Jefferson Center
for mental health

Creating a Health Home: Tools and Checklist

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Getting Started With Integration: Tools

1. HOW INTEGRATED IS YOUR ORGANIZATION CURRENTLY?

Integrated Practice Assessment Tool (IPAT); available at:
www.integration.samhsa.gov/operations-administration/IPAT_v_2.0_FINAL.pdf

Or electronic scoring version at: http://ipats.org

2. ASSESSING YOUR ORGANIZATION'S CAPACITY FOR INTEGRATION:

Behavioral Health Integration Capacity Assessment (BHICA); available at:
www.resourcesforintegratedcare.com / Behavioral Health Integration Capacity Assessment

Behavioral Health Integration Capacity Assessment Interactive Evaluation Grid, available at:
www.resourcesforintegratedcare.com / BH Integration Capacity Assessment Interactive Evaluation

Checklist for Integration

- √ Target population and population's needs
- √ Current resources / infrastructure
- √ Provider and team FTE
- √ Clinical workflow mapping and data mapping
- √ EMR redesign or EMR data exchange
- √ Work with contracting and legal for liability / licensing / contracts
- √ Education on Primary Care / Culture Change
- √ Continuous Communication processes (team, across organizations)
- √ Continuous patient input and feedback
- √ Marketing plan
- √ Maximize billable provider clinical time
- √ Leverage case management and pharmacy services
- √ Continuous Quality Improvement Processes
- √ Clinical data review – how well are we doing?
- √ Billing data and tracking nonbillable activities review – how much is this really costing us?
- √ Measure clinical outcomes and utilization / costs

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Three Health Home Models: Lessons Learned from Implementation in Rural, Suburban, and Urban Settings

Jefferson Center
for mental health

Mental Health Center of Denver
Where Recovery Happens

SOUTHEAST
HEALTH GROUP

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Colorado Behavioral Healthcare Conference

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Learning Objectives

- Describe three mental health centers models
- Challenges
- Successes
- Lessons learned
- Clinical models
- Funding and billing mechanisms, and sustainability planning

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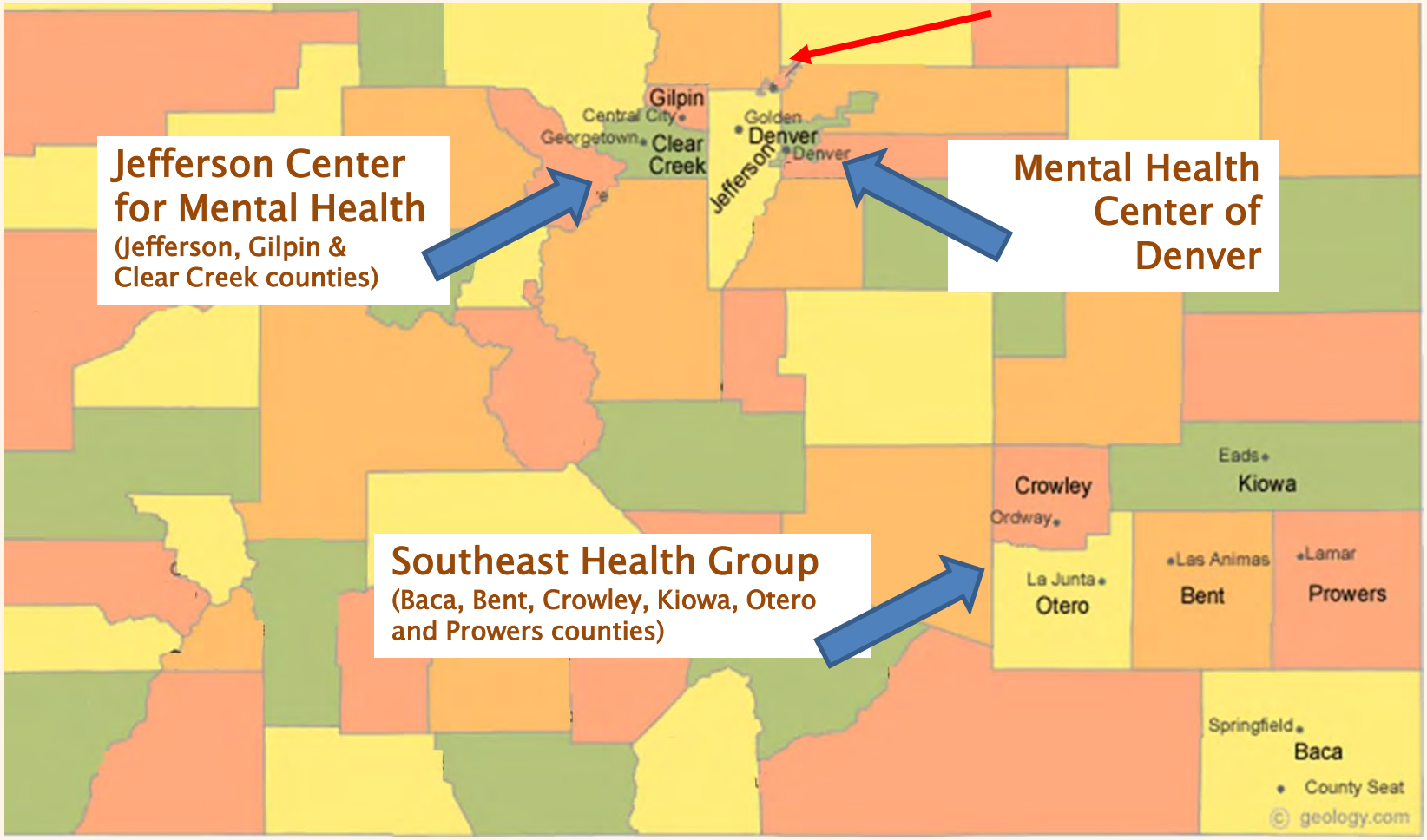
Colorado's Community Mental Health System

5 BHOs (Behavioral Healthcare Organizations),
the managed care organizations for the Medicaid Capitation contracts.



MCHD

Is the community mental health center for Denver County. MHCD is a private charitable organization. The State of Colorado contracts with MHCD to serve people in this community who have serious mental illness.

Population Served

- Mental Health consumers and their families live in Denver.
- Consumers receive outpatient services at MHCD clinics and in community settings.
- MHCD provides focused services to 13,732 people annually and touch the lives of 37,800.

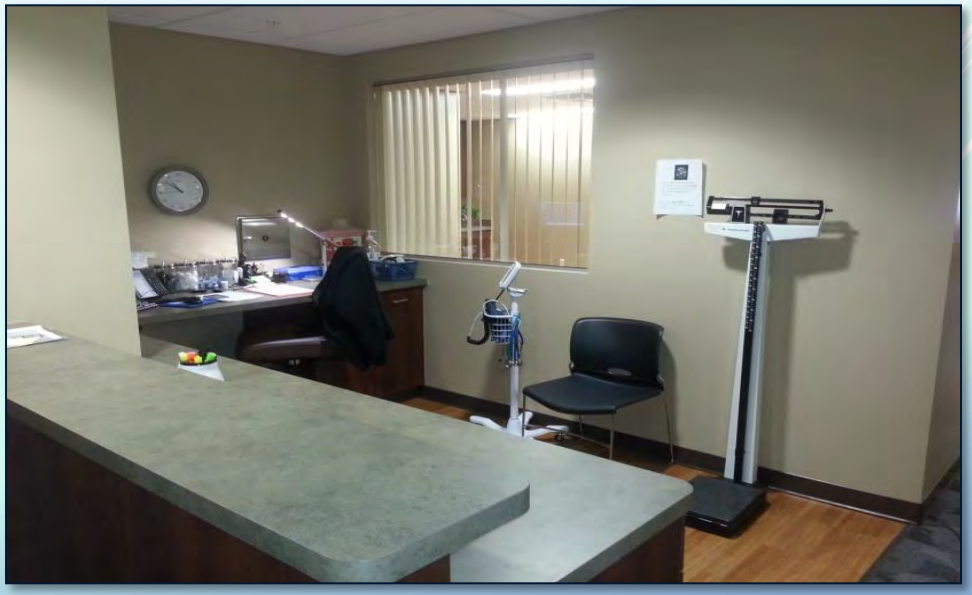
Where Consumers Receive Care

MHCD operates
4 outpatient clinics,
24 residential facilities,
2 adult rehabilitation centers,
2 resource centers
as well provides vocational services, school-based programs, and other community collaborations.

Mental Health Center Of Denver (MHCD)

- Since 2008 been developing primary care services embedded in mental health clinic
- Grant projects funding from Colorado Health Foundation and SAMHSA PBHCI
- Development of Recovery Center with primary care clinic in a large clinic, onsite labs, pharmacy
- Current Partnership with large hospital system (Denver Health)

MHCD Recovery Center



Goals Of Overall MCHD Integrated Primary Care Program

- Provide services in place consumers are comfortable
- Provide whole person care – increase integration/collaboration among providers
- Leverage case management, wellness services

MHCD Model

- Initially Two Clinics At 2 MHCD Locations. Moved To A Single Location (Recovery Center) Sept 2012
- Denver Health Staff: part time nurse practitioner, physician (supervisor)
- MHCD primary care staff: One part time nurse practitioner, one nurse, administrative support from MHCD staff
- EMR: Denver Health (EPIC) and MHCD (AVATAR)
- Billing: Each PC provider's organization handles
- Patient population: mostly Medicare and Medicaid, some uninsured
- Enrollment: MHCD consumer population
- Types of Services: basic primary care services
- 5 exam rooms: sink, exam table, computer/desk, other standard equipment and supplies

Types Of Services Provided

- Ambulatory adult medicine
- Chronic disease management: hypertension, diabetes, hyperlipidemia, obesity, hypothyroidism, musculoskeletal pain
- Preventive services: well woman care, well adult check, screenings
- Patient education and counseling

Clinical Team

- PCP Personnel / support staff
- Nurse care manager with MA or Nurse
- Pharmacist and Nutritionist
- Oversight / supervision
- Communication (internal team, case managers, medical providers, therapists)
  - Mostly asynchronous
- Regular meetings
- Interface within organization, outside organization, hospital staff

Operations

- More than clinical team
- Medical Records, IT, Front desk, insurance/billing/referrals, contracting, medical director(s) or designee(s), office manager
- Regular meetings
- Outcomes tracking / Data mapping

IT / Medical Records

- Two medical records
  - Pros – PCP connection to Hospital System
    - Referrals and Billing
  - Cons – Mental Health Center has separate EHR
- Shared permissions for viewing each others' EHR
- Regional Health Information Exchange (HIE)
  - (CORHIO)

Union Square Health Home (USHH)

Jefferson Center for mental health

Metro Community Provider Network

Arapahoe House

Model

- Jefferson Center for Mental Health
- Metro Community Provider Network (MCPN), a federally qualified health center
- Arapahoe House (AH), a publicly-supported, non-profit substance abuse treatment provider.

Space includes:

- 10 exam room, primary care medical office for MCPN
- an AH Clinical Specialist who is available to provide enhanced substance abuse assessments and interventions.
- Jefferson Center outpatient and wellness services

USHH Goals

- Increase access to integrated health care and care coordination;
- Improve the physical and behavioral health of adults with SMI,
  - particularly those with cardio-metabolic disorders and/or substance abuse disorders;
- Enhance the client experience and the client's adherence to treatment; and
- Reduce or control costs of health care for at-risk clients.

Strategies

- Formal partnership agreements with MCPN and AH to provide collaborative care for patients with acute health needs;
- Comprehensive care management and Monitoring of treatment adherence through a Health Home Care Coordinator;
- Bi-weekly collaborative care management meetings
- Creation of person-centered comprehensive care plans incorporating physical, behavioral, and wellness health goals; routine physical health screenings;
- Shared electronic Patient Registry;
- Benefits enrollment support for clients; and
- Personalized and group health and wellness services.

Collaborative Care Planning

- Weekly meetings of multi-disciplinary care team
- Takes a “whole person” approach
- Includes Primary Care Provider, Medical Assistants, Psychiatrists, Therapists, Care Coordinators (Nurse or Therapist), Health/Wellness Coach, Navigation
- Shared “Collaborative Care Plan” and exchange of continuity of care documents

Staffing

- 1 FTE Health Home Care Coordinator,increasing to 2 FTE for years 3 & 4
- 1 FTE Health Coach
- 1 FTE Jefferson Center Wellness Peer Health Coach
- 0.5 Jefferson Center Wellness Clinician
- 0.5 FTE Jefferson Center Medical Assistant
- Jefferson Center psychiatrists and therapists
- 0.5 FTE Data Management Assistant
- Patient Registry Contractor
- 0.5 FTE Arapahoe House Clinical Specialist
- 1 FTE Union Square Health Home Project Director
- Primary care through MCPN

Union Square Health Home

- Specialty care services accessed through MCPN referral network and/or other community partners
- Wellness Now classes including nutrition, exercise, smoking cessation, Stanford chronic disease self-management and pain management classes
- Benefits acquisition and assistance connecting to community resources and ancillary services through Jefferson Center Navigation Program
- Patient Registry platform
- Health Information Exchange facilitated through CORHIO
- Union Square Health Home Advisory Committee

Universal Screening And Collection Of Health Indices

- Health Indicators
- BMI
- Blood pressure
- Waist circumference
- Breath CO
- Fasting lipid profile
- Fasting glucose and hemoglobin A1c
- Behavioral Health Screening and Assessment
- SBIRT
- AUDIT and DAST
- PHQ-9
- Chronic Pain
- Colorado Client Assessment Record
- Quality of Life/SF-36

Payment Model

- FQHC – Medicaid PPS and 3rd party billing
- Jefferson Center capitation and 3rd party billing
- PBHCI Grant funding (temporary!)
- PCMP $3 PMPM

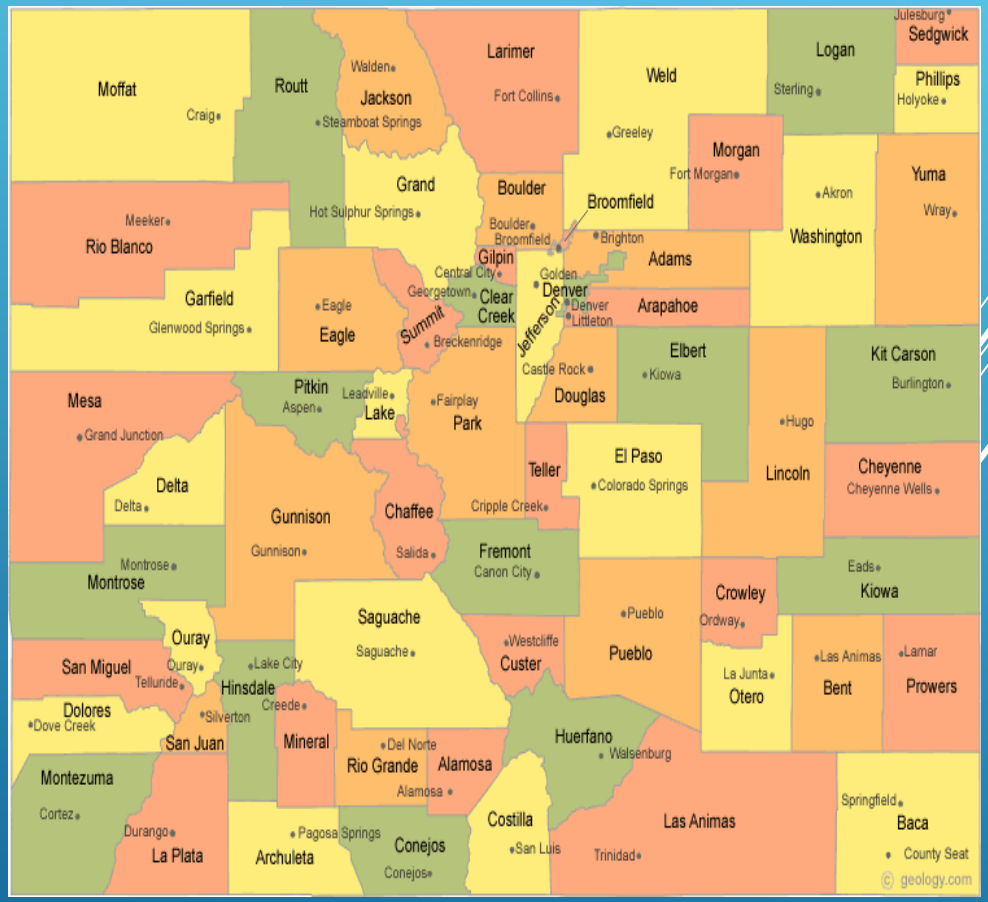
An Emerging Health Home

https://youtu.be/RNsTPBZzvGU

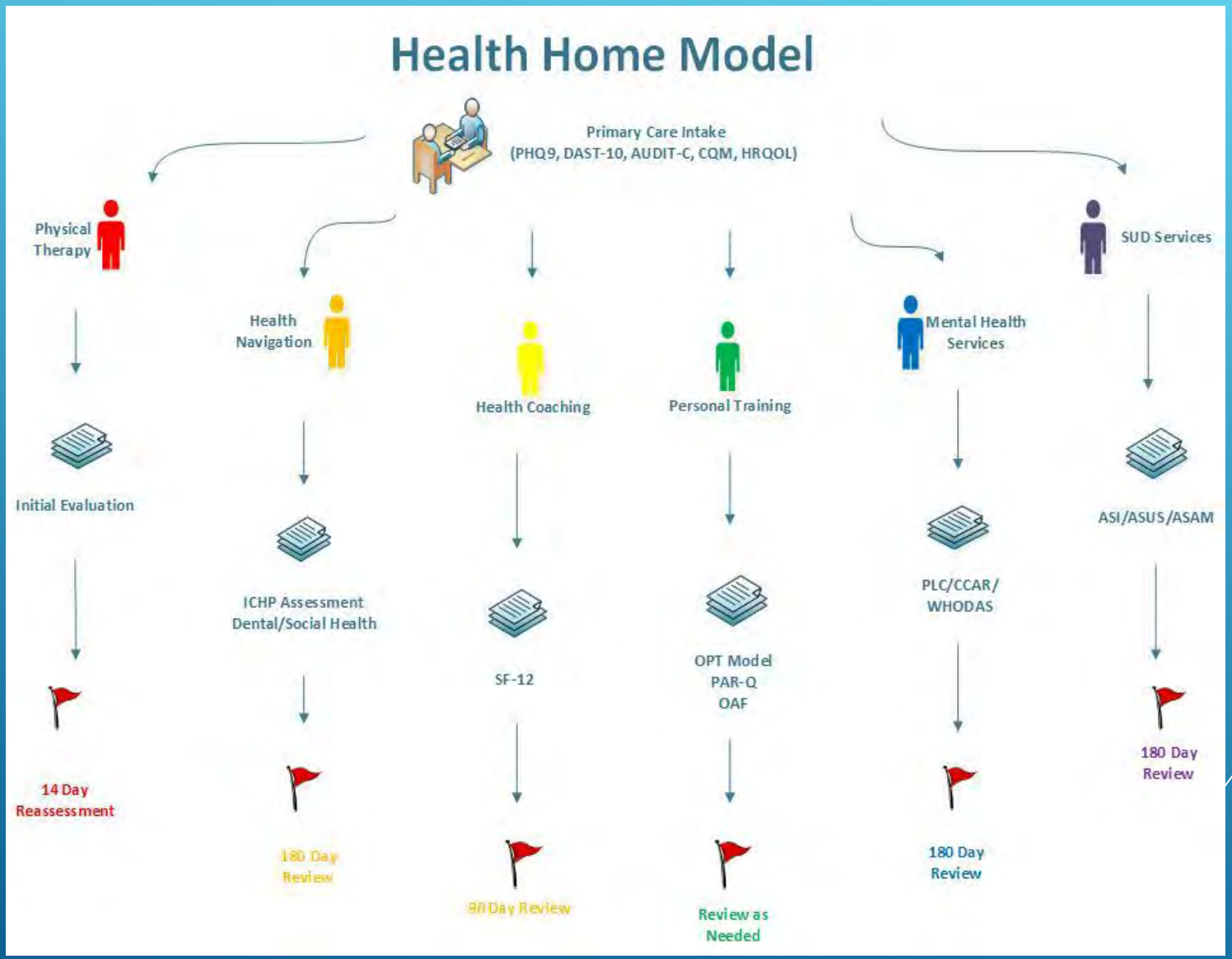
Our Service Area…
Approx. 10,000 Square Miles

Population Mix

- Mental Health Related–750
- Substance Use Disorder/Adjunct–275
- Physical Health Care–1100
- Wellness Center–50
- Health Navigation–300
- Peer Assistance–135



The Primary Care Path



Health Home?

The Affordable Care Act of 2010, Section 2703…Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

- Health Homes are for people with Medicaid who:
- Have 2 or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

Chronic conditions listed in the statute include mental health, substance abuse, asthma, diabetes, heart disease and being overweight. Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval.

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient & family support
- Referral to community & social support services

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/integrating-care/health-homes/health-homes.html

Comprehensive (Not Complete) Health Care

EMERGENCY SERVICES - Available 24/7/365

Crisis intervention
Suicide prevention
Substance use evaluation
Assessment and referral consultations
Involuntary 72-hour evaluation and treatment

MENTAL HEALTH THERAPY

Individual and Family Therapy
Skills training—parenting, relationships, teens, life skills
Therapeutic groups—anxiety, depression, trauma, grief
School-based services, including in-school therapy
Expressive therapies—art, music, movement
Readjustment services for veterans and their families
Respite and skills training for youth during school breaks
Early childhood case management and consultation

ADDICTION/ADJUNCT COUNSELING & SERVICES

Substance use/abuse evaluation
Individual and group counseling
DUI/MIP evaluation and education
Domestic violence evaluation and treatment
Anger management evaluation and education
Moral Reconation therapy
Drug testing
Sex offender treatment
Pharmacological screens for medication-assisted therapy
Vivitrol medication available

PEER SERVICES

Transportation
Respite (Day La Junta)
Respite (Overnight Lamar)
Registration
Emergency Assistance
Community Education & Outreach

PRIMARY CARE

Personal health care for adults and children
Preventive Care
Immunizations
Annual and sports physicals
Diagnosis and treatment of acute illnesses
Fracture and wound care
Chronic disease management
Health Coach
Coordination and referral for specialty care
Lab work
Pain Management

PSYCHIATRIC SERVICES

Psychiatric evaluations and consultation
Medication management group
Consultation with primary care physician
Medication collaboration with agencies and pharmacies

ADVOCACY

Mental health education and consultation
Family support services
Consumer support groups
Employment advocacy
Advocate for consumer complaints and grievances
IEP/school support
Inter-agency referral and linkage

COMMUNITY SUPPORT SERVICES

Continuity of Care
Collaboration with agencies
Community-based recovery services
Case management services
Health navigation services
Residential services, including certification for HUD/subsidized housing
Home care and community-based services
Nursing home outreach (OBRA)
Geriatric services
Vocational Training

PHYSICAL THERAPY

WELLNESS

Health Coaching
Personal Training
Acudetox

COMMUNITY EDUCATION

Mental Health First Aid classes
Healthier Living classes

QUALITY MANAGEMENT SERVICES

Protected Electronic Health Records
Staff development
Risk management
Data collection and reporting

BUSINESS SERVICES

Client trust payee services

Challenges of Implementation

Challenges

- The Practice
- The Environment
- The Patients

Facilitators

- Collaborative partnership
- Patient Engagement
- Case managers and/or Peer Specialists
- Environment
- Communication
- Flexibility
- Payer Involvement

Outcomes

- Clinical data
- Patient data
- Economic data

Thank you!