Missouri Experience: Section 2703 Health Home Initiative

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Presented by Joe Pierle and Angela Herman-Nestor
Missouri Primary Care Association
Section 2703

- What is a Primary Care Health/Medical Home?
- Overview of Missouri Primary Care Health Home Initiative and Goals
- Overview of Section 2703 of the Affordable Care Act
- Current and Planned Qualifying Conditions
- Health Home Team Members
- Data Management and Analytics
- Importance of Leadership
- Performance Measures
- Results to date
What is a Health/Medical Home?

Health/Medical Homes Provide:

• comprehensive and coordinated care in the context of individual, cultural, and community needs
• Medical, behavioral, and related social service needs and supports are coordinated and provided by provider and/or arranged
• emphasize education, activation, and empowerment through interpersonal interactions and system-level protocols
• at the center of the health/medical home are the patients and their relationship with their primary care team
Goals of the Primary Care Health Home Initiative

• Reduce inpatient hospitalization, readmissions and inappropriate emergency room visits
• Improve coordination and transitions of care
• Improve clinical indicators (e.g. A1C, LDL, blood pressure)
• Implement and evaluate the Health Home model as a way to achieve accessible, high quality primary health care and behavioral health care;
• Demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model; and
• Support primary care and behavioral care practice sites by increasing available resources and improving care coordination to result in improved quality of clinician work life and patient outcomes.
Section 2703 of the Affordable Care Act

- Section 2703 of the Affordable Care Act allows states to amend their Medicaid state plans to provide **Health Home Services** for enrollees with qualifying chronic conditions.
- States are eligible for an enhanced federal match, 90% federal, 10% state, for eight quarters (Missouri’s ended December 31, 2013)
- Missouri – approved in 2011 for two Medicaid State Plan Amendments to be able to provide Health Home Services to Missourians who are Medicaid eligible participants with chronic illnesses.
Missouri PCHH Selected Qualifying Conditions

• Combination of Two
  • Diabetes (CMS approved to stand alone as one chronic disease and risk for second)
  • Heart Disease, including hypertension, dyslipidemia, and CHF
  • Asthma
  • BMI above 25 (overweight and obesity)
  • Tobacco Use
  • Developmental Disabilities
Qualifying Conditions Current and Planned

Planned Additions (pending CMS approval)

• Anxiety
• Depression
• Substance use disorder*
• Uncontrolled pediatric asthma (stand-alone)**
• Obesity (BMI >30 or 95th percentile on growth chart) (stand-alone)**

*at least one provider certified to provide MAT
**using MO HealthNet algorithm
Participating Sites

- Provider Requirements
  - Medicaid/Uninsured Threshold
  - Using EMR for six months
  - Apply for National Committee for Quality Assurance (NCQA) Patient Centered Medical Home Recognition within 18 months

- Organizations Selected to Participate (initial, 2012)
  - 18 FQHCs  6 Hospitals

- Organizations Selected to Participate (exp. 2014)
  - 21 FQHCs  9 Hospitals  2 Clinics

- Organizations Selected (exp. 2016)
  - 25 FQHCs  11 Hospitals  3 Clinics
Care Team

- Care Coordinator
- RN Care Manager
- Admin
- RN/LPN/MA
- Provider
- Health Home Director
- BHC
- Specialist

Patient
Health Home Team Members

- Health Home Director (1:2500)
- Nurse Care Manager (1:250)
- Behavioral Health Consultant (1:750)
- Care Coordinator (1:750)
- Physician Champion

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- Administration
- Information Technology
Health Home Director

• Provides leadership for the implementation and coordination of health home activities
• Coordinates activities of other health home staff
• Champions practice transformation based on health home principles
• Monitors health home performance and leads improvement efforts
• Training and technical assistance
• Data management and reporting
Nurse Care Manager

- Must be RN for PCHH
- Direct relationships with patients and coordination with primary care team, specialty care teams, and inpatient facilities.
- Develop care plans
- Utilize MHD health technology programs & initiatives (i.e., CyberAccess and ProAct)
- Monitor HIT tools & reports to identify gaps in care and needed services for enrollees
- Address medication alerts & hospital admissions/discharges including medication reconciliation
- **Identify and address high utilizers**
- Monitor & report performance measures & outcomes
Behavioral Health Consultant

• Focus on managing a population of patients versus specialty care
• Support care team in identifying and behaviorally intervening with patients to improve their physical health condition
• **Assist with high utilizers**
  • Behavioral supports to assist individuals in improving health status and managing chronic illnesses
  • Assistance with medication adherence, treatment plan adherence, self management support/goal setting, and facilitate group classes
• Brief interventions for individuals with behavioral health problems (not long term hour long therapy sessions)
• Brief coaching sessions for SBIRT
Care Coordinator

- This role does not stipulate a specific licensure requirement as the nurse care manager however many health homes have found it helpful to have someone with clinical knowledge such as a LPN or MA in this role.
- Assist with referral tracking and feedback
- Assist with performance improvement and data management.
- Process enrollment/discharge/transfer forms
- Provide assistance with enabling services such as transportation, food, housing, etc.
- Reminding enrollees regarding keeping appointments, filling prescriptions, follow-up on self-management goals, etc.
- Requesting and sending medical records for care coordination
Physician Champion

- Serves in a leadership capacity promoting and implementing the health home and medical home model
- Creates the strategic vision and drives the investment necessary to create the needed PCMH infrastructure
- Participates in health home planning meetings and activities
- Participates in development and maintenance of health home program structure and policies
- Promotes health/medical home transformation to all physicians
- Works with physicians who resist changes resulting from transition to the health home/medical home model
- Review data showing results of health home implementation
Care Coordination Reports

• Hospitalization and ER visit notifications (daily)
• High utilizer lists (monthly) and trend graphs (quarterly)
• Monthly enrollment/discharge list
• Home and Community-based Services and Developmental Disabilities Case Management/Care coordination reports
Use of Health Information Technology to Link Services

- **CyberAccess (MO HealthNet)**
  - Demographics
  - Diagnoses
  - Providers
  - Labs
  - Procedures
  - Medications
  - Care Coordination

- **ProAct (Care Management Technologies-CMT)**
  - Medication Possession Ratio
  - Medication Adherence

- **Electronic Health Records**
  - Performance Measures
  - Patient Portal

- **Data Warehouse (Azara DRVS)**
  - Clinical Information
<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Role/Responsibilities</th>
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<tbody>
<tr>
<td>Missouri Primary Care Association (MPCA)</td>
<td>• Project Owner, receives reports</td>
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<td>• Support staff at FQHCs &amp; PCCs when needed for questions around reporting and data accuracy</td>
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<tr>
<td>Federally Qualified Health Centers (FQHC’s)</td>
<td>Transmit clinical data through Azara DRVS connector</td>
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<tr>
<td>Primary Care Clinics (PCC’s)</td>
<td>Transmit clinical data through flat file upload</td>
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<tr>
<td>Azara Healthcare</td>
<td>• Provide access to DRVS reporting tool and maintains measures in the tool.</td>
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<td>• Assist PCCs in flat file submission</td>
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<tr>
<td>MO HealthNet</td>
<td>Receives reports</td>
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Primary Care Health Home Performance Measures

• Care Coordination
• Behavioral Health and Substance Abuse Screening and Use
• Chronic Disease Management: Diabetes, Cardiovascular disease, Asthma
• Preventative Health: Weight Assessment and Follow-up for Children and Adults, Population Health LDL Control
• Whenever possible national measure definitions were utilized from the National Quality Forum, Healthy People 2020, Meaningful Use, HEDIS, etc. to assist with alignment across programs.
# Primary Care Health Home Performance Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>NQF Code</th>
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<tbody>
<tr>
<td>1. Adult LDL &lt; 100</td>
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<td>2. Hypertension Controlling High Blood Pressure (NQF 0018)</td>
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<td>3. Childhood Weight Screening and Counseling</td>
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<tr>
<td>1. Child Weight Screening / BMI (NQF 0024)</td>
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<tr>
<td>2. Child Weight Screening / Nutritional Counseling (NQF 0024)</td>
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<tr>
<td>3. Child Weight Screening / Physical Activity (NQF 0024)</td>
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<tr>
<td>4. Pediatric and Adult Asthma Controller Medication:</td>
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<tr>
<td>1. Use of Appropriate Medications for Asthma Ages 12-18 (NQF 0036)</td>
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<tr>
<td>2. Use of Appropriate Medications for Asthma Ages 19-50 (NQF 0036)</td>
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<tr>
<td>3. Use of Appropriate Medications for Asthma Ages 51-64 (NQF 0036)</td>
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<tr>
<td>4. Use of Appropriate Medications for Asthma Ages 5-11 (NQF 0036)</td>
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<tr>
<td>5. Diabetes A1c &gt; 9 (NQF 0059)</td>
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<td>6. Diabetes A1c &lt; 8 (NQF 0059 modified)</td>
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<tr>
<td>7. Diabetes BP &lt; 140/90 (NQF 0059 modified)</td>
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<tr>
<td>8. Diabetes LDL Management - LDL &lt; 100 (NQF 0064)</td>
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<tr>
<td>9. Screening for Clinical Depression and Follow-Up Plan (NQF 0418)</td>
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<tr>
<td>10. Adult BMI Screening and Follow-up</td>
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<tr>
<td>1. BMI Screening and Follow-Up &gt;= 65 Years (NQF 0421)</td>
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<tr>
<td>2. BMI Screening and Follow-Up 18 - 64 Years (NQF 0421)</td>
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<tr>
<td>11. Care Coordination (MPCA PCHH)</td>
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<td>12. SBIRT Drug Use (MPCA PCHH)</td>
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<td>13. SBIRT Excessive Drinking (MPCA PCHH)</td>
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<tr>
<td>14. SBIRT Substance Abuse Screening and Follow Up (MPCA PCHH)</td>
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Results to date

- 43,000 persons served (Primary Care and Community Mental Health)
- Total Medicaid cost reduction of $23 million
- Reduction in hospitalizations
- Reduction in ER utilization
- Reduction in uncontrolled blood pressure
- Reduction in uncontrolled LDL levels
- Reduction in diabetes A1C levels
Contact Information

Missouri Primary Care Association
573-636-4222

Joe Pierle: j Pierle@mo-pca.org
Angela Herman-Nestor: aherman@mo-pca.org