



Paving the Way for Healthcare Home

Coming Soon...





Paving the Way for Healthcare Homes Affordable Care Act

- The Affordable Care Act passed by Congress and signed into law by the president in March 2010, provides a variety of approaches to improving the U.S. healthcare system.
- Section 2703 of the Act allows states to amend their Medicaid state plans to provide **Healthcare Homes** for enrollees with chronic conditions.





Paving the Way for Healthcare Homes

What is a Healthcare Home?

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





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Missouri's Healthcare Homes

- Missouri is the first state to amend its Medicaid state plan to implement Healthcare Homes.
- Missouri will have two types of Healthcare Homes
 - **Primary Care Chronic Conditions Healthcare Home**
 - Federally Qualified Health Centers (FQHCs)
 - Rural Health Centers (RHCs)
 - Physician practices
 - **Community Mental Health Center Healthcare Home**
 - CMHCs and CMHC affiliates





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Why CMHC Healthcare Homes?

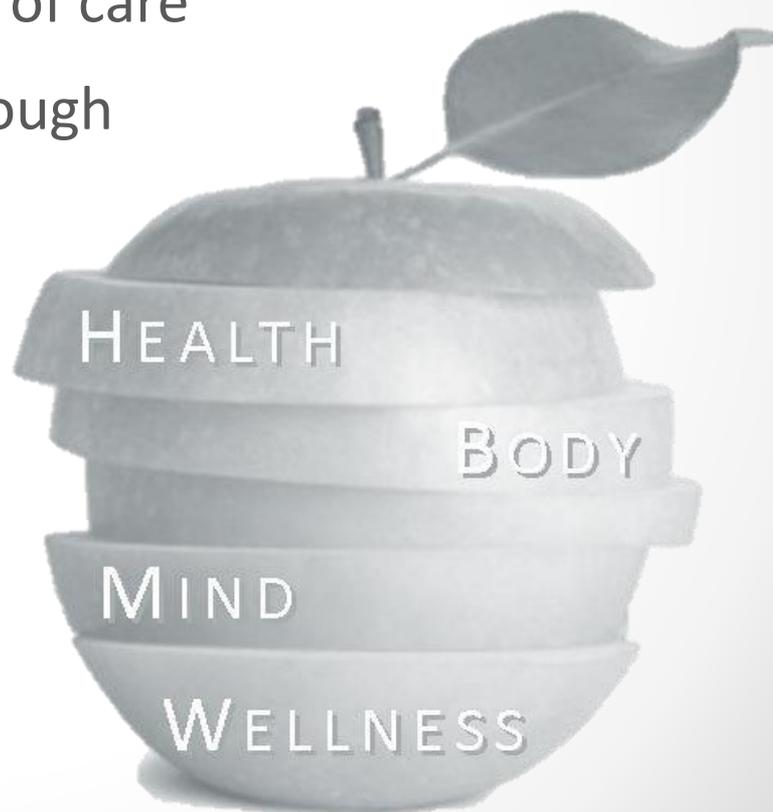
- Because addressing behavioral health needs requires addressing other healthcare issues
 - Individuals with SMI, on average, die 25 years earlier than the general population.
 - 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and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



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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.





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Why CMHC Healthcare Homes?

- Because there is continuing pressure to control Medicaid costs
 - No change is not an option
 - Alternative service delivery approaches are unacceptable
 - Capitated Managed Care
 - Administrative Service Organization with prior authorization
 - The Fiscal Year 2012 state budget assumes \$7.8 million in savings from the Healthcare Home initiative
 - DMH would have faced additional reductions without Healthcare Home implementation



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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



- CMT data analytics
 - Behavioral Pharmacy Management Program
 - Disease Management Report (HEDIS indicators)
 - Medication Adherence Report
- CyberAccess



Paving the Way for Healthcare Homes

Why CMHC Healthcare Homes?

- Because it's the natural next step for Missouri

Step Three: Building Integration Initiatives

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

Step Four: Embracing Wellness and Prevention Initiatives

- Metabolic syndrome screening
- DM 3700 initiative

Next Step: **Becoming a Healthcare Home**





Paving the Way for Healthcare Homes <Insert Agency Name>

In the coming months,
<insert agency name>
will be applying with the state to be designated
as a Healthcare Home provider.

- We will manage the full array of physical health needs, in addition to behavioral health care needs, and needed long-term community care services and supports, social services and family services for individuals enrolled in our Healthcare Home.
- CPRCs already serve the target population and perform many Healthcare Home functions.
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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**



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Target Population

- Chronic health conditions include:
 1. Diabetes
 2. Cardiovascular disease
 3. Chronic obstructive pulmonary disease (COPD)
 - Asthma
 - Chronic bronchitis
 - Emphysema
 4. Overweight (BMI >25)
 5. Tobacco use
 6. Developmental disability





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HH Functions: We are well positioned

- CPR teams already fulfill many Healthcare Home functions:
 - Identification and targeting of high-risk individuals
 - Monitoring of health status and adherence
 - Individualized planning with the consumer
 - Coordination with the patients, caregivers and providers
 - Implementing plan of care with treatment team
 - Promoting consumer self-management





Paving the Way for Healthcare Homes

HH Functions: We are well positioned

- CPR teams already fulfill many Healthcare Home functions:
 - Providing individualized services and supports
 - Linking consumers to community and social supports
 - Hospital admission and discharge follow-up
 - Communicating with collaterals
 - Utilizing health information technology (CyberAccess, CMT reports, etc.) to manage care





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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





Paving the Way for Healthcare Homes

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



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Healthcare Home Team

- CPR teams will be augmented by adding:
 - Consultation by a physician
 - Enhanced health coach training for CSSs
 - Additional Nurse Care Managers
 - Non-nurse care managers may be approved by exception
- Consumers enrolled in the Healthcare Home who are not assigned a community support specialist will be assigned a nurse or care manager.





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Healthcare Home Care Team

- **Behavioral Health Clinicians and CPRC Teams**

- Continue to perform their current functions

- **Community Support Specialists**

- Continue to perform their current functions
- Receive enhanced 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 the chronic health conditions
 - Assist consumers in accessing primary care





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Healthcare Home Care Team

- **Healthcare Home Director**

- Provides leadership in the implementation and coordination of Healthcare Home activities
- Champions practice transformation based on Healthcare Home principles
- Develops and maintains working relationships with primary and specialty care providers, including inpatient facilities
- Monitors Healthcare Home performance and leads improvement efforts
- May design and develop health and wellness initiatives



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Healthcare Home Care Team

- **Healthcare Home Physician**

- Provides medical leadership:

- Participates in treatment planning
- Consults with team psychiatrist
- Consults regarding specific consumer health issues
- Assists coordination with external medical providers





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Healthcare Home Care Team

- **Nurse Care Managers**

- Develop wellness and prevention initiatives
- Facilitate health education groups
- Participate in the initial treatment plan development for all of their Healthcare Home enrollees
- Assist in developing treatment plan healthcare goals for individuals with co-occurring chronic diseases
- Consult with CSSs about identified health conditions
- Assist in contacting medical providers and hospitals for admission/discharge





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Healthcare Home Care Team

- **Nurse Care Managers**

- Provide training on medical diseases, treatments and medications
- Track required assessments and screenings
- Assist in implementing DMH Net health technology programs and initiatives (such as CyberAccess and metabolic screening)
- Monitor HIT tools and reports for treatment and medication alerts and hospital admissions/discharges
- Monitor and report performance measures and outcomes





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Healthcare Home Team

- Physicians
 - 1 hour per enrollee per year, or
 - 520 enrollees = .25 FTE per year (10 hrs. per week)
 - 1,040 enrollees = .5 FTE per year (20 hrs. per week)
 - 2,080 enrollees = 1 FTE per year (40 hrs. per week)
- Nurse Care Managers
 - At least 1 RN
 - 1 care manager for every 250 clients enrolled in Healthcare Home
 - Nurse care manager caseloads may vary based on the number of consumers they serve who do not have a community support specialist.



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Healthcare Home Funding

- Infrastructure payments
 - Covers costs associated with recruiting, training and IT changes
 - Administrative staff
- PMPM payment
 - Covers the costs associated with additional physician time and nurse care managers
 - Not unit-by-unit
- Pay for Performance
 - CMHC Healthcare Homes receive additional funding based on producing outcomes.





Paving the Way for Healthcare Homes Practice Transformations

- Focus on overall health
- Improved CMHC processes (may include)
 - Enhanced scheduling
 - No show/cancellation policies
- Increased patient input processes
- Significant increase in data reporting and outcomes
- Treatment planning tools supported by evidence-based practice





Paving the Way for Healthcare Homes Training

- Healthcare Home Implementation Training
 - Healthcare Home 101
 - *August– November 2011*
- Systems Change Training
 - Phase I – Access to Care
 - *July – September 2011*
 - Phase II – Practice Transformation/Learning Collaborative
 - *December 2011 – August 2012*
 - Phase III – Meeting Missouri’s Healthcare Home Standards
 - *August – December 2012*



Paving the Way for Healthcare Homes Training

- Healthcare Home Team Training
 - Healthcare Home 101
 - Person-centered care
 - Understanding and Managing Chronic Diseases
 - Child and Adolescent Wellness
 - *September 2011*





Paving the Way for Healthcare Homes Expectations

- The Centers for Medicare and Medicaid Services (CMS) expect healthcare homes to:
 - Lower rates of emergency room use
 - Reduce in-hospital admissions and re-admissions
 - Reduce healthcare costs
 - Decrease reliance on long-term care facilities
 - Improve experience of care, quality of life and consumer satisfaction
 - Improve health outcomes
 - HEDIS indicators
 - Management of health conditions





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Expectations: We can meet them

- A recent 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*





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Expectations: We can meet them

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 |



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On the Move: Milestones 2011

- July

- Missouri Medicaid state plan amendment submission to CMS
- Training for system change begins
- Healthcare Home rules and regulations finalized

- August

- Training on healthcare home rules and regulations begins
- MO Medicaid state plan amendment approval expected
- CMHCs designated as Healthcare Home Providers
- Infrastructure payment begins

- September

- Healthcare Home team training begins

- December

- Healthcare Homes begin operating
- Eligible clients auto-enrolled
- Start PMPM payments





Paving the Way for Healthcare Homes Questions?

