I-PaCS Standards and Contracting Requirements

Primary Care Linked Strategy (PCLS)

Comprehensive Patient Support (ComPS)

Support for any Medicaid beneficiary who comes to a primary care site and who screens positive for 1 or more social needs included in the WellRx questions or Z-codes in ICD-10 and / or may require health system navigation or prevention-related services to stop the progression of a recently identified health issue. For Comprehensive Patient Support, CHWs provide general information about and facilitate access to available resources, provide health education or other information, and assist in scheduling appointments with social services agencies.

Model/Framework

	STANDARD	REQUIRED ACTION / DELIVERABLE	I-PaCS	CMS-ACH	PI-CCHH	PCMH	SIM
ELEMENT A Assess and stratify member's individual needs	**A1. Document** the number of Medicaid members that access the clinic annually for preventive services and/ or care.	☐ Provide written documentation of policy regarding consistent recordkeeping and documentation. ☐ Monthly report.		*			
	A2. Verify Medicaid eligibility, contact and demographic information.	☐ Keep and submit log of contact or record review. ☐ Document proof of Medicaid eligibility in patient record.					
	A3. Well Rx Screening: Minimum of 80% of CE patients who access the clinic are offered a screening for social determinants of health at each visit [using the Well Rx and/or CMS Z-Codes in patient health records].	☐ Administer WellRx and record results in patient record. ☐ Provide written documentation of policy regarding administration of WellRx. ☐ Enter corresponding Z-codes in EHR system. ☐ Annual report with analysis of WellRx results, report of Z-codes entered into EHR.	*	*	*	*	*
	A4. SF-12: 100% of Medicaid members who screen positive for adverse SDH and want services, complete or are offered an SF-12 to determine member's self-assessment of functionality. SF-12 completed at intake and yearly at annual exam.	☐ Provide written documentation of policy to offer SF-12 to all MCO members. ☐ Administer SF-12 to those who are interested. ☐ Document results in patient record. ☐ Annual report with number and % of MCO members completing SF-12 and analysis of SF-12 results. The research core, if needed, will provide technical assistance.	*				

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	A5. Identify high-risk or complex patients (see IPS definition) and communicate with MCO regarding these members, following established criteria and process.	☐ Provide written documentation of high-risk or complex patients. ☐ Monthly invoice report with documentation.				*	*
	A6. Pre-visit preparation is conducted. [e.g. CHW checks the EMR of each Medicaid member to see if he/she has been ordered lab tests, referrals to specialists, etc. Checks the MCO referral to see why these patients are considered eligible for care coordination services.]	☐ Provide written documentation of PnP for pre-visit review. ☐ Documentation system for obstacles and member needs. ☐ Report summarizing obstacles and member needs.	*			*	*
	A7. Review clinical diagnoses and primary care referrals from prior visits. Determine status of follow-up and any member obstacles and needs.	☐ PnP showing review process. ☐ Documentation of obstacles or member needs. ☐ Report summarizing obstacles and member needs.					
ELEMENT B Community Service & Health Care Navigation	**B1. Systems:** The CE establishes referral and follow-up systems for social or related services. The CHW matches Medicaid member's identified social needs with community service providers and/or assists member to identify other social supports.	☐ Community services resource inventory. ☐ Documentation of CE referrals to CHW. ☐ Keep CHW log of intervention with patient including patient referral to community service providers and other social supports. ☐ Create patient care plan as appropriate (IPS members only).	*	*			
	B2. **Referral review** and summary with Medicaid member and distributes copy to member.	☐ Provide written documentation of policy to ensure that information is provided to patients in a consistent manner.		*			
	B3. Community resource list: Maintains a current community resource list on topics of importance to the Medicaid member population as determined by WellRx or Z-codes.	☐ Sample list of community resources		*		*	*

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ELEMENT C Follow-up	**C1. Documentation**: CE documents the follow-up contact with Medicaid member within 2 weeks of member accepting community referral.	☐ Create community services resource inventory. ☐ Keep log of contact with member.	*	*			
	C2. Results: Documentation of Medicaid member connection with community service provider or connection unattained and determined as unresolvable.	☐ Keep log of contact with members who accept intervention. ☐ Document outcomes of referral in Log of Contact ☐ Create Care Plan (IPS members only).		*			
	C3. Contact: When Medicaid member has an appointment with healthcare provider at the clinic, CHW or other clinic staff calls the day before and assesses if patient would like to meet again.	☐ Keep Log of Contact or record review. ☐ Provide written documentation of PnP regarding referral and follow-up system.					
ELEMENT D Documentation and Data Collection	**D1. Policy and procedure:** CE has policy and procedure (PnP) for documenting Medicaid member's information (name, DOB, race, ethnicity, telephone, address, dates of previous clinical visits, PCP, etc.) if separate from the primary care provider information system. If one system, verifies Medicaid member's information.	☐ Provide written documentation of PnP for documentation of patient data. ☐ Register patients. ☐ Keep log of contact or record review.					
	D2. Forms and operations: PnPs support documentation of CHW intervention using standard forms and operating procedures. Information must include Medicaid member name, ID, DOB, subscriber ID, CHW name, length of interaction time, nature of interaction, results of interaction, follow-up and resolution.	☐ Provide written documentation of PnP to document CHW interventions. ☐ Keep log of contact or record review.					
	D3. Encounters: PnPs support documentation of each encounter with a Medicaid member and possible systemic barriers faced by members	☐ Provide written documentation of PnP to identify and document member barriers. ☐ Keep log of contact or record review.					
	D4. Patient satisfaction: The practice conducts a patient satisfaction survey to evaluate Medicaid member/family experience on at least three categories according to CE approved PnPs.	☐ Provide written documentation of PnP to administer patient satisfaction survey. ☐ Administer patient satisfaction survey and provide summary of survey results.				*	

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ELEMENT E Culturally and Linguistically Appropriate Services	**E1. Race/ethnicity**: Assess the racial and ethnic diversity of the Medicaid members.	☐ Provide written documentation of PnP to document racial and ethnic self-identification of MCO members ☐ Summary of racial and ethnic report.				*	*
	E2. Language: Assess the language needs of the Medicaid members.	☐ Provide written documentation of PnP to assess the language needs of MCO members. ☐ Summary of language needs report.				*	*
	E3. Services: Provide clinically relevant materials and prevention services that meet the language needs of Medicaid.	☐ Provide written documentation of PnP to provide linguistically appropriate materials to MCO members. ☐ Examples of services provided.				*	*
	E4. Materials: Provide printed materials in the languages of MCO members.	☐ Screen shot or supporting documentation.				*	*
ELEMENT F CHW Care Coordination Training, Supervision, and Practice Team	**F1. Role/scope**: CE demonstrates job descriptions and processes that define CHW (and/or other CE staff) that ensure role and scope for comprehensive patient support.	☐ Provide written documentation of job description. ☐ Provide written description of patient flow matrices or operational policies for patient support services.				*	*
	F2. Training: At a minimum, CE will document that CHWs or other CE staff have functional comprehensive patient support knowledge in: prevalent health conditions, mental health disorders, substance use disorders, interviewing techniques, care planning, cultural competency, self-advocacy, self-direction, parent/family engagement, and community-specific resources, data collection and documentation.	☐ Provide written documentation of policy related to CHW training requirement. ☐ Create a training schedule. ☐ Create HR system for documentation of training. ☐ Provide documentation of training curriculum.		*			
	F3. Supervision: CE provider staff and staff with ties to clinic operations, provide supervision.	☐ Provide written documentation of job description. ☐ Provide documentation of org chart outlining supervisory roles.					
	F4. Check-ins: For CHWs providing comprehensive patient support, one-on-one supervision is provided at least bi-weekly (2x per month).	☐ Provide supervision. ☐ Supervisor keeps notes from check-ins and supervisory meetings.					
	F5. Communication: Having regular CHW team meetings or a structured communication process between CHWs and providers, and among CHWs, regarding identified clinical and social issues.	☐ Provide documentation of PnP regarding regular CHW team meetings and communication. ☐ Keep minutes from meetings (at least quarterly) ☐ Create and keep agendas from meetings.				*	

INTENSIVE PATIENT SUPPORT (IPS)

CEs providing Intensive Patient Support must meet all standards for Comprehensive Patient Support Elements A-F, PLUS Elements G-I.

Individuals who qualify for Intensive Patient Support services must have a) two or more ER visits in last 12 months and identify at least 1 positive on the WellRx, or other social determinant screening tool; b) more than 4 positives on the WellRx or other social determinant screening tool; or c) be referred to the I-PaCS provider by the MCO. CHW intervention may include more intensive follow-up and referral monitoring, home visits, individualized and approved care plans, chronic disease management, case review by MCOs, applying for a broad range of social service assistance, etc.

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ELEMENT G Verification of Eligibility	**G1. Well Rx**: Complete initial clinical and SDH assessment (WellRx or Z-codes) within 30 days of referral from MCO.	☐ Complete assessment. ☐ Place assessment results in patient file. ☐ Provide documentation of completed assessments.					
	G2. PCP: Medicaid member's primary care provider's office of record, if known, is contacted to inform provider of involvement with member.	☐ Keep log of contact or record review					
ELEMENT H Referral Follow-up	**H1. Monthly follow-up:** CHW will follow-up at least monthly with Medicaid member to assess status of social services referral(s), prescription adherence and/ or referrals to specialists or for labs.	☐ Conduct monthly follow-ups. ☐ Keep log of contact or record review. ☐ Document results of follow-up contacts.					
	H2. Missed appointments: CHW will follow up with Medicaid members who have not kept important appointments.	☐ Keep log of contact or record review.				*	*
ELEMENT I Plan and Manage Care	**I1. Develop Care Plan**: CHW collaborates with patient/family/treatment team to develop individual care plan including goals that are updated at each relevant visit.	☐ Document visit to develop plan of care in log of contact. ☐ Plan of care is documented in patient record.	*	*		*	*
	I2. Share with member: Medicaid member is given a written care plan according to established CE protocols.	☐ Monthly report or record review.				*	*

	I3. Referral: Refers at-risk Medicaid members to educational resources to assist in chronic disease self-management and/or other health issues. Provides a list of community resources.	☐ Maintain referral-tracking log. ☐ Enter activity into patient record.	*			*	*
	I4. PCP Relationship: Work with Medicaid member to develop an ongoing relationship with their Primary Care Provider by serving on a care team or facilitating access to initial or follow up patient visits and serving as a patient advocate within the CE.	☐ Maintain in log. ☐ Enter activity into patient record.	*				
	I5. Services: If CE offers group visits or educational services, the CHW or other CE representative coordinates group visits for members with similar chronic diseases. If not, the CE facilitate access to peer support or other group modalities for care coordination and support.	☐ Create and keep meeting agenda. ☐ Take and keep meeting minutes. ☐ Create and keep meeting sign-in sheet. ☐ Other peer support activities are documented in log of contact.	*				
	I6. Navigation: Medicaid member is educated in navigating health care system (Nurse Advice Line, use of ER, urgent care, etc.) more appropriately.	☐ Maintain log of contact or record review. ☐ Maintain CHW intervention log.	*				
	I7. Utilization: Medicaid member is educated on best way to utilize their PCP, SPC, Urgent Care facilities and other condition management programs.	☐ Maintain log of contact or record review.					
	I8. Monitoring: Plan of Care is developed in collaboration with Medicaid member, MCO and CHW including goals that are updated at each relevant visit.	☐ Complete and have patient sign Plan of Care. ☐ Place copy of care plan in patient record				*	*
	I9. Review goals: Meet with MCO to review and determine if Medicaid member has successfully met established goals in Plan of Care at the end of 180 days.	☐ Maintain log of contact or record review.	*				
	I10. Report to MCO on Plan of Care including but not limited to the Medicaid member's progress and barriers and solutions to member's care.	☐ Maintain log of contact or record review.					
	I11. Duration of services: Continue to see Medicaid members until such time as the member is no longer eligible to receive services; refuses services; us unable to be contacted; has successfully met Plan of Care goals; or is unwilling or unable to comply with Plan of Care.	☐ Maintain log of contact or record review.					

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ELEMENT J CHW Training, Supervision and Practice Team	**J1. Role/scope**: Define CHW role and scope for the Intensive Patient Support services for both clinical and nonclinical team members.	☐ Provide written documentation of job description. ☐ Provide written documentation of PnP for reporting.				*	*
	J2. Training: At a minimum, Level 3 CHWs shall have functional knowledge in all the comprehensive patient support areas.	☐ Provide written documentation of policy related to CHW training requirement. ☐ Provide documentation of training curriculum. ☐ Create a training schedule. ☐ Create HR system for documentation of training		*		*	*
	J3. Supervision is provided by CE staff with ties to primary care operations and providers.	☐ Provide written documentation of job description. ☐ Provide documentation of org chart.					
	J4. Check-ins: For CHWs providing Intensive Patient Support, one-on-one supervision is provided at least bi-weekly (2x per month).	☐ Provide supervision. ☐ Supervisor keeps notes from check-ins and supervisory meetings.					
	J5. Communication: Having regular CHW team meetings or a structured communication process between CHWs and providers regarding identified social issues.	☐ Provide documentation of PnP regarding regular CHW team meetings and communication. Keep minutes from meetings (at least quarterly) ☐ Create and keep agendas from meetings.				*	

Community Health Improvement Strategy (CHIS)

	STANDARD	REQUIRED ACTION / DELIVERABLE	I-PaCS	CMS-ACH	PI-CCHH	PCMH	SIM
ELEMENT K Community Assessment	**K1. Social needs**: Contracting Entity (CE) works with Health Council, or other community health planning entity, to conduct an assessment of Medicaid patient health and social needs that includes inquiry, analysis and action. Inquiry: Collect data from Medicaid patients and how needs relate to a community-wide perspective Analysis: Analyze trends within the data and establish priorities for health interventions, bearing in mind that any intervention must be appropriate to Medicaid members within the context of the particular community. Action: A written action/work plan and updates on the interventions. Communications with the community take place to ensure outcomes are satisfactory to all.	☐ Summary of Medicaid members' socials needs are shared with community ☐ Community assessment is conducted incorporating Medicaid members' social needs. ☐ Provide written documentation of time-framed and prioritized action/work plan and strategies. ☐ Provide monthly updates included with MCO invoices for I-PaCS payments.				*	
	K2. Health needs: CE works with Health Council or related entity to conduct a community assessment of health equity/disparities. Assessment to include key factors impacting the health of Medicaid patients **OR** CE works with Health Council or related entity to conduct a comparative analysis of health status indicators to determine health disparities between Medicaid eligible individuals to determine health disparities.	☐ Identify population health data sources. ☐ Identify key equity issues for the community.	*				*
	K3. Grassroots efforts: CE demonstrates CHW or other CE representative's participation in grassroots efforts to address social issues that affect the health of Medicaid community members. If participation is not by CHW, CE must demonstrate how information is shared with CHWs and providers.	☐ Create and keep meeting agendas. ☐ Take and keep meeting minutes. ☐ Keep sign in sheets. ☐ Create community action plans. ☐ Keep plan updates. ☐ Keep meeting logs. ☐ Document communication between CE representative (if applicable), CHWs and providers.					*

	STANDARD	REQUIRED ACTION / DELIVERABLE	I-PaCS	CMS-ACH	PI-CCHH	PCMH	SIM
ELEMENT L Outreach	**L1. Preventative services**: CE demonstrates efforts to inform all clinic-registered Medicaid members about the benefits of clinical preventive services [...including but not limited to primary medical, dental and behavioral health care, nurse advice line, and preventive services such as pre-natal care, vaccines and screenings.]	☐ Create PnP for disseminating information. ☐ Copies of materials disseminated and/ or of electronic communication.	*	*			
	L2. Community resources: CE demonstrates efforts to inform all clinic-registered Medicaid members about community resources available to support preventive care including but not limited to health education classes around healthy and active living, nutrition, walking groups, cooking classes and other health prevention related issues; and information events such as health fairs and eligibility and enrollment fairs.	☐ Create PnP for disseminating information. ☐ Copies of materials disseminated and/ or of electronic communication.	*				*
	L3. Resource list: CHWs and/or other CE staff contributed to community resource list, which may include SHARE NM.	☐ Create list or database of community services and coalitions. ☐ Create PnP for ensuring that the list is maintained and updated.		*			*
ELEMENT M Culturally and Linguistically Appropriate Services	**M1. Role/scope:** Defined CHW role and scope for population health strategies.	☐ Provide written documentation of job description.					
	M2. Population Health CHW Training: At a minimum, CHWs shall have functional knowledge in: leading and/or participate in community health-related coalitions, community needs assessment, interviewing skills, and effective oral communication.	☐ Provide written documentation of policy regarding training. ☐ Provide written documentation of training schedule and curriculum.					
	M3. Communication: CE has regular CHW team meetings or a structured communication process between CHWs and providers regarding identified population health and social issues.	☐ Provide documentation of PnP regarding regular CHW team meetings and communication. ☐ Keep minutes from meetings (at least quarterly). ☐ Create and keep agendas from meetings.				*	