inSocialWork Podcast Series

Episode 102 - Bruce Nisbet, LMSW: Health Homes: A Virtual Home of Care Coordination for Medicaid Enrollees with Chronic Conditions

[00:00:08] Welcome to living proof a podcast series of the University at Buffalo School of Social Work at www.socialwork.buffalo.edu. We're glad you could join us today. The series Living Proof examines social work research and practice that makes a difference in people's lives. I'm your host Adjoa Robinson and I'd like to take a moment to address you our regular listeners. We know you have enjoyed our podcasts as evidenced by the more than 250000 downloads to date thanks to all of you. We'd like to know what value you have found in the podcast. We'd like to hear from all of you practitioners researchers students but especially our listeners who are social work educators. How are you using the podcast in your classrooms. Just go to our Web site at www.socialwork.buffalo.edu/podcasts and click on the contact us tab. Again thanks for listening and we look forward to hearing from you hi from Buffalo. After a recent trip to Frank Lloyd Wright's falling water in Pennsylvania wanted to remind you that Buffalo is home to a number of the Master Architects works including three private residences the lakefront gray cliffs the state and our local jewel the Darwin Martin House complex considered Wright's finest Prairie Style Design and ranking with falling water and the Guggenheim as his finest works. I'm Peter Sobota our guest for this episode is Bruce Nisbet president and CEO of spectrum Human Services a private non-profit community health organization that provides services in the Erie and Wyoming counties of western New York.

[00:02:06] Spectrum provides a wide range of services including the treatment and rehabilitation of psychiatric disability psychological problems and substance related disorders. Spectrum offers mental and behavioral health programs for adults adolescents children and families. Mr. Nisbet discusses his agency's involvement with Health Homes Medicaid health home program that provides integrated and coordinated services to people in the community who have serious and persistent mental illness or two or more physical health conditions. Mr. Nisbet describes the inception of the program as well as the needs the program hopes to address while meeting the challenging demands of a tight fiscal service delivery environment. Mr. Nisbet describes the rationale for the health program including the role that the federal Affordable Healthcare Act played in its inception. Mr. Nisbet notes that the Health Homes are not a physical place but a program of Intensive Care Coordination for individuals provided through a network of providers whose mission is to improve the coordination delivery and communication of all of patients services and providers to maximize the positive outcomes and efficiencies Mr. Nisbet goes on to discuss this program's relevance and implications for social work education and practice. The impact on an agency staff implementing such a program and the impact on the social service system in a particular community. Our guest concludes by describing what he believes could be a broader application of this model in the health care delivery system. Bruce Nisbet is an alum of the School of Social Work and research associate at the Buffalo Center for Social Research here at UB. Mr. Nisbet spoke with our own Dr. Catherine Dulmus associate professor and associate dean for research again here at UB.

[00:04:08] Hello my name is Catherine Dulmus I'm an associate professor and associate dean for research and director of the Buffalo Center for Social Research here in the School of Social Work at the University at Buffalo. And today I have Bruce Nisbet this president CEO aspect of human services in Orchard Park New York. Here with me to talk about health homes. Welcome. Bruce thank you for coming today. Thank you Catherine. I'm really excited to learn the spectrum Human Services has been designated a health home here in the Buffalo New York area. Wondering if you could share with us a little bit about what that means and how that's going to impact practice in the New York State area related to persons with serious and persistent mental illness. Well we're very

excited to have them designated by the New York State Department of Health as a Medicaid health home here in Erie County New York. And let me go back and try and explain what a Medicaid health home is and a little bit where it came from. Back when the Affordable Care Act was passed it included provisions that allowed states to apply to the Center for Medicaid services CMS on a federal level to implement Medicaid health homes within a state. And the Affordable Care Act provided incentives to states to do so in that when they did get permission to establish Medicaid health homes and to implement them from the time they were implemented the state would get instead of their typical close to 50 percent reimbursement on average from the federal government for Medicaid costs. The reimbursement would jump to 90 percent for a two year period.

[00:05:54] So from a financial point of view this certainly is extremely attractive to states who are obviously struggling with their budgets and particularly struggling with the costs of providing Medicaid recipients with the services that they need. So this is federally driven federally driven out of the Affordable Care Act. Now at the heart of why the federal government is promoting Medicaid health homes is that on a national basis and this is also true in New York state. About 20 percent of Medicaid recipients are those recipients whose costs drive about 60 percent of the costs. And the reason for that that these 20 percent of recipients for Medicaid typically are individuals who might have serious and persistent mental illness or chemical dependency needs other chronic health conditions that are physically based such as diabetes or heart disease. And these 20 percent of individuals are those who are least connected to outpatient preventive services whether they be primary care. These are folks that typically don't have a primary care physician. These are folks that if they have mental health or chemical dependency needs who are not connected to outpatient behavioral health services and instead they are really getting any type of medical care that occurs on an emergency basis through emergency rooms and going to emergency rooms to get care or going into the hospital either on a physical basis in terms of heart disease diabetes or other physical emergencies or a mental health or chemical dependency emergency. So what's been recognized and demonstration projects previously and spectrum was actually part of one here in New York state is that if you can provide intensive care coordination of an individual's needs in terms of chronic health conditions linked them to outpatient services and support them and actually following through on those services you can improve the quality of their wellness dramatically you can improve their quality of life.

[00:08:11] And from our point of view secondarily reduce costs significantly that are driven initially by the fact that there is no quality preventive care going on for the individual. Well I think I've already learned something new because I think I was under the understanding that health homes were just for persons on Medicaid who had a serious of persistent mental illness. That sounds like it's beyond that. It is the qualifications under the federal law are either serious and persistent mental illness by itself as a chronic health condition or two or more chronic physical health conditions or a combination of a serious and persistent illness with a chemical dependency addiction or to chronic or more physical health with a chemical dependency addiction. So it broadens the numbers here in New York State. There are about five point four million people who receive Medicaid services who are eligible for Medicaid and on Medicaid. Of that five point four million. About 750000 individuals are eligible under those qualifications that I just talked about serious persistent mental illness two or more chronic conditions physical health wise. About 750000 are eligible to be enrolled and health homes. And here in this particular county of the state there is about 46000 individuals eligible to be served in a health home a health home is not a physical place.

[00:09:42] It is a program that provides intensive care coordination for individuals and has developed a network of providers who have agreed to provide two major elements expedited access to services and secondly to participate in utilizing a care plan that is available to each of the providers who might work with an individual so the individuals getting outpatient behavioral health and as a primary care physician then that care plan would be available to both electronically. And it

is one that is updated regularly by both and used as part of a coordination vehicle so that the left hand knows what the right hand is doing and vice versa. So we as a health home need to provide care coordination to enrollees to do an assessment of what their needs are and those domains include not just physical health and behavioral health but also housing and social services because housing and social services typically are areas that contribute to the instability of many of these folks lives. And so we work not only on stabilizing their physical health and also their behavioral health but looking to food in our network housing providers and social service agencies to help deal with housing and financial needs that are often part of reasons why folks care is so fractured. So together we work with an identified network and we look to move the person forward from what is sort of a crisis style of getting care to one that's planful and preventive. And what this approach has been shown to do is to dramatically improve the wellness for these individuals who are enrolled and at the same time improve the quality of their life from the viewpoint that they're able to actually be able to have some stability in their lives. And then thirdly it does lower costs on average about 30 percent for our experience and the demonstration kinds of projects that we've been involved in. So we think it's exactly the right thing to do.

[00:12:00] We think it will be something that here in New York not only in this county is it being rolled out but it's already been rolled out as of January 1st down in New York City area and some adjoining counties can going up the eastern part of the state. The state is rolling this out in phases. Erie County that we're in was in phase two along with maybe about 12 other counties and now there's the upcoming phase 3 where we're applying to be a health home and to other adjoining counties that we provide services also. So we hope to be providing services in Erie Niagara and Wyoming counties where we provide behavioral health services also. Now I can just interrupt for a moment. Is New York state the first state to have held homes or is this something that's that are out there. Well I know it's one of the first in the country. I think there have been three other states that were approved ahead of New York but New York is the first state to include serious and persistent mental illness in its health home model. The other three states to my knowledge have focused solely chronic physical health. So two or more chronic physical health needs are certainly part of the federal qualification also and those states have chosen to focus in that area. But New York was the first to my knowledge that included the serious and persistent mental illness component as a qualifier and isn't serving that population. And they're planning to go forward even further. That is during the course of this year there's about 55000 individuals and again the initial health home is all for adults 85000 individuals who have developmental disabilities who also qualify for health home based type chronic physical health conditions.

[00:13:50] And then also there's about 230000 individuals in long term care. So they're intending to create specialized health homes for the developmentally disabled population who qualify and also for the individuals who are in long term care because again these are portions of those populations who are not well connected to preventive or wraparound services and therefore utilizing an awful lot of emergency room care that's preventable or inpatient hospitalization this preventable or inpatient rehospitalization within 30 days. So all of this has been shown to be able to be addressed and improved upon by using a health home model. Sounds like a win win but better outcomes ultimately for clients customers as well as the cost reduction for the state and the federal government overall. Absolutely. And that's what makes it to us be the exactly the right thing to do because it is a win win particularly for the consumers. And I think that it also means and is reflective of what's occurring on a national basis which is focusing on reconnecting the head to the body in terms of integrating behavioral health and physical health in a way that really treats the whole person. And I think from a perspective of it as a social worker myself I'm thinking about social work education for example in social work practice. Clearly the whole field of service delivery is moving toward integration of behavioral and physical health.

[00:15:28] I think that speaks to them from an education point of view that master's programs for

social work for example or BMW programs that there needs to be a very strong emphasis on helping to educate future practitioners around the interface of physical and mental health their chemical dependency needs in a way that they should expect that their practice experience going forward. And what organizations are going to expect of them is to have their work embrace supporting the individual as a whole person physically in terms of mental health or chemical dependency and a unified kind of way. You know as a side note we're integrating a number of our mental health chemical dependency clinics that are freestanding into primary care clinics so that it increases access it reduces stigma because folks when they go to an appointment they're going to go to their doctor's office and it enhances the outcomes because we're able to integrate the chemical dependency or behavioral health mental health treatment with the physical health side of treatment. And this is both for adults and children. So that's a simple example of how that is going to be working and Health Homes are the broader example of how the practice is moving in that whole direction of integration we in order to provide the service that's needed in terms of physical health and behavioral health we have expertise spectrum in the whole behavioral health area that is chemical dependency clinics outpatient now health clinics other kinds of mental health and chemical dependency programs. And we've been doing so for 35 plus years. We are looking at this health home opportunity recognize that we also need to integrate physical health expertise into our health home model.

[00:17:23] So we reached out locally here to partner with the Catholic Health System who has been one of the most progressive medical systems in the state and in some ways the country in terms of embedding into their primary care practices nurse care coordinators who focus on disease management for chronic heart disease diabetes and they were closely to with those patients that have those conditions to support them following through on treatment and they get great outcomes and looking at their whole disease management expertise and their analytics expertise in terms of being able to evaluate medical testing and so forth. We felt that we needed to look to partner with some expertise along that way and then we also partnered with another organization who has expertise in treating as well as care coordination for individuals who are HIV positive which is another subgroup of health home enrollee populations. So if I can just pause for a moment. So the hellhound you're a partnership between yourself and Catholic health and the other Evergreen Medical services related to HIV expertise. That's quite a powerful partnership of expertise. Well we think so we think it really positions us to be able to offer the kind of comprehensive expertise. Folks who will be enrolled with us really need and deserve and in that partnership we did so by forming actually a new corporation called Health home partners of western New York LLC a limited liability company which will become not for profit also and through that formal partnership then we are able to wrap and integrate our expertise around the needs of individuals enrolled in our health home program and along with that we have a network of 50 providers besides Catholic Health here in Erie County that include other hospital systems includes primary care practices includes housing providers social services providers and all together we have about three thousand one hundred individual licensed practitioners who are in this network that we can connect and link and follow with coordination of services across virtually every specialty.

[00:19:47] And that's part of the responsibility of a health home is to develop those linkages develop those relationships and then coordinate them effectively so that they go forward and we're obligated we have an accountability to the state to achieve certain outcomes having to do with avoidance of unnecessary emergency room presentations. Avoidance of unnecessary inpatient admissions avoidance of unnecessary readmissions to inpatient along with certain other kinds of measures for physical health that have to do with diabetes or chronic disease which are the two predominant chronic physical health conditions. So we have a lot of obligation to make sure that we're not just providing a service and it's not the quantity of service we provide. It is really the effectiveness of the services we provide and what kind of outcomes are we getting and this is all being tracked through the Medicaid data system. We receive Medicaid data that shows that

utilization in those state tracks it and will compare our outcomes against the outcomes of other health homes. So you need to be one that. And if you don't meet those outcomes and you chronically do so in terms of not meeting them then in a relatively short time you will no longer be a health home. So in this case it's performance that counts. It sounds like you have taken a lot as the help from up and running yet or is that in every stages. Well we were designated as a health home as of about a month ago. We've been certainly working together with our partners in establishing all the various work processes assessment systems and also the electronic exchange of data.

[00:21:30] We're expecting within the next two to three weeks to start receiving listserver and rollies and then we have three months to track down enrollees rollies because in many cases these folks last known address is not necessarily what's recorded with Medicaid so we have three months to track them down. It is a voluntary program so individuals have to agree to be part of that. But in our demonstration experience if we can find individuals they welcome the additional help because this has been a source of tremendous strain and difficulty for them in terms of getting good quality preventive care and we can help make that happen so we can help them with housing issues we can help them with social services issues. It's a win win for the consumer. So it sounds to me like the train has left the station and this is the direction practices going. Absolutely. And I think that it will continue to move in this direction. And I think that not just in New York going across the country. This is the national. This is the whole national focus. And I think that as the next year goes forward there is going to be and I think there's a number of additional states who are put in applications with the Center for Medicaid services to be approved to initiate Health Homes. I think the majority of states are going to adopt this approach. And I think that the coordination the effective coordination of services integrated and wrapped around individuals with high needs and chronic health conditions has been proven to be a highly effective approach to those outcomes of improving wellness improving quality of life reducing costs and it's going to be something that will be absolutely embraced I think on a on a broad basis across the country.

[00:23:24] How do you think it's going to impact your workforce and your agency. Well I think that we're going to need to we do a Care Coordination Program with about 300 individuals that have serious and persistent mental illness. We employ approximately 20 care coordinators. The portion there are three health homes that were designated in this county for an initial population of about 46000 people on average you're going to be working with our caseload of about 88 individuals some who were given an acuity of low need which means its telephone touches and reminders and they can function that way well as long as they are well connected some at a mid range of need and some in a high range of need. So we're anticipating and have the capacity to serve up to 20000 individuals. And so we'll be adding as time goes on a significant number of additional care coordinators who would be a mix of Bashu disagree and some work master's degree in social work some LPN some friends. And so we expect that over time we review any significant way to our workforce. It sounds like a perfect type of position for social workers. There were educated and trained in case management and the Care Coordination model really is case management in this true social work sense. So this might be a real job opportunity for social workers. Absolutely.

[00:24:51] And it's certainly very consistent with the whole history of social work around advocacy because as a care coordinator you're working to really advocate access for individuals to services in the community which are typically difficult for them to get and to advocate for the quality of those services to be at a high level that would be consistent with what we would want for our most cherished loved ones. So it's an opportunity to really impact lives significantly and we know people with serious and persistent mental illness die on average 25 years earlier than those who do not have serious and persistent mental illness so there's a real opportunity not only quality of health but also the length of life to significantly impact on them. That does caused me to stop and think for a moment about really the potential for a significant impact in the lives of these individuals. You've spoken a little bit about how it's going to impact like the agency level and certainly how the

potential for impacting the lives of these individuals. How do you think it's going to impact the social service system within the community. Well I think that it's going to impact by virtue of the fact that as health homes are required to develop and implement electronic methods of exchanging care plans between providers. And that's been a big gap in the community in terms of electronic medical electronic medical records and getting them to be able to talk to each other. And in this case the vehicle for doing that would be sort of an intermediary software that is available out there and in fact is being increasingly developed as a way in which to bridge differences between one electronic medical records system and a different one. So this is going to promote movement forward of getting toward the exchange of health information whether it be medical physical health or behavioral help with permission from the consumer.

[00:26:56] We have to give consent as always in these kinds of situations but with permission to exchange that kind of information in a way that is real time and can actually be useful in coordinating treatment. Right now there are these silos whereby you have your primary care physicians don't necessarily know what the mental health clinician is doing or the psychiatrist in our clinic is doing in terms of medications and vice versa with the primary care. If there are specialists involved typically there are again huge gaps in communication there or knowing that an individual has just gotten into a new housing situation and how that housing provider could potentially be helpful in terms of working together with the other providers also. So I think what's going to happen is that you're going to see a reduction over time and hopefully it's going to be a significant reduction in. Well essentially is the disjointed and siloed like provision of services to folks where communication is only sporadic and often the left hand in the right hand don't know what they're doing. There's duplication of services and a lack of effectiveness that has to do with a lack of coordination. So I think the whole system at a local regional and national level is working toward this not only integration of services related to behavioral and physical health but the integration of the whole delivery of service in a more seamless manner. A couple thoughts I've had is this sounds like a model that would be good for anybody. Rather they have a serious mental illness or not. And I wonder do you see the system moving in that direction that they'll be and help powerless for individuals whether they have chronic health conditions or not going forward. Well there's been some steps in that direction.

[00:28:49] I think people have heard of medical homes and many practices private or private primary care practices have sought out and obtained a certification as a medical home and getting that certification. They have to show increasing evidence of how they are integrating not only the physical health services for an individual but also if a person needs behavioral health services that those services are assessable in a more seamless way. And that's one reason why primary care practices are very receptive to the idea such as what we're doing with spectrum of reaching out and saying why don't we look at leasing some space within your primary care practice space to put up a satellite clinic. Behavioral Health Mental Health Chemical Dependency and then integrate the way which we communicate with each other within the practice that serves their patients well. And it also helps them to qualify for this medical home status and they get additional reimbursement from each MOS and from the insurance companies for achieving that certification because they're showing it more wraparound approach. So in that sense there are many examples of what a HealthOne is and it's the hope for the general population population. Right. And another thought that I had is that it sounds to me if this is done which I'm sure spectrum in your partners will do very well but that it's really going to drive down the need for education that's both at the psychiatric level and it just will help level. Wondered if you might speak to about that.

[00:30:32] Well I think that that is in fact one of the goals with regards to reducing costs that they certainly there are always be a need for inpatient physical health beds and mental health that chemical dependency beds. But if the utilization is reduced as a result of that or preventative care then yes there's going to be a reduction in the need for the number of beds in those areas. And I

think what that means for hospitals and they've been doing this already is that they're trying to more and more shift services to include more and more outpatient treatment approaches that are an alternative to inpatient and that's a function partially of caps on reimbursement for numbers of days. People can stay inpatient as well as the recognition that there are perhaps better ways in which to treat certain conditions but certainly that someone's having a heart attack may need to be in a hospital in intensive care. But there will be ultimately I think a significant impact on the number of beds needed to serve the community where these hospitals are if were effective with both the health home but also the medical home we just talked about for the general public. In closing I can't help but think about what the health care model means for persons with serious and persistent mental illness from a recovery perspective. I wonder if you can kind of closing speak to how this might promote recovery for individuals. Well I think that it has a very powerful opportunity in terms of promoting recovery. If people's lives are chaotic if they are struggling with serious health conditions struggling with a lack of housing that's stable with their lives overall are chaotic then to be thinking about where they would like their lives to go in a more positive direction.

[00:32:31] What kinds of ways that they would like to be able to impact on the quality of their own life. What goals you want to set. That's pretty hard to do. So by helping to provide some quality of preventive services improve health improves stability in terms of housing social services. It really frees up the person to begin to think about more than just sort of survival but really where is it that I want to go and what does my recovery look like from my perspective. What's going to be impacting my quality of life. It has to do with family. It has to do with work has to do with areas that I can be part of that community that maybe I've lost out on being part of. So I think it really does create a platform of a basis in which to really begin to seriously think about ways that we can support a person's goals for recovery. Because they have now a healthier more stable basis in which to free up some energy to do that. Thank you very much Bruce for stopping by and having this conversation with me and congratulations again on spectrums designation as a help here in New York State and perhaps down the road once it's up and running and you have some additional outcomes as his success. I can invite you back for another podcast and you could share with our listeners the progress you're making. Well thank you for having me. And I'm very thankful to work to school with longstanding graduate schools so much of what I've been able to do I would like to go back to school socially. It's always nice to hear an alum say that said Thank you.

[00:34:07] First you've been listening to Mr. Bruce Nisbet discuss spectrum Human Services Health Homes program and living proof. Hi I'm Nancy Smyth professor and dean at the University at Buffalo School of Social Work. Thanks for listening to our podcast. For more information about who we are our history our programs and what we do. We invite you to visit our website at www.socialwork.buffalo.edu. At UB we are living proof that social work makes a difference in people's lives.