5122-29-33 **Health home service for persons with serious and persistent mental illness.**

(A) Health home service for persons with serious and persistent mental illness is a person-centered holistic approach that provides integrated behavioral health and physical health care coordination and care management for individuals with serious and persistent mental illness.

Health home service goals are to improve care coordination for individuals with serious and persistent mental illness, improve integration of physical and behavioral health care, reduce rates of hospital emergency department use and hospital admissions and readmissions, decrease reliance on long-term care facilities, and improve the experience of care, health outcomes and quality of life for consumers.

(B) The following definitions apply to this rule in addition to or in place of the definitions in rule 5122-24-01 of the Administrative Code:

(1) "Adult with serious and persistent mental illness" means an individual age eighteen or older with:

(a) A DSM-IV-TR (or its successor) diagnosis, with the exception of the following exclusionary diagnoses:

(i) Developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders and communication disorders);

(ii) Substance-related disorders;

(iii) Conditions or problems classified in DSM-IV-TR as "other conditions that may be a focus of clinical attention" (V codes); and

(iv) Dementia, mental disorders associated with known or unknown physical conditions such as hallucinosis, amnesic disorder or delirium sleep disorders; and

(b) Treatment history covers the client's lifetime treatment for the DSM IV-TR diagnoses other than those listed as "exclusionary diagnoses" in paragraph (B)(1)(a) of this rule and meets one of the following criteria:

(i) Continuous treatment of twelve months or more, or a combination of, the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or twelve months continuous residence in a residential program (e.g., supervised residential treatment program, or supervised group home); or

(ii) Two or more admissions of any duration to inpatient psychiatric

treatment, partial hospitalization or residential programming within the most recent twelve month period; or

(iii) A history of using two or more of the following services over the most recent twelve month period continuously or intermittently (this includes consideration of a person who might have received care in a correctional setting): psychotropic medication management, behavioral health counseling, community psychiatric supportive treatment, crisis intervention; or

(iv) Previous treatment in an outpatient service for at least twelve months, and a history of at least two mental health psychiatric hospitalizations; or

(v) In the absence of treatment history, the duration of the mental disorder is expected to be present for at least twelve months; and

(c) Global assessment of functioning (GAF) scale ratings of fifty or below.

(2) "Adult with serious mental illness" means an individual age eighteen or older with:

(a) A DSM-IV-TR (or its successor) diagnosis, with the exception of the following exclusionary diagnoses:

(i) Developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders and communication disorders);

(ii) Substance-related disorders;

(iii) Conditions or problems classified in DSM-IV-TR as "other conditions that may be a focus of clinical attention" (V codes); and

(iv) Dementia, mental disorders associated with known or unknown physical conditions such as hallucinosis, amnesic disorder or delirium sleep disorders; and

(b) Treatment history covers the client's lifetime treatment for the DSM IV-TR diagnoses other than those listed as "exclusionary diagnoses" in paragraph (B)(2)(a) of this rule and meets one of the following criteria:

(i) Continuous treatment of six months or more, or a combination of, the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or six months continuous residence in a residential program (e.g., supervised residential

treatment program, or supervised group home); or

(ii) Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent twelve month period; or

(iii) A history of using two or more of the following services over the most recent twelve month period continuously or intermittently (this includes consideration of a person who received care in a correctional setting): psychotropic medication management, behavioral health counseling, community psychiatric supportive treatment, crisis intervention; or

(iv) Previous treatment in an outpatient service for at least six months, and a history of at least two mental health psychiatric hospitalizations; or

(v) In the absence of treatment history, the duration of the mental disorder is expected to be present for at least 6 months; and

(c) Global assessment of functioning (GAF) scale rating between forty and sixty.

(3) "Child or adolescent with serious emotional disturbance" means an individual age seventeen and younger, or an individual eighteen to twenty-one years of age enrolled in high school, in department of youth services or children services custody, or when it is otherwise developmentally/clinically indicated, and:

(a) A DSM-IV-TR (or its successor) diagnosis, with the exception of the following exclusionary diagnoses:

(i) Developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders and communication disorders);

(ii) Substance-related disorder;

(iii) Conditions or problems classified in DSM-IV-TR as "other conditions that may be a focus of clinical attention" (V codes) unless these conditions co-occur with another diagnosable mental or emotional disorder; and

(b) Assessment of impaired functioning at age appropriate levels and difficulty with age appropriate role performance with a global assessment of functioning (GAF) scale rating below sixty; and

(c) Duration of the mental health disorder has persisted or is expected to be present for six months or longer.

(4) "Community providers" means treatment providers including but not limited to AoD treatment providers, primary care providers, medical specialists, hospitals, and service providers, including but not limited to housing entities, nutritionists, courts, or others involved in the clinical or non-clinical care of the consumer.

(5) "SPMI" means a person with serious and persistent mental illness, serious mental illness, or serious emotional disturbance.

(C) Health home service may be provided to the consumer and may include any other individuals who will assist in the consumer's treatment, and may be delivered face-to-face, by telephone, and/or by video conferencing in individual, family and group format or as appropriate to perform the service in locations and settings that meet the needs of the health home consumer. Health home service includes the following components:

(1) Comprehensive care management:

(a) Identify consumers with SPMI who need and can benefit from health home service;

(b) Orient consumers by discussing the benefits of active participation;

(c) Conduct a comprehensive assessment of the individual’s physical health, behavioral health (i.e., mental health disorders, substance abuse disorders, and developmental disabilities), long-term care and social service needs incorporating relevant information from screening tools, medical records, the consumer and his/her family, guardian and/or significant others, other providers, health home team members, and other sources as applicable; develop a team of health care professionals to deliver health home service based on the consumer's needs; establish and negotiate roles and responsibilities, including the accountable point of contact;

(d) Develop a single, person-centered, integrated care plan that addresses and coordinates all of a consumer's clinical and non-clinical needs, and includes prioritized goals and actions with anticipated time frames for completion and reflects the individual's preferences; implement and monitor the integrated care plan to determine adherence to treatment and medication regiment; identify, and to the extent possible, remove barriers to care, or any clinical and non-clinical issues that may impact the individual's health status or progress in achieving the goals and outcomes outlined in the integrated care plan;

(e) At least once every ninety days:

(i) Reassess the consumer and update the comprehensive assessment as needed based upon the results of the reassessment. The reassessment may be based upon clinical interviews with the consumer and/or guardian and review of data or other information (e.g. progress notes, test results, reports from health home and other providers, etc.), and comparing the most recent data with the data collected at earlier assessments.

(ii) Review the integrated care plan, and update it when indicated by the results of the reassessment;

(f) Develop a communication plan to ensure that routine information exchange (clinical patient summaries, medication profiles, updates on patient progress toward meeting goals), collaboration, and communication occurs between the team members, providers, payors, and the consumer and the consumer's family, guardian, and/or significant others; and

(g) Develop a crisis management and contingency plan in collaboration with the consumer and the family, guardian, and/or significant others.

(2) Care coordination:

(a) Implement the integrated care plan;

(b) Assist consumer in obtaining health care, including primary, acute and specialty medical care, mental health, substance abuse services and developmental disabilities services, long-term care and ancillary services and supports;

(c) Perform medication management, including medication reconciliation;

(d) Track tests and referrals, and follow-up as necessary;

(e) Coordinate, facilitate and collaborate with the consumer, team of health care professionals and other providers, and the consumer's family, guardian and/or significant others;

(f) Share the crisis management and contingency plan, assist with and coordinate prevention, management and stabilization of crises and ensure post-crisis follow-up care is arranged and received;

(g) Assist consumer in obtaining referrals to community, social and recovery supports, making appointments and confirming that the consumer

received the service(s);

(h) Provide clinical summaries and consumer information along with routine reports of integrated care plan compliance to the team of health care professionals, including the consumer and the consumer's family, guardian and/or significant others consistent with the communication plan.

(3) Health promotion.

(a) Provide education to the consumer and the consumer's family, guardian and/or significant others that is specific to the consumer's needs as identified in the assessment;

(b) Assist the consumer in acquiring symptom self-monitoring and management skills so that the consumer learns to identify and minimize the effects of the chronic illnesses that negatively impact his/her daily functioning;

(c) Provide or connect the consumer and the consumer's family, guardian and/or significant others with services that promote a healthy lifestyle and wellness through the use of evidence-based, evidence-informed, best, emerging, and/or promising practices;

(d) Actively engage the consumer and the consumer's family, guardian and/or significant others in developing, implementing and monitoring the integrated care plan;

(e) Connect the consumer with peer supports including self-help/self-management and advocacy groups;

(f) Manage patient population through use of clinical and consumer data to remind consumers about services needed for both preventive and chronic care;

(g) Promote positive behavioral health and lifestyle choices; and

(h) Provide education to the consumer and the consumer’s family, guardian and /or significant others about accessing care in appropriate settings.

(4) Comprehensive transitional care and follow-up.

(a) Coordinate and collaborate with providers;

(b) Facilitate and manage care transitions (e.g., inpatient-to-inpatient, residential, community setting(s) to prevent unnecessary inpatient admissions, inappropriate emergency department use and other adverse

outcomes such as homelessness;

(c) Develop a comprehensive discharge and/or transition plan with short-term and long-term follow-up; and

(d) Conduct or facilitate effective clinical hand-offs that include timely access to follow-up post discharge care in the appropriate setting, timely receipt and transmission of a transition/discharge plan from the discharging entity, and medication reconciliation. A clinical hand-off is the transfer of care and responsibility from the outgoing clinician/provider to the oncoming clinician/provider and includes verbal and written communication to relay vital information about the consumer and his/her anticipated needs.

(5) Individual and family supports.

(a) Provide expanded access to and availability of services;

(b) Provide continuity in relationships between consumer, family, guardian and/or significant others with physician and care manager;

(c) Outreach to the consumer and his/her family, guardian and/or significant others, and perform advocacy on the consumer's behalf to identify and obtain needed resources such as medical transportation and other benefits for which he/she may be eligible;

(d) Educate the consumer in self-management of his/her chronic condition:

(i) Facilitate further development of daily living skills;

(ii) Assist with obtaining and adhering to medication and other prescribed treatments;

(iii) Provide interventions that address symptoms and behaviors, and assist the health home consumer in eliminating barriers to seeking or maintaining education, employment or other meaningful activities related to his or her recovery-oriented goal;

(e) Provide opportunities for the family, guardian and/or significant others to participate in assessment and integrated care plan development, implementation and update;

(f) Ensure that health home service is delivered in a manner that is culturally and linguistically appropriate;

(g) Provide assistance in identifying and accessing needed community supports including self-help, peer support and natural supports, i.e.

individual resources as identified by and available to the consumer which are independent from formal services, e.g. a relative, teacher, clergy member, etc.;

(h) Promote personal independence and empower the consumer to improve his/her own environment;

(i) Include the consumer's family, guardian and/or significant others in the quality improvement process including but not limited to, surveys to capture experience with health home service, establishment of a consumer and family advisory council; and

(j) Allow the consumer and his/her family, guardian and/or significant others access to the electronic health record or other clinical information.

(6) Referral to community and social support services.

(a) Provide referrals to community/social/recovery support services; and

(b) Assist the consumer in making appointments, confirm that the consumer attended the appointment, and determine the outcome of the visit and any needed follow-up.

(D) A health home provider must be certified by the Ohio department of mental health in accordance with chapters 5122-24 to 5122-29 of the Administrative Code to provide each of the following services:

(1) Behavioral health counseling and therapy;

(2) Mental health assessment;

(3) Pharmacological management; and

(4) Community psychiatric support treatment.

(E) A health home provider shall demonstrate integration of physical and behavioral health care by:

(1) Having an ownership or membership interest in a primary care organization where primary care services are embedded, on-site or co-located; or

(2) Entering into a written integrated care agreement which is a contract, memorandum of understanding, or other written agreement with a primary care provider that requires through on-site, co-location or collaboration the primary care provider to:

(a) Provide acute and chronic primary care services;

(b) Participate in care coordination and care management activities (e.g. integrated care plan development, contributing to the assessment, participating in health home team meetings, etc.) with the health home provider; and

(c) Contribute to a shared medical record and/or a integrated care plan maintained by the health home provider

(F) A health home provider shall demonstrate integration of physical and behavioral health care by achieving one of the following:

(1) Successful implementation of accrediting body integrated physical health/primary care standards during the next accreditation survey process following Ohio department of mental health certification as a health home provider in which the provider is eligible in accordance with its accrediting body policies and procedures to undergo a review of its integrated physical health/primary care services:

(a) Integrated behavioral health/primary care core program accreditation by the commission on accreditation of rehabilitative facilities; or

(b) Primary physical health care standards by the joint commission behavioral health care accreditation program; or

(c) Integrated behavioral health and primary care supplement standards by the council on accreditation; or

(2) Within eighteen months:

(a) Level one patient-centered medical home recognition by the national committee for quality assurance; or

(b) Equivalent accreditation, certification or recognition approved by the Ohio department of mental health.

(G) A health home provider shall:

(1) Support the delivery of person-centered care by:

(a) Providing expanded, timely access to the services as defined in this rule and provided by the health home provider; and

(b) Utilizing a multi-disciplinary team-based approach for the delivery of health home service through the ongoing use of an established team of members as defined in this rule;

(2) Have the capacity to receive and utilize electronic data from a variety of sources to facilitate all components of health home service;

(3) Meet the following requirements:

(a) Within twelve months, acquire an electronic health record (EHR) product certified by the office of the national coordinator for health information technology;

(b) Within twenty-four months, demonstrate an electronic health record is used to support all health home services, and

(c) Participate in the statewide health information exchanges when established;

(4) Participate in any health home learning communities;

(5) Allow the Ohio department of mental health to conduct site visits to survey health home service standards;

(6) Maintain a comprehensive and continuous quality improvement program in accordance with rule 5122-28-03 (performance improvement) of the Administrative Code and/or the health home provider's national accrediting body;

(7) Collect and report data and meet health home performance measurement requirements which consist of mandatory centers for medicare and medicaid services core measures and measures established by the Ohio department of mental health in conjunction with stakeholder input. To the extent possible, measures should be consistent with nationally recognized and other required standards, which may include national committee for quality assurance (NCQA) healthcare effectiveness data and information set (HEDIS) measures, national quality forum (NQF), agency for healthcare research and quality (AHRQ), substance abuse and mental health services administration (SAMHSA) national outcome measures (NOMS);

(8) Establish relationships with medicaid managed care plans (MCPs) in the service area and develop written policies and procedures that include the following:

(a) Notify the MCP of referrals received by the health home provider for the MCP's members, and of any MCP member who is currently receiving health home service. The health home provider will collaboratively develop a transition plan with the MCP for any plan member that will receive health home service in order to prevent unnecessary duplication of, and avoid gaps in, services;

(b) Form a care management team to effectively manage the consumer's needs that includes the health home provider team, the health home consumer and his/her family/supports and primary care provider, a representative from the consumer's MCP, and other providers, as appropriate;

(c) Work collaboratively with the MCP to ensure all of the consumer's needs identified in the health home integrated care plan are met. Ensure that the integrated care plan is accessible to the MCP and providers involved in managing the consumer's health care;

(d) Request care coordination supports from the MCP, if needed;

(e) Identify a designated contact to collaborate with the MCP's designated single point of contact on such activities as the following: exchanging information about the plan's member, soliciting input to the development of the integrated care plan, participating in health home team meetings, and facilitating to the extent possible, access to services that are outside the scope of the health home provider;

(f) Ensure that if the health home provider has direct ownership of or membership in a primary care provider, or practice, it seeks a contract with the MCPs in the service area for the provision of primary care services. If the health home provider has a co-located relationship or a referral, or coordination, relationship with a primary care provider for the provision of primary care services, the health home provider shall encourage the provider to seek a contract with the MCPs in the service area;

(g) The health home provider shall also:

(i) Provide a list and periodic updates of primary care providers, specialists, inpatient facilities, and other providers, as appropriate, to the MCP, for which the health home provider has established relationships or collaboration;

(ii) Refer to the plan's panel of providers when assisting the consumer in obtaining necessary health care services; and

(iii) Collaborate with the MCP to ensure that the consumer's selected, or assigned, primary care provider is informed the MCP member is enrolled with a health home service provider and provided with information as required in paragraph (G)(11) of this rule. If the consumer requests a change to the selected primary care provider, the health home provider shall inform the MCP so that the plan's existing process to change the primary care provider is promptly

initiated;

(h) Provide timely notification of all inpatient facility discharges and residential setting transitions to the MCP in order to ensure adequate and timely provision of follow-up care. The health home provider will ensure that a discharge or transition plan is in place prior to the consumer discharge or transition. The health home provider will work with the MCP to ensure that post discharge services are prior authorized, if appropriate, and provided by the plan's contracted providers. The health home provider must ensure that the discharge or transition plan is integrated into the integrated care plan and communicated to the care management team;

(i) Ensure the capacity to send electronic data to MCPs and to produce ad hoc reports to more effectively coordinate care; and

(9) Develop an outreach plan to facilitate establishing relationships and collaboration with providers as follows:

(a) The outreach plan developed by the health home provider shall:

(i) Educate providers, as identified below, about the health home service, the health home service goals, and the value of a relationship or collaboration to support the delivery of the service components, as applicable and appropriate, and as outlined in paragraph (C) of this rule;

(ii) Describe how and what type of information will be exchanged between the health home provider and the provider; and

(iii) Describe the role of the provider in coordinating and managing care for the consumer including, but not limited to, integrated care plan development and updates, participation in team meetings, etc.

(b) The health home provider shall establish relationships or collaborations with the following providers, as appropriate:

(i) Specialty care providers including, but not limited to, other behavioral health care or substance abuse treatment providers, pharmacists, cardiologists, pulmonologists, and endocrinologists;

(ii) Long-term care providers including, but not limited to, nursing facilities and home health care providers;

(iii) Hospitals, including emergency departments;

(iv) Community providers;

(v) Alcohol, drug addiction and mental health services or community mental health boards; and

(vi) Third party payor sources as indicated to coordinate benefits; and

(10) Have the ability to track tests and referrals for health care services, and coordinate follow-up care as needed; and

(11) Establish point of care reminders for consumers about services needed for preventive care and/or management of chronic conditions by using consumer information and clinical data.

(12) A health home cannot require a consumer receiving health home services to receive primary care, behavioral health care, specialty care or other services from the health home in instances where the health home offers such service.

(H) A health home provider shall have the capacity to provide all service components described in paragraph (C) of this rule.

(I) A health home provider shall obtain consumer consent, when required, prior to implementing the provisions of this rule regarding involvement of the consumer's family members and/or significant others in the health home service.

(J) A health home provider shall utilize an integrated, multidisciplinary team to deliver health home service. Licensed, certified or registered individuals shall comply with current, applicable scope of practice and supervisory requirements identified by appropriate licensing, certifying or registering bodies. The team shall include:

(1) Health home team leader:

(a) Minimum qualifications:

(i) Licensed independent social worker, professional clinical counselor, independent marriage and family therapist, registered nurse with a master of science in nursing, certified nurse practitioner, clinical nurse specialist, psychologist or physician.

(ii) Supervisory, clinical and administrative leadership experience.

(iii) Health management experience, and competence in practice management, data management, managed care and quality improvement.

(b) Responsibilities:

(i) Provide administrative and clinical leadership and oversight to the health home team, and monitor provision of health home service.

(ii) Monitor and facilitate consumer identification and engagement, completion of comprehensive health and risk assessments, development of integrated care plans, scheduling and facilitation of treatment team meetings, provision of health home service, consumer status and response to health coordination and prevention activities, and development, tracking and dissemination of outcomes.

(2) Embedded primary care clinician:

(a) Qualifications:

Primary care physician, internist, family practice physician, pediatrician, gynecologist, obstetrician, certified nurse practitioner with primary care scope of practice, clinical nurse specialist with primary care scope of practice, or physician assistant.

(b) Responsibilities:

(i) Provide health home service including identification of consumers, assessment of service needs, development of integrated care plan and treatment guidelines, and monitor health status and service use.

(ii) Provide education and consultation to the health home team and other team members regarding best practices and treatment guidelines in screening and management of physical health conditions as well as engage with, and act as a liaison between, the treating primary care provider and the team.

(iii) Meet individually as needed with care managers to review challenging and complex cases.

(iv) It is preferred, but not required, that the embedded primary care clinician also functions as the treating primary care clinician and thus may hold dual roles on the health home team.

(3) Care manager:

(a) Minimum qualifications:

(i) Licensed social worker, independent social worker, professional counselor, professional clinical counselor, marriage and family

therapist, independent marriage and family therapist, registered nurse, certified nurse practitioner, clinical nurse specialist, psychologist or physician.

(ii) Possess core and specialty competencies and skills in working with persons with SPMI, including assessment and treatment planning.

(iii) Demonstrate either formal training or a strong knowledge base in chronic physical health issues and physical health needs of persons with SPMI and be able to function as a member of an inter-disciplinary team.

(iv) Knowledge of community resources and social support services for persons with SPMI.

(b) Responsibilities:

(i) Accountable for overall care management and care coordination, and both provide and coordinate all of the health home service.

(ii) Responsible for overall management and coordination of the consumer's integrated care plan, including physical health, behavioral health, and social service needs and goals.

(iii) Conduct comprehensive assessments and develop integrated care plans.

(iv) Conduct case reviews on a regular basis.

(4) Qualified health home specialist:

(a) Minimum qualifications:

Pharmacist, licensed practical nurse; qualified mental health specialist with a four-year degree, two-year associate degree or commensurate experience; wellness coach; peer support specialist; certified tobacco treatment specialist, health educator or other qualified individual (e.g., community health worker with associate degree).

(b) Responsibilities:

Assist with care coordination, referral/linkage, follow-up and consumer, family, guardian and/or significant others support and health promotion services.

Effective:

R.C. 119.032 review dates:

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Certification

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Date

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