

OHIO MEDICAID HEALTH HOMES FOR THOSE WITH SERIOUS AND
PERSISTENT MENTAL ILLNESS

Quality Improvement Committee

AGENDA

November 10, 2011

1:00 – 4:00 p.m.

Rhodes, Rm. 720-I

Purpose: develop recommendations for approaches and tools to assure fidelity and robustness of integrated care and health homes; review and align all mandatory outcome measures and data requirements under the health home, the ODMH TEOS and the discretionary SAMHSA grant for integrated care; consider burden and feasibility.

- **Welcome & Introductions**
- **Review of Purpose**
- **Review Rhode Island and Missouri State Plan Amendment**
- **Review Draft Section 2703 Health Homes for Enrollees with Chronic Conditions Quality Reporting Guidance**
- **Review Draft Ohio Health Home Measures**
- **Review ODMH Treatment Episode Outcomes System Measures**
- **Review SAMHSA Clinical Registry Code Book**
- **Next Steps**
- **Next Meeting: December 2, 2011, 9:30 a.m. – 12:30 p.m. Rhodes Rm. 720-I**

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Attendees: Scott Adams, Angie Bergefurd, Rich Bowlen, Leslie Brose, Carol Carstens, Marsha Coleman, Beth Ferguson, Mary Haller, Lon Herman, Deb Hrouda, Terry Jones, Afet Kilinc, Heather King, Jody Lynch, Max McGee, Kara Miller, Jen Moses, Frank Sepetauc, Peggy Smith, James Vernon, Mike Witzky

Meeting convened at 1:08 p.m.

Welcome & Introductions

Angie Bergefurd opened the meeting and the group introduced themselves roundtable. Angie reminded the group that the term SPMI will be used in this meeting to describe both children and adults with serious and persistent mental illness. Next, she briefly reviewed the group's purpose.

Review of Purpose

Angie explained that the purpose of the Quality Improvement Committee is to assist in the development of tools to assure quality in integrated care and health homes. In this process, the group will review and align with various outcomes measures and data requirements. She stated that background information was provided to review in advance, as well as two examples of health home state plan amendments from Rhode Island and Missouri. The Rhode Island plan has recently been submitted and the Missouri plan has been approved.

Review of Rhode Island and Missouri State Plan Amendments

Alicia Smith reviewed the state plan amendment examples. She began by stating that the premise of health homes is to facilitate coordination of care for Medicaid recipients; this group is looking specifically at behavioral health. CMS will require outcomes that address improvement of conditions. We will need to track co-occurring conditions in health home consumers, especially those that involve visits to emergency departments. Alicia explained that CMS and Congress will need measured outcomes and predicted cost savings in order to determine whether health homes are making a positive difference in the health care system. CMS will also be looking to the states to inform the creation of an evaluation planned for 2014.

Alicia discussed the fact that both Missouri and Rhode Island have invested in electronic health records. They are well-prepared to use cyber access and have a good understanding of the incidence of co-occurring illnesses in their states. When Missouri ramped up their benefit, they also ramped up their electronic health record. This state also has widespread use of electronic medical records in community mental health centers. The community mental health centers are not all using the same system, but they are working toward doing so. Missouri is working in a different configuration than that of Ohio; they have much fewer agencies.

Rhode Island is small and already has hospital liaisons in their mental health centers. They viewed this as an opportunity for CMS acknowledgement. Not all of them have electronic medical records and those that do use a variety of systems. This state's community mental health centers have longstanding relationships with their hospitals. Each is already required to report core measures that CMS will require health homes to report.

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CMS expects that most of the core measures should be reportable through claims and will not involve manual extraction. However, manual extraction will be necessary for states that do not have an electronic medical record or registry. Because not all people are enrolled in managed care in Rhode Island, the state must be committed to working to obtain records for certain individuals who are enrolled in health homes.

Afet Kilinc pointed out that section 8 in each state plan amendment describes quality measures for health homes. CMS requires that each state plan amendment contain details in this section. The format will look the same, but the content will obviously vary from state to state. We will need to keep this section in mind as we are working in this committee. Collecting and tracking data are very important core qualifying elements. Afet and Angie noted during recent visits to sites providing integrated care that many are using consultants for this work.

Review of Draft Section 2703 Health Homes for Enrollees with Chronic Conditions Quality Reporting Guidance

Afet stated that the draft distributed in the meeting packet is the most current CMS version available to date. She pointed out important highlights to note, including the fact that health homes are described on the front page as cost-effective, longitudinal homes. There is an expectation that hospital admissions and overall health care costs will be reduced. She believes that these measures are not negotiable. CMS will use them as the requirements for all health homes; therefore, this will be a key document for us. The health homes core set of values and the state specific goals need to be in mind as we complete this work. Afet also noted that page 3 lists all of the core measures mandated by CMS. Some of these measures will require diagnostic tools; we will need to consider this, for example, under screening for depression.

Alicia added that the the core measures need to be translated to the state plan amendment and must include tracking of clinical outcomes. CMS expects states to either identify their measures or create specific goals and measure for each of the core qualifying elements. The core measures were not released before Rhode Island and Missouri drafted their state plan amendments; this is why they do not align precisely with them.

Mike Witzky raised a question about whether ODJFS will use MACSIS Medicaid data to establish a baseline for outcomes. He also asked if the focus should be to reduce costs later or to reduce current aggregate costs in Ohio. Alicia stated that the group will decide this, but we will need to be able to compare current and future costs of the population. Jon Barley added that ODJFS has not decided upon this approach yet; they are considering whether to look only at enrolled individuals or whole populations that are similar. The department has the data and capacity to look at this in a variety of ways. Mike suggested that aligning MACSIS historical data with UCI numbers would be a good background exercise that could provide valuable information.

Lon Herman asked whether flexibility exists in the use of survey tools between primary care and health homes. Alicia clarified that as long as the three domains are covered in some way, the requirements have been met. Lon stated that the experience of care may be different depending on the care setting, but we may be able to use tools that ODMH already has in place; Alicia agreed. Carol Carstens discussed ways in which ODMH has used tools such as the Mental

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Health Statistics improvement Program (MHSIP), in the past. Alicia added that the goal is to have uniformity where it can exist while recognizing that areas, such as experience of care, can clearly vary.

Review Draft Ohio Health Home Measures

Afet stated that this draft was developed by ODJFS, noting that they are considering adding high risk pregnancy as a condition under those specified by CMS. The draft does not include all of the CMS required core measures because ODJFS has not completely updated the document yet. Afet reminded the group that per CMS, one serious and persistent mental illness condition qualifies individuals for a health home. Jon clarified that "MC2013" is a managed care code.

Angie stated that, for purposes of this group, we need to look at the SPMI and SED columns and connect them to a measure. For example, we may decide to include a cardiovascular measure for individuals with SPMI. Afet added that the state needs feedback on what should be included, what should not be included and what is missing.

The group noted that the SED column only has one measure and agreed that more should be added. They discussed the fact that SPMI and SED are the focus of this work, rather than MH/SA. Members noted, however, that many SPMI individuals will also have substance abuse issues and measures will be needed for this. Lon pointed out that the group also needs to think about the feasibility of adding measures; we need to be mindful of whether they will be useful and whether they have to potential to add unnecessary burden. Terry Jones added that already existing evidence based practices could also be used in conjunction with these measures.

Deb Hrouda raised the point that we need to keep integration in mind; conditions will not be separate, but one will be a subset of another. We need to think about how we would draw those data together.

Mike asked whether a health home could be created for individuals with MH/SA and another chronic health condition. Jon stated that this is possible in the future. ODJFS is starting with the SPMI population with co-occurring chronic health conditions, but he foresees the potential for health homes for other behavioral health conditions to be created later.

Review of ODMH Treatment Episode Outcome System (TEOS) Measures

Carol provided an overview of the ODMH TEOS Measures. She explained that these measures are also known as the BH Mod. They are already required at ODADAS and will be required at ODMH beginning July 2012. This will be an integrated record for both AoD and mental health clients. The GAF score will be collected in these outcome measures; GAF is used in the definition of SPMI. Concern has been raised about the reliability of the GAF, so the department is implementing a web-based GAF tool to hopefully improve this.

Some of the new questions that are being asked in the TEOS measures are listed at the bottom of the the center column. These include a number of yes/no questions, including one about tobacco use. This is a potential outcome measure for health homes. The question about AoD

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involvement is loosely defined; it could apply to people who simply had a substance abuse screening.

Bio markers were developed with the previous ODMH medical director. A web-based BMI calculator has been developed and is posted on the ODMH website. Carol hopes we can fill additional fields on the client record with utilization records at some point. Linkage to evidence based practices is also provided, and the form must be updated at least yearly. Mike stated that he feels that the information should be updated more often; Carol responded that this will be tested to determine the best frequency for updates. Providers will start completing this form online next week. The department will assess it in the pilot before locking in the requirements.

Jon stated that the TEOS could be a great tool for obtaining information that cannot be accessed in claims. Angie agreed, adding that this is a way to get GAF scores that we could not obtain previously. Max McGee cautioned that the TEOS form should remain brief enough that it does not interfere with time spent caring for the patient.

Crosswalk of CMS Core Quality Measures with ODJFS/ODMH Data Sources and Use of HIT

Alicia reviewed the core quality measures with the group and noted feedback regarding alignment of these measures with state data sources and the use of health information technology. The crosswalk created during this conversation is shown in Appendix A.

General observations include the fact that the group has not decided whether an EMR will be required, but the expectation will be that health homes will be close to achieving this; we cannot require meaningful use. The group also noted the difficulties of connecting physical and behavioral health records, particularly hospital visit data. They agreed that this will be a phase-in goal but not necessarily a requirement. At the same time, they recognize the need to push hospitals to share this data.

Health home consumers will be assigned a unique identifier that can be used to alert hospitals, primary care, and behavioral health providers that the data must be exchanged. Hospitals will benefit from this relationship because it will help manage clients who frequently use emergency departments. The fact that we cannot assure that hospitals will accurately report data is problematic. It was noted that managed care plans could serve as a pass through for this information, but they will only be able to do so for 60% of the SPMI population, as this is the percentage that are enrolled in managed care.

The group also discussed the fact that the measure for clinical depression screening does not seem to make sense for its purposes. They agreed that this seems to be designed for primary care and that if we can negotiate removing a measure, this one should be removed.

Next Steps/Next Meeting

- The group will review the ODJFS Health Homes Measures Draft and provide feedback on the additional items (outside the core measures) by close of business Friday, November 18, 2011
- Next meeting will take place Friday, December 2, 2011 at 1 p.m. in Rhodes Room 1855

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- Feedback will be incorporated and distributed to the group prior to the meeting. This will be used to build a document that will be dropped into the template for the SPA.
- Updates on other health home committees and case scenarios that show examples of health homes for different consumers will also be provided at the next meeting.

Meeting adjourned at 4:05 p.m.

