

CareConnect Health Home

Piloting an Evolution in Integrated Care for People with Developmental Disabilities

Sanders Burstein, MD



Sandy Pelletier, CEO



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MIKE, a 23 year old man

- Developmental Disability
- Independent living, inconsistent housing, compromised family supports
- Pacemaker, stroke in 2011, cardiac abnormalities: medically complex
- Mood disorder and Post Traumatic Stress
- Frequent visits to the emergency department





Challenges

- Behavioral: psychiatric, developmental?
- Social: inconsistent housing and fractured family supports contribute to complex medical, behavioral, long term social support needs
- Communication issues

Care Connect

- Care Plan Pending: Intervention to avoid ED visit, living arrangement strategy, medication reconciliation, scheduling Community Navigator visits, accommodations for communications



People with developmental disabilities are living longer...





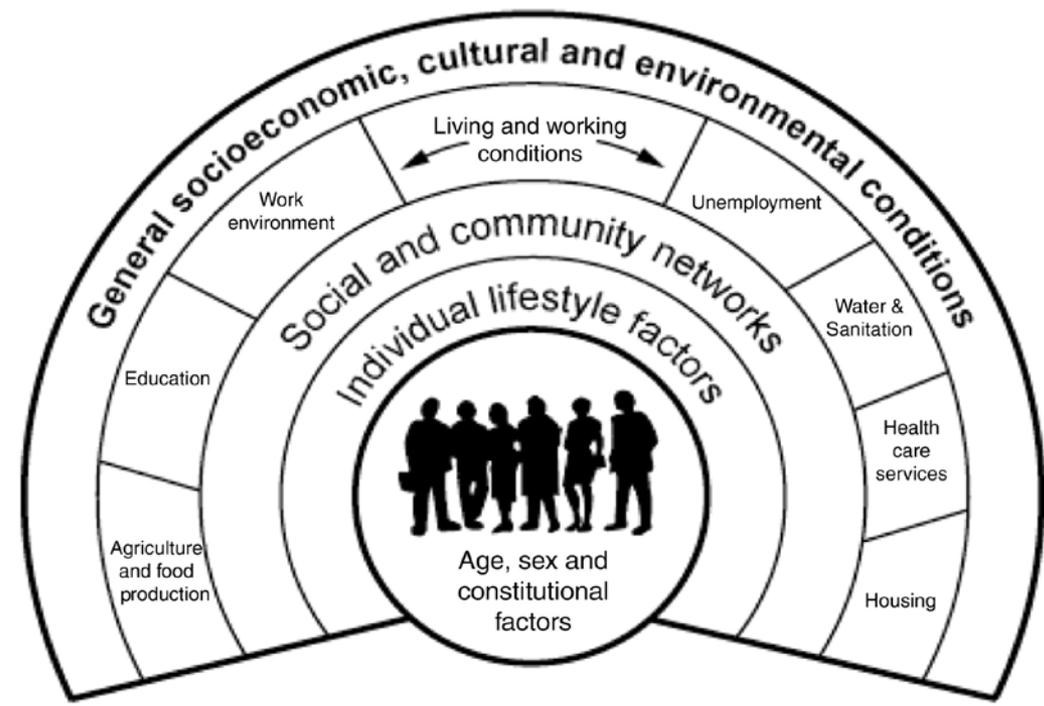
Health Disparities Exist



There are more complex health needs
and evidence of poorer health



Health Disparities Exist



Social determinants of health play a role.



Reflects the need for:



- Health Home/Integrated Care Team



What is a Health Home?

- Authorized under Affordable Care Act, the health reform law enacted in 2010, a Health Home provision [Sec. 2703 & Sec. 1945 (e)]
- Integrated Care Delivery
- Organizational Transformation/Teamwork

Health Home Activity

Partnering for a Healthier You



As of June 2013

 Approved State Plan Amendment(s) (11)

 Planning Grant (17)

Note: States with stripes have both

NATIONAL ACADEMY
for STATE HEALTH POLICY

<http://www.nashp.org/med-home-map>

How does it differ from a Medical Home?

Medical Home = Primary Care Team

- Designed for everyone
- Acute, Chronic, and Preventive Care
- No enhanced federal Medicaid match

Health Home = Primary Care Team +

- For a specific population
- Medical Home PLUS mental health, behavioral, social, & long term care needs addressed by an integrated team.
- Enhanced federal Medicaid match

CareConnect Goal



To measurably improve the health and functional well-being of adults with developmental disabilities while enhancing each individual's experience of medical care and long term support services.

(Innovation, teamwork and attitude)

CareConnect Health Home Pilot Eligibility



Partnering for a Healthier You

Criteria: 45 People with Developmental Disabilities

- Patient at DH Nashua – higher cost clients
- Long Term Services and Supports (LTSS) from Gateways Community Services – Developmental Disability
- 2 chronic conditions; one condition can be complex Mental Health
- 1 chronic condition & being at risk for 2nd condition
- Support Intensity Scale (SIS) score
- Health Risk Screening Tool (HRST)

Key Components



Partnering for a Healthier You

- *Integrated Care Team* (ICT) – Health Service Coordinator (HSC), Community Navigator (CN), DH Care Managers, Primary Care Physicians, Nurses, & Specialists (START/Behavioral Health)
- *Training/Learning Collaborative* –knowledge about patients with I/DD
- *Best Practices* – preventive care/ ED discharge/hospital/ follow-up care
- *Integrated Care Plans* – Develop individualized **CareConnect Agreements** that address medical, behavioral & long term care needs; taking into account social needs, family/home support circumstance

CareConnect



Best Practices

- Integrated Planning Methodology
- Health Service Coordinator
- Care Agreements with Measurements
- Preventive Care (tailored as needed)
- Community Navigator follow-up
- Family Support/Person-Directed

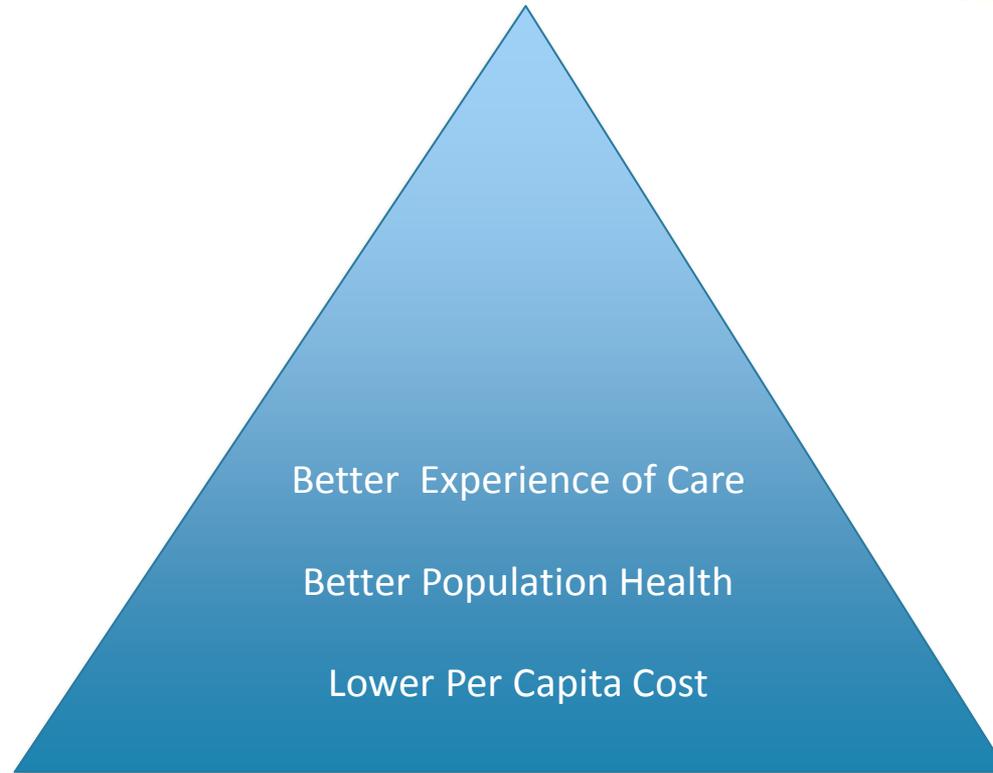
Benefits



Partnering for a Healthier You

- National data indicates that integrated supports (client data sharing, hospital/ED discharges, & follow-up for chronic conditions) can yield 5% reduction in acute medical costs
- Better healthcare through self and assisted management of at home action plans with support from Community Navigator
- Improved experience of care with education and support of Health Service Coordinator
- Next Generation of Care Management – Step One to evolution of integrated care

CareConnect Triple Aim

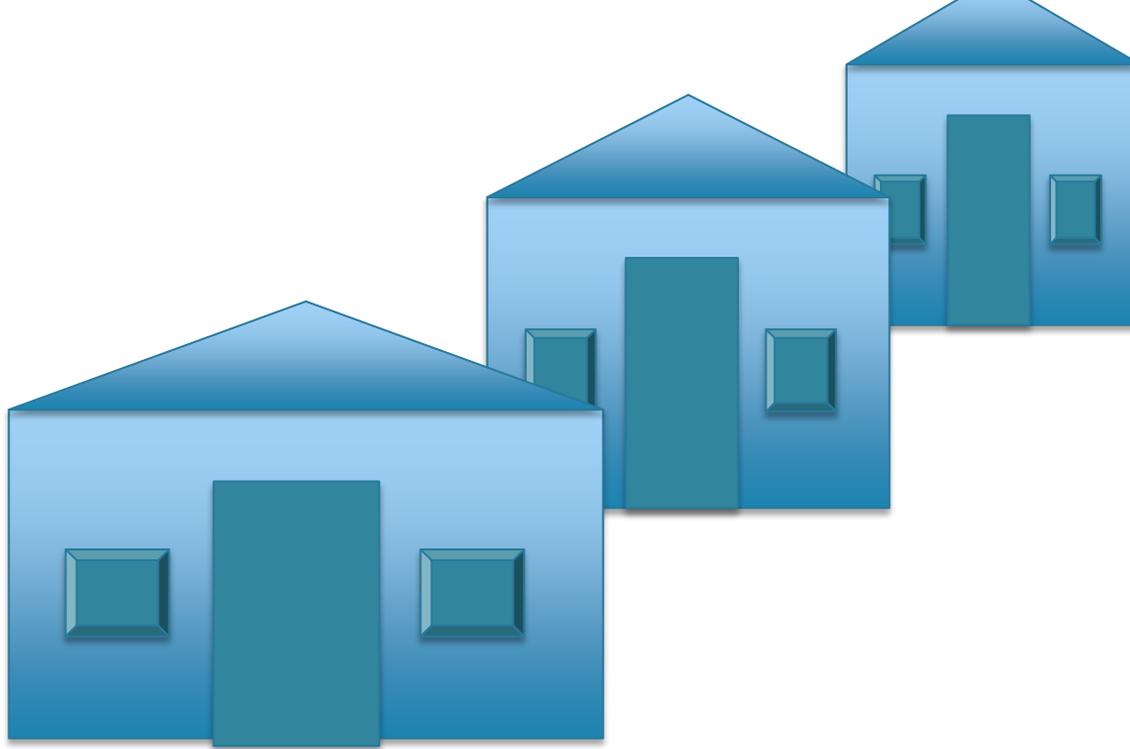


Lessons Learned



- Integrated Care
 - Intervention & Prevention
 - Reduces/Prevents costly co-morbidities
 - Population specific operations gets results

- Sustain & Replicate
 - Infrastructure
 - Payment reform
 - Teamwork



Health Homes -- NH's Next Generation in Care

Questions and Discussion