1. BACKGROUND

Between 2014 and 2016, the Behavioral Health Home Learning Collaborative (BHH LC) supported the efforts of 11 organizations to bring physical health care into behavioral health sites serving high needs, high cost populations experiencing severe mental illness or substance use disorder.

The BHH LC was funded through the Adult Medicaid Quality Grant Program as part of a broader effort to increase the proportion of Medicaid members enrolled in medical homes.

The program was implemented with technical support and data collection provided by the Oregon Rural Practice-based Research Network (ORPRN).

2. METHODS


Data Collection: Chart abstraction at clinic sites, with technical assistance from ORPRN Practice Enhancement Research Coordinators (PERCS)

Selected Adult Medicaid Quality Measures

- Adult Body Mass Index (BMI) Assessment
- Hypertension (HTN): Controlling High Blood Pressure (BP)
- Comprehensive Diabetes (DM) Control:
  - Hemoglobin A1c Testing (A1c)
  - Diabetes Poor Control
- Measurement Year: July 1, 2015 - June 30, 2016

Sample Training Materials for Blood Pressure Control

Step 1: Denominator: Patients with hypertension

- Office visit with HTN Dx between July 1, 2015 and December 31, 2015
- First HTN Dx before December 31, 2015
- Ages 18-85 as of June 30, 2016

HTN Populations: Who is “Controlled”?

3. RESULTS

4. RESULTS

5. CONCLUSIONS

- Reliability and accuracy of data varied substantially across sites.
- A majority of clients entering care in BHHs did not arrive with complete medical histories; previous dx not always recorded in EMR.
- Patients with incomplete data excluded from measures.
- Underestimated prevalence of chronic conditions in the medical record likely translates to potentially inflated estimates of adequate control; shortening look-back periods may improve accuracy for BHH populations.
- Validation of clinic-based measures against state-level encounter data would improve the quality of data reported on both sides.
- To fully assess the effectiveness of BHH models versus delivery of primary care in typical medical homes, evaluation should include robust indicators of social outcomes as well as medical outcomes. These may include: justice system involvement, employment, housing, and enrollment in state-sponsored supportive services.

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