

Appendix 6: Guidance for DEPARTMENT Initiatives provides additional information for several of the required DEPARTMENT Initiatives of Section 215B of the AGREEMENT. Upon request by the DEPARTMENT, the CONTRACTOR will be required to report protocols for the DEPARTMENT Initiatives confirming administration and compliance with each DEPARTMENT Initiative. Where appropriate, the CONTRACTOR may assign responsibility for delivery of the DEPARTMENT Initiative(s) to providers or subcontractors; however, the CONTRACTOR will remain responsible for the quality of the DEPARTMENT Initiatives and all DEPARTMENT reporting requirements.

215B 1) Care Coordination

At a minimum, the CONTRACTOR must provide care coordination efforts under this requirement to PARTICIPANTS who have a diagnosis of heart failure, myocardial infarction, or pneumonia.

The CONTRACTOR shall provide documentation to the DEPARTMENT detailing the care coordination program that is established which must include:

- a. Communication by telephone or home visit to the PARTICIPANT within 3 to 5 business days following the initial discharge from an INPATIENT HOSPITAL stay of more than 24 hours, and
- b. At a minimum, the communication, as applicable to the PARTICIPANT, must cover: (1) medication reconciliation; (2) arrangement for timely follow-up with provider; (3) discussion of any possible problems or troubling symptoms being experienced by the PARTICIPANT; and (4) notification to the PARTICIPANT regarding whom the PARTICIPANT or PARTICIPANT'S family should contact if problems arise before the PARTICIPANT'S post-discharge visit with the provider.

Reporting Metrics

Denominator

Inclusion: PARTICIPANTS \geq 18 years of age discharged from an INPATIENT HOSPITAL stay of more than 24 hours.

Exclusions: PARTICIPANTS also enrolled in Medicare.

Numerator

Number of successful PARTICIPANT contacts that occurred within 3 to 5 business days of a PARTICIPANT'S initial discharged from an INPATIENT HOSPITAL stay of more than 24 hours.

In addition, the CONTRACTOR must:

- a. Further identify the denominator in the report by detailing the type of PARTICIPANTS targeted for care coordination such as: (1) all PARTICIPANTS discharged or (2) specific PARTICIPANT population(s) at high risk for readmission.
- b. Report by the method type of communication used for care coordination, such a phone call or home visit.
- c. The CONTRACTOR must report the number of PARTICIPANTS targeted for each communication type.

215B 2) High Tech Radiology

Acceptable CONTRACTOR approaches toward demonstrating effective and appropriate means of monitoring and directing PARTICIPANT care for prior authorization of high tech radiology include utilization of:

- a. National vendor (e.g. NIA, AIM, etc.);
- b. Software program embedded in electronic medical records (e.g. RadPort or Medicalis); and/or
- c. Medical director review based on evidence-based guidelines (e.g. Milliman), which should, at a minimum, cover all requests by advanced primary care practitioners, internists, family physicians, and pediatricians.

215B 3) Low Back Surgery

Clinical diagnoses or scenarios requiring immediate or expedited referral are referred to as “red flag” situations and include:

- a. The PARTICIPANT has a history of cancer, unexplained weight loss and/or fever, recurrent nighttime pain, immunosuppression or injection drug abuse;
- b. The PARTICIPANT has symptoms suggesting cauda equina syndrome (typically bowel and bladder dysfunction, e.g. urinary retention; saddle anesthesia; and bilateral leg weakness and numbness);
- c. The PARTICIPANT has suspected spinal cord compression, e.g. acute neurologic deficits in a patient with cancer and risk of spinal metastases, and requires emergent evaluation for surgical decompression or radiation therapy; or
- d. The PARTICIPANT has a progressive or severe neurologic deficit.

The CONTRACTOR shall demonstrate that prior authorization criteria are evidence-based (e.g. failure of conservative care that includes management by a physiatrist or co-management by a primary care practitioner that includes physical therapy or chiropractic treatment for at least 3 months).

215 B 4) Shared Decision Making (SDM)

A SDM program is meant to promote informed decision making by the PARTICIPANT. SDM programs are designed to inform PARTICIPANTS about the range of options, outcomes, probabilities, and scientific uncertainties of available treatment options so that the PARTICIPANT can decide the best possible course of treatment.

Satisfaction surveys must be provided to the PARTICIPANT within one month of receiving the Patient Decision Aid (PDA). Unless prior approval is received from the DEPARTMENT, the PARTICIPANT satisfaction survey must contain, at a minimum, the following questions:

1. After reading the [*SDM program name*] and/or discussing your options with [*provider type*], do you have a better understanding of the pros and cons of your treatment options?
 - a. Yes, much better
 - b. Yes, somewhat better
 - c. No, I didn't learn anything new
 - d. No, I am now more confused
2. Do you think the information in the [*SDM program name*] will make your next conversation with your [*provider type*] more effective?
 - a. Yes, much more effective
 - b. Yes, somewhat more effective
 - c. No, somewhat less effective
 - d. No, less effective

Reporting Metrics

Denominator

Inclusion: Number of PARTICIPANTS \geq 18 years of age with acute or subacute low back pain who visited an orthopedist or neurosurgeon for a surgical consultation.

Exclusions: PARTICIPANTS also enrolled in Medicare. PARTICIPANTS presenting “red flag” situations.

Numerator

Number of PARTICIPANTS who receive a PDA and an opportunity for provider follow-up prior to a surgical consultation with an orthopedist or neurosurgeon.

The CONTRACTOR must also provide the DEPARTMENT a summary of the satisfaction survey results including the number distributed and completed.

215B 5) Advanced Care Planning (ACP)/Palliative Care

Reporting Metrics

Denominator

Inclusion: Number of PARTICIPANTS \geq 18 years of age who died during the reporting year.

Exclusions: PARTICIPANTS also enrolled in Medicare.

Numerator

Number of PARTICIPANTS who engaged in one or more ACP conversations.

Number of PARTICIPANTS who accessed hospice care, either in-home or facility based.

Denominator

Inclusion: Number of PARTICIPANTS \geq 18 years and also enrolled in Medicare who died during the reporting year.

Numerator

Number of PARTICIPANTS who engaged in one or more ACP conversations.

Number of PARTICIPANTS who accessed hospice care, either in-home or facility based.