Health Home Models of Care Primer

Context

Behavioral Health Providers are continually searching for ways to meet the Triple Aim (improving the patient experience of care, improving the health of populations, and reducing per capita cost of health care) by implementing new models of integrated care. There is a plethora of accreditations, certifications, and federal regulations that can quickly become confusing and overwhelming for providers. The following distills information from four potential models that can inform integrated care efforts and help clarify which model may be the best fit for an organization:

- Patient Protection and Affordable Care Act (ACA) Section 2703 Health Homes, including the MDHHS State Plan Amendments of 2014 and 2016
- National Committee for Quality Assurance (NCQA) Patient-centered Medical Homes
- NCQA Primary Care Specialty Practices
- CARF Health Home

Defining Terms:

Health homes are specifically for Medicaid beneficiaries with chronic illnesses. Health homes must provide six core services via an interdisciplinary care team.

Patient-centered medical homes are physician-led with a primary care focus. Care coordination and communication are cornerstones of this model, which is structured around six primary functions.

Health Homes – Overview

States have been able to include health homes within the State Plan benefit due to The Affordable Care Act of 2010, Section 2703. Health homes are for people with Medicaid that:

- Have two or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

Some states have up to eight Health Home models[1] to address multiple populations. Chronic conditions may include mental health, substance abuse, asthma, diabetes, heart disease and being overweight. The six core health home services include:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care/Follow-Up
- Patient and Family Support
- Referral to Community and Social Support Services

[1] For summary of programs by state click here

Health home services are to be provided by interdisciplinary teams that may include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, etc. A significant amount of flexibility is provided regarding the design of the health home. The care team may be based in primary care or behavioral health providers' offices, coordinated virtually, or in other settings that meet the needs of those served.

Under a 2703 Health Home model, states receive a 90% enhanced Federal Medical Assistance Percentage (FMAP) for the six core health home services identified above. Health Homes may claim one 8-quarter period of enhanced FMAP for each Health Home enrollee[2].

Similar to requirements for Certified Community Behavioral Health Clinics, health homes are required to collect and report on various performance measures. CMS has identified a core set of Quality and Utilization Measures for health homes. CMS aligned all but one of the health home core set of measures with the initial core set of health care quality measures for Medicaid-eligible adults.

Health Home Core Set Measures

NQF #	Measure Steward	Measure Name
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
0018	NCQA	Controlling High Blood Pressure (CBP)
0418	CMS	Screening for Clinical Depression and Follow-Up Plan (CDF)
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)
0648	AMA-PCPI	Care Transition-Timely Transmission of Transition Record (CTR)
1768	NCQA	Plan All-Cause Readmission Rate (PCR)
NA	NCQA	Adult Body Mass Index Assessment (ABA)
NA	AHRQ	Prevention Quality Indicator: Chronic Conditions Composite (PQI92)

Health Homes Utilization Measures

NQF #	Measure Steward	Measure Name
N/A	NCQA	Ambulatory Care-Emergency Department Visits (AMB)
N/A	CMS	Inpatient Utilization (IU)
N/A	CMS	Nursing Facility Utilization (NFU)

[2] For additional information regarding Health Homes (eligibility, services, financing, etc. contact healthhomes@cms.hhs.gov or visit here.

Health Homes in Michigan

The 2014-2015 Michigan Executive Budget included a Medicaid Health Home Pilot starting July 1st, 2014 (*see State Plan Amendment #14-0008*). Community Mental Health Service Providers (CMHSPs) within Manistee County, Grand Traverse County, and Washtenaw County are designated as health homes. The population eligible for Michigan's health home benefit under this amendment must have a serious and persistent mental health condition with high rates of hospital inpatient or emergency department use. Beneficiaries may also have co-existing chronic physical health conditions.

- *Staffing*: CMHSP health homes much employ a health home director, primary care liaison (may be a Michigan licensed physician, physician assistant or nurse practitioner) and nurse care managers (RNs).
- *Team Approach*: Multi-disciplinary team delivers evidenced based clinical management and self-management support
- *Beneficiary Involvement*: Meaningful and informed involvement by individuals served in their care
- *Clinical Information System*: Use of health information technology (such as patient registries) to provide reminders to patients, provide decision support, and access information about a beneficiary or a group of beneficiaries. Use of data including disease registries, clinical care protocols, care alerts, etc.
- *Planned Care*: Use of patient data to identify needs and organize the team to meet those needs, care is directed by individual care plans, etc.
- *Health Information Technology*: Use of an electronic health record, health information exchange, and care management tools and resources made available by MDHHS.
- *Coordinated Care*: Establish protocols with external health care partners, use of legally compliant data sharing agreements, provision of transitional care, etc.
- *Assessment and Screening*: Use of screening tools for chronic illness, SUD, mental illness, medication use, and prevalent risk factors. Comprehensive health assessment of physical health, behavioral health, and long-term services and supports.

Another amendment in Michigan (*see State Plan Amendment #15-2000*) marks the start of a new health home pilot to focus on individuals with a mild/moderate behavioral health condition and at least one or more chronic conditions (asthma, diabetes, chronic obstructive pulmonary disease, heart disease, or hypertension) served by Federally Qualified Health Centers (FQHCs) and/or Tribal Health Centers (THC) within the following counties: Bay, Genesee, Houghton, Huron, Iron, Kalamazoo, Kent, Lapeer, Lenawee, Macomb, Marquette, Menominee, Monroe, Montcalm, Montmorency, Oakland, Ontonagon, Presque Isle, Saginaw, Shiawassee, and Wayne. This program was effective July 1st 2016. These health homes are required to meet the following eight standards:

- *Enrollment/Recognition/Certification*: Enrolled in Michigan's Medicaid program and achieve PCMH recognition from a national recognizing body.

- *Personal Care Team*: Care teams will include a primary care provider (physician, physician assistant, or nurse practitioner), behavioral health consultants, nurse care manager, community health workers, and health homes coordinator.
- *Whole Person Orientation*: Arrange care for all stages of life: acute care, chronic care, preventative services, long term care and end of life care. Use of person centered planning.
- *Coordinated/Integrated Care*: Provide care coordination, preventative services, and health promotion. Directly provide or use of a contracted provider for:
    - Behavioral health
    - Oral Health
    - Chronic Disease Management
    - Long Term Care and Supports
    - Recovery Services
    - Health Management Behavior Modification Interventions
    - Outreach and Referral System with local Health Systems
    - Transitional Care
    - Medication Reconciliation
    - Assessment of Other Social Needs
    - Referrals Tracking System
- *Emphasis on Quality and Safety*: Demonstrates use of clinical decision support, use of population health management tool, use of formal screening tools, establishes continuous quality improvement program, etc.
- *Enhanced Access*: Provide for 24/7 access to the care team, same day scheduling availability and use of open access, use of email, text messaging and patient portals, etc.
- *Health Information Technology*: Use of EHR, provider must have achieved Meaningful Use Stage 1, use of technology to link services and facilitate communication between patient and care team, ability to electronically report services and outcomes, etc.
- *Health Homes Team*: Participate in MDHHS health home related activities and trainings, commit a management staff member and a clinician champion to serve on the care team at participating sites, etc.

NCQA Recognition - Patient Centered Medical Home

NCQA Patient Centered Medical Home (PCMH) is a model of care that emphasizes care coordination and communication to transform primary care. Only certain practices are eligible for PCMH status. The majority of PCMHs are primary care practices providing the entire spectrum of whole-person, team-based care that is coordinated or integrated across the health care system. Specialty/subspecialty practices can qualify if the practice can demonstrate that it provides the required elements for the majority of its patients (at least 75%).

PCMHs are structured around six primary functions:

- *Patient-Centered Access*: Offering same-day appointments, providing services outside of regular business hours, offering telephone/video chat or secure instant messages between provider and patient, 24/7 access to clinical advice, electronic access for patients to health information, etc.
- *Team-Based Care*: Holding scheduled patient care team meetings, care team includes multiple disciplines, etc.
- *Population Health Management*: Use of problems lists, collecting structured data on a variety of health status items, use of data to identify populations of patients and remind them of needed care, use of evidence-based decision support, etc.
- *Care Management and Support*: Implementation of a process for identifying patients that will benefit from care coordination, development of individual care plan, etc.
- *Care Coordination and Care Transitions:* Completing medication reconciliation, use of electronic prescribing, support self-care and shared decision making, track lab test and results, referral tracking and follow-up, exchange of key clinical information at time of transition, etc.
- *Performance Measurement and Quality Improvement*: Collects and tracks performance on numerous measures such as immunization measures, preventative care measures, chronic or acute care measures, care coordination measures, and measures affecting health care costs. Also measures patient/family experience of care, implements QI activities, achieves improved performance on selected QI measures, produces performance data reports for clinician and practice-level performance, uses certified electronic health record (EHR) technology, etc.

NCQA Recognition - Patient Centered Specialty Practice (PCSP)

For those clinics that do not meet the PCMH criteria, the Patient-Centered Specialty Practice (PCSP) Recognition may be more appropriate. Those practices that demonstrate access, communication, and care coordination can serve as partners that work closely with the primary care medical home.

PCSPs are structured around the following six required activities:

- *Working with Primary Care and Other Referring Clinicians*: Managing initial referrals, assessing initial referral response, the practice has agreements with a subset of primary care providers and set expectations for information sharing and patient care, sets expectations and monitors those expectations to confirm receipt of needed information for referrals, has a documented process for transitioning co-managed patients back to primary care, implementation of a process for connecting self-referred patients with primary care clinicians, etc.
- *Provide Access and Communication*: Provide same day appointments, provide timely clinical advice to patients whether office is open or closed, electronic access to health information for patients, capability to send secure messages, have regular team meetings focused on patients, training and assigning members of care team to coordinate care for patients, etc.
- *Identify and Coordinate Patient Populations*: Use of up-to-date problem lists, collection of various health screening/assessments as structured data, implement evidenced-based reminders for specialty care, implement evidence-based decision support, etc.

- *Plan and Manage Care*: Provision of care management and self-care support for practice-specific conditions, develops plan of care with patient and family/caregiver, uses EHR to provide patient-specific resources to patients, completes medication reconciliation, coordinates medication management with primary care provider, use of electronic prescribing, etc.
- *Track and Coordinate Care*: Requests and tracks receipt of test results from primary care provider and referring clinician, provides primary care provider and referring clinician with results of relevant tests, tracks lab tests until results are available, tracks referrals and follows-up to obtain specialists' report, ensures primary care provider and referring clinician are notified of secondary referral results, implements a process for identifying patients with a hospital admission or emergency department admission, electronically submits summary-of-care record to another setting, etc.
- *Measure and Improve Performance*: Setting goals and acting to improve on at least three clinical quality or UM measures, collects data on at least three clinical measures, coordination of care results, at least two utilization measures, and timely access to care; conducts a survey to evaluate patient/family experience, shares performance data by individual clinician and across the practice, uses a certified EHR technology, etc.

The process to achieve these recognitions can take 6-16 months to complete and does involve survey fees[3]. The survey fees vary depending on the number of clinicians[4] and sites.

CARF Health Home - Accreditation

This accreditation consists of standards that require organizations to coordinate the full spectrum of services, including prevention, wellness promotion, behavioral healthcare, and long-term community-based services and supports. A CARF survey can be completed once an organization demonstrates six months of compliance with the standards. The cost is not published on their website but interested organizations can contact them here.
Health Homes serving individuals receiving behavioral healthcare provide:

- Screening
- Evaluation
- Crisis Intervention
- Medication Management
- Psychosocial Treatment and Rehabilitation
- Care Management
- Community Integration

[3] The survey fees vary depending on the number of clinicians and sites. For single clinic sites, pricing ranges from $550 (one clinician) to $6,600.00 + $55.00 per clinician (13+ clinicians). For multi-site clinics, pricing ranges from $1600.00 (3-5 sites) to $12,600 (51 sites) plus 50% of the survey fees noted above. For additional pricing detail, please visit this site.
[4] For PCMH, clinician is defined as a doctor of medicine (MD), doctor of osteopathy (DO), advanced practice registered nurse (APRN) or physician assistance (PA). For PCSP, eligible clinicians also include the following behavioral healthcare practitioners: psychiatrists, psychiatric nurse practitioners, doctoral or master's-level psychologists, clinical social workers, marriage and family counselors, or alcohol and drug counselors who are state certified or licensed.

This accreditation is based on 20 standards of care[5]. There is significant overlap between the NCQA PCMH and PCSP requirements and the CARF Health Home standards. However, the NCQA standards are far more explicit. Another primary difference is that PCMHs are primary care centric, while the CARF Health Home promotes a healthcare delivery approach that integrates primary care and behavioral healthcare with an emphasis on treatment of behavioral health needs and recognition of general medical/physical concerns with appropriate follow-up.

This primer focused on CARF accreditation as the majority of Community Mental Health Service providers in Michigan are currently CARF accredited, however, there are other national health home accreditations available through the Joint Commission[6] and Accreditation Association for Ambulatory Health Care, Inc. The standards are similar to the CARF Health Home standards and thus are not repeated in this primer.

Next Steps

This summary is just a brief introduction to each of the models of care and related national standards. When a provider organization decides to pursue one of these models, leaders should consider the following options:

- Interview staff from current Michigan SPMI Health Homes to learn more about their experience
- Review and analyze population health data from Community Commons, Care Connect 360 or other sources to identify specific at-risk populations within their catchment area which would benefit from one of these emerging models. It is critical to identify the specific health conditions and/or specific target population within the community when making a decision about the care model which is best aligned to address the identified issue.
- Completion of a gap analysis comparing current practice and staffing models with selected national model(s) of care.
- Continue to pursue pilots of integrated care models (for service delivery and financing) consistent with the State's direction, which is dictated in part by the Final Report of the 298 Facilitation Workgroup.
- Adopt metrics that are consistent with those required in the models described above and/or the metrics identified in the Final Report of the 298 Facilitation Workgroup (Appendix 17). Engage in public reporting of performance on selected measures.
- Identify partners (primary care providers, health plans, hospital systems, public health, etc.) that are invested in creating an integrated system of care to improve the health of the community.

[5] 2013 Health Home Standards can be found here, for 2016 standards purchase a CARF manual here

[6] Joint Commission Behavioral Health Home: Summary of Standards, Health Home Brochure