BEHAVIORAL HEALTH HOMES FOR PEOPLE WITH MENTAL HEALTH & SUBSTANCE USE CONDITIONS

THE CORE CLINICAL FEATURES

SAMHSA-HRSA
Center for Integrated Health Solutions

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EXECUTIVE SUMMARY

The 2010 Patient Protection and Affordable Care Act (ACA) established a "health home" option under Medicaid that serves enrollees with chronic conditions. Behavioral Health Homes for People with Mental Health & Substance Use Conditions: The Core Clinical Features proposes a set of core clinical features of a behavioral health home (i.e., a behavioral health agency that serves as a health home for people with mental health and substance use disorders). It provides context to the development of the health home option and its relationship to the person-centered medical home; outlines established principles of effective care and the chronic care model for serving people with chronic illnesses; applies the chronic care model as the framework for the behavioral health home's clinical features; and describes multiple organizational models for structuring the behavioral health home.

HEALTH HOMES

Federal health home guidance lays out service requirements stemming from the ACA and "well-established chronic care models."[1] The required services (also termed "provider standards" in the guidance) include:

- Each patient must have a comprehensive care plan;
- Services must be quality-driven, cost effective, culturally appropriate, person- and family-centered, and evidence-based;
- Services must include prevention and health promotion, healthcare, mental health and substance use, and long-term care services, as well as linkages to community supports and resources;
- Service delivery must involve continuing care strategies, including care management, care coordination, and transitional care from the hospital to the community;
- Health home providers do not need to provide all the required services themselves, but must ensure the full array of services is available and coordinated; and
- Providers must be able to use health information technology (HIT) to facilitate the health home's work and establish quality improvement efforts to ensure that the work is effective at the individual and population level.

Individuals served by a health home must have one or more chronic conditions such as a mental health or substance use condition, asthma, diabetes, heart disease, or be overweight. Regardless of which conditions states select for focus, states must address mental health and substance use disorders prevention and treatment services and consult with the Substance Abuse and Mental Health Services Administration (SAMHSA) on how it proposes to provide these services.

The Medicaid health home option offers the opportunity to create a behavioral health-based health home for people with serious mental health and substance use disorders. The challenge for behavioral health agencies is how to create a behavioral health home that serves not only as an administrative entity, but also possesses the capacity to improve consumer outcomes.

FOUR PRINCIPLES OF EFFECTIVE CARE

For health homes to work effectively, they must apply principles of quality care delivery. At a 2011 summit on integration of care sponsored by the Advancing Integrated Mental Health Solutions Center (AIMS) at the University of Washington, health systems experts articulated four principles of effective care that can inform the development of care in general and health homes in particular.[2] These principles, detailed below, apply to any primary care, mental health, or substance use treatment setting with the Triple Aim of improving healthcare, containing costs, and improving health outcomes.

- **PERSON-CENTERED CARE.** Basing care on the individual's preferences, needs, and values. With person-centered care, the client is a collaborative participant in healthcare decisions and an active, informed participant in treatment itself.
- **POPULATION-BASED CARE.** Strategies for optimizing the health of an entire client population by systematically assessing, tracking, and managing the group's health conditions and treatment response. It also entails approaches to engaging the entire target group, rather than just responding to the clients that actively seek care.

- **DATA-DRIVEN CARE.** Strategies for collecting, organizing, sharing, and applying objective, valid clinical data to guide treatment. Validated clinical assessment tools monitor response to treatment and information systems such as registries track the data over time.
- **EVIDENCE-BASED CARE.** The best available evidence guides treatment decisions and delivery of care. Both the behavioral health agency and its health provider partner (if applicable) must deliver evidence-based services.

CLINICAL FEATURES OF THE BEHAVIORAL HEALTH HOME

Consumers of mental health and substance use treatment services typically receive the bulk of their care in a setting such as a community mental health center. Many of these individuals may be unable or unwilling to receive care in a primary care clinic and even when they do, coordination between behavioral health and medical services may be poor. Thus, it has been argued that for those individuals who have relationships with behavioral health organizations, care may be best delivered by bringing primary care, prevention, and wellness activities onsite into behavioral health settings.[3]

The Chronic Care Model provides a useful organizing framework for behavioral health homes and has been proposed as an organizing framework for health homes in general[4]. As with the AIMS principles, the following features of the chronic care model apply generally to improving healthcare and health outcomes and containing costs for persons with mental and substance use conditions. [5]

- **SELF-MANAGEMENT SUPPORT.** Activated consumers possess skills to self-manage their care, collaborate with providers, and maintain their health. The behavioral health home helps activate consumers by assessing their activation level and then addressing deficits through self-management support strategies that include both education and coaching components.
- **DELIVERY SYSTEM DESIGN.** The behavioral health home redesigns the care system in key ways, including the forming multidisciplinary practice teams and providing care management. Providers work as part of a team responsible for addressing consumers' comprehensive care needs. Whether housed under one roof or stationed in different settings, team members must function as a single unit, which means maintaining clear roles, a single care plan, effective communication, and mechanisms for coordinating care between team members.

  > *Care management, a component of delivery system design, is a key strategy for ensuring that consumers do not "fall through the cracks." Consumers most likely to benefit will include those living with a mental health and/or substance use disorder with higher utilization of services and those living with numerous comorbid conditions. Care management focuses on client activation and education, care coordination, and, when working with a treating provider, monitoring consumers participation in and response to treatment.*

- **DECISION SUPPORT.** Involving specialists and embedding evidence-based guidelines in the routine provision of care are key decision support strategies for ensuring that clinical care is provided in line with best practices.
- **CLINICAL INFORMATION SYSTEMS.** Clinical information systems organize population-level data to maximize the outcomes for a defined group of consumers. They also organize consumer-level data to optimize individual outcomes. A patient registry is an information tool that enables effective tracking of all consumers with a particular condition or set of characteristics seen in a practice. Electronic reminders are a key function of effective clinical information systems, alerting providers to issues that need attention at the consumer or population level such as when consumers need a preventive procedure, like a colonoscopy.
- **COMMUNITY LINKAGES.** Behavioral health homes augment the services they can offer by linking consumers to community resources such as peer support organizations, self-help groups, senior centers, exercise facilities, and home care programs.

STRUCTURING THE BEHAVIORAL HEALTH HOME

The guidance from the Centers for Medicare and Medicaid Services (CMS) regarding the Medicaid health home option indicates that health homes do not need to provide the full array of required services themselves, but must ensure such services are available and coordinated. This gives a behavioral health agency several options for how to structure the behavioral health home, depending on its resources (e.g., physical facilities, number of consumers served, available workforce, financing options, community partners).

In the **in-house model,** the behavioral health agency provides and owns the complete array of primary care and specialty behavioral health services. The agency must ensure communication across providers and service coordination that allow it to deliver care that is integrated from the consumer's perspective.[7] Having all the necessary providers under one roof does not guarantee that they will work together to provide health home services effectively, just as the integrated primary and behavioral healthcare literature has demonstrated that co-location alone does not ensure true integration.

For behavioral health agencies without the capacity or desire to provide all services in-house, partnerships with outside healthcare providers can still make the behavioral health home feasible. In a **co-located partnership model,** the behavioral health agency arranges for healthcare providers to provide primary care services onsite. The co-located partnership approach may be particularly appropriate for mid-sized organizations that have the infrastructure to develop partnerships but lack the resources and economies of scale to develop an in-house model.

A third structural option is a **facilitated referral model**. In this approach, most primary care services are not provided onsite at the behavioral health agency; however, the agency has processes in place to ensure the coordination of care that is provided offsite. The agency conducts physical health screenings, links clients to primary care providers in the community, and facilitates communication and coordination between the behavioral health agency and health providers – typically with the support of a medical care manager. Given the low cost and relative flexibility of the facilitated referral model, such a structure may be most feasible for smaller agencies and may also serve as a transitional model for those that intend to implement co-located partnership or in-house models in the future.

CONCLUSION

The CMS Medicaid health home option offers an opportunity for behavioral health agencies to optimize the overall health and wellness of clients, build on the experience they have been developing in integrated healthcare, and carve out an important niche in the evolving healthcare system. Becoming a behavioral health home will require a major shift in the roles, processes, and care an agency provides. It will require embracing (or for some, strengthening) a new culture of care based on key principles of quality improvement and chronic illness management. These principles can be applied to improving care in specialty mental health and substance use settings with a goal of addressing the broader goals of better quality, improved outcomes, and reduced costs of care.

BEHAVIORAL HEALTH HOMES FOR PEOPLE WITH MENTAL HEALTH & SUBSTANCE USE CONDITIONS

THE CORE CLINICAL FEATURES

INTRODUCTION

Research literature documents that persons with serious mental illnesses[8,9] and substance use disorders[10] die younger than the general population – mainly due to preventable risk factors (e.g., smoking) and treatable conditions (e.g., cardiovascular disease[11] and cancer[12]). This research has led the behavioral health field to seek ways to improve access to preventive services, wellness programs, and medical care.[13] The mental health and substance use treatment communities have been working on developing interventions to reduce and eliminate this early mortality gap. An important thread of this work has focused on how to improve access to primary care, either by strengthening linkages to community primary care providers or by bringing primary care providers in-house.[14]

At the same time, the healthcare field has been working on addressing quality gaps in how it provides and coordinates medical services for people with chronic health conditions through mechanisms such as the chronic care model and the patient-centered medical home. Now, through authority granted by the Patient Protection and Affordable Care Act (ACA), state Medicaid programs and providers have the opportunity to establish "health homes" for Medicaid beneficiaries with chronic illnesses, including mental health and substance use disorders.

This paper outlines a proposed set of core clinical features of a behavioral health-based health home that serves people with mental health and substance use disorders, with the belief that application of these features will help organizations succeed as Medicaid health homes. The introduction provides context for the development of the health home option and its relationship to the person-centered medical home. Subsequent sections outline established principles of effective care, as well as the chronic care model for serving people with chronic illnesses. The chronic care model is then applied as the framework for clinical features of a behavioral health home. The last section describes multiple organizational models for structuring the behavioral health home.

This paper uses the term "behavioral health home" for multiple reasons: 1) to acknowledge the potential role of a diverse range of providers in providing care in these settings; 2) to highlight the broader range of nonmedical needs that should be addressed in these settings,[15] particularly for persons with mental health and substance use disorders; and 3) to highlight the option of situating these homes in specialty mental health and substance use settings.[16] The ACA offers an opportunity to develop such models for Medicaid enrollees with chronic conditions, including mental health and substance use disorders.[17]

HEALTH HOMES AND THE AFFORDABLE CARE ACT

The ACA, passed in 2010, creates a new option for state Medicaid programs to provide health homes for enrollees with chronic conditions, including mental health and substance use conditions.[18] The option became available to states on January 1, 2011, subject to CMS approval via a state plan amendment.

The new option contains financial incentives for states. For the first eight quarters of a state's health home benefit, the federal medical assistance percentage for health home-related service payments will be 90%.[19] States may propose alternative payment models for health home services (e.g., bundled payments), and may target a certain population, region, or diagnostic group. The ACA authorized state planning grants that are funded at the Medicaid administrative federal matching rate of the requesting state.

CMS health home guidance lays out service requirements contained in the ACA and "well-established chronic care models."[20] The required services (also termed "provider standards" in the guidance) include:

- Each patient must have a comprehensive care plan;
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- Service delivery must involve continuing care strategies, including care management, care coordination, and transitional care from the hospital to the community;
- Health home providers do not need to provide all the required services themselves, but must ensure the full array of services is available and coordinated; and
- Providers must be able to use health information technology (HIT) to facilitate the health home's work and establish quality improvement efforts to ensure that the work is effective at the individual and population level.

Individuals to be served by a health home must have a chronic condition, namely a mental health or substance use condition, asthma, diabetes, heart disease, or be overweight. The guidance from CMS notes that this list may grow over time.[21] While states may propose in their state plan amendment to address all of the eligible chronic conditions, at a minimum they must target the program to people who have either: two or more chronic conditions, one chronic condition and risk of another, or one serious and persistent mental health condition.[22] It is notable that regardless of which conditions are selected for focus, states are instructed to address mental health and substance use services and are required to consult with the Substance Abuse and Mental Health Services Administration (SAMHSA) about how they propose to provide mental health and substance use disorder prevention and treatment.[23,24] The full guidance provided by CMS on Health Homes is included in Appendix B.

With the Medicaid health home state option's strong emphasis on mental health and substance use conditions, it is perhaps not surprising that a number of states are in the process of formulating a health home state plan amendment with a focus on people with serious mental health conditions.[25] So far, only a few states have opted to target substance use conditions, and these are generally addressed in the context of comorbidity with serious mental illnesses. This new option offers the opportunity for behavioral health provider organizations to become health homes for the people they serve, making real the concept of a behavioral health-based health home.[26,27] The challenge for behavioral health agencies is how to create a behavioral health home that is not just an administrative entity, but possesses the capacity to improve outcomes for people with mental health and substance use conditions.

PATIENT-CENTERED MEDICAL HOME

The Medicaid health home option uses the patient-centered medical home (PCMH) as its starting point.[28] Initially, the term "medical home" described a model for addressing the complex health needs of children with multiple medical conditions. With its adoption by the larger healthcare field, the medical home has come to signify a care model in which the patient has a designated primary care provider who leads a care team responsible for coordinating the patient's overall healthcare needs.[29]

Building on the chronic care model,[30] the PCMH has arisen as a prominent framework for improving healthcare for both those with chronic conditions and, more recently, the general population.[31] The PCMH model involves reorganizing primary care delivery such that a designated primary care provider leads a care team responsible for coordinating the patient's overall healthcare needs, with the goal of improving clinical outcomes and reducing costs.[32]

IMPORTANT NOTE ON LANGUAGE DISCREPANCIES

Service recipients and providers in the primary care, mental health, and substance use communities use different terminology to refer to people who receive care in those settings.

While "patient" is most commonly used in the medical field, that term is often viewed negatively by those receiving mental health and substance use care due to its association with a more traditional approach to care. Instead, the mental health and substance use fields variously use the terms "client," "consumer," and "service recipient." It must be noted that there are differences of opinion within the mental health and substance use communities as to which of those terms is most appropriate and respectful.

Because this paper covers literature and concepts from all three fields and its target audiences span all three, it uses a variety of terms for service recipients, with the recognition that a lack of shared language – and the different treatment philosophies that language conveys – is a barrier that must be addressed when these fields work together to integrate care and serve as a health home.

Since the Medicaid health home option builds on the work of the PCMH,[33] behavioral health home implementers can learn a great deal about how to set up a health home from it. Behavioral health agencies working to become a behavioral health home should ensure that they have a good understanding of the PCMH model, the research supporting it, and the relevant implementation efforts. (See Appendix A for a compilation of resources on the PCMH model.)

In 2007, the American Academy of Family Physicians (AAFP), American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association issued a joint statement on the PCMH's core principles, which include:

- A personal physician for each patient;
- A physician-led practice team with responsibility for patients' ongoing, accessible, and comprehensive care across the life span;
- Care that is coordinated across the health system and characterized by quality and safety; and
- Aligned payment methods.[34]

The model is being implemented and tested in numerous efforts. The National Committee for Quality Assurance used this model to develop its medical home recognition program.[35] The Patient-Centered Primary Care Collaborative (PCPCC), a large coalition of employers, payers, providers, and other stakeholders, supports PCMH policy and implementation, in part through pilots in 20 states.❖[36] CMS has pilots underway through the Federally Qualified Health Center Advanced Primary Care Practice Demonstration.[37] TransforMED, an AAFP subsidiary, provides training and support to primary care practices adopting the PCMH model.[38]

A recent policy brief from *Health Affairs* and the Robert Wood Johnson Foundation estimates that over 100 medical home projects have been evaluated to date.[39] The PCPCC summarized recent evaluations of the PCMH model as follows:

"Quality of care, patient experiences, care coordination, and access are demonstrably better. Investments to strengthen primary care result within a relatively short time in reductions in emergency department visits and inpatient hospitalizations that produce savings in total costs. These savings at a minimum offset the new investments in primary care in a cost-neutral manner, and in many cases appear to produce a reduction in total costs per patient."[40]

Research from PCMH demonstration projects has yielded important lessons for would-be adopters. AAFP recently published the evaluation of its medical home pilot program, the TransforMED National Demonstration Project.[41,42] The evaluation found that adopting the PCMH model requires significant resources, both in terms of support around the PCMH model specifically, and support for the organization in general (e.g., change management resources). Implementers tend to underestimate the degree of change in their practice's roles and processes required to become a PCMH. Patient experience (e.g. satisfaction) should be carefully monitored during implementation as the evaluation found that patient experience actually declined during the project, for unclear reasons. Finally, implementation takes a significant amount of time; two years into the project, many sites still did not have a mature program.

This paper aims to provide states and behavioral health providers with a clear understanding of the clinical functions of a behavioral health home, which are most likely to yield positive outcomes for people with mental health and addiction disorders. Building on the relevant research for delivering high quality primary care, mental health, and substance use services, the paper reviews core principles and key clinical features that should guide the behavioral health home's work.❖❖ The paper also discusses options for how behavioral health agencies may structure the behavioral health home and concludes with concrete steps that mental health and substance use disorder providers can take to prepare for becoming a behavioral health home.

❖ In 2009, the Patient-Centered Primary Care Collaborative (PCPCC) formed a behavioral health workgroup to look at how mental health and substance use care fits within the PCMH. The PCPCC website (www.pcpcc.net) provides information on the workgroup's efforts and other materials on the PCMH model.

❖❖ Although equal emphasis was given to mental health and substance use disorders in the research conducted for this paper, readers will find that there is somewhat less content on substance use. This is not because substance use disorders are viewed as less relevant or important, but because the research conducted revealed less work in the substance use disorders field in some of the content areas covered.

FOUR PRINCIPLES OF EFFECTIVE CARE

For health homes to work effectively, they need to apply principles of quality care delivery. At a 2011 summit on integration of care sponsored by the Advancing Integrated Mental Health Solutions (AIMS) program at the University of Washington, participants articulated four principles of effective care that can inform the development of care in general and health homes in particular[43] and that should apply to any primary care, mental health, or substance use setting aimed at improving healthcare, containing costs, and improving health outcomes. These four principles posit that care should be person-centered, population-based, data-driven, and evidence-based.

PERSON-CENTERED CARE is the principle that all care should be based on the individual's preferences, needs, and values.❖ This marks a paradigm shift from the traditional medical model, in which the provider is seen as the expert who determines what and how healthcare is provided and the consumer is a passive recipient who "complies" with treatment. With person-centered care, the consumer is a collaborative participant in care decisions and an active, informed participant in treatment itself.

Self-management support entails helping consumers become active and informed participants in their own care. Following an assessment of the consumer's baseline knowledge, skills, beliefs, motivations, and behaviors around his/her conditions and treatments, the provider works with the consumer to address any gaps. The interventions provided may involve education on the individual's conditions and prescribed treatments, collaborative goal setting, motivational interviewing to increase drive for behavior change, and regular follow-up to assess progress and problem solve continuing issues.[44]

Shared decision-making is a person-centered strategy for empowering consumers to participate in healthcare decisions.[45] Instead of the provider unilaterally deciding what treatment the consumer should have, the provider and the informed, empowered consumer review the best available information about the consumer's condition and its treatments and work together to help the consumer arrive at a thoughtful decision about how he/she would like to proceed with care.[46] Shared decision-making involves a combination of education (often in the form of evidence-based decision aids that cover information on available treatments and examples of real people's decision processes), as well as coaching by a peer, nurse, or other healthcare provider to support the consumer as he/she goes through the materials and weighs the options.

POPULATION-BASED CARE entails strategies for optimizing the health of an entire client population (based on a particular condition, set of characteristics, practice/provider group, or other parameter) by actively and systematically assessing, tracking, and managing the group's health conditions and treatment responses.[47] The idea is that consumers with diabetes, for example, share similar healthcare needs and by applying care guidelines to them as a group, better outcomes can be achieved. It also entails proactive approaches to engage all members of the target group in treatment and monitoring, rather than just responding to whichever consumers happen to show up in the provider's office.

Care management is a key strategy in population-based care. Care management entails following a defined population of consumers to monitor their treatment response and adjust care as needed.[48] Once consumers have been engaged in the program, care management typically begins with educating consumers about their conditions and how to participate in their management. The care manager then follows up with the consumer on a regular basis to assess treatment response, using a valid assessment tool as an objective measure of response. To keep track of the client panel, the care manager uses a patient registry that contains basic clinical data (e.g., assessment or lab results, treatment regimen, and appointments) and allows for data sorting so the care manager and other team members can easily identify who is not responding to care or has not been seen recently for a follow-up visit. Care management is designed to ensure that members of the defined client population do not "fall through the cracks." (See the Care *Management section* for more on care management in the behavioral health home, and the *Clinical Information Systems section* for more on registries.)

DATA-DRIVEN CARE is another core principle of effective care delivery. Strategies entail collecting, organizing, sharing, and applying objective, valid clinical data to guide treatment. Validated clinical assessment tools are used to monitor response to treatment, and information systems such as registries are used to track the data over time. Treatment is repeatedly and systematically adjusted until the consumer's condition can be considered stable or in remission, as indicated objectively by a valid assessment instrument. An

❖ California's CalMEND Project recently released a groundbreaking report on client and family perspectives on integrated healthcare, Integration of Mental Health, Substance Use, and Primary Care Services: Embracing Our Values from a Client and Family Member Perspective. It provides a rich discussion of the core values such as person-centered care that should inform the integration of mental health, substance use, and primary care service delivery. It can be viewed and downloaded online at www.cimh.org/portals/0/documents/CF%20Integration%20Paper%20-%20Volume%201.pdf.

electronic health record or registry can help the practice track scores over time. (See *Clinical Information Systems section* for further discussion.)

In data-driven care, the treatment response of a person living with depression, for example, may be evaluated by tracking changes in his/her Patient Health Questionnaire-9 (PHQ-9) score over time,[49] instead of by asking how he/she is feeling today or whether the depression seems to be lifting. For substance use disorders, scales such as the Alcohol Use Disorders Identification Test (AUDIT) can provide similar guidance in tracking care outcomes.[50]

EVIDENCE-BASED CARE is a core principle of primary and behavioral healthcare, and should also guide care in behavioral health homes. It means using the best available evidence to guide treatment decisions and delivery of care, including preventive and health promotion services, screening, assessment, treatment, and relapse prevention. In contrast to best practices, evidence-based practices are explicitly informed by, and grounded in, relevant clinical research demonstrating treatment effectiveness. Because there is never sufficient evidence to guide all treatment decisions, external clinical evidence from systematic research must be combined with individual clinical expertise.[51]

A 2007 National Quality Forum consensus report focused on substance abuse treatment identified evidence-based standards of care across four broad domains.[52] *Identification* entails screening and case finding, diagnosis, and assessment using standardized tools. *Initiation and Engagement* involves brief interventions for substance use conditions in primary care and mental health settings. *Therapeutic Interventions* include detoxification and clinical interventions provided in specialty substance use treatment settings. *Continuing Care* entails ongoing, coordinated care following acute treatment.

In practice, behavioral health agencies serving as health homes will need to conduct evidence-based screenings for common health conditions and risk factors such as glucose and lipid levels, blood pressure, weight, body mass index, HIV, Hepatitis C, and carbon monoxide levels.[53,54] Behavioral health agencies partnering with health providers to deliver health home services will need to ensure that health providers are screening for mental health and substance use conditions using valid measures such as the PHQ-9 for depression and the AUDIT for substance use.[55,56] Behavioral health homes will also need valid instruments for establishing diagnoses and tracking consumers' treatment response.[57] These measures may or may not overlap with the screening instruments, depending on the measures' psychometric properties. SAMHSA recommends several screening tools for mental health and substance abuse, all of which are evidence-based and publicly available on its website at www.samhsa.gov/healthreform/healthhomes.

Treatment must also be evidence-based. For mental health and substance use conditions, this will include empirically validated counseling and psychotherapies such as motivational interviewing, problem solving treatment, cognitive behavioral therapy, and interpersonal therapy, as well as guideline-informed psychopharmacology. An example of evidence-based intervention in behavioral health is SBIRT (Screening, Brief Intervention, and Referral to Treatment), a model in which people who screen positive for problem alcohol and/or other drug use are provided with a brief intervention designed to educate them about their risky behavior and increase their motivation to change.❖ [58] Healthcare services will also need to be delivered in line with clinical guidelines, regardless of whether they are provided on or offsite.

A key issue in delivering evidence-based care is how to ensure that both providers and consumers have access to the best available evidence when it is needed. Embedding evidence-based guidelines in the routine provision of care is one approach to making sure providers and consumers have access to such evidence.[59] Electronic medical records and other computerized systems can be set up to send providers alerts when they prescribe a treatment that appears to be contraindicated, giving the provider an opportunity to review or explain his/her decision. Standing orders can be incorporated into these systems, streamlining the process of ordering indicated tests, procedures, or treatments. Embedded decision flow charts for various conditions can also help providers and consumers sort through the evidence-based treatment options and decide upon the best course of action. (See Embedding clinical guidelines section for more information.)

With regards to both data-driven and evidence-based care, CMS is concerned with the outcomes health home providers can document for the services they provide.[60] Behavioral health agencies developing their behavioral health home model should pay close attention to the interventions they select, making sure they have a strong evidence base and are likely to yield positive outcomes. They should also look closely at the instruments for assessing consumer outcomes, as these will be used to make the case for anticipated success to payers.

❖ For an extensive annotated bibliography of the research literature on SBIRT, see SBIRT Colorado Literature Review Summary at www.improvinghealthcolorado.org/files/documents/SBIRT_LIT_REV_5.pdf.

CLINICAL FEATURES OF THE BEHAVIORAL HEALTH HOME

To function as a behavioral health home requires a major shift in the roles, processes, and care provided in behavioral health settings. To achieve this shift, the behavioral health home must reorganize care delivery in several key areas: self-management support, delivery system design, decision support, clinical information systems, and community linkages. These are the core elements of the chronic care model, which serves as an overarching framework for the behavioral health home. This section provides an overview of the chronic care model and then examines each of its elements in detail.

FRAMEWORK: THE CHRONIC CARE MODEL

The chronic care model serves as the foundation for the patient-centered medical home structure and collaborative care approaches to the management of common mental disorders in primary care. With support from the Robert Wood Johnson Foundation, Edward Wagner and his colleagues at the MacColl Institute for Healthcare Innovation at Group Health Cooperative of Puget Sound developed the chronic care model in the 1990s, with the goal of improving treatment of chronic health conditions in primary care settings.[61,62]

The model grew out of the awareness that primary care tends to be organized to provide acute care, but conditions such as asthma and depression require a system that can provide ongoing treatment and support. To shift from an acute care model to a continuing care model requires the entire primary care practice to change. More recently, the chronic care model has been conceptualized as describing how care — including preventive and primary care — should be delivered for all health issues, decoupling it from the original focus on chronic conditions.[63]

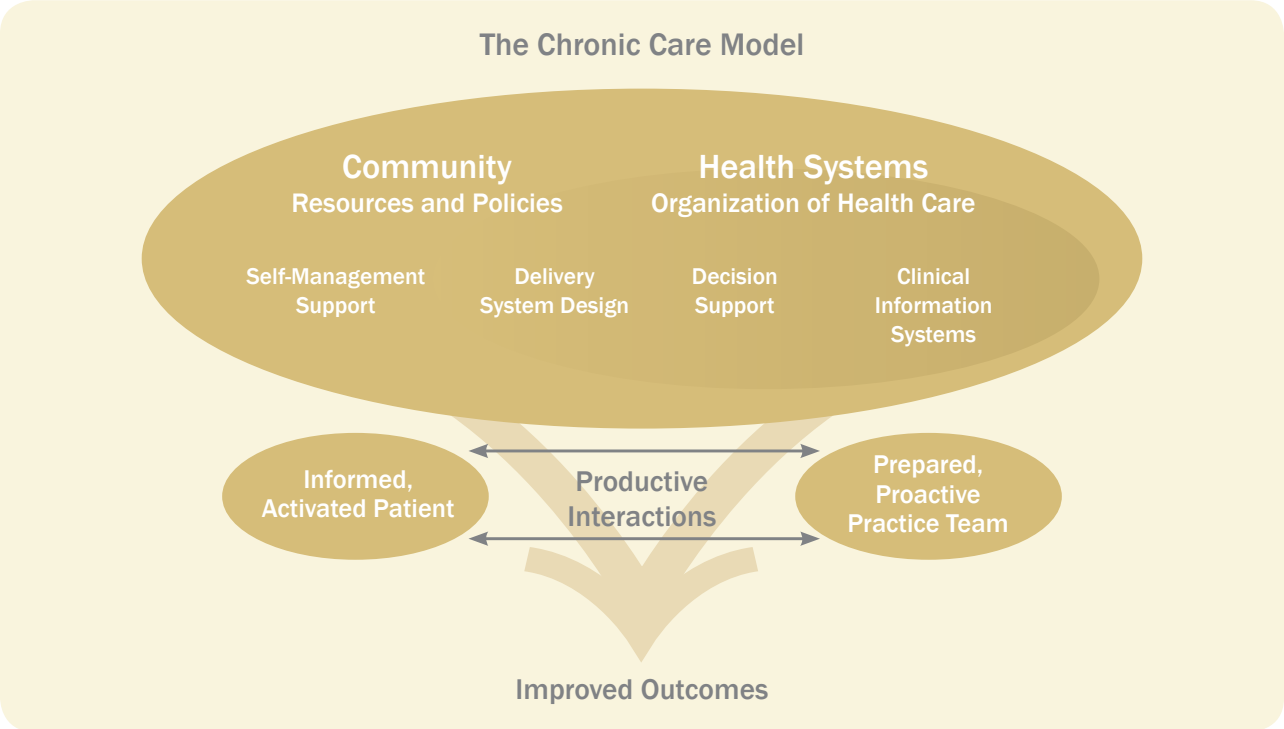

FIGURE 1. A SCHEMATIC OF THE CHRONIC CARE MODEL[64]

At the base of the chronic care model are productive interactions between an informed, activated patient and the prepared, proactive practice team.[65] Being informed and activated, the patient is able to participate as a full partner in his/her care. Multidisciplinary staff members work as a team with clear roles and a shared plan. Rather than simply responding to whatever issues happen to come up during the encounter, they approach each contact with the patient with goals and a plan for the interaction. The patient and practice team's work is supported by the reorganization of care delivery in several interdependent areas, including self-management support,

delivery system design, decision support, clinical information systems, and community linkages. Success is further ensured by the agency's leadership, which demonstrates support for the initiative at all levels of the organization, establishes learning opportunities and quality improvement efforts, and implements policies that support the initiative's sustainability.

Research has shown the chronic care model to be an effective approach for managing conditions like diabetes and asthma.❖ [66,66,67,68,69,70,71] The available research suggests that adopters obtain better outcomes when their implementation hews closely to the model, incorporating most if not all its components.[72]

Numerous studies have shown the chronic care model's value in improving the delivery of behavioral healthcare in primary care settings,[73] and of primary care in mental health and substance use treatment settings.[74,75,76,77] In the case of primary care integration, collaborative care incorporates a behavioral healthcare manager and consulting psychiatrist into the primary care setting. Care managers are trained behavioral health professionals or paraprofessionals responsible for educating consumers about their mental health and substance use conditions and treatments and regularly monitoring their response to treatment with valid clinical assessment tools. A consulting psychiatrist regularly reviews the care manager's panel of clients, providing treatment recommendations that are passed on to the treating primary care provider. The collaborative care model is backed by extensive research demonstrating that it can improve care, particularly for common mental health[78] and substance use conditions[79,80] in primary care. It has also served as a foundation for research examining strategies to improve delivery of primary medical care in specialty behavioral settings.[81,82]

The key features of the chronic care model can be supported in behavioral health homes for people with mental health and substance use conditions. The following subsections examine the core clinical features of the behavioral health home, as informed by the chronic care model's conceptualization of service delivery reorganization via self-management support, delivery system design, decision support, clinical information systems, and community linkages.

	AIMS CORE PRINCIPLES OF EFFECTIVE CARE			
Chronic Care Model Features in the Behavioral Health Home	Person-Centered	Population-Based	Data–Driven	Evidence-Based
Self-management support	X			
Shared decision-making	X			
Delivery system redesign		X	X	
Embedded clinical guidelines		X		X
Client registries		X	X	

TABLE 1. CROSSWALK BETWEEN THE FOUR AIMS PRINCIPLES OF EFFECTIVE CARE AND THE CHRONIC CARE MODEL'S KEY ELEMENTS

SELF-MANAGEMENT SUPPORT

The Institute of Medicine defines self-management as "the tasks that individuals must undertake to live well with one or more chronic conditions," including "having the confidence to deal with the medical management, role management and emotional management of their conditions."[83] The benefit of self-management support is evident when considering, for example, the minimal time people with diabetes spend in a provider's office compared to the time they spend on their own, making decisions about diet, exercise, and medication adherence that dramatically impact their outcomes.

In general, research has shown self-management support programs to be beneficial. Formal self-management support programs have been found to be a key element in successful implementations of the chronic care model and effective in improving outcomes for

❖ See the Improving Chronic Illness Care website for an extensive annotated bibliography of research on the chronic care model at www.improvingchroniccare.org/index.php?p=Chronic_Care_Model_Literature&s=64.

a variety of chronic health conditions.[84,85] As previously noted, such programs are more likely to be effective when they include both education and skill building components (as opposed to education alone).

The behavioral health home helps consumers become activated through self-management support strategies. The emphasis on self-management support stems from the awareness that consumers will not be able to achieve true health and wellness unless they play a substantial role in their own care.[87,88] The activated client is a concept that applies to management of mental, substance use, and medical conditions and care; it is consistent with the understanding of recovery defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[89] Behavioral health agencies partnering with medical providers for the behavioral health home may find it useful to share their experience with recovery concepts and empowered consumers and to establish a shared language of recovery.

A particularly well researched and widely implemented self-management program for chronic health conditions is the Chronic Disease Self-Management Program (CDSMP).[90,91,92] CDSMP is comprised of six 2½-hour sessions led by two trained leaders, one or both of which are peers (i.e., people who have a chronic health condition themselves). People living with different chronic conditions participate together in sessions that cover topics such as exercise, nutrition, dealing with fatigue and pain, appropriate use of medications, effective communication with loved ones and health professionals, and evaluating new treatment options.

CDSMP has been implemented around the world for a range of chronic health conditions, including behavioral health. The program has been piloted in its original form with people who have mental health conditions,[93] and adapted specifically for people with these conditions.[94]

IN PRACTICE

*The **Health and Recovery Peer (HARP) program** is an adaptation of CDSMP for mental health consumers.[95] In this manualized, six-session intervention, peer leaders help participants become more effective managers of their chronic illnesses. Sessions focus on health and nutrition, exercise, and being a more effective consumer. The HARP program's modifications of CDSMP involved adding content on mental health and its interaction with general health and tailoring diet and exercise recommendations for the socioeconomic status of a public sector population. Like CDSMP, HARP helps individuals become more activated consumers of healthcare, but does not provide any direct linkage with medical services.*

A pilot trial randomized 80 consumers with one or more chronic medical illness to either the HARP program or usual care.[96] At 6-month follow-up, HARP participants demonstrated a significantly greater improvement in patient activation and were more likely to have had one or more primary care visits than those in usual care. HARP participants also fared better in physical health-related quality of life (HRQOL), physical activity, and medication adherence. Improvements in HRQOL were largest among medically and socially vulnerable subpopulations. The size of the differences between the HARP group and the usual care group was similar to those seen for CDSMP in general medical populations.

Self-management programs have been also developed specifically for people with mental health and substance use conditions. The Wellness and Recovery Action Plan (WRAP) program is a peer-led intervention that helps people with a mental illness monitor the feelings and behaviors that concern them and develop strategies for reducing or eliminating them.[97,98] In substance use, SMART (Self-Management and Recovery Training) features online and in-person meetings during which participants learn skills to enhance their motivation to quit, cope with urges to use illegal substances, challenge irrational thoughts, feelings, and behaviors around using drugs, and create a balanced life.[99] Self-management support is also a key element of SBIRT (Screening, Brief Intervention, and Referral to Treatment), in which people who screen positive for problem alcohol or other drug use are provided with a brief intervention designed to educate them about their risky behavior and increase their motivation to change.❖ [100]

❖ For an extensive annotated bibliography of the research literature on SBIRT, see the SBIRT Colorado Literature Review Summary at www.improvinghealthcolorado.org/files/documents/SBIRT_LIT_REV_5.pdf.

IN PRACTICE

*The **Wisconsin Initiative to Promote Healthy Lifestyles** uses SBIRT to help persons with alcohol and drug use problems in primary care. The program is offered in more than 20 primary care centers around the state and targets both adults and adolescents.*[101,102] *The program has expanded to address smoking, poor nutrition, lack of exercise, depression, and domestic violence, as well.*

Nurses or medical assistants administer four questions on alcohol and other drug use once a year during a routine primary care visit. Patients who screen positive for problematic substance use conditions are referred to a health educator for one to three 20-minute interventions that use motivational interviewing and the stages of change[103] *approach. Health educators have a bachelor's degree and a minimum of 2 years' human services experiences. They are trained in cultural competence to meet the needs of Wisconsin's diverse population; they must pass a 3-week intensive training and are supervised through weekly calls and reviews of audiotaped sessions.*

The program is associated with strong staff and patient satisfaction, and has been documented to decrease regular and maximal drinking. SBIRT has also been shown to be highly cost effective, and in early 2010, the Wisconsin Medicaid program began covering the program.

Self-management support may be provided by professional staff (e.g., a nurse, social worker, medical assistant), lay workers such as a trained peer (i.e., people who have chronic diseases themselves), community health worker, or health navigator. It is often delivered as part of care management. (See care management section.) There are advantages to having trained peers, community health workers, or health navigators serve in this role, given their increased ability to connect with consumers because of shared experience and/or background. Research has shown these individuals to be effective in providing self-management support.[104,105,106,107,108,109]

Regardless of who assumes this role, the entire behavioral health home team should be aware of the consumer's self-management goals and challenges and reinforce self-management strategies and skills during their interactions with the consumer.[110]

Behavioral health agencies wanting to learn more about self-management support approaches that they may consider incorporating into a behavioral health home may find two summary reports particularly useful. A 2007 RAND report developed for the Agency for Healthcare Research and Quality examined the factors that purchasers and program designers should consider when they are deciding on program components, presenting key findings from a literature review and expert interviews, as well as recommendations for developing a self-management support program.[111] A 2010 California HealthCare Foundation report authored by Bodenheimer and Abramowitz provides case studies of a wide range of programs, as well as a list of training curricula in self-management support.[112]

DELIVERY SYSTEM DESIGN

The chronic care model calls for the reorganization of the care system in a way that is proactive and responsive to the needs of consumers with chronic illnesses. The behavioral health home requires the care delivery system to be reorganized in two key ways:

- Providers must form multidisciplinary practice teams capable of working together to effectively ensure consumers' full range of care needs is met.
- Care management must be in place so that consumers do not "fall through the cracks."

PRACTICE TEAM

The behavioral health home requires providers to work together as part of a multidisciplinary team that shares responsibility for addressing consumers' comprehensive care needs. The team may be housed under one roof or function virtually with members stationed in different settings. Regardless of location, it is essential that the members function as a single unit. This means having clear roles, a shared plan, effective communication, and mechanisms for coordinating care between team members.

The membership of the team will depend on the individual consumer's needs. For people with severe behavioral health conditions receiving care in a behavioral health home, the team would consist, at a minimum, of their current behavioral health clinician and a pri-

mary care provider who may be on or offsite. Regardless of how the health home is constructed or what specific model it employs, the primary care clinician, who may be a physician or a "mid-level provider" (e.g., a nurse practitioner), plays a key role as the provider of actual primary care services.❖ The individual's team may also include a care manager who tracks the individual's treatment response and coordinates care between team members, a peer specialist who provides wellness and recovery support, and/or a community health worker who serves as a health navigator. To round out the team's ability to address the individual's range of health, mental health, and substance use condition needs, a nutritionist, medical specialists (e.g., endocrinologist), pharmacist, and other provider types may be involved. (See the care management section for additional information on care manager functions and training.)

Team members must be clear on their roles in caring for consumers. This is particularly important when team members are housed in different locations and when a consumer's needs require someone other than his or her usual providers to serve as the lead provider on a temporary or permanent basis (e.g., if the individual develops cancer), in which case a care coordination agreement can help the team establish which provider is responsible for what aspects of care and its coordination.[113] The range of needed tasks should be distributed across team members in a way that allows for the most efficient care, a process known as "task shifting."[114] For example, medical assistants or front desk staff may be trained to take on simple screenings or behavioral assessments, a role traditionally reserved for nursing and similar staff.

The team works from a single care plan designed to address all physical health, behavioral health, and wellness needs. The care plan is developed collaboratively with the consumer. All team members need access to the care plan so they can use it when planning their interactions with the consumer and update it as needed.

IN PRACTICE

*The **Connected Care™ Program**, a joint venture of the Community Care Behavioral Health Organization and University of Pittsburgh Medical Center (UPMC) Health Plan with support from the Center for Health Care Strategies' Rethinking Care Program, focuses on improving the connection to and coordination of care for health plan members with serious mental illnesses in southwestern Pennsylvania.[116] Based on the patient-centered medical home model, Connected Care uses an integrated care team and care plan to address consumers' comprehensive medical, behavioral, and social needs.*

Care team members have access to the web-based integrated care plan, which pulls in client data from the participating physical and behavioral health plans. Care managers can access and update client information through an online interface, and the care plan is reviewed and modified during team meetings. The care plan is informed by input from the client and/or caregivers, the primary care provider, behavioral health providers, health plan staff, medical director, nurses, social worker, and pharmacist.

Program staff has found regular team meetings, during which they review the care plan, to be particularly helpful in developing a clear, shared understanding of the medical and behavioral health services consumers have received, gaps in care, and their treatment regimens.

Researchers conducted a pre-post analysis of 5,463 Medicaid recipients with serious mental illness and a history of frequent emergency department and/or inpatient utilization who participated in the program. Participants demonstrated a decline in hospital readmissions (from 64.1 per 1000 to 46.5 per 1000), in ED admissions (from 1975 per 1000 to 1963 per 1000) and costs, resulting in an estimated $609,000 savings in behavioral health expenses and $1.3 million dollars in savings on general medical care.[117]

Connected Care's integrated care plan template can be accessed at www.chcs.org/usr_doc/Integrated_Care_Plan_Template.pdf.

To work well as a team, the members must have rapid and effective communication and be able to coordinate care delivery with each other. For this to happen, there must be mechanisms in place for in-the-moment communications about current consumer needs or team activities. Team members must be able to find out who has seen the consumer and for what reason. If an acute need arises, the appropriate team members must be notified so they can respond. Team members must be able to mobilize quickly to work together

❖ CIHS (www.integration.samhsa.gov) has compiled a number of resources to assist primary care providers delivering care in behavioral health settings, including webinars, reference materials, and training programs.

when problems arise. These communications can occur effectively and efficiently via an electronic medical record (EMR) or a registry. (See clinical information systems section). For teams working in an agency without an EMR or registry, faxes, encrypted emails, and secure online shared documents can facilitate communication and coordination.

There should also be mechanisms in place for routine communication between team members. For some practices, this means starting off each day with a team "huddle," in which the group reviews the consumers to be seen that day. Teams may meet weekly to review and discuss consumers, typically focusing on those in treatment who are not responding well to the current care plan. Teams may also find it useful to meet monthly or quarterly to discuss their work processes, troubleshoot problem areas, exchange program information and lessons learned, and further build a sense of their identity as a team.

It is hard to isolate the impact of a multidisciplinary practice team from that of the clinical functions provided by the individual team members, but there is some evidence that having providers from a range of disciplines work together as a team is more effective than usual care for chronic health conditions.[118] One study of chronic care teams found that effective teams are characterized by their commitment to consumer satisfaction, the presence of a team "champion," and a workable team size (neither too small nor too large).[119]

CARE MANAGEMENT

Care management has evolved as a critical component of the medical home model and collaborative care,[120,121] and it will be a key function of the behavioral health home. Care management focuses on client activation and education, care coordination, and – when working directly with a treating provider – monitoring the consumers' participation in and response to treatment.

The first step in care management is identifying consumers likely to benefit from having a care manager. Care management is a relatively resource-intensive strategy with research showing that it is most effectively when used with particularly complex consumers with chronic conditions.[122] Appropriate candidates in the behavioral health home will be consumers with mental health and substance use disorders who are higher utilizers of services, including ED and inpatient utilization, and those with numerous comorbid conditions, including mental health, substance use, and medical conditions.[124] Some have found it helpful to offer different levels of care management — a very intensive model for the most complex consumers and a less intensive model for moderately complex consumers who still need additional support.[125]

Most behavioral health providers (and healthcare providers) do not have systems in place that allow them to determine consumers' utilization of services outside the agency. However, when asked, clinicians often have a good idea which of their patients have complex healthcare needs and are high-utilizers. Once these initial care management consumers are identified, behavioral health homes will find it helpful to examine their common characteristics (e.g., particular diagnoses, comorbid mental health and substance use conditions, chronic pain, polypharmacy), so they can develop a strategy for identifying appropriate candidates going forward. This may involve collecting some supplementary consumer data, mining existing data on a regular basis, and/or using partnerships with outside providers (e.g., pharmacists, primary care providers) to gain access to additional data.

Once consumers have been identified and recruited into the program, care management typically begins with educating consumers about their conditions and how to manage them, including participating in prescribed treatments. (See self-management support section.) At this point, it is helpful for care managers to assess consumers' perceived barriers to treatment participation. For example, a consumer may have no intention of taking the antidepressant that has just been prescribed because he has heard it makes people "shoot up post offices" or causes sexual side effects. Some consumers may identify the cost of the prescribed drug or psychotherapy as a barrier. Others may simply not understand the need for or potential value of treatment and, therefore, are unwilling to participate. Care managers play a crucial role in identifying and addressing these concerns so consumers are more likely to participate in treatment.

When a treating provider is directly involved, the bulk of the work in care management focuses on monitoring the consumers' participation in and response to treatment. The care manager reaches out to the consumer on a regular basis (often weekly at the start and then more infrequently as the consumer begins to improve) to assess how he/she is doing. At each check-in, the care manager administers a valid assessment tool to objectively evaluate consumers' response to treatment. The check-ins are brief (usually 15 to 20 minutes) and can be conducted by phone or in person. Especially for care managers working in the public system, telephone contacts are often easier because consumers may find it difficult to travel on a frequent basis due to transportation or child care challenges. The provision of care management solely by telephone (i.e., with the care manager never having met face-to-face with the

IN PRACTICE

Compass Health, *a private nonprofit community mental health center servicing four counties in northeastern Washington State, participated in the Washington Community Mental Health Council's 2010-2011 learning collaborative on medical care management.*[126] *Through the pilot, sites had access to a database of Medicaid claims data developed and maintained by the state health agency, which enabled them to identify their clinic's highest risk consumers and to see where else in the community consumers were receiving services or obtaining medications. Each pilot site had leeway to develop their own program eligibility criteria using the database.*

Compass Health used the Medicaid claims database to identify consumers in their clinics who had the highest inpatient and ED utilization. The database also helped them determine which medical providers in the community served the consumers, what medications the consumers were prescribed, and where they filled their prescriptions.

Once consumers were identified through the database as eligible for the program, the nurse care manager conducted outreach to engage them in the program. Consumers in the program regularly completed the Patient Activation Measure,[127] *which assessed their knowledge, skills, and confidence in managing their own health and healthcare. They met regularly with the nurse care manager who provided support, education, and problem solving around their medical conditions and goals and accompanied them to medical appointments as needed.*

The program was not formally evaluated. However, Compass identified several key lessons learned through the pilot. They found that effective medical care management required clear communication and close coordination between the care manager, case manager, mental health prescriber, primary care provider, specialists, and others who interact regularly with the consumer. A key role for the care manager was serving as the bridge between the consumer and primary care provider, especially in terms of helping consumers prepare for appointments and understand providers' instructions and information. Compass also found it was important to meet consumers "where they are," remaining flexible in working on the needs and concerns they identified as most salient.

consumer) has not been found to be as effective as in-person care management; however, doing a combination of telephone and in-person check-ins has worked well for some providers. [128]

The care manager uses a registry to keep track of his/her panel of consumers and to make sure that they are followed up with regularly. The registry contains basic clinical data such as diagnoses, assessment or lab results, current and past treatment regimens, and appointments. It may be paper-, electronic- (e.g., Excel spreadsheet), or web-based. It should allow for data sorting so the care manager and other providers can easily identify who is unresponsive to care or has not been seen recently for a follow-up visit. (See clinical information systems section for further discussion of registries.)

The care manager meets on a regular basis (usually weekly) with a supervisor. The supervisor may be a primary care physician or other medical specialist, if medical care management is being provided in a behavioral health setting. It may be a psychiatrist or other behavioral health specialist, if behavioral healthcare management is being provided in a primary care setting. The purpose of supervision is to review the care manager's panel of consumers and obtain the supervisor's treatment recommendations for consumers who are new or unresponsive to care. The care manager conveys recommendations to the treating provider who then works with the consumer to change the treatment plan. Adjustments continue to be made until the consumer achieves remission or recovery. (See access to medical specialists section for further discussion of the specialist's role.)

Care management functions can be taken on by different types of providers. The training and credentials of the care managers will determine what functions they can appropriately and effectively take on, with more limited services being provided by those with less training. The bulk of research on chronic health conditions and collaborative care for behavioral health conditions has looked at care management provided by social workers (or equivalent master's-level professionals) and nurses.[130,131] Social workers are highly skilled at coordination activities, whereas nurses have more background in medical management and education. Trained peers, community health workers, and health navigators (more often seen in the medical field) offer another good option, especially given their ability to connect with consumers due to shared experience and/or background. Community health workers have effectively provided screening, monitoring, patient education, and self-management support in multiple studies focused on chronic health conditions

IN PRACTICE

*In the **TEAMcare study,** nurse care managers at **14 Group Health Cooperative**-affiliated primary care clinics in the Seattle area worked with consumers who had depression and poorly controlled diabetes and/or coronary heart disease.[129] The 12-month intervention combined self-management support with pharmacotherapy.*

Each patient collaborated with a nurse care manager and primary care provider to set individualized clinical and self-management goals. Then, during structured visits every 2 to 3 weeks, a nurse care manager monitored the patient's depression score, diabetes/coronary heart disease control, and self-management activities. The visits also included problem solving and goal setting to improve the consumer's medication adherence and other self-management behaviors. An electronic registry was used to track depression scores and diabetes and coronary heart disease indicators.

A psychiatrist, primary care provider, and psychologist supervise nurse care managers weekly, during which time they reviewed new cases and patient progress. The supervisors made treatment recommendations, which the nurse care manager communicated to the primary care provider responsible for medication management. Once guideline-based target levels were achieved on depression, diabetes, and coronary heart disease indicators, the nurse care manager and patient developed a relapse prevention plan that included stress reduction, behavioral goals, continued use of medications, and identification of symptoms associated with worsening depression and diabetes control. Nurse care managers then checked in with patients by telephone every 4 weeks, offering follow-up visits and intensified treatment to those whose health deteriorated.

As compared to patients receiving usual care, patients in the nurse care management program experienced greater improvement in diabetes, coronary heart disease, and depression and were more likely to have their treatment proactively adjusted. They also had better quality of life and greater satisfaction with the care they received.

like diabetes and asthma.[132,133] Peer support programs have capitalized on the lived experience of individuals with mental health and substance use disorders to offer education and self-management support services with positive outcomes.[134,135.136] In addition, health navigators have been shown to be effective in providing self-management support in the patient-centered medical home.[137,138] Because these individuals have less training than nurses and social workers, the care management functions they can provide will be more limited.

Care management has been found to improve consumer outcomes, including consumer satisfaction, symptom reduction, functional improvement, and quality of life.[139,140] However, it often takes time for gains to be realized. Several research studies that found no impact for care management at 12 months documented positive gains at 24 months.[141] Successful care management programs are characterized by involving family caregivers, having care managers work in multidisciplinary teams that include physicians, and providing care managers with adequate training.[142]

Care coordination and transitional care are two concepts that overlap closely with care management and are mentioned specifically in the CMS guidance for the Medicaid health home option.[143] Care coordination, a common element of care management, involves strategies to help providers working with the same consumer to communicate with each other to improve the quality of care.[144] Transitional care focuses specifically on care coordination for consumers moving between care settings (e.g., inpatient to outpatient) and systems (e.g., pediatric to adult health systems, behavioral health to primary care settings).[145] Care management has been shown to be highly effective in assisting with transitions from inpatient to outpatient care for medically complex consumers, leading to improved quality, lower rates of rehospitalization, and reduced costs,[146] as well as for adolescents moving into the adult health system.[147] At their core, care management, care coordination, and transitional care all involve providing continuing care.

Finally, it is necessary to distinguish the care management under discussion here from care management delivered through commercial disease management programs. Disease management is typically offered by payers or companies that specialize in the provision of such services. The services are usually provided by telephone from a remote, centralized location, covering numerous practices. Disease management is delivered as a service external to the provider practice and does not involve change in the care provided at the practice level, unlike chronic care approaches.[148] Telephonic disease management appears to be less effective than onsite care management in improving clinical outcomes and reducing costs.[149,150]

DECISION SUPPORT

Decision support involves strategies for ensuring that clinical care is provided in line with best practices. The typical primary care-based health home practice team is largely comprised of generalists. In the behavioral health home, the team will primarily include behavioral health experts. Regardless of setting, the practice team has responsibility for providing or coordinating comprehensive, evidence-based care for consumers. They can best supplement their skills and knowledge with the expertise of specialists and by embedding evidence-based guidelines in the routine provision of care.

ACCESS TO MEDICAL SPECIALISTS

Making medical specialists available to the practice team can be an effective decision support strategy. Medical "specialists" may include primary care providers and/or specialists such as endocrinologists. Primary care providers delivering healthcare services will be the most common medical specialists in the behavioral health home. Such providers may be physicians or "mid-level providers" (e.g., nurse practitioners). Behavioral health homes working with medical specialists need to assess their knowledge and practice of evidence-based care.

If sufficient resources are available, the behavioral health home may contract with or hire specialists to be onsite full-time or 1-2 day a week. This allows for informal training of the clinician and more continuous contact with the same consumers. If that is not feasible, there are models for how to use even a small amount of specialist time to good effect.

When onsite in a full- or part-time capacity, the medical specialist may provide consultation to the practice team on consumers who have particularly complex needs or are unresponsive to treatment. The specialist may also provide care directly to consumers, using a care coordination agreement developed for each consumer to formalize which provider has responsibility for the patient and how communication between providers will happen to ensure coordinated care. Where family members are involved in helping care for a consumer, they are also included in these plans.[151] In its recent position paper on specialists working with medical homes, the American College of Physicians issued a useful set of guidelines for how to set up care coordination agreements.[152] (See Appendix A for a reference to these guidelines.)

What might this look like in a behavioral health home for people with mental health and substance use conditions? The practice team may find, for example, that a significant number of consumers have poorly controlled diabetes, with devastating physical and mental health consequences. The practice may bring in an endocrinologist or a primary care physician with diabetes expertise 1 or 2 days a week to answer the practice team's questions and to see the more challenging consumers. The specialist may see these consumers just for a consultation to generate treatment recommendations for the practice team. In more challenging cases, he/she may end up directly treating some consumers' diabetes over time, communicating with the practice team as laid out in the care coordination agreement.

Some behavioral health homes may not find it feasible to hire or contract with specialists on a full- or part-time basis, but may be able to afford a few hours of the specialist's time each week. In this situation, the specialist is available primarily by phone or email only

IN PRACTICE

Health and Education Services, Inc. *in Massachusetts takes an onsite approach to specialist support. This large behavioral health network has integrated a nurse practitioner into three of its clinics to provide physical exams, lab tests, and other primary care services. The nurse practitioner circulates among several behavioral health clinics, providing basic primary care services. She is supervised by an experienced primary care physician, who provides consultation and supervision that supplements the nurse practitioner's level of knowledge and augments the quality of the care provided.*[153,154]

An initial evaluation of the program found that those who received the nurse practitioner's services in the behavioral health clinic had fewer emergency department visits and were more likely to have had a physical examination than those who did not receive such care. Preliminary results from a larger, more rigorous study of the program show that program participants had greater access to primary care services and felt more empowered regarding their health conditions. The program also appears to have led to lower service costs for participants.[155,156,157]

and typically does not see patients. However, he/she can still answer questions and provide treatment recommendations, a commonly accepted practice known as a "curbside consultation."

This more time-limited approach to specialist support works particularly well in the context of care management. (See care management section for additional information.) Care managers are supervised regularly by a specialist, who provides treatment recommendations for new patients and those unresponsive to treatment. The care manager then communicates the specialist's recommendations to the multiple providers he/she supports. This is an efficient way to use the specialist's time because the minimal hours a week that the care manager spends with the specialist support multiple treating providers. Although the specialist's role is quite limited in this model, it has been shown to be a critical contributor to the consistently positive outcomes achieved in collaborative care studies on behavioral healthcare integrated into primary care settings.[158] (See the "In Practice" inset box for an example of collaborative care implementation.) A downside is that curbside consultations are typically not reimbursable in fee-for-service payment models. Such activities can be included in more innovative payment models such as bundled payments, an option through the CMS health home option.[159]

IN PRACTICE

*In Austin, Texas, **People's Community Clinic**, a nonprofit health center, provides collaborative care for a range of mental health disorders.[160,161] A core piece of the collaborative care model is a consulting psychiatrist, but psychiatrists in the area are expensive and in short supply. With the support of local foundations, People's contracted with a psychiatrist from the area community mental health center for 4 hours a week. The psychiatrist meets weekly with the clinic's care manager who maintains responsibility for educating patients about their mental health conditions, helping them address barriers to treatment, and monitoring treatment response. The consulting psychiatrist reviews the care manager's patient panel, providing treatment recommendations for those who are new, diagnostically complex, or unresponsive to treatment. The care manager conveys the psychiatrist's recommendations to the patient's treating primary care provider who makes treatment changes as he/she sees fit. In his remaining time onsite each week, the psychiatrist conducts evaluations with more complex patients and meets with primary care providers as requested.*

An independent evaluation showed that People's collaborative care program increased patients' access to mental health services, improved their quality of life, and reduced their depression and anxiety —particularly among Spanish-speaking patients.[162] The program led to reduced utilization of primary care and ED services and decreased overall healthcare costs.

EMBEDDING CLINICAL GUIDELINES

Another set of strategies for ensuring the practice team has access to the best available science involves building evidence-based clinical guidelines into the routine delivery of care. Research has clearly demonstrated that simply providing clinicians with such guidelines is ineffective at changing how they deliver care.[163,164,165] Behavior change requires systematic support.

Electronic medical records and other computerized systems can make the provision of guideline-based care a routine event.[166] These

IN PRACTICE

*Researchers at Boston's **Brigham and Women's Hospital** developed a clinical decision support tool to address the common problem of inappropriate use or excessive dosing of psychotropic medications in older patients.[167] The hospital integrated the decision support tool into its existing computerized system called BICS (Brigham Integrated Computer System). In the existing system, when a clinician enters the name of a medication to be prescribed, BICS presents guiding information on the medication, including the most commonly prescribed dose and frequency of administration.*

The experimental decision support tool altered the default dose and default frequency for psychotropic medications for patients 65 years and older and suggested a substitute drug when the provider ordered a psychotropic medication known to be poorly tolerated or to present risks in older patients.

Researchers found that the decision support tool increased the prescription of recommended doses, reduced prescribing of non-recommended medications, and was associated with fewer inpatient falls.

systems can be set up to send providers alerts when they prescribe a treatment that appears to be contraindicated, giving the provider an opportunity to review or explain his/her decision. Standing orders can be incorporated into computerized decision support systems, streamlining the process of ordering indicated tests, procedures, or treatments. These systems can also include more extensive decision flow charts for various conditions that help providers sort through the evidence-based treatment options and decide upon the best course of action. Clinical decision support strategies take evidence-based guidelines down off the shelf and incorporate them into the day-to-day clinical flow of providers' actual work.

A recent literature review identified several characteristics of successful clinical decision support tools:[168]

- Computerized tools tend to yield better results than those that are manual.
- They work best when they push information out to providers (instead of providers having to seek out the information) and when they are integrated with existing charting or order entry systems.
- These tools are most effective when they provide specific recommendations (instead of just an assessment of the situation) and when they are provided at the time and place of the treatment decision.

CLINICAL INFORMATION SYSTEMS

Clinical information systems such as patient registries support the behavioral health home by organizing data to increase the efficiency and effectiveness of care. They organize population-level data to maximize the outcomes for a defined group of consumers, supporting the provision of population-based care. They also organize client-level data to maximize individual outcomes.

These systems can take different forms. They may be part of an electronic medical record or exist as a stand-alone tool that may or may not communicate with the organization's other information systems. They may be computerized or paper-based, and while certain formats are more efficient, it is most important that the systems adopted serve the necessary functions. The behavioral health home needs clinical information systems capable of organizing data on key subgroups of consumers with particular conditions or characteristics, delivering reminders to providers, and providing feedback to clinicians.

A patient registry is an information tool that allows for the effective tracking of all the consumers seen in the practice with a particular condition(s) or set of characteristics. In essence, it is a database in which key data about a target population is organized in one place. The data may include consumers' diagnoses, assessment or lab results, current and past treatment regimens, and appointments.

Registry data are sortable, allowing providers to look at the individual patient level for trends in a particular consumer's treatment response over time and at the population level for the treatment needs of a particular subgroup of patients. At the consumer level, registry data can help providers identify issues to be addressed during appointments and to determine when the treatment regimen is not working and needs to be changed. Providers can review registry data with consumers to help them understand their condition and treatment response, so they can participate actively in decision-making. Registries can include an alert function, informing the provider when a consumer is overdue for a follow-up appointment or necessary procedure. Also, when set up in a format that allows multiple users to access it (e.g., a web-based registry), registries can facilitate communication about a consumer across team members and, when not all services are provided on site, across organizations. At the population level, registry data can be sorted to identify needs in a particular set of patients. For example, for all the behavioral health home's consumers taking the antipsychotic olanzapine, the registry can identify those who are due (or overdue) for blood work, allowing the practice team to schedule those consumers and ensure that the lab work is done in a timely fashion. The registry can be used to identify a subset of consumers with a particular condition or on a particular treatment that are not responding well to care, prompting the practice team to take action (e.g., developing a quality improvement project to address that group). The data can also be sorted by provider, or by practice in larger systems, allowing organizations to evaluate performance and identify training needs.

Importantly, registries are a clinical tool. While they can be used to evaluate programs or facilitate reporting to payers, their purpose is to guide consumer care. A registry's core purpose is to ensure consumers do not "fall through the cracks," a critical goal of a behavioral health home with responsibility for consumers' comprehensive care.

Registries have been used successfully in a number of formats — from a shoebox of index cards to computerized spreadsheets to sophisticated web-based tools.[169,170] Some electronic medical records can be customized to provide a registry function. Others can be modified to allow for integration with the registry. Having a single system or multiple information systems that are able to talk to

each other is optimal, cutting down on data entry and maximizing the systems' usefulness. However, again, the system's functions are more important than their format.

Behavioral health homes looking to develop or purchase a registry may find the California HealthCare Foundation's 2004 report on computerized registries helpful.[171] For those seeking to start with a basic registry, there are free templates available online. A 2006 article in *Family Practice Management* provides instructions for using readily available software (e.g., Microsoft Excel) to design a simple spreadsheet registry and includes a sample diabetes registry template.[172] With free registration, readers can also access a sample depression registry template and instructions from the University of Washington's IMPACT training site.[173]

IN PRACTICE

*More than 200 Washington community health and mental health centers participate in the **Mental Health Integration Program (MHIP),**[174] which the state legislature funded with support from Public Health Seattle and King County. Over 18,000 consumers have received integrated behavioral and physical healthcare through MHIP since its start in January 2008. Employing a collaborative care model, behavioral healthcare managers work closely with primary care providers to support medication management, offer brief evidence-based counseling, track clinical improvement over time, and help facilitate changes in treatment as needed. Consulting psychiatrists support the team, providing recommendations for complex patients.*

A web-based registry, the Mental Health Integrated Tracking System (MHITS), is used to track clinical improvement and identify patients who are in need of follow-up or who are not improving as expected. (See Figure 2 for a screenshot of a registry similar to MHITS.) Team members can sort registry data by patient (viewing the patient's treatment data over time) and also by primary care provider, care manager, or practice (viewing caseload statistics for a particular provider or in a specific practice). MHITS facilitates communication among the treatment team members who can view the system online.

An evaluation of the program's pilot phase found that the intervention reduced inpatient admissions, decreased arrests, and reduced homelessness.[175] The program has since expanded statewide.

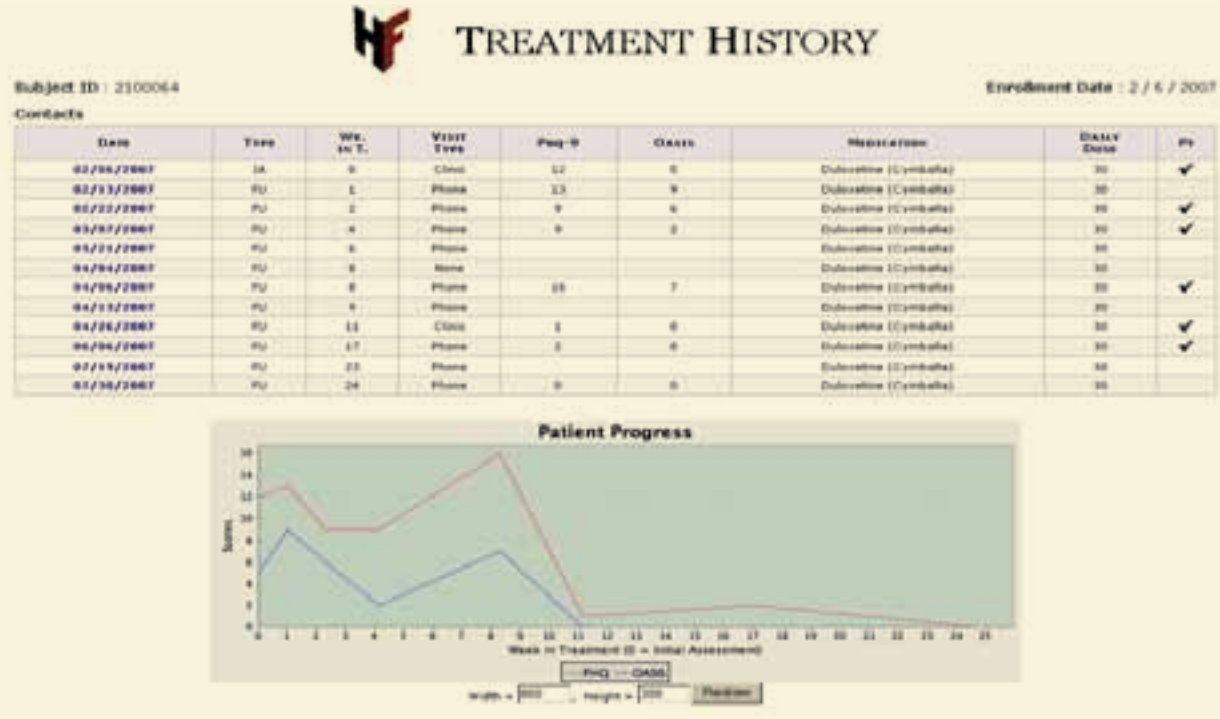

FIGURE 2. SCREEN SHOT OF AN MHITS PRECURSOR, A PATIENT REGISTRY DEVELOPED BY THE UNIVERSITY OF WASHINGTON FOR THE HOGG FOUNDATION FOR MENTAL HEALTH'S INTEGRATED HEALTH CARE INITIATIVE GRANT PROGRAM, SHOWING A DE-IDENTIFIED PRIMARY CARE CLIENT'S DEPRESSION TREATMENT HISTORY AND PROGRESS.

Reminders are a key function of the clinical information systems necessary for a behavioral health home.[177] They can be included in a registry, electronic medical record, or other information system to alert providers to issues that need attention at the client or population level. Of course, alerts do not need to be electronic at all; a reminder may be included on a slip of paper attached to a paper chart. Alerts may notify providers that a consumer is in need of a preventive procedure such as a colonoscopy or breast exam. Some computerized systems can direct reminders directly to consumers, as well.

Data from registries, electronic medical records, or chart audits can be used to provide clinicians and practices with feedback on their performance, another important function of the behavioral health home's clinical information systems.[178] The data can highlight areas where certain providers or practices are not performing as well as others and can be used to track their progress in addressing those deficits.

There have been few studies of clinical information systems as a stand-alone strategy. Unfortunately, data on registries as a singular intervention are unavailable. However, registries have been part of multi-component approaches (including chronic care model implementations) that have been found effective.[179] In general, reminders have been found to be effective in changing provider behavior, with two caveats.[180] If providers are overloaded with reminders, they start ignoring them. Also, if the practice is not equipped to follow up on the actions suggested or required by the reminder, they will not be effective. Finally, research has shown provider feedback to be beneficial in changing practice.[181] The effect sizes for both reminders and provider feedback interventions are typically quite small, suggesting that while they may be useful strategies, they are likely best done as part of a larger model like the behavioral health home.

Clinical information systems aid the behavioral health home in providing evidence-based care, as required in the Medicaid health home option.[182] They also empower consumers to be active participants in and advocates for their care (e.g., when personal health records are used or when electronic medical record data are shared with and made available to consumers).

Electronic medical records can be invaluable in supporting the provision of evidence-based, person-centered care, but they are expensive. The Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009, included incentives for healthcare providers to take up electronic medical records and related technology, but many behavioral health providers were not included as eligible participants. The Behavioral Health Information Technology Act of 2011 (S. 539) would extend the eligibility for health information technology assistance to mental health and substance use disorder providers.[183] It was introduced in the 112th Congress by Senator Sheldon Whitehouse, with bipartisan co-sponsors, and was referred to the Committee on Finance in March 2011.[184]

Another key issue with clinical information systems like electronic medical records is interoperability. Often, these systems cannot "talk" with one another, presenting a problem when there is a need to coordinate care across providers — either within a practice or across settings. Care coordination is a critical element of health homes and this barrier to information sharing can be challenging for partnering providers to resolve.

COMMUNITY LINKAGES

Originally, community mental health centers were established to care for populations within a geographic catchment area. From that perspective, it is important to be able to identify which individuals in the community are not yet linked with care. At the same time, a community focus requires an understanding of the contextual factors, including poverty and lack of access to opportunities for physical activity and healthy eating that may underpin poor health, particularly among vulnerable populations such as people with serious mental health and substance use conditions. It may be possible to improve care by identifying and linking consumers to resources such as grocery stores, community centers, and fitness centers.

Behavioral health homes must become familiar with their area's community resources such as peer support organizations, self-help groups, senior centers, exercise facilities, drop-in centers, child care facilities, and home care programs. It will likely be useful and expedient to have a centralized database of these resources and assign a staff person to update it regularly.

The behavioral health home also has responsibility for linking consumers to community resources, including social service programs such as housing and income support. Certain staff members (e.g., case managers) may be assigned this task, or all practice team members may maintain responsibility for the function. Regardless of how it is accomplished, the referrals and their outcomes should be documented and tracked, for example, in the practice's electronic medical record or patient registry.

IN PRACTICE

Monadnock Family Services, *a community mental health center based in Keene, NH, created* ***InSHAPE (Self Health Action Plan for Empowerment),*** *a health promotion and fitness program designed to decrease risk factors for heart disease, obesity, diabetes, and circulatory conditions in adults with serious mental illnesses.*[185,186]

Program participants complete a fitness and lifestyle assessment with a personal trainer mentor with whom they then work to establish individualized nutrition, fitness, and health goals and create an action plan. Participants meet weekly with their mentor to review their progress and problem solve as needed. The program provides participants with vouchers for membership to fitness facilities in the community. Participants also have access to nutrition counseling and related activities, smoking cessation programs, and a primary care provider at a nearby health center (if they do not already have one).

A pilot study found that over a 9-month period, InSHAPE participation was associated with increased exercise, vigorous activity, and leisurely walking.[187] *There was a trend toward improved readiness to reduce caloric intake and participants demonstrated a reduction in waist circumference. Participants' satisfaction with their fitness and mental health functioning improved and severity of some mental health symptoms decreased.*

The program has been replicated by community mental health centers in Massachusetts, New Hampshire, Rhode Island, and Michigan, and several additional states plan replications.[188]

Little is known about the independent contribution of community linkages to improving health and behavioral health outcomes. A recent review of research on the chronic care model identified just one study that evaluated community linkages' impact,[189] finding that community linkages were independently related to positive outcomes in a diabetes chronic care intervention. There does not appear to be other evidence to support community linkages as an independent variable. As noted earlier, it can be difficult to separate out the impact of individual elements of multi-component interventions such as chronic care, the patient-centered medical home, or collaborative care.

STRUCTURING THE BEHAVIORAL HEALTH HOME

The CMS guidance on the Medicaid health home option indicates that health homes do not need to provide the full array of required services themselves, but they must ensure such services are available and coordinated. This gives a behavioral health agency several options for how to structure the behavioral health home. Which path a behavioral health agency decides to take will depend in large part upon its resources, including existing physical facilities, number of consumers served, available workforce, financing options, availability of community partners, and other factors.

IN-HOUSE MODEL

One option is a model in which the behavioral health agency provides and owns the complete array of primary care and behavioral health services in-house.[191,192] The end result is that all services are delivered by one organization, and is a model for true integration if implemented successfully. Having all the necessary providers under one roof does not guarantee that they will work together to provide health home services effectively, just as the integrated primary and behavioral healthcare literature has demonstrated that co-location alone does not ensure true integration.[193,194,195] However, research supports onsite care delivery as a helpful element. For example, a randomized trial conducted at Kaiser Permanente comparing care delivered in a clinic with onsite primary care to usual care found that among the subset of patients with substance abuse related medical conditions, there were higher rates of abstinence in the integrated care group than the independent care group. The Clinical Features of the Behavioral Health Home section goes into the processes necessary to ensure that providers work together effectively to serve as a true health home.

Relevant examples of behavioral health agencies that have assumed an in-house structure to provide primary care include the Crider Health Center in Missouri and Cherokee Health Systems in Tennessee. Crider was established as a community mental health center in 1979 and became a community health center in 2007, offering mental health, dental, and primary care services to people with serious mental illnesses and the general population under one roof.[197] Cherokee also started out as a mental health center;[198] it began adding primary care services in the 1980s, obtaining community health center status for several of its sites in the 2000s. Cherokee now provides a full range of mental health, substance use, dental, and primary healthcare services. Although the two organizations began as mental health agencies, now they both can be described as fully integrated in their delivery of health and behavioral health services.

IN PRACTICE

*Located east of Los Angeles, **La Puente Clinic** is part of the **BAART Programs**, a non-profit organization that provides integrated substance use, mental health, and primary care services onsite and via mobile vans.[199] BAART Programs began providing drug treatment services in San Francisco in 1977 and now provides comprehensive care in five states.*

Like all BAART Program clinics, La Puente employs a full-time physician and nurse to provide primary care and preventive health services to substance use consumers onsite. All consumers see the primary care team upon intake and receive a physical examination at least annually as part of their ongoing treatment. Consumers are eligible for a variety of services, including immunizations, lab tests, disease management of chronic health conditions, and family planning.

BAART Programs have evaluated the impact of their services on clients' opioid use. In the L.A. area, where La Puente Clinic is located, 40% of clients still use opioids less than a year into the program, 28% use 2 years in, and only 17% of clients still use opioids more than 2 years into the program. [200]

In-house models require considerable resources to both plan and implement; they may be most feasible for larger systems. Self-contained organizations (e.g., Veterans Affairs institutions) and those that have worked out the financing model (e.g., Cherokee) are likely candidates. The major advantage of an in-house approach is that the agency has maximum control over service delivery, the change management process, and the systems necessary to support the initiative's development and sustainability. Potential disadvantages include the costs and economies of scale needed to establish these models, and challenges in financing the services.

CO-LOCATED PARTNERSHIP MODEL

For behavioral health agencies that do not have the desire or capacity to provide all services themselves in-house, partnerships with outside healthcare providers can make the behavioral health home feasible.[201,202] In a co-located partnership model, the behavioral health agency arranges for healthcare providers to provide primary care services onsite.[203] Processes must be in place — beyond simple co-location — to ensure that effective communication and coordination between providers happens routinely. Otherwise, the providers cannot be said to be providing health home services.

The co-located partnership model serves as the primary approach for SAMHSA's Primary Behavioral Health Care Integration (PBHCI) grant program, which has funded 64 behavioral health agencies to bring primary care services onsite.[204] These grant sites focus on adult populations with serious mental disorders, with or without comorbid substance use disorders. Most participating sites partner with a primary care provider, usually a community health center. Nearly all sites have a primary care physician or nurse practitioner onsite and have access to a primary care physician who provides supervision and/or consultation. Most sites also have a nurse care manager.

IN PRACTICE

*One PBHCI grantee site, the **Cobb County Community Services Board** (CSB), a public mental health agency that provides mental health, substance use, and developmental disability services in the Atlanta metro area,[205] partners with West End Medical Centers, a community health center, to deliver primary care services onsite at CSB.*

*The initiative, called **Four Corners: Mental Health, Substance Use, Primary Care, and Wellness**, targets adult consumers with serious mental illness or co-occurring mental health or substance use conditions and cardiometabolic illnesses. Within the chronic care model framework, participating consumers have access to CSB's primary care services and wellness programs. The services provided depend on the consumer's healthcare needs and resources (e.g., whether they already have a primary care provider).*

Through a memorandum of understanding, CSB outstations a West End physician assistant and licensed practical nurse full-time. CSB plans to hire a social worker to provide care management, as they were unable to find an affordable nurse for that role. West End's medical director is the supervising primary care physician. With only 4 hours a week in the role, she does not see consumers herself, but closely supervises the physician assistant. She is also available on a limited basis to answer CSB staff's questions.

To facilitate communication between the sites, CSB and West End have a standing weekly 30-minute conference call that includes the chief financial officer, information technology staff, West End vice president, project director, quality assurance staff, wellness project coordinator, project evaluator, integration consultant, and West End medical director.

West End bills for the medical services provided. CSB bills for the wellness services that are reimbursable.

The co-located partnership approach may be particularly appropriate for mid-sized organizations that have the infrastructure to develop partnerships but lack the resources and economies of scale to develop an in-house model. Advantages of this approach include the potential to provide some primary care services onsite, plus the ability to obtain more specialized services such as internal medicine specialties or dental services maintained by offsite partners. Challenges include identifying appropriate partners, managing differences in the cultures of the home and partner agencies, resolving information-sharing challenges (e.g., how to mesh medical records), and working out billing across organizations.

FACILITATED REFERRAL MODEL

A third structural option for behavioral health agencies wishing to provide behavioral health home services is a facilitated referral model. Sometimes referred to as the Coordinated Care Model, in this approach most primary care services are not provided onsite at the behavioral health agency; however, the agency has processes to ensure the coordination of care provided offsite. Models that have referred consumers out for services without facilitating that process have been unsuccessful; effective coordination with the referral site is essential.[206] Facilitation involves ongoing, proactive follow-up with consumers to make sure they are able to follow through with the referral, and communication and coordination with the referral site to ensure recommendations and treatments are shared with the site making the initial referral. In the facilitated referral model, the behavioral health agency conducts physical health screenings, links consumers to community primary care providers (with whom they may or may not have formal agreements), and facilitates communication between the behavioral health agency and the medical care providers to coordinate care.[207]

For the behavioral health home structured via a facilitated referral model, diagnoses of mental health and substance use disorders continue to be made internally, and diagnoses for health conditions are made by external health provider partners to whom consumers are referred. However, the behavioral health agency needs the capacity to track the status of consumers' health and behavioral health conditions over time, regardless of where the actual care is being provided. These models usually include a medical care manager who educates consumers about their medical conditions and treatments, assists them in becoming more active participants in their care, and serves as the bridge between the consumer, behavioral health providers, and medical care providers.[208]

IN PRACTICE

*In the **Primary Care Access Referral and Evaluation** (PCARE) study in Atlanta, Georgia, two full-time registered nurses followed a manualized protocol to provide medical care management to people with severe mental health disorders at a community mental health center.[209] No primary care services were provided onsite, but the medical care managers were responsible for linking consumers to medical care in the community. The program was associated with significant improvements in the quality and outcomes of care provided.*

*PCARE served as the model for a one-year learning collaborative led by the **Washington Community Mental Health Council.**[210] Through the collaborative, four community mental health centers from around the state identified existing clients with complex medical needs and offered them medical care management, which was provided by either a registered nurse or a case manager with nursing supervision. As with PCARE, no primary care services were provided onsite, but the medical care managers helped consumers with self-management of their medical conditions and connected them with primary care providers in the community. A formal evaluation of the collaborative was not conducted; however, the sites reported anecdotal successes and most intended to continue with the model at the collaborative's end.*

In addition to the facilitated referral models in mental health settings described in the above In Practice box, the model has been implemented in substance use settings. Samet and colleagues studied a facilitated referral team model located within a detoxification unit. The intervention clinic provided consumers a clinical evaluation by a team consisting of a nurse, social worker, and physician, followed by a facilitated referral to an offsite primary care clinic. The study found that this model resulted in a significant increase in the likelihood of successful linkage with primary medical care, although no change in other health outcomes was found. [211]

Given the low cost and relative flexibility of the facilitated referral model, such a structure may be most feasible for smaller agencies and can also serve as a transitional model for those that intend to implement co-located partnership or in-house models in the future. The facilitated referral model may be particularly attractive to stand-alone outpatient substance use agencies, many of which are relatively small, rely primarily on staff with limited training and education, and have minimal administrative resources and infrastructure.[212]

All three structural arrangements — in-house, co-located partnership, and facilitated referral — are compatible with the CMS guidance for the Medicaid health home.[213] Under the right circumstances, each can successfully support the key clinical functions described in this paper. Thus, the choice of model should be based on local clinical, workforce, and financial considerations. The particular model is less important than ensuring that sites support the key clinical functions.

CONCLUSION

The CMS Medicaid health home option presents an opportunity for behavioral health agencies to optimize consumers' overall health and wellness, build on the experience they have developed in integrated healthcare, and carve out an important niche in the evolving healthcare system. Becoming a behavioral health home will require a major shift in the roles, processes, and care agencies provide. It will mean embracing, or strengthening, a new culture of care based on the four principles addressed in this paper: person-centered care, population-based care, data-driven care, and evidence-based care.

Unfortunately, this opportunity comes at a time when many behavioral health organizations are struggling with the difficult economic environment and change fatigue. Agencies committed to taking on this challenge will need to give careful consideration to how to support their organization and its staff and bolster the internal resources necessary to survive and thrive during an extended period of disruptive change.

Behavioral health agencies already positioned to take on the challenge likely have a track record of being an innovative, high-achieving organization. Such agencies are nimble and able to lead and sustain major organizational change. They have embraced recovery principles, including person-centeredness. They are skilled at evidence-based treatments. They have experience using data in both clinical and quality improvement contexts, and are comfortable with information technology. Taking on the challenge of becoming a behavioral health home will push these behavioral health agencies to go further in their commitment to person-centered and evidence-based care and develop new skills in providing care that is data-driven and population-based. Organizations lacking these qualities and experience should not necessarily shy away from becoming a behavioral health home, but they should recognize the additional work required to achieve that goal.

Mental health and substance use disorder treatment agencies interested in becoming a behavioral health home are encouraged to undertake the following action steps:

1. Reach out to the relevant state agencies to express interest and begin making the case for the organization's capacity to succeed as a health home;
2. Develop an understanding of the behavioral health home's key clinical features and the system-level strategies (e.g., potential partnerships and financing strategies) that can support them;
3. Create a strategic plan, including the clinical model, budget, and implementation plan;
4. Start the change management process;
5. Establish agreements that formalize the necessary partnerships with community partners;
6. Regularly update state agencies on progress to fortify ties and demonstrate commitment and capacity;
7. Identify and include relevant stakeholders (e.g., administrators, clinicians, consumers) in the decision-making and strategizing process; and
8. Seek support and guidance/training from colleagues, experts, and leaders of relevant efforts.

Behavioral health agencies should also keep in mind resources and technical assistance available from the SAMHSA-HRSA Center for Integrated Health Solutions,❖ which will continue working to support behavioral health providers' development in pertinent areas.

❖ The Center for Integrated Health Solutions has extensive relevant resources on its website at: www.integration.samhsa.gov.

APPENDIX A
COMPENDIUM OF TOOLS REFERENCED IN REPORT

SELF-MANAGEMENT ASSESSMENT TOOLS

PATIENT ACTIVATION MEASURE

Insignia Meath

www.insigniahealth.com/solutions/patient-activation-measure

ILLNESS MANAGEMENT AND RECOVERY SCALE

Mueser, K.T., & Salyers, M.P., Illness Management and Recovery Scale, Measuring the Promise: A Compendium of Recovery Measures, pp. 32-35 (with full text of measure appended to report.)

www.power2u.org/downloads/pn-55.pdf

INTEGRATED CARE PLANS

INTEGRATED CARE PLAN

Connected Care™ Program, a joint program of Community Care Behavioral Health Organization and University of Pittsburgh Medical Center Health Plan

www.chcs.org/usr_doc/Integrated_Care_Plan_Template.pdf

www.chcs.org/usr_doc/Lovelace.pdf

INTEGRATED SUMMARY

AMERICAN ACADEMY OF FAMILY PHYSICIANS

www.aafp.org/fpm/2003/0400/p33.html

REGISTRIES

DIABETES REGISTRY TEMPLATE

Ortiz OD (2006). Using a simple patient registry to improve your chronic disease care. Family Practice Management, 13(4): 47-52.

www.aafp.org/fpm/2006/0400/p47.html

DEPRESSION REGISTRY TEMPLATE

IMPACT patient tracking tools, University of Washington. http://impact-uw.org/tools/patient.html.

JOINT PRINCIPLES OF THE PATIENT-CENTERED MEDICAL HOME

The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association developed *Joint Principles of the Patient-Centered Medical Home* to describe the characteristics of the patient-centered medical homes. www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

NCQA ACCREDITATION STANDARDS FOR THE PATIENT-CENTERED MEDICAL HOME

In early 2008, the National Committee for Quality Assurance announced the development of standards for medical practices that wish to be certified as patient-centered medical homes. The standards were updated in 2011 and include six standards for practices to meet across the following areas:

- Enhancing access and continuity
- Identifying and managing patient populations
- Planning and managing care
- Providing self-care support and community resources
- Tracking and coordinating care
- Measuring and improving practice performance

NCQA's Standards and Guidelines can be downloaded at www.ncqa.org/tabid/629/Default.aspx#pcmh

SETTING UP AGREEMENTS BETWEEN SPECIALISTS AND MEDICAL HOMES

The American College of Physicians issued a set of guidelines in 2010 for setting up agreements between medical homes and specialists: *The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices.* Available at www.acponline.org/advocacy/where_we_stand/policy/pcmh_neighbors.pdf

APPENDIX B
CMS HEALTH HOMES GUIDANCE

See pages 32-45 for the November 16, 2010 Centers for Medicare and Medicaid Services State Medicaid Director and State Health Official Letter on Health Homes for Enrollees with Chronic Conditions, SMDL #10-024, ACA #12.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP and Survey & Certification

SMDL# 10-024
ACA# 12

November 16, 2010

Re: Health Homes for Enrollees with Chronic Conditions

Dear State Medicaid Director:
Dear State Health Official:

This letter is one of a series intended to provide preliminary guidance on the implementation of the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act. Specifically, this letter provides preliminary guidance to States on the implementation of section 2703 of the Affordable Care Act, entitled "State Option to Provide Health Homes for Enrollees with Chronic Conditions."

Section 2703 adds section 1945 to the Social Security Act (the Act) to allow States to elect this option under the Medicaid State plan. This provision is an important opportunity for States to address and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness. This guidance outlines our expectations for States' successful implementation of the health home model of service delivery and provides initial guidance on important aspects of the health home provision.

The Centers for Medicare & Medicaid Services (CMS) is collaborating with Federal partners, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the HHS Assistant Secretary for Planning and Evaluation (ASPE), the Health Resources and Services Administration (HRSA), and the Agency for Healthcare Research and Quality (AHRQ) to ensure an evidence-based approach and consistency in implementing this statutory provision. We recognize and greatly appreciate their expertise in medical home initiatives, integration of primary care and behavioral health, evaluative experience, and quality measurement.

Background

Health Home Model for Service Delivery

The health home provision authorized by the Affordable Care Act provides an opportunity to build a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for State Medicaid programs. 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 (without any harm whatsoever to individuals, families, or communities).

The health home service delivery model is an important option for providing a cost-effective, longitudinal "home" to facilitate access to an inter-disciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions. While there is still much to learn, we expect that use of the health home service delivery model will result in lower rates of emergency room use, reduction in hospital admissions and re-admissions, reduction in health care costs, less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual.

Health homes can play a particularly pivotal role in improving the health care delivery system for individuals with chronic conditions. Consistent with the intent of the statute, we expect States that provide this optional benefit, and the health home providers with which the State collaborates, to operate under a "whole-person" philosophy – caring not just for an individual's physical condition, but providing linkages to long-term community care services and supports, social services, and family services. The integration of primary care and behavioral health services is critical to the achievement of enhanced outcomes.

Health Homes and Medical Homes

To provide context about the genesis of the health home model, we are providing background in this letter on the medical home model. While Congress defined the term "health home" in section 2703 of the Affordable Care Act, the medical home model provides instructive history on the evolution of the health home model. In 1967, the American Academy of Physicians (AAP) *Standards of Child Health Care* envisioned the medical home as: "one central source of a child's pediatric records to resolve duplication and gaps in services that occur as a result of lack of communication and coordination." In 1992, the AAP applied the medical home term to medical care that is accessible, continuous, comprehensive, family-centered, coordinated, and compassionate; and in 2002, AAP further characterized care in a medical home as accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The Future of Family Medicine Project expanded on the concept in 2004 when it called for every American to have a personal medical home. The American Academy of Family Physicians (AAFP) developed a related policy statement the same year, and the American College of Physicians (ACP) introduced the advanced medical home in 2006. The AAFP and ACP teamed with the AAP and the American Osteopathic Association to draft and disseminate Joint Principles of the Patient-Centered Medical Home. According to the principles, patient-centered medical homes should have these characteristics: a personal physician; physician-directed medical practice; whole-person orientation; coordinated care; quality and safety; enhanced access; and adequate payment.

In 2007, the Commonwealth Fund defined medical home as "a healthcare setting that offers patients a regular source of care, enhanced access to physicians and timely, well-organized care." Other definitions of a medical home include the use of chronic disease management, electronic health records, web-based information, and open access to scheduling. The Patient-Centered Medical Home (PCMH) is a model for care, provided by physician-led practices, that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and individual's complaints with coordinated care for all life stages, acute, chronic, preventive, and

end of life, and a long-term therapeutic relationship. The physician-led care team is responsible for coordinating all of the individual's health care needs, and arranges for appropriate care with other qualified physicians and support services. The individual decides who is on the team and the primary care physician makes sure team members work together to meet the individual's needs in an integrated fashion.

At the Federal level, in an effort led by the Office on Disability, agencies from across the Department of Health and Human Services (HHS), including CMS, worked together in 2008 to develop a conceptual model of the medical home to include service domains, training requirements, financing, policy, and research. The Federal workgroup concluded that the medical or health home is a conduit to lowering health care costs, increasing quality, reducing health disparities, achieving better outcomes, lowering utilization rates, improving compliance with recommended care, and coordinating a spectrum of medical and social services required by the individual across the lifespan.

Since 2009, AHRQ has convened a Federal collaborative around implementation of the PCMH, which includes CMS, SAMHSA, and HRSA. In 2010, AHRQ launched a public website, www.pcmh.ahrq.gov aimed at providing health care decision makers and researchers evidence-based resources about the medical home and its potential to transform primary care. On the site, AHRQ published its definition of the PCMH which emphasizes the importance of team-based care and recognizes that many clinicians may lead a patient-centered health care team.

In 2009, SAMHSA launched its Primary Care and Behavioral Health Care Integration (PBHCI) program. This program seeks to improve the physical health status of people with serious mental illnesses (SMI) by supporting community-based efforts to coordinate and integrate primary health care with mental health services in community-based behavioral health care settings. 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. SAMHSA has funded 56 sites nationally, and, in cooperation with HRSA, has co-funded a national resource center dedicated to integrating primary and behavioral health care in both behavioral health settings and primary care settings.

Many State Medicaid programs have developed medical home models and States receive Medicaid reimbursement for medical homes through a variety of authorities. Under the authority of section 1932(a) of the Act, States have implemented delivery systems beyond traditional primary care case management programs, many focusing on high-cost, high-user beneficiaries (not limited to specific diagnoses). While many of these models are physician-based, there is a growing movement toward interdisciplinary team-based approaches. Services such as care coordination and follow-up, linkages to social services, and medication compliance are reimbursed through a "per member per month" structure. In addition to the authority in section 1932(a) of the Act, some States are using full-risk managed care plans and demonstrations approved under section 1115 of the Act to implement their medical homes.

Given the prior history of Medicaid involvement in medical home models and delivery systems, and the new statutory definition of the term "health home," a goal of implementing section 2703 of the Affordable Care Act will be to expand the traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, in keeping with the needs of persons with multiple chronic illnesses. The whole-person philosophy described below is fundamental to a health home model of service delivery. CMS expects health homes to build on the expertise and experience of medical home models, when appropriate, to deliver health home services.

Coordination with Existing State Programs

The CMS recognizes that many States that are interested in this Medicaid State plan option will want to coordinate with their existing medical home initiatives, including those that utilize private insurance, Medicare, and multi-payer funding streams. CMS encourages States with existing or planned medical home initiatives to compare those programs to the definition of health home in section 2703 of the Affordable Care Act and the intent, population focus, delivery models, services, provider standards, quality measure reporting, and State monitoring required under this health home State plan option, and to design this option to complement those initiatives. CMS is available to provide technical assistance as States begin this analysis.

General Information

The State option to provide health home services to Medicaid beneficiaries with chronic conditions becomes effective on January 1, 2011. A State may elect this option through an amendment to the Medicaid State plan; however, the effective date of the State plan amendment (SPA) may not be earlier than the statutory effective date. We are issuing this letter to provide initial guidance, as well as to inform States of the ability to claim title XIX funds prior to submitting a health home SPA in order to plan and develop their health home model.

Throughout this guidance, there will be references to the "health home model of service delivery" that encompasses all the medical, behavioral health, and social supports and services needed by a beneficiary with chronic conditions. The specific activities authorized by the Affordable Care Act will be referred to as "health home services" throughout this guidance, and are addressed below. Only health home services qualify for the 90 percent Federal medical assistance percentage (FMAP) rate (for the first eight fiscal quarters that a health home State plan amendment is in effect).

We have developed a draft template for States to use in designing and developing health home SPAs that is attached to this letter. We will roll out a web-based submission process for health home SPAs in early December, which will include the same data fields as shown on the draft template screen shots. At that time, we will release a CMCS Informational Bulletin with instructions on use of the web-based tool for submission. CMS is available for technical assistance using the draft template as well as the web-based tool in the future. We strongly encourage States to use the draft template to prepare for SPA submission and the web-based tool

for actual submission, as some of the information from the SPA will be displayed on the www.healthcare.gov website and used for reporting purposes.

Initially, CMS will use the guidance in this letter to review and approve health home SPAs. States are expected to describe in their SPAs how their programs adhere to the guidance reflected in this letter. Upon the issuance of final regulations, States may need to amend their State plans, if necessary, to come into compliance with the regulatory requirements.

We have established an electronic health home mailbox for States and interested parties to use for submission of questions or comments about this provision of the law. Inquiries may be sent to healthhomes@cms.hhs.gov.

Health Home Population Criteria

Section 1945(a) of the Act permits States the option to offer health home services to "eligible individuals with chronic conditions" who select a designated health home provider. The chronic conditions described in section 1945(h)(2) of the Act include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight, as evidenced by a body mass index over 25. Section 1945(h)(2) of the Act authorizes the Secretary to expand the list of chronic conditions reflected in this provision. Further information regarding how the Secretary will use this authority will be articulated in future guidance. Additional chronic conditions, such as HIV/AIDS, will be considered for incorporation into health home models.

Section 1945(h) of the Act sets forth the minimum criteria that an "eligible individual with chronic conditions" must meet. The health home population the State elects must consist of individuals eligible under the State plan or "under a waiver of such plan" who have at least two chronic conditions, as listed in section 1945(h)(2) of the Act, one chronic condition and be at risk for another, or one serious and persistent mental health condition.

The State may elect in its State plan to provide health home services to individuals eligible to receive health home services based on all the chronic conditions listed in the statute, or provide health home services to individuals with particular chronic conditions. While all individuals served must meet the minimum statutory criteria, States may elect to target the population to individuals with higher numbers or severity of chronic or mental health conditions. The population must include all categorically needy individuals who meet the State's criteria (including those eligible based on receipt of services under a section 1915(c) home and community-based services waiver) and a State option may include individuals in any medically needy group or section 1115 demonstration population. There is no statutory flexibility to exclude dual eligible beneficiaries from receiving health home services. CMS recognizes the challenges States face in serving dual eligible beneficiaries and we are working to assist States in their efforts to more effectively integrate Medicare and Medicaid benefits.

Because the statute waives the comparability requirement at section 1902(a)(10)(B) of the Act, it allows States to offer health home services in a different amount, duration, and scope than services provided to individuals who are not in the health home population.

Service Definitions

Section 1945(h)(4) of the Act defines health home services as "comprehensive and timely high quality services," and includes the following health home services to be provided by designated health home providers or health teams:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

CMS recognizes the importance of health information technology in furthering the aims of the health home model of service delivery. While States have the flexibility to determine how to use health information technology in their health home models, CMS encourages States to consider utilizing technologies to provide health home services and improve care coordination across the care continuum. Further information regarding how the Secretary will define these services will be articulated in future guidance.

Payment Methodologies

Section 1945(c)(1) of the Act authorizes States to make medical assistance payments for health home services delivered by a designated provider, a team of health care professionals operating with the designated provider, or a health team. Section 1945(c)(2) of the Act requires that the State include the payment methodology in its State plan, but permits considerable flexibility in designing the payment methodology. Specifically, section 1945(c)(2)(A) of the Act expressly permits States to structure a tiered payment methodology that accounts for the severity of each individual's chronic conditions and the "capabilities" of the designated provider, the team of health care professionals operating with the designated provider, or the health team. In addition, section 1945(c)(2)(B) of the Act permits States to propose alternative models of payment that are not limited to per member per month payments for CMS approval.

Consistent with section 1902(a)(30)(A) of the Act, CMS will review health home SPA submissions for consistency with the goals of efficiency, economy, and quality of care, and require a comprehensive description of the rate-setting policies in the Medicaid State plan. We remind States of the requirement to provide public notice to affected stakeholders of changes in State plan methods and standards prior to the effective date of a SPA, consistent with the public notice requirements at 42 CFR 447.205. CMS does not anticipate any conflict between the provisions described under the health home payment authority and section 1902(a)(32) of the Act, which (excepting certain employment or contractual arrangements) requires direct payments to Medicaid providers.

State officials clearly have much to consider in constructing State plan payment methodologies for health home services that improve service delivery, provide for quality health outcomes for Medicaid beneficiaries and help to document the evaluative measures at section 2703(b) of the Affordable Care Act. CMS encourages States to work closely with their stakeholder and provider communities and to draw upon national experience in developing reimbursement methodologies for these services. We also invite States to work with CMS prior to formally submitting a SPA to ensure that proposed payment methodologies meet these objectives and all applicable Federal and statutory requirements.

Similarly, States interested in implementing a health home SPA in conjunction with using a capitated model are encouraged to work with CMS informally prior to developing an official submission. While CMS envisions a health home model of service delivery with either a fee-for-service or capitated payment structure, we would consider other methods or strategies utilizing additional payment models.

Enhanced FMAP

Section 1945(c)(1) of the Act provides that the FMAP for health home services shall be 90 percent for the first eight fiscal quarters that a SPA is in effect. Thereafter, States can claim at the regular FMAP rate used for other Medicaid services during the calendar quarter. Once CMS approves a State's health home SPA, the State can submit a claim to CMS for reimbursement using the Medicaid and Children's Budget Expenditure System (MBES/CBES) and record the expenditures on a new line item 64.9. The new line item will be called Health Homes for Enrollees with Chronic Conditions.

Expenditures claimed at the enhanced match should be recorded in line 64.9-a, and expenditures claimed at the regular match should be recorded in line 64.9-b. Please be cognizant of the requirement that the eight quarters of 90 percent FMAP begin upon the effective date of the SPA. If there is a delay in implementation, this date could be different from the first day or first quarter when health home services claims are received. There is no time limit by which a State must submit its health home SPA to receive the eight quarters of 90 percent FMAP.

Provider Infrastructure

Section 1945(a) of the Act describes three distinct types of health home provider arrangements from which a beneficiary may receive health home services: designated providers, as defined in section 1945(h)(5) of the Act; a team of health care professionals, which links to a designated provider, as defined in section 1945(h)(6) of the Act; and a health team, as defined in section 1945(h)(7) of the Act.

Section 1945(h)(5) of the Act includes examples of providers that may qualify as a "designated provider," such as physicians, clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined appropriate by the State and approved by the Secretary. This list, therefore, is not an exhaustive

list. States may include additional providers in this category, meeting the criteria of subsection (5), including other agencies that offer behavioral health services. States should describe all designated providers in the proposed SPA, which is subject to CMS approval. As discussed in more detail below, each designated provider must have systems in place to provide health home services, and to satisfy certain qualification standards.

Section 1945(h)(6) of the Act contains examples of the providers comprising a "team of health care professionals," such as physicians and other professionals that may include a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State and approved by the Secretary, but this, too, is not an exhaustive list. These "teams of health care professionals" may operate in a variety of ways, such as free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary. The SPA should include a description of the composition of these teams.

Section 1945(h)(7) of the Act defines "health team" to have the same meaning given this term in section 3502 of the Affordable Care Act, titled "Establishing Community Health Teams to Support the Patient-Centered Medical Home." Section 3502(b)(4) of the Affordable Care Act requires the Secretary to define the health team, but also indicates that the team should be an interdisciplinary, inter-professional team, and that the definition must include the following providers: medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers (including mental health providers, and substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants.

We are interpreting the statute to allow States to choose which provider arrangement(s) to offer, and, if more than one option is offered, the beneficiary may choose among those options. We recognize that there is diversity in provider arrangements across the States. Regardless of the provider arrangement(s) a State may offer, CMS will expect the State to embed the criteria described in the provider standards below in its provider qualifications, and to be accountable for the providers adhering to and upholding those standards on an initial and ongoing basis.

Provider Standards

States will be expected to develop a health home model of service delivery that has designated providers operating under a "whole-person" approach to care within a culture of continuous quality improvement. A whole-person approach to care looks at all the needs of the person and does not compartmentalize aspects of the person, his or her health, or his or her well-being. We expect providers of health home services to use a person-centered planning approach to identifying needed services and supports, providing care and linkages to care that address all of the clinical and non-clinical care needs of an individual.

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Section 1945(b) of the Act requires the Secretary to establish standards for qualification as a designated provider for the purpose of being eligible to become a health home. Pending final guidance, CMS expects designated providers of health home services to address the functions listed below, which were informed by both the provider requirements defined within section 3502 of the Affordable Care Act and other well-established chronic care models. The State must describe in its SPA the methods by which it will support providers of health home services in addressing the following components:

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Coordinate and provide access to mental health and substance abuse services;
- Coordinate and provide 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;
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
- Coordinate and provide access to long-term care supports and services;
- Develop 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;
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- Establish 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.

States are expected to describe the infrastructure in place to provide timely, comprehensive, high-quality health home services. A State with established medical home provider standards wishing to submit a SPA is requested to describe how its existing standards align with the key health homes expectations listed above, and/or have been modified to address the specific health home services.

Support for State Planning Activities

In order to provide assistance to States that would like to receive support in planning their health home SPAs, in accordance with section 1945(c)(3) of the Act, CMS will use title XIX funding to support State health home planning efforts at the State's regular, pre-Recovery Act, medical assistance service match rate. Since the purpose of the planning opportunity is to develop a SPA, such requests will only be considered prior to a State submitting a health home SPA to CMS.

Interested States should submit a *Letter of Request* of no more than two pages describing its health home planning activities, with an estimated budget for this non-competitive opportunity. The following categories would be considered by CMS as appropriate planning activities: the hiring of personnel or contractors to determine feasibility and develop the health home program; outreach initiatives to obtain consumer and provider feedback; training and consultation related to designing components of any provisions of the SPA; the development of systems for reporting and other infrastructure building tasks; and travel to accomplish such activities. A State may discover through its planning activities that a health home SPA is not feasible; under such circumstances, those planning activities are also reimbursable at the regular FMAP, in accordance with section 1945(c)(3)(B) of the Act.

Upon CMS approval of a State's *Letter of Request* outlining its health home planning activities, but not before January 1, 2011, we will authorize State applicants to spend up to $500,000 of title XIX funding for planning activities related to the development of a SPA. If a State believes that it will require in excess of $500,000 for this planning opportunity, it needs to send additional justification beyond the two-page *Letter of Request* and estimated budget to CMS for review and approval. If all States request funding above the $500,000 level, funds may be exhausted before all States have a chance to come in for this planning opportunity. A State must report its approved planning activities and subsequent expenditures on a separate expenditure line on the CMS-64.10. In accordance with section 1945(c)(3)(B) of the Act, this line will be programmed with each State's pre-Recovery Act medical assistance services matching rate. Therefore, for a State with a pre-Recovery Act FMAP of greater than 50 percent, its planning activities will be matched at the higher medical assistance service rate.

States will also be required to submit changes to their Cost Allocation Plans (CAP) to accommodate these health home planning activities. States could draw down the FMAP for planning activities before updating the CAP, as long as it is amended in a timely manner once the State obtains CMS approval for its health home planning activities. OMB Circular A-87, Attachment D, stipulates the following: State public assistance agencies are required to promptly submit amendments to the cost allocation plan to HHS for review and approval.

Letters of request should be sent via email to healthhomes@cms.hhs.gov. There is no deadline for submissions, however only expressions of interest are expected.

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Coordination with SAMHSA

Section 1945(e) of the Act requires States to consult and coordinate with SAMHSA in addressing issues of prevention and treatment of mental illness and substance use disorders for individuals who are low-income and/or have one or more chronic illnesses who are at greater risk of developing mental health and substance use disorders. In addition, individuals with mental health and substance use disorders, especially individuals with a serious mental illness, have significantly higher co-morbid conditions than the general population. When these chronic conditions go untreated, individuals often experience greater physical illnesses that require increased medical treatment, such as costly hospitalizations. Therefore, health home SPAs should address how the proposed approach will assure access to a wide range of physical health, mental health and substance use prevention, treatment, and recovery services. The approaches may include screening for alcohol and certain illegal drugs, identifying available mental health and substance abuse services, discharge planning, care planning that integrates physical and behavioral health services, person/family-centered treatment planning, referral and linkage to other specialty health and behavioral health treatment, and supports that promote recovery and resiliency.

As such, CMS is requiring States to consult with SAMHSA as they develop their approaches to health homes, prior to submitting their State plan amendments. States should send an e-mail to health.homes@SAMHSA.hhs.gov and include: a brief overview of the proposed design of the health home; the specific areas for the consultation; the State contact person; and State timeframes and availability for obtaining the consultation. SAMHSA will be sending letters to the States to further clarify the consultation process. CMS and SAMHSA also encourage States to coordinate with their State behavioral health authorities regarding efforts they are currently undertaking regarding primary care and behavioral health integration. It is important to note that, given the "whole person" approach to a health home, the behavioral health needs of individuals receiving services from a health home provider should be addressed through this model, regardless of the chronic conditions targeted by the State to determine eligibility into the health home.

State Monitoring Requirements

As described in more detail below, the impact of the health homes provision will be examined in both an interim survey of States and an independent evaluation. Both the Interim Survey and the Independent Evaluation will be subsequently followed by Reports to Congress. CMS expects States to collect and report information required for the overall evaluation of the health home model of service delivery, and recommends that States collect individual-level data for the purposes of comparing the effect of this model across sub-groups of Medicaid beneficiaries, including those that participate in the health home model of service delivery and those that do not. This evaluation, and the data gathered for it, will provide States with information that can help inform continued improvement of a State's health home model.

As part of the focus on continued improvement and evaluation, section 1945(f) of the Act requires States that implement these health homes to track avoidable hospital readmissions, calculate cost savings that result from improved coordination of care and chronic disease management, and monitor the use of health information technology to improve service delivery and coordination across the care continuum (including the use of wireless patient technology in improving coordination, management of care, and patient adherence to recommendations made by their providers). For the purposes of the overall evaluation, States are also expected to track emergency room visits and skilled nursing facility admissions.

States will be expected to describe in their SPAs the methods they will use to track, calculate, and monitor all of the above-mentioned monitoring requirements. However, in order to obtain comparable data for the evaluation, CMS plans to provide standardized methodologies for tracking avoidable hospital readmissions and calculating cost savings.

Prior to the availability of standardized methodologies, CMS encourages States to consider the following as they develop their SPAs and determine their preliminary methodologies for tracking avoidable hospital readmissions and calculating cost savings:

- In tracking avoidable hospital readmissions, States are encouraged to consult measures endorsed by the National Quality Forum. States should consider constructing a denominator that counts the total number of hospitalizations for common conditions within the Medicaid population, and a numerator that counts the total number of hospitalizations within the denominator that were followed by another hospitalization within 30 days of the previous hospital stay discharge. For both the denominator and the numerator, a transfer from one acute care hospital to another acute care hospital should be counted as one hospitalization rather than two separate stays. For the purposes of comparison, States should consider calculating hospital readmission rates for health home beneficiaries and a comparable population of non-health home beneficiaries.

- In calculating cost savings, States are encouraged to first define a comparison group. States may consider constructing a pre-/post-comparison of health home beneficiaries or an alternative comparison group of non-health home beneficiaries with similar chronic conditions and characteristics. States are also encouraged to construct a calculation of cost savings that includes a tabulation of all Medicaid expenditures incurred for the health home group and the comparison group.

Quality Measure Reporting Requirements

In order for the State and its participating providers to assess progress, section 1945(g) of the Act requires designated providers of health home services to report to the State on all applicable quality measures as a condition for receiving payment. When appropriate and feasible, quality measure reporting is to be done through the use of health information technology.

As mentioned above, CMS plans to allow States to choose which health home provider arrangement(s) to offer. States may choose to offer health home services through a designated provider, a team of health care professionals, and/or a health team. The quality measure reporting requirements for health homes apply only to designated providers and the team of health care professionals, which is comprised of at least one designated provider. The quality measure reporting requirements for the health team provider arrangement are separately identified in section 3502 of the Affordable Care Act, and include the collection and reporting of data on patient outcomes, including the collection of data on patient experience of care. States planning to operate a health team provider arrangement, in addition to one or more of the other provider arrangements authorized in section 2703 of the Affordable Care Act, are expected to describe in their SPAs how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Act.

CMS will provide further guidance on these reporting requirements. In consultation with States and others, we plan to provide States with a core set of quality measures for assessing the health home model of service delivery. CMS expects the core set to include quality measures that assess individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes. CMS is currently working to align: (1) the mandatory quality measure reporting requirements included within section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA); (2) the voluntary quality measure reporting requirements within section 2701 of the Affordable Care Act; and (3) the mandatory quality measure reporting requirements within section 3502 of the Affordable Care Act.

Until such time that CMS releases a core set of quality measures, States are expected to define the measures they plan to use to assess their health home model of service delivery. The measures are expected to capture information on clinical outcomes, experience of care outcomes, and quality of care outcomes specific to the provision of health home services.

Evaluation

Section 2703(b)(2) of the Affordable Care Act requires the Secretary to survey States that have elected the health home option not later than January 1, 2014, for the purpose of preparing an Interim Report to Congress. States will be required to report to CMS on the nature, extent, and use of the health home model of service delivery, particularly as it pertains to: hospital readmission rates; chronic disease management; coordination of care for individuals with chronic conditions; assessment of program implementation; processes and lessons learned; assessment of quality improvements and clinical outcomes; and estimates of cost savings.

Section 2703(b)(1) of the Affordable Care Act requires the Secretary to enter into a contract with an independent entity or organization to conduct an evaluation and assessment of States that have elected the option to provide a health home model of service delivery. Not later than January 1, 2017, the Secretary is required to submit a Report to Congress on the independent evaluation and the effect of this model on reducing hospital readmissions, emergency room visits, and admissions to skilled nursing facilities. States are required to cooperate with the entity/organization conducting the independent evaluation and assessment. CMS will provide

subsequent guidance on the evaluation design to States implementing the health home model of service delivery.

We look forward to working with States, individually and collectively to provide assistance and to facilitate collaboration in implementing this new Medicaid State plan option. CMS would like to reiterate that this option is but one tool in a broader arsenal that States can use to improve service delivery for all people, not just those with chronic conditions or those covered by Medicaid. States interested in this option may develop a stand-alone initiative or embed it into a broader effort that promotes the goals of the health home.

If you have any questions, please contact Ms. Barbara Edwards, Director of the Disabled and Elderly Health Programs Group, at 410-786-0325. Questions or comments may also be submitted to the health home mailbox, at healthhomes@cms.hhs.gov.

Sincerely,

/s/

Cindy Mann
Director

Attachment

cc:
CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Rick Fenton
Acting Director
Health Services Division
American Public Human Services Association

Andrew Allison
President
National Association of Medicaid Directors

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
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Director for Health Policy
Council of State Governments

Christine Evans, M.P.H.
Director, Government Relations
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

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