BUILDING CAPACITY FOR EMBRACING CO-OCCURRING PRACTICE IN THE BHHO

CCSME Annual Meeting 2015

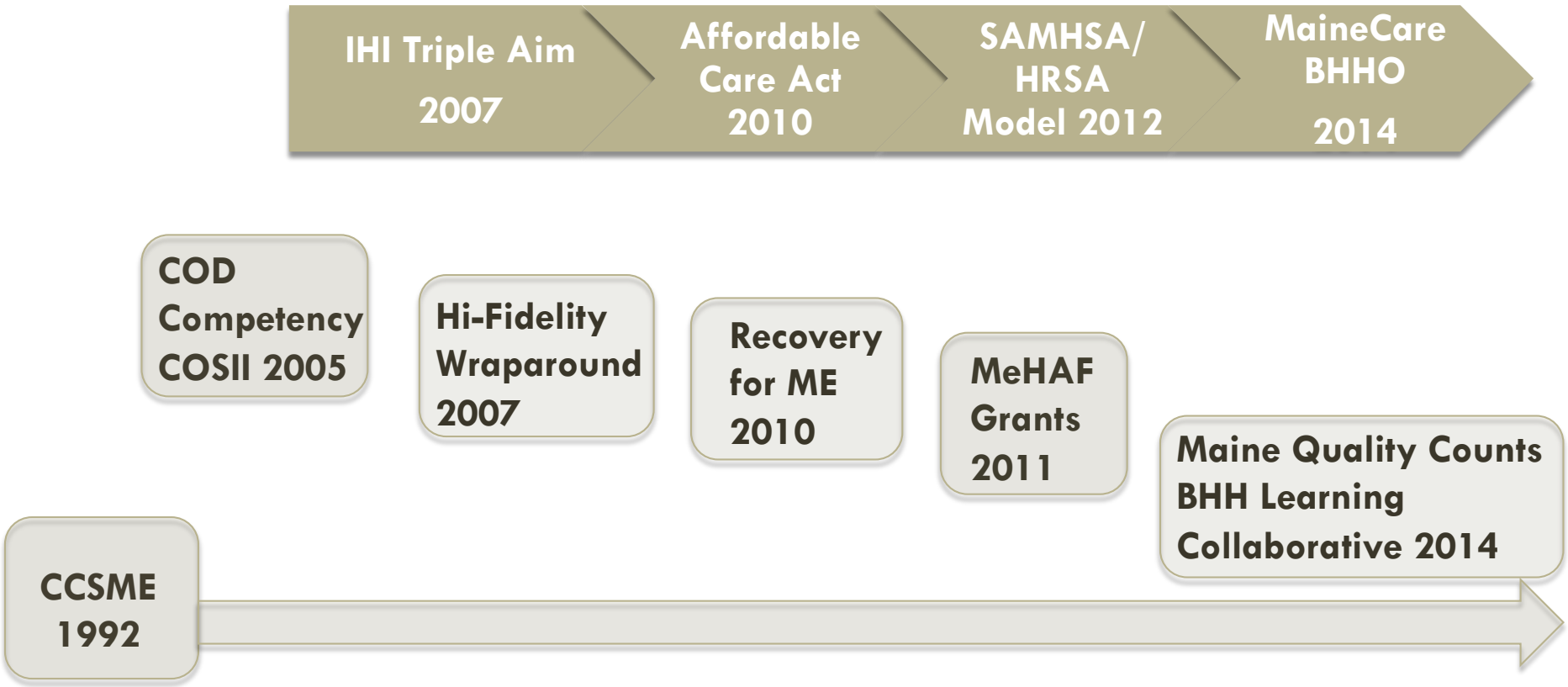
Hope for our time together…

- Explore the motivation within healthcare reform to transform to a more integrated healthcare service models.
- Further explore the MaineCare Behavioral Health Home Model initiative as implemented at The Opportunity Alliance.
- Review best practice advice and the challenges to creating co-occurring competent practice in the BHH integrated model of healthcare and recovery.

Assumptions of Today's Conversation

- COD of substance use and serious/persistent mental illness are both chronic health conditions,
- Traditional healthcare systems are ineffective in improving health outcomes for persons with COD,
- Chronic health conditions require "whole" person service that embrace recovery and wellness activities,
- Those living with chronic health conditions benefit from highly integrated care that is specifically targeted and coordinated approaches that meet their unique needs and strengths, and
- There are significant gaps in SA service for those living with COD.

A Brief History of Building Blocks for Integrated and "Whole" Person Service



Triple Aim Framework (Institute for Healthcare Improvement (www.ihi.org, 2007)

It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the "Triple Aim":

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

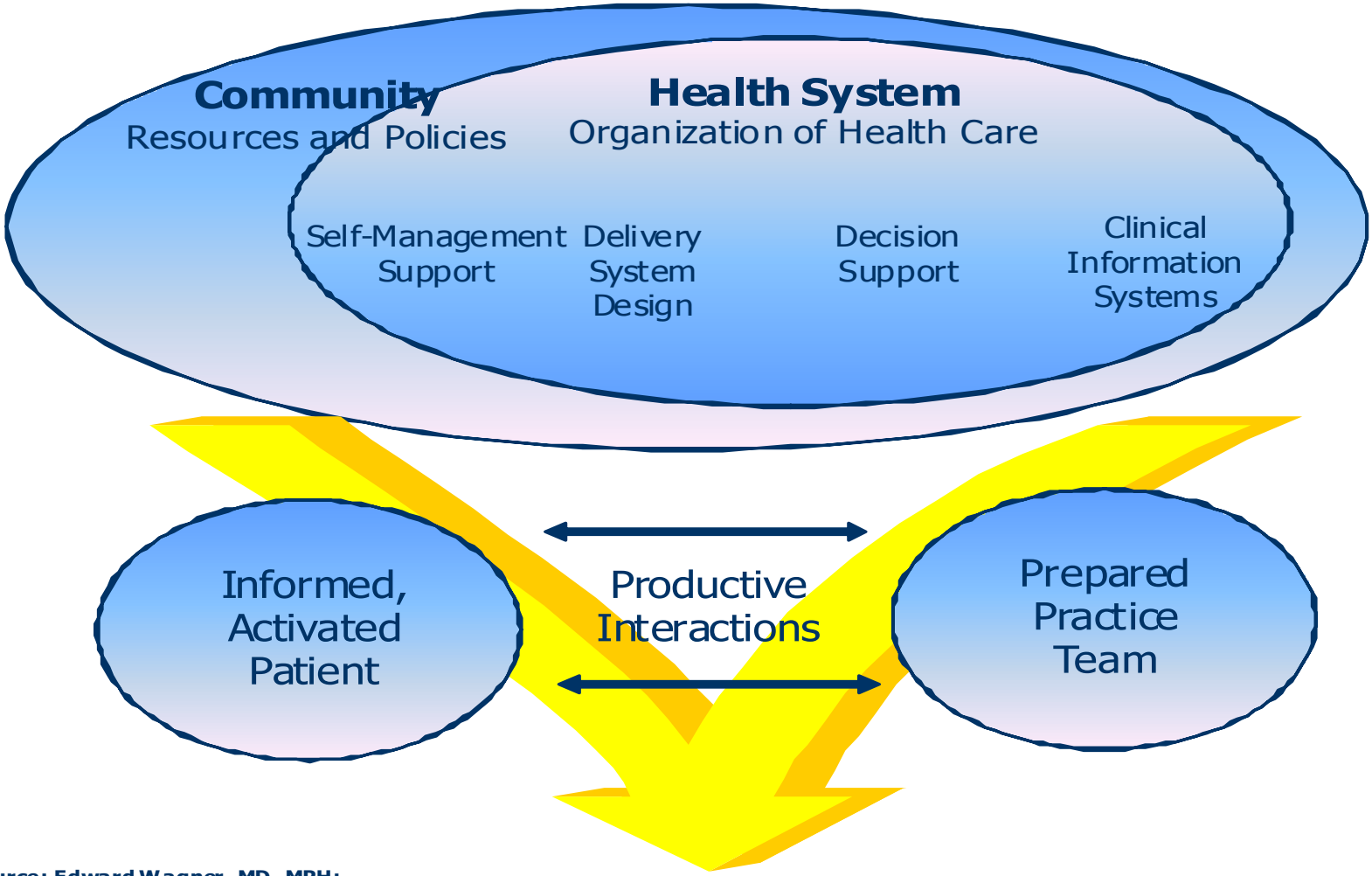
Concept Design of the Triple AIM

- Focus on individuals and families
- Redesign of primary care services and structures
- Population health management
- Cost control platform
- System integration and execution

Approach Continuum to COD

- *Serial treatment* - care is received in sequential treatment episodes, in separate systems of care
- *Simultaneous/parallel* - care is received for both/all disorders simultaneously, but in separate, non-coordinated systems
- *Coordinated/parallel* - care for both/all disorders is received simultaneously in separate but well-coordinated and closely linked systems, with established and formalized collaborative agreements
- *Integrated care* - care for both/all disorders is provided by the same cross trained clinicians and in the same program, resulting in clinical integration of services

Wagner Model Of Chronic Care



Source: Edward Wagner, MD, MPH;
Institute for Health Care Improvement

Standards of Care

(SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS, MAY 2012)

- Each patient must have a comprehensive care plan;
- Services must be quality-driven, cost effective, culturally appropriate, person- and family-centered, and evidence-based;
- Services must include prevention and health promotion, healthcare, mental health and substance use, and long-term care services, as well as linkages to community supports and resources;
- Service delivery must involve continuing care strategies, including care management, care coordination, and transitional care from the hospital to the community;
- Health home providers need not provide all, but must ensure all a full array of services are available and coordinated; and
- Providers must be able to use health information technology (HIT) to facilitate the health home's work and establish quality improvement efforts to ensure that the work is effective at the individual and population level.

What Is a Behavioral Health "Home"

- First, NOT a place, but more an approach
- Designed to serve those with COD and chronic health conditions that is informed and coordinated through the community mental health providers
- Partner with one or more Health Home Practices to manage and coordinate the physical and behavioral health care of individuals with significant mental health and co-occurring needs
- Behavioral Health Homes provides comprehensive care management, health promotion, individual and family support, and other services

MaineCare's BHHO

Behavioral Health Home Organization (BHHO)

+

A Primary Care Practice (HHP)

= **Behavioral Health Homes**

Adults with Serious Mental Illness in Section 17, Community Support Services

Children with Serious Emotional Disturbance in Section 13, Targeted Case Management

Quality Framework

- Goal 1: Reduce inefficient healthcare spending
- Goal 2: Improve chronic disease management
- Goal 3: Promotion of wellness and prevention
- Goal 4: Recovery and effective management of behavioral health conditions
- Goal 5: Improved experience of care for consumers/families

Provider Requirements: BHHO

Ability to deliver team-based care:

- Clinical Team Leader
  - Independently licensed mental health professional, including an Licensed Clinical Social Worker, Licensed Clinical Professional Counselor, Licensed Marriage and Family Therapist, psychologist, psychiatrist
- Health Home Coordinator
  - Qualified TCM case management providers for children or Mental Health Rehabilitation Technician/C certified providers for adults
- Peer Support Specialist
  - Certified Intentional Support Specialist (adults) or other designated training for parents/youth
- Nurse Care Manager
  - Licensed Practical Nurse, Registered Nurse, Nurse Practitioner
- Medical/Psychiatric consultation

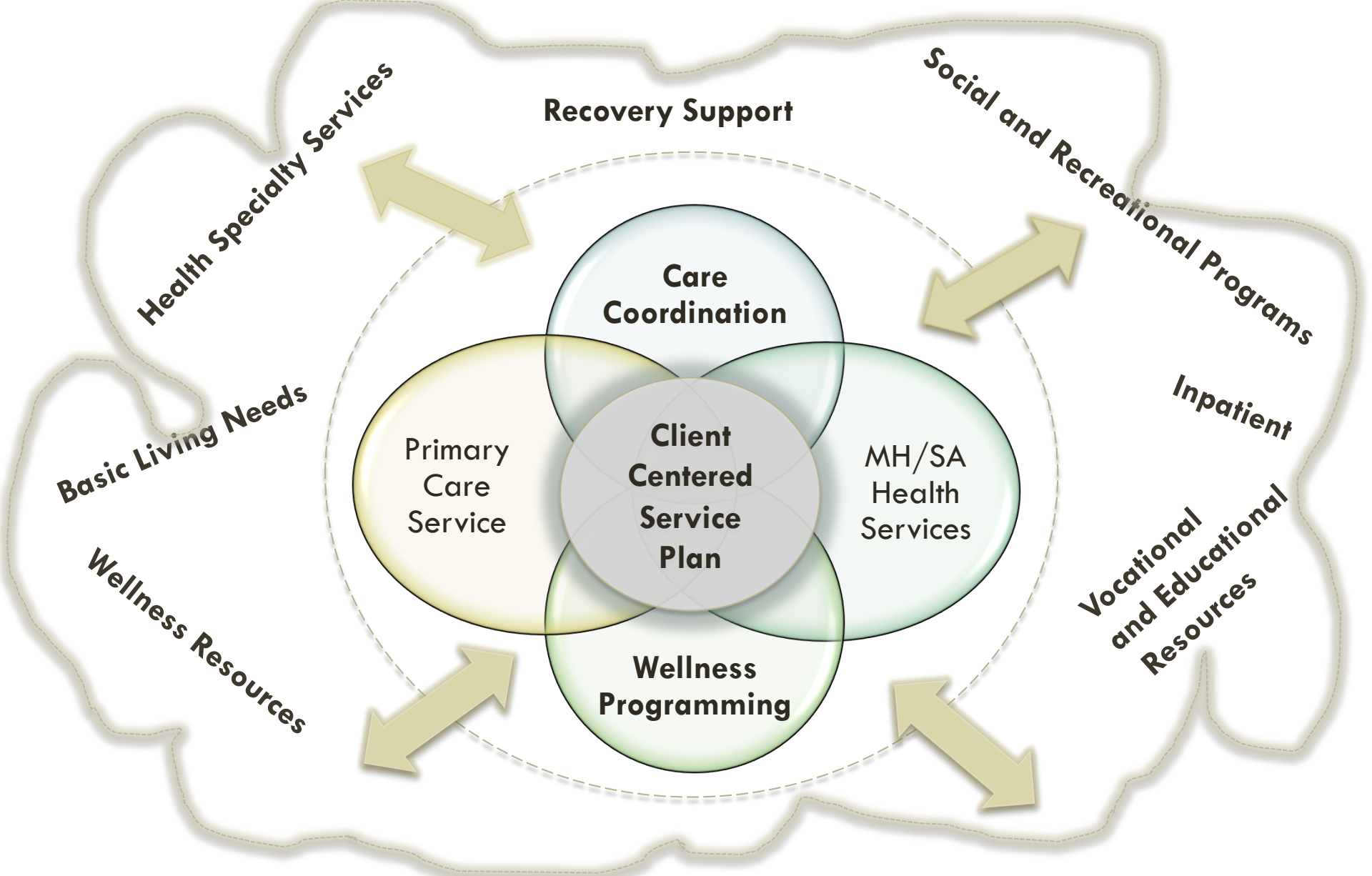
Health Home Practice Requirements

Primary care providers must:

- Be an approved Health Home Practice OR complete a Health Home primary care practice application
- Have implemented an Electronic Health Record (EHR) system.
- Provide Twenty-Four Hour Coverage, as defined in MaineCare Benefits Manual, Ch. VI - Section 1: Primary Care Case Management.
- Have received National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home recognition by date determined by MaineCare
- Have established member referral protocols with area hospitals, which include coordination and communication on enrolled or potentially eligible HHP members.
- Must partner with a community mental health provider that is approved to deliver Behavioral Health Home services.
- Commit to Core Expectations for Health Home practices

The Opportunity Alliance BHHO

- Fully Staffed BHH Service Team
- Capacity to serve 300 Members
- 10 Care Coordinators
- Nurse Care Manager leading the Population Health Efforts
- Fully Integrated Wellness and Peer Programming
- Significant progress in “Family” Engagement
- 14 MOU’s with HHP’s
- Fiscally Stable and Sustainable into the second year
- Meeting all expectations of the Maine Quality Counts Standards of the MaineCare BHHO



HEALTH NEIGHBORHOOD W/I THE COMMUNITY

Challenges to Integrating SA

- Not enough "voice" for SA services within the BHH service provision
- SA recovery needs are still sometimes secondary in health focus as compared to other chronic health concerns
- Challenges of CFR 42 and health information sharing
- Limited SA services and large gaps in the continuum of care
- Unaddressed stigma, ignorance, and fear of SA
- Need for Medically Assisted Treatment outruns the current capacity (esp. opioid dependence)
- Continued need for workforce development of COD competency across the system

Beating the Clash of Culture in Understanding Our Shared Accountability

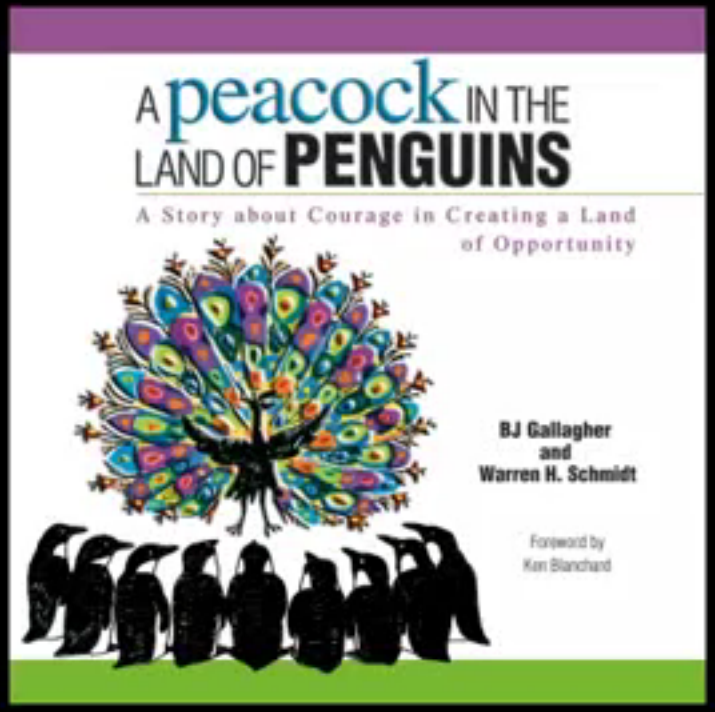
Creating a Culture of Shared Accountability for Inclusion of SA Service

- Having all the right partners at the table
- Build a common commitment to the program goals and implementation strategies
- Commit to best practice models in SA services
- Create a shared understanding health outcomes and performance measures across care system
- Institute a cross-disciplinary team that represents all aspects of treatment, recovery, and wellness
- Retool the service provision to provide a person-centered and “whole” person approach to care
- Build a network/system of service to meet the needs of the population

Let's Talk…

The purpose it to generate some discussion about what CCSME can do to fill member needs.

- What is your experience of the current status of COD responsiveness in integrated care?
- What challenges do you envision lay ahead with advancing COD competent services in the integrated care transformation?
- What support do you or your agency need?
- What training or other activities would you look to CCSME to provide?


A peacock IN THE
LAND OF PENGUINS
A Story about Courage in Creating a Land of Opportunity
BJ Gallagher
and
Warren H. Schmidt
Foreword by
Ken Blanchard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