Health Home Flow
Hypothetical Patient Scenario

Client Background: Soozie SoonerCare

Soozie is a single female, age 42, 5'6" tall 215 pounds. She smokes 2 packs of cigarettes a day. At age 24, Soozie was diagnosed as schizophrenic. At age 37, she was diagnosed as having hypertension. A year ago, she was diagnosed with adult onset diabetes. She was just admitted for the 3rd time in the last 12 months to her local community hospital after coming to the ER for feeling weak, thirsty, and light headed. Her blood sugar in the ER was 470. After her last discharge from the General Hospital for hyperglycemia 6 weeks ago, she did not follow through with the hospital's recommendation to schedule a primary care visit to manage her diabetes. Soozie is a member of SoonerCare Choice and has a Patient Centered Medical Home.

Engagement:
There are two possible pathways to engagement in this scenario. For purposes of this narrative, assume that Soozie was engaged through option (2).

1) After admission, Soozie is visited by Sam the Social Worker at the hospital to coordinate arrange for her follow up care. Sam looks at the hospital's social work resource manual which indicates that persons with serious mental illness may be referred to Metro Health Home if they need care coordination and disease management services. This information is in the resource manual as a result of a MOU covering referral and transitions of care between General Hospital and Metro HEALTH HOME. The relationship between the hospital and Metro Health Home was established a year ago after education and outreach was performed by the Oklahoma Health Care Authority (OHCA) & Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) staff as well as Metro Health Home. With Soozie's permission, Sam calls the Metro Health Home nurse care manager in an effort to ensure Soozie receives the continued care that she needs after discharge from the hospital. Nancy the Nurse Care Manager at Metro visits Soozie in the hospital later that day to educate her on Health Homes and gives her the option to enroll in the Metro Health Home (which Soozie does). Nancy explains to Soozie that she will be involved in her discharge planning, part of which will be to schedule an appointment at Metro Health Home when they know her release date.

2) When **t**he Medicaid Health Home initiative went live 2 months ago, Soozie was identified through claims data in the MMIS as experiencing Serious Mental Illness (SMI) and was auto-enrolled in the Metro Health Home since Soozie resides in the Metro Health Home geographic catchment area.

Behind the Scenes-
Suzie was mailed an engagement letter by OHCA notifying her of her enrollment in the Metro Health Home. The letter includes a brief description of HH services, a description of her options to choose another HH, and a process to opt-out of enrollment in a HH as well as Metro's contact information. An engagement letter was also mailed to Metro notifying them of Soozie's auto-enrollment. Since Soozie is aligned with a SoonerCare Choice PCP, the OHCA care manager informed the PCP as well as the Health Access Network with which the PCP is affiliated that Soozie is enrolled in the Metro Health Home and coordinated communication between the PCP, the HAN and the HH. The letter was followed up with a phone call from a care manager in OHCA's Population Care Management Unit to notify both Soozie and Metro of the enrollment. However, the phone number for Soozie was no longer active. Metro CMHC attempted to engage Soozie through mail and visits to her home over the next two months, but attempts were unsuccessful, as Soozie no longer lived at the address on file with OHCA. The timeframe is such that Metro CMHC is still within the "case finding" group timeframe (three months from the date Soozie was auto-enrolled) and is billing the monthly coordination and outreach HCPCS code.

When Soozie arrived at the ER today, she was triaged and her insurance coverage was verified. The hospital staff verified through the Recipient Eligibility Verification System (REVS) that Soozie is a SoonerCare member and the system also identifies that she is affiliated with a Metro Health Home. The Hospital staff notices that Soozie's information is not up to date in the system so they enter Soozie's current address and phone number. Since Soozie was identified as being affiliated with a health home, the hospital admissions clerk hands Suzie's information over to Sam the Hospital Social Worker to identify Soozie's Health Home. Per the MOU established between General Hospital and Metro Health Home, Sam contacts Nancy NCM at Metro to let her know of Soozie's recent admission.

Behind the Scenes-
Nancy logs into the OHCA Provider Portal to review and print Soozie's medical and behavioral health history over the past 3 years. The Provider Portal reports on all of Soozie's medications prescribed in the last 3 years. It also includes all clinical episodes of both inpatient and outpatient including date, provider, diagnosis and procedure. It also lets Nancy know that Soozie is aligned with a SoonerCare Choice PCP. Nancy contacts General Hospital and provides outpatient medication reconciliation to Soozie's nurse using the report generated from the Provider Portal and provides a copy of the report to the hospital to be used in treatment planning while Soozie is hospitalized.

Behind the scenes-
Metro Health Home does not have an embedded physician consultant and does not have a pre-existing relationship with Soozie's PCP. Nancy NCM initiates contact with the PCP to engage him to be a part of Suzie's Health Home team. The PCP agrees and enters into a mutually agreeable MOU with Metro CMHC. Metro CMHC notifies Soozie's PCP of her recent hospital admission.

The Provider Portal indicates that Soozie has been regularly filling prescriptions for her antipsychotic and antidepressant medication, but has only filled a prescription for her prescribed oral diabetic medication one time which was more than 3 months ago. According to the report, she does not have any prescriptions for her hypertension. She has only seen her PCP three times in the last 3 years and has visited urgent care centers 3 times. Two of the PCP visits were for her diabetes, and one was for hypertension. The urgent care visits were for simple acute complaints, including upper respiratory infection and a sprained ankle.

Transition Coordination and Discharge Planning:

General Hospital notifies Nancy when Soozie is well enough for visitors. Nancy goes to the hospital to visit Soozie and to assist her in getting and keeping her appointments and avoid unnecessary hospital visits in the future. Soozie agrees to accept this assistance. Nancy sets up an appointment for Soozie with Metro Health Home the following week and tells her they will contact and visit her as soon as she is discharged from General Hospital.

Subsequent to the visit, Nancy calls Soozie's hospital unit nurse regularly to track her progress and to be updated regarding her discharge plan. Prior to her discharge, the hospital consults with Metro Health Home team on Soozie's discharge plan. Upon finalization, the hospital faxes Soozie's after-care plan to Nancy at Metro Health Home. Soozie is then discharged from the hospital.

Post Discharge Care Coordination & Follow-Up:

Two days after discharge, Nancy calls Soozie to check on her and to make sure she has filled her prescriptions and is following her discharge plan. Soozie indicates that she has not filled her prescriptions yet because she does not have transportation. Nancy sends a Metro Health Home case manager to Soozie's home. Together, Soozie and the case manager to go the pharmacy to fill her discharge medication orders and then stop back at the Health Home where Nancy reviews the purpose of each medication with Soozie. Nancy helps Soozie in filling a daily medication

administration box for her to use at home. Nancy advises Soozie about diet and engages in a discussion about appropriate exercises. The Metro Health Home case manager takes Soozie back to her home.

Medical Care Coordination & Health Promotion:

The next week, Soozie goes to Metro Health Home for her scheduled appointment (*she received a reminder phone call from the* Health Home *to keep the appointment the previous day).* At this appointment, Soozie is given the usual comprehensive evaluation regarding her behavioral health. She also receives a health risk evaluation from Nancy that includes screening for BMI, blood pressure, cholesterol, triglycerides, and glucose intolerance. This information is entered into Soozie's EHR. Nancy notes the following healthcare problems by a combined review of her history obtained from the Provider Portal, health risk assessment and metabolic screening.

- Although Soozie is aligned with a PCP, she does not have an ongoing relationship with him.
- Soozie has a diagnosis of hypertension, but has not been prescribed any medication for hypertension in the past 2 years, and her current blood pressure is elevated above normal range.
- Soozie was diagnosed with diabetes a year ago, but she has never been given diabetic education except for a brief discussion with her PCP upon diagnosis. She does not really think she has diabetes because they are not giving her insulin. She does not understand the use of oral medications to control high blood sugar so she does not get the prescriptions filled.
- Soozie smokes two packs a day, but wants to quit. She is also obese but does not like the idea of dieting.

Treatment Plan Development:

The Health Home's nurse care manager (Nancy) and behavioral health professional review their evaluations of Soozie with the psychiatrist. Before Soozie leaves the Health Home that day, she engages in a group discussion with Nancy, the behavioral health professional who conducted her behavioral health evaluation, and her case manager. Together, they agree on initial treatment plan that includes:

Soozie's Initial Treatment Plan

Recovery Goal: I will see my primary care physician regularly and will alert him to any changes in my condition. My PCP will manage my hypertension and diabetes.

Outcome: I will stay in touch with my case manager and doctor and will take all of my medications. I want to do a better job at taking care of myself.

Health Home Action Plan: A case manager/care coordinator will visit Soozie at least once weekly and check her medication plan and whether she is taking medication as prescribed.

Recovery Goal: I agree that it is important to stop smoking and will attend the Metro Health Home smoking cessation support group 2 days a week. I will work with my case manager in obtaining access to tobacco cessation aides to assist me with quitting.

Outcome: I understand that smoking is not good for me and I need to try to quit. I also understand that this will be hard and need support from others.

Health Home Action Plan: Soozie's case manager will schedule time to go over all of his SoonerCare options for smoking cessation medications & let him know when support groups meet.

Recovery Goal: I would like to get a job and be able to better support myself. I'm not sure what I want to do, but have always thought about cutting hair.

Outcome: Getting a job may help me be motivated to take better care of myself and to get out of the house and meet new people.

Health Home Action Plan: The Case manager will help Soozie get in touch with vocational rehab services in her community so she can pursue her desire to be a beauty technician.

Per the treatment plan, Nancy calls Soozie's PCP's office to arrange an appointment for Soozie for the following week. The case manager calls Soozie to notify her about the appointment and also calls as a reminder to her the day before the appointment.

Case Management:

Despite the case manager's efforts to remind Soozie, she fails to keep her 9:00 am appointment with her PCP. When the case manager inquires about why the appointment was missed, Nancy states that she rarely wakes before 11am. The case manager tries again and calls the PCPs office to arrange another appointment for Soozie. The case manager assures the PCP's office staff that they will make sure Soozie makes her next appointment. They set the appointment for 2pm the following Tuesday.

Soozie's case manager calls Soozie the day before and goes to Soozie's house at 1pm the following day to accompany her to her 2pm appointment. Soozie's case manager walks the PCP through the summary that was created from the report of Soozie's medical history generated from the Provider Portal. She also shares assists Soozie in sharing with the PCP the nurse care manager's health risk assessment, and Soozie's initial treatment plan. PCP examines Soozie, prescribes a different dosage of her diabetes medication and starts her on antihypertensive medication. PCP amends Soozie's treatment plan as follows:

PCPs Additions to Soozie's Treatment Plan

- ☑ Antihypertensive medication added
- ☑ Reflects different dosage of Metformin for diabetes
- ☑ Psychiatrist may want to consider switching Soozie's antipsychotic medication to one less likely to cause weight gain.
- ☑ Get flu vaccine in the fall.

Behind the scenes –
Three days after the PCP visit, Soozie's PCP contacts Nancy the NCM to share the results of Soozie's lab results which indicate that she is 3 weeks pregnant. PCP and Nancy agree that Soozie's pregnancy is high risk, given her age and chronic conditions (diabetes, high blood pressure, etc.). NCM calls the OHCA Population Care Management nurse to let her know about Soozie's pregnancy which has been identified as high risk and to let her know that Metro Health Home *will assume the lead care coordination role and that OHCA can remove Soozie from the list of individuals to be care coordinated through OHCA's internal high-risk OB care management processes. Nancy also calls the care coordinator with Soozie's Health Access Network and the HAN identifies a OB/GYN and a maternal-fetal medicine specialist within the network that are both accepting SoonerCare patients. The HAN care coordinator gives the specialists' information to Nancy.*

Nancy calls Soozie to set an appointment for the next day to come into Metro Health Home to discuss her lab results that came from her recent PCP visit. Soozie shows up on time for her appointment and Nancy reviews the results of her lab work with Soozie. Soozie was surprised by the results, but excited. Nancy took this opportunity to discuss the following with Soozie:

- ☑ Talked with Soozie about the importance of eating a healthy diet that includes protein, milk and milk products, fruits, and vegetables.
- ☑ Discussed vitamins and supplements for Soozie to take during her pregnancy and explained the importance of taking them every day in order to keep the baby healthy.

- ☑ Discussed symptoms and changes to her body that she should expect over the next few months related to her pregnancy and identified several symptoms that she should be aware of in order to call Metro CMHC right away if they occur (i.e. sudden swelling of her face, hands or feet; severe headache, new vision problems, vaginal bleeding, fever, etc.).
- ☑ Assessed Soozie's progress on her tobacco cessation plan. Stressed the importance of not smoking during her pregnancy. Also educated Soozie on the effects of alcohol consumption during a pregnancy and stressed the importance of not drinking.

Nancy NCM's Additions to Soozie's Treatment Plan

- ☑ Folic Acid Recommended
- ☑ Set appointment with OB/GYN
- ☑ Set appointment for MFM Specialist
- ☑ Set appointment with nutritionist to discuss diet options during pregnancy
- ☑ Set appointments

Improved Outcomes:

Soozie maintained her enrollment with Metro Health Home who assisted her throughout the stages of her pregnancy. Nancy NCM and the rest of the Health Home team were able to coordinate Soozie's care and ensure that she adhered to her Treatment Plan and kept her regularly scheduled appointments with her MFM as well as her PCP. Since she followed the protocols established by her HH team and physicians, Soozie's baby was born healthy with no complications. Nancy NCM worked with Soozie and Soozie's PCP to identify and select an appropriate pediatrician to care for Soozie's baby since Soozie's PCP does not see children below 3 years old.

Metro Health Home maintained Soozie's level of support and care coordination throughout the year following the birth of her child. Ongoing assessment and evaluation by the Health Home team indicated that this was necessary in order to ensure Soozie's success in maintaining the level of functioning needed to support herself and her child in the community.
However, after the year went by, Soozie was determined by the team to be able to successfully support herself and her child without the high level of coordination from Metro Health Home. During a routine Health Home visit, Nancy NCM praised Soozie for the progress she had made over the past several years and discussed options for reducing the amount of supports that she received from her heath home since she had been successful in utilizing the tools given to her by the Health Home team. Soozie was very receptive to the idea and together. Nancy NCM discussed Soozie's current situation with the rest of the Health Home team during their weekly team meeting and together, they revised Soozie's treatment plan:

Modified Treatment Plan

Recovery Goal: I will see my primary care physician regularly and will alert him to any changes in my condition. My PCP will manage my hypertension and diabetes.

Outcome: I will stay in touch with my case manager and doctor and will take all of my medications. I want to do a better job at taking care of myself.

Notes: *Soozie has made considerable improvements in maintaining contact with her PCP and specialists. Instead of relying on her case manager to contact her on a weekly basis, Soozie initiates contact with her case manager every Monday afternoon. During treatment team meetings, PCP has indicated that Soozie arrives at all of her scheduled appointments and has adhered to all medication protocols assigned.*

Health Home Action Plan: A case manager/care coordinator will visit Soozie at least once weekly and check her medication plan and whether she is taking medication as prescribed.

Revised Action Plan: *Soozie has been tobacco free for 1 year and 8 months. She has complied with all of her medication regimens. Action plan is revised to require that Soozie reduce her med checks to once a month at Metro HH. Soozie will check in telephonically with her case manager every other week to check in. Unless something occurs to indicate the need for more intensive services, Soozie will be transitioned to the low level Care Coordination group.*

Behind the scenes –
Nancy NCM uses the completed evaluation and treatment plan update to fill out an updated Client Assessment Record (CAR) and submits a request for a Prior Authorization for the Low Level Care Coordination Health Home Group, which is authorized based on the CAR score submitted. When Metro Health Home submits a claim for Health Home services the following month, reimbursement will be made based on the lower amount affiliated with the Low Level Care Coordination Prior Authorization.