

Transformation Plan Element #1

Physical, Mental Health and Addiction Integration

Transformation Plan Guidance and Technical Assistance

Oregon Health Authority's technical assistance is designed to provide Coordinated Care Organizations (CCOs) with guidance on specific areas each plan should address; examples of approaches and outcomes that can help inform discussions and strategies as the CCO develops its plan; other resources and additional technical assistance available to CCOs; and staff assistance to answer specific questions through an assigned OHA contact. Please call or email your OHA Transformation Plan contact if you need assistance with a particular subject or item.

Overview

One of the primary goals of Health Systems Transformation is the integration of physical health, mental health and addiction services and supports. By implementing strategies and systems that emphasize health promotion, prevention, early identification and early intervention of conditions that lead to chronic mental health and addictions disorders, CCOs have an opportunity to improve outcomes, enhance the members' healthcare experience and reduce overall expenditures.

The CCOs will need clear and well-defined plans to administer a full range of services and supports to meet the healthcare needs of their members and a specific infrastructure related to addictions and mental health treatment services and supports. As referenced in the RFA in Appendix A, this includes care planning, care coordination, transition, care management, services and supports that address the comprehensive transitional care and intensive care coordination needs for members with behavioral health conditions with an emphasis on services for people with serious and persistent mental illness.

OHA Expectations: Using CCO responses to the RFA as the baseline, OHA encourages CCOs to identify progress that has been accomplished to date and describe CCO plans for continuing transformational initiatives that integrate physical and behavioral health.

Background

Health System Transformation provides Oregon with an opportunity to address the environmental and social determinants of health as well as the physical and behavioral health interventions that promote and improve health.

Contractually, CCOs are asked to implement and participate in activities supporting a continuum of care that integrates mental health, addiction treatment, dental health and physical health interventions seamlessly and holistically. Integrated care spans a continuum ranging from communication to coordination to co-management to co-location to the fully integrated Patient Centered Primary Care Home. In addition, this area is a required statewide Performance Improvement Project (PIP).

OHA entered into an agreement with the US Department of Justice to address issues relating to the civil rights of people living with serious and persistent mental illness to receive treatment in

Transformation Plan Element #1

Physical, Mental Health and Addiction Integration

the least restrictive environment possible. The agreement recognizes the work happening in Oregon to create a more coordinated health care system – and it is rooted in a shared understanding that transformational change in health care depends on transforming the mental health system. The goal of the agreement is to use the health system transformation process to better provide people living with serious and persistent mental illness with critical community services they need to live in the most integrated setting possible. The agreement creates a framework, timeline and milestones for the state, coordinated care organizations, and local mental health agencies to work together to improve care so that people receive the right care, at the right time, in the right place.

OHA will partner with the CCOs and the Local Mental Authorities to address the requirements in the agreement. The Transformation Plan will need to address the needs of individuals identified in this agreement.

USDOJ link:

http://www.justice.gov/usao/or/documents/20121109_civil_agreement.pdf

Definitions

Community-based Services: Community-based services include adult foster care, behavioral health outpatient therapy, supports needed for successful community living, medication-assisted treatment and medication management, respite care, case management, housing assistance and supported housing, supported employment, education and social support.

Early Assessment Support Alliance (EASA): Every teen and young adult is at risk of developing psychosis. Psychosis is far more common than insulin-dependent diabetes. It affects three in one hundred people, usually starting between ages 12 and 25. One in one hundred develop schizophrenia (ongoing psychosis), and almost as many develop psychosis associated with bipolar disorder. EASA services include outreach and engagement; assessment and treatment using a multi-disciplinary team consisting of a psychiatrist, social worker, occupational therapist, nurse and vocational specialist; multi-family psycho-education; cognitive behavioral therapy; vocational and educational support; prescribing medication using a low dose protocol; and support for individuals in home, community, school and work settings.

Four Quadrant Clinical Integration Model: The National Council for Community Behavioral Healthcare's widely used [Four Quadrant Model](#) represents a population-based planning framework for the clinical integration of health and behavioral health services. The revised model incorporates the concept of the person-centered healthcare home. The Substance Abuse and Mental Health Services Administration has partnered with the National Council and HRSA to promote the model and provide technical assistance to states on healthcare integration. The Four Quadrant Clinical Integration Model describes levels of integration in terms of primary care complexity and risk and mental health/substance use complexity and risk. The four quadrant model is a popular way to measure a facility's level of integration.

Transformation Plan Element #1

Physical, Mental Health and Addiction Integration

Screening, Brief Intervention and Referral to Treatment (SBIRT): SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders (Substance Abuse and Mental Health Services Administration). Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. SBIRT is a brief conversation, about 10 to 15 minutes, about hazardous alcohol and/or drug consumption.

Serious and Persistent Mental Illness: Serious and Persistent Mental Illness: There are various operational definitions to be found. Most definitions include a major DSM IV mental disorder and a significant functional impairment.

System of Care: A system of care is framework for a collaborative management and policy infrastructure that organizes a set of services and supports for a population of focus by integrating service planning, coordination, and service delivery. It is guided by a philosophy and adheres to a defined set of values and principles but can be tailored for a specific community or population.

As defined in ORS 418.975 (7) “System of Care” means a coordinated network of services including education, child welfare, public health, primary care, pediatric care, juvenile justice, mental health treatment, substance use treatment, developmental disability services and any other services and supports to the identified population that integrates care planning and management across multiple levels, that is culturally and linguistically competent, that is designed to build meaningful partnerships with families and youth in the delivery and management of service and the development of policy and that has a supportive policy and management infrastructure.

Recovery: Recovery is a process of healing and transformation for a person to achieve full human potential and personhood in leading a meaningful life in communities of his or her choice (Adapted from SAMHSA, 2005).

Recovery Management: Long-term, coordinated management of care for behavioral health and co-existing physical health conditions, adapted based on ongoing monitoring of progress. Shifts focus of care from professional-centered episodes of acute symptom stabilization toward intervention within a more sustained continuum including: pre-recovery support services to enhance recovery readiness, in-treatment recovery support services to enhance the strength and stability of recovery initiation, and post-treatment recovery support services to enhance the durability and quality of recovery maintenance.

References/Resources

EASA: Sometime during the calendar year 2013, EASA Technical Assistance (TA) will become a Center of Excellence located at Portland State University. The Center will offer TA throughout Oregon.

OHA State Contact: 503-947-5538

Transformation Plan Element #1

Physical, Mental Health and Addiction Integration

EASA Statewide Website: <http://www.easacommunity.org>

Four Quadrant Clinical Integration Model:

http://www.thenationalcouncil.org/cs/best_practices_programs

SBIRT: The Oregon Health and Science University SBIRT Primary Care Residency Initiative (www.sbirtoregon.org) is helping disseminate SBIRT practices by training the next generation of primary care physicians. In addition, the Northwest Frontier Addiction Technology Transfer Center (NWATTC) housed at OHSU works with the SBIRT Primary Care Residency Initiative and would be a good source of information and partnership for implementing SBIRT in primary care settings.

System of Care:

Extensive research and policy guidance in children's mental health and substance abuse treatment provides a significant framework for CCO system of care development.

<http://www.oregon.gov/oha/amh/pages/wraparound/main.aspx>

http://gucchdtcenter.georgetown.edu/publications/SOC_Brief_Series1_BL.pdf

www.tapartnership.org

Recovery Oriented System of Care for Addiction Recovery:

<http://partnersforrecovery.samhsa.gov/rosc.html>

California - County based mental health system toolkit:

<http://www.ibhp.org/uploads/file/IBHP%20Collaborative%20Tool%20Kit%20final.pdf>

More information about integrated care toolkits:

<http://www.integratedcareresourcecenter.com/hhphysicalbehavioral.aspx>

Components

1. Prevention, Promotion, Early Identification and Early Intervention
 2. Shared Health Information
 3. Training and Cross Training
 4. Individuals with Serious and Persistent Mental Illness
 5. System of Care
 6. Transitions of Care
 7. Recovery Management
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Transformation Plan Element #1

Physical, Mental Health and Addiction Integration

1. Prevention, Promotion, Early Identification and Early Intervention

OHA Expectations

OHA would like CCOs to describe how promotion, prevention, early identification and early intervention of conditions that lead to chronic mental health and addictions disorders will be developed and supported in the system of care.

Examples include:

- Building and strengthening partnerships with local public health and community prevention experts to incorporate behavioral health profiles into the community health assessment and community health improvement plans.
- SBIRT - SBIRT is used to identify members who misuse alcohol or other substances
- Screenings occur for clinical depression and the presence of other mental conditions and follow-up plan for further assessment, treatment and/or services

Measurement Methodology

- OHP population-level health indicators such as depression, tobacco use, alcohol misuse or illicit and prescription drug misuse and addiction.

Baseline

- Selected indicators depending on CCO target area of focus.

Transformative Activity

- Steps to implement Screening, Brief Intervention and Referral to Treatment (SBIRT) identifying members who misuse alcohol or other substances. ****CCO Incentive Measure**
- Steps to implement screening for clinical depression and the presence of other mental conditions and follow-up plan for further assessment, treatment and/or services. ****CCO Incentive Measure**
- Steps to ensure mental health assessment for children in DHS custody.
- Steps to implement EASA.

Improvement Metric

- Individualized based on CCO area of focus. Alcohol, tobacco or illicit drug misuse among OHP member population are examples.

2. Shared Health Information

OHA Expectations

Describe how the CCO is/will be directing and supporting the providers to readily share health information to coordinate care.

Transformation Plan Element #1

Physical, Mental Health and Addiction Integration

Describe plans to assure that timely communication of physical health, mental health and addictions health information is timely transmitted to relevant providers when there is a transition of the level of care.

Describe plans to facilitate the development of shared care plans.

Measurement Methodology

- Percent of behavioral and physical health who share service plans and data regarding individuals participating in services.

Baseline

- N/A – will be individualized based on CCO network of providers.

Transformative Activity

- Directing and supporting the providers to readily share health information to coordinate care.
- Facilitating the development of shared care plans.

Improvement Metric

- Timely transmission of transition record is a CCO Measure.

3. Training and Cross Training

OHA Expectations

Describe how the CCO will facilitate cross training of behavioral health and physical health providers.

Measurement Methodology

- Percentage of physical healthcare providers participated in identified behavioral health training.
- Percentage of behavioral health providers participated in identified physical health training.

Baseline

- N/A

Transformative Activity

- Development of training plan
- Multidisciplinary meetings to identify barriers and develop solutions to further integration

Improvement Metric

- Reported percentages above

Transformation Plan Element #1

Physical, Mental Health and Addiction Integration

4. Individuals with Serious and Persistent Mental Illness

OHA Expectations

While this population should be addressed in response to the above guidance these elements are specific to the target population.

Please describe how the CCO is working with the Local Mental Health Authority to identify opportunities to improve coordination and collaboration regarding non-medical services and supports that provide an opportunity for improved physical health.

Describe plans to provide physical health care for persons with a SPMI and chronic health conditions (cardiovascular disease, diabetes, etc.).

Describe plans to incorporate physical care outreach into the community for this population.

Describe the plan to provide physical health care for this population residing in licensed residential facilities.

Describe plans to enroll individuals in this population into person centered primary care homes.

Measurement Methodology

- Use encounter data to identify physical health care utilization by individuals with a serious and persistent mental illness

Baseline

- Frequency of ED visits for physical healthcare by individuals with a serious and persistent mental illness

Transformative Activity

- CCO to describe plans to address the above OHA expectations

Improvement Metric

- Percentage of increase in utilization of primary care visits and decrease in ED visit for physical health care.

5. System of Care

OHA Expectations

Implementing a system of care approach, incorporating models such as the Four Quadrant Clinical Integration Model of the National Council for Community Behavioral Healthcare or Wraparound for children with behavioral health disorders.

Transformation Plan Element #1

Physical, Mental Health and Addiction Integration

Defined mechanisms and capacity to meet access standards consistent with current standards of practice: emergency, urgent, regular, and post facility-based treatment.

Steps to ensure an adequate network of services is accessible by members in all stages of behavioral health conditions.

Measurement Methodology

- Define provider network able to meet member needs across array of services and supports including emergency, urgent, regular, post-facility based treatment.

Baseline

- Unique to CCO – current integration status among elements included in the Four Quadrant Clinical Integration Model and/or Wraparound for children with behavioral health disorders.

Transformative Activity

- Steps to train provider network on system of care principles.
- Steps to train staff and providers on principles of behavioral health intensive care coordination.
- Efforts to evaluate system against the Four Quadrant Clinical Integration Model and/or Wraparound for children with behavioral health disorders.
- Steps taken to develop screening mechanisms and clinical pathways to ensure members with significant behavioral healthcare needs receive services and supports through integrating service planning, coordination, and service delivery.

Improvement Metric

- Improvement along the continuum of integration factors in Four Quadrant Clinical Integration Model.
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6. Transitions of Care

OHA Expectations

Describe plans to facilitate the effective coordination of care for individuals transitioning levels of care.

- Detoxification (hospital or community residential)
- Residential care (mental health and addictions; adults and children/youth)
- Hospitalization for mental illness (Oregon State Hospital and psychiatric hospital stay in community hospital) ****CCO incentive measure**
- Secure Children's Inpatient Program
- Secure Adolescent Inpatient Program

Describe plans to successfully transition adults with a serious and persistent mental illness to the most integrated community setting.

Transformation Plan Element #1

Physical, Mental Health and Addiction Integration

Describe how the CCO will coordinate care plans for individuals throughout transitions in levels of care.

Describe how appropriate providers will be notified when an individual transitions between providers or levels of care.

Measurement Methodology

- Members who successfully engaging in post-residential or hospital community-based care.

Baseline

- Proportion of members who successfully engaging in post-residential or hospital community-based care.

Transformative Activity

- Describe how the CCO will identify members that have behavioral health intensive care coordination (ICC) needs, the models for providing ICC, and staff competencies needed to ensure continuous care coordination through episodes of care.

Improvement Metric

- - Percentage of members with intensive care coordination who access follow-up services after facility-based residential episode of care within 7 days.
 - Proportion of members who receive intensive care coordination and simultaneously increase access to community-based services and supports.
 - Increased member satisfaction with overall team-based service planning approach.
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7. Recovery Management

OHA Expectations

Describe how the CCO will help members connect with social supports such as housing, vocational services, educational services, basic needs, and other social supports to maintain behavioral health recovery.

Describe how the CCO will help members connect with cultural and peer-delivered services aimed at helping people with behavioral health conditions maintain motivation toward recovery and connections with the recovery community.

Measurement Methodology

- Percentage of members who report improved housing status over the previous year. This measure will be tracked for the Local Mental Health Authorities (LMHA), so partnering with LMHA on this measure is an opportunity.

Transformation Plan Element #1

Physical, Mental Health and Addiction Integration

Baseline

- Utilization of services one year prior to engagement in behavioral health services.

Transformative Activity

- CCO describe plans to shift focus toward recovery vs. symptom management for behavioral health conditions.

Improvement Metric

- Percentage of increase in utilization of primary care visits and decrease in ED visit for physical health care. Reduced hospital and facility-based care.