MISSOURI COALITION FOR COMMUNITY BEHAVIORAL HEALTHCARE

MISSOURI'S BEHAVIORAL HEALTH HOMES

Natalie Cook, MS

Integrated Care Manager

AGENDA

- Planning
- Services
- Reimbursement
- HCH Team
- Implementation
- Accreditation
- Outcome Measures

NATURAL PARTNERSHIPS

- **Missouri Department of Mental Health** (DMH)
  Division of Behavioral Health
- **Missouri Department of Social Services** (DSS)
  MO HealthNet (Medicaid) Division
- **Missouri Coalition for Community Behavioral Healthcare**
  Represents the Behavioral Health Provider System
- **Missouri Primary Care Association** (MPCA)
- **Missouri Hospital Association** (MHA)
- **Missouri Institute for Mental Health** (MIMH)
- **Missouri Health Foundations**

Culture of Collaboration

LOTS OF MEETINGS!

- Health Home Steering Team
  - MO Budget Director, Medicaid Director, DMH, Coalition, and MPCA
- CMHC Healthcare Home Operations Team
  - Medicaid, DMH, Children's Division, Coalition, MIMH
- CMHC/PC Joint Operations Team
  - Medicaid, DMH, Children's Division, Coalition, MPCA, MIMH
- CMHC Implementation Team
  - Weeds: Operations, Data, Training, Evaluation, etc.
  - DMH, Coalition, Practice Coaches, MIMH
- CMHC Healthcare Home Steering Committee
  - Medicaid, DMH, Coalition, Providers
- Practice Coaches
  - Assigned to HCHs for technical assistance

Missouri Evolution of Integrated Care & Data

2008

25-Year Mortality Study, CATIE Trial

Nurse Care Managers

+ Medicaid claims data (diagnosis, procedures, pharmacy)

2010

Chronic Disease Prevalence Studies, Lewin Group Medicaid Review

Metabolic Screening & High Cost / Risk Outreach

+ Vitals, Labs, Health Risk Factors (Metabolic Screening)

2012

Section 2703, Affordable Care Act

Behavioral Healthcare Homes

+ Hospitalizations
+ ER Visits

2017

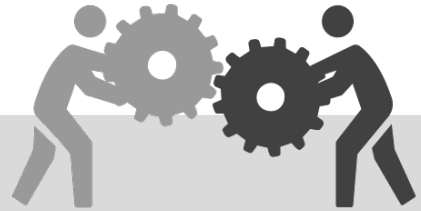
Excellence in Mental Health Act

Certified Community Behavioral Health Clinics

+ Medicaid Eligibility
+ Hospital Follow Up
+ Health Risk Profile

Statewide Care Management & Population Health Tool

INTEGRATED CARE IN MISSOURI



2008

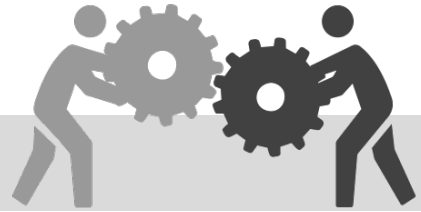
DMH Net Nurse Liaisons

- DMH + MO HealthNet = DMH Net
- Primary care nurses hired at each CMHC (17.5 FTE)
- Introduction of health information outside of CMHC
  - Medicaid claims via CyberAccess
  - Medication Possession Ratio (MPR) reports
  - Behavioral Pharmacy Management (BPM)

DMH Net

Disease Management Initiative

INTEGRATED CARE IN MISSOURI



2010

Disease Management (DM) 3700 Outreach

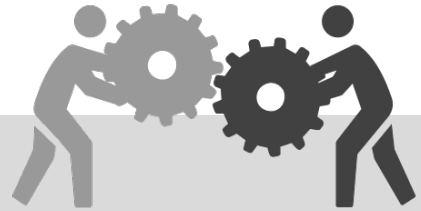
- Targets high cost Medicaid enrollees who have a behavioral health condition and are not engaged in treatment.
  - DM3700 began in 2010 | Goal > outreach and enroll 3700 individuals with MI
  - ADA DM began in 2014 | Goal > outreach and enroll individuals with SUD
- Report outreach status updates
- Metabolic syndrome screening required

Initial Outreach Cohort Needs:

90% physical health 75% dental health 75% vision 56% emergency care

INTEGRATED CARE IN MISSOURI

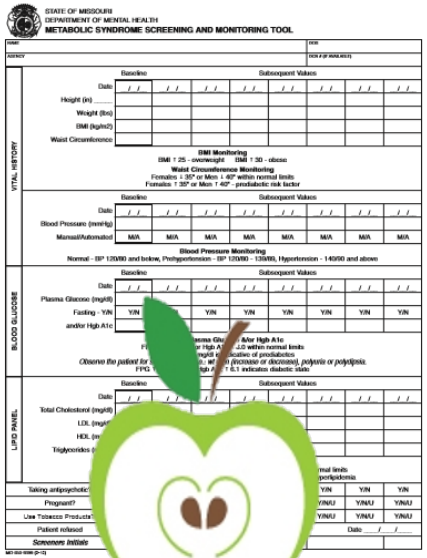
2010



Metabolic Syndrome Screening (MBS)

- Annual screening for youth and adults prescribed an antipsychotic medication
- Monitor vitals, labs, and lipid panel

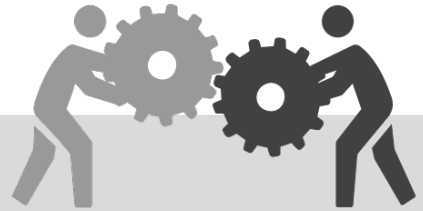
  height • weight • BMI • waist circumference • BMI • A1c • blood glucose • LDL • HDL • triglycerides • cholesterol • pregnancy • tobacco use • antipsychotic medication
- Purchase of Cholestech LDX analyzer
- Report screening results to state system


STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
METABOLIC SYNDROME SCREENING AND MONITORING TOOL

Missouri Department of Mental Health
https://dmh.mo.gov/mentalillness/provider/documents/msshchmemo.pdf

INTEGRATED CARE IN MISSOURI

2012



Behavioral Healthcare Homes (HCH)

- 1st Health Home State Plan Amendment approved in the nation!
- January 2012 | 25k currently enrolled
- Per member per month payment (PMPM) supports added multi-disciplinary team
- Report hospital discharge follow-up and med reconciliation
- Use of MBS data and Medicaid claims data
  - Disease prevalence
  - Outcomes improvement tracking and measures (HEDIS/CMS/MO)
  - Cost savings

Missouri Department of Mental Health
https://dmh.mo.gov/mentalillness/provider/healthcarehome.html

WHAT IS A HEALTH HOME?

Affordable Care Act Section 2703 defines a ***"health home"*** as a designated provider selected by an eligible individual to provide the following services:

1. Comprehensive Care Management
2. Care Coordination and Health Promotion
3. Comprehensive Transitional Care
4. Patient and Family Support
5. Referral to Community and Social Support Services
6. 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:

1. Lower rates of emergency room use
2. Reduce in-hospital admissions and readmissions
3. Reduce healthcare costs
4. Decrease reliance on long-term care facilities
5. Improve experience of care, quality of life and consumer satisfaction
6. Improve health outcomes

REIMBURSEMENT: PER MEMBER PER MONTH

PMPM: $83.56 (Year 1 = $78.74)

- Health Home Director (1:500)
- Primary Care Physician Consultant (1 hr/enrollee/year)
- Nurse Care Manager (1:250)
- Care Coordinator/Clerical Support (1:500)
- Data monitoring and reporting
- Training

THE HEALTHCARE HOME TEAM

- **Primary Care Consulting Physician**
- **Health Care Home Director**
- **Nurse Care Managers**
- **Care Coordinator/Clerical Support**
- Community Support Specialists
- Psychiatrist
- QMHP, PSR, and other Clinical Staff
- Peer Specialist
- Family Support Specialist

ACCREDITATION

- CARF (Commission on Accreditation of Rehabilitation Facilities) met with Missouri HCH leaders in October 2011 to help draft behavioral health home standards.
- Standards were published in July 2012 and training for Missouri occurred in November 2012.
- Practice Coaches attended the training, met with their agencies, and began work towards CARF accreditation.
- The Joint Commission released Behavioral Health Home standards January 2014.
- Missouri participated on the CARF review team to update health home standards in 2015.
- All MO CMHC Healthcare Homes are accredited by CARF or TJC.

IMPLEMENTATION

State Plan Amendment approved 10/20/11

- Effective 1/1/12

28 CMHC Healthcare Homes (now 26 due to mergers)

17,882 individuals auto-enrolled

- CMHC consumers with at least $10,000 Medicaid costs

24,000+ individuals currently enrolled

- 2014- 5,000 additional slots approved for CMHC Healthcare Homes

TRAINING ROLL OUT

1. Access to Care Redesign
2. Organization – Everyone!
   - *Paving the Way for Healthcare Homes*
3. CMHC Leadership HCH 101
4. Healthcare Home Team 101
5. Physician Institute

HCH 101 TRAINING AGENDA

- What is a CMHC Healthcare Home?
- Progress Updates
- HCH Team Responsibilities
- Enrollment Process
- Reporting Requirements
- Performance Measures
- Program Reviews
- Communication
- Training

TRAINING AND DEVELOPMENT

Health Information Technology Tools

Initiatives

- Metabolic Syndrome Screening (January 2010)
- Disease Management 3700 Initiative (November 2010)

Managing Chronic Disease and SMI

- Diabetes
- Cardiovascular Disease and Hypertension
- COPD and Asthma

Role of the Community Support Specialist

Motivational Interviewing

Wellness Coaching

SPECIALIZED CURRICULUMS

U.S. Diabetes Conversation Map Training (Merck/Healthyi)

Health Education Answers (Lilly)

Diabetes Case Manager Workshop Series (Lilly)

Freedom from Smoking (ALA)

Team Solutions and Solutions for Wellness (Lilly)

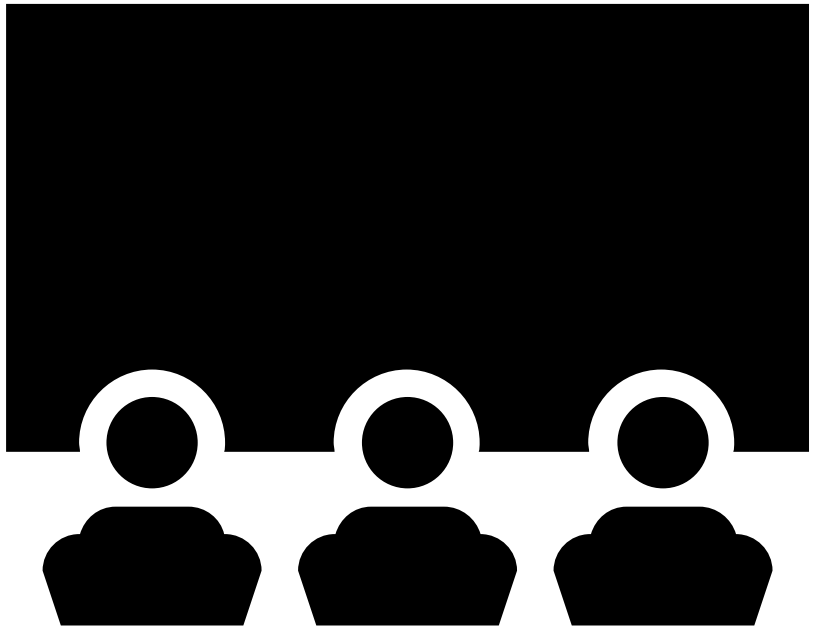
Becoming and Asthma Educator Care Manager (AAE)

My Way to Health (Washington University, St. Louis)

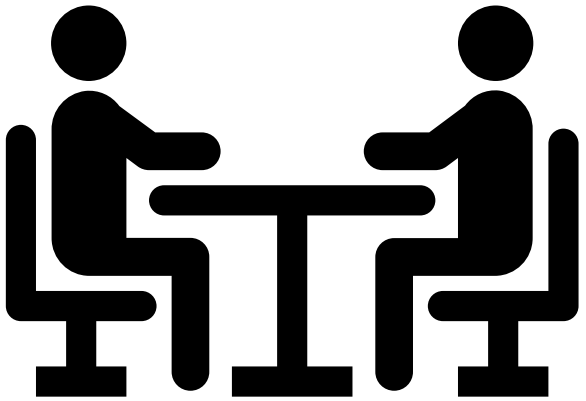
Case to Care Management (National Council)

Tobacco Training Specialist (Mayo Clinic)

Wellness Coaching (Collaborative Support Programs of New Jersey)



PRACTICE COACHES

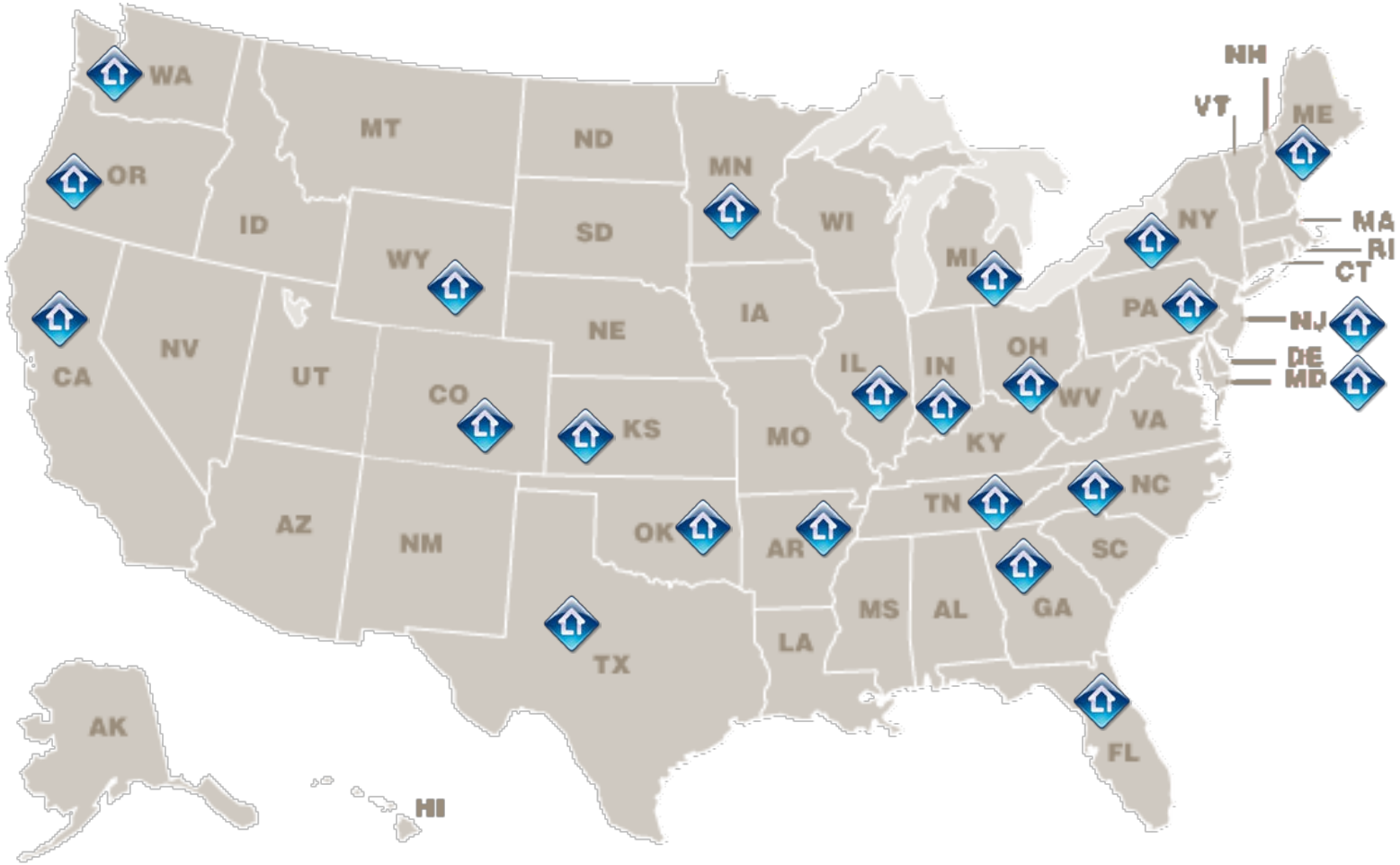


Initially four coaches funded by the Missouri Foundation for Health to assist health homes acquiring CARF accreditation.

Currently coaches:

- Regular teleconferences and site visits as needed
- Identify/develop/share best practices
- Continuing to promote integration and population management
- Coordinate regional meetings as needed
- Technical assistance to address emerging issues
- Assist the HCH Implementation Team in policy development based on knowledge regarding site implementation

= states Missouri has consulted with on health homes and the Missouri model of integrated care



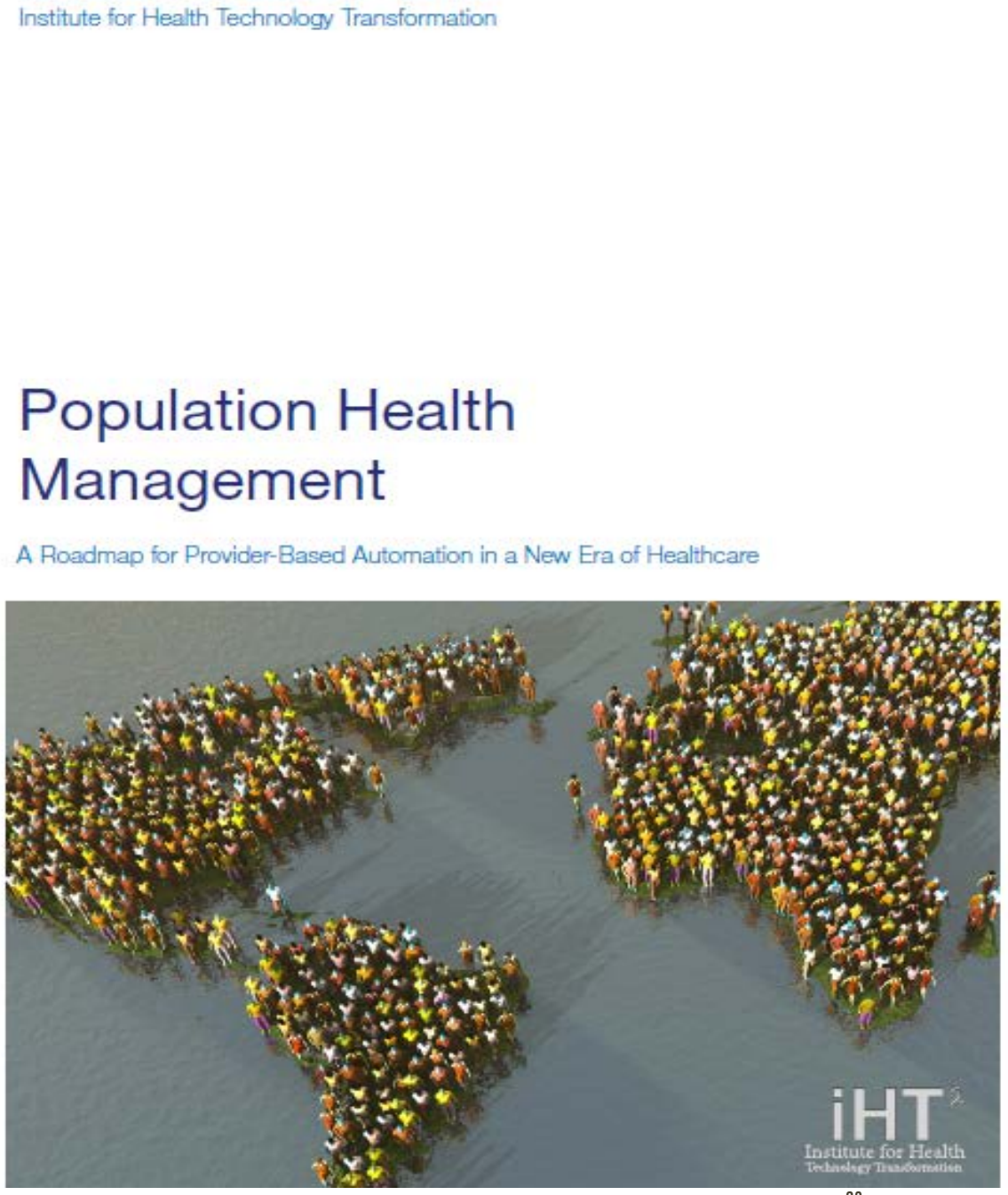
the
Missouri Model
of integrated care

POPULATION HEALTH MANAGEMENT

A Roadmap for Provider-Based Automation in a New Era of Healthcare

Institute for Health Technology Transformation (iHT^2)

Alide Chase, MS; Connie White Delaney, PhD, RN, FAAN, FACMI; Don Fetterolf, MD, MBA; Robert Fortini; Paul Grundy, MD, MPH; Richard Hodach, MD, PhD, MPH; Michael B. Matthews; Margaret O'Kane; Andy Steele, MD, MPH, MSC



[1] Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare, Institute for Health Technology Transformation, Chase, Alide, et.al.

Roadmap for Success

1. Planning for Population Health Management
2. Data Collection, Storage and Management
3. Population Monitoring and Stratification
4. Patient Engagement
5. Team-Based Interventions
6. Measuring Outcomes

START WHERE YOU ARE.
USE WHAT YOU HAVE.
DO WHAT YOU CAN.

ARTHUR ASHE

SHOW-ME OUTCOMES

Behavioral Healthcare Homes

HEALTH HOME MEASURES

9 Adult Measures

- Asthma Medication Adherence
- Blood Pressure Control for Diabetes
- Blood Pressure Control for Hypertension
- Body Mass Index Control
- HbA1c Control for Diabetes
- LDL Control from Cardiovascular Disease
- LDL Control for Diabetes
- Metabolic Screening Complete
- Tobacco Use Control

5 Youth Measures

- Asthma Medication Adherence
- Body Mass Index Control
- HbA1c Control for Diabetes
- Metabolic Screening Complete
- Tobacco Use Control

UNDER DEVELOPMENT

- Blood Pressure Control (for total pop.)
- Statin Therapy for CVD
- Pre-Diabetes
- Weight Loss
- Hospital Follow Up

Find a good PARTNER

NOT another VENDOR

- ✓ Go on dates to find your match
- ✓ Be honest and transparent about your needs and wants (past, present and future)
- ✓ Out of the box won't work
- ✓ CAUTION: Sweet Talk/Buzz Words
- ✓ Get engaged before getting married (take time to pilot)

Netsmart

CAREMANAGER

CareManager was selected as Missouri's new health technology tool for behavioral health providers to use in **care management** and **population health**.

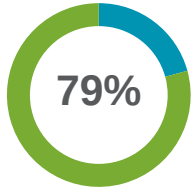
34 providers **800+** end users **250,000** lives managed

CareManager combines **Medicaid claims** data + DMH **client detail** + **hospital** and **ER notification** + **clinical** data from providers to:

- » **alert** the care team of ER and hospital events
- » **assess** populations for risk
- » **monitor** health outcomes
- » **manage** interventions to address gaps in care

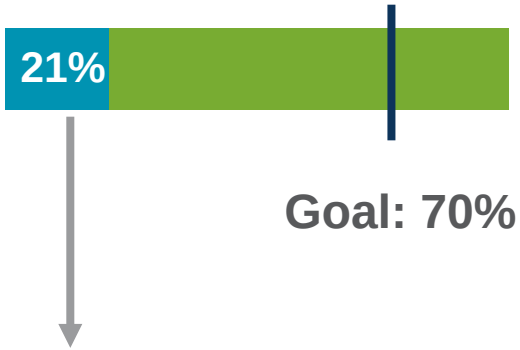
POPULATION HEALTH QUALITY MEASURES

Population View



Adult Body Mass Index (BMI)

904
1292



Drill down to the specific clients needing intervention

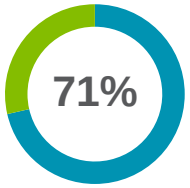
Individual Overview

- ✓ Asthma Medication Adherence (Adult)
- ✓ Blood Pressure Control for Diabetes (Adult)
- ✓ Blood Pressure Control for Hypertension (Adult)
- ● Body Mass Index Control (Adult)
- ● Hemoglobin HbA1c Control for Diabetes (Adult)
- ✓ LDL Control for Cardiovascular Disease (Adult)
- ✓ LDL Control for Diabetes (Adult)
- ● Metabolic Screening Complete (Adult)
- ✓ Tobacco Use Control (Adult)

Visually presenting the whole picture of an individual with metrics that matter

FOCUSING ON INTERVENTIONS

Hemoglobin HbA1c Control for Diabetes



215
301

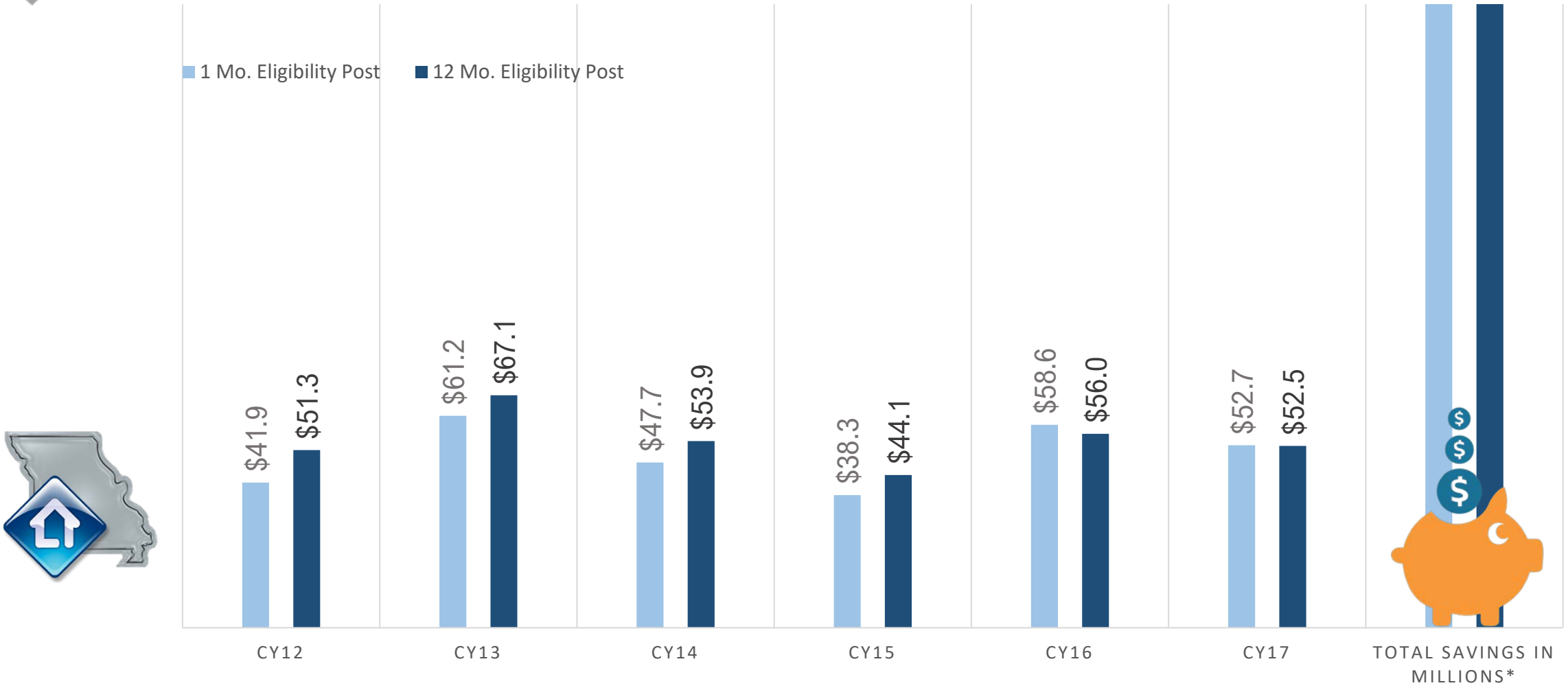
Goal: 60%

ID	Name	Gender	Age	Case Manager	A1c Result
234234	Arenciba, Victor	M	57	Gibson, Janet	8
101	Brown, Todd	M	64	Gibson, Janet	-
456	Walken, Tonya	F	19	Green, Sue	13
6576	Jones, Betty	F	65	Gibson, Janet	10

MISSOURI HEALTH HOME | COST SAVING$

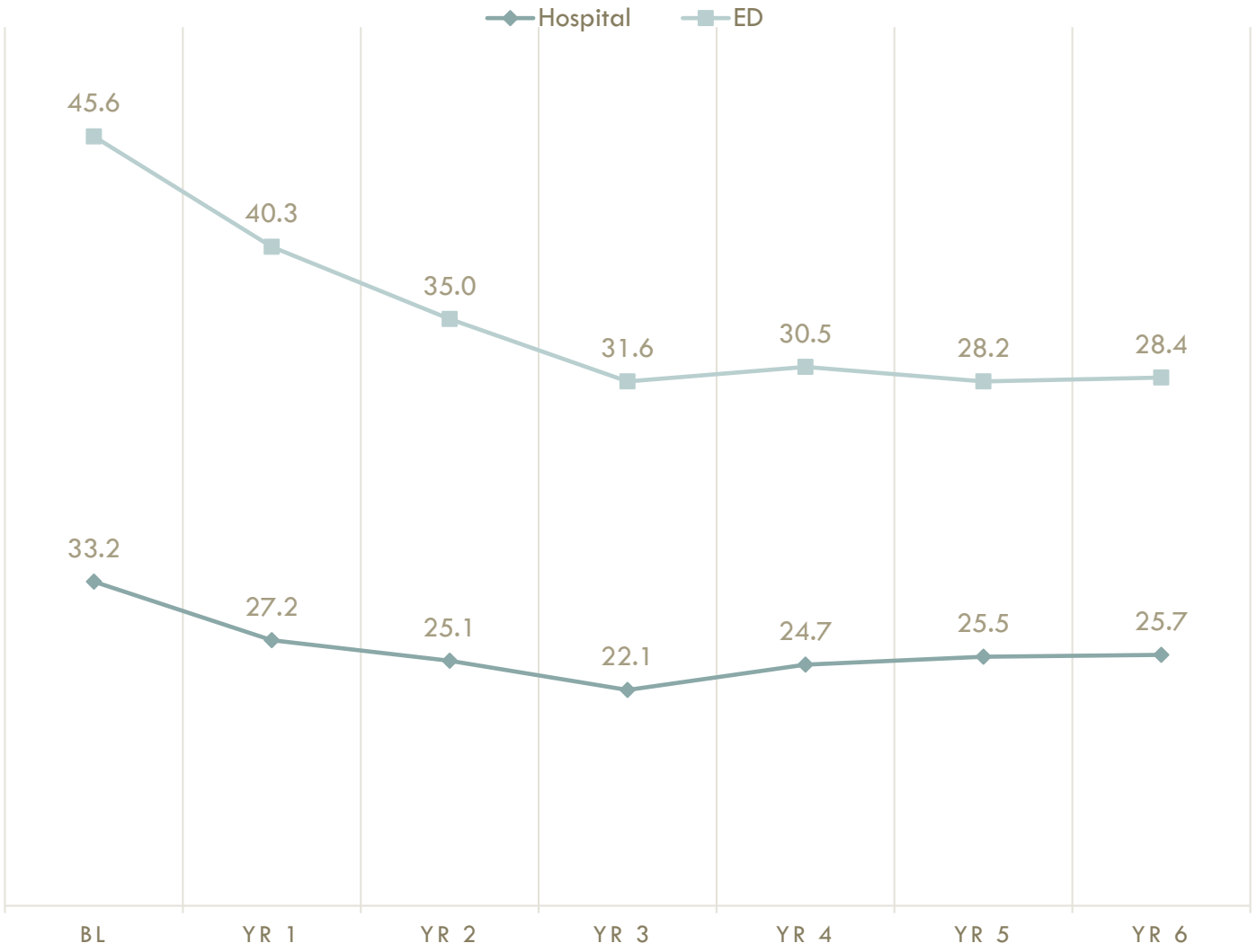
CMHC Healthcare Homes

$300.4M
$324.9M



*CY cost savings reported excludes individuals with costs greater than three (3) standard deviations from the average.

SHOW ME OUTCOMES

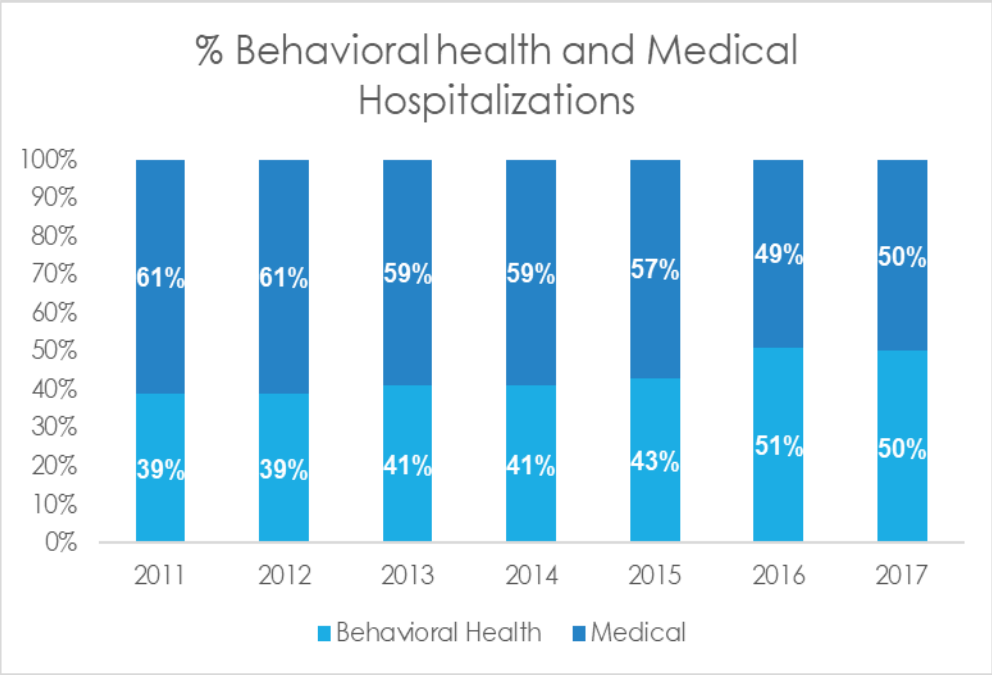


% of Clients with 1+ Hospitalization or ED visit

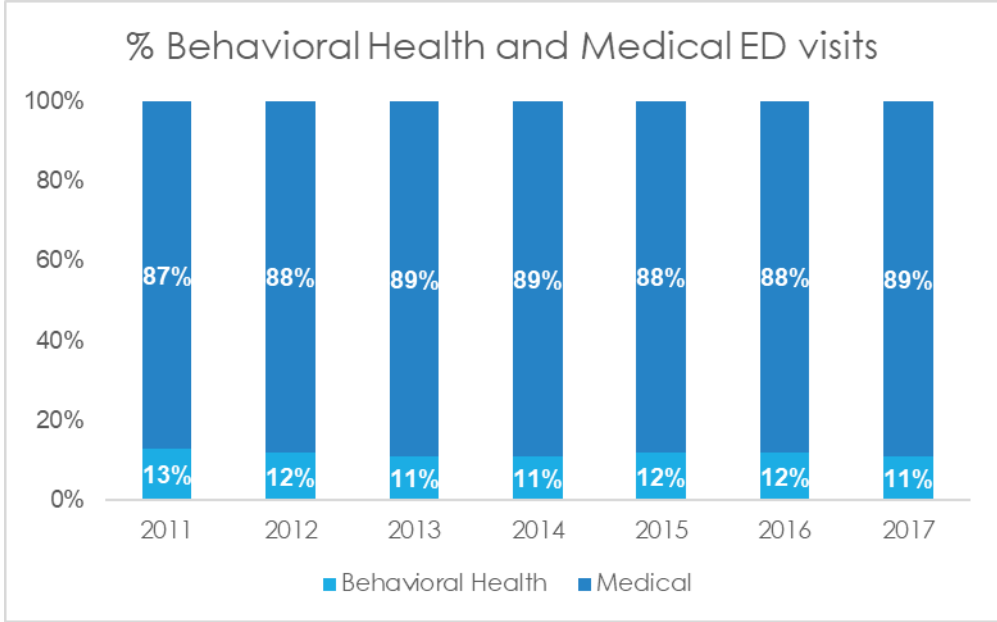
SHOW ME OUTCOMES

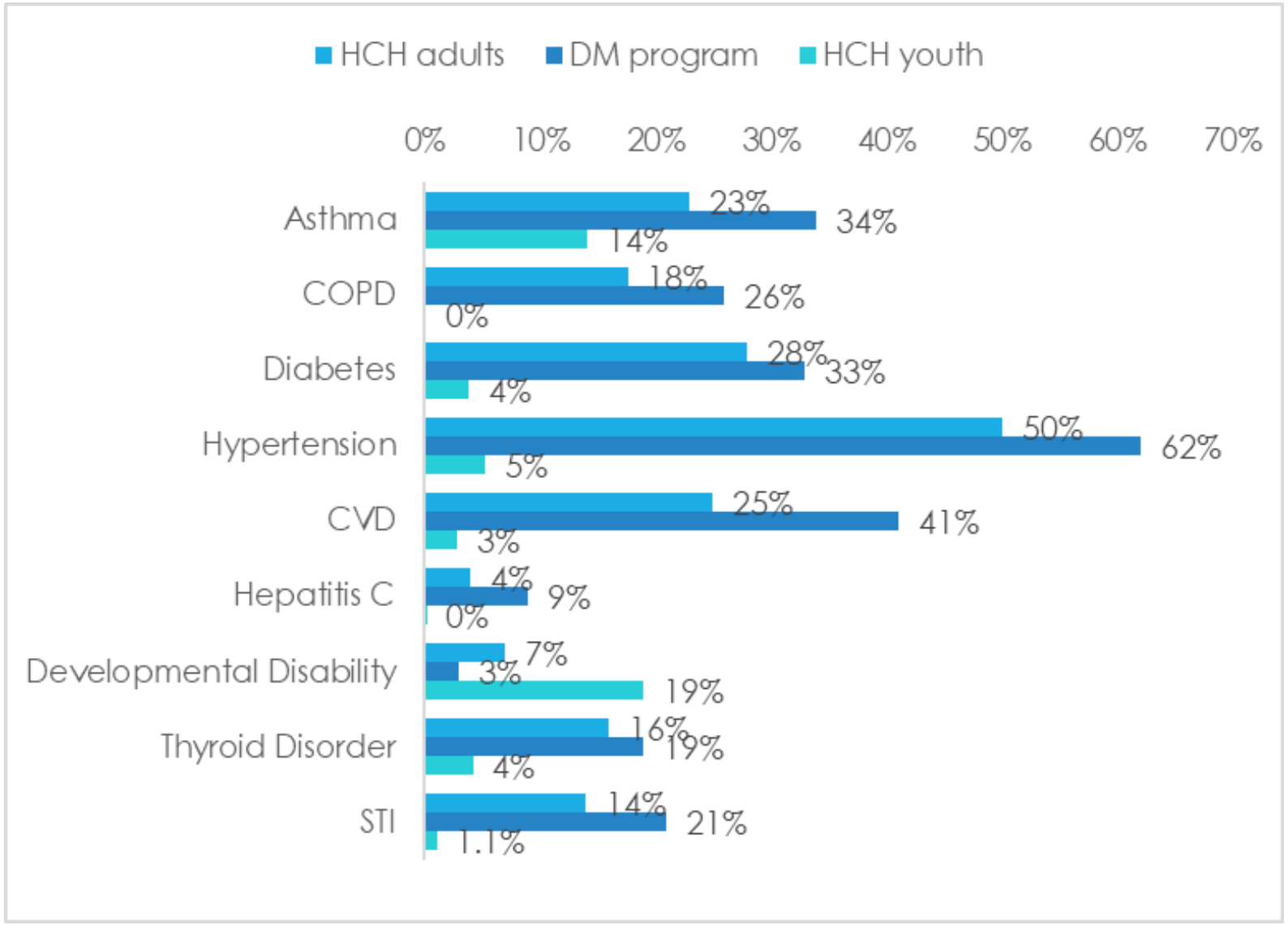
Hospital & ER Encounters

CMHC Health Home **Hospital** Encounters



CMHC Health Home **ER Visit** Encounters

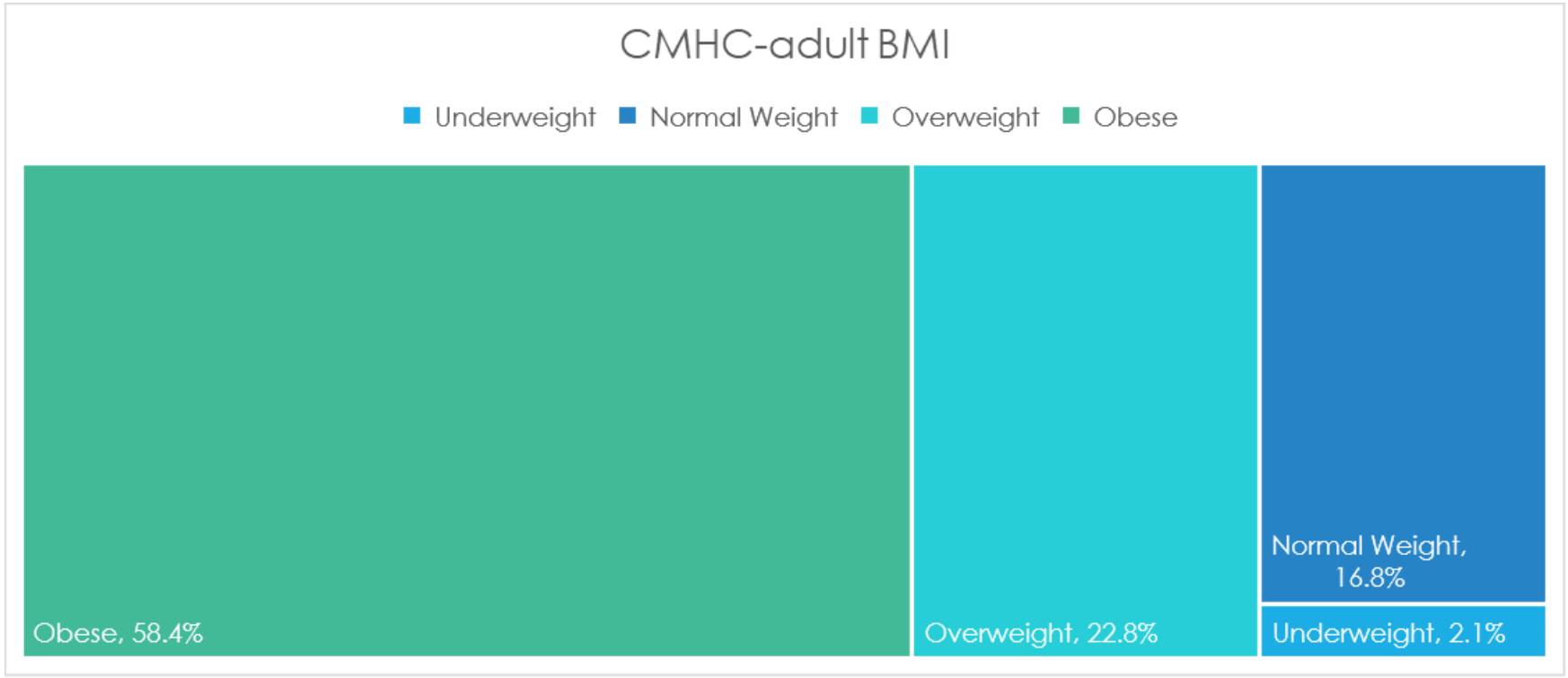




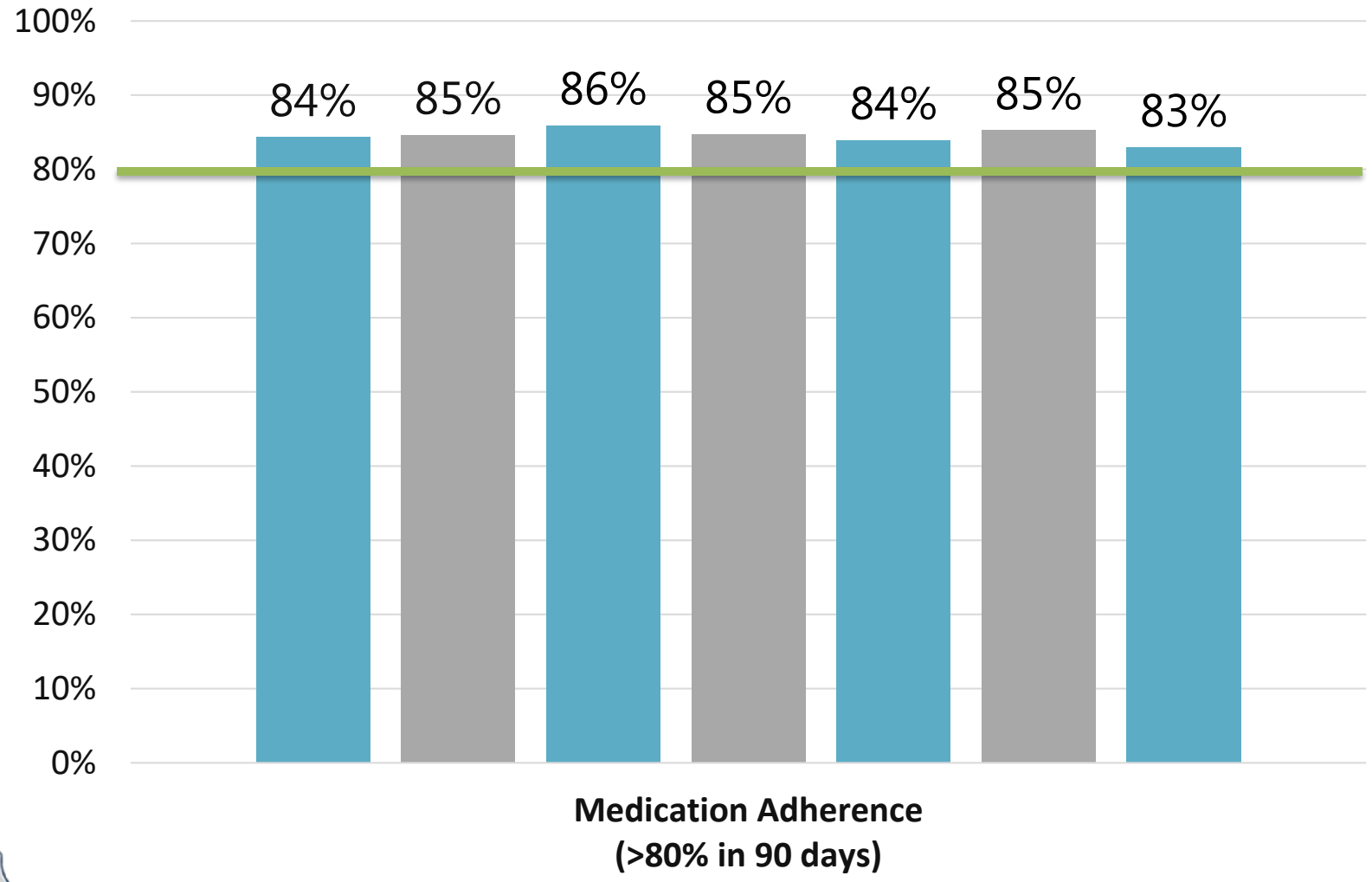
Chronic Health Conditions

SHOW ME OUTCOMES

BMI Measures



SHOW ME OUTCOMES



Medication Adherence

SHOW ME OUTCOMES

small changes make a BIG DIFFERENCE

Cholesterol ↓10%

10% ↓ in **cardiovascular disease**

Triglycerides ↓10 mm/L

5% ↓ in **cardiovascular disease**

Blood Pressure ↓6mm/Hg

16% ↓ in **cardiovascular disease**

42% ↓ in **stroke**

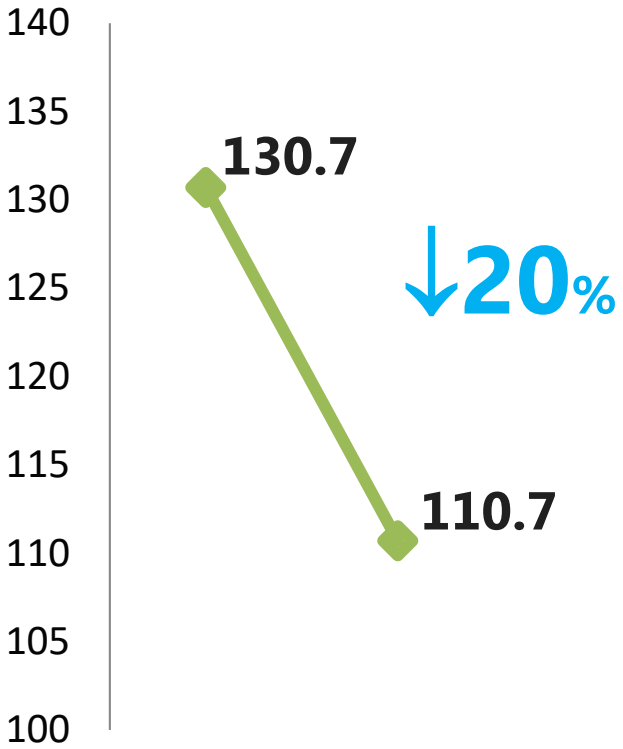
HbA1c ↓1 pt

21% ↓ in **diabetes related deaths**

14% ↓ in **heart attacks**

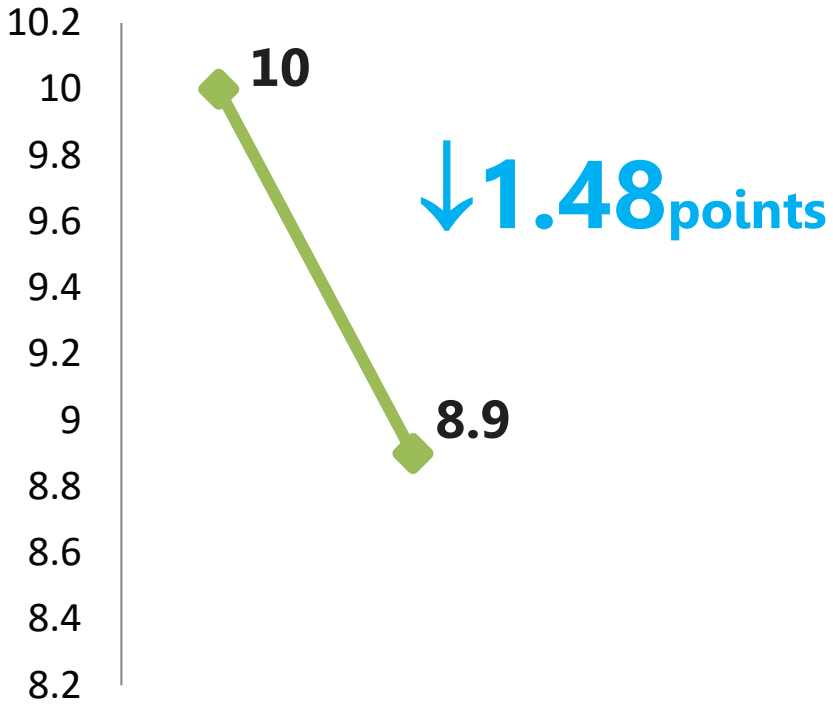
37% ↓ in **microvascular complications**

SHOW ME OUTCOMES



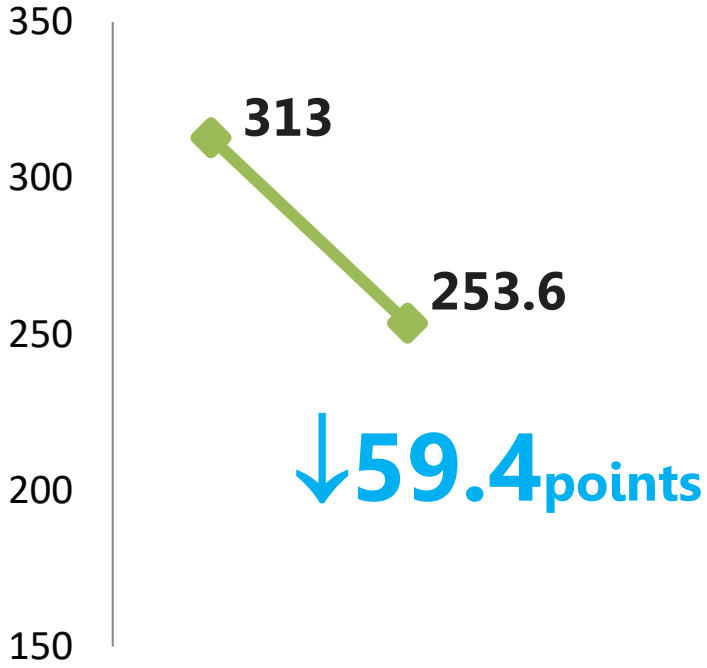
Improving uncontrolled **cholesterol**

small changes make a BIG DIFFERENCE



Improving uncontrolled **A1c**

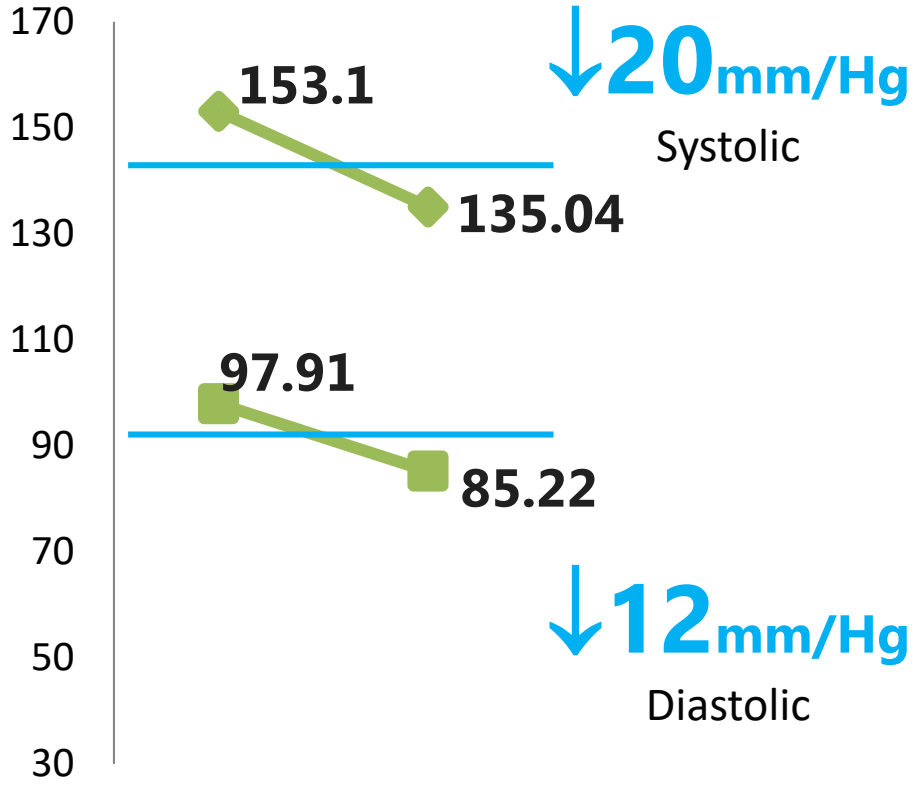
SHOW ME OUTCOMES



↓59.4points

Improving uncontrolled **triglycerides**

small changes make a BIG DIFFERENCE



↓20mm/Hg
Systolic

↓12mm/Hg
Diastolic

Improving uncontrolled **blood pressure**

MISSOURI COALITION FOR COMMUNITY BEHAVIORAL HEALTHCARE

thank you!

MISSOURI'S BEHAVIORAL HEALTH HOMES

Natalie Cook, MS

Integrated Care Manager

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