CT BHH Process Narrative-EXERCISE
Hypothetical Behavioral Health Home Enrollee Scenario

Patient Overview and Background-"Rick":
Rick is married, 45 years old, 5'8" tall and 250 lbs. He is a veteran, honorably discharged, and diagnosed with post-traumatic stress disorder. At age 40 Rick was diagnosed with Type 2 diabetes and struggles with managing his blood sugar levels. He was admitted to the hospital twice in the last 6 months, after going to the ER with symptoms of extreme thirst and light headedness. He had other ER visits with similar symptoms, but was released. He has not followed through with hospital recommendations to maintain primary care appointments to manage his diabetes. Rick smokes 1 pack of cigarettes a day and feels he is overweight.

Rick receives outpatient services at your agency and is eligible for BHH services. You were notified by your local hospital that Rick was admitted last week due to complications with his diabetes, which is probably why he missed his last two appointments with your clinician.

BHH services Rick is eligible for:

Key for behavioral health home services	
Comprehensive care management = (CM)	Comprehensive transitional care = (TC)
Care coordination = (CC)	Patient and family support services = (PS)
Health promotion = (HP)	Referral to community and social support services = (RS)

Since Rick is eligible for BHH services, the outpatient clinician or another BHH Team Member contacts the hospital, or Rick, to help coordinate a transition plan and to schedule a follow-up appt with your agency. Until Rick's discharge from the hospital, the BHH Team Member calls Rick's hospital unit nurse regularly to track his progress and to collaborate regarding his discharge plans **(1)**. Prior to his discharge, the hospital faxes Rick's aftercare plan to the BHH **(2)**.

Rick is discharged from the hospital and the next day a BHH Team Member calls Rick to remind him that he has an appt with the BHH Team in two days and to check to see if Rick filled his prescriptions **(3)**. Rick has a lot of questions about one of the prescriptions and states he didn't fill it because he didn't know why he needs it. The BHH Nurse Case Manager speaks with Rick and explains what the medication is for, why he needs it, and possible side effects **(4)**. Now that Rick is home, he has no way to get to the pharmacy so a BHH Team Member goes to Rick's home and together, Rick and the BHH Team Member go to the pharmacy to fill his discharge medication orders **(5)**. On the way there, the BHH Team Member reviews with Rick the importance of ensuring he has access to transportation so he can get the supports he needs and provides Rick with a list of transportation options in his area **(6)**.

Two days later, Rick comes to your agency for his scheduled appointment. This appointment is longer than his typical outpatient appointment since he is also meeting with the BHH Team. At this appointment,
Rick meets with his outpatient clinician for his regular outpatient appt. His clinician should ensure Rick has had a screening for depression in the last year. If not, a Mental Health Screen should be completed **(7)**. A positive screen requires a more comprehensive depression screening. At the end of the appt, Rick and the clinician are joined by some of the other BHH Team Members so he can meet them, especially the nurse care manager who will be predominantly the one managing his overall plan of care.

It's important that Rick meets with the nurse care manager as soon as possible for a nursing assessment so that Rick's plan of care can be updated to include his medical needs. The BHH nurse care manager will refer back to the hospital discharge paperwork and ensure Rick was screened for BMI (height/weight), blood pressure, cholesterol, triglycerides, and glucose intolerance **(8)**. If the information isn't in the medical records, BMI and blood pressure can be obtained by the nursing staff and the other info is requested from Rick's primary care

doctor. Once received, the information is entered into Rick's health record. After the full health assessment, the BHH Team recognizes the following concerns:

- Rick does not have an ongoing relationship with a primary care physician or endocrinologist for his diabetes;
- He doesn't have a diagnosis of hypertension, but his current blood pressure is above the normal range;
- Despite being diagnosed with diabetes 5 years ago, Rick is still not really certain about what it means for him, his ideal levels, how not managing his levels may contribute to his not feeling well, and that there are supports for him in his community; and
- Rick smokes, and would like to quit, but has not tried cessation interventions in the past.

The BHH Team reviews the health assessment, along with Rick's existing assessment, Rick's current plan of care, and any other supporting information. Together, with Rick, they agree on some updated goals, next steps, and responsibilities of Rick and the Team **(9)**:

RICK'S UPDATED PLAN OF CARE:

Rick's Goal #1:	I will get an immediate appointment and maintain regular appointments with the same primary care physician to manage my diabetes and monitor my blood pressure. Of all of the doctors I've seen in the last year, I liked Dr. Smith and would like her to be my primary care doctor.
Rick's Outcome:	I will stay in touch with my BHH worker & doctor and will take my medications as prescribed. I want to do a better job of taking care of myself.
BHH Next Steps:	A BHH Team Member will call Rick to improve self-management skills for getting and keeping doctor's appointments, will meet with Rick 1 x week to monitor his medication plan **(10)**, and will provide Rick with educational materials on diabetes and diabetes medication **(11)**.
Rick's Goal #2:	I agree that it is important to stop smoking & will attend the BHH smoking cessation support group 1 day a week **(12)**. I will also work with my BHH Team Member to obtain a referral to the smoking cessation education and intervention program at the hospital that occurs twice a week **(13)**.
Rick's Outcome:	I understand that smoking is not good for me & I need to try to quit. I also understand that this will be hard & need support from others in my family.
BHH Next Steps:	Rick's BHH Team Member will schedule a time to go over the community smoking cessation program, the support group, and family support services available **(14)**.

Per the plan of care, the BHH Team Member calls Dr. Smith to confirm Rick has an appt for the following week and identifies any info Rick needs to bring **(15)**. A BHH Team Member then calls Rick to review the appointment info and also calls again the day before the appointment to remind him **(16)**.

Before Rick's appt, a BHH Team Member provides Dr. Smith a copy of the Rick's BHH health assessment and his initial plan of care **(17)**. Dr. Smith examines Rick, prescribes a different dosage of Metformin for his Diabetes. Dr. Smith amends Rick's plan of care as follows **(18)**:

DR. SMITH'S ADDITIONS TO RICK'S PLAN OF CARE:

- Reflects different dosage of Metformin for diabetes
- Psychiatrist(s) may want to consider switching Rick's current medication to one less likely to cause weight gain

At his next visit to the BHH, Rick is given some facts sheets on his condition **(19)** and is shown how to log on to the websites where he can view patient tutorials on managing his diabetes **(20)**. The website also allows him to print off tools to use to help remember things he wants to review with his doctor and to manage his appointments. The nurse care manager is also available to discuss any questions Rick has about his medical care or the recommended questions to go over with his doctor **(21)**.

	Service(s)	Possible Ways to Code
1)		
2)		
3)		
4)		
5)		
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Parts of this were taken and adapted from http://www.chcs.org/media/MO_Narrative.pdf

CT BHH Process Narrative-ANSWERS
Hypothetical Behavioral Health Home Enrollee Scenario

Answers

	Service(s)	Possible Ways to Code
1)	TC	Case Mgmt with Collateral
2)	TC	Case Mgmt with Collateral
3)	PS	TCM with Client By Telephone or Case Mgmt with Client By Telephone
4)	HP	Psycho-Education Individual Face to Face or Psycho-Education Individual By Telephone
5)	PS	TCM with Client Face to Face or Case Mgmt with Client Face to Face
6)	CC or RS	TCM with Client Face to Face or Case Mgmt with Client Face to Face
7)	CM	Positive Screen for Depression or Negative Screen for Depression
8)	CM	TCM with Client Face to Face
9)	CM	TCM with Client Face to Face
10)	PS	TCM with Client By Telephone or Case Mgmt with Client By Telephone
11)	HP	Psycho-Education Individual Face to Face or Psycho-Education Individual By Telephone or Psycho-Education Group
12)	HP	Psycho-Education Group
13)	RS	TCM with Collateral or TCM with Client Face to Face or Case Mgmt with Client Face to Face
14)	PS	TCM with Client Face to Face or Case Mgmt with Client Face to Face
15)	RS	TCM with Collateral
16)	PS	TCM with Client By Telephone or Case Mgmt with Client By Telephone
17)	CC	TCM with Collateral or TCM with Collateral
18)	CM	TCM with Client Face to Face
19)	HP	Psycho-Education Individual Face to Face
20)	HP or PS	Psycho-Education Individual Face to Face or TCM with Client Face to Face or Case Mgmt with Client Face to Face
21)	CC or HP	TCM with Client Face to Face or Case Mgmt with Client Face to Face or Psycho-Education Individual Face to Face