

The Case for the Patient-Centered Medical Home in Correctional Health Care

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Faculty Disclosure

“I do not have any relevant financial relationships with any commercial interests”

Educational Objectives

- Examine the complexities of providing comprehensive health care to individuals who are incarcerated
- Describe the patient-centered medical home (PCMH) model
- Examine how an Implementation Science framework can serve as a basis for planning, implementation and sustainability

What is Comprehensive Health Care?

The concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment. (CGA) (1980) (2013 COD)¹

1. <http://www.aafp.org/about/policies/all/care-definition.html>

Challenges of Providing Comprehensive Correctional Health Care

What are the unique challenges related to providing comprehensive health care in correctional facilities?

- Mission
- Silos
- Limited resources and space
- Complex comorbidities
- Care coordination
- Reentry planning
- Costs

Missions

- **Correctional Facilities**
 - Safety, security, care, control, containment, supervision
- **Health Care Organizations**
 - Improve health care outcomes, patient-centered, inclusive, fostering healthier lifestyles, caring, convenient, cost-effective and accessible manner

Silos



Health Care Silos

- Pharmacy
- Imaging
- Dentistry
- Dieticians
- Mental health
 - Social workers, psychologists, psychiatrists, mental health counselors
- Medical
 - MDs, advanced practitioners, nursing, allied health

Correctional System Silos

- Security staff
- Executive team
- Administrative staff
- Substance abuse treatment staff
- Reentry staff
- Education staff
- Institutional caseworkers
- Food Services

What About the Patient?



Complex Comorbidities

Incarcerated populations have higher rates of mental illness, chronic medical conditions and infectious diseases compared with the general population.^{2,3,4}

2. James DJ, Glaze LE. Bureau of Justice Statistics special report: Mental health problems of prison and jail inmates. 2006. Available from: <http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf>.

3. Maruschak LM. Bureau of Justice Statistics bulletin: HIV in prisons, 2005. 2007. Available from: <http://www.bjs.gov/content/pub/pdf/hivp05.pdf>.

4. Weinbaum CM, Sabin KM, Santibanez SS. Hepatitis B, hepatitis C, and HIV in correctional populations: A review of epidemiology and prevention. *AIDS* 19(Suppl 3):S41–6. 2005. 7. Carson EA, Sabol WJ. Bureau

Complex Comorbidities

- Research demonstrates that in jail populations, of the approximately 17% with serious mental illness, an estimated 72% had a co-occurring substance use disorder⁵
- Another study found that approximately 59% of state prisoners with mental illness had a co-occurring substance use disorder⁶

5. Abram, Karen M., and Linda A. Teplin, "Co-occurring Disorders Among Mentally Ill Jail Detainees," *American Psychologist* 46, no. 10 (1991): 1036–1045.

6. Ditton, *Mental Health and Treatment*

Reentry

- Coordination
 - Social services, substance abuse, medical care, mental health
- Stable housing
 - The elephant in the room
- Paying for healthcare
 - ACA, activating Medicaid vs no access to Medicaid

Reentry and Mortality

- In a 2007 publication, Binswanger, et al found that Washington State inmates had a statistically higher mortality rate in the first two weeks post release compared to Washington State non-incarcerated residents of the same age, race and sex⁷
- The leading cause of death in two weeks post release was drug overdose
 - Released inmates were 129 times more likely to die from a drug overdose than those in the community

Reentry and Mortality

The study also identified other elevated risk factors released inmates must face including, cardiovascular disease, homicide and suicide.

Reentry

Emerging research suggests that underlying health issues, particularly substance use disorders and mental illness, contribute to incarceration and recidivism, and that treatment, combined with seamless care continuity for individuals when they return to communities, can help prevent both.⁸

Costs

- 2017 report from Pew Charitable Trusts, Prison Health Care: Costs and Quality looked at “how and why states strive for high performing systems.”
- In 2015, total state prison health care spending was \$8.1 billion
- From scale 2010 to 2015, real per-inmate spending rose by a median of 2 percent.⁹

9. http://www.pewtrusts.org/~media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf?la=en

What is happening in the community?

- Institute for Healthcare Improvement
- Integrated health care
- Patient-centered medical home (PCMH)

Institute for Healthcare Improvement's Triple Aim

The Institute has articulated three broad critical healthcare reform objectives, known as the Triple Aim:

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability);
- Reduce, or at least control, the per capita cost of total healthcare ¹⁰

10. http://www.ibhpartners.org/wp-content/uploads/2015/12/Business_Case_for_Integration_6-10-Mauer.pdf

Integrated Health Care

- In response to the Affordable Care Act and payment reform efforts, community-based systems are embarking on new models of integrated care in preparation for capitated care systems with aligned financial incentives and risks
- To this end, *integrated primary care/behavioral health* PCMH models have been implemented across various practice settings
- Large initiatives have been funded through the Centers for Medicare and Medicaid Services Innovation Center's Transforming Clinical Practice Initiative

Patient Centered Medical Home Model (PCMH)

- Healthcare reform, beyond insurance coverage expansion, is focused on investing more of the healthcare dollar in better primary care systems (known as Patient-Centered Medical Homes) to achieve the Triple Aim

Integrated PCMH

A PCMH is a care model that involves the coordinated care of individual's overall health care needs and where patients are active in their care¹¹

Integrated PCMH

- A health home offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders.
- It is a team based clinical approach that includes the consumer, his or her providers, and family members when appropriate.

Integrated PCMH

The health home:

- ***Builds*** linkages to community supports and resources
- ***Enhances*** coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses

Integrated PCMH

There is a shift in focus from ***episodic acute care*** to ***care for the whole person***

- Team-based care focused on the whole person and achieved through coordinated care

Core Elements of Integrated PCMH

- **Comprehensive Care Team**

Physicians, advanced practitioners, nurses, pharmacists, social workers, educators, care coordinators

- **Patient Centered Care**

Addresses unique needs each patient, their cultures and values

- **Coordinated Care**

EHR, physical space

- **Accessible Services**

Hours, wait times

- **Quality and Safety**

Evidence-based and incorporating clinical decision support tools

PCMHs in other settings

Such teams have developed in various treatment settings, including community health centers, hospitals, behavioral health clinics, VA medical centers, and Health Care for the Homeless clinics

Where's the data?

What outcomes are you interested in?

- Quality Improvements
- Health Outcomes
- Provider Satisfaction
- Cost Benefit Analysis

Mississippi Integrated Health and Disaster Program

- Data indicated that the Mississippi Integrated Health and Disaster Program's integrated health model significantly improved depression, anxiety, and diabetic self-care among chronic care patients.¹²

The Business Case for Bidirectional Integrated Care

- This business case paper is intended for audiences who want accomplish healthcare objectives of the Institute for Healthcare Improvement's Triple Aim.
- Summarizes case studies & outcome data; argues the need for integrated care to improve healthcare quality and manage expenditures.¹³

PCMH in Correctional Facilities

- There is a lack of research regarding the development and implementation of integrated PCMH models in correctional settings
- Obvious barriers to implementation exist despite the fact that many correctional health care systems have been funded through capitated models for many years. In fact, “multiple correctional and medical roles can undermine patient-centered care”¹⁴ and strict adherence to treatment protocols may undermine efforts to develop individualized treatment plans.

PCMH in Correctional Facilities

Despite the barriers, “A Call for New Models of Care in Correctional Health,” published in the National Commission of Correctional Health Care magazine *Correct Care*, highlights the need to explore such a model and provides suggestions for implementation of several components of integrated care PCMH models.¹⁵

15. <http://www.ncchc.org/filebin/CorrectCare/30-2.pdf>

The Case for PCMH in Correctional Health Care

Given the multi-faced challenges of treating patients with complex co-morbidities in correctional facilities, the increasing adaptation of Medication-Assisted Treatment for substance use disorders in such settings, the current redundancy, inefficiencies and cost of work across different treatment disciplines, and the need for more integrated reintegration plans, models for practice transformation and integrated care must be explored in correctional settings

The Case for PCMH in Correctional Health Care

- Well-run, forward-thinking prison health care systems are vital to state aims of providing care to incarcerated individuals, protecting communities, strengthening public health, and spending money wisely.
- Likewise, poorly performing systems threaten to make states less safe, less healthy, and less fiscally prudent.
- Put simply: The stakes extend far beyond the confines of prison gates. ¹⁶

16. http://www.pewtrusts.org/~/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf?la=en12

California as a Leader

- *California Correctional Health Care Services (CCHCS) shall manage and deliver medically necessary health care services to the patient population. The Complete Care Model (CCM) is based on the industry standard known as the Patient-Centered Health Home.*
- *The CCM shall serve as the foundation for CCHCS health care services delivery. This model improves patient outcomes, reduces the need for hospitalizations and emergency services and enhances staff satisfaction*

How would we even begin this process?



“So should I try to get them to accept the change before or after I shove it down their throats?”

Implementation Science

The use of strategies to introduce or change evidence-based health interventions within specific settings¹⁷

Implementation Research

The scientific study of methods to promote the systematic uptake of proven clinical treatments, practices, organizational and management interventions into routine practice, and hence to improve health¹⁸

Exploration, Preparation, Implementation, Sustainment (EPIS)

A Multiple Phase Process of Implementation

- Aarons, et al. have proposed a conceptual model that serves as a blueprint for long term planning and implementation¹⁹
- Sustainability is factored in during the initial phases and throughout the process

19. Aarons, G.A., Hurlburt, M. & Horwitz, S.M. (2011). Advancing a Conceptual Model of Evidence-Based Practice Implementation in Public Service Sectors. *Administration and Policy in Mental Health and Mental Health Services Research*.38, 4-23.

EPIS Model

Inner Context:

- Intra-Organizational Characteristics: Leadership, policies, cultures, organizational structure, climate, technology capabilities, data analyses
- Individuals Adopter Characteristics: Attitudes, fidelity, individual commitment, organizational commitment, turnover

EPIS Model

Outer Context:

- Service environment
- Inter-organizational environment
- Patients and consumers

Exploration

- Funding/resources
- Contract reviews/RFR development
- Leadership capabilities
- Training needed
- Physical space
- Staff and patient surveys

Exploration tool

- SAMSHA/ HRSA Center for Integrated Health Solutions have created a center promoting the integration of primary care and behavioral health. This has a wealth of resources for getting started.
- https://www.integration.samhsa.gov/integrated-care-models/CIHS_quickStart_decisiontree_with_links_as.pdf

Preparation

- Implementation team
- Coach
- Trainers
- Administrative buy-in
- Clinician and staff availability

Preparation tools

The Patient Centered Medical Home Resource Center, housed at the Agency for Health Care Research and Quality (AHRQ), has a clearinghouse of established training modules.

Implementation

- Space
- Technology
- EHR
- Team huddles
- Reentry planning
- Work assignments

Sustainment

- Patient satisfaction
- Patient outcomes
- Provider satisfaction
- Provider retention
- Tracking costs
- Where's the money?

Additional resources available

- <http://www.cphcs.ca.gov/docs/imspp/IMSPP-v04-ch01.pdf>
- Integrating Behavioral Health and Primary Care.: Robert E. Feinstein, Joseph V. Connelly, and Marilyn S. Feinstein (2017) Oxford: Oxford University Press.
- Overview of EPIS Framework
<http://www.cebc4cw.org/implementingprograms/tools/epis/>
- EPIS Phase Specific Supports
<http://www.cebc4cw.org/implementing-programs/tools/technical-assistance-materials/>

Questions and Comments

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