GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

MHRS Bulletin

Bulletin ID: No. 112
Issued Date: March 3, 2017

CLARIFICATION OF THE HEALTH HOME PROGRAM IN THE FOLLOWING AREAS:

1. Time Requirement For Comprehensive Health Assessment & Comprehensive Care Plan
2. Comprehensive Transitional Care Service
3. Comprehensive Care Management Service/Note, the Staff that May Complete the Service

Area 1:
Clarification of the Health Home Program's Time Requirement for Comprehensive Health Assessment and Comprehensive Care Plan:

This information will replace the information located on page 37, 40, 41, and 45 of the Health Homes Operation Manual (DBH Policy 1000.5)

All Comprehensive Health Assessments and Comprehensive Care Plans must be completed within 60 days of the Consumer's Health Home Opt-In Consent date.

- The timeframe has been increased from 45 days 60 days
- The NCQA time requirements for Managed Care Organizations remain unchanged and require the Comprehensive Health Assessment and Comprehensive Care Plan be completed within 30 days for Health Home Opt-In Consent date for the MCO enrolled consumers.

Area 2:
Clarification that the Comprehensive Transitional Care Service Counts towards the Care Management Service Requirement

This information is located in the Health Home Operations Manual (DBH Policy 1000.5) page 35.

> To receive a monthly payment for High Acuity individuals, HHs must provide and document in iCAMS at least two comprehensive care management (CCM) services (comprised of assessment/screening; care plan development; care plan review; or transition care) and at least two other HH encounters, at least one being face-to-face, with no duration requirement. Low Acuity individuals must receive at least one CCM service and one other HH service, with no face-to-face requirement, documented in iCAMS.

Area 3:
Clarification of Health Home Program's Care Management Service and Note and the Staff that May Author and Complete the Service:

This information will be included as clarification to the information located on page 21 of the Health Homes Operation Manual (DBH Policy 1000.5)

All Health Home Team members (Health Home Director, RN Care Manager, Primary Care Liaison, Care Coordinator or any other Health Home designated staff) may complete or participate in a Care Management Service as well as author a Care Management Note.

- The RN Care Manager continues to oversee and ensure the initiation and completion of the Comprehensive Health Assessment (CHA) and the Comprehensive Care Plan (CCP);
    - The CHA and CCP are the only Care Management Services that require a RN Care Manager co-signature for approval;
    - An Approved Qualified Practitioner (AQP) signature is required for both the CHA and CCP for consumers that receive MHRS;

It is the responsibility of the Health Home Director to ensure the staff understands the definition of a Care Management Service in order to author appropriately.

Background Information:

- The Care Management Service is one the six Health Home Program Services
- Each Health Home service has a dedicated service note that is used to document the Health Home Staff/Team interventions and the consumer's response to the intervention.
- Each Health Home consumer is assigned an acuity level (high or low) that guides the team on service frequency requirements
- In both High and Low acuity, Care Management service(s) is required each month
    - High acuity requires two (2) Care Management services
    - Low acuity requires one (1) Care Management service
- Care Management services include:
    - Comprehensive Care Plan,
    - Comprehensive Health Assessment,
    - Comprehensive Care Management Note,
    - Annual (Retrospective) Note; and
    - Comprehensive Transitional Care Note
- Care Management Notes must follow the service definition as indicated in Health Home Operations Manual DBH Policy 1000.5 TL-295 (See below).

Comprehensive Care Management:

Health Home staff will collaborate with each other and external partners to provide comprehensive care management services to address each consumer's health conditions and well-being. The goal is to maximize health status, functionality, and prevent the development of chronic health conditions. Comprehensive care management consists of:

1. Conducting systematic, planned activities to ensure that all consumers of the Health Home are appropriately assessed to identify, stratify and address health risks;
2. Monitoring ongoing progress and health status of all consumers of the Health Home and taking appropriate actions to address identified service needs;
3. Identifying and using recognized health risk assessment and planning processes and tools, including appropriate screening instruments by Health Home Teams;
4. Development of a Comprehensive Care Plan, in partnership with each consumer, that includes:
    a. The results of a Comprehensive Health Assessment, IRP and other data from the consumers health care team;
    b. Individualized goals agreed upon by the consumer and identified by the comprehensive assessment with time-frames and strategies for addressing each; and
    c. The delineation of the specific roles and responsibilities of the members of the Health Home Team who are assisting the consumer in achieving his/her goals.
5. Development of care management protocols that are relevant to the population of Health Home consumers that include:
    a. Evidence- based practices for assisting the consumers in achieving his/her goals; and
    b. Evidence-base clinical protocols for managing and monitoring specific health conditions.
6. Development and use of programs and approaches including:

    a. Self- management and illness recovery supports and practices;

    b. Community and natural supports systems as identified by the consumers; and

    c. Development and implementation of health promotion campaigns.

7. Development of partnerships with providers and other community-based entities external to the Health Home in order to facilitate shared protocols for care management and coordination and timely communication and effective responses to each consumer's physical and behavioral health needs;

8. Use of DBH's iCAMS to:

    a. Document any unplanned event (i.e., hospitalization, development of a new medical condition, change in medication or community living status); and

    b. Document and monitor service delivery. Documentation includes progress notes with status updates on achieving the stated goals of the consumers.

    c. Development and dissemination of reports to include but not limited to consumer's satisfaction, population and individual health status, service utilization, cost and link how the data and information will be used to assist the individual consumer in meeting their goals and or improve their quality of life

The Health Home will also be responsible for keeping the entire enrolled population of consumers as healthy as possible by minimizing the overall need for expensive and unavoidable health care services such as emergency department visits and hospitalizations. Services will focus on individualized health care prevention strategies, early intervention, chronic care management as well as the use of group-based health promotion activities and campaigns.

Comprehensive care management services are driven by protocols and guidelines developed by the Health Homes Registered Nurse Care Manager and/or Primary Care Liaison in collaboration with the consumer, Health Home team members, health practitioners, community providers and individual's identified by the consumer as his/her natural support system.

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