



CMHC Healthcare Homes

The Natural Next Step



Partners in Planning

A collaborative effort involving

- Dept. of Social Services (Mo HealthNet)
- Dept. of Mental Health
- Primary Care Association (FQHCs)
- Coalition of Community Mental Health Centers
- Hospital Association
- Health Foundations



Missouri's Health Homes

- Missouri has two types of Health Homes
 - CMHC Healthcare Homes (29)
 - Primary Care Health Homes (25)
 - 19 Federally Qualified Health Centers (FQHCs)
 - 5 Public Hospitals
 - 1 Rural Health Clinic (RHC)





Primary Care Target Population

- Clients are eligible for a Primary Care health home as a result of having two chronic conditions; or having one chronic condition and being at risk for a second chronic condition. To be eligible patients must meet one of the following criteria
 - 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



Primary Care Health Homes

- State Plan Amendment approved 12/23/11
- 20,239 individuals auto-enrolled
 - Primary Care patients with at least \$2,600 Medicaid costs annually
- 25 Primary Care Health Homes
 - Phased in
 - January 4 Health Homes
 - February 13 Health Homes
 - March 3 Health Homes
 - April 4 Health Homes



Primary Care Health Homes

- PMPM \$58.57
 - Health Home Director 1 per 2500 enrollees
 - Nurse Care Manager 1 per 250 enrollees
 - Care Coordinator 1 per 750 enrollees
 - Behavioral Health Consultant 1 per 750 enrollees
- Behavioral Health Consultants
 - Screen for behavioral health problems
 - Provide brief interventions for behavioral health issues
 - Provide behavioral health supports to assist individuals in managing their chronic diseases



Primary Care Health Homes

- Provide primary care services
- 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
- Coordinate/monitor ER visits and hospitalizations, including participating in discharge planning and follow up



Context

- Missouri Population 5.98 million
- 25 Service Areas
- Medicaid Rehab Option: 34,000+ consumers
 - 6 affiliates < 500 consumers enrolled
 - 2 CMHCs > 500 consumers enrolled
 - 10 CMHCs between 500 and 1000 consumers enrolled
 - 7 CMHCs between 1000 and 2000 consumers enrolled
 - 4 CMHCs > 2000 consumers enrolled





What is a Health Home?

- ACA Section 2703 defines a ‘health home’ as a designated provider selected by an eligible individual to provide the following services:
 - Comprehensive Care Management
 - Care Coordination and Health Promotion
 - Comprehensive Transitional Care
 - Patient and Family Support
 - Referral to Community and Social Support Services
 - Use of Information Technology to Link Services



What is a Health Home?

- CMS expects Health Homes to be based on a “whole person” philosophy and to:
 - Lower rates of emergency room use
 - Reduce in-hospital admissions and readmissions
 - Reduce healthcare costs
 - Decrease reliance on long-term care facilities
 - Improve experience of care, quality of life and consumer satisfaction
 - Improve health outcomes



What is a Health Home?

- Does CMHC HH = PCMH?
 - Yes
 - NCQA Person-Centered Medical Home standards are (largely) applicable, though their implementation looks different
 - No
 - Often assumes a practice or clinic model
 - NCQA PCMH standards do not capture the important ways in which CMHCs must change in order to be successful Health Homes



CMHC Healthcare Homes

- State Plan Amendment approved 10/20/11
 - Effective 1/1/12
- 29 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



CMHC Healthcare Home

Target Population

- Clients eligible for a CMHC healthcare home must meet one of the following three conditions
 1. **A serious and persistent mental illness**
 - CPR eligible adults, and kids with SED
 2. **A mental health condition and substance use disorder**
 3. **A mental health condition and/or substance use disorder and one other chronic health condition**



CMHC Healthcare Home

Target Population

- Chronic health conditions include:
 1. Diabetes
 2. Cardiovascular disease
 3. Chronic obstructive pulmonary disease (COPD)
 - Asthma
 - Chronic bronchitis
 - Emphysema
 4. Overweight (BMI >25)
 5. Tobacco use
 6. Developmental disability





What is a Health Home?

CMHC Healthcare Homes

- Provide psychiatric rehabilitation, including screening, evaluation, crisis intervention, medication management, psycho-social rehabilitation, and community support services
- Embody a recovery philosophy that respects and promotes independence and responsibility
- Complete a comprehensive health assessment
- Monitor critical health indicators





What is a Health Home?

CMHC Healthcare Home

- Assure access to, and coordinate care across, prevention, primary care (including assuring consumers have a PCP) and specialty medical services.
- Promote healthy lifestyles and support individuals in the self-management of chronic health conditions
- Coordinate/monitor ER visits and hospitalizations, including participating in discharge planning and follow up





What is a Health Home?

- Not just a Medicaid Benefit
- Not just a Program or a Team
- A System and Organizational Transformation





The Rehab Option

- Our Community Psychiatric Rehabilitation program **fulfills many Health Home functions**, though *focused on psychiatric disorders*:
 - Identifies and targets high-risk individuals
 - Monitors health status and adherence
 - Individualizes planning, and services and supports
 - A recovery model based on respect
 - Coordinates with the patients, caregivers and providers
 - Implements plan of care using a team approach
 - Promotes consumer self-management of the psychiatric disorder
 - Links consumers to community and social supports
 - Arranges psychiatric hospital admission and follows up on discharge



HH Functions: Added Emphasis

- Because healthcare homes take a “whole person” approach, we’ll continue and expand our emphasis on:
 - Providing **health and wellness** education and opportunities
 - Assuring consumers receive the **preventive and primary care** they need
 - Assuring consumers with **chronic physical health conditions** receive the medical care they need and assisting them in managing their chronic illnesses and accessing needed community and social supports





HH Functions: Added Emphasis

- Because healthcare homes take a “whole person” approach, we’ll continue and expand our emphasis on:
 - Facilitating **general hospital admissions and discharges** related to general medical conditions in addition to mental health issues
 - Using **health technology** to assist in managing health care
 - Providing or arranging appropriate **education and supports for families** related to consumers’ general medical and chronic physical health conditions



HCH Responsibilities

HCH Team Members

- Community Support Specialists (CSS)
- Psychiatrist
- QMHP, PSR and other Clinical Staff
- Peer Specialists
- Family Support Specialists
- **Health Care Home Director**
- **Primary Care Consulting Physician**
- **Nurse Care Managers (NCM)**
- **HCH Clerical Support Staff**





HCH 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



HCH 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 providers**
- **Documents** individual **client care and coordination** in client records
- **Maintains** a monthly **HCH log**



HCH 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



HCH Team Members

Psychiatrists, QMHPs, PSR and CSSs

- **Continue to fulfill current responsibilities**
- **Collaborate with Nurse Care Managers** in providing individualized services and supports
- **CSSs participate** in required **HCH training** to enable them to serve as health coaches who
 - **Champion healthy lifestyle changes and preventive care efforts**, including helping consumers develop wellness related treatment plan goals
 - Support consumers in **managing chronic health conditions**
 - Assist consumers in **accessing primary care**



Training

- “Paving the Way”
 - What, Why, and How?
- Leadership 101
 - Responsibilities, Enrolling, Payment, and Reporting
- Team 101
 - Staff roles and responsibilities
 - Healthcare Home responsibilities
 - Reporting requirements
 - Performance measures



Training

- Additional Team Training
 - Focus on Clinical Deficits
 - Motivational Interviewing
 - Chronic Diseases
 - Self Management
- Learning Collaborative
 - Sponsored by St. Louis and Kansas City Health Foundations
 - Includes Primary Care Health Homes and Multi-payer Primary Care Providers



What Made It Possible?

- The Rehab Option
- The DMH relationship with the
 - Coalition of CMHCs
 - State Medicaid Authority
 - State Budget Office
 - State Primary Care Association
- Use of Health Information Technology to identify and monitor problems, and assess performance
- Funding Nurse Liaisons





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Relationships

- The Missouri Coalition of CMHCs
 - Stability
 - Trust
- The State Medicaid Authority and State Budget Office
 - Transparency
 - Common Agenda
- The Missouri Primary Care Association
 - CMHC/FQHC Integration Initiative

Behaviors that Promote Trust

- Character
 - Talk Straight
 - Demonstrate Respect
 - Create Transparency
 - Right Wrongs
 - Show Loyalty
- Competence
 - Deliver Results
 - Get Better
 - Confront Reality
 - Clarify Expectations
 - Practice Accountability
- Character & Competence
 - Listen First
 - Keep Commitments
 - Extend Trust



Common Agenda

Better Care Saves Money

- A study of 6,757 consumers eligible for Missouri's Chronic Care Improvement Program (CCIP) served by CMHCs showed significant savings when compared with projected costs for this population
- These individuals had mental illness and one of the following conditions:
 - *Asthma*
 - *Pre-diabetes or diabetes*
 - *Cardiovascular disease*
 - *Chronic obstructive pulmonary disease (COPD)*
 - *Gastroesophageal reflux disease (GERD)*
 - *Sickle cell disease*





Common Agenda

Better Care Saves Money

Cost Savings Analysis of CMHC Clients Enrolled in CCIP

Initial PMPM Cost	\$1,556
Expected PMPM Cost w/o intervention	\$1,815
Actual PMPM Cost following enrollment w/ CMHC	\$1,504
Savings	\$21 million



Utilizing

Health Information Technology

- CyberAccess
 - Allows providers to view patients histories based on Medicaid claims, including diagnoses, pharmacy, services, ER & hospital
- Metabolic Screening
 - Required for all individuals receiving anti-psychotic medications
 - Provides data on
 - Height/Weight/BMI/Waist Circumference
 - Plasma Glucose/Fasting and/or A1c
 - Cholesterol/LDL/HDL/Triglycerides
 - Taking an anti-psychotic?
 - Pregnant?
 - Smoker?





Utilizing

Health Information Technology

- CMT Reports
 - Caveats
 - Based on Medicaid claims data
 - Does not include Medicare or procedures/meds that are provided free, paid by the consumer, or for which no claim was submitted
 - **Medication Adherence Reports**
 - Based on Medicaid pharmacy claims
 - Enables CMHCs to identify all prescriptions that have been filled by consumers and determine Medication Possession Ratios



Utilizing

Health Information Technology

- CMT Reports
 - **Behavioral Pharmacy Management Report**
 - Includes a series of Quality Indicators™ to identify prescriptions that deviate from Best Practice Guidelines
 - Inappropriate polypharmacy
 - Doses that are higher or lower than recommended
 - Multiple prescribers of similar medications
 - Sent to prescribing physician with Clinical Considerations™ that includes Best Practice Guidelines and recommendations
 - Sent to CMHC for all their consumers and includes information for all physicians, regardless of whether they are employed by the CMHC



Utilizing

Health Information Technology

- CMT Reports
 - Disease Management Report
 - Based on Medicaid claims and Metabolic Screening data
 - Identifies individuals with specific diagnoses who are not meeting specific indicators
 - Asthma/COPD – have not been prescribed inhaled corticosteroids
 - Coronary Artery Disease – do not have appropriate lipid or BP levels, or have not been prescribed Statins
 - Hypertension – do not have appropriate lipid levels or BP levels
 - Diabetes – do not have appropriate A1c or lipid levels



Nurse Liaisons

- One per CMHC
- Focus on
 - HIT Reports
 - Management of Chronic Diseases
 - Staff Training
- Problems
 - Caseload Size
 - Demands of recording data





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- Funding Nurse Liaisons





Shared Savings

- A Separate State Plan Amendment
 - Providers share in any savings after the first year
 - Based on provider performance
- Performance Measures
 - 25 measures
 - Benchmark Goals
 - Gap Closing Goals
 - Also used to assess progress at six months



Why CMHC Healthcare Homes?

- Because it's the natural next step for Missouri
 - Step One:** Implementing Psychiatric Rehabilitation Program
 - Step Two:** Implementing Health Information Technology Tools
 - CMT data analytics
 - Behavioral Pharmacy Management Program
 - Disease Management Report (HEDIS indicators)
 - Medication Adherence Report
 - CyberAccess



Why CMHC Healthcare Homes?

- Because it's the natural next step for Missouri

Step Three: Building Integration Initiatives

- DMH Net Nurse liaisons
- FQHC/CMHC collaborations integrating primary and behavioral health

Step Four: Embracing Wellness and Prevention Initiatives

- Metabolic syndrome screening

Next Step: Becoming a healthcare home





Questions?





Performance Measures

Asthma and COPD

Measure	Source	Benchmark Goal	Gap Closing Goal
% of patients 5-17 years old who were prescribed controller medication	CMT Disease Mgt Report (Claims)	>70%	Increase by 10 percentage points
% of patients 18-50 years old who were prescribed controller medication	CMT Disease Mgt Report (Claims)	>70%	Increase by 10 percentage points



Performance Measures

Coronary Artery Disease

Use of statin medications	CMT Disease Mgt Report (Claims)	>70%	Increase by 10 percentage points
% of patients age 18 years and older with lipid level adequately controlled (LDL<100)	CMT Disease Mgt Report (Diagnosis from Claims and Metabolic Screening Registry)	>70%	Increase by 10 percentage points



Performance Measures

Diabetes

Measure	Source	Benchmark Goal	Gap Closing Goal
% of patients 18-75 years old with HbA1c<8.0%	CMT Disease Mgt Report (Claims and Metabolic Screening Registry)	>70%	Increase by 10 percentage points
% of patients age 18-75 with lipid level adequately controlled (LDL<100)	CMT Disease Mgt Report (Claims and Metabolic Screening Registry)	>70%	Increase by 10 percentage points
% of patients age 18-75 with blood pressure adequately controlled (<140/90 mm Hg)	CMT Disease Mgt Report (Claims and Metabolic Screening Registry)	>70%	Increase by 10 percentage points



Performance Measures

Hypertension

Measure	Source	Benchmark Goal	Gap Closing Goal
% of patients age 18 and older with blood pressure adequately controlled (<140/90 mm Hg)	CMT Disease Mgt Report (Claims and Metabolic Screening Registry)	>70%	Increase by 10 percentage points



Change Concepts*

- Population Management (Empanelment)
- Continuous and Team-based Healing Relationships
- Care Coordination
- Person-centered Interactions
- Enhanced Access
- Engaged Leadership
- Quality Improvement Strategy
- Organized Evidence-based Care

*Developed by CSI Solutions based on the MacColl Institute for Healthcare Innovation PCMH-A self assessment tool



Change Concepts

Population Management

- Strength
 - Managing serious mental illness
- Challenges
 - Educating staff to understand chronic diseases, and to promote and enable individuals to manage their conditions
 - Educating staff to understand wellness and healthy lifestyles, and to promote and enable individuals to embrace wellness and adopt healthy lifestyles
 - Modifying systems to track health and medical disease status and risks



Continuous and Team-based Care

- Strength
 - Team approach
- Challenges
 - Integrating new team members
 - Nurse Care Managers
 - Primary Care Physician Consultants
 - Clarifying roles and responsibilities
 - Modifying established procedures



Change Concepts

Care Coordination

- Strength
 - Linking individuals with a broad array of community services and supports
 - Following up on psychiatric admissions and discharges
- Challenges
 - Linking individuals with PCPs
 - Coordinating care with PCPs
 - Following up on all admissions and discharges

Character and Competence

“When you trust people, you have confidence in them – their integrity and their abilities.”

“The opposite of trust –distrust- is *suspicion*”.

“we judge ourselves by our intentions and others by their behavior. This is why...one of the fastest ways to restore trust is to make and keep commitments....”

“generally the quickest way to decrease trust is to violate a behavior of **character**, while the quickest way to increase trust is to demonstrate a behavior of **competence**.”