



Delaware Center for
Health Innovation

Integration of Behavioral Health and Primary Care

January 13, 2016

Introduction

Since July 2014, the Delaware Center for Health Innovation (DCHI) has been convening stakeholders to establish goals for primary care transformation as a key element of Delaware's Health Innovation Plan, contributing to our broader aspirations for improved health, health care quality and experience, and affordability for all Delawareans. While our early work has focused on the general concepts of advanced primary care, the strategy outlined in this consensus paper builds on this foundation to describe our perspective on how we can improve behavioral health care in Delaware through better integration of behavioral health and primary care services.

In order to address the twin challenges of pressing behavioral health needs and associated costs to the system, DCHI has developed a strategy to promote integration of behavioral health and primary care across Delaware. Leaders in Delaware's health care community agree that better integration of behavioral health and primary care will improve chronic disease management and be instrumental in achieving the Triple Aim. To develop this strategy, DCHI convened an advisory group of Delaware experts in primary care and behavioral health. This group identified barriers limiting behavioral health integration today, discussed successful elements of integration and lessons learned through reviews of local and national case studies, and provided input on a set of prioritized options to accelerate integration. DCHI has also sought feedback from providers, purchasers, payers, and other health care organizations about the proposed approach and areas of alignment.

As a result of this work, DCHI puts forward this consensus paper which describes: (1) the case for behavioral health and primary care integration in Delaware; (2) the focus of Delaware's strategy; (3) a vision for behavioral health integration; (4) support for realizing the vision; (5) performance and evaluation of the strategy; and (6) a timeline for implementation. Our goal is for the DCHI Board to adopt this paper as a consensus stakeholder view and position on the strategy for behavioral health.

Following from the adoption of this consensus paper, DCHI will develop an implementation plan for the strategy outlined in this paper and more comprehensively address challenges with respect to payment and workforce development which are introduced in this paper but require further consideration and stakeholder input.

The case for behavioral health and primary care integration in Delaware

BEHAVIORAL HEALTH AND THE TRIPLE AIM

DCHI broadly defines behavioral health as the state of mental and emotional wellbeing. Behavioral health conditions – including mental illness, substance abuse, the impact of stress on chronic illness, and unhealthy behaviors – are common. Approximately 15-30% of the U.S. population currently carry a behavioral health diagnosis.¹ The impact of behavioral health conditions on health outcomes and cost is significant. Individuals with a behavioral health condition have a higher risk of death and have more than twice the total medical cost (per member per month spending across payers) than those without a behavioral health diagnosis.²

Behavioral health conditions are common presenting features of patients in primary care. Approximately 30-50% of adults with a medical condition also have a mental health condition and almost 70% of adults with mental health conditions have a medical condition.³ Consequently, behavioral health conditions are frequently treated in the primary care setting.^{4,5} A behavioral health diagnosis often correlates to poorer overall health and unhealthy behaviors such as smoking, obesity, and non-adherence to medical treatment.⁶ In the primary care setting, health psychology plays a key role in understanding how psychological and behavioral factors contribute to physical health.

CURRENT SITUATION IN DELAWARE

According to America's Health Ranking, Delaware's overall health is below average compared to other states. The state has a growing burden of chronic disease and a persistence of underlying unhealthy behaviors. The number of diabetics exceeds the national average (11.1% versus 9.6% nationally) and the prevalence of obesity has significantly increased over the last ten years with more than 30% of Delawareans being classified as obese.⁷ Delaware also faces significant mental and behavioral health

¹ www.nimh.nih.gov, accessed on 11/24/2015.

² Walker, E.R. et al. (2015). *JAMA Psychiatry*. 72(4):334-341; The Kennedy Forum ISSUE BRIEF: Fixing Behavioral Health Care in America. A National Call for Integrating and Coordinating Specialty Behavioral Health Care with the Medical System.

³ Druss, B.G., and Walker, E.R. (2011). *Mental Disorders and Medical Comorbidity*. RWJF; Melek, S and Norris D. (2008). Chronic conditions and comorbid psychological conditions. Milliman.

⁴ SAMHSA (2012). Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings.

⁵ Kessler et al. (2005). *N. Engl. and J. Med*; 352: 2515-23.

⁶ DiMatteo, M.R., Lepper, H.S., and Croghan, T.W. (2000). *Archives of Internal Medicine*; 160, 2101-2107.

⁷ America's Health Ranking, <http://www.americashealthrankings.org/DE>, accessed 11/23/2015.

challenges. For example, 6.9% of adults report depression and the proportion of adult Delawareans considering suicide rose between 2009 and 2011 (from 3% to 4.3%).⁸

In Delaware, behavioral health and primary care often operate independently, potentially leading to poor behavioral and physical health outcomes and increased costs. Although providers in Delaware continue to experiment with models of integrated care for primary care and behavioral health, few of these have been rolled out on a large scale.⁹

Delaware's providers describe several fundamental barriers to scaling these models statewide:

- **Fee-for-service environment:** Similar to the challenges for coordination of care more broadly, the prevailing fee-for-service payment model impedes integration of behavioral health and primary care. Providers describe ambiguity and variance in reimbursement for a range of integrated care services such as same day consultations, consultations between clinicians, health and behavior services (integrated services) provided by both licensed psychologists and social workers, and front-line screening and treatment for some behavioral health conditions performed by PCPs.
- **Access:** A common challenge to achieving integration is the lack of trained behavioral health providers, particularly in rural areas. Nationally, the critical shortage of behavioral health clinicians in the face of increasing need was highlighted in a 2013 report to Congress.¹⁰ In Delaware, there is a shortage of behavioral health clinicians, and specifically a shortage of psychiatric prescribers with significant variation in access across the state.¹¹ Integration of behavioral health and primary care is not intended to solve the broader access challenge in Delaware. However, access issues limit the availability of behavioral health clinicians working with primary care practices to integrate, co-locate or build co-management agreements.
- **Structural barriers:** Communication between clinicians represents a critical component of delivering integrated care. Currently, behavioral health and primary care clinicians typically do not work from common health records. Providers also describe a general lack of understanding of federal and state policies about sharing behavioral health information across organizations.
- **Training:** Many of today's clinicians have not been trained to work on integrated primary care and behavioral health teams. Primary care clinicians may also need additional training to feel comfortable managing patients presenting with substance

⁸ SAMHSA, State Estimates of Substance Use and Mental Disorders from the National Survey on Drug Use and Health, 2009-2011.

⁹ Project Echo, Nemours, Westside Family Practice, Christiana Care Health System, La Red Health Center.

¹⁰ SAMHSA. (2013). Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues

¹¹ Toth, T. (2014). Delaware Behavioral Health Workforce.

abuse or other behavioral health conditions. Clinicians may also have a limited understanding of the benefits of integration or the new skills required of them.

MODELS OF BEHAVIORAL HEALTH AND PRIMARY CARE INTEGRATION

There are several models for behavioral health integration in primary care which occur along a continuum from fragmented care with limited integration towards the fully integrated, collaborative care model.

EXHIBIT 1. CONTINUUM OF APPROACHES TO BEHAVIORAL HEALTH INTEGRATION



The models of behavioral health integration fall into three categories along this continuum:

- **Collaboration or full integration.** Primary and behavioral health services may be integrated into one care team that jointly develops and executes a care plan for the patient. This may occur by integrating behavioral health services into primary care clinics or by integrating primary care services into behavioral health clinics. For the purposes of this strategy, we will focus on integration into primary care although we recognize that there is also a need to provide better access to primary care for patients with severe and persistent mental illness within the behavioral health setting in which they most often receive services.
- **Co-location.** Delivery of both primary care and behavioral health services occur in the same location or site. This may provide an established referral relationship between providers and an opportunity for improved access for patients. Co-located practices may coordinate to varying degrees, but generally do not share responsibility for patients, provide care coordination or other key components of the collaborative model.
- **Coordination or remote collaboration.** Behavioral health and primary care clinicians may coordinate care, but the actual delivery of services occurs in different settings. In this model, basic information about the patient is generally established and behavioral health care is facilitated through referral relationships. Telehealth can enhance the remote collaboration model by enhancing patient access to a full therapeutic relationship and can move a practice closer to the fully integrated model in areas with a shortage of behavioral health clinicians.

Studies have found that collaborative care can be effective in improving physical and behavioral health outcomes, reducing costs and providing a better patient experience of

care.¹² Addressing common behavioral health disorders, such as depression and anxiety, together with chronic medical conditions substantially improves outcomes and experience of care when compared with treating a chronic medical condition in isolation. For example, the literature suggests that individuals with diabetes and comorbid depression are better able to manage their diabetes, have improvements in exercise and overall functioning, and have lower total health care costs when their depression was treated along with their diabetes.¹³ Programs that have integrated behavioral health professionals in the primary care setting have also demonstrated reduced ER and primary care utilization, reduced total medical costs, and improved medical outcomes.¹⁴ Several different models have incorporated key elements of the collaborative model (e.g., the team-based approach and information sharing) in innovative ways to meet the needs of their communities and have had success.¹⁵

FOCUS OF DELAWARE’S STRATEGY

The preferred model for a primary care practice or system may depend on patient needs, the collaboration skills of the clinicians, and the capacity of the health care team and setting. The National Council for Behavioral Health’s four-quadrant model provides a framework to identify how different population needs can best be addressed in the primary care space, as described in Exhibit 2.¹⁶

¹² Institute for Healthcare Improvement, R&D Report. (2013). Integrating behavioral health and primary care; Health Leaders, Integrating Mental Health and Primary Care; Institute for Healthcare Improvement Integrating Behavioral Health into Primary Care. (2014).

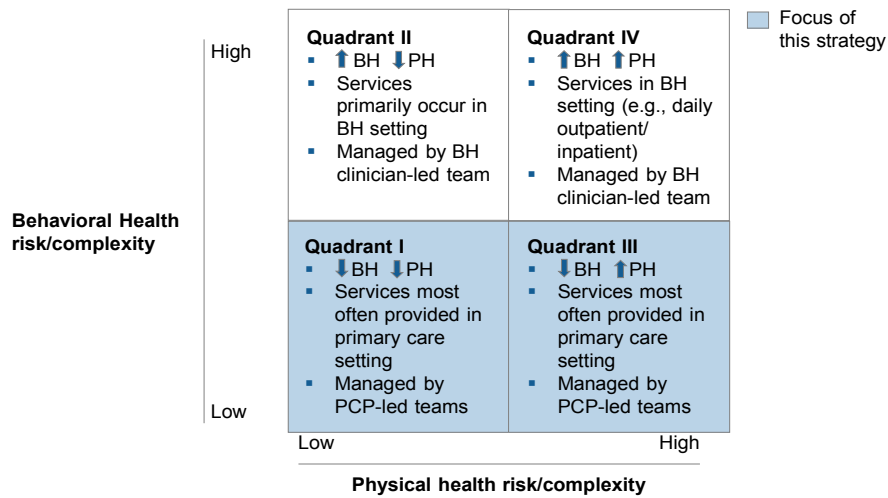
¹³ Williams, J.W., Katon, W., Lin, E.H. et al. (2004). The effectiveness of depression care management on diabetes-related outcomes in older patients; Katon, W., Unutzer, J., Fan, M.Y. et al. (2006). Cost-effectiveness and net benefit of enhanced treatment of depression for older adults with diabetes and depression: IMPACT program.

¹⁴ Unutzer, J., Katon, W.J., Fan, M.Y. et al. (2008). Long-term cost effects of collaborative care for late-life depression. Reiss-Brennan, B., Briot, P.C., Savitz, L.A., Cannon, W., Staheli, R. (2010). Cost and quality impact of Intermountain’s mental health integration program.

¹⁵ Pourat N et al. (2015). One-Stop Shopping: Efforts to Integrate Physical and Behavioral Health Care in Five California Community Health Centers; Sandber SF et al. (2014). Hennepin Health: A Safety-Net Accountable Care Organization For The Expanded Medicaid Population; Intermountain Healthcare. (2014). A Team-Based Approach to Mental Health Integration in Primary Care

¹⁶ Mauer, Barbara J. (2009). “Behavioral Health/Primary Care Integration and the Person Centered Healthcare Home”. The National Council for Behavioral Health Care.

EXHIBIT 2. FOUR QUADRANT MODEL



Source: Adapted from Mauer, Barbara J., "Behavioral Health/Primary Care Integration and the Person Centered Healthcare Home", April 2009. The National Council for Behavioral Health Care.

In this model, patients are stratified by behavioral health needs and physical health needs. For the purposes of this strategy, DCHI will focus on patients in quadrants I and III with chronic physical conditions and relatively lower behavioral health needs. DCHI also recognizes that patients with higher behavioral health needs will present in primary care. For these patients, behavioral health specialists outside the primary care practice may need to be involved in providing care through co-management agreements. Our focus on integrating behavioral health into primary care is also complemented by ongoing initiatives focused on improving behavioral health and physical health care for patients with greater behavioral health needs (e.g., initiatives to improve access and care for patients with severe and persistent mental illness or substance abuse advanced by the Division of Substance Abuse and Mental Health and the Division of Medicaid and Medical Assistance).

Vision for behavioral health integration

Our goal is that all Delawareans should receive convenient, effective, well-coordinated care from the appropriate provider across the continuum of care in a way that supports the Triple Aim. DCHI recognizes that Delaware PCPs may be providing integrated care to varying degrees across the clinical integration continuum, ranging from fragmented care to a collaborative model. DCHI also recognizes that the design decisions around behavioral health integration may vary from practice to practice based on differences in provider scale, patient population, and geographic location. DCHI proposes the following vision and aspirational approach for achieving integrated behavioral health and primary care:

VISION

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

ASPIRATIONAL APPROACH

DCHI's perspective on the aspirational approach to integration in Delaware reflects national best practices for integrated care tailored to Delaware's needs. Recognizing that practices may employ different models, DCHI believes that the following core elements should be considered in the implementation of behavioral health integration:

- 1. Team-based approach.** DCHI strongly recommends that teams of behavioral health and primary care clinicians collaborate within a setting that is most accessible to the patient (e.g., primary care, chronic disease management or chronic mental health). In building a multi-disciplinary team, practices should consider resources such as clinician-to-clinician consultation on medication management, ready access to brief interventions, care coordination to follow a patient through the continuum of care, and the role of non-clinician health team members (e.g., community health workers) working under the supervision of behavioral health and primary care clinicians to provide culturally competent care. These resources can strengthen the team's ability to address behavioral health needs. For the purposes of this paper, we will focus on behavioral health integration into primary care. Preferably, the team would include a behavioral health provider who is located on-site who assists patients with behavioral health conditions and managing the emotional impact and logistical complexities associated with handling chronic conditions. For more complicated behavioral health patients, behavioral health specialists will co-manage patients with the primary care provider with a focus on seamless information sharing and shared responsibility for patient outcomes. This team member may provide different types of services

including counseling, care coordination for patients, referrals to the appropriate resource for further treatment, and coaching on skills and tools to improve self-management (e.g., coping skills, behavioral modification).

- 2. Population management.** Identifying high-risk patients (identified by high costs or utilization, or by chronic medical conditions) who may also have a behavioral health need is foundational to better managing care for individuals with comorbid chronic physical and behavioral health conditions. Universal behavioral health screenings are another tool which can be used to identify patients with behavioral health needs. Interventions in this group would be targeted at addressing the underlying behavioral health condition and any unhealthy behaviors that may contribute to the development of more complex health problems. After identifying patients with behavioral health needs, creating and managing a registry may help practices to ensure these patients receive appropriate follow-up, to monitor adherence to treatment, and to identify and prevent gaps in care.
- 3. Clinical practice guidelines.** Practitioners in an integrated practice will come to a consensus and adopt or modify existing clinical practice guidelines such as an algorithm for the treatment of depression and/or anxiety or referral guidelines. These can build on the strength and expertise of all of the team members and improve comfort with shifting roles so that all team members can practice at the top of their license.
- 4. Information sharing.** Members of the team will communicate certain components of patient care (e.g., medications, active diagnoses, treatment goals) seamlessly through the development of a care plan and integration of electronic medical records. It will be critical that this level of communication extend beyond the primary care team to include the full behavioral health infrastructure should the patient require a higher level of care. Other key aspects of information sharing include warm handoffs directly from a clinician to a behavioral health coach or provider, and communication to close the referral loops.
- 5. Shared panel responsibility.** Responsibility for quality metrics, goals and incentive payments are shared by primary care and behavioral health clinicians. Behavioral health and primary care clinicians must feel equal responsibility for the overall health of their patient panel. This may occur through shared goal setting, performance improvement initiatives and shared risk-sharing or incentive payment agreements.
- 6. Expanded access through telehealth.** Telehealth provides individuals with limited access to behavioral health care the opportunity to receive face-to-face consultation with a behavioral health provider for counseling, coaching, medication management and other services. DCHI promotes telehealth for expanded access particularly when utilized to establish a full relationship between the behavioral health provider and the patient.

ALTERNATIVE APPROACH

Recognizing that every practice in the state is not at a stage where they can implement the aspirational approach, DCHI supports other approaches along the continuum of integration. Providers may choose to integrate care through different models based on the complexity and volume of patient needs, accessibility to infrastructure and the required workforce. Regardless of the model of integration, clinicians should practice in a team-based manner that includes joint decision making, sharing of key medical information, and joint responsibility for patient outcomes.

Some considerations to advance practices along the continuum:

- **Co-location.** Locating physical health and behavioral health clinicians in the same building or office space on at least a part-time basis may be a first step to enable clinician-to-clinician communication and coordination and to allow patients improved access to services.
- **Remote collaboration.** Behavioral health and primary care clinicians may establish different systems through which to refer patients and share necessary information. Practices can identify established behavioral health clinicians in their communities with whom to enter into formal co-management arrangements which may improve access, allow for collaboration on practice guidelines and improve information sharing.
- **Centralized behavioral health resources.** Centralized behavioral health services for in-person or telehealth referrals provide an opportunity for consultation and for patients to have expanded access when a resource may not be available on-site or in close proximity. To help foster a clinician-patient relationship, when feasible, we recommend that patients have at least one in-person visit with their behavioral health clinician.
- **Targeted screening.** The DCHI Common Scorecard promotes screening for depression broadly as an important quality effort for the State, but as primary care practices build this capability they may opt to initially focus screening on high-risk patients and provide care management and behavioral health coaching to this population. PCPs may also choose a targeted screening approach for other behavioral health conditions such as anxiety or substance abuse. Additionally, broader screening efforts may be provided by other community resources such as community health workers as part of Healthy Neighborhoods.

Support for achieving the vision

DCHI anticipates that providers may require support to build the capabilities to transition to any of the models described above or to move forward along the clinical integration continuum. We recognize that the integration of behavioral health and primary care represents a challenging and new way of engaging with patients and the health system for many practices in Delaware. DCHI recommends development of the following types of support for providers to adopt these models, some of which are already planned:

EXISTING OR PLANNED RESOURCES ACROSS DCHI PROGRAM AREAS

A. Electronic Health Records for Behavioral health clinicians.

Elements of integration supported: Information Sharing

As part of Delaware's State Health Innovation Plan, the Delaware Health Care Commission (HCC) will provide funding for behavioral health providers to build electronic health record (EHR) capabilities. This likely will be in the form of an incentive payment to providers. DCHI will make recommendations on the functionality for EHRs and membership to Delaware Health Information Network (DHIN) to better enable information sharing, interoperability, and telehealth capabilities.

B. Practice transformation support.

Elements of integration supported: Team-based care, population management, clinical practice guidelines, information sharing

As part of Delaware's State Health Innovation Plan, primary care practices may receive technical assistance to help adopt changes in clinical and operational processes. The milestones outlined in DCHI's Practice Transformation Consensus Paper recognize when practices have integrated population-based models of care delivery. These milestones include important steps to identifying high-risk individuals, defining a multi-disciplinary care team, and setting forth a specific plan to integrate with behavioral health clinicians.¹⁷ Establishing information sharing processes such as care planning and handoffs are also part of the practice transformation process. As practices advance in their transformation process, support may include helping primary care and behavioral health clinicians to build integrated teams, coordination capabilities, and co-management agreements across the continuum of care.

C. Healthy Neighborhoods.

Elements of integration supported: Team-based care

¹⁷ See DCHI's consensus paper on practice transformation at <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Primary-Care-Practice-Transformation.pdf>.

Healthy Neighborhoods represent multi-stakeholder groups that will engage the community in a culturally competent way beyond the health system to improve health outcomes and lower health care costs. At this stage, the design of Healthy Neighborhoods has not been finalized, but some Neighborhoods may choose to address behavioral health needs in the communities, connecting patients to resources that broaden the team collaborating to assist the patient.

ADDITIONAL SUPPORT SPECIFIC TO BEHAVIORAL HEALTH INTEGRATION

D. Support for incorporating integrated care into practices.

Elements of integration supported: Team-based care, population management, clinical practice guidelines, information sharing

DCHI recommends that resources (e.g., vendors, training resources or learning collaboratives) be identified to support PCPs and behavioral health clinicians to design and implement tailored integration plans and share best practices for behavioral health integration. This support may include:

- Assistance in identifying the approach to integration that best addresses patient need and fits with the practice's business model and contextual factors;
- Training for PCPs and behavioral health clinicians on how to work together in an integrated model;
- Assistance for PCPs to identify patients needing services. This may include assistance with selecting and implementing a behavioral screening tool (e.g., PHQ-9) to identify at-risk patients or developing and managing a patient registry;
- Training for clinicians on delivering front-line behavioral health techniques and interventions (e.g., motivational interviewing, screening tools, treatment guidelines, disorder-focused literature and patient handouts, guidelines for medication management) based on clinical practice guidelines;
- Assistance with building an appropriate team including help with hiring a behavioral health clinician with relevant skills or developing co-management agreements for remote collaboration;
- Training for practice administrators and support staff on how to implement important billing codes for integration;
- Assistance in building and implementing an information sharing plan;
- Coordinating regional learning collaboratives to share best practices.

E. Support for building telehealth capabilities.

Elements of integration supported: Team-based care, information sharing, expanding access through telehealth

Integration of a behavioral health clinician into primary care may not be feasible in some situations, due to scarcity of space or geographic limitations. In these instances, telehealth may improve access for patients and help a primary care practice move forward on the continuum towards integrated care by bringing behavioral health providers into the patient care team and allowing for opportunities for information sharing. Telehealth capabilities should focus on improving access and continuity of care, providing decision support to PCPs, improving attendance and adherence, reducing travel strain and cost, and allowing PCPs to focus on primary care medical conditions.

DCHI recommends that PCPs and behavioral health clinicians be provided with support to operationalize telehealth capabilities and connect with established behavioral healthcare groups that offer telehealth services. Types of support may include technical assistance for implementation, funding for infrastructure and/or technology, and guidance on reimbursement. Support for telehealth should focus on primary care practices in areas with behavioral health professional shortages to build their telebehavioral health program. We estimate there to be approximately 100 primary care practices in Health Resources and Services Administration (HRSA) designated Mental Health Professional Shortage areas.

F. Data and reporting to enable integrated care.

Elements of integration supported: Population management, clinical practice guidelines

PCPs should be supported with data and reporting to identify high-risk patients with behavioral and physical health comorbidities or those at-risk for developing chronic disease. Over the coming months, DCHI should develop a set of recommendations regarding practice data needs and a proposed approach for providing this information to clinicians.

G. Guidelines and common templates for information sharing.

Elements of integration supported: Information sharing

DCHI recommends convening providers to develop a consensus view on common standards for information sharing (ideally electronically). This consensus may include the development of standardized referral and feedback forms to facilitate information sharing between behavioral health and primary care clinicians that are not on the same EHR system. It may also include recommendations on how to achieve interoperability with state entities and other agencies capturing health information, such as the Delaware Health Information Network.

SUPPORT FOR SUSTAINABILITY OF INTEGRATED CARE

H. Ongoing dialogue on reimbursement for integrated behavioral health and primary care.

Elements of integration supported: Team-based care, population management, clinical practice guidelines, information sharing, shared panel responsibility

DCHI also recommends developing the long-term goal of sustainability for behavioral health integration. We recommend convening payers and Accountable Care Organizations (ACOs) to work towards a consistent strategy for reimbursing integrated behavioral health and primary care and to consider innovative payment models that integrate behavioral health (e.g., shared risk agreements based on total cost of care). This strategy should focus on four areas:

- Exploration of innovative payment models that include shared goals and incentives for PCPs and behavioral health clinicians practicing together collaboratively.
- Within the context of the current environment, ensuring reimbursement for behavioral health services identified in this paper as integral to delivering integrated care. These include universal screening, brief intervention and referral to treatment for substance abuse and behavioral health conditions, and the assessment and treatment of behavioral health conditions with and without physical health diagnoses performed by either PCPs or behavioral health clinicians (e.g., licensed psychologists, Masters level clinicians, psychiatrists and others as designated by the State);
- Creating a sustainable telehealth model for both psychiatric and other behavioral health services. This includes telemedicine from a remote location-to-site or from home-to-site;
- Ensuring reimbursement for same-day consultations for prevention and treatment of chronic conditions and behavioral health conditions within the primary care context or the traditional behavioral health model;

DCHI encourages payers to work with primary care practices to fund improvements to move along the clinical integration continuum towards collaborative care and to provide incentives for sustaining integration and evaluate options for developing joint incentive-based payment agreements with collaborating primary care and behavioral health practices.

I. Establishment of a knowledge community on integrated care.

Elements of integration supported: Team-based care, population management, clinical practice guidelines, information sharing, shared panel responsibility

In collaboration with the health sciences community, DCHI supports the longer-term strategy to build capabilities for integrated care through knowledge elevation and dissemination. The primary goals would be:

- **New workforce training.** DCHI would convene a panel of academic institutions to develop training in integrated care for primary care and behavioral health

trainees entering the workforce. This work would be supported by the DCHI Workforce and Education Committee.

- **Sharing best practices.** DCHI would collaborate with academic institutions to gather best practices and disseminate the information through trainings and learning collaboratives to front-line behavioral health and primary care clinicians.
- **Research, evaluation and planning.** DCHI will support academic institutions in evaluating the outcomes of behavioral health integration and testing the impact of innovative models.

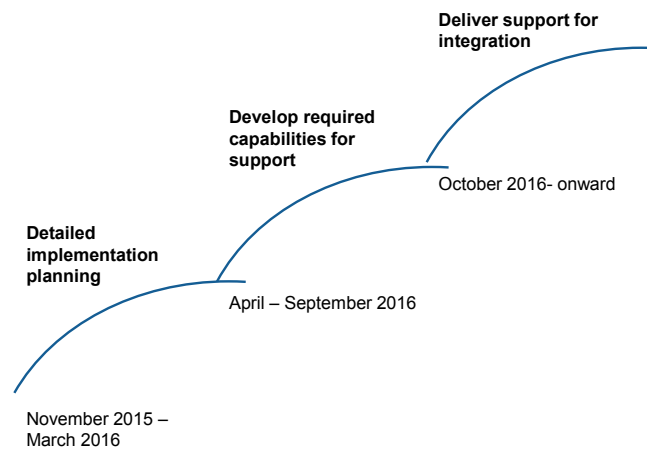
Performance and evaluation

Our evaluation program should assess whether behavioral health integration increases efficiency, produces better overall health outcomes, and lowers costs. Evaluation should occur on an ongoing basis through quality measures, utilization measures, process measures and patient experience measures.

- 1. Process measures** should be used to track implementation of the behavioral health strategy. The number of practices who have developed a plan to address the behavioral health needs of their patients will be collected as part of practice transformation support. DCHI is considering developing a clinician survey to track progress towards the Health Innovation Plan goals. Questions to determine the number of PCPs who have either a behavioral health clinician integrated into their practice or a contractual agreement with a behavioral health clinician/group may be included.
- 2. Quality and utilization metrics** from the Delaware Common Scorecard, which consists of 26 quality and efficiency measures that incentivize high quality, patient-centered, and cost effective care should be tracked for practices participating in models of integrated care. Additionally, specific behavioral health measures should be tracked to monitor clinical progress and adherence to treatment guidelines (e.g., improvement in PHQ-9 scores, patients with depression receiving appropriate treatment).
- 3. Patient experience measures** should be used to track improved experience of care for patients and their families. Metrics may include the percentage of surveyed members reporting overall satisfaction with treatment and services, the percentage of surveyed members reporting a positive experience with access to behavioral health interventions, the percentage of patients reporting improved outcomes or level of functioning as a result of treatment and services. This survey may need to be developed if an existing tool is not available.

Timeline for implementation

EXHIBIT 3. TIMELINE FOR IMPLEMENTATION



Our goal is to adopt a consensus stakeholder view and position of the DCHI Board on behavioral health integration by late 2015. We envision the following timeline for implementation of this strategy:

Detailed implementation planning (December 2015–March 2016)

This will include estimating the number of clinicians to be supported, determining the specific form the support will take and over what time period support should be offered, developing a budget, and identifying potential options for funding support for each component of clinician support. The planning phase may include an evaluation of different approaches to implementation such as a phased approach where different collaborative models may be tested in a variety of practice types (e.g., large practices with existing behavioral health integration, small practices, residencies).

Develop required capabilities for support (April – September 2016)

This phase will include development and release of an RFI or RFP(s) by DCHI or HCC to identify organizations to provide technical assistance. It may also focus on identifying the data and reporting needs to enable integrated care delivery. This analysis would serve as a starting point to help providers tailor their plans for behavioral health integration based on the needs of their patient panel and other practice-specific contextual factors. This phase will also focus on convening any advisory groups needed to achieve the recommendations described in this strategy (e.g., convening payers and ACOs).

Deliver support for integration (October 2016 – onward)

This phase will focus on outreach about integrated care and on providing the support that will be made available to providers to achieve the vision described in this strategy.

Appendix

Members of Advisory group who provided input in development of this strategy

- Alan Greenglass, MD (chair), Christiana Care Quality Partners and Medical Group of Christiana Care
- Greg Bahtiarian, DO, Mid-Atlantic Family Practice
- Mike Barbieri, PhD, Division of Substance Abuse and Mental Health
- Traci Bolander, PsyD, Mid-Atlantic Behavioral Health
- Mary Diamond, DO, Terry Children's Center
- Bruce Kelsey, LCSW, Delaware Guidance
- Jim Lafferty, Mental Health Association
- Rita Landgraf, Department of Health and Social Services
- Meghan Lines, PhD, Nemours Pediatrics
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- Kevin Sheahan, MD, Nemours Pediatrics
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- Doug Tynan, PhD, American Psychological Association

Delaware Health Innovation Plan

Delaware aspires to be a national leader on each dimension of the Triple Aim: better health, improved health care quality and patient experience, and lower growth in per capita health care costs. In 2013, the Delaware Health Care Commission (HCC) convened stakeholders across the state – including consumers, providers, payers, community organizations, academic institutions, and state agencies – to work together to build a strategy to achieve these goals. That work culminated in Delaware's State Health Care Innovation Plan followed by the award of a four-year, \$35 million State Innovation Model Testing Grant from the Center for Medicare and Medicaid Innovation to support the implementation of the plan. Combined with additional investments by purchasers, payers, and providers of care in Delaware, grant funds are intended to support changes in health care delivery to create more than \$1 billion in value over the next 5-10 years. DCHI was established in the summer of 2014 to work with the HCC and DHIN to guide the implementation of the strategy as described in the Innovation Plan as a partnership between public and private sectors.