Integrating Primary Care and Behavioral Health in New Hampshire

Monday, November 24, 2014

Dennis Freeman, Ph.D.
Chief Executive Officer, Cherokee Health Systems

Joel Hornberger, MHS
Chief Strategy Officer, Cherokee Health Systems

Parinda Khatri, Ph.D.
Chief Clinical Officer, Cherokee Health Systems

Christi Granstaff, MSW
Policy Consultant, Cherokee Health Systems

Bob Franko, MBA
Vice President/National Training Coordinator
Common Vision

- Improved population health
- Need for transformation
- Improved care for high-need, high-cost patients
- Manage health care cost
- Strengthen the care delivery system
Best Practice Integration

- Blended care team
- Shared support staff and physical space
- Well orchestrated clinical flow
- One clinical record, unified treatment plan
- Communication is immediate
- Shared patient population
- Reimbursement mechanisms support the model
Promoting Integrated Care in the State of New Hampshire
Developed a database with over 120 contacts

Phoned 51 people/organizations to start

Visited 13 provider sites, met with 17 policy-makers and payers

As of Oct. 31, 2014: Approx 300 manhours
Identification of factors where gaps exist; gaps between where the state is now and where it needs to be to further integrated care practice:

**Expertise** – Identification of leadership and best practices

**Functional** – Systems, logistics and facilities in place

**Financing** – Shift from volume-based contracting to value-based contracting

**Needs** – Current and underserved patients that would benefit

**Workforce** – Access to appropriate personnel

**Training** – How to train the workforce

**Policy** – Current state, payer, and provider policies and agendas can be better aligned
Inhibiting Factors

- Access to trained workforce
- How to adequately train the workforce
- Limited access in certain areas, particularly to specialized mental health services
- Issues related to billing and reciprocity
- Infrastructure – physical space, collaborative agreements, EHR
- Assuring that all stakeholders truly understand integrated care
- How to contract for integrated care – capitated rates, shared savings
- The emergence of MCOs can often be a challenge as payment methodologies are developed
- Linking substance abuse services
Observations of Encouraging Activity:

- A multidisciplinary team for pediatric patients that includes a social worker and dietician
- Better management of chronic illness
- Improved identification of psychosocial factors & mental health issues
- Primary care clinics that have social workers on site
- Community linkage with essential services and supports
- Same day billing allowance that allows for multiple services in one visit
• Health plans allow for integrated care billing codes and same day billing
• Most plans seem willing to negotiate value-based contracts
• Interest throughout the layers of state government in this model and transformation
• Potential of the 1115 Waiver
• In-state expertise
• Most every primary care site we contacted was providing some level of behavioral interventions
Strategies
State Specific
National Best Practices
Actionable
Short, Intermediate, Long-Term Objectives

Immediate
• Understand the functional and beneficial differences between co-location and fully integrated practices
• Re-evaluation of organizational missions that create an integrated care culture

Intermediate
• Build relationships with MCOs around the idea of supporting the infrastructure for integrated care
• This does not necessarily add cost, in fact it’s likely to produce savings
### 3 P’s of Practice Transformation

#### People
- Recognize social determinants of health
- Informed and activated patients
- Personal responsibility for health
- Identify workforce gaps
- Support academic programs to train behaviorists
- Training of current workforce
- Telemedicine
- Leadership and partnerships to support efforts

#### Processes
- Strengthen the safety net within the state
- Convene provider summit to strengthen collaboration and understanding
- Focus on increasing access through population-based scheduling
- Support transformation, i.e. patient-centered practice
- Use of appropriate codes
- Shift to value-based contracting

#### Policies
- Input into the structure of the CMS 1115 Waiver
- Presentation to legislators
- Collaboration with payers and providers on integrated care coding and billing
- Inform state policymakers on the benefits of policies to encourage integrated care
- Remove licensure and regulatory barriers to integrated care practice
Final Report

Tuesday, December 9, 2014
2:30 p.m. – 4:30 p.m.

Comments and Suggestions

Dennis.Freeman@CherokeeHealth.org
Joel.Hornberger@CherokeeHealth.org
Parinda.Khatri@CherokeeHealth.org
Christigranstaff@Bellsouth.net
Bob.Franko@CherokeeHealth.org

Thank You!
See you on December 9 – Happy Thanksgiving