



# Recovery Homes:

## Recovery and Health Homes under Health Care Reform

*4/27/11*

Richard H. Dougherty, Ph.D.

DMA Health Strategies





# *Challenges of health reform*

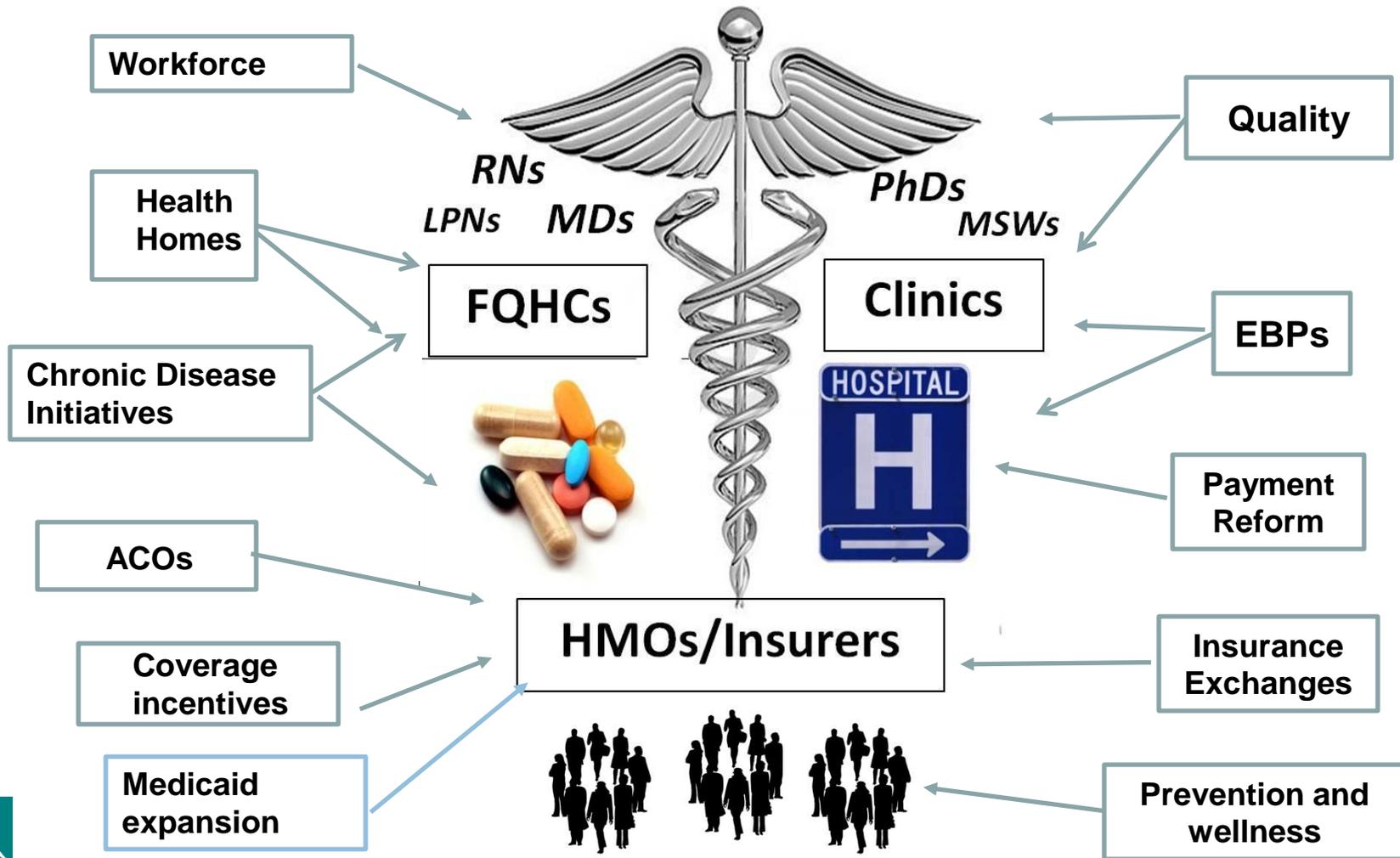
- Increasing “coverage”
  - Reducing costs of coverage
  - Reducing health care service costs
  - Reducing service utilization
- 
- Improving provider access and availability
  - Increasing workforce expertise and use of evidence based practices
  - Optimizing the efficiency and effectiveness of technology
  - Increasing or maintaining quality of care

***The Affordable Care Act addresses each of these areas with discrete initiatives***



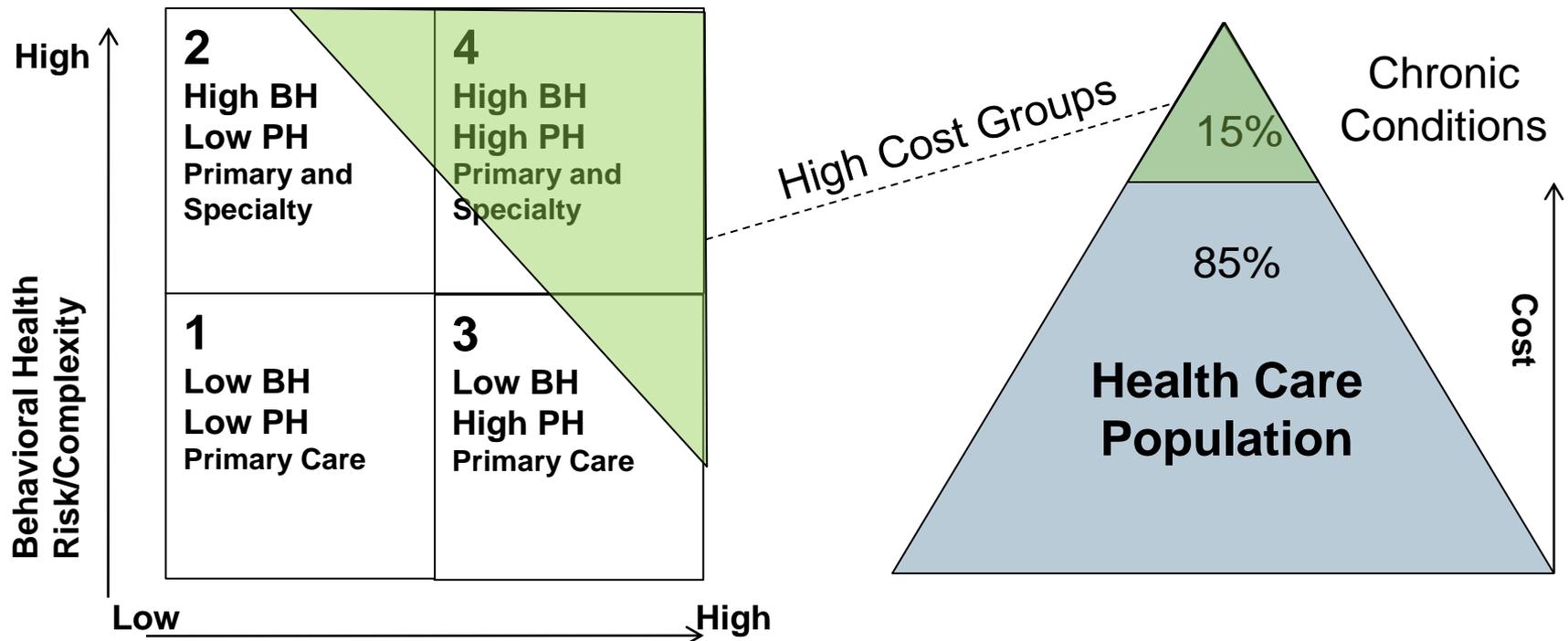
# Reforming the Medical-Industrial Complex – A systemic approach

## Medical-Industrial Complex



# Integrated Care: The Quadrant Model

- Individuals in quadrants 1 & 3 receive most services in primary care, quadrants 2 & 4 in behavioral health settings
- People don't fall into quadrants and the high cost target groups are probably the top ~15% of the population





# Organizing Integrated Care

## Organizational models for integrating care

- 1) Improving collaboration between separate providers
- 2) Medical-provided behavioral health care
- 3) Co-location
- 4) Reverse co-location
- 5) Unified primary care and behavioral health
- 6) Collaborative system of care

*Bi-Lateral care management is the goal.*

*The Individual or family is the shared responsibility of the health care team*



# *Patient Centered and Integrated Care*

- ACA includes extensive references to patient centered care, person centered plans, whole person approaches, recovery, consumer controlled services, self-direction, etc.
- Patient centered care or shared decision making requires a significant culture change in most organizations – focusing on client education as well as significant changes in provider routines
- We need to “convert evidence-based knowledge into condensed “bite-size” interventions with a psycho-educational format, with emphasis on skill building and home-based practice” (Strosahl, 2005)”
- Screening, brief interventions in primary care, referral to specialists and peer/family support should be essential elements of primary care.



# Health Homes

- ACA provides states with 90% FMAP for two years for payments to qualified health homes
- Health homes are designated providers (physician, group practice, rural clinic, CHC, CMHC, etc.), teams of professionals or health teams.
- Health home services include care management, coordination and health promotion; transitional care; patient and family support; referrals, and use of IT
- Eligible recipients include individuals with 2 chronic conditions (includes SA) or serious and persistent mental health disorder
- Most states will use NCQA standards – Standards and Guidelines for Physician Practice Connections – Patient Centered Medical Home
- State Plan Amendment required
- Planning grants available beginning 2011.
- Tiered payments, using PMPM or alternatives
- Planning needed for integration with waivers



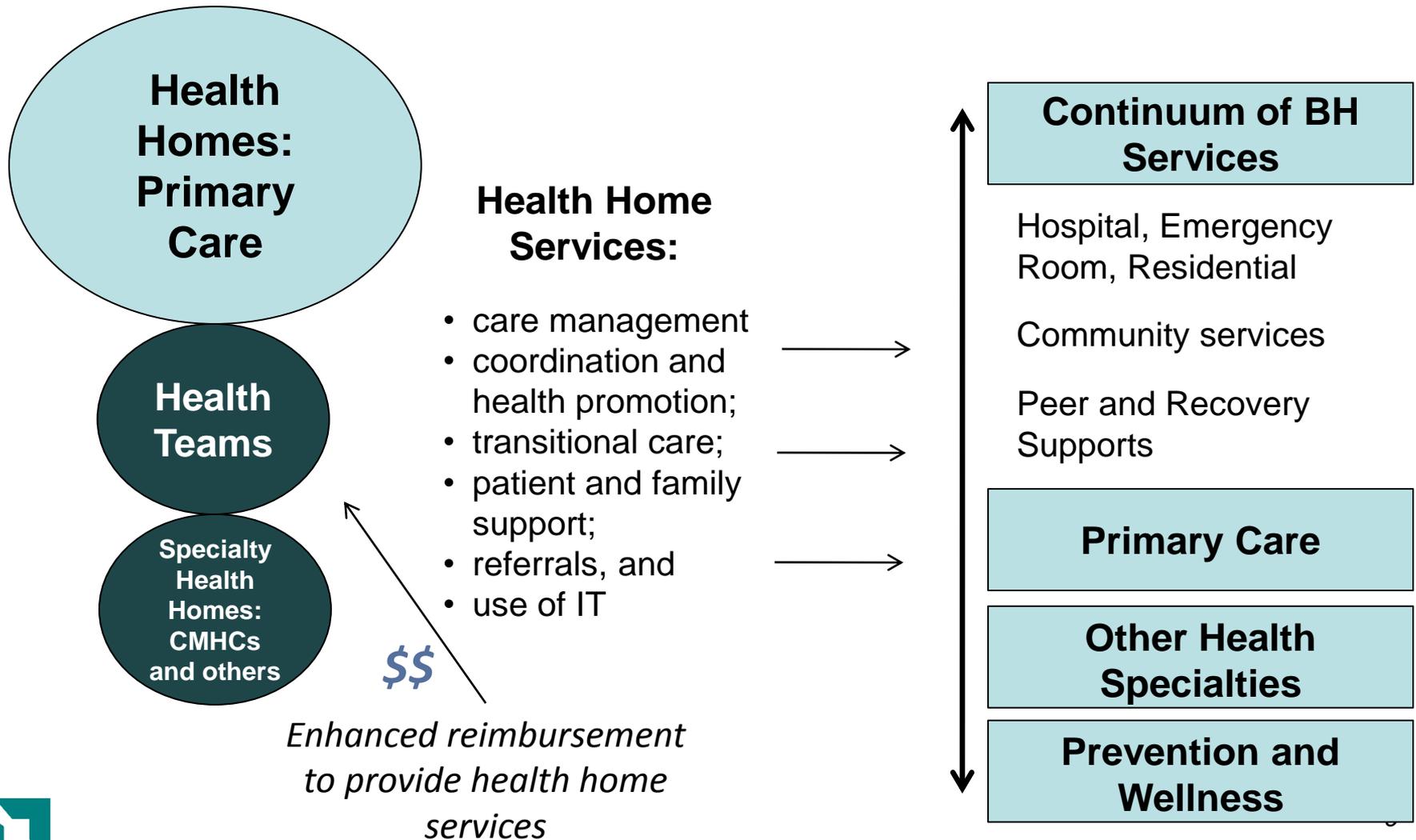


# Health Teams

- Grants or contracts will be provided to establish Health Teams to support primary care practices (ACA Section 3502)
- Teams will be interdisciplinary and inter-professional and may include behavioral and mental health providers
- Teams will:
  - Be a state or a state designated entity, an Indian Tribe or tribal organization
  - Submit a plan for financial sustainability within 3 years
  - Submit a plan for prevention, patient education and care management
  - Agree to provide health home services to individuals with chronic conditions
  - Establish contracts with primary care
  - Support patient centered medical homes
  - Coordinate disease prevention, chronic disease management and case management for patients, including 24 hour care management and support during transitions in care



# Health Homes





# *Recovery Home Services*

**As we go to the extraordinary steps involved in creating health homes for people with serious and persistent mental illnesses, we need to ensure that they support recovery**

## **Health Home Services**

1. care management
2. coordination and health promotion;
3. transitional care;
4. patient and family support;
5. referrals, and
6. use of IT

## **Recovery Home Services**

1. Assertive engagement
2. WRAP and other person centered planning
3. Health education and motivational interventions
4. Patient and family support;
5. “Bridger” transitional services;
6. Coordination and follow-up on referrals , and
7. use of IT





# *Recovery Home Services*

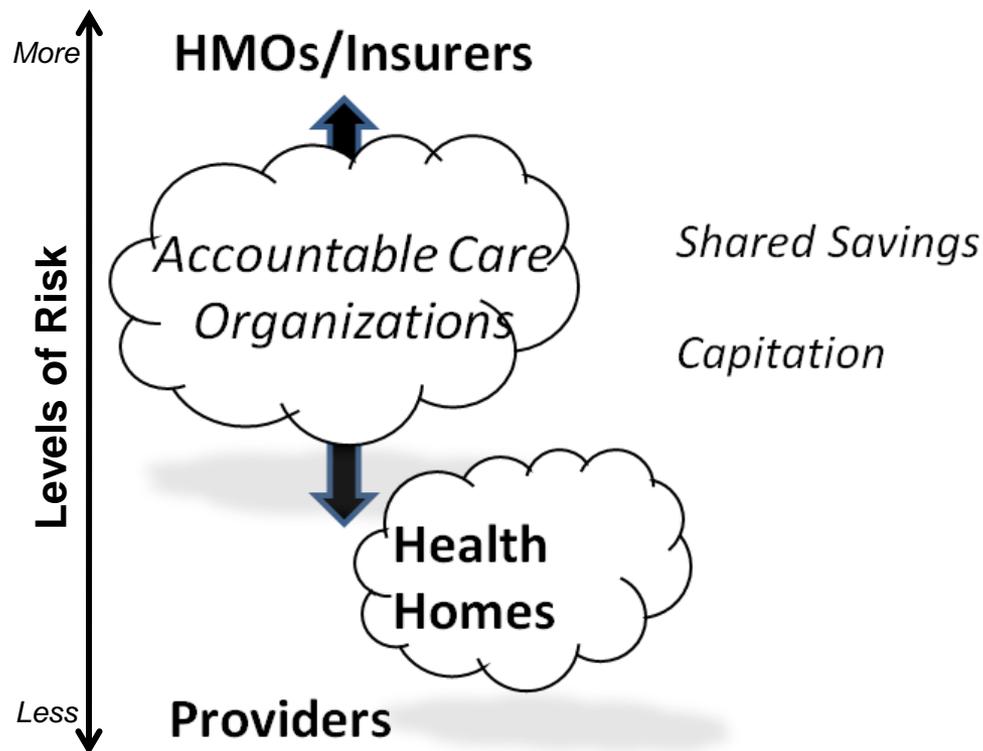
**As we go to the extraordinary steps involved in creating health homes for people with serious and persistent mental illnesses, we need to ensure that they support recovery**

## **Health Home Services** —————> **Recovery Home Services**

- |                                       |  |
|---------------------------------------|--|
| 1. care management                    | 1. Assertive engagement                            |
| 2. coordination and health promotion; | 2. WRAP and other person centered planning         |
| 3. transitional care;                 | 3. Health education and motivational interventions |
| 4. patient and family support;        | 4. Patient and family support;                     |
| 5. referrals, and                     | 5. “Bridger” transitional services;                |
| 6. use of IT                          | 6. Coordination and follow-up on referrals , and   |
|                                       | 7. use of IT                                       |



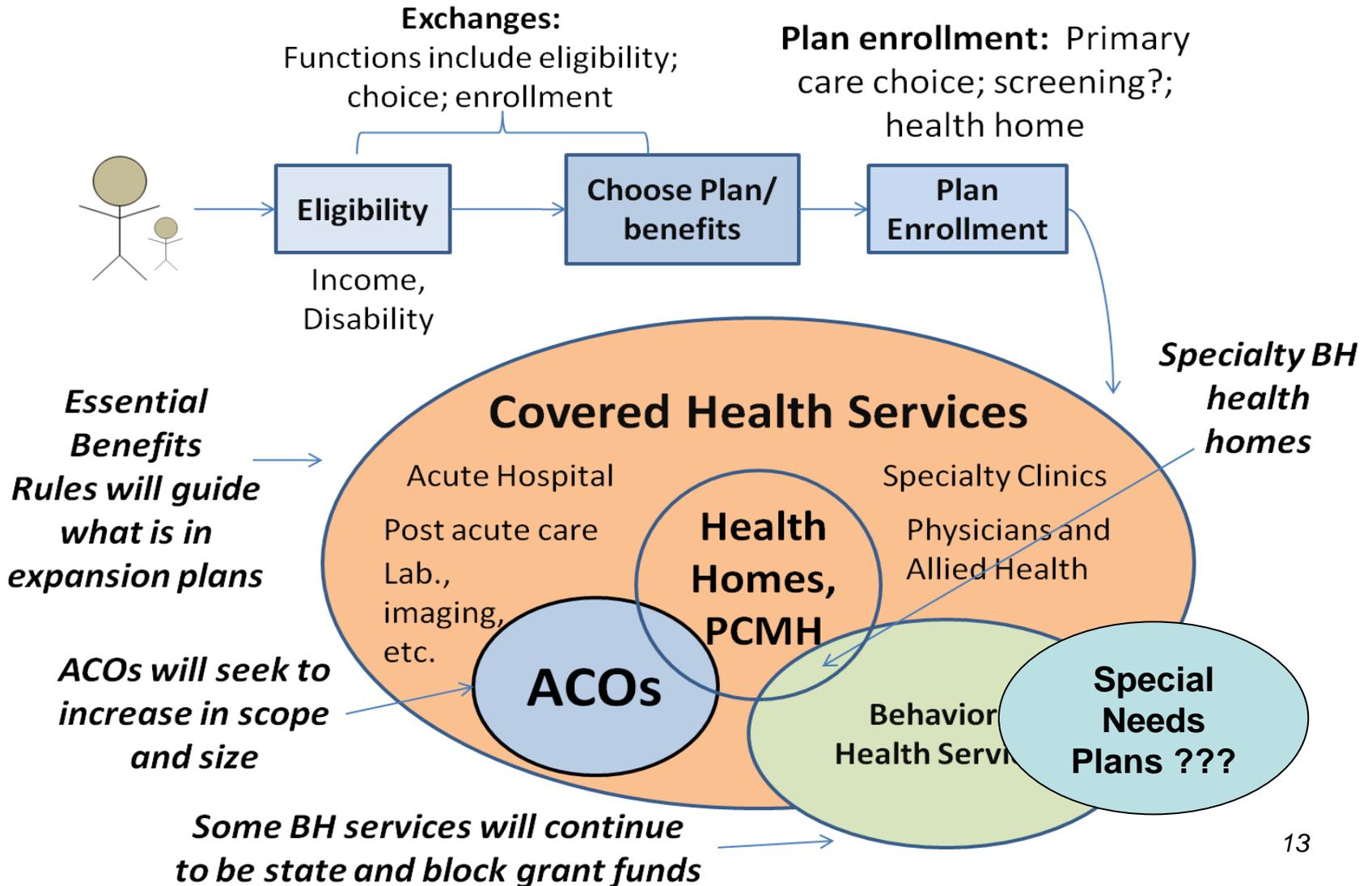
# Accountable Care Organizations



- **Vertically integrated provider systems that include health homes**
- **Not envisioned as condition specific**
- **ACOs started as a Medicare demo - shared savings and partial capitation model – (Section 3022,10307)**
- **Pediatric ACO Demonstration in Medicaid (Section 2706)**
- **ACO must have:**
  - a formal legal structure to distribute incentive or partial capitation payments
  - Sufficient primary care physicians and at least 5000 beneficiaries
  - Processes to implement EBPs and promote patient centeredness
  - Data reporting to include clinical processes and outcomes, patient experience of care and utilization
- **Shared savings when ACO costs are less than specified annual benchmark rates.**



# The New Health Reform Delivery System





Thank you

