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BI-DIRECTIONAL CARE INTEGRATION WORK GROUP MEETING  
JANUARY 30, 2018

# Welcome and Introductions

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Introduce yourself: Name, organization, and county

# WELCOME

# Agenda

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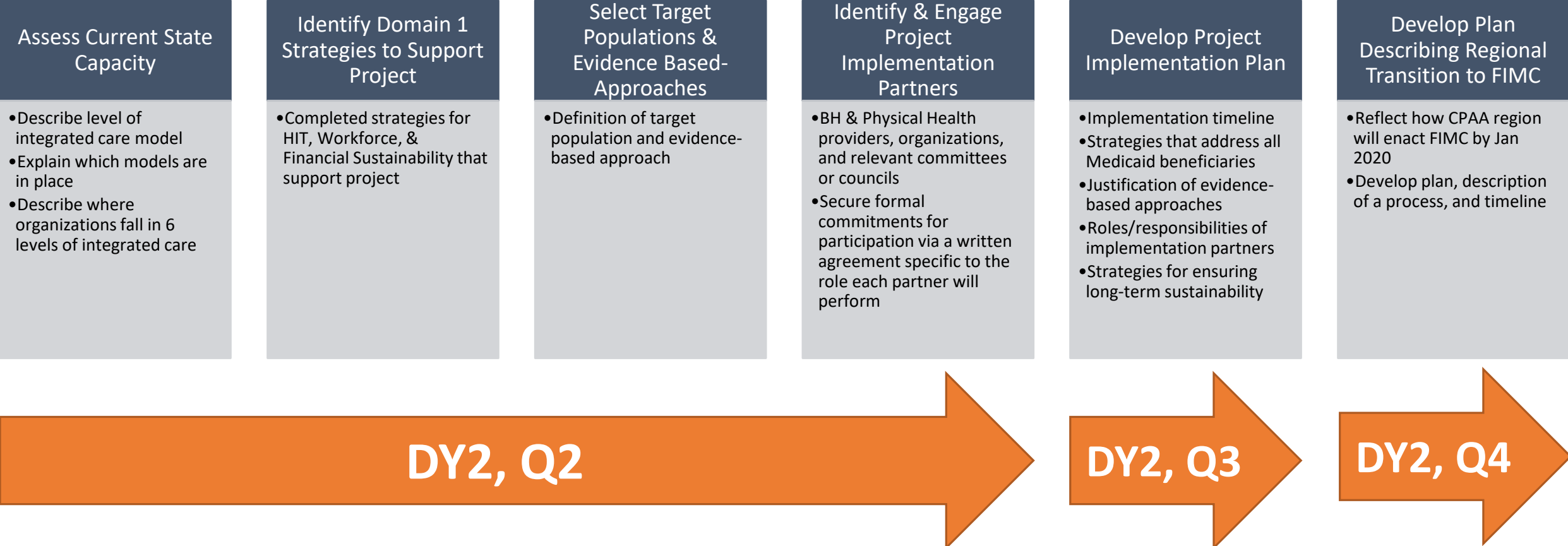
- ✓ Review previous meeting
- ✓ 2018 Milestones
- ✓ Updates
- ✓ Target Populations
- ✓ Discuss First Milestone for 2018: Current State Assessment
- ✓ Building an integrated portfolio – focusing on bi-directional care integration at next Council meeting

# Last Meetings

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- Waiting for our project plan score and funding amounts
- 2018 Milestones
- Focused on assessment strategy
  - Choosing assessments
  - Defining utility of assessment
  - Part of partnering provider commitments as QI

# Project Work Plan Timeline & Milestones - 2018



# Clinical Provider Advisory Committee

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- Discussed Systems/Technology Improvements, VBP, and Formal Commitments
- Key Points
  - Explore data/technology work group feasibility
  - Regional strategy for VBP
  - Need clarity on commitment letters
  - Learn what VBP education is needed
  - Incentives to support Transformation goals

# Council Meeting

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- Thursday, February 8<sup>th</sup> from 12:00 – 3:00pm in Mason County Public Works
- Shared Learning on bi-directional care integration
  - Overview
  - Primary care transformation
  - Success stories
  - Integrated project portfolio

# HCA P4R Updates

## Overview

ACHs can earn incentive payments for successfully submitting key deliverables, and ensuring complete and timely reporting by partnering providers on defined metrics within the timeframes set forth by the state.

## P4R deliverables

- Semi-Annual Reports
- Implementation Plan
- Quarterly Participating Partner Updates
- Quality Improvement Plan
- Mid-Point Assessment
- P4R Metrics

Note: deliverable timelines and format are still under development.



# P4R Deliverable Development

## DY 2 P4R deliverables

Deliverable	Reporting Period	HCA Template Release	ACH Submission Deadline	Submitted through
Semi-Annual Report (2.1)	1/1/2018 – 6/30/2018	March 2018	7/31/2018	CPAS
Implementation Plan	N/A	April 2018	10/1/2018	CPAS
Semi-Annual Report (2.2)	7/1/2018 – 12/31/2018	July 2018	1/31/2019	CPAS

# Finalizing Target Populations

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- Patients screened in primary care and behavioral health settings
- In PC and BH settings, children and adults:
  - Dx w/ mental illness
  - Dx w/ serious mental illness
  - SUD treatment need
    - Also that have co-occurring chronic conditions (diabetes, asthma, heart disease, obesity)
- Questions:
- Should we be more specific than this?
- How might our target populations influence implementation?

# Assess Current State Capacity

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## Assess Current State Capacity

1. Describe level of integrated care model adoption among target providers/organizations
2. Explain which integrated models or practices are in place
3. Describe where organizations fall in 6 levels of integrated care

- Changes to the assessment strategy
- Developing a customized assessment including elements from multiple project areas
- Survey settings: primary care and behavioral health

# Assess Current State Capacity

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## Assess Current State Capacity

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- Taking a phased approach
  - 1<sup>st</sup> phase: To satisfy milestone, “brief” custom survey that includes Integrated Practice Assessment Tool (IPAT)
  - 2<sup>nd</sup> phase: partnering organizations choose a tool from a list of integrated care assessments that works best. This tool is used every 6 months and part of implementation plan.
- Small Group Exercise 1:
  - What feedback do you have on this approach?
  - What additional information on bi-directional care integration should CPAA gather that is actionable?

# Building an Integrated Portfolio

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- Small Group Exercise 2:
- What are the main intersection points and opportunities for the other 5 project areas with bi-directional care integration?
  - 2B: Care coordination (Pathways)
  - 2C: Transitional care
  - 3A: Opioid Response
  - 3B: Reproductive/Maternal & Child Health
  - 3D: Chronic Disease Prevention & Control

# Bi-Directional Integration Strategies

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## • Primary Care Settings

- New team roles
  - BH Care Managers
  - Onsite BH Specialists
  - Psychiatric Consultants
- Measurement-Based Screening and Follow-up (e.g., PHQ-9; GAD-7)
- SBIRT
- Measurement-based treatment to target
- Accountable for BH quality measures
- Medication adherence, including BH

## • Behavioral Health Settings

- New team roles
  - PC Consultants
  - PC RN Care Managers
  - Onsite PCP provider (MD or ARNP)
- Metabolic screening
- Routine preventative care
- Cardiovascular and diabetes care (e.g., BP; A1C)
- Accountable for medical quality measures
- Medication adherence

# Re-Evaluating Workgroup Meeting Structure

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- Quarterly joint meetings w/ breakout sessions
- Enhanced communication in-between meetings
- Webinars as needed
- Localized meetings around region
- Are there any suggestions?

# Summary and Next Steps

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- Next steps
  - Finalize assessment strategy
  - Review Domain 1 strategies by project area
  - What else?