

Health Homes: Rhode Island's Development of a Pediatric Health Home Model

Introduction

The Affordable Care Act (ACA) affords states an opportunity to establish a new care delivery model in Medicaid called a health home, designed to coordinate care and improve outcomes for patients with complex medical needs. Rhode Island, home to an existing community-based care coordination model for children with complex health needs, has taken up this option and created—alongside a program for adults—a health home geared specifically to children and youth with special health care needs (CYSHCN). This paper provides background on care coordination and information about the provision—Section 2703 of the ACA creating a state option to provide health homes for enrollees with chronic conditions—as well as a description of the Rhode Island pediatric health home model.

Background: Origins of the Health Home Concept

Health care industry stakeholders have long advocated for ways to streamline communication and service delivery to improve patient care and, ultimately, health. In 1967, the American Academy of Pediatrics (AAP) defined a medical home as “one central source of a child’s pediatric records to resolve duplication and gaps in services that occur as a result of lack of communication and coordination.”¹ Over time this definition was adapted to convey that, in addition to reducing failures in care delivery, the medical home would be coordinated, patient and family-centered, accessible, and compassionate. In 2004, other organizations called for Americans of all ages to have access to a medical home.² This expansion and interest in medical homes opened up the concept to a larger patient population and also allowed for the model to serve patients longitudinally across their lifespan.

Over time, ideas have evolved about the goals of health services and the most effective ways to provide them. While the goal of health systems was once to find and deliver the most appropriate care for sick people, health care providers and policymakers now work toward effective health maintenance, treatment, and disease management for both individuals and populations. In conjunction with this change in our conception of health care’s goals, we have also expanded our ideas about the most appropriate ways to achieve them. We look for ways to keep individuals in their homes and communities, rather than relying on hospitals as the only places to provide a broad range of services.

¹ Centers for Medicare and Medicaid Services. State Medicaid Director Letter # 10-024, Health Homes for Enrollees with Chronic Conditions. November 16, 2010. <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>

² Ibid.

Health Homes in the ACA

Two aspects of care delivery transformation—services that prevent acute disease episodes, delivered in the community—give rise to the health home model. Similar to the medical home definition throughout its evolution, the health home is a model of service delivery that provides coordinated, person-centered care, including a broad range of physical and mental health services to improve patient outcomes and experience. These services are provided in a community-based setting when possible to keep the patient and family connected to their community, to minimize disruption to the patient's and family's routines, and to keep them connected to their social supports. Additionally, stakeholders including policymakers and providers hope this model will simultaneously reduce per capita cost of care among its participants—largely through decreased acute care use—to drive down overall health care costs and make this model sustainable for states.

Within the provision of the ACA, health homes serve a specific population of Medicaid enrollees who meet one of three health status criteria:³

- Two or more chronic conditions, including mental health conditions
- One serious and persistent mental health condition
- One chronic condition, including a mental health condition, and high risk for another

If a state chooses to elect the health home option, that state is eligible for a 90 percent federal matching rate for health home services during the first eight quarters (two years) of the program. After that introductory period, federal matching will continue at the state's normal Medicaid matching rate.⁴

In order to determine if these programs are effective, the Department of Health and Human Services (HHS) will survey participating states' programs by January 1, 2014 and make an interim report; subsequently, HHS will arrange for an independent evaluation of health homes to be completed by January 1, 2017. These reports will explore the use of health information technology (HIT), continuous quality improvement methodologies, and outcomes measurements, as well as emphasizing cost savings, reductions in emergency department use, and decreased institutionalizations (both hospital and skilled nursing facility admissions).⁵

Rhode Island's Basis for Health Homes

Rhode Island is home to a model of complex care delivery called Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Reevaluation (CEDARR), a program for CYSHCN. At CEDARR centers around the state, licensed clinicians such as registered nurses, licensed clinical social workers, and psychologists coordinate children's care to ensure they are receiving medical and supportive services that are clinically appropriate, family-centric, and based in the community whenever possible. With this program in place, state policymakers saw an opportunity to match their model to the health home option to strengthen the program and bring

³ Kaiser Family Foundation (KFF). Focus on Health Reform: Medicaid's New "Health Home" Option. January 2011. www.kff.org/medicaid/upload/8136.pdf

⁴ Ibid.

⁵ KFF. Focus on Health Reform: Medicaid's New "Health Home" Option.

additional federal dollars into the state. As a state with 12,000 CYSHCN and 7,000 adults with serious and persistent mental illness, policymakers recognized a need for effective care for these populations.

Developing the State Plan Amendment

In applying to the Centers for Medicare and Medicaid Services (CMS) for health home designation, state officials combined both CEDARR centers and an adult-focused program (Community Mental Health Organizations (CMHOs)) into their initiative; this tactic was important to ensure the health home would serve the needs of all eligible Medicaid enrollees. To do this, officials developed an overarching definition of the health home that applies to both CEDARR centers and CMHOs, which is similar to a vision statement and describes the overall goal of the program; then, within that larger definition, each setting is defined with a description of the way services are delivered in that part of the program. This unified superstructure with distinct pediatric and adult programs underneath it met CMS's requirements that the state make these services accessible to all, regardless of age, while simultaneously allowing them to tailor service delivery to be as effective as possible for both children and adults.

For other states considering a state plan amendment to implement health homes and want to be able to focus on the pediatric population, the Rhode Island example is instructive. Although the Rhode Island model is inclusive of patients of all ages—thereby maintaining compliance with the law—the division of the program into settings that are age-specific enables policymakers to connect patients with the most appropriate providers.

Adjusting CEDARR into a Health Home

Working from an existing model presented both advantages and challenges in establishing a health home option. The transition into health homes required adjustments to the CEDARR model, including changes to the structures for communication and information sharing among service providers. In particular, the state worked to improve its data-sharing to comply with the health home definition. Additionally, physician buy-in was integral to the success of the program, as pediatricians had in the past expressed a desire to serve the CYSHCN population more effectively but felt constrained in their ability to do so. Because state officials and CEDARR staff made the case that health homes would bring additional resources to these children, pediatricians supported the model. Additionally, pediatricians appreciated the opportunity to gain a better understanding of the services their patients receive outside of their practices.

One persistent challenge for the CEDARR health home is data collection. One aspect of data collection has been a success: the introduction of more outcome measures, which the state introduced to CEDARR and CMHO sites before the formal health home project began; policymakers use these measures to track progress on the goals they set at the state level. However, state officials are still working to develop methods for recording data they can use to satisfy the CMS Core Measures reporting requirements.

Perpetuating the Health Home Model

Policymakers in Rhode Island are pleased with the performance of the health home model to date, having launched in October 2011. The transition into formal health homes has allowed the state to enhance its existing model and has led to some important developments. For example, one of the goals of the CEDARR health home was to remedy a disconnect between the physical health and mental health sides of patient care. In particular, policymakers thought it was imperative to monitor body mass index (BMI), as the CEDARR population is at high risk of developing other conditions, including obesity and the conditions that stem from it. However, screening revealed that a significant number of children were below a healthy weight and needed intervention to boost their BMI to a healthy level. A similar initiative to screen for depression has led to several diagnoses of depression as an underlying condition in a child with other mental health needs.

Additionally, the model of linked child and adult health homes has proven effective for the state. Even before the state plan amendment was in place, policymakers worked to ensure that children aging out of the CEDARR health home and into the CMHO health home experienced a smooth transition process. As advances in HIT capabilities continue, these transitions should become increasingly seamless.

Rhode Island's health home has been in place for approximately four quarters, which means it is half-way through its period of 90 percent FMAP support from the federal government. However, state leaders are optimistic about continuing the program—and expanding the definition of eligible enrollees—after the enhanced match expires in another year, as they believe the program will prove to be a more cost-effective way of providing complex care than an uncoordinated system.

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