Provider Training: Health Homes for Children & Youth

August 7, 2013
2:30pm - 4:00pm
Program Objectives

• Further integration of behavioral and somatic care through improved care coordination

• Improve patient outcomes, experience of care, and health care costs among individuals with chronic conditions

• Enable Health Homes to act as locus of coordination for SPMI and OTP populations through provision of additional care coordination services
Health Homes for Children & Youth

• Due to the unique needs of the child and adolescent population, Health Homes will emphasize:
  – a focus on prevention, health promotion, wellness;
  – linkages with multiple systems and services; and
  – involvement of family and caregivers.
Participant Eligibility

• Individuals with serious and persistent mental illness (SPMI) engaged with a PRP or Mobile Treatment Services (MTS)

• Children and adolescents with serious emotional disturbance (SED) engaged with a PRP or MTS
  – Participants may continue to receive HH services for up to 6 months after aging out of PRP or MTS

• Individuals with Opioid Substance Use Disorders engaged with opioid maintenance therapy, at risk for an additional chronic condition
Health Home Services

• Comprehensive Care Management
• Care Coordination
• Health Promotion
• Comprehensive Transitional Care
• Individual and Family Support
• Referral to Community and Social Support
Health Home Services: Comprehensive Care Management

- Comprehensive assessment of preliminary service needs, including screening for co-occurring behavioral and somatic health needs
- Development/update of consumer-centered care plan
- Development of treatment guidelines
- Monitoring of individual and population health status and service use to determine adherence to treatment guidelines
- Reporting of progress toward outcomes for consumer satisfaction, health status, service delivery, and costs
Health Home Services:
Care Coordination

Implementation of the consumer-centered care plan, including:

- appointment scheduling;
- conducting referrals and follow-up monitoring, including long-term services and peer-based support;
and
- communicating with other providers and consumers/family members, as appropriate.

Example: tracking and communicating with appropriate providers re: well child visits
Health Home Services: Health Promotion

• Health education, specific to chronic conditions
• Development and follow-up of self-management plans emphasizing person-centered empowerment
• Education regarding immunizations and screenings
• Health promoting lifestyle interventions, such as:
  – Substance use prevention
  – Tobacco prevention and cessation;
  – Nutritional counseling, obesity reduction and prevention; and
  – Physical activity.

Example: counseling regarding sexuality information including STIs and family planning for older youth
Health Home Services: Comprehensive Transitional Care

Comprehensive transitional care services aim to:

• streamline plans of care;
• ease the transition to long-term services and supports; and
• reduce hospital admissions and interrupt patterns of frequent hospital emergency department use.

The Health Home Team will:

• collaborate with clinical, therapeutic, rehabilitative, and other providers to implement the treatment plan;
• increase consumers’ and family members’ ability to manage care and live safely in the community; and
• emphasize proactive health promotion and self-management.

Example: Develop plan with family addressing repeated ER visits resulting from asthma
Health Home Services: Independent & Family Support

• Advocacy for individuals and families
• Assistance with medication & treatment adherence
• Identification of resources to support reaching the highest possible level of health and functioning
• Health literacy improvement
• Support for the ability to self-manage care
• Facilitation of consumer and family participation in ongoing revisions of care/treatment plan.

Example: Care manager assists participant and family in preparing for IEP team meeting
Health Home Services: Referral to Community & Social Supports

Health Homes will provide assistance for consumers to identify, obtain and maintain eligibility for:

- health care services,
- disability benefits,
- housing,
- personal needs, and
- legal services, as examples.

Example: Identify an appropriate summer activity program for participant and assist in enrollment
Provider Enrollment: Eligibility

• Provider types eligible to become Health Homes:
  - Psychiatric Rehabilitation Programs
  - Opioid Treatment Programs
  - Mobile Treatment Providers

• Specialized Criteria
  - Providers serving children must demonstrate a minimum of 3 years of experience providing services to children and youth.
Provider Enrollment: Application

- Application and Instructions available at: [http://dhmh.maryland.gov/bhd/SitePages/Health%20Home%20Requirement%20Information.aspx](http://dhmh.maryland.gov/bhd/SitePages/Health%20Home%20Requirement%20Information.aspx)
  - Must demonstrate initiation of accreditation process with CARF or The Joint Commission
  - Submit protocols for service delivery and ability to meet provider standards
  - Demonstrate enrollment with CRISP and attest to provider requirements
Provider Enrollment: Consortiums

• The Health Home consortium option allows smaller providers to share Health Home staff and thus costs.

  - Consortium is limited to agreements between 2 providers of geographic proximity.
  - Staff sharing is limited to the following clinical positions: Registered Nurse, Nurse Practitioner and Physician/Nurse Practitioner.
  - Health Home standards and protocols are developed and submitted jointly.
  - Addendum will consist of a detailed MOU between the agencies
Provider Enrollment: Staffing

• Health Homes must maintain staff whose time is exclusively dedicated to the planning and delivery of Health Home services at the levels specified.

• Health Homes with under 125 enrollees must meet the minimum ratios based on enrollment of 125

• Providers are encouraged to increase staff time incrementally between the required staffing levels
Provider Enrollment: Staffing (Cont.)

• Required staffing ratios for Health Homes:
  - Health Home Director (.5 FTE/125 enrollees)
  - Health Home Care Managers (.5 FTE/125 enrollees)
  - Physician or Nurse Practitioner Consultant (1.5 hours per Health Home enrollee per 12 months)
CRISP: Maryland’s Health Information Exchange

Dec 2012
Trigger Events
- ER admission
- Inpatient admission
- Intra-hospital transfer
- ER discharge
- Inpatient discharge
- Cancel admission
- Cancel transfer
- Cancel discharge

Recipients
- Single/Multiple recipients

Notification Delivery
- Direct message as email
- Direct message as CSV attachment
- Regular e-mail notification (no PHI)
- HL7 message to sFTP location to ingest into EMR system
- Web service connection

Frequency
- In real time
- Once a day
- Once a week
- Once a month
To Register, E-mail hie@crispheath.org

In order to gain access to the portal…email hie@crispheath.org!

• The organization must:
  – Sign participation agreement
  – Update Notice of Privacy document
  – Make CRISP patient materials and Opt-out forms available

• Each individual user must:
  – Attend Portal training webinar (every Thursday 12 pm & 6pm). Register at: https://crispheath.webex.com/mw0307I/mywebex/default.do?siteurl=crispheath
Way Station Pilot Program: Lessons Learned

- Understanding true meaning of Health Home
  - Not merely a Medicaid Benefit
  - Not merely an Initiative, a Program or Dedicated Team

- A Care Delivery Approach / Enhancement to current clinical practices requiring Organizational Transformation

- Needed to change staff’s perception of their role re. consumer’s physical health, from encouraging system linkages, care coordination and case management to daily, personal accountability for ensuring such actions occur on a consistent basis

- Questions for Way Station may be directed to: srose@waystationinc.org, mlewis@waystationinc.org, or jmoise@waystationinc.org
Health Home Claims and Billing

• Claims submission directly to Medicaid’s fee-for-service MMIS system
• Use of the CMS 1500 form for paper claims
• Electronic submission
• Detailed billing instructions will be distributed prior to implementation
Health Home Claims & Billing

• Flat per member/per month (PMPM) rate of $98.87 based on employment cost
  - Qualifying participants billed once monthly to FFS system
• One-time intake fee for initial assessment
• Dependent on compliance with ongoing requirements
  - Maintain staffing, accreditation, compliance with all requirements and regulations
  - Documentation of minimum monthly HH service(s) per participant
Health Home Billing: Additional Guidelines

• Time limits
  – Claim submitted within 30 days of the end of the month in which services were provided

• Sanctions
  – Possible 10% sanction for claims submitted past 30 days

• Avoiding duplication
  – Services may not be billed elsewhere or counted towards another program’s case rate
eMedicaid: Purpose

- Online portal with user log in
- Central participant enrollment and tracking
- Reporting of baseline data, outcomes, services delivered
- Allows for review of data at the participant and population level
eMedicaid: Intake

• Confirm Medical Assistance eligibility
• Report basic participant demographic information
• Some fields pre-populate based on MA #
• Use initial assessment to report diagnoses, baseline data, and social indicators
• Confirm consent form has been signed
• List of data points included in HH Manual
eMedicaid: Services

• Reporting of services monthly
• Six general categories with specific services below
• Report services prior to billing
• Review services by date or category
• Report can generate list of those who have received x number of services in x period of time
## eMedicaid: Services

### health homes

**Patient Account Number:** 161  **Enrollment Status:** COMPLETE

### Comprehensive Care Management
- Individual Treatment plan (ITP) or Plan of Care (POC) updated
- Review ITP/POC progress with patient

### Care Coordination
- Patient records requested from Primary Care Provider
- Communication with other providers
- Medical Scheduling assistance
- Referral to medical specialist

### Health Promotion

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Date of Service*</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Health education re: chronic condition</td>
<td></td>
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<tr>
<td>Self management plan development</td>
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<tr>
<td>Medication review and education</td>
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<tr>
<td>Promotion of lifestyle interventions (MUST select one or more below)</td>
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<tr>
<td>Substance use prevention</td>
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<td>Smoking prevention or cessation</td>
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<tr>
<td>Nutritional counseling</td>
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<tr>
<td>Physical activity counseling, planning</td>
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<tr>
<td>Other: [ ]</td>
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### Comprehensive Transitional Care

Transitional from:
- Hospital
- Long term care facility
- Other

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eMedicaid: Outcomes & Indicators

• Report qualifying diagnoses and associated baseline data
  – E.g. Obesity and BMI
• Reassess and report basic outcomes every 6 months and as desired
• Social indicator options dependent on age of participant (C&A vs. adult)
eMedicaid: Reports

• Monthly reports for billing and summary purposes
  – Total enrollment, new enrollees, discharges, # with minimum service delivery, etc

• Participant level reports
  – Review services, diagnoses, outcomes

• Population level reports, e.g. by diagnosis
Next Steps

• Submit Provider Application
• Implementation Preparation
  – Staff hiring
  – Training
  – PCP referrals, records requests for intake
• Participant Enrollment
  – Pre-enrollment September 1-30
• October 1\textsuperscript{st} Implementation
  – Service delivery and claims for intakes may begin
• Ongoing provider and participant enrollment
  – Oct 1 is a start date, \textit{not} a deadline
Q & A

Please direct additional questions following this webinar to:
dhmh.healthhomes@maryland.gov