



2013

Missouri Primary Care Health Homes

Interim Evaluation Review Summary

July 2012 - June 2013

MO HealthNet

May 2014

Contents

I.	INTRODUCTION	3
II.	HEALTH HOME ENROLLMENT AND PROGRAM SIZE	3
III:	POPULATION CHARACTERISTICS.....	4
IV:	STAFFING	6
V:	CARE MANAGEMENT	7
VI:	CLINICAL OUTCOMES	8
VII:	FINANCIAL AND UTILIZATION OUTCOMES	16
VIII:	PERFORMANCE/SYSTEM TRANSFORMATION	16
IX.	REIMBURSEMENT.....	14
X:	ACHIEVEMENTS AND LESSONS LEARNED.....	15
XI:	SUCCESS STORIES.....	17

I. Introduction

This report was developed to show progress in the primary care health home (PCHH) initiative through June 30, 2013. PCHH providers have continued the process of transformation into a person-centered medical home care (PCMH) model, and have become more well-grounded in the various aspects of the PCHH initiative. All 24 providers have been working on the submission of their PCMH recognition applications to the National Center for Quality Assurance (NCQA), and several have been notified that they have achieved Level 3 recognition. A list of those is included as Appendix A.

Improvements in clinical measures have also been noted, as have cost savings. More information about these outcomes will be presented later in this report.

II. Health Home Enrollment and Program Size

Enrollment in the PCHH initiative continued to decline following the first six months of the initiative (as reported in the Six Month Review). This continued decline can be attributed to a number of reasons, including

- inability to establish or loss of contact with participants,
- changes in Medicaid status resulting in inactive or ineligible Medicaid coverage,
- failure to meet Medicaid spend down requirements on a consistent basis,
- participants moving and/or changing healthcare providers and no longer receiving care from a health home provider organization,
- inability of health home providers to engage participants in the health home initiative,
- provider staffing issues requiring a down-sizing of participant panels, and
- enrollees deciding not to continue to participate in the initiative.

As of June 1, 2013, the total PCHH enrollment was 15,854 - a reduction from 20,239 that were auto-enrolled at the beginning of the initiative.

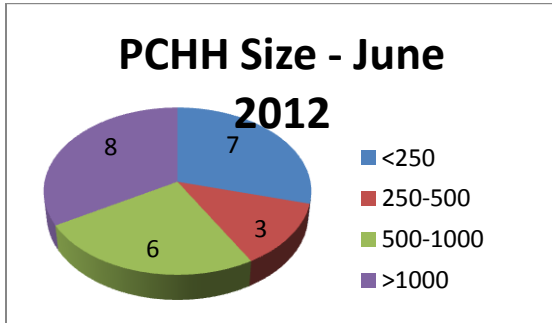
The average loss of enrollees among all PCHH providers since the first six-month report in July 2012 was just under eight percent. The biggest loss for a single provider was 40%. Eight organizations showed changes of less than 5% in the size of their participant panels. A few organizations (four) actually showed panel-size increases of greater than five percent, with the largest two increases being 47% and 35%.

MO HealthNet claims data are mined periodically to identify people who are potentially eligible based on their Medicaid status, provider, diagnoses, and spend amount, but who

are not currently enrolled in a health home. Lists of these individuals are provided to the health homes, and they review them and enroll those who are interested.

A. Primary Care Health Home Program Size

In keeping with the overall reduction in size of the PCHH initiative, there are corresponding decreases in panel size. The tables below show the breakdown of panel sizes in June 2012 and in June 2013. There is one more with a panel size of fewer than 250, and three fewer with panel sizes between 500-1000 and above 1000.



III: POPULATION CHARACTERISTICS

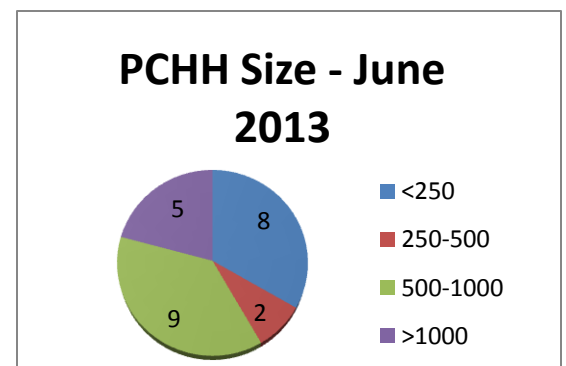
A. Eligibility

Individuals are eligible for enrollment in a primary care health home by virtue of having:

- Two of the following chronic conditions or risk factors, OR one chronic condition plus one risk factor:
 - Diabetes (chronic condition AND risk factor)
 - COPD/Asthma
 - Cardiovascular Disease
 - Developmental Disability
 - BMI>25
 - Tobacco Use (risk factor)

B. Children, Youth and Adults

Although participation in primary care health homes is open to persons of every age, almost 97% of Missouri's PCHHs participants are adults - an increase from 96% a year ago. This is likely because the chronic conditions required for participation are usually more prevalent in adults than children.



The PCHH is encouraging health homes to look for children in their populations that might qualify for the initiative. MO HealthNet has also not excluded any age or date of birth from its data runs that have been done in an attempt to identify potential enrollees.

C. Chronic Disease

Identification of the various conditions listed below was accomplished via data from PCHH electronic medical records - specifically diagnoses, problem lists and fields denoting tobacco use and BMI. It should be noted that data from the 19 federally qualified health centers is obtained through DRVS, a data extraction system coordinated through the Missouri Primary Care Association (MPCA). Data for the other six primary care health homes (hospital-based clinics) is obtained through flat data files submitted by these organizations to Azara (MPCA's contractor).

An average of 30.47 percent of persons enrolled in the PCHH have a diagnosis of **asthma and/or COPD** in their electronic health record's active problem list. Percentages range from 10 to just over 35.

An average of 32.5 percent of all people enrolled in a PCHH have a diagnosis of **diabetes** in the electronic medical record's active problem list. This compares to the Centers for Disease Control's national 2011 prevalence rate of 8.3 percent. Eleven of the primary care health home organizations show percentages of 30 or less, while the other 13 have averages exceeding 30 percent.

The population mean of PCHH participants with **heart disease** is 60.99 percent. Heart disease includes hyperlipidemia, hypertension, coronary artery disease, and congestive heart failure. The Centers for Disease Control reported the prevalence of coronary heart disease in 2010 to be 6 percent.

An average of 3.88 percent of the people enrolled in primary care health homes have one or more **developmental disability** diagnoses. The range is from just under one percent to just under ten percent.

The population mean of PCHH participants who have **obesity** included as a diagnosis or in the active problem list is 73.5 percent, compared with the Centers for Disease Control's 2012 national statistic of 35.7 percent.

An average of 51.64 percent of all individuals enrolled in a PCHH use **tobacco**, according to information reported in diagnosis or problem list fields in electronic medical records, compared to the Centers for Disease Control's 2011 report of a 19 percent national prevalence rate. Since recording tobacco use as either a diagnosis or problem is a relatively new practice, it is likely that this is a very under-reported condition, and that

the actual percentage of people who use tobacco is higher than reported. It is likely that the highest percentages reported are closer to the norm for other PCHHs as well.

D. Dual Eligible Population

The actual number of dual-eligible participants (those covered by both Medicare and Medicaid) has decreased from 6,617 when the program started to 6,267 as of June 1, 2013. The percentage of dual eligible participants, however, has increased - from 32.7% to 39.5%.

E. Managed Care Enrollees

MO HealthNet offers managed care coverage in some parts of Missouri. Because the care management services provided by a health home do not duplicate case management offered by managed care plans, a participant can be enrolled in both a managed care plan and a health home. When the initiative started, there were 1,035 (5.1% of the total) primary care health home participants who were also enrolled in a managed care plan. As of June 1, 2013, that number had dropped to 768 - a decrease to 4.8 percent..

IV: STAFFING

The PCHH State Plan Amendment requires the following staffing levels:

Position	Ratio of Staff to Participants
Health Home Director	1:2500
Nurse Care Manager	1:250
Behavioral Health Consultant	1:750
Care Coordinator	1:750

All PCHH providers are currently adequately staffed, which means they are at least staffed at 85% of the required ratios. At various points during this past year, three organizations were staffed lower than the required 85% level. MO HealthNet is addressing these with a corrective action plan. The relatively high turnover rates experienced in the first six months of the initiative have leveled off in the past year, although there were still 58 instances where staff left or joined a PCHH between July 1, 2012 and June 30, 2013. Nurse care managers and behavioral health consultants are still the positions with the highest turnover rates (35% and 29%, respectively).

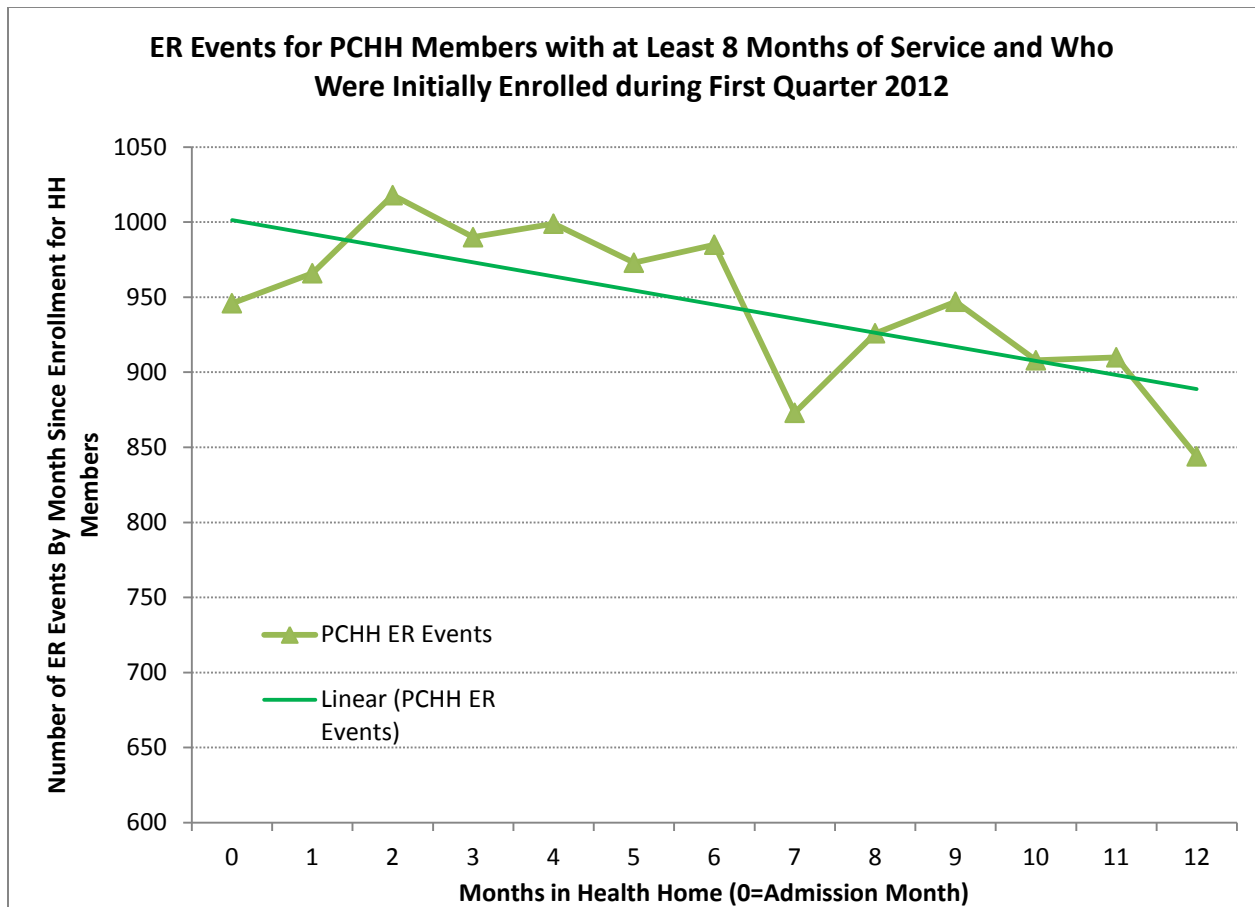
V: CARE MANAGEMENT

A. High Utilizers/Hospitalizations and Emergency Department Visits

A key component of a successful health home is its ability to reduce the number of visits its participants make to emergency departments, and the number of ambulatory-sensitive hospital admissions (those related to ongoing primary care versus those that might be accident or injury-related). MO HealthNet established goals of reducing the number of total emergency department visits in a health home by one for each person enrolled, and the number of hospitalizations by one for each person who had more than one ambulatory-sensitive hospitalization. Tracking this utilization in an accurate manner is challenging because of the unstable nature of each organization's health home panel (see Section II - Health Home Enrollment and Program Size).

In December 2012, MO HealthNet began compiling and sending to each PCHH organization information on their "high utilizers" (people enrolled in their health home who had three or more emergency department visits or more than one hospitalization in a twelve-month period). The lists were provided to help PCHH organizations identify these individuals and target them for more intensive care management, and also to prompt them to develop a process for handling high utilizers in general. These lists have been updated and provided on a routine basis since December. MO HealthNet also provided numerical goals for each health home, corresponding with the methodology noted above.

The graph below looks at emergency department visits for those individuals who were enrolled in one PCHH for at least eight months.



The graph shows that the number of people who visited the emergency department decreased after enrollment in a primary care health home.

VI: CLINICAL OUTCOMES

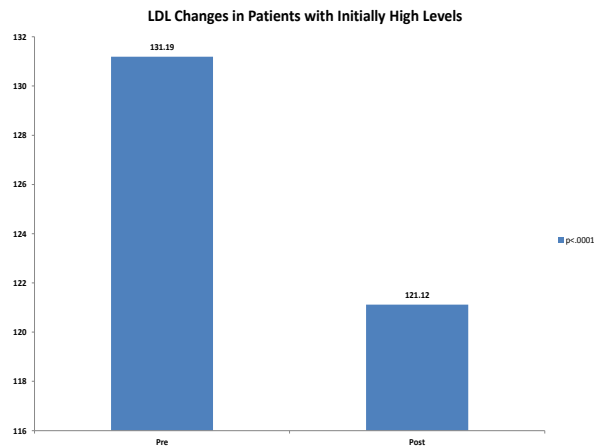
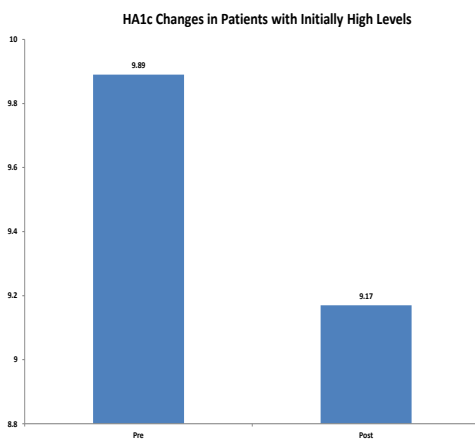
There are seventeen clinical measures in Missouri's PCHH Medicaid State Plan Amendment. Some of these measures are HEDIS and/or meaningful use measures, so most of the health home providers are already meeting the final goals for those (e.g. adult asthma controller medication and adult blood pressure below 140/90). Others, such as hospital discharge/follow up, illicit drug use, and adult weight screening/follow-up, were not captured prior to the implementation of the health home initiative. Building and implementing correct EHR templates, mapping data correctly, training clinical staff, and developing work flow processes that capture needed data as part of the start up and ongoing information system development presented challenges in obtaining accurate data on these measures. As these building blocks get resolved, the data reporting, collection, and analysis steadily improve.

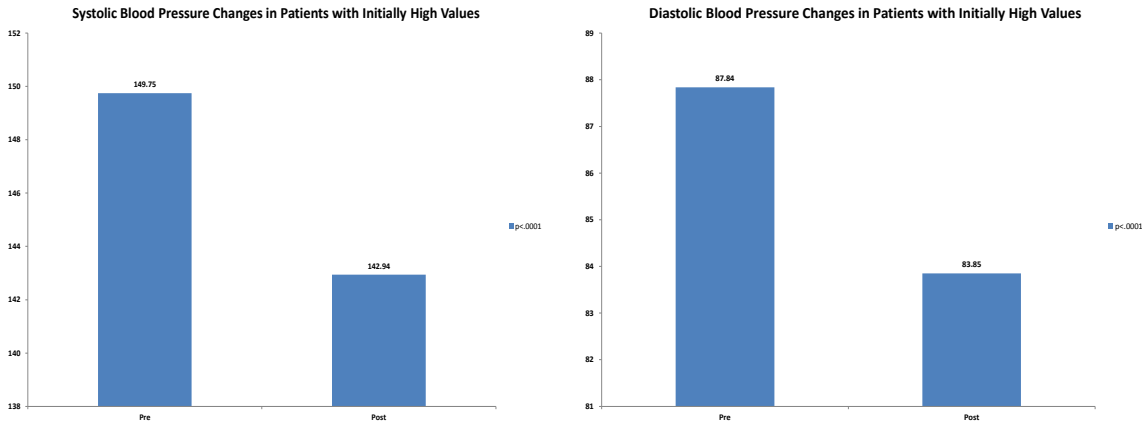
Another challenge for health homes in meeting the discharge follow-up/medication reconciliation measure is getting information from hospitals and emergency rooms in a timely

fashion so that the work can be completed within the required 72 hour period. Some health homes have been more successful than others in developing relationships and implementing processes for data sharing with local hospitals and emergency departments. There are three health information exchanges now functioning in Missouri. We are encouraging our health home providers to join the exchange that includes the hospitals they frequently deal with as a way to improve timely data sharing.

In addition, continued evaluation of the measure specifications continues with proposed modifications for future benchmarks underway. For example, because of the very small number of children in the primary care health home initiative, and the narrow focus of the specific measures, those measures involving children are affected by sample size and fluctuations in that sample. We are proposing that the pediatric measures be calculated only for those health homes that have pediatric sites included. Also, the actual HEDIS specifications on the measure that involves LDL on people with coronary artery disease are so narrowly defined that almost all participants are excluded from its parameters. We are planning to change this measure to better suit Missouri's needs in the future.

Promising results are particularly apparent in three clinical measures: hemoglobin A1C, LDL cholesterol, and both systolic and diastolic blood pressures. These results are noted in the charts below:





There is still much work that needs to be done for all health home providers to reach the ultimate measures goals by December. MO HealthNet and the Missouri Primary Care Association recently implemented a project to "drill down" into the measures with the lowest results to determine specific problems/issues and develop solutions. We anticipate that this will have a large impact on improving measures results.

VII: FINANCIAL AND UTILIZATION OUTCOMES

Mo HealthNet has begun assessing the impact of the health home initiative on service utilization and the cost of care for PCHH enrollees.

Mo HealthNet analyzed Medicaid expenditures for hospitalization and emergency room services for primary care health home enrollees for the year prior to enrollment and the year following enrollment. As the following table illustrates, there was a reduction in both hospital admissions per 1000, and in emergency room use per 1000, for individuals enrolled in primary care health homes.

Hospital Admissions per 1000	Emergency Room Use per 1000
-5.86%	-9.66%

Based on average costs for hospital stays and emergency room services, and adjusting for inflation, together these reductions resulted in a total savings of \$5,678,411 for the period January 2012 through June 2013. Per-member per-month payments for this period totaled \$8,029,691, so the net result is that the PCHH initiative saved 70.72% of the total PMPM payment.

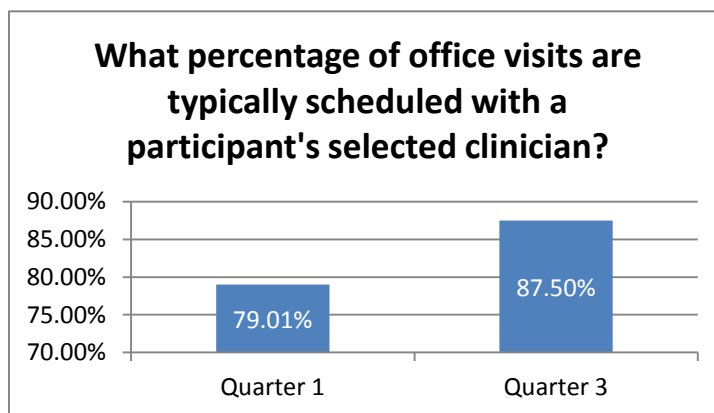
An alternative approach to assessing the cost of care is to compare the total cost to Medicaid of all care for the year prior to enrollment with the total cost to Medicaid of all care for the year following enrollment in a primary care health home. MoHealth Net analyzed total Medicaid cost for individuals enrolled for at least nine months between January 2012 and June 2013. These individuals accounted for a net savings of \$147.97 PMPM, over and above the \$60 average PMPM cost of the PCHH; or total savings to Medicaid of approximately \$2,000,000 compared to the cost of their care in the year prior to enrollment in a PCHH. The largest savings were noted in hospital outpatient and medical/professional categories.

VIII: PERFORMANCE/SYSTEM TRANSFORMATION

A. Quarterly Reports

All primary care health home sites are required to respond to a quarterly survey that was developed to ascertain how sites are doing in various areas of transformation into a health home that have been identified as hallmarks of a successful health home. Because PCHH provider organizations implemented health home services over a four-month period, data were available for only three complete quarters at the time of this report.

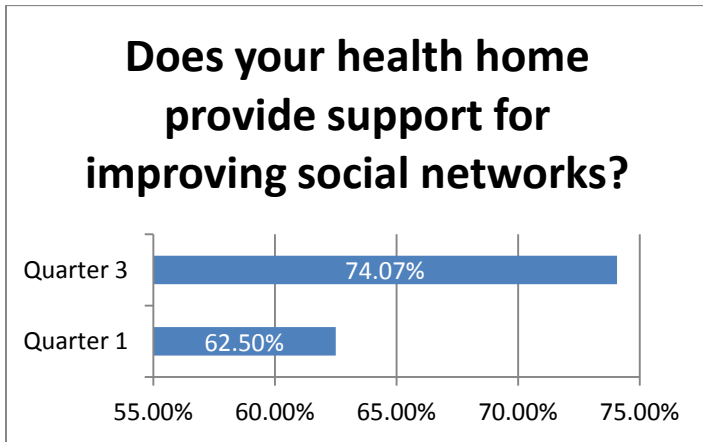
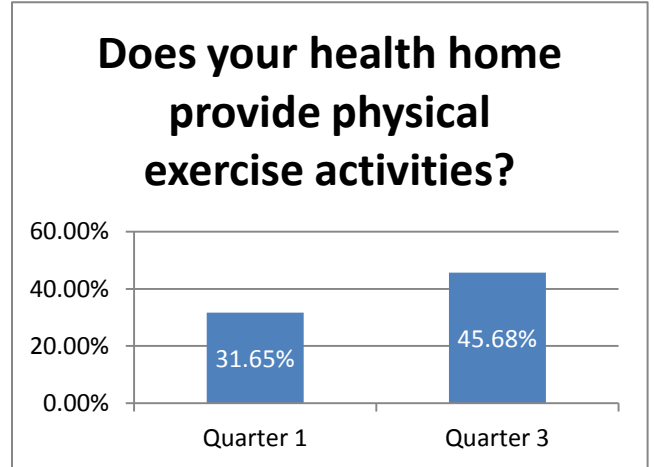
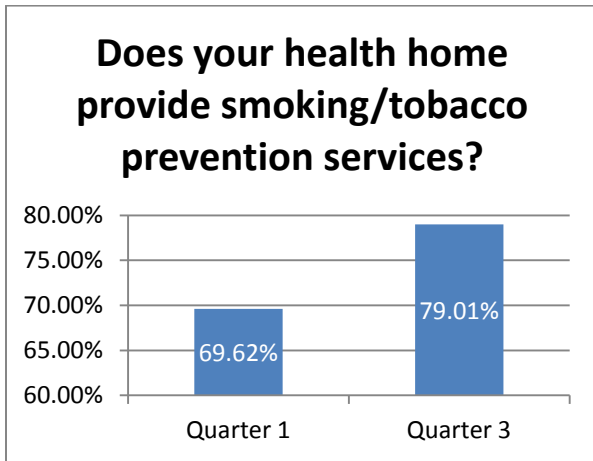
Results from third quarter surveys were compared with those from the first quarter. Overall, progress was noted in almost all areas. Some specific results are detailed below as examples of the types of information gathered in these surveys.



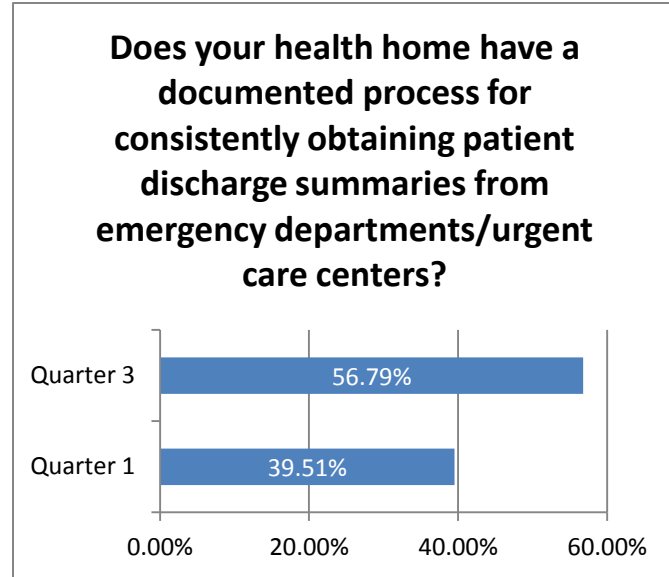
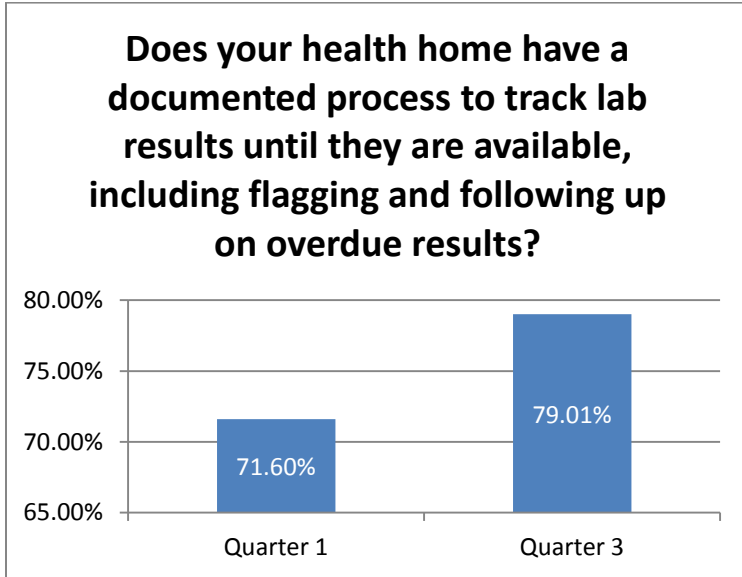
One major criteria for health homes is empanelment - the selection of a specific primary care provider. Although some of the organizations who are health home providers had already started the process of empanelment prior to the implementation of the health home initiative, many had not.

Accompanying the process of empanelment is the ability and capacity to actually schedule patient appointments with the selected clinician. You can see from the above chart that after the first quarter of operation, PCHH organizations reported that appointments were scheduled with selected clinicians 79 percent of the time. At the end of the third quarter, this percentage had increased to 87.5.

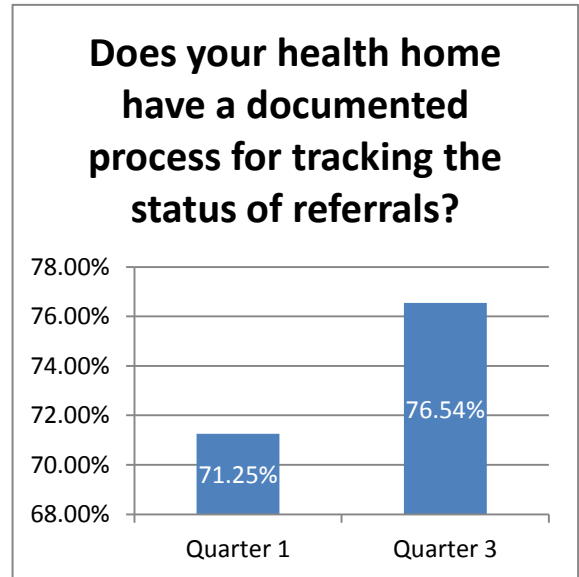
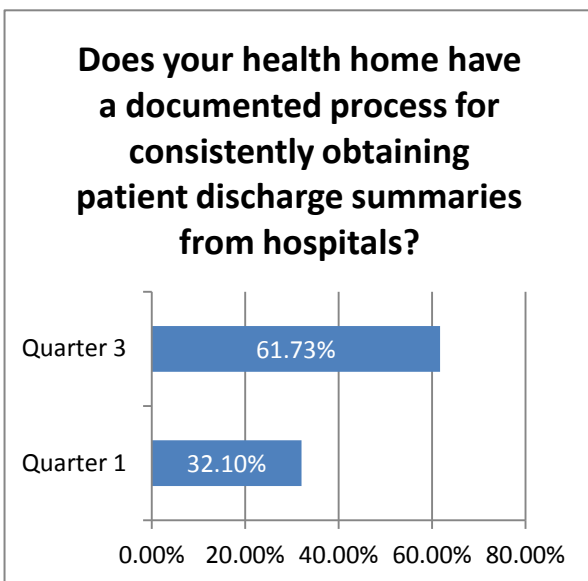
With the focus on comprehensive care management, health homes are encouraged to expand their available services beyond traditional health care. Below are some examples of these enhanced services, and the percentage of health homes offering these services has increased from the first quarter to the third quarter.



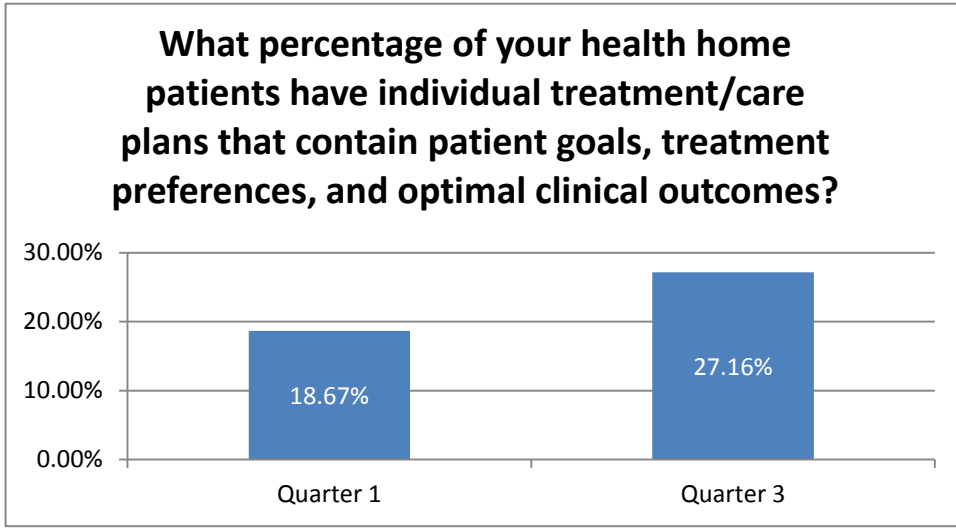
Another major function of comprehensive care management in the health home is following up on care provided outside the clinic. Two examples of this are tracking lab test results and tracking referrals. Below are graphs showing that health homes have reported increases from the first to the third quarters in both of these areas



Managing and coordinating transitions of care are important functions in a health home. Developing policies and processes to facilitate the flow of information for care transitions has been a challenge for PCHH providers. These two graphs show the progress they have made in establishing processes for obtaining discharge information from hospitals and emergency departments.



Participants who are actively engaged in a health home are more likely to show improved health status and reduced hospitalizations and emergency department visits. One way to engage participants is through involving them in developing goals and a care plan, and then following up with them to determine their progress in meeting their goals. This has also been a new concept for most PCHH providers, and has proven to be one of the most challenging. The graph below shows improvement among health homes in the percentage of their participants that have a care plan and goals, although this is one measure where we hope to see more significant improvement in future quarters.



IX. REIMBURSEMENT

A. Attestation

Health home providers have maintained an attestation rate (those for whom health home services were provided during the month) well above 90% throughout the course of the initiative. In April 2013, the average for all PCHH providers was 96.47%.

B. Per-Member-Per-Month Payment/Rejection Rates

The Primary Care Health Home initiative has seen an improvement in the percentage of enrollees that generate a per-member-per-month payment. In July 2012, PCHH providers were paid for an average of 84.31% of total enrollees. As of April 2013, this percentage had risen to 85.15%. The percentage of enrollees rejected for payment decreased correspondingly, from 15.69% in July 2012 to 11.32% in April 2013.

X: ACHIEVEMENTS AND LESSONS LEARNED

A. Accreditation

One of the requirements for organizations selected to participate in the PCHH initiative is to be recognized as a Person Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA). There are various levels of NCQA recognition, and PCHH requirements call for organization to:

i. Attain NCQA 2008 PPC-PCMH “Level 1 Plus” recognition, with meeting Level 1 Plus defined as meeting NCQA 2008 PPC-PCMH Level 1 standards, plus the following NCQA 2008 PPC-PCMH standards at the specified levels of performance (e.g., 3C at 75%, 3D at 100%, and 4B at 50%)

or

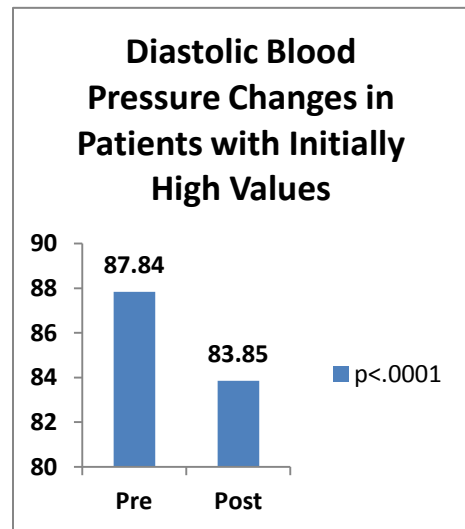
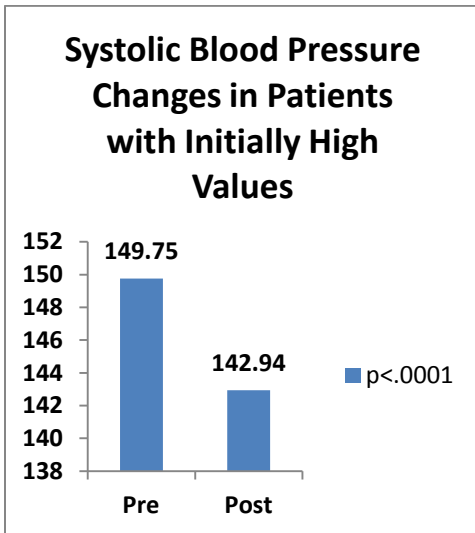
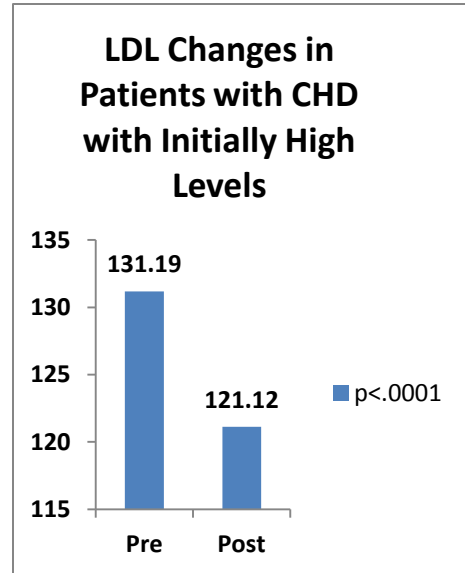
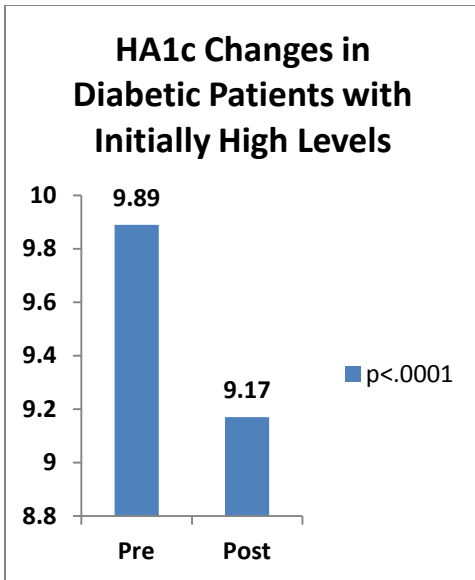
ii. Attain NCQA 2011 PCMH “Level 1 Plus” recognition, with meeting Level 1 Plus defined as meeting NCQA 2011 PCMH Level 1 standards, plus the following NCQA 2011 PCMH standards at the specified levels of performance (e.g., 3B at 100% and 3C at 75%). Minor deficiencies in meeting standards may be addressed through submission and approval by the state of provider plans of correction.

Six of the PCHH organizations had already achieved some level of PCMH recognition prior to the start of the initiative. Since the PCHH started, four organizations have had their sites recognized as Level 3 person-centered medical homes. Several have submitted their applications and are awaiting results. Others are currently working on the application process, and plan to submit by their deadline.

Providing valuable assistance in this process to PCHH organizations are practice coaches funded by the state's two health foundations, Missouri Foundation for Health and the Healthcare Foundation of Greater Kansas City, and the Missouri Hospital Association. Practice coaches have also helped with other areas of practice operations including patient flow, service documentation, EHR issues, etc.

B. Measuring Outcomes

Preliminary results have shown an improvement in several key clinical indicators, including hemoglobin A1C levels in participants with diabetes mellitus, LDL cholesterol levels in participants with heart disease, and both systolic and diastolic blood pressures in participants with heart disease. These improvements can be seen in the charts below.



Although improvements in clinical data have been noted, developing a seamless process for obtaining accurate and complete data has been one of the biggest challenges for the initiative, accompanied by the challenge of developing a common understanding with providers of data related issues and how to address them. After months of no or minimal data submitted on some of the measures, MO HealthNet teamed up with Missouri Primary Care Association to initiate a measures improvement project for the PCHH initiative. A webinar was held with all PCHH providers, and representatives from the organizations' administration, health home, and information technology were expected to participate. The goal of the project is to determine whether existing issues are the result of how data fields were set up, of data mapping errors, or of documentation/ workflow problems. Although this project was just recently implemented, it has already uncovered the source of several problems, and it is expected that clinical measures will show a marked improvement in the coming months.

XI: SUCCESS STORIES

The following are a few "testimonials" received from some of our primary care health home organizations on various types of successes they have experienced in the past year.

One of the participants in our health home was a 6 year-old female with diagnoses of asthma and obesity. We worked with her foster family, and as a result, she was able to lose 21 pounds, and has been able to stop all asthma medications. We were able to discharge her from the health home initiative because both diagnoses resolved.

A patient has shown tremendous success in managing her diabetes with the help of our diabetes education program. Her home glucose readings were extremely high; diet was not monitored, and she was not taking her medication and insulin as prescribed. With support from the care team, the patient is now meeting her glucose goals, keeping a log of her daily diet and is losing weight. She meets with the nurse educator every other week as a check in on her progress. It's amazing to see a non-compliant patient be able to manage their disease and make positive changes that affect their health.

We have a 15 year old girl who recently moved here from Florida. The climate change and allergens here caused her to constantly be in the yellow zone, near the red zone. We educated her and taught the correct technique for using her inhaler. She is currently on a controller and has not been in the office with an exacerbation in 6 months. She was in the green zone when we checked her asthma status at her last visit, which was for another problem.

A 61 year-old female with hypertension, hyperlipidemia, CVA, obesity, depressive disorder and anxiety was noted to have an LDL of 150.6 in December 2012. After medication, education and follow-up by the nurse care manager, the patient was noted to have an LDL of 107.2 in April 2013. She was also educated on low sodium diet and how to lower blood pressure - and improved BP results have also been noted.

A continuing success story is a 65 year-old diabetic male that we helped in the past to lower his Hg A1C from 9.4 in October 2012 to <7 in January 2013, and his LDL from 159.0 in October 2012 to 106 in January 2013. His quality of life continues to improve. He remains employed, but he has dental issues that need to be resolved in order to improve his diet. His NCM was able to find a way for him to have his teeth extracted at a cost he could afford. She also helped find assistance to get him dentures. He is very excited about this new phase in the improvement of his overall health.

A 38 year-old female with hyperlipidemia, hypertension and diabetes had an Hg A1C of 14.0 in February 2013. After starting medications and education, accompanied by monthly follow-up by NCM, her A1C in May 2013 was 6.4. She states, "I have so much more energy and I feel great!"

A 14-year old female with uncontrolled Type 2 diabetes had an Hg A1C of >14 in October 2012. After starting medication, receiving education, and monthly follow-up by NCM, her A1C was 6.8 in April 2013.

A 28 year-old female with Type 2 diabetes, morbid obesity, hyperlipidemia, and hypertension met with a NCM for diabetes and nutritional education in November 2012. She was very discouraged about not being able to lose weight. The NCM encouraged exercise and carbohydrate counting, and also referred her to the behavioral health consultant for help with weight loss as well as depression. Her A1C has gone from 7.0 to 6.3, her LDL from 87.2 to 75, and her weight from 354 to 346. Even though she is still struggling with her weight loss, she is determined to succeed - and her overall demeanor is much improved since the first contact with her.

The following is an excerpt from a letter written by a health home participant about his nurse care manager: *[NCM] has served as a liaison for my health care and wellness programs offered through [health home provider]. She has provided invaluable help and support. On several occasions, she has assisted me with getting in quickly to see the doctor when appointments were booked up. She has checked in with me on general health care needs. I felt supported and like I was receiving quality attention and care. [NCM] has directed me to several wellness programs. These include smoking cessation, pulmonary rehab, and a wellness program using nutritionists, trainers, and access to a gym for rehabilitation. This has literally changed my life. Prior to this I really had no idea how to help myself get better, how to exercise safely and lose weight, considering the limitations of my disability issues. I see my potential for feeling better and being healthier for the first time because of the programs [NCM] has directed me to. My quality of life has improved immensely. This was my ultimate goal. With her help, I have been able to accomplish that goal, and continue to move forward through the process. In the past I would have quit, simply because I didn't know how to proceed.*