Health Homes and Individuals with Behavioral Health Issues SAMHSA's Guidance Document Affordable Care Act Health Home Provision [Sec. 2703 & Sec. 19459(e)]

From SAMHSA's consultations regarding 2703, it is clear that States are at different stages of preparing and planning their State Plan Amendments. To that end, attached is a guidance document for States as they consider taking advantage of 2703 for people with behavioral health (i.e., mental health and substance abuse, MH/SA) disorders. The document serves as a checklist of key behavioral health questions organized according to the Health Home Service components involved in Section 2703. These components are: comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, and referral to community and social services, with health information technology used to support these services. By providing states this structured background regarding the core elements of the 2703 health home, we aim to ensure that key behavioral health topics are considered as States develop health home proposals.   This document serves solely as guidance for entities thinking about health homes, and is not meant to be prescriptive or regulatory. The intended audiences for this document are those involved in developing the State Plan Amendment for 2703, although SAMHSA believes this will be useful to health home providers and others interested in health homes.

GENERAL QUESTIONS

- What is/are the target chronic condition(s) of your health home proposal?

- How will individuals be identified and referred to health homes? How will individuals not connected to either the primary care or behavioral health care system be informed and referred to your health home program?

- Describe the flow (visually or by narrative) depicting how clients will move in, through, and out of your health home program.

- What measures will be used to screen and intervene for behavioral health disorders?

    o Alcohol abuse and/or dependence

    o Drug abuse/dependence

    o Tobacco use/dependence

    o Depression and suicide risk

- Do you anticipate policy and reimbursement barriers regarding the establishment of health homes for individuals with behavioral health conditions (e.g. same day billing issues)?

SERVICE COMPONENTS (N=6)

A. Comprehensive Care Management

- How will your health home providers outreach to, plan, and communicate with other primary and specialty care providers regarding a patient's care?

- How will your health home providers develop an individualized treatment plan, informed by the patient, which integrates care across varied care systems (i.e. mental health, substance use, primary care, etc.)?

- How will your health home providers clarify and communicate the patient's preferences to all involved providers while assuring timely delivery of services?

- Composition of Your Health Home Team

  - What credentials or core competencies are recommended and/or required for health home team members serving individuals with a behavioral health condition? How are health care professionals identified as team members who can treat individuals with chronic illnesses (including MH/SA)? What are the functions of these team members?

  - What are the behavioral health workforce needs of your health home providers?

  - Will individuals in recovery from MH/SA be a part of your health home team approach?

B. Care Coordination and Health Promotion

- What are the linkages established between primary and behavioral health care providers? How will you promote care coordination among your participating health home agencies and other providers within their network (e.g., respite providers)?

- How will information be shared with other agencies patients are referred to? How will records be transferred out of the system if a patient leaves the health home?

- Will your health home providers use an agreed upon shared continuity of care record or similar vehicle? Will this be part of their medical record system?

- What specific mechanisms has your health home team established with community (e.g., YMCA) and specialty care providers? Are there formal mechanisms, such as "Memoranda of Understanding" or network alliances that link those in a specific locale?

- Do you have a shared consent form among providers? How will you manage the exchange of consent information?

- How will you educate patients on their consent options and implications of information sharing?

- How do you define health promotion in the context of your health home providers' activities?

C. Comprehensive Transitional Care (including follow-up from inpatient to other settings)
- What processes will be in place so all Medicaid provider hospitals identify and refer clients to a health home provider?

- How do you propose to ensure planning between levels of care (e.g., hospital to health home)? How will information be shared and updated between levels of care (e.g., how will discharge information be transferred from hospitals or nursing facilities to your health home providers)?

- How will you know how many individuals treated by your Health Home providers have been re-hospitalized within the last thirty days? How will you know how many have seen a primary or specialty care provider within thirty days of hospital discharge?

- Will there be mechanisms to involve health home providers with discharge planning from the hospital? Do your hospitals screen for MH/SA prior to discharge for those in or moving into health homes?

- How will your health home providers communicate and educate patients and caregivers about the transition process? What tools will health home providers use to engage patients in their care planning?

D. Patient and Family Support
- How are you defining patient and family support?

- What is the role, if any, of peers and individuals in recovery in providing patient and family support?

- How will your health home providers consider a patient-directed approach in treatment planning?

E. Referral to Community and Social Services (if relevant)
- How does the State ensure that health home providers make assessments and referral for community and recovery supports (e.g., housing, recovery support services, job training, employment placement, etc)?

- How will these referrals occur (e.g., electronically)? How will you track these referrals and the results? How will the receiving provider be notified about the referral?

Data and Health Information Technology to Link Services (as feasible and appropriate)
- What outcome data do you have/need?

- o What information/data currently exist across the systems?

- o What common information/data can be shared across the systems?

- o What information/data would constitute evidence for a successful intervention?

- Does your EHR generate a bill and can it record a payment? If not, how do you do your billing currently? How will you bill in the health home environment?

- What medical records systems are currently in use by health home providers? How will they interoperate within the health home environment?

- Are your health home provider electronic medical records systems interoperable with other agencies?

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