AN INTEGRATED MODEL OF PRIMARY HEALTH CARE – THE DEVELOPMENTAL DISABILITIES HEALTH HOME

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PURPOSE

- Describe a community-based model of health care delivery for persons with intellectual and developmental disabilities, the DD Health Home
- Explore the background, operation and outcomes associated with this model
- Provide a rational for service integration including the integration of acute and long term care

REDESIGNING HEALTH CARE: THE TRIPLE AIM

- Improve the individual experience of care
- Improve the health of populations
- Reduce per capita costs of care for populations

(Berwick, Nolan and Whittington, 2008)

HOW TO ACHIEVE THE TRIPLE AIM IN DEVELOPMENTAL DISABILITIES

- Dissolve silos/integrate care
- Encourage research/evidence
- Incentivize desired provider behavior through payment reform

EVOLUTION OF THE DEVELOPMENTAL DISABILITIES HEALTH HOME

- Willowbrook/NVTC/MA: Institutional-Based Consultation Services (1980 to Present)
- The Morristown Model: Subsidized/Safety Net (1990 to Present)
- Developmental Disabilities Health Alliance: Market-Based (2000 to Present)

THE DEVELOPMENTAL DISABILITIES HEALTH HOME

- Multiple services and supports are population-based, integrated and unified
- Services and supports are comprehensive –access to health and mental health services, behavioral supports, or other ancillary services as well as specialty care, habilitation supports, or other services
- Services and supports are accessible and provided in natural environments in the community

CLINICAL VIGNETTE

- 50 year old woman with Down syndrome, obesity, DM-2, hypertension, and depression presents with change in behavior (unwillingness to attend day program)
- She takes Metformin, Zoloft, and a blood pressure medication
- A low dose of Risperdal was recently added by a psychiatrist
- A neurologist recommends adding Aricept

IMPLEMENTING THE DEVELOPMENTAL DISABILITIES HEALTH HOME

- Payment Reform – FFS v Capitation
- Service Integration – PC, MH, SZ, Supports
- Reengineered care practices
- Change in patient behavior

PAYMENT REFORM

- FFS – Payments for individual services. Leads to increased # visits, shorter visits, excess utilization and unbundling

- Capitation – A single monthly payment which provides financial support for all covered services. Leads to more comprehensive care. Supports preventive care, less visits, longer visits, bundling, larger practices due to risk (scale)

SERVICE INTEGRATION

- Separate provision of primary care, mental health, and specialty medical care – difficult to coordinate
- Co-located services – internal silos
- Integration of service with cross-training primary care providers
- Interdisciplinary care w/support services

RE-ENGINEERED PRACTICES

- Teams of Nurse Practitioners/Physicians
- Case Loads: 250 vs 2000
- Visits/Year: 1000 to 1500 vs 6000 to 8000
- Visit Length: 50 vs 8 minutes
- Care Coordination: 10 – 15 hours per week
- Same Day Availability
- 24/7/365 Coverage
- ADA Accommodations

CHANGES IN BEHAVIOR

- Identify customer – family, sponsor, group home, case manager
- Contact PCP for all concerns
- Improve service utilization

DDHA OUTCOMES OF CARE

- Dental care and Down Syndrome
- Cardiac/Thyroid care and Down Syndrome
- Immunization rates
- Diagnosis and treatment of mood disorders
- Use of psychotropic medication
- Medication side effects

DDHA OUTCOMES OF CARE

- Nutrition/Gastrostomy Tubes/Pneumonia
- Mortality studies
- Practice guidelines/standards
- ER/Hospital utilization patterns
- Cost patterns/savings
- Satisfaction/Quality

COST STUDIES (CO-LOCATED MODEL)

- Reduced length of by 22.7% (2 to 3 days) Reduced inpatient cost 22.5% to 33.2% (Criscione et al., 1993)
- Reduced number of multiple admissions from 34% to 14% by 22.7% (Criscione et al., 1995)
- Slowed increase in care costs over a decade (43% vs 97% in general pop and 125% in DD pop) (Walsh et. al., 1997)

DDHA OUTCOMES OF CARE COST STUDIES

- Global reduction in Medicaid Managed Care costs: HBR 75% vs 102%
- Annual ER visits: 2.05 vs 6.59 (Danielle's Law)
- Annual inpatient admissions: 0.43 vs 1.29 (crisis response system)

MAJOR CAUSES OF INSTITUTIONALIZATION

- Lack of access to primary care
- Lack of access to mental health services
- Lack of access to behavioral services
- Lack of access to accessible housing (Apgar et. al., 2008)

OPPORTUNITIES FOR IMPROVEMENT

- Integrating primary care, care management and chronic disease management
- Integrating psychiatry and neurology
- Integrating acute care and habilitative/long term care

REFERENCES

- “Health Care for Individuals with Intellectual and Developmental Disabilities: An Integrated DD Health Home Model,” Kastner and Walsh, International Review of Research in Developmental Disabilities, Robert Hodapp, Editor. Academic Press. New York. 2012 Vol. 43: Pages 1-40.

REFERENCES

- CMS Center for Medicare and Medicaid Innovation (CMMI)
- www.innovations.cms/gov
- Affordable Care Act:
  - Bundled Payment Initiatives
  - Shared Savings Initiatives
  - ACO Initiatives
  - Health Care Innovation Challenge