

Leadership Lessons from Missouri's Health Homes

Opening Doors and Creating Momentum



My Background

- Medicaid Director
- Previously DMH Medical Director – 20 years
Practicing Psychiatrist
CMHCs – 10 years
FQHC – 18 years
- Distinguished Professor, Missouri Institute of Mental Health, University of Missouri St. Louis
- Adjunct Professor of Psychiatry – University of Missouri Columbia

Celebrity Endorsements

- "He is not only dull himself, he is the cause of dullness in others." -Samuel Johnson
- "He uses statistics as a drunken man uses lamp-posts... for support rather than illumination." -- Andrew Lang
- "He can compress the most words into the smallest idea of any man I know." -- Abraham Lincoln

Themes



- Leadership issues around implementation
- Self activation/self-care
- Health literacy in the context of health homes
- My Personal Leadership Journey

What is a Health Home?



- Not just a Medicaid Benefit
- Not just a Program or a Team
- A System and Organizational Transformation
- Payments for HH services will be paid PMPM, not unit by unit
- Service needs will be identified by patient health history and status
- Outcomes will be measured by groups of clients

Health Care Home Strategy

- Health technology is utilized to support the service system
- “Care coordination” is best provided by a local community-based provider
- MH Community Support Workers who are most familiar with the consumer provide care coordination at the local level
- Primary Care Nurse Care Managers working within each Health Home provide system support
- Behavioral Health Consultants in each Primary Care Health Home
- Statewide coordination and training support the network of Health Homes

Health Home Target Populations

□ Patients with Diabetes

- At risk for cardiovascular disease and a BMI > 25

□ Patients who have two of the following

- COPD/Asthma
- Diabetes (also as single condition)
- Cardiovascular Disease
- BMI > 25
- Developmental Disabilities
- Use Tobacco

□ Individuals with a serious mental illness; or with other behavioral health problems who also have

- Diabetes
- COPD/Asthma
- Cardiovascular Disease
- BMI > 25
- Developmental Disabilities
- Use Tobacco

Primary Care Health Homes

CMHC Healthcare Homes

Missouri's Health Homes

- Providers
 - 18 FQHCs
 - 67 Clinics
 - 6 Hospitals
 - 22 Clinics
 - 14 Rural Health Clinics
- Enrollment
 - 15,526 adults
 - 428 children
 - 15,954 total

Primary Care Health Homes

- Providers
 - 28 CMHCs
 - 120 Clinics/Outreach Offices
- Enrollment
 - 16,611 adults
 - 2,387 children
 - 18,998 total

CMHC Healthcare Homes



What is Different about Health Homes?

- Individual Practitioner
- Episodic Care
- Focus on Presenting Problem
- Referral to meet other Needs
- Managed Care
 - Manages access to care
 - Does not change clinical practice
- Integrated Primary/Behavioral Health Care Team
- Continuous Care
- Comprehensive Care Management
 - Coordinates care across the healthcare system
 - Data driven population management
 - Transforms clinical practice
 - Emphasizes healthy lifestyles and self-management of chronic health problems

Treatment as Usual

Health Homes

Principles

- One Team
 - ▣ CMHC's composed of pre-2012 CPRC staff plus NCM and PC Consultant
 - ▣ PCHH's composed of new infrastructure and team members
- One Treatment Plan for the Whole Person
 - ▣ Rehab Goals
 - ▣ Medical Goals
 - ▣ Healthy Lifestyle Goals
- Some Goals and Outcomes reference Health Home Performance Measures
- Wrap –Around approach to outside treating PCP, mental health providers, community supports, etc

Population-Based Care

- Don't rely solely on patients to know when they need care and what care to ask for from whom - Use data analytics to outreach to on high need/high utilizer patients
- Don't focus on fixing all care gaps one patient at a time - Choose selected high prevalence and highly actionable individual care gaps for intervention across the whole population
- The population-based health care provider is the public health agency for their clinic population

Principles

- Use the Data you have before collecting more
- Show as much data as you can to as many partners as you can as often as you can
 - Sunshine improves data quality
 - They may use it to make better decisions
 - It's better to debate data than speculative anecdotes
- When showing data ask partners what they think it means
- Treat all criticisms that results are inaccurate or mis-leading as testable hypotheses

More Principles

- Tell your data people that you want the quick easy data runs first. Getting 80% of your request in 1 week is better than 100% in 6 weeks
- Treat all data runs as initial rough results
- Important questions should use more than one analytic approach
- Several medium Data Analytic vendors/sources is better than on big one
- Transparent Bench Marking improves attention and increases involvement

Health Home Team

14

Nurse care managers (1FTE/250pts)

Care coordinators (1FTE/500pts)

Health Home director

Behavioral health consultants (primary care)

Primary care physician consultant (behavioral health)

All must learn collaborative training

And respond to ext day notification of hospital admissions and ER visits



Six CMS Required Health Home Functions



- *Care Management*
- *Care Coordination*
- *Managing Transitions of Care*
- *Health Promotion*
- *Individual and Family Support*
- *Referral to Community Services*

Comprehensive Care Management



- Identification and targeting of high-risk individuals
- Monitoring of health status and adherence
- Identification and targeting care gaps
- Individualized planning with the patient

Step 1 – Create Disease Registry

- Get Historic Diagnosis from Admin Claims
- Get Clinical Values from Metabolic Screening, clinical evaluation and management, care plans
- Combine into EHR Disease Registry (Central Data Registry, PROACT)
- Online Access available to all Providers

Step 2 – Identify Care Gaps and ACT!

- Compare Combined Disease Registry Data to accepted Clinical Quality Indicators
- Identify Care Gaps
- Sort patients groups with care gaps into agency specific To-Do lists
- Nurse care manager helps team decide who will act
- Set up indicated visits and pass on info with request to treat

Care Coordination



- Coordinating with the patients, caregivers and providers
- Implementing plan of care with treatment team
- Planning hospital discharge
- Scheduling
- Communicating with collaterals

A1c, LDL, and Blood Pressure

PERFORMANCE PROGRESS



Good News

Small Changes Make a Big Difference

- Blood cholesterol
 - ▣ 10% ↓ = 30% ↓ in CVD (120-100)
- High blood pressure (> 140 SBP or 90 DBP)
 - ▣ ~ 6 mm Hg ↓ = 16% ↓ in CVD; 42% ↓ in stroke
- Diabetes (HbA1c > 7)
 - ▣ 1% point ↓ HbA1c = 21% dec in DM related deaths, 14% decrease in MI, 37% dec in microvascular complications

Stratton, et al, BMJ 2000

Hennekens CH. *Circulation* 1998;97:1095-1102.

Rich-Edwards JW, et al. *N Engl J Med* 1995;332:1758-1766.

Bassuk SS, Manson JE. *J Appl Physiol* 2005;99:1193-1204

Conclusions

A1c Control

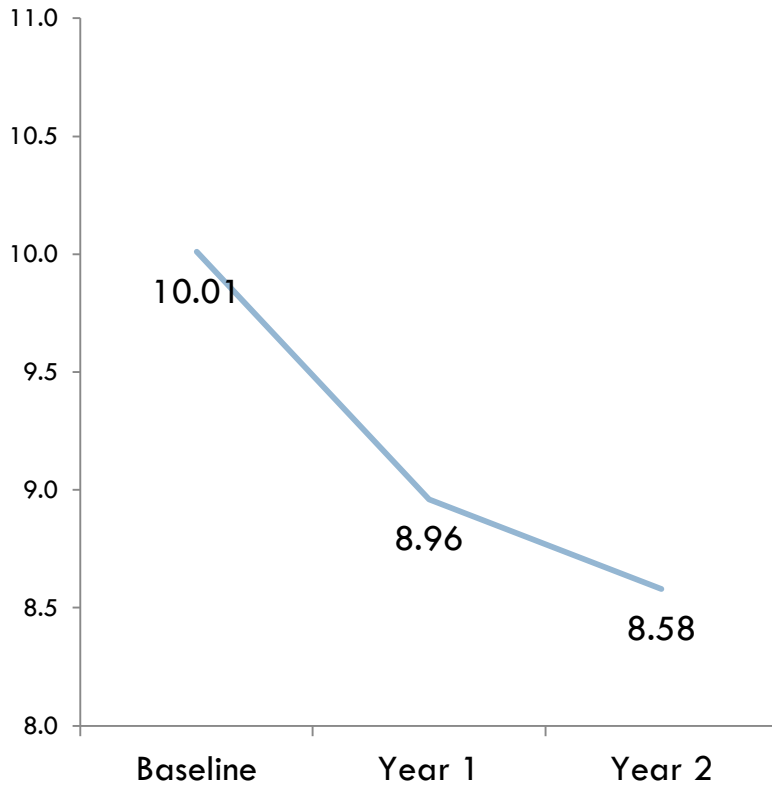
- About 7% had uncontrolled A1c levels
- Cohorts with elevated A1c levels showed at least a 1 point reduction
- Cohorts with normal A1c levels increased by 0.1 point or less

Levels Over Time

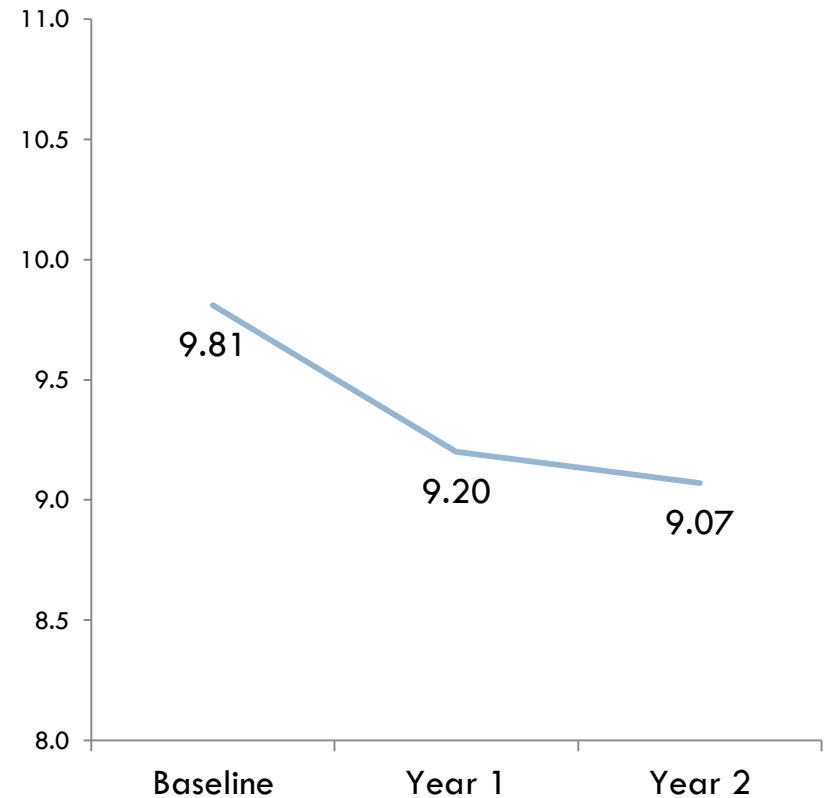
1 POINT DROP IN A1C

- 21% ↓ in diabetes related deaths
- 14% ↓ in heart attack
- 31% ↓ in microvascular complications

CMHC-HHs



PCHHs



Conclusions

LDL Control

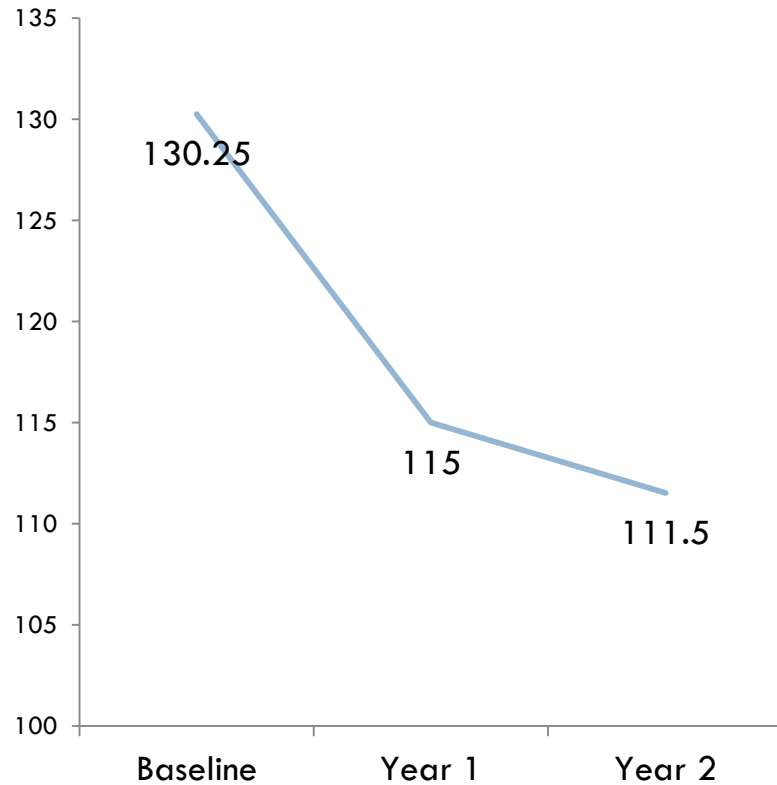
- About 45% had uncontrolled LDL levels
- Cohorts with elevated LDL levels showed more than a 10% reduction
- Cohorts with normal LDL levels increased by 7 to 8 points but remained in the low 80's

Levels Over Time

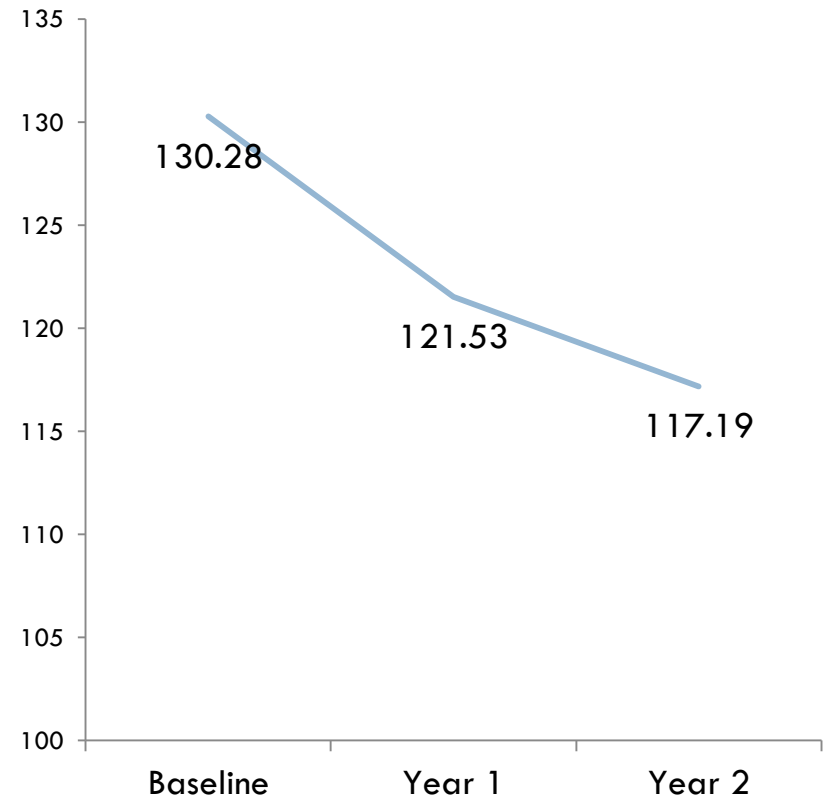
10% DROP IN LDL LEVEL

30% ↓ in cardiovascular disease

CMHC-HHs



PCHHs



Conclusions

Blood Pressure Control

- 20%-24% had uncontrolled Blood Pressure levels
- Cohorts with elevated Blood Pressure levels showed more than a 6 point drop in both systolic and diastolic pressure
- In every cohort, on average, Systolic pressure dropped below 140, and Diastolic pressure dropped below 90
- Systolic and Diastolic pressure increased by 1 to 5 points in cohorts with normal Blood Pressure levels, with Systolic pressure averaging in the low 120's and Diastolic pressure averaging in the mid 70's

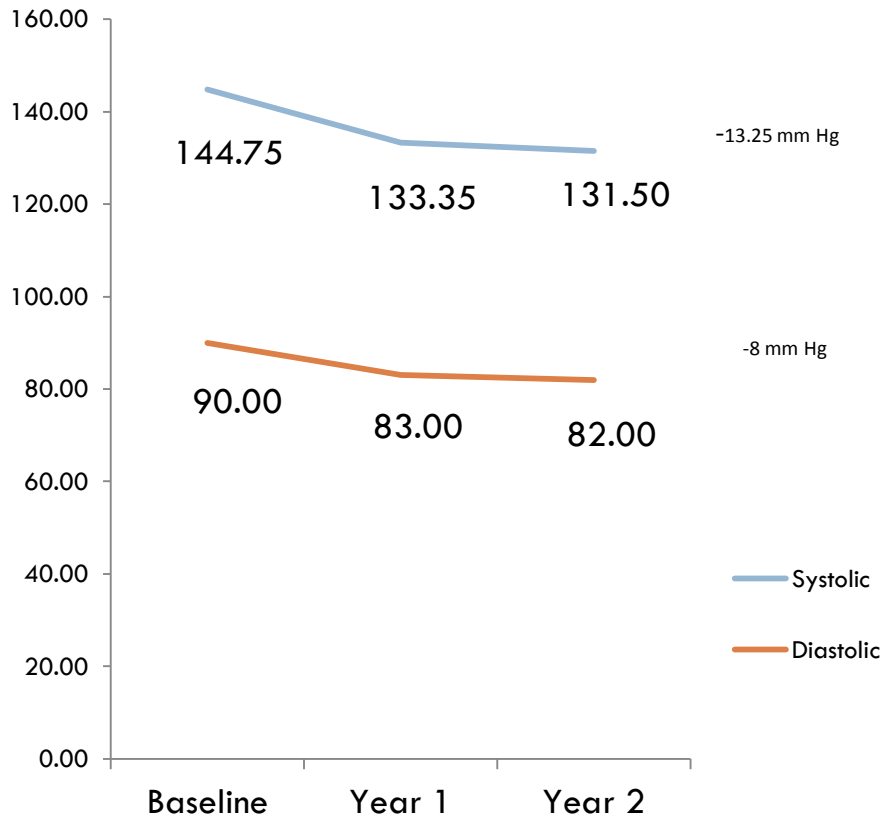
BLOOD PRESSURE Over Time

6 POINT DROP IN BLOOD PRESSURE

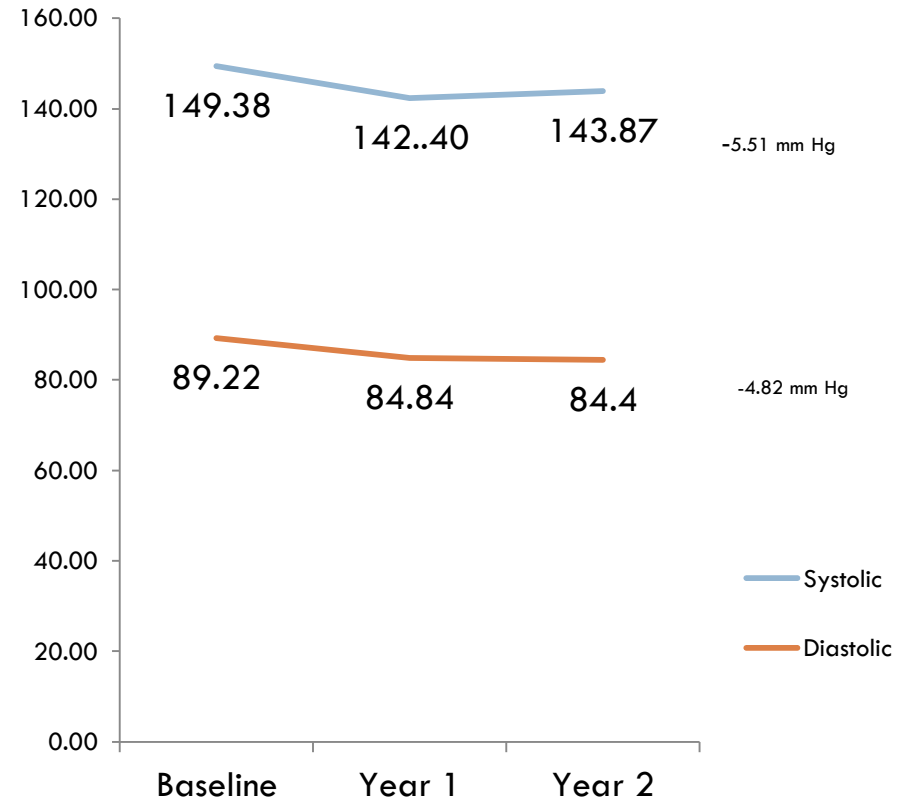
■ 16% ↓ in cardiovascular disease

■ 42% ↓ in stroke

CMHC-HHs



PCHHs



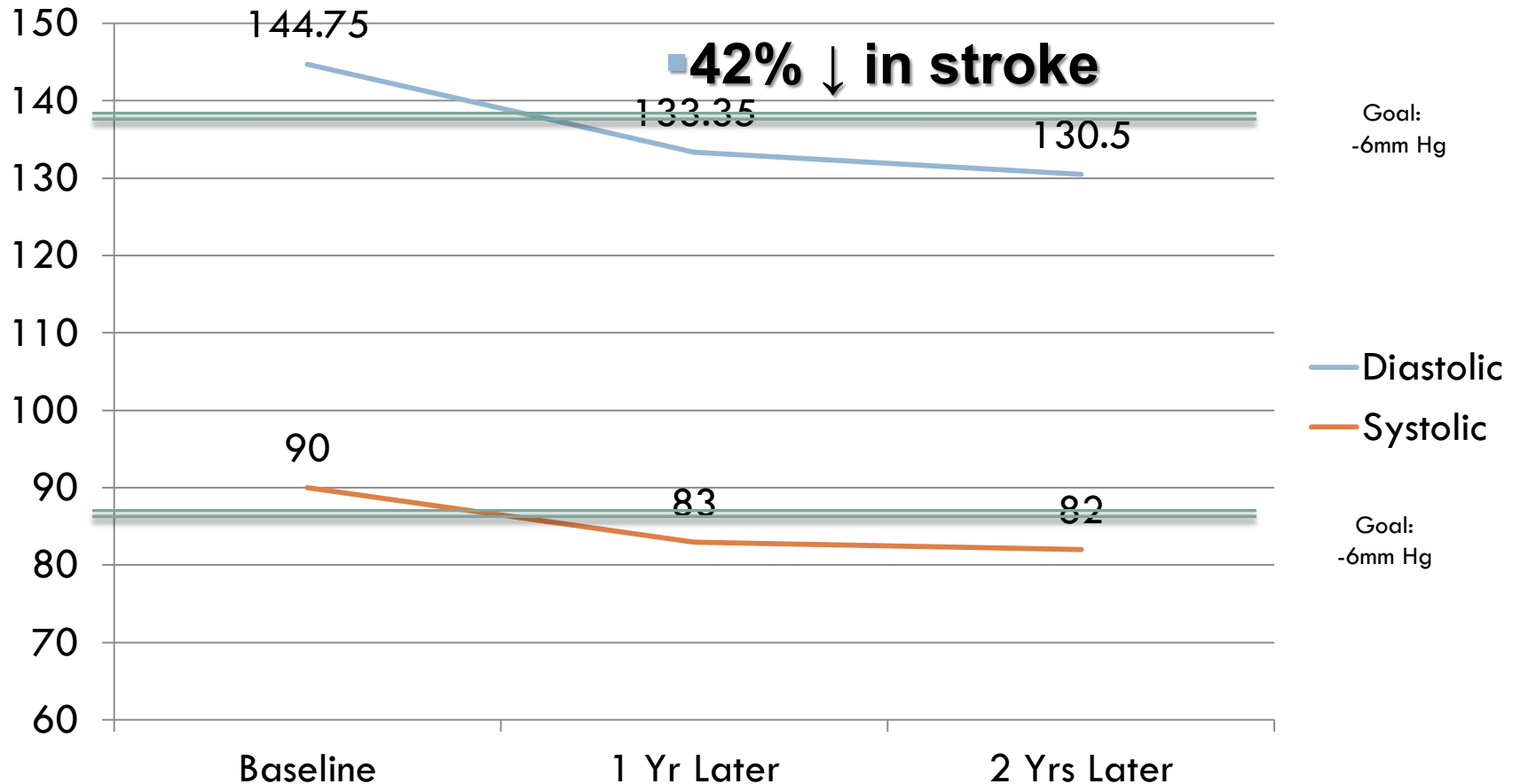
Reduction in Blood Pressure

6 POINT DROP IN BLOOD PRESSURE!

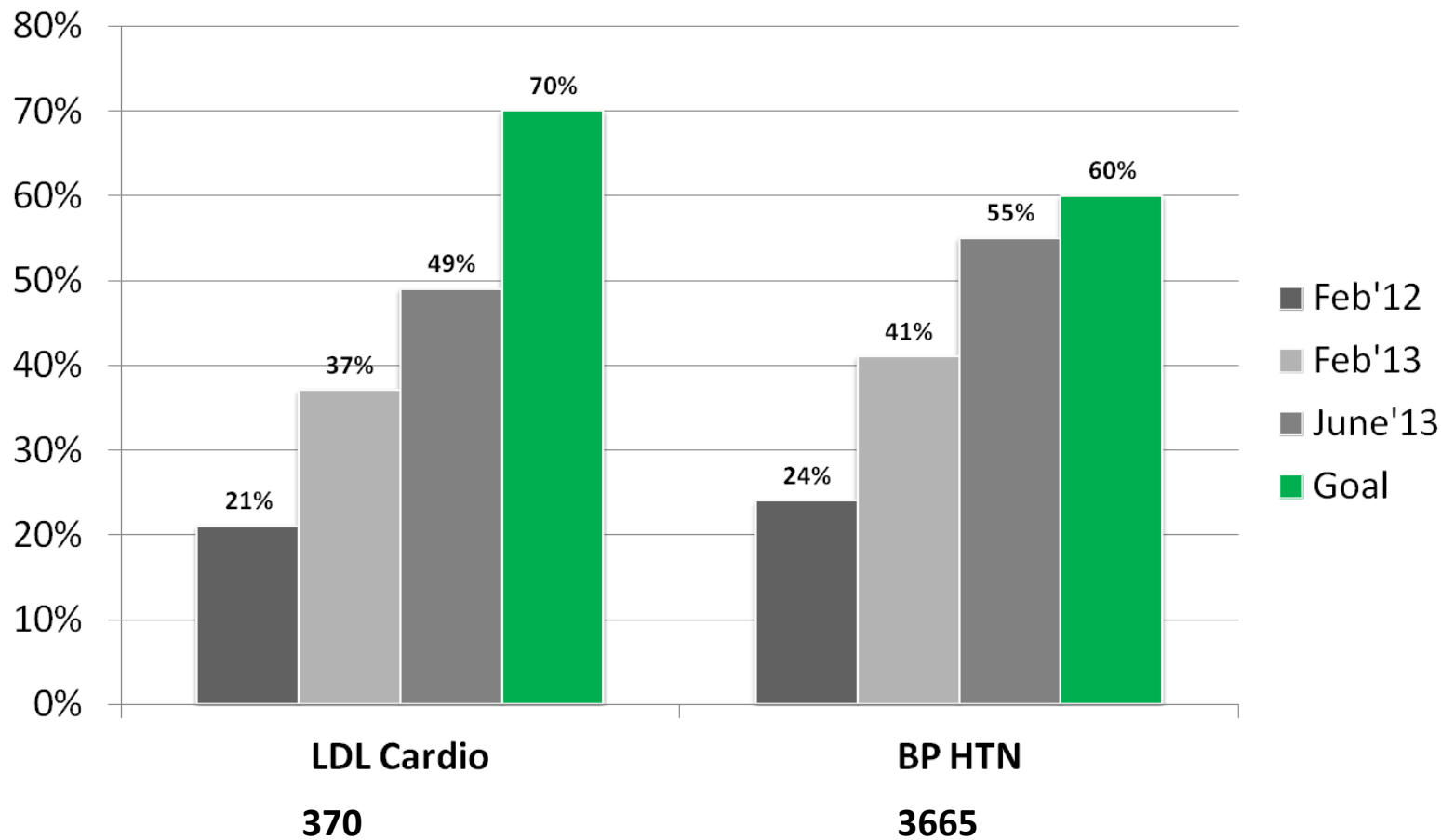
Pressure

16% ↓ in cardiovascular disease

42% ↓ in stroke



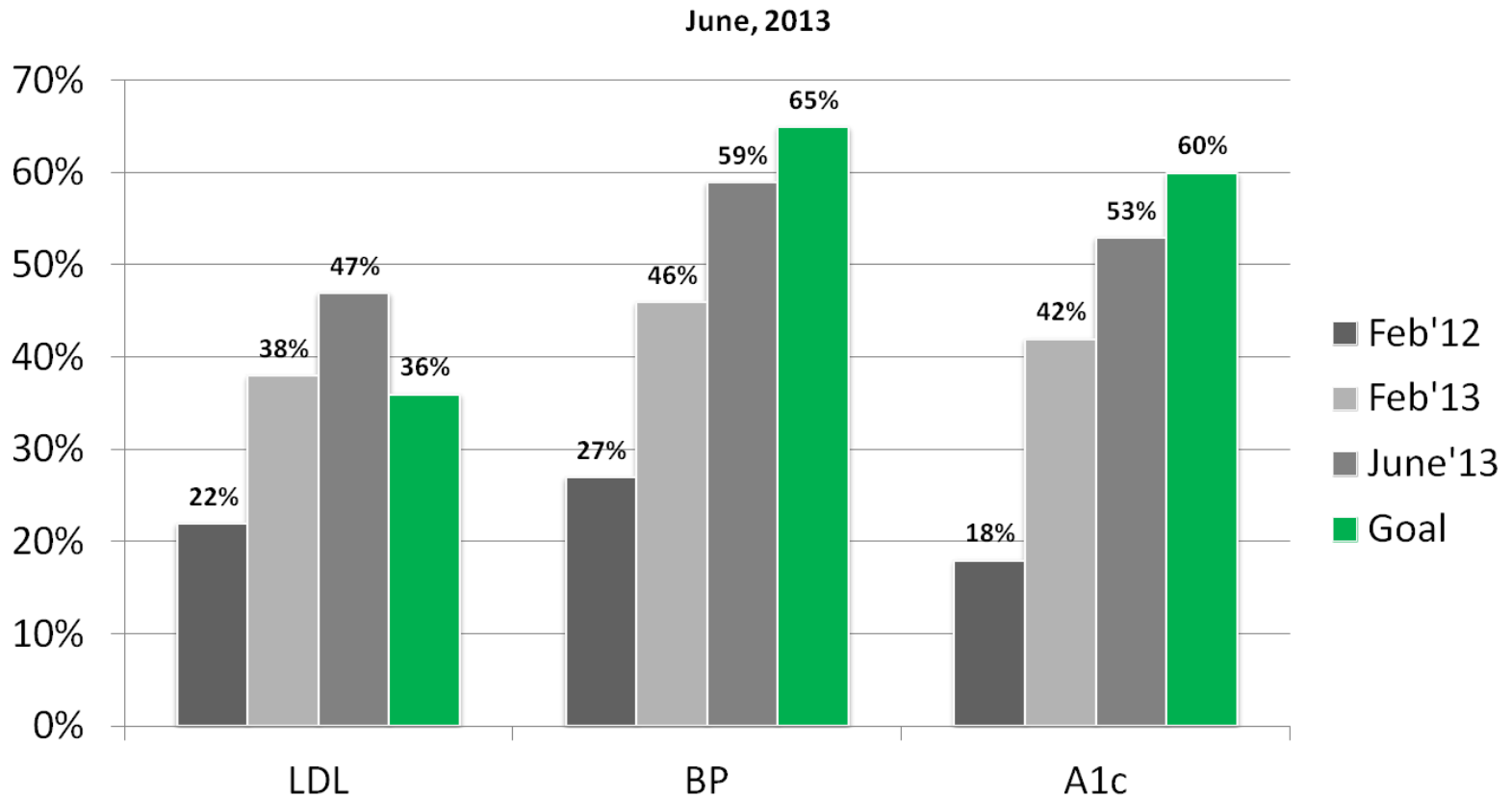
Hypertension and Cardiovascular Disease



Disease Management

Diabetes

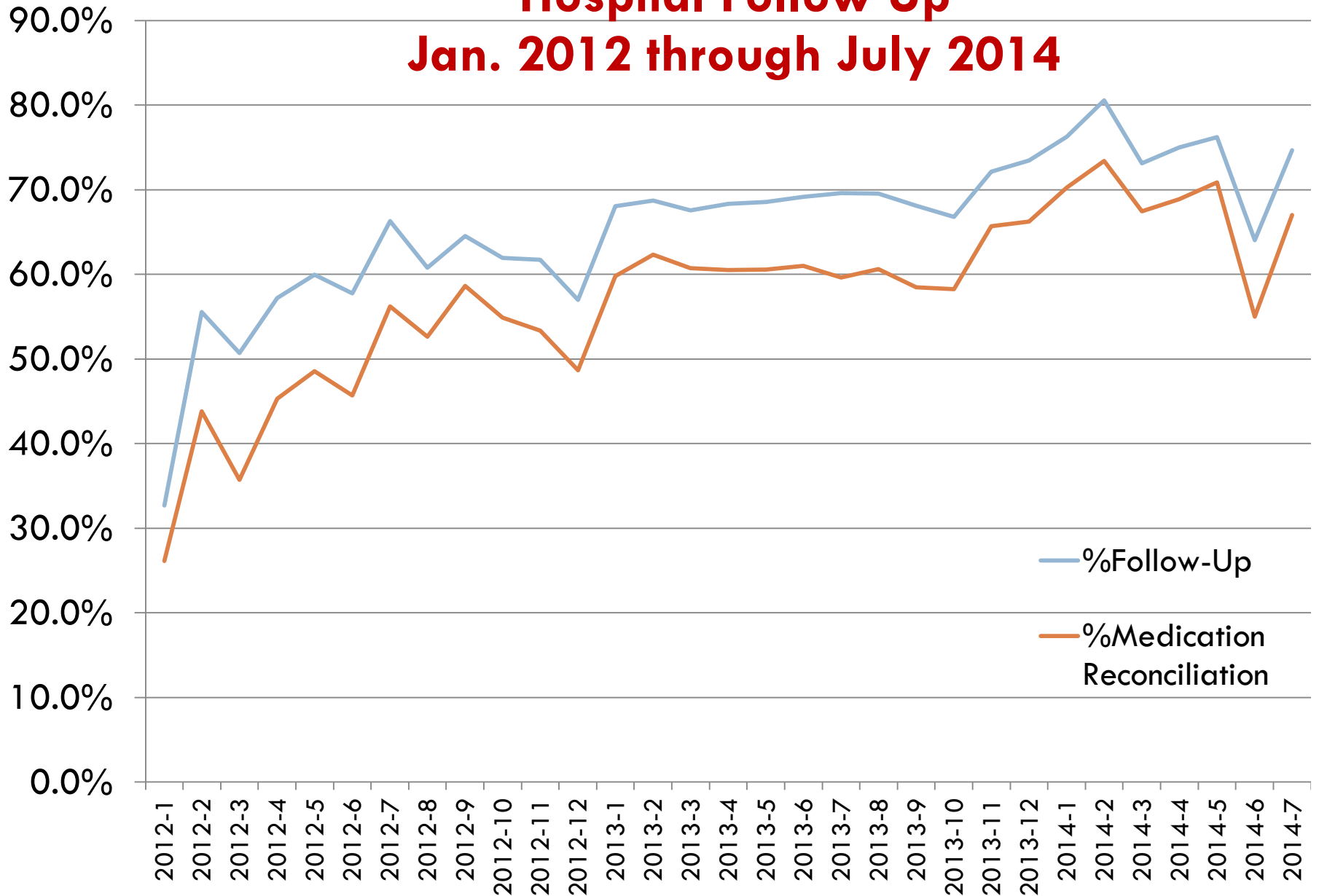
(2822 Continuously Enrolled Adults)*



*29% of continuously enrolled adults

Hospital Follow Up

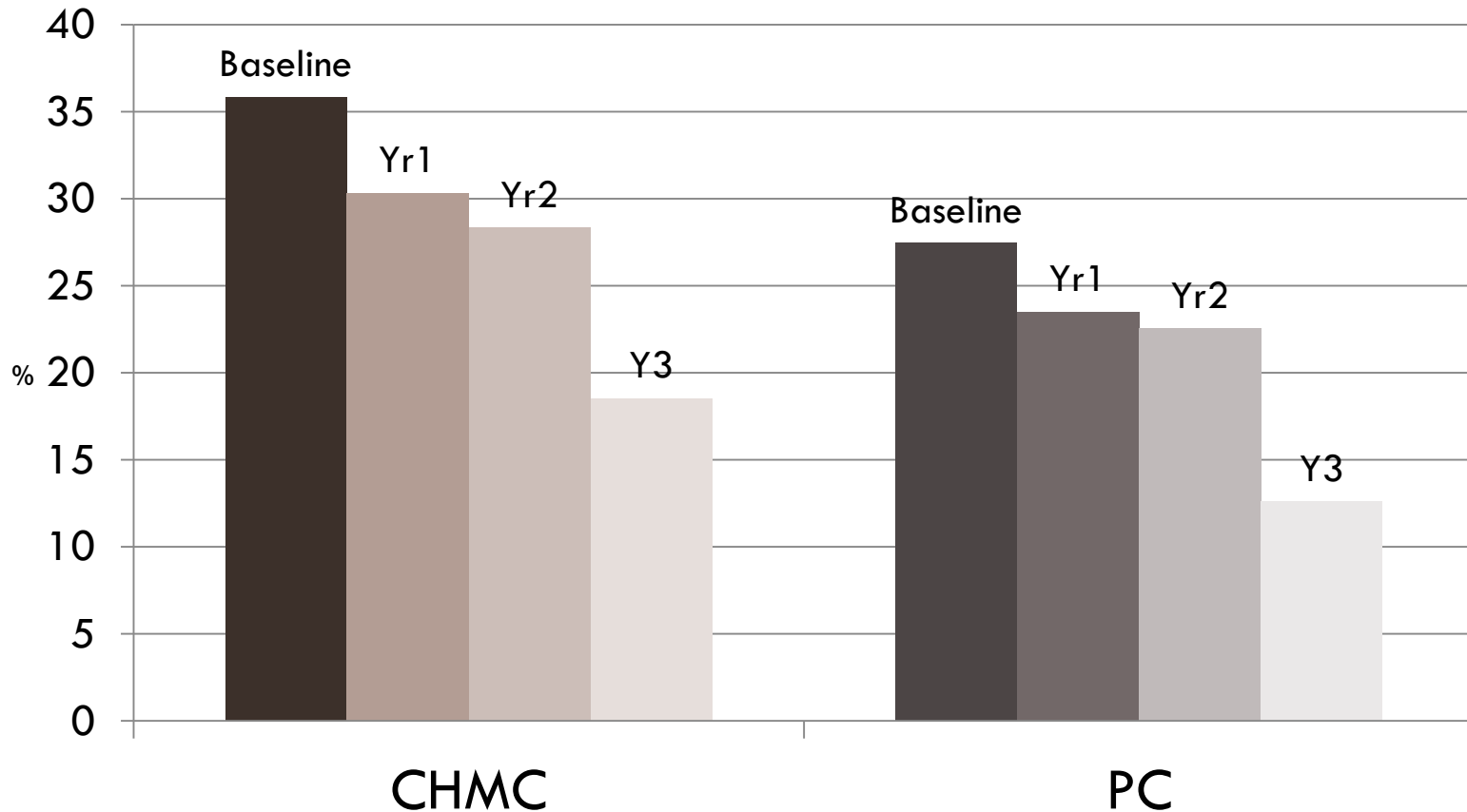
Jan. 2012 through July 2014



Outcomes

Reducing Hospitalization

**% of patients with at least 1 hospitalization
(non-duals, 9+ attestations)**



Initial Estimated Cost Savings after 18 Months

- CMHC Health Homes
 - ▣ 20,031 persons total served (includes Dual Eligibles)
 - ▣ Cost Decreased by \$76.33 PMPM
 - ▣ Total Cost Reduction \$15.7 M

- PC Health Homes
 - ▣ 23,354 persons total served (includes Dual Eligibles)
 - ▣ Cost Decreased by \$30.79 PMPM
 - ▣ Total Cost Reduction \$7.4 M

Initial Estimated Cost Savings after 18 Months

□ Health Homes

- 43,385 persons total served (includes Dual Eligibles)
- Cost Decreased by \$51.75 PMPM
- Total Cost Reduction \$23.1M

□ DM3700

- 3560 persons total served (includes Dual Eligibles)
- Cost Decreased by \$614.80 PMPM
- Total Cost Reduction \$22.3M

Population Management

Requires a significant change in the way of thinking and practice patterns of providers

Care for an entire population, not just for the individual patients who actively seek care

Adopt a new way of doing business

“Health information technology is absolutely ‘necessary but not sufficient’ for creating practice-based population health management; committed executive and clinical leadership, care team development, and care coordination processes are also critical success factors”

Self Activation

- Which Self do you Prioritize to Activate First
 - ▣ Yourself
 - ▣ Your Staff
 - ▣ Your Patience/Consumers
- How to activate All the Selves?
 - ▣ Provide information transparently
 - ▣ Respond rapidly to remove the obstacles they identify
 - ▣ Encourage them to air on the side of action
 - ▣ If the action they choose is better than dangerous keep your mouth shut and encourage them proceed

Creating New Professional Cultures

- Every profession or trade has its own culture
- A living culture automatically trains its members and their roles, skills, and expectations
- Creating and maintaining culture requires regular group contact and discussion of their common experience to form a guild identity.
- The new Health Home professions that need their own culture are:
 - ▣ Nurse Care Manager
 - ▣ Health Home Director
 - ▣ Primary Care Consultant

Culture Creating Activities

- Separate Regular group conference calls
- Separate periodic group face-to-face meetings
 - ▣ Presentations from members of the group on "how they did it" to the rest of the group
 - ▣ Small group breakout sessions with lots of time for discussion
- Separate training and communication specifically for that group
- Annual Awards to the best of the new cultural/professional group



Training Initiatives

- “Paving the Way” – required for CEO to deliver
- Leadership and Team “HCH 101”
- Access to Care – Open Access Scheduling by MTM
- CyberAccess and ProAct Training
- Physician Institutes
- CARF



Technical Assistance

- Monthly HCH Director Calls
- Quarterly HCH Director Meetings
- Progress Reports
- Site Visits
- Practice Coaches



HCH Accreditation

- DMH worked with CARF to develop Health Home accreditation for behavioral health organizations
- CARF provided training on the standards in November, 2011
- Most CMHC Healthcare Homes have already been accredited under the CARF standards and all have had their site visits
- JCAHO subsequently developed health home standards that can also be used to meet the accreditation requirement

Health Literacy

- Prioritize Who Needs to Be Health Literate
 - ▣ Yourself
 - ▣ Your Staff
 - ▣ Your Patients/Consumers
- Done in response to requests from the field
- Modular and Manualized
- Billable as PsychoSocial Rehab
- Increased access to NRTs and Bariatric Surgery in Medicaid – Obesity counseling and Asthma Education under development
- CEOs report improved staff health



More Training Initiatives

- Chronic Illness and Disease Management
- Motivational Interviewing
- TEAMcare
- Wellness Coaching
- CARF
- Tobacco Cessation – Doug Ziedonis and Jill Williams
- Obesity Interventions – Rohan Ganguli and Ginger Nichols

What Makes it Possible?

- A Relationship of Basic Trust between:
 - ▣ Department of Mental Health
 - ▣ Mo HealthNet (medicaid)
 - ▣ State Budget Office
 - ▣ MO Coalition of CMHCs
 - ▣ MO Primary Care Association
- Transparent use of data instead of anecdotes to explore and discuss issues
- Willingness of all partners to tolerate and share risk
- Principled Negotiation and Motivational Interviewing





DYSFUNCTION

THE ONLY CONSISTENT FEATURE OF ALL OF YOUR DISSATISFYING RELATIONSHIPS IS YOU.

Partnership Principles

DON'T

Talk about your need first

Expect to get something

Limit assistance to a project

Make it about this deal

Push a specific position

Withhold information

Let them take their lumps

DO

Ask about their needs first

Give something

Assist wherever you can

Make it about the next 10

Pursue common interest

Reveal anything helpful

Take one for the team

Leadership Mentor - Dancing

- You have to know your Followers location, center of gravity, and velocity before doing anything
- It's about opening doors and getting out of the way not by pushing or pulling in a particular direction
- Successful motion is about where your center goes not what happens with your extremities
(demonstration projects are a waste of time)

Leadership Mentor - Dancing

- Communicating clear and consistent intentionality is essential
- You have to lead at the level that your Follower is able to follow
- If your Follower doesn't look good it's your fault
- Always thank your follower no matter how well or poorly things went

Leadership Mentors

- The Boy Scouts –
 - ▣ Often the most effective way to lead is being the first one to very publicly follow someone else's direction
 - ▣ Make it Fun
- Keith Schafer - Keep communications clear and simple. A single page that your aunt or store clerk could read and understand.
- Dorn Schuffman - Character makes it happen both for individuals and organizations
- Getting to Yes – Principled Negotiation



Transformation =
Changing Who You Are

It's about Character



Character

From GR *charakter* – to engrave

- The essential quality or nature
- Reputation
- The complex accustomed mental and moral characteristics and habitual ethical traits marking a person, group, or nation, or serving to individualize it



Your Character is
your propensity to behave in certain ways

Character = Habits



Character is
both revealed and formed
by how we respond to
opportunities or crises



Serving the Whole Person

Seeing people differently will change

- ▣ how you behave
- ▣ your habits
- ▣ who you are
- ▣ your character

S.M.R. Covey, The Speed of Trust Behaviors that Promote Trust

> Character

- Talk Straight
- Demonstrate Respect
- Create Transparency
- Right Wrongs
- Show Loyalty

> Competence

- Deliver Results
- Get Better
- Confront Reality
- Clarify Expectations
- Practice Accountability

> Character & Competence

- Listen First
- Keep Commitments
- Extend Trust



Leadership Mentor - Pharma

- Repeat Your Message Relentlessly
- Segment your audience and tailor your leadership message for each audience. Everyone doesn't respond to the same images and motivations
- Communicate a lot more about the successes than the shortcomings
- Small gifts help a lot
- Sometimes reality is a group consensual delusion - if you can get everybody to agree that something is so then it becomes so

What I Figured out on My Own

- Organizational culture and professional culture are really important
- Error on the side of Action
- Effective Leaders Are Unrealistically Optimistic
- Most people are surprisingly hungry to get some good leadership - and ready to follow
- Consistent immediate responsiveness increases your influence and power
- Rituals are important and powerful

What I Figured out on My Own

- Focus on continuous incremental change - big sweeping change scares people
- Strategy is about a broad a general direction and not a detailed roadmap
- Move opportunistically - it is easier to influence the direction of momentum than to create momentum
- Reserve time to get to know of sensibly unrelated organizations and industry sectors - you will discover resources and opportunities that you never knew existed

Most Important Principle

- Perfect is the Enemy of Good
- Use an Incremental Strategy
- If you try figure out a comprehensive plan first you will never get started
- Apologizing for a failed prompt attempt is better than is better than apologizing for missed opportunity



PLANNING

MUCH WORK REMAINS TO BE DONE BEFORE WE CAN ANNOUNCE
OUR TOTAL FAILURE TO MAKE ANY PROGRESS.



LIMITATIONS

UNTIL YOU SPREAD YOUR WINGS,
YOU'LL HAVE NO IDEA HOW FAR YOU CAN WALK.



CHANGE

WHEN THE WINDS OF CHANGE BLOW HARD ENOUGH,
THE MOST TRIVIAL OF THINGS CAN TURN INTO DEADLY PROJECTILES.

WebSites

- www.nasmhpd.org/medicaldirector.cfm
- www.dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm