Patient Centered Health Homes

AIDS Foundation Panel Discussion
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Thresholds
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Goal is to expand the traditional medical home model to integrate and coordinate primary, acute, and behavioral health and long term services and supports, for persons with chronic conditions across the lifespan.
Components of PCHH

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow up
- Patient and family support (including authorized representatives)
- Referral to community and social support services if relevant
- Use of health information technology (HIT) to link services
Behavioral Health Care Homes

- Why should we differentiate populations?
  - Past experience shows that individuals with high behavioral health needs benefit from coordination from providers that know how to engage in services.
  - Experiments in early 90s – managed care companies carved in behavioral health and were not successful at managing the care of those with high behavioral health care needs
Why focus on this population?

- Individuals with mental illness die 25 years earlier than the general population
- High co-morbidity of pulmonary, cardiac, diabetes that can be expensive to treat if not connected to regular and routine follow along physical care
- Psychotropic medications can contribute to physical disease processes
- In general, individuals with mental illness are the smallest number of Medicaid enrollees BUT high per person claim costs
What Behavioral Health can bring to the PCHH

- Behavioral health providers can bring more than their appetite to the table around health care homes
- Social determinants of employment and stable housing have a profound impact on connection to physical health resources – traditional focus of behavioral health care providers
What Behavioral Health can bring to the PCHH

Strong emphasis on recovery already and helping individuals self manage disease processes

Challenge is to get front line staff to “own” physical health goals and outcomes
Recognition of the role that BHC can play

- States that have developed Health Care Homes and included behavioral health care home options:
  - Missouri – first state to apply for HCH
  - Rhode Island
  - Ohio
  - Massachusetts
    - To name a few
Current Thresholds Practices related to PCHH

- Diabetes Registry
  - Judith Cook from UIC Research Center looking at current Thresholds members who have diabetes and receive primary care from UIC College of Nurses
  - Nurse Care Coordinator monitors information from registry to call clinical team about appointments, progress in meeting physical health goals such as eye doctor appts., Podiatrist etc. and action lists prepared for community support staff
  - It is missing a component though – focus on behavior change
Current Thresholds Practices related to PCHH

- Williams class members
  - ACLU class action suit against the state under Olmstead – individuals with mental illness living in IMDs
  - Added a nurse care coordinator (NCC) that works with the member, the clinical team and the health care professional
  - NCC does a review of physical needs before discharge, makes sure medication is present, works with clinical team to review medical needs, list out follow up plans
Current Thresholds Practices related to PCHH

- Illini Care pilot
  - Illini Care is one of the managed care companies that currently covers Medicaid recipients in Cook (outside Chicago) and Kankakee County
  - Will also cover dual eligibles that are leaving nursing homes
  - Concerned about costs of high users of Medicaid services – identified 50 high users who had psychiatric disabilities
Illini Care pilot (cont)
- Identified users through claim data
- Interested in partnering with a local entity used to working with this population
- We are funded through a per member per month cost which we established looking at the services that we would provide and their cost
- We are to engage the persons identified by Illini Care and determine if our services can impact high cost services such as inpatient hospitals both psychiatric and primary care
Current Thresholds Practices related to PCHH

- Illini Care (cont)
  - First attempt to really compare a pre-, post- service engagement cost comparison
  - Pilot PMPM does not put us at risk for inpatient costs or primary care costs, but to look at the addition of our wrap around services and if it can decrease overall claims
DMH Title XX proposal

- Excited about this one
- Submitted a proposal to DMH to analyze the impact of our services on Medicaid claims
  - Working with CMT – a data analytics company that will do two things:
    - Identify 100 highest users of Medicaid costs
    - Will use Medicaid data on an ongoing basis through their system called ProAct – based on individual claim data will provide care team with prompts on physical health care interventions
DMH Title XX proposal (cont)

Will look to see if:
- Use of the data analytic tool alone will help our staff reduce costs
- Use of the data analytic tool plus an NCC and a community health navigator makes more of a difference
  - NCC will help team focus on physical health interventions and consult around issues observed through ProAct
  - The community health navigator will help hard to engage consumers around behavioral change – go to appointments with them, help with diet changes, physical activity
Things to Consider

- Behavioral health care staff need to learn how to address and own physical health care interventions
  - Lessons from Missouri – going to get consultation from Peggy Swarbrick (UNJMD) on training on wellness 101 for front line staff
  - New orientation to work – focus on changing behavior around lifestyle choices
In the new world order, it is essential to understand the true cost of your service delivery system

- Movement from FFS to capitation and/or risk based contract
How can you contribute to the triple aim of health care:

- improve health
- Improve the consumer’s experience of health care
- Decrease costs