BHH Designated Provider Agency
Learning Collaborative & Implementation Session
December 15, 2017 ● 10:30am – 3:00pm
Capitol Region Mental Health Center, Hartford

Attendees: DMHAS(Alyse Chin, Lauren Staiger, Kate Parr); BHcare (Crystal Cochrane); Bridges (Trish Kramer, Valerie Mallard); CMHA (Heather Paluso, Lisa Daley, Anna Vitale, Deb Dutkiewicz); CMHC (Madeline Lewis, Gila Dagan, Lisa Lanouette, Nancy Watsky, Tamar Saunders, Martha Staeheli); CRMHC (Meagan McGuire, Judy Moran-Lounsbury, Etheline Bissette, Muriam Stuart, Sylvia Malasklan, Kristen Russell); InterCommunity (Colleen Mastroianni); Rushford (Valerie Walton, Jennifer Williams); RVS (Anne Kiwanuka, Tracey Creighton); SMHA (John Connor, Jesus Silva, Monique Allgood); Sound (Enrique Juncadella); SWCMHS (Victoria Hoey, Misty Gilmore, Anthony Cretella); United Services (Holly Fish, Lori Behling); WCMHN (Arlene Young); ASO (Bonni Hopkins, Jeannie Wigglesworth, Qiyao Zhang, Amy Miller, Denise Roberts, Tanir Watkins); CHR (Donna Wertz for part of IS)

1. **Introductions**
2. **Overview of Agenda and Expectations for the Day**
3. **Large Group Review of P&Ps Submitted**
    a. Process of developing/gathering policies
        i. United Services: Agency has very few "policies". Used some agency-wide procedures, but also developed BHH specific procedures/practices. The documents came together as more of a BHH guidelines document than policies and procedures.
        ii. InterCommunity: Had a good amount of policies already used throughout the agency, but also created some for BHH specific policies. Colleen came on board a year ago and was able to change some of the policies and procedures since then, using the BHH SPA guidance documents as a guideline. She worked on having the policies approved by their committee responsible for compliance.
        iii. SMHA: Examined agency policies to see if they made sense for BHH. Tweaked them if they had any missing pieces. Trying to get these policies and procedures to be a philosophy for all of SMHA.
        iv. CRMHC: Policies and procedures helped reestablish and reinforce a level of care within BHH and the agency. Awareness of these P&Ps was there, but it was an operational refresher to make sure everyone is following them.
        v. WCMHN: Agency is policy heavy so BHH had to work within what was already in place. Fortunately, did not run into a ton of barriers. Had to amend some policies. There are, however, pros and cons to having a lot of agency-wide policies.
    b. Strengths of Submitted Policies and Procedures-presentation of findings from Erica Clough
        i. General thoughts on having a P&P manual:
            1. Can be used to remind all staff of what is expected or to train new staff.
            2. The BHH Proposed Policy and Procedures Areas or P&Ps can be used as a tool for internal self-auditing
        ii. Specific strengths:
            1. Reference of the policy related to each measure or item
            2. Explanation of the procedure being used at the agency
            3. Internal quality assurance process
            4. Assessments that are updated including diagnoses

5. Client centered recovery plans that are updated based on the needs of the client
6. Nursing assessments that are updated and demonstrate changes in medical status
7. Clinical depression screenings (PHQ-9 or other approved screening tool) that demonstrate what constitutes a positive or negative score as well as the response based on the score
8. Demonstration of communication within BHH internal team and with external providers

c. Opportunities for Growth
    i. Establishing a frequency with which assessments and recovery plans are updated. Some policies/procedures did not show when assessments should be updated.
    ii. The scoring of the PHQ-9 (or other appropriate screening tool) and indicating the response based on the score. Unclear procedures around what is a positive or negative depression screening score.
    iii. Tracking and documentation of required data
    iv. Staffing policy or demonstration of the positions within the agency consistent with the expected ratio
    v. Monitoring of chronic conditions and promoting preventative strategies
    vi. Coordination of care with internal and community providers
        1. State-operateds are unable to develop MOUs with outside providers. Some agencies have working relationships with community providers, but do not have any formal written contracts or agreements. For those with an informal approach, they should document their process especially when responding to the credentialing application. DMHAS and provider agencies will work together to develop a better process for state-operateds.
    vii. Linking to community supports, resources, and referrals

d. Key questions to ask when assessing quality of records:
    i. Is the diagnosis and rationale for care seen in the assessment through discharge?
    ii. What makes this client a BHH client versus a non-BHH client?
    iii. Is there documentation of what service is being delivered to the client?
    iv. Is it clear that there is coordination of care with internal and external providers?
    v. Is there documentation that the client has been offered community resources and self-help?

4. Small Group/Individual Work – Review of P&Ps

a. Providers were broken down into group of 3-4 agencies. State-operateds met with other state-operateds and PNPs met with other PNPs to discuss enhancements to policies and procedures. Four agencies that did really well with their submitted policies and procedures led the group conversations: WCMHN, BHcare, SMHA, and Rushford.

b. Providers given a document for self-assessment of P&Ps compared to suggested areas. They could identify if P&Ps were missing, unclear/needs improvement, meets minimum BHH requirements, and/or exceeds minimum requirements

5. BHH Site Visits

a. Next steps-timeline and expectations

i. Submission of additional or updated policies and procedures should be emailed to Erica after LC at Erica.clough@beaconhealthoptions.com
ii. Will begin scheduling site visits in February with plan to have them completed in April-June

6. Holiday Celebration

7. Consumer Satisfaction Survey

a. The consumer satisfaction survey is an annual process for all clients
b. There are two surveys:
    i. Mental Health System Improvement Program (MHSIP)
        1. Mandatory survey
        2. Focuses on services, accessibility, appropriateness of services, outcomes, recovery orientation, participation in treatment decisions, respect
    ii. WHO Health-Related Quality of life
        1. Optional Survey
        2. Although the quality of life survey is optional, it contains really important data that pertain to what should be collected for BHH
c. Identifying and surveying BHH clients is important because a consumer satisfaction is a BHH outcome reporting requirement
d. To account for BHH clients, a "BHH client" checkbox was added to the consumer satisfaction survey. However, not all providers got and used form in time. Many clients didn't know to check the box.
e. 2016
    i. 98 respondents checked BHH box
    ii. A high number of people checked the box that weren't receiving services at a BHH designated agency
    iii. No-one filled out the quality of life section
f. 2017
    i. Saw an improvement in completion from 2016
    ii. More clients checked the BHH box
g. Challenges still exist around making sure that BHH clients check the BHH box and that non-BHH clients do not check the BHH box. Discussed some alternatives for 2018.
h. Provider Experiences
    i. CMHA:
        1. Staff received a luncheon if they hit a certain benchmark for submitted surveys
        2. Clients were reminded to check BHH box if they were enrolled in BHH
        3. Some BHH staff handed out forms as well as program staff. Teams throughout the agency know which clients are BHH.
        4. Include four addition questions on survey that are required for JCAHO BHH Certification option
            a. Heather will send questions to Amy
    ii. United Services:
        1. CSP clients have case workers check off the BHH box for BHH clients

2. Front desk will have the forms and hand out when clients come in for appointments
3. Agency can develop process to know who is BHH and have that information pre-filled on surveys

iii. CMHC:
1. Clients do not know they're BHH
2. Peers have been used in the past to check the box and administer the survey
3. Trying to figure out a way for clients to keep anonymity and also identify as BHH

iv. Sound:
1. Held client fair and had clients fill out the survey during the event. Anyone who completed a survey participated in a raffle
2. BHH team was present and able to identify who was BHH

i. Possible Solution – utilize a separate form for BHH
i. Clients would fill out a BHH specific survey, instead of the current consumer satisfaction survey
ii. Concerns:
1. More work for staff to differentiate between forms
2. Makes a lot of sense, but not sure how the process would work
3. Providers do not want to administer BHH surveys at a different time separate from when consumer satisfaction survey is administered

j. Other ideas
i. DMHAS will complete the analysis, providers will just have to administer and collect data
ii. Spell out Behavioral Health Home Services instead of using the acronym "BHH"
iii. Instead of a check-box, add a question to the beginning of survey asking clients "do you currently receive behavioral health home services"

8. DMHAS, ASO and Provider Updates

a. Service Duration Analysis Results
i. The duration of a service has to be at least eight minutes in order to be billable
ii. Since the beginning of the BHH program, 2,414 services were removed from billing because they were less than eight minutes
iii. Providers reviewed a "Service Duration Analysis Report" for a breakdown of service durations of less than eight minutes by service code, modifier, system, and provider. This information for each provider can be obtained when they run their own BHH missing Data Report.
iv. The programmatic expectation is one hour of service per client/per month
v. If there any questions on how to do this, providers can contact Lauren Staiger at lauren.staiger@ct.gov

b. Credentialing Applications – As a reminder, credentialing applications are due back to ABH on Monday, December 18, 2017. If providers have any questions or concerns they may email Denise Roberts at droberts@abhct.com or call 1-844-551-2736.

c. Reports/Dashboards
    i. Beacon was working on some challenges with the print functionality. Providers should be able to download and print their data from Tableau. An email will go out with more information and instructions, and anyone who experiences any problems should call ABH at 1-844-551-2736.
    ii. Still working on merging health assessment data so it can be made available to the providers in Tableau
    iii. Provider Question:
        1. Would it be possible to have a collapsible table that shows only the current health assessment value, and expose past values if clicked?
            a. Beacon will look into this
d. WCMHN & Cultural Diversity Board
    i. Agency is excited to present the 2016 Population Health data to the board. Will let everyone know how the presentation turns out.

9. **Next Meeting** – January 26, 2018 @ Beacon Health Options, 4th Floor, Huntington Room