organizations

Key Concepts

- Core Component #3 requires a dedicated staff member to perform the care management functions. It is the most resource intensive and requires the most investment by TI participants. Participants are expected to use their TI payments to support this dedicated resource.
- Care Managers will be focusing on members in the high-risk registry with a case load **not to exceed a ratio of 1:100.**

Core Component #3

<p>3. Utilize practice care managers² for members included in the high-risk registry with a case load not to exceed a ratio of 1:100. Care managers may be employed directly or contracted by the practice from external sources. Practice level care management functions should include:</p> <ol style="list-style-type: none"> 1) Conducting a comprehensive assessment with the child/youth that includes family status and home environment assessment. 2) Playing an active role in developing and implementing integrated care plans. These plans should build on family strengths, plan for the transition of youth from pediatric to adult systems of care, as appropriate, and (if applicable) be developed with input from behavioral health Child and Family Teams.³ 3) Coordinating members' medical and behavioral health services, assuring optimal communication and collaboration with MCO and/or other practice case or care management staff so that duplication in efforts does not occur and that member needs are addressed as efficiently as possible. 4) Ensuring the provision of member/family education to help build self-management skills and equipping families with the skills needed to navigate a complex health care system. 5) Working with members and their families to facilitate linkages to community organizations, including social service agencies. 	
<p>Milestone Measurement Period 1 (October 1, 2017–September 30, 2018**)</p> <p>← (x 11) →</p> <p>Practice Reporting Requirement to State</p>	<p>Milestone Measurement Period 2 (October 1, 2018–September 30, 2019**)</p> <p>← (x6) →</p> <p>Practice Reporting Requirement to State</p>
<p>A. By September 30, 2018, identify at least one care manager who has been assigned to provide integrated care management for members listed in the practice high-risk registry. Indicate the caseload per care manager full-time employment (FTE), AND</p> <p>B. By September 30, 2018, Document that the duties of the care manager include the elements of care management listed in this Core Component, and the process for prioritizing members to receive practice care management, consistent with Core Component 2, AND</p> <p>C. By September 30, 2018, demonstrate that the care manager(s) has been trained in:</p> <ol style="list-style-type: none"> 1) Comprehensive assessments of children/youth's needs, including family status, home environment assessments, 2) Using integrated care plans, 3) Member and family education, including managing chronic conditions and self-management (as appropriate), and 	<p>A. Document that care managers have been trained in motivational interviewing to facilitate family engagement and self-management support, and when appropriate, child/youth engagement and self-management support, AND</p> <p>B. Based on a practice record review of a random sample of 20 members, whom the practice has identified as having received behavioral health services during the past 12 months, attest that the care manager has documented: a) completing a comprehensive assessment, b) educating families, c) conducting motivational interviewing, d) appropriately facilitating linkages to community organizations, and e) planning for the transition of youth from pediatric to adult systems, (as appropriate), at least 85% of the time.</p>

Care Manager Requirements

Responsible For	<ul style="list-style-type: none">Care managers are responsible for high-risk patients at one or more defined practices where they work on an ongoing basis as a member of the care team and have relationships with practices and practice teams.
Located	<ul style="list-style-type: none">Care managers can be located within the practice site, nearby, or remotely, and available through telephone or in person through telepresence means.
Required Designation	<ul style="list-style-type: none">A care manager must be a registered nurse with a Bachelor's degree or a Master's prepared licensed social worker.
Acceptable Designations	<ul style="list-style-type: none">In the event the practice is unable to hire a care manager(s) with those qualifications, a licensed practical nurse or a Bachelor's in health or social services is acceptable.

Care Manager Role and Education Requirements cont.

- Care management for children/youth may differ from that for adult populations. Pediatric care management is a patient and family-centered, assessment-driven, team-based function designed to meet the needs of pediatric patients while enhancing the caregiving capabilities of families and promoting self-care skills and independence.
- Care management should be proactive and family-centered and address medical, social, developmental, behavioral, educational and social/financial needs while creating strong community relationships across the continuum of care.
- A care manager must be a registered nurse with a Bachelor's degree or a Master's prepared licensed social worker. In the event the practice is unable to hire a care manager(s) with those qualifications, a licensed practical nurse or a bachelors or an advanced degree in the behavioral health or social services field plus one year of relevant experience in clinical care management, care coordination, or case management are also acceptable.

Future Practice with Care Manager



In the future, your Care Manager and High Risk Registry will enable your practice to provide more coordinated and integrated care for high risk members.

TI Year 2 Measurement Period

October 1, 2017 – September 30, 2018

Reporting Requirement to the State:

By September 30, 2018:

- Identify at least one care manager assigned to provide integrated care management services for members listed in the practice high risk registry. Indicate the caseload per care manager full time equivalent (FTE)

AND

- Document that the duties of the practice care manager include the elements of care management listed in this Core Component, and document the process for prioritizing members to receive practice care management, consistent with Core Component 2,

AND

- Demonstrate that the care manager(s) has been trained in:
 - Use of integrated care plans
 - Member and family education
 - Facilitating linkages to community-based organizations, utilizing resources identified in Core

Attestation and Validation Documentation

- AHCCCS will be opening a TI Attestation Portal through **AHCCCS Online** (<https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f>)
- The portal will be available for milestone attestation in June 2018.
- Not all of the Milestones will require providers to upload documentation through the Attestation Portal for review by AHCCCS.
- In order to attest to meeting this Core Component, participants will need to show they have to identify a care manager(s), document duties, and demonstrate the care managers are skilled in certain requirements.
- More detailed information and guidance about how to use the TI Attestation Portal will be available prior to June 2018.

Sneak Peak of TI Year 3



Sneak Peek: TI Year 3 Measurement Period 2 October 1, 2018 – September 30, 2019

<p>3. Utilize practice care managers² for members included in the high-risk registry with a case load not to exceed a ratio of 1:100. Care managers may be employed directly or contracted by the practice from external sources. Practice level care management functions should include:</p> <ol style="list-style-type: none"> 1) Conducting a comprehensive assessment with the child/youth that includes family status and home environment assessment. 2) Playing an active role in developing and implementing integrated care plans. These plans should build on family strengths, plan for the transition of youth from pediatric to adult systems of care, as appropriate, and (if applicable) be developed with input from behavioral health Child and Family Teams.³ 3) Coordinating members' medical and behavioral health services, assuring optimal communication and collaboration with MCO and/or other practice case or care management staff so that duplication in efforts does not occur and that member needs are addressed as efficiently as possible. 4) Ensuring the provision of member/family education to help build self-management skills and equipping families with the skills needed to navigate a complex health care system. 5) Working with members and their families to facilitate linkages to community organizations, including social service agencies. 	
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Sneak Peek: TI Year 3 Measurement Period October 1, 2018 – September 30, 2019

Practice Reporting Requirement to State

By September 30, 2019:

- Document that care managers have been trained in motivational interviewing to facilitate family engagement and self-management support, and when appropriate, child/youth engagement and self-management support **AND**
- Based on a practice record review of a random sample of 20 members, whom the practice has identified as having received behavioral health services during the past 12 months, attest that the care manager has documented: a) completing a comprehensive assessment, b) educating families, c) conducting motivational interviewing, d) appropriately facilitating linkages to community organizations, and e) planning for the transition of youth from pediatric to adult systems, (as appropriate), at least 85% of the time.

Questions?

Please contact us at
targetedinvestments@azahcccs.gov
if you have any questions



Thank You.

