

Healthcare Home 101

Leadership Training

Agenda

- State Plan Amendment Update
- Enrolling Consumers
- HCH Responsibilities
- Monthly Reports
- Data Collection and Use
- Program Reviews
- HCH Accreditation
- Communication
- Training

State Plan Amendment

- Status
 - Expected date of approval: October 20th
 - Effective date: December 1st
- Shared Savings
 - Will be pursued through a separate State Plan Amendment
- PMPM Components
 - HCH Director: \$19.17
 - Based on 500 enrollees
 - Primary Care Physician Consultant: \$12.50
 - Based on 1 hr per enrollee
 - Nurse Care Manager: \$35.00
 - Based on 1 NCM to 250 enrollees
 - Administrative Support: \$12.07

State Plan Amendment

Changes

- Administrative Support PMPM
 - PMPM Component based on covering the cost of
 - 1 FTE HCH clerical support staff
 - Lost productivity of medical/psychiatric staff due to participation in required training
 - Based on two physicians attending 6 full days of training a year
 - DMH will seek CME's for required training
 - State administrative costs for program administration, including data analytics
 - HCHs will pay \$3 of the PMPM to the MoCMHC each month
 - Administrative Support increased from \$8.67 to \$12.07
 - Total PMPM: \$78.74
- CMS insists that an HCH service must trigger PMPM payment

State Plan Amendment

PMPM Payments

- PMPM payments will be based on the following criteria
 - The individual is on the State patient registry
 - The individual is enrolled as a HCH member at the billing provider
 - One of the two following HCH services has been provided for the individual during the month
 - Care Management monitoring for treatment gaps
 - Another HCH service documented by the HCH Director and/or Nurse Care Manager
- Care Management monitoring of treatment gaps
 - HCH Director and/or Nurse Care Managers review one or more HIT reports to identify care gaps requiring action
 - Month 1: Adherence Reports
 - Month 2: Disease Management Reports
 - Month 3: BPMS Pharmacy Reports
 - HCH Director documents review of HIT reports on Monthly Report
- Payments based on number of enrolled HCH members and Monthly Report documentation that Care Management review has occurred
 - Consumers must meet spend down at the end of the month

State Plan Amendment

Regulations and Manuals

- CSR
 - Emergency Rule effective December 1st
 - Simultaneous File of Rule for Public Review and Comment
- DMH Program Manual
 - Sets forth DMH requirements
 - Available December 1st
- Medicaid Provider Manual

Enrolling Consumers

- Auto-enrollment and auto-assignment
- Consumer Choice
 - Decline Enrollment
 - Transfer to Another HCH
- Toll Free HCH Line
- Meeting with HCH Enrollees
- DM 3700 Clients
- CPR presumptive eligibility option
- Enrolling Additional Consumers

Auto Enrollment and Assignment

- MHN will create a list of current Medicaid enrollees who are eligible for enrolling in a CMHC HCH based on diagnosis retrieved from claims data
- MHN will create a patient registry based on Medicaid enrollees
 - with \$11,000 or more in Medicaid claims in the past year
 - who had at least one CMHC claim in the past 90 days
- Individuals who are auto-enrolled in the patient registry will be auto-assigned to their current CMHC provider
- The list of auto-assigned enrollees by CMHC is expected to be placed on FTP by October 21st.

Auto Enrollment and Assignment

- By 11/1, letters will be mailed to auto-enrollees describing the HCH benefit and indicating that they
 - Have been enrolled and assigned to their current CMHC
 - May decline to participate in the HCH benefit
 - May transfer to another HCH provider if one is available in their area
- DMH will maintain a Toll Free line for consumers to call if they
 - choose to decline to participate in the HCH benefit
 - want to transfer to another HCH provider, or
 - have other questions before the CMHC has a chance to meet with them in person to explain the HCH benefit

Consumer Choice

Decline Enrollment

- Consumers may decline to participate in the HCH benefit at any time without jeopardizing their existing services
- Consumers decline to participate by contacting the Toll Free HCH Line or informing their HCH provider

Consumer Choice

Transfer to Another HCH

- HCH services are an enhancement to existing psychiatric rehab services, therefore consumers cannot choose to receive CMHC HCH services from one CMHC and their psychiatric rehab services from another CMHC
 - Transferring means transferring to a different CMHC for psychiatric rehab services
- Alternative HCH providers are only available where alternative CMHC service providers are available
 - In a service area with only one CMHC, consumers do not have the option to enroll with another CMHC HCH unless they move to another service area, or, if they are eligible, choose to enroll in a Primary Care HCH when they become available
- Transfers will be effective at the beginning of the month following the request to transfer

Consumer Choice

Transfer to Another HCH

- Where multiple CMHCs are available, consumers may request to transfer from one CMHC to another
- Areas with more than one CMHC include
 - St. Louis
 - BJC, Places for People, Independence Center, Adapt, and Hopewell
 - Jackson County
 - Comprehensive Mental Health Services, Inc. Swope Health Services, ReDiscover, and Truman Behavioral Health
 - Columbia
 - Burrell and New Horizons
 - Jefferson City
 - Pathways and New Horizons
 - Service Area 13
 - North Central and Preferred
 - Service Area 14
 - Mark Twain, Preferred, Comprehensive Health Systems (partial)
 - Service Area 15
 - East Central, Comprehensive Health Systems, Preferred (partial)

Toll Free HCH Line

- DMH will maintain a dedicated Toll Free HCH Line to be answered Monday through Friday, 9 a.m. to 4:00 p.m. beginning November 1st
- The Healthcare Home Director shall serve as the enrollment contact for the Department
- If a caller declines to participate in the HCH benefit, DMH will notify the HCH Director by e-mail of the HCH disenrollment. The HCH Director will acknowledge receipt of the disenrollment by e-mail.
 - Natalie Fornelli will be the DMH enrollment contact person
 - natalie.fornelli@dmh.mo.gov
 - 573-526-3683

Toll Free HCH Line

- If the caller requests another HCH provider
 - DMH staff will
 - explain that transferring to another HCH provider means changing CMHCs for all their services;
 - determine whether an alternative provider exists in the service area;
 - if alternative CMHCs are available in the area, ask the caller to identify which of the alternative providers the caller is requesting a transfer to;
 - inform the caller that both their current CMHC and the CMHC they are requesting transfer to will be notified of the callers request and that the caller can expect a contact from their requested CMHC regarding the possibility of transferring services.
 - Both the current and requested CMHC HCH Directors will be notified by e-mail of the requested transfer, and each CMHC HCH Director will acknowledge receipt of the request.

Toll Free HCH Line

- If the caller requests another HCH provider
 - The CMHCs involved will consult with each other regarding the requested transfer
 - if agreement is reached about the appropriateness of the transfer, then the CMHC's will coordinate their efforts to contact the caller and explain whether and how transfer will occur, or why the transfer is not possible. The requested CMHC should be involved in contacting the caller. The CMHC's notify DMH by e-mail of the agreed upon resolution, plan for contacting the caller, and transfer process and date, if applicable.
 - if agreement cannot be reached about the appropriateness of the transfer, then the CMHC HCH Director will notify the DMH enrollment contact person by E-mail for follow up

Toll Free HCH Line

- If the caller is not requesting to decline participation or to transfer, but is seeking information, then
 - If possible, the DMH staff will answer the caller's questions, and notify the HCH Director of the call and disposition by e-mail. The HCH Director will acknowledge receipt of the information by e-mail.
 - If the DMH staff cannot answer the caller's question, they will refer the caller to their CMHC provider, CSS, or the HCH Director as appropriate, and notify the appropriate HCH Director of the call and disposition, by e-mail. The HCH Director will acknowledge receipt of the information by e-mail.

Meeting with Enrollees

- CMHCs may **begin** meeting with auto-assignees to introduce the HCH program **November 1st**
 - Face-to-face meetings should be documented by progress note in client chart
 - If the meeting is conducted by a CSS it may be billed as Community Support
 - All face-to-face meetings must be completed by February, 2012
- Guardians
 - DMH preparing a letter for introducing the CMHC HCH initiative to guardians for distribution through their association
 - May have been the recipient of the CMHC HCH consumer letter
 - CMHCs required to contact guardian if consumer expresses interest in declining enrollment or transferring
- Meeting Protocol and Script

DM 3700 = HCH Outreach

- Current clients will be auto-enrolled and auto-assigned, will receive a letter, and should have a meeting to explain HCH benefit
- Match for HCH Outreach clients comes from DSS
- HCH Outreach clients are presumptively eligible for CPR program
- New HCH Outreach clients will also be enrolled and should receive the same introduction to the HCH programs as auto-enrolled individuals

Presumptive Eligibility

- At the CMHC's option, auto-assigned consumers who are not currently enrolled in the CPR program may be considered presumptively eligible and enrolled in the CPR program
- To enroll auto-assigned 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

Enrolling and Discharging Consumers

- DMH is still in the process of developing the protocol for enrolling new consumers
- HCH may discharge auto-enrolled CPR clients at their discretion, and may request discharge of other auto-enrolled consumers, utilizing the DMH HCH discharge form.
- Funding
 - Each CMHC is being allocated funds based on the projected number of auto-enrolled consumers
 - If the actual number of auto-enrollees is less than the projected number of auto-enrollees, or if an auto-enrollee declines participation, transfers, or is discharged, then the CMHC may enroll a consumer in the HCH without impacting their DMH allocation
 - If a CMHC enrolls consumers beyond the number established by the projected auto-enrollment, then the funding for these new enrollees comes from their DMH allocation

HCH Responsibilities

- What is a Healthcare Home
- HCH Team Members
- Health Screening
- PCPs and other Healthcare Providers
- Hospital MOUs
- Other HCH Responsibilities

HCH Responsibilities

What is a Healthcare Home

- Not just a Medicaid Benefit
- Not just a Program or Team
- A place where individuals can come throughout their lifetime 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 as patients.
- An Organizational Transformation

HCH Responsibilities

HCH Team Members

- *Primary Care Consulting Physician*
- *Health Care Home Director*
- *Nurse Care Managers*
- *HCH Clerical Support Staff*
- Community Support Specialists
- Psychiatrist
- QMHP and other Clinical Staff
- Peer Specialist

HCH Team Members

Primary Care Physician Consultant

- **Assures** that HCH enrollees receive care consistent with **appropriate medical standards**
- **Consults with** HCH enrollees' **psychiatrists** as appropriate regarding health and wellness
- **Consults with NCM and CPR team** regarding specific health concerns of individual HCH enrollees
- **Assists with coordination** of care with **community and hospital medical providers**
- Reviews and **signs off** on all **treatment plans** as a consultant
- **Documents** individual **client care and coordination** in client records
- **Maintains** a monthly **HCH log**

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
 - Physician Assistants may also be substituted for a primary care physician on the same 2 hour to 1 hour basis, but must be approved by DMH in advance based on credentials
 - At least 2 hrs/wk of physician time must be a primary care physician
- CMHC consumers' PCPs
 - May contract with multiple primary care physicians to provide consultation for CMHC consumers who are their patients
 - PCP contracts must include provisions that
 - The PCP cannot bill for any other Medicaid service while providing consultation
 - Address kickback protection
 - The HCH must have 1 hour physician time for those consumers who do not have a consulting PCP
- Psychiatrists cannot serve in this role beyond Sept., 2012
 - Except psychiatrists who are board eligible in primary care, family medicine or internal medicine
- Notify Susan Blume by E-mail of selected approach by November 15th

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** management of **HIT tools**
- **Develops MOUs** with hospitals and **coordinates hospital admissions and discharges** with NCMs

HIT Tools

- CyberAccess (ACS Heritage)
- Direct Inform (ACS Heritage)
- Disease Management Report (CMT)
- Medication Adherence Report (CMT)
- Behavioral Pharmacy Management Online (CMT)
- Hospital Admission/Discharge E-mail Alerts (DMH)
- Metabolic Syndrome Screening Database (Microsoft Access)

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**
- **Maintains** a monthly **HCH log**

HCH Team Members

Nurse Care Managers

- **Champion healthy lifestyles and preventive care**
- **Provide individual care** for consumers on their caseload
 - **Review client records** and patient history within 90 days of auto enrollment
 - **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

Nurse Care Managers

- **Track** required **assessments and screenings** for consumers on their caseload
- **Provide training** on chronic diseases, health coaching, healthy lifestyle choices and medications
- **Monitor HIT tools and reports** for treatment and medication alerts, and hospital admissions/discharges and alerts CSS's as appropriate
- Make initial **contacts with hospitals** regarding **admissions**
- **Contact consumers** within 72 hours of **hospital discharge** and conduct **medication reconciliation**

HCH Team Members

Nurse Care Managers

- **Promote** use of **Direct Inform**
- **Perform CSS functions** for consumers not enrolled in CPR
- **Maintain** a monthly **HCH log**
- **Participate in** required **HCH training**
- **May facilitate** health education groups

HCH Team Members

HCH Clerical Support Staff

- Provide assistance in **faxing, sorting, and distributing reports** and letters related to
 - Disease management coordination
 - CyberAccess Patient Profile Reports and patient history reviews
 - the Behavioral Pharmacy Management program
 - the Metabolic Screening program
- **Complete data entry** related to metabolic screening
- Provide **technical assistance** to HCH team and CSSs on use of CyberAccess and Patient Profile reports
- Assist in **tracking** required assessments and screenings
- **Maintain monthly log** of HCH activities
- **May** serve as a **CyberAccess practice administrator**
- **Provide general clerical support** to the HCH Director and team

HCH Team Members

Community Support Specialists

- **Continue** to fulfill **current CSS responsibilities**
- **Participate** in required **HCH training**
- **Collaborate with Nurse Care Managers** in providing individualized services and supports
- Increasingly **improve** their **skills** in assisting consumers in meeting **wellness and recovery** goals, and **managing chronic illnesses**

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 Responsibilities

Health Screening

- Each HCH enrollee shall have an annual health screen that includes required components.
- For auto-assigned enrollees, the health screen should be completed as part of their annual treatment planning process that follows the meeting with the consumer to introduce them to the HCH benefit
- The Nurse Care Manager shall review the results of the health screen prior to the enrollees annual treatment plan update to determine whether additional health assessments 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
- 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 will be prepared for use when meeting with PCP's and other healthcare providers
- Contacts with PCP's will be documented in the Monthly Implementation Report

HCH Responsibilities

Hospital MOUs

- SPA Requirement
 - Within 3 months of Health Home service implementation, have developed a contract or MOU with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of Health Home participants, as well as maintain a mutual awareness and collaboration to identify individuals seeking ED services that might benefit from connection with a Health Home site, and in addition motivate hospital staff to notify the CMHC Primary Care Nurse Manager or staff of such opportunities.
- Progress documented in the System Transformation Report section of the Monthly Implementation Report

HCH Responsibilities

Other Responsibilities

- Complete Team Contact profiles
- Staffing changes (Vacancies and Hires)
 - Report vacancies by E-mail to Natalie Fornelli within 5 working days, and reported on the Monthly Implementation Report
 - Report hires by Email to Natalie Fornelli within 5 working days, submit updated Team Contact profile, and reported 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
- Hospital Discharges
 - HCH members discharged from the hospital must have a contact by a Nurse Care Manager within 72 hours of discharge
 - Nurse Care Managers must complete a medication reconciliation on HCH members discharged from the hospital
 - Contacts following discharge and medication reconciliations are documented on the Monthly Implementation Report
- HCH Directors participate in monthly TA calls with DMH

Monthly Implementation Report

- Process and Timelines
- Monthly Report Components
 - Cover Sheet
 - HCH Team Log
 - System Transformation Report
 - Client Status Report
 - Hospital Discharge Report

Monthly Implementation Report

- Report Forms will be distributed during the first week of the month following the month the report summarizes
 - The Implementation Report cover sheet, HCH Team Log, and System Transformation Report will be e-mailed to the HCH Director
 - The Client Status and Hospital Discharge Reports will be available on the FTP site
- The Implementation Report must be completed and updated on the FTP site by the 20th of the month following the month the report summarizes
 - The Implementation Report cover sheet, HCH Team Log, and System Transformation Report should E-mailed Natalie Fornelli and your Regional Executive Officer
 - The Client Status and Hospital Discharge Reports are 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, and
 - Documents that the monthly HIT report has been reviewed
- HCH Team Log
 - 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
- System Transformation Report
 - Fulfills requirement to report on organizational transformation
 - Narrative report used to identify
 - Additional training and technical support needs
 - Best practices for collaborative learning

Monthly Report Components

- Client Status Report
 - Documents required that face-to-face meetings with all auto-assigned consumers to engage in HCH by the end of January, 2012 have taken place
 - Documents that when PCP's have been acquired for those enrollees who do not have one
 - Documents that PCPs and other health providers that have been informed that the individual has been enrolled in the HCH
- Hospital Discharge Report
 - Documents that consumers have been contacted within three days of hospital discharge

Data Collection and Use

- Evaluating the HCH Initiative: *Goal Based Quality Measures*
 - Establish benchmarks used to determine progress in achieving one of more of the eight Healthcare Home Initiative goals
 - May be assessed periodically, but are essentially designed to measure the success of the 24 month initiative
- Sharing Savings: *Performance Measures*
 - Establish benchmarks and gap closing goals used to annually assess the performance of each Healthcare Home as part of the process of allocating shared savings
 - Interim performance will be shared with each Healthcare Home as part of the six month review process
- Managing Care: *Care Management Reports*
 - Provide Healthcare Homes with individual patient data for the purpose of assuring the patient care meets quality of care standards
 - May be produced and distributed to Healthcare Homes daily, monthly or quarterly

Data Uses

Goal Based Measures	Performance Measures	Care Management
Patient Use of Personal EHR		
Satisfaction with Services		
BMI Control		
Ambulatory Care Sensitive Condition Admission	Ambulatory Care Sensitive Condition Admission	
ED Visits	ED Visits	
Hospital Readmissions	Hospital Readmissions	
Use of CyberAccess	Use of Cyber Access	
Metabolic Screening	Metabolic Screening	
Use of Illicit Drugs	Use of Illicit Drugs	
Excessive Drinking	Excessive Drinking	

Data Uses

Goal Based Measures	Performance Measures	Care Management
Psych Med Adherence	Psych Med Adherence	Psych Med Adherence
Hosp. Discharge Face-to-face Follow-up	Hosp. Discharge Face-to-face Follow-up	Hosp. Discharge Face-to-face Follow-up
Diabetes A1c <8.0%	Diabetes A1c <8.0%	Diabetes A1c <8.0%
Pediatric Asthma Rx	Pediatric Asthma Rx	Pediatric Asthma Rx
Adult Asthma Rx	Adult Asthma Rx	Adult Asthma Rx
COPD Med Adherence	COPD Med Adherence	COPD Med Adherence
Hypertension Control	Hypertension Control	Hypertension Control
CAD Lipid Control	CAD Lipid Control	CAD Lipid Control
CVD Med Adherence	CVD Med Adherence	CVD Med Adherence
CVD Use of Statins	CVD Use of Statins	CVD Use of Statins

Data Uses

Goal Based Measures	Performance Measures	Care Management
	Psych Meds Inconsistent with Quality Practices	Psych Meds Inconsistent with Quality Practices
	Tobacco Use	

Program Reviews

- Six Month Review
 - Review period: January through June, 2012
 - Approach
 - Monthly review and ongoing compilation of data from
 - HCH Team Log
 - System Transformation and Hospital Discharge Reports
 - Performance Measures
 - Participation in Training and Monthly Calls
 - Sample record review of documentation
 - Outcome
 - Progress report and technical assistance recommendations
- Twelve Month Review - TBD

HCH Accreditation

- DMH is working with CARF to develop Health Home standards by July, 2012
- CARF will provide training on the standards during the fall of 2012
- CMHC Healthcare Homes must be accredited under the CARF standards by July, 2013

Communication

- HCHs maintain up to date Team Contact Profiles
- Monthly phone call with HCH Directors
- Contacts:
 - Enrollment: Natalie Fornelli
 - Monthly Implementation Reports: Natalie Fornelli
 - FTP Website: Clive Woodward
 - Staffing Changes: Natalie Fornelli
- DMH will develop a FAQ list and answers based on Leadership and Team trainings
- HCH information will be available on the CPS website on the Provider Bulletin Board

Training

- Initial HCH Team Training
 - Agenda
 - 1st day- HCH Overview
 - 2nd day – HIT Training
 - Dates
 - October 25th and 26th
 - November 1st and 2nd
 - November 15th and 16th
- MFH Learning Collaborative
- Continuing HCH Team and CSS Training