**CARE TRANSFORMATION COLLABORATIVE (CTC)**

**ATTACHMENT A – COLLABORATIVE AGREEMENT SCOPE OF SERVICE/WORK**

**Consisting of 4 pages**

**Primary Care Practice: Primary Care Practice Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Assigned to IBH Cohort: 3**

1. Introduction/Purpose

The Care Transformation Collaborative of Rhode Island (CTC-RI), with funding from UnitedHealthcare, is providing IBH practice facilitation and practice infrastructure support for 9 primary care practices (family or adult) over a one-year time period.

It is anticipated that primary care practices, through the IBH model, will be able to 1) provide on-site treatment for twenty to thirty percent of the patient population that is seen each year in the primary care practice (PCP) setting; 2) utilize behavioral health compacts for no more than twenty percent (20%) of patients that have moderate to high screening scores for depression, anxiety and/or SUDs.

CTC Sustainable IBH Objectives:

* To assist PCMHs with recruiting and hiring an IBH provider for the primary care practice;
* To increase the identification of patients with behavioral health and substance use disorders (SUD) through universal screening for depression, anxiety and SUD;
* To increase ready access to brief behavioral health intervention for patients with mild to moderate depression, anxiety, SUD and co-occurring chronic conditions;
* To provide referral and care coordination for patients needing specialty mental health or substance use services;
* To provide care coordination and intervention for patients with health-related social needs and/or high emergency department (ED) utilization;

1. Services to Be Provided/Practice Requirements

Primary care patients and practices would benefit from having ready access to on-site behavioral health services and a coordinated referral system to specialty behavioral health services when patient severity requires higher levels of care and coordination. Practices that assist with testing the IBH business model will contribute to create a sustainable primary care program that provides patients with ready access to behavioral health care and assists systems of care with managing risk-based contracts.

Assumptions:

* Primary care practices, through the IBH model, will be able to provide on-site behavioral health treatment for twenty to thirty percent of the patient population that is seen each year in the PCP setting;
* Primary care practices will pre-schedule monthly on-site IBH consultation with system of care (SOC) representation (based on area of focus: i.e. billing, IT enhancements, hiring and credentialing) during the first three months of “ramp up”; With change in circumstances, practices would be expected to re-schedule monthly meetings in order to maintain focus on meeting program objectives, within the same month;
* Systems of care will provide practices with IT support needed to effectively capture and report behavioral health and health related social determinant of health screening and interventions, coding and behavioral health information to successfully bill for behavioral health services in primary care and human resources support to hire and credential behavioral health provider.

Practice Requirements:

IBH Start-Up (1-6 months):

All Phase 1 requirements will be implemented within a 1 to 6-month timeframe with selected deliverables given with a specific timeline expectation as outlined in “ATTACHMENT B: Integrated Behavioral Health Milestone Summary”.

* In conjunction with System of Care (if applicable), provide baseline report on screening for depression, anxiety, and substance use within one (1) month of award notification;
* Hire behavioral health (BH) staff, if not already in place, with a staffing ratio of 1 FTE for every 5,000 patient lives and with staff ready to see patients within 4 (four) months of award notification;
* Provide work space for the BH clinician within the primary care setting within four (4) months of award notification;
* Develop a staffing plan for patients to be able to access BH assessment/treatment with same day to 72-hour access (within one (1) month of start date of IBH clinician or award notification, if IBH clinician already hired);
* In conjunction with System of Care if applicable), establish billing systems that will allow for the billing of BH services and/or establish supervision of BH interns (within two (2) months of start date of IBH clinician or award notification, if IBH clinician already hired);
* Establish compact with specialty mental health for referral for patients with more intensive behavioral health needs (within 3 months);
* Implement program identified, evidence based, screening tools for depression, anxiety, and SUD within five (5) months of award notification; practices may request option with of using screening tools different from the PHQ-9 (depression), GAD (anxiety), or CAGE-AID (alcohol and drugs) with justification
* Submit AIM statement and plan for improving depression, anxiety, and SUD screening results within five (5) months;

Phase 2 Development and implementation of two data driven performance improvement plans; a) Increase screening rates for depression anxiety and substance use disorders; b) Selection and implementation of social determinant of health screening

* In conjunction with System of Care (if applicable), produce quarterly reports on screening results (depression, anxiety, substance use disorders) within seven (7) months of award notification;
* Select and implement an evidence-based health related social determinant of health screening tool that includes at least three (3) domains (recommended domains: housing insecurity, food insecurity, safety and domestic violence within eight (8) months;
* Submit AIM statement and plan for addressing social determinants of health including baseline measurements within eight (8) months;
* Establish a Memorandum of Agreement with community health team for meeting health related social determinant of health needs or with a community agency within 9 months of award notification;
* Submit completed behavioral health screening work plan including final data points (February 2020);
* Submit completed work plan for addressing Social Determinants of Health including final data points (February 2020);
* Complete [Maine Health Access Evaluation Tool](https://www.ctc-ri.org/sites/default/files/uploads/MEHAF.pdf) at baseline (prior to beginning of the funding) and then at completion of the one year (February 2020).

On-Going Learning Commitments

* Commit to and host monthly on-site IBH consultation with membership to include practice leadership, physician/clinical champion, nurse care manager, and system of care leader (within 30 days of award notification);
* Commit to and have practice team participate in quarterly participation in quarterly webinar/live learning events.

Practice Compensation:

Practices/systems of care will be eligible to receive

* $3,500 for infrastructure needs (i.e. hiring and on-boarding behavioral health clinician, EHR adaptations for capturing screening information, billing and coding, clinician templates),
* $3,500 after provider champion/team attendance at the first quarterly learning meeting and submission of 1st PDSA for universal screening of depression, anxiety and substance use disorder,
* $3,000 for provider leadership in assisting team with meeting service deliverables associated with screening thresholds (see below). Payments will be prorated based on targets met / not met.

By February 2020 achieve the following screening results:

|  |  |
| --- | --- |
| Measure | Screening Incentive Threshold |
| Depression | 85% |
| Anxiety | 60% |
| Substance Use Disorder | 60% |
| Health Related Social Needs | AIM statement and reporting on 3 domains: recommend housing insecurity, food insecurity and safety and domestic violence |

Care Transformation Collaborative of RI Primary Care Practice name.



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Signature: Debra Hurwitz, Signature of authorized staff

Executive Director, CTC-RI

ATTACHMENT B: IBH MILESTONES SUMMARY DOCUMENT

ATTACHMENT C: IBH MEASUREMENT SPECIFICATIONS