Ohio | Department of Job and Family Services

John R. Kasich, Governor
Michael B. Colbert, Director

December 23, 2011

Barbara Edwards, Director
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Blvd, Mail Stop S2-14-26
Baltimore, MD 21244-1850

Dear Ms. Edwards:

The Ohio Department of Job and Family Services (ODJFS) is pleased to submit a draft Medicaid State Plan Amendment (SPA) template for Health Home Services for individuals with Serious and Persistent Mental Illness (SPMI). The draft SPA template represents a six-month collaborative effort between ODJFS, the Ohio Department of Mental Health (ODMH) and the Governor's Office of Health Transformation. We look forward to discussing our proposed program design, target population and integrated/bi-directional services approach for community behavioral health centers (CBHCs) who will serve as designated providers for beneficiaries with SPMI.

In recognition of the considerable efforts of our many statewide partners we have included as a separate attachment a list of all stakeholder organizations who have been involved in the development and planning of the CBHC health home model.

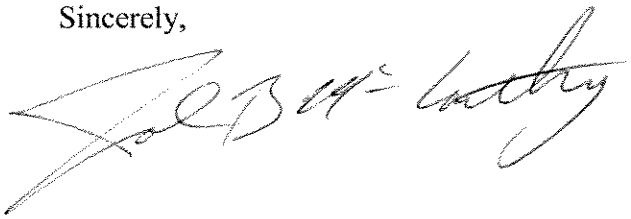
Please note that ODJFS and ODMH will continue to refine program design elements in order to formulate a reimbursement methodology, establish payment levels and develop a cost savings methodology and related assumptions. To that end, we look forward to your feedback and request a preliminary discussion with you and the CMS Health Home team in January about our proposal.

We are targeting the week of January 23rd but will work with your staff to confirm a specific date and time. In preparation for that meeting, ODJFS and ODMH staff may develop and submit specific questions to you prior to our scheduled call.

Please direct questions regarding this draft PA to Andy Jones or Lynne Lyon in the Bureau of Policy & Health Plan Services. Andy can be reached at (614) 752-4611 or andy.jones@jfs.ohio.gov. Lynne can be reached at (614) 752-5044 or lynne.lyon@jfs.ohio.gov.

Thank you for your ongoing assistance as we pursue this important initiative.

Sincerely,



John B. McCarthy, State Medicaid Director

Enclosures:
DRAFT Ohio Community Behavioral Health Center (CBHC) Health Home SPA Template
Participant Organizations for Ohio Community Behavioral Health Center Health Home Project, Fall/Winter 2012

Cc: Verlon Johnson, CMS Associate Regional Administrator
Cc: Heather Brown-Palsgrove, CMS Ohio State Program Representative
Cc: Mary Pat Farkas, Disabled and Elderly Health Programs Group, CMS
Cc: Tracy J. Plouck, Director, Ohio Department of Mental Health
Cc: Andy Jones, Bureau of Policy & Health Plan Services
Cc: Lynne Lyon, Bureau of Policy & Health Plan Services

Ohio Community Behavioral Health Center (CBHC) Health Home SPA Template

See Attached Client Process Narrative

DRAFT for Discussion Purposes Only: Last Updated on December 23, 2011

Community Mental Health Organization - Health Home Description	
Geographic Area (Describe whether statewide or targeted)	Health home services will be provided by eligible community behavioral health centers (CBHCs) in targeted geographic areas.
Population Criteria	The State will establish Medicaid health homes for beneficiaries who meet the State's definition of serious and persistent mental illness (which includes adults with serious mental illness [SMI] and children with serious emotional disturbance [SED]), initially using a regional approach. Ohio's CBHCs will be eligible to apply to become Medicaid health homes for Medicaid beneficiaries with SPMI. The goals of Ohio's CBHC health homes for those with SPMI are aligned to those of CMS: improve the integration of physical and behavioral health care; lower rates of hospital emergency department (ED) use; reduce hospital admissions and re-admissions; reduce healthcare costs; decrease reliance on long-term care facilities; improve the experience of care, quality of life and consumer satisfaction and improve health outcomes. In addition, we expect to achieve better care coordination and management of health conditions as well as increase the use of preventive and wellness management services. SPMI beneficiaries who currently receive services at the CBHC health home will be assigned to the CBHC health home and notified in advance of the assignment [by U.S. mail and other appropriate methods] about their choice of receiving health home services from any qualified CBHC health home provider in the region as well as instructions about opting-out of CBHC health home services. SPMI beneficiaries not connected to a CBHC health home but who are identified as potentially benefiting from CBHC health home services (i.e., Medicaid managed care plan members not receiving CMHC services, individuals referred from a hospital emergency department, inpatient setting, etc.) will be referred to the CBHC health home of their choice for an assessment and potential enrollment in CBHC health home program. Referrals for CBHC health home services will be based on an analysis of Medicaid claims and encounter data which will enable the State to identify, by region, beneficiaries with SPMI who currently receive services at a CBHC as well as those whose diagnoses and utilization pattern indicate a need for CBHC health home services. Beneficiaries who do not indicate a preference will be referred to the CBHC in their geographic area. Notifications to beneficiaries will describe beneficiaries 'choice in selecting a health home as well as a brief description of health home services and describe the process for individuals to opt-out of receiving health home services from the assigned or referred health home provider. Individuals who have been auto-assigned to a CBHC health home will have the choice to opt out of receiving treatment services from the assigned health home provider. There is no requirement that clients receive ongoing treatment at the CBHC health home once referred for care management, coordination and related services to manage chronic conditions. Rather, the CBHC health home must establish a relationship with the client's preferred CBHC mental health treatment and rehabilitative services provider to coordinate care. The CBHC health home will notify other treatment providers (e.g., primary care, substance abuse and other specialist such as OB/GYN) about the goals and services available through the CBHC health home as well as encourage participation in care coordination efforts.
Provider Infrastructure (Indicate whether designated providers, team of health care professionals or health team)	Community behavioral health centers will serve as designated providers for individuals with SPMI and deliver services through a team of health care professionals. CBHCs will be required to meet state-defined qualifying core elements that assure coordination of comprehensive medical, behavioral, long-term care and social services that are timely, quality and integrated. CBHC health homes will be required to demonstrate the integration of behavioral health and primary care services by directly providing - or establishing written agreements with primary care practices that will provide - a minimum level of medical screening and treatment services to be determined by the State. CBHC health homes will be required to establish written agreements with primary care practices that support

Community Mental Health Organization - Health Home Description	
	bidirectional, integrated care. In addition, CBHC health homes are required to establish partnerships and coordinate with other health care resources to address identified client needs, which include, but are not limited to: hospitals, medical service providers, specialists (including OB/GYNs and substance abuse treatment specialists), long-term care service and support providers, managed care plans and other providers as appropriate to meet beneficiaries' needs. Each CBHC health home must establish a core team of health care professionals led by a dedicated Care Manager who will coordinate and facilitate beneficiaries' access to services in accordance with a single, integrated plan. The CBHC must also identify other health care team members necessary to meet whole-person needs as beneficiaries' circumstances dictate. While the composition of the team of health care professionals is flexible and is expected to change as the needs of the health home beneficiary change over time, the core team provides consistency and continuity of care for the SPMI beneficiary. Medical leadership is essential to systematically implement standards of quality care. Clinical personnel with experience in Patient Centered Medical Home transformation bring the expertise of change improvement science (e.g., IHI's Breakthrough Series Model) to drive enhanced system performance leading to improved clinical outcomes. To that end, the Embedded Primary Care Clinician is integral to the success and demonstration of integrated care in CBHC health homes. The Embedded Primary Clinician assesses, monitors and consults on the routine, preventive, acute and chronic physical health care needs of clients. Core CBHC health home team members and roles: - **Health Home Team Leader**: Provides administrative and clinical leadership and oversight to the health home team and monitors provision of health home services. A key function of the Team Leader is to be the champion for health home services and motivate and educate other staff members. The Health Home Team Leader must demonstrate a strong health management background and an understanding of practice management, data management, and managed care. The Health Home Team Leader must also have training and experience in quality improvement. The Health Home Team Leader will monitor and facilitate clinical processes and components of Health Homes, which include but are not limited to: consumer identification and engagement; completion of comprehensive health and risk assessments; development of care plans; scheduling and facilitation of treatment team meetings; provision of health home services; monitoring consumer status and response to health coordination and prevention activities; and development, tracking and dissemination of outcomes. The additional clinical and administrative duties will include hiring and training of the staff, providing feedback regarding staff performance, conducting performance evaluations, giving direction to staff regarding individual cases, and monitoring overall team performance and plan for improvement. - **Embedded Primary care Clinician**: Participates in the provision of health home services including identification of consumers, assessment of service needs, care plan development, development of treatment guidelines, and monitoring of health status and service use. The Embedded Primary Care Clinician will provide education and consultation to the health home team and other team members regarding best practices and treatment guidelines in screening and management of physical health conditions as well as engage with, and act as a liaison between, the treating primary care provider and the team. The Embedded Primary Care Clinician will also meet with Care Managers individually to review challenging and complex cases as needed. The Embedded Primary Care Clinician role can be conducted by any of the following professionals: primary care physicians, pediatricians, gynecologists, obstetricians, Certified Nurse Practitioners with a primary care scope of practice and Physician Assistants. It is strongly preferred that the Embedded Primary Care Clinician also functions as the treating primary care clinician whenever possible and may hold dual roles on the health home team.

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	- **Care Manager**: Is accountable for overall care management and care coordination and able to both provide and coordinate all health home services. A single care management record will be agreed to and shared by all team professionals and case reviews will be conducted on a regular basis. The Care Manager will be responsible for overall management and coordination of the beneficiary's care plan which will include both medical/behavioral health (including substance abuse) and social service needs and goals. Care Managers can utilize Care Manager Aids in the provision of some components of health home services. Care Managers must have the necessary credentials and skills to be able to conduct comprehensive assessments and treatment planning. Care Managers will have formal training as well as practical experience in behavioral health and possess core and specialty competencies and skills in working with SPMI population. Care Managers also need to demonstrate either formal training or a strong knowledge base in chronic physical health issues and physical health needs of the SPMI population and must be able to function as a member of an inter-disciplinary team. Finally, Care Managers must be knowledgeable and experienced in community resources and social support services for the SPMI population. - **Care Manager Aide**: Assists and supports Care Managers with care coordination, referral/linkage, follow-up, family/consumer support and health promotion services and may include Peer Support Specialists as well as other health professionals or credentialed personnel with commensurate experience. CBHCs will be supported in transforming service delivery by participating in statewide learning activities. Given CBHCs' varying levels of experience with organizational change and clinical best practice implementation, the State will assess providers to determine learning needs. CBHCs will therefore participate in a variety of learning supports, up to and including learning collaboratives, specifically designed to instruct CBHCs to provide health home services using a whole person approach that integrates behavioral health, primary care and other needed services and supports. Learning activities may be supplemented with ongoing health home team calls to reinforce the learning sessions, technical assistance, and periodic program reporting (data and narrative) and feedback. Learning activities will support providers of health home services in addressing the following components: - Providing quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services; - Coordinating and provide access to high-quality health care services informed by evidence-based clinical practice guidelines; - Coordinating and providing access to preventive and health promotion services, including prevention of mental illness and substance use disorders; - Coordinating and providing access to mental health and substance abuse services; - Coordinating and providing access to comprehensive care management, care coordination, and transitional care across settings (transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care); - Coordinating and providing access to chronic disease management, including self-management support to individuals and their families; - Coordinating and providing access to individual and family supports, including referral to community, social support, and recovery services; - Coordinating and providing access to long-term care supports and services; - Developing a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services; - Demonstrating a capacity to use health information technology to link services, facilitate communication among team members

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	and between the health home team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate, and; - Establishing a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.	
Health Home Services		
Comprehensive Care Management	**Service Definition**	**Ways HIT Will Link**
	Comprehensive care management begins with the identification of individuals who are potentially eligible to receive health home services. The CBHC health home will be responsible for identifying individuals with severe and persistent mental illness who are currently affiliated with the site. SPMI individuals without a CBHC affiliation or a routine source of care may be identified through a referral from another provider or an administrative data review and connected to a CBHC health home to begin the comprehensive care management process. The next step is for the CBHC to engage the eligible individual and his/her family by explaining the benefits of participating in, and receiving, health home services and the right to opt-out of health home services. The CBHC health home will complete a comprehensive assessment of the individual's physical health, behavioral health (i.e., mental health, substance abuse disorders) and social needs. The assessment must account for the cultural and linguistic needs of the individual and use relevant comprehensive data from a variety of sources, including the individual/family, caregivers, medical records, team of health professional, etc. At a minimum, the CBHC health home will reassess the individual at least once every ninety days. Based on the health assessment, the CBHC health home will form a team of health professionals, and establish and negotiate roles and responsibilities for each member of the team, including the accountable point of contact. The CBHC health home will develop and continuously update a single, integrated, person-centered care plan that will include prioritized goals and actions with anticipated timeframes for completion and will reflect the individual's preferences. Prior to implementation of the care plan, a communication plan must also be developed in order to ensure that routine information exchange (clinical patient summaries, medication profiles, updates on patient progress toward meeting goals), collaboration, and communication occurs between the team members, providers, and the individual/family. The CBHC health home will frequently and routinely monitor the care plan to determine adherence to treatment guidelines and medication regimes, barriers to care, or any clinical issues that may impact the individual's health status or progress in achieving the goals and outcomes outlined in the care plan. As part of the monitoring, the CBHC and team of health professionals are expected to adhere to the communication plan when providing updates and reports on the	The State will phase-in use of HIT to support the delivery of CBHC health home services. In recognition of the varying levels of HIT (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and real-time notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. Within twelve months of receiving designation as a Health Home provider, the CBHC must acquire (or adopt) an electronic health record product that is certified by the Office of the National Coordination for Health Information Technology. Within twenty-four months of receiving designation as a health home provider, the CBHC must demonstrate that the electronic health record is used to support all health home services, including population management. The CBHC health home will also be

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	individual. The Health Home Team Leader, the Embedded Primary Care Clinician, and the Care Manager will participate in the comprehensive care management activities and comprehensive care management service components will be delegated among the health home team members as follow: The health home Team Leader will be responsible for initially screening all new referrals or auto-enrollees, tracking and facilitating transfer/transition of new cases on to the health home team. The Team Leader will also be responsible for reviewing the list of new cases with the entire team during regular team meetings and assigning each health home enrollee to a designated Care Manager and Care Manager Aid based on the individual's preferences, needs and staff availability. The other team members can also help identify and facilitate transition of new cases to the team in collaboration with the Team Leader. A licensed clinician Care Manager will be responsible for a specific caseload, complete the standardized health risk assessment, the comprehensive health assessment and the care plan including a crisis plan with input from other team members. The Care Manager will support and engage individual and family in the assessment process and the development of care plan including prioritization of goals. The Embedded Primary Care Clinician will be responsible for reviewing the assessment and health data and formulating goals/interventions for physical health care to be included in the care plan. The Care Manager will provide specific interventions for managing chronic diseases identified in the assessment and care plan under the supervision of the Team Leader and in consultation with the primary care clinician. The Team Leader will review and monitor timeliness and quality of assessments and care plans, and ensure that health home enrollees receive comprehensive care management service. The Team Leader and Embedded Primary Care Clinician may also complete some components of comprehensive assessments and care plans and provide specific care management interventions.	required to participate in the statewide Health Information Exchange, when available in their region. Following auto-assignment of beneficiaries into health homes and as part of initial Comprehensive Care Management activities, CBHCs will receive health utilization profiles on health home beneficiaries. CBHC health homes will also be required to develop internal processes in order to act on and disseminate the data and demonstrate how data will be utilized to continue ongoing Comprehensive Care Management services. Utilization profiles may be supplied to the CBHC health home no less than quarterly.
Care Coordination	**Service Definition**	**Ways HIT Will Link**
	Care coordination is the implementation of the single, integrated care plan. With a person-centered focus, the CBHC will facilitate and direct the coordination, communication, and collaboration that is necessary for the individual to demonstrate progress on the goals/actions of the care plan and achieve optimal health outcomes. This will include, but not be limited to, the following: providing assistance to the consumer in obtaining health care (i.e., primary and specialty medical care, mental health, substance abuse services and developmental disabilities services, and ancillary services and supports); performing medication management and reconciliation; tracking tests and referrals with necessary follow up; sharing the crisis plan, assisting with and coordinating prevention, management and stabilization of crises and ensuring post-crisis follow-up care is arranged and received; participating in discharge planning; and making referrals to community, social and recovery supports. The CBHC health home will be required to assist the individual with making appointments and validating that the services were	The State will phase-in use of HIT to support the delivery of CBHC health home services. In recognition of the varying levels of HIT (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis,

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	received by the individuals. Although care coordination requires participation of all health home team members in implementation of the care plan, the Care Manager will have the lead care coordinator role across all providers and settings. The Embedded Primary Care Clinician may have a lead role for the coordination of physical health care needs and communication with the treating primary care clinician and medical specialists as appropriate. The Team Leader will take the lead for developing general care coordination and communication protocols for use with external and internal providers. The Team Leader will also serve as the universal point of contact and care coordinator for all consumers on the team and be the back-up for the Care Manager and Care Manager Aid. The Care Manager will utilize Care Manager Aids in coordinating some aspects of the care plan such as referrals to specialists, implementation of discharge plan, accessing housing and other community resources, and obtaining entitlements. The Care Manager will also need to coordinate with other team members such as the nurse on medication management and reconciliation, tracking of labs and results of consults.	medication profiles, etc.) and real-time notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. Within twelve months of receiving designation as a Health Home provider, the CBHC must acquire (or adopt) an electronic health record product that is certified by the Office of the National Coordination for Health Information Technology. Within twenty-four months of receiving designation as a health home provider, the CBHC must demonstrate that the electronic health record is used to support all health home services, including population management. The CBHC health home will also be required to participate in the statewide Health Information Exchange, when available in their region. In the delivery of Care Coordination services, all CBHC health homes will be required to use utilization data and other information to develop /update the integrated care plan, establish relationships with treatment providers (e.g., hospital, LTC, Rx), share information with other providers to facilitate their treatment of clients, conduct medication management and reconciliation, connect clients with necessary social supports, utilize lab portals to retrieve or develop auto-generated letters that notify PCPs of

Community Mental Health Organization - Health Home Description		
		lab values. CBHC health homes will also be required to develop and utilize tracking systems (e.g., track women who are recommended to have a mammogram) to identify delivered and needed services that links to the Care Management plan. In addition, CBHC health home must have the ability to take patient summary info and place it in formats that are useful for the client. If available, develop a unified care plan electronically. If the client chooses not to receive primary care services at the CBHC health home site, then the CBHC must demonstrate how primary care is integrated at the CBHC site.
Health Promotion	**Service Definition**	**Ways HIT Will Link**
	Health promotion services are intended to equip the individual/family with knowledge and skills that will: increase his/her understanding of diseases/conditions identified in the assessment, promote self-management, and improve quality of life and daily functioning. This may be accomplished through the following examples: education about wellness and healthy lifestyle choices; referrals to evidence based wellness programs, such as Tobacco Cessation, Weight Management, Chronic Disease Management Programs, Wellness Management and Recovery, etc.; and connections to peer supports. A focus of health promotion will be to support and engage the individual and the family in development, implementation and monitoring of the care plan. By empowering the individual and promoting self-advocacy, there will be an increased ability to be proactive in the management of existing conditions, the increased utilization of preventative services, and accessing care in appropriate settings. Health promotion can be provided by any member of the health home team. The Care Manager, as the accountable point of contact has the lead responsibility for providing or arranging for health promotion services based on the identified needs in the assessment and goals in the care plan. All members of the team will be able to educate clients and families regarding the primary condition and chronic diseases and teach self-management skills. The Embedded Primary Care Clinician will provide education on physical health and preventive care as needed. Other health promotion services such as tobacco cessation and treatment will be	The State will phase-in use of HIT to support the delivery of CBHC health home services. In recognition of the varying levels of HIT (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and real-time notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. Within twelve months of receiving designation as a Health Home provider, the CBHC must

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	provided by a Care Manager or Care Manager Aid with TTS certification. Care Managers and Care Manager Aids with peer background will co-lead Chronic Disease Self-Management Programs (CDSMP), Wellness Management and Recovery (WMR), and Wellness Recovery Action Plans (WRAP) groups. The Team Leader will have the responsibility for reviewing patient data and developing health promotion programming and resources with input from the team. The Team Leader will also provide direct training or arrange ongoing in-service training for Care Managers and Care Manager Aids in evidence-based health promotion interventions and monitor provision of health promotion services.	acquire (or adopt) an electronic health record product that is certified by the Office of the National Coordination for Health Information Technology. Within twenty-four months of receiving designation as a health home provider, the CBHC must demonstrate that the electronic health record is used to support all health home services, including population management. The CBHC health home will also be required to participate in the statewide Health Information Exchange, when available in their region. HIT supports for Health Promotion involves CBHCs use of electronically received health utilization profiles that connect clients with necessary social supports via phone, fax or web- based commensurate with providers capacity and referral source requirements.
Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)	**Service Definition**	**Ways HIT Will Link**
	Comprehensive transitional care services are designed to ensure continuity of care and prevent unnecessary inpatient readmissions, emergency department visits and/or other adverse outcomes, such as homelessness. The CBHC health home will develop arrangements with inpatient facilities, emergency departments and residential facilities for prompt notification of an individual's admission and/or discharge to/from a hospital emergency department, inpatient unit or residential facility. The CBHC health home will coordinate and collaborate with inpatient facilities, hospital emergency departments, residential facilities and community partners to ensure that a comprehensive discharge plan and/or transition plan, and timely and appropriate follow up is completed for an individual who is transitioning to/from different levels and settings of care. The CBHC health home will conduct and/or facilitate effective clinical hand offs that include timely access to follow-up post discharge care in the appropriate setting, timely receipt and transmission of a transition/discharge plan from the discharging entity, and medication	The State will phase-in use of HIT to support the delivery of CBHC health home services. In recognition of the varying levels of HIT (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis,

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	reconciliation. The Care Manager will be the accountable team member for providing comprehensive transitional care service including the development and coordination of a discharge and transition plan. However, other members of the health home team will provide input in the development and assist with the implementation of the discharge and transition plan. The Care Manager is responsible for exchanging or facilitating exchange of medical records such as the care plan, crisis plan, list of current medications, the most recent psychiatrist note and any other medical documents necessary to facilitate continuity of care during a crisis, hospitalization, incarceration or admission to a residential program. Hospital treatment team meetings will be attended by the Care Manager whenever possible or another team member if the Care Manager is not available. Care Manager Aids will assist with physical discharge process, assisting the client with returning home and community and linking the client to follow-up appointments. The Care Manager will review the discharge records including after-care plan and medications, update care plan accordingly, coordinate with other team members including family, psychiatrist, the hospital liaison worker, nurse and pharmacist and re-engage and re-orient the consumer to the community-based care. The Team Leader will track team clients in crisis, hospitalized or incarcerated, conduct case reviews, review discharge/transition plans, monitor warm hand-off and smooth transition of clients back to community.	medication profiles, etc.) and real-time notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. Within twelve months of receiving designation as a Health Home provider, the CBHC must acquire (or adopt) an electronic health record product that is certified by the Office of the National Coordination for Health Information Technology. Within twenty-four months of receiving designation as a health home provider, the CBHC must demonstrate that the electronic health record is used to support all health home services, including population management. The CBHC health home will also be required to participate in the statewide Health Information Exchange, when available in their region. HIT supports for Comprehensive Transitional Care involve CBHCs use of electronically received health utilization profiles, which notify CBHC health home as soon about inpatient hospital admissions. The State will explore the development of health home designation on the Medicaid eligibility card as well as updates to the online eligibility portal to facilitate timely transition of care.
Individual and Family Support Services	**Service Definition**	**Ways HIT Will Link**
	Individual and family support services include, but are not limited to, the following: providing expanded access and availability of services along with continuity in relationships between the	The State will phase-in use of HIT to support the delivery of CBHC health

Community Mental Health Organization - Health Home Description		
	individual/family, provider(s), and the Care Manager; supporting the delivery of person centered care; performing outreach and advocacy for the individual/family to identify and obtain needed resources (e.g., transportation); educating the individual on self-management techniques; providing opportunities for the individual/family to participate in the assessment and care plan development/implementation, including providing access to electronic health records or other clinical information; and making referrals to community/social/recovery supports. Health home services will also be delivered in a manner that takes into account the individual's and family's preferences and is culturally and linguistically appropriate. Individuals and their families will be integral to the quality improvement process by providing feedback on experience/satisfaction of care through surveys or by participating in patient/family advisory councils. Individual and family supports will be provided by all members of the team. Clients will be served by a constant core team to assure continuity of relationship and support. CBHC health home sites are expected to provide expanded and enhanced access to staff and services for support and client-centered care. Provision of peer support will be provided by the Care Manager Aid with peer specialist qualification. Care Managers and Care Manager Aids will also assist and link clients to natural supports, advocacy organizations, and support or self-help groups in their communities.	home services. In recognition of the varying levels of HIT (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and real-time notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. Within twelve months of receiving designation as a Health Home provider, the CBHC must acquire (or adopt) an electronic health record product that is certified by the Office of the National Coordination for Health Information Technology. Within twenty-four months of receiving designation as a health home provider, the CBHC must demonstrate that the electronic health record is used to support all health home services, including population management. The CBHC health home will also be required to participate in the statewide Health Information Exchange, when available in their region. HIT supports for Individual & Family Support Services will involve CBHCs use of electronically received health utilization profiles that, auto-generate communications sent to

Community Mental Health Organization - Health Home Description		
		patients and family members of next appointment and establishment of a "tickler" system (e.g., e-mail, postcard, phone call) to remind clients to schedule routine exam (dental exam, vision checks, medical test such as lab work, physical exam, mammogram, etc.). CBHCs will also be encouraged to develop internet capacity for information about wellness, promotional information, and supports access to services.
Referral to Community and Social Support Services	**Service Definition**	**Ways HIT Will Link**
	The CBHC health home will offer and/or arrange for onsite and offsite community and social support services through effective collaborations with social service agencies and community partners. The CBHC health home will identify and provide referrals to community, social, or recovery support services such as maintaining eligibility for benefits, obtaining legal assistance, and housing. The CBHC health home will assist the consumer in making appointments; validate the service was received; and complete any follow up as necessary. Care Managers will be responsible for identifying non-clinical services and needs that require referrals to community and social supports during the comprehensive assessment with input from individual and family and other team members. However, Care Manager Aids will largely initiate referrals to community resources and social supports, assist with the completion of paperwork, ensure that needed services, resources and supports are acquired and provide status reports and updates to the team. The Team Leader will monitor team's referral process for community and social supports identify/compile community resources and assist with complex cases.	The State will phase-in use of HIT to support the delivery of CBHC health home services. In recognition of the varying levels of HIT (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and real-time notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. Within twelve months of receiving designation as a Health Home provider, the CBHC must acquire (or adopt) an electronic health record product that is certified by the Office of the National Coordination for Health Information Technology. Within twenty-four months of receiving designation as a

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		health home provider, the CBHC must demonstrate that the electronic health record is used to support all health home services, including population management. The CBHC health home will also be required to participate in the statewide Health Information Exchange, when available in their region. HIT supports for Referral to Community & Social Support Services will involve CBHCs use of electronically received health utilization profiles that connect clients with necessary social supports via phone, fax or web- based commensurate with providers capacity and referral source requirements.

Provider Standards

Each CBHC health home meet state defined core elements in order to qualify as a provider of health home services for individuals with SPMI. Unless otherwise indicated, CBHCs must meet the following minimum requirements prior to providing health home services:

a. Be certified by the Ohio Department of Mental Health as eligible to provide Medicaid covered community mental health services. This certification includes achieving accreditation from any of the following national organizations: The Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or The Council on Accreditation for Children and Family Services.
b. Provide all of the following health home services as necessary and appropriate for beneficiaries: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family supports, and referral to community and social support services.
c. Demonstrate integration of physical and behavioral health by:
    i. Achieving one of the following certifications within 18 months of becoming a CBHC health home provider: 1) the CARF's Integrated Physical Health/Behavioral Health Core Program; or 2) the Joint Commissions' Physical Health Standards module; or 3) the National Committee for Quality Assurance recognition as a Patient Centered Medical Home (Level 1); or 4) equivalent recognition standards as approved by the State; and
    ii. Directly providing – or establishing written agreements with primary care practices that will provide – a minimum level of medical screening and treatment services to be determined by the State;
    iii. Establishing written agreements with primary care practices that support bidirectional, integrated care and include minimum components as specified by the State;

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and

iv. Establishing effective partnerships and referral/coordination processes with specialty providers, hospital emergency departments and inpatient facilities that support the delivery of health home services.

d. Support the delivery of person-centered care by providing:
   i. Expanded, timely access to health care services, preventive/health promotion services and mental health and substance abuse services;
   ii. Orientation of the patient to health home services;
   iii. Services that are delivered to the patient/family in a culturally and linguistically appropriate manner;
   iv. A multi-disciplinary team based approach for the delivery of Health Home services through the continual use of an established team of core members defined by the state, and optional members that are appropriate for the patient's needs;
   v. A single, integrated, person-centered care plan that coordinates all of the clinical and non-clinical needs;
   vi. The ability to track tests and referrals for health care services, and coordinate follow up care as needed; and
   vii. Point of care reminders for patients about services needed for preventive care and/or management of chronic conditions by using patient information and clinical data.
e. Have the capacity to receive electronic data from a variety of sources to facilitate care management, care coordination, and comprehensive transitional care. This includes, at a minimum, clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and real-time notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility.
f. Maintain a comprehensive and continuous quality improvement program capable of collecting and reporting data on utilization and health outcomes, and the ability to report to the State or its designee.
g. Participate in the Medicaid Health Homes Learning Collaborative.
h. Serve as a current eligible provider in the Ohio Medicaid Program.
i. Enter into a contract with the administrator of the Health Homes program in the designated service area.
j. Have the capacity to serve all Medicaid individuals who are eligible to receive health home services in the designated service area.

The State will use national accreditation/certification standards, existing Ohio Administrative Code requirements, and state specified criteria to determine if a CBHC meets the aforementioned minimum requirements.

Assurances	
The State assures that hospitals participating in the State plan or waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.	Yes
The State has consulted and coordinated with the Substance	Yes

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Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.	
The State will report to CMS information submitted by health home providers to inform the evaluation and Report to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.	Yes
Monitoring	
Describe the State's methodology for tracking avoidable hospital readmissions to include data sources and measure specifications.	The State continues to explore the most appropriate methods for tracking avoidable hospital admissions and readmissions.
Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measures specifications.	The state is continuing the design and development of its cost savings methodology.
Describe the State's proposal for using health information technology in providing health home services under this program and improving services delivery and coordination across the care continuum (including the use of wireless patient technology to	The State will phase-in use of HIT to support the delivery of CBHC health home services. In recognition of the varying levels of HIT (i.e., electronic medical records, registries, etc.) utilized by CBHC health homes, the State will initially require that CBHC health homes are able to receive utilization data electronically from a variety of sources. The data will, at a minimum, include clinical patient summaries (e.g., diagnosis, medication profiles, etc.) and real-time notifications of a patient's admission to, or discharge from, an emergency department or inpatient facility. Within twelve months of receiving designation as a Health Home provider, the CBHC must acquire (or adopt) an electronic health record product that is certified by the Office of the National Coordination for Health Information Technology. Within twenty-four months of receiving designation as a health home provider, the CBHC must demonstrate that the electronic health record is used to support all health home services, including population management. The CBHC health home will also be required to participate in the statewide Health Information Exchange, when available in their region.

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improve coordination and management of care and patient adherence to recommendations made by their provider).	Following auto-assignment of beneficiaries into health homes and as part of initial Comprehensive Care Management activities, CBHC health homes will receive health utilization profiles on health home beneficiaries. CBHC health homes will also be required to develop internal processes in order to act on and disseminate the data and demonstrate how data will be utilized to continue ongoing Comprehensive Care Management services. Utilization profiles may be supplied to the CBHC health home no less than quarterly. In the delivery of Care Coordination services, all CBHC health homes will be required to use utilization data and information supplied by the State to develop /update the integrated care plan, establish relationships with treatment providers (e.g., hospital, LTC, Rx), share information with other providers to facilitate their treatment of clients, conduct medication management and reconciliation, connect clients with necessary social supports, utilize lab portals to retrieve or develop auto-generated letters that notify PCPs of lab values. CBHC health homes will also be required to develop and utilize tracking systems (e.g., track women who are recommended to have a mammogram) to identify delivered and needed services that links to Care Management Plan. In addition, the CBHC health home must have the ability to take patient summary info and place it in formats that are useful for the client. If available, develop a unified care plan electronically. If the client chooses not to receive primary care services at the CBHC health home site, then the CBHC must demonstrate how primary care is integrated at the CBHC site. HIT supports for Health Promotion involves CBHCs use of electronically received health utilization profiles that connect clients with necessary social supports via phone, fax or web- based commensurate with providers capacity and referral source requirements. HIT supports for Comprehensive Transitional Care involve CBHCs use of electronically received health utilization profiles from the State, which notify CBHC health home as soon about inpatient hospital admissions. The State will explore the development of health home designation on the Medicaid eligibility card as well as updates to the online eligibility portal to facilitate timely transition of care. HIT supports for Individual & Family Support Services will involve CBHCs use of electronically received health utilization profiles that, auto-generates communications sent to patients and family members of next appointment and establishment of a "tickler" system (e.g., e-mail, postcard, phone call) to remind clients to schedule routine exam (dental exam, vision checks, medical test such as lab work, physical exam, mammogram, etc.). CBHCs will also be encouraged to develop internet capacity for information about wellness, promotional information, and supports access to services. HIT supports for Referral to Community & Social Support Services will involve CBHCs use of electronically received health utilization profiles that connect clients with necessary social supports via phone, fax or web- based commensurate with providers capacity and referral source requirements.

Quality Measures – The seven CMS-required core measures are highlighted below in gray. Remaining measures were identified by the State as important for assessing overall CBHC health home program objectives. The State acknowledges CMS' interest in measurable goals and will utilize the first year of CBHC health home implementation to establish a baseline. The State is interested in options to maintain flexibility to update optional measures without amending the SPA each time a change is necessitated.

Goal #1 – Improve Cardiovascular Care	Measure	Data Source	Measure Specification	How HIT will be Utilized
Clinical Outcomes	IVD: Cholesterol Mgmt.-LDL-C Screening, LDL Control (<100	Claims	Numerator: 1) Screening – LDL-C test performed during the measurement	To be developed.

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	mg/dL) (18 - 75 years)		year. 2) Control – most recent LDL-C level during the measurement year is <100 md/dL Denominator: members 18 -75 who were1) discharged alive for AMI, CABG or PCI in Jan-Nov of the year prior to the measurement year, or 2) diagnosed with IVD who had at least 1 outpatient visit or on acute IP encounter during both the measurement year and the prior year.	
	Controlling High Blood Pressure (Patients with Hypertension <140/90) (18 - 85 years)	Claims, EMR	Numerator: Members whose most recent BP is adequately controlled (<140/90) during the measurement year. Denominator: Members 18-85 years of age with a diagnosis of hypertension appearing in the medical record prior to June 30 of the measurement year.	To be developed.
Experience of Care	NA	NA	NA	NA
Quality of Care	NA	NA	NA	NA
Goal #2 - Improve Care Coordination	**Measure**	**Data Source**	**Measure Specification**	**How HIT will be Utilized**
Clinical Outcomes	NA	NA	NA	
Experience of Care	Satisfaction with care, accessibility of care	MHSIP Survey	Numerator: Total number of patients indicating that they agree or strongly agree with each the following statements: - The location of services was convenient. - Staff were willing to see me as often as I felt it was necessary. - Staff returned my call within 24 hours. - Services were available at times that were good for me.	To be developed.

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			- I was able to get all the services I thought I needed. - I was able to see a psychiatrist when I wanted to. - I like the services I received here. - If I had other choices, I would still get services from this agency. - I would recommend this agency to a friend or family member. Denominator: Total number of patients completing each item on the MHSIP survey	
Quality of Care	Timely Transmission of Transition Record to Healthcare Professional: discharged to home or other facility, w/in 24 hours of discharge (for IP facility discharges)	Claims, EMR	Numerator: Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge Denominator: All patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care	To be developed.
	Medication Reconciliation Post-Discharge (MRP)	Claims	Numerator: Patients (age 65 and older) or their caregiver(s) who received a reconciled medication list at the time of discharge. Denominator: All patients, regardless of age, discharged from an inpatient facility to home/self-care or any other site of care	To be developed.
Goal #3 – Improve diabetes care	**Measure**	**Data Source**	**Measure Specification**	**How HIT will be Utilized**
Clinical Outcomes	Comprehensive Diabetes Care:	EMR	Numerator: Members whose most	To be developed.

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	HbA1c control < 8.0% (18-75 years)		recent HbA1c level (during the measurement year) is <8.0%. Denominator: Members identified as having diabetes during the measurement year or the year prior to the measurement year.	
	Diabetes: Cholesterol Mgmt.-LDL-C Screening, LDL Control (<100 mg/dL) (18 - 75 years)	Claims	Numerator: 1) Screening - Members with an LDL-C test during the measurement year. 2) Control – Members whose most recent LDL-C level (during the measurement year) is <100 md/dL. Denominator: Members identified as having diabetes during the measurement year or the year prior to the measurement year.	To be developed.
Experience of Care	NA	NA	NA	NA
Quality of Care	NA	NA	NA	NA
Goals #4 – Improve Care for Persons with Asthma	**Measure**	**Data Source**	**Measure Specification**	**How HIT will be Utilized**
Clinical Outcomes	Use of Appropriate Medications for People with Asthma (5-64)	Claims	Numerator: Members dispensed at least one prescription for a preferred therapy during the measurement year. Denominator: Members age 5 – 64 years identified as having persistent asthma during the measurement year and the year prior to the measurement year.	To be developed.
Experience of Care	NA	NA	NA	NA
Quality of Care	NA	NA	NA	NA

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Goal #5 – Improve Health Outcomes for Persons with Mental Illness	**Measure**	**Data Source**	**Measure Specification**	**How HIT will be Utilized**
Clinical Outcomes	Medication adherence to Antipsychotics, Antidepressants, and Mood Stabilizers: Medication Possession Ratio (MPR)	Claims	Numerator: Number of members on that class of medication in the past 90 days with medication possession ratios (MPR) > 80% Denominator: Number of all members on that class of medication in the past 90 days.	To be developed.
Experience of Care	Satisfaction with care, accessibility of care	MHSIP Survey	Numerator: Total number of patients indicating that they agree or strongly agree with each the following statements: - The location of services was convenient. - Staff were willing to see me as often as I felt it was necessary. - Staff returned my call within 24 hours. - Services were available at times that were good for me. - I was able to get all the services I thought I needed. - I was able to see a psychiatrist when I wanted to. - I like the services I received here. - If I had other choices, I would still get services from this agency. - I would recommend this agency to a friend or family member. Denominator: Total number of patients completing each item on the MHSIP survey	To be developed.
Quality of Care	Follow Up After Hospitalization for Mental Illness, 7-day - visit with	Claims	Numerator: An outpatient visit, intensive outpatient encounter, or	To be developed.

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	MH practitioner (6+ yrs) - Mental health: percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. http://qualitymeasures.ahrq.gov/content.aspx?id=14965		partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Denominator: Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year	
	Schizophrenia 2: Annual assessment of weight/BMI, glycemic control, lipids	Claims, EMR	Numerator: Total number of patients from the denominator who have had a documented measurement of BMI, glycemic control, and lipids during the measurement year. Denominator: All patients diagnosed with schizophrenia.	To be developed.
	Screening for Clinical Depression and Follow-up Plan - Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented	EMR	Numerator: Total number of patients from the denominator who have follow-up documentation Denominator: All patients 18 years and older screened for clinical depression using a standardized tool	To be developed.
	Bipolar Disorder - Annual assessment of weight/BMI, glycemic control, lipids	Claims, EMR	Numerator: Total number of patients from the denominator who have had a documented measurement of BMI, glycemic control, and lipids during the measurement year. Denominator: Total number of	To be developed.

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			patients with bipolar disorder.	
Goal #6 – Improve Preventive Care	**Measure**	**Data Source**	**Measure Specification**	**How HIT will be Utilized**
Clinical Outcomes	Percent of Live Births Weighing Less than 2,500 grams	Vital Statistics	Numerator: Number of live births less than 2,500 grams. Denominator: Number of live births to members during the measurement year.	To be developed.
Experience of Care	NA	NA	NA	NA
Quality of Care	Prenatal and Postpartum Care - Timeliness of Prenatal Care	Claims	Numerator: A prenatal visit in the first trimester or within 42 days of enrollment. Denominator: Members with a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year.	NA
	Adult BMI Assessment (18 - 74) - Percentage of members 18-74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year	Claims	Numerator: Body mass index documented during the measurement year or the year prior to the measurement year Denominator: Members 18-74 of age who had an outpatient visit	To be developed.
	Weight Assessment: child/adolescent document weight/BMI (3-17)	Claims	Numerator: Children who had evidence of Body Mass Index (BMI) documentation during the measurement year. Denominator: Children 3-17 years of age who had an outpatient visit with a PCP or OB-GYN during the measurement year.	To be developed.
	Adolescent Well-Care Visits (12- 21 years)	Claims	Numerator: Members with at least one comprehensive well-care visit	To be developed.

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			with a PCP or an OB/GYN practitioner during the measurement year. Denominator: Members age 12 -21 years as of December 31 of the measurement year.	
	Adults' Access to Preventive/Ambulatory Health Services (20 and older)	Claims	Numerator: One or more ambulatory or preventive care visits during the measurement year. Denominator: Members age 20-65 years as of December 31 of the measurement year.	To be developed.
	(Appropriate) Treatment for Children with Upper Respiratory Infections (3 mos. – 18 years)	Claims	Numerator: Members who were dispensed an antibiotic medication within a prescribed period before and after the outpatient or ED visit. Denominator: Members age 3 months to 18 years of age as of June 30 of the measurement year, who had an outpatient or ED visit with a diagnosis of URI during the same period.	To be developed.
	Annual Dental Visit (2-21 years)	Claims	Numerator: Members with one or more dental visits with a dental practitioner during the measurement year. Denominator: Members age 2- 21 years as of December 31st of the measurement year.	To be developed.
	Annual Dental Visit (> 21 years)	Claims	Numerator: Members with one or more dental visits with a dental practitioner during the measurement year. Denominator: Members age 22	To be developed.

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			years or older as of December 31st of the measurement year.	
Goal #7 – Reduce Substance Abuse	**Measure**	**Data Source**	**Measure Specification**	**How HIT will be Utilized**
	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment- Engagement of AOD Treatment (13 - 17/18+/Total) - Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following: - Initiation of AOD treatment. - Engagement of AOD treatment.	Claims, EMR	Numerator (Initiation) - Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis Numerator (Engagement) - Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. Denominator: Members 13 years of age and older as of December 31 of the measurement year with a new episode of alcohol or other drug (AOD) during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.	To be developed.

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	Smoking & Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Users to Quit, b. Discussing Cessation Medications, c. Discussing Cessation Strategies (18 years & older)	EMR	Numerator: 1) member received advice to quit smoking or using tobacco, 2) cessation medications were recommended to or discussed with member, 3) cessation strategies were recommended to or discussed with member. Denominator: Members who reach the age 18 or older during the measurement year and are current smokers or tobacco user, who had an outpatient encounter during the measurement year.	To be developed.
Goal #8 – Improve Appropriate Utilization / Site of Care	**Measure**	**Data Source**	**Measure Specification**	**How HIT will be Utilized**
Clinical Outcomes	Ambulatory Care Sensitive Condition Admission (under age 75) - Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years. http://www.guideline.gov/content.aspx?id=15067	Claims	Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years Denominator: Total mid-year population under age 75	To be developed.
	Inpatient & ED utilization - Mental Health, Substance Abuse, General/Acute	Claims	Numerator: Number of acute Inpatient (IP) discharges and emergency department (ED) visits (IP and ED measures reported separately). Denominator: Total number of members and member months for the measurement year.	To be developed.
	Plan - All Cause Readmission (18 and older) - For members 18 years of age and older, the number of	Claims	Numerator: Count the number of Index Hospital Stays with a readmission within 30 days for each	To be developed.

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	acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.		age, gender, and total combination Denominator: Count the number of Index Hospital Stays for each age, gender, and total combination	
Experience of Care	NA	NA	NA	NA
Quality of Care	NA	NA	NA	NA

Evaluations – Describe how the state will collect information from health home providers for the purpose of determining the effects of this program on reducing:			
Hospital Admissions	**Description**	**Data Source**	**Frequency of Data Collection**
	Use of HEDIS data inpatient general hospital/acute care, inpatient alcohol and other drug services, and inpatient mental health services discharges (IPU, IAD and MPT measures).	Claims	Annual
Emergency Room Visits	**Description**	**Data Source**	**Frequency of Data Collection**
	Use of HEDIS data for ED visits (part of ambulatory care (AMB) measure).	Claims	Annual
Skilled Nursing Facility Admissions	**Description**	**Data Source**	**Frequency of Data Collection**
	Use of HEDIS data codes for discharges for skilled nursing facility services (part of inpatient utilization – non-acute care (NON) measure).	Claims	Annual

Evaluations - Describe how the state will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program as it pertains to the following:	
Hospital Admission Rates	The State continues to explore whether to utilize claims and encounter data to either conduct an analysis of pre/post hospital admissions among CBHC health home users or perform an analysis to compare CBHC health home users versus non-users.
Chronic Disease Management	The State is working to identify the most appropriate methods to assess implementation of chronic disease management, with a special focus on comprehensive care management. The method may assess: - Documented self-management support goal setting with all beneficiaries identified by the practice site as high risk; - Health team clinical telephonic or face-to-face beneficiary follow-up within 2 days after hospitalization discharge; and - Whether the Care Manager is operating consistently with the requirements established by the State.
Coordination of Care for Individuals with Chronic	The State is working to identify the most appropriate methods to assess the provision of care coordination services for individuals with SPMI.

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Conditions	
Assessment of Program Implementation	The State is working to identify the most appropriate methods to assess program implementation of CBHC health home services.
Processes and Lessons Learned	The State is working to identify the most appropriate methods to document and report CBHC health home processes and lessons learned.
Assessment of Quality Improvements and Clinical Outcomes	The State is actively considering options for assessing quality process and outcome that will be tracked at both the State and CBHC health home levels.
Estimates of Cost Savings	The state is continuing to explore an approach for analyzing data to determine an estimate of cost savings.
Section 4.19B Reimbursement Methodology	CBHC health homes will be paid for health home services based on a monthly rate will be determined using a consistent, statewide methodology. The monthly rate will be developed based on historic claims costs for CPST as well as home health team composition and caseload. The uniform cost report should serve as the basis for determining costs associated with health home services. The CBHC must determine caseload size but will need to have the capacity to serve the demand in the specified region (county, board, zip code, etc.). Team composition can vary by provider but must be within core team requirements. Payment is contingent upon CBHC meeting core requirements set by the state. Additional factors that could be added to the monthly rate may include: payment for innovative ideas on how the CBHC intends to meet the EHR requirements; shared savings; growing workforce capacity and serving as a training site; exceeding benchmarks and outcome requirements; start-up costs related to equipment, IT, and enrollment & outreach functions. Payment for the health home will be terminated if requirements are not met. CBHC health home services will not result in any duplication of payment or services between Medicaid programs, services or benefits (i.e., managed care, other delivery systems including waivers, any future health homes and other state plan services).

Participant Organizations for Ohio Community Behavioral Health Center Health Home Project, Fall/Winter 2012

Associations	Providers	Payers	State/County Agencies	Hospitals	Advocacy	Others
National Association of Social Workers-Ohio Chapter	Shawnee Mental Health Center	CareSource	Fairfield County Children Services	Cleveland Clinic	The Center for Health Affairs	Positive Education Program
The Ohio Council of Behavioral Health and Family Services Providers	Greater Cincinnati Behavioral Health Services	Molina Healthcare	Franklin County Children Services	Ohio Hospital for Psychiatry	The Ohio Empowerment Coalition	The Village Network
Ohio Association of Child Caring Agencies (OACCA)	Center for Families and Children (CFC)		Richland County Children Services	Belmont Pines Hospital	NAMI-Ohio	The Ohio State University
Ohio Hospital Association	Harbor Behavioral Healthcare		Summit County Children Services		National Coalition for Mental Health Recovery	Center for Evidence-Based Practices at Case Western Reserve University
The Public Children Services Association of Ohio	Connections: Health. Wellness. Advocacy.		Clermont County Mental Health and Recovery Board			BeST Center at Northeast Ohio Medical University
Ohio Association of County Behavioral Health Authorities (OACBHA)	Beech Brook		The Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County			Health Foundation of Greater Cincinnati
Ohio Association for Community Health Centers	Community Support Services		The Fairfield County ADAMH Board			
	South Community Behavioral Healthcare		Hamilton County Mental Health & Recovery Services Board			
	Southeast, Inc.		Mental Health & Recovery Board of Union County			
	Zepf Center		The Alcohol, Drug and Mental Health Board of Franklin			

Associations	Providers	Payers	State/County Agencies	Hospitals	Advocacy	Others
			County			
	Butler Behavioral Health Services					
	Central Clinic at University of Cincinnati					
	Far West Center					