Maryland Health Homes Provider Training

July 9th, 2013

10:00am-1:00 pm

UMBC Tech Center

Welcome & Overview

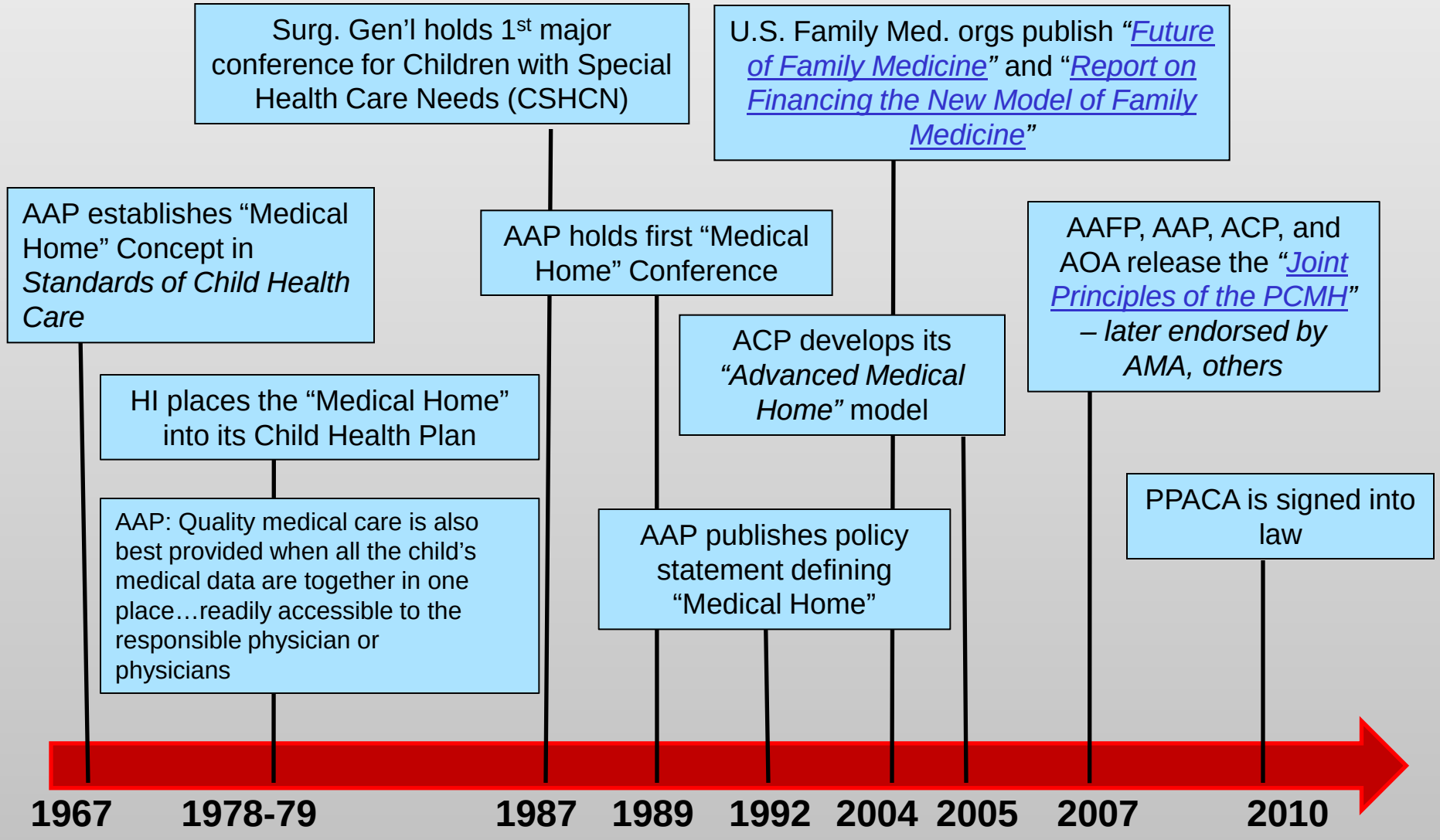
Rebecca Frechard, LCPC
Behavioral Health Division Chief, Medicaid

Health Homes & BH Integration

- Health Homes aim to:
  - further integration of behavioral and somatic care through improved care coordination
  - improve participant outcomes, experience of care and health care costs among individuals with chronic conditions

Health Home Background

Melissa Schober,
Mental Hygiene Administration



Source: Sia, et al. History of the Medical Home Concept. *Pediatrics* 2004; 113; 1473-1478.

Medical Home v. Health Home

Patient Centered Medical Home	**Health Home**
Serves all populations	Serves those with chronic disease, SMI, and/or SA
Typically physician-led, primary somatic care practices	May include PCP practices, but also community mental health centers, FQHCs, home health agencies, etc.
Reimbursement from many payers (commercial insurance, health plans, etc.)	Medicaid-only

Medical Home v. Health Home

Patient Centered Medical Home	**Health Home**
Focused on the delivery of "traditional" health care services, tends to be somatic-focused	Strong focus on BH, SA, social supports, linkages to whole-person benefits
Health IT for prescribing, labs, record-keeping	Health IT for care coordination AND EHR (provider-to-provider communication, telemedicine)

Source: National Center for Primary Care, Morehouse School of Medicine

Health Reform and Health Homes

- Created under Section 2703 of ACA
- As of Jan. 2011, states can submit a State Plan Amendment (SPA) for eligible beneficiaries
- Federal funding is 90, 10% State for coordination services *only*
  - Time limited: 8 quarters, then regular match

Six Mandated Core Services

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care, including appropriate follow-up from inpatient to other settings
- Patient and Family Support
- Referral to community and social services

Provider Requirements

- Provide quality-driven, cost-effective, culturally appropriate, person-/family-centered services;
- Coordinate/provide access to: high-quality, evidence-based preventive services;
- Develop a person-centered care plan that coordinates/ integrates clinical/non-clinical health care needs/services;
- Link services with HIT, communicate across team, individual and family caregivers, and provide feedback to practices; and
- Establish a continuous QI program.

Measurement and Reporting

- States must track and report outcomes (e.g., avoidable readmissions) and calculate cost savings
- Designated providers must report quality measures as condition of reimbursement
- SPA requires substantial description of evaluation and monitoring plans
- Independent evaluator will survey states on impact of health home services on various cost, clinical and utilization measures

Health Homes in Maryland

Morgan Cole, *Medicaid*

Health Homes in Maryland: The Planning Process

- Stakeholder Input Process
- Review of Missouri, New York, and other Health Homes
- Consultation with SAMHSA, CHCS, and CMS
- CMS SPA approval pending
- Regulations released for comment
- Provider Manual developed

Health Homes in Maryland: Eligible Participants

- Individuals with serious and persistent mental illness (SPMI)
- Children and adolescents with serious emotional disturbance (SED)
- Individuals with Opioid Substance Use Disorders, at risk for an additional chronic condition due to one of the following risk factors:
    - Current tobacco, alcohol, or other non-opioid substance use
    - A history of tobacco, alcohol, or other non-opioid substance dependence

Health Homes in Maryland: Next Steps

- Upcoming training opportunities, targeted and general
- Finalized website with provider and consumer materials
- Provider applications accepted August 1st
- Participant enrollment begins September 3rd
- Service provision begins October 1st

Health Home Provider Enrollment

Adrienne Hollimon, *Medicaid*

Provider Enrollment: Eligibility

- Provider types eligible to become Health Homes:
  - Psychiatric Rehabilitation Programs
  - Opioid Treatment Programs
  - Mobile Treatment Providers
- Specialized Criteria
  - Providers serving children must demonstrate a minimum of 3 years of experience providing services to children and youth.

Provider Enrollment: Application

Basic Information

- Complete all provider information including:
  - NPI
  - Medicaid Provider Number
  - Provider Type
  - Site Location (s)
  - OHCQ Registration Information
  - Pay to Address
  - Contact information including email address.

Provider Enrollment: Application

Health Home Accreditation

- Two approved accrediting bodies:
  - Commission on Accreditation of Rehabilitation Facilities' (CARF) Health Homes Standards
  - The Joint Commission's (JCO) Behavioral Health Homes Certification.
- Along with application, provider must submit either:
  - Certificate of Accreditation
  - Evidence that accreditation process has been initiated

Provider Enrollment: Consortiums

- The Health Home consortium addendum 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.
  - Participants will be served at their own provider's location.

Provider Enrollment: Consortiums (cont.)

- Health Home standards and protocols are developed and submitted jointly.

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:

- Standards should be thorough and fully document assessment, identification of needs, intervention and follow up measures.

Provider Enrollment: Consortiums (Cont.)

- Addendum will consist of a detailed MOU between the agencies that includes:
  - Goals, target population, period covered, emergency response protocol and procedure for terminating agreement.
  - Management of shared staff including hiring, supervision and evaluation.
  - The financial agreement describing how shared staff services will be reimbursed.

Provider Enrollment: Health Home Staffing

- *Staffing Requirements*
  - Health Homes must maintain staff in the specified ratios 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.
  - Providers are encouraged to increase the time of their Health Home staff incrementally as enrollment increases.

Provider Enrollment: Staffing (Cont.)

- The following is the required staffing ratios for Health Homes:
  - Health Home Director (.5 FTE/125 enrollees)
  - Health Home Care Managers (.5 FTE/125 enrollees)

    The initial role must be filled by a Registered Nurse or Nurse Practitioner while Health Homes requiring more than 1 FTE in this role may utilize a Physician's Assistant (PA) in this position
  - Physician or Nurse Practitioner Consultant (1.5 hours per Health Home enrollee per 12 months)

Health Home Participant Scenario - PRP

Melissa Schober, *MHA*

Health Home Participant Scenario- OTP

Rhonda Callum, *ADAA*

Participant Scenario-OTP

Katherine

OTP Participant Scenario: Client Engagement & Enrollment

- Determine Eligibility
  - ✓ Opioid Substance Use D/O
  - ✓ Risk in association with Tobacco Use
  - ✓ Cocaine Use History
- Discuss Health Home Program & Obtain Consent
- Comprehensive Health Assessment
  - ✓ Coordinate appointment with PCP
  - ✓ Augment assessment through collaboration with OTP staff (OTP assessment)
- Update Care Plan
  - ✓ Identify supports, goals and challenges

OTP Participant Scenario: Client Engagement & Enrollment

- Complete intake and enrollment using eMedicaid Health Home online portal
  - ✓ Upload recently-updated care plan
    - Assigning the Care Manager
    - Reporting baseline chronic conditions; baseline data; and social indicators
  - ✓ Provider may now submit a claim for reimbursement for the intake process
    - Begin provision of regular Health Home services

OTP Participant Scenario: Provision of Health Home Services

- ***Comprehensive Care Management***
- ***Care Coordination***
- ***Health Promotion***
- ***Comprehensive Transitional Care***
- ***Individual and Family Support Services***
- ***Referral to Community and Social Support Services***

CRISP Overview

Lindsey Ferris, *CRISP*

CRISP: Maryland's Health Information Exchange

Dec 2012

CRISP

Connecting Physicians With Technology to Improve Patient Care in Maryland

Chesapeake Regional Information System for Our Patients

7160 Columbia Gateway Drive, Suite 230
Columbia, MD 21046
T/ 877.952.7477
F/ 443.817.9587
www.crisphealth.org

Topics Covered

- CRISP Background
- Query Portal
  - Prescription Drug Monitoring Program (PDMP) data
- Encounter Notification Service
- Registration Process

What is CRISP?

Chesapeake Regional Information System for our Patients (CRISP) is Maryland's statewide:

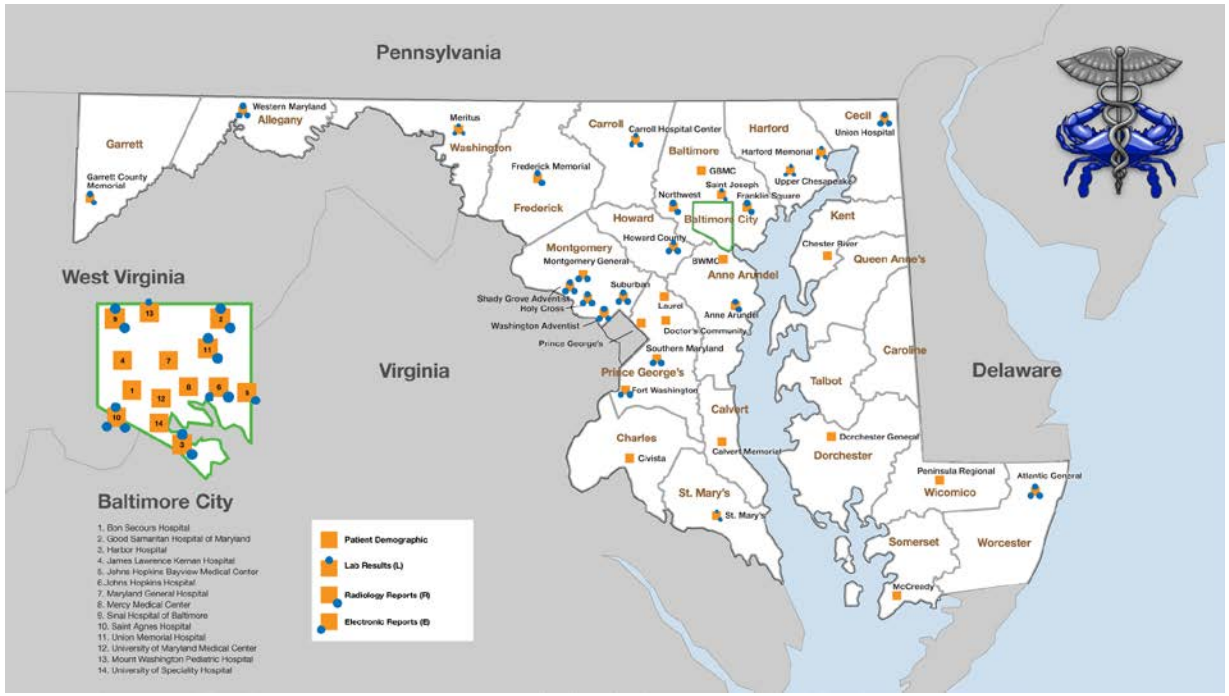
- **Health Information Exchange (HIE)** allows clinical information to move electronically among disparate health information systems.
- **Regional Extension Center** (REC) provides technical, implementation, and educational assistance to increase providers' adoption of electronic medical records (EMRs).

CRISP's Mission & Mandate

Chesapeake Regional Information System for Our Patients

Our Mission is to advance the health and wellness of Marylanders by deploying health information technology solutions adopted through cooperation and collaboration.

Our Mandate is to electronically connect all health care providers in the state of Maryland



CRISP Services

1. **Query Portal**
   - Provides access to prior hospital visits and medication data
   - Provides more complete view of patient
   - Improves efficiency (less time locating records)
   - Will include **Controlled Dangerous Substance** data **(MD PDMP)**
2. **Encounter Notification System (ENS)**
   - Notifies in real time about patient visits to the hospital
   - Increases coordination of care
   - Improves follow-up care
   - Reduces hospital re-admissions

Query Portal

CRISP Query Portal

Chesapeake Regional Information System for Our Patients

Accessing CRISP:

- Access must be part of a treatment encounter
- Single sign-on (SSO) integration can be enabled
  - Allows provider to access from within EMR
  - Single click to see all CRISP data
  - Transparently passes credentials and patient information to CRISP
- $$ No current charge for Ambulatory access

Types of data available:

- Patient demographics
- Lab results
- Radiology reports
- Medication fill history
- Discharge summaries
- History and physicals
- Operative notes
- Consults
- SOON: CDS Data

CRISP is an opt-in health information exchange

CRISP Portal: Connectivity Progress

Chesapeake Regional Information System for Our Patients

- All 46 Maryland hospitals are contributing Encounter data

Health Information Exchange Participants as of 06/27/2013

Sources of Data	Identifier	Patient Demographic	Lab Results	Radiology Reports	Electronic Reports
Hospitals					
Anne Arundel Medical Center	AAMC	✓	Mar-12	Mar-12	
Atlantic General Hospital	AGH	✓	Jun-11	Jun-11	Jun-11
Baltimore Washington Medical Center	UMMS_BWMC	✓			
Bon Secours Baltimore Health System	BSB	✓	Feb-13	Feb-13	
Calvert Memorial Hospital	CVMH	✓	Dec-12	Dec-12	Dec-12
Carroll Hospital Center	CHC	✓	May-12	Apr-12	Apr-12
Chester River Medical Center	CVMH	✓			
Civista Medical Center	CMC	✓			
Doctor's Community Hospital	DCH	✓	Sep-12		
Dorchester General Hospital	UMMS_DRCHSTR	✓			
Fort Washington Hospital	FWMC	✓	Sep-12	Mar-12	May-12
Frederick Memorial Hospital	FMH	✓	Mar-12	Dec-11	
Garrett County Memorial Hospital	GCMH	✓	Jul-11	Apr-12	
Greater Baltimore Medical Center	GBMC	✓	Nov-12	Sep-12	Sep-12
Harford Memorial Hospital	HARM	✓	Jul-12	Jul-12	Jul-12
Holy Cross Hospital	HCH	✓	Sep-10	Sep-10	Sep-10
Howard County General Hospital	HCGH	✓	Feb-12	Nov-11	Nov-11
James Lawrence Kernan Hospital	UMMS_KERNAN	✓			Jul-12
Johns Hopkins Bayview Medical Center	JHH_BVIEW	✓		Feb-12	Jul-12
Johns Hopkins Hospital	JHH	✓		Dec-11	May-12
Laurel Regional Hospital	LRH	✓			Jul-12
McCready Memorial Hospital	MCMH	✓	Aug-12		
MedStar Franklin Square Hospital	MEDSTAR_FSH	✓	Oct-11	Oct-11	Nov-12
MedStar Good Samaritan Hospital	MEDSTAR_GSH	✓	Oct-11	Oct-11	Nov-12
MedStar Harbor Hospital	MEDSTAR_HHC	✓	Oct-11	Sep-11	Nov-12
MedStar Montgomery Medical Center	MGH	✓	Mar-13	Apr-11	Apr-11
MedStar Southern Maryland Hospital Center	SMH	✓		Jul-11	Nov-11
MedStar St. Mary's Hospital	STMH	✓	Jun-12	Mar-12	Dec-12

- See website for list of data hospitals are contributing
  http://hie.crisphealth.org/HIEParticipants/tabid/277/Default.aspx

CRISP Portal: Prescription Drug Monitoring Program

- Per PDMP regulations:
  - Reporting required for Schedule II-V Controlled Dangerous Substances
  - Reporting required every 3 days
- PDMP data presented through same portal as the existing HIE data
- Primary objectives:
  - Provide a single, unified access point for “external” clinical data
  - Avoid complexities and short-comings of multiple websites for different data
- Implementation underway:
  - Pilot users will have access late September
  - All users will have access mid-October

Current CRISP Query Portal View

Chesapeake Regional Information System for Our Patients

https://crisptest.axolotl.com/EA/EmergencyDocuments.nsf/(wProduceTabbedInterface)?OpenAg

SMITH, John J [16-Jan-1942]

VHR Home | Inbox | Support Request | Change Password | Home | Links | Help | Log Out

Welcome, Doctor Jones - Monday, May 9

SMITH, John J - 01/16/1942 M Visit: Facility: From: 1/1/2006 To: 5/9/2011

All | Summary | Cumulative Lab | Lab | Radiology | Reports | ADT | Consent | Office Memos | Encounters | Orders | Patient Info | Open Report

Lab

9/30/2006 4:18:00 PM	CBC	T Nguyen
9/30/2006 4:18:00 PM	OP PROTIME	R Jones
9/30/2006 4:18:00 PM	TROPONIN I	J Contreras
9/30/2006 4:18:00 PM	CPK +MB IF INDI	J Wallaby
9/30/2006 4:18:00 PM	BASIC PANEL-OP	R Jones

Radiology

2/13/2007 10:10:00 AM	HANDS	T Kennedy
9/30/2006 3:00:00 AM	US CAROTID ART	M Keeler
9/30/2006 3:00:00 AM	CT BRAIN W/O	T Morningstar
6/10/2006 3:00:00 AM	CHEST 2 VIEWS	J Contreras
6/5/2006 3:00:00 AM	CHEST 2 VIEWS	J Wallaby

Reports

6/15/2010	Cancellation Policy	D Pcp
6/15/2010	Cancellation Policy	D Pcp
12/19/2006 3:00:00 AM	Chart Notes	M Keeler
10/11/2006 3:00:00 AM	Chart Notes	T Morningstar
8/22/2006 3:00:00 AM	Chart Notes	T Nguyen

ADT

No results matched your search.

Cumulative Lab *Not all lab test results and observations can be displayed in a cumulative view. For specific observations not present in this view, search within the lab or other tabs.*

Elements	09/30/06 04:18 PM	09/19/06 01:45 PM	08/14/06 11:35 AM	06/10/06 12:45 PM	06/07/06 11:25 AM	06/06/06 09:13 AM	06/05/06 02:02 PM	06/04/06 09:37 AM	Next
HCT	34.1	35.9		31.1		25.5	24.0	29.1	
BANDS	3			12			8		
RDW	13.1			12.2		12.8	14.0	12.9	
PROTEIN-TOTAL	6.3								
LDL			85		82				
ESR				90					

Encounter Notification System

Encounter Notification Service (ENS)

- Created by CRISP to utilize the Admission, Discharge, and Transfer notifications received from all Maryland Hospitals
- ENS notifies a participant in real time when one of its patients has an encounter at any hospital in Maryland.
- Based on participant providing list of “Active” patients
- Able to track certain patient populations
- Improves care coordination

ENS Preferences/Options

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

ENS: Additional Information

- Adding fields to ENS messages to provide further value:
  - Admit Reason/Chief Complaint
  - Diagnosis Code/Description
  - Discharge Disposition
  - Discharge Location
  - Death Indicator
  - Date/Time of Death
  - Observation Patient Indicator
  - Allergies
  - Problems

ENS Screenshot (Direct e-mail)

Chesapeake Regional Information System for Our Patients

New Message | Check Mail | Mark As Read | Move To Folder | Delete

Inbox
Sent Items
Drafts
Trash

Manage Folders

Arranged by: Date, Descending

search

MARYLAND JACK DJO MRN:33 EMERGENCY DISCHARGE CRISP	Jan 07	23KB
PENSYLVANIA DAVE DJO MRN:12 INPATIENT DISCHARGE CRISP	Jan 07	23KB
TENNESSEE WENDY DJO MRN:121 INPATIENT ADMIT CRISP	Jan 07	23KB

1 2 3 4 5 › »

Reply | Forward | Print | Save

MARYLAND JACK DJO MRN: 33 EMERGENCY DISCHARGE

CRISP to ... (Jan 07, 03:54 PM)

Encounter Notifications

JACK MARYLAND INPATIENT DISCHARGE

Patient Information:

Patient Name:	JACK MARYLAND
Gender:	M
DOB:	1901-01-01
Address:	8181 MAIN STREET TOWSON, MD 21212
Home Phone:	4435551212
Work Phone:	
Cell Phone:	
PCP:	Dr. Jones, MD

Facility Information:

Hospital Name:	Suburban Hospital
Hospital MRN:	9999999
Event:	Inpatient Discharge
Event Time:	Jan 1 2013 11:59PM
Admit Reason:	RIGHT HAND INJURY

Your Facility Site: Doctor Jones' Office
Your Facility MRN: 33

Additional Info: VHR Portal Link

You are receiving this message because you have requested Encounter Notifications from the statewide health information exchange for your patient panel. Any questions/concerns can be sent to: alert.hie@crisphealth.org

Quick Reply

Send | Save

Registration Process

To Register, E-mail hie@crisphealth.org

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

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

- Each individual user must:
  - 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

BREAK

Lessons Learned

Jean Moise, *Way Station*

Implementation of Behavioral Health Home Pilot at Way Station Inc.

Lessons Learned

DHMH Provider Training

July 9, 2013

Jean Robert Moise

230 West Patrick Street
Frederick, MD

WAY STATION
A Subsidiary of Sheppard & Enoch Pratt Foundation

www.waystationinc.org
301-662-0099

Health Home Pilot Definition

- Thirty-month pilot in Frederick, Howard and Washington counties
- Consists of: HH Management, Nurse Practitioner Consultant, Nurse Care Managers, and Project Specialist
- Enhancing psychiatric rehabilitation (PRP) and assertive community treatment (ACT) programs
- Evolving into comprehensive health homes for 800 low-income adults with serious mental illness

HEALTH HOME
A Program of Way Station

WAY STATION
A Subsidiary of Sheppard & Enoch Pratt Foundation

Health Home Initiative Goals & Objectives

- Improve Health Outcomes
- Reduce Medical Costs (16% off-trend reduction)
  - Increase Access to Primary Care
  - Improve BH and Primary Care Integration
  - Increase Consumer / Client Participation in Primary Care

WAY STATION
A Subsidiary of Sheppard & Enoch Pratt Foundation

Lessons Learned

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

- Rather, A Care Delivery Approach / Enhancement to current clinical practices requiring Organizational Transformation
- Needed to change staff's perception of their role re. consumer's physical health, from ***encouraging*** system linkages, care coordination and case management to daily, personal ***accountability*** for ensuring such actions occur on a consistent basis

WAY STATION
A Subsidiary of Sheppard & Enoch Pratt Foundation

Appreciate Cultural Changes

- Organizational Leaders need to “Champion” the Vision and model change
- Manage & direct change in culture, staff roles, and staff responsibilities
- Encourage focus on Population Management & Data Driven Care Management decisions, in addition to individual patient centered care
- Empower Staff to embrace changes, by arming them with tools and training to achieve goals focus on health outcomes as well as traditional treatment goals

Appreciate Cultural Changes, contd.

- Encourage NCM's to train PRP staff to take the lead in working with clients regarding their health care needs (not the other way around)
- Promote concept of "equal members, with unique expertise, on interdisciplinary team"
- Embed NCM's physically within PRP and ACT teams to develop trust, rapport and confidence in each others' skills
- Add physical health goals to IRP's, rather than having separate HH ITP
- Hire NCM's with strong primary care experience rather than psych expertise

Models of Enhancing Access to Care

- Choose the right model for your culture, clients and organization
  -Co-location of Primary Care (WSI's choice)
  -Direct Provision of Primary Care
  -Close Collaboration with off-site providers

- Leverage existing partnerships
- Schedule regular physician consultations prior to first appointment of the day
- Remember external specialists, providers and hospitals (Hospital MOU, team conferences, etc.)

WAY STATION
A Subsidiary of Sheppard & Enoch Pratt Foundation

Integration of Primary Care and Behavioral Health

- Unlike Supportive Employment, which is integrated but distinct from PRP, Health Home to PRP is as ACT to Mobile Crisis – the former is an enhancement of the latter, requiring full integration throughout and across all levels of the program

- Integrate EMR's and clinical records as much as possible
- Physically integrate / embed HH and PRP staff, as well as treatment plans
- Use NCM's to train non-medical staff and use Team approach to achieve HH outcomes

WAY STATION
A Subsidiary of Sheppard & Enoch Pratt Foundation

Enhance Consumer Participation in Primary Care

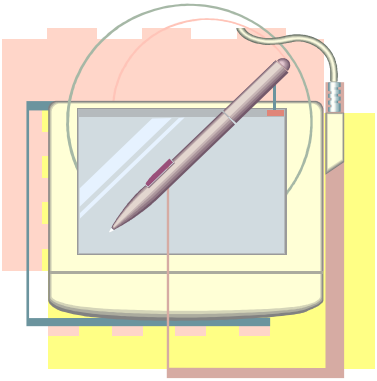
- Consider implementing Integrated Illness Management and Recovery (IIMR), or motivational interviewing, and client education to enhance consumer investment in health outcomes and increase compliance with primary care outcomes
- Focus on Client Empowerment to promote choice
- Provide tools to clients ***and*** staff to make confident, effective decisions regarding primary care issues

Focus on Holistic Vision

- Take a long term, incremental view: "It's a journey." Move the needle, at least a bit.
- Implement year long Wellness plan / calendar
- Focus on quarterly, agency-wide health / wellness / prevention initiatives: coordinating client education groups, population health initiatives, individual client outreach efforts, staff health / wellness incentives, etc.
- "Community" focus: "We're in this together."
- Keep staff energized; use "champions" to build up morale

Employ HIT / Care Management Tool (distinct from EMR)

- Invest in effective HIT / Care Management Tool
  - ProAct – Tool used by Missouri and WSI
    - Individual, Care Management
    - Evidence based, disease management recommendations and tools
    - Program Level / Population Management
  - Features of the tool include:
    - Data Driven, Population Analytics
    - Complex Care Management logarithms
    - Performance / Evaluation of Program, outcomes, and providers



Health Home Billing & eMedicaid for Health Homes

Morgan Cole, *Medicaid*

Health Home Billing: How to Get Started

- Ensure provider has the following elements:
  - OHCQ Certification
  - National Provider Identifier (NPI)
  - Maryland Medical Assistance Provider #
- Enroll as a Health Home Provider
- Use of EVS
- Follow service delivery and billing protocols

Health Home Billing: Submitting Claims

- Claims submission directly to Medicaid's fee-for-service MMIS system
- Use of the CMS 1500 form for paper claims
- Electronic submission
- Detailed instructions will be distributed

Health Home Billing: Services & Codes

- Initial Intake Process- W1760
  - Must complete initial assessment and intake process, including submission into eMedicaid
  - Reimbursed at the same rate as the monthly rate
- Monthly Rate- W1761
  - Must have provided the minimum of two monthly Health Home services
  - Recorded in eMedicaid prior to billing
  - eMedicaid report identifies billable participants

Health Home Billing: Additional Guidelines

- Time limits
  - Claim submitted within 30 days of the end of the month in which services were provided
- Sanctions
  - Possible 10% sanction for claims submitted past 30 days
- Avoiding duplication
  - Services may not be billed elsewhere or counted towards another program's case rate

eMedicaid: Purpose

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

eMedicaid: Getting Set Up

- Enroll with eMedicaid using Medicaid ID
- Administrator enables Health Home option in eMedicaid
- Administrator assigns users
  - Set IDs and passwords

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

eMedicaid: Intake (cont.)

sign out

health homes

Patient Account Number: 182 Enrollment Status: INCOMPLETE

Intake Information

Care Manager Assigned

Select the care manager assigned for the patient. Only the users who are authorized for "Health Homes" services are shown in the list.

Select the care manager

Primary Therapist/Counselor Assigned (if applicable)

Last Name:

First Name:

Primary Care Provider

Last Name:

First Name:

Patient Demographics

Medical Assistance Number: [redacted]

Last Name: [redacted]

First Name*: [redacted]

Date of birth: [redacted]

Gender Identity*: Female

Marital Status: Select marital status

Ethnicity: Non-Hispanic

Sexual Orientation: Select sexual orientation

Race(select one or more)

- [ ] American Indian or Alaskan Native
- [ ] Asian
- [x] Black or African American
- [ ] Native Hawaiian or Other Pacific Islander
- [ ] White
- [ ] Unknown
- [ ] Decline to state

Consent

- [ ] Consent form signed by patient or guardian and included in records*

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
[ ] Health education re: chronic condition		
[ ] Self management plan development		
[ ] Medication review and education		
[ ] Promotion of lifestyle interventions(MUST select one or more below)		
[ ] Substance use prevention		
[ ] Smoking prevention or cessation		
[ ] Nutrional counseling		
[ ] Physical activity counseling, planning		
[ ] Other : _____ *		

Comprehensive Transitional Care

Transitioning from*:

- [ ] Hospital
- [ ] Long term care facility
- [ ] Other _____

Individual and Family Support Services

eMedicaid: Services (cont.)

Patient Profile

Patient Profile | Enter New | Services | Outcomes | Diagnoses | Historical Data

15 health home services found, displaying all health home services.

Service SN	Date Reported	Date of Service	Service Category	Service Delivered	Notes/Description
0	04/10/2013	04/10/2013	Intake		
61	04/25/2013	01/01/2013	Comprehensive Care management	ITP Update	
	04/25/2013	01/01/2013	Individual and Family Support Services	Transportation scheduling assistance	
101	06/25/2013	01/01/2013	Comprehensive Care management	ITP Update	
	06/25/2013	10/01/2012	Referral to Community and Social Support Services	MA eligibility	NOTES
121	06/26/2013	01/10/2013	Comprehensive Care management	ITP Update	
	06/26/2013	05/01/2013	Comprehensive Care management	Review ITP/POC progress with patient	
	06/26/2013	05/04/2013	Care Coordination	Patient records requested from PCP;	Patient records received
	06/26/2013	06/07/2013	Health Promotion	Health education re: chronic condition	
	06/26/2013	06/20/2013	Health Promotion	Self management plan development	
	06/26/2013	06/15/2013	Health Promotion	Substance use prevention	SUBSTANCE USE PREVENTION SERVICE PROVIDED
	06/26/2013	01/01/2013	Comprehensive Transitional Care	Transitioning from Hospital: Patient care plan developed/reviewed	TRANSITIONED FROM HOSPITAL
122	06/27/2013	06/05/2013	Health Promotion	Health education re: chronic condition	SOME NOTE
	06/27/2013	06/27/2013	Comprehensive Transitional Care	Transitioning from Hospital: Patient scheduled for follow-up appt	NOTHING TO REPORT IN NOTES
161	06/28/2013	01/01/2013	Comprehensive Care management	ITP Update	

15 health home services found, displaying all health home services.

Export: Excel

Health Homes Main | Services Home

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: Outcomes & Indicators (Cont.)

Social Indicator

Employment

Education Attainment -the highest level of education the participant has achieved or is currently pursuing.

Residential Status

If other, specify:

Recent Legal Incidents

Notes:

Custody Status

Save & Submit Later | Submit Patient Intake | Cancel

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

eMedicaid: Discharge

- Discharge process
  - May continue in HH up to 6 months following discharge from PRP, OTP, or MT services assuming all other requirements are met
  - Report reason for discharge, indicate discharge planning

eMedicaid: Next Steps

- Possible interaction with EHRs, care management tools
- Additional data analysis and reporting capacities
- Possible link to MMIS for claims data

Q & A

Wrap-Up

- Finalized materials and information will be posted online and distributed to providers and stakeholders
- Training evaluation/survey will be sent out via email
- Additional upcoming training opportunities
- Contact dhmh.healthhomes@maryland.gov with questions

Thank You!