



# ***SAMHSA-HRSA Center for Integrated Health Solutions***

## **Sustainability Strategies for Integrated Health**

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# Topics

- Areas to consider for sustainability
- Person-centered healthcare homes
- Accountable Care Organizations
- Sustainability strategies – examples from the field



# Areas to Consider for Sustainability

- Clinical
- Administration
- Financial



# Clinical Sustainability

- Consumer Demand for the Service
- Embedded Practices from the Grant into the System at Large
- Training of all Staff to be Health Navigators



# Consumer Demand for Services

- Create consumer demand for whole health services
  - Think beyond just your grant population to the whole agency and preparation for health care reform
  - Work with local community groups like Mental Health America and NAMI to advocate for these services
  - Train consumers on whole health initiative(s)



# Embed Practices from the Grant Into the Agency

- Services that are part of the grant are consistent with the Affordable Care Act/Health Care Homes
- Think about spread within and outside your organization now
- Data included in this grant is consistent with data necessary to be successful within an Accountable Care Organization



# Training All Staff to Be Health Navigators/Care Coordinators

- Care Coordination is one of the key factors of successful programs
- Does your project currently allow all staff to be care coordinators or does it limit it to nurses or specific staff?
- What role do your existing (non-grant) staff play in the project?
- What is the role for existing case management staff?
- Health Navigator Training is available for case management staff



# Administrative Sustainability

- Have you adjusted your mission to include integration?
- Are you adjusting policies and procedures to include integration?
  - Can psychiatrists prescribe non-psychiatric medication?
  - Can nurses do primary care tasks under your policies?
  - Are you screening for metabolic syndrome on all consumers?
- Is your Board trained on integration?
- Have you adjusted your job descriptions to include integration?
- Is integrated health included in your orientation for new staff?
- Are you training existing staff on integration?
- Are you having weekly meeting with administrators to discuss project and integration?



# Financial Sustainability

- Current Options – Who can provide What, When and Where?
- State by State Worksheets Under Development
  - Two services in one day
  - Billing for care coordination/case management
  - SBIRT Billing codes
  - 96150 -96155 HBAI Codes
  - 9080\_\_\_\_ Codes



# Person-Centered Healthcare Homes: A New Paradigm

Picture a world where everyone has...

- An **Ongoing Relationship** with a responsible healthcare provider
- A **Care Team** that collectively takes responsibility for ongoing care

And where...

- **Quality and Safety** are hallmarks
- **Enhanced Access** to care is available
- **Payment** appropriately recognizes the **Added Value**

## What does this look like in practice?



## What it's not:

A residential facility  
Primary care provider  
as gatekeeper



# Components of a Healthcare Home

1. Everyone has a health home practitioner & team
2. Team has a patient-centered, whole person orientation...
3. ...And a focus on population health outcomes
4. Care is tailored to the needs of each patient
5. Team engages in care coordination/management



## Components of a Healthcare Home

6. The team also coordinates with other healthcare providers/organizations in the community
7. Patients are active participants
8. There is continuous learning and practice improvement...
9. ...supported by a sustainable business model & appropriately aligned incentives
10. The health home is accountable for achieving improved clinical, financial, and patient experience outcomes



# Are you ready to be a healthcare home?

## Do you...

- Have a provider team with a range of expertise (including primary care)?
- Coordinate consumers' care with their health providers in other organizations?
- Engage patients in shared decision-making?
- Collect and use practice data?
- Analyze and report on a broad range of outcomes?
- Have a sustainable business model for these activities?



# **New Medicaid State Option for Healthcare Homes – Section 2703 Affordable Care Act**

State plan option allowing Medicaid beneficiaries with or at risk of two or more chronic conditions (**including mental illness or substance abuse**) to designate a “health home”

Community mental health organizations are included as eligible providers

Effective Jan. 2011

Additional guidance forthcoming from HHS



## Medicaid Healthcare Homes

90% Federal match rate for the following services during the first 8 fiscal year quarters when the program is in effect:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings
- Patient and family support
- Referral to community and social support services
- Use of health IT to link services (as feasible/appropriate)



## **Other Considerations for SPA**

Policy-level decisions needed to pursue a Health Home Option, including identifying target populations, provider qualifications, team composition, etc.

Selection of quality measures and specifications and the use of HIT in conducting health home services, quality measurement and state reporting

Consideration for rate setting (PMPM, case rate), as well as gain sharing options.



# On Your Mark, Get Set, ACO...

**Accountable Care Organizations** bring together healthcare homes, specialty care, and ancillary services



## **Core Principles of an ACO**

- Directed by a **coordinated set of providers**
- Provides a **full continuum of care** to patients and populations  
Healthcare homes, specialty care, hospital, case management, care coordination, transitions between levels of care...and more
- **Financial incentives** aligned with clinical goals
- **Cost containment**
- Enhancement of **care quality** and the patient experience
- **Improvement of overall health status**



## **ACOs and the Safety Net**

**Coverage expansions:** The massive expansion of coverage in 2014 will require new models to assure access and control costs – particularly for serving Medicaid patients, who will make up 14 million of the newly insured

**Care management:** Individuals served by the safety net experience higher rates of serious mental illness, substance use disorders, and poorly controlled multiple chronic conditions

Community behavioral health organizations have **expertise and experience** in caring for these populations, making them valuable partners in an ACO



# Partnering with Health Homes and Accountable Care Organizations

National Council Report

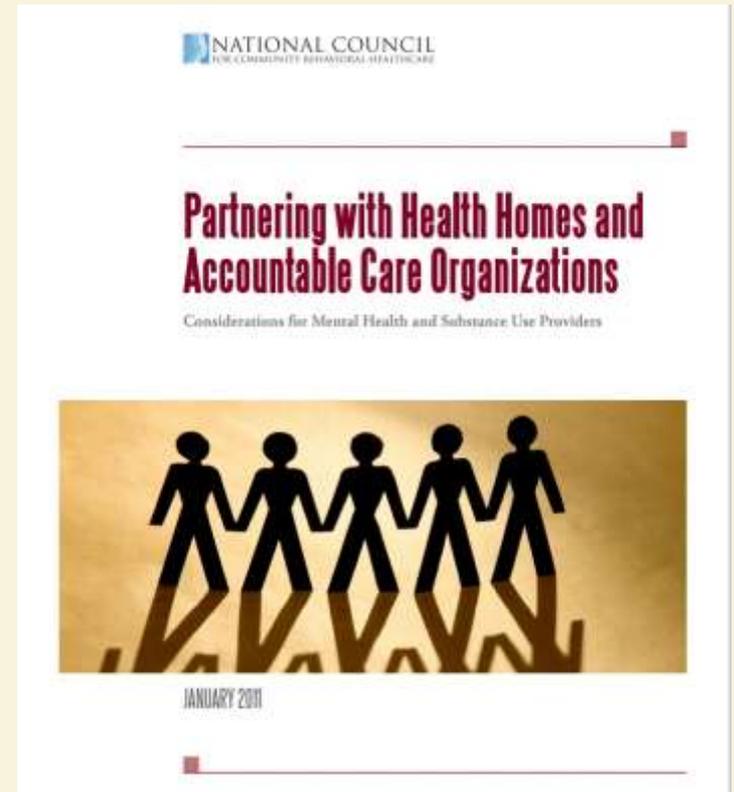
[http://www.thenationalcouncil.org/cs/acos\\_and\\_health\\_homes](http://www.thenationalcouncil.org/cs/acos_and_health_homes)

Webinar with Dale Jarvis & Laurie Alexander

[http://www.thenationalcouncil.org/cs/recordings\\_presentations](http://www.thenationalcouncil.org/cs/recordings_presentations)

Live Blogchat

<http://mentalhealthcarereform.org/aco-webchat/>



# Health IT at the Heart of the ACO Framework & Health Homes

Builds patient-centric systems of care

Improves quality and cost

Coordinates care across participating providers

Uses IT, data, and reimbursement to optimize results

Builds payer partnerships and accepts accountability for the total cost of care

Assesses and manages population health risk

Reimbursed based on savings and quality → value



# Questions and Answers





# ***SAMHSA-HRSA Center for Integrated Health Solutions***

## **A Path to Financial Sustainability**

**A Brief Walkthrough of San Mateo County's Total Wellness**

Chris Esguerra, MD, MBA

Project Director, Deputy Medical Director



# BACKGROUND

...

State Context  
County Context  
Team Constituents



## State Context

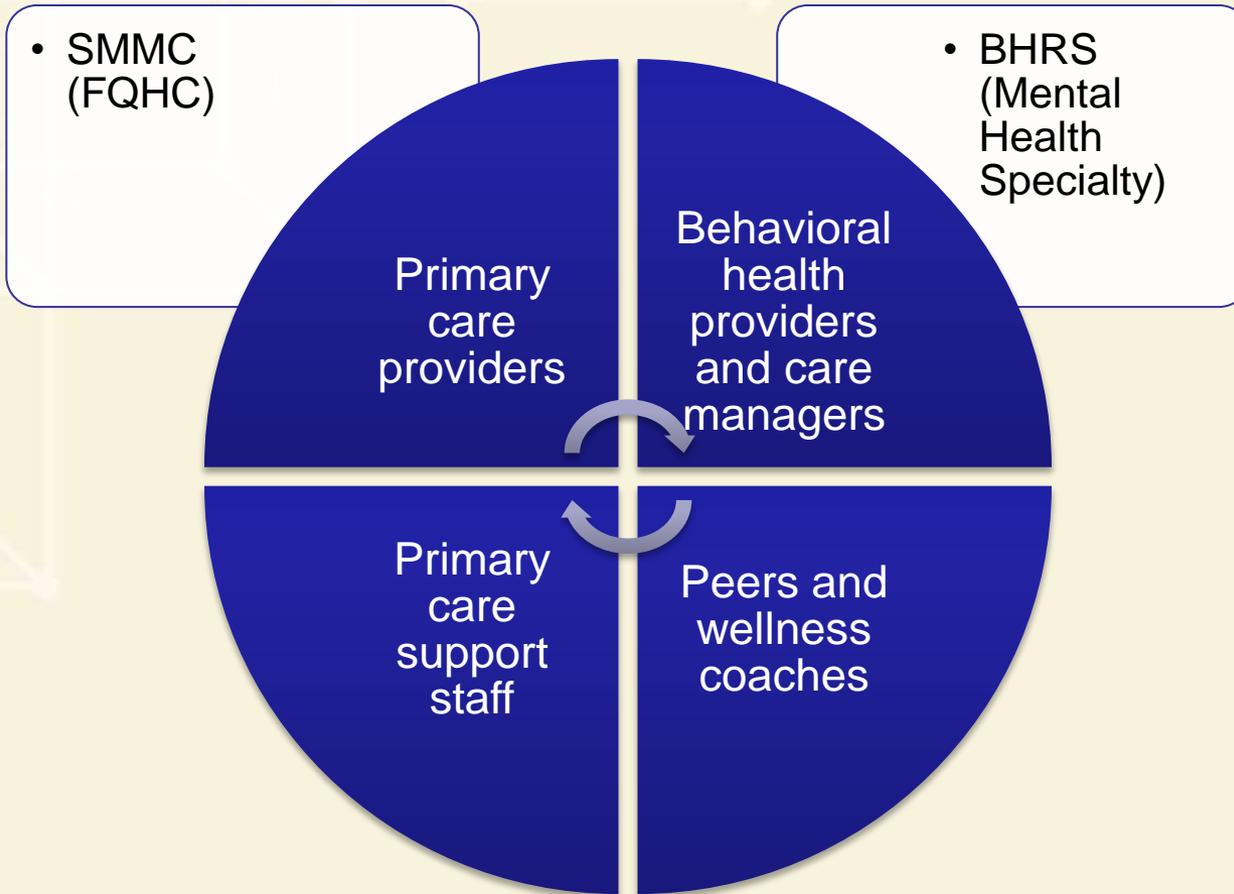
- Mental health funding is carved out
- 1115 Waiver – MCE
- FQHC exclusion (can't bill for two appts in one day)

## County Context

- Manage Health Plan
- Health System
- Two divisions
  - Behavioral Health and Recovery Services (BHRS)
  - San Mateo Medical Center (SMMC) and Primary Care



# Our Team

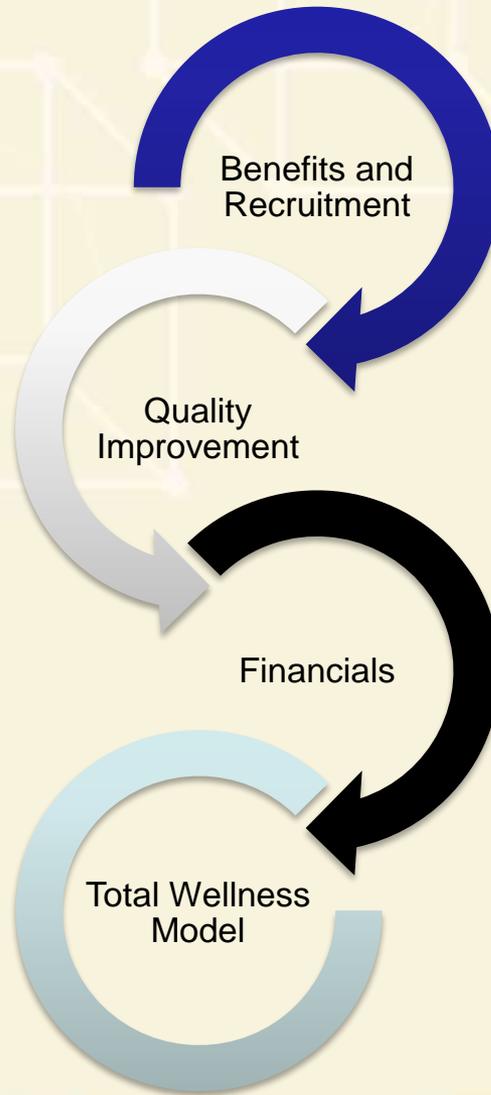


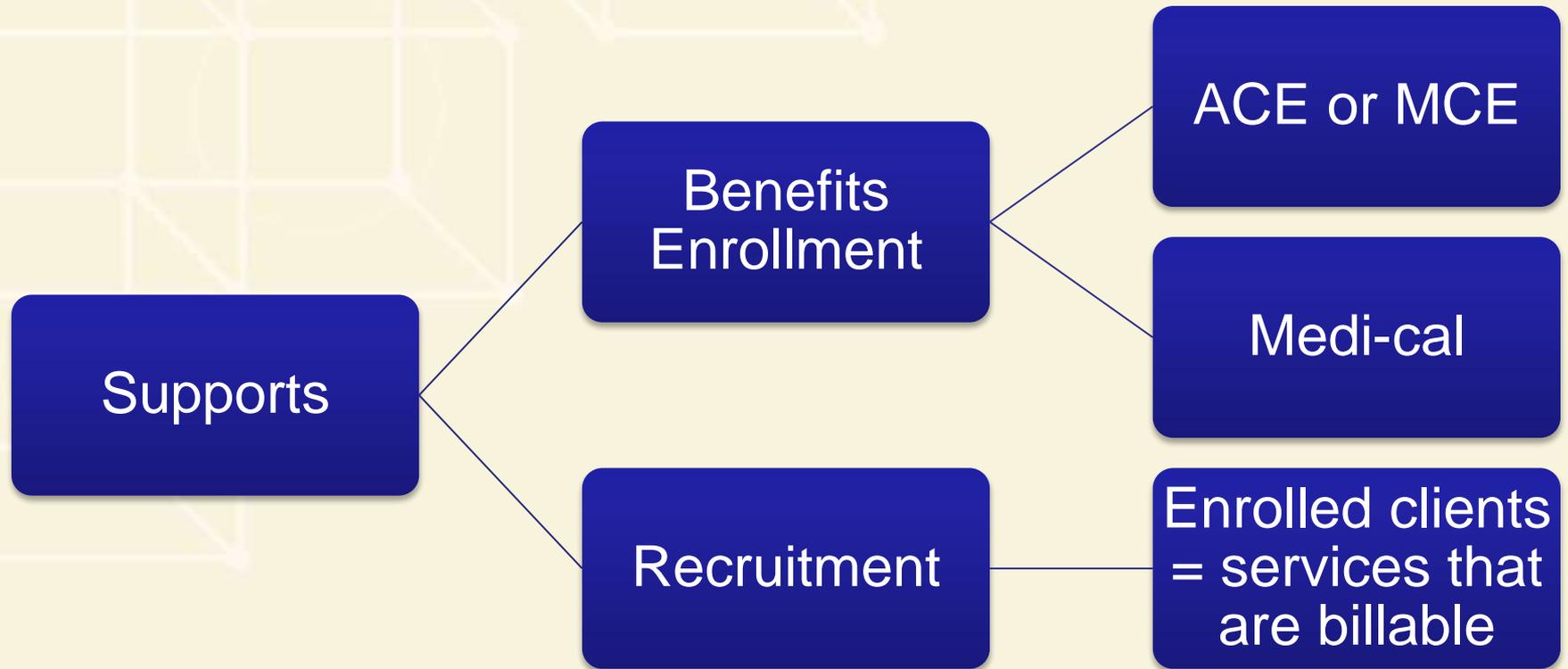
# Model

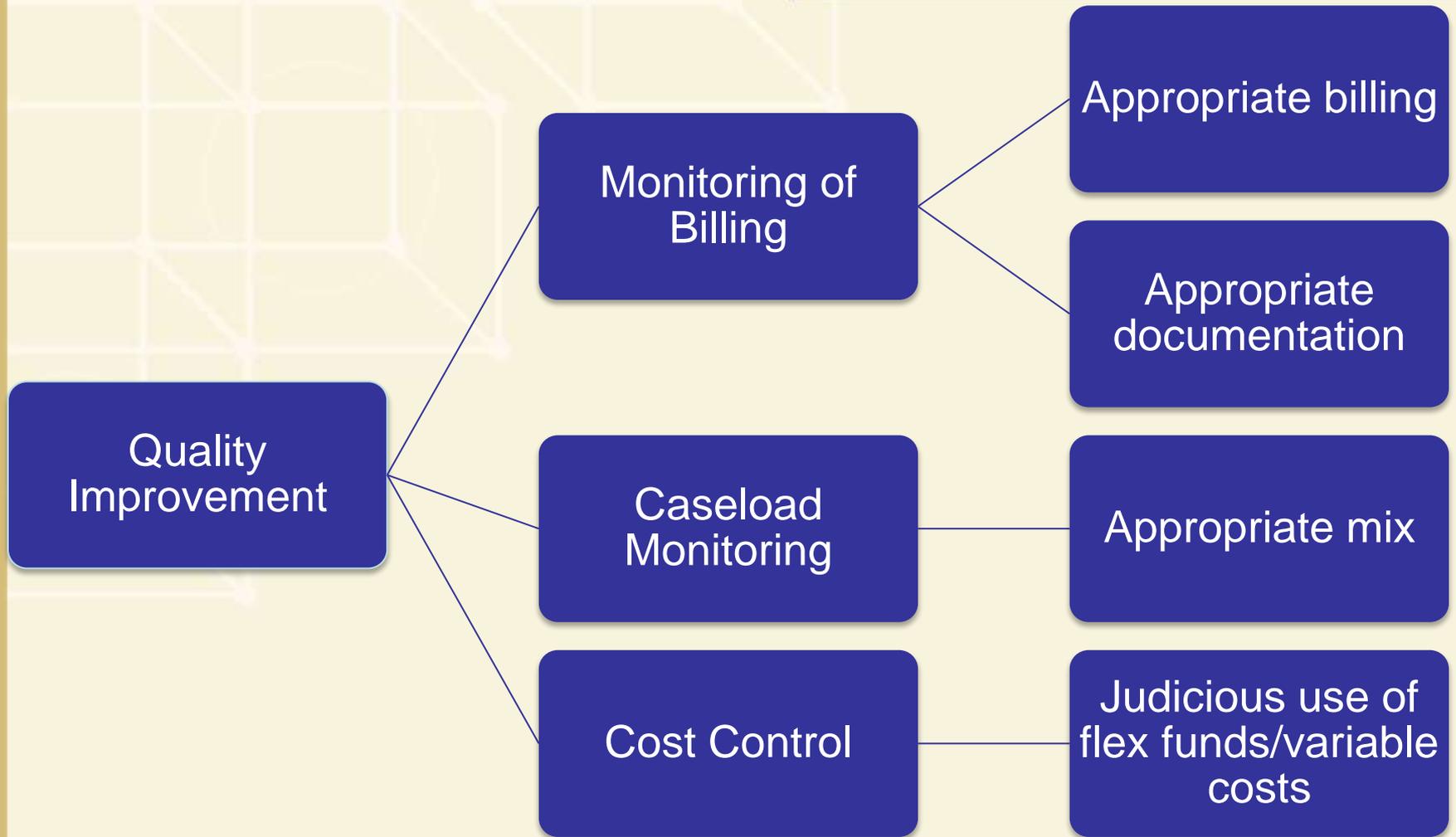
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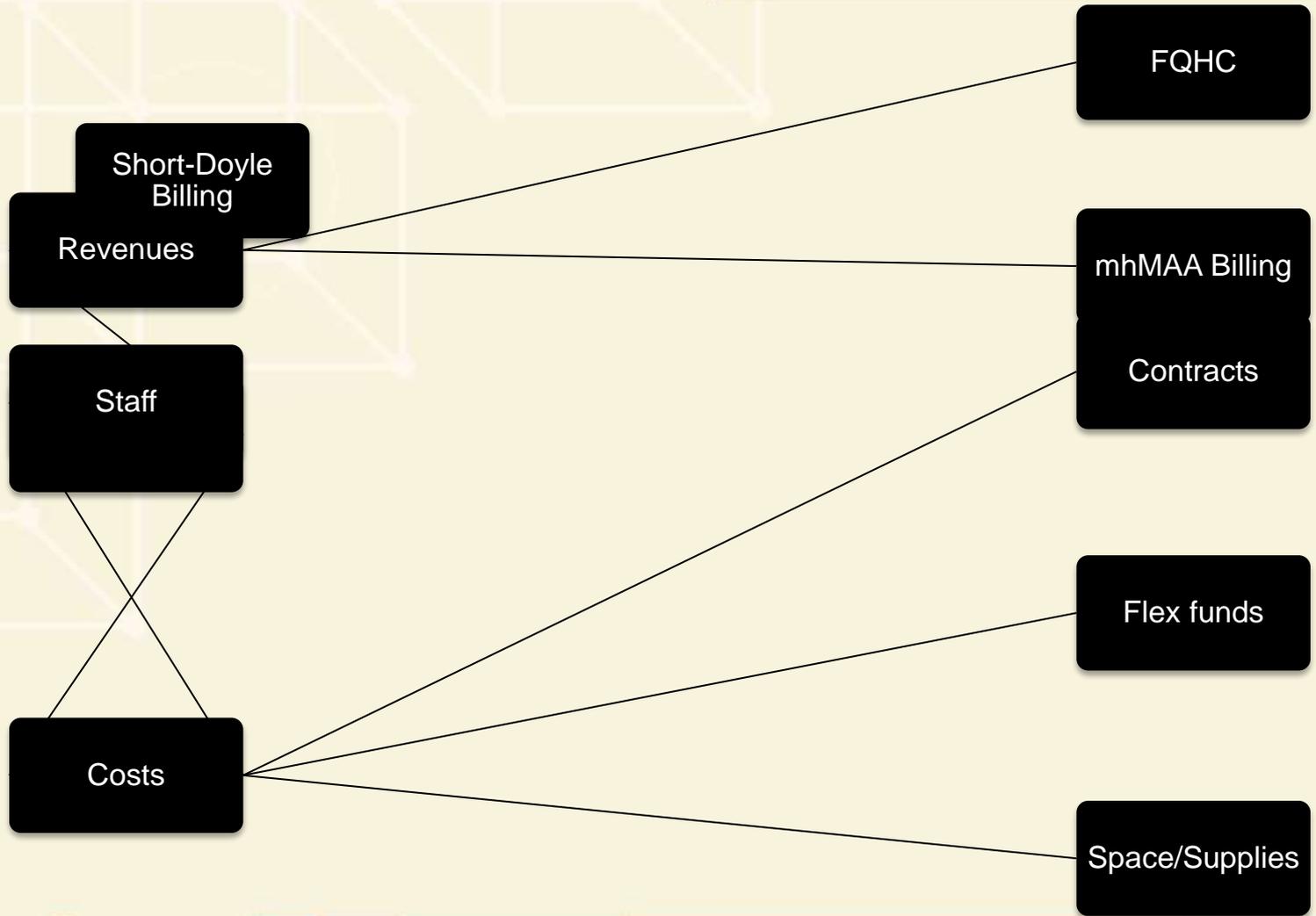
Braided Funding



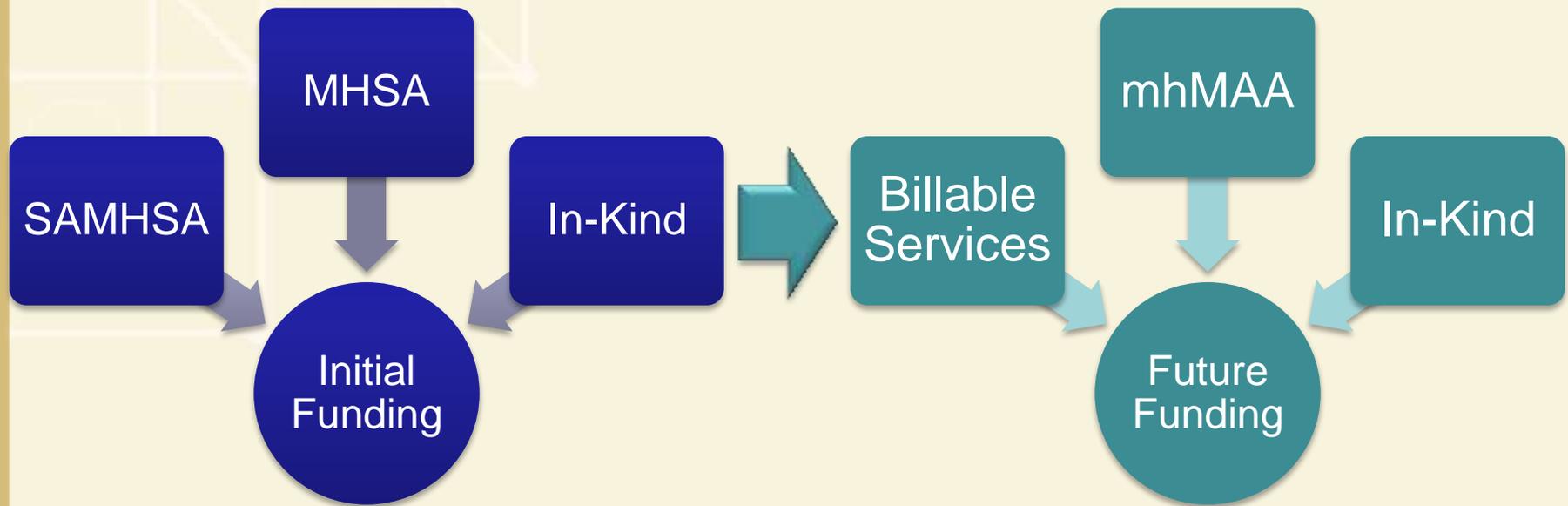








# Our Funding Path



# Understanding Billables

## FQHC

- Provider and license specific
- Office-based
- CPT/E&M Coding

## Mental Health Specialty

- License/training level determines allowable codes
- Allows for rehab codes (Wellness activities)
- Allows for field-based and care coordination activities (Care management activities)

## mhMAA

- Administrative work to improve services to those with medical
- Active linkage work to promote/introduce people to medical services



# Principles

- Determine the right model for your organization
- Determine your best set of billing options
- Understand and track your costs
- Design staffing patterns to maximize billing opportunities so that revenue at least cover if not exceed costs



# San Mateo Total Wellness



# Questions and Answers





# *SAMHSA-HRSA Center for Integrated Health Solutions*

## **What Happens When the Grant Funds Run Out?**

**Wellness Integration Network (WIN) Clinic**

Rick Hankey

Project Director, Sr. Vice President/Hospital Administrator



## The Wellness Integration Network (W.I.N.) Clinic

- The WIN Clinic is part of the comprehensive service delivery system offered by LifeStream Behavioral Center
- Located in Leesburg, Florida





## **W.I.N. Clinic-Program Description**

- **Integration Model:** Co-locate primary care physicians in behavioral health facilities to provide routine primary care services and serve as a consultant to the psychiatric care team; all staff are employed by LifeStream. There is no FQHC involvement. Emphasis on preventive care.
- **Service Delivery:** Includes providing wellness programming and incorporating integrated services; psychiatric and primary care are offered during the same visit. Referrals to specialists and enhanced care coordination Nurse Care Managers provide in home services and coordinate care. Transportation provided to appointments.

**Populations Served:** Adults with serious mental illness living in Lake County who do not have access to primary care services or a medical home.



## **W.I.N. Clinic-Program Description**

- W.I.N. Clinic offers regular wellness education and workshops on topics such as exercise, diet and nutrition, weight management, and tobacco cessation.
- Wellness activities include: wellness testing (fitness and medical tests), health risk appraisals, hypertension screening and education, disease management seminars, exercise and walking classes, in home education with care managers, stress management activities, and time management workshops.
- Access to LifeStream's full continuum of care, including behavioral health and substance abuse services.



# Journey to Sustainability

- Sustainability began on day one
- Committed leadership
- Organizational buy-in
- Know the population
- Potential funding sources identified
- Staff training
- Staff credentialed
- Expansion mindset
- Electronic Health Record modified
- Clinical workflow analysis
- Long range vision and plan



## Program Value

- Important key to making the transition from temporary to permanent funding is demonstration of the program's value in terms that matter to decision makers. This should be captured in evaluation.
- Depending on the audience, key outcomes of interest may include money saved, clients served or improved patient outcomes.
- W.I.N. Clinic evaluation and outcomes include clinical data, cost savings, quality improvement, behavior changes and satisfaction.
- Improvements are measured in the following: patient stabilization, reduced impairment due to management of the patient's disease or disability, increase in social functioning, decrease in total health care costs and better quality of life and greater patient satisfaction with care.



## **Funding Sustainability Activities**

- Identified and addressed funding barriers
- Developed a business plan for funding the clinic
- Identified activities that can be paid for by Primary Care, Mental Health and Substance Abuse funding sources
- Budget matrix-who will fund what activity
  - Payer mix
  - Fee for Service
  - Unfunded patients
- Licensure/Accreditation
- FQHC Contracts
- Insurance panels
- North Lake Taxing District
- Outcomes



## Lessons Learned

- Sustainability must be built into the clinical model
- Different payment systems, staffing and documentation
- Clinical workflow analysis is ongoing
- Outcomes = potential funding
- Organizational buy-in is critical
- Diversified funding is critical to ensure the program survives
- Identifying funding, conducting evaluation and having an eye for expansion and change requires a forward-thinking mindset on the part of the project leadership



# Questions and Answers



# Resources

## **Interim State-based Billing and Financial Worksheets**

<http://www.integration.samhsa.gov/resource/bill-worksheets>

## **Behavioral Health Homes for People with Mental Health & Substance Use Conditions: The Core Clinical Features**

[http://www.integration.samhsa.gov/clinical-practice/CIHS Health Homes Core Clinical Features.pdf](http://www.integration.samhsa.gov/clinical-practice/CIHS_Health_Homes_Core_Clinical_Features.pdf)

## **How to use 96100 HBAI Codes in Primary Care Settings**

[http://www.integration.samhsa.gov/financing/Maine Health code.pdf](http://www.integration.samhsa.gov/financing/Maine_Health_code.pdf)

## **States Paying for BH Visits on Same Day as Medical Visit**

[http://www.integration.samhsa.gov/financing/Paying for BH visits on same day as medical visit.pdf](http://www.integration.samhsa.gov/financing/Paying_for_BH_visits_on_same_day_as_medical_visit.pdf)

## **State Health Home Activity (Integrated Care Resource Center)**

[http://www.chcs.org/usr\\_doc/HHMap\\_v9.pdf](http://www.chcs.org/usr_doc/HHMap_v9.pdf)



# Thank You!

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## **Change Management**

**December 13, 2012**

**2:00 – 4:00 PM EST**

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