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# Integrated Care

## Principles for Rural Healthcare Sustainability from the Designated Agency Perspective

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# Context

- Vulnerabilities
  - Demographic
  - Hospitals
  - Community partners
- Opportunities
  - Increased awareness of importance of addressing SDOH
  - All-Payer Model
- Assumptions
  - ‘Zero sum’ workforce
  - Variability by region in partners/relationships
  - Community partners have long-standing expertise, are under-resourced relative to need, and work most directly to address SDOH
  - Vermonters most at risk for poor health outcomes also least likely to have viable transportation

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# Integrated Models: the Obvious

| Barrier/Challenge to Health Care Delivery | Why Integrated Models Provide a Potential Solution |
| --- | --- |
| • Transportation | • Co-location and/or treatment can occur outside the healthcare setting |
| • Access to Care | • Co-location; ease of referral |
| • Workforce Shortage | • Shared staffing models = flexibility |
| • Workforce Expertise | • Shared staffing models = sharing of expertise |

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# Integrated Models of Care

Four Principles from a Community Provider Perspective:

1. Buy, don’t build
2. Strengthen the system of care
3. Consider that healing happens in the context of relationships
4. Support models of integrated care that go upstream for population health

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# Buy, Don't Build

- Partner organizations have rich expertise and experience
- Efficiencies and continuity of care for patients
- Leverages the flexibility of partners' funding (e.g. home-based care)
- Unintended consequence of 'building': diminishes capacity of partner agencies
- Shared accountability

- Example: SVMC/UCS Liaison Psychiatry model
  Notch It Up (NCSS/The Notch)

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# Strengthen the Local System of Care

Does this integrated model strengthen or diminish the system of care?

- Many points of entry to care, not just health care
- System partners are often best positioned to address SDOH
- Clinical alignment, workforce efficiencies
- Shared ownership and accountability

Examples: Proposed Rutland Secure Recovery Residence, SVMC/UCS Psychiatric Urgent Care

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# Consider that healing happens In the context of relationships

- Integrated Care Models Should Promote
  - Choice of provider
  - Case management that can be home- and community-based and intensive for high-risk Vermonters
  - Ability to easily access episodic care from the same provider for mental health care, not just PCP
  - Reimbursement rates that reduce mental health staff turnover
- Integrated Care Models Should Avoid
  - Brief treatment models that strictly limit visits (and therefore the relationship) at the outset of treatment
  - Integrated care models that require several hand-offs

  Example: WCMHS Integrated Health Home

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# Support models of integrated care that go upstream to promote population health

- Prevention models such as Head Start and other early childhood interventions
- Mental health embedded with law enforcement
- School-based mental health
- Supported housing

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# It's a parallel process

- Just like individual health, population health happens in the context of strong community provider relationships
- A local system of care that maximizes every part of the system takes investment
  - Time/relationship building
  - Trust
  - Awareness of the resources/abilities of the partners
  - Moving toward parity for reimbursement
  - Contracting that reflects shared accountability