Connecticut's Behavioral Health Homes

ENHANCING SERVICES TO ACHIEVE
A WHOLE PERSON APPROACH

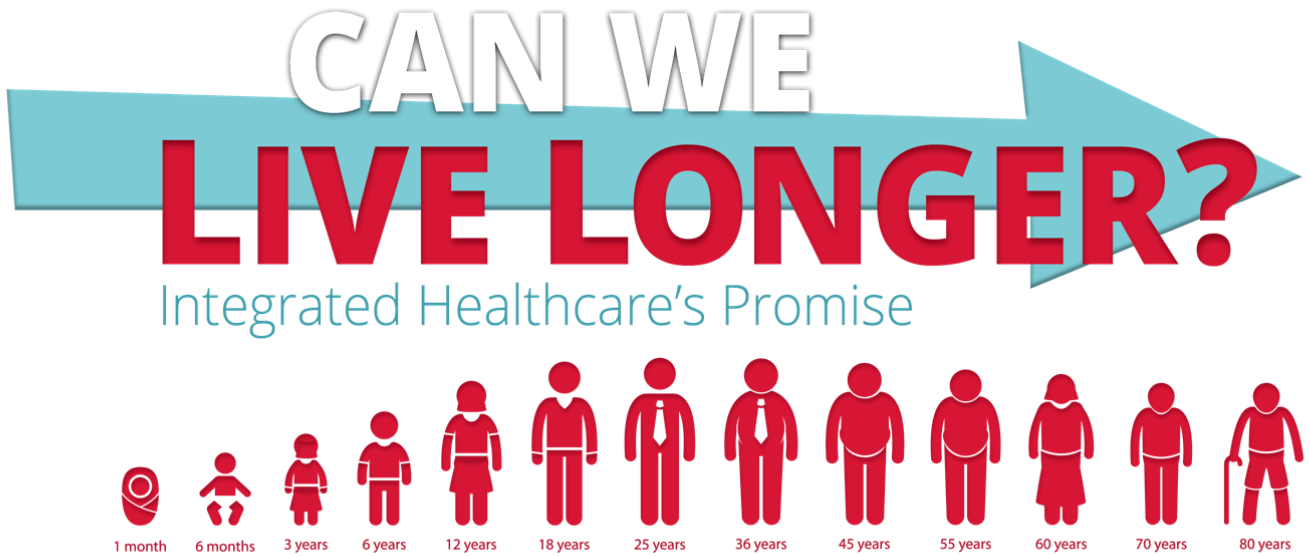
Training Goals

In this training you will learn:

- Why the integration of medical health and behavioral health is important
- What the behavioral health homes (BHH) services are
- How to apply the BHH services to the work you do everyday
- How to document and code the BHH services

You should participate in BHH 101 Training, before attending this training, to learn more about the BHH goals, eligibility criteria, and outcomes

Why is Integration Important?



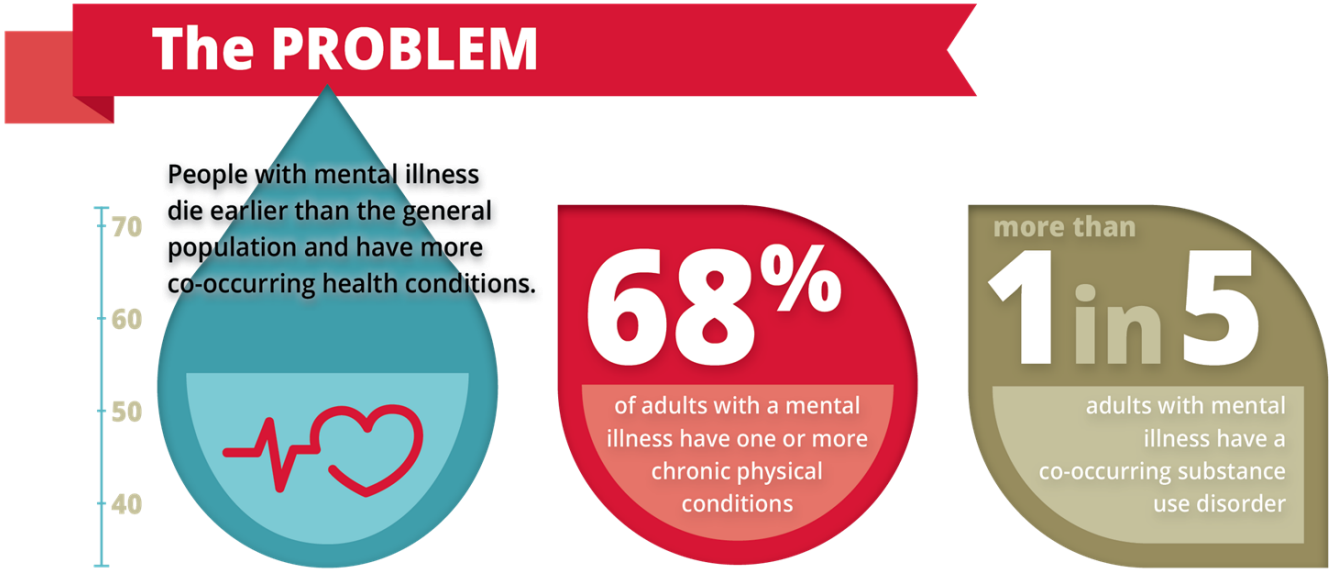
SAMHSA-HRSA
Center for Integrated Health Solutions

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID
Healthy Minds. Strong Communities.

SAMHSA

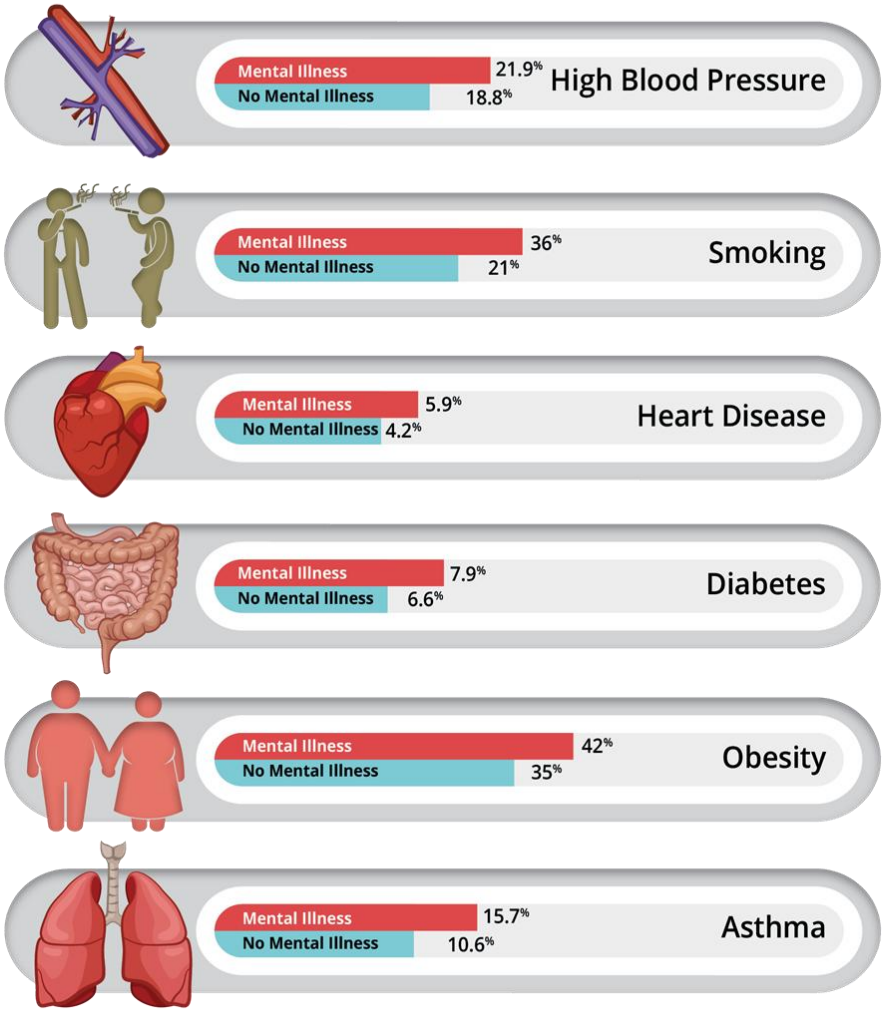
www.integration.samhsa.gov

Why is Integration Important?



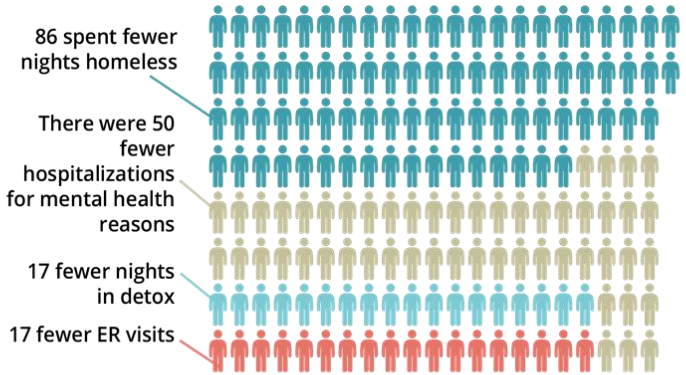
Why is Integration Important?

Co-occurrence between mental illness and other chronic health conditions:



Why is Integration Important?

One integration program* enrolled 170 people with mental illness. After one year in the program, in one month:



This is $213,000 of savings per month.

That's $2,500,000 in savings over the year.

Integration works.
It improves lives.
It saves lives.
And it reduces healthcare costs.

Why is Integration Important?

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Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov 1-877-SAMHSA-7 (1-877-726-4727)

www.integration.samhsa.gov

Sources

www.dsamh.utah.gov/docs/mortality-morbidity_nasmhpd.pdf
www.samhsa.gov/data/2k11/WEB_SR_078/SR110StateSMIAMI2012.htm
www.samhsa.gov/co-occurring/topics/data/disorders.aspx
www.samhsa.gov/data/nsduh/2k8nsduh/2k8results.pdf
www.cdc.gov/features/vitalsigns/SmokingAndMentalIllness
www.ncbi.nlm.nih.gov/pubmed/16912007

Weisner C. Cost Studies at Northern California Kaiser Permanente. Presentation to County Alcohol & Drug Program Administrators Association of California Sacramento, California. Jan. 28, 2010.

Rich-Edwards JW, Manson JE, Hennekens CH, Buring JE. The primary prevention of coronary heart disease in women. N Engl J Med. 1995;332:1758-1766.

Bassuk SS, Manson JE. Epidemiological evidence for the role of physical activity in reducing risk of type 2 diabetes and cardiovascular disease. J Appl Physiol. 2005;99:1193-1204.

Hennekens CH, Increasing burden of cardiovascular disease: current knowledge and future directions for research on risk factors. Circulation. 1998;97:1095-1102.

Heritage Behavioral Health Center, based on data in...
www.ahrq.gov/research/findings/evidence-based-reports/mhsapc-evidence-report.pdf

* A grantee of the Substance Abuse and Mental Health Services Administration's Primary and Behavioral Health Care Integration program.

What's Different about BHH?

- Whole person approach
  - Assessment and goals related to physical health conditions
  - Minimum 1 hr/month - services also address medical needs
- Depth vs. Breadth-Scope is wider, not deeper
- No separate BHH program or service codes
  - Use of existing TCM and case management codes
  - Some new options for screenings and psycho-education
  - No separate billing for BHH services
- Phone contacts count

Organization of Training

1. Meet Bob who is a person served through the behavioral health home.
2. Review the BHH services and how we provide them, through each step in Bob's care, to help Bob with both his medical and behavioral health needs.
3. Discuss the specific tasks associated with each BHH service and how we document and code them.
4. See how the BHH can result in better outcomes for Bob.

 **important BHH outcomes**

 **sample notes**

Who is Bob?

Most likely, Bob is someone you've already been working with who just found out he's eligible for more comprehensive services from the BHH Team.
You can now provide Bob the same quality care, using some new tools, and with an emphasis on overall health

BHH Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Patient and Family Support
- Referral to Community Support Services

Comprehensive Care Management…

…starts with the initial engagement with Bob, providing him with information, education, and support necessary to make fully informed decisions about his care options, so he may actively participate in his care planning.

We manage Bob's care by:

- Assessing his needs
- Developing a Plan of Care with him
- Assigning BHH team members to work with him
- Monitoring his progress

Comprehensive Care Management Services

What is it?

- Assessing
- Assisting
- Linking
- Monitoring
- Planning

What are some example tasks?

- Engage with Bob about the BHH initiative, inform him of his care options, assess interest , and plan services for Bob's overall health
- Review Bob's current assessments (clinical, functional and if applicable, nursing) to ensure they address both behavioral and medical health care needs and to identify any chronic medical conditions
- Ask Bob who his medical provider is, when his last physical and dental exams were, and what his medications are

Comprehensive Care Management Services

What is it?

- Assessing
- Assisting
- Linking
- Monitoring
- Planning

What are some example tasks?

- Identify information, education, and services Bob will need
- Ensure completion of a depression screening annually. Initial Mental Health Screen followed by a more comprehensive, standardized screening for positive screens
- Ensure health assessment also documents the following:
  - Body Mass Index (BMI)
  - Tobacco use and whether or not received cessation interventions

Comprehensive Care Management Services

What is it?	What are some example tasks?
• Assessing • Assisting • Linking • Monitoring • Planning	• Determine who will work with Bob for each need • Check in with Bob's health team members to monitor progress • Update assessment, making adjustments and adding goals to Plan of Care, as needed

Comprehensive Care Management Notes and Coding

- Face to Face
- By Telephone
- With Collateral Contact
- Positive and Negative Screens for Depression
  - New G Codes

☑ *BHH Comprehensive Care Management-"3/17/15, 11:00 am. Spent 15 minutes meeting with client by phone to monitor progress with goal to quit smoking. Client struggling with getting to cessation meetings. This writer will link client to BHH Peer Support Specialist for Patient Support Services to prevent missed meetings and help client achieve goal. Betty Better, LPN"*

TCM or Case Management by Telephone TCM02, 2023PH, T116C, T1016/PH or as defined in electronic health record

Note Requirements

- Document the service & show its relationship to the treatment plan
- Date, time, duration & location of service delivered
- Specify the BHH service/Include description of service delivered
- Include specific plan for the next time you see the client
- Positive screen for clinical depression using a standardized tool and follow-up plan is *documented on the date of the screen*

Care Coordination…

…is the implementation and monitoring of Bob's individualized, person-centered care with active involvement through linkages, referrals, coordination, and follow-up to needed services and supports.

We coordinate Bob's care by:

- Implementing the Plan of Care with Bob, to include linking Bob to services and supports
- Assisting Bob with appropriate referrals, coordination of care, and follow-up to needed services and supports
- Ensuring Bob is linked and can access medical, behavioral health, pharmacological, and recovery supports

Care Coordination Services

What is it?

- Coordinating
- Linking
- Assisting
- Planning
- Prompting

What are some example tasks?

- Communicate with Bob and his outside providers/supports (homecare agencies, physicians, dentists, etc.) to ensure services/supports are coordinated
- Communicate with other BHH team members to ensure coordination of care and that Bob has appropriate linkages
- Identify Bob's follow-up care recommendations and help Bob follow through with them

Care Coordination Services

What is it?

- Coordinating
- Linking
- Assisting
- Planning
- Prompting

What are some example tasks?

- Assist Bob with appointment scheduling and accessing services and supports, including linking Bob to transportation
- Outreach to engage, support, and promote continuity of care for Bob
- Teach/Coach Bob to maximize his independence in the community
- Link Bob to medication monitoring, if it is an identified need

Care Coordination Services

What is it?

- Coordinating
- Linking
- Assisting
- Planning
- Prompting

What are some example tasks?

- Ensure Bob has access to other recovery supports for: housing, insurance and other benefits, vocational training or support, and social needs

Care Coordination Notes and Coding

- Face to Face
- By Telephone
- With Collateral Contact

☑ *BHH Care Coordination-"1/1/15, 2:00 pm, Goal 4, Spent 15 minutes providing care coordination over the phone with the home care agency working with client to ensure they had a copy of the client's Plan of Care in order to best coordinate services. Home care agency staff will continue to report care recommendations, based on visits, and this writer will assist client with following through on recommendations. Sally Caremanager, BA"*

TCM or Case Management with Collateral TCM03, 2023T/CL, T116B, T1016/CL, or as defined in electronic health record

Health Promotion…

…services encourage and support healthy living concepts to motivate Bob to adopt healthy behaviors and promote self-management of his health and wellness.

We promote Bob's health by:

- Promoting health education specific to Bob's chronic condition(s)
- Assisting him with self managing his medical condition(s)
- Educating him about the importance of preventive medicine
- Assisting him with support for improving his social networks
- Intervening to promote wellness and a healthy lifestyle

Health Promotion Services

What is it?

- Coordinating
- Linking
- Assisting
- Advising
- Informing
- Promoting

What are some example tasks?

- Link Bob to health education materials and wellness interventions specific to his chronic condition (e.g. provide educational facts sheets on diabetes, link Bob to videos on how to check blood sugar levels)
- Assist Bob with understanding the benefit of exercise
- Educate Bob and a group of others on the importance of immunizations and health screenings (include early and periodic screening, diagnosis, and treatment program (EPSDT) for children)

Health Promotion Services

What is it?

- Coordinating
- Linking
- Assisting
- Advising
- Informing
- Promoting

What are some example tasks?

- Coordinate health education with Bob re: his condition, for Bob's family members and other natural supports
- Support Bob with improving his linkages to social networks
- Coordinate interventions that promote Bob's health and wellness
  - Give and review with Bob the agency's monthly "Health Tips" newsletter
- Assist Bob with developing skills related to self administration of medications:
  - Make sure Bob understands the medications, when to take them, side effects, etc.

Health Promotion Notes and Coding

- Psycho-Education Face to Face
- Psycho-Education By Telephone
- Psycho-Education In Group

☑ *BHH Health Promotion-"2/1/15 10:00 am, Goal 3, Spent 30 minutes providing face to face health promotion services with client in his home to review newly diagnosed condition, answer questions, and ensure client understands and knows what the purpose of the prescribed medication is. Coordinated a follow-up phone call with client for next week to answer any questions related to health condition, Florence Nightingale, RN, Nurse Care Manager."*

Psycho-Education Face to Face-H2027 or as defined in electronic health record

Comprehensive Transitional Care…

…activities are specialized care coordination services that are proactive rather than reactive, and ensure seamless transitions of care for Bob.

We coordinate Bob's transitions in care by:

- Focusing on Bob's movement between or within different levels of care
- Coordinating Bob's services to:
  - Streamline Bob's plans of care
  - Reduce hospital admissions
  - Interrupt patterns of frequent use of the emergency department for urgent or routine care
  - Prevent gaps in services which could result in readmission to a higher level of care
- Maintaining collaborative linkages with hospitals and inpatient facilities

Comprehensive Transitional Care

What is it?

- Coordinating
- Linking
- Assisting
- Monitoring
- Planning

What are some example tasks?

- Coordinate meetings with area hospitals and inpatient facilities to ensure ongoing communication regarding admissions and discharges and to implement processes for sharing information
- Coordinate and collaborate with Bob and the appropriate facility, to assist in the development and implementation of a discharge or transition plan
- Document receipt of Bob's discharge plans

Comprehensive Transitional Care

What is it?

- Coordinating
- Linking
- Assisting
- Monitoring
- Planning

What are some example tasks?

- Plan and implement a systemic follow-up protocol to monitor Bob's access to follow-up care, medication education, and other needed supports
  - Monitor follow through with follow-up visits
- Reassess for new needs and new goals, based on discharge transition plan

Comprehensive Transitional Care Notes and Coding

- Face to Face
- By Telephone
- With Collateral Contact
- No TCM codes

☑ *BHH Comprehensive Transitional Care-"2/15/15, 11:00 am. Goal 4, Spent 30 minutes of comprehensive transitional care with client and discharge staff at hospital to collaborate on discharge plan for client. Client interested in IOP tx after discharge. Behavioral Health Specialist will coordinate with insurance to ensure IOP authorized and plan to link client to IOP. Brett Bridge, MSW, Care Transition Coordinator."*

Case Management with Client Face to Face-T1016 or as defined in electronic health record

Patient and Family Support…

…services help Bob achieve his goals, increase his advocacy skills, and improve his overall health outcomes.

We support Bob and his family by:

- Ensuring his Plan of Care reflects preferences, goals, resources, barriers, and optimal outcomes of Bob and his identified supports
- Reducing barriers to achieving goals
- Increasing their knowledge literacy about his chronic condition(s)
- Providing supports to increase self-management skills
- Identifying resources to support him in attaining his highest level of wellness

Patient and Family Support

What is it?

- Coordinating
- Linking
- Assisting
- Monitoring
- Teaching
- Coaching
- Prompting

What are some example tasks?

- Assist Bob with accessing self-help, peer support services, technology such as smart phones, support group, wellness centers, and other self care programs
- Teach/Coach Bob on how to access support services on his own
- Assist Bob and his family with identifying and developing social support networks

Patient and Family Support

What is it?

- Coordinating
- Linking
- Assisting
- Monitoring
- Teaching
- Coaching
- Prompting

What are some example tasks?

- Help Bob and his family identify new resources to reduce barriers to support, including resources for transportation, housing, and benefits
- Call Bob to monitor follow through with plans:
  - check if Bob developed healthy menu plan
  - call to remind Bob he has an appt with Nutritionist and ensure he has transportation to attend appt

Patient and Family Support Notes and Coding

- Face to Face
- By Telephone
- With Collateral Contact

☑ *BHH Patient and Family Support -"2/28/15, 1:00 pm. Goal 3, Spent 15 minutes providing face to face patient support by assisting the client at home with filling a daily medication box to facilitate self administration of medications at home. RN will call client next week to monitor the outcome and coordinate another appt to work on teaching Bob to manage his meds. Clara Barton, RN, Nurse Care Manager "*

TCM or Case Management Face to Face-TCM01, 2023T, T1016, or as defined by electronic health record

Referral to Community Support Services…

…ensure Bob has access to a myriad of formal and informal resources which address social, environmental, and community factors, all of which impact his overall health.

We refer Bob to community support services:

- Ensuring Bob has access to formal and informal resources outside of the agency serving as the BHH
- Confirming that Bob has linked with referred services by calling Bob to see if he made it to the appointment
- Assisting him to:
  - Overcome access or service barriers
  - Increase his self-management skills
  - Improve his overall health

Referral to Community Support Services

What is it?

- Coordinating
- Linking
- Assisting
- Monitoring

What are some example tasks?

- Develop and nurture relationships with other community based providers to aid in effective referrals and timely access to services for Bob
- Make direct referrals related to needs identified in Bob's assessment and services Bob identified wanting in his plan of care
- Follow-up with referral sources regarding referrals
- Referral for follow-up clinical services if depression screen was positive

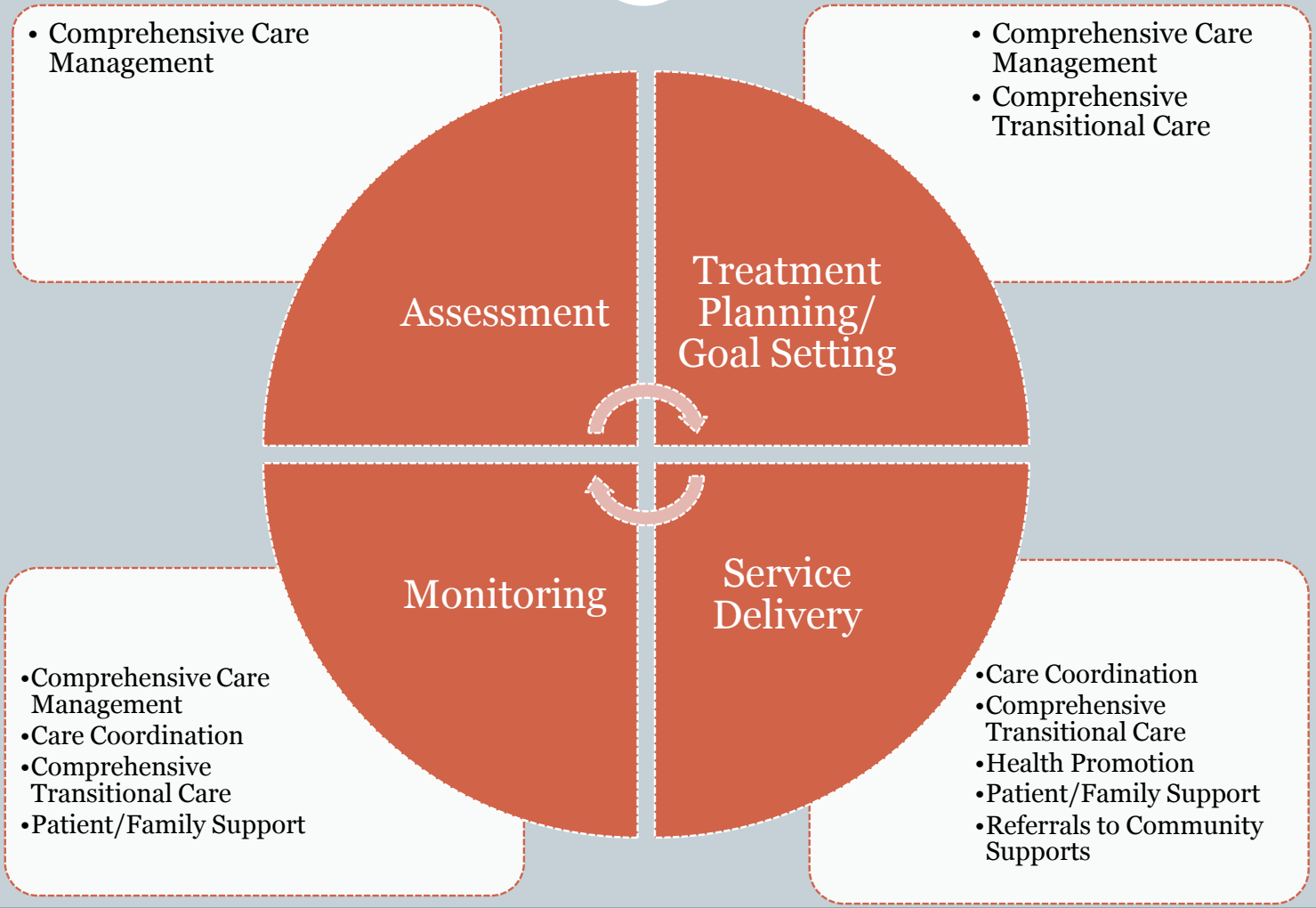
Referral to Community Support Services Notes and Coding

- Face to Face
- By Telephone
- With Collateral Contact

☑ *BHH Referral to Community Support Services -"3/1/15, 2;00 pm. Goal 3, Spent 15 minutes on the phone with collateral providing referral to community services. Called Dr. Smith's office to arrange a first appt. for client to have his teeth cleaned. Will coordinate with Peer Support Specialist to ensure client gets a reminder call one day before appt and that transportation is arranged. Mary Linker, LPC, Care Coordinator."*

TCM with Collateral-TCM03 or 2023/CL, or as defined by electronic health record

BHH Services and What You're Doing Now



THANK YOU

QUESTIONS?

TAKE HOME EXERCISES

EVALUATION