An Integrative Health Home Pilot

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TN Healthcare Innovation Initiative

Primary Care Transformation

- Launched in 2013
- Paying for value vs. volume
- Focus is on prevention, management of chronic illness, and coordination with other providers
- Patient-Centered Medical Home
- Health Home (now known as Health Link)

Background

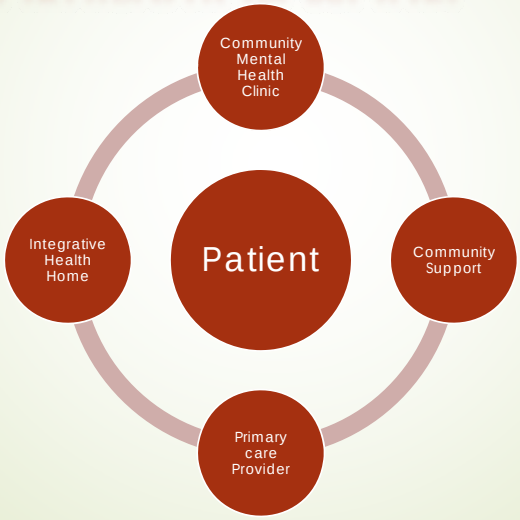
- Barriers to accessing primary care pose significant challenges for the mentally ill population
- Higher rates of CVD, diabetes, COPD, and other co-morbidities compared to the general population (Kaufman, McDonell, Cristofalo, & Ries, 2012; McCabe & Leas, 2008)
- Greater risk of mortality among individuals with a severe and persistent mental illness (McDonell, Kaufman, Srehnik, Ciechanowski, & Ries, 2011; Nover, 2013)
- Health disparities and limited supports contribute to the barriers to accessing primary care (Kaufman et al., 2012)

Background

Quality Improvement Research Project

- In 2014 looked at small sample of patients from HRMC clinic in surrounding county
- Identified three significant barriers to accessing primary care
  - Systemic, patient and provider barriers continually impacted access to primary care for individuals with a mental illness
  - Stigma remained a critical barrier even when access to primary care was available

INTEGRATIVE HEALTH HOME- A CARE COORDINATION MODEL



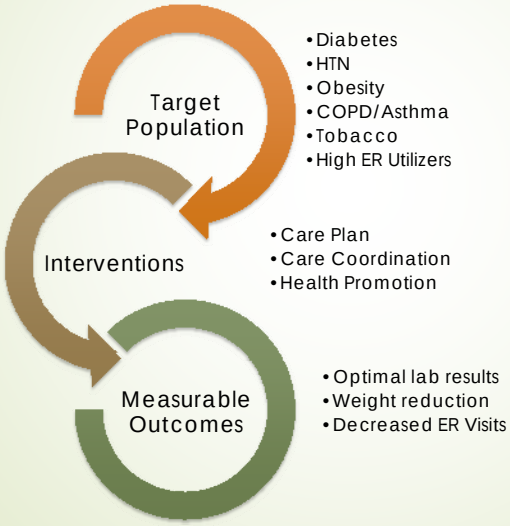
Health Home Pilot – Initiation Phase

- Funding from the Helen Ross McNabb Foundation
- Research Behavioral Health Homes and decide on care coordination model
- Assess for readiness of integrative care within organization (infrastructural changes, EMR, communication of PHI, collaboration among both internal and external providers)
- Identify members of health home team (Director, RN Care Coordinator, Case Manager, Primary Care Provider)
- Determine eligibility criteria
- Identify measurable health indicators
- Implement interventions
- Track outcomes

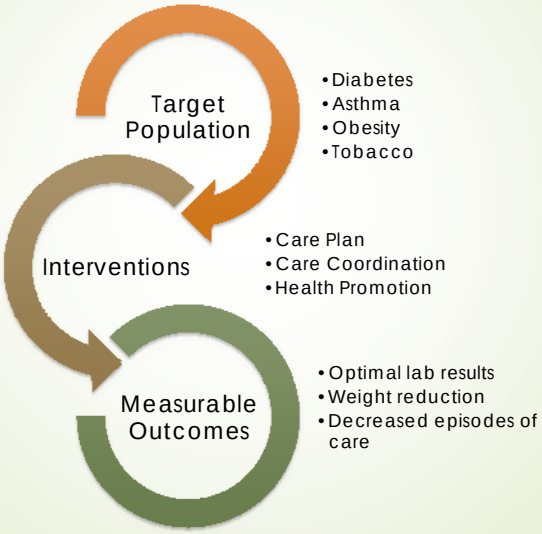
Health Home Team

- Health Home Patient
- Health Home Director
- Health Home RN Care Coordinator
- Primary Care Provider (MD/APN)
- Case Manager

Adult Health Indicators



Pediatric Health Indicators



Interventions

- Access to peer wellness coach
- Use of screening tools to identify potential health risks
- Care coordination among behavioral health and medical providers
- Individualized treatment plan
- Linkage with community resources that meet specific healthcare needs
- Health promotion and education regarding healthy life style choices

Communication

Determine capability of EMR to capture identified health data, track outcomes, and share information among providers

Ensure notes include pertinent information for collecting data

Establish Collaboration Agreement with external providers

Initiate contact with external providers within 7 business days of obtaining appropriate ROI

Maintain ongoing communication among internal and external providers involved in patient care (phone, protected mail, patient portal)

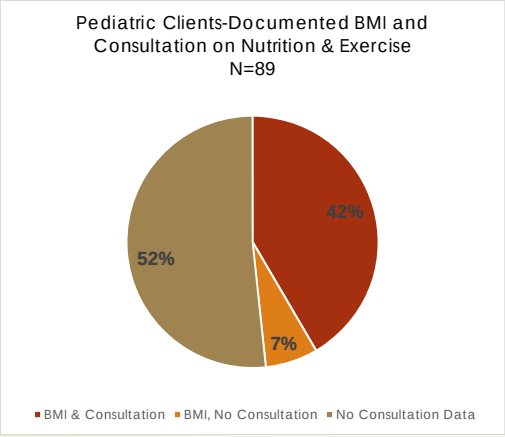
Track Outcomes

- Monitor for improved health outcomes
  - *improved labs, decreased BMI, medication adherence, improved BP*
- Monitor for access to primary care
- Improve health knowledge
  - *documentation of health interventions and counseling/education*
- Reduce frequency of ER visits

One Year Later

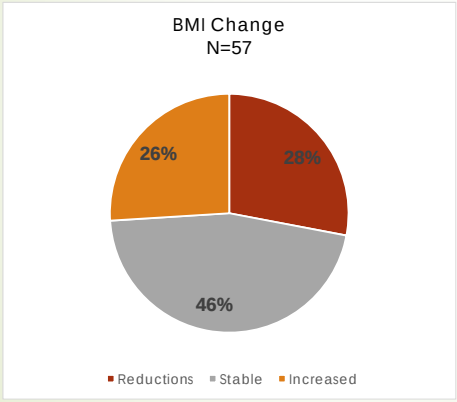
- Total census 220 patients (111 pediatrics/ 109 adults)
- Two RN HH Coordinators
- Clinic work flow
- Educating staff
- Collaborative agreements w/ external providers
- HIT/ Compliance & Quality collaboration
- Trackable outcomes
  - *improved labs, decreased BMI, medication adherence, improved BP*

Weight Assessment and Counseling for Nutrition and Physical Activity for Children



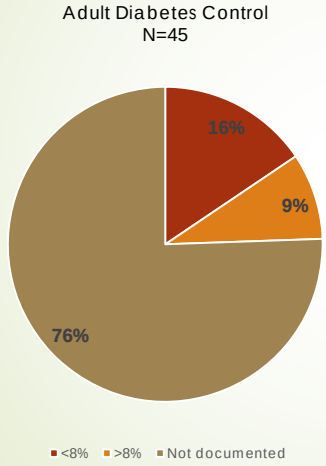
- % of children who had evidence of the following documented:
  - BMI percentile with date
  - Counseling for nutrition
  - Counseling for physical activity
- Number increased from 26% to 42% by 3rd quarter

Body Mass Index (BMI)



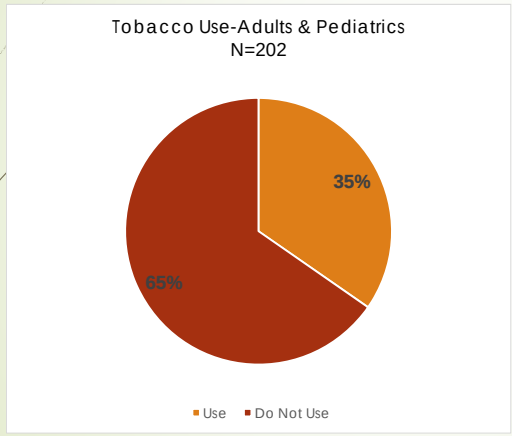
- % of patients identified as overweight (BMI 25-29.9) or obese (BMI 30+) that show a decrease in BMI
- Change from 36% to 28% in 3rd quarter

Comprehensive Diabetes Care for Adults



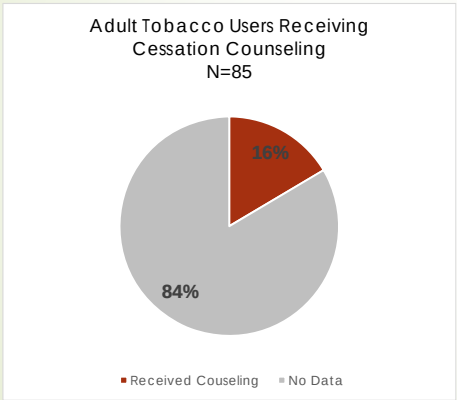
- % of adults with reported HbA1c < 8.0% (controlled)
- Improvement in 3rd quarter from 11% to 16%

Tobacco Use



- % of children and adults reporting tobacco use in previous 3 months
- By end of 3rd quarter 65% of adult and children report no tobacco use

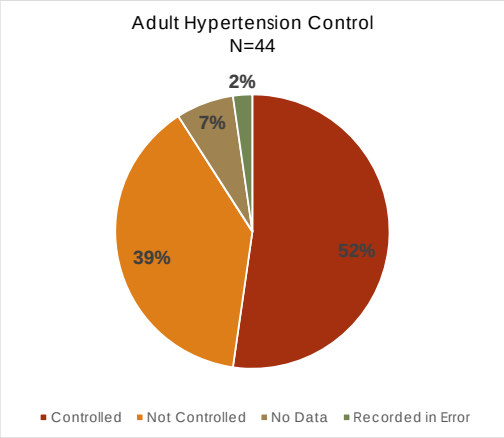
Smoking Cessation



- % of adult smokers that received the following:
  - Advised to quit
  - Discussed cessation medications
  - Discussed cessation strategies

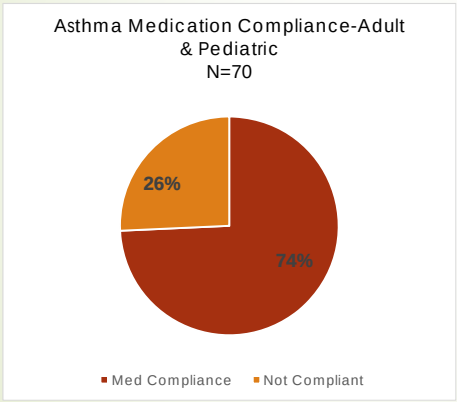
**By end of 3rd quarter only 16% received smoking cessation assistance

Blood pressure



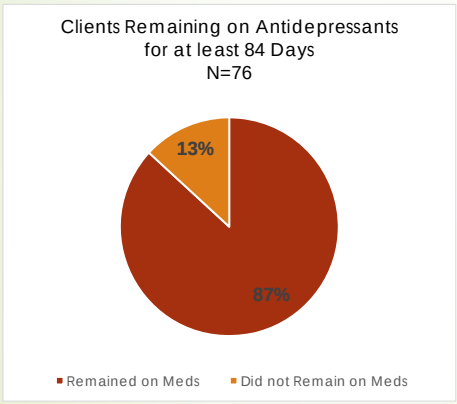
- % of adults with adequate BP control defined as:
  - <140/90
- Numbers declined slightly in the 3rd quarter from 63% to 52%

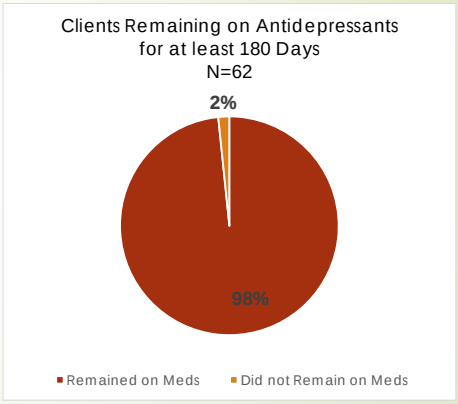
Asthma



- % of people with asthma who remained on medication at least 75% of their treatment period
- Slight drop in 3rd quarter from 76% to 74%

Adult Antidepressant Med Management





What Have We Learned?

- Work Flow
  - RN remains the clinical lead for all coordination; ROI; need care coord tool
  - Identify pertinent billing codes and ensure EMR billing capabilities
  - Health promotion interventions; educational materials; comm resources
- EMR
  - Notes designed to capture reportable data; ability to exchange PHI externally
  - Access/utilize/distribute screening tools and health education/prevention materials
- Onboarding
  - Education and infrastructural changes
  - Importance of RN/CC teams