Proposition 56 Value-Based

Payment Behavioral Health Integration Project Grants

Background: The 2019 California Budget Act authorized $140 million in state funds ($70 million of which is from Proposition 56 tobacco tax revenue) over three years to implement the Behavioral Health Integration Incentive Program. The intent of these funds is to improve physical and behavioral health outcomes, care delivery efficiency and patient experience by expanding fully integrated care with managed care plans provider network, using culturally and linguistically appropriate providers with expertise in primary care, substance use disorder and mental health conditions.

Timeline:

Activity	Date
DHCS Releases the RFA	11/12/19
DHCS Provides Webinar	11/22/19
PHC Webinar with Interested Applicants	12/13/19 1pm
Notice of Intent to Apply due to PHC	12/20/19 *(preferred, not required)*
BHI Applications due to PHC	**1/21/20 by 5:00pm (required)**
PHC reviews applications and submits proposals to DHCS	2/18/20
DHCS reviews submissions by PHC and announces results	3/18/20
BHI Projects Begin	4/1/20

Eligible Providers: Primary care, specialty care, hospital based and behavioral health providers (both mental health and substance use) who deliver services to Medi-Cal beneficiaries and have a current provider contract with the Partnership HealthPlan of California (PHC) or with Beacon Health Options, or who will have a signed contract with PHC or Beacon by January 21, 2020. FQHCs, RHCs and IHS providers are eligible to apply. County providers are also eligible to apply.

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Applications

The application is available on the DHCS website (see below). Although the application form is a DHCS fillable form, applications are to be submitted to Partnership HealthPlan along with all the required documents at BHIgrants@partnershphp.org. Applicants are encouraged to consult with Partnership HealthPlan during the application process. This consultation may include participation in the webinar, PHC's review of the applicant's Notice of Intent to Apply (available at: www.partnershiphp.org)and discussions with individual applicants regarding their project and proposed milestones.

Required Documents:

1. BHI Project Application and budget (application downloadable from DHCS website: https://www.dhcs.ca.gov/provgovpart/Documents/BHI-Project-Application-11.12.19.docx)
2. Attestation and Certification Form Signed (also available on DHCS website)
3. An executed *BHI Incentive Program* MOU between applicant and PHC – (sample MOU is provided by DHCS)
4. Letter of Support from County mental health and County substance use disorder plans, **if** the project involves those with serious mental illness (SMI) and/or with substance use disorder (SUD)

Funding:

Financial support for the program is for a 33-month period, 4/1/20-12/31/22. The first year funds will be an initial upfront payment for the year, no more than 2/3 of each subsequent year's funding. Years 2 and 3 of the project will be quarterly payments based upon achievement of quarterly milestones. Quarterly milestones need to be measurable, tracked, reported on and achieved as a condition of payment. Years 2 and 3 funding amounts will be two equal amounts. For example, if the budget for Year 2 and 3 are $50,000 for each year, then the Year 1 budget would be $33,350.

*Please direct any questions and all submissions to the following: BHIgrants@partnershiphp.org

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

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Behavioral Health Integration Project Incentive Options

Title	Behavioral Health Integration for Beginners	Maternal Mental Health and Substance Use	Medication Management for Beneficiaries with Co-Occurring Chronic Medical/Behavioral Diagnoses	Diabetes Screening and Treatment for People with Serious Mental Illness	Improving Follow-Up after Hospitalization for Mental Illness	Improving Follow-Up after Emergency Department Visit
Target Population	All Providers	Increase prenatal and postpartum access to mental health and/or substance use disorder screening and treatment	Improve evidence based behavioral health prescribing of psychotropic, opioid disorder, and/or alcohol disorder (adult, children or both)	Improve health indicators for patients with both diabetes and SMI	Timely follow-up after hospitalizations for mental illness (adult, children or both)	Increase timeliness of follow-up after an ED visit
Practice Redesign	Culturally appropriate interventions and systems in place to support initial and continuous patient linkage between appropriate physical,	Culturally appropriate interventions and systems in place to support initial and continuous patient linkage between appropriate physical,	Culturally appropriate interventions and systems are in place to support improvement in medication adherence	Culturally appropriate interventions and systems in place to support initial and continuous patient linkage between appropriate physical,	Culturally appropriate are needed that link individuals in inpatient settings to outpatient mental health treatment following acute treatment	Integrate appropriate screening tools, staff training, and culturally appropriate decision support into the emergency department to ensure timely

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	mental and substance use disorder services	mental and substance use disorder services		mental and substance use disorder services		recognition of patients with mental health or SUDs
Activities	Positive Screening will result in brief interventions such as motivational interviewing and warm transfers	Positive Screening will result in brief interventions such as motivational interviewing and warm transfers	Improve patient safety and medication adherence through linkages to community treatment and by self-management skills	Positive Screening will result in brief interventions such as motivational interviewing and warm transfers for further evaluation and treatment	Improve communications between inpatient and outpatient facilities to support linkages through the discharge process using MH Specialists and community services	Enhance access to primary care and behavioral health care using 24/7 care navigators, behavioral specialists to support linkages
Required Measures	*Unhealthy Alcohol Use *Screening for Depression *IET-AD *AMM-AD ***Plus two more**	*CDF-CH *CDF-AD * Unhealthy Alcohol Use *IET-AD ***Plus One More**	*AMM-AD *OHD-AD *SAA-AD *COB-AD *Pharmacotherapy for Opioid Use	*SSD-AD *HPCMI-AD *CDC	FUH-CH FUH-AD	*FUA-AD *FUM-AD

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Glossary of Measures:

Screening for Unhealthy Alcohol Use – Pediatric and Adult
Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)
Screening for Depression and Follow-Up Plan: Ages 18 and Older (CDF-AD)
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) Pediatric and Adult
Antidepressant Medication Management (AMM-AD) Adult
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) Pediatric
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH) Pediatric
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication (ADD-CH) Pediatric
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD) Adult
Concurrent Use of Opioids and Benzodiazepines (COB-AD)
Pharmacotherapy for Opioid Use Disorder
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD-AD)
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) Adult
Medical Assistance With Smoking and Tobacco Cessation (MSC-AD) Adult
Follow Up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH) Pediatric
Follow Up After Hospitalization for Mental Illness: Ages 18 and Older (FUH-AD) Adult
Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) Adult
Follow Up After Emergency Department Visit for Mental Illness (FUM-AD) Adult
Comprehensive Diabetes Care (CDC)
Controlling High Blood Pressure – Adult
Metabolic Monitoring for Children and Adolescents on Anti-Psychotic Medication
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)

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Examples of Core Components and Tasks of Effective Integrated Behavioral Health Care Programs (taken from Appendix A of the application)

Patient Identification and Diagnosis

- Screen for behavioral health problems using valid instruments
- Diagnose behavioral health problems and related conditions
- Use valid measurement tools to assess and document baseline symptom severity

Engagement in Integrated Care Program

- Introduce collaborative care team and engage patient in integrated care program
- Initiate patient tracking in population-based registry

Evidence-Based Treatment

- Develop and regularly update a biopsychosocial treatment plan
- Provide patient and family education about symptoms, treatments, and self-management skills
- Provide evidence-based counseling (e.g. motivational interviewing and behavioral activation)
- Provide evidence-based psychotherapy (e.g. problem solving treatment, cognitive behavior therapy, and interpersonal therapy)
- Prescribe and manage psychotropic medications as clinically indicated
- Change or adjust treatments if patients do not meet treatment targets
- Train staff and providers on trauma-informed care

Systematic Follow-up, Treatment, Adjustment and Relapse Prevention

- Use population-based registry to systematically follow all patients

- Proactively reach out to patients who do not follow up
- Monitor treatment response at each contact with valid outcome measures
- Monitor treatment side effects and complications
- Identify patients who are not improving to target them for psychiatric consultation and treatment adjustment
- Create and support relapse prevention plan when patients are substantially improved

Communication and Care Coordination

- Coordinate and facilitate effective communication among providers
- Engage and support family and significant others as clinically appropriate
- Facilitate and track referrals to specialty care, social services, and community-based resources

Program Oversight and Quality Improvement

- Provide administrative support and supervision for the program
- Provide clinical support and supervision for the program
- Routinely examine provider and program-level outcomes (e.g. clinical outcomes, quality of care, and patient satisfaction), and use this information for quality improvement

Strategies and practice redesign components that can increase your level of integration

- The behavioral health specialist (BHS) is integrated into the workflow of the clinic
- The BHS shares access to the electronic medical record
- Clinic treatment plans reflect an integrated approach to patient behavioral and physical health needs
- The clinic scheduling system allows patients to be scheduled for same day appointments with the BHS
- The clinic systematically triages the behavioral health needs of its patients
- The clinic systematically tracks the progress of behavioral health treatment

- The PCP and BHS do warm hand offs according to patient needs
- The PCP and BHS regularly consult about patient care
- The PCP and BHS collaborate in making decisions about mutual patients
- The clinic has at least one integrated care “champion”