

HAWAI'I PRIMARY CARE ASSOCIATION



2011 ANNUAL CONFERENCE
JOURNEYS OF TRANSFORMATION





PLENARY SESSION

Thoughts on An Integrated Health Care System

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Where is “Behavioral Health”?

*Thoughts on an Integrated
Health Care System
via Health Home Model*



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If Behavioral Health is Everywhere, SO is Stress...



... On your body

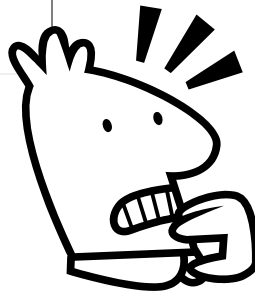
- Headache
- Muscle tension or pain
- Chest pain
- Fatigue
- Change in sex drive
- Stomach upset
- Sleep problems

... On your mood

- Anxiety
- Restlessness
- Lack of motivation or focus
- Irritability or anger
- Sadness or depression

... On your behavior

- Overeating or under eating
- Angry outbursts
- Drug or alcohol abuse
- Tobacco use
- Social withdrawal





New Understandings of Stress

- **Psychoneuroimmunology:** Interactions between the nervous and immune systems and the relationships between mental processes and health.
- Stress affects immune function through emotional and/or behavioral manifestations such as anxiety, fear, tension, anger and sadness and physiological changes such as heart rate, blood pressure, and sweating.
- Researchers have suggested that these changes are beneficial if they are of **limited duration**, but when stress is **chronic**, the system is unable to maintain homeostasis or **allostasis**.
- The main hormonal mediators of the stress response, epinephrine (adrenaline) and cortisol, have both protective and damaging effects on the body.
- **Allostatic Overload:** The human body is adaptable, but it cannot maintain allostatic overload for very long without consequence—"Mental Illness."

How Real is Mental Illness?



~21% of any given population have a diagnosable disorder

- ~5%--Serious Mental illness
 - Mental disorders that interfere with some area of social functioning where clinical help is needed.
- ~3%--Severe and Persistent Mental Illness
 - Schizophrenia, bipolar disorder, other severe forms of depression, panic disorder, and obsessive-compulsive disorder. (~28,000... AMHD touched ~16,000).

Behavioral Health & Physical Health



Per the Review of Several Research Studies:

- People with a history of depression were four times as likely to suffer a heart attack as those not suffering from depression.
- The presence of type 2 diabetes nearly doubles an individual's risk of depression and an estimated 28% of diabetic patients meet criteria for clinical depression.
- Rate of tobacco use among people diagnosed with a mental health condition is approximately twice that of the general population.
- Injury rates for both intentional (ie., homicide) and unintentional (ie., motor vehicle accidents) injuries are approximately 2 to 6 times higher among people with a mental illness than for the general population.
- Diagnosis of a chronic disease appears to contribute to or exacerbate depression and other mental health conditions.
 - For example, after a heart attack, 1 in 3 patients exhibit depressive symptoms and nearly 1 in 6 are formally diagnosed with depression.

Costs in not Addressing Behavioral Health



Two Examples:

- Adults with coronary artery disease who also have depression or anxiety have \$5,700 higher direct annual medical costs than those without anxiety or depression.
- The cost burden to employers for workers with depression was estimated to be \$6,000 per depressed-person per year.

Cost Savings in Addressing Behavioral Health in Primary Care



For Every \$1 Spent...

- For every \$1 spent on mental health services, \$5 is saved in overall healthcare costs. (*American Psychological Association*)
- *The state of California documented saving \$2 in hospital and jail costs for every \$1 spent on mental health services. (NAMI California)*
- Texas Study: For every \$1 spent, Texas would see a return of \$23.

*Perryman, Ray. (2009). "Costs, Consequences, and Cures!!! An Assessment of the Impact of Severe Mental Health and Substance Abuse Disorders on Business Activity in Texas and the Anticipated Economic and Fiscal Return on Investment in Expanded Mental Health Services," The Perryman Group, May 2009.

Conclusions....



There is a strong bi-directional relationship between behavioral health and physical health.

Convinced?

Not Convinced?

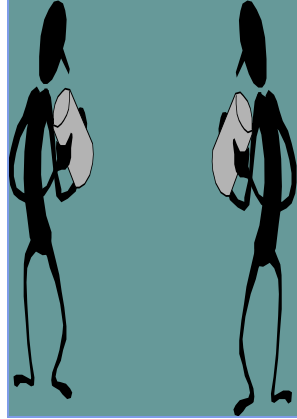


Addressing MI/SA early in the course of treatment can lead to costs savings later on?

Convinced?

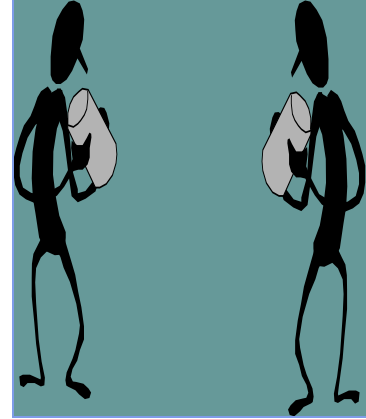
Not Convinced?

Because behavioral health and physical health is so closely connected, primary care and behavioral health should work together?



Convinced?

Not Convinced?



Better Collaboration might Answer some other Questions

Behavioral Health..



- **Why do so few consumers with Severe and Persistent Mental Illness follow-up with their PCP, even when given the referral to do so?**
- **Why are there so many “consumer-no shows”, and how do we know if they’re okay?**
- **Why are we using less individual, family, and/or group therapy – is talk therapy valid anymore?**
- **Why are there ethnic or geographic disparities in mental health when our services are open to all who are eligible?**

Primary Care Providers...



- **Why do so few patients referred to mental health actually follow-up on the referral?**
- **Why do so many “psych” patients come in for care when a mental health clinic is two blocks away?**
- **How can we get patients with chronic conditions like diabetes to change the behaviors so crucial to managing their disease?**
- **How can we be expected to meet all of a patients needs with a 15 minute visit?**



Questions of My Own...

- **Why are Asian/Hawaiian consumers with mental illness twice as likely to enter the system with a diagnosis of Schizophrenia than Caucasian consumers?**
- **Why are our consumers with SMPI dying on an average of 25yrs earlier than the general population?**



**I Pose these Questions
because it
Reveals Serious Problems
for People with
Behavioral Health Issues**



What's The Problem:

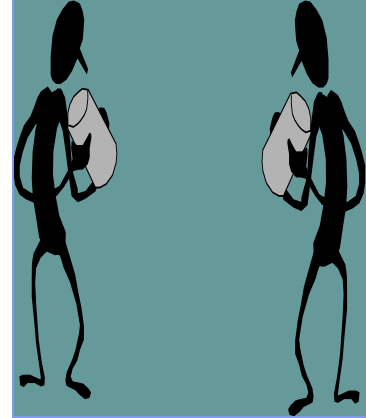
- **The Stigma of Mental Illness/SA Still Exist:**
Thus, some ethnic (or geographic) groups with mild-moderate mental illness prefer going through the “primary care door” rather than the “mental health door”, and by the time they get into the “mental health door”, they have SMPI.



The Problem...cont.:

- **People with SMPI die on an average of 25 years earlier than those without SMPI. This high mortality is largely due to preventable conditions:**
 - ***Smoking***
 - ***Obesity, Diabetes and Metabolic Syndrome***
 - ***Alcohol and Substance Abuse***
 - ***Infectious Diseases (HIV, TB)***

**The Primary Care and
Behavioral Health System
CAN'T
Solve these Problems
Alone or in Isolation.**





We Need to Work Different:

A Person-Centered Integrated Health Care Home where one's behavioral health and primary care needs can be **addressed earlier** -- in a **holistic, culturally appropriate, and non-stigmatizing way.**

At the core of the health home model is better coordination, communication, and patient participation.



BUT...



**Which Target Group
Would we Focus on
and How would it
Be Different?**



I'd say lets focus on the Most Vulnerable first.

1 in 5 Hawaii Residents are Eligible for Medicaid.

Medicaid Enrollees tend to have the most health issues, which translates to high costs for the State.

There is a perception that Medicaid Enrollees tend to receive “second best” services, or are the first to be victims of budget cuts.

Improving Health Care for the Medicaid population first will be a model for the rest of the State.

Why else...



It Could Bring Money to the State: \$9-\$1 federal match for the first 2 years.

The Health Home Must Include the Following:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to outpatient settings
- Individual and family support
- Referral to community and social support services, if relevant
- The use of health information technology to link services, as feasible and appropriate

Cont.... \$9-1 Federal Match

Type of Provider Options To Decide Upon:



- States can choose the provider arrangements that may qualify as a health home. Options include:
 - **Designated providers**, such as physicians, clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies, or any other provider approved by HHS.
 - **A team of health care professionals** linked to a designated provider. This team may include nurse care coordinators, nutritionists, social workers, behavioral health professionals, or any professionals approved by HHS.
 - **A health team**, defined in the law as community-based interdisciplinary teams that support primary care providers in providing health home services.

Why else...



- It Saves Money:
 - The North Carolina Medicaid health home program, which includes strong behavioral health services, saved the state between \$154 and \$170 million in 2006 alone.
 - Illinois saved \$220 million in the first two years that its Medicaid health home program, *Illinois Health Connect*, was fully implemented.
- Its Already Happening: The majority of “behavioral health care” in the US is delivered in primary care settings -- 65% of all behavioral health medications are given through the primary health care system.

But What Health Home Model?

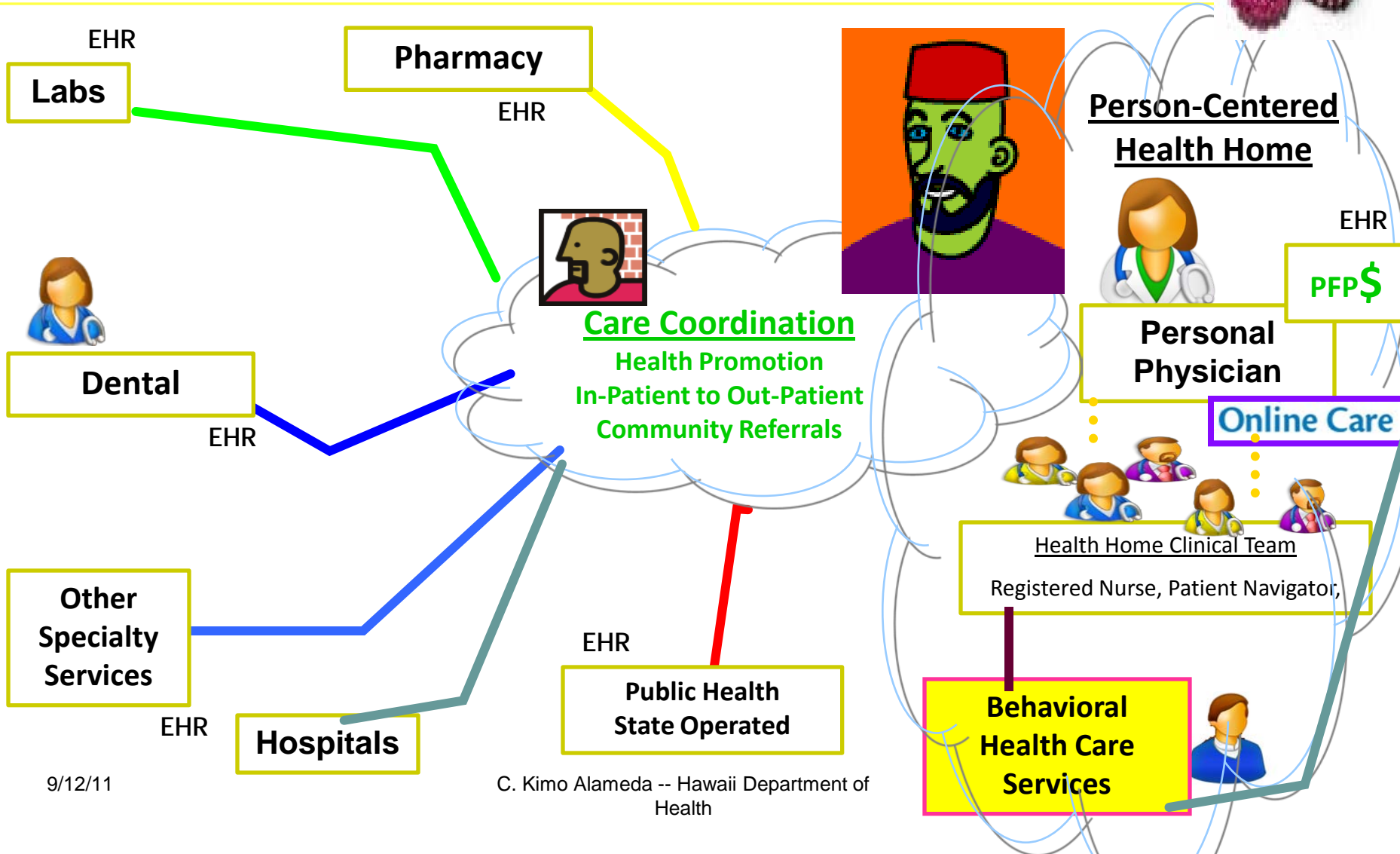


- Depends...
 - **Safety-Net State Operated Participants**
 - **Bi-Directional or Co-Location:** Bringing Primary Care services into *high* need Behavioral Health Care settings and/or bringing *low* need Behavioral Health Care services into Primary Care settings.
 - **On a smaller scale, this model could also include Specialty Consultation and Collaboration:** Sharing of information and Joint treatment planning or Behavioral Health/Primary Care Consultation as needed.
 - **All Others**
 - **Full Integration:** Behavioral Health Providers works under the PCP in a Primary Care Setting and is incorporated seamlessly into care.

1. Bi-Directional Integration

“Primary Health Care Home”

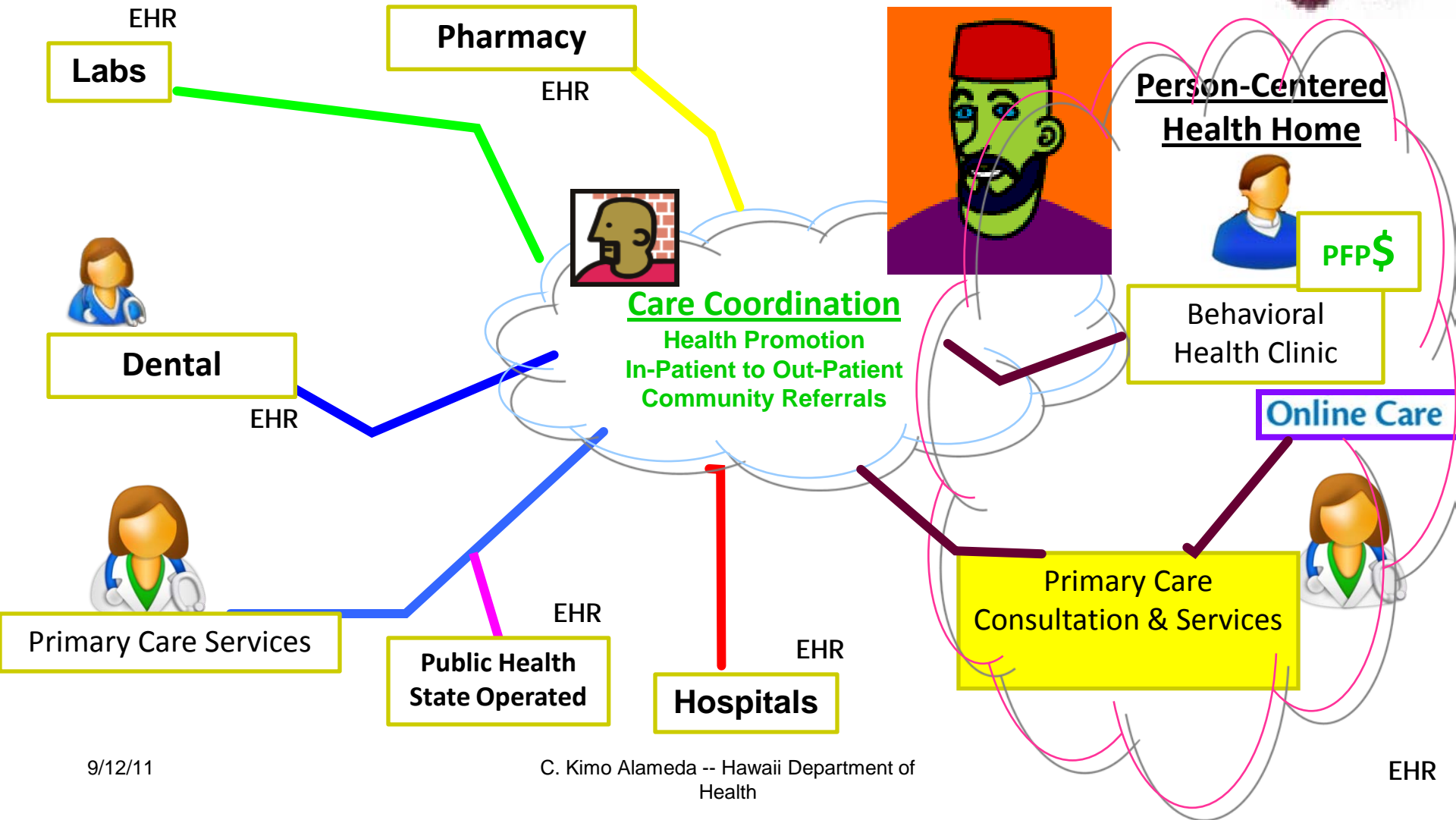
(i.e., FQHCs—Addresses Stigma and Early Mental Health Detection)



1. Bi-Directional Integration

“Behavioral Health Care Home”

(i.e., AMHD Kalihi-Palama Pilot—Addresses High Mortality Rate in SMPI Population)



Bi-Directional Integration via PCHCH



How will a PCHCH make things better?:

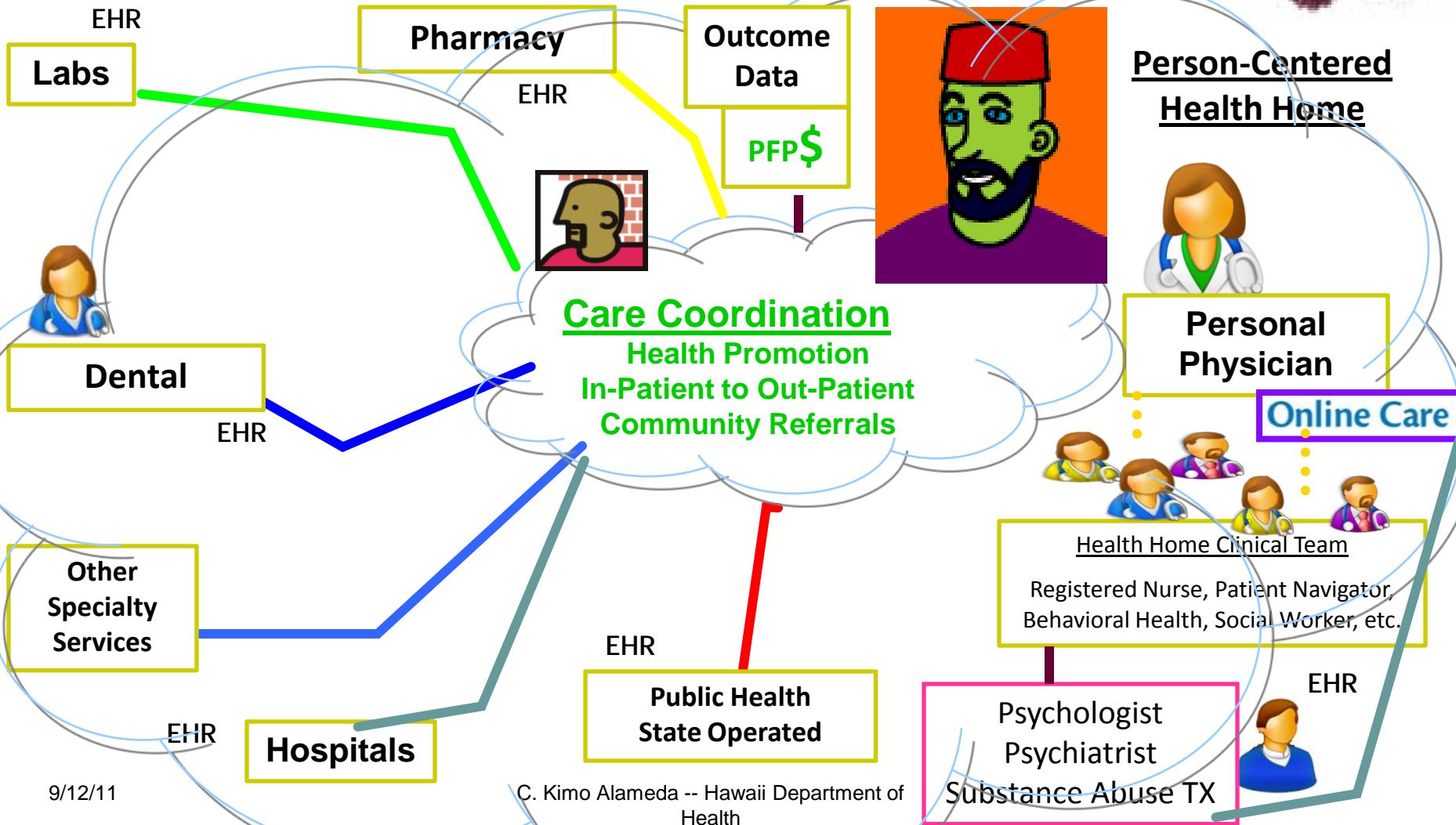
At the front -- catching mental illness at the onset (in primary care), with people who tend not to use mental health services, so they can treat themselves earlier.

At the back – catching chronic disease earlier with the SMPI population so they can live longer.

2. Full Integration in a Primary Care Setting

“Health Plan Coordinated”

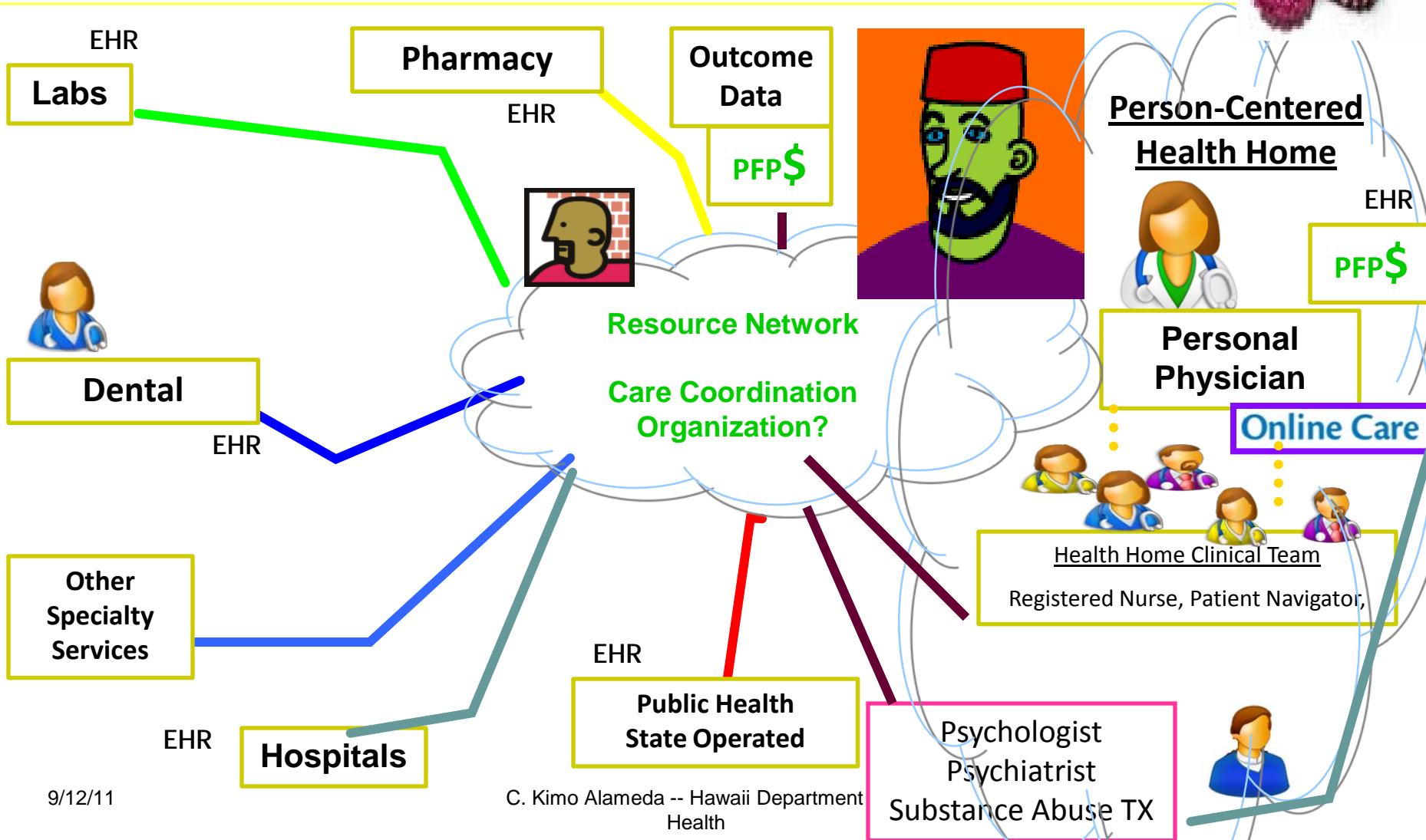
(i.e., Kaiser)



3. “Virtual” Integration via PCP

Health Plans—“Independent Entities”

(i.e., A New Model—HMSA?, Aloha Care?)



FYI: Demonstration Projects Across the Country are Underway



- Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, Vermont.
- Multi-payer Advanced Primary Care Practice Demonstrations started in July, 2011.
- In order to participate, beneficiaries must be covered under the traditional Medicare fee-for-service program and be receiving their primary care from a practice that is participating in the demonstration.
- The State initiative must include Medicaid and majority of the private health plans to assure the availability of resources that are needed to support implementation.
- Providers will continue to receive Medicare fee-for-service claims in the standard manner, AND states will pay additional amounts (i.e., monthly fee per member, pay for performance incentives, shared savings) for transforming their practice into a health home and for providing services not covered by Medicare.



Barriers / Solutions

Some Barriers & Potential Solutions



- **HIPPA as a Barrier**

Solution:

General consent form upon registration.

Or a signature line in the Coordinated Service Plan.

Some Barriers & Potential Solutions



- **Medical Model vs. Recovery Model**
 - Different approaches to care can be a barrier.

Solution: Research has suggested that health and illness is not on a single continuum, but as distinct states that can exist simultaneously.

For example, patients with chronic disease can adopt the strength-based recovery model.

Some Barriers & Potential Solutions



- **Malpractice protection in a co-location could be a Barrier:**

Solution: If we bring health center services into behavioral health clinic then it becomes a satellite office and assumes the same protections as if it were at its home center. Same is true with behavioral health going into primary care.

Some Barriers & Potential Solutions



- **Barrier of Reimbursement:**
 - **What do we know about who pays for what?.**
 - **What are the billing rules by payer (eg., billing primary care visit same day as behavioral health visit, number of visit limits, auth/preauthorization's, etc.?)**
 - **What do we know about the Medicaid requirements for billing?.**

Solution: Work with the Health Plans and with Medicaid. Participate in the State Plan Amendment regarding the \$9-1 federal match.



2 Possible Learning Collaboratives

Big Island Project & Kalihi-Palama Project

Big Island Project



Some “out of the box” Thoughts
for the Big Island

Create a Network of Partners and Payers



Who are the Partners?:

- Dept. of Health-Behavioral Health
- FQHC's or Participating Primary Care Physicians
- Other—Pharmacy, Dental, Social Services
- State Voc. Rehab / UH (Training & Research)

Who are the Payers?:

- Dept. of Human Services—Medicaid
- Health Plans – HMSA, Aloha Care, Kaiser
- Beacon (or ?) Grant (Big Island)?

The Partners



Dept. of Health-Behavioral Health

Objectives:

- All mental health and behavioral health consumers will have a PCP who participates in a health home.
 - The “home” could be the nearest FQHC (or participating PCP health home), the mental health clinic / family guidance center if primary care is brought in, or Private Practice Physicians.
- Pharmacy and Dental will be connected.

The Partners



FQHCs and/or Participating PCPs

Objectives:

- All patients with suspected severe mental illness will be screened for AMHD/CAMHD eligibility.
- FQHCs/PCPs will have Electronic Health Records.
- Health Plans will provide **incentives** to the FQHCs and PCPs to allow for such a move. Such as,
 - Base payment per client per month for being a Health Home?
 - Bonus payment for improved outcomes?
 - A Care Coordinator / Patient Navigator

The Partners



Other—Pharmacy, Dental, Social Services

Objectives:

- All patients with have access to coordinated pharmacy, dental, and social services.. To be funded in the usual way (ie., fee-for-service).
- *The FQHC or PCP, will recognize the added value provided coordinated phramacy, dental, and social services and coordination could be done by a “coordination of care agency”.*
- *The use of Telehealth could also be considered.*

The Partners



State Voc. Rehab / UH (Training/Research)

Objectives:

- A training program will be arranged with VR and/or UH.
- UH Dept. of Psychiatry/Tripler has a TeleHealth initiative for children and families that could be utilized within the health home model.
- A research initiative will be included to track progress and outcomes.

Note: Details TBD

The Payers



Dept. of Human Services—Medicaid

Objectives:

- The possibility of utilizing the \$9-1 ACA federal match.
 - Defining the “type of provider” which qualifies as a health home will be crucial. FQHC, Mental Health Clinics?, Private Practice Physicians?.

The Payers



Health Plans – HMSA, Aloha Care, Kaiser, Etc...

Objectives:

- Health Plans will join in the effort to move all Medicaid eligible participants into a health home, starting with the QExA, and then the QUEST.
- Health Plans will join in the effort to encourage Electronic Health Records/Information Exchange for all Medicaid participants.
- Health Plans will offer FQHC and PCPs participating in a health home with financial incentives.
- Other?

The Payers



Beacon Grant or Another Grant (Big Island)??

Objectives:

- Beacon (or?) will zero-in their efforts on the Medicaid population to ensure all have an Electronic Health Record (EHR) and then a “connector” to ensure Health Information Exchange (ie., a Centralized Repository of Information).
- Beacon (or?) will offer funding for the navigator role in the FQHC and for PCPs participating as a health home for the remainder of the grant...while simultaneously collecting data to justify to the health plans the importance of the navigator role.



What about Kalihi-Palama?

**KP is looking at....
Bi-Directional Integrated
Health Care Approach
By Working with the
FQHC and using the Medicaid Match**



Using the ACA Incentive?

- A. “Medical Home” \$9-\$1 federal match for the first 2 years.**
- **State plan amendment available to all eligible providers state wide.**

NCCBH Four Quadrant Model: A Conceptual Understanding



Mental Health Needs	HIGH	QII: MH is Locus of Care Coordinate with PCP	QIV: MH and/or PC is Locus of Care Combined Care
	LOW	QI: PC is Locus of Care Provide MH by PC?	QIII: PC is Locus of Care Provide MH by PC
		<u>Low</u>	<u>High</u>
		Physical Health Needs	

Note: We are targeting **Quadrant II** and **Quadrant IV** populations

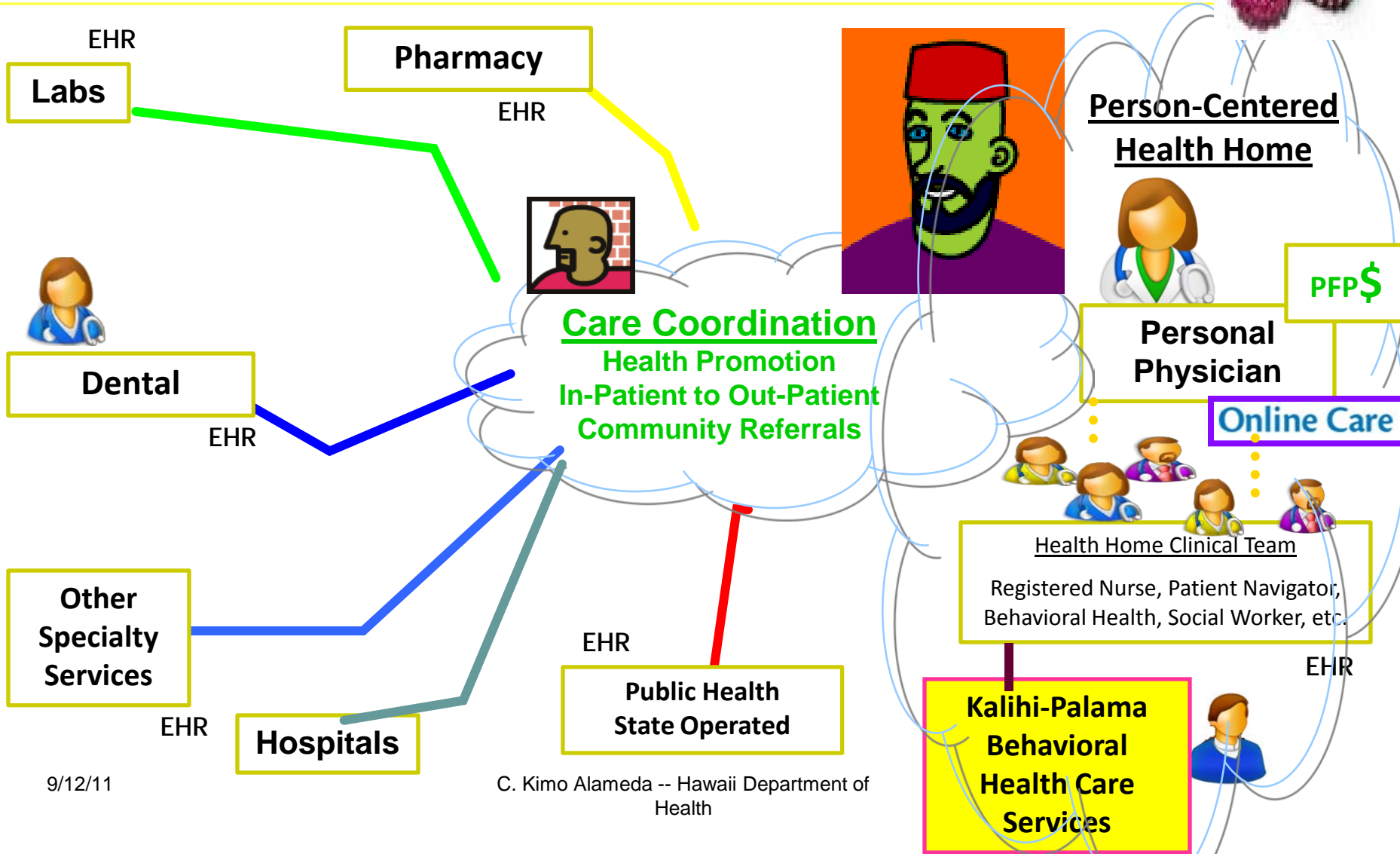
HIGH Primary Care LOW/HIGH Mental Health



(Q1, 3, 4)

“Primary Health Care Home”

(i.e., FQHCs—Addresses Stigma and Early Mental Health Detection)

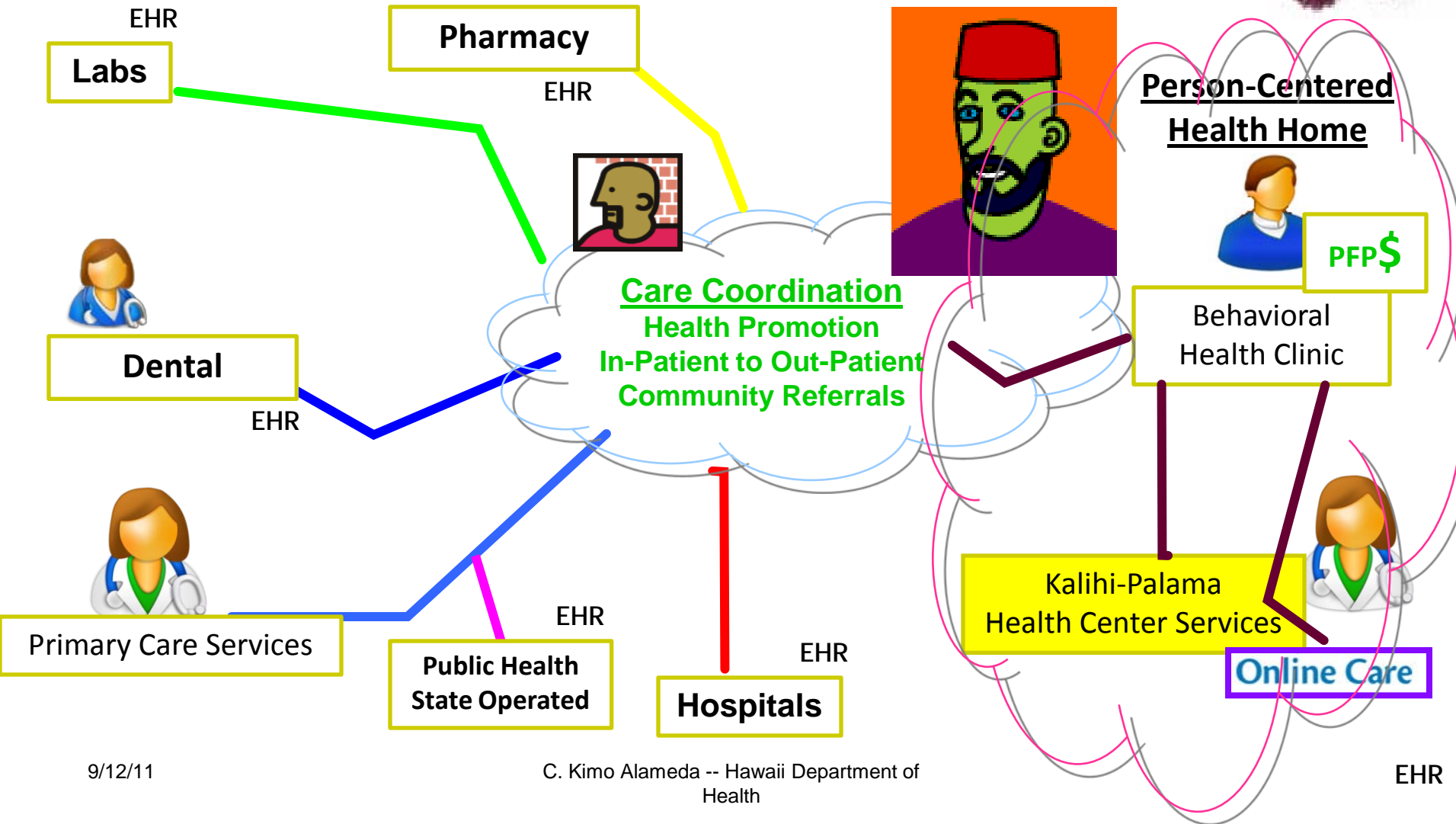


HIGH Mental Health LOW Physical Health

(Q 2, maybe 4)

“Behavioral Health Care Home”

(i.e., AMHD Kalihi-Palama Pilot—Addresses High Mortality Rate in SMPI Population)



More Realistic Thoughts on our Next Steps: The “Starting Small” Approach



- 1. Select a shared population (adult, children)**
- 2. Pick a shared concern (Metabolic Syndrome)**
- 3. Develop a phased approach with a time line.**
- 4. Agree on a few outcome measures to track effectiveness (incentive outcomes?)**

Cont...



- 5. Draft an MOU to include services provided**
- 6. Complete cross-agency forms, cross-procedures, and cross training.**
- 7. Obtain funding for additional staff (patient navigator, researcher, etc) to support the project (check with DVR for training).**

IMAGINE



The Possibilities are There

Other States are Doing It—Why Can't We?

If there is a Better Way to
Increase the Longevity and Quality of Life
of Consumers with SMPI
and

Decrease the High Prevalence of SMPI with Consumers from
Ethnically Diverse and Geographically Underserved Areas

Let Me Know☺

Contact Info:
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Thank You

Questions



Hilo Bay Front

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