

Health Homes (HH)

United Healthcare Service Delivery Model for Kansas

National Model for Health Home Implementation

- UnitedHealthCare has developed a National Health Home model including:
 - Standardized Clinical Model of Care
 - Customized Platform for Health Information Exchange and data transparency
 - Implementation support and training
 - Clinical and analytic support for measurement and reporting
- National model provides structure and support but allows localization for State specific requirements

UHC Approach to Develop HHs in Kansas



- Select CMHCs that our members already use
- Select CMHCs that express interest in participating in a health home
- Initially establish a core number of health homes
- Collaborate with these provider partners to develop an expansion process to include other CMHCs that serve the mentally ill population
- Following a similar approach for other chronic complex conditions
 - we will identify community organizations and primary care practices that are already serving a population of eligible members or are interested in expanding their capacity. We will develop health homes with physician practice groups that serve members with specific target conditions, such as diabetes. This would include, for example, diabetes centers established at university medical centers, private practices, free-standing organizations, and coalitions.

Partnering

- Some entities will have mature processes and services in place and will be able to meet the majority of the needs of the population needing the benefits of a health home.
- Some providers and community partners will have varying strengths and capabilities.
- Our role as a facilitator, where we identify capabilities and bridge gaps that might exist between support services and medical and behavioral health resources.

United Healthcare Partnerships



- Our expertise in care coordination, case and disease management, home and community based services (HCBS) management, network contracting and data management
- Our expertise in utilization management and management of transitions of care
- United Healthcare will oversee and ensure quality of care, service, member satisfaction with care, and member outcomes
- Program clinical consultant position

Critical Building Blocks for HH United Healthcare Provides (slide 1:2)



- Profile and recruit providers to become health homes
- Provide clinical and technical support our partners need to meet the State's health home requirements
- An array of member care coordination services to supplement each providers' individual capacity to offer care coordination
- Monitor the appropriateness of services received by members enrolled in health homes as well as the clinical impact and cost savings of the overall program
- Increased capacity for data collection and analytics, quality improvement and reporting

Critical Building Blocks for HH United Healthcare Provides (slide 2:2)



- Information technology infrastructure to monitor clinical outcomes and other system performance measures
- Collaborative partnerships with providers on quality improvement initiatives
- Grant provider access to available information about their health home members
- Distribute dashboard provider reports with ability to manipulate and analyze data
- Provide access to evidenced-based medicine and other best practices

Critical Building Blocks UHC Examples



- Create an information technology infrastructure that supports a virtual treatment team.
 - For example, members have online access to certain health assessments, copies of their care plan and health education materials.
- Entities partnering with us for health homes can also use our secured system in a variety of ways
- We can provide the State with clinical information for use in ongoing local quality initiatives required by federal or state rules or regulations
- We have the capability to import eligibility and paid claims data (including pharmacy claims data), export enrolled member and designated health home information, accept member enrollment from providers, provide real-time predictive modeling based upon all clinical information reported and more.

GOAL: Member Seamless Experience of Care



- Collaborative health home development with community partners
 - (these partnerships invisible to the member but relationship is transparent)
- Members will be aware of the activities and processes aimed at meeting their needs, but will not feel the burden of those efforts directed at continuity of care.
- One of the key factors in achieving a seamless experience is the Core Resource Group.

Core Resource Group

- Member, along with his family and extended support system, are considered the hub of this team.
- Consisting of a care coordinator, social worker and the member's physician, the Core Resource Group maintains a constant relationship with the member over time that develops mutual trust and respect for all parties.
- May be additional members, depending on the population served by the health home. For example...
 - member with diabetes will have a diabetes educator, pharmacist and nutritionist as part of his Core Resource Group.
 - member from the mentally ill population will have a mental health specialist, pharmacist, psychiatrist, and perhaps a Peer support specialist as part of his long-term support system.
 - individual who is developmentally disabled might have additional core resources of a developmental disabled specialist, a physical therapist or occupational therapist.
- Keeping the member's Core Resource Group a small body of people with mutually trusting relationships helps the member navigate often complex and changing health care systems.

OHIO Example: Member Identification (DSM IV criteria)



- "Adult with serious and persistent mental illness" means an individual age eighteen or older with:
- (a) A DSM-IV-TR (or its successor) diagnosis, with the exception of the following exclusionary diagnoses: listed in their regs.
- (b) Treatment history covers the client's lifetime treatment for the DSM IV-TR diagnoses other than those listed as "exclusionary diagnoses" in paragraph (B)(1)(a) of this rule and meets one of the following criteria:
 - (i) Continuous treatment of twelve months or more, or a combination of, the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or twelve months continuous residence in a residential program (e.g., supervised residential treatment program, or supervised group home); or
 - (ii) Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent twelve month period; or
 - (iii) A history of using two or more of the following services over the most recent twelve month period continuously or intermittently (this includes consideration of a person who might have received care in a correctional setting): psychotropic medication management, behavioral health counseling, community psychiatric supportive treatment, crisis intervention; or
 - (iv) Previous treatment in an outpatient service for at least twelve months, and a history of at least two mental health psychiatric hospitalizations; or
 - (v) In the absence of treatment history, the duration of the mental disorder is expected to be present for at least twelve months;
- (c) Global assessment of functioning (GAF) scale ratings of fifty or below.

Example DSM IV criteria

Attachment 1: Psychiatric Disorders - SPMI

Code	Disorder	Category
309.24	Adjustment Disorder with Anxiety	Adjustment Disorders
309.28	Adjustment Disorder w Mixed Anxiety and Depression	Adjustment Disorders
309.3	Adjustment Disorder with Disturbance of Conduct	Adjustment Disorders
309.4	Adjustment Disorder w Disturbance of Emotions & Conduct	Adjustment Disorders
309.9	Adjustment Disorder Unspecified	Adjustment Disorders
309.0	Adjustment Disorder with Depressed Mood	Adjustment Disorders
300	Anxiety Disorder, NOS	Anxiety Disorders
300.01	Panic Disorder without Agoraphobia	Anxiety Disorders
300.02	Generalized Anxiety Disorder	Anxiety Disorders
300.21	Panic Disorder with Agoraphobia	Anxiety Disorders
300.22	Agoraphobia without History of Panic Disorder	Anxiety Disorders
300.23	Social Phobia	Anxiety Disorders
300.29	Specific Phobia	Anxiety Disorders
300.3	Obsessive Compulsive Disorder	Anxiety Disorders
308.3	Acute Stress Disorder	Anxiety Disorders

Prospective Risk Score for Identification of Health Home Members



- WA: identifying members who are High cost/risk: defined as having at least one chronic condition and a risk score of 1.5 or greater as measured by the algorithm within the Predictive Risk Intelligence System(S) PRISM, a State agency program that provides a unified view of health care service utilization.

PRISM risk scores are derived from the diagnosis-based Chronic Illness and Disability Payment System* (CDPS) and pharmacy-based Medicaid-Rx2 risk models developed by Rick Kronick and Todd Gilmer at the UC San Diego.

PRISM uses a prospective hybrid risk model that combines risk categories comprising CDPS and Medicaid-Rx models.

Prior service data are used to forecast the client's relative PMPM expenditures over the following 12-month period. A score of 1.5 indicates the client is expected to have medical expenditures over the following 12 months that are 50 & higher than the population average on a per member per month basis.

WA predictive modeling

- **Eligibility**
- Health home services will be available to individuals of all ages served by Medicaid. Eligible beneficiaries must have a PRISM risk score of 1.5 or greater and at least one chronic condition OR have at least one chronic condition and one or more of the following:
 - 1. Two medical hospitalizations in the past 12 months:
 - 2. A psychiatric hospitalization in the past 6 months; and
 - 3. A skilled nursing facility stay in the past 6 months.

Quality Goals

United Healthcare has quality metrics developed to measure key areas of performance:

- Reduce Utilization associated with avoidable (preventable) inpatient stays
- Reduce Utilization associated with avoidable (preventable) ER stays
- Improve Outcomes for persons with Mental Illness and/or Substance Use Disorders
- Improve Disease-Related Care for Chronic Conditions
- Improve Preventive Care

HEALTH HOMES and Kansas



- Health Homes for individuals with serious mental illness (SMI) that will enhance the traditional patient-centered medical home in order to better coordinate physical and behavioral health services.
- Community mental health centers (CMHCs) will be eligible to apply to become Medicaid health homes for individuals with SMI.
- By July 2014, Kansas Medicaid will implement Medicaid Health Homes focusing on individuals with qualifying chronic physical health conditions.
- United Healthcare has strategic plan to start with HH for SMI, followed by HH for chronic conditions as a focus.