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
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.
<table>
<thead>
<tr>
<th>Activities</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice facilitation to support rapid cycle improvement projects, using PDSA</td>
<td>Monthly</td>
<td>Bi-weekly</td>
</tr>
<tr>
<td>In-person learning sessions</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Webinars</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Care Management Plus Training</td>
<td></td>
<td>√</td>
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</tbody>
</table>
## YEAR 1 AND 2 AND DATA COLLECTION

<table>
<thead>
<tr>
<th>Data Collection</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-work: Self-Assessment</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Behavioral Health Integration Capacity Assessment (BHICA)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Formal Kick-off meeting</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Focus Group Interviews</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Exit Interviews with project champions</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
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
Percent of agencies listing Dx as one of their top 5 (BHICA):

- Major Depressive Disorder: 100%
- PTSD: 100%
- Anxiety/GAD: 80%
- Bipolar: 60%
- Schizophrenia/Schizoaffective Disorders: 40%
MOST PREVALENT SUBSTANCE ABUSE DIAGNOSES

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

- Alcohol: 100%
- Opioids/Herion: 60%
- Marijuana: 60%
- Tobacco: 50%
- Methamphetamine: 40%
Percent of agencies listing Dx as one of their top 5 (BHICA):

- Hypertension: 80%
- Chronic Pain/Headache/Fibromyalgia: 80%
- Diabetes: 60%
- Asthma/COPD: 50%
- Obesity: 40%
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.
<table>
<thead>
<tr>
<th>Screening Processes in Place</th>
<th>% Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you screen for physical health conditions?</td>
<td>58</td>
</tr>
<tr>
<td>Do you collect information on general health measures?</td>
<td>42</td>
</tr>
<tr>
<td>Is care utilization information recorded in a central place where all providers can access the information?</td>
<td>75</td>
</tr>
<tr>
<td>Are screening data readily available to inform an individual’s care and support services?</td>
<td>67</td>
</tr>
<tr>
<td>Identification of High-Risk and High-Need Individuals and Care Matching</td>
<td>% Yes</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Does the organization identify which individuals appear to have the most complex care needs?</td>
<td>33</td>
</tr>
<tr>
<td>Is the organization able to segment the population into different levels of need?</td>
<td>33</td>
</tr>
<tr>
<td>Does the organization tailor services to a population or condition-specific segments of a population?</td>
<td>67</td>
</tr>
<tr>
<td>Does your organization assess progress for individuals with complex needs?</td>
<td>33</td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>Understanding your population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing your infrastructure</td>
</tr>
<tr>
<td>Identifying the population and matching care</td>
</tr>
<tr>
<td>Assessing the optimal integration approach</td>
</tr>
<tr>
<td>Financing integration</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaders actively support the concepts of integration</td>
<td>91</td>
</tr>
<tr>
<td>Moving toward integrated care is a key component of the organization's strategic plan</td>
<td>90</td>
</tr>
<tr>
<td>Leaders believe their involvement in primary care is required to optimally care for individuals with complex needs</td>
<td>91</td>
</tr>
<tr>
<td>Leaders recognize the need to train the current workforce to meet the needs of the individuals and organization</td>
<td>91</td>
</tr>
</tbody>
</table>

## Top 4 (strongly disagree – disagree)

<table>
<thead>
<tr>
<th>Question</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>The organization has a means for providers to systematically learn from each other</td>
<td>64</td>
</tr>
<tr>
<td>The organization offers ongoing primary care education for behavioral health providers to enhance mutual understanding knowledge</td>
<td>70</td>
</tr>
<tr>
<td>Financial leaders are involved in creating the business plan for increased integration</td>
<td>60</td>
</tr>
<tr>
<td>Leaders work to engage all staff in integration</td>
<td>60</td>
</tr>
</tbody>
</table>
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
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
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
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