IV. BHH Overview

Nationally, individuals with serious mental illness are dying 20-25 years earlier than the general population due to side effects of medications, co-morbid medical conditions, substance use and lack of access to primary and preventative care. Research has shown that many psychotropic medications have some negative impacts contributing to obesity, diabetes, metabolic syndrome and cardio-vascular disease. Additionally, individuals with serious behavioral health needs served by DMHAS are frequently negatively impacted by social determinants, living at or below the poverty level, struggling with food insecurity and are reliant on Medicaid to fund medical services. Compounding these factors is the stark reality that these same individuals are often treated differently due to discrimination and stigma.

The Connecticut Department of Mental Health and Addiction Services (DMHAS) believes that individuals with serious behavioral health needs should receive treatment in the least restrictive community setting, reserving the use of inpatient treatment to only those instances when medically necessary. Departmental interventions aim to help those individuals who frequent hospital emergency departments (EDs) and divert them to community services when appropriate.

Bridging the gap between behavioral health and primary care is not only essential to improving quality of life; it may actually prove to be lifesaving. Under the Affordable Care Act, states were given the option to implement health homes for Medicaid enrollees with chronic conditions. CT submitted a state plan amendment to be able implement behavioral health homes for individuals with serious and persistent mental illness.

DMHAS' mission is to "improve the quality of life of the people of Connecticut by providing an integrated network of comprehensive, effective and efficient mental health and addiction services that foster self-sufficiency, dignity and respect." This is accomplished by a behavioral health system which provides needed treatment and recovery support services to individuals with serious behavioral health needs in the community. By implementing Behavioral Health Homes, DMHAS, along with the other state agency partners, will transform and expand our current statewide behavioral health system to coordinate and integrate behavioral health and primary and preventative care for individuals with serious behavioral health needs.

Goals:

The overarching goals of the BHH initiative are:

- Improved experience in care
- Improved health outcomes
- Reduction in health care costs

These will be achieved through meeting the following Connecticut specific goals:

1. Improve Quality By Reducing Unnecessary Hospital Admissions And Readmissions
2. Reduce Substance Use
3. Improve Transitions of Care
4. Improve the Percent of Individual with Mental Illness Who Receive Preventive Care
5. Improve Chronic Care Delivery for Individuals with SPMI
6. Increase Person-Centeredness and Satisfaction with Care Delivery
7. Increase Connection to Recovery Support Services

V. BHH Overview

BHH Services:

To achieve these goals, BHH designated provider agencies will enhance existing services to ensure persons served have access to both behavioral and physical health services. There are six (6) core behavioral health home services. Agencies may already be providing many of these services, but now the services are more comprehensive to include the physical health needs of the persons served, in addition to their behavioral health needs, to improve their overall health and well being. Services will be captured using a combination of targeted case management, case management, and psycho-education codes.

Services provided through the BHH Initiative are:

Comprehensive Care Management - starts with the initial engagement with individuals, providing them with information, education, and support necessary to make fully informed decisions about their care options, so they may actively participate in their care planning. Comprehensive care management services also involve ongoing assessment and monitoring of the recovery plan goals and objectives. Specific activities include:

- Assessment of service needs
- Development of a treatment and recovery plan with the individual
- Assignment of health home team roles
- Monitoring of progress

Care Coordination - is the implementation and monitoring of the individual's individualized, person-centered care, with active involvement through linkages, referrals, coordination, and follow-up to needed services and supports. Specific activities include:

- Linking to services
- Coordinating care
- Assisting with making sure referrals to appropriate services are in place
- Assisting individuals with improving social networks to support and promote healthy living.
- Education regarding the importance of preventative medicine and screenings

Health Promotion - services encourage and support healthy living concepts to motivate individuals to adopt healthy behaviors and promote self-management of health and wellness. Specific activities include:

- Informing and educating to promote health
- Intervening to promote healthy lifestyles

To access online information about Monthly Health Observances, go to:
http://www.ctintegratedcare.com/health.html.

Patient and Family Support - services help individuals achieve their goals, increase their advocacy skills, and improve their overall health outcomes. Specific activities include:

- Support to overcome barriers
- Coaching and other supports to increase self-management skills
- Support to help individuals access technology and other networks of support
- Involving family members and natural supports, as appropriate, to assist the individual in achieving recovery plan goals

V. BHH Overview

BHH Services (continued):

Comprehensive Transitional Care - specialized care coordination services that are proactive rather than reactive, and ensure seamless transitions of care for individuals. Specific services include:

- Coordination of care between inpatient settings and community care
- Monitoring access to follow-up care after discharge
- Maintaining collaborative linkages with hospitals and inpatient facilities.

Referral to Community Support Services - ensure individuals have access to a myriad of formal and informal resources which address social, environmental, and community factors, all of which impact overall health. Specific services include:

- Submitting referrals and information needed to ensure individuals have access to formal and informal resources outside of the BHH
- Confirming individual linked with referred service by calling to see if the appointment was kept.

BHH Staff:

Designated BHH provider agencies have committed to providing the staff required to provide BHH services to their target number of enrollees. It is expected each BHH agency will provide BHH services using both new BHH staff members and existing in-kind staff members. Since BHH enrollees will be served by existing team members in many situations, the titles of the BHH team members will vary by agency, and the teams may include more than the minimum required team members listed below. The number and type of staff needed will vary by agency and be specified in each agency's approved personnel schedule.

Each BHH will be a little different, but the core BHH Team will be made up of the following team members:

BHH Director – Provides administrative and clinical leadership to the health home team and oversees the implementation and coordination of health home services. The BHH Director leads service delivery transformation based on health home goals and principles and has a strong background in healthcare operations and quality improvement. Other duties include: networking and relationship development with other providers; facilitating clinical processes and team meetings; monitoring BHH performance and instituting quality improvement plans; developing health promotion, wellness, and other BHH initiatives; and reporting outcomes. It is expected the person in this position will have four (4) years of professional experience in Behavioral Health Care and a Master Degree in a clinical discipline, Public Health Administration, Health Care Administration or Hospital Administration. The staff to client ratio for this position is expected to be approximately 1:1,000.

Primary Care Physician Consultant (PC)– Consults with the care team and psychiatrist or APRN regarding specific enrollee health issues. The Physician Consultant also assists in care plan development and coordination of services with other medical professionals. Under BHH, the PC should not provide any physical health services they would bill directly to Medicaid. Their services should be logged on the PC Tracker spreadsheet and may include case reviews, consultation, education to staff, etc. It is expected the person in this position will have a medical degree or be an advanced practice registered nurse (APRN). There is no specific specialty required. It is expected this position will provide 1 hour of service a year, per enrollee. See Practice Guideline #4 for Documentation Guidelines for PC Consultants.

Nurse Care Manager – Initiates the initial care plan development for all enrollees and assists in goal development for individuals with co-occurring chronic conditions. The Nurse Care Manager will be responsible for the overall coordination of the enrollees care plan and will work directly with BHH Specialists and Peer Recovery Specialists in the provision of BHH services. Other duties include: consultation with other medical professionals especially

V. BHH Overview

BHH Staff (continued):

during enrollee admission or discharge from other services; development of training protocols on chronic conditions and other health promotion, wellness, and prevention initiatives; facilitation of health education groups; track and perform required assessments and screenings; and monitor and report required outcomes and goals. It is expected the person in this position will be a registered nurse, with no specific specialty required. The staff to client ratio for this position is expected to be approximately 1:200.

BHH Specialists and Peer Recovery Specialists – Work under the direction of the Nurse Care Manager to provide care coordination, referral, linkage, family support, and health promotion/wellness services. The staff to client ratio for the BHH Specialist position is expected to be approximately 1:100 and 1:50 for the Peer Recovery Specialist position.

BHH Administrative System Specialist – Provides support to the BHH Director and the care team in areas such as scheduling; referral and admission tracking; training and technical assistance; communication with other service providers; and enrollee reminders. The BHH Administrative System Specialist shall have a background in data management and reporting and also have excellent computer skills to navigate electronic health records.

The staff to client ratio for this position is expected to be approximately 1:800.

BHH Care Transition Coordinator—Coordinates activities related to transitions of care for the health home team. The transitions care manager must maintain good working relationships with hospitals, other inpatient units, and emergency departments to ensure the team's ability to: engage individuals upon admission to assist in discharge planning; provide needed resources and tools to ensure smooth transitions in care; and upon discharge, ensure scheduling of follow-up appointments, medication reconciliation, coordination of transportation, and other needed supports. The staff to client ratio for this position is expected to be approximately 1:300.

BHH Health Observances:

In an effort to create statewide unity within the BHH initiative, BHH designated provider agencies will collectively acknowledge selected wellness and/or health observances. These monthly observances are designed to align with the goals and services of the BHH initiative. For that reason, all observances will fall into one of the following categories:

- Medical Health Conditions
- Behavioral Health Conditions
- The Eight Dimensions of Wellness
- The Importance of Preventative Care
- Substance Abuse and Recovery

The ASO will design a year long BHH Observance calendar that includes links to community resources, online resources, and toolkits that will enable BHH designated provider agencies to educate both their staff and clients. In addition, when available, BHH designated provider agencies will receive an observance packet at the last BHH Implementation session of the month with additional promotional and educational materials for the following observance.

The monthly observance calendars can be found at http://www.ctintegratedcare.com/health.html.

To make recommendations for health observances, call Denise Perez at 860-704-6152.