Integration – How Can Behavioral Health And Health Care Be Better Coordinated?

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New York Association of Psychiatric Rehabilitation Services, Inc. (NYAPRS)

A peer-led statewide coalition of people who use and/or provide community mental health recovery services and peer supports that is dedicated to improving services, social conditions and policies for people with psychiatric disabilities by promoting their recovery, rehabilitation, rights and community integration and inclusion.

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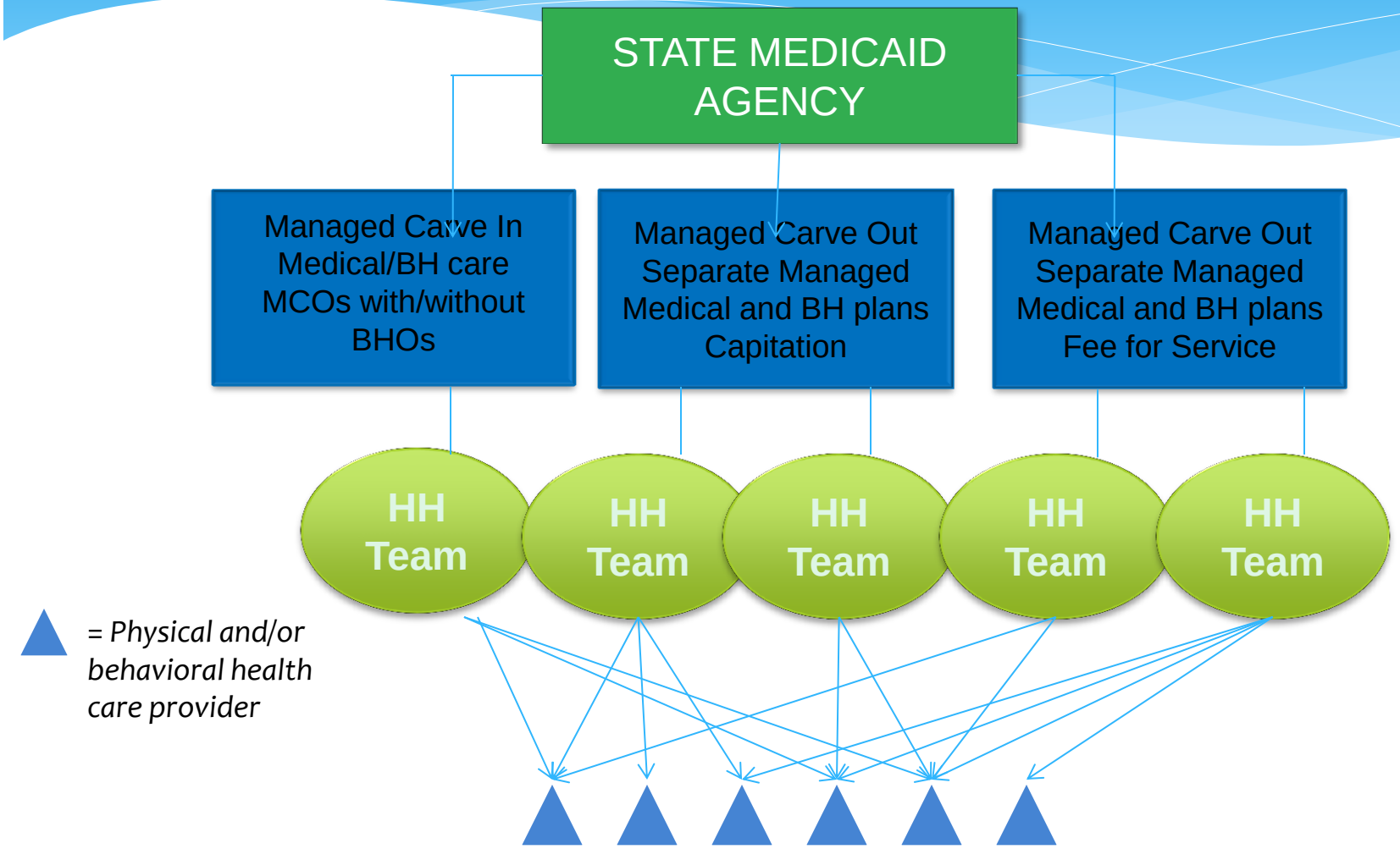
ACA HEALTHCARE REFORMS

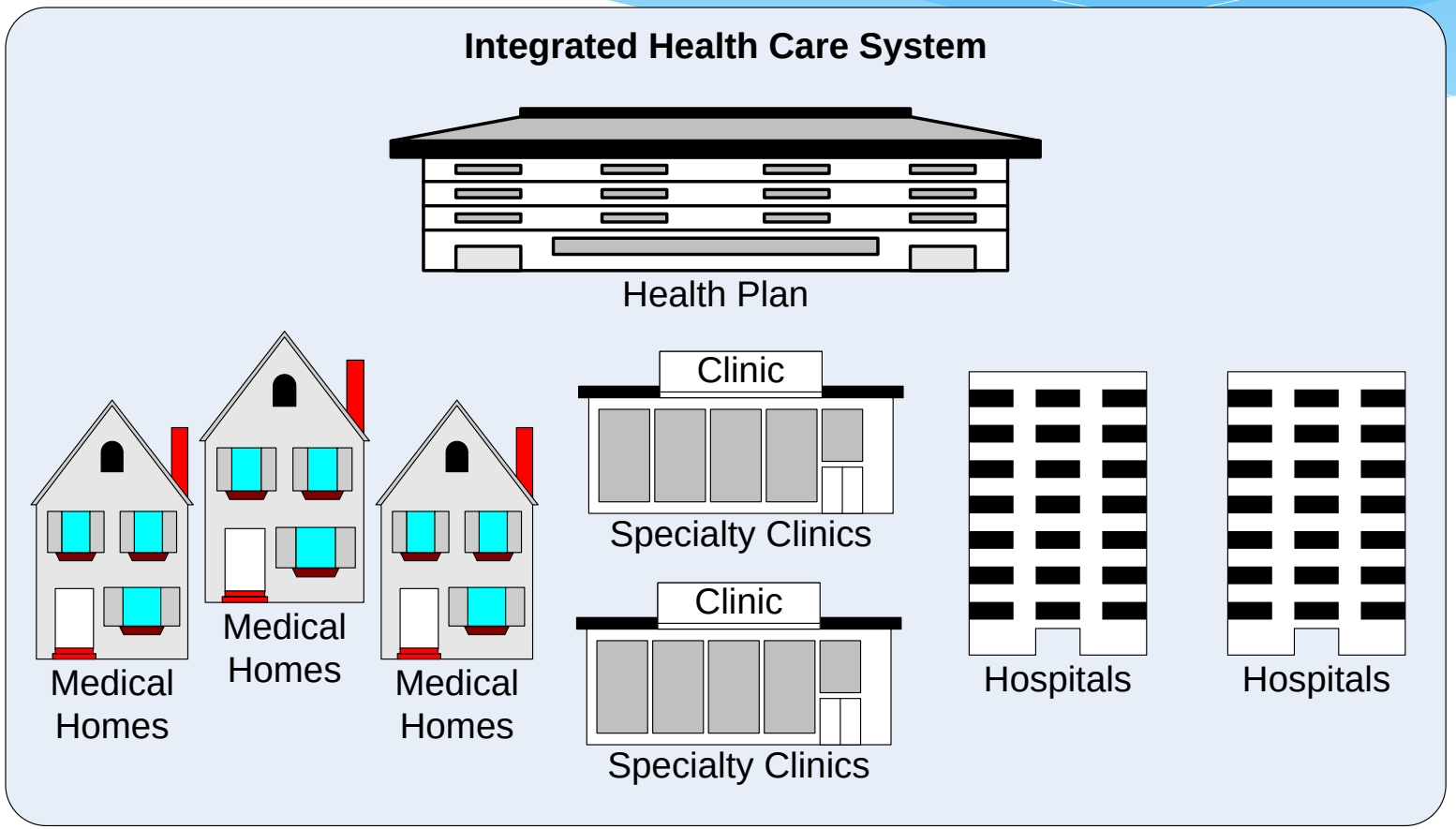
Major Federal Drivers

* **Triple Aim:** improving **outcomes, improving quality, reducing cost**
* Medicaid/managed care **expansion**, BH parity
* Focus on **better coordinated, accountable and integrated** physical and behavioral health care
* Major emphasis on **home and community based services** and less reliance on institutional care
* Promoting **wellness, preventing** relapses **upstream**
* **Person centered individualized care**

Managed Behavioral/Physical Care and Health Homes



Understanding Where the Healthcare Management Models are Headed



Our Opportunity In Managed Care

* Managed care companies and BHOs have great flexibility beyond traditional Medicaid rules to buy approved non traditional services that are proven to work
* States can expect and even require managed care groups to buy peer services… especially if it's in the request for proposals and contracts

Health Homes

* Health homes provide:
  - **Dedicated care managers** who assure that enrollees receive all needed medical, behavioral, and social services from their assembled **networks of treatment, housing and social services**
  - in accordance with a **single care management plan**
  - that is shared with all providers via an **electronic healthcare record**

Heath Homes Goal

* Health homes are **accountable for reducing avoidable health care costs**, specifically preventable hospital admissions and readmissions, skilled nursing facility admissions and emergency room visits and meeting quality measures.
  * Active engagement
  * 24-7 response
  * Focus on well coordinated discharge and treatment planning

Health Home Advantages for Consumers

* Integrated Care
* Help with Navigating the Health Care System
* Better Access
* Better Coordination
* Wellness and Person Centered
* Focus on Skills to Stay Healthy
* Availability of Peer Based Recovery Supports

Health Home Advantages for Providers

* Part of an Integrated Care Team
* Access to Referrals
* Electronic Data Sharing
* Outcome Focused and Accountable
* Positioning for Managed Care
  * Health Homes are organizing networks which will contract with managed care payers

Critical Value of BH Services

* People with behavioral health conditions rank high amongst the most costly beneficiaries and those most frequently involved in avoidable ER visits and inpatient admission.
* New integrated care designs can rely on BH providers to serve as the most engaging ‘front door’ to new networks and a critical partner in supporting beneficiaries to better manage their health and follow up with practitioners.
* Peer run models and practitioners are key

Health Home Financing

* Health home leaders get a **monthly rate** for each person served that pays for care management, electronic health care record system and administrative costs.
* Health home network members continue to bill existing funding streams….until the move to integrated managed care systems.

Peer Services in Health Homes

* Health homes can re-program care management dollars to buy peer services
* Sample arrangement… working in subcontract with a health home to be part of a ‘service triangle’:
  * Care manager
  * Nurse
  * Peer wellness/recovery coach

Valued Roles for Peer/Recovery Coaches

* **Successful Outreach and Engagement** is key to the success of an effective managed care and/or health home service plan.
* By definition, many health home beneficiaries struggle with managing their complex medical, mental health and addiction related conditions and tend to miss scheduled appointments, often due to health and housing economic instability, trauma, disorganization and poverty.

Valued Roles for Peer/Recovery Coaches

* **'Feet on the Street': Peer wellness coaches engage and meet beneficiaries in the communities in which they live,** bringing personalized information, assistance and support to beneficiaries using a personal, patient and persistent approach that takes the time to listen to each individual's needs and to match them up with the appropriate information and response from the plan's or health home's provider network.

Valued Roles for Peer/Recovery Coaches

* **Person Centered Care:** Peer wellness coaches can help ensure that health home service plans and services are truly person centered and self-directed. They can serve as a trusted liaison between the beneficiary and the network who helps translate the needs and concerns of each entity to the other.

Valued Roles for Peer/Recovery Coaches

* Peer wellness coaches are skilled at helping beneficiaries to develop:
  * personal **Wellness Recovery Action Plans** (http://www.mentalhealthrecovery.com/) that identify their needs and patterns to inform and direct both their health home service plan and their
  * **Advance Directive,** a legal document that indicates what kinds of care and support beneficiaries want and need during times of crisis (National Resource Center on Psychiatric Advance Directives http://www.nrc-pad.org/getting-started

Valued Roles for Peer/Recovery Coaches

* There is increasing evidence that individuals who feel empowered and exhibit more self-advocacy have fewer symptoms and are more willing to engage in services. (Jonikas, Copeland, Cook et al, Improving Propensity for Patient Self-Advocacy http://www.mentalhealthrecovery.com/wrap/documents/ImprovingPropensityforPatientSelf-Advocacy.pdf

Valued Roles for Peer/Recovery Coaches

* **Increasing Health Literacy and Self-Management:** Peer wellness coaches help share/teach/learn encourage wellness practices, using tools like:
  * The **8 Dimensions of Wellness**: Emotional, Physical, Financial, Occupational, Social, Spiritual, Intellectual and Environmental
  * **Whole Health Action Management (WHAM)**: a training program and peer support group model that encourage increased resiliency, wellness, and self-management of health and behavioral health conditions via 8-week WHAM groups where members support each other to work toward, achieve, and maintain whole health goals.
* With the help of their coach, a beneficiary can learn to track their own blood pressure, blood sugar and cholesterol and make lifestyle changes that support wellness.

Valued Roles for Peer/Recovery Coaches

* **Advocate, Inform and Help Transform the 'System:'** Peer wellness coaches can educate health home team members about a recovery frame work and the recovery process; they can share information about the beneficiaries' needs and circumstances that are not recognized by the team and to advocate for their preferences in ways that boost team success with previously unresponsive beneficiaries.

Valued Roles for Peer/Recovery Coaches

- Peer coaches can focus service plans on the critical importance of addressing the "**social determinants of health**" by asking about basic elements
- Income, employment and education
- Housing, social support, social exclusion
- Stress, early childhood experiences
- Social exclusion, discrimination (e.g. racism) and lack of access to resources

Valued Roles for Peer/Recovery Coaches

* **Relapse Prevention and Crisis Management Support: Peer wellness coaches can s**upport effective relapse prevention and crisis management approaches that provide alternatives to avoidable ER and inpatient readmission. They often serve as the 'supporter of first/last resort'.
  * Crisis respite houses
  * Warm lines
  * Peers in the ER

Valued Roles for Peer/Recovery Coaches

* **Introduce/Encourage Participation in EHR, Technology:** Peer wellness coaches can encourage beneficiaries' ownership in the MCO/health home service plan by ensuring they
  * have access to their electronic health record,
  * use peer run crisis 'warm lines' and respite centers and to
  * use website and applications that promote self-care, e.g. OptumHealth Whole Health Tracker and apps like *What's My Mood, 12 Step Companion, 24 Hours*

Valued Roles for Peer Brokers

* **Individualized Budgets:** redirect service dollars – based on wellness/service plans – in order to purchase services and supports as beneficiaries pursue recovery and wellness.
* Beneficiaries are typically assisted by peer brokers in the financial management of the budget.
* Peer supported models that feature such 'self-directed budgeting' are demonstrating impressive results in Texas and Pennsylvania managed care initiatives.

NYAPRS/OPTUM Wellness coaching: One Person's Outcomes

* 40 year old man with long standing addiction, mental health and medical issues
* 2009-prior to enrollment**: 7 detox stays** (4 different facilities) **$52,282**
* Peer coach services: transitional and follow up support, re-engagement in AA, wellness coaching, relapse prevention aid
* 2010-1 detox, 1 rehab (referred by the CIDP team) **$20,650** Abstinent for 1 year
* 2011-1 relapse with detox/rehab no claim

Protecting the Integrity of Peer Support

* Peer workers are not ‘cheap staff that get people to take their meds’ or assistant case managers or transportation aides
* Peers start with the person and their stated needs; we don’t begin with diagnosis and meds but focus on personalized engagement, for as long as it takes.
* Peers frequently work for peer run agencies and are supervised by peers
* Emerging competency, training, credentialing and accreditation standards

Beyond Peer Specialists

Examples of Peer Run Specialty Services

* Peer Crisis Diversion: warm lines, respite house
* Peer Bridging: from state and Medicaid hospitals, adult and nursing homes, homeless shelters, criminal justice settings
* Peer Wellness/Recovery Coaches
* Rights Protection & Advocacy: Ombuds
* Life Coaching: work, economic self sufficiency
* Peer Supported Housing
* Peer ombudspersons

Peer Service Outcomes

* 2010 study: 90% of PEOPLe Inc's Rose House crisis respite guests did not return to hospital in the following two years
* NYAPRS Peer Bridger programs helped support a:
  * 72% drop in NY state psychiatric hospital and a
  * 50% drop in numbers of people hospitalized in local Medicaid psychiatric inpatient units and total hospital days when admitted

Peer Service Outcomes

* 2010 Optum Health Peer Link reduced hospital days by 71% in Wisconsin, by 41% in Tennessee
* 2010: Mental Health Peer Connection's Life Coaches helped 53% of individuals with employment goals to successfully return to work
* 2011: Housing Options Made Easy helped 70% of residents to successfully stay out of hospital in the following year

1915.i Home and Community Based Services Option

* **Services in Support of Participant Direction:** Information and Assistance in Support of Participant Direction and Financial Management Services
* **Crisis:** Crisis Respite
* **Support Services:** Community Transition, Family Support, Advocacy/ Support and Training and Counseling for Unpaid Caregivers
* **Empowerment Services:** Peer Supports
* **Service Coordination**
* **Rehabilitation:** Pre-vocational, Transitional Employment, Assisted Competitive, Employment, Supported Employment, Supported Education, Onsite Rehabilitation, Respite and Habilitation

NYS Proposed Integrated Managed Care Design Outcomes

* Participation In Employment;
* Enrollment In Vocational Rehab Services And Education/Training;
* Housing Status;
* Community Tenure;
* Criminal Justice Involvement;
* **Peer Service Use** And
* Improving Functional Status