

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

Quality Improvement Committee

AGENDA

December 2, 2011

9:30 – 12:30 p.m.

Rhodes, Rm. 806

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 Last Meeting
Recommendations/Crosswalk Document
- Case Studies
- Updates from Other Committees
- Additional Feedback on Measures
- Next Steps
- Next Meeting: December 16, 2011

1:00 p.m. – 4:00 p.m., Rhodes State Office Tower
Lobby Hearing Room

**Quality Improvement Committee
Meeting Minutes
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Attendees: Mary Applegate, Angie Bergefurd, Rich Bowlen, Leslie Brose, Beth Ferguson, Deb Hrouda, Afet Kilinc, Jody Lynch, Max McGee, Kara Miller, Jennifer Millisor, Jen Moses, Christine Neumann, Mark Rizzutti, Kim Shuntz, Peggy Smith, James Vernon

Welcome and Introductions

Angie opened the meeting and the group introduced themselves round table.

Health Homes Measures Draft

Dr. Applegate reviewed the Health Homes Measures Draft which was distributed to the group during the meeting. She stated that the draft is a work in progress; it will be narrowed down in the coming weeks. The feds are interested in seeing evidence of true physical and behavioral health integration. As part of the process in drafting these measures, state staff looked for measures that show that both types of services will be provided to every person in the health home. Originally, the document contained 4 pages of measures, but it was reduced to reflect the main causes of death and morbidity in both physical and behavioral health care. She also explained that the core measures that are listed in the document are dictated by the feds.

The feds are also interested in cost; the hope is that blending care of a variety of providers will reduce the incidence of chronic diseases and emergency department visits. Dr. Applegate pointed out that we are not allowed to discriminate who can be in a health home based upon age. Therefore, pediatric-specific measures also need to be included. We are limited to measures that are not too labor intensive; already-existing measures are easiest to use even if they are not always granular measures. The state also attempted to align the measures as much as possible with meaningful use.

In reviewing the various measures on this document. Dr. Applegate and Dr. McGee discussed who is responsible for follow up after hospitalization for mental illness. It was clarified that this person does not necessarily need to be a doctor; the only requirement is that the person is a mental health practitioner. The group requested that this be more specifically clarified in the document; Dr. Applegate agreed to do so.

It was also noted that the requirement for screening for clinical depression is controversial in that it is already happening in behavioral health care. The group agreed that this measure is more important in the physical healthcare aspect of the health home.

Dr. Applegate also noted measures which are already required of managed care plans and various requirements that directly relate to reduction of stroke and heart attacks. She stated that numerous agencies have identified that post discharge transition is crucial to preventing patients from being readmitted to physical and behavioral healthcare hospitals. This is part of the thinking behind the measures in this document.

Dr. McGee and Dr. Applegate discussed the issue of treatment compliance in substance

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abusers. They were unable to find metrics for this issue but agreed that it would be helpful to follow up on this at each health home site regardless of the fact that it may not appear on the measures score card.

Diabetes was also discussed briefly. This is a focus area of the measures, specifically targeting patients whose diabetes is out of control. Dr. Applegate stated that the biggest concern is with patients with Type 2 Diabetes because this type gets out of control more slowly and is not as easily recognized. The measure that was created was designed to be the most helpful for all patients, but is particularly best for the aged population. The state will be working to match these measures with managed care plan requirements.

Dr. Applegate also talked about the measures related to pregnancy. The focus was on prenatal care for high risk mothers and preventing pre-term newborns (weighing 5 pounds or less). She feels that ultimately, the goal will be to allow the health home client to engage in family planning. This cannot be added as a measure but family planning services could be offered in the future.

In discussing the measure for adolescent well care visits, it was noted that the screening rate for this age group is very low (20%). Dr. Applegate stated that this measure provides a great opportunity to address this issue; a problem list and a plan will be generated from the adolescent well care exam so that problems can be addressed and follow up care can be provided. Dr. Applegate stated that the measures can be used as a score card for health homes to gauge their performance.

In response to Dr. Applegate's request of the group to let her know if any measures have been omitted that should be included, Dr. McGee asked whether a dental measure was considered. Dr. Applegate stated that this was discussed, and this will be part of the overall checkup. She added that the goal is to limit the number of measures; if there are too many, they will not be meaningful. Dr. McGee stated that this is a huge issue in the SMD population; group members agreed.

Dr. Applegate maintained that lack of dental care is not killing people and the focus needs to be on diseases that are causing death. She added that this does not mean that other services cannot be considered later if health home consumers are motivated to have access to them. Afet Kilinc stated that behavioral health providers repeatedly mention concern about dental care; there is no question about motivation or desire to have this access. Jennifer Moses stated that her clinic has a mobile dental service for which clients line up around the building. She added that dental care reduces the number of emergency room visits for these clients.

Beth Ferguson pointed out that education will be needed to make sure that providers understand that multiple services can be provided in one visit. She stated that many are

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under the impression that this cannot be done. Dr. Applegate agreed to clarify the coding piece of this issue.

Mary Haller asked whether the repeat hospitalization portion of the measures separates psychiatric from physical health admissions; Dr. Applegate confirmed that they do. Mary added that based upon the feedback she heard in the meeting with consumers and families yesterday, she suggests that a quality of life or client satisfaction metric be added to the document. Dr. Applegate stated that in previous discussions, the state decided that this should be part of the care provided at individual sites. The sites can create reports based upon surveys that ask patients, guardians, and parents if it seems that the health home has improved their lives.

Mary also raised the issue of measuring community stability in the living arrangements. Afet stated that this is an outcome measure in the new system that Carol Carstens presented in the last meeting. This is an ODMH measure that might be reported to SAMHSA in the future as well. She will follow up on this and report back to the group.

Mary added that the consumer and family group also talked about the need for metrics on expulsions and the number of prescribers a clients uses. Dr. Applegate agreed that this would be helpful, but she sees this as a level two health home metric, not to be required in the first health homes.

Mike Witzky stated that another issue to consider is the satisfaction of the clinicians. He feels that it will be important to take into account the stress and resistance to change that will be involved in the process. Dr. Applegate agreed that the transition will be difficult; however, the outcome will be that clinicians are happier in the long run.

The group discussed ideas for items that could be addressed in future metrics. Afet pointed out that there are a number of good measures in the new ODMH model she mentioned previously. Mike emphasized the importance of GAF training. Afet stated that ODMH is currently working on a web-based training for providers for assigning GAF scores. Participants discussed problems with the GAF measure, but recognized that this is not used in determining funding and is only part of the qualifying categories that define serious and persistent mental illness.

Next, they discussed which measures should be core measures (other than those federally mandated). It was noted that core measures would be reported to the feds and that we would be held accountable to them. These measures would hopefully be used for outcomes in the future.

Lon Herman stated that he would advocate for keeping the metric reporting at the state level in order to keep options flexible in the future. He suggested considering the cost, risk and value associated with the requirement to report to the feds. His opinion is that

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we should not add additional core measures to those that are federally mandated. The group agreed to keep the federal requirements and to only add the emergency room visit and inpatient admission measures discussed previously. Mark Rizzutti will revise the document and send it back to the group. Angie stated that the core measures document will replace the crosswalk distributed during the last meeting; she will report this back to Alicia Smith.

Case Studies

Afet reviewed one of the case studies included in the meeting packet. This case involved a nine year old girl who entered a health home in which a variety of needs were addressed, including child protective services, behavioral health counseling, diabetes diagnosis and treatment, and foster care. Rick Bowlen stated that the prospect of health homes is exciting because it could mean a reduction in the length of time that a child is under care and would also avoid the child being shuffled around among a large number of providers. The health home will allow an opportunity to have true care coordination and continuity.

Dr. Applegate recommended that future case studies show less intake activities. She feels that it is important to reduce the steps that are taken to enter the health home. The group briefly discussed ways in which the process of entering into a health home could be simplified. It was agreed that this would vary depending on the situation; flexibility in the models will be needed. Members also agreed that access metrics and housing metrics should be added in phase 2 health home models.

Mike stated that he was impressed by the client-centeredness of the treatment plan in the case study. He felt this case study was a great illustration of how the care team can work together behind the scenes. He added that he feels that the plan should include a medical focus; it needs to be multi-layered.

Dr. Applegate added that the plans that work best are those that are simple, but include all needed care. These plans should be specifically tailored to the client. Afet stated that the treatment plan was also discussed at ODMH during another meeting. It is in some ways not a treatment plan, but a coordination plan. Mike added that it is important not to assume that people understand this structure.

Next Steps/Next Meeting

- Afet will follow up on the metrics recommended today that may be included in the new ODMH measures (community stability, housing arrangements)
- Mark will update the health homes measures document and distribute it to the group.
- Next meeting is the wrap-up meeting on December 16, 2011 in the Rhodes Lobby Hearing Room from 1 to 4 p.m.

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