

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

Consumer & Family Engagement Committee

December 1, 2011

2:00 – 4:00 p.m.

Rhodes, Rm. 1855

Purpose: develop recommendations for: approaches to consumer/family education and engagement; use of peers; practice guidelines for client/family-centered care; assessing consumer experience of care; and consumer enrollment including opt-in versus opt-out.

- Welcome & Introductions
- Review of Last Meeting Recommendations
- Case Studies
- Updates from Other Committees
- Remaining Questions
- Next Steps
- Next Meeting : December 16, 2011
1:00 p.m. – 3:00 p.m., Rhodes State Office
Tower Lobby Hearing Room

**Consumer & Family Engagement Committee
Meeting Minutes
December 1, 2011**

Attendees: Crystal Allen, Jon Barley, Angie Bergefurd, Jack Cameron, Marsha Coleman, Beth Detrich, Beth Ferguson, Sharon Fitzpatrick, Mary Haller, Betsy Johnson, Terry Jones, Afet Kilinc, Heather King, Lisa Leopold, Jody Lynch, Kara Miller, Peggy Smith, Patricia Waits.

Welcome & Introductions

Angie Bergefurd opened the meeting and the group introduced themselves round table. She requested that any edits to the draft minutes be sent to Heather King after the meeting.

Review of Last Meeting Recommendations

Angie asked for comments regarding the recommendations. Crystal Allen asked which committee is discussing who is eligible for health homes; she noticed in the examples provided at the last meeting that this can vary. Angie stated that in the previous ODMH Behavioral Health Benefits Subcommittee, the group developed definitions of seriously mentally ill adults and children. For health homes, these populations are the ones that will be eligible. Crystal stated that she is trying to figure out how kids fit in to the health homes; she will refer to the definitions and diagram provided to the group previously.

Beth Detrich asked if every SED child will be covered under the health home. Angie stated they will, as long as they meet the definition requirements, live in the region, and are Medicaid recipients. Afet stated that the criteria for SED are quite generous. Terry pointed out that there is also a provision that in absence of treatment history, the clinician may determine that the illness will last longer than 6 months; this would qualify the child as SED.

Angie also stated that other groups have also requested the same suggestion made in this group regarding a feedback and follow up loop for consumers and family members on the health home process. This will be addressed as the health home is developed. In a recent conference call, SAMHSA asked ODMH whether the feedback process needs to occur in the health home or if it can be a regional approach. Betsy Johnson stated that her impression was that it would be at each site, perhaps with something at the regional or state level as well. Jon Barley stated that he understands that it might be difficult to have consumer advisory councils at each site from the beginning; having feedback at the regional level will be helpful in these cases; state level feedback will be helpful in designing future health homes.

Angie reported that the state will be strongly encouraging, but not requiring peer support specialists on the health home teams. Jack stated that peer support works best when it is face to face. He added that in the health home recommendations, he is not seeing enough recovery mentioned. We have many tools that we did not once have and the peer support specialists are the ones that can use these. He thinks that peer

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support specialists make the most difference in the lives of the “hot-spotters.” If we have peer specialists at the site, there will be a better chance to engage the costly people and to work with them throughout their recovery.

Angie asked whether the peer support requirement could be phased in, rather than requiring it immediately. Jon supported this, stating that he does not want to exclude people from becoming a health home because of this requirement. Jack was undecided about this; he feels that peer support is extremely important and noted that this is already being used by managed care programs in the form of patient navigators. Patricia Waits stated that it would need to be clear that the health home is expected to implement peer support services in a certain timeframe. Marsha Coleman agreed that it is important to provide peer support services from the beginning.

Beth Detrich pointed out that the idea of peer support gets confusing with kids. Patricia stated that she feels it would be more important in kids’ cases to have peer support for the parents. Angie stated that the peer support group is looking at defining the service and that she would not want to duplicate this process because it needs to be consistent. The group discussed the logistics of phasing in the peer support requirement.

Betsy said that one of the things that makes parent advocacy work is the fact that they are peers and are not professionals. If we add this service, she is concerned about the nature of the peer to peer aspect changing. Afet asked for Jack’s opinion on this; he stated that even though the service has not been reimbursed traditionally, there are ways to reconcile this problem. Betsy stated that this aspect cannot be overregulated.

Angie stated that we will need to look at how the peer support service will be financed. Crystal suggested that perhaps stipends could be used. Jack stated that other states are being reimbursed at \$40 per hour for the service and the peer specialist makes between \$12 and \$15 per hour.

Crystal mentioned that Cuyahoga County had a great program for addicted mothers who lost custody of their children. She would like to include someone on staff there in the peer support group. Jack also mentioned that Frank Sepetauc has employed peer specialists for a long time and would be a good resource.

Terry Jones suggested that affiliation agreements could be used to ensure that peer support specialists would be available. The group responded positively to this idea. It was agreed that a phased in approach, with expectation that peer support will be available in the future, will be used.

It was also agreed that a site-specific feedback process is ideal, but that this should not be required on day one. Terry suggested linking with ADAMH board consumer and

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advisory councils. Betsy is concerned that this group is further in recovery and would not be reflective of the populations in the health homes.

Jon expressed concern that sites may be asked to implement too much in the beginning; he does not want this to exclude potential health home agencies. Betsy stated that if the health homes are going to be consumer and family driven, the advisory councils will be needed. Jody stated that in meetings she has attended, most providers seem to already have the advisory councils in place. Jon recommended asking providers if this is too much to ask. Angie pointed out that she and Jon need to balance the requirements with both physical and behavioral healthcare settings in mind.

Remaining Questions

Below is a summary of the discussions related to the remaining questions for consideration that were not addressed during the first meeting.

How do we engage family members and significant others in Health Homes?

Beth Detrich suggested that the group consider that advance directives can be helpful in allowing the sharing of information. Jack pointed out that rules have changed a little with regard to what you can share if it is in the best interest of the person's continuity of care. Beth stated that primary care has tightened this up and we have loosened it, so we may need to meet in the middle in order to integrate effectively. Angie mentioned that we need to think about the 42CFR rule related to releasing information about substance abuse history. Terry and Afet stated out that providers continue to be very conservative about the information they release despite changes to the rules.

The group recommended implementing a communication plan in each health home that requires signatures; this could perhaps be part of the treatment plan. Kara pointed out that this is part of the service definition. Betsy asked what this would look like in practical terms, she is curious as to whether the family would be part of the treatment planning process. Kara stated that the service definition covers this; families and a team of professionals will be part of the process. Crystal asked if that would include child welfare; Kara stated that it would if child welfare is part of the care team.

Marsha pointed out that we need to think about communication both when the case workers jump in and when they leave. Angie stated that in the SAMHSA call, they were prepared to talk about Sandra; within a few seconds they wanted to hear about an SED child. They spent most of the call talking about SED kids; they were very interested in that scenario.

What outcomes are families and consumers looking for through the Health Home program?

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Angie mentioned that information is available in claims data that can be used to track outcomes, but that the state wants to hear the consumer perspective related to outcomes. Crystal talked about how child welfare measures success; they look at whether the child is stable, if he or she has stepped down from residential care, and whether he or she is leaving foster care, among other items. Group agreed that finding measurable outcomes that are consistent in different situations is difficult. They agreed that the overall goals that should be tracked are reduction in lengths of stay and the number of placements in residential care.

Crystal also recommended looking at educational performance. For kids that are seriously emotionally disturbed, educational performance should be considered as an indicator. Group discussed whether this is feasible; they briefly talked about how the data could also be viewed in an aggregate manner. Angie stated that we can think about adding these measures in the future without using them on day one.

Betsy suggested measuring if people are living longer when they are enrolled in health homes. Jack stated that another good outcome to look at is reduction of ER visits, reduction of clients visiting variety of providers, and reduction of incidences in which consumers are over-medicated. Other suggestions included quality of life indicators, such as GAF scores, MISSIP functional outcomes, and consumer satisfaction, as well as prevention outcomes such as dental and wellcare.

Case Studies

Crystal suggested that the child welfare worker appear more in the case study about Lisa. Betsy reminded the group that in many cases kids in the system are no longer in the custody of their parents due to custody relinquishment in order to obtain care for the child. It was agreed that this could be tweaked further and that it is a good example overall.

Angie requested that the group provide feedback on the case studies. She stated that feedback she has received so far includes making sure to include behavioral health and not focus too heavily on physical health, to weave recovery throughout the example, and to specifically describe what the CPST worker does and does not do.

Beth stated that obtaining children's preventative healthcare records is very difficult and that this is something that needs to be considered. Afet stated that the group has talked about having this be in the initial assessment when the child enters the health home. Angie talked about how and where this information will become available. The information would come from the MCP or from ODJFS.

Marsha asked if there are going to be caps on the costs of the care for the health home

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client. Angie reminded the group that these will be specifically outlined services. Marsha asked if that will become clear to the client and whether the direct services will still be paid for, or just the coordination of those services. Angie stated that this is an expansion of the services; the coordination is now being paid for, but the services that Medicaid paid for before will still be paid. No new direct services will be added.

Jack asked whether software programs have been created that combine all of the health home information. Mary Haller stated that the agencies that are already providing integrated care have indicated that this is challenging – ph and bh records are claims related but are documented differently and they are difficult to combine into one system. Angie mentioned that this has been discussed in the HIT committee and that these challenges are part of the reason why they are looking at requiring HIT tools on a phased in basis.

Updates from Other Committees

Angie reported that the Reimbursement Committee has discussed:

- Monthly health home rates
- A standardized health home rate methodology that takes SPMI population of the region into account
- Staffing arrangements for the health home
- CPST services that are currently provided
- Adjustment factors to the health home rate
- Consideration of incentives for electronic health records, shared savings, pay for performance (not on day one), or tiered pricing.

The Documentation Committee has taken the core elements of the health home program and drilled down into standards, focusing on how they relate to health information technology as well as behavioral and physical health integration. They have recommended a more specific definition and parameters around expectations of the provider related to enhanced and expanded access.

The Quality Improvement Committee discussed the health homes measures which are federally mandated. They are looking into whether other measures should be added and which outcomes will be tracked.

The Health IT Committee has spent a considerable amount of time looking at individual service components, information profiles, sharing, and ways of getting information they need. Their overall feedback has been that anything is better than what they have today.

The Staffing Arrangements Committee is reviewing requirements and discussing which clinical levels can perform the various functions in the health home.

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Next Steps

- ODMH will update the recommendations document and distribute it to the group.
- The next meeting will be a wrap-up meeting of all the health homes committees. It will take place Friday, December 16, 2011 at 1 p.m. in the Rhodes Lobby Hearing Room.