HEALTH HOME MANUAL

FY2016

Revised 2-5-2016

PURPOSE

This Health Home Manual is intended as a reference document for Oklahoma Department of Mental Health and Substance Abuse certified providers with contracts for SoonerCare reimbursed Health Home Services. It contains requirements for provision, reimbursement and reporting of Health Home services, and is intended to complement existing policy. Although every effort is made to keep this Manual up-to-date, the information provided is subject to change.

POLICY

SoonerCare policy on Health Home programs can be located at:
http://www.okhca.org/xPolicy.aspx?id=734 under Chapter 30, SubChapter 5, Part 22.

ODMHSAS policy on Health Home programs can be located at:
http://ok.gov/odmhsas/ under Find it at ODMHSAS, ODMHSAS Rules, Administrative Rules That Are Currently In Effect, in Chapter 17 and Chapter 27.

Oklahoma's current State Plan Amendment (SPA) approved February 10, 2015 (effective January 1, 2015) for individuals under age 18 with serious emotional disturbance (#14-0011) and for individuals age 18 and older with a serious mental illness (#14-0012), can be located at:
http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html

SERVICE QUESTIONS- WHO TO CONTACT

For service questions please call Malissa McEntire, Manager of Integrated Care, (405) 522-4148.

TABLE OF CONTENTS

HEALTH HOME MANUAL REVISIONS 3

INTRODUCTION 8

ADULT HEALTH HOMES 9

ADULT HEALTH HOME TEAMS 10

CLIENT ELIGIBILITY AND ENROLLMENT 12

ADULT LEVELS OF CARE COORDINATION 13

ADULT HEALTH HOME SERVICES 15

ADULT HEALTH HOME CORE SERVICE REPORTING 18

Comprehensive Care Management 18

Care Coordination 25

Health Promotion 31

Comprehensive Transitional Care 36

Individual and Family Support Services 39

Referral to Community and Social Support Services 43

FY 2016 SERVICE FUNCTIONS BY HEALTH HOME TEAM MEMBER 46

CHILDREN'S HEALTH HOMES 56

CHILDREN'S HEALTH HOME TEAM 57

CLIENT ELIGIBILITY AND ENROLLMENT 58

CHILDREN'S LEVELS OF CARE COORDINATION 59

CHILDREN'S HEALTH HOME SERVICES 61

CHILDREN'S HEALTH HOME CORE SERVICE REPORTING 64

Comprehensive Care Management 64

Care Coordination 69

Health Promotion 74

Comprehensive Transitional Care 78

Individual and Family Support Services 80

Referral to Community and Social Support Services 83

FY 2016 SERVICE FUNCTIONS BY HEALTH HOME TEAM MEMBER 85

HEALTH RISK APPRAISAL VS ASSESSMENT 96

CLIENT ASSESSMENT RECORD (CAR) 98

HEALTH HOME PRIOR AUTHORIZATION 111

HEALTH HOME RATE SHEET 113

HEALTH HOME QUALITY MEASURES 116

HEALTH HOME FREQUENTLY ASKED QUESTIONS (FAQs) 122

HEALTH HOME SERVICE AREAS 129

HEALTH HOME DOCUMENTS (Examples) 132

HEALTH HOME MANUAL REVISIONS

December 16, 2015

- Restructured Manual to have separate sections for Adult Health Homes and Children's Health Homes, and did some clean up and clarification
- Under the Adult Health Homes section of the Manual:
  - Under Adult Health Home Teams:
    - Revised Behavioral Health Case Manager (BHCM) requirements under Moderate Intensity to include both BHCM I and II
  - Under Adult Levels of Care Coordination:
    - Revised language used in the Services Requirements for both Moderate Intensity and High Intensity
    - Revised Moderate intensity to include Level 4
    - Revised Medical Necessity Criteria for High Intensity
  - Under Adult Health Home Services:
    - Revised Staff Requirement for HH Outreach and Engagement
    - Revised definition for Health Home Initial Assessment and Plan Development (Non-PACT)
    - Revised definition for Health Home Initial Screen, Assessment and Plan Development (PACT)
    - Deleted Telemedicine Originating Site Fee under Health Home Initial Assessment and Plan Development (Non-PACT)
    - In the Health Home Core Services Note, clarified the language re: service requirements and revised Staff Requirements
  - Under Adult Health Home Core Reporting Services:
    - Revised the note
    - Under Comprehensive Care Management:
      - Under Qualified Professionals added BHCM I
      - Revised Non-PACT tables to include BHCM I where applicable, and added reporting code for BHCM I for Targeted Case Management Services
      - Added Intra-agency Consultation as a reporting function for team member collaborative efforts on Integrated Care Plan development/update and implementation
      - Added Provider Transportation/Driving as a reporting function
      - Revised the note for Wellness Resource Skills Development
    - Under Care Coordination:
      - Under Qualified Professionals added BHCM I
      - Revised tables to include BHCM I where applicable, and added reporting code for BHCM I for Targeted Case Management Services
      - Added Intra-agency Consultation as a reporting function for team member collaborative efforts on Integrated Care Plan development/update and implementation

            - Under reporting table added additional eligible team members for the service functions reported under the Medication Reminder code
            - Added Provider Transportation/Driving and Participating in an Appointment as reporting functions
        - Under Health Promotion:
            - Revised Note
            - Added Health Risk Appraisal (HRA) as a service function, so it will be allowed to be reported under Comprehensive Care Management and Health Promotion- as it is function relatable to both HH Core Service
            - Added Intra-agency Consultation as a reporting function for team member collaborative efforts on Integrated Care Plan development/update and implementation
            - Added service functions that are reported under the Clinical Time – Non Face to Face code, so it will be allowed to be reported under Comprehensive Care Management and Health Promotion- as it is function relatable to both HH Core Service
            - Added service function that is reported under Wellness Resource Skills Development code under Care Coordination to the services functions reported under Wellness Resource Skills Development code under Health Promotion, so it will be allowed for in both sections
            - Added Provider Transportation/Driving and Participating in an Appointment as reporting functions
            - Added service functions that are reported under Case Management (outpatient in an inpatient setting) code, so it will be allowed to be reported under either Comprehensive Transitional Care or Health Promotion- as it is function relatable to both HH Core Service
            - Added service functions that are reported under Targeted Case Management code, so it will be allowed to be reported under either Referral to Community and Social Support Services or Health Promotion- as it is function relatable to both HH Core Service
            - Added medication reminder services functions, so it will be allowed to be reported under either Care Coordination or Health Promotion
        - Under Comprehensive Transitional Care:
            - Under Qualified Professionals added BHCM I
            - Revised tables to include BHCM I where applicable, and added reporting code for BHCM I and revised service function language for Case Management (outpatient in an inpatient setting)
        - Under Individual and Family Support Services:
            - Under Qualified Professionals added BHCM I
            - Revised tables to include BHCM I where applicable
            - Revised list of team members who can provide the HH functions that are reported under the exiting Family and Training Support code to include BHCM I and II, so that these services can also be provided for adults
        - Under Referral to Community and Social Support Services:
            - Under Qualified Professionals added BHCM I
            - Revised tables to include BHCM I where applicable, and added reporting code for BHCM I for Targeted Case Management Services
    - Added a new section called 2016 Service Functions by Health Home Team Member
- Under the Children's Health Homes section of the Manual:
    - Under Children's Health Home Teams:
        - Removed note in Care Coordinator definition

- Under Client Eligibility and Enrollment
    - Revised Notes
- Under Children's Levels of Care Coordination:
    - Revised Medical Necessity Criteria for High Intensity
    - Revised Service Requirements for Moderate Intensity
    - Clarified language in Notes section
- Under Children's Health Home Services:
    - Revised Staff Requirements under HH Outreach and Engagement
    - Deleted Telemedicine Originating Site Fee under Health Home Initial Assessment and Plan Development
    - In the Health Home Core Services Note, clarified the language re: service requirements and revised State Requirements
- Under Children's Health Home Core Reporting Services:
    - Revised the note
    - Under Comprehensive Care Management:
        - Revised Notes
        - Clarified that for functional assessment, the 6 hours of non-face-to-face time for report preparation is allowed per Prior Authorization (PA) period when provided in conjunction with needed assessment
        - Added Intra-agency Consultation as a reporting function for team member collaborative efforts on Integrated Care Plan development/update and implementation
        - Added Provider Transportation/Driving as a reporting function
        - Revised the note for Wellness Resource Skills Development
    - Under Care Coordination:
        - Added Intra-agency Consultation as a reporting function for team member collaborative efforts on Integrated Care Plan development/update and implementation
        - Under reporting table added additional eligible team members for the service functions reported under the Medication Reminder code
        - Added Provider Transportation/Driving and Participating in an Appointment as reporting functions
    - Under Health Promotion:
        - Revised Note
        - Added Health Risk Appraisal (HRA) as a service function, so it will be allowed to be reported under Comprehensive Care Management and Health Promotion- as it is function relatable to both HH Core Service
        - Added Intra-agency Consultation as a reporting function for team member collaborative efforts on Integrated Care Plan development/update and implementation
        - Added service functions that are reported under the Clinical Time – Non Face to Face code, so it will be allowed to be reported under Comprehensive Care Management and Health Promotion- as it is function relatable to both HH Core Service
        - Added service function that is reported under Wellness Resource Skills Development code under Care Coordination to the services functions reported under Wellness Resource Skills Development code under Health Promotion, so it will be allowed for in both sections
        - Added Provider Transportation/Driving and Participating in an Appointment as reporting functions

            - Added service functions that are reported under Transition SOC Wraparound Case Management code, so it will be allowed to be reported under either Comprehensive Transitional Care or Health Promotion- as it is function relatable to both HH Core Service
            - Added service functions that are reported under Transitional Case Management code, so it will be allowed to be reported under either Comprehensive Transitional Care or Health Promotion- as it is function relatable to both HH Core Service
            - Added service functions that are reported under Targeted Case Management code, so it will be allowed to be reported under either Referral to Community and Social Support Services or Health Promotion- as it is function relatable to both HH Core Service
            - Added medication reminder services functions, so it will be allowed to be reported under either Care Coordination or Health Promotion
        - Under Comprehensive Transitional Care:
            - Revised language in Transitional CM and Transitional SOC Wraparound CM service functions
        - Under Individual and Family Support Services:
            - Added HRA as a function under Wellness Resource Skills Development
    - Added a new section called 2016 Service Functions by Health Home Team Member
- Under the Health Home Prior Authorization Section of the Manual:
    - Revised/clarified prior authorization process
- Under Health Home Rate Sheet section of the Manual
    - Deleted Telemedicine Originating Site Fee
- Under the Health Home Quality Measures section of the Manual:
    - Under Improved Coordination of Care:
        - Revised language for the Denominator under Follow-up After Hospitalization for Mental Illness
- Under the Health Home Frequently Asked Questions (FAQs) section of the Manual:
    - Added new question(s)/answer(s) under Eligibility
    - Added new question(s)/answer(s) under HH Team Composition
    - Revised answer(s) under Outreach & Engagement
    - Revised answer under General Billing
    - Added new question(s)/answer(s) under Service Reporting
    - Revised answer(s) under Service Requirements

February 5, 2016

- Replaced the reporting codes for HH functions attached to Intra-agency Clinical Consultation and System Support- from 99368 to G9007
- Replaced the reporting code for the HH function attached to Comprehensive Assessment- from T1001 HE to S5190
- Under the Adult Health Homes Section of the Manual:
    - Under Adult Levels of Care Coordination:
        - Deleted minimum requirement language for both Moderate and High Intensity
- Under the Children's Health Homes Section of the Manual:
    - Under Children's Level of Care Coordination:
        - Deleted minimum requirement language for both Moderate and High Intensity

- Under both Adult and Children's Health Home Core Service Reporting Sections:
    - Revised language regarding service reporting for 15 minute increments
- Under Health Home Frequently Asked Questions (FAQs):
    - Revised bullet point under General Billing
    - Deleted Service Requirements
    - Clarified language regarding service reporting for 15 minute increments

INTRODUCTION

Health Homes are to promote enhanced integration and coordination of primary, acute, behavioral health, and long-term services and supports for persons across the lifespan with chronic illness, including adults with serious mental illness (SMI) and children with Serious Emotional Disturbance (SED). Care is delivered using an integrated team that will comprehensively address physical, mental health and substance use disorder treatment needs; with a goal to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote the use of Health Information Technology (HIT), and avoid unnecessary care. There are specialized teams for adults with SMI, and for children with SED.

ADULT HEALTH HOMES

ADULT HEALTH HOME TEAMS

Health Homes deliver services through a multidisciplinary team of physical and behavioral health care professionals. The eligible team members for service reporting are listed below for each level of Adult Health Home care coordination. Health Homes are responsible for ensuring that all team members work within their scope of practice.

ADULTS (SMI) – Moderate Intensity

Health Home Director– An individual who meets or exceeds the following qualifications:

1) Possesses a Bachelor's degree from an accredited university and has at least two years of experience in health/behavioral health administration;
2) Possesses a Master's degree from an accredited university in health or social services related field;
3) Licensed as a Registered Nurse with the Oklahoma Board of Nursing; or
4) Licensed as a Physician or Nurse Practitioner.

Nurse Care Manager – A Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Work must be performed within the individual's scope of practice.

Consulting PCP – A Physician, Physician Assistant (PA) or Advanced Practice Registered Nurse (APRN) that is embedded, or a partnership with multiple Patient-Centered Medical Homes (PCMHs), an FQHC or I/T/U (Indian Health Service, Tribally operated facility/program, and Urban Indian clinic) facility.

Psychiatric Consultant – A Board Certified/Eligible Psychiatrist, Physician Assistant (PA) or APRN with a psychiatric specialty.

Certified Behavioral Health Case Manager – A team member that has been certified by ODMHSAS as a Behavioral Health Case Manager I or II.

*Under Adult Moderate Intensity Level of Care Coordination, a Case Manager's caseload should not exceed 125. This is a maximum, it is anticipated that a smaller caseload is likely to be more effective. Health Homes should evaluate caseload #'s and their impact on overall HH outcomes.

Wellness Coach – A team member that has 1) either been certified by ODMHSAS as a Peer Recovery Support Specialist (PRSS) or has a high school diploma or equivalent; and 2) has completed ODMHSAS designated Wellness training.

Hospital Liaison/Health Home Specialist – A team member that has been certified by ODMHSAS as a Behavioral Health Case Manager I or II, and complete trainings as required by ODMHSAS.

ADULTS (SMI) – High Intensity (including PACT)

Health Home Director – An individual who meets or exceeds the following qualifications:

1) Possesses a Bachelor's degree from an accredited university and has at least two years of experience in health/behavioral health administration;
2) Possesses a Master's degree from an accredited university in health or social services related field;
3) Be licensed as a Registered Nurse with the Oklahoma Board of Nursing; or
4) Be licensed as a Physician or be licensed as a Nurse Practitioner.

Nurse Care Manager – A Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Work must be performed within the individual's scope of practice.

Consulting PCP – A Physician, Physician Assistant (PA) or Advanced Practice Registered Nurse (APRN) that is embedded, or a partnership with multiple Patient-Centered Medical Homes (PCMHs), an FQHC or I/T/U (Indian Health Service, Tribally operated facility/program, and Urban Indian clinic) facility.

Psychiatric Consultant – A Board Certified/Eligible Psychiatrist, Physician Assistant (PA) or APRN with a psychiatric specialty.

Certified Behavioral Health Case Manager – A team member that has been certified by ODMHSAS as a Behavioral Health Case Manager II.

*Under Adult High Intensity Level of Care Coordination, a Case Manager's caseload is limited to 10.

Wellness Coach – A team member that has 1) either been certified by ODMHSAS as a Peer Recovery Support Specialist (PRSS) or has a high school diploma or equivalent; and 2) has completed ODMHSAS designated Wellness training.

Hospital Liaison/Health Home Specialist – A team member that has been certified by ODMHSAS as a Behavioral Health Case Manager I or II, and complete trainings as required by ODMHSAS.

Licensed Behavioral Health Professional (LBHP) [FOR PACT ONLY] – A team member who meets requirements as a Licensed Behavioral Health Professional (LBHP) listed in OAC: 317:30-5-240.3.

CLIENT ELIGIBILITY AND ENROLLMENT

Individuals who are eligible for SoonerCare, and who meet eligibility criteria for Health Homes (see the Adult Levels of Care Coordination within this section of the Manual), may "opt-in" and voluntarily participate in a Health Home. Individuals may choose to participate in any Health Home (HH).

The HH must obtain informed consent specific to enrollment in the HH. The consent must 1) be specific to the extent that it permits the HH team members to share information relevant to the delivery of HH services (a form example can be located in the Health Home Documents section of this Manual), and 2) be obtained within a process that educates individuals, and ensures understanding, regarding their right to choose between qualified HHs or to "opt-out" of the HH service. For new HH clients, the consent does not have to be signed immediately to begin receiving HH services. Clients may not be immediately comfortable with signing the consent, so this is to allow some extra time to get the consent signed. If a client continues to refuse to sign the consent form, and that is not anticipated to change, the HH will need to dis-enroll the client as HHs require coordination between providers.

Additional guidance regarding the enrollment process will be provided in other sections of this Manual. The outreach and engagement services and initial assessment and plan development services (and related billing) that occur prior to HH enrollment can be found in the Health Home Services section of this Manual. Health Home enrollment/prior authorization can be found in the Health Home Prior Authorization section of this Manual. The Level of Care Coordination that an individual should be enrolled in will be based on screening/assessment, and identification/prediction of client risk levels relating to health care needs, services, and coordination. The eligibility for those Levels of Care Coordination can be found under the Adult Levels of Care Coordination within this section of the Manual.

Note: An individual may be enrolled in both a Health Home and a Patient Centered Medical Home (PCMH) however roles and responsibilities must be clearly identified in order to avoid duplication. Individuals may not be enrolled in Health Home and currently be enrolled in other programs like: Intellectual or Developmental Disability Targeted Case Management (I/DD-TCM); Advantage Waiver TCM; and SoonerCare Health Management Program (HMP). Individuals are given the choice as to which care management/care coordination services would best meet their needs. Duplication of services is not allowed.

ADULT LEVELS OF CARE COORDINATION

Adult Health Home services are provided to individuals with a Serious Mental Illness (SMI), age 18 & older. Services are provided under the following levels of care coordination:

Moderate Intensity–
Medical Necessity Criteria: Individual Client Assessment Record (CAR) scores meet criteria for Prevention & Recovery Maintenance Level (PRM), Level 1, Level 2, Level 3, or Level 4.
Service Requirements- Up to 500 clients on the team caseload.
High Intensity -
Medical Necessity Criteria: Individual Client Assessment Record (CAR) scores meet criteria for Level 4, and the score for CAR Domain 4 (Medical/Physical) is 30 or above. A history of multiple (a minimum of two) psychiatric hospitalizations and/or admissions to community-based structured crisis care over the past 24 months; and At least three of the following: • Persistent or recurrent severe affective, psychotic or suicidal symptoms; • Coexisting substance use disorder greater than six months; • High risk of or criminal justice involvement over the past 24 months which may include frequent contact with law enforcement personnel, incarcerations, parole or probation; • Homeless, imminent risk of being homeless or residing in substandard or unsafe housing; • Residing in supported housing but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring supported housing if more intensive services are not available; • Inability to participate in traditional office-based services or evidence that they require a more assertive and frequent non-office based service in order to meet their other clinical needs; or • Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community. **For PACT, individuals must meet the PACT Admission criteria outlined in OAC 450:55-3-2.**
Service Requirements- Up to 100 clients on the team caseload.

NOTES:

- For individuals with Developmental Disabilities, the Health Home will refer to and coordinate with the approved Developmental Disabilities case management entity for these services.

- The total team caseload can be distributed across all HH team members in a manner that is determined by the HH. This is to allow for optimal flexibility is meeting service needs. The only restrictions are caseload limits for specific team members (refer to the Health Home Teams section of this Manual).
- In order to meet Medical Necessity Criteria for continued stay in Health Home, the following must be also be present at 6 month service plan update: 1) The clinical condition(s) continues to warrant HH services in order to coordinate care to prevent the onset of disease or to treat a disease and prevent onset of serious complications, OR 2) Progress toward Integrated Care Plan (ICP) identified goals is evident and has been documented based on the objectives defined for each goal, but the goals have not yet been substantially achieved despite sound clinical practice consistent with the chronic care model, OR 3) Progress has not been made, and the multidisciplinary team has identified and implemented changes/revisions to the ICP to support the goals of the client/family.

ADULT HEALTH HOME SERVICES

Billable Health Home services for adults are as follows:

Health Home Outreach and Engagement
Through outreach and engagement the client is informed about: Health Home enrollment; the benefits of Health Home enrollment to the client (including potential benefits); privacy; and selecting a PCP. A Health Home may provide outreach and engagement service to a client attributed to, but not yet enrolled in, Health Home. In order to be eligible to receive this service, clients must be age 18 or older and already designated as having a Serious Mental Illness (SMI), or they must be referred for Health Home services by a hospital, crisis or residential facility.

Note: A Prior Authorization is not required. The reimbursement for outreach and engagement is limited to once per month and is not reimbursable in the same month that the Health Home receives reimbursement for Health Home Bundled Services. Only 3 months of billing are allowed per year (a rolling year), and must be billed using a unique Client ID. If Health Home Outreach and Engagement is initiated through a referral from a hospital, crisis or residential facility, the referral must be documented in the client record.

Staff Requirement: [HH] Any Agency Staff Member

	Billing Code	**Rate/Unit**
	G9001	$53.98 / Per Month

Health Home Initial Assessment and Plan Development (Non-PACT)
An Agency LBHP with knowledge of Health Home programs will complete the Initial Health Home assessment and plan. The initial Health Home plan will be utilized for the provision of HH services during the client's initial 30 days in the HH program, until the HH comprehensive assessment and integrated care plan are completed. Initial assessment and initial plan development should be provided and billed for as follows:

- If a new client to the agency, the LBHP will complete a BH Assessment (NON-MD)- Moderate Complexity if a minimum of 2 hours or more, or Low Complexity if a minimum of 1 ½ hours. They will also complete a Behavioral Health Service Plan Development Moderate Complexity. This should be billed for under a PG038 (prior to admission to HH).
- If an existing client to the agency who has already had an outpatient comprehensive assessment and has an existing outpatient service plan (or someone who is returning to the agency after a break less than a year and is not eligible for a PG038 or a new comprehensive outpatient assessment/plan), the LBHP will complete the BH Service Plan Development Low Complexity which includes meeting with client to complete an updated CAR (updated biopsycosocial) and to complete an updated service plan that will serve as the initial HH plan. This should be billed under the client's existing outpatient PA (prior to admission to HH).

ADULT		**Billing Code**				**Rate/Unit**
BH Assessment (Non-MD) Low Complexity (Minimum of 1 ½ Hours)		H0031	HE/HF/HV/HH	TF		$79.03 / Event
	Telemedicine	H0031	HE/HF/HV/HH	TF	GT	$79.03 / Event

BH Assessment (Non-MD) Moderate Complexity (Minimum of 2 Hours)		H0031	HE/HF/HV/HH			$105.38 / Event
	Telemedicine	H0031	HE/HF/HV/HH	GT		$105.38 / Event
BH Service Plan Development Low Complexity		H0032	HE/HF/HV/HH	TF		$54.42 / Event
	Telemedicine	H0032	HE/HF/HV/HH	TF	GT	$54.42 / Event
BH Service Plan Development Moderate Complexity		H0032	HE/HF/HV/HH			$87.07 / Event
	Telemedicine	H0032	HE/HF/HV/HH	GT		$87.07 / Event

Health Home Initial Screening, Assessment and Plan Development (PACT)

A screening of each potential HH client's service needs will be completed. An Agency LBHP with knowledge of Health Home programs will complete the Initial Health Home assessment and plan. The initial Health Home plan will be utilized for the provision of HH services during the client's initial 30 days in the HH program, until the HH comprehensive assessment and integrated care plan are completed. Initial screening, assessment and initial plan development should be provided and billed for as follows:

- An integrated screening of each potential HH client, whether new to the agency or an existing client, will be completed to determine clinical eligibility for HH services. This should be billed for under a PG038 (prior to admission to HH).
- If a new client to the agency, upon determination of appropriate admission, the LBHP will complete an initial assessment and treatment plan in accordance with the standard in OAC 450:55-5-4. This should be billed for under a PG038 (prior to admission to HH).
- If an existing client to the agency who has already had an outpatient comprehensive assessment and has an existing outpatient service plan (or someone who is returning to the agency after a break less than a year and is not eligible for a PG038 or a new comprehensive assessment/plan), the LBHP will complete an updated assessment and an updated service plan that will serve as the initial HH plan. This should be billed under the client's existing outpatient PA (prior to admission to HH).

ADULT	**Billing Code**				**Rate/Unit**
Screening	T1023	HE/HF/HH/HV			$55.80 / Event
ACT,F2F (Assessment & Plan)	H0039	HE/HF/HH/HV			$32.11 / 15 minutes

Health Home Core Services

Health Home (HH) services are covered for adults with Serious Mental Illness (SMI) who are enrolled in the HH program. Eligible core services are as follows: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care Services, Individual Family Support Services, and Referral to Community and Social Support Services. The goal of HH core services is to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote use of Health Information Technology (HIT) and avoid unnecessary care.

Note: Prior Authorization is required (see the Prior Authorization Section of the Manual). All core HH services are billed using the "G" codes listed below, and must be billed using a unique Client ID. These codes are Per Member, Per Month (PMPM) codes and are inclusive of all the core HH services provided to the client during one month. In order to bill for the month, the service requirements must be met (refer to the HH Levels of Care Coordination section of this Manual). Although the "G" codes for the monthly service can be billed under any HH team member (see Staff Requirement below), the individual service functions provided throughout the month must be provided by team members meeting the staff requirements listed in the "Health Home (HH) Core Services Reporting" section of this Manual. A progress note is not required when billing the "G" codes. Progress notes are required when providing the individual service functions that are reported under "Health Home (HH) Core Services Reporting."

Limitations: The following services will not be reimbursed separately for individuals enrolled in a Health Home:

- Targeted case management (T1016 and T1017);
- Service plan development, moderate and low complexity (H0032);
- Medication training and support (H0034);
- Behavioral health prevention education (H0025);
- PACT medication management and support and coordination linkage (H0039)*;
- Medication reminder (S5185);
- Medication administration (T1502); and
- Outreach and engagement (T0123).

Adults for whom case management services are available through Home and Community Based Waiver (i.e. ADvantage, Living Choice, In Home Support, etc.) staff are not eligible for concurrent Health Home services.

*For clients that are PACT and in a Health Home, the teams can bill H0036 for those direct services that are not covered in the Health Home Core Services.

Staff Requirement: [HH] Any eligible Health Home team member listed under Adult Levels of Service Provider in this Manual

			Billing Code	**Rate/Unit**
Urban	Adult	Moderate Intensity (PRM, or Levels 1-3)	G9002	$127.35 / Per Month
		High Intensity (Level 4)	G9005	$453.96 / Per Month
Rural	Adult	Moderate Intensity (PRM, or Levels 1-3)	G9002TN	$146.76 / Per Month
		High Intensity (Level 4)	G9005	$453.96 / Per Month

ADULT HEALTH HOME CORE SERVICE REPORTING

Health Homes are required to report the service functions provided/billed under "Health Home Core Services". Guidelines for reporting are as follows:

NOTE: Providers will report all eligible service functions provided under the Health Home Core Services billing code per client, per month. These eligible service functions will be reported in MMIS. To do this reporting electronically (rather than manually), specific HH service functions were assigned an existing code in the system. Although the existing code/service title may be similar in function to the HH service function, they are not intended to be exact. For reporting, providers will need to follow the HH service functions, including staff requirements, as outlined below. Progress notes should be written for each of the service functions provided.

On reporting tables in this section, if the note reflects "Count each 15 minutes" the service should be counted in 15 minute increments as follows: if the documented service is 15 minutes or less (which does not follow the 8 minute rule), it will count as one 15 minute unit, and if the service is more than 22 minutes but less than 38 minutes, it will count as two 15 minute units (the second unit of service, and any subsequent units, follow the 8 minute rule).

Comprehensive Care Management

Comprehensive care management services consist of developing a Comprehensive Care Plan to address the needs of the whole person and involves the active participation of HH team members, the client, family and caregivers.

Comprehensive care management services include the following, but are not limited to:

- Identifying high-risk clients and utilizing client information to determine level of participation in care management services:
- Assessing preliminary service needs, participating in comprehensive person-centered development of an integrated care plan, responsible for member physical and behavioral health goals, preferences and optimal clinical outcomes.
- Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions.
- Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines.
- Developing and disseminating reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and cost.

NOTES (Regarding specific service functions in the Comprehensive Care Management tables below):

For documentation of Non-Face to Face services: record date and amount of time spent providing non-face to face services (preferably start/stop times), a brief description of the services provided, and team member providing the service and their credentials.

The *Health Risk Appraisal (HRA)* is a preliminary screening that, together with a Health Risk Assessment, helps determine acuity of needs. The HRA may be furnished through an interactive telephonic or web-based program or community encounter with a team member. For all New HH

adult enrollees, a HRA must be completed before or as a part of a Health Risk Assessment/physical exam within 2 weeks of Health Home enrollment. For established (grandfathered) clients, available data should be accessed (SoonerCare provider portal, OKDHS Child Portal, EHR, PCP data) and reviewed for critical health needs, and the HRA must be completed no later than the next care plan update.

The Comprehensive Assessment (CA):

- The extended psychosocial assessment includes all components of the initial assessment (conducted prior to enrollment in HH), and is intended to provide additional assessment time for a client with complex needs in order to allow for a complete and meaningful assessment. The information gathering may be collected with or without client present.
- The nursing assessment of medical, dental and other health needs includes completion of a Health Risk Assessment, which must be completed within 30 days of new enrollment, or referral may also be made to a primary care provider for physical examination, to be completed by the time of the first patient- centered plan revision (within three months). Information may be gathered from the client's primary health care provider (if any), contingent upon the client's consent. A nursing assessment must be conducted by a Registered Nurse, per Oklahoma Board of Nursing. Patient Assessment Guidelines can be located at: https://www.ok.gov/nursing/ptassessgl.pdf
- For other assessments, refer when medically necessary; use appropriate CPT codes if applicable.
- Individuals enrolled in PACT teams must follow PACT rules for comprehensive assessment found at OAC 450: 450-55-5-5.

For Review of Integrated Care Plan: A revised active plan must include information from the client's initial evaluation and comprehensive assessments and updates, the progress toward goals specified in the written care plan, and changes, as applicable, in goals.

Provider Transportation/Driving – The provider should maintain adequate documentation to demonstrate the cost of travel (mileage logs).

QUALIFIED PROFESSIONALS- Comprehensive care management services are provided by the following professionals and paraprofessionals:

- Nurse Care Manager (RN or LPN);
- Certified Behavioral Health Case Manager II;
- Certified Behavioral Health Case Manager I;
- Psychiatric Consultant; and
- Primary Care Practitioner PCP.

Comprehensive Care Management (Non-PACT)							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Clinical Time – Non Face to Face	T2022	HE			• Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions. [Non-Face to Face] • Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines [Non-Face to Face] • Developing and disseminating reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and cost [Non-Face to Face]	Count at least 15 minutes of clinical staff time per calendar month. Monitoring EHR and scanning for gaps in care would count toward the minimum requirement for a client with an open, active integrated care plan.	PCP, or Nurse Care Manager (RN or LPN)
					• Monitoring the client's condition (physical, mental, social). Must be part of the integrated care plan. [Non-Face to Face] • Performing medication reconciliation and overseeing the client's self-management of medications [Non-Face to Face] • Psychiatric Consultation. Must be part of the integrated care plan. [Non-Face to Face] • PCP consultation on best practice protocol. Must be part of the integrated care plan. [Non-Face to Face]	Count at least 15 minutes of clinical staff time per calendar month	PCP, or Nurse Care Manager (RN or LPN), or Psychiatric Consultant
					• Initially reviewing client records and client history and reviewing and signing off on health assessments. Must be part of the integrated care plan. [Non-Face to Face] • Consultation with team about identified health conditions of their clients. Must be part of the integrated care plan. [Non-Face to Face]	Count at least 15 minutes of clinical staff time per calendar month	Nurse Care Manager (RN or LPN)
Wellness Resource Skills Development	T1012	HE/HF			• Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]	Count each 15 minutes	PCP, Nurse Care Manager (RN or LPN), or BHCM II, or BHCM I

Comprehensive Care Management (Non-PACT)								
Service Title		**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Targeted Case Management-	PCP or Pych. Consult	T1017	HE / HF / HH / HV	HO		• Comprehensive Assessment: Extended Psychosocial including an extended assessment of education and/or employment, social development and functioning, activities of daily living, and family structure and relationships. • Development of Integrated Care Plan (Adult)- Coordination of the Adult Health Home teams development of a client directed, integrated active care plan for each enrolled client that reflects input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), and others the client chooses to involve. • Review of Integrated Care Plan (Adult)– Coordination of the Adult Health Home teams review, revision and documentation of the integrated care plan as frequently as the client's condition requires, but no less frequently than every (6) six months. • (Adult) Completion of the Post Traumatic Stress Disorder Checklist (PCL) short screen, and the full PCL assessment if the screen is positive.	Count each 15 minutes	PCP, Psychiatric Consultant, Nurse Care Manager (RN or LPN), or BHCM II
	Nurse Care Mgr, BHCM II	T1017	HE / HF / HH / HV	HN				
Comprehensive Assessment		S5190				• Comprehensive Nursing Assessment: Medical dental and other health needs for adults (may include some reconciliation with biometrics obtained by the provider like blood lipids and glucose, blood pressure, etc.).	Count each 15 minutes	RN Nurse Care Manager
Intra-Agency Clinical Consultation		G9007				• A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or BHCM I, or Psychiatric Consultant, or PCP

Comprehensive Care Management (Non-PACT)							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Provider Transportation/Driving		A0160			• Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent driving to do a home visit when the client is not home.	Up to one hour of travel per month per client will be allowed to count towards the minimum monthly service requirement	PCP, or Psychiatric Consultant, or Nurse Care Manager (RN or LPN), or BHCM II, or BHCM I

Comprehensive Care Management (PACT)							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Clinical Time – Non Face to Face	T2022	HE			• Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions. [Non-Face to Face] • Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines [Non-Face to Face] • Developing and disseminating reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and cost [Non-Face to Face]	Count at least 15 minutes of clinical staff time per calendar month	PCP, or Nurse Care Manager (RN or LPN)
					• Monitoring the client's condition (physical, mental, social). Must be part of the integrated care plan. [Non-Face to Face] • Performing medication reconciliation and overseeing the client's self-management of medications [Non-Face to Face] • Psychiatric Consultation. Must be part of the integrated care plan. [Non-Face to Face] • PCP consultation on best practice protocol. Must be part of the integrated care plan. [Non-Face to Face]	Count at least 15 minutes of clinical staff time per calendar month	PCP, or Nurse Care Manager (RN or LPN), or Psychiatric Consultant
					• Initially reviewing client records and client history and reviewing and signing off on health assessments. Must be part of the integrated care plan. [Non-Face to Face] • Consultation with team about identified health conditions of their clients. Must be part of the integrated care plan. [Non-Face to Face]	Count at least 15 minutes of clinical staff time per calendar month	Nurse Care Manager (RN or LPN)
Wellness Resource Skills Development	T1012	HE/HF			• Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]	Count each 15 minutes	PCP, Nurse Care Manager (RN or LPN), or BHCM II

Comprehensive Care Management (PACT)							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Provider Transportation/Driving	A0160				• Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent driving to do a home visit when the client is not home.	Up to one hour of travel per month per client will be allowed to count towards the minimum monthly service requirement	PCP, or Psychiatric Consultant, or Nurse Care Manager (RN or LPN), or BHCM II
PACT for Health Home Client – Bundled Services	H0039	HE			• Comprehensive Assessment: Extended Psychosocial including an extended assessment of education and/or employment, social development and functioning, activities of daily living, and family structure and relationships. • Development of Integrated Care Plan (Adult)- Coordination of the Adult Health Home teams development of a client directed, integrated active care plan for each enrolled client that reflects input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), and others the client chooses to involve. • Review of Integrated Care Plan (Adult)– Coordination of the Adult Health Home teams review, revision and documentation of the integrated care plan as frequently as the client's condition requires, but no less frequently than every (6) six months.	Count each 15 minutes	PCP, Nurse Care Manager (RN or LPN), BHCM II or Psychiatric Consultant
					• Comprehensive Nursing Assessment: Medical dental and other health needs for adults (may include some reconciliation with biometrics obtained by the provider like blood lipids and glucose, blood pressure, etc.).	Count each 15 minutes	RN Nurse Care Manager
Intra-Agency Clinical Consultation	G9007				• A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or Psychiatric Consultant, or PCP

Care Coordination

Care coordination is the implementation of the integrated care plan with the active client involvement through appropriate linkages, referrals, coordination and follow-up to needed services and supports.

Care coordination services include the following, but are not limited to:

- Care coordination for primary health care, specialty health care and transitional care from emergency departments, hospitals and Psychiatric Residential Treatment Facilities (PRFTs);
- Ensuring integration and compatibility of mental health and physical health activities;
- Providing on-going service coordination and link clients to resources;
- Tracking completion of mental and physical health goals in client's integrated care plan;
- Coordinating with all team members to ensure all objectives of the integrated care plan are progressing;
- Appointment scheduling;
- Conducting referrals and follow-up monitoring;
- Participating in hospital discharge processes; and
- Communicating with other providers and clients/family.

NOTES (Regarding specific service functions in the Care Coordination tables below):

For documentation of Non-Face to Face services: record date and amount of time spent providing non-face to face services (preferably start/stop times), a brief description of the services provided, and team member providing the service and their credentials.

Targeted Case Management:

- Services can be face to face and non-face to face. Non-face to face contacts, such as written communication and telephone calls are not to become the predominant means of providing comprehensive care management/care coordination services.
- Telephone calls with family members, probation officers, etc. regarding a client are counted. When voice messages are used, the Case Manger must have sufficient documentation justifying a care coordination service was actually provided. Leaving a name and number asking for a return call is not sufficient to count this activity,
- Written communication (including e-mail) and leaving voice messages may be documented as non-face to face functions. Written communication must be about a specific individual and must be documented in the case record with a paper copy of either a mailed letter or e-mail.

Participating in an Appointment – Count all time spent in direct contract with the client/family and or other parties involved in implementing the care plan.

Provider Transportation/Driving – The provider should maintain adequate documentation to demonstrate the cost of travel (mileage logs).

QUALIFIED PROFESSIONALS - Care coordination services are provided by the following professionals and paraprofessionals:

- Nurse Care Manager (RN or LPN);
- Certified Behavioral Health Case Manager II;
- Certified Behavioral Health Case Manager I
- Hospital Liaison/HH Specialist;
- Health Home Director.

Care Coordination (Non-PACT)							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Clinical Time – Non Face to Face	T2022	HE			• Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face] • Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]	Count each 15 minutes	Nurse Care Manager (Rn or LPN), or Hospital Liaison/HH Specialist, BHCM I, or BHCM II or Health Home Director
Targeted Case Management	T1017	HE / HF / HH / HV	HN		• Ensuring that every enrollee is aligned with or linked with a PCP available through the HH, with in the first 3 months of enrollment in HH. [Non-Face to Face] • Consulting with other team member's about client's health status. [Non-Face to Face]	Count each 15 minutes	Nurse Care Manager (RN or LPN)
Medication Reminder	S5185	HE / HF / HH / HV			• Providing a telephone prompt for each client that has at least one or more billable face-to-face services. • Delivery of medication.	Count each 15 minutes	Nurse Care Manager (RN or LPN), BHCM I, or BHCM II, or Hospital Liaison/HH Specialist
Wellness Resource Skills Development	T1012	HE/HF			• The process of providing direction and coordinating support activities that promote good physical health.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or BHCM I, or Hospital Liaison/HH Specialist

Care Coordination (Non-PACT)							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Targeted Case Management	Nurse Care Mgr, BHCM II	T1017	HE / HF / HH / HV	HN	• Referral, linkage and advocacy to assist with the implementation of the integrated care plan, including appointment scheduling and arranging transportation. • Monitoring and follow-up activities with treatment or service providers (including intra-agency) for the purposes of monitoring client attendance of scheduled physician/medication, therapy, rehabilitation, or other supportive service appointments. • Follow-up activities with the client to identify any new resource needs or to assist with implementation of the integrated care plan, including making appointment reminders. • Crisis diversion- connecting with the resources needed to avert a clinical crisis. • Ensuring integration and compatibility of mental health and physical health activities. • Tracking completion of mental and physical health goals in client's integrated care plan. • Participating in hospital discharge processes.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or BHCM I, Hospital Liaison/HH Specialist
	BHCM I, Hospital Liaison / HH Specialist	T1017	HE / HF / HH / HV	HM			
Intra-Agency Clinical Consultation	G9007				• A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II or BHCM I, or Hospital Liaison/HH Specialist, or Health Home Director
Participating in an Appointment	T2001	HE			• Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or BHCM I, or Hospital Liaison/HH Specialist
Provider Transportation/ Driving	A0160				• Time spent driving to do a home visit when the client is not home. • Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent waiting for a client during an appointment or escorting a member to an appointment.	Up to one hour of travel per month per client will be allowed to count towards the minimum monthly service requirement	Nurse Care Manager (RN or LPN), or BHCM II, or BHCM I, Hospital Liaison/HH Specialist

Care Coordination (PACT)							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Clinical Time – Non Face to Face	T2022	HE			• Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face] • Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or Hospital Liaison/HH Specialist, or Health Home Director
Targeted Case Management	T1016	HE			• Ensuring that every enrollee is aligned with or linked with a PCP available through the HH, with in the first 3 months of enrollment in HH. [Non-Face to Face] • Consulting with other team member's about client's health status. [Non-Face to Face]	Count each 15 minutes	Nurse Care Manager (RN or LPN)
Medication Reminder	S5185	HE			• Providing a telephone prompt for each client that has at least one or more billable face-to-face services. • Delivery of medication.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or Hospital Liaison/HH Specialist
Wellness Resource Skills Development	T1012	HE			• The process of providing direction and coordinating support activities that promote good physical health.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or Hospital Liaison/HH Specialist

Care Coordination (PACT)							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Targeted Case Management	T1016	HE			• Referral, linkage and advocacy to assist with the implementation of the integrated care plan, including appointment scheduling and arranging transportation. • Monitoring and follow-up activities with treatment or service providers (including intra-agency) for the purposes of monitoring client attendance of scheduled physician/medication, therapy, rehabilitation, or other supportive service appointments. • Follow-up activities with the client to identify any new resource needs or to assist with implementation of the integrated care plan, including making appointment reminders. • Crisis diversion- connecting with the resources needed to avert a clinical crisis. • Ensuring integration and compatibility of mental health and physical health activities. • Tracking completion of mental and physical health goals in client's integrated care plan. • Participating in hospital discharge processes.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or Hospital Liaison/HH Specialist
Intra-Agency Clinical Consultation	G9007				• A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or Hospital Liaison/HH Specialist, or Health Home Director
Participating in an Appointment	T2001	HE			• Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or Hospital Liaison/HH Specialist

Care Coordination (PACT)						
Service Title	**Code**	**Modifiers**		**HH Service Functions**	**Notes**	**Team Member**
Provider Transportation/Driving	A0160			• Time spent driving to do a home visit when the client is not home. • Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent waiting for a client during an appointment or escorting a member to an appointment.	Up to one hour of travel per month per client will be allowed to count towards the minimum monthly service requirement	Nurse Care Manager (RN or LPN), or BHCM II, or Hospital Liaison/HH Specialist

Health Promotion

Health promotion consists of providing health education specific to the client's chronic condition.

Health promotion will minimally consist of the following, but is not limited to:

- Providing health education specific to client's condition;
- Developing self-management plans with the client;
- Providing support for improving social networks and providing health promoting lifestyle interventions including:
    - Substance use prevention
    - Smoking prevention and cessation
    - Obesity reduction and prevention
    - Nutritional counseling
    - Increasing physical activity

NOTES (Regarding specific service functions in the Health Promotion tables below):

Oral/Injection Medication Administration: Can include time for observation.

Participating in an Appointment – Count all time spent in direct contract with the client/family and or other parties involved in implementing the care plan.

Provider Transportation/Driving – The provider should maintain adequate documentation to demonstrate the cost of travel (mileage logs).

The *Health Risk Appraisal (HRA)* is a preliminary screening that, together with a Health Risk Assessment, helps determine acuity of needs. The HRA may be furnished through an interactive telephonic or web-based program or community encounter with a team member. For all New HH adult enrollees, a HRA must be completed before or as a part of a Health Risk Assessment/physical exam within 2 weeks of Health Home enrollment. For established (grandfathered) clients, available data should be accessed (SoonerCare provider portal, OKDHS Child Portal, EHR, PCP data) and reviewed for critical health needs, and the HRA must be completed no later than the next care plan update.

QUALIFIED PROFESSIONALS - Health promotion services are provided by the following professionals and paraprofessionals:

- Nurse Care Manager (RN or LPN);
- Primary Care Practitioner PCP;
- Wellness Coach; and
- Hospital Liaison/HH Specialist.

Health Promotion (Non-PACT)								
Service Title		**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Wellness Resource Skills Development		T1012	HE/HF			• The process of providing direction and coordinating support activities that promote good physical health. • Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support. • Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]	Count each 15 minutes	PCP, Nurse Care Manager (RN or LPN), Wellness Coach, or Hospital Liaison/HH Specialist
	Tobacco Cessation	T1012	HE/HF	SE				
Intra-Agency Clinical Consultation		G9007				• A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.	Count each 15 minutes	PCP, Nurse Care Manager (RN or LPN), or Wellness Coach, or Hospital Liaison/HH Specialist
Clinical Time – Non Face to Face		T2022	HE			• Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face] • Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]	Count each 15 minutes	Nurse Care Manager (Rn or LPN), or Hospital Liaison/HH Specialist, or Wellness Coach

Health Promotion (Non-PACT)								
Service Title			**Code**	**Modifiers**		**HH Service Functions**	**Notes**	**Team Member**
Participating in an Appointment			T2001	HE		• Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Wellness Coach, or Hospital Liaison/HH Specialist
Provider Transportation/Driving			A0160			• Time spent driving to do a home visit when the client is not home. • Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent waiting for a client during an appointment or escorting a member to an appointment.	Up to one hour of travel per month per client will be allowed to count towards the minimum monthly service requirement	PCP, or Nurse Care Manager (RN or LPN), or Wellness Coach, or Hospital Liaison/HH Specialist
Case Management (Outpatient in an inpatient setting)	Nurse Care Mgr	T1017	HE	HN	HK	• Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for adults age 22 and older.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Wellness Coach, or Hospital Liaison/HH Specialist
	Wellness Coach, Hospital Liaison / HH Specialist	T1017	HE	HM	HK			
Targeted Case Management	Nurse Care Mgr		T1017	HE / HF / HH / HV	HN	• Referral, linkage and advocacy to assist with obtaining and maintaining needed resources, services and supports; including arranging for non-emergency transportation.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Wellness Coach, or Hospital Liaison/HH Specialist
	Wellness Coach, Hospital Liaison / HH Specialist		T1017	HE / HF / HH / HV	HM			
Medication Reminder			S5185	HE		• Providing a telephone prompt for each client that has at least one or more billable face-to-face services. • Delivery of medication.	Count each 15 minutes	Nurse Care Manager (RN or LPN), PCP, or Wellness Coach, or Hospital Liaison/HH Specialist

Health Promotion (PACT)								
Service Title		**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Wellness Resource Skills Development		T1012	HE			• The process of providing direction and coordinating support activities that promote good physical health. • Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support. • Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]	Count each 15 minutes	PCP, Nurse Care Manager (RN or LPN), Wellness Coach, or Hospital Liaison/HH Specialist
	Tobacco Cessation	T1012	HE	SE				
Intra-Agency Clinical Consultation		G9007				• A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.	Count each 15 minutes	PCP, Nurse Care Manager (RN or LPN), or Wellness Coach, or Hospital Liaison/HH Specialist
Clinical Time – Non Face to Face		T2022	HE			• Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face] • Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]	Count each 15 minutes	Nurse Care Manager (Rn or LPN), or Hospital Liaison/HH Specialist, or Wellness Coach

Health Promotion (PACT)								
Service Title		**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Participating in an Appointment		T2001	HE			• Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Wellness Coach, or Hospital Liaison/HH Specialist
Provider Transportation/Driving		A0160				• Time spent driving to do a home visit when the client is not home. • Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent waiting for a client during an appointment or escorting a member to an appointment.	Up to one hour of travel per month per client will be allowed to count towards the minimum monthly service requirement	PCP, or Nurse Care Manager (RN or LPN), or Wellness Coach, or Hospital Liaison/HH Specialist
Case Management (Outpatient in an inpatient setting)	Nurse Care Mgr	T1017	HE	HN	HK	• Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for adults age 22 and older.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Wellness Coach, or Hospital Liaison/HH Specialist
	Wellness Coach, Hospital Liaison / HH Specialist	T1017	HE	HM	HK			
Targeted Case Management	Nurse Care Mgr	T1017	HE / HF / HH / HV		HN	• Referral, linkage and advocacy to assist with obtaining and maintaining needed resources, services and supports; including arranging for non-emergency transportation.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Wellness Coach, or Hospital Liaison/HH Specialist
	Wellness Coach, Hospital Liaison / HH Specialist	T1017	HE / HF / HH / HV		HM			
Medication Reminder		S5185	HE			• Providing a telephone prompt for each client that has at least one or more billable face-to-face services. • Delivery of medication.	Count each 15 minutes	Nurse Care Manager (RN or LPN), PCP, or Wellness Coach, or Hospital Liaison/HH Specialist

Comprehensive Transitional Care

Care coordination services for comprehensive transitional care are designed to streamline plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency room use.

In conducting comprehensive transitional care, the Nurse Care Manager and the Behavioral Health Case Manager will work as co-leads. Their duties include, but are not limited to the following:

- Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home clients;
- Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and
- Motivate hospital staff to notify the Health Home staff of such opportunities.

Care management services must be provided for the purposes of discharge planning and must be translated into the patient care management plan. The care manager must share the client's care plan and coordinate with all of the client's providers to make sure that all needed services are in place to ensure a safe and timely discharge. The client should be actively engaged during the discharge planning process, and care managers should follow up with clients within two (2) business days post-discharge via a home visit, phone call or on-site appointment.

NOTES (Regarding specific service functions in the Comprehensive Transitional Care tables below):

Transitional Case Management – Payment will continue if adult enrollee has been admitted to URC, crisis center, residential or community Inpatient setting less than 17 beds, or Inpatient Med/Surgical Hospital. Payment will not be made for individuals ages 22-64 in IMD or for inmates.

QUALIFIED PROFESSIONALS - Comprehensive transitional care services are provided by the following professionals and paraprofessionals:

- Nurse Care Manager (RN or LPN);
- Certified Behavioral Health Case Manager II; and
- Certified Behavioral Health Case Manager I.

Comprehensive Transitional Care (Non-PACT)								
Service Title		**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
System Support		G9007				• Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home clients; • Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and • Motivate hospital staff to notify the Health Home staff of such opportunities.	Is not counted as one of the minimum HH billable activities	Nurse Care Manager (RN or LPN), or BHCM II
Case Management (Outpatient in an inpatient setting)	Nurse Care Mgr / BHCM II	T1017	HE	HN	HK	• Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for adults age 22 and older.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or BHCM I
	BHCM I	T1017	HE	HM	HK			

Comprehensive Transitional Care (PACT)							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
System Support	G9007				• Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home clients; • Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and • Motivate hospital staff to notify the Health Home staff of such opportunities.	Is not counted as one of the minimum HH billable activities	Nurse Care Manager (RN or LPN), or BHCM II
Case Management (Outpatient in an inpatient setting)	T1017	HE	HN	HK	• Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for adults age 22 and older.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II

Individual and Family Support Services

Individual and family support services assist individuals in accessing services that will reduce barriers and improve health outcomes, with a primary focus on increasing health literacy, the ability of the client to self-manage their care and facilitate participation in the ongoing revision of their integrated care plan.

Individual and family support services include, but are not limited to:

- Teaching individuals and families self-advocacy skills;
- Providing peer support groups;
- Modeling and teaching how to access community resources;
- Assisting with obtaining and adhering to medications and other prescribed treatments; and
- Identifying resources to support the client in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services.

QUALIFIED PROFESSIONALS - Individual and family support services are provided by the following professionals and paraprofessionals:

- Nurse Care Manager (RN or LPN);
- Certified Behavioral Health Case Manager II;
- Certified Behavioral Health Case Manager I; and
- Wellness Coach.

Individual and Family Support Services (Non-PACT)							
Service Title		**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Wellness Resource Skills Development		T1012	HE/HF			• Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Wellness Coach, or BHCM II, or BHCM I
	Tobacco Cessation	T1012	HE/HF	SE				
Family Training and Support		T1027	HE / HF / HH / HV			• Provide training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process. • Increase client/family ability to provide a safe and supportive environment in the home and community. • Assist client/family in the acquisition of knowledge and skills necessary to understand and address specific needs in relation to illness and treatment; including understanding crisis plans and plan of care process. • Development and enhancement of specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management. • Training on medications or diagnoses, and interpreting choice offered by service providers.	Count each 15 minutes	Nurse Care Manager (RN or LPN), Wellness Coach, or BHCM II, or BHCM I
Medication Training and Support		H0034	HE / HF / HH / HV			• Supportive therapy; Interviews with clients to discuss health concerns and wellness and treatment goals. • Provide education about medications. • Individual care by Nurse Care Manager for clients on their caseload; including monitoring medication compliance and side effects.	Count each 15 minutes	RN Nurse Care Manager

Individual and Family Support Services (Non-PACT)							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Oral/Injection Medication Administration	T1502	HE			• Oral/Injection Medication Administration	Count each 15 minutes	Nurse Care Manager (RN or LPN)

Individual and Family Support Services (PACT)								
Service Title		**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Wellness Resource Skills Development		T1012	HE			• Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Wellness Coach, or BHCM II
	Tobacco Cessation	T1012	HE	SE				
Medication Training and Support		H0034	HE			• Provide education about medications. • Monitoring medication compliance and side effects.	Count each 15 minutes	RN Nurse Care Manager
PACT for Health Home Client – Bundled Services		H0039	HE			• Order medication from pharmacy (not payment to the pharmacy) • Provide preventative health education • Schedule maintenance visits • Provide reproductive counseling and sex education	Count each 15 minutes	RN Nurse Care Manager
Oral/Injection Medication Administration, RN		T1502	HE			• Oral/Injection Medication Administration	Count each 15 minutes	RN Nurse Care Manager
Family Training and Support		T1027	HE / HF / HH / HV			• Provide training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process. • Increase client/family ability to provide a safe and supportive environment in the home and community. • Assist client/family in the acquisition of knowledge and skills necessary to understand and address specific needs in relation to illness and treatment; including understanding crisis plans and plan of care process. • Development and enhancement of specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management. • Training on medications or diagnoses, and interpreting choice offered by service providers.	Count each 15 minutes	Nurse Care Manager (RN or LPN), Wellness Coach, or BHCM II

Referral to Community and Social Support Services

Provide clients with referrals to community and social support services in the community.

Providing assistance for clients to obtain and maintain eligibility for the following services as applicable, including but not limited to:

- Healthcare;
- Disability benefits;
- Housing;
- Transportation;
- Personal needs; and
- Legal services.

NOTES (Regarding specific service functions in the Referral to Community and Social Support Services tables below):

Arranging Non-Emergency Transportation – Transportation for a HH enrollee is not included in the rate. SoonerCare contracts with a broker to ensure Non-Emergency Medical Transportation (NMT) and may be available for HH enrollees. Not all SoonerCare members are eligible for SoonerRide (See OAC 317:30-5-327) and not all covered services are eligible. In order to avoid overlap and possible duplication with transportation programs under other federal authorities, SoonerCare does not contract for NET for covered services to schools, day programs and group skills training programs. The service site or a community organization often provides or funds transportation to these activities. The HH should work with the client/family to determine the program that best fits their needs.

It is important to note that SoonerRide NET services must be scheduled with the transportation broker, and that transportation is provided by SoonerRide when medically necessary in connection with examination and treatment to the nearest appropriate facility.

Participating in an Appointment – Count all time spent in direct contract with the client/family and or other parties involved in implementing the care plan.

Provider Transportation/Driving – The provider should maintain adequate documentation to demonstrate the cost of travel (mileage logs).

QUALIFIED PROFESSIONALS- Referral to community and social support services are provided by the following professionals and paraprofessionals:

- Nurse Care Manager (RN or LPN);
- Certified Behavioral Health Case Manager II; and
- Certified Behavioral Health Case Manager I.

Referral to Community and Social Support Services (Non-PACT)							
Service Title		**Code**	**Modifiers**		**HH Service Functions**	**Notes**	**Team Member**
Targeted Case Management	Nurse Care Mgr / BHCM II	T1017	HE / HF / HH / HV	HN	• Referral, linkage and advocacy to assist with obtaining and maintaining needed resources, services and supports; including arranging for non-emergency transportation.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or BHCM I
	BHCM I	T1017	HE / HF / HH / HV	HM			
Participating in an Appointment		T2001	HE		• Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II, or BHCM I
Provider Transportation/Driving		A0160			• Time spent driving to do a home visit when the client is not home. • Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent waiting for a client during an appointment or escorting a member to an appointment.	Up to one hour of travel per month per client will be allowed to count towards the minimum monthly service requirement	Nurse Care Manager (RN or LPN), or BHCM II, or BHCM I

Referral to Community and Social Support Services (PACT)						
Service Title	**Code**	**Modifiers**		**HH Service Functions**	**Notes**	**Team Member**
Targeted Case Management	T1016	HE		• Referral, linkage and advocacy to assist with obtaining and maintaining needed resources, services and supports; including arranging for non-emergency transportation.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II
Participating in an Appointment	T2001	HE		• Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or BHCM II
Provider Transportation/Driving	A0160			• Time spent driving to do a home visit when the client is not home. • Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent waiting for a client during an appointment or escorting a member to an appointment.	Up to one hour of travel per month per client will be allowed to count towards the minimum monthly service requirement	Nurse Care Manager (RN or LPN), or BHCM II

FY 2016 SERVICE FUNCTIONS BY HEALTH HOME TEAM MEMBER

T2022 HE

- Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions. [Non-Face to Face]
- Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines [Non-Face to Face]
- Developing and disseminating reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and cost [Non-Face to Face]
- Monitoring the client's condition (physical, mental, social). Must be part of the integrated care plan. [Non-Face to Face]
- Performing medication reconciliation and overseeing the client's self-management of medications [Non-Face to Face]
- Initially reviewing client records and client history and reviewing and signing off on health assessments. Must be part of the integrated care plan. [Non-Face to Face]
- Consultation with team about identified health conditions of their clients. Must be part of the integrated care plan. [Non-Face to Face]
- Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face]
- Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]

G9007

- A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.

T1012 HE/HF

T1012 HE/HF, SE (Tobacco Cessation) – Cont'd

- Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support.
- Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]
- The process of providing direction and coordinating support activities that promote good physical health.

S5185 HE/HF/HH/HV

- Providing a telephone prompt for each client that has at least one or more billable face-to-face services.
- Delivery of medication.

A0160

- Travel time to and from meetings for the purpose of development or implementation of the individual care plan.
- Time spent driving to do a home visit when the client is not home.
- Time spent waiting for a client during an appointment or escorting a member to an appointment.

H0039 HE (PACT) – RN Only

S5190 – RN Only

- Comprehensive Nursing Assessment: Medical dental and other health needs for adults (may include some reconciliation with biometrics obtained by the provider like blood lipids and glucose, blood pressure, etc.).

T1502 HE

- Oral/Injection Medication Administration

T2001 HE

- Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.

T1017 HE, HN, HK

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for adults age 22 and older.

G9007

- Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home clients;
- Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and
- Motivate hospital staff to notify the Health Home staff of such opportunities.

T1027 HE/HF/HH/HV

- Provide training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process.
- Increase client/family ability to provide a safe and supportive environment in the home and community.
- Assist client/family in the acquisition of knowledge and skills necessary to understand and address specific needs in relation to illness and treatment; including understanding crisis plans and plan of care process.
- Development and enhancement of specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management.
- Training on medications or diagnoses, and interpreting choice offered by service providers.

H0034 HE/HF/HH/HV- (RN Only)

- Supportive therapy; Interviews with clients to discuss health concerns and wellness and treatment goals.
- Provide education about medications.
- Individual care by Nurse Care Manager for clients on their caseload; including monitoring medication compliance and side effects.
- Provide education about medications (**PACT Only)**
- Monitor medication compliance and side effects **(PACT Only)**

H0039 HE- PACT (RN Only)

- Order medication from pharmacy (not payment to the pharmacy)
- Provide preventative health education
- Schedule maintenance visits
- Provide reproductive counseling and sex education

H0039 HE (PACT)
T1017 HE/HF/HH/HV, HN

- Comprehensive Assessment: Extended Psychosocial including an extended assessment of education and/or employment, social development and functioning, activities of daily living, and family structure and relationships.
- Development of Integrated Care Plan (Adult)- Coordination of the Adult Health Home teams development of a client directed, integrated active care plan for each enrolled client that reflects input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), and others the client chooses to involve.
- Review of Integrated Care Plan (Adult)– Coordination of the Adult Health Home teams review, revision and documentation of the integrated care plan as frequently as the client's condition requires, but no less frequently than every (6) six months.

T1016 HE (PACT)
T1017 HE/HF/HH/HV, HN

- Referral, linkage and advocacy to assist with the implementation of the integrated care plan, including assistance with obtaining and maintaining needed resources, services and supports; appointment scheduling and arranging for non-emergency transportation.
- Monitoring and follow-up activities with treatment or service providers (including intra-agency) for the purposes of monitoring client attendance of scheduled physician/medication, therapy, rehabilitation, or other supportive service appointments.
- Follow-up activities with the client to identify any new resource needs or to assist with implementation of the integrated care plan, including making appointment reminders.
- Crisis diversion- connecting with the resources needed to avert a clinical crisis.
- Ensuring integration and compatibility of mental health and physical health activities.
- Tracking completion of mental and physical health goals in client's integrated care plan.
- Participating in hospital discharge processes.
- (Adult) Completion of the Post Traumatic Stress Disorder Checklist (PCL) short screen, and the full PCL assessment if the screen is positive.
- Ensuring that every enrollee is aligned with or linked with a PCP available through the HH, with in the first 3 months of enrollment in HH. [Non-Face to Face]
- Consulting with other team member's about client's health status. [Non-Face to Face]

T2022 HE

- Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions. [Non-Face to Face]
- Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines [Non-Face to Face]
- Developing and disseminating reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and cost [Non-Face to Face]
- Monitoring the client's condition (physical, mental, social). Must be part of the integrated care plan. [Non-Face to Face]
- Performing medication reconciliation and overseeing the client's self-management of medications [Non-Face to Face]
- Psychiatric Consultation. Must be part of the integrated care plan. [Non-Face to Face]
- PCP consultation on best practice protocol. Must be part of the integrated care plan. [Non-Face to Face]

T1012 HE/HF
T1012 HE/HF, SE (Tobacco Cessation)

- The process of providing direction and coordinating support activities that promote good physical health.
- Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support.
- Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]

G9007

- A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.

H0039 HE (PACT)
T1017 HE/HF/HH/HV, HO

- Comprehensive Assessment: Extended Psychosocial including an extended assessment of education and/or employment, social development and functioning, activities of daily living, and family structure and relationships.
- Development of Integrated Care Plan (Adult)-Coordination of the Adult Health Home teams development of a client directed, integrated active care plan for each enrolled client that reflects input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), and others the client chooses to involve.
- Review of Integrated Care Plan (Adult)–Coordination of the Adult Health Home teams review, revision and documentation of the integrated care plan as frequently as the client's condition requires, but no less frequently than every (6) six months.
- (Adult) Completion of the Post Traumatic Stress Disorder Checklist (PCL) short screen, and the full PCL assessment if the screen is positive.

A0160

- Travel time to and from meetings for the purpose of development or implementation of the individual care plan.
- Time spent driving to do a home visit when the client is not home.
- Time spent waiting for a client during an appointment or escorting a member to an appointment

S5185 HE/HF/HH/HV

- Providing a telephone prompt for each client that has at least one or more billable face-to-face services.
- Delivery of medication.

T2022 HE • Monitoring the client's condition (physical, mental, social). Must be part of the integrated care plan. [Non-Face to Face] • Performing medication reconciliation and overseeing the client's self-management of medications [Non-Face to Face] • Psychiatric Consultation. Must be part of the integrated care plan. [Non-Face to Face] • PCP consultation on best practice protocol. Must be part of the integrated care plan. [Non-Face to Face] **H0039 HE (PACT)** **T1017 HE/HF/HH/HV, HO** • Comprehensive Assessment: Extended Psychosocial including an extended assessment of education and/or employment, social development and functioning, activities of daily living, and family structure and relationships. • Development of Integrated Care Plan (Adult)- Coordination of the Adult Health Home teams development of a client directed, integrated active care plan for each enrolled client that reflects input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), and others the client chooses to involve. • Review of Integrated Care Plan (Adult)– Coordination of the Adult Health Home teams review, revision and documentation of the integrated care plan as frequently as the client's condition requires, but no less frequently than every (6) six months. • (Adult) Completion of the Post Traumatic Stress Disorder Checklist (PCL) short screen, and the full PCL assessment if the screen is positive. **G9007** • A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.	**A0160** • Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent driving to do a home visit when the client is not home.	

H0039 HE *(PACT)*
T1017 HE/HF/HH/HV, HN *(CM II Only)*

- Comprehensive Assessment: Extended Psychosocial including an extended assessment of education and/or employment, social development and functioning, activities of daily living, and family structure and relationships.
- Development of Integrated Care Plan (Adult)- Coordination of the Adult Health Home teams development of a client directed, integrated active care plan for each enrolled client that reflects input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), and others the client chooses to involve.
- Review of Integrated Care Plan (Adult)– Coordination of the Adult Health Home teams review, revision and documentation of the integrated care plan as frequently as the client's condition requires, but no less frequently than every (6) six months.
- (Adult) Completion of the Post Traumatic Stress Disorder Checklist (PCL) short screen, and the full PCL assessment if the screen is positive.

T1016 HE *(PACT)*
T1017 HE/HF/HH/HV, HN *(CM II)*
T1017 HE/HF/HH/HV, HM *(CM I)*

- Referral, linkage and advocacy to assist with the implementation of the integrated care plan, including assistance with obtaining and maintaining needed resources, services and supports; appointment scheduling and arranging for non-emergency transportation.
- Monitoring and follow-up activities with treatment or service providers (including intra-agency) for the purposes of monitoring client attendance of scheduled physician/medication, therapy, rehabilitation, or other supportive service appointments.
- Follow-up activities with the client to identify any new resource needs or to assist with implementation of the integrated care plan, including making appointment reminders.
- Crisis diversion- connecting with the resources needed to avert a clinical crisis.

T1016 HE *(PACT)*
T1017 HE/HF/HH/HV, HN *(CM II)*
T1017 HE/HF/HH/HV, HM *(CM I) – Cont'd*

- Ensuring integration and compatibility of mental health and physical health activities.
- Tracking completion of mental and physical health goals in client's integrated care plan.
- Participating in hospital discharge processes.

G9007

- A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.

A0160

- Travel time to and from meetings for the purpose of development or implementation of the individual care plan.
- Time spent driving to do a home visit when the client is not home.
- Time spent waiting for a client during an appointment or escorting a member to an appointment.

T2022 HE

- Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face]
- Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]

S5185 HE/HF/HH/HV

- Providing a telephone prompt for each client that has at least one or more billable face-to-face services.
- Delivery of medication.

T1017 HE, HN, HK (CM II)
T1017 HE, HN, HK (CM I)

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for adults age 22 and older.

T1012 HE/HF
T1012 HE/HF, SE (Tobacco Cessation)

- Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support.
- Completion of the Health Risk Appraisal (HRA)- Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]
- The process of providing direction and coordinating support activities that promote good physical health.

T2001 HE

- Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.

T1027 HE/HF/HH/HV • Provide training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process. • Increase client/family ability to provide a safe and supportive environment in the home and community. • Assist client/family in the acquisition of knowledge and skills necessary to understand and address specific needs in relation to illness and treatment; including understanding crisis plans and plan of care process. • Development and enhancement of specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management. • Training on medications or diagnoses, and interpreting choice offered by service providers. **G9007 (CM II Only)** • Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home clients; • Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and • Motivate hospital staff to notify the Health Home staff of such opportunities.		

Wellness Coach

T1012 HE/HF
T1012 HE/HF, SE (Tobacco Cessation)

- Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]
- The process of providing direction and coordinating support activities that promote good physical health.
- Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support.

G9007

- A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.

T1017 HE, HM, HK

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for adults age 22 and older.

A0160

- Travel time to and from meetings for the purpose of development or implementation of the individual care plan.
- Time spent driving to do a home visit when the client is not home.
- Time spent waiting for a client during an appointment or escorting a member to an appointment.

T2001 HE

- Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.

T2022 HE

- Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face]
- Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]

T1017 HE/HF/HH/HV, HM

- Referral, linkage and advocacy to assist with obtaining and maintaining needed resources, services and supports; including arranging for non-emergency transportation.

T1027 HE/HF/HH/HV

- Provide training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process.
- Increase client/family ability to provide a safe and supportive environment in the home and community.
- Assist client/family in the acquisition of knowledge and skills necessary to understand and address specific needs in relation to illness and treatment; including understanding crisis plans and plan of care process.
- Development and enhancement of specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management.
- Training on medications or diagnoses, and interpreting choice offered by service providers.

S5185 HE/HF/HH/HV

- Providing a telephone prompt for each client that has at least one or more billable face-to-face services.
- Delivery of medication.

T2022 HE

- Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face]
- Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]

S5185 HE/HF/HH/HV

- Providing a telephone prompt for each client that has at least one or more billable face-to-face services.
- Delivery of medication.

T1016 HE *(PACT)*
T1017HE/HF/HH/HV, HM

- Referral, linkage and advocacy to assist with the implementation of the integrated care plan, including assistance with obtaining and maintaining needed resources, services and supports; appointment scheduling and arranging for non-emergency transportation.
- Monitoring and follow-up activities with treatment or service providers (including intra-agency) for the purposes of monitoring client attendance of scheduled physician/medication, therapy, rehabilitation, or other supportive service appointments.
- Follow-up activities with the client to identify any new resource needs or to assist with implementation of the integrated care plan, including making appointment reminders.
- Crisis diversion- connecting with the resources needed to avert a clinical crisis.
- Ensuring integration and compatibility of mental health and physical health activities.
- Tracking completion of mental and physical health goals in client's integrated care plan.
- Participating in hospital discharge processes.

T2001 HE

- Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.

A0160

- Travel time to and from meetings for the purpose of development or implementation of the individual care plan.
- Time spent driving to do a home visit when the client is not home.
- Time spent waiting for a client during an appointment or escorting a member to an appointment.

T1012 HE/HF
T1012 HE/HF, SE (Tobacco Cessation)

- Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]
- The process of providing direction and coordinating support activities that promote good physical health.
- Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support.

T1017 HE, HM, HK

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for adults age 22 and older

T1017 HE/HF/HH/HV, HM

- Referral, linkage and advocacy to assist with obtaining and maintaining needed resources, services and supports; including arranging for non-emergency transportation.

G9007

- A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.

T2022 HE • Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face] • Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face] **G9007** • A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.		

CHILDREN’S HEALTH HOMES

CHILDREN'S HEALTH HOME TEAM

Health Homes deliver services through a multidisciplinary team of physical and behavioral health care professionals. The eligible team members for service reporting are listed below, and are for both levels of care coordination for children (Moderate and High Intensity). Health Homes are responsible for ensuring that all team members work within their scope of practice.

Health Home Director – An individual who possesses a Bachelor's degree in the field of social or human sciences from an accredited university, has at least three years' work experience in the social service field and has a minimum of one year experience in an administrative position.

Nurse Care Manager – A Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Work must be performed within the individual's scope of practice.

Consulting PCP – A Physician, Physician Assistant (PA) or Advanced Practice Registered Nurse (APRN) that is embedded, or a partnership with multiple Patient-Centered Medical Homes (PCMHs), an FQHC or I/T/U (Indian Health Service, Tribally operated facility/program, and Urban Indian clinic) facility.

Psychiatric Consultant – A Board Certified/Eligible Psychiatrist, Physician Assistant (PA) or APRN with a psychiatric specialty.

Care Coordinator – An individual who meet the requirements for a Wraparound Facilitator Case Manager. A Wraparound Facilitator Case Manager is an LBHP, CADC, or Certified Behavioral Health Case Manager II and has the following:

(1) Successful completion of the ODMHSAS training for wraparound facilitation within six months of employment; and
(2) Participate in ongoing coaching provided by ODMHSAS and employing agency; and
(3) Successfully complete wraparound credentialing process within nine months of beginning process; and
(4) Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS.

Family Support Provider – An individual that meets the following requirements:

(1) Have a high school diploma or equivalent;
(2) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years of experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);
(3) successful completion of ODMHSAS Family Support Training; and
(4) pass background checks.

Youth/Peer Support Specialist – An individual that has been certified by ODMHSAS as a Peer Recovery Support Specialist (PRSS).

Children's Health Home Specialist – An individual certified by ODMHSAS as a Behavioral Health Case Manger I or II, and has completed trainings as required by ODMHSAS including but not limited to Behavioral Health Aide and Well Power.

CLIENT ELIGIBILITY AND ENROLLMENT

Individuals who are eligible for SoonerCare, and who meet eligibility criteria for Health Homes (see the Children's Level of Care Coordination within this section of the Manual), may "opt-in" and voluntarily participate in a Health Home. Individuals may choose to participate in any Health Home (HH).

The HH must obtain informed consent specific to enrollment in the HH. The consent must 1) be specific to the extent that it permits the HH team members to share information relevant to the delivery of HH services (a form example can be located in the Health Home Documents section of this Manual), and 2) be obtained within a process that educates individuals, and ensures understanding, regarding their right to choose between qualified HHs or to "opt-out" of the HH service. For new HH clients, the consent does not have to be signed immediately to begin receiving HH services. Clients may not be immediately comfortable with signing the consent, so this is to allow some extra time to get the consent signed. If a client continues to refuse to sign the consent form, and that is not anticipated to change, the HH will need to dis-enroll the client as HHs require coordination between providers.

Additional guidance regarding the enrollment process will be provided in other sections of this Manual. The outreach and engagement services and initial assessment and plan development services (and related billing) that occur prior to HH enrollment can be found in the Health Home Services section of this Manual. Health Home enrollment/prior authorization can be found in the Health Home Prior Authorization section of this Manual. The Level of Care Coordination that an individual should be enrolled in will be based on screening/assessment, and identification/prediction of client risk levels relating to health care needs, services, and coordination. The eligibility for those Levels of Care Coordination can be found under the Children's Level of Care Coordination within this section of the Manual.

Note:

- An individual may be enrolled in both a Health Home and a Patient Centered Medical Home (PCMH) however roles and responsibilities must be clearly identified in order to avoid duplication. Individuals may not be enrolled in Health Home and currently be enrolled in other programs like: Intellectual or Developmental Disability Targeted Case Management (I/DD-TCM); Advantage Waiver TCM; SoonerCare Health Management Program (HMP); Child Welfare- TCM; or Juvenile Justice TCM. Individuals are given the choice as to which care management/care coordination services would best meet their needs. Duplication of services is not allowed.
- All children enrolled in Health Home must also be added to the YIS system.

CHILDREN'S LEVELS OF CARE COORDINATION

Children's Health Home services are provided to children with Serious Emotional Disturbance (SED), ages 0-18. Transition to adult can be served up to age 21. Services are provided under the following levels of care coordination:

Moderate Intensity (Service Coordination)–
Medical Necessity Criteria: Individual Client Assessment Record (CAR) scores meet criteria for Level 3.
Service Requirements: Up to 30 clients on the team.
High Intensity (Wraparound)–
Medical Necessity Criteria: Individual Client Assessment Record (CAR) scores meet criteria for Level 4; A caregiver rated Ohio Scale shows critical impairment (score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscales; and At least one of the following conditions: • Psychiatric hospitalization within the past 3 months; • Multiple psychiatric hospitalizations, ED use and/or crisis center admissions (at least two); • Intensive array of services are in place, including (at a minimum): case management, therapy, and medication management; • Chronic physical health condition, such as diabetes, asthma or other chronic physical health condition; • Child was in the custody of OKDHS or OJA, or had been in and out of court multiple times, within the past six months; or • At high risk of out of home/out of community placement as indicated by an attestation signed by a LBHP (form provided by the State). The attestation will include narrative explaining the changes and challenges in function and the circumstances surrounding imminent out of home/community placement and an updated psychosocial assessment with support CAR scores.
Service Requirements: Up to 10 clients on the team.

NOTES:

- For individuals with Developmental Disabilities, the Health Home will refer to and coordinate with the approved Developmental Disabilities case management entity for these services.
- Care Coordinators are not the only HH team member who can carry a caseload. The total number being served by the HH team can be assigned to HH team member caseloads in a

manner that is determined by the HH. This is to allow for optimal flexibility in meeting service needs. The only restrictions are caseload limits for specific team members (refer to the Health Home Teams section of this Manual).

- In order to meet Medical Necessity Criteria for continued stay in Health Home, the following must be also be present at the time of 6 month service plan update: 1) The clinical condition(s) continues to warrant HH services in order to coordinate care to prevent the onset of disease or to treat a disease and prevent onset of serious complications, OR 2) Progress toward Integrated Care Plan (ICP) identified goals is evident and has been documented based on the objectives defined for each goal, but the goals have not yet been substantially achieved despite sound clinical practice consistent with the chronic care model, OR 3) Progress has not been made, and the multidisciplinary team has identified and implemented changes/revisions to the ICP to support the goals of the client/family.

CHILDREN'S HEALTH HOME SERVICES

Billable Health Home services for children are as follows:

Health Home Outreach and Engagement
Through outreach and engagement the client is informed about: Health Home enrollment; the benefits of Health Home enrollment to the client (including potential benefits); privacy; and selecting a PCP. A Health Home may provide outreach and engagement services to a client attributed to, but not yet enrolled in, Health Home. In order to be eligible to receive this service, clients must be ages 0-18 (or up to age 21 if transition youth), and already designated as having a Serious Emotional Disturbance (SED) and a CAR level 3 or 4, or they must be referred for Health Home services by a hospital, crisis or residential facility.

Note: A Prior Authorization is not required. The reimbursement for outreach and engagement is limited to once per month and is not reimbursable in the same month that the Health Home receives reimbursement for Health Home Bundled Services. Only 3 months of billing are allowed per year (a rolling year), and must be billed using a unique Client ID. If Health Home Outreach and Engagement is initiated through a referral from a hospital, crisis or residential facility, the referral must be documented in the client record.

Staff Requirement: [HH] Any Agency Staff Member

	Billing Code	**Rate/Unit**
	G9001	$53.98 / Per Month

Health Home Initial Assessment and Plan Development
Health Homes will have LBHP FTE(s) associated with the HH teams. These LBHPs will have training and understanding of how to frame initial assessment and initial plan development in a way that adequately identifies client needs and the treatment objectives that can best be addressed in the HH program. This initial Health Home plan will be utilized for the provision of HH services during the client's initial 30 days in the HH program, until the HH comprehensive assessment and integrated care plan are completed. Initial assessment and initial plan development should be provided and billed for as follows:

- If a new client to the agency, the LBHP associated with HH will complete a BH Assessment (NON-MD)- Moderate Complexity if a minimum of 2 hours or more, or Low Complexity if a minimum of 1 ½ hours. They will also complete a Behavioral Health Service Plan Development Moderate Complexity. This should be billed for under a PG038 (prior to admission to HH).
- If an existing client to the agency who has already had an outpatient comprehensive assessment and has an existing outpatient service plan (or someone who is returning to the agency after a break less than a year and is not eligible for a PG038 or a new comprehensive outpatient assessment/plan), the LBHP associated with HH will complete the BH Service Plan Development Low Complexity which includes meeting with client to complete an updated CAR (updated biopsycosocial) and to complete an updated service plan that will serve as the initial HH plan. This should be billed under the client's existing outpatient PA (prior to admission to HH).

CHILDREN		Billing Code				Rate/Unit
BH Assessment (Non-MD) Low Complexity (Minimum of 1 ½ Hours)		H0031	HE/HF/HV/HH	TF		$82.98 / Event
	Telemedicine	H0031	HE/HF/HV/HH	TF	GT	$82.98 / Event
BH Assessment (Non-MD) Moderate Complexity (Minimum of 2 Hours)		H0031	HE/HF/HV/HH			$110.64 / Event
	Telemedicine	H0031	HE/HF/HV/HH	GT		$110.64 / Event
BH Service Plan Development Low Complexity		H0032	HE/HF/HV/HH	TF		$57.16 / Event
	Telemedicine	H0032	HE/HF/HV/HH	TF	GT	$57.16 / Event
BH Service Plan Development Moderate Complexity		H0032	HE/HF/HV/HH			$91.44 / Event
	Telemedicine	H0032	HE/HF/HV/HH	GT		$91.44 / Event

Health Home Core Services

Health Home (HH) services are covered for children with Serious Emotional Disturbance (SED) who are enrolled in the HH program. Eligible core services are as follows: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care Services, Individual Family Support Services, and Referral to Community and Social Support Services. The goal of HH core services is to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote use of Health Information Technology (HIT) and avoid unnecessary care.

Note: Prior Authorization is required (see the Prior Authorization Section of the Manual). All core HH services are billed using the "G" codes listed below, and must be billed using a unique Client ID. These codes are Per Member, Per Month (PMPM) codes and are inclusive of all the core HH services provided to the client during one month. In order to bill for the month, the service requirements must be met (refer to the HH Levels of Care Coordination section of this Manual). Although the "G" codes for the monthly service can be billed under any HH team member (see Staff Requirement below), the individual service functions provided throughout the month must be provided by team members meeting the staff requirements listed in the "Health Home (HH) Core Services Reporting" section of this Manual. A progress note is not required when billing the "G" codes. Progress notes are required when providing the individual service functions that are reported under "Health Home (HH) Core Services Reporting."

Limitations: The following services will not be reimbursed separately for individuals enrolled in a Health Home:

- Targeted case management (T1016 and T1017);
- Service plan development, moderate and low complexity (H0032);
- Medication training and support (H0034);
- Peer recovery support (H2015); and
- Family training and support (T1027).

Children/families for whom case management services are available through OKDHS/OJA or Home and Community Based Waiver (i.e. DDSD, ICF/ID, etc.) staff are not eligible for concurrent Health Home services.

Staff Requirement: [HH] Any eligible Health Home team member listed under Children's Levels of Service Provider in this Manual

			Billing Code	Rate/Unit
Urban	Child	Moderate Intensity (Level 3)	G9009	$297.08 / Per Month
		High Intensity (Level 4)	G9010	$864.82 / Per Month
Rural	Child	Moderate Intensity (Level 3)	G9009TN	$345.34 / Per Month
		High Intensity (Level 4)	G9010TN	$1,009.60 / Per Month

CHILDREN'S HEALTH HOME CORE SERVICE REPORTING

Health Homes are required to report the service functions provided/billed under "Health Home Core Services". Guidelines for reporting are as follows:

NOTE: Providers will report all eligible service functions provided under the Health Home Core Services billing code per client, per month. These eligible service functions will be reported in MMIS. To do this reporting electronically (rather than manually), specific HH service functions were assigned an existing code in the system. Although the existing code/service title may be similar in function to the HH service function, they are not intended to be exact. For reporting, providers will need to follow the HH service functions, including staff requirements, as outlined below. Progress notes should be written for each of the service functions provided.

On reporting tables in this section, if the note reflects "Count each 15 minutes" the service should be counted in 15 minute increments as follows: if the documented service is 15 minutes or less (which does not follow the 8 minute rule), it will count as one 15 minute unit, and if the service is more than 22 minutes but less than 38 minutes, it will count as two 15 minute units (the second unit of service, and any subsequent units, follow the 8 minute rule).

Comprehensive Care Management

Comprehensive care management services consist of developing a Comprehensive Care Plan to address the needs of the whole person and involves the active participation of HH team members, the client, family and caregivers.

Comprehensive care management services include the following, but are not limited to:

- Identifying high-risk clients and utilizing client information to determine level of participation in care management services:
- Assessing preliminary service needs, participating in comprehensive person-centered development of an integrated care plan, responsible for member physical and behavioral health goals, preferences and optimal clinical outcomes.
- Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions.
- Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines.
- Developing and disseminating reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and cost.

NOTES (Regarding specific service functions in the Comprehensive Care Management tables below):

For documentation of Non-Face to Face services: record date and amount of time spent providing non-face to face services (preferably start/stop times), a brief description of the services provided, and team member providing the service and their credentials.

The *Health Risk Appraisal (HRA)* is a preliminary screening that, together with a Health Risk Assessment, helps determine acuity of needs. The HRA may be furnished through an interactive telephonic or web-based program or community encounter with a team member. For children, a HRA should be completed if the Health Risk Checklist identifies red flags. For established (grandfathered) clients, available data should be accessed (SoonerCare provider portal, OKDHS Child Portal, EHR,

PCP data) and reviewed for critical health needs, and the HRA must be completed no later than the next care plan update.

The Comprehensive Assessment (CA):

- The extended psychosocial assessment includes all components of the initial assessment (conducted prior to enrollment in HH), and is intended to provide additional assessment time for a client with complex needs in order to allow for a complete and meaningful assessment. The information gathering may be collected with or without client present.
- The nursing assessment of medical, dental and other health needs includes completion of a Health Risk Assessment, which must be completed within 30 days of new enrollment, or referral may also be made to a primary care provider for physical examination, to be completed by the time of the first patient- centered plan revision (within six months). Information may be gathered from the client's primary health care provider (if any), contingent upon the client's consent. A nursing assessment must be conducted by a Registered Nurse, per Oklahoma Board of Nursing. Patient Assessment Guidelines can be located at: https://www.ok.gov/nursing/ptassessgl.pdf
- Under Early Periodic Screening Diagnostic and Treatment (EPSDT) Screening, and Dental Assessment, children should receive their EPSDT visits as indicated on the periodicity schedule which can be located at: http://www.okhca.org/providers.aspx?id=588&menu=74&parts=7581_7583
- The functional assessment is required for all enrolled children. It can include SOC specific assessment in relation to strengths, needs and cultural discovery; crisis plan; and safety plan, and can include up to 6 hours of non-face-to-face time for report preparation. The 6 hours of non-face-to-face time for report preparation is allowed per Prior Authorization (PA) period in conjunction with needed assessment.
- For other assessments, refer when medically necessary; use appropriate CPT codes if applicable.

For Review of Integrated Care Plan: A revised active plan must include information from the client's initial evaluation and comprehensive assessments and updates, the progress toward goals specified in the written care plan, and changes, as applicable, in goals.

Provider Transportation/Driving – The provider should maintain adequate documentation to demonstrate the cost of travel (mileage logs).

QUALIFIED PROFESSIONALS- Comprehensive care management services are provided by the following professionals and paraprofessionals:

- Nurse Care Manager (RN or LPN);
- Care Coordinator;
- Psychiatric Consultant; and
- Primary Care Practitioner PCP.

Comprehensive Care Management							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Clinical Time – Non Face to Face	T2022	HE			• Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions. [Non-Face to Face] • Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines [Non-Face to Face] • Developing and disseminating reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and cost [Non-Face to Face]	Count at least 15 minutes of clinical staff time per calendar month. Monitoring EHR and scanning for gaps in care would count toward the minimum requirement for a client with an open, active integrated care plan.	PCP, or Nurse Care Manager (RN or LPN)
					• Monitoring the client's condition (physical, mental, social). Must be part of the integrated care plan. [Non-Face to Face] • Performing medication reconciliation and overseeing the client's self-management of medications [Non-Face to Face] • Psychiatric Consultation. Must be part of the integrated care plan. [Non-Face to Face] • PCP consultation on best practice protocol. Must be part of the integrated care plan. [Non-Face to Face]	Count at least 15 minutes of clinical staff time per calendar month	PCP, or Nurse Care Manager (RN or LPN), or Psychiatric Consultant
					• Initially reviewing client records and client history and reviewing and signing off on health assessments. Must be part of the integrated care plan. [Non-Face to Face] • Consultation with team about identified health conditions of their clients. Must be part of the integrated care plan. [Non-Face to Face]	Count at least 15 minutes of clinical staff time per calendar month	Nurse Care Manager (RN or LPN)
Wellness Resource Skills Development	T1012	HE/HF			• Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]	Count each 15 minutes	PCP, Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager)

Comprehensive Care Management							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Clinical Evaluation and Assessment children/specialty settings - SOC	S9482	HE	TF		• Time spent preparing specialty assessment reports (ex: SNCD, Ohio Scales) [Non-Face to Face]	Up to 6 hours of non- face to face time is allowed for report preparation. This is allowed per Prior Authorization (PA) period in conjunction with needed assessment.	Care Coordinator (Wraparound Facilitator Case Manager)
SOC Wraparound Case Management	T1016	HE / HF / HH / HV	HN		• Comprehensive Assessment: Child Functional Assessment including strengths and needs assessment, Ohio Scales Rating, and assembling a Wraparound team. • Development of Integrated Care Plan (Child)- Coordination of the Child Health Home teams development of a client directed, integrated active care plan for each enrolled client that reflects input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), and others the client chooses to involve. • Review of Integrated Care Plan (Child)– Coordination of the Children's Health Home teams review, revision and documentation of the integrated care plan as frequently as the client's condition requires, but no less frequently than every (6) six months. • (Child) Completion of the Child and Adolescent Trauma Screen (CATS), and if the screen is positive refer to an LBHP to administer the CATS assessment.	Count each 15 minutes	Care Coordinator (Wraparound Facilitator Case Manager)

Comprehensive Care Management							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Comprehensive Assessment	S5190				• Comprehensive Nursing Assessment: Medical dental and other health needs (may include some reconciliation with biometrics obtained by the provider like blood lipids and glucose, blood pressure, etc.).	Count each 15 minutes	RN Nurse Care Manager
					• Comprehensive Assessment: Health Screening and Assessment for Children – Early Periodic Screening Diagnostic and Treatment (EPSDT) Screening, and Dental Assessment		PCP
Intra-Agency Clinical Consultation	G9007				• A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager), or Psychiatric Consultant, or PCP
Provider Transportation/Driving	A0160				• Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent driving to do a home visit when the client is not home.	Up to one hour of travel per month per client will be allowed to count towards the minimum monthly service requirement	PCP, or Psychiatric Consultant, or Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager)

Care Coordination

Care coordination is the implementation of the integrated care plan with the active client involvement through appropriate linkages, referrals, coordination and follow-up to needed services and supports.

Care coordination services include the following, but are not limited to:

- Care coordination for primary health care, specialty health care and transitional care from emergency departments, hospitals and Psychiatric Residential Treatment Facilities (PRFTs);
- Ensuring integration and compatibility of mental health and physical health activities;
- Providing on-going service coordination and link clients to resources;
- Tracking completion of mental and physical health goals in client's integrated care plan;
- Coordinating with all team members to ensure all objectives of the integrated care plan are progressing;
- Appointment scheduling;
- Conducting referrals and follow-up monitoring;
- Participating in hospital discharge processes; and
- Communicating with other providers and clients/family.

Health Homes serving children will place particular emphasis on coordination with school officials and care providers, primary care providers, and relevant agencies such as Social Services. Care Coordination will also include tracking of EPSDT needs, well-child check schedules, and dental screening, with appropriate follow-up.

NOTES (Regarding specific service functions in the Care Coordination tables below):

For documentation of Non-Face to Face services: record date and amount of time spent providing non-face to face services (preferably start/stop times), a brief description of the services provided, and team member providing the service and their credentials.

SOC Wraparound Case Management:

- Services can be face to face and non-face to face. Non-face to face contacts, such as written communication and telephone calls are not to become the predominant means of providing comprehensive care management/care coordination services.
- Telephone calls with family members, probation officers, etc. regarding a client are counted. When voice messages are used, the Case Manger must have sufficient documentation justifying a care coordination service was actually provided. Leaving a name and number asking for a return call is not sufficient to count this activity,
- Written communication (including e-mail) and leaving voice messages may be documented as non-face to face functions. Written communication must be about a specific individual and must be documented in the case record with a paper copy of either a mailed letter or e-mail.

Participating in an Appointment – Count all time spent in direct contract with the client/family and or other parties involved in implementing the care plan.

Provider Transportation/Driving – The provider should maintain adequate documentation to demonstrate the cost of travel (mileage logs).

QUALIFIED PROFESSIONALS - Care coordination services are provided by the following professionals and paraprofessionals:

- Nurse Care Manager (RN or LPN);
- Care Coordinator;
- Family Support Provider;
- Youth/Peer Support Specialist; and
- Health Home Director.

Care Coordination							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Clinical Time – Non Face to Face	T2022	HE			• Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face] • Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager), Family Support Provider, or Youth Peer Support Specialist, or Health Home Director
SOC Wraparound Case Management	T1016	HE / HF / HH / HV	HN		• Participating in the creation and update of the Health Passport for every enrolled DHS custody child. [Non-Face to Face] • Ensuring receipt of all recommended EPSDT screens. [Non-Face to Face] • Ensuring that every enrollee is aligned with or linked with a PCP available through the HH, with in the first 3 months of enrollment in HH. [Non-Face to Face] • Consulting with other team member's about client's health status. [Non-Face to Face]	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager)
Medication Reminder	S5185	HE / HF / HH / HV			• Providing a telephone prompt for each client that has at least one or more billable face-to-face services. • Delivery of medication.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager), or Family Support Provider, or Youth/Peer Support Specialist
Wellness Resource Skills Development	T1012	HE/HF			• The process of providing direction and coordinating support activities that promote good physical health.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager), or Family Support Provider, or Youth/Peer Support Specialist

Care Coordination							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
SOC Wraparound Case Management	T1016	HE / HF / HH / HV	HN		• Referral, linkage and advocacy to assist with the implementation of the integrated care plan, including appointment scheduling and arranging transportation. • Monitoring and follow-up activities with treatment or service providers (including intra-agency) for the purposes of monitoring client attendance of scheduled physician/medication, therapy, rehabilitation, or other supportive service appointments. • Follow-up activities with the client to identify any new resource needs or to assist with implementation of the integrated care plan, including making appointment reminders. • Crisis diversion- connecting with the resources needed to avert a clinical crisis. • Ensuring integration and compatibility of mental health and physical health activities. • Tracking completion of mental and physical health goals in client's integrated care plan. • Participating in hospital discharge processes.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager) or Family Support Provider or Youth/Peer Support Specialist
Intra-Agency Clinical Consultation	G9007				• A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager), or Family Support Provider, or Youth/Peer Support Specialist, or Health Home Director

Care Coordination						
Service Title	**Code**	**Modifiers**		**HH Service Functions**	**Notes**	**Team Member**
Participating in an Appointment	T2001	HE		• Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager), or Family Support Provider, or Youth/Peer Support Specialist
Provider Transportation/Driving	A0160			• Time spent driving to do a home visit when the client is not home. • Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent waiting for a client during an appointment or escorting a member to an appointment.	Up to one hour of travel per month per client will be allowed to count towards the minimum monthly service requirement	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager), or Family Support Provider, or Youth/Peer Support Specialist

Health Promotion

Health promotion consists of providing health education specific to the client's chronic condition.

Health promotion will minimally consist of the following, but is not limited to:

- Providing health education specific to client's condition;
- Developing self-management plans with the client;
- Providing support for improving social networks and providing health promoting lifestyle interventions including:
    - Substance use prevention
    - Smoking prevention and cessation
    - Obesity reduction and prevention
    - Nutritional counseling
    - Increasing physical activity

NOTES (Regarding specific service functions in the Health Promotion tables below):

Oral/Injection Medication Administration: Can include time for observation.

Participating in an Appointment – Count all time spent in direct contract with the client/family and or other parties involved in implementing the care plan.

Provider Transportation/Driving – The provider should maintain adequate documentation to demonstrate the cost of travel (mileage logs).

The *Health Risk Appraisal (HRA)* is a preliminary screening that, together with a Health Risk Assessment, helps determine acuity of needs. The HRA may be furnished through an interactive telephonic or web-based program or community encounter with a team member. For children, a HRA should be completed if the Health Risk Checklist identifies red flags. For established (grandfathered) clients, available data should be accessed (SoonerCare provider portal, OKDHS Child Portal, EHR, PCP data) and reviewed for critical health needs, and the HRA must be completed no later than the next care plan update.

QUALIFIED PROFESSIONALS - Health promotion services are provided by the following professionals and paraprofessionals:

- Nurse Care Manager (RN or LPN);
- Primary Care Practitioner PCP; and
- Children's Health Home Specialist.

Health Promotion								
Service Title		**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Wellness Resource Skills Development		T1012	HE/HF			• The process of providing direction and coordinating support activities that promote good physical health. • Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support. • Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]	Count each 15 minutes	PCP, Nurse Care Manager (RN or LPN), or Children's Health Home Specialist
	Tobacco Cessation	T1012	HE/HF	SE				
Intra-Agency Clinical Consultation		G9007				• A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.	Count each 15 minutes	PCP, Nurse Care Manager (RN or LPN), or Children's Health Home Specialist
Clinical Time – Non Face to Face		T2022	HE			• Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face] • Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]	Count each 15 minutes	Nurse Care Manager (Rn or LPN), or Children's Health Home Specialist

Health Promotion								
Service Title			**Code**	**Modifiers**		**HH Service Functions**	**Notes**	**Team Member**
Participating in an Appointment			T2001	HE		• Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Children's Health Home Specialist
Provider Transportation/Driving			A0160			• Time spent driving to do a home visit when the client is not home. • Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent waiting for a client during an appointment or escorting a member to an appointment.	Up to one hour of travel per month per client will be allowed to count towards the minimum monthly service requirement	PCP, or Nurse Care Manager (RN or LPN), or Children's Health Home Specialist
Transitional Case Management	Nurse Care Mgr	T1017	HE / HF / HH / HV	HN	TG	• Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Intensive Care Coordination children ages 0-21).	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Children's Health Home Specialist
	Children's HH Specialist	T1017	HE / HF / HH / HV	HM	TG			
Transitional SOC WraparoundCase Management		T1016	HE / HF / HH / HV	HN	TG	• Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Wraparound children ages 0-21).	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Children's Health Home Specialist
Case Management (Outpatient in an inpatient setting)	Nurse Care Mgr	T1017	HE	HN	HK	• Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for clients age 21 and under if they are in an IMD.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Children's Health Home Specialist
	Children's HH Specialist	T1017	HE	HM	HK			

Health Promotion							
Service Title		**Code**	**Modifiers**		**HH Service Functions**	**Notes**	**Team Member**
Targeted Case Management	Nurse Care Mgr	T1016	HE / HF / HH / HV	HN	• Referral, linkage and advocacy to assist with obtaining and maintaining needed resources, services and supports; including arranging for non-emergency transportation.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Children's Health Home Specialist
	Children's Health Home Specialist	T1016	HE / HF / HH / HV	HM			
Medication Reminder	S5185	HE / HF / HH / HV			• Providing a telephone prompt for each client that has at least one or more billable face-to-face services. • Delivery of medication.	Count each 15 minutes	PCP, Nurse Care Manager (RN or LPN), or Children's Health Home Specialist

Comprehensive Transitional Care

Care coordination services for comprehensive transitional care are designed to streamline plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency room use.

In conducting comprehensive transitional care, the Nurse Care Manager and the Behavioral Health Case Manager will work as co-leads. Their duties include, but are not limited to the following:

- Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home clients;
- Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and
- Motivate hospital staff to notify the Health Home staff of such opportunities.

Care management services must be provided for the purposes of discharge planning and must be translated into the patient care management plan. The care manager must share the client's care plan and coordinate with all of the client's providers to make sure that all needed services are in place to ensure a safe and timely discharge. The client should be actively engaged during the discharge planning process, and care managers should follow up with clients within two (2) business days post-discharge via a home visit, phone call or on-site appointment.

NOTES (Regarding specific service functions in the Comprehensive Transitional Care tables below):

Transitional Case Management – Payment will continue if child enrollee has been admitted to URC, crisis center, residential or community Inpatient setting less than 17 beds, or Inpatient Med/Surgical Hospital. Payment will be made for children in IMD.

QUALIFIED PROFESSIONALS - Comprehensive transitional care services are provided by the following professionals and paraprofessionals:

- Nurse Care Manager (RN or LPN);
- Care Coordinator;
- Family Support Provider; and
- Youth/Peer Support Specialist.

Comprehensive Transitional Care								
Service Title		**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
System Support		G9007				• Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home clients; • Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and • Motivate hospital staff to notify the Health Home staff of such opportunities.	Is not counted as one of the minimum HH billable activities	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager)
Transitional Case Management	Nurse Care Mgr/CC	T1017	HE / HF / HH / HV	HN	TG	• Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Intensive Care Coordination children ages 0-21).	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager) or Family Support Provider or Youth/Peer Support Specialist
	FSP/ Yth/Peer Support Specialist	T1017	HE / HF / HH / HV	HM	TG			
Transitional SOC WraparoundCase Management		T1016	HE / HF / HH / HV	HN	TG	• Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Wraparound children ages 0-21).	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager) or Family Support Provider or Youth/Peer Support Specialist
Case Management (Outpatient in an inpatient setting)	Nurse Care Mgr /CC	T1017	HE	HN	HK	• Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for clients age 21 and under if they are in an IMD.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager) or Family Support Provider or Youth/Peer Support Specialist
	FSP/ Yth/Peer Support Specialist	T1017	HE	HM	HK			

Individual and Family Support Services

Individual and family support services assist individuals in accessing services that will reduce barriers and improve health outcomes, with a primary focus on increasing health literacy, the ability of the client to self-manage their care and facilitate participation in the ongoing revision of their integrated care plan.

Individual and family support services include, but are not limited to:

- Teaching individuals and families self-advocacy skills;
- Providing peer support groups;
- Modeling and teaching how to access community resources;
- Assisting with obtaining and adhering to medications and other prescribed treatments; and
- Identifying resources to support the client in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services.

QUALIFIED PROFESSIONALS - Individual and family support services are provided by the following professionals and paraprofessionals:

- Nurse Care Manager (RN or LPN);
- Care Coordinator;
- Family Support Provider;
- Youth/Peer Support Specialist; and
- Children's Health Home Specialist.

Individual and Family Support Services								
Service Title		**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Wellness Resource Skills Development		T1012	HE/HF			• Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support. • Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Children's Health Home Specialist, or Care Coordinator (Wraparound Facilitator Case Manager) or Family Support Provider or Youth/Peer Support Specialist
	Tobacco Cessation	T1012	HE/HF	SE				
Family Training and Support		T1027	HE / HF / HH / HV			• Provide training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process. • Increase client/family ability to provide a safe and supportive environment in the home and community. • Assist client/family in the acquisition of knowledge and skills necessary to understand and address specific needs in relation to illness and treatment; including understanding crisis plans and plan of care process. • Development and enhancement of specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management. • Training on medications or diagnoses, and interpreting choice offered by service providers.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Children's Health Home Specialist, or Care Coordinator (Wraparound Facilitator Case Manager), or Family Support Provider, or Youth Peer Support Specialist
Medication Training and Support		H0034	HE / HF / HH / HV			• Supportive therapy; Interviews with clients to discuss health concerns and wellness and treatment goals. • Provide education about medications. • Individual care by Nurse Care Manager for clients on their caseload; including monitoring medication compliance and side effects.	Count each 15 minutes	RN Nurse Care Manager

Individual and Family Support Services							
Service Title	**Code**	**Modifiers**			**HH Service Functions**	**Notes**	**Team Member**
Oral/Injection Medication Administration	T1502	HE			• Oral/Injection Medication Administration	Count each 15 minutes	Nurse Care Manager (RN or LPN)

Referral to Community and Social Support Services

Provide clients with referrals to community and social support services in the community.

Providing assistance for clients to obtain and maintain eligibility for the following services as applicable, including but not limited to:

- Healthcare;
- Disability benefits;
- Housing;
- Transportation;
- Personal needs; and
- Legal services.

NOTES (Regarding specific service functions in the Referral to Community and Social Support Services tables below):

Arranging Non-Emergency Transportation – Transportation for a HH enrollee is not included in the rate. SoonerCare contracts with a broker to ensure Non-Emergency Medical Transportation (NMT) and may be available for HH enrollees. Not all SoonerCare members are eligible for SoonerRide (See OAC 317:30-5-327) and not all covered services are eligible. In order to avoid overlap and possible duplication with transportation programs under other federal authorities, SoonerCare does not contract for NET for covered services to schools, day programs and group skills training programs. The service site or a community organization often provides or funds transportation to these activities. The HH should work with the client/family to determine the program that best fits their needs.

It is important to note that SoonerRide NET services must be scheduled with the transportation broker, and that transportation is provided by SoonerRide when medically necessary in connection with examination and treatment to the nearest appropriate facility.

Participating in an Appointment – Count all time spent in direct contract with the client/family and or other parties involved in implementing the care plan.

Provider Transportation/Driving – The provider should maintain adequate documentation to demonstrate the cost of travel (mileage logs).

QUALIFIED PROFESSIONALS- Referral to community and social support services are provided by the following professionals and paraprofessionals:

- Nurse Care Manager (RN or LPN);
- Care Coordinator;
- Family Support Provider; and
- Youth/Peer Support Specialist.

Referral to Community and Social Support Services							
Service Title		**Code**	**Modifiers**		**HH Service Functions**	**Notes**	**Team Member**
Targeted Case Management	Nurse Care Mgr / Care Coordniator	T1016	HE / HF / HH / HV	HN	• Referral, linkage and advocacy to assist with obtaining and maintaining needed resources, services and supports; including arranging for non-emergency transportation.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager), or Family Support Provider, or Youth/Peer Support Specialist
	FSP / Yth/Peer Support Specialist	T1016	HE / HF / HH / HV	HM			
Participating in an Appointment		T2001	HE		• Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.	Count each 15 minutes	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager), or Family Support Provider, or Youth/Peer Support Specialist
Provider Transportation/Driving		A0160			• Time spent driving to do a home visit when the client is not home. • Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent waiting for a client during an appointment or escorting a member to an appointment.	Up to one hour of travel per month per client will be allowed to count towards the minimum monthly service requirement	Nurse Care Manager (RN or LPN), or Care Coordinator (Wraparound Facilitator Case Manager), Family Support Provider, or Youth/Peer Support Specialist

FY 2016 SERVICE FUNCTIONS BY HEALTH HOME TEAM MEMBER

T2022 HE

- Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions. [Non-Face to Face]
- Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines [Non-Face to Face]
- Developing and disseminating reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and cost [Non-Face to Face]
- Monitoring the client's condition (physical, mental, social). Must be part of the integrated care plan. [Non-Face to Face]
- Performing medication reconciliation and overseeing the client's self-management of medications [Non-Face to Face]
- Initially reviewing client records and client history and reviewing and signing off on health assessments. Must be part of the integrated care plan. [Non-Face to Face]
- Consultation with team about identified health conditions of their clients. Must be part of the integrated care plan. [Non-Face to Face]
- Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face]
- Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]

T1012 HE/HF
T1012 HE/HF, SE (Tobacco Cessation)

- Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support.
- Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]
- The process of providing direction and coordinating support activities that promote good physical health.

S5185 HE/HF/HH/HV

- Providing a telephone prompt for each client that has at least one or more billable face-to-face services.
- Delivery of medication.

A0160

- Travel time to and from meetings for the purpose of development or implementation of the individual care plan.
- Time spent driving to do a home visit when the client is not home.
- Time spent waiting for a client during an appointment or escorting a member to an appointment.

T1016 HE/HF/HH/HV, HN

- Referral, linkage and advocacy to assist with the implementation of the integrated care plan, including assistance with obtaining and maintaining needed resources, services and supports; appointment scheduling and arranging for non-emergency transportation.
- Monitoring and follow-up activities with treatment or service providers (including intra-agency) for the purposes of monitoring client attendance of scheduled physician/medication, therapy, rehabilitation, or other supportive service appointments.
- Follow-up activities with the client to identify any new resource needs or to assist with implementation of the integrated care plan, including making appointment reminders.
- Crisis diversion- connecting with the resources needed to avert a clinical crisis.
- Ensuring integration and compatibility of mental health and physical health activities.
- Tracking completion of mental and physical health goals in client's integrated care plan.
- Participating in hospital discharge processes.

G9007

- A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.

T1017 HE/HF/HH/HV, HN, TG

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Intensive Care Coordination children ages 0-21).

T1016 HE/HF/HH/HV, HN, TG

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Wraparound children ages 0-21).

T1017 HE, HN, HK

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for clients age 21 and under if they are in an IMD.

G9007

- Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home clients;
- Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and
- Motivate hospital staff to notify the Health Home staff of such opportunities.

T1027 HE/HF/HH/HV

- Provide training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process.
- Increase client/family ability to provide a safe and supportive environment in the home and community.
- Assist client/family in the acquisition of knowledge and skills necessary to understand and address specific needs in relation to illness and treatment; including understanding crisis plans and plan of care process.
- Development and enhancement of specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management.
- Training on medications or diagnoses, and interpreting choice offered by service providers.

H0034 HE/HF/HH/HV- *(RN Only)*

- Supportive therapy; Interviews with clients to discuss health concerns and wellness and treatment goals.
- Provide education about medications.
- Individual care by Nurse Care Manager for clients on their caseload; including monitoring medication compliance and side effects.

T1502 HE

- Oral/Injection Medication Administration

T2001 HE

- Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.

T1016 HE/HF/HH/HV, HN

- Participating in the creation and update of the Health Passport for every enrolled DHS custody child. [Non-Face to Face]
- Ensuring receipt of all recommended EPSDT screens. [Non-Face to Face]
- Ensuring that every enrollee is aligned with or linked with a PCP available through the HH, with in the first 3 months of enrollment in HH. [Non-Face to Face]
- Consulting with other team member's about client's health status. [Non-Face to Face]

S5190- *(RN Only)*

- Comprehensive Nursing Assessment: Medical dental and other health needs (may include some reconciliation with biometrics obtained by the provider like blood lipids and glucose, blood pressure, etc.).

T2022 HE

- Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions. [Non-Face to Face]
- Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines [Non-Face to Face]
- Developing and disseminating reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and cost [Non-Face to Face]
- Monitoring the client's condition (physical, mental, social). Must be part of the integrated care plan. [Non-Face to Face]
- Performing medication reconciliation and overseeing the client's self-management of medications [Non-Face to Face]
- PCP consultation on best practice protocol. Must be part of the integrated care plan. [Non-Face to Face]

T1012 HE/HF
T1012 HE/HF, SE (Tobacco Cessation)

- The process of providing direction and coordinating support activities that promote good physical health.
- Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support.
- Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]

G9007

- A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.

A0160

- Travel time to and from meetings for the purpose of development or implementation of the individual care plan.
- Time spent driving to do a home visit when the client is not home.

T1001 HE

- Comprehensive Assessment: Health Screening and Assessment for Children – Early Periodic Screening Diagnostic and Treatment (EPSDT) Screening, and Dental Assessment

S5185 HE/HF/HH/HV

- Providing a telephone prompt for each client that has at least one or more billable face-to-face services.
- Delivery of medication.

Psychiatric Consultant

T2022 HE • Monitoring the client's condition (physical, mental, social). Must be part of the integrated care plan. [Non-Face to Face] • Performing medication reconciliation and overseeing the client's self-management of medications [Non-Face to Face] • Psychiatric Consultation. Must be part of the integrated care plan. [Non-Face to Face] **G9007** • A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.	**A0160** • Travel time to and from meetings for the purpose of development or implementation of the individual care plan. • Time spent driving to do a home visit when the client is not home.	

S9482 HE, TF

- Time spent preparing specialty assessment reports (ex: SNCD, Ohio Scales) [Non-Face to Face, Child Teams Only]

T2022 HE

- Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face]
- Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]

T1016 HE/HF/HH/HV, HN

- Comprehensive Assessment: Child Functional Assessment including strengths and needs assessment, Ohio Scales Rating, and assembling a Wraparound team.
- Development of Integrated Care Plan (Child)- Coordination of the Child Health Home teams development of a client directed, integrated active care plan for each enrolled client that reflects input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), and others the client chooses to involve.
- Review of Integrated Care Plan (Child)– Coordination of the Children's Health Home teams review, revision and documentation of the integrated care plan as frequently as the client's condition requires, but no less frequently than every (6) six months.
- (Child) Completion of the Child and Adolescent Trauma Screen (CATS), and if the screen is positive refer to an LBHP to administer the CATS assessment.

T1016 HE/HF/HH/HV, HN – ***Cont'd***

- Participating in the creation and update of the Health Passport for every enrolled DHS custody child. [Non-Face to Face]
- Ensuring receipt of all recommended EPSDT screens. [Non-Face to Face]
- Ensuring that every enrollee is aligned with or linked with a PCP available through the HH, with in the first 3 months of enrollment in HH. [Non-Face to Face]
- Consulting with other team member's about client's health status. [Non-Face to Face]
- Referral, linkage and advocacy to assist with the implementation of the integrated care plan, including assistance with obtaining and maintaining needed resources, services and supports; appointment scheduling and arranging for non-emergency transportation.
- Monitoring and follow-up activities with treatment or service providers (including intra-agency) for the purposes of monitoring client attendance of scheduled physician/medication, therapy, rehabilitation, or other supportive service appointments.
- Follow-up activities with the client to identify any new resource needs or to assist with implementation of the integrated care plan, including making appointment reminders.
- Crisis diversion- connecting with the resources needed to avert a clinical crisis.
- Ensuring integration and compatibility of mental health and physical health activities.
- Tracking completion of mental and physical health goals in client's integrated care plan.
- Participating in hospital discharge processes.

A0160

- Travel time to and from meetings for the purpose of development or implementation of the individual care plan.
- Time spent driving to do a home visit when the client is not home.

S5185 HE/HF/HH/HV

- Providing a telephone prompt for each client that has at least one or more billable face-to-face services.
- Delivery of medication.

T2001 HE

- Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.

A0160

- Travel time to and from meetings for the purpose of development or implementation of the individual care plan.
- Time spent driving to do a home visit when the client is not home.
- Time spent waiting for a client during an appointment or escorting a member to an appointment.

G9007

- Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home clients;
- Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and
- Motivate hospital staff to notify the Health Home staff of such opportunities.

T1017 HE, HN, HK

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for clients age 21 and under if they are in an IMD.

T1027 HE/HF/HH/HV

- Provide training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process.
- Increase client/family ability to provide a safe and supportive environment in the home and community.
- Assist client/family in the acquisition of knowledge and skills necessary to understand and address specific needs in relation to illness and treatment; including understanding crisis plans and plan of care process.
- Development and enhancement of specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management.
- Training on medications or diagnoses, and interpreting choice offered by service providers.

T1012 HE/HF
T1012 HE/HF, SE (Tobacco Cessation)

- Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]
- The process of providing direction and coordinating support activities that promote good physical health.
- Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support.

G9007

- A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.

T1017 HE/HF/HH/HV, HN, TG

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Intensive Care Coordination children ages 0-21).

T1016 HE/HF/HH/HV, HN, TG

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Wraparound children ages 0-21).

T2022 HE

- Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face]
- Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]

S5185 HE/HF/HH/HV

- Providing a telephone prompt for each client that has at least one or more billable face-to-face services.
- Delivery of medication.

T1016 HE/HF/HH/HN, HN

- Referral, linkage and advocacy to assist with the implementation of the integrated care plan, including assistance with obtaining and maintaining needed resources, services and supports; appointment scheduling and arranging for non-emergency transportation.
- Monitoring and follow-up activities with treatment or service providers (including intra-agency) for the purposes of monitoring client attendance of scheduled physician/medication, therapy, rehabilitation, or other supportive service appointments.
- Follow-up activities with the client to identify any new resource needs or to assist with implementation of the integrated care plan, including making appointment reminders.
- Crisis diversion- connecting with the resources needed to avert a clinical crisis.
- Ensuring integration and compatibility of mental health and physical health activities.
- Tracking completion of mental and physical health goals in client's integrated care plan.
- Participating in hospital discharge processes.

T2001 HE

- Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.

A0160

- Travel time to and from meetings for the purpose of development or implementation of the individual care plan.
- Time spent driving to do a home visit when the client is not home.
- Time spent waiting for a client during an appointment or escorting a member to an appointment.

T1017 HE, HM, HK

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for clients age 21 and under if they are in an IMD.

T1012 HE/HF
T1012 HE/HF, SE (Tobacco Cessation)

- The process of providing direction and coordinating support activities that promote good physical health.
- Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support.
- Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]

T1027 HE/HF/HH/HV

- Provide training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process.
- Increase client/family ability to provide a safe and supportive environment in the home and community.
- Assist client/family in the acquisition of knowledge and skills necessary to understand and address specific needs in relation to illness and treatment; including understanding crisis plans and plan of care process.
- Development and enhancement of specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management.
- Training on medications or diagnoses, and interpreting choice offered by service providers.

G9007

- A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.

T1017 HE/HF/HH/HV, HM, TG

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Intensive Care Coordination children ages 0-21).

T1016 HE/HF/HH/HV, HN, TG

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Wraparound children ages 0-21).

T2022 HE

- Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face]
- Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]

S5185 HE/HF/HH/HV

- Providing a telephone prompt for each client that has at least one or more billable face-to-face services.
- Delivery of medication.

T1016 HE/HF/HH/HN, HN

- Referral, linkage and advocacy to assist with the implementation of the integrated care plan, including assistance with obtaining and maintaining needed resources, services and supports; appointment scheduling and arranging for non-emergency transportation.
- Monitoring and follow-up activities with treatment or service providers (including intra-agency) for the purposes of monitoring client attendance of scheduled physician/medication, therapy, rehabilitation, or other supportive service appointments.
- Follow-up activities with the client to identify any new resource needs or to assist with implementation of the integrated care plan, including making appointment reminders.
- Crisis diversion- connecting with the resources needed to avert a clinical crisis.
- Ensuring integration and compatibility of mental health and physical health activities.
- Tracking completion of mental and physical health goals in client's integrated care plan.
- Participating in hospital discharge processes.

T2001 HE

- Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.

A0160

- Travel time to and from meetings for the purpose of development or implementation of the individual care plan.
- Time spent driving to do a home visit when the client is not home.
- Time spent waiting for a client during an appointment or escorting a member to an appointment.

T1017 HE, HM, HK

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for clients age 21 and under if they are in an IMD.

T1012 HE/HF
T1012 HE/HF, SE (Tobacco Cessation)

- The process of providing direction and coordinating support activities that promote good physical health.
- Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support.
- Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]

T1027 HE/HF/HH/HV

- Provide training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process.
- Increase client/family ability to provide a safe and supportive environment in the home and community.
- Assist client/family in the acquisition of knowledge and skills necessary to understand and address specific needs in relation to illness and treatment; including understanding crisis plans and plan of care process.
- Development and enhancement of specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management.
- Training on medications or diagnoses, and interpreting choice offered by service providers.

T1017 HE/HF/HH/HV, HM, TG

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Intensive Care Coordination children ages 0-21).

T1016 HE/HF/HH/HV, HN, TG

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Wraparound children ages 0-21).

G9007

- A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.

T1012 HE/HF
T1012 HE/HF, SE (Tobacco Cessation)

- Completion of the Health Risk Appraisal (HRA)-Wellness plan development; A systematic approach to collecting information from individuals that identifies risk factors, provides individualized feedback, and links the person with at least one intervention to promote health, sustain function and/or prevent disease [Non-Face to Face]
- The process of providing direction and coordinating support activities that promote good physical health.
- Education and support focusing on areas such as nutrition, exercise, tobacco cessation, support with averting or managing physical health concerns like heart disease, diabetes, and cholesterol, and support regarding the effects medications have on physical health. Services can include support groups, and individual physical wellness plan development, implementation assistance and support.

G9007

- A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.

T1016 HE/HF/HH/HV, HN, TG

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Wraparound children ages 0-21).

A0160

- Travel time to and from meetings for the purpose of development or implementation of the individual care plan.
- Time spent driving to do a home visit when the client is not home.
- Time spent waiting for a client during an appointment or escorting a member to an appointment.

T2001 HE

- Sitting in an appointment with a doctor/provider with the client while receiving treatment to assist the client in advocating for their needs or to assist in coordination of care.

T2022 HE

- Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face]
- Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face]

T1017 HE/HF/HH/HV, HM, TG

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility (for Intensive Care Coordination children ages 0-21).

T1017 HE, HM, HK

- Provide referral, linkage and advocacy services needed for successful discharge planning and transition from an inpatient facility for clients age 21 and under if they are in an IMD.

T1016 HE/HF/HH/HV, HM

- Referral, linkage and advocacy to assist with obtaining and maintaining needed resources, services and supports; including arranging for non-emergency transportation.

T1027 HE/HF/HH/HV

- Provide training and support necessary to ensure active participation of the client/family in the treatment planning process and with the ongoing implementation, support and reinforcement of skills learned throughout the treatment process.
- Increase client/family ability to provide a safe and supportive environment in the home and community.
- Assist client/family in the acquisition of knowledge and skills necessary to understand and address specific needs in relation to illness and treatment; including understanding crisis plans and plan of care process.
- Development and enhancement of specific problem-solving skills, coping mechanisms, and strategies for symptom/behavior management.
- Training on medications or diagnoses, and interpreting choice offered by service providers.

S5185 HE/HF/HH/HV

- Providing a telephone prompt for each client that has at least one or more billable face-to-face services.
- Delivery of medication.

T2022 HE • Communicating and coordinating care with external health care providers (pharmacies, PCPs, FQHCs, home health agencies, etc.) and other community service providers utilized by the client. [Non-Face to Face] • Provide education and address questions from patient, family, guardian, and/or caregiver. [Non-Face to Face] **G9007** • A formal and structured process of interaction among staff from the same agency for the purpose of discussion and problem-solving regarding effective utilization of treatment modalities and supports in clinical service provision.		

HEALTH RISK APPRAISAL VS ASSESSMENT

Health Risk Appraisal	Health Risk Assessment
• Brief Screening • May be completed by a variety of designated HH team members • May be self-administered or done electronically • All HH clients must receive within 2 weeks for new enrollees; for grandfathered clients no later than next care plan update • Identifies areas for health and wellness goals • Identifies risk factors; provides individualized feedback • Links client with at least one intervention to promote health	• Full Assessment • Must be completed by an RN or APRN • Only completed if warranted by appraisal (any “flag” on the appraisal would warrant a full assessment) • If warranted, assessment must be completed within 30 days of new enrollee; for grandfathered clients no later than the next care plan update. May be referred to PCP for assessment within 3 months • Identifies medical needs and medical follow up

CLIENT ASSESSMENT RECORD (CAR)

GENERAL INFORMATION

The purpose of the Client Assessment Record (CAR) is to give clinicians a tool to evaluate the functioning level of their customers.

The clinician must have knowledge of the customer's behavior and adjustment to his/her community based on the assessment, and other information. The knowledge must be gained through direct contact (face-to-face interview). It can also include a systematic review of the customer's functioning with individuals who have observed and are acquainted with the customer. *For Health Home, the Case Manager or Care Coordinator can meet with the customer/client face-to-face to collect information for the CAR, but an LBHP or Licensure Candidate must score the CAR. The LBHP or Licensure Candidate is expected to meet face-to-face with the customer/client if there are clinical red flags reflected in the information collected, or further clinical assessment is necessary to determine an accurate score.*

The CAR levels of functioning have been structured within a "normal curve" format, ranging from Above Average Functioning (1-10) to Extreme Psychopathology (50). Pathology begins in the 20-29 range. The CAR format provides a broad spectrum of functioning and permits a range within which customers can be described.

The clinician's rating in each domain needs to based on assessment information: 1) the frequency of the behavior (How often does the behavior occur?); 2) the intensity of the behavior (How severe is the behavior?); 3) duration of the behavior (How long does the behavior last?); and 4) the impact the symptoms/behaviors have on daily functioning, to establish the severity of the customer's current condition.

Only current information is to be rated, not historical information.

CAR DOMAIN DEFINITIONS

1. FEELING/MOOD/AFFECT: Measures the extent to which the person's emotional life is well moderated or out of control.
2. THINKING/MENTAL PROCESS: Measures the extent to which the person is capable of and actually uses clear, well-oriented thought processes. Adequacy of memory and overall intellectual functioning are also to be considered in this scale.
3. SUBSTANCE USE: Measures the extent to which a person's current use of synthetic or natural substances is controlled and adaptive for general well-being and functioning. Although alcohol and illegal drugs are obvious substances of concern, any substance can be subjected to maladaptive use or abuse, especially if compounded by special medical or social situations.
4. MEDICAL/PHYSICAL: Measures the extent to which a person is subject to illness, injury and/or disabling physical conditions, regardless of causation. Demonstrable physical effects of psychological processes are included, but not the effects of prescribed psychotropic medications. Physical problems resulting from assault, rape, or abuse are included.
5. FAMILY: Measures the adequacy with which the customer functions within his/her family and current living situation. Relationship issues with family members are included as well as the adequacy of the family constellation to function as a unit.
6. INTERPERSONAL: Measures the adequacy with which the person is able to establish and maintain interpersonal relationships. Relationships involving persons other than family members should be compared to similar relationships by others of the same age, gender, culture, and life circumstances.

7. ROLE PERFORMANCE**:** Measures the effectiveness with which the person manages the role most relevant to his or her contribution to society. The choice of whether job, school, or home management (or some combination) is most relevant for the person being rated depends on that person's age, gender, culture and life circumstances. If disabled, intellectually, mentally or physically, the client would be scored relative to others with the same disability and in the same situation. Whichever role is chosen as most relevant, the scale is used to indicate the effectiveness of functioning within the role at the present time.
8. SOCIO-LEGAL**:** Measures the extent and ease with which the person is able to maintain conduct within the limits prescribed by societal rules and social mores. It may be helpful to consider this scale as a continuum extending from pro-social to anti-social functioning. *****Other Behavioral Non-Chemical Addictions would be rated here: gambling, internet, pornography, sexual, etc.**
9. SELF CARE/BASIC NEEDS: Measures the adequacy with which the person is able to care for him/herself and provide his/her own needs such as food, clothing, shelter and transportation. If the customer lives in a supportive or dependent situation for reasons other than lack of ability (e.g. confined on criminal sentence), estimate the ability to make arrangements independently and freely. Children, the disabled and elderly persons who are cared for by others should also be rated on their own ability to make arrangements compared to others their age.

LEVEL OF FUNCTIONING RATING SCALE

- **1 - 9 (Above Average):** Functioning in the particular domain is consistently better than that which is typical for age, gender, and subculture, or consistently average with occasional prominent episodes of superior, excellent functioning. Functioning is never below typical expectations for the average person.
- **10 - 19 (Average):** Functioning in the particular domain as well as most people of same age, gender, and subculture. Given the same environmental forces is able to meet usual expectations consistently. Has the ability to manage life circumstances.
- **20 - 29 (Mild to Moderate):** Functioning in the particular domain falls short of average expectation most of the time, but is not usually seen as seriously disrupted. Dysfunction may not be evident in brief or casual observation and usually does not clearly influence other areas of functioning. Problems require assistance and/or interfere with normal functioning.
- **30 - 39 (Moderate to Severe):** Functioning in the particular domain is clearly marginal or inadequate, not meeting the usual expectations of current life circumstances. The dysfunction is often disruptive and self-defeating with respect to other areas of functioning. Moderate dysfunction may be apparent in brief or casual interview or observation. Serious dysfunction is evident.
- **40 - 49 (Incapacitating):** Any attempts to function in the particular domain are marked by obvious failures, usually disrupting the efforts of others or of the social context. Severe dysfunction in any area usually involves some impairment in other areas. Hospitalization or other external control may be required to avoid life-threatening consequences of the dysfunction. Out of control all or most of the time.
- **50 (EXTREME):** The extreme rating for each scale, suggests behavior or situations totally out of control, unacceptable, and potentially life threatening. This score indicates issues that are so severe it would not be generally used with someone seeking outpatient care.

FEELING / MOOD AFFECT

1 – 9 (ABOVE AVERAGE): Anxiety, depression, or disturbance of mood is absent or rare. The person's emotional life is characterized by appropriate cheer and optimism given a realistic assessment of his/her situation. Emotional control is flexible, with both positive and negative feelings clearly recognized and viewed as within his/her control. Reactions to stressful situations are clearly adaptive and time limited.

10 – 19 (AVERAGE): No disruption of daily life due to anxiety, depression or disturbance of mood. Emotional control shows consistency and flexibility. A variety of feelings and moods occur, but generally the person is comfortable, with some degree of pleasant or warm affect. When strong or persistent emotions occur, the object and approximate causes are readily identified.
ADULT: Able to cope, either alone or with the help of others, with stressful situations. Not overwhelmed when circumstances seem to go against him/her. Doesn't dwell on worries; tries to work out problems. Frustration, anger, guilt, loneliness, and boredom are usually transient in nature and resolve quickly. Considers self a worthy person.
CHILD: Not overwhelmed when circumstances seem to go against him/her. Frustration, anger, guilt, loneliness, and boredom are usually transient in nature and resolve quickly. Reactions to stressful events are age appropriate.

20 – 29 (Mild to Moderate): Occasional disruption due to intense feelings. Emotional life is occasionally characterized by volatile moods or persistent intense feelings that tend not to respond to changes in situations. Activity levels may occasionally be inappropriate or there may be disturbance in sleep patterns.
ADULT: Tends to worry or be slightly depressed most of the time. Feels responsible for circumstances but helpless about changing them. Feels guilty, worthless and unloved, causing irritability, frustration and anger.
CHILD: Frustration, anger, loneliness', and boredom persist beyond the precipitating situation. May be slightly depressed and/or anxious MOST OF THE TIME.

30 – 39 (Moderate to Severe): Occasional major (severe) or frequent moderate disruptions of daily life due to emotional state. Uncontrolled emotions are clearly disruptive, affecting other aspects of the person's life. Person does not feel capable of exerting consistent an effective control on own emotional life.
ADULT: The level of anxiety and tension (intense feelings) is frequently high. There are marked frequent, volatile changes in mood. Depression is out of proportion to the situation, frequently incapacitation. Feels worthless and rejected most of the time. Becomes easily frustrated and angry.
CHILD: Symptoms of distress are pervasive and do not respond to encouragement or reassurance. May be moderately depressed and/or anxious most of the time or severely anxious/depressed occasionally.

40 – 49 (Incapacitating): Severe disruption or incapacitation by feelings of distress. Unable to control one's emotions, which affects all of the person's behavior and communication. Lack of emotional control renders communication difficult even if the person is intellectually intact.
ADULT: Emotional responses are highly inappropriate most of the time. Changes from high to low moods make a person incapable of functioning. Constantly feels worthless with extreme guilt and anger. Depression and/or anxiety incapacitate person to a significant degree most of the time.
CHILD: Emotional responses are highly inappropriate most of the time. Reactions display extreme guilt and anger that is incapacitating.

50 (EXTREME): Emotional reactions or their absence appears wholly controlled by forces outside the individual and bears no relationship to the situation.

Scoring Tips:

- When determining if a person scores in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "Unable to control one's emotions, which affects all of the person's behavior and communication."

THINKING/MENTAL PROCESS

This domain refers to the person's intellectual functioning and thought processes only. If there is a lowering of functioning level in either one, please rate the more severe of the two.

1 – 9 (ABOVE AVERAGE): Superior intellectual capacity and functioning. Thinking seems consistently clear, well organized, rational and realistic. The person may indulge in irrational or unrealistic thinking, or fantasy, but is always able to identify it as such, clearly distinguishing it from more rational realistic thought.

10 – 19 (AVERAGE): No evidence of disruption of daily life due to thought and thinking difficulties. Person has at least average intellectual capacity. Thinking is generally accurate and realistic. Judgment is characteristically adequate. Thinking is rarely distorted by beliefs with no objective basis.
ADULT: Capable of rational thinking and logical thought processes. Oriented in all spheres. No memory loss.
CHILD: Intellectual capacity and logical thinking are developed appropriately for age.

20 – 29 (Mild to Moderate): Occasional disruption of daily life due to impaired thought and thinking processes. Intellectual capacity slightly below average ("Dull Normal" to Borderline) and/or thinking occasionally distorted by defensive, emotional factors and other personal features. Poor judgment may occur often, but is not characteristic of the person. Communications may involve misunderstandings due to mild thought disorders. Includes specific impairments of learning or attention and the ability to generalize from acquired knowledge.
ADULT: Borderline retardation; but can function well in many areas. Peculiar beliefs or perceptions may occasionally impair functioning. Occasionally forgetful, but is able to compensate.
CHILD: Bordering retardation or developmentally delayed, but can function well in many areas. Inability to distinguish between fantasy and reality may, on occasion, impair functioning.

30 – 39 (Moderate to Severe): Frequent or consistent interference with daily life due to impaired thinking. Mild to moderate mental retardation and/or frequent distortion of thinking due to emotional and/or other personal factors may occur Frequent substitution of fantasy for reality, isolated delusions, or infrequent hallucinations may be present. Poor judgment is characteristic at this level.
ADULT: Mild to moderate retardation, but can function with supervision. Delusions and/or hallucinations interfere with normal daily functioning. Frequently disoriented as to time, place, or person. Person is unable to remember recent or past events.
CHILD: Mild to moderate retardation. May be preoccupied by unusual thoughts of attachments.

40 – 49 (Incapacitating): Incapacitated due to impaired thought and thinking processes. Severe to profound mental retardation and/or extreme disruption or absence of rational thinking may exist. Delusions or frequent hallucination that the person cannot distinguish from reality may occur. Communication is extremely difficult
ADULT: Unable to function independently. Severely disoriented most of the time. Significant loss of memory.
CHILD: Severely disoriented most of the time. Loss of memory. If speech is present, it may manifest itself in peculiar patterns.

50 (EXTREME): Profound retardation, comatose, or vegetative. No process that would ordinarily be considered "thinking" can be detected, although person may appear to be conscious. Communication is virtually impossible. Extreme catatonia.

NOTE: A score of 40 or more in this domain must include a statement indication the customer's ability to participate in treatment planning and benefit from the OP services requested.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "Severely disoriented most of the time"

SUBSTANCE USE

1 – 9 (ABOVE AVERAGE): All substances are used adaptively with good control. Substances known to be harmful are used sparingly, if at all.

10 – 19 (AVERAGE): No impairment of functioning due to substance use. Substance use is controlled so that it is not apparently detrimental to the person's over-all functioning or well-being. Substances used and amount of use are within commonly accepted range of the person's subculture. Infrequent excesses may occur in situations where such indulges have no serious consequences.
ADULT: No functional impairment noted from any substance use. Reports occasional use of alcohol with no adverse effects.
CHILD: No effects from intake of alcohol drugs, or tobacco other than possible one occurrence of experimentation.

20 – 29 (Mild to Moderate): Occasional or mild difficulties in functioning due to substance use. Weak control with respect to one or more substances. May depend on maladaptive substance use to escape stress or avoid direct resolution of problems, occasionally resulting in increased impairment and/or financial problems.
ADULT: Occasional apathy and/or hostility due to substance use. Occasional difficulty at work due to hangover or using on the job.
CHILD: Occasional incidence of experimentation with alcohol, drugs or other substance with potential adverse effects.

30 – 39 (Moderate to Severe): Frequent difficulties in functioning due to substance use. Has little control over substance use. Lifestyle revolves around acquisition and abuse of one or more substances. Has difficulty on the job, at home and /or in other situations.
ADULT: Needs alcohol, drugs or other substances to cope much of the time, without them, feels upset and irritable. Frequent hangovers/highs or other effects of substance abuse that are causing difficulty on the job, at home and/or other situations.
CHILD: Repeated use of alcohol, drugs, or other substances causing difficulty at home and/or school.

40 – 49 (Incapacitating): Disabled or incapacitated due to substance use. Substance abuse dominates the person's life to the almost total exclusion of other aspects. Serious medical and/or social consequences are accepted as necessary inconveniences. Control is absent, except as necessary to avoid detection of an illegal substance.
ADULT: Major focus on obtaining desired substance. Other functions ignored. Unable to hold job due to use of alcohol, drugs or other substances
CHILD: Unable to function at home or in school due to substance use. Life revolves around obtaining desired substance.

50 (EXTREME): Constantly high or intoxicated with no regard for basic needs or elemental personal safety. May include extreme vegetative existence.

NOTE: The use of substances by family members is recorded in domain #5, as it relates to the family's ability to operate as a functional unit.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "Substance abuse dominated the person's life to the almost total exclusion of other aspects".
- In addition to scoring substance use in this domain, you can also score substance dependence for someone who is not using at this time. Example of this would be- how frequently is someone thinking of using and how does that impact their daily functioning (i.e. if someone is thinking of using all the time, and is participating in 5 AA meetings daily to keep from using- this may be impacting their ability to hold down a job, etc.).

MEDICAL/PHYSICAL

1 – 9 (ABOVE AVERAGE): Consistently enjoys excellent health. Infrequent minor ills cause little discomfort, and are marked by rapid recovery. Physical injury is rare and healing is rapid. Not ill or injured at this time of rating and in good physical condition.

10 – 19 (AVERAGE): No physical problems that interfere with daily life. Generally good health without undue distress or disruption due to common ailments and minor injuries. Any chronic medical/physical condition is sufficiently controlled or compensated for as to cause no more discomfort or inconvenience than is typical for the age. No life-threatening conditions are present.
ADULT: Occasional common colds, fatigue, headaches, gastrointestinal upsets, and common ailments that is endemic in the community. No sensory aids required. No medications.
CHILD: Occasional common ailments. Rapid recovery with no long-term effects. No sensory aids required. No medications.

20 – 29 (Mild to Moderate): Occasional or mild physical problems that interfere with daily living. Physical condition worse than what is typical of age, sex, and culture and life circumstances; manifested by mild chronic disability, illness or injury, or common illness more frequent than most. Includes most persons without specific disability, but frequent undiagnosed physical complaints. Disorders in this range could become life threatening only with protracted lack of care.
ADULT: Controlled allergies. Needs glasses, hearing aid, or other prostheses, but can function without them. Needs medication on a regular basis to control chronic medical problem.
CHILD: Illnesses more frequent than average. Controlled allergies. Needs glasses, hearing aid, or other prostheses, etc.

30 – 39 (Moderate to Severe): Frequent and/or chronic problems with health. Person suffers from serious injury, illness or other physical condition that definitely limits physical functioning (though it may not impair psychological functioning or productivity in appropriately selected roles). Includes conditions that would be life threatening without appropriate daily care. Cases requiring hospitalization or daily nursing care should be rated 30 or above, but many less critical cases may be in this range also.
ADULT: Diabetes, asthma, moderate over/underweight or other evidence of eating disorder. Cannot function without function without glasses, hearing aid or other prostheses. Heavy dependence on medications to alleviate symptoms of chronic illness.
CHILD: Diabetes, asthma, moderate over/underweight or other evidence of eating disorder. Cannot function without glasses, hearing aid, or other prostheses. Physical problems secondary to abuse. Heavy dependence on medication.

40 – 49 (Incapacitating): Incapacitated due to medical/physical health. The person is physically incapacitated by injury, illness, or other physical co9ndition. Condition may be temporary, permanent or progressive, but all cases in this range require at least regular nursing-type care.
ADULT: Medical/physical problems are irreversible and incapacitating. Must have special medication in order to survive.
CHILD: Medical/physical problems are irreversible and incapacitating.

50 (EXTREME): Critical medical/physical condition requiring constant professional attention to maintain life. Include all persons in a general hospital intensive care unit.

NOTE: Include how the medical condition limits the customer's day-to-day function for score of 20 and above.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "but all cases in this range require at least regular nursing-type care".
- When determining if a person scored in the 30-39 range, please note that just having Diabetes, Asthma, etc. does not automatically equate a score in this range. In addition, symptoms/condition "definitely limits physical functioning".

FAMILY

1 – 9 (ABOVE AVERAGE): Family unit functions cohesively with strong mutual support for its members. Individual differences are valued.

10 – 19 (AVERAGE): Major conflicts are rare or resolved without great difficulty. Relationships with other family members are usually mutually satisfying.

*****DEFAULT TO AVERAGE RATING IF ADULT HAS NO FAMILY OR LACK OF FAMILY CONTACT. Feelings about lack of contact would be noted in domain #1*****

ADULT: Primary relationships are good with normal amount of difficulties. Feels good with family relationships and secure in parent role. Destructive behavior among family members is rare.
CHILD: Conflicts with parents or siblings are transient; family is able to resolve most differences promptly. Parenting is supportive and family is stable.

20 – 29 (Mild to Moderate): Relationships within the family are mildly unsatisfactory. May include evidence of occasional violence among family members. Family disruption is evident. Significant friction and turmoil evidenced, on some consistent basis, which is not easily resolved.
ADULT: Family difficulties such that client occasionally thinks of leaving. Some strife with children.
CHILD: Problems with parents or other family members are persistent, leading to generally unsatisfactory family life. Evidence of recurring conflict or even violence involving adults and children.

30 – 39 (Moderate to Severe): Occasional major or frequent minor disruption of family relationships. Family does not function as a unit. Frequent turbulence and occasional violence involving adults and children.
ADULT: Turbulent primary relationship or especially disturbing break-up. Adult rage and/or violence directed toward each other or children.
CHILD: Family inadequately supportive of child. Constant turmoil and friction. Family unit is disintegrating.

40- 49 (Incapacitating): Extensive disruption of family unit. Relationships within family are either extremely tenuous or extremely destructive.
ADULT: Not capable of forming primary relationships. Unable to function in parenting role. Abusive or abused.
CHILD: Isolated. Lacking family support. Abused or neglected.

50 (EXTREME): Total breakdown in relationships within family. Relationships that exist are physically dangerous or psychologically devastating.

NOTE: For adults, note and score current, ACTIVE family problems only. For children report and score the behavior of the current family as it affects the child.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is “incapacitating”. A good guide for this is “Abusive or abused” for adults, and “Abused or neglected” for children.
- Score only the current family system (in the last 30 days). Family system can include anyone that the person identifies as family (ex: common law husband/wife might be scored here). Please note that if someone is identified and scored as family, they should not be included and scored again under domain 6. Interpersonal.

INTERPERSONAL

1 – 9 (ABOVE AVERAGE): Relationships are smooth and mutually satisfying. Conflicts that develop are easily resolved. Person is able to choose among response styles to capably fit into a variety of relationships. Social skills are highly developed.
ADULT: Has wide variety of social relationships and is sought out by others.
CHILD: Social skills highly developed for age.

10 – 19 (AVERAGE): Interpersonal relationships are mostly fruitful and mutually satisfying. Major conflicts are rare or resolved without great difficulty. The person appears to be held in esteem within his or her culture.
ADULT: Good relationship with friends. Forms good working relationships with co-worker.
CHILD: Client is able to relate well to peers or adults without persistent difficulty.

20 – 29 (Mild to Moderate): Occasional or mild disruption of relationships with others. Relationships are mildly unsatisfactory although generally adequate. May appear lonely or alienated although general functioning is mostly appropriate.
ADULT: Some difficulty in developing or keeping friends. Problems with co-workers occasionally interfere with getting work done.
CHILD: Some difficulty in forming or keeping friendships. May seem lonely or shy.

30 – 39 (Moderate to Severe): Occasional major or frequent disruption of interpersonal relationships. May be actively disliked or virtually unknown by many with whom there is daily contact. Relationships are usually fraught with difficulty.
ADULT: Has difficulty making and keeping friends such that the relationships are strained or tenuous. Generally rejects or is rejected by co-workers; tenuous job relationships.
CHILD: Unable to attract friendships. Persistent quarreling or social withdrawal. Has not developed age social skills.

40 – 49 (Incapacitating): Serious disruption of interpersonal relationships or incapacitation of ability to form relationships. No close relationships; few, if any, casual associations which are satisfying.
ADULT: Socially extremely isolated. Argumentative style or extremely dependent style makes work relationships virtually impossible.
CHILD: Socially extremely isolated. Rejected, unable to attach to peers appropriately.

50 (EXTEME): Relationship formation does not appear possible at the time of the rating.

NOTE: Relationships with family members are reported in domain #5.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is “incapacitating”. A good guide for this is “No close relationships”.
- This domain scores only the person’s ability to make and maintain relationships outside of the family system- not the type of people they choose to have relationships with. If they are maintaining relationships with people who are getting them into trouble/putting them at risk, this may be a consideration for poor judgment when scoring in domain #2.

ROLE PERFORMANCE

1 – 9 (ABOVE AVERAGE): The relevant role is managed in a superior manner. All tasks are done effectively at or before the time expected. The efficiency of function is such that most of the tasks appear easier than for others of the same age, sex, culture, and role choice.

10 – 19 (AVERAGE): Reasonably comfortable and competent in relevant roles. The necessary tasks are accomplished adequately and usually within the expected time. There are occasional problems, but these are resolved and satisfaction is derived from the chosen role.
ADULT: Holds a job for several years, without major difficulty. Student maintains acceptable grades with minimum of difficulty. Shares responsibility in childcare. Home chores accomplished.
CHILD: Maintains acceptable grades and attendance. No evidence of behavior problems.

20 – 29 (Mild to Moderate): Occasional or mild disruption of role performance. Dysfunction may take the form of chronic, mild overall inadequacy or sporadic failures of a more dramatic sort. In any case, performance often falls short of expectation because of lack of ability or appropriate motivation.
ADULT: Unstable work history. Home chores frequently left undone; bills paid late.
CHILD: Poor grades in school. Frequent absences. Occasional disruptive behavior at school.

30 – 39 (Moderate to Severe): Occasional major or frequent disruption of role performance. Contribution in the most relevant role is clearly marginal. Client seldom meets usual expectations and there is a high frequency of significant consequences, i.e. firing, suspension.
ADULT: Frequently in trouble at work, or frequently fired. Home chores ignored; some bills defaulted.
CHILD: Expelled from school. Constantly disruptive and unable to function in school.

40 – 49 (Incapacitating): Severe disruption of role performance due to serious incapacity or absent motivation. Attempts, if any, at productive functioning are ineffective and marked by clear failure.
ADULT: Client not employable. Is unable to comply with rules and regulations or fulfill ANY of the expectations of the client's current life circumstance.
CHILD: Expelled from school. Constantly disruptive and unable to function in school.

50 (EXTREME): Productive functioning of any kind is not only absent, but also inconceivable at the time of rating.

NOTE: Identify and assess only the customer's primary role. Family role would be described in domain #5. If residing in an RCF, RCF resident would be considered the primary role. Score functioning relative to others in the same life circumstance.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "Attempts, if any, at productive functioning are ineffective and marked by clear failure".

SOCIO-LEGAL

1 – 9 (ABOVE AVERAGE): Almost conforms to rules and laws with ease, abiding by the "spirit" as well as the "letter" of the law. Any rate deviations from rules or regulations are for altruistic purposes.

10 – 19 (AVERAGE): No disruption of socio-legal functioning problems. Basically a law-abiding person. Not deliberately dishonest, conforms to most standards of relevant culture. Occasional breaking or bending of rules with no harm to others.
ADULT: No encounters with the law, other than minor traffic violations.
CHILD: Generally conforms to rules. Misbehavior is non-repetitive, exploratory or mischievous.

20- 29 (Mild to Moderate): Occasional or mild disruption of socio-legal functioning. Occasionally bends or violates rules or laws for personal gain, or convenience, when detection is unlikely and personal harm to others is not obvious. Cannot always be relied on; may be in some trouble with the law or other authority more frequently than most peers; has no conscious desire to harm others.
ADULT: Many traffic tickets. Creates hazard to others through disregard of normal safety practices.
CHILD: Disregards rules. May cheat or deceive for own gain

30 – 39 (Moderate to Severe): Occasional major or frequent disruption of socio-legal functioning. Conforms to rules only when more convenient or profitable than violation. Personal gain outweighs concern for others leading to frequent and/or serious violation of laws and other codes. May be seen as dangerous as well as unreliable.
ADULT: Frequent contacts with the law, on probation, or paroled after being incarcerated for a felony. Criminal involvement. Disregard for safety of others.
CHILD: Unable to consider rights of others at age appropriate level. Shows little concern for consequences of actions. Frequent contact with the law. Delinquent type behaviors.

40 – 49 (Incapacitating): Serious disruption of socio-legal functioning. Actions are out of control without regard for rules and law. Seriously disruptive to society and/or pervasively dangerous to the safety of others.
ADULT: In confinement or imminent risk of confinement due to illegal activities. Imminent danger to others or property.
CHILD: In confinement or imminent risk of confinement due to delinquent acts.

50 (EXTREME): Total uncontrolled or antisocial behavior. Socially destructive and personally dangerous to almost all unguarded persons.

NOTE: Since danger to others is a clear component of scores of 30 and over, a clear statement as to the customer's danger to others must be included in the request.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "In confinement or imminent risk of confinement" due to illegal activities/ delinquent acts.

SELF CARE/BASIC NEEDS

1 – 9 (ABOVE AVERAGE): Due to the fundamental nature of this realm of behavior, "above average" may be rated only where needs can be adequately and independently obtained in spite of some serious obstacle such as extreme age, serious physical handicap, severe poverty or social ostracism.

10 – 19 (AVERAGE): Customer is able to care for self and obtain or arrange for adequate meeting of all basic needs without undue effort.
ADULT: Able to obtain or arrange for adequate housing, food, clothing and money without significant difficulty. Has arranged dependable transportation.
CHILD: Able to care for self as well as most children of same age and developmental level.

20 – 29 (Mild to Moderate): Occasional or mild disruption of ability to obtain or arrange for adequate basic needs. Disruption is not life threatening, even if continued indefinitely. Needs can be adequately met only with partial dependence on illegitimate means, such as stealing, begging, coercion or fraudulent manipulation.
ADULT: Occasional assistance required in order to obtain housing, food and/or clothing. Frequently has difficulty securing own transportation. Frequently short of funds.
CHILD: More dependent upon family or others for self care than would be developmentally appropriate for age.

30 – 39 (Moderate to Severe): Occasional major or frequent disruption of ability to obtain or arrange for at least some basic needs. Include denial of need for assistance or support, meeting needs wholly through illegitimate means. Unable to maintain hygiene, diet, clothing and/or prepare food.
ADULT: Considerable assistance required in order to obtain housing, food and/or clothing. Consistent difficulty in arranging for adequate finances. Usually depends on others for transportation. May need assistance in caring for self.
CHILD: Ability to care for self considerably below age and developmental expectation.

40 – 49 (Incapacitating): Severe disruption of ability to independently meet or arrange for the majority of basic needs by legitimate or illegitimate means. Unable to care for self in a safe and sanitary manner.
ADULT: Housing, food and/or clothing must be provided or arranged for by others. Incapable of obtaining any means of financial support. Totally dependent on others for transportation.
CHILD: Cannot care for self. Extremely dependent for age and developmental level.

50 (EXTREME): Person totally unable to meet or arrange for any basic needs. Would soon die without complete supportive care.

NOTE: When rating a child in this domain, rate on child's functioning only, without regard to adequacy of parent's provisions for basic needs. The developmental level of the child must also be considered.

Scoring Tips:

- When determining if a person scored in the 40-49 range, remember that symptoms must be at a level that is "incapacitating". A good guide for this is "Severe disruption of ability to independently meet or arrange for the majority of basic needs by legitimate or illegitimate means".

CAR LEVELS

PREVENTION AND RECOVERY MAINTENANCE
CAR Scores must be listed
LEVEL ONE
CAR Scores (a minimum of the following): a. 20-29 in 4 domains (Domains 1-9); or b. 30-39 in 2 domains (Domains 1-9); or 20-29 in 3 domains and 30-39 in 1 or more domains (Domains 1-9).
LEVEL TWO
CAR Scores (a minimum of the following): a. 30-39 in 3 domains (Domains 1-9); or 40-49 in 1 domain (Domains 1-9).
LEVEL THREE
CAR Scores (a minimum of the following): a. 30-39 in 4 domains with 2 domains being in 1, 6, 7, or 9 (Domains 1-9); or b. 40-49 in 2 domains with 1 domain in 1, 6, 7, or 9 (Domains 1-9); or 30-39 in 2 domains and 40-49 in 1 domain with either the 40 or 2 of the 30's being in domains 1, 6, 7, or 9
LEVEL FOUR
CAR Scores (a minimum of the following): Adult- a. 40 in 4 domains, with 1 being 1, 6, 7, or 9 Child- a. 40 in 3 domains, with 1 being in 1, 6, 7, or 9

CAR TRAINING AND TECHNICAL ASSISTANCE

Web-based Client Assessment Record (CAR) training can be located at http://ok.gov/odmhsas/ under "Quick Links". Click on "ODMHSAS E-Learning Module", and follow the instructions to either log in to Access Control or create a new Access Control account. Once signed in, you will have access to the CAR training. There are two (2) separate training modules that must be completed for the CAR: "CAR Module 1" which is completed first, and then "CAR Completion". Once you have successfully completed the quiz for the "CAR Completion" training module, you will be able to print out a training certificate. The training is approved for one (1) CEU.

If you have questions about administering and/or scoring the CAR, please contact Jacki Millspaugh at jmillspaugh@odmhsas.org or (405) 522-3863.

HEALTH HOME
PRIOR AUTHORIZATION

Current Agency Client- If the client to be enrolled in the HH program is already receiving outpatient behavioral health services at the agency, HH services can be authorized in one of two ways:

- By revising the CDC of the current prior authorization (PA) to add HH under Secondary Referral (60 – Moderate, 61 – High Intensity).
- By submitting a new PA request for outpatient services and including HH under Secondary Referral (60 – Moderate, 61 – High Intensity).

New Client- If the client to be enrolled in the HH program is new to the agency, HH services can be authorized as follows:

- By submitting a PA request for outpatient services and including HH under Secondary Referral (60 – Moderate, 61 – High Intensity).

Things to Note-

- If a client is enrolled in HH, any future authorizations to continue services will require one of the following listed under Secondary Referral: for continued HH a 60 – Moderate or 61 - High Intensity; to discontinue HH and continue with a standard outpatient authorization a 62 – Opt Out. The exception to that is for instant authorizations and the PG033- they will not require the HH Secondary Referral.
- Clients under the age of 21 that are enrolled using referral code 60 or 61 will be placed in the Children's HH if criteria has been met. If the individual wishes to be in an adult HH, use the referral code 63 (Moderate for adults 18-20) or 64 (High for adults 18-20).
- It is the provider's responsibility to ensure that the client meets all Medical Necessity Criteria for any HH level they request.
- SMI must be checked on the CDC for adults, and SED must be checked for children.
- When the HH PA is acquired, a standard outpatient PA is also issued for the Level of Care identified. They are two separate PAs with two separate financial caps. Some services can be provided under the standard outpatient PA; in conjunction with services provided under the HH PA (see Limitations above for excluded services).
- <u>Collaborating with Other Agencies:</u> As there is a standard outpatient PA, in addition to the HH PA, collaboration with another agency regarding that outpatient PA can occur- only the financial cap for the outpatient PA would be shared. If a HH provider wants to collaborate with another agency on the provision of HH Core Services, the HH provider would be responsible for payment to the collaborating agency for HH services.
- If once an HH PA is acquired and the client loses TXIX, the system will deny the monthly HH Core Services code/rate. However, any service functions submitted (intended for HH reporting) will waterfall to ODMHSAS for payment under the outpatient service PA for providers with ODMHSAS contracts (it will <u>not</u> waterfall for agencies without ODMHSAS contracts). Since the HH reporting codes may be matched with HH service functions that are not in line with that codes allowed usage under standard outpatient rules, providers will need to watch TXIX eligibility closely.
- A HH PA can be ended in one of two ways:
  - Through the entry of a formal discharge; or
  - Through revising the CDC for the existing PA, changing the Secondary Referral to 62 – Opt Out.
- If a client is transitioning from one HH program, to a HH program at another agency, the initial HH agency would need to end their HH PA by revising the CDC Secondary Referral to 62 – Opt Out. The New HH agency will not be able to admit/enroll until this occurs.

HEALTH HOME RATE SHEET

PRIOR TO HH ENROLLMENT			
HEALTH HOME OUTREACH AND ENGAGEMENT			
Health Home Outreach & Engagement		G9001	$53.98 / Per Month
HEALTH HOME INITIAL ASSESSMENT AND PLAN DEVELOPMENT (NON-PACT)			
Adult			
BH Assessment (Non-MD) Low Complexity (Minimum of 1 ½ Hours)		H0031 HE/HF/HV/HH, TF	$79.03 / Per Event
	Telemedicine	H0031 HE/HF/HV/HH, TF, GT	$79.03 / Per Event
BH Assessment (Non-MD) Moderate Complexity (Minimum of 2 Hours)		H0031 HE/HF/HV/HH	$105.38 / Per Event
	Telemedicine	H0031 HE/HF/HV/HH, GT	$105.38 / Per Event
BH Service Plan Development Low Complexity		H0032 HE/HF/HV/HH, TF	$54.42 / Per Event
	Telemedicine	H0032 HE/HF/HV/HH, TF, GT	$54.42 / Per Event
BH Service Plan Development Moderate Complexity		H0032 HE/HF/HV/HH	$87.07 / Per Event
	Telemedicine	H0032 HE/HF/HV/HH, GT	$87.07 / Per Event
Child			
BH Assessment (Non-MD) Low Complexity (Minimum of 1 ½ Hours)		H0031 HE/HF/HV/HH, TF	$82.98 / Per Event
	Telemedicine	H0031 HE/HF/HV/HH, TF, GT	$82.98 / Per Event
BH Assessment (Non-MD) Moderate Complexity (Minimum of 2 Hours)		H0031 HE/HF/HV/HH	$110.64 / Per Event
	Telemedicine	H0031 HE/HF/HV/HH, GT	$110.64 / Per Event
BH Service Plan Development Low Complexity		H0032 HE/HF/HV/HH, TF	$57.16 / Per Event
	Telemedicine	H0032 HE/HF/HV/HH, TF, GT	$57.16 / Per Event
BH Service Plan Development Moderate Complexity		H0032 HE/HF/HV/HH	$91.44 / Per Event
	Telemedicine	H0032 HE/HF/HV/HH, GT	$91.44 / Per Event
HEALTH HOME INITIAL SCREENING, ASSESSMENT AND PLAN DEVELOPMENT (PACT)			
Screening		T1023 HE/HF/HV/HH	$55.80 / Per Event
ACT, F2F (Assessment & Plan)		H0039 HE/HF/HV/HH	$32.11 / 15 minutes

AFTER HH ENROLLMENT			
HEALTH HOME CORE SERVICES			
Adult			
Urban	Moderate Intensity (PRM, or Levels 1-3)	G9002	$127.35 / Per Month
	High Intensity (Level 4)	G9005	$453.96 / Per Month
Rural	Moderate Intensity (PRM, or Levels 1-3)	G9002TN	$146.76 / Per Month
	High Intensity (Level 4)	G9005	$453.96 / Per Month
Child			
Urban	Moderate Intensity (Level 3)	G9009	$297.08 / Per Month
	High Intensity (Level 4)	G9010	$864.82 / Per Month
Rural	Moderate Intensity (Level 3)	G9009TN	$345.34 / Per Month
	High Intensity (Level 4)	G9010TN	$1,009.60 / Per Month

HEALTH HOME QUALITY MEASURES

IMPROVED HEALTH OUTCOMES					
Domain	**Measures**	**Data Source**	**Specifications**	**Populations**	**HIT Utilization**
Clinical Outcomes	Ambulatory Care – Sensitive Condition Admission	Claims	Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years Denominator: Total mid-year population under age 75	Behavior Health/Substance Abuse/Chronic Care	Claims Data
Clinical Outcomes	Plan – All Cause Readmission	Claims	Numerator: Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination Denominator: Count the number of index Hospital Stays for each age, gender, and total combination	Behavior Health/Substance Abuse/Chronic Care	Claims Data
Clinical Outcomes	Percentage of clients who were prescribed lipid-lowering therapy.	Claims	Numerator: Clients from the denominator who were prescribed lipid lowering therapy Denominator: All clients with coronary artery disease (CAD)	Behavior Health/Substance Abuse/Chronic Care	Claims Data
Clinical Outcomes	Percent of outpatients with a diagnosis of hypertension (uncomplicated) on antihypertensive multi-drug therapy where the regimen includes a thiazide diuretic.	Claims	Numerator: Number of unique outpatients with a diagnosis of hypertension (uncomplicated) on antihypertensive multi-drug therapy with an active prescription for a thiazide diuretic Denominator: Number of unique outpatients with a diagnosis of hypertension (uncomplicated) on antihypertensive multi-drug therapy	Behavior Health/Substance Abuse/Chronic Care	Claims Data

Domain	Measures	Data Source	Specifications	Populations	HIT Utilization
Clinical Outcomes	The percentage of youth who show improvement in functioning	Claims	Numerator: Number of clients with improved functioning on Ohio Scales Denominator: Number of clients less than 18 years of age	Behavior Health/Substance Abuse/Chronic Care	Youth Information System (YIS)
Clinical Outcomes	Percent of youth with a reduction in self harm attempts	Claims	Numerator: Number of clients with a reduction in arrests on Ohio Scales Denominator: Number of clients less than 18 years of age	Behavior Health/Substance Abuse/Chronic Care	Youth Information System (YIS)
Clinical Outcomes	Percent of youth with a reduction in arrests	Claims	Numerator: Number of clients with a reduction in self harm attempts on Ohio Scales Denominator: Number of clients less than 18 years of age	Behavior Health/Substance Abuse/Chronic Care	Youth Information System (YIS)
Clinical Outcomes	Percent of youth with reduction in contacts with law enforcement	Claims	Numerator: Number of clients with a reduction in contacts with law enforcement on Ohio Scales Denominator: Number of clients less than 18 years of age	Behavior Health/Substance Abuse/Chronic Care	Youth Information System (YIS)
Clinical Outcomes	Percent of youth with a reduction in days absent from school	Claims	Numerator: Number of clients with a reduction in days absent from school on Ohio Scales Denominator: Number of clients less than 18 years of age	Behavior Health/Substance Abuse/Chronic Care	Youth Information System (YIS)
Clinical Outcomes	Percent of youth with a reduction in days suspended from school	Claims	Numerator: Number of clients with a reduction in days suspended from school on Ohio Scales Denominator: Number of clients less than 18 years of age	Behavior Health/Substance Abuse/Chronic Care	Youth Information System (YIS)

IMPROVED PREVENTIVE CARE					
Domain	**Measures**	**Data Source**	**Specifications**	**Populations**	**HIT Utilization**
Quality of Care	Adult BMI Assessment	EMRs	Numerator: Body mass index documented during the measurement year or the year prior to the measurement year Denominator: Clients 18-74 years of age who had an outpatient visit	Behavior Health/Substance Abuse/Chronic Care	EMR
Quality of Care	Percent of children and adolescents with a documented weight assessment (BMI)	EMRs	Numerator: Children in the denominator population who had evidence of Body Mass Index (BMI) documentation during the measurement year Denominator: Children 3-17 years of age who had an outpatient visit with a PCP or OB-GYN during the measurement year; Continuous enrollment- the measurement year	Behavior Health/Substance Abuse/Chronic Care	EMR
Quality of Care	Percentage of clients age 18 years or older screened for clinical depression using a standardized tool AND follow-up documented	Claims	Numerator: Total number of clients from the denominator who have follow-up documentation Denominator: All clients 18 years or older screened for clinical depression using a standardized tool	Behavior Health/Substance Abuse/Chronic Care	Claims Data
Quality of Care	Percentage of women 50 to 69 years of age screened in the past two years for breast cancer	Claims	Numerator: Women with evidence of a mammography performed in the past two years Denominator: Women age 50 to 69 at the time of the qualifying visit	Behavior Health/Substance Abuse/Chronic Care	Claims Data

Domain	Measures	Data Source	Specifications	Populations	HIT Utilization
Quality of Care	Percent of women age 21 to 64 screened for cervical cancer in the past three years	Claims	Numerator: Women age 24 to 64 screened for cervical cancer in the past three years Denominator: Woman age 24 to 64 at the time of the qualifying visit	Behavior Health/Substance Abuse/Chronic Care	Claims Data

IMPROVED COORDINATION OF CARE					
Domain	**Measures**	**Data Source**	**Specifications**	**Populations**	**HIT Utilization**
Quality of Care	Care Transition – Transition Record Transmitted to Healthcare Professional	EMR Docum-entation	Numerator: Clients for whom a transition record was transmitted to the facility or primary physician or other healthcare professional designated for follow-up care within 24 hours of discharge Denominator: All clients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care	Behavior Health/Substance Abuse/Chronic Care	EMR
Quality of Care	Follow-up After Hospitalization for Mental Illness	Claims	Numerator: An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation, for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Denominator: Clients 6 years of age and older discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year. This measure does not include discharge due to death.	Behavior Health/Substance Abuse/Chronic Care	Claims Data

Domain	Measures	Data Source	Specifications	Populations	HIT Utilization
Quality of Care	Initiation of Engagement of Alcohol and Other Drug Dependence Treatment	Claims	Numerator: Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Clients with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization with 14 days of diagnosis Numerator: Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. Denominator: Clients 13 years of age and older as of December 31 of the measurement year with a new episode of alcohol or other drug (AOD) during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.	Behavior Health/Substance Abuse/Chronic Care	Claims Data
Quality of Care	The percentage of plans of care that meet Wraparound Fidelity Index parameters	National Wrap-around Initiative Wrap-around Fidelity Index	Numerator: The number of plans of care that meet WFI parameters Denominator: All HH comprehensive care plans for children with SED with the most complex needs	Behavior Health/Substance Abuse/Chronic Care	Youth Information System (YIS)

HEALTH HOME FREQUENTLY ASKED QUESTIONS (FAQs)

CAR

- **Can a Care Coordinator/Case Manager do the CAR scores?** *For Health Home, the Case Manager or Care Coordinator can meet with the customer/client face-to-face to collect information for the CAR, but an LBHP or Licensure Candidate must score the CAR. The LBHP or Licensure Candidate is expected to meet face-to-face with the customer/client if there are clinical red flags reflected in the information collected, or further clinical assessment is necessary to determine an accurate score.*

Eligibility

- **After July 1, 2015 will non-Medicaid children be eligible for HH bundled services? For example, would a family with private insurance be eligible?** They would be eligible, but it is unlikely that private insurance will pay.

- **Are adults with a secondary insurance of Medicaid eligible for HH services?** Yes they are eligible, but according to Third Party Liability rules, providers must submit the claim to private insurance first and receive a denial before Medicaid will pay.

- **As individuals lose and regain Medicaid eligibility, will they be re-enrolled in the same health home?** As long as there is an active PA, the client will remain in the HH.

- **Many children have dual eligibility, with Medicaid being secondary. Are they eligible for HH?** Yes.

- **Will dual Medicaid and Medicare adults be enrolled?** Yes.

- **Will a provider have to offer HH with no Medicaid funding?** No, although it would be a good thing if the HH had an alternative way to fund those services.

General Billing

- **If a client is receiving Fee For Service (FFS) and then on the last day of the month they enroll in HH, and the G code is billed, will the FFS payments for that month be recouped?** No, the G code goes along with the HH PA.

- **How many of the bundled services do we have to provide before we can bill the child G code for kids?** Pursuant to OAC 317:30-5-251, The G code can be billed after one bundled service is provided. To ensure that the clients are receiving the appropriate level and intensity of care coordination, the Health Home should have data reporting mechanisms in place to track the amount of care coordination activities provided across the Health Home's panel of clients.

General Prior Authorization (PA)

- **If a client gets one level of HH but it's decided they need to be in a different level, do we do a PA change request?** Request a new PA

- **If two providers are both seeing a Medicaid client in the same service area, and they are both HHs, which provider gets to enroll the client?** The client will be on both provider's lists, but the client will have the choice of where to enroll.

- **If a HH client needs to be transferred to a crisis unit, and that crisis unit is a program of the same provider who has the HH, does the client have to be opted out of the HH program?** The system current allows HH members to go into a crisis unit without interrupting the HH segments. To do this, a provider submits a Level of Care change requesting the crisis level of care, and does NOT put a secondary referral of HH (otherwise the system thinks you are trying to add the HH payment to the crisis PA). The system will keep the outpatient PA with the HH open, and create a crisis PA. The same works for all other DH authorizations and the PG033, PG051 and the PG059. When submitting anyone of these authorizations you can just leave the secondary referral blank and it will keep the HH eligibility open.

HH Reports

- **Are there PICIS reports for HH?** Yes, in PICIS you will go to Reports and then Health Home Reports. Examples of reports available: Eligible Locations; Managing HH Eligibility Locations; Health Home Shadow Billing Extract; Active Health Home Customers; and Open Customers Eligible for Health Homes.

HH Team Composition

- **Do we need to formally change all of our staff titles to the designated HH titles?** No, there is no need to change job titles.

- **Under Adult Health Home Teams, the definition for Hospital Liaison/Health Home Specialist refers "complete trainings as required by ODMHSAS", what trainings does this refer to?** Trainings in development. ODMHSAS will notify HH providers of upcoming trainings.

- **Under Children's Health Home Teams, can the Youth/Peer Support Specialist be an existing PRSS?** Yes, it can be an existing PRSS. It tends to work better if the existing PRSS is a younger adult. **Will there be any PRSS trainings available that are specific to working with youth in a peer capacity?** Yes, training is currently being developed.

Hospitalization

- **If a current HH client is hospitalized, can HH services and billing continue?** Yes, if the client is not inpatient for the entire month and other services such as care transition occur while the client is in the hospital.

Integrated Care Plan

- **Does the PCP consultant have to sign every treatment plan?** No. Behavioral health staff and the PCP should work off of a single treatment plan, interact regularly, and have an integrated medical record. A sign off to every treatment plan may be difficult if the PCP is not

co-located. The CM/Care Coordinator coordinate the development (and review/revision), and typically sign off on the Integrated Care Plan as the team lead. Therefore in either HH model, team findings must be communicated in the integrated care plan. The PCP should sign and/or be actively involved in the integrated care plan that involves psychotropic drugs through the EHR. There must be an easy and efficient way to report back to the physician about several factors: that the client was seen, the diagnosis, the integrated care plan and any other pertinent information. When treatment has been completed, or the client has terminated prematurely, communication also needs to be made with the physician through a convenient method.

Nurse Care Manager

- **Does the Nurse Care Manager have to be an RN?** A Nurse Care Manager can be an LPN, but they cannot do everything that a RN can do in a HH, under state law. The HH may have a mix of moderate to high risk clients that may require the skill level of an RN. If a HH is using an LPN, they may also have to make arrangements for an RN to do various functions.

- **Will the nurses that are a part of the HH be required to attend Wrap 101 trainings?** No, but it is highly recommended.

Ohio Scales

- **What type of permission do HH providers need for the Ohio Scales?** There is a nominal charge to use Ohio Scales. The ODMHSAS pays that fee for statewide usage in our Systems of Care, so individual agencies will not have to pay in order to use.

Outreach & Engagement

- **If we are discussing HH and conducting outreach and engagement in a case management or therapy session, can we bill the HH outreach and engagement code (G9001) for the time we spent in session on it?** In traditional outpatient services, case management that is provided during a therapy session is included as a part of the therapy session and is not billed separately. So, if during the course of a therapy session, the therapist mentions HH, that time would be included as a part of the therapy session and would not be billed separately under G9001. It would work the same way for a case management session. If scheduled for a regular CM session to assist with designated resources on the client's service plan and HH is mentioned during that session, it would be billed as a part of the general CM session, and would not be billed separately under G9001. In order to bill G9001, the HH outreach and engagement would need to be a separate, distinct event.

- **Can we bill outreach and engagement for someone who likely meets criteria for HH, but is not yet an active client of our agency?** Yes, as long as they meet the following criteria: *Adults:* Individuals must be age 18 or older and already designated as having a Serious Mental Illness (SMI), or they must be referred for Health Home services by a hospital, crisis or residential facility. *Children:* Individuals must be ages 0-18 (or up to age 21 if transition youth), and already designated as having a Serious Emotional Disturbance (SED) and a CAR level 3 or 4, or they must be referred for Health Home services by a hospital, crisis or residential facility.

- **Can HH outreach and engagement be billed the same day as another service such as therapy or medication clinic?** Yes

- **Can outreach and engagement include attempting to locate someone, for example, driving to their home and they don't answer or looking for them at a local shelter, talking to their family in attempts to locate them or leaving them a voice-mail?** Yes

PACT

- **Does a HH have to complete the 6 assessments as listed in 450:17-5-151? Would one bio-psychosocial assessment suffice for this requirement, if all areas are addressed and there is only one narrative assessment at the end?** PACT programs must still adhere to Chapter 55 standards. HH High Intensity outside of PACT does not have to do these. Yes, one assessment that covers all areas would suffice.

- **If a client is PACT and in a Health Home, can they bill the H0036 code for those direct services that aren't covered in the HH Core Services?** Yes

- **Will PACT clients meet criteria for HH High Intensity, regardless of CAR scores?** Yes

- **If a PACT client opts out of HH, do they remain at the current PACT H0039 rate?** Yes

- **If a client is already enrolled in a HH and a provider receives a referral on them for PACT, will that provider be able to utilize the Outreach and Engagement code while going through the PACT screening process with them?** No.

PHQ-9

- **In regards to the PHQ-9, how often would we complete this during the client's involvement in HH?** For agencies currently contracted to provide PHQ-9, please continue to use current protocol. For agencies that are not currently providing PHQ-9, you will want to access training/additional information.

Service Reporting

- **For HH clients, is it okay to report Case Management/Care Coordination (T1016, T1017) for less than the standard 8 minutes?** Yes

- **Can Care Coordination be reported by multiple staff at the same time, on the same client? If we have multiple staff who are meeting to consult about a client, can each of the participating staff report their time?** Yes

- **Under Comprehensive Care Management the Wellness Coach is not eligible to provide and report on Wellness Resource Skills Development. Was this an oversight?** A Wellness Coach is not currently listed an eligible professional in Rule/SPA for Comprehensive Care Management, however, the same Wellness Resource Skills Development service

functions that are listed under Comprehensive Care Management can also be provided under Health Promotion, for which a Wellness Coach is identified as an eligible professional.

- **Can all team members that are listed on the HH Core Services reporting tables as an eligible team member for HH service functions that are being reported under the code for Targeted Case Management, provide and report the service even if they do not have BHCM certification?** Yes. Just a reminder that under HH the service functions listed are HH specific functions, we only report them under existing CM codes for ease of reporting. It is not expected that all team members will have BHCM certification. Also, not all service functions that are reportable under the CM codes are functions that are appropriate for a Certified BHCM to complete- they function may be medical in nature and require a Nurse Care Manager.

- **Under Comprehensive Care Management, why is the Nurse Care Manager (RN or LPN) the only eligible team member to review client records and history? Shouldn't other team members be able to do this?** The reason that the Nurse Care Manager (RN or LPN) is the only team member listed as eligible to provide this service function, is that the service function of initial review of records and client history is specifically related to the Nurse Care Manager being brought up to speed on the client and then reviewing and signing off on health assessments.

- **There are many HH service functions that seem like all HH team members should be eligible to do. Why are they not all included?** The team members/professionals who are eligible to provide services under each HH Core Service area are limited by what is currently allowed for in Rule/SPA. There are proposed Rule/SPA changes, however, those will likely not be effective until next Fiscal Year. In the meanwhile we have tried to incorporate existing service functions in a variety of HH Core Service areas, as applicable to the service functions, in an effort to include more eligible team members/professionals.

- **In the Notes column of the reporting tables for the HH Core Services "Count each 15 minutes" is frequently noted. What does this mean? T**he service should be counted in 15 minute increments as follows: if the documented service is 15 minutes or less (which does not follow the 8 minute rule), it will count as one 15 minute unit, and if the service is more than 22 minutes but less than 38 minutes, it will count as two 15 minute units (the second unit of service, and any subsequent units, follow the 8 minute rule).

- **Under Comprehensive Transitional Care, please explain the purpose of the service functions listed for reporting under System Support (99368), and what client ID should be used to report them?** These functions are to allow for documentation and capturing the time providers spend establishing relationships with outside providers. These functions should be reported with a generic Customer ID (999999992).

Wellness Coach

- **Are wellness coaches required to attend both "Well Power" and "Wellness Coach" training or just the "Wellness Coach" training?**
  We are transitioning into an official "Wellness Coach Training". The exact details of the training are not in place yet, but those who have just gone through "Well Power" training will not be required to immediately retake the new training. As you hire new staff, please send them through the Wellness Coach training.

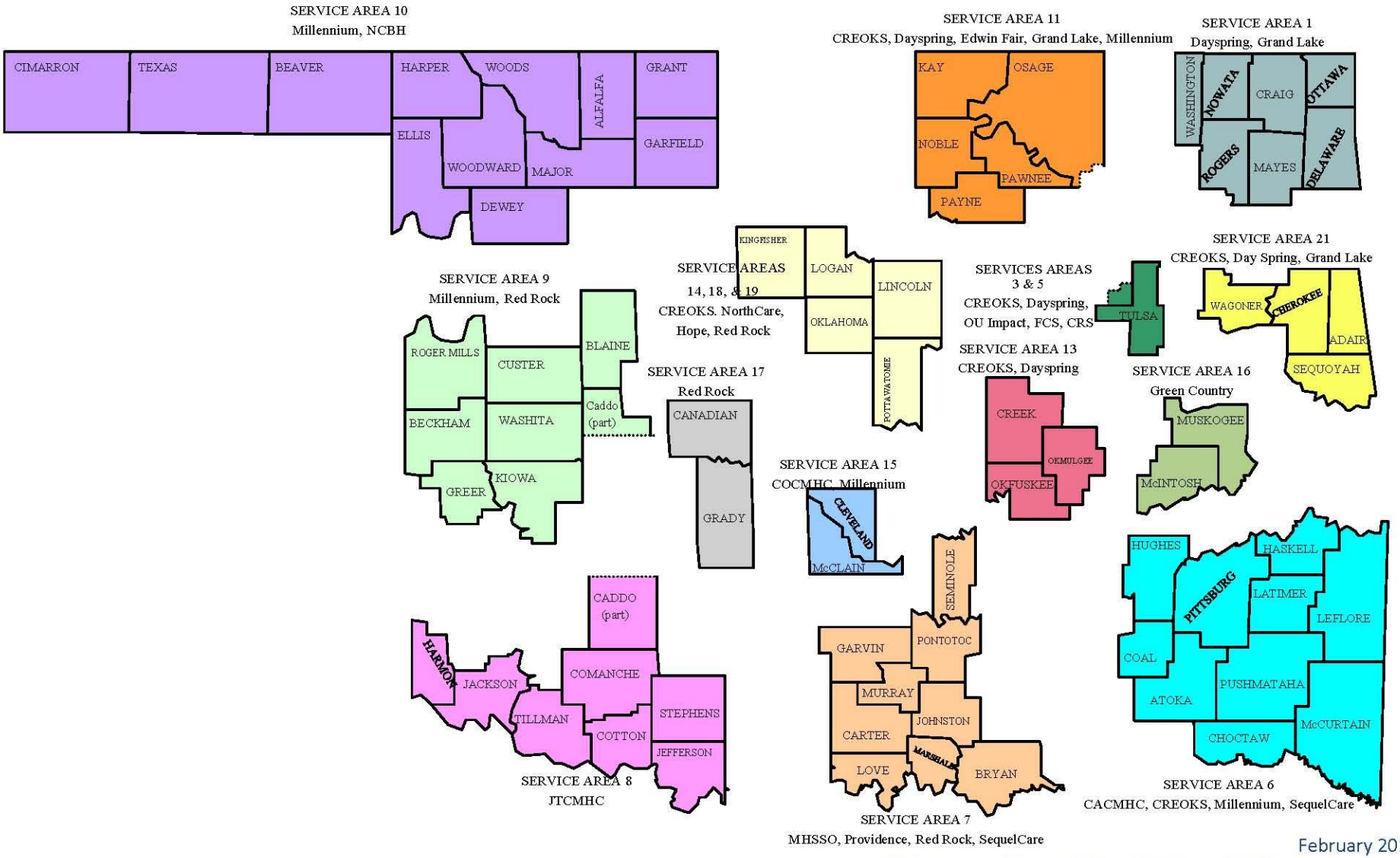
YIS System

- **What do we need to do in the YIS system for kids going from Wrap to Services Coordination?** No need to discharge- that are within the same HH; still do Ohio Scales on the same schedule.

HEALTH HOME SERVICE AREAS

OKLAHOMA DEPARTMENT OF MENTAL HEALTH
AND SUBSTANCE ABUSE SERVICES

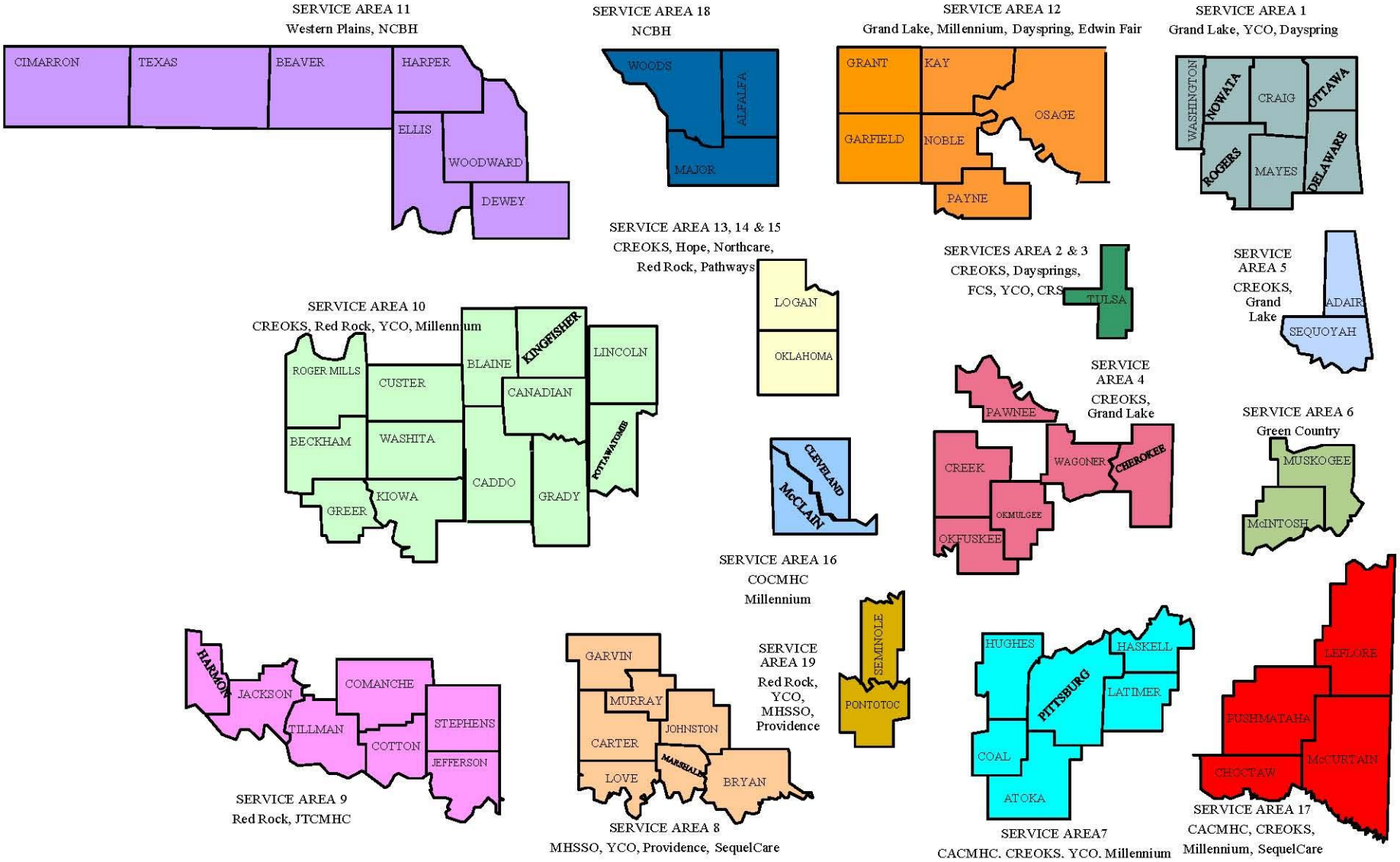
Adult Service Areas



February 2014
K:\Systemwide Projects\Maps\MH Maps FY14 Service Areas.pptx

OKLAHOMA DEPARTMENT OF MENTAL HEALTH
AND SUBSTANCE ABUSE SERVICES

Children Health Home Service Areas



September 2014
K:\Systemwide Projects\Maps\Children Health Home Service Areas

HEALTH HOME DOCUMENTS (Examples)

Admin. Letter Template

[TYPE THE SENDER COMPANY NAME]

[Type the sender company address]

[Type the recipient title]

[Type the recipient address]

[TYPE THE SALUTATION]

The Oklahoma Healthcare Authority has partnered with the Oklahoma Department of Mental Health and Substance Abuse Services to provide Health Home services to eligible members. A Health Home is a new approach to healthcare, which focuses on integrated care. Integrated healthcare is the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.

This program targets populations with serious mental illness or serious emotional disturbance and 1 or more chronic health conditions. Health Homes are designed to enhance whole-person, patient-centered care to improve overall health conditions. Health Homes provide the following six core services

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Supports

Through a competitive bid process; 22 Health Home providers have been chosen in multiple locations across the state. For more information including list of providers and provider location maps

- Oklahoma Department of Mental Health and Substance Abuse Services http://www.ok.gov/odmhsas/Mental_Health_/Oklahoma_Health_Homes/index.html.
  Malissa McEntire, Manager of Integrated Care 405-522-4146
- Oklahoma Health Care Authority http://www.okhca.org/providers.aspx?id=16525

The expectation is that behavioral health homes will result in improved quality of care and more cost efficiencies; improved experience with care on the part of members; and reductions in the use of hospitals, emergency departments, and other expensive facility-based care.

[TYPE THE CLOSING]

Administrator

[Type the sender's address]

[Pick the Date]

Consumer Letter Template

[TYPE THE SENDER COMPANY NAME]

[Type the sender company address]

[Type the recipient title]

[Type the recipient address]

[TYPE THE SALUTATION]

The Oklahoma Healthcare Authority has partnered with the Oklahoma Department of Mental Health and Substance Abuse Services to provide Health Home services to eligible members. A Health Home is a new approach to healthcare. A Health Home can help you meet all your health needs and goals. A team of professionals will work together to better coordinate your care. A Health Home can assist and guide you with all your health care needs including; mental health, dental, nutrition and other chronic diseases such as, asthma, diabetes, and heart disease.

By receiving this letter, you have been identified as an eligible member. The approved Health Home(s) in your area are_____.

For more information please see the attached Frequently Asked Question page, or you may contact

- _____
  _____
- Oklahoma Department of Mental Health and Substance Abuse Services http://www.ok.gov/odmhsas/Mental_Health_/Oklahoma_Health_Homes/index.html
  Malissa McEntire, Manager of Integrated Care 405-522-4146
- Oklahoma Health Care Authority http://www.okhca.org/providers.aspx?id=16525

The goal Health Homes is to improve your health and access to healthcare. Please contact us with any questions or concerns.

[TYPE THE CLOSING]

Administrator

[Type the sender's address]

[Pick the Date]

HH Children's Referral Form

Oklahoma Systems of Care
Health Home Referral Form

(To be completed by external referring organization)

Date of Referral: ____/____/_____

Person making Referral: _____ Phone: _____

Youth Information

Name: _____ SSN: _____ Medicaid / Member #: _____

Birth Date: ____/____/____ Gender: _____

Caregiver Name: _____ Relationship to Child: _____

Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referring Organization and Circumstance *(check only one box)*

Child Welfare:	☐ Involved (open CW case)	☐ In DHS custody
OJA:	☐ Involved	☐ In custody
☐ **Other Law Enforcement** *(specify)*: _____		
☐ **Primary Care** – If chronic health condition, please specify: _____		
School System:	☐ IEP	☐ 504 Plan
	☐ Other *(specify)* _____	
☐ **Inpatient Facility**		
☐ **Other referrer**: _____		

Reason for Referral

_____

_____

_____

_____

3/10/2015

Consent to Treat

Oklahoma Department of Mental Health and Substance Abuse Services
Health Home Consent for Treatment

Name of Consumer:					
Record #:		**Date of Birth:**		**Social Security #:**	

You are eligible to receive Health Home services at _____. These services will help you become healthier, live longer, and manage any chronic illnesses you may have. Your Comprehensive Care Plan will include both mental health and physical health goals. You will receive intensive care coordination and care management, help with transitioning in and out of any different levels of care that might be needed, and referrals and linkages to community support and services. You will still receive some current services as usual. Some services might change (for instance, case management). There may be more than one Health Home available in your area, and if so, you have a choice.

By signing this form you are saying that you have read this Consent and understand it, and that you agree to participate in _____ **Health Home Program**.

If, at a later time, you decide you no longer want Health Home, you may withdraw. If, at a later time, you decide you want to switch to a different Health Home, you may do that, if there is another available in your service area.

_____

Consent to Treat - Child

Oklahoma Department of Mental Health and Substance Abuse Services
Health Home Consent for Treatment of Child

Name of Consumer:					
Record #:		Date of Birth:		Social Security #:	

Your child is eligible to receive Health Home services at _____. These services will help your child become healthier, live longer, and manage any chronic illnesses he or she may have. The Comprehensive Care Plan will include both mental health and physical health goals. Your child will receive intensive care coordination and care management, help with transitioning in and out of any different levels of care that might be needed, and referrals and linkages with community support. Your child will still receive some current services as well. Some services might change if they are being received somewhere else (for instance, case management). There may be more than one Health Home in your area, and if so, you have a choice available.

By signing this form you are saying that you have read this Consent and understand it, and that you agree for your child to participate in _____ **Health Home Program**.

If, at a later time, you decide you no longer want your child to participate in Health Home, you may withdraw at that time. If, at a later time, you decide you want to switch your child to a different Health Home, you may do so, if there is another in your service area.

_____

HH Appraisal Example 1

Health Risk Appraisal

Name: _____ Appraisal Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Source of Information: (ex: consumer, parent/guardian/caretaker, PCP, Other): _____

1 Do you have any of the following medical conditions?

_____ Diabetes _____ Emphysema/COPD _____ Asthma

_____ High Blood Pressure _____ Heart Disease _____ High Cholesterol

Please list any other physical health challenges that you feel is important for us to know:

_____

_____

_____

2) Do you have or need any of the following:

Primary Care Physician____ Has ____ Needs Dentist ____ Has ____ Needs

Eye doctor ____ Has ____ Needs Audiologist ____ Has ____ Needs

Medical Equipment ____ Has ____ Needs

Other Specialist _____ ____Has ____ Needs

3) Are you on 4 or more medications? Yes or No

4) Are you on medications that are not prescribed at this agency? Yes or No

5) Do you use any special medical equipment in your home? Yes or No

6) Do you use any mobility tools? Yes or No

7) Have you been to an emergency room within the last 3 months? Yes or No

8) Have you been in the hospital in the last 3 months? Yes or No

9) Do you see more than one doctor other than us? Yes or No

10) Do you smoke or use other tobacco products? Yes or No

11) Do you want help to quit? Yes or No

12) Do you worry that you use too much alcohol or drugs? Yes or No

13) Has a doctor ever told you that you are overweight? Yes or No

14) Do you want help to lose weight? Yes or No

15) How would you rate your overall health and wellness?
(0 = not at all; 10 = completely satisfied)

0 1 2 3 4 5 6 7 8 9 10

HH Appraisal Example 2 – Adult
(5 pages)

SoonerCare Adult Health Risk Profile

Name:_____Date of Birth/Age:_____Male:____Female:____ MR# or SSN#:_____

Ethnicity:_____Medications:_____Old Records:_____

Allergies:_____Smoker:_____ETS:_____Date:_____

Screening	Annual Assessment of Risk Factors	Counseling Provided
1. Vaccine-preventable diseases	Needs the following immunizations: __ Td booster - ≥ 10 yr since last booster Date of last Td _____ __ Hepatitis B – at increased risk __ Varicella – nonimmune adults __ Rubella – nonimmune females of childbearing age and health care workers without evidence of immunity or prior immunization __ Hepatitis A – at high risk __ Influenza - ≥ 50 yr or high risk Pneumococcal ≥ 65 yr or high risk	
2. Blood pressure (BP)	__ Weight __ BP __ Does not exercise 30 minutes most days of week __ First-degree family history of high blood pressure or personal history of hypertension __ Diabetes mellitus	
3. Height/weight	__ Above healthy weight range for height **OR** __ BMI > 25. Formula for calculating BMI is $\frac{\text{Weight (kg)}}{\text{Height (m)}^2}$	
4. Diabetes	__ Adults with hypertension or hyperlipidemia	

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SoonerCare Adult Health Risk Profile

Screening	Annual Assessment of Risk Factors	Counseling Provided
5. Cholesterol	__ In males ≥ 35 yr and females ≥ 45 yr __ > 1 yr since previous abnormal test __ Diabetes mellitus __ Family history of cardiovascular disease < 50 yr in male relatives, < 60 yr in female relatives __ Family history suggestive of familial hyperlipidemia __ Multiple coronary heart disease risk factors (e.g., tobacco use, hypertension)	
6. Pap Smear	__ Is or has been sexually active __ > 3 yr since last Pap Smear __ Abnormal __ Date	
7. Mammogram	__ ≥ 40 yr and has not had a mammogram within the past 1-2 yr __ Family history of breast cancer	
8. Colorectal cancer screening	__ ≥ 50 yr __ Family members who have a positive history of cancer of colon, Intestine, breast, ovaries, or uterus __ History of polyps	
9. Osteoporosis	__ Women ≥ 65 __ Women ≥ 60 at increased risk for fractures	
10. Problem drinking	__ Drinks > 2 drinks/day (men) or > 1 drink/day (women)	
11. Vision	__ If > 65 yr, does not see an eye doctor for regular eye exams __ Glaucoma __ Diabetes mellitus __ Wears glasses __ Family history of glaucoma	
12. Hearing	__ >65 yr strains to hear a normal conversation __ Turns up volume on TV and radio so loud that others complain	

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SoonerCare Adult Health Risk Profile

Screening	Annual Assessment of Risk Factors	Counseling Provided
13. Chlamydial infection	__ Is sexually active and ≤ 25 yr __ Prior history of STD __ New or multiple sex partners __ Had cervical ectopy __ Uses barrier contraceptives inconsistently	
For Persons at High Risk	Annual Assessment of Risk Factors	Counseling Provided
14. STD/HIV	__ Contraception __ Has or has had any one of the following risk factors: Previous STD, multiple sex partners, or shared needles	
15. Tuberculosis (TB) infection	__ Close contact with a person who has active TB __ Occupational high risk (health care, correctional, residential, etc.) __ Lived in endemic area in the past year (SE Asia, Africa, Latin America) __ Medical risk factors (e.g. diabetes, HIV, alcoholism) __ PPD status __ INH	
Chemoprevention	Annual Assessment of Risk Factors	Counseling Provided
16. Discuss aspirin to prevent Coronary heart disease	__ At risk for coronary heart disease	
17. Discuss breast cancer Chemoprevention	__ Women of older age __ Breast cancer in first degree relative __ Atypical hyperplasia or breast biopsy	
Screening	Annual Assessment of Risk Factors	Counseling Provided
18. Tobacco use	__ Currently smokes cigarettes, cigars, or pipes or uses smokeless tobacco __ Is exposed to tobacco smoke regularly __ Number of packs per day __ Carcinoma __ Coronary artery disease	

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SoonerCare Adult Health Risk Profile

Screening	Annual Assessment of Risk Factors	Counseling Provided
19. Alcohol/drug use	__ Long-term use of certain prescription drugs __ Has had medical/social problems related to alcohol or drug use __ Uses or has used "street drugs"	
20. Nutrition	__ Does not limit intake of fat and cholesterol, maintain caloric balance in diet, or eat foods containing fiber	
21. Physical activity	__ Does not exercise 30 minutes most days	
22. Oral Health	__ Poor dental hygiene (e.g. does not brush with a fluoride toothpaste and floss daily) __ Does not see a dentist regularly __ Smokes or chews tobacco and/or drinks alcohol	
23. Sun exposure	__ Immunosuppression __ Family history of skin cancer __ Freckles and poor tanning ability Light skin, hair, and eye color	
24. Injury prevention	__ Does not use seatbelts when in a motor vehicle __ Does not use a helmet when on a bike/motorcycle __ Drinks alcohol and drives, or rides with someone who does __ Medicines, chemicals/poisons, or firearms are accessible to children __ Does not have working smoke detectors in the home __ At risk for battering or abuse (emotional, verbal, or physical)	
25. STD/HIV	__ Contraception Previous STD, multiple sex partners, or shared needles	
26. Unintended pregnancy	__ Sexually active male or sexually active female of childbearing age __ Does not desire a pregnancy/is not using a reliable birth control method	
27. Multivitamin with folic acid	__ Sexually active female of childbearing age	

SoonerCare Adult Health Risk Profile

Screening	Annual Assessment of Risk Factors	Counseling Provided
28. Osteoporosis	__ Does not do weight-bearing exercises __ Does not get adequate calcium __ Low body weight __ Caucasian female __ Hormone replacement therapy (HRT) __ Menopause at ≤ 40 yr	

Notes/Instruction:_____

_____

_____

_____

_____

Completed by:_____Date:_____

Reviewed by:_____Date:_____

Note: Information based on U.S. Preventive Services Task Force recommendations.
ETS = environmental tobacco smoke; Td = tetanus-diphtheria; BMI = body mass index; HIV – human immunodeficiency virus; STD = sexually transmitted disease; PPD = tuberculin purified protein derivative; INH = isoniazid.

First published in A Step-by-Step Guide to Delivering Clinical Preventive Services: A systems approach. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Rockville, MD, 20001. AHRQ Pub. No. APPIP01-0001.

Revised January 2003.

HH Appraisal Example 3 – Child/Adolescent
(4 Pages)

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SoonerCare Child and Adolescent Health Risk Profile

Name:_____Date of Birth/Age:_____Male:____Female:____ MR# or SSN#:_____

Ethnicity:_____Medications:_____Old Records:_____

Allergies:_____Smoker:_____ETS:_____Date:_____

Screening	Annual Assessment of Risk Factors	Counseling Provided
1. Height/weight	__ Above or below healthy weight range for height	
2. Blood pressure	__ Screen during office visits	
3. Vision	__ Screen at approximately 3-4 yr __ Eyes turning inward or outward __ Squinting __ Headaches __ Not doing as well in school as before __ Blurred or double vision	
4-6. PKU, hemoglobinopathies, Hypothyroidism	__ Screening tests done in first 7 days after delivery __ Records from hospital should be in chart	
7. Hearing	__ Family history of hereditary childhood sensorineural hearing loss __ Congenital perinatal infections with herpes __ Perinatal infection with herpes, syphilis, rubella, cytomegalovirus, or toxoplasmosis __ Malformations involving head or neck __ Birth weight below 1500 g __ Bacterial meningitis __ Hyperbilirubinemia requiring exchange transfusion __ Severe perinatal asphyxia __ Ototoxic medications	

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SoonerCare Child and Adolescent Health Risk Profile

Screening	Annual Assessment of Risk Factors	Counseling Provided
8. Anemia (for those at high risk)	__ Lives in poverty __ Black, Native American, or Alaska Native __ Immigrant from developing country __ Preterm and low birth weight infant __ Drinks primarily unfortified cow's milk	
9. Cholesterol (for those at high risk)	__ Has a parent who has high cholesterol __ Has a parent or grandparent who died suddenly or had heart disease before age 55 __ Child is obese __ Has high blood pressure	
10. Lead	__ Blood lead lab test all children at 12 months and 24 months; minimum one documented blood lead lab test all children by 72 months __ Lived in or regularly visited a house built before 1950 __ Lived in or regularly visited a house built before 1978 with recent, ongoing, or planned renovation or remodeling __ Had a brother or sister, housemate, or playmate followed or treated for lead poisoning __ Is anemic	
11. Tuberculin skin test (for those at high risk)	__ Close contact with a person who has active tuberculosis __ Occupational high risk (healthcare, correctional, residential, etc.) __ Lived in endemic area in the past year (SE Asia, Africa, Latin America) __ Medial risk factors (e.g., diabetes, HIV, alcoholism)	
12. HIV test (for those at high risk)	__ High-risk mother and antibody status of mother is unknown __ Inconsistent and incorrect use of barrier contraceptives __ Has or has had any one of the following risk factors: previous STD, multiple sex partners, or shared needles.	
13. Chlamydia	__ Is sexually active and $\leq$ 25 yr	
14. Pap smear	__ Os sexually active and has been over 3 yr since last test	
15. Sleep position	__ Places baby on stomach	

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SoonerCare Child and Adolescent Health Risk Profile

Screening	Annual Assessment of Risk Factors	Counseling Provided
16. Injury prevention	__ Does not use child safety car seats/booster seats __ Does not use lap/shoulder belts __ Does not use a bicycle helmet __ Does not have hot water heater temperature < 120-130 ° F __ Medicines, chemicals/poisons, or firearms are accessible to children __ Does not have window/stair guards or a pool fence __ Does not have syrup of ipecac or the poison control phone number __ Does not have working smoke detectors in the home	
17. Nutrition	__ Mother does not breast-feed __ Does not limit intake of fat and cholesterol, maintain calorie balance in diet, or eat foods containing fiber __ Inadequate calcium intake for teen girls	
18. Physical activity	__ Does not get 30 minutes of physical activity most days	
19. Oral health	__ Poor dental hygiene (e.g. does not brush with a fluoride toothpaste and floss daily) __ Does not see a dentist regularly __ Smokes or chews tobacco and or drinks alcohol	
20. Sun exposure	__ Immunosuppression __ Family history of skin cancer __ Freckles and poor tanning ability __ Light skin, hair, and eye color	
21. Tobacco use	__ Currently smokes cigarettes, cigars, or uses smokeless tobacco __ Lives with an adult who smokes inside the home	
22. Alcohol/drug use	__ Drinks more than 2 drinks/day (men) or 1 drink/day (women) (quantity _____ frequency_____) __ Uses or has used "street drugs" __ Has had medical and/or social problems related to alcohol or drug use	
23. Multivitamin with folic acid	__ Sexually active female of childbearing age	

SoonerCare Child and Adolescent Health Risk Profile

Screening	Annual Assessment of Risk Factors	Counseling Provided
23. Unintended pregnancy/STDs/HIV	__ Sexually active male or sexually active female of childbearing age __ Does not desire a pregnancy/is not using a reliable birth control Method Has or has had previous STD, multiple sex partners, or shared needles	

Notes/Instruction:_____

_____

_____

_____

_____

Completed by:_____Date:_____

Reviewed by:_____Date:_____

Information based on U.S. Preventive Services Task Force recommendations.
ETS = environmental tobacco smoke; PKU = phenylketonuria; HIV – human immunodeficiency virus; STD = sexually transmitted disease.

HH Assessment Example 1
(6 Pages)

Health Risk Assessment
(to be completed by qualified nurse)

Name: _____ Assessment Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Source of Information: (ex: consumer, parent/guardian/caretaker, PCP, Other): _____

[ ] Diagnosis

_____
_____
_____

[ ] Current medications and effectiveness

_____
_____
_____
_____

Hospitalizations (number, duration, diagnoses, status of condition causing hospitalization): [ ] None

_____
_____
_____

Major Illnesses (type, frequency of each type, dates/duration, and general treatment): [ ] None

_____
_____
_____

Injuries (type, frequency of each type, dates/duration, and general treatment): [ ] None

_____
_____
_____

Corrective devices (use and effectiveness): [ ] None

_____
_____
_____

Laboratory results
[ ] Initial laboratory test results were review on: _____ (Date)
[ ] Annual laboratory test results were review on: _____ (Date)
[ ] Laboratory test results were within normal limits and required no follow-up action.
[ ] Laboratory test results were abnormal and follow-up action was required: (list abnormal results, follow-up action, and resolution):

Comments:

_____
_____
_____

Allergies
[ ] No Known Allergies
[ ] When in contact with _____ (environmental factors), the following reaction occurs:
_____
[ ] When _____ (medication) is taken, the following reaction occurs
_____
[ ] When _____ (food) is consumed, the following reaction occurs:
_____
The following precautions are in place:
_____

Immunizations:
Immunizations are current: [ ] PPD [ ] Influenza [ ] Pneumonia [ ] Tetanus
Hepatitis surface antigen tested _____(date), _____(results)
Hepatitis core antigen tested _____(date), _____(results)
Hepatitis antibodies tested _____(date), _____(results)
[ ] History of significant tuberculin skin test on _____(date)
Exhibits: [ ] weakness, [ ] anorexia (loss of appetite), [ ] weight loss, [ ] night sweats, [ ] low grade fever, [ ] productive cough,
[ ] hemoptysis (blood in sputum). [ ] The above were addressed by the physician on _____ (date).
HIV status: [ ] Unknown [ ] Known _____

Head & Neck [ ] No relevant history
History of: [ ] head trauma [ ] macrocephaly [ ] microcephaly [ ] hydrocephalus [ ] shunt
[ ] head banging [ ] slapping head/face [ ] hypothyroidism [ ] frequent colds
[ ] frequent infections [ ] neck injuries [ ] displaced trachea
[ ] Pain: _____ (location & description)
Comments:
_____

Nose & Sinuses [ ] No relevant history
History of: [ ] nosebleeds [ ] sinus infections [ ] Allergies [ ] Snoring [ ] difficulty breathing
[ ] discharge [ ] drip [ ] uses inhalants [ ] headaches [ ] recent trauma [ ] surgery
[ ] places foreign objects in nose
Comments:
_____

Mouth & Pharynx [ ] No relevant history [ ] last dental exam: _____ (date) [ ] dentures
History of: [ ] dental problems [ ] impaired swallowing [ ] recent appetite or weight change
[ ] chewing problems [ ] mouth pain [ ] mouth lesions [ ] self-injurious behavior (biting)
[ ] risk for tongue injury (seizures, biting) [ ] places foreign objects in mouth & pharynx [ ] cleft lip or palate
Comments:
_____

Eyes and Ears
Eyes [ ] No relevant history
[ ] medications that place individual at risk for glaucoma or cataracts [ ] keratoconus [ ] retinal detachment
[ ] corrective lenses [ ] contacts [ ] legally blind [ ] total blindness (no vision)
History of: [ ] eye infection [ ] inflammation [ ] disease [ ] drainage [ ] eye surgery [ ] trauma
[ ] diabetes [ ] hypertension [ ] eye pain [ ] cataracts [ ] glaucoma [ ] glaucoma suspect
[ ] using drops [ ] redness, irritation [ ] itching/rubbing eyes [ ] places foreign objects in eyes
Last eye exam (optometrist/ophthalmologist) _____ (date)
Comments:
_____

Ears[ ] No relevant history
History of: [ ] infections [ ] drainage [ ] redness [ ] pain [ ] tinnitus [ ] vertigo [ ] disorder(s)
[ ] chronic otitis media [ ] tubes [ ] itching or pulling ears [ ] excessive cerumen
[ ] foreign objects in ears [ ] hearing problems [ ] hearing aide [ ] ototoxic medications
Last hearing exam (audiologist) _____ (date)
Comments:

_____

Heart & Vascular [ ] No relevant history
History of Congenital Heart Disease: [ ] endocardial cushion defect [ ] septal defect(s) [ ] mitral prolapse
[ ] Tetrology of Fallot [ ] mitral regurgitation [ ] murmurs [ ] extra heart sounds (clicks, rubs)
[ ] pulmonic stenosis [ ] coartation of the aorta (malformed narrowing)
History of Cardiovascular Disease: [ ] congestive heart failure [ ] endocarditis [ ] myocardial infarction
[ ] pre-medicate with antibiotics for dental or invasive procedures
[ ] Pain: (Location)
_____
_____ (include precipitating and relieving factors)
[ ] known abnormalities regarding B/P and pulses:
_____
_____
History of: [ ] smoking [ ] excessive caffeine [ ] diabetes [ ] hypertension [ ] swelling [ ] peripheral vascular disease [ ] phlebitis [ ] varicose veins [ ] leg cramps [ ] cyanosis [ ] dependent edema
[ ] pacemaker
_____
(specify)
[ ] nausea [ ] dyspnea [ ] fatigue [ ] palpitations [ ] tingling or numbness

Comments:

_____

Thorax & Lungs [ ] No relevant history
History of: [ ] respiratory disease [ ] reoccurring pneumonia [ ] recurrent aspiration syndrome [ ] COPD
[ ] asthma [ ] Past positive TB [ ] smoking [ ] allergies [ ] risk factors for aspiration present
[ ] esophageal motility disorders [ ] hiatal hernia with reflux [ ] achalasia (failure of sphincter to relax)
[ ] gastroesophageal reflux [ ] chronic constipation & increased intra-abdominal pressure
[ ] delayed stomach emptying [ ] high frequency vomiting [ ] regurgitation
[ ] nasal feeding tube [ ] impaired swallow reflex [ ] absent or hyperactive gag reflex
[ ] reduced level consciousness [ ] infectious saliva from poor oral hygiene [ ] seizure disorders
[ ] spinal deformities or orthopedic corsets that increase intra-abdominal pressure
[ ] dependency for feeding & positioning [ ] impaired cough reflex [ ] aerophagia [ ] pica
[ ] ingestion of hydrocarbon derivatives (glue, acetone) [ ] hoarseness [ ] wheezing

Comments:

_____

Gastrointestinal
Abdomen [ ] No relevant history
History of: [ ] constipation [ ] diarrhea [ ] incontinence [ ] foul odor [ ] flatulence
[ ] abnormal stool color [ ] frequent belching [ ] distention [ ] GI/hepatobiliary infection [ ] parasites
[ ] infectious hepatitis [ ] chronic liver disease [ ] pancreatitis [ ] nausea [ ] vomiting [ ] pain
Surgical history:
_____
Disorders of abdominal organs: [ ] stomach [ ] small intestine [ ] large intestine [ ] appendix [ ] pancreas
[ ] gallbladder [ ] spleen

Ostomy presence: [ ] gastrostomy [ ] jejunostomy [ ] large intestine ostomy [ ] appliance: _____
[ ] self-care of ostomy [ ] dependent care of ostomy
Bowel movement: [ ] Normal [ ] small [ ] medium [ ] large [ ] soft [ ] formed [ ] hard

Comments:
_____

Nutritional/Metabolic Pattern [ ] No relevant history
Nutritional Status: [ ] good appetite [ ] poor appetite or loss of appetite
Weight fluctuations: [ ] None significant _____ pounds [ ] gained [ ] lost in last _____
[ ] recurrent emesis [ ] rumination (month(s) or year)
Eating Skills: [ ] too slow [ ] too fast [ ] excessive spillage [ ] requires special utensils [ ] needs to be positioned
Swallowing: [ ] difficulty [ ] delayed [ ] pockets food [ ] silent aspiration [ ] no thin liquids
[ ] Special diet [ ] special feeding techniques: _____ (describe)
Enteral Feedings: Reason: [ ] dysphagia [ ] surgery [ ] hypermetabolic status (burns, trauma, sepsis, cancer)
[ ] GI disease [ ] Other: _____

Comments:
_____

Genitourinary (Gynecological & Breasts)
[ ] No relevant history
Bladder: Frequency: _____ [ ] nocturia [ ] urgency [ ] dysuria [ ] pain/burning [ ] oliguria
[ ] hematuria [ ] urine clear [ ] urine cloudy [ ] urinary retention [ ] foul odor to urine.
[ ] indwelling catheter [ ] external catheter [ ] Intermittent catheterization [ ] History of chronic urinary infection
[ ] incontinence _____ (total) _____ (daytime)_____ (nighttime) _____ (occasional)
[ ] difficult delayed voiding
Current bladder program: [ ] Dietary measures: _____ (list)
[ ] medication(s): _____ (list)
[ ] bladder training: _____ (schedule)
[ ] intermittent catheterization: _____ (schedule)
[ ] monitoring of urinary frequency [ ] fluid intake/output
[ ] sexually active [ ] with partner(s) [ ] by self [ ] unknown [ ] last PSA: _____ (date & result)
Comments:
_____

Gynecological & Breast [ ] No relevant history
[ ] regular menses [ ] irregular menses [ ] primary amenorrhea [ ] secondary amenorrhea [ ] menopausal
[ ] post hysterectomy [ ] heavy flow [ ] dysmenorrheal
Surgical History:
_____
[ ] no significant findings on monthly breast examination
[ ] significant findings on monthly breast examination on _____ (date) with following action: _____
[ ] independent breast self-exam [ ] needs instructions [ ] unable to complete
last Pap test done: _____ (date) _____ (result with date)
Comments:
_____

Musculoskeletal [ ] No relevant history.

History of: [ ] arthritis [ ] inflammatory disease [ ] pain/cramps [ ] swelling

[ ] fracture: _____ (describe)
[ ] ambulatory [ ] nonambulatory [ ] mobile using: _____ [ ] immobile

Neurological
Mental & Emotional Statues
[ ] alert [ ] aware of environment [ ] non-verbal [ ] impaired level of consciousness
[ ] able to communicate [ ] limited verbalization [ ] vocalized sounds only
[ ] Communication device:
_____
[ ] intellectual impairment [ ] memory impairment [ ] general knowledge deficit [ ] abstract reasoning impaired
[ ] impaired association ability [ ] impaired judgment [ ] sleeps well at night [ ] difficulty falling asleep
[ ] difficulty staying asleep [ ] difficulty with early awakening
[ ] naps during day due to: [ ] age [ ] health status [ ] medications
[ ] sleep aids used:
_____
[ ] sleep safety devices used: [ ] bedrails [ ] pillow(s) [ ] mat beside bed
[ ] other:
_____
Comments:
_____

Behavior [ ] No maladaptive behaviors
Maladaptive Behaviors: [ ] self injurious behavior [ ] aggression to others [ ] PICA behavior [ ] mood swings
[ ] receives: _____ (medication) for behavior(s)
[ ] a behavior program is in place [ ] an exception to behavior medication reduction is in place
Comments:
_____

Seizure Disorders & Epilepsy [ ] No relevant history
[ ] History of seizure disorder (see Seizure Outcome Assessment form)
Comments:
_____

Tardive Dyskinesia & Movement Disorders [ ] No relevant history
History of: [ ] movement disorder [ ] Huntington's [ ] Parkinson's [ ] benign essential tremor
[ ] resting tremor [ ] bradykinesia [ ] clonus
[ ] Other: _____ (specify)
[ ] Receiving antipsychotic/amoxapine/metoclopramide:
_____
Baseline TD assessment was completed on _____ (date) with the following results:
_____
TD assessment completed during the past year: _____(date)
_____ (Result)
_____(date) _____ (Result)
Comments:
_____

Other Neurologic Conditions [ ] No other neurologic problems noted
Description (including signs & symptoms of neurologic problem not noted above:
_____

Mental & Emotional Status
[ ] alert [ ] aware of environment [ ] impaired consciousness [ ] Glasgow coma scale score: _____

[ ] changed level of consciousness [ ] unchanged level of consciousness
[ ] able to communicate [ ] vocalizes sounds [ ] limited verbalization [ ] non-verbal
[ ] change in communication pattern [ ] unchanged communication
Communication device:
_____

[ ] intellectual impairment unchanged [ ] memory impairment unchanged [ ] general knowledge deficit unchanged
[ ] abstract reasoning unchanged [ ] impaired association ability unchanged [ ] impaired judgment unchanged
[ ] changes in mental & emotional status (describe):
_____
Comments:
_____

Motor Function
[ ] impaired coordination [ ] fine motor skills impaired
[ ] balance maintained while standing with eyes closed [ ] loss of balance immediate

Reflexes
patellar reflex: [ ] 0: no response [ ] 1+ low (normal with slight contraction
[ ] 2+ normal, visible muscle twitch and extension of lower leg
[ ] 3+ brisker than normal
[ ] 4+ hyperactive, very brisk
Comments:
_____

Notes
_____
_____
_____
_____
_____
_____

Recommendations
_____
_____
_____
_____
_____

Follow Up
_____
_____
_____
_____

Signature and credentials _____

HH Assessment Example 2
(11 pages)

oklahoma health care authority

SoonerCare
Health Risk Assessment

DEMOGRAPHICS:

Patient Name:_____ SoonerCare ID#:_____

Assessment Date:___/____/_____ Patient SSN:_____

SoonerCare Status:_____

Age: _____ Gender:_____ Date of Birth:_____

Parent/Guardian:_____ Home Phone #:_____

Work Phone #:_____ Cell Phone #:_____

Pager #:_____ Best Time to Call:_____

Patient Address:_____
City State Zip Code

Emergency Contact:_____ Phone #:_____

Sources of Information (Ex: Emerging Asthma Report, Patient, Parent/Guardian, Referral, PCP/Other):
_____

Patient's General Perception of Health:
(Poor, Fair, Good, Very Good, Excellent):_____ Height: _____
Weight:_____

Chief Complaint (Reason for Referral):_____
_____

Comments:_____
_____
_____

- 1 -

oklahoma health care authority

SoonerCare
Health Risk Assessment

FAMILY/PERSONS LIVING IN THE HOME:

Name:	DOB:	Age:	Relationship	Sooner Care
_____	___/___/___	_____	_____	☐
_____	___/___/___	_____	_____	☐
_____	___/___/___	_____	_____	☐
_____	___/___/___	_____	_____	☐

Comments:_____
_____
_____

DISEASE MANAGEMENT/MEDICAL CONDITIONS:
(Ask about Hypertension, Heart Disease, and other clinical indicators related to identified conditions.)

Diabetes: ☐Yes ☐No
Comments:_____
_____
_____

Asthma: ☐Yes ☐No **Stage**_____
Comments:_____
_____
_____

COPD: ☐Yes ☐No
Comments:_____
_____
_____

CHF: ☐Yes ☐No
Comments:_____
_____
_____

- 2 -

oklahoma health care authority

SoonerCare
Health Risk Assessment

Obesity: ☐Yes ☐No
Comments:_____
_____
_____

OTHER MEDICAL CONDITIONS:

Condition: _____
Comments:_____
_____

Condition: _____
Comments:_____
_____

Condition: _____
Comments:_____
_____

Condition: _____
Comments:_____
_____

Condition: _____
Comments:_____
_____

MEDICATIONS:

Any Drug Allergies ☐Yes ☐No **If yes, describe:**_____
_____
_____

Pharmacy (Most Frequently Used):_____

- 3 -

oklahoma health care authority

SoonerCare
Health Risk Assessment

Medication Name:	Date Filled	Prescription/OTC/ Herbal/Other
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL EQUIPMENT (DME):

	Description:	Supplier:
☐ Has ☐ Needs ☐ No Need	_____	_____
☐ Has ☐ Needs ☐ No Need	_____	_____
☐ Has ☐ Needs ☐ No Need	_____	_____
☐ Has ☐ Needs ☐ No Need	_____	_____

Comments:_____

_____

HEALTH:

PCP ☐ Has ☐ Needs Date of Last Visit: ___/___/_____
Comments:_____

_____

Eye Doctor ☐ Has ☐ Needs Date of Last Visit: ___/___/_____
Comments:_____

_____

Dentist ☐ Has☐ Needs Date of Last Visit: ___/___/_____
Comments:_____

_____

- 4 -

oklahoma health care authority

SoonerCare
Health Risk Assessment

Smoking: ☐Yes ☐No **Number of Cigs:** _____ **Wants to Quit:** ☐Yes ☐No
Exposure to Smoke: ☐Yes ☐No
Comments:_____
_____

EPSDT/Well Child Checks ☐ Has ☐ Needs **Date of Last Visit:** ___/___/_____
Comments:_____
_____

Specialists: ☐ Has ☐ Needs

1. _____ **Date of Last Visit:** ___/___/_____

Comments:_____
_____

2. _____ **Date of Last Visit:** ___/___/_____

Comments:_____
_____

3. _____ **Date of Last Visit:** ___/___/_____

Comments:_____
_____

4. _____ **Date of Last Visit:** ___/___/_____

Comments:_____
_____

General Notes:

_____
_____
_____
_____
_____

- 5 -

oklahoma health care authority

SoonerCare
Health Risk Assessment

IMMUNIZATIONS/FLU SHOTS/OTHER:

Name:

_____ ☐ Has ☐ Needs Last Date of: ___/___/_____

_____ ☐ Has ☐ Needs Last Date of: ___/___/_____

_____ ☐ Has ☐ Needs Last Date of: ___/___/_____

_____ ☐ Has ☐ Needs Last Date of: ___/___/_____

_____ ☐ Has ☐ Needs Last Date of: ___/___/_____

_____ ☐ Has ☐ Needs Last Date of: ___/___/_____

_____ ☐ Has ☐ Needs Last Date of: ___/___/_____

SOCIAL ISSUES:
(Does patient or parent/guardian need parenting classes, or have other needs, i.e., child care, help with the care of medically fragile child, care for elderly parent or others living in the home?)

Financial/Legal: ☐Yes ☐No
Comments:_____
_____
_____

Housing: ☐Yes ☐No
Comments:_____
_____
_____

Educational Barriers/Literacy: ☐Yes ☐No
Comments:_____
_____
_____

oklahoma health care authority

SoonerCare
Health Risk Assessment

Environmental: ☐Yes ☐No
Comments:_____

Support System: ☐Yes ☐No
Comments:_____

Transportation: ☐Yes ☐No
Comments:_____

Family Issues: ☐Yes ☐No
Comments:_____

Inability to care for oneself: ☐Yes ☐No
Comments:_____

Food Stamps: ☐Yes ☐No
Comments:_____

Other Social Issue
Comments/Notes:_____

oklahoma health care authority

SoonerCare
Health Risk Assessment

MENTAL HEALTH (PATIENT):
(Any history of violence, abuse or neglect?)

Substance Abuse: ☐Yes ☐No
Comments:_____

ADHD/ADD: ☐Yes ☐No
Comments:_____

Depression: ☐Yes ☐No
Comments:_____

Patient has a mental health worker/counselor: ☐Yes ☐No
Name of counselor: _____

Other: ☐Yes ☐No
Comments:_____

MENTAL HEALTH (PARENT/GUARDIAN):
(Any history of violence, abuse or neglect?)

Substance Abuse: ☐Yes ☐No
Comments:_____

- 8 -

oklahoma health care authority

SoonerCare
Health Risk Assessment

ADHD/ADD: ☐Yes ☐No
Comments:_____
_____
_____

Depression: ☐Yes ☐No
Comments:_____
_____
_____

Patient has a mental health worker/counselor: ☐Yes ☐No
Name of counselor: _____

Other: ☐Yes ☐No
Comments:_____
_____
_____
_____
_____
_____
_____
_____

FUNCTIONAL(PATIENT):
(Does patient/guardian need special services such as OT, PT, ST; Family Support Services, etc.)

Cognitive Impairment: ☐Yes ☐No

Severity of Patient's Cognitive Impairment: ☐ Unknown
Comments: _____
_____
_____

Motor Impairment: ☐Yes ☐No

Severity of Patient's Motor Impairment: ☐ Unknown
Comments: _____
_____
_____

- 9 -

oklahoma health care authority

SoonerCare
Health Risk Assessment

Other: ☐**Yes** ☐**No**
Comments: _____
_____
_____

FUNCTIONAL(PARENT/GUARDIAN):
(Does patient/guardian need special services such as OT, PT, ST; Family Support Services, etc.)

Cognitive Impairment: ☐**Yes** ☐**No**

Severity of Parent/Guardian's Cognitive Impairment: ☐ **Unknown**
Comments: _____
_____
_____

Motor Impairment: ☐**Yes** ☐**No**

Severity of Parent/Guardian's Motor Impairment: ☐ **Unknown**
Comments: _____
_____
_____

Other: ☐**Yes** ☐**No**
Comments: _____
_____
_____

UTILIZATION ISSUES:

Adherence Issues: ☐**Yes** ☐**No**
Comments: _____
_____
_____

ED Visits: ☐**Yes** ☐**No** **Diagnosis:**_____ **Date of Last Visit:** ___/___/____
Comments: _____
_____
_____

oklahoma health care authority

SoonerCare
Health Risk Assessment

Health Insurance/Access: ☐Yes ☐No
Comments: _____
_____
_____

Hospital (IP): ☐Yes ☐No **Diagnosis:**_____**Date of Last Visit:** ___/___/___
Comments: _____
_____
_____

High Cost/High Risk: ☐Yes ☐No
Comments: _____
_____
_____

Pharmacy Issues: ☐Yes ☐No
Comments: _____
_____
_____

General Comments/Notes:
_____
_____
_____
_____

OTHER AGENCIES OR PEOPLE CURRENTLY HELPING PATIENT/FAMILY?

Name/Agency:	Type of Assistance:	Phone:

Completed by: _____ **Date:**___/___/_____

☐ **Initial Assessment**
☐ **Updated Assessment**