# BEHAVIORAL HEALTH HOME LEARNING COLLABORATIVE


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# OBJECTIVES

- Describe the emerging role of the behavioral health home
- Characterize the capacity of participating agencies to deliver integrated primary care
- Describe the role of practice facilitation in preparing for integration

# LEARNING COLLABORATIVE PARTICIPANTS

- 13 Behavioral Health Agencies across the State
- Oregon Health Authority
- Oregon Rural Practice-based Research Network (ORPRN)

# BACKGROUND

- Adults with serious mental illness (SMI) or substance use disorders (SUD) are far less likely to access medical services in primary care settings and, as a result, tend to experience particularly poor health outcomes, including multiple, untreated chronic conditions and premature death

- Supported by the Adult Medicaid Quality Grant, the Behavioral Health Home Learning Collaborative is part of a larger effort in Oregon to increase the proportion of Medicaid recipients enrolled in medical homes.

# YEAR 1 AND 2 ACTIVITIES

| | | Year 1 | Year 2 |
|---|---|---|---|
| Activities | Practice facilitation to support rapid cycle improvement projects, using PDSA | Monthly | Bi-weekly |
| | In-person learning sessions | 3 | 2 |
| | Webinars | 3 | 3 |
| | Care Management Plus Training | | √ |

# YEAR 1 AND 2 AND DATA COLLECTION

| | | Year 1 | Year 2 |
|---|---|---|---|
| Data Collection | Pre-work: Self-Assessment | √ | √ |
| | Behavioral Health Integration Capacity Assessment (BHICA) | √ | √ |
| | Formal Kick-off meeting | | √ |
| | Focus Group Interviews | | √ |
| | Exit Interviews with project champions | √ | √ |

# BHH LC PROJECT MEASURES

BHH project teams are asked to link their quality improvement projects to Adult Medicaid Quality Grant Program core measures. Examples include:

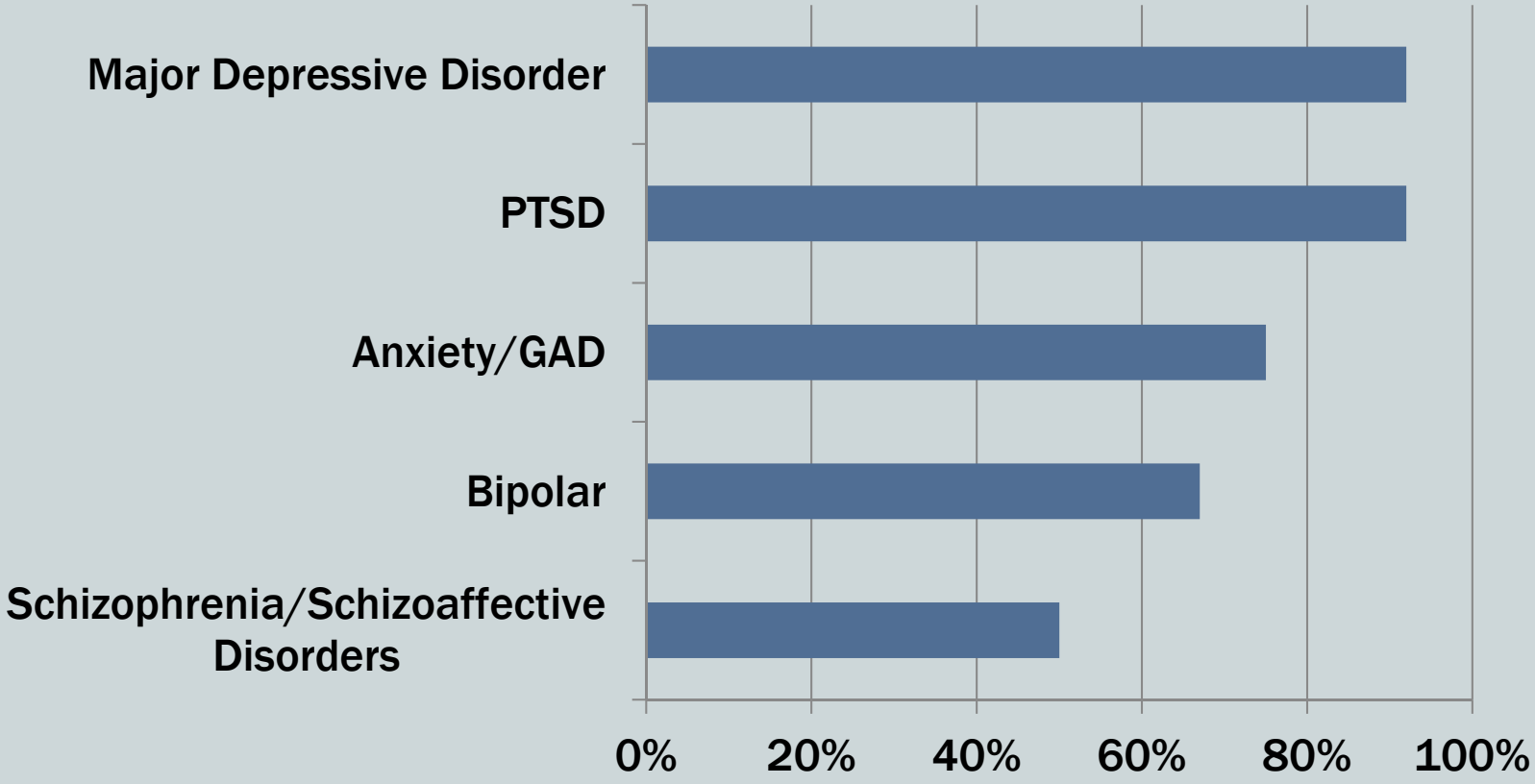
- Reduction in Adult Body Mass Index (BMI)
- Increase screening for clinical depression and follow-up plans
- Controlling High Blood Pressure
- Controlling diabetes

**THIS IS REALLY REALLY REALLY HARD!**

# CHARACTERISTICS OF PARTICIPATING AGENCIES AND THEIR CLIENTS

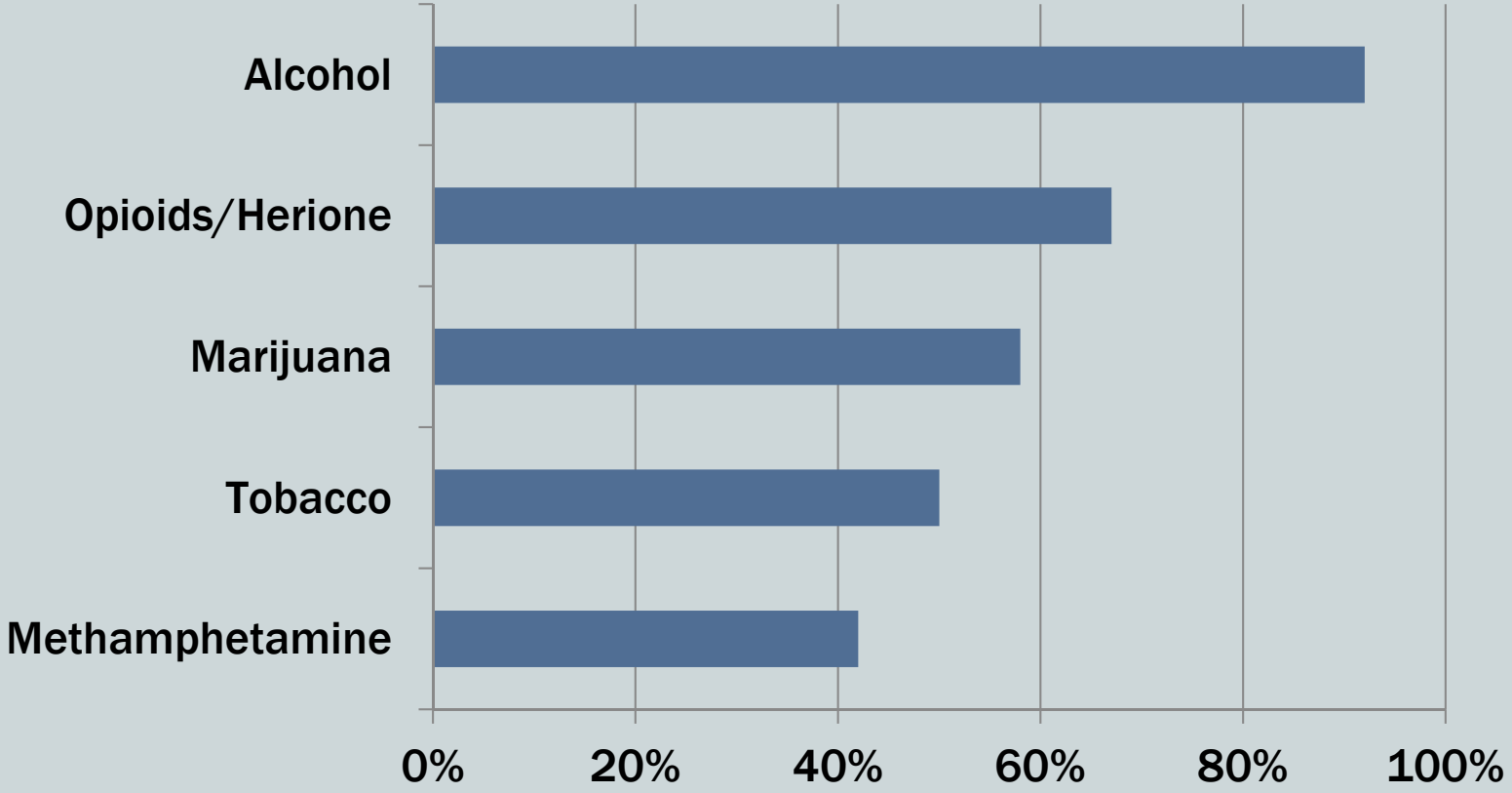
# MOST PREVALENT MENTAL HEALTH DIAGNOSES

Percent of agencies listing Dx as one of their top 5 (BHICA):



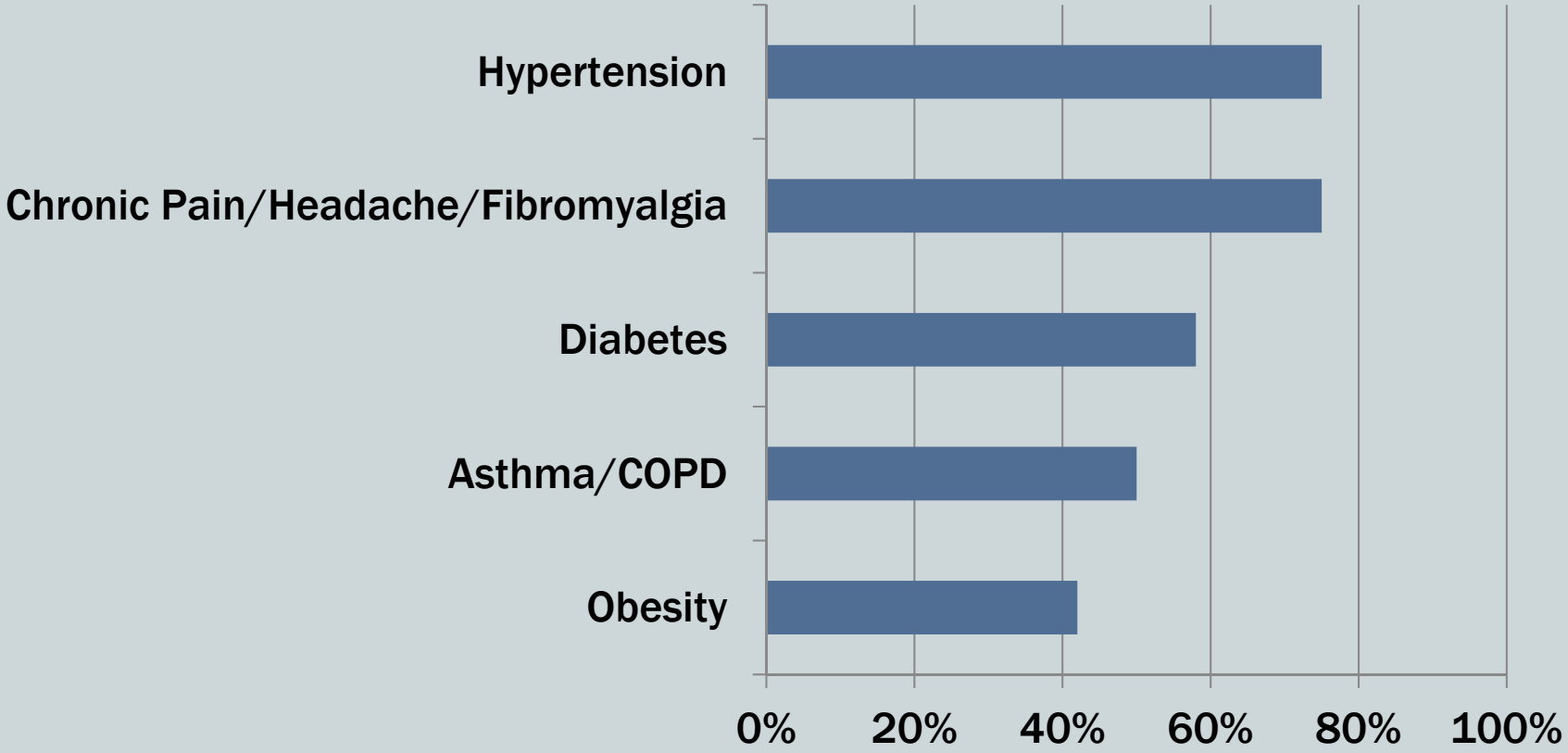
# MOST PREVALENT SUBSTANCE ABUSE DIAGNOSES

Percent of agencies listing Dx as one of their top 5 (BHICA):

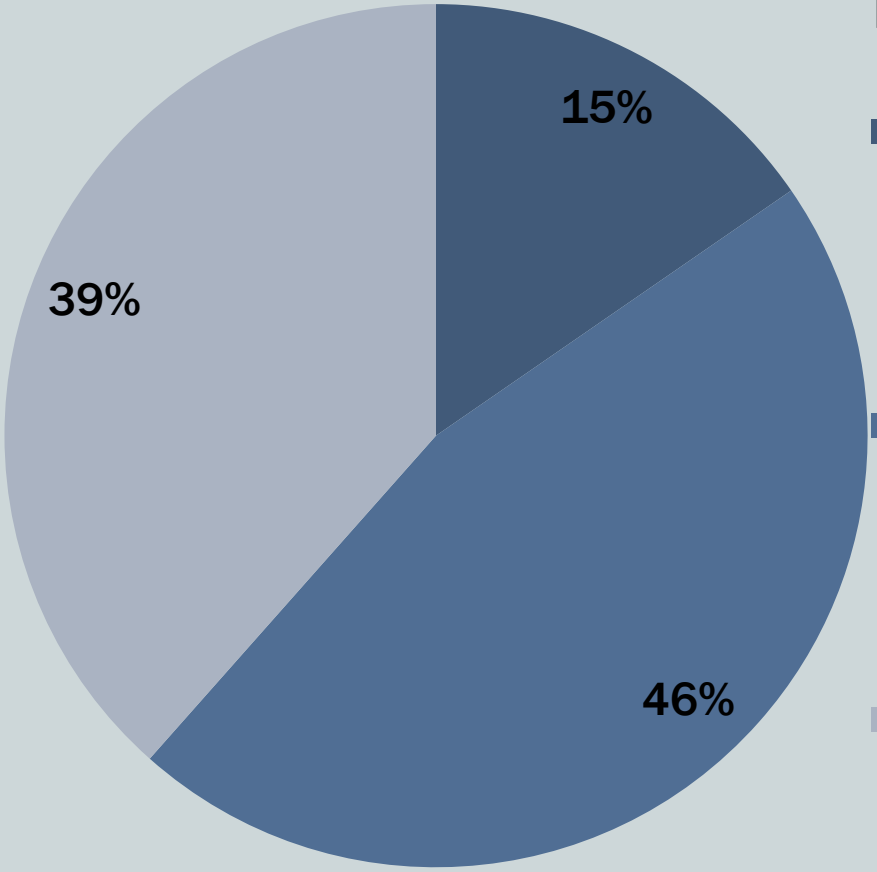


# MOST PREVALENT PHYSICAL HEALTH DIAGNOSES

Percent of agencies listing Dx as one of their top 5 (BHICA):



# BASELINE INTEGRATION




**Level of Integration (N = 13)**

- Physical healthcare is available from community clinics, but no system exists for regular communication and care coordination
- There is some co-location and/or coordination across physical health care providers and behavioral health care providers
- Physical health care providers are completely integrated into the practice

| Screening Processes in Place | % Yes |
|---|---|
| Do you screen for physical health conditions? | 58 |
| Do you collect information on general health measures? | 42 |
| Is care utilization information recorded in a central place where all providers can access the information? | 75 |
| Are screening data readily available to inform an individual's care and support services? | 67 |

| Identification of High-Risk and High-Need Individuals and Care Matching | % Yes |
|---|---|
| Does the organization identify which individuals appear to have the most complex care needs? | 33 |
| Is the organization able to segment the population into different levels of need? | 33 |
| Does the organization tailor services to a population or condition-specific segments of a population? | 67 |
| Does your organization assess progress for individuals with complex needs? | 33 |

# HOW DO YOU SUPPORT 13 AGENCIES WITH SUCH DIVERSITY?

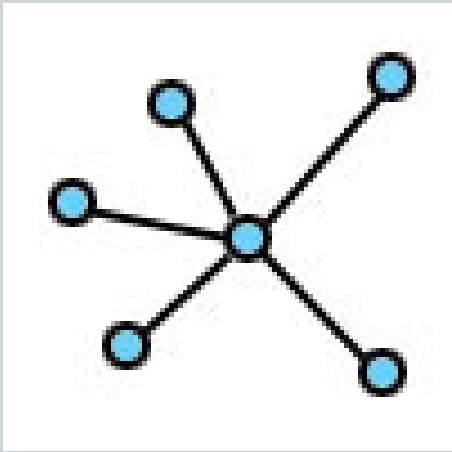
# PRACTICE FACILITATION

"…a supportive service provided to a primary care practice by a trained individual or team of individuals." (Knox et al., 2011)

Work with practices "to make meaningful changes designed to improve patients' outcomes. [They] help physicians and improvement teams develop the skills they need to adapt clinical evidence to the specific circumstance of their practice environment." (DeWalt, Powell, Mainwaring, et al., 2010)

Support includes:

- Meetings, huddles
- PDSA cycles
- Workflow analysis
- HIT assistance
- Connect practices/share best practices
- Collect and analyze data



# BEHAVIORAL HEALTH INTEGRATION CAPACITY ASSESSMENT (BHICA)

| 5 sections of the BHICA (developed by the Institute for Healthcare Improvement and the Lewin Group under a contract from the CMS Medicare-Medicaid Coordination Office) |
| --- |
| Understanding your population |
| Assessing your infrastructure |
| Identifying the population and matching care |
| Assessing the optimal integration approach |
| Financing integration |

https://www.resourcesforintegratedcare.com/tool/bhica

# BHICA SECTION 2: ASSESSING INFRASTUCTURE

Practice Culture (1-5: strongly agree – strongly disagree)

- ***Leadership:*** There is administrative support and leadership buy-in to pursue integration, encourage change, and remove barriers.
  - Leaders actively support the concepts of integration
  - Moving towards integrated care is a key component in the organization's strategic plan.
  - The organization's policies allow for flexibility in job roles.

# BHICA SECTION 2: ASSESSING INFRASTUCTURE

Practice Culture (1-5: strongly agree – strongly disagree)

- ***Provider & Staff Engagement:*** Staff is committed to making changes to accommodate integration efforts. Behavioral health and primary care providers are comfortable working with each other.
  - Staff members would feel comfortable working with a member of the primary care team in designing a joint treatment and recovery support plan.
  - Staff members are willing to make changes to their work habits to accommodate offering integrated services.
  - Staff members embrace a whole person approach to care.

# ORGANIZATIONAL CULTURE

| Top 4 questions (strongly agree – agree) | Percent |
|---|---|
| Leaders actively support the concepts of integration | 91 |
| Moving toward integrated care is a key component of the organizations strategic plan | 90 |
| Leaders believe their involvement in primary care is requied to optimally care for individuals with complex needs | 91 |
| Leaders recognize the need to train the current workforce to meet the needs of the individuals and organization | 91 |
| **Top 4 (strongly disagree – disagree)** | |
| The organization has a means for providers to systematically learn from each other | 64 |
| The organization offers ongoing primary care education for behavioral health providers to enhance mutual understanding knowledge | 70 |
| Financial leaders are involved in creating the business plan for increased integration | 60 |
| Leaders work to engage all staff in integration | 60 |

# OVERVIEW OF PROJECTS

- Project Guidelines:
  - Related to one of the 4 core areas of behavioral health homes, as defined by SAMHSA
    - Screening/referral for needed physical health prevention
    - Registry/tracking system for physical health needs
    - Care management
    - Prevention and wellness support services

# OVERVIEW OF PROJECTS

- Project Guidelines:
  - Logical link to CMS adult core quality metrics
    - Controlling high blood pressure
    - Care Transition — Transition Record Transmitted to Healthcare Professional
    - Surveying patients on experience of care (CAHPS)
    - Diabetes: A1C

# OVERVIEW OF PROJECTS

- Focus on a specific population/condition
  - Hypertension
  - Diabetes
  - Anxiety
- Focus on a process
  - Shared Care Plans
  - Referral Coordination/Health Information Exchange

# OUTPATIENT MH AGENCY WITH EMBEDDED PRIMARY CARE

- Focus on HTN patients
  - Leveraged client/therapist relationship
  - PCP held BP educational sessions for clients and therapists on BP
  - Supplied clinic and clients with BP cuffs and BP tracking forms
  - Therapists used Motivational Interviewing techniques to help clients pick self-management goals
  - Created reporting fields in medical record
  - Protected time for therapists and PCP to discuss patients' progress

# COORDINATED CARE: FQHC AND BEHAVIORAL HEALTH AGENCY

- Focus on Shared Care Plan
  - MH and PC collaborate: create shared care plan
  - Integration of Shared Care Plan into EMR
  - Flipped visits (therapist meets with patient first to go over care plan)
  - Weekly BH/PC huddles to discuss patient progress

# LESSONS LEARNED

- Embedded primary care – strength
- Involved leadership
- Interdisciplinary management of services
- Coordinated, collaborative staff
- Shared Care Planning: process and document

# ACKNOWLEDGEMENTS


- Participating Agencies
  - Benton Health Services
  - Birch Grove Health Center – La Clinica
  - Bridgeway Recovery Center
  - Cascadia Behavioral Healthcare
  - Center for Family Development
  - Community Health Alliance
  - Eastern Oregon Alcoholism Foundation
  - Lane County Behavioral Health
  - Lifeworks NW
  - Mid-Columbia Center for Living
  - Old Town Recovery Center
  - Options for Southern Oregon
  - Willamette Family Inc.
- Project team
  - Rita Moore, PhD – OHA
  - Elizabeth Needham Wadell, PhD – ORPRN
  - Sonya Howk, MPA - ORPRN
  - Beth Sommers, MPH, CPHQ – ORPRN
  - Mark Remiker, MA – ORPRN
  - Molly Hamlin – ORPRN
- Project funding
  - Adult Medicaid Quality Grant