Missouri's CMHC Healthcare Homes

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Agenda

- The Affordable Care Act: Medicaid Health Homes
- Missouri's Primary Care Health Homes
- Missouri's CMHC Healthcare Homes
  - Why CMHC Healthcare Homes?
  - What is a CMHC Healthcare Home?
  - Care Management: Tools and Reports
  - Performance Measures
  - Program Reviews, Evaluations, and Accreditation
  - Training
  - Outcomes

The Affordable Care Act

Medicaid Health Homes

What is a Health Home?

The Affordable Care Act

Section 2703 of the Affordable Care Act **allows states to amend their Medicaid state plans** to provide **Health Homes** for enrollees with chronic conditions.

Qualifying Patient Conditions:

- **Serious and persistent mental illness**
- Two qualifying chronic conditions
- One qualifying chronic condition and at risk for a second qualifying chronic condition
- State Defined Conditions

Health Home Services

ACA Section 2703 defines a 'health home' as a designated provider selected by an eligible individual to provide the following "health home services":

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Patient and Family Support
- Referral to Community and Social Support Services
- Use of Information Technology to Link Services

CMS Expectations

Health Homes embody a "whole person" approach

Health Homes coordinate and provide access to:

- Health services
- Preventive and health promotion services
- Mental health and substance abuse services

Health Homes achieve results

- Lower rates of emergency room use
- Reduce in-hospital admissions and readmissions
- Reduce health care costs
- Improve experience of care, quality of life, and consumer satisfaction
- Improve health outcomes

Missouri's Health Homes

- **Missouri has two types of Health Homes**
  - CMHC Healthcare Homes (28)
  - Primary Care Health Homes (33)

Primary Care

Health Homes

Primary Care Health Homes

- **State Plan Amendment approved 12/23/11**
- **Auto-enrollment**
  - Primary Care patients with at least $2,600 Medicaid costs annually
- **Current Enrollment: 17,110**
  - As of March 2015

Primary Care Health Homes

- **33 Primary Care Health Homes**
  - 21 Federally Qualified Health Centers (FQHCs)
  - 9 Public Hospitals
  - 1 Independent Clinic
  - 1 Rural Health Clinic (RHC)
  - 1 County Health Department

Primary Care
Target Population

- Clients are eligible for a Primary Care Health Home as a result of having two chronic conditions or having one chronic condition and being at risk for a second chronic condition. To be eligible patients must meet one of the following criteria

1. **Have Diabetes**
   - At risk for cardiovascular disease and a BMI>25
2. **Have two of the following conditions:**
   1. **COPD/Asthma**
   2. **Cardiovascular disease**
   3. **BMI>25**
   4. **Developmental Disability**
   5. **Use Tobacco**
      - At risk for COPD/asthma and cardiovascular disease

Primary Care Health Homes

- Provide primary care services, including screening for, and "comprehensive management" of, behavioral health issues
- Ensure access to, and coordinate care across, prevention, primary care, and specialty medical care, including specialty mental health services
- Promote healthy lifestyles and support individuals in managing their chronic health conditions
- Monitor critical health indicators
- Divert inappropriate ER visits
- Coordinate hospitalizations, including psychiatric hospitalizations, by participating in discharge planning and follow up
- Incorporated a Behavioral Health Consultant

CMHC Healthcare Homes

Risk of Obesity Among Patients with SMI

Joseph Parks, M.D., National Council, 4/14/12

Disorder	↑ Odds of Obesity
Depression	1.2 - 1.8x[1,2]
Bipolar Disorder	1.5 – 2.3x[1,2]
Schizophrenia	3.5x[3]

1. Simon GE et al Arch Gen Psychiatry. 2006 Jul;63(7):824-30.
2. Petry et al Psychosom Med. 2008 Apr;70(3):288-97
3. Coodin et al Can J Psychiatry 2001;46:549–55

Psychotropic Medications and Weight Gain

Most antidepressants[1]

Most mood stabilizers[2]

Most antipsychotic medications[3]

There are alternative drugs within each class that are potentially weight-neutral

1. Rader et al J Clin Psychiatry. 2006 Dec;67(12):1974-82.
2. Kerry et al Acta Psychiatr Scand 1970: 46: 238-43.
3.Newcomer J Clin Psychiatry. 2007;68 Suppl 4:8-13.

Joseph Parks, M.D., National Council, 4/14/12

Mental Disorders and Smoking

- Higher prevalence of cigarette smoking (56-88%) for SMI patients (overall US prevalence 25%).
- More toxic exposure for patients who smoke (more cigarettes, larger portion consumed).
- Smoking is associated with increased insulin resistance.
- 44% of all cigarettes in US are smoked by persons with mental illness.

Joseph Parks, M.D., National Council, 4/14/12

George TP et al. Nicotine and tobacco use in schizophrenia. In: Meyer JM, Nasrallah HA, eds. Medical Illness and Schizophrenia. American Psychiatric Publishing, Inc. 2003; Ziedonis D, Williams JM, Smelson D. Am J Med Sci. 2003(Oct);326(4):223-330

The CATIE Study

At baseline investigators found that:

- **88.0%** of subjects who had dyslipidemia
- **62.4%** of subjects who had hypertension
- **30.2%** of subjects who had diabetes

were NOT receiving treatment.

Joseph Parks, M.D., National Council, 4/14/12

A Few Observations

- The leading contributors include significant preventable causes.
- Lifestyle issues are significant.
- Iatrogenic effects of medications are significant.
- Inattention by medical and behavioral health professionals is significant.
- **And inadequate care is very expensive!**

Joseph Parks, M.D., National Council, 4/14/12

2003 RAND Study

- 2003 RAND Quality of Health Care study found:
  - Overall, adults receive 55% of recommended care, and they receive care that is not recommended and potentially harmful 11% of the time.
  - Gaps were seen even in patients with good health insurance and access to health care.
  - People with diabetes received 45% of the care needed. Less than 25% had their blood sugar levels measured regularly.
  - People with coronary artery disease received 68% of recommended care, but only 45% of heart attack patients received life-saving medications.
  - Patients with high blood pressure received les than 65% of recommended care, greatly increasing the risks of heart disease, stroke and death.

This study included a random sample of nearly 7,000 adults from 12 metropolitan areas in the US.

Missouri Medicaid Reviewed by Lewin Group

- 2010 - Lewin Group conducted a review of the Missouri Medicaid program.
- High Cost Beneficiary Report
  - 58,000 consumers reached $25,000 cost level in CY 2008.
  - This cohort represented 5.4% of the Medicaid population, but they incurred 52.5% of all Medicaid costs.
  - Of those:
    - 85% had at least one claims for a mental health diagnosis. Of those:
      - 30% had a mental health prescription, but NO office visit
    - 80% of the high volume med/surg users had evidence of at least one behavioral health condition

SOURCE: http://www.dss.mo.gov/mhd/oversight/reports.htm

CMHC Healthcare Homes

First in the Nation!

- On October 20th, 2011, Missouri became the first state in the nation to receive approval of a Medicaid State Plan Amendment (SPA) establishing Health Homes under Section 2703 of the Affordable Care Act.
- The first approved SPA in the nation established behavioral health homes: Missouri's CMHC Healthcare Homes.
- Effective January 1, 2012

Why CMHC Healthcare Homes?

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.

Why CMHC Healthcare Homes?

- Addressing general health issues is necessary in order to improve outcomes and quality of care
- Treating illness is not enough -
  - Wellness and prevention are as important as treatment and rehabilitation.

Why CMHC Healthcare Homes?

- It was the natural next step for Missouri

Step One: Implementing Psychiatric Rehabilitation Program

Step Two: Implementing Health Information Technology Tools

- CyberAccess
- CMT data analytics
  - Behavioral Pharmacy Management
  - Disease Management
  - Medication Adherence

Step Three: Missouri's Chronic Care Improvement Program

Why CMHC Healthcare Homes?

- It was the natural next step for Missouri

Step Four: Building Integration Initiatives

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

Step Five: Embracing Wellness and Prevention Initiatives

- Metabolic syndrome screening
- DM 3700 initiative

Next Step: Becoming a Healthcare Home

Disease Management 3700

- MHN/DMH collaboration started in November 2010
  - Targets Medicaid recipients who:
    - Are high cost, high risk
    - Have co-occurring chronic medical illness, and serious and persistent mental illness
    - Have not been connected to a CMHC
  - MHN identifies new individuals every four months
  - CMHCs try to find these individuals and enroll them in the CPR program in order to assist in managing their total health care costs
  - Seen as the outreach component for HCH

What is a CMHC Healthcare Home?

CMHC Healthcare Home

A place where individuals can come throughout their lifetimes to have their health care needs identified – and the medical, behavioral, and related social services and supports they need – provided or arranged for in a way that recognizes all of their needs as persons, not just patients.

Target Population

- Clients eligible for a CMHC Healthcare Home must meet one of the following three conditions (identified by patient's health history):
  1. A serious and persistent mental illness
     - CPR eligible adults and kids
  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

Target Population

- **Chronic health conditions include:**
  1. **Diabetes**
  2. **Cardiovascular Disease**
  3. **COPD/Asthma**
  4. **Overweight (BMI >25)**
  5. **Tobacco Use**
  6. **Developmental Disability**

Metabolic Syndrome

- Metabolic syndrome is a group of metabolic risk factors that exist in one person.
- Presenting with a combination of these factors increases the likelihood of developing cardiovascular disease
- Some of the underlying causes of this syndrome that give rise to the metabolic risk factors include:
    - being overweight or obese
    - having insulin resistance
    - being physically inactive
    - genetic factors

American Heart Association: http://www.heart.org/HEARTORG/Conditions/More/MetabolicSyndrome/About-Metabolic-Syndrome_UCM_301920_Article.jsp

Metabolic Syndrome

- **How is metabolic syndrome diagnosed?**
- Metabolic syndrome occurs when a person has at least three of the following measurements:
  - Abdominal obesity (waist circumference of 40 inches or above in men, and 35 inches or above in women)
  - Triglyceride level of 150 milligrams per deciliter of blood (mg/dL) or greater
  - HDL cholesterol of less than 40 mg/dL in men or less than 50 mg/dL in women
  - Systolic blood pressure (top number) of 130 millimeters of mercury (mm Hg) or greater, or diastolic blood pressure (bottom number) of 85 mm Hg or greater
  - Fasting glucose of 100 mg/dL or greater

American Heart Association: http://www.heart.org/HEARTORG/Conditions/More/MetabolicSyndrome/About-Metabolic-Syndrome_UCM_301920_Article.jsp

What is Diabetes?

Insulin is required to move sugar (glucose) from the blood into cells

Diabetes is the inability to appropriately transfer glucose from the blood to the body's cells due to the reduced effectiveness of insulin

Two Types of Diabetes

Type I	Type II
• Body does not produce insulin • Onset typically early in life ("juvenile diabetes")	• Insufficient insulin or decreased responsiveness to it • Most common • Develops in middle age

What is Cardiovascular Disease?

Cardiovascular Disease (CVD) is a broad term used to describe three different diseases of the blood vessels:

- **Coronary Artery Disease** – narrowing of the blood vessels to the heart – potential for **heart attack**
- **Cerebral Vascular Disease** – narrowing of the blood vessels to the brain – potential for **stroke**
- **Peripheral Vascular Disease** – narrowing of the blood vessels to the legs and feet – potential for **amputation**

What is Hypertension?

The Silent Killer

Most individuals do not have symptoms

Hypertension = High Blood Pressure

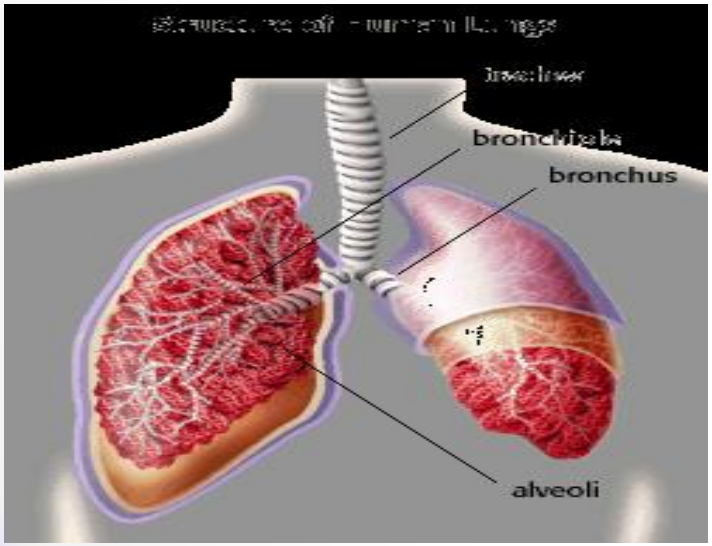
- Blood Pressure (systolic) ≥ 140
- **OR**
- Blood Pressure (diastolic) ≥ 90

Consumers with diabetes or kidney disease are considered to be hypertensive if BP is above 120/80

What is COPD?

Chronic Obstructive Pulmonary Disorder

Changes in the lungs and airways that impede the flow of air



- Emphysema
  - Destruction of air sacs
  - Loss of elasticity
- Chronic Bronchitis
  - Inflammation and mucous production that clogs airways

What is Asthma?

Reversible obstruction of the airways, usually due to inflammation

Symptoms similar to COPD, but less likely to be fatal

Typically there are identifiable “triggers” (allergens and irritants) of acute episodes

What is Body Mass Index (BMI)?

A measure of obesity standardized for people of different heights that is easily determined based on weight and height

Category	BMI	Height/Weight
Underweight	<18	5'8" = <124 lbs.
Normal	18-25	5'8"=125-163 lbs.
Overweight	25-30	5'8" = 164-196 lbs.
Obese	30-40	5'8"=197-261 lbs.
Extreme Obesity	>40	5'8"=262 lbs.

Missouri's CMHC HCH

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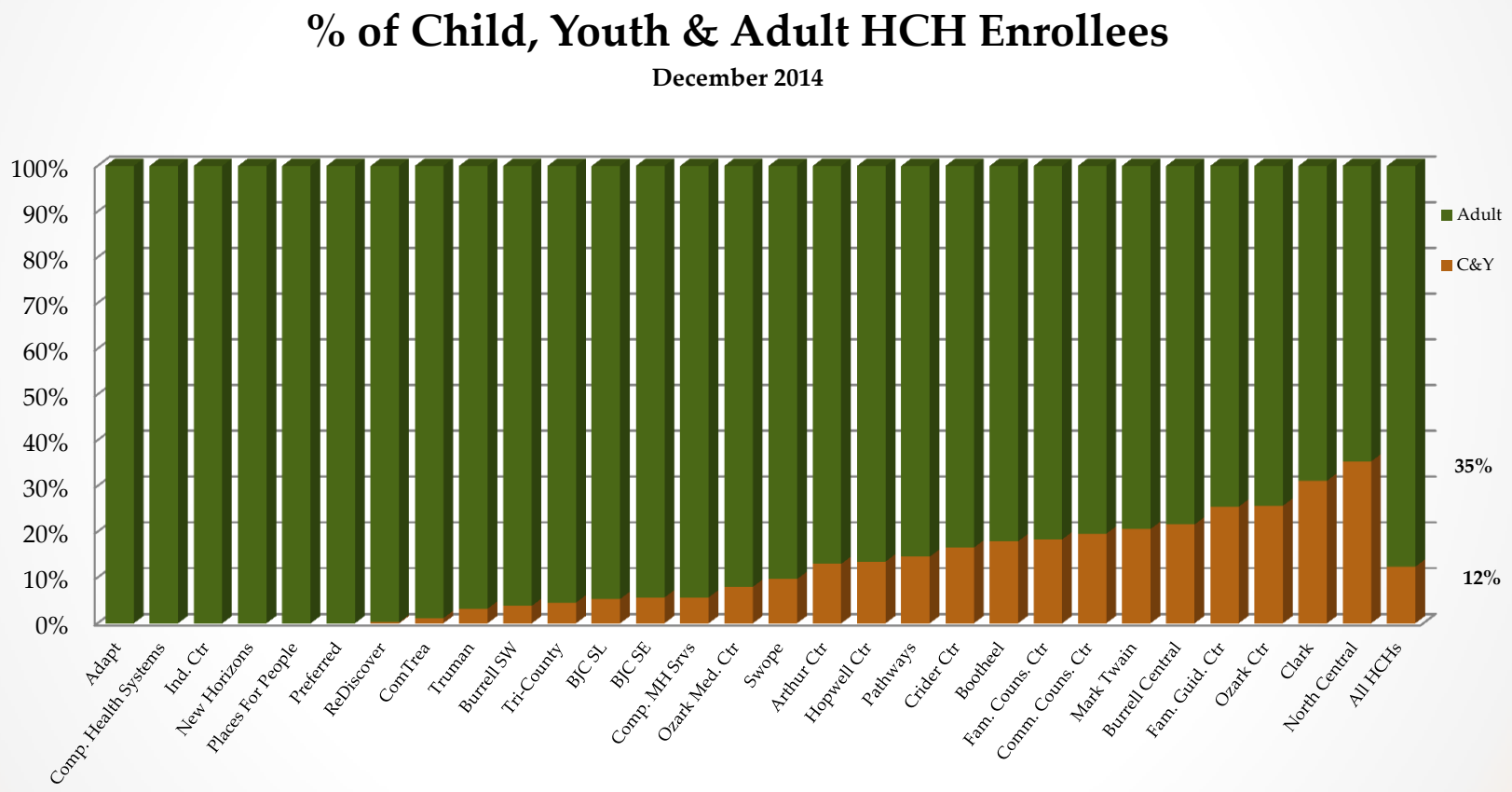
Population Characteristics

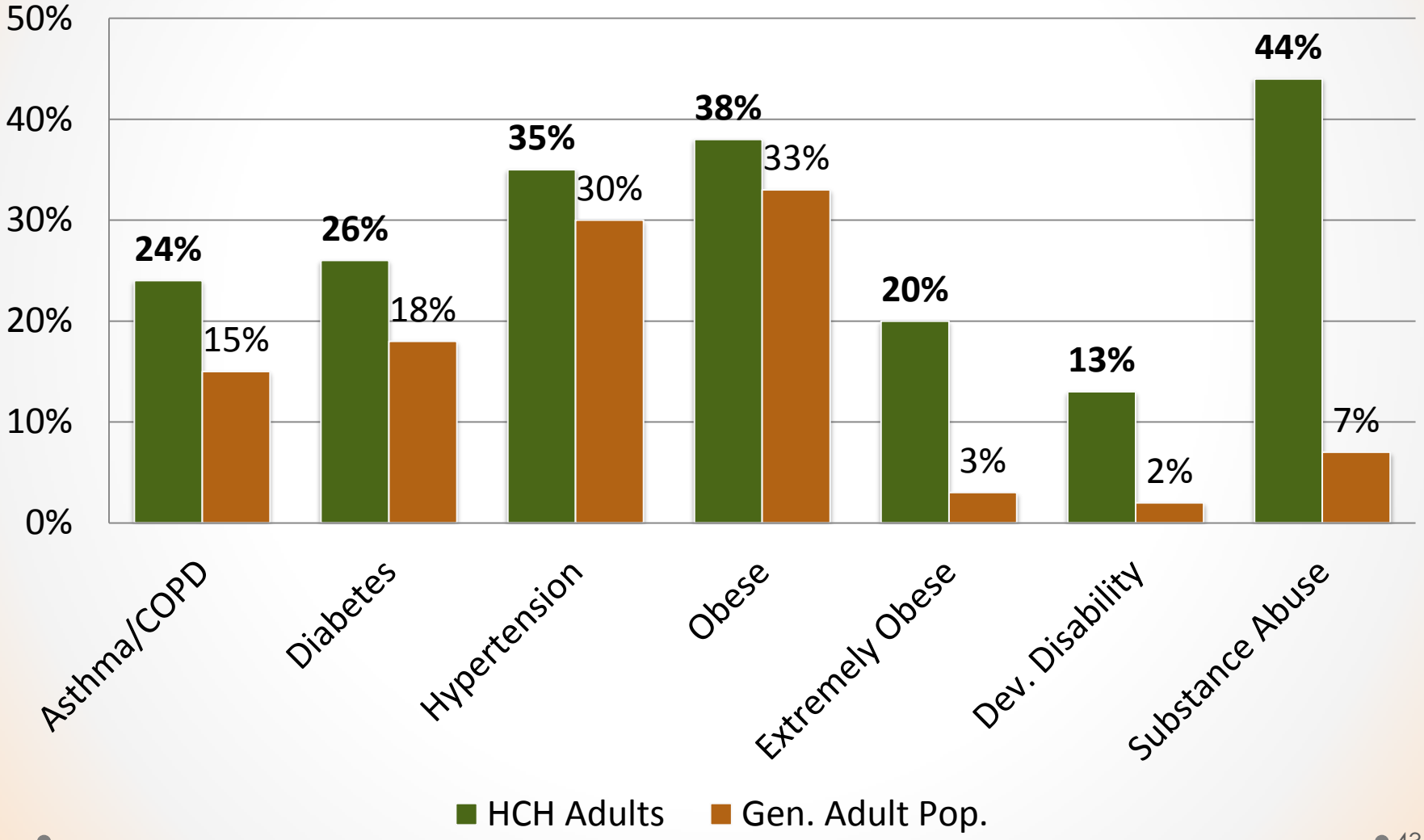
Snapshot of HCH Population

- 89% have a serious mental illness
- 36% with **Major Depression**
- 30% with **Schizophrenia**
- 28% with **Bipolar Disorder**
- 16% with **Post Traumatic Stress Disorder**
- About 23% with COPD/Asthma
- More than 26% with Diabetes
- 35% with Hypertension
- 81% with a BMI>25
- At least 50% report smoking
- About 50% of adults have a history of substance abuse

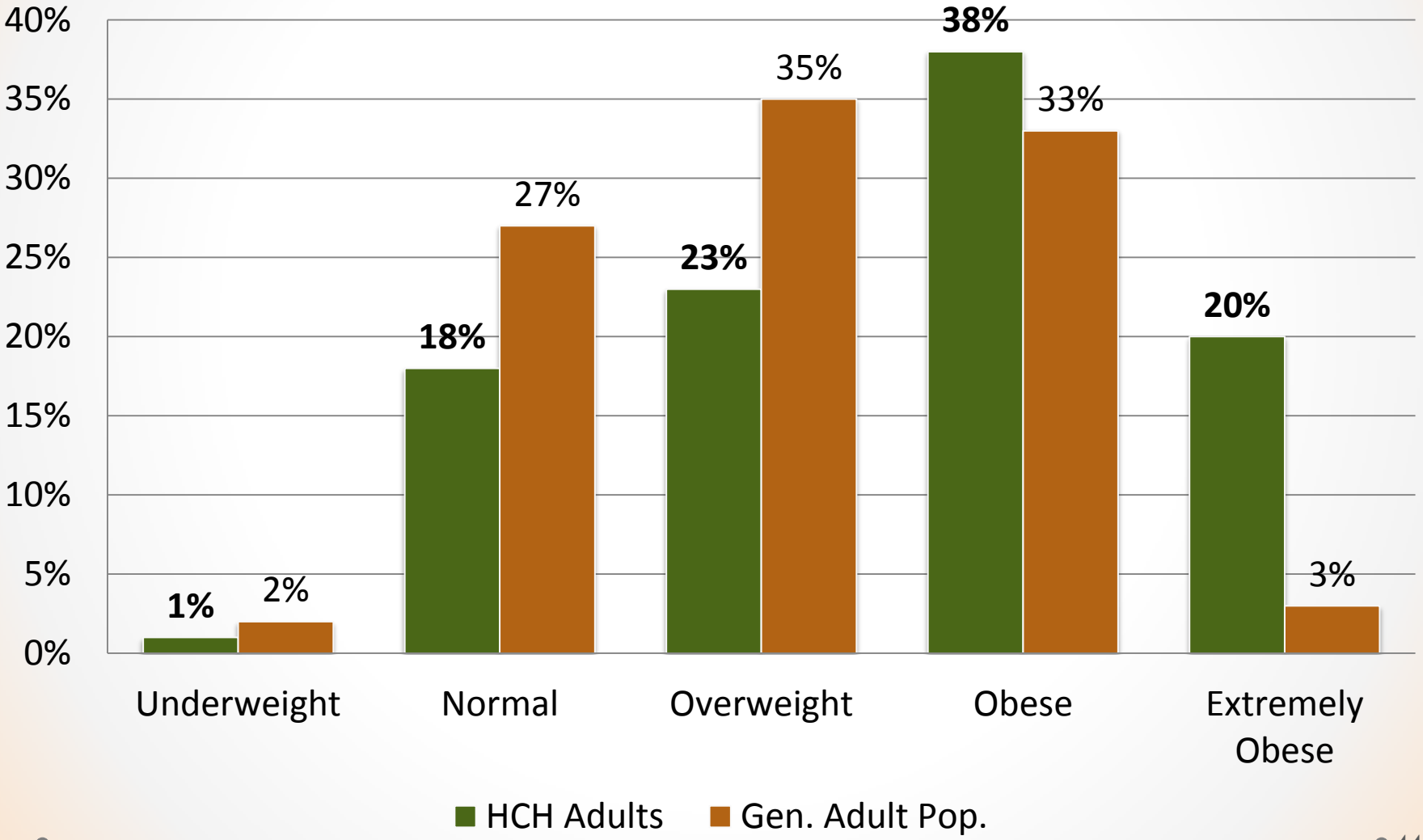
% of Child, Youth & Adult HCH Enrollees



Prevalence | Chronic Disease



Prevalence | BMI and Obesity



Small Changes can make a BIG Difference!

Cholesterol

- 10% ↓ in cholesterol =
  - 30% ↓ in CVD (120-100)

High Blood Pressure

- ~ 6 mm/Hg ↓ BP (> 140 SBP or 90 DBP) =
  - 16% ↓ in CVD
  - 42% ↓ in stroke

Diabetes

- 1% point ↓ HbA1c =
  - 21% ↓ in diabetes related deaths
  - 14% ↓ in heart attack
  - 37% ↓ in microvascular complications

Serving the Whole Person

"A whole person approach to care looks at all the needs of the person and does not compartmentalize aspects of the person, his or her health, or his or her well-being…. [and uses} a person-centered planning approach to identifying needed services and supports, providing care and linkages to care that address all of the clinical and non-clinical care needs of an individual."

- CMS Letter to State Medicaid Directors, Re: Health Homes for enrollees with Chronic Conditions, 11/16/2010

HH Functions: Added Emphasis

- Healthcare Homes takes a "whole person" approach; we are expanding our emphasis on:
  - Providing **health and wellness** education and opportunities
  - Assuring consumers receive the **preventive and primary care** they need
  - Guaranteeing 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

HH Functions: Added Emphasis

Healthcare Homes take a "whole person" approach, we are expanding 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

CMHC Healthcare Homes

28 CMHC Healthcare Homes

- CMHC consumers with at least $10,000 Medicaid costs
- Average Medicaid cost $26,000+ annually

Auto-enrollment

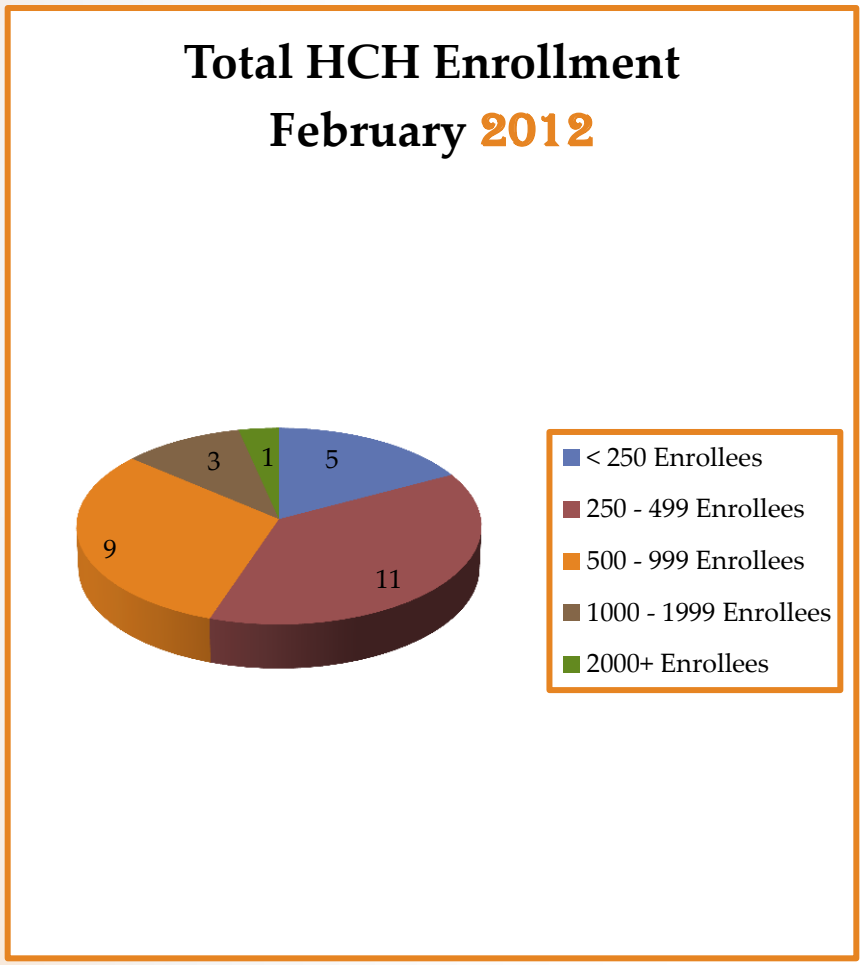
Effective January 1, 2012

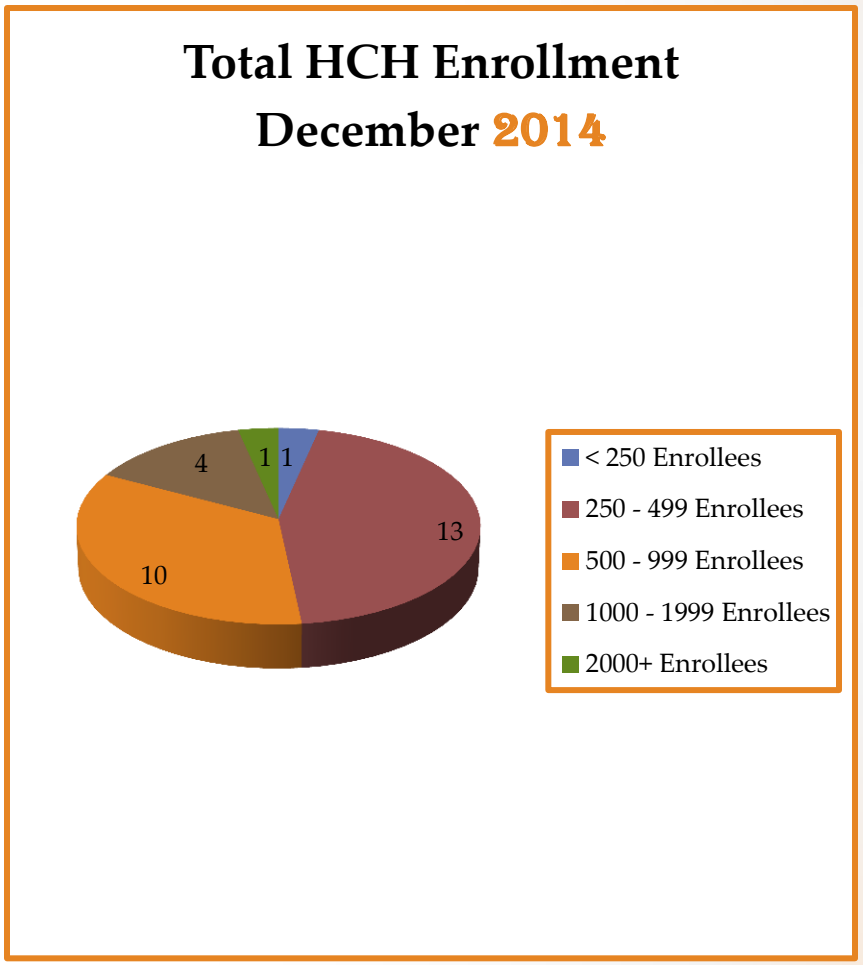
As of March 2015

- Adult: 18,624 (88%)
- Children & Youth: 2,624 (12%)

Current Enrollment: 21,248

Total HCH Enrollment





Staffing Expectations

These are the positions we added:

Health Home Director

- Each Health Home has at least a half-time Director
- Based on 1 FTE per 500 enrollees
- Maintain administrative staffing commensurate with size

Nurse Care Managers

- Maximum caseload: 250 enrollees

Primary Care Physician Consultant

- Physician: at least 1 hour per enrollee
- Advanced Practice Nurse: at least 2 hours per enrollee

Care Coordinator/Clerical Support

- Based on 1 FTE per 500 enrollees.

Medicaid Rehab Option

- Team Caseloads: 125
- Master's Level BH Clinician: 1
- BA Level Community Support Specialists (CSSs): 5
- Psychiatrist (serves multiple teams)
- Psycho-social rehabilitation staff (serve multiple teams)

Health Home Reimbursement:

PMPM

PMPM: $83.56

- Healthcare Home Director
- Primary Care Physician Consultant
- Nurse Care Manager
- Care Coordinator/Clerical Support
- Data monitoring and reporting
- Training

What is a Healthcare Home?

Not just a Medicaid Benefit

Not just a Program or Team

An Organizational Transformation

What is a Healthcare Home?

Population Health Management

We already know how to

Manage the care of individuals with serious mental illness and serious emotional disorders, including empowering them to manage their own care

We are learning to

- See the full spectrum of health and wellness issues faced by the people you serve
- Apply what we already know about managing and empowering to help people with their health and wellness needs and issues
- Begin thinking in terms of improving the health and health status of populations, in addition to managing the care of individuals

Population Health Management

"The unsustainable growth of health costs, the growing lack of access to healthcare, and increasing disparities in care have forced the U.S. to start changing how healthcare is delivered."[1]

2010 → *Patient Protection and Affordable Care Act*

→ HEALTH HOMES!

[1] **Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare, Institute for Health Technology Transformation, Chase, Alide, et.al.**

Population Health Management

GOAL → "The goal of population health management (PHM) is to keep a patient population as healthy as possible, minimizing the need for expensive interventions such as: emergency department visits, hospitalizations, imaging tests, and procedures."[1]

"While PHM focuses partly on the high-risk patients who generate the majority of health costs, it *systematically addresses the preventive and chronic care needs of every patient*. Because the distribution of health risks changes over time, the *objective is to modify the factors that make people sick or exacerbate their illnesses.*"

Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare, Institute for Health Technology Transformation, Chase, Alide, et.al.

Population Health Management

Definition: "The health outcomes of a group of individuals, including the distribution of such outcomes within the group."

Provider Definition: "The population health improvement model highlights three components: the **central care delivery** and leadership roles of the primary care physician; the critical importance of patient activation, involvement and **personal responsibility**; and the patient focus and capacity expansion of **care coordination** provided through wellness, disease and chronic care management programs." *(Care Continuum Alliance)*

Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare, Institute for Health Technology Transformation, Chase, Alide, et.al.

How to Succeed

Population Health Management

Supply proactive preventive and chronic care to all of a provider's patients, both during and between encounters with the healthcare system

Maintain regular contact with patients and support their efforts to manage their own health

Care managers must manage high-risk patients to prevent them from becoming unhealthier and developing complications

Use of evidence-based protocols to diagnose and treat patients in a consistent, cost-effective manner

Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare, Institute for Health Technology Transformation, Chase, Alide, et.al.

Connections | Population Health Management

"Population health management requires healthcare providers to develop ***new skill sets*** and ***new infrastructures*** for delivering care."

Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare, Institute for Health Technology Transformation, Chase, Alide, et.al.

Continuous Team-based Care

We already know how to

- Work as a team
- Provide continuous care
- Be proactive

We are creating new teams for whole person care

Comprehensive Care Management

We already

- Recognize the importance of meeting basic needs, so we already (sort of) see the whole person
- Have extensive experience in linking individuals with a broad array of community services and supports
- Follow up on psychiatric admissions and discharges
- Have experience in working with Primary Care providers
- Have been working with a variety of care management tools and reports

Comprehensive Care Management

We are learning how to

- Help individuals acquire a PCP if they do not have one
- Develop effective working relationships with PCPs and other health professionals to coordinate care
- Help consumers develop health and wellness goals
- Use data on health status indicators to establish priorities, choose interventions, and adjust treatment regimes
- Follow up on hospitalizations and ER use

Care Coordination

Care Coordination is the implementation of an individualized treatment plan (with active client 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: appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes, and communicating with other providers and clients/family members. – Missouri SPA definition

How can you coordinate care?

Person Centered Empowerment

We are already committed to:

- Being consumer and family focused
- A Recovery Model

We are learning to:

- Support individuals with self-management of co-occurring substance use disorders and other chronic medical conditions
- Support individuals in adopting healthy lifestyles

Recovery

Sense of Self

- Independence
- Belonging
- Responsibility

Sense of Power or Mastery

Sense of Meaning

Sense of Hope

Wellness and Healthy Lifestyles

- "Wellness is a philosophy of living that can help people live a more satisfying, productive, and happy life." Wellness is not the absence of disease, illness, and stress, but is the presence of:
  - Purpose in life;
  - Active involvement in satisfying work and play;
  - Joyful relationships;
  - **A healthy body** and living environment; and
  - Presence of happiness. We are already committed to helping people live well.
- We are still learning to support people to learn to have a healthy body.

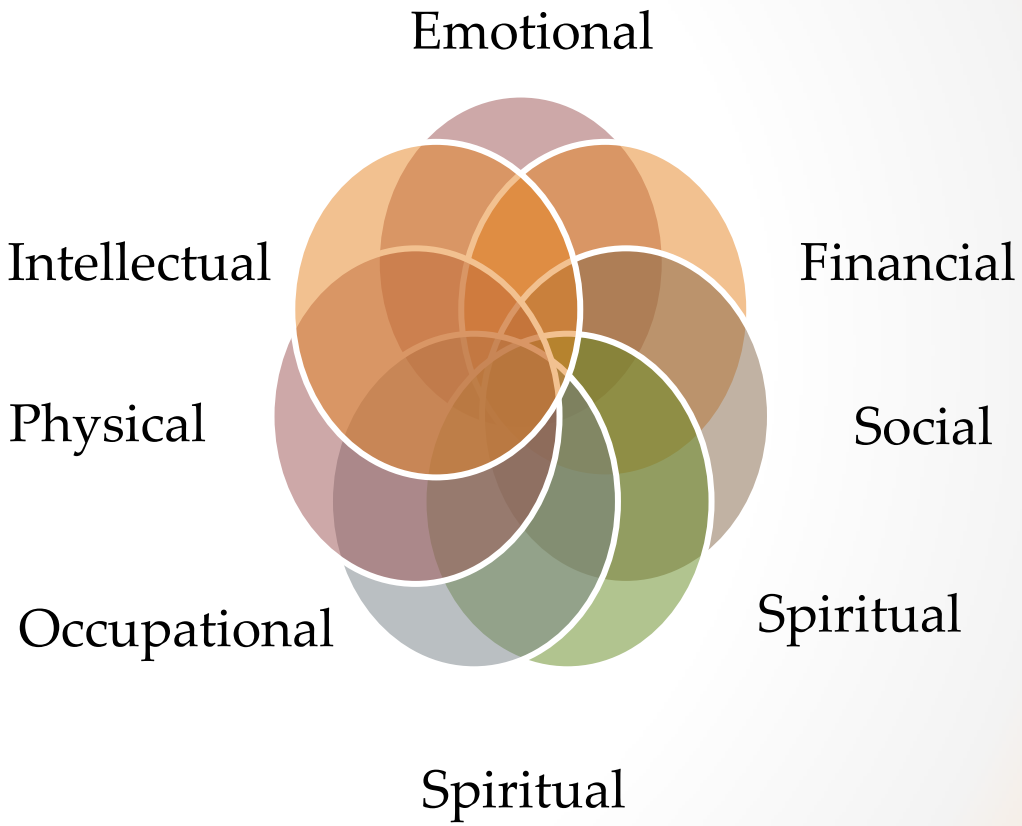
Introduction to Wellness Coaching, 2012. Collaborative Support Programs of New Jersey, Inc. p 16-17

Wellness and Healthy Lifestyles

A Wellness Lifestyle is:

- Conscious and deliberate
- Involves making choices
- Self-defined
- A process of adapting patterns of behavior

- We have learned what a wellness lifestyle is but we still are learning how all dimensions affect each other. We are learning how to incorporate all dimensions of wellness into treatment.



Introduction to Wellness Coaching, 2012. Collaborative Support Programs of New Jersey, Inc.

Healthcare Home

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Team Member Responsibilities

HCH Team Members

Responsibilities

Care Coordinator/ Clerical Support Staff

Nurse Care Managers

Community Support Specialists

Primary Care Consulting Physician

Psychiatrist

Health Care Home Director

QMHP, PSR and other Clinical Staff

Family Support Specialist

Peer Specialist

HCH Team Members

Primary Care Physician Consultant

Establishes priorities for disease management and improving health status.

Participates in case consultation with psychiatrist, QMHP, nurse care managers, and community support specialists

Helps educate community support specialists, case managers, and clinical staff on the nature, course, and treatment of chronic diseases

Develops collaborative relationships with treating PCPs and Psychiatrists, as well as other healthcare professionals and facilities

Primary Care Physician Consultant

Nurse Practitioners and Advanced Practice Nurses

- Up to 50% of physician time can be provided by an Advanced Practice Nurse on a 2 hour for 1 hour basis
- At least 2 hrs/wk of physician time must be a physician

Primary Care Physician Consultant

OPTIONS

- May contract with multiple primary care physicians to provide consultation for CMHC HCH consumers who are their patients
- May be appropriate to contract with a specialist as a consultant for consumers with certain chronic health conditions
  - Heart Disease: Cardiologist
  - Severe Diabetes: Endocrinologist
- PCP contracts must include provisions that PCPs cannot bill for any other Medicaid service while providing consultation and address kickback protection

HCH Team Members

Healthcare Home Director

Oversees the implementation and coordination of Healthcare Home activities

- **Champions** Healthcare Home **practice transformation**
- **Oversees** the **daily operation** of the HCH
- **Tracks enrollment**, declines, discharges, and transfers
- **Assigns** NCM **caseloads**
- **Coordinates** review and utilization of the **Care Management reports**
- **Promotes** the development of **working relationships with hospitals**, and **coordinates hospital admissions and discharges** with NCMs
- Coordinates staff training on HIT tools and initiatives
- Reviews and completes monthly implementation reports

HCH Team Members

Healthcare Home Director

Participates in **quarterly meeting**

Participates in impromptu webinars/calls as needed

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**

May facilitate health education groups, if qualified

Participate in team meetings with CPR Managers to address & facilitate full integration efforts

Assure HCH Performance Outcomes are shared with CPRC staff

HCH Team Members

Nurse Care Managers

Champions a holistic, person-centered approach for coordinating the healthcare needs and wellness goals of their clients

- Unlike a clinic or hospital based nurse, the NCM **is not personally responsible** for all aspects of care for each individual on their caseload
- The traditional nurse/patient relationship **does not apply**, except temporarily during specific face-to-face interactions
- The NCM **is not expected to** address all aspects of care for all patients on the caseload immediately
- The NCM **is expected to** identify actionable areas to improve care in a portion of their caseload.

HCH Team Members

Nurse Care Managers

- **Champion healthy lifestyles** and **preventive care**
- **Participate in monitoring** the monthly **Care Management reports**, and **establishing priorities and strategies** for interventions
  - Communicate with client's treatment team regarding alerts, follow-ups, and recommendations
- **Provide training** and support to CPR staff **regarding health, wellness, and chronic disease** to enable them to better assist consumers in maintaining healthy lifestyles, and managing chronic diseases
- **Provide educational groups** regarding health, wellness, and chronic disease **for consumers**, and **health and wellness opportunities for consumers and staff**

HCH Team Members

Nurse Care Managers

May provide individual interventions for consumers on their caseload

- **Follow up** on hospital discharges within 72 hours and **complete medication reconciliation** with input from PCP
- **Review client records and patient history**
- **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
- **Communicate with CSSs** about identified health conditions of their clients
- In conjunction with community support staff, c**oordinate** care **with external health care providers** (pharmacies, PCPs, FQHCs etc.)
- **Document** individual **client care and coordination** in client records
- Along with CPR staff, tracks required screenings (health screening and metabolic screening) for clients on their caseload

HCH Team Members

Care Coordinator/Clerical Support

Assists with the coordination of Healthcare Home activities

- **May facilitate and assist in the review** of the monthly **Care Management** and **Hospital Admission** reports
- May complete **metabolic screening data entry**
- Assists with **appointment scheduling** and **client tracking**
- Provides assistance in **faxing, sorting, and distributing reports** and letters related to CyberAccess and Care Management reports
- Provides **technical assistance** to HCH team and CSSs on use of CyberAccess and Patient Profile reports, and may serve as a **CyberAccess practice administrator**
- **Provides clerical support** to the HCH Director and team
- **May** provide **case management** for HCH enrollees who do not have a CSS or other case manager

HCH Team Members

Psychiatrists, QMHPs, PSR and CSSs

Continue to fulfill **current responsibilities**

Collaborate with Nurse Care Managers in providing individualized services and supports

CSSs participate in required **HCH training** to enable them to serve as wellness coaches who

- **Champion healthy lifestyle changes and preventive care** efforts, including helping consumers develop wellness related treatment plan goals
- Support consumers in **managing chronic health conditions**
- Assist consumers in **accessing primary care**

HCH Team Members

Peer Specialist

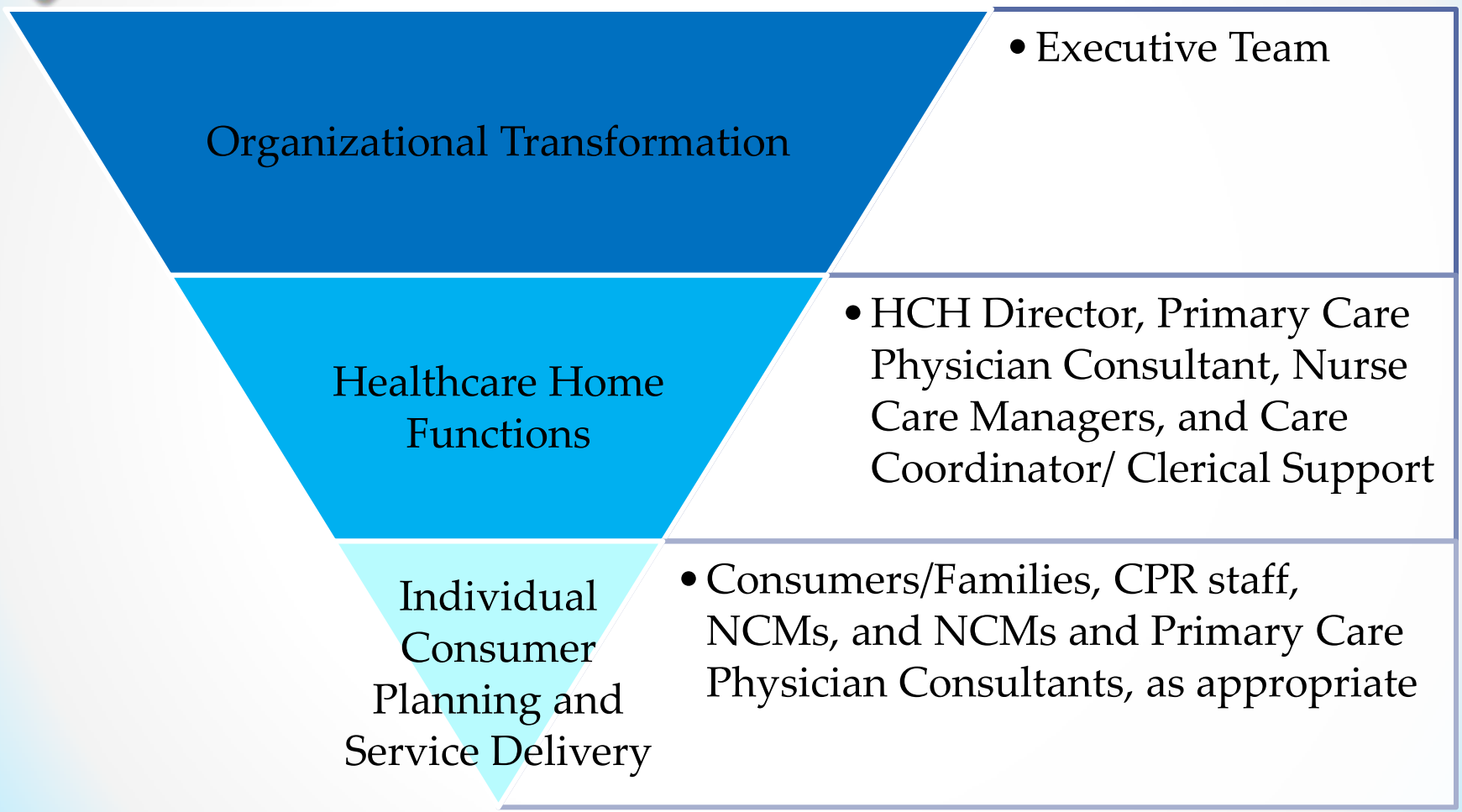
- Can be critical to
  - **Helping** individuals **recognize** their **capacity for recovery and resilience**
  - **Modeling** successful **recovery behaviors**
  - **Assisting** individuals with **identifying strengths and personal resources** to aid in their recovery
  - **Helping** individuals **set and achieve recovery goals**
  - **Assisting** peers **in** setting goals and **following through on wellness and health activities**

HCH Team Members

Family Support Specialist

- Can be critical to
  - **Helping** families **navigate** the service delivery system
  - **Coaching** families to **increase their knowledge and awareness** of their child's needs
  - **Providing emotional support**
  - **Helping** enhance **problem solving skills**

Who is the Team?



Healthcare Home

. . .

Responsibilities

HCH Responsibilities

Health Screening

Each HCH enrollee must have an annual health screen that includes required components.

The health screen should be completed as part of the admission or annual treatment planning process

Although the health screening information may be collected by other agency staff, the Nurse Care Manager must review the results of the health screen prior to the enrollees initial or annual treatment plan to determine whether additional health screenings 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

Establishing a PCP & Communication

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

If a HCH enrollee does not have a PCP, the HCH should assist the enrollee in acquiring a PCP

HCH should inform PCP of client's enrollment into the HCH program

A letter generated by DMH & MHD introducing the HCH program is provided for use when meeting with PCPs and other healthcare providers

HCH Responsibilities

Hospital Admissions

A joint letter prepared by the MO Hospital Association and MO HealthNet was distributed to all hospitals describing the Healthcare Home initiative and encouraging hospital cooperation.

MOU vs Relationship

- **Relationship** is the most important!

HCH Responsibilities

Hospital Admissions

HCHs receive daily e-mails regarding planned hospital admissions

- Recently began receiving ER Contacts Reported to DHSS

HCH members discharged from the hospital must have contact within 72 hours of discharge

- This contact may be made by the individual's CSS, case manager, or NCM

Nurse Care Managers must complete a medication reconciliation on HCH members discharged from the hospital

- Information regarding the enrollees medications may be collected by the individual's CSS or case manager for review by the NCM

Medication Reconciliation

Medication reconciliation is the process in which health care providers review a patient's medication regimen at transitions in care (such as admission and discharge from a hospital and transfers to long term and home care) in an effort to avoid inconsistencies, adverse effects, and duplicative or unnecessary medications (1).

Medication errors and adverse events caused by them are common during and after a hospitalization. The impact of these events on patient welfare and the financial burden, both to the patient and the healthcare system, are significant (2).

1. American Society of Health-System Pharmacists, 2010, ASPH Endorses Best Practices for Medication Reconciliation, retrieved from http://www.ashp.org/menu/AboutUs/ForPress/PressReleases/PressRelease.aspx?id=602, on 2/21/12.
2. 2010 Society of Hospital Medicine Journal of Hospital Medicine Vol 5 No 8 October 2010 477

Medication Reconciliation

"Successful implementation of medication reconciliation requires a concerted interdisciplinary effort in order to prevent medication errors at transition points in patient care" (2).

- 1 in 5 patients experienced an adverse event in transition from hospital to home.
- Adverse drug events were the most common (66%).
- Of these, 62% were considered preventable (1).

One of the major issues faced in this process is providers retrieving medication history from sources other than patient. 70% of drug-related problems discovered only through a patient interview where discrepancies exist between documentation, prescription bottles, and patient's actual use of medications. To avoid medication errors such as omissions, duplications, dosing errors, or drug interactions ,it is imperative that staff compare a patient's medication orders to all of the medications that a patient has been taking at every transition of care in which new medications are ordered or existing orders rewritten.

1. Scope of Problem – Discharge Forster AJ, et al. Ann Intern Med. 2003;138:161-7
2. American Society of Health-System Pharmacists, 2010, ASPH Endorses Best Practices for Medication Reconciliation, retrieved from www; http://www.ashp.org/menu/AboutUs/ForPress/PressReleases/PressRelease.aspx?id=602, on 2/21/12.

Hospital Admissions

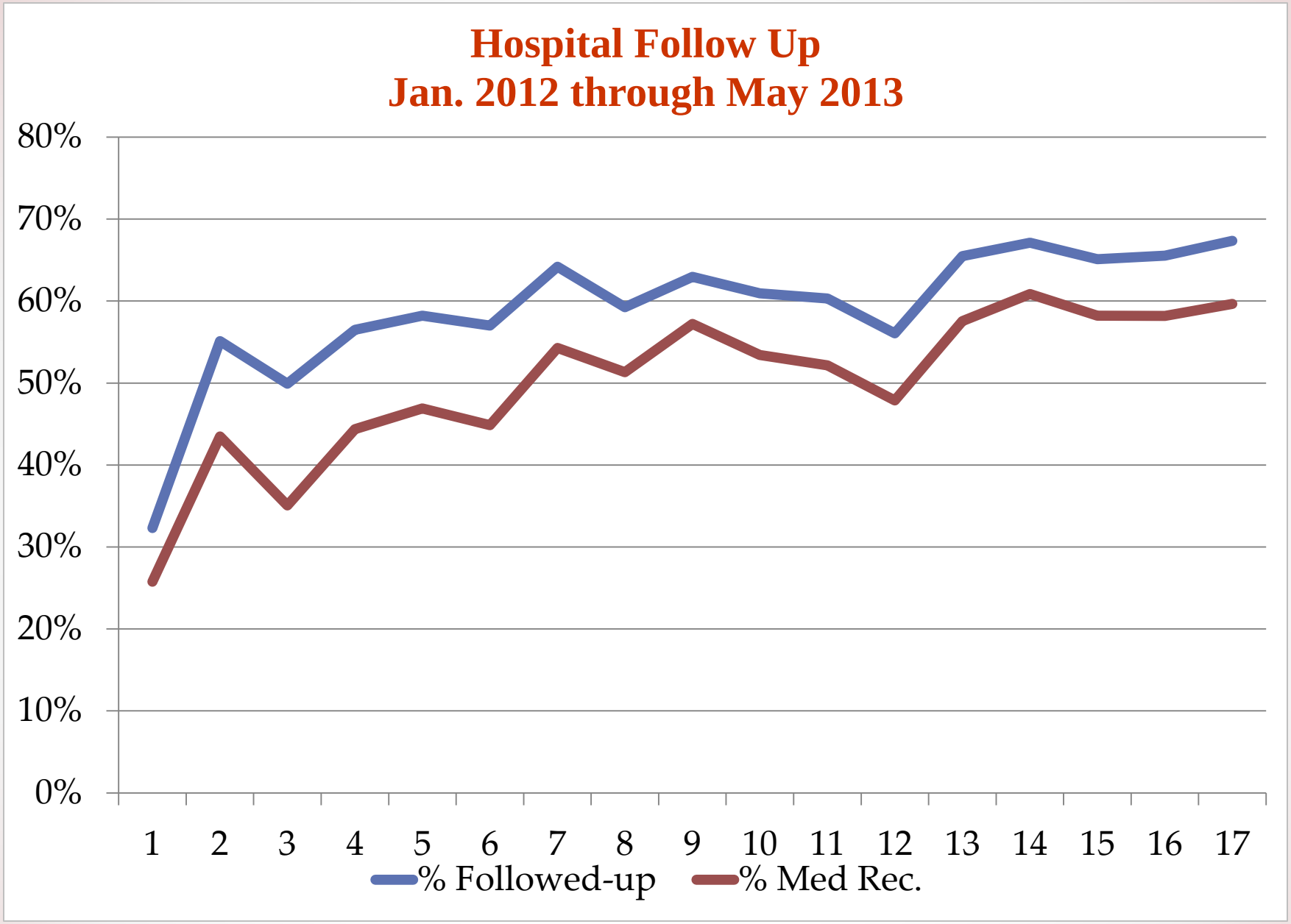
Following Up is Complicated

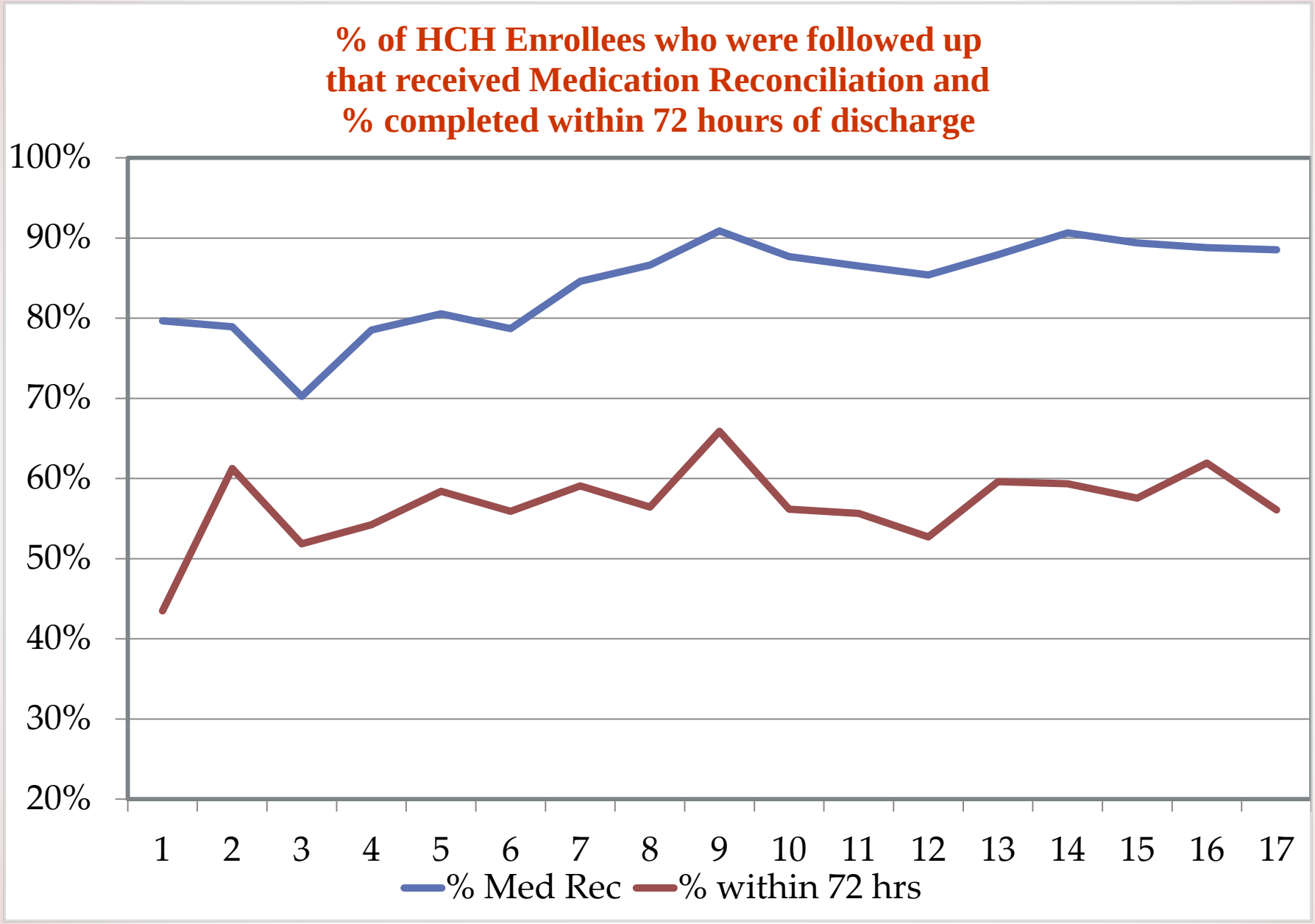
False Positives and Missing Data

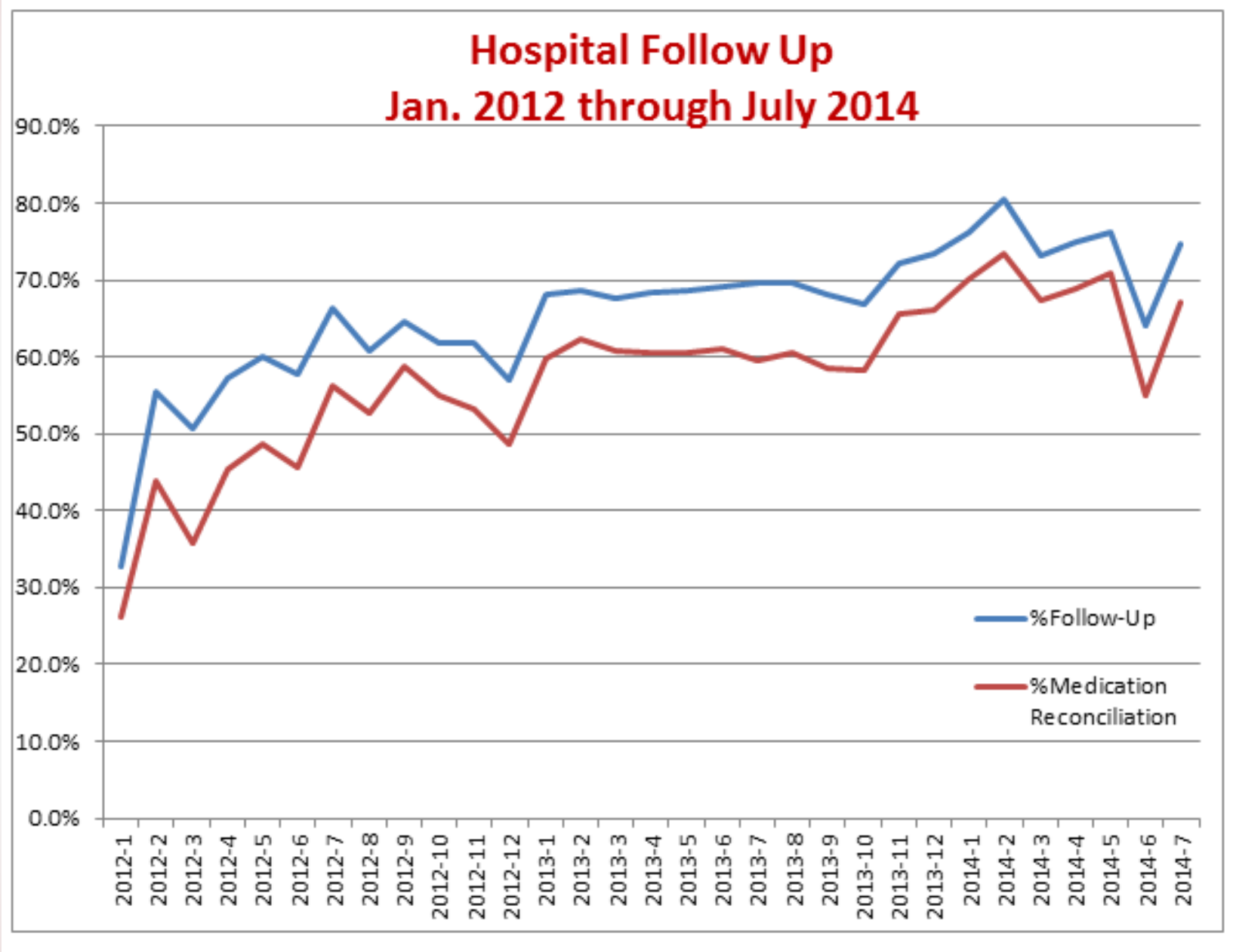
- Late notification
- Appealing denials
- Dual Eligibles

Working with Multiple Hospitals

- Barnes Hospital had admissions from half of the HCHs
- BJC and Crider had admissions to 17 hospitals in one month
- Pathways had admissions to 38 hospitals in one month


Hospital Follow Up
Jan. 2012 through May 2013
80%
70%
60%
50%
40%
30%
20%
10%
0%
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
% Followed-up
% Med Rec.


% of HCH Enrollees who were followed up that received Medication Reconciliation and % completed within 72 hours of discharge
100%
90%
80%
70%
60%
50%
40%
30%
20%
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
% Med Rec
% within 72 hrs


Hospital Follow Up
Jan. 2012 through July 2014
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
2012-1
2012-2
2012-3
2012-4
2012-5
2012-6
2012-7
2012-8
2012-9
2012-10
2012-11
2012-12
2013-1
2013-2
2013-3
2013-4
2013-5
2013-6
2013-7
2013-8
2013-9
2013-10
2013-11
2013-12
2014-1
2014-2
2014-3
2014-4
2014-5
2014-6
2014-7
%Follow-Up
%Medication Reconciliation

HCH Responsibilities

Care Management Reports

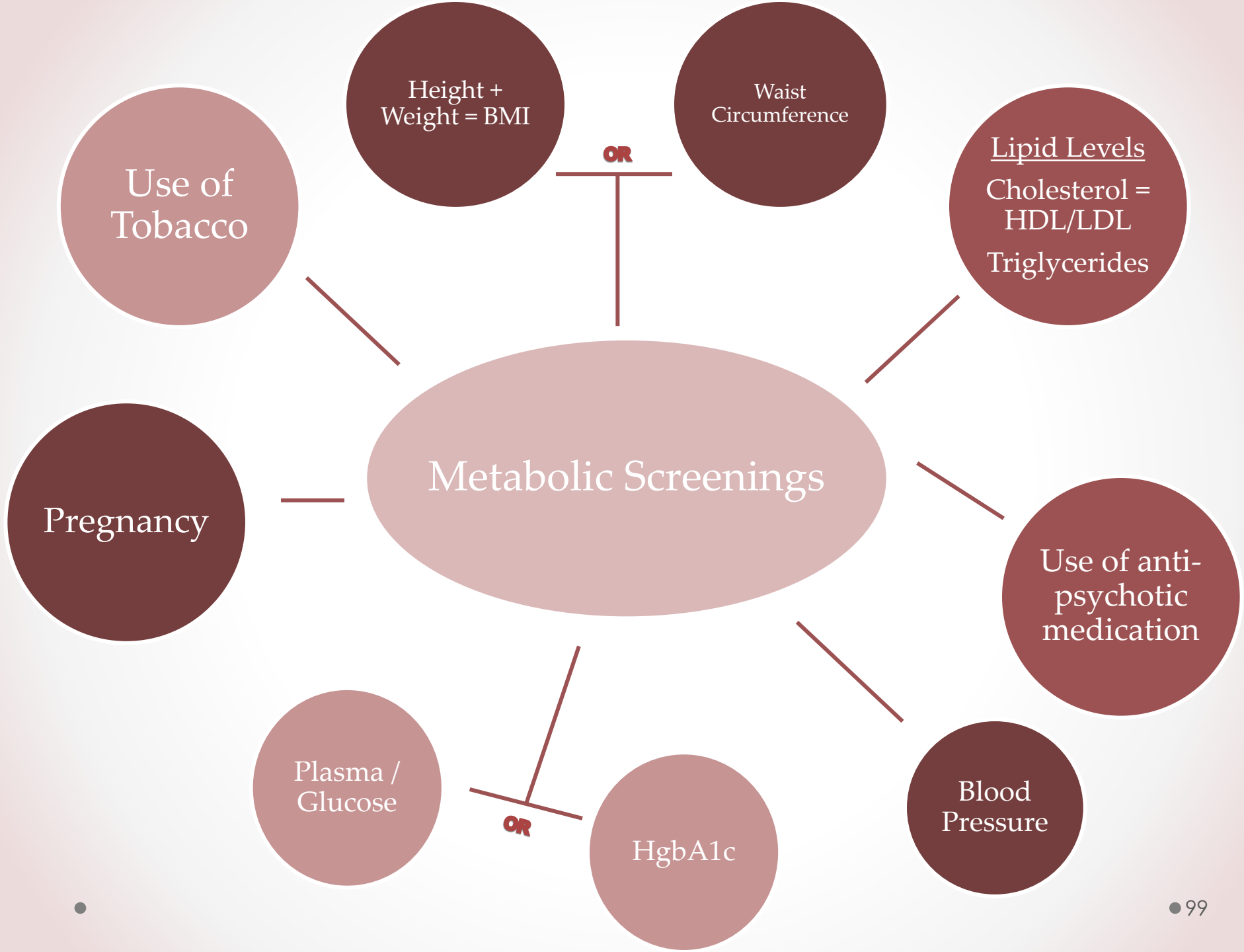
Review monthly Care Management reports to identify high risk patient populations

Prioritize interventions

- Not all individuals with flags require intervention
- Not all flags need to be addressed in a given quarter
- Some individual interventions may be necessary to address acute or immanently harmful clinical situations
- Select interventions that have the potential to impact the care/health status of a relatively larger portion of patients

Annual Metabolic Screening

- Required for all CPRC individuals receiving anti-psychotic medications
- Required for all HCH enrollees
- Why are screenings required?


Height + Weight = BMI
OR
Waist Circumference
Use of Tobacco
Lipid Levels
Cholesterol = HDL/LDL
Triglycerides
Pregnancy
Metabolic Screenings
Use of anti-psychotic medication
Plasma / Glucose
OR
HgbA1c
Blood Pressure

HCH Responsibilities

HCH MBS Requirements

Adults – required components (full MBS)

- Height, weight, blood pressure, BMI and/or waist circumference, blood glucose and/or HgbA1c, lipid levels, status of antipsychotic medication use, tobacco use, and pregnancy status.

Children - minimal required components

- Height, weight, blood pressure, BMI and/or waist circumference, status of antipsychotic medication use, tobacco use, and pregnancy status.

Children with diagnosis of diabetes or receiving an antipsychotic – requires full MBS

- Height, weight, blood pressure, BMI and/or waist circumference, blood glucose and/or HgbA1c, lipid levels, status of antipsychotic medication use, tobacco use, and pregnancy status.

HCH Responsibilities

Annual Metabolic Screening Opt Outs

There are circumstances in which a consumer may opt-out of certain procedures due to the consumer's concern of the invasiveness of the procedure.

If at any time a provider fails to collect the minimal standard of 80% metabolic screenings of their HCH enrollees, that provider's enrollments will be suspended until their collection rates meet minimal standards.

- A consumer may opt-out of blood glucose, HgbA1c, and lipid level collection.
- It is expected all other values are obtained.

- Opt-outs should be used on a limited basis.
- It is expected that communication regarding the opt-out will occur with the consumer's healthcare providers.

HCH Responsibilities

Monthly Implementation Report

Process and Timelines

Monthly Report Components

- Cover Sheet
- HCH Team Log
- Client Status Report
  - FTP
- Hospitalization follow-up report
  - FTP
- Hospitalization follow-up self-report

HCH Responsibilities

Other Responsibilities

Complete Team Contact profiles

Staffing changes (Vacancies and Hires)

Billing for Services Prohibited

- HCH Team members may not bill for any services while their time is covered via the PMPM

HCH Responsibilities

Documentation

Progress Notes

- Face-to-face interactions
- Care Coordination
  - Care Management Report Flags
  - Hospital Discharges & Medication Reconciliation
  - With other community providers
  - Client consultation in team meetings

Treatment Goals

Annual Metabolic Screening

Annual Health Screening

Monthly Attestation

Each month your agency completes a Cyber Access report attesting whether or not individuals enrolled in your HCH have received at least one health home service in order to qualify for a PMPM.

HCH Responsibilities

HCH Enrollees w/o Case Managers

Some HCHs have HCH enrollees who do not have a case manager

Nurse Care Managers should not serve as case managers

Options:

- Coordinate client "case management" support from other case managers, clinic nurses or outpatient clinicians
- Expand the number of CSS staff or case managers
- Assign individuals who require minimal case management to your HCH Care Coordinator (if qualified)

Care Management Tools and Reports

Care Management

Tools and Reports

CyberAccess

- Web-based Medicaid data system maintained by Xerox
- Allows providers to view patients histories based on Medicaid claims, including diagnoses, pharmacy, services, ER & hospital
- Contact Melissa Bishop for training in how to access and utilize CyberAccess :
  - Melissa.Bishop@xerox.com

Care Management
Tools and Reports

CMT Care Management Reports

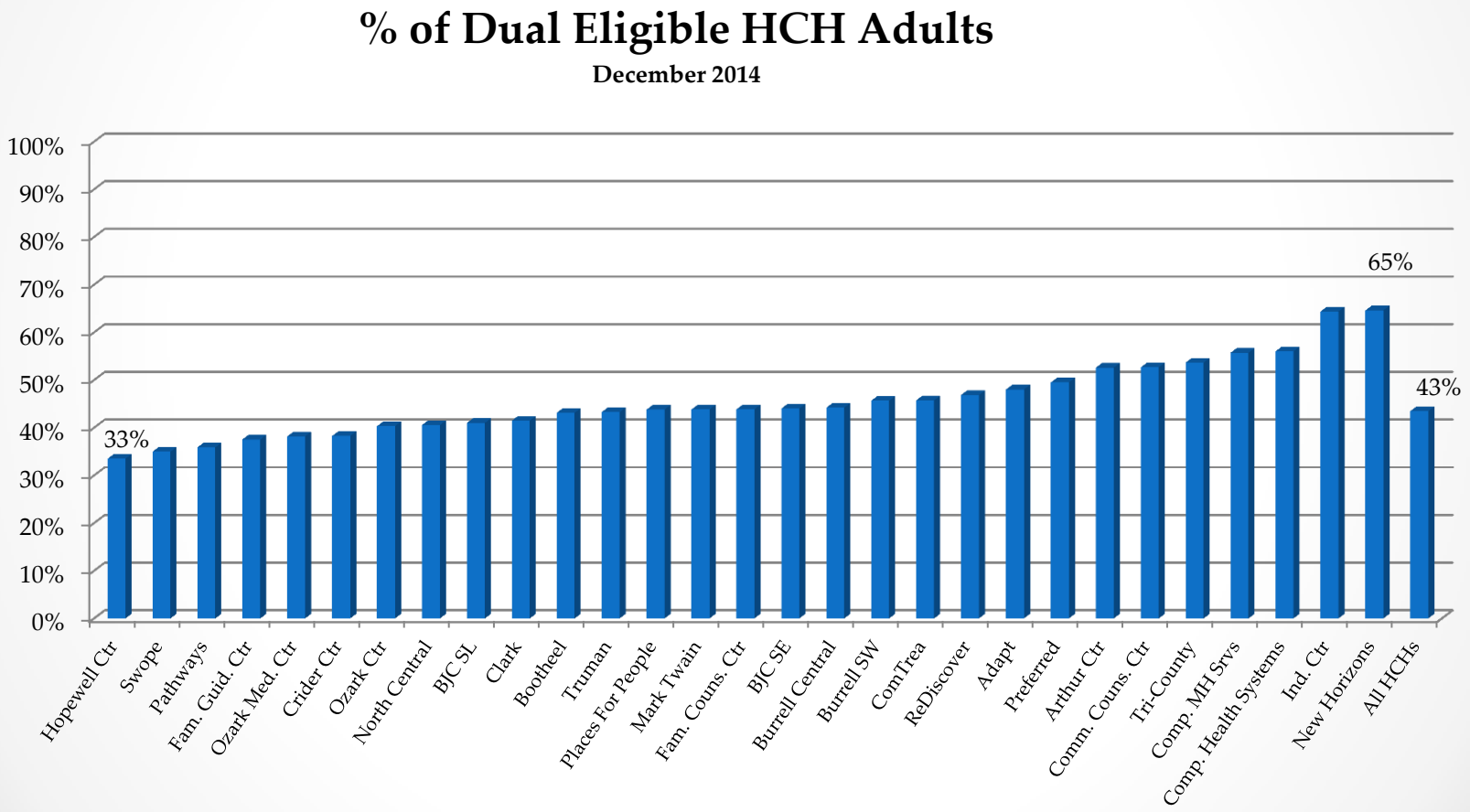
Includes the following reports which are updated monthly

- Behavioral Pharmacy Management (BPM)
- Medication Adherence
- Disease Management

Limitations

- Based on paid Medicaid claims data
- Does not include procedures/meds that are provided free, paid by the consumer, or for which no claim was submitted
- Includes claims for individuals who are dually eligible for Medicare/Medicaid where Medicaid pays the co-insurance or deductible, except pharmacy claims
- False positives (can be corrected)

% of Dual Eligible HCH Adults



Care Management
Tools and Reports

Behavioral Pharmacy Management Report

Includes a series of Quality Indicators™ to identify prescriptions that deviate from Best Practice Guidelines

- Inappropriate polypharmacy
- Doses that are higher or lower than recommended
- Multiple prescribers of similar medications

Sent to prescribing physician with Clinical Considerations™ that includes Best Practice Guidelines and recommendations

Sent to CMHC for all their consumers and includes information for all physicians, regardless of whether they are employed by the CMHC

May be most appropriately reviewed by the CMHC Medical Director

Care Management

Tools and Reports

Medication Adherence Report:

- Based on Medicaid pharmacy claims

- Includes
  - Anti-Depressant medications
  - Anti-Hypertensive medications
  - Anti-psychotic medications
  - Mood Stabilizers
  - Cardiovascular medications
  - Diabetes medications
  - COPD medications

- Enables CMHCs to identify all prescriptions that have been filled by consumers and determine Medication Possession Ratios
  - An MPR of .8 means that the prescription was filled for 80% of the quarter being reviewed.

Tools and Reports

Disease Management Report

- Based on Medicaid claims and Metabolic Screening data
- Identifies individuals with specific diagnoses/conditions who are not meeting specific indicators
  - Includes separate measures for adults and children
  - Identifies individuals based on not meeting specific test values (e.g. A1C, BP, and LDL levels)
  - Includes data on BMI control and tobacco use
  - Provides a mechanism to identify false positives

Enrolling Individuals in a CMHC Healthcare Home

HCH Transfers

Transfers

- CMHCs collaborate to effect a transfer between HCHs by submitting a transfer form explaining the reason for the proposed transfer to the Health Home Enrollment Coordinator for review and approval
- Transfer can occur between:
  - Primary Care and CMHC Healthcare Homes
    - Must submit discharge and enrollment request forms
  - CMHC Healthcare Homes
    - Means transferring to another CMHC for all of their psychiatric rehab services

No Solicitation Policy

DM 3700 = HCH Outreach

DM clients should be enrolled in HCH

- Should be presented as a packaged deal
  - Although participation in the Health Home is voluntary
    - Declining to enroll does not affect any other services an individual is receiving

Match for these clients comes from DSS

These clients are presumptively eligible for the CPR program

Presumptive Eligibility

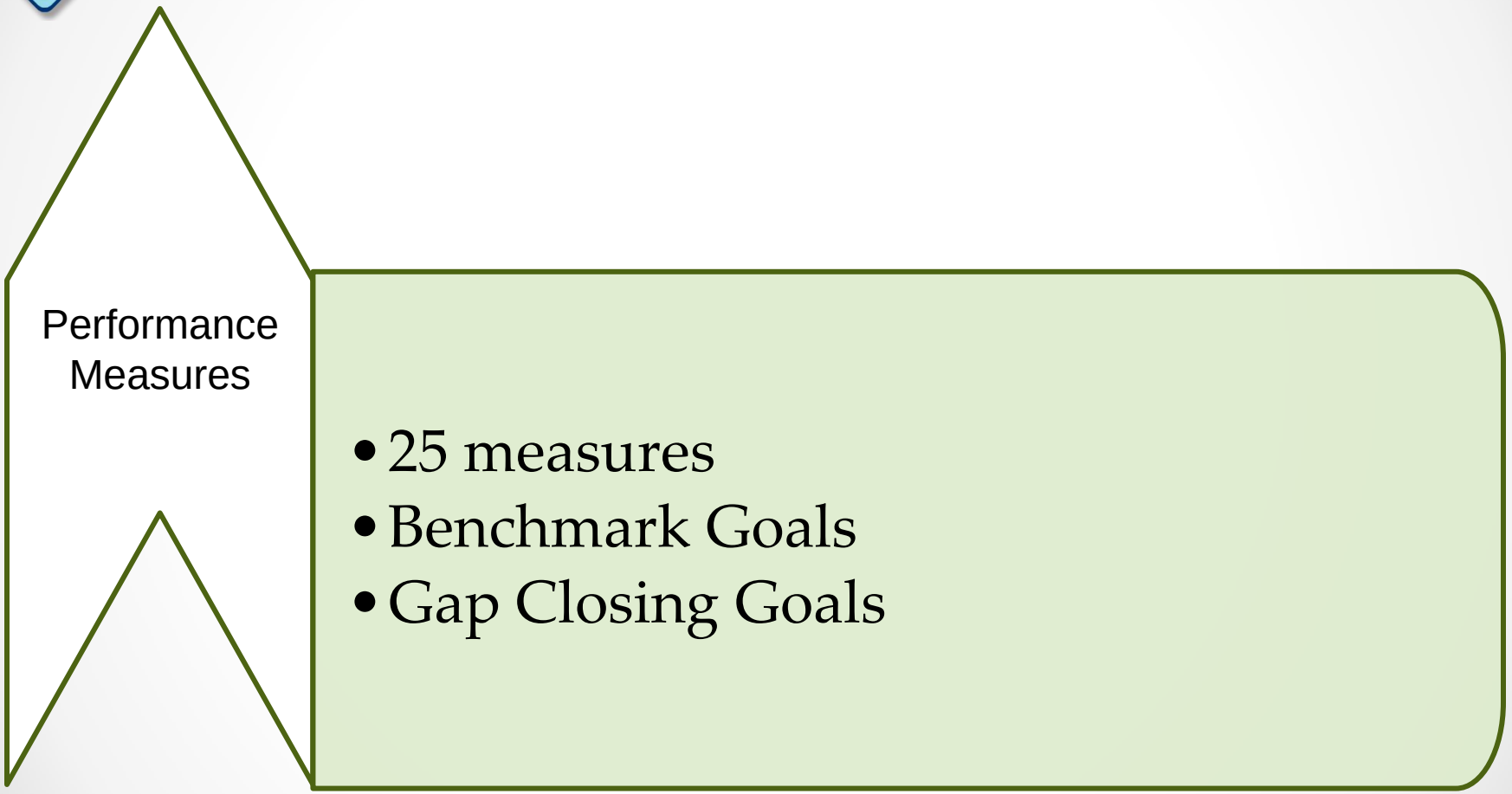
At the CMHC's option, Healthcare Home enrollees who are not currently enrolled in the CPR program may be considered presumptively eligible and enrolled in the CPR program

To enroll Healthcare Home 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

Performance Measures

Performance Measures



DM Performance Measures | Revised Benchmark Goals

Indicator	Goal	Outcome (May14)	NEW GOAL	Notes
Asthma Med (A)	70%	90%	90%	
Asthma Med (C)	70%	91%	90%	
BP Control HTN (A)	60%	59%	70%	
LDL Control Cardio (A)	70%	52%	60%	Reduced to align with Diabetes LDL Control (A)
Diabetes BP Control (A)	65%	63%	70%	
Diabetes LDL Control (A)	36%	50%	60%	Increased to align with LDL Control Cardio (A)
Diabetes A1c Control (A)	60%	56%	60%	No change
Diabetes A1c Control (C)	60%	45%	60%	No change
Metabolic Screen (A&C)	80%	75%	80%	No change
No Tobacco Use (A)	56%	44%	56%	No change
No Tobacco Use (C)	56%	96%	95%	

DM Performance Measures | Revised Indicators

Indicator	Notes
BP Control HTN (A)	Reviewing specs of claims identifying the target population. (2014 NQF 0018)
LDL Control Cardio (A)	Reviewing specs of claims identifying the target population. (2014 NQF 0064)
Diabetes BP Control (A)	Reviewing specs of claims identifying the target population. (2011 NQF 0061)
Diabetes LDL Control (A)	Reviewing specs of claims identifying the target population. (2014 NQF 0064)
Diabetes A1c Control (A)	Reviewing specs of claims identifying the target population. (2011 NQF 0575)
Diabetes A1c Control (C)	
BMI Control (A)	Remove measure from targeted indicators, and add NEW measures to monitor weight loss.
BMI Control (C)	DELETE, and add NEW measure to appropriately calculate BMI for children based on growth chart percentiles.

NQF = National Quality Forum | www.qualityforum.org

DM Performance Measures | NEW Indicators

Indicator	Notes
Diabetes A1c >9.0% (A)	Creating new indicator to monitor A1c outside of normal range. Reviewing 2014 NQF 0059.
Diabetes A1c >9.0% (C)	Creating new indicator to monitor A1c outside of normal range. Reviewing 2014 NQF 0059.
BP Prevention Control (A)	Creating new indictor to monitor BP control for all clients regardless of diagnosis. *Excluding clients in BP Control HTN and Diabetes BP Control measures.
LDL Prevention Control (A)	Creating new indictor to monitor LDL control for all clients regardless of diagnosis. *Excluding clients in LDL Control Cardio and Diabetes LDL Control measures.
Percentage of Weight Loss	Creating new indicator(s) to monitor weight loss for BMI categories.
NEW BMI Control (C)	Creating new indicator to appropriately calculate BMI for children based on growth chart percentiles.

CMHC HEALTHCARE HOME REVIEWS, EVALUATIONS, AND ACCREDITATION

Program Reviews

Progress Reports

- Approach
  - Monthly review and ongoing compilation of data from
    - HCH Team Log, Client Status, and Hospitalization Follow-up Reports
    - Performance Measures
    - Participation in Training and Monthly Calls
    - Practice Coaches
  - Sample record review of documentation
- Outcome
  - Progress report and technical assistance recommendations

HCH Accreditation

DMH worked with CARF to develop Health Home accreditation for behavioral health organizations.

CARF provided training on the standards in November 2011.

All CMHC Healthcare Homes have been accredited under the CARF standards.

The Joint Commission subsequently developed health home standards that can also be used to meet the accreditation requirement.

TRAINING

...

Training Initiatives

- "Paving the Way"
- Leadership and Team "HCH 101"
- Access to Care – MTM
- CyberAccess and ProAct Training
- Physician Institute
- Disease Management
- Motivational Interviewing

Training Initiatives

- TEAMcare
- Wellness Coaching
- CARF
- DLA 20-Functional Assessment Tool
- Asthma & Diabetes Educator
- Health Literacy
- HIPAA & 42 CFR
- Population Management
- My Way to Health

Technical Assistance

- Quarterly HCH Director Meetings
- Progress Reports
- Site Visits
- Practice Coaches
- Healthcare Home Implementation Team

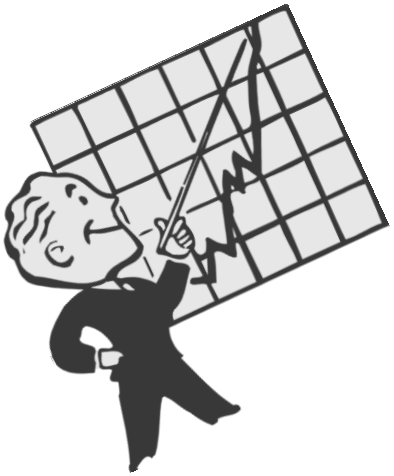
Practice Coaches

Allyson Ashley

and

Tom Rehak

- **Site visits as needed**
- **Identifying/developing/ sharing best practices**
- **Continuing to promote integration and population management**
- **Coordinate regional meetings, as needed**
- **Technical assistance to address emerging issues**
- **Assist the HCH Implementation Team in policy development based on knowledge regarding site implementation**



Impact

SMALL CHANGES HAVE MADE A BIG DIFFERENCE!

Improving Uncontrolled A1c

Baseline to Year 1

Reduced the mean A1c

9.9 to 8.9

Baseline to Year 2

Reduced the mean A1c

9.9 to 8.5

1 point drop in A1c!

- 21% ↓ in diabetes related deaths
- 14% ↓ in heart attack
- 31% ↓ in microvascular complications

SMALL CHANGES MAKE A BIG DIFFERENCE!

Improving Uncontrolled LDL

10% drop in LDL level!

- 30% ↓ in cardiovascular disease

Baseline to Year 1

Reduced the mean LDL

131 to 116

Baseline to Year 2

Reduced the mean LDL

131 to 113

SMALL CHANGES MAKE A BIG DIFFERENCE!

Improving Uncontrolled BP

Baseline to Year 1
Reduced the mean BP

Systolic: **144** to **134**

Diastolic: **90** to **84**

Baseline to Year 2
Reduced the mean BP

Systolic: **144** to **131**

Diastolic: **90** to **82**

6 point drop in Blood Pressure!

- 16% ↓ in cardiovascular disease
- 42% ↓ in stroke

SMALL CHANGES MAKE A BIG DIFFERENCE!

Show Me Outcomes | Cost Savings (after 1 year)

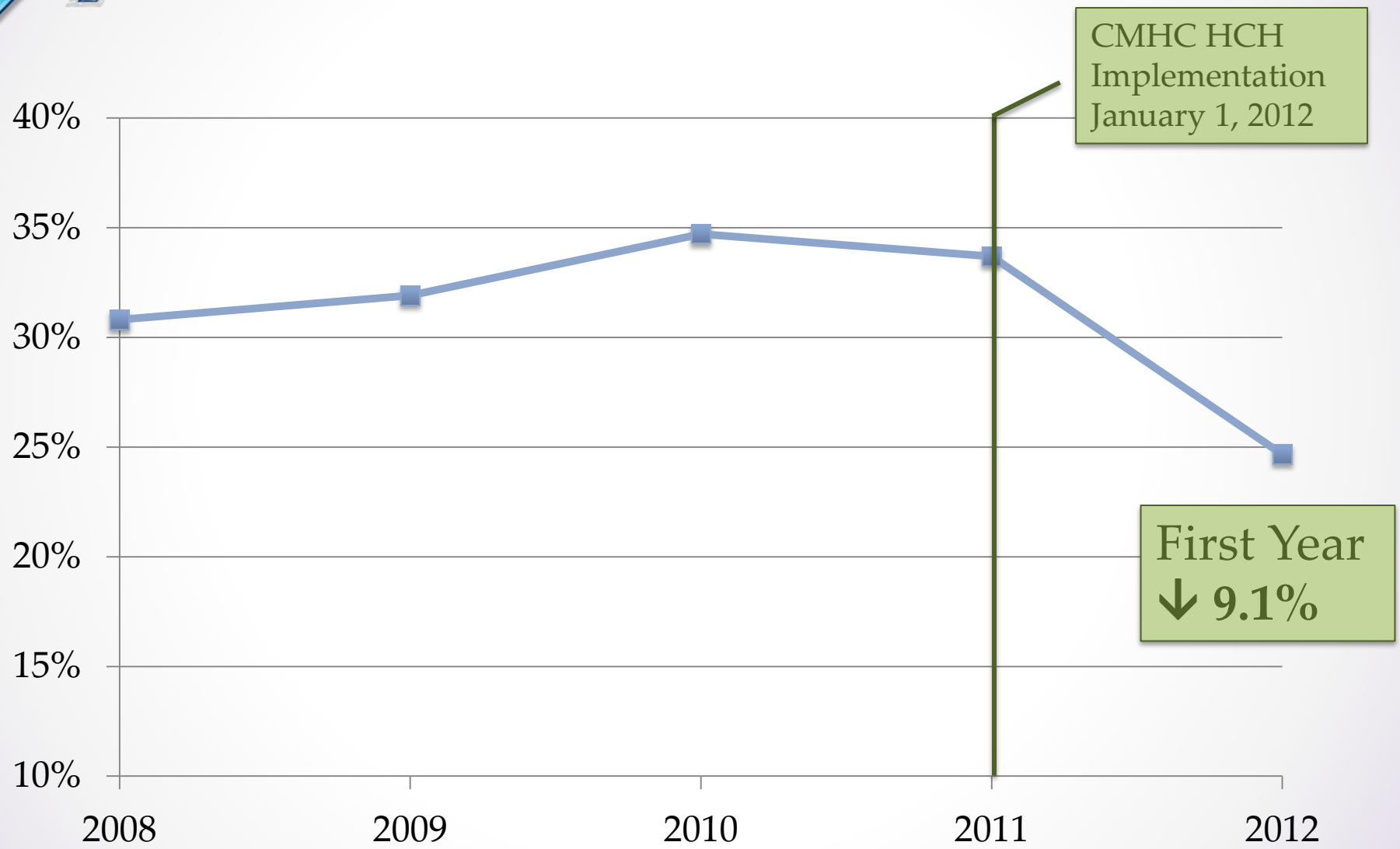
Missouri's Health Homes have saved an estimated **$36.3 million**.

SAVINGS = $60 PMPM

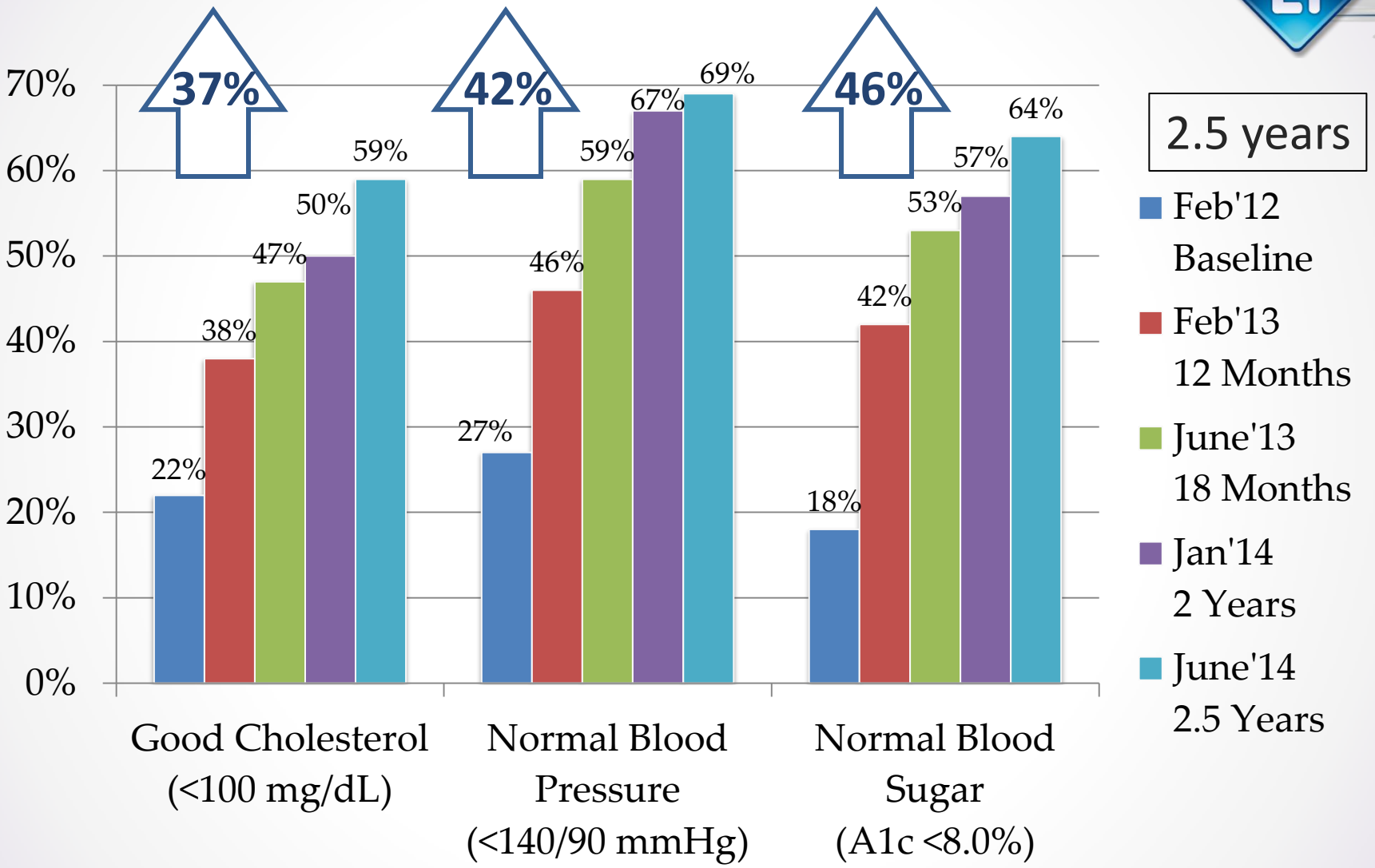
Community Mental Health Centers Healthcare Homes have saved Missouri **$31 million**!

SAVINGS = $98 PMPM

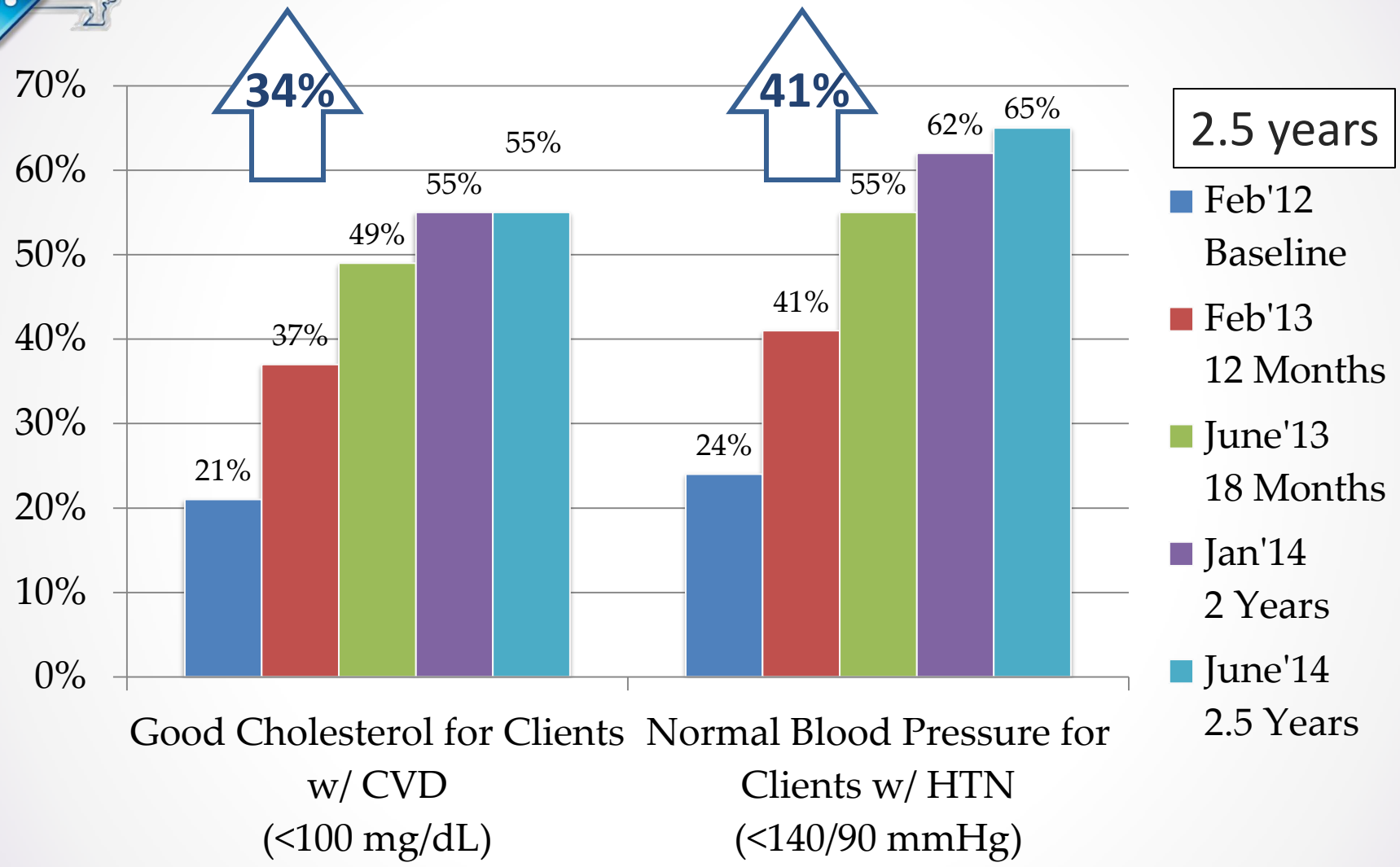
Outcomes | % of Clients w/ 1+ Hospitalization



Outcomes | Diabetes

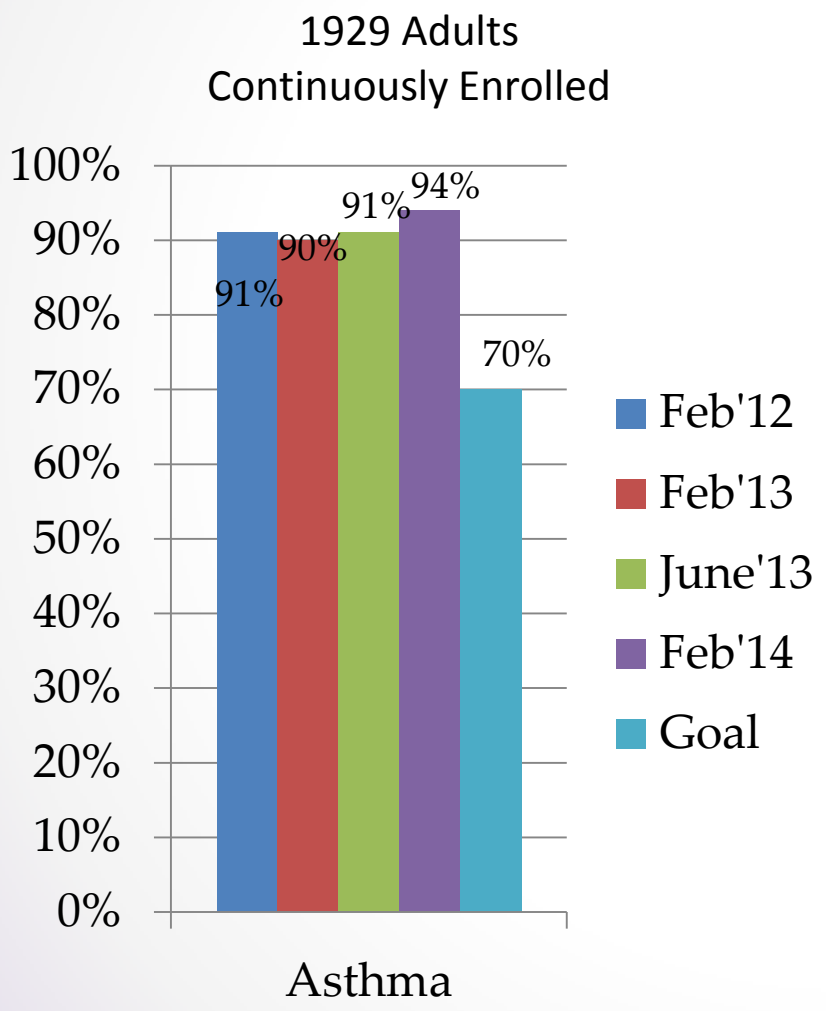


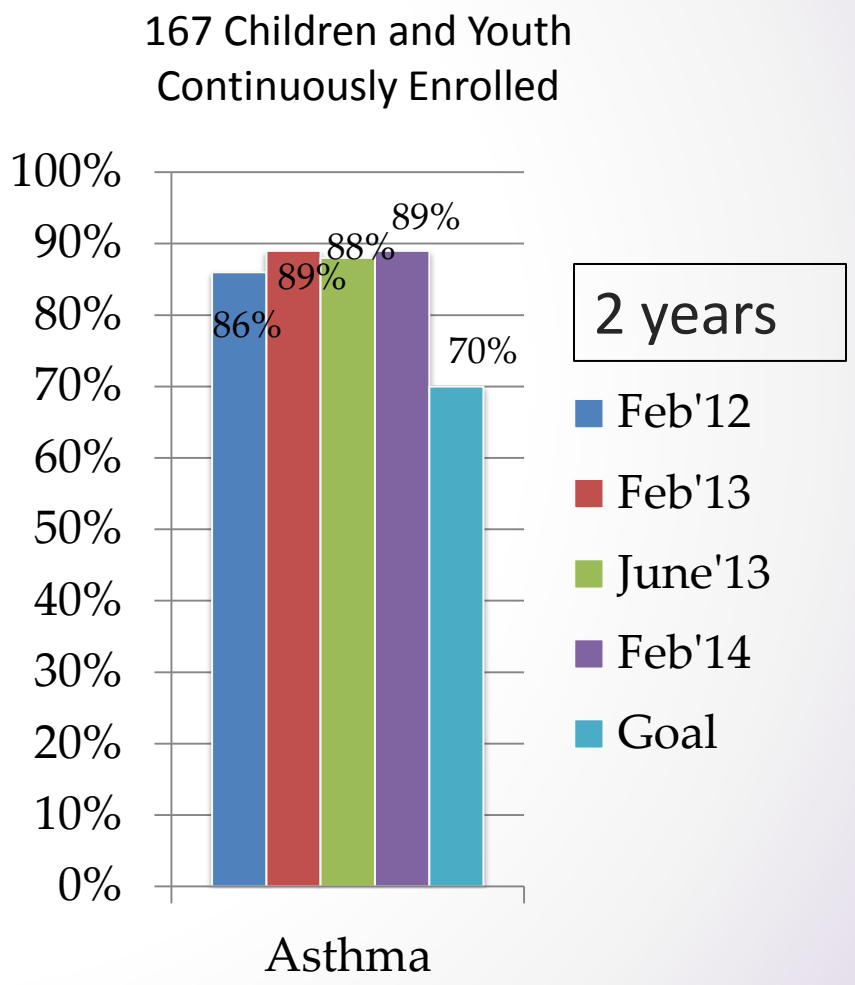
Outcomes | Hypertension and Cardio



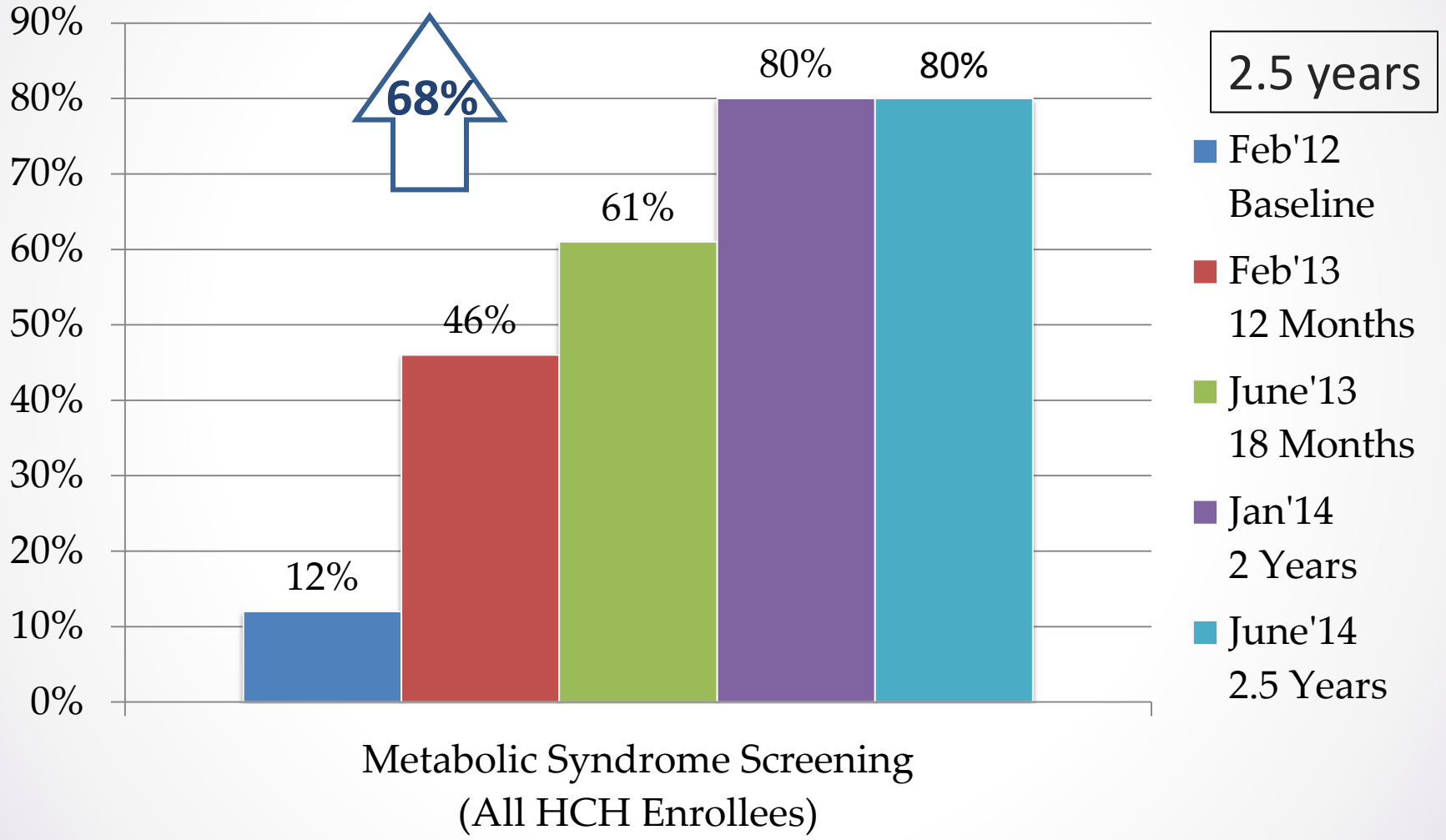
Disease Management

Asthma

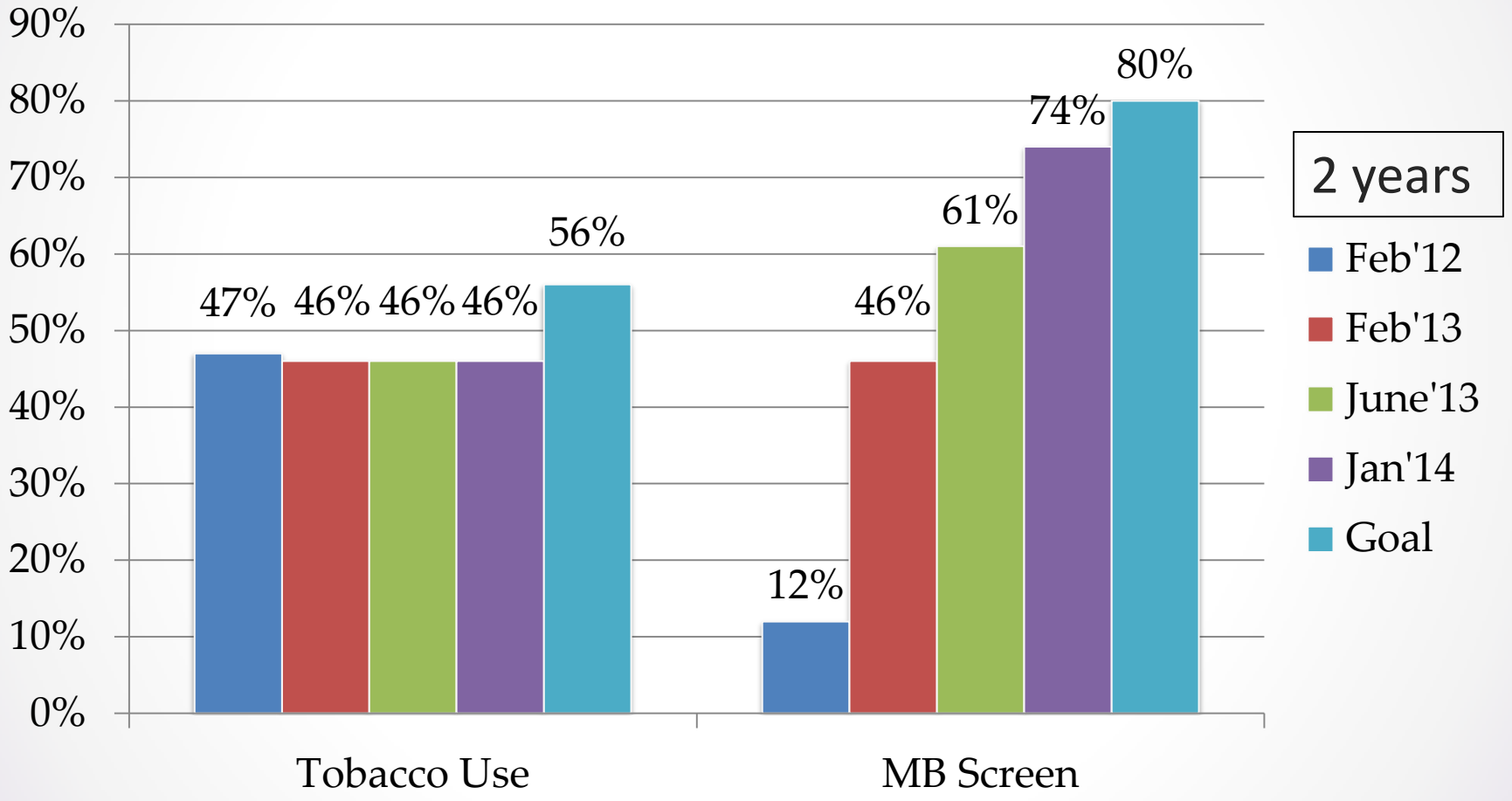




Outcomes | Metabolic Syndrome Screening



Tobacco and Complete Screens



We Are Still Learning

Adjusting expectations to reality

Continuing to understand and clarify

- How things work
- How roles and responsibilities fit together

Helping staff acquire new skills

SUCCESS

Because you too can own this face of pure accomplishment

HCH: WHO TO CONTACT

Missouri Coalition for Community Behavioral Healthcare

Rachelle Glavin
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Copy in Emails regarding ProAct
Inquiries or Enhancement Requests
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Tom Rehak
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Katie Horstman
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ProAct

ProAct Customer Support Center
ProAct Accounts/Password
System or Data Inquiries
support@cmthealthcare.com
9:00-5:00
1-888-754-1129

CyberAccess

Melissa Bishop
CyberAccess Inquiries
Melissa.bishop@xerox.com
573-659-6943

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