

Ohio Medicaid Health Homes

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**INFORMATIONAL WEBINAR FOR
HOSPITALS**

SEPTEMBER 21, 2012

A Health Home is ...

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- A new service delivery model for Medicaid consumers with uncoordinated care
- Whole person care coordination / care management for consumers with complex conditions
- Person-centered planning approach to identify needed services and supports
- Consideration of the needs of the person without compartmentalizing aspects of the person, his/her health, or his/her well-being
- Providing care and linkages to care that address all of the clinical and non-clinical needs

Related to, but Not the Same as, the Patient-Centered Medical Home

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- Use Patient-Centered Medical Home (PCMH) as foundation for Medicaid Health Homes
- Medicaid Health Homes expand on PCMHs by:
 - Focusing on patients with multiple chronic and complex conditions;
 - Coordinating across medical, behavioral, and long-term care; and
 - Building linkages to community, social supports, & recovery services
- Focus on outcomes – reduced ED & hospital admissions & readmissions, reduced reliance on LTC facilities, improved experience of care and quality of care

Health Home Goals are...

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- Improve care coordination
- Improve integration of physical and behavioral health care
- Improve health outcomes
- Lower rates of hospital emergency department use
- Reduce hospital admissions and readmissions
- Decrease reliance on long-term care facilities
- Improve the experience of care and quality of life for the consumer
- Reduce healthcare costs

Eligible Health Home Consumers Are...

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- **Adults and children with Medicaid who have:**
 - Serious and Persistent Mental Illness
 - Serious Mental Illness
 - Serious Emotional Disturbance
- **Eligible consumers include:**
 - Persons currently receiving services at the community mental health agency
 - Persons referred to health home from hospitals, specialty providers, MCP or other referral sources
- **Eligibility will be determined at the health home**

Health Home Population Criteria: Serious and Persistent Mental Illness

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- **Serious and Persistent Mental Illness (SPMI):**
 - Must be 18 years of age or older
 - Must meet criteria for any of the DSM-IV TR diagnoses, except the exclusionary diagnoses (DD, AOD, V Codes & Dementia)
 - Treatment history criteria
 - Global Assessment of Functioning scale (GAF) Score of 50 or below

Health Home Population Criteria: Serious and Persistent Mental Illness

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○ Treatment history criteria

- ✦ Continuous treatment of 12 months or more, or a combination of, the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or 12 months continuous residence in a residential program (e.g., supervised residential treatment program, or supervised group home); or
- ✦ Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent 12 month period; or
- ✦ A history of using two or more of the following services over the most recent 12 month period continuously or intermittently (this includes consideration of a person who might have received care in a correctional setting): psychotropic medication management, behavioral health counseling, CPST, crisis intervention.
- ✦ Previous treatment in an outpatient service for at least 12 months, and a history of at least two mental health psychiatric hospitalizations; or
- ✦ In the absence of treatment history, the duration of the mental disorder is expected to be present for at least 12 months.

Health Home Population Criteria: Serious Mental Illness

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- **Serious Mental Illness (SMI) :**
 - Must be 18 years of age or older
 - Must meet any of the DSM-IV TR diagnoses, except the exclusionary diagnoses (DD, AOD, V Codes & Dementia)
 - Assessment of impaired functioning measured by the GAF (score of 40 to 60)
 - Treatment history criteria

Health Home Population Criteria: Serious Mental Illness

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○ Treatment history criteria

- ✦ Continuous treatment of 6 months or more, or a combination of, the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or six months continuous residence in a residential program (e.g., supervised residential treatment program, or supervised group home); or
- ✦ Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent 12 month period; or
- ✦ A history of using two or more of the following services over the most recent 12 month period continuously or intermittently (this includes consideration of a person who received care in a correctional setting): psychotropic medication management, behavioral health counseling, CPST, crisis intervention; or
- ✦ Previous treatment in an outpatient service for at least six months, and a history of at least two mental health psychiatric hospitalizations; or
- ✦ In the absence of treatment history, the duration of the mental disorder is expected to be present for at least 6 months.

Health Home Population Criteria: Serious Emotional Disturbance

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- **Serious Emotional Disturbance (SED):**
 - ✦ Must be 17 years of age or younger
 - ✦ Must meet criteria for any of the DSM-IV TR diagnoses, except the exclusionary diagnoses (Developmental disorders, Substance use disorders, and V Codes)
 - ✦ Duration of the mental health disorder has persisted or is expected to be present for 6 months or longer
 - ✦ Assessment of impaired functioning as measured by the Global Assessment of Functioning scale (GAF Score of below 60)

Health Home Providers Are...

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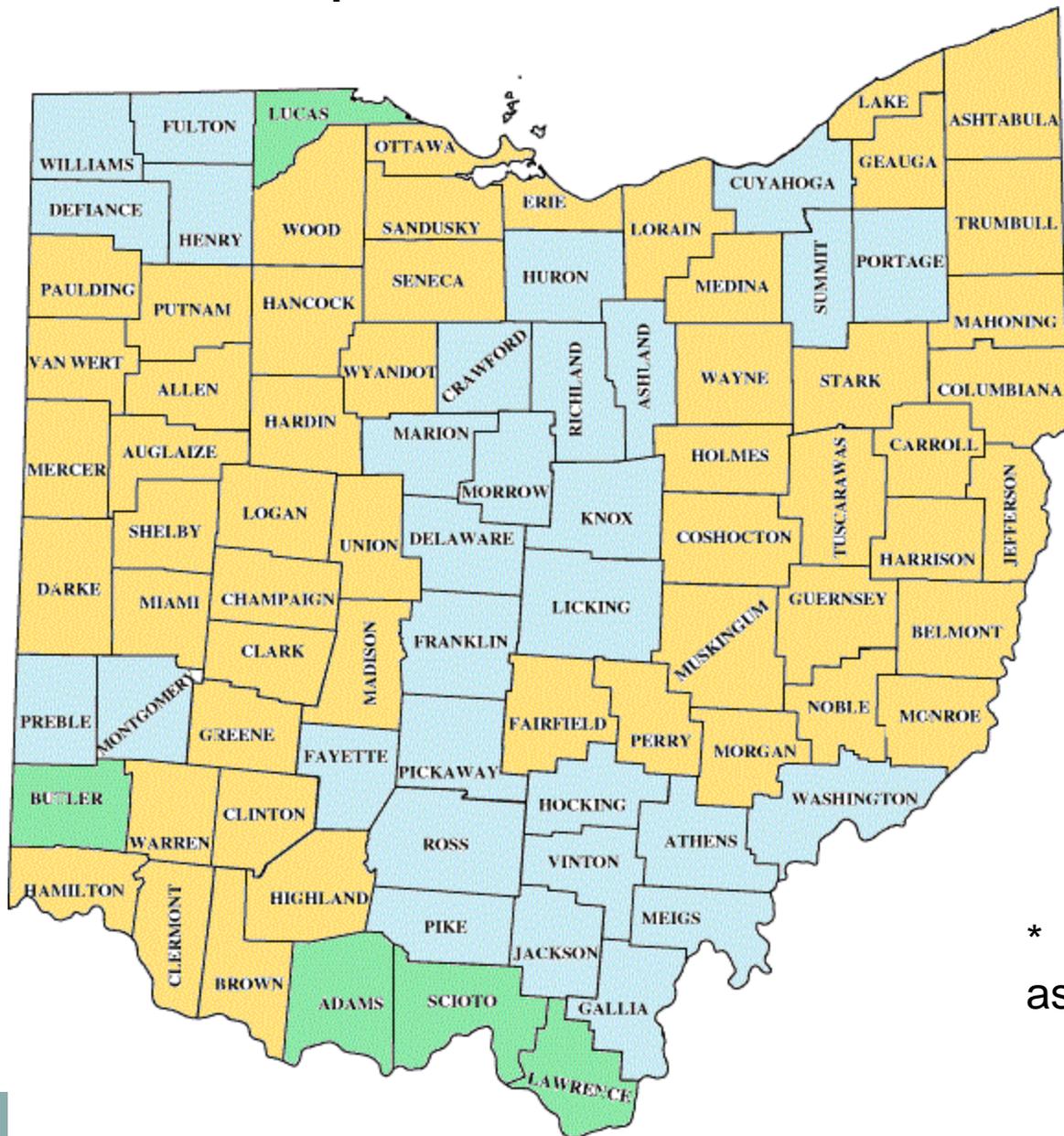
- Community Mental Health Agencies (CMHAs) who are certified to provide the Health Home service for individuals with SPMI and meet requirements as set forth in the State Plan Amendment (SPA) and Ohio Administrative Code (OAC); and
- Health Home Team that is housed at CMHAs and consists of the following four mandatory positions:
 - Health Home Team Leader
 - ✦ LISW, PCC, IMFT, RN-MSN, licensed psychologist, psychiatrist
 - Embedded Primary Care Clinician
 - ✦ Primary care physicians, pediatricians, gynecologists, obstetricians, Certified Nurse Practitioner/Clinical Nurse Specialist with primary care scope of practice and Physician Assistants).
 - Care Manager
 - ✦ LSW, LISW, PC or PCC, MFT or IMFT, RN Nurses
 - Qualified Health Home Specialist
 - ✦ Pharmacists, CPST/TO, wellness coaches, peer support specialists, certified tobacco treatment specialists, health educators and other qualified workers

Health Home Service Areas and Regional Implementation Schedules Are...

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- Phase I to be implemented in October 2012 in the following counties: Butler, Adams, Scioto, Lawrence, and Lucas;
- Phase II tentatively scheduled for implementation in April 2013 in the following counties: Fulton, Williams, Defiance, Henry, Cuyahoga, Summit, Portage, Huron, Crawford, Richland, Ashland, Marion, Morrow, Delaware, Knox, Franklin, Licking, Preble, Montgomery, Fayette, Pickaway, Hocking Ross, Vinton, Athens, Washington, Pike, Jackson, Gallia, and Meigs;
- Phase III tentatively scheduled for implementation in July 2013 in the remaining Ohio counties.

Health Home for SPMI Implementation Schedule based on Letters of Intent*



Recommended Implementation Schedule

Green - October
2012
Blue - April 2013
Yellow - July 2013

* Non-binding letters of intent
as submitted by CBHCs

Health Home Services Are...

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- **Comprehensive Care Management**
- **Care Coordination**
- **Health Promotion**
- **Comprehensive Transitional Care & Follow-up**
- **Individual and Family Support**
- **Referral to Community and Social Support Services**
- **Use of health information technology to link services**

Health Home Service Components

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- **Comprehensive Care Management**
 - Identification of consumers who are SPMI and potentially eligible for health home services;
 - Recruit and engage consumers through discussing the benefits and responsibilities of participating and any incentives for active participation and improved health outcomes;
 - Conduct comprehensive health assessment; form a team of health care professionals to deliver health home services based on the consumer's needs; establish and negotiate roles and responsibilities, including the accountable point of contact;
 - Develop and update the care plan.

Health Home Service Components

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• Care Coordination

- Implementation of individualized treatment plan;
- Assist consumer in obtaining health care, including mental health, substance abuse services and developmental disabilities services, ancillary services and supports;
- Medication management, including medication reconciliation;
- Track tests and referrals and follow-up as necessary;
- Coordinate, facilitate and collaborate with consumer, family, team of health care professionals, providers;
- Develop a crisis management and contingency plan working with the individual, family and significant others;
- Assist consumer in obtaining referrals to community, social and recovery supports, making appointments and validating that the consumer received the service;
- Monitor care plan and the individual's status in relation to his or her care plan goals;
- Reassess the consumer at least once every 90 days to determine if a change is needed in the treatment plan or if there is a change in health status;
- Provide clinical summaries and consumer information along with routine reports of treatment plan compliance to the team of health care professionals, including consumer/family.

Health Home Service Components

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- **Health Promotion**

- Provide education to the consumer and his or her family /guardian/significant other that is specific to his/her needs as identified in the assessment;
- Assist the consumer to acquire symptom self-monitoring and management skills so that the consumer learns to identify and minimize the negative effects of the chronic illness that interests with his/her daily functioning;
- Provide or connect the consumer with the services that promote healthy lifestyle and wellness and are evidence based;
- Actively engage the consumer in developing and monitoring the care plan;
- Connect consumer with peer supports including self-help/self-management and advocacy groups;
- Develop consumer specific self-management plan anticipating possible occurrence or re-occurrences of situations required an unscheduled visit to health home or emergency assistance in a crisis;
- Population management through use of clinical and consumer data to remind consumers about services need for preventive/chronic care;
- Promote health behavioral and good lifestyle choices;
- Educate consumer about accessing care in appropriate settings.

Health Home Service Components

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- **Comprehensive Transitional Care**
 - Coordinate with providers;
 - Facilitate and manage care transitions (inpatient to inpatient, residential, community settings) to prevent unnecessary inpatient admissions, inappropriate emergency department use and other adverse outcomes such as homelessness;
 - Develop a comprehensive discharge and/or transition plan with short-term and long-term follow-up;
 - Conduct or facilitate clinical hand-offs as face-to-face interactions between providers to exchange information and ask questions.

Health Home Service Components

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- **Individual & Family Support Services**
 - Provide expanded access and availability;
 - Provide continuity in relationships between consumer/family with physician and care manager;
 - Outreach to the consumer and their family and perform advocacy on their behalf to identify and obtain needed resources such as medical transportation and other benefits to which they may be eligible;
 - Educate the consumer in self-management of their chronic condition;
 - Provide opportunities for the family to participate in assessment and care plan development;
 - Ensure that health home services are delivered in a manner that is culturally and linguistically appropriate;
 - Referral to community supports; assist with “natural supports;”
 - Promote personal independence; empower consumer to improve their own environment;
 - Include the consumer family in the quality improvement process including surveys to capture experience with health home services; use of a patient/family advisory council at the health home site;
 - Allow consumers/families access to electronic health record information or other clinical information.

Health Home Service Components

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- **Referral to Community & Social Support Services**
 - Provide referrals to community/social/recovery support services;
 - Assist consumers in making appointments and validating that the consumer attended the appointment and the outcome of the visit and any needed follow-up.

Hospitals and Health Homes

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- To facilitate health home beneficiaries' access to needed services, health homes must establish relationships with:
 - Specialty (including substance abuse) care providers
 - Long-term care providers
 - Hospitals (including emergency departments)
 - Other community providers (e.g., nutritionists, housing, etc.)

Hospital ED – Health Home ACA Requirement

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- **Hospitals participating in the Medicaid program must establish procedures for referring eligible individuals with serious and persistent mental illness who seek or need treatment in a hospital ED to health homes**
- **Hospital referral procedures should be developed in collaboration with the health home(s) in their service area**

Hospitals and Health Home Data Sharing

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- **Health home enrollment status & contact information-** Hospital EDs will have access to the client's Health Home enrollment information to facilitate timely communication, care coordination and referrals
- **Psychiatric Inpatient Admission Alerts-**Health homes will receive e-mail alerts and have access to FFS Prior Authorization data for inpatient psychiatric admissions
- **Client Utilization Report-** Health homes will receive client utilization reports with historical claims data for ED utilization and hospital services

Hospitals and Health Home Data Sharing

- **Steps for Checking Health Home Enrollment Status and Contact Information:**
 - **Step 1:** By logging into the MITS secured web portal, hospitals will be able to access health home eligibility information by using the Eligibility Search drop down feature on their web portal landing page. (Fall, 2012)
 - **Step 2:** The Eligibility Search drop down will show the Eligibility Verification Request panel where the hospital may enter the Health Home consumer's Medicaid Billing Number, Birth Date, and an eligibility search period (search period is 6 months or less) in order to view the consumer's MITS assignment plans with the appropriate effective and end dates of eligibility. (Fall, 2012)
 - **Step 3:** Under the Lock-in field the hospital can find the assignment plan for Health Homes, the Health Home name and the Health Home phone number. (Fall, 2012)
- **Screen shot will be shared with hospitals once the system functionality has been developed and approved by the Office of Medical Assistance. (Fall, 2012)**

Hospital Related Health Home Quality Measures

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- Health Homes are accountable for reducing inappropriate ED and inpatient utilization
 - Timely Transmission of Transition Record (discharge record)
 - Reconciled Medication List Received by Health Home
 - Follow-up After Hospitalization for Mental Illness
 - Ambulatory Care Sensitive Conditions Hospitalization Rate
 - Inpatient and Emergency Department (ED) utilization Rate
 - All-Cause Readmission

Hospitals & Health Home Referrals

Hospitals and EDs should refer potentially eligible clients to Health Homes within their service area

- Health homes are expected to develop internal policies and procedures and share information with hospitals to coordinate new client referrals
- Health homes are expected to provide expanded timely access to Health home services including acceptance of referrals
 - State is not mandating a Health home response time
- Health homes will assess and determine eligibility for each referral
 - If client is NOT SPMI then Health home is encouraged to work with ED to find appropriate care setting
- Hospitals and EDs are encouraged to share information about their referral procedures with health homes when available

Hospital ED Utilization & Health Homes

- It is the responsibility of each health home to determine how reducing hospitalizations and inappropriate ED is best accomplished through their own program design and arrangements with Hospital EDs in their service area.
- Where appropriate, the health home will be expected to coordinate with the patient and the hospital ED staff, develop a plan and assist the patient for accessing services in appropriate settings, including addressing transportation.
- The health homes and the hospitals EDs are expected to respect the client's choice and rights when intervening at the hospital ED, consider a case-by-case approach and collaborate to ensure the best outcome for the consumer.
- The State will give Hospital EDs access to the client's health home provider information to facilitate timely communication and coordination. (Fall, 2012)

Hospital Admissions and Health Homes

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- All health homes are accountable for reducing hospital admissions and readmissions and must have the capacity to provide comprehensive transitional care and follow-up as needed.
- The health homes will receive real time notifications of inpatient psychiatric admissions in order to coordinate care and begin the transition process as soon as possible.
- As the program matures, the State anticipates the health homes will re-design their expanded access and transitional care strategies to fit the needs of each community they serve.
- Health homes are expected to develop relationships with the hospital inpatient units in their service area, and share information about their hours of operation and services.
- Health homes are required to provide or arrange for 24/7 crisis support in case of a crisis or emergency.

Hospital ED - Follow Up Appointments

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If a patient is stabilized in the ED but needs a follow up appointment, how is the health home accountable for assuring appointment takes place in a timely manner?

- *Health homes are expected to provide or arrange timely, comprehensive, and quality services including medication assistance through integration of primary care, network of diverse providers and collaboration with Managed Care Plans.*

Hospital Admissions and Transitional/Follow-up Care

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What is the obligation (including timeliness) of Health homes to transition patients from inpatient settings?

- Health homes will receive notifications of inpatient FFS psychiatric admissions in order to coordinate care and begin the transition process as soon as possible.
- Transition to an outpatient setting is a shared responsibility between the health home and hospital
 - *warm handoff*
- Health homes are required to provide or arrange for 24/7 crisis support in case of a crisis or emergency

Hospital Training Opportunities

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- Health Home Webinars
- Health Home Regional Forums
- Health Home Learning Communities

Questions ?

Additional questions can
be submitted to the
healthhomes@mh.ohio.gov