MIDD Advisory Committee
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RFA for PRI-03 Prevention and Early Intervention Behavioral Health for Adults over 50 is planned for release in mid-May 2019 for new contracts to start in January 2020.

Summary of Initiative

This initiative provides behavioral health screening for older adults receiving primary medical care in the health safety net system. Those who screen positive are enrolled in the Mental Health Integration Program (MHIP) based on the evidence-based Collaborative Care Model. MHIP is a short-term intervention (6-8 months) delivered in the primary care setting

Our current subcontractors, with a few changes over the years, have been engaged in providing services under this initiative since the beginning of MIDD in King County in 2008. They currently include 5 King County Federally Qualified Health Centers (FQHCs) and Harborview Medical Center outpatient clinics. Collectively these agencies provide primary care at over 27 sites in King County.

In the 2017 MIDD Annual Report, this initiative:

- Screened **12,870** older adults for depression and other behavioral health issues.
- Engaged **1,164** of the older adults who screened positive in the Mental Health Integration Program (MHIP).
- Reduced depression symptoms for **67%** of those older adults who were served long enough to have multiple symptom measure.

Braided Funding

Since the beginning of the initiative, this funding has been braided with funding from the Veterans and Human Services Levy (VHSL) which also invests in MHIP services for other vulnerable populations in the health safety net primary care system including pregnant and parenting women, the uninsured/low-income under-insured (the former GAU population) and veterans and their family members. With the renewal of the levy and the addition of the Seniors population, funding has now been added to address behavioral health integration for seniors.

King County MHIP Success and Medicaid Transformation

The success of King County's 10+ year investment in this work through both the MIDD and the VSHSL has received statewide recognition. MHIP has been identified as a model to be scaled as part of Medicaid Transformation efforts underway in Washington State towards bi-directional integration of physical and behavioral health.

Request for Application (RFA)

- It has been over a decade since this funding was originally awarded.
- The RFA, scheduled to be released in mid-May, will continue to braid funding from the renewed VSHSL.
- We are working with staff from both the VSHSL and MIDD to develop the RFA and the evaluation plan so the contracting process will be as seamless as possible for agencies who may receive both streams of funding.
- The scope of work is also being updated in the RFA to reflect changes in the health safety net primary care environment since the initiative began and to align with Medicaid Transformation in King County being led by HealthierHere, King County's Accountable Community of Health (ACH).

Essential Elements of MHIP

1. Patient Centered Team Care
    a. Primary care and behavioral health providers collaborate using a shared care plan
    b. Care Team consists of the Primary Care Provider, the Behavioral Health Care Manager and a Psychiatric Consultant.
    c. Patients receive physical and mental health care at a familiar location
2. Population-Based Care
    a. Care Team shares a defined group of patients tracked in a registry so no one falls through the cracks
    b. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation
3. Measurement-based Treatment to Target
    a. Clinical outcomes are routinely measured using evidence-based tools (such as the PHQ-9 and GAD-7)
    b. Treatments are actively changed if patients are not showing improvement as expected until the clinical goals are achieved
4. Evidence-Based Care
    a. Patients are offered treatment with credible research evidence to support their efficacy in treating the target condition

What does this look like for a patient?

- **Identification of a behavioral health condition in the primary care setting**

  A 56-year old patient, Isabel, comes in to see her primary care provider (Dr. Alicia) for a check-up related to her diabetes. As part of her pre-visit paperwork, Isabel completes a PHQ-9 screening questionnaire for depression and gives it to the medical assistant. The medical assistant tallies the questionnaire and alerts Dr. Alicia that the patient has an elevated score indicating depression. Dr. Alicia notes in the list of medications that Isabel is already on an anti-depressant medication. After they finish with the diabetes check-up, Dr. Alicia asks Isabel how she is feeling and if she thinks her anti-depressant medication is helping. She learns that Isabel is sad and worried about problems and conflict within her family. Dr. Alicia asks if Isabel would like to meet with her colleague Jamie, another health care provider, who could work with her to help her feel better.

- **Warm hand-off to a behavioral health care manager**

  Dr. Alicia calls Jamie to come in to the exam room to meet Isabel and to talk about scheduling a follow up appointment. Isabel comes back at the end of the week for an appointment with Jamie. Jamie does a clinical assessment to more fully understand Isabela's situation and other behavioral health conditions that may be contributing. She also asks Isabel what her goals are for treatment. They agree that Isabel will come for counseling with Jamie every two weeks to start and Jamie will work with the doctor to think about other medications that may help.

- **Psychiatric consultation**

  In her weekly meeting with the Psychiatric Consultant assigned to work with Jamie, she presents Isabel's case and asks about other medications that may help Isabel. The psychiatrist reviews Isabel's current medications and makes a recommendation for Jamie to discuss with Dr. Alicia. In a follow up appointment, Isabel meets with Dr. Alicia who explains the medication and Isabel agrees to try it.

- **Treatment**

  Isabel starts the new medication and meets every two weeks for counseling with Jamie which includes CBT, mindfulness and assertiveness training. At every visit, Jamie and Isabel complete the PHQ-9 to see if her depression symptoms are improving. In between visits, Jamie meets with the psychiatric consultant and continues to check in about Isabel's progress, including her PHQ-9 scores, and discuss any recommendations for adjusting treatment.

- **Discharge after 6-8 months of Treatment**

  After 3 months of meeting with Jamie and starting her new medication, Isabel's PHQ-9 scores have improved and her most recent score indicates that she no longer has symptoms of depression. Isabel is feeling much better and has achieved her goal for treatment. She and Jamie agree to meet once a month for a few months to check in. After 3 more months, Isabel and Jamie agree that Isabel is doing well and does not need to come back unless she starts to feel sad and anxious again.