

Ohio Medicaid Health Homes for Individuals with Serious and Persistent Mental Illness

Health Homes Overview

Individuals with Serious and Persistent Mental Illness commonly experience physical health conditions such as heart disease and obesity. These health problems, often made worse by medications taken to treat mental illness, are preventable when care providers treat the whole person instead of a particular illness.

Leaders of Ohio's health and human services agencies believe that better care coordination can result in improved health outcomes while spending less of the taxpayer's dollars. House Bill 153 authorized Ohio Medicaid to design a person-centered system of care, called a health home, for people with serious health risks.

Health homes aim to integrate physical and behavioral health care by offering medical, behavioral and social services that are timely, quality and coordinated by an individualized treatment team. Ohio Medicaid teamed up with the Ohio Department of Mental Health to focus first on creating health homes for people on Medicaid who have Serious and Persistent Mental Illness.

What is a health home?

A health home is not a building; it is a coordinated, person-centered system of care. An individual who is eligible for health home service can obtain comprehensive medical, mental health, drug and/or alcohol addiction, and social services coordinated by an integrated treatment team.

What specific health home services will be available for individuals with serious and persistent mental illness?

1. Comprehensive Care Management

- Assess the individual's physical health, behavioral health and social/cultural needs with a reassessment at least every 90 days
- Develop the individual's treatment team, establishing roles and responsibilities of each team member and a point of contact
- Routinely monitor the individual's care plan to determine effectiveness and progress in achieving its goals and outcomes

2. Care Coordination

- Implement a single, integrated care plan for the individual
- Facilitate the coordination, communication, and collaboration necessary for the individual to achieve the best possible health outcomes, including but not limited to:

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- Providing assistance in obtaining health care
 - Performing medication management
 - Tracking tests and referrals
 - Assisting with prevention/stabilization of crises
 - Ensuring post-crisis follow-up
 - Participating in discharge planning
 - Making referrals to community, social and recovery supports
- Assist the individual with making appointments
 - Validate that services were received

3. Health Promotion

- Provide the individual/family with knowledge and skills to increase understanding of the individual's health needs
- Promote self-management and improve quality of life and daily functioning through referrals to wellness programs such as weight management, wellness management and recovery, smoking cessation, chronic disease management and connections to peer supports
- Engage individual/family in development, implementation and monitoring of the individual's care plan
- Empower the individual by promoting self-advocacy and teaching self-management skills which increase the individual's ability to manage existing conditions, use preventative services and access care as needed

4. Comprehensive Transitional Care

- Ensure continuity of care and prevent unnecessary inpatient readmissions, emergency department visits and/or other adverse outcomes, such as homelessness
- Coordinate and collaborate with all care providers to ensure that a comprehensive discharge/transition plan, as well as timely and appropriate follow up, is completed for individuals transitioning to or from different levels and settings of care
- Facilitate timely access to follow-up post discharge care and medication information

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5. Individual and Family Support Services

- Provide and accommodate expanded access to services based on individual patient needs
- Ensure continuity in relationships between individual/family, provider(s), and the Care Manager
- Support the delivery of person centered care
- Perform outreach and advocacy for the individual/family to identify and obtain needed resources (e.g. transportation)
- Assist individual with self-management techniques
- Provide opportunities for the individual/family to participate in the assessment and care plan development/implementation
- Offer access to electronic health records or other clinical information
- Make referrals to community/social/recovery supports

6. Referral to Community and Social Support Services

- Assist consumers with making appointments, validate the service was received, and complete any follow up as necessary
- Offer and/or arrange onsite and offsite community and social support services
- Identify and provide referrals to recovery support services such as maintaining eligibility for benefits, obtaining legal assistance, and housing

Why health homes?

Ohio Medicaid health homes for individuals with serious and persistent mental illness are designed to achieve accessible, high quality primary and behavioral healthcare in a cost effective, coordinated manner. The state will analyze data from a variety of sources to ensure the goals of the health home are met. The quality measures identified below represent the overall goals of this initiative:

- Improve care coordination
- Improve integration of physical and behavioral health care
- Improve health outcomes
- Lower rates of hospital emergency department use
- Reduce hospital admissions and readmissions
- Decrease reliance on long term care facilities
- Improve the experience of care and consumer quality of life
- Reduce healthcare costs

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Who will provide health home services to individuals with serious and persistent mental illness in Ohio?

Community behavioral health providers, who meet state-defined requirements, including the integration of primary and behavioral health care services, can qualify as health homes. Health home services will be provided by a team of health care professionals.

Who are the core members of the health home care team?

1. **Health Home Team Leader** – provides administrative clinical leadership/oversight to the health home team and monitors provision of health home services. A key function of the Team Leader is to be the champion for health home services and motivate and educate other staff members.
2. **Embedded Primary Care Clinician** – assesses consumer service needs, develops care plan/treatment guidelines and monitors individual health status/service use. The Embedded Primary Care Clinician provides education and consultation to the health home team regarding best practices.
3. **Care Manager** – accountable for overall care management/coordination of all health home services. The Care Manager is responsible for managing and coordinating beneficiary care plans, which will include both medical/behavioral health (including substance abuse) and social service needs and goals.
4. **Care Manager Aide** – assists and supports Care Managers with care coordination, referral/linkage, follow-up, family/consumer support and health promotion services.

Who will be eligible for health home services in community behavioral health centers?

All adults and children who have Medicaid benefits and meet the State of Ohio definition of serious and persistent mental illness, which includes adults with serious mental illness and children with serious emotional disturbance, will be eligible for health home services in community behavioral health centers.