

# Integrated Communities of Health

## State Experiments that May Change Your Life

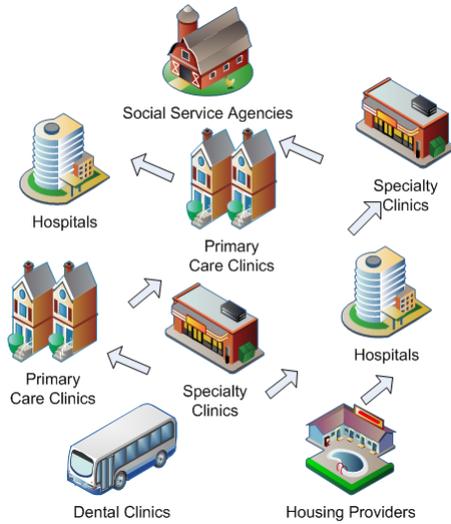
Harvey Rosenthal,  
Executive Director, NYAPRS  
Dr. Dan Lessler, CMO,  
Washington State Health Care Authority  
Dale Jarvis, Dale Jarvis & Associates

## Integrated Communities of Health Overview

- New York and Washington State
- Embarking on Important Experiments
- Attempting to Join the Ranks of Oregon and Vermont

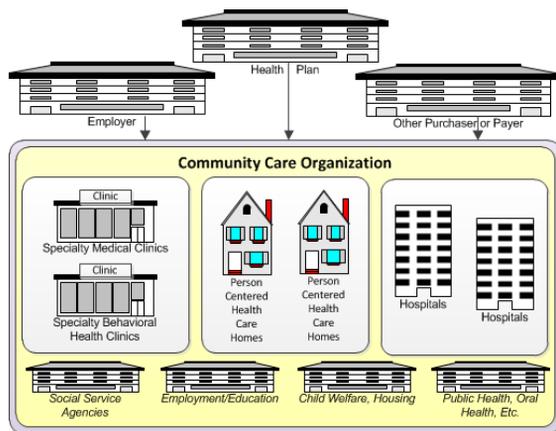


# We all live and breathe the Problem



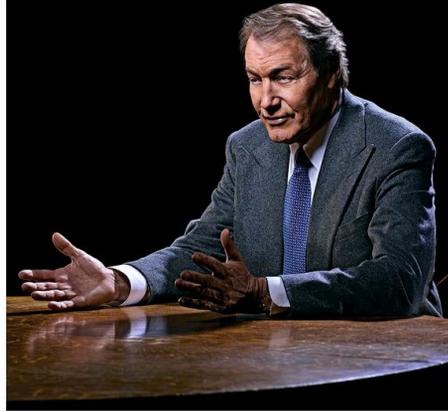
Provider ↔ Integration  
 tied to  
 Payor ↔ Integration

# Purchasers & Payors Leading Reform



- BH-PC Integration in full service 1-stops
- Tackling the Social Determinants of Health
- Collective Impact
- Health Neighborhoods
- Sick Care to Health

## Format for Our Session



## First Question to the Panelists

- Who are you and how were you involved in your state's current healthcare reform effort?



## New York State's Medicaid Reform Core Ideas: Harvey Rosenthal

### Medicaid Spending by the Numbers

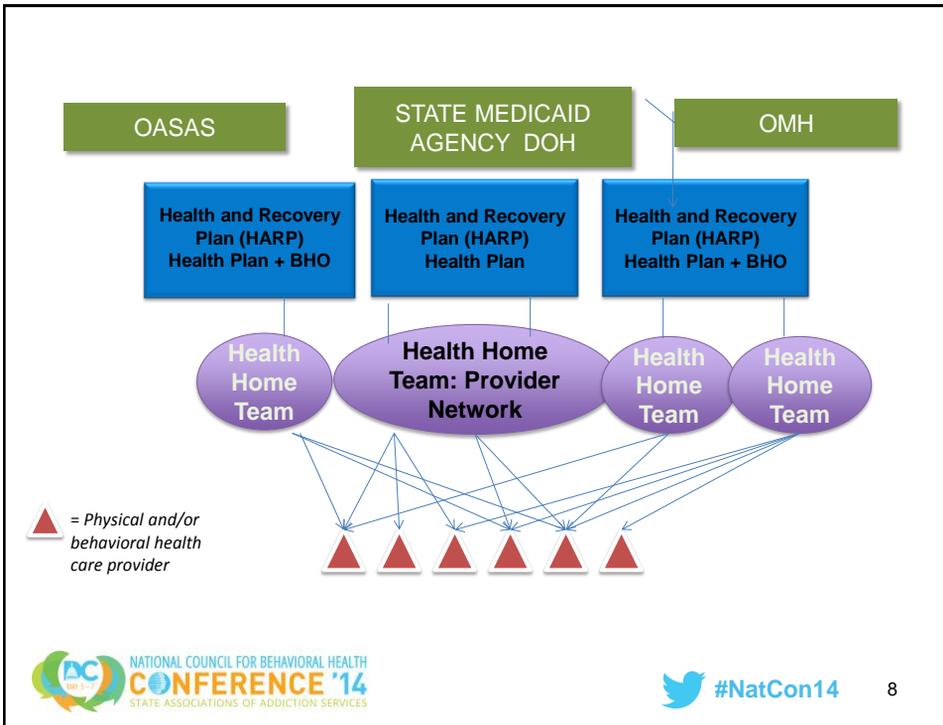
- \$54 billion Medicaid Program 5m beneficiaries
- 20% use 80% of these dollars
  - ✓ Hospital, emergency room, medications, longtime 'chronic' services
  - ✓ 40+% have behavioral health conditions
- NYS avoidable Medicaid hospital readmissions: \$800m to \$1 billion annually (last in nation)
  - ✓ 70% have behavioral health conditions, 3/5 of these admissions are for medical reasons



## New York's Medicaid Redesign Team - MRT

- Carve-In of Behavioral Health Benefit
- Two Types of Carve-Ins:
  - HMOs – BH for 700,000
  - HARPS – Whole Health for 148,000 with “serious” conditions (85,000 in NYC; 63,000 Upstate)
- Behavioral Health PMPM = \$2,674
- Savings to be Reinvested in Recovery Supports





## Secret Ingredient #1: Principle-Based Transformation

- **Person-Centered:** Improving patient care & experience through a more efficient, patient-centered, coordinated system.
- **Transparent:** Decision making process takes place in the public eye and that processes are clear and aligned across providers.
- **Collaborative:** Collaborative process reflects the needs of the communities and inputs of stakeholders.
- **Accountable:** Providers are held to common performance standards, deliverables and timelines.
- **Value Driven:** Focus on increasing value to patients, community, payers and other stakeholders.

**Better care, less cost**

The bottom of the slide features the logo for the National Council for Behavioral Health Conference '14, the Twitter hashtag #NatCon14, and the page number 9.

## Secret Ingredient #2: Targeted Transformation Spending

### 2014-15 NYS BUDGET

- **\$25,000,000:** State Hospital Reinvestment (crisis & respite beds, supported housing, urgent care walk-in centers, peer support, mobile teams, etc.)
- **\$120,000,000:** BH Transformation Initiatives (managed care readiness, integrated care, health home \$ for people with 'high needs', 1915.i services)



### NYS MEDICAID WAIVER

- **\$500,000,000:** Fund to ensure Medicaid safety net providers can transform their way to the future
- **\$6,420,000,000:** Delivery System Reform Incentive Payments (DSRIP): planning grants, provider incentive payments, workforce transformation)
- **\$1,080,000,000:** Other Medicaid Redesign (health home development, long term care workforce, enhanced 1915.i services)

In return, NYS has to deliver by **bending the cost curve results** including reducing avoidable hospitalizations by 25% over 5 years

## Secret Ingredient #3: 1915i HCBS Option Enhanced Benefit for HARPS

### Rehabilitation

Psychosocial Rehabilitation  
Community Psychiatric Support and Treatment (CPST)  
Residential Supports/Supported Housing

### Habilitation

### Crisis Intervention

Short-Term Crisis Respite  
Intensive Crisis Intervention  
Mobil Crisis Intervention

### Educational Support Services

### Support Services

Family Support and Training  
Non- Medical Transportation

### Individual Employment Support Services

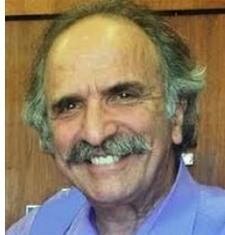
Prevocational  
Transitional Employ. Support  
Intensive Supported Employ.  
On-going Supported Employ.

### Peer Support

### Self Directed Services



# Clarifying Questions for Harvey



# Washington's Medicaid Reform Core Ideas: Dr. Dan Lessler

- Design came out of the CMMI funded State Innovation Planning Grant Process

Washington State  
Health Care Innovation Plan



The Washington Way



# Strategies for Better Health, Better Care, and Lower Cost

Strategy 1

Drive value-based purchasing across the community, starting with the State as “first mover”

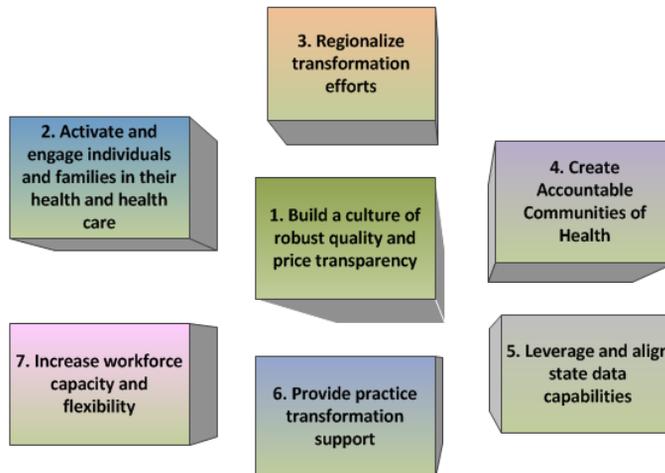
Strategy 2

Improve health overall by building healthy communities and people through prevention and early mitigation of disease throughout the life course

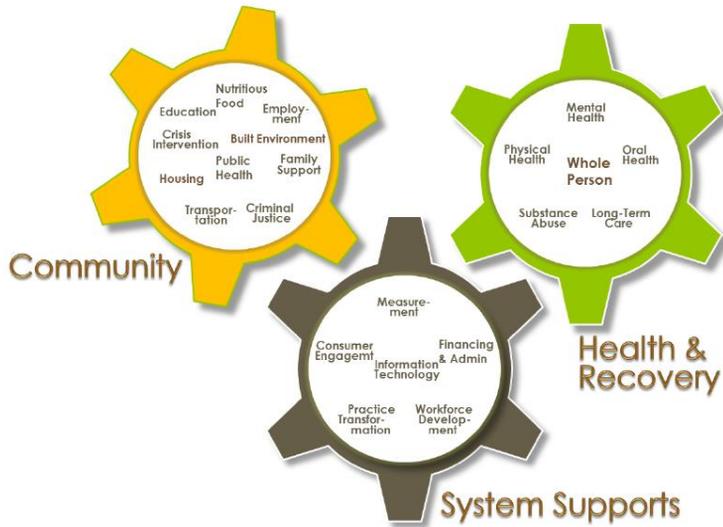
Strategy 3

Improve chronic illness care through better integration of care and social supports, particularly for individuals with physical and behavioral co-morbidities

## Seven Foundational Building Blocks

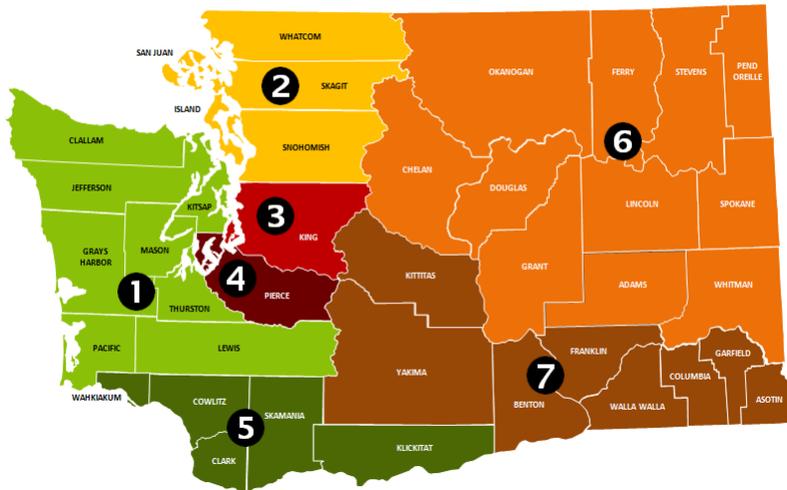


# Whole Health Silo Busting

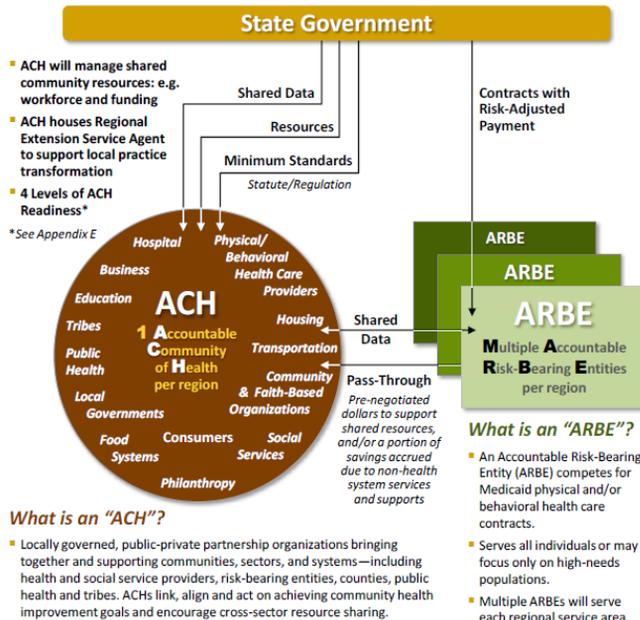


# Untangling the Geography

Seven-Region Straw Man for Future Dialogue



# Inside Each Region



## Integrated Care is Cost-Effective and Improves Outcomes

### For patients with depression

“More than ten studies of collaborative care models for depression [with mental health specialists or trained primary care providers treating depression in primary care settings] in a wide range of health care systems have demonstrated that they are more effective than usual care. Such models have been shown to improve clinical outcomes, employment rates, functioning, and quality of life, and they are cost-effective compared with other commonly used medical interventions.”

### For patients with serious mental illness

“[F]or a cohort of patients with serious mental illness, integrated, on-site delivery of primary care was feasible, promoted greater access to primary care and preventive care, and resulted in a significantly larger improvement in health status than usual care.”

### For patients with substance abuse-related comorbidities

Trials integrating primary care into specialty mental health settings “were consistent in reporting improvements in medical care, quality of care, and patient outcomes. Two programs were found to be cost-neutral ... There was also a significant decline in annual costs for a subsample of patients with substance-related mental and medical comorbidities compared to the control group.”

Sources: Unützer, JU, M Schoenbaum, BG Druss, and WJ Katon. January 2006. Transforming Mental Health Care at the Interface with General Medicine: Report for the Presidents Commission. *Psychiatric Services* 57:1, 37-47. Druss, BG, RM Rohrbaugh, CM Levinson, and RA Rosenheck. September 2001. Integrated Medical Care for Patients With Serious Psychiatric Illness: A Randomized Trial. *Archives of General Psychiatry* 58:9, 861-868. Butler, M, et al. October 2008. Evidence Report/Technology Assessment No. 173: Integration of Mental Health/Substance Abuse and Primary Care. Rockville: AHRQ.

## Levels of Integration at the System Level

Minimal Coordination	Basic Coordination	Close Coordination	Full Integration
<ul style="list-style-type: none"> <li>Have separate systems</li> </ul>	<ul style="list-style-type: none"> <li>Have separate systems</li> </ul>	<ul style="list-style-type: none"> <li>Some shared systems and workarounds</li> </ul>	<ul style="list-style-type: none"> <li>Function as one integrated system</li> </ul>
<ul style="list-style-type: none"> <li>Limited understanding of each other's roles and resources</li> </ul>	<ul style="list-style-type: none"> <li>Appreciation of each other's roles as resources</li> </ul>	<ul style="list-style-type: none"> <li>Understanding of each other's roles and culture</li> </ul>	<ul style="list-style-type: none"> <li>Roles and cultures that blur or blend</li> </ul>
<ul style="list-style-type: none"> <li>Communicate rarely, typically under compelling circumstances only</li> </ul>	<ul style="list-style-type: none"> <li>Communicate periodically about shared patients, driven by specific patient needs</li> </ul>	<ul style="list-style-type: none"> <li>Frequent communication and collaboration</li> </ul>	<ul style="list-style-type: none"> <li>Consistent communication and collaboration</li> </ul>
<ul style="list-style-type: none"> <li>Physical and behavioral health needs treated as separate issues</li> </ul>	<ul style="list-style-type: none"> <li>Physical and behavioral health needs treated separately</li> </ul>	<ul style="list-style-type: none"> <li>Physical and behavioral health needs treated collaboratively for certain sets of patients</li> </ul>	<ul style="list-style-type: none"> <li>Physical and behavioral health needs treated collaboratively for all patients</li> </ul>
<ul style="list-style-type: none"> <li>No coordination or management of collaborative efforts</li> </ul>	<ul style="list-style-type: none"> <li>Some leadership efforts around systematic information sharing</li> </ul>	<ul style="list-style-type: none"> <li>Leadership support for integration through mutual problem-solving</li> </ul>	<ul style="list-style-type: none"> <li>Leadership support for integration as driving model of operations</li> </ul>
<ul style="list-style-type: none"> <li>Separate funding streams, and no resource sharing</li> </ul>	<ul style="list-style-type: none"> <li>Separate funding streams with some shared resources</li> </ul>	<ul style="list-style-type: none"> <li>Blended funding streams, with some shared expenses</li> </ul>	<ul style="list-style-type: none"> <li>Integrated funding, with shared resources, expenses</li> </ul>

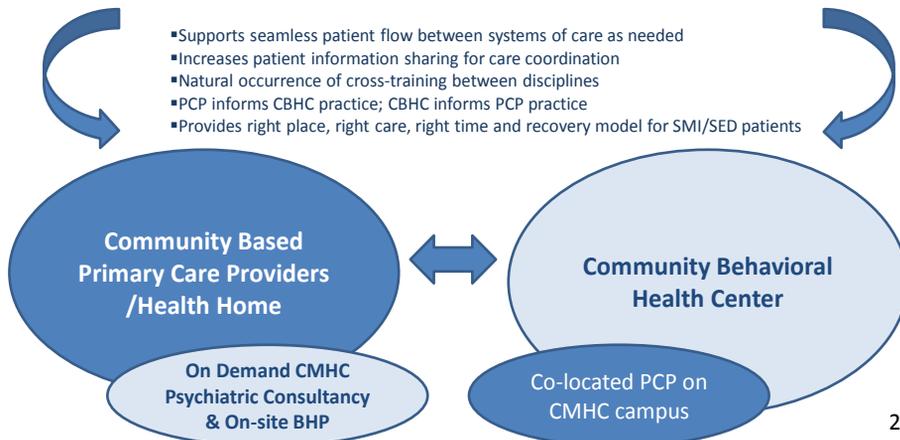
While there are some instances of integrated service infrastructure, Washington's overall physical, mental health and substance abuse service systems largely reflect "basic coordination" at the administrative and system levels

Note: Levels of integration adapted from the SAMHSA-HRSA Center for Integrated Health Solutions' A Standard Framework for Levels of Integrated Healthcare



## Bi-directional Care Model

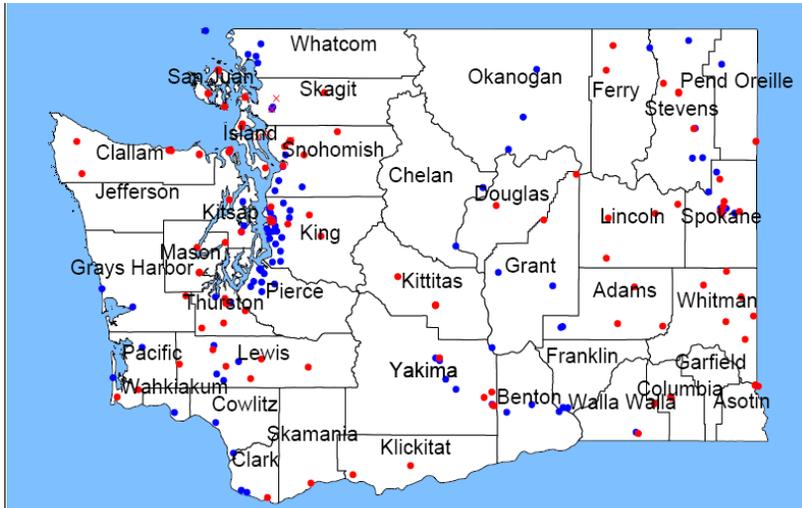
- CBHC Psychiatric consultation for all PCP's supports rapid diagnostic, med management, training
- CBHC BHP co-located in PCP offices for low/ moderate BH needs & to coordinate access as needed to specialty BH services
- PCP co-located on CBHC supports BH patients who prefer PCP services on BH site



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## Mental Health Integration Program

> 38,000 clients served ... 5 FTE psychiatrists



Slide courtesy of Dr. Jurgen Unutzer, University of Washington

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## Principles of Effective Integrated Behavioral Health Care

### Patient Centered Team Care / Collaborative Care

- Colocation is not Collaboration. Team members have to learn new skills.

### Population-Based Care

- Patients tracked in a registry: no one 'falls through the cracks'.

### Measurement-Based Treatment to Target

- Treatments are actively changed until the clinical goals are achieved.

### Evidence-Based Care

- Treatments used are 'evidence-based'.

### Accountable Care

- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

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Slide courtesy of Dr. Jurgen Unutzer, University of Washington

## Legal and Policy Framework

- **E2SSB 6312: “An act relating to state purchasing of mental health and chemical dependency treatment services”**
- **Directs that mental health, chemical dependency, and medical care services for Medicaid clients be fully integrated by January 1, 2020**

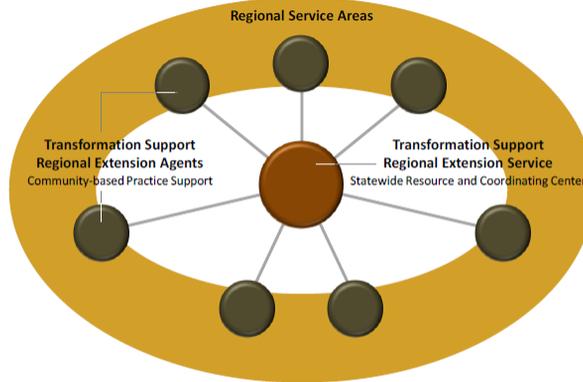
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## 6312: A Roadmap for the Future

- **Directs the Department of Social and Health Services and the Health Care Authority to establish regional service areas**
- **Establishes:**
  - ✓ Process for awarding contracts for behavioral health organizations in regional service areas (by April 1, 2016)
  - ✓ Contract requirements for the purchase of behavioral health services including coverage for peer and community support services, supported housing and employment services, accountability for client outcomes and performance measures
  - ✓ Requirements for contracts to assure that primary care services are available in behavioral health settings and behavioral health services are available in primary care settings
  - ✓ Allows for “early adopters” at County level of full integration (financing and delivery) and provides incentives through shared savings

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# Transformation Support Regional Extension Service



## Data & Metrics Support

Separate function informing Regional Extension Service. Extension Service and Agents serve supportive role in clinical achievement of performance measure targets.

# Clarifying Questions for Dan



## 'Provocative' Questions from Dale

**Question 1:** Great design! What happened inside Albany and Olympia to get from the previous non-integrated Medicaid design to these different but equally promising models?

**Question 2:** Both designs are new. What's the next big hurdle you have to get over to keep the momentum going?

**Question 3:** What advice do you have for behavioral health leaders and other key stakeholders in other states that are not pushing integrated communities of health?

**Question 4:** Where do you put the behavioral health leaders in the state on the continuum of: let's kill it because you're disrupting the status quo; to, we're ready to be early innovators and help this thing succeed?



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