

TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS

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Project Title	Behavioral Health Integration Program: Building an evidence-based, integrated foundation within Washington’s primary care system.
Rationale for the Project	
<ul style="list-style-type: none"> ● <i>Problem statement</i> Our current Medicaid health system is not person-centered and often does not deliver services in the client’s preferred or optimal setting. The systems do not have common performance goals, quality metrics or other measurement-based tools to support proven, evidence-based practices and allow practices to make the transformative changes needed. While Washington has received great recognition for its ground breaking models of behavioral health integration in spite of the fragmented system, integration of behavioral health into primary care has not had the ability to scale and spread models to promote a more uniform and seamless system of care. ● <i>Supporting research</i> Over 80 randomized controlled trials support the use of measurement-based care in treatment strategies such as collaborative care (including Washington’s Mental Health Integration Program (MHIP), including extensive evidence that collaborative care for depressed adults improves clinical outcomes. There is also some evidence that the Primary Care Behavioral Health model can enhance outcomes for depression, generalized anxiety disorder, and general mental health functioning for adults and children. The US Preventive Services Task Force recommends that routine screening of adults for depression is justified only when collaborative depression follow up care is in place. In addition, long term analyses have demonstrated that \$1 spent on collaborative care saves \$6.50 in health care costs.² ● <i>Relationship to federal objectives for Medicaidⁱ with attention to how project benefits Medicaid beneficiaries</i> Per the numerous studies listed above, scaling and spreading this proposed system of care will support Washington’s health system in achieving the objectives for Medicaid. Specifically, Medicaid beneficiaries will see improved health outcomes and will increase efficiency and quality of care for Medicaid. A 2015 study of over 3,500 diverse patients who were followed over six months found a significant reduction of the disparities for outcomes in medication compliance, remission, and persistence of depression symptoms for minority patients with depression who were treated with collaborative care instead of usual care. 	
Project Description	
<p><i>Which Medicaid Transformation Goalsⁱⁱ are supported by this project/intervention? All apply</i></p> <p>X Reduce avoidable use of intensive services, Improve population health, focused on prevention, Accelerate transition to value-based payment, Ensure Medicaid per-capita growth is below national trends</p> <p><i>Which Transformation Project Domain(s) are involved? All apply</i></p> <p>X Health Systems Capacity Building, Care Delivery Redesign, Population Health Improvement – prevention activities</p>	
<p><u>Region(s) and sub-population(s) impacted by the project. Include a description of the target population</u></p> <p>Medicaid patients of all ages who, through age-appropriate socioemotional and behavioral health screenings, are found to have developmental concerns, mental illness and/or substance use disorders. The program we propose will screen for common behavioral conditions in children and adults, including pregnant women. This program can be implemented within urban and rural areas. More rural communities and/or smaller practices can share staff or leverage telephonic modalities.</p>	
<p><u>Project goals, interventions and outcomes expected during the waiver period, including relationship to improving reducing health disparities. Relationship to Washington’s Medicaid Transformation goals.</u></p>	
<p>The Medicaid Behavioral Health Integration Program (BHIP) is a comprehensive “stepped care” foundation of integration of</p>	

¹ Organizational Partners references entities that provided an indication of direct support. This project will require partnership across the state from payers, providers and communities. We look forward to working in partnership with the state and partners to further develop this approach.

² <https://aims.uw.edu/collaborative-care/dollars-sense>

behavioral health services into primary care that leverages two models already activated within Washington. The two levels of care include an initial population health based screening and brief intervention option available via “warm handoff” for all individuals presenting with a behavioral health need, followed by comprehensive collaborative care management for patients with an identified behavioral health need that requires ongoing condition management. Referral of more seriously mentally ill or emotionally disturbed, or substance abusing individuals to specialty outpatient, residential, and inpatient behavioral health services would be retained and incented through this model. It is critical to underscore the necessity of simultaneous development and investment in a robust continuum of care in which these core steps are within this proposal are a part of. (see appendix) Deliberate connection, linkage and partnership across projects that support integration of primary care into behavioral health, outreach and engagement and community and social wraparound supports will be necessary to build successful integrated delivery systems.

Outcome Goals for the Proposed Stepped-Care Model for Integration of Behavioral Health into Primary Care:

Goal #1³ Expand the number of primary care teams staffed and trained to increase culturally appropriate, population-based behavioral health screening⁴ and brief treatment options for patients. Through the integration of a behavioral health consultant or behaviorist (typically psychologists, licensed social workers or mental health counselors) to the primary care team increased capacity to provide a warm hand-off from care team members for brief interventions (typically 10-30 minutes) will occur.

Goal #2⁵: Expand the number of primary care teams that are adequately staffed and trained to deliver collaborative care management for patients with more intensive behavioral health needs that can be addressed in primary care. Validation of fidelity to the collaborative care model would be established through a certification program.⁶

Goal #3: Create value-based payment strategies and align service expectations across all participating Medicaid health plans. Aligning the payment mechanisms and model of care will allow all participating clinics to adequately staff and support their implementation of a single, proven model of integrated behavioral health care for all Medicaid patients in their practice.

Intervention #1: In all participating primary care settings, establish population-based health screening using standardized tools, ensuring that no one with behavioral health concerns falls through the cracks. As an enhancement, some sites could include a Diabetes A1C screen in tandem to address the co-occurring nature of diabetes and depression.

Intervention #2: Clinics capably deliver appropriate care to those patients who screen positive with a coordinated clinical delivery system that integrates Primary Care Behavioral Health and Collaborative Care (MHIP) components, including consistent measurement and monitoring of behavioral health condition severity, close proactive follow-up by a clinic-based behavioral health care manager, and regular psychiatric consultation focused on treatment changes for patients who are not improving with initial treatment. The system would be measurement-based (consistent with 2016 NCQA metrics and other established standards) and stepped in the intensity of services it can deliver, so that patients receive the right level of intervention needed to address their severity and complexity. If the screening presents more serious mental illness or substance use disorders, the individual will be referred to a community behavioral health setting (if the individual so chooses). The duration of the collaborative care intervention once activated would most likely show evidence of improvement after 5-7 months, but possibly up to 12 months. No later than 5-7 months will a review of treatment be done to assess if referral to community based behavioral health/specialty behavioral health is necessary if evidence of improvement is not present

Outcomes:

By scaling and spreading a stepped care approach based on evidence and promising practices of integration of behavioral health into primary care and in parallel addressing how this system is paid for, Washington will build a sustainable, core link in the care continuum. This approach will support Washington in achieving the four primary Medicaid transformation goals. Increasing population based behavioral health screening and elements of the PCBH model increase reach and access to care in a primary care setting for behavioral health.⁷ There is extensive evidence from randomized controlled trials and large scale implementations that collaborative care for adults with common mental health conditions improves patient outcomes. This effective model of care has been shown to improve patient outcomes in both studies & in large scale implementations, such as

³ The Primary Care Behavioral Health component is already widely established in many WA state health systems, including Community Health Centers, Providence NW and SW regions, and Swedish Medical Group.

⁴ Validated, evidence based scale, for example PHQ9

⁵ The Mental Health Integration Program (MHIP). Many primary care clinics are already participating in MHIP but only for a portion of their patient population.

⁶ Curriculums have been developed in Washington, Minnesota and New York that can be the base of a certification approach.

⁷ <http://www.ncbi.nlm.nih.gov/pubmed/24059274>

MHIP, the Minnesota DIAMOND program & the IMPACT trial. Collaborative care produces better patient outcomes (with rates of remission & response that are approximately twice those of usual care) and can produce net cost savings over four years. Outcomes include reducing health disparities: A number of studies have examined racial differences in response rates to collaborative care treatment programs for veterans & other populations. Racial disparities in depression care were found to be ameliorated through collaborative care programs for veterans. The study concludes that collaborative care management for depression is associated with a significant reduction of the disparities for clinical outcomes in depression for minority patients.

Links to complementary transformation initiatives (a selection of examples below):

- 1) Washington State’s plan to fully integrate care for mental health, substance use and physical health by 2020 via Early Adopter of Fully Integrated Managed Care; supporting efforts to integrate at the delivery-level. Supported through legislation and State Innovation Model Test.
- 2) A stepped, integrated, primary care system will connect to and engage with services such as supportive housing and supported employment benefits, if approved. It also can more effectively support relationships and engagements with the Health Home program.
- 3) The new program can leverage the UW Integrated Care Psychiatry Training Program (UWICPTP), supported by Washington’s 2015-2017 biennial budgets, to train psychiatrists and other health care providers in proven, population-based integrated behavioral healthcare, including collaborative care.
- 4) Training support for the program can be designed to complement and align with support that may become available through the Practice Transformation Hub SIM or funded through a waiver transformation project in the future.
- 5) The program will leverage existing child psychiatry consultants, expertise, resources and established pediatric screening tools made available through the Partnership Access Line (PAL) guidance already in wide use among Medicaid providers

Potential partners, systems, and organizations Community Health Centers, UW AIMS Center, ACHs, MCOs, primary care providers serving Medicaid populations, BHOs, hospitals, substance use disorder treatment providers, Community Mental Health Clinics/Centers.

Core Investment Components

Proposed activities and cost estimates (“order of magnitude”) for the project.

All Medicaid enrollees would be screened and a portion of patients that meet diagnostic criteria would receive treatment through the stepped model. In order to cover 5% of the eligible population (18,000) in active collaborative care management over a six month average enrollment period, & basing our cost estimates on existing bundled monthly case rates for similar programs (NYS Medicaid and Diamond), we estimate the total annual cost of implementing the second step of BHIP to be \$20 million. If program were to cover 10% (36,000), the cost would be \$35 million. More investigation of cost estimates needs to be done to assess the rate adjustment to include the screening & brief intervention within the first step. We do know that a full time behaviorist can see 1500-2000 individuals a year, which is not calculated in the percentage rates above. It is important to note some of the capacity & infrastructure (e.g. registry build out and interoperability) costs are not included within this projection.

Best estimate (or ballpark if unknown) for how many people served, when fully implemented.

Overall, the number of individuals impacted by this project is extensive. We do have some research that reflects that once fully implemented, the second step of Medicaid BHIP could cover 20,000 to 36,000 Medicaid enrollees at any given time.

For both estimates above, a ratio approach could be used to scale the model more broadly.

How much you expect the program to cost per person served, on a monthly or annual basis.

Based on monthly case rates established for similar programs, we expect average annual costs of \$900 to \$1,080 per person served, based on an average enrollment of six months. We propose to work with HCA and partners to establish a case rate payment using the “Year 1” encounter data & existing studies of MHIP utilization data. The case rate could be set up so that it is divided into two parts with one element tied to demonstration of capacity (this demonstration would include evidence of staff recruitment, hiring, workflow redesign and some process based metrics) and the second portion tied to achievement of performance. The translation of a case rate to an incentive based approach aligns with DSRIP requirements. If a clinic site is already demonstrating capacity, more of the dollars should be tied to performance & moving the site toward increased capacity to demonstrate the ability to take on value based arrangements and risk.

How long to fully implement the project within a region where you expect it will have to be phased in?

It will take approximately 6 months to expand the model at existing clinic sites and 8-12 months to onboard new clinics & organizations once identified. Recruitment & hiring of the appropriate staff should be considered when building out a timeline. It will be imperative for regions and health systems to assess their capacity assets and gaps for the model. In addition, recognition of building capacity to develop the curriculum and training components for certification will be imperative. The ability to scale and spread more quickly might utilize a “centers of excellence model” and/or a train the trainer model, to leverage existing resources.

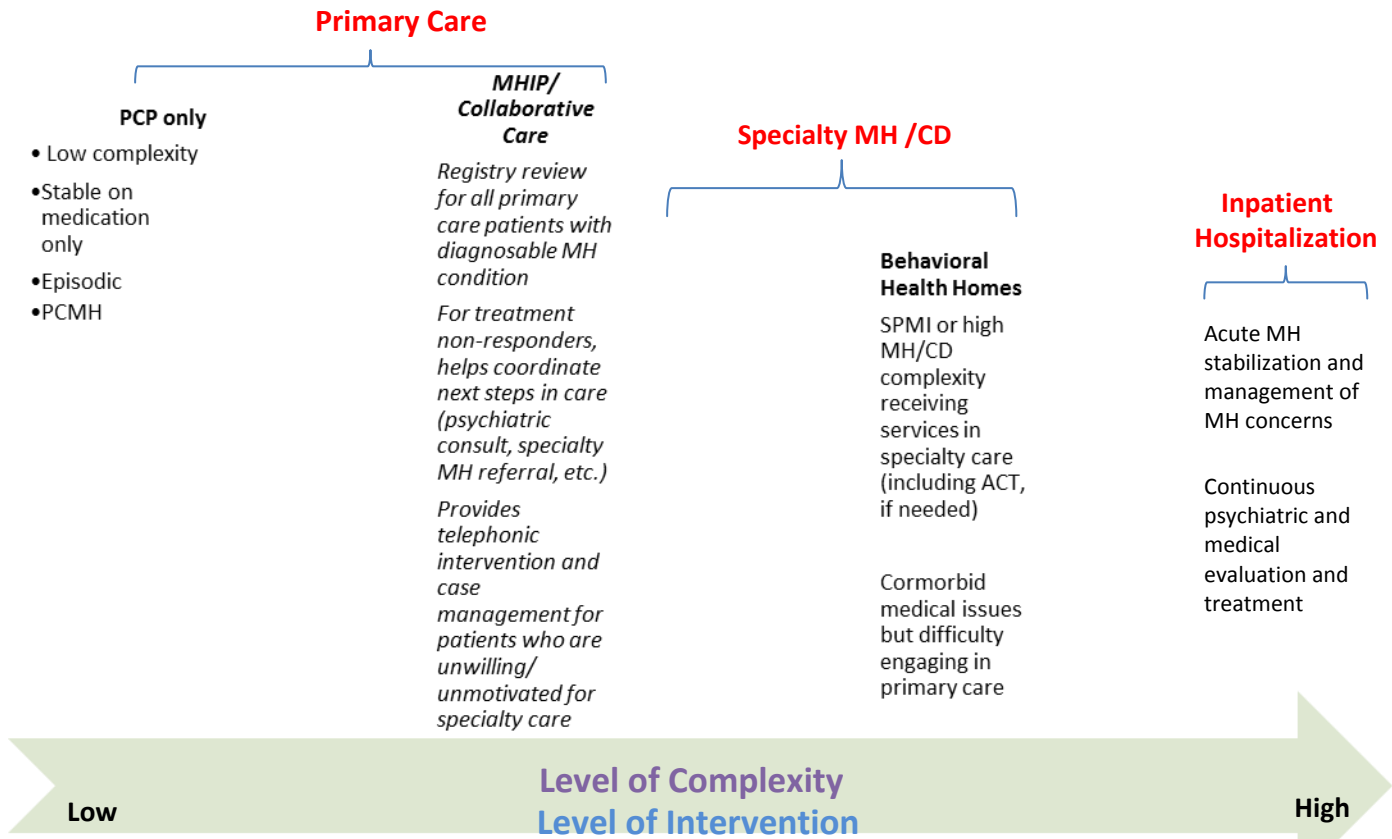
The financial return on investment (ROI) opportunity, including estimated amounts and ROI timeline?

A robust review of 12 economic evaluations covering 10 collaborative care trials to improve depression treatment in primary care has consistently shown high value. The IMPACT model, a collaborative care management model for treating patients with depression, showed a savings of \$3,365 per patient (n = 272) over patients receiving usual primary care over four years, even though the intervention ended after one year. MHIP in Washington State demonstrated hospital savings of over \$11.2 million in initial 14 months of statewide MHIP implementation for the Disability Lifeline population – net savings of \$66 PMPM. In addition individuals receiving MHIP services demonstrated the following over a two year period: reduced inpatient admissions, reduction in inpatient psychiatric costs, lower rates of housing instability and reduction in criminal justice engagement.

Project Metrics

This project utilizes metrics at three distinct levels. First, the clinical model of care incorporates new and innovative methods of providing measurement based practice (MBP). As the name implies, MBP utilizes real-time, trended clinical outcomes and process data for making clinical decisions. Examples of clinical outcomes metrics include PHQ-9 scores for depression. Clinical process measures include assessment and service intensity measures. The second layer is the use of real-time performance reports, tied to payments that incentivize key components of care and model fidelity. The third layer of project metrics includes system performance and evaluation measures. We propose an initial dataset to include three of Washington’s core measures: 30-day Psychiatric Inpatient Readmission, the NCQA Depression Medication Management, and Potentially Avoidable ED Visits. We also plan to measure Depression screening, Control of Major Depression Disorder, and Substance Abuse Screening Brief Intervention and Referral (SBIRT) rates. As measures are developed around mental health and substance use disorder treatment penetration for Washington, these should be attributed to demonstration of success.

Behavioral Health System Integration Continuum:



PCBH
 Low to mid complexity co-managed with PCP
 Brief intervention and/or crisis stabilization for high complexity until next step of care is achieved (MHIP, Specialty MH, etc.)
 Health behavior change and prevention intervention
 Episodic, 1-3 visits per episode

County and Community-Based MH/CD Services
 Mid to high complexity
 Longer-term psychotherapy
 Psychiatry assessment, management, and prescribing
 Engaged with PCP for medical needs within BH facility

Residential Treatment
 Perm. Supportive Housing / CD
 Sober living
 SPMI or high risk CD population
 Psychiatry and primary care onsite or highly coordinated with living facility

Additional Features of the Continuum:

Wrap-around services, community and social supports are necessary to support all steps in this continuum.

Utilizing outreach and engagement to engage and/or reengage individuals in the continuum will be important.

The ability for individuals to move across the continuum when necessary will be a marquee feature of an integrated delivery system. This requires a collective accountability across the continuum, effective transitions of care and strong partnerships.