OHIO MEDICAID HEALTH HOMES FOR THOSE WITH SERIOUS AND PERSISTENT MENTAL ILLNESS

Health IT/Health Record & Treatment Plan Integration Committee

November 30, 2011

12:30 – 3:30 p.m.

Rhodes, Rm. 806

Purpose: *develop comprehensive recommendations for integrated personal health record that is inclusive of key health information data, providers and services such as assessment/screenings, diagnoses, medical tests, medications, clinical & non-clinical services, and treatment plan; align treatment plan requirements; identify barriers at the practice level and clinician level that hinder the development and use of a single, integrated treatment plan and recommend solutions.*

- Welcome & Introductions
- Review of Last Meeting Recommendations
- Case Studies
- Updates from other groups
- Discuss Treatment Plan Integration
- Next Steps
- Next Meeting: December 16, 2011

  1:00 p.m. – 4:00 p.m., Rhodes State Office Tower Lobby Hearing Room

Health IT/Health Record & Treatment Plan Integration Committee
Meeting Minutes
November 30, 2011

Attendees: Jon Barley, Angie Bergefurd, Kueiting Betts, Anita Bowman, Rafiat Eshett, Mary Haller, Cynthia Holstein, Deb Hrouda, Afet Kilinc, Teresa Lampl, Jody Lynch, Mary Norman, Cheri Rodman, Jean Solomon, James Vernon, Lisa Wiltshire, Joe Weisenberger, Hugh Wirtz

WELCOME AND INTRODUCTION:
The meeting opened and the attendees introduced themselves. Reviewed the agenda. Draft minutes for the last meeting were provided. Please contact Ms. Betts for any edits.

Questions were asked and below are the answers:
There will be no RFP process to become a health home. Providers will need to submit applications and get approval in order to become health homes. State will be selecting a few regions to roll out health homes. Providers that meet the core element requirements will be able to apply. Even though we will be doing regionally, State will communicate about the Health Home program statewide so everyone is aware of the new program. Do not know how many regions will be selected and possible providers have not been identified at this point. Will follow-up to see if this information needs to be identified in the SPA. The size of the health home program will be controlled (number of patients enrolled by limiting the number of region) to stay within the budget. It was suggested to explain this structure process at the meeting on 12/16.

REVIEW OF LAST MEETING RECOMMENDATIONS:
Ms. Bergefurd provided an overview of the received recommendations and asked for further feedback. Please see the handout "recommendations for use of HIT to support components of health home" for detailed recommendations. Below are the feedback from the group:

Comprehensive Care Management Component:

- A question was raised if the term "electronic format" has been defined. Is email considered electronic format? Ms. Bergefurd stated that we purposely left that open, to be determining. If an email exchange occurred with spreadsheet attached, the provider needs to have capacity to take the information and use it.
- All laws have to be followed in regards to the security of data transfer. Will follow-up on the capacity to exchange non-Medicaid data and regional psychiatric hospital.
- State will be figuring out the best way to share Medicaid MACSIS claims data with providers. State will be meeting with Managed Care Company in regards to this issue after the health home workgroups/meetings are done in order to fully understand the hot issues and concerns. There will not be a separate contract with Managed Care Company. The arrangements will be built into the currently contract as an amendment.

Care Coordination Component:

- Will need to look into other scenarios when identifying health home enrollees, i.e. nursing facilities, admission/discharge, children moving in and out of home or residential setting, jail/prison
- Have some kind of indicator on the card/portal can help some of these scenarios. The notification process is built into the new PASRR. ODMH can provide the linkage on this

piece, and split between 30-day and long term.
- Children's relocation issue was brought up. Ms. Haller will follow-up on how to identify when a child is enrolled in a health home.
- Not only should there be some kind of indictor to identify health home enrollees, but providers should also know the communication protocols so they know what to do when they treat patients who are enrolled in the health home program.
- Concern was raised in regards to 42CFR issue when sharing information with other providers.
- It was suggested to consider some kind of up-front investment in the PMPM around EHR or infrastructure investment. Mr. Wirtz to provide the fact sheet of the Medicare Share Savings program advanced payment model to Ms. Bergefurd.

Comprehensive Transition Care Component:
- Issues for consumers in jail/prison were brought up (Medicaid eligibility suspension and reactivation, transition, medication reconciliation, etc.). It would be a great resource to connect these consumers to health home. Jail/Prison system should be educated about the health home program. Boards should also be aware of the program to "connect the dots". The challenge is: will this project enable us to expand the capability to do this? Will there be diversion savings from other high cost places that we can reinvest, in terms of capacity, i.e. reduce hospitalization, ED visit, etc. There is a lot of potential to partner with local reentry coalitions for collaboration coordination and providing linkage. There is a big difference big between prison reentry and jail. There are people in jail that are many counties away because of capacity issues and local cut to county jail systems. How do these people get linked back to their health homes? There is no clarity on how the 88 counties implement Medicaid suspension when someone placed in jail and when does it get reactivated. How does Medicaid know when someone is placed in jail?
- Two other scenarios should be added into the transitional care component: 1) when a consumer transitioning from one health home into another health home, one region to another region, and 2) transitioning people out of health home when people lose their Medicaid eligibilities. How do you transition this population from health home program to another program? Does this population lose their benefits?
- Issue on Medicaid spend down was raised. Policy decision will be made in regards to this issue.
- This discussion should also be wrapped into the hospital scenarios, like missing redeterminations, appointments or eligibility suspension.
- Another scenario should also be considered: If someone is eligible for Medicaid but exceeds the benefit limit.

Referral to Community and Social Supports Component:
- If there is a web based process/system in place, providers can access to connect people to services and supports. This is a possibility.
- Benefit Bank also provides some electronic base supports.
- The notion of provider utilization profile language should be added into each component.

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Health Promotion Component:

- Provide web based self-help resources in the providers' website or provide links of resources.
- The recommendations for individual and family support services component can also be put under this component.
- TV program from Shawnee Mental Health Center????
- Future requirement – create a ticker system that can be individualized to remind patients when certain visits are due
- It was confirmed that health home program do expect providers to have access to dental care for adults and children. Dental professionals should be added into the team composition document.

Individual and Family Support Services Component:

- Add the general statement around the use of data around the patients' profiles.
- Add some of the recommendations for the health promotion component.

The recommendation document will be modified accordingly. However, there will be no guarantee that all details will be sorted through in terms of some of the State's capacity to be able to support these functions. A fair amount of work will be done to see what resources will be available and what type of work will be involved.

Ms. Bergefurd asked the group to identify the barriers in order to help move forward on electronic health record and treatment plan between primary care and behavioral health.

- The following questions should be answered in order to help providers understand the health home concept. What are the differences between plan of care with the holistic approach and individual treatment plan? How does that work functionally in the largely paper based environment and how can IT be helpful? Complications of PCPs embedded in the health home vs. the link with external PCPs.
- One provider indicated that their PCPs do treatment plan at every visit. However, one mental health diagnosis lasts a life time. Therefore, it is difficult to incorporate information into one treatment plan.
- A lot of time psychiatrists have issues signing of on the same plan as they may not agree with everything that the clinician has written in the plan and prefer separate document.
- Under integrated plan, the requirement of community behavioral health would follow the ODMH certification rules around ISP and treatment plans. We should not lock into that as that is not how the rest of health care works. It should be person centered and integrated around what the person's needs are as the driving point of that. Follow up with Alicia Smith on how other states are approaching.
- Discussion on what it means to be patient centered in the behavioral health system? We are not advocating that we continue to do volume of papers. We should build on what is good in our system rather than additional requirements. We need to be cautious in terms of trying to dictate too much.
- Initial expectation – it is okay to have multiple treatment plans from various providers.

However, we do want to make sure all the providers and the patient agree on the top three priority goals for the individual. Health home should make sure to have the right players at the table to coordinate the service plan. This recommendation should be added to the core elements around integration as a requirement. We can take step approach to get fully integrated in the future. The possible next step is the integration around behavioral health and physical health, and then having that integrated where there is a shared plan and including extended care (hospitals, specialists).

- The plan needs to include not only medical approach but also non-clinical and social support.

CASE STUDY:

Dr. Kilinc provided an overview on one of the hypothetical health home scenarios (Sandra, a 43 year old woman). Please see the handout for the detailed case scenario. Discussion ensued and below are the highlights:

- Why PMH-APN refers Sandra to a PCP to screen for diabetes? Sandra needs to be referred to a PCP to not only do diabetes screening but also check if there are any other physical health issues that have not been diagnosed and do any preventive cares. In addition, it has been a challenge for psychiatric office to bill this type of service.
- The health home program should auto enroll qualified individuals with an opt-out choice. However, this scenario takes a different kind of approach – Sandra's case is sent to health home team to check her eligibility and then offer the services. This information needs to be modified in this case scenario.
- The created case scenarios will be reviewed by the SAMHSA to illustrate patients' flow.
- Another workgroup has asked to clarify the role of care manager and CPST worker. Also needs to pay more attention on the behavioral health care side rather than primary care/physical care side.
- Need to demonstrate on how health home care coordination function different from CPST.

Send any additional feedback to Ms. Bergefurd and Dr. Kilinc.

UPDATES FROM OTHER GROUPS:

Ms. Bergefurd provided updates from other group:

<u>Reimbursement Group</u>:

- Already had the second meeting.
- PMPM rate will be moving toward standardized statewide reimbursement rate methodology.
- A base methodology comprised of different components that providers could flex within depending on their models. Providers will not be at risk.
- Monthly payment for the health home services.
- Discussed methodology components: cost report, caseload, CPST and additional adjusters to incentivize innovations.

<u>Consumer and Family Engagement Group</u>:

- Have not had the second meeting.

- Provide opt-out choice for consumers.
- Will fine tune the feedback loop that consumers are involved in and family engagement process.

Documentation, Billing & Regulatory Requirements Group:

- Already had the second meeting.
- Picked apart the core elements/requirements and narrowed down ways providers need to do to demonstrate that they are meeting those.

Quality Improvement Group:

- Have not had the second meeting.
- Worked on the quality measures.

Staffing Arrangement & Team Composition Group:

- Revised the team composition document based on the group's recommendations.
- A question was raised on why we want to have an independent licensed behavioral health clinician as the lead to do coordination function work, non-clinical treatment plan and non-clinical services. It was clarified that it is necessary to have someone with a clinical background to work across the systems and be able to speak the language. In response, one provider stated that it would be really hard to find an independent licensed clinician in rural areas. Is it possible to have Care Manager or APN as the team leader? Case Manager will be doing a lot of comprehensive assessment, development of care plan, updating care plan and assessment and overall coordination. However, we do need to have an independent licensed clinician to supervise at the clinical level and oversee the health home for an agency and doing administrative oversight – like a head of the product line and meeting standards. (The concept of health home team is different than ACT team model.) We also need to make sure the team composition model that we created can be approved by CMS and most of the patient centered medical homes around the country are physician driven as team leaders. There might be some flexibility on other disciplines that can be qualified as a team leader.

NEXT MEETING:

- Next meeting is scheduled for 12/16/2011.