SCALING INTEGRATION THROUGH HEALTH POLICY

NORTH CAROLINA POLICY SUMMIT

EUGENE S. FARLEY, JR. HEALTH POLICY CENTER

COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION
North Carolina, like many states, is currently pursuing new models of care that better integrate mental health and substance use services.

In partnership with the Collaborative Family Healthcare Association and the North Carolina Center for Excellence in Integrated Care, the Eugene S. Farley, Jr. Health Policy Center at the University of Colorado School of Medicine led a half-day policy summit to create specific actionable items for the state to pursue in support of better integration of behavioral health with primary care. After a series of speeches by experts on specific topics, three main areas for North Carolina to consider were discussed.

- Defining a vision for integrated care
- Developing the workforce for integrated care
- Creating policies and payments in support of integrated care

Through a series of small workgroups, each of these topics led to a series of recommendations that were proposed to be presented to North Carolina leadership for consideration.
On October 12, 2016, in partnership with the Center of Excellence for Integrated Care (COE) and the Collaborative Family Healthcare Association (CFHA), the Eugene S. Farley, Jr. Health Policy Center hosted the North Carolina “Scaling Integration through Health Policy: North Carolina Policy Summit.” Held at the Duke Endowment in Charlotte, North Carolina, this event directly preceded the 2016 CFHA Annual Conference.

The purpose of the policy summit was to bring together leaders from across the state to discuss ways to advance mental health and substance use services, hereafter referred to as behavioral health, within larger health reform efforts. Specifically, the need to integrate behavioral health in primary care was highlighted as one possibility for better addressing unmet behavioral health needs. Integration, as defined by the Agency for Healthcare Research and Quality, is “the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of healthcare utilization.” As is the case in many states, there are often policy barriers that stand in the way of achieving integrated care. North Carolina is no different.

To address these issues, over 50 attendees from across North Carolina state government, professional associations, healthcare practice, academic institutions, continuing education, and funders joined speakers from other states to determine critical action necessary to make integrated care work. The event was designed to provide a platform for action, beginning with a line-up of state- and nationally-recognized speakers selected to identify crucial drivers that are promoting fragmentation and stalling the movement.
Dave Richard, Deputy Secretary, Medical Assistance at North Carolina Department of Health and Human Services opened up the meeting after opening remarks from Dr. Benjamin F. Miller, Director of the Farley Health Policy Center at the University of Colorado School of Medicine.

Mr. Richard presented the needs for future planning for the integration of behavioral health and medical care. Focusing on the 1115 Waiver North Carolina submitted to the Center for Medicare and Medicaid Services, he asserted that continuity would be key and “person-centered health communities” are essential in closing care gaps. However he indicated that how integrated care will be defined and delivered and how systems will work together have yet to be determined. Mr. Richard stated that “the needs of the people in North Carolina will drive change.” Looking at the person and family outside of the healthcare setting was a key point that set the stage for the meeting.

Focusing on what’s next for North Carolina and integrated care, Courtney Cantrell, former Senior Director, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, presented on the importance of using data to drive better payment options and to support a strong business case. Dr. Cantrell asserted that the ability to pay for integrated care services have stalled. Both state government and private insurers need to reform the payment policies that are currently placing a ceiling on reimbursement and sustainability. She further asserted that to drive these changes, strategic use of robust sources of data is necessary. Dr. Cantrell’s comments relate to North Carolina but are generalizable to the nationwide push to better address behavioral health.

“The needs of the people in North Carolina will drive change.”
Dr. Benjamin Miller followed Dr. Cantrell’s comments by highlighting lessons learned from other states and connecting those to North Carolina’s vision of reform. “Who gets what care where?” is one of the central questions to be answered, according to Dr. Miller.

Those responsible for practice transformation and policies should focus on appropriate levels of care as well as acknowledge the fact that healthcare is only a small percentage of a person’s overall wellness. Measurement drives development and improvements – most payers and funders want the goals and outcomes for integrated services and programs to be clearly identified. Dr. Miller emphasized that the “how” and “what” to measure are where we should concentrate our energy. Measuring health outcomes only can “back us into a corner” without considering the process measures, “reach,” quality, and most importantly, the patient and family experience and reported outcomes.

Dr. Miller connected the financial and workforce issues that are plaguing the development of integrated care. He commented that if we change from a fee-for-service model to “take healthcare professionals out of their respective silos,” we will have to develop ways to measure these new teambased models. In addition, he emphasized that the way we view workforce needs to shift from traditional licensure requirements that do not take into consideration the competencies required to work in new delivery settings for behavioral health like primary care. And finally, Dr. Miller asked the participants to consider how the social determinants of health fit into the way we are planning and executing new standards of care. Again, healthcare planners and providers will have to acknowledge all of the factors outside of their practice settings that influence health and wellness.
Dr. Alexander Blount from the University of Massachusetts offered a deeper dive into integrated care implementation and workforce.

Sharing the lessons learned from Massachusetts, a state that embraced integrated care in its Medicaid reform, he reported that success did not happen “overnight.” Obstacles related to pushing a state-wide integrated care initiative are complex but possible to be addressed if all levels of the system are on board. From policy-makers to providers, he emphasized the need for everyone to be willing to make fundamental changes to payment models, provider credentialing, and use of data to drive improvement. However, he noted, Massachusetts’s shift was not without its problems. Dr. Blount described the importance of having emergency funding available to assist many of the qualifying practices that did not have the adequate infrastructure or knowledge to execute integrated care. Also, he noted that if the practice did not serve enough Medicaid patients, the program was not sustainable.

On the subject of workforce, Dr. Blount asserted that on-the-ground training and support was critical to successful implementation. Webinars and assembled meetings are not enough to transition traditional practices. They also found that investing in the additional training needed for clinicians and staff to succeed — “growing their own workforce” — ultimately saved money. He also observed that care managers, which are central strategy in North Carolina’s Medicaid program, are essential members of the integrated care team.

The last presentation addressed federal-level payment reform. Dr. Lesley Manson from Arizona State University offered an overview of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This legislation is relevant to the future of integrated care due to it push for value and quality over volume in healthcare through changes to traditional payment systems. While only applicable to Medicare at this time, other payers may look to Medicare’s initiatives as they make future revisions.
Phase two of the summit required participants to select one of three breakout sessions:

1. **Defining Your Organizational Vision**; 2. **Workforce and Educational Needs**; or 3. **Policy and Payment Reform**. Dr. Adam Zolotor, President and CEO of the North Carolina Institute of Medicine, facilitated the group process. The break-out groups reported the actions items required to further integrated care in North Carolina:

**Defining a vision for integrated care**

» Define what integrated care is for North Carolina
» Create a model that can provide equal care to all individuals
» Inventory local innovation and successes
» Use patient and provider stories of integrated care
» Keep a local community focus throughout all redesign efforts
» Create a space for defining the vision

Attendees recognized how organizations may use these action items to help begin strategically planning for integrated care. It was agreed that even though the pace of healthcare change moves quickly and is often reactionary, most of these steps are essential for organizational transformation.

Once the vision for integrated care is created, it will then require a workforce that is capable of delivering this type of care. The group identified several workforce needs that North Carolina may pursue.

**Developing the workforce for integrated care**

» Retrain the existing behavioral health workforce equipping them with skills necessary to work in primary care
» Develop statewide inter-professional standards for behavioral health and offer trainings to these standards
» Develop statewide competencies for behavioral health providers working in primary care
» Restructure training and education programs to be more focused on team based care delivery

The group’s action items aligned with many of the points presented throughout the day, highlighting a more intentional, multi-systemic approach to training both the incumbent and the emerging workforce. Participants discussed how the workforce should be taught competencies that can be applied to all members of the integrated care teams. The North Carolina AHEC system also emerged as a potential organization to centralize some of the proposed training initiatives.
Creating policies and payments in support of integrated care

» Pursue a mechanism to align payers in support of integrated care
» Highlight and pursue promising payment models that support integrated care
» Assess which policies limit behavioral health services outside of traditional behavioral health settings
» Consider pursuing revisions to Chapter 122C
» Convene a task force on healthcare analytics and behavioral health metrics (NCIOM is currently developing)

During the review of these recommendations, there was general agreement that the current payment models are not compatible with integrated care practice. Policies that guide payment on the state level may change the proposed 1115 Waiver; however, it was noted that longer-term, comprehensive solutions should to be identified to fit the state system. For example:

» Consider that integrated care may not be simply about changing the way behavioral health is paid for, but more accurately may be about changing the way primary care is paid for that includes behavioral health
» Create payment models that make sure the delivery setting is getting paid to keep the patient healthy, not per patient visit (e.g. move as quickly as possible away from fee for service to value based payment models)
» Support the inclusion of incentives to encourage primary care clinicians to work with behavioral health (e.g. hold them accountable or at risk for certain behavioral health conditions)

In closing the event, participants were asked to identify people or organizations that could be responsible for executing the action items in the coming year. It was decided that the North Carolina Center of Excellence would bring these recommendations back to the North Carolina Integrated Care steering committee to determine next steps. The Integrated Care steering committee includes representatives from across the healthcare and policy sectors. Participants also recommended that a white paper be drafted to summarize the current state of integrated care in North Carolina, which would be submitted to the NC Journal of Medicine. This report would include the proceedings from this summit. Finally, the group agreed that a progress report outlining the results of the action items should be presented during the policy summit at the 2017 CFHA Annual Conference in Houston, Texas.