Integrated Health Homes - For Iowa Plan Members

Magellan Behavioral Care of Iowa
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MAGELLAN BEHAVIORAL HEALTH

What is an Integrated Health Home?

In partnership with IME and community-based providers, Magellan is supporting the development of ***specialized* health homes** for Iowa Plan members* with:

- Serious and persistent mental illness (SPMI)
- Serious emotional disturbances (SED)

* Includes approximately 411,000 members; most all Medicaid members are eligible for the Iowa Plan

Goals for IHH under the new State Plan Agreement

- Expand BH led integrated health homes across the state
  - Develop the capacity of BH providers such as CMHCs and providers of children's services to function as health homes
  - Expand the program in phases from the more urban to very rural areas
- Improve the quality and coordination of care for the SMI and SED populations.
  - Improve the management of chronic illnesses
  - Avoid unnecessary hospital admissions, ER use and other institutional care
  - Measure and improve the cost of care
  - Support the sharing of clinical information between providers
  - Increase community tenure
  - Optimize the use of community resources
- Support the state in the implementation of the mental health redesign

Why?

People with chronic mental illness **die 25 to 30 years younger** than their peers who do not have a mental health condition, often due to unaddressed physical conditions.

Much of this is preventable.

2006. National Association of State Mental Health Program Directors. “Morbidity and Mortality in People with Serious Mental Illness.” Alexandria, VA. http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortaility%20-%20Final%2011-06.pdf.

Working to Achieve the Triple Aim

Target Populations

- Two or more chronic health conditions – e.g., mental health or substance use condition, asthma, diabetes, heart disease, or overweight; OR
- One chronic condition and at risk for another; OR
- One serious and persistent mental health condition

Note: Regardless of which conditions are selected, states must address mental health and substance use conditions and consult with SAMHSA on their treatment and prevention

Attributed Medicaid Member Population

- Identified through Magellan claims information
  - 30,000 SPMI adults statewide
  - 16,000 SED children and youth statewide
- Required to meet diagnostic criteria
- Assigned membership will be automatically enrolled to health home in area
- Cannot be assigned to both physical health home and specialized integrated health home

Diagnostic Criteria for IHH Membership

The SMI diagnosis is defined by the following diagnosis categories:

- Psychotic disorders
- Schizophrenia
- Schizoaffective disorder
- Major depression
- Bipolar disorder
- Delusional disorder
- Obsessive-compulsive disorder

Serious emotional disturbance (SED) means:

- A diagnosable mental, behavioral or emotional disorder of sufficient duration to meet DSM diagnostic criteria
- Results in functional impairment

What Do Health Homes Do?

Use health teams to integrate an individual's health care, addressing the physical, behavioral and other key social needs of members in a holistic manner to achieve better health, better care, greater satisfaction and lower cost.

- Responsible for attributed set of people with SPMI/SED
- Provide care coordination services
- Use data to identify gaps in care, identify people needing service attention, manage the population with efficiency rather than just one-by-one
- Use information technology to inform treatment practices with timeliness, and improve cross-provider communication and coordination
- Enhance customer service and overall satisfaction
- Focus on health promotion, prevention and wellness education and activities

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

Magellan's IHH Model of Care *(continued)*

- Ensure coordination among providers:
  - Staff and tools dedicated to coordinate care
  - Apply integrated care guidelines
  - Facilitate joint treatment planning sessions between providers
  - Use of health information technology (HIT) for a full, integrated picture of the member's health information

Systems of Care Approach for Child IHH

Child sites will function using Systems of Care model

- Child- and family-centered
- Strengths-based approach
- Family team meetings
- Wraparound process
- Community engagement
- Use of natural supports

Health Homes Services

1. Comprehensive care management
2. Care coordination and health promotion
3. Comprehensive transitional care
4. Individual and family support services
5. Referral to community and social support services

GREAT things are done by a series of small things brought TOGETHER.

IHH Staffing

- Care coordination teams integrated within IHH sites
- Ratio-based positions dependent on number of attributed members
  - Nurse (RN) 1:400
  - Care Coordinator (BS/BA) 1:250
  - Peer or Family Support Specialist (certified) 1:250
- Non-ratio-based positions
  - Program Director
  - Supervisor
  - Administrative Assistant

Provider Qualifications

- Accredited/licensed mental health provider of good standing in the Iowa Plan
- Capacity to serve a significant number of the targeted population
- Demonstrated capacity to use HIT to measure outcomes
- Commitment from highest levels of leadership to lead transformational change according to the IHH program principles
- Demonstrated readiness to complete the change transformation curriculum in a year
- Demonstrated capacity to manage quality improvement processes
- Ability to staff the program with the necessary teams to manage

Flexible Payment Methodology

- Health homes services paid on a **per member per month (PMPM) basis**
- Blended rate of high-need to low-need member costs of care
- Allows for flexibility in delivery of care
- Concentration of efforts can be given where needed with less cost concern
- Fee-for-service remains in place for traditional services available (e.g., therapies, medication management, BHIS, etc.)
- Large primary care sites will be paid lower PMPM to participate in care coordination, communication for common members

Rates: (including a 25% performance based bonus)

Children: $103 pmpm; Adults $80 pmpm; ICM $200 pmpm

Practice Transformation Coaching

- Practice transformation coaches will be routinely onsite to instruct and assist practices with quality improvement efforts to transform site to patient-centered practice
- Ongoing technical assistance for 2 years
- Tools to assess readiness and transformation progress
- Learning Collaboratives to learn from others, share best practices
- Adult IHH – HealthTeamWorks will be providing coaching expertise
- Child IHH – University of Iowa CHSC will be providing coaching expertise

Initial assessment

- Sites have staffed up to meet demand – perhaps more than needed
- Magellan continues to work through operational details – enrollment issues, provider identification, etc.
- Sites are aggressively enrolling people (pmpm is a strong incentive)
- Some positions are hard to find
  - Analyst
  - Medical director (especially part time)
- There are many opportunities for communication gaps, misunderstandings, and acrimony. It's important to be a clear and concrete as possible with all participants.

IHH Is a **Team** Approach

Magellan

- Selects IHH providers
- Provides care management support through
  - ✓ Claims-based reporting to identify gaps in care
  - ✓ Risk analysis
  - ✓ Development of online tools

  to support daily service delivery and population management needs

Community IHH Provider

- Develops care teams to work with members
- Uses data and technology to oversee and intervene in the total care of the member
- Works with community services and supports to address member/family needs
- Develops whole-health approaches for care

Iowa IHH Program Tools and Support

Magellan will provide

- Data and analytic services (Impact Pro, HEDIS vendor reporting, ad hoc analyses, operational reporting)
- Support for data sharing between providers
- Tools to support care coordination
- Oversight of the program at a programmatic as well as individual level for the very high risk population
- Coaching for health home development and system of care
- Support care coordination for highest risk members

Information Sharing and Care Coordination Tools:

- IHH Member Website
- IHH Provider Portal:
  - Enrollment and AUD status
  - Health and Wellness Questionnaire (HWQ)
  - Member Profile
  - Care Coordination Plan (CCP)
  - Continuity of Care Documents (CCD)
  - Provider Best Practices resources (future)

Iowa IHH Program Tools and Support - Children

Focused on integrating services especially for those children interacting with and being served by multiple agencies

System of Care

- Builds on existing model from the University of Iowa and consistent with the State's mental health redesign
- Pediatric Integrated Health Home
  - Uses child health teams
  - Multi-disciplinary
  - Uses care coordinators and family navigators (trained by the University)
- Uses a broad service delivery model combining a medical model with social support
- Uses "wrap around" intensive individualized care planning for children involved with multiple child serving agencies

Using Data to Manage Member Population

- A move from thinking of health care as a series of isolated, reactive, crisis-type encounters, to a big-picture approach that anticipates needs and improves outcomes
- A process of scanning large groups of patients and asking, “What are the pressing health needs of this population, and how can we best satisfy or even pre-empt those?”
- A “population” is a group of people with a shared condition, such as diabetes, schizophrenia or asthma
- Use data, such as claims or encounters, to inform areas of intervention needed to improve or maintain health status
- Example: Diabetic patients may need annual eye exam, foot exam, HbA1c testing, medication management, etc.

Using Information Technology

- Allows for immediate health information access
- Electronic Medical Records (EMRs)
  - Allow for improved internal information-sharing
  - Allow critical patient medical information to move to outside providers quickly
- Continuity of Care Document (CCD) - electronic document exchange standard for sharing patient summary information
- Create tools to inform next steps within practice:
  - Look across practice patient population
  - Sort and group patients by common traits
  - Make informed choices about where dollars and energy are best spent
  - Measure progress in real time

Use of HIT

- Identify the population at-risk
  - Claims data to identify high utilizers past and future
  - Claims data to identify gaps in care
  - Health and Wellness Questionnaire to identify patient-reported health risks (smoking, obesity, lack of exercise, social supports, living situation)
- Develop care and care coordination plans

HRA Results

% SMI by 9 Block Category

9 Block		Physical Health: Low	Physical Health: Moderate	Physical Health: High	*Total*
Behavioral Health	High	10.9%	6.1%	2.6%	*19.6%*
	Moderate	21.7%	12.8%	3.8%	*38.3%*
	Low	26.1%	12.7%	3.2%	*42.1%*
	Total	*58.8%*	*31.6%*	*9.7%*	***100.0%***

Quality Outcomes Expectation

- Demonstrated effectiveness is critical
- Quality measures will be monitored related to health status, improvement in function, etc.
- Financial incentives available to sites for meeting health measures

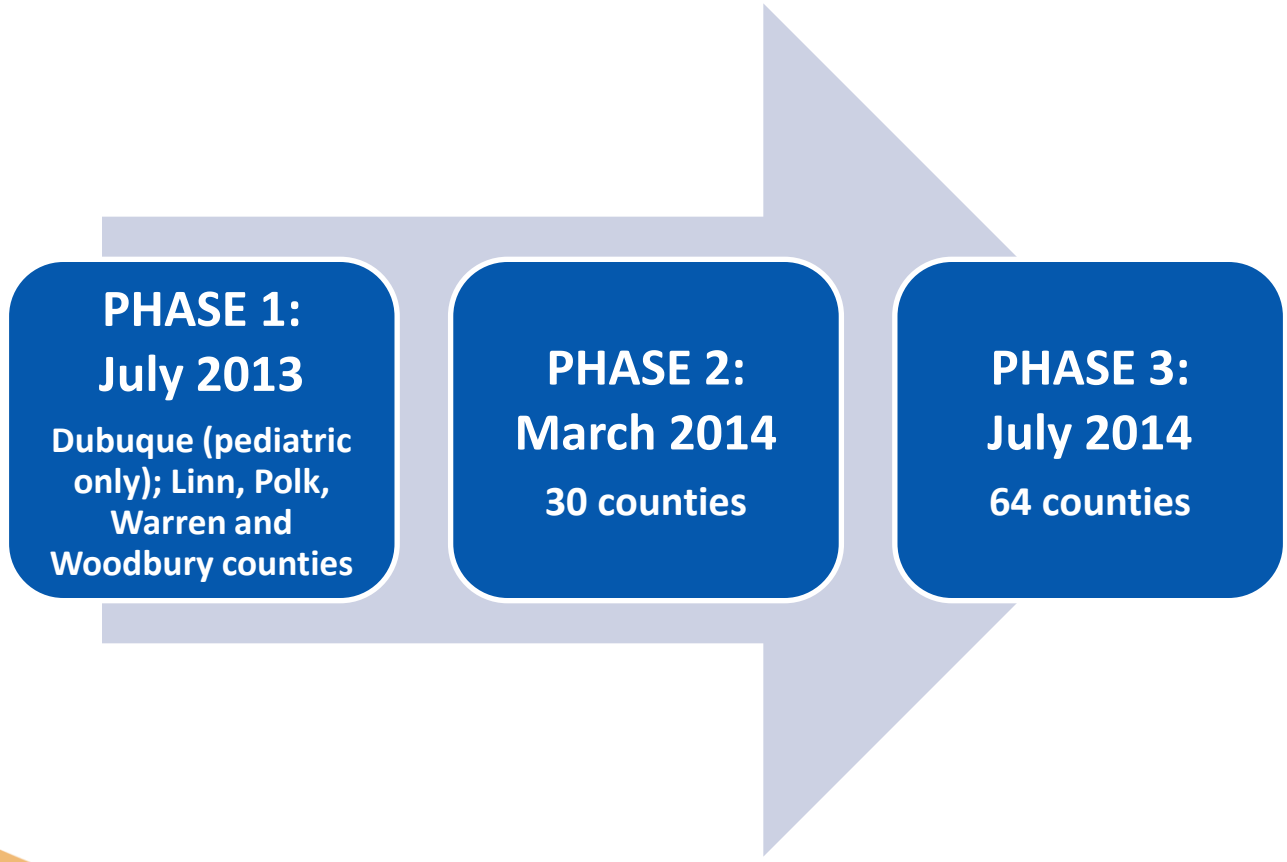
Performance evaluation

- Incentives
  - Initial program was “block grant” of reinvestment funds ($250,000/site)
  - Current program is pmpm ($103/80 kids/adults) with 25% based on hitting performance targets
- Initial evaluation focused on process and engagement measures
  - HWQ completions
  - Participation in practice transformation activities
  - Percentage of members with BMI measured
- Future measures are more outcome oriented
  - Percentage of people with diabetes with HgbA1c measured every 6 months
  - Future measure moves to percentage of people with HgbA1c better controlled

Performance Evaluation

- CMS has a set of core measures for health homes
  - Selected HEDIS measures
  - Readmission rates
  - Potentially avoidable admissions
- Iowa has required measures
  - Cost comparisons to be done by the University of Iowa (many challenging issues in design)
  - Member experience with care - CAHPS

Phased Statewide Roll-Out



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