Connecting the Dots to Achieve Integrated Care: The 1115 Waiver, Health Homes, and Certified Community Behavioral Health Clinics (CCBHCs)
How Many of You Remember...

• “The past is a foreign country, they do things differently there.”

• “Prediction is very difficult, especially if it’s about the future.”

• “My interest is in the future because I am going to spend the rest of my life there.”
I ask because of the *Forgetting Curve*

- *Within one hour,* you will have forgotten an average of 50 percent of the information you presented;
- *Within 24 hours,* you will have forgotten an average of 70 percent of new information; and
- *Within a week,* the numbers rises to an average of 90.
- And what I’m going to discuss might be too important to forget!

*Figure 1: The forgetting curve*
outcomes integration population workers
management across screening patient-centered
improvement inappropriate shared physical
screens benchmarks
multi-disciplinary diseases community
behavioral coordinate delivery increase housing
other target systems quality home
palliative point purchasing including
whole inpatient homes risk ER
within between coordinator chronic
primary high coordination follow-ups positive
reconciliation value-bases total people
analytic frontline collection
supportive integration data use settings
people whose goals PCPs capacity
value-based promote medication
services
We’ve Been Scratching Our Heads
Are All of the California Initiatives...

• A Jackson Pollack Painting?

• A Finely Orchestrated Design?
I’ve Concluded...

• This is a once in a generation opportunity.
• Communities across the state will either flourish or flounder.
• The outcome is uncertain.
• We’d like all of you to be on the flourish end.

flounder¹

[ˈflaʊndər] (ɔr)

VERB

1. struggle or stagger helplessly or clumsily in water or mud:
   “he was floundering about in the shallow offshore waters”

  synonyms: struggle · thrash · flail · twist and turn · splash · stagger · [more]
Life Expectancy by Neighborhood/County

And if you have a Serious Mental Illness, anywhere in California, take 20 years off the lightest shaded areas.
# Let’s Unpack the Initiatives

<table>
<thead>
<tr>
<th></th>
<th>1115 PRIME</th>
<th>1115 WPC Program</th>
<th>2703 HHP</th>
<th>IEHP BHII</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Name</strong></td>
<td>California Medi-Cal 2020 Demonstration 1115 Waiver Public Hospital Redesign and Incentives in Medi-Cal</td>
<td>California Medi-Cal 2020 Demonstration 1115 Waiver Whole Person Care (WPC) Program</td>
<td>ACA Section 2703 Medical Health Home Program State Plan Option</td>
<td>Behavioral Health Integration Initiative</td>
</tr>
<tr>
<td><strong>Short Description</strong></td>
<td>A $7.5 billion program to transform California’s public hospitals into entities that take responsibility for the quality and cost of their patients, achieving sustainability of the new models by 6/30/2020</td>
<td>A $3 billion program to test county-based pilots that coordinate health, behavioral health and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple systems and continue to have poor outcomes.</td>
<td>An initiative to develop Community-based Care Management entities that wrap care around the highest risk Medi-Cal enrollees. Funded with a 90% federal Medi-Cal match</td>
<td>A local, IEHP-funded initiative to support teams in primary care clinics, behavioral health providers, and local hospitals to develop customized approaches to provider integrated care for individuals with behavioral health disorders and complex health conditions</td>
</tr>
<tr>
<td><strong>Time Frame</strong></td>
<td>Beginning first half of calendar year 2016 through the end of SFY2020</td>
<td>Round 1 applications will likely be due by 5/15/2016. There may be a round 2 of additional funds are available. Funds run through 12/31/2020</td>
<td>Beginning 7/1/2017 for members with SMI and 1/1/2018 for Other Eligible Members; Extra federal funding for 8 quarters</td>
<td>Two-year program, with a clock that starts ticking in early 2016</td>
</tr>
<tr>
<td><strong>Target Population</strong></td>
<td>The most vulnerable patients of public hospitals who are “super-utilizers”. Note: Integration of Physical and Behavioral Health is a required activity.</td>
<td>Includes those with avoidable and repeated use of ERs, hospitals and nursing homes; 2+ chronic health conditions; mental health and/or substance use disorders; homeless or at risk of homelessness</td>
<td>The top 3% to 5% most expensive persons in the Medi-Cal population who will benefit from having care wrapped around them; includes persons with 2+ chronic health conditions and/or a serious mental illness</td>
<td>Individuals have two or more chronic conditions, one of which is a mental health disorder (moderate to severe substance use disorders are included as chronic conditions) and, or a substance use/addictive disorder</td>
</tr>
</tbody>
</table>
The California Trifecta

<table>
<thead>
<tr>
<th>What</th>
<th>Medi-Cal 2020 PRIME</th>
<th>Medi-Cal 2020 Whole Person Case</th>
<th>2703 Health Home Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiative to transform Public Hospitals into entities that take responsibility for the quality and cost of their patients inside the hospitals and in the community. Begins NOW.</td>
<td>County-Based, Lead-Entity Led Pilots to coordinate health, behavioral health and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple systems. Begins late spring 2016.</td>
<td>Community-Based Care Management Entities that wrap care around the highest risk Medi-Cal enrollees to improve outcomes and health. Begins July 2017.</td>
<td></td>
</tr>
<tr>
<td>Who</td>
<td>Designated Public Hospitals, District Municipal Public Hospitals</td>
<td>County Agencies, Designated Public Hospitals, District Municipal Public Hospitals</td>
<td>Primary Care Clinics &amp; Other Provider Organizations that serve a high volume of HHP-eligible members.</td>
</tr>
<tr>
<td>Goals</td>
<td>Improve Care Coordination, Increase Integration Across Systems, Increase Team-Based Care, Integrate Physical and Behavioral Health, Improve Population Health, Improve Data Collection and Sharing, Improve Health Outcomes, Improve Cost, Increase Access to Social Services and Supports, focusing on the MOST COMPLEX, MOST EXPENSIVE MEMBERS!</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Plus the 4th Puzzle Piece: CCBHCs

- CCBHC = A Federal Definition
- CCBHC = The BH Sibling to FQHCs
- CCBHC = A Comprehensive Community Behavioral Health Provider Organizations with...
  - Common Scope of Services
  - Common Quality Metrics
  - Paid with a Prospective Payment System (PPS)
- With the same Goals…

Improve Care Coordination, Increase Integration Across Systems, Increase Team-Based Care, Integrate Physical and Behavioral Health, Improve Population Health, Improve Data Collection and Sharing, Improve Health Outcomes, Improve Cost, Increase Access to Social Services and Supports, focusing on the MOST COMPLEX, MOST EXPENSIVE MEMBERS!
The Overarching Aim

• Turn the existing delivery system silos...
Into...

- Supported by billions and billions of dollars
  - WPC: $3B
  - PRIME: $7.5B
  - 2703: TBD
  - CCBHC: TBD

Layer 1: Wellness, Prevention, Early Intervention
- Initiatives to prevent health conditions before they begin to develop

Layer 2: Person Centered Health Homes/Health Neighbors (Whole Person Care and Hospital Prevention)
- Health-Home Based Centers of Excellence
- Specialty Health & BH Centers of Excellence

Layer 3: World Class Crisis and Acute Care
What’s the Catch?

- Medi-Cal 2020 Waiver
  - California has convinced CMS that over 5 years, the programs will succeed to the point where they are saving as much Medi-Cal money as its spending on the initiatives.

- Section 2703 Health Home Program
  - California is promising that by the end of two years, the program will learn how to save enough money to be self-sustaining.

- CCBHCs
  - The additional FMAP is for 2 years; after that the program needs to pay for itself.

Translation: In the words of Don Berwick...

“The choice is stark: chop or improve.”
4 Key Areas of Improvement

1. Achieving Centers of Excellence within Organizations
2. Created Integrated Care EVERYWHERE
3. Expanding People, Place and Program to address the Social Determinants of Health
4. Reengineering for World Class Care Transitions

In order to achieve better care, better health and better costs

Paul Farmer, et. al. (Partners in Health)
## Let’s Talk...

<table>
<thead>
<tr>
<th>What</th>
<th>Medi-Cal 2020 PRIME</th>
<th>Medi-Cal 2020 Whole Person Case</th>
<th>2703 Health Home Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiative to transform Public Hospitals into entities that take responsibility for the quality and cost of their patients inside the hospitals and in the community. Begins NOW.</td>
<td>County-Based, Lead-Entity Led Pilots to coordinate health, behavioral health and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple systems. Begins late spring 2016.</td>
<td>Community-Based Care Management Entities that wrap care around the highest risk Medi-Cal enrollees to improve outcomes and health. Begins July 2017.</td>
<td></td>
</tr>
<tr>
<td>Who</td>
<td>Designated Public Hospitals, District Municipal Public Hospitals</td>
<td>County Agencies, Designated Public Hospitals, District Municipal Public Hospitals</td>
<td>Primary Care Clinics &amp; Other Provider Organizations that serve a high volume of HHP-eligible members.</td>
</tr>
<tr>
<td>Goals</td>
<td>Improve Care Coordination, Increase Integration Across Systems, Increase Team-Based Care, Integrate Physical and Behavioral Health, Improve Population Health, Improve Data Collection and Sharing, Improve Health Outcomes, Improve Cost, Increase Access to Social Services and Supports, focusing on the MOST COMPLEX, MOST EXPENSIVE MEMBERS!</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>