NASADAD ANNUAL MEETING

Opioid Treatment Program Health Home Initiative

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Recognition of An Opportunity

New England's heroin problem

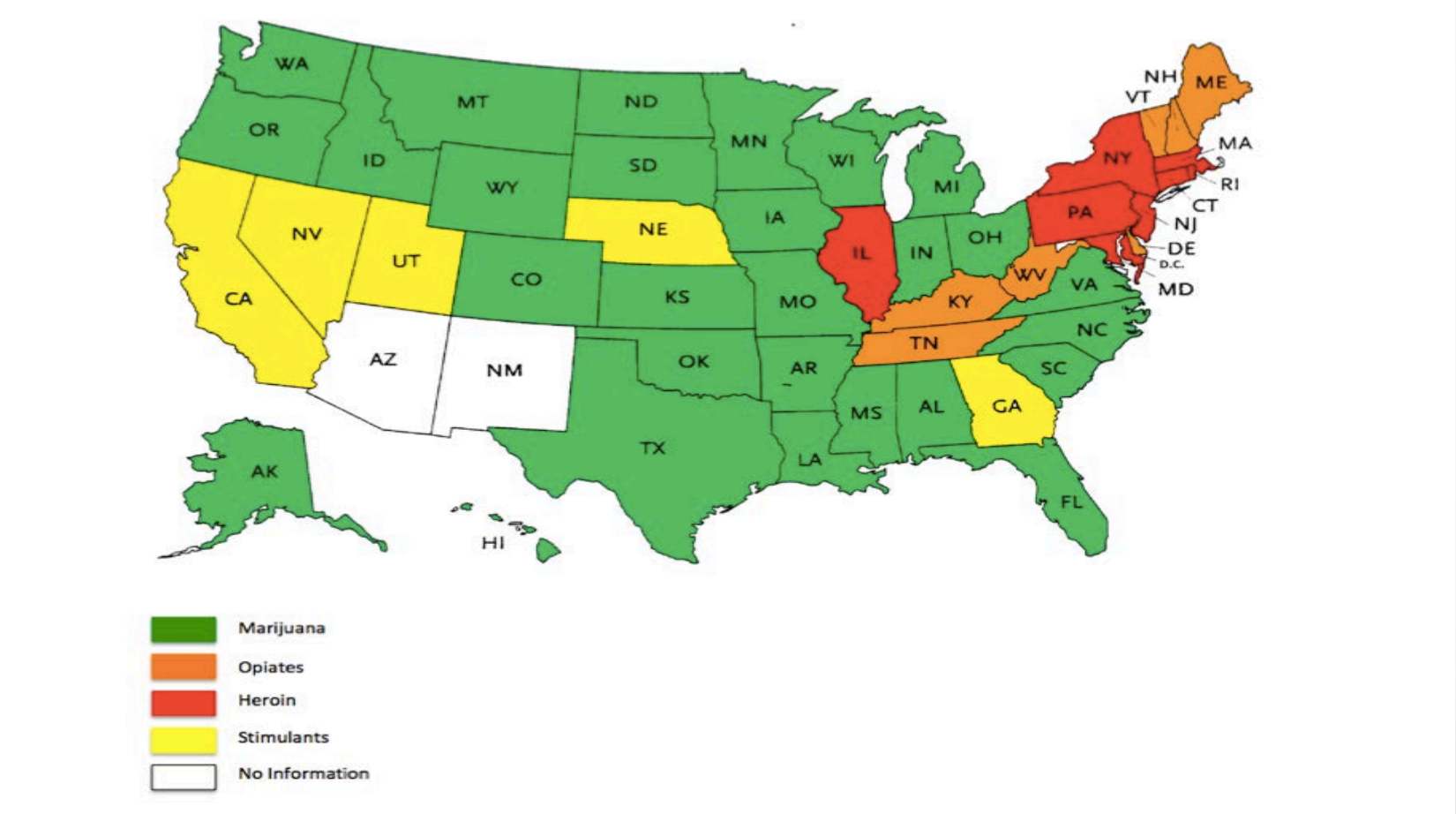
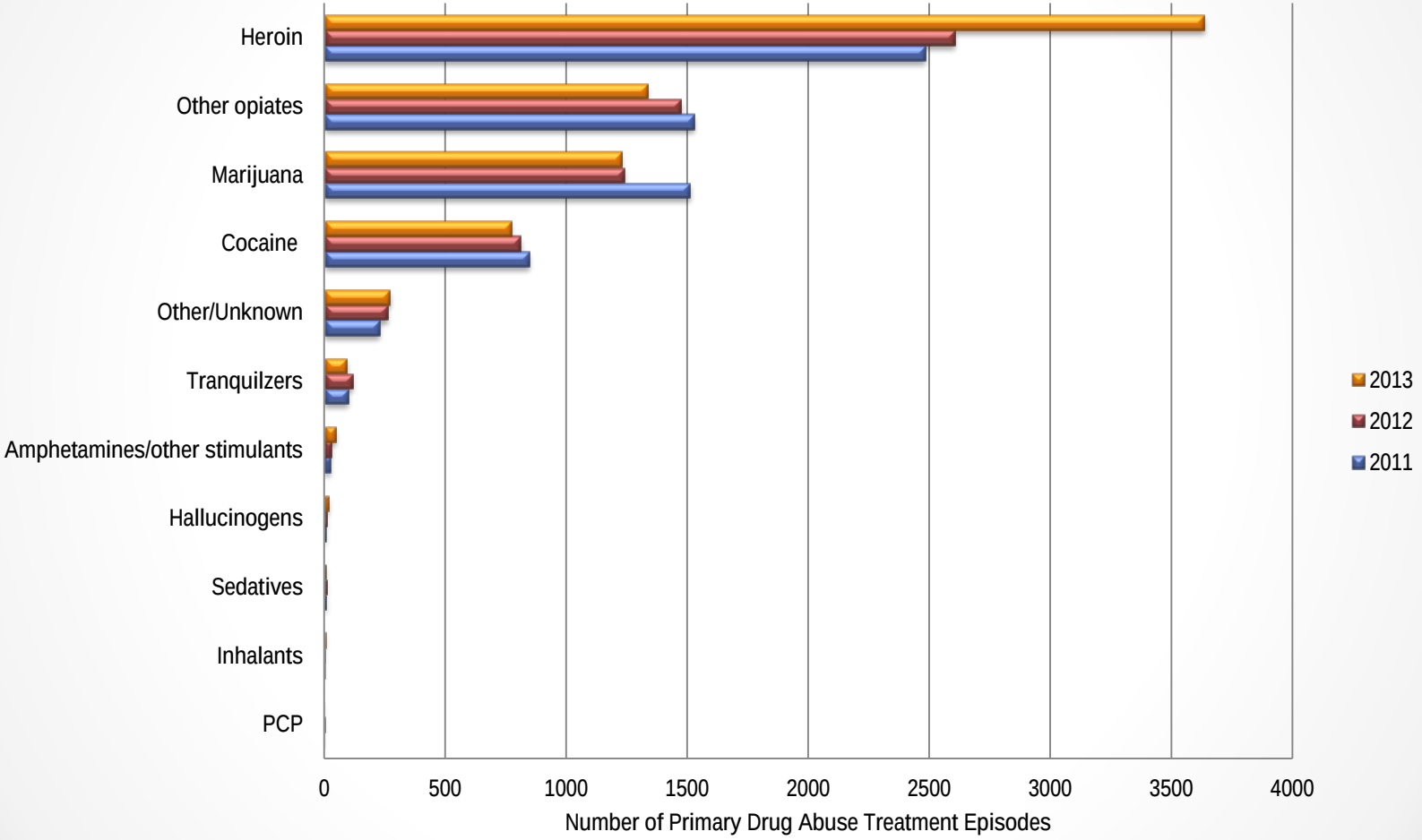


Image Credit: Fiona Breslin

RI Primary Drug Abuse Treatment Episodes, 2011-2013



SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS) 2011; National Survey of Substance Abuse Treatment Services (NSSATS), 2010

Health Homes: Recognition of An Opportunity

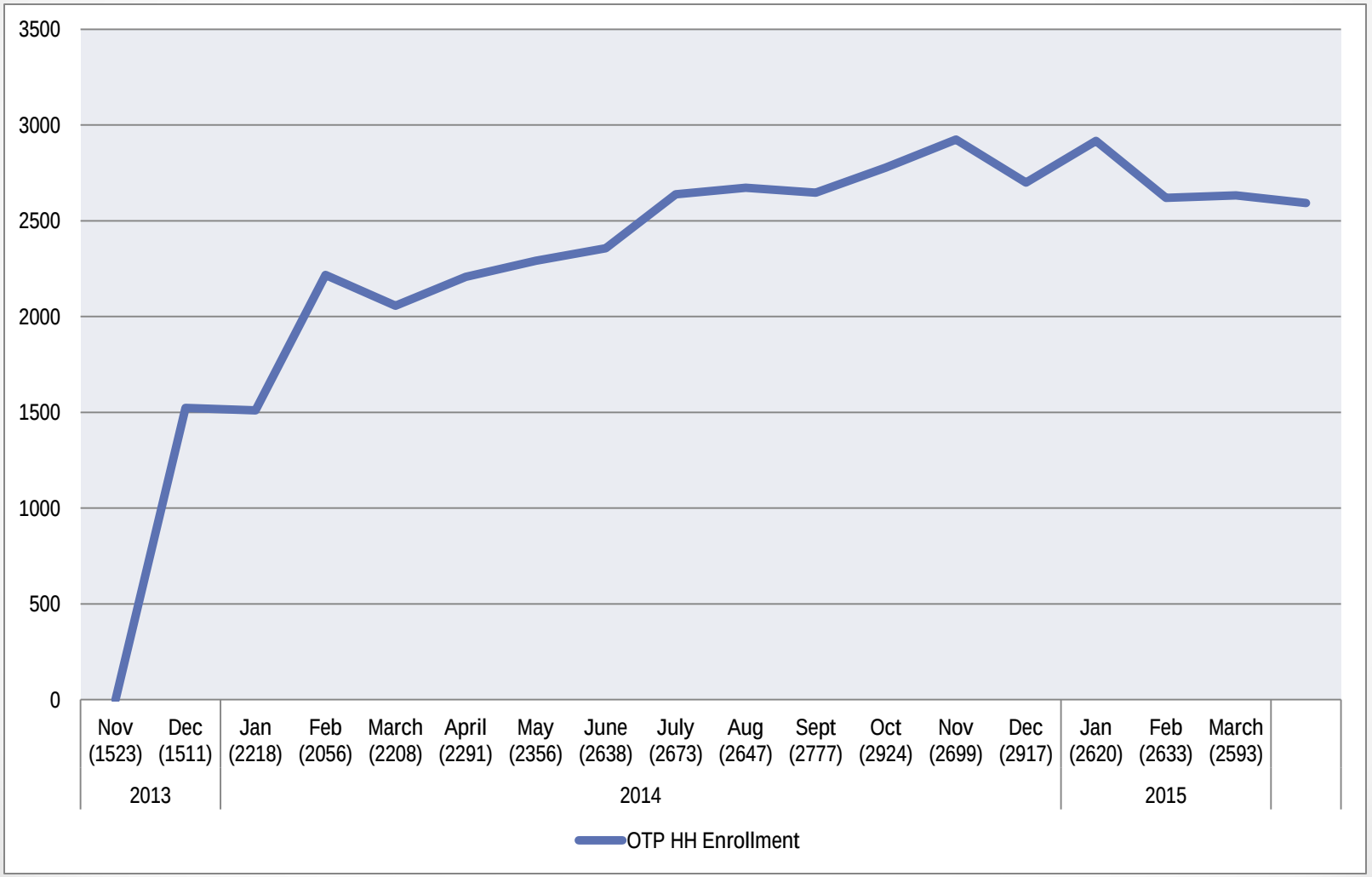
- Patients receiving MAT would benefit from care coordination
- Usually present with multiple comorbidities
- Often have poor connections for primary care, do not attend wellness appointments, and are not connected to necessary specialists
- Often fear stigma associated with MAT and substance use histories
- Alignment with goals of a recovery – oriented system of care

Coordination of Care

Who We Serve…

- The OTP Health Homes:
  - provide dedicated attention to patients with two or more chronic health conditions, or with one chronic condition and at risk for another
  - is free to Medicaid and RIteCare recipients who are currently receiving, or meet the criteria for MAT for opioid dependence and eligible to participate.
- Patients meeting criteria for MAT for opioid dependence and not eligible to participate in Health Homes are welcome. An assessment to determine level of services and limited case management services are provided.

OTP Health Home Patient Enrollment



The OTP Health Home Team

Qualifications	FTE
Master's Level Team Leader	1.00
Physician	0.25
Registered Nurse	1.00
Case Manager-Hospital Liaison	1.00
Case Manager	1.00
Pharmacist	0.10

Total of 4.35 FTEs/125 patients*

Programs share three collaborative positions

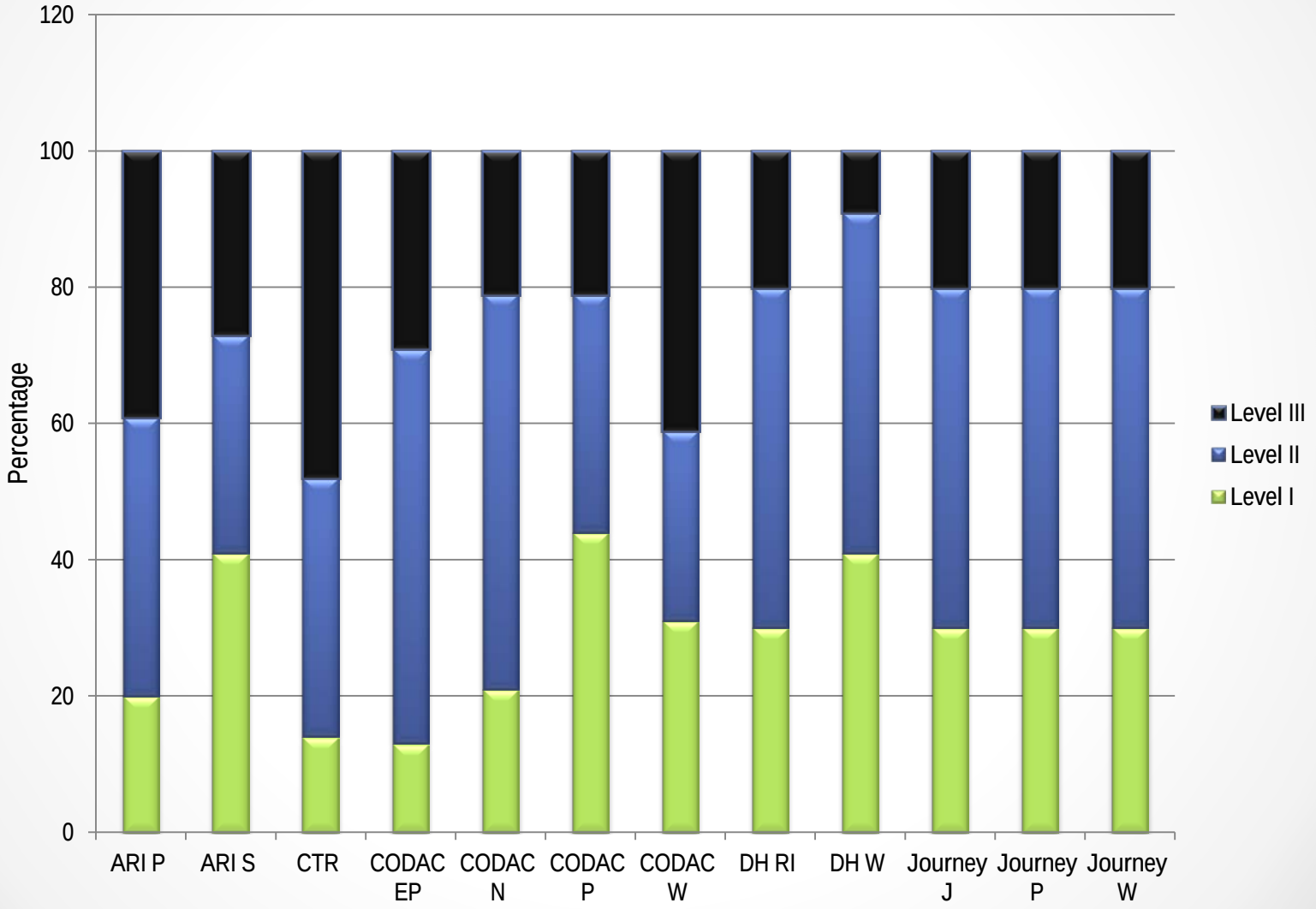
Administrative Level Coordinator	1.00
HIT Coordinator	0.50
Training Coordinator	0.50

* Number of patients vary secondary to acuity levels

Patient Acuity Levels

Level I	Level II	Level II
Low Risk Practice healthy behaviors Involved with primary care **Moderate Risk** Borderline results from blood analysis Not consistent with practicing healthy behaviors Focus: Prevention, maintenance Activities: Individual coaching; group participation, wellness promotion activities, etc.	**High Risk** Blood analysis indicates development of disease process Participate in high risk behaviors (smoking, high caloric intake, etc.) High utilizers of resources (ED visits, missed appointments, etc.) Focus: Refer to appropriate provider(s), prevent further progression of disease process, reduce high risk behaviors, etc. Activities: Case management activities including referrals, transition to needed level of care when appropriate, monitor medication adherence, engage family and/or community support services etc.	**Chronic Conditions** Involvement with primary and/or specialty care Disease process requires community supportive programming and/or assistance Focus: Maintain or improve level of functioning Activities: Monitoring and re-evaluating patient needs to ensure they are being met, monitor medication adherence, coordination of care with health care providers, etc.

Patient Acuity Levels



Highlights

- Successful implementation of Health Homes in 12 clinics across the state
- 21 Health Home Teams providing services to more than 2,600 patients
- Employed 59 full-time and 3 part-time staff
- Overlay of patient acuity model allowing Health Home teams to better address patients needs
- Development of collaborative relationships with Neighborhood Health Plan of RI, CMHOs, CHCs, Recovery Services, private practitioners, etc.
- Creation of an OTP Health Home Database
- Development of a state-wide educational and consultative network
- Professional development activities
- Clinic-based pilot programs (i.e., acupuncture, home visits, NHP teams monthly meetings with HH teams, etc.)

Implementation Experience

- Pre-arrange MOUs, Qualified Service Agreements, etc. with community agencies , hospitals, managed care organizations, etc.
- Develop standardized forms, policies, guidance, etc.
- Identify and/or develop reporting systems needed for outcomes, payment and patient tracking
- Provide education to existing and new staff including clarification of roles, team building activities, expectations, responsibilities, etc.
- Address EMR and re-disclosure issues – HIPPA and Confidentiality Regulations
- Communication is essential especially to the community at large
- Understanding the importance of team building activities

Opportunities for Continued Growth

- Workforce recruitment , training, and retention
- Patient engagement strategies
- Addressing Stigma
- Establish and/or enhance bi-directional communication and screening, assessment and referral processes with community based primary care physicians through strategic partnerships
- Work toward developing unified strategies among all providers to drive positive patient outcomes
- Examine opportunities for co-location and/or integration with mental health and/or primary care (i.e., partner to extend case management services, etc.)

PATIENT SATISFACTION SURVEY RESULTS

Table 3.1. Sample Percentages and Patient Ratings Reflective of Level of Patient Agreement Relating to Health Home Experience, Patient Satisfaction Survey, 2014

Strongly Agree	Agree	Neither Agree, Nor Disagree	Disagree	Strongly Disagree
The Health Home staff has an understanding of my health care needs and successfully coordinates care with my other healthcare providers.				
54.5%	**37.5%**	6.7%	0.8%	0.5%
The Health Home staff sees me as a whole person and addresses multiple needs when necessary.				
59.9%	**34.4%**	5.0%	0.5%	0.2%
I feel the Health Home staff helped me obtain information I needed so that I could take charge of managing my health and/or illness.				
56.6%	**36.1%**	6.4%	0.8%	0.2%

What patients are saying

I love this clinic and Love Health homecare! I love the people that work here :) Thank you for the support you have given me!!

I have a lot of help with getting important appointments made and have had help with finding a new Dr.

I utilize health homes to the fullest that I can. They have helped me a lot with a lot of stuff since I have started coming to XXXX. I benefit from health homes so much. I would honestly be disappointed if those services were no longer available.

ADHD HH Team went through a considerable amount of extra effort to get my obama health insurance for me. If they didn't do what they did, I would have paid or had to detox.

I would love them to stay in this program, I have been more thinking about my well being now that I am in this program. Please keep up the good work- Thank you for caring about me