**Framework for Health Homes & Behavioral Health Homes Learning Collaboratives\* and learning events**: Health Homes and Behavioral Health Homes Core Expectations (as outlined in Chapter 2, Sec 91 & 92 of the MaineCare Benefits Manual) and the Care Transitions Primary Care Roadmap for Change (updated 2015) and Behavioral Health Homes Roadmap for Improving Care Transitions (developed 2015).

**Goals:**

1. Primary care practices participating in the MaineCare Health Homes (HH) initiative and the HH Learning Collaborative will successfully implement the PCMH/HH 10 Core Expectations and HH required screenings, resulting in improvements in clinical quality, integrated care, and patient experience, and decreasing avoidable health care spending for individuals with chronic conditions.

2. BHHO teams receiving QI support through the BHH Learning Collaborative, will be successful in fulling the 10 BHH Core Expectations, resulting in improvements in integrated care, improved physical and behavioral health outcomes, increased communication between health care providers, greater use of preventive services, community supports, and self-management tools for adults with Serious Mental Illness and children with Serious Emotional Disturbance.

3. Focus on QI approaches to reduce avoidable deliverables in both PCMH/HH and BHHO Learning Collaboratives, using all scheduled channels for delivering best practices and promising strategies to deploy the medical home/health home and behavioral health home models.

**Background:** In Maine, approximately 1 in 6 Medicare patients are re-hospitalized within 30 days of discharge (CMS Medicare Readmission Rates). Nationally, “potentially avoidable” Medicare readmissions alone cost $17 billion annually (Jencks et al, NEJM, 2009).The Robert Wood Johnson Foundation termed this the “revolving door syndrome” and has been working to promote a new approach to care. While many hospitals have been working to improve their discharge process with initial promising results, we recognize that primary care teams play a critical role in addressing this problem and improving care. The Care Transitions Roadmap summarizes key roles for primary care teams to promote safe and effective care transitions and reduce readmissions, and emphasizes the need for rapid and complete flow of information from all involved.

Additionally, in 2012, Maine’s 30-day readmission rates for “Mental Health” is 21.5%, compared to the U.S. average of 11.8%. Reasons related to circulatory, respiratory, or digestive problems also hovered around 20% in Maine compared to 11% nationally. Behavioral Health Homes can play a critical role in developing connections with primary care and other medical providers to support the reduction of these events. We can acknowledge that the Behavioral Health Homes has provided a new way to explore health integration and supporting individuals living with co-morbidities and are at great risk for adverse health events and utilization of health care services.

In 2016, QC will continue to offer quality improvement (QI) support to the 190+ primary care practices and nearly 30 community mental health agencies through the Health Homes and Behavioral Health Homes Learning Collaboratives. In this joint effort, we seek to provide practices and community mental health agencies with QI support, access to state and national strategies for healthcare transformation, including tools, resources, and best practice examples, and promote collaborative peer to peer learning. We recognize that these healthcare providers bring a wide range of experience and needs, and that each has “something to teach and something to learn”.

*\*Important Note – This document is a working draft in order to accommodate changes in practice educational needs over time. Listed topics for future webinars in particular are typically not confirmed more than 6 months in advance and are subject to change based on needs of practices.*

**Health Homes & Behavioral Health Homes Learning Collaborative Plan of Activities: Jan-Sept 2016**

|  |  |
| --- | --- |
|  | HH LC Activities  |
|  | BHH LC Activities |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| M | T | W | T | F |
| January 2016 |
|  |  |  |  | 1 |
| 4 | 5 | 6 | 7 | 8 |
| 11 | 12 | 13 | 14 | 15 |
| 18 | 19 | 20 | 21 | 22 |
| 25 | 26 | 27 | 28 | 29 |
| February 2016 |
| 1 | 2 | 3 | 4 | 5 |
| 8 | 9 | 10 | 11 | 12 |
| 15 | 16 | 17 | 18 | 19 |
| 22 | 23 | 24 | 25 | 26 |
| March 2016 |
| 29 | 1 | 2 | 3 | 4 |
| 7 | 8 | 9 | 10 | 11 |
| 14 | 15 | 16 | 17 | 18 |
| 21 | 22 | 23 | 24 | 25 |
| 28 | 29 | 30 | 31 |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| M | T | W | T | F |
| April 2016 |
|  |  |  |  | 1 |
| 4 | 5 | 6 | 7 | 8 |
| 11 | 12 | 13 | 14 | 15 |
| 18 | 19 | 20 | 21 | 22 |
| 25 | 26 | 27 | 28 | 29 |
| May 2016 |
| 2 | 3 | 4 | 5 | 6 |
| 9 | 10 | 11 | 12 | 13 |
| 16 | 17 | 18 | 19 | 20 |
| 23 | 24 | 25 | 26 | 27 |
| 30 | 31 |  |  |  |
| June 2016 |
|  |  | 1 | 2 | 3 |  |
| 6 | 7 | 8 | 9 | 10 |
| 13 | 14 | 15 | 16 | 17 |
| 20 | 21 | 2 | 2 | 23 | 24 |
| 27 | 28 | 29 | 30 |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| M | T | W | T | F |
| July 2016 |
|  |  |  |  | 1 |
| 4 | 5 | 6 | 7 | 8 |
| 11 | 12 | 13 | 14 | 15 |
| 18 | 19 | 20 | 21 | 22 |
| 25 | 26 | 27 | 28 | 29 |
| August 2016 |
| 1 | 2 | 3 | 4 | 5 |
| 8 | 9 | 10 | 11 | 12 |
| 15 | 16 | 17 | 18 | 19 |
| 22 | 23 | 24 | 25 | 26 |
| 29 | 30 | 31 |  |  |
| September 2016 |
|  |  |  | 1 | 2 |
| 5 | 6 | 7 | 8 | 9 |
| 12 | 13 |  | 14 | 15 | 16 |
| 19 | 20 | 21 | 2229 | 23 |
| 26 | 27 | 28 |  |  | 30 |

**Health Homes & Behavioral Health Homes Learning Collaborative Date of Activities At-A-Glance - 2016**

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| --- |
| **Health Homes Learning Collaborative Activities (Please note, topics are in draft form and subject to change)** |
| **Webinars** (*topics subject to change based on practice needs*) | **Learning Sessions** | **Other Activities** |
| **Jan 27 -** Best Practices and Strategies for Meaningful Review of Meds Post-Discharge |  |  |
| **Feb 24 -** Empanelment how to improve care coordination and reduce fragmentation | **Feb 5 -** Basics to Breakthroughs in Primary Care Transformation |  |
| **Mar 23 -**  Ha1c screening in practice better care for Chronic conditions |   | **Mar 10 -** Spring Regional Forums: Primary Care Role in MAT |
| **Apr 27 -**  Knowing the Data - MaineCare Data Emergency Department & Substance Abuse Mental Health Services Use |  | **Apr 29 -** Submission of Quarterly Report |
| **May 25 -**  Palliative care, advanced directives, POLST how to provider the care patients want and reduce ER& readmissions |  |  |
| **June 22 -** Learning Session Follow Up – Tracking Health Outcomes & Using Data (Combined with BHH) | **June 3 - Combined with BHHs**Improving Health Outcomes |  |
| **July 27 -** TBD based on QIS Feedback and LC Evaluations |  | **July 29 -** Submission of Quarterly Report |
| **Aug 24 -** TBD based on QIS Feedback and LC Evaluations |  |  |
| **Sept 13 -** Learning Collaborative Highlights (Combined with BHH) | **Sept 29 - Combined with BHHs**Celebration, Success, and Sustainability | **Sept 30 -** Submission of Quarterly Report |
| **Behavioral Health Homes Learning Collaborative Activities** |
| **Webinars** (*topics subject to change based on practice needs*) | **Learning Sessions** | **Other Activities** |
| **Jan 12 -** Deep Dive into the Utility VMS and HIN Dashboards |  | **Jan 29 -** Submission of Quarterly Report |
| **Feb 9 -** Exploring the Role of Community Mental Health in Integrated Care | **Feb 25 -** ExploringIntegrated Community Mental Health Workflow |  |
| **Mar 8 -** Highlight of MaineCare ED Utilization Project |  |  |
| **Apr 12 -** Team Roles – Medical and Psychiatric Consultants |  | **Apr 29 -** Submission of Quarterly Report |
| **May 10 -**  Evidence Based Psychiatric Medication Prescribing  |  |  |
| **June 22 -** Learning Session Follow Up – Tracking Health Outcomes & Using Data (Combined w/ Health Homes) | **June 3 - Combined w/ Health Homes**Improving Health Outcomes |  |
| **July 12 -** Quality Improvement Projects Successes |  | **July 29 -** Submission of Quarterly Report |
| **Aug 9 -** Critical Role of BHHOs in Improving Health Outcomes (Reducing Readmissions, Diabetes Care, Fragmented Care) |  |  |
| **Sept 13 -** Learning Collaborative Highlights (Combined w/ Health Homes) | **Sept 29 - Combined w/ Health Homes** Celebration, Success, and Sustainability | **Sept 30 -** Submission of Quarterly Report |