Implementing Health Homes: Lessons Learned as We Go Forward

April 8, 2015

Agenda

I. Health Home Program Overview
II. Health Home Program Services and Benefits
III. Success Stories from Patient Care Networks
IV. Questions
V. Next Steps

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Health Home Program Overview

Section 1

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Health Home Program Overview

A Medicaid State Plan Option to integrate and coordinate primary, acute, behavioral health and long-term services across the lifespan for beneficiaries with chronic conditions.

- Statewide
- Previously known as Patient Care Networks
- In 2012, AMA modified its Patient Care Networks program to exclusively focus on the Health Home eligible recipients in Patient 1st
- Primary Medical Providers* receive expanded case management fees for patients with chronic conditions of $8.50 PMPM

*Excludes FQHCs / RHCs

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Care Coordination for Complex Patients

Health Homes provide quality-driven, cost effective, culturally appropriate, and person- and family-centered health home services for Patient 1st recipients with:

- Asthma
- Diabetes
- Cancer
- COPD
- HIV
- Mental Health Conditions
- Cardiovascular Disease
- Substance Use Disorders
- Transplants
- Sickle Cell
- Heart Disease
- Obesity
  - BMI ≥ 25
- Hepatitis C

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Health Home Program Services and Benefits

Section 2

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Health Home Program Services and Benefits

The Health Home program is set up to add an additional level of support to Patient 1st PMPs.

Service Type	Care Coordination	Transitional Care	Medication Management
Provided By	• Nurses • Licensed Social Workers	• Nurses • Licensed Social Workers	• Pharmacists
Services to Include	• Completion of psychosocial assessments to determine needs of recipients • Referral for needed resources including transportation, financial assistance, food, and support services • Providing education regarding chronic illness and provided support in managing their care	• Assist patients transitioning from one level of care to another • Partnering with medical facilities to develop discharge plans • Medication reconciliation • Education and support services in managing chronic conditions	• Medication reconciliation • Education to recipients regarding medication management

Health Home Program Benefits to Patients





Embed care coordinators in the PMP's office

Integration of medical and behavioral health
- Behavioral Health Nurses link recipients to needed care

Network with regional providers

Shared learning and technical assistance
- Compare practice patterns for efficiencies and cost savings measures

Additional time
- Care coordinators free-up PMP office resources

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Health Home Program Benefits to Patients


Assistance transitioning from an inpatient setting back to the community


Assessment by a nurse or social worker to determine barriers to healthy living and develop a plan to assist in managing chronic conditions

Availability of a pharmacist to review medications and assist with medication regime


Referrals to needed community resources


Linkage to medical or behavioral health services


Education on chronic diseases or behavioral health condition

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Health Home Program Success Stories

Section 3

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Care Network of Alabama

Health Home Program Success Stories

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Patient Identification

- 33 year old female with history of congestive heart failure in process of evaluation for heart transplant list
  - 5 ED visits/12 months, 1 admission
- Identified through inpatient referral for transitional care and care coordination
- Risk stratified as high – patient is high risk for frequent access of care through ED, potential high cost

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Services Provided/Coordinated

- Telehealth
- Local county transportation resource
- Education regarding Medicaid NET program
- Education regarding Medicaid visits/referral process
- Nutrition Education
- Mental Health

Care Network of Alabama, Inc.

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Outcomes

- Telehealth – active participation, well managed blood pressure
- Transportation – patient is currently utilizing NET and self- reporting
- Nutrition Education – weight loss currently at 80 pounds
- Mental Health – active in mental health counseling, increased ability to articulate fears, stresses and coping mechanisms
- ED utilization – zero ED visits since enrollment

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Questions - Program

Section 4

Questions Received by the Agency: Health Home Services

Will patients who receive Health Home services be "home bound" and not come to doctor visits?

"Health Home" is not the same as "home health." Health Home services provide intense care coordination for recipients with chronic conditions or a serious mental health condition. These services include a social worker or nurse to assist patient through community resources, education, and transitional care services.

Can a PMP have patients in both a Health Home and in Patient 1st?

Yes. In order to participate in the Health Home program, the patient must be in the Patient 1st Program or opt-in to the Health Home program as a dual eligible recipient.

Questions Received by the Agency: Health Home and Patient 1st Program

What is the incentive for the patient to join an RCO or Health Home if they can just stay in Patient 1st?

The incentive for patients with chronic conditions to join a Health Home is to get comprehensive care management, care coordination services and transitional care services they would otherwise not receive in the Patient 1st program alone.

What if some patients choose not to participate in the Health Home but are still in the Patient 1st program in the next one to two years?

Recipients who qualify for Health Home services can decide if they want the extra services or not. If a Patient 1st recipient qualifies for the Health Home program, but decides to stay with a PMP who is not signed up for the Health Home program, that patient will still get Medicaid services, but will not get any of the extra services available through the Health Home program.

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Questions Received by the Agency: Health Home and Patient 1st Program

How are providers who are not Patient 1st providers (i.e. skilled nursing facilities, assisted living facilities, hospitalists) affected by the RCOs & Health Homes?

The primary goal of Health Homes includes the integration of care between medical, behavioral health and long term care services. In order to achieve this goal, Health Home staff must develop relationships with medical facilities and community agencies in addition to the Patient 1st providers.

What happens to the Health Home Program when the RCOs go live?

The RCO will continue to provide Health Home services to qualified recipients after they become full risk on October 1, 2015.

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KG34 For Carolyn: Please draft an answer to the second question.
Kian Glenn, 4/2/2015

Next Steps

Section 4

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Contact Information: Probationary RCOs Contracted for the Health Home Program

- Providers may contact the Probationary RCOs in any region to participate in the Health Home Program.
  - More contacts can be found on Medicaid's website

Region	Probationary RCOs	Contact Name	Phone #
A	Alabama Community Care – Region A	Dana Garrard	(256) 382-2366
	My Care Alabama	Stacy Copeland	(256) 713-9461
B	Alabama Care Plan	Michael Battle	(205) 558-7645
C	Alabama Community Care – Region C	Tina Stevenson	(205)553-4661
D	Care Network of Alabama	Kim Eason	(334) 528-5867
E	Gulf Coast Regional Care Organization	Sylvia Brown	(251) 380-8440

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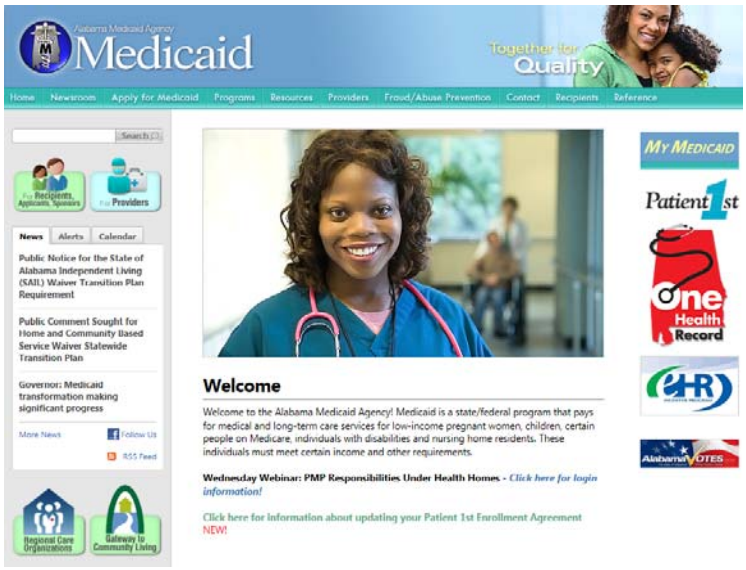
IC13 Contact info should be on the Health Home Page
Ida Common, 4/2/2015

Questions?

The Agency wants to support you – ***how can we help***?



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Please Remember…

Our goal is to have a seamless transition to the state wide expansion of the Health Home Program

- Upcoming noon webinar:
  - Health Home from the PMP Perspective (April 22nd)

Contact Us:

- Submit Questions to the: RCOPortal@Medicaid.Alabama.gov
- PMP Assistance Center: 1-800-688-7989

www.Medicaid.Alabama.gov > Programs > Health Homes

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KG33 Carolyn to confirm April 22 webinar name
Kian Glenn, 4/2/2015