Webster’s Unabridged Dictionary defines:

Integrate - to make whole

AND

Integration - the act of making entire
Person-Centered Integration

- Starts from the person out to the system

- Must occur in all areas
  - Psychosocial needs
  - Social services
  - Clinical care
  - Case management
Integration

- Process moves to focus on whole person
- Service delivery and case management become a team sport
- Everyone (clinicians, case managers, social agencies, others, e.g., justice) focus on whole person
  - Move beyond their swim lanes
  - More importantly are willing to engage the person beyond their comfort zone
Value-Based Payment (VBP)

- VBP: Strategy to promote quality & value of health care services
- Shifts from FFS, volume-based payments to payments more closely tied to outcomes
  - Examples: pay-for-performance programs, bundled payments

- VBP links dollars to quality
- Expands focus to include total health of individual (head to toe) and health of population
Healthfirst Steps Toward Integration & VBP

- Moving Toward Integrated CM
- VBP Pilots

- 2014
- 2015
- 2016
- 2017
- 2018
- 2019
- 2020

Promoting Clinical Integration

BH VBP Readiness Program

NYS Goal: 50-60% of Managed Care Payments are VBPs by 2020
How Integrated CM Has Progressed at Healthfirst

2014  HARP CM Model
- Began as a team of general medical care managers and a team of behavioral health care managers collaborating to deliver and support care management
- Each team had their own clinical leader and department

2015-2016
- Clinical leaders worked together to merge team into a functioning whole
- Joint meetings & trainings, documentation in shared electronic CM system

Today
- One integrated HARP team led by a Clinical Director (RN) who reports to a psychiatrist (Medical Director) in charge of the HARP
- HARP CMs practice transactional Case Management to support about 20k members

Tomorrow
- Apply lessons learned to expand this approach to our MMC membership of almost 1M and then to our entire membership
From Collaboration to Integration

- Initially case managers stayed within their comfort zone & swim lanes
- HARP case manager leadership understood process and goals
  - Championed the concept of asking about all aspects of an individual’s health
  - Encouraged removal of swim lane lines
- Leaders acknowledged discomfort
  - Reviewed model and goals for integrated case management
  - Worked to get case manager buy-in
  - Recognized need for support and training (case conferences)
- Training
  - Short webinar modules: over 30 topics (required but easily accessible)
  - Topics included:
    - types of housing and access
    - key general medical issues
    - psychotropic medication
    - person-centered planning
    - recovery
Key Areas of Attention

- Reinforce concept of team sport
- Continue to address areas of case manager discomfort—understand, support, educate
- Show impact (by example) of working within the transaction and as a team to reinforce value
- **Core understanding**—individual is at the center of everything we do
Promoting Clinical Integration

- Clinical integration goes hand-in-hand with case management integration
- Healthfirst uses a Clinical Partnerships team to work with PCPs
- Clinical Partnerships promotes practice transformation
  - Holistic approach to care
  - Data sharing to improve population & individual management
  - Training and technical assistance
- Partnerships was engaged by BH team to further integration efforts at the delivery level
- Behavioral Health Clinical Director now embedded to fully support Clinical Partnerships
Helping PCPs move toward integration

- PCP survey: understand readiness, experience with primary BH care and collaboration with BH specialists
- Introduced PHQ-9
- Depression/Postpartum depression screening in Primary, OBGYN and Pediatric Practices
- Moving toward screening for anxiety, substance use disorders
- Developing “prompt access” referral sources for PCPs so they don’t feel stuck when patients screen + for SUDS
- Technical support for larger practices implementing collaborative care model
- Engaging and linking PCPs to BH specialists in communities served
Promoting Clinical Integration

- Engaging BH Providers across all levels of care
  - Meetings to learn what services they provide, to who, where, barriers, challenges, concerns
  - BH Network Survey in progress to understand practice-level interest in linking with Primary Care Providers so that BH, SUD and physical/medical needs can be met comprehensively, simultaneously & in a coordinated fashion
    - will use info to create new linkages and partnerships
  - Work with behavioral health providers to help them learn and implement communication practices for working with PCPs and other medical specialists
Moving Toward Value-Based Payment

- HF is test driving new financial arrangements and alliances
- Participating in 3 NYS VBP Pilots
- Participating in NYS BH VBP Readiness Program
- HF ambulatory VBP pilot
NYS VBP Pilots

- **HARP VBP Pilot 1**
  - Evolved from pre-HARP pilot
  - Lead Partners taking high level 2 risk, others participate in level 1 gain sharing

- **HARP VBP Pilot 2**
  - Primary goal is to reduce avoidable admissions and ED visits
  - Partners collaborate across health system to improve member engagement (HF generates alerts to hospital team for ED and IP visits, MSHS ambulatory primary care clinics outreach their HARP populations)

- **TCGP (Total Care for the General Population) Pilot**
  - Working closely with IPA to develop this

- Performance metrics for all initiatives include PH and BH targets
- Integrated metrics drives focus on whole person
  - HARP pilot metrics—PCP and behavioral health together
BH VBP Readiness Program

- Help prepare BH providers who form a BHCC (behavioral health care collaborative) to engage in VBP arrangements
  - BHCC: network of providers delivering entire spectrum of BH services available in natural service area
  - BHCC must demonstrate links between Medical/Physical health providers, MH and SUDs providers and Agencies addressing social determinants of health (housing, education, etc.)

- Encourage payers to work with BH providers who demonstrate value as part of an *integrated* care system, accountable for person-centered outcomes

- HF will support the development of BHCC’s and achievement of deliverables
On the Horizon—Steps Toward VBP

- HF partnering with a CBO to develop a VBP pilot
  - Focus on Non Hospital-Affiliated Ambulatory Care Practices
  - Integrated outcome metrics (total cost of care)
  - Look at social determinants
  - Share lessons learned
    - Define steps
    - Create a road map
Key Takeaways

- Transformation takes time and isn’t easy/pretty
- Requires a shift toward population health and integration
- Alliances: work with old partners in new ways & new ones in new ways
- Team Sport mindset is a must: “we’re in this together warts and all”
- Work with ALL providers to understand each other’s needs, delivery model
- Arriving at a clear understanding of how partners will work together is key to success
Key Takeaways

- Taking risk is complicated and important to understand
- A certain amount of scale and dollars are needed to create infrastructure for data and care management
  - Shared cost for build across groups of providers is gaining favor
- Provider’s must be willing to assume risk for total cost of care not just their own slice (integrated performance metrics)

The Individual is at the center of everything we do!