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

Higher rates of modifiable risk factors

- Smoking
- Alcohol consumption
- Poor nutrition
- Lack of exercise
- Unsafe sexual behavior

Alcohol and substance use disorders co-occur in 40 to 70% of individuals with SMI

Complex interplay between SMI and medical conditions

- interplay of drugs and conditions
- unaddressed physical health issues causing higher anxiety

Impact of psychotropic medications

- Cause metabolic syndrome, weight gain, and diabetes
- Side effects can mask symptoms of medical illnesses

Symptoms associated with SMI can impede getting needed care

- Feelings of hopelessness and powerlessness
- Fear of accessing care
- Difficulty in following medical recommendations
- Decreased motivation
- Impaired communication skills

High rates of chronic medical conditions

- Cardiovascular disease
- Diabetes
- Obesity
- Respiratory disease
- Infectious disease
- Musculoskeletal problems

Disease Impact

- 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

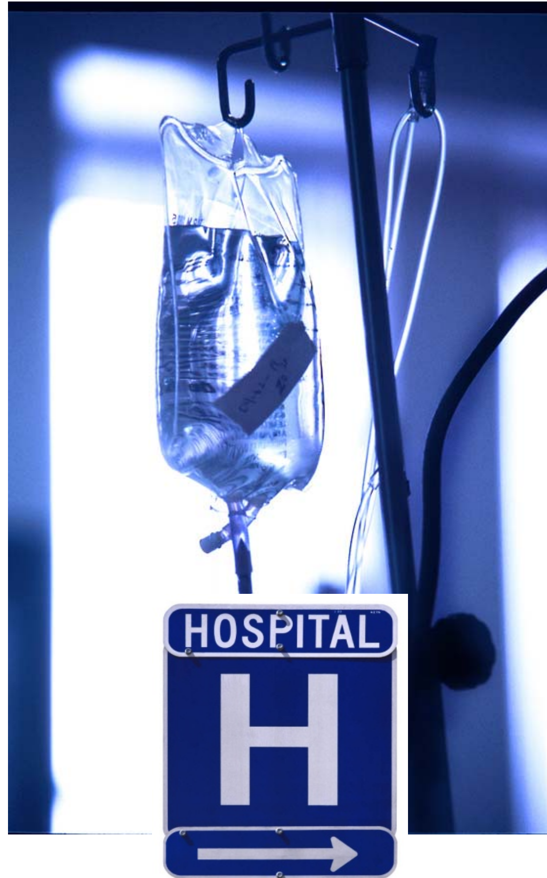
Nationwide, people with SMI have a life expectancy 25 years shorter than the general population.

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

ClaimTrak Systems, Inc. on STLMOTS25 - DCC Live

File Edit Clients Reports Billing Processing Clinical Maintenance Utilities Login Window Help

Username: mmhall, Staff ID: IT116, Selected Site: EVALUATIONS DEPARTMENT
Printer: HP LaserJet 1200 Series PCL Logged In: 08/05/11 7:10 AM

Health Risk Assessment

Client ID: **RT090284M0** DOB: **09/02/1984** Active Plan: EOC Date: **03/10/2009**
Name: **TEST, REFERRAL** Age: **26** Sex: **M** Packet: **07/08/2011**

1. Living Situation

Where do you currently live?

House/APT	Assisted Living	Shelter	Homeless	Supervised
☑	☐	☐	☐	☐

Who do you live with?

Alone	Roomate	Partner/Spouse	Adult Family	Minor Children
☐	☑	☐	☐	☑

6. Social Activity

How often do you do the Following:

	Never	Rarely	Sometimes	Frequently
Recieve invitations to go out and do things	☐	☐	☐	☑
Talk to someone about personal/family problems	☑	☐	☐	☐

2. Hospital/Office Visit History

In the past 12 months, how many times have you:

	Never	1 - 2	3 - 5	6 or more
Visited a Doctors office:	☑	☐	☐	☐
Gone to an Emergency Room:	☐	☐	☐	☑
Stayed overnight in a hospital:	☐	☐	☐	☑

7. Preventative Test History

When was the last time you've had:

	Never	Less Than 1 year	1 - 2 yr	3 - 4 yr	5 + yr	Don't Know
Colon Cancer Screen	☑	☐	☐	☐	☐	☐
Flu Vaccine	☑	☐	☐	☐	☐	☐
Pneumonia Vaccine	☑	☐	☐	☐	☐	☐
Tetanus Vaccine	☑	☐	☐	☐	☐	☐
Dental Exam	☑	☐	☐	☐	☐	☐
Pap test	☑	☐	☐	☐	☐	☐
Mammogram	☑	☐	☐	☐	☐	☐

3. Substance Use History

Do you consume any of the following?

	Never	Previously	Currently
Cigarettes	☐	☐	☑
Cigars	☐	☐	☑
Pipe tobacco	☐	☐	☑
Snuff/Chewing tobacco	☐	☐	☑
Alcohol	☐	☐	☑

Cigarettes Per Day	Years since last Cigarette	Years Smoked
66	0	44

	None	1	2	3	4+
Alcoholic Drinks Per Day:	☐	☐	☐	☐	☑

**1 Drink = 1 Beer, 1 Glass of wine, 1 Mixed drink, or 1 shot

8. Chronic Condition History

Do you have any of the following conditions?:

	Never	In the past	Currently Diagnosed	Currently Taking Medication	Under Medical Care
Allergies (Seasonal)	☐	☐	☑	☑	☑
Asthma	☐	☐	☑	☑	☐
Bronchitis/COPD	☐	☐	☑	☐	☐
Chronic Pain	☐	☐	☑	☑	☐
Diabetes	☐	☐	☐	☑	☑
Heart Problems	☐	☐	☑	☐	☐
High Blood Pressure	☐	☐	☐	☑	☐
Stroke	☐	☐	☑	☐	☑
HIV	☐	☐	☐	☑	☐
Hepatitis	☐	☐	☐	☑	☐

Considering your age, how would you rate your overall physical health:

Poor Not Good Average Good Excellent

4. Lipid Profile

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

5. Vitals

Date: 07/08/2011
Temp: 0.00 Height: 0.00 BMI:
Pulse 0.00 Weight: 0.0 0.000

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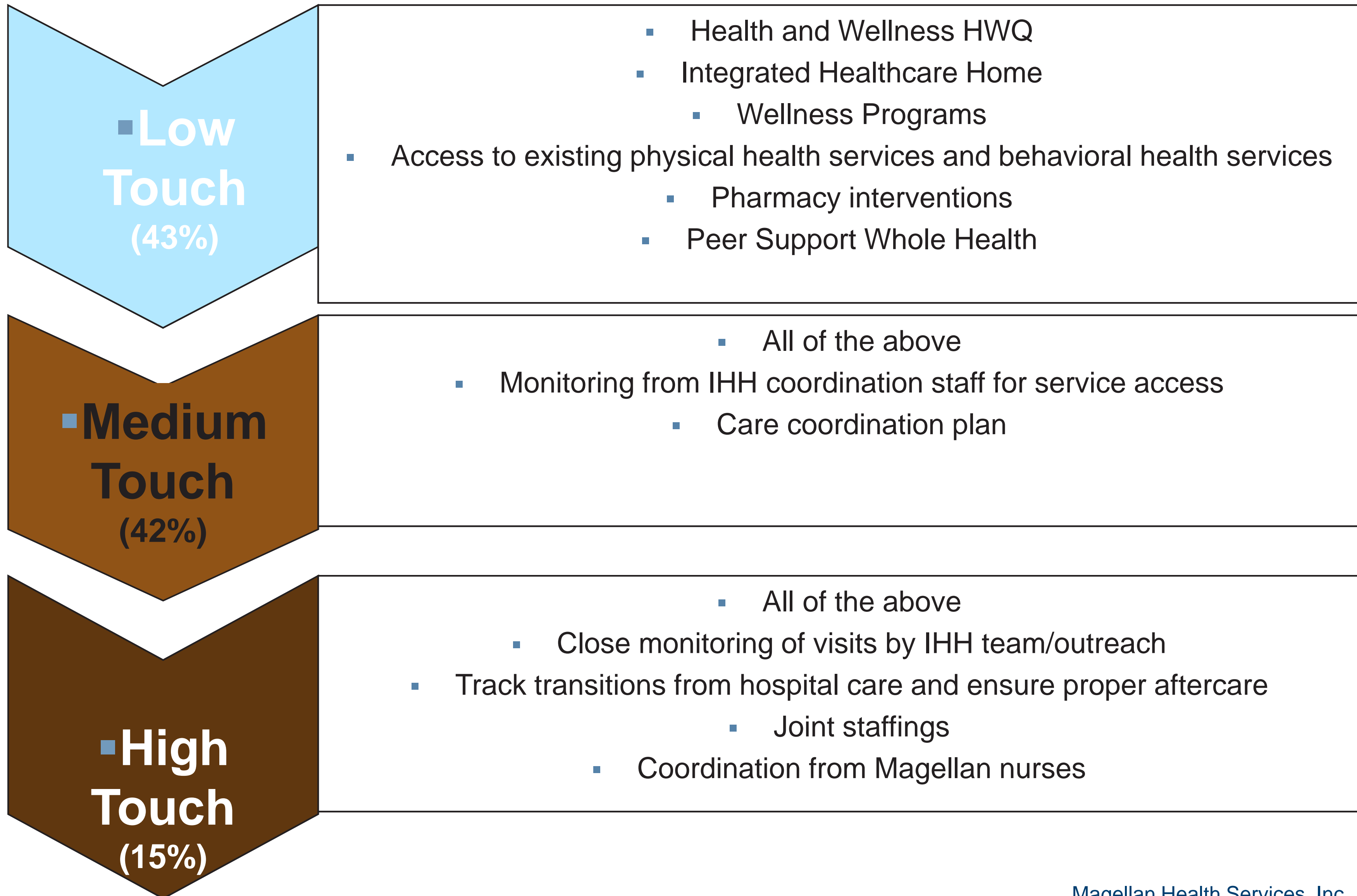
Coordination Model



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)

Peers Helping Peers

- 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.

PSWH Training

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

Lyon Osceola Dickenson Emmet Kossuth Winnebago Worth Mitchell Howard Winneshiek Allamakee

Sioux O'Brien Clay Palo Alto Hancock Cerro Gordo Floyd Chickasaw

Fayette Clayton

Plymouth Cherokee Buena Vista Pocahontas Humboldt Wright Franklin Butler Bremer

Black Hawk Buchanan Delaware Dubuque

Webster

Woodbury Ida Sac Calhoun Hamilton Hardin Grundy

Tama Benton Linn Jones Jackson

Monona Crawford Carroll Greene Boone Story Marshall

Clinton

Cedar

Harrison Shelby Audubon Guthrie Dallas Polk Jasper Poweshiek Iowa Johnson

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Fremont Page Taylor Ringgold Decatur Wayne Appanoose Davis Van Buren

Lee

Phase 1

Phase 2

September 2012