

CHAPTER 9

Behavioral Health Homes

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Many patients with serious mental illness (SMI) and substance use disorders are often seen more frequently by behavioral health specialty organizations such as a community mental health center (CMHC) than by other health care providers. As a group, these individuals have substantially higher rates of chronic medical conditions and premature mortality than the

general population (Colton and Manderscheid 2006a, 2006b) and are less likely to receive adequate care for their medical conditions (Parks et al. 2006). Many of these individuals may be unable or unwilling to receive care in a primary care clinic, and even when they do, coordination between behavioral health and medical services may be poor (Druss and Walker 2011). For those individuals who have relationships with behavioral health organizations, care may be best delivered by bringing primary care, prevention, and wellness activities on site into behavioral health settings (Parks et al. 2005).

The 2010 Patient Protection and Affordable Care Act (PPACA) established a “health home” (HH) option under Medicaid to serve enrollees with chronic conditions by building a person-centered system of care that achieves improved outcomes for beneficiaries and better services and value for state Medicaid programs (Mann 2013; Parks et al. 2005). The HH service delivery model is intended to provide a cost-effective, longitudinal “home” to facilitate access to an interdisciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions. HHs are designed to improve the health care delivery system for individuals with chronic conditions by employing a “whole-person” approach—caring not just for an individual’s behavioral and physical condition but providing linkages to long-term community care services and supports, social services, and family services. The integration of primary care and behavioral health services is critical to the achievement of enhanced outcomes. The HH service delivery model is expected to result in lower rates of emergency room use, reduction in hospital admissions and readmissions, reduction in health care costs, less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual. The guidance from the Centers for Medicare and Medicaid Services (CMS) regarding the Medicaid HH option indicates that HHs do not need to provide the full array of required services themselves, but they must ensure such services are available and coordinated (Mann 2010). This gives a behavioral health agency several options for how to structure the behavioral HH, depending on its resources (e.g., physical facilities, number of patients/consumers served, available workforce, financing options, community partners). In this chapter, I will provide an overview of the HH model and a description of services and team members included in this approach to care, and examine the role of the psychiatrist.

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A TALE OF TWO TITLES

The HH model described in this chapter was made possible by the PPACA (Public Law 111–148, as revised by Public Law 111–152), Section 2703 entitled “State Option to Provide Health Homes for Enrollees with Chronic Conditions.” Section 2703 created a new section 1945 within the preexisting Social Security Act (SSA; Section 1945). Because of this, it is referenced sometimes as Section 2703 and sometimes as Section 1945.

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HISTORY

The medical/HH model was originally proposed by pediatricians and family medicine physician groups. In 1967, the American Academy of Pediatrics (Council on Pediatric Practice 1967 pg 77) proposed the medical home as “one central source of a child’s pediatric records to resolve duplication and gaps in services that occur as a result of lack of communication and coordination.” The American Academy of Family Physicians, American College of Physicians, American Academy of Physicians, and the American Osteopathic Association wrote the “Joint Principles of the Patient-Centered Medical Home,” stating that patient-centered medical homes should have seven characteristics: a personal physician; physician-directed medical practice; whole-person orientation; coordinated care; quality and safety; enhanced access; and adequate payment (American Academy of Family Physicians et al. 2007 pg 79). In 2008, the Department of Health and Human Services developed a conceptual model of the medical home, including service domains, training requirements, financing, policy, and research. It intended for the model to lower health care costs, increase quality, reduce health disparities, produce better outcomes, lower utilization rates, improve compliance with recommended care, and coordinate medical and social services required by the individual across the lifespan. The National Committee for Quality Assurance used this model to develop its medical home recognition program (Mann 2010).

AUTHOR: Please note change from American Academy of Physicians to American Academy of Pediatrics in second sentence above. Is this correct?

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State Medicaid programs have implemented delivery systems expanding on traditional primary care case management programs, many focusing on high-cost, high-user beneficiaries (not limited to specific diagnoses). While many of these models are physician-based, there is a growing movement toward interdisciplinary team-based approaches. Services such as care coordination and follow-up, linkages to social services, and medication compliance are reimbursed through a “per member per month” structure. Prior to the PPACA, states had already been using the authority in other sections of the SSA, such as Section 1932(a) and full-risk-managed care plans and demonstrations approved under Section 1115 of the SSA to implement their medical homes. This new option offers the opportunity for behavioral health provider organizations to become HHs for the people they serve (Alakeson et al. 2010).

~~-----Health Home Name~~
~~Nuances-----HOME NAME~~
~~NUANCES~~

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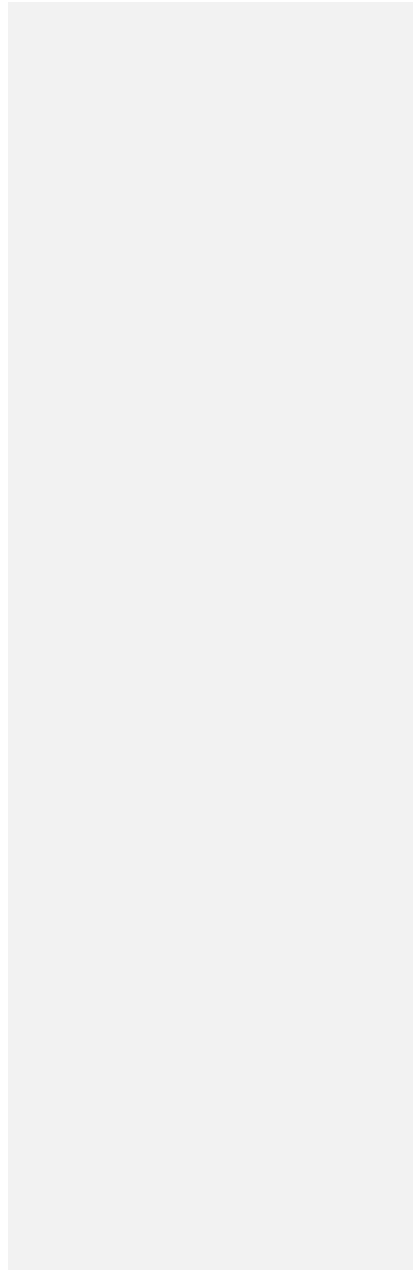
Medical homes (also know as person-centered medical homes): This is a model for delivering primary care that includes the following: patient-centered care; comprehensive care, addressing physical and mental health needs, prevention, and wellness; coordinated care; accessible care; and a systems approach to quality and safety (Agency for Healthcare Research and Quality 2013). This model has evolved since 1967 and has had various funding mechanisms.

Health homes: Section 2703 of the PPACA allows states to amend their state plans (often referred to as State Plan Amendments or SPAs) to include integrated care models for individuals with chronic health conditions, including mental and substance use disorders. These HHs provide “person-centered, continuous, coordinated and comprehensive care.” This model and its specific funding mechanism was created in 2010 by Section 2703 of the PPACA to expand the traditional medical home models to build linkages to other community and social supports and to enhance coordination of med-

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ical and behavioral health care in keeping with the needs of persons with



multiple chronic illnesses. CMS expects HHs to build on the expertise and experience of medical home models, when appropriate, to deliver HH services.

SECTION 2703 REQUIREMENTS

The state option to provide HH services to Medicaid beneficiaries with chronic conditions became effective on January 1, 2011. Federal HH guidance lays out service requirements stemming from the PPACA and “well-established chronic care models” (American Academy of Family Physicians et al. 2007). The required services include the following:

- Each patient must have a comprehensive care plan.
- Services must be quality-driven, cost-effective, culturally appropriate, person- and family-centered, and evidence-based.
- Services must include prevention and health promotion, health care, mental health and substance use and long-term care services, as well as linkages to community supports and resources.
- Service delivery must involve continuing-care strategies, including care management, care coordination, and transitional care from the hospital to the community.
- HH providers do not need to provide all the required services themselves, but they must ensure the full array of services is available and coordinated.
- Providers must be able to use health information technology to facilitate the HH’s work and establish quality improvement efforts to ensure that the work is effective at the individual and population level.

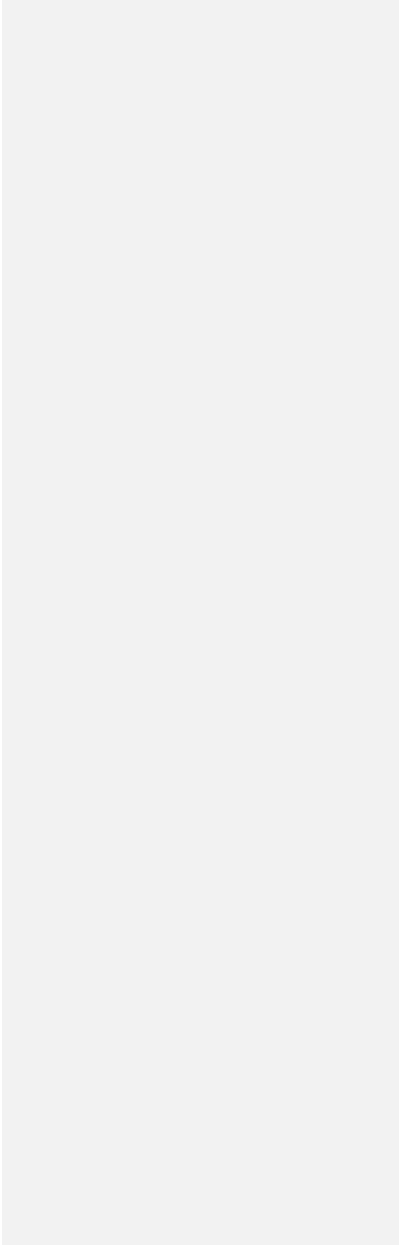
Selecting Patients: Eligibility and Enrollment

Individuals who are eligible for HH services must have at least [one of](#) the following:

- Two chronic conditions
- One chronic condition and the risk of having a second or
- One serious and persistent mental health condition.

“Chronic conditions” that a state HH model may select to focus on by statute include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight or obese as evidenced by a body mass index over 25. CMS can, and has, authorized additional chronic conditions for incorporation ([A. Smith, personal communication, 2013](#)) into HH models. [For example Missouri Health Homes added developmental disabilities as a chronic condition to its HH state plan amendments.](#) CMS also can and has authorized

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state-proposed definitions of



conditions and situations that constitute a “risk of having a second chronic condition.” CMS also authorizes additional risks as proposed by states. Examples in Missouri include smoking and diabetes. Having diabetes classed as both a chronic condition and a risk of a second condition means that like SMI diabetes alone qualifies a person for HH> The eligibility criteria are so potentially broad as to be able to cover almost all clients in a state’s public mental health system.

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Regardless of which conditions states select for focus, they states must address mental health and substance use disorders, and prevention and treatment services, and consult with the Substance Abuse and Mental Health Services Administration (SAMHSA) on how they propose to provide these services. States may apply to have their Medicaid state plan amended to include HHs, either in primary care, behavioral health specialty care, or both.

Health Home Service Definitions

Section 1945(h)(4) of the SSA lists six required HH services. CMS has not provided definitions of the six services but, instead, requires states to define each service, describe which team members are responsible for that service, and describe how health information technology will be used to deliver and support each service. States have broad flexibility to determine how to use health information technology in their HH models. An example of how Missouri defined these services will be described later in this chapter. rneluded in a later example (other exam ples are available at <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html> www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-SPA-Matrix-11-13.pdf). These six services include the following:

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care from inpatient to other settings, including follow-up
5. Individual and family support, which includes authorized representatives
6. Referral to community and social support services if relevant.

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Health Home Providers

The PPACA defines three distinct types of HH provider arrangements from which a beneficiary may receive HH services: designated providers, a team of health care professionals that links to a designated provider, or a health team. Examples of providers that may qualify as a “designated provider” include physicians, clinical practices or clinical group practices, rural health clinics, community health centers, CMHCs, home health agencies, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined appropriate by the state and approved by CMS. Each designated provider must have systems in place to provide HH services and satisfy certain qualification standards.

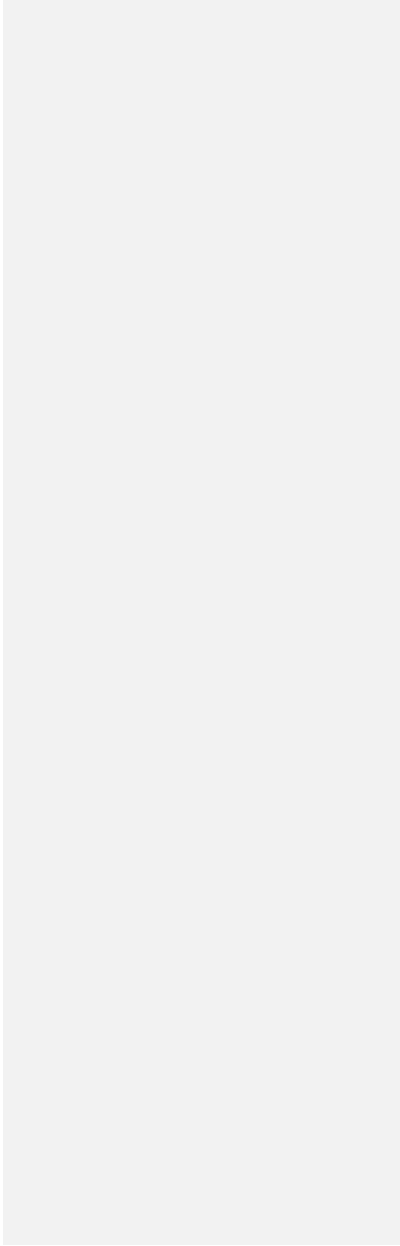
Examples of the providers that compose a “team of health care professionals” are physicians and other professionals that may include a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the state and approved by CMS. These “teams of health care professionals” may operate in a variety of ways, such as freestanding, virtual, or based at a hospital, community health center, CMHC, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the state and approved by CMS. The designated provider must have documentation evidencing that it has the systems and infrastructure in place to provide HH services and must meet qualification standards developed by the state and approved by CMS.

AUTHOR: Correct as changed above: “Examples of the providers that compose a “team of health care professionals” are physicians ...”? If not, please clarify.

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PAYMENT METHODOLOGIES

Section 1945(c)(1) of the SSA authorizes states to make payments for HH



services, and the payment is for a team and not an individual provider. States have considerable flexibility in designing the payment methodology. States can structure a tiered-payment methodology that accounts for the severity of each individual’s chronic conditions and the “capabilities” of the designated provider, the team of health care professionals operating with the designated provider, or the health team. ~~They and~~ can also propose alternative models of payment that are not limited to per member per month payments for CMS approval. CMS requires a comprehensive description of the rate-setting policies in the Medicaid state plan and will judge the proposed method for consistency with the goals of efficiency, economy, and quality of care. While the PPACA specifically authorizes capitation payment for Section 2703 HHs, CMS has chosen to interpret its overall authority such that it will not allow true capitation payment (designated provider paid for every enrolled person each payment period) of a HH provider. CMS will only allow payment if the HH provider can document that the enrolled person actually received at least one of the six specific HH services during the payment period (commonly referred to as a case rate payment).

To provide an incentive for states to implement Section 2703, CMS includes a provision for an enhanced federal medical assistance percentage (FMAP) for HH services of 90% for the first eight fiscal quarters that an SPA is in effect. Thereafter, states can claim at the regular FMAP rate used for other Medicaid services during the calendar quarter. However, there is also a requirement that the eight quarters of 90% FMAP begin upon the effective date of the SPA. If there is a delay in implementation, this date could be different from the first day or first quarter when HH services claims are received. There is no time limit by which a state must submit its HH SPA to receive the eight quarters of 90% FMAP.

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-----FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)-----

Medicaid is a health insurance program jointly funded by the federal government and the states. The federal government’s share of most Medicaid service costs is determined by the FMAP, which varies by state and is determined by a formula set in statute. The FMAP formula compares each state’s per capita income relative to U.S. per capita income and provides higher reimbursement to states with lower incomes (with a statutory maximum of 83%) and lower reimbursement to states with higher incomes (with a statu-

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tory minimum of 50%). Certain Medicaid services receive a higher federal match.

DATA AND METRICS

HHs are required by CMS to track avoidable hospital readmissions, calculate cost savings that result from improved coordination of care and chronic disease management, and monitor the use of health information technology to improve service delivery and coordination across the care continuum. For the purposes of the overall evaluation, states are also expected to track emergency room visits and skilled nursing facility admissions. CMS requires states to calculate cost savings, preferably using a comparison group or, as an alternative, constructing a precomparison/postcomparison of HH beneficiaries or an alternative comparison group of non-HH beneficiaries with similar chronic conditions and characteristics. Calculation of cost savings should include a tabulation of all Medicaid expenditures incurred for the HH group and the comparison group. CMS intends to at some time require a set of mandatory core measures. Until such time that CMS releases a core set of quality measures, states are expected to define the measures they plan to use to assess their HH model of service delivery. The measures are expected to capture information on clinical outcomes, experience of care outcomes, and quality of care outcomes specific to the provision of HH services.

EVALUATION OF HEALTH HOMES

The impact of the HH implementations will be examined in both an interim survey and an independent evaluation with reports to Congress. CMS requires states to collect and report information required for the overall evaluation of the HH model of service delivery. It is also a requirement that states collect individual-level data for the purposes of comparing the effect of this model across subgroups of Medicaid beneficiaries, including those that participate in the HH model of service delivery and those that do not. This evaluation, and the data gathered for it, will provide information that can help inform continued improvement of the HH models.

KEY PRINCIPLES OF THE EFFECTIVE HEALTH HOME

For HHs to work effectively, they must apply principles of quality care delivery (AIMS Center 2011).

Person-Centered Care

Person-centered care is the principle that all care should be based on the individual’s preferences, needs, and values. In person-centered care, the patient is a collaborative participant in health care decisions and an active, informed participant in treatment. HHs provide an opportunity to transition from the traditional chronic model of illness to a recovery-based model in which health care providers help the people they serve have hope for the future (Substance Abuse and Mental Health Services Administration 2012³).

Integrated Care

Individuals with mental health and substance use disorders, especially individuals with SMI, have significantly higher comorbid conditions than the general population. When these chronic conditions go untreated, individuals often experience more serious physical illnesses that require increased medical treatment, such as costly hospitalizations (Parks et al. 2006). CMS requires that HHs have systems and processes to assure access to a wide range of physical health, mental health, and substance use prevention, treatment, and recovery services. The PPACA requires states to consult and coordinate with SAMHSA in addressing issues of prevention and treatment of mental illness and substance use disorders for individuals who are low-income and/or have one or more chronic illnesses who are at greater risk of developing mental health and substance use disorders. CMS and SAMHSA require states to coordinate with their state behavioral health authorities in designing their HH model and require that the behavioral health needs of individuals receiving services from a HH provider should be addressed through a “whole-person” approach.

AUTHOR: Correct to change to “more serious” above: “... individuals often experience more serious physical illnesses”? If not, is “more physical illnesses” appropriate?

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Evidence-Based Care

Evidence-based care is a core principle of integrating primary and behavioral health care and should guide care in behavioral HHs. It means using the best available evidence to guide treatment decisions and delivery of care. Care guidelines are the usual approach to condensing and summarizing all available research on a clinical problem. Embedding evidence-based guidelines in the routine provision of care through electronic medical records (EMRs), pa-

tient registries, and other computerized systems allows providers and consumers access to evidence needed for care decisions. Embedded decision flow charts for various conditions help users sort through the evidence-based treatment options and decide upon the best course of action. Finally, clinical decision support uses data analytics to match a single evidence-based care recommendation out of a whole guideline to an individual's specific clinical situation. This prevents health care providers from having to memorize multistep guidelines or spend their limited time researching information [on a specific condition](#).

Population-Based Care

One of the greatest flaws of current care delivery arrangements is that they typically depend on the patients alone to know when they need care and what care to ask for. One of the greatest changes that an agency must make to become a HH is transitioning from care that is driven by a series of individual patient's current chief complaints to care that is driven by analyzing the whole population served for care gaps and then using data analytics to select a group of patients with the most urgent care needs for the greatest opportunities for care improvement. Population-based care focuses on the health of an entire patient population by systematically assessing, tracking, and managing the group's health conditions and treatment response across the entire target group rather than just responding to the patients that actively seek care. Systems such as registries track the patient care data over time and can select for a particular condition, set of characteristics, practice/provider group, or other parameter by actively and systematically assessing, tracking, and managing the group's health conditions and treatment responses (Halpern and Boulter 2000).

Data-Driven Care

Overall, HHs must change from the traditional way of thinking about the problems of the people they serve as a series of anecdote-driven activities to understanding the problems of the people they serve using explicit quantitative and qualitative analysis. It is a cultural change and work flow change not to be underestimated.

Data-driven care requires collecting, organizing, sharing, and applying objective, valid clinical data to guide treatment (Parks et al. 2008). The first step in HH development is to develop an inventory of potentially available data sets with individual demographic, health, and community status information, and a strategy for obtaining and integrating the available data sets into a relational database for program planning and individual care manage-

ment (Druss and von Esenwein 2006). Because health care providers often do not have systems in place, or data available that allow them to determine utilization of services outside the agency, initial selection of persons to be enrolled in HHs is best done by the payer. There are two major sources of individual personal health information usually available for this initial analysis: payer patient claims information and EMR data extracts. There are advantages and shortcomings associated with both. Patient claims information has the advantage of providing a limited record of all care by all providers funded by that individual payer. Claims provide a record of all medications, emergency room visits, hospital admissions, outpatient visits, and specialty services that includes the date of service, specific provider, diagnosis, specific identity code for each specific service, and the type, dosage, prescriber, dispensing pharmacy, and days' supply of medications. They have the limitation of not providing important specific clinical values such as vital signs and laboratory results and do not include any health care situation that is not directly linked to a billable service (e.g., use of tobacco or whether a patient received a follow-up contact within 72 hours after admission). Claims also have the advantage of being in a standardized data format and aggregated database. EMR extracts have the advantage of containing much greater clinical detail, in particular vital signs and specific laboratory values. They have the disadvantage that each separate HH EMR has to be individually programmed to extract the data and then combine it into a single integrated database. EMR data extracts are also only available from practices willing to participate actively in care coordination. Most patients in HHs will be going to multiple providers; many of whom will not be providing EMR data. Therefore, EMR data provide much greater detail from a few providers but fail to provide any information from other providers.

HHs must develop the capacity to gather and aggregate data to use in three ways:

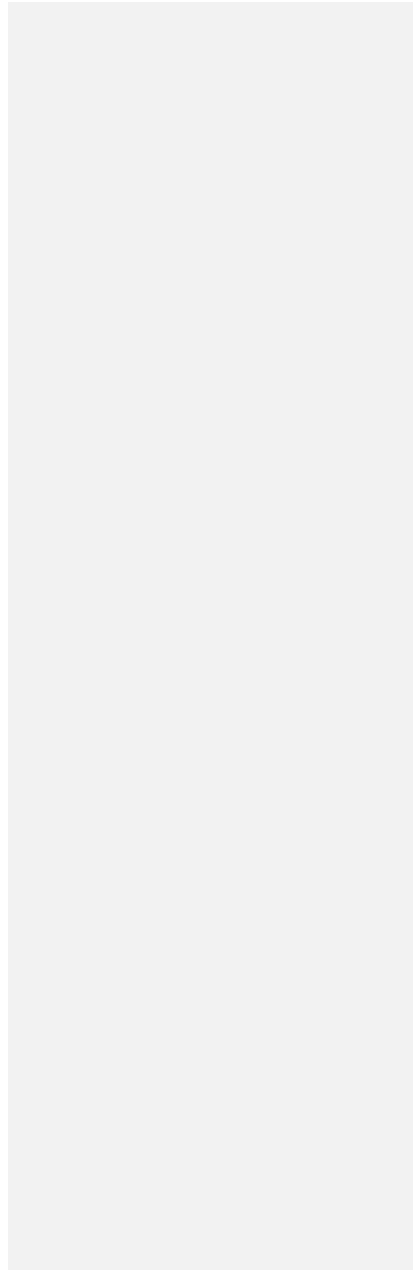
1. To develop a comprehensive picture of overall care received and current care gaps for each individual patient/client and the all patients served in the organization.
2. To sort out which individual patient should receive immediate attention that day/week out of their total HH population
3. To track population level improvement in both process and clinical outcome performance indicators both internally and in comparison with other health problems.

The key data analytics tool is the patient registry, which is a database where key information about a target population is organized in one place. It supports the HH with information to increase the efficiency and effectiveness of care, maximize the outcomes for specific patient groups, and support

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the provision of population-based care. The HH clinical information system



must be capable of organizing data on key subgroups of patients with particular conditions or characteristics, delivering reminders to providers, and providing feedback to clinicians. The data may include patient diagnoses, assessment or laboratory results, current and past treatment regimens, and appointments, which allows for the effective tracking of all the patients seen in the practice. Registry data must be sortable, allowing providers to select from a particular subgroup of patients or individual patients with specific treatment needs. Registries can identify subgroups of patients who are overdue for a follow-up appointment or necessary procedure. When set up in a format that allows multiple users to access it (e.g., a Web-based registry), registries can facilitate communication and coordination of care across multiple health care providers and, when not all services are provided on site, across organizations. The data can also be sorted by provider or by practice in larger systems, allowing organizations to evaluate performance and identify training needs. Some EMRs can be customized to provide a registry function or can be modified to allow for integration with [an external](#) the registry.

CARE MANAGEMENT: PUTTING THE PRINCIPLES INTO ACTION

Care management combines the preceding principles in an integrated health care delivery work flow and entails following a defined population of patients to monitor their treatment response and adjust care as needed. Care management is a relatively resource-intensive strategy that is most effective when used with particularly complex patients with chronic conditions (Bodenheimer and Berry-Millet 2009). The care manager (CM) uses data to select patients with high utilization of avoidable services, such as emergency room visits and inpatient hospital admissions, and uses data to determine actionable care gaps to reduce this level of intervention in the future. The program enrollees are analyzed as a population to identify their common characteristics (e.g., particular diagnoses, comorbid mental health and substance use conditions, chronic pain, polypharmacy), which allows for identification of patient-specific actionable issues. Care management typically includes a health risk assessment, followed by educating patients about their conditions and how to manage them and recommended best treatments. The main work in care management consists of identifying care gaps and remediating them. Care gaps include not receiving a recommended preventive care screening, not monitoring laboratory results for the selected chronic conditions, not using best practice treatment for a chronic condition, nonadherence to medications, and lack of periodic follow-up with primary care or behavioral health care providers.

AUTHOR: Correct to insert “not” (sentence above): “not monitoring” and “not using best practices”? If not, please clarify.

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Within the HH team, the CM (often a nurse) utilizes the disease registry to monitor and identify gaps in care and then, working with the other HH team members, decides who will intervene regarding the identified problem. The CM or another delegated member of the HH team reaches out to the patient on a regular basis (often weekly at the start and then more infrequently as the patient begins to improve) to assess how they are doing, educate, and intervene as needed. The check-ins can be brief (usually 15 to 20 minutes) and can be conducted by phone or in person. Use of validated, standardized tools such as the Clinical Global Improvement or World Health Organization Disability Assessment Schedule 2.0 (World Health Organization 2012) to assess response to treatment is a best practice in care management. CMs use a registry as described earlier to keep track of their panel of patients and to make sure that they are followed up with regularly.

The HH team, composed of all the CMs, possibly a primary care provider (PCP), and all the members of the traditional mental health treatment team, meets on a regular basis (usually weekly) and at the meeting reviews their panel of patients, prioritizes which ones present the greatest immediate need for care or opportunity for improvement, and plans for which members of the HH team will be responsible for specific interventions with those select patients. The selected HH team member conveys recommendations to the treating provider (could be primary care or behavioral health provider) who then works with the patient to change the treatment plan and fix the identified care gap. This data-driven facilitated-referral approach has been proven effective in reducing Framingham Risk scores and increasing utilization of preventive care (Druss et al. 2010a).

AUTHOR: Which Druss et al. 2010 reference (a or b) is intended above?

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Care management functions can be done by different types of providers. The training and credentials of the CM will determine what functions he/she can appropriately and effectively manage, with more limited services being provided by those with less training. Historically, care management has mostly been provided by nurses and social workers (or equivalent master’s-level professionals). Social workers are highly skilled at coordination activities, whereas nurses have more background in medical management and education.

Trained peers, community health workers, and health navigators (more often seen in the medical field) are increasingly being used to augment nurses and social workers in care management and for providing other wellness-related services. Community health workers have effectively provided screening, monitoring, patient education, and self-management support focused on chronic health conditions like diabetes and asthma (Goodwin and Tobler 2008). Peer support programs have excelled in patient engagement and empowerment (activation) (Druss et al. 2010**b**) because of the lived experience of individuals with mental health and substance use disorders when offering education and self-management support services (Salzer et al. 2010). Because these individuals have less training than nurses and social workers, the care management functions they can provide will be more limited and must be overseen and integrated with licensed CMs. However, they have the advantage of being lower cost than licensed CMs. Care management teams integrating both are likely to be more effective and have lower costs than either used alone. States implementing HHs will have to explain how HH care management is not the same as managed-care care management (see Table 9-1). CMS will not pay for the same thing twice.

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HEALTH HOME TEAM

The HH requires providers to work together as part of a multidisciplinary team that shares responsibility for addressing patients' comprehensive care needs. The team may be housed under one roof or function virtually with members stationed in different settings. Regardless of location, it is essential that the members function as a single unit. Most behavioral health organizations implementing a HH care delivery model will already have multidisciplinary teams delivering behavioral health care. The HH team and behavioral health team should be the same team, not two separate teams, as it is less likely to be effective when implemented as a separate service within the behavioral health organization. In most behavioral health organizations, this will mean adding at least a **HH** CM and other additional staff to the existing behavioral health treatment team. The membership of the team will depend on the individual's needs. For people with SMI receiving care in a behavioral HH, the team would consist, at a minimum, of their current psychi-

TABLE 9–1. Apples and oranges: managed care and care management

Managed-care care management	Health home care management
Population: most are well most of the time	Population: all have multiple chronic conditions
Most have a few health care providers	Most have many health care providers
Primary focus: avoidable overutilization	Primary focus: inappropriate underutilization
Mostly communicates with providers	Mostly communicates with patients directly
Administrative relationship	Face-to-face personal relationship
Mostly e-mail, fax, or telephone communication	Mostly in-person communication
Intermittent contact by different care managers	Ongoing contact with stable team
Strangers working together	You know them and they know you
Provision of service not necessary to be paid	Provision of service necessary to receive payment

atric provider and behavioral health clinician (could be a therapist or case manager) and a PCP who may be on or off site. It should also include the CM, who tracks the individual’s treatment response and coordinates care between team members, and may include a peer specialist, who provides wellness and recovery support, and/or a community health worker, who serves as a health navigator. Other providers such as a nutritionist, medical specialists (e.g., endocrinologist), pharmacist, and other provider types may be involved based on the individual’s needs. Regular team meetings and clear roles help the team establish which provider is responsible for what aspects of care and its coordination. In a behavioral health organization–based HH, the PCP, who may be a physician or a “mid-level provider” (e.g., a nurse practitioner), plays a key role either as the provider of actual primary care services or in some models as a “consultant” within the HH team.

Different personnel could perform the team leader role, and they must be willing to take responsibility for assuring that the six core HH services are being delivered. The physician (or physician’s delegate, such as an advanced practice nurse or physician assistant) who has the most frequent contact with the patient would be an excellent choice for the team leader if adequate time and funding are provided to allow them to fulfill this role (lost productivity in the direct provision of behavioral health in exchange for a key role in improving the health status of the population with SM). In many behavioral health organizations, this will be the treating psychiatric provider. It is es-

sential that the team leader physician regularly attend the treatment team meetings and be available to the CMs. This requires that the psychiatrist now becomes involved with, and responsible for, the patient's general medical care to the same extent that he/she is involved with and responsible for his/her patients getting behavioral health community support services such as assistance with housing and employment. The team leader psychiatrist is not responsible for the actual provision and quality of primary and general medical care in a HH, but he/she is responsible for identifying that there are unmet needs (in this case general medical care) and assuring that someone on the team is working to get those needs met. Ideally, a PCP works with the HH team to oversee the treatment of general medical conditions and review the registry data. The PCP-psychiatrist partnership creates an ideal platform for ensuring the health care of patients with SMI receives high-level attention and intervention.

Case Example: Integration in the CMHC Health Home

Treating patients as a HH team benefits patients, psychiatrists, and PCPs. Dr. Day is both a PCP at an FQHC and a PCP consultant at a CMHC. Because Dr. Asher is a psychiatrist at the same FQHC and CMHC, the two physicians collaborate on the care of many patients. One patient of the FQHC, L.R., was diagnosed with major depression. His somatic preoccupation and depression were so disabling that L. lost his job. Because of the loss of income, his housing was threatened. The PCP referred to Dr. Asher, who adjusted L.R.'s psychotropic medications and referred L.R. to the CMHC for case management. Dr. Day took over L.R.'s primary care and followed Dr. Asher's recommendation to see him more often because of his disabling somatization. Because of depression treatment by Dr. Asher with simultaneous fibromyalgia treatment by Dr. Day, his PHQ-9 (Patient Health Questionnaire depression [scale module](#)) decreased to below 10, he is more stable and independent, and he needs to be seen only infrequently [now](#) by his two physicians. When problems do reemerge, Drs. Day and Asher consult with each other because they recognize that the treatment of the whole patient requires a HH team.

AUTHOR: Please provide surname initial for Larry if possible. Patients are being referred to by initials within the book.

Comment [d20]: L.R.

The functions of the PCP in the Missouri HH are listed [below in Table 9-2](#) and can serve as a guide for other states wishing to include this important feature in the makeup of their team. The PCPs in the Missouri HH model are called "consultants," and in the Ohio model they are called "embedded" PCPs. [Their functions are somewhat different. In Missouri they guide the health home team but do not provide direct primary care service while in Ohio they could do both \(but SPA funding cannot be used for this direct provision of primary care](#)

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services. The HH psychiatrist is in a position analogous to PCPs who, while not responsible for the direct provision of specialty medical care, are responsible for

identifying when there is a need for specialty care and doing their best to see that that need is addressed. The roles of the HH psychiatrists are listed in Table 9-3 and provide a nice example of how the psychiatric and primary care staff can have a synergistic relationship in their approach to taking care of patients. It is necessary for HH psychiatrists and CMs, who may be psychiatric nurses, to have access to PCPs and nurse CMs as members of the HH team in order to adequately provide the link to knowledge about general medical conditions in order to fulfill the responsibility of care delivery in the HH model. Models that rely solely on the medical knowledge of their existing psychiatric providers and psychiatrically trained nurses will lose this essential benefit.

Comment [d21]: new Table 9-2 added

AUTHOR: The PCP consultant role material has been formatted as a table. Please provide a text callout that precedes new Table 9–2. Thanks.

Comment [d22]: ok

TABLE 9–2. Primary care provider consultant role in the Missouri health home

Establish priorities for disease management based on reviewing data. Identify patients that require immediate attention and select chronic diseases for intervention and initiatives that will have the greatest impact on the care of the population.
Provide education to both medical and nonmedical staff, the community, and patients.
Provide case consultation through regular team meetings with case managers, psychiatric providers, and other members of the health home team.
Develop collaborative relationships with psychiatric medical team, external primary care providers, hospitals, and other community linkages to improve care.

Comment [d23]: new table 9-3
Source (for both tables 9-2 and 9-3) – Missouri Health Home Physician Summits (June 20-12 9-2 and June 2013 9-3).

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Table 9-3 Psychiatric provider role in the Missouri health home

Medical leadership and shared medical oversight.

Psychiatric prescribers should provide leadership in the medical treatment of psychiatric disorders and share medical oversight with their primary care colleagues in the management of co-morbid medical conditions. This includes medical treatment of psychiatric disorders, minimizing iatrogenic complications due to psychotropic medications, treating medical conditions by referral to PCPs or some limited algorithm guided treatment in collaborating with the individual’s PCP, and collaborating with the PCP by sharing lab results and treatment regimens to manage the overall health of each individual.

Collaboration with other team members in the comprehensive care management of healthcare home enrollees.

Behavioral Health Homes

Psychiatrists and psychiatric prescribers should collaborate with the other healthcare home team members in promoting recovery from serious mental illness, the self-management of other chronic medical conditions, and the adoption of healthy lifestyles. This includes participation in team meetings to plan the overall treatment, counseling individuals regarding life style modifications, developing comprehensive care management strategies for individuals with complex medical/behavioral needs, engaging with the PCPs to improve each other's ability to "see the whole person" by exchange of information, and championing behavioral health expertise in support of behavior change.

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The team works from a single care plan designed to address all physical health, behavioral health, and wellness needs. There should not be separate care plans for the HH and traditional behavioral health services, and the care plan is developed collaboratively with the patient. The plan should contain and integrate behavioral health goals, medical care goals, functional/rehabilitation goals, and wellness lifestyle goals to effectively facilitate recovery and wellness using a whole-person approach.

Teams usually meet weekly to review and discuss patients, typically focusing on those in treatment who are not responding well to the current care plan. Some teams start off each day with a team "huddle" in which the group reviews the patients to be seen that day. Communications can occur effectively and efficiently via an EMR or a registry. For teams working in an agency without an EMR or registry, faxes, encrypted e-mails, and secure on-line shared documents can facilitate communication and coordination. Teams may also find it useful to meet monthly or quarterly to discuss their work processes, troubleshoot problem areas, exchange program informa-

tion and lessons learned, cross train, and further build a sense of their identity as a team. Tasks should be delegated among team members in a way that allows for the most efficient care. For example, medical assistants or front desk staff may be trained to take on simple screenings or behavioral assessments, a role traditionally reserved for nursing and similar staff. Having providers from a range of disciplines work together as a team is more effective than usual care for chronic health conditions. Effective teams are characterized by their commitment to patient satisfaction, the presence of a team “champion,” and a workable team size (neither too small nor too large) (Bodenheimer 2003).

MISSOURI CASE STUDY

The first SPA that was approved by CMS served eligible enrollees using CMHCs in Missouri. It was approved by CMS on October 20, 2011, and creates HHs in CMHCs for Medicaid enrollees with behavioral health conditions.

Program Design and Structure

The Missouri CMHC-HH program is overseen by the Medicaid authority, MO HealthNet, and is codirected by the Missouri Department of Mental Health. Other collaborating organizations include the Missouri Coalition of CMHCs, Missouri Hospital Association, Missouri Foundation for Health, Health Care Foundation of Greater Kansas City, and Missouri Primary Care Association (representing FQHCs). The Department of Mental Health provides mental health services to the state of Missouri, particularly assisting those with SMI and children with severe emotional disturbances. The state’s 29 CMHCs are the primary treatment providers for adults and children in child protective services, and all are part of CMHC-HH. They are also members of the Missouri Coalition of Community Mental Health Centers, a key collaborator on CMHC-HH, who also played a role in training and outreach to the member associations.

Missouri uses ProAct, an electronic health record and care management tool developed by Care Management Technologies, a provider of evidence-based behavioral health analytics and decision support tools. Care Management Technologies provides behavioral pharmacy, medication adherence, and disease management reports, which are key tools of the HH program as described in detail in the section “Missouri Definition: Six Health Home-Required Services.” Several years prior to the HH project, Missouri implemented another all-provider Web-based electronic health record called CyberAccess that allows providers to view claims-based diagnosis data and

medication data, prescribe electronically, receive alerts, and request prior authorizations for Medicaid enrollees. CyberAccess is available to all Medicaid providers, including CMHC and primary care HH providers, and is used for care coordination and attestation in the HH program.

AUTHOR: Correct section specified for "below" above?

Comment [d24]: yes

The CMHC-HH program was implemented at all 29 CMHCs in January 2012. Medicaid beneficiaries were enrolled in the CMHC-HH program through an autoenrollment process. Beneficiaries who were identified as meeting one of the three conditions outlined in the approved Missouri SPA and who met the Medicaid spending threshold of at least \$10,000 were then autoenrolled and assigned to one of the designated HHs, as this particular population was deemed best able to achieve cost savings through better care coordination.

All of Missouri's 29 CMHCs serve as HHs, and each agreed to achieve HH certification from the Commission on Accreditation of Rehabilitation Facilities (CARF) and to provide services to their assigned catchment area (25 total catchment areas for the state). The CMHC-HH philosophy and model of care involves provision of psychiatric rehabilitation services with a focus on facilitating disease management and care coordination, while also promoting independence and community integration. The goals of the HH are to improve access to services, promote healthy lifestyles, and educate enrollees on how to manage their own conditions and coordinate their care with other providers, including specialists, emergency departments, and hospitals.

Missouri Definition: Six Health Home-Required Services

1. *Comprehensive care management* services are conducted by the nurse care manager (NCM), PCP consultant, the HH administrative support staff, and HH director with the participation of other team members. It consists of identification of high-risk individuals and use of client information to determine level of participation in care management services; assessment of preliminary service needs; treatment plan development, which will include client goals, preferences, and optimal clinical outcomes; assignment of health team member roles and responsibilities; development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions; monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines; and development and dissemination of reports that indicate progress toward meeting out-

- comes for client satisfaction, health status, service delivery, and costs.
2. *Care coordination* is the implementation of the individualized treatment plan (with active patient involvement) through appropriate linkages, referrals, coordination, and follow-up to needed services and supports, including referral and linkages to long-term services and supports. Specific activities include, but are not limited to, the following: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes, and communicating with other providers and clients/family members. NCMs, with the assistance of the HH administrative support staff, will be responsible for conducting care coordination activities across the health team. The primary responsibility of the NCM is to ensure implementation of the treatment plan for achievement of clinical outcomes consistent with the needs and preferences of the client.
 3. *Health promotion services* shall minimally consist of providing health education specific to an individual's chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, fostering child physical and emotional development, providing support for improving social networks, and providing health-promoting lifestyle interventions, including, but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity. Health promotion services also assist clients with participating in the implementation of their treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions.
 4. *Comprehensive transitional care* includes appropriate follow-up from inpatient to other settings. In conducting comprehensive transitional care, a member of the health team provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt patterns of frequent hospital emergency department use. The health team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community and shift the use of reactive care and treatment to proactive health promotion and self-management. The NCM and PCP consultant will participate in providing comprehensive transitional care activities, including, whenever possible, participating in discharge planning.
 5. *Individual and family support services* activities include, but are not limited to, the following: advocating for individuals and families, assisting

with obtaining and adhering to medications, and assisting with other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services. A primary focus will be increasing health literacy and the ability to self-manage their care and facilitating participation in the ongoing revision of their care/treatment plan. For individuals with developmental disabilities, the health team will refer to and coordinate with the approved developmental disabilities case management entity for services more directly related to habilitation and coordinate with the approved developmental disabilities case management entity for services more directly related to a particular health care condition. NCMs will provide this service.

6. *Referral to community and social support services*, including long-term services and supports, involves providing assistance for clients to obtain and maintain eligibility for health care, disability benefits, housing, and personal need and legal services, as examples. For individuals with developmental disabilities, the health team will refer to and coordinate with the approved developmental disabilities case management entity for this service. The NCM and administrative support staff will provide this service.

Missouri Health Home Team

Each CMHC must have a HH director, NCM, PCP consultant, and care coordinators/community support workers (CSWs). The CMHC-HH payment model supports the following ratio of HH staff to patient enrollees:

- 1 HH director: 500 enrollees
- 1 NCM: 250 enrollees
- 1 hour of a PCP consultant time per enrollee per year
- 1 care coordinator/CSW per 500 enrollees

Any additional staff employed by the HH must be funded outside the CMHC-HH payment model.

The role of the HH director is to oversee the practice transformation and training of the HH team. The NCMs insure metabolic screening (lipid level, hemoglobin A1c, and blood pressure) is occurring at least annually for each enrollee in addition to helping patients develop health goals and care plans to manage their chronic health conditions. Annual metabolic screening is a required component of the CMHC-HH program and a key source of clinical

data for care management. NCMs review the claims-based diagnosis, medication, medication adherence, and treatment history reports generated by the Care Management Technologies care management tool ProAct, and coordinate follow-up with enrollees if they have been discharged from a hospital. NCMs may organize health fairs and conduct classes on topics, such as ~~smokingtobacco~~ cessation, to raise awareness among HH enrollees, staff, and the broader CMHC-HH membership.

The PCP consultant is one of the more prominent additions to the CMHCs as a result of the HH program funding. The consultant does not provide any direct care to the enrollee, unless he/she happens to be the enrollee's primary care physician outside of the CMHC. The physician consultant's role is to assist the CMHCs in strengthening their primary care coordination activities. The duties of the Missouri PCP consultants were ~~mentioned~~listed in the section "Health Home Team." Some examples of their work many include an "ask the doc" session for patients, which allows them to better understand their diagnosis and medication regimens. Brown bag lunches for staff help educate them about chronic health conditions so they can better explain and track this in their patients. The PCP consultant provides a unique opportunity to partner with the in-house psychiatric team to review patients with chronic conditions, consult on urgent issues, and retrain ~~the m-team~~ in the current treatment of common conditions. PCP consultants write letters to their outside specialist or primary care physician with suggestions for altering their medication or care plan. These letters are not always well received, ~~or~~and may be ignored, by outside physicians, while at other times they are appreciated, thus highlighting the PCP consultant's important role in fostering positive relationships with these providers.

AUTHOR: Correct to specify "earlier" as "Health Home Team" section above? If not, please specify.

Comment [d25]: yes

AUTHOR: Please note "them" was changed to "team" above: "... retrain the team in the current treatment of common conditions. Is this accurate? Meaning intact?"

Comment [d26]: yes

PCP Consultant Role in the Missouri Health Home

"The health care home has very much become part of the culture now. It is fascinating to attempt to apply baseline medical care on a population-based scale. Mainly, I believe our clients benefit from our efforts, which is the way I measure the success of the program."

J.G., PCP consultant, Missouri

AUTHOR: The above quote has been lightly edited. Correct that the quote has not been previously published? If published, please provide full reference.

Comment [d27]: ok, not prev published

The CSW is the HH team member with the most direct and frequent contact with the HH enrollees. The CSW role is not new to CMHCs as CSWs were also part of the Department of Mental Health preexisting Comprehensive Psychiatric Rehab program. However, as a result of the HH program, CSWs are now better trained to help enrollees manage their health conditions. The CSWs work with the enrollee to complete the day-to-day tasks related to maintaining their health. This might include helping them make care appointments for other medical care, schedule transportation to appointments, pick up pre- scriptions, purchase healthy foods, or maintain a fitness plan. CSWs often attend appointments with enrollees to make sure that the primary care phy- sician consultants' suggestions are shared with the enrollees' other health care providers. CSWs are provided training by PCP consultants and NCMs in chronic medical illness and wellness lifestyle to facilitate their new role as wellness coaches.

AUTHOR: Correct that "they" refers to "CSWs" in second sentence above: "The CSW role is not new to CMHCs as CSWs were also part ..."?

Comment [d28]: yes

**Payment in
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The CMHC-HH receives a \$78.74 per member per month fee to cover the cost of a HH director, NCM, PCP consultant, and care coordinators/case managers. In order to receive payments, HH sites must attest monthly to providing HH services required by Section 2703. At a minimum, this includes providing monitoring for HH enrollees for health care gaps that require care coordination or disease management intervention and keeping records of the monitoring for auditing purposes. Examples of services that

Comment [d29]: This is still a subsection of the Missouri example. Not a separate chapter section

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meet the criteria for payment include phone calls to the enrollee to discuss care plans, follow-up after hospital discharges, and face-to-face meetings with a NCM, CSW, or PCP consultant. Payments are given only for those patients who are Medicaid-eligible and meet the spend-down criteria (documentation of medical care expenses that cover the amount that is in excess of the limit to qualify for Medicaid) by the last day of the month. The funding provided to the CMHC provider organi-

zations through the CMHC-HH program did not supplant any previous funding they received prior to becoming a HH.

Results of the Missouri Health Home Implementation

Since implementation of the PMPM payments, the health homes have provided the vast majority of enrollees with broad access to needed medications, improved performance on various processes including metabolic screening (increased from 12 to 61 percent) and postdischarge followup, better chronic disease outcomes measures including improved diabetes, hypertension and lipid measures and reduced utilization and costs (12.8 percent decline in hospital admissions, 8.2 percent drop in emergency room visits) (dmh.mo.gov/docs/mentalillness/18MonthReport.pdf).

Comment [d30]: This is still a subsection of the Missouri Case Study so different font

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CONCLUSION

The ~~PPACA Patient Protection and Accountable Care Act~~ Section 2703, which ~~deals with~~ authorizes health homes for persons with chronic conditions, offers psychiatrists and the ~~CMHCs~~ community mental health centers they work in an opportunity to si- multaneously reduce the excess morbidity and premature mortality in their patients, integrate with primary care providers, and build a new role for themselves in the larger health care system ~~as care managers by providing coordinated medical oversight~~ for the sickest, most complicated, and most expensive patients. Missouri’s implementation of Section 2703 has proven effective in improving health care outcomes and reducing the total cost of care.

AUTHOR: Correct as changed in first sentence above: “... which deals with ...”?

Comment [d31]: No – use text above – “authorizes”

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AUTHOR: Please confirm that Colton and Manderscheid references above and below are different articles.

Comment [d32]: Same – deleted one

Colton CW, Manderscheid RW: Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Prev Chronic Dis* 3(2):1–14, 2006b

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AUTHOR: Please ensure that both Druss et al. 2010 references above and below are cited in text.

Comment [d33]: Yes they are

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AUTHOR: Reference above not cited in text. Please cite or delete.

Comment [d34]: deleted

Parks J, Pollack D, Bartels S, et al: Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities. 11th Technical Report. Alexandria, VA, National Association of State Mental Health Program Directors Medical Directors Council, January, 2005. Available at: <http://www.nasmhpd.org/docs/publications/MDCdocs/Final%20Technical%20Report%20on%20Primary%20Care%20-%20Behavioral%20Health%20Integration.final.pdf>. Accessed December 6, 2013.

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AUTHOR: Please update HHS publication number above and confirm title.

Comment [d35]: done, still pending but renamed

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