Delaware Center for Health Innovation

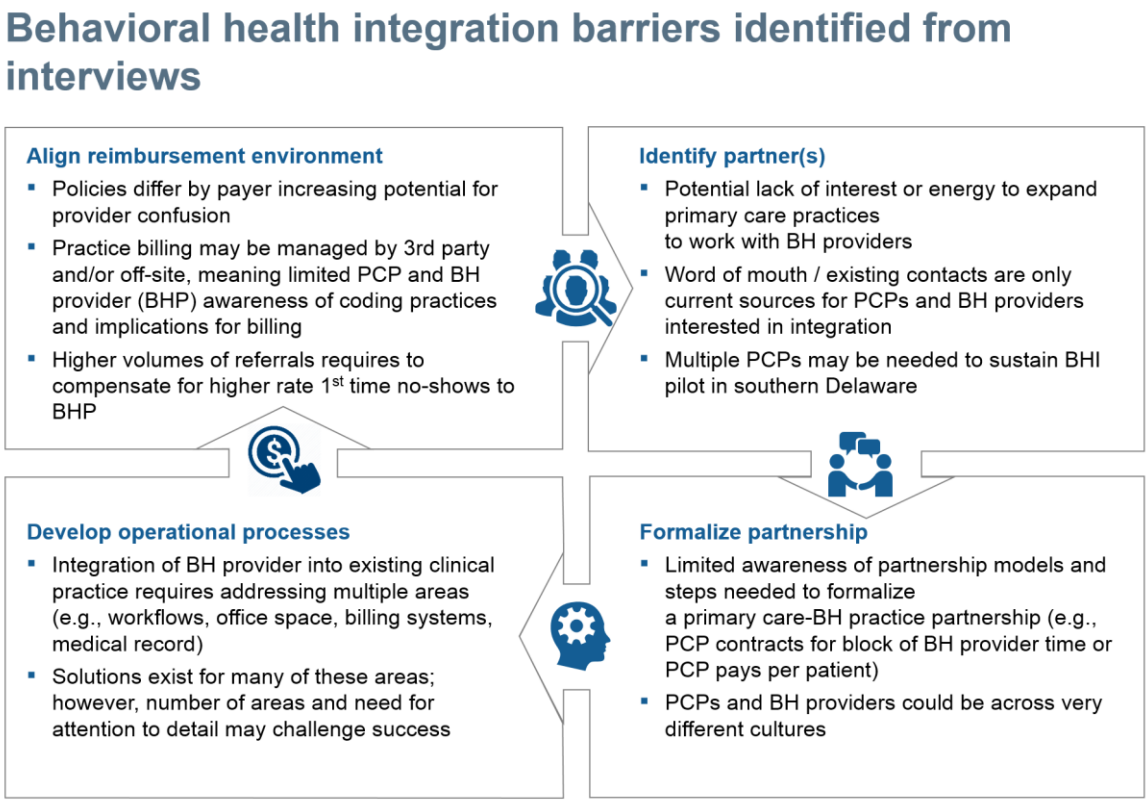
Behavioral Health Integration Testing Program Implementation Plan

August 10, 2016

BACKGROUND ON BEHAVIORAL HEALTH INTEGRATION

Behavioral health and substance use conditions are common presenting features of patients in primary care. Approximately 30-50% of adults with a medical condition also have a mental health condition and almost 70% of adults with mental health conditions have a medical condition.[1] Additionally, people with mental health conditions have high rates of adverse health behaviors, including substance abuse.[2] Consequently, behavioral health (BH) and substance abuse conditions are frequently treated in the primary care setting by primary care physicians (PCPs).[3,4] In Delaware, however, BH and primary care often operate independently, potentially leading to poor behavioral and physical health outcomes and increased costs. Although providers in Delaware continue to experiment with models of integrated care for primary care and BH, few of these have been rolled out on a large scale due, in large part, to 4 major barriers to behavioral health integration (BHI) which were identified during stakeholder interviews: identifying partners, formalizing relationships, developing operational processes, and an aligned reimbursement environment (Exhibit 1).

EXHIBIT 1: KEY BHI CHALLENGES IDENTIFIED THROUGH INTERVIEWS



[1] Druss, B.G., and Walker, E.R. (2011). Mental Disorders and Medical Comorbidity. RWJF; Melek, S and Norris D. (2008). Chronic conditions and comorbid psychological conditions. Milliman

[2] Gerrity, M. (2016). Evolving Models of Behavioral Health Integration: Evidence Update 2010-2015

[3] SAMHSA (2012). Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings

[4] Kessler et al. (2005). N. Engl, and J. Med; 352: 2515-23

VISION OF BEHAVIORAL HEALTH INTEGRATION IN DELAWARE

The Delaware Center for Health Innovation (DCHI) has recognized the need to improve the integration of behavioral and physical health services in Delaware and proposed the following vision for achieving integrated behavioral and primary care:

Our vision is to improve patient outcomes and experience by providing patients with the level of integrated care they require in the least restrictive manner: with special focus on patients with higher physical health needs – and also to create a system that enables clinicians to practice at the top of their license.

DCHI has developed a BHI strategy with input from healthcare leaders that is outlined in the DCHI Consensus Paper on "Integration of Behavioral Health and Primary Care"[5]. In the strategy, DCHI outlines 6 elements of integration that a PCP should consider when integrating behavioral health services into his/her practice:

1. **Develop a team-based approach.** DCHI strongly recommends that teams of BH and primary care clinicians collaborate within a setting that is most accessible to the patient (e.g., primary care, chronic disease management or chronic mental health)
2. **Utilize population management.** Identifying high-risk patients (identified by high costs or utilization, or by chronic medical conditions) who may also have a BH need is foundational to better managing care for individuals with comorbid chronic physical and BH conditions
3. **Apply clinical practice guidelines.** Providers in an integrated practice should adopt or modify existing clinical practice guidelines such as an algorithm for the treatment of depression and/or anxiety or referral guidelines. These can build on the strength and expertise of all of the team members and improve comfort with shifting roles so that all team members can practice at the top of their license
4. **Share information.** Members of the team should communicate certain components of patient care (e.g., medications, active diagnoses, treatment goals) seamlessly through the development of a care plan and integration of electronic medical records. It will be critical that this level of communication extend beyond the primary care team to include the full BH infrastructure should the patient require a higher level of care
5. **Share panel responsibility.** Responsibility for quality metrics, goals, and incentive payments should be shared by primary care and BH clinicians. BH and primary care clinicians must take equal responsibility for the overall health of their patient panel
6. **Expand access through telehealth.** Telehealth and telemedicine provide individuals with limited access to BH care the opportunity to receive face-to-face consultation

[5] Available from: http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-Behavioral-Health-Primary-Care-Integration.pdf

with a behavioral health provider (BHP)[6] for counseling, coaching, medication management and other services. Where possible, telehealth and telemedicine should be used.

Over the next several years, Delaware seeks to have broad adoption of models that integrate behavioral health and primary care. Scaling BHI across the state will bring Delaware closer to its aspiration of being a national leader for each dimension of the Triple Aim – better health, improved health care quality and patient experience, and lower growth in per capita healthcare costs. Studies have found that collaborative care through BHI is effective in accomplishing the Triple Aim. Several states (e.g., Colorado, Maine, Massachusetts, Vermont) have embarked on a similar journey towards integrated behavioral health and primary care and there are even examples within Delaware of practices that have begun to integrate. Still, there is limited experience and, thus, uncertainty around how to operationalize these programs across a variety of practice types, specialties, settings, and geographies. DCHI aims to launch a BHI testing program to test the operational feasibility of various models of integration and develop solutions to the barriers observed by practices. The testing program will consist of a diverse representation of primary care practices adopting various levels of behavioral health integration and will monitor / evaluate progress in order to ultimately make recommendations on how to scale BHI[7] across the state.

DCHI would like to acknowledge the substantial contributions of many individuals from across Delaware in shaping this implementation plan, many of whom are full-time practicing clinicians[8].

This implementation plan addresses 4 topics:

1) Details of the testing program
2) Resources/funding for the testing program participants
3) Overall timeline
4) Plan to scale up BHI

DETAILS OF THE TESTING PROGRAM

The goal of DCHI's BHI testing program is to test the operational feasibility of BHI in advance of promoting adoption of integrated models statewide. Given the shorter time frame and focus on operational aspects, the testing program is not intended to test

---

[6] BHPs are people licensed by the state to address patients' behavioral issues (e.g., psychiatrists, psychologists, LCSWs)

[7] For the purposes of this program, "behavioral health" includes both mental health and substance abuse

[8] Contributors include Dr. Doug Tynan, Dr. Kathy Willey, Dr. Alan Schwartz, Dr. Shalini Shah, Lydia De Leon, Dr. Mark Friedlander, Gary Kirchoff, Roberta Montemayor, Kathleen Dougherty

whether BHI achieves superior health outcomes or financial feasibility. Testing models of integration is important for 3 specific reasons:

1) Proof of concept. Integrating behavioral health into primary care is a new activity for many health practitioners and, although many providers recognize the clinical value, uncertainty remains about how to execute. It will be beneficial to provide tested operational models as examples for other Delaware providers

2) Operational testing. A number of operational barriers to integration have been raised. The testing program seeks to further understand the barriers and assess whether the proposed interventions are sufficient to overcome them

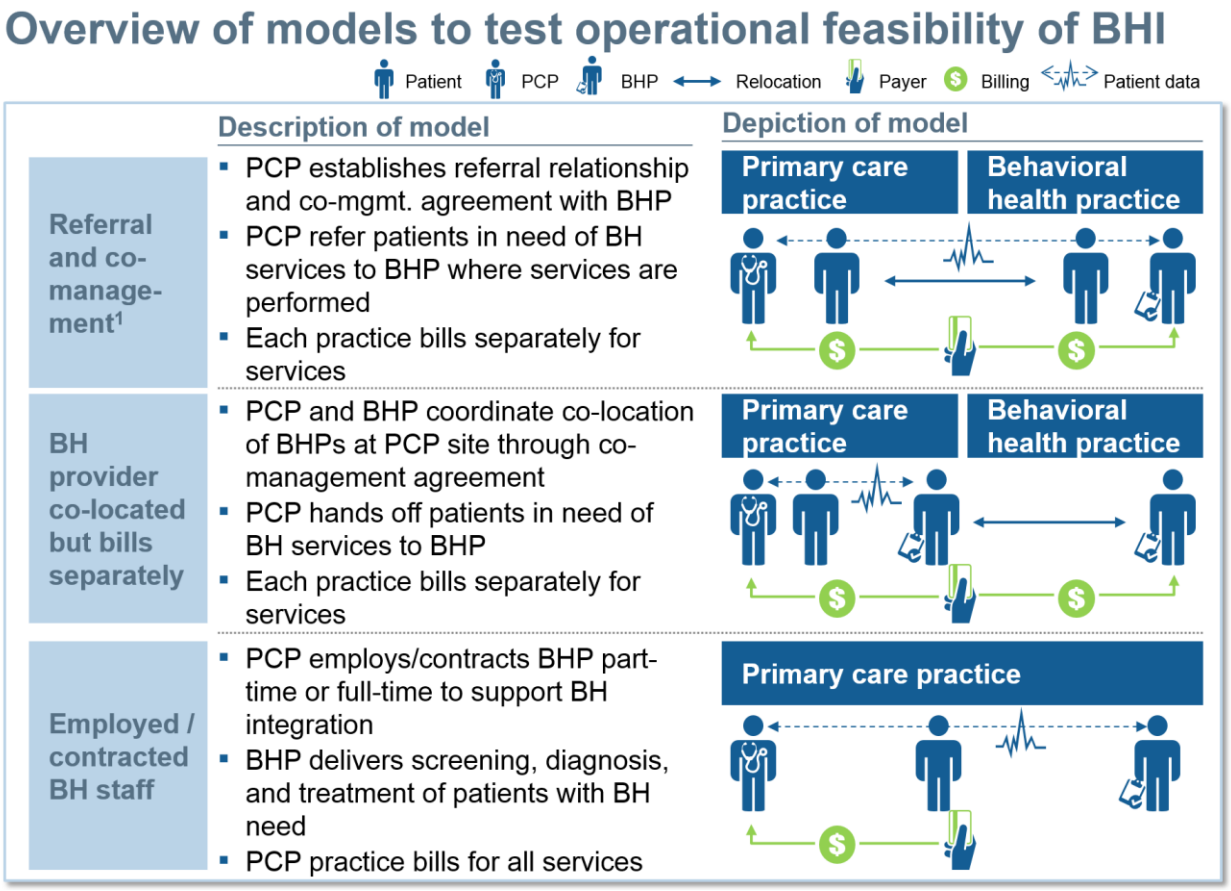
3) Refinement of elements of integration. The 6 proposed elements of integration may need to be modified/optimized based on observations made during the testing program

Description of BHI testing program models

DCHI will launch 3 distinct models along a spectrum of integration from referral and co-management to employed integration. While the aspiration is for all practices to fully integrate behavioral health into primary care, providers in the state will be able to draw insights from the model that is most appropriate for their practice at the time of implementation.

The 3 models are 1) referral to BHPs with existing co-management agreement, 2) co-location of BHPs with a PCP while maintaining separate billing, and 3) employing or contracting BHPs in the primary care setting and billing all services under one practice (Exhibit 2). Each model incorporates the 6 elements of the BH aspirational model in its design. In the referral (1) and co-location (2) models, BHPs and PCPs will form partnerships, with assistance from DCHI when desired, to enable integration of behavioral health services into primary care.

EXHIBIT 2: OVERVIEW OF 3 MODELS OF BHI



1) Referral and co-management. PCPs will establish a referral-based relationship with partner BHPs and develop a co-management agreement[9]. Both practices will establish clear roles and responsibilities for referrals through the use of this co-management agreement. PCPs will be encouraged to create and manage a registry in coordination with BHPs to ensure patients receive appropriate follow-up, to monitor adherence, and identify and prevent any gaps in care. Any gaps in care should be flagged for the BHP. Practices should share information on patients in a timely fashion using either a common electronic medical record (EMR), Delaware Health Information Network (DHIN), or secure fax and should outline this in a data sharing agreement. Providers should establish through the co-management agreement shared responsibilities for the management of patient panels (e.g., same-day appointments for high-risk patients with urgent BH conditions) as well as outline sharing of risk, responsibility, costs, and incentive payments for shared panels. The 2 practices continue to manage their billing independently

[9] The co-management agreement is an agreement of mutual accountabilities, responsibilities, and liabilities under the integrated model of care signed by both practices in the testing program

2) BH provider co-located, but bills separately. BHPs will be co-located in the primary care office, potentially on a part-time basis. Providers will develop a co-management agreement and are encouraged to integrate their scheduling functions. PCPs and BHPs may also establish a co-location agreement which may include the co-location schedule and responsibilities of the BHP (e.g., assessment of urgent BH patients, availability for warm handoffs and/or provider-provider consultation). PCPs will be encouraged to create and manage a registry in coordination with BHPs to ensure patients receive appropriate follow up, to monitor adherence, and identify and prevent any gaps in care. Any gaps in care should be flagged for the BHP. Practices should share information on patients in a timely fashion using either a common EMR, DHIN, or secure fax and should outline this in a data sharing agreement. Providers should establish through the co-management agreement shared responsibilities for the management of patient panels (e.g., same-day appointments for high-risk patients with urgent BH conditions) as well as outline sharing of risk, responsibility, costs, and incentive payments for shared panels. The 2 practices continue to manage their billing independently

3) Employed/contracted BH staff. PCPs employ or contract BHPs to support integration. PCPs and BHPs will need to go through licensing and credentialing processes as appropriate in advance of billing for services. Providers should establish guidelines on the roles and responsibilities of the BHP (e.g., screening, assessment, treatment, therapy) in the practice. The practice should also develop processes to enable warm hand-offs to the BHP and guidelines on writing clear and concise notes. The BHP should oversee the management of a BH patient registry to ensure appropriate follow-up, medication adherence, and address any gaps in patient care. Both the BHP and PCP will communicate patient information (e.g., medications, diagnoses, treatment) using the practice's EMRs. The practice is responsible for scheduling and billing for all primary care and behavioral health services

Cross-cutting elements. In all models, PCPs will adopt or modify existing clinical practice guidelines for the diagnosis of BH conditions (e.g., depression, anxiety) in accordance with the co-management agreement, where applicable. PCPs will also establish processes to identify patients with BH conditions and screen high-risk patients (e.g., high cost, high utilization, or chronic medical conditions) with the ultimate aim of universal screening of all patients. Providers should consider establishing telehealth capabilities to enhance patient access to counseling, coaching, and medication management where feasible/necessary.

Governance

The BHI testing program will be coordinated and managed by DCHI with input from several additional stakeholders including an advisory group, the state, and payers.

DCHI. The Delaware Center for Health Innovation is an organization established to work with the Delaware Health Care Commission (HCC) and DHIN to guide the State

Innovation Model effort and track its progress. DCHI, through the Clinical Committee, will select participants for the testing program and monitor/evaluate their progress throughout the testing program. To ensure program participants are supported effectively, DCHI will coordinate BHI training and start-up support and host regular phone calls and meetings for the testing program participants. DCHI will also review overall program progress through surveys and progress reports from participating practices. DCHI will act as the liaison between participating practices, coordinate resources available for funding and support of BHI and ultimately facilitate statewide rollout of BHI.

Advisory group. The advisory group will consist of healthcare leaders in Delaware experienced with BHI. The advisory group will be made available to BHI testing program participants for consultation related to BHI throughout the course of the program and may also participate in learning collaboratives to share learnings related to BHI in Delaware.

State. Representatives from Delaware will also play an advisory role in the testing program governance. The HCC was created to develop a pathway to basic, affordable health care for all Delawareans. DCHI will ensure the BHI testing program is coordinated with other behavioral health initiatives including HCC's EMR incentive program. The EMR incentive program is run separately through HCC and encourages BHPs to apply for funding to adopt/upgrade EMRs. Details are forthcoming from HCC. Other representatives from the state (e.g., Division of Substance Abuse and Mental Health, Division of Medicaid & Medical Assistance) may play advisory roles during the testing program.

Payers. Payers may provide subject matter experts (e.g., integration expert, billing coach) to serve as resources to program participants on billing and reimbursement issues. Payers may also serve on DCHI's advisory committee and representatives will be asked to attend at least 2 annual meetings for the testing program, hosted by DCHI. Payers will work with testing program participants to report on utilization and reimbursement for patients and services in the joint BHP/PCP panel using claims-based data.

Practice eligibility

Primary care practices and behavioral health practices in Delaware are eligible to apply. DCHI will aim to achieve program participant representation across clinic characteristics, patient characteristics, geography, and payer mix. Ideally, participants recognize the value in BHI and have identified a population of patients who would benefit from the integrated services. Data sharing and coordinated care are critical enablers of BHI. Given the short timeline for the testing program and the relatively long timeline required to integrate EMR systems, for models 1 and 2, DCHI will prioritize PCP/BHP practices that have existing EMRs for participation in the BHI testing program.

Primary Care Providers. PCPs interested in models 1 and 2 will need to jointly apply to the testing program with a BHP practice and commit to coordinating with that practice to form co-management agreements. PCPs interested in model 3 need to apply and commit to hire/contract BHPs for integrated services. PCPs will collaborate with BHPs to operationalize BHI in their clinics according to their model of choice. They will be required to report on the progress of integration at their practice periodically and contribute to meetings, events, and surveys hosted by DCHI.

Behavioral Health Providers. BHPs will need to have been selected to receive funding for EMR adoption or upgrade through HCC's EMR incentive program or already have a high-performing EMR in place. BHPs interested in models 1 and 2 will need to jointly apply to the testing program with a PCP practice and commit to coordinating with that practice to form co-management agreements. BHPs interested in model 3 need to be hired/contracted for integrated services by a primary care practice. BHPs will collaborate with PCPs to operationalize BHI in the primary care practice according to their model of choice. They will be required to report on the progress of integration at their practice periodically and contribute to meetings, events, and surveys hosted by DCHI.

DCHI will use the following selection criteria:

- Demonstration of commitment to BHI
- Clarity of operational changes proposed by the applicants according to the model selected
- Commitment of practice leadership to play an active role in the testing program
- Payer mix (testing program participants should accept all insurance populations)
- Practice size (at least 3000 visits for PCPs annually)
- Presence of existing relationship between behavioral health and primary care practice

DCHI will use the following exclusion criteria:

- Practice outside of Delaware
- PCP already has BHPs fully integrated at practice
- Unable to commit to all terms of testing program
- Practices with non-traditional reimbursement models (e.g., enhanced reimbursement from Medicare/Medicaid)

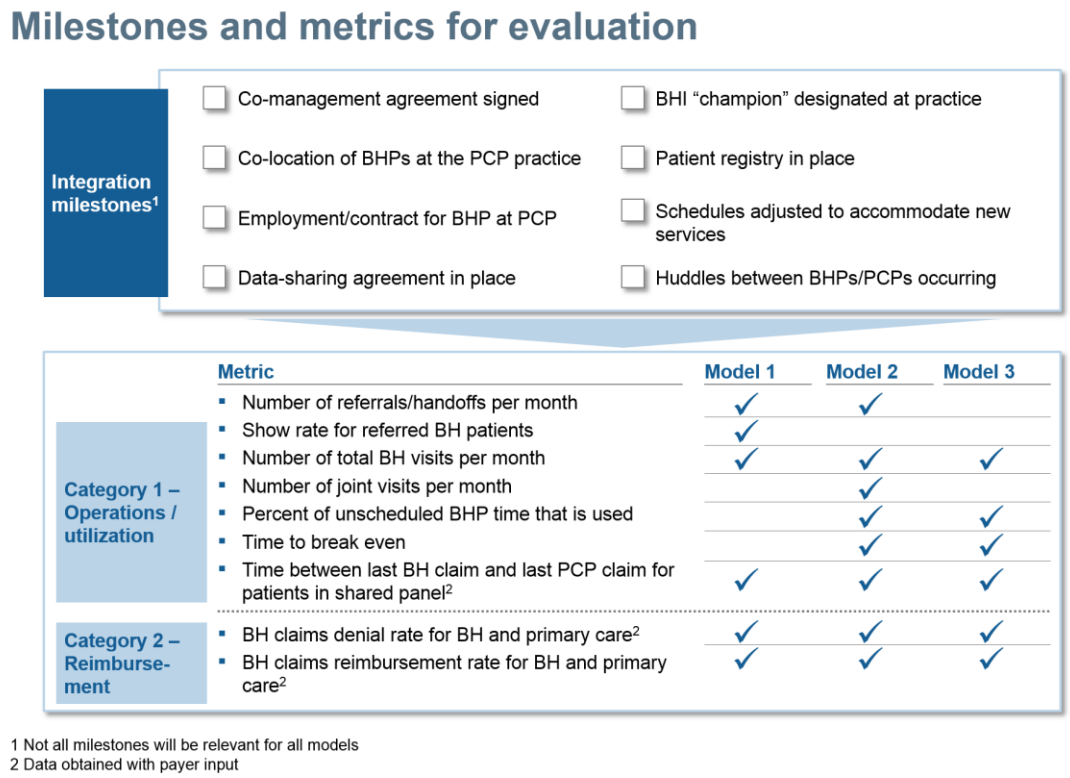
Milestones and metrics for evaluation

A key goal of the testing program is confirming operational feasibility; the testing program participants should monitor the operational feasibility of integration for both the PCP and the BHP. DCHI proposes a set of integration milestones and 2 categories of

evaluation measurements that will be assessed throughout the testing program (Exhibit 3). Achieving success across the milestones and evaluation metrics will signal that integration is operationally feasible for program participants:

- **Integration Milestones** – completion of activities required for, and enabling BH integration
- **Category 1: operations/utilization** – assessment of practices' progress towards operationalizing integrated services
- **Category 2: reimbursement** – assessment of practices' ability to receive reimbursement for BH claims at a rate and lag time similar to those for medical claims

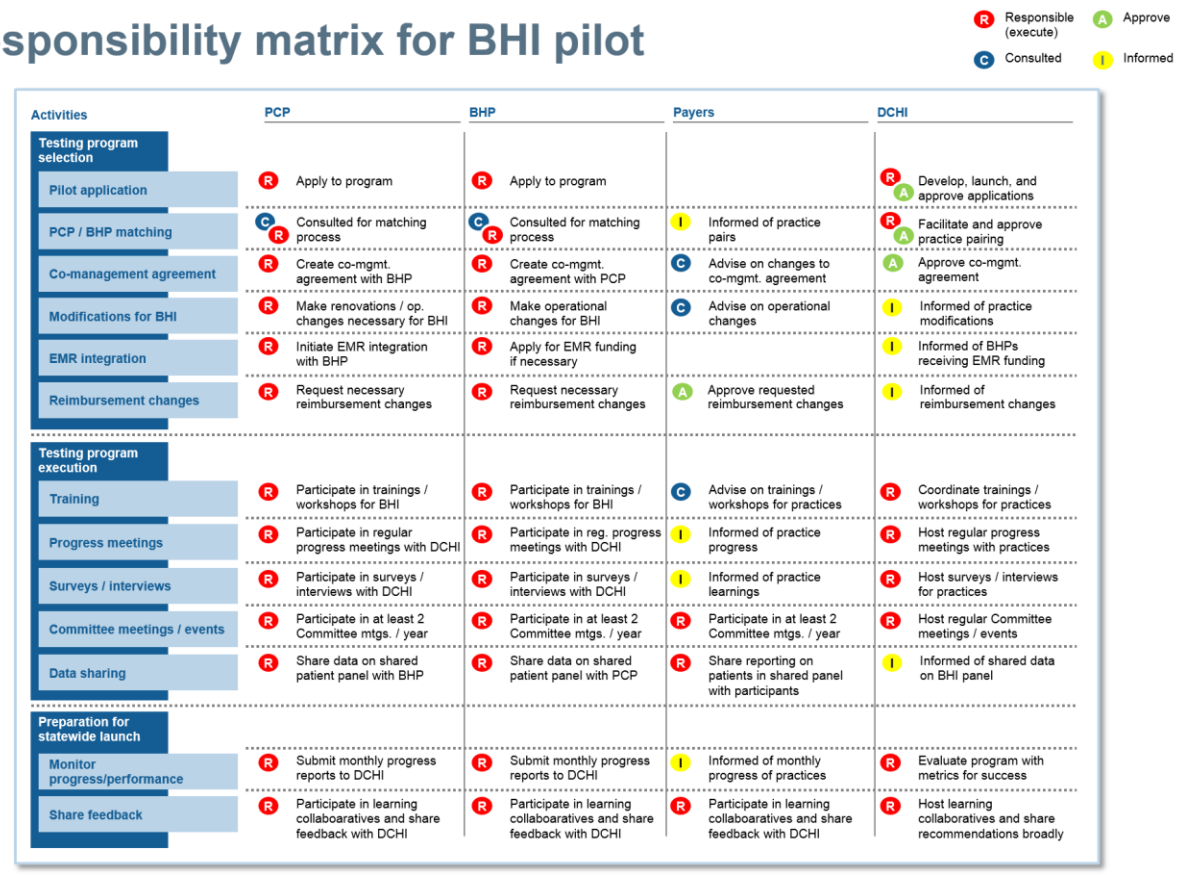
EXHIBIT 3: MILESTONES AND METRICS FOR TESTING PROGRAM EVALUATION



Testing program expectations

Participants and stakeholders will need to commit to several responsibilities across 3 phases of implementation (detailed below) to foster success of the program (Exhibit 4).

EXHIBIT 4: RESPONSIBILITIES AND ACCOUNTABILITIES FOR PROGRAM PARTICIPANTS



BHPs and PCPs, in particular, are expected to complete the following for participation in the program:

Application. BHPs and PCPs will need to submit interest applications to DCHI including practice characteristics, model selection, and behavioral health services desired/offered. Once selected into the program, PCP/BHP practices will form partnerships and will need to submit a joint application detailing their practice characteristics and plans for integration.

Initiation. Testing program participants are expected to submit co-management and data sharing agreements for review and approval by DCHI. Participants are expected to make the appropriate modifications to their sites (e.g., office renovations) as well as formalize plans to modify workflows and clinical guidelines to enable integration. Participants in models 2 and 3 will need to make the necessary scheduling, contracting, or employing decisions to accommodate co-location or integrated services.

Training. Testing program practices are expected to participate in BHI training coordinated by DCHI as well as to train their staff/clinicians as appropriate on any changes resulting from integration.

Administrative. Practices are required to participate in progress meetings with DCHI and other stakeholders every other month. A representative from each of the practices will be expected to attend at least 2 DCHI Clinical Committee meetings during the year (in Wilmington, DE). Practices may also participate in additional events hosted by DCHI (e.g., community forum, cross-Committee meeting) sharing their experiences over the course of the testing program.

Data and reporting. PCP practices will be expected to report progress against a series of evaluation metrics throughout the course of the testing program. These metrics, detailed above, include integration milestones, operational/utilization measures, and reimbursement measures. Practices will be encouraged to identify a cohort of high BH utilizers or the complete shared patient panel within 2 months of program launch and will work with payers to analyze claims-based reporting to monitor utilization and reimbursement for these patients. Practices will also be asked to submit monthly progress reports and, when requested, evaluative surveys to assess progress of integration.

Learning collaboratives. Practices will be asked to participate in trainings and working sessions to share learnings related to BHI while in the program and at the end of the program, during statewide rollout. These meetings will help to refine processes related to integration to support practices during scale-up.

EMR integration. EMR integration is an enabler of care coordination as it facilitates appropriate information flow between BHPs and PCPs. While EMRs are widely used in primary care settings, a relatively small number of BHPs utilize EMRs, and even fewer are integrated with PCPs. BHPs and PCPs in the BHI testing program will be expected to take the necessary measures to integrate their EMRs and share appropriate information (e.g., patient notes, medication history, laboratory results).

Value-based payment participation. By the end of testing program, PCPs will need to be enrolled in a value-based payment model and DCHI's practice transformation program, barring any limitations from panel size. BHPs will need to be enrolled in Delaware's Transforming Clinical Practice Initiative (TCPI), if eligible. Practices will need to consider when, over the course of the program, it will be most beneficial to engage in these services.

RESOURCES

The healthcare landscapes in both Delaware and the nation are changing rapidly. One change is payers moving towards value-based payments linked to outcomes. It will be increasingly important for practices to coordinate care for their patients across providers and sites/types of care to better manage their patient populations. Integrating behavioral health into primary care can also diversify services and improve the care operating model, both outcomes that could prove to be financially beneficial. DCHI is committed to supporting practices seeking to realize these benefits of BHI and, as such, will make 5

types of resources available for participants – 1) consolidated directory of existing resources, 2) economic preparation, 3) access to leaders in DE experienced in BHI, 4) data and reporting, and 5) funding,. In addition to these resources, detailed below, DCHI will make available administrative resources that can support testing program participants on issues that may arise during the program[10].

Consolidated directory of existing resources

Several organizations have compiled resources to facilitate practices in their BHI journeys. DCHI will aggregate these resources and make them easily accessible to testing program participants including:

- Agency for Healthcare Research and Quality BHI resources[11]
  - Implementation framework designed to help primary care practices design and implement integrated behavioral health services at any level of integration
  - Evidence-based research to adopt/develop clinical practice guidelines for behavioral health-related treatment
  - Integrated BH Care Quality Measures set
- Substance Abuse and Mental Health Services Administration BHI resources[12]
  - Online resources, phone consultations, educational webinars, trainings, and case studies to provide assistance/tools for PCPs/BHPs undergoing BHI
  - Information on developing integrated care models, clinical screening tools/protocols, billing, organizational workflows, policies/procedures, training, etc.

Economic preparation

DCHI will make available a basic economic model for BHI that was developed through stakeholder interviews. This model, if used appropriately, can provide PCPs with considerations for integration costs and economic impact over time, particularly in model 3 of the testing program. A draft of this model has already been developed and will be available to practices prior to launch.

Access to leaders experienced in BHI in DE

DCHI will convene healthcare leaders in the state through an advisory group made available for consultation and assistance for the BHI testing program participants. The

---

10 Additional support for BHI may be available through grants from local and national organizations

11 A Framework for Measuring Integration of Behavioral Health and Primary Care. Available from: https://integrationacademy.ahrq.gov/atlas/frameworkIBHC

12 http://www.integration.samhsa.gov/operations-administration

group may include practices/systems that have integrated behavioral health into primary care, representatives from insurers in the state focused on behavioral health, and others as needed. The advisory group may also participate in learning collaboratives which will serve as knowledge-sharing forums for practices involved in the testing program.

Data and reporting

An important component of the testing program will be collecting data, and reporting, on patients treated through the integrated model. DCHI plans to coordinate with payers in the state to produce patient-level claims-based data on utilization and reimbursement for patients in PCP/BHP's shared panel for program participants.

Funding

DCHI will coordinate support for practices involved in the testing program to facilitate start-up activities. Support will come in 2 forms:

- Training for BHI – DCHI will coordinate with BHI experts both locally and nationally to provide training for both BHPs and PCPs involved in the BHI testing program. Training will cover clinical, operational, and financial factors related to BHI
- Start-up costs – DCHI will work towards securing supplemental payment to account for potential underutilization of behavioral health providers in models 2 and 3 during the ramp-up phase of integration

TIMELINE

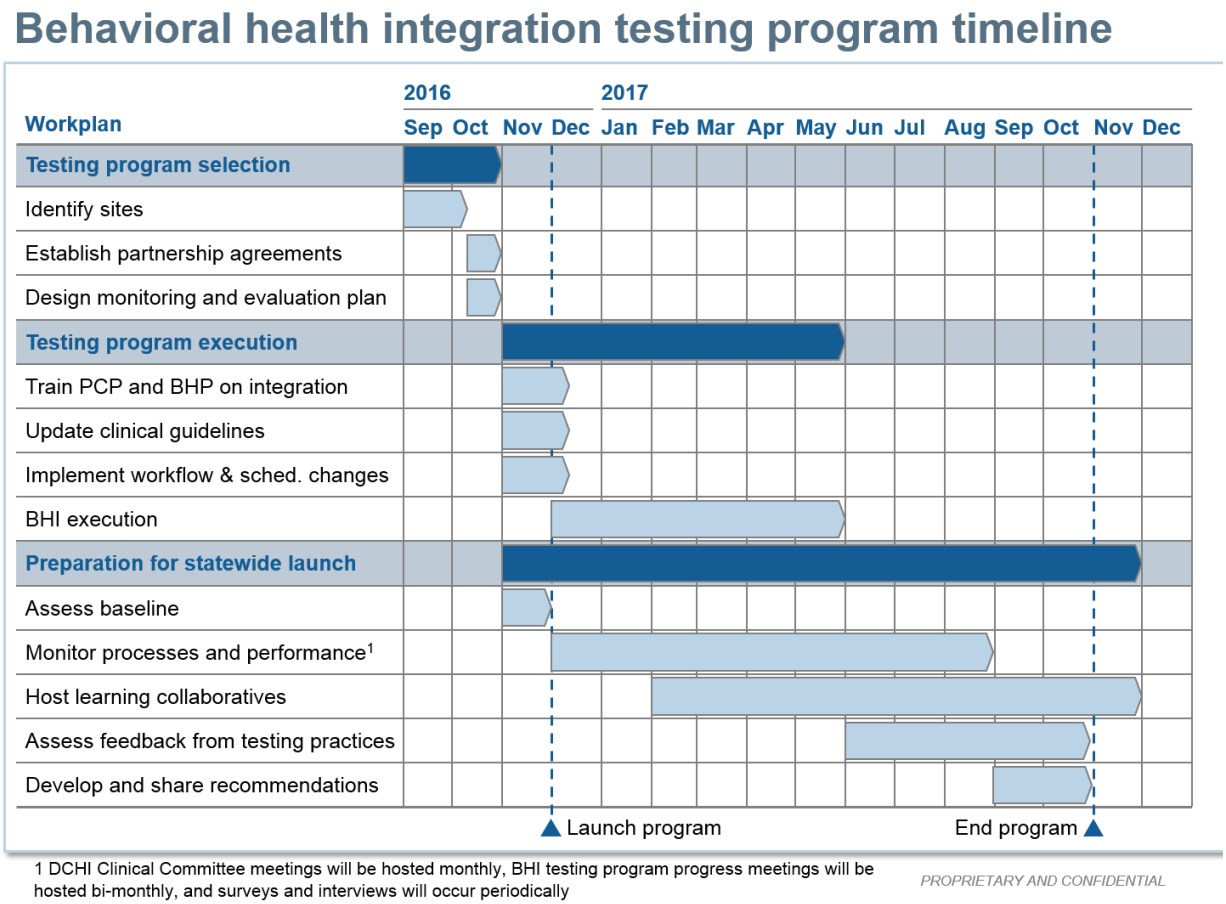
DCHI proposes a 3-phase approach to selecting, launching, and evaluating the BH integration testing program participants – 1) Phase 1: Testing program participant selection, 2) Phase 2: Testing program execution, and 3) Phase 3: Preparation for statewide launch. A timeline is provided in Exhibit 5.

- **Testing program participant selection.** DCHI will identify BHP and PCP testing program participants through the application process and selection criteria specified above. Practices will be made aware of all practices selected into the program and encouraged to collaborate to find appropriate partners. DCHI will play a facilitating role in the formation of partnerships between practices. Once partnered, practices will jointly develop partnership agreements (e.g., co-management agreement, data sharing agreement) detailing BHI at their practices
- **Testing program execution.** Testing program participants will participate in BHI training, adopt clinical practice guidelines, and develop workflow changes to support integration. Program participants should regularly monitor clinical process adoption (e.g., ensure that the new clinical processes are being followed), assess team-based

behavior (e.g., review state of integration in the primary care office), and assess overall performance (e.g., monthly tracking of performance metrics). Testing program participants should be proactive in refining and improving clinical workflow and patient experience over the course of the testing program

- **Preparation for statewide launch.** Testing program participants will record baseline performance for evaluation metrics. At the conclusion of the testing program, the practice may also wish to review overall operational performance and evaluate financial sustainability. DCHI will aggregate findings across testing program participants and develop a report outlining learnings from the testing program participants. DCHI will also convene learning collaboratives to share lessons and best practices from the various models of integration with other providers in the state interested in integrating behavioral health into primary care

EXHIBIT 5: BHI TESTING PROGRAM TIMELINE



Phase 1 – testing program participant selection (September-November 2016)

September-October 2016

- DCHI will identify BHPs interested in the BHI testing program through expression of interest on HCC's EMR incentive application
- DCHI will release BHI testing program interest questionnaires for PCPs
- DCHI will facilitate partnering of interested primary care practices with interested behavioral health practices (considering model selection, patient population, practice characteristics, BH services needed/offered, and geography)
- DCHI will release joint BHI testing program applications for partnered practices
- Practices submit joint applications to DCHI for the proposed integrated model

- DCHI will review joint applications and select testing program participants

October-November 2016

- Testing program participants will establish co-management agreements
- DCHI will review/advise on co-management agreement
- DCHI will finalize and release monitoring and evaluation plans

Phase 2 – testing program execution (November 2016-June 2017)

November-December 2016

- Testing program participants will participate in BHI start-up activities (e.g., BHI training, orientation with DCHI, implementation meetings)
- Testing program participants will update clinical guidelines and implement workflow and scheduling changes

December 2016-June 2017

- Testing program participants will begin participating in bimonthly progress meetings with DCHI and other stakeholders (meetings will be largely by phone and last 30-60 minutes)
- Testing program participants will start contributing to surveys/interviews when requested by DCHI (surveys will be distributed as needed to assess testing group progress)
- Testing program participants and payers will be invited to monthly DCHI Clinical Committee meetings, and will be expected to attend at least 2 meetings a year
- Testing program participants will participate in learning collaboratives or working sessions, to share learnings and continue training related to BHI both during and after the program

Phase 3 – preparation for statewide launch (November 2016-November 2017)

November-December 2016

- Practices will identify a cohort of high BH utilizers within 2 months of initiation and will be expected to report to DCHI basic characteristics of the high BH cohort and implement a monitoring plan
- DCHI will assess the baseline of practices performance against the metrics for evaluation

November 2016-November 2017

- Testing program participants will complete a monthly progress report developed by DCHI
- Payers will provide claims-based reports for patients in the shared BHP/PCP panel
- Practices will retrospectively reconcile reimbursement status of BH claims to evaluate codes submitted vs. codes reimbursed
- DCHI will review monthly progress reports for testing program participants and update the Board regularly on progress of testing program participants

PLAN TO SCALE UP BHI

DCHI is committed to promoting broad adoption of models that integrate behavioral health and primary care services across the state over the next several years. While this testing program will help identify the necessary components to make BHI operationally feasible, it will be important to get practices across the state excited about, and invested in, BHI. DCHI proposes scaling up BHI by performing various activities across 3 categories – 1) share learnings, 2) refine processes, 3) support implementation.

Share learnings. Throughout the BHI testing program, DCHI will host learning collaboratives where practices involved in the program can learn from BHI experts. These collaboratives will be opportunities to share learnings openly and broadly with the BHI community in the state. After the program, participants will be expected to continue contributing to learning collaboratives, educating more nascent practices in implementing BHI. DCHI will also evaluate feedback from testing program participants and patients in order to synthesize learnings and understand the successes and challenges in each model. These learnings will be made available to all Delawareans in a testing program report.

Refine processes. Learnings from the testing program will be used to refine policies and processes related to BHI. DCHI will convene BHPs, PCPs, payers, and other healthcare stakeholders to discuss program learnings and necessary changes with the goal of creating an ecosystem where BHI can occur flawlessly without significant medical, operational, legal, and financial limitations.

Support implementation. In order to support BHI implementation at all practices, DCHI will create a BHI starter pack. Similar to practice transformation, this resource will provide milestones, timelines, and guidelines for effectively integrating behavioral care into primary care across the 3 models tested. It will also include resources (e.g., playbooks, training, clinical workflows) that practices can leverage during their integration process and clearly defined metrics to measure success along the path to integration. DCHI will create a "marketplace" of BHPs and PCPs to facilitate communication and partnership between providers interested in integration.