Recovery Homes:

Recovery and Health Homes under Health Care Reform

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DMA Health Strategies

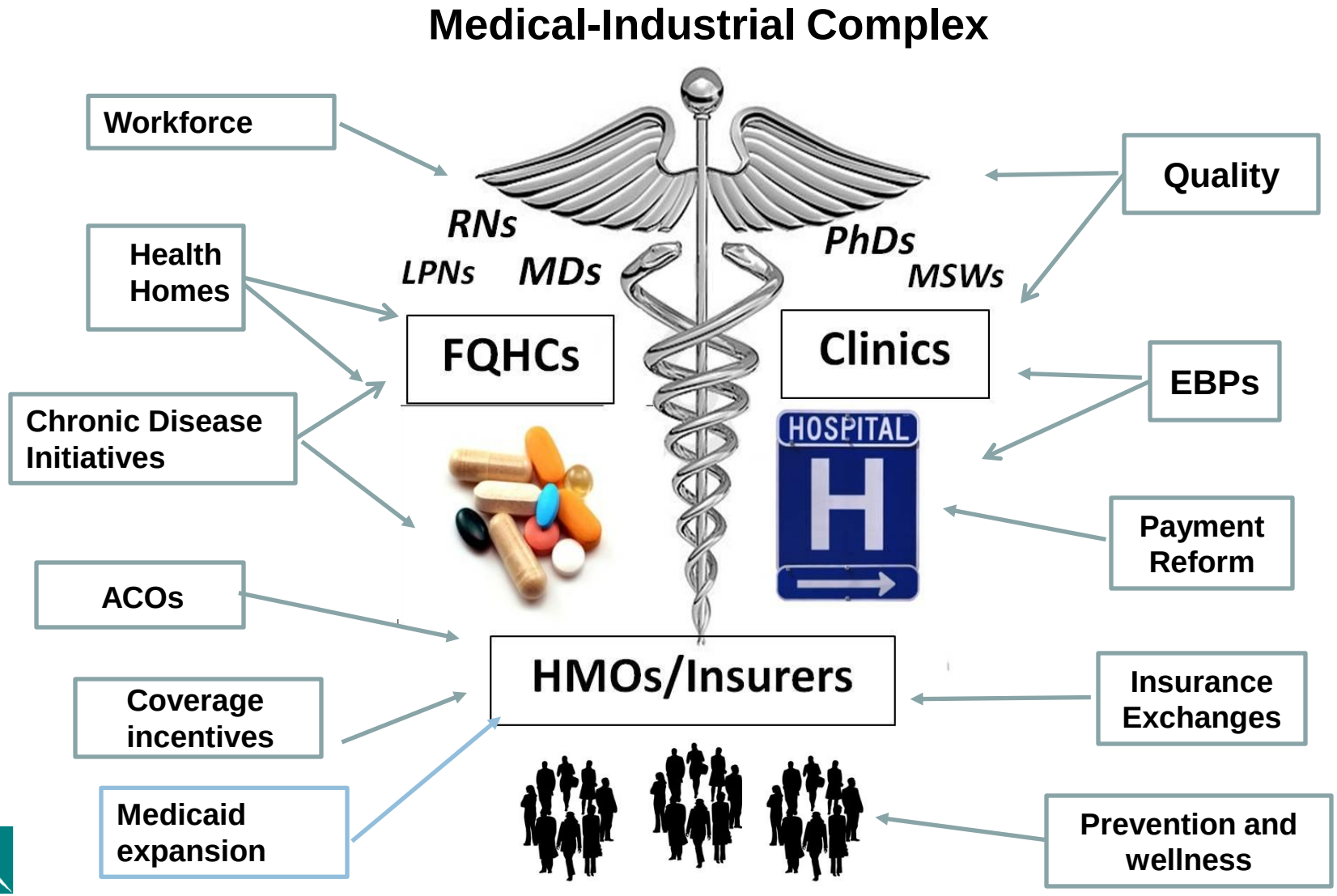
Challenges of health reform

- 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

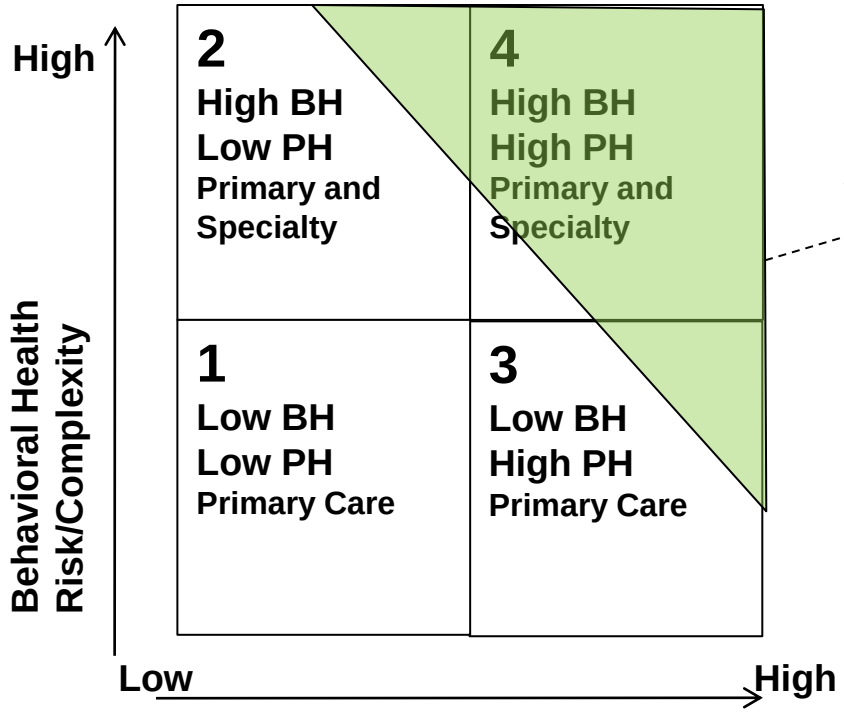
The Affordable Care Act addresses each of these areas with discrete initiatives

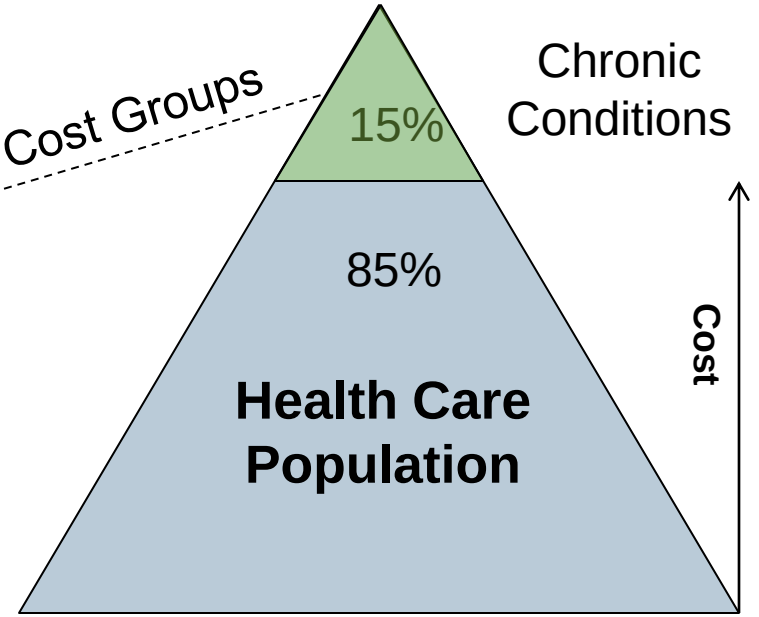
Reforming the Medical-Industrial Complex – A systemic approach



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





Mauer, B. 2002/2006

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

Adapted from "Evolving Models of Integration in Primary Care", Milbank (2010)

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.

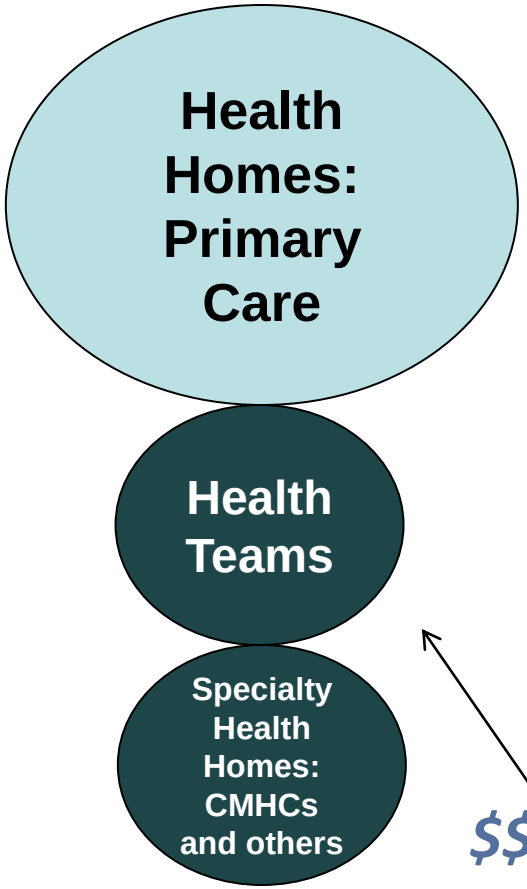
Health Homes

- 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



Health Home Services:

- care management
- coordination and health promotion;
- transitional care;
- patient and family support;
- referrals, and
- use of IT

$$

Enhanced reimbursement to provide health home services

Continuum of BH Services

Hospital, Emergency Room, Residential

Community services

Peer and Recovery Supports

Primary Care

Other Health Specialties

Prevention and Wellness

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

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Health Home Services	**Recovery Home Services**
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5. referrals, and	5. “Bridger” transitional services;
6. use of IT	6. Coordination and follow-up on referrals , and
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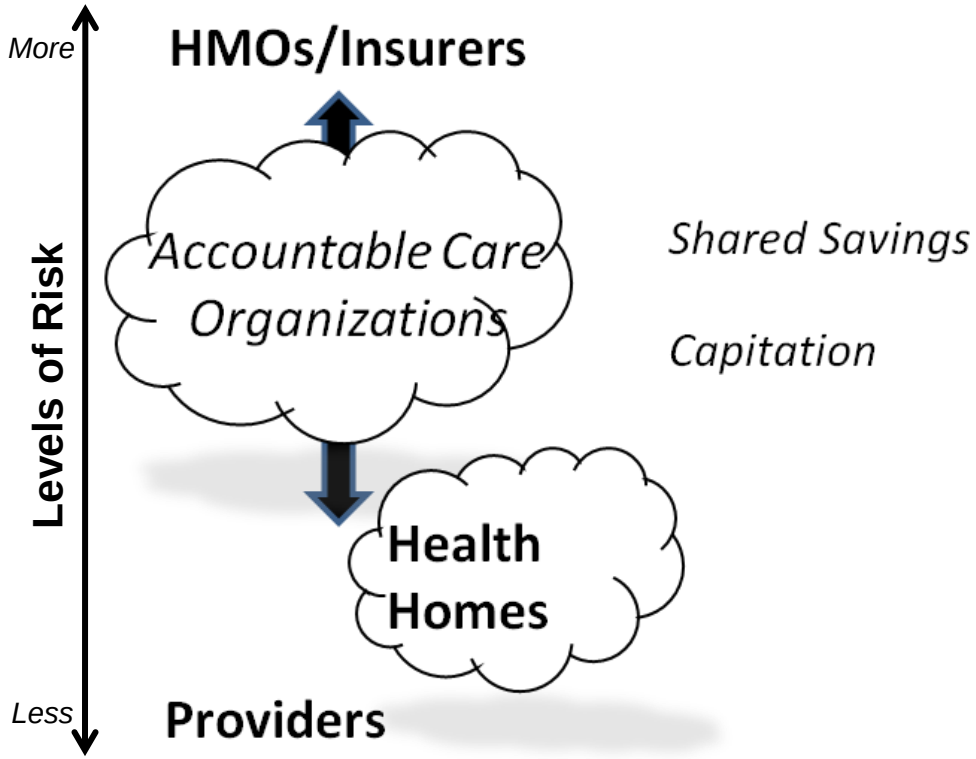
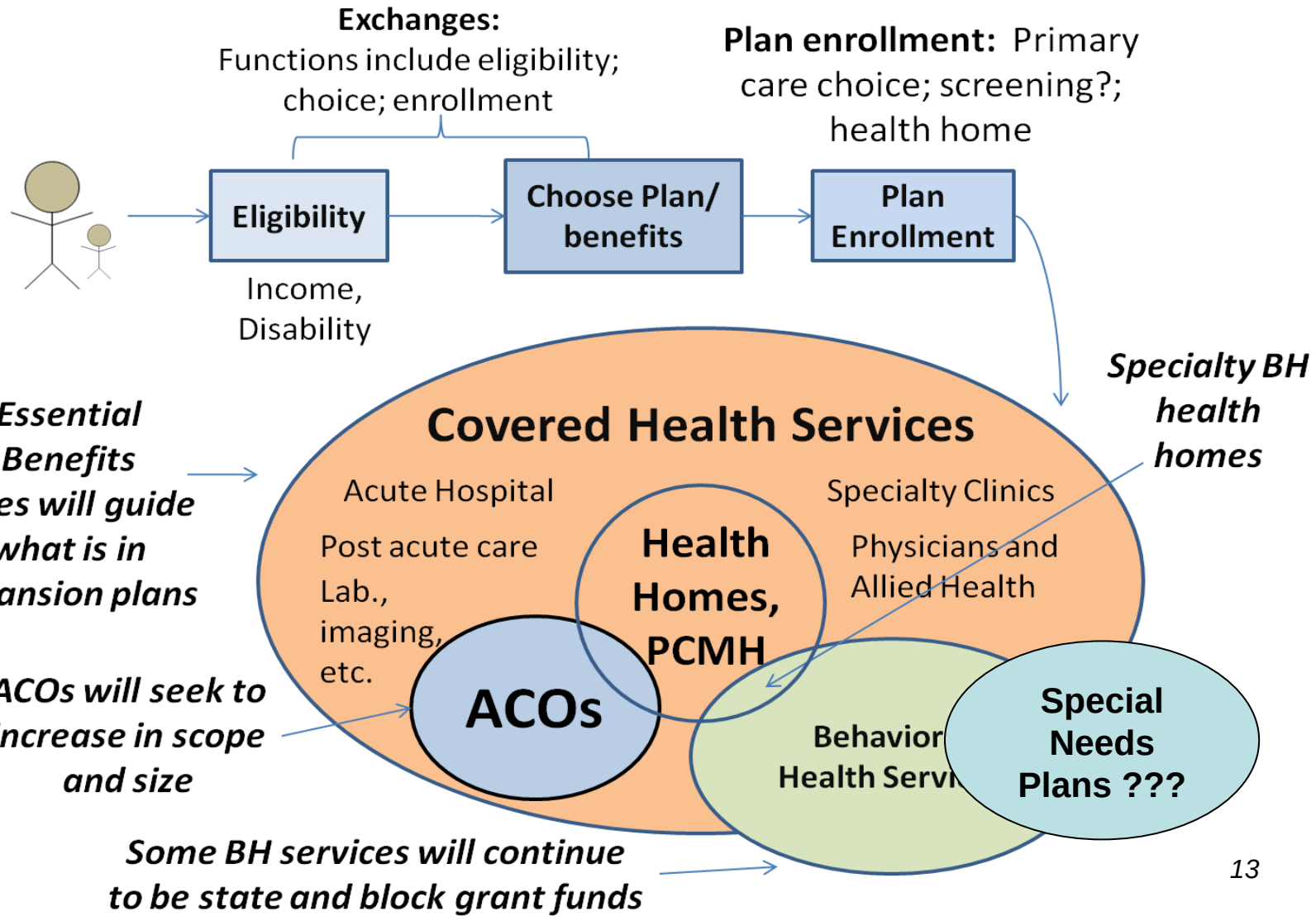
Accountable Care Organizations



- **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