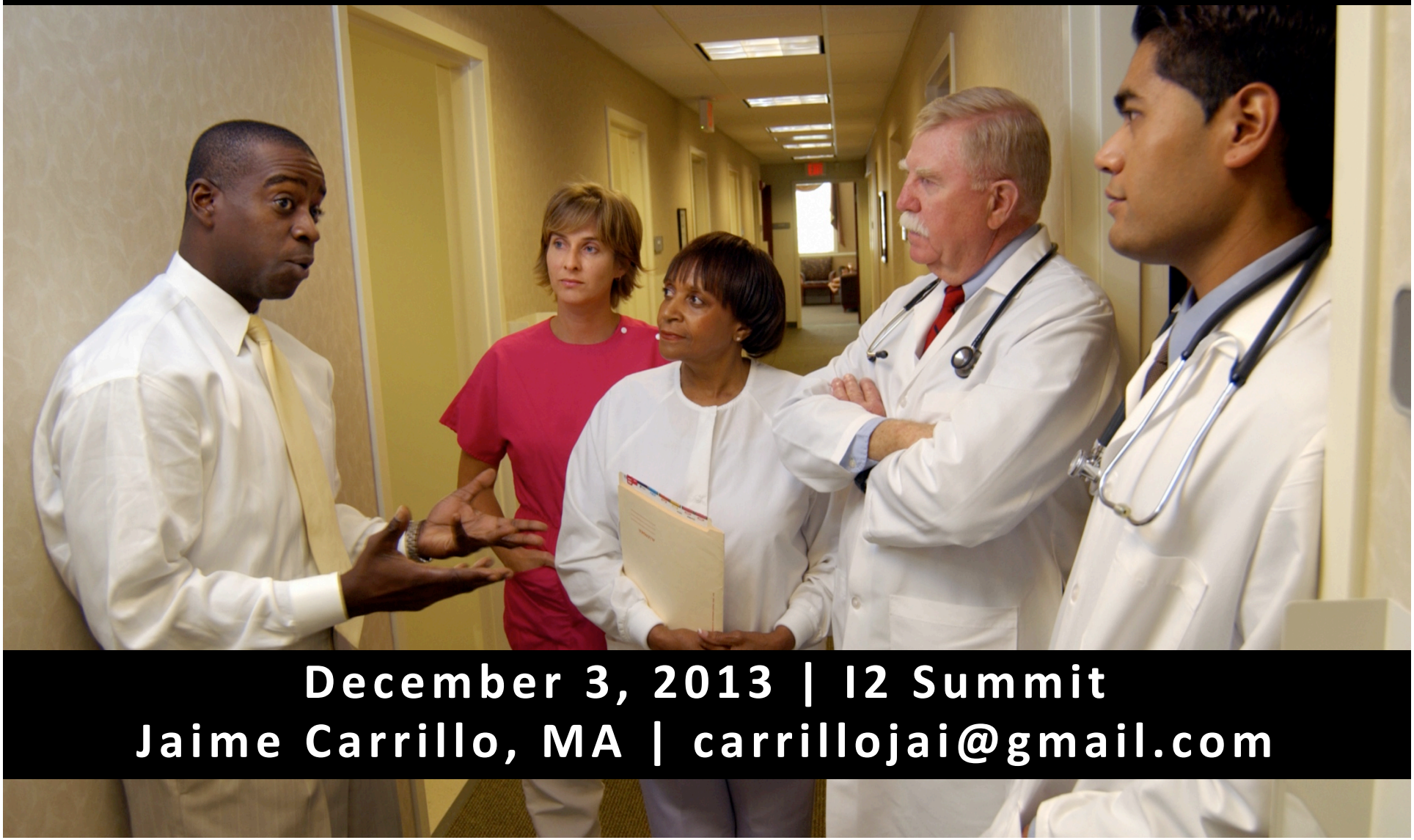
Patient Centered Medical Home for Behavioral Health Providers & Agencies



December 3, 2013 | I2 Summit

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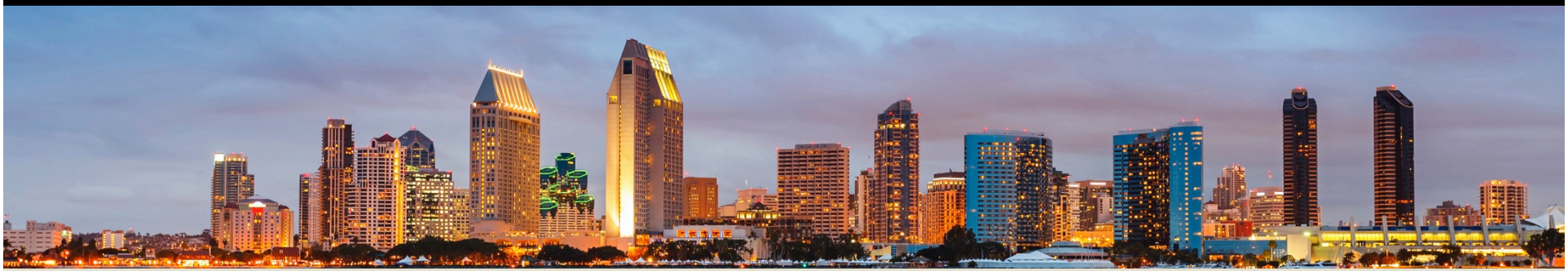
OBJECTIVES

Understand the elements of the Patient Centered Medical Home (PCMH) & learn where there are PCMHs in our community.

Explore the concept of Behavioral Health Homes and how they dovetail with PCMH.

Discuss where there are opportunities for integration between behavioral health providers and agencies in the PCMH model.

PCMHs in San Diego County



Level 3

85-100 Points, Meet 6 0f 6 Must Pass Requirements

Vista Community Clinic | North County Health Services | Family Health Centers of San Diego

Level 2

60-84 Points, meet 6 of 6 Must Pass Requirements

Family Health Centers of San Diego | Imperial Beach Health Center | La Maestra Community Health Center | Linda Vista Health Care Center | Mid-City Community Clinic | Neighborhood Healthcare (Escondido, El Cajon, Lakeside)

Level 1

35-59 Points, meet 6 of 6 Must Pass Requirements

Mid-City Pediatrics | Neighborhood Healthcare (Pauma Valley, Temecula, Pediatrics)

SECTION 2703 OF THE AFFORDABLE CARE ACT

[PCMH] *Offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. The health home is a team-based clinical approach that includes the consumer, his or her providers, and family members, when appropriate.*

CPCA
California Primary Care Association

An approach to delivering primary care that uses a 'whole person' orientation to provide comprehensive health care by facilitating an active partnership between patients, their family, and their primary care provider team to provide high quality, timely care in a coordinated and consistent way.

PCMH 2011 Content and Scoring

PCMH1: Enhance Access and Continuity	Pts
A. Access During Office Hours**	**4**
B. After-Hours Access	4
C. Electronic Access	2
D. Continuity	2
E. Medical Home Responsibilities	2
F. Culturally and Linguistically Appropriate Services	2
G. Practice Team	4
	20

PCMH2: Identify and Manage Patient Populations	Pts
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
D. Use Data for Population Management**	**5**
	16

PCMH3: Plan and Manage Care	Pts
A. Implement Evidence-Based Guidelines	4
B. Identify High-Risk Patients	3
C. Care Management**	**4**
D. Manage Medications	3
E. Use Electronic Prescribing	3
	17

PCMH4: Provide Self-Care Support and Community Resources	Pts
A. Support Self-Care Process**	**6**
B. Provide Referrals to Community Resources	3
	9

PCMH5: Track and Coordinate Care	Pts
A. Test Tracking and Follow-Up	6
B. Referral Tracking and Follow-Up**	**6**
C. Coordinate with Facilities/Care Transitions	6
	18

PCMH6: Measure and Improve Performance	Pts
A. Measure Performance	4
B. Measure Patient/Family Experience	4
C. Implement Continuously Quality Improvement**	**4**
D. Demonstrate Continuous Quality Improvement	3
E. Report Performance	3
F. Report Data Externally	2
	20

****Must Pass Elements**

MAIN (MUST-PASS) ELEMENTS

- **Enhance Access & Continuity** - Access During & After Office Hours
- **Identify & Manage Patient Populations** - Use Data For Population Management
- **Plan & Manage Care** - Care Management
- **Provide Self-Care Support & Community Resources** - Support Self-Care Process
- **Track & Coordinate Care** - Referral Tracking & Follow-Up
- **Implement Continuous Quality Improveme**nt – Measure & Improve Performance

Medicaid Health Home v. Patient-Centered Medical Home

	Health Home	Patient-Centered Medical Home
Target Population	Enhanced Medicaid reimbursement for services to individuals with approved chronic conditions [9]	Serves all populations across the lifespan
Typical Providers	May include primary care practices, community mental health organizations, addiction treatment providers, Federally Quality Health Centers, health home agencies, etc.	Typically defined as physician-led primary care practices, but may include some mid-level practitioners such as Nurse Practitioners
Payer(s)	Currently a Medicaid-only construct	Exist for multiple payers (e.g., Medicaid, commercial insurance)
How is Care Organized	Team-based, whole-person orientation with *explicit* focus on the integration of behavioral healthcare and primary care; includes individual and family support services.	Team-based, whole person orientation achieved through care coordination
Provider Requirements	State Medicaid determined	State Medicaid and NCQA determined
Payment	Usually PMPM for 6 required services with more intensive care coordination and patient activation	Payment is in line with added value; usually small PMPM

Behavioral Health Homes

Core Clinical Features

- Self Management Support
- Delivery system design
- Decision support
- Clinical information systems
- Community Linkages

Structures

- In-House (*from* BH/MH provider)
- Co-Located (*at* BH/MH provider, *from* CBO)
- Facilitated Referral

What Can Clinics Do With You?

PCMH Element	Who at Clinic	Strategies	Who at BH/MH	BHH Clinical Features
Enhance Access & Continuity	Front Desk Care Coordinator Care Team Referral Specialists	1.Identify who is on the care team, and who is on your team, “gatekeepers”.	Intake Clerk/Front Desk Case Manager Referral Specialists	Delivery System Design
Use Data for Population Management	Clinical Quality Director IT & Admin Supports Population Managers	1. Identify which clinical data to share with partners and how. 2. Share it often, and use it to guide care.	Quality Director IT & Admin Supports IS Managers	Clinical Information Systems
Care Management	Care Teams: -Physician -Nurse Practitioner -Nurse -Care Coordinator -Referral Specialists -Medical Assistants	1. Identify care teams at both entities. 2. Develop relationships and join teams. 3. Discuss how to check in and do it. 4. Share models of care and assessment tools.	-Psychiatrist, Psychologist -Social Worker/Therapist -Mental Health/Psych Nurse -Care Manager -Referral Specialists	Decision Support
Support self-care process	Care Team Health Coaches Promotoras/Peer educators	1. Share support processes with each other and integrate. 2. Use the same language with patients.	Case Manager Social Worker Peer supports	Self-management support
Referral tracking and follow-up	Care Coordinator Referral Specialist	1. Work with each otherto coordinate access 2. Identify who is on the care team, and who is on your team, “gatekeepers”.	Case Manager Social Worker Referral Specialist	Community Linkages
Implement Continuous Quality Improvement	CEO/COO/CCO/CMO Clinical Quality Director Operations Manager(s)	1. Identify who to partner and champion integration with.	CEO/CMHO/CPO/COO/CCO Clinical Quality Director Operations Manager(s)	Delivery System Design

Contributions Psychologists Can Make To An Integrated Healthcare Team

- Conduct cognitive, capacity, diagnostic and personality assessments that differentiate normal processes from pathology, side effects of medications, adjustment reactions, or combinations of these.
- Offer behavioral health assessment and treatment that provides individuals with the skills necessary to effectively manage their chronic conditions.
- Diagnose and treat mental and behavioral health problems (e.g. depression, suicide risk, anxiety disorders, addiction and insomnia).
- Offer consultation and recommendations to family members, significant others, and other health care providers.
- Contribute to research expertise to the design, implementation, and evaluation of team care and patient outcomes.
- Develop interventions that are responsive to specific individual and community characteristics that may impact the treatment plan.

Croghan, TW, Brown, JD. Integrating Mental Health Treatment Into the Patient Centered Medical Home. (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2.) AHRQ Publication No. 10-0084-EF. Rockville, MD: Agency for Healthcare Research and Quality. June 2010.

…the missing link…and golden thread…

The patient/consumer/client/ person is still

the center to care in PCMH, BHH, and integration.

Models of care need to be explained to patient in layperson/ common terms for both primary and behavioral health care.

The patient is also part of the team and has assets to contribute.

Sometimes they are really hidden…so it's on you to search.

SOME KEY CHALLENGES…

- Change Fatigue Everywhere
- Technology Is Still Catching Up –
  So Are Privacy Policies & Laws
- Environmental & Community Factors
- Reimbursement Models & Funding
- Access To Specialty Providers
- So Little Time, So Many Patients

Resources

- California Primary Care Association – Health Home Resources
  http://cpca.org/index.cfm/health-center-resources/health-home/
- SAMHSA-HRSA Center for Integrated Health Solutions
  http://www.integration.samhsa.gov/integrated-care-models/health-homes
- Behavioral Health Homes for People with Mental Health & Substance Use Conditions (May 2012)
  http://www.integration.samhsa.gov/clinical-practice/CIHS_Health_Homes_Core_Clinical_Features.pdf
- Iowa Department of Public Health – Why Should Mental Health Problems be Priorities for the PCMH?
  http://www.idph.state.ia.us/IDPHChannelsService/file.ashx?file=8BF8B60A-CF13-4166-A647-30C41D74AC5D
- National Council for Community Behavioral Healthcare – Compare and Contrast Medicaid Health Homes and Patient Centered Health Homes
  http://www.integration.samhsa.gov/integrated-care-models/Medicaid_HH_and_Patient_Centered_Medical_Homes.pdf
- National Committee for Quality Assurance Clinician Recognition Directory:
  http://recognition.ncqa.org