

# MO Primary Care Health Home Initiative (PCHH)



# What is a medical home?

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## Medical Homes Provide:

- comprehensive and coordinated care in the context of individual, cultural, and community needs
- Medical, behavioral, and related social service needs and supports are coordinated and provided by provider and/or arranged
- emphasize education, activation, and empowerment through interpersonal interactions and system-level protocols
- at the center of the medical home are the patients and their relationship with their primary care team

# Missouri's Health Homes

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- Two health home initiatives in Missouri
  - Primary Care
    - Behavioral health care into the traditional primary care model through the addition of a behavioral health cons
  - Behavioral Health
    - Primary care into the traditional behavioral health model
- Providers that meet the health home requirements will receive a Per-Member-Per-Month (PMPM) payment for performing health home services and activities (“touches”)

# Patient Enrollment Eligibility for PCHH

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- Participant must meet the following criteria:
  - MO HealthNet eligible
  - Not be locked into hospice
  - Not living in nursing home
  - PCHH organization must be PCP for enrollee
  - Patient not enrolled in another PCHH or CMHC Health Home
  - Meet spend-down, and/or pay any premiums due
  - Have paid/final claims (excluding original claims that were reversed/ voided) with an approved PC diagnosis in one of the first five positions on a claim.
  - Have one of three stand alone qualifying conditions and/or two or more qualifying conditions/risk factors
  - Have at least \$775 of MO HealthNet paid costs prior to enrollment

# Missouri PCHH Qualifying Conditions

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- Combination of Two
  - Diabetes (CMS approved to stand alone as one chronic disease and risk for second)
  - Heart Disease, including hypertension, dyslipidemia, and CHF
  - Asthma
  - Overweight/Obesity (BMI  $\geq$  25 or 85<sup>th</sup> percentile)
  - Tobacco Use
  - Developmental Disabilities
  - Pediatric Asthma\*\*
  - Obesity (BMI  $\geq$  30 or 95<sup>th</sup> percentile)\*\*
- Behavioral Health Conditions (only one of these)
  - Anxiety
  - Depression
  - Substance Use Disorder\*

\*must have at least one provider certified to provide medication-assisted treatment

\*\*stand-alone conditions – must meet certain criteria

# Missouri PCHH Updated Qualifying Conditions

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Proposed to begin later in 2019 (conditional on CMS approval of SPA)

- Chronic Pain (condition and risk factor)
  - Chronic Pain is pain that lasts past the time of normal tissue healing. Risk stratification for severity of pain, as well as for worsening condition and/or opioid dependency will be incorporated into eligibility. Qualified participant eligibility shall be limited to chronic non-cancer neck and back pain, chronic pain post trauma, (i.e., motor vehicle collision), and others as determined medically necessary through a prior approval process.
  - The criteria for the risk of developing another chronic condition includes chronic pain that can lead to other problems in individuals, such as substance use disorder, overweight/obesity, depression, anxiety, or low self-esteem.

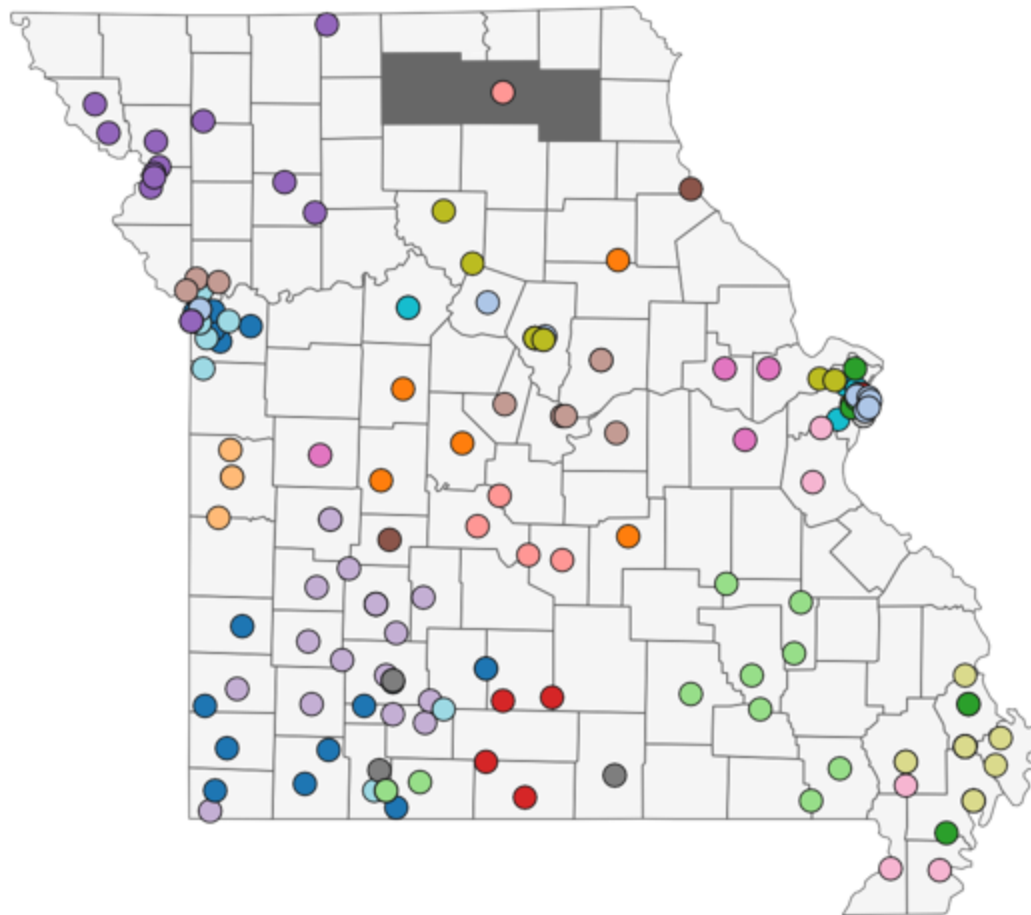
# Participating Sites

	Jan-12	Apr-16	May-17	Jul-18	Feb-19
<b>Participants Enrolled in PCHH</b>	<b>20,239</b>	<b>19,500</b>	<b>24,686</b>	<b>24,191</b>	<b>29,000</b>

FQHCs	18	21	23	24	27
Hospital-affiliated organizations	6	9	9	9	11
Independent primary care clinics	0	2	3	3	4
Local public health department	0	0	0	0	1
<b>Total organizations</b>	<b>24</b>	<b>32</b>	<b>35</b>	<b>36</b>	<b>43</b>

<b>Total clinic sites</b>	<b>134</b>	<b>172</b>
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## MHD Primary Care Health Home Locations February 2019



- PCHH**
- |                                      |                                     |
|--------------------------------------|-------------------------------------|
| Access Family Care                   | Katy Trail Community Health         |
| Affinia Healthcare                   | Managed Care, Inc.                  |
| Arthur Center Community Health       | Missouri Delta Medical Center       |
| Bates County Memorial Hospital       | Missouri Highlands Health Care      |
| Betty Jean Kerr Peoples Health Ce... | Missouri Ozarks Community Health    |
| Bridges Medical Services             | Northeast Missouri Health Council   |
| Care STL (formerly Myrtle Hilliard   | Northwest Health Services           |
| Central Ozarks Medical Center        | OCH Health System                   |
| Children's Mercy Hospital            | Ozarks Community Health Center      |
| Citizens Memorial Healthcare         | Priority Care Pediatrics, LLC       |
| Clarity Healthcare (Preferred Famil  | Samuel U. Rodgers Health Center     |
| Community Health Center of Centr     | Southeast Missouri Health Network   |
| Compass Health Wellness              | Southern Missouri Community Hea     |
| COMTREA Community Health             | SSM Cardinal Glennon Children's     |
| CoxHealth                            | SSM Pediatrics                      |
| Family Care Health Centers           | SSM St. Mary's                      |
| Family Health Center                 | St. Louis County Department of Pu   |
| Ferguson Medical Group               | Swope Health Services               |
| Fitzgibbon Hospital                  | Truman Medical Centers              |
| Fordland Clinic                      | University of Missouri Health Syste |
| Jordan Valley Community Health C     | Your Community Health Center        |
| Kansas City CARE Clinic              |                                     |



# Goals of the Primary Care Health Home Initiative

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- Reduce inpatient hospitalization, readmissions and inappropriate emergency room visits
- Improve coordination and transitions of care
- Improve clinical indicators ( e.g. A1C, LDL, blood pressure)
- Implement and evaluate the Health Home model as a way to achieve accessible, high quality primary health care and behavioral health care;
- Demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model; and
- Support primary care and behavioral care practice sites by increasing available resources and improving care coordination to result in improved quality of clinician work life and patient outcomes.

# Reports

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- Hospitalization and ER visit notifications
- High utilizers (reports and graphs)
- CyberAccess usage (detail and summary)
- Possible PCHH enrollees
- Monthly enrollment/discharge list
- Payment rejects
- Staffing/payment comparisons
- Retrospective payments
- Managed care participants

# Health Home Services/Attestation

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## Comprehensive care management

- Review of medical records
  - Pre Planning visits
- Review of Cyberaccess claims
- Meet with patient during office visits
- Huddles with team to discuss care
- Care plan development including patient goals, preferences and optimal clinical outcomes
- Address barriers to learning
- Utilizing EMR and other Population Health tools to manage and track chronic disease management goals

NOTE: Touches must be documented-best practice documentation in EMR

# Health Home Services/Attestation

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## Care Coordination

- Appropriate linkages, referrals, coordination and follow-up as needed
  - Assist pt with scheduling appointments
  - Setting up referral appointments
  - Closing transition of care loop

# Health Home Services/Attestation

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## Health Promotion

- Providing health education specific to an individuals:
  - Chronic condition
  - Development of self-management goals/plans
- Assist patient to find group classes, or lead group classes
  - Tobacco cessation
  - Diabetes
  - Exercise
- Age Appropriate screenings and immunizations

**NOTE:** Newsletters or other educational materials can be used if they are targeted to a person's specific conditions.

# Health Home Services/Attestation

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## Comprehensive Transitions of Care

- Comprehensive transitional care including follow-up from inpatient and other settings – **Medication Reconciliation**
- Review hospitalization certification reports from MHN and f/u as necessary
- F/u with outside support services

# Health Home Services/Attestation

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## Patient and Family Support

- Identify resources
- Advocating for patients and families, assist with obtaining medication and other treatment supplies.
- Discuss caregiver role, encourage BHC

# Health Home Services/Attestation

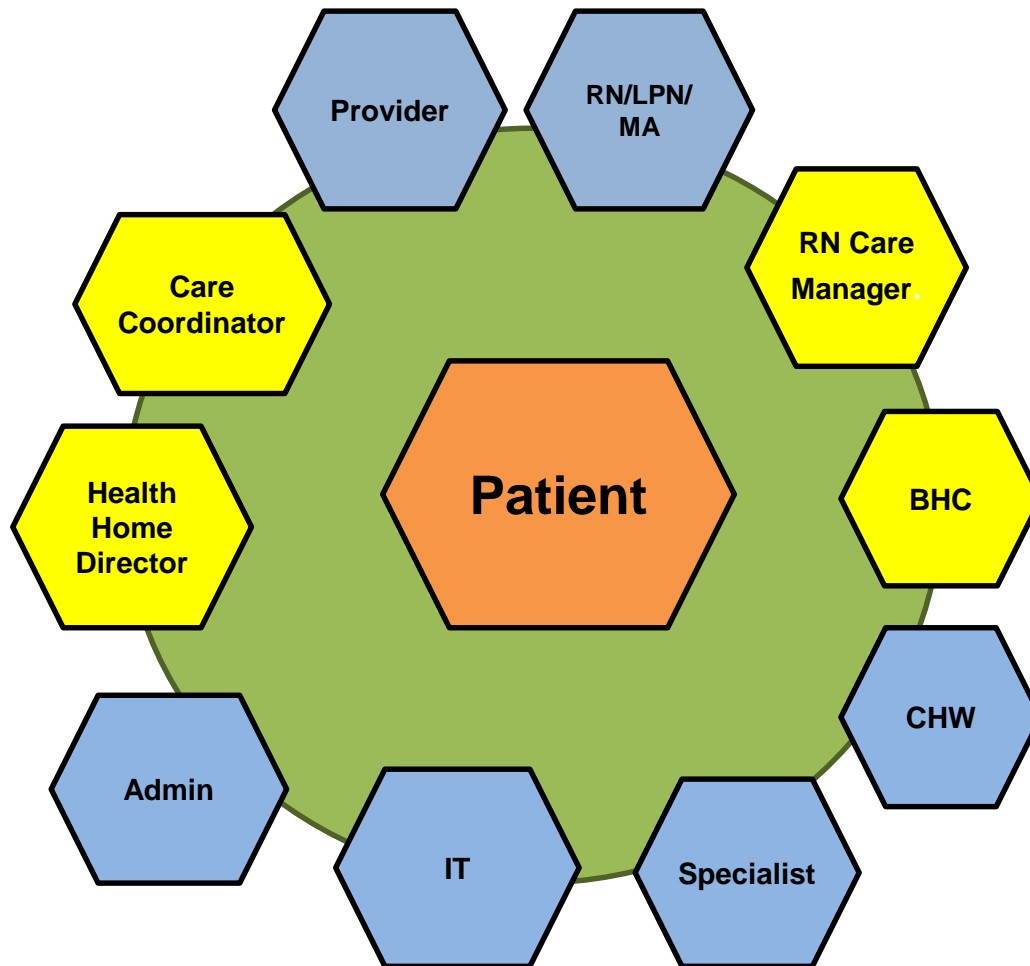
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## Referral to Community and Support Services

- Home health visits and DME supplies medication and other treatment supplies
- Assist with paperwork for housing, healthcare coverage, etc.
- Transportation, housing, food securities, work with CHW on barriers and needs



# Care Team



# Four Required Health Home Team Members

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- Health Home Director (1 FTE:2500 Enrollees)
- Nurse Care Manager (1 FTE:250 Enrollees)
- Behavioral Health Consultant (1 FTE:750 Enrollees)
- Care Coordinator (1 FTE:750 Enrollees)
- Physician Champion

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- Administration
  - Information Technology

# Health Home Director

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- Provides leadership for the implementation and coordination of health home activities
- Coordinates activities of other health home staff
- Champions practice transformation based on health home principles
- Monitors health home performance and leads improvement efforts
- Training and technical assistance
- Data management and reporting
- Assist with enrollment/discharge processing

# Nurse Care Manager

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- Direct relationships with patients and coordination with primary care team, specialty care teams, and inpatient facilities.
  - Visit 1:1 with patients in clinic
  - Contact via portal or phone
  - Educational/outreach programs
- Develop care plans that are patient driven and must be documented in EMR and updated at least once per year
- Utilize MHD health technology programs & initiatives (i.e., CyberAccess)
  - Medication adherence reporting
- Track patient progress, review labs, triage calls, provide education

# Nurse Care Manager

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- Utilize DRVS and other reports provided by MHD to identify gaps in care and needed services for enrollees
- Address medication alerts, hospital admissions/ discharges and ER visits - **including medication reconciliation**
- **Identify and address high utilizers**
- Monitor & report performance measures & outcomes
  - Updates team on progress

# Behavioral Health Consultant

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- Requires LCSW, Clinical Psychologists and/or individuals that are working towards certification and are currently in clinical supervision
- Focus on managing a population of patients versus specialty care
- Support care team in identifying and behaviorally intervening with patients to improve their physical health condition
- **Assist with high utilizers**
- Behavioral supports to assist individuals in improving health status and managing chronic illnesses
- Assistance with medication adherence, treatment plan adherence, self management support/goal setting, and facilitate group classes
- Brief interventions for individuals with behavioral health problems (not long term hour long therapy sessions)
- Brief coaching sessions for SBIRT

# Care Coordinator

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- This role does not stipulate a specific licensure requirement as the nurse care manager however many health homes have found it helpful to have someone with clinical knowledge such as a LPN or MA in this role.
- Assist with referral tracking and feedback
- Assist with performance improvement and data management.
- Process enrollment/discharge/transfer forms
- Provide assistance with enabling services such as transportation, food, housing, etc.
  - Utilize CHW to assist
- Reminding enrollees regarding keeping appointments, filling prescriptions, follow-up on self-management goals, etc.
- Requesting and sending medical records for care coordination

# Physician Champion

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- Serves in a leadership capacity promoting and implementing the health home and medical home model
- Creates the strategic vision and drives the investment necessary to create the needed PCMH infrastructure
- Participates in health home planning meetings and activities
- Participates in development and maintenance of health home program structure and policies
- Promotes health/medical home transformation to all physicians
- Works with physicians who resist changes resulting from transition to the health home/medical home model
- Review data showing results of health home implementation





# 2019 Primary Care Health Home Performance Measures

1. Adult Hypertension Controlling High Blood Pressure (NQF 0018)
2. **Childhood Weight Screening and Counseling**
  1. **Child Weight Screening / BMI (NQF 0024)**
  2. **Child Weight Screening / Nutritional Counseling (NQF 0024)**
  3. **Child Weight Screening / Physical Activity (NQF 0024)**
3. **Pediatric and Adult Asthma Controller Medication Ages 5-64 (CMS126v5):**
  1. **Use of Appropriate Medications for Asthma Ages 5-11 (NQF 0036)**
  2. **Use of Appropriate Medications for Asthma Ages 12-18 (NQF 0036)**
  3. **Use of Appropriate Medications for Asthma Ages 19-50 (NQF 0036)**
  4. **Use of Appropriate Medications for Asthma Ages 51-64 (NQF 0036)**
4. Adult Diabetes A1c > 9 (NQF 0059)
5. Adult Diabetes A1c < 8 (NQF 0059 modified)
6. Adult Diabetes BP < 140/90 (NQF 0059 modified)
7. **Screening for Clinical Depression and Follow-Up Plan (NQF 0418)**
  1. **Ages 12-17**
  2. **Ages 18 and older**
8. Adult BMI Screening and Follow-up (NQF 0421)
9. **Care Coordination (MPCA PCHH)**
  1. **Ages 3-17**
  2. **Ages 18 and older**
10. Adult SBIRT Substance Abuse Screening and Follow Up (MPCA PCHH)
  1. Adult SBIRT Drug Use (MPCA PCHH)
  2. Adult SBIRT Excessive Drinking (MPCA PCHH)
11. Statin Therapy for Prevention & Treatment of CVD (CMS Prev-13)



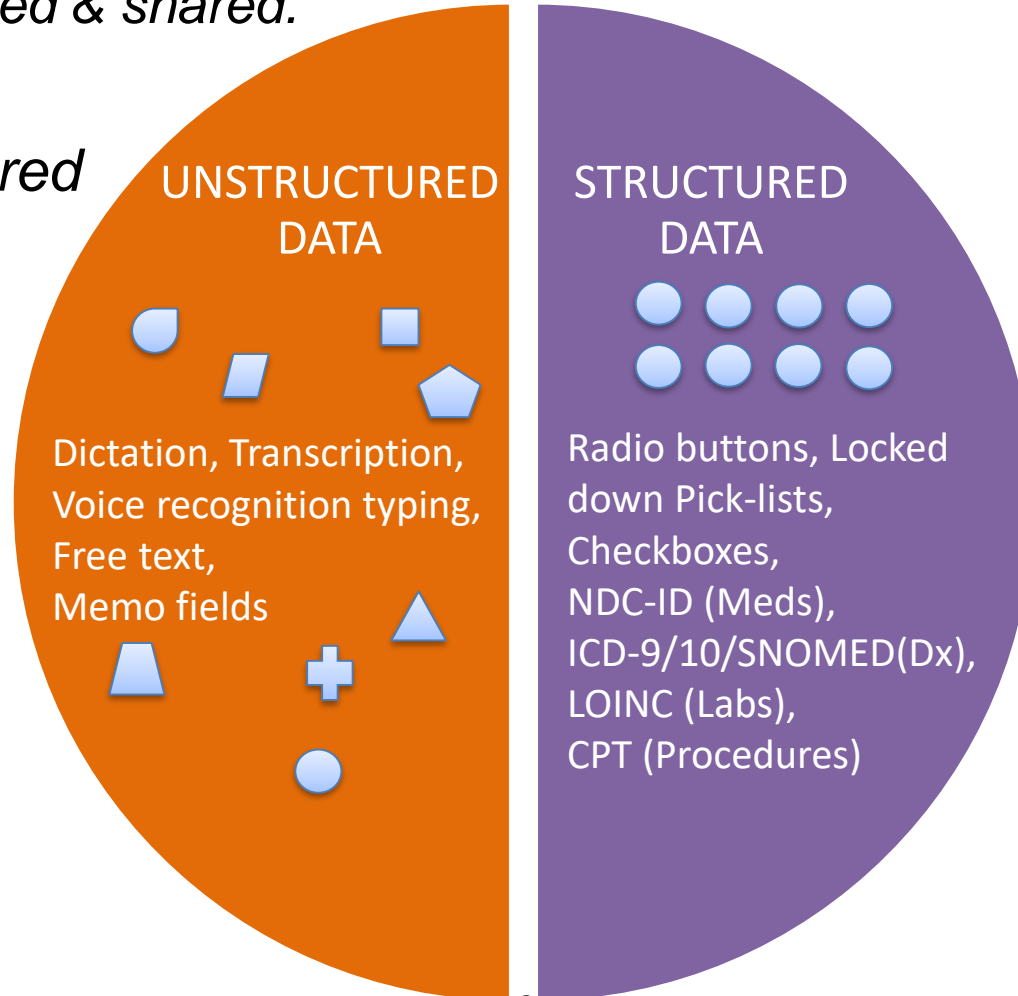
# 2019 Primary Care Health Home Performance Measure Final Goals 12/19

Measures	Final MO HealthNet Aggregate Goal 12/19
BMI Screening and Follow-Up 18+ Years (NQF 0421/eCQM 69v5)	78%
Care Coordination (MPCA PCHH)	75%
Care Coordination 3-17 (MPCA PCHH)	NA
Care Coordination 18+ (MPCA PCHH)	NA
Child Weight Screening / BMI (NQF 0024)	85%
Child Weight Screening / Nutritional Counseling (NQF 0024)	70%
Child Weight Screening / Physical Activity (NQF 0024)	60%
Diabetes A1c < 8 (NQF 0059 modified)	65%
Diabetes A1c > 9 or Untested (NQF 0059)	<25%
Diabetes BP < 140/90 (NQF 0059 modified)	70%
Hypertension Controlling High Blood Pressure (NQF 0018)	66%
SBIRT Substance Abuse Screening and Follow Up (MPCA PCHH)	70%
SBIRT Drug Use (MPCA PCHH): Measure reporting and tracking is still required and performance will be compared to state and national prevalence data to monitor screening effectiveness	NA
SBIRT Excessive Drinking (MPCA PCHH) Measure reporting and tracking is still required and performance will be compared to state and national prevalence data to monitor screening effectiveness	NA
Screening for Clinical Depression and Follow-Up Plan (NQF 0418)	80%
Screening for Clinical Depression and Follow-Up Plan 12-17 yrs (NQF 0418)	NA
Screening for Clinical Depression and Follow-Up Plan 18+ yrs (NQF 0418)	NA
Use of Appropriate Medications for Asthma Ages 5-64 (CMS126v5)	75%
Use of Appropriate Medications for Asthma Ages 5-11 (NQF 0036 modified)	NA
Use of Appropriate Medications for Asthma Ages 12-18 (NQF 0036 modified)	NA
Use of Appropriate Medications for Asthma Ages 19-50 (NQF 0036 modified)	NA
Use of Appropriate Medications for Asthma Ages 51-64 (NQF 0036 modified)	NA
Statin Therapy for Prevention & Treatment of CVD (CMS Prev-13)	75%

# Structured vs. Unstructured Data

*There is tremendous value in recording data using a common vocabulary and methodology. Creates data which can be recognized, ordered, analyzed, reported & shared.*

*Data not captured  
in structured  
fields is not  
reportable*



# Medication Adherence Reports

- Delivered by MPCA data team
- Measures medication adherence
- Percentage of time patient has access to their medications  
Research indicates that an MPR of 0.8 or higher (medications available 80% of the time) is adequately adherent
- This allows for a few days gap between refills

Drug MPR =

# of days of supply dispensed to patient

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# of total days in time period

# What to do with MPRs?

- Identify patients with difficulty refilling medications as prescribed
  - Intervene, consider using BHC to help with compliance
  - Discuss alternatives/care plan modification
- Patients who just got a refill
  - Low MPRs should be investigated EVEN IF the patient recently refilled the medication, potential adherence issue
  - Low MPRs indicate an adherence issue that should be addressed

# MPRs in CyberAccess and ProAct

- Not all MPRs are created equal
- CyberAccess and ProAct calculate MPRs differently
  - CyberAccess uses a 1-year period of time
  - CyberAccess will identify claims in real time (or up to 1 day)
  - ProAct uses a 90-day period of time, paid pharmacy claims
- A shorter period of time is best for intervening with current adherence problems

# PCHH Practice Transformation Coaching



# MPCA PCHH Practice Coach Enhanced Approach and Goals

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- MO HealthNet has partnered with MPCA to provide the practice coach support provided to PCHH organizations.
- MO HealthNet Goals and Desired Results of Practice Coaching:
  - Advance practice transformation for services provided to PCHH enrollees
  - Enhanced team-based care at participating PCHH organizations
  - Improved Clinical Outcomes of PCHH enrollees at individual provider organizations and collectively across the initiative
  - Support cost savings efforts of PCHH organizations with special focus on high utilizers of the emergency room and in-patient
  - Improved Population Health of PCHH enrollees
  - Technical assistance and training that meets the needs of individual PCHH organizations and PCHH organizations collectively



# MPCA PCHH Practice Coach Focus Areas

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- Advancing Team-based Care
- Care Coordination and Management
  - High utilizers of hospital and emergency room
- Patient Engagement in Care
- Performance Improvement and Data Driven Decision Making
- Population health management
- Quality improvement
- Practice transformation for Patient Centered Medical Home

# Interactions with MPCA Practice Coach

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- Monthly meetings via Zoom with Health Home Director and team
- Monthly outreach via e-mail including scorecard, practice ranking, medication adherence, other tools/resources
- Telephone, email, Zoom support as needed/requested
- Regular training opportunities: Coach bulletins, webinars, and in-person (care team forum, regional BHC meetings, regional Nurse Care Manager meetings)
- Annual site visit with PCHH team
- PDSA cycle support to drive performance improvement of PCHH measures
- PCHH Practice Transformation work plan development and implementation

# Plan-Do-Study-Act (PDSA) Improvement Model



For more information, please contact MPCA's Practice Improvement Coach:

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## Plan-Do-Study-Act



- Plan**
  - Make a plan for the change. Ask
    - What are we trying to accomplish?
    - How will we know that a change is an improvement?
    - What change can we make that will result in improvement?
  - Collect baseline data
  - Communicate the test of the change to staff
- Do**
  - Implement the solution or process change
    - Test the change
    - Document the results; continue to monitor the data
  - Follow the plan and monitor the milestones
    - Tools include flowchart, matrix diagram, run charts, control charts
- Study**
  - Review and evaluate the results of the change
    - Confirm/establish measure of monitoring
    - Are the measures reliable and valid?
    - Compare pre-solution data to post-solution data
    - Is the solution having the intended effect?
    - Were there any unintended consequences?
- Act**
  - Reflect on what has been learned
    - Assess the results
    - Assess the problem-solving process
    - Recommend changes—modify or abandon plan or targets, or implement a successful plan
    - Repeat cycle until targets are met
  - Develop ongoing monitoring plan and consider implementing the change throughout the system
  - Celebrate success!

### Sequence for Improvement-PDSA Summary:

- Develop a change (theory and prediction)
- Test a change under a variety of conditions
- Implement a change as part of routine operations
- Spread to other locations

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## PCHH PDSA (Test Name)

PCHH Organization:		Start Date:		Target Date:	
Facilitator:		Team Members:			
1. Plan	What we are trying to accomplish:				
	Why this is important:				
	Change to be implemented (PCHH measure selected for improvement):				
	Our plan for change:				
	Baseline data: Goal: % Num: Denom: Result: %				
2. Do	TEST #1: Date change is implemented:				
	Actions taken:				
	1.				
	2.				
	3.				
	Monitor of Change (halfway through test #1):				
	Date: Num: Denom: Result: %				
	Observations made (halfway through test #1):				
	1.				
	2.				
3. Study	Monitor of Change (at end of test #1):				
	Date: Num: Denom: Result: %				
	Observations made (at end of test #1):				
	1.				
	2.				
	3.				
	Analyze your results:				
	Are the measures valid and reliable? Yes / No If no, what didn't work?				
	Is the solution having the intended effect? Yes / No If no, what didn't work?				
	Were there any unintended consequences? Yes / No If yes, what?				

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Reflecting on lessons learned, we will (circle one):					
Abandon / Modify / Adopt and Spread					
4. Act	If Adopt plan, continue monitoring (1x):	Date:	Num:	Denom:	Result %
	If Adopt plan, continue monitoring (2x):	Date:	Num:	Denom:	Result %
	If Modify plan, how?	Date:	Modification:		
(If Modifications Needed:)					
2. Do	TEST #2: Date change is implemented:				
	Actions taken:				
	1.				
	2.				
	3.				
	Monitor of Change (halfway through test #2):				
	Date: Num: Denom: Result: %				
	Observations made (halfway through test #2):				
	1.				
	2.				
3. Study	Monitor of Change (at end of test #2):				
	Date: Num: Denom: Result: %				
	Observations made (at end of test #2):				
	1.				
	2.				
	Analyze your Test #2 results:				
	Are the measures valid and reliable? Yes / No If no, what didn't work?				
	Compare benchmark and test data:				
	Is the solution having the intended effect? Yes / No If no, what didn't work?				
	Were there any unintended consequences? Yes / No If yes, what?				
4. Act	Reflecting on lessons learned from Test #2, we will (circle one):				
	Abandon / Modify / Adopt and Spread				
	If Adopt plan, continue monitoring (1x):	Date:	Num:	Denom:	Result %
	If Adopt plan, continue monitoring (2x):	Date:	Num:	Denom:	Result %
If Modify plan, how? Date: Modification:					



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# PCHH Practice Transformation Work Plan

## Primary Care Health Home Practice Transformation

Health Home Name:

Date Initiated:



### 1. Advancing Team-Based Care

Item	Current Status	Need F/U?	Action Plan	Who is Responsible?	F/U Date	Due Date	Date Completed	Result
1- Adequately staffed with all team members								
2- Physician champion is engaged and active with the team								
3- Team member roles are clearly defined								
4- BHC is fully integrated into team								
5- Team has regularly scheduled care meetings								
6- Huddles occur daily								
7- High risk patients are discussed by the team								

### 2. Care Coordination

Item	Current Status	Need F/U?	Action Plan	Who is Responsible?	F/U Date	Due Date	Date Completed	Result
1- Care Coordinator participates in huddles; patients are aware of this role								
2- ER & Inpatient discharge information is received timely								
3- Discharge follow-ups & medication reconciliation occur w/in 72 hours								
4- Referrals and orders are tracked								
5- Receive patient info through an HIE								

# Care Team Forum—Spring 2019

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- Training for Primary Care Health Home Team Members
- Focus on team-based care
- Best Practices for addressing high risk enrollees and high utilizers of services
- Care Coordination and Patient Centered Goal setting
- Strategies for utilizing data and technology solutions to drive quality improvement and patient-centered care.
- Peer to Peer Networking
- Condition and skill specific sessions
- BH/PC integration for health home team

# MPCA PCHH Practice Coaches

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**What Questions  
Do You Have?**