Domain 2: Care Delivery Redesign

Transformation projects within this domain focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes.

Project 2A: Bi-directional Integration of Physical and Behavioral Health through Care Transformation

Project Objective: Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through MCOs, for people enrolled in Medicaid.

Target Population: All Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).

ACHs must implement a project that includes:

- **At least one approach from integrating behavioral health into primary care settings, and**
- **At least one approach from integrating primary care into the behavioral health setting.**

Evidence-based Approaches for Integrating Behavioral Health into Primary Care Setting:

1. Bree Collaborative's Behavioral Health Integration Report and Recommendations: http://www.breecollaborative.org/topic-areas/behavioral-health/.
2. Collaborative Care Model: http://aims.uw.edu/collaborative-care
   - The Collaborative Care Model is a team-based model that adds a behavioral health care manager and a psychiatric consultant to support the primary care provider's management of individual patients' behavioral health needs.
   - The model can be either practice-based or telehealth-based, so it can be used in both rural and urban areas.
   - The model can be used to treat a wide range of behavioral health conditions, including depression, substance use disorders, bipolar disorder, PTSD, and other conditions.

Approaches based on Emerging Evidence for Integrating Primary Care into Behavioral Health Setting:

These approaches are described in the report "*Integrating Primary Care into Behavioral Health Settings: What Works for Individuals with Serious Mental Illness,"* http://www.milbank.org/wp-content/files/documents/papers/Integrating-Primary-Care-Report.pdf.

For any approach, apply core principles of the Collaborative Care Model (see above) to integration into the behavioral health setting.

1. Off-site, Enhanced Collaboration
2. Co-located, Enhanced Collaboration
3. Co-located, Integrated

Reference the "Project Implementation Guidelines" for additional details on the project's core components, including Domain 1 strategies and evidence-based approaches, to guide the development of project implementation plans and quality improvement plans.

Project Stages

Stage 1 – Planning

Milestone	**Proof of Completion**	**Timeline** ***(complete no later than)***
• Assess current state capacity of Integrated Care Model Adoption: Describe the level of integrated care model adoption among the target providers/organizations serving Medicaid beneficiaries. Explain which integrated models or practices are currently in place and describe where each target provider/organization currently falls in the five levels of collaboration as outlined in the Standard Framework for Integrated Care (http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf).	Completed current state assessment	DY 2, Q2
• Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project	Completed Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2A efforts	DY 2, Q2
• Select target population(s) and evidence-based approach (es) informed by regional health needs	Definition of target population and evidence based approach	DY 2, Q2

• Identify and engage project implementation partnering provider organizations, including: behavioral and physical health providers, organizations, and relevant committees or councils ○ Identify, recruit, and secure formal commitments for participation from all target providers/organizations via a written agreement specific to the role each will perform in the project.	Identified implementation partners and binding letters of intent	DY 2, Q2
• Develop project implementation plan, which must include: ○ Implementation timeline ○ Selected evidence-based approaches to integration and partners/providers for implementation to ensure the inclusion of strategies that address all Medicaid beneficiaries (children and adults) particularly those with/or at-risk for behavioral health conditions ○ Justification demonstrating that the selected evidence-based approaches and the committed partner/providers are culturally relevant and responsive to the specific population health needs in the region ○ Description of how project aligns with related initiatives and avoids duplication of efforts ○ Roles and responsibilities of implementation partners: should include key organizational and provider participants that promote partnerships across the care continuum, including payer organizations, social services organizations, and across health service settings. ○ Describe strategies for ensuring long-term project sustainability	Completed implementation plan	DY 2, Q3
• Engage and convene County Commissioners, Tribal Governments, Managed Care Organizations, Behavioral Health and Primary Care providers, and other critical partners to develop a plan and description of a process and timeline to transition to fully integrated managed care ○ Plan should reflect how the region will enact fully integrated managed care by or before January 2020	Completed plan describing regional transition to fully integrated managed care	DY 2, Q4

○ For regions that have already implemented fully integrated managed care, implementation plans should incorporate strategies to continue to support the transition		
Stage 2 – Implementation		
Milestone	**Proof of Completion**	**Timeline** ***(complete no later than)***
• Develop guidelines, policies, procedures and protocols	Adopted guidelines, policies, procedures and/or procedures	DY 3, Q1
• Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected approaches.	Completed and approved QIP, reporting on QIP measures	DY 3, Q2
• Implement project, including the following core components across the approaches selected: ○ Ensure implementation addresses the core components of each selected evidence-based approach ○ Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to perform their role in the integrated model. ○ Implement shared care plans, shared EHRs and other technology to support integrated care. ○ Provide participating providers and organizations with financial resources to offset the costs of infrastructure necessary to support integrated care models. ○ Establish a performance-based payment model to incentivize progress and improvement.	Identify number of practices and providers implementing integrated evidence-based approach(es) Identify number of practices and providers trained on evidence-based practices; projected vs. actual and cumulative	DY 3, Q4
• Implementation of fully integrated managed care (applicable to mid-adopter regions)	Attestation from Managed Care Organizations that the MCOs have entered into a contractual relationship with HCA to cover	DY3, Q1

	Medicaid behavioral health services.	
Stage 3 – Scale & Sustain		
Milestone	**Proof of Completion**	**Timeline *(complete no later than)***
• Increase adoption of the integrated evidence-based approach by additional providers/organizations	Document Stage 3 activities in Semi-Annual Reports.	DY 4, Q4
• Identify new, additional target providers/organizations.		DY 4, Q4
• Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required		DY 4, Q4
• Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion ○ Leverage regional champions and implement a train-the-trainer approach to support the spread of best practices.		DY 4, Q4
• Identify and document the adoption by partnering providers of payment models that support integrated care approaches and the transition to value based payment for services		DY 4, Q4
• Implementation of fully integrated managed care (applicable to regions that did not pursue early or mid-adopter status)	Attestation from Managed Care Organizations that the MCOs have entered into a contractual relationship with HCA to cover Medicaid behavioral health services.	DY 4, Q1

Project Metrics

Year	Metric Type	Metric	Report Timing
	P4R – ACH Reported	• Report against QIP metrics	Semi-Annual

DY 3 – 2019		• Identify number of practices and providers implementing integrated evidence-based approach (es). • Identify number of practices and providers trained on evidence-based practices: projected vs. actual and cumulative • % PCP in partnering provider organizations meeting PCMH requirement • Number of partnering primary care providers who achieve special recognitions/certifications/licensure (for medication-assisted treatment, such as buprenorphine administration, for example).	
	P4P – State Reported	• Antidepressant Medication Management • Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Medication Management for People with Asthma (5 – 64 Years) • Mental Health Treatment Penetration (Broad Version) • Outpatient Emergency Department Visits per 1000 Member Months • Plan All-Cause Readmission Rate (30 Days) • Substance Use Disorder Treatment Penetration	Annual
DY 4 – 2020	**P4R – ACH Reported**	• Report against QIP metrics • Identify number of practices and providers implementing integrated evidence-based approach (es). • Identify number of practices and providers trained on evidence-based practices: projected vs. actual and cumulative • % PCP in partnering provider organizations meeting PCMH requirement • Number of partnering primary care providers who achieve special recognitions/certifications/licensure (for medication-assisted treatment, such as buprenorphine administration, for example)	Semi-Annual
	P4P – State Reported	• Antidepressant Medication Management • Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Follow-up After Discharge from ED for Mental Health • Follow-up After Discharge from ED for Alcohol or Other Drug Dependence	Annual

		• Follow-up After Hospitalization for Mental Illness • Inpatient Hospital Utilization • Medication Management for People with Asthma (5 – 64 Years) • Mental Health Treatment Penetration (Broad Version) • Outpatient Emergency Department Visits per 1000 Member Months • Plan All-Cause Readmission Rate (30 Days) • Substance Use Disorder Treatment Penetration	
DY 5 – 2021	**P4R – ACH Reported**	• Report against QIP metrics • Identify number of practices and providers implementing integrated evidence-based approach (es). • Identify number of practices and providers trained on evidence-based practices: projected vs. actual and cumulative • % PCP in partnering provider organizations meeting PCMH requirement • Number of partnering primary care providers who achieve special recognitions/certifications/licensure (for medication-assisted treatment, such as buprenorphine administration, for example).	Semi-Annual
	P4P – State Reported	• Antidepressant Medication Management • Child and Adolescents' Access to Primary Care Practitioners • Comprehensive Diabetes Care: Eye Exam (retinal) performed • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Comprehensive Diabetes Care: Medical Attention for Nephropathy • Follow-up After Discharge from ED for Mental Health • Follow-up After Discharge from ED for Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Inpatient Hospital Utilization • Medication Management for People with Asthma (5 – 64 Years) • Mental Health Treatment Penetration (Broad Version) • Outpatient Emergency Department Visits per 1000 Member Months • Plan All-Cause Readmission Rate (30 Days) • Substance Use Disorder Treatment Penetration	Annual

Project Implementation Guidelines: This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and quality improvement plans.

Guidance for Project-Specific Domain 1 Strategies

- **Population Health Management/HIT:** Current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **Workforce:** Capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:
  - Shortage of Mental Health Providers, Substance Use Disorder Providers, Social Workers, Nurse Practitioners, Primary Care Providers, Care Coordinators and Care Managers
  - Opportunities for use of telehealth and integration into work streams
  - Workflow changes to support integration of new screening and care processes, care integration, communication
  - Cultural and linguistic competency, health literacy deficiencies
- **Financial Sustainability:** Alignment between current payment structures and guideline-concordant physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

Guidance for Evidence-Based Approaches

Integrating Behavioral Health into Primary Care Setting

Standards adopted by the Bree Collaborative in the Behavioral Health Integration Report and Recommendations. As part of this option, regions will implement the core components that are consistent with the standards adopted by the Bree Collaborative.

Summary of Core Elements and Minimum Standards for Integrated Care Element Specifications under consideration by the Bree Collaborative:

- Integrated Care Team: Each member of the integrated care team has clearly defined roles for both physical and behavioral health services. Team members, including clinicians and non-licensed staff, may participate in team activities either in person or virtually.

- Routine Access to Integrated Services: Access to behavioral health and primary care services are available routinely, as part of the care team's daily work flow and on the same day as patient needs are identified as much as feasible. Patients can be engaged and receive treatment in person or by phone or videoconferencing, as convenient for the patient.
- Accessibility and Sharing of Patient Information: The integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care. All clinicians work together to jointly support their roles in the patient's shared care plan.
- Access to Psychiatry Services: Access to psychiatry consultation services is available in a systematic manner to assist the care team in developing a treatment plan and to advise the team on adjusting treatments for patients who are not improving as expected.
- Operational Systems and Workflows Support Population-based Care: A structured method is in place for proactive identification and stratification of patients for behavioral health conditions. The care team tracks patients to make sure each patient is engaged and treated-to-target (i.e., to remission or other appropriate individual improvement goals).
- Evidence-based Treatments: Age-appropriate, measurement-based interventions for physical and behavioral health interventions are adapted to the specific needs of the practice setting. Integrated practice teams use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether their patients are improving.
- Patient Involvement in Care: The patient's goals are incorporated into the care plan. The team communicates effectively with the patient about their treatment options and asks for patient input and feedback into care planning

Collaborative Care Model. As part of this option, regions can choose to focus initially on depression screening and treatment program (such as tested in the IMPACT model). Many successful Collaborative Care pilot programs begin with an initial focus on depression and later expand to treat other behavioral health conditions, including substance use disorders.

Implement the core components and tasks for effective integrated behavioral health care, as defined by the AIMS Center of the University of Washington and shown here:

- Patient Identification & Diagnosis:
  - Screen for behavioral health problems using valid instruments.
  - Diagnose behavioral health problems and related conditions.
  - Use valid measurement tools to assess and document baseline symptom severity.
- Engagement in Integrated Care Program:
  - Introduce collaborative care team and engage patient in integrated care program.
  - Initiate patient tracking in population-based registry.
- Evidence-based Treatment:
  - Develop and regularly update a biopsychosocial treatment plan.

- Provide patient and family education about symptoms, treatments, and self-management skills.
- Provide evidence-based counseling (e.g., Motivational Interviewing, Behavioral Activation).
- Provide evidence-based psychotherapy (e.g., Problem Solving Treatment, Cognitive Behavioral Therapy, Interpersonal Therapy).
- Prescribe and manage psychotropic medications as clinically indicated.
- Change or adjust treatments if patients do not meet treatment targets.

- Systematic Follow-up, Treatment Adjustment, and Relapse Prevention:
  - Use population-based registry to systematically follow all patients.
  - Proactively reach out to patients who do not follow-up.
  - Monitor treatment response at each contact with valid outcome metrics.
  - Monitor treatment side effects and complications.
  - Identify patients who are not improving to target them for psychiatric consultation and treatment adjustment.
  - Create and support relapse prevention plan when patients are substantially improved.
- Communication & Care Coordination:
  - Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location.
  - Engage and support family and significant others as clinically appropriate.
  - Facilitate and track referrals to specialty care, social services, and community-based resources.
- Systematic Psychiatric Case Review & Consultation (in-person or via telemedicine) :
  - Conduct regular (e.g., weekly) psychiatric caseload review on patients who are not improving.
  - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
  - Provide psychiatric assessments for challenging patients, either in-person or via telemedicine.
- Program Oversight and Quality Improvement:
  - Provide administrative support and supervision for program.
  - Provide clinical support and supervision for program.
  - Routinely examine provider- and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use this information for quality improvement.

Integrating Primary Care into Behavioral Health Setting

Off-site Enhanced Collaboration

Primary Care and Behavioral Health providers located at a distance from one another will move beyond basic collaboration (in which providers make referrals, do not share any communication systems, but may or may not have periodic non-face-to-face communication including sending reports), to enhanced collaboration that includes tracking physical health outcomes, with the following core components:

- Providers have regular contact and view each other as an interdisciplinary team, working together in a client-centered model of care.
- A process for bi-directional information sharing, including shared treatment planning, is in place and is used consistently.
- Providers may maintain separate care plans and information systems, but regular communication and systematic information sharing results in alignment of treatment plans, and effective medication adjustments and reconciliation to effectively treat beneficiaries to achieve improved outcomes.
- Care managers and/or coordinators are in place to facilitate effective and efficient collaboration across settings ensuring that beneficiaries do not experience poorly coordinated services or fall through the cracks between providers.
- Care managers and/or coordinators track and monitor physical health outcomes over time using registry tools, facilitate communication across settings, and follow up with patients and care team members across sites.

Co-located, Enhanced Collaboration; or Co-located, Integrated

Apply and implement the core principles of the **Collaborative Care Model** to integration of primary care; implement the core components and tasks for effective integration of physical health care into the behavioral health setting.

- Patient Identification & Diagnosis:
  - Screen for and document chronic diseases and conditions, such as obesity, diabetes, heart disease and others.
  - Diagnose chronic diseases and conditions.
  - Assess chronic disease management practices and control status.
- Engagement in Integrated Care Program:
  - Introduce collaborative care team and engage patient in integrated care program.
  - Initiate patient tracking in population-based registry.
- Evidence-based Treatment:
  - Develop and regularly update a biopsychosocial treatment plan.
  - Provide patient and family education about symptoms, treatments, and self-management skills.
  - Provide evidence-based self-management education.

- Provide routine immunizations according to ACIP recommendations as needed.
- Provide the U.S. Preventive Services Task Force screenings graded A & B as needed.
- Prescribe and manage medications as clinically indicated.
- Change or adjust treatments if patients do not meet treatment targets, refer to specialists as needed.

- Systematic Follow-up, Treatment Adjustment:
  - Use population-based registry to systematically follow identified patients.
  - Proactively reach out to patients who experience difficulty following up.
  - Monitor treatment response at each contact with valid outcome metrics.
  - Monitor treatment side effects and complications.
  - Identify patients who are not improving to target them for specialist evaluation or connection to increased primary care access/utilization.
- Communication & Care Coordination:
  - Coordinate and facilitate effective communication among all providers on the treatment team, regardless of clinic affiliation or location.
  - Engage and support family and significant others as clinically appropriate.
  - Facilitate and track referrals to specialty care, social services, and community-based resources.
- Systematic Case Review & Consultation (in person or via telemedicine):
  - Conduct regular (e.g., weekly) chronic disease and condition caseload review on patients who are not improving.
  - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
- Program Oversight and Quality Improvement:
  - Provide administrative support and supervision to support an integrated team.
  - Provide clinical support and supervision for care team members that are co-located.
  - Routinely examine provider-level and program-level outcomes (e.g., clinical outcomes, quality of care, patient satisfaction) and use to inform quality improvement processes and activities.