Southwest Michigan BEHAVIORAL HEALTH

Opioid Health Home Service Encounters

OHH encounters are extra services that must support clients in one of the six OHH core areas:

Care Management, including but not limited to:

- Completing OHH Paperwork (ROI, Consent to Treat, Needs Assessment, Care Plan, etc)
- Documentation of paperwork in EMR
- Review of Care Plan/Needs Assessment

Care Coordination, including but not limited to:

- Care coordination with other service providers (PCP, MH services, specialists, social services, etc)
- Coordinating transitions between levels of care (hospitalization, rehab, etc)
- Assisting in making appointments and arranging transportation for or with client
- Medication adherence and monitoring (running MAPS, checking on refills, etc)
- Case consultation/OHH team meetings
- Tracking test results (urine drug screens, labwork, etc- receiving information, sharing information with other providers, uploading documentation into EMR, etc)

Health Promotion, including but not limited to:

- Providing information about healthcare concerns (diabetes education, nutrition education, medication education, etc)
- Encouraging preventative care such as wellness checks, immunizations, screenings, etc
- Assessing the patient and family's understanding of the health condition and motivation to engage in self-management
- Connecting beneficiary to resources (smoking cessation, nutritional counseling, obesity reduction, etc)

Comprehensive Transitional Care, including but not limited to:

- Connecting beneficiary to health services (assisting with scheduling, transportation, etc)
- Follow up with client after specialist appointments (phone calls or in person)
- Receiving and reviewing care records from other providers
- Post-discharge outreach to ensure appropriate follow up care
- Medication reconciliation (reviewing MAPS, checking pharmacy refills, etc)
- Pharmacy coordination (checking on scripts, refills, prescribers, etc)
- Educating about proactive care versus reactive care
- Coordination of care through transitions of care (getting out of rehab, jail, etc)

Individual and Family Support, including but not limited to:

- Use of community supports (peer recovery coach, AA, Al-anon, SMART Recovery, etc)
- Including supportive family in treatment adherence
- Including supportive family input in treatment needs and goals
- Working with client to build sober support network
- Helping clients work through barriers to adherence to treatment (issues with transportation, reminder calls, etc)

Referral to Community and Social Supports, including but not limited to:

- Referring clients to social supports (housing, employment, education, etc)
- Providing resource materials for clients

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- Assisting clients in obtaining resources, including disability, food stamps, unemployment, etc.
- Follow up with clients after being referred to social supports

Billing:

- S0280 HG- Service is provided to client in person.
- S0280 HG:TS- Non face-to-face. Phone/video or services in which the client is not participating.

Frequently Asked Questions:

- Do I have to talk directly to the client or can I leave a voicemail for an appointment reminder call?
    - We would like to make every effort to speak to the client directly so that we can ensure they don't have other needs that need to be met. For example, say peer calls client and client doesn't answer. He leaves a voicemail stating "hey client, wanted to remind you of your appointment tomorrow. I know transportation has been an issue recently, so I wanted to confirm you had a ride for tomorrow. If you don't, please let me know asap and we can try to arrange a ride." Peer then follows up with client after appointment to check on how things went, etc. Leaving a voicemail and not following up afterwards is not best practice.
- Do the OHH care team's efforts to re-engage a beneficiary in OHH services count as a service?
    - The care team's efforts to re-engage a beneficiary does not fall into one of the core health home services. Simply calling the patient to re-engage them, for example, would not fall under one of the six core health home services. If you are providing a health home service but do not necessarily contact that patient, that would count (such as appointment making assistance or referral tracking). Maintaining contact with the beneficiary would also count as long as you make contact with them either in-person or telephonically to support one of the qualified health home services (such as care coordination).
- If another member of the agency coordinates care for the client, does this count as a service?
    - No. OHH services must be completed by members of the OHH team. However, if the other member of the agency then informs the OHH team about their care coordination, that would be considered a service, as the team is now coordinating care with the other agency member.

- If I am unable to meet with a client directly, can I leave resource paperwork for them to grab at our front desk?
    - Yes. Time was spent gathering information for the client's need, which would fall into the guidelines of care coordination. For example, if a client is struggling with food insecurity so you gather paperwork about food pantries to leave at the front desk for client to get when they are at the agency next. While you may not be working directly with the client, you are working on one of the core OHH services (referral to community and social supports) for that client. Best practice would be to follow up with the client, whether in person or via phone to ensure they received the paperwork and if they needed any additional support in regards to the paperwork.