

Medical Home Telephone Conference

January 24, 2006

Deb Bilder and Josette Dorius
University Neuropsychiatric Home Project

The Home Program is a program that started July 2000, and the purpose of the program is to serve children and adults with developmental disabilities that also want care coordination of services for medical as well as mental health. Dr. Scott Stiefel, a triple board physician, had this vision that got this all going. It was a start-up through a Robert Wood Johnson grant with the Medicaid re-design project. The Medicaid re-design project had been in place for a couple of years and Robert Wood Johnson was saying this is wonderful you are focusing on adults with special health care needs, but we would really like you to focus on a population that utilizes all of Medicaid dollars not just medical dollars but also look at mental health dollars as well as habilitative or community resources through the home and community based waiver. Dr. Stiefel said I have the population, because he had the neuro-behavior clinic, and also he had a contract with the DSPD program which is the Division of Services for People with Disabilities. We started this program, and the way this program was funded, it's never been funded off of grant dollars it's always been funded through Medicaid dollars, we get the money from the State, we get the medical premium that would normally go to an HMO for the medical care like Altius or Healthy U and we also get the mental health dollars that would normally go to Valley Mental Health for those that are in Salt Lake

They have to be a Medicaid patient with disability Medicaid to be eligible for the Home Program because that's how we receive the funding. They can be anywhere in the state.

Patients in Northern or Southern Utah, we would see the patient for evaluations but coordinate his/her primary care with their primary care provider. What about patients in the SLC area, what role does the primary care provider take? Generally they are wanting care coordination so the care coordination actually often happens in our clinic. A lot of the patients have wanted to get all the primary care as well as the mental health care at our clinic. We currently do not have anybody that lives in SLC that is being seen by a primary care physician else where. It can be done but it just hasn't. The families prefer to have all the care provided at one place. A lot of what has happened is that they have a relationship with the pediatricians and they like that relationship and so basically what we've done is if they have insurance, and they are only wanting some help with the coordination of the mental health services we have enrolled them in our Neuro-Behavior Clinic (NB clinic). Who can be seen in neuro-behavior clinic?

Basically, kids that have insurance that want mental health services. They don't have to be Medicaid they can have insurance. We're contracted with most insurances, (PEHP, IHC, United Behavioral Health), so what we do for the mental health services, we contact Valley or whomever they are with, to get the prior authorization for the services and as long as we have a referral from the primary care we generally don't have any issues and then we can get that information back to the primary care provider.

Examples of typical types of patients referred to UNI Home or neuro-behavior clinic: Either a child or an adult with a developmental disability, usually mental retardation, we also consider autism or a social developmental disability. In the neuro-behavior clinic many also have behavioral or emotional problems, typically the way this manifests in one of our patients is a behavior disturbance. Maybe they are really anxious and they have a hard time transitioning between activities like going to school or coming home from school or they may act out and have trouble at school because of that behavior. Maybe they have anxiety that causes them to have trouble when you change their routine and they may act out because of that. Acting out behavior is usually related to anxiety or maybe they are depressed or mood disturbance, some have bi-polar. They have the mental retardation and then they also have anxiety or the mood problems. Sometimes it's attentional issues, impulsivity, hyper-activity, or difficulty focusing. The typical patient that is seen is usually behavioral outbursts and a developmental disability and it is our job to figure out why they are having these problems with their behavior and how can we help them so that they can function better at home, school, work, or in their community setting. A lot of kids have seizure disorders or other neurologic problems, pre-maturity, genetic disorders, sleep disturbance, have been abused and/or have PTSD (Post Traumatic Stress Disorder).

How would a clinician refer a patient to either the Neuro-Behavior Clinic or the UNI Home Program? Basically, if there is an inquiry in regards to wanting services because they have a developmental disability and want help with care coordination or with the behaviors they want some support with the mental health diagnosis, medication management or therapy they would make a phone call to our clinic and the phone number they would call is 585-1819, Margaret Dingman would take the referral information and this is given to the administrative teams who make sure the patient meets the criteria for either NBC or Home Programs and then we notify whoever has made the referral and also the family to make sure they understand what the services are that have been requested, we mail out an intake packet to them asking to be completed before scheduling an appointment, most of the time they will get them in quickly, then the appointment is scheduled. For the Home program we do what is called the welcome intake visit, this really talks to them about the whole program, talks about how we have case managers who coordinates the care and work with the physicians. We have nurse practitioners that are qualified in working with the clients in regard to medical and mental health needs. We have social workers that can provide therapy, also a behavior specialist and a case manager specialist if they are

hospitalized or if there is case management needs she works closely with the family and the patient to make sure all that care is coordinated.

Question Kathy Heffron from IHC Sandy

When I have tried (I am a care coordinator) and I work at Sandy Health Center and Mountain View Pediatrics to refer to the home project for a client with either DSPD or Medicaid I was told that the parents would have to give up their pediatrician to be accepted.

Josette: The problem is who is the doc? Are they IHC providers.

Kathy: The patients are Medicaid.

Josette: In the Salt Lake area which includes Sandy the patients often choose to have their care in our clinic because we have medical as well as mental health providers and so we have been able to coordinate services so they can come in for their medical appointment and see the therapist on the same day. If they haven't wanted to do that we haven't taken patients in the Salt Lake or Sandy area because it is better to have that care coordination done here.

Lisa: Could Kathy refer patients to the neurobehavior clinic instead of the Uni Home project if they wanted to keep their physicians?

Josette: She could if the services were mental health related. All of our patients in both clinics have developmental disability. We specialize in serving the population with DD or autism spectrum disorder or social disabilities.

In order to use the UNI Home project the family must consider giving up their physician if they are in the Salt Lake Area. Otherwise they may go into the neuro-behavior clinic and we would need a referral from the primary care doc for mental health care through the NB clinic. Any kind of insurance is accepted, Medicaid, IHC etc. We coordinate that service by calling and getting the prior authorizations.

Debbie Bilder. In the past the NB clinic was closed except for those patients with DSPD services. Our NB clinic is now open again. The clinic is now getting support from the department so we have increased our capacity. The strongest emphasis is for individuals to enroll in the home program.

There are 366 enrollees in the Home Program and Medicaid has given the ok to up that to 600. Also what is happening with a lot of the pediatricians is that when the patient turns 18 they are having a difficult time finding a doctor who is comfortable in working with this population so we get a number of referrals to the Home Program for these kids.

What services are available to the outlining areas. The outlining areas, as long as they have disability Medicaid they can enroll in the Home Program and we can work with Montezuma Creek for the primary care services and can also help with the coordination of psychiatric evaluations and medication management. Can also establish tele-health services as long as you have a sight we can work with. We currently have a psychiatrist that goes down to Blanding every three months.

If there are capabilities in your area for tele-medicine we would be able to help you with it. We are contracted with Ogden Clinic and Wee Care Pediatrics. We already have a number of clients in Ogden No one is enrolled as of yet in Logan but telemedicine can be coordinated if we have a patient there.

For the initial psychiatric evaluations they need to come to Salt Lake but we could do follow-up by telehealth after that.

Attendees: Lisa Samson-Fang, Barbara Ward, Deb Bilder, Josette Dorius, Grace Baugh, Jessica Carpenter, Kathy Coopersmtih, Lisa Lee, Diane Behl, Robert Terashima, Susan Kerr, Amy Steadman, Jeff Schmidt, Kathy Heffron, Melissa Higley, Darlene Pead, Val Jones, Kendra Tortalita, Gladina Yanito, Donna, Fred, Lois, Cathi

Next Conference Call: February 28, 2006. Sports Medicine and Dance Clinic.