Montana Health Home Learning Community

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About Us

The **National Council for Behavioral Health** is the unifying voice of America's mental health and addictions treatment organizations. Together with 2,500 member organizations, serving 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery.

The National Council was instrumental in bringing Mental Health First Aid to the USA and more than 500,000 individuals have been trained. In 2014, the National Council merged with the State Associations of Addiction Services (SAAS). To learn more about the National Council, visit www.TheNationalCouncil.org.

Objectives for Today

- Understand key trends in the US Healthcare System that are driving Montana's adoption of Health Home and other reforms
- Define, compare, and contrast key concepts (e.g., Patient Centered Medical Home, Health Home, Care Coordination, Care Management, etc.)
- Develop your Health Home Action Plan

Agenda:

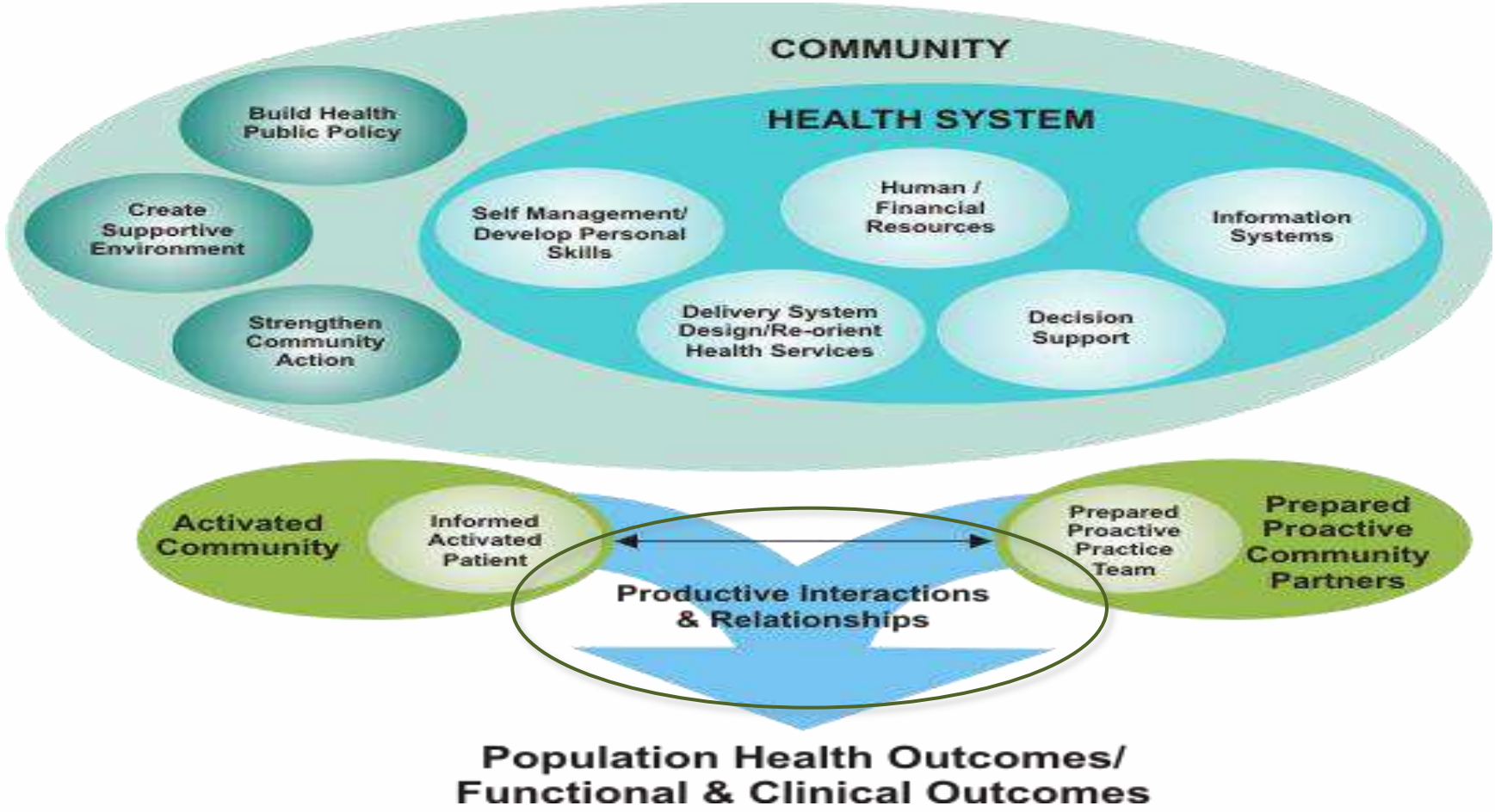
- What is driving the changes in health care today?
- Same foundation, different models. Examining the key components that are driving value-based integration models.
- Reviewing the evidence…why do health homes make sense?
- Designing your plan for Health Home adoption!

So Many Terms…So Much Happening!

Transformation of Health Care

Whole Health	Wellness	Recovery/Resilience
• Integrated & coordinated care • Primary care partnerships: Inside & outside • Prevention & screening • Population health management • Data driven care • Knowledge of mind/body connections • Increased Health Literacy • Care Coordination • Care Transitions • Trauma informed care	• Organizational culture of wellness • Health Behavior Change • Activation/increasing self management • Stage Wise Interventions • Motivational Interviewing • Trauma specific approaches	• Person Centered Planning • Community Connections • Cultural Humility • Activated Hope • Universal precautions for trauma

Wagner's Chronic Care Model

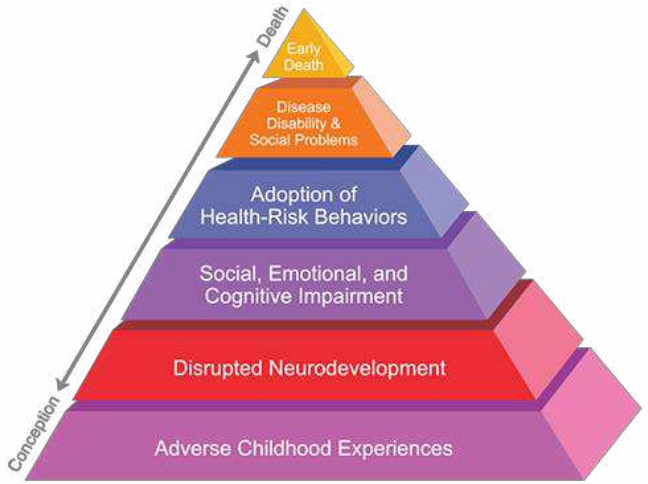


Source: Victoria Barr, Sylvia Robinson, Brenda Martin-Link, Lisa Underhill, Anita Drotts & Darlene Ravensdale (2002). Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry S., Solberg, L. (2001). *Does the chronic care model also serve* as a *template for improving prevention? The Milbank Quarterly*, 79(4), 579—612, and The World Health Organization, Health and Welfare Canada and Canadian Public Health Association (1986). Ottawa Charter of Health Promotion.

Why discuss the chronic care model?

1. Because good theory should inform successful interventions.
2. Because with integrated care (**and all of healthcare reform**) we are really talking about managing health behavior change and chronic illness, which is different than episodic care.

Adverse Childhood Experiences



Mechanisms by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

The #1 Chronic Health Epidemic in the United States

"The impact of ACEs can now only be ignored as a matter of conscious choice. With this information comes the responsibility to use it"

(Anda and Brown, CDC)

ACE Study DVD from Academy on Violence and Abuse

Life-Long Physical, Mental & Behavioral Health Outcomes Linked to ACEs

- Alcohol, tobacco & other drug addiction
- Auto-immune disease
- Chronic obstructive pulmonary disease & ischemic heart disease
- Depression, anxiety & other mental illness
- Diabetes
- Multiple divorces
- Fetal death
- High risk sexual activity, STDs & unintended pregnancy
- Intimate partner violence—perpetration & victimization
- Liver disease
- Lung cancer
- Obesity
- Self-regulation & anger management problems
- Skeletal fractures
- Suicide attempts
- Work problems—including absenteeism, productivity & on-the-job injury

Defining Our Terms

- Terms are the building blocks for determining how we structure our beliefs/mental models
- Terms are at the core of how we think and act
- You can see, if policy makers, clinicians &/or administrators are not clear/in agreement the definition and source of their terms it is difficult to design or implement an integrated health model…

Integration Model or Practice?

Definition of a Model:

A system or thing used as an example to follow or imitate.

Definition of Practice:

a. The actual application or use of an idea, belief, or method as opposed to theories about such application or use.

b. Repeated exercise in or performance of an activity or skill so as to acquire or maintain proficiency in it.

c. Perform (an activity) or exercise (a skill) repeatedly or regularly in order to improve or maintain one's proficiency.

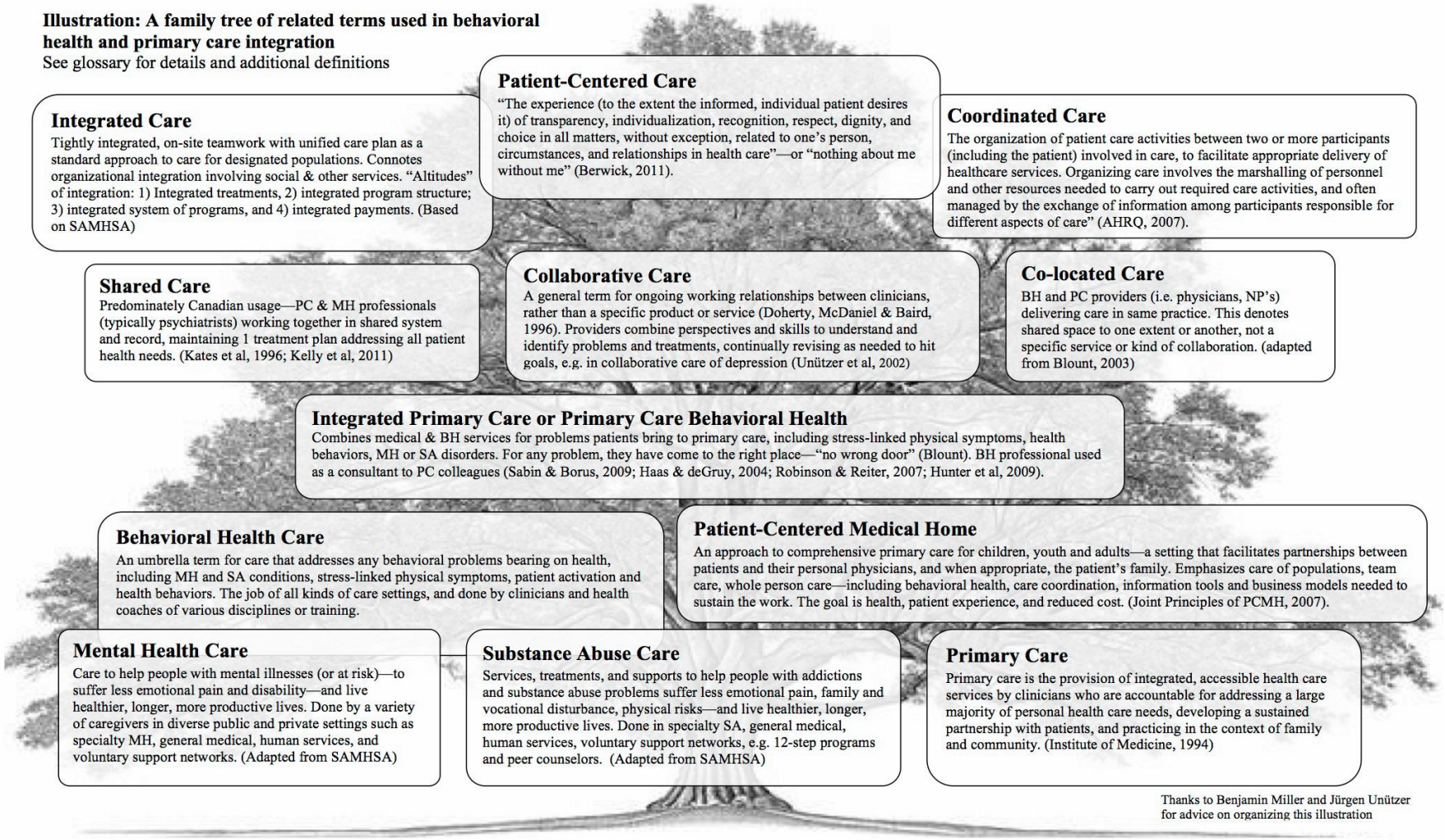
d. Carry out or perform (a particular activity, method, or custom) habitually or regularly.

Integration Terms

Some Integrated Health Term Sources:

- **Research Literature-** ”Collaborative Care”
- **Policy-** “Health Home”
- **Accrediting Bodies-** “Patient Centered Medical Home”
- **Provider Agencies-** “Pt. Centered Healthcare Home”

Defining Integrated Health…



From: Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

Defining Integrated Health

"Integrated Health results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization."

Source: Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

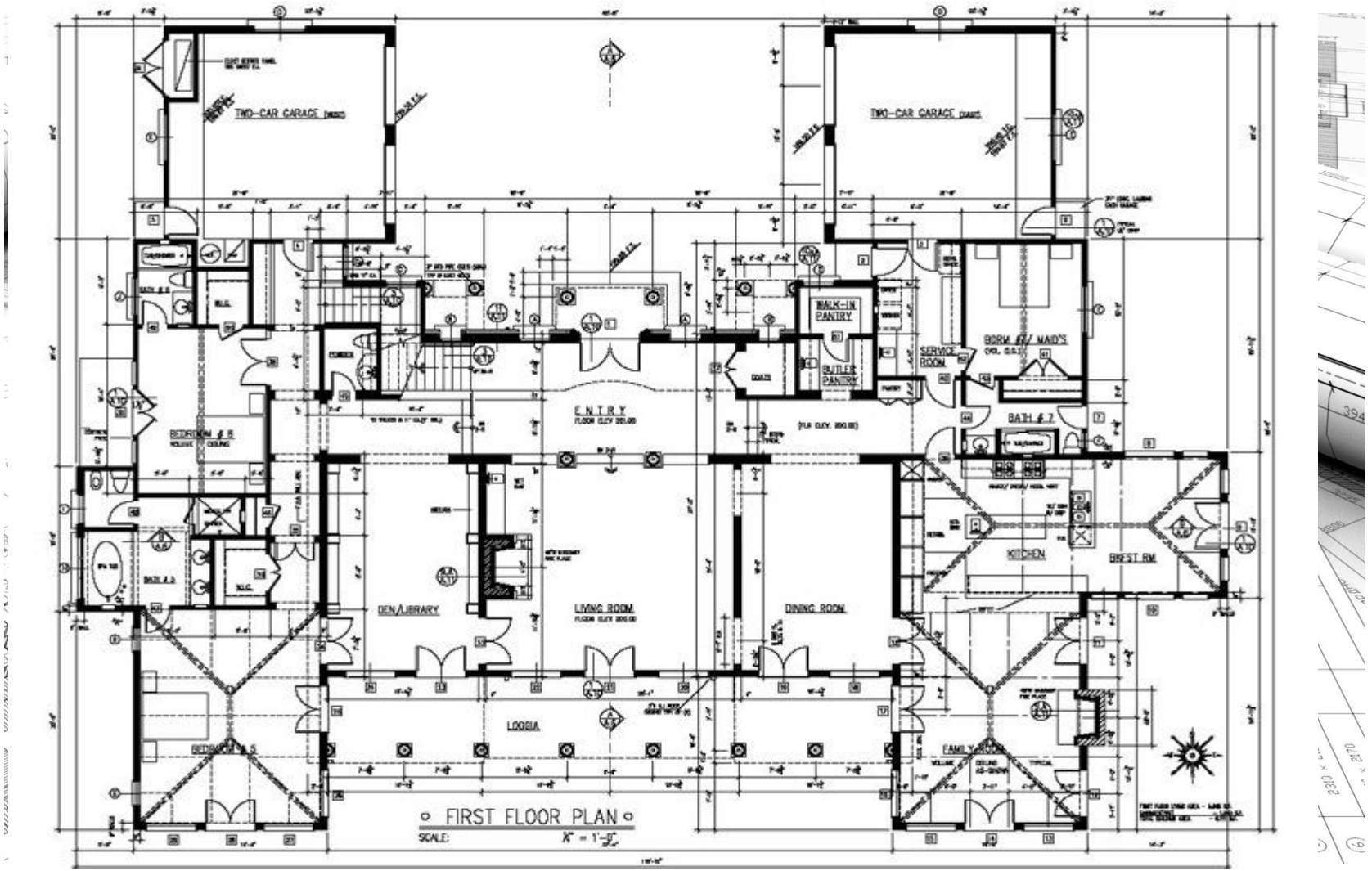
Defining Integrated Health

"At the simplest level, integrated behavioral & physical health care occurs when behavioral health specialty & primary care providers work together to address the physical & behavioral health needs of their patients."

"Integration can be bi-directional: either (1) specialty behavioral health care introduced into primary care settings, or (2) primary health care introduced into specialty behavioral health settings."

Source: Butler M, Kane RL, McAlpine D, Kathol, RG, Fu SS, Hagedorn H, Wilt TJ. Integration of Mental Health/Substance Abuse and Primary Care No. 173 (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009.) AHRQ Publication No. 09- E003. Rockville, MD. Agency for Healthcare Research and Quality. October 2008.

IH Models


TWO-CAR GARAGE
TWO-CAR GARAGE
WALK-IN PANTRY
BUTLER PANTRY
SERVICE ROOM
BATH # 7
ENTRY
BEDROOM # 5
DEN/LIBRARY
LIVING ROOM
DINING ROOM
KITCHEN
BREAKFAST RM
LOGGIA
FIRST FLOOR PLAN
SCALE:

Driver: Need for Integrated & Evidence-based Care Pathways

“The concept of **'integrated care pathways'** aims to shift clinicians & managers to thinking more about the **'patient journey**‘…

An **Integrated Care Pathway** aims to have:

- the **right people**,
- in the **right order**,
- doing the **right thing**,
- at the **right time**,
- with the **right outcomes**,

& all with attention to the **patient experience**.”

Source: WHO, 2008 http://www.who.int/healthsystems/technical_brief_final.pdf

Core Components of Integrated Models

- **Person-centered care.** Basing care on the individual's preferences, needs, and values. With person-centered care, the client is a collaborative participant in healthcare decisions and an active, informed participant in treatment itself.
- **Care Management & Coordination:** The deliberate organization of patient care activities with the patient and between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services.
- **Population-based care.** Strategies for optimizing the health of an entire client population by systematically assessing tracking, and managing the group's health conditions and treatment response. It also entails approaches to engaging the entire target group, rather than just responding to the clients that actively seek care.
- **Data-driven care.** Strategies for collecting, organizing, sharing, and applying objective, valid clinical data to guide treatment. Validated clinical assessment tools monitor response to treatment and information systems such as registries track the data over time.
- **Evidence-based care.** The best available evidence guides treatment decisions and delivery of care. Both the behavioral health agency and its health provider partner must deliver evidence-based services.

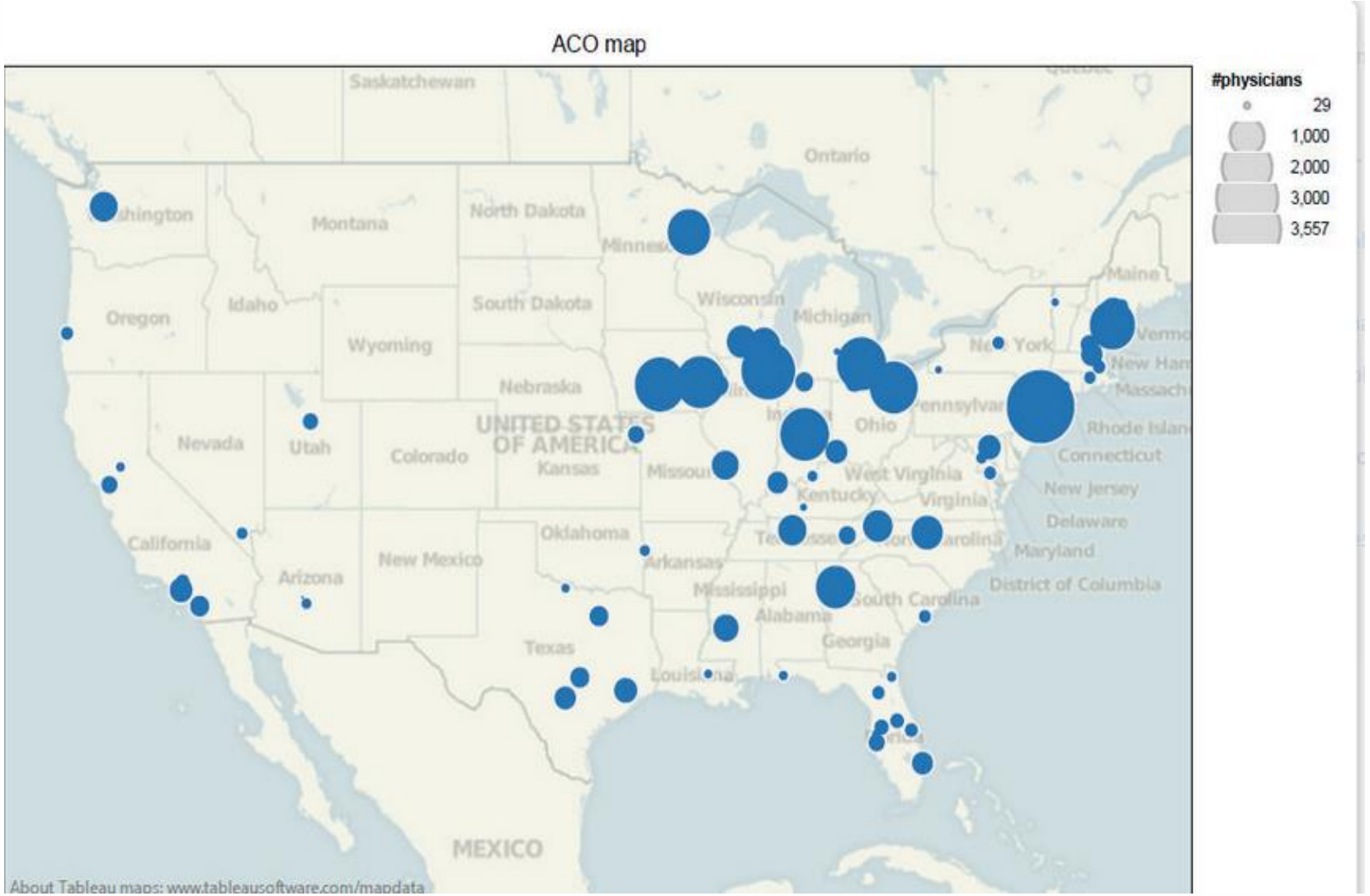
Source: Adapted from Behavioral Health Homes for People with MH & SA, 2012. http://www.integration.samhsa.gov/clinical-practice/CIHS_Health_Homes_Core_Clinical_Features.pdf

IH Staff Competencies

1. Interpersonal Communication
2. Collaboration & Teamwork
3. Screening & Assessment
4. Care Planning & Care Coordination
5. Evidence-based Intervention Skills
6. Cultural Competence & Adaptation
7. Systems Oriented Practice
8. Practice Based Learning & Quality Improvement
9. Informatics

Source: Annapolis Coalition on Behavioral Health Workforce White Paper, "Core Competencies for Integrated Behavioral Health and Primary Care"

Accountable Care Orgs. – National Perspective



On Your Mark, Get Set, ACO…

Accountable Care Organizations
bring together healthcare homes, specialty care, and ancillary services

Core Principles of an ACO

- Directed by a **coordinated set of providers**
- Provides a **full continuum of care** to patients and populations
  - Healthcare homes, specialty care, hospital, case management, care coordination, transitions between levels of care…and more
- **Financial incentives** aligned with clinical goals
- **Cost containment**
- Enhancement of **care quality** and the patient experience
- **Improvement of overall health status**

ACOs and the Safety Net

- **Coverage expansions:** The massive expansion of coverage in 2014 will require new models to assure access and control costs – particularly for serving Medicaid patients, who will make up 14 million of the newly insured
- **Care management:** Individuals served by the safety net experience higher rates of serious mental illness, substance use disorders, and poorly controlled multiple chronic conditions
- Community behavioral health organizations have **expertise and experience** in caring for these populations, making them valuable partners in an ACO

Healthcare Reform Context

Under an ACO model, the ***value*** of healthcare services will depend on our ability to:

1. Be accessible (fast access to all needed services)
2. Be efficient (provide high-quality services at lowest possible cost)
3. Connect with other providers (via electronic information exchange)
4. Focus on episodic care needs
5. Produce outcomes

Health Homes

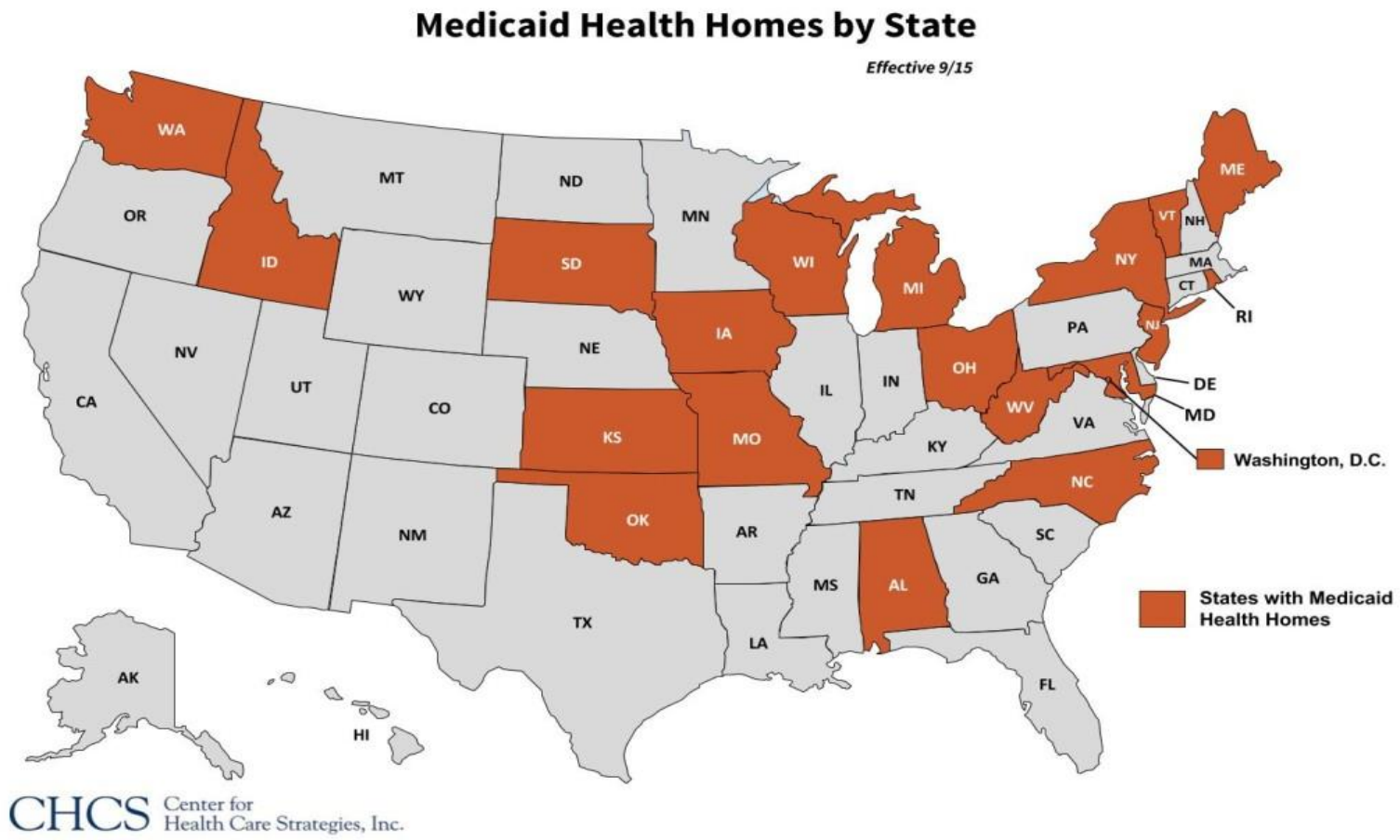
Before we move to talking about health homes at your tables!

- **Discuss the target population you will be serving in this project:**
  - What are their key needs—for physical health care, for prevention of physical health problems, for behavioral health, for community support?
  - What are the key gaps you see now either in their care or in their support network?
  - What are some solutions you are hoping for?
  - Who are you thinking will be the best staff type for your care coordinator?

Current Sect. 2703 Health Homes

As of January 2016:

- **19 states & the District of Columbia have Approved HH's**
- **27 Different Health Home Models/Designs**



Health Home Themes

Core Service	Common Themes Among States	Best Practices
Comprehensive Care Management	• Individualized care plan • Integration of physical and behavioral health • Family involvement	• Tracking care plan goals • Mental health and substance abuse screenings • Periodic reassessment
Care Coordination	• Development and implementation of care plan • Adherence to treatment/ medication monitoring • Referral tracking	• Emphasis on face-to-face contacts • Use of case conferences • Tracking test results • Requiring discharge summaries • Housing coordination • Automated notification of admission
Health Promotion	• Development of self-management plans • Evidence-based wellness and promotion • Patient education	• Patient engagement • Addressing clinical as well as non-clinical needs • Tobacco cessation training
Comprehensive Transitional Care	• Notification of admissions/discharge • Receipt of summary care record, continuing care document, or discharge summary • Medication reconciliation	• Pharmacist coordination • Shift from reactive to proactive care • Specialized transitions (age-related, corrections) • Use of hospital liaisons • Home visits
Individual and Family Supports	• Use of peer supports, support groups, self-care programs • Facilitation of improved adherence to treatment • Advocacy for individual and family needs • Efforts to increase health literacy	• Use of advance directives • Assistance with attaining highest level of functioning in the community • Assistance with development of social networks
Referral to Community Resources	• Identification of community-based resources • Follow-up post referral • Assistance with housing	• Resource manual • Emphasis on resources closest to home and least restrictive • Policies, procedures, and accountabilities with community-based organizations

Source: Seizing the Opportunity: Early Medicaid HH Lessons. Moses, & Ensslin Center for Health Care Strategies March 2014 Brief

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
STATE ASSOCIATIONS OF ADDICTION SERVICES

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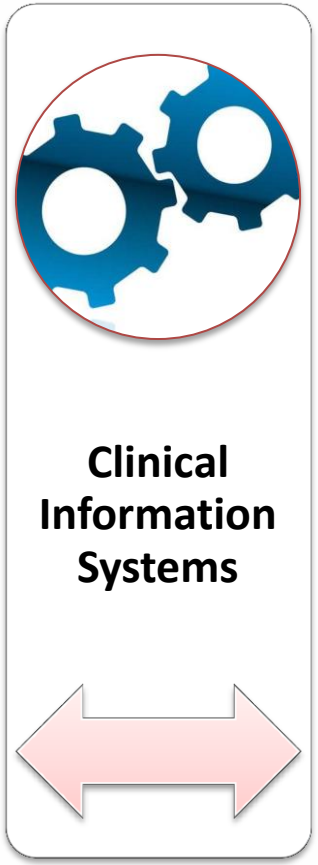
Defining the Healthcare Home

Defining the Healthcare Home

Superb Access to Care

- Everyone has a health home practitioner and team
- Patients can easily make appointments and select the day and time.
- Waiting times are short.
- Email and telephone consultations are offered.
- Off-hour service is available.

Defining the Healthcare Home



- Systems support high-quality care, practice-based learning, and quality improvement.
- Practices maintain patient registries; monitor adherence to treatment; have easy access to lab and test results; and receive reminders, decision support, and information on recommended treatments.
- There is continuous learning and practice improvement.

Defining the Healthcare Home

- The health home team engages in care coordination & management within the team
- The team also coordinates with other healthcare providers/organizations in the community
- Systems are in place to prevent errors that occur when multiple physicians are involved.
- Follow-up and support is provided.

Care Coordination

- **The Care Coordination Standard:** When I need to see a specialist or get a test, including help for mental health or substance use problems, help me get what I need at your clinic whenever possible and stay involved when I get care in other places.

- Services are supported by electronic health records, registries, and access to lab, x-ray, medical/surgical specialties and hospital care.

Six Core Functions

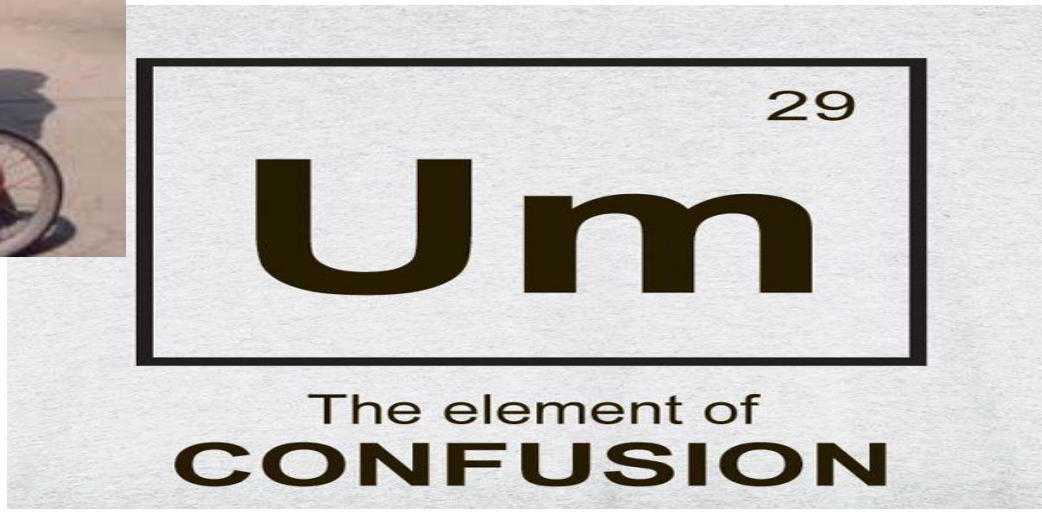
Health Homes 101

The Medicaid health home state plan option (ACA Section 2703) promotes access to and coordination of primary and acute physical and behavioral health services and long-term services and supports. Health homes may be virtual or located in primary care or behavioral health providers' offices or other settings that best suit beneficiaries' needs. Health homes must provide six core services, linked as appropriate and feasible by health information technology:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care/follow-up;
- Individual and family support; and
- Referral to community and social support services.

To be eligible for health home services, an individual must be diagnosed with either: (1) two chronic conditions; (2) one chronic condition and risk for a second; or (3) a serious mental illness. States implementing Medicaid health homes receive an enhanced 90/10 federal match for the first eight fiscal quarters of the health home program.

5 Most Common Responses to the Talk about Data or Measurement!



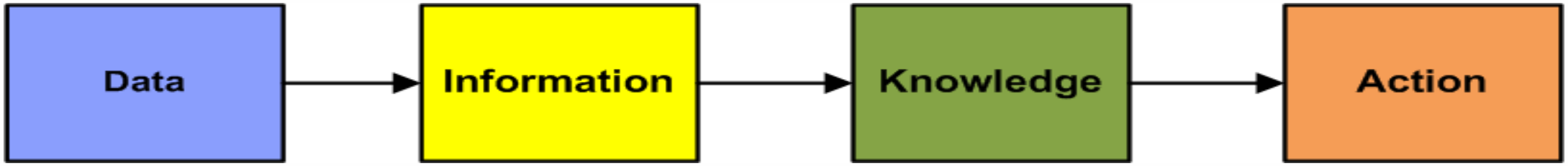
Data Jam!

- What data do you collect?
- What instruments do you use?
- For whom do you collect the data?
- What do you do with it to make your lives and the lives of the people you serve better?

What is the ultimate purpose of collecting & sharing data?

To turn it into action!

(AKA Continuous Quality Improvement)



Cert. Comm. BH. Center Quality Measures

1. Number/Percent of clients requesting services who were determined to need routine care
2. Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients
3. Mean number of days before the comprehensive person-centered and family centered diagnostic and treatment planning evaluation is performed for new clients
4. Number of Suicide Deaths by Patients Engaged in Behavioral Health (CCBHC) Treatment
5. Documentation of Current Medications in the Medical Records
6. **Patient experience of care survey**
7. **Family experience of care survey**
8. Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up
9. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (see Medicaid Child Core Set)

Cert. Comm. BH. Center Quality Measures

10. Controlling High Blood Pressure (see Medicaid Adult Core Set)
11. Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
12. Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling
13. Initiation and engagement of alcohol and other drug dependence treatment (see Medicaid Adult Core Set)
14. Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment (see Medicaid Child Core Set)
15. Adult major depressive disorder (MDD): Suicide risk assessment (use EHR Incentive Program version of measure)
16. Screening for Clinical Depression and Follow-Up Plan (see Medicaid Adult Core Set)
17. Depression Remission at 12 months

Population Health Management

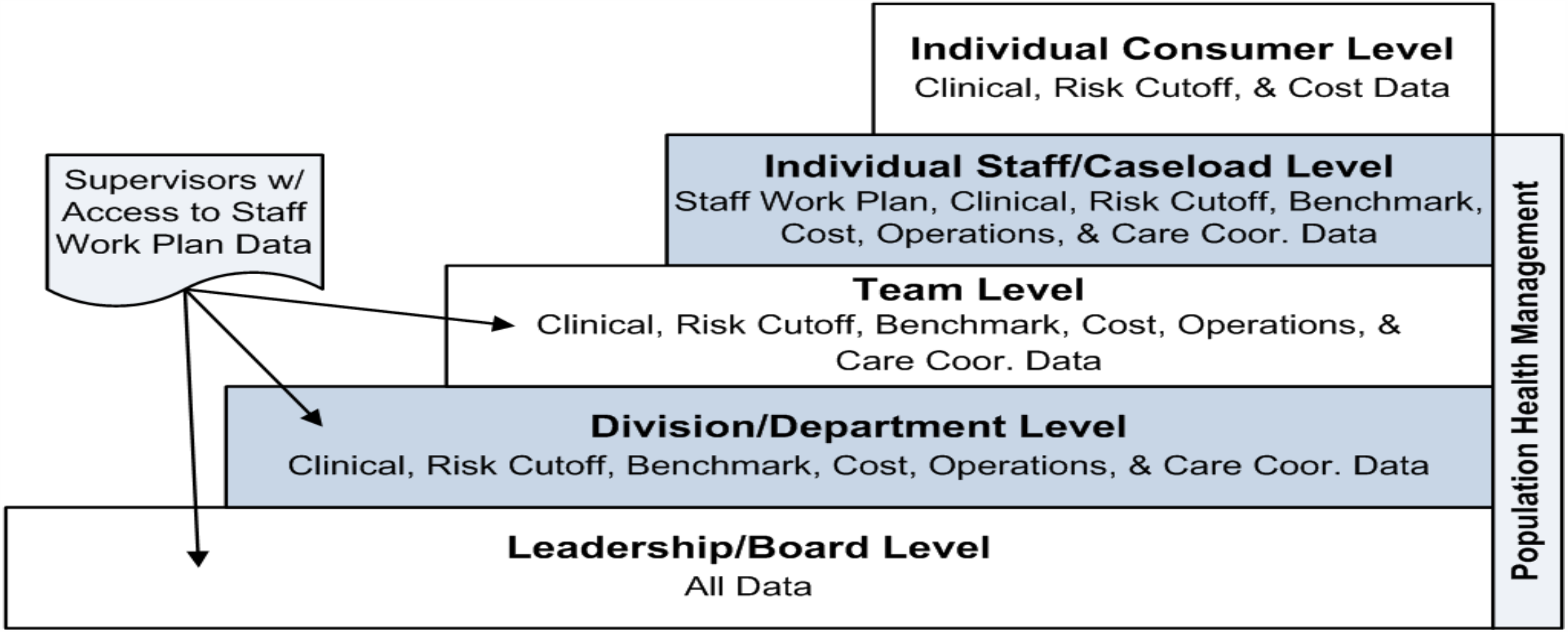
- Strategies for optimizing the health of an entire client population by systematically assessing tracking, and managing the group's health conditions and treatment response.

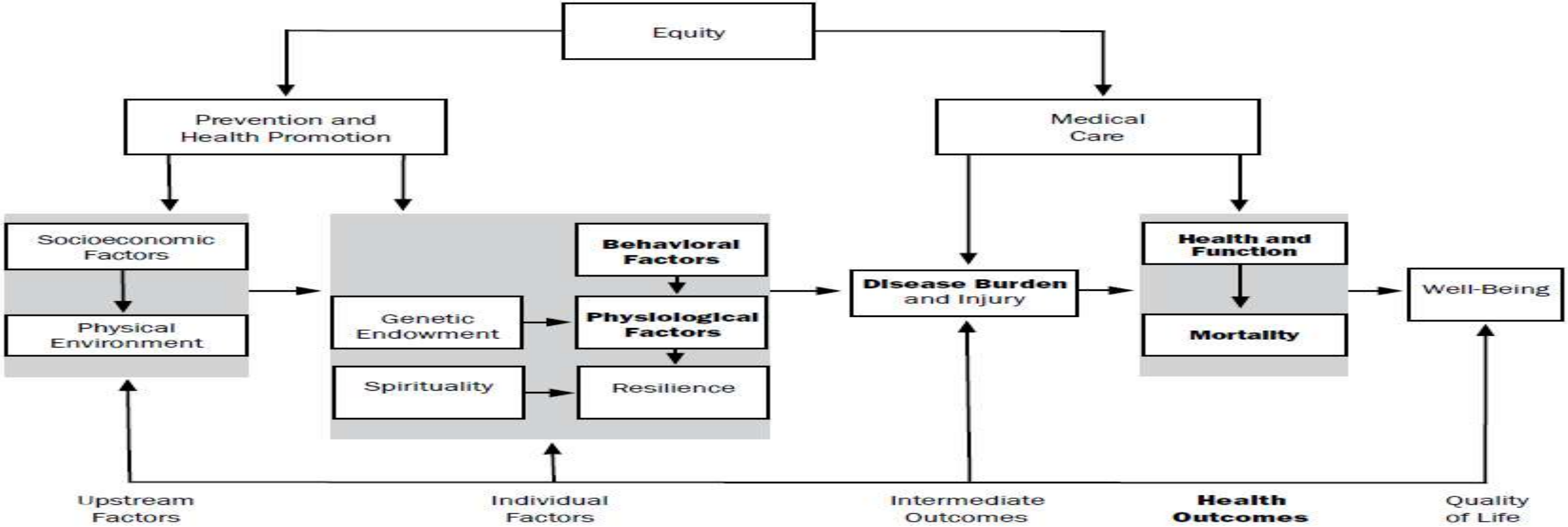
- It also entails approaches to engaging the entire target group, rather than just responding to the clients that actively seek care.

PHM In Four Steps:

1. Knowing what to ask about your population
2. Data registry describing your population
3. Engage in CQI Process to respond to the findings
4. Use Dashboards for making data understandable

Organizing & Operationalizing Data w/ Dashboards

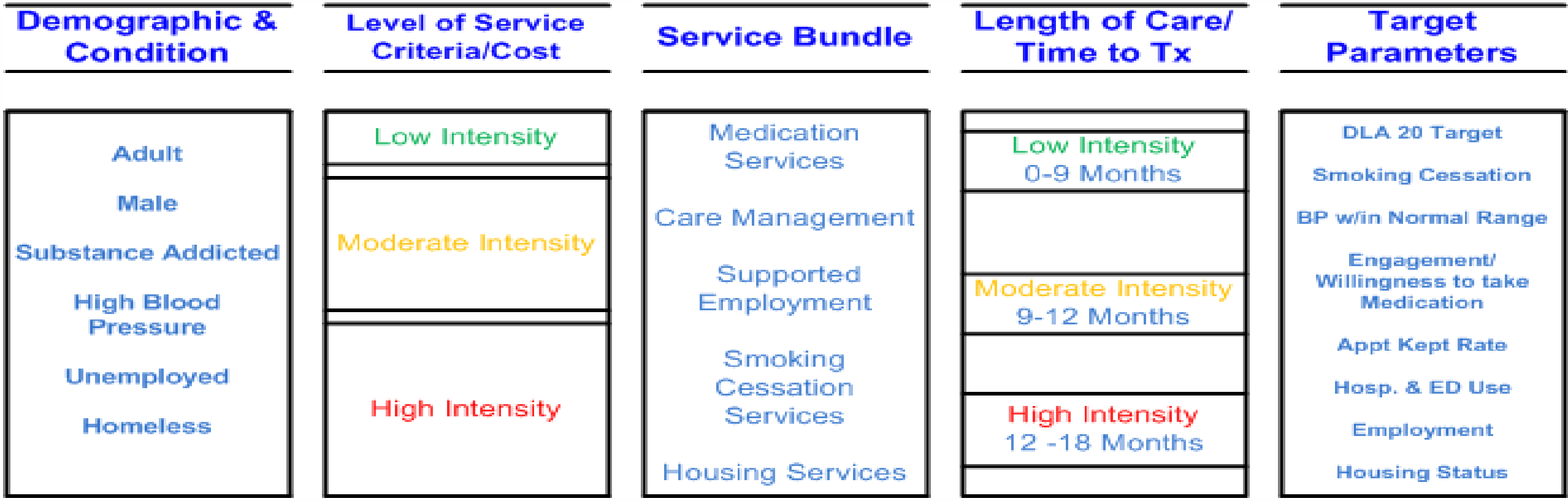




Note: Measures of population health in the Triple Aim measurement menu in Table 1 appear in **bold** text in Figure 1.

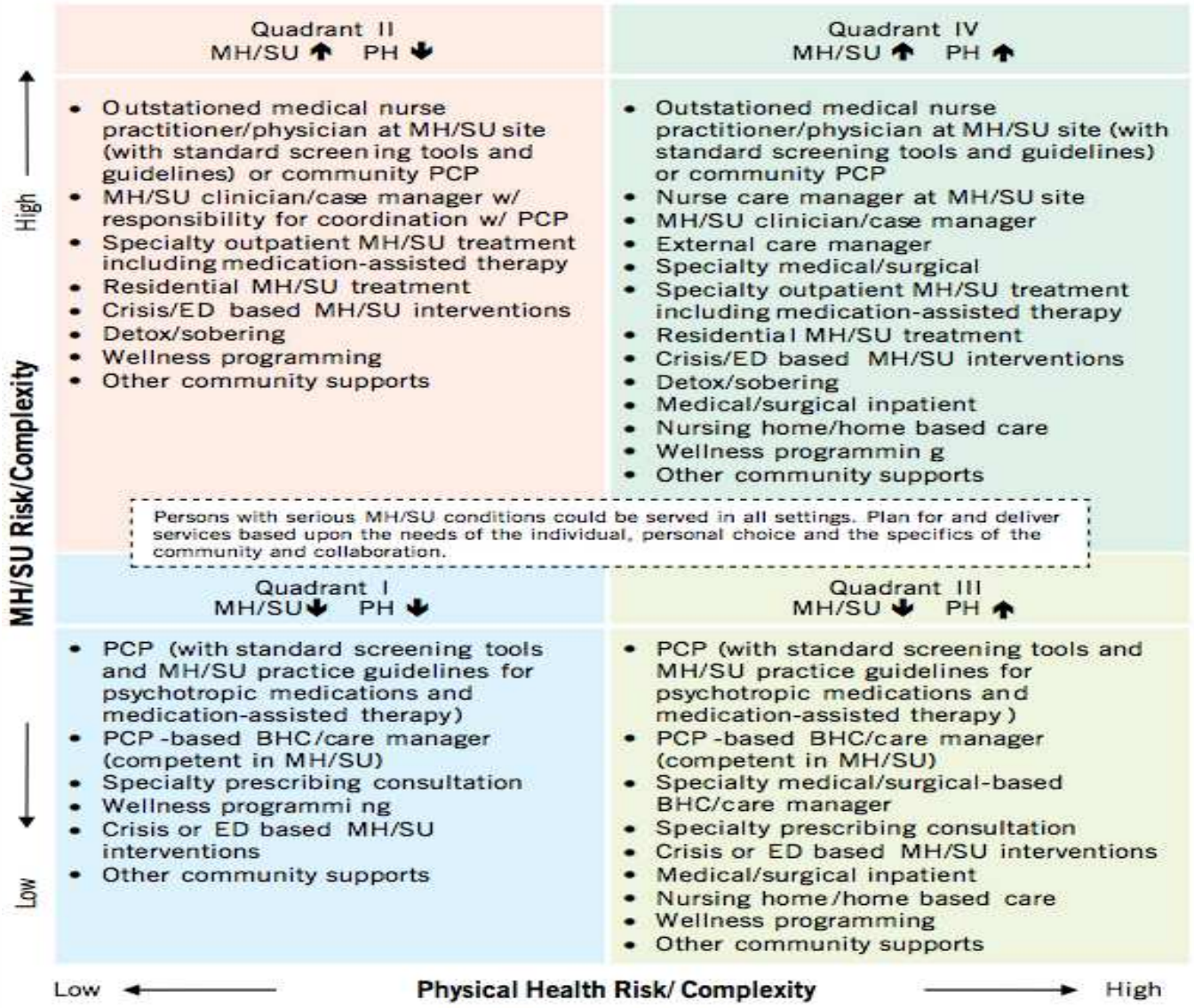
Resar, Griffin, Haraden, Nolan, (2012) Using Care Bundles to Improve Health Care Quality. IHI Innovation Series White Paper, Institute for Health Care Improvement, Cambridge, Massachusetts

Simple Bundling Logic Model



Developing Community Partnerships

Four Quadrant Model



Community Partnerships

- Who are key community partners that you:
  - Have a relationship with and need to strengthen?
  - Need to develop a relationship with?
  - Need to share data with and/or collect data from?

Common Integration Needs

- Defining & communicating the vision
- Investigating best practices/strategies
- Designing the business model
- Finding a BH or PC partner or hiring your own
- Bridging the cultural divide between PC & BH
- Developing policies & procedures
- Clarify what data to collect

Common Integration Needs

- Clarifying funding sources & maximizing profit
- Est. or strengthening networks of care partnerships
- Developing BH registries & data collection/sharing to support clinician/administrator decision making
- Conducting work flow analysis to leverage time & cost while making same day access a reality
- Training staff in BH interventions & team based approaches to care coordination

Role of Leadership and Core Implementation Team

Leaders and leadership teams who employ research informed approaches are more likely to activate the organization to support a change initiative

John Kotter's The Heart of Change

The Heart of Change

Keys to Success

- Shared Vision between Partners
- Change Management Technology
- Communication Plan
- Clear Statement of Work/Charge
- Work Plan: Tasks, Accountability, Measures, Timelines & Resources
- Risk Management Plan

Action Planning

Next Steps!

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