OPERATIONAL PROTOCOLS FOR COLLABORATION BETWEEN HEALTH PLANS AND HEALTH HOMES

Introduction

The Contractor's Agreement with the Executive Office of Health and Human Services (EOHHS) states that Contractor shall ensure clear delineation of responsibilities between the Health Home and Contractor in order to avoid duplication by the Contractor of care management services provided by the Health Home for each Health Home enrollee.

The purpose of this document is to outline the EOHHS operational protocols for communication and care coordination between health plans[1] and Health Homes for Medicaid managed care enrollees. EOHHS has designated two providers as Health Homes: Community Mental Health Organizations (CMHOs) and the Comprehensive, Evaluation, Diagnosis, Assessment, Referral and Re-Evaluation (CEDARR) Family Centers. The CMHOs will serve as Health Home for individuals with Severe and Persistent Mental Illness (SPMI) and CEDARR Family Centers (CFC) will serve as Health Homes for children with Severe Emotional Disturbance (SED) and Children with Special Health Care Needs (CSHCN). EOHHS may designate additional providers as Health Homes in the future. At that time, these protocols will be amended to include those providers.

For MCO enrollees active with a CEDARR Health Home or a CMHO Health Home, the MCO will leverage the care management provided at the Health Home and will not duplicate services. The MCO will work collaboratively with the Health Home to ensure all the member's needs are met.

CEDARR Health Homes - Description

CEDARR is an acronym for Comprehensive, Evaluation, Diagnosis, Assessment, Referral and Re-Evaluation. CEDARR Health Homes have statewide capacity. Their goal is to address fragmentation of care by promoting coordination of services through access and integration in order to maximize the value of the existing system. The core values of CEDARR are:

- To be Family centered
- To promote the use of evidence based practices
- To provide family supports
- To refer or provide community supports
- To provide clinical expertise for all disabilities
- To be data driven

CEDARR Health Homes provide a variety of basic and enhanced services and supports[2].

Basic Services and Supports	Enhanced Services	Other Services
• Provision of Special Needs Resource Information • System Mapping and Navigation	• Health Needs Coordination • Therapeutic Counseling	• Family Assessment • Clinical Specialty Evaluation • Treatment Consultation

[1] This includes any and all health plan subcontractors.

[2] The CEDARR certification standards are currently being modified. Definitions of services are subject to change.

Basic Services and Supports	Enhanced Services	Other Services
• Resource Identification • Eligibility Assessment and Application Assistance • Peer Family Support and Guidance	• Health Promotion • Group Maintenance	• Family Care Plan Development • Family Care Plan Review

The health plans' care management or "service coordination" program shall serve as a continuing resource to children and families as circumstances and needs change. Where possible, continuity in relationships with care managers will be preserved. EOHHS strongly encourages a team approach to service coordination between all parties for the best possible outcome for the enrolled child.

The Health Plan will designate a Care Manager/Service Coordinator as the liaison to the CEDARR Health Home. For specific care management activities related to RIte Care members, the child's assigned Care Manager/Service Manager will be responsible for assisting with the coordination of services with the CEDARR Health Home as appropriate. This will include assuring that duplication of services does not occur, and that any in-plan services recommended on the care plan are authorized by the plan. A description of in-plan and out of plan services is described in Attachment B of this document.

A. CEDARR Services

CEDARR Health Homes (CFC) assess the needs with the family and child and identify the possible range of service options, including CEDARR Enhanced Services and/or CEDAAR Direct Services. The family is given provider options, and a referral is sent to the provider selected by the family with recommended treatment hours. When services begin, the CEDARR shares its assessment and care plan with the chosen CEDARR Direct Service provider.

The CEDARR Direct Service Provider conducts a focused assessment with child and family and the provider develops a Treatment Plan with the family that will address the child's specific goals for the treatment period. The proposed plan is reviewed by the CEDARR Health Home and the CEDARR Health Home submits the recommended treatment plan hours to EOHHS for approval.

CEDARR Direct Services are:

- Home Based Therapeutic Services (HBTS)
- Personal Assistance Services and Supports (PASS)
- KidsConnect – Therapeutic Day Care
- Respite

A description of each of these services can be found in Attachment C of these protocols.

B. Referral Requirements

Health Plan care managers may refer to CEDARR Health Homes at any time. Services provided by, or accessed through a CEDARR Health Home, such as PASS or Kids Connect, may support and enhance in-plan services resulting in improved outcomes for members.

The Health Plans' CEDARR liaison will participate in periodic meetings with the CEDARR Health Home clinical staff, as often as is necessary. The goal of these periodic meetings is to:

- Insure a team approached focus to care coordination and avoid duplication
- Improve positive outcomes for the Member
- Discuss Quality Improvement Initiatives

C. Information Exchange and Collaboration Requirements

For children enrolled in a CEDARR Health Home, the CEDARR Health Home is the lead provider for all care coordination and care management services. To facilitate collaboration, both the CEDARR and the MCO will be provided with necessary data from the Department.

On a quarterly basis, the Department will provide the MCO with a list of their members who are enrolled with which CEDARR Health Home. The format for this file will be an agreed upon format between the MCO and EOHHS. The MCO will store this information in a central database that can be accessed by all relevant staff. On an interim basis, the CEDARR Health Home will inform the MCO directly of any new Health Home enrollees.

On a quarterly basis, the MCO will send the CEDARR Health Home a health utilization profile for the most recent twelve-month period, for every new member of the Health Home. The format and transmission method for this health utilization profile will be mutually agreed upon by the CEDARR Health Home and the MCO. The elements of the health utilization profile will include but will not be limited to physician office visits (primary care and specialty), prescriptions, emergency room (ER) visits, and inpatient stays.

The CEDARR Health Home will inform the MCO, with the permission of the family/legal guardian of the member child, of the Health Homes involvement with the child within five (5) days of intake, in a format agreed upon by the Health Home and MCO (subject to EOHHS approval). The CEDARR Health Home will also provide the MCO with a high-level summary of the care plan, upon completion, in a format agreed upon by the Health Home and the MCO.

The MCO will inform the CEDARR Health Home of all inpatient admissions prior to discharge, and will engage the CEDARR in a collaborative discharge planning process, whenever possible. Upon discharge, the CEDARR Health Home will contact the family to ensure all appropriate services and supports are in place to prevent future hospitalization. The CEDARR will coordinate with the MCO to obtain any necessary authorizations for in-plan services, as appropriate.

Notification of Emergency Room (ER) visits will also be provided by the MCO to the CEDARR Health Home. Once notified of an ER visit, the CEDARR will contact a family to discuss the reason for the ER visit as well as any additional community support or education that may be needed to avoid an ER visit in the future. The CEDARR will coordinate with the MCO to obtain any necessary authorizations for in-plan services, as appropriate.

CMHO Health Homes – Description

The State will implement health home services through Community Mental Health Organizations (CMHOs) for individuals with serious and persistent mental illnesses (SPMI). Currently, many individuals with serious and persistent mental illness do not routinely or appropriately access primary care services. Implementation of health home services is intended to facilitate increased access to primary care services and smoother transitions from institutional to community settings. The Health Plan will designate a Care Manager/Service Coordinator as the liaison to the CMHO Health Home. For specific care management activities related to RIte Care or Rhody Health Partners members, the child's assigned Care Manager/Service Manager will be responsible for assisting with the coordination of services with the CMHO Health Home as appropriate. This will include assuring that duplication of services does not occur, and that any in-plan services recommended on the care plan are authorized by the plan. A description of in-plan and out of plan services is described in Attachment B of this document.

These health home services include: (See Appendix D)

- Comprehensive Care Management Services
- Care Coordination
- Health Promotion Services
- Comprehensive Transitional Care Services
- Individual and Family Support Services
- Referrals to Community and Social Support Services

A. CMHO Direct Care Services

CMHO direct care services are:

- 24-Hour Emergency, Crisis Intervention and Crisis Stabilization Services
- Medication Prescription and Management
- Bio-psychosocial Assessment
- Psychotherapy
- Counseling
- Psychiatric Evaluation
- Community Psychiatric Supportive Treatment (CPST) specific to substance use treatment and supported employment.
- Mental Health Psychiatric Rehabilitative Residence (MHPRR)
- Rhode Island Assertive Community Treatment I (RIACT-I
- Rhode Island Assertive Community Treatment II (RIACT-II)
- Substance Use Treatment
- Integrated Dual Diagnosis Treatment
- Supported Housing / Residential Services

B. Information Exchange and Collaboration Requirements

For clients enrolled in a CMHO Health Home, the CMHO is the lead provider for all care coordination and care management services. To facilitate collaboration, both the CMHO and the MCO will be provided with necessary data from the Department.

On a quarterly basis, the Department will provide the MCO with a list of their members who are enrolled with which CMHO Health Home. The format for this file will be an agreed upon format between the MCO and EOHHS. The MCO will store this information in a central database that can be accessed by all relevant staff. On an interim basis, the CMHO Health Home will inform the MCO directly of any new Health Home enrollees.

On a quarterly basis, the MCO will send the CMHO Health Home a health utilization profile for the most recent twelve-month period, for every new member of the Health Home. The format and transmission method for this health utilization profile will be mutually agreed upon by the CMHO Health Home and the MCO. The elements of the health utilization profile will include but will not be limited to physician office visits (primary care and specialty), prescriptions, emergency room (ER) visits, and inpatient stays.

The CMHO Health Home will provide the MCO with a high-level summary of the care plan, in a format agreed upon by the Health Home and the MCO.

The MCO will inform the CMHO Health Home of all inpatient admissions prior to discharge, and will engage the CMHO in a collaborative discharge planning process, whenever possible. Upon discharge, the CMHO Health Home will contact the member to ensure all appropriate services and supports are in place to prevent future hospitalization. The CMHO will coordinate with the MCO to obtain any necessary authorizations for in-plan services, as appropriate.

Notification of Emergency Room (ER) visits will also be provided by the MCO to the CMHO Health Home. Once notified of an ER visit, the CMHO will contact a family to discuss the reason for the ER visit as well as any additional community support or education that may be needed to avoid an ER visit in the future. The CMHO will coordinate with the MCO to obtain any necessary authorizations for in-plan services, as appropriate.

ATTACHMENT A

CEDARR AND CMHO HEALTH HOME CONTACTS

CEDARR HEALTH HOME	CONTACT
About Families CEDARR 203 Concord St. Suite 335 Pawtucket, RI	Michael Pearis, Director 365-6855 ext. 129
Empowered Families CEDARR 1471 Elmwood Ave. Cranston, RI	Belinda Taylor, Program Manager 383-3669 ext. 111
Families First CEDARR 765 Allens Ave. Providence, RI	Nancy Bowering 444-7591
Solutions CEDARR 134 Thurbers Ave. Suite 102 Providence, RI	Heather Brennan, Director 461-4351

CMHO HEALTH HOME	CONTACT
East Bay Center 1445 Wampanoag Trail Suite 106 East Providence, RI	Leslie Cohn 437-8844 ext. 104
South Shore Center 55 Cherry Lane Wakefield, RI	Jerold Cutler 364-7705
Gateway Healthcare Inc 1516 Atwood Avenue Johnston, RI	James DiNunzio 553-1000 ext. 1001
NRI Community Services PO Box 1700 Woonsocket, RI	Mary Dwyer 235-7060
Fellowship Health Resources 25 Blackstone Valley Place Suite 300 Lincoln, RI	Elizabeth Folcarelli 642-4440
Fellowship Health Resources 1070 Main Street 2nd Floor, Suite 1 Pawtucket, RI	Bethany Goldberg 739-8333
Newport County CMHC 65 Valley Road Middletown, RI	Heather Locke 846-6620 ext. 150
The Providence Center 528 North Main Street Providence, RI	Deborah O'Brien 528-0181

CMHO HEALTH HOME	CONTACT
Newport County CMHC 127 Johnnycake Hill Road Middletown, RI	Francis Paranzino 846-1213 ext. 115
The Providence Center 530 North Main Street Providence, RI	James Pinel 276-6375
The Kent Center 2758 Post Road Suite 104 Warwick, RI	Rena Sheenan 738-1338 ext. 232
Riverwood MHS PO Box 226 Warren, RI	James Thomas 247-4278

ATTACHMENT B

RITE CARE AND RHODY HEALTH PARTNERS BENEFITS

IN-PLAN SERVICES	OUT OF PLAN SERVICES
• Inpatient hospital • Outpatient hospital • Physician services • Family planning services • Prescription drugs • Non-prescription drugs • Laboratory Services • Radiology Services • Diagnostic Services • Mental Health and Substance Abuse Outpatient • Mental Health and Substance Abuse Inpatient • Children and Adolescent Intensive Treatment Services (CAITS) • EPSDT Services • Home Health Services • School-based clinic services • Emergency Room and Emergency Transportation • Skilled Nursing Facility Services • Services of other Practitioners • Podiatry (under 21 only) • Optometry • Hospice • Durable Medical Equipment • Early Intervention • Nutrition Services • Education Classes • Interpreter Services • Transplant Services	• Dental services • Court ordered mental health and substance abuse services in which the court order specifies a non-network provider • Non-Emergency Transportation Services (coordinated by the health plans) • AIDS non-medical case management • Neonatal intensive care Unit (NICU) Services at Women's and Infants Hospital • Special Education services as defined in the child's Individual Education Plan (IEP) for children with special health needs or developmental delays • Lead Program home assessment and non-medical case management provided by Department of Health or Lead Centers for lead poisoned children • CEDARR Health Home Services • CEDARR Direct Services • Non-medical case management for Head Start children • Residential substance abuse treatment services for adolescents aged 13 to 17 • Residential Treatment for children ordered by DCYF; covered benefits exclude room and board except in a JCAHO-accredited facility • Comprehensive Emergency Services (administered by DCYF) • Child sexual abuse evaluations, parent/child evaluations, and DCYF-ordered emergency room evaluations prior-approved by the State, (medically necessary follow up therapy is an in-plan benefit) • DCYF ordered administratively necessary inpatient days prior-approved by the State • Intensive community-based treatment prior approved by the State (administered by DCYF) • Early Start Programs (administered by DCYF) **FOR RHP ADULT ENROLLEES** • Nursing home services in excess of 30 consecutive days • Residential services for MR/DD clients

IN-PLAN SERVICES	OUT OF PLAN SERVICES
	• Services covered by Home and Community Based Waivers (described in Appendix T – Waivers) **<u>Mental Health</u>** • Psychiatric Rehabilitation Day Programs • Community Psychiatric Supportive Treatment • Crisis Intervention for individuals with SPMI enrolled in CPST • Clinician's services delivered at a CMHC for individuals with SPMI enrolled in CPST • Mental Health Psychiatric Rehabilitation Residence (MHPRR) • RI-Assertive Community Treatment I and II **<u>Substance Abuse</u>** • Community-based narcotic treatment • Community-based detoxification • Residential treatment
SERVICES NOT COVERED	
• Experimental Procedures • Abortion services, except to preserve the life f the woman, or in cases of rape or incest • Private rooms in hospitals (unless medically necessary) • Cosmetic surgery • Infertility Treatment Services • Medications for Sexual or Erectile Dysfunction	

ATTACHMENT C

CEDARR HEALTH HOME SERVICES DEFINED

Home Based Therapeutic Services (HBTS)- HBTS provides home and community services to children up to age 21 with significant behavioral health, developmental and physical disabilities. HBTS includes one on one therapeutic services given to a child in a home or community setting by paraprofessionals. HBTS may not exceed 40 hours per week – services generally range between 15-20 hours/week. There are five different HBTS services: Intensive, ABA, pre, post and group.

Personal Assistance Services and Supports (PASS)- PASS services include assessment and service plan development, direct services, service plan implementation, and clinical consultation. Direct services are assistance, either hands-on or with cueing, to accomplish the objectives in the Service Plan. Cueing is the use of signals or prompts that should be sufficient to produce the desired behavior or outcome. PASS uses a strength-based and consumer directed approach – families select, train and supervise PASS workers.

Kids Connect – KidsConnect is a program that allows Medicaid-eligible children and youth with special health care needs to participate in child and youth care. Focus is on inclusion with peers who are typically developing. KidsConnect is not intended to replace other services such as Early Intervention, Special Education or Head Start. Kids Connect services include therapeutic integration assessment and plan development, RN Nurse Services, and therapeutic integration direct services.

Respite Services for Children- Temporary, care-giving services in the absence of the caregiver relative. Provided by providers certified by EOHHS. Families may receive up to 100 hours of respite per year. Due to federal and state program rules, recipients of Respite must meet certain criteria and be enrolled in the Respite for Children Program Waiver in order to maintain eligibility to receive Respite services.

APPENDIX D

CMHO HEALTH HOME SERVICES DEFINED

Comprehensive Care Management Services

Comprehensive care management services are conducted with high need individuals, their families and supporters to develop and implement a whole-person oriented treatment plan and monitor the individual's success in engaging in treatment and supports. Comprehensive care management services are carried out through use of a bio-psychosocial assessment.

A bio-psychosocial assessment of each individual's physical and psychological status and social functioning is conducted for each person evaluated for admission to the CMHO. Assessments may be conducted by a psychiatrist, registered nurse or a licensed and/or master's prepared mental health professional (consistent with the Rhode Island Rules and Regulations for the Licensing of Behavioral Healthcare Organizations). The assessment determines an individual's treatment needs and expectations of the individual served; the type and level of treatment to be provided, the need for specialized medical or psychological evaluations; the need for the participation of the family or other support persons; and identification of the he staff person (s) and/or program to provide the treatment. Based on the bio-psychosocial assessment, a goal-oriented, person centered care plan is developed, implemented and monitored by a multi-disciplinary team in conjunction with the individual served.

Care Coordination

Care coordination is the implementation of the individualized treatment plan (with active involvement of the individual served) for attainment of the individuals' goals and improvement of chronic conditions. Care managers are responsible for conducting care coordination activities across providers and settings. Care coordination involves case management necessary for individuals to access medical, social, vocational, educational, as well as other individualized supportive services, including, but not limited to:

- Assessing support and service needed to ensure the continuing availability of required services;
- Assistance in accessing necessary health care; and follow up care and planning for any recommendations
- Assessment of housing status and providing assistance in accessing and maintaining safe and affordable housing;
- Conducting outreach to family members and significant others in order to maintain individuals' connection to services; and expand social network
- Assisting in locating and effectively utilizing all necessary community services in the medical, social, legal and behavioral health care areas and ensuring that all services are coordinated; and
- Coordinating with other providers to monitor individuals' health status, medical conditions, medications and side effects.

Health Promotion Services

promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health. Health promotion services may be provided by any member of the CMHO health home team.

Health promotion activities place a strong emphasis on self-direction and skills development for monitoring and management of chronic health conditions. Health promotion assists individuals to take a self-directed approach to health through the provision of health education. Specific health promotion services may include, but are not limited to, providing or coordinating assistance with:

- Promoting individuals' health and ensuring that all personal health goals are included in person centered care plans;
- Promotion of substance abuse prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and increased physical activity;
- Providing health education to individuals and family members about chronic conditions;
- Providing prevention education to individuals and family members about health screening and immunizations;
- Providing self-management support and development of self-management plans and/or relapse prevention plans so that individuals can attain personal health goals; and
- Promoting self direction and skill development in the area of independent administering of medication.

Comprehensive Transitional Care Services

Comprehensive transitional care services focus on the transition of individuals from any medical, psychiatric, long-term care or other out-of-home setting into a community setting. Designated members of the health team work closely with the individual to transition the individual smoothly back into the community and share information with the discharging organization in order to prevent any gaps in treatment that could result in a re-admission.

To facilitate timely and effective transitions from inpatient and long-term settings to the community, all health home providers will maintain collaborative relationships with hospital emergency departments, psychiatric units of local hospitals, long-term care and other applicable settings. In addition, all health home providers will utilize hospital liaisons to assist in the discharge planning of individuals, existing CMHO clients and new referrals, from inpatient settings to CMHOs. Care coordination may also occur when transitioning an individual from a jail/prison setting into the community.

Hospital liaisons, community support professionals and other designated members of the team of may provide transitional care services. The team member collaborates with physicians, nurses, social workers, discharge planners and pharmacists within the hospital setting to ensure that a treatment plan has been developed and works with family members and community providers to ensure that the treatment plan is communicated, adhered to and modified as appropriate.

Individual and Family Support Services

Individual and family support services are provided by community support professionals and other members of the health team to reduce barriers to individuals' care coordination, increase skills and engagement and improve health outcomes. Individual and family support services may include, but are not limited to:

- Providing assistance in accessing needed self-help and peer support services;
- Advocacy for individuals and families;
- Assisting individuals identify and develop social support networks;
- Assistance with medication and treatment management and adherence;
- Identifying resources that will help individuals and their families reduce barriers to their highest level of health and success; and
- - Connection to peer advocacy groups, wellness centers, NAMI and Family Psycho educational programs.
- Any member of the CMHO health home team may provide individual and family support services.

Referrals to Community and Socials Support Services

Referral to community and social support services provide individuals with referrals to a wide array of support services that will help individuals overcome access or service barriers, increase self-management skills and improve overall health. Referral to community and social support involves facilitating access to support and assistance for individuals to address medical, behavioral, educational, social and community issues that may impact overall health. The types of community and social support services to which individuals will be referred may include, but are not limited to:

- Primary care providers and specialists
- Wellness programs, including smoking cessation, fitness, weight loss programs, yoga
- Specialized support groups (i.e. cancer, diabetes support groups)
- Substance treatment links in addition to treatment - supporting recovery with links to support groups, recovery coaches, 12-step
- Housing
- Social integration (NAMI support groups, MHCA OASIS, Alive Program (this program and MHCA are Advocacy and Social Centers) Anchor Recovery Center
- Assistance with the identification and attainment of other benefits
- Supplemental Nutrition Assistance Program (SNAP)
- Connection with the Office of Rehabilitation Service as well as internal CMHO team to assist person in developing work/education goals and then identifying programs/jobs
- Assisting person in their social integration and social skill building
- Faith based organizations
- Access to employment and educational program or training
- Any member of the CMHO health home team may provide referral to community and social support services.