Washington Community Mental Health Council Input 7/24/12
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Washington State Health Home Provider Qualification and Standards for Chronic Medical, Behavioral Health, and Long-Term Care Services and Supports Populations

Under Washington State's approach to health home implementation, a health home is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist, behavioral health and long-term care services and supports through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services.

Section 1945 (h) (4) of the Social Security Act defines health home services as "comprehensive and timely high quality services" and includes the following health home services that must be provided by designated health home providers:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of HIT to link services, as feasible and appropriate.

General Qualifications

1. All providers serving beneficiaries shall be part of a health home network. The health home network must:
   - Identify a lead entity, which will be accountable for administration of the health home. The lead entity must have a NPI on file.
     - Administration functions:
       - Payment disbursement, quality monitoring, contracting, reporting and ensuring standards are met;
       - Collecting, analyzing and reporting financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals;
   - Have procedures in place for referring any health home beneficiary who seeks or needs treatment/services to a Medicaid designated provider.
   - Demonstrate use of an interdisciplinary team of providers that can address the full breadth of clinical and social service expertise for individuals who require assistance due to complex chronic conditions, mental health and substance use disorder issues and long-term service needs and supports.
   - Include providers from the local community that authorize Medicaid, state or federal funded mental health, long-term services and supports (including the direct care workforce), chemical dependency and medical services. For example, Regional Support Networks (RSNs), Community Mental Health Agencies (CMHAs), Area Agencies on Aging, Substance Use Disorder providers, and community supports that assist with housing.
2. Provide care coordination and integration of health care services to all health home beneficiaries through an assigned Care Coordinator who has access to an interdisciplinary team when necessary for care integration.
3. Directly provide or subcontract for the provision of health home services.

Comment [WCMHC1]: Are the services that this provider is providing to the beneficiary the six health home services listed above or does this apply to **any** provider delivering treatment or support to beneficiaries?

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Comment [WCMHC2]: Where is this team located? Is it a virtual team comprised of providers identified on the Health Action Plan?

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Comment [WCMHC3]: What is the intent of this requirement? Is it to include both authorizing entities and treatment providers? Is the requirement that RSNs and AAAs are part of every health home network?

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Comment [WCMHC4]: Same question about interdisciplinary team as above

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4. Remain responsible for all health home program requirements, including services performed by any subcontractor.
5. Health homes must be qualified by the state of Washington Medicaid program, and agree to comply with all Medicaid program requirements.
6. Health home interventions must be targeted to high risk/high cost beneficiaries and supported through assignment of a Care Coordinator who demonstrates the ability to:
   - Provide in-person beneficiary health assessments;
   - Accompany the beneficiary to critical appointments;
   - Actively engage the beneficiary in developing a Health Action Plan; this shall be done in person whenever possible;
   - Reinforce and support the beneficiary's Health Action Plan;
   - Coordinate with authorizing and prescribing entities as necessary to reinforce and support the beneficiary's health action goals;
   - Advocate, educate and support the beneficiary to attain and improve self-management skills;
   - Assure the receipt of evidence-based care; and
   - Support beneficiaries and families during discharge from hospital and institutional settings, including providing evidence-based transition planning.
7. The beneficiary's Health Action Plan is under the direction of a dedicated Care Coordinator who is accountable for facilitating access to medical, behavioral health care, long-term services and support and community social supports and coordinating with entities that authorize these services as necessary to support the achievement of individualized health action goals.
8. Hospitals that are part of a health home network must have procedures in place for referring beneficiaries who seek or need treatment in a hospital emergency department to the enrollee's qualified health home.

I. Comprehensive or Intensive Care Management

Policies, procedures and data collection systems are in place to create, document, execute and update an individualized, patient-centered Health Action Plan of care for each beneficiary that demonstrates a strong integrated network that is capable of providing the "high touch" support that is necessary to be effective with beneficiaries with complex, chronic conditions.

Most care management services should be delivered in person with periodic follow-up by phone. This includes the ability to accompany beneficiaries to health care provider appointments, as needed. Care Coordinator's assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers and support the achievement of individualized health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning. A Care Coordinator will help the beneficiary develop a Health Action Plan which will be accessible to the beneficiary, all health home team members, the beneficiary's providers, and family/caregivers.

Comment [WCMHC5]: How would transportation needs be met?

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The beneficiary Health Action Plan and/or care management case file shall provide evidence of:

1. A comprehensive and culturally appropriate health assessment conducted within 30 days of enrollment using evidence-based/informed practices where available. The assessment identifies chronic conditions, severity factors and gaps in care, the beneficiary's activation level[1] and opportunities for potentially avoidable emergency room, inpatient hospital and institutional use.
2. Screening for depression and alcohol or substance use disorder appropriate to the age of the beneficiary and referral to services, as appropriate.

Comment [WCMHC6]: Screening for depression and alcohol or substance use disorder is very important. However, this does not begin to identify or address the range of psychiatric disorders often present in the high risk/high cost population.

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[1] Training will be provided on the use of the Patient Activation Measure (PAM).

3. Measurement of the beneficiary's activation level using the Patient Activation Measure tool or when appropriate the Caregiver Activation Measure (Insignia products); the beneficiary shall be reassessed every 6 months while receiving health home services.
4. Beneficiary to Care Coordinator ratio not to exceed 50:1. The ratio may be adjusted when community health workers, peer counselors or other non-clinical staff is used to facilitate the work of the assigned Care Coordinator.
5. Active engagement of the beneficiary in goal setting, defining interventions and establishing the timeframes for goal achievement identified in the beneficiary's Health Action Plan. Beneficiaries and their designees play a central and active role in the development, implementation, and monitoring of their Health Action Plan. An individualized Health Action Plan shall reflect beneficiary and family preferences, education and support for self-management and other resources as appropriate.
6. Evidence-based/informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting health and health care choices.
7. Targeted clinical outcomes, including a description of how progress toward outcomes will be measured.
8. Outreach and engagement activities that support the beneficiary's participation in their care and that promote continuity of care.
9. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes.
10. Use of peer supports, support groups and self-care programs to increase the beneficiary's knowledge about their health conditions and improve adherence to prescribed treatment.
11. Routine and periodic health reassessment, at minimum every 6 months to include reassessment of the patient's likelihood for continued benefit from comprehensive care management and progress towards meeting clinical and patient-centered Health Action Plan goals. Changes are made to the Health Action Plan based upon changes in beneficiary need or preferences.
12. Access to and retention of needed health care and community services and resources.
13. Identification of the role of formal and informal supports, including direct care providers of long-term services and supports, whom the beneficiary has identified to assist them in achieving health action goals.

II. Care Coordination and Health Promotion

The dedicated Care Coordinator shall play a central and active role in the development and execution of a cross-system Health Action Plan of care including assisting the beneficiary to access needed services. The Care Coordinator shall assure communication is fostered between the providers of care including the designated health home team, the treating primary care provider, medical specialists and entities providing or authorizing behavioral health services and long-term services and supports.

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Comment [WCMHC7]: It is not sufficient for the care coordinator to communicate with the RSN or the AAA – this does not ensure that adequate quality communication will occur at the treatment level where interventions with beneficiaries occur.

The beneficiary Health Action Plan and/or care management case file shall provide evidence of:

1. Communication between the dedicated Care Coordinator and the treating/authorizing entities and assurance that the Care Coordinator can discuss with these entities on an as needed basis, changes in patient circumstances, condition or Health Action Plan that may necessitate changes in treatment or service need.
2. Release of information to allow sharing of information that facilitates coordination of and transitions in care, as agreed to by the beneficiary.
3. Care coordination and collaboration through case review meetings as needed, including all members of the Health Home team.
4. 24 hours/seven days a week availability to provide information and emergency consultation services to the beneficiary.

Comment [WCMHC8]: Who makes up this team?

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5. Priority appointments for health home beneficiaries to medical, behavioral health, and long-term care services within the health home provider network to avoid unnecessary, inappropriate utilization of emergency room, inpatient hospital and institutional services.
6. Wellness and prevention education specific to the beneficiary's chronic conditions, Health Action Plan, including routine preventive care, support for improving social connections to community networks and linking beneficiaries with resources that support a health promoting lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder prevention, nutritional counseling, obesity reduction and prevention, increasing physical activity, disease specific or chronic care management self-help resources, and other services, such as housing, based on individual needs and preferences.
7. Policies, procedures and accountabilities (contractual or memos of understanding/agreements) to support and define the roles and responsibilities for effective collaboration between primary care, specialists, behavioral health, long-term services and supports and community based organizations.

III. Comprehensive Transitional Care

Comprehensive transitional care shall be provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment or residential habilitation setting) and to ensure proper and timely follow-up care.

The beneficiary Health Action Plan and/or care management case file shall provide evidence of:

1. A notification system in place with hospitals, nursing homes and residential/rehabilitation facilities in their network to provide the health home prompt communication of a beneficiary's admission and/or discharge from an emergency room, inpatient, nursing home or residential/rehabilitation and if proper permissions, a substance use disorder treatment setting.
2. The use of a health home Care Coordinator as an active participant in all phases of care transition; including discharge visits during hospitalizations or nursing home stays post hospital/institutional stay home visits and telephone calls.
3. Beneficiary education that supports discharge care needs including medication management, follow-up appointments and self-management of their chronic or acute conditions, including information on when to seek medical care and emergency care. Involvement of formal or informal caregivers when requested by the beneficiary.
4. A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post discharge care.

IV. Individual and Family Support Services (including authorized representatives and identified decision makers)

The health home provider shall recognize the unique role the beneficiary may give family, identified decision makers and caregivers in assisting the beneficiary to access and navigate the health care and social service delivery system as well as support health action planning.

Peer supports, support groups, and self-management programs will be used by the health home provider to increase beneficiary and caregiver's knowledge of the beneficiary's chronic conditions, promote the beneficiary's engagement and self management capabilities and help the beneficiary improve adherence to their prescribed treatment.

The beneficiary Health Action Plan and/or care management case file shall:

1. Identify and refer to resources that support the beneficiary in attaining the highest level of health and functioning in their families and in the community, including transportation to medically necessary services and housing.
2. Reflect and incorporate the preferences, education about and support for self-management; self-help recovery and other resources necessary for the beneficiary, their family and their caregiver to support the beneficiary's individualized health action goals.
3. Identify the role that families, informal supports and caregivers provide to achieve self-management and optimal levels of physical and cognitive function.
4. Demonstrate discussion of advance directives including mental health advance directives when a mental health diagnosis is present with beneficiaries and their families.
5. Demonstrate communication and information sharing with individuals and their families and other caregivers with appropriate consideration of language, activation level, literacy and cultural preferences.

V. Referral to Community and Social Support Services

The health home provider identifies available community-based resources and actively manages referrals, assists the beneficiary in advocating for access to care, and engagement with community and social supports. Community and social support services include long-term services and supports, mental health, substance use disorder and other community and social services accessed by the beneficiary.

The beneficiary's Care Coordinator/Health Home team shall:

1. Identify available community-based resources discussed with the beneficiary and actively manage appropriate referrals, advocates for access to care and services, provides coaching to beneficiaries to engage in self-care and follow-up with required services.
2. Provide assistance to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services. These services are coordinated with appropriate departments of local, state and federal governments and community based organizations.
3. Have policies, procedures, and accountabilities (through contractual or memos of understanding/agreements) to support effective collaboration with community based resources, which clearly define roles and responsibilities.
4. Provide documentation of referrals to and access by the beneficiary of community based and other social support services as well as health care services that contribute to achieving the beneficiary's health action goals.

VI. Use of Health Information Technology to Link Services

Health home providers will make use of available health information technology (HIT) and access data through the Predictive Risk Intelligence System (PRISM), Medicaid managed care organization or fee-for-service systems, and other processes as feasible as the state develops Electronic Medical Records standards for Medicaid providers.

The health home infrastructure shall:

1. Use HIT to identify and support management of high risk beneficiaries in care management.
2. Use conferencing tools to support case conferences/team based care, including audio, video and/or web deployed solutions when security protocols and precautions are in place to protect Protected Health Information (PHI).
3. Use a system to track and share beneficiary information and care needs across providers, to monitor processes of care and outcomes, and to initiate changes in care, as necessary, to address beneficiary need and preferences.
4. Use web-based HIT registries and referral tracking systems.

5. Track service utilization and quality indicators and provide timely and actionable information to the Care Coordinator regarding under, over or mis-utilization patterns.
6. Develop a system with hospitals, nursing homes and residential/rehabilitation facilities to provide the health home prompt notification of a beneficiary's admission and/or discharge from an emergency room, inpatient, or residential/rehabilitation setting.
7. Develop methods to communicate real-time use of emergency room, inpatient hospitalizations, missed prescription refills and the need for evidence-based preventive care to the Care Coordinator.
8. Use the clinical decision support tool (PRISM) to view cross-system health and social service utilization to identify care opportunities.

VII. Quality Measures Reporting to State

Health Home providers must demonstrate the ability to collect, report, and share data with other providers, including HCA and ADSA for quality reporting purposes.

The health home lead entity is accountable for reducing avoidable health care costs specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes as measured by HCA and CMS required quality measures. Performance measures are identified on the following table.

Program Goals	Objectives	Measure Description	Measure Source	Accountable Party
1.Increase Beneficiary Participation and Activation	1a.Increase percent of high-risk health home beneficiaries willing to set a health action goal **(Participation Rate)**	**Numerator:** Number of high-risk health home beneficiaries willing to set a care plan goal **Denominator:** Total number of eligible high-risk health home beneficiaries	Enrollment data; validated in High-risk Client Assessment Database[2]	Managed Care Plan and Health Home
	1.bIncrease average PAM score of participating high-risk health home beneficiaries (**Activation Rate)**	**Numerator:** Sum of Patient-Activation Measure (PAM) scores **Denominator:** Total number of enrolled high-risk health home beneficiaries with baseline PAM score	Beneficiary reported. Insignia PAM database	Managed Care Plan and Health Home
2. Reduce Non-Emergent Emergency Department Visits	2a. Decrease non-emergent Emergency Department visits per 1000 enrolled beneficiary member months.	**Numerator:** Number of non-emergent Emergency Department visits (New York University algorithm or Washington State developed diagnosis list **Denominator**: Total enrolled beneficiary	Claims and Encounter data	Managed Care Plan and Health home

[2] In MCO contract – "Enrollees with Special Health Care Needs Database," page 107

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		member months/1000		
3. Reduce Avoidable Hospital Admissions and Nursing Home Placements	3a. Decrease hospitalization admissions per 1000 beneficiary member months -Overall hospitalization with Emergency Department activity	**Numerator:** - Admission with emergency department indicator **Denominator:** Total enrolled **b**eneficiary member months /1000	Claims and Encounter data	Managed Care Plan and Health Home
	3b. Decrease skilled nursing facility placements per 1000 beneficiary member months	**Numerator:** Skilled nursing facility placements **Denominator:** Beneficiary member months /1000	Claims and Encounter data	Managed care
4. Reduce Hospital Readmissions	4a. Decrease 30 day all-cause readmissions per 1000 enrolled beneficiaries	**Numerator:** Number of 30 day all cause readmissions **Denominator:** Health home member months/1000	Claims and Encounter data	Managed Care Plan and Health Home
	4b. Increase percent of hospitalized mentally ill individuals who had a visit with a mental health practitioner within 7 days of discharge	**Numerator:** An outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. **Denominator:** Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental	Claims and Encounter data	Managed Care Plan and Health Home

		health diagnosis on or between January 1 and December of the measurement year.		
5. Improve mental health identification and treatment	5a. Increase percent of enrolled adult high-risk health home clients screened for clinical depression using PHQ-9 (Patient Health Questionnaire)	**Numerator**: Number of enrolled high-risk health home clients 18 years and older screened for clinical depression using PHQ-9 **Denominator**: Total number of enrolled high-risk health home clients 18 years and older	High-risk Client Assessment Database[3]	Health Home
6.Improve initiation and engagement of alcohol and substance use treatment	6a. Increase percent of beneficiaries with initiation and engagement of alcohol and other drug dependence treatment (HEDIS)	**Numerator:** Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis. Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.	Claims, encounters and High-risk Client Assessment Database[4]	Managed Care Plan and Health Home

[3] In MCO contract – "Enrollees with Special Health Care Needs Database," page 107
[4] In MCO contract – "Enrollees with Special Health Care Needs Database," page 107

		Denominator: Members 13 years of age and older as of December 31 of the measurement year with a new episode of alcohol or other drug (AOD) during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.		

Health Home Provider Functional Requirements (SMD 10-024)

Health home providers must demonstrate their ability to perform each of the following federally-required functions, including documentation of the processes used to perform these functions and the processes and timeframes used to assure service delivery takes place in the described manner. Documentation should also include a description of the proposed multifaceted health home service interventions that will be provided to promote patient engagement, participation in their plan of care and that ensure patients appropriate access to the continuum of physical and behavioral health care and social services needs.

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, care coordination, and 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 health care.
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
8. Coordinate and provide access to long-term care supports and services.
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.

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10. Demonstrate a capacity to use health information technology 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.
11. 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.