Realizing the Promise of Health Homes and Care Coordination

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CBC is a not-for-profit organization launched in 2011 by many of New York City’s most well-respected behavioral health providers, leaders in New York’s medical, behavioral health, rehabilitation and supportive housing service systems.

CBC is dedicated to realizing the unprecedented opportunities under Medicaid redesign to improve the quality of care for members and their families, while reducing potentially preventable inpatient and emergency services use by people with serious mental illness, chronic health conditions and/or substance use disorders.

CBC is aimed to be at the forefront of the changes in the overall health care delivery system in order to ensure that all members receive the needed services in their community in the most expeditious and appropriate manner. CBC will be the voice of the Behavioral Health community through direct support and continued advocacy for the maintenance and strengthening of the service delivery system as the shift to managed care and integrated care take hold.
Pathways to Wellness Health Home

CBC PTW network serves Brooklyn, Manhattan and is the only designated lead Health Home in Staten Island, and CBC is a contracted partner in the Bronx Lebanon Health Home.

Our Network spans entire five boroughs, and lead regular Network Meetings with over 110 Network Partners. Our HH Network is large, but each member’s Network is unique to their individual needs.

CBC PTW subcontracts with 32 Care Management Agencies and has a network of more than 100 comprehensive medical clinics, more than 100 licensed mental health clinics, a full continuum of other mental health programs including PROS, ACT and Clubhouses, more than 60 licensed SA treatment programs, more than 20 home care programs, and an estimated 20,000 shelter and supported housing beds with supportive services.
CBC’s Origins in Care Management

Diverse Expertise—27 of the Care Management Agencies are Targeted Case Management, COBRA, MATS and CIDP providers with community ties and strong provider relations.

Program Manual—CBC’s Policies and Procedures are based on lessons-learned from converting programs; also informed by best and promising practices, outreach programs.

Community Presence—5 of the Care Management Agencies are Non-Converting programs and offer unique expertise in additional areas such as housing, outreach, and shelter operations.

Promulgating Successes—Committee structure creates a feedback loop to disseminate lessons-learned.
Building a Health Home Model of Care

• Care Management Team Composition
• Training
• Caseload Size and Management
• Intervention Type and Frequency
• Opportunities for Innovations
From Implementation to Realization

As of March 31, 2014, CBC's HH is providing outreach or care management services to 13,187 individuals in the five boroughs, with 53% enrolled and the remainder in outreach or just assigned. Brooklyn residents comprise 55% of CBC's HH clients. To date, CBC’s HH has processed almost 25,000 referrals.

CBC is working to resolve issues and discrepancies to the Patient Tracking System so that the numbers coincide with the HCS portal. We are arranging our infrastructure to support the heavy data management needs of HH operations.

Systems transformation continues to require education about HH roles and responsibilities. As local governance has divergent viewpoints of HH implementation, our direct care staff often bear the heaviest weight of HH education.

In cultivating working relationships with Plans, opportunities for improving patient care are present but payment for services remains tangled.
Emerging Trends

CBC is taking the steps needed to position itself for future opportunities that NYS has announced, such as Health & Rehabilitation Plans (HARPS) and DSRIP. A number of the founding agencies have formed a not-for-profit Independent Practice Association (IPA) called Community Coordinated Care (CCC) that will specialize in services for Medicaid recipients with serious behavioral disorders.

Critical to the CBC partnership is the shared goal of strengthening community-based services through integrated care delivery, and improved care transitions for at-risk Medicaid recipients. Through CBC and CCC, CBC member agencies can collaborate to improve care quality and health status for Medicaid recipients, while working with local hospitals to reduce inpatient admissions and shortening length of stay.
Opportunities for Innovation

Participation in Pilot Projects
- Both Implementation and Sustainability in focus
- City Offices, Managed Care Plans, Hospitals

Engagement and the use of Technologies
- “Patient Kiosks”
- Consumer Advisory Boards

Culturally Competent Care
- Cross-sectioning Data

Social Media in Healthcare
- Facebook, Twitter, YouTube, Foursquare, Blogs
Meet James

James is a 44yo African American man who enrolled with a CBC CMA in April, 2012 after the agency completed a data match of a list sent by NYS DOH through CBC. At the time of enrollment, he was living in a shelter on Ward’s Island, attending a PROS program in Queens, and cycling in and out of hospitals in the Bronx and Brooklyn. He was obese, had been diagnosed with Type 1 Insulin-dependent diabetes, schizoaffective disorder, and past SUD with cocaine and cannabis.

James moved to NYC in 2010 after his girlfriend, pregnant with their first child, was killed in a car accident. He moved in with a cousin and spent time with his uncle. At times of the year that triggered thoughts of the accident, he would both use substances and skip his insulin, requiring hospitalization. While at the hospital, he would verbalize thoughts of hurting himself and would be transferred from medical to psychiatric care. He reported that cycle continued about twice a month, every month.

On top of making poor choices in his diet, he reported that shelter residents were stealing his needles. James would try and spend time with his family, but it was his uncle who introduced him to cocaine when he moved to NYC. When he enrolled, he said “I don’t know where else to go”.

CBC
TRANSFORMING COMMUNITY HEALTHCARE
“Not a place to stay. A home.”

The CMA’s team was comprised of a care manager, care coordinator, peer, and RN. Each provided health education about his DM, and the potential deadly side effects of drug use and psychotropic medications. The team provided promising and best practice interventions for healthy eating, diabetes self-management, and built the interventions from a trauma-informed lens.

The CMA facilitated James’s move out of the shelter to one of their Treatment Apartment Programs in October, 2012. He was connected to a PCP in his neighborhood and an outpatient treatment provider for therapy as he had always been compliant with his psychotropic medication. The CMA also connected him to a pharmacy that would deliver his medications to his home. All connections were within the CBC Network, and currently comprise his unique network listed on his consent. James also attends AA and NA in his community, and knows how to find a meeting wherever he is.
“I’m bored. I want to work.”

One of the ways that the CMA knew that James was back in the driver’s seat of his health was when he talked about being bored. Since enrolling in the HH, his focus had always been on the short-term—a month without hospitalization, then two, but it was difficult for him to focus on long-term goals. He’d graduated HS and held positions in security and maintenance, but none consistently since 2010.

He is currently attending a community health program that serves adults with chronic medical conditions and has recently added goals of employment to his care plan. He participates in a Consumer Advisory Board hosted by the CMA.

James has not had an inpatient stay since October, 2013.
This is not the end of the work that lies ahead; it is, instead, a very exciting and productive beginning of a long-term process that will alter the face of mental health care in this country for generations to come.
Thank you

Questions?

http://www.cbcare.org/
http://www.pathways2wellness.org/

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