Paving the Way for Healthcare Home

Coming Soon...
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.
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.
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
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
  o Wellness and prevention are as important as treatment and rehabilitation.
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
  o Behavioral Pharmacy Management Program
  o Disease Management Report (HEDIS indicators)
  o Medication Adherence Report

• CyberAccess
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**
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.
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**
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
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
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**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
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
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
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
  o Continue to perform their current functions

• Community Support Specialists
  o Continue to perform their current functions
  o 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**
  o Develop wellness and prevention initiatives
  o Facilitate health education groups
  o Participate in the initial treatment plan development for all of their Healthcare Home enrollees
  o Assist in developing treatment plan healthcare goals for individuals with co-occurring chronic diseases
  o Consult with CSSs about identified health conditions
  o Assist in contacting medical providers and hospitals for admission/discharge
• **Nurse Care Managers**
  
  o Provide training on medical diseases, treatments and medications
  
  o Track required assessments and screenings
  
  o Assist in implementing DMH Net health technology programs and initiatives (such as CyberAccess and metabolic screening)
  
  o Monitor HIT tools and reports for treatment and medication alerts and hospital admissions/discharges
  
  o Monitor and report performance measures and outcomes
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
  o Covers costs associated with recruiting, training and IT changes
  o Administrative staff

• PMPM payment
  o Covers the costs associated with additional physician time and nurse care managers
  o Not unit-by-unit

• Pay for Performance
  o CMHC Healthcare Homes receive additional funding based on producing outcomes.
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Practice Transformations

• Focus on overall health
• Improved CMHC processes (may include)
  o Enhanced scheduling
  o 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
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- Healthcare Home Team Training
  - Healthcare Home 101
  - Person-centered care
  - Understanding and Managing Chronic Diseases
  - Child and Adolescent Wellness
- September 2011
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
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

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial PMPM Cost</td>
<td>$1,556</td>
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<tr>
<td>Expected PMPM Cost w/o intervention</td>
<td>$1,815</td>
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<tr>
<td>Actual PMPM Cost following enrollment w/ CMHC</td>
<td>$1,504</td>
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<tr>
<td>Savings</td>
<td>$21 million</td>
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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
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Questions?