

## Health Home Flow

### Hypothetical Child Scenario

#### Child Background: Sammy SoonerCare

Sammy is a fifteen year old male with two younger siblings and a single mother, Sharon. He is five feet six inches tall and weighs 170 pounds. He was diagnosed two years ago with bipolar disorder, and since that time has also been diagnosed with Post-Traumatic Stress Disorder and Intermittent Explosive Disorder. He has been hospitalized four times in two years, with an additional four admissions to the Children's Crisis Center. He has gained 40 pounds in six months since being prescribed Olanzapine (Zyprexa). This weight gain has been accompanied by increased depression and increased suicidal ideation. He has lost interest in participating in sports. He recently beat up a boy after school for making fun of his weight, and is currently suspended from school. He has withdrawn from his usual social activities and tends to stay in his room and play video games for hours at a time. He was hospitalized two days ago after locking himself in his room with a knife and threatening to kill himself. This happened in the evening after he was suspended for fighting at school. His mother was in the process of grounding him when an argument ensued.

#### Engagement

*There are three possible pathways to engagement in this scenario. For purposes of this narrative, assume that Sammy was engaged through option 2.*

**Engagement Scenario #1)** After admission, Sammy is visited by John the Social Worker at the hospital to coordinate his follow-up care. John looks at the hospital's social work resource manual which indicates that children and youth with serious emotional disturbance may be referred to Metro Health Home if they need care coordination and care management services. This information is in the resource manual as a result of a MOU covering referral and transitions of care between General Hospital and Metro Health Home. The relationship between the hospital and Metro Health Home was established a year ago after education and outreach was performed by the Oklahoma Health Care Authority (OHCA) & Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) staff as well as Metro Health Home. With Sammy's and his mother's permission, John calls the Metro Health Home nurse care manager Nancy in an effort to ensure Sammy receives the continued care that he needs after discharge from the hospital. Tom, the care coordinator at Metro, visits Sammy in the hospital later that day to educate him on Health Homes and gives him and his mother the option to enroll in the Metro Health Home (which Sammy does). In a follow-up phone call, Nancy explains to Sammy and his mother that Metro HH will be involved in his discharge planning and that Tom, the care coordinator/case manager, will return to the hospital and begin the Wraparound process with Sammy and his mother. The Metro Health Home team will also begin to work with Sammy's mother for his transition back home, including engaging and putting together a child and family team and a safety plan for Sammy. Another step will be to schedule an appointment at Metro Health Home when they know his release

date, which will include a full intake after the nurse care manager's analysis of his last three years of health and mental health records.

Engagement Scenario #2) When the Medicaid Health Home initiative went live one month ago (prior to Sammy's hospitalization), Sammy was identified through claims data in the MMIS as experiencing Serious Emotional Disturbance (SED) and was auto-enrolled in the Metro Health Home since he resides in the Metro Health Home geographic catchment area. The HH had begun engagement attempts through outreach to Sammy and his mother. His mother had cancelled two appointments, stating that her work schedule was currently more demanding than usual, but an initial outreach visit was made

***Behind the Scenes-***

*Suzie was mailed an engagement letter by OHCA notifying her of Sammy's enrollment in the Metro HH. The letter includes a brief description of HH services, including a description of the Wraparound process, a description of the family's option to choose another HH, and a process to opt-out of enrollment in a HH as well as Metro's contact information. An engagement letter was also mailed by OHCA to Metro notifying them of Sammy's auto-enrollment. Since Sammy is aligned with a SoonerCare Choice PCP, the OHCA NCM also informed the PCP as well as the Health Access Network with which the PCP is affiliated, that Sammy is enrolled in the Metro HH, coordinating communication between the PCP, the HAN and the HH. The initial letters were followed up with phone calls from a care manager in OHCA's Population Care Management Unit to again notify Sammy and his mother and Metro HH of the enrollment. Since Sammy had been receiving outreach calls and visits through Metro prior to the go live date of HHs in Oklahoma, engagement and initiation of HH services went smoothly and quickly. The timeframe is such that Metro HH is well within the "case finding" group timeframe (two weeks from the date Sammy was auto-enrolled) and billing the HCPC codes.*

with the family by the family support provider, and Sammy and his mother subsequently indicated they did want HH services.

*Engagement Scenario #3) If Sammy were in the custody of Oklahoma Department of Human Services (OKDHS), OKDHS would staff children in their custody that are identified by OHCA as SED. Through an interagency agreement between the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), OHCA, and OKDHS, OKDHS and OHCA would utilize the agreed upon process to screen and refer children to HH. The agencies also have a process in place to monitor children who may need to opt out of HH.*

When Sammy arrived at the psychiatric hospital, he was triaged and his insurance coverage was verified. The hospital staff verified through the Recipient Eligibility Verification System (REVS) that Sammy is a SoonerCare member and the system also identifies that he is affiliated with a Metro Health Home. Sammy's mom also informed Tom that Sammy was affiliated with a Health Home. Per the MOU established between General Hospital and Metro Health Home, John, the social worker at the hospital, contacts Nancy NCM at Metro to let her know of Sammy's recent admission.

**Behind the Scenes-**

*Nancy logs into the OHCA Provider Portal to review and print Sammy's medical and behavioral health history over the past 3 years. The Provider Portal reports on all of Sammy's medications prescribed in the last 3 years. It also includes all clinical episodes of both inpatient and outpatient including date, provider, diagnosis and procedure. It also lets Nancy know that Sammy is aligned with a SoonerCare Choice PCP. Nancy contacts the Psychiatric Hospital and provides outpatient medication reconciliation to Sammy's nurse using the report generated from the Provider Portal and provides a copy of the report to the hospital to be used in treatment planning while Sammy is hospitalized.*

**Behind the Scenes-**

*Metro Health Home does not have an embedded physician consultant but does have a pre-existing relationship with Sammy's PCP. Nancy (NCM) initiates contact with the PCP to engage him to be a part of Sammy's Health Home team. The PCP agrees and already has a mutually agreeable MOU with Metro CMHC/HH. Metro CMHC/HH informs Sammy's PCP of his recent hospital admission.*

*If Metro Health Home had an embedded PCP which Sammy and his mother chose to utilize, the integration of mental health and health care would be seamless, but either way, there is coordination with the PCPs.*

The Provider Portal indicates that Sammy's mother has been regularly filling prescriptions for his antipsychotic and antidepressant medication. He has seen his PCP two times in the last 3

**Transition Coordination and Discharge Planning (after either Engagement Scenario):**

General Hospital notifies Nancy when Sammy is well enough for visitors. Tom, the care coordinator assigned goes to the hospital to visit Sammy and his mother. They discuss the family's culture, strengths and needs and begin a Strengths Needs and Culture Discovery (SNCD) on which to later build the outpatient care plan. They also set additional appointment times to develop a safety plan for after he returns home, and to identify potential child and family team members that will assist with the Wraparound process and development of the Care Plan. The Care Plan will determine the outpatient services and supports necessary in order to keep Sammy at home in his own community.

Meanwhile, Sally, the family support provider conducts engagement, educational and other supportive activities with Sammy's mother, siblings, and other natural supports. She is preparing them for success when Sammy returns home.

Nancy NCM calls Sammy's hospital unit nurse regularly to track Sammy's progress and to facilitate HH involvement in his discharge plan. Prior to his discharge, the hospital consults with Metro Health Home team on Sammy's discharge plan. Upon finalization, the hospital faxes Sammy's after-care plan to Nancy at Metro Health Home. Sammy is then discharged from the hospital.

### **Post Discharge Care Coordination & Follow-Up:**

Two days after discharge, Nancy calls Sammy and his mother to check on him and to make sure he has filled his prescriptions and is following his discharge plan. An appointment is set for the care coordinator and family support provider to visit the family at home to plan a smooth transition. Also, the initial medical aftercare appointment is set with the HH for the same afternoon as discharge. Meanwhile, the care coordinator contacts and ensures that all identified child and family team members are still willing and able to participate in the Wraparound process, and a meeting is set that includes Sammy (Note: The team has met while Sammy was in the hospital to identify strengths of the team and begin providing needed support to Sammy's mother and siblings).

The child and family team meet and develop the first HH Care Plan, which focuses on safety, reduction in depression and suicidal ideation, and includes a diet and exercise plan that Sammy embraces. The team also identifies baseball as an activity that makes Sammy feel better about himself. The wellness coach on the HH team was selected as a part of the child and family team and will work with Sammy on his wellness plan.

### **Medical Care Coordination & Health Promotion:**

The next week, Sammy's mother is scheduled to take him to Metro Health Home for his scheduled appointment (*he received a reminder phone call from the Health Home to keep the appointment the previous day*). *She calls the day before to notify Tom, the CC, that her car has broken down and she will not be able to bring Sammy to the appointment. Tom coordinates with Sally, the FSP to pick up Sammy and his mother for the appointment.* At this appointment, Sammy is given the usual comprehensive evaluation regarding his behavioral health. He also receives a health risk evaluation from Nancy that includes screening for BMI, blood pressure, cholesterol, triglycerides, and glucose intolerance. This information is entered into Sammy's EHR. Nancy notes the following healthcare problems by a combined review of his history obtained from the Provider Portal, health risk assessment and metabolic screening.

- Although Sammy is aligned with a PCP, he does not have an ongoing relationship with him.
- Sammy has experienced a rapid weight gain due partially to medication.
- Sammy has experienced a major depressive episode which resulted in his hospitalization.
- Sammy admits to smoking both cigarettes and pot when he can obtain them.
- Sammy is very resistant to dieting, but very upset with weight gain.
- Sammy's current medication regimen has not worked as well as hoped to control his bipolar disorder and explosive episodes.

### **Sammy's Initial Care Plan**

**Recovery Goal:** I will live a healthy life with no harm to myself or others.

**Outcome:** I will participate actively on my child and family team, and follow my safety and care plan.

**Health Home Action Plan:** A care coordinator/case manager will visit Sammy at least once weekly and child and family teams will take place at least once weekly. Aunt Sue will be available for Sammy to call on weeknights if he is having thoughts of harming himself or others, and his friend Tim will be available for him to call on weekends. His mother will be home by 9 in the evenings at the latest, and will be available if he needs to call her while she is at work or out.

**Recovery Goal:** I agree that it is important to stop smoking and lose weight and will attend the Metro Health Home teen smoking cessation support group once a week. I understand that smoking is not good for me and I need to try to quit.

**Outcome:** I also understand that this will be hard and need support from others. I also understand I need to exercise and eat healthy food. My mother will not smoke in front of me or allow me to smoke. I will work with my wellness coach to learn about exercise and nutrition.

**Health Home Action Plan:** Sammy's care coordinator will schedule time for the wellness coach to meet with Sammy to begin work on smoking cessation and weight. The wellness coach will work with Sammy to make healthier eating choices and to establish daily exercise, including baseball league. Medications will be reviewed.

**Recovery Goal:** I need to be in school.

**Outcome:** I will get back into school with the help of my mother, care coordinator and FSP.

**Health Home Action Plan:** The CC will set a meeting at school to negotiate terms.

### **Care Coordinator (Case Management):**

Tom, the care coordinator, arranges for the family support provider to provide transportation and support for Sammy and his mother to attend the appointment with his PCP. When the FSP arrives to pick them up, they are not ready and are having an argument. She is able to use the moment to teach some techniques for planning ahead for important appointments. She contacts Tom, who reschedules the appointment for the next week.

Tom, the Care Coordinator, calls Sammy and his mother the day before their appointment with the PCP and the FSP goes to their house at 1pm to accompany them to the 2pm appointment. Tom walks the PCP through the summary that was created from the report of Sammy's medical history generated from the Provider Portal. He also assists Sammy in sharing with the PCP the nurse care manager's health risk assessment, and Sammy's initial treatment plan. PCP examines Sammy. PCP amends Sammy's treatment plan as follows:

### PCPs Additions to Sammy's Treatment Plan

- ☑ Psychiatrist may want to consider switching Sammy's antipsychotic medication to one less likely to cause weight gain.
- ☑ The PCP agrees to implement more frequent metabolic monitoring protocols recommended by the ADA/APA and to work with the consulting psychiatric on gradually reducing medications dosages.

A 4-week follow-up appointment was made with the PCP, and an appointment was made with Sammy's psychiatrist to review current medications for possible changes. Sammy's mother was able to get him there without assistance. The psychiatrist discontinued Zyprexa and prescribed Geodon instead.

### **Improved Outcomes:**

Sammy lost 10 pounds during the three months of following his Care Plan, and reduced his smoking by half. He followed his safety plan and was able to avoid being sent to the Children's Crisis Center or the hospital. Medication dosage was reduced slightly.

Metro Health Home maintained the Wraparound level of support for Sammy for the following year, with reduced suicidal ideation and no self-harm attempts. Sammy did not go out of home for treatment, and reported reduced depression.

Because of the improved outcomes, the level of support was decreased to service coordination at the end of one year. The emphasis of treatment in the new Care Plan was on totally eliminating suicidal ideation.

### ***Behind the Scenes-***

*When Sammy's mother took him to enroll in the baseball league, and learned how much it would cost for the uniform and gear, she told him he could not do this because she did not have the money. Sammy began feeling suicidal that evening, thinking his life would never improve. He followed his safety plan and called his aunt who immediately came over and talked him through these feelings. His aunt called the FSP who also came over. The FSP was able to explain how they could apply for flexible funds through Wraparound to assist with this activity, and Sammy was able to participate.*

### **Modified Treatment Plan**

**Recovery Goal:** I will stay on my diet and exercise regimen, and totally forget about killing myself. I will not smoke cigarettes or pot. I will work hard on my baseball skills and hope to play for the high school team.

**Outcome:** I will stay in touch with my care coordinator and doctor, and will take all my medications. I will see my therapist regularly and work with her to eliminate suicidal thoughts. I want to do a better job taking care of myself.

**Notes:** *Sammy and his mother have made considerable improvements in attending all appointments as scheduled, without needing to be reminded or have an FSP attend with them. Sammy's mother has seen the benefit of his participation in baseball and has managed to budget for that ongoing activity.*

**Health Home Action Plan:** A care coordinator/case manager will check on Sammy at least once a week to determine that progress is maintained.

**Revised Action Plan:** *Sammy has been tobacco free for 8 months. He has lost 25 pounds. He has complied with his medication regimen. Action plan is revised to require that Sammy reduce his med checks to once a month at Metro HH. Sammy's care coordinator will check in telephonically with him every other week. Unless something occurs to indicate the need for more intensive services, Sammy will be transitioned to the Service Coordination group. Sammy will see the PCP at least once a year.*

***Behind the Scenes-***

*Nancy NCM uses the completed evaluation and treatment plan update to fill out an updated Client Assessment Record (CAR) and submits a request for a Prior Authorization for the Lower Level Service Coordination Health Home Group, which is authorized based on the CAR score submitted. When Metro Health Home submits a claim for Health Home services the following month, reimbursement will be made based on the lower amount affiliated with the Lower Level Service Coordination Prior Authorization.*