MO HealthNet Oversight Committee
July 31, 2012

Primary Care Health Home Update

Background

- Two Medicaid Health Home initiatives- primary care and mental health
  - Partnership between MO HealthNet and Department of Mental Health
  - Collaboration with Missouri Primary Care Association (MPCA), Missouri Hospital Association (MHA), CMHC's and Coalition for Mental Health
- One Learning Collaborative for all participants
  - Collaboration between MFH, Health Care Foundation of Greater Kansas City, MPCA, and MHA

Health Home Goals

- By implementing the health home program we hope to demonstrate
  - Reduced inappropriate ED utilization
  - Reduced avoidable in-patient utilization
  - Improved patient outcomes
  - Reduction in health care costs

Health Home Services

- Key Health Home Services for MO:
  - Comprehensive Care Management
  - Care Coordination
  - Health Promotion
  - Comprehensive Transitional Care
  - Individual and Family Support Services
  - Referral to Community and Social Support Services

Health Home Services and Activity Examples

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

Health Home Eligibility

- Eligible individuals have at least two of the following:
  - Asthma
  - Cardiovascular disease
  - Diabetes
  - Developmental disabilities
  - Overweight (BMI>25) OR
- One of the above and tobacco use
- Diabetes as single condition

Health Homes Numbers

- Primary Care Health Homes (24)
  - 18 Federally Qualified Health Centers (FQHCs)
  - 6 Public and Private Hospitals
  - ~19,000 enrolled individuals, children and adults

Health Home Team

- Practice site physician or nurse practitioner-led
- Health Team
  - Primary care physician or nurse practitioner
  - Behavioral health consultant
  - Nurse care manager
  - Care Coordinator
  - Others per practice

Primary Care Health Home Team Ratios

- Health Home Director 1:2500
- Nurse Care Manager 1:250
- Behavioral Health Consultant 1:750
- Care Coordinator 1:750

- Currently, health homes are staffed overall according to their specific staff:patient ratios

Integration of Behavioral Health and Primary Care

- Behavioral Health Consultant Credentials
  - PhD Psychologists/Doctor of Psychology
  - Licensed Social Workers
  - License Masters in Social Work

Integration of Behavioral Health and Primary Care

- Support to primary care physician/teams by
  - identifying patients who could benefit from behavioral intervention
  - behaviorally intervening with patients who could benefit from behavioral intervention.
- Part of front line interventions
  - manage behavioral health needs within the primary care practice.
  - Focus on managing a population of patients versus specialty care

Integration of Behavioral Health and Primary Care

- Management of mental illness
  - Health home has capacity to manage

OR

  - Referral made to mental health provider

Integration of Behavioral Health and Primary Care

- Identification of the problem behavior, discuss impact, decide what to change
- Specific and goal directed interventions
  - Use monitoring forms
  - Use behavioral health “prescription”
  - Multiple interventions simultaneously
- Education
  - Handouts
  - Teach back strategy
  - Tailored to specific issues

Integration of Behavioral Health and Primary Care

- Behavioral supports to assist in
  - Improving health status
  - Managing chronic disease
- Screening/evaluation of individuals for
  - Mental disorders
  - Substance abuse disorders
- Brief interventions for individuals with behavioral health problems

Integration of Behavioral Health and Primary Care

- Meets regularly with the primary care team to plan care and discuss cases
- Feedback to PCP
  - Clear, concise, brief
  - Focused on referral question
  - Description of action plan
  - Plan for follow-up
- Exchanges appropriate information with team members
  - Informal “curbside “ manner as part of the daily routine of the clinic

Health Home Evaluation

- MO HealthNet planned evaluations include:
  - Trending of clinical measures over time, starting with baseline measurement
    - Beginning the baseline measurement
  - Quarterly reports from the health homes will be scaled over time
    - First set have been completed
  - Utilization and cost reports/trending over time