



Orientation to the Minnesota Behavioral Health Homes: Frequently Asked Questions

Q: What is a health home?

A: A health home is a Medicaid State Plan Option under Section 2703 of the Affordable Care Act (ACA) for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance abuse) and long-term services and supports for persons across the lifespan with chronic illness. This is an opportunity to build a person-centered system of care that achieves improved health outcomes for individuals as well as better services and value for State Medicaid programs.

Q: What are the federal eligibility criteria for individuals to be served by a health home?

A: Federally, these are minimum criteria that an eligible individual with chronic conditions must meet:

- Two chronic conditions
- One chronic condition and “at risk” for another
- Only one chronic condition if it is a serious mental illness (Serious Emotional Disturbance for population 18 years old and under)
 - The other chronic conditions include asthma, diabetes, heart disease, and being overweight as evident by a BMI over 25.

Q: What is the Minnesota vision for health homes?

A: DHS is developing a “health home” framework to serve the needs of complex populations covered by Medicaid. DHS is starting with the populations with serious mental illness because of their well-known barriers to health care access, high co-occurrence of chronic health conditions, and early mortality.

The Chemical and Mental Health Services and Health Care Administrations are working together to design a Behavioral Health Home (BHH) model which will operate under a “whole person” philosophy and assure access to and coordinated delivery of primary care and behavioral health services for children and youth with Serious Emotional Disorders and adults with Serious Mental Illness or Serious and Persistent Mental Illness.

This framework will have the potential to be utilized for health homes for additional complex populations in the future.

Q: How are Behavioral Health Homes different from Health Care Homes (aka Medical Health Homes)?

A:

- Behavioral Health Homes are Medicaid only whereas Health Care Homes are an all payer system.
- Behavioral health Homes will be uniquely equipped to provide integrated mental health and primary health care to children and youth with SED and Adults with SMI or SPMI.

Q: What is the theory supporting the health home?

A: This provision supports CMS's overarching approach to improving health care through the simultaneous pursuit of three goals: improving the experience of care; improving the health of populations; and reducing per capita costs of health care.

Evidence suggests that better coordination and integration of primary and behavioral health care will result in: improved access to primary care services; improved prevention, early identification and intervention to reduce the incidence of serious physical illnesses including chronic disease; and increased availability of integrated holistic care for physical and behavioral disorders as well as better overall health status for individuals.

Use of the health home service delivery model will aim at in lower rates of emergency room use, reduction in hospital admissions and re-admissions, reduction in healthcare costs and less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual.

Q: What are the key federal requirements for health homes?

A: The ACA sets specific requirements in the following areas that must be met in order for an agency or a partnership of agencies to be determined a health home:

- Eligibility criteria
- Services delivered
- Provider standards
- Evaluation and reporting requirements

Q: What are the minimal standards that that Health Home providers must meet?

A: Behavioral Health Home providers must have the capacity to perform core services specified by Centers for Medicare and Medicaid Services (CMS). DHS will certify Behavioral Health Homes and providers must be enrolled as a Medicaid provider. The qualification may be amended but minimally require that each Behavioral Health Home:

- Be responsible for the provision of the 6 health home services with a team of professionals or subcontracting/partnering to provide them,
- Meet standards to be certified by the State,

- Have the capacity to report on CMS and State measures,
- Use health information technology (i.e. patient registry, electronic health records, secure and timely exchange of health information) to link services, identify and manage care gaps; and facilitate communication among health home team members and other providers,
- Establish/maintain a continuous quality improvement program including State designated priorities,
- Establish written Partners Collaboration Agreements (including health information sharing) with other key providers.

Q: What are the services that BHH must deliver?

A: There are 6 services that will be offered by the Behavioral Health Homes defined as follows:

1) Comprehensive Care Management

Comprehensive Care Management is a collaborative process designed to manage medical, social, and mental health conditions more effectively based on population health data and tailored to the individual patient.

Specific services include but are not limited to:

(Activities applicable to all patients collectively)

- Design and implement new activities and workflows that increase patient engagement and optimize clinical efficiency.
- Select common clinical conditions and target cohorts on which to focus and define your patient population.
- Measure and monitor population data to report on health status, quality metrics, and outcomes for the target population.
- Obtain and implement technologies such as electronic health registries and reporting systems to facilitate data collection, client tracking and outcome reports.
- Deploy electronic and non-electronic tools to effectively make use of best practices and evidence to guide care efficiently and correctly.
- Design and implement communication and care coordination tools, to ensure that care is consistent among a client's many providers, as well as between the provider and the home.

(Activities specific to an individual patient within targeted populations)

- Evaluate each patient initially, periodically, and at critical junctures. Elements include the patient's clinical condition, feasibility of completing various interventions, and the patient's values, preferences and readiness to engage in self-management and treatment.
- Create written recommendations for health action plan that balance best practices for managing the targeted condition(s) with feasibility and patient preference, in a manner that optimizes outcomes.
- Measure services and interventions offered, reason for implementation or non-implementation, modifiers and outcomes.
- Utilize care strategies including health information technology and other tools to communicate and coordinate with the patient and with other caregivers to ensure that the care plan is being executed safely and efficiently.

2) Care Coordination

- Care Coordination is the compilation, implementation, and monitoring of the individualized, holistic Health Action Plan with the client/client's identified supports through appropriate linkages, referrals, coordination and follow-up to needed services and supports.
- Overarching activities of Care Coordination include the provision of case management services necessary to ensure individuals and their identified supports have access to medical, behavioral health, pharmacology and recovery support services (e.g. housing, access to benefits, vocational, social, and educational, etc.).
- Specific Care Coordination activities are conducted with individuals and their identified supports, medical, behavioral health and community providers, across and between care settings to ensure that all services are coordinated. Specific activities include, but are not limited to:
 - Completion of the initial needs assessment and activities to address immediate client needs and/or risks.
 - Coordination of HH team members to complete their part in the assessment, written recommendations for the health action plan, and for team meetings.
 - Compilation and organization of written recommendations of HH team members to create the health action plan.
 - Assistance with appointment scheduling and accessing and coordinating necessary health care and recovery support services as defined in the care plan, including transportation.
 - Assistance in follow up care and follow through on recommendations.
 - Conducting referrals and follow-up monitoring.
 - Outreach to engage, support and promote continuity of care for the individual.
 - Ensuring linkage to medication monitoring if it is an identified need.
 - Initiate coordination and collaboration within the HH team on behalf of the client and foster communication with and amongst the individual, their providers and their identified supports.
 - Services which support, educate, and advocate for the client and/or their identified supports in improving health management skills.
 - Monitoring client progress on goals in care plan and the need for plan alterations.
 - Participating in discharge/transition services, including but not limited to, child welfare, juvenile justice, special education, residential behavioral health, and hospital discharge planning.

3) Health Promotion Services

- Health Promotion Services encourage and support healthy living concepts to motivate individuals and/or their identified supports to adopt healthy behaviors and promote better management of their health and wellness. Health Promotion Services place a strong emphasis on skills development through health education and wellness interventions so individuals and/or their identified supports can monitor and manage their chronic health conditions to improve health outcomes.
 - Health Promotion and Wellness activities should be conducted from a holistic approach and should assist the client and/or client's identified supports in gaining relevant knowledge and skills which will:
 - A. Increase their understanding of the illnesses/health conditions identified in the assessment and how said conditions relate to and impact various facets of their life.

- B. Increase their knowledge of illness-specific management as well as overall, daily health maintenance.
 - C. Support them in activities aimed at increasing their self-efficacy and reaching their health goals.
 - D. Support them in recovery and resiliency.
 - E. Help client and/or client's identified supports to make healthy lifestyle choices within their budget.
 - F. Support client and/or client's identified supports in improving their social networks.
- Wellness and health-promoting lifestyle interventions include but not limited to substance use prevention/early intervention and harm reduction, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy support, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, increasing physical activity, and promoting independence and skill development related to self-administration of medications.

4) Comprehensive Transitional Care

Comprehensive Transitional Care activities are specialized care coordination services that focus on the movement of individuals between or within different levels of care or settings while shifting from the use of reactive care and treatment to proactive care via health promotion and health management. Transition services are designed to streamline plans of care and crisis management plans, reduce barriers to timely access, reduce inappropriate hospital, residential treatment, and nursing home admissions, interrupt patterns of frequent emergency department use, and prevent gaps in services which could result in (re)admission to a higher level of care or longer lengths of stay at an unnecessary level of care.

Comprehensive transitional care services include but are not limited to:

- Ensuring adequate and continuous client services and supports following and in between services and settings such as, hospitalization, homelessness, shelters, domestic violence shelters, residential treatment, prison, juvenile justice, children and family services, treatment foster care, foster care, special education and other settings and services with which the client may be involved.
- Participation in discharge planning in collaboration with the individual and the appropriate facility staff to assist in the development and implementation of the transition of the client to the least restrictive setting possible.
- Development and implementation of a systematic follow-up protocol with individuals, as they change levels of care or providers within the same level of care, to ensure timely access to follow-up care, medication education and reconciliation, and other needed services and supports.

5) Referral to Community and Social Support Services

- In collaboration with the client and /or their identified supports, the HH provider identifies and provides referrals, including but not limited to, medical and behavioral health care, entitlements and benefits, respite, housing, transportation, legal services, educational and employment services, financial services, wellness and health promotion services, specialized support groups, substance use prevention and treatment, social integration and skill building, and other services as identified by the individual and/or their identified supports.
- Assist the client in making appointments, as needed. Accompany or coordinate accompaniment with client, to and from appointments, as needed. Confirm client and provider's encounters and continue follow up coordination.

6) Individual and Family Support Services

Individual and Family Support Services are activities, materials, or services aimed to help clients reduce barriers to achieving goals, increase health literacy and knowledge about chronic condition(s), increase self-efficacy skills, and improve health outcomes.

Individual and Family Support Service activities include but are not limited to:

- Assistance in accessing self-help, help for identified supports, peer support services, support groups, wellness centers, and other care programs focused on the individual and their family and/or identified supports.
- Teaching, advocacy coaching and systems navigation for individuals, their identified supports and their identified supports.
- Health education, wellness promotion, prevention and early intervention services.
- Assistance in identifying and developing social support networks.
- Assistance with obtaining and adhering to prescribed medication and treatments.
- Helping to identify and utilize resources to aid in reduction of barriers to support clients in attaining their highest level of health and functioning within their families and community, including non-medical recovery supports such as transportation and housing

NOTE: Utilization of Health Information Technology is federally required to link services, as possible and appropriate. BHH provider standards will evolve as experience is gained and as permitted by Minnesota law.

Q: What are the possible qualifications of the Behavioral Health Home team members and what will be their responsibilities?

A: (see below)

Team Member: Client

Possible Qualifications:

- Children and Youth with Serious Emotional Disturbances (SED) as defined in Minnesota Statute 245.4871 Subdivision 6
- Adults with Serious Mental Illness (SMI) as defined at <http://mn.gov/dhs/>
- Adults with SPMI as defined in statute 245.462 Subdivision 20

Roles and Responsibilities:

It is the responsibility of the client and their identified supports to voluntarily choose to participate in the Behavioral Health Homes (BHH). They are responsible for voicing their needs, concerns, questions, barriers, strengths, skills, desires and goals to their Behavioral Health Home team with the support and assistance of the Qualified Health Home Specialist and the Care Coordinator as needed. They are responsible for communicating regularly with the behavioral health home team, including reaching out to appropriate team members as needed and returning phone calls, emails, and all other appropriate forms communication. They are responsible for engaging in the planning and implementation processes of their treatments and therapies.

Team Member: Team Leader

Possible Qualifications:

- Clinic Manager
- Other Executives

Roles and Responsibilities:

Although the Team Leader is not the primary entity responsible for Health Promotion Services or Individual Family Support Services, they contribute to the provision of those services through the following functions. The Team Leader provides the BHH with executive leadership as a champion for integration. They determine the size and overall composition of the BHH team. They are responsible for ensuring that needed memorandums of understanding are in place and that the BHH has access to resources and tools including but not limited to overhead, health information technology, protected time on a calendar, support staff, medical records, and screening tools. They serve as the outward facing liaison to the wider community and provide administrative outreach to diverse communities. They provide oversight and set appropriate regulations in place to ensure diversity of population enrollment with regards to severity of client's illness. The Team Leader determines quality improvement and communication protocols for the BHH.

Team Member: Integration Specialist (*Care Management*)

Possible Qualifications:

- Registered Nurse including Advanced Practice Nursing Licenses when BHH service are offered in a mental health setting.
- Mental Health Professionals including those under statute 245.4871 Subd. 27, 1-6 when BHH services are offered in a primary care setting.

Roles and Responsibilities:

The Integration Specialist position illustrates the importance that the BHH program places on integration of primary care and mental health. The Integration Specialist is the reciprocal professional whose required qualifications are contingent on the setting of the BHH. If the BHH is located in a mental health setting, the Integration Specialist must be a Registered Nurse whereas if the BHH is located in a primary care setting, the Integration Specialist must be a Mental Health Professional. Primary care settings certified as BHH will be a rare circumstance reserved for distinctive, state-selected pediatric clinics and distinctive, state-selected, uniquely integrated, primary care clinics.

With the guidance of their supervisor and in collaboration with the BHH team, the Integration Specialist is the primary entity responsible for the provision of Comprehensive Care Management within the BHH. The Integration Specialist will utilize the patient registry to manage medical, social, and mental health conditions based on population health data and tailored to the individual patient. The Integration Specialist is responsible for both activities that are applicable to all patients collectively, as well as to individual patients within the targeted populations.

On the collective scale, Integration Specialists are responsible for the following:

- Designing and implementing new activities and workflows that increase patient engagement, quality improvement, and optimize clinical efficiency.

- Leads the BHH team to select common clinical conditions and target cohorts on which to focus health interventions.
- Measures and monitors population data to identify outstanding health issues and gaps in care as well as to report on health status, quality metrics, and outcomes for the target population.
- Obtains and implements technologies such as electronic health registries and reporting systems to facilitate data collection, client tracking and outcome reports.
- Deploys electronic and non-electronic tools to effectively make use of best practices and evidence to guide care efficiently and correctly.
- Designs and implements communication and care coordination tools, to ensure that care is consistent among a client's medical and mental health providers, as well as between the providers and the health home.

On the individual scale the Integration Specialists are responsible for the following:

- Evaluates each patient initially, periodically, and at critical junctures. Elements include the patient's clinical condition, feasibility of completing various interventions, and the patient's values, preferences and readiness to engage in self-management and treatment.
- Creates written recommendations for health action plan that balance best practices for managing the targeted condition(s) with feasibility and patient preference, in a manner that optimizes outcomes.
- Measures services and interventions offered as well as reasons for implementation or non-implementation, modifiers and outcomes.
- Utilizes care strategies including health information technology and other tools to communicate and coordinate with the patient and with other caregivers to ensure that the care plan is being executed safely and efficiently.

The Integration Specialist is responsible for Individual and Family Support Services in relation to the management of population health. Although the Integration Specialist is not the primary entity responsible for Care Coordination, Health Promotion Services, Referral to Community and Social Support Services, or Comprehensive Transitional Care, they may contribute to the provision of those services. The Integration Specialist is also available to run wellness groups for clients as appropriate. In some settings the Integration Specialist may serve as the supervisor of the Care Coordinator or the same individual may serve both positions in settings where client populations are small.

Team Member: Behavioral Health Home Systems Navigator (*Case Management/Care Coordination*)

Possible Qualifications:

- Case Manager as defined in MN statute [M.S. 245.462](#) Subd.4
- Mental Health Practitioner as defined at <http://mn.gov/dhs/>

Roles and Responsibilities:

With the guidance of their supervisor and in collaboration with the BHH team, the BHH Systems Navigator is the primary entity responsible for the provision of the Care Coordination within the BHH.

- Care Coordination is the implementation and monitoring of the individualized, holistic Health Action Plan with the recipient/recipient's caregivers through appropriate linkages, referrals, coordination and follow-up to needed services and supports.

- Overarching activities of Care Coordination include the provision of case management services necessary to ensure individuals and their identified supports have access to medical, behavioral health, pharmacology and recovery support services (e.g. housing, access to benefits, vocational, social, and educational, etc.).
- Specific Care Coordination activities are conducted with individuals and their identified supports, medical, behavioral health and community or county providers, across and between care settings to ensure all services are coordinated. Specific activities include, but are not limited to:
 - Initiates coordination and collaboration within the HH team on behalf of the client and fosters communication with and amongst the individual, their providers and their identified supports.
 - Conducts an initial needs assessment and creates a preliminary care plan which assists client to prioritize any immediate needs or risks that must be addressed first. Coordination and Implementation of preliminary care plan to address immediate needs and/or risks together with the client.
 - Bridges client with all team members for assessments and subsequent appointments.
 - Constructs a compilation of the written recommendations provided by each team member to create the health action plan along with the oversight of their supervisor and/or the consulting physicians.
 - Monitoring recipient progress on goals in care plan and identifies possible needs for plan alterations.
 - Coordinates Comprehensive Transitional Care activities, including but not limited to, child welfare, juvenile justice, special education, residential behavioral health, and hospital discharge planning.
 - Provides Referrals to Community and Social Support Services which includes appointment assistance, transportation coordination, appointment accompaniment, and follow up coordination or referral to Qualified Health Home Specialist for assistance in these activities as appropriate.
 - Provides Individual and Family Support Services on a regular basis for overall client needs.

Although the BHH Systems Navigator is not primary entity responsible for Health Promotion Services and they will often contribute to the provision of this service. In settings with a large client population, there may be multiple BHH Systems Navigators within one BHH. Conversely, in settings with small client populations, there may be one individual that fulfills the roles of both Care Manager and Care Coordinator. They are also available to conduct wellness groups as appropriate contingent on their individual training.

Team Member: Qualified Health Home Specialist

Possible Qualifications:

- Care Guide whose description as defined at <http://www.healthcarecopilot.com>
- Case Management Associate as defined at MN Statute [M.S. 245.462](#) Subd.4
- Mental Health Rehabilitation Worker as defined at <http://mn.gov/dhs/>
- Community Health Worker as defined at mnchwalliance.org
- Peer Support Specialist as defined at <http://mn.gov/dhs/>
- Family Peer Support Specialist (upcoming definition and certification at DHS)

Roles and Responsibilities:

The Qualified Health Home Specialist serves as a coach whose main focus is to support and assist clients in reaching their goals. They interact with the clients on the phone or in person on a regular basis to build trusting relationships. They can meet with patient before appointments help patients organize health concerns and prioritize issues to discuss with health providers. They can also meet with patient after office visits to review provider instructions and check for patient understanding and access to resources to follow provider instructions. They provide ongoing motivation, encouragement, and positive feedback when client makes constructive changes or progress. Through built trust and rapport, conversations can be personal aimed at identification of barriers to care.

With the guidance of their supervisor and in collaboration with the BHH team, the Qualified Health Home Specialist is the primary entity responsible for the Health Promotion Services and assists the BHH Systems Navigator in coordinating care, serving as the secondary entity responsible for Care Coordination Services.

- Health Promotion Services encourage and support healthy living concepts to motivate individuals and/or their caregivers to adopt healthy behaviors and promote better management of their health and wellness. Health Promotion Services place a strong emphasis on skills development through health education and wellness interventions so individuals and/or their caregivers can monitor and manage their chronic health conditions to improve health outcomes.
 - Health Promotion and Wellness activities should be conducted from a holistic approach and should assist the recipient and/or recipient's caregivers in gaining relevant knowledge and skills which will:
 - G. Increase their understanding of the illnesses/health conditions identified in the assessment and how said conditions relate to and impact various facets of their life.
 - H. Increase their knowledge of illness-specific management as well as overall, daily health maintenance.
 - I. Support them in activities aimed at increasing their self-efficacy and reaching their health goals.
 - J. Support them in recovery and resiliency.
 - K. Help recipient and/or recipient's caregivers to make healthy lifestyle choices within their budget.
 - L. Support recipient and/or recipient's caregivers in improving their social networks.
- Wellness and health-promoting lifestyle interventions such as, but not limited to, substance use prevention/early intervention and harm reduction, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, increasing physical activity, and promoting independence and skill development related to self-administration of medications.

The Qualified Health Home Specialist is responsible for providing Individual and Family Support Services on a regular basis for overall client needs. Although the Qualified Health Home Specialist is not the primary entity responsible for Comprehensive Transitional Care and Referral to Community and Social Support Services, they often contribute to the provision of these services. Qualified Health Home Specialists are also available to conduct wellness groups as appropriate contingent on their individual training. There may be multiple Qualified Health Home Specialists dependent on the size of the BHH.

Team Member: Consulting Physicians

Possible Qualifications:

- Primary Care Physicians
- Psychiatrists
- Specialized MDs/ therapists

Roles and Responsibilities:

The Consulting Physician is not a required team member but rather an option contingent on the needs of the client. However, final approval of a consulting Psychiatrist is necessary for implementation and significant changes to the health action plan.

The Consulting Physician is responsible for ongoing case consultation and recommendations for the health action plan. Although the Consulting Physician is not the primary entity responsible for Individual and Family Support Services, Care Coordination, Health Promotion Services, Referral to Community & Social Support Services, or Comprehensive Transitional Care, they contribute to the provision of these services through case consultation.

Team Member: External Professionals

Possible Qualifications:

Providers such within

- Housing
- Food
- Special Education
- Criminal/Justice system
- Respite care
- Social support services
- Additional community support services

Roles and Responsibilities:

The External Professional is not a required team member but rather an option contingent on the needs of the client. As needed and appropriate, External Professionals will provide recommendations for the health action plan and ongoing consultation. Although the External Professionals are not the primary entity responsible for Individual and Family Support Services, Care Coordination, Health Promotion Services, Referral to Community & Social Support Services, or Comprehensive Transitional Care, they contribute to the provision of these services through case consultation.

Q: What will be the BHH Payment Structure?

A: The Health Care Administration and Chemical and Mental Health Services are considering a per-member, per-month (PMPM) tiered payment system for qualified health homes that meet state and federal standards. This model is subject to change, based on further analysis and stakeholder input. The tiered payment will include an outreach and engagement PMPM payment. The tiered payment will include an outreach and engagement PMPM payment that will be available for three months per recipient while BHH providers work to find and enroll the recipient.

Q: What measures will be tracked, reported, and evaluated within the BHH program?

A: (see below)

Monitoring

DHS must demonstrate that there is a defined methodology, including data sources and measurement specifications, for:

- Tracking avoidable hospital readmissions
- Calculating cost savings that result from improved chronic disease management, and
- Tracking the use of health information technology in providing health home services to improve coordination and management of care and patient adherence to recommendation made by their provider.

Evaluation

DHS must provide assurance that it will report to CMS information submitted by Behavioral Health Home providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act as described by CMS.

Additional State Performance Measures

DHS must create a set of performance measures specific to the targeted populations of adults and children with serious mental illness. These measures will include:

- Follow up after hospitalization for mental illness,
- Use of Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Services Intensity Instrument (ECSII), and
- Patient experience of care.

Also, the State's Olmsted Plan identifies measures that will be developed by DHS under the health home framework and used across State health programs. These measures will include:

- Use of routine and preventative primary care,
- Use of dental care,
- Well-child physician visits,
- Screening for alcohol and other drug use, and
- Depression remission using PHQ-9 for adults.

Quality Measures

DHS must provide assurance that it will require that all Behavioral Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State. The following table provides a brief description of each Core Set measure, the measure steward(s), and data sources needed to report the measure. As noted in the table, the data sources for the measures are administrative (such as claims, encounters, vital records, and registries), hybrid (a combination of administrative data and medical records), and medical records. These measures are based on the Core Set of health care quality measures for Medicaid-eligible adults, but have been modified to allow for

Health Home program reporting, which may also include children. The technical specifications in Chapter III of this manual provide additional details for each measure.

Acronym	Measure	Measure Steward (web site)	Description	Data Source
ABA-HH	Adult Body Mass Index (BMI) Assessment	NCQA/HEDIS http://www.ncqa.org	Percentage of Health Home enrollees ages 18 to 74 who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year	Administrative or hybrid
CDF-HH	Screening for Clinical Depression and Follow-Up Plan	CMS https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html	Percentage of Health Home enrollees age 12 and older screened for clinical depression using a standardized tool, and if positive, a follow-up plan is documented on the date of the positive screen	Hybrid
PCR-HH	Plan All-Cause Readmission Rate	NCQA/HEDIS http://www.ncqa.org	For Health Home enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days of discharge and the predicted probability of an acute readmission	Administrative
Acronym	Measure	Measure Steward (web site)	Description	Data Source
FUH-HH	Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS http://www.ncqa.org	Percentage of discharges for Health Home enrollees age 6 and older who were hospitalized for treatment of selected	Administrative

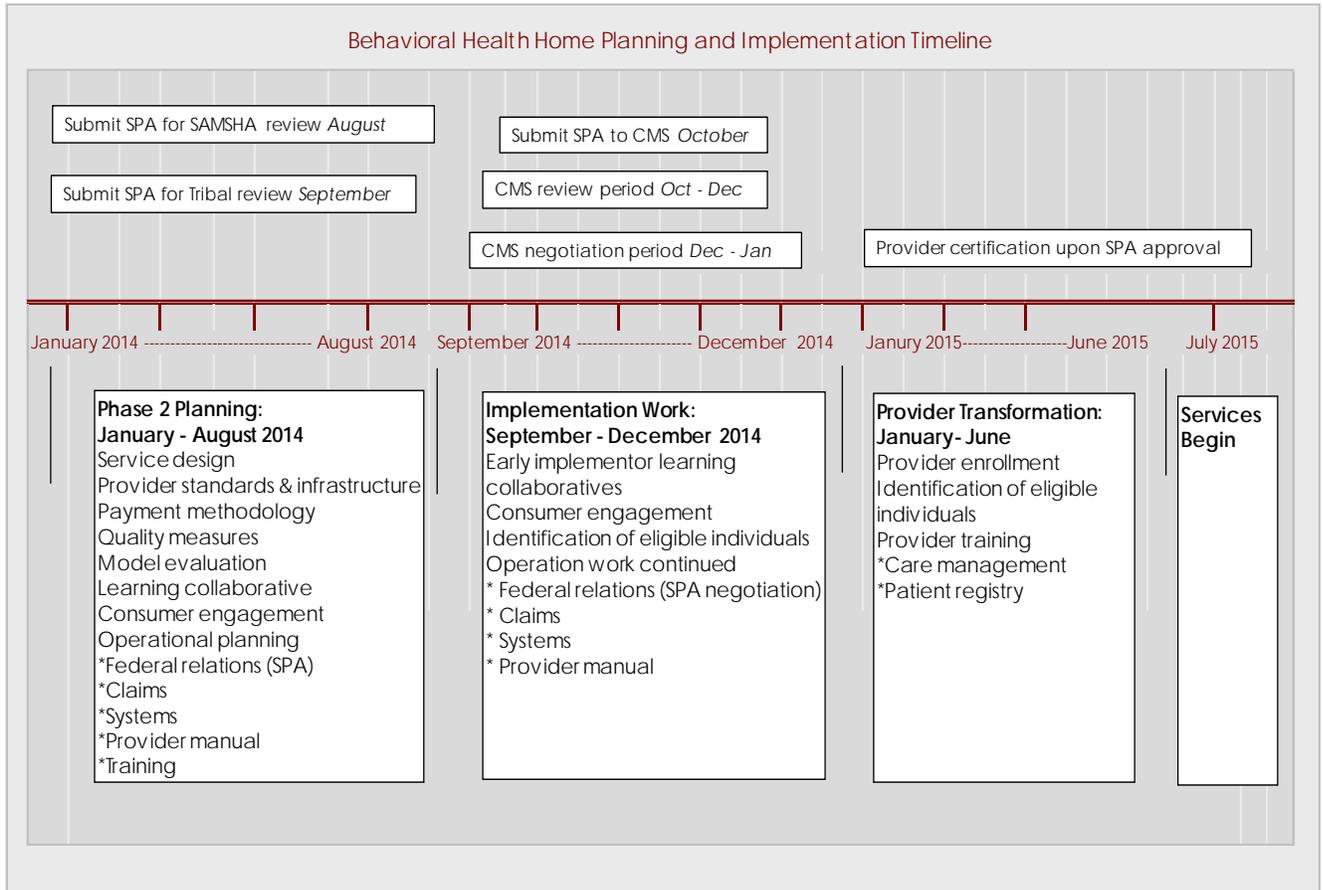
			mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge	
CBP-HH	Controlling High Blood Pressure	NCQA/HEDIS http://www.ncqa.org	Percentage of Health Home enrollees ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year	Hybrid
CTR-HH	Care Transition – Timely Transmission of Transition Record	American Medical Association/ Physician Consortium for Performance Improvement (PCPI) http://www.ama-assn.org	Percentage of Health Home enrollees discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility, Health Home provider or primary physician, or other health care professional designated for follow-up care within 24 hours of discharge	Hybrid
Acronym	Measure	Measure Steward (web site)	Description	Data Source
IET-HH	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA/HEDIS http://www.ncqa.org	Percentage of Health Home enrollees age 13 and older with a new episode of alcohol or	Administrative or hybrid

			<p>other drug (AOD) dependence who:</p> <p>(a) Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis</p> <p>(b) Initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit</p>	
PQI92-HH	Chronic Condition Hospital Admission Composite— Prevention Quality Indicator	AHRQ http://www.qualityindicators.ahrq.gov/	The total number of hospital admissions for chronic conditions per 100,000 Health Home enrollees age 18 and older	Administrative

- a. The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes.

Q: What is the timeline for the health homes?

A:



Q: What additional resources can I read to familiarize myself with national rules, regulations, and research surrounding health homes?

A: Three articles of significance are included in this packet:

- 1) Pires, Sheila A. (2013) Customizing Health Homes for Children with Serious Behavioral Health Challenges: Prepared for U.S. Substance Abuse and Mental Health Services Administration. Human Services Collaborative. Retrieved 12/3/2013 from: <http://www.integration.samhsa.gov/>
- 2) Thielke, Stephen; Vannoy, Steven; Unutzer, Jurgen. (2007) Integrating Mental Health and Primary Care. Primary Care: Clinics in Office Practice. (34)571-592
- 3) SAMHSA-HRSA Center for Integrated Health Solutions. (2012) Behavioral Health Homes for People with Mental Health & Substance Use Conditions: The Core Clinical Features. Retrieved 12/3/2013 from <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

*Websites with additional information:

<http://www.dhs.state.mn.us/>

<http://www.integration.samhsa.gov/integrated-care-models>

<http://www.thenationalcouncil.org/areas-of-expertise/integrated-healthcare/>

*Please direct follow-up questions to one of the following employees at the Minnesota Department of Human Services:

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