



Missouri's CMHC Healthcare Homes



Agenda

- The Affordable Care Act: Medicaid Health Homes
- Missouri's Primary Care Health Homes
- Missouri's CMHC Healthcare Homes
 - Why CMHC Healthcare Homes?
 - What is a CMHC Healthcare Home?
 - Care Management: Tools and Reports
 - Enrolling Consumers
 - Monthly Reports
 - Performance Measures
 - Program Reviews, Evaluations, and Accreditation
 - Training



The Affordable Care Act

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Medicaid Health Homes



What is a Health Home?

The Affordable Care Act

- Section 2703 of the Affordable Care Act **allows states to amend their Medicaid state plans to provide Health Homes** for enrollees with chronic conditions.
- **“Eligible individual with chronic conditions’** means an individual who is eligible for medical assistance...and has at least 2 chronic conditions; 1 chronic condition and is at risk of a second chronic condition; or **1 serious and persistent mental health condition.**”
- Provides an **enhanced 90:10 match rate** for 8 fiscal year quarters
- Though Missouri will return to its traditional match rate in January, 2014, CMHC Healthcare Homes will experience **no change in their reimbursement**



What is a Health Home?

Health Home Services

- ACA Section 2703 defines a ‘health home’ as a designated provider selected by an eligible individual to provide the following “health home services”:
 - Comprehensive Care Management
 - Care Coordination and Health Promotion
 - Comprehensive Transitional Care
 - Patient and Family Support
 - Referral to Community and Social Support Services
 - Use of Information Technology to Link Services



What is a Health Home?

CMS Expectations

- Health Homes embody a “whole person” approach
- Health Homes coordinate and provide access to
 - Health services
 - Preventive and health promotion services
 - Mental health and substance abuse services
- Health Homes achieve results
 - Lower rates of emergency room use
 - Reduce in-hospital admissions and readmissions
 - Reduce healthcare costs
 - Improve experience of care, quality of life and consumer satisfaction
 - Improve health outcomes



Missouri's Health Homes

- Missouri has two types of Health Homes
 - Primary Care Health Homes (25)
 - 19 Federally Qualified Health Centers (FQHCs)
 - 5 Public Hospitals
 - 1 Rural Health Clinic (RHC)
 - CMHC Healthcare Homes (28)





Primary Care Health Homes

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Primary Care Health Homes

- State Plan Amendment approved 12/23/11
- 20,239 individuals auto-enrolled
 - Primary Care patients with at least \$2,600 Medicaid costs annually
- 25 Primary Care Health Homes
 - Phased in from January through April, 2012



Primary Care Target Population

- Clients are eligible for a Primary Care health home as a result of having two chronic conditions; or having one chronic condition and being at risk for a second chronic condition. To be eligible patients must meet one of the following criteria
 - 1. Have Diabetes**
 - At risk for cardiovascular disease and a BMI>25
 - 2. Have two of the following conditions**
 - 1. COPD/Asthma**
 - 2. Cardiovascular disease**
 - 3. BMI>25**
 - 4. Developmental Disability**
 - 5. Use Tobacco**
 - At risk for COPD/asthma and cardiovascular disease





Primary Care Health Homes

- Provide primary care services, including screening for, and “comprehensive management” of, behavioral health issues
- Ensure access to, and coordinate care across, prevention, primary care, and specialty medical care, including specialty mental health services
- Promote healthy lifestyles and support individuals in managing their chronic health conditions
- Monitor critical health indicators
- Divert inappropriate ER visits
- Coordinate hospitalizations, including psychiatric hospitalizations, by participating in discharge planning and follow up



CMHC Healthcare Homes

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CMHC Healthcare Homes First in the Nation!

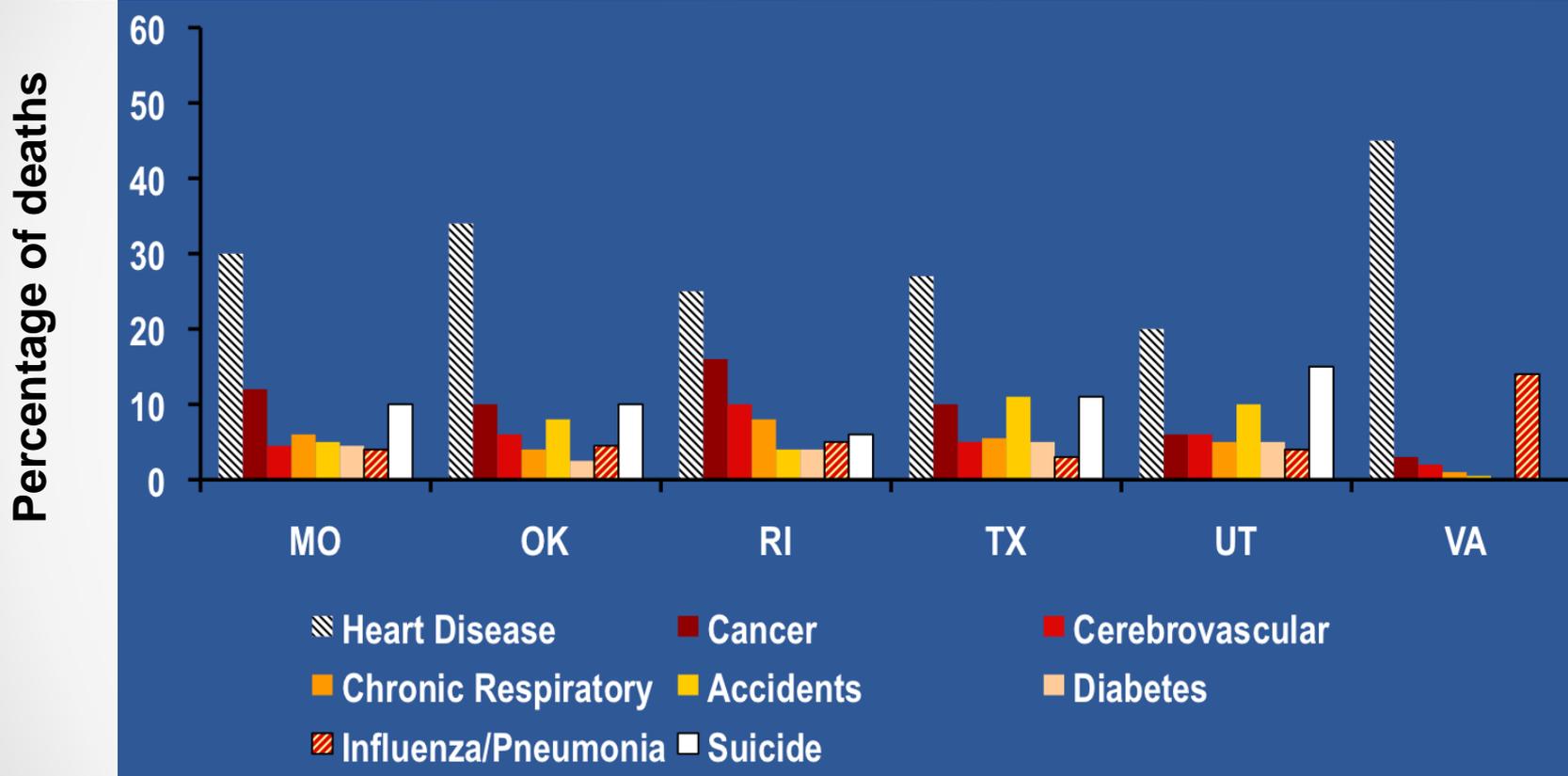
- On October 20th, 2011, Missouri became the first state in the nation to receive approval of a Medicaid State Plan Amendment (SPA) establishing Health Homes under Section 2703 of the Affordable Care Act.
- The first approved SPA in the nation established behavioral health homes: Missouri's CMHC Healthcare Homes.
- Effective January 1, 2012



Why CMHC Healthcare Homes?

- Because addressing behavioral health needs requires addressing other healthcare issues
 - Individuals with SMI, on average, die 25 years earlier than the general population.
 - 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases.
 - Second generation anti-psychotic medications are highly associated with weight gain, diabetes, dislipidemia (abnormal cholesterol) and metabolic syndrome.

Cardiovascular Disease Is Primary Cause of Death in Persons with Mental Illness



*Average data from 1996-2000.

Colton CW, Manderscheid RW. Prev Chronic Dis [serial online] 2006 Apr [date cited].

Lori Raney, M.D., Physician Institute, 6/12



Risk of Obesity Among Patients with SMI

Joseph Parks, M.D., National Council, 4/14/12

Disorder	↑ Odds of Obesity
Depression	1.2 - 1.8x ^{1,2}
Bipolar Disorder	1.5 – 2.3x ^{1,2}
Schizophrenia	3.5x ³

1. Simon GE et al Arch Gen Psychiatry. 2006 Jul;63(7):824-30.

2. Petry et al Psychosom Med. 2008 Apr;70(3):288-97

3. Coodin et al Can J Psychiatry 2001;46:549-55



Psychotropic Medications and Weight Gain

- Most antidepressants¹
- Most mood stabilizers²
- Most antipsychotic medications³
- However there are alternative drugs within each class that are potentially weight-neutral



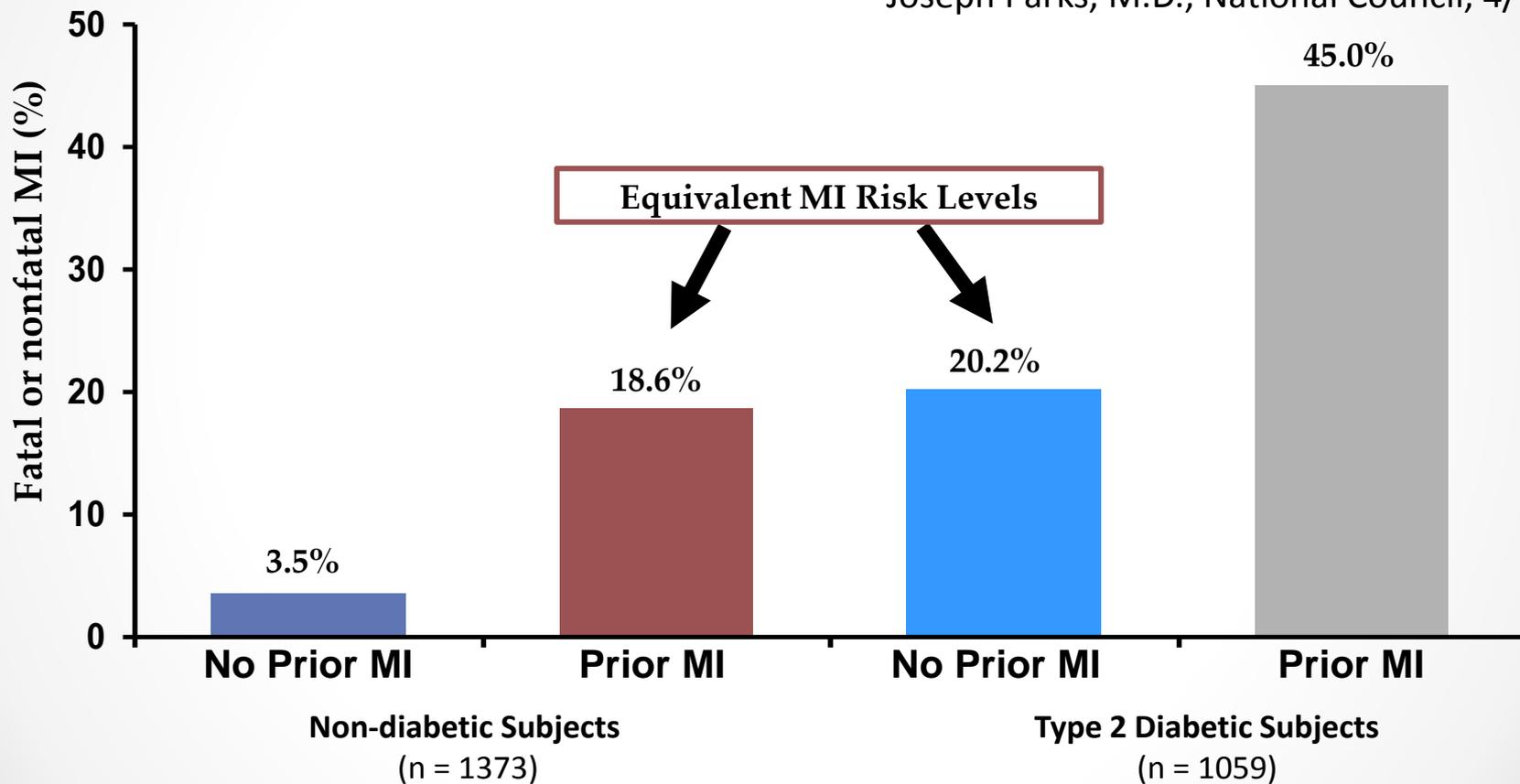
Joseph Parks, M.D., National Council, 4/14/12

1. Rader et al J Clin Psychiatry. 2006 Dec;67(12):1974-82.
2. Kerry et al Acta Psychiatr Scand 1970; 46: 238-43.
3. Newcomer J Clin Psychiatry. 2007;68 Suppl 4:8-13.



Diabetes is a CVD Risk Equivalent to Previous Myocardial Infarction

Joseph Parks, M.D., National Council, 4/14/12



Haffner SM et al. N Engl J Med. 1998;339:229-234.



Mental Disorders and Smoking



- > Higher prevalence of cigarette smoking (56-88%) for SMI patients (overall US prevalence 25%).
- > More toxic exposure for patients who smoke (more cigarettes, larger portion consumed).
- > Smoking is associated with increased insulin resistance.
- > 44% of all cigarettes in US are smoked by persons with mental illness.

Joseph Parks, M.D., National Council, 4/14/12



The CATIE Study

At baseline investigators found that:

- **88.0%** of subjects who had dyslipidemia
- **62.4%** of subjects who had hypertension
- **30.2%** of subjects who had diabetes

were NOT receiving treatment.

Joseph Parks, M.D., National Council, 4/14/12



A Few Observations



- The leading contributors include significant preventable causes.
- Lifestyle issues are significant.
- Iatrogenic effects of medications are significant.
- Inattention by medical and behavioral health professionals is significant.
- **And inadequate care is probably very expensive!**

Joseph Parks, M.D., National Council, 4/14/12



Good News

Small Changes Make a Big Difference

- Blood cholesterol
 - 10% ↓ = 30% ↓ in CHD (200-180)
- High blood pressure (> 140 SBP or 90 DBP)
 - ~ 6 mm Hg ↓ = 16% ↓ in CHD; 42% ↓ in stroke
- Diabetes (HbA1c > 7)
 - 1% point ↓ HbA1c = 21% dec in DM related deaths, 14% decrease in MI, 37% dec in microvascular complications

Stratton, et al, BMJ 2000

Hennekens CH. *Circulation* 1998;97:1095-1102.

Rich-Edwards JW, et al. *N Engl J Med* 1995;332:1758-1766.

Bassuk SS, Manson JE. *J Appl Physiol* 2005;99:1193-1204



Good News

Small Changes Make a Big Difference

- Cigarette smoking cessation
 - ~ 50% ↓ in CHD
- Maintenance of ideal body weight (BMI = 18.5-25)
 - 35%-55% ↓ in CHD
- Maintenance of active lifestyle (~30-min walk daily)
 - 35%-55% ↓ in CHD

Stratton, et al, BMJ 2000

Hennekens CH. *Circulation* 1998;97:1095-1102.

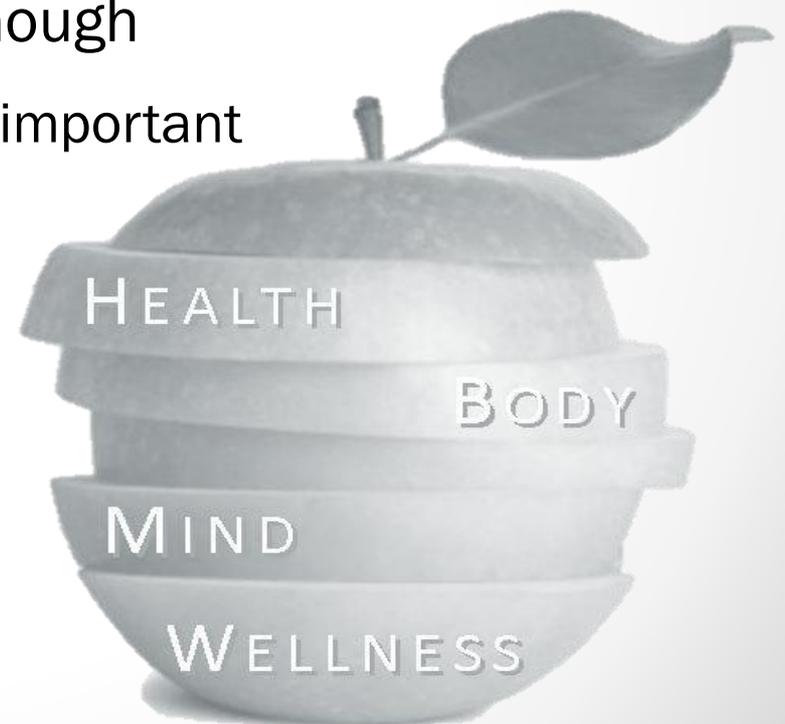
Rich-Edwards JW, et al. *N Engl J Med* 1995;332:1758-1766.

Bassuk SS, Manson JE. *J Appl Physiol* 2005;99:1193-1204



Why CMHC Healthcare Homes?

- Because addressing general health issues is necessary in order to improve outcomes and quality of care
- Because treating illness is not enough
 - Wellness and prevention are as important as treatment and rehabilitation.





Why CMHC Healthcare Homes?

- Because it's the natural next step for Missouri
 - Step One:** Implementing Psychiatric Rehabilitation Program
 - Step Two:** Implementing Health Information Technology Tools
 - CyberAccess
 - CMT data analytics
 - Behavioral Pharmacy Management
 - Disease Management
 - Medication Adherence
 - Step Three:** Missouri's Chronic Care Improvement Program



Why CMHC Healthcare Homes?

Chronic Care Improvement Program

- A study of 6,757 consumers eligible for Missouri's Chronic Care Improvement Program (CCIP) served by CMHCs showed significant savings when compared with projected costs for this population
- These individuals had mental illness and one of the following conditions:
 - *Asthma*
 - *Pre-diabetes or diabetes*
 - *Cardiovascular disease*
 - *Chronic obstructive pulmonary disease (COPD)*
 - *Gastroesophageal reflux disease (GERD)*
 - *Sickle cell disease*





Why CMHC Healthcare Homes? Chronic Care Improvement Program

Cost Savings Analysis of CMHC Clients Enrolled in CCIP

Initial PMPM Cost	\$1,556
Expected PMPM Cost w/o intervention	\$1,815
Actual PMPM Cost following enrollment w/ CMHC	\$1,504
Savings	\$21 million



Why CMHC Healthcare Homes?

- Because it's the natural next step for Missouri

Step Four: Building Integration Initiatives

- DMH Net Nurse liaisons
- FQHC/CMHC collaborations integrating primary and behavioral health

Step Five: Embracing Wellness and Prevention Initiatives

- Metabolic syndrome screening
- DM 3700 initiative

Next Step: Becoming a healthcare home





What is a CMHC Healthcare Home?

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CMHC Healthcare Home

A place where individuals can come throughout their lifetimes to have their healthcare needs identified – and the medical, behavioral and related social services and supports they need – provided or arranged for in a way that recognizes all of their needs as persons, not just patients.





Target Population

- Clients eligible for a CMHC healthcare home must meet one of the following three conditions (identified by patient health history):
 - 1. A serious and persistent mental illness**
 - CPR eligible adults and kids with SED
 - 2. A mental health condition and substance use disorder**
 - 3. A mental health condition and/or substance use disorder and one other chronic health condition**



Target Population

- Chronic health conditions include:

1. Diabetes
2. Cardiovascular disease
3. COPD/Asthma
4. Overweight (BMI >25)
5. Tobacco use
6. Developmental disability





What is Diabetes?

- Insulin is required to move sugar (glucose) from the blood into cells
- Diabetes is the inability to appropriately transfer glucose from the blood to the body's cells due to the reduced effectiveness of insulin



Two Types of Diabetes

- Type I
 - Body does not produce insulin
 - Onset typically early in life (“juvenile diabetes”)
- Type II
 - Insufficient insulin or decreased responsiveness to it
 - Most common
 - Develops in middle age



What is Cardiovascular Disease?

- **Cardiovascular Disease (CVD)** is a broad term used to describe three different diseases of the blood vessels:
 - **Coronary Artery Disease** – narrowing of the blood vessels to the heart – potential for **heart attack**
 - **Cerebral Vascular Disease** – narrowing of the blood vessels to the brain – potential for **stroke**
 - **Peripheral Vascular Disease** – narrowing of the blood vessels to the legs and feet – potential for **amputation**



What is Hypertension?

- Hypertension = High Blood Pressure
 - Blood Pressure (systolic) ≥ 140
 - OR**
 - Blood Pressure (diastolic) ≥ 90
- Consumers with diabetes or kidney disease are considered to be hypertensive if BP is above 120/80

The Silent Killer

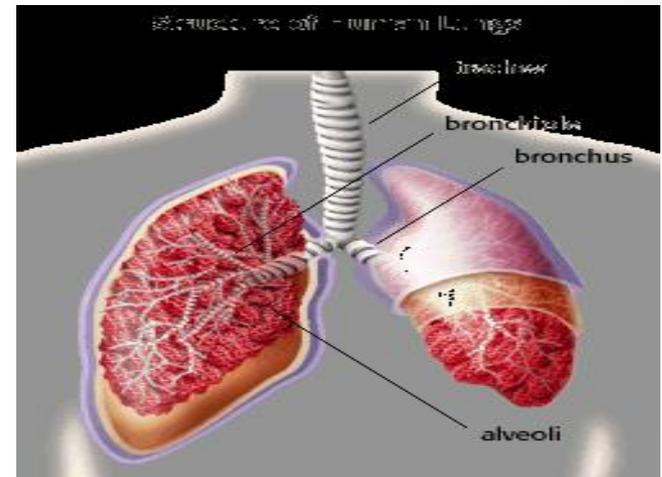
Most individuals do not have symptoms



What is COPD?

Chronic Obstructive Pulmonary Disorder

- Changes in the lungs and airways that impede the flow of air
 - Emphysema
 - Destruction of air sacs
 - Loss of elasticity
 - Chronic Bronchitis
 - Inflammation and mucous production that clogs airways





What is Asthma?

- Reversible obstruction to the airways usually due to inflammation
- Symptoms similar to COPD, but less likely to be fatal
- Typically there are identifiable “triggers” (allergens and irritants) of acute episodes

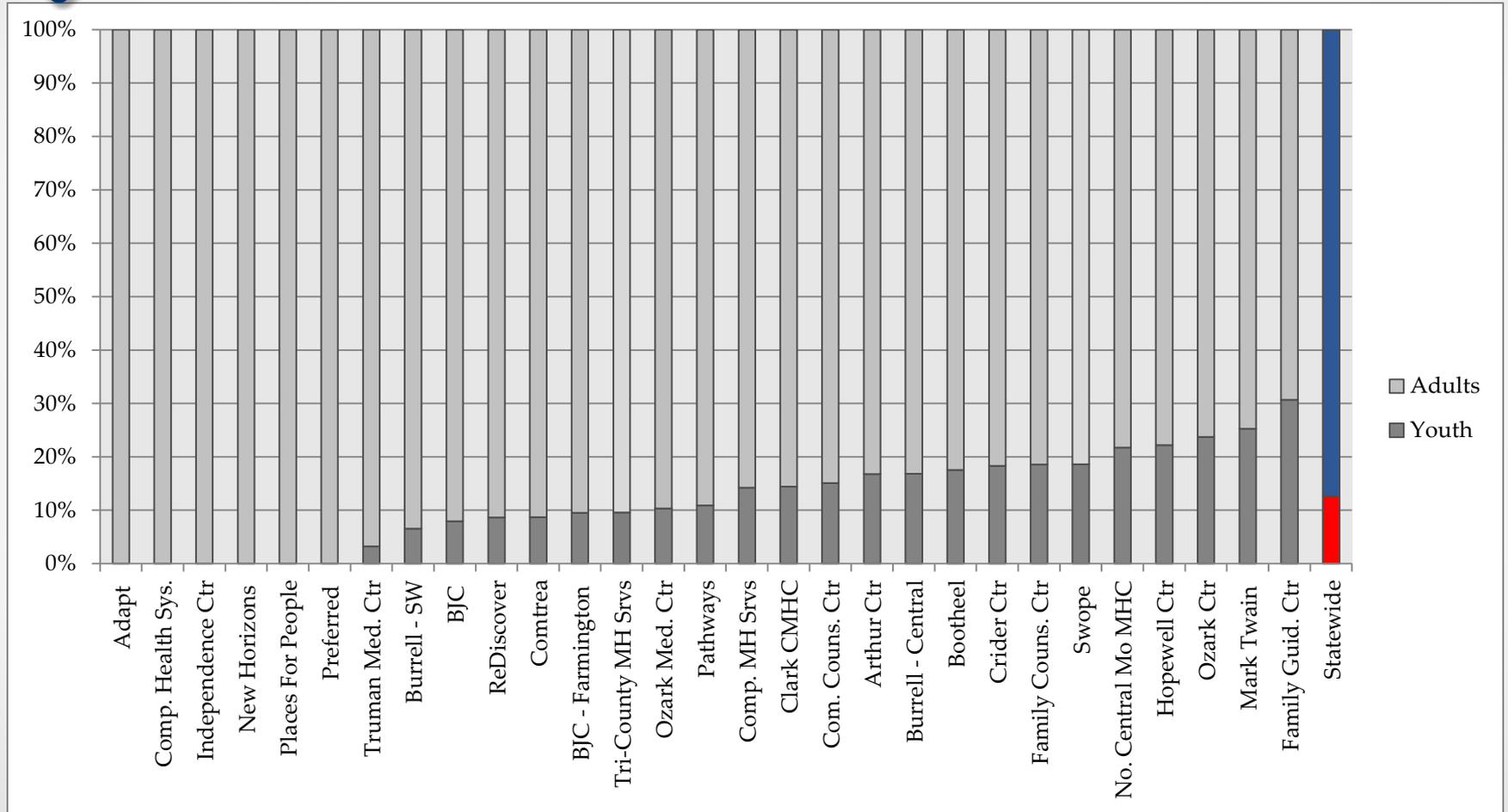


What is Body Mass Index (BMI)?

- A measure of obesity standardized for people of different heights that is easily determined based on weight and height
 - Underweight <math><18</math> (5'8" = <math>< 124</math> lbs.)
 - Normal BMI: 18-25 (5'8" = 125-163 lbs.)
 - Overweight: 25-30 (5'8" = 164-196 lbs.)
 - Obese: 30-40 (5'8" = 197-261 lbs.)
 - Extreme Obesity: > 40 (5'8" = > 262 lbs.)

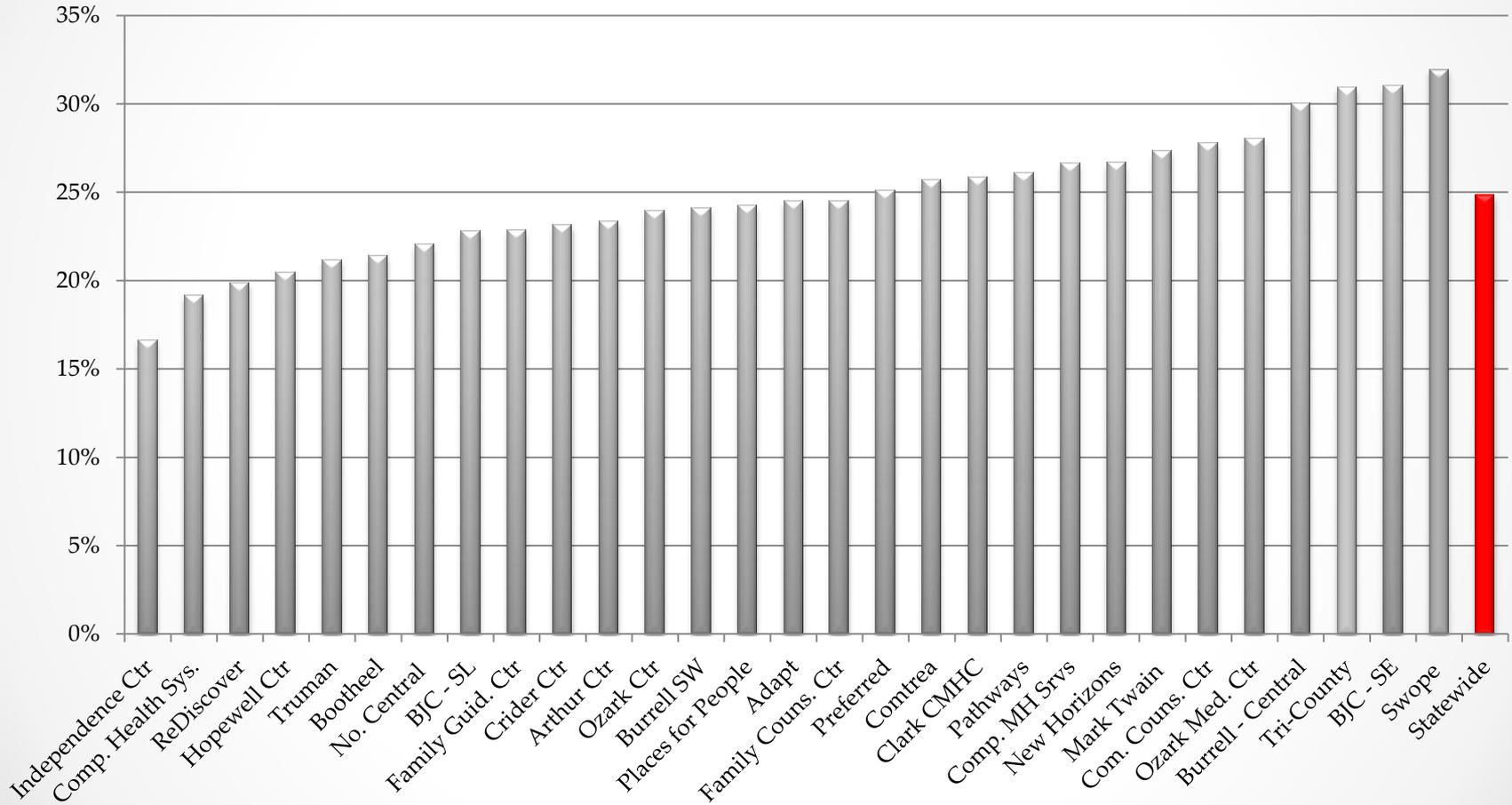


% of Youth and Adult HCH Enrollees



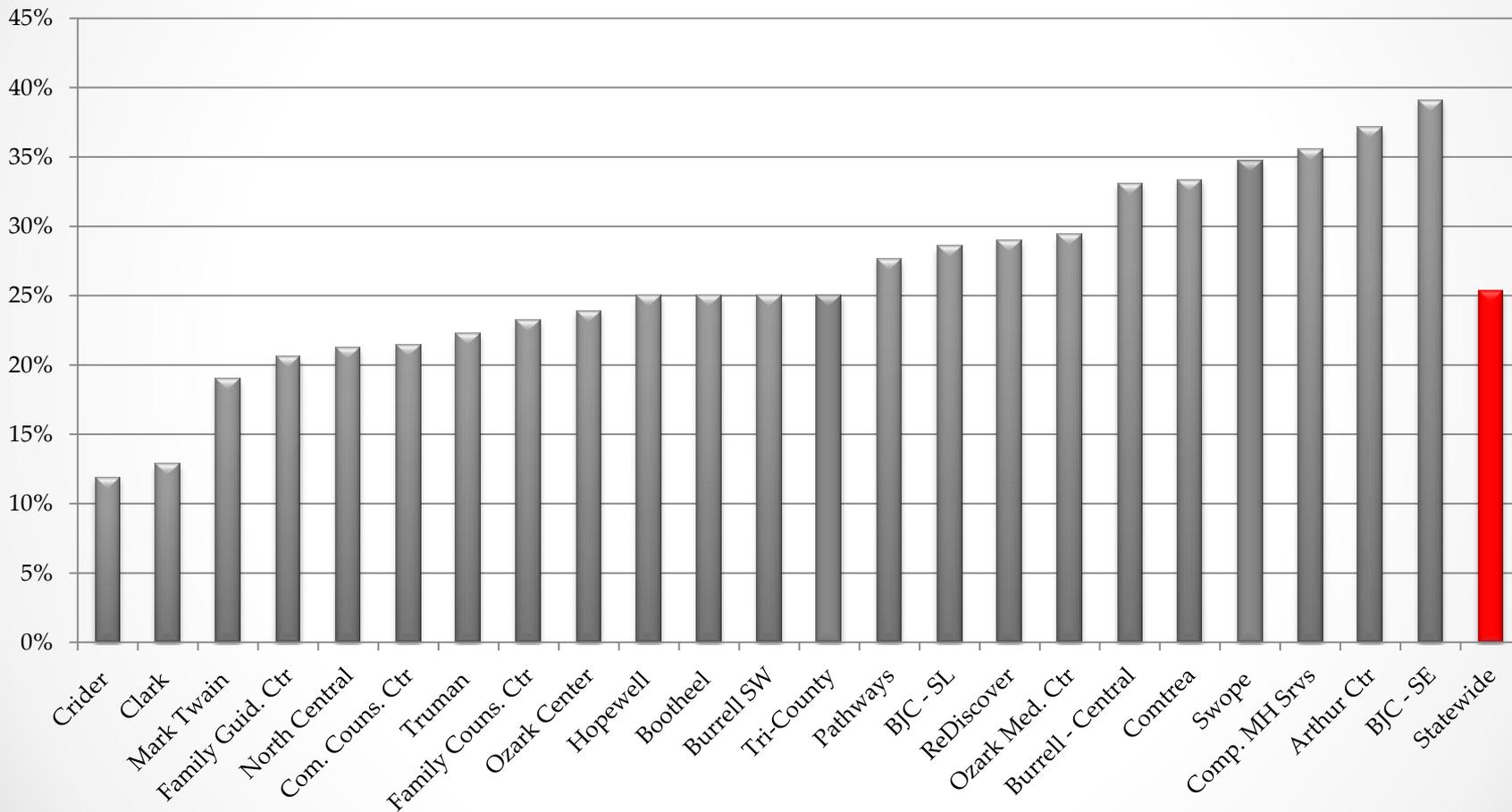


% Adult HCH Enrollees with Asthma



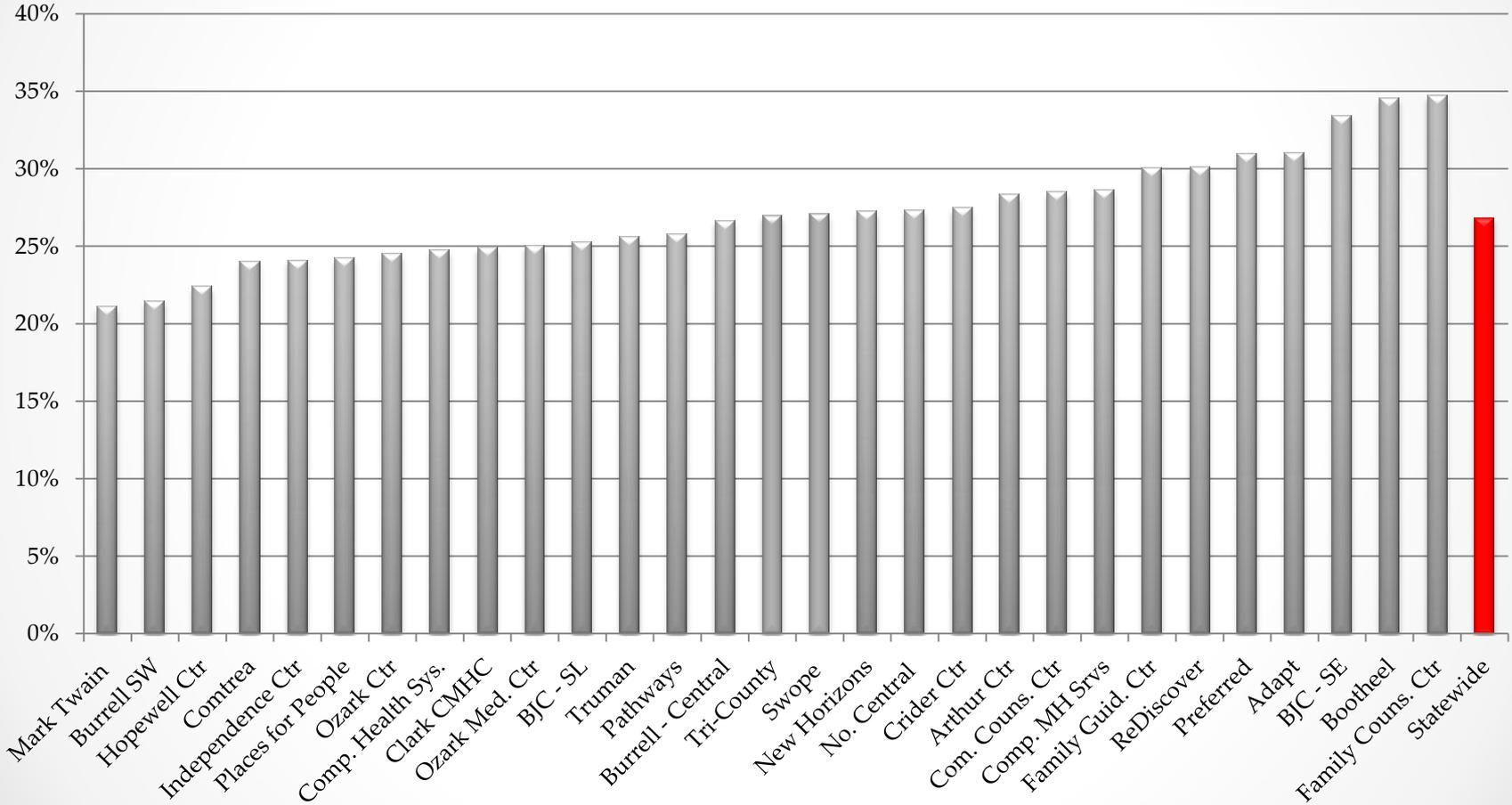


% of Children & Youth HCH Enrollees with Asthma/COPD



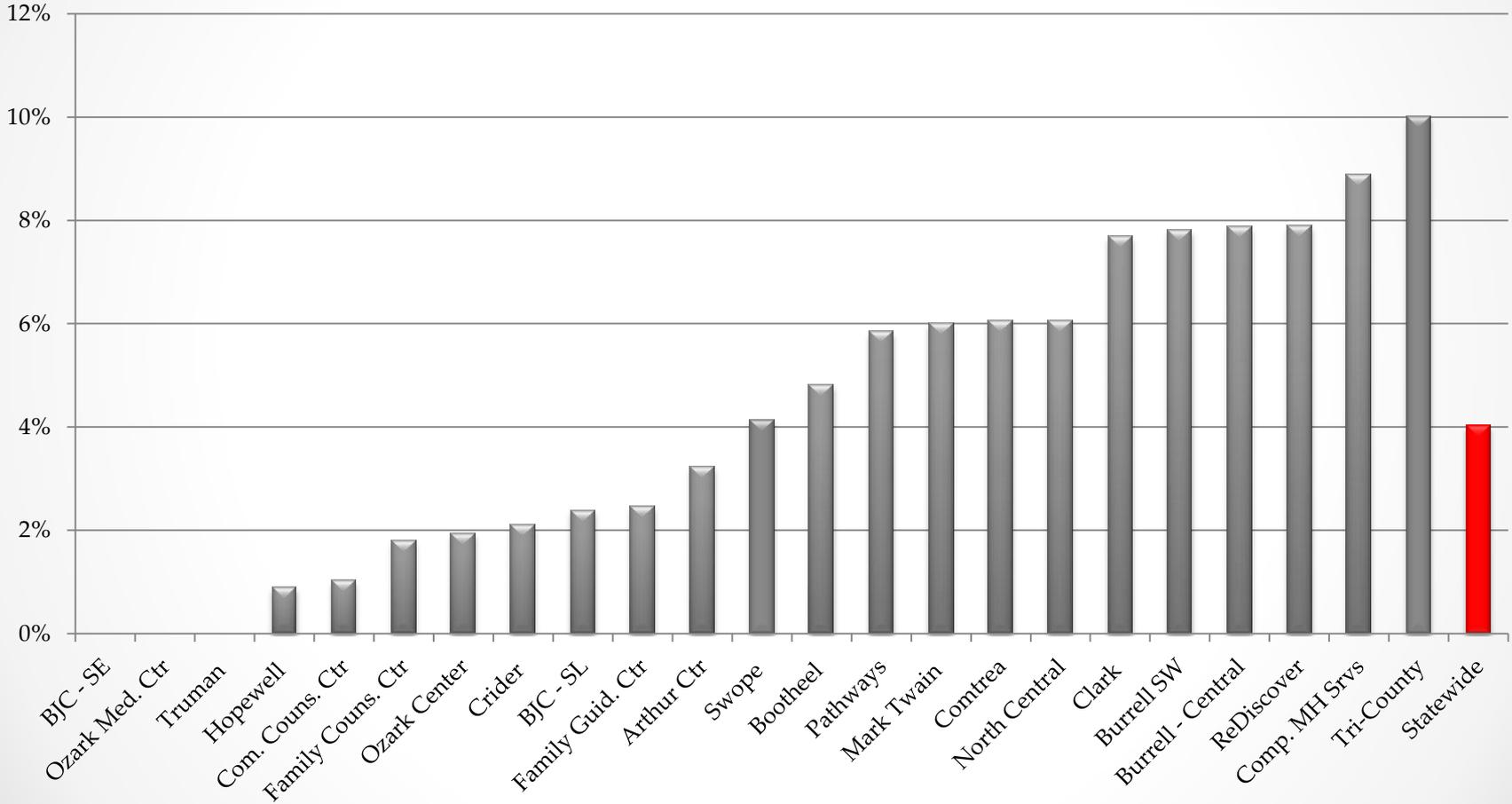


% of Adult Enrollees with Diabetes



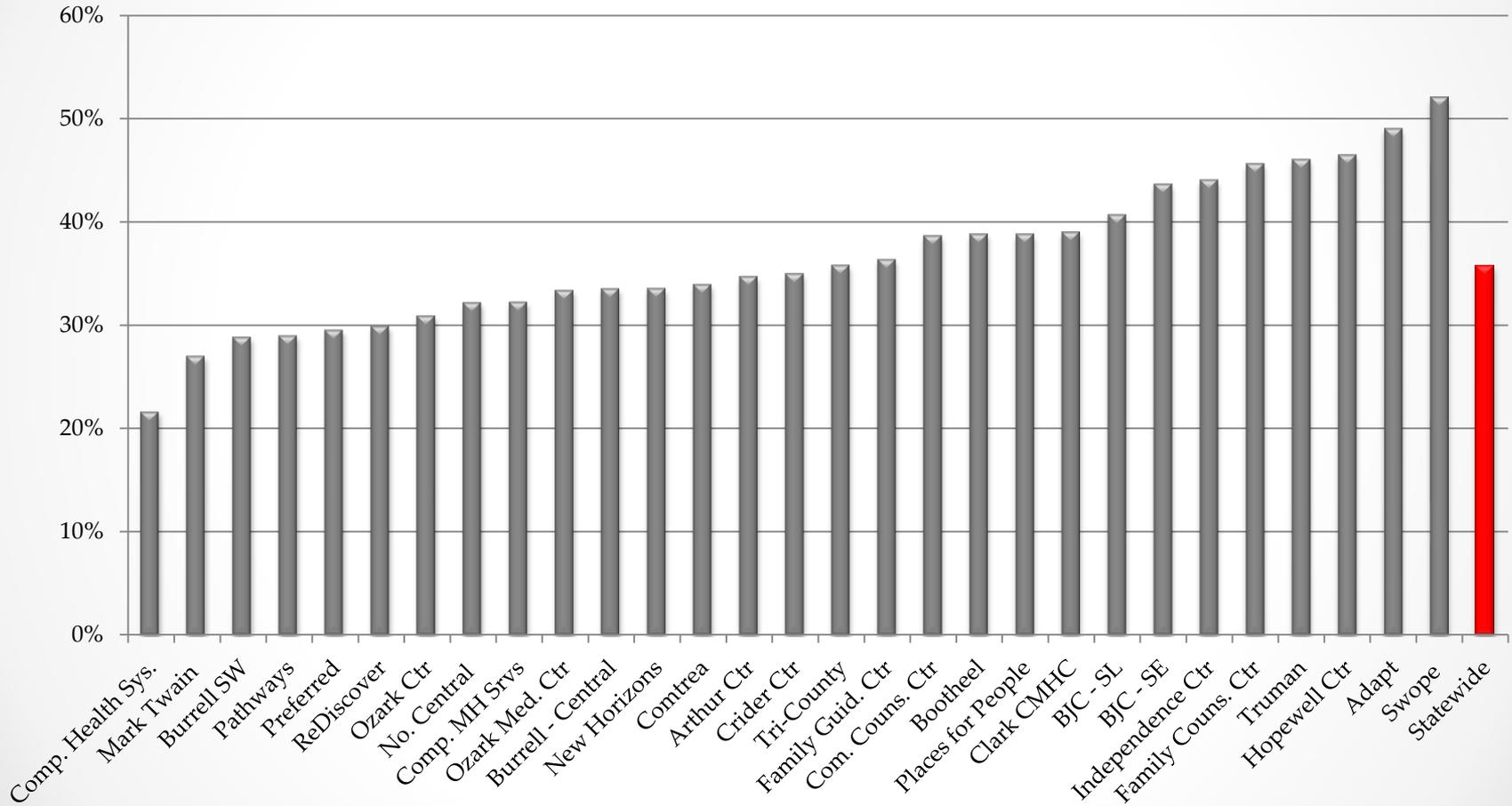


% of Children and Youth Enrollees with Diabetes



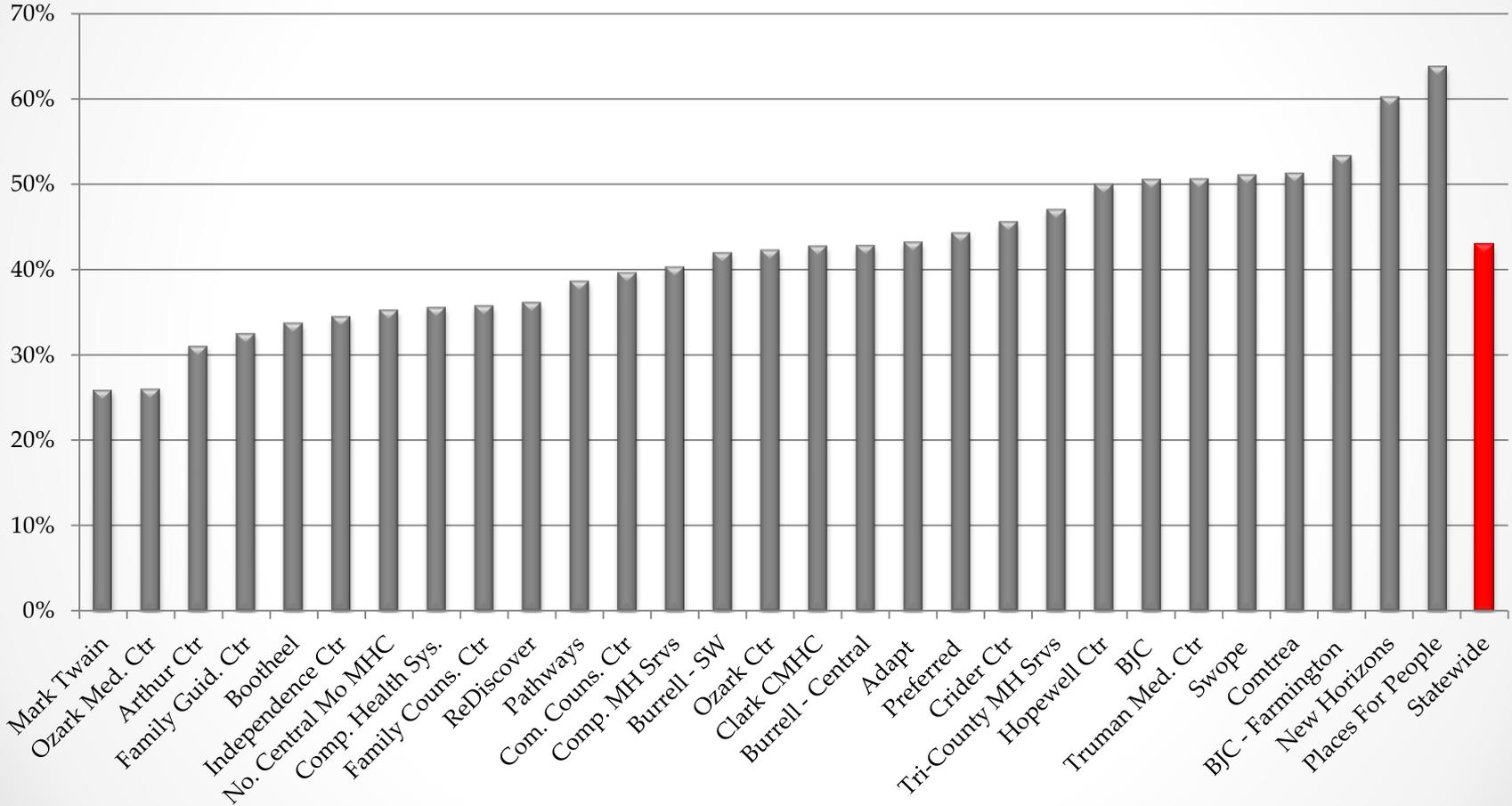


% of Adult HCH Enrollees with Hypertension



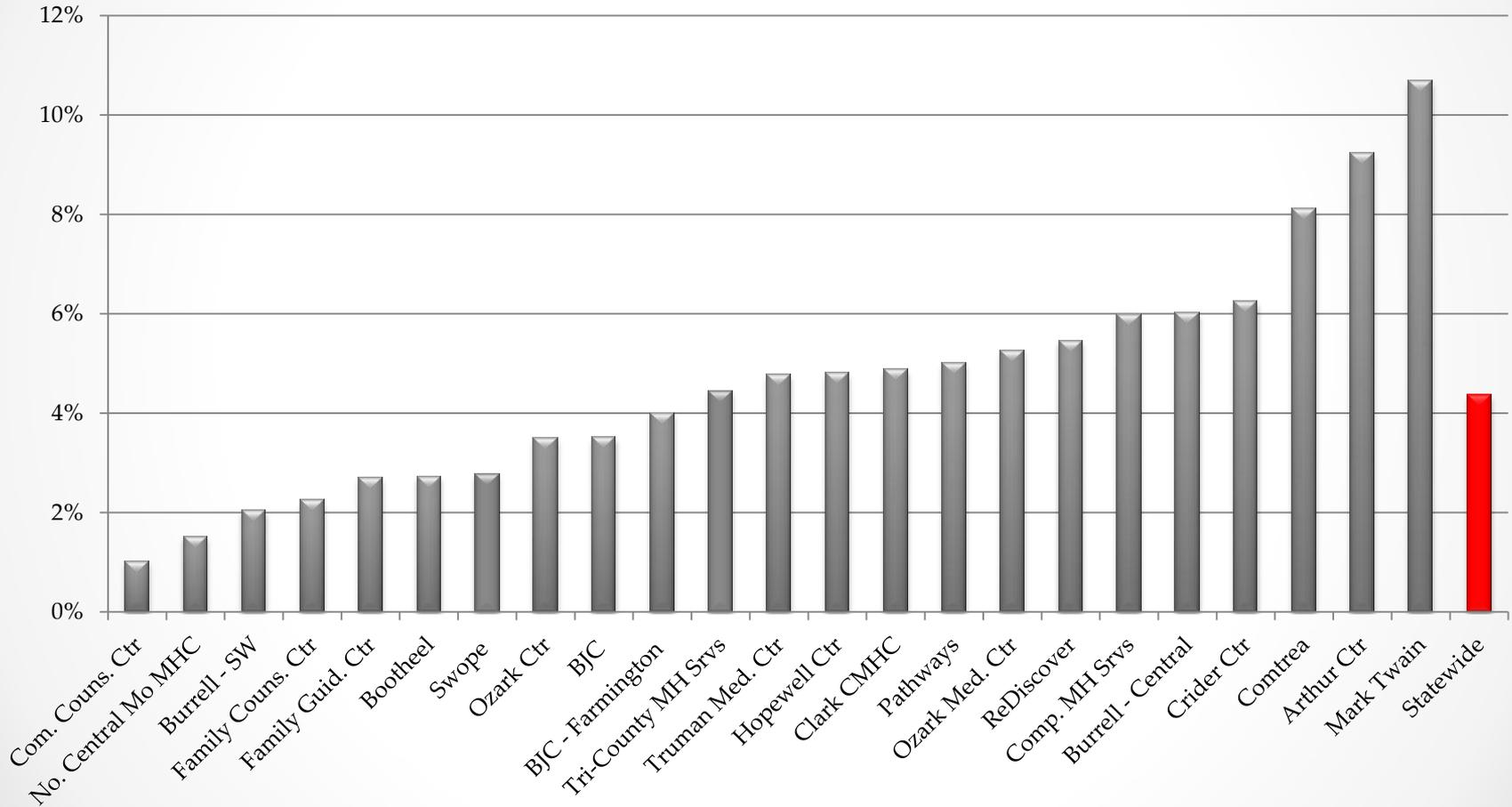


% of HCH Adults with a History of any ADA Diagnosis





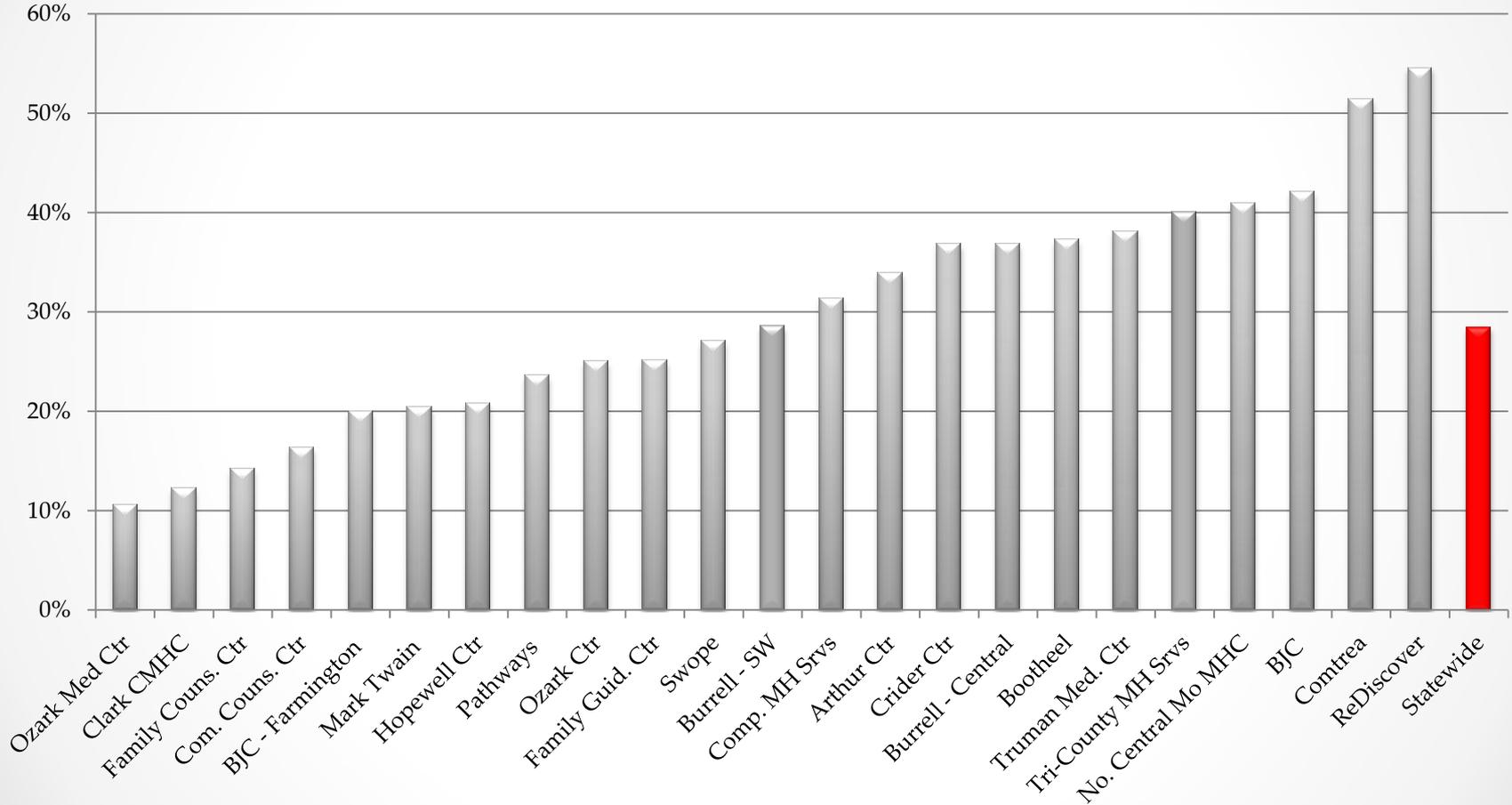
% of HCH Youth with a History of any ADA Diagnosis





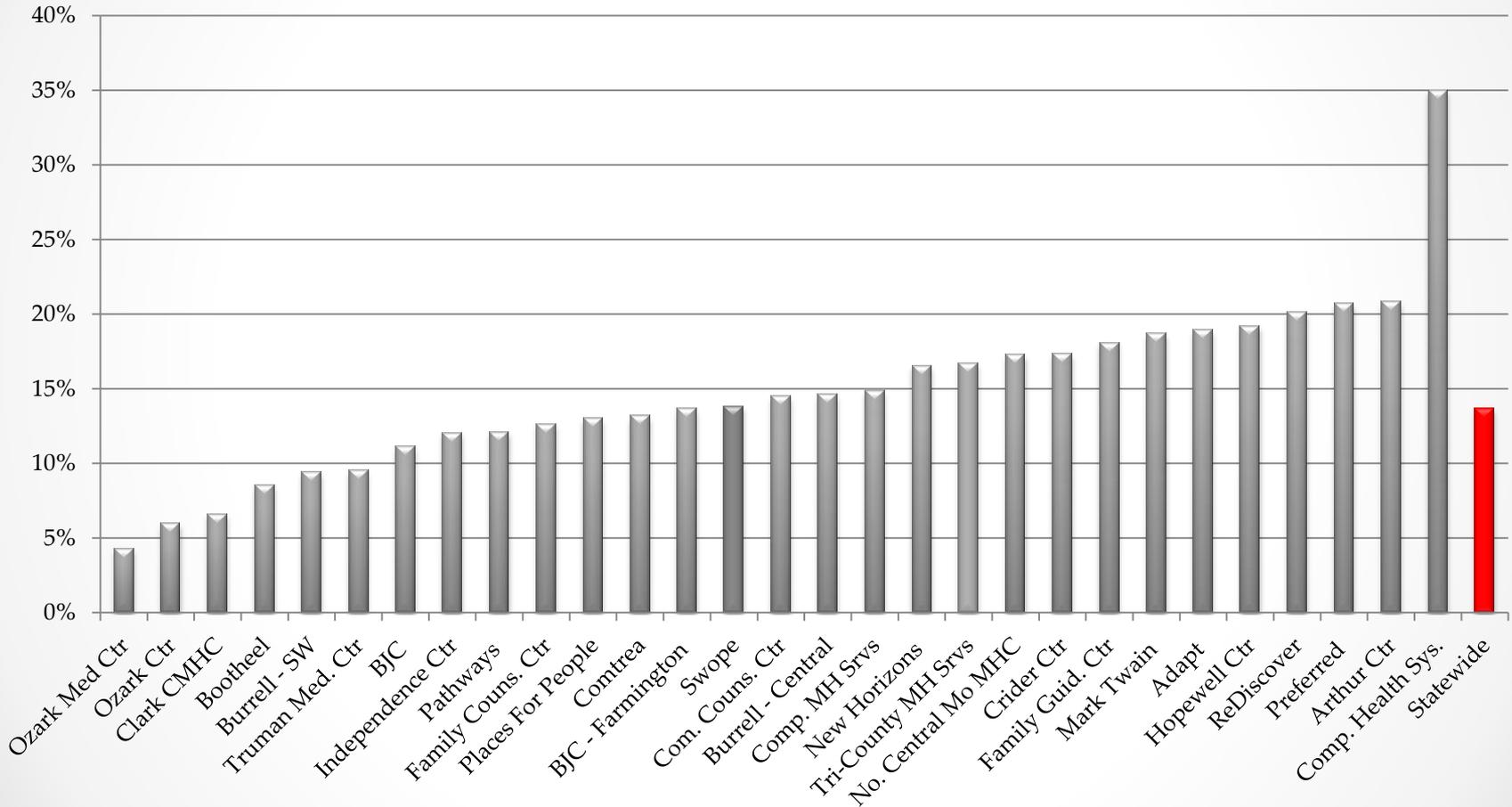
% of HCH Youth with an

“Episode of Care” in the DD Division





% of HCH Adults with an “Episode of Care” in the DD Division





Target Population

- 89% have a serious mental illness
 - 36% with **Major Depression**
 - 30% with **Schizophrenia**
 - 28% with **Bipolar Disorder**
 - 16% with **Post Traumatic Stress Disorder**
- More than 25% with COPD/Asthma
- More than 27% with Diabetes
- 36% with Hypertension
- 80% with a BMI>25
- At least 50% report smoking
- About 50% of adults have a history of substance abuse



Serving the Whole Person

“A whole person approach to care looks at all the needs of the person and does not compartmentalize aspects of the person, his or her health, or his or her well-being.... [and uses} a person-centered planning approach to identifying needed services and supports, providing care and linkages to care that address all of the clinical and non-clinical care needs of an individual.”

CMS Letter to State Medicaid Directors, Re: Health Homes for enrollees with Chronic Conditions, 11/16/2010



HH Functions: Added Emphasis

- Because healthcare homes take a “whole person” approach, we’ll continue and expand our emphasis on:
 - Providing **health and wellness** education and opportunities
 - Assuring consumers receive the **preventive and primary care** they need
 - Assuring consumers with **chronic physical health conditions** receive the medical care they need and assisting them in managing their chronic illnesses and accessing needed community and social supports





HH Functions: Added Emphasis

- Because healthcare homes take a “whole person” approach, we’ll continue and expand our emphasis on:
 - Facilitating **general hospital admissions and discharges** related to general medical conditions in addition to mental health issues
 - Using **health technology** to assist in managing health care
 - Providing or arranging appropriate **education and supports for families** related to consumers’ general medical and chronic physical health conditions



CMHC Healthcare Homes

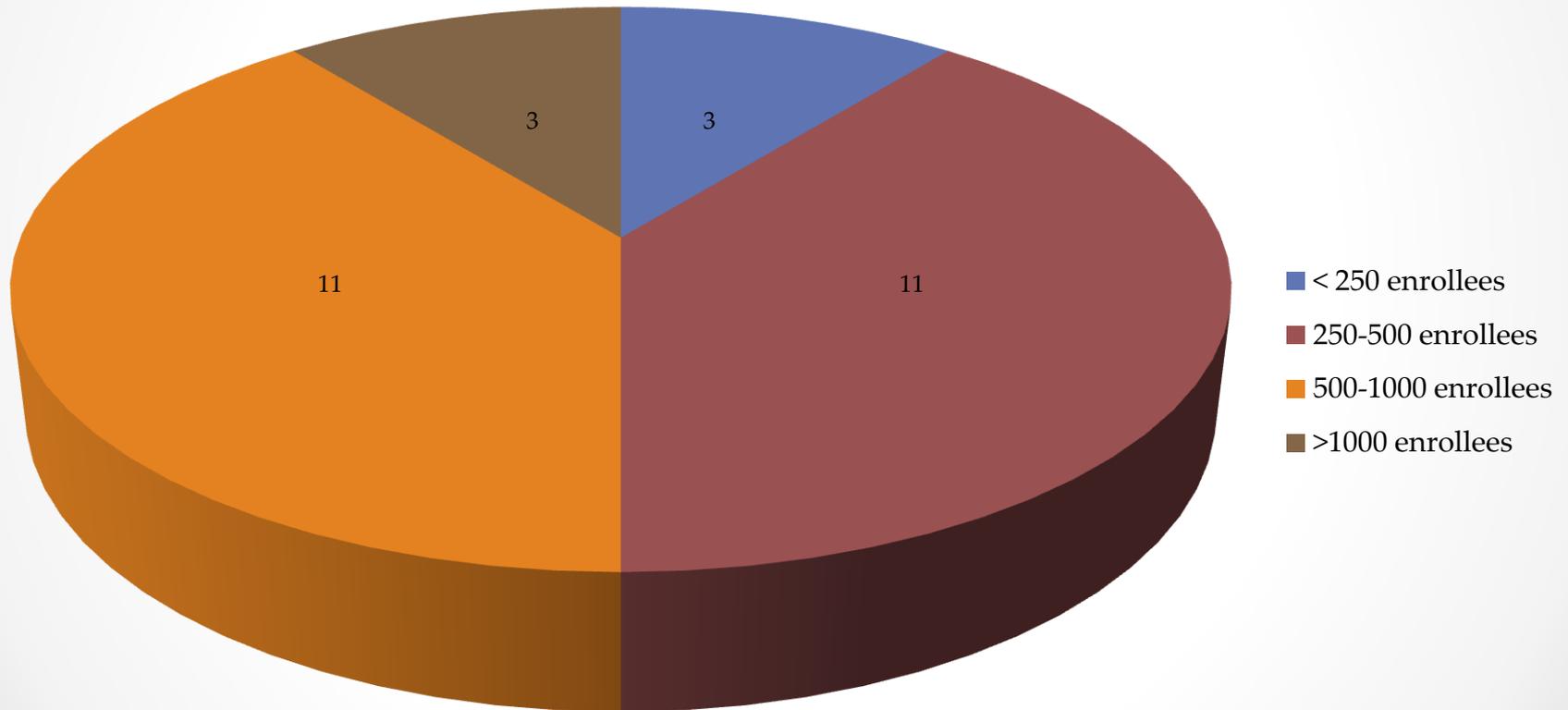
- 28 CMHC Healthcare Homes
- 17,882 individuals auto-enrolled
 - 3203 children and youth (18%)
 - CMHC consumers with at least \$10,000 Medicaid costs
 - Average Medicaid cost \$26,000+ annually
- Effective January 1, 2012



Total HCH Enrollment

12/31/12

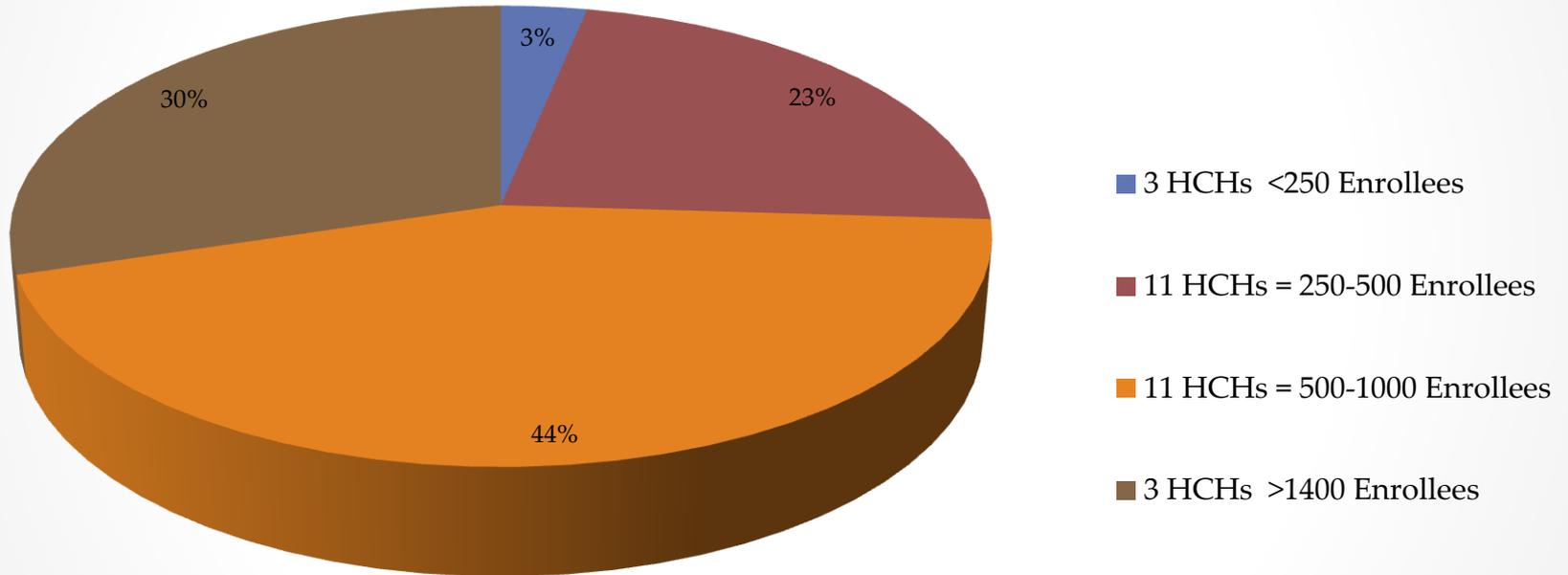
Total HCH Enrollment



% of Enrollees by Program Size



12/31/12





Health Home Reimbursement: Per Member Per Month

- PMPM: What It's Not
 - Capitation
 - No risk or reconciliation
 - A Case Rate
 - Reimbursement for individual services
- PMPM: Based on the cost of
 - Clinical staff capacity
 - Data monitoring and reporting
 - Administration





Health Home Reimbursement: PMPM

- PMPM: \$80.31
 - Health Home Director
 - Primary Care Physician Consultant
 - Nurse Care Manager
 - Care Coordinator/Clerical Support
 - Data monitoring and reporting
 - Training



Staffing Expectations

- Health Home Director
 - Each Health Home has at least a half-time Director
 - Based on 1 FTE per 500 enrollees
 - Maintain administrative staffing commensurate with size
- Nurse Care Managers
 - Maximum caseload: 250 enrollees
- Primary Care Physician Consultant
 - Physician: at least 1 hour per enrollee
 - Advanced Practice Nurse: at least 2 hours per enrollee
- Care Coordinator/Clerical Support
 - Based on 1 FTE per 500 enrollees.



What is a Healthcare Home?

- Not just a Medicaid Benefit
- Not just a Program or Team
- An Organizational Transformation





What is a Healthcare Home?

- Population Management
- Continuous Team-based Care
- Comprehensive Care Management
- Person Centered Empowerment
- Wellness and Healthy Lifestyles



Population Management

- You already know how to
 - Manage the care of individuals with serious mental illness and serious emotional disorders, including empowering them to manage their own care
- You will
 - Learn to see the full spectrum of health and wellness issues faced by the people you serve
 - Apply what you already know about managing and empowering to help people with their health and wellness needs and issues
 - Begin thinking in terms of improving the health and health status of populations, in addition to managing the care of individuals



Continuous Team-based Care

- You already know how to
 - Work as a Team
 - Provide continuous care
 - Be proactive
- You are creating new teams for whole person care



Comprehensive Care Management

- You already
 - Recognize the importance of meeting basic needs, so you already (sort of) see the whole person
 - Have extensive experience in linking individuals with a broad array of community services and supports
 - Follow up on psychiatric admissions and discharges
 - Have experience in working with Primary Care providers
 - Have been working with a variety of care management tools and reports



Comprehensive Care Management

- You will
 - Help individuals acquire a PCP if they don't have one
 - Develop effective working relationships with PCP's and other health professionals to coordinate care
 - Help consumers develop health and wellness goals
 - Use data on health status indicators to establish priorities, choose interventions, and adjust treatment regimes
 - Follow up on hospitalizations and ER use



Person-centered Empowerment

- You are already committed to
 - Being consumer and family focused
 - A Recovery Model
- You will
 - Support individuals with self-management of co-occurring substance abuse and other chronic medical conditions
 - Support individuals in adopting healthy lifestyles



Healthcare Home Responsibilities

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HCH Responsibilities

HCH Team Members

- Community Support Specialists
- Psychiatrist
- QMHP, PSR and other Clinical Staff
- Peer Specialist
- Family Support Specialist
- **Primary Care Consulting Physician**
- **Health Care Home Director**
- **Nurse Care Managers**
- **Care Coordinator/Clerical Support Staff**





HCH Team Members

Primary Care Physician Consultant

- **Establishes priorities** for disease management and improving health status.
- **Participates in case consultation** with psychiatrist, QMHP, nurse care managers, and community support specialists
- **Helps educate** community support specialists, case managers, and clinical staff on the nature, course, and treatment of chronic diseases
- **Develops collaborative relationships** with treating PCPs and Psychiatrists, as well as other healthcare professionals and facilities



Primary Care Physician Consultant

Options

- Nurse Practitioners and Advanced Practice Nurses
 - Up to 50% of physician time can be provided by a Nurse Practitioner or Advanced Practice Nurse on a 2 hour for 1 hour basis
 - At least 2 hrs/wk of physician time must be a primary care physician



Primary Care Physician Consultant

Options

- CMHC consumers' PCPs
 - May contract with multiple primary care physicians to provide consultation for CMHC consumers who are their patients
 - May be appropriate to contract with a specialist as a consultant for consumers with certain chronic health conditions
 - Heart Disease: Cardiologist
 - Severe Diabetes: Endocrinologist
 - PCP contracts must include provisions that PCPs cannot bill for any other Medicaid service while providing consultation and address kickback protection
 - The HCH must have 1 hour physician time for those consumers who do not have a consulting PCP



HCH Team Members

Healthcare Home Director

- **Champions Healthcare Home practice transformation**
- **Oversees the daily operation** of the HCH
- **Tracks enrollment**, declines, discharges, and transfers
- **Assigns NCM caseloads**
- **Coordinates** review and utilization of the **Care Management reports**
- **Promotes** the development of **working relationships** (including MOU's) **with hospitals**, and **coordinates hospital admissions and discharges** with NCMs



HCH Team Members

Healthcare Home Director

- Reviews and/or completes **monthly implementation reports**
- Participates in **monthly TA calls**
- **May facilitate health education groups**, if qualified
- **May serve as a NCM** on a part-time basis
 - HCHs must have at least a half-time HCH Director
- **May serve as a CyberAccess Practice Administrator**



HCH Team Members

Nurse Care Managers

- Unlike a clinic or hospital based nurse, the NCM is **not personally responsible** for all aspects of care for each individual on their caseload
- The traditional nurse/patient relationship **does not apply**, except temporarily during specific face-to-face interactions
- Liability **does not extend to** being unable to locate or engage a patient in a particular intervention
- The NCM is **not expected to** address all aspects of care for all patients on the caseload immediately
- The NCM is **expected to** identify actionable areas to improve care in a portion of their caseload.



HCH Team Members

Nurse Care Managers

- **Champion healthy lifestyles and preventive care**
- **Participate in monitoring** the monthly **Care Management reports**, and **establishing priorities and strategies** for interventions
- **Provide training** and support to CPR staff **regarding health, wellness, and chronic disease** to enable them to better assist consumers in maintaining healthy lifestyles, and managing chronic diseases
- **Provide educational groups** regarding health, wellness, and chronic disease **for consumers**, and **health and wellness opportunities for consumers and staff**



HCH Team Members

Nurse Care Managers

- **Provide individual care** for consumers on their caseload
 - **Review client records and patient history**
 - **Participate in annual treatment planning** including
 - Reviewing and signing off on health assessments
 - Conducting face-to-face interviews with consumers to discuss health concerns and wellness and treatment goals
 - **Consult with CSS's** about identified health conditions of their clients
 - **Coordinate care with external health care providers** (pharmacies, PCPs, FQHC's etc.)
 - **Document individual client care and coordination** in client records



HCH Team Members

Care Coordinator/Clerical Support

- **Facilitates review** of the monthly **Care Management** and **Hospital Admission** reports
- Completes **metabolic screening data entry**
- Assists with **appointment scheduling** and **client tracking**
- **May** provide **case management** for HCH enrollees who do not have a CSS or other case manager
- Provides assistance in **faxing, sorting, and distributing reports** and letters related to CyberAccess and Care Management reports
- Provides **technical assistance** to HCH team and CSSs on use of CyberAccess and Patient Profile reports, and may serve as a **CyberAccess practice administrator**
- **Provides clerical support** to the HCH Director and team



HCH Team Members

Psychiatrists, QMHPs, PSR and CSSs

- **Continue to fulfill current responsibilities**
- **Collaborate with Nurse Care Managers** in providing individualized services and supports
- **CSSs participate** in required **HCH training** to enable them to serve as health coaches who
 - **Champion healthy lifestyle changes and preventive care** efforts, including helping consumers develop wellness related treatment plan goals
 - Support consumers in **managing chronic health conditions**
 - Assist consumers in **accessing primary care**



HCH Team Members

Peer Specialist

- Can be critical to
 - **Helping** individuals **recognize** their **capacity for recovery and resilience**
 - **Modeling** successful **recovery behaviors**
 - **Assisting** individuals with **identifying strengths and personal resources** to aid in their recovery
 - **Helping** individuals **set and achieve recovery goals**
 - **Assisting** peers **in** setting goals and **following through on wellness and health activities**



HCH Team Members

Family Support Specialist

- Can be critical to
 - **Helping** families **navigate** the service delivery system
 - **Coaching** families to **increase their knowledge and awareness** of their child's needs
 - **Providing emotional support**
 - **Helping** enhance **problem solving skills**



HCH Responsibilities

Health Screening

- Each HCH enrollee must have an annual health screen that includes required components.
- The health screen should be completed as part of the admission or annual treatment planning process
- Although the health screening information may be collected by other agency staff, the Nurse Care Manager must review the results of the health screen prior to the enrollees initial or annual treatment plan to determine whether additional health screenings are required and to prepare for assisting with the revision or development of health related goals at the time of the annual treatment plan update.



HCH Responsibilities

PCPs and other Healthcare Providers

- As the HCH for an individual, it is important to have a good working relationship with the individual's PCP and other healthcare providers involved with the individual
- If a HCH enrollee does not have a PCP, the HCH should assist the enrollee in acquiring a PCP
- The HCH should advise PCP's and other healthcare providers serving enrollees that they are serving as the HCH for the enrollee
- A letter signed by Dr. McCaslin and Dr. Parks introducing the HCH program has been provided to your organization for use when meeting with PCP's and other healthcare providers



Hospital Admissions

- The importance of following up on hospital discharges
- A joint letter prepared by the Mo Hospital Association and Mo HealthNet was distributed to all hospitals describing the Health Home initiative and encouraging hospital cooperation.
- A draft Memorandum of Understanding has been distributed to your CMHC administration to use as a guide in developing an MOU with hospitals serving your area.



HCH Responsibilities

Hospital Admissions

- HCHs receive daily e-mails regarding planned hospital admissions
- HCH members discharged from the hospital must have a contact within 72 hours of discharge
 - This contact may be made by the individual's CSS, case manager, or NCM
- Nurse Care Managers must complete a medication reconciliation on HCH members discharged from the hospital
 - Information regarding the enrollees medications may be collected by the individual's CSS or case manager for review by the NCM



Hospital Admissions

Following Up is Complicated

- False Positives and Missing Data
 - Late notification
 - Appealing denials
 - Dual Eligibles
- Working with multiple hospitals
 - Barnes Hospital had admissions from half of the HCHs
 - Pathways had admissions to 38 hospitals in one month
 - BJC and Crider had admissions to 17 hospitals in one month



Hospital Admissions

Results

- Average about 4% of HCH enrollees per month
- 58% were contacted following discharge
 - Each month several HCHs contacted 100%
- Of the individuals contacted
 - Medication reconciliation completed: 83%
 - Medication reconciliation completed within 72 hours: 69%

HCH Responsibilities



HCH Enrollees w/o Case Managers

- Some HCHs have many HCH enrollees who do not have a case manager
- Nurse Care Managers should not serve as case managers
- Options
 - Expand the number of CSS staff or case managers
 - Assign individuals who require minimal case management to your HCH Care Coordinator (if qualified)
 - Consider discharging individuals who do not require or refuse case management

HCH Responsibilities

Care Management Reports

- Review monthly Care Management reports to identify high risk patient populations
- Prioritize interventions
 - Not all individuals with flags require intervention
 - Not all flags need to be addressed in a given quarter
 - Some individual interventions may be necessary to address acute or immanently harmful clinical situations
 - Select interventions that have the potential to impact the care/health status of a relatively larger portion of patients



HCH Responsibilities

Other Responsibilities

- Complete Team Contact profiles
- Staffing changes (Vacancies and Hires)
 - Report vacancies by E-mail to DMH HCH Liaison (Tara Crawford) within 5 working days, and on the Monthly Implementation Report
 - Report hires by Email to DMH HCH Liaison (Tara Crawford) within 5 working days, submit updated Team Contact profile, and report on the Monthly Implementation Report
- Billing for Services Prohibited
 - HCH Team members may not bill for any services while they are being reimbursed via the PMPM



HCH Responsibilities

Documentation

- Progress Notes
 - Face-to-face interactions
 - Care Coordination
 - Care Management Report Flags
 - Hospital Discharges
 - With other community providers
 - Client consultation in team meetings
- Treatment Goals
- Annual Metabolic Screening
- Annual Health Screening
-



HCH Responsibilities

Who is the Team?

- Healthcare Home Functions
 - HCH Director, Primary Care Physician Consultant, Nurse Care Managers, and Care Coordinator/ Clerical Support
- Individual Consumer Planning and Service Delivery
 - Consumers/Families, CPR staff, NCMs, and, as appropriate, Primary Care Physician Consultants
- Organizational Transformation
 - The Executive Team



Care Management Tools and Reports

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Care Management

Tools and Reports

- **CyberAccess**

- Web-based Medicaid data system maintained by ACS Heritage
- Allows providers to view patients histories based on Medicaid claims, including diagnoses, pharmacy, services, ER & hospital
- Training in how to access and utilize CyberAccess is provided the first Friday of the month. To participate in training contact:
 - Kimberly.hicks@acs-heritage.com





Care Management

Tools and Reports

- Metabolic Screening Database
 - Required for all individuals receiving anti-psychotic medications
 - Provides data on
 - Height/Weight/BMI/Waist Circumference
 - Plasma Glucose/Fasting and/or A1c
 - Cholesterol/LDL/HDL/Triglycerides
 - Taking an anti-psychotic?
 - Pregnant?
 - Smoker?
 - Feeds into a statewide data base and is combined with CyberAccess data to generate the quarterly Disease Management report



Care Management

Tools and Reports

- CMT Care Management Reports
 - Limitations
 - Based on paid Medicaid claims data
 - Does not include Medicare or procedures/meds that are provided free, paid by the consumer, or for which no claim was submitted
 - Ability to note “false positives’ coming by January, 2013
 - Includes the following reports which are updated monthly
 - Behavioral Pharmacy Management (BPM)
 - Medication Adherence
 - Disease Management





Care Management

Tools and Reports

- Behavioral Pharmacy Management Report
 - Includes a series of Quality Indicators™ to identify prescriptions that deviate from Best Practice Guidelines
 - Inappropriate polypharmacy
 - Doses that are higher or lower than recommended
 - Multiple prescribers of similar medications
 - Sent to prescribing physician with Clinical Considerations™ that includes Best Practice Guidelines and recommendations
 - Sent to CMHC for all their consumers and includes information for all physicians, regardless of whether they are employed by the CMHC
 - May be most appropriately reviewed by the CMHC Medical Director



Care Management

Tools and Reports

- Medication Adherence Report
 - Based on Medicaid pharmacy claims
 - Includes three classes of prescriptions
 - Anti-psychotic medications
 - Cardiovascular medications
 - Diabetes medications
 - Enables CMHCs to identify all prescriptions that have been filled by consumers and determine Medication Possession Ratios
 - A Medication Possession Ratio of .8 means that the prescription was filled for 80% of the quarter being reviewed.
 - Helps identify individuals who are having difficulty in taking their medications regularly



Tools and Reports

- Disease Management Report
 - Based on Medicaid claims and Metabolic Screening data
 - Identifies individuals with specific diagnoses/conditions who are not meeting specific indicators
 - Currently being revised to
 - Include separate measures for adults and children
 - Identify individuals based on not meeting specific test values (e.g. A1C, BP, and LDL levels) rather than not having specific tests performed
 - Add measures regarding BMI control and tobacco use
 - Provide a mechanism to identify false positives



HCH Responsibilities

Care Management Reports

- Review monthly Care Management reports to identify high risk patient populations
- Prioritize interventions
 - Not all individuals with flags require intervention
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Enrolling Individuals in a CMHC Healthcare Home

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Auto Enrollment and Assignment

- An initial group of individuals were auto-enrolled and auto-assigned to your CMHC
 - Consumers with \$10,000 or more in Medicaid claims in the past year who had at least one Medicaid claim at your CMHC in the past 90 days.
- Letters were mailed to auto-enrollees describing the HCH benefit and indicating that they have been enrolled and that **participation in the HCH was voluntary**



Auto Enrollment and Assignment

- CMHCs met with auto-assignees to introduce the HCH program and to explain that participation in the HCH was voluntary
 - Protocol and script
- Because auto-enrollees were identified using historical data, some of these individuals had to be discharged from the HCH because they
 - Were no longer receiving services from the CMHC and could not be located
 - Had moved and were currently receiving services from another provider
 - Were no longer Medicaid eligible



Consumer Choice

- Participation in the Health Home is voluntary
 - Declining to enroll does not affect any other services an individual is receiving
- Transfers
 - Between Primary Care and CMHC Healthcare Homes
 - Between CMHC Healthcare Homes
 - Means transferring to another CMHC for all of their psychiatric rehab services
 - Transfers are effective at the beginning of the month following the request to transfer



New Admissions, Discharges and Transfers

- Admissions
 - CMHCs may propose new admissions by e-mailing admission forms documenting that the individuals meet the admission criteria to the Health Home Enrollment Coordinator for review and approval
- Discharges
 - CMHCs may propose to discharge an individual from their HCH by e-mailing a discharge form explaining the reason for the proposed discharge to the Health Home Enrollment Coordinator for review and approval
- Transfers
 - CMHCs collaborate to effect a transfer between HCHs by submitting a transfer form explaining the reason for the proposed transfer to the Health Home Enrollment Coordinator for review and approval



Disease Management 3700

- MHN/DMH collaboration started in November, 2010
 - Targets Medicaid recipients who:
 - Are high cost, high risk
 - Have co-occurring chronic medical illness, and serious and persistent mental illness
 - Have not been connected to a CMHC
 - MHN identifies new individuals every four months
 - CMHC's try to find these individuals and enroll them in the CPR program in order to assist in managing their total health care costs



DM 3700 = HCH Outreach

- Current DMH 3700 clients were auto-enrolled in your Healthcare Home
- New clients will also be enrolled and should receive the same introduction to the HCH programs as all other enrollees
- Match for these clients comes from DSS
- These clients are presumptively eligible for the CPR program



Presumptive Eligibility

- At the CMHC's option, Healthcare Home enrollees who are not currently enrolled in the CPR program may be considered presumptively eligible and enrolled in the CPR program
- To enroll Healthcare Home consumers in CPR, assign the individual to the CPR program in CIMOR, establish the level of care, and update the individual's assessment and treatment plan as appropriate
- All of the CPR program requirements, except the diagnostic eligibility criteria, apply to presumptively enrolled consumers



Monthly Reports

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Monthly Implementation Report

- Process and Timelines
- Monthly Report Components
 - Cover Sheet
 - HCH Team Log
 - Client Status Report
 - Hospitalization Follow-up Report



Monthly Implementation Report

- Report Forms are distributed by the second week of each month
 - The Implementation Report cover sheet, and HCH Team Log will be e-mailed to the HCH Director, and should be returned to Tara Crawford
 - The Client Status and Hospitalization Follow-up Reports will be available on the FTP site, and should be updated on the FTP site



Monthly Report Components

- Cover Sheet
 - Provides an assurance that each section of the report has been completed or updated on the FTP site
- HCH Team Log
 - Documents current HCH staffing
 - Documents that no other billing to CMS occurs during time covered by the PMPM
 - Tracks vacancies to assure adequate staffing relative to the PMPM payment
 - HCH must maintain 85% of required staffing during the first year



Monthly Report Components

- Hospitalization Follow-up Report
 - Documents that consumers have been contacted within three days of hospital discharge and that a medication reconciliation has been performed
- Client Status Report
 - Documents when PCP's have been acquired for those enrollees who do not have one
 - Documents that PCPs and other health providers have been informed that the individual has been enrolled in the HCH



Monthly Attestation

- Each month your agency completes a Cyber Access report attesting that each individual enrolled in your HCH has received at least one health home service in order to receive a PMPM for that individual
 - The minimum health home service required is a review of the monthly Care Management report to determine whether that individual has been “flagged” (i.e. identified as failing to meet an established standard of care) and for those individuals who have been “flagged”, determining whether an intervention is required, and initiating an intervention for those who require it.



Performance Measures

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Shared Savings

- A Separate State Plan Amendment
 - Providers share in any savings after the first year
 - Based on provider performance
- Performance Measures
 - 25 measures
 - Benchmark Goals
 - Gap Closing Goals



Performance Measures

Asthma and COPD

Measure	Source	Benchmark Goal	Gap Closing Goal
% of patients 5-17 years old who were prescribed controller medication	CMT Disease Mgt Report (Claims)	>70%	Increase by 10 percentage points
% of patients 18-50 years old who were prescribed controller medication	CMT Disease Mgt Report (Claims)	>70%	Increase by 10 percentage points



Performance Measures

Coronary Artery Disease

Use of statin medications	CMT Disease Mgt Report (Claims)	>70%	Increase by 10 percentage points
% of patients age 18 years and older with lipid level adequately controlled (LDL<100)	CMT Disease Mgt Report (Diagnosis from Claims and Metabolic Screening Registry)	>70%	Increase by 10 percentage points



Performance Measures

Diabetes

Measure	Source	Benchmark Goal	Gap Closing Goal
% of patients 18-75 years old with HbA1c<8.0%	CMT Disease Mgt Report (Claims and Metabolic Screening Registry)	>60%	Increase by 10 percentage points
% of patients age 18-75 with lipid level adequately controlled (LDL<100)	CMT Disease Mgt Report (Claims and Metabolic Screening Registry)	>36%	Increase by 10 percentage points
% of patients age 18-75 with blood pressure adequately controlled (<140/90 mm Hg)	CMT Disease Mgt Report (Claims and Metabolic Screening Registry)	>65%	Increase by 10 percentage points



Performance Measures

Hypertension

Measure	Source	Benchmark Goal	Gap Closing Goal
% of patients age 18 and older with blood pressure adequately controlled (<140/90 mm Hg)	CMT Disease Mgt Report (Claims and Metabolic Screening Registry)	>60%	Increase by 10 percentage points



Performance Measures

Adherence to Medications

Measure	Source	Benchmark Goal	Gap Closing Goal
COPD Medications	Adherence Report	>90%	Increase by 5 points
Cardiovascular Disease Medications	Adherence Report	>90%	Increase by 5 points
Diabetes Medications	Adherence Report	>90%	Increase by 5 points
Antipsychotic Medications	Adherence Report	>90%	Increase by 5 points
Antidepressant Medications	Adherence Report	>90%	Increase by 5 points
Mood Stabilizer Medications	Adherence Report	>90%	Increase by 5 points
Anti-Hypertensive Medications	Adherence Report	>90%	Increase by 5 points



Performance Measures

Quality Practice Indicators

Measure	Source	Benchmark Goal	Gap Closing Goal
% of patients with a completed metabolic screening	CMT Disease Mgt Report	80%	50% gap reduction
Use of CyberAccess per member per month for non-MCO enrollees	DMH/ACS Heritage	1 access PMPM	50% gap reduction
% of psychiatric prescriptions flagged as potentially inconsistent with quality practices	CMT BPMS Report (Claims)	<10%	Decrease by 5 percentage points



Performance Measures

Hospital Admissions and ED Visits

Measure	Source	Benchmark Goal	Gap Closing Goal
% of patients readmitted within 30 days	DMH (Claims)	NCQA 50 th percentile regional rate for Medicaid managed care	Decrease by 10 percentage points
% of preventable admissions per 1000	DMH (Claims)	NCQA 50 th percentile regional rate for Medicaid managed care	Decrease by 10 percentage points
% of emergency department visits per 1000	DMH (Claims)	NCQA 50 th percentile regional rate for Medicaid managed care	Decrease by 10 percentage points



Performance Measures

Hospital Discharges

Measure	Status	Benchmark Goal	Gap Closing Goal
% of hospitalized patients who have a clinical face-to-face or telephonic follow-up visit with the Nurse Care Manager within 72 hours of discharge	Admissions Report and Monthly Implementation Report	80%	Increase by 25%



Performance Measures

Substance Abuse

Measure	Source	Benchmark Goal	Gap Closing Goal
% of adults 18 and older who report excessive drinking in the past 12 months	DMH Status Report	9%	Reduce by 2 percentage points
% of adults 18 and older who report using any illicit drug in the past 12 months	DMH Status Report	5%	Reduce by 2 percentage points



Performance Measures

Tobacco Use

Measure	Source	Benchmark Goal	Gap Closing Goal
% of adults 18 and older who report smoking at the time of the annual metabolic screening	CMT Disease Mgt Report (Metabolic Screening Registry)	40%	Reduce by 5 percentage points



CMHC Healthcare Home Reviews, Evaluations, and Accreditation

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Program Reviews

- Progress Reports
 - Approach
 - Monthly review and ongoing compilation of data from
 - HCH Team Log, Client Status, and Hospitalization Follow-up Reports
 - System Transformation Reports
 - Performance Measures
 - Participation in Training and Monthly Calls
 - Sample record review of documentation
 - Outcome
 - Progress report and technical assistance recommendations



Program Evaluations

- Rutgers CERTS:
 - “Impact of a CMHC-based Medical Home Model on Effective and Safe Use of Therapeutics: Clinic Practices and Experiences”
- CMS
 - Urban Institute and NORC
 - Program Implementation and Effectiveness
 - Financial Review
 - PMPM rate



HCH Accreditation

- DMH worked with CARF to develop Health Home accreditation for behavioral health organizations
- CARF provided training on the standards in November, 2011
- CMHC Healthcare Homes must be accredited under the CARF standards by January, 2014

Training

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Training Initiatives

- “Paving the Way”
- Leadership and Team “HCH 101”
- Access to Care – MTM
- CyberAccess and ProAct Training
- Physician Institute
- Disease Management
- Motivational Interviewing
- TEAMcare
- Wellness Coaching
- CARF



Technical Assistance

- Monthly HCH Director Calls
- Quarterly HCH Director Meetings
- Progress Reports
- Site Visits
- Practice Coaches



Practice Coaches

- Missouri Foundation for Health Grant
 - Primary Care Association with a subcontract to the Coalition of Community Mental Health Centers
 - November, 2012 through October, 2013
 - To assist health homes in developing health home functionality and acquiring NQCA or CARF accreditation
- Practice Coaches
 - Experienced CMHC administrators
 - Monthly teleconferences and up to two site visits with each site
 - Monthly consultation with and feedback to DMH Healthcare Home implementation team



CMHC Healthcare Homes

Still A Very New Initiative

- Adjusting expectations to reality
- Continuing to understand and clarify
 - How things work
 - How roles and responsibilities fit together
- Helping staff acquire new skills



Contacts

- Contacts
 - Enrollment: Marcia Seaborne
marcia.seaborne@dmh.mo.gov
 - Policy: Natalie Fornelli natalie.fornelli@dmh.mo.gov
 - FTP Website: Clive Woodward
clive.woodward@dmh.mo.gov
 - Monthly Implementation Reports, Staffing Changes, HCH Director Liaison: Tara Crawford
tara.crawford@dmh.mo.gov