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| ***Population Criteria and Enrollment*** |
| **Geographic Area** | Richmond |
| **Population Criteria**  | * Per agreed VAHP/DMAS criteria utilizing diagnosis, pharmaceutical, and utilization screening criteria
* 50–75 members at start
* Possible expansion after refinement of program
 |
| **Enrollment of Participants** | * Individuals who meet eligibility criteria will be reviewed by case manager and case summary presented to supervisor and medical director. After approval of medical director, individuals will be assigned to the Behavioral Health Home provider.
* Individuals will not, in general, have the opportunity to opt out of the Behavioral Health Home pilot. Special cases will be reviewed by the Medical Director for approval.
* Members with comorbid physical and mental illness represent a wide spectrum from primarily physical illness with very little BH issues, to severe mental health issues and little physical medical illness. Some members will have a combination of SMI and serious complex medical conditions.
* Depending on the degree of medical and mental health issues, the member may be assigned to either the VCU CAHM or the RBHA centers as their primary Behavioral Health Home provider. Both VCU CAHM and the RBHA will coordinate with the other center professionals as needed to optimize the members overall well-being.
 |
| ***Provider Requirements*** |
| **Provider Infrastructure**  | Designated Providers  |
| **Types of Providers** | Local Community Service Board, Local Physicians and Hospitals, and Mental Health Providers. |
| **Provider Partners** | Provider Partners will be:* Richmond Behavioral Health Authority (RBHA)
* VCU Center for Advanced Health Management (CAHM) - Richmond
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| ***Provider Requirements cont.*** |
| **Provider Standards** | All behavioral health homes will be required to meet the following conditions, which may be amended from time-to-time as necessary and appropriate: * Meet all applicable state licensure requirements
* Have capacity to serve additional individuals who are eligible for behavioral health home services in the designated service area
* Meet access requirements including enrollee access to the health home team and 24/7 access to crisis intervention and other needed services
* Conduct a standardized assessment and complete status reports to document enrollees’ living arrangement, employment, education, legal, entitlement, custody, etc.
* Have a strong, engaged leadership committed and capable of leading the provider through the transformation process
* Develop and maintain a single person-centered care plan that coordinates and integrates all behavioral health, primary care, and other needed services and supports with documentation to demonstrate that behavioral health home services are being delivered in accordance with program rules and requirements
* Conduct wellness interventions as indicated based on enrollees’ level of risk
* Agree to convene regular documented behavioral health home team meetings for case consultation.
* Have a comprehensive data collection system and Electronic Medical Record
* Have the capacity to collect and report data in the form and manner specified by CoventryCares
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| ***Health Home Service Delivery System*** |  |
| **Type of Service Delivery System**  | This program will be a hybrid of the In-house / Co-located Partnership and Facilitated Referral Model. Our goal is to keep the majority of care within the two listed provider partners to facilitate integrated and coordinated care and effective communications and collaboration. |

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| ***Payment Methodology***  |  |
| **Type of Payment Methodology** | FFS, with the possible addition of an enhanced case management fee per enrolled member. Possibility of a capitated payment or shared savings model in the future |
| ***Service Delivery*** |  |
| **Behavioral Health Home Services**  | * Single Point of Contact / Liaison with MCO Staff
* Completing a comprehensive integrated assessment that addresses the member’s needs across all psychosocial domains, including psychiatric, medical, and general health issues
* Collaborating with the member to design a person-centered service plan that enables them to actively manage their own medical and psychiatric conditions
* Assisting the member to access medical screening services and utilize health education and navigation resources on a regular basis to improve their understanding of their illnesses, and to improve their ability to manage their chronic conditions
* Provide aggressive discharge planning to the member in the event that they require hospitalization for medical or psychiatric issues in order to successfully transition them back to the community as quickly as possible
* Assist the member to effectively transition to less intensive, lower levels of community-based care/services, as soon as clinically indicated and authorized
* Comprehensive Care Management/Care Coordination
* Enhanced Case Management Services
* Health Promotion Services/Individual and Family Support Services
* Comprehensive Transitional Care
* Referral to Community and Social Support Services
* Use of Health Information Technology (HIT) to link services as available
* Services will be coordinated with Magellan Health as necessary
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| ***Service Delivery cont.*** |  |
| **Managed Care Organization (MCO) Services** | * Identification of members with SMI assigned to BH home
* Program Design in conjunction with BH home and Magellan staff
* Identify Single Point of Contact / Liaison with BHH Staff
* Expedited “Gold Card” prior authorization
* Integrated Medical and Behavioral Health Case Management
* Lead Multidisciplinary Meetings with MCO, health home(s) and Magellan staff at least monthly and adhoc as necessary
* Joint Operating Meeting (JOC) at least quarterly to include MCO, BHH and Magellan staff
* Reports and Data Analysis
* Operational and Quality Oversight
 |
| ***Evaluations*** |  |
| **Quality Outcome Goals*** Reduce Unnecessary Hospital Admissions and Readmissions
* Reduce Substance Use
* Improve Transitions of Care
* Improve the Percent of Individuals with SMI who receive preventive care
* Improve chronic care delivery for individuals with SMI
* Increase satisfaction with care delivery for members with SMI
 | Potential Quality Measures:* Clinical Encounters Per Month Per Member
* Unnecessary admissions - Ambulatory Care Sensitive Conditions
* All Cause Readmission Rates - Medical and BH
* Emergency Department Visits - Medical and BH
* Transition Record Transmitted to Health Care Professional post hospitalization
* Follow-up after Hospitalization for Mental Illness
* Adult Body Mass Index (BMI) Assessment documented
* Screening for Clinical Depression and Follow-up Plan
* Adult Asthma Control
* Controlling High Blood Pressure
* HbA1c Level Screening
* Improve Cardiovascular Care for Individuals with CAD
* Tobacco Cessation Intervention
* Initiation and Engagement of Alcohol and Other Drug Dependence Tx
* General Satisfaction With Care, Access, Quality and Appropriateness
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