Integrated Health Home

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Community Integration
Principles

• Integrated Care is the foundation for Integrated Health Home.
  • The need for Integrated Care
  • Better outcomes, lower cost

• Clarifying function and roles

• Impact of IHH in the delivery of primary care, behavioral health, and substance use disorders.

• Role providers can play as IHH rolls out.
On a personal note, why integration matters to me...
Background
History and Overview

• Founded in 1972 as a drop in center for youth
• Expanded community based services: youth development services, work force, SUDS, parent support, head start, juvenile justice, crisis response and intervention
• Opened first (FQHC) health center 1999
• Began development of Integrated Care in 2003
Our Reach

65,000+
PATIENTS

600+
COMMUNITIES

800+
EMPLOYEES

30+
LOCATIONS IN 9 COUNTIES

Illinois Counties where Aunt Martha’s patients and clients reside

Age

61% FEMALE

39% MALE

44% BLACK

43% HISPANIC OR LATINO

Insurance

67%

22%

8%

3%

Uninsured

Medicaid

Private

Medicare
Locations

- Aurora
- Aurora Health & Outreach Center* (Homeless/Refugee)
- Blue Island* (Thresholds – SMI)
- Carpentersville
- Chicago – Integrated Care Center* (DCFS)
- Chicago - Southeast Side
- Chicago Admin
- Chicago – South East Alcohol & Drug Abuse Center
- Chicago Heights Vincennes
- Chicago Heights Pediatric Health & Wellness
- Chicago Heights Women’s Health
- Danville
- Danville – Center for Children’s Services
- Hazel Crest^ (ADVOCATE)
- Hillside – CARES
- Joliet East
- Joliet West (Amita)
- Joliet – Foster Care
- Kankakee
- Midlothian – Independence Place
- Olympia Fields – Admin
- Olympia Fields – Care Coordination
- Palatine* (Little City - DD)
- Park Forest – Foster Care/Community Wellness
- Park Forest – Evening Reporting Center
- Rockford^ (SwedishAmerican)
- South Holland
- Toulon
- Watseka
- Woodstock^ (Northwestern)

*a Special Population
^Hospital Partnership
The Evolution of Our Integrated Care Model

- **Early Integration (2003)**
  - Expanding BH access through primary care

- **Social Determinants**
  - Integrating multiple risk assessments and screenings into primary care workflows

- **Telepsychiatry (2007)**
  - Expanding BH access through telehealth

- **Social Supports**
  - Integrating supportive services into primary care workflows

- **Shared Risk/Savings**
  - Operating in risk-sharing models with health plans

- **A Network Leader (2016-2018)**
  - Network leader in care coordination outcomes; top performer in MLR
Integrated Care
Higher Costs: Medicaid individuals with diagnosed behavioral health needs make up ~25% of the population, but ~56% of the total spend

FY2015 members and spend

Annualized members (millions), dollars (billions)

100% = 3.1

- 25% Individuals with diagnosed behavioral health needs
- 62% Individuals with no diagnosed behavioral needs
- 6% Individuals with only care coordination fee
- 7% Individuals with no claims

10. 3% Behavioral health core spend
- 48% Medical spend
- 44% Spend for non-behavioral health members
- 0% Spend for members with only care coordination fee spend

SOURCE: FY15 State of Illinois DHFS claims data
Adopted from: 1115 Waiver Advisory Committee Discussion Document 1.19.2017
What is Integrated Healthcare?

• “the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs” (SAMHSA-HRSA)

• “an approach characterized by a high degree of collaboration and communication among health professionals” (APA)

• “the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system” (WHO)
The Need for Primary Care & Mental Health Integration

• *Primary health care IS mental health care*
  • 70% of all health visits have primarily a psychosocial basis\(^1\)
  • *Highest utilizers of health care* commonly have untreated/unresolved mental health needs\(^2\)

People with Serious Mental Illness (SMI) are dying **25 years earlier** than the general population – at least two thirds due to preventable or treatable medical conditions \(^3\)

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1. Strosahl, 1998; Fries, et. al., 1993; Shapiro, et. al., 1985
2. Von Korff, et. al., 1992; Katon, et. al., 2003
Why integrate?

Integration creates a better healthcare
PATIENT EXPERIENCE

Integration decreases the
cost of healthcare delivery

Integration promotes better health outcomes
Aunt Martha’s Model of Care Coordination

- Ongoing patient assessments, risk stratification, care plan updates
- Ensures patients are connected to primary care provider (PCP), specialists, and behavioral health services
- Utilizes Electronic Health Record system to coordinate patient care and share care plans
- Coordinates with Hospital Emergency Departments and Discharge Departments
- Manages patient care plans with patient involvement
- Connects patients to support services such as transportation, housing, food

Outreach

Specialists (MH/SUD)

Referral Team

Care Coordinators

Nurse Care Managers

Panel Management

Hospital Follow-Up
Integrated Health Home
Definition and Background

• Medicaid state option providing comprehensive care coordination with chronic conditions.

• IHHs will integrate and coordinate all primary, acute, behavioral health and long term services,

• Supporting the WHOLE person across lifespan.

• Focus on social determinants: incentivizing outcomes.
What it Is and Is Not....

**Integrated Health Homes in Illinois are:**

Primary focus is on coordination of care...

- Integrated, individualized care planning and coordination resources, spanning physical, behavioral and social care needs
- An opportunity to **promote quality** in the core provision of physical and behavioral health care
- A way to **encourage team-based care** delivered in a member-centric way
- A way of **aligning financial incentives** around evidence-informed practices, wellness promotion, and health outcomes

For members with the highest needs:

- A means of facilitating **high intensity, wraparound care coordination**
- An opportunity to obtain **enhanced match for care coordination needs**
- **Identifying enhanced support** to help these members and their families manage complex needs (e.g., housing, justice system)

**Integrated Health Homes in Illinois are NOT:**

... and NOT on the **provision of all services**

- Provider of all services for members
- **A gatekeeper** restricting a member’s choice of providers
- A **physical place** where all Integrated Health Home activities occur
- A **care coordination approach that is the same for all members** regardless of individual needs
Each IHH member will be attributed to a tier based on physical and behavioral health information in the medical history and/or a review of claims. Each tier has specific criteria. This information will be shared with the member’s health plan by HFS.
ADULT Model

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transition care
- Patient / Family support
- Referral to community and social support services

**MCOs oversee IHH network: administration, network management, availability of health information for IHH members; manage payment flow**

- **Engagement Specialists and Care Coordinator**
- MCOs issue payments
- Makes referrals to community partners for non-Medicaid funded services
- Rewarded $$ for outcomes
Children Model

HIGH BEHAVIORAL NEEDS

- Comprehensive care management
- Care coordination and health promotion
- Transitional Support
- Individual / Family Support (Family Peer Support)
- Referral to community and social support services
- Staff must be CERTIFIED

- High fidelity wraparound (high intensity level; 1:1)
  - Monthly visits/+ phone contact, crisis safety plan, WRAPAROUND Model,

- Intensive Care Coordination (moderate intensity level; 1:25)
  - Face to face Child & Family meetings every 60 days, crisis safety plan
Children Model

HIGH PHYSICAL NEEDS

- MCO driven; at a staff ratio of 1:75
- Structured similar to Adults
- Identified through existing tiering process
- Care Coordination > ensuring child is connected to medical services
- Family Support and Home Visits are essential to receiving care and support
- Care team led by medical team: PCP, nurse manager
- Referrals to Behavioral Health if needed
Implications / Considerations
Implications and Considerations

• The state is turning over the IHH to the MCOs
  • We will have to contract with each MCO individually
  • The MCO can decide whether to pay providers a PMPM or FFS
  • No Rates have been set, HFS will release soon

• IlliniCare takes over DCFS on November 1\textsuperscript{st}; IHH roll out will be January 1\textsuperscript{st}

• The Children’s IHH model will resemble the Oklahoma children’s model

• All staff working directly with IHH children and families will have to be **certified** (the State is contracting with a vendor to will provide the care coordination certification)

• The Adult IHH model will look more like a community health worker model (no training certification is required)
Implications and Considerations

• **Staffing Ratio:**
  - To be determined by MCO; generally expected to demonstrate experience and competence in care coordination.

• **Must have **data management** capacity**

• **You can sign on to a Collaborative Agreement as a clinical or support resource:**
  - MH therapy
  - Work force development
  - Housing
  - DV services
  - Food pantry
Thanks & Questions