

SOONERCARE Health Homes

A strategy to build a system of care to improve health, enhance access and quality and control costs for members with SMI or SED

Oklahoma Department of Mental Health
and Substance Abuse Services





What Is A Health Home?

- ❖ A place where individuals can come throughout their lifetimes to have their health care needs identified and to receive the medical, behavioral and social supports they need, coordinated in a way that recognizes all of their needs as an individual, not just patients.

Why Coordinated Care Matters

- ❖ People with SMI die 25 years earlier than individuals in the general population, mostly for medical reasons rather than suicide or accidental death.

Reasons For Early Death:

Problems Related Directly to Mental Illness*

- Amotivation
- Cognitive Limitations
- Poverty
- Lack of Self-Advocacy Skills

**A Randomized Trial of Medical Care Management for Community Mental Health Settings. American Journal of Psychiatry, Druss, et al, (2010).*

Reasons For Early Death: Service System Factors

❖ Physicians

- ❖ Lack of knowledge or comfort with people with chronic mental disorders
- ❖ Clinical demands that make it difficult to address multiple comorbidities

❖ Mental Health Professionals

- ❖ Lack of knowledge or comfort regarding medical issues
- ❖ Lack of time and resources to address health concerns in busy practices

Why Health Homes For Children?

- ❖ Limited coordination between primary medical and behavioral health specialty care
- ❖ Significant number of children in child welfare receiving psychotropic medications with no coordinated system of care to monitor appropriate utilization.
- ❖ Lack of time in primary care setting to spend 1-2 hours with family

Required Health Home Activities

- ❖ Provide comprehensive care management;
- ❖ Provide care coordination;
- ❖ Provide health promotion;
- ❖ Coordinate transitional care from inpatient to other settings
- ❖ Refer and link to community supports;
- ❖ Provide individual and family support;
- ❖ Use health information technology to link services.

Wagner, E.H. (2000). The role of patient care teams in chronic disease management. *British Medical Journal*.

Benefits of a Team!

- ❖ Effective chronic illness models generally rely on multidisciplinary teams.
- ❖ Successful teams can provide critical elements of care that doctors do not have the time or training to do.
- ❖ Participation of medical specialists in consultative and educational roles contribute to better outcomes.

Wagner, E.H. (2000). The role of patient care teams in chronic disease management. *British Medical Journal*.



In Partnership

In Oklahoma, Health Homes will integrate physical health and behavioral health

Health Homes

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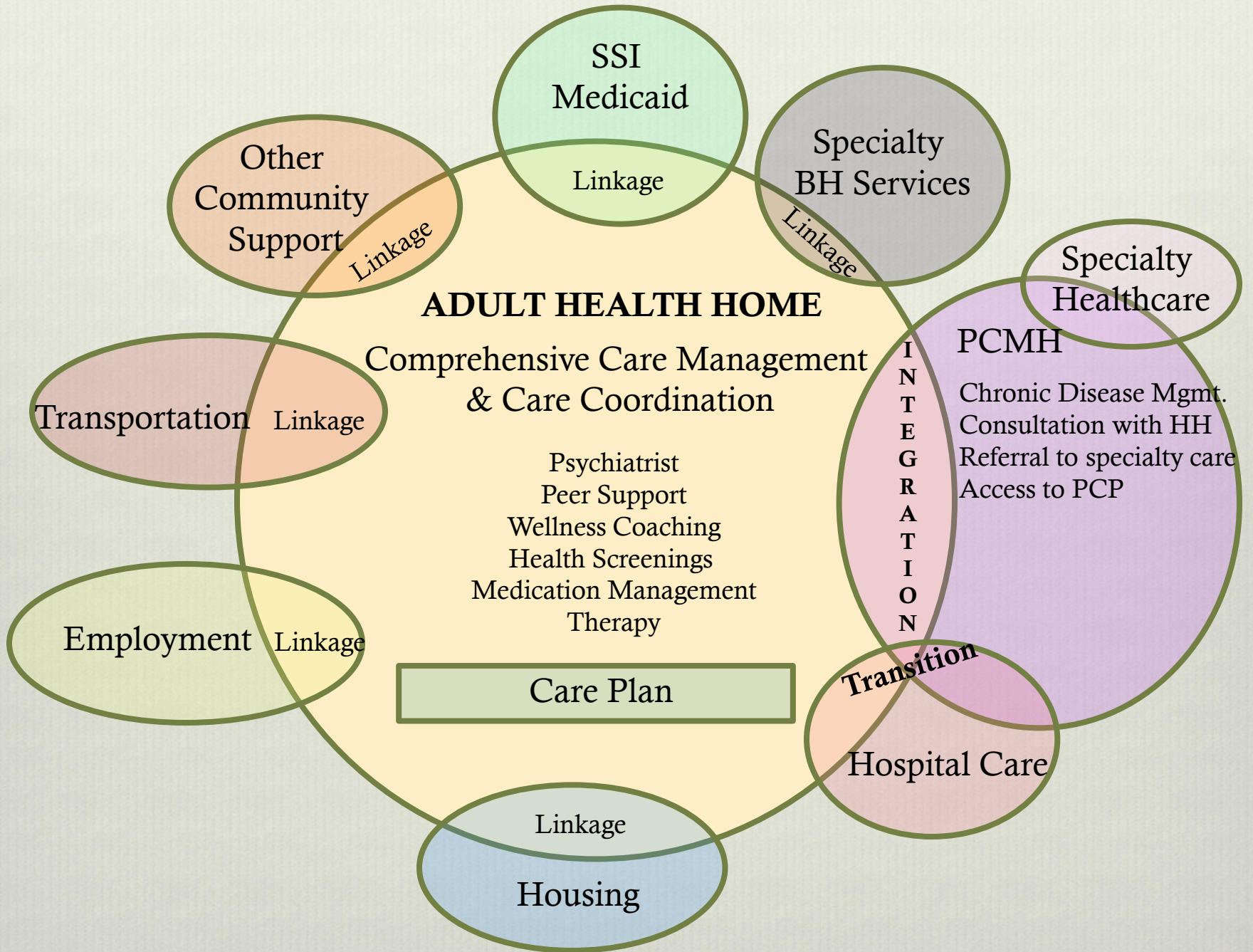
Outpatient Behavioral Health Agency

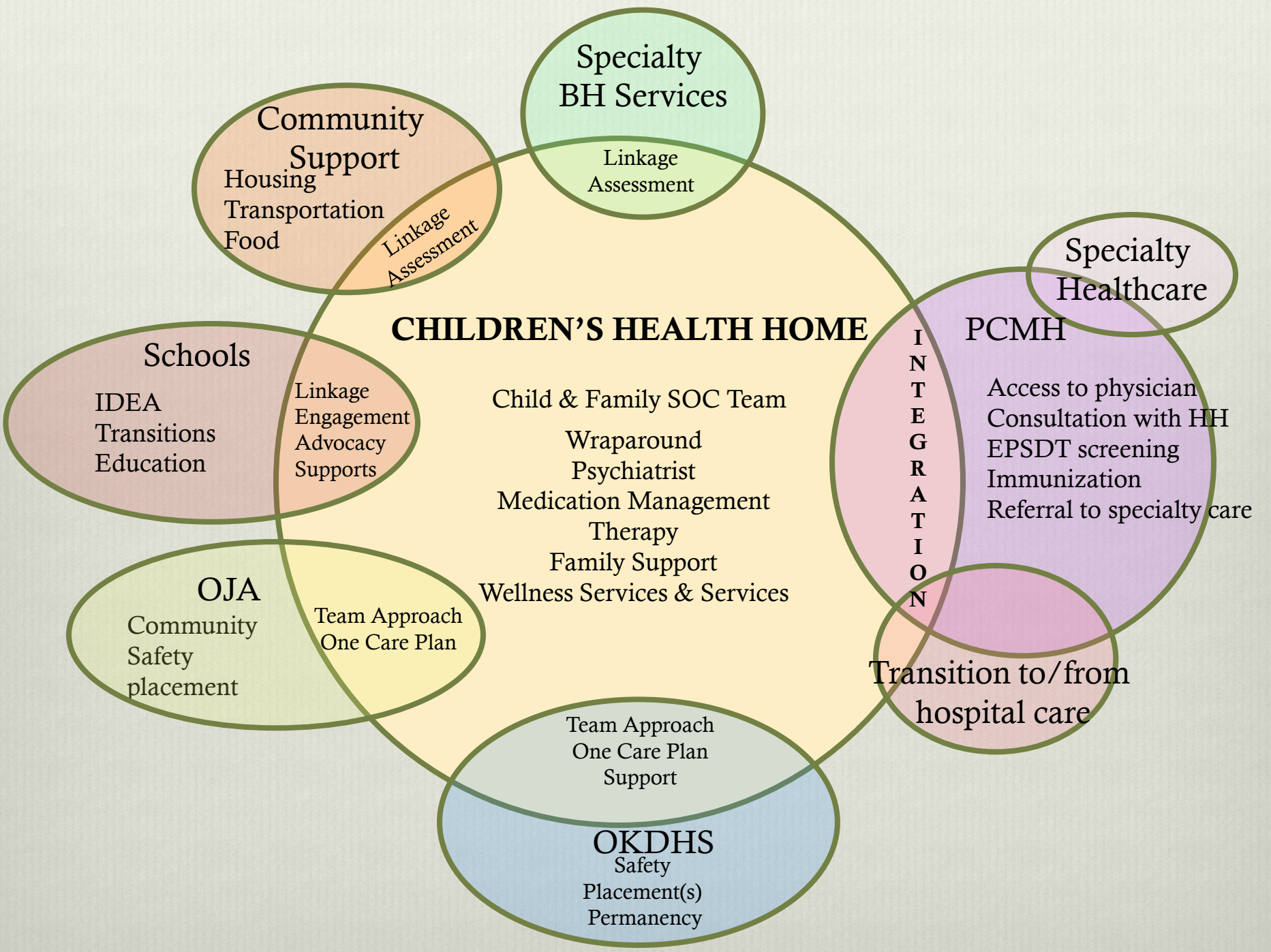
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Primary Care Physicians

The Health Home Team

- ❖ An interdisciplinary team
- ❖ Person/Family Centered process
- ❖ Identifies strengths and needs
- ❖ Creates a unified plan
- ❖ Empowers persons towards self-management
- ❖ Coordinates the varied healthcare needs





Health Home Team Members

Adults



Child and Family Team

Physician Team Member

HH Director

Licensed Nurse Care Manager

Behavioral Health Case Manager

Wellness Coach/Peer Specialist

Consulting Psychiatrist

Physician Team Member

Licensed Nurse Care Manager

Behavioral Health Care Coordinator

Family Support Provider

Consulting Psychiatrist

Role of Physician Team Member

- ❖ Coordinates and cooperates with HH Case Manager and/or Nurse Care Manager in development of integrated care plan
- ❖ Consults with CMHC on-site HH psychiatrists as needed;
- ❖ Supplies post visit follow-up and relays information back to HH;
- ❖ Maintains a system to track referrals;
- ❖ Coordinates the delivery of medical care services with all specialists, case manager and other medical providers;
- ❖ Educates members on appropriately using medical resources such as emergency rooms.

Role of Physician Team Member

(PCMH, FQHC, IHS, PCP)

Requirements for Children

- ❖ Educates regarding the importance of immunizations and screenings, child physical and emotional development;
- ❖ Links each child with screening in accordance with the EPSDT periodicity schedule;
- ❖ Identifies children in need of immediate or intensive care management for physical health needs;
- ❖ Provides opportunities and activities for promoting wellness and preventing illness, including the prevention of chronic physical health conditions; and
- ❖ Assist HH care manager in developing wellness goals to be included in the comprehensive care plan.

Health Home Assignment

- ❖ OHCA will attribute to Health Homes, SoonerCare members with a qualifying SMI/SED designation who have an existing relationship with the HH agency. Members will be notified via US mail service. Message will include:
 - ❖ a brief description of Health Home services;
 - ❖ a description of individuals' options to choose another Health Home;
 - ❖ a process to opt out of enrollment in a HH; and
 - ❖ encouragement to continue any existing relationship with their primary care provider (PCP).

Questions??

❖ Contact Information

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