Contact Information	Lilián Bravo Washington Association of Community and Migrant Health Centers 360-786-9722 ext. 236 lbravo@wacmhc.org *Organizations involved:* WACMHC staff and the WACMHC Behavioral Health Committee, which is comprised of leaders from fourteen of our twenty-six member community health centers.
Project Title	Provider trainings in the Primary Care Behavioral Health model for use in the Patient Centered Medical Home setting.

Rational for the Project

Washington State is committed to fully integrate physical and behavioral health services through a variety of avenues including the Medicaid Transformation Waiver and the State Health Care Innovation Plan.

Problem Statement

In order to successfully reach patients that need behavioral health services, individualized training in an integrated model is necessary for providers to utilize a high level of care coordination and team-based care. Technical assistance, in the form of workforce training, is essential to providers who work at community health centers (CHCs). CHCs only see 10% (52,311) of the total CHC patient population for behavioral health, including mental health, and/or substance abuse services. Contrary to the fact that nearly 20% of all Americans are affected by a behavioral health condition.[1] Primary care and behavioral health providers are not generally trained to work with patients in an integrated manner.

Supporting Research

A survey conducted by the Washington Community Mental Health Council identified workforce (availability of trained staff, cultural competency) as one of the key barriers to the spread of integrated service delivery. For this reason, WACMHC is proposing a project that would respond to the immediate need for in-depth training, education, and practice support for providers, to work in an integrated physical and behavioral health setting.

The most efficient model to do so, is the Primary Care Behavioral Health Model. This model is simultaneously collaborative, co-located, and integrated in the primary care setting. This model trains behavioral health providers to be available at the time of need, to be interruptible, and allows the medical providers to get their questions answered while the patient is on-site. For these reasons, CHCs support the full implementation of the PCBH model across Washington State.

Relationship to federal objectives for Medicaid and how this project will benefit Medicaid beneficiaries

This training will support the federal quality objectives for Medicaid beneficiaries by increasing the provider's capacity to identify, prevent, treat, and refer out, individuals with complex chronic care needs as well as behavioral health needs, including issues with mental health or substance abuse.

Project Description

Region and sub-population impacted by the project

This state wide project will be targeted towards behavioral health and medical providers who work primarily with Medicaid patients. Both Medical and Behavioral Health providers who work at CHCs are examples of providers who would fit this description.

Relationship to Washington's Medicaid Transformation goals:

Which Medicaid Transformation Goals[i] *are supported by this project/intervention? Check box(es)*

☒ Reduce avoidable use of intensive services

With a highly trained workforce, there will be a reduction in the avoidable use of intensive services and settings by training a highly efficient staff that will work on the front end to treat mild to moderate behavioral health issues, and

[1] A.Soni "The Five Most Costly Conditions, 2006: Estimates for the U.S. Civilian Noninstitutionalized Population" Statistical Brief #248 (Rockville, MD: Agency for Healthcare Research and Quality, July 2009). This estimate does not include those with substance abuse disorders

develop a robust referral system for more severe behavioral health issues and disorders, and/or related chronic diseases.

☒ Improve population health, focused on prevention
The Medicaid population's health will improve by providing behavioral health counseling to prevent, or mitigate, harmful health behaviors, as well as by assisting with the following of treatment plans for those with chronic diseases, in a manner that is coordinated and centered upon whole-person care principles.

☒ Accelerate transition to value-based payment
By promoting the PCBH model adoption in the patient centered medical home setting, value and quality of care will be practiced and prioritized over the traditional volume based model.

☒ Ensure Medicaid per-capita growth is below national trends
Abundant evidence demonstrates that total cost of care is reduced across a broad array of chronic conditions when integrated behavioral health services are included.

Which Transformation Project Domain(s) are involved? Check box(es)

☒ Health Systems Capacity Building
Improved collaborative care models in the CHCs, as well as an increase in access to behavioral health providers will be accomplished. Second, there will be an increase in the number of referrals related to behavioral health services, more accurately reflecting the variety of behavioral health issues patients possess.

☒ Care Delivery Redesign
The PCBH model is a model of care delivery redesign which can be scaled up and implemented in any setting. Training providers in the PCBH model will support the integration of physical and behavioral health services.

☒ Population Health Improvement – prevention activities

A skilled physical and behavioral health workforce will support all prevention activities by encouraging patients to follow treatment plans and healthy behaviors, to prevent, or mitigate, the onset of complex chronic conditions.

Project goals, interventions, and outcomes expected during waiver period

WACMHC is proposing a workforce training project in the form of 5-day, individualized training for providers who are currently employed at an organization that has the infrastructure to support integrated services. These trainings will be designed to aid providers in following the Primary Care Behavioral Health model within the patient centered medical home setting. The training will assist the providers with building a solid foundation for delivery of high impact behavioral health services in the patient-centered medical home, particularly for patients with chronic disease. The objectives of this training are to strengthen workforce capacity and flexibility in relation to the integration of behavioral health and primary care services using the PCBH model.

Links to complementary initiatives

Providers working with the PCBH model will immediately see its links to the ongoing PCMH Transformation goals, of promoting care coordination and team-based models.

Potential partners, systems, and organizations

Medicaid physical and behavioral health providers will be trained in order to provide better services to their patients. While CHC providers are well-positioned to begin this training immediately, this model of training can be applied to all other providers who have the infrastructure in place as well. In order to maximize this training, providers who have demonstrated a commitment to integrating their physical and behavioral health services by supporting team-based care and care coordination, are the best initial investment. In the future, this PCBH training model can be scaled up to all other primary care and behavioral health providers in the state as well.

Core Investment Components

ACTIVITY	FEES	UNIT	TOTAL
Individual Consultations	$15,000 (5 days)	26 CHCs	$390,000

CHCs served 885, 210 people in 2014, and given that the CHC population rose by 9% from 2013 to 2014, we anticipate being able to serve 964,879 patients in 2016 and beyond.

At a minimum, 26 CHCs will receive this workforce training. However, these 26 organizations have 250 sites, and as such, only 10% of the CHC providers would receive the direct training. This project proposal assumes that the CHCs will have a system in place to diffuse the information to the rest of their health center clinics and providers. Also, CHC clinic locations are very diverse, and each has its own unique needs. For this reason, when this model is scaled up to other primary care facilities in the future, trainings should be offered to individual clinics-and not large organizations.

As stated in the Healthcare Innovation Plan the following savings are estimated:

Impact Area	% Savings
Physical and behavioral health integration	2.5%
Other chronic disease management	1%
Obesity reduction/other prevention	0.37%

Metrics

Currently, there is a limited amount of behavioral health metrics and behavioral health related benchmark data available. There has been much work to establish new metrics to implement in the incoming years. The two primary sets of metrics come from the WA Common Core Measures.

WA Common Core Measures:

1. % of adults reporting 14 or more day of poor mental health
   Indirect Measures of Success:
2. Follow-up after hospitalization for mental illness after 7 days
3. Follow-up after hospitalization for mental illness after 30 days
4. Follow-up after discharge from the ER for Mental Health, Alcohol, or Other Drug Dependence

In order for these metrics to be properly utilized, there must be technical assistance available to establish data systems that will support the automatic reporting of these measures, in order to prevent overburdening organizations with reporting mechanisms that are not supported at the large scale.