CALHIVE BEHAVIORAL HEALTH INTEGRATION (BHI)
IMPROVEMENT COLLABORATIVE

EXHIBIT A
PARTICIPANT REQUIREMENTS

Participation requirements for the CalHIVE Behavioral Health Integration (BHI) Improvement Collaborative are defined below:

A. Data Reporting

Participant agrees to identify a practice or clinic that will serve as a pilot site for behavioral health integration. Participant will enroll and provide data for all clinicians across their organization and the identified pilot practice or clinic site through October 2026.

For the duration of the collaborative data reporting includes

- Submission of required data deliverables on-time. A high level overview of the data submission cycles in provided below in Table 1.
- Use of standard reporting templates provided by CalHIVE (e.g., clinician enrollment file, measurement results file)
- Report on all required measures within the CalHIVE BHI measure set and selected optional measures based on organizational priorities (see Appendix, Table 1)
- Report on all measures for all practice/clinic sites in network, identifying which are from the implementation pilot site
- Report on measurement data based on a 3-month lag in claims processing. The CalHIVE BHI measure set includes a mix of claims/administrative based measures and electronic clinical quality measures designed for reporting from electronic health record systems
- Report on measurement data for rolling 12-month basis at the individual clinician level (Type 1 National Provider Identifier), identifying their associated practice or site of care, and payer/product mix
- Submission of clinician enrollment at beginning of program, with clinician and practice identifiers including: Type-1 NPIs, Type-2 NPIs and Tax Identification Numbers (TIN), practice/clinic address, eligible provider type

Table 1 – Data Submission Cycles Submission

2023			July Cycle Test 1	October Cycle Test 2
2024		April Baseline	July Cycle 1	October Cycle 2
2025	January Cycle 3	April Cycle 4	July Cycle 5	October Cycle 6
2026	January Cycle 7	April Cycle 8	July Cycle 9	October Cycle 10

B. Staff Commitment

Participant will identify individuals to fulfill the following roles for the improvement collaborative by the time of the program launch in July 2023. Note that if roles are not filled by July 2023 there should be a documented plan for hiring that role. These roles may be filled by the same individual.

Team roles should include:

- Executive Sponsor – overall program champion and executive responsible for meeting the program requirements; provides strategic alignment to organization's goals; ensures accountability
- Project Lead – key contact to PBGH staff; manages project day-to-day; ensures milestones are on track
- Clinician Leader – responsible for leading practice improvement and engaging clinicians; understands clinical implications of project
- Behavioral Health Program Lead (if BH services are already offered) – responsible for designing and executing pilot program; understands behavioral health workflows and processes
- Data Manager – person responsible for aggregating and submitting data
- Technical expert (health IT) – has knowledge of current technical systems and ability to make changes
- Quality/performance measurement lead – leads quality improvement projects; has knowledge of organizational performance; able to access patient feedback data

C. Participation in Learning and Improvement Advising

Phases

The improvement collaborative is broken down into two distinct phases, outlined below. Participating provider organizations will be required to complete the following:

- Phase 1: Preparation/Boot Camp (2023 –2024)
    - Understand and build capabilities for collecting and reporting data through coding and clinical documentation
    - Identify a care team; hiring and on-boarding new roles as necessary
    - Identify a pilot practice or clinic site for behavioral health implementation
    - Participants will be required to graduate from the program's Preparation/Boot Camp Phase to participate in Phase 2 (measured by completion of certain milestones in the Implementation Milestone Assessment Tool)
- Phase 2: Implementation & Scaling (2024 – 2026)
    - Apply the program's curriculum, defined in seven distinct steps
    - Implement their BHI model at the pilot practice
    - Refine and begin scaling the integration model more broadly across their network of providers

During both Phase 1 and Phase 2 of the improvement collaborative, participants will be required to actively engage in the program, as demonstrated by:

- Participating in improvement advising (IA) sessions designed to support teams (at least 2 per month)

- Completing offline activities to advance in the program
- Joining and contributing in monthly learning events and webinars
- Attending in-person convening(s) where participating organizations come together for peer-to-peer sharing and learning. No more than two in-person convenings will be hosted in any calendar year.

D. Program Deliverables

With support of an assigned Improvement Advisor, each participant will be responsible for completion of the following program deliverables for core funding:

- Needs Assessment – completed at the beginning of program; will identify strengths and opportunities at organization and pilot site
- Implementation Milestone Assessment Tool – completed four times over course of program; will assess scored progress on milestones across nine domains (project planning, patient/family engagement, workforce, health IT, clinical/care model, financing data/reporting, sustainability, health equity)
- Behavioral Health Integration implementation plan – 1) design of and 2) implementing a workplan to integrate behavioral health into primary care at pilot site
- Sustainability plan – identify workplan for scaling behavioral health integration across entire organization/network

With support of an assigned Improvement Advisors, each participant must complete the following program deliverables for incentive funding:

- Disparity reduction plan – analyze data to identify a health disparity on reported measure and identify plan to remediate
- Depression outcomes – demonstrate improvement at pilot site in "Depression Remission or Response for Adolescents and Adults" measure

EXHIBIT B
PAYMENT SCHEDULE

Total payments of up to $100,000 over the duration of the agreement are available to each participant. Funding includes core (85%) and incentive performance-based payments (15%).

Core payments will be based on three milestones:

- Data Reporting (see Exhibit A, Section A)
- Participation in Learning and Improvement Advising (see Exhibit A, Section C)
- Fulfillment of Program Deliverables (see Exhibit A, Section D)

Incentive payments will be based on two milestones (see Exhibit A, Section D).

The Payment schedule and associated deliverables are outlined in the table below.

Table 2: Payment Schedule & Deliverables

Program Year	Funding Amount - Type	Milestones
Program Year 1 July 2023 – June 2024	Sub-total: $40,000 available	
Payment no earlier than 1/1/24	$20,000 - Core	• Data: Submission of 2 Reporting Cycles (July and October 2023) • Participation: IA & Learning Events • Deliverables: Needs Assessment & Implementation Milestone Assessment (IMAT) (1 of 4)
Payment no earlier than 7/1/24	$20,000 - Core	• Data: Submission of 1 Reporting Cycle (April 2024) • Participation: IA & Learning Events • Deliverables: Implementation Milestone Assessment (IMAT) (2 of 4) • Documented Behavioral Health Integration implementation plan
Program Year 2 July 2024 – June 2025	Sub-total: $35,000 available	
Payment no earlier than 7/1/25	$30,000 - Core	• Data: Submission of 4 Reporting Cycles (July 2024, October 2024, January 2025, April 2025) • Participation: IA & Learning Events • Deliverables: Implementation Milestone Assessment (IMAT) (3 of 4) • Implemented Behavioral Health Integration implementation plan
Payment no earlier than 7/1/25	$5,000 - Incentive	• Documented disparity reduction plan

Program Year	Funding Amount - Type	Milestones
Program Year 3 July 2025 – June 2026	Sub-total: $25,000 available	
Payment no earlier than 7/1/26	$15,000 - Core	• Data: Submission of 4 Reporting Cycles (July 2025, October 2025, January 2026, April 2026) • Participation: IA & Learning Events • Deliverables: Implementation Milestone Assessment (IMAT) (4 of 4) • Implemented Behavioral Health Integration sustainability plan
Payment no earlier than 12/31/26	$10,000 - Incentive	• Data: Submission of 2 Reporting Cycles (July 2026, October 2026) • Depression outcomes at pilot site

Payments will be made by PBGH within 30 days of invoice to PBGH.

To receive payment:

- Participant must submit a W9 form, updated annually
- Participant must establish electronic funds payment via ACH form
- Upon approval from CQC program office for annual deliverables, Participant must issue an invoice to PBGH 30 days prior to payment being issued

APPENDIX
Table 1: CalHIVE BHI Measure Set

Required **Measure & *NQF ID***	**Numerator Description**	**Denominator Description**
Depression Screening and Follow-Up for Adolescents and Adults (DSF) *NQF ID 0418*	Members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care on or up to 30 days after the date of the first positive screen.	Members 12 years of age and older at the start of the Measurement Period. Exclude members with any of the following: - Bipolar disorder during the year prior to the Measurement Period. - Depression during the year prior to the Measurement Period. - In hospice or using hospice services during the Measurement Period.
Depression Remission or Response for Adolescents and Adults (DRR) - 4-8 Months	**Depression Follow Up:** A PHQ-9 total score in the member's record during the Depression Follow-Up Period (4-8 months) **Depression Remission:** Members who achieve remission of depression symptoms, as demonstrated by the most recent PHQ-9 total score of <5 documented during the Depression Follow-Up Period (4-8 months). **Depression Response:** Members who indicate a response to treatment for depression, as demonstrated by the most recent PHQ-9 total score being at least 50 percent lower than the PHQ-9 score associated with the IESD, documented during the Depression Follow-Up Period (4-8 months).	Members 12 years and older as of the start of the Intake Period who meet all the following criteria: - A PHQ-9 total score >9 documented during the Intake Period. - A diagnosis of major depression or dysthymia that starts before and overlaps or starts during the IESD. - Participation in the measurement period. Exclude members with any of the following at any time during the Intake Period or during the Measurement Period. - Bipolar disorder. - Personality disorder. - Psychotic disorder. - Pervasive developmental disorder. - In hospice or using hospice services during the Measurement Period.
Preventive Care and Screening: Unhealthy Alcohol	Members 18 years of age and older who were screened for unhealthy alcohol use using a standardized tool and received	Members 18 years of age and older with at least one eligible encounter during the measurement period

Required Measure & *NQF ID*	**Numerator Description**	**Denominator Description**
Use: Screening & Brief Counseling *NQF ID 2152*	appropriate follow-up care if they screened positive	
Diabetes: HbA1c Poor Control (>9%)	Patients with most recent HbA1c test >9% or missing result during the measurement period	Patients 18–75 years of age with diabetes (type 1 and type 2)
ED Visits/1000/Yr.	Number of emergency department visits	Member years of enrollment with Participant (or with clinician)/1000