Missouri Health Home Update

November, 2012

CHANGE

When the Winds of Change Blow Hard Enough,
The Most Trivial of Things can turn into Deadly Projectiles.

Defining health homes

- Provides states the option to cover care coordination for individuals with chronic conditions through health homes

- Eligible Medicaid beneficiaries have:
  - Two or more chronic conditions,
  - One condition and the risk of developing another, or
  - At least one serious and persistent mental health condition

Defining health homes

- Provides 90% FMAP for eight quarters for:
  - Comprehensive care management
  - Care coordination
  - Health promotion
  - Comprehensive transitional care
  - Individual and family support
  - Referral to community and support services

- Services by designated providers, a team of health care professionals or a health team

Population Based

- Payments for HH services will be paid PMPM, not unit by unit
- Service needs will be identified by patient health history and status
- Outcomes will be measured by groups of clients (i.e., by organization, region, medication used, co-morbid conditions)

States with CMS Approved HH State Plan

State	Plan Approved	Effective	Provider Types
Missouri	10/20/2011	1/1/2012	CMHC, PC
Rhode Island	11/23/2011	10/1/2011	CMHC, Child-PC
New York	2/3/2012	1/1/2012	CMHC, PC, Home Health
Oregon	3/12/2012	10/1/2011	mult provider types
North Carolina	5/24/2012	10/1/2011	PC only
Iowa	6/8/2012	7/1/2012	CMHC, PC

States Developing HH State Plans

- Plans Submitted
  - Alabama
  - Ohio
  - Wisconsin
- Draft Plan Being Reviewed
  - Oklahoma
  - Illinois
  - Maine
  - West Virginia
  - Idaho

States Planning for Health Homes

- New Mexico
- Arkansas
- District of Columbia
- Washington
- California

- Arizona
- Mississippi
- New Jersey
- Nevada

Achievements

- Selecting and Enrolling Health Home Practices
- Recruiting and Hiring Health Home Staff
- Selecting and Enrolling Health Home Participants
- Standing Up New IT Systems
  - Arcadia/Azara Data warehouse and reporting
  - CMT PROACT reporting
  - Automatic Notification of Hospital Admission
  - SBIRT interfaces with EMRs
  - Attestation of HH Service received and payment
- Initial rounds of training

CMHC Healthcare Homes

- State Plan Amendment approved 10/20/11
  - Effective 1/1/12
- 27 CMHC Healthcare Homes
- 17,882 individuals auto-enrolled
  - CMHC consumers with at least $10,000 Medicaid costs
- PMPM Staffing: $78.74
  - Health Home Director 1 per 500 enrollees
  - Primary Care Physician Consultant 1hr per enrollee
  - Nurse Care Managers 1 per 250 enrollees

Primary Care Health Homes

- State Plan Amendment approved 12/23/11
- 20,239 individuals auto-enrolled
  - 776 children and youth (4%)
  - Primary care patients with at least $2,600 Medicaid costs annually
- Current Enrollment: 18,000
- 24 Primary Care Health Homes
  - 18 FQHCs operating 67 clinic sites
  - 6 Hospitals operating 22 clinic sites

Requirements

- All primary care health homes were required to have an EMR system (up and running for at least six months) to apply for PCHH
- Greater than 25% Medicaid plus uninsured casemix
- Accreditation/Recognition
  - PCHH: PCMH recognition through NCQA
  - CMHC: CARF

Launching HHs

- Start-up: Primary care health homes started in phases
  - January 4
  - February 11
  - March 5
  - April 4
- All CMHC health homes started in January

New Staff Hired

- 5 State Staff (4.5 FTE)

- 93 Nurse Care Managers (60.7 FTE)
- 37 Care Coordinators (25.8 FTE)
- 46 Behavioral Health Consultants (20.5 FTE)
- 29 Health Home Directors (12.0 FTE)

- 200 Total (122.5 FTE)

Primary Care Target Population

Persons are eligible for a primary care health home if they have two chronic conditions or one chronic condition plus risk of developing another

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

Clients Eligible for CMHC HH

- A Serious and Persistent Mental Illness
  - Adults with SMI (Schizophrenia, Bipolar Disorder, Major Depression Recurrent)
  - Youth with Severe Emotional Disturbance

Clients Eligible for CMHC HH

- A mental health condition, **OR**
- A substance abuse condition, **AND**
- One other chronic health condition
  - asthma,
  - cardiovascular disease,
  - diabetes,
  - substance abuse disorder,
  - developmental disability
  - overweight BMI>25

Healthcare Home Team Members

Healthcare Home Director

- Champions Healthcare Home practice transformation
- Oversees the daily operation of the HCH
- Tracks enrollment, declines, discharges, and transfers
- May serve as a NCM on a part-time basis
  - HCHs must have at least a half-time HCH Director
- Coordinates management of HIT tools
- Develops MOUs with hospitals and coordinates hospital admissions and discharges with NCMs

Healthcare Home Team Members

Nurse Care Managers

- Champion healthy lifestyles and preventive care
- Provide individual care for consumers on their caseload
  - Initially review client records and patient history
  - Participate in annual treatment planning including
    - Reviewing and signing off on health assessments
    - Conducting face-to-face interviews with consumers to discuss health concerns and wellness and treatment goals
  - Consult with CSS's about identified health conditions of their clients
  - Coordinate care with external health care providers (pharmacies, PCPs, FQHC's etc.)
  - Document individual client care and coordination in client records

Healthcare Home Team Members

Primary Care Physician Consultant

- Assures that HCH enrollees receive care consistent with appropriate medical standards
- Consults with HCH enrollees' psychiatrists as appropriate regarding health and wellness
- Consults with NCM and CPR team regarding specific health concerns of individual HCH enrollees
- Assists with coordination of care with community and hospital medical provide
- Maintains a monthly HCH log

Behavioral Health Consultant
Integration with Primary Care

- Support to primary care physician/teams by
- Part of front line interventions
- Management of mental illness

Behavioral Health Consultant
Interventions

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

Work Groups

- Executive Oversight (monthly)
- PCHH Operations (weekly)
- CMHC Operations (weekly)
- Joint HH Operations (biweekly)
- PCHH Provider Conference Call
- LC Training Curriculum Advisory Group

Training Completed

- Learning Collaborative by CSI
  - 4 regional live & 5th as Webinar
- Behavioral Health Consultant by SLBMI
  - Regional workshops, site visits, webinars, & conf calls
- SBIRT by MIMH
  - Live Workshops
- DVR by Azara/Arcadia

- PROACT by CMT
  - Webinars & conf calls
- CyberAccess by Xerox
  - Webinars & conf calls

Challenges

- Enrollment lower than planned
- High turnover in New HH staff Positions
- Too much new stuff to learn all at once
  - How to use all that data
  - Implementing Behavioral Health Consultants
  - Implementing SBIRT

Where We Focus Next

- Using the new IT Tools
- Integrating Care Managers and Coordinators into existing Clinical workflows
- Integrating Behavioral Health Consultant into existing Clinical workflows
- Increasing use of Population/Data Based Decision Making
- Developing and Implementing Health Promotion Interventions
- Getting better at Treatment Planning and Team Care

Evaluations Underway

- Urban Institute (HHS- ASPE)
  - Outcome Evaluation due in 2017
  - Site visit done in July
- NORC (CMS)
  - Implementation Evaluation due in 2013
  - Site visit done in September
- Rutgers (AHRQ) – voluntary, CMHC-HH only
- Missouri State Internal
  - 6 month initial report just completed

What Made it Possible? - Relationships

- DSS - MO HealthNet
- DMH
- State Budget Office
- The Missouri Primary Care Association
- Missouri Coalition of CMHCs
- MO Foundation for Health (MFH)
- Consultants: Michael Bailit & Alicia Smith
- Missouri Hospital Association (MHA)
- Vendors: Xerox, CMT, Arcadia/Azara, MIMH

Primary Care Health Home Measures

Measure	Standard	Measure Definition
Hospital Discharge Care Coordination	N/A	• Percent 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 Illicit Drug Use	N/A	• Percent of adults (18 years and older) who report use of illicit drug in the past 30 days
Adult Excessive Drinking	N/A	• Percent of patients 18 and older with at least one medical encounter in the reporting period who reported excessive drinking in the past 30 days
Adult Depression Screening	N/A	• Percent of patients 18 and older receiving depression screening through the use of standardized screening instruments within the measurement period
Adult Substance Abuse Screening and Follow-Up	N/A	• Percent 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.
Adult BMI 18.5 - 24.9	N/A	• Percent of patients 18-64 years of age with documented BMI between 18.5-24.9
Adult Weight Screening and Follow-Up	NQF 0421	• Percent 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.
Weight Assessment and Counseling for Children	NQF 0024	• Percent of children 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.

Primary Care Health Home Measures

Measure	Standard	Measure Definition
Childhood Immunizations	NQF 0038	• Percent of children 2 years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, one chicken pox vaccine (VZV) and four pneumococcal conjugate vaccines by their second birthday.
Adult Diabetes A1C < 8.0%	NQF 0575	• Percent of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c< 8.0%
Adult Diabetes BP < 140/90	NQF 0061	• Percent 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	NQF 0064	• Percent of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100 mg/dL
Pediatric Diabetes A1C < 8.0%	NQF 0575 (modified)	• Percent of patients under 18 years of age with diabetes (type 1 or type 2) who had HbA1c < 8.0%
Pediatric Asthma Controller Medication	NQF 0036 (modified)	• Percent of patients 5-17 years of age who were identified as having persistent asthma and were appropriately prescribed medication (controller medication) during the measurement period.
Adult Asthma Controller Medication	NQF 0036 (modified)	• Percent of patients 18-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.
Adult Hypertension BP < 140/90	NQF 0018	• Percent 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 CAD LDL < 100	NQF 0075	• Percent of patients aged 18 years and older diagnosed with CAD with lipid level adequately controlled (LDL<100).
Adult Tobacco Use Cessation Intervention	NQF 0028b	• Percent of adults reporting tobacco use and received cessation intervention