State of California—Health and Human Services Agency
Department of Health Care Services

BEHAVIORAL HEALTH INTEGRATION (BHI) INCENTIVE PROGRAM MILESTONE TECHNICAL ASSISTANCE GUIDE

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I. OVERVIEW

Program Objective

The objective of the Department of Health Care Services (DHCS) Behavioral Health Integration (BHI) Incentive Program is to incentivize improvement of physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated care in a Medi-Cal managed health care plan's (MCP) network. For more information, please visit the DHCS BHI Incentive Program webpage.

Document Purpose

The purpose of this BHI Incentive Program Technical Assistance Guide is to provide MCPs with information and resources to assist providers in developing, refining, and finalizing milestones as needed.

Reporting

MCPs are responsible for overseeing the project options, including monitoring and verifying that milestones are satisfactorily achieved. MCPs will collect and evaluate all information related to implementation of the provider's project options for the purposes of ensuring progress toward the provider's goals and objectives, and reporting to DHCS the project status.

Providers are responsible for the implementation of the project options and compliance with state and federal guidelines. The provider will perform tasks necessary to meet milestones and shall provide their partner MCP with information necessary to demonstrate progress in achieving the milestones. Providers shall submit reports in a manner specified by the partner MCP.

Funding Uses and Restrictions

The purpose of the BHI Incentive Program funding is to better integrate physical and behavioral health care for Medi-Cal members.

The BHI Incentive Program funding cannot duplicate or supplant other previously identified funding that is specifically dedicated to the milestone deliverables and cannot be used to reimburse for services currently reimbursable under Medi-Cal. In addition, milestones tied to capital investments are not appropriate uses of funds as outlined in the CMS Special Terms and Conditions. For more information on other uses and restrictions, please visit the DHCS Medi-Cal 2020 Demonstration webpage.

MCPs are responsible for ensuring that their subcontractors and providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including All Plan Letters and Policy Letters.

II. MILESTONE TECHNICAL ASSISTANCE

Section Purpose

The purpose of this section is to provide MCPs with guidance on how to assist their providers in developing or refining milestones that support achievable implementation objectives. Examples provided show how vague milestones can be refined to be reasonable, measureable, and obtainable. The examples also include possible components/tasks and deliverable(s) MCPs and providers can develop together to demonstrate completion of a milestone.

Practice Redesign and Components and Tasks

The practice redesign components/tasks are activities and accomplishments needed in order to meet the goals or objectives of a project option. Providers shall demonstrate completion of a milestone in a manner specified by the partner MCP.

3.1 BASIC BEHAVIORAL HEALTH INTEGRATION

GOAL

Improve medical and behavioral health integration practices with a primary care, specialty care, or behavioral health provider's office or clinic.

PRACTICE REDESIGN

Ensure interventions and systems are in place to support initial and continuous patient linkage between appropriate physical, mental, and substance use disorder (SUD) services.

EXAMPLE 1

Vague Milestone: Screen 100 patients for behavioral health conditions.

Refined milestone: In PY 1, screen a minimum of 100 patients identified with a potential behavioral health condition using a standardized tool.

Components/Tasks: Create standardized assessment tool. Identify patients for screening. Utilize tool to collect necessary screening data.

Demonstration of Completion: Provide 1) copy of standardized tool and 2) report of completed screenings.

EXAMPLE 2

Vague milestone: Survey SUD patients to gauge satisfaction with behavioral services.

Refined milestone: Quarterly, survey a minimum of 40% of SUDs patients to gauge satisfaction with behavioral health services.

Components/Tasks: Create survey, identify population, and administer survey quarterly.

Demonstration of Completion: Provide 1) copy of standardized tool and 2) report of completed screenings.

3.2 MATERNAL ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER SCREENING AND TREATMENT

GOAL

Increase prenatal and postpartum access to mental health and SUD screening and treatment.

PRACTICE REDESIGN

Ensure interventions and systems are in place to support initial and continuous patient linkage between appropriate physical, mental, and SUD.

EXAMPLE

Vague milestone: Conduct depression and SUD screenings, and provide treatment coordination as needed.

Refined milestone: Conduct depression and SUD screenings for 40% of the perinatal population, and provide treatment coordination for at least 80% of those patients within 60 days

Components/Tasks: Conduct screenings, track perinatal patients with depression or SUD, and coordinate behavioral health services within 60 days.

Demonstration of Completion: Provide tracking log.

3.3 MEDICATION MANAGEMENT FOR BENEFICIARIES WITH CO-OCCURRING CHRONIC MEDICAL AND BEHAVIORAL DIAGNOSES

GOAL

Improve behavioral health prescribing and management of psychotropic, opioid use disorder (OUD), and alcohol use disorder medications.

PRACTICE REDESIGN

1) Ensure interventions and systems are in place to support improvement in medication adherence, follow-up care, psychosocial care, and metabolic monitoring; 2) Implement appropriate systems to improve patient safety and medication adherence through monitoring per the current evidence-based clinical guidelines; 3) Deploy sustainable interventions to target improvements in medication management and adherence, linkage to community treatments, and enhance self-management strategies.

EXAMPLE 1

Vague milestone: Children with attention deficit hyperactivity disorder (ADHD) will have a follow-up visit after prescription issued.

Refined milestone: 50% of newly diagnosed children with ADHD will have a follow-up visit within 30 days of prescription issued.

Components/Tasks: Identify newly diagnosed children and create tracking tool to ensure follow-up visits are scheduled within 30 days.

Demonstration of Completion: Provide 1) copy of tracking tool and 2) data report.

EXAMPLE 2

Vague milestone: Conduct caseload review for patients who are not improving.

Refined milestone: Conduct psychiatric medication review within 60 days for patients who have been identified as not improving.

Components/Tasks: Identify population and conduct quarterly medication reviews.

Demonstration of Completion: Provide tracking report.

3.4 DIABETES SCREENING AND TREATMENT FOR PEOPLE WITH SERIOUS MENTAL ILLNESS

GOAL

Improve health indicators for patients with both diabetes and serious mental illness.

PRACTICE REDESIGN

Ensure interventions and systems are in place to support initial and continuous patient linkage between appropriate physical, mental, and SUD services. Preventive care screenings, including medical and behavioral health screenings, diabetes screenings would be implemented for all patients to identify unmet needs.

EXAMPLE 1

Vague milestone: Complete 300 screenings for depression, Screening, Brief Intervention (SBRIT), and Referral to Treatment and Social Determinant of Health (SDOH)

Refine milestone: In PY 1, complete a minimum of 300 unique screenings for depression, SBRIT, and SDOH for patients with a co-morbid diabetes diagnosis.

Components/Tasks: Create or adopt a screening tool. Create policy and procedure for conducting the unique screenings. Provide screenings.

Demonstration of Completion: Provide data report.

EXAMPLE 2

Vague milestone: Improve patient follow-up after discharge.

Refine milestone: In PY 2, improve follow-up for patients identified with serious mental illness after discharge by 20% compared to PY 1.

Components/Tasks: Create policies and procedures. Conduct quarterly review of patient charts to ensure improved patient follow-up.

Demonstration of Completion: Provide quarterly status reports.

3.5 IMPROVING FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

GOAL

Improve timely follow-up after hospitalization for mental illness.

PRACTICE REDESIGN

1) Culturally appropriate interventions are needed that link individuals in inpatient settings to outpatient mental health treatment following acute treatment; 2) Enhanced access to primary care and/or to mental health specialists could be integrated into discharge planning for these patients; 3) Improved communication mechanisms and data sharing between inpatient and outpatient facilities through the discharge process; 4) Implementation of outpatient patient navigators, peer navigators, peer support, and/or case management, and developing protocols regarding follow-up after hospitalization and/or missed visits.

EXAMPLE

Vague milestone: Conduct assessments and follow-up with behavioral health patients assessed.

Refined milestone: Conduct assessment for 20% of eligible patients and provide follow-up within one week to a minimum of 50% of the patients assessed.

Components/Tasks: Create assessment policies and procedures. Conduct and track follow-up with patients.

Demonstration of Completion: Provide data report.

3.6 IMPROVING FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR BEHAVIORAL HEALTH DIAGNOSIS

GOAL

Improve timely follow-up after emergency department visit for mental illness and SUD.

PRACTICE REDESIGN

1) Integrate appropriate screening tools, staff training, and culturally appropriate decision support into the emergency department (ED) to ensure timely recognition of patients with mental health and/or SUD; 2) Enhanced access to primary care and/or to behavioral health specialists; 3) When appropriate, patients should be started on behavioral health medications in the ED; 4) Use of ED care navigators may be used to support linkages.

EXAMPLE

Vague milestone: Provide behavioral health services to patients with positive alcohol use disorder (AUD) screening.

Refined milestone: In PY 1, provide behavioral health services to a minimum of 25% of patients discharged from emergency department with a positive AUD screening.

Components/Tasks: Create policies and procedures, identify population, and provide behavioral health services to patients who tested positive for AUD.

Demonstration of Completion: Provide data report.

OTHER EXAMPLES OF REFINED MILESTONES

EXAMPLE 1

Milestone: In PY 1, conduct staff training(s) for evidence-based brief interventions and trauma-informed care.

Components/Tasks: Create policies, procedures, and protocols. Identify and train staff according to roles and responsibilities. Administer training(s) and provide training manuals.

Demonstration of Completion: Provide training certificates.

EXAMPLE 2

Milestone: Care coordinator will identify and assist patients to overcome barriers of care within 60 days.

Components/Tasks: Create policies and procedures. Care coordinator may conduct activities such as phone call reminders, arrange transportation as needed, navigate health care system, and educate and train in self-care.

Demonstration of Completion: Provide policies and procedures, grievances and appeals, and tracking log.

EXAMPLE 3

Milestone: Conduct bi-weekly care coordination meetings with treatment team to consult on psychiatric clients, identify challenges, and track referrals to outside resources.

Components/Tasks: Meetings attended by treatment team members such as: psychiatric care coordinator, field case manager, hospital discharge planner, housing coordinator and mental health and SUD providers.

Demonstration of Completion: Provide bi-weekly meeting schedule.

EXAMPLE 4

Milestone: Connect patients to behavioral health services with a warm hand-off to a specialist within 30 days.

Components/Tasks: Create care coordination policies, procedures, and protocols to ensure warm hand-off to specialist.

Demonstration of Completion: Provide tracking log.

EXAMPLE 5

Milestone: Quarterly follow-up of all post hospitalizations and provide treatment adjustment as needed using an electronic health record (EHR) population health management tool.

Components/Tasks: Acquire or develop EHR health management tool. Create policies and procedures for follow-up and file review for treatment adjustments.

Demonstration of Completion: Provide EHR health management tool description/specification and a copy of the policy and procedure.

EXAMPLE 6

Milestone: 60% of outpatient treatment plans (OPTP) completed within 30 days of ED discharge.

Components/Tasks: Create OPTP for patients discharged from mental health or SUD-related ED visits, collaborate with the patient, hospital discharge planner, and care coordinator.

Demonstration of Completion: Provide data report.