SAMHSA-HRSA
Center for Integrated Health Solutions

Behavioral Health Homes: The Core Clinical Features

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2:00 – 3:30 pm ET

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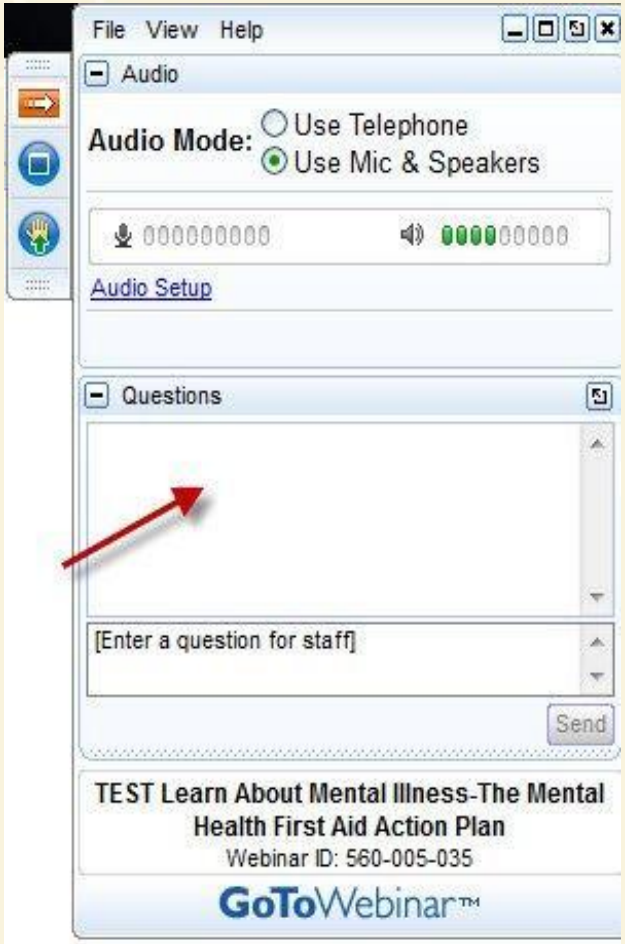

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The Clinical Work of Effective Behavioral Health Homes

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Context

The ACA created a new option for state Medicaid programs to provide health homes for enrollees with chronic conditions, including MH & SU conditions

- Became effective 1/1/2011
- Subject to CMS approval of state plan amendment

Program provides financial incentives for states

- 90% FMAP for health home-related services for 1st 8 quarters
- Alternative payment models
- Incentive grants

Required services

- Each patient must have a comprehensive care plan;
- Services must be quality-driven, cost effective, culturally appropriate, person-/family-centered, and evidence-based;
- Services must include prevention and health promotion, healthcare, mental health and substance use disorder, long-term care services, as well as linkages to community supports and resources;

Required services (continued)

- Service delivery must involve continuing care strategies, including care management, care coordination, and transitional care from the hospital to the community;
- Health home providers do not need to provide all the required services themselves, but must ensure the full array of services is available and coordinated; and
- Providers must be able to use health information technology (HIT) to facilitate the work of the health home and establish quality improvement efforts

Target populations

- Two or more chronic health conditions
  - i.e., MH or SU condition, asthma, diabetes, heart disease, or overweight; OR
- One chronic condition and at risk for another; OR
- One serious and persistent mental health condition

Note: Regardless of which condition(s) are selected, states must address MH and SU conditions and consult with SAMHSA on their treatment and prevention

The opportunity

MH and SU treatment providers can become a health home for the people they serve

- A behavioral health-based health home

The challenge

To create a behavioral health home capable of functioning effectively at ***both*** the administrative and ***clinical*** levels

Focus of this webinar (& paper): The **clinical** piece

- How to improve outcomes for people with MH and SU conditions in a behavioral health-based health home

Redesigning care to serve as health home

Core elements of the Chronic Care Model:

- Self-management support
- Delivery system design
- Decision support
- Clinical information systems
- Community linkages

Self-management support

Activated consumers have skills to:

- self-manage their care
- collaborate with providers
- maintain their health

The behavioral health home helps consumers become activated by:

- Assessing the consumer's activation level
- Addressing deficits through self-management support strategies
  - Important to include both education and coaching components

In practice: Self-management support

The **Health and Recovery Peer (HARP) program** is a manualized, 6-session intervention in which peer leaders help participants become more effective managers of their chronic illnesses.

Sessions focus on health and nutrition, exercise, and being a more effective consumer of services.

HARP helps individuals become more activated consumers, but does not provide any direct linkage with medical services.

Delivery system design

Care system is redesigned in key ways, including:

- Formation of multidisciplinary practice teams
  - Clear roles
  - Single care plan
  - Effective communication
  - Mechanisms for coordinating care between team members
- Provision of care management
  - Client activation and education
  - Care coordination
  - Monitoring consumers' participation in and response to treatment (when treating provider is part of team)

In practice: Care management

Compass Health participated in the Washington Community Mental Health Council's learning collaborative on medical care management.

Used Medicaid claims data to identify highest-utilizing consumers and the physicians and pharmacies they see

Nurse care manager administered the Patient Activation Measure and met regularly with participants to offer support, education, and problem solving around their medical conditions and goals.

Decision support

Ensure clinical care is provided in line with best practices by:

- Involving specialists
- Embedding evidence-based guidelines in routine care provision

In practice: Decision support

Brigham and Women's Hospital developed a clinical decision support tool to address inappropriate use or excessive dosing of psychotropic medications in older patients.

The tool modified the existing computerized orders system for patients 65+ so the default dose/frequency for psychotropic medications was changed and a substitute drug was suggested when the provider ordered a psychotropic medication known to be poorly tolerated or risky for older patients.

Clinical information systems

Support organization of data

- At the population level helps maximize outcomes for defined groups of consumers
- At the individual level helps maximize consumer's outcomes

Regardless of format, necessary functions include:

- Organizing data at population and individual level
- Delivering reminders to providers (and consumers)
- Providing feedback to clinicians (and consumers)

In practice: Clinical information systems

A web-based registry is key element of the **Mental Health Integration Program** (WA)

Supported by psychiatrists, behavioral health care managers work with PCPs to monitor and support consumers' integrated care

The registry tracks consumers' progress and identifies those in need of follow-up or treatment changes

Community linkages

Develop an understanding of the contextual factors (e.g., poverty) that may underpin consumers' poor health

Support consumers' connections to care and resources in the community

- Become familiar with the area's community resources
- Link consumers to them
- Track referrals

In practice: Community linkages

Monadnock Family Services created **InSHAPE** (Self Health Action Plan for Empowerment)

Participants complete a fitness/lifestyle assessment with a personal trainer mentor and create an action plan

Participants receive vouchers for membership to fitness facilities in the community

Participants access nutrition counseling, smoking cessation programs, and primary care at a nearby health center

Structuring the behavioral health home

Several options depending on the behavioral health provider's resources:

- In-house model
- Co-located partnership model
- Facilitated referral model

In-house model

The behavioral health agency provides and owns the complete array of primary care and specialty behavioral health services.

The agency ensures communication across providers and coordination of services that allow it to deliver care that is integrated from the consumer's perspective

In practice: Cherokee (TN); Crider (MO)

Co-located partnership model

The behavioral health agency arranges for healthcare providers to provide primary care services onsite

Processes must be in place — beyond simple co-location — to ensure that effective communication and coordination between providers happens routinely

In practice: SAMHSA's Primary Behavioral Health Care Integration (PBHCI) grantees

Facilitated referral model

Most primary care services are not provided onsite, but the agency ensures coordination of care provided offsite.

The agency conducts health screenings, links clients to PCPs in the community, and facilitates communication and coordination with health providers – typically with the support of a medical care manager.

In practice: PCARE; Samet et al's facilitated referral intervention in a detoxification unit

Action steps to consider

Reach out to the relevant state agencies

Master the health home's key clinical features and the system-level strategies that support them;

Create a strategic plan, including the clinical model, budget, and implementation plan;

Start the change management process;

Action steps (continued)

Formalize partnerships with community partners;

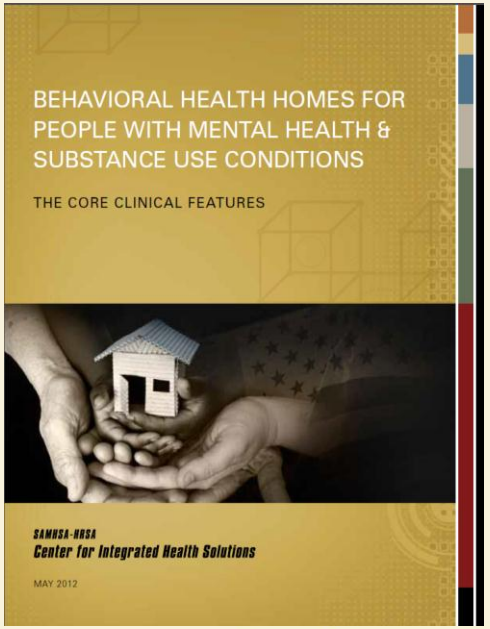
Regularly update state agencies on progress;

Identify and include relevant stakeholders in the decision-making and strategizing process; and

Seek support and guidance/training from colleagues, experts, and leaders of relevant efforts.

For more information

Executive summary and full report are available to download at: www.integration.samhsa.gov



CIHS and Health Homes

Questions