Your Health Home Digest

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

The monthly newsletter of the Ohio Health Home Implementation Office Training and Technical Assistance Center (OHIO-TTAC)

MARK YOUR CALENDARS!

Case to Care Training: This one-day training programs is designed for direct care staff in your facility to begin identifying and implementing important practice changes in their daily efforts. Learn the fundamentals of care management, including integration concepts, health promotion and wellness, and identify the steps to implement changing roles of case managers.

UPCOMING DATES	
March 26	Northcoast Behavioral Health
March 27	Beechbrook (Child-focused)
April 15	Ohio Department of Administrative Services
April 16	Ohio DAS (Child-focused)

Visit www.thenationalcouncil.org/cs/HH_TA_Resource_Center_Case_to_Care_Training to obtain the registration form and email it to reservations@mh.ohio.gov.

FEATURED TOPIC: WHAT IS A HEALTH HOME?

The 2010 Patient Protection and Affordable Care Act (ACA) established a "health home" option under Medicaid. A Health Home is not a building, house, hospital, or home healthcare service; it is a *coordinated, person-centered system of care*. Health Homes were developed to provide dedicated attention to people with or two or more chronic health conditions, with one chronic condition and at risk for another, or who have serious mental illness, and as a result of their condition, require care coordination above and beyond conventional medical home practice.

Ohio Medicaid teamed up with the Ohio Department of Mental Health to focus on creating health homes for individuals on Medicaid who have serious and persistent mental illness (SPMI). For specific information on the design of Health Homes in Ohio, go to http://mentalhealth.ohio.gov.

Who Will Be Eligible for Health Home Services in Ohio?

For health home eligibility criteria, go to http://mentalhealth.ohio.gov.

FOUR PRINCIPLES OF QUALITY CARE DELIVERY IN A HEALTH HOME

1. **Person-centered care.** Basing care on the individual's preferences, needs, and values. With person-centered care, the client is a collaborative participant in healthcare decisions and an active, informed participant in treatment itself.
2. **Population-based care.** Strategies for optimizing the health of an entire client population by systematically assessing, tracking, and managing the group's health conditions and treatment response. It also entails approaches to engaging the entire target group, rather than just responding to the clients that actively seek care.
3. **Data-driven care.** Strategies for collecting, organizing, sharing, and applying objective, valid clinical data to guide treatment. Validated clinical assessment tools monitor response to treatment and information systems such as registries track the data over time.
4. **Evidence-based care.** The best available evidence guides treatment decisions and delivery of care. Both the behavioral health agency and its health provider partner, if applicable, must deliver evidence-based services.

CLINICAL FEATURES OF THE BEHAVIORAL HEALTH HOME

- Self-management support. Activated consumers possess skills to self-manage their care, collaborate with providers, and maintain their health. The behavioral health home helps activate consumers by assessing their activation level and then addressing deficits through self-management support strategies that include both education and coaching components.

- Delivery system design. The behavioral health home redesigns the care system in key ways such as the forming multidisciplinary practice teams and providing care management. Providers work as part of a team responsible for addressing consumers' comprehensive care needs. Whether housed under one roof or stationed in different settings, team members must function as a single unit, which means maintaining clear roles, a single care plan, effective communication, and mechanisms for coordinating care between team members. Care management, a component of delivery system design, is a key strategy for ensuring that consumers do not "fall through the cracks."
- Decision support. Involving specialists and embedding evidence-based guidelines in the routine provision of care are key decision support strategies for ensuring that clinical care is provided in line with best practices.
- Clinical information systems. Clinical information systems organize population-level data to maximize the outcomes for a defined group of consumers. They also organize consumer-level data to optimize individual outcomes. A patient registry is an information tool that enables effective tracking of all consumers with a particular condition or set of characteristics seen in a practice. Electronic reminders are key functions of effective clinical information systems, alerting providers to issues that need attention at the consumer or population level such as when consumers need a preventive procedure, like a colonoscopy.
- Community linkages. Behavioral health homes augment the services they can offer by linking consumers to community resources such as peer support organizations, self-help groups, senior centers, exercise facilities, and home care programs.

DELIVERY SYSTEM DESIGN IN A HEALTH HOME

The chronic care model calls for the reorganization of the care system in a way that is proactive and responsive to the needs of consumers with chronic illnesses. The behavioral health home requires the care delivery system to be reorganized in two key ways:

- Providers must form multidisciplinary practice teams capable of working together to effectively ensure consumers' full range of care needs are met through a single, integrated care plan.
- Care management must be in place so that consumers do not "fall through the cracks."

In the health home, all team professionals share a single care management record and consumer case reviews are conducted on a regular basis. The care plan is developed collaboratively with the consumer. All team members need access to the care plan so they can use it when planning their interactions with the consumer and update it as needed.

THE HEALTH HOME PRACTICE TEAM

The behavioral health home requires providers to work together as part of a multidisciplinary team that shares responsibility for addressing consumers' comprehensive care needs. The team may be housed under one roof or function virtually with members stationed in different settings. Regardless of location, it is essential that the members function as a single unit. This means having clear roles, a shared plan, effective communication, and mechanisms for coordinating care between team members.

To work well as a team, the members must have rapid and effective communication and be able to coordinate care delivery with each other. For this to happen, there must be mechanisms in place for in-the-moment communications about current consumer needs or team activities. Team members must be able to find out who has seen the consumer and for what reason. If an acute need arises, the appropriate team members must be notified so they can respond. Team members must be able to mobilize quickly to work together when problems arise. These communications can occur effectively and efficiently via an electronic medical record (EMR) or a registry.

There should also be mechanisms in place for routine communication between team members. For some practices, this means starting off each day with a team "huddle," in which the group reviews the consumers to be seen that day. Teams may meet weekly to review and discuss consumers, typically focusing on those in treatment who are not responding well to the current care plan. Teams may also find it useful to meet monthly or quarterly to discuss their work processes, troubleshoot problem areas, exchange program information and lessons learned, and further build a sense of their identity as a team.

Who's Who on the Health Home Team?

HEALTH HOME TEAM LEADER

The Health Home Team Leader provides administrative and clinical leadership and oversight to the health home team and monitors provision of health home services. A key function of the Team Leader role is to be a champion for health home services and motivate and educate other staff members. The Health Home Team Leader must possess a strong health management background and an understanding of practice management, data management, and managed care. The Health Home Team Leader must also have training and experience in quality improvement. The Health Home Team Leader will monitor and facilitate clinical processes and components of Health Homes, which include but are not limited to: consumer identification and engagement; completion of comprehensive health and risk assessments; development of care plans; scheduling and facilitation of treatment team meetings; provision of health home services; monitoring consumer status and response to health coordination and prevention activities; and development, tracking and dissemination of outcomes. The additional clinical and administrative duties will include hiring and training of staff, providing feedback regarding staff performance, conducting performance evaluations, providing direction to staff regarding individual cases, and monitoring overall team performance and plan for improvement. The minimum qualifications consist of a Master's Degree or higher in a healthcare related field.

EMBEDDED PRIMARY CARE CLINICIAN

Medical leadership is essential to systematically implement standards of quality care. To that end, the Embedded Primary Care Clinician is integral to the success and demonstration of integrated care in CBHC health homes. The Embedded Primary Clinician assesses, monitors and consults on the routine, preventive, acute and chronic physical health care needs of clients.

This role brings education and consultation to the health home team regarding best practices and treatment guidelines in screening and management of physical health conditions. The embedded primary care clinician also acts as a liaison between the treating primary care provider and the team. This position can be filled by any of the following professionals: primary care physicians, pediatricians, gynecologists, obstetricians, Certified Nurse Practitioners with primary care scope of practice and Physician Assistants.

CARE MANAGER

Care management focuses on consumer activation and education, care coordination, and, when working with a treating provider, monitoring consumers participation in and response to treatment.

The Care Manager is accountable for the overall management and coordination of the consumer's care plan including medical/behavioral health, substance abuse, long-term care, and social service needs and goals. As such, the Care Manager must be able to both provide and coordinate all health home services. Care Managers can utilize Qualified Health Home Specialists in the provision of some components of health home services.

Care Managers must have the necessary credentials and skills to be able to conduct comprehensive assessments and treatment planning. The minimum qualifications for the Care Manager include social workers with LSW or LISW, counselors with PC or PCC, Marriage and Family Therapists with MFT or IMFT, RN Nurses (including a 3 year RN degree) with extensive experience 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 SPMI population and must be able to function as a member of an inter-disciplinary team. Finally, Care Managers must be knowledgeable and experienced in community resources and social support services for the SPMI population.

QUALIFIED HEALTH HOME SPECIALIST

Qualified Health Home Specialists assist and support Care managers with care coordination, referral/linkage and follow-up and provide family/consumer support and health promotion services. This role may be filled by any of the following: LPN nurses, CPST workers with four year degrees or 2 year Associate Degrees, wellness coaches, peer support specialists, certified tobacco treatment specialists, health educators and other qualified workers.

HEALTH HOME IN PRACTICE

The ***Connected Care™ Program***, a joint venture of the Community Care Behavioral Health Organization and University of Pittsburgh Medical Center (UPMC) Health Plan with support from the Center for Health Care Strategies' Rethinking Care Program,[1] focuses on improving the connection to and coordination of care for health plan members with serious mental illnesses in southwestern Pennsylvania.[2]

Features: Based on the patient-centered medical home model, Connected Care uses an integrated care team and care plan to address consumers' comprehensive medical, behavioral, and social needs.

- Care team members have access to the web-based integrated care plan, which pulls in client data from the participating physical and behavioral health plans.
- Care managers can access and update client information through an online interface, and the care plan is reviewed and modified during team meetings.
- The care plan is informed by input from the client and/or caregivers, the primary care provider, behavioral health providers, health plan staff, medical director, nurses, social worker, and pharmacist.
- Program staff has found regular team meetings, during which they review the care plan, to be particularly helpful in developing a clear, shared understanding of the medical and behavioral health services consumers have received, gaps in care, and their treatment regimens.

Results: Researchers conducted a pre-post analysis of 5,463 Medicaid recipients with serious mental illness and a history of frequent emergency department and/or inpatient utilization who participated in the program. Findings:

- Participants demonstrated a decline in hospital readmissions (from 64.1 per 1000 to 46.5 per 1000),
- ED admissions declined (from 1975 per 1000 to 1963 per 1000)
- Costs declined, resulting in an estimated $609,000 savings in behavioral health expenses and $1.3 million dollars in savings on general medical care.[3]

Connected Care's integrated care plan template can be accessed at www.chcs.org/usr_doc/Integrated_Care_Plan_Template.pdf.

1. Center for Health Care Strategies. (April 2008). Rethinking Care for Medicaid's Highest-Need, Highest-Cost Populations. Retrieved from www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=676169.

2. Lovelace J. (October 27, 2009). Connected Care Program. Presentation made as part of the Center for Health Care Strategies webinar, Establishing Accountable Physical/Behavioral Health Care Homes: Medicaid Innovations. Retrieved from http://www.chcs.org/usr_doc/Lovelace.pdf. More information from the webinar available at www.chcs.org/publications3960/publications_show.htm?doc_id=1066660.

3. Casey T. (April 18, 2011). Medicaid beneficiaries and serious mental illnesses. First Report Managed Care. Retrieved from www.firstreportnow.com/articles/medicaid-beneficiaries-and-serious-mental-illness?page=0,0.

REACH OUT TO THE NATIONAL COUNCIL: TECHNICAL ASSISTANCE

We are here to help make your health home work easier. Here are few simple tips to help us response quickly and effectively to your requests:

- Assume the person you're asking help from knows nothing about your program.
- Paint a picture that gives the context and steps already taken to address the need.
- Describe the research you did to address the need and understand the problem.
- Be as specific as possible.

Good Example:

We need help with referrals.

Better Example:

We are trying to figure out how to meet the HH requirement that we must track referrals. We currently call and then fax information to sites where we refer clients. Referral sites rarely respond back. How can we do this better.

Best Example:

We are a small, rural, licensed CMHC mental health and substance abuse provider who refers clients to three primary care provider sites and various specialty healthcare providers none of which are located near our CMHC. We are trying to figure out how to meet the HH requirement that we must track referrals and use the information to make the referral process more effective. Barriers our HH implementation team has identified are: 1.) we currently call and then fax information to sites where we refer clients. Referral sites rarely respond back and 2.) Since we are a rural provider there is no public transportation to support people making their referral appointments and very few of our clients have cars. Please send your reply to...at Joeshmo@email.org.

Contact OHIO-TTAC@thenationalcouncil.org for technical assistance. A specialist will respond within 24 hours of your request.

RESOURCES

Million Hearts is a national initiative of the U.S. Department of Health and Services to prevent 1 million heart attacks and strokes over the next 5 years. Heart disease and stroke are two of the leading causes of death in the United States. Million Hearts brings together communities, health systems, nonprofits, federal agencies, and private-sector partners from across the country to fight heart disease and stroke.

www.integration.samhsa.gov/health-wellness/samhsa-10x10

The Agency for Healthcare Research and Quality commissioned the University of North Carolina at Chapel Hill to develop and test this Health Literacy Universal Precautions Toolkit. The toolkit offers primary care practices a way to assess their services for health literacy considerations, raise awareness of the entire staff, and work on specific areas.

Health Literacy Universal Precautions Toolkit. AHRQ Publication No. 10-0046-EF, April 2010. Rockville, MD: Agency for Healthcare Research and Quality. www.ahrq.gov/qual/literacy/index.html

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2. Ohio Medicaid Health Home Program Health Home Informational Forums Kick-Off Webinar on April 12, 2012