BI-DIRECTIONAL CARE INTEGRATION WORK GROUP

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AUGUST 28, 2018

Welcome and Introduction

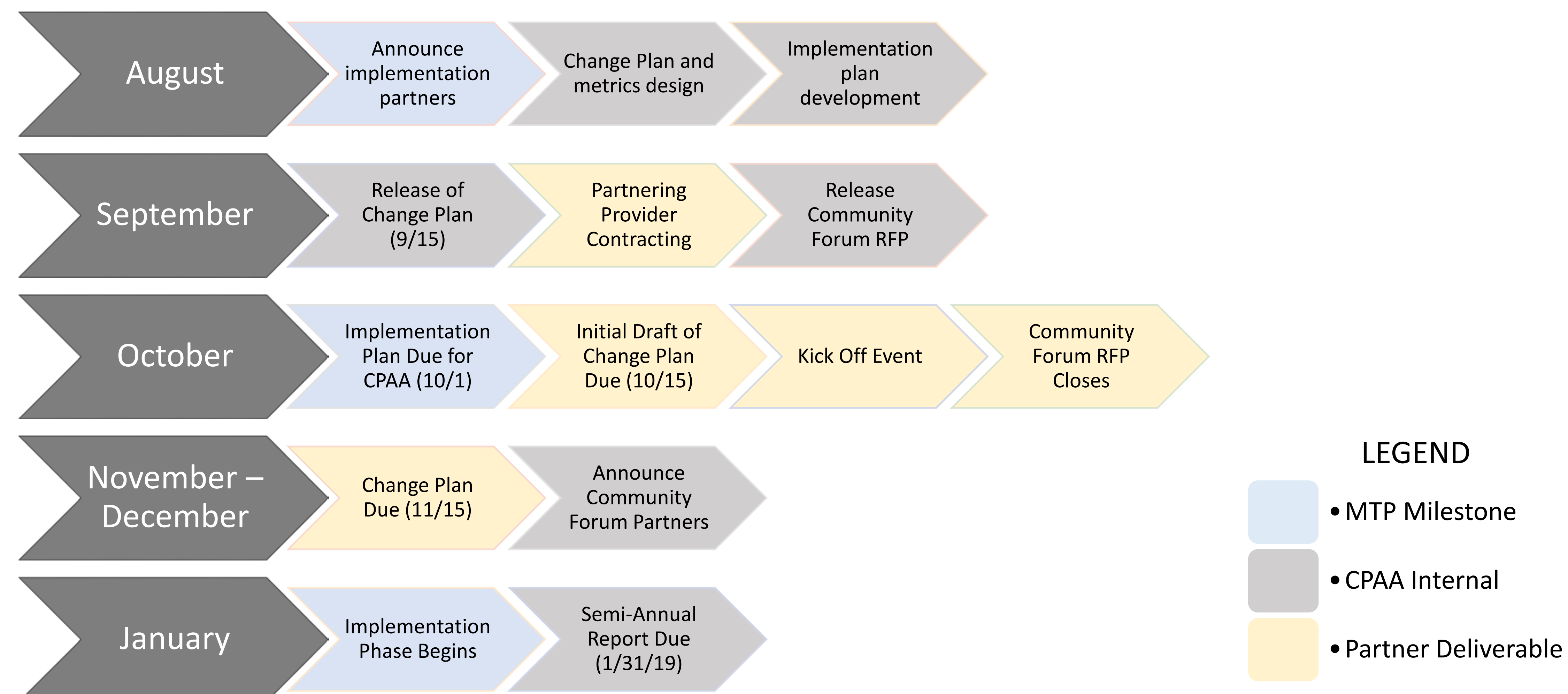
Introduce yourself: Name and Organization

WELCOME

Agenda

- ✓ Mention pre-meeting updates
- ✓ CPAA Timeline
- ✓ AIMS Center Whole Person Care training program
- ✓ Psychiatric Consultation Opportunity
- ✓ Review Change Plan
- ✓ Assess Work Group Structure
- ✓ Next Steps

CPAA Timeline Draft 2018-2019



AIMS Center Whole Person Care Training Program

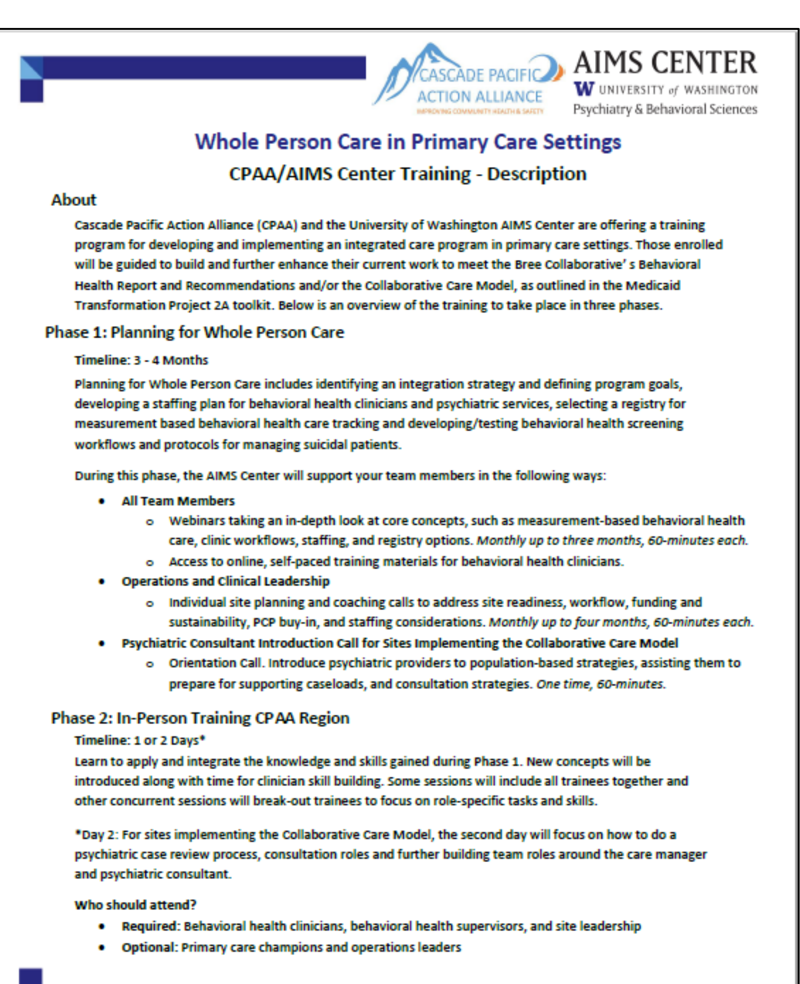
- One year program but variable depending on practice readiness factors
- Three phases
  - 1. Planning for whole person care: 3 – 4 months
  - 2. In-person training for integration: 1 or 2 days
  - 3. Virtual coaching and additional training: 3 – 6 months

AIMS Center Whole Person Care Training Program

- CE credits Available
  - Phase 2: in person
  - Problem Solving Treatment
- Training website w/ resources
- Includes Caseload Tracker
  - Licensing required
- Informational call on 9/5/18 at 12:30pm

- CPAA is covering the cost!

How Do You Enroll?



CASCADE PACIFIC ACTION ALLIANCE — AIMS CENTER, UNIVERSITY of WASHINGTON, Psychiatry & Behavioral Sciences

Whole Person Care in Primary Care Settings

CPAA/AIMS Center Training - Description

About

Cascade Pacific Action Alliance (CPAA) and the University of Washington AIMS Center are offering a training program for developing and implementing an integrated care program in primary care settings. Those enrolled will be guided to build and further enhance their current work to meet the Bree Collaborative's Behavioral Health Report and Recommendations and/or the Collaborative Care Model, as outlined in the Medicaid Transformation Project 2A toolkit. Below is an overview of the training to take place in three phases.

Phase 1: Planning for Whole Person Care

Timeline: 3 - 4 Months

Planning for Whole Person Care includes identifying an integration strategy and defining program goals, developing a staffing plan for behavioral health clinicians and psychiatric services, selecting a registry for measurement based behavioral health care tracking and developing/testing behavioral health screening workflows and protocols for managing suicidal patients.

During this phase, the AIMS Center will support your team members in the following ways:

- **All Team Members**
  - Webinars taking an in-depth look at core concepts, such as measurement-based behavioral health care, clinic workflows, staffing, and registry options. *Monthly up to three months, 60-minutes each.*
  - Access to online, self-paced training materials for behavioral health clinicians.
- **Operations and Clinical Leadership**
  - Individual site planning and coaching calls to address site readiness, workflow, funding and sustainability, PCP buy-in, and staffing considerations. *Monthly up to four months, 60-minutes each.*
- **Psychiatric Consultant Introduction Call for Sites Implementing the Collaborative Care Model**
  - Orientation Call. Introduce psychiatric providers to population-based strategies, assisting them to prepare for supporting caseloads, and consultation strategies. *One time, 60-minutes.*

Phase 2: In-Person Training CPAA Region

Timeline: 1 or 2 Days*

Learn to apply and integrate the knowledge and skills gained during Phase 1. New concepts will be introduced along with time for clinician skill building. Some sessions will include all trainees together and other concurrent sessions will break-out trainees to focus on role-specific tasks and skills.

*Day 2: For sites implementing the Collaborative Care Model, the second day will focus on how to do a psychiatric case review process, consultation roles and further building team roles around the care manager and psychiatric consultant.

Who should attend?

- **Required:** Behavioral health clinicians, behavioral health supervisors, and site leadership
- **Optional:** Primary care champions and operations leaders

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Whole Person Care in Behavioral Health Settings

CPAA/AIMS Center Training - Enrollment Form

In order to join the CPAA/AIMS Center Training my organization is committed to the following:

- ☐ Senior and clinical leadership support the program and have agreed to commit staff time and resources to fully develop an integrated care program for the organization.
- ☐ Senior leadership is aware of potentially competing projects and/or grant initiatives and has a plan in place for coordinating across multiple projects.
- ☐ We have identified a project team to manage and coordinate the integrated care program. The project team agrees to be available for planning meetings and webinars. Team members include:

Senior Leader:		Site Manager:	
Clinical Director:		Other Staff:	
Day-to-Day Leader:			

- ☐ We have a staffing plan in place for a care manager and/or a care coordinator to help clients with chronic medical conditions. As part of our staffing plan, we agree to allow staff to attend in-person and virtual trainings and coaching calls.
- ☐ Within three to four months from the start of training program we agree to hire, contract, or train an existing staff member as a care manager and/or care coordinator to help clients' with their medical needs.
- ☐ Within three to four months from the start of the training program we will make arrangements for facilitating direct primary care services to improve access to primary care for our clients onsite or in collaboration with a local provider.
- ☐ Within three months from the start of the training program we will choose a registry and be ready to use it for measurement-based physical health care tracking.
- ☐ Within three months from the start of the training program we will work internally and with the AIMS Center to develop and test a physical health screening workflow.

CPAA will provide:

- Full cost of Whole Person Care Training Program

Training Start Date: January 2019

Organization/Practice: ____________

Printed Name: ____________

Signature: ____________ Date: ____________

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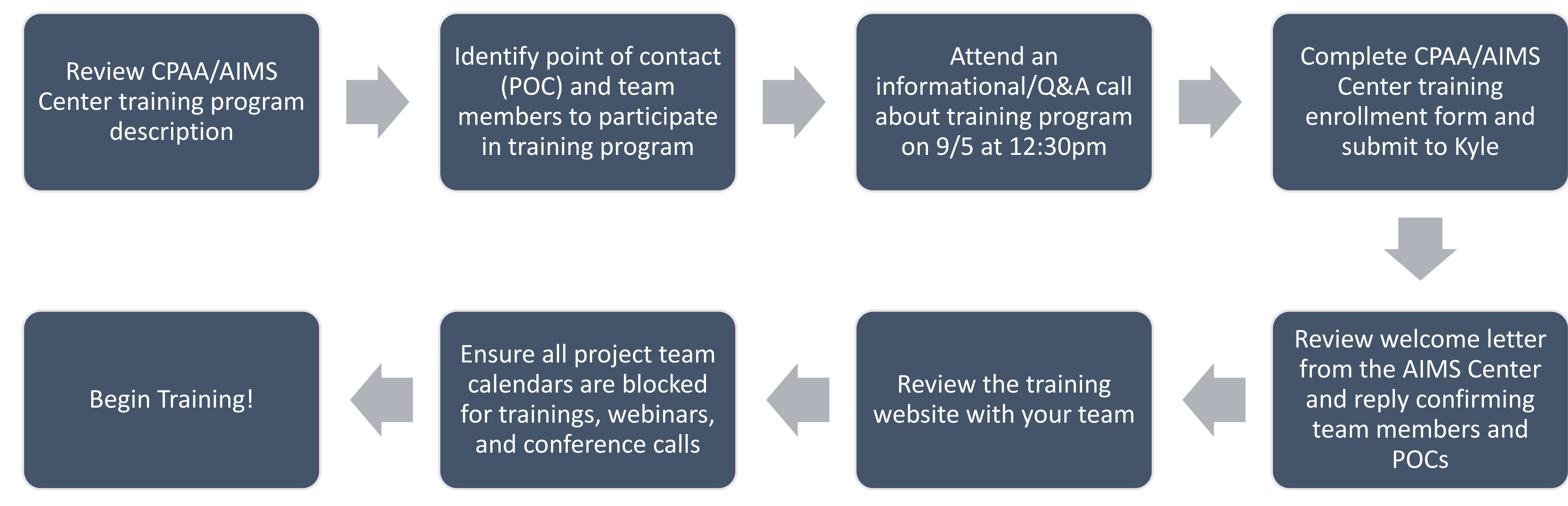
Enrollment Process



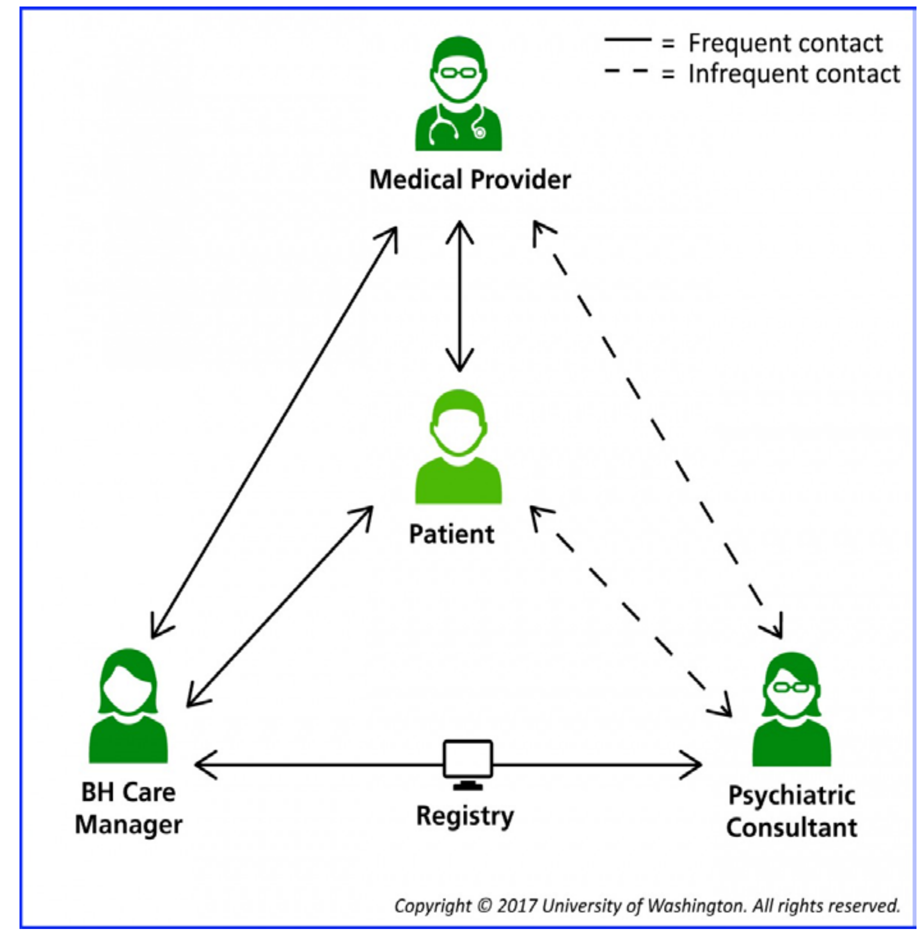
Psychiatric Consultation Opportunity

- Psychiatrist in SW WA looking to fill psych consultation role
- Currently in Community-Based Integrated Care Fellowship at UW
- Preference to work in CoCM involving MAT and addiction medicine
- MAT program consultation

Psychiatric Consultation

- Supports collaborative care team through regular consultation
  - Advises prescribing medical provider
  - Educates care manager
  - Reviews patient registry
  - Recommends treatment adjustments
  - Writes consultation notes

- All of this time is billable



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Change Plan Draft

- Required planning tool document for MTP activities
- Goals, implementation progress, accountability
- Usable document over 4 years – update as necessary

PROJECT AREA: Bi-Directional Care Integration						
EVIDENCE-BASED INTERVENTION: Integrating behavioral health into primary care - Collaborative Care Model & Bree Collaborative						
SMART Goal: Implement the integrated care standards outlined in the Bree Collaborative Report by 9/30/2019.						
Metric(s)	Data Source	Data Frequency	2017 Baseline[1]	2019 Target	2020 Target	2021 Target
1. *MeHAF Site Self Assessment*						
2. *Depression Screening and Follow Up for Adolescents and Adults*						
3. *Depression Remission or Response for Adolescents and Adults*						
Notes:						

Planning (October 2018-December 2018)		
Milestones	Target Date	Lead Person

[1] If data in not available, describe the process in which you will collect data.

PROJECT AREA: Bi-Directional Care Integration						
EVIDENCE-BASED INTERVENTION: Integrating primary care into behavioral health – Co-located, enhanced collaboration						
SMART Goal: Implement the core principles of collaborative care for effective integration of physical health services by 8/31/2019.						
Metric(s)	Data Source	Data Frequency	2017 Baseline[2]	2019 Target	2020 Target	2021 Target
1. *MeHAF Site Self Assessment*						
2. *Universal BMI screening and follow-up plan*						
3. *Universal blood pressure screening and follow-up plan*						
Notes:						

Planning (October 2018-December 2018)		
Milestones	Target Date	Lead Person

[2] If data in not available, describe the process in which you will collect data.

Implementation (January - December 2019)		
Milestones (insert additional milestones)	**Target Date**	**Lead Person**
Establish integrated care team including BH specialist/ care manager and psychiatric services		
Establish integrated care team's vision statement		
Implement patient registry (write name in reporting template)		
Identify patient population to track in registry (define in reporting template)		
Identify behavioral health metrics tracked in registry (list in reporting template)		
Implement screening tools in primary care setting for BH conditions (list tools in reporting template)		
Implement PDSA or other QI process demonstrating BH screening workflow has been tested		
BH provider/care manager trained on EBP in primary care		
PCP(s) trained on evidence-based best practices for psychotropic medications		
Incorporate project 2A metrics into current QI/patient satisfaction program		
Establish billing for BH providers		
Engage with payers to establish long term sustainability of integrated care program		
Scale and Sustain (Jan 2020-2021)		
Milestones	**Target Date**	**Lead Person**

MTP Transformation Activities

External Supports Needed (CPAA Staff, Technical Assistance, Training)	
Support Details	**Justification**
Potential Implementation Risks (What could go wrong? How could the risk be mitigated?)	
Potential Risk	**Mitigation Plan**
Health Equity Activities (How will a health equity lens be used in decision making and providing services?0	
Milestone	**Expected Outcome**

Date Updated/Reviewed: __/__/____

Attestations:

1. We are registered and active in the Financial Executor Portal.

Yes	No

If "No" what steps have you taken to register in the portal:

2. A quality improvement/assurance plan is in place and ready for review upon request.

2A Change Plan Metrics

- Primary care settings
  - MeHAF Site Self Assessment
  - Depression screening and follow up
  - Depression remission and response
- Behavioral health settings
  - MeHAF Site Self Assessment
  - Universal BMI screening and follow up plan
  - Universal blood pressure screening and follow up plan
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (Pediatrics)

Work Group Structure Moving Forward

Goal: Identify a work group structure that is highly effective in delivering education, incorporating quality improvement, and increasing engagement

1. What best describes what you've gained from attending this work group?
2. What best describes what you would like to gain?
3. What educational content would you benefit from in future meetings?
4. How do you envision quality improvement being an aspect of this work group?
5. Any additional thoughts to share?

Summary and Next Steps

- Next steps
  - Next meeting is August 28
  - Informational call is 9/5/18 at 12:30pm
  - Complete your enrollment forms