**2022 – CCT and HOME Provider Team Core Standards Report**

Please complete the form below and sign to attest the accuracy of the information. In the empty space provided beside each Core Standard found in [MaineCare Benefits Manual, Chapter II, Section 91.02-5(a-j)](https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s091.docx), please explain how your organization is currently meeting the requirement:

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| --- | --- |
| Name of Organization: | |
| Date: | |
| Name of Individual Completing this Form: | |
| **Core Standards** | **Description of Core Standards Sustained Implementation** |
| **Demonstrated Leadership** | |
| CCTs and HOME Providers shall identify at least one individual as a leader within the care team who champions the implementation and continued maintenance of the Core Standards. |  |
| **Team-Based Approach to Care** | |
| CCTs and HOME Providers shall implement a team-based approach to comprehensive care management, coordination, and supports that includes expanding the roles of non-billable professionals (e.g. nurses, medical assistants, peer support staff, CHWs, and/or housing navigators). CCTs and HOME Providers shall review policies, procedures, data, and structures to improve care delivery, access, efficiency, and Member engagement in specific ways, including two or more of the following:     1. Identifying roles and responsibilities across care team members; 2. Training on and integration of non-licensed team professionals as meaningful partners in service delivery; 3. Holding regular team meetings; 4. Expanding Member education and support opportunities; and 5. Providing greater data support to enhance the quality and cost-effectiveness of CCT and HOME Providers services. |  |
| **Population Risk Stratification and Management** | |
| CCTs and HOME Providers shall adopt processes internally and with external partners (e.g., primary care practices, behavioral health providers, social service agencies) to identify and stratify patients who are at risk for adverse outcomes and shall adopt procedures that direct resources or care processes to reduce those risks. CCTs and HOME Providers shall utilize predictive analytics and/or risk models based on clinical, demographic, social, and/or other model inputs. CCTs and HOME Providers shall retain risk assessment documentation in the Member’s record.  (“Adverse outcomes” includes, but is not limited to, loss of housing, incarceration, or a negative clinical outcome and/or avoidable use of healthcare services such as crisis services, hospital admissions, and/or emergency department visits.) |  |
| **Enhanced Access to Care** | |
| The CCTs and HOME Providers shall enhance access to services for their population by: |  |
| 1. Ensuring access to Member records twenty-four (24) hours a day, seven (7) days a week; |  |
| 1. Implementing processes to monitor and ensure access to care, e.g., from referral to intake; and |  |
| 1. Following up on Member inquiries within one (1) business day of the Member’s inquiry. |  |
| ***In addition, if you are a HOME provider;*** Home providers shall have a system in place, such as an on-call staff or answering service, for Members to reach a member of the organization or an authorized entity twenty-four (24) hours a day, seven (7) days a week to triage and address the Members’ needs. |  |
| **Integrated Care Management** | |
| CCTs and HOME Providers shall have policies and procedures in place to provide care management services for patients at high risk of experiencing adverse outcomes. Care management staff shall have clear roles and responsibilities, receive explicit training to provide care management services, and have processes for tracking outcomes for patients receiving care management services. CCTs and HOME Providers shall contribute to health management strategies and planning processes with their clinical and community partners. |  |
| **Behavioral-Physical Health Integration** | |
| Annually, CCTs and HOME Providers shall submit a completed assessment of their Behavioral and Physical Health Integration progress and identify an area of focus for the following twelve-(12) month period to improve Behavioral and Physical Health Integration. The assessment tool will be provided by the Department. |  |
| **Inclusion of Patients and Families** | |
| CCTs and HOME Providers shall include and document Members and family members as regular participants at leadership meetings or in committees/meetings to advise leadership on patient-centered needs and solutions to improve services. |  |
| CCTs and HOME Providers shall implement systems to gather Member and family input at least annually (e.g., via mail survey, phone survey, point of care questionnaires, focus groups, etc.). CCTs and HOME Providers shall have a process in place to design and implement changes that address needs and gaps in care identified via Member and family input. |  |
| **Connection to Community Resources and Social Support Services** | |
| CCTs and HOME Providers shall have processes in place to identify local community resources and social support services, including those that provide self-management support to assist Members overcome barriers to care and meet health goals and health-related social needs. |  |
| **Commitment to Reducing Waste, Unnecessary Healthcare Spending, and Improving Cost-effective Use of Healthcare Services** | |
| CCTs and HOME Providers shall implement processes to reduce wasteful spending on healthcare resources and to increase the cost-effective use of healthcare services as evidenced by at least one initiative that targets waste reduction from the following list:     1. Reducing avoidable hospitalizations; 2. Reducing avoidable emergency department visits; 3. Reducing avoidable escalation of service needs such as crisis, residential, and inpatient stays; 4. Directing referrals to medical and/or behavioral health specialists who consistently demonstrate and document high quality and cost-efficient use of resources. |  |
| **Integration of Health Information Technology** | |
| CCTs and HOME Providers shall use an electronic data system that includes identifiers and utilization data about patients. Member data is used for monitoring, tracking, and indicating levels of care complexity for the purpose of improving patient care.    The system is used to support Member care, including one or more of the following:     1. The documentation of need and monitoring of clinical care; 2. Supporting implementation and use of evidence-based practice guidelines; 3. Developing plans of care and related coordination; or 4. Determining outcomes (e.g., clinical, functional, satisfaction, and cost outcomes); or 5. Assessing risk (e.g., predictive analytics, risk scores/models). |  |
| *By submitting this report to the Department, you attest that the information you have submitted is accurate to the best of your understanding.* | |