

## Integrated Care Technical Assistance (ICTA) Program

### Provider Information Session

*The Integrated Care Technical Assistance Program (ICTA) is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$4,616,075.00 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS, or the U.S. Government.*

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# THIS PRESENTATION WILL COVER:

## ■ SESSION AGENDA

- + **Welcome and Introductions**
- + **ICTA Program Overview and Goals**
- + **Types of Learning Opportunities –  
Choosing the Best Fit for You and Your  
Organization**
- + **Next Steps for Group and Individual  
Learning**
- + **Q and A**

## ■ TEAM MEMBERS PARTICIPATING AND PRESENTING



Mary Kate Brousseau, MPH  
Senior Consultant, HMA



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Project Manager, DCHF HCRIA



Caitlin Thomas-Henkel, MSW  
Principal, HMA

## ■ WHAT IS INTEGRATED CARE?

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*The systemic approach to provide **person-centered care** for a defined population that coordinates **physical and behavioral healthcare** through a team of **primary care and behavioral health practitioners**, working with the **individuals served, families, and other natural and informal supports**.*

*Integrated care models ensure that **mental health, substance use disorder, primary care, and specialty services** are coordinated and delivered in a manner that is most effective to caring for **individuals with multiple health care needs** and produces the best outcomes.*

*Source: DC Department of Health Care Finance and Department of Behavioral Health working definition from Medicaid Behavioral Health Transformation Request for Information*

## ■ WHY INTEGRATED CARE?

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***Integrated whole-person care has been shown to improve patient outcomes and increase beneficiary satisfaction.***

### ***What's in it for you as providers?***

- More resources and effective tools in your toolbox to be ready to serve the influx of patients needing behavioral health treatment and bring together physical, behavioral and SUD health care services.
- Regular support to help you troubleshoot issues and develop workflows.
- Improved and streamlined referral relationships.
- Stay informed about evolving evidence-based practices and new District initiatives.
- Preparation for long-term, upcoming changes in the District relating to MCO contracts or value-based payment arrangements.



## ■ WHAT IS THE ICTA PROGRAM?

The Integrated Care Technical Assistance Program (ICTA) is a five-year program aimed to enhance Medicaid providers' capacity and core competencies to deliver whole person care for physical, behavioral health, SUD and social needs of beneficiaries.

The ICTA Program is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). Health Management Associates will provide the training and technical assistance.

**I**ntegrated

**C**are

**T**echnical

**A**ssistance



## ■ HMA AND PRACTICE TRANSFORMATION IN THE DISTRICT

We are a leading independent, national healthcare research and consulting firm providing technical and analytical services.

We specialize in publicly-funded health programs, system reform and public policy.

We work with purchasers, providers, policy-makers, program evaluators, investors and others.

Prior to this program, DHCF and HMA worked with the My Health GPS practices through the Individualized Technical Assistance Program to successfully:

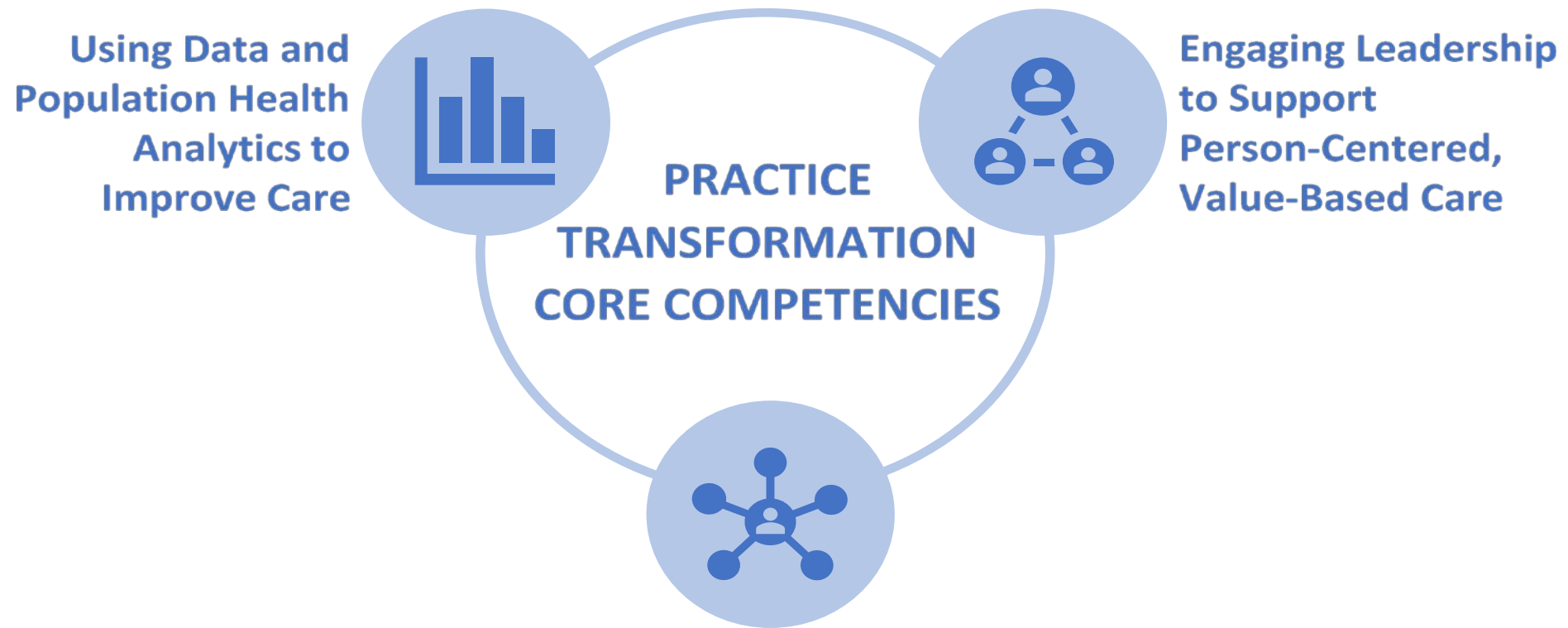
- Implement biopsychosocial assessments and improve care plan development and tracking, including transitions of care.
- Optimize care team models to support care coordination and increased beneficiary enrollment
- Manage patient panels and target interventions using CRISP and population health analytics tools.

A summary and results from that initiative are on the DHCF site [here](#).

***ITA focused on care coordination in primary care settings. This project broadens to include BH and SUD integration with primary care. TA will include all team members – not only care management teams.***

## ■ WHAT ARE THE GOALS OF THE ICTA PROGRAM?

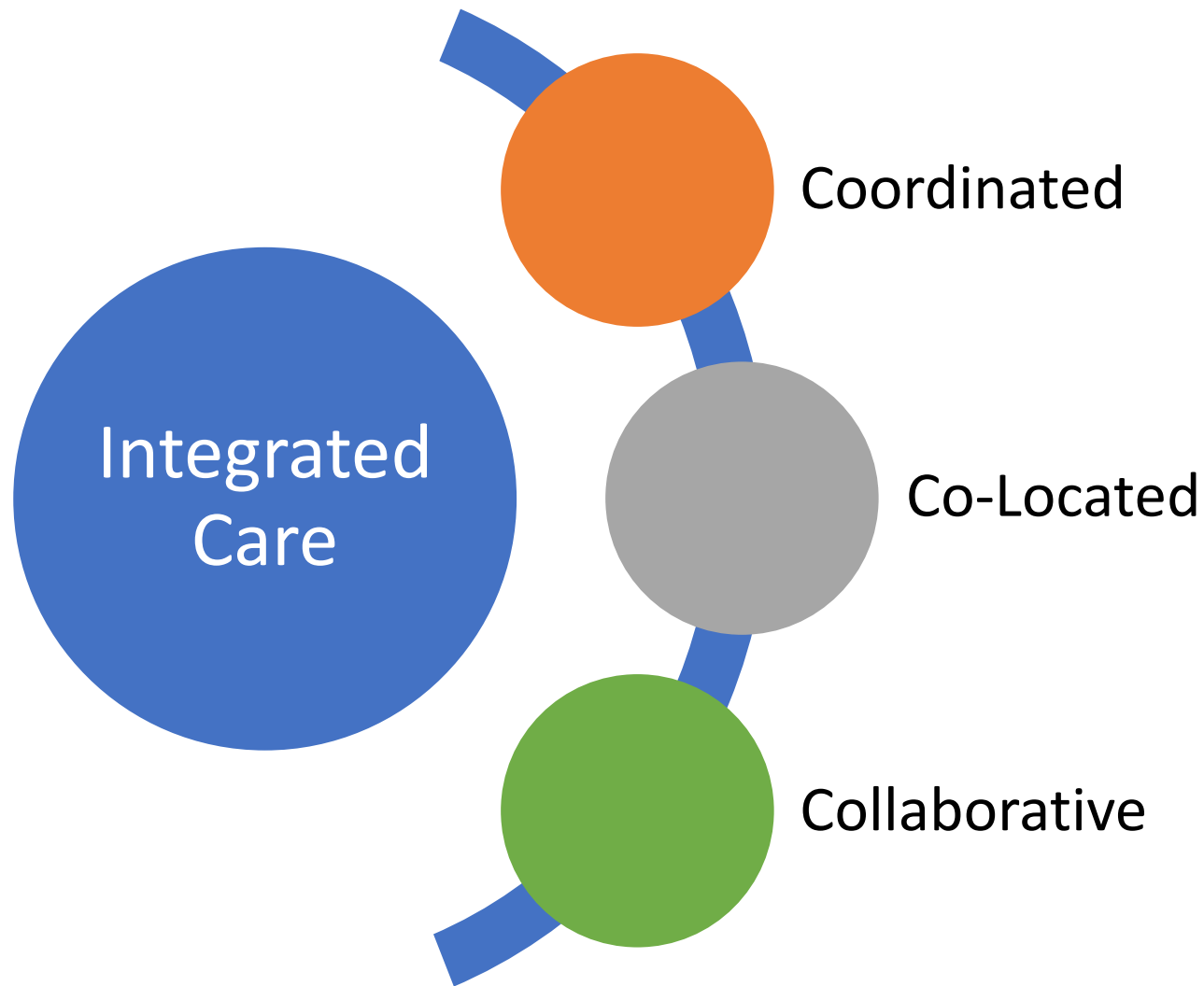
The goal is to improve care and Medicaid beneficiary outcomes within three practice transformation core competencies:



**Delivering Patient-Centered Care Across the  
Care Continuum to Improve Patient Outcomes**



## ■ WHAT DOES PROGRAM SUCCESS LOOK LIKE?



- **ICTA Program-Level:** Engage at least 15 providers in Phase 1 individualized TA, and 50 -75 over the entire program period.
- **Practice-Level:** Will depend on priority goals. Examples include:
  - Starting to provide MAT
  - Universal screening for SUDs
  - Expand SUD/MAT panel size
  - Care Compact/referral network
  - Increased screening for physical health conditions (e.g., diabetes, hypertension)

*\*Some organizations may focus on reverse integration which is a component of the framework.*



# Types of Learning Opportunities

*What is the best fit for me?*

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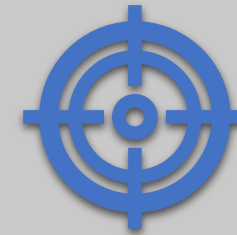
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## ■ ICTA PROGRAM: TWO TYPES OF LEARNING OPPORTUNITIES FOR PROVIDERS



### Community

- Webinars on integrated care topics
- ICTA website for resources and communications
- Annual Public Meeting\*



### Individualized TA

- At least 12-month commitment* - Community activities, plus:
- Assessment to identify practice level strengths, gaps, inform goal setting and track progress
  - Site-specific sessions with HMA integrated care experts\*
  - Coaching cohort and clinical office hour sessions\*

## ■ HOW DO I CHOOSE WHICH OPTION IS A GOOD FIT FOR OUR ORGANIZATION?

A few questions to assess fit for individualized TA learning opportunities:

- Am I a provider type that is **eligible** for individualized TA learning opportunities?
- Do we have **leadership commitment** (e.g., provider champion, CEO) to integrate physical/behavioral health care?
- Do we have **time** to participate in monthly TA and implementation activities over at least 12 months?
- Do we have a **dedicated staff member** to serve as the TA lead in coordinating team meetings, webinars and key activities?
- Do we have a **multi-disciplinary team** that can contribute & participate in ongoing activities throughout the project?

## ■ WHO IS ELIGIBLE TO PARTICIPATE?

Group Learning Opportunities: Available to all DC Medicaid providers.

Individualized Learning Opportunities: Focused on **seven** priority groups:

- Health Home providers (My Health GPS and My DC Health Home)
- Department of Behavioral Health certified providers
- Federally Qualified Health Centers
- Free Standing Mental Health providers
- Long term services and supports providers, including home health agencies
- Certified or waived Medications for Addiction Treatment (MAT) providers, including methadone providers
- Specialty providers





## WHO SHOULD WE INCLUDE ON OUR INTEGRATED CARE TA TEAM?

The TA is oriented toward a multi-disciplinary team approach that may include representation from:



## ■ WHAT ARE SAMPLE LEARNING TOPICS?

Addressing Stigma

Evidence based  
practices for  
SUD/OD

Screening, Brief  
Intervention and  
Referral to  
Treatment (SBIRT)

Motivational  
Interviewing

Telehealth and  
eConsult Strategies

Respectful and  
Culturally Informed  
Care

Developing  
Partnerships and  
Care Compacts

Care Team  
Optimization

Health Equity

Trauma Informed  
Care

ASAM Levels of  
Care


Integrating IT into  
Workflow

Data and CQI

Population Health

Value Based  
Purchasing  
Strategies

- HMA is a CME provider through the American Academy of Family Physicians and will develop and submit CME materials for approval and accreditation to provide AMA Level 1 Credit.



# **Next Steps Individual and Group Learning**

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## ■ ICTA TIMELINE: LEARNING OPPORTUNITIES START IN JANUARY



### August 2020 to January 2021

Launch ICTA website

Recruit providers in alignment with DHCF practice transformation activities

Complete assessments for practices engaging in individualized TA



### January to August 2021

Launch TA curriculum

Convene virtual learning sessions, individualized and cohort coaching sessions

Develop and maintain website, online resource library



### June to August 2021

Conduct annual meeting\*

Complete interim assessment

Gather key findings and complete base period evaluation

# NEXT STEPS: PROJECT TEAM TO SUPPORT TA



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*Project Director*  
*Integrated care; telehealth*



**Mary Kate Brousseau, MPH**  
*Project Manager*  
*Quality Improvement*

**Zane and HMA IT experts**



**Caitlin Thomas-Henkel, MSW**  
*BH expert*



**Lori Raney, MD**  
*Psychiatrist, Integrated care expert*




**Scott Haga, PA-C**  
*SUD/OD treatment expert*



**Nancy Jaeckels Kamp, RN**  
*Care Management expert*



**Kima Taylor, MD, MPH**  
*Pediatrics, Quality Improvement expert*



**Shannon Robinson, MD**  
*Addiction psychiatrist*  
*MAT expert*



**Shelly Virva, LCSW, FNAP**  
*BH and MAT expert*

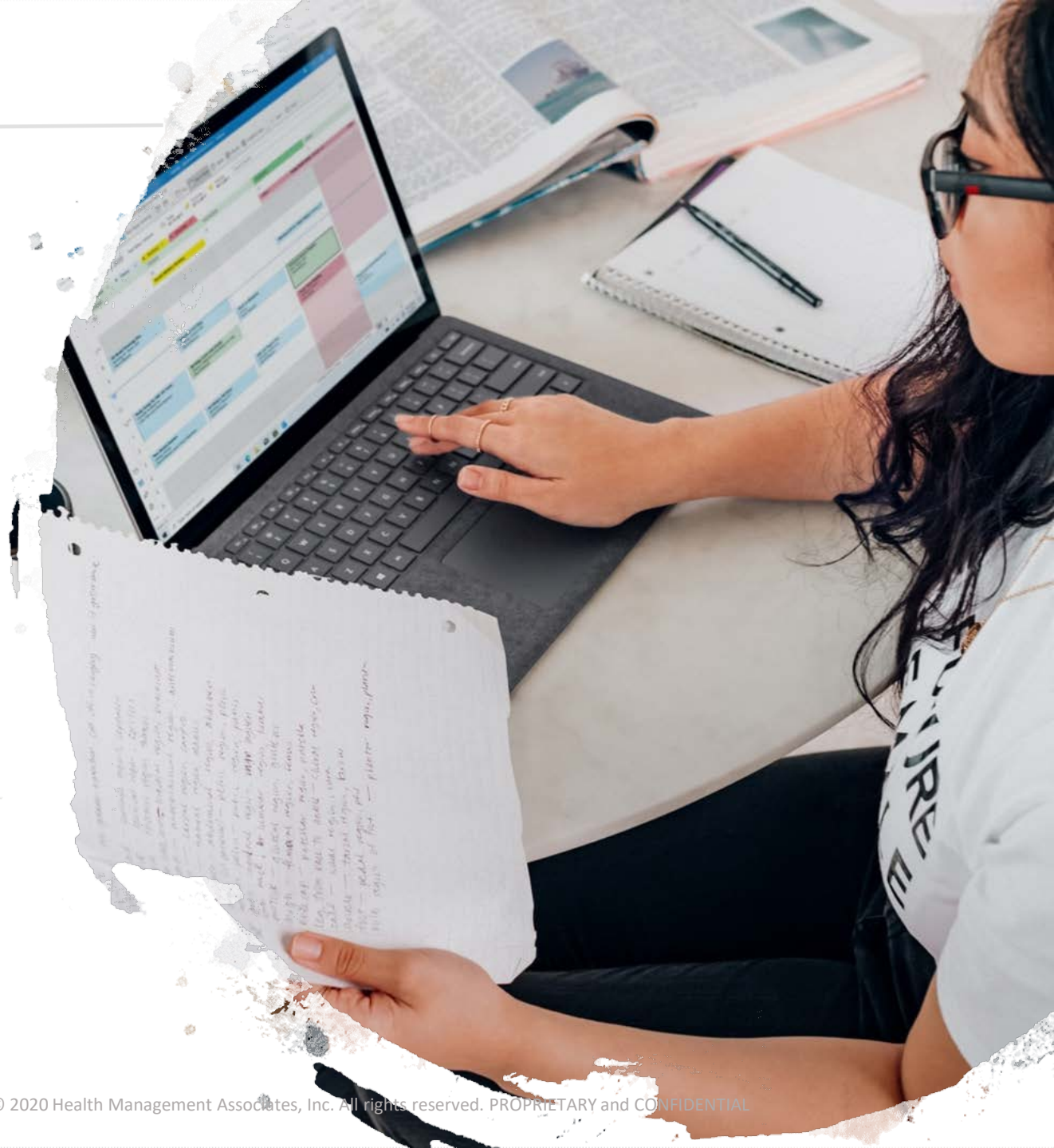


**Jodi M. Pekkala, MPH**  
*Quality Improvement expert*



## NEXT STEPS: SIGN UP TO PARTICIPATE

- Visit the ICTA Program website - [integratedcaredc.com](https://integratedcaredc.com).
- Complete and submit the signup form to select preferred learning opportunities.
- For group learning, webinars start in January.
- For individualized TA, sign up by January 8th.
  - Practices will be notified about individualized coaching by the end of January.
  - Phase 1 practices will be sent the self-assessment link to complete and will be assigned an HMA coach in February.
  - Practices not included in Phase 1 will be sent information on other ways to participate and options for Phase 2 (starting Sept/Oct 2021)





## NEXT STEPS FOR INDIVIDUAL LEARNING: WHAT IS THE ASSESSMENT?

### Goals:

- To collect information to jump start 1:1 coaching
- To identify strengths and gaps to individualized coaching
- To prioritize topics for webinars and learning collaboratives
- To aggregate data from all participating practices
- To track and report progress over time

### Process:

- In order to be eligible for individualized coaching, practices will need to complete a baseline assessment.
- Format:
  - Web-based multiple choice with some free text
  - Responses can be saved and changed during the completion process so that other team members can contribute
  - Work as a team to complete and submit one assessment
- Re-assessments will be completed periodically through duration of individualized TA

# PRACTICE ASSESSMENT: GLIMPSE AT FORMAT

The image displays two overlapping screenshots of the DC ICTA Assessment interface. The background screen is titled "DC ICTA Assessment" and focuses on "Core Competency 1: Deliver Person Centered Care Across the Care Continuum to Improve Patient Outcomes". It specifically addresses "1.1 Triage/prioritize patients" and asks the user to select the response that best aligns with their practice's criteria/process for behavioral health screening, initial assessment, and follow-up. Five response options are listed: "Screening, assessment, and follow-up do not occur, or unsure if these occur.", "Patient/clinician individual decision for identification of those with symptoms - not systematic.", "Systematic screening of target populations (e.g., diabetes, CAD), with follow-up for assessment and engagement.", "Systematic screening of all patients, with follow-up for assessment and engagement.", and "Population stratification/analysis as part of outreach and screening, with follow-up for assessment and engagement." The foreground screen is partially visible and asks two questions: "Does your practice use validated screening tools for BH/SUD disorders such as PHQ9, GAD7, CAGE, AUDIT, DAST, BAM, NIDA Quick Screen, ASSIST, TAPS?" with five response options ranging from "Yes, for behavioral health disorders including substance use disorders" to "I am unsure whether we use validated screening tools for BH/SUD.", and "Does your practice have a method for measuring progress towards goals through systematic repeat of validated measurement tools (such as PHQ9)?" with three response options: "Yes", "Unsure", and "No". Navigation buttons for "Previous questions" and "Next questions" are visible at the bottom of the foreground screen.

DC ICTA Assessment

Core Competency 1: Deliver Person Centered Care Across the Care Continuum to Improve Patient Outcomes

1.1 Triage/prioritize patients

Select the response that best aligns with your practice's criteria/process for behavioral health screening, initial assessment, and follow-up.

Screening, assessment, and follow-up do not occur, or unsure if these occur.

Patient/clinician individual decision for identification of those with symptoms - not systematic.

Systematic screening of target populations (e.g., diabetes, CAD), with follow-up for assessment and engagement.

Systematic screening of all patients, with follow-up for assessment and engagement.

Population stratification/analysis as part of outreach and screening, with follow-up for assessment and engagement.

Does your practice use validated screening tools for BH/SUD disorders such as PHQ9, GAD7, CAGE, AUDIT, DAST, BAM, NIDA Quick Screen, ASSIST, TAPS?

Yes, for behavioral health disorders including substance use disorders.

Yes, for some behavioral health disorders but not substance use disorders.

Yes, for substance use disorders but not other behavioral health disorders.

No, we do not use validated screening tools for BH/SUD.

I am unsure whether we use validated screening tools for BH/SUD.

Does your practice have a method for measuring progress towards goals through systematic repeat of validated measurement tools (such as PHQ9)?

Yes

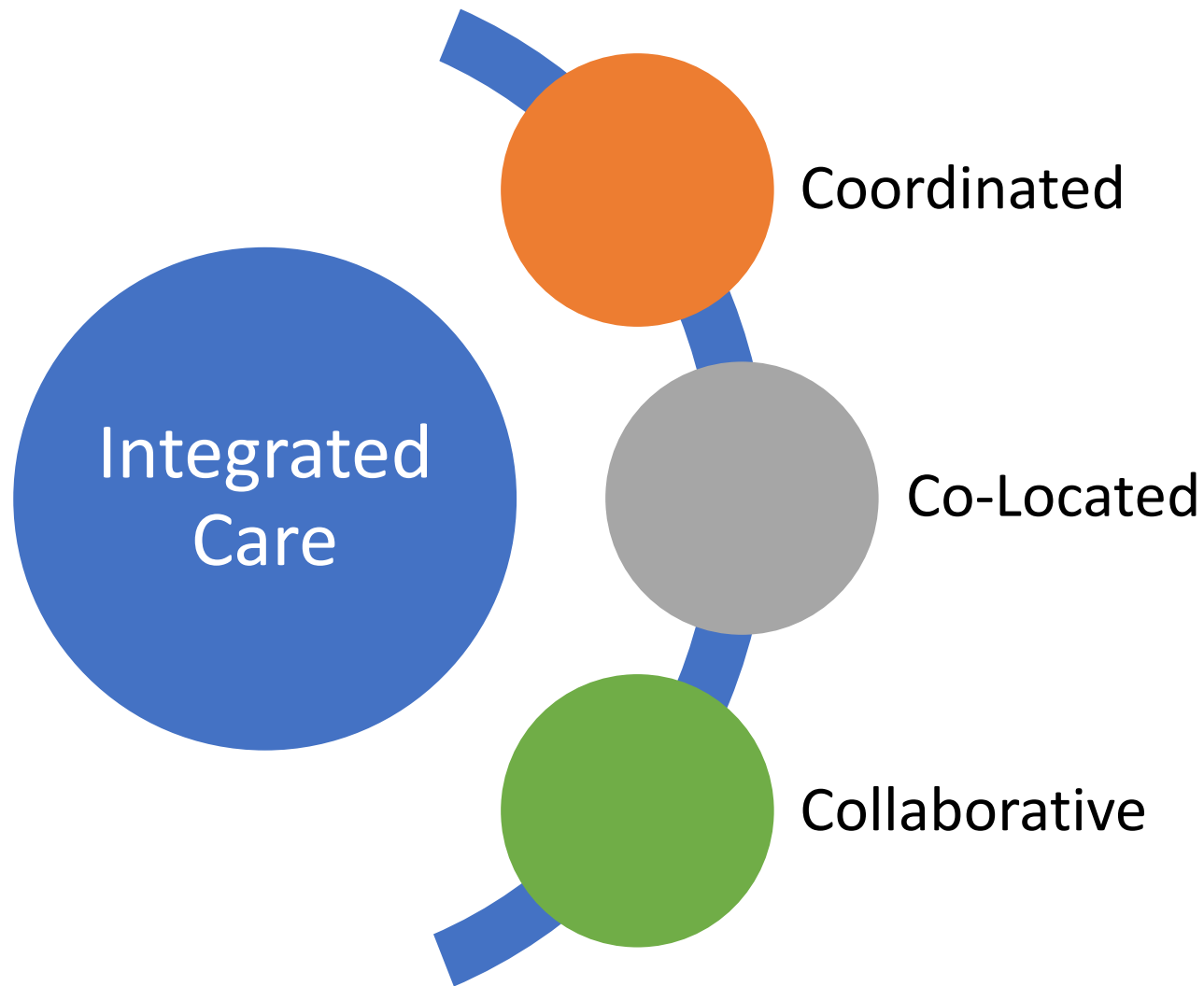
Unsure

No

← Previous questions

Next questions →

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**Questions?**  
**Comments?**

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# Contact Us!

- Visit [www.integratedcaredc.com](http://www.integratedcaredc.com) and sign up for technical assistance.
- For more information, please reach out to Mary Kate Brousseau, ICTA Program Manager,  
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