Washington State
Department of Social and Health Services
Behavioral Health and Primary Care
Integration Collaborative

Vision for a System of Integrated Mental Health/Substance Use/Primary Care Treatment Services in Person-Centered Healthcare Homes

Discussion Draft
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Executive Summary

In March 2010, Congress enacted a sweeping set of changes to the American healthcare system with the passage of the Patient Protection and Affordable Care Act (ACA). Along with federal parity legislation, the ACA offers an unprecedented opportunity to rethink how mental health (MH) and substance use (SU) disorders are identified and treated as a part of the healthcare system.

Simultaneously, Washington State embarked on an Integration Collaborative, supported by funding from Washington's Mental Health Transformation Project, to describe a long range (2014-2019) shared vision for a system of integrated person-centered healthcare homes implemented within healthcare reform. This vision reflects the evidence base and the shared language and ideas developed by participating state staff. The vision was articulated with the intent that healthcare reform structural and financing mechanisms be aligned in support whenever possible. The vision process did not address specific structural or financial mechanisms, as these will unfold as part of implementing healthcare reform.

It was recognized that many Washington communities and providers have been working on the integration ideas summarized here for almost ten years and are ahead of the state in their thinking and practice. Others are just starting new initiatives, and still others are only now beginning to think about their future within parity and healthcare reform. However, without attention to barriers, it may be difficult to sustain what is in place and challenging to move forward. While this is a long range vision, opportunities exist to address barriers within state level decisions leading up to 2014.

In the midst of fiscal crisis at the state and national levels, healthcare reform seeks to invest more of the healthcare dollar in better primary care systems. There is also a case for investing more of the healthcare dollar in treatment for MH and SU disorders and ensuring parity of access to these services. A systematic approach will be necessary to ensure that the healthcare system developed for the future is prepared to deliver this vision of person-centered, integrated healthcare to the few (e.g., those with serious to severe MH/SU/physical health conditions) as well as the many (e.g., those with mild to moderate MH/SU/physical health conditions).

A painful paradox is that the current economic crisis forces reduction in services while the future requires expanded access to better integrated services to improve quality and flatten the cost curve—working together on a shared vision can help ensure that current choices maximize future possibilities. Opportunities in the near term include:

- Washington State Medical Home Collaborative
- Washington State Multi-Payer Medical Home Reimbursement Pilot
- ACA Section 2703 Health Homes for Enrollees with Chronic Conditions
- Healthy Options/Basic Health Joint Procurement
- Chemical Dependency and Mental Health Integrated Washington Administrative Code
- PRISM, the DSHS Predictive Risk Intelligence System
- Community Conversations

Introduction

In March 2010, Congress enacted a sweeping set of changes to the American healthcare system with the passage of the Patient Protection and Affordable Care Act (ACA). The ACA includes insurance reforms, coverage expansion for uninsured individuals, healthcare workforce development and changes to the delivery of healthcare through primary care redesign and adoption of payment reforms for primary care, hospitals and medical/surgical specialty providers. Along with federal parity legislation,[1] the ACA offers an unprecedented opportunity to rethink how mental health (MH) and substance use (SU) disorders are identified and treated as a part of the healthcare system.

Simultaneously, Washington State embarked on an Integration Collaborative supported by funding from Washington's Mental Health Transformation Project[2] to:

- Deepen the knowledge and understanding of the state agency participants[a] regarding Integrated Mental Health/Substance Use/Primary Care Treatment Services in Person-Centered Healthcare Homes,[b]
- Study key aspects of healthcare reform,[c] and
- Describe a long range (2014-2019) shared vision for a system of integrated healthcare homes implemented within healthcare reform.

Building on Mental Health Transformation's earlier recommendations regarding integration of services and DSHS's agency vision and health priorities, this vision document outlines ideas for consideration in future healthcare reform policy and financing. It is the distillation of many hours of internal discussion and is intended to support further dialogue and collaboration with community and health systems partners. It reflects the evidence base for integrated healthcare homes and the shared language and ideas developed by participating state staff.

This vision was articulated so that healthcare reform structural and financing mechanisms can be aligned in support whenever possible. The vision process did not address specific structural or financial mechanisms, as these will unfold as part of implementing healthcare reform (e.g., recent documents have been released by the Healthcare Cabinet to test an initial set of ideas; the Joint Select Committee on Health Reform Implementation has been studying patient-centered medical homes).

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[a] Two half-day training sessions were offered to DSHS employees across the agency's program areas. The sessions were also open to staff from the Department of Health (DOH), Health Care Authority (HCA), Department of Corrections (DOC) and other state agencies. Subsequently, the two training sessions were offered to key community stakeholders, including counties (Regional Support Network, Human Service and Public Health directors and staff), Medicaid health plans, the Washington Community Mental Health Council, the Washington Association of Community and Migrant Health Centers, and other interested parties.

[b] Variously known as Patient-Centered Medical Homes, Person-Centered Healthcare Homes, Health Homes, Advanced Primary Care Practices, Intensive Outpatient Care etc. Referred to in this document as integrated healthcare homes, unless reference is made to a project that uses a different taxonomy.

[c] Following the DSHS trainings, a group of about 50 employees from across DSHS as well as key staff from DOH and HCA met for a series of extended work sessions that included additional reading materials, training content, and development of this vision document.

A systematic approach will be necessary to ensure that the healthcare system developed for the future is prepared to deliver this vision of person-centered, integrated healthcare to the few (e.g., those with serious to severe MH/SU/physical health conditions) as well as the many (e.g., those with mild to moderate MH/SU/physical health conditions).

Over the last 50 years, health and human service systems evolved along different pathways. Healthcare experienced consolidation of health plans, hospitals, and provider groups and, generally, focused on covered populations, as Medicaid and Medicare emerged along with commercial coverage. The federal government invested in federally qualified health centers to serve those without coverage. Washington State counties, as local public health entities, frequently provided safety-net healthcare in addition to traditional public health functions.

Washington counties also planned for and managed local mental health, substance abuse, and developmental disabilities services beginning in the 1960s. As the federal government devolved direct mental health and substance abuse funding into state block grants in the 1980s, local governments expanded their management of these services. Based on 1989 legislation, counties started operating as Regional Support Networks in the 1990s, assuming management of residential facilities and Medicaid MH services as well as state general fund and federal block grant MH resources.

By the 1990s, counties (and cities) had expanded into low income housing, employment/training and other activities supported by federal funding streams. The county tax base, limited by legislative authority, supports law/safety/justice, public health and other local government roles. However, counties also have invested in human service initiatives such as domestic violence, sexual assault, youth and/or child care services as well as healthcare provided by safety-net organizations.[d] These services, delivered directly or through contracts, have been "wrapped around" vulnerable individuals as an extension of the healthcare services they received. A systematic relationship between the health and human services sectors, however, has been difficult to achieve because of this history of separate financing, regulatory and results analysis.

In initiating the dialogue among state staff, it was recognized that many Washington communities and providers have been working on the integration ideas summarized here for almost ten years and are ahead of the state in their thinking and practice. Others are just starting new initiatives, and still others are only now beginning to think about their future within parity and healthcare reform. State and federal policy, regulations and financing methods have been documented as barriers to implementing integrated care.[3] Without attention to barriers, it may be difficult to sustain what is in place and challenging to move forward. While this is a long range vision (2014-2019), opportunities exist to address barriers within state level decisions leading up to 2014.

[d] For example, in a 2004 study of human services in King County, the analysis of investment in five goals mutually adopted by United Way, King County, Seattle, Bellevue, and the South King County Human Services Forum (*1.Food to eat and a roof overhead; 2.Supportive relationships within families, neighborhoods, and communities; 3.Safe haven from all forms of violence and abuse; 4.Health care to be as physically and mentally fit as possible; and, 5.Education and job skills to lead an independent life)* reported that over $100 million was being invested by King County, the City of Seattle, and the suburban cities. Unfortunately, these revenue streams have been decimated by the impact of the economy on local governments.

A painful paradox is that the current economic crisis forces reduction in services while the future requires expanded access to better integrated services to improve quality and flatten the cost curve. Working together on a shared vision can help ensure that current choices maximize future possibilities. Collectively the challenge will be to sustain what has already been developed within current resource constraints and encourage integration initiatives that use existing resources in new ways.

Meeting the biopsychosocial needs of our most vulnerable populations is a shared responsibility across state and local governments and other community resources. Given the geographic differences across the state—what works in King County won't work in Asotin County and vice-versa—state policies need to be flexible enough to support the range of communities and their future needs and resources.

A System of Integrated Healthcare Homes: Vision, Values, and Principles

The DSHS Vision:
Safe, healthy individuals, families and communities.

The System Values:[e]

1. Person-centered healthcare which incorporates the voice of individuals and families in creating personal plans of care and in the governance and policy development of the systems that deliver that care
2. Team-based care that integrates general healthcare with treatment for MH/SU[f] disorders, delivered in the setting most acceptable to the persons served
3. Culturally competent care and culturally relevant specific services
4. Individual accountability for personal health and self-management
5. Accountability by the integrated healthcare home, networks of providers and health plans to ensure improved quality and management of total healthcare expenditures in response to statewide goals for health outcomes and costs
6. Prevention and wellness as part of the integrated healthcare home, coordinated with public health and other efforts in the community that provide community-based population prevention, address the social determinants of health, and ensure access to community supports and services necessary for a healthy life in the community
7. Anti-stigma efforts that seek to reduce the barriers for those in need
8. Workforce development that prepares existing and future providers of services with the skills, competencies and mutual respect needed to thrive in integrated care settings

[e] These values are consistent with those articulated in the Fall 2009 DSHS stakeholder meetings.

[f] The broad term, Substance Use Disorder (adopted by the Institute of Medicine in reports relating to improving quality for treatment of MH/SU conditions) is used here to foster awareness of the need for early identification and intervention, as in the Screening, Brief Intervention, Referral and Treatment (SBIRT) model as well as services in the traditional categories of substance abuse and substance dependence.

9. Policy, regulation and finance that aligns with and supports the vision of the integrated healthcare home

The System is Guided by these Principles:

1. The integrated healthcare home assesses the biopsychosocial needs of those it serves and ensures that people are linked to services that address their needs, with particular attention to the complex needs of vulnerable populations.
2. The integrated healthcare home utilizes a prevention/wellness model that includes recommended prevention services, standardized screening and interventions (for MH/SU conditions in primary care and for healthcare in specialty MH/SU treatment settings), early intervention, and wellness education and planning.
3. The integrated healthcare home is holistic[4] and flexible across the life span, assuring family-centered care for children (including attention to the risk factors generated by another family member's illness) as well as end-of-life care.
4. For individuals who are principally served in specialty MH/SU treatment settings, the integrated healthcare home focuses on recovery as an expectation for everyone, improved health and access to primary care, reduced stigma, empowerment, and provision and coordination of social and interpersonal supports (e.g., housing, peer supports, skill building, transportation) that allow other interventions to be effective.
5. The integrated healthcare home is focused on self-management, grounded in recovery and resilience, and connects to community resources that plan and deliver communitywide prevention and health promotion strategies, provide supports and services for individuals with specific needs, and actively educate about prevention and self-management.
6. The integrated healthcare home is supported by training and skill development for all the members of the healthcare team, with the expectation that everyone works at "the top of their license." The training/skill development process defines core competencies, supports clarity of roles, and promotes increased communication and respect among members of the healthcare team, increasing understanding and acceptance of attention to healthcare conditions in specialty MH/SU treatment settings and MH/SU conditions in general healthcare treatment settings.
7. The integrated healthcare home operates in an environment that aligns incentives for providers, patients, and payers by focusing on appropriate care and overall health outcomes, utilization and costs. There is transparency about costs, payment methods and incentives that align with desired outcomes. Funding streams are coordinated and follow the person, based on need rather than eligibility category. Payment and billing rules promote clinical coordination.

A System of Integrated Healthcare Homes: Why

A systematic approach to implementation is necessary to ensure that the healthcare system of the future is prepared to deliver this vision of person-centered, integrated healthcare to the few as well as the many.

In the midst of fiscal crisis at the state and national levels, healthcare reform seeks to invest more of the healthcare dollar in better primary care systems to achieve the three critical objectives articulated by the Institute for Healthcare Improvement's *Triple Aim: 1) improve the health of the population; 2) enhance the patient experience of care (improvement in health care quality, access, and consistency in which care is delivered); and 3) reduce, or at least control, the per capita cost of total healthcare*. The case for investment in the patient-centered medical home as a vehicle for reform was made recently to the Joint Select Committee on Health Reform Implementation by Group Health, the Boeing/Regence Intensive Outpatient Care Program and others.[5]

There is also a case for investing more of the healthcare dollar in treatment for MH and SU disorders and ensuring parity of access to these services. This can be accomplished by 1) ensuring robust specialty services for serious and severe MH/SU conditions and integrating primary care capacity into MH/SU treatment settings and 2) integrating services for mild and moderate MH/SU conditions into primary care settings. Examples of the case for investment in MH/SU services, drawn from the literature, include:

Integrating Treatment for Mild and Moderate MH/SU Conditions in Primary Care Settings

- Example: *Milliman conducted an analysis of the cost impact of co-morbid depression and anxiety on commercially insured patients with chronic medical conditions. They found that*: "*Many individuals with chronic medical conditions and co-occurring depression or anxiety are never diagnosed or treated for their psychiatric conditions…the treatment prevalence rate…is significantly lower than the expected co-morbidity rates…*

  If a 10% reduction can be made in the excess healthcare costs of patients with co-morbid psychiatric disorders via an effective integrated medical-behavioral healthcare program, $5.4 million of healthcare savings could be achieved for each group of 100,000 insured members…the cost of doing nothing may exceed $300 billion per year in the United States." [6]

- Example: *Depression is one of the top ten conditions driving medical costs, ranking 7th in a national survey of employers.*[7] *A study by Simon and colleagues*[8] *showed that people diagnosed with depression had nearly twice the annual healthcare costs of those without depression. The IMPACT model, which integrates collaborative MH services into primary care, has demonstrated significant clinical improvement and cost savings*.[9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19]

Integrating Primary Care Services into Specialty MH/SU Treatment Settings

- Example: *The Veterans Administration placed primary care services in a specialty MH clinic and found that it significantly increased the rates and number of visits to medical providers and reduced likelihood of ED*[g] *use; significantly improved quality of routine preventive services; significantly improved scores on SF-36 Health Related Quality of Life; and was cost-neutral (i.e., primary care costs offset by reduction in inpatient costs).* [20]

[g] Emergency Department

- Example: *In a California analysis of Medicaid Ambulatory Care Sensitive[h] diabetes hospitalizations, individuals with serious mental illnesses (SMI) had a 53% increase in the odds of being hospitalized for ACS diabetes in a given year*.[21] *Analysis has demonstrated that people with SMI die at the average age of 53, have higher prevalence of chronic medical conditions than other Medicaid recipients, and have difficulty accessing and receiving appropriate healthcare services.*[22] *Without access to effective and timely medical care, co-morbid chronic medical conditions can result in lower quality, higher cost ACS hospitalizations*.
- Example: *Kaiser Northern California examined differences in treatment outcome and costs between individuals receiving medical care integrated with SU treatment versus an independent model of delivering both medical care and SU treatment. They found that integrated care patients with Substance Abuse-related Medical Conditions (SAMC) had significantly higher abstinence rates than SAMC independent care patients. SAMC integrated care patients demonstrated a significant decrease in inpatient use, and average medical costs (excluding addiction treatment) decreased from $470.39 PMPM[i] to $226.86 PMPM*.[23]

Treatment for SU Conditions in Specialty or Primary Care Settings

- Example: *Washington State studied Medicaid medical expenses prior to specialty treatment for SU disorders and in a five-year follow up, compared to Medicaid expenses for the untreated population. Average monthly medical costs were $414 per month higher for those not receiving treatment. In the Medicaid population, 66% of frequent users[j] of EDs had SU disorders*.[24, 25, 26, 27]
- *Example: A new 2010 report provides information on Washington's progress achieved in expanding access to treatment for SU disorders—finding that "the increase in…treatment penetration has coincided with a significant relative reduction in rates of growth in medical and nursing facility costs for Medicaid Disabled and GA-U [now Disability Lifeline] clients with substance use problems. By 'bending the curve' in health care costs, the …Expansion achieved an impressive return on investment (ROI)…we estimate an ROI of 2:1 in the first four years of implementation…that is, there were two dollars in…costs saved per dollar invested…"* [28]
- Example: *A related Washington report argues that the Medicaid expansion population will have relatively high rates of SU disorders, that untreated SU disorders drive chronic physical disease progression, resulting in qualification for disability-related Medicaid coverage, and there is a financial incentive for Washington State to provide treatment for SU disorders in the Medicaid expansion population, due to the differential federal match rates for disability-related Medicaid (50%) compared to Medicaid expansion (initially 100%, phasing to 90%*).[29]

[h] Ambulatory care sensitive conditions are those in which the nature of the illness is controllable with effective and timely outpatient care and disease management.

[i] Per member per month

[j] Those with 31 or more visits in a year.

Without addressing the healthcare needs of persons with serious MH/SU disorders as well as the treatment needed for MH/SU disorders in the general population, it may be very difficult to achieve the Triple Aim—services addressing MH/SU disorders can improve quality outcomes and reduce costs.

A System of Integrated Healthcare Homes: Who, What, Where and How

A systematic approach to implementation of this vision requires clarity about who will be served, with what services, delivered where and how.

Population to be Served

The process of developing the vision focused on at-risk, vulnerable populations, including people with physical or developmental disabilities, people whose functional abilities are limited due to MH and/or SU disorders, children in foster care, individuals living in poverty/with low income, and individuals representing diverse ethnicities, racial backgrounds and/or languages.

While vulnerable populations are most at-risk, it is also increasingly clear[k] that the basic premise—services for MH/SU disorders must become integrated with health services—applies to the entire population. The ideas in the vision coupled with the purchasing power of Washington State could influence much of what unfolds in healthcare reform—the Washington way.

The Patient-Centered Medical Home as a Foundation

Describing the "what, where and how" of the integrated healthcare home begins with understanding the concept of the patient-centered medical home[l], which is meant to ensure safe, effective, person-centered, timely, accessible healthcare.[30] Care coordination, provided by a member of the healthcare team, builds a partnership within the team and with the person/family, helping the person: 1) understand the healthcare system; 2) make healthcare decisions and self-management plans; and, 3) obtain access to needed services. Medical homes provide primary care which, generally, includes these services:

- Preventive screening and follow up[m]
- Developmental screening and assessment for children/youth
- Acute primary care
- Women's health
- Care management of chronic health conditions
- Pharmacy, including medication reconciliation and management
- Access to dental, vision, medical /surgical specialties and hospital care

[k] For example, in presentations to the Joint Select Committee on Health Reform Implementation.[5]

[l] A taxonomy that preceded the idea of the integrated healthcare home, which incorporates these medical home ideas.

[m] Newly released regulations under the ACA require that certain preventive services be covered without cost-sharing barriers. These include the services scored as A or B by the United States Preventive Services Task Force (USPSTF) which includes alcohol and depression screening/intervention.

- End of life care (e.g., palliative care, hospice services, education and support for the individual and family)
- Supported by enabling services, access to lab, x-ray, outreach services (i.e., nursing homes, home care)

The Washington Patient-Centered Medical Home Collaborative[31] currently includes 33 primary care practices from across Washington State, working under the auspices of the Department of Health and the Washington Academy of Family Physicians. These practices have completed the first year of a two-year learning collaborative that is focused on primary care transformation, seeking to incorporate the Planned Care Model[n] and change current processes of care to become more patient-centered.

In answer to the question, *How does a patient-centered medical home differ from "good enough" primary care?,* the Collaborative articulated a number of opportunities for process improvement. The following improvement examples are drawn from that work:

- Example: *Open access scheduling for same day appointments plus robust supports outside business hours to prevent emergency room visits; may use e-mail, phone contact, alternate hours or a combination of approaches to create improved access outside regular hours*
- Example: *30 minute visits become the norm particularly for patients with multiple chronic illnesses; patients gain access through e-visits and phone contact to improve overall access*
- Example: *Works on population health using registry to improve care for diagnostic groups or groups that share a common risk; includes healthy patients for prevention and screening services*
- Example: *Care pathways or other protocols clarify the extended role of the nurse or medical assistant so that each team role works to the top of their skill level and each role on the team has a clear added value for the patient*

In addition to the Medical Home Collaborative, Washington State, in partnership with major health plans, will begin the Multi-Payer Medical Home Reimbursement Pilot in 2011. The pilot will test new payment methods that support process improvements such as those described above.

The Integrated Healthcare Home

The integrated healthcare home incorporates the values and guiding principles described above as well as all of the services and approaches described for patient-centered medical homes; it is broader than the patient-centered medical home. It brings together in a single setting the best practices that are now delivered through separate systems (e.g., MH/SU/primary care treatment services)—primary care services are integrated into specialty MH/SU treatment settings and MH/SU treatments are integrated into primary care service settings. There are numerous examples in Washington State of this bidirectional integration of services, in both the public and private sectors.

[n] See Attachment A

The integrated healthcare home is complementary to the established service accountabilities of the state for MH/SU disorders and the specialty MH/SU treatment settings which serve those with serious to severe MH/SU conditions, collaborate with other systems such as the criminal justice system, and implement Involuntary Treatment Act (ITA) services. These specialty MH/SU treatment systems should include the nine areas of support[o] identified in the recent Substance Abuse and Mental Health Administration's (SAMHSA) continuum of services for MH/SU disorders.[32]

Specialty MH/SU treatment settings of the future will need to develop the SAMHSA nine areas of support and corresponding evidence-based practices; develop necessary infrastructure for participation in healthcare systems;[p] continue to improve their coordination with inpatient MH/SU services, including ITA and state hospital services; incorporate access to primary care services (either through on-site services or accountability to connect consumers with primary care); and, add communication around health status as well as MH status when coordinating with other systems.

The integration model for those with mild to moderate conditions is primary care-based MH/SU treatment services. Interaction between primary care and the ITA and state hospital system will be infrequent if "stepped care" models[q] are used and primary care settings transition individuals needing more intensive services to the specialty MH/SU treatment system.

Whether in primary care or in specialty MH/SU settings, evolution of the integrated healthcare home will build on the skills and capacities of practitioners, in clinics and agencies statewide, who are striving to meet the complex needs of those they serve.

Detailed aspects[r] of the integrated healthcare home are described in Attachment C, using the Four Quadrant Clinical Integration Model as an organizing structure and incorporating the Planned Care Model and SAMHSA continuum of MH/SU services.

The Role of Prevention and Community Supports and Services

While public discussion has focused on key elements of healthcare reform, some have been thinking about addressing the root causes of illness and injury—ensuring community capacity to address primary prevention as well as ensuring availability of non-medical supports and services. This is a conversation that has occurred among community partners in many areas of Washington and needs to be expanded into a statewide conversation.

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[o] Healthcare Home/Physical Health, Prevention and Wellness, Engagement Services, Outpatient & Medication Services, Community and Recovery Support (Rehabilitative), Other Supports (Habilitative), Intensive Support Services, Out-of-Home Residential Services, Acute Intensive Services. Reference to Acute Intensive Services in the continuum is considered to include Washington's Involuntary Treatment Act admissions and the services of state hospitals. See Attachment B for the full continuum.

[p] For example, the NIATx Accelerating Reform Collaborative http://www.niatx.net

[q] Such as that successfully deployed in the Disability Lifeline implementation, in which there is primary care registry tracking of clinical and functional outcomes, care management and psychiatric consultation that supports a team-based approach to adjusting care as needed.

[r] Developed during the extended work sessions of participating staff.

We know that many factors influence health status. As just one example, in the ground-breaking Adverse Childhood Experiences (ACEs) study, it was learned that adverse childhood experiences[s] can have a broad-based, harmful influence on adult health which may not manifest for decades. The more kinds of adverse childhood experiences reported, the greater the individual's risk for a given health problem and for more health problems (co-morbidity).[33] The ACEs study and other MH/SU disorders research (e.g., addressing the risk and protective factors associated with adolescent substance use, violence, teen pregnancy) show that prevention must be broad and community-based, as has been demonstrated for years in prevention of chronic health conditions.

The Accountable Care Act includes a substantial focus on prevention—partnerships around the nation are at work on how to implement these concepts.

- Example: *The National Prevention, Health Promotion and Public Health Council is formulating a National Prevention and Health Promotion Strategy. Their draft strategies include activities targeted at early identification and intervention[t] for MH/SU disorders*.[34]
- Example: *In Vermont, pilots of community health teams supporting Medical Homes are funded by the major public and private payers. These multi-disciplinary teams include a prevention specialist from the Vermont Department of Health. Three tasks of the teams are to complete a community risk profile, prioritize prevention interventions and implement a local prevention plan in coordination with the delivery system*.[35]
- Example: *In Atlanta, Fulton County is planning and implementing neighborhood-based "one-stop" health centers that integrate services for primary care, MH/SU disorders and on-site programs that assist with housing, employment services, and public health.*

Communities are complex organisms that rely on the leadership of local government (counties everywhere and cities in densely populated areas) to plan for and provide such services as public health, human services, housing, employment assistance, child care support, law enforcement, jails, and juvenile justice. State and local governments make policies that affect the social determinants of health. Each community includes the leadership of businesses, foundations, faith communities, volunteers—and, every community is different. While the future and the economy demands that the delivery of and purchasing of services will need to adapt, the details will be locally driven. We need to learn more about how the state, as the purchaser and provider of some of these services and supports, can be a part of the system conversations.

To fully achieve the Triple Aim,[u] integrated healthcare homes must be connected to public health and other governmental and private sector community resources, as reflected in the diagram below, to:

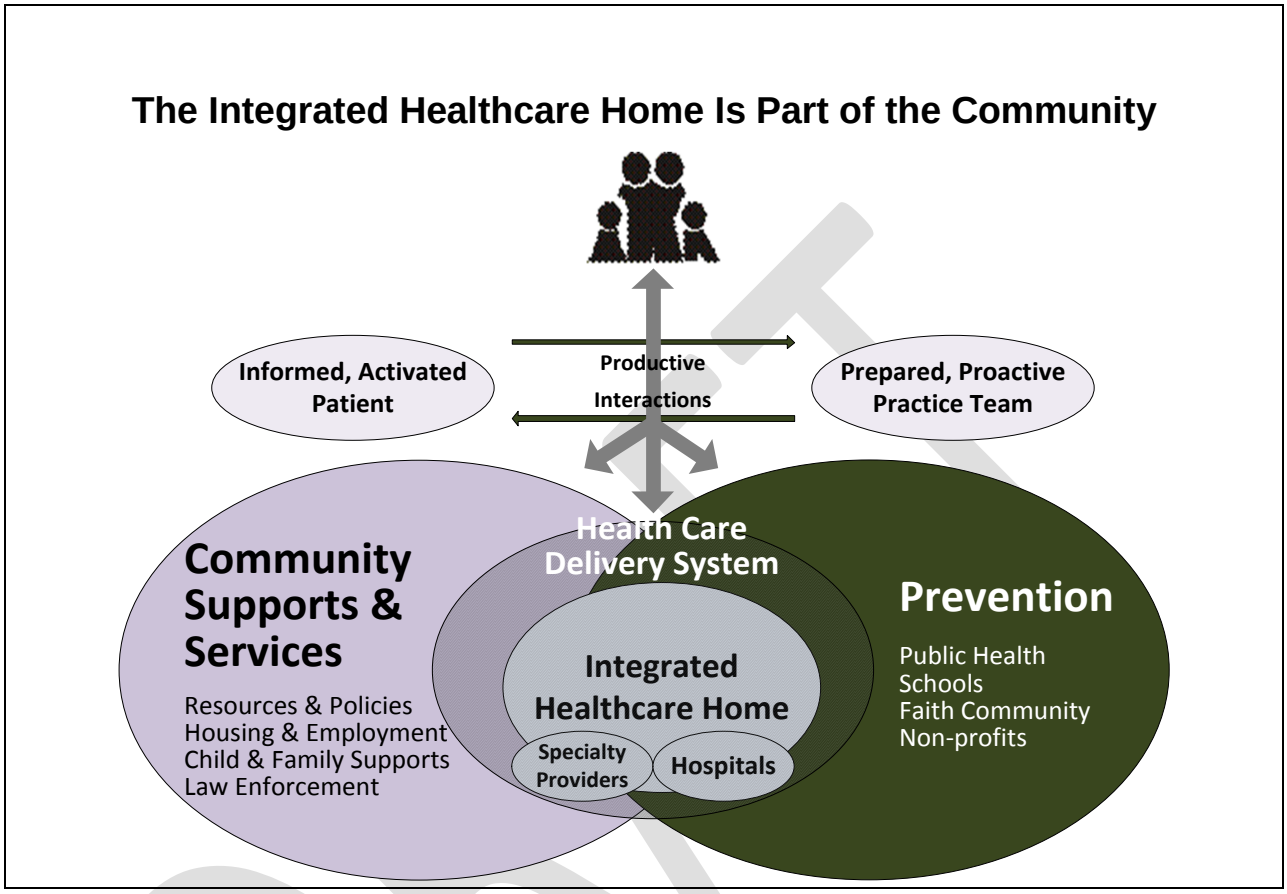
- Develop primary prevention and health promotion initiatives that address MH/SU conditions as well as physical health conditions,

[s] For example, domestic violence, physical abuse or neglect.

[t] For example, alcohol screening and intervention, rated by the USPSTF at the same level as colorectal cancer screening/treatment and hypertension screening/ treatment and depression screening/intervention rated at the same level as osteoporosis screening and cholesterol screening/treatment.

[u] Defined on page 3

- Address the social determinates of health, and
- Ensure community supports and services (formal and natural) are available to address the biopsychosocial needs of children and families, adults, and older adults as well as support individuals' self-management and recovery goals.



The Policy and Fiscal Environment

In *Crossing the Quality Chasm: A New Health System for the 21st Century*[30] the Institute of Medicine described the components of an effective healthcare system, including a payment and regulatory environment that supports providers in developing and maintaining high performing person-centered teams that can achieve the system's aims. Although some communities are seeing success in implementing integrated healthcare homes or integrated service delivery on a small scale, current policies, regulation and finance play a part in how these local efforts can be sustained or expanded. Healthcare reform implementation provides the opportunity to address system barriers.

The vision discussion focused on several ACA-related opportunities that will affect the organization and delivery of healthcare services in the future.[v] Participating staff developed potential approaches to measurement[w] in implementing healthcare reform.

[v] Parity Implementation; Medicaid Plan Amendments for Health Home Pilots; Managed Care for the ABD/SSI and Dual Eligible Populations; Health Plan Exchanges and Benchmark Benefits; and, Accountable Care Organizations.

[w] Summarized in Attachment D

These measures center on tracking access to MH/SU/general health treatment and ensuring that at-risk, vulnerable populations don't "fall through the cracks." The potential measures reflect the learning among participants regarding the implications of healthcare reform as they considered the question, "What would be relevant to measuring the impact of [for example, Accountable Care Organizations] on the development of integrated healthcare homes and vulnerable populations?"

Challenges

Currently, few primary care practices can deliver on the vision of the integrated healthcare home presented here, and few specialty MH/SU treatment providers have developed the corollary capacities that are envisioned for the future. Locally delivered services and state and local purchasing strategies will need to adapt to support the changes required. The scope of development and change in practice is enormous—the implementation process will have to break this down into strategies and supports to be disseminated over time.

The future policy/regulatory and financing environment will need to be aligned with implementation strategies and supports, or transformation will be difficult to achieve. Examples include:

- Develop a statewide uniform data set (MH/SU/general health treatment settings) that can be analyzed to inform policy and practice regarding integrated care outcomes
- Standardize and streamline the documentation requirements across the "silos" of physical health, mental health and substance use treatment services
- Establish a consistent approach to the state's certification/licensure of specialty providers of services for MH/SU conditions—establish standards that are relevant across payer categories and settings of services (primary care vs. specialty)
- Assess current level of adoption of Electronic Health Records (EHRs) in specialty MH/SU provider organizations, impact on productivity, ability to provide data for ongoing measurement as well as research

The overarching challenge is that of moving forward with value-based purchasing, including payment reforms supporting integrated services, within current financial parameters.

Workforce

Throughout the discussion of implementing the integrated healthcare home, the issue of workforce capacity reoccurred. The ACA incorporates significant new initiatives and financing for healthcare workforce development. It will establish a National Health Care Workforce Commission with accountability to study workforce capacity, projected demands, and integration within the health care delivery system.[x] Training and technical assistance for the current workforce as well as those in the academic pipeline is required. It will be important for the state to develop clearinghouse capacity regarding workforce development, to both maximize and coordinate potential workforce initiatives.

[x] Includes nursing, oral health, mental and behavioral healthcare, allied health and public health care.

As federal, state and local initiatives for workforce development move forward, the following ideas should be incorporated, especially in regard to currently employed staff:

- Invest in system training, systems of care, and collaborative learning
- Transform organizational cultures that integrate healthcare through a significant coordinated effort
- Engage the entire staff of provider organizations
- Develop strategies that result in mutual respect among disciplines and effective teamwork models
- Expand diversity of providers and assure culturally competent care and culturally relevant specific services
- Define future roles (navigator, coach, health educator, others) for peers/family partners and develop methods to recruit, train and certify them in these roles
- Identify a set of shared core competencies and evidence-based practices and train to that set for currently employed staff and those in the educational pipeline
- Engage all community partners for local workforce initiatives
- Seek clinical training program curriculum adjustments that support integrated practice

Next Steps

The actions taken in the years leading up to 2014 will be decisive in whether Washington State and its partners use their purchasing power to facilitate implementation of integrated healthcare homes. Near term opportunities for advancing integration include:

- ***Washington State Medical Home Collaborative:*** There is a federal grant opportunity[y] to expand the medical home collaborative to smaller practices. Collaborative staff are also exploring how to build on local systems of care to strengthen current participants' ability to meet the MH/SU needs of patients served. The next Learning Session of the Collaborative will focus on this issue. Several of the current Medical Home Collaborative participants have applied to participate in the Multi-Payer Medical Home Reimbursement Pilot.
- ***Washington State Multi-Payer Medical Home Reimbursement*** **Pilot:** This project, sponsored by the HCA, has engaged eight health plans[z] in development of new payment methods to be piloted in Medical Homes. For small to medium primary care practices, the pilot will pay fee for service plus a care management fee per enrolled patient, plus shared savings. All payers will use the same payment methods and metrics for evaluation, which will focus on avoidable ED and hospital use and meeting quality indicators.
- ***ACA Section 2703 Health Homes for Enrollees with Chronic Conditions:*** MPA/HCA and ADSA are in early stages of developing a response to this grant opportunity which will be informed by the Integration vision.

[y] Agency for Healthcare Research and Quality

[z] United Healthcare, Aetna, CIGNA, Molina, Community Health Plan of WA, Premera Blue Cross, Regence Blue Shield, Group Health Cooperative

- ***Healthy Options/Basic Health Joint Procurement:*** Staff leading the development of the joint procurement participated in creation of this vision document. This is an opportunity for MH/SU/primary care integration concepts to be embedded in the procurement development.
- ***Chemical Dependency and Mental Health Integrated Washington Administrative Code*** (***WAC):*** DBHR Licensing and Certification staff are working with stakeholders to create a combined, simplified WAC for agencies currently working under separate Mental Health, Chemical Dependency and Problem Gambling rules. Application to integrated healthcare homes can be examined as a part of this process.
- ***PRISM:*** PRISM, the DSHS Predictive Risk Intelligence System, is currently being used in several pilots to support care management services in limited settings including community mental health and Area Agencies on Aging. There may be additional opportunities to expand these initiatives into other communities.
- ***Community Conversations:*** Along with these activities, the state wants to participate in an ongoing cross-sector dialogue among government and healthcare leaders towards:
    - Adoption of a shared vision regarding integrated healthcare homes to address the continuum of needs across populations
    - Refining how we will define and measure success in the implementation of integrated healthcare homes and healthcare reform, using the preliminary suggestions in Attachment D as a starting point—the adage that “what we measure is what we do” is central to future progress
    - Establishing a venue to discuss and address barriers and support system transformation
    - Establishing system level training that supports transformational thinking and implementation at the clinical, local and state level

Attachment A: Models Incorporated in The Integrated Healthcare Home

The vision of the integrated healthcare home is built on several national models for improving primary care and the integration of MH/SU services.

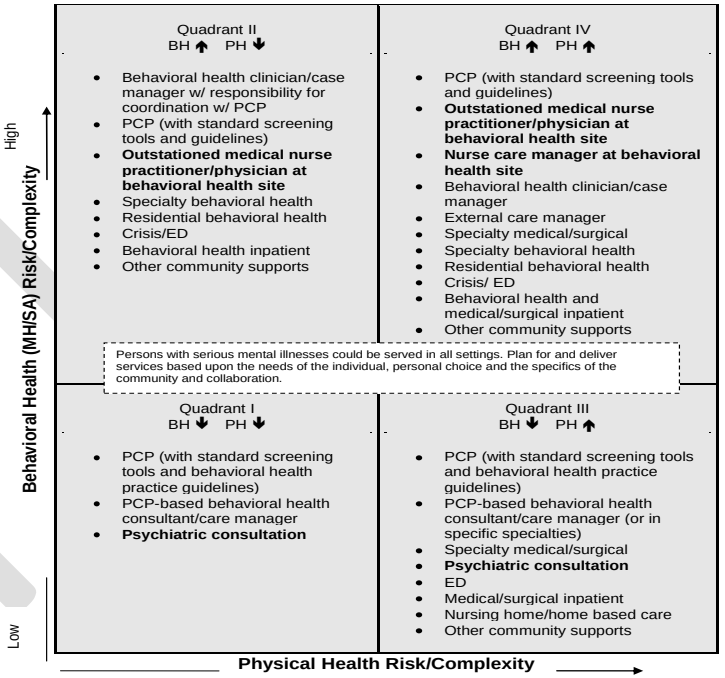
The National Council for Community Behavioral Healthcare's ***Four Quadrant (4Q) Model*** [36] is a planning tool for addressing the needs of the population in each community (system planning must be population-based, while service planning must be person-centered). The 4Q Model indicates that there are levels of care in the mental health, substance use and physical healthcare systems (from primary care to specialty providers, hospitals and emergency rooms) and that the integrated care model needs to be articulated at all these levels. The 4Q model provides a structure for a community to plan across the physical, mental and substance use healthcare systems.

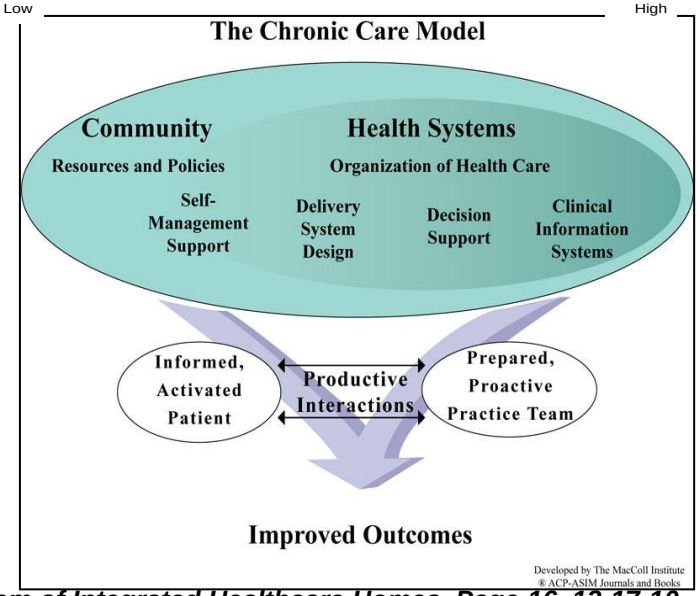
The ***Planned (or Chronic) Care Model***,[37] developed to improve primary care for people with chronic health conditions, such as diabetes or cardiovascular disease, underpins the Medical Home concept. The Care Model expands the view beyond the clinical setting, incorporating self-management and the resources of the family/ neighborhood/community. Care Model Elements[37] include:

1. *"Health System: Create a culture, organization and mechanisms that promote safe, high quality care*
2. *Delivery System Design: Assure the delivery of effective, efficient clinical care and self-management support*
3. *Decision Support: Promote clinical care that is consistent with scientific evidence and patient preferences*
4. *Clinical Information Systems: Organize patient and population data to facilitate efficient and effective care*
5. *Self-Management Support: Empower and prepare patients to manage their health and health care*
6. *The Community: Mobilize community resources to meet needs of patients"*

The Substance Abuse and Mental Health Services Administration has described the elements of a ***Modern Addictions and Mental Health Service System*** and summarized key components of that system in the matrix shown as Attachment B.

The Four Quadrant Clinical Integration Model





These three national models are the foundations of the integrated healthcare home, as further envisioned by participating staff, in Attachment C.

Attachment B: SAMHSA Description of a Modern Addictions and Mental Health Service System

Healthcare Home / Physical Health	Prevention and Wellness	Engagement Services	Outpatient & Medication Services	Community and Recovery Support (Rehabilitative)	Other Supports (Habilitative)	Intensive Support Services	Out-of-Home Residential Services	Acute Intensive Services
• Screening, brief intervention & referral • Acute primary care • General health screens, tests & immunization • Comprehensive Care management	• Prevention Programs* • Wellness Programs* • Smoking Cessation Education Session on MI/SUD • Health Promotion • Brief Interviews • Warm line	• Assessment • Specialized Evaluations (psychological, Neurological) • Service planning (including crisis planning) • Consumer/ Family education • Outreach	• Individual Evidenced Based Therapies * • Group therapy • Family therapy • Multi-family counseling • Medication management • Pharmacotherapy (including Opioid Maintenance Therapies) • Laboratory services • Specialized consultation	• Peer supports • Recovery Support Services* • Family Training & Support • Skill building (social, daily living, cognitive) • Case Management • Continuing Care • Behavioral management • Supported employment • Permanent Supportive housing • Recovery housing • Therapeutic mentoring • Traditional healing services	• Personal Care • Homemaker • Respite • Educational Services • Transportation • Assisted Living Services • Recreational Services • Other Goods & Services* • Trained behavioral health interpreters	• Substance abuse intensive outpatient services • Partial hospital • Assertive community treatment • Intensive home based treatment/ • Multi-systemic therapy	• Crisis residential/ stabilization • Residential services* • Supports for children in foster care	• Mobile crisis services • Urgent care Services • 23 hour crisis stabilization service • Psychiatric inpatient & medical detoxification services • 24/7 Crisis Hotline Services

* Specific activities or services will need to be further defined in the next several months

Attachment C: Detailed Aspects of the Integrated Healthcare Home

These detailed aspects of the integrated healthcare home were developed by participating state staff based on review of the literature and the needs of vulnerable populations.

	Adults and Older Adults		Children and Youth	
	Mild/Moderate MH/SU Needs Quadrants I and III	**Serious/Severe MH/SU Needs Quadrants II and IV**	**Mild/Moderate MH/SU Needs Quadrants I and III**	**Serious/Severe MH/SU Needs Quadrants II and IV**
What and Where				
Be primary care-based and provide the services listed above with Primary Care Practitioners (PCPs) [e.g., Family practitioner, internist, ARNP] knowledgeable enough to evaluate other areas (e.g. MH/SU) and have immediate access (i.e., the "warm hand-off" or psychiatric advice line) to services for MH/SU disorders.	X		X	
Understand that treatment capacity for MH/SU disorders is paramount to the delivery of holistic care, and build internal capacity as well as referral capacity.	X		X	
Bidirectional Integration Locate the PCP in the specialty MH/SU treatment setting to provide access to primary care services for people who principally are seen in specialty MH/SU treatment settings.		X		X
Offer the full range of acute and ongoing specialty services for MH/SU disorders, including evidence-based practices,[38] peer and family supports, housing and employment services, in partnership with community resources. See SAMHSA Modern System continuum.		X		X
How				
For children/youth with more than moderate MH/SU disorders, utilize a wrap-around process to convene a team that includes the child/youth and family that is coordinated by a team facilitator. The team develops a strengths-based plan that includes non-traditional services and supports.				X
Employ a multi-disciplinary team (e.g., the PCP, RN/LPN, MSW, medical assistant) that, to the extent possible, is comprised of staff representing the ethnic and cultural diversity in the community. Team	X	X	X	X

	Adults and Older Adults		Children and Youth	
	Mild/Moderate MH/SU Needs Quadrants I and III	**Serious/Severe MH/SU Needs Quadrants II and IV**	**Mild/Moderate MH/SU Needs Quadrants I and III**	**Serious/Severe MH/SU Needs Quadrants II and IV**
members work "at the top of their license".				
Be available (e.g., small patient load, longer visits, open access scheduling), accessible (e.g., 24/7 access, extended hours, nurse consulting line or other methods), and acceptable (e.g., with empathy, effective communication, quality defined by the person's experience).	X	X	X	X
Adopt and use universal screening tools, uniform protocols and guidelines/decision trees/algorithms. Provide proactive care, using pre-visit client interviews, registries, flags and reminders.	X	X	X	X
Use single treatment plans (that include results of universal screening) as the central document of the Healthcare Home, shared and built collectively among treating providers.	X	X	X	X
Refer out to specialists who refer/communicate back, closing the loop and keeping the PCP as the central information location for care of the individual. Have clear lines for referral to services for special needs. Provide a fast response and subsequent feedback on referrals/requests to and from other providers. Develop universal mechanisms for co-management with specialty care.	X	X	X	X
Use the electronic health record (EHR) for care coordination and continuity of care and to support an individual's access to his/her own record, assisted by other information technology (e.g., flags, registries, telemedicine, telehealth, e-mail access to the team, web-based wellness resources, phone apps, clinic feedback on achieving standard of care and outcomes).	X	X	X	X
Address state and federal confidentiality issues within the Healthcare Home through use of the MOU/release of information/business associate agreement and provide quick access to and sharing of health records. Address issues such as age of consent, guardianship, and other areas related to locus of patient decision making.	X	X	X	X
Person-Centered Focus				
Have a care coordinator function to assist with access to needed	X	X	X	X

	Adults and Older Adults		Children and Youth	
	Mild/Moderate MH/SU Needs Quadrants I and III	**Serious/Severe MH/SU Needs Quadrants II and IV**	**Mild/Moderate MH/SU Needs Quadrants I and III**	**Serious/Severe MH/SU Needs Quadrants II and IV**
services, with each person having a choice regarding the level of coordination provided.				
Engage individuals in their own care, employing strategies (e.g., community-based education, group education, trained peers as health coaches) and tools similar to the Patient Activation Measure (PAM©) and Wellness Recovery Action Plans (WRAP) in support of self-management. Build a partnership between the provider team and the individual that is driven by individual choice/voice.	X	X	X	X
Treat the whole person and teach each person to be his/her own advocate.	X	X	X	X
Support generational care (i.e., recognize that appropriate methods of service delivery differ among age groups).	X	X	X	X
Encourage co-location with other disciplines, or have established relationships that promote fluid transition between areas of care. Consider ways of integrating MH/SU/primary care treatment with the human service/social welfare services that are best for that particular community and individual, treating the whole person and reducing social barriers to receipt of effective care.	X	X	X	X
Assist older and/or disabled individuals with special needs: • Companionship (natural support) beyond family support for kinship care prior to palliative care and hospice • In-home providers and families educated to provide appropriate support • Transportation • Appropriate written communication (e.g., large print, correct voice/tone, age appropriate explanation with minimal jargon) • Access to community/civic supports for basic needs due to physical limitations (e.g., firewood, meals on wheels, help with moving, home and yard maintenance, legal assistance)	X	X	X	X

Attachment D: Potential Measurement Approaches

On October 28, 2010, the National Advisory Council on Healthcare Research and Quality, Subcommittee on Quality Measures, previewed their Final Recommendations for the Initial Core Quality Measures for Adults in Medicaid, as required under the Affordable Care Act. Of the 51 recommended measures, 12 are related to MH/SU disorders. The final recommended measure set will be posted in the Federal Register by January 1, 2011. Comments are currently being collected from Medicaid programs.

The measurement approach for Washington's future performance-based contracting should track the integration of primary care with MH and SU treatment services as well as the impact of healthcare reform on at-risk and vulnerable populations. Consistent measures across multiple elements of healthcare reform[aa] would support a broad assessment regarding implementation of the vision of the integrated healthcare home. The table that follows contains potential measurement approaches for future consideration. They are organized into the following categories:

- Structure (e.g., facility capacity, equipment, staffing levels)
- Process (e.g., how healthcare is provided, how the system works)
- Outcome (e.g., health status, does it make a difference?)[bb]

Potential Measures
Structure
1. Every enrollee has a healthcare home • Evidence of healthcare home capacity (identified PCP, care manager, behavioral health consultant, 24/7 phone access to health advice) • Evidence of face-to-face engagement (either visit instigated by patient within year, or if not, in-person outreach by plan)
2. Degree of MH/SU integration with primary care • Number of healthcare homes where MH/SU and primary care services are organized into a team ÷ all healthcare homes = % of healthcare homes with integrated team-based MH/SU/primary care • Number of healthcare homes where MH/SU and primary care services are in the same building (e.g., Compass) ÷ all healthcare homes = % of healthcare homes with co-located MH/SU/primary care • Number of healthcare homes where MH/SU and primary care services are in the same system (e.g., Multicare) ÷ all healthcare homes = % of healthcare homes with system level access to MH/SU/primary care • Number of healthcare homes where MH/SU and primary care services are offered through referrals across systems ÷ all healthcare homes = % of healthcare homes with referral access to MH/SU/primary care
3. Adoption of Electronic Health Records (EHRs) • Number of healthcare homes with EHR ÷ all healthcare homes = % of healthcare homes with EHR • Number of healthcare homes with EHR that contain core elements (to be established) ÷ all healthcare homes = % of healthcare homes with EHRs containing core elements • Number of healthcare homes with screening that covers all three domains (physical, MH, SU) ÷ all healthcare homes = % of healthcare homes with screening that covers all three domains

[aa] Accountable Care Organizations (ACOs), Health Plan Exchanges, Health Plans, Integrated Healthcare Homes, etc.

[bb] Donabedian cautioned that outcomes measurement alone cannot distinguish efficacy from effectiveness (outcomes may be poor because the right treatment is badly applied or the wrong treatment is carried out well).

Potential Measures
4. Shared information among healthcare homes and specialty providers
• Number of providers in a network that have access to the same EHR or organized Health Information Exchange (HIE) ÷ total providers in the network = % of providers with access to shared information
5. Shared information across payers
• % of enrollees entering any tier of eligibility (Medicaid, Medicaid Expansion to 133% of Poverty, Exchange up to 400% of poverty, Exchange all others) that are captured in a common HIE containing enrollment, demographic, clinical and service data for care management • The HIE serves as the single portal for entry and tracking across the entire system. • This HIE is robust enough to support all the subsequent measure calculations described here. To do that, it must have some PRISM-like features
6. Continuity of healthcare home
• % of enrollees that move between tiers of eligibility that retain their PCP and medications. There is continuity although eligibility status might change.
7. Parity of access
• Equal access to all services across continuum of all three domains (physical, MH, SU)
8. Options available for diversion from avoidable ED and inpatient services
• Evidence of capacity (network standards for types of providers, providers per thousand enrollees, # providers within distance standards) • Evidence of monitoring of capacity (changes in provider availability over time; provider participation rate)
• Ratio of mobile crisis teams to the population (mobile crisis teams could serve a variety of individuals, e.g., mentally ill in crisis, seniors in crisis)
• Ratio of "PACT Teams" to the population (population could be defined by the ACO or county).
• Ratio of preventive care (i.e., evidence-based, outpatient services) to inpatient care over time
Process
1. Screening in all three domains (physical, MH, SU)*
• Number of individuals with screening completed in 1 domain÷ total persons served = % of individuals with 1 domain screened • Number of individuals with screening completed in 2 domains ÷ total persons served = % of individuals with 2 domains screened • Number of individuals with screening completed in all 3 domains ÷ total persons served = % of individuals with 3 domains screened • Number of individuals screened using approved tools (to be established) ÷ total persons served = % of individuals screened with approved tools * (e.g., developmental screens, hypertension, cholesterol, glucose, substance use, depression, anxiety)
2. Methods for obtaining further assessment
• Number of individuals screening positive who are immediately introduced to the MH/SU/primary care provider doing further assessment ÷ total persons screening positive in all 3 domains = % of individuals with a "warm hand-off" • Number of individuals screening positive who are provided a scheduled appointment with the MH/SU/primary care provider doing further assessment ÷ total persons screening positive in all 3 domains = % of individuals with a referral appointment • Number of individuals screening positive who are provided information about how to contact a MH/SU/primary care provider doing further assessment ÷ total persons screening positive in all 3 domains = % of individuals with an information-only referral
3. Proportion of enrollees identified in MH/SU screening
• Number of individuals identified as needing MH/SU services ÷ number that would be expected based on prevalence studies = % of comparative MH/SU penetration
4. Individuals that screen positive have further assessment
• Number of individuals screening positive who have a documented assessment ÷ total persons screening positive in all three domains = % of individuals receiving further assessment

Potential Measures
5. Individuals that screen positive follow through on further assessment
• Number of individuals screening positive who decline further assessment ÷ total persons screening positive in all 3 domains = % of individuals declining referral
• Number of individuals screening positive who accept further assessment ÷ total persons screening positive in all 3 domains = % of individuals accepting referral
• Number of individuals screening positive who attend first session with MH/SU/primary care referral ÷ total person screening positive in all 3 domains = % of individuals activating referral
• Number of individuals screening positive who attend second session with MH/SU/primary care referral ÷ total person screening positive in all 3 domains = % of individuals engaging in further assessment
6. Timeliness of access to further assessment
• Number of individuals screening positive who are immediately introduced to the MH/SU/primary care provider doing further assessment ÷ total persons referred = % of individuals with same day access
• Number of individuals screening positive who are seen within 7 days by the MH/SU/primary care provider doing further assessment ÷ total persons referred = % of individuals with timely access
• Number of individuals screening positive who are seen within 14 days by the MH/SU/primary care provider doing further assessment ÷ total persons referred = % of individuals with access
7. Timeliness of primary care and specialty care
• Measured by surveys (e.g., *Consumer Assessment of Healthcare Providers and Systems* (CAHPS), other surveys)
• Dependent on unit of analysis – the Exchange Plan, the ACO and/or Healthcare Home
8. Experience of care
• Measured by surveys such as CAHPS
• Dependent on unit of analysis – the Exchange Plan, the ACO and/or Healthcare Home
6. Drug management program
• Evidence of mechanisms for measuring non-adherence [refill gaps of # days] for psychiatric medications, medications associated with high risk chronic diseases and medications associated with alcohol / drug treatment
Outcomes
1. Rate of continuous medication use
• % of individuals with prescribed psychiatric medications, medications associated with high risk chronic diseases and medications associated with alcohol / drug treatment with no refill gaps of # days
2. Individuals being treated are getting appropriate levels of service
• Higher levels of intensity/duration of services for higher levels of need (physical, MH, SU)
3. Rate of avoidable ED visits
• Use New York or California measures
4. Rate of avoidable hospitalizations (AHRQ – PQI)
• Would be expanded to include not just physical care, but psychiatric hospitalizations
5. Reduced use of hospital services
• Readmission rates reduced
• Post-hospital follow-up visits increased
6. Increase # and % who meet disease-specific quality care standards (HEDIS measures)
• Dependent on unit of analysis – the Exchange Plan, the ACO and/or Healthcare Home
7. Total healthcare expenditures will flatten or decrease
• Focus on all enrollees who fit the definition of “vulnerable population”
8. Reduced mortality rates
• Stratified to track mortality of individuals with MH and/or SU conditions

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