Integrated Health Homes:

Provider Requirements, Expectations and Staffing Ratios

August 23, 24 and 27, 2018

Housekeeping Items

- Phone lines are in listen only mode
- Questions can be submitted through the "chat" function **on the right hand side of the screen.**
- Answers to questions will be posted on HFS' website as a Integrated Health Home Frequently Asked Questions document

How can we become an IHH?

Who can enroll as an IHH?

As long as the requirements are met, **any provider** can enroll as an IHH.

Must be able to provide **coordination of care across physical, social and behavioral health** and enroll with Medicaid in IMPACT as well as have agreement with MCO(s).

General Requirements

- Required Professionals – Collaborative and/or Cooperative Agreements
- Maintain appointment standards
- Establish relationships with hospitals, residential settings, other treatment centers, and other care providers
- Facilitate direct access
- Facilitate and participate in interdisciplinary team meetings
- Ability to receive notifications on member status from rendering providers
- Develop capacity for a minimum panel size of 500

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General Requirements

Required Professionals

The IHH must maintain the following categories of professional staff:

1. **Physician:** Appropriate clinical license and/or professional certification and referring capabilities to appropriate medical specialists
2. **Psychiatrist/Psychologist/Mental Health Specialist:** Appropriate clinical license and/or professional certification, e.g., Licensed Practitioner of the Healing Arts (LPHA)
3. **Substance Use Disorder (SUD) Specialist:** Appropriate clinical license.
4. **Social Worker/Social Service Specialist:** Possess, at minimum, a bachelor's degree in a relevant subject
5. **Nurse Care Manager:** One lead nurse care manager (qualified RN) per practice, with further nurse care managers as needed.
6. **Clinical Care Coordinator:** Possess, at minimum, a bachelor's degree with previous case management experience and appropriate clinical licenses and/or professional certification

General Requirements

Maintain Appointment Standards

Type of Appointments	Tiers A & B	Tier C
Routine/Preventative for adults	Within 3 weeks	Within 5 weeks
Routine/Preventative infants less than 6 months	Within 1 weeks	Within 2 week
Urgent Care Non-emergencies	Within 24 hours	Within 24 hours
Problems/Issues deemed as not being serious	Within 2 weeks	Within 3 weeks
Prenatal 1st Trimester	Within 1 weeks	Within 2 weeks
Prenatal 2nd Trimester	Within 5 days	Within 1 week
Prenatal 3rd Trimester	Within 2 days	Within 3 days

General Requirements

Facilitate Direct Access for Members

- 24 hours, 7 days a week
- At a minimum, an answering service/direct notification/other preapproved arrangement, such as a secure electronic messaging system and/or video conferencing system to offer interactive clinical advice to members

Inter-Disciplinary Meetings

- Facilitate and participate / both behavioral and physical health
- Meeting the needs of the member for the coordination of care

Communication

- Bi-directional communication with members and appropriate service providers
- Develop protocols for ongoing communication and prompt notification as member's transition from residential to community
- Ability to receive notification on members' status from rendering providers (e.g. ADT feed, working toward EHR)

Other Requirements

- Building capacity to receive electronic records or notification.
- Panel size requirements

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IHH Structure

Allowable options	Approach	Demonstration of integration	Proof of eligibility	Entities receiving payment
One, fully integrated, responsible provider	▪ Single, integrated behavioral health provider (e.g., CMHC), physical health provider (e.g., FQHC), and social service health provider (e.g., Lutheran SS)	▪ Entity is capable of providing both physical and behavioral health care coordination services	▪ Provider must attest to having the necessary staff and capabilities	▪ One (i.e., single integrated provider receives full payment)
Lead provider brings contracts/ collaborative agreement	▪ One lead provider (type dependent on member need) **AND** ▪ Contract or Collaborative agreement with the other provider types	▪ Must submit a contract or Collaborative Agreement (CA)	▪ Contract or CA must contain explicit agreements in line with integration requirements laid out by State	▪ One lead entity, with potential disbursement of funds to partner entities left up to lead provider's discretion

Enrollment and Ongoing Participation

Requirements to…

Enroll as an IHH

- **Collaborative agreements** with practice(s) with complementary capabilities for both high- and low-needs members
- Specific **care coordination personnel** (IMPACT-enrolled)
- Medicaid provider **in good standing**
- Meet certain **activity requirements** prior to enrollment
- **500-member minimum panel size**, with exceptions where needed
- **Usage** of or **progress** towards **implementing** an **EHR system**
- **Ability** to perform **multi-modal outreach**

Remain an IHH

- **Continue to meet enrollment requirements**
- **Continue to provide care coordination services under the following five categories (HCPCS codes):**
  - G9004 - Comprehensive Care Management
  - G9005 - Care Coordination and Health Promotion
  - G9007 - Transitional Care
  - G9010 - Patient and Family Support
  - G9011 - Referral to Social Services
- **Measurements**
  - 10 measures for outcomes based payments, e.g., controlling high blood pressure
  - 8 measures for reporting only, e.g., emergency department utilization per 1,000

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Required IHH Activities to Meet System Transformation Goals

Barriers to integrated care		Integrated care facilitated by IHH care coordination
Infrequent data sharing and communication between providers **Siloed care planning**	**Integrated care planning and monitoring**	Providers take **holistic view of health,** supplying full set of services appropriate to members' needs **Comprehensive care plans** developed with member and caregivers, supported by ongoing communication with behavioral and physical healthcare providers
Frequent barriers to attendance to medical appointments **Little continuity in care delivery** across providers	**Physical health provider engagement**	**Improved access** to providers for routine appointments and time-sensitive support Integrated experience with **seamless connections and communication across providers**
Frequent barriers to attendance to behavioral health appointments **Little continuity in care delivery** across providers	**Behavioral health provider engagement**	**Improved access** to providers for routine appointments and time-sensitive support Integrated experience with **seamless connections and communication across providers**
Limited provider engagement with community supports in the care and recovery process	**Supportive service coordination**	**Access to and collaboration with community supports** is prioritized Member **needs are communicated to community partners**
Infrequent follow-ups and outreach to members and their caregivers (e.g., partners, foster parents,) **Reactive treatment programs**, with little emphasis on self-care, education, and independent living skills	**Member engagement & education**	Support for **treatment and medication adherence** Enhanced **social skills training, emphasis on independent living and engagement with supports**
Providers take a **case-by-case view of population health** Member **focus determined based on episodes** Providers make **limited use of screening tools**	**Population health management**	Improved dialogue among providers **on quality outcomes across panel** Continuous **stratification of panel and use of standardized assessment processes to identify highest-needs members**

Integrated Care Planning and Monitoring Requirements Examples of Related Activities

Create and Update Integrated Care Plan

- Initiate, complete, update, and monitor the progress of a comprehensive, culturally-competent, person-centered, goal-oriented care plan, following a comprehensive assessment of the member's behavioral and physical health needs within 30 days of member enrollment. Plan should be updated at least twice a year and address the member's overall health treatment and care coordination needs, including protocols for treatment adherence and crisis management.

- Plan should be developed by an interdisciplinary care team that includes all appropriate Required Staff and input from:
  - The member, the member's caregiver, and the member's social supports
  - The member's MCO (if applicable)
    - The IHH should give particular attention in engaging with the MCO on care planning particularly to achieving the requisite prior authorizations for treatment, and, if necessary, making appeals on the member's behalf
  - The member's primary behavioral and physical health providers as well as specialty care providers

- Conduct screenings and coordinate use of functional assessments to understand members' strengths and levels of functional need

Integrated Care Planning and Monitoring Requirements Examples of Related Activities

Prepare and Implement Transitional Care Plan

- Develop a systemic protocol to assure timely access to follow-up care post discharge that includes at a minimum all of the following:
  - Receipt of a summary of care record from the discharging entity
  - Medication reconciliation
  - Reevaluation of the care plan to include and provide access to needed community support services
  - A plan to ensure timely scheduled appointments
- Establish relationships with hospitals, residential settings, rehabilitation settings, other treatment settings, LTSS, and support providers to facilitate transitions as member moves between levels of care or back into community including developing protocols for prompt notification and ongoing communication
- Communicate and provide education to the member, the member's supports, the providers located at the setting from which the member is transitioning, and those at the setting to which the member is transitioning
- Participate in implementation of discharge plan for each hospitalization to support member's transition, particularly to ensure all relevant follow-up after discharge takes place (including with partner agencies and member's MCO). This includes discharges from ERs, inpatient residential, rehabilitative, and other treatment settings
- Have ability to receive notifications on member status from rendering providers (e.g., via ADT feeds)

Physical and Behavioral Health Provider Engagement Requirements
Examples of Related Activities

Improve Access to Clinical Care

- **Facilitate and participate in regular interdisciplinary care team meetings,** including clinicians from the members' behavioral and physical health providers
- **Communicate with partner entities and other providers** (including MCOs) to understand significant changes in members' physical and behavioral health status, and translate into care plan
- **Follow up with other providers or clinical staff,** including specialists, as needed to understand additional physical and behavioral health needs, incorporating these in the care plan
- **Make available settings of care** and methods of interaction outside of physical clinics (e.g., telehealth) to accommodate the needs of those members who would prefer a non-clinical setting
- **Proactively outreach** to partner entities regarding specific gaps in care
- **Implement the member's comprehensive integrated care plan**, through collaboration with a behavioral health provider if the Integrated Health Home is a physical health provider or through collaboration with a physical health provider if the lead entity is a behavioral health provider

Supportive Service Coordination Requirements
Examples of Related Activities

Increase Awareness and Access to Social Supports

- Identify community supports where applicable that would facilitate members in achieving their highest level of function, social skill development, independence, and wellness/self-management
- Provide information, assistance, and referrals where applicable to members and their caregivers to enhance access to social support services, and undertake follow-up

Engage Social Supports in Care Planning and Delivery Process Meeting Members Needs

- Engage community partners to support the member outreach process
- Communicate member needs to community partners and incorporate information from community partners into care planning process, ensuring social determinants of health are addressed within this
- Communicate with partner agencies (e.g., DCFS) to involve social supports (e.g., caseworkers) and incorporate appropriate legal guidance
- Coordinate consolidation of information on member held by social supports and community partners, with member's consent, in order to improve care planning and delivery process

Member Engagement and Education Requirements
Examples of Related Activities

Increase member investment and participation in treatment

- Engage in outreach to establish and renew relationship with member
- Coordinate access to additional support in crisis situations when other resources are unavailable, or as alternative to ED (including developing with member crisis self-support plan in advance)
- Coordinate access to in-person support to ensure treatment and medication adherence (including medication reconciliation, medication management for specialty medications, medication drop-off, and help arranging transportation to appointments)
- Provide direct access to members for coverage 24 hours a day, seven days a week at the very least through an answering service/direct notification mechanism or other approved arrangement
- Develop emergency contact protocols for members to establish contact with clinical personnel directly during crisis situations and protocols for timely sharing of information with others providers relevant to member's care
- Support scheduling and reduce barriers to adherence for medical and behavioral health appointments, including in-person accompaniment to appointments
- Check-ins with member to support treatment adherence
- Maintain appointment standards for members

Member Engagement and Education Requirements
Examples of Related Activities

Increase member investment and participation in treatment

- Coordinate access (via MCO if applicable) to caregiver counseling or training including skill development to help members improve function, understand information on their condition, and navigate service system
- Identify and communicate resources to assist individuals and family supporters in acquiring and improving self-help/advocacy, socialization, and adaptive skills
- Coordinate access for members and families to independent living skill and wellness/prevention education, respite care, and peer support
- Seek out and integrate member feedback on all relevant elements of their experience

Population Health Management Requirements
Examples of Related Activities

Engage in Continuous Improvement to Meet Members' Needs

- Identify highest risk members on a continuous basis, supported by appropriate stratification tools, to focus resources and interventions
- Track and make improvements based on quality outcomes
- Seek out and integrate member feedback on all relevant elements of their experience
- Participate in learning collaboratives

IHH Care Coordination Codes and Activity Examples

G9004 - Comprehensive Care Management

- Complete/revise an individualized patient-centered plan of care with the member to identify member's needs/goals and include family members and other social supports as appropriate.
- Consult with multidisciplinary team on client care plan/needs/goals.

G9005 - Care Coordination and Health Promotion

- Coordinate with service providers and health plans as appropriate to secure necessary care, share crisis intervention (provider) and emergency info.
- Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.

G9007 - Transitional Care

- Facilitate discharge planning from an ER, hospital/residential/rehabilitative setting to a safe transition/discharge where care needs are in place.
- Link client with community supports to assure that needed services are provided at the time of discharge.

G9010 - Patient and Family Support

- Develop/review/revise the individual's plan of care with the client/family to ensure that the plan reflects individual's preferences, education and support for self- management.
- Refer client/family to peer supports, support groups, social services, entitlement programs as needed.

G9011 - Referral to Social Services

- Identify resources and link client with community supports as needed.
- Collaborate/coordinate with community base providers to support utilization of services based on client/family need.

Upcoming Webinars

Provider Requirements, Expectations and Staffing Ratios
- Friday, August 24, 2018 - 9:00 am – 10:30 am
- Monday, August 27, 2018 - 9:00 am – 10:30 am

Quality Indicators, Incentive Payments and Reporting
- Thursday, August 23, 2018 - 1:00 pm – 2:30 pm
- Friday, August 24, 2018 - 1:00 pm – 2:30 pm
- Monday, August 27, 2018 - 1:00 pm – 2:30 pm

Attribution,Tiering and Assignment
- Thursday, August 30, 2018 - 9:00 am – 10:30 am
- Friday, August 31, 2018 - 9:00 am – 10:30 am
- Tuesday, September 4, 2018 - 9:00 am – 10:30 am

Enrollment in the IMPACT System
- Wednesday, August 29, 2018 - 1:00 pm – 2:00 pm
- Thursday, August 30, 2018 - 1:00 pm – 2:00 pm
- Tuesday, September 4, 2018 - 1:00 pm – 2:00 pm

A schedule of the following subject matter webinars will be held at a later date.
- Billing, Claiming and Payment