
BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES FOR ADULTS

DRAFT - Final Documents to be provided to awarded Contractor

ATTACHMENT P

BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES FOR ADULTS

The following provides a description of the Integrated Health Home Program (IHH) and the Assertive Community Treatment Programs (ACT). These services are specific to individuals with serious mental illness. The second part of the document refers to the continuum of mental health and substance use services. These services will be provided to any adult member, based on need. EOHHS, BHDDH, and the Contractor will work together to transition these services from Fee-for-Service into managed care. EOHHS recognizes as this transition occurs, the program and service features may change. EOHHS will continue to hold the Contractor responsible for ensuring all members with need receive appropriate and timely access to care.

1. Overview

Adults with serious mental illness require specialized programs that deliver recovery-oriented care, addressing all clinical needs both behavioral and medical. These specialized programs are responsible for ensuring integration of care which includes coordinating the recipient's comprehensive health care needs including physical health, mental health, substance use and social supports. The performance of these programs will be measured, and the goal is improved access to high quality community-based services and decreased costs.

The specialized programs will be for adults with a range of serious mental health illness identified based on diagnostic characteristics. The specialized programs described in this document which will be carried out by the Community Mental Health Organizations (CMHOs) licensed by BHDDH are referred as: Assertive Community Treatment (ACT) and Integrated Health Homes (IHH). Program monitoring and evaluation by the Contractor is required to ensure validity to the model and the effective implementation of responsibilities and functions by the Managed Care Organizations and the CMHOs. The program will be supported by BHDDH regulations.

It is the State's expectation that for those members who are active with a Health Home, the care manager on site at the Health Home will be the Lead Care Manager for that member. Contractor's care management staff will coordinate between the Health Home and any necessary physical health care a member may need. The Contractor will have a designated Lead Care Coordinator or Care Manager to work directly with the CMHO and OTP Health Homes. The Contractor will employ predictive modeling tools that identify and stratify members at risk. If an at-risk member is identified, they will be referred to a Health Home.

The Contractor will have policies and procedures that document how the Contractor will conduct transitions of care and hospital discharge activities, to ensure all appropriate medical, social, and behavioral health needs are met when a member transitions back to the community.

2. Goals

The specialized programs for adults with serious mental illness will be a holistic, person- centered care model that aims to improve member outcomes and takes into account behavioral (mental health and substance use) and primary medical and specialist needs in order to strengthen the connection these high-risk patients have to the comprehensive health care system. Emphasis is

placed on the monitoring of chronic conditions, timely post inpatient discharge follow-up and preventative and education services focused on self-care, wellness and recovery. This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. The programs will meet the Triple Aim of improving care and access, reducing cost, and improving quality.

Improve care and access	<ul style="list-style-type: none"> • Person-centered approach (whole person care) • Commitment to recovery/resiliency focused services • Coordinate care across medical, mental health and substance use system • Expand capacity of and access to high quality community-based services
Reduce cost	<ul style="list-style-type: none"> • Ensure that a sufficient range of community-based services are available to decrease ER and inpatient utilization • Decrease total cost of care for highest utilizers • Alignment of incentives to support providers in sharing accountability for the cost of care
Improve quality	<ul style="list-style-type: none"> • Continuous quality improvement • Promote clinical and service excellence through evidence-based practices • Alignment of incentives to promote increased quality

3. Mental Health Parity

The Contractor will comply with the Mental Health Parity Addiction Equity Act (MHPAEA). Requirements include:

- Treatment limitations that are applied to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- There are no separate treatment limitations that apply only to mental health or substance use disorder benefits.
- Medical management techniques used by the Contractor must be comparable to and applied no more stringently than the medical techniques that are applied to medical/surgical benefits.

In addition, the contractor agrees that its non-quantitative treatment limits for behavioral health services will not be more restrictive, nor applied more stringently, than the plan's non-quantitative treatment limits for its commercial population. This includes policies and procedures for medical necessity determination, prior approval, and concurrent and retrospective review.

Program Description

Target Populations

Eligible participants in ACT or IHH must be 18 years or older and are actively enrolled in the following Medicaid product lines: RItE Care, Medicaid Expansion, and Rhody Health Partners (RHP).

Participants are initially defined by their diagnostic characteristics, specifically a primary DSM V/ICD-10 mental health diagnosis. To be eligible for ACT and IHH participants must also meet the appropriate level of acuity as defined by the State approved standardized assessment tool Daily Living Activities Functional Assessment (DLA).

- ACT participants must have a DSM V/ICD-10 mental health diagnosis and an impaired functional level score based on the DLA.
- IHH participants must have a DSM V/ICD-10 mental health diagnosis and an impaired functional level score based on the DLA.
- Individuals who do not meet diagnostic criteria but require IHH services due to significant functional impairment as measured by the state approved standardized assessment tool, may be admitted to the program through an appeals process established by the State.

Core CMHO Functions and Responsibilities

The CMHOs will carry out the following functions under both ACT and IHH Programs:

- Identify participants eligible for specialized programs (based on Target Population parameters)
- Complete a comprehensive risk assessment using the standardized tool, DLA, to identify participant.
- Based on Assessment score, determine and place individual in appropriate specialized program level of service: IHH or ACT. Individuals that do not meet IHH or ACT will not be assigned to the programs and but remain eligible for services and care management in the community.
- Develop a person-centered, individualized Care Plan
- For all Health Home admissions, discharges and transfers, a State approved enrollment form must be completed and kept in the client's medical record. If a client is already enrolled in a Health Home program it is up to the Provider to coordinate with the client's current Health Home Provider
- Carry out treatment and recovery services with fidelity to the ACT model of care
- Carry out treatment and recovery services in the IHH model of care
- Actively use Current Care for communication between medical and BH settings, especially for inpatient and ER alerts, for clients that opt into the Current Care program

- Participate in active discharge planning with medical and BH/SU inpatient, acute care and other facilities
- Collaborate to create new delivery system capacity as needed through on-going evaluation of the needs of the system.
- Work with the Contractor's care management staff to facilitate access to the member's PCP and specialty medical providers.
- Work with the Contractor's utilization review staff to ensure timely access to follow-up care, post inpatient psychiatric hospitalization, including medication reconciliation.
- Submit required the Contractor and EOHHS metric reporting and data exchange
- Coordinate with the Opioid Treatment Provider (OTP) Health Home Program to avoid duplication of services. Members can only be enrolled in one specialized program at a time and cannot be simultaneously enrolled in ACT, IHH and OTP Health Home
- Notify the Contractor and BHDDH of staffing changes impacting the CMHO's ability to provide the services required for IHH or ACT within 14 calendar days. Providers will submit a monthly staffing census to BHDDH/MCO that will be reviewed and evaluated for provision of services.
- Provide primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services.

Program Elements

The ACT and IHH specialized programs both use a multi-disciplinary team model where medical care coordination staff and behavioral health treatment staff work together to meet the comprehensive health and wellness needs of assigned participants. The team is responsible for coordinating the medical, behavioral and substance use care of all participants. Care is provided with fidelity to the evidence-based practices of ACT and IHH. The model of care promotes recovery, hope, dignity and respect with the belief that all consumers can recover from mental illness. Active treatment and supports are provided with cultural competence.

Program Definitions

Assertive Community Treatment (ACT) Services provided through RI Integrated Health Homes (IHH) have the responsibility to coordinate and ensure the delivery of person-centered care; provide timely post discharge follow-up, and improve patient health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services. Emphasis is placed on the monitoring of chronic conditions, and preventative and education services focused on self-care, wellness and recovery.

This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. Regardless of the level of care, these outcomes are achieved by adopting a whole person approach to the consumer's needs and addressing the consumer's primary medical, specialist and behavioral health care needs; and providing the following comprehensive/timely services:

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

The ACT team is available to provide services 24 hours per day seven days per week, 365 days per year. An ACT team is best conceptualized as continuous care team that functions as a vehicle to provide an array of clinical services or practical needs a person requires. As the provider of most of the services, the continuous care team assures that the services are integrated and provided in the context of the client's current needs, with all activities directed toward helping the client to live a stable life of quality in the community. A major focus of the team is to help the client to gain the skills and confidence needed to move toward greater degrees of independence.

Integrated Health Home (IHH) is built upon the evidence-based practices of the patient-centered medical home model. IHH builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including Addiction care) in keeping with the needs of persons with multiple chronic illnesses. IHH is a service provided to community-based clients by professional behavioral health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. IHH teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. IHH uses a team-based approach for care coordination, mental health and physical health chronic condition management, health promotion and peer/family support.

IHH activities are focused in four areas:

1. Care coordination and health promotion

Each client will be assigned a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the person-centered treatment/care coordination plan, ensure plans are revised and updated as clients' needs change and advocate for client rights and preferences. In addition,

collaborate with primary and specialty care providers as required and provide education about medical medications (e.g. educating through written materials, etc.). The Health Home team is responsible for managing clients' access to other healthcare providers and to act as a partner in encouraging compliance with care plans established by these providers. Health promotion activities are delivered by the team to engage clients in addressing healthy lifestyles and include but are not limited to: smoking cessation; nutrition; increasing activity levels; relaxation strategies; and stress management.

2. Chronic condition management and population management

The IHH team supports its consumers as they participate in managing the care they receive. Interventions provided under IHH may include, but are not limited to:

- Assisting in the development of symptom self-management, communication skills and appropriate social networks to assist clients in gaining effective control over their psychiatric symptoms and their life situations, including minimizing social isolation and withdrawal brought on by mental illness, to increase client opportunities for leading a normal, socially integrated life;
- Provide health education, counseling and symptom management challenges to enable client to be knowledgeable in the prevention and management of chronic medical illness as advised by the client's primary/specialty medical team.
- Maintaining up-to-date assessments and evaluations necessary to ensure the continuing availability of required services;
- Assisting the client in locating and effectively utilizing all necessary community services in the medical, social and psychiatric areas and ensuring that services provided in the mental health area are coordinated with those provided through physical health care professionals;
- Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to manage the symptoms of their psychiatric and medical issues to live in the community. This includes:
 - Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance; Social Services; Transportation and Legal advocacy).
 - Find housing which is safe, of good quality and an affordable place to live-apartment hunting, finding a roommate, landlord negotiations, cleaning, furnishing and decorating and procuring necessities (i.e. telephone, etc.).

- Provide ongoing assessment, problem solving, side-by-side services, skill training, supervision (e.g. prompts, assignments, monitoring, and encouragement) and environmental adaption to assist support client to maintain housing).
- Teach money-management skills (e.g. budgeting and bill paying) and assist client assessing financial services.
- Develop skills related to reliable transportation (help obtain driver's license, use of mass transit, arrange for cabs.
- Provide individual supportive therapy (e.g. problem solving, role playing, modeling and support), social skill development, and assertive training to increase client 's social and interpersonal activities in community settings) e.g. Plan, structure, and prompt social and leisure activities on evenings, weekends, and holidays, including side-by-side support and coaching.
- Assistance with other activities necessary to maintain personal and medical stability in a community setting and to assist the client to gain mastery over their psychiatric symptoms or medical conditions and disabilities in the context of daily living. For example:
 - Support the client to consistently adhere to their medication regimens (e.g. daily scheduling, delivering and supervision of medication regime, telephone prompting, Motivational interviewing, etc.), especially for clients who are unable to engage due to symptom impairment issues.
 - Accompanying clients to and assisting them at pharmacies to obtain medications.
 - Accompany consumers to medical appointments, facilitating medical follow up.
 - Provide side-by-side support and coaching to help clients socialize (e.g. going with a client to a baseball game, etc.) - structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support.

The IHH team will conduct the necessary analysis related to how well they are managing entire populations, based on measurable health outcomes and utilization. This information helps IHHs improve their care delivery system, to the benefit of each IHH clients receiving care.

3. Comprehensive transitional care

The IHH team will ensure consumers are engaged by assuming an active role in discharge planning. The IHH team will communicate and ensure collaboration between consumers, professionals across sites of care and the Contractor's care management and utilization review staff potentially reducing medical errors, missed appointments, and dissatisfaction

with care. Specific functions include:

- a. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.
- b. Upon hospital discharge (phone calls or home visit):
 - i. Ensure that reconciliation of pre-and post-hospitalization medication lists is completed.
 - ii. Assist consumer to identify key questions or concerns.
 - iii. Ensure Consumer understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent health problem becoming worse; has scheduled all follow- up appointments.
 - iv. Prepare consumer for what to expect if another next level of care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).
 - v. The Contractor's care management and utilization review staff will work with the IHH team to review transition care goals, relevant transfer information (i.e. all scheduled follow-up appointments; any barriers preventing making appointments), function as resource to IHH consumers – to clarify all outstanding questions.
- c. Identify and facilitate linkages between long-term care and home and community-based services.

4. Individual and Family support services

IHH team will provide practical help and support, advocacy, coordination, side-by-side individualized support with problem solving, direct assistance, helping clients to obtain medical and dental health care. Services include individualized psycho-education about the client's illness and the role of the family and their significant people in the therapeutic process. Also, to assist clients with children regarding service coordination (e.g. services to help client fulfill parenting responsibilities; services to help client restore relationship with children, etc.).

IHH peer support specialists will help IHH consumers utilize support services in the community and encourage them in their recovery efforts by sharing their lived experience and perspective. Peer support serves to validate clients' experiences, guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, offer peer support services to:

- a. Help clients establish a link to primary health care and health promotion activities.

- b. Assist clients in reducing high- risk behaviors and health risk factors such as smoking, poor illness self-management, inadequate nutrition, and infrequent exercise.
- c. Assist clients in making behavioral changes leading to positive lifestyle improvement.
- d. Help clients set and achieve a wellness or health goal using standardized programs such as Whole Health Action Maintenance (WHAM).

Assessment

The CMHOs are expected to use a single, standardized assessment tool approved by the State. Assessments based on other tools will not be accepted.

Assessment Frequency

- An assessment will be administered at the time of initial engagement and every 6 months or more frequently when a significant change is identified.
- A reassessment with the standardized tool will be conducted within 48 hours of a discharge from a hospital or nursing home.

Plan of Care

A comprehensive Plan of Care must address behavioral health needs, medical and social needs with measurable, realistic and time sensitive goals. The following are required:

- Plan of care developed within thirty (30) days of completion of the assessment.
- Plan of care developed with and agreed to by the member or caregiver, or those chosen by the member to participate in the care plan. (verbal or written acceptance)
- Reviewed at least every 6 months and when a significant change is identified

Reporting

A complete listing of quality and monitoring measures is listed below. The State reserves the right to make modifications to required data elements and aggregate reports.

5. Assertive Community Treatment (ACT) and IHH Requirements

The requirements of ACT and IHH have several shared requirements but differ in the characteristics of the participants and the level of service intensity, as determined by the functional level score. ACT and IHH participants must have a DSM V/ICD-10 mental health diagnosis and an impaired functional level score based on the DLA.

Service Requirements

Participants are outreached by members of the ACT Team continually to engage in care to the maximum extent necessary to achieve individual goals. If a member refuses care or declines participation for ninety (90) days, the CMHO must notify the Contractor to review the Care Plan.

Participants are outreached and engaged by members of the IHH Team over the course of each month. The IHH Team members must be flexible and available to meet more frequently when needed. The IHH Team Leader is available 24 hours/day 7 days a week if needed.

The ACT and IHH Teams provides or coordinates the following services:

• Crisis Stabilization Services 24/7
• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports
• Medication Management Medication administration, monitoring and reconciliation
• Individual, Group and Family Therapy
• Medical and Substance Use Treatment Coordination Activities
• Recovery and Rehabilitation Skills
• Substance Use Treatment (for ACT participants only)
• Supported Employment/Schooling Assessment and Assistance
• Care Transition – hospital, incarceration or nursing home to home
• Outreach and engagement
• Identification and engagement of natural supports and Social relationships
• Peer Support and IADL Support Services
• Education, Support, and Consultation to Clients’ Families and Other Major Supports

A. Service Coordination/Care Management

Each client will be assigned a service coordinator (care manager) who coordinates and monitors the activities of the client’s individual treatment team and the greater ACT/IHH team. The primary responsibility of the service coordinator is to work with the client to develop the treatment plan, provide individual supportive counseling, offer options and choices in the treatment plan, ensure that immediate changes are made as the client’s needs change, and advocate for the client’s wishes, rights, and preferences. The service coordinator is the first staff person called upon when the client is in crisis and is the primary support person and educator to the individual client’s family. Members of the client’s individual treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is unavailable. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

B. Crisis Stabilization

Crisis stabilization will be available and provided 24 hours per day, seven days per week. Crisis intervention response must be provided in a timely manner.

These services will include telephone and face-to-face contact. The Contractor will make available a current listing of all subcontractors engaged for this service.

A. Therapy

This will include but is not limited to the following:

1. Ongoing comprehensive assessment of the client's mental illness symptoms, accurate diagnosis, and response to treatment.
2. Individual and family Psychoeducation regarding mental illness and the effects and side effects of prescribed medications
3. Symptom-management efforts directed to help client identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects.
4. Individual, group and family supportive therapy
5. Psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to facilitate recovery.

B. Medication Prescription, Administration, Monitoring and Documentation

The ACT/IHH team psychiatrist or registered nurse will provide education about medication, benefits and risks, obtain informed consent and assess and document the client's mental illness symptoms and behavior in response to medication. Team members will monitor and document medication side effects and provide supportive services. This clinical team will also assist the client with medication adherence strategies for all psychiatric and medical prescriptions.

C. Dual Diagnosis Substance Use Disorder Services

Provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance use, and has client-determined goals. This will be provided by an addiction specialist and include but is not be limited to individual and group interventions in:

1. Engagement (e.g., empathy, reflective listening, avoiding argumentation)
2. Assessment (e.g., stage of readiness to change, client-determined problem identification)
3. Motivational enhancement (e.g., developing discrepancies, psych education)
4. Active treatment (e.g., cognitive skills training, community reinforcement)
5. Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).

D. Supportive Employment-Related Services

Work-related services to help clients value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with community-based employers. The principles of the evidence-based practice Individual Placement and Support (IPS) will be used to find employment. Services Include but are not limited to:

- a. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.
- b. Assessment of the effect of the client's mental illness on employment with identification of specific behaviors that interfere with the client's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations.
- c. Development of an ongoing employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job.
- d. Individual supportive counseling to assist clients to identify and cope with mental illness symptoms that may interfere with their work performance.
- e. On-the-job or work-related crisis intervention.
- f. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.
- g. Job Development
- h. On-site supports as needed
- i. Coordination of supports through in collaboration with the Office of Rehabilitation Services (ORS)
- j. Job coaching

E. Activities of Daily Living/ADL's

Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist clients to gain or use the skills required to:

- a. Find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, decorating; and procuring necessities such as telephones, furnishings, linens)

- b. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry
- c. Carry out personal hygiene and grooming tasks, as needed
- d. Develop or improve money-management skills
- e. Use available transportation
- f. Have and effectively use a personal physician and dentist

F. Natural Supports and Social/Interpersonal Relationship Identification

Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure clients' time, increase social experiences, and provide opportunities to practice social skills and receive feedback and support required to:

- a. Improve communication skills, develop assertiveness, and increase self-esteem
- b. Develop social skills, increase social experiences, and develop meaningful personal relationships
- c. Plan appropriate and productive use of leisure time
- d. Relate to landlords, neighbors, and others effectively
- e. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

G. Peer Support Services

Services to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, services to help clients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce clients' self-imposed stigma. Services include:

- 1. Peer counseling and support
- 2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery

H. Instrumental Activities of Daily Living Support Services (IADL)

Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not limited to:

1. Medical and Dental services
2. Safe, clean, affordable housing
3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance)
4. Social services
5. Transportation
6. Legal advocacy and representation

I. Education, Support, and Consultation to Clients' Families and Other Major Supports

Services provided regularly under this category to clients' families and other major supports with client agreement or consent, include:

- 1) Individualized psycho education about the client's illness and the role of the family and other significant people in the therapeutic process
- 2) Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people
- 3) Ongoing communication and collaboration, face-to-face and by telephone, between the ACT/IHH team and the family
- 4) Introduction and referral to family self-help programs and advocacy organizations that promote recovery
- 5) Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:
 - a) Services to help clients throughout pregnancy and the birth of a child
 - b) Services to help clients fulfill parenting responsibilities and coordinate services for the child/children
 - c) Services to help clients restore relationships with children who are not in the client's care and custody

J. Care Transitions

The ACT/IHH team will ensure consumers are engaged by assuming an active role in discharge planning. The team will communicate and ensure collaboration between consumers, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

1. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.
2. Upon hospital discharge (phone calls or home visit):
 - Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.
 - Assist consumer to identify key questions or concerns.
 - Ensure the client understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent worsening of health conditions and facilitate the scheduling of all follow-up appointments.
 - Review transition care goals with the team, provide relevant follow up and transfer information, function as resource to the client on all matters related to transition.
3. Identify and educate on linkages between primary and specialty medical care, behavioral healthcare, long-term care and home and community-based services.

Team Composition and Staffing Levels

The Team Lead for an ACT team must be a licensed clinician. The Team Lead for an IHH team can be licensed as a Registered Nurse or have a Master's in Social Work. The assignment of the appropriate type of Lead CM is based on the level member's level of needs. In addition to the Team Lead, the ACT Team and IHH teams are expected to have a staff as defined in the *IHH Provider Manual*.

Reimbursement Arrangement

The provider is reimbursed based on a bundled rate for their ACT or IHH participants and MCO Fee for Service for selected services.

Billing for ACT will be a bundled rate. Providers will be required to submit encounter data/shadow claims to the MCOs for MCO clients and for the State for Medicaid FFS clients. If a service provided for in the bundle is billed separately from the bundle, by the ACT provider or another provider, the claim will deny.

Individuals involved in the MHPRR program are not able to enroll in ACT. ACT billing is not allowed for persons in institutionalized settings. Refer to the *Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Provider Billing Manual*, for detailed information on billing. For any individual that is in a residential setting for more than thirty (30) days, the provider will report to the Contractor, BHDDH, and EOHHS on these members for the State to make a determination if this person is still appropriate for this level of service.

Billing for IHH will consist of the specified IHH code as well as other clinical services provided

apart from the bundle. The IHH bundled rate is for care coordination activities only and does not include any clinical services. IHH can be billed while an individual is in an institutionalized setting. Refer to the *Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Provider Billing Manual*, for detailed information on billing. For any individual that is in a residential setting for more than thirty (30) days, the provider will report to the Contractor, BHDDH, and EOHHS on these members for the State to make a determination if this person is still appropriate for this level of service.

ACT Bundled Services	ACT MCO Fee for Service
<ul style="list-style-type: none"> Crisis Stabilization Services including 24/7 access 	<ul style="list-style-type: none"> Clubhouse
<ul style="list-style-type: none"> Housing Assistance, Tenancy Supports and Activities of Daily Living Supports 	<ul style="list-style-type: none"> Methadone
<ul style="list-style-type: none"> Recovery & Rehabilitation skills 	
<ul style="list-style-type: none"> Supported Employment/Schooling assessment and assistance 	
<ul style="list-style-type: none"> Case Management- Identification and engagement of natural supports and Social relationships 	
<ul style="list-style-type: none"> Care Coordination- Outreach and engagement Medical and Substance Use Treatment Coordination Activities 	
<ul style="list-style-type: none"> Team Rounding 	
<ul style="list-style-type: none"> Peer Support and IADL Support Services 	
<ul style="list-style-type: none"> Care Transition – hospital, incarceration or nursing home to home 	
<ul style="list-style-type: none"> Outpatient Clinical services provided at the CMHO including: Medication Management Medication administration, monitoring and reconciliation, Individual, Group and Family Therapy 	
<ul style="list-style-type: none"> Medication management including reconciliation 	
<ul style="list-style-type: none"> Substance Use Treatment (for ACT participants only) 	

In general, the IHH program billing will encompass:

<ul style="list-style-type: none"> Crisis Stabilization Services including 24/7 access 	<ul style="list-style-type: none"> Residential Treatment Substance Use Treatment
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<ul style="list-style-type: none"> Housing Assistance, Tenancy Supports and Activities of Daily Living Supports 	<ul style="list-style-type: none"> Outpatient Clinical services provided at the CMHO and in community- Medication Management Medication administration, monitoring and reconciliation, Individual, Group and Family Therapy
<ul style="list-style-type: none"> Recovery& Rehabilitation skills 	<ul style="list-style-type: none"> Clubhouse
<ul style="list-style-type: none"> Case Management- Identification and engagement of natural supports and Social relationships 	<ul style="list-style-type: none"> Supported Employment/Schooling assessment and assistance

<ul style="list-style-type: none"> Care Coordination-Care Transition – hospital, incarceration or nursing home to home 	
<ul style="list-style-type: none"> Medical and Substance Use Treatment Coordination Activities 	
<ul style="list-style-type: none"> Team Rounding 	
<ul style="list-style-type: none"> Care Transition – hospital, incarceration or nursing home to home 	

Contractor Responsibility:

The Contractors will support the following:

- Provide CMHOs with reporting to facilitate the coordination of medical and behavioral health care.
- The Contractor will use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with CMHOs.
- The Contractor will be responsible for oversight to ensure contract requirements are being met.
- The Contractor will assist the CMHOs with identifying necessary components of metric reporting.
- The Contractor will adhere to the reporting date requirements as specified by EOHHS.
- The Contractor will adhere to a quality performance payment methodology and process that could include recoupments or withholds, as specified by EOHHS.
- Continuity of care requirements, including maintenance of relationships between members and treating providers. This includes beneficiaries transitioning into the managed care organization.

- The Contractor will hold the member harmless.
- The Contractor will ensure that the CMHO's are submitting HIPAA compliant claims data for services delivered under the IHH and ACT bundles.

Integration with Rehabilitation Practices

Additional services not mentioned above for ACT/ IHH will integrate clinical treatment, services, and Rehabilitation practices including:

- Integrated Dual Diagnosis Treatment (substance use and mental illness), an evidence-based practice
- Mental Health Psychiatric Rehabilitation Residences (MHPRR)

Value-based Purchasing & Monitoring

The Contractor will adhere to a quality performance payment methodology and process that may include recoupments or withholds, as specified by EOHHS.

The information collected from each measure will be used for program monitoring and must be provided based on the parameters. These measures will be routinely reviewed and modified, based on industry trends.

6. In Plan Benefits

1. MENTAL HEALTH AND SUBSTANCE USE SERVICES

The Contractor commits to providing all Medicaid managed care adults a full continuum of mental health and substance use services. The Contractor's services will address all levels of need. The Contractor will have a robust network of providers that meet the needs of the community. Providers should be a mix of CMHCs and community-based providers. All services should be provided to any adult member, as needed.

Services are not restricted to a specific pay level or category (such as an SPMI designation). The following provides an example of services that a CMHC or equivalent provider should provide. These include but are not limited to:

A. ACUTE SERVICES:

Acute Services represent the highest level of service intensity based on the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

1. Emergency Service Intervention:

24 hour/7 days a week, face-to-face care management and intervention of an individual experiencing a behavioral health crisis. Such crises include an imminent, real, and significant risk of serious harm to self or others that requires immediate treatment. The activities are conducted by a licensed behavioral health provider in a hospital emergency room, residential placement setting, the individual's home, police station, or other community setting that the family and the child-family competent clinician agree is safe and clinically suitable to resolve the mental health crisis.

- When a member is clinically assessed in an Emergency Room Setting and is not admitted to an inpatient level of care, the health plan will ensure that the member has a follow up appointment within three (3) business days of discharge from the Emergency Room. The health plan may fulfill this requirement by contract with their providers; or by utilizing the health plans care manager for outreach; or another care coordination entity in the community. The health plan must demonstrate compliance to this requirement within ninety (90) days of the execution of this amendment.
- The discharge plan will be shared with the member's physician within three (3) business days of the Emergency Room discharge. If a member is involved with a care coordinating entity, it is recommended that the discharge plan is shared within (3) business days of the emergency room discharge.
- The Contractor must demonstrate compliance to this requirement within ninety (90) days of the execution of this amendment".

The plan will work with the hospital delivery system to ensure coordination of integrated care for members who may present with primary medical condition who have an underlying BH issue including but not limited to:

- Alcohol Related Disorders
- Anxiety Disorders
- Mood Disorders

2. Observation/Crisis Stabilization/Holding Bed:

A secure and protected, medically staffed, psychiatrically supervised program designed for those individuals who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or who are acutely and significantly disabled and cannot meet their basic needs and functions, and who require extended observation and treatment in order to determine the most appropriate level of care and to avoid acute inpatient hospitalization.

3. Inpatient Acute Hospitalization:

Services provided in a hospital- or freestanding detoxification facility staffed by licensed physicians (including psychiatrists) with 24-hour skilled nursing in a

structured treatment milieu for the treatment of individuals with a mental health or substance use disorder of sudden onset and short, severe course who cannot be safely or effectively treated in a less intensive level of care.

4. Acute Residential Treatment:

A community based short-term service or hospital step- down that provides comprehensive multidisciplinary behavioral health evaluation and treatment in a staff setting offering high levels of supervision, structure, restrictiveness and intense treatment on a 24-hour basis. The treatment should include individual, family, and group clinical therapy, crisis management, & medication evaluation and management.

Acute Residential Treatment requires:

- The provider to be licensed as a Residential Treatment provider
- Available licensed physician on staff or on call, 24 hours per day, and 7 days per week to adjust medications as needed or to address members in crisis.
- RN on staff or an RN available to meet member's needs.
- 24/7 availability of certified clinical staff adequate to meet the member's medical and psychological needs
- Program structure includes therapeutic treatment services, modalities and intensity as appropriate to meet family and member's needs. It is recommended that the structure includes at minimum 4 hours/ day Monday- Friday and 4 hours/day on weekends. Recreational and educational activities do not count toward therapeutic treatment.

B. INTERMEDIATE SERVICES and OUTPATIENT

Acute Services represent the highest level of service intensity based in the member's need for either a locked or staff secured 24-hour clinical setting that offers full behavioral health management. These services are represented within a continuum of care including services such as Inpatient, Acute Residential Treatment Services (ARTS), Observation/Crisis Stabilization/Holding Bed, and Emergency Service Intervention.

1. Partial Hospitalization (PHP):

A short term, comprehensive, multidisciplinary behavioral health program that promotes and maintains a therapeutic milieu/community. The PHP is an alternative to or step-down from inpatient care. PHP is designed to provide stabilization of acute, severe, mental illness, substance use disorders, or dual diagnosis.

A PHP requires daily psychiatric evaluation and treatment comparable to that provided by an inpatient setting. A PHP may be provided by both hospital-based and freestanding facilities and available 6-9 hours per day at minimum 5 days per week. For adults, a PHP provides services similar to hospital level care for members who have a supportive environment to return to in the evening. As the adult's symptoms improve

and a transition plan effectively transitions the adult back to the community. The PHP consults and coordinates the member's care with other treating providers, and community supports. The PHP implements behavior plans, monitors, manages, and administers medication, and has 24/7 physician availability for emergencies.

Minimum program requirements include:

- Members receive clinical treatment & scheduled programming based on member's clinical needs. It is recommended that this is provided at least 20 hours per week for BH and/or SUD
- Individualized treatment plan, assessment, medication and evaluation, individual, family, & group counseling; crisis intervention, and activity therapies or psycho education, when determined to be clinically appropriate to meet the needs of the member.
- Members must be able to tolerate and participate in the PHP program.
- A licensed practitioner responsible to supervise program and staff and a treatment plan will be provided for each member.
- The Contractor will be responsible for ensuring that the provider has a treatment plan for each member and that the treatment plan includes member goals and a method for measuring these goals.

2. Day/Evening Treatment:

A structured program focused on enhancing current levels of functioning and skills while maintaining community living. Adults who no longer require active medically based services may have significant residual symptoms that require extended interventions to address recovery. The goal of day/evening treatment is to assist members with behavioral health disorders to achieve and maintain their highest level of functioning and work toward appropriate development goals. The services provided include: individual and family behavioral health therapies; psychosocial and adjunctive treatment modalities including rehabilitative, pre-vocational and life skill services to enable the individual to attain adequate functioning in the community.

3. Intensive Outpatient Treatment (IOP):

A clinically structured outpatient program for individuals similar to a Day Treatment offering short-term day, evening, or combination which consists of intensive treatment within a stable therapeutic milieu for those individuals who can be safely treated in a less intense setting than a partial, day or evening program but require a higher level of intensity than that available in outpatient therapy. IOP's primary treatment modality is group therapy which supports positive and safe communication and interactions in a supportive therapeutic milieu which is an essential component for member recovery.

Minimum program requirements include:



- Members receive clinical treatment based on the member's clinical needs. It is recommended that the clinical services are provided at least 3 hours per day, 3 times/week for BH and/or SUD.
- Individualized treatment plan, assessment, medication and evaluation, group, individual, and family, counseling; crisis intervention, and activity therapies or psycho education, when determined to be clinically appropriate based on the member's needs.
- Licensed physician on staff or on call that can adjust and evaluate medication if needed. Alternatively, designated program clinical staff will coordinate, collaborate, and/or link a member to a prescriber, if needed.
- A licensed practitioner responsible to supervise program and staff and a treatment plan will be provided for each member.

4. ACT & IHH:

Integrative behavioral and physical health care management model. Assessment, evaluation to identify member's behavioral and physical health needs. Care plan developed based on members identified needs with the goal of client stability and long-term community tenure. Coordination through regular contact and correspondence with primary care, social support, family, and treatment providers the member is involved with. Assist member in accessing social supports, vocational training and support, medical and behavioral health treatment, education training and support as identified through members' assessment and care plan. Case Manager must assist a member with transition from any 24-hour level of care or to prevent an admission. Case Management is delivered by adequately trained agency staff in accordance with applicable program specifications, State certification or licensing requirements, in addition to applicable MCO credentialing requirements.

The Contractor will reimburse these services in a manner defined by the State.

5. Peer Support/Recovery Coach:

A personal guide and mentor for people seeking or in recovery. The peer support/Recovery Coach assists to remove barriers and obstacles and links the recovering person to the recovery activities and supports.

6. Clubhouse:

The Clubhouse International model has been recognized by SAMHSA as an Evidence Base Practice for those with severe and persistent mental illness. Clubhouse has community structure, evidence-based practice, led by peers, recovery model with a focus on employment, wellness, and development of a community support network.

The Contractor will reimburse these services in a manner defined by the State.

Clubhouse services should include a minimum of three (3) hours per service, at least 1 time per week. At a program level, twenty-five percent (25%) of all members in the program must have an employment outcome of either supported employment, transitional employment or independent employment.

7. Integrated Dual Diagnosis Treatment for Substance Use Disorders:

Care management services provided in accordance with an approved treatment plan to ensure members with primary substance use maintain and build stability, recovery capital, and continued community tenure.

8. General Outpatient:

Clinical services inclusive of individual, group, family, crisis intervention, diagnostic evaluation, psychological testing, and medication evaluation and management. Treatment can be conducted in an office, home-based or community setting. Member has access to full continuum of Behavioral Health and Substance Use benefits offered by the Contractor (PHP, IOP, etc.) Clinical services are delivered by adequately trained behavioral health professionals in accordance with applicable program specifications, State licensing requirements, in addition to applicable Contractor.

9. Center of Excellence Program (COE):

Through the work of the Governor's Opioid Overdoes Prevention and Intervention Task Force, BHDDH will certify providers that meet the established COE certification standards. EOHHS will work with CODAC, and future providers who become certified, to ensure that proper arrangements are in place to allow COE providers to bill medication via J-codes or other methods that will allow them to dispense medication to members at their facility rather than prescribe to the member for self-management, under a point of sale system.

The program is reimbursed by fee for service for managed care members, with the exception of the medications (table or films) which is currently in the formulary of the Contractor and is a benefit for their members.

C. LONG TERM RESIDENTIAL PROGRAMS

Long Term SUD Residential Services:

The Contractor is required to contract with and support the SSTAR Birth Residential Program. This requirement includes but is not limited to a minimum six (6) month length of stay for the family unit. EOHHS reserves the right to review and approve any prior authorization process required by the Contractor.

Services must meet ASAM Level 3.5, Level 3.3, or 3.1

A. ASAM Level 3.5 Clinically Managed High- Intensity Residential:

Level 3.5 provides a structured, therapeutic community environment focused on addressing member life skills, reintegration into the community, employment, education, and recovery.

Minimum Requirements:

- Member meets at least all 3.5 ASAM level criteria.
- Capacity to address the medical needs of the member.
- Medication and evaluation.
- It is recommended that at least 12 clinical services per week including individual, group, & family, based on the member's need.

B. ASAM Level 3.3 Short- Term Clinically Managed- Medium Intensity:

Level 3.3 is a non- acute residential level of care that focuses on member stabilization, integration, employment, education, and recovery. A component of member treatment may focus on habilitation due to immediate service delivery needs for continuity of services (e.g. medications, assistive medical technology or supplies, ongoing relationships with providers, potential needs for prior authorizations or special arrangements to assure continuity with current providers, and potential met and unmet needs for assistance in accessing services and/or identifying to discharge from institutional level of care).

Minimum Requirements:

- Member meets all 3.3 ASAM level criteria.
- Capacity to address the medical needs of the member.
- Medication and evaluation.
- It is recommended that at least 12 clinical services per week including individual, group, & family, based on the member's need.

C. ASAM Level 3.1 Clinically Managed Low- Intensity Residential Services:

Minimum Requirements:

- Member meets at all 3.1 ASAM level criteria.
- Capacity to address the medical needs of the member.
- Medication and evaluation.
- It is recommended that at least 5 clinical services (1 hour per week of clinical treatment and 4 group and/or family sessions) per week including individual, group, & family, based on the member's need.

Mental Health Psychiatric Rehabilitative Residential (Group Home and Supportive Housing)

A Mental Health Psychiatric Rehabilitative Residence (MHPRR): is a licensed residential program that provides 24-hour staffing for a sub-population of the Integrated Health Home clients.

A physician must authorize all MHPRR services.

The “24-hour staffing” requirement means that the Provider must provide staff coverage 24 hours a day, 7 days a week as long as there are clients physically present in the living quarters of a program. Staff is on site for these programs.

The service elements offered by a residential program include to the following based on each resident’s individualized recovery-focused treatment plan:

- Mental health therapeutic and rehabilitative services for the resident to attain recovery
- Medication prescription, administration, education, cueing and monitoring
- Educational activities (appropriate to age and need)
- Menu planning, meal preparation and nutrition education
- Skill training regarding health and hygiene
- Budgeting skills training and/or assistance
- Community and daily living skills training
- Community resource information and access
- Transportation
- Social skills training and assistance in developing natural social support networks
- Cultural/Spiritual Activities
- Limited temporary physical assistance, as appropriate

In addition, each residential program provides the following for its residents:

- A homelike and comfortable setting
- Opportunities to participate in activities not provided within the residential setting
- Regular meetings between the residents and program personnel
- A daily schedule of activities
- Sleeping arrangements based on individual need for group support, privacy, or independence, as well as, the individual's gender and age.
- Provisions for external smoking areas, quiet areas, and areas for personal visits

Supervised Apartments: A Supportive Mental Health Psychiatric Rehabilitative Residence Apartments (MHPRR-A) is a licensed residential program which provides 24-hour staffing for IHH clients in which the clients receive a wide range of care management, treatment, psychiatric rehabilitation and individual care services. Beds may be designated as Intensive, Specialty, Basic, Crisis/Respite, or any combination thereof.

Specific services may include, but are not limited to:

- a) Medication: Education, administration and monitoring;
- b) Social casework: Client-based advocacy; linkage to outside service providers; monitoring the use of outside services; individualized treatment planning and skill teaching; income maintenance; and medical care assistance
- c) Limited physical assistance as required: Mobility; assistance with non-injectable

medications; dressing; range-of-motion exercises; transportation; and household services;

- d) Skill assessment and development: Personal hygiene; health care needs; medication compliance; use of community resources; social skills development and assistance; support in the development of appropriate behaviors to allow the residents to participate, to the fullest extent possible, in normalized community activities.

The “24-hour staffing” requirement is interpreted to mean that the Provider must provide staff coverage 24-hours a day, 7 days a week as long as there are clients physically present in the living quarters of a program. Staff will be on site. Due to the complexity of these populations, staffing ratios are expected to be greater than traditional MHPRR settings. In addition, group home rules and expectations, levels of supervision and unaccompanied off-site travel will be specifically designed to address the needs of the population.

Target Population:

Services are for adults with complex mental illness who are stable and require specialized rehabilitation services versus basic MHPRR services, in order to continue on their recovery journey. Need indicators for placement will be based on:

- History of Risk of harm to self to others
- Unpredictable behavior and likelihood of relapse
- Motivation and capacity in the areas of self-management
- Socialization
- Mental Health Court Order for residential services.

The Contractor will reimburse MHPRR facilities at a rate defined by EOHHS.

Quality/Outcome:

Through chart audits at the CMHC, members in MHPRR should routinely attend all care management and integrated BH and medical services.

I. LEVEL OF CARE CRITERIA BASED UPON MEDICAL NECESSITY

The Contractor will provide descriptions of services and treatment settings. The criteria for medical necessity must be compliant with the medical necessity definition contained in Section 1.74 of the Contract and include admission, continuing stay and discharge criteria for each.

II. EARLY IDENTIFICATION AND ACCESS

The Contractor will have defined methods to promote access to care and for early identification of adults with behavioral health needs, including:

1. Identification of members who may be in an inpatient setting and who will require intensive outpatient services following and to facilitate discharge,
2. Direct referral by a family member or other health care provider.

III. ACCESSIBILITY, AVAILABILITY, REFERRAL AND TRIAGE

The behavioral health program will have defined performance criteria for accessibility, availability, referral and triage that meet and/or-exceed NCQA standards.

IV. PROVIDER NETWORK AND NETWORK ADEQUACY

The Contractor will develop and monitor behavioral health provider network standards, subject to review by the Department, to ensure the full continuum of behavioral health needs is met on a timely basis and to promote geographic accessibility.

V. TRANSITION PLAN

1. The Contractor is required to honor all prior authorizations for the period of the authorization and with the provider authorized.
2. The Contractor will complete a readiness process approved by the state prior to IHH program implementation
3. The Contractor will complete a review and identify and report to EOHHS on:
 - a. IHH
 - b. ACT
 - c. A Community Health Team (CHT)
 - d. Patient Medical Centered Medical Home (PCMH)

The Opioid Treatment Program Health Home Program Description

The following provides a description of the Opioid Treatment Program Health Home (OTP HH). These services are specific to individuals with opiate dependence disorders who have or are at risk of chronic physical illnesses. The second part of the document refers to the continuum of mental health and substance use services. These services will be provided to any adult member, based on need. EOHHS will continue to hold the Contractor responsible for ensuring all members with need receive appropriate and timely access to care.

1. Overview

The Opioid Treatment Program Health Home Program

The Opioid Treatment Program (OTP) Health Home (HH) initiative is a state-wide collaborative model designed to decrease stigma and discrimination, monitor chronic conditions, enhance coordination of physical care and treatment for opioid dependence, and promote wellness, self-care, and recovery through preventive and educational services. It is the fixed point of responsibility in the provision of person-centered care; providing timely post-discharge follow-up, and improving consumer health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers.

OTP Health Home(s): as the fixed point of responsibility to coordinate and ensure the delivery of **person-centered care**, the OTP Health home staff ensure and provide timely post discharge follow-up and coordination with other behavioral health providers and primary care providers in the delivery of medical services to the member. The OTP Health Home places emphasis on the monitoring of chronic conditions, and preventative and education services focused on self-care, wellness and recovery. This program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions, avoidable emergency room visits and better alignment with standards of care for chronic medical conditions such as Hepatitis C, HIV, Diabetes, Asthma, and COPD.

Patient Eligibility

Opioid Dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment and have or are at risk of another chronic health condition are eligible for the OTP Health Home. The OTP Health Home will provide documentation of such risk by completing the OTP Health Home Eligibility checklist form developed by the Rhode Island Office of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH).

Provider Eligibility

The Rhode Island Office of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) licenses Opiate Treatment Programs and OTP Health Homes.

2. Goals of OTP HH

The specialized programs for adults with opioid dependence and co-occurring chronic conditions or risk of chronic conditions will be a holistic, person-centered care model that aims to improve member outcomes and takes into account behavioral (mental health and substance use) and primary medical and specialist needs in order to strengthen the connection these high-risk patients have to the comprehensive health care system. Emphasis is placed on the monitoring of chronic conditions, timely post inpatient discharge follow-up and preventative and education services focused on self-care, wellness and recovery. This OTP Health Home program is accountable for reducing health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits. The programs will meet the Triple Aim of improving care and access, reducing cost, and improving quality.

Improve care and access	<ul style="list-style-type: none"> • Person-centered approach (whole person care) • Commitment to recovery/resiliency focused services • Coordinate care across medical, mental health and substance use system • Expand capacity of and access to high quality community-based services
Reduce cost	<ul style="list-style-type: none"> • Ensure that a sufficient range of community-based services are available to decrease ER and inpatient utilization • Decrease total cost of care for highest utilizers

	<ul style="list-style-type: none"> • Alignment of incentives to support providers in sharing accountability for the cost of care
Improve quality	<ul style="list-style-type: none"> • Continuous quality improvement • Promote clinical and service excellence through evidence-based practices • Alignment of incentives to promote increased quality

3. Program Description

Patient Eligibility

Opioid Dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment and have or are at risk of another chronic health condition are eligible for the OTP Health Home. The OTP Health Home will provide documentation of such risk by completing the OTP Health Home Eligibility checklist form developed by the Rhode Island Office of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH).

Core Functions and Responsibilities of OTP Health Home Providers

The OTP Health Homes will carry out the following functions:

- Identify participants eligible for specialized programs (based on Target Population parameters)
- Complete a comprehensive risk assessment using the BHDDH-approved OTP Eligibility Checklist form. Based on the finding on the checklist and a bio-psychosocial assessment, the provider will determine and place the individual in the OTP Health Home. Develop a person-centered, individualized Care Plan
- Carry out treatment and recovery services in the OTP Health Home OTP HH model of care
- Actively use CurrentCare for communication between medical and BH settings, especially for inpatient and ER alerts, for clients that opt into the CurrentCare program
- Participate in active discharge planning with medical and BH/SU inpatient, acute care and other facilities
- Submit required metric reporting and data exchange to the Health Home Administrative Coordinator
- Coordinate with the Integrated Health Home and ACT program to avoid duplication of services. Members can only be enrolled in one specialized program at a time and cannot be simultaneously enrolled in ACT, OTP HH and OTP Health Home
- Notify the Contractor and BHDDH of staffing changes impacting the OTP Health Home's ability to provide the services required for OTP Health Home OTP HH within 14 calendar days. Providers will submit a monthly staffing census to BHDDH/MCO that will be reviewed and evaluated for provision of services.

- Provide primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers of comprehensive, integrated services.

Program Elements

The OTP Health Home is a OTP HH specialized program that uses a multi-disciplinary team model where medical care coordination staff and behavioral health treatment staff work together to meet the comprehensive health and wellness needs of assigned participants. The team is responsible for coordinating the medical, behavioral and substance use care of all participants. The OTP HH model of care promotes recovery, hope, dignity and respect with the belief that all consumers can recover from addiction and lead healthier lives and manage their other chronic conditions. Active treatment and supports are provided with cultural competence.

Program Definitions

The OTP Health Home services are defined below:

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

The OTP Health Home (OTP HH) is built upon the evidence-based practices of the patient-centered medical home model. The OTP Health Home builds linkages to other community and social supports, and enhances coordination of primary medical, specialty and behavioral healthcare, (including mental health treatment) in keeping with the needs of persons with a primary diagnosis of opioid dependence and multiple chronic illnesses or who is at risk of chronic illnesses. OTP Health Home is a service provided to community-based clients by professional behavioral health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure. OTP Health Home teams monitor and provide medically necessary interventions to assist in the enhancement of health, management of symptoms of illness, as well as overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. OTP Health Home uses a team-based approach for care coordination, mental health and physical health chronic condition management, health promotion and peer/family support.

OTP HH activities are focused in four areas:

1. Care coordination and health promotion

Each client will be assigned a primary case manager who coordinates and monitors the activities of the individual treatment team and has primary responsibility to write the person-centered treatment/care coordination plan, ensure plans are revised and updated as clients' needs change and advocate for client rights and preferences. In addition, the primary care manager will collaborate with primary and specialty care providers as required and provide education about medications (e.g. educating through written materials, etc.). The OTP Health Home team is responsible for managing clients' access to other healthcare providers and to act as a partner in encouraging compliance with care plans established by these providers. Health promotion activities are delivered by the team to engage clients in addressing healthy lifestyles and include but are not limited to: smoking cessation; nutrition; increasing activity levels; relaxation strategies; and stress management.

2. Chronic condition management and population management

The OTP HHOTP HH team supports its consumers as they participate in managing the care they receive. Interventions provided under OTP HH may include, but are not limited to:

- Assisting in the development of symptom self-management, communication skills and appropriate social networks to assist clients in gaining effective control over their opiate addictions and their life situations;
- Provide health education, counseling and symptom management challenges to enable client to be knowledgeable in the prevention and management of their opiate addiction and other chronic medical illnesses as advised by the client's primary/specialty medical team.
- Assisting the client in locating and effectively utilizing all necessary community services to address the client's medical, social and psychiatric needs and ensuring that services provided are coordinated with those provided through physical health care professionals;
- Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to address their symptoms of addiction. Activities include:
 - Provide a range of support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to: financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Home Energy Assistance; Social Services; Transportation and Legal advocacy).
- Find housing which is safe, of good quality and an affordable place to live- apartment hunting, finding a roommate, landlord negotiations, cleaning, furnishing and decorating and procuring necessities (i.e. telephone, etc.).

- The OTP HH team will conduct the necessary analysis related to how well they are managing entire populations, based on measurable health outcomes and utilization. This information helps OTP HH's improve their care delivery system, to the benefit of each OTP HH clients receiving care.

3. Comprehensive transitional care

The OTP HH team will ensure consumers are engaged by assuming an active role in discharge planning. The OTP HH team will communicate and ensure collaboration between consumers, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

- Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.
- Upon hospital discharge (phone calls or home visit):
- Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.
- Assist consumer to identify key questions or concerns.
- Ensure Consumer understands medications; potential side-effects; is knowledgeable about indications if their condition is worsening and how to respond; how to prevent health problem becoming worse; has scheduled all follow-up appointments.
- Prepare consumer for what to expect if another next level of care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).
- Review with the OTP HH team transition care goals, relevant transfer information (i.e. all scheduled follow-up appointments; any barriers preventing making appointments), function as resource to OTP HH consumers – to clarify all outstanding questions.
- Identify and facilitate linkages between long-term care and home and community-based services.

4. Individual and Family support services

OTP HH team will provide practical help and support, advocacy, coordination, side-by-side individualized support with problem solving, direct assistance, helping clients to obtain medical and dental health care. Services include individualized substance use education about the client's opiate addiction and other chronic illnesses and the role of the family and their significant people in the therapeutic process.

OTP HH recovery support specialists will help OTP HH consumers utilize support services in the community and encourage them in their recovery efforts by sharing their lived experience and perspective. Recovery support serves will validate clients' experiences, guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, offer peer support services to:

- Help clients establish a link to primary health care and health promotion activities.
- Assist clients in reducing high- risk behaviors and health risk factors such as smoking, poor illness self-management, inadequate nutrition, and infrequent exercise.
- Assist clients in making behavioral changes leading to positive lifestyle improvement.
- Help clients set and achieve a wellness or health goal using standardized programs such as Whole Health Action Maintenance (WHAM).

Assessment

The OTP Health Home Providers will use the BHDDH-designed checklist to assess clients' needs for OTP Health homes.

Assessment Frequency

- An assessment will be administered at the time of initial engagement and every 6 months or more frequently when a significant change is identified.
- A reassessment with the standardized tool will be conducted within 48 hours of a discharge from a hospital or detoxification program.

Plan of Care

A comprehensive Plan of Care must address behavioral health needs, medical and social needs with measurable, realistic and time sensitive goals. The following are required:

- Plan of care developed within thirty (30) days of completion of the assessment.
- Plan of care developed with and agreed to by the member or caregiver, or those chosen by the member to participate in the care plan. (verbal or written acceptance)
- Reviewed at least every 6 months and when a significant change is identified

5. OTP HH Reporting Requirements

The OTP HH Reporting Requirements are managed by the OTP Health Home Administrator and coordinated with BHDDH and the OTP HH providers. All reports must be submitted to EOHHS at a frequency defined by EOHHS.

6. Service Delivery and Coordination

The OTP HH Teams provide or coordinate the following services:

• Housing Assistance, Tenancy Supports and Activities of Daily Living Supports
• Individual, Group and Family Therapy
• Medical and Substance Use Treatment Coordination Activities
• Recovery and Rehabilitation Skills
• Care Transition – hospital, incarceration or nursing home to home

• Outreach and engagement
• Identification and engagement of natural supports and Social relationships
• Education, Support, and Consultation to Clients' Families and Other Major Supports

7. Service Coordination/Care Management

Each client will be assigned a service coordinator (care manager) who coordinates and monitors the activities of the client's individual treatment team and other members of the OTP HH team. The primary responsibility of the service coordinator is to work with the client to develop the treatment plan, provide individual supportive counseling, offer options and choices in the treatment plan, ensure that immediate changes are made as the client's needs change, and advocate for the client's wishes, rights, and preferences. The service coordinator is the first staff person called upon when the client is in crisis and is the primary support person and educator to the individual client's family. Members of the client's individual treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is unavailable. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

8. Therapy

This will include but is not limited to the following:

1. Ongoing comprehensive assessment of the client's opiate addiction and response to treatment.
2. Individual and family education regarding opiate addiction and the effects and side effects of prescribed medications
3. Addiction management efforts directed to help client identify/target the symptoms and occurrence patterns of his or her opiate addiction and develop methods (internal, behavioral, or adaptive) to help lessen the effects.
4. Individual, group and family supportive therapy
5. Psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to facilitate recovery.

9. Medication Prescription, Administration, Monitoring and Documentation

The OTP HH team psychiatrist or registered nurse will provide education about medication, benefits and risks, obtain informed consent and assess and document the client's mental illness symptoms and behavior in response to medication. Team members will monitor and document medication side effects and provide supportive services. This clinical team will also assist the client with medication adherence strategies for all psychiatric and medical prescriptions.

10. Contractor Responsibilities

The Contractor is responsible for offering contracts to all EOHHS specified OTP HH providers. The Contractor will pay a specified rate to each provider for OTP HH services as directed by the EOHHS. The Contractor is responsible for following all guidance material distributed by EOHHS relating to this program, including the *OTP HH Billing Manual*. The Contractor will not pay less than currently established rates but may bundle or provide global rates, with the approval of EOHHS.”

11. Supportive Employment-Related Services

Work-related services to help clients value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with community-based employers. The principles of the evidence-based practice Individual Placement and Support (IPS) will be used to find employment. Services Include but are not limited to:

1. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.
2. Assessment of the effect of the client’s mental illness on employment with identification of specific behaviors that interfere with the client’s work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations.
3. Development of an ongoing employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job.
4. Individual supportive counseling to assist clients to identify and cope with mental illness symptoms that may interfere with their work performance.
5. On-the-job or work-related crisis intervention.
6. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.
7. Job Development
8. On-site supports as needed
9. Coordination of supports through in collaboration with the Office of Rehabilitation Services (ORS)
10. Job coaching

12. Ensuring Safe and Stable Housing

1. Find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, decorating; and procuring necessities such as telephones, furnishings, linens)
2. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry
3. Carry out personal hygiene and grooming tasks, as needed
4. Develop or improve money-management skills

5. Use available transportation
6. Have and effectively use a personal physician and dentist

13. Natural Supports and Social/Interpersonal Relationship Identification

Provide opportunities to practice social skills and receive feedback and support required to:

1. Improve communication skills, develop assertiveness, and increase self-esteem
2. Develop social skills, increase social experiences, and develop meaningful personal relationships
3. Plan appropriate and productive use of leisure time
4. Relate to landlords, neighbors, and others effectively
5. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

14. Recovery Support Services

Services to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery.

1. Recovery counseling and support
2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery

15. Education, Support, and Consultation to Clients' Families and Other Major Supports

Services provided regularly under this category to clients' families and other major supports with client agreement or consent, include:

1. Individualized psychoeducation about the client's opiate addiction and chronic illness and the role of the family and other significant people in the therapeutic process
2. Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people
3. Ongoing communication and collaboration, face-to-face and by telephone, between the OTP HH team and the family
4. Introduction and referral to family self-help programs and advocacy organizations that promote recovery
5. Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:
 - a. Services to help clients throughout pregnancy and the birth of a child

- b. Services to help clients fulfill parenting responsibilities and coordinate services for the child/children
- c. Services to help clients restore relationships with children who are not in the client's care and custody

16. Care Transitions

The OTP HH team will ensure consumers are engaged by assuming an active role in discharge planning. The team will communicate and ensure collaboration between consumers, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Specific functions include:

1. Engage with the client upon admission to the hospital and ensure that the discharge plan addresses physical and behavioral health needs.
2. Upon hospital discharge (phone calls or home visit):
 - Ensure that reconciliation of pre- and post-hospitalization medication lists is completed.
 - Assist consumer to identify key questions or concerns.
 - Ensure the client understands medications, their potential side-effects, is knowledgeable about indications if their condition is worsening and how to respond and is educated on how to prevent worsening of health conditions.
 - Review transition care goals with the team, provide relevant follow up and transfer information, function as resource to the client on all matters related to transition.
3. Identify and educate on linkages between primary and specialty medical care, behavioral healthcare, long-term care and home and community-based services.

Team Composition and Staffing Levels

The OTP Health Home staff is made up of the following multi-disciplinary complement of staff:

- The OTP Health Home team staff composition required to provide services, based on a population of one hundred twenty-five patients (125) per team, is outlined below. *Any deviation from that staffing pattern will require a written proposal to the Department for approval that includes clinical and financial justification.*

Qualifications:

Health Home FTE*

Master's Level Team Coordinator	1.0
Physician	0.25
Registered Nurse	1.0
Case Manager –	
Hospital/Healthcare Liaison	1.0
Case Manager	1.0

Pharmacist	0.10
Total Personnel	4.35

Reimbursement Arrangement

The provider is reimbursed based on a bundled rate for their OTP HH participants.

Billing for OTP Health Home will be a bundled rate. Providers will be required to submit encounter data/shadow claims to the Contractor for MCO clients and for the State for Medicaid FFS clients.

Billing for OTP HH will consist of the specified OTP HH code as well as other clinical services provided apart from the bundle. The OTP HH bundled rate is for care coordination activities only and does not include any clinical services or Medication Assistance Treatment (MAT) services. OTP HH can be billed while an individual is in an institutionalized setting. Refer to the *OTP HH Program Description* for detailed information on billing.

Contractor Responsibility:

The Contractors will support the following:

- Provide OTP Health with reporting to facilitate the coordination of medical and behavioral health care.
- The Contractor will use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with OTP Health Homes.
- The Contractor will be responsible for oversight to ensure contract requirements are being met.
- The Contractor will assist the OTP Health Homes with identifying necessary components of metric reporting.
- The Contractor will adhere to the reporting date requirements based on a reporting calendar.
- The Contractor will adhere to the withhold payout requirements based on a reporting calendar.
- Continuity of care requirements, including maintenance of relationships between members and treating providers. This includes beneficiaries transitioning into the managed care organization.
- The Contractor will hold the member harmless.

The Contractor will ensure that the OTP Health Homes are submitting HIPAA compliant claims data for services delivered under the OTP HH and ACT bundles.

DRAFT - Final Documents to be provided to awarded Contractor