and management, clinical considerations, screening and assessments, early intervention and prevention, and establishing “no wrong door” access to comprehensive services.

LEVERAGING STRENGTHS TO SUPPORT INTEGRATED CARE

Our integrated approach combines our experience managing programs and networks for Medicaid and low-income populations, dual eligibles and persons with complex health issues with our partners’ expertise serving the needs of the local community. This total health management strategy is informed by advanced analytics, backed by innovative information technology solutions, and subjected to ongoing quality improvement monitoring and reporting. It is designed to:

• Promote healthy behavior
• Effectively manage chronic illness
• Eliminate barriers to treatment
• Increase service coordination and provider collaboration
• Enhance the members experience with care
• Contain health care costs

If these are your goals as well, we welcome an open dialogue to discuss shared experiences and unique program innovations.

For more information, please contact our Integrated Care Customer & Product Strategy team at: IntegratedCareToolkit@valueoptions.com or visit us at http://www.valueoptions.com/company/integrated.htm, where you can access the integrated care toolkit.

Real Options to Care Integration: A ValueOptions Approach

States, health plans, and providers are embarking on a challenging journey to improve quality, satisfaction, and the use of scarce financial resources. This challenge of doing more with less, better than it’s ever been done before, has taken on a special urgency.

ValueOptions is a national, highly specialized healthcare organization providing proven integration strategies for high risk populations. We help people live to their fullest potential by holistically addressing the thoughts, feelings and behaviors that are central to good health. We manage integrated behavioral health services and programs for individuals in more than 45 publicly funded programs in 17 States and the District of Columbia.

The goal of our integrated care approach is to improve the overall health of individuals who have significant behavioral health needs. We offer practical, feasible, and easily deployable solutions for an evolving healthcare landscape.

We envision a better health care system built on the structural and functional integration of behavioral health and substance use disorder care, physical health care (including medical and oral health), and social supports.

The foundational elements of this vision are:

• A medical home for everyone
• A wellness-based perspective that views all people as deserving of quality physical and behavioral health care
• A focus on prevention that keeps members from moving into higher, more costly levels of care
• A trained behavioral health workforce prepared to work effectively with and in primary care
• A densely networked system of care that leverages the expertise of professional providers and the effectiveness of social support systems such as government agencies, community-based organizations, and peer based recovery resources.

The science is clear that individuals experiencing a serious mental illness die on average 25 years younger than the general population. Total costs for chronic medical conditions are more than 50% greater when there is behavioral health co-morbidity. The Robert Wood Johnson Foundation’s 2011 report on mental health and medical co-morbidity notes that 68% of adults with mental health conditions have physical health conditions, and 29% with medical conditions also have mental health conditions.

DESIGNING A COMPREHENSIVE SYSTEM OF CARE

We define integration broadly, along a continuum, and support it at all levels from integrated care management to practice consultation and support. We recognize that solutions must be tailored to readiness. To this end we are skilled at working within practice and state-level constraints. We specialize in developing systems of care that ensure the highest degree of seamlessly integrated services across all levels of the care delivery spectrum.

We focus on the physical, behavioral, and psychosocial environmental needs of individuals we serve. We deploy evidence-based practice guidelines based on behavior-change principles and supported by best-in-class analytical, assessment, and care planning tools. We feature an extremely flexible design that is easily adaptable to clients’ program preferences.

The core features of our integrated approach include:

• A densely networked system of care
• A focus on prevention that keeps members from moving into higher, more costly levels of care
• A trained behavioral health workforce prepared to work effectively with and in primary care
• A medical home for everyone
• A wellness-based perspective that views all people as deserving of quality physical and behavioral health care
1. **Member Engagement:** ValueOptions uses advanced and comprehensive technologies and approaches to engage members in our programs. For example, across our public sector programs, our members and providers have access to Achieve Solutions, our award-winning member education portal that provides more than 6,000 articles and tip sheets on over 200 health topics covering behavioral and physical health and wellness, family care, depression, anxiety, substance abuse, recovery from mental illness and work/life balance.

Our approach to member engagement has been honed in our Massachusetts Behavioral Health Partnership’s Integrated Care Management Program. This program connects members and their families with primary care and behavioral health professionals (along with state agency Case Managers) to align service delivery with established clinical guidelines for chronic conditions. A key feature of this program is our Member Engagement Center, which provides a single gateway to all health care information, promotes program services, and refers members to appropriate contacts and resources. The center is staffed 24/7 with highly trained health experts, coaches, and peer navigators who use active listening, and motivational interviewing techniques to keep members engaged.

2. **Data Analytics, Business Intelligence and Reporting:** Our integrated care programs are built on advanced analytics and reporting. We analyze benefits at every program level starting with our network providers using our Integrated Practice Assessment Tool (IPAT)®, a newly-developed evaluation tool designed to help health care organizations more accurately determine their integration level. The IPAT enables us to better measure integration both within and across health care settings and our provider networks.

Additionally, our high-performance data warehouse platform, KnowledgeConnect incorporates data from various external sources including behavioral, medical, and pharmacy. Data is routinely used for risk stratification, predictive modeling, and quality reporting at both the individual member and aggregate level. Performance metrics are derived from a variety of sources the National Center for Quality Assurance (NCQA), the National Quality Forum (NQF), and HEDIS®. Ongoing quality analyses are conducted on key performance indicators such as ER use and hospital admissions and readmissions and are used to guide care managers in scheduling follow-up care with either the PCP and/or behavioral health specialist. Additional reporting at both the individual patient and the aggregate level includes:

- **Individual Provider Profiling and Panel Comparative Reporting**
- **Member and Population Care Gap analysis**
- **Integrated Health Clinical and Financial Analytics**

3. **Integrated Information Technology Solutions:** We deploy our integrated care management platform to identify and manage our member’s complete physical, behavioral, and psychosocial environment needs. This platform is accessed through our member-centric record, Spectrum®. Spectrum serves as an easily accessed central hub to support information sharing among the member, ValueOptions’ Clinical Care Managers, Health Plan Case Managers, and physical and behavioral health providers, using role-based secure access. It stores and displays critical information available to provide a holistic view of the member.

4. **Clinical Supports:** Our specialized care management team is comprised of registered psychiatric nurses, social workers, and embedded peer specialists who help individuals:

- Understand treatment plans prescribed by their primary care provider
- Understand and manage their complex conditions
- Obtain easy-to-understand health information
- Schedule follow-up calls
- Improve adherence to prescribed treatment plans
- Facilitate the closure of gaps in care
- Improve quality and performance metrics

We offer a tiered intensive care management program for individuals with complex behavioral and physical health needs. Individuals are initially assigned to one of three risk levels – low, moderate or high risk - using the predictive model application or through assessment of their health status and acuity rating. The risk-rating report has three dimensions (primary care risk, behavioral health risk, and substance abuse risk), instead of just the traditional one or two-axis versions. We develop an individualized care plan for each member, based on the member’s unique situation and perceived needs.

In addition, we offer practice-level clinical service delivery supports that include resources and trainings for implementing population based screening, evidenced-based and best-practice approaches for integrated care, workflow redesign, and health and behavior change. We can deploy virtual/telehealth services for direct and consultative care when physical co-location of behavioral and physical health providers is not possible. Instead of just the traditional one or two-axis versions. We develop an individualized care plan for each member, based on the member’s unique situation and perceived needs.

We also support practices moving along the integration continuum through targeted trainings in integrated care delivery.

Since 2013, our Connecticut enhanced care coordination program has resulted in reduced inpatient admissions by over 50% and reductions in Emergency Department visit utilization by over 15%.

In Connecticut, we deploy these clinical supports in partnership with Community Health Network, a Medicaid Health Plan. This program targets members with a co-morbid physical health and serious mental illness. Using a cohesive, whole health management approach, we deliver intensive behavioral and physical health care coordination for those persons with complex conditions, such as coronary artery disease, diabetes, and bipolar disorder. The goals of the program are to: improve outcomes by reducing preventable hospitalizations and emergency room visits, improve health-related quality of life, reduce polypharmacy, and increase patient satisfaction.

5. **Practice Transformation:** We recognize that committed and engaged providers are essential to improving our members’ health status, enhancing their experience, and ensuring cost-effective care delivery. To support providers we have developed a comprehensive integrated care toolkit to help practices transition to an integrated model. It includes important background information as well as practical resources for meeting these challenges.

In addition, our provider consultation and engagement supports extend far beyond traditional provider relations strategies. Our model deploys high touch technical assistance to establish linkages to community resources.

Additionally we support practices moving along the integration continuum through targeted trainings in integrated care delivery.