Iowa’s Integrated Health Home Program for Medicaid
Definitions

- **HEALTH HOME** = COORDINATION FROM A PHYSICAL CARE HEALTH HOME FOR WHOLE PERSON CARE

- **INTEGRATED HEALTH HOME (IHH)** = COORDINATION FROM A CMHC OR ACT TEAM FOR PERSON WITH A SERIOUS MENTAL ILLNESS (SMI)

- **IHH COORDINATION** = THE COORDINATION OF ALL PHYSICAL CARE, MENTAL HEALTH, SUBSTANCE ABUSE SERVICES AND NATURAL SUPPORTS/FAMILY – WHOLE PERSON PLAN

- THE “HOME” IS NOT A PLACE TO LIVE
Managing Health for SMI Individuals and Helping to Control Associated Costs

Affordable Care Act Section 2703 State Plan Amendment

- Gives states the opportunity to apply for new Health Home activities
- These are coordination activities to manage the whole person and integrate care
- Financial incentives available to states to begin these activities
Integrated Health Home Core Activities

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Individual family support, which includes authorized representatives
- Referral to community resources and social support
- Use of health information technology to link services if feasible and appropriate

Center for Medicare and Medicaid Services Guidance letter 2010
### SMI Population Characteristics

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<thead>
<tr>
<th>Higher rates of modifiable risk factors</th>
<th>Alcohol and substance use disorders</th>
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<tbody>
<tr>
<td>Smoking</td>
<td>co-occur in 40 to 70% of individuals</td>
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<tr>
<td>Alcohol consumption</td>
<td>with SMI</td>
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<tr>
<td>Poor nutrition</td>
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<td>Lack of exercise</td>
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<td>Unsafe sexual behavior</td>
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<tr>
<th>Complex interplay between SMI and medical conditions</th>
<th>Impact of psychotropic medications</th>
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<td>interplay of drugs and conditions</td>
<td>Cause metabolic syndrome, weight gain, and</td>
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<td>unaddressed physical health issues causing higher anxiety</td>
<td>diabetes</td>
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<td></td>
<td>Side effects can mask symptoms of medical illnesses</td>
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<tr>
<th>Symptoms associated with SMI can impede getting needed care</th>
<th>High rates of chronic medical conditions</th>
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<tr>
<td>Feelings of hopelessness and powerlessness</td>
<td>Cardiovascular disease</td>
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<tr>
<td>Fear of accessing care</td>
<td>Diabetes</td>
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<tr>
<td>Difficulty in following medical recommendations</td>
<td>Obesity</td>
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<td>Decreased motivation</td>
<td>Respiratory disease</td>
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<td>Impaired communication skills</td>
<td>Infectious disease</td>
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<td></td>
<td>Musculoskeletal problems</td>
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• High use of emergency and urgent care services
• Lack of preventive services
• Lower rates of cardiovascular procedures
• Inadequate diabetes care
• Polypharmacy
• People with SMI die on average 25 years earlier than the general population
  ➢ 30–40% due to suicide and injuries
  ➢ 60–70% due to medical conditions
Disease Impact

Survival

Nationwide, people with SMI have a life expectancy 25 years shorter than the general population.

6-12 times more likely to die by suicide than the general population.

50% have a decreased likelihood of survival without strong social relationships.

Weight

40-60% of people who are diagnosed with Schizophrenia are overweight (BMI over 25).

- At least 75% smoke tobacco
- 15% of people with Schizophrenia have diabetes account for 12 million visits annually to ER
- 70% with significant MH/SUD had at least 1 chronic health condition, 45% have 2 and almost 30% have 3 or more.

National Association of State Mental Health Program Directors (2006),
What Are the Systemic Barriers?

- Social barriers.
- Lack of transportation.
- Lack of reimbursement methods for coordinated care.
- Lack of reimbursement for health education, support and family services.
- Inadequate services to support self-management.
- Poor coordination between physical and behavioral health care systems.

- PCPs do not feel comfortable or have much experience managing patients with SMI.
- Primary care offices can feel uncomfortable with people with SMI.
- General lack of communication between BH and PH makes the medical management of SMI patients more challenging.
- SMI symptoms can interfere with accessing medical care.
- Symptoms and treatments for SMI can lead to sedentary lifestyle.
Population Served

- Iowa Medicaid recipients who have been determined SMI
Iowa IHH Enrollment

- SMI = Diagnosis of major depression, Bi Polar Disorder, Schizophrenia plus other diagnoses and a process for exceptions

- SMI diagnosis alone qualifies adults with Medicaid for an Integrated Health Home

- No current or history of health problems required for enrollment
Magellan’s Integrated Health Home

- Most physical health providers do not understand the special needs, treatment plans or medications of the SMI population.
- Patients have strong relationships with their behavioral health provider, which is often their major interaction with the health care system.
- Through IHH, the behavioral health provider leads both the behavioral health treatment AND the routine physical health care of this population.
- Magellan stimulates and facilitates communication between providers.
- Clinical protocols and guidelines extend care management to physical health conditions to include:
  - Preventive care
  - Health maintenance
  - Chronic condition management
- With Magellan’s IHH program, SMI individuals have an “integrated health home” – where the behavioral health provider is the “Home.”
Iowa IHH Implementation

- RFP released to providers – March 2011
- Projects selected – May 2011
- Projects began – July 2011
  - Abbe Center CMHC/Linn Community Care
  - Eyerly-Ball CMHC/Primary Health Care
  - Heartland ACT/Council Bluffs CHC
  - Siouxland CMHC/Siouxland CHC
  - Broadlawns Medical Center (January 2012)

- Members consent/opt-in to use primary care at the CMHC site
- Over 700 members enrolled as of August 2012
IHH Provider Standards

- Trained peer support specialists on staff/Use of peer support whole health/wellness
- Move toward certification/accreditation (NCQA/CARF/Joint Commission health home standards)
- Increased access to care for members
- Whole person orientation – health/mental health/substance abuse/wellness)
- Coordinated/Integrated Care
- Psychiatrist-Directed Care team
- Quality/outcomes
- Electronic health record – CCD capable
Iowa IHH – Who is Involved?

- Magellan has Integrated Care Nurse Coordinator to oversee enrollment, risk profile and coordination planning. Managing transitions from provider to provider.

- CMHCs provide a nurse, care coordinator and peer support specialist. They are providing on the ground coordination for the member. They are ensuring a whole person plan is in place for the member.

- The FQHCs have opened a satellite office at the CMHC and are providing a medical NP to provide routine and preventative physical care.

- For ACT teams, they have added coordination and peer support for improved physical outcomes
Magellan’s IHH Model of Care

- Meet consumers where they already are:
  - At the behavioral health care site

- Recognize and address the challenges consumers with SMI face in accessing and coordinating their health care needs:
  - Strong and robust use of care management, outreach, and community services
  - Carefully manage transitions in care and medications
  - Engage peer support specialists for social and lifestyle change support

- Use a whole person approach

- Ensure coordination across providers:
  - Staff and tools dedicated to coordinate care
  - Apply integrated care guidelines
  - Facilitate joint treatment planning sessions between providers for high need
  - Use of HIT for a full, integrated picture of the member’s health information
Magellan’s Role in IHH

- Identify people who will benefit from care coordination and help addressing gaps in care.

- Provide infrastructure to facilitate coordinating complex care (policies, standards, protocols, and training) to make the program a success.

- Provide tools and staff to customize care management interventions based on the physical/behavioral health risk level of recipient and gaps in care.

- Perform data analytics on medical and pharmacy data to pinpoint problems/fragmented care.

- Provide outcomes tools/measurement protocols to assess IHH concept effectiveness.

- Information technology to facilitate collaboration through health information exchange, plus a variety of tools for members and providers.
**Health Risk Assessment**

### Client ID: RT000284MO

**Name:** TEST, REFERRAL  
**DOB:** 06/02/1984  
**Age:** 26  
**Sex:** M

### 1. Living Situation

- Where do you currently live?  
  - House/ Apt  
  - Assisted Living  
  - Shelter  
  - Homeless  
  - Supervised  

- Who do you live with?  
  - Alone  
  - Roommate  
  - Partner/Spouse  
  - Adult Family  
  - Minor  
  - Children  

### 2. Hospital/Office Visit History

- In the past 12 months, how many times have you:  
  - Visited a Doctors office:  
  - Gone to an Emergency Room: ✓  
  - Stayed overnight in a hospital: ✓  

### 3. Substance Use History

- Do you consume any of the following?  
  - Cigarettes  
  - Clear  
  - Pipe tobacco  
  - Snuff/Chewing tobacco  
  - Alcohol  

- Cigarettes Per Day  
- Years since last Cigarette  
- Years Smoked  

- Alcoholic Drinks Per Day:  
  - None  
  - 1  
  - 2  
  - 3  
  - 4+  

### 4. Lipid Profile

- Date: 07/22/2011  
- HDL-C: 0  
- LDL-C: 0  
- Triglycerides: 222  
- Total Cholesterol: 255

### 5. Vitals

- Date: 07/08/2011  
- Temperature: 0.0  
- Height: 0.0  
- BMI: 0.0  
- Pulse: 0.0  
- Weight: 0.0  
- Blood Pressure: 0.0  

### 6. Social Activity

- How often do you do the following?  
  - Receive invitations to go out and do things: Never  
  - Talk to someone about personal/family problems: Never  

### 7. Preventative Test History

- When was the last time you've had:  
  - Colon Cancer Screen: ✓  
  - Flu Vaccine: ✓  
  - Pneumonia Vaccine: ✓  
  - Tetanus Vaccine: ✓  
  - Dental Exam: ✓  
  - Pap test: ✓  
  - Mammogram: ✓

### 8. Chronic Condition History

- Do you have any of the following conditions?:  
  - Allergies (Seasonal): ✓  
  - Asthma: ✓  
  - Bronchitis/COPD: ✓  
  - Chronic Pain: ✓  
  - Diabetes: ✓  
  - Heart Problems: ✓  
  - High Blood Pressure: ✓

### 9. Considering your age, how would you rate your overall physical health?:  

- Poor  
- Not Good  
- Average  
- Good  
- Excellent
Coordination Model

- **Low Touch (43%)**
  - Health and Wellness HWQ
  - Integrated Healthcare Home
    - Wellness Programs
  - Access to existing physical health services and behavioral health services
    - Pharmacy interventions
    - Peer Support Whole Health

- **Medium Touch (42%)**
  - All of the above
  - Monitoring from IHH coordination staff for service access
    - Care coordination plan

- **High Touch (15%)**
  - All of the above
  - Close monitoring of visits by IHH team/outreach
    - Track transitions from hospital care and ensure proper aftercare
      - Joint staffings
    - Coordination from Magellan nurses
Member Summary from HWQ Self Report

- 9% did not visit a medical provider in the past year
- 22% visited the ER 3 or more times in the past year
- 10% had 3 or more inpatient admissions in the past year
- 66% currently smoke cigarettes
- 22% use alcohol
- 37% have a BMI of 35 or higher, 19% have a BMI of 40 or higher
Examples of Care Coordination Activities

- Arranged for tobacco cessation treatment
- Planned hospital transition for member hospitalized with pneumonia
- Conducted diabetes education and coordinated referral to a cardiologist
- Setup plan to provide frequent contact with NP for member with multiple ER visits
- Coordinate plan for alternative treatment options for stress and pain relief for member
- Arrange lab work to be drawn at home for homebound member on Coumadin (blood thinner)
- Coordinated transportation to help member use routine/urgent care vs. ER.
Member Profiling

- IHH providers input member data on Magellan website
- Magellan nurses create a “Member Health Profile” with all physical, mental health and substance abuse services
  - Full list of medications
  - Gaps in care noted and individualized
  - Health promotion opportunities noted: E.g. colon cancer screen, flu shot, tetanus vaccine, dental/eye exam, mammogram and PAP test
- Results can be aggregated by provider to look for opportunities for health promotion of the group (e.g. # of females age 50 or higher who have not received a mammogram)
Peer Support Whole Health – A health self-management approach

Values are consistent with peer support for mental health recovery

Looks comprehensively at a person’s health life-style

Is a strength-based and focuses on a person’s strengths, interests and natural supports;

Stresses creating new health life-style habits and disciplines through self-determined strategies and choices

Provides peer support delivered by peer specialists trained to promote self-directed whole health.
The PSWH training is also built on a Person Centered Planning (PCP) process that focuses on six health lifestyle domains

- Healthy Eating
- Physical Activity
- Restful Sleep
- Stress Management
- Service to Others
- Support Network
Peer Support Whole Health: Goals

- Do not focus on changing ‘bad’ behaviors (e.g. – smoking) or poor health conditions (e.g. – overweight)
- Focus on creating attainable, self-determined lifestyle habits to improve overall health
  - “I will walk for 15 minutes, four days a week, for the next 3 months, starting August 30th.”
  - “I will go to the weekly depression support group at the church starting the first week in September through the end of the year.”
  - “I will participate in the IHH walking group three times per week”.
Peer Specialists in Action

- Improve health literacy
- Teach wellness self-management approaches
- Help engage in other services and supports, including primary care (Peer Support Whole Health)
- Share experiential knowledge
Peer Specialists in Action

- Services are most effective when delivered in the community
- Emphasis on community inclusion, linkages to other peer and social support networks
- Activities are readily tied to service plans, goals, and objectives
- Peer specialists can help members better participate in service planning
Lessons to date

- Many members with SMI have not accessed routine/preventative medical care in the past
- Many members like personal relationship with medical provider at CMHC site
- Strong connection to peer support staff
- Collaboration at a systematic level is new for CMHCs and FQHCs
Goals – IHH Members

- Increase life expectancy
- Improve outcomes for members with complex medical conditions
- Improve the member’s service experience and satisfaction
- Increase health literacy for members
- Reduce unnecessary emergency and hospital care
  - Preliminary data show reductions in mental health hospital days
- Increased functioning on Consumer Health Inventory (CHI) scores
Next Steps

- Work with state to submit State Plan Amendment to CMS for continued funding of IHH
- Expand to other parts of Iowa from 5 to 34 counties beginning in 2013
- Develop children’s model