The National Landscape: Health Homes, Accountable Care Organizations and Integration and Its Impact on Massachusetts

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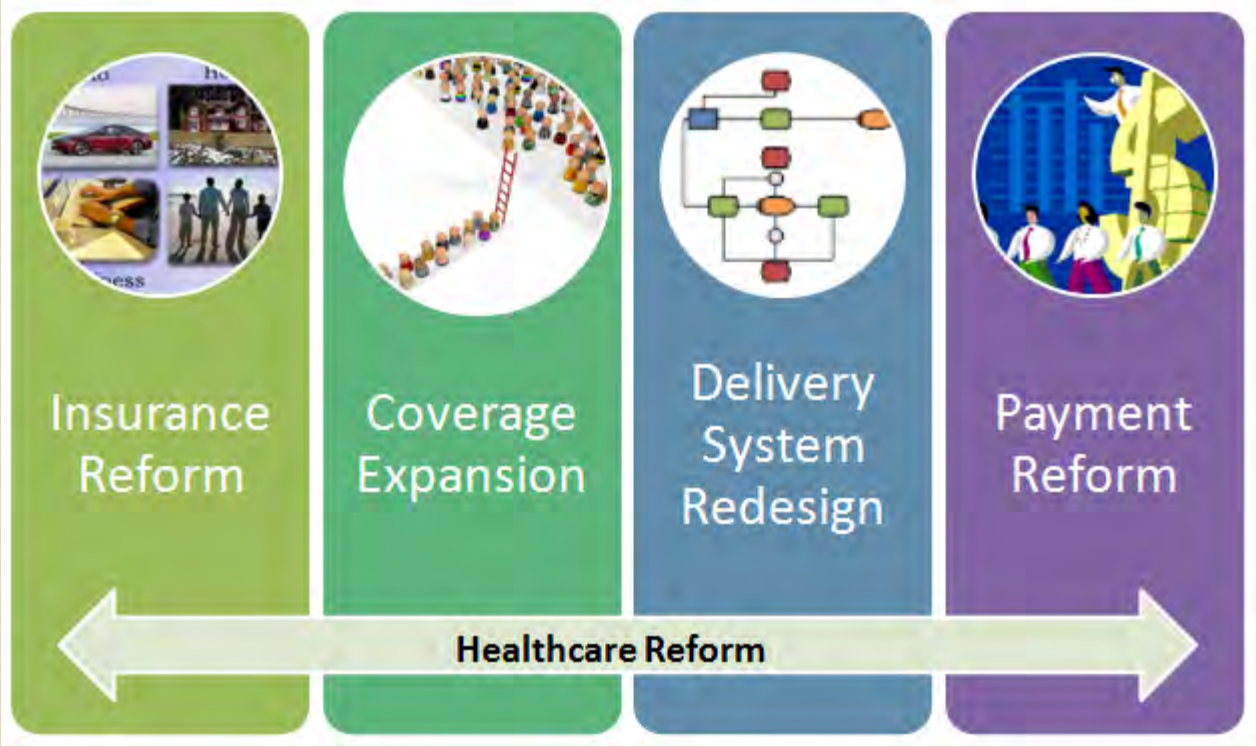
Overview

- 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?

Affordable Care Act – Four Key Strategies



Delivery System Redesign – Health Homes (Medical Homes)

Status of Health Home Statewide Work

- 6 State Plans have been approved:
  - Missouri (2) – Behavioral Health and Primary Care
  - Rhode Island (2) – adults and children with SMI
  - New York – chronic behavioral and physical health
  - Oregon

- 3 states have submitted State Plans and await approval:
  - Iowa, North Carolina, Washington

- 15 States with Planning Grants:
  - Alabama, Arizona, Arkansas, California, District of Columbia, Idaho, Maine, Michigan, Nevada, New Jersey, New Mexico, North Carolina, Washington, West Virginia, and Wisconsin

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?**

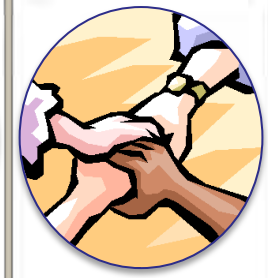
Defining the Healthcare Home

Superb Access to Care

Patient Engage-ment in Care

Clinical Infor-mation Systems

Care Coor-dination



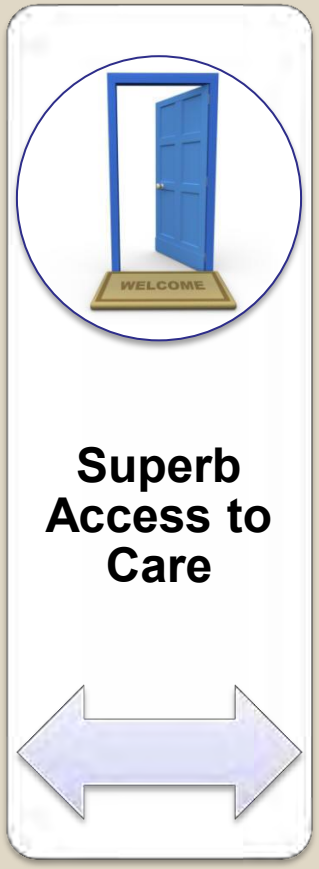
Team Care

Patient Feed-back

Publicly Available Infor-mation

Person-Centered Healthcare Home

Defining the Healthcare Home

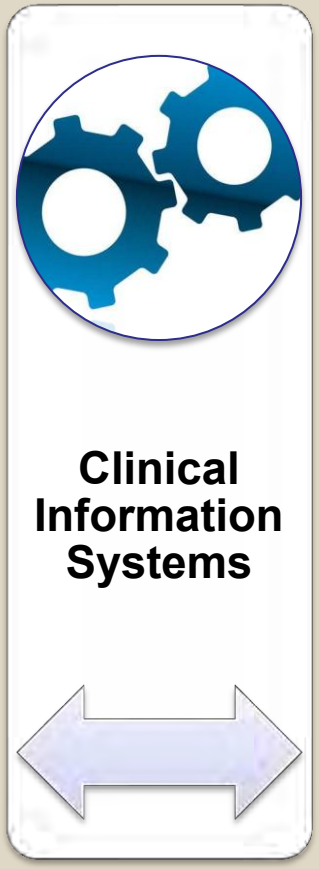


- Everyone has a health home practitioner and team
- Patients can easily make appointments and select the day and time.
- Waiting times are short.
- Email and telephone consultations are offered.
- Off-hour service is available.

Open Scheduling Same Day Access Model – Consumer Engagement Standards

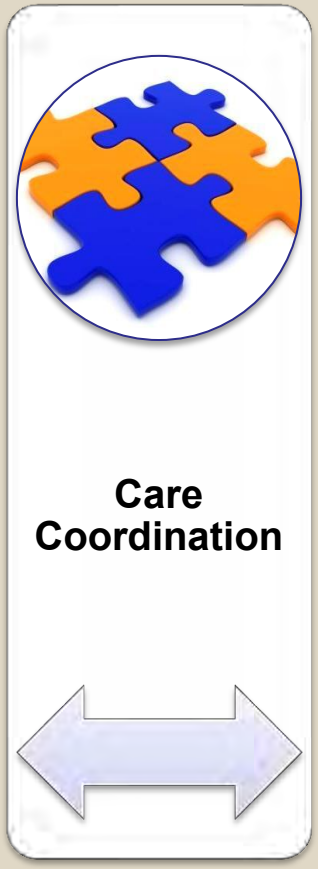
1. Master's Level assessment provided the same day of call or walk in for help (If the consumer calls after 3:00 p.m. they will be asked to come in the next morning unless in crisis or urgent need)
2. Initial diagnosis and assessed service needs determined
3. Level of care and benefit design identified with consumer that includes an estimate of time needed
4. Initial treatment plan developed based on benefit design package
   - 2nd clinical appointment for TREATMENT within 8 days of initial intake
   - 1st medical appointment within 10 days of initial intake

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.

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?

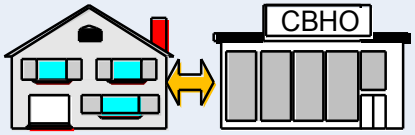
Health Homes Serving Individuals with SMI and Substance Use Disorders

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

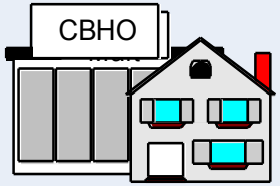
Clinical Design for Adults with Low to Moderate and Youth with Low to High BH Risk and Complexity



Primary Care Clinic with Behavioral Health Clinicians embedded, providing assessment, PCP consultation, care management and direct service

Partnership/ Linkage with Specialty CBHO for persons who need their care stepped up to address increased risk and complexity with ability to step back to Primary Care

Clinical Design for Adults with Moderate to High BH Risk and Complexity



Community Behavioral Healthcare Organization with an **embedded Primary Care Medical Clinic** with ability to address the full range of primary healthcare needs of persons with moderate to high behavioral health risk and complexity

Accountable Care Organizations

On Your Mark, Get Set, ACO…

Accountable Care Organizations bring together healthcare homes, specialty care, and ancillary services

Core Principles of an ACO

- Directed by a **coordinated set of providers**
- Provides a **full continuum of care** to patients and populations
  - Healthcare homes, specialty care, hospital, case management, care coordination, transitions between levels of care…and more
- **Financial incentives** aligned with clinical goals
- **Cost containment**
- Enhancement of **care quality** and the patient experience
- **Improvement of overall health status**

Getting to the ACO Table

Are you in conversation with local integrated health systems and at the table of ACO development efforts in order to “pitch” the importance of MH/SUD services to improving quality and bending the cost curve and building a case for how you can help these organizations succeed in the new world of risk?

Initial Approved ACOs for Medicare

-1.Allina Hospitals & Clinics Minnesota and Western Wisconsin

•2. Atrius Health Services Eastern and Central Massachusetts

•3. **Banner Health Network Phoenix, Arizona Metropolitan Area (Maricopa and Pinal Counties)**

•4. Bellin-Thedacare Healthcare Partners Northeast Wisconsin

•5. Beth Israel Deaconess Physician Eastern Massachusetts

•6. Bronx Accountable Healthcare Network (BAHN) New York City (the Bronx) and lower Westchester County, NY

•7. Brown & Toland Physicians San Francisco Bay Area, CA

•8. Dartmouth-Hitchcock ACO New Hampshire and Eastern Vermont

•9. Eastern Maine Healthcare System Central, Eastern, and Northern Maine

•10. Fairview Health Systems Minneapolis, MN Metropolitan Area

•11. Franciscan Health System Indianapolis and Central Indiana

•12. Genesys PHO Southeastern Michigan

•13. Healthcare Partners Medical Group Los Angeles and Orange Counties, CA

•14. Healthcare Partners of Nevada Clark and Nye Counties, NV

•15. Heritage California ACO Southern, Central, and Costal California

•16. JSA Medical Group, a division of HealthCare Partners Orlando, Tampa Bay, and surrounding South Florida

•17. Michigan Pioneer ACO Southeastern Michigan

•18. Monarch Healthcare Orange County, CA

•19. Mount Auburn Cambridge Independent Practice Association (MACIPA) Eastern Massachusetts

•20. North Texas Specialty Physicians Tarrant, Johnson and Parker counties in North Texas

•21. OSF Healthcare System Central Illinois

•22. Park Nicollet Health Services Minneapolis, MN Metropolitan Area

•23. Partners Healthcare Eastern Massachusetts

•24. Physician Health Partners Denver, CO Metropolitan Area4

•25. Presbyterian Healthcare Services -Central New Mexico Pioneer Accountable Care Organization Central New Mexico

•26. Primecare Medical Network Southern California (San Bernardino and Riverside Counties)

•27. Renaissance Medical Management Company Southeastern Pennsylvania

•28. Seton Health Alliance Central Texas (11 county area including Austin)

•29. Sharp Healthcare System San Diego County

•30. Steward Health Care System Eastern Massachusetts

•31. TriHealth, Inc. Northwest Central Iowa

•32. University of Michigan Southeastern Michigan

Health IT at the Heart of the ACO Framework

- Builds patient-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**

Healthcare Reform Context

Under an ACO model, the ***value*** of healthcare services will depend on our ability to:

1. Be accessible (fast access to all needed services)
2. Be efficient (provide high-quality services at lowest possible cost)
3. Connect with other providers (via electronic information exchange)
4. Focus on episodic care needs
5. Produce outcomes

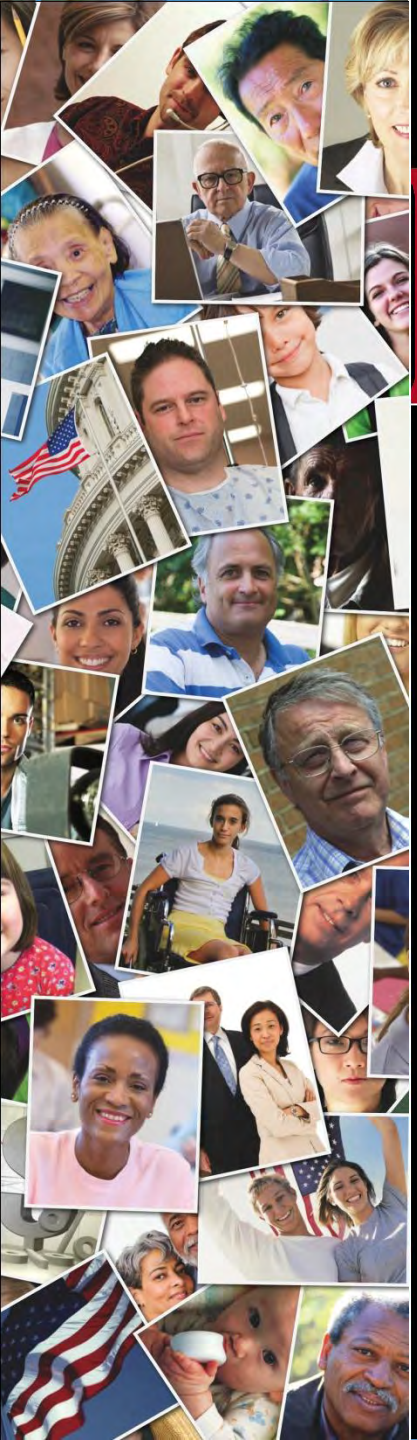
Partnering with Health Homes and Accountable Care Organizations

- 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/



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Mental health and addictions services are at the core of healthcare reform

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Questions?

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