

1-1-2014

Early Lessons Learned in Implementing MaineCare Health Homes

Kimberley S. Fox MPA

University of Southern Maine, Muskie School of Public Service

Carolyn E. Gray MPH

University of Southern Maine, Muskie School of Public Service

Katherine Rosingana

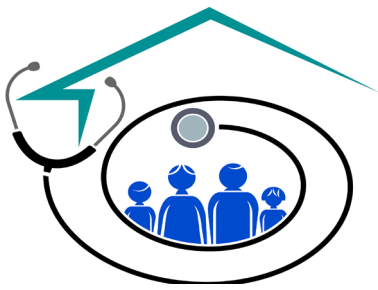
University of Southern Maine, Muskie School of Public Service

Follow this and additional works at: <https://digitalcommons.usm.maine.edu/healthpolicy>

Recommended Citation

Fox, K., Gray, C., & Rosingana, K. (2014). Early lessons learned in implementing MaineCare health homes. Portland, ME: University of Southern Maine, Muskie School of Public Service.

This Policy Brief is brought to you for free and open access by the Cutler Institute for Health & Social Policy at USM Digital Commons. It has been accepted for inclusion in Population Health & Health Policy by an authorized administrator of USM Digital Commons. For more information, please contact jessica.c.hovey@maine.edu.



Early Lessons Learned in Implementing MaineCare Health Homes

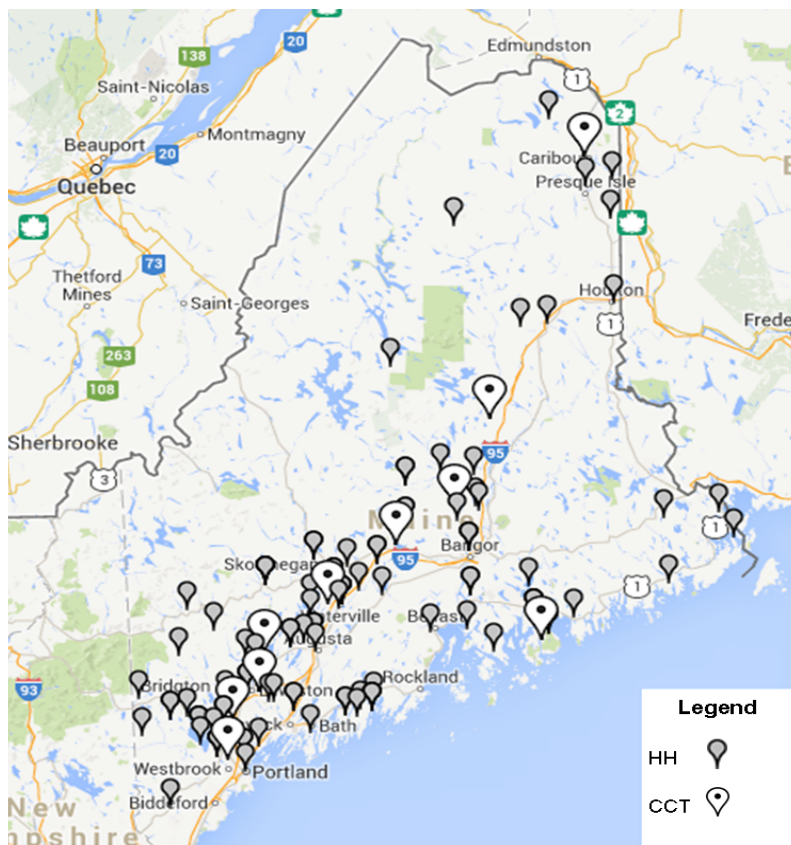
Kimberley Fox, Carolyn Gray, Katie Rosingana
Muskie School of Public Service, University of Southern Maine

September 2014

Overview

The MaineCare Health Homes Initiative is designed to improve care coordination for MaineCare members with complex chronic medical conditions. The initiative, which began in January 2013, builds off the State’s existing multi-payer Patient Centered Medical Home (PCMH) Pilot project and Medicare Advanced Primary Care Practice (MAPCP) Demonstration by providing add-on payments to primary care practices to provide “whole person” integrated care coordination for MaineCare members with specific chronic conditions. For the highest need patients, practices work with Community Care Teams (CCT) that provide short-term care management and social support services. The Muskie School of Public Service is evaluating the implementation of this new care model. This issue brief highlights key lessons learned from the first year of implementing Health Homes. A separate issue brief describing MaineCare members enrolled in the first year can be found at <http://muskie.usm.maine.edu/Publications/PHHP/MaineCare-HealthHomes-Enrollment.pdf>

Figure 1. Community Care Teams and Health Homes in Maine



Key Findings

MaineCare’s Health Homes initiative has expanded Maine’s capacity for chronic care management in primary care practices and community care teams (CCT).

CCTs provide valuable additional support to patients of Health Homes, including home visits and social supports in the community.

Flexibility in program design allowed for wide variation of service delivery models within CCTs.

3% of Health Home members were referred to CCTs by the end of the first year, but overall practice referral rates varied by CCT- from 1% to 7% of HH members within their associated practices.

For more information about this study, contact Kimberly Fox at kfox@usm.maine.edu

[Link to full report](#)

Findings

MaineCare Health Homes expanded primary care and CCT chronic care management capacity

- By the end of the first year of implementation, 157 practices (over one-third of all primary care practices serving MaineCare members) and 10 CCTs were participating in the program and providing health home services, significantly increasing care coordination capacity throughout the State (See Figure 1).
- More than 80 of these practices and 2 CCTs were newly involved and had not previously participated in Maine’s PCMH Pilot and MAPCP demonstrations, providing additional chronic care services to eligible MaineCare members.
- In year one of the initiative, all practices were working to maintain or build their infrastructure for more robust care management, including hiring or re-assigning RNs or care managers, scanning for gaps in care and identifying higher-needs patients as a multi-disciplinary team, and attempting to increase in-person patient contact. Practices that had participated in the PCMH pilot had much of the infrastructure in place at the start, but practices brand new to the initiative had a steeper learning curve.
- CCT services are available across the state but vary widely in the organizations delivering the services, staffing models, type of services provided, the number of associated HH practices (2 to 39 practices) and HH members referred and served by CCT (25 to 437 members).

Figure 2. Use of Health Home Practices Affiliated with CCTs. Data as of December 21, 2013.

CCT Name	Number of Practices	Percent of Members Utilizing CCTs	CCT Member Panel Count
Overall	157	3%	1325
Newport Family Practice, Pa	2	7%	59
Aroostook Mental Health Services, Inc.	11	5%	155
DFD Russell Medical Center	4	5%	55
Mount Desert Island	15	4%	112
Androscoggin Home Health Services, Inc	30	4%	437
Eastern Maine Homecare Dba Bangor Area Visiting Nurses	39	2%	212
Penobscot Community Health Center	17	2%	138
Maine Medical Center	20	2%	99
Community Health & Nursing Services	5	1%	25
Mainegeneral Medical Center	14	1%	33

Source: Health Home Enrollment System

Use of CCTs by Health Home practices varies, but are seen as providing valued additional support to meet the needs of most vulnerable patients

- 3% of HH members were being referred by HH practices to CCTs by the end of the first year, but HH practice referral rates varied by CCT from 1% to 7% of HH members within associated HH practices (See Figure 2). Generally, referral rates tended to be higher in cases where the CCT had fewer assigned HH practices and/or were co-located or embedded with their HH practices.
- 60% of CCT referrals were for patients with three or more chronic conditions and/or who failed to meet treatment goals or had high social or behavioral health needs interfering with their care (See Figure 3).

- Health Home practices that use CCTs saw the added value they provide, particularly home visits, medication reconciliation, mental health and social work support, all of which helped practices understand the whole person in their environment, in order to determine the best strategies to meet a patient’s needs.
- While it was too early to see a broader impact on patient health outcomes, practices and CCTs reported some health improvements for specific patients: reduced use of ER by developing a checklist with the patient for them to review before calling the ambulance; improved compliance of self-monitoring glucose levels because the practice team is working with the patient; and medication reconciliation, including identifying and correcting wrong dose of insulin by CCT, resulting in improved adherence.
- The ability for HH practices and CCTs to share a common EMR or to get real-time notifications of emergency department visits through HealthInfoNet was seen as extremely advantageous to timely communication and improved care management.

Figure 3. Patient Referrals to CCT as of December, 2013.

Reason for Patient Referral to CCT	Percent of Occurances
3+ chronic conditions and/or failure to meet treatment goals	33%
High social service needs interfering with care	28%
Identified by MaineCare as high-risk or high-cost	17%
ED Utilization: 3+ in 6 months or 5+ in year	15%
Polypharmacy: 15+ chronic medicines and/or multiple high risk medications	4%
Hospital Admissions: 3+ in 6 months or 5+ in year	2%

Source: Health Home Enrollment System

What are Health Homes and CCTs and What New Services do They Provide?

Health Homes are Maine primary care practices that meet specified standards (i.e. fully implemented electronic medical records (EMR), NCQA PCMH Level 1 recognition within a specified time period, and that commit to meeting Maine’s PCMH model 10 Core Expectations).² These practices also agree to provide comprehensive care management, care coordination, comprehensive transitional care, individual and family support, and referral to community and social support services to eligible MaineCare members who have at least two chronic medical conditions, or have one chronic condition and are at risk for another chronic condition.³ For the highest need patients (approximately 5% of Health Home members), Health Home practices work with multi-disciplinary, community-based Community Care Teams (CCTs) that provide additional care support services to help patients manage their illness in the community and reduce their emergency department use and hospital admissions.

Other Implementation Lessons in the First Year

- Many HH practices and CCTs felt they could have benefited from more up-front training prior to implementation to more fully understand the initiative (e.g. what members were eligible, what services needed to be provided to receive payment -- minimum billable activity, new attestation requirement)
- Practices and CCTs valued MaineCare data provided through the HHES web portal for population management, but wanted more data on patients' service use patterns and needs to help manage care.⁴
- Getting eligible patients enrolled was challenging due to confusion about who was eligible for Health Homes versus who should be in Behavioral Health Homes (which began in April 2014).
- Many Health Home practices and CCTs indicated that the payment model was challenging.⁵ The lack of predictable and sustainable long term funding made it difficult to hire staff. This was particularly true for CCTs given greater uncertainty of month to month caseloads which depend on practice referrals. Several CCTs suggested that the current MaineCare reimbursement model for CCTs may not be financially sustainable.

Conclusion

After one year of implementation, the MaineCare Health Homes initiative has significantly expanded the number of primary care practices and CCTs providing chronic care management to MaineCare members. After initial start-up challenges, HH practices and CCTs are increasingly working to improve population health management for chronic care patients and providing needed services to support patient self-management. The Muskie School will continue to evaluate the implementation of this new care model to assess any refinements or changes made by HH practices CCTs and MaineCare as well as to measure the program's impact on MaineCare members' outcomes.

Endnotes

1. Practices were initially expected to have NCQA PCMH Level 1 recognition by January 1, 2013, but to encourage greater participation this date was extended to June, 2013 and then to December, 2013.
2. Accessed Jan & Aug 2014: http://www.mainequalitycounts.org/image_upload/PCMH_2013%20PCMH%20Core%20Expectation%20Requirements_12.20.12.pdf
3. Conditions may include: diabetes, substance abuse, heart disease, high blood pressure, high cholesterol, obesity or overweight, smoking/tobacco use, chronic obstructive pulmonary disorder, developmental disorders or autism, heart and lung defects, asthma, seizure disorder, brain injury, and some mental health issues. For more information, please see <http://www.maine.gov/dhhs/oms/vbp/>
4. The HHES portal was modified in October 2013, after evaluative interviews with practices, to include some of these suggested improvements.
5. In contrast to the PCMH Pilot and MAPCP expansion, that prospectively pays practices and CCTs monthly for all patients on their panel, HH payments may vary from month to month because HH practices and CCTs are only paid for eligible members enrolled who the practice and CCT attest have received health home services during that month.