

Pace Car Rapid Learning Network Call Summary:

Ten Key Takeaways for Health Home Provider Identification and Outreach

The following information was gathered from the *Health Homes Pace Car Rapid Learning Network*, a call series for a small group of Medicaid programs leading the way in health home program development and implementation. The February 14, 2012 call featured Missouri and Rhode Island as the first two states to operate health home programs. The call captured the following 10 key lessons from their experiences to date specific to their health home provider network.

1. **Anticipate broad variation in provider capacity.** Recognize that the initial launch of a health home program and delivery of services may be uneven across the provider network depending on the skill set, capacities, and readiness of the individual health home providers. States that use a competitive application process may have less unevenness, versus states that contract with all eligible providers (e.g., all FQHCs, or all CMHCs) across the state.
2. **Recognize differences across provider types.** Understand that the gaps in capabilities for health home providers may differ across provider types. For example, a health home that is a patient-centered medical home may be well-versed in population management and the management of chronic conditions, but less familiar with strategies to address the social and non-medical needs of beneficiary (e.g., loss of Medicaid eligibility, transportation, housing, etc.). Similarly, on the behavioral health side, a health home provider that is a community mental health center may offer strong individual and family support and team-based care, but may not be as experienced with population and chronic disease management. To address these gaps, states can design learning collaboratives with separate tracks tailored to the unique needs of the different provider groups.
3. **Standardize a patient assessment approach.** Identify and select a common patient assessment tool that health home providers will use. It may be difficult to reach consensus across providers; however, it will be helpful in ensuring consistency across the program for the purposes of care management, reporting, tracking, outcomes, etc.
4. **Include providers early and meaningfully in design discussions.** Involve your health home provider network and provider trade associations in the development of health home program tools and reporting templates. Not only will their involvement provide a better idea of what information will be practical and valuable to collect, but the report development process will create an inherent “on the job training” for providers.
5. **Engage hospital partners to address care transitions.** It will be challenging, but critical to engage hospitals in the health home program. Transitional care is one of the core health home services and critical to cost reduction. Consider developing a joint letter from the hospital association and the Medicaid program requesting hospital support of the health homes program. This letter can also preempt any concerns hospitals may raise regarding sharing of information and HIPAA issues.
6. **Identify and engage a physician champion.** Engaging a committed physician partner can help facilitate discussions as you design and roll out your program. This individual can help increase provider engagement in the health home program. Other key stakeholders include provider trade

associations and consumer and family advocacy groups who will play a key role in the lives of many of the eligible beneficiaries.

7. **Gain consensus on clear policies to support information sharing.** Initially there will likely be resistance to sharing information and data on health home beneficiaries. It may be seen as intrusive or a breach of trust between a beneficiary and provider. Keep the health home team members -- primary care providers, behavioral health providers, health plans, etc. -- focused on the goal: having a well-informed health home leader at the heart of the care plan; supporting the patient and his/her family; and preventing negative outcomes for the patient. A well designed consent form for use across all health home providers is also critical.
8. **Devise strategies to reduce “burn out” for care managers.** The level and intensity of care management needed by health home beneficiaries may be unexpected and very challenging for providers. Health home teams may want to discuss realistic expectations as well as appropriate patient caseloads.
9. **Identify and address potential conflict of interest issues.** It is possible that some health home providers will be hospital-owned. This could raise concerns about referring patients from the emergency department to the hospital-owned health home/clinic. Consider establishing a formal memorandum of understanding (MOU) that can help address and eliminate these concerns.
10. **Define clear responsibilities for all stakeholders.** If the state is involving its health plans in its health home program, ensure there is a clear distinction between what services and activities are the responsibility of the health home provider and which reside with the plan. This division of labor can be confusing and is necessary to avoid duplication of services. A formal document that clarifies what party is responsible for what activities can be useful.