Understanding bi-directional integration for the Medicaid Transformation Demonstration

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Today's presenters

- Kali Klein, Medicaid Transformation Manager, Washington State Health Care Authority
- Ginny Weir, MPH, Program Director, Dr. Robert Bree Collaborative
- Anne M. Shields, RN, MHA, Associate Director, University of Washington AIMS Center
- Brian Sandoval, PsyD, Primary Care Behavioral Health Program Manager, Yakima Valley Farm Workers Clinic
- Joan Miller, Senior Policy Analyst, Washington Council for Behavioral Health

Today's presentation

- **Purpose**
  - To discuss bi-directional integration in the context of the Medicaid Transformation Demonstration
- **Goals**
  - Gain understanding of why bi-directional integration is so important
  - Gain understanding of the opportunities under Project 2A for providers to accelerate and support bi-directional integration
  - Gain high-level understanding of funds flow and performance measurement within the demonstration
  - Understand approaches and options within the Demonstration Toolkit

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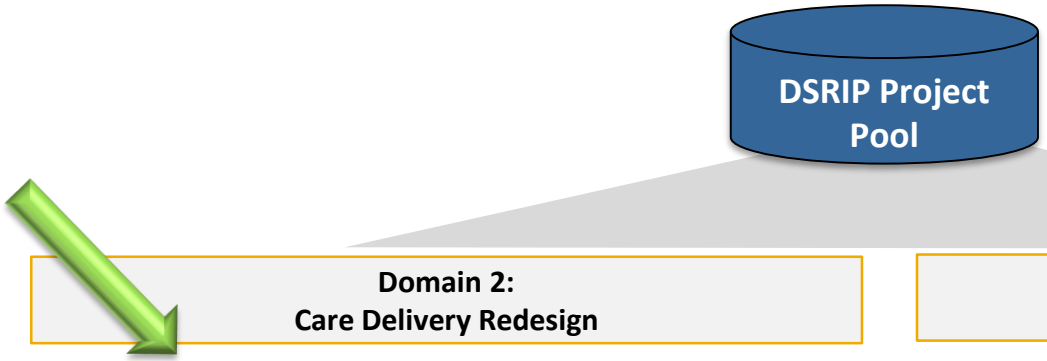
Project 2A: Bi-directional integration of physical & behavioral health through care transformation

Demonstration Toolkit

- Each ACH will coordinate and submit a Project Plan application by **November 16, 2017**
- **ACHs must select at least four projects** from Domains 2 and 3, including both 2A and 3A and one additional project from each of those domains
- In addition, all ACH project plans under Domains 2 and 3 must integrate the cross-cutting Domain 1 strategies



Domain 2:
Care Delivery Redesign

- 2A: Bi-directional integration of physical & behavioral health through care transformation
- 2B: Community-based care coordination
- 2C: Transitional care
- 2D: Diversions interventions

Domain 3:
Prevention and Health Promotion

- 3A: Addressing the Opioid Use Public Health Crisis
- 3B: Reproductive, Maternal & Child Health
- 3C: Access to Oral Health Services
- 3D: Chronic Disease Prevention and Control

Domain 1:
Health Systems and Community Capacity Building

- 1A: Financial sustainability through VBP
- 1B: Workforce
- 1C: Systems for population health management

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Project 2A 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.

"Bi-directional integration" means integrating behavioral health services into primary care settings and integrating primary care services into behavioral health settings.

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ACH requirements

- Project 2A is mandatory
  - Each ACH must implement this project within its region.
- Approaches to project implementation and required milestones are laid out in the toolkit
- ACHs must implement a project that includes:
  - At least one approach integrating behavioral health into primary care settings, **and**
  - At least one approach integrating primary care into the behavioral health setting.

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Demonstration Project Plan

- Project plans are due November 16, 2017
- Each ACH must submit a Project Plan that provides details for selected projects and identified partnering providers

ACHs work with community partners to decide on transformational projects in their region.

Together, they select projects to develop a Project Plan. Projects must align with the Demonstration Project Toolkit.

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How ACHs earn incentive payments

Pay-for reporting (P4R)

- For each project, an ACH must report on progress milestones, set by the state, beginning in Year 1
- Progress milestones adjust over the course of the project to track project planning, implementation, and activities to scale and sustain successful strategies

Pay-for-performance (P4P)

- P4P standards will be phased in starting in Year 3 and ramp up in Year 4 and 5
- Each project has select P4P measures that will be assessed using a "gap-to-goal" or "improvement over self" methodology
- ACH improvement targets will be set by the state and released during Year 2
- P4P is measured at a regional, not a provider, level

Demonstration Year		DY 1	DY 2	DY 3	DY 4	DY 5
P4R	Progress Milestones	Stage 1: Planning		Stage 2: Impl.		Stage 3: Scale & Sustain
P4P	Outcome Metrics	*N/A*	*N/A*	State Reported		

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Project metrics

Progress milestones* (P4R)	Project metrics* (P4P)
Stage 1: Planning progress measures • Complete current state assessment • Define target population and evidence-based approach informed by regional health needs • Complete Project Implementation Plan **Stage 2: Implementation progress measures** • # of practices / providers implementing integrated approaches • Develop quality improvement plan to support selected approaches **Stage 3: Scale & sustain progress measures** • Increase adoption of integrated evidence-based approach by additional providers/organizations • Provide ongoing supports (e.g. learning collaboratives) to support continuation and expansion	**State reported metrics:** • Antidepressant Medication Management • Comprehensive Diabetes Care: Hemoglobin A1c Testing • Follow-up After Discharge from ED for Mental Health • Follow-up After Hospitalization for Mental Illness • Inpatient Hospital Utilization • Medication Management for People with Asthma • Mental Health Treatment Penetration • Outpatient Emergency Department Visits • Substance Use Disorder Treatment Penetration

**See the Project Toolkit for a complete list*

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Partnering provider opportunities

- Participate in Project 2A through the ACH to be eligible to earn DSRIP incentive funds to support integration efforts
- Key considerations:
  - Understand the integration "choices" and the work involved for successful implementation
  - Understand how funds will flow
    - *How dollars are earned by the ACH is not necessarily how partnering providers earn incentives*

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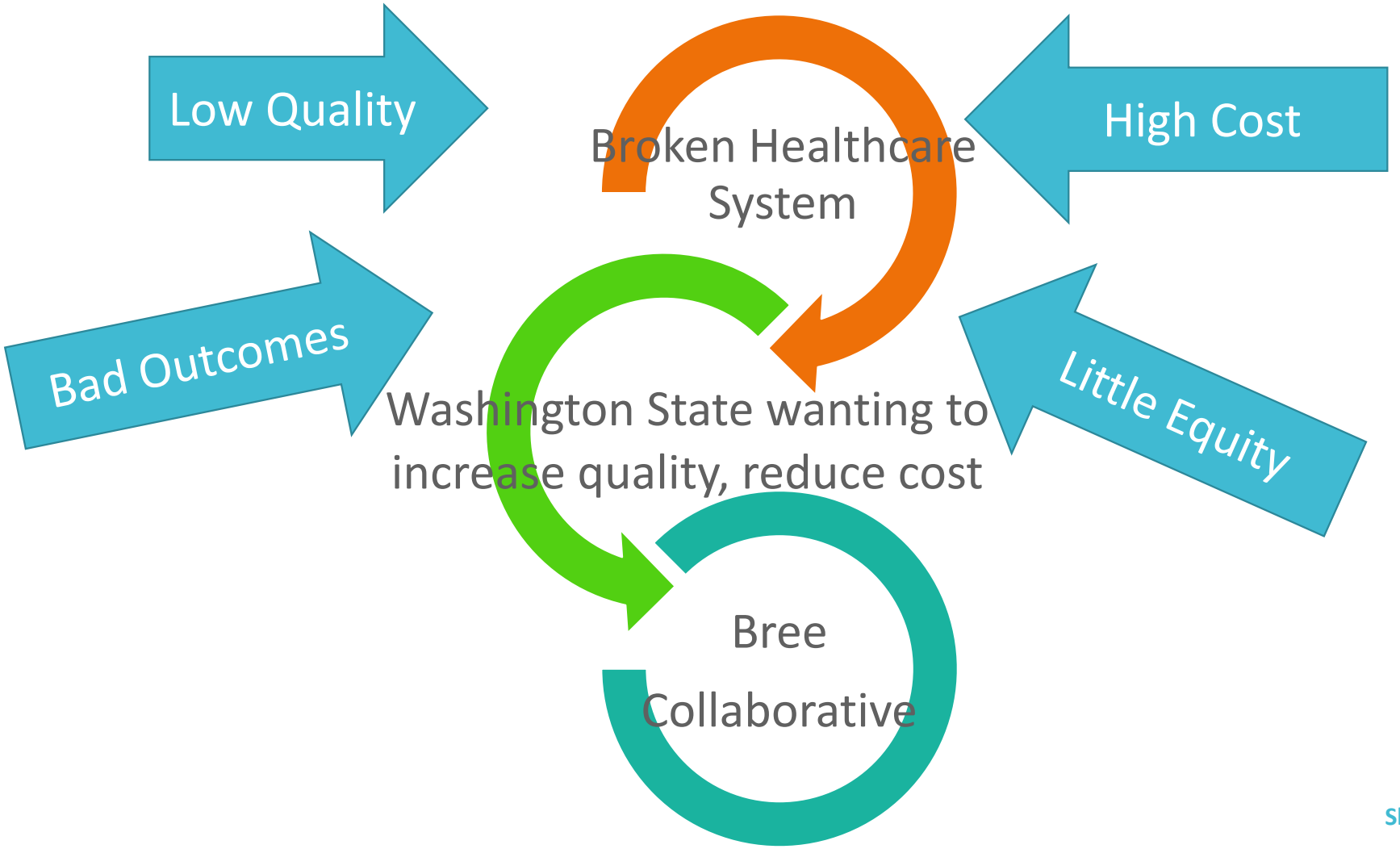
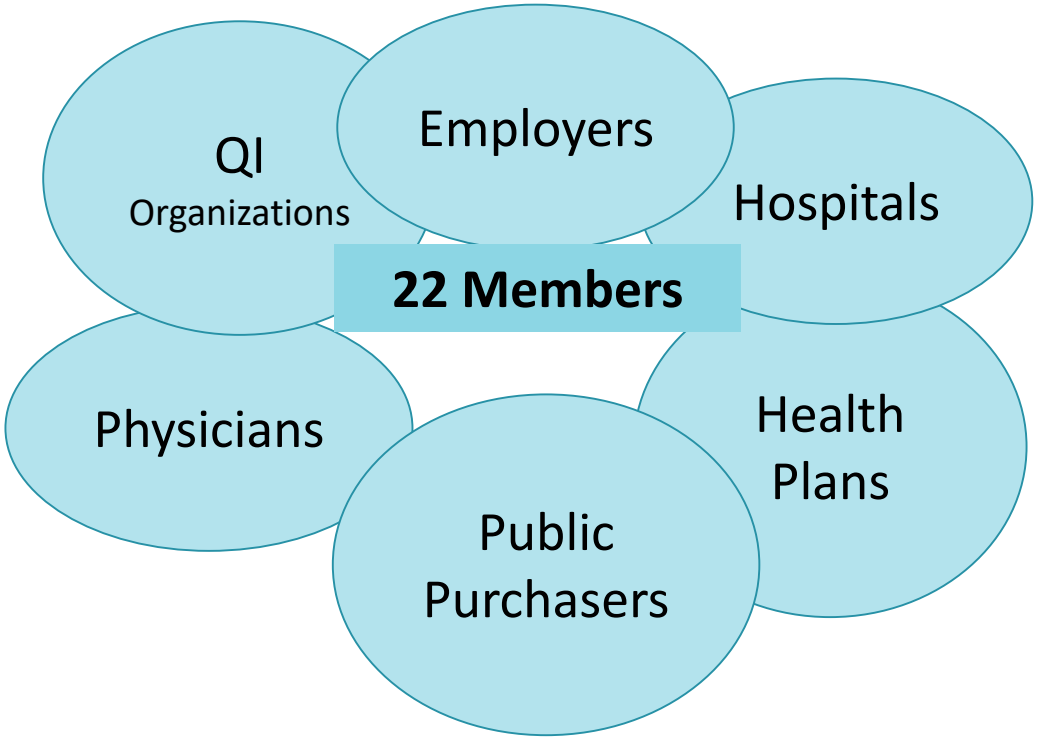
The Bree Collaborative: Behavioral Health Integration Workgroup

How the Bree Collaborative Fits
Health Care Environment



Background

House Bill 1311

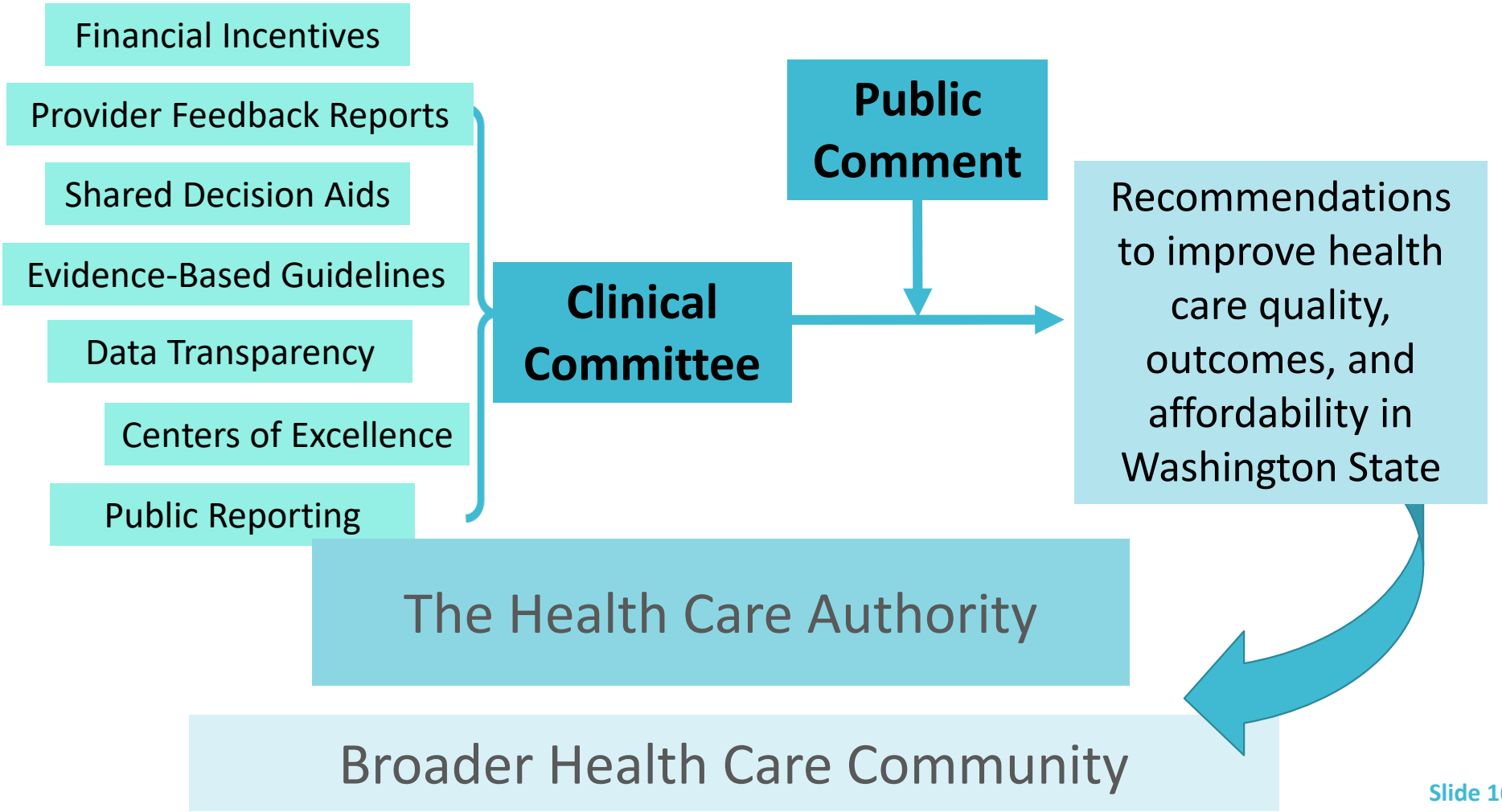


Identify health care services with high:

- **Variation**
- **Utilization**

Without producing better outcomes

Process


Financial Incentives
Provider Feedback Reports
Shared Decision Aids
Evidence-Based Guidelines
Data Transparency
Centers of Excellence
Public Reporting
Clinical Committee
Public Comment
Recommendations to improve health care quality, outcomes, and affordability in Washington State
The Health Care Authority
Broader Health Care Community

Past Work

- Obstetrics
- Cardiology
- Elective Total Knee and Total Hip Replacement Bundle and Warranty
- Elective Lumbar Fusion Bundle and Warranty
- Coronary Artery Bypass Surgery Bundle and Warranty
- Bariatric Surgical Bundled Payment Model and Warranty
- Low Back Pain and Spine SCOAP
- Hospital Readmissions
- End-of-Life Care
- Addiction and Dependence Treatment
- Prostate Cancer Screening
- Oncology Care
- Pediatric Psychotropic Drug Use
- Behavioral Health Integration

Behavioral Health Integration Workgroup

- **Chair:** Mary Kay O'Neill MD, MBA, Partner, Mercer
- Brad Berry, Executive Director, Consumer Voices Are Born
- Regina Bonnevie, MD, Medical Director, Peninsula Community Health Services
- Michelle Guerra, MD, Senior Clinician, Premera
- Larry Marx, MD, Medical Director, Behavioral Health Support Services, Group Health Cooperative
- Kim McDermott, MD, Physician, NeighborCare
- Rose Ness, MA, LMHC, CDP, Sound Integration for Behavioral Healthcare
- Joe Roszak, CEO, Kitsap Mental Health Services
- Anna Ratzliff, MD, PhD, Director of the UW Integrated Care Training Program, Associate Director for Education and Anne Shields, MHA, RN, Associate Director, AIMS Center, University of Washington
- Jeff Reiter, PhD, Lead Psychologist, Swedish Medical Services
- Julie Rickard, PhD, Program Director of Integrated Behavioral Services, Confluence Health
- Brian Sandoval, PsyD, Behavioral Health Manager, Oregon and Washington Services, Yakima Valley Farmworkers Clinics
- Lani Spencer, RN, Vice President, Health Care Management Services, Amerigroup –Washington
- Emily Transue, MD, MHA, Senior Medical Director, Coordinated Care
- Melet Whinston, MD, Medical Director, United Health Care

Defining Integrated Care

Team-based care provided to individuals of all ages, families, and their caregivers in a whole-person oriented setting or settings by licensed primary care providers, behavioral health clinicians, and other care team members working together to address one or more of the following:

- Mental illness
- Substance use disorders
- Health behaviors that contribute to chronic illness, life stressors, and crises
- Developmental risks/conditions
- Stress-related physical symptoms
- Preventative care
- Ineffective patterns of health care utilization

Eight Elements

National Standards

- SAMHSA
- AHRQ
- Oregon PCPC

Local Standards

- UW AIMS Center
- Qualis Health

1. Integrated Care Team
2. Patient Access to Behavioral Health as a Routine Part of Care
3. Accessibility and Sharing of Patient Information
4. Practice Access to Psychiatric Services
5. Operational Systems and Workflows to Support Population-Based Care
6. Evidence-Based Treatments
7. Patient Involvement in Care
8. Data for Quality Improvement

1. Integrated Care Team

- Clearly defined roles
- Understanding of roles
- Participation in typical practice activities in-person or virtually
  - Team meetings
  - Daily huddles
  - Pre-visit planning
  - Quality improvement

2. Patient Access to Behavioral Health as a Routine Part of Care

- Same-day access, as much as feasible
- At minimum, plan is developed on the same day including continuous patient engagement

3. Accessibility and Sharing of Patient Information

- Shared care plan at point of care
  - Care team access to actionable information (medical and behavioral health)
- Clinicians working together via regularly scheduled consultation and coordination

4. Practice Access to Psychiatric Services

- Systematic access to psychiatric consultation services to assist care team
  - Developing treatment plan
  - Adjusting treatments if no improvement
- Availability of specialty behavioral health services
  - For patients with more severe or complex symptoms
  - Well-coordinated with primary care

5. Operational Systems and Workflows to Support Population-Based Care

- Proactive identification and stratification of patients for targeted conditions
- Systematic clinical protocols based on screening results and other patient data
- Track patients with target conditions to make sure patient is engaged and **treated-to-target/remission**
- Proactive follow-up plan to assess improvement and adapt treatment accordingly

6. Evidence-Based Treatments

- Age language, culturally, and religiously-appropriate measurement-based interventions
- Adapted to specific needs of practice setting
- Systematic use of behavioral health symptom rating scales to determine improvement
- Strategies include patient's goals of care and appropriate self-management support

7. Patient Involvement in Care

- Patient goals inform care plan
- Practice communicates effectively with patients about treatment options
- Practice asks for patient input and feedback

8. Data for Quality Improvement

- Track system-level data on:
  - Access to behavioral care
  - Patients experience
  - Patient outcomes
- Quality improvement efforts employed to achieve patient access goals and outcome standards

Roadmap to Integrated Care

	Element	Specifications	Patient Perspective	Operational Details for Integrating Behavioral Health Care into Primary Care
1	**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, understand their roles and participate in typical practice activities in-person or virtually such as team meetings, daily huddles, pre-visit planning, and quality improvement.	*I can see how my care team takes my concerns into consideration when making treatment decisions and can talk to members of my integrated care team about any of my concerns, including feeling low or depressed, or concerns about my drinking. The team will be able to answer my questions and help me get treatment if I choose to.*	**Usual Care:** Behavioral health support is provided by the primary care provider, who may not feel adequately supported or adequately trained in managing all behavioral health conditions in his/her patient panel. **Steps Toward Integration**: Behavioral health professionals are onsite or available remotely but do not participate in clinic-level workflows and are not part of the usual patient care. Behavioral health may closely coordinate and follow up with the primary care provider on all patients that are referred to them for treatment. **Integrated Care:** Practices are committed to developing and maintaining a culture of integration and teamwork including both engaging providers in integrated approaches to care proven to help patients get better and achieve their treatment goals and cross-training providers on behavioral health and primary care. The integrated care team utilizes shared workflows to systematically screen and treat common behavioral health conditions and uses measurement-based behavioral health scales and tools to screen and track patient progress toward treatment goals. Behavioral health professionals participate in primary care workflows. Behavioral health professionals may be practice-based, (i.e., located in the same physical space as the integrated care team) or telemedicine-based (i.e., available to the practice onsite on a regular but not daily basis, and available by phone, pager or videoconference) to assist primary care providers and patients during practice hours when they are not onsite.

Stepped integrated behavioral health care

Stepped Integrated Behavioral Health Care

Models vs. Principles: Evidence-Based Bi-Directional Integration

Team-Based and Person-Centered

Primary care and behavioral health providers collaborate effectively, using shared care plans.

Population-Based

A defined group of clients is tracked in a registry so that no one "falls through the cracks."

Measurement-Based Treatment to Target

Measurable treatment goals clearly defined and tracked for every patient.

Treatments are actively changed until clinical goals are achieved.

Medicaid Project Toolkit

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).

Project Metrics

- 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, 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

Start with the end in mind!

ACHs must implement a project that includes:

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

The Integration "Choices"

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

Common Principles for Project 2A

Bree Specs for Integration (Bree Element #)

- BHP part of primary care team (1)
- Systematic BH screening (1,5)
- Measurement-based (1)
- Access to psychiatry services (4)
- Population-based care; treatment to target (5)
- Tracking and follow up (5)
- Evidence-based treatments (6)

Collaborative Care Model

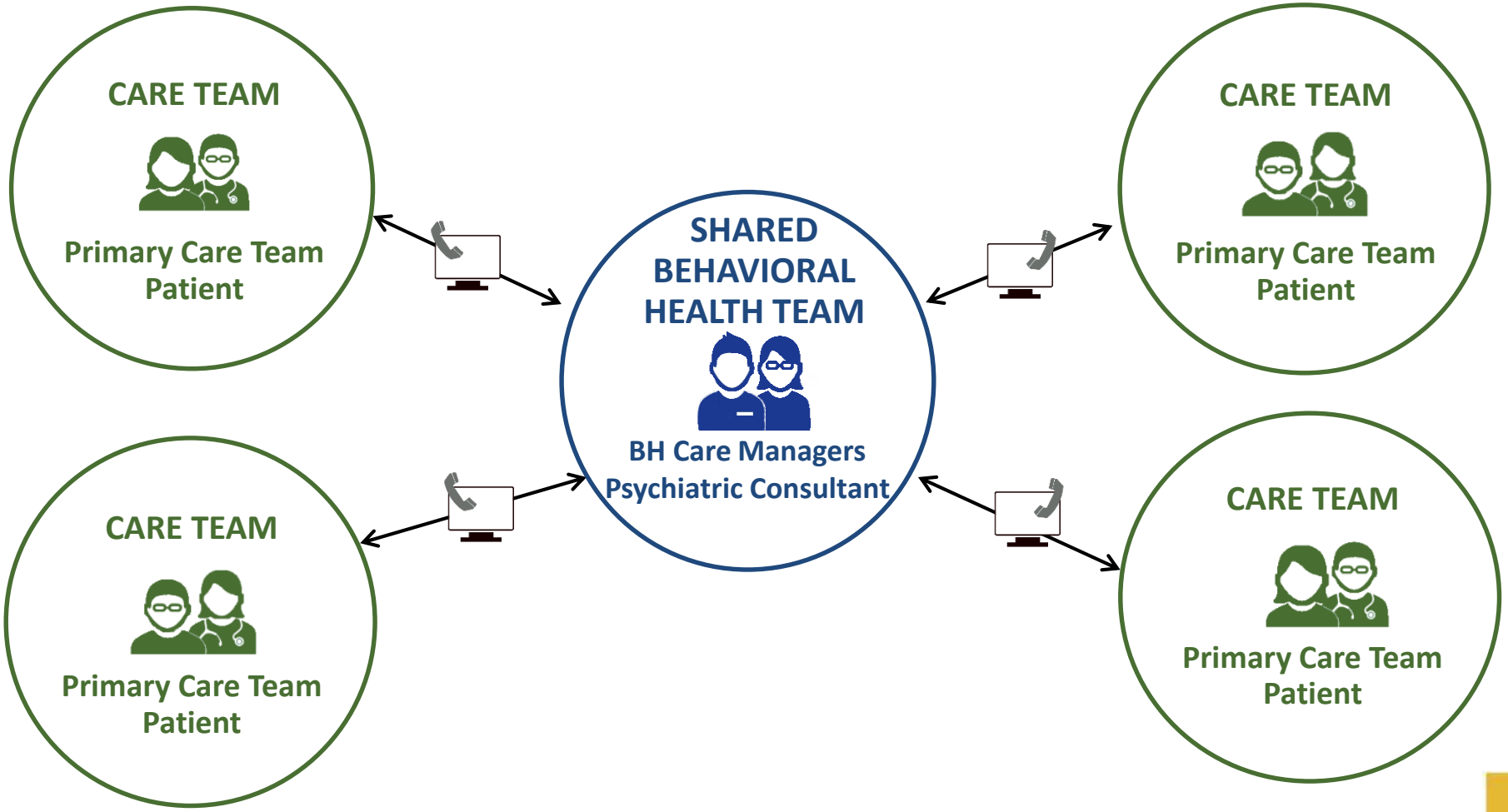
- BHP part of primary care team
- Systematic BH screening
- Measurement-based
- Psychiatric case review
- Population-based
- Tracking and active treatment to target
- Evidence-based treatment

Common Elements Summary

- Shared care plan at point of care
- Access to psychiatry consultation
- Screening/identification/stratification
- Systematic tracking and follow-up using registry tools
- Quality improvement protocol (treatment response, ED utilization, etc.)

Telemedicine-Based Integrated Care

Strategies for Rural WA Counties



ACH Training Strategies for Project 2A

- Consider workforce challenges up front
  - Expanded roles for nurses & pharmacists
- Expect providers' "readiness" for training to happen at different times, over time
  - Help small learning groups move forward nimbly as ready, small practice groups inform larger IHI-style learning collaboratives
- Expect variation as providers adapt integration strategies to fit needs and circumstances
- **Don't get hung up on the model!**

Integration in the behavioral health setting

Integration in the Behavioral Health Setting

The Other Half of Bi-directional Integration

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Who Is this Population?

- People with serious & persistent mental illness and/or substance use disorders.
- Health disparities in this population:
  - Reduced life expectancy due to preventable physical conditions
  - Co-morbidity
  - Inadequate access to or inadequate care in primary care settings
  - Diagnostic overshadowing
- Primary driver of all-cause readmission rates in the Medicaid/Medicare population.

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Where Should They Be Served?

- Integrated services should be offered by the provider who knows the patient best.
  - ❖ *"Patients are most likely to change their health-related behaviors in response to a frequently recurring face-to-face relationship."* – Dr. Joe Parks
- For people with serious mental illness and/or substance use disorders, there are tremendous barriers to receiving effective care in a primary care setting.
- The setting most appropriate for the patient is not necessarily permanent. It will ebb and flow depending on the level and type of care needed.
- In Missouri, behavioral health based health homes resulted in more than double the amount of cost-savings ($15.7M) realized by primary care based health homes ($7.4M).

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What Other Supports Does this Population Need?

Licensed community behavioral health agencies also offer a full range of behavioral health services to provide stability and improve the health of their patients that are not typically found in primary care settings:

- Supportive housing services and low-income housing
- Supported employment
- Wraparound services
- Comprehensive care management
- Peer support and wellness coaching
- Group treatment
- Family treatment
- 24/7 crisis intervention and stabilization
- In-home services
- Outpatient SUD treatment
- Outreach & engagement

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Bi-directional Integration Strategies

- **Primary Care Settings**
  - New Team Roles
    - ✓ BH Care Managers
    - ✓ Onsite BH Specialists
    - ✓ Psychiatric Consultants
  - Measurement-Based Screening and Follow-up (e.g., PHQ9; GAD-7)
  - Screening and brief intervention for SUD (SBIRT)
  - Measurement-based Treatment to Target
  - Accountable for BH quality measures
  - Medication adherence, including BH

- **Behavioral Health Settings**
  - New Team Roles
    - ✓ PC Consultants
    - ✓ PC RN Care Managers
    - ✓ Onsite PCP provider (MD or ARNP)
  - Metabolic Screening
  - Routine Preventative Care
  - Cardiovascular and Diabetes Care (e.g., BP; A1C)
  - Measurement-based Treatment to Target
  - Accountable for medical quality measures
  - Medication adherence, including medical

What Integration Models Should be Used for this Population?

- There is no single correct model or “right way” to integrate primary care services into a behavioral health setting.
- The model, however, should include the following principles:
  - Provide patient choice
  - Build on local or community resources
  - Establish formal communication pathways among multidisciplinary providers
  - Ensure opportunity for team meetings, virtual or in-person
  - Use a variety of mechanisms for CBHA and CHC/FQHC integrated care collaboration
    - ❑ Direct hire of staff
    - ❑ Co-location of partner agency staff
    - ❑ Shared care planning through data-sharing mechanisms

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Examples for Project Plans

- The project toolkit describes three different approaches; each approach reflects different levels of integration in behavioral health settings:
  - **Off-site enhanced collaboration**
    - ✓ Information-sharing agreement
    - ✓ Care managers to track physical health outcomes and facilitate communication
  - **Co-located enhanced collaboration**
    - ✓ PC and BH in same location
    - ✓ Care managers facilitate communications
    - ✓ Separate treatment planning and records are used
  - **Co-located integrated**
    - ✓ Integrated team-based care
    - ✓ Limited or full-scope onsite primary care

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Resources

Resources

- **UW AIMS Center Medicaid Transformation Demonstration 2A Training and Technical Assistance Resources:**

  https://aims.uw.edu/washington-state-medicaid-transformation-demonstration

- **Contact: Sara Barker, Program Manager, barkers@uw.edu**

Resources

- Initiative 1 FAQs: https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources
- UW AIMS Center/National Council/WA Council TA & Training Package: https://www.thewashingtoncouncil.org/training-technical-assistance/
- Email Me!: jmiller@thewashingtoncouncil.org

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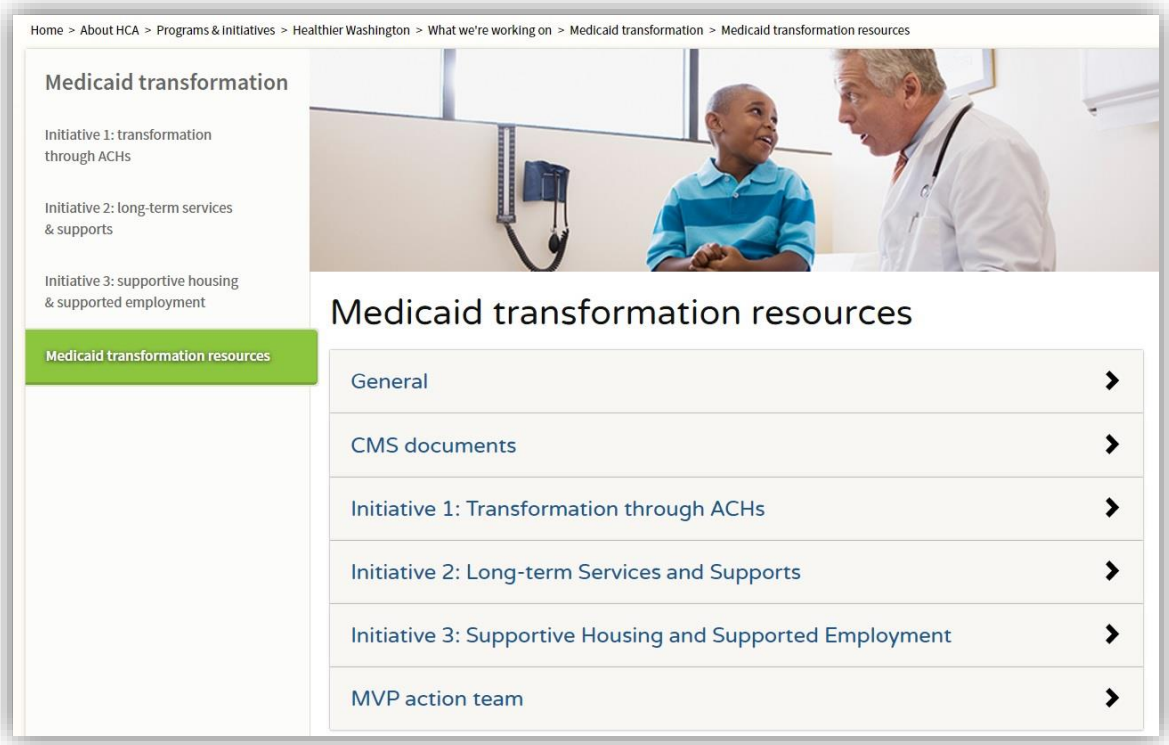
Demonstration Resources

What you'll find:

- ✓ Project Plan Template
- ✓ Project Toolkit
- ✓ Frequently asked questions
- ✓ Fact sheets
- ✓ …and more



www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources

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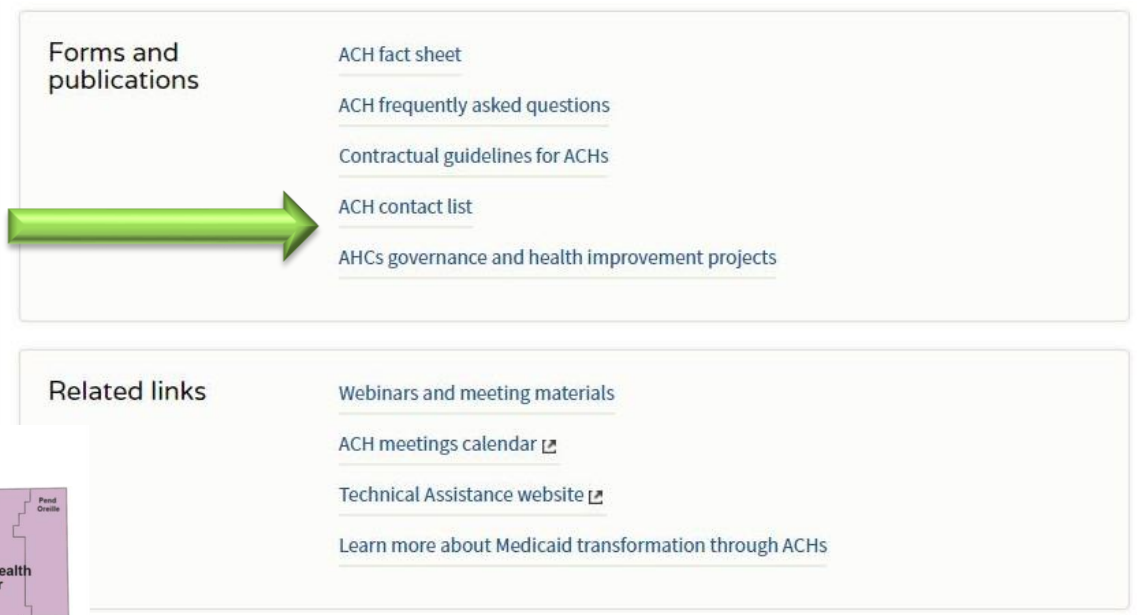
Connecting with Accountable Communities of Health



ACH Regions Map

https://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach

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For More Information

Hub Help Desk: (206) 288-2540
or (800) 949-7536 ext. 2540 or by email HubHelpDesk@qualishealth.org.

Healthier Washington Practice Transformation Support Hub Web sites:

- Healthier Washington: www.hca.wa.gov/hw/
- Qualis Health: www.QualisHealth.org/hub
- Hub Resource Portal: www.waportal.org

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