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The Transition to Health Homes

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About the Speaker

Jeffrey M. Levine, MD, Project Director, Bronx-Lebanon Hospital Center

Jeffrey M. Levine, M.D., is Chairman of the Department of Psychiatry at Bronx-Lebanon Hospital Center, Bronx, N.Y. and Professor of Clinical Psychiatry & Behavioral Sciences at Albert Einstein College of Medicine, Bronx, NY. Board certified in Internal Medicine, Psychiatry, and Psychosomatic Medicine, Dr. Levine has a career interest in the interaction of mental health and general medicine. In 2007, he served as Project Director at Bronx-Lebanon for the High Cost Care Initiative funded by the United Hospital Fund of New York City. In 2009, Dr. Levine was awarded a grant from the New York State Health Foundation for a clinical trial called "The Intensive Wellness Program" in which intensive, multidisciplinary care was provided to high cost high risk Medicaid patients and showed a savings of approximately $7,000 per patient per year. In 2010, Dr. Levine became Project Director for the PBHCI program at Bronx-Lebanon Hospital Center, the Mental Health Intensive Wellness Program. In 2012, he was named Medical Director of the Bronx Health Home.

Agenda

- What is a Health Home?
- The Bronx Health Home
- Differences and Similarities to PBHCI
- The skewed nature of healthcare costs
- Limitations and Opportunities
- Questions

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Who we are

- Bronx-Lebanon Hospital Center
- Located in South Bronx, New York
- Group 3
- Work in 2 hospital-based mental health practices and 1 affiliated FQHC (Martin Luther King, Jr. Health Center)
- Have enrolled 494 patients thus far
- Have integrated EMR and secure health messaging
- Weekly reviews of all clients who visit the BLHC ED, CPEP or who are hospitalized

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PBHCI Team

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Not the Bronx Health Home

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What is a Health Home?

- Not a residence or building…It is a care management model
- Network of medical, behavioral health and social service providers, which form a coordinated care delivery system
- Assures that consumers' healthcare and social needs are addressed in a comprehensive, coordinated manner.
- A Care Coordinator oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital.

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What are Health Homes Expected to Do?

Health Home providers are required to provide:

- Comprehensive care management.
- Care coordination and health promotion
- Comprehensive transitional care
- Patient and family support
- Referral to community and social support services
- Use of health information technology (HIT) when feasible

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Payment

ACA authorizes CMS to fund 90% of the *cost of care coordination* for chronically ill Medicaid patients through "Health Homes".

- 2 year demonstration only
- Payment $69-$500/month; average approximately $150/month

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Quality Metrics

Inpatient Utilization (Decrease)
ED Visits (Decrease)
Outpatient Mental Health Visits (Increase)
Follow-up after inpatient SA (7 days)
Outpatient Quality Measures (HEDIS/QARR):

- % Antidepressants for Dx depression
- % Asthma RX
- % with HbA1c and LDL measurements
- Beta blockers 6 months post MI
- Lipid testing after coronary event
- HIV/AIDS primary care frequency, viral load

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How Do Health Homes Relate to PBHCI?

- Both aim to improve health and decrease the health disparities among persons with a chronic mental illness
- Health Homes place a greater emphasis on cooperation and coordination among multiple agencies
- Health Homes place greater emphasis on control of unnecessary healthcare utilization and cost

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Stability of Skewed Utilization into the Managed Care Era

Monheit and Berk, *Health Affairs* 2001; 20:9-18

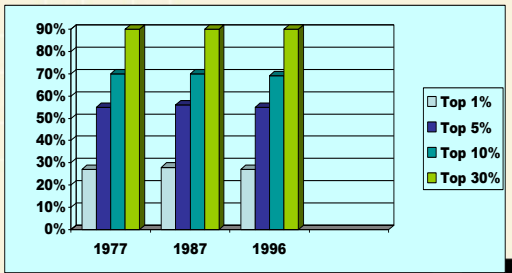

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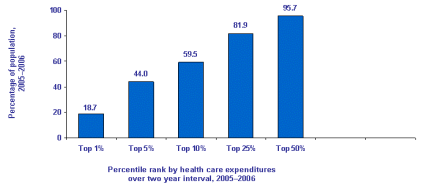
Figure 1. Concentration of health care expenditures over two year interval, U.S. civilian noninstitutionalized population, 2005–2006



Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, HC-106 (Panel 10, 2005–2006)

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Maritza, 49 year old woman admitted to Medical Service 4 times in past year for abdominal pain due to "colitis"

- Referred to Health Home for recurrent hospitalizations and chronic depression
- Abdominal CT scans all showed same minor abnormality
- Pain followed relapse on alcohol
- Relapse followed recurrence of severe depression and PTSD
- Depression and alcohol relapse followed son's relapses on cocaine
- Son's relapses led him to steal her SSI checks
- Interventions: Increased psychotherapy; limit setting and referral for son; new antidepressants that decrease diarrhea; work with PCP and with Emergency Department so that the reflex would not be medical admission
- No further medical admissions

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Tara, 51 year old woman with traumatic brain injury and "migraine" headaches

- Depression and headaches since AA age 16
- Headaches had markedly increased over past two years
- 13 medical Emergency Department admissions and 4 hospitalizations for pain control in the past one year
- Now opiate dependent
- Headaches had markedly increased after the breakup with her partner
- Interventions: Twice weekly team meetings; buprenorphine; "sweep" of house for narcotics; gradual alliance with patient
- Education of neurologist and Emergency Department (Health Home Community Physician Liaison placed in medical ED)

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Adende, 26 year old man with 6 admissions in past year for out of control diabetes

- Chronic blood glucose 400-600 mg%
- In each admission, blood sugar controlled with insulin (multiple injection/day regimen) and diabetic teaching performed
- Glucose always >400 upon visit to PCP/Clinic
- Frequently referred to ED; admitted
- Problems: Bipolar, illegal housing, no refrigerator
- Referred to housing partner; benefits obtained; placed on long acting antipsychotic medications
- Liaison with PCP and with ED

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Barriers:

- Multiple agencies with differing capacities, foci, and procedures
- Limitations of skills of Care Coordinators
- Requires strong administrative and medical/mental health leadership – and cooperation
- The health care system itself is full of problems
- Still don't really know if it is cost effective

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Lessons learned

- Need leadership from state and from one or two key community organizations
- Need weekly organizational meetings for 6 months prior to implementation
- Need agencies that are expert in health, mental health, substance abuse and housing
- Shared EMR and RHIO are very helpful
- There must be medical leadership at the Health Home level, not just at each organization

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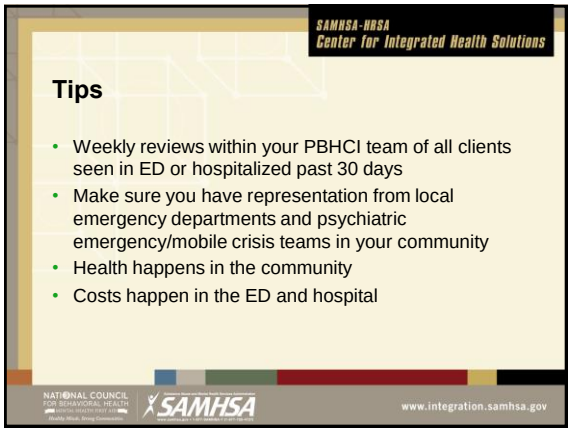
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Tips
• Weekly reviews within your PBHCI team of all clients seen in ED or hospitalized past 30 days
• Make sure you have representation from local emergency departments and psychiatric emergency/mobile crisis teams in your community
• Health happens in the community
• Costs happen in the ED and hospital
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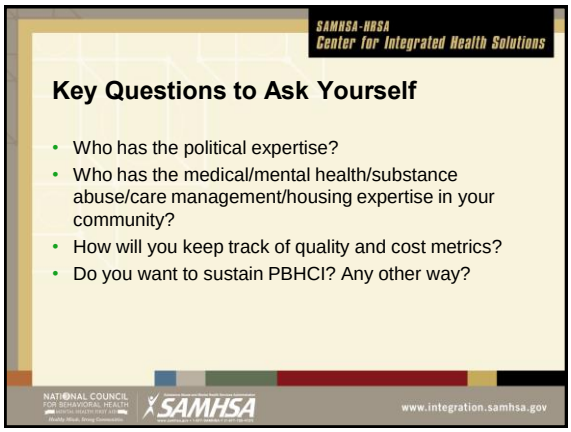
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Key Questions to Ask Yourself
• Who has the political expertise?
• Who has the medical/mental health/substance abuse/care management/housing expertise in your community?
• How will you keep track of quality and cost metrics?
• Do you want to sustain PBHCI? Any other way?
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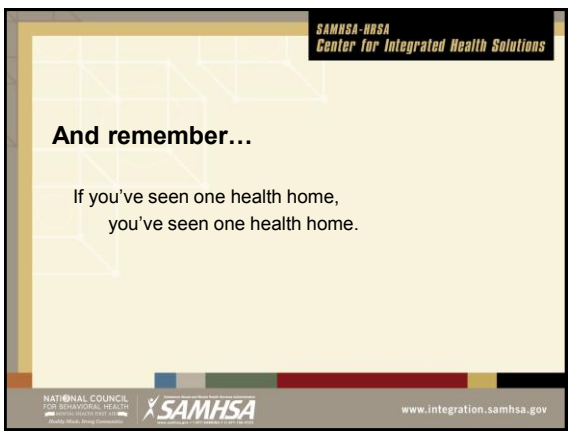
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