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

Staffing Arrangements & Team Composition Committee

AGENDA

Purpose: review functions and credentials of the care manager, the supervisory structure and team requirements.

December 2, 2011

1:30 – 4:30 p.m.

Rhodes, Rm. 1855

- Welcome & Introductions
- Review of Last Meeting Recommendations
- Case Studies
- Updates from Other Committees
- Revised Documents
  - Team Composition
  - Staffing Template
- Next Steps
- Next Meeting : December 16, 2011

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

Staffing Arrangements & Team Composition Committee
Meeting Minutes
December 2, 2011

Attendees: Kristina Allwood, Mary Applegate, Trudy Prugh, Jon Barley, Angie Bergefurd, Kueiting Betts, Beth Ferguson, Mary Haller, Deb Hrouda, Betsy Johnson, Terry Jones, Afet Kilinc, Lynne Lyon, Jody Lynch, Kara Miller, Jen Moses, Jeff O'Neil, Chris Neumann, Nicholas Pichichero, Gina Reed, Kimberly Shontz, Peggy Smith, Nancy Trux

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

REVIEW OF LAST MEETING RECOMMENDATIONS:
The document of the gathered recommendation from the last meeting was shared with the group. Ms. Bergefurd provided an overview of the recommendations and the group agreed. Please see the handout for detailed information.

TEAM COMPOSITION – REVISED DOCUMENT:
The revised CBHC Health Home Core Team document was reviewed by the group. Dr. Kilinc provided an overview of the health home core team. Please see the handout for detailed information. Discussion ensued and below are the highlights:

Health Home Team Leader:

- Professionals' credentials need to meet their scope of practices.
- Need to understand people's skill sets.
- It was suggested that practice facilitator is needed in the beginning (not needed the whole way) to help transform, i.e. process of care and outcomes responsibility. This individual should be a master level person that has some QI training. This practice facilitator would not be an additional team member. However, the team leader needs to have training in QI. We should consider this at the state level for all of the health homes. One of the strategies is to have facilitator go to different health homes to train the team. The other strategy is to train the team leads when they are identified. This team lead would be the person who already knows the organization's culture and the practice facilitator can focus on the consultation role.

Embedded Primary Care Clinician:

- The embedded primary care clinician will be a full member (not a full-time position) of the health home team, not part-time or as needed basis. This person can be in the dual role. This person can see patients and provide primary care services, and be on the team providing advice, setting up medical guidelines, educating team, etc.

Care Manager:

- This position will be putting the health home services in action and provide all the services of health home.
- This person should be trained in behavioral health and health care (needs strong experience in SPMI behavioral health) with additional training in primary care and integration.

- A question was asked whether a RN with years of experience but without BSN would be qualified for the Care Manager position. The group agreed it is crucial to have someone with experience and it is better than a person right out of the school. Bachelor level in health care is still recommended for Care Manger position. It is also important to keep in mind to have someone that can get work done and meet the outcomes.
- Three-year RN with experience is the minimum qualification requirement for Care Manager. Need higher level of education and experience for the team leader.
- The language "with equivalent credentials" and "with approval of CMS and State" should be added so other credentials can be considered for the position.
- The language "preferred" should also be added to let people know preferred credentials for the position but not mandatory.

CARE MANAGER AIDES:

- Need individual with 1) two-year Associate Degree with specific credentials, or 2) four-year degree without credentials in behavioral health filed but need to have experience and training.
- The language "with equivalent credentials" and "with approval of CMS and State" should be added so other credentials can be considered for the position.
- Even though there are not a lot of experienced CPST workers without a degree, it is still helpful to define the minimum qualification for this population.
- It was encouraged that organizations use their existing staff as much as possible for the health home. There is going to be a modified CPST component that providers can still provide CPST services and bill these separate from the health home.
- We will try to make it more flexible in order to be able to select someone with a lot of experience but lack of educational degree.

Optional Team Member – Peer Support Specialist:

- Peer support specialist can be an optional team member for the health home.
- Should include the provision of peer support – to have access to peer support group, such us Wellness Management Recovery (WMR) peer facilitators, consumer operated service centers, etc. Health home process should not be held back because an organization does not have a peer support specialist to put on health home team. This should be a phase in process to add this position to the team. Peer support specialists are not required to be on the health team as the day one requirement.
- Planning for the future, we should also identify the definition of peer support services, establish certification process and have peers trained to become peer specialists.
- It was questioned if peer support specialist need to be at every team or just a subset of the group. It would be effective to use peer support specialist if a health home team is serving dual diagnosed consumers with serious substance abuse issues or criminal justice populations.
- There is a variety of uses of peer support/wellness coaches, such as socialization engagement. However, this all depends if an individual consumer wants to have a peer support specialist involved in his/her case. Some consumers prefer not to have any peer support specialist involved in their lives.
- Currently, we should list wellness coaches as a category for the Care Manager Aides.

This also indicates that this is a phase in process and possible requirement for the future.

- The language "equivalent experience personnel with state approval" should be added to the qualification requirement.
- Need to make sure this individual can function and provide the health home services.

Other Team Member – Pharmacists:

- Organizations are free to propose additional members. We are still looking at the payment methodology to figure out if we can accommodate additional optional members to the health home team. Pharmacists are not required to be on the health team as the day one requirement.

Further Discussions:

- Client, family members and guardians are always part of the team.
- We are exploring if there is a need to have patient and family advisory council/group at the site or regional level.
- As some professionals have been identified as part of the team, it is necessary to make this more specific to our team expectations and develop the rate structure. It was suggested to look at the costs associated with the structure to make sure that we cover all the costs.
- It is important to keep in mind that the core team
- If an individual has a treating primary care physician (PCP) other than the embedded primary care clinician at the health home; in this case scenario, it was questioned whether the treating PCP outside of the health home or the embedded primary care clinician in the health home should be part of the core team to provide health home services. The group agreed that the embedded primary care clinician should be part of the core team to provide the health home services and work/coordinate with the treating PCP located outside of the health home. For providers that partner with FQHCs, these providers can purchase PCPs' time as the embedded primary care clinicians.
- Only core team members who provide health home services are eligible for the PMPM payments.
- PCPs and Psychiatrics need to be part of the core team to provide care.
- Dr. Applegate proposed a diagram to use different colors to show different payment sources.
- State should be providing training to health home providers. Health home providers should also develop internal training to help their staff.
- The last two paragraphs of the CBHC Health Home Care Team document indicate coordination requirements, not core team requirement. It was suggest moving the language to care coordination service definition.
- One provider indicated that they experienced challenges on care management. It was hard to understand the concept and the need for care management. It was suggested that care management is a critical training area.

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CASE STUDY:
Four different case scenario documents were shared with the group. The purposes of these case scenarios are: 1) to illustrate patients' flow for SAMHSA, 2) to illustrate how we move forward from patients' perspective, and 3) as an educational tool (with less narratives). Few recommendations received so far: clarify Health Home versus CPST, role of managed care plan, etc.

NEXT MEETING:
- Next meeting is scheduled for December 16, 2011