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The Makings of a Health Home

Monday, May 16, 2011

Chuck Ingoglia, MSW
Vice President Public Policy
National Council for Community Behavioral Healthcare

Where Should Care Be Delivered? The National Council Four Quadrant Integration Model

- Organize our understanding of the many differing approaches—there is no single method of integration
- Think about the needs of the population and appropriate targeting of services
- Clarify the respective roles of PCP and BH providers, depending on the needs of the person being served
- Identify the system tools and clinician skill and knowledge sets needed and how they vary by subpopulation
- Population based for system planning, services should be person-centered

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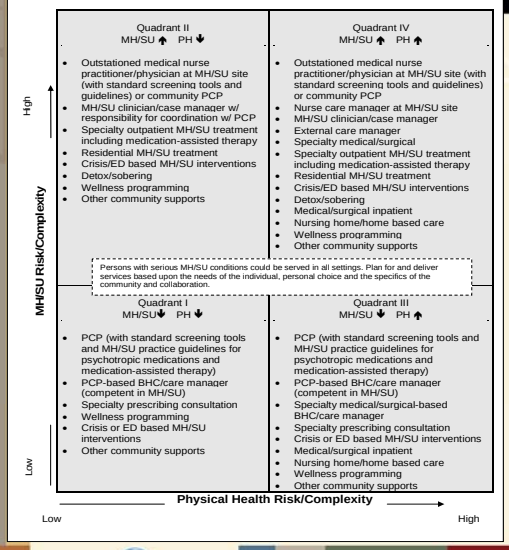

The Four Quadrant Clinical Integration Model (MH/SU)

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Where Should Care Be Delivered? Stepped Care

- There is always a boundary between primary care and specialty care
- There will always be tradeoffs between the benefits of specialty expertise and of integration
- *Stepped care* is a clinical approach to assure that the need for a changing level of care is addressed appropriately for each person—IMPACT research demonstrates the effectiveness of a stepped care model and is the basis for the National Council Collaborative Care Project
- We need to implement this model bi-directionally—to identify people in primary care with MH conditions and serve them there unless they need specialty care, and to identify people in MH care that need basic primary care and step them to a full scope medical home for more complex care—the Four Quadrant model has been revised to reflect this thinking

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Person-Centered Healthcare Homes: A new paradigm

Picture a world where everyone has...

- An **Ongoing Relationship** with a responsible healthcare provider
- A **Care Team** that collectively takes responsibility for ongoing care

And where...

- **Quality and Safety** are hallmarks
- **Enhanced Access** to care is available
- **Payment** appropriately recognizes the **Added Value**

What does this look like in practice?

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What it's not:

- A residential facility
- Primary care provider as gatekeeper

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FOCUS: QUADRANTS I AND III

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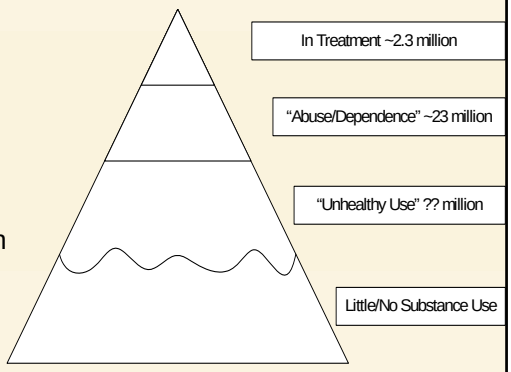
SU Conditions are Relevant for Primary Care

SU conditions are prevalent in primary care
- Tens of millions (McLellan)

SU conditions add to overall healthcare costs, especially for Medicaid

SU conditions can cause or exacerbate other chronic health conditions

SU interventions can reduce healthcare utilization and cost



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SU Impact on Healthcare Costs
Kaiser Permanente Northern California

Kaiser studies reported are retrospective, using historical enrollee data

Pre/Post SU Treatment and Medical Costs

- Analysis of average medical cost PMPM in 18 months pre and post SU treatment using historical data
- Treatment group had a 26% reduction in cost, from $239 PMPM to $208 PMPM, with reduced ER and hospitalizations post treatment compared to matched control group

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SU Impact on Healthcare Costs
Kaiser Permanente Northern California

Analysis of continuing care (CC) and effect on remission, CC defined as:

- SU treatment when needed
- Psychiatric services when needed (for adults with psychiatric symptoms after SU treatment)
  - Those who received 2.1 or more hours of psychiatric services/year were 2.22 times more likely to be abstinent at five years after SU treatment
  - Those with high psychiatric severity at initiation of treatment had $1000 PMPM, reduced to about $300 PMPM at five years
- Primary care at least every year
- Patients receiving CC were more than twice as likely to be remitted at each follow–up over 9 years
- Those receiving CC in the prior interval were less likely to have ER visits and hospitalizations subsequently (even when not in remission)

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SU Impact on Healthcare Costs Kaiser Permanente Northern California

- Analysis of the medical conditions and costs of family members of individuals with SU conditions using historical data
- Pre-treatment, families of all SU patients have higher medical costs than control families
- Adult family members have significantly higher prevalence of 12 medical conditions compared with control group; child family members have significantly higher prevalence of 9 medical conditions
- At 2-5 years post-intake for SU services, if family member w/SU condition were abstinent at 1 year, family members had similar average PMPM medical costs as control group
- Family members of SU patients who were not abstinent at 1 year had a trajectory of increasing medical cost relative to control group

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Morbidity and Mortality in People with Serious Mental Illness

Persons with serious mental illness (SMI) **die on average between the ages of 53-56.**

While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases (NASMHPD, 2006)

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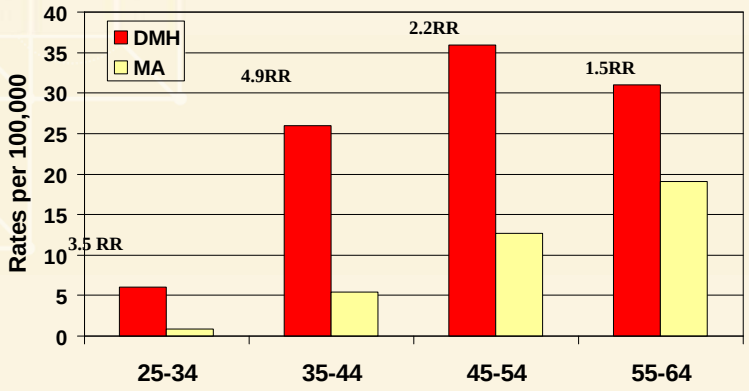
Massachusetts Study:
Deaths from Heart Disease by Age Group/DMH Enrollees with SMI Compared to Massachusetts 1998-2000



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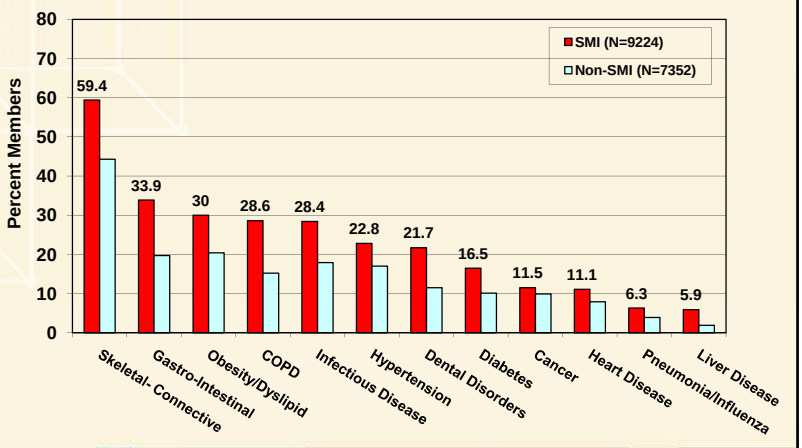
Maine Study:
Comparison of Health Disorders Between SMI & Non-SMI Groups



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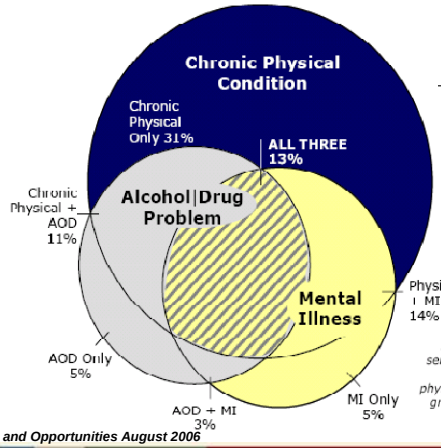
The Picture in Primary Care is Complex

Co-occurring Diagnoses and the GA-U Population

52 percent had **substance abuse** or **mental illness** identified

31 percent had a **chronic physical condition** only



PRIMARY CONDITIONS	
Chronic Physical	69%
Mental Illness	36%
Substance Abuse	32%

SOURCES: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2003 04. Chronic physical and mental illness diagnosis groups derived from CDPS grouper

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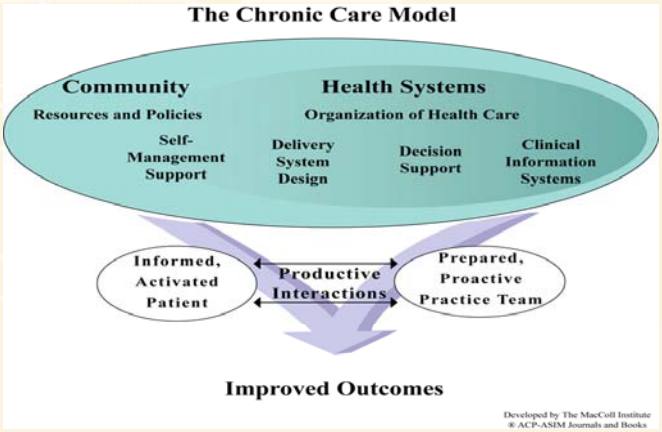
Overall Model for Improving Primary Care



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IMPACT Collaborative Care in Primary Care

TWO PROCESSES	TWO NEW 'TEAM MEMBERS'	
	Care Manager/BHC	Consulting Mental Health Expert
1. Systematic diagnosis and outcomes tracking e.g., PHQ-9 to facilitate diagnosis and track depression outcomes	- Patient education / self management support - Close follow-up to make sure pts don't 'fall through the cracks	- Caseload consultation for care manager and PCP (population-based) - Diagnostic consultation on difficult cases
2. Stepped Care - Change treatment according to evidence-based algorithm if patient is not improving - Relapse prevention once patient is improved	- Support medication Rx by PCP - Brief counseling (behavioral activation, PST-PC, CBT, IPT) - Facilitate treatment change / referral to mental health - Relapse prevention	- Consultation focused on patients not improving as expected - Recommendations for additional treatment / referral according to evidence-based guidelines

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Components of a Healthcare Home

1. Everyone has a health home practitioner & team
2. Team has a person-centered, whole person orientation…
3. …And a focus on population health outcomes
4. Care is tailored to the needs of each patient
5. Team engages in care coordination/management

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Components of a Healthcare Home

6. The team also coordinates with other healthcare providers/organization in the community
7. Patients are active participants
8. There is continuous learning and practice improvement…
9. …supported by a sustainable business model & appropriately aligned incentives
10. The health home is accountable for achieving improved clinical, financial, and patient experience outcomes

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Are you ready to be a healthcare home? Do you…

- ☑ Have a provider team with a range of expertise (including primary care)?
- ☑ Coordinate consumers' care with their health providers in other organizations?
- ☑ Engage patients in shared decision-making?
- ☑ Collect and use practice data?
- ☑ Analyze and report on a broad range of outcomes?
- ☑ Have a sustainable business model for these activities?

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New Medicaid State Option for Healthcare Homes – Section 2703 Affordable Care Act

- State plan option allowing Medicaid beneficiaries with or at risk of two or more chronic conditions **(including mental illness or substance abuse)** to designate a "health home"
- Community mental health organizations are included as eligible providers
- Effective Jan. 2011
- Additional guidance forthcoming from HHS

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Medicaid Healthcare Homes

90% Federal match rate for the following services during the first 8 fiscal year quarters when the program is in effect:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings
- Patient and family support
- Referral to community and social support services
- Use of health IT to link services (as feasible/appropriate)

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Other Considerations for SPA

- Policy-level decisions needed to pursue a Health Home Option, including identifying target populations, provider qualifications,, team composition, etc.
- Selection of quality measures and specifications and the use of HIT in conducting health home services, quality measurement and state reporting
- Consideration for rate setting (PMPM, case rate), as well as gain sharing options.

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Health IT at the Heart of the ACO Framework & Health Homes

- Builds person-centric systems of care
- Improves quality and cost
- Coordinates care across participating providers
- Uses IT, data, and reimbursement to optimize results
- Builds payer partnerships and accepts accountability for the total cost of care
- Assesses and manages population health risk
- Reimbursed based on savings and quality → value

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Health IT Requires More than an EHR

Requirements	Data Sources to be Mined
• Predictive modeling • Registries • EHR interfaces • Reminder Systems • Claims and clinical data warehouses • Episode of care analysis systems • Specifications for integrated claims & clinical databases • Patient portal options • Health enabling information exchange alternatives	• Medical records • Clinical outcomes data • Patient billing systems • Payer data • Quality measures abstracts • Charge master • Physician, payer, service line utilization data • Infection surveillance data • Labor, productivity and throughput records • Adverse drug events

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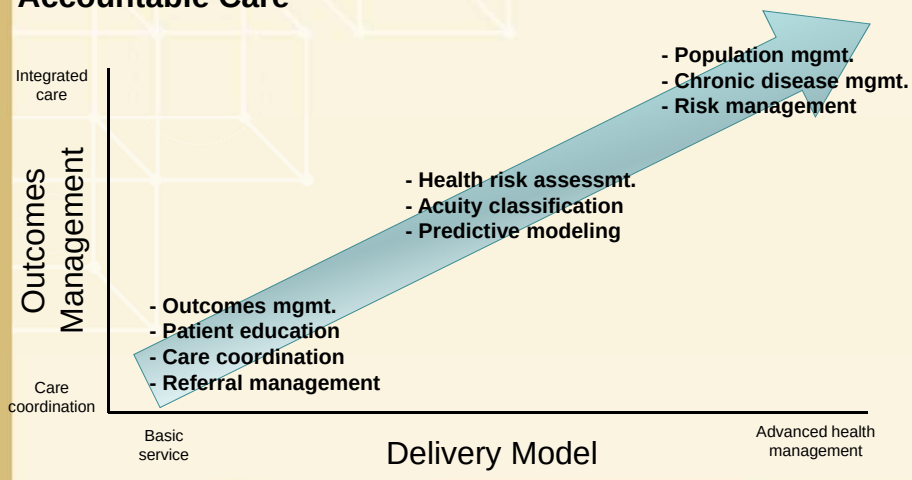
From Meaningful Use to Accountable Care



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Integration and HIT

- Stage 1 Meaningful Use Objectives include:
- Recording patient information into EHRs, such as gender, race, preferred language, height, **weight, smoking status,** and **blood pressure**

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Making Health Homes Person-Centered

Monday, May 16, 2011

Larry Fricks
Deputy Director
SAMHSA/HRSA Center for Integrated Health Solutions

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CIHS Peer Support Whole Health and Resiliency Training

Purpose of the training is to support individuals:

- To be driver of his/her own health and resiliency
- To be a peer leader supporting others to achieve the same

Training engages in strength-based, person-centered planning (PCP) to create new health behaviors and learn skills for self-managed whole health and resiliency for secondary and tertiary prevention

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10 Health and Resiliency Domains for PCP

1. Healthy Eating
2. Physical Activity
3. Restful Sleep
4. Stress Management
5. Service to Others
6. Support Network
7. Optimism Based on Positive Expectations
8. Cognitive Skills to Avoid Negative Thinking
9. Spiritual Beliefs and Practices
10. A Sense of Meaning and Purpose

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4. Stress Management PCP Example

- These are some causes of stress in my life:
- These are my favorite activities for relaxing or having fun:
- I do these things on a regular basis to take care of myself:
- When I am feeling stressed out, I like to do these things to take care of myself:

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Relaxation Response

- Taught as an essential resiliency tool
- As predictable as medication in immediately reversing the stress-induced, fight-or-flight response.
- Counters unremitting stress that can negatively impact genetically vulnerable areas of our bodies to promote mind/body illness and premature death

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7. Optimism Based on Positive Expectations - Resiliency Research

Duke University Medical School study published 2011:

- 15-year study of 2,800 heart patients
- Patients with positive expectations about recovery were 30% less likely to die over the next 15 years

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7. Optimism Based on Positive Expectations PCP Example

- I would rate on a scale of 1-5 how optimistic I usually am about the future as…:

  Not optimistic at all 1 2 3 4 5 *Very optimistic*

- I do these things to help me stay positive:
- When I am becoming pessimistic or negative about the future, doing these things helps me become more optimistic:

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"Since many of the most important risk factors for chronic disorders are behavioral in nature, it stands to reason that efforts aimed at reducing stress and enhancing resiliency will have a tendency to reduce mental and physical illness vulnerabilities. These approaches are especially welcome because they can lead to self-care that can make a real difference in a person's wellness and quality of life. The Peer Support Whole Health and Resiliency Program is designed to reduce stress through relaxation response training and enhance resiliency through social support, cognitive skills, problem solving and positive thinking. It therefore represents a welcome addition to our public health self-care strategies."

Gregory L. Fricchione, MD
Director, Benson-Henry Institute for Mind Body Medicine
Director, Division of Psychiatry and Medicine
Massachusetts General Hospital
Professor of Psychiatry, Harvard Medical School

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For Financial Sustainability

- Training teaches skills to write health goals for treatment plans.
- Some states have billable service under Medicaid coverage for trained peers to support PCP health goals.
- Weekly action plan taught for health goal success can be PCP progress notes.

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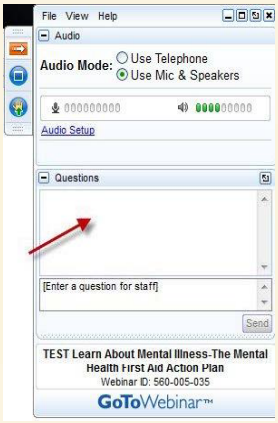
Questions

Please type your questions into the question box and we will address your questions.



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Contact the CIHS

- integration@thenationalcouncil.org
- www.centerforintegratedhealthsolutions.org
- **(202) 687-7457 x 231 to speak with Laura Galbreath, Deputy Director**

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Save the date for the next CIHS webinar
June 1,2011, 1:00-2:30 Eastern
Primary Care Providers and Behavioral Health Treatments, presented by Dr. Alexander Blount
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