Missouri Primary Care Association CHCs

- 29 FQHCs in Missouri
- Over 185 Delivery Sites
- Medical Home to 450,000 Missourians
- 1.6 million encounters each year
- Reimbursement is not PPS but rather alternative payment mechanism using cost based reimbursement
- State has not expanded Medicaid
Trends Affecting Health Centers

- Payer demand for quality and efficiency
- New and developing payment models – ACOs, IPAs, others
- Transparency/Public Reporting
- Meaningful Use incentives and expectations
- Patient Centered Health Home
Drivers of Missouri’s Quality Journey

• Understanding of impact of payment reform on health centers.
• Importance of high-functioning Health Homes; “recognition” is not enough.
• Data is essential.
• Take advantage of transition.
• Invest in relationships.
• Chart a course to move forward successfully.
FQHC Reform Opportunity

- Health Centers are better equipped to thrive under health reform than private physician networks however many are gaining ground.
- Emerging payment models align with comprehensive primary care.
- Success will require care delivery transformation:
  - New technical tools and methods for measuring success.
  - Rethinking roles and responsibilities.
- Health Center leadership should be aware of cultural challenges of transforming.
Quality Journey Overview

• For the past several years, MPCA and its Members have Invested Heavily in the Following Areas:
  • PCMH: Recognition, Practice Transformation, and Quality Coaching
  • Behavioral Health and Primary Care Integration
  • Data: EHR Adoption, Validating Data, Building a Data Warehouse, Utilizing a Reporting Tool (DRVS), and Using Data to Drive Quality
  • Managed Care: Capturing the Market
  • Reimbursement Models: Section 2703
2006 • MPCA launched Center for Health Care Quality and CEOs of FQHCs and CMHCs begin PC/BH Integration conversations

2007 • State appropriations for Behavioral Health and Primary Care Integration and data warehouse

2010 • Missouri Quality Improvement Network Established, ARRA funding for HCCN and Initial Data Road Map created

2012 • Missouri Primary Care Health Home launched January 2012 with enhanced federal match and ACA funding continuation of HCCN December 2012

2013 • October 2013 MPCA Board of Directors vote to form Independent Practice Association and November 2013 MPCA received funding for Practice Transformation and Quality Coaching from two major Health care conversion Foundations

2014 • January 2014 Health Home continued at tradition federal match, April 2014 Missouri Health+ officially becomes clinically integrated Network and October 2014 Medicaid began covering HBAI and SBIRT Codes to support Behavioral Health and Primary Care Integration

2015 • May 2015 legislature approves geographic expansion of Medicaid managed care from 35 counties to all 114 counties, October 2015 Missouri Health+ finalized contracts with the three Medicaid Managed-care companies, October 2015 MPCA updates data road map to meet the needs of the Association and its members from 2015 and beyond.
Quality Journey: 2006

- MPCA Board approved the formation of the Missouri Center for Primary Care Quality and Excellence
  - National dialogue was moving toward transparency in cost and quality
  - Belief that we had to fundamentally shift the founding purpose of the PCA from one of advocacy toward being able to advocate for a quality product, meaning that MPCA was going to ramp up its infrastructure to support performance improvement in our members
  - Founding purpose of Center was to focus on quality improvement, performance improvement, and best practices; data collection and analytics, research, technical assistance, and network development.
Integrating Primary Care and Behavioral Health
One Strategy for Treating the Whole Person

• 2007 state legislature appropriated general revenue funding to the Department of Mental Health for Behavioral Health and Primary Care Integration
• Current appropriation is $1.5 million yearly
• State Partners
  – Missouri Department of Mental Health
  – Missouri Primary Care Association
  – Missouri Coalition for Community Behavioral Healthcare
• Seven FQHC/CMHC partnerships funded in January 2008
• Eight FQHC/CMHC partnerships are participating in the 2015-2016 contract
• Contract for Behavioral Health Consultant and Team Based Care Training and Technical Assistance
Behavioral Health and Primary Care Integration
What Is It About?

- **Improving Access**
  - To primary care for people with serious mental illness
  - To behavioral health services for people with previously unrecognized and/or untreated mental health problems
  - To behavioral health supports for people who require assistance in effectively managing their chronic disease or improving health status

- **Improving Clinical Care**
  - Seeing mental health as essential to overall health
  - Seeing and treating the whole person
  - Emphasizing wellness and preventive care

- **Improving Collaboration Between Systems of Care**
  - Finding ways to promote synergies and efficiencies by bringing two safety net systems of care together
Levels of Integration

Traditional Model

Co-located Model

Behavioral Health Consultant

Less Integrated  More Integrated
Lessons Learned from Early BH/PC Integration

Missouri’s initiative is as much about bringing two systems of care together, as it is about integrating primary and behavioral health care

• Funding
  – Start-up funding needed for one-time costs helps to overcome turf issues
  – Though current systems do not readily support costs associated with integration, the Healthcare Home initiative and Healthcare Reform provide an opportunity

• Myths, Misunderstandings, and Real Differences
  – CMHCs and FQHCs generally do not understand each other’s funding sources and financing mechanisms, often leading to myths and misunderstandings that must be addressed
  – Real differences also require attention, such as differences in approaches to consumer/patient financial participation

• Having the right people in the right positions and training all staff well are both critical
Lessons Learned from Early BH/PC Integration

- “All politics is local”
  - Local conditions dictate nearly every aspect of the actual form, progress and success of implementation
  - The history of past collaborations influences progress

- Collaboration and Culture
  - The hard work of team building between the organizations and at the clinical level should not be ignored
  - Primary care and behavioral health care typically have very different cultures that must be recognized and addressed

- Momentum
  - Two Associations continue to advocate for funding for integration and previous partnerships gained each a seat at the table during the development and ongoing implementation of the Section 2703 Health Home Initiatives
  - Early work led to the staffing and underlying architecture of Missouri’s two 2703 Health Home Initiatives
Quality Journey, 2007

- $5 Million State HIT Appropriation
- Funding to support Centralized Data Warehouse
- Quickly realized without CHCs being live on EHRs couldn’t create a data warehouse.
- Didn't make much progress for the first 18 months to two years on the data warehouse because we tried to do a home grown warehouse (we highly discourage a home grown system)
Vision for HIT in 2007

- All health centers should have an EMR
- Integration with state and local systems
- Collaborative Reporting
- Centralized data warehousing
- Ability to respond to external data requests
- Develop IT capacity
- Health Information Exchange (HIE)
Quality Journey 2010

- HITECH Award funding initial HCCN and Congressional Earmark
- Data Roadmap developed with Arcadia Solutions and Selection of DRVS: outcomes measurement and clinical reporting; MU compliance; Population Health Management; Reporting on Operational and Financial Metrics
- Creation of MOQuIN
- Contract with Missouri HIT Assistance Center to assist FQHCs obtain full Meaningful Use payments
- Reform Ready Initiative
Quality Journey 2010: Missouri Quality Improvement Network (MOQuIN)

- Formed in 2010
- Organized statewide quality improvement program
- Meet Bi-Monthly to provide training, technical assistance, peer to peer networking, and share best/promising practices
- Bring Clinical, Quality, HIT, Finance, and Operations staff together
- Accurate, reliable, timely, and transparent clinical quality measures reporting with plans to move to operational and finance measures going forward
- Accomplishment of meaningful use and related measures so member FQHCs will receive full benefit of meaningful use incentives.
Quality Journey 2012

- ACA HCCN Award
- Mapping expansion, data validation, connecting more CHCs to DRVS
- Quality coaches using DRVS data to monitor and plan interventions
- Started thinking about transitioning advocacy away from "direct" government funding to value-based care and what capacity MPCA needed to build
Own Your Data…Own Your Future

- Adoption
- Quality of data equals quality of care
- Quality Improvement
- ACO / PCMH/IPA

Encounter Based | Patient Based | Population Based
Progression of Vision for Data Warehouse and DRVS

Advocacy

Quality Improvement

Care Coordination

Daily Ops / Visit Planning

Support for $ Incentives and IPA
Population Health Management and Performance Improvement

State Level
- Statewide Reporting
- Funding Opportunities
- Data Driven Advocacy
- Research Opportunities

Organizational & Site Level
- Drive Quality Improvement
- Tailored Reporting for PCMH
- Identify Best Practices & Benchmark for Improvement

Patient Level
- Reduce time for Pre-Visit Planning
- Engage Care Management
- Registries to manage populations
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<th>Measure Name</th>
<th>UDS 2015</th>
<th>HCCN</th>
<th>MPCA Clinical Quality Award 2015</th>
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</table>
CHC Use of DRVS

• Internal Quality Monitoring and Improvement
  – Measures
  – Registries
  – Pre-Visit Planner
• UDS reporting
• Meaningful Use
• NCQA Recognition
MPCA Use of DRVS

• Primary Care Health Home (ACA Section 2703)
  – Identify potential enrollees
  – Clinical Quality Reporting to MO HealthNet (Missouri Medicaid)
  – Quality Coaching

• Gateway to Better Health
  – Medicaid demonstration in St. Louis
  – Conversion of direct Disproportionate Share Hospital grant funding to service/claims reimbursement
  – Clinical quality statistics from DRVS determine distribution of performance incentives

• MO Department of Health and Senior Services
  – Chronic Disease Collaborative (CVD, DM, Tobacco, Obesity, Asthma)
  – Pharmacy Integration Project (Hypertension and Diabetes targets)
Anticipated Future Research Utilizing DRVS and Planned Enhancements

• Research Partner – University of Missouri-St. Louis Advanced Practice Nurse Preceptor/Placement grant
  – Do quality and practice efficiency improve when a nurse practitioner student is on the team?

• Health plan member attribution lists
• Risk/cost level indicators
• Embedded links to external data/documents
• Additional HEDIS measures
Bridging the Quality Chasm

**Performance Data Reflects Quality of Care Delivered, Financial Reward Achieved**

- **Workflow Mapping**
- **Validation**
- **DRVS Mapping**
- **Ongoing Monitoring**

<table>
<thead>
<tr>
<th>Manage care and document to reflect true quality.</th>
<th>IT and EHR Experts</th>
<th>Clinical, Quality, Operations, and Front-line staff</th>
<th>Executive Leadership</th>
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<tr>
<td>Use of Data at Point of Care</td>
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<td>Get maximum credit for the work you do!</td>
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<tr>
<td>EHR Documentation of patients/visits</td>
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<td>Better Quality, Patient Experience &amp; Lower Cost</td>
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<td>Accurate Data for Reporting and Analytics</td>
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</tbody>
</table>

Graphic created in partnership with Azara Healthcare
Quality Improvement

• Primary Care Health Home
  – Clinical Quality Reporting to MO HealthNet Division
  – Quality Coaching to Primary Care Health Homes
  – Data supplied for external analysis

• Chronic Disease Collaborative
  – Clinical Reporting to Department of Health and Senior Services for Federal Centers for Disease Control Reporting
  – Measure improvement and PDSA cycle support
Chronic Disease Collaborative

• Contract with the State Department of Health and Senior Services with funding from their Federal Centers for Disease Control grant award.

• Contract focuses on chronic disease management, risk factor reduction, and expansion of Care Team to include pharmacists, care managers, and behavioral health consultants.

• DRVS is utilized for the reporting of the clinical data, measure performance, PDSA Cycle support and care gap identification utilizing the following functionalities:
  – Reports/Scorecards
  – Measure Analyzer
  – Clinical Registries
  – Patient Visit Planning Report
Quality Journey 2012

• Implementation of Medicaid Primary Care Health Home Initiative
• State-authorized contracts with Primary Care Health Homes to report clinical quality measures from DRVS
Missouri PCHH Selected Qualifying Conditions

• Combination of Two
  • Diabetes (CMS approved to stand alone as one chronic disease and risk for second)
  • Heart Disease, including hypertension, dyslipidemia, and CHF
  • Asthma
  • BMI above 25 (overweight and obesity)
  • Tobacco Use
  • Developmental Disabilities
Participating Sites

- Initial participating sites:
  - 18 FQHCs and 6 Hospital Affiliated Primary Care Clinics
- Expansion of Number of Participating Sites Approved during the Spring 2014 legislative session.
- Current Participating Sites:
  - 21 FQHCs 9 Hospitals 2 Clinics
- Participation requirements:
  - Medicaid/Uninsured Threshold
  - Using EMR for six months
  - Apply for National Committee for Quality Assurance (NCQA) Patient Centered Medical Home Recognition within 18 months
- Current Enrollment: 17,872
Goals of the Primary Care Health Home Initiative

- Reduce inpatient hospitalization, readmissions and inappropriate emergency room visits
- Improve coordination and transitions of care
- Improve clinical indicators (e.g. A1C, LDL, blood pressure)
- Implement and evaluate the Health Home model as a way to achieve accessible, high quality primary health care and behavioral health care;
- Demonstrate cost-effectiveness in order to justify and support the sustainability and spread of the model; and
- Support primary care and behavioral care practice sites by increasing available resources and improving care coordination to result in improved quality of clinician work life and patient outcomes.
Use of Health Information Technology to Link Services

- **CyberAccess (MO HealthNet)**
  - Demographics
  - Diagnoses
  - Providers
  - Labs
  - Procedures
  - Medications
  - Care Coordination

- **ProAct (Care Management Technologies-CMT)**
  - Medication Possession Ratio
  - Medication Adherence

- **Electronic Health Records**
  - Performance Measures
  - Patient Portal

- **Data Warehouse (Azara DRVS)**
  - Clinical Information
<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Role/Responsibilities</th>
</tr>
</thead>
</table>
| Missouri Primary Care Association (MPCA)| • Project Owner, receives reports  
|                                          | • Support staff at FQHCs & PCCs when needed for questions around reporting and data accuracy |
| Federally Qualified Health Centers (FQHC’s) | Transmit clinical data through Azara DRVS connector |
| Primary Care Clinics (PCC’s)            | Transmit clinical data through flat file upload |
| Azara Healthcare                        | • Provide access to DRVS reporting tool and maintains measures in the tool.  
|                                          | • Assist PCCs in flat file submission |
| MO HealthNet                            | Receives reports |

Azara Healthcare

• Provide access to DRVS reporting tool and maintains measures in the tool.
• Assist PCCs in flat file submission
Data Flow Process

MPCA

FQHCs
Directly Connected PCCs

Azara data warehouse

EHR & PMS Connected to data warehouse (pulls data nightly)
FQHC has direct access to reporting tool to pull its own reports

MPCA runs reports and sends them to each PCC

PCC monthly uploads flat file to Azara warehouse

List of PCHH Enrollees transferred to warehouse

MPCA has direct access to all reports

MPCA sends all reports to MO HealthNet for FQHCs & PCCs each month

CMS reporting from MO HealthNet

Standard PCCs

MO HealthNet
Primary Care Health Home Performance Measures

• Care Coordination
• Behavioral Health and Substance Abuse Screening and Use
• Chronic Disease Management: Diabetes, Cardiovascular disease, Asthma
• Preventative Health: Weight Assessment and Follow-up for Children and Adults, Population Health LDL Control
• Whenever possible national measure definitions were utilized from the National Quality Forum, Healthy People 2020, Meaningful Use, HEDIS, etc. to assist with alignment across programs.
Primary Care Health Home Performance Measures

1. Adult LDL < 100

2. Hypertension Controlling High Blood Pressure (NQF 0018)

3. Childhood Weight Screening and Counseling
   1. Child Weight Screening / BMI (NQF 0024)
   2. Child Weight Screening / Nutritional Counseling (NQF 0024)
   3. Child Weight Screening / Physical Activity (NQF 0024)

4. Pediatric and Adult Asthma Controller Medication:
   1. Use of Appropriate Medications for Asthma Ages 12-18 (NQF 0036 modified)
   2. Use of Appropriate Medications for Asthma Ages 19-50 (NQF 0036 modified)
   3. Use of Appropriate Medications for Asthma Ages 51-64 (NQF 0036 modified)
   4. Use of Appropriate Medications for Asthma Ages 5-11 (NQF 0036 modified)

5. Diabetes A1c > 9 (NQF 0059)

6. Diabetes A1c < 8 (NQF 0059 modified)

7. Diabetes BP < 140/90 (NQF 0059 modified)

8. Diabetes LDL Management - LDL < 100 (NQF 0064)

9. Screening for Clinical Depression and Follow-Up Plan (NQF 0418)

10. Adult BMI Screening and Follow-up
    1. BMI Screening and Follow-Up >= 65 Years (NQF 0421)
    2. BMI Screening and Follow-Up 18 - 64 Years (NQF 0421)

11. Care Coordination (MPCA PCHH)

12. SBIRT Drug Use (MPCA PCHH)

13. SBIRT Excessive Drinking (MPCA PCHH)

14. SBIRT Substance Abuse Screening and Follow Up (MPCA PCHH)
Quality Journey 2013

- October 2013 MPCA Board of Directors vote to form Independent Practice Association
- November 2013 Contract with two health care foundations for Quality Coaching and Practice Transformation
Training and Technical Assistance

• Investing in training and technical assistance is essential to the success of the health home.

• Primary Types
  • MPCA Quality Coaches
  • Care Team Forums
  • Behavioral Health and Primary Care Integration
  • SBIRT
MPCA Quality Expectations and Activities

- Assistance with PCHH Performance measure submission, maintaining data mapping/connectivity, and DRVS reporting.
- Assistance with data driven performance improvement to improve achievement of PCHH measures.
- Assistance with addressing high utilizers (MO HealthNet #1 priority)
- Assistance with identification and resolution of Quality/workflow issues
- Assistance with training and technical assistance needs of health home team.
- Practice Transformation and PCMH Recognition application/reapplication
- Monthly contact via e-mail, phone, and/or webinar
- Yearly On-site visit
Care Team Forums

• Training for Primary Care Health Home Team Members
• Focus on team-based care
• Best Practices for addressing high risk enrollees and high utilizers of services
• Strategies for utilizing data and technology solutions to drive quality improvement and patient-centered care.
• Peer to Peer Networking
• Condition and skill specific sessions
• Joint Nurse Care Manager and BHC Training (Spring 2015 and Spring 2016)
• NCQA PCMH 2014 Recognition Training (Spring 2015)
• BH/PC integration and team based care training for health home team (Fall 2015)
• High utilizer webinar (Targeted for Winter 2016)
• Asthma Educator Training (Targeted for Spring 2016)
MPCA Quality Coaches

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Behavioral Health and Primary Care Integration

• Focus on assisting Behavioral Health Consultants provide integrated services in the primary care setting

• Format of Training and Technical Assistance
  • Centralized and regional Face to Face Meetings for BHCs
  • Care Team Forums for BH/PC integration for health home team
  • Quarterly administrative telephone consultation
  • Webinars for primary care providers on common behavioral health topics
  • On-site technical assistance
  • Telephone/e-mail consultation
Screening, Brief Intervention, and Referral to Treatment (SBIRT)

• Evidenced based primary prevention program for addressing risky substance use
• Integrated into general medical and other community settings
• Key elements:
  • Screen everyone 18 years and older using the four question pre-screening tool
  • Follow-up for positive prescreen tool utilizing the World Health Organization ASSIST tool that is completed in eSBIRT
  • Brief Intervention when indicated
  • Referral for Treatment as needed
• Uses a public health model incorporating population screening and brief interventions into routine practice
• As part of a continuum of care its primary focus is on the more common risky drinking and drug use rather than alcohol or drug dependence.
SBIRT Required Training/Certification

- **Screening** (Training typically completed by rooming staff such as nurse, MA)
  - Why and how to administer the brief screen to identify patients who need a closer look at their alcohol or substance use risks. (Two training modules and quiz, about 30 minutes.)

- **Brief Education/Intervention** (Training typically completed by rooming staff such as nurse, MA)
  - Assess patients for risky alcohol and drug use and use the personal risk assessment report to guide a brief motivational education session to those at moderate levels of risk. (Five training modules and quizzes, about 70 minutes.)

- **Brief Coaching** (Training must be completed by BHC)
  - Coach patients with significant alcohol and drug use risks in a 6 session manualized process using motivational enhancement and cognitive behavioral therapy techniques. (Training modules, quiz, sample recording and phone/Skype feedback session, about 4 hours.)
Quality Journey 2014

- 2014 Legislative session Governor and State Legislature supported continuation of Primary Care Health Home and CMHC Health Homes at the traditional federal match.
- April 2014 Missourihealth+ (Missouri’s Independent Practice Association made up of 23 of the 29 CHCs in the state) officially becomes clinically integrated network allowing joint contract negotiations with managed care companies.
- October 2014 Medicaid began coverage of Health Behavioral Assessment and Intervention (HBAI) and Screening Brief Intervention Referral and Treatment (SBIRT) codes for Primary Care Health Homes
## Coverage of Health and Behavioral Assessment and Intervention Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96150</td>
<td>Health and Behavioral assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment</td>
</tr>
<tr>
<td>96151</td>
<td>Re-assessment MHD will define as 15 minute code.</td>
</tr>
<tr>
<td>96152</td>
<td>Health and behavior intervention, each 15 minutes face-to-face; individual</td>
</tr>
<tr>
<td>96153</td>
<td>Group (2 or more patients) MHD will define as 15 minute code.</td>
</tr>
<tr>
<td>96154</td>
<td>Family (with the patient present) MHD will define as 15 minute code.</td>
</tr>
<tr>
<td>96155</td>
<td>Family (without the patient present): Not covered by Medicaid</td>
</tr>
</tbody>
</table>
## Coverage of Screening Brief Intervention Referral to Treatment (SBIRT) Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0049</td>
<td>Alcohol and/or drug screening</td>
</tr>
<tr>
<td>99408</td>
<td>Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST, and ASSIST), and brief intervention (SBI) services; 15 to 30 minutes (Includes initial screening and brief intervention; Services of 15 minutes or more)</td>
</tr>
<tr>
<td>99409</td>
<td>greater than 30 minutes (Only initial screening and brief intervention)</td>
</tr>
<tr>
<td>H0050</td>
<td>Alcohol and/or drug services, brief intervention, per 15 minutes</td>
</tr>
</tbody>
</table>
Quality Journey 2015

- May 2015 legislature approves geographic expansion of Medicaid managed care from 35 counties to statewide.
- October 2015 Missourihealth+ finalized contracts with all three Medicaid managed care companies.
- July-October 2015 MPCA Updated data roadmap to meet the needs of the Association and its members from 2015 and beyond.
Factors Impacting the Future

- High Expectations – Triple Aim
  - Better Care, Lower Costs, Happier Patients
- Intense and Increasing Scrutiny
- Public Reporting
- Transparency
- Accountability to Deliver
- Uncertain Public Funding
- Shifts in Policy and Funding to 3rd Party Payers
- Varying Reimbursement Models (VBC)
Factors Impacting the Future Continued

- Competition for Patients
- Competition for Providers
- Competition for Staff
- Competition for Leadership
- Increased Cost to Operate
- Increased Demand for Services
- Consolidation
- Technology
Recipe for Success: High Performing HC-Top Ten List

- Recruit and Retain Quality Employees
- Build effective governance
- Align with other providers across the continuum of care, and participate in integrated networks
- Utilize evidence based practices and data to drive quality
- Improve efficiency through productivity and strong financial management
- Maximize information systems
- Educate and engage employees, providers, and board members in cultivating culture of excellence, leadership, and customer service
- Partner with Payers and leverage collective value with payers
- Seek population health improvement/Be grounded in the Community
- Implement an ongoing Advocacy strategy
Moving Forward: Quality Journey 2016 and Beyond

- Understanding key trends affecting CHCs and impact of health reform and payment reform on health centers
- Importance of high-functioning Health Homes; Care teams and real Transformation
- Data is essential to improve quality and drive reimbursement
- Demonstrate Value by managing Cost, improving Quality, taking and managing Risk, and Scale
- Implementing strategies to take advantage of transition/change
- Constant Performance Improvement
- Adding additional competencies at MPCA and CHCs
- Chart a course to move forward successfully: Continue to Own our Future!
Contact Information

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