




Changing the World:
Community BH Organizations (CBHOs)
Inspiring Hope, Health and Recovery
for People with Behavioral Health Needs

*Transforming Systems and Organizations—
Becoming Resource-Smart, Value-Driven,
Customer-Oriented, and Integrated*

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The Role of CBHOs in
Value-driven, Customer-oriented, and
Integrated Behavioral Health Systems
in Tennessee

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Outline:
Three Pillars of Transformation

- Part 1: Envisioning a Value-based Integrated System of Care
- Part 2: Developing Functional Structures and Partnerships
- Part 3: Improving Processes, Programs, and Practice

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Part 1: Envisioning a Value-based Integrated System of Care

- We design our system/organization at every level to be about the needs and hopes of the people who come for help.
- Every process, program, policy, procedure, practice, piece of paperwork; every person providing help; with every penny we have.
- We are accountable for producing “value” in terms of how we serve people in accordance with our values.

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Envisioning a Value-based Integrated System of Care

It is important for CBHOs to model effective implementation of system values in all programs and services.

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Core Value: “Person-centered” Customer-oriented

All system processes, programs, practices, and services are designed to make it easy for our customers (both individuals/families with behavioral health/health needs *and* partnering systems) to get help whenever and wherever they need it for as long they need it.

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**Core Value: “Recovery-oriented”
Hope Inspiring**

- In order for our systems and services to inspire people and families with serious challenges and multiple issues, we need to be in the hope business.
- Hope: Every person, including those with the greatest challenges, is inspired when they meet us with the possibility of achieving a happy, hopeful, productive, and meaningful life.


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**Core Value: “Welcoming”
Responsive to Diversity**

Individuals and families have co-occurring issues (including trauma) and complex needs.


Examples:

- MH & SA • BH & CJ
- PH & BH • BH & CPS/JJ/Education
- DD/BI & BH • BH & Housing & Homelessness
- Cultural & linguistic diversity

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**Core Value: “Complexity Capable”
Integrated Services at Every Level**

- Individuals with complex multiple issues have the poorest outcomes in multiple domains.
 - Most likely to cost a lot of money, most likely to die
 - Often seen as misfits rather than priorities to serve
 - Often lose hope because they don't fit in programs
- Complexity is an expectation, not an exception.
- Each system, organization (CBHO) and program (in the CBHO) must be designed to welcome, inspire, and serve people with complexity as a priority for care.

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Core Value: “Integrated System of Care”
Alignment of *all* resources with our values

- All funding streams and resources (state and local; BH, PH, human service; public and private) can be coordinated to support **one system of care** for all.
- CBHOs have potential capability to help coordinate *all* resources for the local population.
- Every penny that we have is designed to support value-based services for our customers.
- All system/organization activities are aligned to improve the overall wellness of our complex population – The Triple (or Quadruple) Aim.

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CCISC—ZiaPartners Value-based Implementation Framework

- All **organizations and programs** (e.g., CBHOs) become welcoming, hopeful, strength-based (recovery- or resiliency-oriented), trauma-informed, and complexity-capable.
- All **persons delivering care** (e.g., in CBHOs) become welcoming, hopeful, strength-based, trauma-informed, and complexity-capable.
- 12-Step Program of **Recovery for Systems**

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Recovery-oriented Complexity Capability

Each process or program organizes itself, within its mission and resources, to deliver integrated, matched, hopeful, strength-based, best-practice interventions for multiple issues to individuals/families with complex needs who are coming to the door.


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Recovery-oriented Complexity Capability

All programs are complexity capable, but different programs have different jobs, based on:

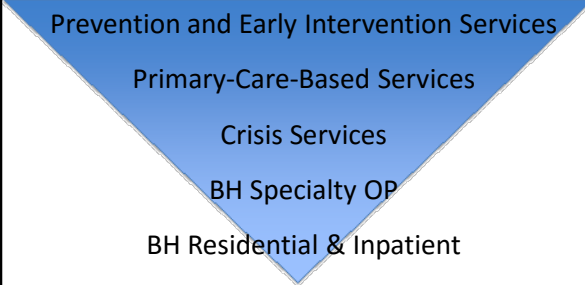
- Customer preference
- Acuity
- Severity – “4 Quadrants”
 - MH/SA, PH/BH, BH/DD-ID
- Cross-system involvement—Vocational, housing, CJ, CPS, JJ

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System Continuum Diagram:

CBHOs either provide directly or partner with others.



Prevention and Early Intervention Services


Primary-Care-Based Services

Crisis Services

BH Specialty OP

BH Residential & Inpatient

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CCISC Tools for Implementation Strategies

- CCISC Program Self-assessment Tools: **COMPASS-EZ™**, **COMPASS-ID™**, **COMPASS-PH/BH™**, **COMPASS-Prevention™**
- System of Care Tool: **SOCAT™**
- **12 Steps for Programs** toward SOC Principle-driven Care and Complexity Capability
- CCISC Clinician Self-assessment Tool: **CODECAT-EZ™**
- **12 Steps for Staff** Developing Complexity Competency


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Center for Integrated Health Solutions (CIHS)
**Organizational Assessment Toolkit
for Integration (OATI)**

For CBHOs, FQHCs, and any provider partners

- Co-authored by
CIHS, ZiaPartners, and MTM Associates
- <http://www.integration.samhsa.gov/operations-administration/assessment-tools#OATI>

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**Part 2: Developing Functional
Structures & Partnerships:
State – Local - CBHO**

What is a system and how does it function?


Sets of nesting Russian dolls
that are not quite so nesting:

- Systems*
within systems
sitting next to other systems
within systems.

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**What is Transformation Redesign
and How Does It Happen?**

- Involves EVERY system, subsystem, and sub-sub-system in a common process to achieve a common vision, with EVERY dollar spent and EVERY policy, procedure and practice.
- In Tennessee, CBHOs are a “sub-system.”
- In a provider organization (CBHO), involves the agency as a whole, every program/ unit in the agency, and every person delivering care working toward a common vision.

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Who is Responsible for System Transformation and Redesign

- State vision, structure, partnership, oversight, and alignment of resources and incentives
- Local/regional system collaborations for population management
- CBHO accountability for both internal change and external collaboration within the local system

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Intermediary Structures

- All large and many mid-size states have intermediary structures (e.g., counties, CSBs, PIHPs, managing entities) to hold accountability for their populations.
- Some smaller states and middle-size states have designated CBHOs in lead roles.
- **CBHOs** may play a role as designated system leaders in their communities and local systems.
- **CBHOs** are critical system partners in building systems of care in all communities.

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Local System Design Characteristics: Local "Ownership" and Accountability

- **State-local provider partnerships for continuous improvement**
- Local collaborations that represents all community partners.
- Capacity to coordinate multiple funding streams, including Medicaid MCOs, to manage local population
- Integration of MH, SA, DD, BI, and health, along with CJ, CSOC, housing, DV, etc...
- Strategic plan using CQI
- Data-driven population health management

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**Respective Roles: State
(DMHSAS, TennCare)**

- Defines local population management and integration structures/processes.
- Aligns funding, regulatory support, and incentives for local empowerment and improvement.
- Supports CBHOs to be important partners in building capacity.

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**Respective Roles:
Local Collaborations**

- Organize local system collaboration structure.
- CBHOs are important partners and leaders.
- Design and operationalize a transformation strategic plan (e.g., SMART goals).

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“Effective behavioral health care systems are conceived, designed, implemented and sustained under the guidance of collaborative leadership and driven by the power of partnership.” – C. Cline

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Respective Roles: CBHO

- Functions as a key local system leader—and partner—with shared population responsibility.
- Establishes an *internal* horizontal/vertical CQI partnership structure to manage transformation.
- Responsible for maximizing effectiveness of its own service continuum.
- Responsible for being a helpful partner with providers of other types of services.


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Part 3: Improving Processes, Programs and Practice

Within this framework, what do CBHO leaders do?


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What do CBHO leaders do?

- Implement a strategic CQI transformation plan that covers a *full* range of processes, programs, and practice improvement activities, within a population management framework.
- Include both *internal* value-based integration improvement activities *and* collaboration with health, BH, and human service partners.


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Tennessee Alignment and Opportunity

- DMHSAS Co-occurring Disorders Strategic Initiative
- TennCare Health Link BH Health Homes


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Clinical Foundation: Principle-based Practices

Research-based principles of successful intervention that can be applied to any population in any program by any person delivering care, and are the foundation of almost all evidence-based practices/programs.


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Six Principles Made Simple

1. Welcome people with complexity as an expectation (e.g., MH, SA, PH, ID/DD, DV, CJ, CPS).
2. Integrated, strength-based, hopeful, client/family-driven partnerships making small steps of progress over time.
3. All people with complexity are not the same: each person has unique needs and each type of program has a different job (4 Quadrants).


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Six Principles Made Simple

4. Integrated issue-specific best-practice interventions for EACH of the *multiple primary* issues.
5. Integrated stage-matched interventions for EACH primary issue.
6. Positively rewarded skill-based learning for EACH primary issue.

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Principles Made Simple Summary

Welcoming, empathic, hopeful, continuous, integrated recovery & support partnerships

- Addressing multiple primary issues
- Providing adequately supported, positively rewarded, strength-based, skill-based, stage-matched, community-based learning for each issue
- Moving toward goal of a happy, meaningful life

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Organizational Foundation: Customer-oriented Quality Improvement

RECOVERY PROCESS FOR SYSTEMS:

- Continuous improvement of *each* process, program and practice
- Horizontal & vertical quality improvement partnership
- Trauma-informed, empowering systems
- Empowered Change Agents, including peers
- FOCUS-PDCA Change Cycles
- Information systems provide actionable data for CQI
- Anchoring value-driven change into the bureaucracy
- Serenity Prayer of System Change

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System Redesign Activities: Components and Processes

CBHOs address each of these (directly or with partners) using clinical principles/system values/CQI:

- Customer-oriented CQI redesign – includes cultural fluency, complexity capability, trauma-informed
- Welcoming integrated access and engagement
- Integration of health and behavioral health (PHBHI)
- Integration of MH/SA, BH/ID-DD-BI, etc.
- *Full* continuum of integrated MH/SA crisis services, including all types of diversion programming

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System Redesign Activities: Components and Processes (cont.)

CBHOs address (continued):

- Continuum of PHBHI and MH/SA care management, utilization management, and care coordination
- Managing the “high utilizers”
- Continuum of integrated PHBHI and MH/SA services at various levels of intensity for all age groups
- Evidence-based practices as indicated
- Workforce development
- Peer support expansion

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System Redesign Activities: Partnerships

- MH & SA; OP, IOP, residential, IP
- Primary health and behavioral health
- Intellectual/developmental disability/brain injury
- Criminal justice/juvenile justice
- Veterans Administration
- Housing/homelessness
- Employment/education
- Child/Adult Protective Services
- Disability benefits/Vocational Rehabilitation
- Prevention/early intervention

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System Redesign Activities

Simple Starting Places

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System Redesign Activities

Customer-oriented CQI Redesign

- **Customer experience is a priority.**
- Prioritize most challenging customers – complexity and diversity.
- Utilize **Continuous Quality Improvement (CQI)** to improve processes in all programs.
- CQI is prioritized over QA and compliance.
- **Align** multiple initiatives with customers at the center.
- **“Anchor”** values and **“backfill”** progress into **ALL** policies, procedures, and paperwork over time.

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System Redesign Activities

Welcoming Integrated Access and Engagement

- Easy access to help – “open access.”
- Welcome those with the greatest challenges.
- Remove “arbitrary” rules that impede access.
- Easier access to continuity for those with complexity.
- Facilitate mobile outreach and transportation.
- Provide outreach to areas with geographic and/or cultural barriers.
- Each program in the system is welcomed as a “priority partner” for other programs.

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System Redesign Activities
Integration of MH-SA

- All programs and staff are co-occurring capable.
- All funding and policy instructions support best practice integrated services within each funding stream.
- Assessment and recovery planning is integrated, recovery-oriented, person-driven, strength-based, stage-matched.
- MH consultants are part of SA team, and vice versa.
- Toolkits for Integration (e.g., COMPASS-EZ™, CODECAT-EZ™).

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System Redesign Activities
Integration of Health and Behavioral Health

- All programs and staff are PH-BH capable.
- Bidirectional integration: MH/SA consultants are part of PH team, and vice versa.
- Ongoing integrated disease management/collaborative care
- Population management and care coordination
- Multimodal information sharing
- CIHS Organizational Assessment Toolkit for Integration **(OATI)-COMPASS PH/BH.**
- CIHS – Culture of Wellness Organizational Self-Assessment (COW-OSA)

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System Redesign Activities
Continuum of Integrated Crisis Services

- Welcoming safety net for high-risk clients.
- Design crisis response so it is easy to ask for help sooner—*before* needing commitment.
- Integrated continuity of crisis intervention services (not “one and done”) —Critical Time Intervention.
- Flexible continuum of crisis diversion.
- Partnership and collaboration with acute psych services in community/private hospitals.


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System Redesign Activities

Continuum of Integrated Care Management, UM & Care Coordination

- Person-centered vs. slot-centered.
- All services co-occurring MH-SA/PH-BH capable (vs. parallel care).
- Flexibility in service intensity provided within a continuing recovery partnership.
- Ongoing UM supports flexibility and integration – LOCUS, ASAM.
- “Low touch” AND “High touch” care coordination
- Ongoing “disease management” for MH/SA and PH/BH.
- Teams move from *caseloads* to *population management*.

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System Redesign Activities

Managing “High Utilizers”

- Identify high-risk/high-volume/high-cost/poor-outcome cohorts.
- Assume system mis-design for these cohorts.
- Develop wraparound services to *fit* the individuals—not the other way around.
- Service intensity flexibly matches need and cost.

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System Redesign Activities

Continuum of Integrated MH, SA, PH Services

- Children, adolescents, TAY, Adults, Older Adults
- Early intervention in primary care (e.g., SBIRT)
- School-based intervention/LTC intervention
- Early episode psychosis
- Trauma-informed services, with trauma-specific Rx
- Full range of MH service intensity (Wraparound, MST, ACT)
- Full range of SA service intensity (ASAM)
- Intensive PHBHI services for medically complex
- Opioid medication-assisted Rx
- Full range of BH recovery, rehab, and peer services

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System Redesign Activities

BH Workforce Development

- State/local/CHBO BH workforce development strategies – all ages, settings, disciplines
- Prescribers (all types), non-prescribers, peers
- Continuous improvement
- Provider/funder/training program collaborations
- Value-based training and competency
- Pre-hire *and* post-hire development
- System-based, value-based, population-based practice and competency
- Expand capacity through interdisciplinary teamwork

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System Redesign Activities

Peer Support Expansion

- Peer support is a core component of all services, including medication management.
- Peer support is cost-effective in all systems (MH, SA, PH, DD).
- Peer specialists become co-occurring competent, provide wellness coaching, and reflect cultural diversity.

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System Redesign Activities

Evidence-based Medicine and Evidence-based Practice (Flaum, Univ. of Iowa)

“First, do no harm”

- Concerns about EBP funding mandates: If the only thing you are going to pay for is EBPs, you are not going to pay for lots of things that probably work.
- Over 98% of “best practice” is not defined by an EBP.
- So what do we do? We encourage implementation of EBPs in a manner that promotes (or at least doesn’t infringe upon) good common sense clinical practice and innovation.


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System Redesign Activities
Selected EBPs

- **Practices** (Integrated, strength-based, stage-matched, person-centered planning)
 - MI, CBT, TF-CBT, SBIRT, DBT, CTI, contingency management, peer support, wraparound, disease management, skills training, therapeutic justice, collaborative care
 - Technology-based interventions, cognitive enhancement
- **Psychopharm**
 - Clozapine, opioid MAT, anti-craving agents
 - Shared decision-making
- **Programs**
 - ACT, MST, modified TCs, BH health homes

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System Redesign Case Example

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System Redesign Case Example
PHBH Integration – High Utilizers

Oakland County (MI) High Utilizer PHBH Care Management (2014)
Includes financial incentives, welcoming engagement, crisis continuum, PHBH integration, and high utilizers.

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System Redesign Case Example
Starting Places

Community Hospital

- No psych unit.
- Experiencing Medicare penalties for high medical utilizers.
- Complexity is an expectation in high utilizers.
- At risk for penalties from Medicaid HMOs.

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System Redesign Case Example
Starting Places

County MH Crisis Intervention Program

- CBHO contracted with Oakland County CMHA.
- Providing co-occurring-capable mobile crisis, crisis case management, crisis stabilization beds for BH clients.
- Proactively planning for PHBH integration.
- Only county program with experience working with high utilizers in crisis.

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System Redesign Case Example
The Program

- Negotiated shared risk with the hospital.
- Started with a small number of patients (10).
- Crisis program went at risk to show results.
- Reviewed cases identified by hospital.
- Used an innovation team to design “program.”
- Person-centered integrated engagement.
- Modeled on Missouri “3700 project.”
- Engaged high utilizers through mobile outreach.
- Goal: reduce medical ER and inpatient use; improve OP engagement.

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System Redesign Case Example
Lessons Learned

- Keep it simple at the beginning.
- Engaging selected patients is a good start.
- Services need to fit the person/family.
- Small progress can produce big results.
- Progress takes months.

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System Redesign Activities
System Redesign Partnerships

Simple Starting Places

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System Redesign Activities - Partnerships
Starting Places

- Organize a local system collaboration.
- Develop a value-based strategic plan with SMART goals.
- Implement change in small, achievable steps in selected priority areas.
- Keep going.

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System Redesign Activities - Partnerships
Prevention/Early Intervention

- Local system prevention collaborative
- Holistic prevention—MH, SA, DV, obesity, suicide, JJ, smoking, bullying, etc.
- Reduction of trauma – ACES scores
- Improvement of resiliency
- Universal integrated screening/early intervention
- Targeted outreach to high-risk populations
- Zero-suicide initiatives

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System Redesign Activities - Partnerships
Children's System of Care

- CSOC collaborative
- Universal application of wraparound principles
- Best practice child welfare
- Best practice juvenile justice
- School-based screening and intervention
- Home-based, family-based services for high-need kids

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System Redesign Activities - Partnerships
Primary Health/Behavioral Health Integration

- Local/regional population health planning
- Coordination of indigent funds, Medicaid/Medicare
- Formal collaborations with FQHCs, RHCs, CHCs, ERs
- Care coordination for high-need patients
- Universal PH/BH capability development
- Cross-consultation in all sites
- Information sharing/HIE
- Funding policies incentivize integrated team-based care
- Boundary-spanning wellness coaching

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System Redesign Activities - Partnerships
Behavioral Health/Criminal Justice

- County-level BH-CJ collaboration
- Data and information sharing
- Sequential intercept mapping
- Continuous improvement at each intercept
- Universal police/jail screening
- Pre-arrest/post-arrest diversion
- Recovery-oriented integrated jail/BH residential services
- Universal application of therapeutic justice principles
 - Courts and probation
- BH services are “CJ capable”
- Criminologic risk interventions

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Veterans Administration

- VA is a partner in local system collaborative.
- CBHO has formal collaboration with VA service continuum.
- Protocols ensure *no vet falls through the cracks*.
- CBHO services aligned with VA values, principles and standards.
- Accommodations for vets in rural areas.

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System Redesign Activities - Partnerships
Housing - BH

- Local collaboration – BH system and housing continuum of care
- Commitment to end homelessness
- Strategic plan includes BH population needs
- Continuum of services for individuals/families
- Congregate and independent
- Wet/damp/dry
- Supports/services on-site/in-home/off-site
- Housing based on preferences as well as needs

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