SAMHSA-HRSA
Center for Integrated Health Solutions

Medicaid Health Home Implementation in Missouri: A Year Later

June 27, 2013

SAMHSA-HRSA
Center for Integrated Health Solutions

Slides for today's webinar are available on the CIHS website at:

www.Integration.samhsa.gov

under About Us/Webinars

Welcome!

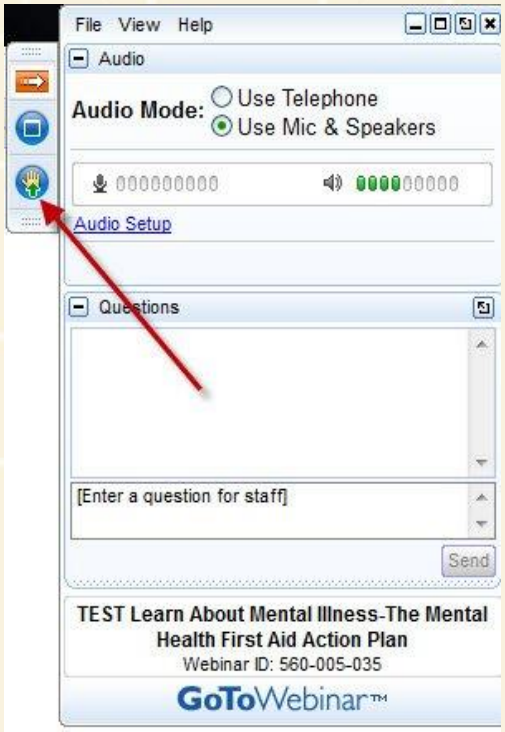
- Laura Galbreath, SAMHSA-HRSA Center for Integrated Health Care Services
- Kathy Moses, Senior Program Officer, Center for Health Care Strategies
- Joseph Parks, MD, Chief Clinical Officer, Missouri Department of Mental Health
- North Central Missouri Mental Health Center, NCMMHC
  - Tammy Floyd, HealthCare Home Director
  - Debbie Graham, Clinical Director

CHCS
Center for Health Care Strategies, Inc.

A non-profit health policy resource center dedicated to improving services for Americans receiving publicly financed care

- **Priorities**: (1) enhancing access to coverage and services; (2) advancing quality and delivery system reform; (3) integrating care for people with complex needs; and (4) building Medicaid leadership and capacity.
- **Provides:** technical assistance for stakeholders of publicly financed care, including states, health plans, providers, and consumer groups; and informs federal and state policymakers regarding payment and delivery system improvement.
- **Funding:** philanthropy and the U.S. Department of Health and Human Services.

How to ask a question during the webinar



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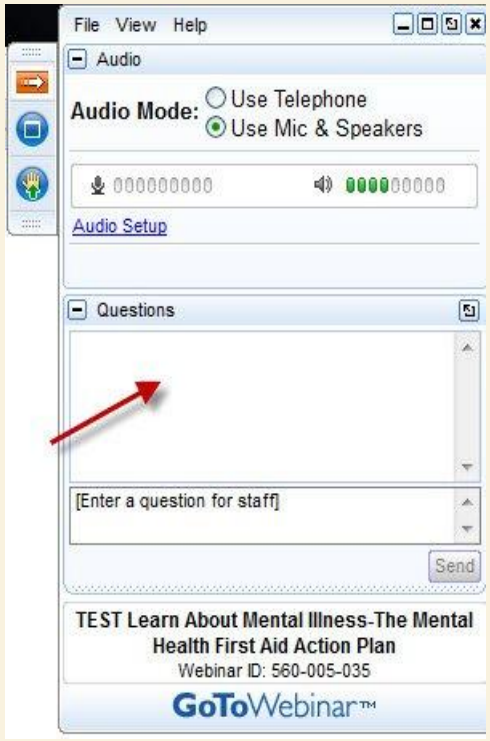

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Missouri Health Homes

2013

My Background

- DMH Medical Director
- Consultant to MoHealthNet (Missouri Medicaid)
- President NASMHPD Medical Director's Council
- Practicing FQHC Psychiatrist
- Director, Missouri Institute of Mental Health – University of Missouri St. Louis

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

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
• Care Coordinator	1 per 500 enrollees

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

What is a CMHC Healthcare Home?

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

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

Healthcare Home Team Members

Psychiatrists, QMHPs, PSR and CSWs

- Continue to fulfill current responsibilities
- Collaborate with Nurse Care Managers in providing individualized services and supports
- CSWs are trained 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

Comprehensive Care Management

- Identification and targeting of high-risk individuals
- Monitoring of health status and adherence
- Development of treatment guidelines
- Individualized planning with the consumer

Method

- Screen for general health with priority for high risk conditions
- Prescribers will screen, monitor and intervene for metabolic syndrome and related care gaps
- Treatment per practice guidelines: eg, heart disease, diabetes, smoking cessation, use of novel anti-psychotics
- Offer prevention and intervention for modifiable risk factors and care gaps
- Track and improve performance thru patient disease registry

Step 1 – Create Disease Registry

- Get Historic Diagnosis from Admin Claims
- Get Clinical Values from Metabolic Screening
- Combine into EHR Disease Registry
- Online Access available to all Providers

Metabolic Syndrome Disease Registry

Metabolic Syndrome

- Obesity - weight height
- Cholesterol
- Triglycerides
- Blood pressure
- Blood sugar

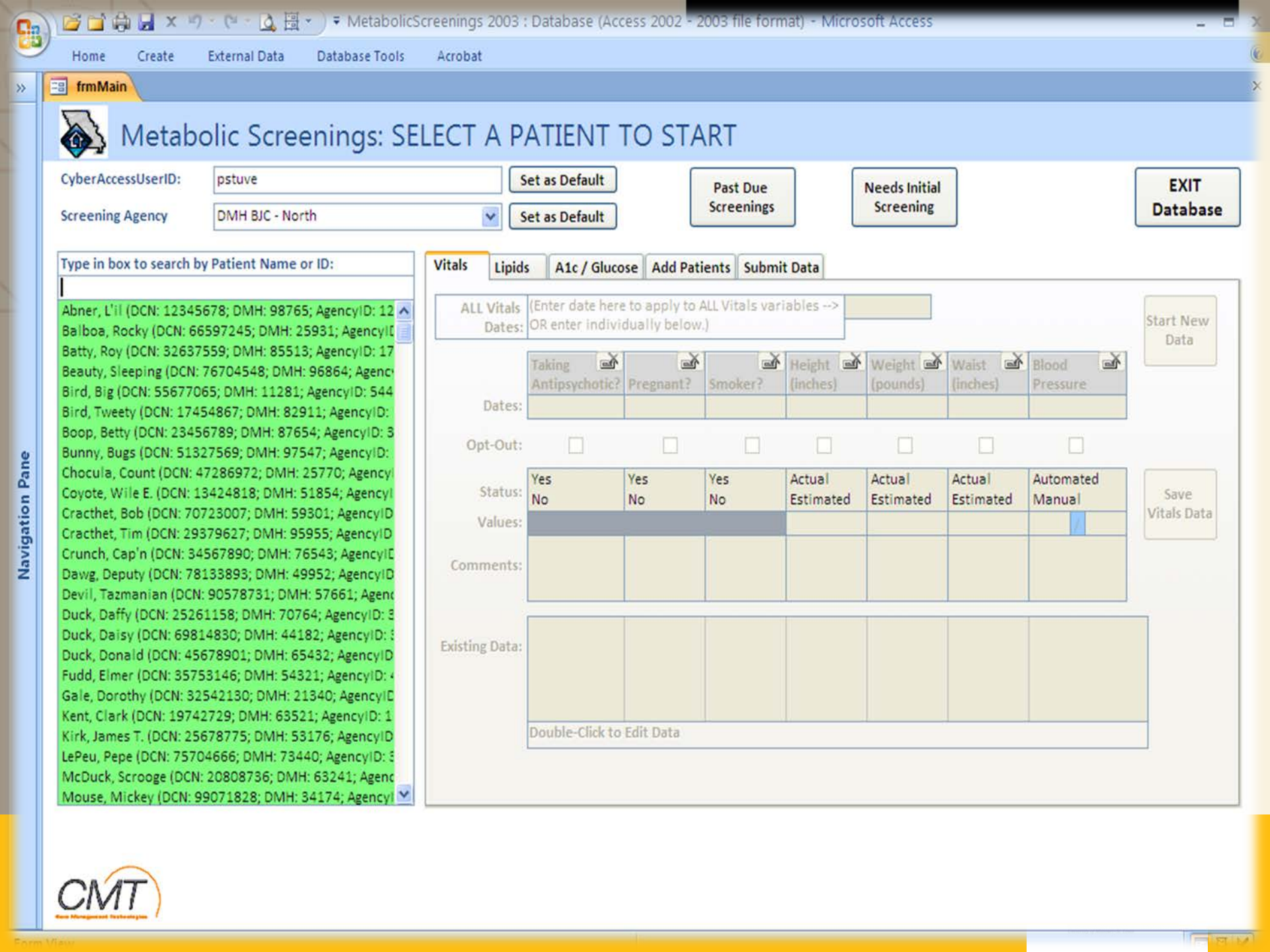
- Screening Required Annually since 2010
- Disease registry with results maintained on cyber access
- Billing Code under Rehab Option

Step 2 – Identify Care Gaps and ACT!

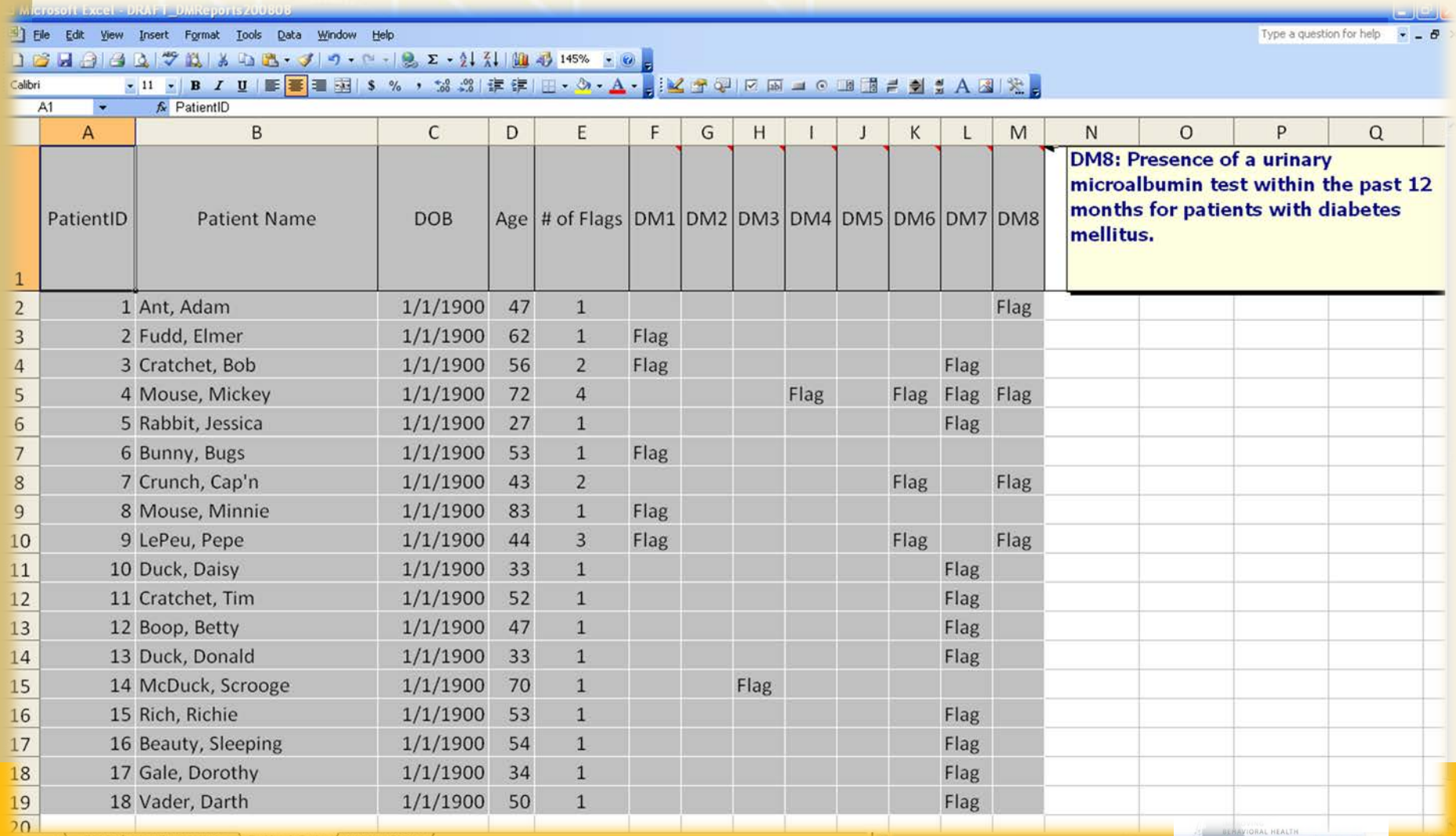
- Compare Combined Disease Registry Data to accepted Clinical Quality Indicators
- Identify Care Gaps
- Sort patients with care gaps into agency specific To-Do lists
- Send to CMHC nurse care manager
- Set up PCP visit and pass on info with request to treat

DMHNET Performance Indicators

- Use of inhaled corticosteroid medications by persons with a history of COPD (chronic obstructive pulmonary disease) or Asthma.
- Adherence to * different Classes of Medication
- Contact and medication reconciliation within 72 hours of Hospital Discharge
- Control of Blood Pressure and Glucose
- Obesity Substance abuse and Smoking Measures


MetabolicScreenings 2003 : Database (Access 2002 - 2003 file format) - Microsoft Access
Home
Create
External Data
Database Tools
Acrobat
frmMain
Metabolic Screenings: SELECT A PATIENT TO START
CyberAccessUserID:
pstuve
Set as Default
Screening Agency
DMH BJC - North
Set as Default
Past Due Screenings
Needs Initial Screening
EXIT Database
Type in box to search by Patient Name or ID:
Abner, L'il (DCN: 12345678; DMH: 98765; AgencyID: 12
Balboa, Rocky (DCN: 66597245; DMH: 25931; AgencyID
Batty, Roy (DCN: 32637559; DMH: 85513; AgencyID: 17
Beauty, Sleeping (DCN: 76704548; DMH: 96864; Agenc
Bird, Big (DCN: 55677065; DMH: 11281; AgencyID: 544
Bird, Tweety (DCN: 17454867; DMH: 82911; AgencyID:
Boop, Betty (DCN: 23456789; DMH: 87654; AgencyID: 3
Bunny, Bugs (DCN: 51327569; DMH: 97547; AgencyID:
Chocula, Count (DCN: 47286972; DMH: 25770; Agency
Coyote, Wile E. (DCN: 13424818; DMH: 51854; Agency
Cracthet, Bob (DCN: 70723007; DMH: 59301; AgencyID
Cracthet, Tim (DCN: 29379627; DMH: 95955; AgencyID
Crunch, Cap'n (DCN: 34567890; DMH: 76543; AgencyID
Dawg, Deputy (DCN: 78133893; DMH: 49952; AgencyID
Devil, Tazmanian (DCN: 90578731; DMH: 57661; Agenc
Duck, Daffy (DCN: 25261158; DMH: 70764; AgencyID: 3
Duck, Daisy (DCN: 69814830; DMH: 44182; AgencyID: 3
Duck, Donald (DCN: 45678901; DMH: 65432; AgencyID
Fudd, Elmer (DCN: 35753146; DMH: 54321; AgencyID: 4
Gale, Dorothy (DCN: 32542130; DMH: 21340; AgencyID
Kent, Clark (DCN: 19742729; DMH: 63521; AgencyID: 1
Kirk, James T. (DCN: 25678775; DMH: 53176; AgencyID
LePeu, Pepe (DCN: 75704666; DMH: 73440; AgencyID: 3
McDuck, Scrooge (DCN: 20808736; DMH: 63241; Agenc
Mouse, Mickey (DCN: 99071828; DMH: 34174; Agency
Vitals
Lipids
A1c / Glucose
Add Patients
Submit Data
ALL Vitals Dates:
(Enter date here to apply to ALL Vitals variables --> OR enter individually below.)
Start New Data
Taking Antipsychotic?
Pregnant?
Smoker?
Height (inches)
Weight (pounds)
Waist (inches)
Blood Pressure
Dates:
Opt-Out:
Status:
Yes No
Yes No
Yes No
Actual Estimated
Actual Estimated
Actual Estimated
Automated Manual
Values:
Comments:
Save Vitals Data
Existing Data:
Double-Click to Edit Data
Navigation Pane
CMT

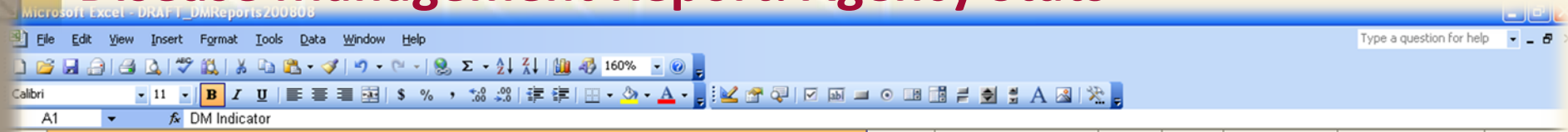
Disease Management Report: Patient Data



PatientID	Patient Name	DOB	Age	# of Flags	DM1	DM2	DM3	DM4	DM5	DM6	DM7	DM8
1	Ant, Adam	1/1/1900	47	1								Flag
2	Fudd, Elmer	1/1/1900	62	1	Flag							
3	Cratchet, Bob	1/1/1900	56	2	Flag						Flag	
4	Mouse, Mickey	1/1/1900	72	4				Flag		Flag	Flag	Flag
5	Rabbit, Jessica	1/1/1900	27	1							Flag	
6	Bunny, Bugs	1/1/1900	53	1	Flag							
7	Crunch, Cap'n	1/1/1900	43	2						Flag		Flag
8	Mouse, Minnie	1/1/1900	83	1	Flag							
9	LePeu, Pepe	1/1/1900	44	3	Flag					Flag		Flag
10	Duck, Daisy	1/1/1900	33	1							Flag	
11	Cratchet, Tim	1/1/1900	52	1							Flag	
12	Boop, Betty	1/1/1900	47	1							Flag	
13	Duck, Donald	1/1/1900	33	1							Flag	
14	McDuck, Scrooge	1/1/1900	70	1			Flag					
15	Rich, Richie	1/1/1900	53	1							Flag	
16	Beauty, Sleeping	1/1/1900	54	1							Flag	
17	Gale, Dorothy	1/1/1900	34	1							Flag	
18	Vader, Darth	1/1/1900	50	1							Flag	

DM8: Presence of a urinary microalbumin test within the past 12 months for patients with diabetes mellitus.

Disease Management Report: Agency Stats



	A	B	C	D	E	F	G	H
1	**DM Indicator**	**Goal**	**Total Patients**	**# NA**	**# OK**	**# Flagged**	**% OK**	
2	DM1: Use of inhaled corticosteroid medications by persons with a history of COPD (chronic obstructive pulmonary disease) or Asthma.	>70%	78	61	12	5	70.6%	
3	DM2: Use of ARB (angiotensin II receptor blockers) or ACEI (angiotensin converting enzyme inhibitors) medications by persons with a history of CHF (congestive heart failure).	>70%	78	76	2	0	100.0%	
4	DM3: Use of beta-blocker medications by persons with a history of CHF (congestive heart failure).	>70%	78	76	1	1	50.0%	
5	DM4: Use of statin medications by persons with a history of CAD (coronary artery disease).	>70%	78	74	3	1	75.0%	
6	DM5: Use of H2A (histamine 2-receptor antagonists) or PPI (proton pump inhibitors) medications for no more than 8 weeks by persons with a history of GERD (gastro-esophageal reflux disease).	<50%	78	0	0	0	0.0%	
7	DM6: Presence of a fasting lipid profile within the past 12 months for patients with CAD (coronary artery disease).	>70%	78	74	1	3	25.0%	
8	DM7: Presence of a DRE (dilated retinal exam) within the past 12 months for patients with diabetes mellitus.	>70%	78	59	8	11	42.1%	
9	DM8: Presence of a urinary microalbumin test within the past 12 months for patients with diabetes mellitus.	>70%	78	59	2	17	10.5%	
10								
11								

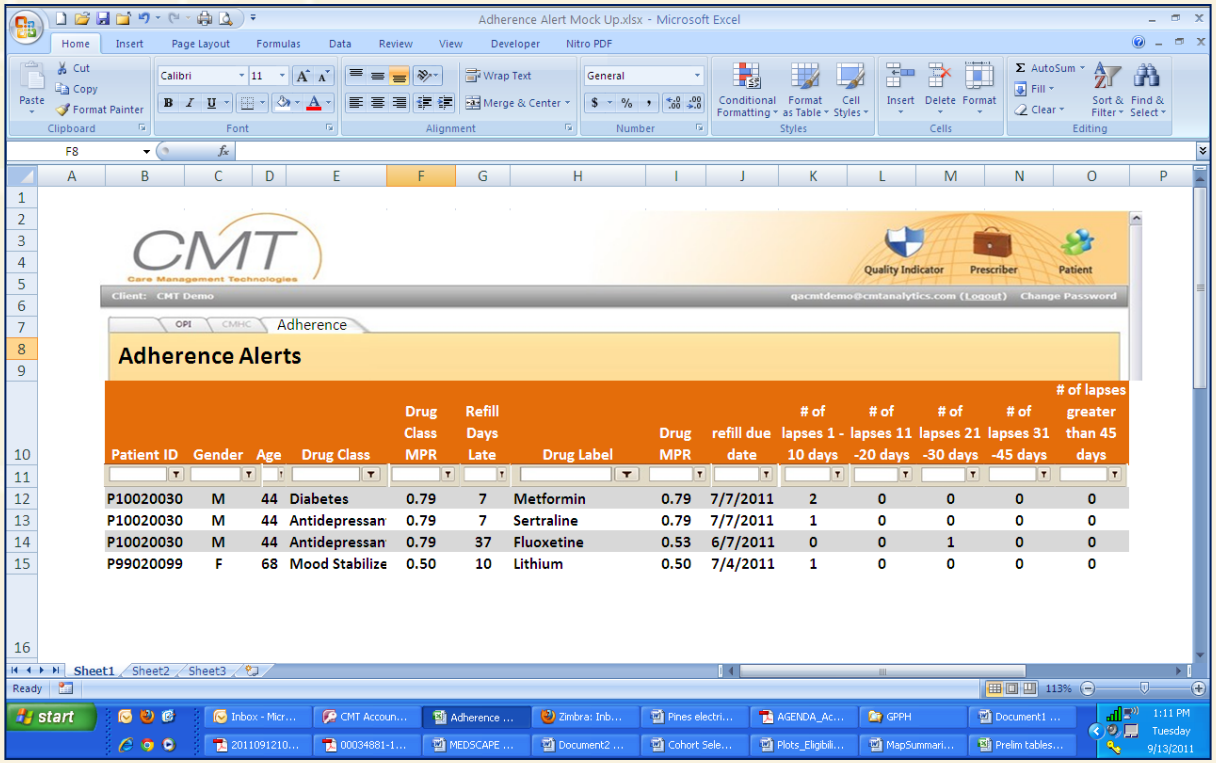
Medication Adherence Reports

- 7 Drug Classes:
  - Antidepressants
  - Antipsychotics
  - Mood Stabilizers
  - Antihypertensives
  - Asthma/COPD Medications
  - Cardiovascular Medications
  - Diabetes Medications

Medication Possession Ratios (MPRs)

- MPR is a measure of medication adherence.
- Based on pharmacy claims and delays in getting refills.
- Refers to the percentage of time that a patient has a prescribed medication in their possession.
  - In a 3 month period, if a patient fills the medication for the first 30 days, then skips the next 30 days, 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 – an MPR of 0.67.
- An MPR of 1.0 is perfect adherence (100% possession).
- An MPR of 0.8 or higher (possession 80% of the time) is considered adherent, per the scientific literature.

Adherence: Lapsed Refill Alerts



Patient ID	Gender	Age	Drug Class	Drug Class MPR	Refill Days Late	Drug Label	Drug MPR	refill due date	# of lapses 1 - 10 days	# of lapses 11 -20 days	# of lapses 21 -30 days	# of lapses 31 -45 days	# of lapses greater than 45 days
P10020030	M	44	Diabetes	0.79	7	Metformin	0.79	7/7/2011	2	0	0	0	0
P10020030	M	44	Antidepressan	0.79	7	Sertraline	0.79	7/7/2011	1	0	0	0	0
P10020030	M	44	Antidepressan	0.79	37	Fluoxetine	0.53	6/7/2011	0	0	1	0	0
P99020099	F	68	Mood Stabilize	0.50	10	Lithium	0.50	7/4/2011	1	0	0	0	0

Initial Results

- Provide specific lists of CMHC clients with care gaps as identified by HEIDIS indicators to CMHC primary care nurse liaisons quarterly
- Provide HEIDIS indicator/disease state training on standard of care to CMHC MH case managers
- First quarter focus on indicator one-asthma substantially reduced percentage with care gap
    - Range 22% - 62% reduction
    - Median 45% reduction

Care Coordination

- Coordinating with the patients, caregivers and providers
  - Implementing plan of care with treatment team
  - Planning hospital discharge
  - Scheduling
  - Communicating with collaterals

Provide Information to Other Healthcare Providers

- HIPAA permits sharing information for coordination of care
- Nationally consent not necessary

Exceptions:

- HIV
- Substance abuse treatment – not abuse itself
- Stricter local laws

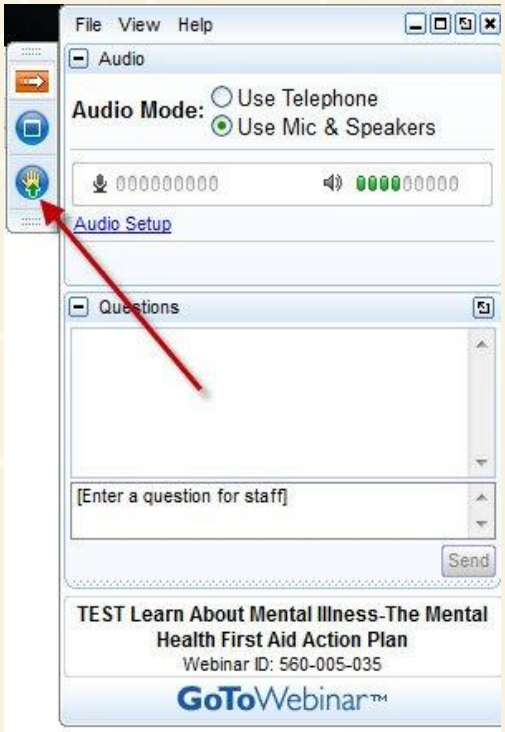
Use of Health Information Technology to Link Services

- Medicaid requires hospitals to notify MHN within 24 hours of a new admission of any Medicaid enrollee and provide information about diagnosis, condition and treatment for authorization of an inpatient stay using a web based tool.
- A daily data transfer listing all new hospital admissions discharges is transferred to the HH data analytic staff
- New admits are matched to the list of all persons assigned and/or enrolled in a healthcare home.
- An Automated email notifies the healthcare home provider of the admission.

Support Patient Wellness through Self Management using Peer Specialists and Case Managers

- Re-trained CSWs to be Wellness Coaches consistent with recovery principles, including supports for smoking cessation, good nutrition, physical activity and healthy weight.
- Educate patient on implications of psychotropic drugs
- Teach/support wellness self-management skills
- Teach/support decision making skills using Direct Inform
- Use motivational interviewing techniques
- New psychosocial rehab focus
  - Smoking cessation
  - Enhancing Activity
  - Obesity Reduction/Prevention

How to ask a question during the webinar



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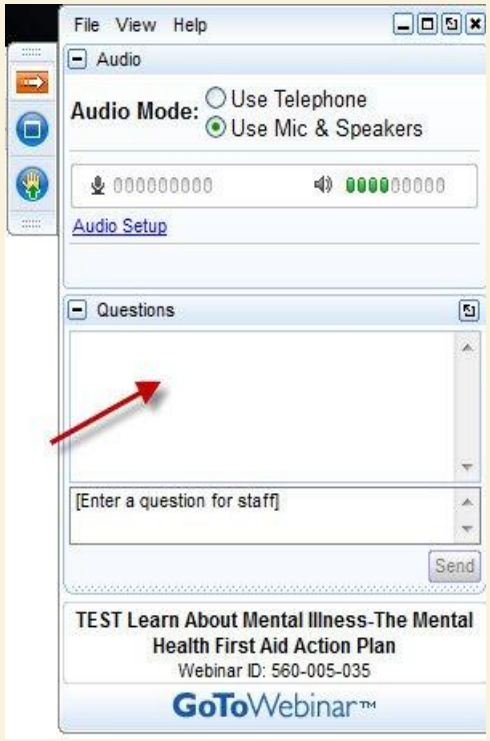

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What did we learn from our first year of implementation?

North Central Missouri Mental Health Center

Agency Leadership Buy-In

- Implementation was led by DMH & Coalition
  - Helped standardize implementation
  - Paving the Way
  - Accreditation (CARF)
- Assist other programs to include HCH
- Time for in-house trainings
  - Assist other programs to include HCH

Agency Leadership Buy-In

- Setting up the right team
  - HCH Director
    - Experience in Primary & Behavioral health
  - HCH NCM
    - Promote from within
  - Primary Care Consultant
  - Care Coordinator
  - Having a QMHP available for cold calls/assmts.
- Equipment
  - LDX machine, B/P cuffs

Organizational Changes

- Policies and Procedures
- Job descriptions
- Additional trainings
  - Standardize duties across staff
  - Discuss success stories
  - Community trainings
  - Identify transformational change

Training

- Medical training for CSS
  - NCM highlight what the CSS needs to target
  - CSS needs to bill to staff clients with NCM
  - NCM make health care meaningful to CSS
    - CSS recognition of how health care helps each client
    - Medication and side effects
    - Preventative care

Treatment Team Meetings

- NCM is a must
- Provide medical perspective
- NCM brings primary consultation opinion
- Solidify primary & behavioral health interventions

EMR

- Electronic Medical Records
  - Allows communication among treatment team
  - All treatment team members add information
  - Progress notes
    - Psychiatric Nurse (vitals)
    - NCM (Cyber Access)
    - CSS (Direct care)
    - QMHP (Treatment Planning)
    - Primary consult (Medication interactions)

Common Challenges

- Write a good treatment plan
  - Core Competency QA
    - Treatment Plans
    - Health Screenings
    - Metabolic Screenings
    - Progress notes
- Buy-in
  - Taking blood pressures
  - Training clients to care for their health care
- More work than staff

Outcomes

- Pro Act
  - Flags
  - Medication adherence
- Core Competencies
  - Global and individual targets
- Technology
  - Stay on top of what is needed to complete work

Surprises

- Health education for clients, transfers
  - Good results for clients
  - Good results for family
  - Good results for staff

Success Stories

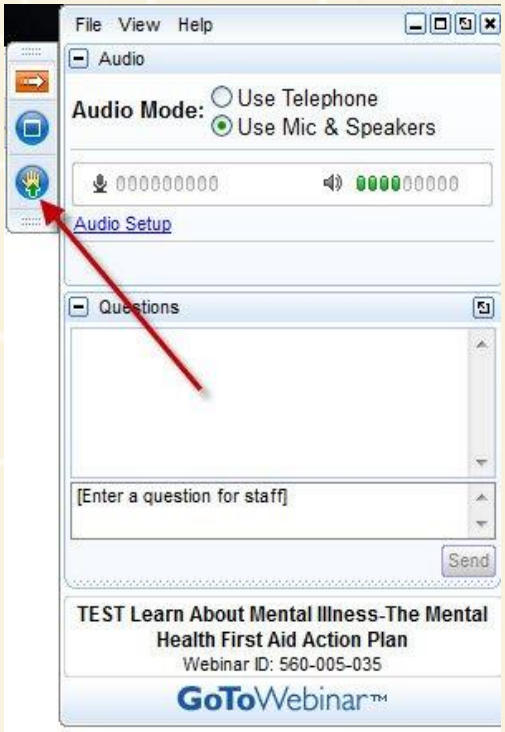
- Billie lost 19 pounds and reduced her BMI from 55.6 to 51.34 in 12 months and in the last 3 weeks has lost another 4 pounds.

- Susan was working on smoking cessation. During this time she had a stroke. With the help of her nurse care manager and CSS she was able to go to a nursing home with her handicapped daughter, whom she cares for, to recover. The nurse care manager and CSS then helped her and her daughter transition back to her home. Through all this Susan achieved her goal and quit smoking.

Tips

- Have the correct staff on the team
- Total buy-in
  - Leadership
  - Middle management
  - Front line staff
  - Support staff

How to ask a question during the webinar



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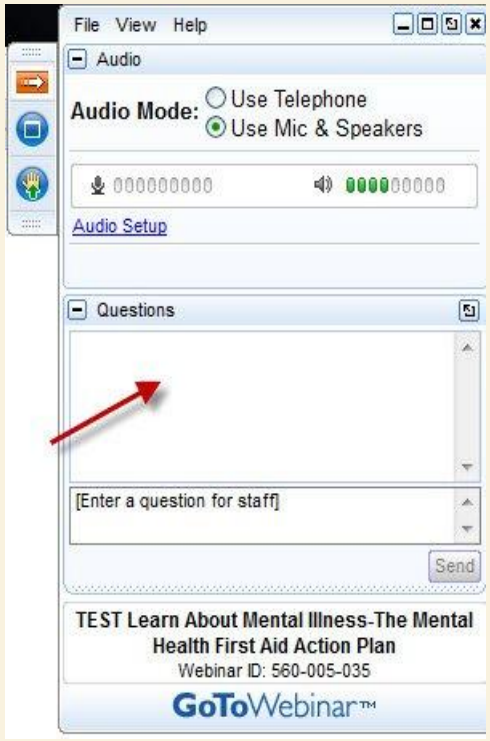
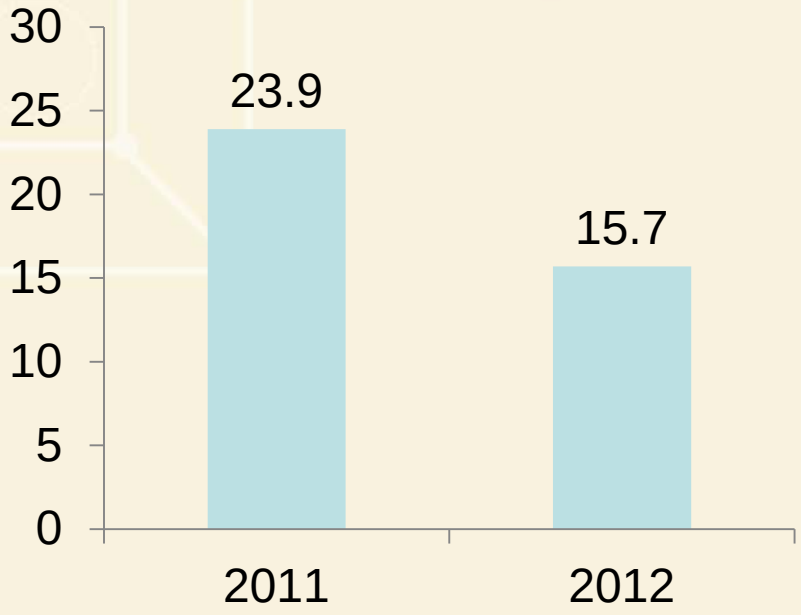


Outcomes

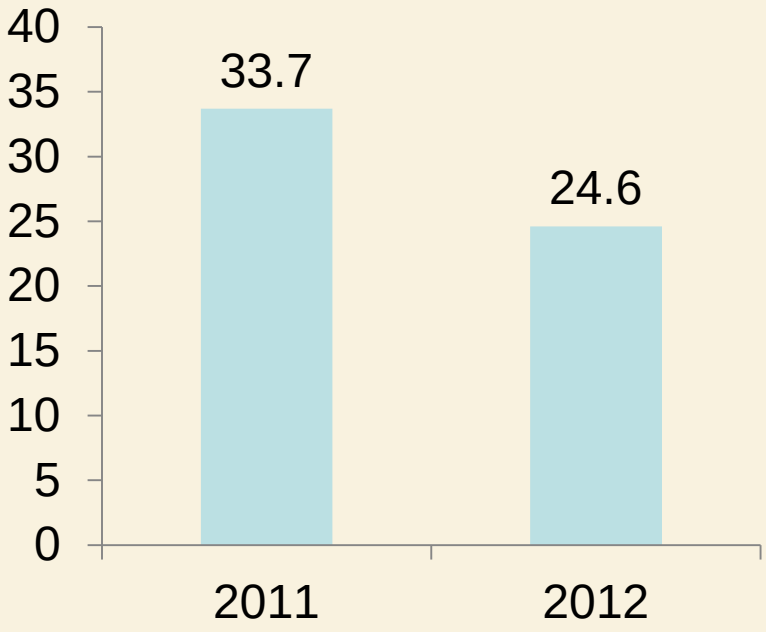
- Cost
- Quality of Care
  - Medication adherence
  - HEDIS indicators
- Clinical Outcomes
  - Avoidable hospital readmissions
- Experience of care
  - MHSIP

Outcomes
Reducing Hospitalization

Primary Care Health Homes

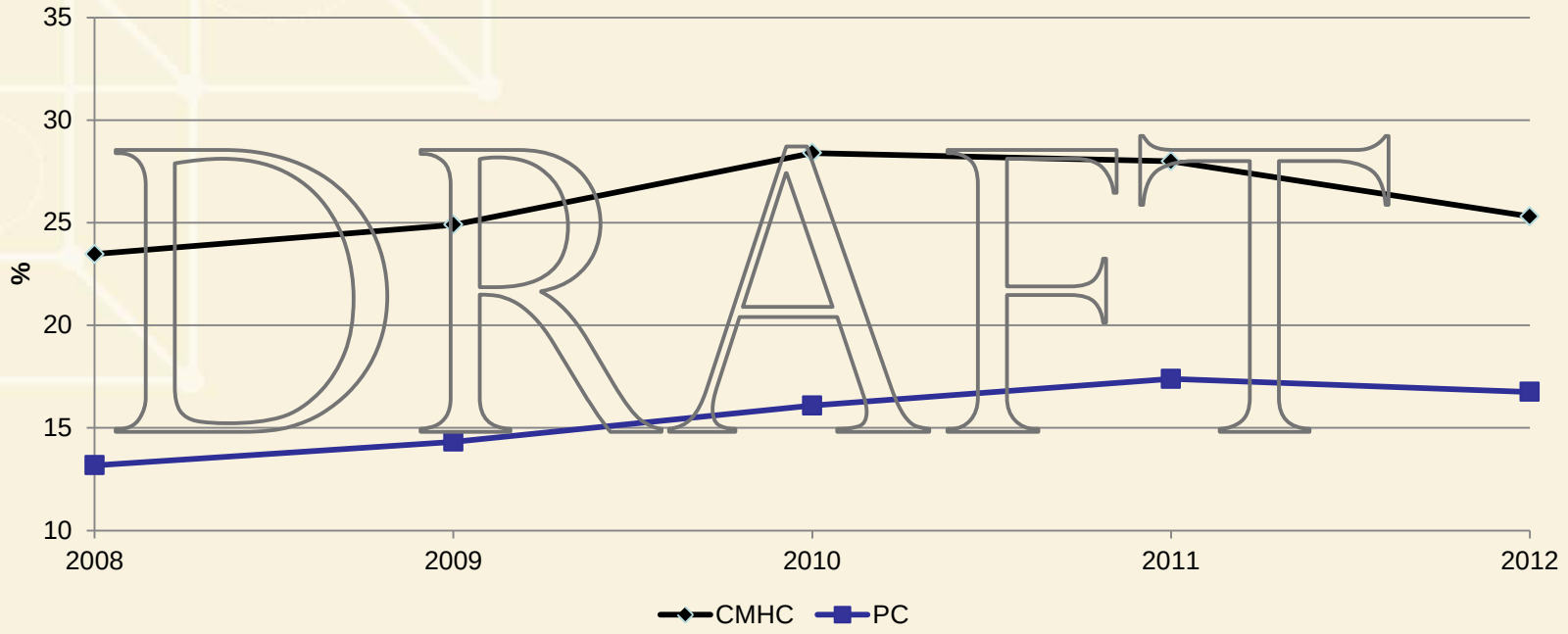


CMHC Healthcare Homes



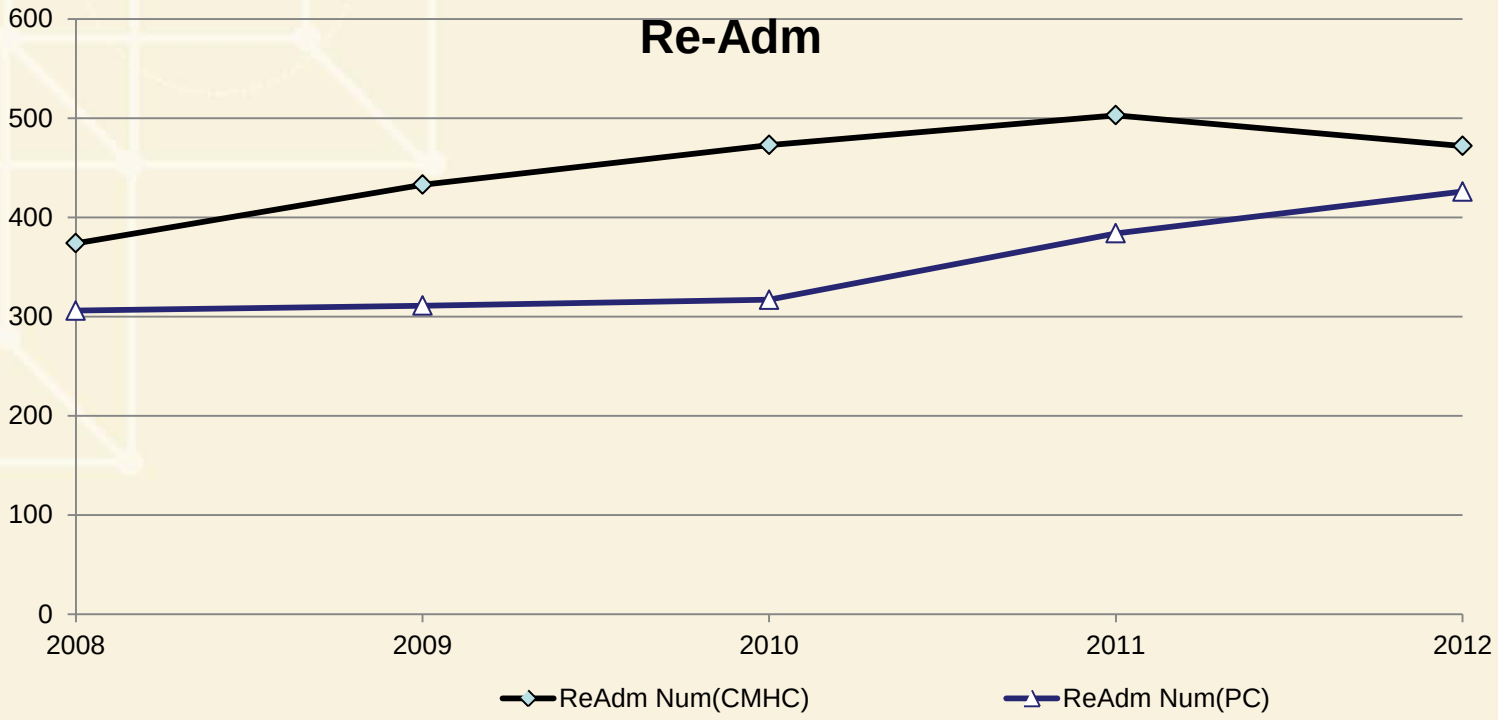
Preliminary Health Home Outcomes Reduction in Hospitalization

Percentage of patients with at least 1 hospitalization (CMHC)



Individuals enrolled in health home at least 2 months

All Cause Re-Admission Rate per 1,000 Patients with at least 1 Hospitalization



Preliminary Health Home Outcomes

Cost Savings

- ER and Hospital
  - Reduction in admissions per 1000: 12.8%
  - Reduction in ER usage per 1000: 8.2%
  - Difference = $127.55 PMPM
  - Cost = $78.74 PMPM
  - **Net Savings: $48.81 PMPM**

Preliminary Health Home Outcomes

Cost Savings

- Total Medicaid Savings
  - Pre-HCH Average Cost: $28,280
  - Post- HCH Average Cost: $26,316
  - Difference = $162 PMPM
  - Cost = $78.74
  - **Net Savings $83.26 PMPM**

Collaborative Progress: Mental Health

	St. Louis Central	Columbia	St. Louis South	Kansas City
HbA1c	+	+	+	+
PCP BP	+	+	+	+
PCP LDL	+	+	+	+
Tobacco Cessation	+	+	U	U
Pediatric Asthma	U	U	U	U
Adults Asthma	U	U	U	U
Pediatric BMI	-	U	U	U
Adult BMI	U	U	U	U

Lessons learned

- Start filling out the CMS template with draft languages early as possible – it will firm up your thinking quicker
- Request frequent informal phone discussions with CMS to get early feedback
- Insist on talking to the financial people that CMS early in your drafting process

Lessons learned

- Start looking at your data before you decide on your program structure and characteristics
- Do not underestimate the amount of administrative staff time required – a whole lot!
- Do not attempt to have existing staff do this in addition to their regular duties. This is a full-time effort for at least two staff
- Use senior staff who have good relations with both the state and the providers and are knowledgeable about your system

Establishing Standard Health Indicators

- ***What gets measured gets done***

Principles

- Use the Data you have before collecting more
- Show as much data as you can to as many partners as you can as often as you can
    - Sunshine improves data quality
    - They may use it to make better decisions
    - It's better to debate data than speculative anecdotes
- When showing data ask partners what they think it means
- Treat all criticisms that results are inaccurate or mis-leading as testable hypotheses

Data You Need to Manage the Project

- Eligibility/Enrollment Registry
- Payment System
- Health Home Work Process Tracking
  - Data reporting
  - Use of HIT Care management tools
  - Staffing as required and turnover
  - Attending training and Conference calls
- Health Home Aggregate Outcomes
- Individual Patient Look-Up/Drill down

Data Uses

- Aggregate Reporting – performance benchmarking
- Individual drill down – care coordination
- Disease Registry – care management
  - Identify Care Gaps
  - Generate to-do lists for action
- Enrollment Registry – deploying data and payments
- Understanding – planning and operations
- Telling your story – presentation like this

Most Important Principle

- Perfect is the Enemy of Good
- Use an Incremental Strategy
- If you try figure out a comprehensive plan first you will never get started
- Apologizing for a failed prompt attempt is better than is better than apologizing for missed opportunity

Lessons Learned

- Do not underestimate the amount of technical assistance and training required by the providers
- Monthly phone conferences for health home administrators and care managers
- Quarterly face-to-face learning collaborative meetings
- Weekly calls with practice coaches for individual sites

Most Important Principle

- Perfect is the Enemy of Good
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Welcome to the MISSOURI DEPARTMENT OF MENTAL HEALTH

MoHealthNet

MPCA Missouri Primary Care Association
www.mo-pca.org

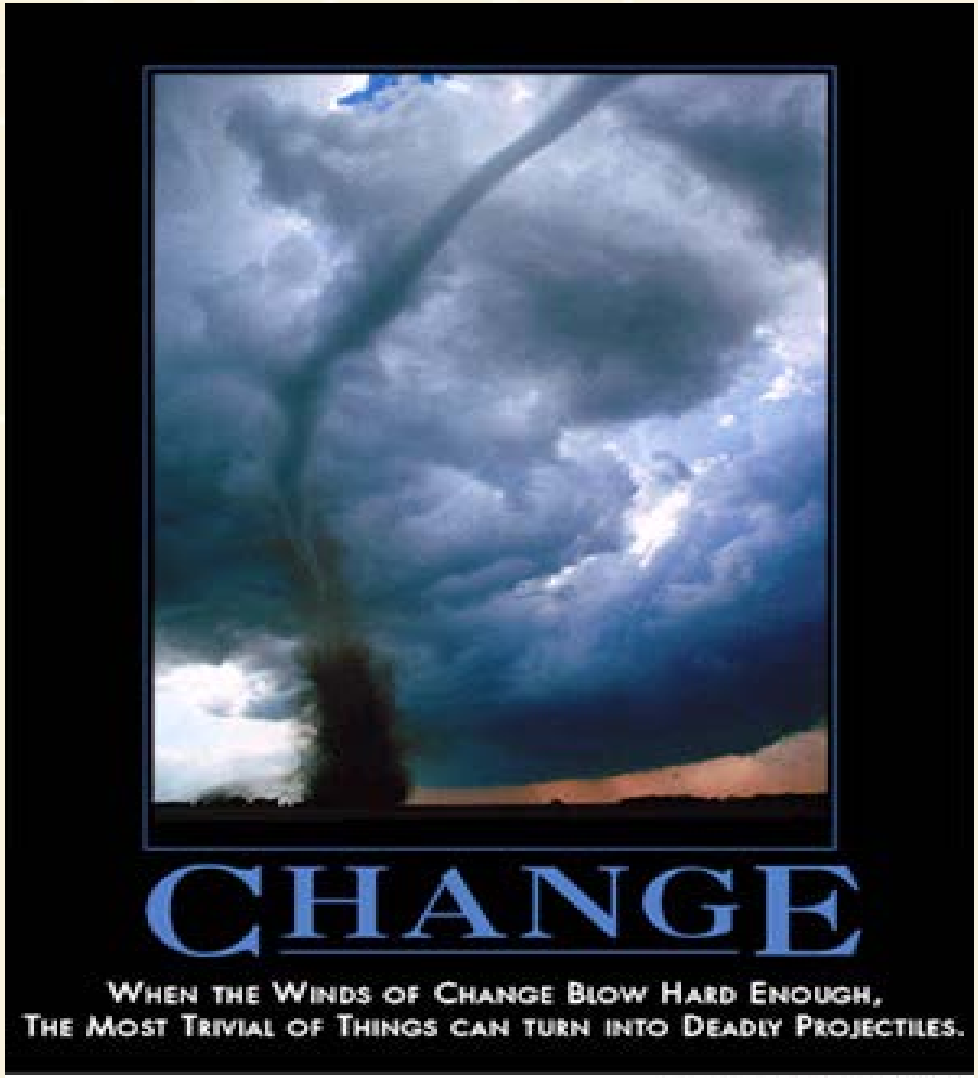
MISSOURI COALITION OF COMMUNITY MENTAL HEALTH CENTERS

ACS
A xerox Company

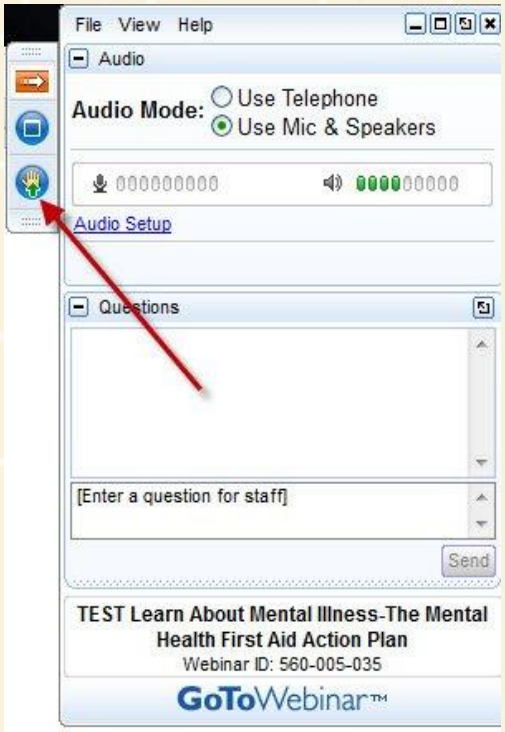
CMT
Care Management Technologies

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

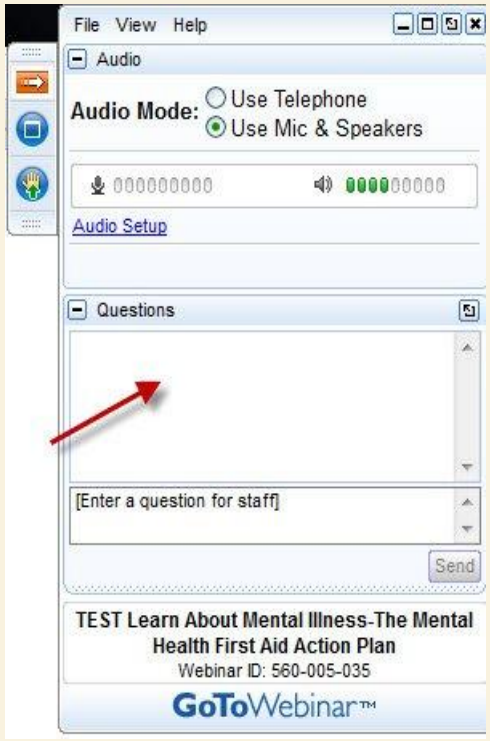

CHANGE
When the Winds of Change Blow Hard Enough,
The Most Trivial of Things can turn into Deadly Projectiles.
www.despair.com

How to ask a question during the webinar



If you dialed in to this webinar on your phone please use the "raise your hand" button and we will open up your lines for you to ask your question to the group. **(left)**

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**



Resources

- **Map of Health Home activity**: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html
- **The Core Clinical Features of Behavioral Health Homes for People with Mental Health & Substance Use Conditions** http://www.integration.samhsa.gov/integrated-care-models/person-centered-healthcare-homes
- **Health Home Information Resource Center** http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html
- **The Collaborative Care Model: An Approach to Integrating Physical and Mental Health Care in Medicaid Health Homes** ttp://www.chcs.org/publications3960/publications_show.htm?doc_id=1261528
- **Missouri Health Home materials** http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm
- **National Association of State Mental Health Program Directors** http://www.nasmhpd.org/Policy/service_integration.aspx

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Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today's webinar.