

SOONERCARE Health Homes

A strategy to build a system of care to improve health, enhance access and quality and control costs for members with SMI or SED

Oklahoma Department of Mental Health
and Substance Abuse Services





What Is A Health Home?

- ❖ A place where individuals can come throughout their lifetimes to have their health care needs identified and to receive the medical, behavioral and social supports they need, coordinated in a way that recognizes all of their needs as an individual, not just patients.

Why Coordinated Care Matters

- ❖ People with SMI die 25 years earlier than individuals in the general population, mostly for medical reasons rather than suicide or accidental death.

Reasons For Early Death:

Problems Related Directly to Mental Illness*

- Amotivation
- Cognitive Limitations
- Poverty
- Lack of Self-Advocacy Skills

**A Randomized Trial of Medical Care Management for Community Mental Health Settings. American Journal of Psychiatry, Druss, et al, (2010).*

Reasons For Early Death: Service System Factors

❖ Physicians

- ❖ Lack of knowledge or comfort with people with chronic mental disorders
- ❖ Clinical demands that make it difficult to address multiple comorbidities

❖ Mental Health Professionals

- ❖ Lack of knowledge or comfort regarding medical issues
- ❖ Lack of time and resources to address health concerns in busy practices

Why Health Homes For Children?

- ❖ Limited coordination between primary medical and behavioral health specialty care
- ❖ Significant number of children in child welfare receiving psychotropic medications with no coordinated system of care to monitor appropriate utilization.
- ❖ Lack of time in primary care setting to spend 1-2 hours with family

Required Health Home Activities

- ❖ Provide comprehensive care management;
- ❖ Provide care coordination;
- ❖ Provide health promotion;
- ❖ Coordinate transitional care from inpatient to other settings
- ❖ Refer and link to community supports;
- ❖ Provide individual and family support;
- ❖ Use health information technology to link services.

Wagner, E.H. (2000). The role of patient care teams in chronic disease management. *British Medical Journal*.

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. *British Medical Journal*.



In Partnership

In Oklahoma, Health Homes will integrate physical health and behavioral health

Health Homes

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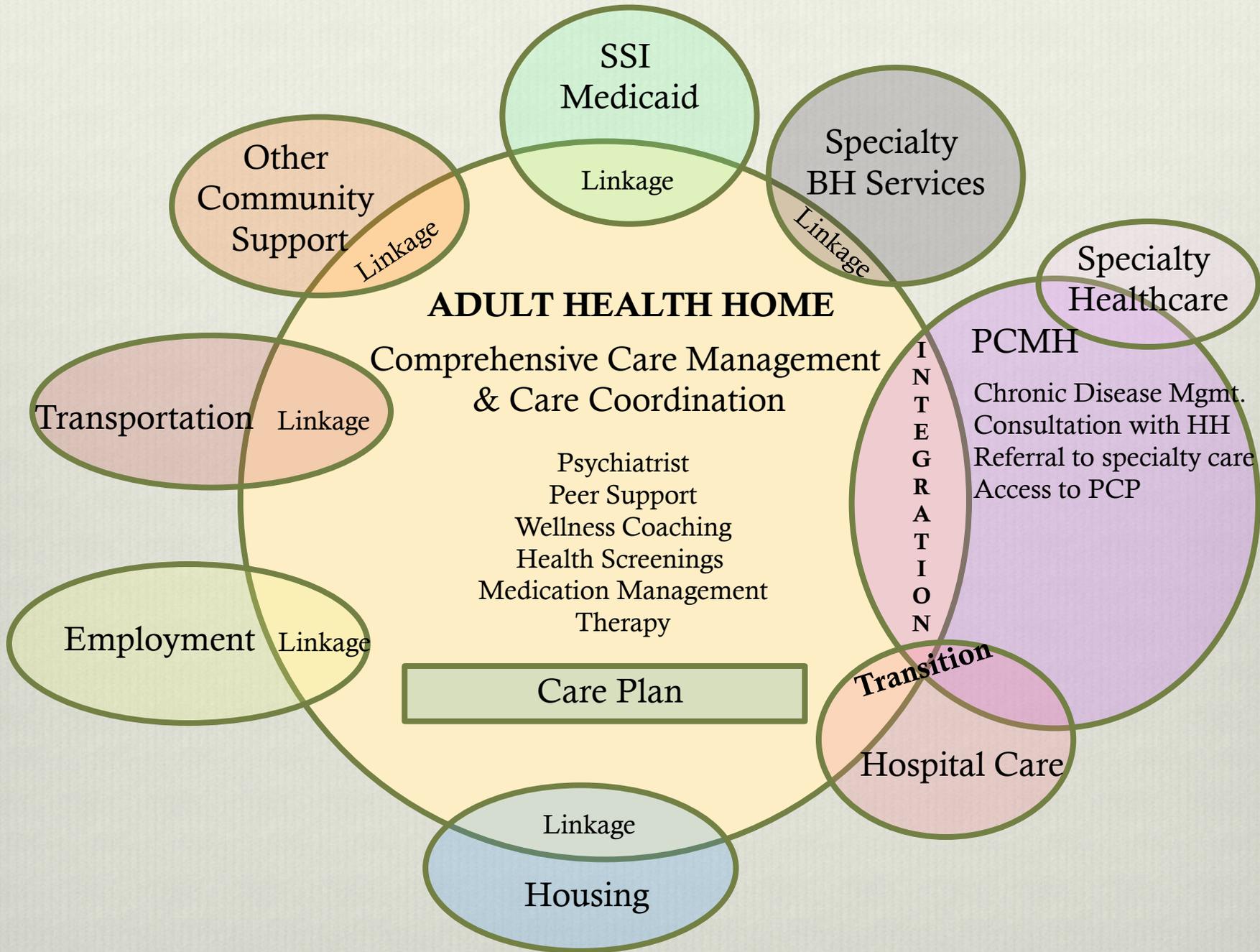
Outpatient Behavioral Health Agency

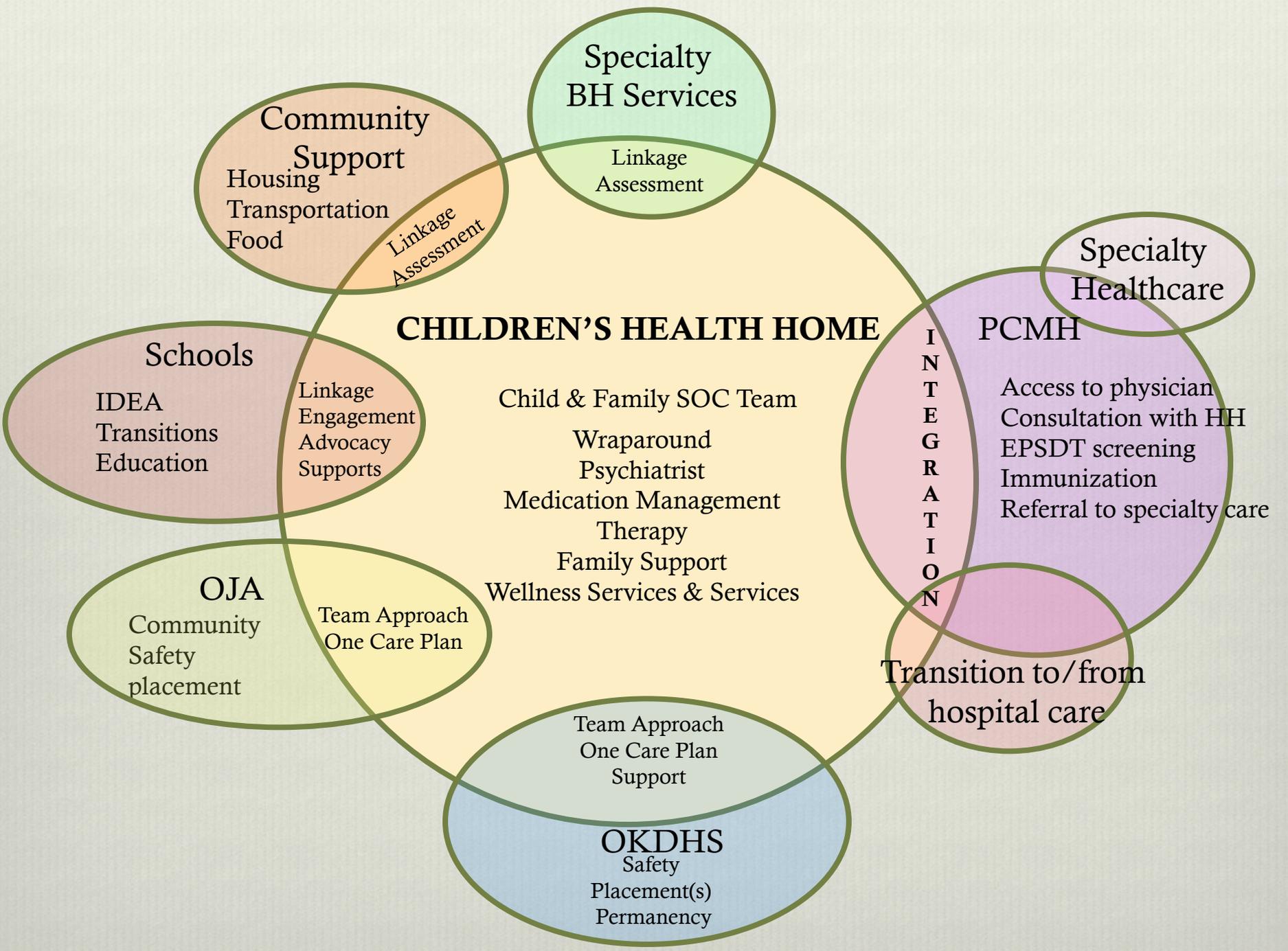
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Primary Care Physicians

The Health Home Team

- ❖ An interdisciplinary team
- ❖ Person/Family Centered process
- ❖ Identifies strengths and needs
- ❖ Creates a unified plan
- ❖ Empowers persons towards self-management
- ❖ Coordinates the varied healthcare needs





Specialty
BH Services

Linkage
Assessment

Community
Support
Housing
Transportation
Food

Linkage
Assessment

Specialty
Healthcare

CHILDREN'S HEALTH HOME

PCMH

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Child & Family SOC Team
Wraparound
Psychiatrist
Medication Management
Therapy
Family Support
Wellness Services & Services

Access to physician
Consultation with HH
EPSDT screening
Immunization
Referral to specialty care

Schools
IDEA
Transitions
Education

Linkage
Engagement
Advocacy
Supports

OJA
Community
Safety
placement

Team Approach
One Care Plan

Transition to/from
hospital care

Team Approach
One Care Plan
Support

OKDHS
Safety
Placement(s)
Permanency

Health Home Team Members

Adults



Child and Family Team

Physician Team Member

HH Director

Licensed Nurse Care Manager

Behavioral Health Case Manager

Wellness Coach/Peer Specialist

Consulting Psychiatrist

Physician Team Member

Licensed Nurse Care Manager

Behavioral Health Care Coordinator

Family Support Provider

Consulting Psychiatrist

Role of Physician Team Member

- ❖ Coordinates and cooperates with HH Case Manager and/or Nurse Care Manager in development of integrated care plan
- ❖ Consults with CMHC on-site HH psychiatrists as needed;
- ❖ Supplies post visit follow-up and relays information back to HH;
- ❖ Maintains a system to track referrals;
- ❖ Coordinates the delivery of medical care services with all specialists, case manager and other medical providers;
- ❖ Educates members on appropriately using medical resources such as emergency rooms.

Role of Physician Team Member

(PCMH, FQHC, IHS, PCP)

Requirements for Children

- ❖ Educates regarding the importance of immunizations and screenings, child physical and emotional development;
- ❖ Links each child with screening in accordance with the EPSDT periodicity schedule;
- ❖ Identifies children in need of immediate or intensive care management for physical health needs;
- ❖ Provides opportunities and activities for promoting wellness and preventing illness, including the prevention of chronic physical health conditions; and
- ❖ Assist HH care manager in developing wellness goals to be included in the comprehensive care plan.

Auto-Enrollment

- ❖ OHCA will attribute to Health Homes, SoonerCare members with a qualifying SMI/SED designation and notify members via US mail service. Message will include:
 - ❖ a brief description of Health Home services;
 - ❖ a description of individuals' options to choose another Health Home;
 - ❖ a process to opt out of enrollment in a HH; and
 - ❖ encouragement to continue any existing relationship with their primary care provider (PCP).

Questions??

❖ Contact Information

❖ For PCMH Questions/Comments:

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