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Behavioral Health Home Learning Collaborative Executive Summary

Introduction

The Oregon Health Authority (OHA) launched the Behavioral Health Home Learning Collaborative (BHH LC) to support behavioral health (BH) sites working to increase access to primary health care among their clients with serious mental illness (SMI) or substance use disorders (SUD). This report documents the experiences of the 13 sites that participated in the Behavioral Health Home Learning Collaborative (BHH LC) from May 2014 through December 2016. The BHH LC was funded through the Adult Medicaid Quality Grant Program as part of a broader effort to increase the proportion of Medicaid members enrolled in medical homes. The program was implemented with technical support and data collection provided by the Oregon Rural Practice-based Research Network (ORPRN).

Activities: June 2014-December 2016

The BHH LC supported a total of 13 behavioral sites in pursuing integrated health care services. The principle intervention of this learning collaborative was intensive, individualized practice coaching to help participating sites design and implement their chosen integration model. Other activities included seven in-person learning sessions, specialized cross-training, and webinars as well as extensive data collection (quantitative and qualitative) to identify and codify barriers and facilitators to integration of primary care in the behavioral health setting. ORPRN's Practice Enhancement Research Coordinators (PERCs) used a range of organizational development, project management, quality improvement, and practice improvement approaches and methods to help participating organizations identify barriers to integration and conduct quality improvement activities. In Year 3, each site collected up to four Adult Core Quality Measures (ACQMs) to assess treatment and control of chronic conditions among integrated patients who were members of the Oregon Health Plan (OHP). These included: Adult Body Mass Index (BMI); Controlling High Blood Pressure (CBP); and Comprehensive Diabetes (DM) Testing and Control.

Findings

Participating sites identified a total of 2,927 integrated BHH clients who were OHP members with both a primary care and behavioral health visit in the measurement year. A total of 449 clients received services in one of the In-house BHH models, 40 received services through a facilitated referral model, and the majority (N=2438) received services in a co-located BHH model. Overall, 87% of BHH clients had a BMI recorded in their electronic health records (EHRs) or paper health record. Of those with diagnosed hypertension, 71% were reported by sites to be controlled. Among those with diagnosed diabetes, 91% had a Hemoglobin A1c recorded in their health record, and only 29% were poorly controlled. The precision required to accurately identify patients with diagnosed hypertension and diabetes is not simple, particularly with client populations who have histories of serious mental illness or substance use disorder. A majority of clients entering care in BHHs did not arrive with medical histories, and PCPs were frequently starting from scratch and diagnosing conditions at the first visit. Underestimated prevalence of chronic conditions in the medical record likely translates to potentially inflated estimates of adequate control.

Although BHH LC sites have used a variety of models, the individuals involved in the work across sites show a remarkable consensus on the core features of a BHH for SMI and SUD clients, as well as challenges for effective implementation. Through focus group and key informant interviews, participating staff described a wide range of factors that both support and challenge the development and sustainability of integrated primary and behavioral health care in BHHs. Detailed findings are presented through the lens of core medical home attributes: Comprehensive Whole Person Care, Care Coordination & Integration, and Accountability.



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Recommendations for Providers:

- Recognize, respect and address differing cultures . Fully integrated care requires some flexibility and adaptation on both the medical and the behavioral sides.
- Cross train BHH staff to bridge professional cultures and develop an emerging integrated workforce.
- Adjust panel size and scheduling to accommodate clients with complex social needs.
- Information accessibility: make client records available to both the primary care and BH providers. The referral process works best when care coordination records are available to the entire care team.
- Communicate: schedule regular, interdisciplinary care team meetings.
- Enter data in shared EHRs using structured fields.
- Create patient registries to inform resource allocation, enable proactive patient outreach, and track population health outcomes for quality improvement efforts and to demonstrate a return on investment.
- Create and sustain interdisciplinary quality improvement teams with balanced representation from behavioral health, primary care, and site administration.

Recommendations for Payers and Policy Makers:

- Reimburse prevention and wellness support services offered through community-based peer supports.
- Offer flexibility in alternative payment structures to match the structure and target population of the BHH.
- Provide financial and technical support for BHHs seeking to move to a shared EHR.
- Support agency efforts to develop and implement universal consent and release of information documents.
- Contribute to regional efforts to build and operate Health Information Exchanges.
- Evaluate program effectiveness of BHH models through a combination of locally collected and administrative data sources.
- Acknowledge and respond to technological, practice and measurement challenges presented in BHHs.
- Validate clinic-based quality measures against state-level encounter data to improve the quality of data reported on both sides.



Elizabeth N. Waddell, PhD
Director of Health Disparities Research
Oregon Rural Practice-based Research Network
Assistant Professor, OHSU/PSU School of Public Health
waddelle@ohsu.edu

