Health and Human Services Transformation

Integrated Health Homes: Overview of approach

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Discussion document

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The HHS transformation has been enabled by an historic level of collaboration

Thirteen agencies / departments / offices are participating in HHS transformation…

1. Governor's Office
2. Department of Healthcare and Family Services (DHFS)
3. Department of Children and Family Services (DCFS)
4. Department of Human Services (DHS)
5. Department of Juvenile Justice (DJJ)
6. Department of Corrections (DOC)
7. Department of Aging (DOA)
8. Department of Public Health (DPH)
9. Department of Veteran's Affairs (DVA)
10. Illinois Housing Development Authority (IHDA)
11. Department of Innovation and Technology (DoIT)
12. Illinois State Board of Education (ISBE)
13. Illinois Criminal Justice Information Authority (ICJIA)

…and focusing on five pillars

1. Prevention and population health
2. Pay for value, quality and outcomes
3. Moving from institutional to community care
4. Education and self sufficiency
5. Data integration and predictive analytics

As a pressing issue that transcends agencies and populations across Illinois, behavioral health is a lynchpin in the transformation effort

Governor's Office and 12 Illinois agencies with shared sense of mission

Groundwork laid in Healthy Illinois 2021 plan, supported by State Health Assessment, SIM grants, and State Health Improvement Plan

Disproportionate level of spend on members with behavioral health needs, i.e., **mental health and substance use issues**

Rapid increase in **opioid-related deaths**

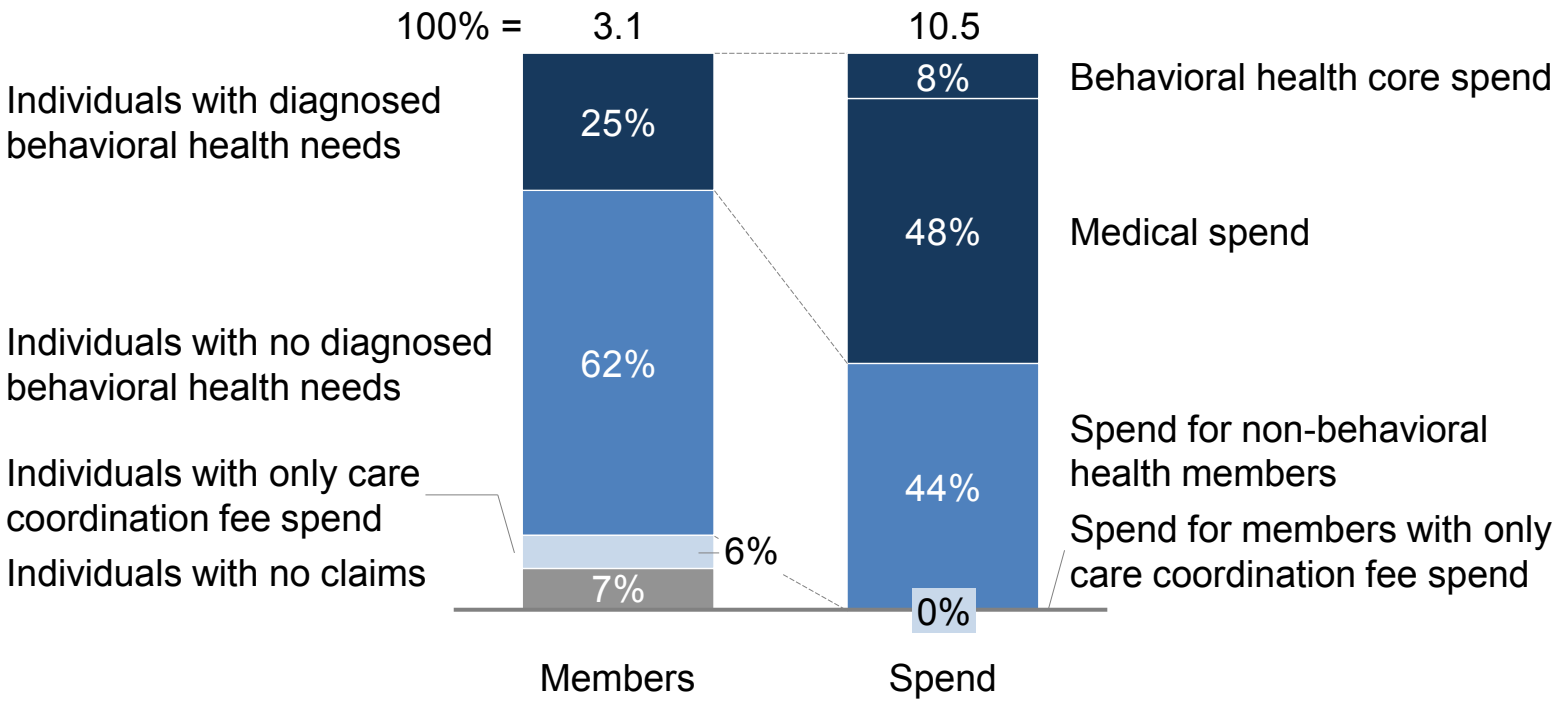
Large **undiagnosed or untreated subpopulations**

Underutilization of community services and **overutilization of intensive institutional care**

Medicaid individuals with diagnosed behavioral health needs make up ~25% of the population, but ~56% of the total spend

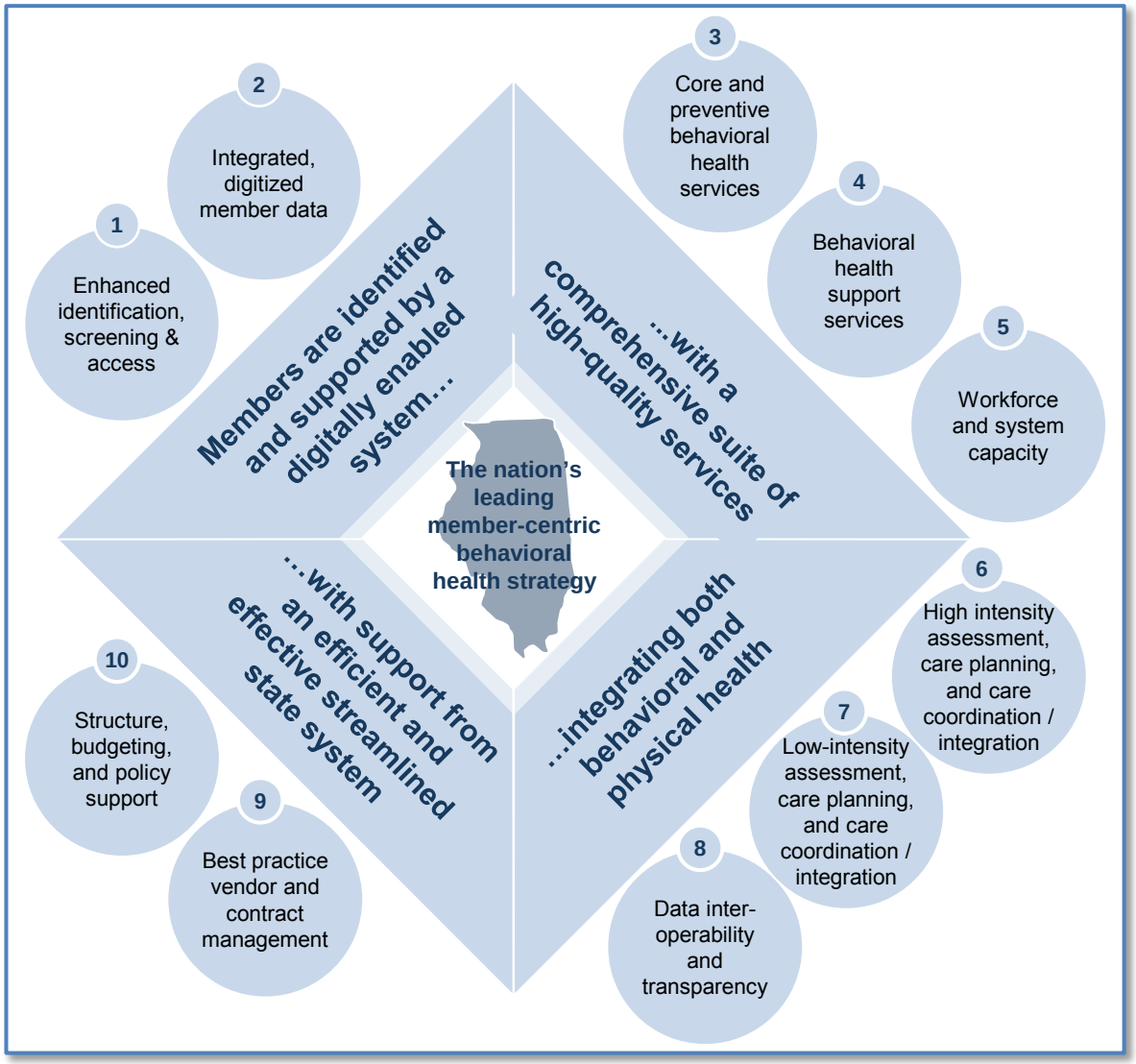
FY2015 members and spend

Annualized members (millions), dollars (billions)



SOURCE: FY15 State of Illinois DHFS claims data

Objectives of the Illinois HHS Transformation to address these challenges



The 1115 waiver will allow Illinois to realize a set of high-priority benefits, alongside initiatives that will maximize their effectiveness

Demonstration waiver benefits

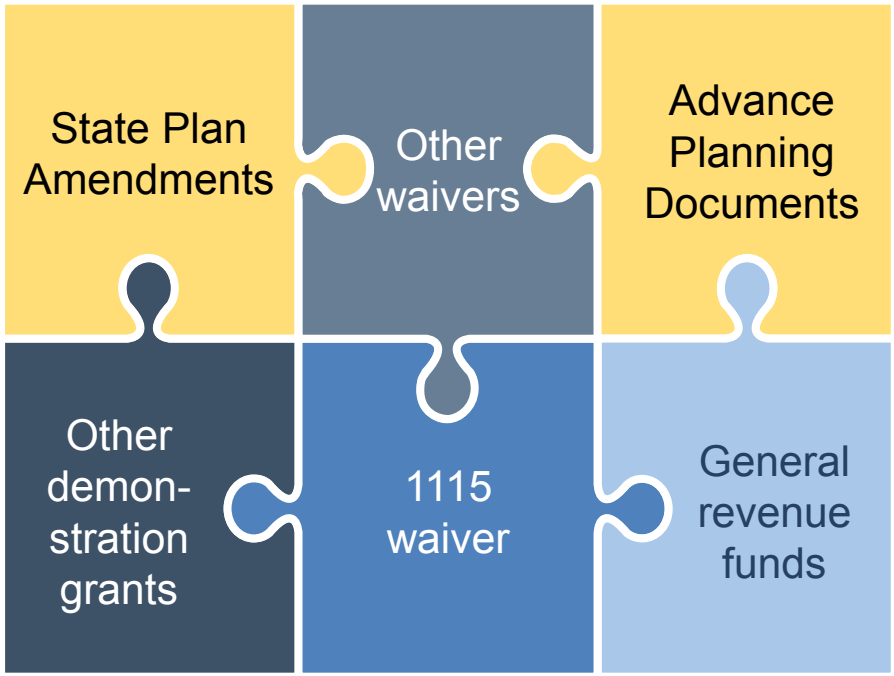
#	Benefit
1	Supportive housing services
2	Supported employment services
3	Services to ensure successful transitions for IDOC- and Cook County Jail (CCJ)-incarcerated individuals
4.1	Services for individuals with substance use disorder in short-term stays in IMDs
4.2	SUD case management
4.3	Withdrawal management
4.4	Recovery coaching for SUD
5.1	Services for individuals with mental health issues in short-term stays in IMDs
5.2	Crisis beds
6	Respite care

Demonstration waiver initiatives

#	Initiative
1	Behavioral and physical health integration initiatives
2	Infant/Early childhood mental health interventions
3	Workforce-strengthening initiatives
4	First episode psychosis (FEP) programs

The State will also pursue initiatives outside the waiver to advance its behavioral health strategy

Non-waiver initiatives covered here



Other initiatives

- State Plan Amendments (SPAs), including, but not limited to:
  - Integrated physical and behavioral health homes
  - Crisis stabilization and mobile crisis response
  - Medication-assisted treatment (MAT)
  - Uniform Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA)
- Advance Planning Documents (APDs)
  - Data interoperability through 360-degree view of behavioral health member

The Waiver Advisory Committee will be instrumental to shaping the transformation across several topics

PRELIMINARY

■ Focus for the next two meetings

Working groups presenting material for input

Integrated Health Homes	**Home Visiting Pilot**	**Supportive Housing**	**Workforce Development**
Supported Employment Services	**Justice-involved**	**Respite Care**	**SUD Case Management**
Withdrawal Management	**SUD Recovery Coaching**	**Discussions across topics will focus on the insights from your experience and potential implications of design decisions under considerations** 	

What an Integrated Health Home is and is not

Integrated Health Homes in Illinois are:

Primary focus is on coordination of care…

- **Integrated, individualized care planning and coordination resources,** spanning physical, behavioral and social care needs
- An opportunity to **promote quality** in the core provision of physical and behavioral health care
- A way to **encourage team-based care** delivered in a member-centric way
- A way of **aligning financial incentives** around evidence-informed practices, wellness promotion, and health outcomes

For members with the highest needs:

- A means of facilitating **high intensity, wraparound care coordination**
- An opportunity to obtain **enhanced match for care coordination needs**
- **Identifying enhanced support** to help these members and their families manage complex needs (e.g., housing, justice system)

Integrated Health Homes in Illinois are NOT:

… and NOT on the **provision of all services**

- **Provider of all services for members**
- **A gatekeeper** restricting a member's choice of providers
- **A physical place** where all Integrated Health Home activities occur
- **A care coordination approach that is the same for all members** regardless of individual needs

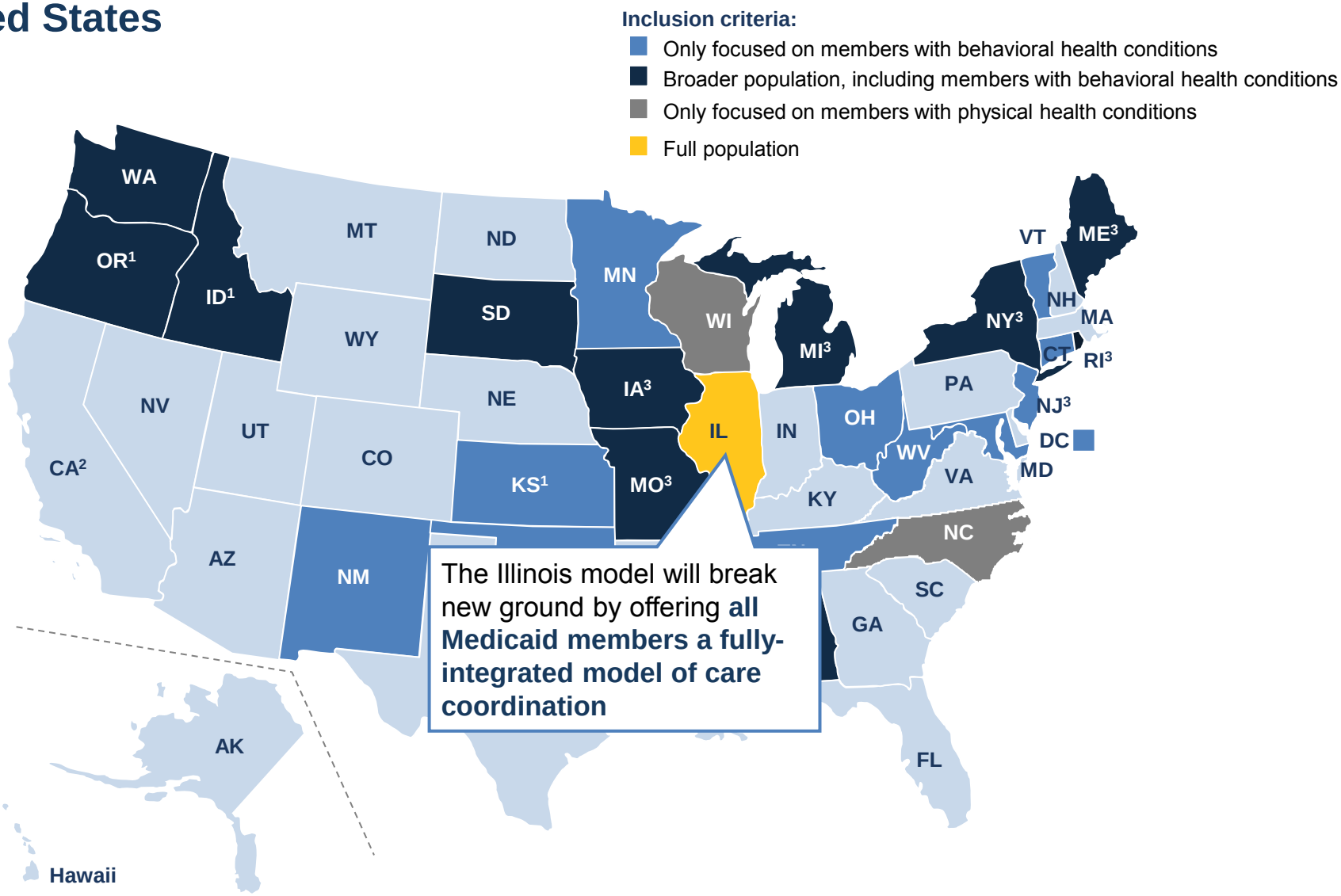
Anything else you would add to these lists?

Principles for Integrated Health Homes in Illinois

- Develop a **person- and family-centered care delivery model for the whole Medicaid population, regardless of match status,** that encourages member and family engagement
- Evolve toward **full clinical integration of behavioral, physical, and social healthcare**
- Craft a flexible care delivery approach that reflects **the diverse needs of members in Illinois** and recognizes that member needs change over time
- Acknowledge and accommodate **geographical variation in provider capabilities, readiness, and priorities**
- Strike an **appropriate balance between provider flexibility and accountability** to enable capabilities and readiness
- Prioritize **economic sustainability of care delivery model** at both the systemic and provider levels

Goal is to begin launch of model by July 2017

To date, 33 Health Home models have been developed throughout the United States



1 Oregon, Idaho, and Kansas have opted not to continue their programs
2 California will launch its Health Home model in July 2017
3 State has initiated multiple health home models
SOURCE: Open Minds; CMS database of approved Medicaid Health Home State Plan Amendments, as of December 2016

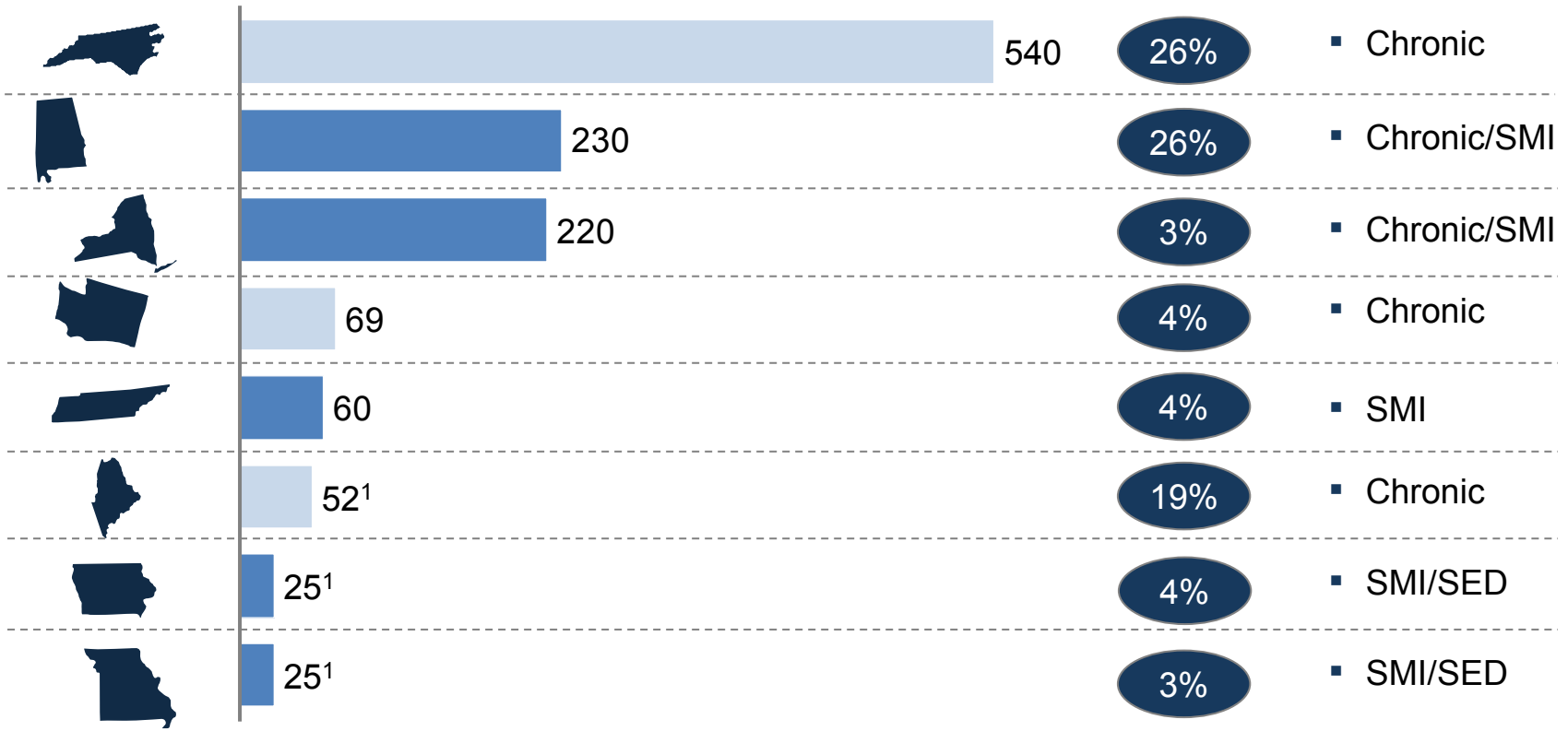
Profiles of ACA Health Homes launched to date

Illinois would be first fully integrated Health Home

Includes members with SMI/SEDs

Largest Medicaid Health Home programs developed to date

Number of enrollees, thousands



Many states also employ PCMH programs to coordinate the physical health needs of their members separately, but **Illinois model would coordinate both physical and behavioral health care for all ~3.1m Medicaid members**

1 Only includes members who are part of the state's largest Health Home program

SOURCE: CMS Health Home Information Resource Center

Illinois' model would address the needs of a broad range of member archetypes

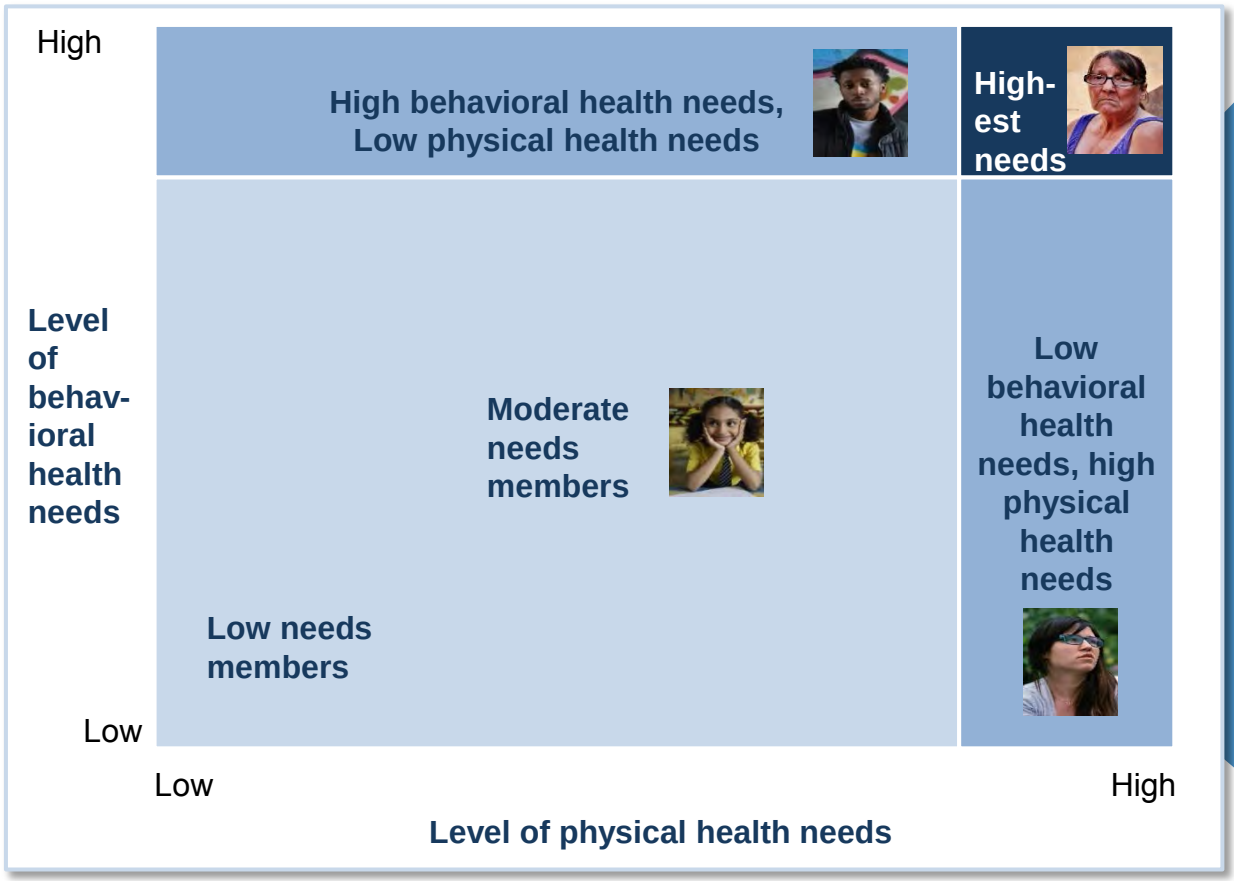
Archetype	Age	Living situation	Behavioral health condition
 Jerry	Toddler	In at-risk home	At-risk
 Jane	Child	Youth in care	ADHD/ODD
 Connor	Teenager	Transferring to congregate care	Severe aggression
 Brice	Teenager	Urban home	Major depression
 Mike	Teenager	Juvenile institution	Bipolar disorder/ alcohol and marijuana abuse
 Mia	Teenager	Rural home	Opioid abuse
 Jenn	Young Adult	Rural home	Anxiety
 Greg	Young Adult	Correctional facility	Schizophrenia
 Stephen	Adult	Experiencing homelessness	Actively psychotic/ opioid abuse
 Darnell	Adult	Experiencing homelessness	Post-traumatic stress
 Ashley	Adult	Permanent supportive housing	Schizophrenia
 Tom	Adult	Friend's couch	Alcohol and heroin abuse
 William	Adult	Rural home	Alcohol abuse
 Cynthia	Aged	Skilled nursing facility	Moderate anxiety and depression

Approach for reviewing care delivery model design decisions

- The items that follow comprise the working group's **initial perspective on key care delivery model design decisions,** thanks to close collaboration between representatives from the Department of Healthcare and Family Services, Division of Mental Health, Department of Children and Family Services, Division of Alcoholism & Substance Abuse, and the Illinois Department of Public Health
- These ideas **build on work done** as part of the Healthy Illinois 2021 plan, supported by a State Health Assessment, SIM grants, and a State Health Improvement Plan
- **The working group seeks your input on these decisions**, both on the direct questions posed on the following pages, and with regard to any other queries or modifications you might suggest as we discuss the decisions more broadly.
- **Your responses today will help refine and improve these decisions**, and will be reflected wherever possible

1 Potential expectations for providers in coordinating care for high need members

ILLUSTRATIVE

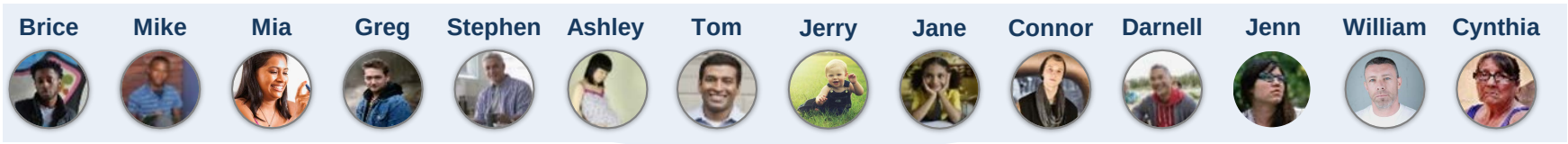


For high need members, IHHs:

- **Provide multi-faceted care co-ordination** (e.g., develop integrated care plan, engage member caregivers)
- **Address acute events** with referrals to specialists (e.g., crisis pregnancies with OB-GYNs) and demarcate respective care coordination responsibilities for duration
- **Collaborate with MCO care co-ordinator** as needed
- Co-ordinate care on long term basis for **their significant chronic conditions**
- May be able to directly provide **more of the needed services**

- **All high need members to be attributed to provider equipped to address their needs**
- **Any provider serving high need members should be capable of serving members with low of moderate needs**
- **Additional requirements are expected of IHHs serving members with high needs**

2 Integrated Health Homes will deliver improvements in care delivery across a range of areas



Managed Care Organizations

Enhanced access, screening, and assessment

Higher-needs population[1] | Lower-needs population[1]

Integrated Health Homes

Higher-intensity Integrated Health Homes

- Integrated care planning and monitoring
- Physical/ maternal health provider engagement
- Behavioral health provider engagement
- Population health management
- Member engagement and education
- Supportive service coordination

Lower intensity Integrated Health Homes

Reporting of quality and efficiency of care (i.e., member outcomes)

Payment streams, in response to Integrated Health Homes meeting requirements and improving outcomes

1 Actual tiering of intensity of care coordination may not be binary

2 IHHs achieve 6 main goals for members and families

Barriers to integrated care		Integrated care facilitated by IHH care coordination
Infrequent data sharing and communication between providers **Siloed care planning**	**Integrated care planning and monitoring**	Providers take **holistic view of health,** supplying full set of services appropriate to members' needs **Comprehensive care plans** developed with member and caregivers, supported by ongoing communication with behavioral and physical healthcare providers
Frequent barriers to attendance to medical appointments **Little continuity in care delivery** across providers	**Physical / maternal health provider engagement**	**Improved access** to providers for routine appointments and time-sensitive support Integrated experience with **seamless connections and communication across providers**
Frequent barriers to attendance to behavioral health appointments **Little continuity in care delivery** across providers	**Behavioral health provider engagement**	**Improved access** to providers for routine appointments and time-sensitive support (e.g., MCR) Integrated experience with **seamless connections and communication across providers**
Limited provider engagement with community supports in the care and recovery process (e.g., schools, Big Brothers/Sisters, AA)	**Supportive service coordination**	**Access to and collaboration with community supports** is prioritized (e.g., supported housing, employment, and services offered by agency partners) Member **needs are communicated to community partners**
Infrequent follow-ups and outreach to members and their caregivers (including foster families) **Reactive treatment programs**, with little emphasis on self-care, education, and social skill development	**Member engagement & education**	Support for **treatment and medication adherence** (e.g. Ritalin, MAT) Enhanced **social skills education, self-care, and engagement with supports** (e.g., child & family teams)
Providers take a **case-by-case view of population health** Member **focus determined based on episodes** Providers make **limited use of screening tools** (e.g., CANS, ANSA)	**Population health management**	Improved dialogue among providers **on quality outcomes across panel** Continuous **stratification of panel and use of standardized assessment processes to identify highest-needs members**

What should be added to these goals?

2 Meet Brice, a teenager with depression and multiple suicide attempts

ILLUSTRATIVE

How the system is set up for Brice today

- Brice is **16 years old**, lives at home, and is **Medicaid-eligible**
- Brice has major depressive disorder and has had **multiple suicide attempts**

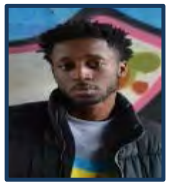
- Brice is linked in to a **community mental health** center who manages his behavioral health treatment and **coordinates his care** with his school psychologist and his primary care physician
- When Brice is actively suicidal he receives **crisis stabilization services from his CMHC** and, when necessary, they admit him for inpatient psychiatric care
- When Brice gets older, the agencies and providers involved in his care help him **transition into the adult system**

Health care pain points

- **Value**
  - Brice's physician does not adhere to a preferred drug list and **prescribes expensive**, non-generic anti-depressants
  - Brice's **utilization of inpatient treatment is not optimal**; he is often admitted unnecessarily or not admitted when it is necessary. When he is admitted, his length of stay is sometimes longer or shorter than necessary
- **Quality**
  - Brice is prescribed anti-depressants, but d**oes not receive evidence-based psychotherapy services** for his depression
  - His psychiatrist is not aware that Bryce uses alcohol and marijuana on weekends due to difficulty coordinating lab testing
- **Continuity**
  - Brice's inpatient psychiatrists **do not effectively communicate** with his CMHC to optimize his care during his inpatient stays
  - **Data is siloed**, so the prescribing CMHC physician is blind to other prescribers who may be providing care to Brice
  - Brice's school and church notice when he is more depressed, but are **not linked with his CMHC** to inform them of the change
- **Access**
  - When Brice turns 19 he loses his Medicaid eligibility and **does not sign up for health insurance**

2 For consideration: How should Brice's IHH deploy resources to help manage his changing level of need over time?

Level of need



- Brice is a 16 year old from Chicago with **major depression and suicidal ideation**
- Before joining an IHH, **Brice's conditions were not managed effectively or holistically**
- Since joining an IHH with the right capabilities to meet his changing needs, his care has been **better integrated, leading to improved outcomes for him**

1 Brice is admitted to an ED after expressing a strong desire to harm himself. The hospital alerts his MCO and IHH via ADT feeds. **Brice, his IHH, and the hospital create a discharge plan together**

2 On discharge, **the IHH updates Brice's care plan** (including his medication regimen), with input from him and clinical specialists. The IHH involves his Child and Family Team in **finding him a psychotherapist to help manage his depression**, with extended hours to reduce Brice's reliance on EDs

3 The IHH **secures Brice's parents' consent to share and gather medical data** from his social supports, like his pastor. Soon after, his pastor alerts the IHH that Brice may be experiencing a spike in his suicidal ideation. Brice's IHH immediately connects him with **crisis stabilization services**

4 Brice's IHH ensures he is **regularly screened for substance use**. On testing positive for marijuana, his nurse care coordinator provides education on substance abuse. As Brice approaches adulthood, **the IHH begins working with his family and social worker to make sure he retains Medicaid eligibility** and is able to continue his membership at the IHH

5 Brice's IHH is alerted that he has broken his leg. It begins preparation for a new discharge plan, and **seeks out physical therapists to help Brice recover from his injury**

Day 1 | Week 1 | Month 1 | Month 6 | Month 9

Which other clinical or supportive services should Brice's IHH prioritize connecting him with?

Meet Tom, an adult with alcohol and opioid use disorders and spent time in the correctional system

ILLUSTRATIVE

How the system is set up for Tom today

- Tom is 36 years old, **newly Medicaid eligible,** and lives in a friend's home
- Tom has **alcoholism and opioid use disorder as well as early signs of diabetes**
- Tom receives level **II substance use disorder treatment** from a local outpatient substance use disorder provider
- Tom gets **primary care services** from his local PCP; the clinic regularly screens him for diseases common in alcoholics and **coordinates his care** with his substance use disorder provider
- If Tom suffers an opioid overdose, EMS brings him to the **emergency room** where he is stabilized and discharged to a **withdrawal management treatment center**
- Tom's outpatient substance use disorder provider (level II) works with Tom's residential treatment providers to plan for a **safe discharge and transition**
- Tom may be eligible for Medication Assisted Treatment and may be evaluated by a trained physician/methadone provider
- Tom **may be eligible for Level III.5** care if he has difficulty staying sober; however he must sufficiently engage in withdrawal management before he will be allowed admission
- Tom has access to a variety of services to support him including **recovery homes and alcoholics anonymous**

Behavioral health pain points

- **Value**
  - Tom is at risk for losing his housing (his friend has given him one week to get off the couch); living on the street will likely exacerbate Tom's addictions eventually leading to **need for high intensity care**
  - Tom's alcoholism puts him **at risk for serious medical illnesses**, but he does not see his PCP so is not provided counseling or screening for these diseases; when they finally manifest they are severe and expensive
  - There is a shortage of withdrawal management programs for opiate addiction so **Tom must engage in withdrawal management in the expensive ED/acute care hospital**
- **Quality**
  - When Tom is drunk on the street and brought to the ED the providers discharge him when he is sober without offering him any substance use disorder recovery services
  - Tom **requires but does not receive testing for diabetes** and education on the disease and its treatment
- **Continuity**
  - Tom finally does go to an inpatient substance use disorder treatment facility, but is **discharged without a holistic array of recovery services like case management and job training,** leading to a quick relapse
- **Access**
  - Tom's addictions lead him to **avoid doctors** and so he does not seek medical treatment for his feet which he notices are slowly becoming numb; an early sign of diabetes
  - Tom sometimes stays in homeless shelters; **but he does not receive substance use disorder referrals** while there
  - Tom does not have access to transportation, causing him to frequently miss appointments
  - There is a **shortage of withdrawal management programs for opiate addiction** and Tom has trouble finding a place to stabilize so that he can become eligible for Level III.5 services

2 For consideration: After joining, Tom's IHH uses screenings to identify his unmet needs and engages social supports extensively

Level of need

- Tom is a 36 year old with **opioid use disorder, alcoholism, and early signs of diabetes** who is currently **staying on his friend's couch**
- He has **intermittent relationships with several providers** and was **not previously recognized as Medicaid eligible**
- He has been **admitted to an ED before** for substance use but has **continued to use and no one has followed-up**

1 Tom is **brought to an ED after being apprehended by the police for public intoxication** and is admitted for inpatient withdrawal management. The hospital and an MCO **recognize his eligibility for Medicaid and connect him with an Integrated Health Home** that is capable of serving his needs

2 Tom's Integrated Health Home immediately connects him to a **provider specializing in substance use disorders**. Additionally, his care coordinator orders a **series of appropriate screenings** for Tom, and tests for physical conditions commonly observed in alcoholics and opioid addicts, **resulting in a diagnosis of diabetes for which he is referred to an endocrinologist**

3 Tom's friend will no longer allow him to sleep on his couch. Tom has no other friends to turn to and is **suddenly homeless**. Feeling helpless, he considers turning to drugs. He calls his **substance use disorder provider, who asks Tom to visit and relays his housing difficulties to his care coordinator**. His care coordinator finds a **homeless shelter** for Tom to spend the night in, and puts him in touch with **supportive housing services**

4 Tom continues seeing his substance use provider and **begins to stabilize**. He expresses his desire to **return to the workforce**, and his care coordinator puts him in touch with **employment training and placement services**

5 Tom begins to notice **signs of hyperglycemia**. Rather than heading directly to the ED, he **contacts his care coordinator**, who is able to schedule him to see his PCP for immediate treatment. He is then scheduled for a **follow-up appointment with his endocrinologist** and is given **coaching on how to avoid future episodes**

Day 1 Week 1 | Month 1 | Month 6 | Month 9

3 Provider types under consideration for inclusion in the program vary depending on member need

	Members with low or moderate behavioral health needs	Members with high behavioral health needs	
	Physical health provider is lead entity ("PCP on steroids")	**Scenario 1: Behavioral health provider is lead entity[1]**	**Scenario 2: Physical health provider is lead entity[1]**
Eligible physical health provider types	▪ Primary care physicians ▪ Clinical practices or clinical group practices ▪ Rural health clinics ▪ Physicians and physician groups employed by hospitals ▪ Community health centers ▪ Federally qualified Health centers	▪ Any physical health provider type in accordance with the Health Home SPA default list ▪ Any other State-approved physical health provider type[2]	▪ The same set of physical health providers eligible to serve as IHHs for members with low or moderate behavioral health needs
Eligible behav-ioral health provider types	▪ Any behavioral health provider type in accordance with the Health Home SPA default list (e.g., community/behavioral health agencies) ▪ Any other provider type capable of serving members with moderate behavioral health needs (e.g., clinic within hospital)[2]	▪ Community mental health centers ▪ Other eligible specialty behavioral health provider types as approved by the State[2]	▪ Community mental health centers ▪ Other eligible specialty behavioral health provider types as approved by the State[2]

Are there additional provider types that should be explicitly included or excluded from consideration here?

1 With collaborative agreement in place with corresponding entity 2 Excludes e.g., psychiatric rehabilitation programs

3 Potential approaches to providing support

Type	Approach	Description
Capability building	Learning collab-orative	▪ Entity that supports regular discussions, exchanges of best practice, conversations on working effectively with Medicaid/MCOs, and networking/mentoring among IHH providers
	Coaching	▪ Training and technical support on workforce development, care coordination/ integration, and other topics central to IHH performance
	Pilots	▪ Disease-specific integration pilots to build a foundation for behavioral and physical health collaboration among relevant providers (e.g., diabetes and depression; non-opioid collaborative therapy etc.)
Infra-Struc-ture	Grant support	▪ Support grant applications to enhance provider infrastructure or capabilities (e.g., workflow or member data analysis software, telemedicine systems)
Program eligibility support	Readiness assessment	▪ Development of an IHH readiness assessment tool to evaluate processes that providers have in place and ability to perform integrated activities, permitting providers to baseline their capabilities and learn from best practice
	Outreach, support, & technical guidance	▪ Efforts spanning initial attempts to alert providers to existence of program and its benefits, through to targeted support and guidance through application process, e.g., through supplying draft text of collaborative agreement

What other forms of support should be offered to providers – and when?
What capabilities will providers require greatest help in developing?