

# **Health Home Learning Collaborative**

Making the Behavioral and  
Physical Healthcare Marriage  
Work

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# This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid Enterprise

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# Logistics

- Mute your line
- Do not put us on hold
- We expect attendance and engagement.
- Type questions in the chat as you think of them, we will address them at the end.

# AGENDA

1. Introductions
2. Health Home Updates.....Pam Lester, IME
3. Chronic Condition Health Home.....Emma AGP
4. Health Home Case Study or Health Home Spotlight.....Emma AGP
5. Open Discussion.....All

*(Open discussion on current issues or barriers, potentially leading to future monthly topics)*

*Coming up:*

- *June 17, 2019 Comprehensive Assessment*
- *July 15, 2019 interRAI*
- *July 29, 2019 Person Centered Planning Philosophy Requirements*

# Health Home Updates

- Enrollment
  - Adult 11,638
  - Child 6,557
- News: Informational letters and provider list sign up  
<https://dhs.iowa.gov/ime/providers/news-and-announcements>
- News and Initiatives: Subscribe to the page.  
<https://dhs.iowa.gov/node/3253>
- Share the Member link to how to change MCOs.  
<https://dhs.iowa.gov/iahealthlink/resources/member-specific>
- Remind about using the IME Health Home inbox for questions.  
[healthhomes@dhs.state.ia.us](mailto:healthhomes@dhs.state.ia.us)

# Objectives

- Overview of the Chronic Condition Health Home (CCHH) and Integrated Health Home (IHH) Programs
- How are they supported
- Understand appropriate referrals

# Authority: ACA Section 2703

- Option to submit State Plan Amendment (SPA) depicting a health home model targeting chronic conditions:
  - Primary Care SPA:
    - Approved June 8, 2012 / Effective July 1, 2012
  - SPMI Population SPA (Mental Health focus):
    - Adults and Kids, SOC approach
    - Effective date July 2013
    - Phased-in by county between July 1, 2013-July 1, 2014
- Draw 90/10 Federal match for 8 quarters for Health Home Services

# Eligible Plan Types

- Members who get full Medicaid benefits.
- Members who get full Medicaid benefits who also have Medicare.

## **Members in the Following Programs are Not Eligible for the Chronic Condition Health Home:**

- Iowa Health and Wellness Plan
- *Hawki*
- Family Planning Program (FPP)
- Qualified Medicare Beneficiary
- Special Low-Income Medicare Beneficiary
- Program of All-Inclusive Care for the Elderly (PACE)
- Presumptive Eligible

# CCHH Provider list



CCHH Agency	County	Address	City, State	Zip Code	Phone Number
ALL CARE HEALTH CENTER	POTTAWATTAMIE	902 S 6TH	COUNCIL BLUFFS, IA	51501	(712) 325-1990
BLANK CHILDREN'S ADOLESCENT CLINIC	POLK	1212 PLEASANT STREET STE 406	DES MOINES, IA	50309	(515) 241-8336
BLANK CHILDREN'S PEDIATRIC CLINIC	POLK	1212 PLEASANT STREET STE 300	DES MOINES, IA	50309	(515) 241-8923
BROADLAWNS MEDICAL CENT	POLK	1801 HICKMAN ROAD	DES MOINES, IA	50314	(515) 282-2200
COMM HEALTH CTRS OF SOUTHEASTERN IA	LOUISA	2409 SPRING STREET	COLUMBUS CITY, IA	52737	(319) 728-4800
COMM HEALTH CTRS OF SOUTHEASTERN IA	HANCOCK	951 BROADWAY	HAMILTON, IL	62341	(217) 847-2112
COMM HEALTH CTRS OF SOUTHEASTERN IA	LEE	400 NORTH 17TH STREET	KEOKUK, IA	52632	(319) 524-5734
COMM HEALTH CTRS OF SOUTHEASTERN IA	DES MOINES	1706 W AGENCY RD	WEST BURLINGTON, IA	52655	(319) 768-5858
COMMUNITY HEALTH CARE, INC.	SCOTT	500 W RIVER DRIVE	DAVENPORT, IA	52801	(563) 336-3000
COMMUNITY HEALTH CARE, INC.	SCOTT	120 N RIPLEY STREET	DAVENPORT, IA	52801	(563) 336-3000
CORNERSTONE FAMILY PRACTICE	CLAYTON	104 S MAIN STREET	GARNAVILLO, IA	52049	(563) 964-2608
CORNERSTONE FAMILY PRACTICE	CLAYTON	200 MAIN STREET	GUTTENBERG, IA	52052	(563) 252-2141
CORNERSTONE FAMILY PRACTICE	CLAYTON	101 S WASHINGTON	EDGEWOOD, IA	52042	(563) 964-2608
COVENANT CLINIC SUITE 210	BLACK HAWK	2710 ST FRANCIS DR STE 210	WATERLOO, IA	50702	(319) 272-5000
COVENANT CLINIC-ARROWHEAD	BLACK HAWK	226 BLUEBELL ROAD	CEDAR FALLS, IA	50613	(319) 575-5800
COVENANT CLINIC-PEDIATRICS	BLACK HAWK	2710 ST FRANCIS DR STE 510	WATERLOO, IA	50702	(319) 272-5000
CRESCENT COMMUNITY HEALTH CENTER	DUBUQUE	1789 ELM STREET STE A	DUBUQUE, IA	52001	(563) 690-2860
EAST DES MOINES FAMILY CARE CENTER	POLK	840 E UNIVERSITY AVE	DES MOINES, IA	50316	(515) 265-4211
EASTERN IOWA HEALTH CENTER	LINN	1201 3RD AVENUE SE	CEDAR RAPIDS, IA	52403	(319) 730-7300
FAMILY MEDICINE CLINIC PC	MONONA	1614 DIAMOND STREET PLACE	ONAWA, IA	51040	(712) 423-1525
HIAWATHA PEDIATRIC CLINIC	LINN	1075 N CENTER POINT ROAD	HIAWATHA, IA	52233	(319) 743-1440
MCFARLAND CLINIC PC AFTER HOURS CLI	STORY	1018 DUFF AVENUE	AMES, IA	50010	(515) 663-8621
MERCY CLINICS PEDIATRICS CENTER	POLK	330 LAUREL STREET STE 2100	DES MOINES, IA	50314	(515) 643-8611
MERCY CLINICS PEDIATRICS EAST	POLK	5900 E UNIVERSITY #300	PLEASANT HILL, IA	50327	(515) 643-2600
MERCY FAMILY CLINIC BUFFALO CENTER	WINNEBAGO	115 NORTH MAIN	BUFFALO CENTER, IA	50424	(641) 562-2424
MERCY FAMILY CLINIC CLEAR LAKE	CERRO GORDO	1410 6TH AVENUE SOUTH	CLEAR LAKE, IA	50428	(641) 357-2191
MERCY FAMILY CLINIC FOREST CITY	WINNEBAGO	635 EAST US HIGHWAY 9	FOREST CITY, IA	50436	(641) 585-2904

[https://dhs.iowa.gov/sites/default/files/CCHH\\_Provider\\_List.pdf?032520191924](https://dhs.iowa.gov/sites/default/files/CCHH_Provider_List.pdf?032520191924)

# Health Home Maps

- CCHH and IHH Maps are coming and will be posted to the website.
- Subscribe to get updates.

<https://dhs.iowa.gov/ime/providers/enrollment/healthhome>

<https://dhs.iowa.gov/ime/providers/integrated-health-home>

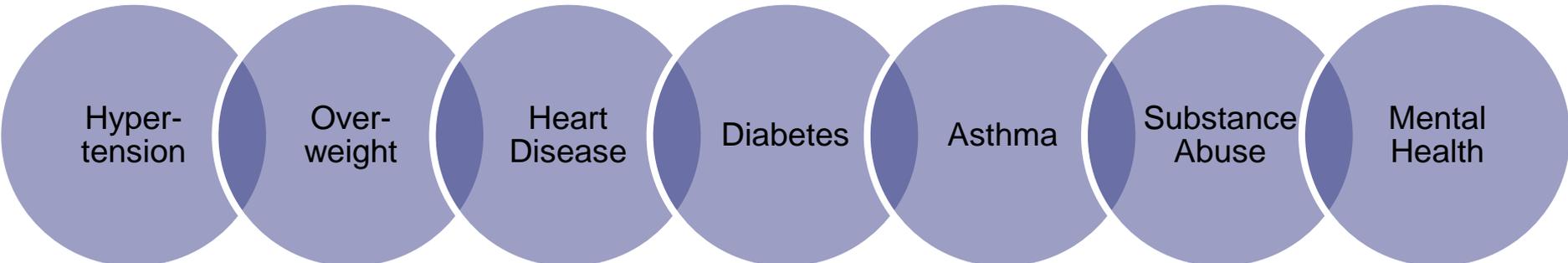
# Health Home Stats

- IHH
  - Adult 11,638
  - Child 6,557
- CCHH
  - 1776

# Chronic Condition Health Home Provider Qualifications

<p>1. Designated Provider must be Medicaid enrolled and at a minimum fulfill the following roles:</p> <ul style="list-style-type: none"><li>• Designated Practitioner</li><li>• Dedicated Care Coordinator</li><li>• Health Coach</li><li>• Clinic support staff</li></ul>	<p>2. Seek Medical Home recognition or equivalent within 12 months</p>
<p>3. Effectively utilizes population management tools to improve patient outcomes</p>	<p>4. Use an EHR, registry tools, and connect to Iowa HIE (IHIN) to report quality data</p>

# Chronic Condition Health Home Member Qualifications



Hypertension

Overweight

Heart Disease

Diabetes

Asthma

Substance Abuse

Mental Health

Adults and Children with  
at least two chronic conditions, or  
one chronic condition and at-risk of a second condition  
from the above list. (Note overweight vs. obese)

# Patient Tiering Assessment Tool (PTAT)

- Assessment is completed before enrollment and annually
- Identifies if the member qualifies to be in a CCHH and identifies the tier.

# IHH and CCHH

	Integrated Health Home	Chronic Condition Health Home
Who can be a Health Home provider?	Primarily a Community Mental Health Center, Psychiatric Medical Institute for Children (PMIC), or Mental Health Service Provider	Primary Care Provider (Designated provider)
Care Team	<ul style="list-style-type: none"> <li>• Nurse Case Manager</li> <li>• Social Workers / Care Coordinators</li> <li>• Peer Support/Family Support Specialist</li> </ul> Team is engaged with Physicians, Primary Care clinics, Specialist clinics, hospitals, etc...	<ul style="list-style-type: none"> <li>• Designated Provider</li> <li>• Dedicated Care Coordinator</li> <li>• Health Coach</li> <li>• Clinic Support Staff</li> </ul> Care team doesn't include a peer support specialist.
Services Provided (Health Homes are generally considered a care coordination service)	Care team provides six core Health Home services to members.  The IHH care coordinator is the primary case manager for Habilitation (non waiver) and Children's Mental Health waiver.	Care team provides six core Health Home services to members.
Waivers and Health Homes	Members on waivers can also be enrolled in IHHs. Members on the Children's Mental Health waiver are required to be enrolled in an IHH.	Members on waivers can be enrolled in CCHHs. Members on the Children's Mental Health waiver cannot be enrolled in an IHH.

# Who is eligible to be enrolled in a HH?

Integrated Health Home	Chronic Condition Health Home
<ul style="list-style-type: none"> <li>• Adults with a serious mental illness (SMI)                             <ul style="list-style-type: none"> <li>• Psychotic Disorder</li> <li>• Schizophrenia</li> <li>• Schizoaffective disorder</li> <li>• Major depression</li> <li>• Bipolar disorder</li> <li>• Delusional disorder</li> <li>• Obsessive-compulsive disorder</li> </ul> </li> <li>• Children with a serious emotional disturbance (SED)</li> </ul>	<p>Adults or Children with the two of the following conditions or one condition and at risk for another:</p> <ul style="list-style-type: none"> <li>• Mental Health</li> <li>• Substance Use Disorder</li> <li>• Asthma Diabetes</li> <li>• Heart Disease</li> <li>• Overweight (BMI &gt;25 or 85<sup>th</sup> percentile)</li> <li>• Hypertension</li> </ul>
<p>If a member does not meet criteria for SMI or SED, functional limitations (i.e. how the member's functioning affects their daily life) can be considered as a reason for enrollment.</p>	
<p>ADHD and Autism are not considered a SED or Mental Health Condition. A member could be eligible; however, if he/she has a primary diagnosis of SED and a secondary of ADHD or Autism.</p>	



# Health Home Services

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient & family support
- Referral to community & social support services

# Member Choice

- A provider presents the qualifying member with the benefits of a health home and the member agrees to opt-in to health home services.
- Eligible individuals agree to participate in the health home at the initial engagement of the provider in a health home practice.
- The member will always be presented with the choice to opt-out at any time.

# Referrals to a CCHH

- The CCHH would also be the member's PCP
- If the member doesn't want to switch to another PCP and the PCP is not a CCHH, a referral to a CCHH would not be appropriate.
- Reasons to refer to a CCHH
  - Chronic Conditions are outweighed by the Mental Health Conditions.
  - Where the member feels most comfortable getting their care (Member Choice)

# Questions?

# Health Home Case Study

## Shenandoah and Waubonsie: A Case Study on Collaboration

- Female- she was a member of our IHH here at Waubonsie became pregnant and the OBGYN physician wanted her enrolled in the Medical Home as she was gestational diabetic.

She had several needs:

- Diabetic education
- Access to Dietician
- Financial needs
- After birth care
- It was then that Sue called IHH in Clarinda- and she was staffed and it mutually agreed that the Medical home would best meet her needs.

# Open Discussion

Thank you!