Project H.E.A.L.T.H
Abstract

The Center for Health Care Services (CHCS), the local mental health authority in San Antonio, Texas, proposes a recovery-oriented approach to integrated behavioral and physical health care. CHCS will demonstrate the efficacy of the model with a target population of adults with severe mental illness or co-occurring mental illness and substance abuse disorders who have or are at risk of chronic physical diseases. They will be residents at Prospects Courtyard (PCY), an outdoor safe sleeping area for homeless adults not yet ready to live inside the adjacent Haven for Hope homeless campus. Project services will be placed within existing behavioral health clinics, delivering better care and improving health outcomes at a lower cost by introducing three innovative features: 1) reversing the traditional order of care, stabilizing behavioral health first so patient can be actively engaged in primary care, prevention and wellness; 2) embedding Peer Support Specialists throughout the care trajectory to build and sustain readiness for change, motivation and compliance; and, 3) using Health Navigators and a multi-disciplinary Care Team to both teach wellness self-management and deliver collaborative, seamless care and treatment.

Today, 40% of the target population is Medicaid insured and an additional 45% are eligible. By 2014, most all will be Medicaid insured and efficient and effective methods of delivering care for what is often called a high utilizer patient population will be an economic imperative.

Most enabling groundwork and program infrastructure necessary to bring the CHCS model to scale has been completed or is in process. Critical partners -- CHCS, Haven for Hope, CentroMed (FQHC) and Methodist Healthcare (largest local hospital system) – already coordinate services and resources through a comprehensive inter-agency MOU and all partners contributed to the planning, gaps analysis and consensus building that advised the model. The CHCS model will launch from this existing service framework, expanded by the partners’ long-standing and mutually supportive relationships. The current availability of enabling resources and the familiarity and trust that exists between the partners will enable implementation of the CHCS model by the sixth month of the grant period.

Goals:
1. Improve health care by improving consumers’ capacity to participate and self-manage.
2. Improve health outcomes by delivering the right care (behavioral then physical) at the right time (once stability and sobriety are achieved) and the right place (behavioral health clinic). 3. Lower the cost of care with implementation of a streamlined, bundled payment structure that proportionately values behavioral, primary and tertiary health care.

Number of projected participants: 260 for the 36-month project period

Cost of care savings: 34.57% savings PBPY

Fund use: Staffing the integrated care clinic, evaluation, workforce development training, health care supplies
**AIMS AND OUTCOMES**

**Improve Health Care for Project Population with Complex Behavioral and Physical Health Disorders**

A minimum of 260 participants will be enrolled in the program (45 in the first year). Within one month of enrollment, 70% of enrollees will participate in BH services, and 50% will utilize primary care services in the first year. In relation to the comparison group, clients receiving project services will, based on measurements at baseline, 6 months, and 12 month follow-up:

- Report lower psychological stress
- Report greater readiness to address BH and physical health issues, greater access to support for chronic health issues, and greater satisfaction with services.
- Report greater self-efficacy and self-management.
- Report feeling hopeful

**Improve Behavioral and Physical Health Outcomes for Project Population.**

In relation to the comparison group, clients receiving project services will report 6 months following enrollment:

- Improved psychological functioning,
- Reduced use of tobacco, alcohol, and illegal drugs.
- Higher rates of average ranges of blood pressure, BMI, blood sugar, and cholesterol.
- Higher health-related quality of life ratings.

**Lower the Health Care Costs of the Project Population**

In the 12 months following enrollment in project services: Participants in the program will use significantly less high cost ER, psychiatric, and medical hospitalization services resulting in significantly lower health care costs relative to the comparison group.

The resultant cost savings for the participant group will be higher than the costs of services provided in the project. Other social costs will be reduced including County jail utilization – which is often associated with public intoxication.

Total cost savings for the project are projected to be $7,626,013

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**PRIMARY DRIVERS**

- Stabilization of Client Behavioral Health First
- Build Trust and Increase Client Motivation, Engagement, Hope, and Retention in Care
- Wellness Self-Management
- Implementation of a Care Team of Behavioral and Primary Care Providers
- Increased Access to Behavioral Health, Primary Health, and other recovery support and wellness services
- Documentation of Improvement in Health Care Outcomes and Reduction of Inappropriate Use of Health Care Resources
- Health Care Workforce Realignment and Development
- Sustainability of the Model

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**SECONDARY DRIVERS**

- Make varying levels of care available to clients based on stage of readiness for services.
- Project personnel will use Motivational Interviewing techniques to enhance readiness.
- Provide Peer specialists with BH backgrounds
- Assist clients develop their own recovery plans and provide individualized recovery support services.
- Use a Chronic Care Model (not just acute care) for identifying and addressing needs.
- Project personnel will provide self-care management education and assist clients in considering a range of wellness services tailored to their individual needs.
- BH and Primary care personnel combined in a single clinic operation to provide integrated health care.
- Utilize Peer Specialists to recruit, engage, and maintain support clients to receive integrated, individualized care.
- Deployment of Health Navigators to educate and advise clients about health care utilization
- Deployment of Peer Specialists who will have a caseload of project enrollees.
- Integration of BH and Primary Care services
- Enhancement of Electronic Health Record and Patient Registry in order to Facilitate care and cost documentation and improve Inter-Clinician Communication.
- Health Outcomes Monitoring –Client Tracking.
- Health Care Utilization Review.
- Integration of Trained Peer Support Specialists and Health Navigators into Workforce Structure, and Increased proximity of Primary Health care for persons with BH needs.
- Evidence-Based Behavioral Competency Training for Primary and Tertiary Health Care Providers.
- Health Care Cost Study Outcomes.
- Negotiated Bundled Case Rate with Managed Care Programs for Behavioral and Primary Care.