

PACT Service Array and Health Homes (HHs)

| PACT Component | Description / Example of Activities | Included in HH Rate | Health Home Component | Code |
|--|---|---------------------|---|--|
| Initial Screening | <ul style="list-style-type: none"> Screening to Determine Appropriateness of Admission | N | | T1023 |
| Assertive Outreach and Engagement | <ul style="list-style-type: none"> Persistence in efforts to reach out to consumers and help them actively engage in rehabilitation and recovery. | | Outreach and Engagement 3 x per year | G9001 |
| Initial Assessment and initial Plan | <ul style="list-style-type: none"> Initial Assessment (Intake) and Initial Treatment Plan, per OAC 317:30-5-241.5 (a)(5)(A)(1). Content requirements found at 450:55-5-4. (See also 42 CFR 485.914). | N | | H0039 This code will have to be billed for the <i>DAY OF ADMISSION</i> to PACT and <i>PRIOR TO ENROLLMENT</i> in HH. Once enrolled, this code is no longer active, |
| <p>Comprehensive assessment (CA). The CA is the organized process of gathering and analyzing current and past information with each consumer and the family and/or support system and other significant people in the individual's social network. The multidisciplinary team gathers data pertaining to its specialty on the PACT team. (See requirements at 450-55-5-5 and 450: 450:55-25-12 for HH. Since PACT admission supersedes the PACT-HH enrollment, the documentation requirements at 450:55-5-5 should be followed.</p> | | | | |
| Comprehensive Assessment and Plan | (1) Psychiatric Dx Assessment | N | | 90791; 90792 |
| | (2) Medical, Dental and Other Health Assessment by RN; or LPN under supervision of RN or Physician | Y | Comprehensive Care Management | H0039 |
| | (3) Extent and effect of any violence within the consumer's living situation(s) or personal relationships; | Y | | |
| | (4) The current version of the Alcohol Severity Index (ASI) within the first 6 weeks of admission and as clinically indicated thereafter; | Y | | |
| | (5) Education and Employment; | Y | | |
| | (6) Social development and functioning by a team professional as approved by the team leader; | Y | | |
| | (7) Activities of daily living, to be completed by the team professional or Recovery Support specialist under the supervision of the team leader; | Y | | |
| | (8) Family structure and relationships by a team professional as approved by the team leader; and | Y | | |
| | (9) Historical Timeline | Y | | |
| • Comprehensive Person Centered/ Integrated Plan | Y | | | |
| Case Management (1) (Face to Face) | <ul style="list-style-type: none"> Review of Person Centered Plan, F2F Team Meetings, F2F Accompanying consumers to scheduled medical appointments | Y Y Y Y | Care Coordination | H0039 |

* Any team member that was previously eligible to bill H0039 prior to HH implementation can bill H0039 for a HH enrollee.

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| Case Management (2) (Non Face to Face) | Non-Clinical Services | | Care Coordination | T1016 |
| | • Ongoing/Update of Assessments (F2F when appropriate) | Y | | |
| | • Review of Person Centered Plan, NF2F | Y | Referral to Community and Social Supports | |
| | • Team Meetings, NF2F | Y | | |
| | • Coordination with family service agencies | Y | | |
| | • Arranging for Transportation | Y | | |
| | • Monitoring and follow-up activities with treatment or service providers (including Intra-agency) for the purposes of monitoring consumer attendance of scheduled physician/medication, therapy, rehabilitation, or other supportive service appointments; | Y | | |
| | • Making appointment reminders | Y | | |
| | Clinical Services | | | T2022 |
| | • Monitoring of individual and population health status and service use to determine adherence to or variance from best practice guidelines; | Y | | |
| • Development and dissemination of reports that indicate progress toward meeting outcomes for consumer satisfaction, health status, service delivery and costs | Y | | | |
| • Performing medication reconciliation and overseeing the consumer's self-management of medications; | Y | | | |
| • Monitoring the consumer's condition (physical, mental, social); | Y | | | |
| • Psychiatric Consultation; | Y | | | |
| • PCP consultation on best practice protocol | Y | | | |
| Case Management (3) (F2F/NF2F) | <ul style="list-style-type: none"> Transitional Case Management Developing and maintaining contractual and data sharing agreements, policies, procedures, that support and define roles for effective collaboration with the health home and its local network (primary care, specialists, behavioral health providers, hospitals) (may be LBHP) | Y | Comprehensive Transitional Care/Follow-up | T1016 T2022 Non-productive time that is included in rate and does not count toward required min. |
| Work opportunities (1) | Help to find volunteer and vocational opportunities | Y | Referral to Community and Social Supports | H0039 |
| Work opportunities (2) | <ul style="list-style-type: none"> Provide liaison with and educate employers Serve as job coach for consumers | N | | Supported Employment State Only |
| Entitlements | <ul style="list-style-type: none"> Assist with documentation Manage food stamps Assist with redetermination of benefits | Y Y Y | Referral to Community and Social Supports | H0039 |

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|---|---|---------------------|---|--|
| Health Promotion (1) | <ul style="list-style-type: none"> • Provide preventive health education • Schedule maintenance visits • Provide liaison for acute medical care • Provide reproductive counseling and sex education • Wellness Coaching (Individual and group) | Y | Health Promotion | H0039 T1012 |
| | | Y | | |
| | | Y | | |
| | | Y | | |
| | | Y | | |
| Health Promotion (2) | <u>Conduct Medical Screening for general health with priority for high-risk conditions</u> <ul style="list-style-type: none"> • Provide Preventive Health screens recommended by USPSTF; • Screening, monitoring and intervening for metabolic syndrome and related care gaps | Y | Health Promotion | H0039 - Adults only Use appropriate CPT code for youth (18-20) and dual eligibles |
| Medication support | <ul style="list-style-type: none"> • Order medications from pharmacy (not payment to pharmacy) • Deliver medications /Medication Reminder • Provide education about medication • Monitor medication compliance and side effects • Administration of Oral Injections | Y | Individual and Family Support | H0039 S5185 H0034 T1502 |
| | | Y | | |
| | | Y | | |
| | | Y | | |
| | | Y | | |
| Housing Assistance (1) | <ul style="list-style-type: none"> • Find suitable shelter • Develop relationships with landlords • Financial management • Troubleshoot financial problems (for example, disability payments) | Y | Referral to Community and Social Supports | H0039 |
| | | Y | | |
| | | Y | | |
| | | Y | | |
| Housing Assistance (2) | <ul style="list-style-type: none"> • Purchase and repair household items • Secure leases and pay rent • Assist with bills | N | | Supported Housing State Only |
| | | N | | |
| | | N | | |
| Counseling (LBHP) | <ul style="list-style-type: none"> • Use problem-oriented approach • Integrate counseling into continuous work • Ensure that goals are addressed by all team members • Promote communication skills development • Provide counseling as part of comprehensive rehabilitative approach | N | | H0036 H0036 H0036 H0036 H0036 H0036 |
| | | N | | |
| | | N | | |
| | | N | | |
| | | N | | |
| | | N | | |
| Crisis Intervention | <ul style="list-style-type: none"> • Crisis management, Face to Face • Crisis Diversion, Telephone • Crisis Stabilization (Residential) | N | Care Coordination | H0036 H0039 |
| | | Y | | |
| | | N | | |
| Rehabilitative approach to daily living skills | <ul style="list-style-type: none"> • Grocery shopping and cooking • Purchase of clothing • Care of clothing • Use of transportation • Help with social and family relationships • Family involvement • Counseling and psychoeducation with family and extended family • Improve housekeeping skills (not doing chores) • Plan budget • Increase independence in money management | N | | H0036 State Only H0036 H0036 H0036 H0036 H0036 H0036 H0036 H0036 |
| | | N | | |
| | | N | | |
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| | | N | | |
| Transportation | <ul style="list-style-type: none"> • Patient Non-Emergency Transportation • Time spent conducting outreach without successfully finding an enrolled consumer (services outside the G9001); • Time spent driving to do a home visit when the consumer is not home; • Travel time to and from meetings for the purpose of development or implementation of the individual care plan; • Accompanying consumers to entitlement offices | N | Non-Productive Time included in rate | SoonerRide S0215 S0215 S0215 S0215 |
| | | Y | | |
| | | Y | | |
| | | Y | | |
| | | Y | | |

** Any qualified team member can bill H0036 w/in scope of practice