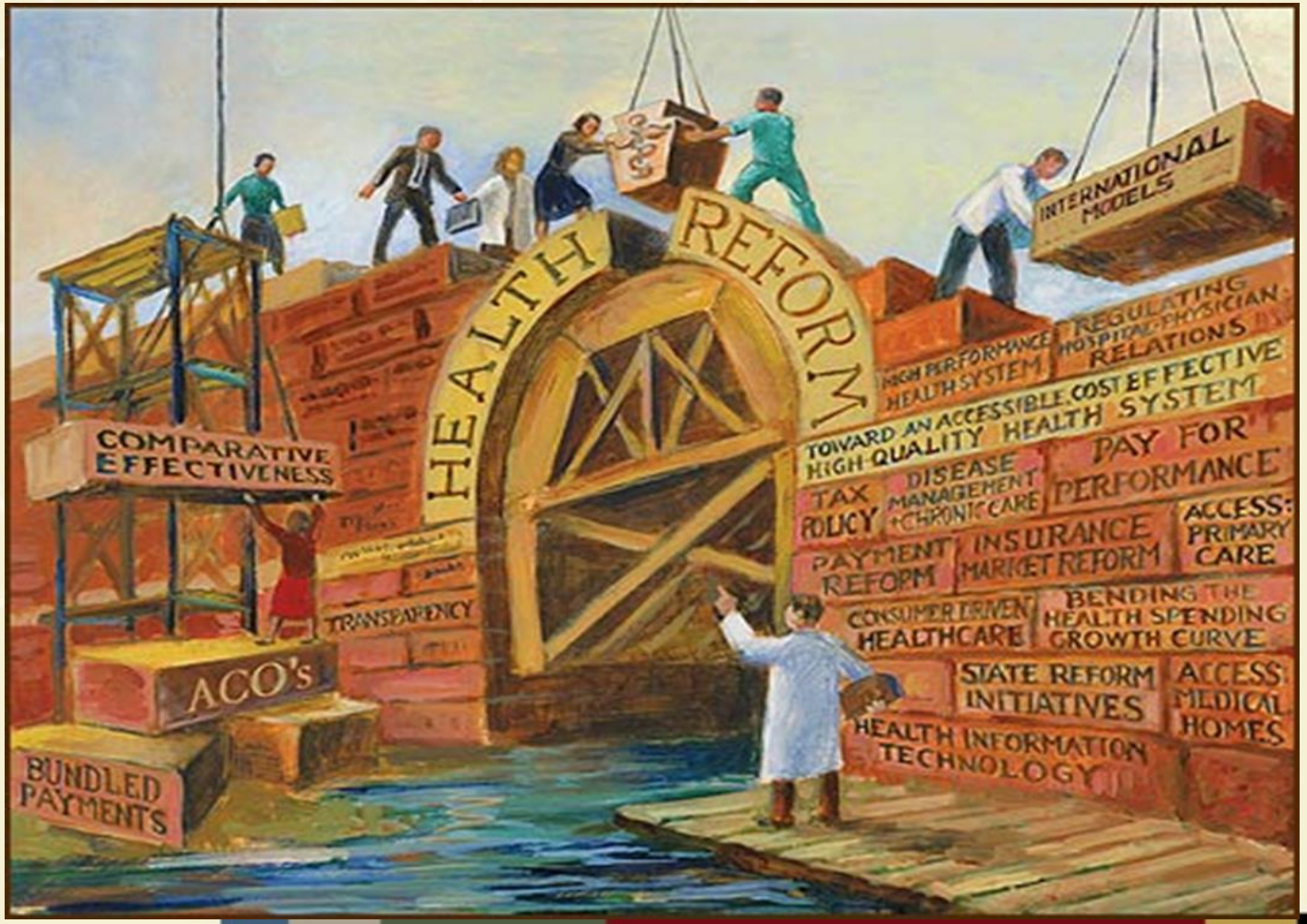
SAMHSA-HRSA
Center for Integrated Health Solutions

National, State & Provider Perspectives on Integrated Health

Jeff Capobianco

There's a lot going on…



Trends in Healthcare

- 73% increase in hospital mergers/acquisitions from 2009-2011. Movement appears to be same for behavioral healthcare providers.
  Source: DHG Healthcare, 2013

- 2012 to 2013, 40 states implemented/planning to implement significant managed Medicaid initiatives. source: Openminds.com

Investment in BH

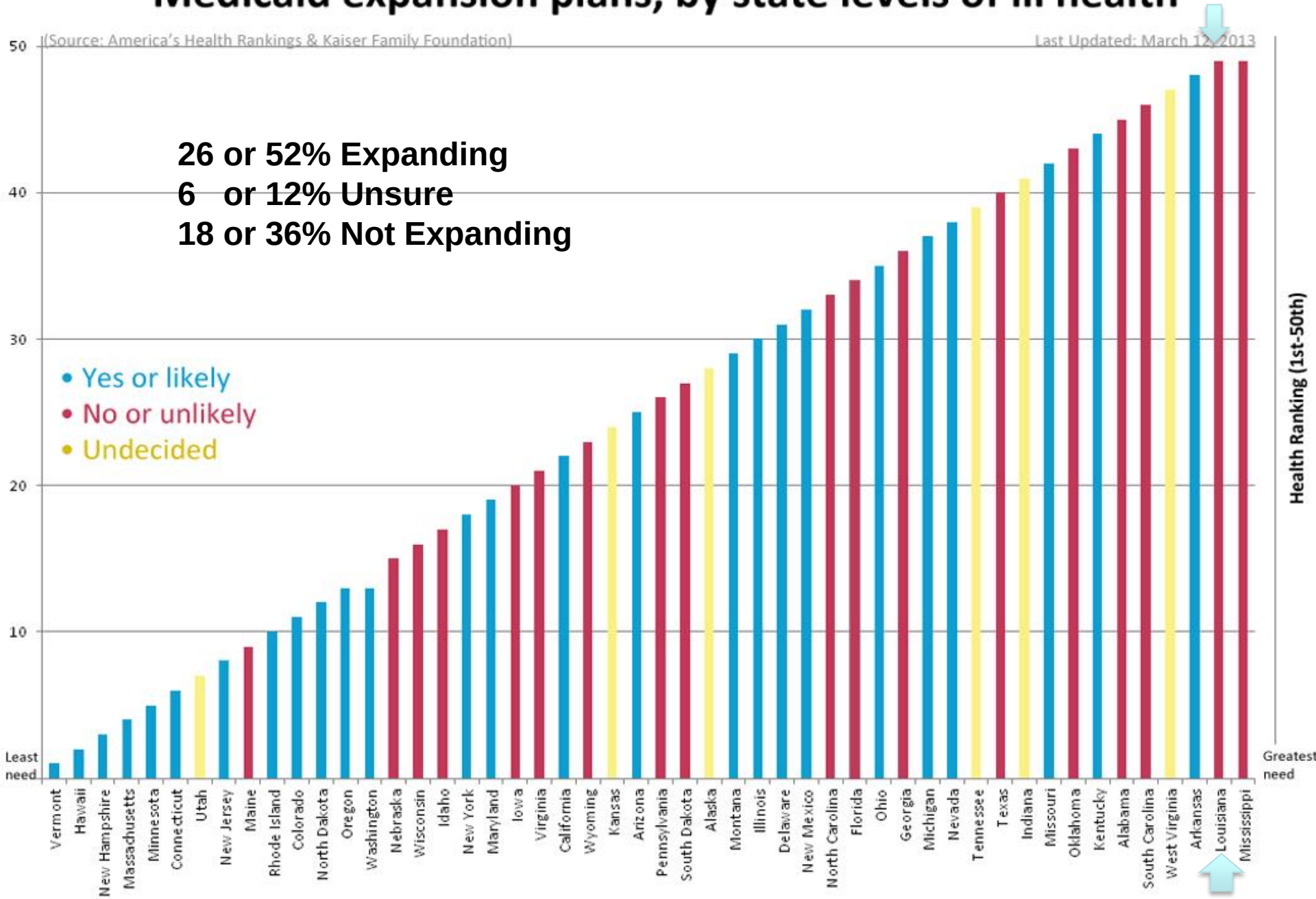
www.TheNationalCouncil.org

BH is attractive to investors b/c:

- Growing Market: National expenditures on BH are expected to reach $239 billion in 2014, up from $121 billion in 2003 (7% compounding growth rate).
- Favorable Legislation: Includes ACA, Parity, Carve-in approaches, & states moving to Managed Medicaid.
- Diverse Payer Mix: Mcare, Third Party, Mcaid (most risky)
- Attractive Financing Model: Compared to general acute care hospitals margins=mid-teens, inpatient behavioral healthcare margins = 20-40% for acute hospitalization & 15-25% for residential treatment w/ maintenance at 2% of revenue.
- Niche Markets: BH with untapped “Downsize fitness” business models.

Private equity investors accounting for roughly 30% of overall activity during 2010 & 2011. (Source: Jon Hill; Triple-Tree.com)

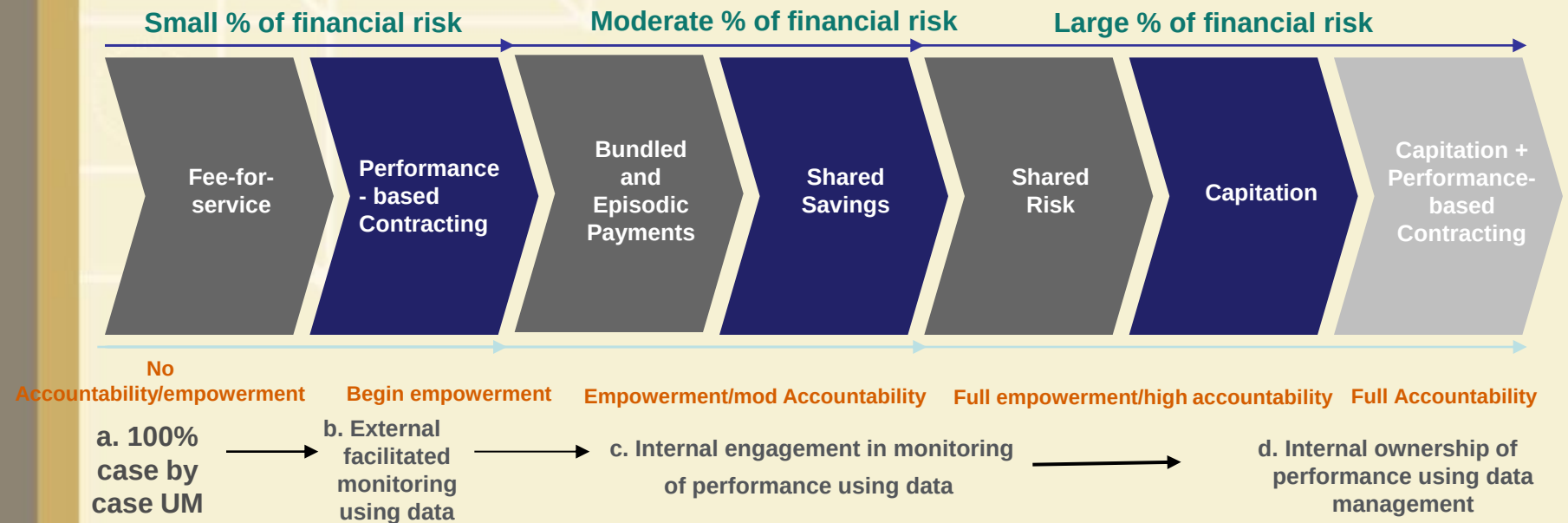
Medicaid expansion plans, by state levels of ill health



Transitioning to Supporting Financial Risk, Accountability, & Utilization Management Practices

Provider Compensation Continuum

(Level of Financial Risk)

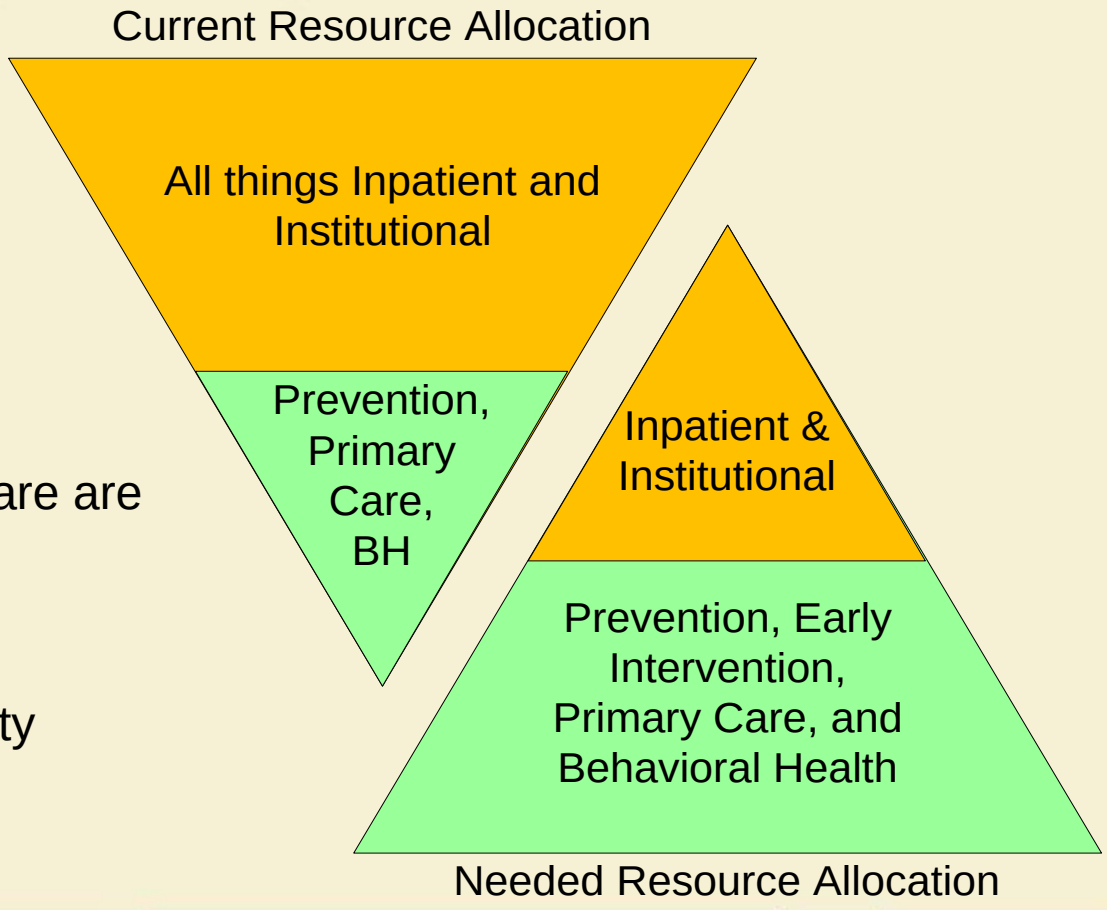


Source: Rhonda J Robinson Beale, M.D.
Optum Chief Medical Officer, External Affairs

Service Delivery and Payment Reform

It's about Inverting the Resource Allocation Triangle so that:

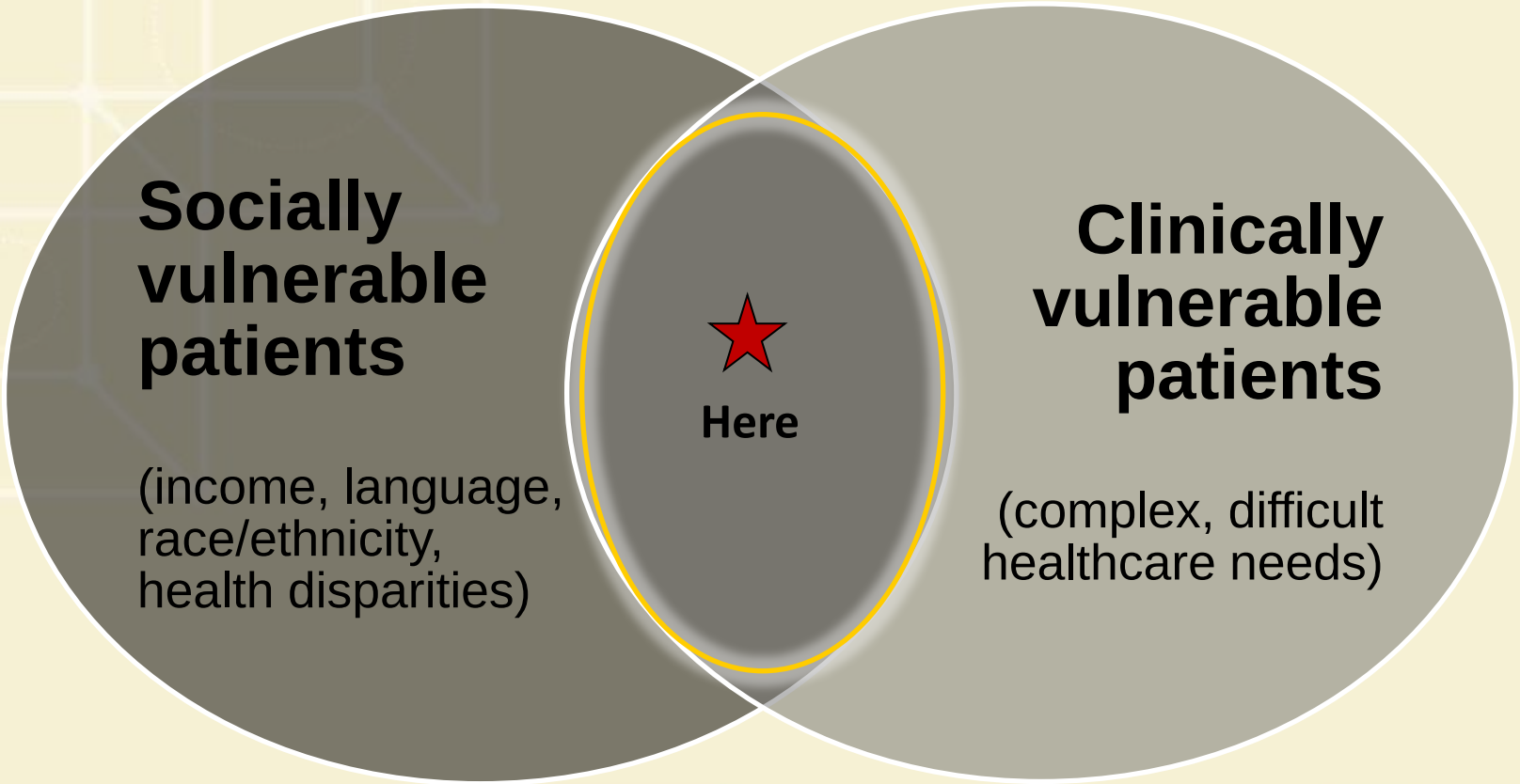
- Inpatient and Institutional Care are limited
- Chronic conditions are care coordinated in the community



So Maybe Your Thinking…

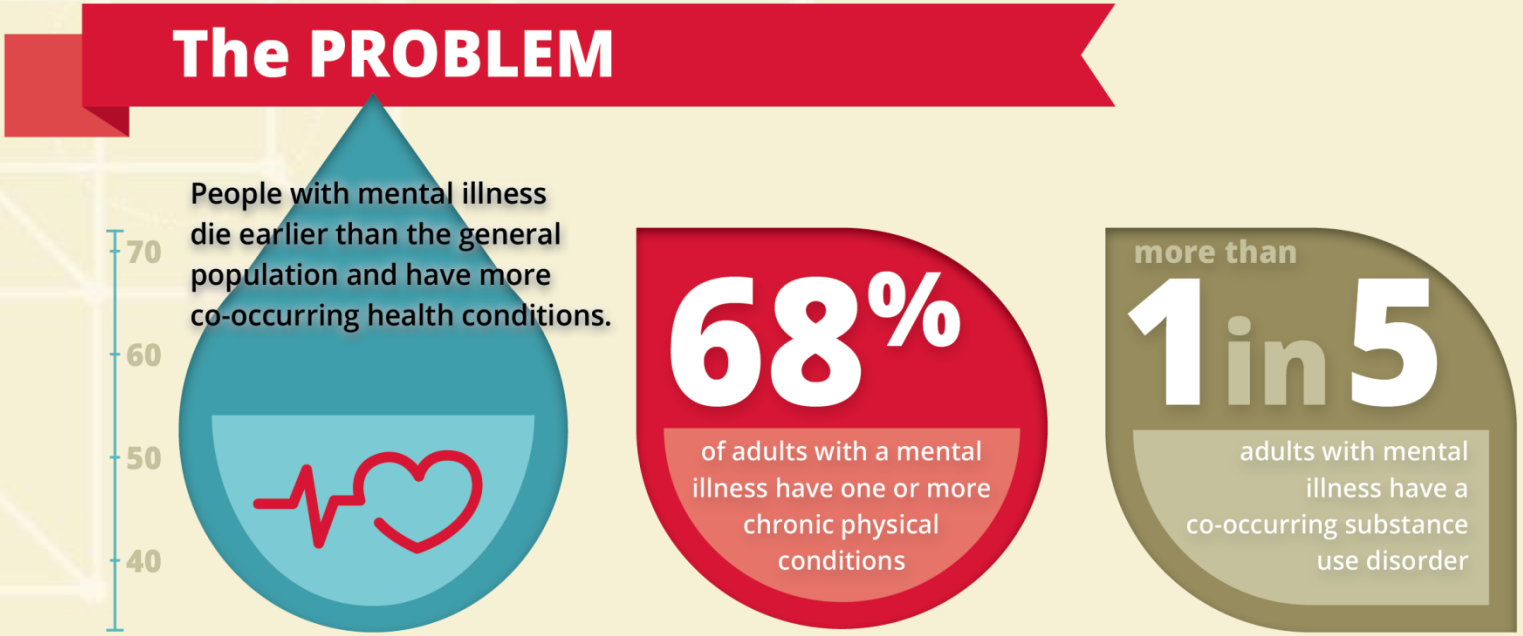
Or…

"We're ready to begin the next phase of keeping things exactly the way they are."



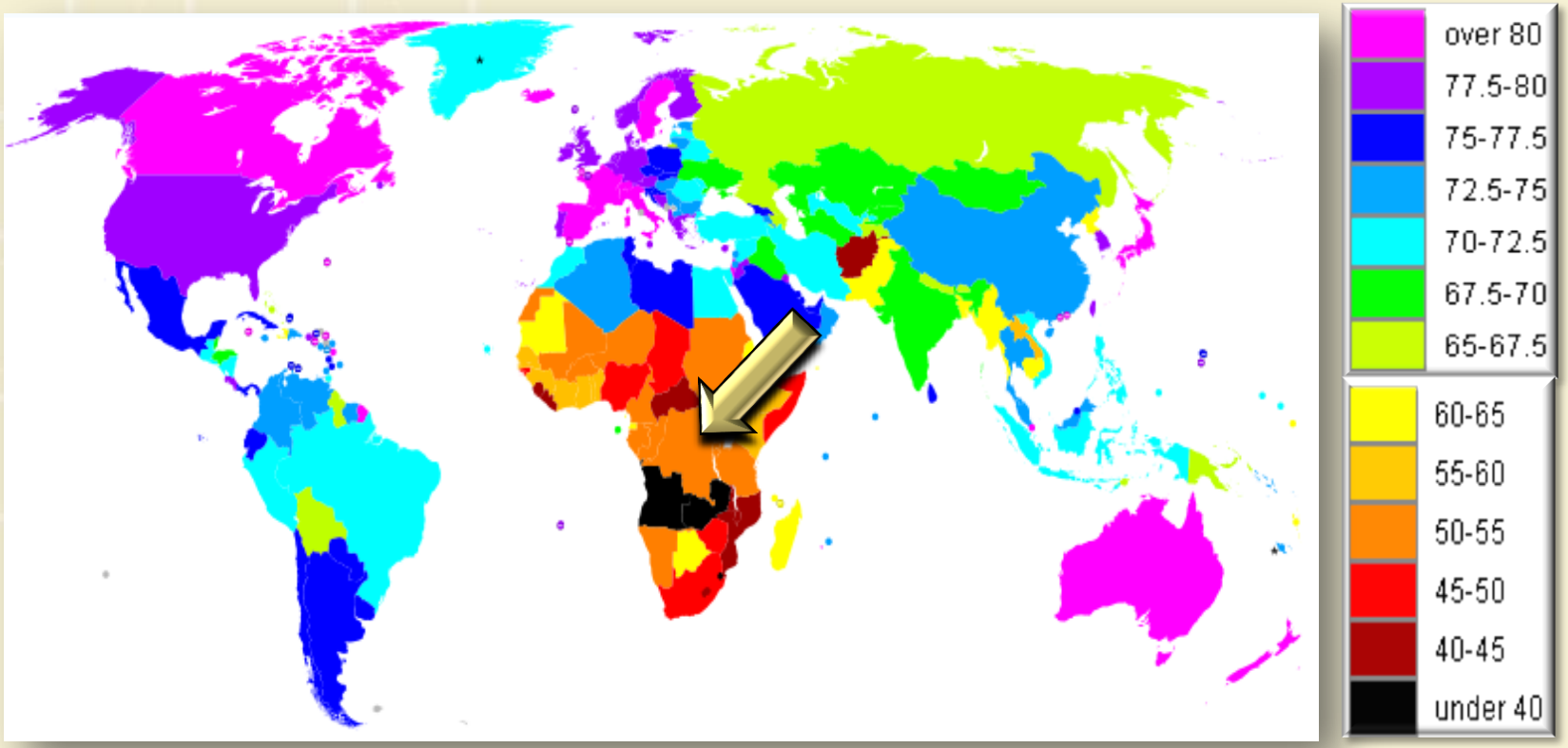
Source: Health Affairs: VA Lewis, et al. "The Promise and Peril of Accountable Care for Vulnerable Populations: A Framework for Overcoming Ob
2012.

Healthcare Services Change:



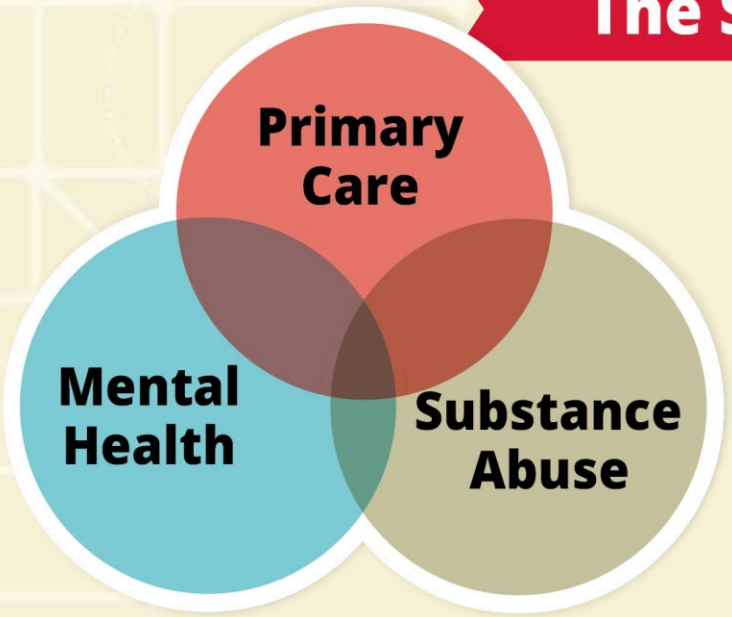
Source: http://www.integration.samhsa.gov/Integration_Infographic_8_5x30_final.pdf

The 53 year lifespan for people *with* Serious Behavioral Health Conditions is comparable with Sub-Saharan Africa



NASMHPD 2006 Study: *Morbidity and Mortality in People with Serious Mental Illness*

The SOLUTION



The solution lies in integrated care – the coordination of mental health, substance abuse, and primary care services.

Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.

Source: http://www.integration.samhsa.gov/Integration_Infographic_8_5x30_final.pdf

Standard Framework for Integration

Referral (Good)		Co-Located (Better)		Integrated (Best)	
Key Element: Communication		**Key Element: Physical Proximity**		**Key Element: Practice Change**	
Level 1 *Minimal Collaboration*	**Level 2** *Basic Collaboration at a Distance*	**Level 3** *Basic Collaboration On-Site*	**Level 4** *Close Collaboration On-Site with Some System Integration*	**Level 5** *Close Collaboration Approaching an Integrated Practice*	**Level 6** *Full Collaboration in a Transformed/ Merged Integrated Practice*
Behavioral health, primary care and other healthcare providers work:					
In separate facilities.	**In separate facilities.**	**In same facility not necessarily same offices.**	**In same space within the same facility.**	**In same space within the same facility (some shared space).**	**In same space within the same facility, sharing all practice space.**

Collaboration Continuum between Primary & Behavioral Healthcare

Levels of Integration

Domains of Integration

	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
	Minimal Collaboration	*Basic Collaboration at a Distance*	*Basic Collaboration On-Site*	*Close Collaboration On-Site with Some System Integration*	*Close Collaboration Approaching an Integrated Practice*	*Full Collaboration in a Transformed/ Merged Integrated Practice*
Consumer Access to Primary & Behavioral Health Services	Two front doors; consumers go to separate sites and organizations for services	Two front doors; consumers go to separate sites; clients supported w/ transportation & coordination of scheduling	Separate reception, but accessible at same site cross system conversations on individual cases with signed releases of information	Separate reception, but accessible at same site; easier collaboration at time of service	Same reception; some joint service provided with two providers on site with some overlap	One reception area where appointments are scheduled; usually one health record, one visit to address all needs; integrated provider model
Clinical Services Coordination	Separate and distinct services (i.e., two Rx'ers and treatment plans); Clinicians rely on client for health information from providers seen outside of their service	Separate and distinct services with occasional sharing of treatment plans for consumers with high/urgent Behavioral and Physical Health Care needs	Separate and distinct services and treatment plans; two physicians (i.e., psychiatry & primary care) prescribing; Beh staff attend some appts at primary care	Two physicians prescribing with consultation; two treatment plans but routine sharing/coordination regarding individual consumers; Beh/Primary Care staff have protocols for services coor.	Two physicians prescribing same treatment plan integration, but not consistently with all shared consumers	One treatment plan with all consumers, one site for all services; ongoing team consultation between providers; one set of lab work;
Funding	Separate systems and funding sources, no sharing of resources	Separate systems and funding sources, sharing of financial information	Separate funding systems; both may contribute to one project with goal of shared funding	Separate funding, but sharing of some on-site expenses	Separate funding with shared on-site expenses, shared staffing costs and infrastructure	Integrated funding, with resources shared across needs; maximization of billing and support staff; potential new fl[redacted]

Collaboration Continuum between Primary & Behavioral Healthcare

Levels of Integration

Domains of Integration	Level 1 *Minimal Collaboration*	Level 2 *Basic Collaboration at a Distance*	Level 3 *Basic Collaboration On-Site*	Level 4 *Close Collaboration On-Site with Some System Integration*	Level 5 *Close Collaboration Approaching an Integrated Practice*	Level 6 *Full Collaboration in a Transformed/ Merged Integrated Practice*
Organizational Governance & Infrastructure	Separate systems with little to no collaboration; consumer is left to navigate the chasm	Separate systems with little to no collaboration; consumer is left to navigate the chasm	Two governing Boards; line staff work together on individual cases; policies and procedures take into consideration care integration	Two governing Boards with Executive Director collaboration on services typically for high need/utilizing consumers	Two governing Boards that meet together periodically to discuss mutual issues and strategic planning	One Board with equal representation from each partner; Board members include consumers of services
Use of Evidence-Based Practices (EBP's)	Individual EBP's implemented in each system;	Two providers, some sharing of EBP information but responsibility for care cited in one clinic or the other	Two providers, more formal sharing of information (e.g., cross training/brown bag lunch sharing) but responsibility for care cited in one clinic or the other	Some sharing of EBP's around high need/utilizers; agreed upon process for ongoing sharing of knowledge betw providers	Sharing of EBP's across systems; joint monitoring of health conditions for low and high need/utilizing consumers; cross-site protocols for EBP provision	Use of same EBP's for example use of validated screening and assessment tools of BH and PC; Motivational Interviewing, disease pathway protocols, etc. provided for all consumers
Management of Data	Separate data systems, often paper based, little if any sharing of data; no focus on population management	Separate data systems, often paper based; sharing of data via fax or secure email for high/utilizers; no focus on population management	Separate data systems; charting in two records; staff with access to both records; some discussion of population management high cost/use clients; little to no QI process	Separate systems; well defined consent and data sharing process; dashboards for population management for high cost/use clients; QI process not routinely used in response to data findings	Separate data systems, some individual case collaboration; some aggregate data/population level data sharing; registry in development; all clients reviewed via dashboards for pop management; QI process in use	Fully integrated, (electronic) health record with information available to all practitioners on need to know basis; clinical data registry in place for managing population for all clients, robust QI process for response to data findings

Resources

http://kff.org/report-section/integrating-physical-and-behavioral-health-care-promising-medicaid-models-issue-brief/

(Kaiser: Newly Released Kaiser Issue Brief on IH)

http://www.integration.samhsa.gov/

(Center for Integrated Health Solutions: Great resource on everything integration)

http://www.integratedcareresourcecenter.com/

(Integration Care Resource Center: details what is happening with health reform in each state)

http://www.chcs.org/

(Center for Healthcare Strategies: Focused on publicly funded healthcare and the transformations underway)

http://www.h2rminutes.com/main.html

(Updates on the ACA for professions—great site to sign up for email notices)

http://integrationacademy.ahrq.gov/atlas

(Agency for Healthcare Research and Quality: Integration Academy resources)

Summit Work Groups

Overall Purpose: To move forward the great Integrated Health work being done around the state by identifying common local/regional needs and best practices that can be addressed at the state level by work group members, the state government, MCO's, universities, foundations, etc.

Work Group Goals

Financing Work Group: Identify barriers and solutions to funding Integration.

Strategic Communication Work Group: Identify a comprehensive approach and means for state level communication to policy makers, funders, and providers about what IH is, how to accomplish it, and to provide a statewide mechanism for providers to share information about IH.

Work Group Goals (cont.)

Care Coordination Work Group: Identify state level system approaches, barriers, and solutions to facilitate seamless care coordination for consumers of services.