Iowa Medicaid's Proposed Health Home Model – Provider Standards

IME is seeking comments regarding the below standards from interested Iowa stakeholders. Please direct comments to Marni Bussell at mbussel@dhs.state.ia.us or (515)256-4659.

I. Provider Standards

To enroll as a health home practice, Designated Providers must sign an agreement attesting adherence to the below standards:

1. **Recognition/Certification –**
   - **a.** Comply with standards specified in the Iowa Department of Public Health rules. Those rules will likely require National Committee for Quality Assurance (NCQA) or other national accreditation.
   - **b.** Until those rules are final, providers shall meet the following recognition/certification standards:
     - Complete the TransforMed self-assessment and submit to the State at the time of enrollment in the program.
     - Achieve NCQA or other national accreditation within the first year of operation
       - a. Exception applied for Health Homes past the first year where an application has been submitted and pending ruling. The Health Home must prove application submission status on demand and the State may terminate health home enrollment if recognition/certification status has not be achieved within 2 years of operation.
2. **Personal provider for each patient**
   - **a.** Each patient has an ongoing relationship with a personal provider, physician, nurse practitioner or physician assistant, trained to provide first contact, continuous and comprehensive care, where both the patient and the provider/care team recognize each other as partners in care. This relationship is initiated by the patient choosing the health home. [1]
   - **b.** The patient has the right to leave the health home at any time.
3. **Practitioner-Directed Care Team**
   - **a.** Eligible patients[2] shall have a Continuity of Care Document (CCD), detailing all important aspects of the patient's medical needs, treatment plan and medication list. The CCD shall be updated and maintained by the health home team including the personal provider.
4. **Whole Person Orientation**

[1] Definition developed in part by the following two sources: (http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home) and (Ed Wagner, MD, MPH, MACP; MacColl Institute for Healthcare Innovation, Group Health Research Institute.

[2] Eligible patients include members with a serious and persistent mental illness, two chronic conditions or one chronic condition and at risk for a second.

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a. The provider is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, long term care, and end of life care.[3]

5. **Coordinated/Integrated Care**
   a. Dedicate a care coordinator, defined as a member of the practitioner-directed care team, responsible for assisting members with medication adherence, appointments, referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support and/or lifestyle modification, and behavior changes.
   b. Communicate with patient, and authorized family and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.
   c. Monitor, arrange, and evaluate appropriate evidence-based and/or evidence informed preventive services.
   d. Coordinate or provide:
      - Mental health/ behavioral health
      - Oral health
      - Long term care
      - Chronic disease management
      - Recovery services and social health services available in the community
      - Behavior modification interventions aimed at supporting health management (e.g., obesity counseling, tobacco cessation, health coaching)
      - Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
   e. Maintain system and written standards/protocols for tracking patient referral.
6. **Emphasis on Quality and Safety**
   a. Demonstrate use of Clinical Decision Support within the practice workflow.
   b. Demonstrate evidence of acquisition, installation and adoption of an electronic health record (EHR) system and establish a plan to meaningfully use health information in accordance with the Federal Register requirement.
   c. When available, connect to and participate with the Statewide Health Information Network (HIN).
   d. Each health home shall implement or support a formal Diabetes Disease Management Program. The Disease Management Program shall include:
      - The goal to improve health outcomes using evidence-based guidelines and protocols.
      - A measure for diabetes clinical outcomes that include timeliness, completion, and results of A1C, LDL, microalbumin, and eye examinations for each patient identified with a diagnosis of diabetes.
      - The Department may choose to implement subsequent required disease management programs anytime after the initial year of the health home program.

[3] Definition cited from (http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home)

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Based on population-specific disease burdens, individual health homes may choose to identify and operate additional disease management programs at anytime.

e. Each health home shall implement a formal screening tool to assess behavioral health (mental health and substance abuse) treatment needs along with physical health care needs.

f. Provide the Department outcomes and process measure reporting as defined in the health home model.

7. Enhanced Access

a. Provide for 24/7 access to the care team that includes, but is not limited to, a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations.

b. Monitor access outcomes such as the average 3rd next available appointment and same day scheduling availability.

c. Use of email, text messaging, patient portals and other technology as available to the practice to communicate with patients is encouraged.

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