

Oklahoma Health Homes Services Manual

November 2018



PURPOSE

This Health Home Manual is intended as a reference document for Oklahoma Department of Mental Health and Substance Abuse certified providers with contracts for SoonerCare reimbursed Health Home Services. It contains requirements for provision, reimbursement and reporting of Health Home services, and is intended to complement existing policy. Although every effort is made to keep this Manual up-to-date, the information provided is subject to change.

POLICY

SoonerCare policy on Health Home programs can be located at: <http://www.okhca.org/xPolicy.aspx?id=734> under Chapter 30, SubChapter 5, Part 22.

ODMHSAS policy on Health Home programs can be located at: <http://ok.gov/odmhsas/> under Find it at ODMHSAS, ODMHSAS Rules, Administrative Rules that are currently in effect, in Chapter 17 and Chapter 27.

Oklahoma's current State Plan Amendment (SPA) approved February 10, 2015 (effective January 1, 2015) for individuals under age 18 with serious emotional disturbance (#14-0011) and for individuals age 18 and older with a serious mental illness (#14-0012), can be located at:

<http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html>

SERVICE QUESTIONS- WHO TO CONTACT

For service questions please call Malissa McEntire, Manager of Integrated Care, (405) 522-4148.



Oklahoma Health Homes

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Overview

Health Home services refers to a model of care focused on integration of primary care, mental health services, and social services and supports for adults diagnosed with serious mental illness or children diagnosed with serious emotional disturbance. The Health Home services model of care utilizes a inter-disciplinary team to deliver person-centered services designed to support a person in coordinating care and services while reaching his or her health and wellness goals.

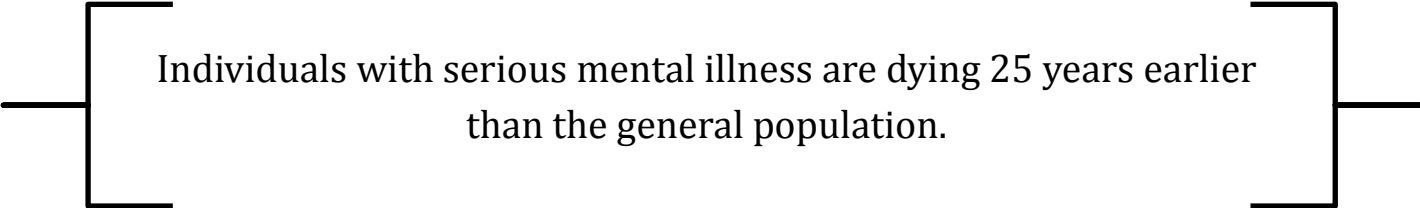
The Health Home provides opportunities for adult Medicaid beneficiaries with serious mental illness and child Medicaid beneficiaries with serious emotional disturbance to receive services in their own home or community. Implementation of Health Home will help to create an environment where service providers, clients, families, and government partner to help clients prevent and manage chronic health conditions and recover from serious mental illness and serious emotional disturbance.

Coordination and collaboration should guide all aspects of treatment to support effective partnerships among the client, family and other key natural supports and service providers.

Health Home services are designed to help connect people to medically appropriate services, and to help people remove barriers that keep them from effectively engaging with medically necessary services.



Why Integrated Care and Health Homes?



Individuals with serious mental illness are dying 25 years earlier than the general population.

People with SMI are dying of preventable cause (NASMHPD), due to high rates of modifiable risk factors:

- ♦ Smoking,
- ♦ Alcohol consumption,
- ♦ Poor nutrition,
- ♦ Obesity,
- ♦ Lack of exercise,
- ♦ Unsafe sexual behaviors,
- ♦ Drug use and,
- ♦ Residence in group care facilities or homeless shelters.

People with SMI, children with SED and families of these individuals also experience higher rates of vulnerability due to:

- ♦ Homelessness,
- ♦ Victimization,
- ♦ Trauma,
- ♦ Poverty,
- ♦ Incarceration and,
- ♦ Social isolation.

Why Integrated Care and Health Homes?

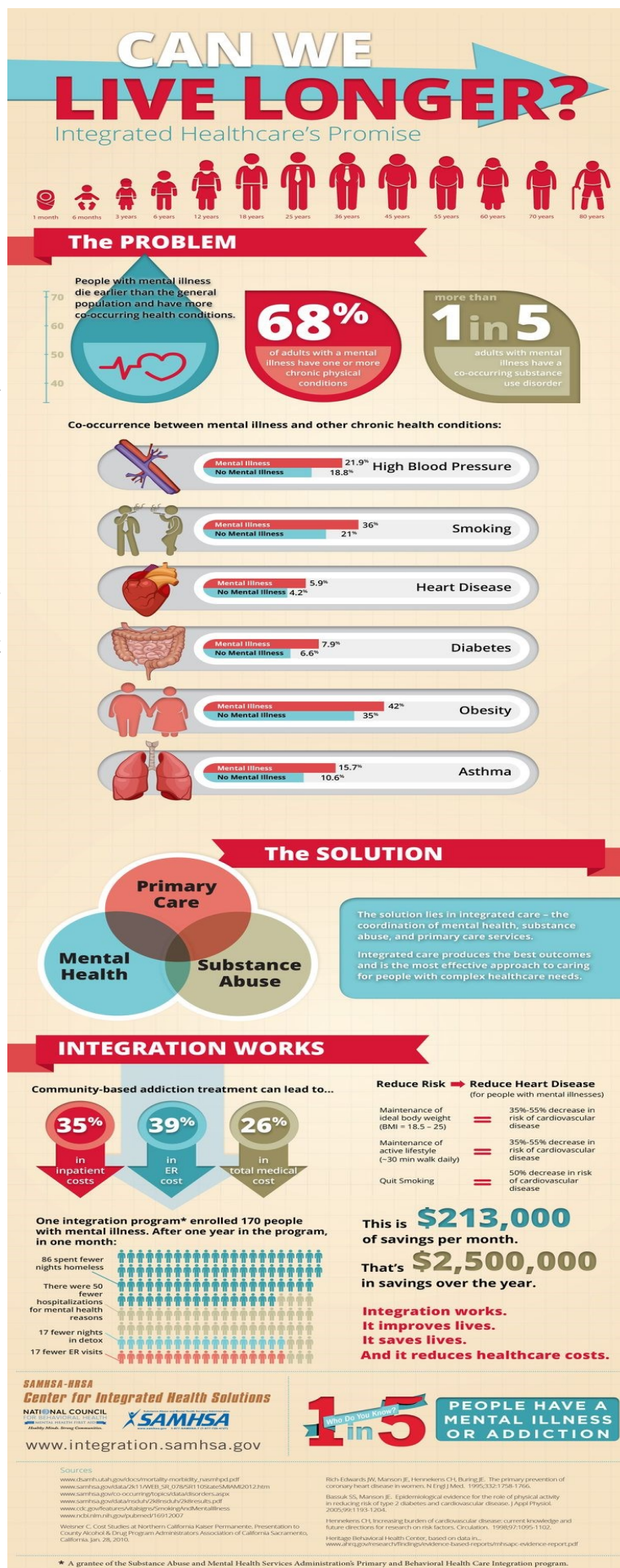
Health Homes are to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness, including adults with serious mental illness (SMI) and children with Serious Emotional Disturbance (SED).

Care is delivered using an integrated team that will comprehensively address physical, mental health and substance use disorder treatment needs; with a goal to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote the use of Health Information Technology (HIT), and avoid unnecessary care.

There are specialized teams for adults with SMI, and for children with SED.

The goals of behavioral health home services are that an individual:

- ⇒ Has access to and utilizes routine and preventative health care services.
- ⇒ Has consistent treatment of mental health and other co-occurring health conditions.
- ⇒ Gains knowledge of health conditions, effective treatments and practices of self-management of health conditions.
- ⇒ Learns and considers healthy lifestyle routines.
- ⇒ Has access to and uses social and community supports to assist the individual meet his or her health wellness goals.
- ⇒ **Improved health outcomes.**





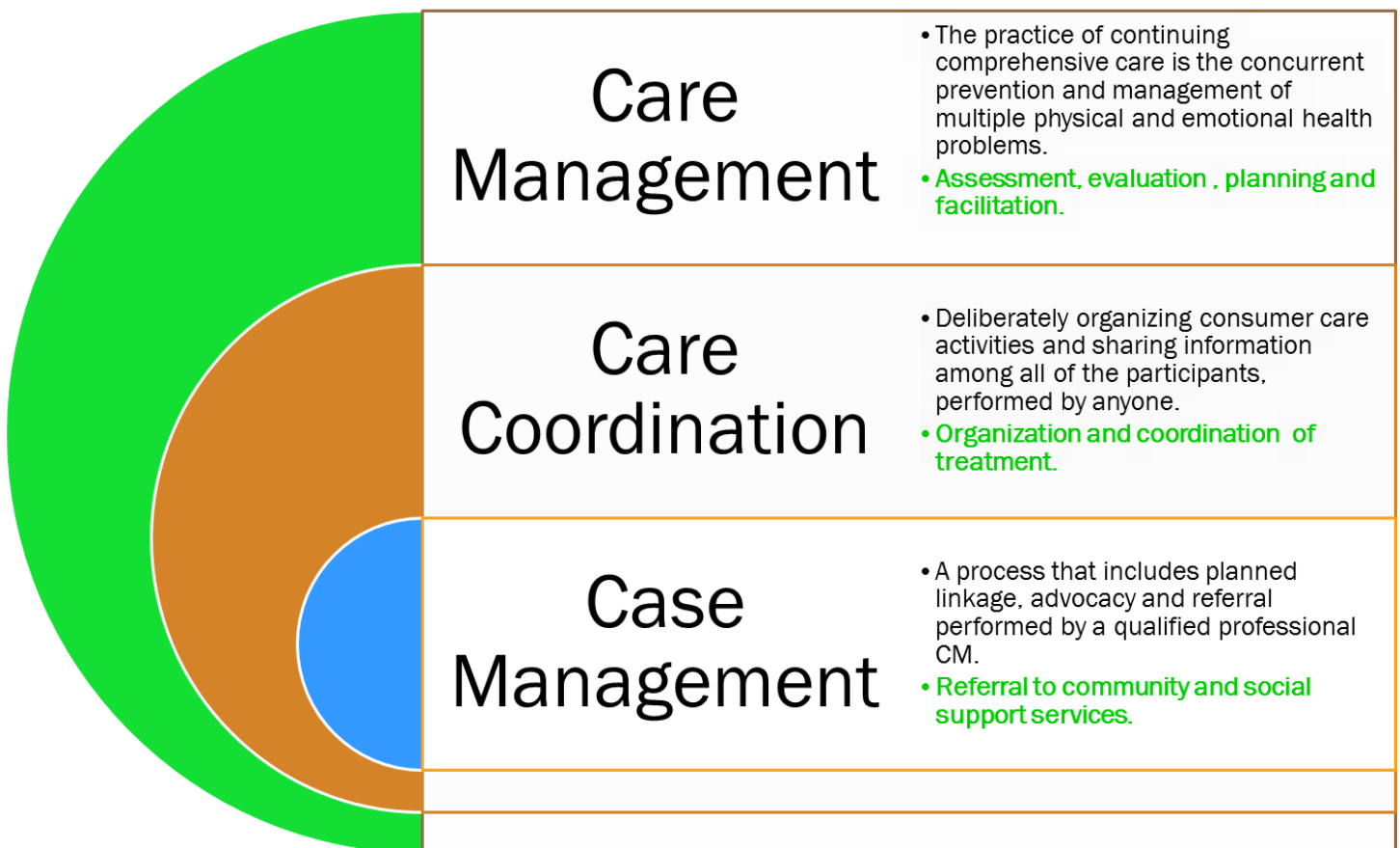
Health Home Core Services

Health Home (HH) services are covered for children with Serious Emotional Disturbance (SED) who are enrolled in the HH program. Eligible core services are as follows: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care Services, Individual Family Support Services, and Referral to Community and Social Support Services. The goal of HH core services is to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote use of Health Information Technology (HIT) and avoid unnecessary care.

A Whole Health Approach

Seven Required Core Components/Service Categories of Health Home

- 1) ☐ Provide comprehensive care management;
- 2) ☐ Provide care coordination;
- 3) ☐ Refer and link to community supports (traditional case management);
- 4) ☐ Coordinate transitional care from inpatient to other settings
- 5) ☐ Provide health promotion;
- 6) ☐ Provide individual and family support;
- 7) ☐ Use health information technology to link services.



A Team Approach

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.

A core concept and integral part of a Health Home is the team. Health Homes deliver services through a inter-disciplinary team of physical and behavioral health care professionals.

The interdisciplinary Health Home Team should:

- provide person/family centered care,
- identify strengths and needs,
- create a unified plan, coordinate varied healthcare needs and,
- empower persons toward self-management.



A Team Approach

Team Meetings

Huddles

- Frequent (recommended daily).
- Targeted to that day's clients.
- Flag challenges.
- Identify what needs to be attended to first.

Team Meetings

- Periodic check in (recommended weekly).
- Includes the whole team.
- Brief review of everyone.
- Updates.
- Identify clients for case conference.

“The high-performing team is now widely recognized as an essential tool for constructing a more patient-centered, coordinated, and effective healthcare delivery system.”

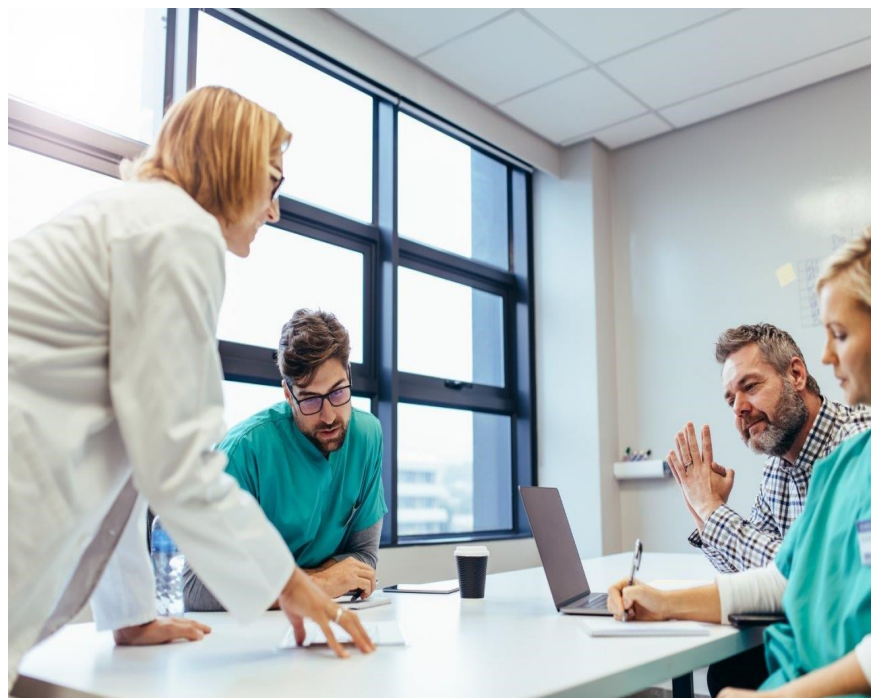
Source: Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, & I. Von Kohorn. (2012). *Core principles & values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washing-

Case Conferences

- As needed (recommended monthly).
- Includes the whole team.
- Talk about the high need individuals, not everyone.
- Problem solve barriers and needs.
- Action planning.

Celebrations

- Recommended 2-4 times a year.
- Celebrate successes.
- Review team performance.
- Shout outs.
- Action planning for the team, if needed.



	Adults	Children
	Low/Moderate Intensity	Moderate Intensity
	Health Home Director , 1:500 max	
	Nurse Care Manager ; 1:250 max Case Managers ; 1:125 max PCP Consultant ; 1 hour/enrollee/year Psychiatric Consultant ; .25 FTE	Project Director ; (Supervisor to CC ratio), 1:8 Care Coordinator ; 1:25 Family Support Provider ; 2.5 FTE Children's HH Specialist/BHA ; .25 FTE Nurse Care Manager ; .20 FTE PCP Consultant ; .5 hour/enrollee/year Psychiatric Consultant ; .14 FTE
Minimum Service Requirements per authorization month for G-code	Two (2) HH core service categories. One (1) face-to-face service. Average minimum for all service categories = 1 hour.	Two (2) HH core service categories. Three (3) hours face-to-face services with the youth and family. Average minimum per youth/family for all service categories = 5 hours.
	High Intensity	High Intensity
	Nurse Care Manager ; 1:100 max Case Manager ; 1:25 max PCP Consultant ; 1 hour/enrollee/year Psychiatric Consultant ; .33 FTE	Project Director ; (Supervisor to CC Ratio), 1:8 Care Coordinator ; 1:10 Family Support Provider ; 1:10 Children's HH Specialist/BHA .25 FTE Nurse Care Manager ; .20 FTE PCP Consultant ; .5 hour/enrollee/ year Psychiatric Consultant ; .14 FTE
Minimum Service Requirements per authorization month for G-code	Two (2) HH core service categories. Two (2) hours face-to-face. Average minimum for all service categories= 3 hours.	Two (2) HH core service categories. Eight (8) hours face-to-face services and weekly contact with the youth and family. Average minimum per youth/family for all service categories= 12 hours.
Wellness Coach 1 per team minimum Hospital Liaison role must be identified as 1 CM or duties divided out among CMs. Administrative Support ; 1:500 LBHP ; .50 FTE <i>per team</i> , Youth Peer Support Specialist should be made available as needed on the children's teams.		

A Team Approach

Important notes regarding staffing and ratios.



Minimum Service Requirements: Services provided and reported in any HH core service category are counted toward required hours. Some limitations apply.

This is a maximum ratio; it is anticipated that a smaller caseload is likely to be more effective.

Health Homes should evaluate caseload numbers based on number served, need, intensity and their impact on overall HH outcomes. Caseloads will be monitored for compliance, at a minimum, at annual reviews.

Each FSP should not carry a caseload of over 25 active families that are in HH moderate.

It is encouraged to have FSPs calling families monthly that do not have an assigned FSP, to check in, see if they understand the process or have any questions. At such time as a family decides they do want an FSP, then one should be assigned for quick access.

It is recommended that FSPs work independently in their specified roles. The FSPs ideally work across the CCs caseloads.

Service Tip: It is a best practice to utilize FSPs' time as the "first step" – as an engagement contact to explain what the services are in HH and what an FSP can provide.



A Team Approach

Health Home Director

1:500 max ratio

Health Homes are responsible for providing adequate supervision to their HH staff and for monitoring accordingly based on number served, need and intensity.

Education

- ⇒ **Possesses a Bachelor's degree from an accredited university and has at least two years of experience in health/behavioral health administration;**
- ⇒ **Possesses a Master's degree from an accredited university in health or social services related field;**
- ⇒ **Licensed as a Registered Nurse with the Oklahoma Board of Nursing; or**
- ⇒ **Licensed as a Physician or Nurse Practitioner.**

Role and Functions

- Engages and works with community partners;
- Plans community wellness and prevention events and activities;
- Supervises health home;
- Ensures all health home team members receive adequate supervision;
- Tracks enrollment, declines, discharges and transfers;
- Coordinates management of HIT tools;
- Develops MOUs with hospitals and coordinates hospital admissions and discharges with nurse care manager.

A Team Approach

Case Manager (adults)

Adult Mod 1:125 max ratio
Adult High 1:25 max ratio
PACT: Follow PACT standards

The role of Hospital Liaison must be covered by Case Managers.

Education

A team member that has been certified by ODMHSAS as a Behavioral Health Case Manager I or II.

Role and Functions

- * Serves as primary liaison to all team members;
- * Coordinates between all members of team as necessary;
- * Coordinates input from all team members into the comprehensive care plan;
- * Coordinates behavioral health referrals and follows up to ensure linkages;
- * Ensures that each client is aligned with a PCP;
- * Ensures transportation to appointments;
- * Reports the G-Code, as the primary provider for the client.

A Team Approach

Care Coordinator (children)

Child Mod 1:25 max ratio
Child High 1:10 max ratio

Education

An individual who meet the requirements for a Wraparound Facilitator Case Manager. A Wraparound Facilitator Case Manager is an LBHP, CADC, or Certified Behavioral Health Case Manager II and has the following:

- (1) Successful completion of the ODMHSAS training for wraparound facilitation within six months of employment;**
- (2) Participate in ongoing coaching provided by ODMHSAS and employing agency;**
- (3) Successfully complete wraparound credentialing process within nine months of beginning process; and**
- (4) Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS.**

Role and Functions

- * Under the direct leadership of the Project Director, the Care Coordinator is responsible for coordinating the development of child and family teams, facilitating child and family team meetings, and facilitating the development and implementation of the individualized Comprehensive Care Plan;
- * Reports the G-Code as the primary provider for the client;
- * Consult and cooperate with community systems to facilitate linkage, referral, crisis management, advocacy, and follow up with the focus on attaining goals;
- * Provides direct services to children and families;
- * Assesses the strengths and needs of families;
- * Monitors the progress in meeting established goals;
- * Assists families with accessing community resources;
- * Provides individual case management and activity of daily living services as needed.

A Team Approach

Project Director (children)

Child Mod & High

Wraparound Supervisor responsible for 1:8 CCs max, team capacity 200 max

Education

An individual who meets the requirements for a Wraparound Facilitator Case Manager. A Wraparound Facilitator Case Manager is an LBHP, CADAC, or Certified Behavioral Health Case Manager II and has the following:

- (1) Successful completion of the ODMHSAS training for wraparound facilitation within six months of employment;
- (2) Participate in ongoing coaching provided by ODMHSAS and employing agency;
- (3) Successfully complete wraparound credentialing process within nine months of beginning process;
- (4) Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS.

Role and Functions

- * Supervises and assists with planning activities, such as convening Child and Family Teams, providing guidance and assisting as necessary with wraparound facilitation and comprehensive care plan development processes;
- * Provides guidance and consultation for Care Coordinators (Wraparound Facilitators) as they work with child/youth, family (or the child/youth's authorized healthcare decision maker) and others to identify strengths, needs and goals of the child/youth and family as needed.

A Team Approach

Nurse Care Manager

Adult Mod 1:250 max ratio
Adult High 1:100 max ratio
PACT: Follow PACT standards
Child Mod & High .20 FTE

Education

A Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Work must be performed within the individual's scope of practice.

Role and Functions

- * Processes referrals;
- * Gathers all pertinent health and mental health information;
- * Conducts initial appointments - does initial health screenings;
- * Completes healthcare goals and contributes to comprehensive care plan in partnership with team;
- * Develops client registries;
- * Coordinates care with external providers (e.g. FQHCs, pharmacies, PCP);
- * Inputs all pertinent health information into electronic health record.

Role and Functions RE: Children

- * Communicates with the primary caregiver regarding the need for youth to be seen by their PCP;
- * Tracks data for client compliance with visits and medical care recommendations and ensures EPSDT screenings in accordance with periodicity schedule;
- * Integrates PCP consent into the electronic medical record;
- * Trains Project Director and Care Coordinator to integrate medical domain in comprehensive care plan;
- * Ensures that children taking multiple psychotropic medications are seen by PCP at least once per year;
- * Helps implement team recommendations;
- * Develops client registries;
- * Communicates with clients' parents and guardians.

A Team Approach

Primary Care Physician Consultant

Adult Mod & High 1 hour per client per year
Child Mod & High .5 hour per client per year

Education

A Board Certified/eligible Physician, Physician Assistant (PA) or APRN.

A Physician, Physician Assistant (PA) or Advanced Practice Registered Nurse (APRN) that is embedded or employed by the health home, or a partnership with multiple Patient-Centered Medical Homes (PCMHs), an FQHC or I/T/U (Indian Health Service, Tribally operated facility/program, or Urban Indian clinic) facility.

Role and Functions

- * Provides input into care planning;
- * Consults with team psychiatrist;
- * Consults regarding specific client health issues;
- * Assists with external medical providers;
- * Consults with members of team as necessary;
- * Contributes input into the comprehensive care plan.

A Team Approach

Psychiatric Consultant

Adult Mod .25 FTE
Adult High .33 FTE
Child Mod & High .15 FTE

Education

A Board Certified/eligible Psychiatrist, Physician Assistant (PA) or APRN with a psychiatric specialty.

Role and Functions

- * Participates in team meetings;
- * Contributes to care plan development;
- * Collaborates with team members;
- * Arranges behavioral health referrals.

Role and Functions RE: Children

- * Consults with team and provides recommendations and referrals related to complex diagnostic, psychopharmacologic and other treatment needs;
- * Contributes to comprehensive care plan;
- * Consults and provides psychiatric support to PCPs.

A Team Approach

Wellness Coach

1 per team minimum

Education

An individual who is actively working on personal wellness and who is designated to collaborate with others to identify their personal strengths and goals within the 8 dimensions of wellness (spiritual, occupational, intellectual, social, physical, environmental, financial and emotional).

In order to qualify as a Wellness Coach, individuals shall:

1. Have a behavioral health related associate degree or 2 years experience in the field and/or have an active certification and/or license within the behavioral health field (e.g. PRSS, Behavioral Health Case Manager, LBHP, LPN, etc.). And
2. Complete the ODMHSAS Wellness Coach Training Program and pass the examination with a score of 80% or better.

Role and Functions

- * Engages person in wellness process;
- * Reminds client of appointments;
- * Provides various wellness programs;
- * Conducts a variety of wellness activities and groups;
- * Coaches on wellness goals in comprehensive care plan;
- * Works under supervision of nurse manager;
- * Interacts with all team members as needed.

A Team Approach

Family Support Provider

Child Mod 2.50 FTE per team of 200
Child High 1:10 max ratio

Family Support Providers must be available to all families, as needed. FSPs shall not carry an active case-load of more than allowed ratios above.

Education

An individual that meets the following requirements:

- (1) Have a high school diploma or equivalent;
- (2) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years of experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);
- (3) successful completion of ODMHSAS Family Support Training; and
- (4) pass background checks.

Role and Functions

- * Develops and links with informal and formal supports;
- * Assists in the development of goals;
- * Serves as an advocate, mentor, or facilitator for resolution of issues;
- * Teaches skills necessary to improve coping abilities;
- * Creates a family plan and course of action based on the individual needs of a family, with input to the comprehensive care plan;
- * Provides training to family members to increase their ability to provide a safe and supportive environment;
- * Advocates for the family in the agency setting, and with other agencies and organizations identified;
- * Guides the family concerning agency interactions, benefits and programs;
- * Uses personal judgment to identify and explain available options for agencies and organizations as appropriate to meet a particular family's needs; and
- * Participates in team meetings to help the family members find their voice and express their choices.

A Team Approach

Children's Health Home Specialist, BHA

Child Mod & High .25 FTE

Education

Children's Health Home Specialists must be credentialed by ODMHSAS as a Behavioral Health Aide or higher and complete training in Well Power or credentialed as a Wellness Coach through ODMHSAS.

May be an individual certified by ODMHSAS as a Behavioral Health Case Manager I or II, and has completed trainings as required by ODMHSAS including but not limited to Behavioral Health Aide and Well Power.

Role and Functions

Children's Health Home Specialist means an individual within the children's Behavioral Health Home interdisciplinary team that will provide support, coaching and activities that promote good physical and mental health to individuals, families and groups.

- * Assists with the individuals' physical wellness plan development, implementation, assistance and support;
- * Conducts support, exercise, and other groups for children and for adult caregivers and identified natural supports;
- * Provides prevention, support, and group activities for interested individuals, not necessarily participants in HH;
- * May provide the Live Longer, Live Stronger Program;
- * Assists the child and family regarding behavioral, interpersonal, communication, self help, safety, substance use decisions, and specific goal-setting and problem-solving activities;
- * May assist with understanding Crisis Plans and Comprehensive Care Plan process. May provide assistance with understanding medication side effects and possible effects on overall health and wellness.

A Team Approach

Youth Peer Support Specialist

For young adults 16 and up, they should have access to a Youth Peer Support Specialist as needed.

Though peers cannot bill PRS within the HH bundle, they are a valuable resource to your team. They should be made available to clients as needed.

Education

An individual that has been certified by ODMHSAS as a Peer Recovery Support Specialist (PRSS).

Role and Functions

- * Participates in team meetings;
- * Creates a family plan and course of action based on the individual needs of a family, with input to the comprehensive care plan;
- * Advocates for the family in the agency setting, and with other agencies and organizations identified;
- * Uses personal judgment to identify available options for agencies and organizations as appropriate to meet a particular family's needs;
- * Guides the family concerning agency interactions, benefits and programs;
- * Ensures child/ youth involvement in Wraparound meetings, family teams and other meetings involving the child/youth;
- * Conducts presentations to community groups or other agencies regarding local resources, services, and youth group activities;
- * Provide supervision to youth, demonstrate leadership skills, serve as a role model and involve youth in all activities

A Team Approach

Licensed Behavioral Health Professional

1 per team as needed, as clinical lead for initial treatment planning and staffings.

Education

A team member who meets requirements as a Licensed Behavioral Health Professional (LBHP) listed in OAC: 317:30-5-240.3.

Role and Functions

- * Participates in comprehensive care planning;
- * Completes behavioral health assessment;
- * Provides behavioral health therapy, as needed, outside the HH bundle.

A Team Approach

Program Assistant/Administrative Support Staff

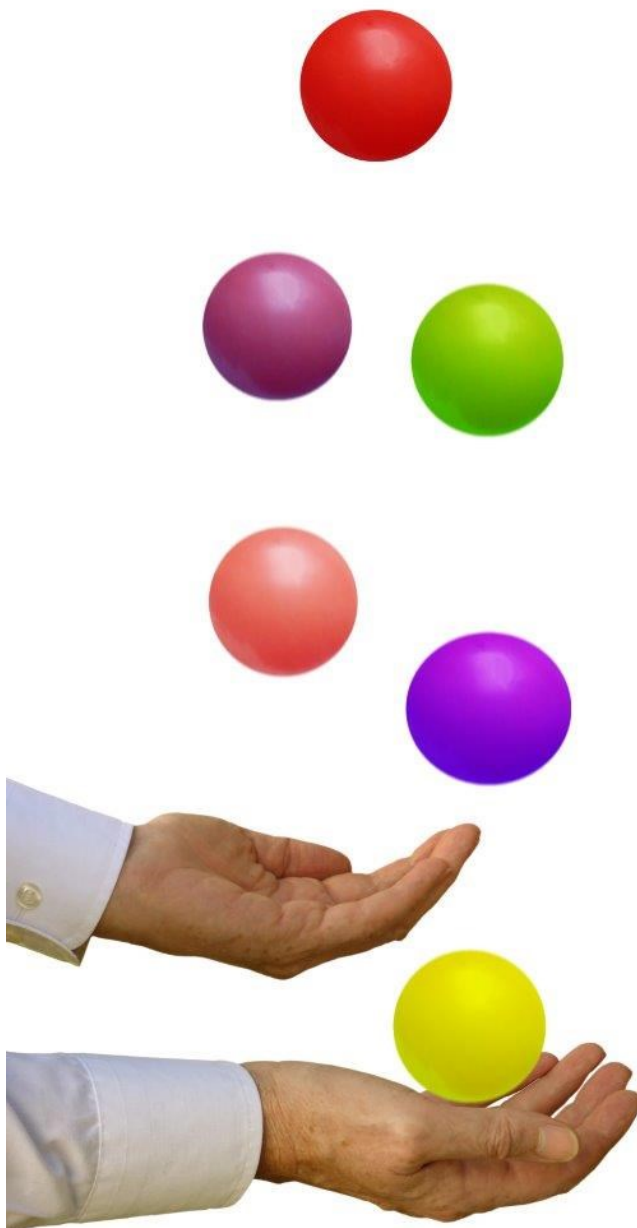
1 per team as needed
Although the Administrative Assistant is not a clinical team member, they are an integral part of the team.
Their work reduces the administrative burden on other team members.

Role and Functions

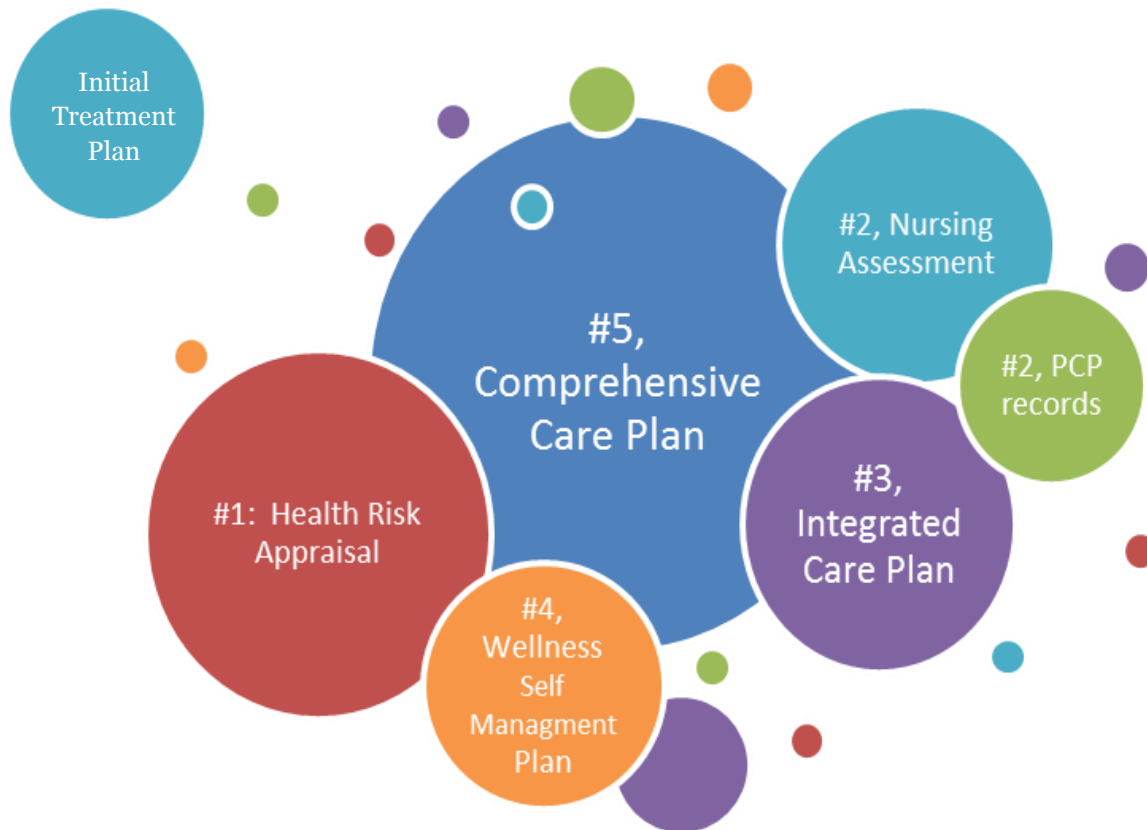
- * Serves as first point of contact ;
- * Assists with electronic health record entry;
- * Assists with scheduling appointments;
- * Supports core team;
- * Assists with wellness and community connections.

A Team Approach

Treatment Planning in Health Home



Treatment Planning in Health Home



Treatment Planning in Health Home

Health Risk Appraisal vs Nursing Assessment

Health Risk Appraisal

- ◆ Brief screening
- ◆ May be completed by anyone
- ◆ May be self-administered or done electronically
- ◆ All HH clients must receive appraisal within 2 weeks
- ◆ Identifies areas for health and wellness goals
- ◆ Identifies risk factors
- ◆ Links client with at least one intervention to promote health
- ◆ Is the catalyst for a Self-Management Plan

Nursing Assessment

- ◆ Full assessment
- ◆ Must be completed by an RN or above
- ◆ Only completed if warranted by any “flag” on the appraisal
- ◆ If warranted, assessment must be completed within 30 days
- ◆ If client has PCP, PCP records may be obtained instead of assessment
- ◆ Identifies medical needs and medical follow-up
- ◆ Should be re-assessed annually

Wellness Self-Management Plan

All health and wellness information gathered from **Health Risk Appraisal** and **Nursing Assessment**, plus any additional identified health information should be utilized by a Wellness Coach to assist client in creation of their own self-management plan.

A **Wellness Self-Management Plan** is a plan created by the client with help from the HH Wellness Coach that identifies any chronic illness, risk factors and/or healthy lifestyle changes the client wishes to work on. The plan provides individualized feedback, and links the person with at least one intervention to manage chronic illness, promote health, sustain function and/or prevent disease.

Treatment Planning in Health Home

Initial Treatment Plan vs Integrated Care Plan

Initial Treatment Plan

- ♦ Completed by LBHP
- ♦ Includes initial assessments
- ♦ Includes initial goals for treatment

Integrated Care Plan

- ♦ Care Manager or Care Coordinator driven
- ♦ Completed after initial plan, but within 30 days
- ♦ Incorporates additional information obtained: nursing assessment, PCP records, etc.
- ♦ Incorporates disease specific goals

Comprehensive Care Plan

- ♦ All plans together form the Comprehensive Care Plan

— [Ideal Scenario] —

In an ideal situation, the client would receive initial assessments and treatment plan by LBHP. Then on subsequent visits, would see Nurse Care Manager and CM/CC, possibly even the Wellness Coach. The team would then staff the client at a team meeting. The client should know about and be invited to the meeting. CM/CC would gather and organize input from the entire team, any additional records obtained would be reviewed, and finally CM/CC would coordinate completion of the Integrated Care Plan.

Children's Health Homes

And Oklahoma Systems of Care

Systems of Care: Systems of Care is an organizational framework for providing supports for children, youth, and young adults with a serious emotional disturbance. Their families are also supported. The Systems of Care philosophy encourages collaboration across agencies and promotes the active involvement of families, children, youth, and young adults in the design and implementation of their treatment plans. Systems of Care improves access to and expands the array of coordinated



Wraparound: Wraparound is a process utilized to improve the lives of children with complex needs and their families by developing individualized plans of care. The key element of the process is a care plan developed by a family-centered team, individualized based on the strengths and culture of the child and her/his family, and driven by needs rather than services. In addition to addressing the needs of the identified youth, the needs of caregivers and siblings are also addressed in the design of comprehensive care plans. Through the team-based planning and implementation process, Wraparound also aims to develop the problem-solving skills, coping skills, health and wellness, and self-efficacy of the young person and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network. Wraparound is how we implement the System of Care at the child and family level. Essentially, it is the service delivery component offered through a local System of Care

Purpose of Wraparound

Wraparound works to help the family discover the basic unmet needs that are the driving forces behind their current situation. Wraparound staff then work with families in designing a unique set of actions, services, and supports that draw on the family's strengths to address those needs and help the family experience concrete, positive, and measurable improvements in their lives. Emphasis is also placed on integrating the youth into the community and building the family's social support network.

Wraparound Helps

The client is not the only person Wraparound helps. Wraparound also helps the families of the client, including household members and extended family members. Additionally, Wraparound helps system representatives and service providers who are struggling with strategies and solutions to help these clients, and community members who would like to help support children, youth, and young adults with serious emotional disturbances.

Service Coordination is a service model designed for children, youth, and young adults with behavioral health issues that do not rise to the same level of intensity required for Wraparound, or for families who qualify for Wraparound but choose not to participate.

To learn more about Systems of Care or Wraparound Login to the E-Learning Course here: <https://learn.eteam.ou.edu/>

Youth Information System (YIS): As the evaluator for OKSOC, E-TEAM designed and maintains a statewide evaluation data collection effort based on data collected through the Youth Information System (YIS) by the local OKSOC sites. The YIS is a secure, web-based application which provides real-time access to evaluation and program monitoring data to state management, to individual site leadership, and to site wraparound facilitators. Data collected in the YIS are accessible on a continuous basis at the site and state levels. A significant amount of information is collected to evaluate change across time.

Demographic and outcome data are collected at enrollment and at 6-month intervals thereafter during a youth's involvement with the program. In addition to demographic and outcome measures, the YIS also captures information about site staffing, caseload assignments, wraparound process and progress, family team meetings and composition, and flex fund expenditures. These data are used to inform program design, to improve service delivery, and, ultimately, to contribute to better outcomes in the lives of youths and families. E-TEAM has the primary responsibility for organizing, analyzing and interpreting these data, so they can be used effectively by OKSOC stakeholders – from ODMHSAS managers to local community members and families.

Visit the **Youth Information System (YIS)** at systemsofcare.ou.edu for more information

Ohio Scales: The evaluation team—composed of state leadership and staff; provider leadership and staff; evaluators; family members; and youths—adopted the Ohio Scales as our primary measure of psychological impairment and social functioning. The characteristics of the Ohio Scales have been an excellent match to our needs in rapidly expanding our wraparound program statewide. The Ohio Scales was originally designed as a statewide instrument and has qualities appropriate to statewide implementations.

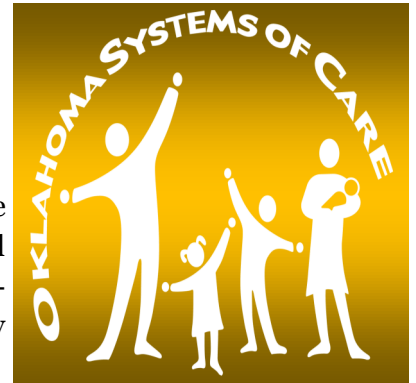
The Ohio Scales provides OKSOC with a measure of appropriateness for service: Since the establishment of our wraparound program, whether we are enrolling the youths we are mandated to serve has been a recurring and vexatious question. This issue has grown in importance as we have come to serve more numerous and widely dispersed OKSOC communities. We have used the Ohio Scales not only as a partial measure of overall referral appropriateness but also to analyze differences in the appropriateness for service of youths arriving from diverse referral sources, i.e., juvenile justice, child welfare, the schools, etc. The Ohio Scales also allows us to compare -- using the definitions of 'critical impairment' laid down in the research -- the appropriateness of youths recruited by the referral networks of individual sites and of their sponsoring host agencies.

Results from the Ohio Scales have been incorporated into OKSOC evaluation protocols as performance measures. In order to assess the overall effectiveness of our wraparound program – given that there are too many sites to allow frequent, in-depth reviews of caseloads and outcomes – OKSOC has identified several process and outcome elements of our evaluation dataset that it has adopted as performance measures. Two of these are related to scores on the Problems and Functioning scales.

CRITERIA AND ENROLLMENT PROCESS FOR CHILDREN AGE 0-5

Important Note – Children birth to 5:

Going forward, beginning **December 15, 2018**, Health Homes will **not** be able to enroll children under the age of 4 in the Health Home program. It will be rare for a child under 6 to meet requirements for HH enrollment, but possible. The ODMHSAS will be monitoring these numbers carefully on a case by case basis.



Additionally, rather than the Ohio Scales, use the Survey of Well-Being for Young Children (SWYC) as the screener for children age 0-60 months.

It is extremely important for any HH site which is planning on serving children ages 4 and 5 in HH recruit and maintains clinicians trained in developmentally appropriate assessments for children age 0-5, including the DC: 0-5, both for diagnosis/assessment, and for treatment, and/or develop partnerships with clinicians that are trained to provide clinical services to the family and serve on the child and family team. The child and family team guides the service delivery.

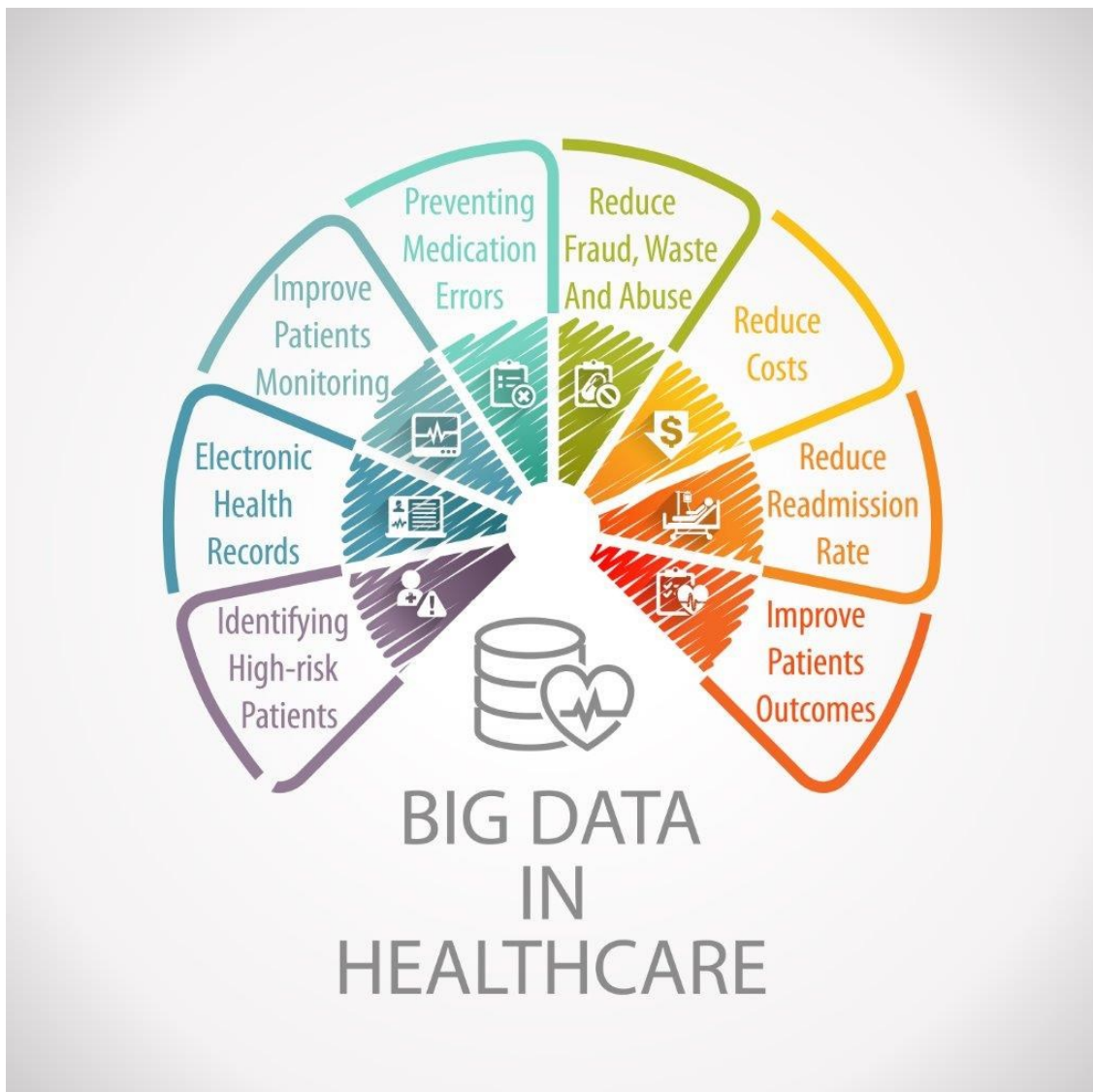
Note: As of **January 15, 2019**, the Health Home will transition children under four years of age and their families to services that can be rendered utilizing fee for service billing **at their next treatment plan update**.

Note: The Health Home may only serve a child under the age of 4 in a Health Home model of care coordination for children with serious emotional disturbance if an “exceptional case” request is made through the Senior Manager for infant and early childhood mental health at the ODMHSAS. This should be a rare occurrence. Providers will receive instructions detailing this process by **December 15, 2018**.



Oklahoma Health Home

Data & Outcomes Measurement



Data in Health Homes

Health Home Quality Measures

[RFP Requirements RE: Health Information]

Per Health Home RFP, Health Homes are required to:

- ⇒ Have and utilize a functioning Electronic Health Record system that meets meaningful use;
- ⇒ Submit data to a health home information management system, ProAct, that will act as a patient registry, care management device and outcomes measurement tool; and
- ⇒ Utilize a Health Information Exchange that allows health care providers to share referrals, continuity of care documents, lab results, and other health information.

Data in Health Homes

Health Home Quality Measures

To support ongoing assessment of the effectiveness of the Health Home model, The Centers for Medicare & Medicaid Services has established a recommended Core Set of health quality measures.

- ♦ Adult body mass index (BMI)
- ♦ Screening for clinical depression and follow-up plan
- ♦ Plan all-cause readmission rate
- ♦ Follow-up after hospitalization for mental illness
- ♦ Controlling high blood pressure
- ♦ Care transition-timely transmission and transition of records
- ♦ Initiation of alcohol and other drug dependence treatment
- ♦ Chronic condition hospitalization admission composite

New Health Home quality measures reporting codes

- ⇒ G8431 HE Screening for clinical depression is documented as being positive and a follow-up plan is documented.
- ⇒ G8510 HE Screening for clinical depression is documented as negative, a follow-up plan is not required.

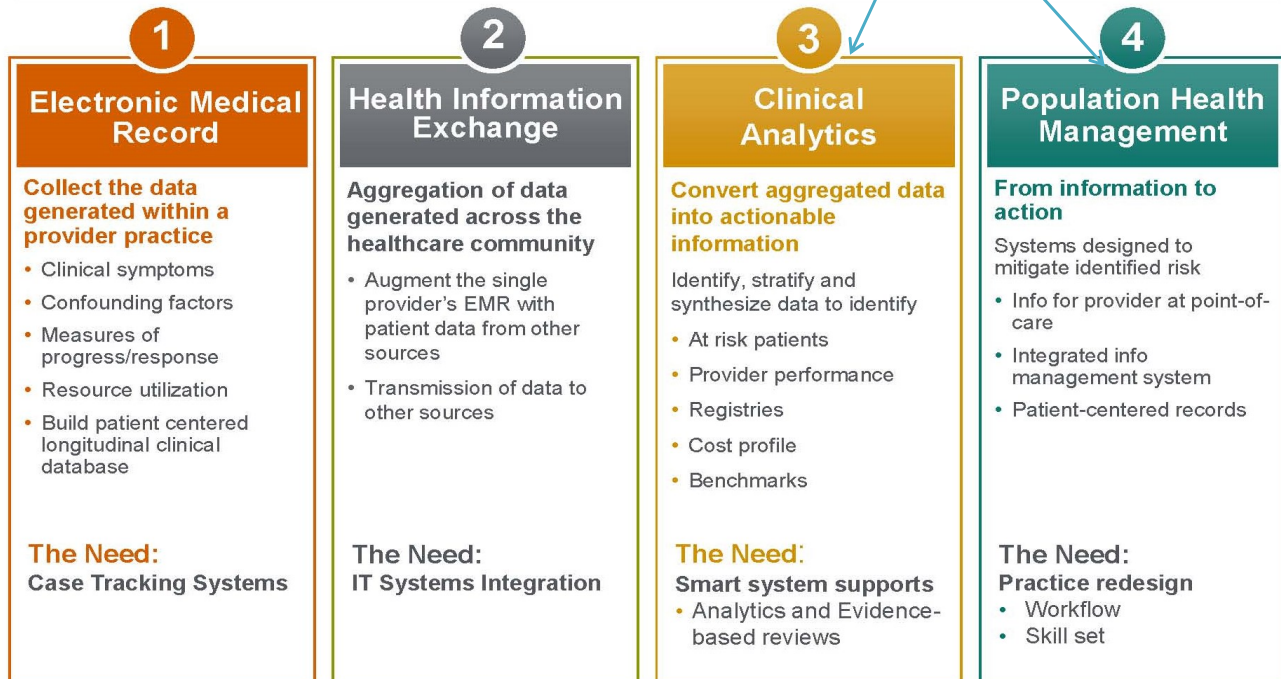
Data in Health Homes

Use of Technology in Health Home

Smart Technology: Beyond the EHR

Information technology is a “must” in the new world

Technical Blueprint For IT Functionality in Practice Changes



Adler, D. "How Technology Can Reduce Costs and Promote Accountable Care." Optum Behavioral Solutions, 10/24/13.

Data in Health Homes

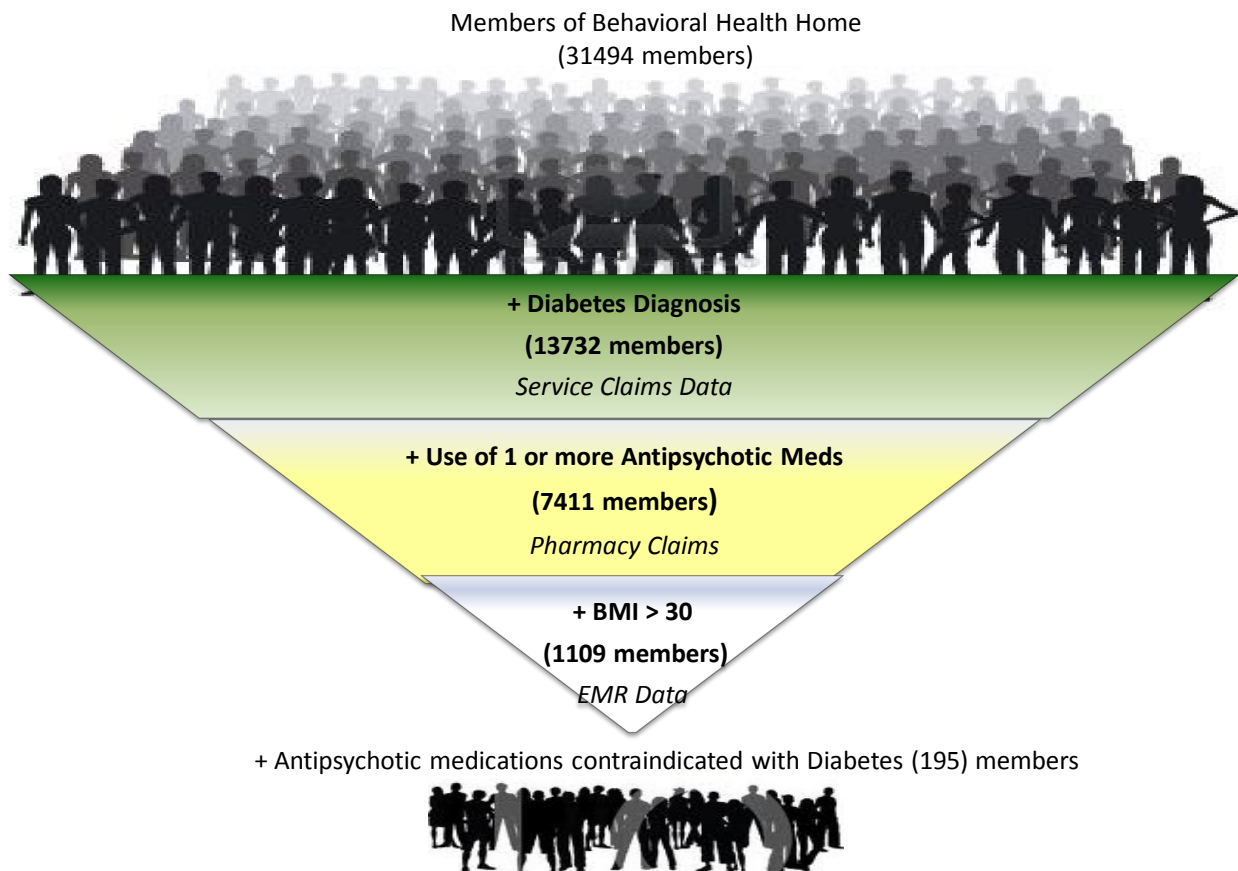
Population Health in Health Home



Population Health gives you the power to study the population, or drill down to the individual on a particular condition.

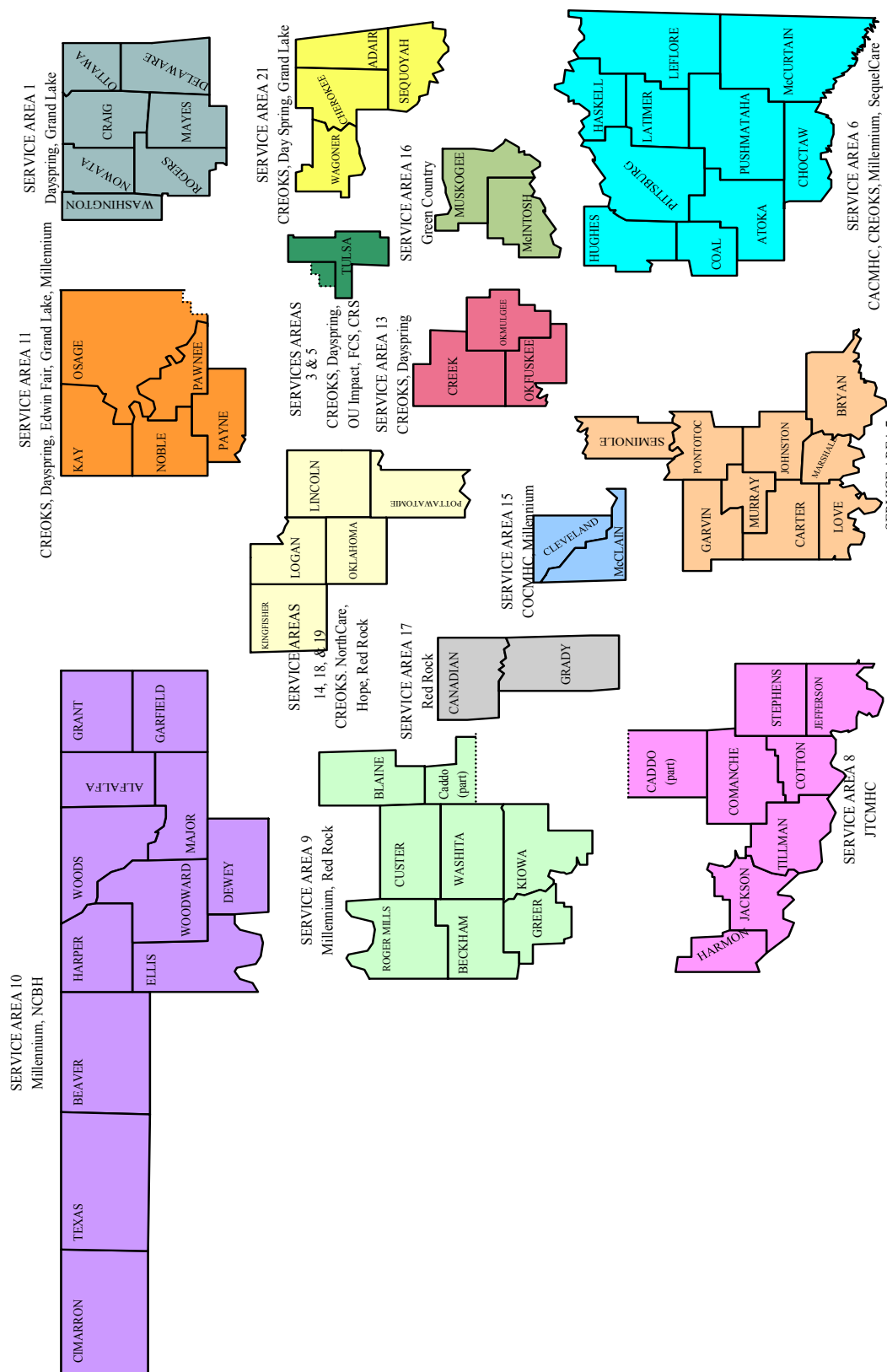


Population Health Diabetes Registry



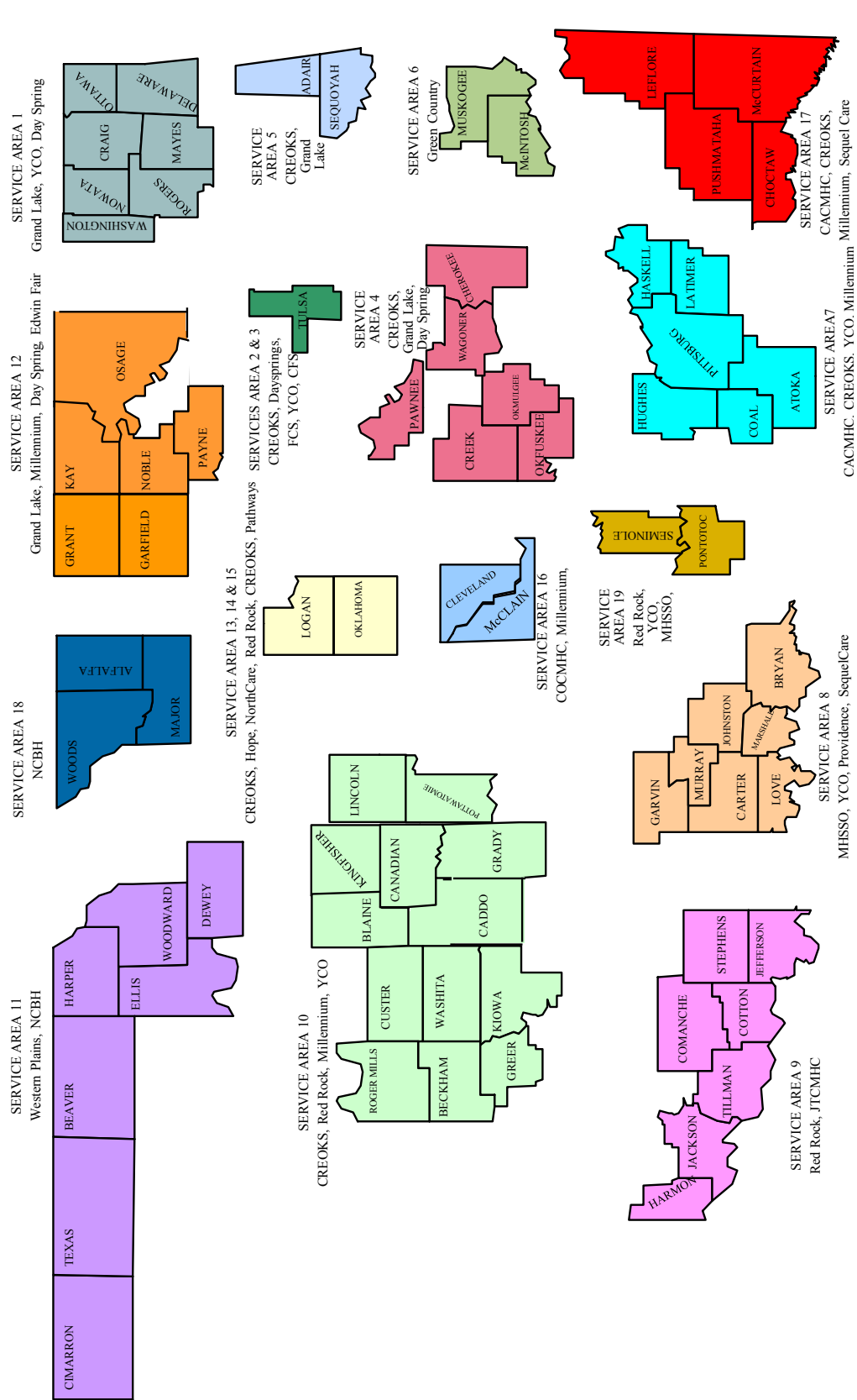
OKLAHOMA DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Adult Service Areas



OKLAHOMA DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Children Health Home Service Areas



September 2014
K:\Systemwide Projects\Maps\Children Health Home Service Areas

A word cloud shaped like a heart, composed of various terms related to health, wellness, and mental well-being. The words are arranged in a way that they form the overall shape of a heart, with some words being larger and more prominent than others.

Large Words:

- Mental
- Health
- Lifestyle
- Active
- Wellness
- Body
- Life
- Dieting
- Attitude
- Optimism
- Care
- Relationship
- Philosophy
- FAMILY
- Nutrition
- Calories
- Exercise
- Motivation
- Brain
- Training
- Feel
- Help
- Emotional
- Transformation
- Goals
- Focus
- WISDOM
- Vitality
- Balance
- Relaxation
- Recreation
- Leisure
- Time
- Energy
- Strength
- Endurance
- Flexibility
- Coordination
- Agility
- Speed
- Power
- Stamina
- Resilience
- Immunity
- Longevity
- Quality of Life
- Satisfaction
- Purpose
- Meaning
- Growth
- Learning
- Curiosity
- Open-mindedness
- Empathy
- Compassion
- Kindness
- Patience
- Gratitude
- Forgiveness
- Humility
- Modesty
- Generosity
- Altruism
- Selflessness
- Integrity
- Honesty
- Transparency
- Authenticity
- Genuineness
- Sincerity
- Trustworthiness
- Reliability
- Consistency
- Perseverance
- Determination
- Commitment
- Dedication
- Devotion
- Loyalty
- Fidelity
- Devotion
- Love
- Passion
- Enthusiasm
- Excitement
- Eagerness
- Zeal
- Enthusiasm
- Excitement
- Eagerness
- Zeal

Oklahoma Health Home Definitions

Care Coordination (T2022)

Care coordination is the implementation of the plans of care with active client involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports.

Care coordination is the deliberate organization of client care which includes sharing information among all the participants concerned to achieve safer and more effective care. This means the client's needs and preferences are known ahead of time and communicated at the right time to the right people, and this information is used to provide safe, appropriate and effective care to the client. (AHRQ). These primarily non-face to face services must be documented in the client's medical record and are primarily driven by protocols and guidelines developed by the PCP consultant or RN in collaboration with the client's behavioral health practitioners.

Community Support/Resource Connections, Individual (H2016)

Adults

This service connects the client with professional and nonprofessional services and resources available in the community that can help meet his or her individual needs on the road to recovery and relevant to the goals in the ICP. Examples of activities include:

- training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process;
- providing services to increase client/family ability to provide a safe and supportive environment in the home and community;
- assisting the client/family in the acquisition of knowledge and skills necessary to understand and address specific needs about illness and treatment; including understanding crisis plans and plan of care process; and
- developing and enhancing specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management.

Exclusion(s) Peer mentoring or coaching activities that are billable outside of Health Homes (HH)

Children, Youth, and Young Adults

Services that are designed to provide moderate level support activities that are age appropriate, culturally sensitive and relevant to the goals specified in the plans of care. In general, these address the emotional and social dimensions of wellness. For Young Adults in Transition (YAT), it may also include addressing the occupational dimension of health. Support may include:

- activities for each member to restore, retain and improve the self-help, communication, socialization, and adaptive skills necessary to reside successfully in home and community-based settings;
- self-esteem enhancement, violence alternatives, communication skills or other related skill development.

Exclusion(s): This service does not include tutoring.

Comprehensive Care Management

The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems, focusing on assessment, evaluation, planning, and facilitation.

Comprehensive care management services consist of developing a comprehensive, integrated care plan to address needs of the whole person and involve the active participation of the Nurse Care Manager (NCM), certified Behavioral Health Case Manager, Primary Care Practitioner, and Health Home clinical support staff with participation of other team members, family and caregivers. The development includes initial and comprehensive standards for high intensity.

Case Management (T1017)

Case Management is the planned referral, linkage, monitoring and support, and advocacy provided in partnership with a client to support him or her in self-sufficiency and community tenure. Case management actions may take place in the client's home, in the community, or in the facility.

Services include, but are not limited to:

- Healthcare;
- Disability benefits;
- Housing;
- Transportation;
- Personal needs; and
- Legal Services.

Child and Family and Team Meeting (S5110)

The Child and Family and Team Meeting is a meeting between the Wrap Staff, the family, and Child and Family Team members. For this meeting to be considered a formal Family Team Meeting, the child/youth must be present (unless in placement), as well as the guardian, and at least one additional team member is not living in the home.

Comprehensive Transitional Care

Comprehensive Transitional Care (CTC) is provided to clients discharged from hospitals or other qualifying institutions or facilities. CTC is designed to keep the client well-supported during the transition from higher levels of care to help avoid readmissions, relapses, etc. and by doing so, to reduce healthcare costs. Transitional care also includes transitions from child-serving to adult systems.

Community Support/Resource Connections (adults) (H2016)

This service connects the client with professional and nonprofessional services and resources available in the community that can help meet his or her individual needs on the road to recovery. Examples of activities include:

- provide training and support necessary to ensure active participation of the client/family in the treatment planning process, and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process;
- increase client/family ability to provide a safe and supportive environment in the home and community;
- assist client/family in the acquisition of knowledge and skills necessary to understand and address specific needs about illness and treatment, including understanding crisis plans and plan of care process; and
- develop and enhance specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management.

This service may be provided by a peer, certified with wellness training. Mentoring or coaching activities should be billed outside of HH. <http://recoveryishappening.org/waprs.pdf>

Crisis Diversion (H2016) – Adults (F2F)

This is a service for unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community to assist client(s) from progression to a higher level of care.

Crisis (Family) De-escalation and Stabilization (T1027 TG) – Children (Face to Face)

This is the urgent response to children experiencing mental health crises and their families. The goal is to help these children and youth stay in their homes by responding quickly, helping families navigate the system to make informed choices about services and supports that best fit their needs, and connecting with the resources needed to avert a clinical crisis. Includes education and advocacy to ensure families can obtain appropriate services and crisis de-escalation.

Crisis Mobile Response Team, Children (S5110 TF)

This service consists of an urgent response to children experiencing crises and their families. The goal is to help these children and youth stay in their homes by responding quickly, helping families navigate the system to make informed choices about services and supports that best fit their needs and connecting them with the resources needed to avert a clinical crisis. Travel to the location of the crisis to support the child & family is included.

Components include:

- Identify the nature of the issues causing the crisis, and the danger or risk posed to the child or someone else (LBHP, billed separately);
- If possible, prevent the need for out-of-home placement of the child in a psychiatric inpatient unit, residential treatment center or detention facility;
- Reduce foster care disruption;
- Initiate a crisis response and treatment plan in the child's home to stabilize the child and help reduce the incidence of a future crisis;
- Link the child and family to other community mental health services or other supports; and
- Provide short-term case management.

Family Conference (90887)

This face-to-face service occurs to interpret or explain the results of psychiatric and/or other medical examinations and procedures to family members or other responsible persons or to advise them on how to assist the client.

Family Training & Support (T1027) (F2F)

Training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process, provided by a credential Family Support Provider.

Health Risk Appraisal (HRA)

The Health Risk Appraisal is a preliminary screening that helps determine the acuity of needs. The Appraisal should be completed for all new clients at intake or within 2 weeks, for all new clients and updated annually. The appraisal may be self-reported or administered by a team member.

Health Promotion

Health promotion is the process of enabling clients to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions. Health promotion consists of providing health education specific to the client's chronic condition.



Integrated Care Plan (ICP)

An ICP is a shared plan of care that combines all aspects of treatment to encourage a team approach to care. An ICP is facilitated by the Care Manager; it includes all aspects of treatment, it incorporates all additional information obtained after the initial intake and has input from all team members.

Integrated Care Plan, Development of (ICP) (So280) - General Requirements

The HH team must develop a client directed, integrated care plan (ICP) for each enrolled client. The ICP must address all services necessary to assist the client in meeting his or her physical and behavioral health goals. It must include:

- client diagnoses relative to behavioral and physical health conditions identified by both the providing HH and other treatment providers (PCP, specialists, etc.);
- treatment goals related to health and wellness, including preventive/primary care services;
- interventions, including follow up with necessary medical providers;
- documentation of medications, treatments, and individual and/or group activities; and
- documentation that the client's HH Team participated in the development of the plan of input from the HH Team.
- documentation of the client's or representative's and/or primary caregiver's (if any) understanding, involvement, and agreement with the ICP.
- The ICP includes a periodic reassessment of the client's needs, clearly identifies the client's progress in meeting goals, and indicates changes in the ICP based on the progress and needs of the client at a minimum of 6 months.

ICPs must be complete for clients within 30 days of intake.

Integrated Care Plan/Comprehensive Assessment & Plan, Development of (H0039) (HH-PACT)

Comprehensive assessment and plan with the following elements: Psychiatric DX assessment (billed separately), nursing assessment (separately reported), and extended biopsychosocial assessment with narrative and historical timeline. The HH-PACT will assign each client a primary case manager who coordinates and monitors the activities of the treatment team and has primary responsibility to coordinate the writing of the ICP, to provide individual supportive therapy, to ensure immediate changes are made in ICPs as client's needs change, and to advocate for client's rights and preferences.

Integrated Care Plan Review/Update (So281)

A revised ICP must include information from the client's initial evaluation and comprehensive assessments. The ICP includes periodic reassessment of the client's needs, clearly identifies the client's progress in meeting goals, and indicates changes in the ICP based on the progress and needs of the client at a minimum of 6 months. It updates the progress toward goals specified in the written ICP, and documents changes, as applicable, in the ICP goals. BHCMI or higher.



Intensive In-home (IIH) Support, Skills Training (child) (S5110)

These services are designed to restore, rehabilitate and support the client's emotional and social development and learning. They are intended for children, youth and young adults to provide intensive, on-going interventions that are specified in the person-centered plans of care. These services also reinforce the desired behavioral or cognitive changes by assisting the child and family in everyday application of the plans of care strategies and resultant insights. And, they are designed to avoid the need for more restrictive care such as hospitalization and residential care. Components include:

- (1) **"Problem identification"** is made in collaboration with the client regarding obstacles and barriers to the client's personal goals in his/her current life;
- (2) **"Goal setting"** generates short-term approximations to the client's personal goals with the specification of the social behavior that is required for successful attainment of the short-term, incremental goals. The goal-setting endeavor requires the provider to elicit from the client detailed descriptions, for example: what communication skills are to be learned? With whom, where and when should they be used;
- (3) **"Roleplay" or "behavioral rehearsal."** Through these, the client demonstrates the verbal, nonverbal, and other skills required for successful social interaction in the interpersonal situation set as the goal. Positive and corrective feedback is given to the client focused on the quality of the behaviors exhibited in the role play;
- (4) **"Social modeling"** is provided by demonstrating the desired interpersonal behaviors in a form that can be vicariously learned by the observing client;
- (5) **"Behavioral practice"** by the client is repeated until the communication reaches a level of quality tantamount to success in real-life situations;
- (6) **"Positive social reinforcement"** is given contingent on those behavioral skills that showed improvement; and
- (7) **"Positive reinforcement" and "problem-solving"** is provided based on the client's experience using the skills on their own in a real-life setting.

This includes child and family team meetings.

Medication Reconciliation (G8256)

Medication reconciliation is the process of comparing a client's medication orders to all of the medications that the client has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. This service may be provided by an RN. This should be documented in the EMR within 30 days of discharge from an inpatient facility. Client follow-up must occur within 72 hours after discharge. The physician needs to order any changes, additions, or deletions to the medication.

Medication Reminder (S5185)

Medication reminders may include telephone prompts, electronic alerts, and medication deliveries. Smartphone medication adherence

Medication Assistance and Support; Education (HH-PACT, (H0039)

Assisting clients in accessing medication, developing the ability to take medications with greater independence, and providing medication setup. This includes the prescription, administration, and order of medication by appropriate medical staff. Educating clients on the role and effects of medications in treating symptoms of mental illness and the side effects of medications is crucial.

Medication Training and Support (H0034)

A documented review and educational session performed by a licensed registered nurse or physician assistant focusing on the client's response to medication and compliance with the medication regimen. The client must be present at the time of the service. The review will include current medications and vital signs. A physician is not required to be present but must be available for consult, if necessary. The service is designed to maintain the client on the lowest level of the least intrusive medications, encourage normalization and prevent hospitalization.

Nursing Assessment (T1001)

A nursing assessment is a comprehensive assessment of medical, dental and other health needs. If there is a gap in care of more than one year, or if the team cannot obtain a history and physical that identifies the medical dental and other health needs completed within the last 12 months, an RN must complete the nursing assessment, or a referral must be made to a PCP for a wellness visit. A nursing assessment must be conducted by a Registered Nurse, per Oklahoma Board of Nursing. Patient Assessment Guidelines can be located at <https://www.ok.gov/nursing/ptassessgl.pdf>

- For adults, either obtain annual physical records from primary care or update nursing assessment annually.
- For children, instead of doing a nursing assessment the nurse or CC must ensure an EPSDT visit is complete and obtain records.

Nursing Visit (99211)

Nursing services pertain to an evaluation and management (E/M) service. The CPT manual defines code 99211 as an office or another outpatient visit “that may not require the presence of a physician.” Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.

Outreach and Engagement (G9001) (Before Enrollment)

Through outreach and engagement, the client is informed about HH enrollment; the benefits of HH enrollment to the client; privacy; and selecting a PCP, if needed.

Patient Registries

Registries provide a mechanism for tracking and benchmarking the magnitude of a clinical problem across a population.

Population Health

The population health will be used with analytics to determine where clients are along the continuum of well to sick on certain conditions.

Provider Travel (A0160)

This means travel time to and from meetings or to collateral visits for development or implementation of the ICP. This also means time spent driving to do a home visit when the client is not home.

Review or Modification of Plan (G9012) (Physician / PCP Consultation)

This includes direction and general supervision of care management services that are provided for behavioral health conditions, which are generally provided by clinical staff.

- Management and/or coordination of services are provided and overseen, as needed, for all medical conditions, psychosocial needs, and activities of daily living.
- Monitor usage of psychotropic medications through report analysis and follow up with outliers ([OAC 450:17-5-158\(c\)](#));
- Collaboration with OKDHS, OHCA, other care partners and stakeholders to share information and to ensure state protocols are in place to improve the use of psychotropic medications among children in foster care, in accordance with Federal guidance and best practice guidelines;
- This service may also include inter-professional consultations which are services requested by telephone or internet by a physician or other qualified healthcare professional seeking a consultant’s expert opinion for an enrolled HH client without a face-to-face client encounter with the consultant.

Sitting/Participating in an Appointment (T2001)

HH team member may accompany a client to a medical appointment while the client is receiving treatment to assist the client in meeting their needs. An HH intervention must be provided to report this code, i.e., client education, reinforcing self-management skills, and modeling or assisting with questions to healthcare providers regarding health concerns.

Targeted Case Management (T1016)

Targeted case management is case management, as defined above, directed at specific groups, which may vary by state. CMS defines targeted case management as case management furnished without regard to requirements of statewide provision of service or comparability that typically apply for Medicaid reimbursement. 42 CFR § 440.169(b). Examples of groups that might be targeted for case management are children with serious emotional disturbance, adults with serious mental and/or substance use disorders, pregnant women who meet risk criteria, individuals with HIV, and such other groups as a state might identify as in need of targeted case management.

Transitional Support (T1002, T1003)

Transitional Supportive Services include services specifically relating to chronic medical conditions for successful discharge planning and transition for children, youth, young adults in transition, and adults discharging from an inpatient facility, emergency department, or crisis unit, provided by RN or LPN.

Treatment Team Meeting (G9007)

A formal, structured process of interaction among three (3) or more staff from the same HH agency for discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision will be used. It will be used to identify additional resources needed, to discuss the transition of the client to a different level within the complex care program, and to modify the ICP as necessary.

Wellness Facilitation (T1012) (Adults)

Wellness plan facilitation is the implementation of the self-management plan. It is the process of providing direction and coordinating self-help recovery and should include areas such as tobacco cessation, physical activity, nutrition and other resources and services based on individual client needs and preference. Services can include support groups and exercise groups.

Wellness Facilitation (T1012) (Children)

Interactive, health-promoting and preventive interventions that may include training in life skills, such as eating nutritious foods, sleep hygiene, participating in physical activities, problem-solving, responsibility, communication and decision-making skills, which enable individuals to successfully resist social and other pressures that are destructive to their health and future.

Wellness Facilitation (Groups) (T1012 HQ)

General health education, support and exercise groups may be led by certified wellness coaches and should be based on evidence-based programs such as Live Longer, Live Stronger.

Group sizes should not exceed 10 clients

Wellness

Wellness means overall well-being. It includes the emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual aspects of a client's life. Incorporating aspects of the Eight Dimensions of Wellness, such as choosing healthy foods, forming strong relationships, and often exercising, into everyday habits can help people live longer and improve quality of life.

Wellness Self-Management Plan

A Wellness Self-Management plan is a plan created by the client with help from the HH Wellness Coach that identifies any chronic illness, risk factors and/or healthy lifestyle changes the client identifies as areas of focus. The plan provides individualized feedback and links the person with at least one intervention to manage chronic illness, promote health, sustain function and/or prevent disease.

Wellness Self-Management Plan Development (S5190)

Adults - Individual physical wellness plan development is a systematic approach to collecting information from clients that identifies risk factors, provides individualized feedback and links the client with at least one intervention to promote health, sustain function and/or prevent disease. [The Wellness Plan should address the 8 dimensions of Health).

Children - Wellness goals for children may be set around: physical health and development, behavioral/emotional functioning, and social functioning. These goals may be identified in the Wraparound Plan.

Oklahoma Health Home

Billing and Reporting Guide



Health Home Billing and Reporting Guide

Medical Necessity Criteria

Effective January 15, 2019

Adult Moderate Intensity

- Is diagnosed and assessed as seriously mentally ill -SMI (as defined in OAC 317:30-5-240.1).

Adult High Intensity

- Is diagnosed and assessed as seriously mentally ill -SMI (as defined in OAC 317:30-5-240.1), with Client Assessment Record (CAR) scores meeting criteria for level 4, and CAR Domain 4 (Medical/Physical) score is 30 or above; AND
- Has had one or more hospitalizations due to chronic illness*, admissions to community-based structured crisis care, and/or incarcerations over the past 12 months. Documentation must be in chart (this includes records, assessments, care plans, notes). The documentation from outside sources will be placed in the chart within sixty (60) days of admission.

Notes:

- *The primary chronic illness for which care is coordinated is serious mental illness, followed by co-occurring conditions, such as diabetes, obesity and cardiovascular disease.
- For agencies who operate certified PACT programs, individuals must also meet PACT admission criteria when admitted to HH, as outlined in OAC 450:55-3-2. Once stabilized and no longer needing the highest intensity of the PACT model, individuals will be stepped down to HH high.
- The HH is responsible for monitoring progress and stepping individuals down from high intensity to moderate when they are stabilized in the community and no longer need intensive level of service.

Health Home Billing and Reporting Guide

Medical Necessity Criteria

Effective January 15, 2019

Children Moderate Intensity

- Is diagnosed and assessed as seriously emotionally disturbed (SED) (as defined in OAC 317:30-5-240.1) with Individual Client Assessment Record (CAR) scores that meet criteria for Level 3;

AND one or more of the following, **with documentation in chart** (this includes records, assessment, care plan, and notes). The documentation from outside sources will be placed in the chart within sixty (60) days of admission.*;

- Is being stepped down from Health Home High level of services due to improvement but still in need of Health Home services;
- With medical record confirmation; is being referred through the state contracted mobile crisis response (not telephonic);
- With medical record confirmation: Was admitted to an acute inpatient psychiatric facility at least once in their lifetime;
- With medical record confirmation: Is taking multiple psychotropic medications at time of referral;
- With medical record confirmation: Has a chronic health condition such as diabetes, obesity or asthma;
- With confirmation of law enforcement documented: Has had two or more contacts with law enforcement within the past 12 months;
- With signed parental statement detailing the exact situation and supporting documentation: Is homeless or is at imminent risk of being homeless due to being unstably housed or couch-surfing;
- With school confirmation in writing on letterhead: Is currently on long-term (at least a ten day) suspension from school, has had a minimum of two short term suspensions (less than ten days) during the current school year, has had a minimum of three in-school suspensions during the current school year, parents have been instructed to pick up the child for misbehavior early a minimum of five times during the past two months, or has dropped out of school;
- With copy of document: Is determined disabled by the Social Security Administration because of a mental health disorder. This includes individuals who qualify for SSDI or SSI due to a mental health disability; or
- With copy of document: Has a current Individual Education Plan (IEP), 504 Plan, or is in alternative education program because of emotional/behavioral disturbance.
- With medical record confirmation: Has experienced self-harm or documented suicidality within the past thirty days.

Notes:

- Health Homes may request additional time to obtain certain documents with specification of extenuating circumstances. These extensions will be given on a limited, case by case basis.

Health Home Billing and Reporting Guide

Medical Necessity Criteria

Effective January 15, 2019

Children High Intensity (Wraparound)

- The child is seriously emotionally disturbed (SED) (as defined in OAC 317:30-5-240.1), with Individual Client Assessment Record (CAR) scores meeting criteria for Level 4, and the Ohio Scale caregiver rating shows critical impairment (score of 25 and above on the Problem Subscale or a score of 44 and below on the Functioning Subscale);

AND, is being transitioned out of acute psychiatric inpatient, crisis center or residential care, **with documentation in the chart**, back to the community for a HH high-intensity Wraparound process coordinating an array of services and supports, to be led by a child and family team;

OR, Is being referred by ODMHSAS contracted mobile crisis response (not telephonic), as an alternative to a higher level of care *for a HH high-intensity Wraparound process coordinating an array of services and supports, to be led by a child and family team, with documentation in the chart*;

OR, Has experienced a psychiatric acute inpatient hospitalization admission or admission to community-based structured crisis care (crisis center) within the past 12 months and is at-risk for re-admission, **with documentation in the chart**;

OR, At least two of the following, **with documentation in the chart** (i.e., records, assessment, care plan, and notes) The documentation from outside sources will be placed in the chart within sixty (60) days of admission:*

- With medical record: Has experienced two or more psychiatric hospitalizations or admissions to community-based structured crisis care in the past five years;
- With a copy of the document: Has been determined disabled by the Social Security Administration because of a mental health disorder. This includes children who qualify for SSDI or SSI due to a mental health disability;
- With a copy of the document: Has a current Individual Education Plan (IEP) or 504 Plan, or is attending alternative school due to emotional/behavioral disturbance;
- With medical record: Has a co-occurring chronic health condition (such as diabetes or obesity);
- With signed parental/primary caregiver statement detailing the exact situation and any supporting documentation available: Is homeless;
- With clinical records: Has experienced suicidal ideation with intent within the last 3 months; or
- With the written confirmation of law enforcement: Has had two or more contacts with law enforcement personnel, incarcerations, or involvement with the Office of Juvenile Affairs in the past 6 months, or was in the custody of OKDHS or OJA within the past 6 months.

Health Home Billing and Reporting Guide

Medical Necessity Criteria

Effective January 15, 2019

Notes Regarding Children's HH High:

As stated in the RFP, Health Home high intensity is designed to be delivered through a Wraparound process that coordinates a comprehensive array of services, directed by a child and family team.

The HH is expected to provide “whatever it takes” to stabilize the child/youth/young adult in the community.

HH high intensity is not intended to be long-term. Progress should be made, and stabilization should occur. Initial authorization will be issued for six months.

In order to meet Medical Necessity Criteria for continued stay in Children's Health Home High, the following must be also be present at 6 month service plan update:

- 1) The clinical condition(s) continues to warrant HH high intensity in order to coordinate care to prevent the onset of disease or to treat disease and prevent onset of serious complications;
- 2) Progress toward Care Plan identified goals is evident and has been documented based on the objectives defined for each goal, but the goals have not yet been substantially achieved despite sound clinical practice consistent with the chronic care model; or
- 3) Progress has not been made, and the multidisciplinary team has identified and is ready to implement clearly delineated changes/revisions to the Care Plan to support the goals of the client/family.

Attestation by an LBHP will be required in the chart, and backup documentation **may be required**.

As of December 15, 2019: children currently in HH high will be assessed utilizing new criteria **at their next six-month treatment plan update** to ascertain whether they will remain in HH high or move to HH moderate.

The Care Plans for HHs serving children in HH-High may include gathering of additional information from multiple sources to form a complete assessment (see 450:17-5-151) and a Wraparound Planning process (see 450:17-5-152).

The systematic process of moving High Intensity services to Moderate Intensity if minimum services are not met will remain in effect. See http://www.odmhsas.org/picis/Documents/Health_homes/HHChange20180202.pdf.

Health Home Billing and Reporting Guide

Client Eligibility and Enrollment

Individuals who are eligible for SoonerCare, and who meet eligibility criteria for Health Homes, may “opt-in” and voluntarily participate in a Health Home. Individuals may choose to participate in any Health Home (HH).

The HH must obtain informed consent specific to enrollment in the HH. The consent must 1) be specific to the extent that it permits the HH team members to share information relevant to the delivery of HH services, and 2) be obtained within a process that educates individuals, and ensures understanding, regarding their right to choose between qualified HHs or to “opt-out” of the HH service.

An individual may be enrolled in both a Health Home and a Patient Centered Medical Home, (PCMH) however roles and responsibilities must be clearly identified in order to avoid duplication.

Individuals may not be enrolled in Health Home and currently be enrolled in other programs like: Intellectual or Developmental Disability Targeted Case Management (I/DD-TCM); Advantage Waiver TCM; and SoonerCare Health Management Program (HMP). Individuals are given the choice as to which care management/care coordination services would best meet their needs. Duplication of services is not allowed.

Children receiving Child Welfare TCM (CW-TCM), Office of Juvenile Affairs (OJA-TCM), Multisystemic Therapy (MST), and Partial Hospitalization (PHP) are not eligible for HH.

Children can receive EI-CM and SB-CM while in HH, as long as roles and responsibilities are delineated in order to avoid duplication.

HH services must be coordinated with case managers of clients receiving Early intervention Case Management (EI-CM) or school-based (SB-CM)

Health Home Billing and Reporting Guide

Outreach and Engagement

PRIOR TO HH ENROLLMENT		
HEALTH HOME OUTREACH AND ENGAGEMENT		
Health Home Outreach & Engagement	G9001	\$53.98 / Per Month

A Prior Authorization is not required.

Through outreach and engagement the client is informed about: Health Home enrollment; the benefits of Health Home enrollment to the client; privacy; and selecting a PCP if needed.

A Health Home may provide outreach and engagement services to eligible clients age six (6) and up.

If Health Home Outreach and Engagement is initiated through a referral from a hospital, crisis or residential facility, the referral must be documented in the client record.

The reimbursement for outreach and engagement is limited to once per month and is not reimbursable in the same month that the Health Home receives reimbursement for Health Home Bundled Services.

Only 3 months of billing are allowed per rolling year, and must be billed using a unique Client ID.

Health Home Billing and Reporting Guide

Client Eligibility and Rates

AFTER HH ENROLLMENT			
HEALTH HOME CORE SERVICES			
Adult			
Urban	Moderate Intensity	G9002	\$127.35 / Per
	High Intensity (Level 4)	G9005	\$453.96 / Per Month
Rural	Moderate Intensity	G9002TN	\$146.76 / Per
	High Intensity (Level 4)	G9005	\$453.96 / Per Month
Child			
Urban	Moderate Intensity (Level 3)	G9009	\$297.08 / Per Month
	High Intensity (Level 4)	G9010	\$864.82 / Per Month
Rural	Moderate Intensity (Level 3)	G9009TN	\$345.34 / Per Month
	High Intensity (Level 4)	G9010TN	\$1,009.60 / Per Month

Note: These codes are Per Member, Per Month (PMPM) codes.

- Adult HH Moderate; Two (2) HH core service categories per month, to include one (1) face-to-face service.
- Adult HH High; Two (2) HH core service categories per month, to include two (2) hours face-to-face.
- Child HH Moderate: Two (2) HH core service categories per month to include three (3) hours face-to-face services with the youth and family.
- Child HH High; Two (2) HH core service categories per month, to include eight (8) hours face-to-face services and weekly contact with the youth and family.

In order to bill for the month, the service requirements must be met.

Service reporting must be completed for all services.

G-Codes must be reported by primary Care Manager or Care Coordinator.

Health Home Billing and Reporting Guide

Prior Authorization

Current Agency Client- If the client to be enrolled in the HH program is already receiving outpatient behavioral health services at the agency, HH services can be authorized in one of two ways:

- ♦ By revising the CDC of the current prior authorization (PA) to add HH under Secondary Referral (60 – Moderate, 61 – High Intensity).
- ♦ By submitting a new PA request for outpatient services and including HH under Secondary Referral (60 – Moderate, 61 – High Intensity).

New Client- If the client to be enrolled in the HH program is new to the agency, HH services can be authorized as follows:

- ♦ By submitting a PA request for outpatient services and including HH under Secondary Referral (60 – Moderate, 61 – High Intensity).

Things to Note-

- ♦ If a client is enrolled in HH, any future authorizations to continue services will require one of the following listed under Secondary Referral: for continued HH a 60 – Moderate or 61 - High Intensity; to discontinue HH and continue with a standard outpatient authorization a 62 – Opt Out. The exception to that is for instant authorizations and the PGO33- they will not require the HH Secondary Referral.
- ♦ Clients under the age of 21 that are enrolled using referral code 60 or 61 will be placed in the Children's HH if criteria has been met. If the individual wishes to be in an adult HH, use the referral code 63 (Moderate for adults 18-20) or 64 (High for adults 18-20).
- ♦ It is the provider's responsibility to ensure that the client meets all Medical Necessity Criteria for any HH level they request.
- ♦ SMI must be checked on the CDC for adults, and SED must be checked for children.
- ♦ When the HH PA is acquired, a standard outpatient PA is also issued for the Level of Care identified. They are two separate PAs with two separate financial caps. Some services can be provided under the standard outpatient PA; in conjunction with services provided under the HH PA (see Limitations above for excluded services).
- ♦ Collaborating with Other Agencies: As there is a standard outpatient PA, in addition to the HH PA, collaboration with another agency regarding that outpatient PA can occur- only the financial cap for the outpatient PA would be shared. If a HH provider wants to collaborate with another agency on the provision of HH Core Services, the HH provider would be responsible for payment to the collaborating agency for HH services.
- ♦ If once an HH PA is acquired and the client loses TXIX, the system will deny the monthly HH Core Services code/rate. However, any service functions submitted (intended for HH reporting) will waterfall to ODMHSAS for payment under the outpatient service PA for providers with ODMHSAS contracts (it will not waterfall for agencies without ODMHSAS contracts). Since the HH reporting codes may be matched with HH service functions that are not in line with that codes allowed usage under standard outpatient rules, providers will need to watch TXIX eligibility closely.

Health Home Billing and Reporting Guide

P.A.s and Limitations

- ♦ A HH PA can be ended in one of two ways:
- ♦ Through the entry of a formal discharge; or
- ♦ Through revising the CDC for the existing PA, changing the Secondary Referral to 62 – Opt Out.
- ♦ If a client is transitioning from one HH program, to a HH program at another agency, the initial HH agency would need to end their HH PA by revising the CDC Secondary Referral to 62 – Opt Out. The New HH agency will not be able to admit/enroll until this occurs.
- ♦ For individuals with Developmental Disabilities, the Health Home will refer to and coordinate with the approved Developmental Disabilities case management entity for these services.

Health Home Limitations

Limitations: The following services will not be reimbursed separately for individuals enrolled in a Health Home:

- Targeted case management (T1016 and T1017);
- Service plan development, moderate and low complexity (H0032);
- Medication training and support (H0034);
- PACT medication management and support and coordination linkage (H0039)*;
- Medication reminder (S5185);
- Medication administration (T1502); and
- Outreach and engagement (T0123).

Adults for whom case management services are available through Home and Community Based Waiver (i.e. Advantage Waiver, Living Choice, HMP, In Home Support, etc.) member are not eligible for concurrent Health Home services.

Children receiving Child Welfare TCM (CW-TCM), Office of Juvenile Affairs (OJA-TCM), Multisystemic Therapy (MST), and Partial Hospitalization (PHP) are not eligible for HH.

Children can receive EI-CM and SB-CM while in HH, as long as roles and responsibilities are delineated in order to avoid duplication.

HH services must be coordinated with case managers of clients receiving Early intervention Case Management (EI-CM) or school-based (SB-CM)

*For clients that are PACT and in a Health Home, the teams can bill H0036 for those direct services that are not covered in the Health Home Core Services.

Service are effective August 1, 2018																						
All services must be conducted within the scope of the license/certification of the individual providing the service.																						
Description	Code	Valid Modifier1	Valid Modifier2	Valid Modifier3	Support *							BH Specialists					Nurs e CC			Medical Specialist	time unit	
					Wellness Coach	Peer to Peer Family Youth Provider	Family Support Provider	Children's Health Home Specialist (BHA)	Hospital Liaison / Health Home Specialist *	BHCHM I	BHCHM II	BHCHM III, Wraparound Facilitator	CADC	LC, Candidate	LBHP	LPN	RN	Physician Assistant	APRN			Psychiatrist
Services Billed Separately (Prior to HH Admission)																						
Outreach and Engagement																						
Initial Assessment																						
Initial Plan (if done before admission as designed, it will be paid FFS, if not, it's included in the bundle)																						
Initial Plan (PACT)																						
Screenings - An integrated screening of each potential HH client, whether new to the agency or an existing client, will be completed to determine clinical eligibility for HH services. This should be billed for under a PG038 (prior to admission to HH).																						
Comprehensive Care Management (CCM) - Assessment/Evaluation, Planning: Per OHCA rules qualified professionals to provide comprehensive care management are nurse care manager, CBHCM, PCP consultant, psychiatric consultation, and LBHP.																						
Performing medication reconciliation																						
Nursing Assessment: (Medical, Dental and other health needs)																						
Development of Integrated Care Plan by the Health Home team																						
The integrated care plan will be developed based on an initial assessment conducted by an LBHP. The integrated care plan will be developed in a coordinated effort by the adult or child HH team and will reflect input of each team member. The BHCMI will coordinate input of the team members and may sign, ensuring input of all. The consulting primary care practitioner or APRN may be involved as needed in the medical components of the plan. The RN will lead and/or manage the comprehensive nursing assessment. Addenda will be added to reflect ongoing development of a comprehensive treatment plan, with the RN leading medical components, LBHP leading clinical components, and BHCMI coordinating efforts and signing to ensure all treatment team members pertinent to the plan have developed their parts and agree on the plan.																						
Comprehensive Assessment & Dev of Integrated Care Plan: (PACT HH Team 450:55-25-1 and 55:2-10(a)(8))																						
Comprehensive Assessment and plan with the following elements: Psychiatric DX Assessment (billed separately) Nursing assessment, (separately reported) Extended Biopsychosocial Assessment with narrative and historical timeline. The PACT will assign each consumer a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the treatment plan, to provide individual supportive therapy, to ensure immediate changes are made in treatment plans as consumer's needs change and to advocate for consumer rights and preferences																						
Ongoing Review of Patient Status:																						

All services must be conducted within the scope of the license/certification of the individual providing the service.																						
Description	Code	Valid Modifier1	Valid Modifier2	Valid Modifier3	Support *						BH Specialists					Nurs e CC		Medical Specialist	time unit			
					Wellness Coach	Peer to Peer Family Youth Provider	Family Support Provider	Children's Health Home Specialist (BHA)	Hospital Liaison / Health Home Specialist *	BHCM I	BHCM II	BHCMIII, Wraparound Facilitator	CADC	Lic. Candidate	LBP	LPN	RN			Physician Assistant	APRN	Psychiatrist
Integrated Care Plan Review/Update: A revised active plan must include information from the client's initial evaluation and comprehensive assessments, and updates the progress toward goals specified in the written care plan, and changes, as applicable, in goals. BHCMII or higher Review by the Psychiatric consultant with modification of plan, if recommended [Non-Face to Face]																						
	S0281	HE										X	X					X	X	X	X	15 min
	G0012	HE	AM																X	X		15 min
	G0012	HE	AG															X	X			15 min
	G0012	HE																X	X	X	X	15 min
	90887	HE/HF																X	X	X	X	15 min
Care Coordination (CC) - Facilitating and Coordinating Treatment: Per OHCA rules qualified professionals to provide Care Coordination are nurse care																						
Administrative Activities																						
	T2022	HE	TD															X	X	X		15 min
	T2022	HE	TE															X	X	X		15 min
	T2022	HE																X	X		X	15 min
	T2022	HE																X	X	X	X	15 min
	T2022	HE	TF															X	X		X	15 min
	T2022	HE																X	X	X	X	15 min
Facilitation and Coordination Examples include:																						
	T2022	HE																			X	15 min
	T2022	HE																X	X	X		15 min

All services must be conducted within the scope of the license/certification of the individual providing the service.												Support *				BH Specialists				Nurs e CC		Medical Specialist		
Description	Code	Valid Modifier1	Valid Modifier2	Valid Modifier3	Wellness Coach	Peer to Peer Family Youth Provider	Family Support Provider	Children's Health Home Specialist (BHA)	Hospital Liaison / Health Home Specialist *	BHCMI	BHCMI II	BHCMI, Wraparound Facilitator	CADC	LIC Candidate	LBP	RN	Physician Assistant	APRN	Psychiatrist	Primary Care Practitioner	HH Director	Time unit		
•Monitoring and follow-up activities with treatment or service providers (including intra-agency) for the purposes of monitoring client attendance of scheduled physician/medication, therapy, rehabilitation, or other supportive service •Ensuring that every enrollee is aligned with an external PCP through which care is coordinated OR linked with a PCP available through the HH, within the first 3 months of enrollment in HH. [Non-Face to Face]	T2022	HE				X	X		X	X	X	X		X	X	X					X	15 min		
A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.	G9007	HE/HF				X	X		X	X	X	X		X	X	X					X	15 min 15 min		
Health Promotion (HP) Per OHCA rules qualified professionals to provide Health Promotion are PCP Consultatant, Nurse Care Manager, Wellness Coach, HH Specialist if Wellness Coach Certified.																								
Wellness Self-Management Plan Development (with HRA) A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]	S5190	HE/HF			X			X	X						X	X				X	X	15 min		
Wellness Self-Management Plan Facilitation (450:17-5-15 min 8.) The process of providing direction and coordinating support activities that promote good physical health, sustain function and/or prevent disease. Education and support focuses on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health.	T1012	HE/HF			X			X	X						X	X			X	X	15 min			
Wellness Services	T1012	HE/HF			X			X	X						X	X				X	X	15 min		
Wellness Services, group	T1012	HE/HF	HQ		X			X	X						X	X				X	X	15 min		
Tobacco Cessation (Use CPT if physician)	T1012	HF	SE		X			X	X						X	X				X	X	15 min		
Medication Injection	T1502	HE													X	X						15 min		
Nursing Services, (Services within scope of Nurse Practice Act) and within CPT billing guidelines, Established patient (F2F). This can only be reported by RN or LPN with appropriate supervision. Please use code link for more details.	99211	HE													X	X					15 min			
Comprehensive Transitional Care (CTC): Per OHCA rules qualified professionals to provide Transitional Care are CBHCM; and nurse care manager, including Hospital Liaison (if case management certified); and FSP.																								
Document supportive services for successful discharge planning and transition for children, youth, and transitional age youth (18-20) discharging from an inpatient facility, ED, crisis unit (non wraparound).	T1017	HE/HF	HN/HM	TG					X	X	X	X	X	X								15 min		
Document supportive services for successful discharge planning and transition for children, youth, and transitional age youth (18-20) discharging from an inpatient facility, ED, crisis unit (wraparound).	T1017	HE/HF	HN/HM	TG					X	X	X	X	X	X					X			15 min		

All services must be conducted within the scope of the license/certification of the individual providing the service.																									
Description	Code	Valid Modifier1	Valid Modifier2	Valid Modifiers	Support *								BH Specialists				Nurs e CC			Medical Specialist					
					Wellness Coach	Peer to Peer Family Youth Provider	Family Support Provider	Children's Health Home Specialist (BHA)	Specialist *	BHCM I	BHCM II	BHCM III	BHCM, Wraparound Facilitator	CADC	Lic Candidate	LBP	RN	Physician Assistant	APRN	Psychiatrist	Primary Care Practitioner	HH Director	Time unit		
Facilitate supportive services for successful discharge planning and transition for children, youth, and transitional age youth (18-20) discharging from an inpatient facility, ED, crisis unit. (FSP)	T1027	HE	TS				X																		15 min
Document supportive services for adults (non PACT) experiencing discharge from an inpatient, long term care, skilled nursing, rehabilitation, crisis unit, or emergency department environment to a home or community setting.	T1017	HE/HF	HN/HM	TG					X																15 min
Document supportive services for adults (PACT) experiencing discharge from an inpatient, long term care, skilled nursing, rehabilitation, crisis unit, or emergency department environment to a home or community setting.	T1016	HE/HF	HN/HM	TG					X																15 min
Document supportive services specifically relating to chronic medical conditions for successful discharge planning and transition for children, youth, transitional age youth, and adults discharging from an inpatient facility, ED, crisis unit. RN	T1002	HE																X							15 min
Document supportive services specifically relating to chronic medical conditions for successful discharge planning and transition for children, youth, transitional age youth, and adults discharging from an inpatient facility, ED, crisis unit. LPN	T1003	HE																X							15 min
Performing medication reconciliation.	G8256	HE	TG															X	X	X	X				15 min
Individual and Family Support Services (IFS): Per OHCA rules qualified professionals to provide Individual and Family Support are Wellness Coach, RSS, Children HH Specialist, Care Coordinator, FSP, and Nurse Care Manager.																									
Intensive In-Home Supports: Wraparound Facilitator (450:17-5-155; 450:27-9-16)																									
•Services are designed to restore, rehabilitate and support the individual's emotional and social development and learning.																									
•Services are intended for children, youth and young adults to provide intensive, on-going interventions that are specified in the individual's person-centered, individualized plan of care.	S5110	HE																							15 min
This code is also used for the facilitation of family team meetings.																									
In-home or community crisis response and stabilization - connecting with the resources needed to avert a clinical crisis.	S5110	HE	TF						X																15 min
Family Training & Support: FSP; Youth/Peer Specialist																									
•Provide training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process.																									
•Training provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child.																									
•Assisting the family with the acquisition of the skills and knowledge necessary to facilitate an awareness of their child's needs and the development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management.	T1027	HE							X	X															15 min
Crisis De-Escalation - FSP	T1027	HE	TG						X																15 min

All services must be conducted within the scope of the license/certification of the individual providing the service.										Support *			BH Specialists					Nurs e CC		Medical Specialist		time unit
Description	Code	Valid Modifier1	Valid Modifier2	Valid Modifier3	Wellness Coach	Peer to Peer Family Youth Provider	Family Support Provider	Children's Health Home Specialist (BHA)	Hospital Liaison / Health Home Specialist *	BHCHM I	BHCHM II	BHCHM III, Wraparound Facilitator	CADC	LBP	LPN	Physician Assistant	APRN	Psychiatrist	Primary Care Practitioner	HH Director		
Community Support / Resource Connections •Provide training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process. •Increase client/family ability to provide a safe and supportive environment in the home and community. •Assist client/family in the acquisition of knowledge and skills necessary to understand and address specific needs in relation to illness and treatment; including understanding crisis plans and plan of care process. •Development and enhancement of specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management. •Sitting/Participating in an appointment with a doctor/provider with the client while receiving treatment to assist the client in meeting their needs.	H2016	HE			X			X	X	X	X	X			X	X	X				15 min	
Medication Training and Support •Training on medications or diagnoses, and interpreting choice offered by service providers. •Individual care by Nurse Care Manager for clients on their caseload; including monitoring medication compliance and side effects. •Overseeing the client's self-management of medications after discharge from higher level of care Training on medications or diagnoses, and interpreting choice offered by service providers	T2001	HE			X			X	X	X	X	X			X	X	X				15 min	
Medication Reminder •Providing a telephone prompt for each client that has at least one or more billable face-to-face services. Provider Travel •Travel time to and from meetings for the purpose of development or implementation of the individual care plan. •Time spent driving to do a home visit when the client is not home.	S5185	HE			X	X	X	X	X	X	X	X									15 min	
Referral to Community and Social Support Services (RCS) Per OHCA rules qualified professionals to provide RCS are CBHCM Nurse Care Manager or FSP with CMIL certification. Referral, linkage and advocacy to assist with obtaining and maintaining needed resources, services and supports; including arranging for non-Traditional Case Management (non PACT and Non wraparound clients)	A0160	HE			X	X	X	X	X	X	X	X			X	X	X	X	X	X	15 min	
Referral to Community and Social Support Services (RCS) Per OHCA rules qualified professionals to provide RCS are CBHCM Nurse Care Manager or FSP with CMIL certification.																						
Referral, linkage and advocacy to assist with obtaining and maintaining needed resources, services and supports; including arranging for non-Traditional Case Management (non PACT and Non wraparound clients)																						
Targeted Case Management (Wraparound)																						
Targeted Case Management (PACT)																						
Quality Measures Reporting Codes																						
Screening for clinical depression is documented as being positive and a follow-up plan is documented																						
1 unit (\$0)																						



Oklahoma Health Homes