



2012

Missouri Community Mental Health Center Healthcare Homes

Six Month Review

October 2012

Mo HealthNet and the Department of Mental Health

Missouri's Medicaid State Plan Amendment (SPA) establishing CMHC Healthcare Homes outlined initial and ongoing provider qualifications, and indicated that the state would assess the progress of providers in "continuing development of fundamental health home functionality at 6 months and 12 months..."

Before January, 2012, though some providers and some public mental health systems (most especially Missouri's public mental health system) had experience with various aspects of the comprehensive care management encompassed in the concept of a health home, no such entity existed anywhere in the U.S. that focused on serving individuals with serious mental illness. Primary care organizations had the Person Centered Medical Home (PCMH) model and the NCQA PCMH standards to serve as a guide in developing Health Homes for individuals with chronic health conditions. But no such model or standards existed to guide the development of Health Homes for individuals with serious mental illness.

We recognized that establishing CMHC Healthcare Homes would inevitably transform the public mental health system in Missouri. Adopting a "whole person" approach means learning to see people differently, and when you see them differently (seeing their struggle with diabetes, appreciating the skills they've mastered in living with asthma, understanding the barriers they face in accessing basic health screening and lab work that you take for granted), it changes how you behave, your habits, who you are, your character. Maturing and developing character take time.

Consequently, we recognized that while the CMHC Healthcare Homes established in January, 2012 were health homes as we conceived and described them in our approved Health Home State Plan Amendment, our understanding of what it means to be a CMHC Healthcare Home and how best to realize that understanding would continue to mature; so that the CMHC Healthcare Homes operating in January, 2014 would be different, more mature, versions of those established in January, 2012.

This report documents that the CMHC Healthcare Homes have made appropriate progress in continuing to develop health home functionality during the first six months as indicated by their progress in

- meeting CMHC Healthcare Home staffing standards;
- participation in required and optional training and technical assistance opportunities;
- submission of required reports;
- the use of Care Management reports to monitor, and intervene as appropriate, to assist enrollees in improving their healthcare, health status, and clinical indicators;
- engaging PCPs for health home enrollees;
- following up with health home enrollees after hospitalizations and performing medication reconciliations in a timely manner; and

- beginning the organizational transformations required to function as a mature health home for individuals with serious mental illness.

Based on our experience during the first six months, and especially on our review of the characteristics of the individuals served by the CMHC Healthcare Homes during the first six months, we have identified areas for further development and improvement, both for specific CMHC Healthcare Homes and for our system as a whole, that will be the focus of training and technical assistance over the coming months.

Enrollment

Individuals are eligible for enrollment in a CMHC Healthcare Home by virtue of having

- A serious and persistent mental illness, **or**
- A mental health condition and a substance abuse disorder, **or**
- A mental health condition or a substance abuse disorder, and one of the following chronic conditions or risk factors:
 - Diabetes
 - COPD/Asthma
 - Cardiovascular Disease
 - Developmental Disability
 - BMI>25
 - Use tobacco

In January, 2012, CMHC Healthcare Homes began providing services to 15,051 enrollees. These individuals were selected for initial enrollment because they were already receiving services from the CMHCs, met the diagnostic criteria for enrollment, and were significant users of Medicaid services as evidenced by an annual cost to Medicaid in the previous year of over \$10,000. The actual average annual cost to Medicaid for each of these individuals was more than \$24,000 in the previous year.¹

During the first six months, additional enrollments, discharges, and transfers resulted in an overall growth in enrollment of about 3% to 15,419, although the enrollment of some CMHC Healthcare Homes actually declined during the first six months, while that of others increased at a much greater rate than the statewide average.

¹ For current adult HCH enrollees, on average, general hospital care, personal care, pharmacy, MR/DD Waiver services, and Community Psychiatric Rehabilitation services, taken together, accounted for more than 80% of Medicaid costs in the previous year. For children and youth enrollees, the picture was more complicated, with managed care, MR/DD Waiver services, state operated hospital and residential care, and Children's Division rehabilitation services having differential impacts based on geographic area.

As of June, 2012, five CMHCs had fewer than 250 HCH enrollees, while three had more than 1000 HCH enrollees. Ten CMHCs had between 250 and 500 HCH enrollees, and ten CMHCs had between 500 and 1000 HCH enrollees.

Population Characteristics

Children, Youth and Adults

Individuals are eligible for enrollment in a health home regardless of age, but the great majority of CMHC Healthcare Home enrollees are adults.

Of the 15,419 HCH enrollees for whom CMHCs received a PMPM payment in June, **85% were adults** (13,128) and **15% were children and youth** (2,291). Children and youth account for more than 20% of the total number of individuals enrolled in only seven CMHCs, including two in which they account for slightly more than 30% of the total number of individuals enrolled.²

Serving children and youth is quite different from serving adults. Because children and youth account for a relatively small number of the individuals enrolled in most CMHC Healthcare Homes, we want to be sure that CMHC Healthcare Homes appropriately attend to the needs of their children and youth enrollees. During the next several months we will be focusing attention on children and youth, working both to understand and promote the best ways to support children, youth and their families when they represent a significant number of the Healthcare Home enrollees, and when there are very few children and youth enrolled in a CMHC Healthcare Home.

Chronic Conditions and Risk Factors

CMHC Healthcare Homes serve individuals with behavioral health conditions.

Eighty-nine percent (89%) of CMHC Healthcare Home enrollees have a diagnosis that qualifies them for also being enrolled in Missouri's Medicaid rehabilitation option for individuals with serious mental illness: the Community Psychiatric Rehabilitation (CPR) program. Thirty-six percent (36%) of HCH enrollees have been diagnosed with major depression, 30% with schizophrenia, 28% with bipolar disorder, 17% with PTSD, 15% with anxiety disorder, and 8% with a personality disorder. Individuals may, of course, have more than one diagnosis.

All of the children and youth enrolled in a CMHC Healthcare Home have a Serious Emotional Disturbance as evidenced by an Axis I diagnosis (exclusive of conduct disorder, mental retardation, developmental disorder, substance abuse, or V code) resulting in substantial impairment in their ability to function at a developmentally appropriate level in two of the

² Six Healthcare Homes were established in organizations that were created exclusively to serve adults with severe, disabling mental illness. Although these six CMHC Healthcare Homes do not enroll any children or youth; there is a comprehensive CMHC Healthcare Home in each of Missouri's twenty-five service areas that does serve both children and youth.

following: self care, social relationships, self-direction, family life, learning ability, and/or self expression.

In addition to a serious mental illness or serious emotional disturbance, CMHC Healthcare Home enrollees also struggle with other chronic conditions and risk factors at much higher rates than the general population:

More than 25% of HCH enrollees have been **diagnosed with COPD or Asthma.**

More than 25% of HCH enrollees have been **diagnosed with Diabetes Mellitus.**

About 3% of HCH enrollees have been **diagnosed with Congestive Heart Failure.**

About 6% of HCH enrollees have been **diagnosed with Coronary Artery Disease.**

One third of HCH enrollees have been **diagnosed with Hypertension.**

The majority of HCH enrollees **are at risk of developing cardiovascular disease** due to the fact that they have diabetes, have a Body Mass Index greater than twenty-five, or are smokers.

About 80% of CMHC Healthcare Home enrollees **have a BMI>25.**

About 50% of CMHC Healthcare Home enrollees **report that they are smokers.**

More than 50% of the adults and **about 8% of the children and youth** enrolled in CMHC Healthcare Homes **have a history of substance abuse.**

About 28% of children and youth, and **14% of adults** enrolled in CMHC Healthcare Homes **have received services through the Division of Developmental Disabilities.**

Dual Eligibles

Statewide about 35% of CMHC Healthcare Home enrollees are dually eligible for Medicare and Medicaid (range: 22% to 64% across HCHs). This is significant because the HCH Care Management Reports and hospital admissions notification system are based on Medicaid paid claims and Medicaid authorizations, respectively. (See “Care Management”, below.)

Consequently, the Care Management Reports do not reflect services or medications purchased by Medicare, and the daily hospital admission notifications do not capture admissions paid by Medicare. Therefore, the higher the percentage of dual eligibles enrolled in a Healthcare Home, the greater the likelihood the HCH will have less than a complete picture of the health status and service utilization of enrollees, spend time tracking down “false positives” (i.e. cases where it appears an individual has not received a needed service or medication when Medicare has, in fact, paid for the service or medication), and will not be notified of a significant number of hospital admissions.

Managed Care

MC+ is Missouri's managed care program serving primarily children, youth, and pregnant women. It is available principally along the I-70 corridor running from Kansas City to St. Louis. Consequently, the percentage of HCH enrollees who are also enrolled in MC+ is a function both of geographic location and the percentage of children and youth enrolled in the CMHC Healthcare Home. Statewide only about 10% of HCH enrollees are also enrolled in MC+. But CMHC Healthcare Homes serving individuals living along the I-70 corridor tend to have higher percentages of enrollees who are also enrolled in MC+.

CMHC Healthcare Home Staffing

In order to function effectively as health homes, CMHCs are required to enhance their existing treatment teams by adding 1 FTE Nurse Care Manager for every 250 HCH enrollees, and to engage a Primary Care Physician Consultant based on at least one hour per HCH enrollee per year. In addition, CMHC Healthcare Homes with less than 500 enrollees must employ at least a half-time Director and clerical staff. Healthcare Homes with between 500 and 625 enrollees should have a fulltime Director and clerical staff, and Healthcare Homes with more than 625 enrollees should have a fulltime Director and additional administrative staff commensurate with their actual enrollment.

Nurse Care Managers

Although there was concern that CMHCs would not be able to hire an adequate numbers of nurses to fill the projected number of Nurse Care Managers needed, when the CMHC Healthcare Home opened in January, only six CMHCs did not fully meet the Nurse Care Manager staffing standard. By February only three of these sites did not fully meet the staffing standard, and by April, only one site continued to have difficulty meeting the standard. Most sites exceeded the Nurse Care Manager staffing standard every month.

A few CMHCs experienced some turnover in their Nurse Care Manager positions, resulting in falling below the standard for a short period until a replacement could be hired; but turnover has been less than might be expected given the nursing shortage and competition for nursing staff.

Primary Care Physician Consultants

The Primary Care Physician Consultant position was created to introduce a primary care perspective into organizations focused on behavioral health. The Primary Care Physician Consultant:

- Assists the CMHC Healthcare Home in establishing priorities for disease management and improving health status,

- Helps educate community support specialists, case managers, and other clinical staff in the nature, course, and treatment of diabetes, COPD/asthma, cardiovascular disease, metabolic syndrome, and other prevalent chronic conditions,
- Participates in case reviews of individual CMHC Healthcare Home consumers, and
- Assists the CMHC in developing collaborative relationships with treating PCPs, as well as other healthcare professionals and facilities serving CMHC Healthcare Home enrollees.

CMHC Healthcare Homes can choose to utilize an Advanced Practice Nurse to help meet the Primary Care Physician Consultation staffing requirement. But a physician must provide at least one-half the required Primary Care Physician Consultant hours, with the Advanced Practice Nurse providing double the number of hours the physician would have provided.³

Engaging primary care physicians (PCPs) in this new role proved to be challenging for several CMHCs. Seven CMHCs were unable to secure the consultation services of a PCP for the month of January, and difficulty in understanding how to best utilize Primary Care Physician Consultants resulted in under utilization of their time. However, CMHC Healthcare Homes have dramatically improved in meeting the Primary Care Physician Consultant staffing requirement. Over the course of a year, CMHC Healthcare Homes are expected to meet at least 85% of the staffing standard. By June, the six CMHCs that used the combination of a PCP and an Advanced Practice Nurse were all exceeding the Primary Care Physician Consultant staffing expectations.

HCH Administration

Seven of the larger CMHC Healthcare Homes did not fully meet the administrative staffing expectations during the first six months. All of these CMHCs had a full time Healthcare Home Director and at least one clerical staff. The issue these larger Healthcare Homes faced was how best to utilize the additional administrative support available to them as part of their PMPM Healthcare Home reimbursement. These organizations were given time to have some experience with operating their Healthcare Homes so that they could better assess their administrative needs. Each must submit an administrative plan for approval by the Department, and each is expected to meet at least 85% of the administrative staffing standard over the course of the year.

Care Management

CMHC Healthcare Homes use a variety of tools and reports to monitor the health status and health care needs of enrollees, including several tools and reports developed by CMT, a data analytics organization. These tools and reports identify individuals enrolled in the Healthcare

³ For example, if a total of 500 hours were required, a physician would have to provide at least 250 hours, and an Advanced Practice Nurse would be required to provide 500 hours in order to substitute for the additional 250 physician hours required.

Home for whom an intervention may be required in order to assist in improving health status, or in accessing a needed service.

Although most of these tools and reports were being used prior to the development of the CMHC Healthcare Homes, because we only have two quarters worth of data for HCH enrollees, it is too early to assess whether CMHC Healthcare Homes are having an impact on improving the health status and access to care of enrollees.

Metabolic Screening

Because of the significant potential for developing Metabolic Syndrome, CMHCs are required to conduct an annual metabolic screening on all individuals receiving psychotropic medications. CMHCs report metabolic screening values to a statewide data base. This information is compared with Medicaid claims data to generate components of the Disease Management Reports (see below).

Metabolic screening is usually completed at the time of the individual's annual treatment plan update, though screening may be done more frequently as appropriate. Because annual treatment plan updates are typically spread unevenly throughout the year, it would not be surprising to find that fewer than 50% of the individuals enrolled in the CMHC Healthcare Homes had updated metabolic syndrome screens during the first six months. However, Metabolic Screening data was updated for only about one-third of the CMHC Healthcare Home enrollees as of June, 2012.

Improving the percentage of CMHC Healthcare Home enrollees with updated metabolic syndrome values will be a major focus for the second half of the year.

Behavioral Pharmacy Management System Reports

CMT's Behavioral Pharmacy Management System (BPMS™) reports compare prescribing practices for psychotropic medications prescribed by Medicaid providers with 25 Quality Indicators™ to identify prescriptions that deviate from Best Practice Guidelines, including inappropriate poly-pharmacy, doses that are higher or lower than recommended, and multiple prescribers of similar medications. CMHCs receive BPMS™ reports identifying all of their Medicaid consumers who have been prescribed a psychotropic medication that deviates from a Quality Indicator™ regardless of who prescribed the medication. The BPMS™ reports provide CMHCs with the opportunity to follow up with prescribers to determine whether changing the prescription would be appropriate. There are separate BPMS™ reports for adults, and for children and youth.

For the quarter ending in June, **15.2% of adults** and **18.9% of children and youth** enrolled CMHC Healthcare Homes had a psychotropic prescription that deviated from at least one of the ten top BPMS™ Quality Indicators™. In both cases, this was a slightly higher percentage than

the average percentage for the previous eighteen months for all adult (13.4%) and children and youth (13.7%) CMHC clients.

We expect to see the HCH “exception or outlier” percentages declining.

Medication Adherence Reports

Routinely taking prescribed medications is important to the management of chronic illness. Medication Adherence Reports help CMHCs identify individuals who are not routinely filling their prescriptions, by identifying individuals who have a low Medication Possession Ratio (MPR). The MPR is a measure of the percentage of time that an individual has a prescribed medication in their possession.⁴ An MPR of 0.80 or higher (possession 80% of the time) is considered adherent according to the scientific literature.

Medication Adherence Reports, developed by CMT, identify individuals with MPRs of less than 0.80 for three medication classes: anti-psychotic medications, cardiovascular medications, and diabetes medications. DMH has established as a **goal** for all three drug classes that **90%** of individuals who have been prescribed the relevant medications have **an MPR of 0.8 or higher**.

By the end of the second quarter of 2012, **at least 85% of both adult, and children and youth HCH enrollees had an MPR of 0.8 or higher in all three drug classes**, and the percentage of HCH enrollees with an MPR of 0.8 was higher than the percentage of general CMHC consumers with an MPR of 0.8 for both adults, and children and youth.

Disease Management Reports

Because it recognized that a significant percentage of the individuals it serves have other chronic diseases, in 2007 DMH worked with CMT to develop the Disease Management Reports to enable CMHCs to identify current clients who had not received tests, services, or medications usually associated with treating their chronic disease.

Initially, these reports monitored ten indicators related to the treatment and management of individuals with chronic obstructive pulmonary disease (COPD), asthma, congestive heart failure (CHF), coronary artery disease (CAD), gastro-esophageal reflux disease (GERD), and diabetes mellitus, and were forwarded to the CMHC’s on a quarterly basis. The reports are based on matching diagnoses found in the Medicaid paid claims data base with pharmacy and service claims in the same data base, and with data submitted by the CMHCs to the statewide Metabolic Screening data base.

With the advent of the health home initiative, the reports have been modified to focus on the chronic diseases being targeted by the CMHC Healthcare Homes, and we have continued to

⁴ For example, in a three month period, if an individual fills the prescription for the first 30 days, then skips the next 30 days, and then fills it for the last 30 days; they have the medication in their possession for 60 out of the 90 days (60/90) or 67% of the time – and MPR of 0.67.

refine, update, and add to the ten indicators originally being monitored. Most recently, in September, indicators that simply identified whether an individual has been screened for metabolic syndrome, or had their lipid, blood pressure, and A1C levels tested, have been supplemented by indicators that identify individuals whose lipid levels, blood pressure, and A1C levels are outside of expected ranges. Additional revisions and updates of the Disease Management including indicators regarding BMI control and tobacco use are in development. The following table provides the list of Disease Management Report indicators expected to be in place by the end of the year.

Indicator	Description
Asthma Med (A) Goal: 70%	% of patients 18-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.
Asthma Med (C) Goal: 70%	% 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.
BP Control HTN (A) Goal: 90%	% of patients 18 years and older with a diagnosis of hypertension with a blood pressure <140/90 mmHg, or during the most recent office visit within a 12 month period.
LDL Control Cardio(A) Goal: 70%	% of patients 18 -75 years of age with a diagnosis of CAD with lipid level adequately controlled (LDL <100 mg/dL).
Diabetes LDL Control (A) Goal: 70%	% of patients 18-75 years of age with a diagnosis of diabetes (type 1 or type 2) who had LDL,100mg/dL
Diabetes BP Control (A) Goal: 70%	% of patients 18-75 years of age with a diagnosis of diabetes (type 1 or type 2) who had a blood pressure <140/90 mmHg.
Diabetes A1c Control (A) Goal: 70%	% of patients 18-75 years of age with a diagnosis of diabetes (type 1 or type 2) who had an HbA1c <8.0%.
Diabetes A1c (C) Goal: 70%	% of patients under 18 years of age with diabetes (type 1 or type 2) who had an HbA1c <8.0%.
Metabolic Screen (A) Goal: 80%	% of members 18 years and older screened in the previous 12 months - Metabolic Screening (BMI, BP, HDL, cholesterol, triglycerides, and HbA1c or FBG)
Metabolic Screen (C) Goal: 80%	% of members under 18 years of age screened in the previous 12 months - Metabolic Screening (BMI, BP, HDL, cholesterol, triglycerides, and HbA1c or FBG)
BMI Control (A) Goal: 37%	% of patients 18 years and older with documented BMI between 18.5-24.9
BMI Control (C) Goal 37%	% of patients under 18 years of age with documented BMI between 18.5-24.9

Tobacco Use (A)	% of patients 18 years and older reporting NO tobacco use in previous 12 months
Tobacco Use (C)	% of patients under 18 years of age reporting NO tobacco use in the previous 12 months

Because we only have two quarters of data, and we have significantly revised and expanded the indicators, it is not possible to assess the performance of CMHC Healthcare Homes for most indicators in any meaningful way. However, we do know that **more than 80% of HCH enrollees with diabetes mellitus had both A1c tests and fasting lipid profiles performed** as required, and that **more than 70% of HCH enrollees with coronary artery disease also had fasting lipid profiles performed** as required.

Though CMHC Healthcare Homes are meeting or exceeding the standards regarding whether appropriate tests have been performed, the more critical issue that will be measured by the revised indicators introduced in September is whether or not the blood pressure, LDL, and A1C levels of the individuals with coronary artery disease, hypertension, and diabetes mellitus are under control.

Hospital Follow-Up

CMHC Healthcare Homes are responsible for participating in discharge planning and following up with HCH enrollees who have been hospitalized for any reason within 72 hours of discharge, and Nurse Care Managers are responsible for completing a medication reconciliation within 72 hours of the discharge of a HCH enrollee. Our **goal** is to **follow up and reconcile medications within 72 hours for 80% of HCH enrollees** admitted to a hospital.

Participating in discharge planning and follow up is complicated by the fact that many CMHC Healthcare Homes must work with several hospitals. In one month, a CMHC Healthcare Home responsible for several for Service Areas in south central Missouri had 78 unique hospital episodes involving 38 separate hospitals; and a suburban St. Louis area and City of St. Louis CMHC, each had HCH enrollee admissions to 17 separate hospitals in one month. One large hospital in St. Louis had HCH enrollee admissions from one-half of all the CMHC Healthcare Homes across the state in one month.

Though CMHC Healthcare Homes receive a daily e-mail notifying them when Medicaid has approved a request for payment of a hospital admission for one of their consumers, the requests have not always been submitted by the hospital in a timely manner, and some requests are actually “false positives” due to requests for extensions or appeals of requests previously denied. This, of course, complicates the work of the CMHC Healthcare Home in following up.

During the first six months, on average, each month CMHC Healthcare Homes received notification of 658 unique hospital episodes of care. CMHCs were able to follow up on **54%** of these episodes. Remarkably, each month a few CMHC Healthcare Homes were able to follow up with 100% of their enrollees, and seven or eight CMHC Healthcare Homes contacted at least 80% of their enrollees following discharge.

Of the HCH enrollees contacted following discharge, **71% were contacted within 72 hours of discharge**; and each month several CMHC s contacted 100% of the HCH enrollees within 72 hours of discharge.

Medication reconciliations were completed for 78% of the discharged individuals who were contacted, and **73% of the medication reconciliations were completed within 72 hours**; and each month 8 to 10 CMHC Healthcare Homes completed medication reconciliations on 100% of the enrollees contacted following discharge.

Given the complexities and shortcomings of the process for notifying CMHC Healthcare Homes of hospital admissions, we are pleased that CMHC Healthcare Homes have been able to follow up on 54% of all admissions, and we believe **it is remarkable that CMHC Healthcare Homes are already very nearly meeting the 80% goal** of following up and completing a medication reconciliation within 72 hours for those individuals they were able to contact following discharge.

PCP Engagement

Assuring that HCH enrollees have a Primary Care Physician (PCP), that the individual has an effective healthcare relationship with their PCP, and that the health home has an effective working relationship with each PCP are among the most important responsibilities of a CMHC Healthcare Home.

Overall CMHCs report that **89% of HCH enrollees have a PCP**, 3% do not have a PCP, and that for 8% of HCH enrollees it has not yet been determined if they have a PCP. For those HCH enrollees who have PCPs, **CMHCs have contacted 90% of the PCPs to inform them that their patient is enrolled in the CMHC Healthcare Home.**

Case Management

We initially expected Nurse Care Managers to provide case management for HCH enrollees who did not already have a case manager or community support specialist. However, we underestimated both the percentage of HCH enrollees who did not already have a case manager, as well as the extent of the case management services these individuals required. As of June, about **20% of adult and 25% of children and youth HCH enrollees did not have a case manager or community support specialist.** Though individuals who have not already been assigned a case manager tend to be psychiatrically stable, and may only be receiving medication

management services, as HCH enrollees they generally have other health or wellness issues that require more case management support than is appropriate for Nurse Care Managers to provide.

Several strategies have been employed to address this issue. If the individual(s) serving in the HCH clerical position(s) is qualified, DMH has recommended utilizing that position to provide needed case management to a small cohort of enrollees. In some cases, CMHCs may reassess whether an individual's current health status warrants enrollment in the Healthcare Home. But the most likely remedy is to assign individuals to a case manager or community support specialist. Of course, expanding the case manager/community support specialist capacity to meet this increased demand takes time. This is one of the areas we will continue to monitor, and will reassess and report progress at the end of the year.

Training, Technical Assistance, and System Transformation

Training and technical assistance have been, and will continue to be, critical to the successful implementation of the CMHC Healthcare Home initiative.

In the summer of 2011, each CMHC was required to introduce the health home initiative by presenting "Paving the Way for CMHC Healthcare Homes", a PowerPoint overview describing the reasons for, and key elements of, the initiative, to all of their staff. In the fall of 2011, the leadership of each CMHC attended training on HCH implementation, and all new HCH staff attended two days of "Healthcare Home 101" training that included an introduction in how to use the Care Management reports and tools.

Beginning in July 2011 through June, 2012, the consulting group MTM Services worked with each CMHC to improve access to care using strategies such as collaborative documentation, same day access models, no show models, centralized scheduling, utilization review and utilization management, and staff productivity/performance standards.

Monthly HCH Directors calls/webinars have been used to manage implementation issues, and HCH team members have been able to participate in monthly calls designed to improve their ability to use the Care Management reports and tools.

In March, the Care Management Reports that CMHCs receive migrated to a new web-based system developed by the data analytics company, CMT, called 'ProAct'. Following an initial March webinar in how to use ProAct, CMT has offered bi-weekly conference calls designed to both provide general training in utilizing ProAct and to answer specific questions and/or problems have in utilizing ProAct.

A Physician's Institute held in June provided the first opportunity for Primary Care Physician Consultants to convene on a statewide basis for training and networking.

Nurse Care Managers and other clinical staff have had opportunities to participate in training regarding the nature, course and treatment of chronic diseases, motivational interviewing, and TEAMcare.

All CMHCs are now in a major initiative to train community support specialists and case managers in Wellness Coaching.

CMHCs have appropriately participated in the monthly HCH Director webinars, required administrative and team training, as well as taking advantage of the variety of optional training opportunities offered.

DMH and Coalition of Community Mental Health Centers staff has conducted a number of on-site reviews at CMHC Healthcare Homes to assess the progress of implementation, clarify policies and procedures, and provide technical assistance. Site visits will continue to be conducted as part of the process of assuring that CMHCs continue development of fundamental health home functionality.

Early in 2012, Missouri was approached by the Council on Accreditation of Rehabilitation Facilities (CARF) and asked to work with them on the development of standards for Behavioral Health Homes. The new standards were published in the summer of 2012.

Most CMHCs in Missouri already have CARF Accreditation for many of their programs. Those CMHCs that already have CARF accreditation for some of their programs must be accredited by CARF as Behavioral Health Homes by January, 2014. The small number of CMHCs who do not currently have, and have not already been preparing for, CARF accreditation will have until April, 2014 to receive CARF accreditation of their Healthcare Homes.

As the result of a grant from the Missouri Foundation for Health, beginning in November, CMHC Healthcare Homes will be assigned Practice Coaches to assist them in preparing to meet the CARF Behavioral Health Home standards, and to assist in continuing to develop health home functionality.

Transformational Challenges

As they continue to mature as health homes over the coming months, CMHCs face a number of challenges in the ways they think about their work and in their actual practice.

We have noted that most HCH enrollees have a Primary Care Physician. However the challenge is to assure that individuals don't just have a PCP, but rather that they actually use them, and have an effective clinical relationship with them. Also it is not enough for the PCP to be aware that their patient is enrolled in a HCH. The HCH should have an effective working relationship with the PCP, sharing appropriate clinical information on a regular basis.

We have already acknowledged some of the challenges involved in following up on hospitalizations. Developing the multiple relationships need to effective work with a variety of hospitals will be a continuing challenge.

Helping staff to learn more about chronic diseases, and health and wellness, and how to assist individuals in managing their chronic diseases and improve their health status will be an ongoing challenge.

Perhaps most challenging will be the learning that will come as a result of the variety of care management reports now available to the CMHCs.

Care management reports provide more information about the individuals they serve than they have ever had before. For the first time, they provide an opportunity to focus on proactively managing the health status of populations (all individuals with diabetes or asthma, or who are significantly overweight), in addition to responding to the needs of individual consumers.

The volume of information is almost overwhelming. Prioritizing becomes critical; as do learning how to sift through the information and identify what is most important to focus on, as well as how to routinely use the available data in making clinical decisions and monitoring progress.

In the coming months, we will be trying to understand what works best, and looking for new ways to facilitate the new learning that is required, as well as assessing our progress toward maturity as a Healthcare Home system.