

Behavioral Health Home Learning Collaborative

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Participating Project Teams

Organizations

- Bridgeway Recovery Services
- Cascadia Behavior Health
- Lifeworks NW
- Options for Southern OR
- Eastern Oregon Alcoholism FND.
- Community Health Services
- Community Health Alliance
- Lane County Behavioral Health
- Old Town Recovery Center
- La Clinica

- ORPRN Practice Coach
- ORPRN Practice Coach
- ORPRN Practice Coach

Locations

Salem
Portland
Portland/Hillsboro
Grants Pass
Pendleton
Benton & Linn Co.
Roseburg
Eugene
Portland
Medford

Prineville
Eugene
Portland

Team Contacts

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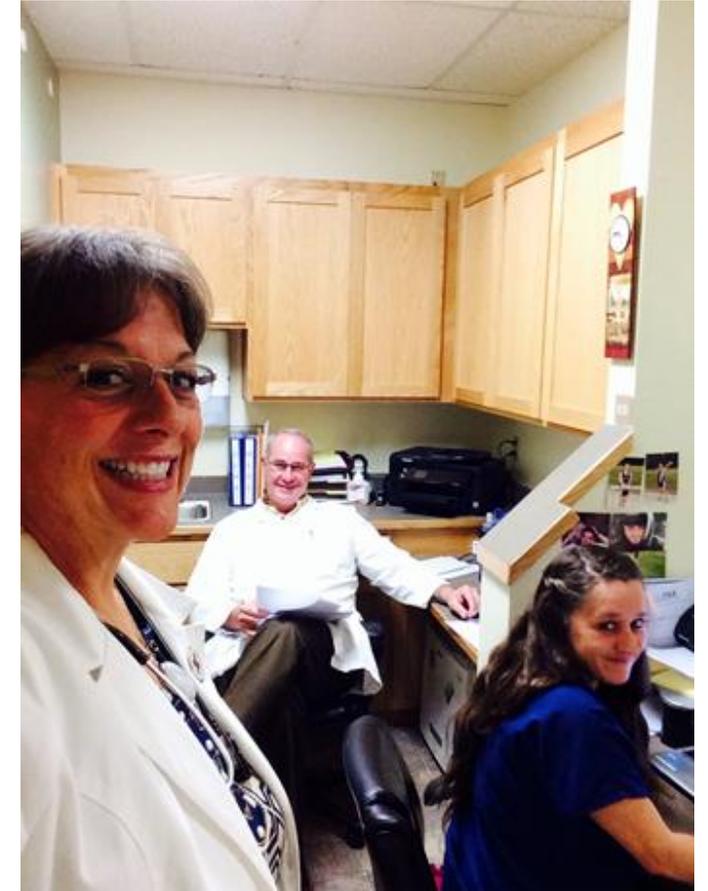
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Background & Evidence

- Persons with Severe and Persistent Mental Illnesses (SPMI) or are recovering from Substance Abuse Disorders (SUD) have a high incidence of chronic medical problems. They have specialized care needs that are difficult to address in general primary care practices. The Behavioral Health Home Learning Collaborative is supporting organizations serving SPMI and SUD populations with integrating primary care into their programs.
- Oregon's Patient Centered Primary Care Home model is based on evidence-based best practices in managing chronic health conditions. The BHH Learning Collaborative will apply elements of the PCPCH model into behavioral health settings. SAMHSA and AHRQ have identified those BHH components that are core for serving persons with SPMI and SUD. The state of Missouri has demonstrated the efficacy of broadly implementing this model.

Project goals

- Goal:
Improve the health of persons with severe and persistent mental illness and substance use disorders
- Objectives:
 - ✓ Adopt and adapt PCPCH principles and practices in behavioral health settings
 - ✓ Apply continuous quality improvement tools to improve specific health conditions
- Examples:
 - ✓ Improve screening for unmet physical or behavioral health needs
 - ✓ Create registries of clients in need of integrated care
 - ✓ Promote team-based care across primary care, mental health and addictions treatment



BHH Project Measures

BHH project teams will link their quality improvement projects to Adult Medicaid Quality Grant Program core measures. Examples include:

- Reduce adult body mass index (BMI)
- Increase follow-up after hospitalization for mental illness
- Reduce in all cause hospital readmissions
- Increase screening for clinical depression and follow-up plans
- Increase screening, initiation and engagement in alcohol and other drug dependence treatment
- Control high blood pressure
- Control diabetes

Progress to-date:

- Most projects have begun providing primary care medical services for an identified population of behavioral health patients
- All project teams are working with ORPRN Practice Enhancement Research Coordinators (PERCs) to implement their programs
- All project teams have been trained and are using PDSA cycles focused on specific quality improvement objectives

Next steps:

- Train project teams to use care management protocols and tools
- Create a BHH tool kit and resource guide to spread the model