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# HMA

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HEALTH MANAGEMENT ASSOCIATES

*Delaware Behavioral Health Integration  
Pilot Program  
Final Report and Recommendations*

PREPARED FOR THE  
DELAWARE HEALTH CARE COMMISSION

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## Executive Summary

### Background

In August 2017, Health Management Associates (HMA) was awarded a contract by the State of Delaware, Department of Health and Social Services, Delaware Health Care Commission (DHCC), to support statewide health system transformation initiatives. The contract included designing and operationalizing a Behavioral Health Integration (BHI) pilot program. The program was intended to test three integration models within the Delaware provider community to inform further statewide implementation. The three models reflect practice options along the continuum of behavioral health and primary care integration and include the following tracks:

- Track 1: Enhanced referral relationships and connectivity between primary care and behavioral health practices.
- Track 2: Co-location model development through hiring or contractual relationships of behavioral health providers in primary care practices or primary care providers in behavioral health practices.
- Track 3: An integrated model of care, through the Collaborative Care Model, that supports a team-based approach to addressing the behavioral health needs of primary care patients.

The BHI pilot project was divided into two cohorts of practices, each receiving technical assistance over a six-month period. The first cohort ran from January to June 2018 and the second from July 2018 through December 2018, with the first cohort of practices continuing in the second six-month period for a complete year of coaching. In total, 22 primary care and behavioral health practices participated across the two cohort periods.

To implement the BHI pilot, HMA provided a comprehensive, multi-faceted training and coaching solution for participating practices, including face-to-face group training collaboratives and facilitated sharing sessions, virtual education and networking, and individualized practice coaching. Each practice received a dyad of coaches who had experience in working in primary care and/or behavioral health settings and knowledge relevant to the practice's selected track. Practices also had access to subject matter experts related to components of integrated care who were available as needed. In addition to group learning sessions and individualized coaching, HMA provided several additional supports to respond to needs that were identified during the pilot project. Concurrently, HMA conducted a comprehensive evaluation to objectively analyze the effectiveness of pilot implementation and BHI technical assistance.

### Results

Participating practices reported positive feedback on all learning sessions, whether in-person or virtual and across both cohorts. Evaluations of individualized coaching were likewise positive, and practices indicated BHI had improved as a result of participation.

Quantitative analyses also demonstrated that practices made substantial progress over the technical assistance period. Practices have made advancements in every area assessed (i.e., Practice and Organizational Leadership, Practice Team Commitment, Practice Functions, Level of Integration,

Screening and Treatment), with some variability between primary care and behavioral health practices and by cohort. Practice transformation support varied by practice, and focused on screening and treatment workflow development, implementation of measurement-based care, financial modeling, and brokering partnerships. Practices also made significant progress in achieving their individually identified goals in these areas.

Despite these significant successes, practices still have transformation needs to achieve the level of integration of their chosen track, and ongoing support is needed for sustainability of BHI.

## Considerations for the Sustainability of Behavioral Health Integration

The evaluative components of the BHI project form a comprehensive assessment of challenges, successes, and lessons learned, and inform some key considerations for the State in providing the support needed to sustain ongoing BHI transformation and spread in Delaware. Partnership development, establishing measurement-based care, building organizational capacity, and supporting financial viability are critical components of BHI that would benefit from ongoing state-level support and prioritization. In addition, considerations in these critical areas, taken more broadly, also hold important take-aways for other statewide integration efforts, and could be applied as relevant within those contexts (e.g., in efforts to integrate SUD treatment into primary care related to opioid use).

1. **Develop Partnerships to Support Integration:** The DHCC should consider ways to support ongoing partnership and communication:
  - Hold forums to talk about challenges of holistically addressing primary and behavioral health care and encourage time to network.
  - Gather and disseminate statewide information to facilitate referrals and provider connections by surveying practices to gather more complete information about services provided, populations served, and group affiliations.
  - Optimize the health information exchange as an avenue to support better exchange of information among practices.
2. **Embrace Measurement-Based Care:** The DHCC should consider ways to:
  - Meet with the BHI pilot practices who have effectively implemented measurement-based care to learn how it informs treatment and can align with quality and incentive payments.
  - Support registry development and maintenance at the practice and statewide level.
  - Optimize the health information exchange as an avenue to support better exchange of information among practices.
  - Encourage and possibly require measurement-based care across systems through pay for performance or value-based payment models.
3. **Build Organizational Capacity to Perform Integrated Care:** The DHCC should contemplate the following action items to support infrastructure and organizational capacity:
  - Acknowledge the organizational resources entailed with building and maintaining incentive and payment, quality improvement, and HIT structures and prioritize a phased approach to change.

- Tune in to the experts, such as practice group of advisors, doing the work and getting input around what is feasible and what would be effective in moving integration forward and sustaining it.
4. **Develop Methods to Support Financial Viability:** To invest in the widespread adoption and spread of integrated care, the DHCC should examine methods to:
- Adopt CPT codes that recognize the importance of managing populations of patients within a primary care practice including codes for the collaborative care model, chronic condition codes, and HABI.
  - Encourage alignment of quality measures across payers, including Medicaid MCOs as well as other payers in the State, as part of value-based payment reform activities.

## Conclusion

The BHI pilot practices have made substantial progress over the past 12 months, both in measures of objective transformation assessment as well as in the pursuit of their individually established goals, and still need further transformation to achieve the level of integration for their chosen track. Many sites have confirmed an interest and commitment to continue this transformation beyond the pilot project.

Much of the technical assistance provided to the practices focused on change management, evidence-based screening processes, incorporating measurement-based care, and treatment offered. Practices have made significant strides in incorporating these features into their practice workflows, and are steadily advancing from no providers, or few providers, using these to broader use across their providers. In addition, partnership building among practices has really taken a foothold, with practices continuing to establish communication and workflow details, referral relationships and care compacts.

Commitment to ongoing primary care and behavioral health integration remains strong, a solid foundation for its continued growth among BHI pilot practices is evident. However, ongoing state-level support will be needed to ensure sustainability and statewide spread. Support for partnerships, measurement-based care adoption, and building organizational capacity to perform integrated care are key areas in which Delaware can impact practices' ability to integrate care and underpinning all these efforts is the financial support to pursue this transformation. The lack of payment remains a significant barrier impacting practices' ability to transform (and the speed at which they transform), and financial reimbursement will be a critical factor in determining feasibility of long-term sustainability and spread.

## **Introduction**

In August 2017, Health Management Associates (HMA) was awarded a contract by the State of Delaware, Department of Health and Social Services, Delaware Health Care Commission, to support statewide health system transformation initiatives. The contract included three components: State Innovation Model (SIM) project management, analytics and grant facilitation (“Component A”); behavioral health integration program management and analysis (“Component B”); and healthy neighborhoods program implementation and analysis (“Component C”). As part of Component B: Behavioral Health Integration, HMA was tasked with designing and operationalizing a Behavioral Health Integration (BHI) pilot program. The program was intended to test three integration models within the Delaware provider community to inform further statewide implementation. The three models reflect practice options along the continuum of behavioral health and primary care integration and include the following tracks:

- Track 1: Enhanced referral relationships and connectivity between primary care and behavioral health practices.
- Track 2: Co-location model development through hiring or contractual relationships of behavioral health providers in primary care practices or primary care providers in behavioral health practices.
- Track 3: An integrated model of care, through the Collaborative Care Model, that supports a team-based approach to addressing the behavioral health needs of primary care patients.

To implement the BHI pilot, HMA provided a comprehensive, multi-faceted training and coaching solution for participating practices, including face-to-face group training collaboratives and facilitated sharing sessions, virtual education and networking, and individualized practice coaching. Concurrently, HMA conducted a comprehensive evaluation to objectively analyze the effectiveness of pilot implementation and BHI technical assistance. This report comprises the final evaluation of the BHI pilot.

## **BHI Pilot Design and Implementation**

The BHI pilot project includes both primary care practices within the State of Delaware who are committed to integrate behavioral health services as part of their core services to patients, as well as behavioral health practices committed to integrating primary care services. The pilot design was rooted in the understanding that practices interested in integration were at various stages of readiness and had different staffing models, so engaging them in BHI would require aligning practices with multiple technical assistance tracks accordingly (i.e., enhanced referral relationships, co-location, and fully integrated collaborative care).

Practices were recruited and eligible for participation based on a demonstrated organizational commitment and cultural readiness to implement behavioral health integration and serving a patient population that would benefit from enhanced integration. HMA worked collaboratively with the Delaware Health Care Commission to develop and execute an aggressive recruitment plan across Delaware. With no financial incentive or compensation as part of practice participation or implementation of the BHI tracks of work, it was imperative to have a comprehensive approach to practice recruitment that included stakeholder engagement and a messaging platform describing the value proposition for this work across the quadruple aim of improving patient outcomes, decreasing

unnecessary costs, and providing highest patient and provider care experience. The recruitment plan included meeting with key stakeholders from across the State, identifying opinion leaders and health care leaders within the community, outreach to health care organizations—both primary care and behavioral health practices representative of different regions, delivery system structures, and patient populations. HMA promoted the BHI pilot program, available technical assistance, and expectations for participation to State partners through the Delaware Center for Health Innovation’s Clinical Committee, Delaware Health Information Network, practice transformation vendors, and two BHI kickoff webinars. HMA also met Public Health Department staff, the Division of Substance Abuse and Mental Health (DSAMH), and the Office of the Lieutenant Governor Bethany Hall-Long’s Behavioral Health Consortium. HMA met individually with identified key behavioral health and primary care providers and networks to encourage individual practices to participate in the BHI Pilot. Interested practices submitted an application for technical assistance; HMA conducted initial assessment interviews to determine eligibility and readiness for participation. Once the practice was accepted for participation in one of the three integration pilot tracks, HMA assigned a dyad of coaches who had experience in working in primary care and/or behavioral health settings and knowledge relevant to the practice’s selected track. Assigning a dyad of coaches to each practice provided two unique perspectives to drive integration activities and facilitated timely follow-up. In addition to the assigned coaches, practices had access to subject matter experts who were made available through the coaches to delve into specific issues. Regular meetings of the entire BHI Pilot coaching team supported practice relationship development and leveraged resources to identify best practices for sharing across sites.

Many of the participating primary care practices had participated in the Practice Transformation initiative offered in the first SIM period. Many of the practices provide services in multiple sites; in these cases, technical assistance focused on behavioral health integration in one of the multiple sites as a starting point for the pilot.

HMA provided technical assistance for each practice through a variety of modalities including learning collaboratives, webinars, training and coaching with the goal to advance integration between behavioral health and primary care. When applicable, participation in group learning events was incentivized through the provision of continuing medical education (CME credits).

The first phase of the technical assistance process included an initial onsite practice readiness assessment, conducted by the practice coaches and intended to determine whether a practice had the basic processes and systems in place to proceed with their selected track, and how far along the continuum of behavioral health/primary care integration the practice was at baseline. At the completion of the readiness assessment, the coaches and the practices identified goals for integration. The individual practice coaching was then tailored to the goals that each participating practice created based on the results of the readiness assessment and their stated objectives. The coaching used resources, toolkits and training modules to support the individual goals. At the completion of the pilot period, the same readiness assessment was administered again to evaluate progress and achievement of practice goals.

The BHI pilot project was divided into two cohorts of practices, each receiving technical assistance over a six-month period. The first cohort ran from January to June 2018 and the second from July 2018

through December 2018, with the first cohort of practices having the option to continue in the second six-month period for a complete year of coaching.

### Evaluation Methodology

HMA utilized a comprehensive evaluation approach comprised of regular quantitative and qualitative data collection and analysis to analyze the effectiveness of pilot implementation and BHI technical assistance. This approach included evaluations of each learning session conducted; coaching surveys to assess satisfaction with individualized assistance, practice baseline and post-pilot assessments to determine progress made toward achieving BHI, and coaching goal summaries and progress reports, completed by practice coaches, to qualitatively summarize the degree to which practices achieved defined goals, successes, and barriers encountered.

**Figure 1: Evaluation Components**

### A Four-Pronged Quantitative and Qualitative Approach to Data Collection:



The Kirkpatrick Four-Level Evaluation Model provided the framework for the technical assistance evaluation. The Kirkpatrick Model is one of the most widely used methods for evaluating training, and consists of four levels, as shown below.

Figure 2: Kirkpatrick Model



**Levels 1 and 2:** The Reaction and Learning measures were gathered via surveys immediately following learning sessions. Participants had the opportunity to share whether they achieved the learning objectives for each session and whether they have the confidence and commitment to apply the learnings at their practice. The surveys also included a section for narrative comments and suggestions for improvement that were shared with the HMA team for continuous improvement.

**Levels 3 and 4:** Behavior and Results were measured by gathering data to show how practices met the specific milestones and goals of BHI. HMA evaluated behavioral change by using the practice readiness assessments conducted at baseline and post-technical assistance, as well as coaching goal summary reports prepared by the practice coaches. Results were further informed by facilitated discussions with practice coaches, who served as key informants with perspective on each practice, as well as across practices. A survey conducted of practices also assessed their transformation progress.

Together, these components provide a 360-degree view of the technical assistance provided and the progress made toward BHI, including a comprehensive assessment of challenges, successes, lessons learned and recommendations for ongoing spread of the models to other providers in the State.

## Participating Practices

Twenty-two (22) practices participated in total across the two cohorts, including 14 practices that were originally engaged in Cohort 1, who also continued throughout the second cohort, and eight new practices who were added as part of Cohort 2.<sup>1</sup> In both cohorts, practices were evenly split between primary care and behavioral health sites. Practices were predominately located in New Castle county (77 percent of practices), including nearly all primary care practices, while behavioral health practices, though also predominantly in New Castle, were a slightly more spread across the State. Practices represented a range of sizes in terms of number of providers. Most primary care practices were private practices, while behavioral health practices were more of a mix of private practice and community behavioral health organizations (CBHOs). Primary care practices most frequently specialized in family medicine, though there was a good representation of pediatric practices, and some behavioral health

<sup>1</sup> One Cohort 2 “practice” included three separate private practices that are part of the same ACO, and function as a single practice for the purposes of technical assistance and the analysis

practices also specialized in substance use disorder (SUD). Primary care practices were predominantly interested in the Collaborative Care Model (i.e., Track 3 Technical Assistance), while the majority of behavioral health practices were interested in pursuing referrals to primary care practices (i.e., Track 1 Technical Assistance). All practices interested in co-location (i.e., Track 2 Technical Assistance) were engaged in the first cohort; no added practices in Cohort 2 chose to pursue this track.

**Table 1: Demographic Characteristics of Practice Sites**

	PC C1		PC C2		BH C1		BH C2		Total C1		Total C2		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
<b>Total</b>	7		4		7		4		14		8		22	
<b>County</b>														
Kent	1	14%	0	0%	2	29%	1	25%	3	21%	1	13%	4	18%
New Castle	6	86%	4	100%	4	57%	3	75%	10	71%	7	88%	17	77%
Sussex	0	0%	0	0%	1	14%	0	0%	1	7%	0	0%	1	5%
<b>Clinical Providers</b>														
1-3	1	14%	1	25%	2	29%	1	25%	3	21%	2	25%	5	23%
4-10	2	29%	3	75%	2	29%	0	0%	4	29%	3	38%	7	32%
10+	4	57%	0	0%	3	43%	3	75%	7	50%	3	38%	10	45%
<b>Organization Type</b>														
Private Practice	4	57%	4	100%	2	29%	2	50%	6	43%	6	75%	12	55%
Clinic (CHC, RHC, or hospital)	3	43%	0	0%	0	0%	0	0%	3	21%	0	0%	3	14%
CBHO	0	0%	0	0%	2	29%	2	50%	2	14%	2	25%	4	18%
CBHO/SUD	0	0%	0	0%	2	29%	0	0%	2	14%	0	0%	2	9%
SUD	0	0%	0	0%	1	14%	0	0%	1	7%	0	0%	1	5%
<b>Predominant Specialty</b>														
Family Medicine	4	57%	2	50%	0	0%	0	0%	4	29%	2	25%	6	27%
Pediatrics	2	29%	1	25%	0	0%	0	0%	2	14%	1	13%	3	14%
Multi-specialty	1	14%	1	25%	0	0%	0	0%	1	7%	1	13%	2	9%
Behavioral Health	0	0%	0	0%	4	57%	4	100%	4	29%	4	50%	8	36%
Behavioral Health; SUD	0	0%	0	0%	2	29%	0	0%	2	14%	0	0%	2	9%
SUD	0	0%	0	0%	1	14%	0	0%	1	7%	0	0%	1	5%
<b>Track</b>														
Referral	1	14%	1	25%	3	43%	4	100%	4	29%	5	63%	9	41%
Co-location	3	43%	0	0%	3	43%	0	0%	6	43%	0	0%	6	27%
CoCM	3	43%	2	50%	1	14%	0	0%	4	29%	2	25%	6	27%

PC: Primary Care; BH: Behavioral Health; C1: Practices that began in Cohort 1; C2: New practices added to Cohort 2

## Results

Comprehensive assessment to evaluate the effectiveness of technical assistance and learning opportunities, as well as to assess transformation progress and the adoption of integrated care, through regular surveys and quantitative and qualitative data analysis provides a rich and multi-layered assessment of the BHI pilot allows for a solid understanding of challenges, successes, lessons learned and recommendations for ongoing spread of the models to other providers in the State. The results of these evaluation methods are each presented in depth and form the basis for subsequent lessons learned and summative conclusions.

### Technical Assistance: Group Learning Sessions and Practice Coaching

HMA's technical assistance approach was multi-modal, including monthly group learning events paired with individualized coaching provided by the assigned coaching dyad. Each modality was evaluated using the Kirkpatrick Model described above and are described in aggregate here.

#### Group Learning Sessions

During the twelve-month pilot period, HMA presented and facilitated a total of 13 group learning sessions,<sup>2</sup> broken down as follows:

- Four Learning Collaboratives: Full-day in-person sessions on the collaborative care model, leadership and change management, measurement-based care, brief behavioral health interventions, and other topics relevant to the Delaware behavioral health integration environment.
- Seven Webinars: One-hour virtual sessions, hosted by subject matter experts, focused on specific topics to support care integration, including financing options and sustainability, psychotropic prescribing, patient registries, and leadership in a changing landscape.
- One Regional Knowledge Sharing Opportunity: One half-day in-person best practice forum held during Cohort 1 where practices shared successes, and barriers.
- One Final Report and Sustainability Learning Collaborative: A full-day in-person event focused on sustainability and summarizing the results of the project and progress made, sharing the results of the evaluation, and exploring the lessons learned.

The in-person learning collaboratives appeared to have higher participation levels, with an average of 47, compared with an average of 20 registered attendees for each of the virtual webinars (though it is possible that multiple individuals were sharing phone lines and did not individually register).

After each learning session, HMA distributed and analyzed a brief evaluation to assess participants' reaction and learning. The surveys assessed level of achievement of learning objectives, effectiveness of learning modalities, and suggestions for improvement for both coaching and the learning community. Overall, evaluation response rates were higher for in-person sessions (87 percent), where evaluations were paper-based and completed onsite at the end of the session, compared to the response rate for

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<sup>2</sup> For a full schedule of group sessions, including title and content summary, see Appendix E: Summary of Behavioral Health Integration Pilot Period Learning Sessions.

webinars (35 percent), which were via web-based and sent via email link post-webinar. For learning sessions eligible for CME credit, evaluation forms also aligned with CME requirements to ensure CME credit could be provided to attendees. In total, 24.25 CME credits hours were awarded across all learning sessions, with 84 participants receiving at least one credit hour.

#### *Practice Feedback on Group Learning Sessions*

Participating practices reported positive feedback on all learning sessions, whether in-person or virtual and across both cohorts. The overall average rating of all sessions was 4.6 out of 5, on a scale of 1, representing poor, to 5 representing excellent. All learning sessions<sup>3</sup> scored higher than a 4 out of 5. The rating of the quality of each presentation, which included the knowledge of the instructor and organization of content, also scored an average of 4.6 out of 5. When asked about learning session topics and materials, 92 percent of practices, on average, reported that the content was just right.

#### **Individualized Coaching**

Individualized coaching sessions with each practice's coaching dyad were designed to occur monthly, though they could be more or less frequent depending on the needs of the practice and how those needs evolved over time. Many of these sessions occurred in person, which were particularly helpful for engaging leadership and staff and facilitating working sessions, while other coaching sessions were virtual. The practices initially engaged as part of Cohort 1 (i.e., those practices that received a full 12 months of technical assistance), received an average of 13 individual coaching sessions, while the practices engaged at the start of Cohort 2 (i.e., practices that received six months of technical assistance) received an average of eight individual coaching sessions. Through these sessions, practices and their coaches focused on achieving the practice's individual goals, addressing challenges and barriers faced by the sites.

#### *Practice Feedback on Site Coaching Activities*

At the end of each six-month cohort period, HMA distributed a brief survey to request practice feedback on individual technical assistance received. Surveys were sent to practice staff that had engaged in any of the individual coaching sessions throughout the period. For sites with more than one respondent, results for the practice were aggregated in the analysis to prevent skewing toward sites with more participants.

At the end of the pilot period, 18 of the 22 participating practices (82 percent) submitted coaching evaluations. The introductory question was a rating of all the technical assistance combined (including webinars, learning collaboratives, regional knowledge sharing and individual coaching sessions), while the remaining questions focused on the individual sessions specifically. Participants rated, on average, their satisfaction with *all* technical assistance 4.48 and their satisfaction with the overall knowledge and expertise of their practice coach(es) 4.72, each on a scale of 1 representing very dissatisfied to 5 representing very satisfied.

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<sup>3</sup> The final learning session was not yet complete as of the date of this report and is not included in these evaluation results.

Respondents were asked to rate their specific TA coach along several dimensions, on a scale of 1 (strongly disagree) to 5 (strongly agree). Responses were positive, with all statements averaging between 4 (agree) and 5 (strongly agree). No respondents strongly disagreed or disagreed with any statement. When asked if the practice level of BH/PC integration had improved as a result of the technical assistance/ coaching received, the average response was 4.15 out of 5.

## **Additional Technical Assistance: Statewide Workgroup Support and Registry Development**

In addition to group learning sessions and individualized coaching, HMA provided several additional supports to respond to needs that were identified during the pilot project. While it was not initially anticipated within the scope of the project, these supports arose as areas where collaborative efforts across participating practices, facilitated by HMA, would best address key needs related to data exchange between primary care and behavioral health providers; efforts to record, track, and monitor care; and the evaluation of payment reform for BHI.

### **Behavioral Health Integration Data Workgroup**

Throughout the first half of 2018, leaders from behavioral health organizations across Delaware were convened by HMA as part of our role supporting integrated care in the State. There were two main objectives of this effort: 1) to develop a list of data elements that participants wanted to exchange to support more effectively integrated care between primary care and behavioral health providers; and 2) to identify barriers and approaches to sharing this information that are consistent with confidentiality of substance use disorder patient information obligations under §42CFR part 2.

The Workgroup developed a series of use cases to better illustrate the circumstances under which exchange of data is necessary as well as why specific data elements are needed<sup>4</sup>. These use cases frame the importance of sharing data, what data is needed, and the circumstances that inform the need for specific content. The group explored privacy and consent issues that might impact sharing of data, and discovered discrepant views across primary care and behavioral health providers regarding what can/should be exchanged, particularly regarding behavioral health data that the group identified that many healthcare providers remain concerned about the exchange of *any* behavioral health data, though from a legal perspective, the confidentiality protections are specific to data for individuals receiving services from federally funded substance abuse treatment programs (i.e. §42 CFR part 2), a subset of behavioral health data.

### **Registry Tool Development**

In early 2018, HMA developed a Microsoft Excel-based patient registry for use as part of the BHI project, based on a similar patient registry developed for the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington. The goal with this registry was to deploy a low-cost, effective tool that would align with the overall goals of the BHI project to help primary care and behavioral health providers in Delaware record, track, and monitor care. The registry tool was created

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<sup>4</sup> Appendix F: Behavioral Health Integration Data Workgroup Use Cases Report

along with an extensive instruction manual to support users in understanding how specific fields are related to one another, and to assist in adoption and use.

To support the use of the registry and its integration into practice patterns, HMA demonstrated the registry through several learning sessions during both cohort periods. In addition, HMA practice coaches encouraged individual practices to adopt use of the registry. Each practice received an adjusted registry to better suit their needs. A generic and 'blank' copy of the registry (as well as a full instruction manual) will be transferred to the State of Delaware and will be available for download as needed by participating practices.

### **Delaware Center for Health Innovation Payment Workgroup**

HMA participated in the Delaware Center for Health Innovation (DCHI) Payment Workgroup meetings to address financing options to sustain BHI. The meetings focused on the promise and limitations of integration of behavioral health into primary care and bi-directional integration (primary care into behavioral health). Participants represented both providers and payers and each meeting included a discussion on the CoCM as an overarching structure that could streamline current billing processes. From August to December 2018, the Workgroup met four times and HMA provided support to:

- Present an overview of BHI pilot program progress and the evidence base for integrated care, with an emphasis on the CoCM.<sup>5</sup>
- Work with payers to gather all BHI CPT codes, determine current reimbursement practices, and identify opportunities for improvement.
- Research and inform participants of current state and large payer initiatives supporting reimbursement for CoCM to provide guidance and recommendations for implementation in Delaware.
- Examine and resolve concerns around denials and payment delays for bi-directional sites.

At the end of the first meeting, the Workgroup agreed to begin a process of listing all the potential codes that could be used for BHI, and then determine, by payer, who is currently reimbursing them, who is not, and what opportunities exist for change. The information provided by the payers was collated into a grid and distributed for discussion and refinement at subsequent meetings. The Workgroup agreed that integrated care is important in Delaware and demonstrated the desire to find solutions. Nationally, many commercial payers reimburse for these codes. Options need further exploration to enhance and support integration efforts, including payers allowing the chronic care management codes to be billed in behavioral health settings or applying for a SPA for health homes. This was not fully examined during this time due to the focus on primary care but bi-directional BHI represents a significant value opportunity for payers as the population with serious mental illnesses and substance use disorders cost the overall health care system two to three times more than a member without SMI/SUD (Milliman Report 2018 data shared with group). Additional financial support for management of this SMI population, which typically has two or more chronic physical health conditions, is to allow the chronic care and transitional care management (CCM – 99490, TCM 99495) to be billed in the

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<sup>5</sup> Appendix G: Financing for Behavioral Health Integration

behavioral health location as they are currently in the primary care location for a similar purpose. This presents a potential parity issue for the payers also.

HMA met with Delaware Medicaid in October 2018 to take a deeper dive into considerations to initiate reimbursement for the CoCM CPT codes. The group addressed concerns about monitoring adherence, adapting the financial model to fit Delaware's needs, and potential regulatory requirements. HMA provided research and reference documents from other states, including attestation forms, frequency asked questions, and Medicaid guidance for providers. The HMA team promoted the significant workforce training and practice transformation to support integration models during the BHI pilot period and encouraged the State to take advantage of the current environment.

## **Practice Transformation Progress**

Practice transformation progress (i.e., Behavior and Results under the Kirkpatrick Model) were evaluated by a comparative analysis of the practice readiness assessments conducted at baseline and post-technical assistance, the coaching goal summary reports prepared by practice coaches, a survey conducted of practices, and were further informed by a series of facilitated discussions the evaluation team held with practice coaches.

## **Readiness Assessment Process**

Initial and post-technical assistance readiness assessments were conducted utilizing a Practice Readiness Assessment Tool developed by HMA and tailored for practice type (i.e., behavioral health or primary care).<sup>6</sup> The tools focused on assessing current behavioral health/primary care integration levels, readiness for further integration, and allowed for the tracking of progress over time. Practice Coaches conducted initial assessments during onsite visits with Cohort 1 practices in January–March 2018, and Cohort 2 practices in July–August 2018. The primary focus of the visit was to meet with key leaders in each of the practices and review the assessment questions. During the visit, HMA practice coaches responded to questions about the overall BHI Pilot, set expectations for coaching calls/visits, and exchanged background information and experience with their assigned practice teams. The site visits also served to begin a working relationship between the HMA coaches and the practice team, allowing for a walk-through of the site, and discussion on gaps and goals. HMA practice coaches asked respondents to evaluate their current integration, selecting options within the tool that most closely aligned with the practice's current processes related to primary care-behavioral health integration.<sup>7</sup> As necessary, practice coaches gathered additional baseline information at subsequent coaching sessions. Upon completion of the initial Practice Readiness Assessment, coaches used the results for discussion with each practice to facilitate identification of practice goals, an action plan, and priority areas for technical assistance.

Post-technical assistance Practice Readiness Assessments were completed at two time points: in July 2018 at the conclusion of the six-month technical assistance period for Cohort 1 practices, and in December 2018 at the conclusion of the second six-month technical assistance period for Cohort 1 and 2

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<sup>6</sup> See Appendices B and C: Primary Care and Behavioral Health Practice Readiness Assessment Tools.

<sup>7</sup> While the general categories of assessment were the same for behavioral health and primary care practices, specific questions differed and were targeted to practice type.

practices. The two post-assessments completed for Cohort 1 practices (i.e., after 6 months and after 12 months) allowed for a mid-point assessment of the project and feedback to inform the second six months of technical assistance, as well as allowed for a consistent point of comparison across both cohorts of practices (i.e., allows for comparison of results of both cohorts after just six months of technical assistance). For the post assessment, HMA practice coaches consulted with the sites and utilized their own knowledge and familiarity with sites to re-score the assessment tool based on any progress that had been made during the technical assistance period.

The key areas of primary care-behavioral health integration that the tools assessed included:

1. **Practice and Organizational Leadership:** assesses leadership's understanding of, commitment to, and involvement in practice transformation.
2. **Practice Team Commitment:** assesses the practice team's awareness of and commitment to practice transformation, and confidence implementing and sustaining change.
3. **Practice Functions:** assesses other practice functions, such as trainings, EHR sophistication, and quality improvement experience, that could impact how readily the practice could proceed with PC/BH integration.
4. **Level of Integration:** assesses the practice's current level of PC/BH integration in comparison to its chosen track.
5. **Screening:** assesses the frequency, intensity and standardization of screening (BH screening in primary care practices, and primary care/physical health care screening in BH practices).
6. **Treatment:** assesses the frequency, intensity and standardization of treatment (treatment of BH conditions in primary care practices, and primary care/physical health care treatment in BH practices).

Each response was scored according to a built-in and pre-developed algorithm and contributed to a total score for each area of assessment. These aggregated scores aligned with four potential levels of readiness.

1. **Complete Transformation Need:** The practice had not achieved any points in this area (i.e., the systems and processes are not in place) and full transformation would be needed to achieve the practice's chosen track.
2. **High Transformation Need:** A high level of transformation needed for this area. Systems and processes are needed.
3. **Medium:** A moderate work level of transformation needed for this area. The practice has some processes in place, but more work is needed.
4. **Low:** Minimal level of transformation needed for this area.

## Readiness Assessment Results<sup>8</sup>

A comparison of the initial and post-technical assistance assessment scores (see Figure 3 on page 18 and Table 2 on page 19)<sup>9</sup> demonstrates that practices made substantial progress over the technical assistance period. Practices have made advancements in every area assessed (i.e., Practice and Organizational Leadership, Practice Team Commitment, Practice Functions, Level of Integration, Screening and Treatment), with some variability between primary care and behavioral health practices. Despite these significant successes, practices still have transformation needs to achieve the level of integration of their chosen track. Overall, the majority of sites (77 percent) demonstrate a medium level of continuing transformation need, compared to over two-thirds of sites (69 percent) who had a high or complete transformation need at the start of the pilot. Most sites have low need for further transformation in terms of their practice and organizational leadership's understanding of primary care/behavioral health integration (91 percent) and practice team commitment (68 percent).

Substantial improvements were shown in regard to screening processes, where 45 percent of practices had a high/complete initial transformation need, to only 14 percent of practices having a high need after the pilot period; and treatment processes, where 82 percent of practices had a high/complete initial transformation need, to only 41 percent of practices having a high need after the pilot period. Slower, but still notable, progress was made in the two other assessment areas—practice functions and integration level—where sites went from 59 to 41 percent and 95 percent to 73 percent high/complete transformation need, respectively.

### *Comparing Cohorts*

Practices engaged as part of Cohort 2 had lower levels of initial practice team commitment, which is perhaps reflective of the pilot design—practices willing to engage initially (i.e., the “early adopters”) had already bought into the behavioral health integration, while perhaps Cohort 2 practices joined only after hearing successes from the first cohort. These differences may be partially equalized after the pilot, however—while both cohorts demonstrated substantial improvements in team commitment, these improvements were most substantial for Cohort 2 practices. In other areas, Cohort 2 practices tended to advance slightly slower than Cohort 1 practices—regardless of whether comparing to Cohort 1 after six months or twelve months, though the same patterns of improvement were noted (i.e., greatest improvements in team commitment, screening and treatment).

### *Comparing Primary Care and Behavioral Health Practices*

Some similarities and differences are also evident in comparing primary care and behavioral health practices. In Cohort 1, primary care practices transformed more in practice functions that could impact how readily the practice could proceed with PC/BH integration compared to behavioral health practices (the same trend was not seen in Cohort 2 practices). In both cohorts, primary care practices had less transformation needs in regard to screening processes compared to behavioral health practices, which may have been anticipated given that the field of primary care has a long history and experience with

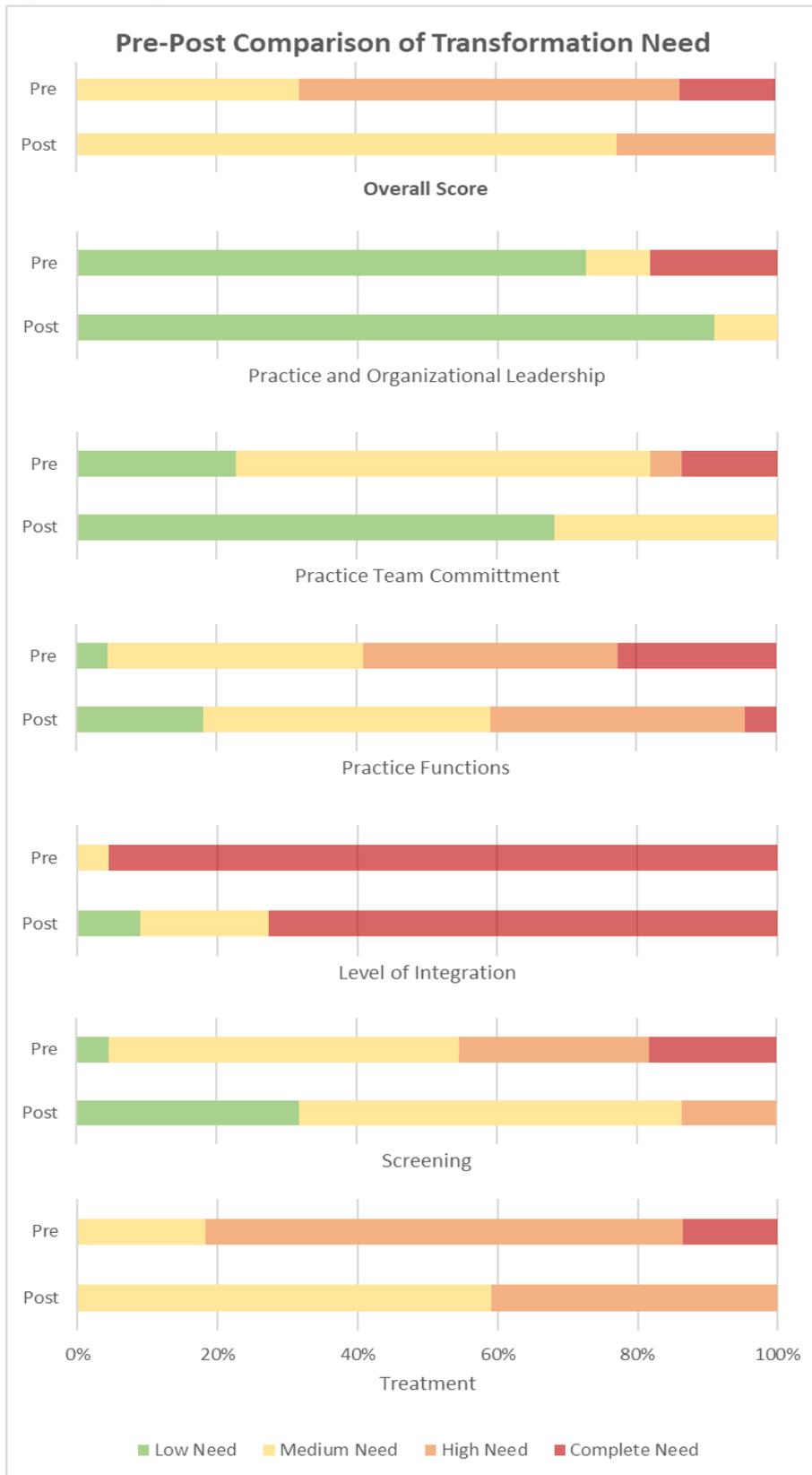
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<sup>8</sup> With only 22 practices included in the two cohorts, data points are not statistically significant and are for descriptive purposes only. Due to the small sample sizes, results were not analyzed by individual question and data analyses focused on summary scores only.

<sup>9</sup> Full results broken down by practice type, cohort and assessment period are provided in Appendix D.

measurement based standardized screening. Cohort 1 primary care practices advanced further in screening processes compared to their behavioral health counterparts, though in Cohort 2, behavioral health practices appeared to make more progress in screening. The trends noted in terms of screening transformation needs were similar for treatment transformation needs for both cohorts and practice types, though with lesser magnitude.

**Figure 3: Comparisons of Transformation Need, Pre to Post Technical Assistance**



**Table 2: Pre-Post Scoring Summaries for Delaware Behavioral Health Integration Pilot Sites**

		Primary Care				Behavioral Health				Total			
		Pre		Post		Pre		Post		Pre		Post	
Transformation Need		N	%	N	%	N	%	N	%	N	%	N	%
<b>Overall Score</b>													
	Low	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
	Medium	4	36%	8	73%	3	27%	9	82%	7	32%	17	77%
	High	6	55%	3	27%	6	55%	2	18%	12	55%	5	23%
	Complete	1	9%	0	0%	2	18%	0	0%	3	14%	0	0%
<b>Practice and Organizational Leadership</b>													
	Low	7	64%	9	82%	9	82%	11	100%	16	73%	20	91%
	Medium	2	18%	2	18%	0	0%	0	0%	2	9%	2	9%
	High	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
	Complete	2	18%	0	0%	2	18%	0	0%	4	18%	0	0%
<b>Practice Team Commitment</b>													
	Low	2	18%	8	73%	3	27%	7	64%	5	23%	15	68%
	Medium	7	64%	3	27%	6	55%	4	36%	13	59%	7	32%
	High	1	9%	0	0%	0	0%	0	0%	1	5%	0	0%
	Complete	1	9%	0	0%	2	18%	0	0%	3	14%	0	0%
<b>Practice Functions</b>													
	Low	1	9%	4	36%	0	0%	0	0%	1	5%	4	18%
	Medium	7	64%	6	55%	1	9%	3	27%	8	36%	9	41%
	High	2	18%	1	9%	6	55%	7	64%	8	36%	8	36%
	Complete	1	9%	0	0%	4	36%	1	9%	5	23%	1	5%
<b>Level of Integration</b>													
	Low	0	0%	1	9%	0	0%	1	9%	0	0%	2	9%
	Medium	1	9%	3	27%	0	0%	1	9%	1	5%	4	18%
	High	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
	Complete	10	91%	7	64%	11	100%	9	82%	21	95%	16	73%
<b>Screening</b>													
	Low	0	0%	5	45%	1	9%	2	18%	1	5%	7	32%
	Medium	7	64%	3	27%	4	36%	9	82%	11	50%	12	55%
	High	3	27%	3	27%	3	27%	0	0%	6	27%	3	14%
	Complete	1	9%	0	0%	3	27%	0	0%	4	18%	0	0%
<b>Treatment</b>													
	Low	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
	Medium	1	9%	5	45%	3	27%	8	73%	4	18%	13	59%
	High	9	82%	6	55%	6	55%	3	27%	15	68%	9	41%
	Complete	1	9%	0	0%	2	18%	0	0%	3	14%	0	0%

\*The pre-assessment period for Cohort 1 practices was 2/18; for Cohort 2 practices, it was 7/18. The post-assessment period for both Cohorts was 12/18.

## Practice Transformation Progress Aligning with Individualized Goals

While the examination of the overall transformation progress tracked by the standardized pre and post Readiness Assessments is informative, a full understanding of the progress made requires a closer examination of practice progress on the achievement of individualized goals. Throughout the technical assistance periods, coaching dyads worked with practices to advance their level of PC/BH integration through an assessment-informed strategic approach that considered the overall transformation needed, but also allowed for a tailored focus on areas of particular interest and need of the practice. Depending on the site, practice transformation support may have focused more heavily on screening and treatment workflow development, implementation of measurement-based care, financial modeling, or brokering partnerships, for example. The practice-specific, fluid approach to individualized technical assistance allowed coaches to meet practice needs as they evolved over time at a pace that accounted for the practice's ability engage in the transformation.

At the outset of the project, coaches and the practices identified goals for integration, and progress made relative to these individualized goals was monitored throughout the coaching process. On average, each practice set five goals specific to their own transformation needs and chosen track. The goals varied from simple one-variable tests of change to multi-variable complex changes in delivery models. Multi-variable changes required multi-faceted change processes, and though practices advanced in these areas, many could not be completed within the technical assistance timeframe. By the end of the pilot period, practices achieved 46 percent of the identified goals and made significant progress in achieving an additional 44 percent of goals. Practices that participated in both cohorts generally had more coaching sessions, were able to advance further, and added more overall BHI goals as practice transformation activities progressed.

### *Screening and Measurement-Based Care*

The adoption of screening tools and measurement-based care is fundamental to PC/BH integration and all practices had at least one goal focused on achieving these components. Much of the technical assistance provided to the practices focused on evidence-based screening processes and the incorporation of measurement-based care into treatment options. Specific practice goals and activities ranged in sophistication and included team training on core principles, review and selection of validated screening tools, implementation of screening and measurement protocols, and use of a registry to improve program measures. Analysis of the post Readiness Assessments in combination with coaching goals and technical assistance progress indicates that progress has been made in these areas, but transformation is still needed.

At the conclusion of the 12-month technical assistance period, all primary care practices had specific criteria or a routine process for behavioral health screening, using validated tools, and most (55 percent) were also using validated screening tools for substance use disorders. Fewer than half, however, had these screening tools for all age groups served by the practice (44 percent), and even less (27 percent) have a protocol with validated tool for re-assessing symptoms. Primary care practices also improved in

The practice coaches, with time, helped me see the benefit of ongoing patient measurement and enhanced referral relationships.

- Cohort 2 practice staff member

their use of using evidence-based (EVB) protocols in a few key conditions, particularly for Cohort 1 practices. In 45 percent of practices, at least some providers are now using EVB protocols for the treatment of depression (57 percent for Cohort 1 practices). Just over a third of practices were using EVB protocols for ADHD; in two of these, the entire practice has now adopted and follows standard EVB protocols across all providers. In a few practices, at least one provider has started using EVB protocols for anxiety. Use of EVB protocols for substance use disorder and serious mental illness remain low.

In contrast to primary care practices, not all behavioral health practices, though still the majority (64 percent) have specific criteria or a routine process for primary care/medical conditions screening; still, these practices have made significant advancements in this regard. In addition, a greater percentage (73 percent) were measuring at least one vital sign (i.e., BP, weight, and/or BMI). In addition, behavioral health practices have made substantial improvements in their use of tools for measurement-based care. Whereas the initial assessments indicated that the vast majority of Cohort 1 and Cohort 2 behavioral health practices were not using tools for measurement-based care (87 and 75 percent, respectively), now 73 percent use tools at least “sometimes,” including 27 percent who “usually or always” use measurement-based tools. The percentage is even greater when examining just Cohort 1 practices, where 87 percent use the tools at least “sometimes,” including 43 percent who “usually or always” use measurement-based tools.

The recognition for continued advancement in the area of screening tools and measurement-based care was evident in practice progress reports—all sites who had not yet achieved their goals in this area had plans to initiate them in early 2019.

#### *Partnerships to support integration*

Another key goal of all practices was to build partnerships with other providers. Delaware is a relatively small State; however, many of the participating practices had not partnered together for integrated care delivery. The BHI Pilot framework facilitated in-person and virtual connections resulting in initial discussions, leading to referral network development. Many of these introduction and relationship building activities occurred in conjunction with in-person Learning Collaborative events, with practices continuing to establish communication and workflow details in follow up meetings. Through these channels, 100 percent of practices were able to meet their goal of building partnerships.

The process of developing workflows associated with care compacts generated more enthusiasm for

How exciting it is to feel a part of a team so large coming together to problem solve!

- *Learning Collaborative 3 Attendee*

partnership and implementation. Relationships developed from initial discussions to established referral and tracking processes and care compacts. In addition to traditional one-to-one partnerships, the practices built a community and learned how to communicate best practices with each other using a common language, across the primary care and behavioral health divide and within. During the pilot period:

- Participating practices initiated 40 new relationships with other practices in the State of Delaware. Of those 40 relationships, 35 were with other practices participating in the BHI pilot program.

- Twelve relationships resulted in established referral and tracking processes between sites.
- Four relationships were solidified as care compacts and three evolved into a contract for staff time and/or designated service delivery.

### *Staffing structure and supports*

Successful participation in the BHI Pilot Program required practices to commit to making organizational changes to integrate care. Staff roles need to change or adapt to manage individuals presenting with behavioral health needs in addition to, or instead of, physical health needs. Augmenting the role of medical assistants or nurses in primary care practices requires training and new skill sets. Some primary care practices added behavioral health care managers to support more complex individuals. In behavioral health practices, clinicians need to think holistically about the clients they serve and include services outside of the traditional therapy services and may consider hiring a nurse to manage the physical and preventive care needs of their clients. Eighty-two (82) percent of primary care practices and 55 percent of behavioral health practices completed staffing enhancements, including hiring a new care manager or psychiatric consultant, adjusting the team structure to support co-location, and/or conducting trainings on brief interventions.

### *Practice Goals Beyond the Pilot Period*

While practices accomplished many of their set goals, continuing transformation to achieve the remainder of project goals as well as to establish more goals to drive program improvement is needed. For example, some practices proposed comprehensive systemwide changes to their service delivery model, which take longer than six or twelve months to complete. Also, a select group of practices continue to work on strategies to improve payment tied to integrated care delivery, including collaboration with payers to support incentives, payment for care coordination, and the development of a sustainable payment structure to support collaborative care.

## **Considerations for the Sustainability of Behavioral Health Integration**

The evaluative components of the BHI project form a comprehensive assessment of challenges, successes, and lessons learned, and inform some key considerations for the State in providing the support needed to sustain ongoing BHI transformation and spread in Delaware. Partnership development, establishing measurement-based care, building organizational capacity, and supporting financial viability are critical components of BHI that would benefit from ongoing state-level support and prioritization. In addition, considerations in these critical areas, taken more broadly, also hold important take-aways for other statewide integration efforts, and could be applied as relevant within those contexts (e.g., in efforts to integrate SUD treatment into primary care related to opioid use).

## **Develop Partnerships to Support Integration**

One of the most remarkable outcomes from the BHI Pilot programs were the number of relationships developed between participating practices. Often practices operating in close proximity had not previously connected and where unsure how to approach another practice, in some cases unsure of how to have that conversation, and with whom they would need to speak in the other practice. Having a cohort of peers who were similarly interested in integration and receptive to engagement, the assistance of coaches to refine the conversations and points that would need to be discussed, along with

an actual physical in-person forum for connection allowed practices to connect in meaningful ways. In New Castle County, where 77 percent of participating practices were located, the opportunity to connect and engage with others was particularly useful. In contrast, the sole participating provider (behavioral health) from Sussex County reported challenges finding primary care partners with whom to collaborate, suggesting a need for engaging a more geographically diverse group of practices to ensure statewide sustainability. To improve partnership connection, this practice established a discussion group for DE behavioral health agencies to discuss management and legislative issues, which provided a forum for connection and laid the groundwork for closer partnerships in the future.

In addition to establishing partnerships with other participating practices, some practices attempted connections with non-participating practices. These outside engagement attempts had mixed results—in some cases, a lack of common language made a collaboration more difficult, while other practices were able to successfully establish referral workflows and care compacts with some larger hospital groups.

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### Considerations for Sustainability

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Giving providers opportunities to engage with other providers interested in integrated care and a platform for communication provides the foundation for forming the partnerships needed to establish integrated care. The DHCC should consider ways to support ongoing partnership and communication through the proposed action items:

- Hold forums to talk about challenges of holistically addressing primary and behavioral health care and provide time to network.
- Gather and disseminate statewide information to facilitate referrals and provider connections by surveying practices to gather more complete information about services provided, populations served, and group affiliations.
- Optimize the health information exchange as an avenue to support better exchange of information among practices.

### Embrace Measurement-Based Care

All participating practices implemented or improved measurement-based care processes to support primary and behavioral health care integration. For some practices, measurement-based care was a new concept and required a cultural change within the organization; for practices already using concepts of measurement-based care, it was an extension of processes already in place. For example, growth charts, developmental screening tools and immunization registries are standard processes ingrained in pediatric care; the addition of behavioral health-focused screening tools and registries to track improvements and referral resources for their patients with depression did not require a systematic shift in the way care was provided. For behavioral health practices that were not routinely conducting standardized screenings or previously utilizing these types tools, the incorporation of measurement-based care was a significant shift in care delivery that required all new workflows and training.

To advance the use of registries, HMA developed a Microsoft Excel-based patient registry tailored for use as part of the BHI project, along with technical assistance and supports to assist in adoption and use. This registry was deployed in several practices. Many practices used this tool to track needed screenings, trigger timely follow-ups and care management activities, and, ultimately, patient/client progress towards improved outcomes. One primary care practice had registries for various disease types and leveraged that familiarity and comfort to add a registry for behavioral health patients. The adoption of

registries proved more difficult for other adult practices, that encountered resistance from primary care providers concerned over workflows and lack of referral opportunities. These providers expressed concern about identifying patients with high PHQ-9 scores without sufficient resources in place to address the need for care in advance. Primary care practices needed to first build the referral partner list; once treatment options were established, providers were more comfortable implementing universal screening and improvement tracking. Behavioral health provider practices, perhaps having less concern that community resources were insufficient to address primary care, did not encounter the same provider resistance. Two behavioral health providers made a concerted effort to push universal screening and tracking by developing a clear value proposition for team members and leadership.

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### Considerations for Sustainability

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Measurement-based screening tools and treatment protocols are crucial to effectively treat mild to moderate mental health conditions, and standardized implementation of these processes are necessary for primary and behavioral health care integration and providing care across settings. Implementation of measurement-based care is complex—it requires the staff knowledge, training, data systems, workflows, and organizational capacity to incorporate it into the provider practice. The DHCC should consider ways to:

- Meet with the BHI pilot practices who have effectively implemented measurement-based care to learn how it informs treatment and can align with quality and incentive payments.
- Support registry development and maintenance at the practice and statewide level.
- Optimize the health information exchange as an avenue to support better exchange of information among practices.
- Encourage and possibly require measurement-based care across systems through pay for performance or value-based payment models.

### Build Organizational Capacity to Perform Integrated Care

Systems change requires a team effort and leadership is key—without comprehensive top-down and bottom-up buy-in, a practice cannot implement and effectively sustain the myriad of change processes needed to effectively integrate care. Regardless of size or location, the practices that actively invested more time and resources in the coaching and learning process and valued each team member from front desk staff to the executive director made the most progress in accomplishing goals. Practices that lacked the leadership buy-in or had inconsistent team member involvement in the technical assistance and transformation made less progress toward individualized goals and care integration; this issue was exacerbated in practices with frequent staff turnover. Transformation requires attention and prioritization; practices unable to allocate staff time toward participation in technical assistance were correspondingly unable to allocate staff time toward the implementation of change. Strong team leadership is needed to ensure that staff know the importance of transformation and that their time should be allocated accordingly—team members need the authority and empowerment to conduct and implement the change.

As participating practices recognized the importance of involving the full team in transformation efforts, many adjusted their planning and implementation teams during the pilot period. One primary care practice started with a single staff member responsible for integration transformation, making timely action difficult. As the team evolved to include additional representation from multiple levels and disciplines, support of change activities and team enthusiasm significantly improved. A particularly

successful primary care practice had full leadership involvement from the outset, including consistent involvement of the Medical Director. Frequently practice teams did not realize how effective they could be until they had the right people at the table, and the engagement of additional team members in the technical assistance corresponded to greater transformation progress. Engaged teams blunted the impact of staff turnover (i.e., transformation was not resting of the efforts of a single staff member), and practices that anticipated staff turnover and responded by developing reference resources and/or engaged in more technical assistance touches to get new staff members up to speed and engaged were less impacted by staffing changes.

The BHI pilot included practices of varying size, and many smaller practices reported that they lacked the resources and staff to effectively integrate care. Yet it was adaptive teams and leadership, more so than practice size, that provided the foundation to support effective referral partnerships and measurement-based care. Smaller practices benefited from less organizational structure that can impede swift change and were able to take timely actions with less change management. With effective leadership and team involvement, even small practices were able to effectively initiate transformation.

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### Considerations for Sustainability

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The key feature in the practices that were most successful were those with positive adaptive change traits, including a willingness to learn, grow and apply in those areas as well as time and resources to support changes associated with integration of care. The DHCC should contemplate the following action items to support infrastructure and organizational capacity:

- Acknowledge the organizational resources entailed with building and maintaining incentive and payment, quality improvement, and HIT structures and prioritize a phased approach to change.
- Tune in to the experts, such as practice group of advisors, doing the work and getting input around what is feasible and what would be effective in moving integration forward and sustaining it.

### Develop Methods to Support Financial Viability

Building the components of an integrated care model—the development of partnerships, the implementation of new processes and workflows, and the efforts to engage teams and manage change—require the investment of resources. Practices need to devote the resources needed alongside of current business processes and financials that support those processes. Current payment models do not support the upfront investments needed to take on new initiatives, and short-term grant funding is often the most tangible option to support the development of pilot programs. Long-term sustainability and spread, however, requires a sustainable financial underpinning, and the implementation of payment models helps ensure practices' ability to transformation and the pace of transformation.

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### Considerations for Sustainability

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Payment models that support integrated care may be needed to encourage statewide implementation and sustainability beyond the pilot period, both for practices that participated in the BHI pilot as well as other practices within the State. Current payment mechanisms in Delaware do not support the upfront investment needed to develop the components of integrated care, or reward providers for the outcomes that can be achieved in an integrated care environment. In 2017, CMS established CPT codes

within its Medicare Fee Schedule specifically for use in collaborative care and allows primary care providers to bill for services provided by psychiatrists under the collaborative care model. State Medicaid programs have begun to adopt these reimbursement codes (e.g., North Carolina and Washington), but to date, Delaware Medicaid has not adopted these codes and providers are unable to use them to bill for services. To invest in the widespread adoption and spread of integrated care, the DHCC should examine methods to:

- Adopt CPT codes that recognize the importance of managing populations of patients within a primary care practice including codes for the collaborative care model, chronic condition codes, and HABI.
- Encourage alignment of quality measures across payers, including Medicaid MCOs as well as other payers in the State, as part of value-based payment reform activities.

## Conclusion

The BHI pilot practices have made substantial progress over the past 12 months, both in measures of objective transformation assessment as well as in the pursuit of their individually established goals, but still need further transformation to achieve the level of integration for their chosen track. Many sites have confirmed an interest and commitment to continue this transformation beyond the pilot project.

Much of the technical assistance provided to the practices focused on change management, evidence-based screening processes, incorporating measurement-based care, and treatment offered. Practices have made significant strides in incorporating these features into their practice workflows, and are steadily advancing from no providers, or few providers, using these to broader use across their providers. In addition, partnership building among practices has really taken a foothold, with practices continuing to establish communication and workflow details, referral relationships and care compacts.

Commitment to ongoing primary care and behavioral health integration remains strong, a solid foundation for its continued growth among BHI pilot practices is evident. However, ongoing state-level support will be needed to ensure sustainability and statewide spread. Support for partnerships, measurement-based care adoption, and building organizational capacity to perform integrated care are key areas in which Delaware can impact practices' ability to integrate care and underpinning all of these efforts is the financial support to pursue this transformation. The lack of payment remains a significant barrier impacting practices' ability to transform (and the speed at which they transform), and financial reimbursement will be a critical factor in determining feasibility of long-term sustainability and spread.

## Appendix A: Behavioral Health Integration Pilot Practices

Site	Location	Organization Type	Predominant Specialty	Track
ABC Pediatrics	Dover	Private Practice	Pediatrics	Track 3: CoCM
Brandywine Counseling & Community	Wilmington	CBHO; SUD	BH; SUD	Track 2: Co-location
Connections Community Support Programs	Wilmington	CBHO; SUD	BH; SUD	Track 2: Co-location
Delaware Guidance Services for Children & Youth, Inc.	Lewes	CBHO	Behavioral Health	Track 2: Co-location
Delaware Pediatrics	Townsend	Private Practice	Family Medicine	Track 1: Referral
Family Practice Associates	Wilmington	Private Practice	Family Medicine	Track 2: Co-location
Henrietta Johnson Medical Center	Wilmington	FQHC	Multi-specialty	Track 2: Co-location
Just Kids Pediatrics	Newark	Private Practice	Pediatrics	Track 2: Co-location
Mid-Atlantic Behavioral Health	Newark	Private Practice	Behavioral Health	Track 3: CoCM
New Behavioral Network	Dover	CBHO	Behavioral Health	Track 1: Referral
PACE, Inc.	Wilmington	SUD	SUD	Track 1: Referral
Psychiatric Access for Central DE, P.A.	Dover	Private Practice	Behavioral Health	Track 1: Referral
St. Francis Hospital	Wilmington	Hospital Owned Clinic	Family Medicine	Track 3: CoCM
Westside Family Healthcare	Wilmington	CHC	Family Medicine	Track 3: CoCM
Advanced Treatment Options	Wilmington	Private Practice	BH	Track 1: Referral
Associates in Health Psychology	Wilmington	Private Practice	BH	Track 1: Referral
Bear Internal Medicine and Pediatrics	Newark	Private Practice	Peds; IM	Track 1: Referral
Brandywine Pediatrics	Wilmington	Private Practice	Pediatrics	Track 3: CoCM
Jewish Family Services	Newark	CBHO	BH; Prevention	Track 1: Referral
Nurse Managed Primary Care	Newark	Private Practice	Family Medicine	Track 3: CoCM
People's Place	Milford	CBHO	BH	Track 1: Referral
UM ACO United Medical Clinic*	Bear	Private Practice	FM; IM	Track 3: CoCM

\*The United Medical ACO included three distinct private practices: United Medical Clinic, Medical Associates of Bear, and Irene Szeto, MD, who functioned as a single practice for the purposes of this pilot project in terms of the technical assistance received. As such, it is included as a single practice in this analysis

## **Appendix B: Primary Care Readiness Assessment Tool**

(See attached Excel file)

# Appendix C: Behavioral Health Readiness Assessment Tool

(See attached Excel file)

## Appendix D: Pre-Post Scoring Summaries for Delaware Behavioral Health Integration Pilot Sites

**Cohort 1: Pre, Mid and Post Scoring Summaries for Delaware Behavioral Health Integration Pilot Sites**

	Primary Care Cohort 1						Behavioral Health Cohort 1						Total Cohort 1						
	Pre (2/18)		Mid (7/18)		Post (12/18)		Pre (2/18)		Mid (7/18)		Post (12/18)		Pre (2/18)		Mid (7/18)		Post (12/18)		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
<b>Overall Score</b>																			
Low Transformation Need	0	0%	0	0%	0	0%	0	0%	0	0%	1	14%	0	0%	0	0%	1	7%	
Medium Transformation Need	2	29%	6	86%	6	86%	3	43%	7	100%	6	86%	5	36%	13	93%	12	86%	
High Transformation Need	5	71%	1	14%	1	14%	4	57%	0	0%	0	0%	9	64%	1	7%	1	7%	
Complete Transformation Need	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
<b>Practice and Organizational Leadership</b>																			
Low Transformation Need	5	71%	6	86%	6	86%	5	71%	7	100%	7	100%	10	71%	13	93%	13	93%	
Medium Transformation Need	1	14%	1	14%	1	14%	0	0%	0	0%	0	0%	1	7%	1	7%	1	7%	
High Transformation Need	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
Complete Transformation Need	1	14%	0	0%	0	0%	2	29%	0	0%	0	0%	3	21%	0	0%	0	0%	
<b>Practice Team Commitment</b>																			
Low Transformation Need	2	29%	5	71%	5	71%	3	43%	6	86%	6	86%	5	36%	11	79%	11	79%	
Medium Transformation Need	4	57%	2	29%	2	29%	4	57%	1	14%	1	14%	8	57%	3	21%	3	21%	
High Transformation Need	1	14%	0	0%	0	0%	0	0%	0	0%	0	0%	1	7%	0	0%	0	0%	
Complete Transformation Need	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	
<b>Practice Functions</b>																			
Low Transformation Need	1	14%	3	43%	4	57%	0	0%	0	0%	0	0%	1	7%	3	21%	4	29%	
Medium Transformation Need	4	57%	4	57%	3	43%	1	14%	2	29%	2	29%	5	36%	6	43%	5	36%	
High Transformation Need	2	29%	0	0%	0	0%	5	71%	5	71%	5	71%	7	50%	5	36%	5	36%	
Complete Transformation Need	0	0%	0	0%	0	0%	1	14%	0	0%	0	0%	1	7%	0	0%	0	0%	
<b>Level of Integration</b>																			
Low Transformation Need	0	0%	1	14%	1	14%	0	0%	1	14%	1	14%	0	0%	2	14%	2	14%	

	Primary Care Cohort 1						Behavioral Health Cohort 1						Total Cohort 1					
	Pre (2/18)		Mid (7/18)		Post (12/18)		Pre (2/18)		Mid (7/18)		Post (12/18)		Pre (2/18)		Mid (7/18)		Post (12/18)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Medium Transformation Need	0	0%	1	14%	1	14%	0	0%	1	14%	1	14%	0	0%	2	14%	2	14%
High Transformation Need	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Complete Transformation Need	7	100%	5	71%	5	71%	7	100%	5	71%	5	71%	14	100%	10	71%	10	71%
<b>Screening</b>																		
Low Transformation Need	0	0%	4	57%	5	71%	1	14%	1	14%	2	29%	1	7%	5	36%	7	50%
Medium Transformation Need	5	71%	2	29%	1	14%	2	29%	6	86%	5	71%	7	50%	8	57%	6	43%
High Transformation Need	2	29%	1	14%	1	14%	3	43%	0	0%	0	0%	5	36%	1	7%	1	7%
Complete Transformation Need	0	0%	0	0%	0	0%	1	14%	0	0%	0	0%	1	7%	0	0%	0	0%
<b>Treatment</b>																		
Low Transformation Need	0	0%	0	0%	0	0%	0	0%	0	0%	2	29%	0	0%	0	0%	2	14%
Medium Transformation Need	0	0%	4	57%	4	57%	3	43%	6	86%	5	71%	3	21%	10	71%	9	64%
High Transformation Need	7	100%	3	43%	3	43%	4	57%	1	14%	0	0%	11	79%	4	29%	3	21%
Complete Transformation Need	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%

**Cohort 2: Pre-Post Scoring Summaries for Delaware Behavioral Health Integration Pilot Sites**

	Primary Care Cohort 2				Behavioral Health Cohort 2				Total Cohort 2			
	Pre (7/18)		Post (12/18)		Pre (7/18)		Post (12/18)		Pre (7/18)		Post (12/18)	
	N	%	N	%	N	%	N	%	N	%	N	%
<b>Overall Score</b>												
Low Transformation Need	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Medium Transformation Need	2	50%	2	50%	0	0%	2	50%	2	25%	4	50%
High Transformation Need	1	25%	2	50%	2	50%	2	50%	3	38%	4	50%
Complete Transformation Need	1	25%	0	0%	2	50%	0	0%	3	38%	0	0%
<b>Practice and Organizational Leadership</b>												
Low Transformation Need	2	50%	3	75%	4	100%	4	100%	6	75%	7	88%
Medium Transformation Need	1	25%	1	25%	0	0%	0	0%	1	13%	1	13%
High Transformation Need	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Complete Transformation Need	1	25%	0	0%	0	0%	0	0%	1	13%	0	0%
<b>Practice Team Commitment</b>												
Low Transformation Need	0	0%	3	75%	0	0%	1	25%	0	0%	4	50%
Medium Transformation Need	3	75%	1	25%	2	50%	3	75%	5	63%	4	50%
High Transformation Need	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Complete Transformation Need	1	25%	0	0%	2	50%	0	0%	3	38%	0	0%
<b>Practice Functions</b>												
Low Transformation Need	0	0%	1	25%	0	0%	0	0%	0	0%	1	13%
Medium Transformation Need	3	75%	2	50%	0	0%	1	25%	3	38%	3	38%
High Transformation Need	0	0%	1	25%	1	25%	2	50%	1	13%	3	38%
Complete Transformation Need	1	25%	0	0%	3	75%	1	25%	4	50%	1	13%
<b>Level of Integration</b>												
Low Transformation Need	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Medium Transformation Need	1	25%	2	50%	0	0%	0	0%	1	13%	2	25%
High Transformation Need	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Complete Transformation Need	3	75%	2	50%	4	100%	4	100%	7	88%	6	75%

	Primary Care Cohort 2				Behavioral Health Cohort 2				Total Cohort 2			
	Pre (7/18)		Post (12/18)		Pre (7/18)		Post (12/18)		Pre (7/18)		Post (12/18)	
	N	%	N	%	N	%	N	%	N	%	N	%
<b>Screening</b>												
Low Transformation Need	0	0%	1	25%	0	0%	1	25%	0	0%	2	25%
Medium Transformation Need	2	50%	1	25%	2	50%	3	75%	4	50%	4	50%
High Transformation Need	1	25%	2	50%	0	0%	0	0%	1	13%	2	25%
Complete Transformation Need	1	25%	0	0%	2	50%	0	0%	3	38%	0	0%
<b>Treatment</b>												
Low Transformation Need	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Medium Transformation Need	1	25%	1	25%	0	0%	2	50%	1	13%	3	38%
High Transformation Need	2	50%	3	75%	2	50%	2	50%	4	50%	5	63%
Complete Transformation Need	1	25%	0	0%	2	50%	0	0%	3	38%	0	0%

## Appendix E: Summary of Behavioral Health Integration Pilot Period Learning Sessions

### RESULTS BY LEARNING SESSION: COHORT 1

#### *Learning Collaborative 1 - February 22, 2018*

The Kickoff Learning Collaborative provided an overview of the Behavioral Health Integration Pilot Program and expectations for practice participation, a presentation on leadership through change, and breakout sessions on foundational components for the three pilot tracks – the Collaborative Care Model, Co-Location, and Enhanced Referral for both behavioral health practices integrating primary care and primary care practices integrating behavioral health services. HMA held the full-day session at Dover Downs, with 56 participants in attendance, eligible for 6.5 CME/CEU credits. Participants reported positive feedback, with individual session ratings ranging from 4.68 to 4.92 on a scale of 1 representing poor to 5 representing excellent. Qualitative results indicated participants found the Collaborative informative and comprehensive and appreciated the opportunity to meet and establish relationships with other primary care and behavioral health providers in the state. Suggestions for future trainings include more time for participant networking and sharing. Overall summary of results:

<b>Learning Collaborative 1 - February 22, 2018 (CME)</b>	
Number of Delaware participants	56
Number of completed evaluations	49
Percent completed evaluations	88%
Practices represented	14
Session Met Objectives	100%
Overall Rating Average for all Sessions	4.8
Content was Just Right	92%

#### *Webinar 1: Financing Options for Behavioral Health Integration – March 22, 2018*

The first webinar for practice participating in Cohort 1 was presented by Dr. Lori Raney, HMA Principal and leading authority on the collaborative care model and the bidirectional integration of primary care and behavioral health. The learning objectives were to understand how to support BHI in a fee-for-service system; describe the use of new collaborative care codes to financially support integrated care; create a shift in thinking and models to support integration in a value-based payment structure; and develop a plan for financial sustainability within the pilot practices. Participants rated the value of the topic 4.27 and the quality of the presentation 4.64, each on a scale of 1 representing poor to 5 representing excellent. Qualitative input reflected that participants plan to use the information to evaluate current staffing models and fee schedules. Overall summary of results:

<b>Webinar 1 - Financing Options - March 22, 2018</b>	
Number of Delaware participants	30
Number of completed evaluations	12
Percent completed evaluations	40%
Practices represented	6
Session Met Objectives	100%
Quality of Presentation (organized content, knowledgeable instructor)	4.64
Overall Rating	4.55
Content was Just Right	80%

### *Learning Collaborative 2 – April 19, 2018*

The second Learning Collaborative meeting opened with practice teams sharing progress since the first learning collaborative meeting before breaking out into two tracks for the remainder of the day. The first track presented practice workflows to support the Collaborative Care Model and the role of behavioral health providers in primary care. Track two participants learned about and shared best practices for co-location and enhanced referrals and gained skills to develop measurement-based care tools, registries, and workflows. The participants were almost equally split between tracks, with 17 in Track 1 and 21 in Track 2. The overall average rating for all sessions was 4.45, on a scale of 1 as poor and 5 as excellent. When broken out by track, the two Collaborative Care Model (CoCM) track sessions averaged 4.85 and the four co-location and enhanced referral track sessions averaged 4.21, each out of 5. The highest rated session was “Practice Workflows to Support CoCM” at 4.88. Qualitative input demonstrated an appreciation of time for networking, time to work as teams, and learning about registries and measurement-based care tools.

<b>Learning Collaborative 2 - April 19, 2018 (CME)</b>	
Number of Delaware participants	41
Number of completed evaluations	38
Percent completed evaluations	93%
Practices represented	13
Session Met Objectives	100%
Quality of Presentation (organized content, knowledgeable instructor)	4.65
Overall Rating Average for all Sessions	4.45
Content was Just Right	97%

### *Webinar 2: Update on Psychotropic Prescribing – May 15, 2018*

The second webinar for practices participating in Cohort 1 was presented by Dr. Lori Raney, HMA Principal and board-certified psychiatrist. She is a distinguished fellow with the American Psychiatric Association and received the organization’s presidential commendation in 2015. The learning objectives were to understand the major classes of psychotropic medications; describe the process of measurement-based treatment to target care through use of appropriate medication strengths; and list

the common side effects of commonly used medications. Participants rated both the value of the topic and the quality of the presentation 4.77, each on a scale of 1 representing poor to 5 representing excellent. Qualitative input reflected that participants plan to use the information to better understand side effects and measurement goals, and to educate others within the practice. One participant reported greater comfort with maximizing medication dosages as a result of the webinar. Overall summary of results:

<b>Webinar 2 - Psychotropic Med - May 15, 2018 (CME)</b>	
Number of Delaware participants	24
Number of completed evaluations	13
Percent completed evaluations	54%
Practices represented	7
Session Met Objectives	100%
Quality of Presentation (organized content, knowledgeable instructor)	4.77
Overall Rating	4.69
Content was Just Right	92%

### *Webinar 3: Understanding and Using Population-based Registries – May 29, 2018*

The third webinar for practices participating in Cohort 1 was presented by Nancy Jaeckels-Kamp, HMA Principal and Registered Nurse, and David Bergman, HMA Principal. The learning objectives were to understand the basics of population health management and how the concept drives a team base care approach; learn how a standard registry can be used to guide focused care management and improve outcomes through measurement-based care; and view a demonstration of a BHI registry model that practice coaches could help their own team implement. Participants rated both the value of the topic and the quality of the presentation 3.83, each on a scale of 1 representing poor to 5 representing excellent. Qualitative input reflected that participants plan to use the information to utilize a population health registry in their practice. Overall summary of results:

<b>Webinar 3 - Registry - May 29, 2018</b>	
Number of Delaware participants	17
Number of completed evaluations	7
Percent completed evaluations	41%
Practices represented	7
Session Met Objectives	100%
Quality of Presentation (organized content, knowledgeable instructor)	3.83
Overall Rating	4
Content was Just Right	83%

### *Regional Knowledge Sharing Opportunity (RKSO) – June 13, 2018*

Practices participating in Cohort 1 were offered a Regional Knowledge Sharing Opportunity, a facilitated forum for practices to come together and share successes, challenges and key lessons learned. The

RKSO included two panel discussions, focused on Enhanced Referrals and Measurement-Based Care, where several practices presented on their best practices followed by discussion among the participants. These panels were facilitated by Bren Manuagh, HMA Principal and LCSW, and Lori Raney, HMA Principal and board-certified psychiatrist, respectively. The RKSO also featured a “Report from Component C: Healthy Neighborhoods – Behavioral Health” presentation, and a round robin where practices described 1-2 concrete actions they would take based on their learnings of the previous 6 months. Participants rated, on average, the value of the topics a 4.68 and the quality of the presentations 4.78, each on a scale of 1 representing poor to 5 representing excellent. Qualitative input reflected that participants plan to use the information to continue making progress toward the items they had been working on. They appreciated the opportunity to connect with other practices and would have enjoyed even more time to hear each practice’s best practices. Overall summary of results:

<b>RKSO - June 13, 2018</b>	
Number of Delaware participants	28
Number of completed evaluations	23
Percent completed evaluations	82%
Practices represented	12
Quality of Presentation (Average, organized content, knowledgeable instructor)	4.78
Overall Rating	4.76
Content was Just Right	100%

#### *Practice Coach Survey – January-June 2018*

Practices participating in Cohort 1 were asked to evaluate their individual coaching sessions they received during Cohort 1. Surveys were sent to practice staff that had engaged in any of the individual coaching sessions throughout the 6-month period of Cohort 1. For sites with more than one respondent, results for the practice were aggregated in the analysis to prevent skewing toward sites with more participants. The introductory question was a rating of all the technical assistance combined (including webinars, learning collaboratives, regional knowledge sharing and individual coaching sessions), while the remaining questions focused on the individual sessions specifically.

Participants rated, on average, their satisfaction with *all* technical assistance 4.46 and their satisfaction with the overall knowledge and expertise of their practice coach(es) 4.69, each on a scale of 1 representing very dissatisfied to 5 representing very satisfied. Participants were able to describe a variety of ways in which practice coaches had helped to integrate PC/BH in their practices. Stated one respondent, “The practice coaches surprisingly knew a lot about our state and were very proactive in attempting to link the different entities together so that they could collaborate and be most effective for Delaware and the general area as a unit.” Overall summary of results:

<b>Individual Coaching Sessions - January-June 2018</b>	
Number of Delaware participants sent evaluations	23
Number of completed evaluations	13
Percent completed evaluations	57%
Practices represented	9
Satisfaction with overall quality of TA (including webinars, learning collaboratives, regional knowledge sharing and individual coaching sessions)	4.46
Satisfaction with the overall knowledge and expertise of (individual) practice coach(es)	4.69

## **RESULTS BY LEARNING SESSION: COHORT 2**

### *Learning Collaborative 1 – August 16, 2018*

The Kickoff Learning Collaborative for Cohort 2 provided an overview of the Behavioral Health Integration Pilot Program and expectations for practice participation, a presentation on leadership through change (with separate sessions for new Cohort 2 practices and returning Cohort 1 practices), and breakout sessions on foundational components for the pilot tracks – the Collaborative Care Model, and Co-Location/Enhanced Referral for both behavioral health practices integrating primary care and primary care practices integrating behavioral health services. Forty-six (46) participants attended and were eligible for 6.5 CME/CEU credits.

Feedback was, on average, positive, though more mixed than it had been during Cohort 1. These results reflected a challenge in delivering content to both returning and new practices. In general, new practices rated the sessions highly, ranging from a 4.9 to a 4.8 on a scale of 1 representing poor to 5 representing excellent, while returning practices gave slightly lower but still positive ratings, from 4.38 to 4.10. In addition, the session on the Collaborative Care Model received more positive feedback (4.88 to 4.75) than the session on Co-Location/Enhanced Referral (4.00 to 3.61). Qualitative comments indicate that returning practices would like more hands-on activities, more time to network with other practices, and more time to work through their individual practice processes. Overall summary of results:

<b>Learning Collaborative 1 - August 16, 2018 (CME)</b>	
Number of Delaware participants	46
Number of completed evaluations	41
Percent completed evaluations	89%
Practices represented	22
Overall Rating Average for all Panels	4.35
Quality of Presentation Average for Panels	4.48
Content was Just Right	74%

### *Webinar 1: Financing Options for Behavioral Health Integration – September 20, 2018*

The first webinar for practice participating in Cohort 2 was presented by Dr. Lori Raney, HMA Principal and leading authority on the collaborative care model and the bidirectional integration of primary care and behavioral health. The content was the same as for Cohort 1. The learning objectives were to understand how to support BHI in a fee-for-service system; describe the use of new collaborative care codes to financially support integrated care; create a shift in thinking and models to support integration in a value-based payment structure; and develop a plan for financial sustainability within the pilot practices. Participants rated the value of the topic and the quality of the presentation 4.67 each, on a scale of 1 representing poor to 5 representing excellent. Overall summary of results:

<b>Webinar 1 - Financing for BH - September 20, 2018 (CME)</b>	
Number of Delaware participants	19
Number of completed evaluations	6
Percent completed evaluations	32%
Practices represented	6
Session Met Objectives	100%
Quality of Presentation (organized content, knowledgeable instructor)	4.67
Overall Rating	4.67
Content was Just Right	100%

### *Learning Collaborative 2 – October 17, 2018*

The second Learning Collaborative meeting opened with an opportunity for practices to “speed network” with other sites, followed by a presentation and panel on measurement-based care, and an introduction to brief interventions and patient engagement. The collaborative then split into a series of building block sessions, allowing attendees to choose a workshop that best aligned with their practice. One building block in each of the three one-hour sessions was tailored toward the CoCM track.

Forty-six (46) of 57 attendees, representing 24 practices, completed an evaluation (81 percent completion rate). Overall, respondents rated sessions a 4.59, between “Excellent” (5) and “Good” (4), with individual session ratings ranging from 4.19 to 4.92. Results were slightly higher for new Cohort 2 respondents compared to respondents in practices that had been part of Cohort 1. Respondents indicated that they enjoyed the structure of the Learning Collaborative, appreciated the tool-based, interactive approach, the ability to network and work within their own team, and felt that it was an improvement over the August Learning Collaborative. While the lowest rated session was Speed Dating, qualitative input indicates that this was a valued and important session, but that respondents would have liked more time. In general, respondents indicated that some sessions were shorter than they would have liked to complete the activities. Respondents indicated that they will use the information obtained to continue to develop workflows and referral processes and continue collaborations and PC-BH partnerships.

<b>Learning Collaborative 2 – October 17, 2018 (CME)</b>	
Number of Delaware participants	57
Number of completed evaluations	46
Percent completed evaluations	81%
Practices represented	24
Session Met Objectives	100%
Quality of Presentation Average (organized content, knowledgeable instructor)	4.64
Overall Rating Average for all Sessions	4.59
Content was Just Right	88%

*Webinar 2: Patient Registry Overview and Demo – November 14, 2018*

The second webinar for Cohort 2 was presented by Lori Raney, HMA Principal and Psychiatrist, and David Bergman, HMA Principal. The learning objectives were to observe how a registry is built over time; to learn how a registry can be used to track and manage patients to improve outcomes; and to view a demonstration of a registry focused on behavioral health that is aligned with collaborative care billing requirements. Participants rated the quality of the presentation 5.00, on a scale of 1 representing poor to 5 representing excellent. Qualitative input reflected that participants plan use registries to manage caseloads across sites and with behavioral consultants in primary care settings. Overall summary of results:

<b>Webinar 2 - Patient Registry Overview and Demo</b>	
Number of Delaware participants	13
Number of completed evaluations	3
Percent completed evaluations	23%
Practices represented	6
Session Met Objectives	100%
Quality of Presentation (organized content, knowledgeable instructor)	5
Overall Rating	4.67
Content was Just Right	100%

*Webinar 3: Financially Sustaining Integrated Care – December 12, 2018*

The third webinar for practices participating in Cohort 2 was presented by Dr. Lori Raney, HMA Principal and leading authority on the collaborative care model and the bidirectional integration of primary care and behavioral health. The learning objectives were to understand potential traditional billing opportunities in integrated settings, articulate the key tasks necessary to bill the collaborative care codes, and describe one example of a financial modeling tool. Participants rated both the value of the topic and the quality of the presentation 4.5, each on a scale of 1 representing poor to 5 representing excellent. Qualitative input reflected that participants plan to use the information to utilize the new codes in newly established partnerships, and to provide in-service training to all staff. Overall summary of results:

<b>Webinar 3 - Registry - December 12, 2018</b>	
Number of Delaware participants	19
Number of completed evaluations	4
Percent completed evaluations	21%
Practices represented	4
Session Met Objectives	100%
Quality of Presentation (organized content, knowledgeable instructor)	4.5
Overall Rating	4.5
Content was Just Right	100%

*Webinar 4: Finding your Footing in Quicksand: How Leaders Can Navigate Rapid Change to Maintain Momentum – January 9, 2019*

The fourth and final webinar for practices participating in Cohort 2 was presented by Bren Manaugh, HMA Principal, and Dr. Barry Jacobs, HMA Principal and focused on change management and adaptive leadership to support continued integration of care and sustainability. The learning objectives were to define the ingredients of effective organizational change for BHI; delineate distinct approaches for managing adaptive change and technical changes; apply the tenets of transformational leadership for working with team resistance to change; and identify means of aligning change strategies with team members’ behaviors. Ten participants representing eight Cohort practices participated; however, none submitted an evaluation.

*Practice Coach Survey – July-December 2018*

Practices participating in Cohort 2 were asked to evaluate their individual coaching sessions they received during Cohort 2. Surveys were sent to practice staff that had engaged in any of the individual coaching sessions throughout the 6-month period of Cohort 2. For sites with more than one respondent, results for the practice were aggregated in the analysis to prevent skewing toward sites with more participants. The introductory question was a rating of all the technical assistance combined (including webinars, learning collaboratives, regional knowledge sharing and individual coaching sessions), while the remaining questions focused on the individual sessions specifically.

Participants rated, on average, their satisfaction with *all* technical assistance 4.48 and their satisfaction with the overall knowledge and expertise of their practice coach(es) 4.72, each on a scale of 1 representing very dissatisfied to 5 representing very satisfied. Participants were able to describe a variety of ways in which practice coaches had helped to integrate PC/BH in their practices, including medication management, enhanced referral relationships, and ongoing patient measurement. Stated one respondent, “Our two coaches have been amazing. They have given us new ideas for more efficient practice that is easy to understand and manageable. They are so knowledgeable and understanding of the agency limitations and challenges when it comes to integration efforts. They have made this process enjoyable.” Overall summary of results:

<b>Individual Coaching Sessions - July-December 2018</b>	
Number of Delaware participants sent evaluations	52
Number of completed evaluations	23
Percent completed evaluations	44%
Practices represented	18
Satisfaction with overall quality of TA (including webinars, learning collaboratives, regional knowledge sharing and individual coaching sessions)	4.48
Satisfaction with the overall knowledge and expertise of (individual) practice coach(es)	4.72

## Appendix F: Behavioral Health Integration Data Workgroup Use Cases Report

### INTEGRATION DATA WORKGROUP

Throughout the first half of 2018, leaders from across Delaware were convened by HMA as part of our role supporting integrated care in the State. There were two main objectives of this effort: 1) to develop a list of data elements that participants wanted to exchange to support more effectively integrated care between primary care and behavioral health providers; and 2) to identify barriers and approaches to sharing this information that are consistent with obligations under §42CFR part 2.

The Data Workgroup developed a series of use cases to better illustrate the circumstances under which exchange of data is necessary as well as why specific data elements are needed. In total, the workgroup developed four specific uses case which describe the nature of the referral, patient characteristics, and the ideal set of data that would be exchanged. All the use cases are illustrative; none are based on actual clinical situations, although they represent common clinical scenarios. As a result, these use cases frame the importance of sharing data, what data is needed, and the circumstances that inform the need for specific content. In two cases, a BH provider is referring a patient to a primary care provider (one adult, one pediatric); in two the primary care provider is referring to a behavioral health provider (one adult, one pediatric).

Finally, our group concluded with a discussion of privacy and consent issues that might impact sharing of data. The consensus is that knowledge of what can/should be exchanged is varied across the Behavioral Health (BH) and Primary Care (PC) sectors, particularly regarding behavioral health data. It is worth noting that the perception is that healthcare providers are concerned about the exchange of any behavioral health data, when the greatest legal sensitivity concerns data for individuals receiving services from federally funded substance abuse treatment programs (i.e. §42 CFR part 2), a subset of behavioral health data.

Ideally, Delaware Health Information Network (DHIN) would facilitate exchange of this data—but it would require adaptations across the healthcare delivery sector in Delaware. First, many of the BH providers reported that their Electronic Health Records (EHR)s do not readily connect to DHIN, nor do they contribute data to DHIN's Community Health Record (CHR). Several BH providers reported that they are connected to DHIN and view the CHR, but the EHRs used by BH providers (including Substance Use Disorder (SUD) providers) cannot connect with DHIN typically because data cannot be shared consistent with obligations under §42 CFR part 2.

When BH providers *do* share data with primary care providers, they have several means to do so—the DHIN's Direct Protocol, or via fax. Using the Direct Protocol—which functions much like a secure email with an attachment containing a Coordination of Care Document (CCD)—is not always effective. Several users reported that when they had used this to share patient information, the receiving provider had not checked their system to see that content had been received, and/or was not aware of how to access or view the information. Data workgroup participants speculated that most physical health providers

were familiar with how to review information on the CHR, but not with supplemental information via direct since it is not a widely used information conduit. Inherently, this places behavioral health providers at a structural disadvantage since, as noted above, their information is not otherwise contained in the CHR.

The use cases outline four clinical scenarios and detail the information that would be shared between BH and PC providers. Each use case depicts a different referral arrangement: primary care referral to behavioral health for an adult; primary care referral to behavioral health for a child; behavioral health referral to primary care for an adult; and, behavioral health referral to primary care for a child. Within each scenario, the group determined the type and detail of data provided with the referral including the treatment plan and documentation of that plan. It is the hope of the data workgroup that these use cases—and the discussion of the privacy/consent issues involved—will help to identify where and how data can be shared going forward. In an ideal world, all BH data (including SUD data) would be available via the DHIN in a manner consistent with patient consent and all other legal obligations; however, we recognize that this is an objective that is further in the future. In the interim, the strategies laid out here represent several ways that Delaware providers could collaborate to improve behavioral health integration in conformance with legal obligations and patient consent.

## USE CASE #1: BEHAVIORAL HEALTH PROVIDER REFERS AN ADULT PATIENT TO A PRIMARY CARE PROVIDER

- Scenario
  - Patient comes in for an initial evaluation
  - 32-year-old female requesting care
  - Referral from Delaware Family Services because of behavior related to care of her children
  - Patient has an affirmative diagnosis of Major Depression
  - Patient has not had a physical in several years.
    - Last MD visit was for post-partum visit 5 years ago
  - Patient does not currently have a Primary Care Provider (PCP)
- Core Data to be exchanged
  - Time frame
    - New visit but long interval since last PCP visit
  - Synopsis
    - Mother of two kids under 8 years old
    - Sole care giver for kids
    - Major Depressive Disorder (MDD) episode lasting eight years
    - Referred to BH provider by DFS
    - Housing Status: In Section 8 housing, now in jeopardy because of long-term impact of MDD
    - Currently working as a waitress in a coffee shop
    - Basic demographics: Primary Language: English (4<sup>th</sup> grade level)
  - Diagnosis
    - MDD
    - Some Self-medication (Marijuana)
    - Birth control consult needed
  - Goals
    - Decrease symptoms of depression
    - Develop positive coping mechanisms
    - See PCP and check in on overall well being
    - Parenting skills enhancement
  - Treatment Approach
    - Weekly meetings scheduled
    - PHQ-9: 18
  - Med list (*if the referring BH provider is a psychiatrist*)
    - Recommend evaluation for use of anti-depressants
    - No other known meds
- Treatment Approach
  - Did the initial intake
  - Subsequent sessions will focus on:
    - Assess social connectedness
    - Use of CBT to address issues
    - Build strong therapeutic relationships
    - Enhance social connectedness
  - Conducting education on addiction. If SUD involved.

## USE CASE #2: BEHAVIORAL HEALTH PROVIDER REFERS A PEDIATRIC PATIENT TO A PRIMARY CARE PROVIDER (PEDIATRICIAN)

- Scenario
  - Child is doing poorly in school
  - Reports no friends at school
  - Picks fights with siblings
  - Referred to agency by school counselor
- Core Data to be exchanged
  - Overview
    - Child is 14-year-old Caucasian adolescent male
    - Long history of previous therapy
    - Problems started in first grade
    - Oldest of four children
    - Always been anxious about attending school
    - Teachers are concerned about social isolation
    - Problems
    - Hasn't seen identified PCP for a long time
  - Diagnosis
    - Generalized Anxiety Disorder (GAD)
    - GAD-7: 15
  - Goals
    - Improve social cohesion in school
    - Decrease anxiety
    - Increase feeling of comfort at school
    - Identify and address school-related issues
    - Identify and address home-related issues
  - Treatment Approach
    - Weekly meetings with family
    - Structural Family Therapy
    - Simultaneous referral to a Psychiatrist to evaluate for Rx
  - Med list
    - None reported
    - Evaluate for physical issues that may impact readiness for school:
      - Hearing loss
      - Evaluate sight
      - Food insecurity

### USE CASE #3: PRIMARY CARE PROVIDER (THAT IS NOT AN SUD PROVIDER) REFERS AN ADULT PATIENT TO A BEHAVIORAL HEALTH PROVIDER

- Scenario
  - Patient presents complaining of back pain and asking for oxycodone by name
  - PCP checks the PDMP and finds the patient has received 30 days of opioids in the last 15 days.
  - Suspects substance misuse
  - Attempts some motivational interviewing gets patient to agree to see a substance use disorder specialist
  - Asks if other dx prescribed and for history of substance misuse
    - Provider learns patient is taking benzos for anxiety
    - Prior treatment for alcohol use
- Core Data to be exchanged
  - Overview
    - Demographics
      - Adult Male
      - Caucasian
      - Mostly healthy
      - Reported back injury
      - On disability because of injury
      - Married with 1 child (6)
  - Diagnosis/clinical impressions
    - Drug seeking behavior (opioids)
    - History of Alcohol use/misuse
    - Patient has anxiety
  - Goals
    - Assessment for substance use disorder
    - Alternative pain management techniques
    - Treatment for anxiety
  - Med list
    - 10 days left of oxycodone (from a prior script)
    - Benzodiazepines (for anxiety)

#### USE CASE #4: PRIMARY CARE PROVIDER REFERS A PEDIATRIC PATIENT TO A BEHAVIORAL HEALTH PROVIDER

- Scenario
  - Mom brought kid in because concerned about child behavior
  - Mom concerned about sexual activity
  - Found inappropriate photos on child's phone
  - Daughter threatened suicide/suicidal ideation when confronted
  - Child is 15 years old
  - PCP does a PHQ2 and finds no imminent risk of self-harm
  - PCP asks mom to leave
  - PCP (with nurse present) discusses sexual activity and suicidal ideation
  - Child reports thoughts of suicide
  - PCP refers to a BH professional
  - No apparent physical issues
- Core Data to be exchanged
  - Overview
    - Child demographics
    - Presenting problem (early sexual activity and suicidal ideation)
    - Family constellation (living with Mom, spends every other weekend with dad, two younger full siblings, one half sibling from her father. Father is remarried.)
  - Diagnosis
    - Preliminary dx of depression/anxiety
  - Goals
    - Safe sex practices
    - Address depression
  - Med list
    - Albuterol for asthma

## PRIVACY DISCUSSION

In the abstract, there is no problem with a BH provider sharing information of this sort for the purposes of coordinating care. However, it may require additional consent depending on the type of behavioral health provider involved.

For a clinician—a psychiatrist, therapist, or other behavioral health clinician—operating independently or in an organization that does not provide any federally-funded substance abuse treatment services, this exchange of data is governed exclusively by HIPAA. Therefore, information can be shared without the explicit consent of the patient or the patient’s parent or guardian.

If the BH care provider provides or is in an entity that DOES provide federally-funded substance abuse treatment services, §42 CFR part 2 may apply. If so, the BH provider would have to obtain a signed consent from the patient that includes the explicit authorization to share this information with the primary care provider to whom the referral is sent. The consent should include such details as what information can be shared, with whom it is being shared, and for how long the authorization is valid to comply with §42 CFR part 2 requirements.

Ideally, this information could be shared via DHIN’s Community Health Record (CHR)—through a series of mechanisms including a consent registry. However, this is rarely, if ever, adequate. Instead, if BH providers in DE are connected to the DHIN, they can send information via the direct protocol, where it must be retrieved by the primary care provider. Or information can be sent via fax, which seems to be the far more common mechanism today, if it is shared at all.

For information flowing in the other direction—primary care providers referring to behavioral health providers—there are much fewer restrictions on sharing data. Only providers or entities who ‘hold themselves out’ as delivering federally funded substance abuse treatment services are subject to restrictions through §42 CFR part 2. As a result, even the suspected substance abuse identified in Use Case #3 would not be restricted since the primary care provider would be readily identified as a substance abuse treatment provider.

Sadly, most SUD providers are not currently connected to the DHIN, and they do not currently contribute owing to challenges around §42 CFR part 2. Even if the SUD provider was connected to the DHIN not all this information will be conveyed through DHIN or the CHR. As a result, sharing this information would likely require the primary care provider to fax a referral summary to the SUD provider. Ideally, the PCP and the SUD provider would have formalized a care compact, which would define many of the data elements for sharing data, and how (And what kind of) communication would be returned to the original referring provider.

## **Appendix G: Financing for Behavioral Health Integration**

(See attached PDF file)



# HEALTH MANAGEMENT ASSOCIATES

## Financing for Behavioral Health Integration: Fee- for-Service and New Approaches

Lori Raney, MD  
Principal



MILLIMAN RESEARCH REPORT

# Potential economic impact of integrated medical- behavioral healthcare

Updated projections for 2017

January 2018

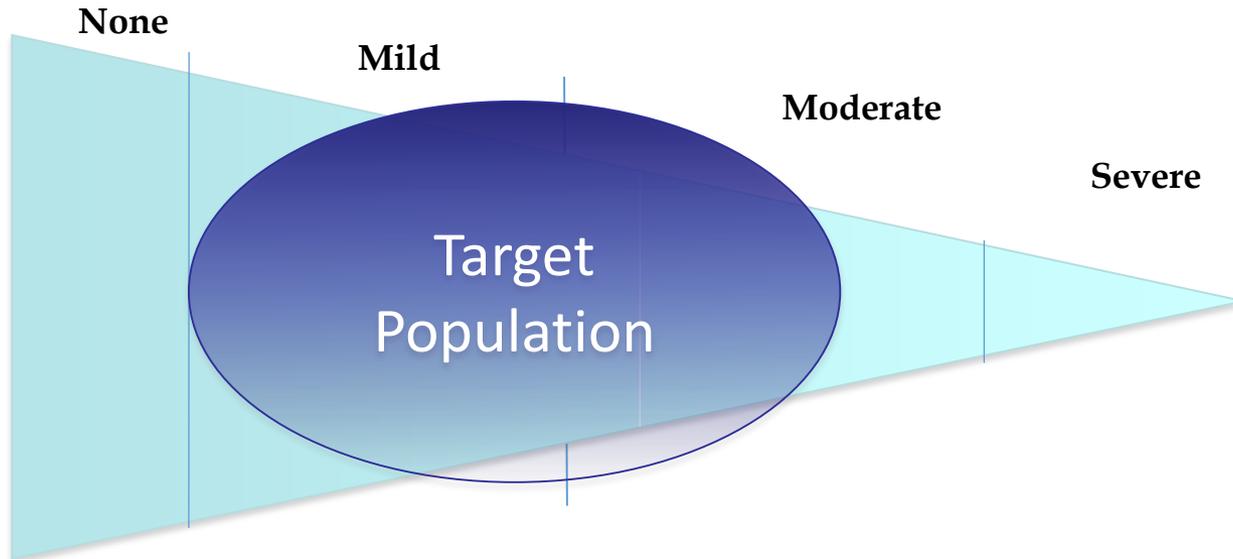
Stephen P. Melek, FSA MAAA  
Douglas T. Norris, FSA, MAAA, PhD  
Jordan Paulus, FSA, MAAA  
Katherine Matthews, ASA, MAAA  
Alexandra Weaver, ASA, MAAA  
Stoddard Davenport

**FIGURE 14: IMPACT OF BEHAVIORAL COMORBIDITIES, MEDICAID POPULATION, 2017 TOTAL PMPM COSTS**

BODY SYSTEM (CONDITION)	NO MH/SUD	MH/SUD
BENIGN/IN SITU/UNCERTAIN NEOPLASM	\$922	\$2,123
CARDIORESPIRATORY ARREST	\$6,445	\$6,896
CEREBROVASCULAR	\$2,756	\$4,432
COGNITIVE DISORDERS	\$3,115	\$4,772
DIABETES	\$1,432	\$3,181
EARS, NOSE, AND THROAT	\$656	\$1,954
EYES	\$789	\$2,182
GASTROINTESTINAL	\$1,132	\$2,595
GENITAL SYSTEM	\$889	\$2,066
HEART	\$1,375	\$2,867
HEMATOLOGICAL	\$1,906	\$4,034
LIVER	\$1,784	\$3,444
LUNG	\$990	\$2,568
MALIGNANT NEOPLASM	\$2,569	\$4,278
MUSCULOSKELETAL AND CONNECTIVE TISSUE	\$931	\$2,181
NEUROLOGICAL	\$1,982	\$3,177
NUTRITIONAL AND METABOLIC	\$1,095	\$2,583
PREGNANCY-RELATED	\$1,540	\$2,242
SKIN AND SUBCUTANEOUS	\$804	\$2,379
URINARY SYSTEM	\$1,449	\$3,217
VASCULAR	\$2,428	\$4,533
<b>TOTAL (INCLUDING THOSE WITHOUT ANY MEDICAL CONDITIONS)</b>	<b>\$494</b>	<b>\$1,708</b>

Potential calculated savings with IC \$175 billion

## ■ “SWEET” SPOT FOR INTEGRATED CARE & THE COLLABORATIVE CARE MODEL



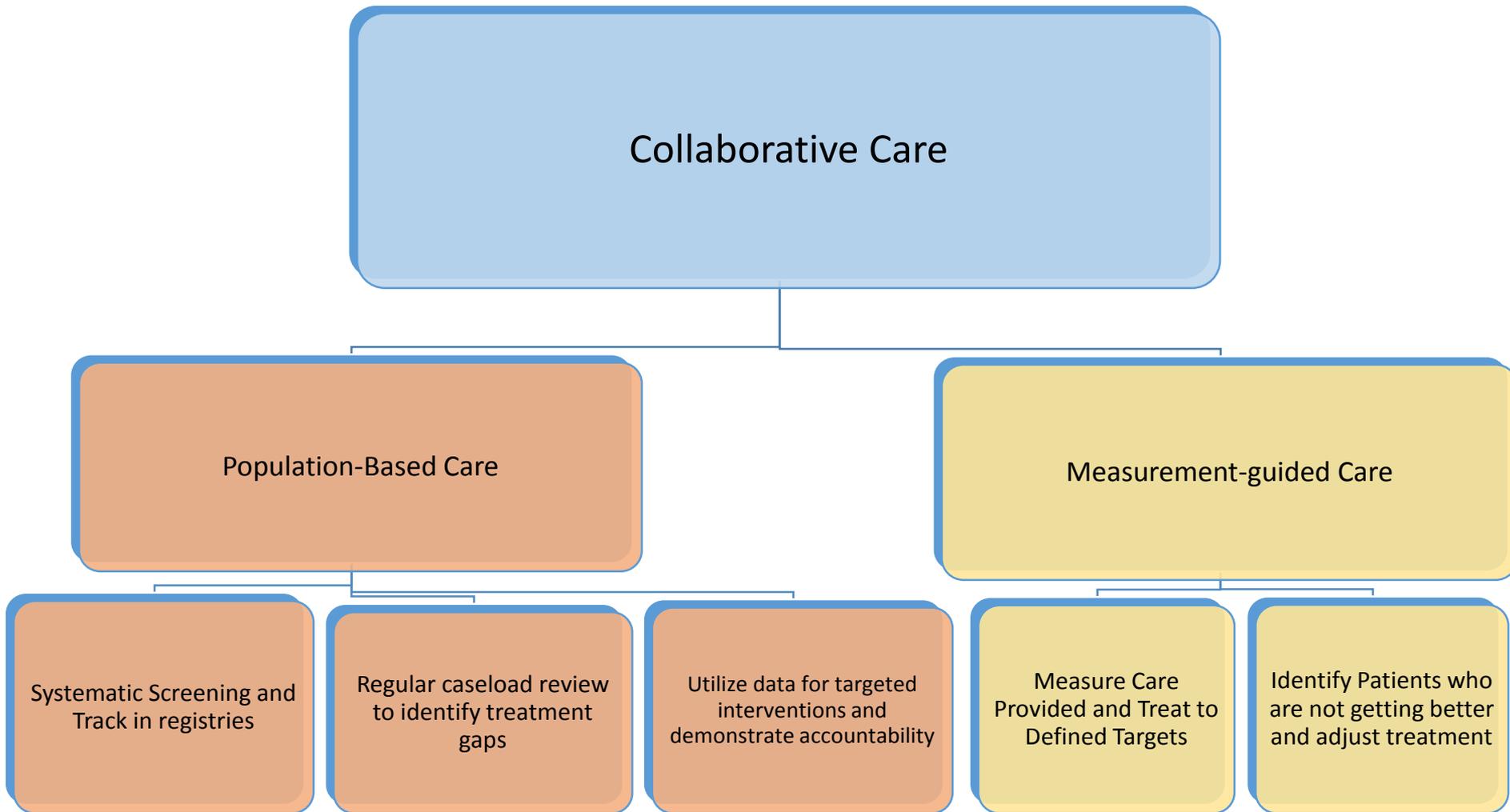
- Issues with depression and substance abuse must be pre-empted, rather than treated once advanced.
- Goal is to detect early and apply early interventions to prevent from getting more severe

# STEPPED MODEL OF INTEGRATED BEHAVIORAL HEALTH CARE



<https://aims.uw.edu/>

## COLLABORATIVE CARE COMPONENTS



# THE COLLABORATIVE CARE MODEL



**Informed,  
Activated Patient**



***PRACTICE  
SUPPORT***



**PCP Supported by Care Manager**



**Measurement-based  
Treat to Target**



**Psychiatric  
Consultation**



**Caseload-focused  
Registry Review**

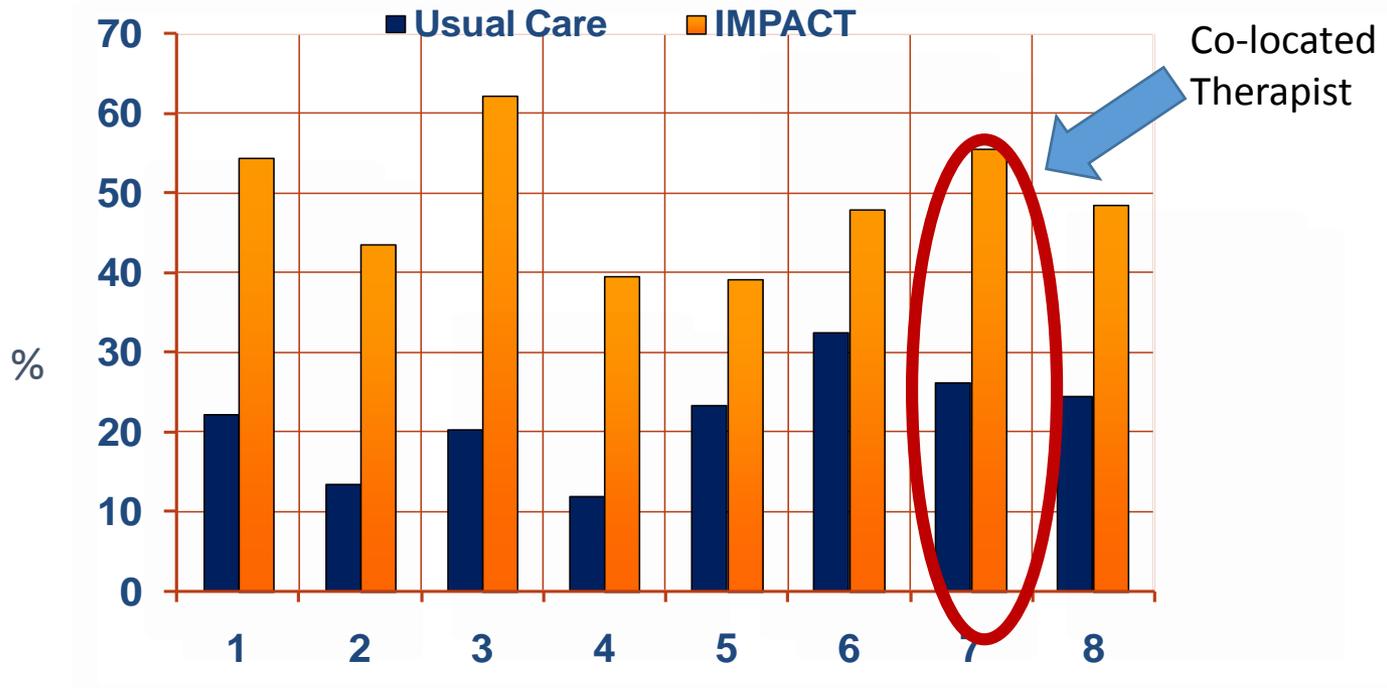


**Training/Implementation  
Support**  
<https://aims.uw.edu/>

# DOUBLES EFFECTIVENESS OF CARE FOR DEPRESSION



50 % or greater improvement in depression at 12 months



Participating Organizations

Unützer et al., JAMA 2002

## CUMULATIVE RESEARCH EVIDENCE OVER PAST DECADE

### Over 80 Randomized Controlled Trials

- Cochrane meta analysis: Collaborative care for people with depression and anxiety. Archer J et al. 2012: 79 RCTs.
- Community Preventive Services Task Force. Recommendation from the community preventive services task force for use of collaborative care for the management of depressive disorders. *Am J Prev Med.* 2012; 42(5):521-524: 69 RCTs.
- Gilbody S. et al. *Archives of Internal Medicine*; Dec 2006: Collaborative care (CC) for depression in primary care (US and Europe): 37 RCTs.

Collaborative care is consistently more effective than care as usual.

## BUSINESS CASE: REDUCES HEALTH CARE COSTS

Cost Category	4-year costs in \$	Intervention group cost in \$	Usual care group cost in \$	Difference in \$
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7,284	6,942	7,636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8,452	7,179	9,757	-2578
Inpatient mental health / substance abuse costs	114	61	169	-108
<b>Total health care cost</b>	<b>31,082</b>	29,422	32,785	<b>-\$3,363</b>

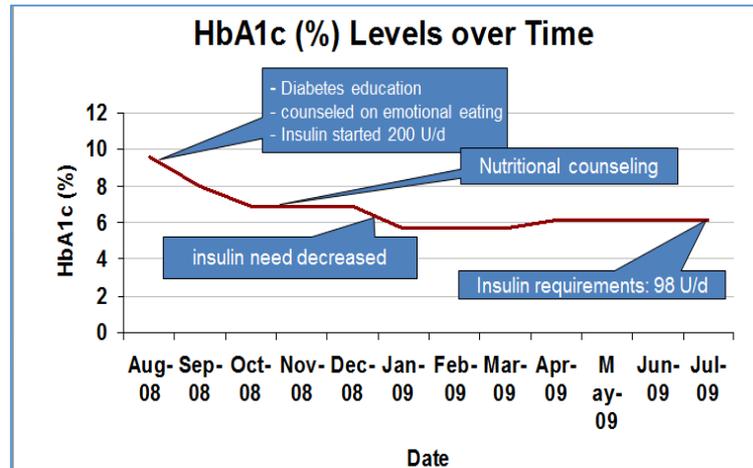
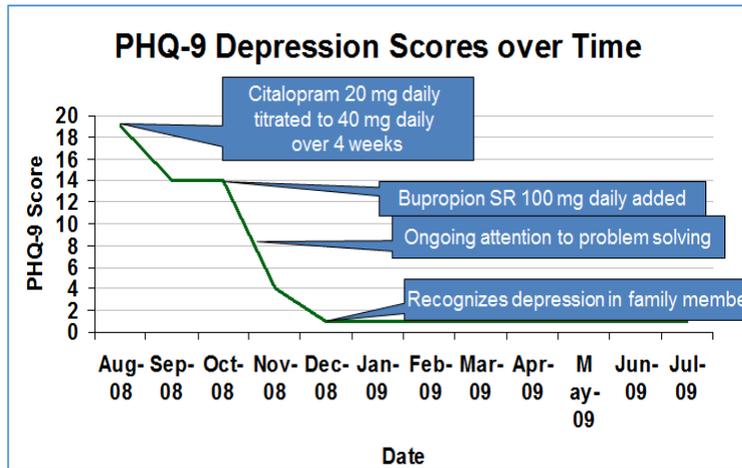
Savings



ROI  
\$6 : \$1

Unützer et al., *Am J Managed Care* 2008.

# Multi-Condition Collaborative Care



- Diabetes nurse educators
- Caseload supervision
  - Depression: psychiatrist
  - Diabetes and CAD: family doctor
  - E-mail to diabetologist for complex cases



Cost Savings  
\$600-1100/patient

Katon et al NEJM 2010, Katon et al Archives of General Psychiatry 69 (5), 2013

## ■ WHAT CAN YOU BILL NOW in FFS? TRADITIONAL THERAPY

---

- + Diagnostic Evaluations – 90791 (90792 if psychiatric provider sees patient)
- + Brief therapy
  - 90832 (30 minutes)
  - 90834 (45 minutes)
  - Group therapy
- + Must be able to meet documentation requirements/compliance standards for CPT coding
- + SOAP/DAP documentation
- + Initial evaluation components
- + Medical necessity
- + Chronic care management codes (CCM) for 20 minutes each month

# REIMBURSEMENT OPTIONS – HBAI CODES

+ Health Behavior Assessment and Intervention (HBAI) 96150-155 – psychologists – NOT PAID IN DELAWARE

+ Developed by CMS in 2002 to support determining the biological, psychological, and social factors affecting the patient’s physical health and any treatment problems, and related interventions by psychologists.

State: Alaska, July 2014

CPT Code		Diagnostic Code	Community Health Center					
			Medicare			State Medicaid		
			Paid?	Credentials	Paid?	Code	Credentials	Comments
E & M Codes	99201-99205 New PT	May be used for behavioral health or physical health services	Yes	MD, PA, ANP	Yes	99201-99205 New PT	MD, PA, ANP	All CPT codes must be reported, but services are reported at the FQHC rate
	99211 - 99215 Est. Pt.		99211 - 99215 Est. Pt.					
Health and Behavior (HABI)	96150 Assessment	Services are secondary to a physical health diagnosis	Yes	PhD Psychologist at this time; excludes LMSW	Yes	96150 Assessment	Psychologist and Licensed Clinical Social Worker	All CPT codes must be reported, but services are reported at the FQHC rate
	96151 Reassessment		Yes			96151 Reassessment		
	96152 Individual TX		Yes			96152 Individual TX		
	96153 Group TX		Yes			96153 Group TX		
	96154 Family TX w/ PT		Yes			96154 Family TX w/ PT		
	96155 Family TX w/o PT		No			96155 Family TX w/o PT		
Tele-medicine	90791 GT Psych eval w/o medical services	Psychiatric diagnosis	Yes	Physician, NP, PA, CNS, Clinical Psychologist, Clinical Social Worker	Yes	90791 GT Psych eval w/o medical services	Physician, PA, NP, CNS	
	90792 Psych eval w/ medical services			Physician, NP, PA, CNS				
	90832-38 GT Therapy Services			Psychiatrist, CNP, Clinical Psychologist, Clinical Social	Yes	90832-38 GT Therapy Services	Physician, PA, Clinical Psychologist, NP, CNS, CSW	
	99201-99215 Office or other OP services	Both MH & PH diagnosis	Yes	Physician, NP, PA, CNS	Yes	99201-99215 GT Office or other OP services	Physician, PA, Clinical Psychologist, NP, CNS	
	96150-54 HABI							

## ■ FEE FOR SERVICE: WHAT DO WE HAVE TROUBLE BILLING FOR?

- + Brief interventions
- + Stress/no diagnosis
- + Huddles
- + Hallway conversations/consultations
- + Warm hand-offs
- + Curbside consultations with psychiatric consultants
- + Phone calls to patients
- + Repeating rating scales
- + Interdisciplinary team meetings
- + Registry management

*\*\*Payment approaches are necessary for these services that do not work in a typical FFS environment. "What works can't be coded."*

## ■ CARE OF MENTAL, PHYSICAL AND SUBSTANCE USE SYNDROMES

### (COMPASS)

- Depression – 60% improved
- Uncontrolled DM – 21% controlled
- Cardiovascular Disease – HTN 40% in control

The project described is supported by Cooperative Agreement Number 1C1CMS331048-01-00 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services, ACA 2010



## NEW MEDICARE CODES FOR CoCM REQUIRE ATTENTION TO DETAIL

99492 (Initial month, CoCM) - \$161

99493 (Subsequent month, CoCM) - \$129

99494 (Add'l 30 mins, CoCM) - \$69

99484 – other models of BHI - \$48

Billed once a month by the PCP

### Codes cover:

- + Outreach and engagement by BH Provider or Care Manager
- + Initial assessment of the patient, including administration of validated rating scales
- + Entering patient data in a registry and tracking patient follow-up and progress
- + Participation in weekly caseload review with the psychiatric consultant
- + Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
  
- + GCCC2 – code for FQHCs \$135/month starting January 1, 2018

## ■ MEDICARE CoCM BILLING MUST HAVES

- + These codes are billed by the medical provider (primary care provider) once a month
- + Needs an initiating visit – new patients unless seen in the past year
- + Must have weekly caseload reviews with a psychiatric consultant
- + Broad consent obtained
- + Co-pays apply
- + Must be able to show time spent – how to time stamp your work?
- + MEDICARE ONLY for now

For a helpful reference, see:

[http://aims.uw.edu/sites/default/files/CMS\\_FinalRule\\_2017\\_CheatSheet.pdf](http://aims.uw.edu/sites/default/files/CMS_FinalRule_2017_CheatSheet.pdf)

## BILLING CODES FOR CoCM – 1<sup>st</sup> MONTH

HCPCS Code	Long Descriptor
99492	<p>Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:</p> <ul style="list-style-type: none"><li>• outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;</li><li>• initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;</li><li>• review by the psychiatric consultant with modifications of the plan if recommended;</li><li>• entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and</li><li>• provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.</li></ul>

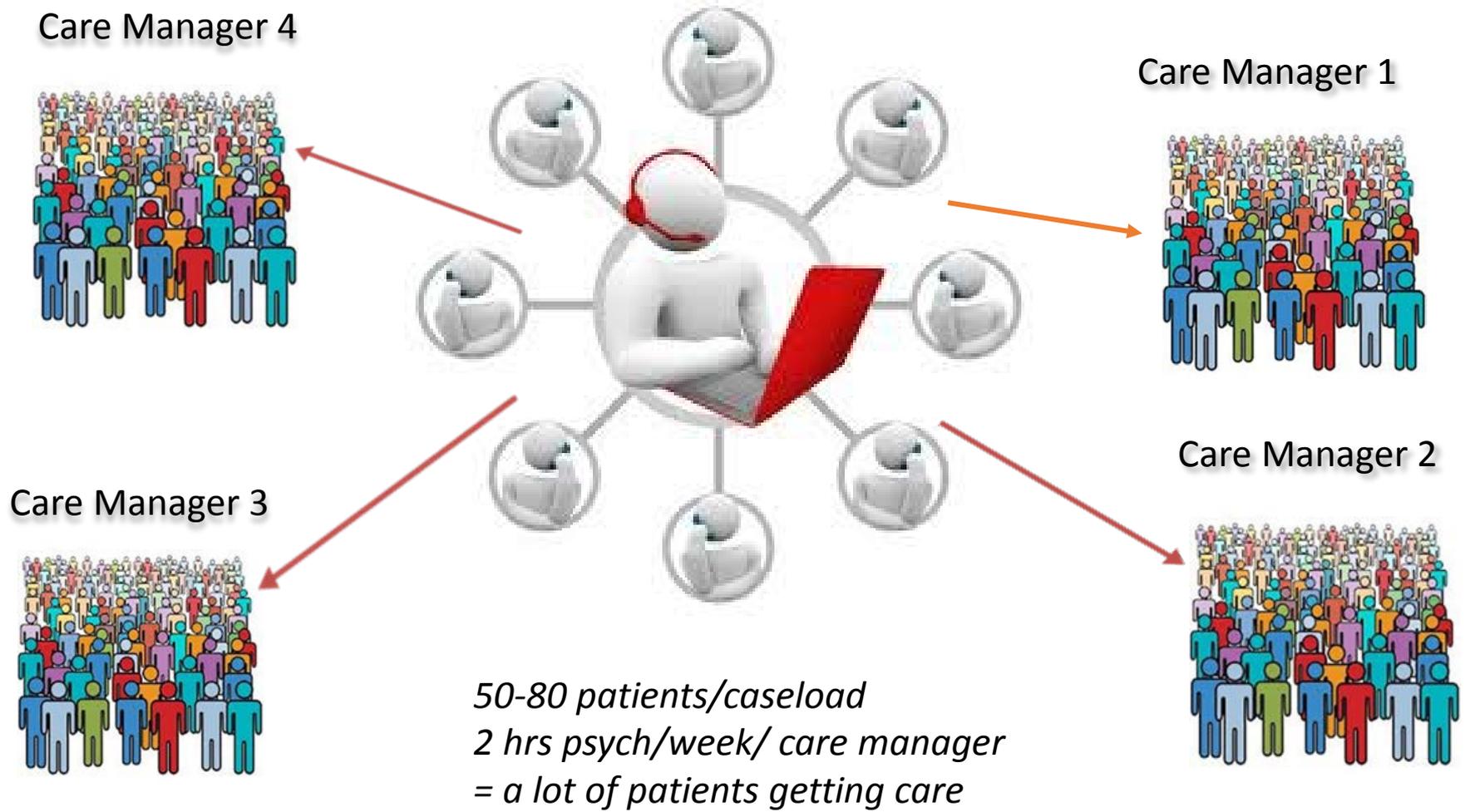
## BILLING CODES FOR CoCM – SUBSEQUENT MONTHS

HCPCS Code	Long Descriptor
99493	<p>Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:</p> <ul style="list-style-type: none"> <li>• tracking patient follow-up and progress using the registry, with appropriate documentation;</li> <li>• participation in weekly caseload consultation with the psychiatric consultant;</li> <li>• ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;</li> <li>• additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;</li> <li>• provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;</li> <li>• monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.</li> </ul>

## BILLING CODES FOR CoCM – EXTRA TIME

HCPCS Code	Long Descriptor
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure). (Use G0504 in conjunction with G0502, G0503).

# PSYCHIATRIC CONSULTANTS SUPPORTING TEAMS



## OTHER MODELS OF INTEGRATED CARE

HCPCS Code	Long Descriptor
99484	<p>Care management services for behavioral health conditions, at least 20 minutes of clinical staff time per calendar month. Must include:</p> <ul style="list-style-type: none"><li>• Initial assessment or follow-up monitoring, including use of applicable validated rating scales;</li><li>• Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;</li><li>• Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and</li><li>• Continuity of care with a designated member of the care team.</li></ul> <p>Can only be reported by a treating provider and cannot be independently billed. For 99484, a behavioral health care manager with formal or specialized education is not required. CMS rules allow “clinical staff” to provide 99484 services using the same definition of “clinical staff” as applied under the Chronic Care Management benefit.</p>

# COMMON PERFORMANCE MEASURES FOR ACOs, VALUE-BASED PAYMENT

## Process Metrics

- Percent of patients screened for depression
- Percent with follow-up with care manager within 2 weeks
- Percent not improving that received case review and psychiatric recommendations
- Percent treatment plan changed based on advice
- Percent not improving referred to specialty BH

## Outcome Metrics

- Percent with 50% reduction PHQ-9 – Clinical Response at 6 and 12 months
- Percent reaching remission (PHQ-9 < 5 ) at 6 and 12 months

Experience— patient and provider

Functional – work, school, homelessness

## Utilization/Cost

- ED visits, 30 day readmits, med/surg/ICU, overall cost

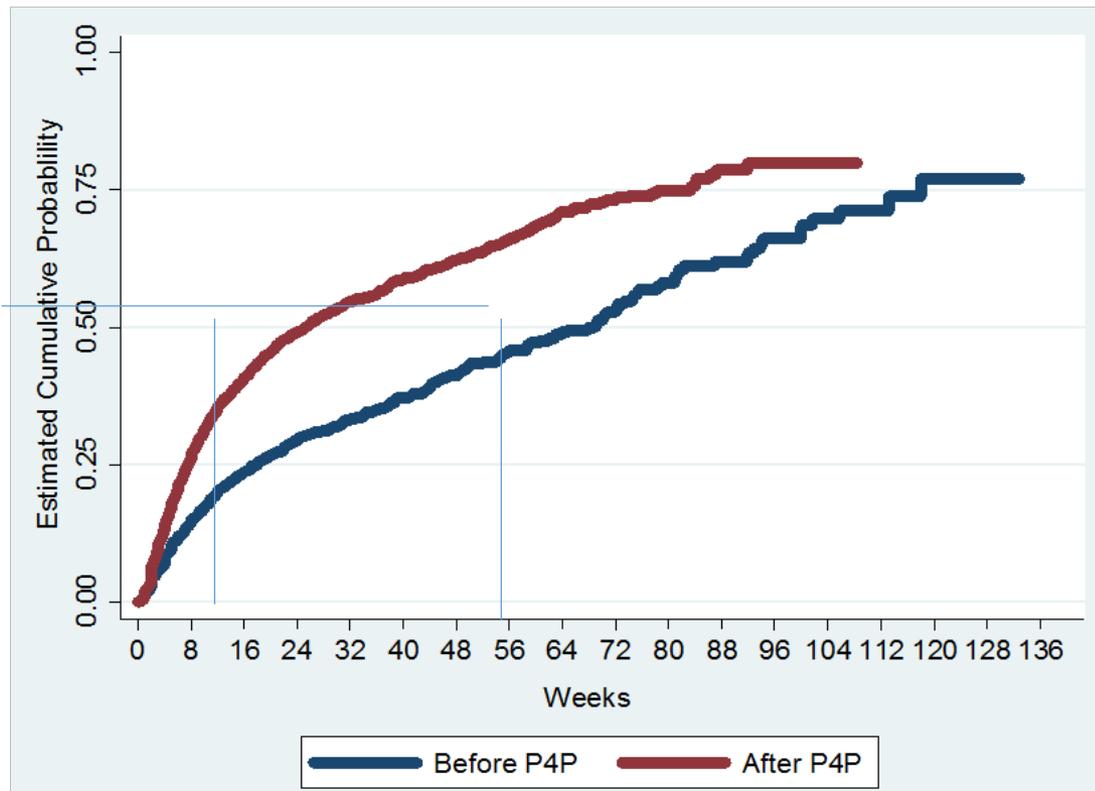
**NQF 712**

**NQF 1884 and 1885 (benchmark > 40%)**  
**NQF 710 and 711 (benchmark > 20%)**

Raney, Lasky, Scott, Integrated Care: A Guide to Effective Implementation; APPI; 2017

## PAY-FOR-PERFORMANCE SUCCESSFULLY INCENTS IMPROVEMENTS

American Psychiatric Association found that when P4P arrangements were in place, median time to depression treatment response was reduced by half



+ Cut median time to depression response in half

Unützer et al., 2012

## VBP EXAMPLE – 25% WITHHOLD

Domain of CoCM	Phase 1 VBP Target	Fidelity Measure	% Returned when fidelity measure met
Systematic follow-up	1. Maintain minimum monthly caseload	1. At least one contact a month	5%
	2. >50% of caseload receives $\geq 2$ contacts from BHP a month	2. Same as above	5%
Measurement-based care	> 75% of the caseload has at least one PHQ9 recorded each month	At least one PHQ9 administered in a 4 week period	5%
Stepped care	1. Care coordinator reviewed $\geq 50\%$ of caseload with the psychiatric consultant each month	1. At least one psychiatric consultation of the case in each 4 week period	5%
	2. Registry documents current psychiatric medications in $\geq 75\%$ of caseload	2. Medications included in the registry	5%

Modified from Bao et al., 2018

# ATTESTATION FOR COLLABORATIVE CARE MODEL

## Attestation for Collaborative Care Model (CoCM)

This attestation is for any single provider\* or provider\* group to attest that they are actively providing care consistent with the Collaborative Care Model (CoCM) as described in the agency's Collaborative Care Model Guidelines.

Submission on behalf of Individual Provider\* or Group Practice:

- Individual provider\* –

Billing address:	Billing NPI number:
	Phone number:
	Email:

NOTE: requires each billing provider\* submit an attestation

Provider Name:
----------------

- Group Practice –

NOTE: attestation must cover all billing providers\* within the practice and ensure new providers are trained in CoCM

Billing provider name:	Billing NPI:
Billing address:	Tax ID number:
	Phone number:
	Email:

For practices with multiple sites, each site must have its own attestation. If there are multiple providers\* within the practice, you are attesting that those individuals being identified as the servicing provider on the claim billing the CoCM codes, are trained and following the agency guidelines for the CoCM Model. I attest that my practice is actively providing care in a Collaborative Care Model as described in the agency guidelines. This CoCM includes the following required principles:

- Patient Center Team Care
  - Primary care/medical provider
  - Behavioral health care manager
  - Psychiatric consultation
  - Beneficiary-client
- Team structure with staff identified in the guideline
- Measurement-Based Treatment to Target using validated tools
- Accountable Care using a Registry

I have received and reviewed the CoCM guidelines, understand them, have received training and implemented the CoCM consistent with said guidelines and agree to comply with said guidelines. By signing this attestation, you attest that your individual or group practice is actively practicing a collaborative care model consistent with that described in the agencies CoCM guideline. If at any time your individual or group practice no longer meets the requirements for CoCM, you will immediately notify the agency by contacting provider enrollment at XXX.

WA Medicaid 2018 – signed by physician, nurse practitioner, or physician's assistant

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**HMA**