BHTWG CORE ELEMENTS
MENU OF OPTIONS

CORE ELEMENTS	BEST PRACTICES				
	Clinical	**Operational/ Administrative**	**Financial**	**Oversight**	**Population-Specific Considerations (i.e. Medi-Medi; SMI and Specific Quadrant(s)**
1. Care Management	• Screening on intake and periodically thereafter to determine clear treatment pathways • Personal physician assigned to each patient who is responsible for overall care • Care Coordination • Team-based care • Shared philosophy of care between BH, SU and PCP staff • Shared treatment plans • Psychiatric consultation/back to PCP and care manager • Define treatment and service array	• Co-location of MH/SU and Primary Care, including "virtual" • Partnerships Between County MH/SU and Primary Care Providers • Buy-in by top leadership and health providers • Inter-disciplinary collaboration, communication and cross-training • Ensuring connection to and, to the extent possible, enrollment in other medical and social benefits programs • Navigators to help facilitate linkages	• Case rate to cover care mgmt; risk adjustment for quadrant • Same day visit reimbursement • Alignment of incentives • Reimbursement for MFT's services at primary care • Removal of two-session cap on psychologist session	• Locally accountable entity to oversee integration	• Target highest-intensity services to SMI population • Quadrants 2,3,4 • Composition of care teams dependent on Quadrant

2. Data Management and Information Exchange	• Feedback mechanisms to inform patients clients and administrators using data • Registry for outcomes tracking and care planning • Population-based care and panel management	• Information technology/electronic data systems to facilitate information sharing • Interim paper-based systems but only to allow time for electronic systems to develop • Mechanisms to address confidentiality issues • Analytic capacity to interpret and analyze data and document outcomes	• Tracking costs and expenditures	• Assignment of responsibility and MOUs	
3. Engagement of Consumers	• Self management and coping skills training • Consumer participation in care plan development • Linkage of consumer with support resources in the community • Appointment reminders and follow-up	• Pilot program design • Evaluation of services • Use of peers/promotores • Expanded clinic hours • Open scheduling • Non-visit options for communication, such as phone and/or email • Expanded access	• Mechanism for paying for peers as part of care team • Mechanism for paying for support services linking consumer with needed resources • Paying for outreach		

	• Incentives for initial engagement (ie food vouchers) • Health coaching	through telehealth			
4. Clear Designation of Person-Centered Health care Home	• Regular screening (for MH/SU in primary care and for health status in MH/SU settings) • Bi-directionality • Determine role for SU provider as potential health home • Provider engagement, including substance use • "Warm" hand-off • Stepped care, informed by registry data • Follow up assessments	• Training for staff • Creation of Registry • Inclusion of experienced staffing in mental health, physical health and substance abuse (as they relate to different quadrants) • Use of evidence-based algorithms and guidelines to determine initiation, termination, type and level of treatment • Assignment of responsibility for follow up assessments	• Alignment of incentives to support treatment with the preferred choice of provider of the consumer	• Locally accountable entity to oversee integration • Use IPI Continuum to identify responsibilities of different providers	• For Q 1 & 3, HC home likely in primary care site • For Q 2 & 4, HC Home may be mental health site
5. Performance Measures	• Standardized clinical measures across all three disciplines and feedback mechanisms • Quality of life indicators	• Process measures	• Financial incentives for meeting process measures • Financial incentives for quality		