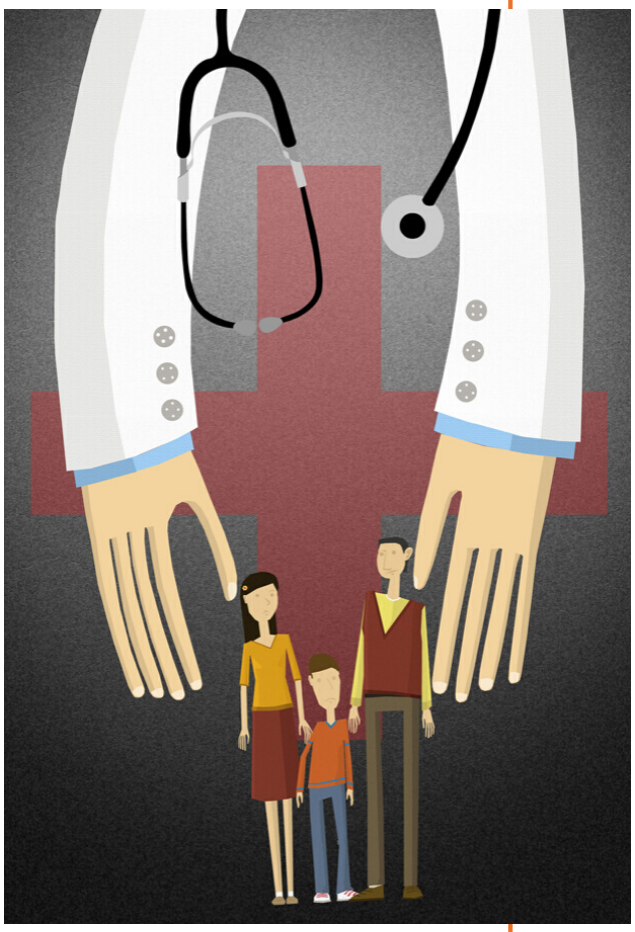
JANUARY 2018-JUNE 2019

PRIMARY CARE HEALTH HOME (PCHH)

MoHealth Net

UMSL | MIMH
Missouri Institute of Mental Health

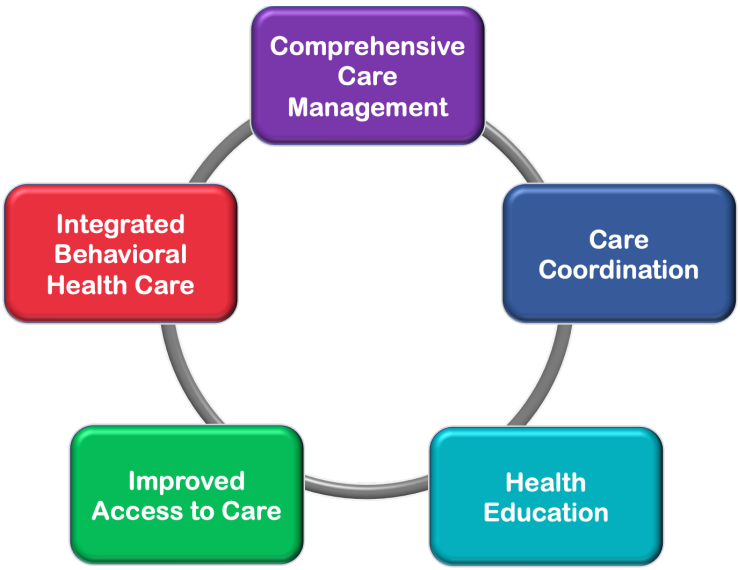
MPCA
Missouri Primary Care Association



Executive Summary

The PCHH began in January 2012, and has been in operation for 7 years and 6 months

PCHH Services



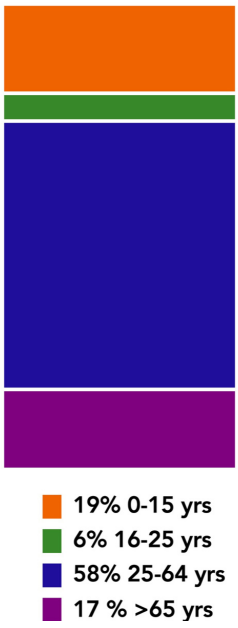
The PCHH saved over $160 Per Member Per Month in 2018

36,626 enrolled at least 1 month through July 2019

29% enrolled in 2019 for first time

10% in PCHH>5 years

Age of 2019 Enrollees



Executive Summary

CLINICAL IMPROVEMENTS

Cholesterol Levels

19%

Blood Pressure Levels

12%

A1c

1.73 points

Weight Loss

20.5% lost 10%+ body mass

REDUCTIONS IN UTILIZATION

Emergency Department (ED) Visits

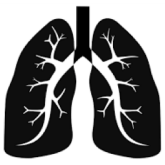
35%

Hospitalizations

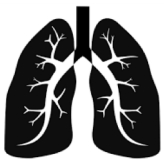
25%

Prevalence of chronic conditions is much greater in the PCHH compared to the general population.

Asthma 3.5X Adults



Asthma 6X Kids



Substance Use 2X

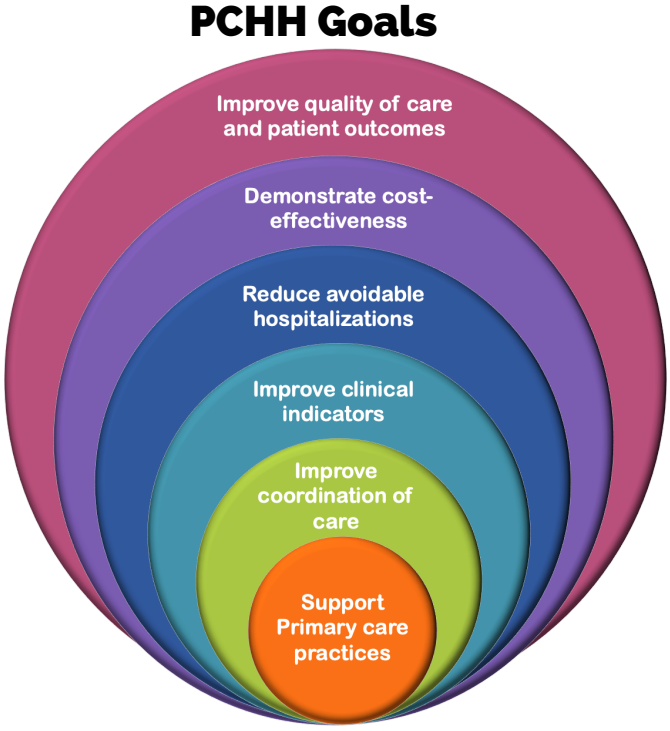
Diabetes 3.5X

Hypertension 2X

Why are Health Homes Important to MO HealthNet and MISSOURI

- **Health Homes provide care to individuals in MO with chronic health conditions that are associated with**
  - **High mortality rates, overuse of ED and inpatient settings**
  - **Disproportionately high Medicaid costs**
- **PCHH addresses these issues through**
  - **Integrated physical/behavioral health care**
  - **Provision of clinical training, technical assistance, and practice coaching in policy development and utilization management**
  - **Data sharing to better manage and report on Medicaid costs, to report outcomes/cost of care, and to influence policies and utilization management**

- **Will inform Missouri's Transition to Value-Based Care across the State**



PCHH PROVIDER BREAKDOWN

	2012	2016	2017	2018	Jul-19
Participants enrolled*	22,586	28,790	30,878	31,234	36,626
FQHCs	18	21	23	24	27
Hospital-affiliated organizations	6	9	9	9	11
Independent primary care clinics	0	2	3	3	4
Local public health departments	0	0	0	0	1
Total organizations	**24**	**32**	**35**	**36**	**43**
Total clinic sites				**134**	**172**

*Includes any enrollee who had at least 1 attestation in year shown.

Currently 40+ of the 170+ total clinic sites participaing in PCHH are designated rural health clinics.

Health Home Organization Qualifications

- **Minimum of 25% (site-specific) of population covered by MO HealthNet or uninsured**
- **Develop/maintain a health home capable of overall effectiveness**
- **Have strong engaged leadership**
  - **Medical director**
  - **Physician champion**
  - **Administrators**
- **Information technology**
- **Empanelment for providers**
- **Use CyberAccess for care coordination**
- **Interoperable patient registry (e.g. for tracking and measuring care, automated reminder, and exception reports)**

How does it happen?
Staffing of PCHH

Director

- Ensures day to day operations of PCHH are completed
- May also hold another PCHH role
- May have other responsibilities within an organization
- Advocate for PCHH within the organization

Nurse Care Manager

- Most intensive role
- Primary point of contact for PCHH participants
- Provide education and support to participants and family members
- Develop care plans with participants
- Responsible for hospital and ED discharge follow-up and medication reconciliation
- Advocate for PCHH within the organization
- May also hold another PCHH role

Behavioral Health Consultant

- Focus on behavioral interventions to improve chronic physical conditions
- Make contact with participants and support PCHH team
- Provide education about behavioral health conditions to staff and participants
- May have other roles within the agency

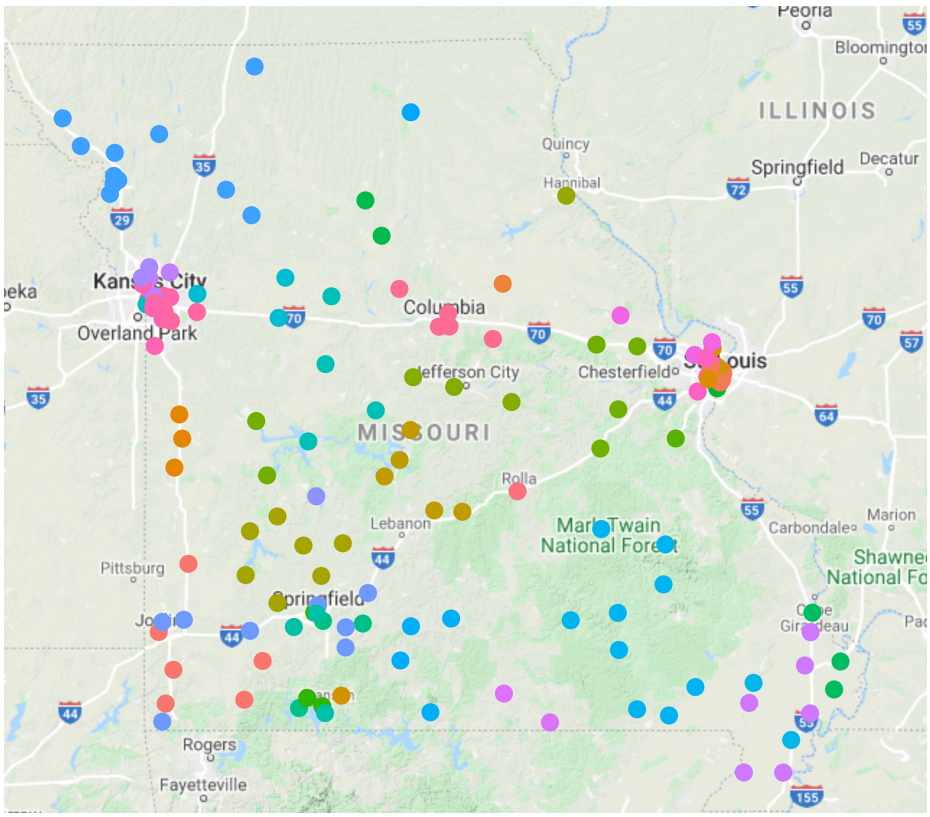
Care Coordinator

- May support the PCHH team in all administrative activities associated with participation in the PCHH
- May also serve as a referral coordinator or in more of a community or participant support role

Physician Champion

- Supports PCHH program with all clinical providers
- Reviews performance measures and helps troubleshoot workflow issues
- Helps develop and guides PCHH policies and protocols

PCHH Clinic Locations



- Access Family Care
- Affinia Healthcare
- Author Center
- Bates County Memorial Hospital
- Betty Jean Kerr Peoples Health Centers
- Bridges Medical Services
- Care StL
- Central Ozarks Medical Center
- Childrens Mercy Hospital
- Citizens Memorial Healthcare
- Clarity Healthcare Preferred Family Health
- Community Health Center of Central Missouri
- Compass Health Wellness
- Contera Community Health
- Cox Health
- Family Care Health Centers
- Family Health Center of Boone County
- Ferguson Medical Group St. Francis Medical Center
- Fitzgibbon Hospital
- Fordland Clinic
- Great Mines Health Center
- Jordan Valley Community Health Center
- Katy Trail Community Health
- KC Care Clinic
- Livewell Community Health
- Managed Care Inc.
- Missouri Delta Medical Center
- Missouri Highlands Health Care
- Missouri Ozarks Community Health
- Northeast Missouri Health Council
- Northwest Health Services
- OCH Health System
- Ozarks Community Health Center
- Priority Care Pediatrics LLC
- Samuel U Rogers Health Center
- Southeast Missouri Health Network
- Southern Missouri Community Health Center
- SSM Cardinal Gelnnon Danis Pediatrics
- SSM Cardinal Glennon Pediatrics
- SSM Internal Medicine
- SSM Pediatrics
- St. Louis County Department of Public Health
- Swope Health Services
- Truman Medical Centers
- University of Missouri Health System
- Your Community Health Center

PCHH Eligible Conditions

Combination Diagnoses

Participants must have 2 of these chronic conditions, or have 1 of these chronic conditions *and* be at risk for another of these conditions.

- Asthma / COPD
- Developmental Disabilities
- Tobacco Use
- Overweight (BMI ≥ 25 or 85th percentile)
- Cardiovascular Disease, including: hypertension, dyslipidemia, congestive heart failure

Behavioral Health Conditions

Only 1 of these behavioral conditions may count towards the minimum of 2 chronic conditions needed to qualify.

- Anxiety
- Depression
- Substance Use Disorder+

Stand-Alone Diagnoses*

These conditions are the exception, and only 1 of these conditions are needed to qualify.

- Obesity (BMI ≥ 30 or 95th percentile)
- Chronic Pain#
- Pediatric Asthma
- Diabetes

PCHH Patient Eligibility Criteria

- MO HealthNet eligible
- Not on hospice
- Not living in a skilled nursing facility
- PCHH organization must be PCP for enrollee
- Not enrolled in another PCHH or CMHC Health Home
- Meet spend-down and / or pay any premiums due
- Have required qualifying diagnoses / conditions / risk factors
- Have at least $775 of MO HealthHet-paid costs in the 12 months prior to enrollment

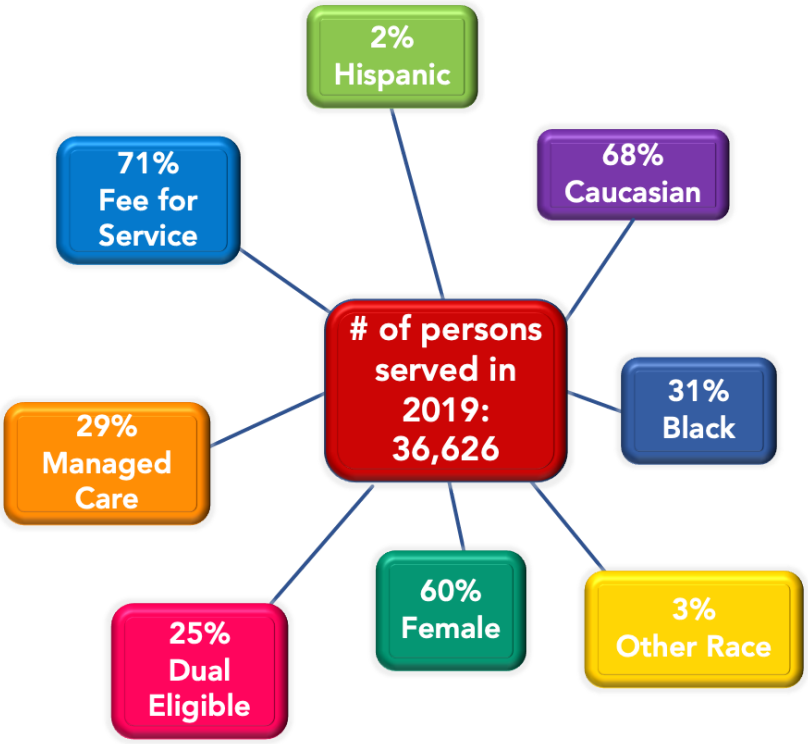
A Note on Chronic Pain

Chronic Pain is pain that lasts past the time of normal tissue healing. Risk stratification for severity of pain, as well as for worsening condition and/or opioid dependency will be incorporated into eligibility. Qualified participant eligibility shall be limited to chronic non-cancer neck and back pain, chronic pain post trauma, (i.e., motor vehicle collision), and others as determined medically necessary through a prior approval process.

The criteria for the risk of developing another chronic condition includes chronic pain that can lead to other problems in individuals, such as substance use disorder, overweight/obesity, depression, anxiety, or low self-esteem.

* stand-alone conditions, must also meet eligibility criteria; +must have at least one provider certified to provide medication-assisted treatment; #must have board certified pain management specialist on staff or available via contractual arrangement OR regularly participate in the pain management ECHO sessions

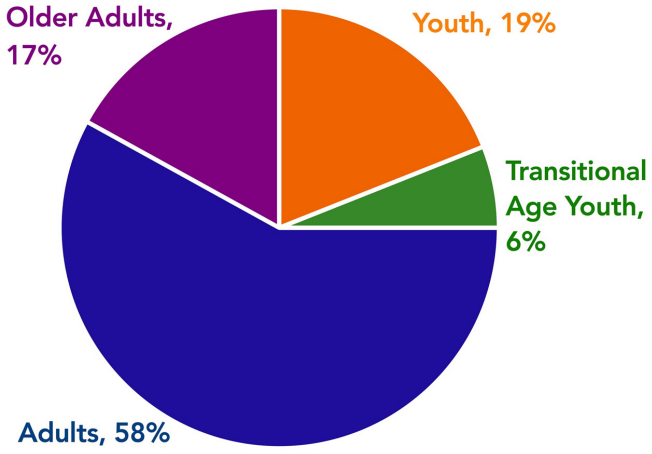
POPULATION



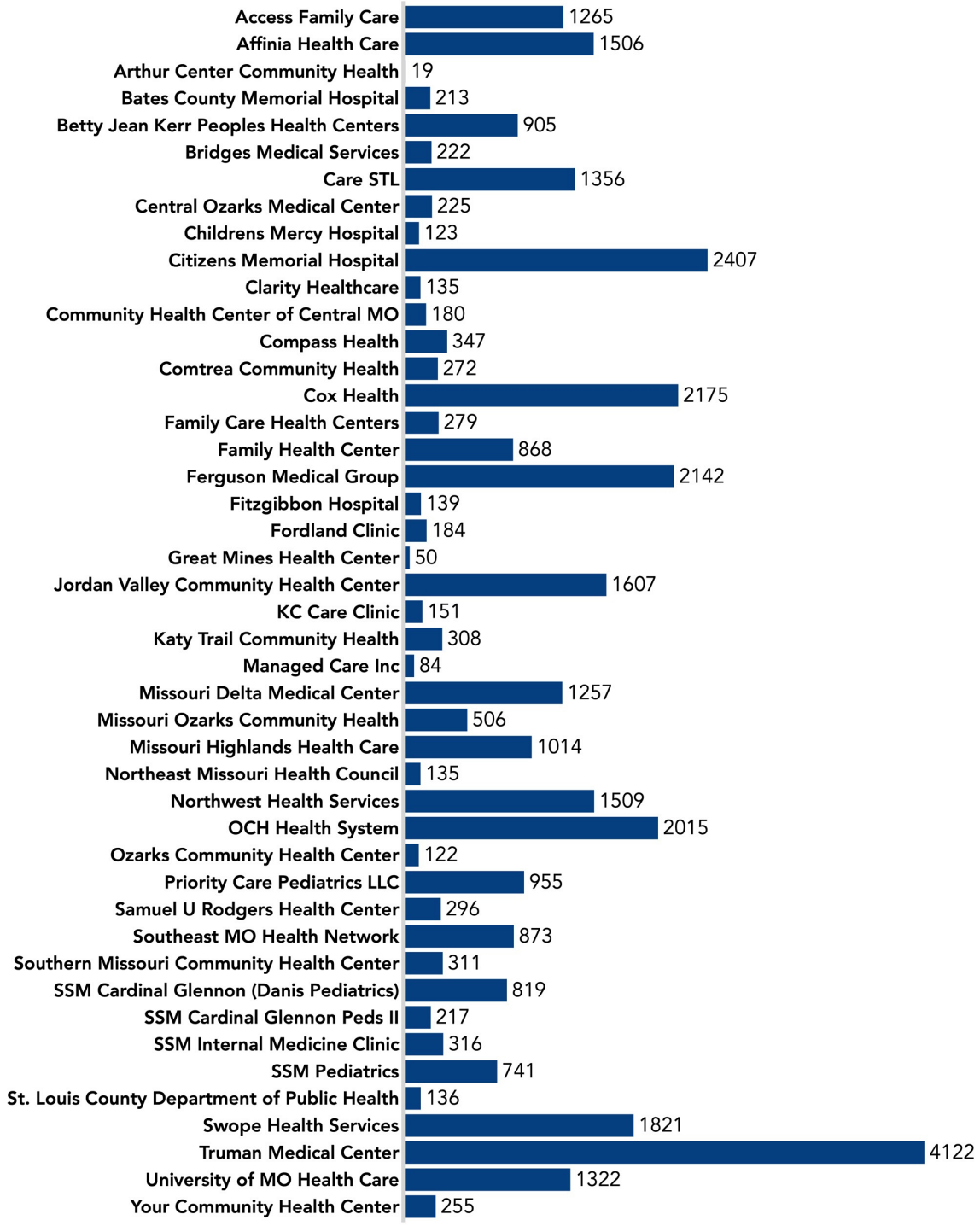
The number of people served in FY2019 includes all individuals who had at least one attestation as of June 2019. Percentages are based on the # of persons served.

Age of FY2019 Enrollees

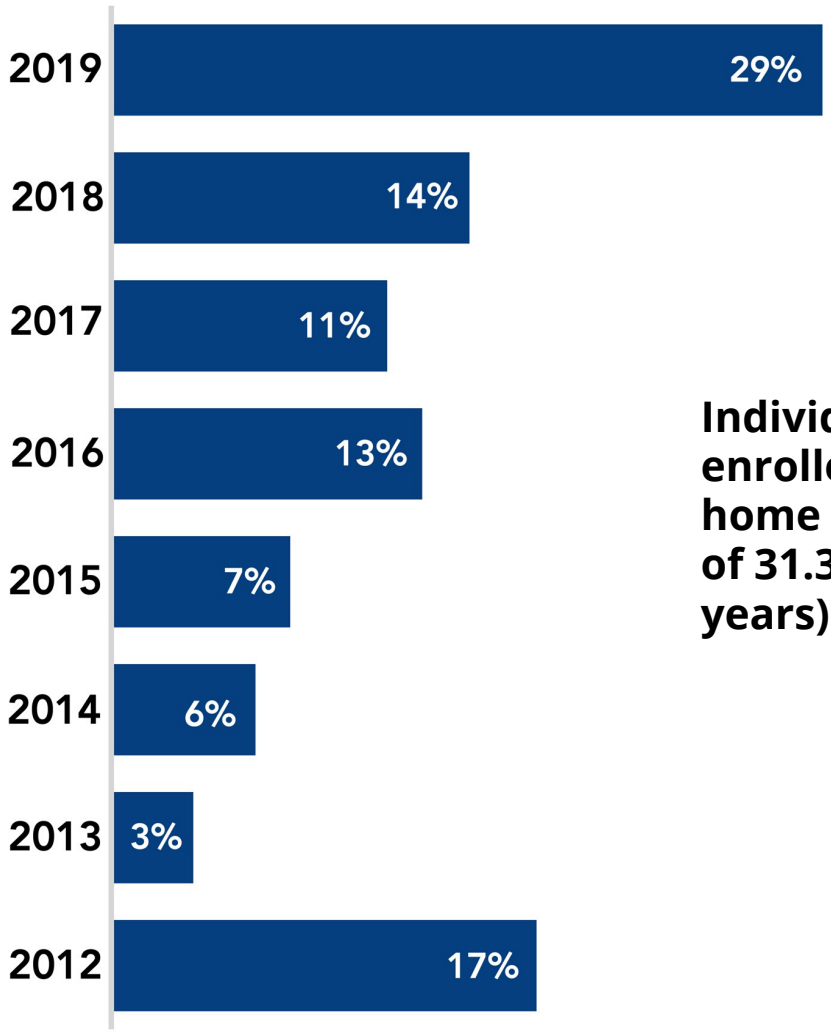
Youth includes children between the ages of 0-15. Transition age Youth are between the ages of 16-25. Adults are ages 26-64. Older adults are ages 65 or older.



NUMBER OF PARTICIPANTS BY AGENCY



Percent of enrollees by year of enrollment



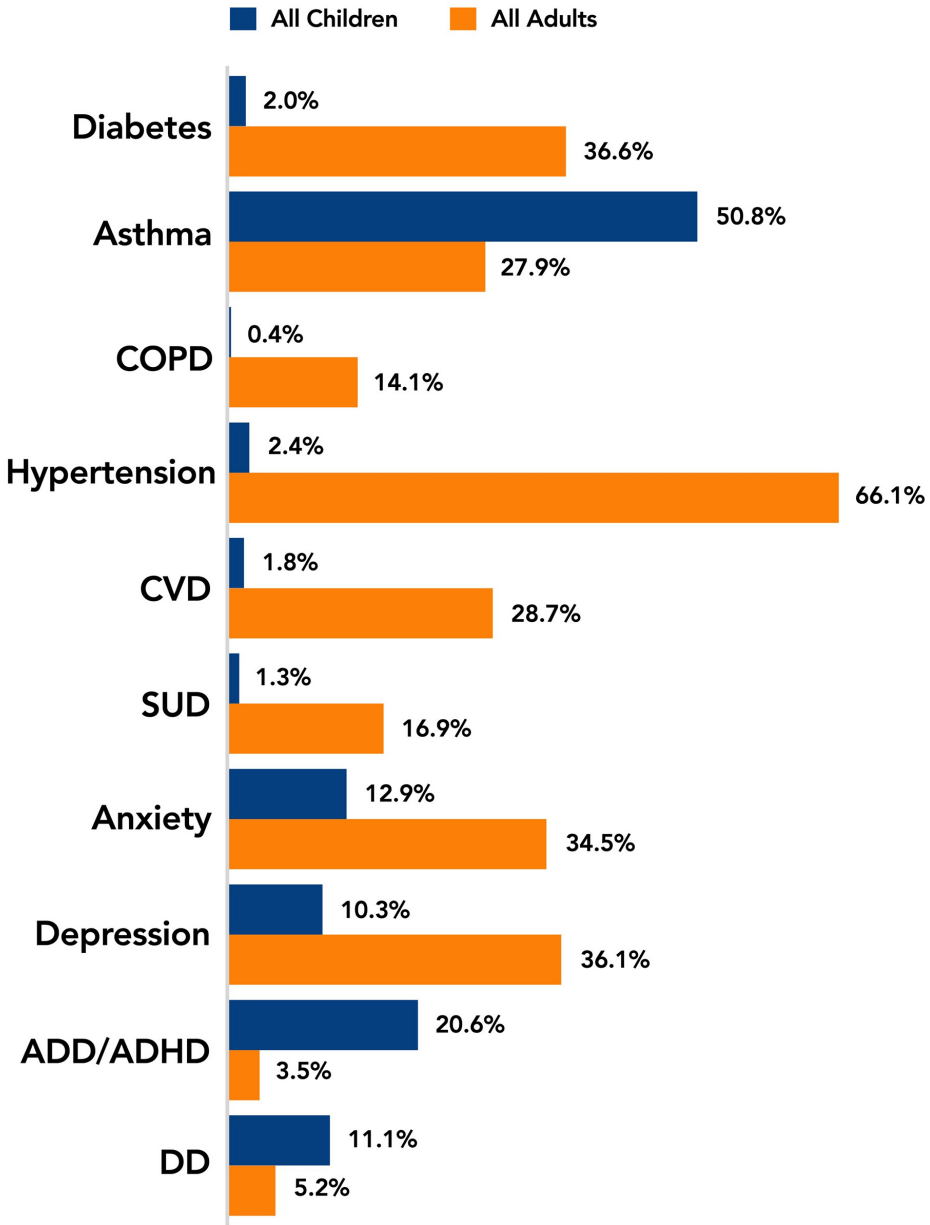
Individuals have been enrolled in a health home for an average of 31.3 months (2.6 years).

The majority of participants in the population represented were new to the PCHH in 2019. The second largest group represented in this report had their first attestation in 2012, the year the Health Homes began. The year of enrollment is based on the first date a person was ever engaged in a health home, and may have had breaks in the time they were participating in the PCHH, or may have been previously enrolled with a Health Home operated by Missouri Community Mental Health Centers or Certified Community Behavioral Health Organizations. Participants can only be enrolled in one Health Home at a time to reduce duplication of services.

Prevalence: Chronic Health Conditions

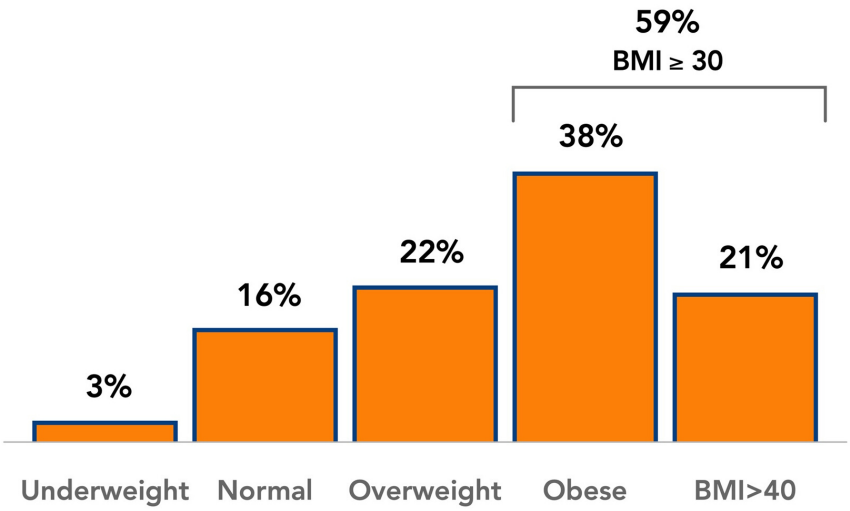
Most PCHH enrollees have ***three or more*** chronic health conditions or risk factors identified by their agency prior to their enrollment.

Hypertension is the most common condition/risk factor for adults.
Asthma is the most common condition for children (under 18 years).



BMI- for adults

Obesity is a risk fact
development of a numbe
conditions. Nearly *60% o*
participants have a BMI
BMI is a difficult measu
significant change. How
of every 5% of body ma
clinically meaningful i
metabolic function. *



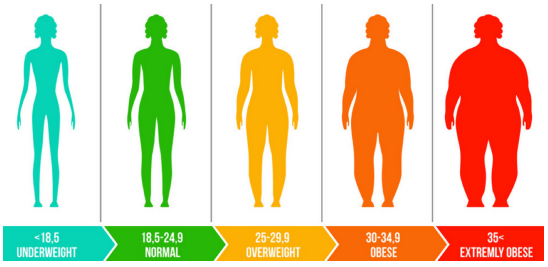
Modest Weight Reduction

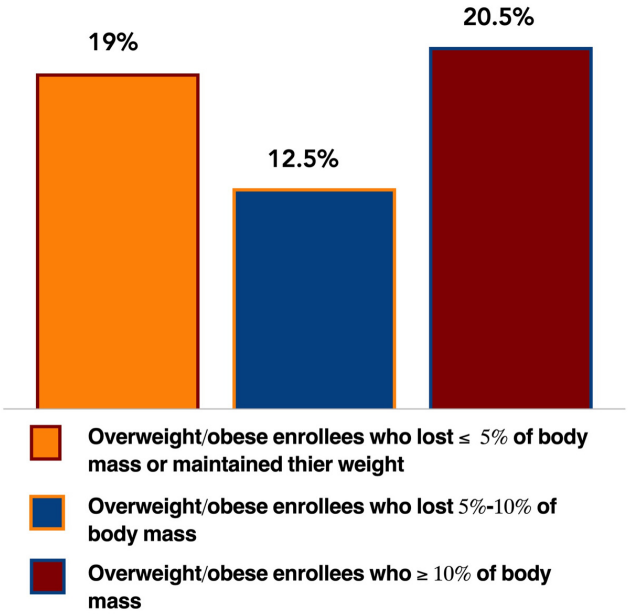
- ↓ 5% - 10% of total body weight

  leads to
- ↓ in blood pressure
- ↓ in cholestrol
- ↓ A1c**

Reducing Weight and Body Mass

In patients who were overweight or obese at the first reading, and had at least 2 readings for comparison, *20.5% of patients lost 10% or more body mass,* 12.5% lost 5%-10% body mass, and 19% lost less than 5% or maintained their weig





*Effects of Moderate and Subsequent Progressive Weight Loss on Metabolic Function and Adipose Tissue Biology in Humans with Obesity. Magkos F, Fraterrigo G, Yoshino J, Luecking C, Kirbach K, Kelly SC, de Las Fuentes L, He S, Okunade AL, Patterson BW, Klein S. Cell Metab. 2016 Feb 22. pii: S1550-4131(16)30053-5. doi: 10.1016/j.cmet.2016.02.005. [Epub ahead of print]. PMID: 26916363.

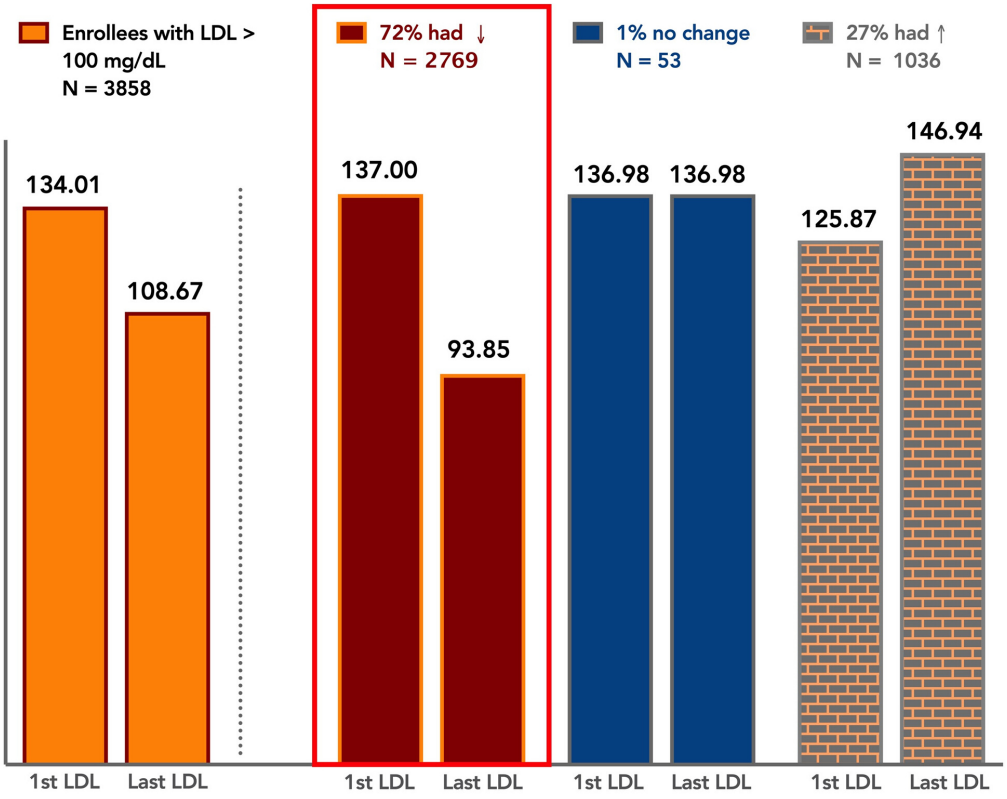
**Reference for 5%: Blackburn G. (1995). Effect of degree of weight loss on health benefits. Obesity Research 3: 211S-216S. Reference for 10%: NIH, NHLBI Obesity Education Initiative. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. Available online: http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf

CLINICAL INDICATORS
SMALL CHANGES MAKE A BIG DIFFERENCE

Reducing LDL Cholesterol Levels

In patients who had LDL levels over 100 at the first reading, and had at least 2 readings for comparison, 72% of patients had improvement, 1% had no change, 27% had an increase in LDL levels*

19% reduction in LDL levels



Improving Uncontrolled Cholesterol

- **10%** ↓ in cholesterol

  leads to

- **20%** ↓ in cardiovascular disease**

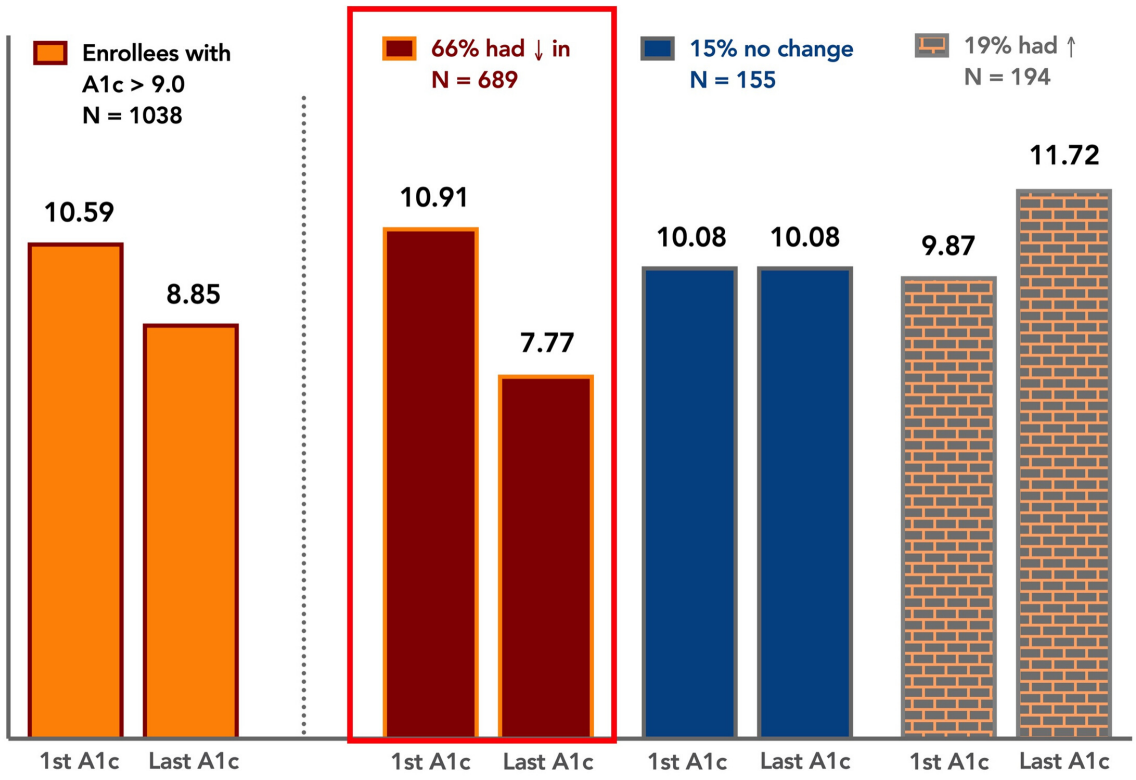
*Months between readings: Overall = 38.18; participants with LDL reduction = 38.92; participants with no change in LDL = 30.40; participants with LDL increase = 36.38.

**Law, M. R., Wald, N. J., & Thompson, S. G. (1994). By how much and how quickly does reduction in serum cholesterol concentration lower risk of ischaemic heart disease British Medical Journal, 308(6925), 367-372.

CLINICAL INDICATORS
SMALL CHANGES MAKE A BIG DIFFERENCE

A1c Improvement

In patients who had an A1c>9.0 at the first reading, and had at least 2 readings for comparison, 66% of patients had improvement, 15% had no change, *19% had increase* in A1c levels.*



1.74 point reduction in A1c levels

Improving Uncontrolled A1c (blood sugar)

- **1 point** ↓ in A1c

  leads to

- **21%** ↓ in diabetes related deaths
- **14%** ↓ in heart attacks
- **14%** ↓ in microvastular complications**

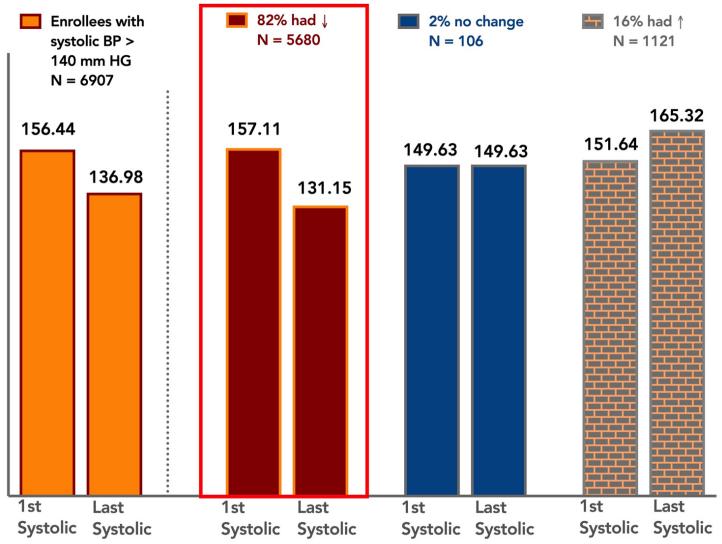
*Months between readings: Overall = 40.97; participants with A1c reduction = 42.15; participants with no change in A1c = 35.45; participants with A1c increase = 41.21.

**Center for Health Law and Policy Innovation of Harvard Law School: Reconsidering Cost-Sharing for Diabetes Self-Management Education: Recommendation for Policy Reform. https://www.diabeteseducator.org/docs/default-source/advocacy/reconsidering-cost-sharing-for-dsme-chlpi-paths-6-11-2015-(final-draf.pdf?sfvrsn=2

CLINICAL INDICATORS
SMALL CHANGES MAKE A BIG DIFFERENCE

Blood Pressure Reductions

In patients with high blood pressure at their first reading, and had at least 2 readings for comparison, 74% of patients had improvement, 3% had no change, *23% had increase* in blood pressure levels.*

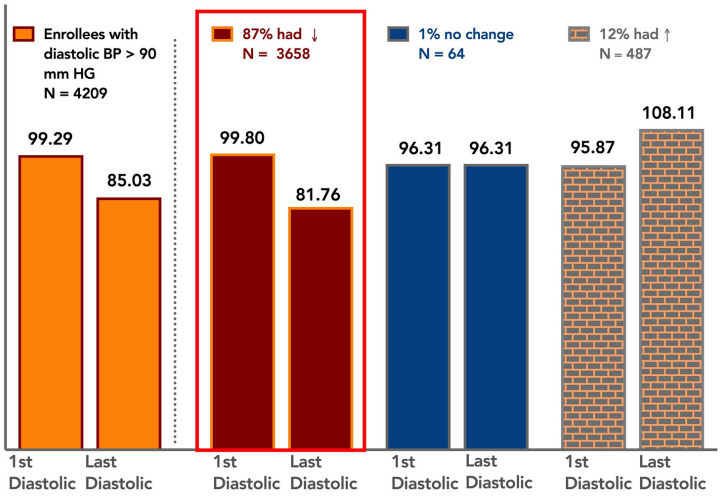


25 mm Hg decrease in systolic BP

18 mm Hg decrease in diastolic BP

Improving Uncontrolled Blood Pressure

- ↓ 6 mm HG
  leads to
- **16%** ↓ in cardiovascular disease
- **42%** ↓ in stroke**



*Months between readings: Systolic Overall = 42.94; participants with systolic BP reduction = 43.98; participants with no change in systolic BP = 39.15; participants with systolic BP increase = 43.34. Diastolic Overall = 43.80; participants with diastolic BP reduction = 43.84; participants with no change in diastolic BP = 35.17; participants with diastolic BP increase = 37.24.

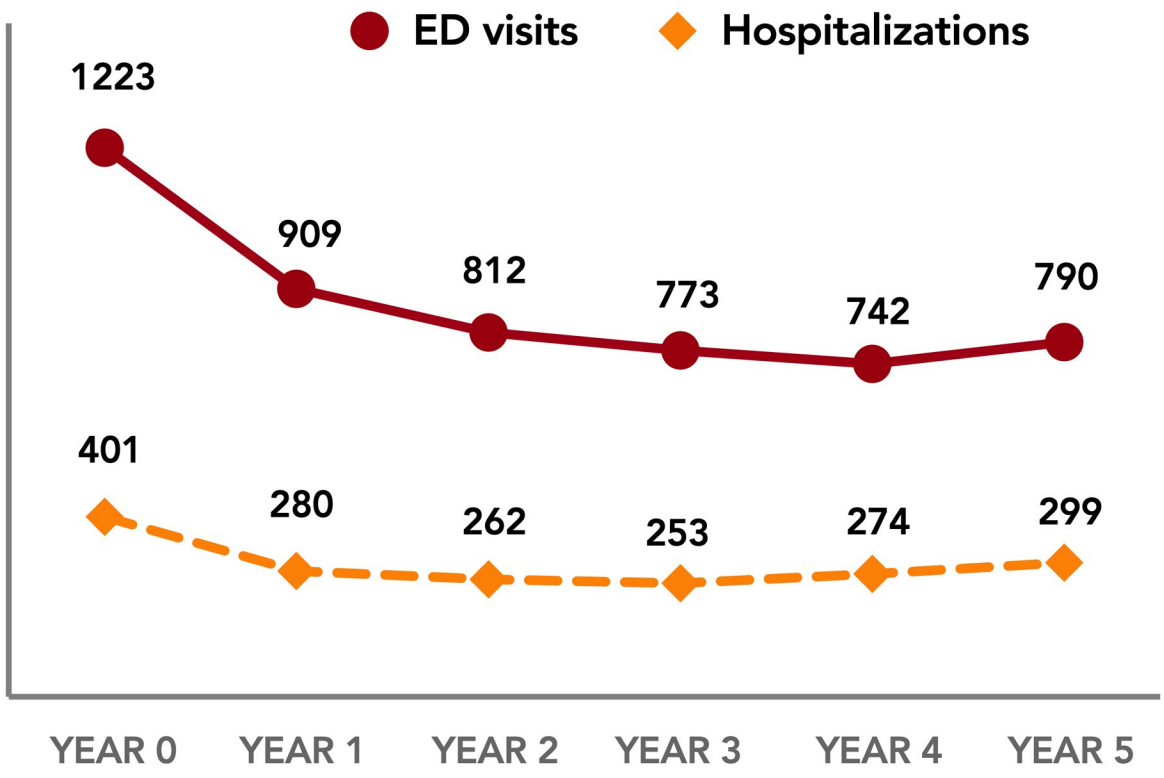
**Sleight, P. (1991). Cardiovascular risk factors and the effects of intervention. American heart journal, 121(3), 990-995

HOSPITALIZATIONS AND ED VISITS

per 1000 PCHH enrollees who had at least 1 attestation in FY 2019

35% in ED visits

25% in Hospitalizations



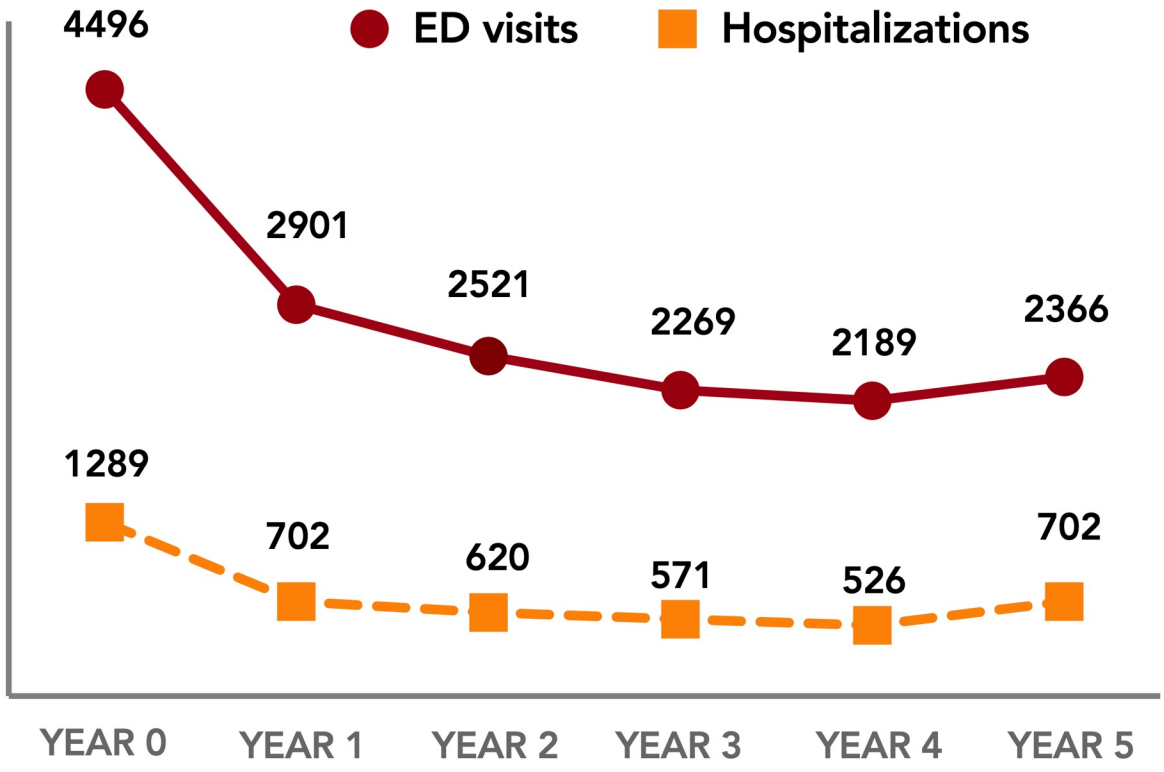
The maximum benefit for reductions in ED visits and hospitalizations seems to be for people who are in health home for approximately 3 years. Beyond three years, rates do not continue to decrease at a population level, but increase slightly indicating that people who stay in the PCHH beyond 3 years might be a population with greater healthcare needs. Though the greatest reduction occurs in Year 1 of enrollment, the decreases in ED visits and hospitalizations are sustained across multiple years.

HOSPITALIZATIONS AND ED VISITS- HIGH UTILIZERS

per 1000 PCHH enrollees who had at least 1 attestation in FY 2019

47% in High Utilizer ED visits

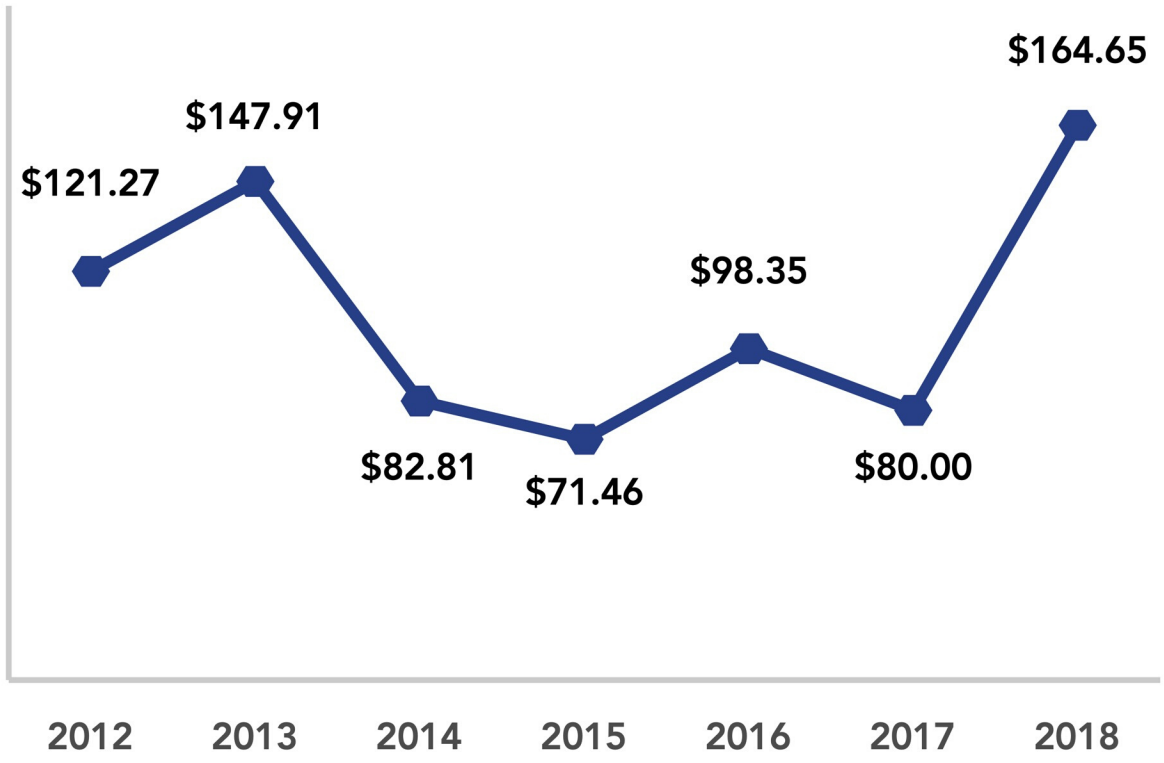
46% in High Utilizer Hospitalizations



High Utilizers have three or more emergency department visits or two or more hospitalizations in the 12 months prior to their first attestation in the PCHH. They represent 18.3% of the overall PCHH population. Compared to all other enrollees, their ED use is 3 times greater, as is their baseline (Year 0) hospital use. This group shows a greater percentage decrease in ED and hospital visits across five program years with the initial greatest drop in Year 1.

PCHH Cost Savings through 2018

For calendar year 2018, the average per-member-per-month cost savings for someone enrolled in PCHH for 12 months was $164.65.*



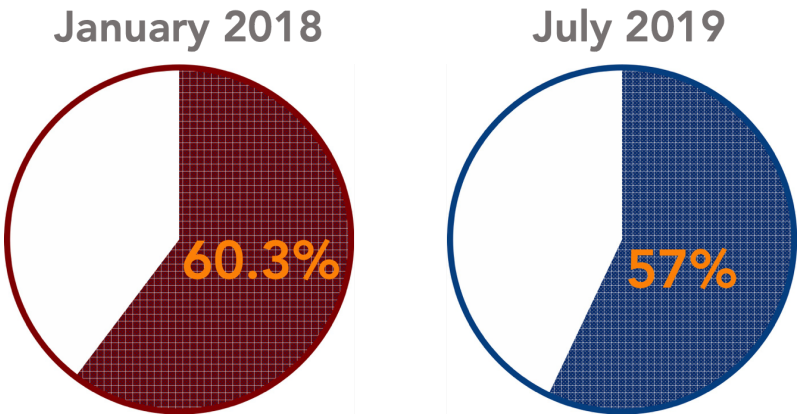
* Those with costs greater than three (3) standard deviations of the population averave were removed from the cost savings calculation.

Hospital Follow-up (Care Coordination)

One of the overarching goals of the PCHH is to reduce hospital use and emergency department visits by providing necessary, routine care for participants with chronic health conditions. This is accomplished through the care management provided by the PCHH staff.

The statewide goal is for 75% of all ED visits and hospitalizations to have a follow-up call or face-to-face visit between the PCHH enrollee and nurse care manager. Of note, Missouri has set the bar high for hospital and ED follow-up. The 72-hour time frame for follow-up is a goal that exceeds the standard 7-day period recommended in a number of other settings.

Percent of individuals receiving a follow-up from a PCHH Nurse Care Manager within 72 hours of a hospitalization:



Notifications provided by MO HealthNet to practices about hospital pre-authorizations and surveillance data provided by the MO Department of Health & Senior Services are used to inform PCHH teams about their participants. PCHH nurse care managers may call or schedule an appointment for a participant to reconcile medications, address any needs, care gaps, or barriers to care that might be leading to ED or hospital visits.

Additionally, community health workers have been integrated into a number of clinics to help address basic needs, or social determinants of health that might need to be addressed to support the overall health of the participants, and provide them the necessary help to manage their chronic conditions and avoid being hospitalized.

Other Activities

Coordination and administration of the PCHH requires effort and collaboration from multiple partners.

In 2018 and 2019 multiple networking and trainings were provided to PCHH staff through efforts coordinated by Missouri Primary Care association, University of Missouri-St. Louis, and St. Louis Behavioral Medicine Institute including:

- 2018 and 2019 Care Team Forums
- Regional Behavioral Health Consultant Learning Collaboratives
- Regional and Joint (with Behavioral Healthcare Homes) Nurse Care Manager Learning Collaboratives
- PCHH team member-specific and content-specific webinar trainings
- PCHH periodic informational webinars