Health Homes: Children, Youth and Mental Health

Missouri’s Primary Care and CMHC Health Homes
Section 2703 of the Affordable Care Act allows states to amend their Medicaid state plans to provide Health Homes for enrollees with chronic conditions.

“’Eligible individual with chronic conditions’ means an individual who is eligible for medical assistance...and has at least 2 chronic conditions; 1 chronic condition and is at risk of a second chronic condition; or 1 serious and persistent mental health condition.”

Provides an enhanced 90:10 match rate for 8 fiscal year quarters
CMS Goal

“to expand the traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, in keeping with the needs of persons with multiple chronic illnesses”
CMS Expectations

• Health Homes embody a “whole person” approach
• Health Homes coordinate and provide access to
  o Health services
  o Preventive and health promotion services
  o Mental health and substance abuse services
• Health Homes achieve results
  o Lower rates of emergency room use
  o Reduce in-hospital admissions and readmissions
  o Reduce healthcare costs
  o Improve experience of care, quality of life and consumer satisfaction
  o Improve health outcomes
Missouri’s Health Homes

- Missouri has two types of Health Homes
  - Primary Care Health Homes (25)
    - 19 Federally Qualified Health Centers (FQHCs)
    - 5 Public Hospitals
    - 1 Rural Health Clinic (RHC)
  - CMHC Healthcare Homes (29)
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
  o 776 children and youth (4%)
  o Primary Care patients with at least $2,600 Medicaid costs annually

• 25 Primary Care Health Homes
  o Phased in
    • January       4 Health Homes
    • February      13 Health Homes
    • March         3 Health Homes
    • April         4 Health Homes
Primary Care Health Homes

• 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

• Coordinate/monitor ER visits and hospitalizations, including participating in discharge planning and follow up, including psychiatric hospitalizations
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
Why Did DMH Develop Health Homes?

- Because addressing behavioral health needs requires addressing other healthcare issues
  - Individuals with SMI, on average, die 25 years earlier than the general population.
  - 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases.
  - Second generation anti-psychotic medications are highly associated with weight gain, diabetes, dyslipidemia (abnormal cholesterol) and metabolic syndrome.
Why Did DMH Develop Health Homes?

• Because addressing general health issues is necessary in order to improve outcomes and quality of care
• Because treating illness is not enough
  o Wellness and prevention are as important as treatment and rehabilitation.
Why Did DMH Develop Health Homes?

• Because there is continuing pressure to control Medicaid costs
  o No change is not an option
  o Alternative service delivery approaches are unacceptable
    • Capitated Managed Care
    • Administrative Service Organization with prior authorization
  o An opportunity to save state funds without cutting services
    • DMH would have faced an additional $7.8 million reduction without Health Home implementation
Context

• Missouri Population 5.98 million

• 25 Service Areas

• Medicaid Rehab Option: 34,000+ consumers
  o 29 Comprehensive Psychiatric Rehab Centers

• CMHCs serve as “Administrative Agents” for the DMH
CMHC Healthcare Homes

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

- 29 CMHC Healthcare Homes

- 17,882 individuals auto-enrolled
  - 3203 children and youth (18%)
  - 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 or serious emotional disorder
  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
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
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
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
Our Medicaid 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
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
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
Health Home Learning Collaborative

- Missouri Foundation for Health and the Healthcare Foundation of Greater Kansas City

- Includes teams from
  - Primary Care Heath Homes
  - CMHC Healthcare Homes, and
  - Private sector primary care providers participating in a multi-payer demonstration project in St. Louis

- Initially assumed that accreditation by NCQA as a “Person-centered Medical Home” (PCMH) was the target

- Managed by CSI Solutions
Change Concepts*

- Empanelment (Population Management)
- 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
  o Managing serious mental illness and serious emotional disorders

• Challenges
  o Educating staff to understand other chronic diseases, and to promote and enable individuals to manage their conditions
  o Educating staff to understand wellness and healthy lifestyles, and to promote and enable individuals to embrace wellness and adopt healthy lifestyles
  o Modifying systems to track health and medical disease status and risks
Continuous and Team-based Care

• **Strength**
  o Team approach

• **Challenges**
  o Integrating new team members
    • Nurse Care Managers
    • Primary Care Physician Consultants
  o Clarifying roles and responsibilities
  o Modifying established procedures
Change Concepts

Care Coordination

• Strength
  o Linking individuals with a broad array of community services and supports
  o Following up on psychiatric admissions and discharges

• Challenges
  o Linking individuals with PCPs
  o Coordinating care with PCPs
  o Following up on all admissions and discharges
Change Concepts

Person-centered Interactions

• Strength
  o Consumer/Family Focus
  o Recovery Model

• Challenges
  o Supporting individuals with self-management of their chronic medical conditions
  o Supporting individuals in adopting healthy lifestyles
What is a CMHC Healthcare Home?

- Not just a Medicaid Benefit
- Not just a Program or a Team
- A System and Organizational Transformation
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
  o Initially review client records and patient history
  o 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
  o Consult with CSS’s about identified health conditions of their clients
  o Coordinate care with external health care providers (pharmacies, PCPs, FQHC’s etc.)
  o 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**
What Made It Possible?

• The Rehab Option

• The DMH relationship with the
  o Coalition of CMHCs
  o State Medicaid Authority
  o State Budget Office
  o State Primary Care Association

• Use of Health Information Technology to identify and monitor problems, and assess performance

• Funding Nurse Liaisons
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
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
Cost Savings Analysis of CMHC Clients Enrolled in CCIP

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Initial PMPM Cost</td>
<td>$1,556</td>
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<tr>
<td>Expected PMPM Cost w/o intervention</td>
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<tr>
<td>Actual PMPM Cost following enrollment w/ CMHC</td>
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</tr>
<tr>
<td><strong>Savings</strong></td>
<td><strong>$21 million</strong></td>
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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
  o 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
  o 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
  o Behavioral Pharmacy Management Report
    • Includes a series of Quality Indicators™ to identify prescriptions that deviate from Best Practice Guidelines
      o Inappropriate polypharmacy
      o Doses that are higher or lower than recommended
      o 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
  o Disease Management Report
    • Based on Medicaid claims and Metabolic Screening data
    • Identifies individuals with specific diagnoses who are not meeting specific indicators
      o Asthma/COPD – have not been prescribed inhaled corticosteroids
      o Coronary Artery Disease – do not have appropriate lipid or BP levels, or have not been prescribed Statins
      o Hypertension – do not have appropriate lipid levels or BP levels
      o Diabetes – do not have appropriate A1c or lipid levels
What Made It Possible?

• The Rehab Option
• The DMH relationship with the
  o Coalition of CMHCs
  o State Medicaid Authority
  o State Budget Office
  o State Primary Care Association
• Use of HIT to Identify and Monitor Problems, and Assess Performance
• Funding Nurse Liaisons
Resources

• Missouri Department of Mental Health Website

  http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm

  o Primary Care Health Home State Plan Amendment
  o CMHC Health Home State Plan Amendment
  o Health Home Client Flyers
  o PowerPoint Presentations
    • Paving the Way for Health Homes
      o Introduction of CMHC Healthcare Homes
    • CMHC Healthcare Home 101 Leadership Training
      o Describes CMHC Healthcare Home Requirements
    • Draft Health Homes and Hospitals MOU
    • FAQ for CMHC Healthcare Homes
Questions?