Provider Training: Mental Health Providers PRP, MT, & ACT

August 8, 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
Participant Eligibility

• Individuals with serious and persistent mental illness (SPMI) engaged with Psychiatric Rehabilitation Program (PRP), Mobile Treatment Services (MTS), or Assertive Community Treatment (ACT)

• 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 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;
- participating in hospital discharge processes; and
- communicating with other providers and consumers/family members, as appropriate.
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.
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.
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, including transportation to medically-necessary services
- Health literacy improvement
- Support for the ability to self-manage care
- Facilitation of consumer and family participation in ongoing revisions of care/treatment plan.
Health Home Services: Referral to Community & Social Supports

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

• health care services,
• disability benefits,
• housing,
• personal needs, and
• legal services, as examples.
Provider Enrollment: Application

• Application and Instructions available at: 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
## ENS Preferences/Options

<table>
<thead>
<tr>
<th>Trigger Events</th>
<th>Notification Delivery</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ER admission</td>
<td>• Direct message as email</td>
<td>• In real time</td>
</tr>
<tr>
<td>• Inpatient admission</td>
<td>• Direct message as CSV attachment</td>
<td>• Once a day</td>
</tr>
<tr>
<td>• Intra-hospital transfer</td>
<td>• Regular e-mail notification (no PHI)</td>
<td>• Once a week</td>
</tr>
<tr>
<td>• ER discharge</td>
<td>• HL7 message to sFTP location to ingest into EMR system</td>
<td>• Once a month</td>
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<tr>
<td>• Inpatient discharge</td>
<td></td>
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<tr>
<td>• Cancel admission</td>
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<tr>
<td>• Cancel transfer</td>
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<tr>
<td>• Cancel discharge</td>
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### Recipients
- Single/Multiple recipients
In order to gain access to the portal…email hie@crisphealth.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://crisphealth.webex.com/mw0307l/mywebex/default.do?siteurl=crisphealth](https://crisphealth.webex.com/mw0307l/mywebex/default.do?siteurl=crisphealth)
Consumer Scenario: Alex

- **Serious and persistent mental illness:**
  - Dx’d with schizophrenia in 20s; 10 year history of inpatient treatment.

- **Other chronic conditions:**
  - Alcohol use disorder & rapidly advancing kidney disease

- **Lacks family support/care coordination**
  - Estranged from all but one daughter
  - Mental illness major barrier to treatment for somatic conditions
Consumer Scenario: Alex

Engagement & Enrollment:

• PRP determines eligibility, appropriateness

• Employ motivational interviewing
  – Somatic conditions are barrier to employment → Alex agrees to meet Nurse Care Manager
  – Physician consultant performs comprehensive health assessment

• Consent given and Alex enrolled in HH
Consumer Scenario: Alex

• Care Coordination
  – Nurse Care Manager (NCM) works to re-establish relationship with PCP to treat somatic conditions
  – Assists dialysis staff in understanding Alex’s mental illness

• Health Promotion
  – NCM and PRP work on alcohol use reduction and eventual abstinence (IDDT)
  – Emphasis on treatment compliance using IMR to help Alex develop skills to manage his conditions
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 MMIS
- 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 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>
</tr>
</thead>
<tbody>
<tr>
<td>□ Health education re: chronic condition</td>
<td></td>
<td></td>
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<tr>
<td>□ Self management plan development</td>
<td></td>
<td></td>
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<tr>
<td>□ Medication review and education</td>
<td></td>
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<tr>
<td>□ Promotion of lifestyle interventions (MUST select one or more below)</td>
<td></td>
<td></td>
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<tr>
<td>□ Substance use prevention</td>
<td></td>
<td></td>
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<tr>
<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>
<td></td>
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<tr>
<td>□ Other: [ ]</td>
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</tr>
</tbody>
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### Comprehensive Transitional Care

**Transitioning from:**
- [ ] Hospital
- [ ] Long term care facility
- [ ] Other [ ]

Individual and Family Support Services
eMedicaid: Outcomes & Indicators

• Report qualifying diagnoses and associated baseline data
  – E.g. Diabetes and blood sugar levels

• 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, \textbf{not} a deadline
Q & A