Missouri Primary Care Health Home Initiative

Agenda

- What is a Primary Care Health/Medical Home?
- Overview of Section 2703 of the Affordable Care Act
- Overview of Missouri Primary Care Health Home Initiative
- Data Collection and Reporting
- NCQA/PCMH Recognition
- Training and Technical Assistance

What is a Health/Medical Home?

Health/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 health/medical home are the patients and their relationship with their primary care team

Section 2703 of the Affordable Care Act

- Section 2703 of the Affordable Care Act allows states to amend their Medicaid state plans to provide **Health Home Services** for enrollees with qualifying chronic conditions.
- States are eligible for an enhanced federal match for eight quarters (**Missouri's ended December 31, 2013**)
- Missouri – approved in 2011 for two Medicaid State Plan Amendments to be able to provide Health Home Services to Missourians who are Medicaid eligible participants with chronic illnesses.

Missouri's Health Homes

- Two health home initiatives in Missouri
  - Primary Care
  - Behavioral Health
- Similarities and Differences
  - PCHH incorporates behavioral health care into the traditional primary care model through the addition of a behavioral health consultant (more on the BHC later)
  - CMHC healthcare homes incorporate primary care into the traditional behavioral health model through the addition of nurse care managers and primary care physician consultants (they don't provide primary care, but do provide care management/care coordination for both mental and physical health for their participants)

Missouri PCHH Selected Qualifying Conditions

- 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
  - BMI above 25 (overweight and obesity)
  - Tobacco Use
  - Developmental Disabilities

Participating Sites

- Initial participating sites:
  - 18 FQHCs and 6 Hospital Affiliated Primary Care Clinics
- Expansion of Number of Participating Sites Approved during the Spring 2014 legislative session.
- Eleven new organizations applied in May 2014 and all were approved to participate beginning in October 2014 (One hospital and one health department withdrew and Two CHCs merged).
- Participating Organizations:
  - 21 FQHCs
  - 9 Hospitals
  - 2 Clinics

Goals of the Primary Care Health Home Initiative

- 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.

Use of Health Information Technology to Link Services

- **CyberAccess**

  Demographics Diagnoses Providers Labs
  Procedures Medications Care Coordination

- **ProAct**

  Medication Possession Ratio Medication Adherence

- **Electronic Health Records**

  Performance Measures Patient Portal

- **Data Warehouse (DRVS)**

  Clinical Information

Reports

- Hospitalization and ER visit notifications
- High utilizers
- Possible PCHH enrollees
- Monthly enrollment/discharge list
- Payment rejects
- Staffing/payment comparisons
- Retrospective payments
- Care coordination reports (e.g. HCBS, DD)

Health Home Services ("Touches")

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care including follow-up from inpatient, ER, other settings
- Patient and family support
- Referral to community and support services

NOTE: Touches must be documented

Health Home Services: Comprehensive Care Management

- Identification of high-risk individuals and use of patient information in care management services; assessment of preliminary service needs;
- Care plan development, which will include patient goals, preferences and optimal clinical outcomes;
- Assignment by the care manager 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 that indicate progress toward meeting outcomes for patient satisfaction, health status, service delivery and costs.

Health Home Services: Care Coordination

- Implementation of the individualized care plan (with active patient involvement)
- Appropriate linkages, referrals, coordination and follow-up to needed services and supports -- e.g.
  - appointment scheduling
  - facilitating and making referrals and follow-up monitoring
  - participating in hospital discharge processes
  - communicating with other providers and clients/family members.

Health Home Services: Health Promotion

- Providing health education specific to an individual's:
  - chronic conditions
  - development of self-management plans with the individual
  - education regarding the age appropriate immunizations and screenings
  - 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 patients to participate in the implementation of their treatment plan with a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions.

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

Health Home Services: Comprehensive Transitional Care

- Comprehensive transitional care including follow-up from inpatient and other settings – Medication Reconciliation
- Member of the health home team provides care coordination services designed to streamline plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency department use.
- The health home team member collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing patients' and family members' ability to manage care and live safely in the community
- Shift the use of reactive care and treatment to proactive health promotion and self management.

Health Home Services: Patient and Family Support

- Advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments.
- Health home 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
- For individuals with developmental disabilities the health team will refer to and coordinate with the approved developmental disabilities case management entity

Health Home Services: Referral to Community and Support Services

- Assistance to patients including but not limited to:
  - obtaining and maintaining eligibility for healthcare
  - disability benefits
  - housing
  - personal need and legal services
- For individuals with developmental disabilities the health home team will refer to and coordinate with the approved DD case management entity for this service.

Payment Method

- Providers that meet the health home requirements will receive a Per-Member-Per-Month (PMPM) payment for performing health home services and activities (“touches”)
- Providers pay a small PMPM to MPCA to cover administrative costs associated with data management, training, technical and administrative support, and practice coaching
- The current state plan may be amended in the future to add a request for a second payment method so that providers may receive **incentive payments** based on shared savings and relating to performance.

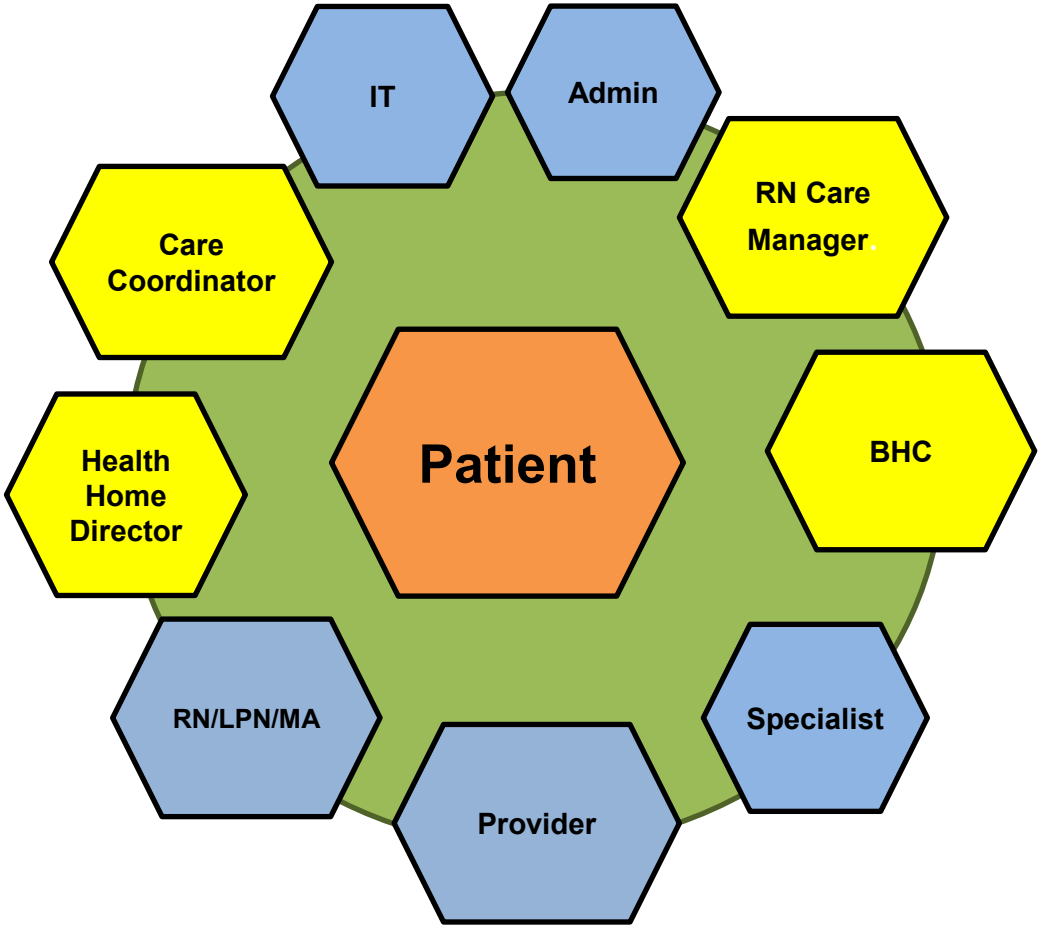
Enrollment Eligibility

- Participant had to meet the following criteria:
  - MO HealthNet eligible
  - Not be locked into hospice
  - 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 two or more of the approved chronic conditions or one of the approved chronic conditions and be at risk for a second chronic condition by being overweight/obese or tobacco use
  - Have at least $2600 in spend
  - If seen by more than one eligible health home provider the patient is attributed to the health home provider seen the most during the analysis period

Current Enrollment Process

- Determine eligible diagnoses and other criteria (e.g. PCP at central clinic site)
- Check eMOMED for current Medicaid eligibility and spend down status
- Check CyberAccess to determine whether person is already enrolled in a health home
- Prepare and submit enrollment forms
  - Name form using Lastname, Firstname convention.
  - Send only one type of form in an email
  - Make sure each form is only sent one time
  - Send forms to Marcia Seabourne (info on form)

Care Team


IT
Admin
RN Care Manager.
Care Coordinator
Patient
BHC
Health Home Director
RN/LPN/MA
Specialist
Provider

Health Home Team Members

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

- Administration
- Information Technology

Health Home Director

- 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

Nurse Care Manager

- Must be RN for PCHH
- Direct relationships with patients and coordination with primary care team, specialty care teams, and inpatient facilities.
- Develop care plans
- Utilize MHD health technology programs & initiatives (i.e., CyberAccess and ProAct)
- Monitor HIT tools & reports 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

Behavioral Health Consultant

- 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

- 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.
- Reminding enrollees regarding keeping appointments, filling prescriptions, follow-up on self-management goals, etc.
- Requesting and sending medical records for care coordination

Physician Champion

- 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

Importance of Communication

- Communication with and between care team members
- Communication with patient/families
  - Accurate patient contact information/Patients desired way to receive communication
    - Verifying with patient their contact information
    - Ask “How can I reach you today”
    - What communication preference do you have
- Communication with hospitals, specialists, and community partners
- Electronic Communication sources
  - Patient portal
  - Email/secure messaging
  - HIE

Medical Home Neighborhood Partnerships

- Hospital Partnership
  - MOU
  - Workflow to receive ER/IP discharge information
  - Key contact person
  - Electronic access
  - State provides Daily ER/IP notification for PCHH enrollees
- Specialty Services
- Other Community Resources
  - Health Department

Data Management and Analytics

Stakeholder	Role/Responsibilities
Missouri Primary Care Association (MPCA)	• Project Owner, receives reports • Support staff at FQHCs & PCCs when needed for questions around reporting and data accuracy
Federally Qualified Health Centers (FQHC's)	Transmit clinical data through DRVS connector
Primary Care Clinics (PCC's)	Transmit clinical data through flat file upload
Azara Healthcare	• Provide access to DRVS reporting tool and maintains measures in the tool. • Assist PCCs in flat file submission
MO HealthNet	Receives reports

Performance Goals and Measures

- Care Coordination
- Behavioral Health and Substance Abuse Screening and Use
- Chronic Disease Management: Diabetes, Cardiovascular disease, Asthma
- Preventative Health: Weight Assessment and Follow-up for Children and Adults, Population Health LDL Control
- Whenever possible national measure definitions were utilized from the National Quality Forum, Healthy People 2020, Meaningful Use, HEDIS, etc. to assist with alignment across programs.

14 Primary Care Health Home Performance Measures

- Care Coordination: Percentage of patients discharged from hospital with whom the care manager made telephonic or face-to-face contact within 3 days of discharge and performed medication reconciliation with input from PCP.
- Adult Excessive Drinking: Percentage of patients 18 and older with at least one medical encounter in the reporting period who reported excessive drinking in the past 3 months.
- Adult Illicit Drug Use: Percentage of adults (18 years and older) who report use of illicit drug in the past 12 months
- Adult Substance Abuse Screening and Follow-up: Percentage of members age 18 years and older screened for substance abuse using a standardized tool with a follow-up plan documented as necessary with SBIRT.

14 Primary Care Health Home Performance Measures Continued

- Depression Screening and Follow-up: Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.
- Weight Assessment and Counseling for Children and Adolescents: Percentage of 2-17 years of age who had an outpatient visit with a PCP who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the reporting period.
- Adult Weight Screening and Follow-Up: Percentage of patients aged 18 years or older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.

14 Primary Care Health Home Performance Measures Continued

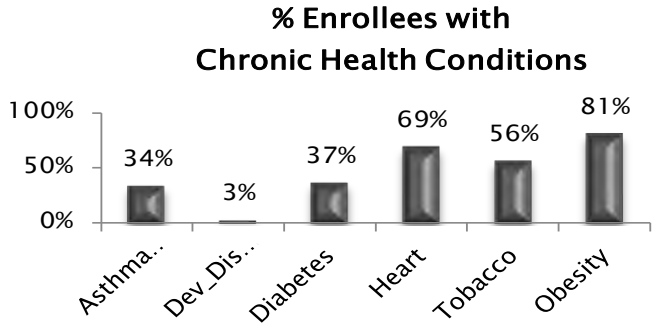
- Diabetes HbA1C <8.0: Percentage of patients 18-75 years age with diabetes (type 1 or type 2) who had HbA1c< 8.0%
- Diabetes HbA1C >9.0: Percentage of patients 18-75 years of age with diabetes who had HbA1C>9.0%
- Adult Diabetes Blood Pressure < 140/90 mmHg: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure <140/90 mmHg
- Adult Diabetes LDL < 100 mg/dl: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100 mg/dL

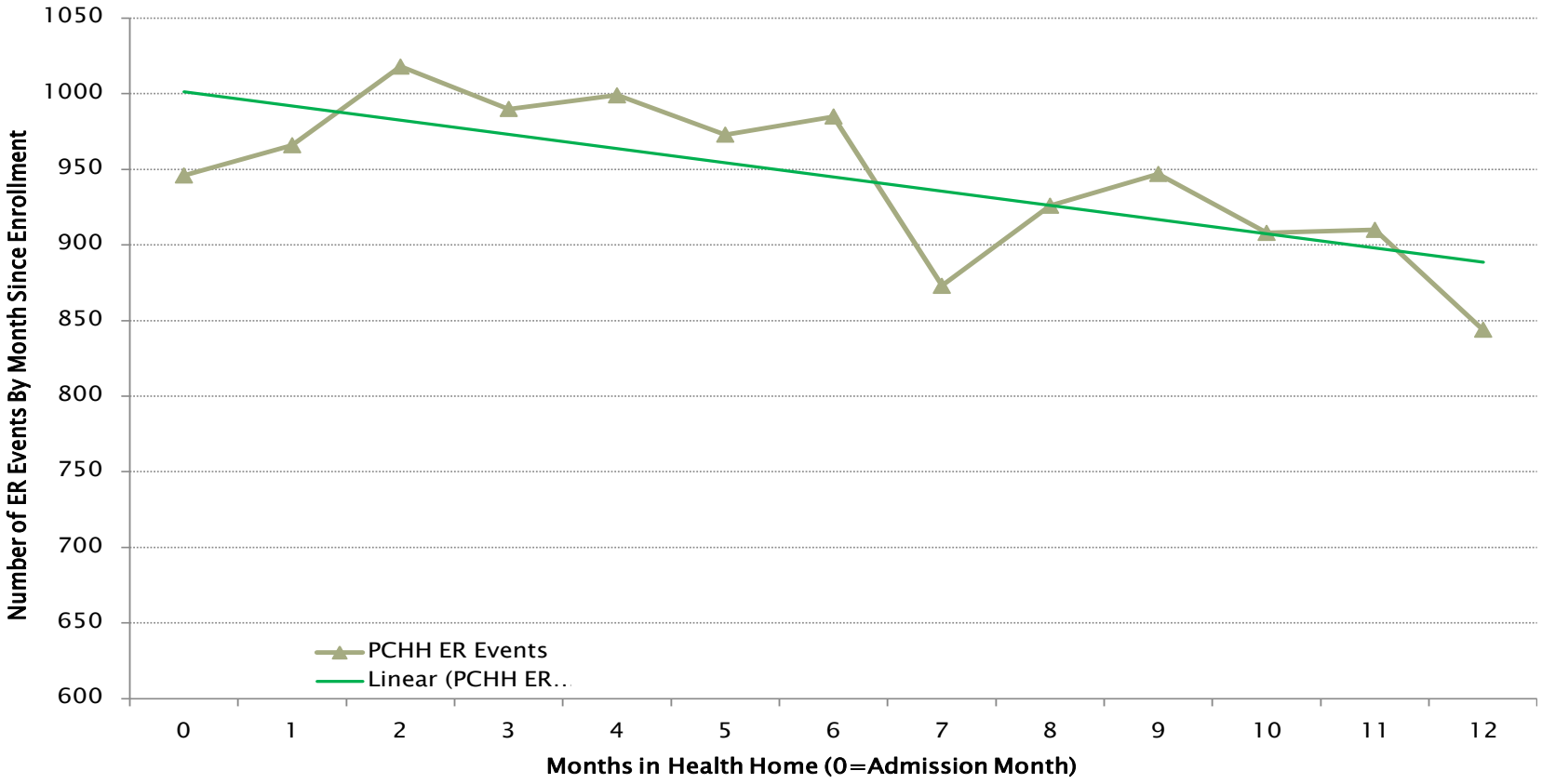
14 Primary Care Health Home Performance Measures Continued

- Pediatric and Adult Asthma Controller Medication: Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period.
- Adult Hypertension Blood Pressure < 140/90 mmHg: Percentage of patients aged 18-85 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, w/ blood pressure adequately controlled (BP< 140/90) during the measurement period.
- Adult LDL < 100 mg/dl: Percentage of patients aged 18 years and older with lipid level adequately controlled (LDL<100).

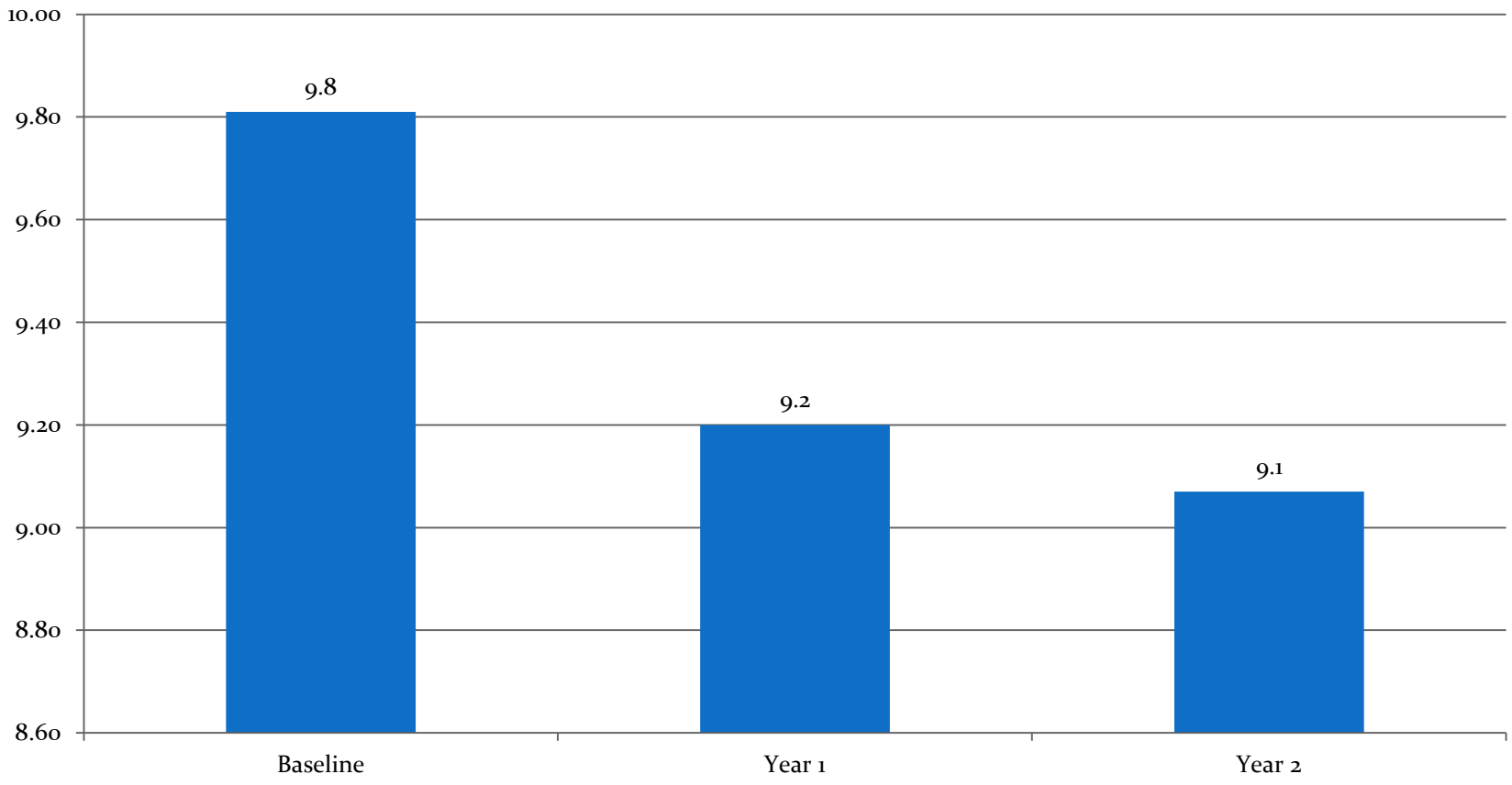
PCHH Evaluation

ER Events for PCHH Members with at Least 8 Months of Service and Who Were Initially Enrolled during First Quarter 2012

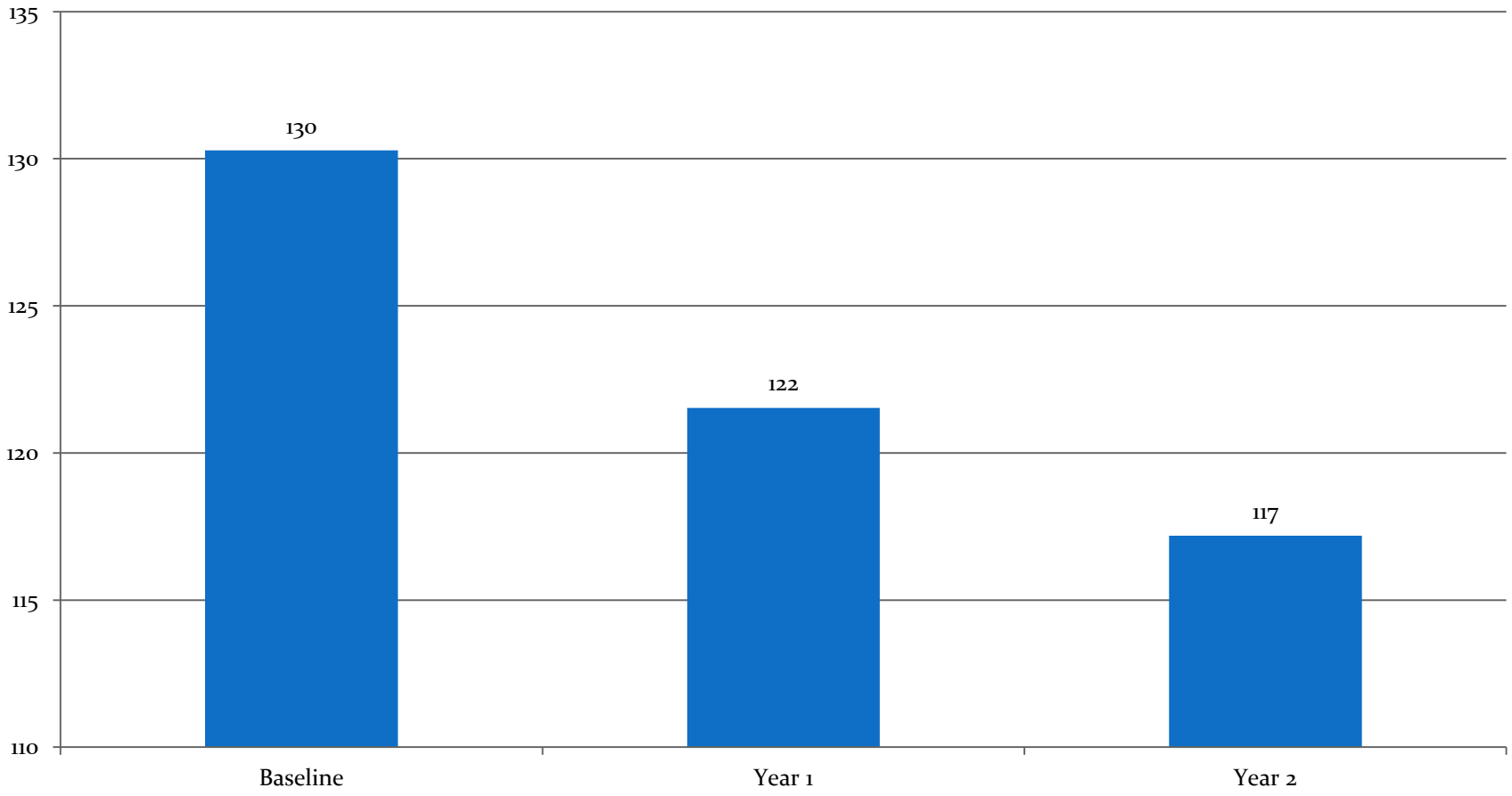




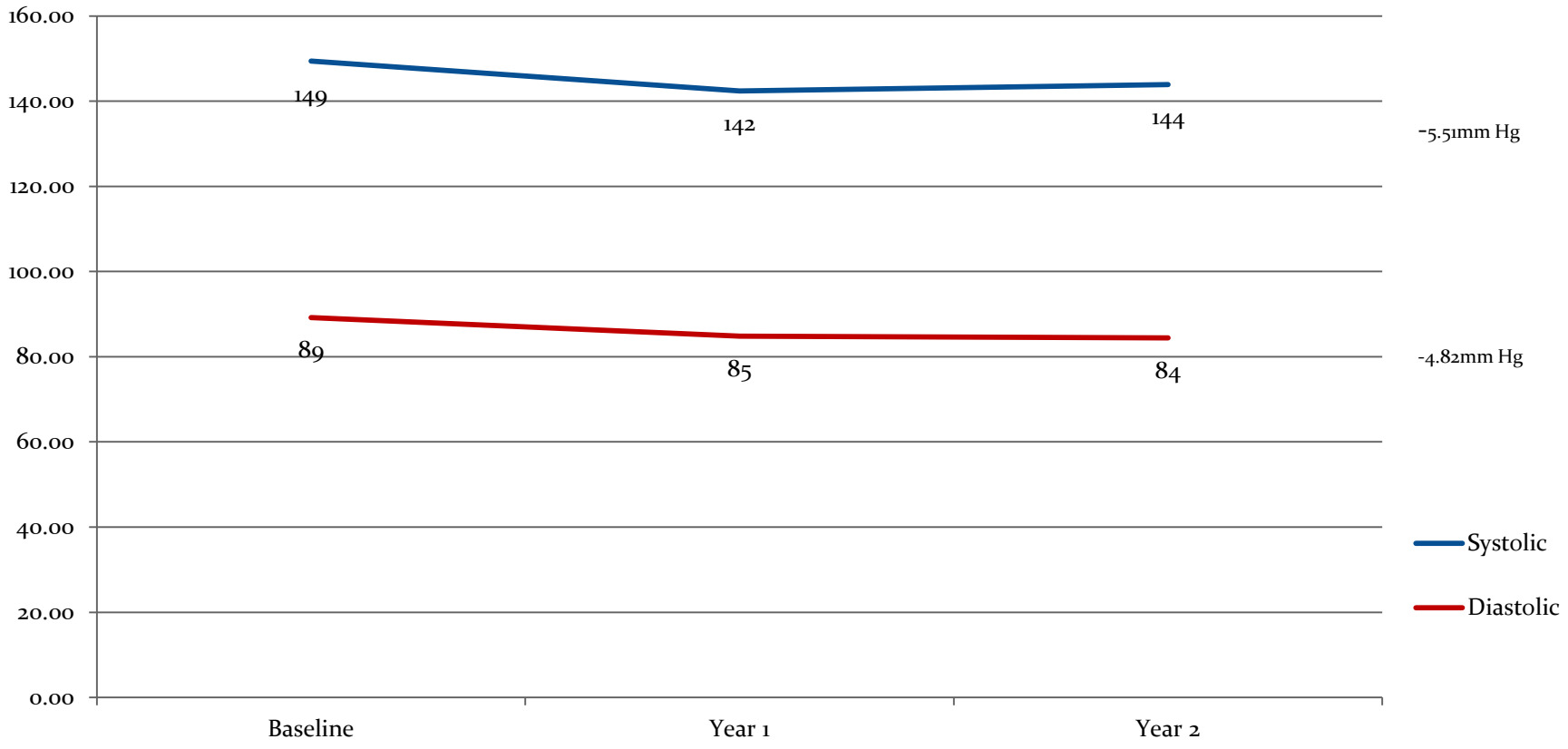
Reduction in A1C for Individuals with Initially High Levels and Values Recorded at Baseline, 1 and 2 Years



Reduction in LDL for Individuals with Initially High LDL and Values Recorded at Baseline, 1 and 2 Years



Reduction in Blood Pressure for Individuals with Initially High BP and Values Recorded at Baseline, 1 and 2 Years



Questions