

INTEGRATED CARE DC PROGRAM OVERVIEW

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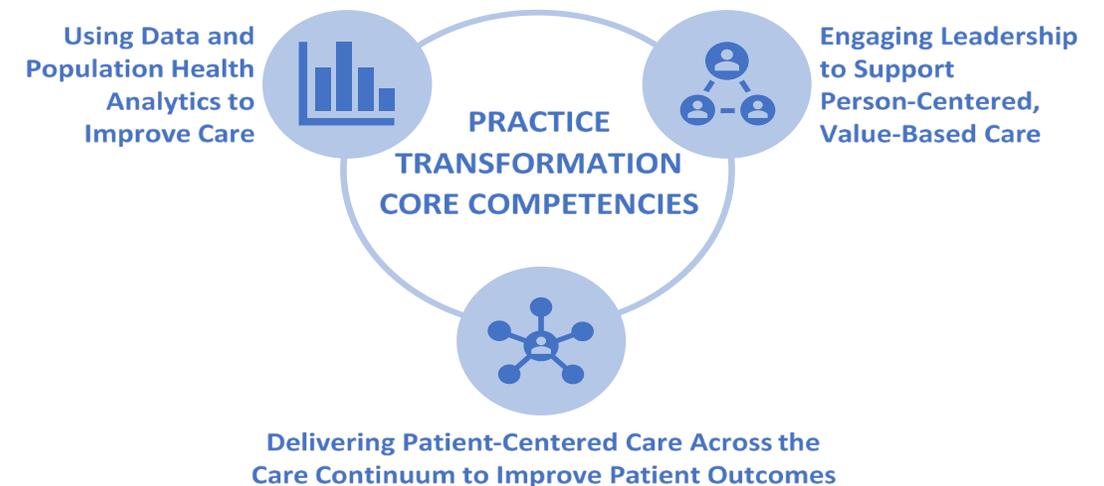
THIS PRESENTATION WILL COVER:

- + Introductory comments
 - + Elizabeth Garrison, DHCF****
- + What is the Integrated Care DC project?**
- + Who is eligible to participate?**
- + Why should I participate?**
- + Where can I learn more?**

WHAT IS THE INTEGRATED CARE PROGRAM?

- >> Integrated Care DC 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.
- >> Integrated Care DC 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.

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



WHAT IS THE INTEGRATED CARE PROGRAM?

*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

- » The program offers several components of coaching and training. Material is presented in various formats. The content is created and delivered by HMA subject matter experts with provider spotlights.
- » All material is available on the project website: www.integratedcaredc.org
- » Educational credit is offered at no cost to attendees for select elements.



1357

Individual users
on
Integratedcaredc.com

22

Practice Sites
engaged in coaching

18

Completed
assessments

80+

Resources on the
website

170

Individuals participated
on webinars

72

Organizations
represented on webinars



Community

- Webinars, workshops and quick takes on integrated care topics
- Integrated Care website for resources and communications
- Telehealth Assessment
- 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

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)
- » DBH 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 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

Health Equity

SBIRT and Motivational Interviewing

Telehealth and eConsult Strategies

Developing Partnerships and Care Compacts

Getting Paid for Integrated Care

Care Team Optimization

Metrics for Integrated Care

Trauma Informed Care

ASAM Levels of Care

Integrating IT into Workflows

Data and CQI

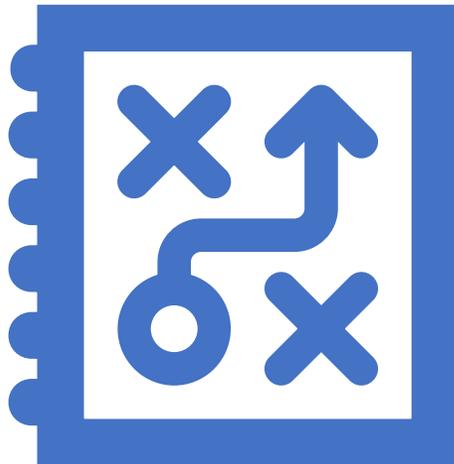
Population Health

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.

- » Anchor Health/Catholic Charities
- » Bread for the City
- » Columbia Road (Unity)
- » Community Connections
- » Gerald Family Care
- » Healthy Steps (Unity)
- » Hillcrest Children's Center
- » Howard University FPP
- » La Clinica del Pueblo, Inc
- » Mary's Center for Maternal & Child
- » Medstar Washington Hospital Center/Behavioral Health Center
- » Medical Home Development group (MHDG)
- » MBI Health Services LLC
- » PIDARC
- » Prestige Healthcare Resources Inc.
- » Regional Addiction Prevention (RAP)
- » SOME (So Others Might Eat) Inc
- » United Planning Organization (UPO)
- » Unity Health Care (BHI workgroup)
- » Unity Health Care (Jail-based)
- » Unity Health Care (Anacostia/Minnesota)
- » Whitman- Walker Clinic Inc

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



INTEGRATED CARE DC

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)?

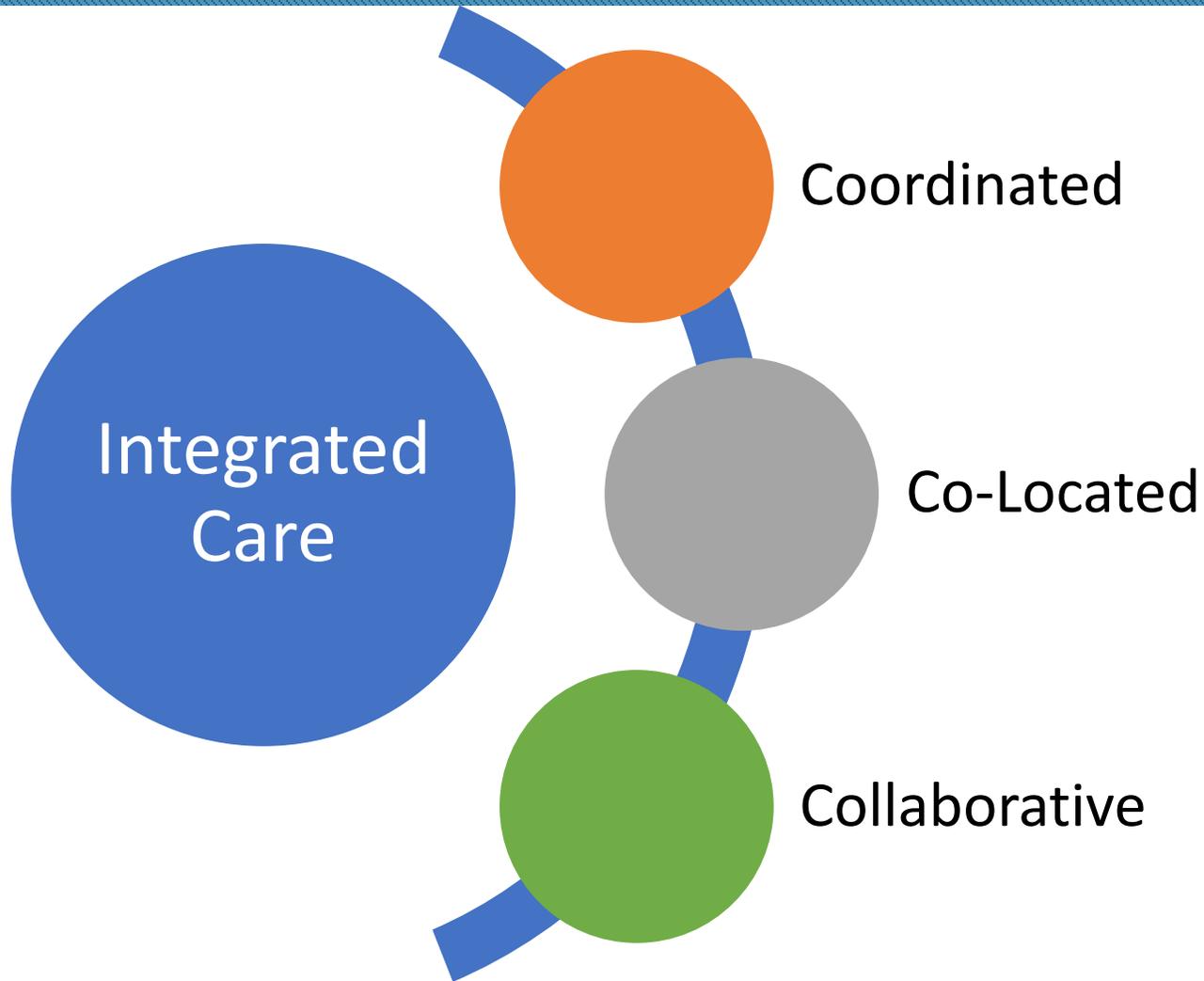
Yes

Unsure

No

← Previous questions

Next questions →



- **Program-Level:** Engage at least 50 -75 practice sites 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)

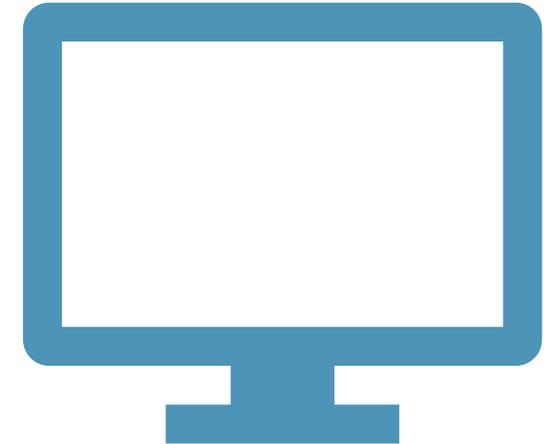
**Some organizations may focus on reverse integration which is a component of the framework.*

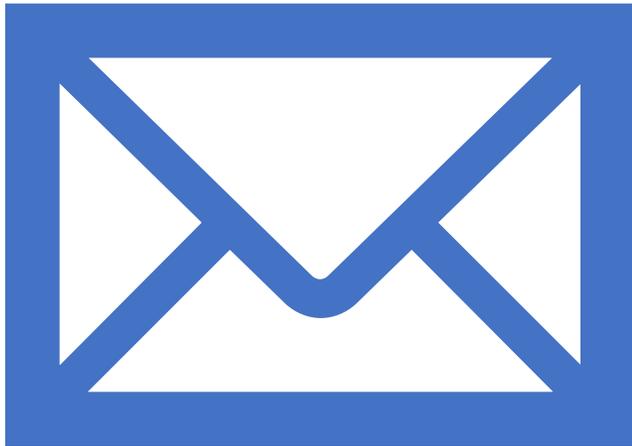
NEXT STEPS: SIGN UP TO PARTICIPATE

- » Visit the Integrated Care program website.
- » Complete and submit the signup form to select preferred learning opportunities.
 - » <https://www.integratedcaredc.com/signup-form/>
- » For group learning, webinars are ongoing.
- » For individualized TA, sign up is open **NOW!**
 - » Practices will be notified about individualized coaching on a rolling basis
 - » Practices will be sent the self-assessment link to complete and will be assigned an HMA coach.



- » **Webinar: Adapting Evidence Based Practices for Integrated Care**, October 19, 2021, 12:00 – 1:00 pm EST ([Register Here](#))
- » **Workshop 1: Cognitive Behavioral Therapy**, October 21, 2021, 3:00-3:30 pm EST ([Register Here](#))
- » **Workshop 2: Behavioral Interventions for Stress**, October 26, 2021, 12:00-12:30 pm EST ([Register Here](#))
- » **Workshop 3: Problem Solving Therapy**, November 1, 2021, 11:30am -12:00pm EST ([Register Here](#))





- >> Visit www.integratedcaredc.org.
- >> Sign up for technical assistance <https://www.integratedcaredc.com/signup-form/>
- >> For more information, please reach out to Integrated Care DC Project Director, Jean Glossa jglossa@healthmanagement.com