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CMHC Clinical Directors and Healthcare Home Directors:

Implementing a new program, or creating a new function, often involves some confusion and inefficiencies as initial expectations are modified to accommodate the realities of the work, roles and responsibilities are clarified, and people learn new tasks. We are, of course, in the initial stages of implementing Healthcare Homes: adjusting expectations to reality as we go, continuing to understand and clarify how things need to work, how roles and responsibilities fit together, and struggling to help staff acquire new skills.

Understandably, many Nurse Care Managers, in particular, are feeling overwhelmed as they adjust to a new role, get to know the individuals on their caseloads as well as the other members of the Healthcare Home team, work with others to figure out how to integrate into existing systems of care, and acquire new skills in accessing data and managing their caseloads.

In order to ease some concerns we have heard expressed by Nurse Care Managers about their role, as well as their responsibilities regarding the CMT reports, we thought it might be helpful to clarify further the role of the Nurse Care Managers and our expectations regarding the use of the CMT reports.

Role of the Nurse Care Managers

The role of CMHC Healthcare Home Nurse Case Managers (NCM's) combines some of the functions performed by a Public Health Nurse with some functions typically performed by an insurance plan Care Manager. Consequently, NCM's do not have the same nurse/patient relationship with the individuals on their caseloads as nurses working in a clinic or hospital nursing assignment. Unlike clinic or hospital nurses, NCM's are not personally responsible for all aspects of care for each individual on their caseloads.

NCM's are expected to identify actionable areas to improve the care and health status of individuals on their caseloads. The actionable areas chosen should be a balance between attending to the more acute or critical needs of some individuals on their caseloads, and addressing issues where the health or wellness of a relatively larger portion of the individuals on their caseloads can be improved.

NCM's are not somehow liable if an individual assigned to their caseload cannot be located or engaged in a particular intervention such as medication reconciliation, diabetes education, or health risk screening.

The traditional nurse/patient relationship only occurs during specific face-to-face interactions such as review of the health risk screening or medication reconciliation with individuals on their caseloads, or diabetes education. In such situations, NCM's are responsible for giving the usual quality of clinical intervention and education for the duration of that intervention.

NCM's are not expected to address all aspects of care for all individuals on their caseloads. It is important for NCM's to think in terms of improving the health and wellness of a cohort of patients. Consequently, it is appropriate for NCM's to focus their time and attention on those interventions that they believe have the potential for improving the health and wellness of the greatest number of individuals on their caseloads. Of course, NCM's should attend to any individual situations involving individuals on their caseloads that they judge to be critical or immediately harmful.

There is no expectation that all measures of care can be attended to for all individuals on an NCM's caseload. A 50% improvement on 50% of the care measures for 50% of the Healthcare Home enrollees over a two year period would be an astounding success.

Utilizing the CMT Reports

Each month your CMHC Healthcare Home receives one of three reports designed to identify treatment gaps in the care of Healthcare Home enrollees:

- the Medication Adherence,
- Disease Management, and
- Behavioral Pharmacy Management System reports.

These reports, prepared by Care Management Technologies (CMT) and available through ProAct, compare MO Health Net paid claims for all your CMHC Healthcare Home enrollees against established standards of care in order to identify individuals for whom an intervention may be appropriate to assure that they are getting the care they need and/or that their health status is improving.

Since these reports are based on MO Health Net paid claims, they do include false positives, i.e. cases where an individual is actually receiving a service, but does not appear to be because MO Health Net is not paying for that service. These are cases where the service was paid through another source (e.g. Medicare, self-pay, free medication samples, etc.).

Your CMHC Healthcare Home team should review each monthly report to determine which CMHC Healthcare Home enrollees have been "flagged" on the report (i.e. have been identified as failing to meet an established standard of care), and, for those individuals who have been "flagged", determine whether an intervention is required.

Not every CMHC Healthcare Home enrollee who is "flagged" on a monthly report will warrant an intervention.

The information provided by the reports should help you make decisions regarding which individuals require an immediate intervention, as well as, guide your Healthcare Home team in developing strategies for improving the standard of care and/or health status of cohorts of your CMHC Healthcare Home enrollees.

For example, a review of the Disease Management report may lead you to target a particular indicator where the greatest number of CMHC Healthcare Home enrollees are below the standard of care (e.g. only 50% of enrollees with a history of coronary artery disease have been prescribed a statin medication compared to the goal of 70%). A review of the Medication Adherence Report may lead you to target an intervention to those individuals that the report indicates have had a problem with

Medication Adherence over an extended period of time, or who are having a problem with Medication Adherence with a particularly critical medication, or who have very low Medication Possession Ratios. A review of the Behavioral Pharmacy Report may lead you to target a particularly critical standard of care, e.g. multiple prescribers of a particular medication, or a particular type of poly-pharmacy.

The interventions your organization chooses will likely require time to fully implement, and because your organization receives each report only once a quarter, it will, of course, take time to assess the effectiveness of the interventions you choose.

We know that the system transformation we are engaged in is stressful, and we want to do whatever we can to ease the transition and make sure that we are not needlessly adding to the stress.

I hope this clarification of the role of the Nurse Care Managers and our expectations regarding the use of the CMT reports is helpful.

Sincerely,

A handwritten signature in cursive script that reads "Joseph Parks, M.D.".

Joseph Parks, M.D.
Chief Clinical Officer