



# Health Homes 101

## What is a Health Home?

- Health Homes created by Section 2703 of the ACA to help reduce the cost of services for some High Cost High Risk Medicaid populations.
- Health Homes build a person centered system of care that achieves improved outcomes for recipients and better services and value for state Medicaid programs.
- The Medicaid Solutions Workgroup recommended that DSS look into implementing Health Homes.
- Several States are currently approved to do Health Homes including, MO, IA, NE, NY, RI, OR and NC.
- 57% of our costs in Medicaid come from 5% of our population.
- 83% of Health Home eligible individual are included in the individuals in the 5% who make up our Highest Cost Highest Risk Group.

## What Must a Health Home Do

- Provide quality-driven, cost-effective, culturally appropriate, person-/family-centered services;
- Coordinate/provide access to: high-quality, evidence-based services; preventive/health promotion services; MH/SA services; comprehensive care management/ coordination/ transitional care across settings; disease management; individual/family supports; LTC supports and services;
- Develop a person-centered care plan that coordinates/ integrates clinical/non-clinical health care needs/services;
- Link services with HIT, communicate across team, individual and family caregivers, and provide feedback to practices; and
- Establish a continuous QI program.

# What are Health Home Services?

- Six Core Services must be provided:
  - Comprehensive care management;
  - Care coordination;
  - Health promotion;
  - Comprehensive transitional care/follow-up;
  - Patient and family support; and
  - Referral to community and social support services.
- May or may not be provided within the walls of a primary care practice.

## Related to, but not the same as, patient centered Medical Homes

- Medical homes can be foundation of Health Homes.
- Health Homes are developed specifically for Medicaid recipient.
- Health homes expand on traditional medical home models by:
  - Focusing on patients with multiple chronic and complex conditions;
  - Coordinating across medical, behavioral, and long-term care; and
  - Building linkages to community and social supports.
- Focus on outcomes – reduced ED, hospitalizations/readmissions, reduced reliance on LTC facilities.

# Populations to be Served by SD Two Proposed Health Homes

- Approximately 35,685 recipients are eligible for the two Health Homes
- Primary Care Provider Health Homes include individuals with two or more chronic diseases listed below OR one chronic and one at risk condition listed below.
  - **Chronic diseases include:** Asthma, COPD, Diabetes, Heart Disease, Hypertension, Obesity, HIV, Musculoskeletal and Neck and Back Disorders.
  - **At-risk conditions include:** Pre-Diabetes, tobacco use, Cancer Hypercholesterolemia, Depression, and use of multiple medications (6 or more classes of medications).
- The Behavioral Health Health Homes includes individuals with a primary diagnosis of one Severe Mental Illness or Emotional Disturbance and Substance Abuse.
  - Schizophrenia, bipolar, major depression, mood disorders, Ethyl Alcohol-related psychotic disorders, anxiety, personality/social disorders, Attention Deficit Hyperactivity Disorder.
- Can't exclude recipients eligible for both Medicaid and Medicare or kids.

# Provider Infrastructure for Primary Care Provider Health Homes

- Designated Provider for PCP Health Homes
  - Designated providers include a primary care physician (e.g., family practice, internal medicine, pediatrician or OB/GYN) or midlevel practitioner, working in a Federally Qualified Health Center, Rural Health Clinic, or clinic group practice.
  - The designated provider is part of a physician led team, supported by a team of health care professionals and support staff that establishes an ongoing relationship with the patient.
  - A designated provider team of health care professionals may also include behavioral health providers, a health coach/care coordinator/care manager, chiropractor, pharmacist, support staff, and other services as appropriate and available.
  - A health home may include multiple sites identified as a single organization that share policies, procedures and electronic systems.

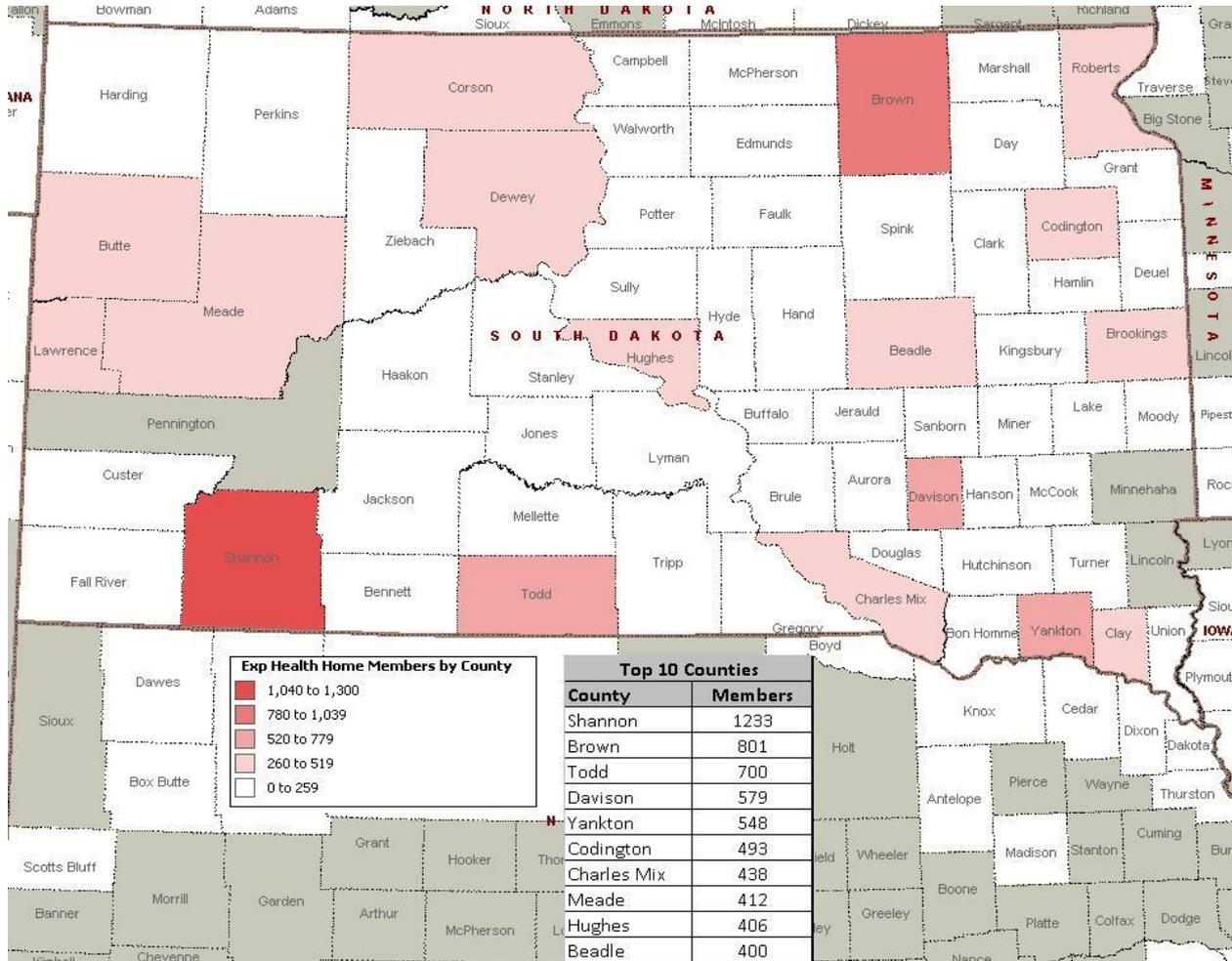
# Provider Infrastructure for Behavioral Health Health Homes

- Designated Provider for BH Health Homes
  - Designated providers include mental health professionals working in community mental health center or other behavioral health setting.
  - The designated provider will be supported by a team of health care professionals including a primary care physician or midlevel practitioner and support staff that establishes an ongoing relationship with the patient.
  - A designated provider team of health care professionals may also include a health coach/care coordinator/care manager, chiropractor, pharmacist, support staff, and other services as appropriate and available.
  - A health home may include multiple sites identified as a single organization that shares policies, procedures, and electronic systems.

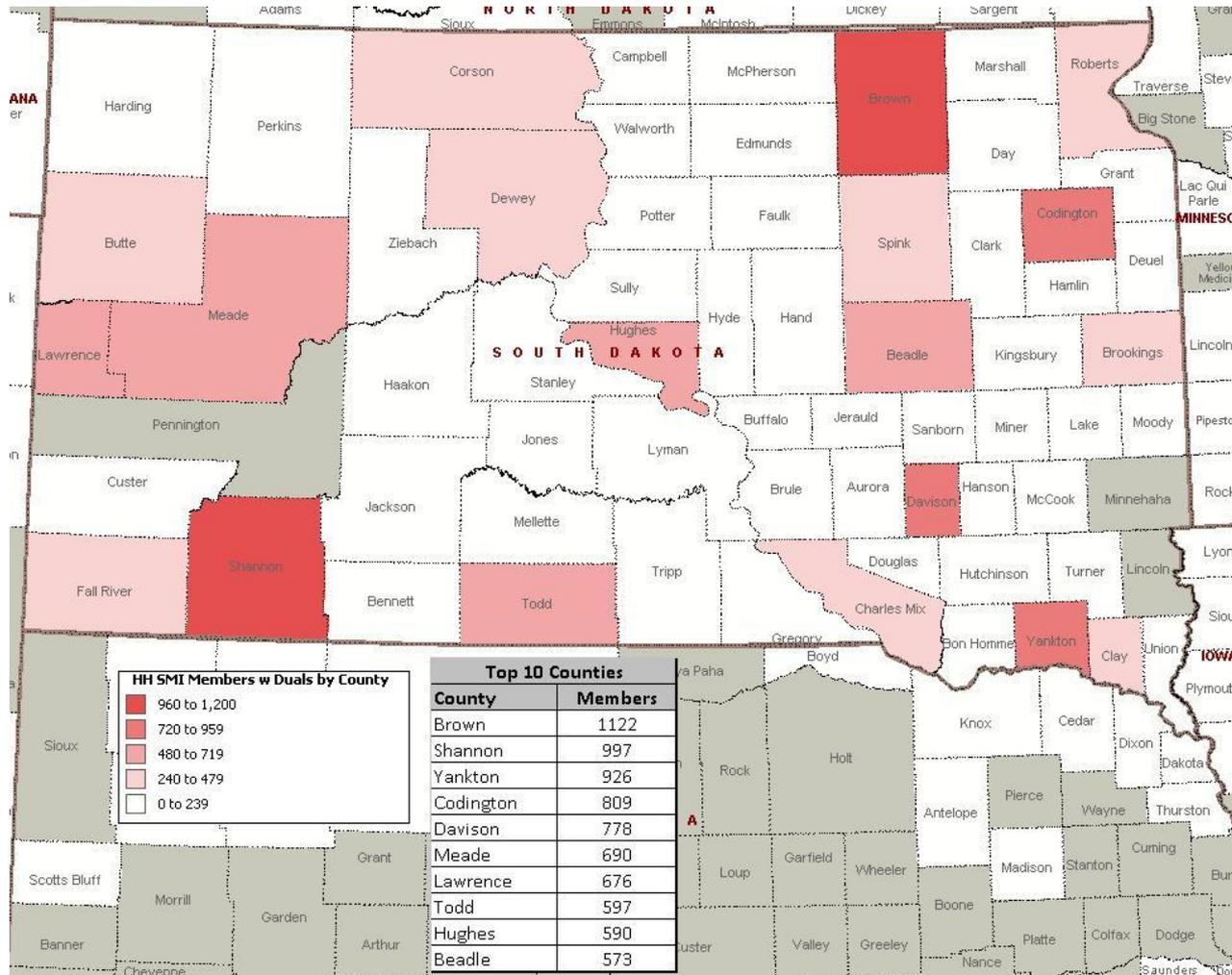
# Proposed Quality Methodology

- State Plan Amendments (SPA) require goals with measures in the areas of Clinic Outcomes, Experience of Care and Quality of Care.
- Each SPA includes a set of outcomes that have three goals and appropriate measures.
- Two different Quality Plans with three goals and appropriate measures have been developed for both the PCP and BH Health Homes.
- Minimum of one clinical indicator for each disease category.
- Patient and Family experience/satisfaction measures.
- Cost and Effectiveness measures.

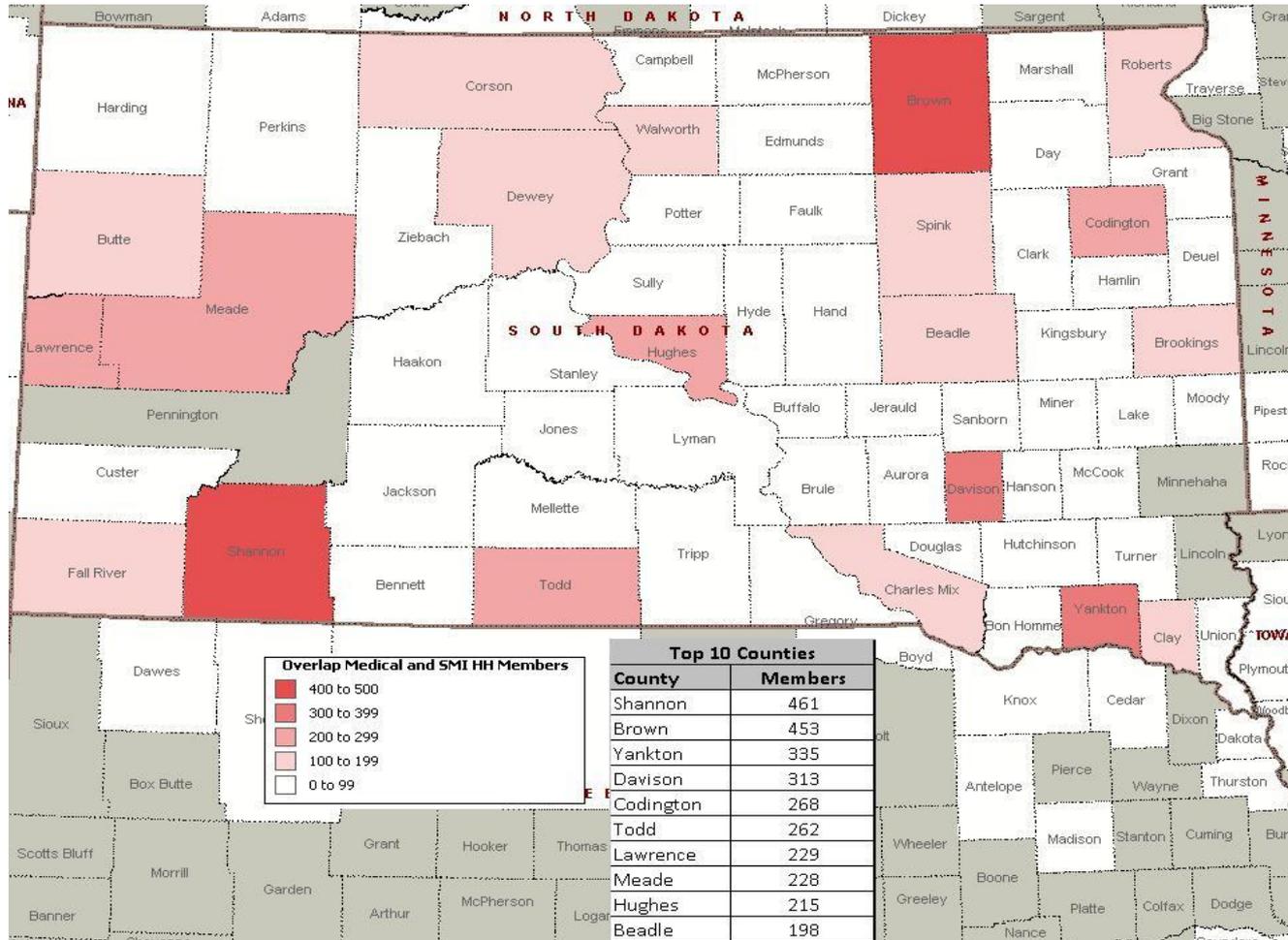
# Primary Care Health Home



# Behavioral Health Health Home



# Primary Care and Behavioral Health Overlap



## Next Steps

- Final Workgroup meeting on October 30, 2012.
- State Plan Amendment Process
  - Consultation with CMS and SAMSHA
  - Tribal and Public Notification Period
  - SPA Approval
- Educating Health Homes about the process of enrollment.
- Enrolling Health Home providers.
- Educating eligible recipients about the functions and benefits of a Health Home.



**Thank-you.**