EMERGING SYSTEM DELIVERY MODELS FOR INTEGRATED CARE
SUMMER INSTITUTE

PRESENTERS

With 20+ years experience as a clinician and administrator, Zohreh leads Inter-Growth’s team of experts and works with clients on initiatives such as achieving company-wide transformation, securing community-based program funding, and winning public sector contracts.

With over 15 years of experience in quality management and performance improvement, Sondra works with clients on quality improvement systems, implementation, program and systems evaluation, proposal strategy and response development, and strategic planning.

With over 15 years of strategic executive project management, business development, and operational enhancement/quality management experience, Robert works with clients on quality improvement, program design, and training initiatives.

TODAY’S PRESENTATION

- The Integrated Care Continuum
  - What Is It?
  - Why Do It?
- Integration at the System Level (i.e., MCOs, ACOs)
- Integration at the Provider Level (i.e., PCCM, PCMH, BHH)

WHAT IF?

What if air travel worked like healthcare?
INTEGRATED CARE CONTINUUM - THE FIVE LEVELS

INTEGRATION LEVELS I AND II

Level I: Minimal Collaboration
- Providers work in separate settings and systems, and rarely communicate with each other

Level II: Basic Collaboration from a Distance
- Providers do not share systems or work in the same setting
- Providers communicate periodically on shared cases, mostly through phone and email/letter rather than face-to-face

INTEGRATION LEVELS III-V

Level III: Basic Collaboration Onsite
- Facilities may be shared, but not systems
- Providers communicate more regularly and occasionally face-to-face

Level IV: Close Collaboration/Partly Integrated
- Some of the same facilities and systems may be shared across providers
- Providers regularly meet face-to-face and coordinate treatment plans for the most challenging cases

Level V: Fully Integrated
- Individuals receive seamless treatment as a result of shared systems, facilities, and vision
- Providers routinely collaborate and fully understand each other’s roles
WHY CHOOSE INTEGRATION!

- Over half of all Medicaid beneficiaries with disabilities are diagnosed with mental illness
- Health care costs are as much as 75% higher for those with mental illness
- Co-occurring substance use disorders result in two to three times higher health care costs
- Of those eligible for Medicare and Medicaid (dual eligible), 44% have at least one mental health diagnosis

Increasing and promoting the availability of integrated, holistic care for members will help members achieve better overall health and an improved quality of life.

SUPPORTING INTEGRATED CARE

- Managed Care Organizations
- Accountable Care Organizations
- Primary Care Case Management Model
- Patient-Centered Medical Home
- Behavioral Health Homes

MANAGED CARE ORGANIZATIONS: INTEGRATION POINTS

- Provider
- Payment Methods
- Member Services
- Provider Relations
- Quality

Managed Care Organizations
MANAGED CARE ORGANIZATIONS: CONSIDERATIONS

- Fully integrated data informs utilization management and care management
- Beneficiaries have seamless access to benefits and services
- Clinical and network capacity critical to address behavioral health services
- Strong oversight assures behavioral health services do not fall through the cracks
- Contract provisions and incentives help mitigate potential issues with integrating care among subcontractors
- MCO Special Needs Plans targeted to SMI population are an emerging model and yet to be tested

ACCOUNTABLE CARE ORGANIZATIONS

- Comprised of many medical homes across the continuum of care
- ACOs have been dubbed “medical neighborhoods”
- Accountable for cost and quality both within and outside primary care

ACCOUNTABLE CARE ORGANIZATIONS: CONSIDERATIONS

- Provides accountability for member outcomes and service quality
- Aligns incentives through shared savings
- Standardizes infrastructure and administrative practices as well as centralized scheduling, care coordination, and clinical information sharing
- Enables use of dollars across a wider range of patients and conditions to allow for better overall cost management, less variation within the population, and the ability to track and trend for quality
- The model is still in its infancy and lacks care management technologies (predictive modeling) as well as lack of coordination with behavioral health

INTEGRATION AT THE PROVIDER LEVEL

What does integration really look like?

- Shared medical records
- Systematic screening
- Integration of clinical care processes
- Care management
- Health care team
### Characteristics of an Integrated Model

**Systematic Screening**
- Co-location
- Systematic communication method
- Shared medical records
- Shared decision-making

**Process of Care**
- Integrating Providers
- Systematic communication method
- Shared medical records
- Shared decision-making

**Identify mental health problem**
- Primary Care Providers or Primary Care/Mental Health Providers
- Awareness of mental health programs
- Comfort treating mentally ill patients and/or coordinating service with MH providers for complex patients
- Adherence to evidence-based guidelines

**Integrated Care/Proactive Follow-up**
- New services offered
- Standardized follow-up
- Formal adherence and clinical monitoring feedback
- Education

**Patients**
- Access to care
- Reduced stigma
- Engagement in care
- Adherence

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### PCCM Mechanisms for Integration

- Primary care providers receive additional fees to support care coordination and care management
- Community-based care teams extend reach of practice-based care
- Health information technology supports electronic health information exchange, population management, and performance measurement
- Incentives can be developed to promote and encourage integration
- Example of this model: Community Care of North Carolina ([http://www.ncdhhs.gov](http://www.ncdhhs.gov))

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### PCCM Considerations

- Integration of primary care and behavioral health systems dependent on developing successful provider-level relationships
- Investments in provider-level infrastructure integrates care delivery at the ground level
- Implementation can be challenging given the need to align payment methodologies and reporting requirements across disparate organizations
- Implementation may be more difficult in larger, more heterogeneous states
- Medicare and Medicaid funding streams are not fully blended for dual eligible individuals, resulting in less flexibility for providers to tailor benefits

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### Patient-Centered Medical Home (PCMH)

- Member-centered, comprehensive, team-based, and focused on quality and safety
- Enables providers and care teams to meet patients where they are
- Members are treated with respect, dignity, and compassion
- Model for achieving care in the right place, at the right time, and in the manner that best suits a member’s needs
- Example: Colorado Patient-Centered Medical Home: ([http://www.youtube.com](http://www.youtube.com))
PCMH MECHANISMS FOR INTEGRATION

**Core Component** | **Description**
--- | ---
Comprehensive Care | The PCMH is accountable for meeting the large majority of the individual's physical and behavioral health needs through a team-based approach to care.
Patient-Centered Care | Delivering care that is oriented to the whole person by partnering with individuals and families through an understanding of and respect for culture, unique needs, preferences, and values.
Coordinated Care | Coordinated care across all elements of the health system, such as specialty health care, hospitals, and community resources, with an emphasis on effective care transitions.
Accessible Services | Enhanced access to services by minimizing wait times, expanded hours, and after hours access to providers through email and telephone communication.
Quality and Safety | Commitment to safe, high-quality care through clinical decision-making support tools, evidence-based care, shared decision-making, performance measurement, and population-health management.

IMPLEMENTING A PCMH MODEL

**Settings**
- Federally Qualified Health Centers
- Rural Health Centers
- Primary Care Clinics
- Behavioral Health Clinics

**Critical Elements**
- Health IT
- Workforce development
- Fundamental payment reform

BEHAVIORAL HEALTH HOME (BHH)

- Integrated, recovery-oriented model centered.
- Access to an inter-disciplinary array of behavioral and medical care, and community-based social services and supports for individuals with chronic conditions.
- Four principles for behavioral health homes to succeed:
  - Person-centered care
  - Population-based care
  - Data-driven care
  - Evidence-based care
BHH MECHANISMS FOR INTEGRATION

- Self-management support
- Care management
- Delivery system design
- Decision support
- Clinical information systems
- Community linkages

BEHAVIORAL HEALTH HOMES – CORE COMPONENTS

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<tr>
<th>CORE COMPONENT</th>
<th>DESCRIPTION</th>
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<tr>
<td>Self-management support</td>
<td>The tasks that individuals must undertake to live well with one or more chronic conditions, including having the confidence to deal with the medical management, role management and emotional management of their conditions.</td>
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<td>Care management</td>
<td>Focuses on client activation and education, care coordination, and monitoring the individuals' participation in and response to treatment.</td>
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<td>Delivery system Design</td>
<td>Using multi-disciplinary teams to be proactive and responsive to the needs of individuals with chronic illnesses.</td>
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<td>Decision support</td>
<td>The practice team has responsibility for providing or coordinating comprehensive, evidence-based care.</td>
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<td>Clinical Information Systems</td>
<td>Organize population and client level data to maximize the outcomes for a defined group of consumers and to maximize individual outcomes.</td>
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<td>Community linkages</td>
<td>Behavioral health homes must be able to connect individuals to community resources such as peer support organizations, self-help groups, senior centers, exercise facilities, drop-in centers, child care facilities, and home care programs.</td>
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BEHAVIORAL HEALTH HOME STRUCTURES

- In-home Model
- Co-located Partnership Model
- Facilitated Referral Model

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