Health Homes

2013 Provider Manual

Updated July 2013

Table of Contents

I. Introduction
- ***Health Homes for Overall Wellness*** 1
- ***Health Homes for Children and Adolescents*** 1

II. Provider Eligibility and Enrollment
- ***Health Home Provider Application*** 2
- ***Staffing Requirements*** 2
  - Health Home Director 3
  - Health Home Care Managers 3
  - Physician or Nurse Practitioner Consultant 3
  - Administrative Support Staff 4
- ***Health Home Consortiums*** 5
  - Accreditation 5

III. Participant Eligibility and Enrollment
- ***Participant Eligibility*** 6
- ***Enrollment Process*** 6

IV. Health Home Service Delivery
- ***Service Delivery and Description*** 7
  - Comprehensive Care Management 8
  - Care Coordination 9
  - Health Promotion 9
  - Comprehensive Transitional Care 10
  - Individual and Family Support Services 10
  - Referral to Community and Social Support Services 11
- ***Health Home Discharge*** 11

V. Reporting
- ***eMedicaid Reporting Requirements*** 12
- ***Biannual Program Assessment*** 12

VI. Health Information Technology
- ***eMedicaid*** 13
  - Participant Intake 13
  - Ongoing Service Reporting 13
  - Outcomes Reporting 13
  - Data Review and Reports 14
  - Comprehensive eMedicaid Instructions 14
- ***CRISP*** 14
- ***Electronic Health Records and Care Management Tools*** 14

VII. Billing and Payment
- ***Claims Submission and Reimbursement*** 15
- ***Duplicative Billing*** 15
- ***Time Limits and Sanctions*** 15

VIII. Appendices A-G

Introduction

Health Homes for Overall Wellness

Health Homes offer enhanced services and supports for participants with serious and persistent mental illness (SPMI), serious emotional disturbance (SED), and opioid substance use disorders. The complexity of managing these conditions often increases the challenges of treating and preventing additional chronic health issues, both behavioral and somatic. Those with behavioral health conditions face unique barriers in addressing their physical health needs, resulting in disproportionately poor health outcomes, low engagement in preventive health efforts, and high rates of avoidable hospital and emergency department (ED) encounters.

Health Homes assist participants of all ages in improving overall wellness through a whole-person approach to addressing their behavioral, somatic, and social needs. Becoming a Health Home allows behavioral health providers to augment their existing services, building upon and adding to their staff and activities to better serve participants. This is accomplished through connecting participants and caregivers to the myriad of supports and services available to them, offering health promotion activities, monitoring both somatic and behavioral health needs, and assisting with transitional care. The Health Home becomes the locus of care, building participants' self-management capacity while reducing avoidable hospital usage and ultimately improving outcomes.

Health Homes for Children and Adolescents

Like adults with serious mental illness, children and adolescents with serious emotional disturbance face an elevated risk of adverse health consequences. While all Health Homes aim to reduce these negative outcomes, those serving children emphasize coordinated prevention, health promotion, and wellness activities that focus on their health-related choices and behaviors. These efforts involve augmenting the existing services provided to children with SED through not only the somatic and behavioral health care systems, but also through local school systems, the child welfare and juvenile justice authorities when applicable, and other child and family service providers as appropriate.

Health Homes aim to improve outcomes for children with SED by emphasizing the needs of the whole person while supporting their families and caregivers as 1) central decision makers in the process of accessing and utilizing health care; 2) key players in developing self management skills in the young person; and 3) crucial in providing role modeling and encouragement for their children in adopting healthy lifestyles.

Provider Eligibility and Enrollment

Health Home Provider Application

Providers interested in becoming Health Homes must first complete a Maryland Medicaid Provider Application if they are not already enrolled with Medicaid. To begin the application process, please visit https://encrypt.emdhealthchoice.org/emedicaid/webservices?submit=Enroll.

Providers enrolled with Medicaid must then submit an additional Health Home application, which can be found in Appendix E of this manual with instructions for completion. The application will also be available electronically on the Maryland Health Homes website and may be submitted with supporting materials to dhmh.healthhomes@maryland.gov.

Provider types eligible to become Health Homes include psychiatric rehabilitation programs (PRP), mobile treatment services (MTS) providers, and Opioid Treatment Programs (OTP). These providers may only enroll into Health Home services individuals currently receiving their respective PRP, MTS, or OTP services. Providers serving children must demonstrate a minimum of three years experience serving a child and adolescent population.

Staffing Requirements

Health Homes must maintain staff in the ratios specified below, whose time is exclusively dedicated to the planning and delivery of Health Home services.

The staffing ratios specified as "per 125 Health Home enrollees" act as a minimum, requiring providers with less than 125 enrollees to maintain this level regardless of their enrollment. While it is not until reaching the subsequent enrollment level (e.g. 250 or 375 enrollees) that a Health Home must increase to the next required staffing level, providers are encouraged to increase the time of their Health Home staff incrementally as enrollment increases.

Health Home staff members must be dedicated to health home duties at a level of .5 FTE minimally; staffing requirements may not be divided among staff at levels below .5 FTE each.

To begin offering health home services, a provider must have in place a health home director and health home care manager at levels of .5 FTE each, minimally. Additional staff required to meet the staffing levels specified above must be hired within 30 days of beginning service provision.

Although Health Home staff must be dedicated exclusively to Health Home activities at the levels specified, qualified staff members within the PRP, MTS or OTP—such as licensed counselors or nurses—may provide Health Home services as well. It is expected that all staff members, not only those dedicated exclusively to the Health Home, will be fully informed of the goals of the Health Home and collaborate to serve participants.

Provider Eligibility and Enrollment (2)

Health Home Director

.5 full time equivalent (FTE) per 125 enrollees

A Health Home requiring a Health Home director and Health Home care manager of .5 FTE each may employ 1 FTE individual to serve in both roles, provided that individual meets the requirements for both positions.

A Health Home requiring more than .5 FTE Health Home directors may choose to designate a lead Health Home director and fulfill the additional FTE requirement with key management staff rather than additional directors. Such roles could include a clinical director, head of quality assurance, or others.

Subsequent key management staff fulfilling the director FTE requirement must meet the requirements of items i and ii below.

The lead Health Home Director must

i. Possess a Bachelor's degree from an accredited university and 2 years experience in health administration; or
ii. Possess a Master's degree from an accredited university in a related field; or
iii. Be licensed as a Registered Nurse with the Maryland Board of Nursing; or
iv. Be licensed as a Physician or be licensed as a Nurse Practitioner.

Role of Health Home Director

The Health Home Director is responsible for training and oversight of Health Home staff, identification of quality improvement opportunities, population-level care management, partnership building with relevant entities (hospitals, providers, orgs), participation in Care Plan planning as appropriate, leading regular staff meetings, and general administrative oversight.

Health Home Care Manager

.5 FTE per 125 enrollees

The initial Health Home Care Manager role must be filled by a registered nurse or nurse practitioner licensed pursuant to COMAR 10.27.01 or COMAR 10.27.07 respectively, while Health Homes requiring more than 1 FTE in this role may utilize a Physician's Assistant (PA) in this position. Pursuant to COMAR 10.32.03.04, Physicians' Assistants must be supervised by a physician.

Role of Health Home Care Manager

Care Managers are responsible for coordinating care for participants assigned to them, ensuring implementation of the treatment plan in partnership with the individual and family, conducting health promotion and education, providing referrals, and offering additional supports as needed.

Physician or Nurse Practitioner Consultant

1.5 hours per Health Home enrollee per 12 months

The physician or nurse practitioner must meet the requirements set forth in COMAR 10.32.01 or COMAR 10.27.07, respectively.

Role of Physician or Nurse Practitioner Consultant

The Health Home Physician or Nurse Practitioner will sign off on the initial intake assessment, consult on medical issues as necessary, and participate in periodic Health Home case reviews and quality improvement efforts.

Provider Eligibility and Enrollment (3)

Administrative Support Staff

Health Homes are not required to employ administrative support staff at a specific level, with the understanding that this need will vary depending on EHR capabilities and the use of additional care management tools. However, it is highly recommended that Health Homes realistically assess the level of staff needed to fulfill administrative and reporting requirements of program.

Staffing Level Requirements

Health Home Enrollment	Health Home Director (or key management staff)	Health Home Care Manager	MD/MD Consultant
0-249	.5 FTE	.5 FTE	1.5 hours/participant/ year
250-374	1 FTE	1 FTE	1.5 hours/participant/ year
375-499	1.5 FTE	1.5 FTE	1.5 hours/participant/ year
500-624	2 FTE	2 FTE	1.5 hours/participant/ year
625-749	2.5 FTE	2.5 FTE	1.5 hours/participant/ year
750-874	3 FTE	3 FTE	1.5 hours/participant/ year
875-999	3.5 FTE	3.5 FTE	1.5 hours/participant/ year

Provider Eligibility and Enrollment (4)

Health Home Consortiums

Health Home providers serving smaller participant panels may partner with others in their region to share Health Home staff. Providers wishing to pursue this option must submit an addendum to their Health Home application, which may be found in Appendix E of this manual.

Accreditation

Health Home providers must obtain accreditation from an accrediting body approved by the Department. This currently includes the Commission on Accreditation of Rehabilitation Facilities' (CARF) Health Homes Standards, and The Joint Commission's Behavioral Health Homes Certification.

Upon submitting a Health Home provider application to the Department, the provider must demonstrate that they have obtained, or have begun the process of obtaining, this accreditation by submitting one of the following:

1) Certificate of Accreditation, or
2) Evidence that accreditation process has been initiated:
    a. CARF: Letter of Intent to Survey
    b. The Joint Commission: Copy of submitted application and proof of payment

Providers must complete the accreditation process within 18 months of becoming Health Homes. If not completed within the allotted time, the State may reconsider Health Home status.

For additional information regarding the accreditation process:

-CARF: contact Maryland Resource Specialist Kathy Lauerman at klauerman@carf.org or 888-281-6531 ext. 7168.

-The Joint Commission: contact BHC@jointcommission.org

Participant Eligibility and Enrollment

Participant Eligibility

Those eligible to participate in Health Homes include:

1. Individuals with SPMI receiving PRP or MTS services

2. Individuals with a SED receiving PRP or MTS services

3. Individuals with an Opioid Substance Use Disorder at risk for an additional chronic condition due to one of the following risk factors:
   - -Current alcohol, tobacco, or other non-opioid substance use
   - -History of alcohol, tobacco, or other non-opioid substance dependence

Individuals receiving the following services are excluded from participation in Health Homes:
- -Services via 1915(i) State Plan Amendment
- -Targeted Mental Health Case Management

When an individual is newly engaged with a provider, providers may seek to enroll participants in Health Home and PRP/MTS/OTP services simultaneously. However, final submission of the Health Home intake cannot occur until the individual's enrollment in PRP/MTS/OTP is appropriately pre-authorized.

Enrollment Process

When enrolling an individual in Health Home services, the Department recommends following these steps:

1. Determine participant eligibility
2. Discuss the Health Home option with the potential participant and caregivers, as appropriate
3. Obtain consent (consent form in Appendix D)
4. Conduct/update a biopsychosocial assessment to inform step 5
5. Create/update care plan
6. Complete and submit eMedicaid intake
7. Submit claim for Health Home intake
8. Begin Health Home service provision

Health Home Service Delivery

Service Delivery and Description

Health Home activities are intended to augment existing services offered by the provider, rather than to function independently. For this reason, although Health Home staff must be dedicated exclusively to Health Home activities at the required levels, qualified staff members within the PRP, MTS or OTP—such as licensed counselors or nurses—may provide Health Home services as well. It is expected that all staff members, not only those dedicated exclusively to the Health Home, will be fully informed of the goals of the Health Home and collaborate to serve participants.

While not all Health Home services will be delivered face to face, and there are no pre-determined time requirements, services must include a substantive interaction or effort. For example, distributing an informational pamphlet regarding smoking cessation would not qualify as a health promotion activity, whereas a 15 minute discussion between care manager and participant regarding the risks of smoking, how these relate to the individual's condition, setting of smoking-specific goals, and updating of the care plan would be an appropriate Health Home activity. Providers are encouraged to use, as appropriate, evidence-based practices in the implementation of Health Home activities, such as Integrated Illness Management and Recovery (IIMR), Assertive Community Treatment, and Family Psychoeducation.

Sample participant scenarios found in Appendix B illustrate the provision of Health Home services in a variety of settings.

For detailed service descriptions, please turn to the next page.

Health Home Service Delivery (2)

Comprehensive Care Management

Health Home staff will collaborate to provide comprehensive care management services with active participant and family participation. The Health Home will be responsible for coordinating primary and behavioral health care and social services to address the whole-person needs of participants at both the individual and population levels. This will include the following:

Initial Assessment

The Health Home will conduct a comprehensive assessment of enrollees' both physical and mental health and chemical dependency and social service needs, if such an assessment has not been completed within the past six months. This assessment will inform completion of the eMedicaid intake process, and while final sign off from a physician or nurse practitioner is required, it is expected to be a collaborative effort with assistance from additional Health Home and PRP/MTS/OTP staff. The Health Home may choose to assist the participant in scheduling a visit with their PCP, the results of which can inform the initial assessment as well.

Development of Care Plan

Using the initial assessment, the Health Home will work with the participant to incorporate Health Home-specific goals into the individual's care plan, including goals and time frames, community networks and supports, and optimal clinical outcomes.

Delineation of Roles

The Health Home will assign each staff member clear roles and responsibilities. Participant care plans will identify the various providers and specialists within and outside of the Health Home involved in the consumer's care.

Monitoring and Reassessment

The Health Home will monitor individual health status and progress towards care plan goals. This will include documenting changes, adjusting care plans as needed, and updating indicators in eMedicaid every six months at minimum.

Outcomes and Reporting

The Health Home will use the eMedicaid portal and other available HIT tools to review and report quality metrics, assessment and survey results, and service utilization in order to evaluate client satisfaction, health status, service delivery, and costs.

Population-based Care Management

Providers will monitor population health status and service use to determine adherence to or variance from treatment guidelines. The Health Home will identify and prioritize population-wide needs and trends, then implement appropriate population-wide treatment guidelines and interventions.

Comprehensive Care Management services will be reported in eMedicaid as:

- ☐Care Plan updated
- ☐Care Plan progress reviewed with participant

Health Home Service Delivery (3)

Care Coordination

Care coordination will include implementation of the consumer-centered care plan through appropriate linkages, referrals, coordination, and follow-up to needed services and support. Health Homes serving children will place particular emphasis on coordination with school officials and care providers, primary care providers, and relevant agencies such as Social Services. Care Coordination will also include tracking of EPSDT needs, well-child check schedules, and dental screening, with appropriate follow-up.

At the population level, the Health Home provider will develop policies and procedures to facilitate collaboration between primary care, specialist, and behavioral health providers, as well as agencies and community-based organizations; and for children, school-based providers. Such policies will clearly define the roles and responsibilities of each in order to ensure timely communication, use of evidence-based referrals, follow-up consultations, and regular case review meetings with all members of the Health Home team.

Care Coordination services will be reported in eMedicaid as:

- ☐Participant records request from PCP
- ☐Communication with other providers and supports
- ☐Medical scheduling assistance
- ☐Referral to medical specialist
- ☐Immunization tracking
- ☐Screening (cancer, STI, etc.), tracking, and referral

Health Promotion

Health Promotion services assist participants and families to participate in the implementation of their care plan and place a strong emphasis on skills development for monitoring and management of chronic and other somatic health conditions. Health Homes working with children will emphasize these preventive health initiatives, while actively involving parents and other caregivers in the process. This will include identifying conditions for which the child may be at risk due to family, physical, or social factors, and working with the participant and caregivers to address these areas.

At the population level, the Health Home team will use data to: identify and prioritize particular areas of need with regard to health promotion; research best-practice interventions; implement the activities in group and individual settings; evaluate the effectiveness of the interventions; and modify each accordingly.

Health promotion services will be reported in eMedicaid as:

- ☐Health education regarding a chronic condition
- ☐Sexuality information and education and family planning
- ☐Self-management plan development
- ☐Depression screening
- ☐Medication review and education
- ☐Promotion of lifestyle interventions:
  - ☐*Substance use prevention*
  - ☐S*moking prevention or cessation*
  - ☐*Nutritional counseling*
  - ☐*Physical activity counseling, planning*
- ☐Other

Health Home Service Delivery (4)

Comprehensive Transitional Care

Health Homes will provide services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, interrupt patterns of frequent hospital emergency department use, and ensure timely and proper follow-up care. The Health Home will increase consumers' and family members' ability to manage care and live safely in the community, shifting the use of reactive care and treatment to proactive health promotion and self-management.

Transitional care services will vary by age of participants, and may include transitions to or from residential care facilities. Services will address the needs of participants and their caregivers as the older adolescents begin the transition to adult services and programs. To accomplish these goals, providers will establish a clear protocol for responding to CRISP alerts or notification from any other inpatient facility to facilitate collaboration in treatment, discharge, and safe transitional care. Care Managers will follow up with consumers within two business days post-discharge via a home visit, phone call, or with an on-site appointment.

Comprehensive Transitional Care services will be reported in eMedicaid as:

- ☐Participant care plan developed/reviewed
- ☐Transitional support
- ☐Medication review with participant
- ☐Medication reconciliation
- ☐Home visit
- ☐Participant scheduled for follow-up appointment

Individual and Family Support Services

The Health Home will provide support to individuals, families, and caregivers as appropriate to assist and empower them in attaining their highest level of health and functioning possible in their communities. This may include a wide range of services such as advocating for individuals and families; assisting with medication and treatment adherence; improving health literacy; increasing the ability to self-manage care; facilitating participation in the ongoing revision of care/treatment plan; and providing information as appropriate on advance directives and health care power of attorney.

At the population level, services will include: collecting and analyzing individual and family needs data; developing individual and family support materials and groups regarding the areas listed above; soliciting community organizations to provide group support to the population; and providing training and technical assistance as needed regarding the special needs of and effective interventions for the population.

Individual and Family Support Services will be reported in eMedicaid as:

- ☐Medication adherence support
- ☐Providing participant tool kits
- ☐Health literacy
- ☐Scheduling support
- ☐Advocacy for participants and/or caregivers
- ☐Other

Health Home Service Delivery (5)

Referral to Community and Social Support Services

The Health Home will identify available community-based resources and actively manage appropriate referrals, access to care, and engagement with other community, social, and school-based supports. The Health Home will assist in coordinating these services and following up with consumers post-service engagement.

At the population level, the Health Home team will: develop and monitor cooperative agreements with community and social support agencies that establish collaboration, follow-up, and reporting standards; recruit agencies to enter into those collaborative agreements; and provide training and technical assistance as needed regarding the special needs of and effective interventions for the population.

Health Homes will additionally connect participants with peer support services, support groups, and self-care programs as appropriate, which may occur on-site. Although provision of such programs does not qualify as a Health Home service, the initial referral may.

Referral to Community and Social Support Services will be reported in eMedicaid by reporting referrals made or assistance provided to access any of the following services:

- ☐Medicaid eligibility
- ☐Disability benefits
- ☐Social services
- ☐Narcotics/Alcoholics Anonymous
- ☐Housing
- ☐Legal services
- ☐Peer support
- ☐Life skills
- ☐Educational/vocational training and support
- ☐Other

Health Home Discharge Process

Discharge from the Health Home will primarily result from incidents such as relocation or loss of Medicaid eligibility. In such cases, the Health Home provider will follow discharge protocol appropriate to the circumstances. In such cases where an individual's PRP, MTS, or OTP services cease due to stabilization or reaching age 18, they may remain in the Health Home for six months, during which time the Health Home provider will support their transition to the appropriate level of care. Discharge planning may include the development of a discharge plan with referrals to the appropriate services and providers which ensure continuity of care. The Health Home provider will report in eMedicaid the discharge of a participant, as well as note the completion of discharge planning.

Reporting

eMedicaid Reporting Requirements

Health Homes must report in eMedicaid all services delivered on a monthly basis in order to confirm that a participant has received the minimum of two services. eMedicaid will generate a monthly report of services delivered, to be reviewed prior to submitting requests for payment. The Department will monitor these eMedicaid reports and claims received to confirm appropriate billing practices.

As indicated under Health Home Service Delivery, providers should reassess participants' medical conditions and social indicators every six months, and update these in eMedicaid.

Biannual Program Assessment

Every six months, on an ongoing basis following enrollment as a Health Home, providers must complete a brief program assessment and submit to the Department. This should be informed in part by Health Homes staff meeting every six months at minimum to discuss Health Home status and goals. Please refer to Appendix G for a copy of this assessment.

Health Information Technology

eMedicaid

The eMedicaid Health Homes tool will be used for purposes of Health Home intake, service reporting, outcomes reporting, and basic care management. Providers must be enrolled with Maryland Medicaid to gain access to eMedicaid. Following enrollment, the provider's site administrator may authorize access to the Health Home portal and assign staff user IDs to report and review services and outcomes, as well as enroll participants.

Participant Intake

In order to enroll a new participant in Health Home services, a provider must complete the initial intake and assessment process specified in this document.

Providers will use the eMedicaid portal to report the following information during intake:

- ☐Demographic information and identifiers,
- ☐Conditions qualifying participants for the Health Home
- ☐Additional chronic conditions or risk factors, as applicable
- ☐Baseline health indicators
- ☐Social indicators

Ongoing Service Reporting

Providers must report on a monthly basis Health Home services delivered to each participant, to be completed in full prior to submitting a claim for the monthly rate, and within 30 days of the end of the month in which the services were delivered. Services are categorized into six primary core areas, with an option to report "other" available as appropriate. Staff are encouraged to report services as they are delivered, rather than waiting until the end of a month to do so, in order to allow for timely billing.

Outcomes Reporting

At any time, providers may use eMedicaid to report updated outcomes and indicators related to both health and social factors such as housing or employment. A re-assessment and reporting of a set of indicators is required on a biannual basis.

Health Information Technology (2)

Data Review and Reports

Providers may review information entered into eMedicaid at any time for the purposes of basic care management, as well as generating a variety of reports at the participant or provider level.

Comprehensive eMedicaid Instructions

The Department will provide training and instructional materials specifically addressing the use of eMedicaid among Health Home providers. An instructional manual is available on the DHMH Health Homes website and will be distributed to providers upon request or receipt of a Health Home provider application.

Chesapeake Regional Information System for Our Patients (CRISP)

Health Home providers must enroll with the Chesapeake Regional Information System for Our Patients (CRISP) to participate in CRISP's encounter notification system (ENS) and pharmacy monitoring capability. CRISP will notify Health Homes in real time when a participant is encountered at any hospital in Maryland, as well as allowing providers to monitor prescription drugs dispensed to their participants.

To register with CRISP:

Email: hie@crisphealth.org

Visit: http://www.crisphealth.org/Contact/tabid/111/Default.aspx

Electronic Health Records and Care Management Tools

While Health Homes are not required to use an electronic health record (EHR) or care management tool, providers are encouraged to do so. Such tools can significantly aid in improving efficiency, participant outcomes, and population level care management. The Department will work with providers using HIT tools to determine whether these may assist in reporting Health Home services and outcomes.

Billing and Payment

Claims Submission and Reimbursement

Health Home providers will submit claims directly to the Department's fee-for-service system using the CMS 1500 form. Providers may be reimbursed for two types of Health Home services-- the initial intake process and the ongoing per member, per month rate for monthly Health Home services. The initial intake process may be billed once per participant, upon completion and submission of the eMedicaid intake.

Before submitting a claim for a participant's monthly Health Home rate, the Health Home should confirm that the individual:

- Is Medicaid eligible at the time of service delivery and engaged in treatment or rehabilitation with either an OTP or PRP or MTS services;
- Is enrolled as a Health Home member at the billing Health Home provider; and
- Has received a minimum of two Health Home services in the stated month that have been documented in eMedicaid.

Step-by-step instructions regarding billing of Health Home services using the CMS Form 1500 are available on the DHMH Health Homes website, and will be distributed to providers upon request or receipt of a Health Home provider application.

Duplicative Billing

Providers may not designate as a Health Home service any activity that has already been billed to or counted towards a service requirement for another Medical Assistance Program or other program. This is particularly relevant in the case of PRP Health Home participants, for whom services such as some health promotion activities could reasonably be categorized as either PRP or Health Home services. In such instances, the provider must decide to which program the service will be attributed and recorded accordingly.

Time Limits and Sanctions

Health Home providers are asked to submit claims within 30 days of the end of the month for which they are requesting payment. For example, if 200 Health Home participants have received the two or more minimum services required in the month of October, the Health Home should report these in eMedicaid and submit claims by November 30th. Failure to do so may result in a 10% reduction in payment by the Department.

Appendices

a. Acronyms
b. Participant Scenarios
c. Resource List
d. Participant Consent Form
e. Health Home Provider Application
f. Health Home Consortium Addendum
g. Biannual Program Assessment

Acronyms

Acronym	Definition
ASO	Administrative Service Organization
CARF	Commission on Accreditation of Rehabilitation Facilities
CMS	Centers for Medicare & Medicaid Services
COMAR	Code of Maryland Regulations
CRISP	Chesapeake Regional Information System for our Patients
DHMH	Department of Health and Mental Hygiene
EHR	Electronic Health Records
EIN	Employer ID Number
ENS	Encounter Notification System
EPSDT	Early Periodic Screening & Diagnostic Testing
ER	Emergency Room
FTE	Full-Time Equivalent
HIPPA	Health Insurance Portability Assurance and Accountability Act
HIT	Health Information Technology
IBR	Incorporation by Reference
IIMR	Integrated Illness Management and Recovery
ITP	Individual Treatment Plan
MA	Medical Assistance
MTS	Mobile Treatment Services
NPI	National Provider Identification
OHCQ	Office of Health Care Quality
OMT	Opiate Maintenance Therapy
OP	Outpatient
OTP	Opioid Treatment Program
PA	Physician's Assistant
PCP	Primary Care Physician
PRP	Psychiatric Rehabilitation Program
SED	Serious Emotional Disturbance
SPMI	Serious Persistent Mental Illness
STI	Sexually Transmitted Infection

Participant Scenarios

Psychiatric Rehabilitation Program Health Home
SPMI Participant Narrative

Participant Background
"Alex*" is a 45 year old man with a current primary mental health diagnosis of schizophrenia, and a co-occurring alcohol abuse disorder. His mental illness emerged in his 20s, with target symptoms over the years including auditory hallucinations (hearing voices telling him to hurt himself), paranoia (that his now-estranged wife and the CIA are trying to poison him), delusions (that he has government secrets making him a CIA target, that his excessive alcohol consumption isn't harmful, and that one day he will be a famous spy novelist), denial of mental and physical health conditions, treatment non-compliance, and combative behavior (often triggered by hearing the voices or feeling that he doesn't need healthcare and that health care providers are trying to kill him). He is estranged from his wife and two of his three daughters, with the third minimally and cautiously involved. Alex spent a total of 10 years in state psychiatric hospitals and general hospital psychiatric units. Most recently, he has had several hospital admissions for kidney related issues, after which he does not comply with the treatment. Upon his most recent admission it became evident that Alex was in the early stages of chronic kidney disease due to the decades of alcoholism, and that without appropriate intervention, his condition will deteriorate to the point of needing dialysis.

Referral for Health Home Services
There are two elements to Alex's initial engagement with a Psychiatric Rehabilitation Program (PRP) Health Home.

1. Referral for PRP services

The major barriers to Alex's physical health originate from the symptoms of his behavioral health disorders. Therefore, a PRP program specializing in aggressive outreach to individuals in denial about their mental illness and resistant to care may be best able to impact his physical health while treating his behavioral health conditions. Alex's daughter called for the ambulance leading up to his most recent admission, and remained involved with his care following admission, expressing to hospital staff that she is overwhelmed by his current condition. A hospital social worker assigned to Alex upon admission refers Alex to a PRP Health Home near his residence, and the PRP sends an intake staff member to meet with Alex and his daughter prior to his discharge.

2. Referral for Health Home Services

The local PRP serves as a Health Home as well, with protocols in place to begin the Health Home enrollment process as an individual is evaluated for PRP services.

Participant Scenarios (2)

Client Engagement and Enrollment

The Health Home Director and the Director of PRP services discuss the referrals, and recognize through the organization's experience in working with treatment-resistant individuals with serious persistent mental illness (SPMI) that a PRP outreach counselor should partner with the Nurse Care Manager (NCM) in engaging Alex with PRP and Health Home services. The two share responsibilities to complete the following steps, with support from additional staff.

1. Determine eligibility for PRP and Health Home services

a. PRP Health Home staff confirm a diagnosis of SPMI and obtain pre-authorization for PRP services from Maryland's Administrative Services Organization (ASO).

2. Employ motivational interviewing to engage Alex in services

a. Applying the basic principles of Motivational Interviewing, it is clear in referral that Alex's desire to work as a spy novelist is a hugely motivating factor in his life. So, the PRP counselor visits Alex with the idea that the PRP can help him pursue his vocational dream, and begins to build some trust and interest. The PRP counselor and Alex decide to pursue part-time "entry-level" job possibilities at the public library, shelving books and other administrative support tasks, and it becomes clear to Alex that his health condition is a barrier to his vocational dream. As such, Alex agrees to see the PRP Care Manager to work towards the goal of improving his health conditions.

3. Physician or Nurse Practitioner Consultant performs comprehensive health assessment including somatic, behavioral health, and social support needs, in collaboration with Care Manager and PRP staff.

4. Update care plan with input from Alex and his daughter

5. Discuss the Health Home program and obtain consent

6. Complete participant's intake and enrollment using the eMedicaid Health Home online portal

a. This process includes uploading the recently-developed care plan, formally assigning the Care Manager, and reporting Alex's baseline chronic conditions, measures, and social indicators.

b. The Health Home may now submit a claim for the intake process and begin providing regular Health Home services.

Participant Scenarios (3)

Provision of PRP Health Home Services

The Care Manager, Physician or Nurse Practitioner Consultant, and the PRP staff provide holistic PRP and Health Home Services that help Alex with his physical health conditions, particularly his chronic kidney disease. Below are examples of some of the services.

1. Comprehensive Care Management

As mentioned above, the Care Manager completes a health assessment and the entire team works with Alex to develop a comprehensive care plan that integrates both PRP and Health Home services. This addresses his physical and behavioral health needs with clear goals and action steps. A primary goal is to address Alex's rapidly advancing kidney disease, and the following actions are delineated:

a. Establish regular care with Primary Care Provider (PCP)
b. Abstinence from alcohol
c. Medication compliance

2. Care Coordination

Alex has not been seen by his PCP in over a year and cannot recall the provider's name, so the Health Home's administrative support staff contacts his MCO to identify the provider and assist Alex in scheduling an appointment with the PCP. The staff member follows up with Alex the day before to remind him of the appointment.

The Care Manager meets with Alex at least once per month to monitor his health. Unfortunately, over time, Alex's disease worsens despite the Health Home's best efforts, and he needs to receive dialysis, so the Care Manager coordinates arrangements with an outpatient dialysis center. However, Alex at times refuses to attend dialysis, and occasionally has angry outbursts upon arrival. The Care Manager conducts an in-service training to the dialysis center staff regarding how to accommodate Alex's mental illness and associated behaviors.

3. Health Promotion

The Care Manager works with Alex on two health promotion goals arising from his Care Plan:

i) reduce alcohol use; and
ii) comply with treatment recommendations around kidney disease.

For the first goal, the Care Manager, as well as the PRP staff, work with Alex to emphasize the importance of stopping alcohol use, but it is done in the context of the SAMSHA-endorsed evidence-based practice of Integrated Dual Disorders Treatment, which is a multi-disciplinary team intervention for people with co-occurring mental illness and substance use disorders. In particular, the Care Manager uses a harm reduction vs. abstinence approach when working with Alex about his continued alcohol use. Through motivational interviewing, the Care Manger does not tell Alex that he needs to stop all together, but instead, helps Alex to see that he wants to drink less because it reduces barriers in his life.

With regard to the treatment compliance, the Care Manager, as well as the PRP staff, implement the evidence-based practice of Integrated Illness Management and Recovery (IIMR), an intervention that helps SPMI individuals

Participant Scenarios (4)

develop the motivation and skills to manage chronic diseases, adopt healthy lifestyles, and comply with primary care treatment recommendations. For example, the Care Manager helps Alex to borrow an iPod from his daughter so he can listen to his favorite music when he goes for dialysis, as a way to encourage him to go, and to calm him when he is there.

The Care Manager regularly utilizes CRISP's prescription drug monitoring tool to track Alex's medication compliance. When it becomes evident that he is not filling his prescriptions as regularly as necessary, the Care Manager discusses with Alex the importance of the medication in improving his health and reaching his personal goals.

4. Comprehensive Transitional Care

The Care Manager receives an alert through CRISP any time Alex is encountered at a hospital, triggering transitional care protocol, including working with the hospital's discharge coordinator to develop an appropriate care plan. In one instance, the hospital discharge plan stipulates follow-up to the local dialysis center that had already refused to continue serving Alex. The Care Manager identifies this issue, communicates the misunderstanding to the hospital, and secures a different dialysis provider.

On a second occasion, the Care Manager receives notification through CRISP that Alex visited the emergency department (ED) that day from his board-and-care room. In response, the Care Manager goes to the ED to provide support and to divert an unnecessary hospitalization. Alex was complaining of stomach pains because he thought he had been poisoned, when in fact, he was nervous about an upsetting prognosis he had been given that morning.

5. Individual and Family Support Services

The Care Manager communicates regularly with Alex's daughter on a number of issues, including soliciting her support in checking in with Alex in his boarding room, and around possibly being the designated guardian for her father. The Health Home's CM discusses with Alex and his daughter the process this would require and refers them to the local agency who can further familiarize them with this option. The Care Manager also communicates regularly with Alex and facilitates his access to services he desires, such as supported employment.

6.Referral to Community and Social Support Services

The Care Manager, with support from the rehabilitation team, contacts the pastor of a church Alex once belonged to in hopes that a natural support system might be able to enrich and supplement the support provided by the PRP and his daughter.

*Name has been changed to protect client confidentiality.

Participant Scenarios (5)

Opioid Treatment Program Health Home

Substance Use Disorder Participant Narrative

Participant Background

"Katherine*" is a 50-year-old female with a 30-year history of intravenous heroin and crack cocaine use who started methadone maintenance treatment for opioid addiction in July 2008. Katherine has a ninth grade education, and despite significant trouble with reading throughout school, she was never tested or evaluated for a learning disability. At 15 years old, she became pregnant and put the child up for adoption. This was a very difficult decision for Katherine and she fell into a deep depression. The baby's father then introduced her to heroin and cocaine, and she used these along with tobacco over the next 30 years. During this time, she had another child, and is now a grandmother and has a positive relationship with her family. She currently lives in the second floor apartment of the elderly woman for whom she cares.

Katherine initially sought treatment for her addiction upon receiving a diagnosis of Hepatitis C during an emergency department visit at age 46. Katherine stopped using heroin completely after reaching a therapeutic dose of methadone, which for her has been 115 mg once daily since January 2009. She has continued to struggle with her cocaine and tobacco use.

Referral for Health Home Services

Katherine is already engaged in methadone treatment with an approved OTP Health Home provider, who can directly identify her as eligible for Health Home services and begin the enrollment process.

Client Engagement and Enrollment

The Health Home Director and a Health Home Care Manager discuss Katherine's case and feel that she could significantly benefit from Health Home services in partnership with her ongoing OTP services. With support from additional staff, the Director and Care Manager complete the following steps to enroll Katherine in the Health Home:

1. Determine eligibility for Health Home services

a. Katherine qualifies for the Health Home program due to her diagnosis of an opioid substance use disorder, combined with her risk for developing additional chronic conditions due to her tobacco use and history of cocaine use.

2. Discuss the Health Home program and obtain consent

3. Perform comprehensive health assessment including somatic and behavioral health needs

a. Coordinate an appointment with the PCP for a full health assessment.
b. Augment assessment through collaboration with OTP staff.

4. Update care plan with input from Katherine and her daughter, identifying supports, goals, and challenges

5. Complete participant intake and enrollment using the eMedicaid Health Home online portal

a. This process includes uploading the recently-updated care plan, formally assigning the Care Manager, and reporting Katherine's baseline chronic conditions, baseline data, and social indicators as assessed during the earlier stages.
b. The provider may now submit a claim for reimbursement for the intake process, and begin provision of regular Health Home services.

Provision of OTP Health Home Services

The Care Manager, Physician Consultant, and additional OTP staff provide comprehensive OTP and Health Home Services that help Katherine with her physical and behavioral health conditions. Below are examples of some of these services.

1. Comprehensive Care Management

As mentioned above, the Care Manager ensures a comprehensive health assessment is completed by the PCP, and augments with a standardized mental health screening and input from OTP staff involved in Katherine's care to inform the update of her care plan, which integrates both OTP and Health Home services and goals. This addresses her physical and behavioral health needs with clear goals and action steps. The care plan emphasizes the following issues:

a. Re-engagement with PCP
b. Hepatitis C management
c. Tobacco cessation
d. Cocaine use reduction

2. Care Coordination

Katherine has not been seen regularly by her PCP in a number of years, so the Care Manager and administrative support staff assist her with scheduling the initial full health assessment, as well as consistent follow-up. These appointments include monitoring of Katherine's Hepatitis C to ensure that the condition is well-managed. Through regular contact and communication, the Health Home makes progress towards establishing an ongoing, trusting relationship between the PCP, Katherine, and the Health Home itself.

Participant Scenarios (7)

3. Health Promotion
The Health Home's health promotion activities emphasize the goals outlined in Katherine's care plan. Upon enrollment, Katherine and her Care Manager have an extensive discussion regarding her Hepatitis C, addressing steps that she can take to minimize the risk of complications and manage her condition. They also discuss her continuing tobacco and cocaine use and how these behaviors could have a significant negative effect on her health. The Care Manager refers Katherine to her counselor within the OTP for further intensive health education regarding tobacco and cocaine cessation.

4. Comprehensive Transitional Care
The Care Manager receives a real-time alert through the Chesapeake Regional Information System for Our Patients (CRISP) any time Katherine is encountered at a hospital, triggering transitional care protocol. This includes working with the hospital's discharge coordinator to develop an appropriate care plan, and assisting Katherine in scheduling the appropriate follow-up appointments. The Health Home receives an alert that Katherine has been hospitalized for a large pulmonary embolus, and reviews the treating provider's discharge plan. Upon discharge, Katherine is dependent on continuous home oxygen and has been prescribed Coumadin. She is staying with her daughter and grandchildren after her discharge from the hospital.

The day of Katherine's discharge, the Care Manager performs a home visit and speaks with Katherine and her daughter about her condition. They decide that she should move in permanently with her daughter to be closer to her support system and allow her daughter to assist with Katherine's care. The Health Home staff meets to discuss and update Katherine's care plan with her input, re-emphasizing the need for tobacco and cocaine cessation. The hospitalization has had considerable effect on Katherine's self-motivation regarding the importance of these measures, and over the following months she is able to successfully eliminate all tobacco and cocaine usage with significant support from her counselor and a peer support group. Additionally, the Health Home team assists Katherine in following up with the Coumadin clinic.

5. Individual and Family Support Services
In one instance, Katherine arrives at the Health Home frantic because someone has called her from the durable medical equipment company stating that they were coming to pick up the oxygen within three days as it is no longer covered by her insurance. She tried contacting her Managed Care Organization (MCO) but had a difficult time managing the automated telephone system and is now extremely anxious that she will lose her oxygen. The administrative support staff member assists in connecting her with the MCO, and together they identify and resolve the miscommunication.

As Katherine works towards reducing and eventually halting her tobacco and cocaine use, she struggles with anxiety and finds herself putting on weight as she overeats in response. The counselor with whom she has been working addresses the issue with her and together they decide that she could benefit from additional counseling with a peer support group within the OTP. It is this group that proves extremely helpful in addressing Katherine's anxiety and substance use cessation efforts. To address the recent weight gain, Katherine and her Care Manager note a new goal on her care plan—to reach and maintain a healthy weight—and discuss her action steps towards this objective.

Participant Scenarios (8)

6. Referral to Community and Social Support Services

During a visit with her Care Manager, Katherine expresses an interest in continuing her education and improving her reading skills so that she can better manage daily tasks and read with her grandchildren. The Care Manager identifies several potential adult education programs and Katherine selects one closest to her residence. The administrative support staff then assists her with scheduling an appointment with the organization to review their options and enroll in the program.

*Name has been changed to protect client confidentiality.

Resources

Name	Region	Phone/Fax	Email	Website
Administrative Services Organization				
Value Options	Maryland	P: 800-888-1965 or 866-835-2755		Maryland.valueoptions.com
Community Groups				
On Our Own of Maryland	Maryland	P: 410.646.0262 or 1.800.704.0262 F: 410.646.0264	ooomd@earth-link.net	http://www.onourownmd.org/
Healthy Teeth Healthy Kids	Maryland	P: 1-855-458-3384		http://healthyteethhealthykids.org/
Greater Baltimore Asthma Alliance (GBAA)	Baltimore			http://www.baltimoreasthma.org/
Core Service Agencies				
Maryland Association of Core Service Agencies	Maryland	P: 301-682-9754 F: 301-682-6019	macsa@mhma.net	http://www.marylandbehavioralhealth.org/
Baltimore Mental Health Systems	Baltimore	P: 410-837-2647 F: 410-837-2672	info@bmhsi.org	http://www.bmhsi.org/
Allegany County Mental Health System's Office	Allegany County	P: 301-579-5070 F: 301-777-5621	mhso@herein-town.net	http://www.alleganyhealthdept.com/mhso/
Anne Arundel County Mental Health Agency	Anne Arundel County	P: 410-222-7858 F:410-222-7881	info@aamental-health.org	http://www.aamentalhealth.org/
Baltimore County Bureau of Behavioral Health	Baltimore County	P: 410-887-3828 F: 410-887-3786	health@balti-morecountymd.gov	http://www.baltimorecountymd.gov/Agencies/health/health-services/mental/

Resources

Calvert County Core Service Agency	Calvert County	P: 410-535-5400 F: 410-414-8092	CoreServicesC-CHD@dhmh.state.md.us	http://www.calverthealth.org/personalhealth/mentalhealth/coreagency.htm
Mid-Shore Menta Health Systems, Inc.	Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties	P: 410-770-4801 F: 410-770-4809	csa@msmhs.org	http://www.msmhs.org/
Carroll County Core Service Agency	Carroll County	P: 410-876-4440 F: 410-876-4929		http://www.carrollhealthdepartment.dhmh.md.gov/mental.html
Cecil County Core Service Agency	Cecil County	P: 410-996-5112 F: 410-996-5134	info@cecil-countyhealth.org	http://www.cecilcountyhealth.org/ccdhxx/ccdhCoreSer-vice.htm
Charles County Department of Health Core Service Agency	Charles County	P: 301-609-5757 F: 301-609-5749 1-800-735-2258		http://www.charlescountyhealth.org/Divisions/CoreSer-viceAgency/tabid/502/Default.aspx
Mental Health Management Agency of Frederick County	Frederick County	P: 301-682-6017 F: 301-682-6019		http://www.mhma.net/
Garrett County Core Services Agency	Garrett County,	P: 301-334-7440 F: 301-334-7441	gccsa.gchd@maryland.gov	http://www.garretthealth.org/departments/core.htm
Office on Mental Health of Harford County	Harford County	P: 410-803-8726 F: 410-803-8732	cswartz@harfordmen-talhealth.org	http://harfordmentalhealth.org/
Howard County Mental Health Authority	Howard County	P: 410-313-7350 F: 410-313-7374	hcmha@hcm-ha.org	http://www.hcmha.org/
Montgomery County Core Service Agency/ Behavioral Health Planning and Management	Montgomery County	P: 240-777-1400 F: 240-777-1145		http://www3.montgomerycountymd.gov/311/Solutions.aspx?SolutionId=1-9LUNX

Dept. of Family Services Mental Health & Disabilities Division Prince George's County Core Service Agency	Prince George's County	P: 301-265-8400 F: 301-248-4886		http://www.princegeorgescountymd.gov/government/agencyindex/familyservices/mental_health.asp
Wicomico Somerset County Regional Core Service Agency	Somerset and Wicomico Counties	P: 410-543-6981 F: 410-219-2876		http://www.wicomicohealth.org/index.aspx?pageId=61
St. Mary's County Dept. of Aging & Human Services	St. Mary's County	P: 301-475-4200 ext. 1682 F: 301-475-4000		http://www.co.saint-marys.md.us/
Washington County Mental Health Authority	Washington County	P: 301-739-2490 F: 301-739-2250	wcmha@wcm-ha.org	http://www.wcmha.org/
Worcester County Core Service Agency	Worcester County	P: 410-632-3366 F: 410-632-0065		http://www.worcesterhealth.org/planning-sidebar/core-service-agency-csa
Fact Sheets				
Oral Health Information - Dept. of Health & Mental Hygiene				http://phpa.dhmh.maryland.gov/oralhealth/SitePages/OH_factsheets.aspx
Youth Tobacco Cessation and Prevention: A Guide for Making Informed Decisions - Centers for Disease Control & Prevention				http://www.cdc.gov/tobacco/quit_smoking/cessation/youth_tobacco_cessation/
Publications from Division of Adolescent and School Health - Centers for Disease Control & Prevention				http://wwwn.cdc.gov/pubs/dash.aspx

Opiod Treatment Information SAMHSA Division of Pharmacotherapy			otp-extranet@opioid.samhsa.gov	http://www.dpt.samhsa.gov/medications/medsindex.aspx
Smoke Free Teen	USA			http://teen.smokefree.gov/default.aspx
Hotlines				
Baltimore Crisis Hotline	Baltimore	410-433-5175		
Maryland Youth Crisis Hotline	Maryland	P: (800) 422-0009		
Mental Health Assistance Hotline	Maryland	P: (800) 888-1965		
Maryland Local Health Departments				
Maryland Local Health Departments	Maryland			http://msa.maryland.gov/msa/mdmanual/01glance/html/healloc.html
Anne Arundel County Health Department	Anne Arundel County		hdchan22@aacounty.org	http://www.aahealth.org/
Baltimore City Health Department	Baltimore City	P: 410-396-4398	bchd2@baltimorecity.gov	http://www.baltimorehealth.org/
Baltimore County Health Department	Baltimore County	P: 410-887-2243	health@baltimorecountymd.gov	http://www.baltimorecountymd.gov/agencies/health/index.html
Calvert County Health Department	Calvert County	P: 410-535-5400 F: 410-535-5285	calvert.admin@maryland.gov	http://www.calverthealth.org/
Caroline County Health Department	Caroline County	P: 410-479-8030 F: 410-479-0554		http://www.carolinehd.org/
Carroll County Health Department	Carroll County	P: 410-857-5000 or 410-876-2152 or 410-875-3390		http://www.carrollhealthdepartment.dhmh.md.gov/

Cecil County Health Department	Cecil County	P: 410-996-5550		http://www.cecilcountyhealth.org/ccdhxx/default.php
Charles County Health Department	Charles County	P: 301-609-6900 F: 301-934-4632 TTY: 800-735-2258		http://www.charlescountyhealth.org/
Dorchester Health Department	Dorchester County	P: 410-228-3223 F: 410-228-9319	dchd-webmas-ter@dhmh. state.md.us	http://www.dorchesterhealth.org/
Frederick County Health Department	Frederick County	P:301-600-1029 F:301-600-3111		http://www.frederickcountymd.gov/index.aspx-?nid=2347
Garrett County Health Department	Garrett County	P: 301-334-7777 or 301-895-3111 F: 301-334-7701	webmaster@ garrettheath. org	http://www.garretthealth.org/
Harford County Health Department	Harford County	P: 410-838-1500 F: 410-638-4952 (Note: check web-site for other office numbers)	harfordcounty. healthdepart-ment@mary-land.gov	http://www.harfordcountyhealth.com/
Howard County Health Department	Howard County	P: 410-313-6300 or 1-866-313-6300 F: 410-313-6303	askhealth@ howardcoun-tymd.gov	http://www.hchealth.org/
Kent County Health Department	Kent County	P: 410-778-1350 F: 410-778-6119 1-800-735-2258		http://www.kenthd.org/
Montgomery County Department of Health & Human Services	Montgomery County	P: 240-777-1266	hhsmail@ montgomery-countymd.gov	http://www.montgomerycountymd.gov/hhs/indexnew.html
Prince George's County Health Department	Prince George's County	P: 301-883-7879 F: 301-883-7896		http://www.princegeorgescountymd.gov/health/

Resources

Queen Anne's County Department of Health	Queen Anne's County	P: 410-758-0720	qawebmas-ter@dhmh.state.md.us	http://www.qahealth.org/
St. Mary's County Health Department	St. Mary's County	P: 301-475-4330 F: 301-475-4350		http://www.smchd.org/
Somerset County Health Department	Somerset County	P: 443-523-1700 F: 410-651-5680		http://www.somersethd.org/
Talbot County Health Department	Talbot County	P: 410-819-5600 F: 410-819-5690	webmaster@talbothealth.org	http://www.talbothealth.org/
Washington County Health Department	Washington County	P: 240-313-3200	wash.health@maryland.gov	http://www.washhealth.org/
Wicomico County Health Department	Wicomico County	P: 410-749-1244 F: 410-543-6975		http://www.wicomicohealth.org/index.aspx?pageId=1
Worcester County Health Department	Worcester County	P: 410-632-1100		http://worcesterhealth.info/
Provider Directories				
"Find a Provider" Search Engine	Maryland			https://encrypt.emdhealthchoice.org/searchable/main.action
Buprenorphine Physician & Treatment Program Locator - SAMHSA				http://buprenorphine.samhsa.gov/pls/bwns_locator/!provider_search.process_query?alternative=CHOICEG&one_state=MD
Public Agencies				
Maryland Local Departments of Social Services	Maryland	P: 800-332-6347		http://www.dhr.state.md.us/blog/?page_id=3241
Mental Health Association of Maryland	Maryland	P: 443-901-1550	info@mhamd.org	http://www.mhamd.org/
Resource Finders				

Resources

Alcohol and Drug Abuse Administration (ADAA) Resource Directory	Maryland			http://adaa.dhmh.maryland.gov/SitePages/ADAA-ResourceDirectory.aspx
Network of Care				http://networkofcare.org/splash.aspx?state=maryland
Maryland Coalition of Families for Children's Mental Health	Maryland	P: 410.730.8267 or 1.800.607.3637 F: 410.730.8331	info@mdcoalition.org	www.mdcoalition.org/resources/organizations
National Alliance for Mentally Ill	Maryland	P: 410-884-8691or 1-877-878-2371	info@namimd.org	http://www.namimd.org/resource_center
County Coordinators and HG 8-505 Evaluators	Maryland			http://adaa.dhmh.maryland.gov/SitePages/County%20Coordinators%20and%20HG%20%C2%A78-505%20Evaluators.aspx
Maryland Community Services Locator (MDCSL)	Maryland			http://www.mdcsl.org/advantagecallback.asp?template=map_search
Alliance for the Advocates of Buprenorphine Treatment				https://www.treatmentmatch.org/patients.cfm
Videos				
What You Need To Know About Chlamydia				http://www.youtube.com/watch?v=HmYSC8zzMR4&feature=youtu.be

Health Homes Informed Consent

Health Home Participant Information Sharing Consent Form

By signing this form, you agree to be in the _____ Health Home.
To be in a Health Home, health care providers and other people involved in your care need to be able to talk to each other about your care and share your health information with each other to give you better care. While being in a Health Home will help make sure you get the care you need, you will still be able to get health care and health insurance even if you do not sign this form or do not want to be in the _____ _____ Health Home.

This form lets the Health Home partners listed at the end of this form to get your health information in order to improve your care. The partners may get your health information including your health records and some prescription drug information. The partners listed on this form may get, see, read, copy, and share ALL of your health information that they need to give you care, manage your care, or study your care to make health care better for participants. The health information they may get, see, read, copy and share may be from before and after the date you sign this form.

Your health records may have information about illnesses or injuries you had or may have had before; test results, like X-rays or blood tests; and the medicines you are now taking or have taken before. Your health records may also have information on:

1. Alcohol or drug use programs which you are in now or were in before as a patient;
2. Family planning services like birth control and abortion;
3. Inherited diseases;
4. HIV/AIDS;
5. Sexually-transmitted diseases and treatment; and
6. Mental health conditions

The partners may give your health information to your other health care providers or other people involved in your care. Your health information is private and cannot be given to other people without your express consent under Maryland and U.S. laws and rules. Some special laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The partners that can get and see your health information must obey all these laws. They cannot share your information unless you agree or the law says they can give the information to other people. This is true if your health information is on a computer system or on paper.

Please read all the information on this form before you sign it.

Health Homes Informed Consent

I AGREE to be in the _____ Health Home and agree that all of the Health Home partners listed at the end of this form may receive my health information through paper or electronic means if they need the information to give or manage my care, check if I am in a health plan and what it covers, to confirm whether I am in a Health Home program, or to study information to improve the care of all patients. I understand this Consent Form takes the place of other Consent Forms I may have previously signed to share my health information, except for my Maryland Medicaid form. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form and giving it to one of the Health Home partners.

DETAILS ABOUT PATIENT INFORMATION AND THE CONSENT PROCESS

1. How will partners use my information?
If you agree, partners will use your health information to:

- Give you health care and manage your care;
- Check if you have health insurance, belong to a Health Home, and what it pays for; and
- Study and improve health care for all participants.

The choice you make does NOT let health insurers see your information so they can decide to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers must use.

2. Where does my health information come from?
Your health information comes from places and people that gave you health care or health insurance in the past. These may include hospitals, doctors, drugstores, laboratories, health plan companies, the Medicaid program, and other groups that share health information. You can get a list of all the places and people by calling _____or talking to your care manager.

3. What laws and rules cover how my health information can be shared?
These laws and regulations are Health-General Article, Title 4, Subtitle 3, Annotated Code of Maryland; and the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 CFR Parts 160 and 164 and the federal confidentiality regulations 42 CFR Part 2.

4. If I agree, who can get and see my information?
The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for a Health Home partner and who are involved in your health care; health

Health Homes Informed Consent

care providers who are working for a Health Home partner who is giving you care; and people who work for a Health Home partner who is giving you care to help them check your health insurance or to study and make health care better for all patients.

When you get care from a person who is not your usual doctor or provider, like a new drugstore, new hospital, or other provider, some information, like what your health plan pays for or the name of your Health Home provider may be given to them or seen by them.

5. What if a person uses my information and I didn't agree to let them use it?
If you think a person used your information, and you did not agree to give the person your information, call the Medicaid Helpline at 1-800-541-2831.

6. How long does my consent last?
Your consent will last until the day you take back your consent, or if you leave the Health Home program, or if the Health Home stops operating.

7. What if I change my mind later and want to take back my consent?
You can take back your consent at any time by signing a Withdrawal of Consent Form and giving it to one of the Health Home partners. If you agree to share your information, all Health Home partners listed at the end of this form will be able to get your health information. If you do not wish the Health Home partners listed on this form to get your health information, you need to take away your consent from the Health Home program. You can get this form by calling _____. Your care manager will help you fill out this form if you want. Note: Even if you decide later to take back your consent, providers who already have your information do not have to give your information back to you or take it out of their records.

8. How do I get a copy of this form?
You can have a copy of this form after you sign it.

Participant Name_____

Participant Signature_____ Date_____

Please submit names of Participating Partners on the following page and attach additional pages if necessary.

Health Homes Informed Consent

Name of Participating Partner _____

Name of Participating Partner _____

Name of Participating Partner _____

Name of Participating Partner _____

Name of Participating Partner _____

Name of Participating Partner _____

Name of Participating Partner _____

Name of Participating Partner _____

Name of Participating Partner _____

Name of Participating Partner _____

Name of Participating Partner _____

Maryland Medicaid Health Home Provider Application

1. Applicant Information:

NPI: _____ Medicaid Provider Number: _____

Organization Name: _____

Primary Organization Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Telephone Number: _____ Fax Number: _____

County Code: _____ Website: _____

Provider Type (check all that apply): ☐ Adult PRP ☐ Child PRP ☐ MT ☐ OTP

For child PRP providers, list number of years of experience providing PRP services to children: _____

Federal Employer Identification Number (EIN): _____ Name of EIN Owner: _____

Medicare Provider Number: _____ Fiscal Year End Date: _____

OHCQ Registration Number: _____ Date Issued: _____Expiration Date: _____

Pay-To-Address: _____

City: _____ State: _____ Zip Code: _____

Organization Contact Person: _____

Title: _____ Telephone Number: _____

Fax Number:_____ Email Address: _____

Other Practice Location Information (attach additional sheet if needed)

Practice Address #2: _____

City: _____ State: _____ Zip Code: _____ County Code: _____

Telephone Number: _____ Fax Number: _____

NPI: _____

Practice Address #3: _____

City: _____ State: _____ Zip Code: _____ County Code: _____

Telephone Number: _____ Fax Number: _____

NPI: _____

2. Health Home Accreditation:

Please check the appropriate box regarding the status of your organization's Health Home accreditation.

☐ Currently have CARF Health Home accreditation

Date Issued: _____ Expiration Date: _____

☐ Do not currently have CARF Health Home accreditation, have attached CARF Letter of Intent to survey for the Health Home

☐ Have JCO general accreditation and will pursue JCO Health Home accreditation once it is available

Date Issued: _____ Expiration Date: _____

3. Consortium:

Will this application include a consortium agreement with another agency?

☐ Yes ☐ No

If yes, sections 4b through 5 will be submitted jointly.

4. Health Home Staffing:

A. What is your organization's current number of Medicaid enrollees? _____

B. Based on this Medicaid enrollment number, what are the staffing levels your organization must have for the following Health Home positions? Please see the attached application instructions for an explanation of how to determine staff levels required for a given enrollment number.

1) Nurse Care Manager: _____

2) Health Home Director: _____

3) Physician or nurse practitioner: _____

4) Administrative support staff: _____

C. Provide the job descriptions used to recruit the Health Home staff, including the qualifications and responsibilities of each position:

1) Nurse Care Manager:

2) Health Home Director:

3) Physician or nurse practitioner:

4) Administrative support staff:

5. Health Home Provider Standards:

Describe the systems and protocols your Health Home will use to meet each of the core service requirements and functional components. The detailed description should include the staff performing, process, procedure, and outcome evaluation.

1) Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home services:

2) Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines:

3) Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders:

4) Coordinate and provide access to mental health and substance abuse services:

5) Coordinate and provide access to comprehensive care management:

6) Coordinate and provide access to care coordination:

7) Coordinate and provide access to transitional care across settings (transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of care):

8) Coordinate and provide access to chronic disease management, including self-management support to individuals and their families:

9) Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services:

10) Coordinate and provide access to long-term care supports and services:

11) Develop a person-centered care plan for each enrollee that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:

12) Demonstrate a capacity to use HIT to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:

13) Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level:

6. HIT, Reporting, and Evaluation:

A. Please answer the following questions regarding your organization's HIT capabilities:

1) Does your organization have structured, interoperable HIT systems, policies, procedures, and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every participant?

☐ Yes ☐ No

2) Does your organization use an electronic health record (EHR) system that allows a participant's health information and plan of care to be accessible to the interdisciplinary team of providers?

☐ Yes ☐ No

3) Does your organization use HIT to facilitate communication among provider team members and between the provider team and the client and client's family caregivers?

☐ Yes ☐ No

4) Is your organization enrolled with the Chesapeake Regional Information System for our People (CRISP) Encounter Notification System to receive alerts of participant admissions, discharges, or transfers in a hospital or emergency department setting?

☐ Yes ☐ No

If Yes, please provide your organization's CRISP identification number: _____

If No, please attach documentation that you have begun the enrollment process.

5) Is your organization enrolled with Value Options (VO), the State's Administrative Services Organization (ASO), to access participant pharmacy data?

☐ Yes ☐ No

If Yes, please provide your organization's VO identification number: _____

If No, please attach documentation demonstrating you have begun the enrollment process.

B. Please answer the following questions regarding reporting and evaluation requirements.

1) Does your organization agree to participate in CMS and state-required evaluation activities, including submitting monthly online eMedicaid reports documenting Health Home service delivery and enrollees' health and social outcomes?

☐ Yes ☐ No

7. Attestations:

Health Home applicants must attest to the following:

1) Health Home services will include coordination of care and services post critical events (such as emergency department use, hospital inpatient admission, and hospital inpatient discharge).

   ☐ Yes ☐ No

2) Health Home services will include language access/translation capability.

   ☐ Yes ☐ No

3) Health Homes will offer 24 hour, 7 days a week on call and crisis intervention services by telephone.

   ☐Yes ☐ No

4) Health Home services will include crisis intervention.

   ☐ Yes ☐ No

5) Health Home services will include links to acute and outpatient medical, mental health, and substance abuse services.

   ☐ Yes ☐ No

6) Health Home services will include links to community-based social support services (including housing services).

   ☐ Yes ☐ No

7) Health Home services will include beneficiary consent for program enrollment and for sharing of participant information and treatment.

   ☐ Yes ☐ No

8) The Health Home will not bill the State until staffing requirements are met and service provision begins.

   ☐ Yes ☐ No

9) The Health Home will notify the State of any changes in Health Home staff.

   ☐ Yes ☐ No

10) The Health Home will engage in periodic reporting as required by the State.

   ☐ Yes ☐ No

8. Rights of the State:

A. The State reserves all rights generally afforded to the State in contracting with Medicaid providers, pursuant to Title XIX and Title XXI of the Social Security Act, Health-General, Title 15, Annotated Code of Maryland and state regulations promulgated thereunder.

B. The State reserves the following rights specifically regarding the Health Home program:

1) The State reserves the right to assign beneficiaries to a specific Health Home.

2) The State reserves the right to cancel a Health Home provider's approved status based on failure of the provider to provide Health Home services in accordance with Maryland Health Home regulations

(COMAR 10.09.33) provide quality Health Home services to its clients, or on other significant findings determined by the State.

3) The State reserves the right to cancel the Health Home program at any time for lack of funding, and/or if, after evaluation of the program, desired results in quality, efficiency, and decreased costs are not shown, or any other reason determined by the State.

☐ Yes I have read and understand.

Instructions for Completing the Maryland Medicaid

Health Home Provider Application

SECTION #1
APPLICANT INFORMATION

Enter the National Provider Identification (NPI) and the Medicaid Provider number of the group.

Enter the organization name, address, telephone and fax number of the primary practice.

Enter the appropriate two-digit code for county of your business or practice location. A listing of the county codes is provided for your reference at the end of these instructions.

Enter the website address (if applicable).

Check the appropriate box for provider type. If a child PRP provider, list the number of years providing PRP services to children.

Enter the Federal Employer ID Number (EIN), name of the EIN Owner, and Medicare Provider Number.

Enter the Office of Health Care Quality (OHCQ) License Number, issue date and expiration date. Note that if the date on your certification has expired you must obtain a letter of good standing from OHCQ and attach a copy to your application. To request a letter of good standing, please contact Jackie Cooper, Substance Abuse Certification Unit at 410-402-8054.

Enter the Pay-To-Address, you want your Medicaid related correspondence and remittance advices mailed. If you leave this blank, your checks will be mailed to the primary practice location entered earlier in the application.

Enter contact name, title, telephone and fax number, as well as email address.

Enter other locations where you serve this population.

SECTION #2
Health Home Accreditation

Check the appropriate box regarding accreditation.

If you currently have CARF Health Home Accreditation, enter the CARF Certificate issue and expiration dates.

If you do not currently have CARF Health Home Accreditation but are in the process, attach a CARF letter of Intent to Survey for the Health Home.

If you have current JCO accreditation and will pursue JCO Health Home accreditation once it is available, enter the JCO Certificate issue and expiration dates.

SECTION #3
Consortium

Check the appropriate box. If providing Health Home services as a consortium for the purpose of staff sharing, both agencies should submit an individual application. However, sections 4b through 5 will be submitted jointly.

SECTION #4
Health Home Staffing

4A. Enter your organization's current number of Medicaid enrollees served.

4B. Based on the Medicaid enrollment number entered in 4A and Health Home COMAR regulations (10.09.33), enter the staffing levels required for each position. Consortium providers will complete this information based on the combined number of Medicaid enrollees and the shared staff. Please refer to the Health Home Provider Manual for detailed staffing requirements.

4C. Job descriptions should be submitted with the application for each position.

SECTION #5
Health Home Provider Standards

The systems and protocols should include detailed descriptions of the procedure for meeting the standard or requirement. For example, it should describe:

- The goal, component or requirement,
- The staff that will perform it,
- How will the need be identified,
- Procedure for completing,
- How will outcome be assessed,
- What is process for evaluation, and
- The method for documentation.

In care management, or transitional care, the following is an example of what should be completed in utilizing the CRISP notifications:

- Who will receive the emails
- What are parameters for responding (i.e. 24-48 hours for emergency room visits)
- Who is responsible for outreach
- What type of outreach
- What strategies will be used when client does not respond to outreach attempts,
- Who will monitor outcomes and follow up as needed.

SECTION #6
HIT, Reporting, and Evaluation

Check the appropriate box for each question. Provide CRISP and Value Options identification numbers, if applicable.

SECTION #7
Attestations

Check the appropriate box for each attestation question.

SECTION #8
Rights of the State

Check the box to indicate you have read and understand the Rights of the State.

COUNTY CODES

01 Allegany	**07 Cecil**	**13 Howard**	**19 Somerset**	**40 Washington, DC**
02 Anne Arundel	**08 Charles**	**14 Kent**	**20 Talbot**	**99 Other State**
03 Baltimore County	**09 Dorchester**	**15 Montgomery**	**21 Washington**	
04 Calvert	**10 Frederick**	**16 Prince George's**	**22 Wicomico**	
05 Caroline	**11 Garrett**	**17 Queen Anne's**	**23 Worcester**	
06 Carroll	**12 Harford**	**18 St. Mary's**	**30 Baltimore City**	

Health Home Consortium Application Addendum

The Health Home consortium addendum allows providers to share Health Home staff and thus costs. The consortium is not limited to providers with less than 125 enrollees.

The consortium is limited to agreements between two (2) providers. In areas affected by shortages in health care professionals, three (3) agencies may enter into an agreement, subject to Departmental approval.

The consortium is contingent upon geographic proximity; agencies that wish to form a consortium must be physically located within 50 miles of each.. Exceptions to the geographic proximity requirement are subject to Departmental approval.

Participants will be served at the location from which they currently receive PRP, OMT, or MTS services. Each provider is responsible for individual billing and eMedicaid documentation.

Staff sharing is limited to the following clinical positions: Registered Nurse, Nurse Practitioner and Physician. Professionals in consortiums that serve adults and children must be trained to serve both populations; documentation of such training must be provided and is subject to Department approval.

Shared staff should be given dual access for utilization of eMedicaid.

Shared Staff should participate in team meetings with both agencies.

The consortium must agree to have policies and procedures that are consistent across agencies and available to all staff. Additionally, a community resource manual should be developed for each agency.

The consortium agreement must include the following components:

1. The goals and objectives;
2. An effective date and period covered by the agreement;
3. Definitions included in the agreement. It is permissible to state "As per COMAR 10.09.33" if no additional definitions are utilized;
4. The target populations to be served, especially significant if multiple populations are being served. For example, if a PRP that serves children links with an OMT, then the rationale for such a consortium must be included;
5. A list of professional credentials needed to successfully serve adults and children;
6. A description of the procedures for information-sharing between agencies and access to records; including a confidentiality agreement;
7. A description of how how a breach of confidentiality will be addressed. The description must include a statement that mentions that DHMH, Health Home staff _____, 410-767-____will be notified immediately;

8. A description of management of of shared staff, including:
    - Who will be responsible for verifying credentials, hiring and evaluating?
    - Who will be responsible for clinical supervision?
    - Who will oversee nonclinical matters, such as work hours and absences?
    - How will payment for their services be handled?
    - Where and when will work space be provided?
    - Who will order and pay for supplies?
9. A description of documentation of time exclusively dedicated to the planning and delivery of Health Home services;
10. A brief description of employee orientation for shared staff.
11. A description of emergency response availability and/or referral processes;
12. A description of the procedures for resolving operational problems and/or disagreements with minimal disruption to service provision;
13. A sample termination agreement that specifies a 60 day notice for foreseeable circumstances. The agreement must also include procedures to notifying DHMH and Health Home staff of immediate, unforeseen, or urgent resignation or termination; and
14. A description of the financial agreement, including how shared staff services will be reimbursed.

Health Home Program Assessment

Health Home providers must complete this assessment on a biannual basis, every 6 months upon gaining approval as a health Home. The form should be completed in full and submitted to the Department at dhmh.healthhomes@maryland.gov.

1. Date: _____

2. Name of Agency: _____

3. Member of Health Home Consortium: ☐ Yes ☐ No

4. Total Health Home enrollment: _____

   a. Number of new members _____

   b. Number discharged _____

5. Staffing (include vacancies):

- Health Home Director(s)

Name	FTE

- Health Home Care Manager(s)

Name	FTE

- Physician or Nurse Practitioner Consultant(s)

Name	Staffing Level

6. Summary of quality improvement initiatives over the previous six months:

Report completed by: _____ Title: _____