

Health and Human Services Transformation

Illinois HHS Medicaid Waiver Advisory Committee Discussion

Discussion document

January 19, 2017

Medicaid Waiver Advisory Committee members (1/2)

Meeting Chair

- Howard A. Peters (Vice-Chairman, Medicaid Advisory Committee)

Committee members

<u>Name</u>	<u>Role and location</u>
▪ Jennifer Craig	▪ COO, Centerstones Illinois (Alton, Marion, Carbondale)
▪ Regina Crider	▪ Youth and Family Peer Support Alliance (Champaign County)
▪ Victor Dickson	▪ Safer Foundation (Chicago)
▪ Kathy Donahue	▪ SVP, Catholic Charities (Chicago)
▪ Dennis Duke	▪ President, Robert Young Center/Unity Point Health (Quad Cities)
▪ Philip Eaton	▪ President/CEO, Rosecrance Health Network (Rockford)
▪ Doug Elwell	▪ EVP, Cook County Health and Hospital System (Chicago)
▪ Raul Garza	▪ President/CEO, Aunt Martha's (Chicago Heights)
▪ Phyllis Glink	▪ Executive Director, Irving Harris Foundation (Chicago)
▪ Angie Hampton	▪ CEO, Egyptian Health Department (Eldorado, Harrisburg, Carmi)
▪ Arlene Happach	▪ EVP/COO, Children's Home and Aid (Chicago)
▪ Cathy Harvey	▪ Board President, Association of Managed Health Plans (Chicago)
▪ Cindy Hoffman	▪ EVP, Children's Home Association of Illinois (Peoria)
▪ Sara Howe	▪ CEO, IL Association of Behavioral Health (Springfield)

Medicaid Waiver Advisory Committee members (2/2)

Committee members

Name	Role and location
▪ Tom Hughes	▪ Executive Director, Illinois Public Health Association (Springfield)
▪ Thomas Huggett, MD	▪ Lawndale Christian Health Center (Chicago)
▪ Marvin Lindsey	▪ CEO, CBHA (Chicago)
▪ Mark Mroz	▪ Mado Management
▪ Kathryn Nelson	▪ DuPage Federation
▪ Gail Nourse	▪ VP, Illinois Policy, Ounce of Prevention
▪ Heather O'Donnell	▪ Thresholds (Chicago)
▪ Barb Otto	▪ CEO, Health and Disability Advocates (Chicago)
▪ Jim Runyon	▪ CEO, Easter Seals (Peoria)
▪ Janet Stover	▪ President/CEO, IARF (Springfield)
▪ Mark Stutrud	▪ President/CEO, Lutheran Social Services of Illinois (Chicago)
▪ AJ Wilhemi	▪ CEO, Illinois Hospital Association (Naperville)
▪ Kari Wolf, MD	▪ Associate Professor, Chairperson of Psychiatry, SIU (Springfield)
▪ Daniel Yohanna, MD	▪ Illinois State Psychiatric Society
▪ TBD	▪ Illinois State Medical Society
▪ TBD	▪ Illinois Mental Health Partnership

Agenda for today's discussion

Context of the Illinois HHS Transformation	15 minutes
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Objectives of Waiver Advisory Committee	15 minutes
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Introduction to Integrated Health Home model	20 minutes
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Care delivery model topics for input today	60 minutes
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Path forward	10 minutes
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Introduction

The HHS transformation has been enabled by an historic level of collaboration

Thirteen agencies / departments / offices are participating in HHS transformation...

1. Governor's Office
2. Department of Healthcare and Family Services (DHFS)
3. Department of Children and Family Services (DCFS)
4. Department of Human Services (DHS)
5. Department of Juvenile Justice (DJJ)
6. Department of Corrections (DOC)
7. Department of Aging (DOA)
8. Department of Public Health (DPH)
9. Department of Veteran's Affairs (DVA)
10. Illinois Housing Development Authority (IHDA)
11. Department of Innovation and Technology (DoIT)
12. Illinois State Board of Education (ISBE)
13. Illinois Criminal Justice Information Authority (ICJIA)

...and focusing on five pillars

1. Prevention and population health
2. Pay for value, quality and outcomes
3. Moving from institutional to community care
4. Education and self sufficiency
5. Data integration and predictive analytics

As a pressing issue that transcends agencies and populations across Illinois, behavioral health is a lynchpin in the transformation effort



Governor's Office and 12 Illinois agencies with shared sense of mission

Groundwork laid in Healthy Illinois 2021 plan, supported by State Health Assessment, SIM grants, and State Health Improvement Plan

Disproportionate level of spend on members with behavioral health needs, i.e., **mental health and substance use issues**

Rapid increase in **opioid-related deaths**

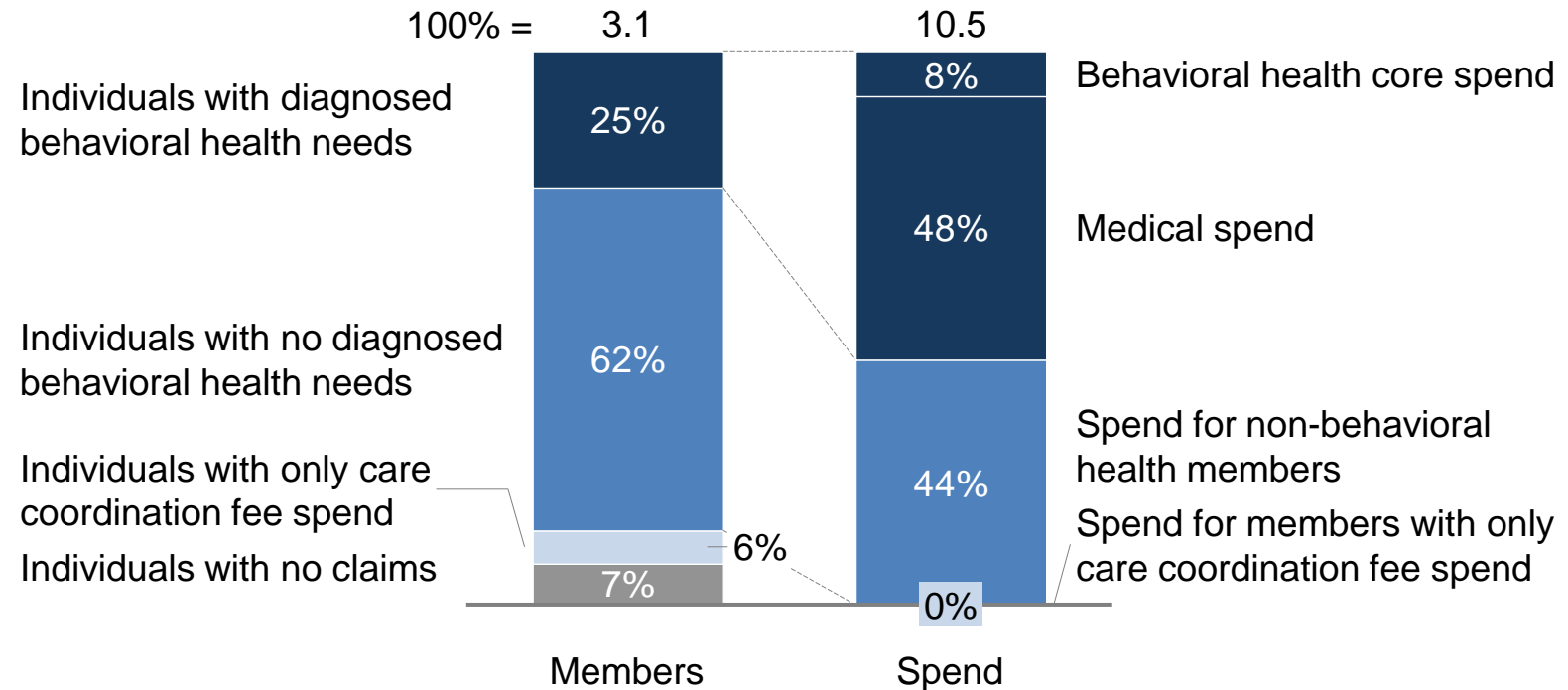
Large **undiagnosed or untreated subpopulations**

Underutilization of community services and **overutilization of intensive institutional care**

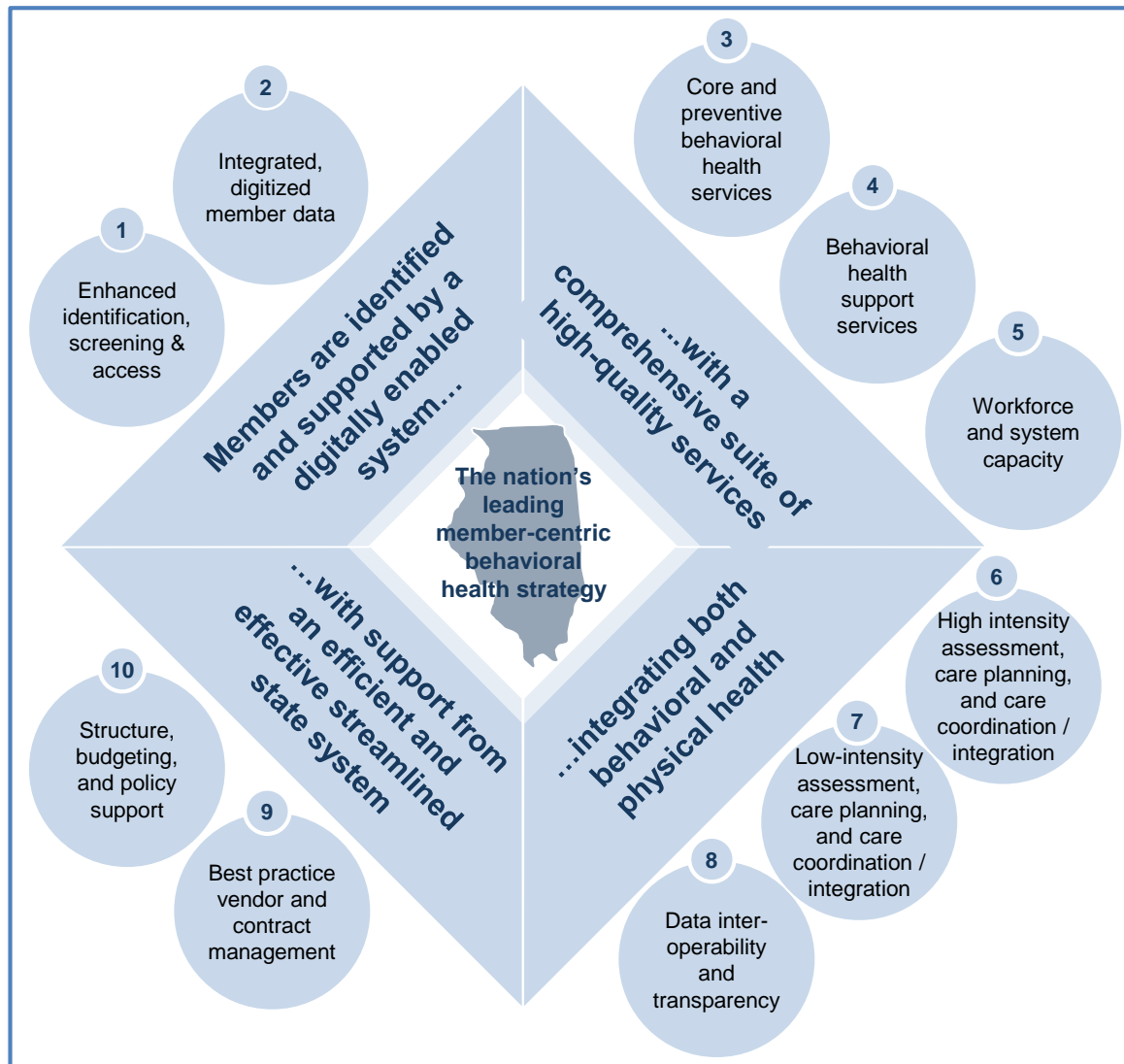
Medicaid individuals with diagnosed behavioral health needs make up ~25% of the population, but ~56% of the total spend

FY2015 members and spend

Annualized members (millions), dollars (billions)



Objectives of the Illinois HHS Transformation to address these challenges



The 1115 waiver will allow Illinois to realize a set of high-priority benefits, alongside initiatives that will maximize their effectiveness

Demonstration waiver benefits

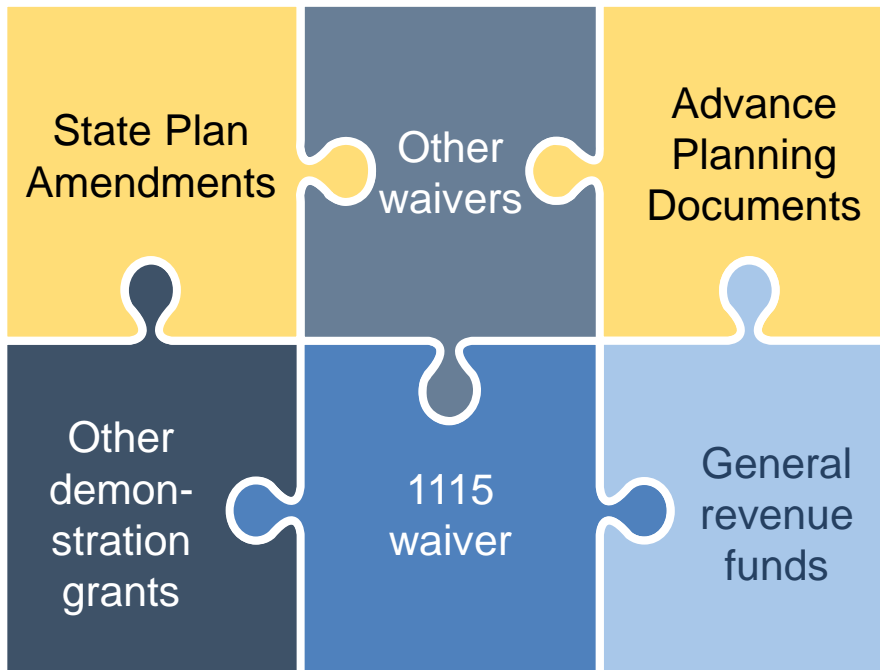
#	Benefit
1	Supportive housing services
2	Supported employment services
3	Services to ensure successful transitions for IDOC- and Cook County Jail (CCJ)-incarcerated individuals
4.1	Services for individuals with substance use disorder in short-term stays in IMDs
4.2	SUD case management
4.3	Withdrawal management
4.4	Recovery coaching for SUD
5.1	Services for individuals with mental health issues in short-term stays in IMDs
5.2	Crisis beds
6	Respite care

Demonstration waiver initiatives

#	Initiative
1	Behavioral and physical health integration initiatives
2	Infant/Early childhood mental health interventions
3	Workforce-strengthening initiatives
4	First episode psychosis (FEP) programs

The State will also pursue initiatives outside the waiver to advance its behavioral health strategy

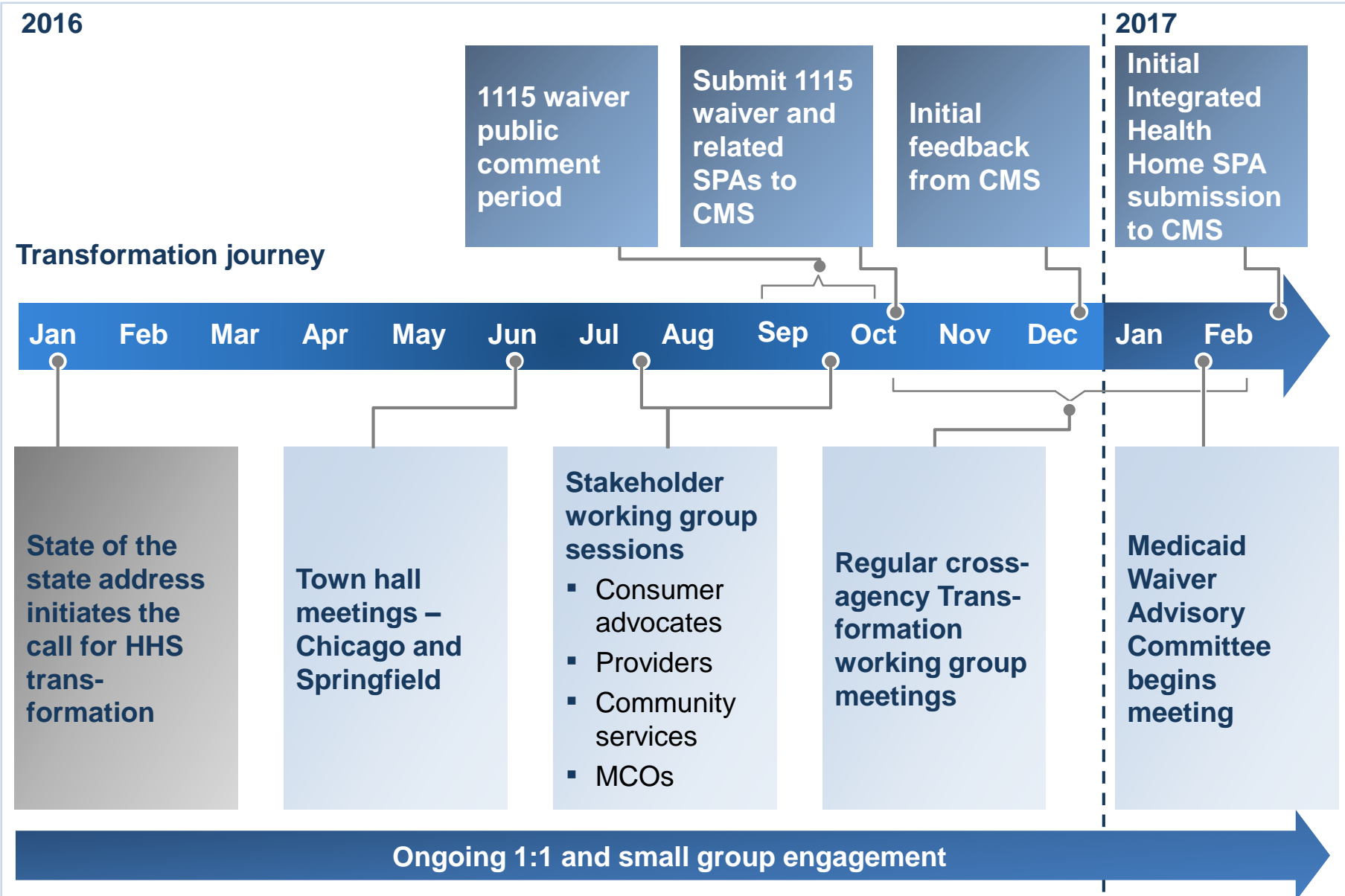
■ Non-waiver initiatives covered here



Other initiatives

- State Plan Amendments (SPAs), including, but not limited to:
 - Integrated physical and behavioral health homes
 - Crisis stabilization and mobile crisis response
 - Medication-assisted treatment (MAT)
 - Uniform Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA)
- Advance Planning Documents (APDs)
 - Data interoperability through 360-degree view of behavioral health member

Overview of transformation journey to date



Agenda for today's discussion

Context of the Illinois HHS Transformation 15 minutes

Objectives of Waiver Advisory Committee 15 minutes

Introduction to Integrated Health Home model 20 minutes

Care delivery model topics for input today 60 minutes

Path forward 10 minutes

The Waiver Advisory Committee will be instrumental to shaping the transformation across several topics

■ Focus for the next two meetings

Working groups presenting material for input

Integrated Health Homes

Home Visiting Pilot

Supportive Housing

Workforce Development

Supported Employment Services

Justice-involved

Respite Care

SUD Case Management

Withdrawal Management

SUD Recovery Coaching

Discussions across topics will focus on the insights from your experience and potential implications of design decisions under considerations



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Integrated Health Homes topics for advisory committee consideration

■ Focus for today

Care delivery model (January 19)

- Foundational decisions for **an Integrated Health Home's role in the ecosystem:**
 - 1 **Member inclusion**
Who should be included in the model?
 - 2 **Care delivery improvements**
How can we best meet members' needs?
 - 3 **Provider standards and support**
What requirements should be expected of providers, and how can we support them in reaching these?

Detailed model (Following meeting)

- Next set of **detailed design decisions** including:
 - **Activity requirements**
What forms of care coordination should providers be capable of offering members?
 - **Incentives for value-based care**
How can we drive increases in provider performance?
 - **Quality and efficiency measures**
How should we measure provider performance?
 - **Scale-up approach**
How should the program be rolled out?

What an Integrated Health Home is and is not

Integrated Health Homes in Illinois are:

Primary focus is on coordination of care...

- **Integrated, individualized care planning and coordination resources**, spanning physical, behavioral and social care needs
- An opportunity to **promote quality** in the core provision of physical and behavioral health care
- A way to **encourage team-based care** delivered in a member-centric way
- A way of **aligning financial incentives** around evidence-informed practices, wellness promotion, and health outcomes

For members with the highest needs:

- A means of facilitating **high intensity, wraparound care coordination**
- An opportunity to obtain **enhanced match for care coordination needs**
- **Identifying enhanced support** to help these members and their families manage complex needs (e.g., housing, justice system)

Integrated Health Homes in Illinois are NOT:

... and NOT on the **provision of all services**

- **Provider of all services for members**
- **A gatekeeper** restricting a member's choice of providers
- **A physical place** where all Integrated Health Home activities occur
- **A care coordination approach that is the same for all members** regardless of individual needs

Anything else you would add to these lists?

Principles for Integrated Health Homes in Illinois

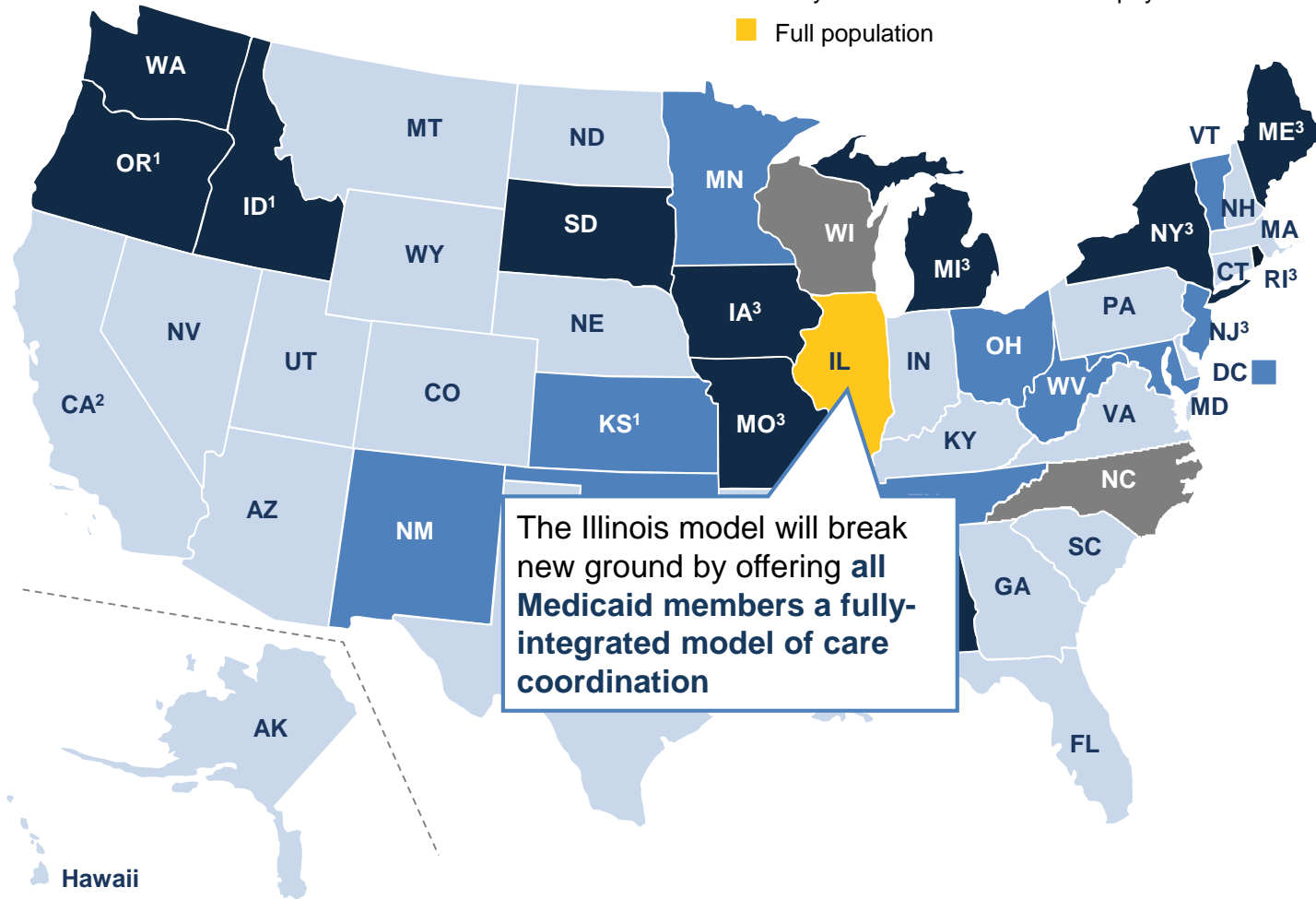
- ✓ Develop a **person- and family-centered care delivery model for the whole Medicaid population, regardless of match status**, that encourages member and family engagement
- ✓ Evolve toward **full clinical integration of behavioral, physical, and social healthcare**
- ✓ Craft a flexible care delivery approach that reflects **the diverse needs of members in Illinois** and recognizes that member needs change over time
- ✓ Acknowledge and accommodate **geographical variation in provider capabilities, readiness, and priorities**
- ✓ Strike an **appropriate balance between provider flexibility and accountability** to enable capabilities and readiness
- ✓ Prioritize **economic sustainability of care delivery model** at both the systemic and provider levels

Goal is to begin launch of model by July 2017

To date, 33 Health Home models have been developed throughout the United States

Inclusion criteria:

- Only focused on members with behavioral health conditions
- Broader population, including members with behavioral health conditions
- Only focused on members with physical health conditions
- Full population



The Illinois model will break new ground by offering all Medicaid members a fully-integrated model of care coordination

1 Oregon, Idaho, and Kansas have opted not to continue their programs

2 California will launch its Health Home model in July 2017

3 State has initiated multiple health home models

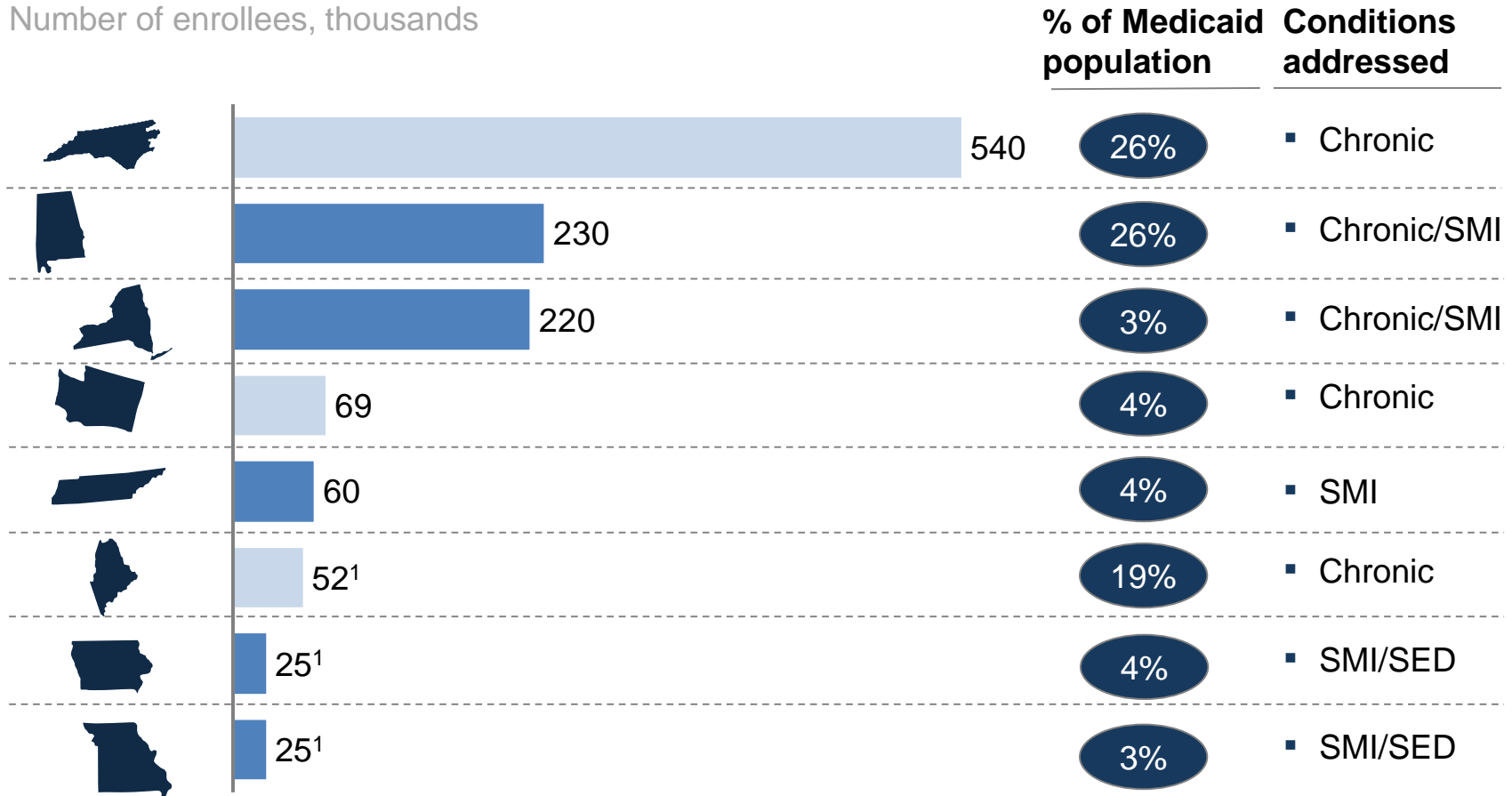
SOURCE: Open Minds; CMS database of approved Medicaid Health Home State Plan Amendments, as of December 2016

Profiles of ACA Health Homes launched to date

Illinois would be first fully integrated Health Home

■ Includes members with SMI/SEDs

Largest Medicaid Health Home programs developed to date

















Many states also employ PCMH programs to coordinate the physical health needs of their members separately, but **Illinois model would coordinate both physical and behavioral health care for all ~3.1m Medicaid members**

¹ Only includes members who are part of the state's largest Health Home program

Illinois' model would address the needs of a broad range of member archetypes



Archetype	Age	Living situation	Behavioral health condition
 Jerry	Toddler	In at-risk home	At-risk
 Jane	Child	Youth in care	ADHD/ODD
 Connor	Teenager	Transferring to congregate care	Severe aggression
 Brice	Teenager	Urban home	Major depression
 Mike	Teenager	Juvenile institution	Bipolar disorder/ alcohol and marijuana abuse
 Mia	Teenager	Rural home	Opioid abuse
 Jenn	Young Adult	Rural home	Anxiety
 Greg	Young Adult	Correctional facility	Schizophrenia
 Stephen	Adult	Experiencing homelessness	Actively psychotic/ opioid abuse
 Darnell	Adult	Experiencing homelessness	Post-traumatic stress
 Ashley	Adult	Permanent supportive housing	Schizophrenia
 Tom	Adult	Friend's couch	Alcohol and heroin abuse
 William	Adult	Rural home	Alcohol abuse
 Cynthia	Aged	Skilled nursing facility	Moderate anxiety and depression

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Approach for reviewing care delivery model design decisions

- The items that follow comprise the working group's **initial perspective on key care delivery model design decisions**, thanks to close collaboration between representatives from the Department of Healthcare and Family Services, Division of Mental Health, Department of Children and Family Services, Division of Alcoholism & Substance Abuse, and the Illinois Department of Public Health
- These ideas **build on work done** as part of the Healthy Illinois 2021 plan, supported by a State Health Assessment, SIM grants, and a State Health Improvement Plan
- **The working group seeks your input on these decisions**, both on the direct questions posed on the following pages, and with regard to any other queries or modifications you might suggest as we discuss the decisions more broadly.
- **Your responses today will help refine and improve these decisions**, and will be reflected wherever possible

Integrated Health Homes working team

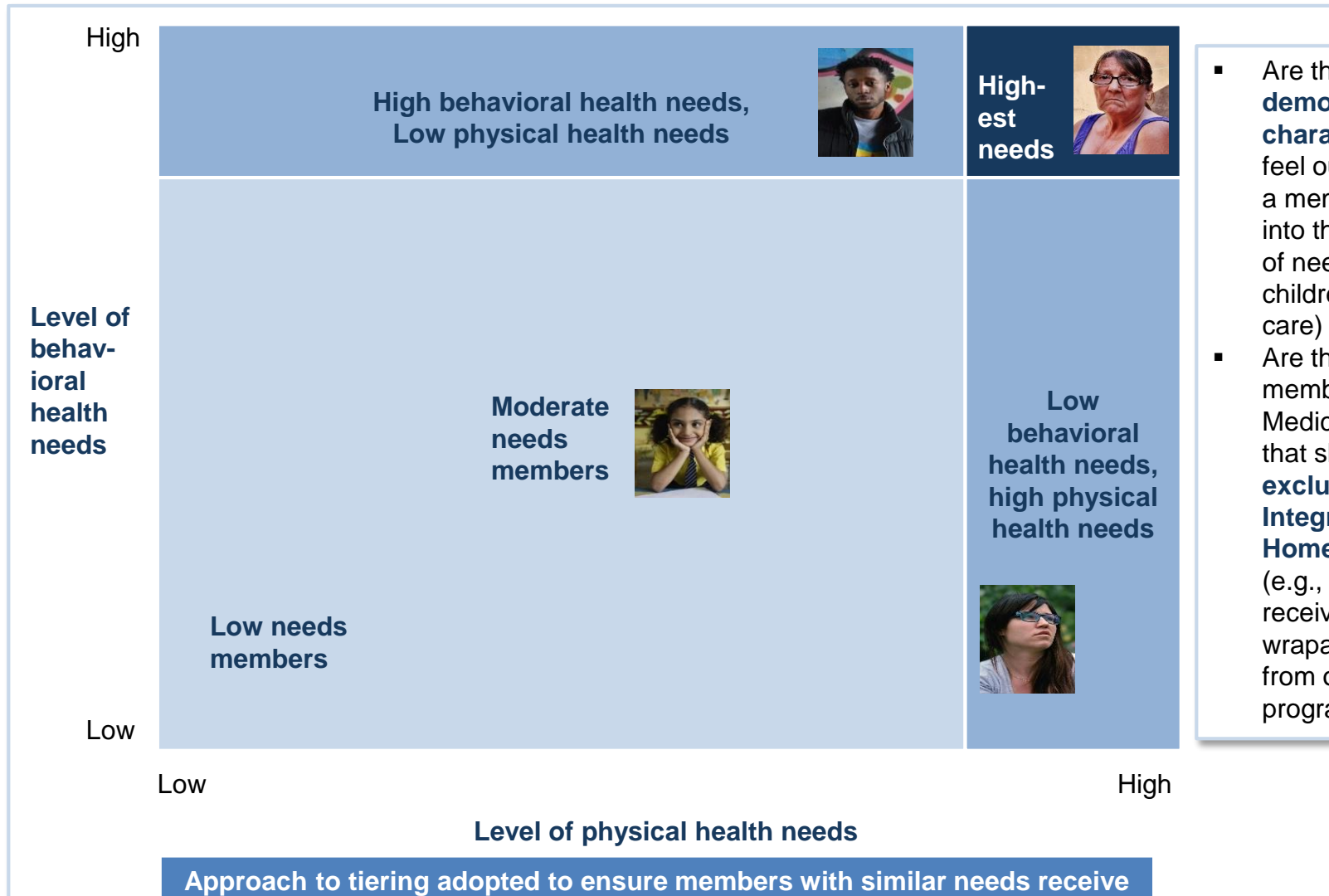
Team lead

Teresa Hursey

Team members

<u>Name</u>	<u>Agency</u>	<u>Name</u>	<u>Agency</u>
Jayne Antonacci	DASA	Paula Jaudes	DCFS
Maria Bruni	DASA	Diana Knaebe	DMH
Mary Doran	HFS	David Kuriniec	HFS
Juliana Harms	DCFS	Catina Latham	HFS
Amy Harris-Roberts	HFS	Shannon Lightner	IDPH
Kristine Herman	HFS	Lee Ann Reinert	DMH

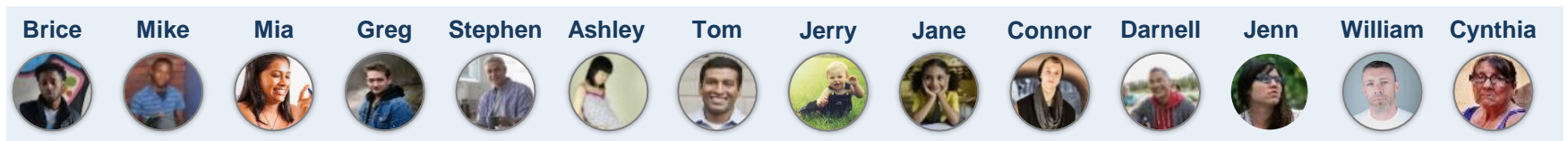
1 Member inclusion and engagement: Introduction to suggested approach



- Are there **demographic characteristics** you feel ought to qualify a member for entry into the highest tiers of need (e.g., children in DCFS care)
- Are there any members of the Medicaid population that should be **excluded from Integrated Health Home membership** (e.g., those already receiving wraparound support from other programs?)

Approach to tiering adopted to ensure members with similar needs receive comparable care coordination support, and to focus resources on those members who need greatest support

2 Integrated Health Homes will deliver improvements in care delivery across a range of areas



Managed Care Organizations

Enhanced access, screening, and assessment

Higher-needs population¹

Lower-needs population¹

Integrated Health Homes

Higher-intensity Integrated Health Homes

Lower intensity Integrated Health Homes

Integrated care planning and monitoring

Physical/maternal health provider engagement

Behavioral health provider engagement

Population health management

Member engagement and education

Supportive service coordination

Reporting of quality and efficiency of care (i.e., member outcomes)

Payment streams, in response to Integrated Health Homes meeting requirements and improving outcomes

¹ Actual tiering of intensity of care coordination may not be binary

2 IHHs achieve 6 main goals for members and families

Barriers to integrated care	Integrated care facilitated by IHH care coordination
<p>Infrequent data sharing and communication between providers</p> <p>Siloed care planning</p>	<p>Providers take holistic view of health, supplying full set of services appropriate to members' needs</p> <p>Comprehensive care plans developed with member and caregivers, supported by ongoing communication with behavioral and physical healthcare providers</p>
<p>Frequent barriers to attendance to medical appointments</p> <p>Little continuity in care delivery across providers</p>	<p>Improved access to providers for routine appointments and time-sensitive support</p> <p>Integrated experience with seamless connections and communication across providers</p>
<p>Frequent barriers to attendance to behavioral health appointments</p> <p>Little continuity in care delivery across providers</p>	<p>Improved access to providers for routine appointments and time-sensitive support (e.g., MCR)</p> <p>Integrated experience with seamless connections and communication across providers</p>
<p>Limited provider engagement with community supports in the care and recovery process (e.g., schools, Big Brothers/Sisters, AA)</p>	<p>Access to and collaboration with community supports is prioritized (e.g., supported housing, employment, and services offered by agency partners)</p> <p>Member needs are communicated to community partners</p>
<p>Infrequent follow-ups and outreach to members and their caregivers (including foster families)</p> <p>Reactive treatment programs, with little emphasis on self-care, education, and social skill development</p>	<p>Support for treatment and medication adherence (e.g. Ritalin, MAT)</p> <p>Enhanced social skills education, self-care, and engagement with supports (e.g., child & family teams)</p>
<p>Providers take a case-by-case view of population health</p> <p>Member focus determined based on episodes</p> <p>Providers make limited use of screening tools (e.g., CANS, ANSA)</p>	<p>Improved dialogue among providers on quality outcomes across panel</p> <p>Continuous stratification of panel and use of standardized assessment processes to identify highest-needs members</p>

What should be added to these goals?

2 Meet Brice, a teenager with depression and multiple suicide attempts

How the system is set up for Brice today



- Brice is **16 years old**, lives at home, and is **Medicaid-eligible**
- Brice has major depressive disorder and has had **multiple suicide attempts**
- Brice is linked in to a **community mental health** center who manages his behavioral health treatment and **coordinates his care** with his school psychologist and his primary care physician
- When Brice is actively suicidal he receives **crisis stabilization services from his CMHC** and, when necessary, they admit him for inpatient psychiatric care
- When Brice gets older, the agencies and providers involved in his care help him **transition into the adult system**

Health care pain points

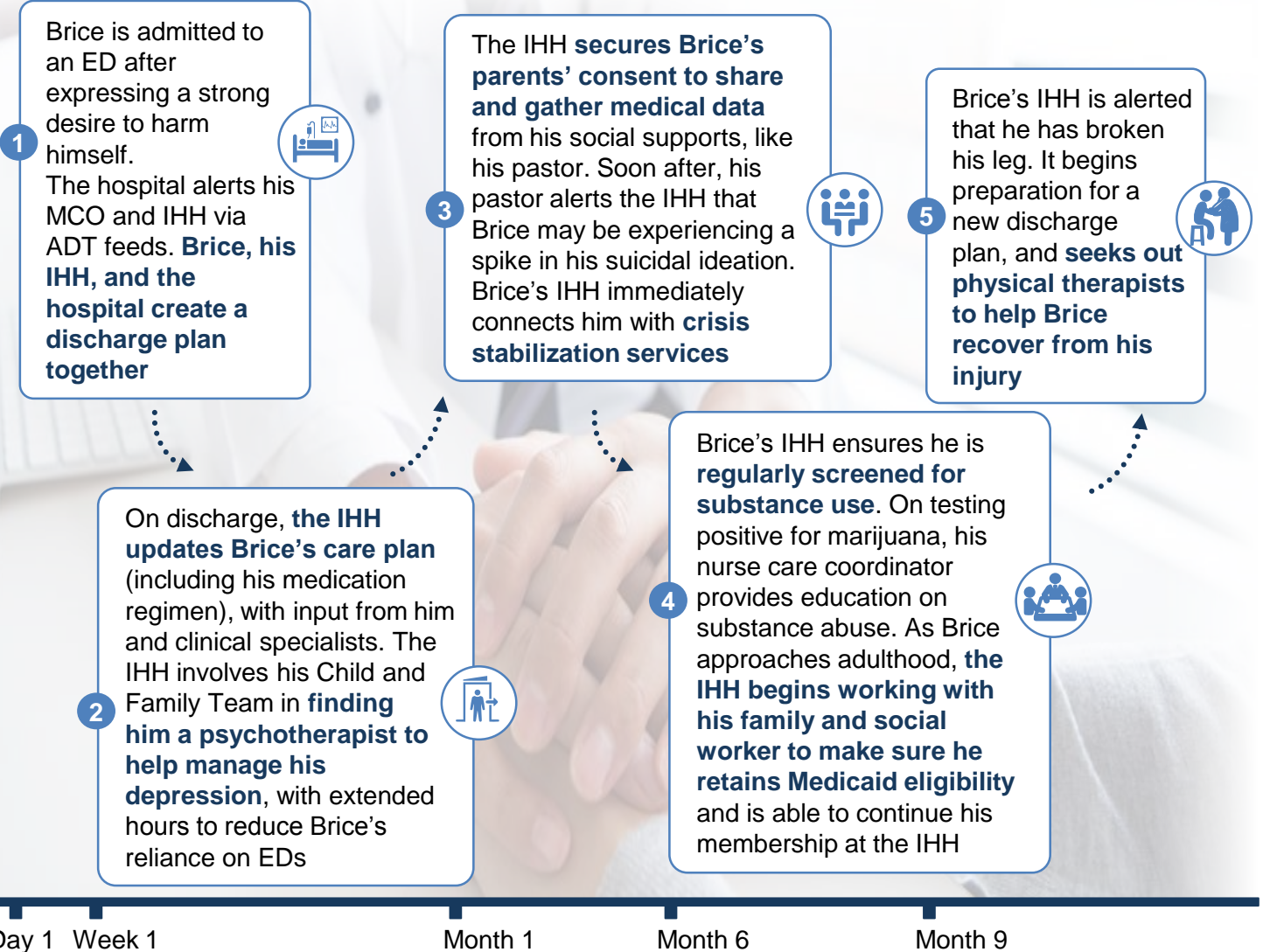
- **Value**
 - Brice's physician does not adhere to a preferred drug list and **prescribes expensive**, non-generic anti-depressants
 - Brice's **utilization of inpatient treatment is not optimal**; he is often admitted unnecessarily or not admitted when it is necessary. When he is admitted, his length of stay is sometimes longer or shorter than necessary
- **Quality**
 - Brice is prescribed anti-depressants, but **does not receive evidence-based psychotherapy services** for his depression
 - His psychiatrist is not aware that Bryce uses alcohol and marijuana on weekends due to difficulty coordinating lab testing
- **Continuity**
 - Brice's inpatient psychiatrists **do not effectively communicate** with his CMHC to optimize his care during his inpatient stays
 - **Data is siloed**, so the prescribing CMHC physician is blind to other prescribers who may be providing care to Brice
 - Brice's school and church notice when he is more depressed, but are **not linked with his CMHC** to inform them of the change
- **Access**
 - When Brice turns 19 he loses his Medicaid eligibility and **does not sign up for health insurance**

2 For consideration: How should Brice's IHH deploy resources to help manage his changing level of need over time?

Level of need



- Brice is a 16 year old from Chicago with **major depression and suicidal ideation**
- Before joining an IHH, **Brice's conditions were not managed effectively or holistically**
- Since joining an IHH with the right capabilities to meet his changing needs, his care has been **better integrated, leading to improved outcomes for him**



Which other clinical or supportive services should Brice's IHH prioritize connecting him with?

Meet Tom, an adult with alcohol and opioid use disorders and spent time in the correctional system

How the system is set up for Tom today



- Tom is 36 years old, newly **Medicaid eligible**, and lives in a friend's home
- Tom has **alcoholism and opioid use disorder as well as early signs of diabetes**
- Tom receives **level II substance use disorder treatment** from a local outpatient substance use disorder provider
- Tom gets **primary care services** from his local PCP; the clinic regularly screens him for diseases common in alcoholics and **coordinates his care** with his substance use disorder provider
- If Tom suffers an opioid overdose, EMS brings him to the **emergency room** where he is stabilized and discharged to a **withdrawal management treatment center**
- Tom's outpatient substance use disorder provider (level II) works with Tom's residential treatment providers to plan for a **safe discharge and transition**
- Tom may be eligible for Medication Assisted Treatment and may be evaluated by a trained physician/methadone provider
- Tom **may be eligible for Level III.5** care if he has difficulty staying sober; however he must sufficiently engage in withdrawal management before he will be allowed admission
- Tom has access to a variety of services to support him including **recovery homes and alcoholics anonymous**

Behavioral health pain points

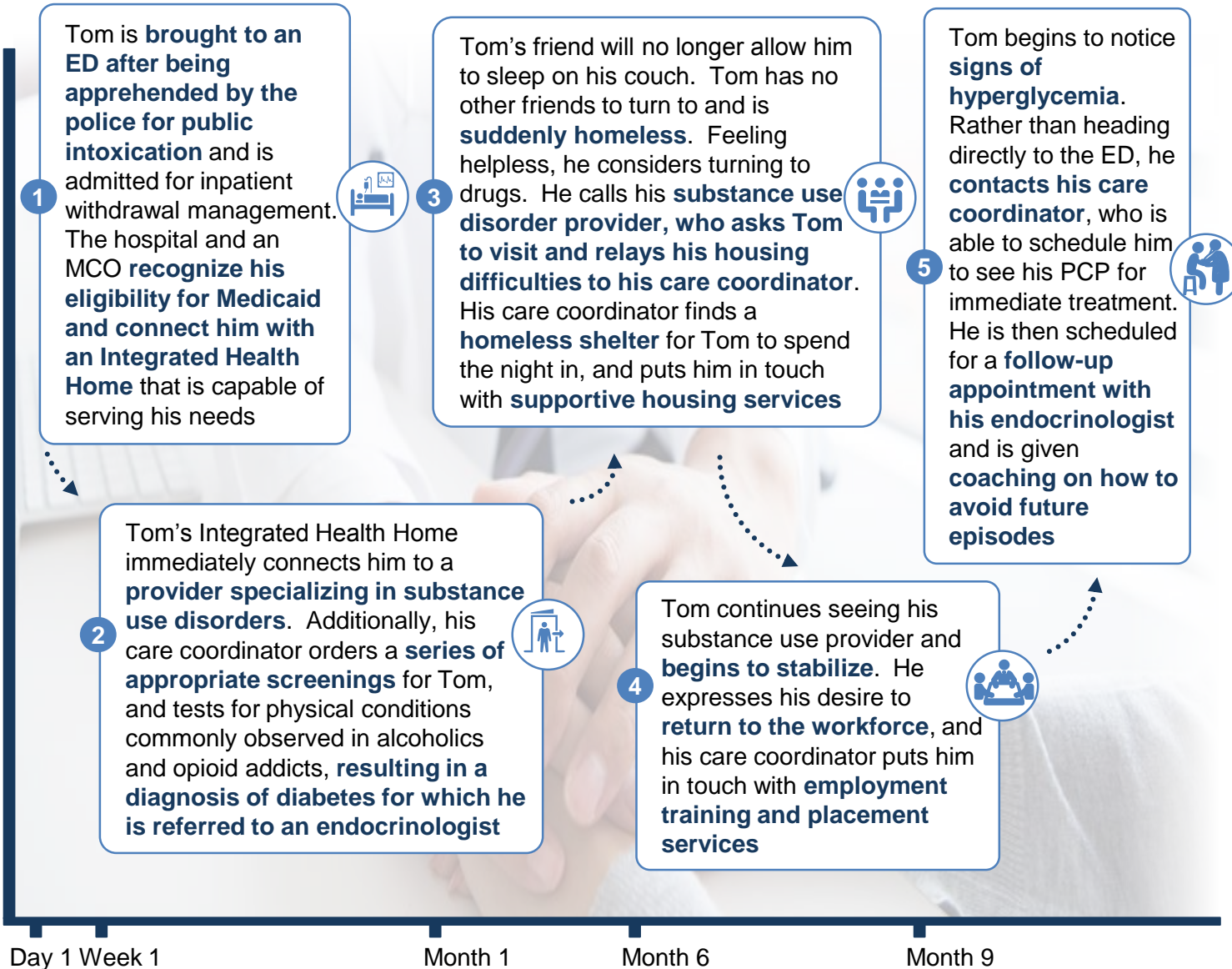
- **Value**
 - Tom is at risk for losing his housing (his friend has given him one week to get off the couch); living on the street will likely exacerbate Tom's addictions eventually leading to **need for high intensity care**
 - Tom's alcoholism puts him **at risk for serious medical illnesses**, but he does not see his PCP so is not provided counseling or screening for these diseases; when they finally manifest they are severe and expensive
 - There is a shortage of withdrawal management programs for opiate addiction so **Tom must engage in withdrawal management in the expensive ED/acute care hospital**
- **Quality**
 - When Tom is drunk on the street and brought to the ED the providers discharge him when he is sober without offering him any substance use disorder recovery services
 - Tom **requires but does not receive testing for diabetes** and education on the disease and its treatment
- **Continuity**
 - Tom finally does go to an inpatient substance use disorder treatment facility, but is **discharged without a holistic array of recovery services like case management and job training**, leading to a quick relapse
- **Access**
 - Tom's addictions lead him to **avoid doctors** and so he does not seek medical treatment for his feet which he notices are slowly becoming numb; an early sign of diabetes
 - Tom sometimes stays in homeless shelters; **but he does not receive substance use disorder referrals** while there
 - Tom does not have access to transportation, causing him to frequently miss appointments
 - There is a **shortage of withdrawal management programs for opiate addiction** and Tom has trouble finding a place to stabilize so that he can become eligible for Level III.5 services

2 For consideration: After joining, Tom's IHH uses screenings to identify his unmet needs and engages social supports extensively

Level of need



- Tom is a 36 year old with **opioid use disorder, alcoholism, and early signs of diabetes** who is currently **staying on his friend's couch**
- He has **intermittent relationships with several providers** and was **not previously recognized as Medicaid eligible**
- He has been **admitted to an ED before** for substance use but has **continued to use and no one has followed-up**



3 Guiding principles for determining eligibility of provider types

- Include provider types already capable of **providing fully-integrated physical and behavioral health care**
- Ensure other provider types can **demonstrate capability to collaborate effectively with other providers** whose abilities complement their own
- Select provider types whose institutional character ensures ability to **maintain long-term relationship with members**
- Avoid excluding provider types where significant numbers of members have shown **preference for establishing therapeutic and/or coordination relationships**
- Exclude provider types catering exclusively to specific age-groups, in order to **ensure providers will be able to coordinate care for whole families**

What other principles should be considered?

3 States may choose from among a set of provider types in the Health Home SPA, and may add additional provider types beyond this set

	<u>Physical Health Providers</u>	<u>Behavioral Health Providers</u>
Provider types offered by default in Health Home SPA	<ul style="list-style-type: none"> ▪ Primary care physicians ▪ Clinical practices or clinical group practices ▪ Rural health clinics ▪ Community health centers ▪ Case management agencies ▪ Home health agencies ▪ Federally Qualified Health Centers 	<ul style="list-style-type: none"> ▪ Community mental health centers ▪ Community/behavioral health agencies
Select provider types observed in other Health Homes	<ul style="list-style-type: none"> ▪ Physicians/physician groups employed by hospitals (e.g., Missouri) ▪ Tribal health centers (e.g., Michigan) 	<ul style="list-style-type: none"> ▪ Substance abuse providers (e.g., Vermont) ▪ Mental health providers employed by hospitals ▪ Psychiatric rehabilitation programs ▪ Mobile treatment service providers (e.g., Maryland)

1 Also permissible to use teams of select healthcare specialist types (with one designated as lead entity) and entities with state-specific accreditation (e.g., Maine's Enhanced Primary Care Practice)

SOURCE: CMS SPA guidelines; State Health Home SPAs

3 Provider types under consideration for inclusion in the program vary depending on member need

	Members with low or moderate behavioral health needs	Members with high behavioral health needs	
	Physical health provider is lead entity (“PCP on steroids”)	Scenario 1: Behavioral health provider is lead entity ¹	Scenario 2: Physical health provider is lead entity ¹
Eligible physical health provider types	<ul style="list-style-type: none"> Primary care physicians Clinical practices or clinical group practices Rural health clinics Physicians and physician groups employed by hospitals Community health centers Federally qualified Health centers 	<ul style="list-style-type: none"> Any physical health provider type in accordance with the Health Home SPA default list Any other State-approved physical health provider type² 	<ul style="list-style-type: none"> The same set of physical health providers eligible to serve as IHHs for members with low or moderate behavioral health needs
Eligible behavioral health provider types	<ul style="list-style-type: none"> Any behavioral health provider type in accordance with the Health Home SPA default list (e.g., community/behavioral health agencies) Any other provider type capable of serving members with moderate behavioral health needs (e.g., clinic within hospital)² 	<ul style="list-style-type: none"> Community mental health centers Other eligible specialty behavioral health provider types as approved by the State² 	<ul style="list-style-type: none"> Community mental health centers Other eligible specialty behavioral health provider types as approved by the State²

Are there additional provider types that should be explicitly included or excluded from consideration here?

¹ With collaborative agreement in place with corresponding entity ² Excludes e.g., psychiatric rehabilitation programs

3 Staffing and technical requirements suggested to deliver effective care coordination and to reflect current provider capabilities

IHHs serving members with low or moderate behavioral health needs

Staffing requirements

- **Health coordinators:** Lead nurse care manager; nurse care manager; clinical care coordinator
- **Clinical experts:** Physician and psychiatrist or similar behavioral health specialist

Software requirements

- State-mandated screening tools and functional assessments, with use of Admission, Discharge, Transfer feeds as rolled out, **and progression toward Electronic Health Record use encouraged**

Collaborative agreements

- **Collaborative agreement** with a provider capable of providing for moderate behavioral health needs

IHHs also serving members with high behavioral health needs

- **Health coordinators:** As above, with expectation of training to ensure compliance with High Fidelity Wraparound approach and comparable approaches for adults
- **Clinical experts:** As above, with substance use disorder specialist & psychologist
- **Social supports:** Social worker; recovery support specialist

- **Same requirements** as for providers serving members with low and moderate needs

- **Collaborative agreement** with:
 - A PCP if the lead entity is a specialist behavioral health provider
 - A behavioral health provider capable of treating members with high behavioral health needs if the lead entity is a PCP

- What challenges might there be in different parts of Illinois to meet these requirements?
- How can collaborative agreements be written to ensure true collaboration among providers?
- At what point should EHR usage become mandatory for providers?

3 Potential approaches to providing support

Type	Approach	Description
Capability building	Learning collaborative	<ul style="list-style-type: none"> Entity that supports regular discussions, exchanges of best practice, conversations on working effectively with Medicaid/MCOs, and networking/mentoring among IHH providers
	Coaching	<ul style="list-style-type: none"> Training and technical support on workforce development, care coordination/integration, and other topics central to IHH performance
	Pilots	<ul style="list-style-type: none"> Disease-specific integration pilots to build a foundation for behavioral and physical health collaboration among relevant providers (e.g., diabetes and depression; non-opioid collaborative therapy etc.)
Infra-Structure	Grant support	<ul style="list-style-type: none"> Support grant applications to enhance provider infrastructure or capabilities (e.g., workflow or member data analysis software, telemedicine systems)
Program eligibility support	Readiness assessment	<ul style="list-style-type: none"> Development of an IHH readiness assessment tool to evaluate processes that providers have in place and ability to perform integrated activities, permitting providers to baseline their capabilities and learn from best practice
	Outreach, support, & technical guidance	<ul style="list-style-type: none"> Efforts spanning initial attempts to alert providers to existence of program and its benefits, through to targeted support and guidance through application process, e.g., through supplying draft text of collaborative agreement

What other forms of support should be offered to providers – and when?
 What capabilities will providers require greatest help in developing?

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Integrated Health Homes – agenda for our next discussion

Detailed model (Following meeting)

- Next set of **detailed design decisions** including:
 - **Activity requirements**
What forms of care coordination should providers be capable of offering members?
 - **Incentives for value-based care**
How can we drive increases in provider performance?
 - **Quality and efficiency measures**
How should we measure provider performance?
 - **Scale-up approach**
How should the program be rolled out?

Appendix

Glossary of acronyms (1/2)

Acronym	Meaning
AA	Alcoholics Anonymous
ADT	Admission, discharge, transfer messaging
ANSA	Adult Needs and Strengths Assessment
CANS	Child and Adolescent Needs and Strengths assessment
CMHC	Community Mental Health Center
ED	Emergency department
EMS	Emergency medical services
IAPD	Implementation Advanced Planning Document
IHH	Integrated Health Home
IMD	Institution for mental disease
MAT	Medication Assisted Treatment

Glossary of acronyms (2/2)

Acronym	Meaning
MCO	Managed care organization
MCR	Mobile crisis response
ODD	Oppositional defiant disorder
OAPD	Operations Advanced Planning Document
PAPD	Planning Advanced Planning Document
PCP	Primary care physician
SBIRT	Screening, brief intervention, and referral to treatment
SED	Serious emotional disorder
SMI	Severe mental illness
SPA	State Plan Amendment
SUD	Substance use disorder