



John R. Kasich, Governor
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Medicaid Health Home Highlights

April 26, 2013

The Health Home Team

A Health Home provider shall utilize an integrated, multidisciplinary team to deliver the Health Home service. Licensed, certified or registered individuals shall comply with current, applicable scope of practice and supervisory requirements identified by appropriate licensing, certifying or registering bodies. To function effectively, each team member must understand his/her role(s), work collaboratively on care plans and assure coordination of comprehensive medical, behavioral, long-term care and social services that are timely, quality-driven and integrated.

The Health Home team shall include:

Health Home Team Leader

The Health Home Team Leader provides administrative and clinical leadership and oversight to the team and monitors the provision of the Health Home service. A key function of the Team Leader role is to champion the Health Home service and motivate and educate other staff members.

Specific responsibilities of the Health Home Team Leader include monitoring and facilitating:

- Consumer identification and engagement
- Completion of consumer comprehensive health and risk assessments
- Development of integrated care plans
- Scheduling and facilitation of treatment team meetings
- Provision of the Health Home service
- Health promotion and illness prevention activities
- Development, tracking and dissemination of consumer health outcomes

The minimum qualification for a Health Home Team Leader is a licensed independent social worker, professional clinical counselor, independent marriage and family therapist, registered nurse with a master of science in nursing, certified nurse practitioner, clinical nurse specialist, psychologist or physician. The Health Home Team Leader must possess supervisory, clinical and administrative leadership experience.

Embedded Primary Care Clinician

The Embedded Primary Care Clinician is essential to the success of integrated care in Health Homes. The Embedded Primary Care Clinician is responsible for assessing, monitoring and consulting on the routine, preventive, acute and chronic physical health care needs of consumers. This role incorporates education and consultation to the Health Home team related to best practices and treatment guidelines in the screening and management of physical health conditions.

The Embedded Primary Care Clinician role can be conducted by any of the following health care professionals:

- Primary care physicians
- Internists
- Family practice physicians
- Pediatricians
- Gynecologists

- Obstetricians
- Certified Nurse Practitioners with a primary care scope of practice
- Clinical Nurse Specialists with a primary care scope of practice
- Physician assistants

Population management is a key responsibility of the Embedded Primary Care Clinician and is critical to effective disease management and care coordination for consumers with chronic and complex health needs. The Embedded Primary Care Clinician also acts as a liaison between the treating primary care provider and the Health Home team. It is strongly preferred that the Embedded Primary Care Clinician also functions as the treating primary care clinician whenever possible and he/she may hold dual roles on the Health Home team.

Care Manager

Health Home Care Managers are accountable for care management and care coordination of all Health Home services including the management of the beneficiary's care plan, integration of medical and behavioral health care needs and services, treatment of substance abuse, provision of long-term care, and social service needs and goals.

Care Managers must have the necessary credentials and skills to conduct comprehensive assessments and treatment planning. Care Managers should have formal training as well as practical experience in behavioral health and possess core and specialty competencies and skills in working with the SPMI population. Care Managers will also need to demonstrate either formal training or a strong knowledge base in chronic physical health issues and physical health needs of the serious and persistent mental illness (SPMI) population and must be able to function as a member of an inter-disciplinary team.

Care Managers can utilize Qualified Health Home Specialists in the provision of some components of Health Home services. The minimum qualifications for the Care Manager role include:

- Social workers with LSW or LISW
- Marriage and family therapists with MFT or IMFT
- Counselors with PC or PCC
- Registered Nurses with extensive experience working with the SPMI population

Qualified Health Home Specialist

This versatile role assists and supports the Care Manager with care coordination, referral/linkage, follow-up, consumer/family support and health promotion services. The Qualified Health Home Specialist role should be filled by a professional whose background and skills fit into the consumer's individualized care plan and may include:

- CPST workers with four-year degrees or two-year Associate degrees
- Pharmacists
- Licensed Practical Nurses
- Health educators
- Peer support specialists
- Certified tobacco treatment specialists
- Wellness coaches
- Other qualified individuals

Reminder: Training and Technical Assistance Resources

ODMH encourages providers interested in becoming certified for the Health Home service option to take advantage of the [trainings and technical assistance resources](#) available through the National Council for Community Behavioral Healthcare and Case Western Reserve University's Center for Evidence-Based Practices.

Visit http://www.thenationalcouncil.org/cs/HH_TA_Resource_Center for updates about these programs and future call dates.

Calendar of Training and Technical Assistance Events — April/May 2013

Please note: These trainings and technical resources are available to **all providers** that are Health Homes or interested in becoming Health Homes.

Monday	Tuesday	Wednesday	Thursday	Friday
<p>April 29</p>	<p>30 Special Webinar: Role of the Embedded Primary Care Clinician Speaker: Lori Raney, M.D. 2-3:30 p.m.</p> <p>Click the link to join: https://www2.gotomeeting.com/register/957272986</p>	<p>May 1</p>	<p>2</p>	<p>3 Northeast coaching call 11 a.m.-12:30 p.m.</p> <p>Click the link to join the call: https://www2.gotomeeting.com/join/980623490</p>
<p>6 Adult Case to Care Training in Northeast Ohio Northeast Ohio Medical University (NEOMED), 4209 St. Rout 44, Rootstown</p> <p>Case Western Training: Promoting Health Behavior Change (Columbus)</p> <p>Click here to learn more</p>	<p>7</p>	<p>8</p>	<p>9</p>	<p>10 Northwest coaching call 11 a.m.-12:30 p.m.</p> <p>Click the link to join the call: https://www2.gotomeeting.com/join/929762938</p>
<p>13 Webinar: Health Home Financing and Sustainability 2-3:30 p.m.</p> <p>Register: https://www2.gotomeeting.com/register/328789922</p>	<p>14 Face-to-Face Health Integration Forum — Columbus</p>	<p>15 Case Western Training: Promoting Health Behavior Change (Athens)</p> <p>Click here to learn more</p>	<p>16</p>	<p>17 Southeast coaching call 11 a.m.-12:30 p.m.</p> <p>Click the link to join the call: https://www2.gotomeeting.com/join/531561946</p>

National Council for Community Behavioral Healthcare=Blue font; Case Western Reserve University=Gray font

Questions?

Please submit any questions regarding Ohio Medicaid Health Homes to healthhomes@mh.ohio.gov or visit <http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/medicaid/health-home-committees.shtml>.