

Gold Award: Community-Based Program: A Health Care Home for the “Whole Person” in Missouri’s Community Mental Health Centers

Missouri Community Mental Health Center Health Home Program, Jefferson City, Missouri

The premature mortality associated with serious mental illness is largely preventable. There is strong evidence that access to high-quality, integrated care can improve the health of individuals with serious mental illnesses. In 2011, the state of Missouri made a commitment to its citizens to focus on prevention efforts. Using an integrated care approach, Missouri’s Department of Mental Health (DMH) collaborated with the state’s Medicaid system (MO HealthNet) and community mental health system to establish “health homes” throughout the state’s 29 community mental health centers (CMHCs).

All adults enrolled in Missouri’s CMHC Health Home Program have a serious mental illness, and all children and youths in the program have a serious emotional disorder. Estimates indicate that 70% of individuals with a significant mental disorder or substance use disorder have at least one chronic health condition, 45% have two, and almost 30% have three or more, and prevalence of these conditions far exceeds that in the general population. The health home approach allows eligible Medicaid enrollees to receive health care for targeted chronic conditions such as diabetes, chronic obstructed pulmonary disease, hypertension, and asthma, as well as mental health care. Health homes either strengthen linkages to community primary care providers (PCPs) or bring PCPs in house.

Because people with serious mental illness have a significant potential to develop metabolic syndrome, since 2010 the Missouri DMH has required CMHCs to conduct metabolic screening for all individuals receiving psychotropic medications. At that time, DMH established a benchmark goal of screening 80% of CMHC Health Home Program enrollees, and screening has increased steadily, from the baseline rate of 12% in February 2012 to 86% as of March 2015.

The “facility” that developed, implemented, and operates the CMHC Health Home Program is an innovatively structured “virtual organization” based on successful partnerships and cooperative business practices that coordinate staffing, funding, and data and information systems. Joining Missouri DMH and MO Health Net in the enterprise are the Missouri Coalition for Community Behavioral Healthcare, Missouri Primary Care Association, Missouri Institute of Mental Health, and Care Management Technologies (a private data-analytics disease management company). CMHC Health Home Program

Director Joseph Parks, M.D., described the organization as “a private/public/academic, provider/payer, nonprofit/for-profit, behavioral health–primary care partnership based on mutual trust and willingness to undertake risk.” With innovative funding, data collection, and data sharing within the program, multiple partners work to advance one mission: to integrate health care and treat the “whole person.”

The goals of the Missouri CMHC Health Home Program are to improve interventions by helping clients develop social and independent living skills; to tailor a treatment plan to the individual’s needs to reduce and manage symptoms; to provide services that result in positive outcomes in employment, housing, and community and family living; to reduce hospitalizations and emergency visits; to improve hospitalization discharge processes so that individuals are linked to care and medication within 72 hours of discharge; to improve overall health by conducting annual metabolic screening and follow-up; and to develop and support clients’ wellness and recovery goals.

Careful screening, reporting results, tracking results against Medicaid records, and following up with clients have paid big dividends: After the first year of implementation, the Missouri CMHC Health Home Program resulted in a \$98 per-member-per-month (PMPM) reduction in health care costs, which led to \$31 million in Medicaid savings and significantly improved clinical health outcomes for beneficiaries with behavioral disorders. These savings are primarily attributed to reductions in hospitalizations and emergency room visits.

In recognition of its leadership in establishing health homes to provide integrated care to its CMHC clients and demonstrating dramatic improvement in health outcomes, Missouri’s CMHC Health Home Program, a “virtual organization” based on innovative Missouri partnerships, was selected to receive APA’s 2015 Gold Achievement Award for community-based programs. The winner of the 2015 Gold Achievement Award in the category of academically or institutionally sponsored programs is described in an accompanying article. The award will be presented October 8, 2015, at the opening session of the Institute on Psychiatric Services in New York City.

A PIONEER IN INTEGRATED CARE

Missouri was the first state in the country to win approval from the Centers for Medicare and Medicaid Services (CMS)

for health homes within its Medicaid system. Prior to the Affordable Care Act (ACA) and the authorization of health homes, Missouri's CMHCs had already started to train providers on chronic conditions and use of data-analytic tools. Missouri's DMH had designated CMHCs as the central care coordination sites for consumers without a regular PCP. CMHCs had primary care nurse liaisons on site to educate the behavioral health staff about general medical issues and train case managers in recognizing and managing chronic medical conditions. This care coordination was in addition to the traditional behavioral health case management activities.

With implementation of the CMHC Health Home Program, the case managers were able to provide services such as assisting with adherence to medications for medical conditions, scheduling and keeping appointments, and obtaining a PCP. Furthermore, these case managers coordinate care across health care providers and between clinic visits on behalf of their consumers.

Missouri's CMHC health homes embrace a recovery philosophy and are focused on the recovery goals of their clients. The health homes provide the necessary supports to individuals, families, and caregivers to assist and empower them in attaining their highest level of health and functioning possible in their communities. As Dr. Parks explains, "Research has documented that informed and engaged consumers have a vital role to play in improving the quality of their care. The expectation is that when consumers are armed with the right information, they will demand high-quality services from their providers, choose treatment options wisely, and become active participants and self-managers of their own health and health care. Services must be quality driven, cost effective, culturally appropriate, person and family centered, and evidence based. Most consumers in CMHC health homes want to change their behaviors and lifestyle choices but have not had the tools to do so." Furthermore, as consumers learn about their illness and about treatment and services, they become empowered to ask questions about their primary care and become their own advocate in the health care system.

AN INNOVATIVE VIRTUAL ORGANIZATION FOR WHOLE-PERSON, INTEGRATED CARE

The CMHC Health Home Program is a virtual organization that behaves as an integrated and unsiloed organization. All of the partners have access to all data—clinical, utilization, and financial. "This program works because it is not several programs collaborating—it is a single organization which happens to draw its staff from multiple employers," explains Parks.

Through the state's 29 CMHCs, the Health Home Program operates at over 120 sites and serves over 21,000 Health Home Program enrollees. Although CMHCs vary greatly in size and organization (hospital-owned center versus federally qualified health center versus traditional CMHC), they use a common, shared electronic health record, disease registry, and next-day notification of emergency

and hospital use systems. Other key unifying elements include a uniform staffing model and performance and outcome measures that are used across sites.

Funding by the state and federal government provides resources to support three key enhancements that enabled the existing CMHC treatment programs to make the changes necessary to function as health homes for their consumers: additional health home staffing, improved care management reports and tools, and targeted training and technical assistance. For fiscal year 2014, the program was funded \$15.2 million—\$5.8 million from state general revenue and \$9.4 million from federal Medicaid. The funding structure for the program is innovatively structured to reinforce the partnerships. The state pays fees to each CMHC health home at a PMPM rate. The health home sends approximately \$3 of the total PMPM to the Missouri Coalition of Community Mental Health Centers for technical assistance and support, of which \$1 is used to hire staff at the Missouri Coalition of Community Mental Health Centers. Of the remaining PMPM, approximately \$2 is contracted to the University of Missouri—St. Louis to provide management staff, evaluation faculty, and the data-analytics services from Care Management Technologies. This interreliance helps to secure the relationships between the state, each health home, the statewide CMHC system as a whole, and the data management vendor.

METABOLIC SCREENING, ANALYSIS, AND FOLLOW-UP

CMHC health homes receive monthly reports based on Medicaid paid claims data that enable monitoring of enrollees in three key areas: psychotropic medications, medication adherence, and chronic disease management. Care Management compares enrollment data to Medicaid paid claims data and to metabolic screening data submitted by the CMHC health homes to generate the reports. The CMHCs conduct metabolic screening and collect values on body mass index, waist circumference, blood pressure, blood glucose or HgbA1c, and lipid levels. CMHCs also gather information about use of antipsychotic medication, pregnancy status, and tobacco use. This information is reported to all members of the partnership team and compared with Medicaid claims data to generate disease management reports that are used to monitor the health status of individuals with chronic diseases.

Medication adherence by patients with at least one of four chronic vascular diseases (congestive heart failure, hypertension, diabetes, and dyslipidemia) leads to substantial medical savings due to reductions in hospitalization and emergency department use. Missouri currently exceeds benchmarks for adherence rates, showing 90% medication adherence among its health home patients. CMHC health homes use these medication adherence reports to help identify individuals who are not routinely filling their prescriptions or not taking their medications as prescribed.

In addition to these reports, CMHC health homes are constantly updated on any hospitalization of their clients. All initial authorization claims for admissions are identified, sorted, and sent to an individual's health home. This gives health homes immediate information so that hospitalizations can be tracked and individuals can be contacted within 72 hours of hospital discharge, get a medication reconciliation, and be linked with services on discharge. MO HealthNet's analysis of Medicaid expenditures found a 12.8% reduction in hospital admissions per 1,000 individuals and an 8.2% reduction in emergency room use per 1,000 individuals for CMHC Health Home Program enrollees from the years prior to enrollment to the years after enrollment.

With this constant loop of screening, reporting, and analysis of results, CMHC health homes follow up at the individual level as well as at the system level to ensure strong outcomes. For example, metabolic screening is a key tool for identifying diabetes, hypertension, and cardiovascular disease; assessing progress in managing these chronic diseases; and improving health status related to obesity and tobacco use. Screening has increased by 74 percentage points since DMH set a benchmark goal of 80% in 2010. Between February 2012 and June 2014, increasing proportions of CMHC health home clients have achieved better control of their conditions. For example, among clients with cardiovascular disease, those screened and found to be maintaining "good cholesterol" levels have increased from 21% to 55%. Among clients with hypertension, only 24% had been screened and found to have normal blood pressure readings in early 2012, whereas 65% had good readings in mid-2014. And a higher proportion of clients with diabetes were screened and found to have gained control of blood sugar levels, increasing from 18% to 64% of clients in the period analyzed.

STAFFING TO CHAMPION HEALTHY LIFESTYLES AMONG CONSUMERS

In addition to having a strong existing psychiatric rehabilitation team and new positions for a CMHC Health Home Program director and care coordinator, staffing is anchored by nurse care managers (NCMs), who are responsible for the clinical enhancements of the CMHC health home. Among other tasks, NCMs identify where to improve care of consumers on their caseload, champion healthy lifestyles and preventive care, monitor monthly care management reports and prioritize intervention, train other staff in wellness and disease management, and provide psychoeducation for consumers and families. NCMs also engage in discharge planning and medication reconciliation in the event a client is hospitalized, and provide liaison with community support workers and external health care providers.

The health home psychiatrists provide leadership in the medical treatment of psychiatric disorders, share medical oversight with their primary care colleagues in the

management of comorbid medical conditions, treat psychiatric disorders while minimizing complications of psychotropic medications, refer medical conditions to PCPs, and collaborate with them by sharing lab results and treatment regimens to manage the overall health of each individual. Psychiatrists collaborate with health home team members in promoting recovery from serious mental illness, self-management of other chronic medical conditions, and adoption of healthy lifestyles. Psychiatrists also engage with the PCPs to improve each other's ability to "see the whole person" by exchanging information and championing behavioral health expertise in support of behavior change.

Health home psychiatrists and their teams are also provided with primary care physician consultants. These physicians are employed by and work on site directly in the CMHC. They consult on the chronic general medical conditions of individual clients, advise the psychiatrist and CMHC health home team on interventions to care for these conditions, educate staff on standards of care and management of chronic medical conditions, and serve as liaisons to the other primary care physicians in their community. There is a long history of placing psychiatric consultants within primary care practices. Missouri CMHC health homes put primary care consultants into psychiatric practices to provide CMHC health home psychiatrists more diverse physician colleagues and more connections to medicine as a whole.

CHALLENGES

The challenges facing the Missouri CMHC Health Home Program mainly concern data collection and training staff in new systems. Gaining timely access to comprehensive Medicare data remains challenging. Approximately 40% of the population served are dually eligible for Medicaid and Medicare, and without a view into all of the services and supports individuals are receiving, tracking clinical outcomes and the system impact of health home services is significantly restricted. In addition, there are very few data-analytic tools on the market to assess the progress of enrollees toward recovery from serious mental illness and serious emotional disorders; the program is working to integrate data from a functional assessment tool into its data-analytics system.

The launch of the CMHC Health Home Program challenged staff to collect and organize new types of data and analyze new reports generated from that data, revise existing processes, and measure outcomes and benchmarks. Providers and staff had to learn a significant amount of information provided by the NCM related to diseases, wellness, and coordination of care within the larger health care system, in addition to covering their behavioral health responsibilities. At times, they have faced resistance from PCPs, but through concise reporting and relationship building, plus the evidence

of improved health indicators, outside PCPs have become engaged in the health home concept.

NATIONAL RECOGNITION AND A MODEL FOR OTHER STATES

Missouri's investment in integrated care is a behavioral health innovation that has resulted in improved care coordination and has placed Missouri on a national stage as a model in integration. The state's CMHC health homes have been nationally recognized by the Substance Abuse and Mental Health Services Administration, CMS, and the National Council for Behavioral Healthcare. Missouri has provided consultation to several states working to launch their own CMHC health home programs. Maryland, Iowa, and Ohio are using the same model, and Georgia, Kansas,

Oklahoma, and Washington have reached out to Missouri for guidance as they embark on similar programs. The program was honored to be selected as a Harvard business case study, which will be presented at the October meeting of the National Association of State Chief Administrators. The CMHC Health Home Program has even participated in discussions regarding the development of international accreditation standards for behavioral health organizations seeking to serve as health homes for individuals with serious mental illness.

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Psychiatric Services 2015; 66:e5–e8; doi: 10.1176/appi.ps.661013