Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

For projects to be considered for inclusion in the Medicaid Transformation Project List, please provide the information requested in the template. We are looking for summarized information – **2-3 pages maximum per project**.
Please email completed templates by **January 15, 2016,** to MedicaidTransformation@hca.wa.gov with the subject **Medicaid Waiver Project**. Thank you for your interest and support.

Contact Information	*Robert Hilt, MD Associate Professor of Psychiatry, University of Washington* *206-987-3073, Robert.hilt@seattlechildrens.org* *Project suggestion was developed by Seattle Children's Hospital and the Partnership Access Line in collaboration with the Washington Chapter of the American Academy of Pediatrics and the University of Washington Department of Psychiatry AIMS Center*
Project Title	*Child Mental Health Integrated Care Expansion for Partnership Access Line (PAL Plus)*

Rationale for the Project

- *Problem statement:* According to "The State of Mental Health in America 2015," 46% of Washington's children who needed mental health services failed to receive any, and our state ranked 47th in the country regarding youth behavioral health service needs and access to care. We do not and are not expected to get enough child mental health specialty care providers to serve community needs in the traditional referral to care models. This pushes children and families to rely on accessing mental and behavioral health supports through other settings like primary care. To be effective, primary care needs help to deliver good quality mental health services, making integrated behavioral health systems a necessity. The Partnership Access Line is an existing on-demand child mental health consult phone line run by Washington Medicaid available to all WA providers since 2008, whose rare commodity of available child specialist resources could be better leveraged to support new local Medicaid integrated care systems through linking to these two basic care elements:
  1. *Direct family support from trained behavioral health service providers assigned to serve specific regional practices*
  2. *Individual case tracking with specialist support and feedback to ensure positive treatment and referral outcomes*
- *Supporting research (evidence-based and promising practices) for the value of the proposed project.*

  Fortney JC, Pyne JM, Mouden SB et al. Practice-based versus telemedicine-based collaborative care for depression in rural federally qualified health centers: a pragmatic randomized comparative effectiveness trial. *American Journal of Psychiatry* 2013; 170:414-425.

  Hilt RJ, Barclay RP, Bush J, Stout B, Anderson N, Wignall JR. A Statewide Child Telepsychiatry Consult System Yields Desired Health System Changes and Savings. *Telemedicine and e-Health Journal*. 2015 Jul;21(7):533-7.

  Richardson LP. Ludman E. McCauley E. Lindenbaum J. Larison C. Zhou C. Clarke G. Brent D. Katon W. Collaborative care for adolescents with depression in primary care: a randomized clinical trial. *JAMA*. 312(8):809-16, 2014 Aug 27.

  Hilt RJ, Romaire MA, McDonnell MG, Sears JM, Krupski A, Thompson JN, Myers J, Trupin EW. The Partnership Access Line: Evaluating a child psychiatry consult program in Washington State. *JAMA Pediatrics* 2013 Feb; 167(2): 162-8

  Martini R, Houston M, Chenven M, Hilt R, Marx L, Sarvet B, et al. "ACOs & CAPs: Preparing for the impact of healthcare reform on child and adolescent psychiatry practice." April 2013, accessed online at aacap.org

  Mental Health America. "Parity or Disparity: The State of Mental Health in America 2015," accessed online at wwwmentalhealthamerica.net
- *Relationship to federal objectives for Medicaid with particular attention to how this project benefits Medicaid beneficiaries:* Implementing this proposal would meet all of the Medicaid objectives outlined in GAO report 15-239, April 2015. This includes 1) increase and strengthen coverage of low income individuals., 2) Increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations.3) Improve health outcomes for Medicaid and low-income populations.4) Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks

Project Description

Which Medicaid Transformation Goals are supported by this project/intervention? All of these apply: 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.

Which Transformation Project Domain(s) are involved? All of these apply: Health Systems Capacity Building, Care Delivery Redesign, Population Health Improvement through more accessible early intervention activities

Describe:

- *Region(s):* The strength of a PAL Plus program would be that it can rapidly be developed to provide primary care child mental health integration services in any or all regions of the state, work in different health systems, work for both large and small practices, build on the existing statewide and primary care accepted PAL structure, and build on the accumulated U. of Washington AIMS center community collaborative care systems and experience. Depending on funding, we propose starting within the boundaries of just one or two of the state's nine new Accountable Communities of Health (ACH) for phase 1 rollout. All Medicaid covered children in the assigned region(s) served by any of that region's primary care practices would be eligible for program support, though children with moderate to severe symptoms would be primarily directed to be served by local, traditionally delivered mental health services. Phase 1 implementation should involve a rural-inclusive ACH region to ensure the system works well in thinly resourced areas, though ideally both a rural and an urban ACH region would be phase 1 implementation areas.
- *Relationship to Washington's Medicaid Transformation goals:* Timely primary care supported child mental health would 1. Reduce avoidable use of intensive services and settings such as acute care hospitals, emergency rooms and psychiatric hospitals, 2. Improve population health by preventing and managing mental illness and substance use disorders in a coordinated and whole-person centered way. 3. Accelerate the transition to value-based payment by establishing statewide data on clinical assessments and outcomes tracking, and 4. Ensure that Medicaid per-capita cost growth is minimized by reducing the use of higher level specialty and psychiatric emergency care.
- *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.* Goals will be to 1. Start by training locally based child behavioral health service providers (BHSPs) and connect them with their supported primary care providers, 2. Through a one-person-helps-many practitioners and patients approach, the BHSPs will increase rapid and evidence supported mental health service access to children and families 3. BHSPs will improve the family experience of care through family centeredness and ease/flexibility of access, 4. BHSPs and their PAL Plus structure/support will reduce behavioral health symptoms through treat to target prospective measurement and tracking.
- *Links to complementary transformation initiatives* – this program would directly meet the Medicaid Transformation Goal of improving population health, because Washington Medicaid children in need of services and not currently receiving them will through this program start to receive evidence supported and measured/tracked care. Also some of the children currently engaging traditional specialty care services but not truly needing that level of care would instead be helped by their current primary care setting. All of the tracked clinical outcomes will provide a new basis for value based purchasing in future value based payment models.
- *Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project.* Partners would include Seattle Children's where PAL is based, University of Washington Psychiatry AIMS Center, Health Care Authority (by extending their existing PAL implementation partnership), the Washington Chapter of the American Academy of Pediatrics, the new regional Accountable Communities of Health (ACHs), and regional Mental Health Service Agencies.

Core Investment Components

Describe:

- *Proposed activities and cost estimates ("order of magnitude") for the project.*

PAL Plus service will be targeted to help children and families with Medicaid coverage who have behavioral health concerns not already being served by the RSN system or other local specialty care providers, and who instead are receiving treatment from their primary care providers. Services offered would include regionally based and multi-practice shared behavioral health service providers (BHSPs) who deliver in person and over the telephone (upon primary care request) evaluation/diagnostic support, individual patient care progress tracking, behavior management coaching and other evidence supported psychosocial care supports which are delivered as an early and easily accessed intervention for Medicaid families. The PAL team child psychiatrists and psychologists would provide these BHSPs with training and support, weekly care plan reviews and support on their caseloads, direct patient evaluations for selected enhanced assessments, and will utilize a shared electronic reporting/tracking system to ensure that children not improving are identified as such and receive additional services. Because children with moderate to severe mental disorders would be coached/facilitated by the service to enroll in traditional mental health specialty services (and once engaged in those services would become inactive PAL Plus cases), we estimate at one point in time only ~1% of all Medicaid clients would be actively managed though many more would be touched by this program during any given implementation year.

- *Best estimate (or ballpark if unknown) for how many people you expect to serve, on an annual basis, when fully implemented.* Approximately 2600 child Medicaid clients per year if servicing only one regional ACH, or twice that number if serving two. Data assumptions: there are approximately 780,000 children on Washington Medicaid (www.kff.org), approximately $1/9^{th}$ are in any given ACH, at any single point in time 1% of all child Medicaid clients would be engaged with this support service, though about 3 times as many would be directly served annually. There would be about 75 active cases per BHSP, so 12 BHSPs would serve one ACH region. If funded to serve two ACH regions during the phase 1 stage, these figures would double.
    - How much you expect the program to cost per person served, on a monthly or annual basis. The annual cost per person served after startup is approximately $536
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.*
    - We will need 6-8 months to hire and train personnel.
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.*
    - Long term analyses by UW AIMS center have demonstrated that $1 spent on adult collaborative care saves $6.50 in health care costs (https://aims.uw.edu/collaborative-care/dollars-sense). Collaborative care for kids also creates opportunities for cost savings, but kids have an overall lower medical cost per capita to influence. Another form of collaborative care with kids found that $1 spent on saved approximately $2 (ex. Hilt et al. 2015). Using this same general ratio, a potential ROI would yield up to $536 per person through fewer primary care referrals to the ED, fewer inpatient admissions, lower inpatient psychiatry costs, and fewer clinically unnecessary specialty outpatient care referrals. The estimated timeline to reach servicing 2,600 patients is approximately 14 – 16 months into the project.

Project Metrics

- *This project's metrics will include: 1. Measurement based and treat to target care, using brief phone and in-person behavioral health symptom rating scale collection as a standard aspect of service delivery, and subsequent database entry with shared visual progress tracking for BHSPs, consultants and primary care, 2. BHSP clinical activity monitoring and incentivized reimbursement for thresholds of key integrated care activities as pioneered by UW AIMS Center and Community Health Plan of Washington, and 3. Health system benchmark measures of potentially avoidable ED visits, depression medication management, psychiatric readmissions, patient experience, SBIRT rates, and working with the Healthcare Authority for a claims data analysis.*