Missouri Coalition of Community Mental Health Centers

2011 ANNUAL MEETING

HEALTHCARE HOME IMPLEMENTATION

Tuesday, June 28

12:30 p.m. – 2:30 p.m.

Osage/Gravois Room

Camden on the Lake
Lake Ozark, Missouri

The Healthcare Home model is gaining momentum as a way of effectively delivering care in the context of chronic disease. What will the Healthcare Home model look like in Missouri for people living with serious mental illnesses? How will community mental health centers need to change to become Healthcare Homes for the population they serve?

This presentation is a requirement for all agencies who wish to apply to become CMHC Healthcare Homes. CEO participation and commitment are important. Ideally, CEOs will attend this presentation and pave the way for Healthcare Homes in their agency.

Presenters

Tim Swinford

Missouri Coalition of Community Mental Health Centers

Dorn Schuffman

Department of Mental Health

MISSOURI COALITION OF COMMUNITY MENTAL HEALTH CENTERS

Community Mental Health Center

Healthcare Home Implementation

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Paving the Way for Healthcare Home

Facilitator Guide


Paving the Way for
Healthcare Home
Coming Soon…

This slide provides the national context for the development of Healthcare Homes.

National Health Care Reform has the potential to change our health care system in a variety of ways. We know that the current system has a tendency to fragment care; that what gets paid for are discrete treatments; that little funding is available for promoting healthy life styles; and that there is almost no financial support for the hard work of coordinating care across multiple providers and systems of care.

Now Section 2703 of the Affordable Care Act provides an opportunity for states to improve care for Medicaid enrollees with chronic health conditions, including serious mental illness, by providing federal funding for comprehensive care management and coordination, as well as health education and promotion activities.

Under this section states can amend their Medicaid state plans to create Healthcare Homes with federal financial participation.

This slide simply describes what a Healthcare Home is.

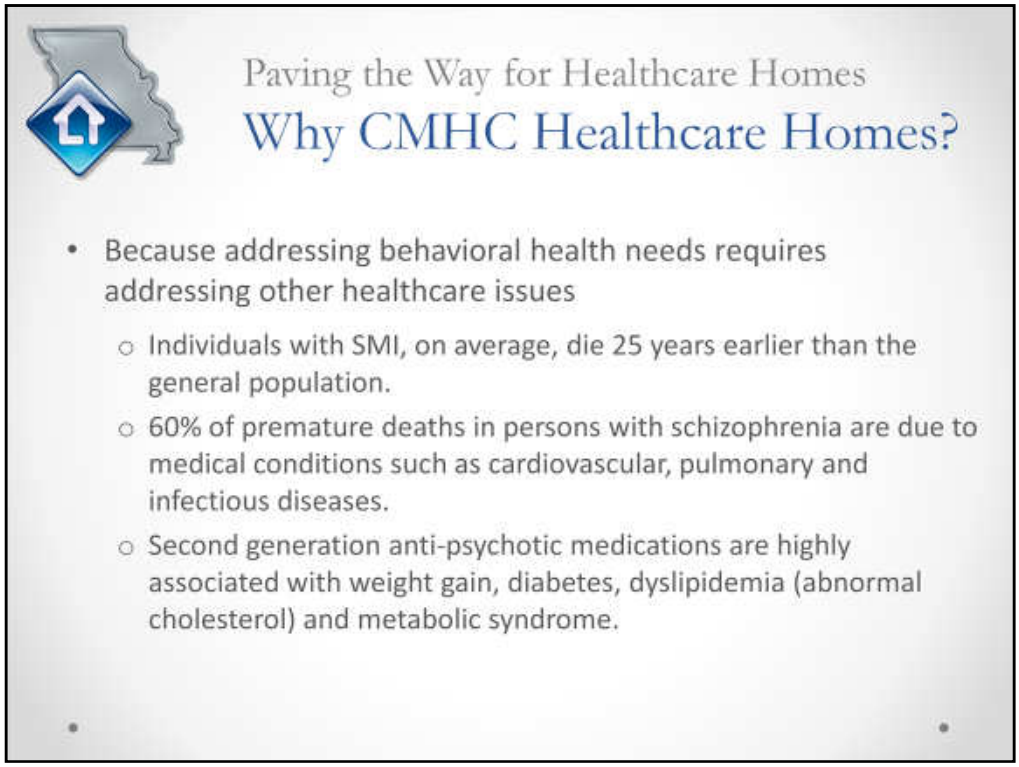
Here is what a Healthcare Home is. **[Read slide.]**

This slide explains that Missouri is amending its Medicaid state plan to provide for the creation of Healthcare Homes. Though we focus on CMHC Healthcare Homes, it is important to recognize that FQHCs and RHCs may also be designated Healthcare Homes since some CMHC consumers receive services from these providers. CMHC consumers will most likely be enrolled in CMHC Healthcare Homes rather than FQHC Healthcare Homes, since they receive the majority of their care from CMHCs.

The Department of Mental Health has been working with MO HealthNet to amend the Medicaid state plan to create the opportunity for CMHCs to be designated as Healthcare Homes for individuals with behavioral health problems, and we appear to be among the very first states to take advantage of this opportunity.

The Medicaid state plan is also being amended to allow federally qualified health centers, rural health centers and some physicians practices to be designated as Healthcare Homes for individuals with other chronic diseases.

CMHCs that have a collaborative relationship with an FQHC/RHC may want to discuss the initiative with the collaborating agency and provide more details for their staff.



The next five slides give some of the reasons why it is important for the CMHC's to become Healthcare Homes.

There are a number of reasons it is important for CMHCs to continue to broaden our scope by assuming the responsibilities of a Healthcare Home for the people we serve.

First, because we know that we cannot effectively meet the behavioral needs of consumers if we ignore the fact that individuals with SMI, on average die 25 years earlier than the general population, and that 60% of these premature deaths are due to medical conditions, such as cardiovascular disease and pulmonary and infectious diseases that are either going undiagnosed or untreated.

In addition, we know that our own treatment approaches can contribute to high risk health conditions: second generation anti-psychotic medications are highly associated with weight gain, diabetes, abnormal cholesterol levels and metabolic syndrome.

We also know that treating illness is not enough. Wellness and prevention are as important as treatment and rehabilitation.

And in order to truly improve outcomes and the quality of life for the individuals we serve, we have to focus more attention on the general health care problems that interfere with recovery.

There is continuing pressure to find new ways to control state Medicaid costs. From our perspective, alternative approaches to controlling costs, such as capitated managed care or ASO prior authorization are unacceptable. Consequently, we have supported implementation of the Healthcare Home model as a reasonable approach to controlling the growth in Medicaid costs. In fact, the FY'12 state budget is based on the assumption that implementing Healthcare Homes will save the state $7.8 million by providing better and more timely care for chronic illnesses, and thereby reducing utilization of more costly inpatient and emergency room care, as well as inefficient use of primary care, specialty care and pharmaceuticals. If the state had not made this commitment to implementing Healthcare Homes, DMH would have faced additional budget reductions in FY'12.

This slide and the next make the case that becoming Healthcare Homes is the logical next step in our evolution.

We continue to evolve consistent with our values and understanding of what it takes to assist individuals in recovering from serious mental illness. If we look back just a few years we can see that many of the recent changes we have made in our system and approach to care have been preparing for the natural next step of becoming a Healthcare Home.

The creation of the CPR Program established a team approach to care, and focused attention on the importance of meeting a broad array of needs (housing, work, recreation, etc.) to successfully support individuals with serious mental illness.

The availability of a range of new health information technology tools, including the Behavioral Pharmacy Management Program, Disease Management Report, Medication Adherence Report and CyberAccess, has both improved the quality of care we provided, and pointed us toward a closer working relationship with the larger healthcare system.

Creating the nurse liaison positions was a major step in helping us better utilize the new health information technology, and in introducing a much stronger focus on the general health care needs of consumers.

Three years ago, DMH in partnership with the Coalition and the Primary Care Association began supporting local FQHC/CMHC collaborations aimed at integrating behavioral health consultants into FQHC primary care teams and improving access to primary care for CMHC consumers as one strategy for treating "the whole person".

More recently, CMHCs began screening consumers for metabolic syndrome in recognition, at least in part, that our own medication management can negatively impact an individuals overall health.

Finally, we began reaching out to individuals with serious mental illness that we had not seen before, but who had significant health problems as indicated by their utilization of general healthcare services.

All of these initiatives have prepared us for, and led us to the next step: Becoming a Healthcare Home!

This is the CMHCs commitment statement to becoming a Healthcare Home.
<Insert agency logo>

We are committed to this next step: managing the full array of physical health needs, in addition to behavioral health care needs, as well as needed long-term community services and supports, and social and family services for individuals enrolled in our Healthcare Home.

As we will see, we are already fulfilling many of the Healthcare Home functions in our CPR program.

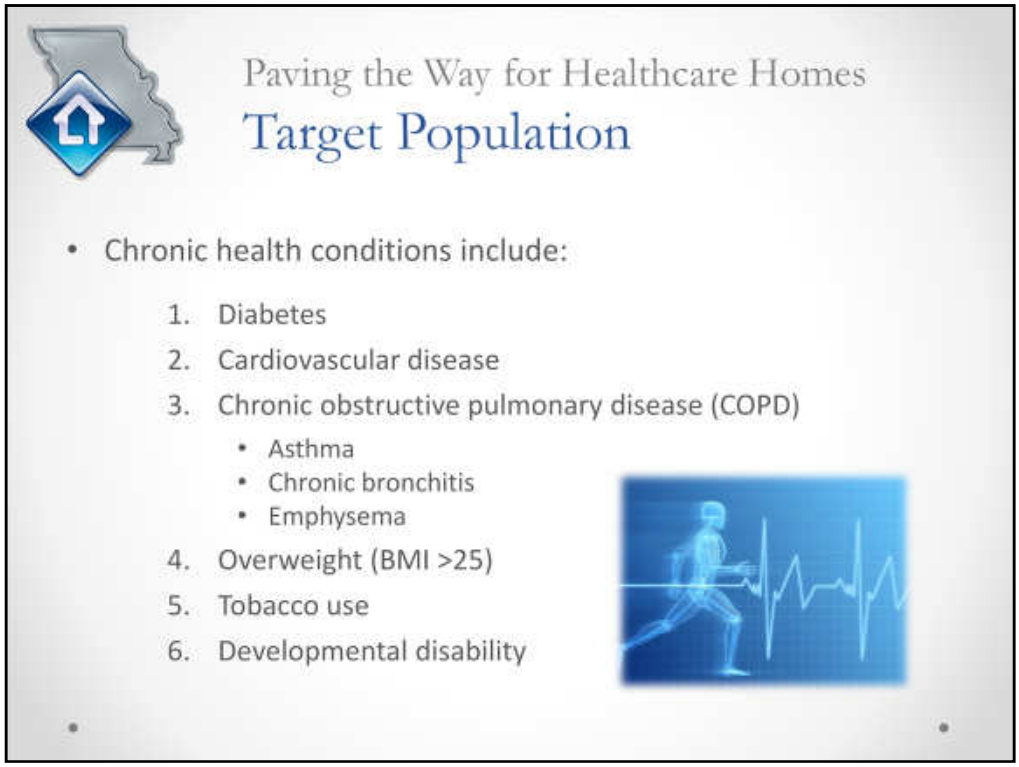
This slide and the next outline the target population for CMHC Healthcare Homes.

To be eligible for enrollment in our Healthcare Home, an individual must meet one of the following three conditions:

1. They have a serious and persistent mental illness. This includes adults who meet the criteria for enrollment in CPR and children with SED. OR

2. They have a mental health condition and a substance abuse disorder. OR

3. They have a mental health condition OR substance abuse disorder AND one other chronic health condition.



There is no need to read this slide aloud.

This slide shows what are considered "other chronic health conditions".

So, to summarize, an individual is eligible for enrollment in a Healthcare Home simply by meeting the criteria for enrollment in the CPR program or the criteria for having an SED. They are not required to meet any other conditions.

Individuals with mental health conditions other than a serious and persistent mental illness are eligible for enrollment if they also have a substance abuse disorder, or diabetes, cardiovascular disease or COPD; or if they are overweight, use tobacco or have a developmental disability.

Similarly individuals with a substance abuse disorders are eligible for enrollment if they have a mental health condition, or diabetes, cardiovascular disease, or COPD.; or if they are overweight, use tobacco or have a developmental disability.

In short, the vast majority of individuals we serve will be eligible for enrollment in our Healthcare Home.

This slide and the next list Healthcare Home functions that are already being provided by CPR teams. It is not necessary to read through all of these functions. Pick a few to highlight. The point is to emphasize that we are already performing many Healthcare Home functions and so the next step is more about enhancing, rather than changing, what we do.

As I indicated earlier, we already perform many Healthcare Home functions in our CPR Program. Particularly if you keep in mind our primary target population as a CMHC Healthcare Home is individuals with serious and persistent mental illness, it is obvious we already fulfill many Healthcare Home functions for this population. Whether it is monitoring health status and adherence, developing individualized plans of care, or promoting consumer self-management, as listed on this slide, or **[turn to next slide]**

Providing individualized services and supports, linking consumers with community and social supports, or utilizing health information technology to manage care, we are well positioned to serve as a Healthcare Home.

The topics listed on this slide and the next are the areas that will be receiving the most attention in the move to becoming a Healthcare Home, and will also be the areas in which CPR will receive additional staffing and training. The extent to which agencies have already given emphasis to these issues varies, so acknowledge your progress, but also encourage continued growth. Of course, give special attention to areas you believe need more work.

Though we have been steadily moving toward a "whole person" approach, to fully embrace this approach and function as a comprehensive Healthcare Home, we will need to give added emphasis to several aspects of care.

We know that being healthy is not just about getting treatment when we are sick, and we have, of course, begun to take seriously health and wellness, but this is likely an area that we will need to continue to develop our skills.

We'll need to assure that individuals enrolled in our Healthcare Home have access to good preventive and primary care. This means not just that they can say who their primary care physician is, but also that they have been seen regularly and received appropriate screenings and preventive care.

Because so many people we serve have other chronic physical health conditions that have previously gone undetected or inadequately treated, focusing on good chronic care and helping people learn how to manage their chronic conditions will be a major emphasis.

We already have experience with admissions and discharges to psychiatric inpatient units. Now we will also be facilitating admissions and discharges related to general medical conditions for the individuals we serve.

Our experience in using health information technology has prepared us well for even greater utilization of these tools.

Finally, we've provided education and supports for families whose loved ones are dealing with serious mental illness. Now we'll be called upon to also provide information and supports to help families understand and deal with the general medical and chronic physical health conditions of their loved ones.

The next seven slides explain how CPR teams will be augmented in order to create a Healthcare Home Team capable of fulfilling all the Healthcare Home functions.

Medicaid funding for our Healthcare Home will enable us to augment CPR teams by adding consultation by a physician, additional nurse care managers, and enhancing training for community support specialists so that we can fulfill all of the responsibilities of serving as a Healthcare Home and better meet the needs of the people we serve.

You'll note that in some cases individuals who are not nurses may be trained to fulfill the nurse care manager responsibilities. But the Department has made it clear that this will be the exception and not the rule. Increasing our nursing capacity is critical to fulfilling our responsibilities.

Most of the people enrolled in our Healthcare Home will be enrolled in CPR and have a community support specialist who is working with them. However, there may be some individuals who are enrolled in the Healthcare Home who do not have a community support specialist. If this happens, then the nurse care manager will perform the needed community support functions that would otherwise be performed by the community support specialist.

Behavioral health clinicians and CPR teams will continue to perform the same functions they always have.

In general community support specialists will still have the same responsibilities and perform the same functions. But we know that the personal support that community support specialist provide to the individuals they work with is critical to helping make the changes that promote recovery. Therefore, over time, community support specialists will receive enhanced training designed to enable them to better assist the individuals they work with adopt healthy lifestyles, learn how to manage chronic health conditions, and better utilize primary care services.

We will be adding a Healthcare Home director who will be responsible for overseeing the implementation of the Healthcare Home.

Note: If you are an agency that serves more than one region, you may be approved to have a Healthcare Home director for each region.

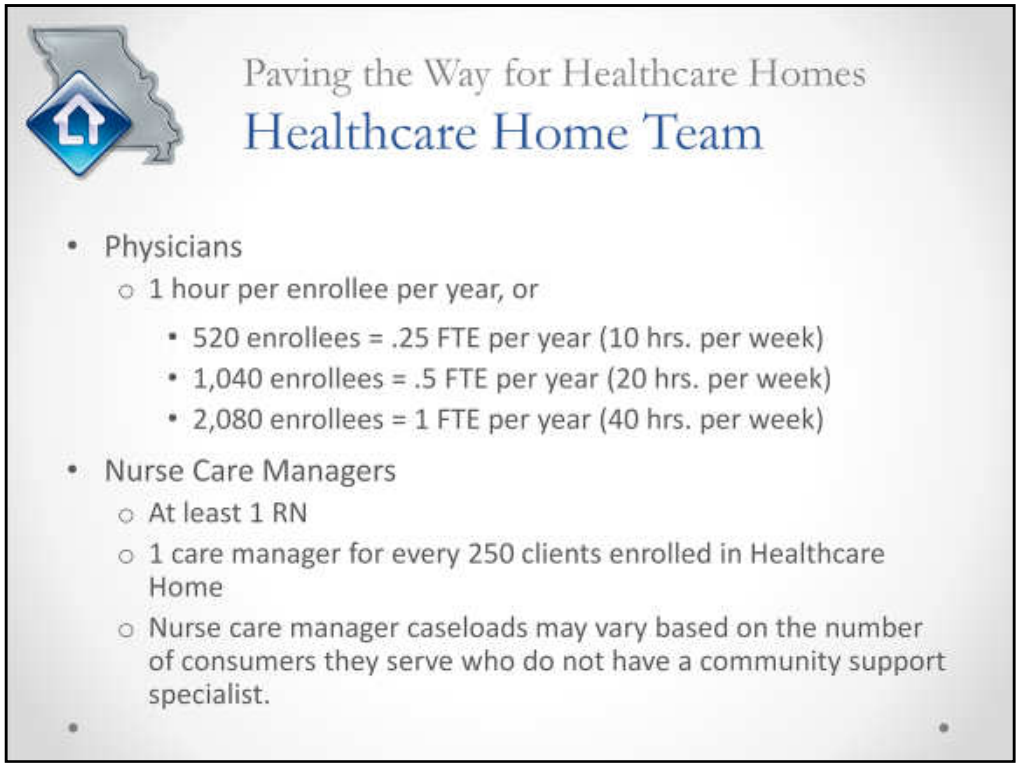
The Healthcare Home director will be responsible for providing leadership for the overall development of the Healthcare Home, and will champion the practice transformation that will be required. The Healthcare Home director will both develop working relationships with other healthcare providers, and monitor performance of the Healthcare Home in meeting program standards and improving performance. The director may also be involved in designing and developing health and wellness initiatives for our consumers.

In addition, a physician will be providing medical leadership for the Healthcare Home functions by participating in treatment planning and consulting with team psychiatrists as appropriate , consulting with CPR teams on specific consumer health issues, assisting in coordination with external medical providers, and assuring the Healthcare Home meets standards of care.

Nurse care managers are fundamental to successfully fulfilling the Healthcare Home responsibilities. **[Read through the dot points on this slide and the next.]**

[After reading through these dot points add:]

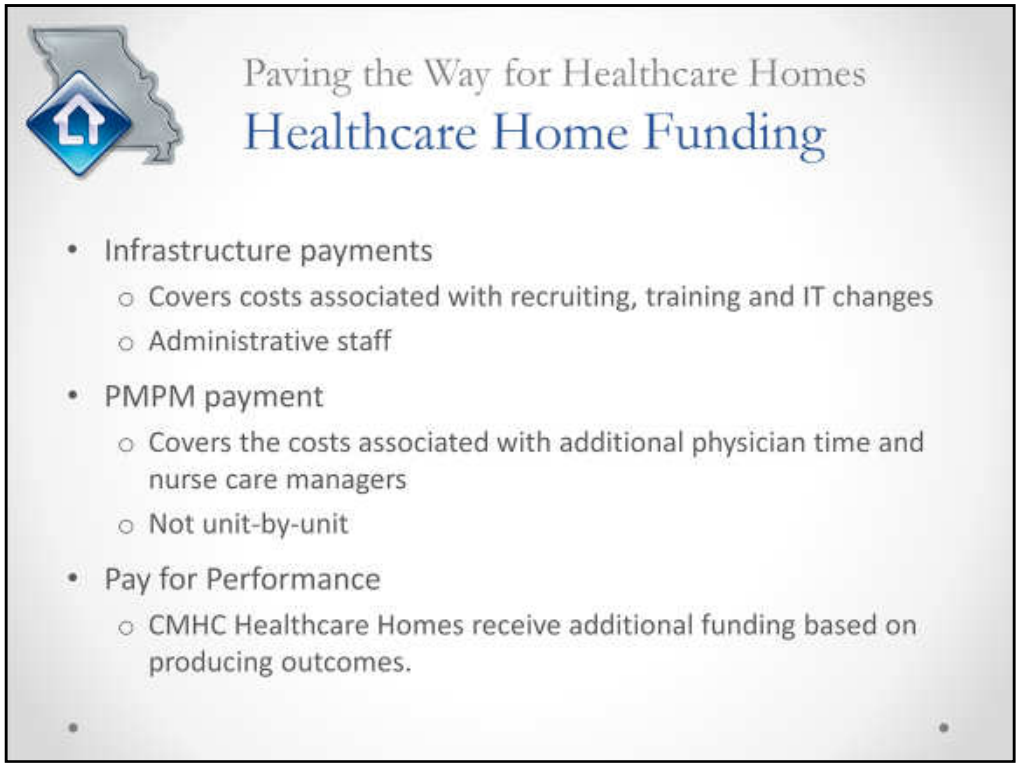
The current nurse liaisons have obviously fulfilled many of these functions, and they will continue to do so in the future, only there will be more of them so that they have manageable caseloads, and they will be called “nurse care managers.”



We'll be adding enough physician consultation to assure at least a quarter time physician for every 520 clients enrolled in the Healthcare Home. **[Note other examples if needed]** We currently have about **[#_____]** consumers enrolled in CPR, so if all of them are enrolled in the Healthcare Home, that means we will be adding at least **[# _____ hours per week]** physician to provide consultation.

The state requires that at least one nurse care manager be an RN, but LPNs are also eligible to serve as nurse care managers. We will be adding enough nurse care managers to assure that we have at least one for every 250 clients enrolled in the Healthcare Home. If we hire a care manager that is not a nurse, then they will be mentored by one of the nurse care managers, and the caseload of the nurse care manager may be reduced somewhat.

Nurse care managers will also have smaller caseload if they are serving a number of consumers who do not have a community support specialist.



The additional Healthcare Home staffing is funded through two new payment mechanisms.

We will receive time limited infrastructure payments to cover the costs associated with recruiting, training the new staff, IT changes, as well as new training for existing staff.

We'll also receive ongoing infrastructure payments to cover the cost of the Healthcare Home director and support staff.

The costs associated with the additional physician consultation and nurse care managers will be covered by a PMPM (per member per month) payment from Medicaid for each individual enrolled in the Healthcare Home. The PMPM payment allows us to cover the costs associated with comprehensive care management, care coordination, health and wellness education activities and transitional care activities that we have not previously had any way to support.

In addition, if we perform well in improving outcomes for the people we serve, there will be an opportunity to receive additional pay for performance funding.

This slide introduces larger organizational and practice transformations that will accompany the effort to successfully fulfill the Healthcare Home functions. Some of these changes are not just as a result of the Healthcare Home initiative, but are necessary in order to improve efficiency and compete in the larger health care system. Select one or two of these that you understand best to highlight.

There are something changes we need to make as organization, not just to fulfill the Healthcare Home functions, but to continue to improve our efficiency and compete in the larger health care system as health care reform becomes a greater reality.

In particular we will be looking at ways to improve the time it takes for new people seeking service to get care, and as well as the time it takes existing consumers to access the services they need. For example, we'll be looking at open access scheduling which might allow existing consumers to get in much sooner for an acute need.

We will also have new outcome measures to track and report, as well as other new data to collect, analyze and report.

But, as we'll see in a moment, we'll have some help in addressing these issues.

The next two slides introduce the training program being developed by DMH and the Coalition. They do not provide much detail. The narrative below provides a bit more content for each phase of the Systems Change Training. At this point, it is enough to know that there will be a major training initiative beginning with the Access to Care in July and Healthcare Home 101 training in August.

DMH and the Coalition are developing a major training initiative to accompany implementation of the CMHC Healthcare Homes. There are three components to the training:

1. Training designed to assist CMHC's in understanding and implementing the Healthcare Home initiative as specified in state rules, regulations and manuals. This "Healthcare Home 101" training will be provided beginning in August.
2. Training designed to change the way we provide care and to improve efficiency. This "Systems Change Training" has three phases and will involve staff through out the organization.
   - Phase I begins this summer. MTM Services has been retained to assist the CMHC in assessing and improving access to care in their organizations.
   - Phase II will begin in December and involves participating in a Learning Collaborative with the other CMHC's designed to enhance service delivery and promote practices supporting a "whole person" approach to care.
   - Phase III will begin next summer and is designed to help us meet national Healthcare Home accreditation or certification standards, as adopted by the State of Missouri.

The third training component focuses on the new Healthcare Home staff and community support specialists.

It is designed to assure that the new staff understand the Healthcare Home model, incorporate appropriate person-centered and "whole person" strategies, and have the knowledge and skills they require to understand and assist in managing chronic diseases, and to work with child and adolescents with a basic understanding of wellness.

It will also be designed to enable community support specialists to better assist the individuals they work with adopt healthy lifestyles, learn how to manage chronic health conditions, and better utilize primary care services.

This training will begin in September and will be ongoing.

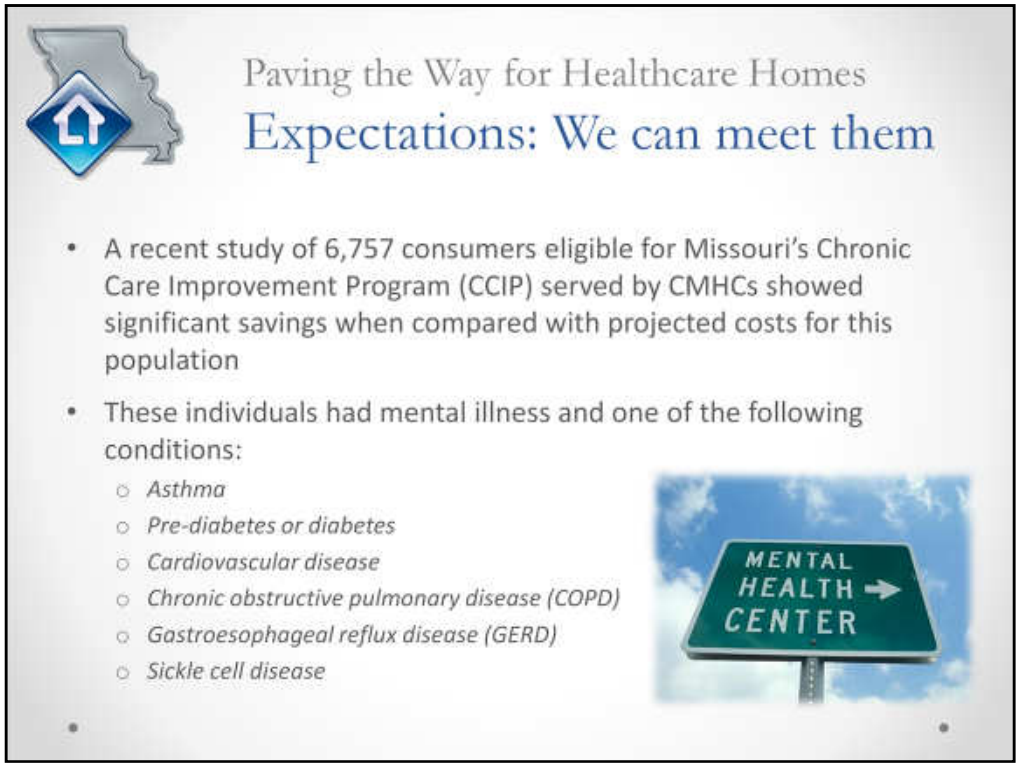
This slide lists some of the expectations CMS laid out in its letter to the states introducing the Healthcare Home opportunity. The purpose of this slide is to show that CMS is expecting Healthcare Homes to have a significant impact on the people served and the system of care. The next two slides show that we have good reason to believe we can meet these expectations based on our past performance.

As you can see, the Center for Medicare and Medicaid have high expectations for the Healthcare Home program. **[Read the dot points.]**

These are high expectations but we have reason to believe we can meet them.

HEDIS stands for Health Effectiveness Data and Information Set

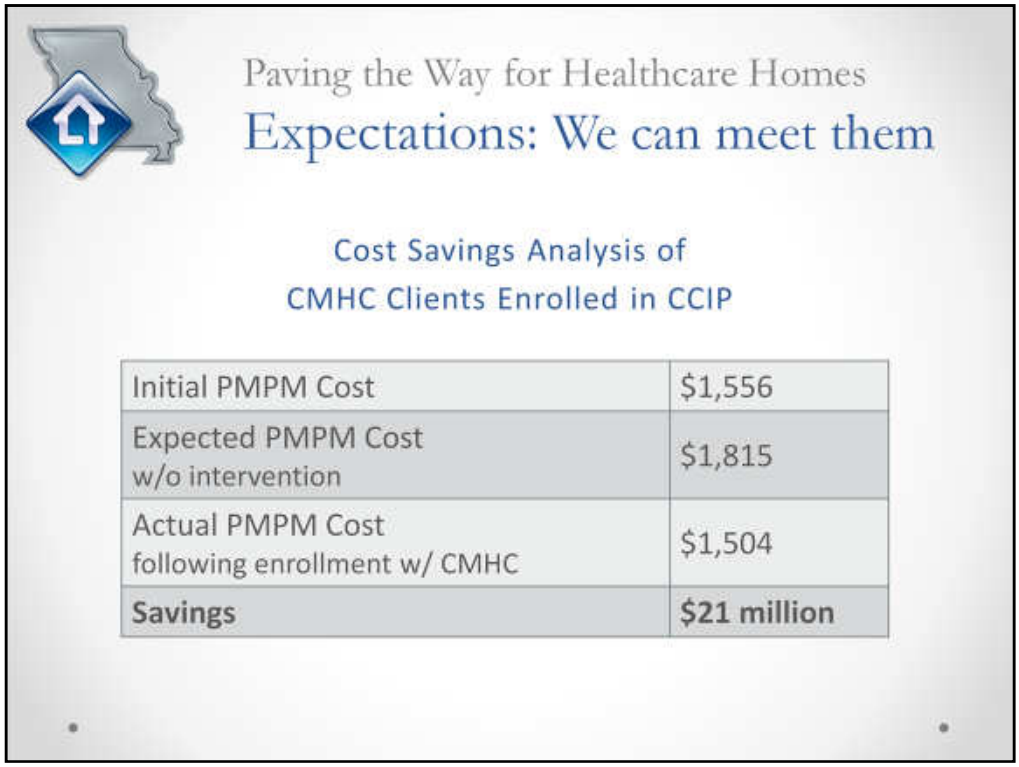
HEDIS indicators are "used by more than 90% of America's health plans to measure performance on important dimensions of care and service." (NCQA, "HEDIS and Quality Measurement")



These next two slides show that we can have made the kind of impact CMS expects.

You may be aware that we participated in the state Chronic Care Improvement Program (CCIP). The individuals we served in this program had a mental illness and one of the other chronic health conditions listed on this slide – very much the same conditions that are included in the Healthcare Home initiative.

Collectively, the CMHC's served 6757 individuals who were eligible for the CCIP program.



This slide shows the results of a study of what happened to the individuals enrolled in CCIP and served by the CMHCs.

The year before CCIP enrollment, the per member per month cost to Medicaid for these individuals was $1556. Health care analysts projected that without the CMHC intervention, the PMPM costs would rise to $1815 in one year. The actual PMPM cost for consumers served by the CMHC's after one year was $1504. Note that this is less than the $1556 PMPM for the previous year. But more importantly, it is dramatically less than the project upward trend in cost for these individuals. The difference between the actual PMPM of $1504 and the projected PMPM of $1815 is $311 per member per month. When you multiply $311 times 12 for a year's cost times the 6757 consumers served, you get a savings off of projected costs of more than $21 million.

We know how to do this work, and we can get better at it as well.

This slide provides general timelines for implementation of the Healthcare Home initiative.

The Medicaid state plan amendment, which would authorize reimbursement for Healthcare Homes, was submitted to the Centers for Medicare and Medicaid (CMS) in June. At the end of June, the PowerPoint I have just presented to you was presented to the CMHCs at the Coalition annual meeting so that we could in turn present it to you.

At the same time, we were given an application for CMHC Healthcare Home Provider Status to complete and submit to DMH by July 20th.

Also in June, the Coalition contracted with M.T.M. Services to conduct Phase I of the Systems Change training which focuses on assess and improving access to care. This month M.T.M. has already been working with us to collect and analyze data on how consumers access our services.

Right now DMH is working with MO HealthNet to finalize the rules, regulations and handbooks for the Healthcare Home program. In August we will get training on those rules and regulations. It is expected that CMS will approve the state plan amendment by the end of August, and that we will be designated as a Healthcare Home by September and will receive our first infrastructure payment at that time. Healthcare Home team training will begin then and continue through December when we anticipate being able to begin enrolling consumers, providing Healthcare Home services and receiving PMPM payments.

Any questions you may receive during your presentation that you either need feedback or would like to share with the rest of the CMHC providers, can be forwarded to Dorn Schuffman and Rachelle Glavin. Technical assistance will be offered and questions with feedback will be distributed to the CMHCs.

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HEALTHCARE HOME IMPLEMENTATION

"Paving the Way for Healthcare Home"

<Insert Agency Name>	<Insert Date>
<Insert Location>	<Insert Time>
<Insert Presenter(s) Name>	<Insert Presenter(s) Title/Position>
Please email sign-in sheets to Susan Blume, susan.blume@dmh.mo.gov, at the Department of Mental Health.	

Name	Title/Position

MO HealthNet and Department of Mental Health

Application for Healthcare Home Service Provider Status as a Community Mental Health Center

Healthcare Home

CMHC HEALTHCARE HOME

APPLICATION

June 28, 2011

Agenda

- CMHC Healthcare Home Application Form
- Provider Requirements
  - Initial Requirements
  - Ongoing Requirements
- Healthcare Home Program Requirements

Paving the Way for Healthcare Homes

Why CMHC Healthcare Homes?

- Because it's the natural next step for Missouri

Step One: Implementing Psychiatric Rehabilitation Program

Step Two: Implementing Health Information Technology Tools

- CMT data analytics
  - Behavioral Pharmacy Management Program
  - Disease Management Report (HEDIS indicators)
  - Medication Adherence Report
- CyberAccess

Paving the Way for Healthcare Homes

Why CMHC Healthcare Homes?

- Because it's the natural next step for Missouri

Step Three: Building Integration Initiatives

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

Step Four: Embracing Wellness and Prevention Initiatives

- Metabolic syndrome screening
- DM 3700 initiative

Next Step: Becoming a Healthcare Home

CMHC Healthcare Home

Application Form

- Section A: Practice Site Information
- Section B: Healthcare Home Transformation
- Section C: Current Performance and Areas Requiring Prompt Remediation

SECTION A: PRACTICE SITE INFORMATION

1. General Information for CMHC

a. Name of CMHC:	
b. Name of person completing application:	Title: Email: Phone:
c. Address of CMHC sites applying for Healthcare Home recognition that will have a Healthcare Home Director or Nurse Case Manager either onsite or providing services at the locations:	
d. Name of Governing Board President:	Email: Phone:
e. Name of CEO:	Email: Phone:
f. CMHC Federal Tax Identification Number:	
g. If the CMHC is part of a larger organization, please identify the name of the larger organization:	
h. Are you currently accredited as a Healthcare Home? i. If so, what national accrediting agency did you use?	

2. **CMHC Clinicians with Patient Panels:** Please provide totals in full-time equivalences (FTEs) and subtotals by category of clinician in number of people filling those positions, to the extent that the CMHC has such personnel and whether the positions are staffed or vacant:

a. Total Physician FTEs_____ • # of staffed full-time physicians_____ • # of staffed part-time physicians_____ • # of vacant full-time physician positions_____ • # of vacant part-time physician positions_____	b. Total Nurse Practitioner (NP) FTEs_____ • # of staffed full-time NPs_____ • # of staffed part-time NPs_____ • # of vacant full-time NP positions_____ • # of vacant part-time NP positions_____
c. Do individual physicians and NPs each have defined panels of patients? _____Yes _____No	

3. Medical Records

a. If the CMHC uses an electronic health record (EHR):
   i. What vendor do you use?
   ii. Does it meet meaningful use?
   iii. When was it implemented?
   iv. What functions does it serve?

Comments (optional):

b. If the CMHC does not use an EHR, does the CMHC have plans to implement an EHR?
   i. In 2011? _____Yes _____No
   ii. In 2012? _____Yes _____No

Comments (optional):

c. Are you a member of a Regional Health Information Exchange, if so which one?

Comments (optional):

d. How many CyberAccess registered users do currently have total for the CMHC?

e. Who are your registered CyberAccess Practice/Site Administrator(s) employed by your organization?

Section B: Healthcare Home Transformation

- Describe
  - Your goals and objectives in providing healthcare home services (1 paragraph)
  - The experience of the Healthcare Home Director, the challenges he or she will face in implementing the Healthcare Home in your organization, and what he or she will do to ensure the successful evolution of your Healthcare Home (2 or 3 paragraphs)
  - How you will involve patients, families and/or caregivers in the process of defining the elements of a 'person-centered' CMHC, giving one or two examples (2 or 3 paragraphs)

Section B: Healthcare Home Transformation

- Describe
  - The successes and challenges you have faced in implementing the DMH Net initiative and the DM 3700 project, and how these experiences translate into implementing a Healthcare Home. (2 or 3 paragraphs)
  - What your organization expects to gain from the systems change training on Access to Care
  - Your organization's history of use of the quarterly disease management report (HEDIS indicators)
  - Your commitment to conducting wellness interventions based on a clients' level of risk

Section B: Healthcare Home Transformation

- Identify
  - Your organization's leadership team
    - CEO/President, CFO, Clinical Director and CPRC Director
    - These individuals will participate in Leadership and Organizational training
  - Your proposed additional Healthcare Home staff
    - Healthcare Home Director(s), Physician Leader, and Nurse Care Managers
    - These individuals will participate in Healthcare Home Team training

Section B: Healthcare Home Transformation

- Provide
  - Your proposed Healthcare Home staffing plan
    - Expected enrollment
    - Physician leadership FTE
    - Nurse care manager FTEs
    - Expected nurse care manager caseloads
    - Healthcare Home Director(s)
  - Anticipated training needs

Potential Auto-Enrollment for CMHC Healthcare Homes

	Total Consumers w/ CMHC Claims 3 months	[illegible]	[illegible]
Pathways Community Behavioral Healthcare, Inc.	2,5[illegible]	10.74	1.2[illegible]
Burrell Behavioral Health Care Center	1,8[illegible]	7.50	0.91
BJC Behavioral Health	1,7[illegible]	7.23	0.89
Crider Health Center, Inc.	1,0[illegible]	4.30	0.52
Family Guidance Center	7[illegible]	3.04	0.37
Community Counseling Center	643	2.58	0.31
Truman Medical Center Behavioral Health	542	2.27	0.28
Swope Health Services	5[illegible]	2.23	0.26
ReDiscover	455	1.87	0.24
Mark Twain Association for Mental Health, Inc.	4[illegible]	1.9	0.22
Clark Center	4[illegible]	1.81	0.22
Tri-County Mental Health Services	445	1.79	0.2[illegible]
Comprehensive Mental Health Services	424	1.68	0.20
Family Counseling Center, Inc.	3[illegible]	1.53	0.18
Bootheel Counseling Services	3[illegible]	1.52	0.1[illegible]
Hopewell Center	3[illegible]	1.42	0.1[illegible]
Adapt of Missouri, Inc.	3[illegible]	1.37	0.1[illegible]
Community Treatment, Inc.	315	1.27	0.15
New Horizons Community Support Services	3[illegible]	1.24	0.15
Preferred Family Healthcare, Inc.	3[illegible]	1.22	0.15
East Central Missouri Behavioral Health Services	280	1.12	0.14
North Central Missouri Mental Health Center	275	1.1	0.13
Places For People	24[illegible]	1.02	0.12
Ozarks Medical Center	22[illegible]	0.91	0.11
Independence Center	20[illegible]	0.84	0.10
Comprehensive Health Systems, Inc.	172	0.82	0.09
[illegible] Community Mental Health Center	17[illegible]	0.68	0.0[illegible]
	15,2[illegible]	62	7.60

Healthcare Home Application Form

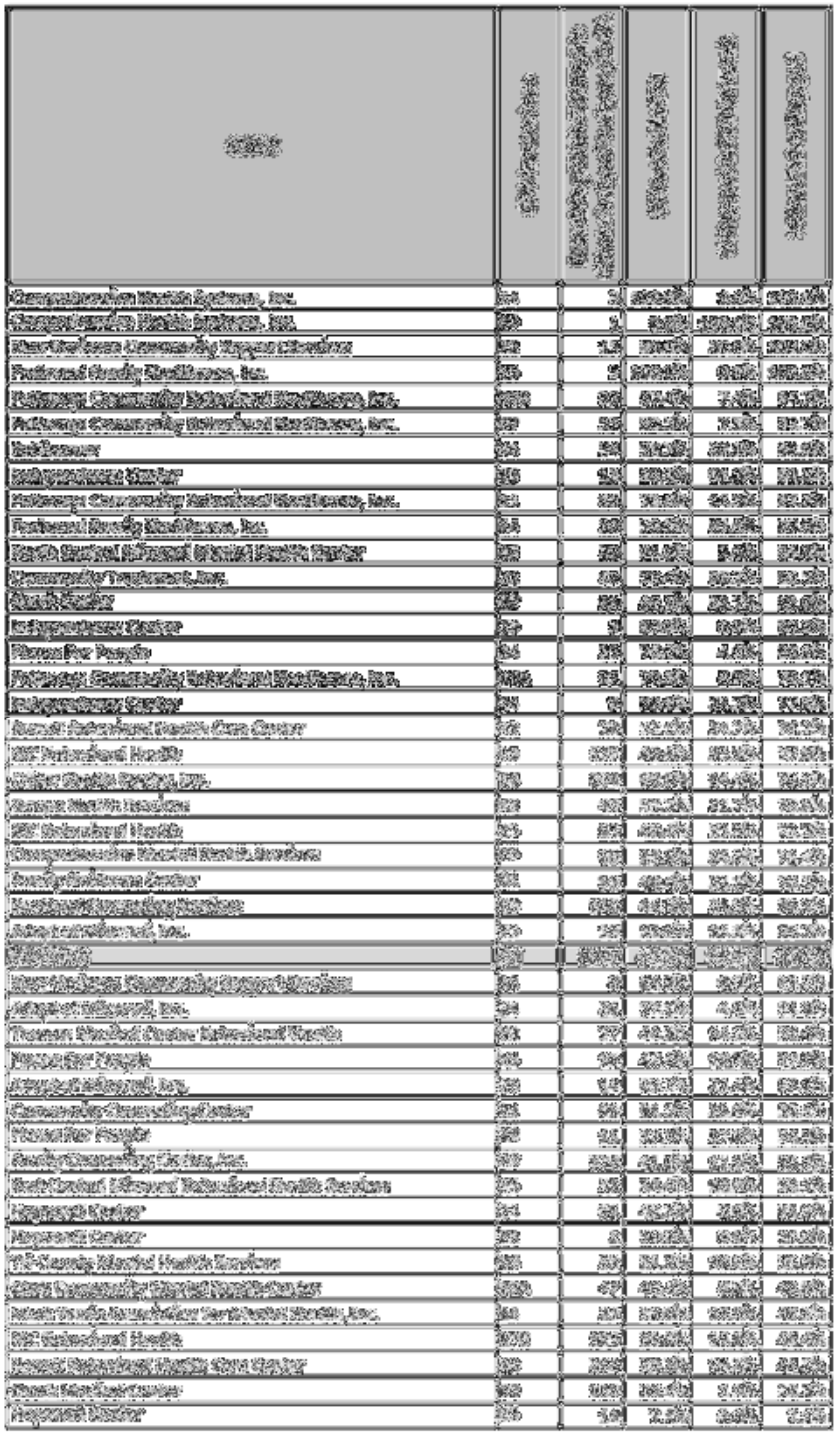
Section C: Current Performance/Expected Remediation

- Benchmark Reports
  - Completion Rate of Metabolic Screenings
  - Enrollment and Outreach Percentage of DMH 3700 Clients
  - Completion Rate of CPS Adult and Youth Status Reports
  - Completion Rate of MHSIP Surveys
  - CyberAccess Patient History Utilization
  - CMHC Behavioral Pharmacy Management Report
- Provide a plan of correction or proposed approach to improving performance for each of the above measures on which your agency is performing below the average of your peers.

Completion Rate of Metabolic Screenings

Agency	[illegible]	[illegible]	%
BJC - 17[illegible]	557	493	113.[illegible]%
Ozarks Medical Ctr.	203	273	74.4%
North Central MO Mental Health Ctr.	249	33[illegible]	73.4%
Independence Ctr.	1[illegible]	22[illegible]	71.5%
BJC	1242	19[illegible]	6[illegible]%
Preferred Family Healthcare	2[illegible]	427	5[illegible].7%
Mark Twain Behavioral Health	2[illegible]	4[illegible]	5[illegible].2%
Community Counseling Ctr.	3[illegible]	7[illegible]	48.[illegible]%
Comprehensive Health Systems	78	161	48.4%
Burrell Behavioral Health 10	7[illegible]	16[illegible]	43.1%
Swope Health Ctr.	14[illegible]	37[illegible]	38.2%
Arthur Ctr.	171	4[illegible]	3[illegible]%
[illegible]	[illegible]	[illegible]	[illegible]
Burrell Behavioral Health 12	345	957	36.1%
ReDiscover	302	894	33.8%
Places for People	73	220	33.2%
Hopewell	159	481	33.1%
Pathways Behavioral Healthcare	1041	3161	32.9%
Comtrea	153	560	27.3%
Comprehensive Mental Health	117	434	27.0%
Family Guidance Ctr.	227	857	26.5%
Ozark Center	192	730	26.3%
Adapt	82	358	22.9%
Bootheel Counseling Ctr.	95	451	21.1%
New Horizons	62	322	19.3%
Tri-County Mental Health Services	142	748	19.0%
Clark Mental Health Ctr.	37	203	18.2%
Family Counseling Ctr.	61	451	13.5%
Truman	59	686	8.6%
Crider	8	1579	0.5%
Mineral Area	0	66	0.0%
SEMO CTC	0	45	0.0%

Enrollment and Outreach % of DM 3700 Clients



Completion Rate of CPS Adult Status Report

Agency/Site	Adult CPS Admissions	ADS Completed upon CPS Admission*	Completion Rate
[illegible] of Missouri - Service Area 18	4	4	100.0%
[illegible] of Missouri - Service Area 14	27	27	100.0%
[illegible] Health Sys - Service Area 14	32	32	100.0%
[illegible] Health Sys - Service Area 13	8	8	100.0%
Family Counseling Center, Inc.	139	139	100.0%
Independence Center - Service Area 18	6	6	100.0%
Independence Center - Service Area 19	5	5	100.0%
Independence Center - Service Area 20	4	4	100.0%
New Horizons (CPS Service Area 14)	14	14	100.0%
[illegible] Medical Center	80	78	97.5%
North Central Missouri Mental Health Center	43	41	95.3%
Preferred - Service Area 10	26	24	92.3%
[illegible] of Missouri - Service Area 17	55	50	90.9%
Places for People - Service Area 24	11	10	90.9%
Mineral Area CPRC	10	9	90.0%
Ozark Center	180	161	89.4%
Community Counseling Center	54	48	88.9%
Places for People - Service Area 19	8	7	87.5%
Preferred - Service Area 20	7	6	85.7%
Burrell Behavioral Health - Service Area 15	206	172	83.5%
New Horizons (CPS Service Area 16)	90	75	83.3%
Crider Health Center, Inc.	160	130	81.3%
Mark Twain Association for Mental Health, Inc.	58	46	79.3%
Burrell Behavioral Health - Service Area 12	175	138	78.9%
Preferred - Service Area 13	18	14	77.8%
Pathways (CPS Admin Agent Service Area 18)	144	111	77.1%
BJC - St. Louis City (Service Area 22)	83	64	77.1%
Places for People - Service Area 22	4	3	75.0%
Pathways (CPS Admin Agent Service Area 7)	105	78	74.3%
East Central Missouri Behavioral Health Services	98	72	73.5%
All Agency CPS Admissions	3175	2300	72.4%
Clark Community Mental Health Center	11	8	72.7%
Pathways (CPS Admin Agent Service Area 11)	149	106	71.1%
Pathways (CPS Admin Agent Service Area 17A)	127	87	68.5%
BJC - St. Louis County (Service Area 23)	245	165	67.3%
ReDiscover	89	58	65.2%
Bootheel Counseling Services	64	41	64.1%
Truman Medical Center Behavioral Health	52	29	55.8%
BJC - Farmington (Service Area 17B)	73	40	54.8%
Family Guidance Center	94	50	53.2%
Hopewell Center	52	25	48.1%
Tri-County Mental Health Services	74	31	41.9%
Community Treatment, Inc.	180	65	36.1%
Comprehensive Mental Health Services	21	6	28.6%
Swope Health Services	50	12	24.0%
BJC - St. Patrick Center (ACT) - SA 23	1	0	0.0%
Southeast Missouri Behavioral Health, Inc.	1	0	0.0%

Completion Rate of CPS Youth Status Report

Agency Site	Youth CPS Admissions	YSR Completed upon CPS Admission*	Completion Rate
Burrell Behavioral Health - Service Area 22	43	43	100.0%
North Central Missouri Mental Health Center	18	18	100.0%
Ozarks Medical Center	12	12	100.0%
Mark Twain Association for Mental Health, Inc.	57	54	94.7%
Pathways (CPS Admin Agent Service Area 7)	60	56	93.3%
Bootheel Counseling Services	25	23	92.0%
Pathways (CPS Admin Agent Service Area 11)	49	45	91.8%
Pathways (CPS Admin Agent Service Area 17A)	39	33	84.6%
Clark Community Mental Health Center	30	25	83.3%
Burrell Behavioral Health - Service Area 12	40	33	82.5%
Pathways (CPS Admin Agent Service Area 8)	46	37	80.4%
Crider Health Center, Inc.	194	149	76.8%
BJC - St. Louis City (Service Area 23)	12	9	75.0%
Community Counseling Center	25	18	72.0%
Hopewell Center	38	27	71.1%
All Youth CPS Admissions	[illegible]	[illegible]	[illegible]
Ozark Center	63	33	52.4%
BJC - Farmington (Service Area 17B)	18	10	55.6%
Community Treatment, Inc.	39	22	56.4%
BJC - St. Louis County (Service Area 25)	41	22	53.7%
Tri-County Mental Health Services	78	41	52.6%
East Central Missouri Behavioral Health Services	30	15	50.0%
ReDiscover	15	7	46.7%
Family Counseling Center, Inc.	25	10	40.0%
Swope Health Services	36	8	22.2%
Family Guidance Center	127	15	11.8%
Comprehensive Mental Health Services	18	1	5.6%
Truman Medical Center Behavioral Health	11	0	0.0%

Completion Rate of MHSIP Surveys (Adult)

Agency	[illegible] MHSIP Surveys Returned	[illegible] Open (Adults) [illegible]	[illegible] MHSIP Completion Rate
Comprehensive Health Systems	[illegible]	139	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
New Horizons SA12	[illegible]	219	[illegible]
[illegible]	[illegible]	367	[illegible]
[illegible]	[illegible]	211	[illegible]
Independence Center	[illegible]	251	[illegible]
Family Counseling	[illegible]	456	[illegible]
New Horizons SA11	85	235	[illegible]
[illegible] Counseling	[illegible]	635	[illegible]
[illegible]	227	645	[illegible]
[illegible] Family	121	395	[illegible]
Pathways SA07	[illegible]	380	[illegible]
[illegible]	[illegible]	475	[illegible]
Pathways SA[illegible]	[illegible]	795	[illegible]
Burrell SA12	[illegible]	[illegible]	[illegible]
[illegible]	65	285	[illegible]
Burrell SA18	[illegible]	1042	[illegible]
Places For People	7[illegible]	292	[illegible]
North Central	61	317	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
Clark Center	[illegible]	255	[illegible]
[illegible] Center	223	1432	[illegible]
Family Guidance	120	783	[illegible]
BJC SA17B	71	615	[illegible]
East Central	21	204	[illegible]
Comprehensive Mental Health	43	435	[illegible]
BJC SA25	112	1210	[illegible]
BJC SA2[illegible]	[illegible]	[illegible]	[illegible]
ReDiscover	70	[illegible]	[illegible]
Tri County	75	1325	[illegible]
Pathways SA11	33	617	[illegible]
Pathways SA17A	[illegible]	395	[illegible]
[illegible] Center	[illegible]	434	[illegible]
[illegible]	12	402	[illegible]
[illegible]	24	651	[illegible]
Hopewell Center	[illegible]	454	[illegible]
[illegible] Area	[illegible]	[illegible]	[illegible]

Completion Rate of MHSIP Surveys (Youth)

Agency	Youth CPR MHSIP Surveys Returned	Youth CPR Clients w/ 1 yr LOS	Youth CPR MHSIP Completion Rate
Swope Parkway	75	115	65.22%
NuDiscover	35	80	43.75%
Mark Twain	65	149	43.62%
Burrell SA12	67	177	37.85%
Comm Counseling	35	117	29.91%
Ozarks Medical	18	54	33.33%
BJC SA25	17	58	29.31%
Pathways SA06B	33	123	26.83%
BJC SA17B	19	98	23.47%
North Central	19	96	19.79%
Youth CPR Subtotal	[illegible]	[illegible]	[illegible]
Pathways SA07	25	147	17.01%
Burrell SA10	53	308	[illegible]
Pathways SA11	25	165	15.15%
Tri County	17	114	14.91%
East Central	7	49	14.29%
Crider Center	54	451	11.97%
Clark Center	5	52	9.62%
Family Guidance	12	140	8.57%
Truman	5	67	7.46%
Bootheel	2	37	5.41%
BJC SA23	6	114	5.26%
Pathways SA17A	2	127	1.57%
Comprehensive Mental Health	0	59	0.00%
Cardea	0	47	0.00%
Family Counseling	0	31	0.00%
Hopewell Center	0	29	0.00%
[illegible] Center	0	65	0.00%

CyberAccess Patient History Utilization

	Patient History Review (Total)	Patient History Review (Month)	# Cases with EOC (Tier 1)	Avg Hits per Case with EOC
New Horizons	22,493	11,063	459	2.48
Independence Center	1,945	1,021	209	2.29
Burrell	21,277	11,401	5,021	2.03
Pathways	90,472	41,575	5,098	1.95
Places for People	4,989	4,241	337	1.16
Comprehensive Health	1,942	1,421	127	1.12
Preferred Family	3,890	3,480	424	1.04
Family Guidance Center	4,783	3,218	2,098	0.77
Family Counseling Center	3,059	2,582	907	0.71
[illegible]				0.68
COMTREA	3,924	2,343	1,322	0.67
Mark Twain	1,759	1,284	988	0.58
Comprehensive Mental Health	1,952	1,331	1,374	0.52
BJC	14,193	11,981	6,437	0.44
Adapt of Missouri	419	219	485	0.40
Tri-County	7,055	5,227	2,487	0.44
Bootheel Counseling Center	2,091	2,102	1,434	0.32
Crider	5,810	4,534	3,287	0.29
East Central	3,331	2,921	1,458	0.28
Ozark Center	7,763	6,575	3,228	0.27
Hopewell Center	1,205	499	2,382	0.27
Ozarks Medical Ctr	1,695	1,523	794	0.25
Community Counseling Center	3,997	3,125	3,658	0.24
Clark	981	820	673	0.24
ReDiscover	2,317	1,775	3,905	0.16
North Central MO	318	301	899	0.02
Swope Health Services	259	234	2,869	0.08
Total	164,942	127,748	52,281	0.71

CMT Behavioral Pharmacy Management Report (Adult)

Agency	Number Outlier Prescriptions	Total Behavioral Pharmacy Prescriptions	% Outlier Prescriptions
Hopewell Center	463	5,405	8.6%
North Central Missouri Mental Health Center	422	4,407	9.6%
Truman Medical Center Behavioral Health	874	8,641	10.1%
Ozark Center	2,028	18,826	10.8%
Swope Health Services	706	5,919	11.9%
Pathways Community Behavioral Healthcare, Inc.	6,157	49,926	12.3%
Crider Health Center, Inc.	2,371	18,788	12.6%
ReDiscover	1,560	12,289	12.7%
Community Counseling Center	2,600	19,982	13.0%
Ozark Medical Center	610	4,560	13.4%
Bootheel Counseling Services	1,156	8,590	13.4%
Total Avg CMHC Outlier Prescriptions	43,759	298,018	14.7%
Community Treatment, Inc.	1,474	9,812	15.0%
Clark Community Mental Health Center	635	4,200	15.1%
Comprehensive Mental Health Services	1,060	6,901	15.4%
BJC Behavioral Health- St.	3,491	22,573	15.5%
Tri-County Mental Health Services	2,069	13,334	15.5%
Preferred Family Healthcare, Inc.	878	5,602	15.7%
Places for People	633	3,928	16.1%
East Central Missouri Behavioral Health Services	1,585	9,448	16.8%
Family Counseling Center	2,340	14,133	16.6%
New Horizons Community Support Services	779	4,634	16.8%
Burrell Behavioral Health - Springfield	3,992	22,937	17.5%
Burrell Behavioral Health- Central	2,332	12,890	18.1%
Family Guidance Center	2,301	11,927	19.2%
Adapt of Missouri, Inc.	831	4,159	19.2%
Mark Twain Behavioral Health	1,827	9,477	19.3%
Comprehensive Health Systems, Inc.	553	2,892	19.1%
Independence Center	593	2,687	22.1%
BJC Behavioral Health- SE	1,905	8,141	23.5%
Mineral Area Community Psych Rehab Center	453	1,282	35.3%

[illegible]

CMT Behavioral Pharmacy Management Report (Youth)

Agency	Number Outlier Prescriptions	Total Behavioral Pharmacy Prescriptions	% Outlier Prescriptions
Ozark Center	391	5,668	6.9%
ReDiscover	229	3,216	7.1%
Swope Health Services	146	2,062	7.1%
Ozark Medical Center	72	970	7.4%
Family Guidance Center	337	3,430	9.8%
Burrell Behavioral Health- Central	263	2,182	12.1%
Truman Medical Center Behavioral Health	93	704	13.2%
Tri-County Mental Health Services	239	1,769	13.5%
Bootheel Counseling Services	271	1,959	13.8%
Hopewell Center	139	986	14.1%
Total Avg (All CMHCs) Outlier Prescriptions	[illegible]	[illegible]	[illegible]
Community Counseling Center	676	4,603	14.6%
Clark Community Mental Health Center	171	1,148	14.9%
Burrell Behavioral Health -- Springfield	402	2,606	15.5%
Pathways Community Behavioral Healthcare, Inc.	1,471	9,579	15.4%
BJC Behavioral Health- St. L.	392	2,443	16.1%
North Central Missouri Mental Health Center	182	1,129	16.1%
Community Treatment, Inc.	365	2,249	16.2%
Comprehensive Mental Health Services	177	1,011	17.5%
Mark Twain Behavioral Health	393	2,299	17.1%
Crider Health Center, Inc.	1,064	5,479	19.4%
Family Counseling Center	449	2,103	21.4%
BJC Behavioral Health- SE	282	1,237	22.7%
East Central Missouri Behavioral Health Services	604	2,264	26.7%

* for specified Quality Indicators** ([illegible])

CMHC Healthcare Home

Application

- Timetable
  - Application Released: **June 28**
  - Application Due: **July 20**
  - Anticipated Date of Determination: **August 15**
- Submit electronically to susan.blume@dmh.mo.gov
- Submit one application per Medicaid provider number
  - Note some parts of the application apply to the organization and some to specific sites
- Cover letter
- Application Form
- Technical Assistance

CMHC HEALTHCARE HOME

PROVIDER REQUIREMENTS

Initial Requirements

- Must be a state designated CMHC
- Demonstrate cost-effectiveness based on the projected # enrollees and the proposed mix and # of staff
- Have engaged leadership as demonstrated by presentation of “Paving the Way” to staff and board
- Have a primary care physician, psychiatrist or advanced practice nurse providing physician leadership for the Healthcare Home

Initial Requirements

- Have a history of and commitment to:
  - Using Mo HealthNet's EHR for care coordination and prescription monitoring
  - Tracking DMH-specified performance measures (see Appendix A)
  - Using the behavioral pharmacy management system
  - Completing DMH status reports

CMHC Healthcare Home

Initial Requirements

- Demonstrate commitment to:
  - Using a patient registry to input metabolic screening results, track and measure care, automate care reminders, and produce exception reports for care planning
  - Conducting wellness interventions based on clients level of risk

Ongoing Requirements

- Continue engaged leadership
  - Successful participation in the Leadership and Organizational Training initiatives, and the Healthcare Home Learning Collaborative
- Maintain required staff levels
  - Healthcare Homes that fail to maintain staffing at least 85% of the time during the first year will be subject to recoupment of PMPM payments
    - 15% vacancy for 1.5 FTE = 11.7 out 78 weeks with a vacancy
    - 15% vacancy for 3 FTE = 23.4 out of 156 weeks with a vacancy
    - 15% vacancy for 5 FTE = 39 out of 260 weeks with a vacancy

Ongoing Requirements

- Quality Improvement
  - Quarterly reports documenting performance as measured by clinical outcomes, and outlining plans for improvement based on implementing Practice Transformation concepts
    - The initial Practice Transformation concept reported on will be Access to Care
    - Additional Practice Transformation concepts will be added as the Healthcare Home Collaborative introduces them
- Successfully complete 6 and 12 month assessments conducted by DMH

Ongoing Requirements

- Submit a monthly report documenting
  - CMHC Leadership engagement
  - Healthcare Home staffing
  - Healthcare Home enrollment
- Participate in training and technical assistance opportunities and work groups as required
- Obtain Healthcare Home accreditation within 18 months from the beginning of PMPM payments

CMHC HEALTHCARE HOME

PROGRAM REQUIREMENTS

CMHC Healthcare Home

Program Requirements

A. Healthcare Home Services
B. Healthcare Home Staffing
C. Training
D. Patient Registry
E. Data Reporting
F. Evidence of Practice Transformation
G. Evaluation

Healthcare Home Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion Services
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Support

Healthcare Home Staffing

- Clinical Director/CPRC Director
- Physician Leadership
- Behavioral Health Clinicians and Teams
- Healthcare Home Director
  - At least .5 FTE
  - Flexibility for larger organizations

Healthcare Home Staffing

- Nurse Care Managers
  - At least 1 RN
    - May be the Healthcare Home Director
  - There will be an exceptions process to propose a Care Manager who is not an RN or LPN
- Community Support Specialists/Case Managers
- Clerical Support Staff

Healthcare Home Staffing

- Internal Practice Team Meetings
  - The Healthcare Home Director, Physician Leader, and Nurse Care Managers meet regularly to plan and implement continuing practice transformation and the evolution of the Healthcare Home
- Notification of Staffing Changes
  - CMHCs notify DMH of staffing vacancies in the following positions within 5 days
    - Healthcare Home Director
    - Physician Leadership
    - Nurse Care Managers
    - Healthcare Home Clerical Support

Leadership and Organizational Training

- The CMHC leadership team participates in the following training opportunities
  - Paving the Way: An introduction to Healthcare Homes
  - Healthcare 101: An introduction to Healthcare Home Rules and Regulations
  - Systems Change Training: A Learning Collaborative
    - Phase I: Access to Care
    - Phase II: Practice Transformation
    - Phase III: Meeting Missouri's Healthcare Home Standards

Healthcare Home Team Training

- Healthcare Home Directors and Nurse Care Managers, participate in the following training opportunities
  - Paving the Way: An introduction to Healthcare Homes
  - Healthcare 101: An introduction to Healthcare Home Rules and Regulations
  - Person-Centered Care
  - Understanding and Managing Chronic Diseases
  - Child and Adolescent Wellness

Healthcare Home Team Training

- Healthcare Home Physician Leaders participate in the following training opportunities
  - Paving the Way: An introduction to Healthcare Homes
  - Healthcare 101: An introduction to Healthcare Home Rules and Regulations
  - Additional opportunities as appropriate

Healthcare Home Team Training

- Community Support Specialist participate in the following training opportunities
  - Paving the Way: An introduction to Healthcare Homes
  - Healthcare 101: An introduction to Healthcare Home Rules and Regulations
  - Training opportunities designed to improve their ability to serve as health coaches

CMHC Healthcare Home

Program Requirements

- Patient Registry
- Data Reporting
- Evidence of Practice Transformation
- Evaluation

CMHC Healthcare Home

Payment Methodology

- Infrastructure Payments
  - Initial
    - Based on 2/3 of projected auto-enrollment
    - Covers cost of start up and training
    - Begins with SPA approval and recognition as a provider
  - Ongoing
    - Quarterly reimbursement for actual costs incurred
    - Covers cost of continued training and other required administrative changes

Payment Methodology

- PMPM
  - Covers cost of new Healthcare Home staff
    - Healthcare Home Director, Nurse Care Managers, and clerical support
  - Begins upon completion of required Healthcare Home Team training

CMHC Healthcare Home

Payment Methodology

- Payment for Performance
  - Based on improvement in performance measures
  - Share in projected savings
  - Begins at end of Year One
- All payments subject to continuing to meet Healthcare Home requirements

Patient Eligibility and Enrollment

- Medicaid beneficiaries who meet one of the following criteria
  - Diagnosed with a serious and persistent mental health condition (adults with SMI and children with SED)
  - Diagnosed with a mental health condition and substance abuse disorder
  - Diagnosed with a mental health condition and/or substance abuse condition and one of the following chronic health conditions
    - Diabetes
    - COPD
    - Cardiovascular Disease
    - BMI>25
    - Tobacco use
    - Developmental Disability

Patient Eligibility and Enrollment

- Auto-enrollment
  - Beneficiaries with CPR claims in each of three previous months will be assigned to their CPR provider for auto-enrollment
  - Beneficiaries will be given information regarding alternative Healthcare Home providers and also given the choice to opt-out of Healthcare Home services
- Additional enrollments
  - Additional beneficiaries who meet the enrollment criteria may be enrolled if the CMHC has appropriate resources to assure required staffing

2011

MO HealthNet and Department of Mental Health

Application for Healthcare Home Service Provider Status as a Community Mental Health Center

A Healthcare Home is a place where individuals can come throughout their lifetimes to have their healthcare needs identified and to receive the medical, behavioral and related social services and supports they need, coordinated in a way that recognizes all of their needs as individuals -- not just patients.

June 28, 2011

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APPENDICES:

ATTACHMENT:

A. Overview

The Missouri Department of Social Services (DSS) and the Missouri Department of Mental Health (DMH) seek Community Mental Health Centers (CMHC) with existing Division of Comprehensive Psychiatric Services (CPS) contracts to serve as Healthcare Homes for Medicaid beneficiaries. The Healthcare Home is an alternative approach to the delivery of healthcare services that promises better patient experience and better results than traditional care. The Healthcare Home has many characteristics of the Patient-Centered Medical Home (PCMH)[1], but is customized to meet the specific needs of low-income patients with chronic medical conditions.

The recognized CMHC is expected to evolve as a Healthcare Home. To assist in transforming their practices, consistent with Healthcare Home principles, recognized CMHCs will be required to participate in a learning collaborative established by DMH.

Healthcare Home services are available to the eligible population and cannot be restricted by age.

CMHCs will also be required to obtain Healthcare Home accreditation by the National Committee for Quality Assurance (NCQA), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission (formally the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)) or other nationally recognized Healthcare Home accrediting organization. DMH may also develop Missouri interpretive standards for Healthcare Homes to use in lieu of a national accreditation, which may be aligned with NCQA, CARF or the Joint Commission.

CMHCs that meet the Healthcare Home requirements will receive infrastructure payments for performing certain start-up activities, will receive per-member-per-month (PMPM) payments for performing various Healthcare Home activities, and may receive incentive payments relating to performance, as more fully described in **Section 3.A**.

[1] For more information on the PCMH, see www.pcpcc.net/files/PCMH_Vision_to_Reality.pdf.

B. Healthcare Home Qualifications

In order to be recognized as a Healthcare Home, a CMHC must, at a minimum, be a state designated CMHC as of the date of application submission and meet the following criteria:

1. Present a proposed Healthcare Home delivery model that DSS/DMH determines to have a reasonable likelihood of being cost-effective. Cost effectiveness will be determined based on the size of the Healthcare Home, Medicaid caseload, percentage of caseload with eligible chronic conditions of patients and other factors to be determined by the DSS/DMH;

2. Have a strong, engaged leadership personally committed to and capable of leading the CMHC through the transformation process and sustaining transformed CMHC processes as evidenced by presenting "Paving the Way for Healthcare Homes" to CMHC staff and board members.

3. Have a primary care physician, psychiatrist or advanced practice nurse assigned as the physician leadership for the Healthcare Home team;

4. Have a history of and commitment to:

    a. Utilizing MO HealthNet's comprehensive electronic health record (EHR) to conduct care coordination and prescription monitoring for Medicaid participants;

    b. Tracking DMH-specified performance measures (see **Appendix A**) and develop care gap to-do lists;

    c. Utilizing a behavioral pharmacy management system to determine problematic prescribing patterns; and

    d. Completing DMH status reports to document clients' housing, legal, employment status, education, custody, etc.

5. Have demonstrated commitment to:

    a. Utilizing an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders and produce exception reports for care planning; and

    b. Conducting wellness interventions as indicated based on clients' level of risk.

a. Ongoing Provider Qualifications

CMHCs will also be expected to:

1. Continue to have a strong, engaged leadership personally committed to and capable of leading the CMHC through the transformation process and sustaining transformed CMHC processes as evidenced by successful participation in the Leadership and Organizational training and learning collaborative, as explained in **Section 2.C**);

2. Maintain an average of 85% of healthcare home staff positions (Healthcare Home Director, Physician Leadership, Nurse Care Managers and Clerical Support Staff) over Year One[2] of Healthcare Home implementation (see **Section 2.B**);

3. Develop quality improvement plans to address gaps and opportunities for improvement identified during and after the application process;

4. Demonstrate continuing development of fundamental Healthcare Home service functionality through a 6 month and 12 month assessment, as explained in **Section 2.G**, to be applied by the state;

5. Demonstrate significant improvement on performance measures specified by and reported to the state;

6. Provide a Healthcare Home that demonstrates overall cost effectiveness;

7. Submit the data reports specified in **Section 2.E**;

8. Participate in ad hoc, time-limited topical work groups (i.e. primary care and behavioral health integration) as requested by DSS and/or DMH;

9. Participate in technical assistance conference calls and webinars as requested by DSS and/or DMH; and

10. CMHCs will be required to obtain Healthcare Home accreditation by NCQA, CARF, the Joint Commission or other nationally recognized Healthcare Home accrediting organization by the 18th month from the date at which PMPM payments commence. DMH may also develop Missouri interpretive standards for Healthcare Homes to use in lieu of a national accreditation, which may be aligned with NCQA, CARF or the Joint Commission.

[2] Year One is defined as the twelve-month period starting with the month of the first learning collaborative session.

CMHCs will work individually, and in some cases with one another collectively, to continually evolve as Healthcare Homes by fulfilling the responsibilities delineated in this section. ***Failure to meet these requirements will be cause for suspension of Healthcare Home payments and/or loss of Healthcare Home provider status.***

This section describes substantially the activities CMHCs will be required to engage in and the responsibilities they will fulfill if recognized as a Healthcare Home provider. Healthcare Home status is also subject to change should the Centers of Medicare and Medicaid Services (CMS), DSS or DMH action cause the elimination of the Healthcare Home provider type.

A. Healthcare Home Services

The Healthcare Home Team (Healthcare Home Director, Physician Leadership and Nurse Care Managers) shall assure that the following health services are received as necessary by all members of the Healthcare Home:

1. **Comprehensive Care Management** – includes the following services:
    - Identification of high-risk individuals and use of client information to determine level of participation in care management services;
    - Assessment of preliminary service needs;
    - Development of treatment plans, including client goals, preferences and optimal clinical outcomes;
    - Assignment of health team 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 and indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

2. **Care Coordination** – Care coordination consists of the implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports. Specific care coordination 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. Healthcare Homes must conduct care coordination activities across the

Care Team (composition of Care Team outlined in **Section 2.B**). The primary responsibility of the Community Support Specialist (CSS)/Case Managers 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** – 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 screening, 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 to participate in the implementation of the treatment plan and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions.

4. **Comprehensive Transitional Care** – members of the Care Team must provide care coordination services designed to streamline plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency department use. Members of the Care Team collaborate 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.

5. **Individual and Family Support Services** – services include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, Care 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, ability to self-manage care and facilitate participation in the ongoing revision of their care/treatment plan. For individuals with developmental disabilities (DD) the Care Team will refer to and coordinate with the approved DD case management entity for services more directly related to habilitation or a particular healthcare condition.

6. **Referral to Community and Social Support** – involves providing assistance for clients to obtain and maintain eligibility for healthcare, disability benefits, housing, personal need and legal services, as examples. For individuals with DD, the Care

Team will refer to and coordinate with the approved DD case management entity for this service.

B. Healthcare Home Staffing

Healthcare Home providers will augment their current CPR teams by adding a Healthcare Home Director, Physician Leadership and Nurse Care Managers to provide consultation as part of the Care Team, and assist in delivering Healthcare Home services. Clerical support staff will also be funded to assist with Healthcare Home supporting functions. These additional positions will be funded by the Healthcare Home payments, as explained in **Section 3.A**, and will be expected to log their Healthcare Home activities as determined by DMH.

a. Care Team

The Care Team is composed of existing CPR team members and additional Healthcare Home staff positions (see **Appendix B** for staff roles and responsibilities):

1. **Clinical Director/CPRC Director** – Continues to provide the same functions within the CMHC, and supports the implementation of Healthcare Home.

2. **Physician Leadership** (added with Healthcare Home) – The physician provides medical leadership to the Care Team by participating in treatment planning and consultation regarding identified health conditions. The physician leadership position can be a primary care physician, psychiatrist or advanced practice nurse.

    - 1 hour physician time per client enrolled in Healthcare Home, for example:
        - 520 enrollees = .25 FTE per year (10 hrs. per week)
        - 1,040 enrollees = .5 FTE per year (20 hrs. per week)
        - 2,080 enrollees = 1 FTE per year (40 hrs. per week)

3. **Behavioral Health Clinicians and Teams** – Continue to provide the same functions within the CMHC and support the implementation of Healthcare Home.

4. **Healthcare Home Director** (added with Healthcare Home) – The Healthcare Home Director oversees the implementation and coordination of Healthcare Home activities, and provides oversight to Nurse Care Managers. A clinician (with minimum RN credentials) or non-clinician

with strong administrative skills may be qualified for the Healthcare Home Director position.

- Minimum Healthcare Home Director FTEs will be determined by DMH for each CMHC recognized as a Healthcare Home.

5. **Nurse Care Managers** (added with Healthcare Home) – Nurse Care Managers assist in managing the client's full array of physical health care needs, in addition to behavioral health care needs, taking a "whole person" approach. RNs and LPNs are qualified as Nurse Care Managers; however, one RN Nurse Care Manager must be on the Healthcare Home Team.

   - One Nurse Care Manager FTE cannot exceed a caseload of more than 250 clients enrolled in Healthcare Home.
   - CMHCs may request an exception to fill a Nurse Care Manager position with a non-nurse. DMH will review exceptions on a case-by-case basis.

6. **Community Support Specialists/Case Managers** – Continue to provide the same functions within the CMHC, and support the implementation of Healthcare Home. CSS/Case Managers will also receive training focused on the health of the "whole person" and design to equip them with health coaching skills and education on chronic diseases.

7. **Clerical Support Staff** (added with Healthcare Home) – Clerical Support Staff will assist the CMHC in Healthcare Home reporting and other supporting roles.

8. **Healthcare Home Clients** – All clients eligible and enrolled to receive Healthcare Home services will have access to a Nurse Care Manager. In addition, clients eligible for CPR may also have a CSS/Case Manager. Clients are active participants in managing their care/treatment plan.

b. Internal Practice Team Meetings

CMHCs shall convene regular internal Healthcare Home Team meetings with the Healthcare Home Director, Physician Leader and Nurse Care Managers to plan and take steps to support continual Healthcare Home evolution.

c. Notification of Staffing Changes

CMHCs are required to notify DMH within five working days of vacancies in the Healthcare Home Director, Physician Leadership, Nurse Care Managers and Clerical Support positions for Healthcare Home.

C. Learning Collaborative

DMH shall require all CMHC recognized Healthcare Homes to participate in a Healthcare Home learning collaborative as follows:

a. Leadership and Organizational Training

The Leadership and Organizational Training is a 15 month process that will require participation of the CMHC leadership, which must include the CEO/President, CFO, Clinical Director, CPRC Director, Healthcare Home Director and Physician Leader. The leadership and organizational training includes the following (training dates are tentative and subject to change):

1. **Paving the Way for Healthcare Homes (June 28, 2011)** – CMHC leadership is expected to attend this train-the-trainer session, and shall subsequently train all CMHC staff on Healthcare Homes.

2. **Healthcare Home 101 (August 9-10, 2011)** – CMHCs will be trained on the state rules and regulations for Healthcare Homes, Healthcare Home team roles and responsibilities, organizational change and health information technology tools and initiatives.

3. **Phase I: Systems Change Training: Access to Care (July-November 2011)** – MTM Services[3] has been contracted to deliver access to care training detailing access to care flow processes, integration of quality improvement strategies and techniques, costing, data mapping and design of standardized process specific to the CMHC.

4. **Phase II: Systems Change Training: Practice Transformation Healthcare Home Learning Collaborative (December 2011 – August 2012)** – This learning collaborative consists of four workshops over an eight month period and incorporates components of the PCMH model:

    - **Workshop 1**: Patient-centeredness and involvement of the patient in goal setting, action planning, problem solving and follow-up
    - **Workshop 2**: Patient and family education and self-management support
    - **Workshop 3**: Care coordination across settings and population-based tracking

[3] For more information on MTM Services, visit www.mtmservices.org.

- **Workshop 4**: Multi-disciplinary team-based approach to care, evidence-based care delivery and integration of quality improvement strategies

5. **Phase III: Systems Change Training: Meeting Missouri's Healthcare Home Standards (August-December 2012)** – CMHCs will integrate learning collaborative work to meet the Missouri DMH interpretive standards for Healthcare Home, unless the CMHC has already been, or in the process of being, accredited as a Healthcare Home by NCQA, CARF, the Joint Commission or other nationally recognized Healthcare Home accrediting organization.

b. Mastery of the Required Healthcare Home Core Competencies

CMHCs shall transform how they operate in order to retain their status as a Healthcare Home. Transformation entails mastery of Phase I and II of the Systems Change Training for leadership described above.

c. Healthcare Home Team Training

All Healthcare Home Directors and Nurse Care Managers will attend all four levels of training:

1. **Level One: Healthcare Home 101** – Training on state rules and regulations for Healthcare Homes, Care Team roles and responsibilities, health information technology tools and initiatives, orientation to the public health and primary care models and DMH services and resources.

2. **Level Two: Person-Centered Care** – Training on patient-centeredness, motivational interviewing, medication treatment and adherence and primary care resources.

3. **Level Three: Understand and Managing Chronic Diseases** – Training on disease management and pharmacology, health and wellness/lifestyle change, substance abuse and treatment, orientation to the public health and primary care models.

4. **Level Four: Child and Adolescent Wellness** – Training introducing child wellness, disease management and pharmacology, health and wellness/lifestyle change, substance abuse and treatment, and medication treatment and adherence for children and adolescents.

D. Patient Registry

Healthcare Homes shall utilize the DMH/DSS provided EHR patient registry. A patient registry is a system for tracking information that DSS/DMH deems critical to the management of the health of a Healthcare Home's patient population, including dates of delivered and needed services, laboratory values needed to track chronic conditions, and other measures of health status. The registry shall be used for:

- Patient tracking;
- Patient risk stratification;
- Analysis of patient population health status and individual patient needs; and
- Reporting, as specified in **Section 2.E** below.

E. Data Reporting

CMHCs shall submit to DMH the following reports, as further specified by DMH, within the time frames specified below:

- Monthly CMHC Healthcare Home Implementation Report providing updates to the CMHC leadership, Healthcare Home staff and CMHC prescribers, and a status update on Healthcare Home enrollment;
- Quarterly CMHC Healthcare Home Quality Improvement Report describing utilization of HIT reports, performance measures and clinical data contained within the CMHC patient registry, and implementation of practice transformation concepts presented in the Healthcare Home learning collaborative;
- Other reports, as specified by DSS/DMH.

F. Demonstrated Evidence of Healthcare Home Transformation

CMHCs are required to demonstrate evidence of Healthcare Home transformation on an ongoing basis using measures and standards established by DSS and DMH, and communicated to the CMHCs. As of the publication date of this application, DMH defines evidence of Healthcare Home transformation as follows:

- Demonstrates development of fundamental Healthcare Home functionality at six months and 12 months based on an assessment process explained in **Section 2.G** below; and
- Demonstrates significant improvement on clinical indicators specified by and reported to DMH.

G. Participation in Evaluation

CMHCs shall participate in an evaluation. Participation may entail responding to surveys and requests for interviews with CMHC staff and clients. CMHCs shall provide all requested information to the evaluator in a timely fashion.

SECTION 3: HEALTHCARE HOME PAYMENT

Subject to all required federal approvals, DMH has developed the following payment structure for recognized CMHC Healthcare Home providers. No payments will be made to any Healthcare Home until the calendar month immediately following the first learning collaborative session, and all payments are contingent on the CMHC meeting the requirements set forth in this application, as determined by DMH. Failure to meet such requirements is grounds for revocation of Healthcare Home status and termination of payments specified within this application.

The anticipated payment methodology for CMHCs is as follows:

A. DRAFT Payment Methodology

Type of Payment	Covered Services	Payment Amount
Infrastructure Payment (limited)	Start-up payment per CMHC site for start-up and initial infrastructure development practice costs during the first quarter of Year One, as determined by DMH. Subsequent payment awarded after Year One of implementation based upon the 6 and 12 month evaluations, and other factors as determined by DMH.	Payment to be determined
Infrastructure Payment (ongoing)	Quarterly payment per CMHC for FTE allocation of Healthcare Home Director and Clerical Support Staff, as determined by DMH. Payment will start concurrent with PMPM payments.	Payment to be determined
Per-Member-Per-Month (PMPM) Payment	PMPM payment for Healthcare Home services, explained in **Section 2.A**, and other activities to be taught during the course of the learning collaborative sessions, explained in **Section 2.C**. Payment will start when the CMHC has demonstrated compliance and readiness, as determined by DMH, to begin offering Healthcare Home services.	PMPM = $
Payment for Performance	Incentive payments awarded to CMHCs that display significant improvements to performance measures (see **Appendix A**), as determined by DMH, and maintains sufficient Healthcare Home staffing and leadership commitment to learning collaborative.	Payment to be determined

The PMPM payment described in the payment methodology table above will be based on DSS' count of Medicaid beneficiaries assigned to or attributed to the CMHC on a date certain each month. During Year One, payments shall be made for only those beneficiaries meeting the eligibility criteria explained in **Section 3.B** below.

Should experience reveal to DSS/DMH that elements of the payment methodology will not function, or are not functioning, as DSS/DMH intended; DSS/DMH reserves the right to make changes to the payment methodology after consultation with recognized Healthcare Homes and receipt of any and all required federal approvals.

B. Patient Eligibility and Enrollment

Medicaid beneficiaries eligible for Healthcare Home services from recognized CMHC Healthcare Home service providers must meet one of the following criteria:

1. Diagnosed with a serious and persistent mental health condition, including:
    - Adults with serious mental illness (SMI); and
    - Children with serious emotional disturbance (SED) (see **Appendix E** for definition).
2. Diagnosed with a mental health condition and substance use disorder
3. Diagnosed with a mental health condition and/or substance use disorder, and one other chronic condition (diabetes, COPD, cardiovascular disease, overweight (BMI >25), tobacco use and developmental disability)

DSS/DMH will consider the addition of beneficiaries with other chronic conditions and risk factors for Year Two.

Beneficiaries will be attributed to the CMHC using a standard patient attribution algorithm adopted by DSS/DMH. Recognized CMHC Healthcare Home providers will be required to inform beneficiaries of other Healthcare Home provider options in the state prior to the beneficiary being enrolled. Beneficiaries will also be given the choice to opt-out of Healthcare Home services.

A. Application Timetable

DMH may adjust the application timetable as it deems necessary. The CMHC President/CEO, COO, and Clinical Director will be notified of any adjustments made to the application timetable and/or application requirements.

Application Status	Projected Timeline (dates subject to change)
Application Released to CMHCs	**Tuesday, June 28, 2011**
Application Due to DMH	**Wednesday, July 20, 2011**
Anticipated CMHC Notification of Healthcare Home Provider Status	**Monday, August 15, 2011**

B. General Submission Instructions

Applications must be submitted electronically by e-mail to Susan Blume, susan.blume@dmh.mo.gov, by Wednesday, July 20, 2011.

C. General Application Requirements

CMHCs must complete and submit one application per organization.

CMHCs should note that parts of the application request information pertaining to the organization and other parts request information specific to each CMHC site/location.

D. Contents of the Submission

The applicant must submit:

1. A **cover letter** that clearly states the name of the applicant organization and the name of the applicant's contact person. The letter must be signed by an individual authorized to bind the applicant; and

2. The **completed application form** (**Appendix D**).

APPENDIX A

MO CMHC HEALTHCARE HOME PERFORMANCE MEASURES

The nine performance measures CMHCs are currently tracking are:

1. Use of inhaled corticosteroid medications by persons with a history of COPD (chronic obstructive pulmonary disease) or Asthma.
2. Use of ARB (angiotensin II receptor blockers) or ACEI (angiotensin converting enzyme inhibitors) medications by persons with a history of CHF (congestive heart failure).
3. Use of beta-blocker medications by persons with a history of CHF (congestive heart failure).
4. Use of statin medications by persons with a history of CAD (coronary artery disease).
5. Use of H2A (histamine 2-receptor antagonists) or PPI (proton pump inhibitors) medications for no more than 8 weeks by persons with a history of GERD (gastro-esophageal reflux disease).
6. Fasting lipid profile completed within the past 12 months for patients with CAD (coronary artery disease).
7. Urinary microalbumin test completed within the past 12 months for patients with diabetes mellitus.
8. At least 2 hemoglobin A1c tests completed within the past 12 months for patients with diabetes mellitus.
9. Fasting lipid profile completed within past 12 months for patients with diabetes mellitus.

APPENDIX B

HEALTHCARE HOME TEAM ROLES AND RESPONSIBILITIES

The roles and responsibilities of the Healthcare Home Director, Physician Leader and Nurse Care Managers, as outlined below, are preliminary functions those positions may perform.

Nurse Care Manager

- Champions healthy lifestyle changes, including tobacco prevention and cessation, nutrition and physical activity.
- Champions preventive care efforts on healthcare issues and alcohol and drug abuse.
- Assists the CMHC in developing and enhancing wellness initiatives such as, but not limited to, wellness support groups, nutrition and physical activity programs, periodic staff and consumer education classes, consumer health fairs and screenings.
- Facilitate health education groups and/or activities for clients/staff/community, or refer to other PSR staff leading groups (per the criteria and guidelines of the specific programs/curriculum).
- Promotes the use of Direct Inform with clients.
- Consult with CSSs about identified health conditions of their clients and provide education training on medical diseases, health coaching and medications
- Support and educate CSS staff on health coaching, chronic diseases, healthy lifestyle choices and medication adherence.
- Provide technical assistance to CSSs on use of CyberAccess and running a Patient Profile Report.
- Responsible for performing roles supported by the community support specialist (for clients w/o a CSS).
- Maintains a time log of HH activities with DMH and reports CE courses/training.
- Tracks that all required assessments and screenings are completed for each client, in accordance of performance measures, and follows-up if necessary.
- Follows through on performance measures.
- Manages HIT tools and reports on HH caseload, received from HH director, and reviews for accuracy, outlying prescription patterns and practices.
- Monitors HIT tools and reports for treatment and medication alerts and hospital admissions/discharges.
- Assists with Department of Mental Health state-operated facilities and general hospitals in discharge planning of HH caseload.
- Makes the initial contact with the hospital regarding client admission/discharge.
- Coordinates with the CSS and Care Team on treatment and medication alerts and hospital admissions/discharges.
- Follows through with client on treatment and medication alerts and hospital admissions/ discharges (for clients w/o a CSS).
- Communicates algorithm concerns, problems or suggestions to HH director.
- Assists in developing the treatment plan for clients, and identifying 1 or 2 healthcare goals.
- Coordinates care with MO HealthNet contracted pharmacies and providers in the community, and federal qualified health center (FQHC) clinical staff.

Healthcare Home Director	Physician Leadership
The Healthcare Home director oversees the implementation and coordination of healthcare home activities. Responsibilities include: • Champions Healthcare Home practice transformation change. • Provides consultation with the physician leadership and nurse care managers regarding healthcare home functions or client specific concerns. • Facilitates periodic meetings with the physician leader and nurse care managers. • Oversees that nurse care managers complete the HH training and certification and obtain the required CE credits. • Coordinates hospital admission/discharge planning. • Responsible for initial intake process of newly enrolled HH clients and assigns them to HC caseload appropriately based on the HC's current caseload composition of acuity. • Assures all hospital admission/discharge alerts are promptly acted upon by the Care Team. • Assists with staff training on disease management HIT tools and initiatives. • Provides technical assistance to Care Team on HIT tools, and running a CyberAccess Patient Profile Report. • Carries the role as one of the CyberAccess Practice Administrators, responsible for maintaining the accounts of authorized users. • Communicates algorithm concerns, problems or suggestions to designated technical representatives. • May coordinate and/or facilitate health education groups and/or activities for clients/staff/community, or refer to other qualified PSR staff leading groups (per the criteria and guidelines of the specific programs/curriculum). • Develops quality indicator projects surrounding healthcare screening, treatment plan healthcare goals and prescriber information.	The physician provides medical leadership to the Care Team. Responsibilities include: • Participates in treatment planning and approves plans as necessary or appropriate. • Consults with team psychiatrists. • Consults on identified health conditions. • Assists with coordination with medical providers in the community.

APPENDIX C

DEFINITION FOR CHILDREN AND YOUTH WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

Serious emotional disturbance is a term used to describe children and youth who have serious disturbances in psychological growth. There are a number of characteristics that may distinguish these youth. The definition of serious emotional disturbance in the State of Missouri is defined as:

1. Children and youth under 18 years.

2. Children and youth exhibiting substantial impairments in their ability to function at a developmentally appropriate level due to the presence of a serious psychiatric disorder. They must exhibit substantial impairment in two or more of the following areas:

    a. Self-care including their play and leisure activities;

    b. Social relationships: ability to establish or maintain satisfactory relationships with peers and adults;

    c. Self-direction: includes behavioral controls, decision making, judgment, and value systems;

    d. Family life: ability to function in a family or the equivalent of a family (for a child birth through six years, consider behavior regulation and physiological, sensory, attentional, motor or affective processing and an ability to organize a developmentally appropriate or emotionally positive state);

    e. Learning ability;

    f. Self-expression: ability to communicate effectively with others.

3. Children and youth who have a serious psychiatric disorder as defined in Axis I of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). An "exclusive" diagnosis of V Code, conduct disorder, mental retardation, developmental disorder, or substance abuse as determined by a Department of Mental Health, Comprehensive Psychiatric Services Provider does not qualify as a serious emotional disturbance. Children from birth through three years may qualify with an Axis I or Axis II diagnosis as defined in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC-3).

4. Children and youth whose inability to function, as described, require mental health intervention. Further, judgment of a qualified mental health professional should indicate that treatment has been or will be required longer than six months.

5. Children and youth who are in need of two or more State and/or community agencies or services to address the youth's serious psychiatric disorder and improve their overall functioning.

Serious emotional disturbance occurs more predictably in the presence of certain risk factors. These factors include family history of mental illness, physical or sexual abuse or neglect, alcohol or other substance abuse and multiple out of home placements. While these risk factors are not classified as specific criteria in the definition of serious emotional disturbance, they should be considered influential factors.

APPENDIX D

APPLICATION FOR CMHC HEALTHCARE HOME PROVIDER STATUS

SECTION A: PRACTICE SITE INFORMATION

1. General Information for CMHC

a.	Name of CMHC:	
b.	Name of person completing application:	Title: Email: Phone:
c.	Address of CMHC sites applying for Healthcare Home recognition that will have a Healthcare Home Director or Nurse Care Manager either onsite or providing services at the location:	
d.	Name of Governing Board President:	E-mail: Phone:
e.	Name of CEO:	E-mail: Phone:
f.	CMHC Federal Tax Identification Number:	
g.	If the CMHC is part of a larger organization, please identify the name of the larger organization:	
h.	Are you currently accredited as a Healthcare Home?	
i.	If so, what national accrediting agency did you use?	

2. **CMHC Clinicians with Patient Panels**: Please provide totals in full-time equivalences (FTEs) and subtotals by category of clinician in number of people filling those positions, to the extent that the CMHC has such personnel and whether the positions are staffed or vacant:

a. Total Physician FTEs_____ • # of staffed full-time physicians_____ • # of staffed part-time physicians_____ • # of vacant full-time physician positions_____ • # of vacant part-time physician positions_____	b. Total Nurse Practitioner (NP) FTEs_____ • # of staffed full-time NPs_____ • # of staffed part-time NPs_____ • # of vacant full-time NP positions_____ • # of vacant part-time NP positions_____
c. Do individual physicians and NPs each have defined panels of patients? _____Yes _____No	

3. **Medical Records**

a. If the CMHC uses an electronic health record (EHR): i. What vendor do you use? ii. Does it meet meaningful use? iii. When was it implemented? iv. What functions does it serve? Comments (optional):
b. If the CMHC does not use an EHR, does the CMHC have plans to implement an EHR? i. In 2011? _____Yes _____No ii. In 2012? _____Yes _____No Comments (optional):
c. Are you a member of a Regional Health Information Exchange, if so which one? Comments (optional):
d. How many CyberAccess registered users do currently have total for the CMHC? e. Who are your registered CyberAccess Practice/Site Administrator(s) employed by your organization?

SECTION B: HEALTHCARE HOME TRANSFORMATION

1. In one paragraph, describe your organizations primary goals and objectives in providing Healthcare Home services.
2. In two or three paragraphs, describe (1) the experience of the Healthcare Home Director(s) who will provide organizational leadership for Healthcare Home transformation, (2) what he or she will do to ensure successful Healthcare Home evolution, and (3) your understanding of the challenges this individual will face inherent in Healthcare Home transformation within the CMHC.
3. In two or three paragraphs, describe and provide one or two examples of how the CMHC will involve patients, families and/or caregivers in the process of defining the elements of a "person-centered" CMHC.
4. In two or three paragraphs, describe your organization's success and challenges in implementing the DMH Net initiative and the DM 3700 project, and how those experiences may translate to implementing Healthcare Home.
5. As a CMHC, what does your organization hope to gain from Phase I: Systems Change Training on Access to Care?
6. Describe your organization's history of use of the quarterly disease management report (HEDIS indicators) and commitment to conducting wellness interventions as indicated based on clients' level of risk.
7. For the purpose of initial training on Healthcare Home transformation processes, please list the names and titles of the CMHC's proposed Leadership Team, which must include the CEO/President, CFO, Clinical Director and CPRC Director. Also include projected Healthcare Home staff that will operate in each CMHC site (i.e. Healthcare Home Director, Physician Leader and Nurse Care Managers).

   CMHC Leadership

Name	Title/Position

   CMHC Healthcare Home Director, Physician Leadership and Nurse Care Managers

Name	Healthcare Home Position

8. Please provide your anticipated staffing plan for Healthcare Home, including the size and composition of projected caseloads and projected number of Nurse Care Managers, and what your training needs would be to meet that plan.

SECTION C: CURRENT PERFORMANCE AND AREAS REQUIRING PROMPT REMEDIATION

Please find attached with this application, *CMHC Benchmark Reports June 2011*, showing eligible CMHCs benchmarked performance in the areas of:

1. Completion Rate of Metabolic Screenings
2. Enrollment and Outreach Percentage of DM 3700 Clients
3. Completion Rate of the CPS Adult and Youth Status Reports
4. Completion Rate of MHSIP Surveys
5. CyberAccess Patient History Utilization
6. CMHC Behavioral Pharmacy Management (BPM) Benchmark Report

Performing well as a Healthcare Home under this initiative will require performing well on all the above listed measures. Successful application requires a plan of correction or efforts of improvement for any of the above measures on which your CMHC is performing below average compared to its peers.

CMHC Benchmark Reports

June 2011

1. Completion Rate of Metabolic Screenings
2. Enrollment and Outreach Percentage of DM 3700 Clients
3. Completion Rate of CPS Adult and Youth Status Reports
4. Completion Rate of Adult and Youth MHSIP Surveys
5. CyberAccess Patient Utilization Report
6. CMHC Behavioral Pharmacy Management (BPM) Benchmark Report for Adult and Youth Prescribers

Jan-Dec 2010 Metabolic Screening Data

Number of records submitted to DMH for submission to ACS, includes some non Medicaid clients

Agency	CMHC Clients w/ CY10 Metabolic Data	CMHC Clients w/ CY10 Antipsychotic Claims	%
BJC - 17B	557	492	113.2%
Ozarks Medical Ctr.	203	273	74.4%
North Central MO Mental Health Ctr.	248	338	73.4%
Independence Ctr.	158	220	71.8%
BJC	1242	1976	62.9%
Preferred Family Healthcare	238	427	55.7%
Mark Twain Behavioral Health	248	475	52.2%
Community Counseling Ctr.	383	788	48.6%
Comprehensive Health Systems	78	161	48.4%
Burrell Behavioral Health 10	710	1687	42.1%
Swope Health Ctr.	148	378	39.2%
Arthur Ctr.	171	467	36.6%
CPR Grand Total	7539	20887	36.1%
Burrell Behavioral Health 12	345	957	36.1%
ReDiscover	302	894	33.8%
Places for People	73	220	33.2%
Hopewell	159	481	33.1%
Pathways Behavioral Healthcare	1041	3161	32.9%
Comtrea	153	560	27.3%
Comprehensive Mental Health	117	434	27.0%
Family Guidance Ctr.	227	857	26.5%
Ozark Center	192	730	26.3%
Adapt	82	358	22.9%
Bootheel Counseling Ctr.	95	451	21.1%
New Horizons	62	322	19.3%
Tri-County Mental Health Services	142	748	19.0%
Clark Mental Health Ctr.	37	203	18.2%
Family Counseling Ctr.	61	451	13.5%
Truman	59	686	8.6%
Crider	8	1579	0.5%
Mineral Area	0	68	0.0%
SEMO CTC	0	45	0.0%

CMHC Clients w/ CY10 antipsychotic claims are clients enrolled in CPR in CIMOR matched to CY10 MHN claims for antipsychotics

Disease Management Program -- Assigned Clients engaged or enrolled in DM as of 6/1/11 status update

CMHC	CPS Service Area	Remaining DM & CPR Eligible Clients Assigned to Agency in SA	% Enrolled in DM	% Engaged in DM Outreach	% Enrolled or Engaged
Comprehensive Health Systems, Inc.	14	3	100.0%	0.0%	100.0%
Comprehensive Health Systems, Inc.	15	1	0.0%	100.0%	100.0%
New Horizons Community Support Services	12	15	80.0%	20.0%	100.0%
Preferred Family Healthcare, Inc.	15	5	100.0%	0.0%	100.0%
Pathways Community Behavioral Healthcare, Inc.	08B	95	87.4%	7.4%	94.7%
Pathways Community Behavioral Healthcare, Inc.	07	55	85.5%	7.3%	92.7%
ReDiscover	04	54	53.7%	38.9%	92.6%
Independence Center	23	13	30.8%	61.5%	92.3%
Pathways Community Behavioral Healthcare, Inc.	11	63	73.0%	14.3%	87.3%
Preferred Family Healthcare, Inc.	14	20	50.0%	35.0%	85.0%
North Central Missouri Mental Health Center	13	33	81.8%	3.0%	84.8%
Community Treatment, Inc.	22	63	52.4%	30.2%	82.5%
Ozark Center	09	89	48.3%	33.7%	82.0%
Independence Center	25	5	80.0%	0.0%	80.0%
Places For People	24	25	76.0%	4.0%	80.0%
Pathways Community Behavioral Healthcare, Inc.	17A	91	70.3%	8.8%	79.1%
Independence Center	24	9	55.6%	22.2%	77.8%
Burrell Behavioral Health Care Center	12	73	52.1%	24.7%	76.7%
BJC Behavioral Health	23	170	40.6%	35.3%	75.9%
Crider Health Center, Inc.	16	104	60.6%	14.4%	75.0%
Swope Health Services	03	46	52.2%	21.7%	73.9%
BJC Behavioral Health	25	95	48.4%	25.3%	73.7%
Comprehensive Mental Health Services	05	63	36.5%	34.9%	71.4%
Family Guidance Center	01	95	48.4%	22.1%	70.5%
Bootheel Counseling Services	20	100	44.0%	24.0%	68.0%
Adapt of Missouri, Inc.	25	18	55.6%	11.1%	66.7%
All CMHC	**All**	**2750**	**46.4%**	**17.9%**	**64.4%**
New Horizons Community Support Services	11	8	62.5%	0.0%	62.5%
Adapt of Missouri, Inc.	24	21	57.1%	4.8%	61.9%
Truman Medical Center Behavioral Health	02	77	44.2%	14.3%	58.4%
Places For People	25	19	47.4%	10.5%	57.9%
Adapt of Missouri, Inc.	23	14	35.7%	21.4%	57.1%
Community Counseling Center	21	89	31.5%	23.6%	55.1%
Places For People	23	11	27.3%	27.3%	54.5%
Family Counseling Center, Inc.	19	376	41.5%	12.0%	53.5%
East Central Missouri Behavioral Health Services	15	32	34.4%	18.8%	53.1%
Hopewell Center	24	81	43.2%	8.6%	51.9%
Hopewell Center	23	2	50.0%	0.0%	50.0%
Tri-County Mental Health Services	06	32	31.3%	18.8%	50.0%
Clark Community Mental Health Center	08A	47	40.4%	8.5%	48.9%
Mark Twain Association for Mental Health, Inc.	14	25	32.0%	16.0%	48.0%
BJC Behavioral Health	17B	125	29.6%	16.8%	46.4%
Burrell Behavioral Health Care Center	10	264	29.2%	15.2%	44.3%
Ozark Medical Center	18	110	26.4%	1.8%	28.2%
Hopewell Center	25	14	7.1%	0.0%	7.1%

Adult Status Reports Completed for CPR Clients -- Jan - March 2011 admissions*

Agency Site	Adult CPR Admissions	ASR Completed upon CPR Admission*	Completion Rate
Adapt of Missouri - Service Area 23	6	6	100.0%
Adapt of Missouri - Service Area 24	15	15	100.0%
Comp Health Sys - Service Area 14	19	19	100.0%
Comp Health Sys - Service Area 15	3	3	100.0%
Family Counseling Center, Inc.	81	81	100.0%
Independence Center - Service Area 23	8	8	100.0%
Independence Center - Service Area 24	3	3	100.0%
Independence Center - Service Area 25	4	4	100.0%
New Horizons (CPS Service Area 12)	14	14	100.0%
Ozark Medical Center	38	38	100.0%
North Central Missouri Mental Health Center	42	41	97.6%
Preferred - Service Area 14	28	27	96.4%
Adapt of Missouri - Service Area 25	26	25	96.2%
Places for People - Service Area 24	20	19	95.0%
Mineral Area CPRC	10	9	90.0%
Ozark Center	138	123	89.1%
Community Counseling Center	55	49	89.1%
Places for People - Service Area 25	8	7	87.5%
Preferred - Service Area 13	7	6	85.7%
Burrell Behavioral Health - Service Area 10	146	124	84.9%
New Horizons (CPS Service Area 11)	18	15	83.3%
Crider Health Center, Inc.	366	304	83.1%
Mark Twain Association for Mental Health, Inc.	58	46	79.3%
Burrell Behavioral Health - Service Area 12	275	218	79.3%
Preferred - Service Area 15	18	14	77.8%
Pathways (CPS Admin Agent Service Area 8B)	148	115	77.7%
BJC - St. Louis City (Service Area 25)	83	63	75.9%
Places for People - Service Area 23	4	3	75.0%
Pathways (CPS Admin Agent Service Area 7)	107	79	73.8%
East Central Missouri Behavioral Health Services	98	72	73.5%
All Adult CPR Admissions	3175	2311	72.8%
Clark Community Mental Health Center	11	8	72.7%
Pathways (CPS Admin Agent Service Area 11)	149	106	71.1%
Pathways (CPS Admin Agent Service Area 17A)	127	87	68.5%
BJC - St. Louis County (Service Area 23)	249	168	67.5%
ReDiscover	89	59	66.3%
Bootheel Counseling Services	64	42	65.6%
Truman Medical Center Behavioral Health	92	59	64.1%
BJC - Farmington (Service Area 17B)	73	43	58.9%
Family Guidance Center	96	50	52.1%
Hopewell Center	52	25	48.1%
Tri-County Mental Health Services	74	31	41.9%
Community Treatment, Inc.	180	65	36.1%
Comprehensive Mental Health Services	21	6	28.6%
Swope Health Services	50	12	24.0%
BJC - St. Patrick Center (ACT) - SA 25	1	0	0.0%
Southeast Missouri Behavioral Health, Inc.	1	0	0.0%

* accepted as completed upon admission if entered into CIMOR through June 22 2011

Youth Status Reports Completed for CPR Clients -- Jan - March 2011 admissions*

Agency Site	Youth CPR Admissions	YSR Completed upon CPR Admission*	Completion Rate
Burrell Behavioral Health - Service Area 12	43	43	100.0%
North Central Missouri Mental Health Center	18	18	100.0%
Ozark Medical Center	12	12	100.0%
Mark Twain Association for Mental Health, Inc.	57	54	94.7%
Pathways (CPS Admin Agent Service Area 7)	60	56	93.3%
Bootheel Counseling Services	25	23	92.0%
Pathways (CPS Admin Agent Service Area 11)	49	45	91.8%
Pathways (CPS Admin Agent Service Area 17A)	39	33	84.6%
Clark Community Mental Health Center	30	25	83.3%
Burrell Behavioral Health - Service Area 10	40	33	82.5%
Pathways (CPS Admin Agent Service Area 8B)	46	37	80.4%
Crider Health Center, Inc.	194	146	75.3%
BJC - St. Louis City (Service Area 25)	12	9	75.0%
Community Counseling Center	25	18	72.0%
Hopewell Center	38	27	71.1%
All Youth CPR Admission	1175	772	65.7%
Ozark Center	68	39	57.4%
BJC - Farmington (Service Area 17B)	18	10	55.6%
Community Treatment, Inc.	29	16	55.2%
BJC - St. Louis County (Service Area 23)	41	22	53.7%
Tri-County Mental Health Services	78	41	52.6%
East Central Missouri Behavioral Health Services	30	15	50.0%
ReDiscover	15	7	46.7%
Family Counseling Center, Inc.	25	10	40.0%
Swope Health Services	36	8	22.2%
Family Guidance Center	117	25	21.4%
Comprehensive Mental Health Services	19	0	0.0%
Truman Medical Center Behavioral Health	11	0	0.0%

* accepted as completed upon admission if entered into CIMOR through June 22 2011

Adult MHSIP "Perception of Care" Surveys Returned for CPR Clients in CY10

Agency	Adult CPR MHSIP Surveys Returned	Adult CPR Clients w/ 1 yr LOS	Adult CPR MHSIP Completion Rate
Comprehensive Health Systems	133	139	95.7%
SEMO	13	19	68.4%
New Horizons SA12	128	213	60.1%
Mark Twain	204	357	57.1%
Ozarks Medical	109	211	51.7%
Independence Center	116	263	44.1%
Family Counseling	183	458	40.0%
New Horizons SA11	89	235	37.9%
Comm Counseling	184	533	34.5%
Truman	227	686	33.1%
Preferred Family	121	388	31.2%
Pathways SA07	106	380	27.9%
Adapt	109	406	26.8%
Pathways SA08B	204	765	26.7%
Burrell SA12	219	866	25.3%
Swope Parkway	65	265	24.5%
Burrell SA10	396	1642	24.1%
Places For People	70	292	24.0%
North Central	61	317	19.2%
Adult CPR total	3777	20873	18.1%
Clark Center	36	206	17.5%
Crider Center	223	1438	15.5%
Family Guidance	120	783	15.3%
BJC SA17B	71	615	11.5%
East Central	21	204	10.3%
Comprehensive Mental Health	43	438	9.8%
BJC SA25	112	1212	9.2%
BJC SA23	162	1913	8.5%
ReDiscover	76	939	8.1%
Tri County	75	1265	5.9%
Pathways SA11	32	617	5.2%
Pathways SA17A	18	538	3.3%
Ozark Center	15	494	3.0%
Bootheel	12	402	3.0%
Comtrea	24	851	2.8%
Hopewell Center	0	454	0.0%
Mineral Area	0	69	0.0%

Youth MHSIP "Perception of Care" Surveys Returned for CPR Clients in CY10

Agency	Youth CPR MHSIP Surveys Returned	Youth CPR Clients w/ 1 yr LOS	Youth CPR MHSIP Completion Rate
Swope Parkway	76	115	66.09%
ReDiscover	35	80	43.75%
Mark Twain	65	149	43.62%
Burrell SA12	67	177	37.85%
Comm Counseling	39	117	33.33%
Ozarks Medical	18	54	33.33%
BJC SA25	17	59	28.81%
Pathways SA08B	33	123	26.83%
BJC SA17B	18	68	26.47%
North Central	19	96	19.79%
Youth CPR total	601	3088	19.46%
Pathways SA07	26	147	17.69%
Burrell SA10	50	306	16.34%
Pathways SA11	28	186	15.05%
Tri County	17	114	14.91%
East Central	7	48	14.58%
Crider Center	54	481	11.23%
Clark Center	5	52	9.62%
Family Guidance	12	140	8.57%
Truman	5	67	7.46%
Bootheel	2	37	5.41%
BJC SA23	6	114	5.26%
Pathways SA17A	2	127	1.57%
Comprehensive Mental Health	0	59	0.00%
Comtrea	0	47	0.00%
Family Counseling	0	31	0.00%
Hopewell Center	0	29	0.00%
Ozark Center	0	65	0.00%

CyberAccess Patient History Utilization Report

March 1 - June 13, 2011

	Patient History Review (June)	Patient History Review (March)	# Cons with EOC (Mar 1)	Avg Hits per Cons with EOC
New Horizons	12,468	11,015	456	3.19
Independence Center	1,690	1,021	293	2.28
Burrell	21,577	11,411	5,091	2.00
Pathways	50,422	41,175	5,028	1.84
Places for People	4,863	4,241	537	1.16
Comprehensive Health	1,842	1,621	197	1.12
Preferred Family	3,931	3,490	424	1.04
Family Guidance Center	4,782	3,219	2,028	0.77
Family Counseling Center	3,570	2,902	947	0.71
Total Avg Hits Per Consumer				**0.71**
COMTREA	3,910	2,843	1,593	0.67
Mark Twain	1,788	1,264	968	0.54
Comprehensive Mental Health	1,922	1,130	1,525	0.52
BJC	14,190	11,191	6,467	0.46
Adapt of Missouri	419	205	464	0.46
Tri-County	7,033	5,927	2,487	0.44
Bootheel Counseling Center	2,651	2,198	1,404	0.32
Crider	5,810	4,834	3,397	0.29
East Central	3,331	2,921	1,458	0.28
Ozark Center	7,762	6,875	3,228	0.27
Hopewell Center	1,109	499	2,263	0.27
Ozarks Medical Ctr	1,698	1,503	794	0.25
Community Counseling Center	3,997	3,125	3,659	0.24
Clark	981	820	679	0.24
ReDiscover	2,317	1,775	3,305	0.16
North Central MO	319	301	899	0.02
Swope Health Services	260	234	2,690	0.01
Total	**164,642**	**127,740**	**52,281**	**0.71**

Overall Usage Increase from March 1, 2011 - June 13, 2011 **28.89%**

* TMC Behavioral Health - June Only Data 2,874

Agencies Benchmark Report

Missouri - Adult (18-64)

January 2011 - April 2011

Agency	*Number Outlier Prescriptions	Total Behavioral Pharmacy Prescriptions	% Outlier Prescriptions
Hopewell Center	463	5,405	8.6%
North Central Missouri Mental Health Center	422	4,467	9.5%
Truman Medical Center Behavioral Health	874	8,641	10.1%
Ozark Center	2,008	18,625	10.8%
Swope Health Services	705	5,919	11.9%
Pathways Community Behavioral Healthcare, Inc.	6,157	49,925	12.3%
Crider Health Center, Inc.	2,371	18,785	12.6%
ReDiscover	1,560	12,309	12.7%
Community Counseling Center	2,600	19,982	13.0%
Ozark Medical Center	610	4,550	13.4%
Bootheel Counseling Services	1,156	8,599	13.4%
Total Avg CMHC Outlier Prescriptions	47,756	324,916	14.7%
Community Treatment, Inc.	1,474	9,812	15.0%
Clark Community Mental Health Center	635	4,200	15.1%
Comprehensive Mental Health Services	1,060	6,901	15.4%
BJC Behavioral Health- SL	3,491	22,573	15.5%
Tri-County Mental Health Services	2,069	13,334	15.5%
Preferred Family Healthcare, Inc.	878	5,602	15.7%
Places for People	633	3,926	16.1%
East Central Missouri Behavioral Health Services	1,565	9,448	16.6%
Family Counseling Center	2,349	14,133	16.6%
New Horizons Community Support Services	779	4,634	16.8%
Burrell Behavioral Health - Springfield	3,992	23,507	17.0%
Burrell Behavioral Health- Central	2,322	12,810	18.1%
Family Guidance Center	2,001	11,027	18.2%
Adapt of Missouri, Inc.	951	5,153	18.5%
Mark Twain Behavioral Health	1,027	5,477	18.8%
Comprehensive Health Systems, Inc.	553	2,892	19.1%
Independence Center	663	2,857	23.2%
BJC Behavioral Health- SE	1,935	8,141	23.8%
Mineral Area Community Psych Rehab Center	453	1,282	35.3%

* for specified Quality Indicators™ (105,111,114,116,122,123,206,211,512,513)

Agencies Benchmark Report

Missouri - Child (0-17)

March 2011 - May 2011

Agency	*Number Outlier Prescriptions	Total Behavioral Pharmacy Prescriptions	% Outlier Prescriptions
Ozark Center	391	5,668	6.9%
ReDiscover	229	3,215	7.1%
Swope Health Services	145	2,032	7.1%
Ozark Medical Center	72	970	7.4%
Family Guidance Center	337	3,456	9.8%
Burrell Behavioral Health- Central	265	2,182	12.1%
Truman Medical Center Behavioral Health	93	704	13.2%
Tri-County Mental Health Services	230	1,709	13.5%
Bootheel Counseling Services	271	1,950	13.9%
Hopewell Center	139	986	14.1%
Total Avg CMHC Outlier Prescriptions	8,803	61,221	14.4%
Community Counseling Center	678	4,563	14.9%
Clark Community Mental Health Center	171	1,145	14.9%
Burrell Behavioral Health - Springfield	402	2,680	15.0%
Pathways Community Behavioral Healthcare, Inc.	1,471	9,578	15.4%
BJC Behavioral Health- SL	392	2,442	16.1%
North Central Missouri Mental Health Center	192	1,195	16.1%
Community Treatment, Inc.	389	2,340	16.6%
Comprehensive Mental Health Services	177	1,041	17.0%
Mark Twain Behavioral Health	356	2,080	17.1%
Crider Health Center, Inc.	1,064	5,476	19.4%
Family Counseling Center	443	2,168	20.4%
BJC Behavioral Health- SE	262	1,267	20.7%
East Central Missouri Behavioral Health Services	634	2,374	26.7%

* for specified Quality Indicators™ (105,111,114,116,122,123,206,211,512,513)

Healthcare Home Training

Learning Collaborative &

Team Certification

CEO • CFO • Clinical Director • CPR Director
Healthcare Home Director • Physician Leadership

Paving the Way for Healthcare Home	• **June 28, 2011** • Train-the-trainer for leadership to train CMHC staff and board members
Healthcare Home 101	• **August 9-10, 2011** • Central training for leadership • Trainers: DMH/MO Coalition of CMHCs
Systems Change Training Phase I **Access to Care**	• **July- Septemer 2011** (3 months) • Central training for leadership • Trainer: Scott Lloyd, David Swann and Joy Fruth, MTM Services
Systems Change Training Phase II **Practice Transformation Healthcare Home Learning Collaborative**	• **December 2011 - August 2012** (8 months) • Central training for bimonthly workshops (4 total) • Trainers: TBD
Systems Change Training Phase III **Meeting Missouri's Healthcare Home Standards**	• **August - December 2012** (4 months) • Central training for bimonthly workshops (2 total) • Trainers: DMH/TBD

Leadership & Organization Training

DRAFT

INTRODUCTION

Paving the Way for Healthcare Home

Timeline: June 28, 2011 (MO Coalition Annual Conference)

Objectives:

- Affordable Care Act
- Missouri's Healthcare Home Initiative
- Healthcare Home Functions
- Healthcare Home Team
- Service Delivery Impact
- Practice Transformations
- Next Steps - Training

Training Model:

- Provide leadership with training materials to introduce their staff to Healthcare Homes, and what it means for their organization.

SPA RULES & REGULATIONS

Healthcare Home 101

Timeline: August 9-10, 2011

Trainer: DMH/MO Coalition of CMHCs

Objectives:

- Program Training for CMHC MO SPA
  - State Rules and Regulations
    - Billing & Documentation
  - Healthcare Home Functions
  - Quality Improvement Measures
    - Clinical Outcomes
    - Experience of Care
    - Quality of Life
- Healthcare Home Team and Roles and Responsibilities
- Technical Assistance in Establishing a Successful Team Approach
- Team and Agency Certification
- Organizational Change
- HIT and Disease Management Initiatives
- Orientation to the Public Health and Primary Care Models

PHASE I

Systems Change Training

Access to Care

Timeline: July - Sept 2011

Trainers: Scott Lloyd, David Swann and Joy Fruth, MTM Services

Pre-Phase:

- Constitute the MO CMHC Project Teams
- Provide Project Orientation to All Team Members

Phase I: 5 months

- Access to Care Flow Processes
  - No Show/Cancel
  - Open Access
  - 24 Hour Coverage
- Integration of Quality Improvement Strategies and Techniques
- Costing
- Data Mapping
- Design of Standardized Process

PHASE II

Systems Change Training

Practice Transformation Healthcare Home Learning Collaborative

Timeline: Dec 2011 - Aug 2012

Trainer: TBD

Phase II: 8 months / 4 workshops

- Workshop 1
  - Patient-centeredness
  - Involvement of the patient in goal setting, action planning, problem solving & follow-up
- Workshop 2
  - Patient & family education
  - Self-management support
- Workshop 3
  - Care coordination across settings
  - Population-based tracking
- Workshop 4
  - Multi-disciplinary team-based approach to care
  - Evidence-based care delivery
  - Integration of quality improvement strategies

TA Support:

- Monthly technical assistance calls

PHASE III

Systems Change Training

Meeting Missouri's Healthcare Home Standards

Timeline: Aug - Dec 2012

Trainer: DMH/TBD

Phase III: 4 months / 2 workshops

- CMHCs will integrate learning collaborative work to meet the Missouri DMH interpretive standards for Healthcare Home. This may be aligned with NCQA, CARF or the Joint Commission.

TA Support:

- Monthly technical assistance calls

Statewide Missouri Access to Services Healthcare Home Consultation Initiative

Consultation Initiative

June 14, 2011 Version

Prepared and Presented By:

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P. O. Box 1027
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Phone: 919-387-9892
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Together…we can make a difference!

Scope of Work:

We look forward to working with each of you for the next six months to help bring about substantive and impactful improvements to your Access Systems. Each team will work in their Internet meetings from July/August through December/January to identify their exact needs, and those needs will be addressed via a rapid-cycle change plan. Although each team's scope of work will be determined by their needs, the recommended base scope of work for the Access Redesign Quality Improvement Initiative is as follows:

a. Provide Internet based meetings for participating CBHOs with MTM Services consultation team members to:

   i. Provide First Call to First Appointment measurement tool for each CBHO to use to confirm the wait time and no show/cancellation levels for each new client from first call to Intake, from the Intake to the first treatment appointment, and from the first treatment appointment to the first appointment with a member of a medical team
   ii. Develop a standardized process flow for each center that will minimize the staff and client time required to positively impact the no show/cancellation rate and develop a set of procedures to support training/implementation of the new flow
   iii. Identify case study access to care solution models developed and implemented by other CBHOs to prevent each CBHO from having to "start over"
   iv. Identify the rapid cycle change management processes that will be used to implement changes
   v. Identify baseline and outcome measurement needed to ensure adequate measurement capability to determine the level of attainment for proof of concept outcomes
   vi. Identify/design current process flows being used within each CBHO from first call to referral into medical services
   vii. Develop data mapping for documentation requirements use by each CBHO in the first call to treatment planning processes to identify and reduce redundant collection of information and ensure that the appropriate level of data is being collected based on an awareness of cost of process versus revenues to offset costs
   viii. Develop a cost analysis of the first call to treatment planning process and compare against the revenue available for the processes for each participating CBHO

ix. Develop a rapid cycle implementation plan and support for implementing the agreed upon changes for each participating CBHO at the rate of one two hour meeting per month for six months during the grant year.

b. Sponsor a one day learning conference within the state at the end of the grant to provide a summary of findings and recommendations for the participating state trade association(s) and/or state department/divisions and the respective CBHOs.

Team Descriptions

Having the right people at the table will make all the difference in the success of your project. Here are some guidelines for who should be in your meetings in the order of the meetings:

First Internet Meeting (July/August 2011) - **Gap Analysis Team** (GAT) - The representatives in this meeting should include all those who have contact with a client from their first call through intake, screening, assessment, and/or treatment planning prior to the client's first treatment appointment. The representatives should be the line staff who carries out these functions, not the staff who supervise them as we need a reporting from those as close to the reality of your practice as possible. If possible, we prefer to have at least two reps for each position, to give us multiple time inputs to assure better accuracy.

Gap Analysis:

Gap Analysis Detail: Use Internet meetings to perform a full Gap Analysis that will:

a. Quantify the Client Time, Staff Time and Cost required to complete the following organizational service processes (Including but not limited to): Referral or Client Call/Walk-In, Intake(s), Assessment(s), Treatment Planning, and the client's first billable service as an "open" client.

b. Identify the Organization's access to care bottle necks and develop solutions to streamline and standardize the processes reviewed.

c. Meeting Preparation/Things to bring if available: Although we want to focus mainly on the staff's experiences, we can also use real data to come to the best information possible if you have it available in your system. With that in mind, you can bring data points for access that you have collected around the following information:

i. No Show Rates: Initial and Ongoing Appointments
ii. **Net** Reimbursement Rates: The net rate collected (blended rate with Medicaid, self pay, sliding fee scale, insurance, etc.) for the organization's intake services
iii. Intake Counts: Average number of intakes by service area actually delivered per month.

iv. Wait time between contacts: How long do clients wait between contacts to get from the first call to the first appointment and subsequent access/intake follow up appointments

Gap Analysis Review – Rapid Cycle Change Team Kickoff:

Once the initial Gap Analysis meeting has been completed with the direct service staff listed above, there will be a second meeting to review the results of the Gap Analysis with the organization's management and/or rapid cycle change team.

Second–Sixth Internet Meetings (August/September-December/January) - **Rapid Cycle Change Team** (RCCT) - This team will consisting of four to six people that will have the authority to implement change and will be able to provide adequate time, energy and enthusiasm to participate in this CQI process. The representatives in this meeting should be a mix of line staff (Direct service and non-direct service) who can offer open and honest feedback in regard to the current realities of your workplace and leaders who have the authority to make changes happen quickly. This team will be challenged to move at a quick pace and make data driven decisions that will lead the team to measureable outcomes during our work together. Additional information about Rapid Cycle Change can be found below under the Additional Information Section.

If Needed - *(Based upon the results of the Gap Analysis and Rapid Cycle Change Meetings)**:***

Data Mapping Team descriptions: The Data Mapping consultation will be completed in two phases by two teams:

Data Mapping Team One (DMT-1) - should consist of 3 to 4 people who can capture all of the data elements from your organization's current form sets and enter that information into the mapping file.

Data Mapping Team Two (DMT-2) - should consist of 10 to 12 members. This team should include members from Team One as a point of reference, but would need to be expanded to include clinical representation that can confirm the clinical relevance of each data point currently being collected in your system.

First Steps – What you need to do to get started!

1. **First Call to First Appointment Measurement** - Please start your First Call to First Appointment measurement on July 1, 2011. The blank First Call to First Appointment Excel worksheets can be found online via the following link:

Copy and paste into your browser:

http://www.mtmservices.org/FirstCallWorksheet_1-6-11_ik3e0z.html

- or -

Click Here: http://www.mtmservices.org/FirstCallWorksheet_1-6-11_ik3e0z.html

More information about the First Call to First Appointment Measurement sheets can be found below in the Additional Information Section.

2. **Schedule your Internet Meetings** - You will need to schedule Internet meetings as outlined above for your Gap Analysis and Rapid Cycle Change Teams. Each month you will have a 2 hour Internet meeting via our GoToMeeting software. To accommodate this meeting, you will need:
    a. A computer connected to the Internet
    b. A projector connected to the computer to display the work for the team
    c. A speaker phone to provide the audio for the meeting

We have a web interface available for you to select the best times that meet your needs. To access this site, please utilize the following:

Web Based Booking Calendar for MTM Team Members

URL Address is: http://mtmservices.acfconsulting.com/

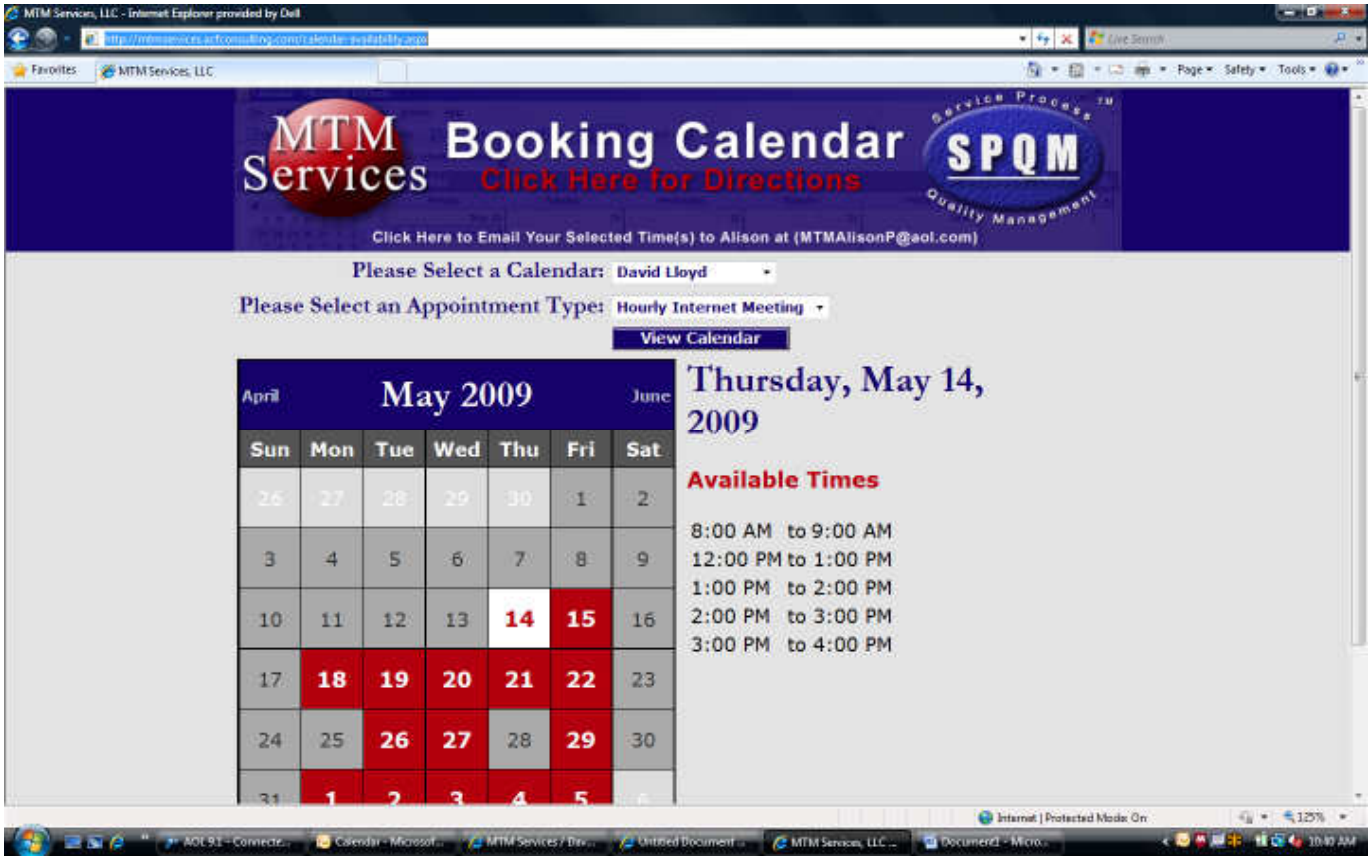
Instructions:

1. **Please Select a Calendar:** Click on the MTM Team member's name you would like to search in the drop down window (i.e., David Lloyd)
2. **Please Select an Appointment Type**: In this drop down menu select "SPQM Meeting/Two Hour Meetings" for two-hour offsite Internet meetings or phone conferences.
3. **Click "View Calendar"**
4. You can click on the months on the right or left to navigate to a different month.
5. Red dates indicate availability within the selected month of the appointment type selected.
6. Click on the red date and the "available times" will be displayed to the right of the calendar
7. Confirm with Alison Pleasants, MTM Executive Administrative Coordinator , the time you would like to book at her email address: Alison.pleasants@mtmservices.org. Note: You can clinic on the email notation at the top of the page to automatically email Alison.

Additional Information:

A few days prior to the meeting, you will be sent a meeting notice that contains the access information for the online meeting. You will need an internet connection to access the meeting, and a phone to dial in to the conference call. If a group is planning to attend, you can gather everyone in one room and use a projector for

your screen and a speaker phone, or up to 23 attendees can access it separately from their individual locations. We look forward to working with you!



As we have to book on a first come first serve basis, we recommend that you act quickly to schedule your meetings to assure that you are able to get the times that you desire. Again, your scheduling contact is:

Alison Pleasants
Executive Administrative Coordinator
MTM Services, LLC
Website: mtmservices.org
PO Box 1027
Holly Springs, NC 27540
Phone/Fax: (919) 387-9892
E-mail: Alison.pleasants@mtmservices.org

Additional Information

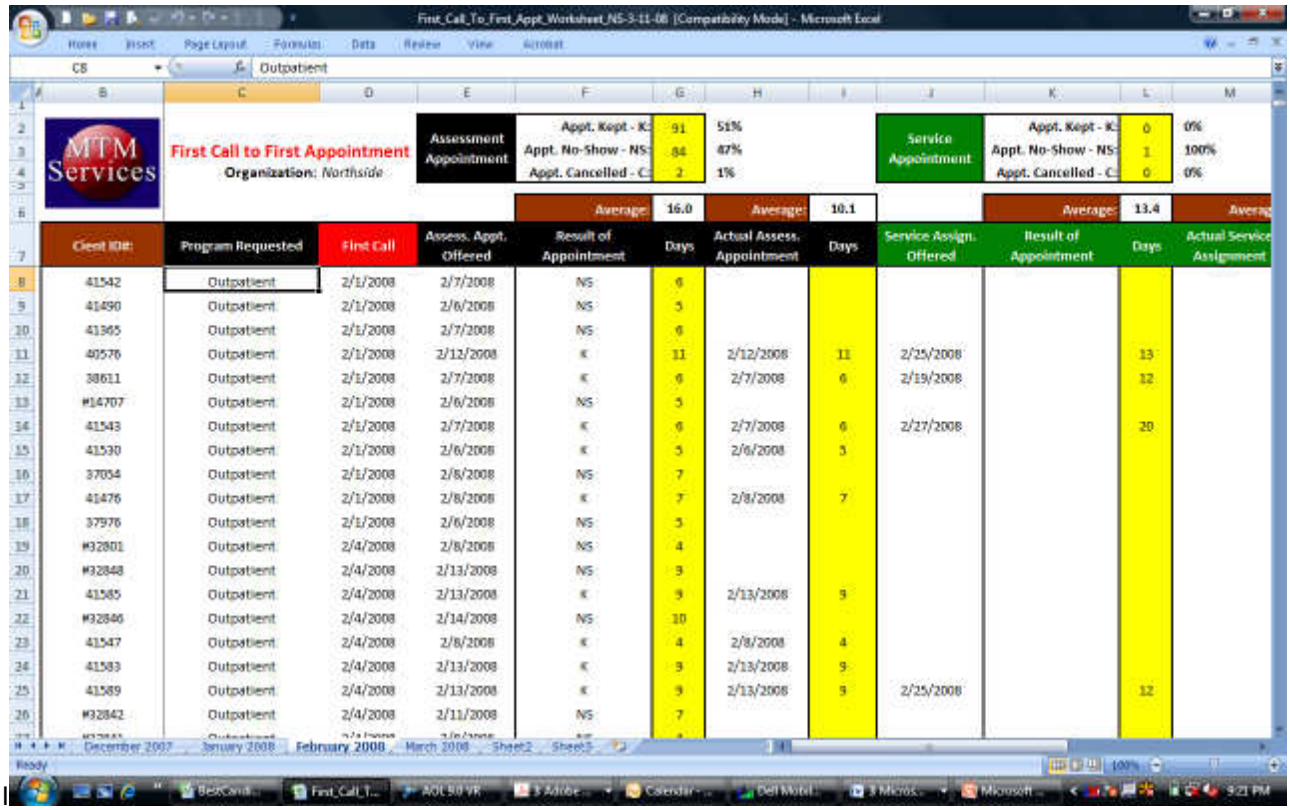
1. **First Call to First Appointment** - The MTM Services project management faculty developed a uniform access to care measurement capacity through the use of a newly designed First Call to First Appointment measurement report as identified in Figure Three. The purpose of this report is to provide each collaborative member the ability to track all new clients beginning December 1, 2007 from his/her first call for services to the first available Intake appointment. The measurement tool also provides the ability to measure the first offered appointment date and the actual appointment date along with measurement of client no shows and client cancellations.

   Secondly, the measurement tool tracks the access for clients that kept his/her Intake appointment to the first treatment appointment that would typically be used to develop a treatment plan. Again, the measurement tool provides the ability to record the first available appointment date and the actual appointment date along with measurement of whether the client kept, canceled or no showed for the first treatment appointment.

   Thirdly, the measurement tool tracks the access for clients that kept his/her first treatment appointment to the first appointment with a psychiatrist or advanced nurse specialist along with the disposition of the scheduled appointment.

   The measurement outcomes from collaborative members has been very revealing regarding the level of no show/cancelation activity in correlation to the wait time in days between each of the face to face service opportunities.

Figure One:



First Call to First Appointment

Organization: Northside

Assessment Appointment			Service Appointment		
Appt. Kept - K:	91	51%	Appt. Kept - K:	0	0%
Appt. No-Show - NS:	84	47%	Appt. No-Show - NS:	1	100%
Appt. Cancelled - C:	2	1%	Appt. Cancelled - C:	0	0%

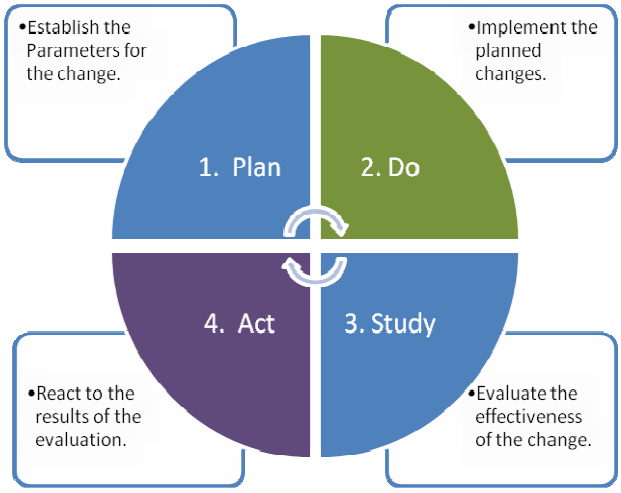
				Average: 16.0		Average: 10.1			Average: 13.4	
Client ID#:	Program Requested	First Call	Assess. Appt. Offered	Result of Appointment	Days	Actual Assess. Appointment	Days	Service Assign. Offered	Result of Appointment	Days	Actual Service Assignment
41542	Outpatient	2/1/2008	2/7/2008	NS	6						
41490	Outpatient	2/1/2008	2/6/2008	NS	5						
41365	Outpatient	2/1/2008	2/7/2008	NS	6						
40576	Outpatient	2/1/2008	2/12/2008	K	11	2/12/2008	11	2/25/2008		13	
38611	Outpatient	2/1/2008	2/7/2008	K	6	2/7/2008	6	2/19/2008		12	
#14707	Outpatient	2/1/2008	2/6/2008	NS	5						
41543	Outpatient	2/1/2008	2/7/2008	K	6	2/7/2008	6	2/27/2008		20	
41530	Outpatient	2/1/2008	2/6/2008	K	5	2/6/2008	5				
37054	Outpatient	2/1/2008	2/8/2008	NS	7						
41476	Outpatient	2/1/2008	2/8/2008	K	7	2/8/2008	7				
37976	Outpatient	2/1/2008	2/6/2008	NS	5						
#32801	Outpatient	2/4/2008	2/8/2008	NS	4						
#32848	Outpatient	2/4/2008	2/13/2008	NS	9						
41585	Outpatient	2/4/2008	2/13/2008	K	9	2/13/2008	9				
#32846	Outpatient	2/4/2008	2/14/2008	NS	10						
41547	Outpatient	2/4/2008	2/8/2008	K	4	2/8/2008	4				
41583	Outpatient	2/4/2008	2/13/2008	K	9	2/13/2008	9				
41589	Outpatient	2/4/2008	2/13/2008	K	9	2/13/2008	9	2/25/2008		12	
#32842	Outpatient	2/4/2008	2/11/2008	NS	7						

2. **Outline of Rapid Cycle Testing Methods:** While all changes do not lead to improvement, all improvement requires change. The ability to develop, test, and implement changes is essential for any individual, group, or organization that wants to continuously improve. A change concept is a general notion or approach to change that has been found to be useful in developing specific ideas for changes that lead to improvement. Creatively combining these change concepts with knowledge about specific subjects can help generate ideas for tests of change. After generating ideas, Plan-Do-Study-Act (PDSA) cycles test a change or group of changes on a small scale to see if they result in improvement (Refer to Figure Two). If they do, the tests are expanded and gradually incorporate larger and larger samples until there is confidence that the changes should be adopted more widely.

   Throughout the Collaborative the focus is on results with a strong, early emphasis on establishing performance measurement systems within participating institutions. Results depend on the performance of numerous planned, structured tests of change while collecting data to learn from those tests. The ideas being tested are, in general, already proven in the literature, successfully used elsewhere, and supported by experts in the field.

The purpose of testing change is iterative inductive-deductive learning about, and change in, our systems of care to achieve documented improvements in outcomes. Several thorough descriptions on the topic of testing change and using the scientific method in clinical care recently have been published.

Figure Two:



The Deming Cycle, Deming's wheel, or the PDSA cycle above is a long time utilized continuous quality improvement change philosophy created as part of W. Edwards Deming's Total Quality Management process (TQM) in the 1950's. Deming's work was based off of the Plan, Do and See cycle created by Mr. Walter A. Shewart in the 1920's, and has created successful change initiatives across multiple industries

a. **Rapid Cycle Change Action Plan Model:**

MTM Services has developed Rapid Cycle Action Work Plans to support project management nationally with CBHOs. The attainment focused plans have assisted in timely completion of each task needed to complete a specific phase of the change initiative. Figure Three provides a sample of the Action Work Plan to operationalize the solution as a part of the overall Rapid Cycle Change Plan that will be used by the consulting team and the participating CBHOs.

Figure Three:

Healthcare Home Director • Nurse Care Managers

Level 1 **Healthcare Home 101**	• **September 2011 - January 2012** • Central training in Jefferson City for start-up period
Level 2 **Person-Centered Care**	• **September 2011 - January 2012** • Central training in Jefferson City for start-up period • Trainers: Training workgroup coordinates training with trainers
Level 3 **Understanding & Managing Chronic Diseases**	• **September 2011 - January 2012** • Central training in Jefferson City for start-up period • Trainers: Training workgroup coordinates training with trainers
Level 4 **Child & Adolescent Wellness**	• **September 2011 - January 2012** • Central training in Jefferson City for start-up period • Trainers: Training workgroup coordinates workshops with trainers
Special Program Certification	• **September 2011 - January 2012** • Central training in Jefferson City for start-up period • Trainers: Training workgroup coordinates workshops with trainers
CMHC Healthcare Home Manual for CSS/Case Managers	• **January 2012** • Delivered to CMHCs to distribute to staff • Team: Training workgroup will develop CMHC HH manual

LEVEL 1

Healthcare Home 101

- The CMHC Healthcare Home
  - State Plan Amendment
    - Billing & Documentation
  - Healthcare Home Functions
  - Quality Improvement Measures
    - Clinical Outcomes
    - Experience of Care
    - Quality of Life
- Healthcare Home Core Team and Roles and Responsibilities
- Technical Assistance in Establishing a Successful Team Approach
- Team Certification
- HIT and Disease Management Initiatives (*DMH Net manual*)
- Orientation to the Public Health and Primary Care Models
  - How to communicate effectively within the medical community

DMH Services and Resources

- Comprehensive Psychiatric Services
  - Community Support Services
- Alcohol and Drug Abuse
- Developmental Disabilities
  - Eligibility

LEVEL 2

Person-Centered Care

Introduction to Becoming Patient-Centered

- What it means to be Patient-Centered?

Motivational Interviewing

- Health Behavior Change
- Chronic Disease Self-Management

Medication Treatment and Adherence

- Psychopharmacy
- Polypharmacy
- Treatment Adherence (*Team Solutions*) & Drug Interactions

Primary Care Resources

- IHI PC Toolkit (*CMH/SAMHSA*)
- Shared Decision Making (*SAMHSA*)
- Trauma Informed Care

LEVEL 3

Understanding & Managing Chronic Diseases

Disease Management and Pharmacology (*HCO monographs, DMH Net materials, Health Education Answers*)

- Diabetes (*Diabetes Education Toolkit; Lilly Case Manager Workshop Series: fundamentals, cardiovascular disease, SMI*)
- Asthma/COPD
- Cardiovascular Disease/Hypertension
- Overweight

Health and Wellness/Lifestyle Change (*Solutions for Wellness; Take Charge to Wellness; Health Education Answers*)

- Healthy Eating
- Physical Activity
- Tobacco Cessation (*Learning About Healthy Living*)

Substance Abuse and Treatment

Orientation to the Public Health and Primary Care Models

- How to communicate effectively within the medical community

LEVEL 4

Child & Adolescent Wellness

Introduction to Child Wellness

- Living and Community Resources
- Working with Families and Support
- Developmental Disabilities
  - Developmental milestones
- Bullying and Abuse

Disease Management and Pharmacology (*Health Education Answers*)

- Diabetes
- Asthma
- Cardiovascular Disease
- Overweight

Health and Wellness/Lifestyle Change (*Health Education Answers*)

- Health Eating
- Physical Activity
- Tobacco Prevention and Cessation for Youth
- Substance Abuse

Medication Treatment and Adherence for Children & Adolescents

Implementation Planning

GANTT: CMHC Healthcare Home Implementation

April 2011 - January 2013

GANTT Updated: Tuesday, June 28, 2011

	Task	Workgroup	Status to Date	Target Goal	Task Completed
State Plan Amendment (SPA)					
A	Write-up CMHC HH payment methodology	Joe Parks, Tim Swinfard, Ian McCaslin	In progress - working internally (DSS/DMH) and with CMS to finalize payment methodology.	5/1/2011 - 1st draft submitted 6/20/2011 - 2nd draft submitted (in progress)	
B	Update SPA with CMS response questions	DSS, DMH, Alicia Smith	In progress - CMS gave a second round of additional feedback on PC and CMHC SPA 6/15. DSS/DMH working with CMS.	5/15/2011 - 1st response for informal review 6/20/2011 - 2nd response for informal review (in progress)	
C	Submit official SPA to CMS	DSS, DMH	DSS/DMH in comment period with CMS to address 2nd round of CMS feedback.	7/2011 (CMS response due in 90 days) *Date pushed back to address CMS feedback	
Healthcare Home Payments					
A	Providers meet criteria for infrastructure payment	Criteria: (1) leadership presents "Paving the Way for HH" to staff & board, (2) attend HH 101 training for leadership, (3) approved as HH service provider status as a CMHC (4) commit to Phase I: Access to Care (MTM Services) (5) commit to Phase II & III: Systems Change Training	In progress	6/28 - 8/15/2011	
B	Infrastructure payment start date	Provider action plan: (1) present Paving the Way for HH to agency, (2) hire/promote staff for HH team, (3) gear up for HH team certification training	Payment methodology still to be determined	8/15/2011 Possibly 9/1/2011	
C	Providers meet criteria for PMPM payment	Criteria: attained sufficient HH staff who have attended the HH Certification Training		9/1 - 12/15/2011	
D	PMPM payment start date	CMHCs begin HH	Payment methodology still to be determined	11/1/2011	
DMH Rules & Regulations					
A	Rule making process	MHN, CPS Policy Team		8/1/2011	
B	Outline SPA questions TBD	CPS Policy Team	In progress - CPS policy team meets every Wednesday morning & will begin mapping out the rules & regulations for HH	6/15/2011	
C	Client eligibility	CPS Policy Team	In progress	8/1/2011	
D	HH team qualifications, ratios & requirements	CPS Policy Team	In progress	8/1/2011	
E	Agency recognition & HH team certification requirements	CPS Policy Team	In progress	8/1/2011	
F	Billing procedures	CPS Policy Team	In progress	8/1/2011	
G	Documentation requirements	CPS Policy Team	In progress	8/1/2011	
H	HH provider manual	CPS Policy Team	In progress	9/1/2011	

GANTT: CMHC Healthcare Home Implementation

April 2011 - January 2013

GANTT Updated: Tuesday, June 28, 2011

	Task	Workgroup	Status to Date	Target Goal	Task Completed
Application for Healthcare Home Provider Status					
A	Finalize MHN/DMH application for HH service provider status as a CMHC	HH Coordinating Team	**COMPLETE**	6/15/2011	x 6/20/11
B	Release HH application at the Coalition Annual Conference	DMH, Coalition	**COMPLETE**	6/28/2011	x 6/28/11
C	HH applications due to DMH	Providers	Technical assistance for completing the application is available. Providers will submit their application to Susan Blume, DMH.	7/20/2011	
D	Recognition of HH status to ready providers (response to applicants)	DMH		8/15/2011	
Leadership & Organization Training					
A	Implementation status update and application review for leadership at the Coalition Annual Confernece	DMH, Coalition	**COMPLETE**	6/28/2011	x 6/28/11
B	Introduce & distribute **Paving the Way for HH Training** to leadership at the Coalition Annual Conference	DMH, Coalition	**COMPLETE**	6/28/2011	x 6/28/12
C	Develop "HH 101" training module	Training workgroup		8/1/2011	
D	**HH 101 Leadership Training**	DMH, Coalition	Tentative: training will take the place of the August Coalition Meeting Back-up training date TBD	8/9-10/2011	
E	**Phase I:** Systems Change Training / Access to Care	MTM Services	In progress - MTM has contacted CMHCs to begin scheduling meetings w/ staff.	7/1 - 9/2011	
F	**Phase II:** Systems Change Training / Practice Transformation Healthcare Home Learning Collaborative	Training workgroup	Outlining the learning collaborative and preparing for training delivery	12/1/2011 - 8/1/2012 4 workshops over 8 months	
G	**Phase III:** Systems Change Training / Meeting Missouri's Healthcare Home Standards	Training workgroup, CMHC HH Steering group will work on converting HH standards into a Missouri version for CMHCs	Once MO standards have been determined, training workgroup will begin outlining the training workshops and prepare for training delivery	8/1/2012 - 12/1/2013 2 workshops over 4 months	
H	Provide implementation & staff TA	HH Coordinating Team	Available	-	

GANTT: CMHC Healthcare Home Implementation

April 2011 - January 2013

GANTT Updated: Tuesday, June 28, 2011

	Task	Workgroup	Status to Date	Target Goal	Task Completed
HCH Team Certification Training					
A	Develop Levels One - Four training modules for HH team certification training	Training workgroup	Training workgroup meets every Friday starting 4/22	4/15/2011 - 8/1/2011	
B	Cordinate team certfication training dates	Training workgroup		8/1 - 9/1/2011	
C	Review & finalize Levels One - Four training modules	DMH, Coalition, CMHC HH Steering group		8/15/2011	
D	**Kick-off HH Team Certification Training** (start-up centralized trainings)	DMH, Coalition		9/1/2011 - 1/1/2012	
E	Provide add'l training & staff TA	DMH, Coalition		9/1/2011 -	
Patient Registry					
A	Develop CMHC HH paitient registry	DMH, MO HealthNet	IT group meeting to outline the patient registry	5/1/2011 - ?	
Communication					
A	Introduce and update CMHC HH plan with consumer advocacy groups	DMH, Coalition	CMHC HH presentations have been made to NAMI, MHA, Federation of MO Advocates, MOPRA	4/1/2011 - ?	X

Potential Auto-Enrollment for CMHC Healthcare Homes

 # CPS Consumers with Open EOC on March 1, 2011

	Total Consumer w/ CPR MHN Claims 3 months	**Nurse Care Managers FTE** max caseload 250	**Physician FTE**
Pathways Community Behavioral Healthcare, Inc.	2,685	10.74	1.29
Burrell Behavioral Health Care Center	1,898	7.59	0.91
BJC Behavioral Health	1,789	7.16	0.86
Crider Health Center, Inc.	1,088	4.35	0.52
Family Guidance Center	760	3.04	0.37
Community Counseling Center	641	2.56	0.31
Truman Medical Center Behavioral Health	542	2.17	0.26
Swope Health Services	537	2.15	0.26
ReDiscover	492	1.97	0.24
Mark Twain Association for Mental Health, Inc.	455	1.8	0.22
Ozark Center	453	1.81	0.22
Tri-County Mental Health Services	448	1.79	0.22
Comprehensive Mental Health Services	414	1.66	0.20
Family Counseling Center, Inc.	398	1.59	0.19
Bootheel Counseling Services	380	1.52	0.18
Hopewell Center	369	1.48	0.18
Adapt of Missouri, Inc.	342	1.37	0.16
Community Treatment, Inc.	313	1.25	0.15
New Horizons Community Support Services	310	1.24	0.15
Preferred Family Healthcare, Inc.	305	1.22	0.15
East Central Missouri Behavioral Health Services	298	1.19	0.14
North Central Missouri Mental Health Center	275	1.1	0.13
Places For People	249	1.00	0.12
Ozark Medical Center	228	0.91	0.11
Independence Center	209	0.84	0.10
Comprehensive Health Systems, Inc.	172	0.69	0.08
Clark Community Mental Health Center	170	0.68	0.08
	16,220	65	7.80