



# 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: Consortia

- 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**

*Connecting Physicians With Technology  
to Improve Patient Care in Maryland*

Chesapeake Regional Information System for Our Patients

# CRISP: Maryland's Health Information Exchange

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7160 Columbia Gateway Drive, Suite 230  
Columbia, MD 21046  
T/ 877.952.7477  
F/ 443.817.9587  
[www.crisphealth.org](http://www.crisphealth.org)

Dec 2012





# ENS Preferences/Options

Chesapeake Regional Information System for Our Patients

## 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@crisphealth.org](mailto:hie@crisphealth.org)

Chesapeake Regional Information System for Our Patients

In order to gain access to the portal...email [hie@crisphealth.org](mailto: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:
  - Complete user request form:  
<http://hie.crisphealth.org/UserRequestForm/tabid/280/Default.aspx>
  - Attend Portal training webinar (every Thursday 12 pm & 6pm). Register at:  
<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<sub>23</sub>



## 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

[sign out](#)

## 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

| Service Provided   | Date of Service*     | Notes                |
|--|----------------------|----------------------|
| <input type="checkbox"/> Health education re: chronic condition                              | <input type="text"/> | <input type="text"/> |
| <input type="checkbox"/> Self management plan development                                    | <input type="text"/> | <input type="text"/> |
| <input type="checkbox"/> Medication review and education                                     | <input type="text"/> | <input type="text"/> |
| <input type="checkbox"/> Promotion of lifestyle interventions(MUST select one or more below) |                      |                      |
| <input type="checkbox"/> Substance use prevention  | <input type="text"/> | <input type="text"/> |
| <input type="checkbox"/> Smoking prevention or cessation                                     | <input type="text"/> | <input type="text"/> |
| <input type="checkbox"/> Nutritional counseling  | <input type="text"/> | <input type="text"/> |
| <input type="checkbox"/> Physical activity counseling, planning                              | <input type="text"/> | <input type="text"/> |
| <input type="checkbox"/> Other : <input type="text"/> *                                      | <input type="text"/> | <input type="text"/> |

### 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<sup>st</sup> Implementation
  - Service delivery and claims for intakes may begin
- Ongoing provider and participant enrollment
  - Oct 1 is a start date, not a deadline



# Q & A