Integrated Health Homes Panel

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Overview

- A changing landscape for behavioral health
- Medicaid expansion and the influx of new consumers
- New approaches to organizing care
- Demonstrating value and accountability: Are you ready?

"We're ready to begin the next phase of keeping things exactly the way they are."

- 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?**

What it's not:

- A residential facility
- Primary care provider as gatekeeper

Defining the Healthcare Home

Superb Access to Care

Patient Engagement in Care

Clinical Information Systems

Care Coordination

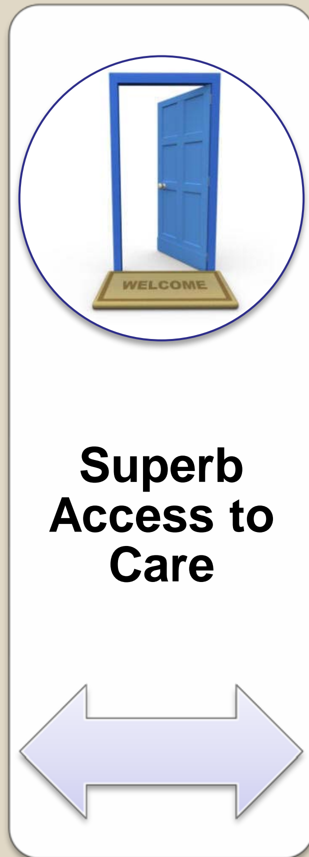
Team Care

Patient Feedback

Publicly Available Information

Person-Centered Healthcare Home

Defining the Healthcare Home

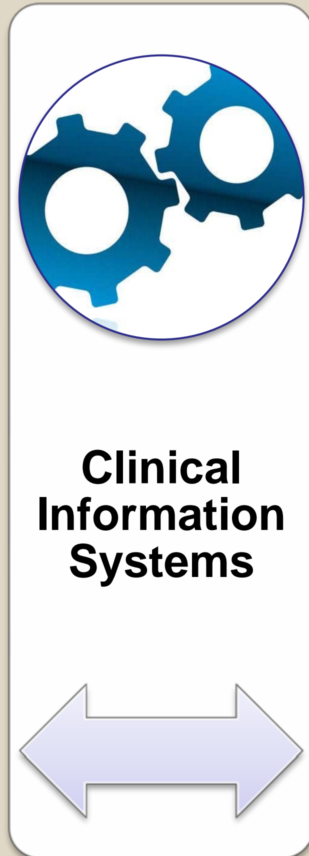


- Everyone has a health home practitioner and team
- Patients can easily make appointments and select the day and time.
- Waiting times are short.
- Email and telephone consultations are offered.
- Off-hour service is available.

Defining the Healthcare Home

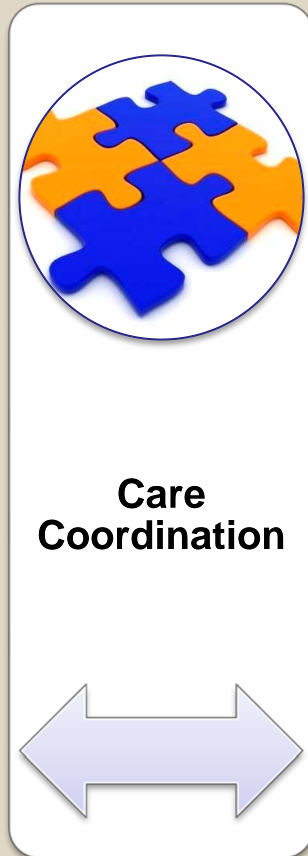
- Health Home team has a patient-centered, whole person orientation
- Care is tailored to the needs of each patient
- Patients are active participants, with the option of being informed and engaged partners in their care.
- Practices provide information on treatment plans, preventive and follow-up care reminders, access to medical records, assistance with self-care, and counseling.

Defining the Healthcare Home



- Systems support high-quality care, practice-based learning, and quality improvement.
- Practices maintain patient registries; monitor adherence to treatment; have easy access to lab and test results; and receive reminders, decision support, and information on recommended treatments.
- There is continuous learning and practice improvement.

Defining the Healthcare Home



- The health home team engages in care coordination & management within the team
- The team also coordinates with other healthcare providers/organizations in the community
- Systems are in place to prevent errors that occur when multiple physicians are involved.
- Follow-up and support is provided.

Care Coordination

- **The Care Coordination Standard:** When I need to see a specialist or get a test, including help for mental health or substance use problems, help me get what I need at your clinic whenever possible and stay involved when I get care in other places.
- Services are supported by electronic health records, registries, and access to lab, x-ray, medical/surgical specialties and hospital care.

Defining the Healthcare Home

Team Care

- Integrated and coordinated team care depends on a free flow of communication among physicians, nurses, case managers and other health professionals (including BH specialists).
- Duplication of tests and procedures is avoided.

Defining the Healthcare Home

- Patients routinely provide feedback to doctors; practices take advantage of low-cost, internet-based patient surveys to learn from patients and inform treatment plans.
- Patients have accurate, standardized information on physicians to help them choose a practice that will meet their needs.

Additional Necessary Components

- The health home is supported by a sustainable **business model** & appropriately aligned incentives
- The health home is **accountable** for achieving improved clinical, financial, and patient experience outcomes

Payment Models for Healthcare Homes

- Fee for Service is headed towards extinction
- Healthcare Home models are beginning with a 3-layer funding design with the goal of the FFS layer shrinking over time:

Layer	Description
Case Rate	• Prevention, Early Intervention, Care Management for Chronic Medical Conditions
Fee for Service	• Per Service (Fee for Service) Payments for services provided by Primary Care Providers
Bonus	• Share in Savings from Reduced Total Healthcare Expenditures (bending the curve)

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

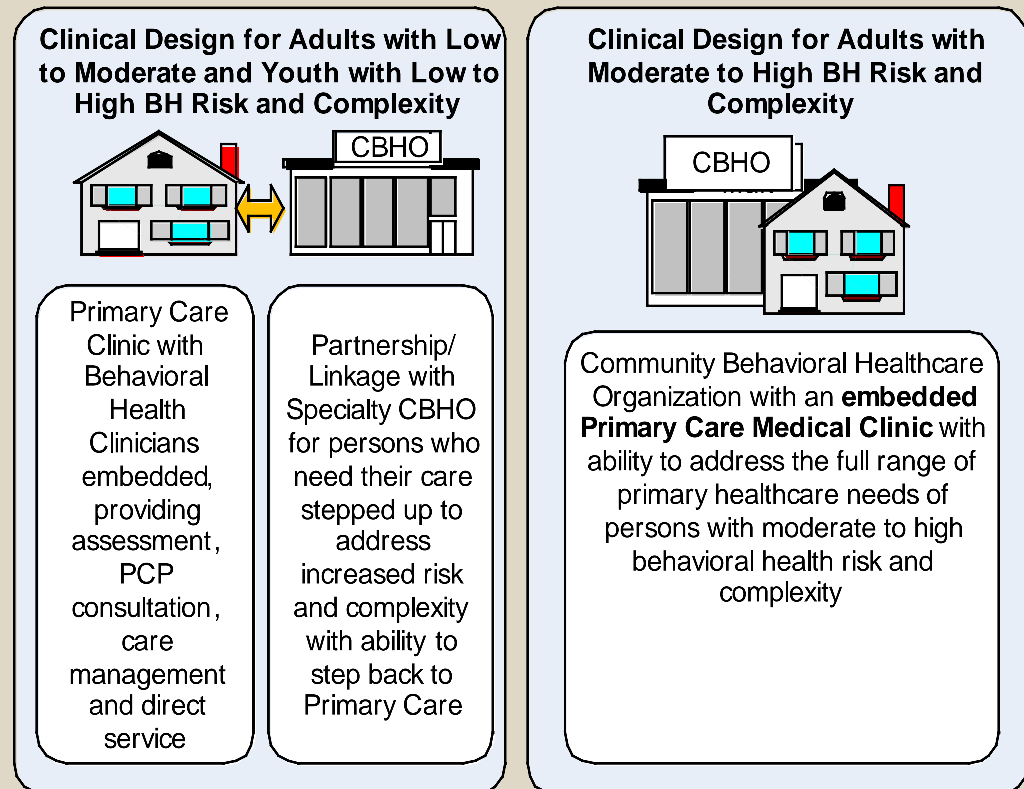
- ☑ Have a provider team with a range of expertise (including primary care)?
- ☑ Coordinate consumers' care with their health providers in other organizations?
- ☑ Engage patients in shared decision-making?
- ☑ Collect and use practice data?
- ☑ Analyze and report on a broad range of outcomes?
- ☑ Have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

Health Homes Serving Individuals with SMI and Substance Use Disorders

1. Assure regular health status screening and registry tracking/outcome measurement
2. Locate medical nurse practitioners/primary care physicians in MH/SU facilities
3. Identify a primary care supervising physician
4. Embed nurse care managers
5. Use evidence-based practices developed to improve health status
6. Create wellness programs

New Paradigm – Primary Care in Behavioral Health Organizations

Funding starting to open up for embedding primary medical care into CBHOs, a critical component of meeting the needs of adults with serious mental illness



What does it mean to provide primary care?

- It's more than having a nurse on staff
- Primary care is the provision of **integrated, accessible** health care services by clinicians who are **accountable** for addressing a range of personal health care needs, developing a **sustained partnership** with patients, and practicing **in the context of family and community.**
- Partnerships with primary care providers/FQHCs

Health Home Services

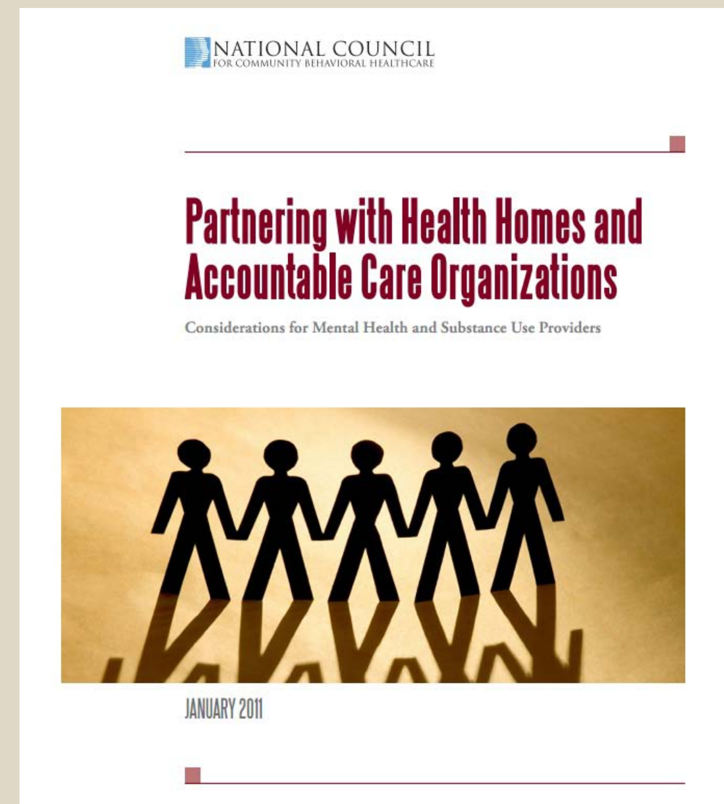
- 90% Federal match rate for the following services during the first 8 fiscal year quarters when the program is in effect:
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional care from inpatient to other settings
  - Patient and family support
  - Referral to community and social support services
  - Use of health IT to link services (as feasible/appropriate)

States to Date

- 5 States have planning grants: WV, AR, MI, NV, AZ
- SAMHSA Discussions: MO, MN, NH
- No SPA approved
- Quite a few states seem to be considering this option for populations with serious mental illness — no substance abuse proposals yet

Partnering with Health Homes and Accountable Care Organizations

- National Council report
  http://www.thenationalcouncil.org/cs/acos_and_health_homes
- Webinar with Dale Jarvis & Laurie Alexander
  http://www.thenationalcouncil.org/cs/recordings_presentations
- Live Blogchat
  http://mentalhealthcarereform.org/aco-webchat/



Happy to Be Here……

"Integration": Merging or putting together

PROS - It's the way it should be….

- One stop shopping
- A base for navigation
- Many different "models" to choose from

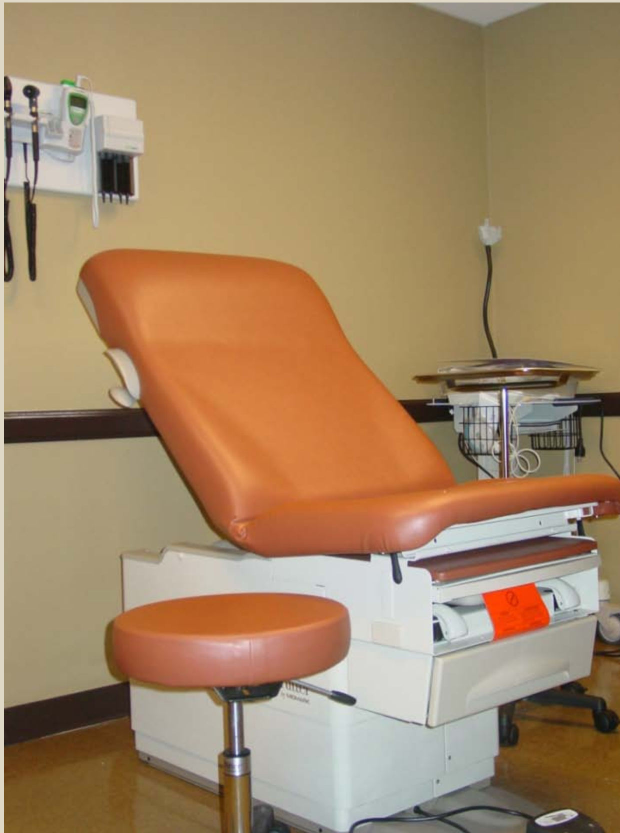
CONS – Always takes longer and requires more planning and communication than expected….

- Timeline = funded 10/2010, open 2/2011
- Renovation always takes longer than expected….
- Planning phase
- Differing philosophies

The Hub of Clinic Activity

Mid-Level Practitioners Make it Possible

Exam Room Options



Consult Room

Multiple Resources All in One Place

Places to Meet and Greet

Place to Relax

Other Considerations

- Limited “evidence base” for BH population
- FQHC vs private provider
- Large institutional provider vs small business
- Differing views and definitions of integration
- Differing philosophies between BH and PC
- Funding and billing issues
- Documentation and EMR Issues

Healthcare Integration Initiatives

Organization Background

- Provider since early 1900s
- Snohomish, Skagit, Island and San Juan Counties
- Full continuum of Behavioral Health Services

Catalyst for Change

- Life Expectancy of Public Mental Health consumers
- Other Study Results
- Healthcare Reform – Expected Outcomes
- Mental Health Parity – Expected Outcomes

Our Initiatives

- Partnership with Molina Healthcare of Washington/Molina Medical
- Disability Lifeline partnership with Community Health Plans of Washington
- Prism Project – WCMHC and Mental Health Transformation Grant
- Other Partnerships

Partnership with Molina

- Background
- Reasons for Partnership
- Timeline for Clinic Launch
- Achievement to Date
- Integration Challenges
- Healthcare Education and Wellness Component
- Clinic #2

Partnership with Community Health Plans

- Building on success of Pilot Projects
- Level 1 Services
- Level 2 Services
- Co-location to Care Collaboration

Prism

- Transformation Grant through WCMHC
- Description of database
- RN Care Coordination
- Skill set development for Chronic Disease Management

Other Partnerships

- Genoa Healthcare
- Catholic Community Services

Contact Information

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