Behavioral Health Homes Refresher

THE WHO, WHAT, WHY AND HOW

Agenda

- 10:30am Introductions and Agenda
- 10:45am Overview and History of BHH
- 10:55am Goals and Objectives
- 11:05am BHH Model
- 11:20am Break
- 11:30pm Core BHH Services
- 11:50am Service Examples
- 12:15pm Tools/Resources
- 12:25pm Survey

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What is Behavioral Health Homes?

- An integrated healthcare service delivery model that is recovery-oriented, person and family centered

- Promises better patient experience and better outcomes than those achieved in traditional services due to the care coordination it provides

- An important option for providing a cost-effective, longitudinal “home” to an array of inter-disciplinary behavioral health care, medical care, and community-based social services and supports for adults with chronic conditions

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Who is Involved in BHH?

- CT Department of Mental Health and Addiction Services
- CT Department of Social Services
- CT Department of Children and Families
- Beacon Health Options
- Advanced Behavioral Health
- 14 State and Private LMHAs and Identified Affiliates

Why is BHH Essential?

- Access to appropriate primary health care:
  - Individuals diagnosed with chronic behavioral health conditions are traditionally underserved in primary health care and often experience barriers in accessing care
- Mortality rate/age:
  - People living with SPMI die earlier than the rest of the population, in large part due to preventable physical health conditions
- Behavioral health is an essential component of optimal health
- Unmanaged chronic health conditions are significant barriers to the achievement of recovery
- Many people diagnosed with SPMI have strong relationships with behavioral health providers who in most cases are already providing services consistent with the 6 Health Home services

BHH History Highlights

Developed in response to Section 2703 of the Affordable Care Act

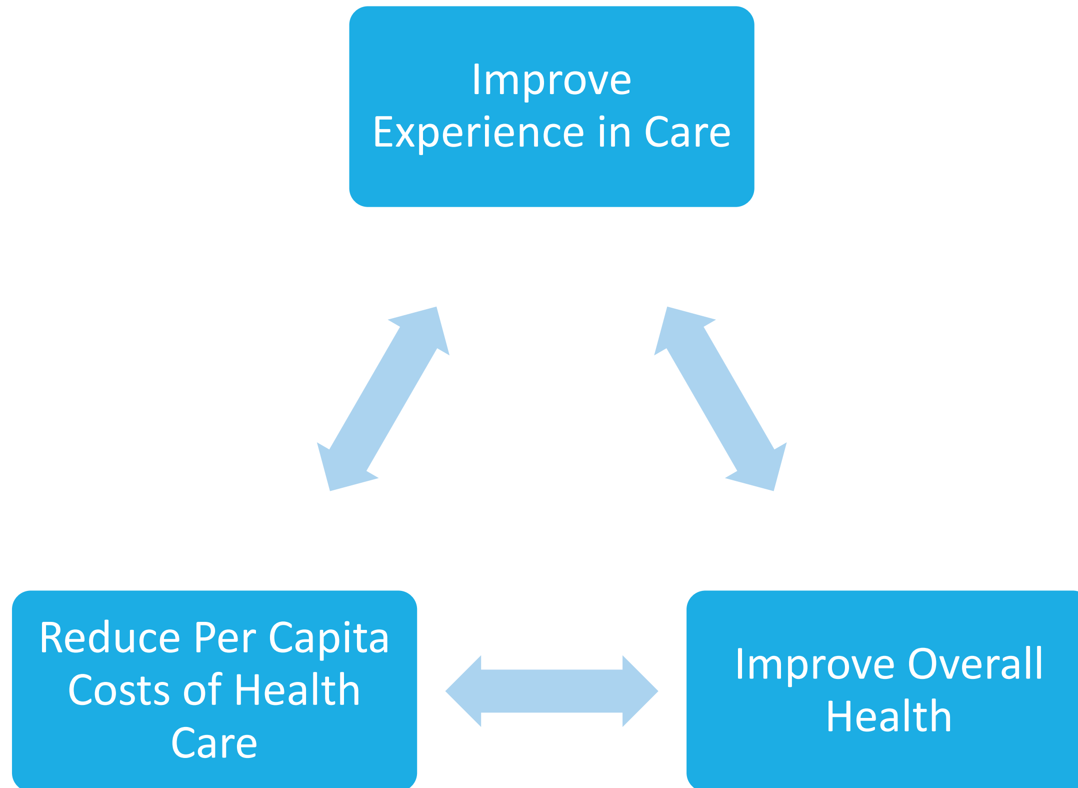
Since then:

- March 2015: BHH payor entered for 100% of adults on eligibility list statewide
- October 2015: Enrollment - 4,082 Services - 2,158
- May 2016: Children are enrolled in BHH
- June 2016: First BHH reports released to assist providers
- September 2016: BHH State Plan Amendment is approved
- October 2017: Database created to enter and track health assessments
- October 2017: Enrollment - 7,122 Services-5,165

BHH Goals

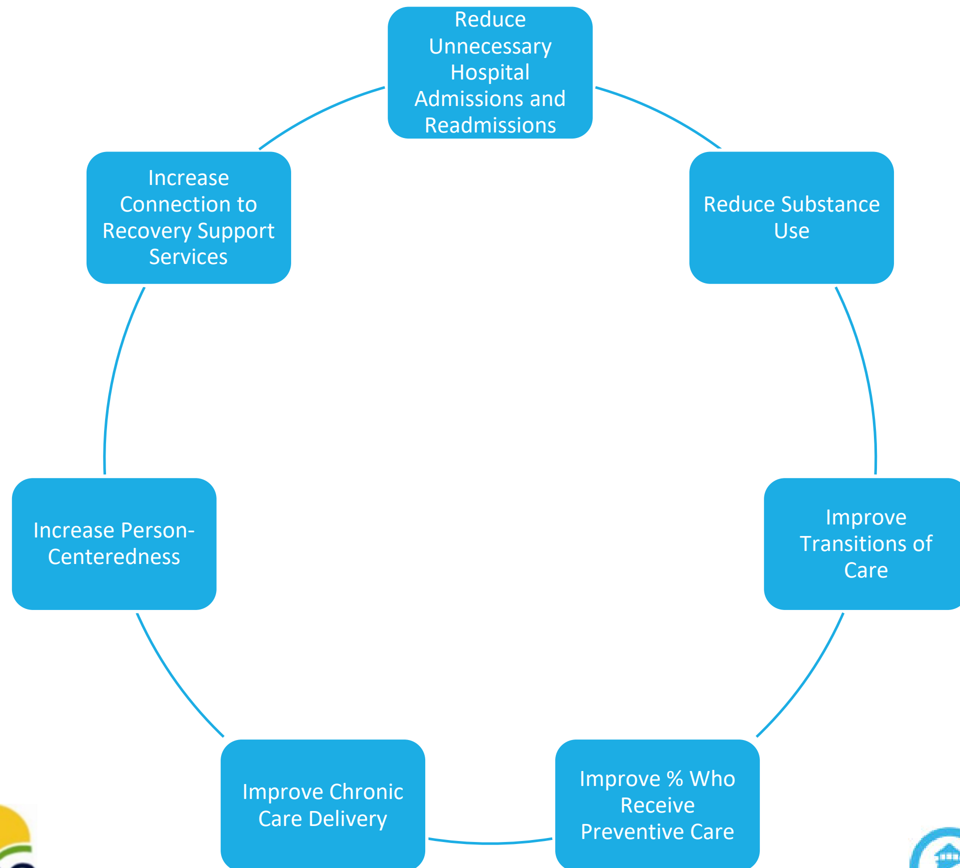
CT GOALS AND OVERARCHING GOALS

The Triple Aim/Overarching Goals



- Improve experience in care – coordination, integration, collaboration
- Improve overall health – whole-person philosophy, inter-disciplinary teams
- Reduce per capita costs of healthcare – high quality care, focus on prevention

Connecticut Specific Goals



= Better overall health and health care received

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The BHH Model

BHH DESIGNATED PROVIDER AGENCIES, STAFF, AND CLIENTS

BHH Designated Provider Agencies

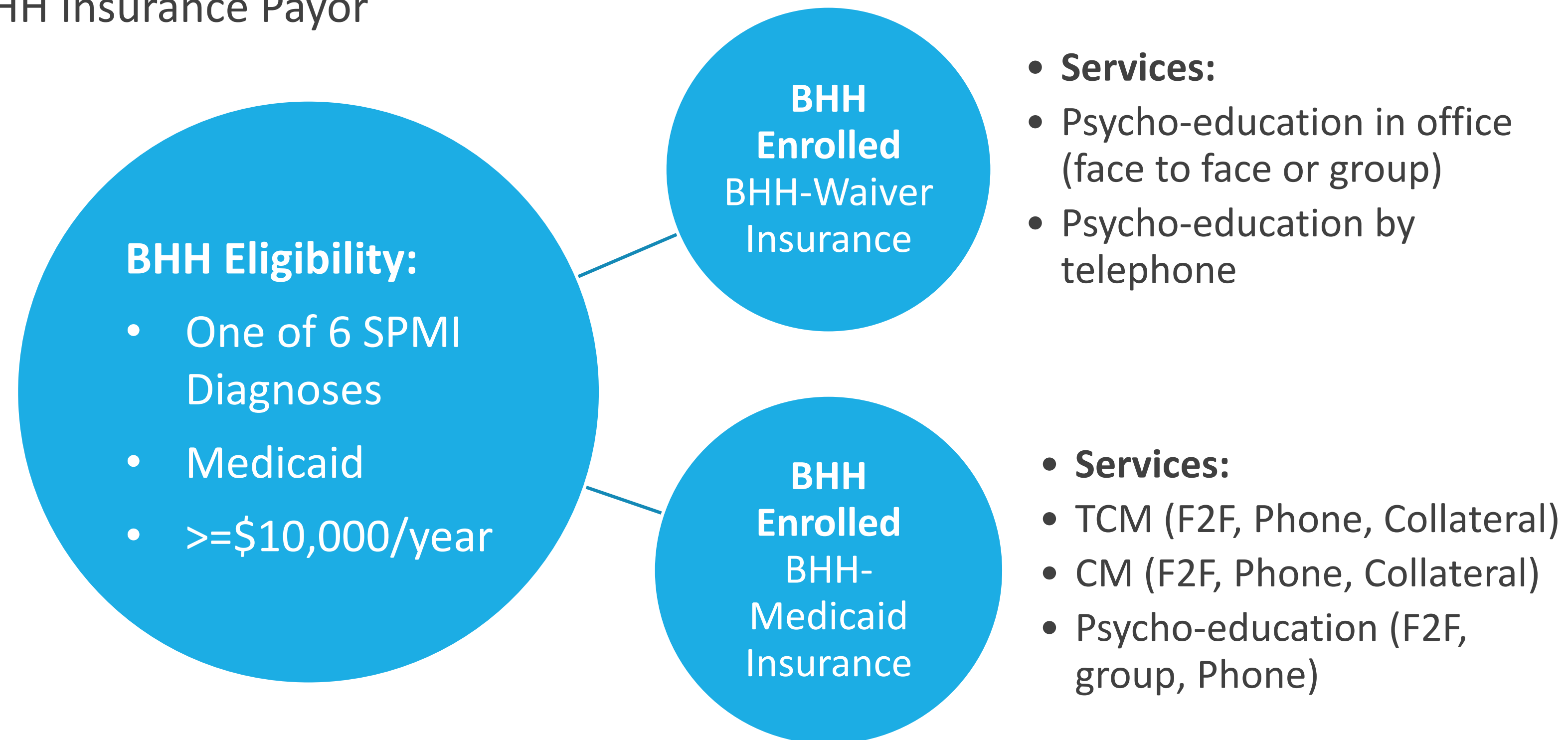
- Entire agency is a Behavioral Health Home provider
- Provider requirements, as defined in the State Plan Amendment
- Coordination with medical providers and emphasis on improving health and wellness
- Access to large amounts of data and other resources for care coordination and enhanced service provision
- Data Collection Requirements (see handout)

BHH Staff

- Anyone working with a client who is enrolled in BHH is a BHH staff person
- Services are provided to BHH clients by BHH funded staff and in-kind staff
    - In-kind staff are staff from programs already serving BHH clients (CSP, ACT, YAS) – time with BHH clients is in-kind time
    - BHH funded staff assist case managers serving BHH clients, and serve those who are not active in any other program
- Roles and Responsibilities (see handout)
- BHH is everyone's business!

BHH Clients

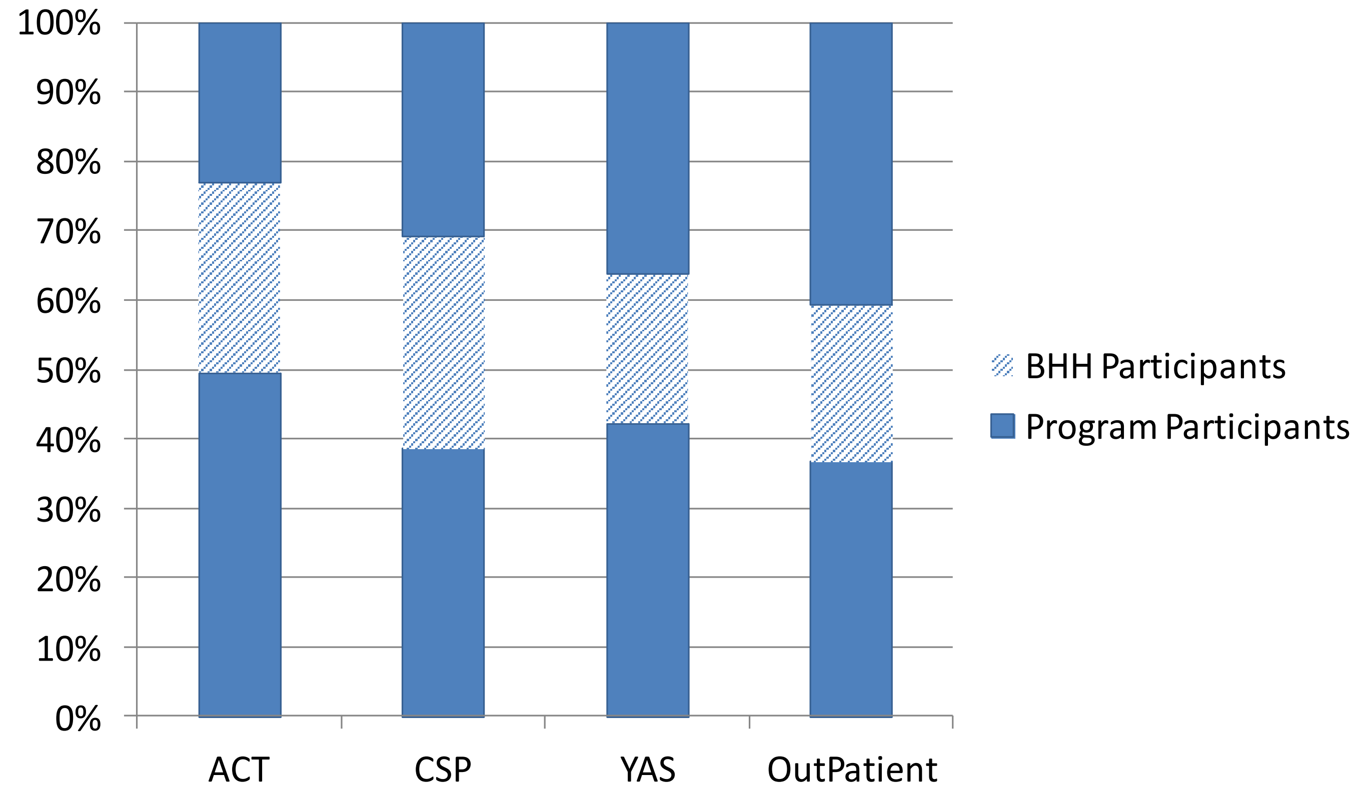
BHH Enrolled = BHH Insurance Payor



- **Services:**
- Psycho-education in office (face to face or group)
- Psycho-education by telephone

- **Services:**
- TCM (F2F, Phone, Collateral)
- CM (F2F, Phone, Collateral)
- Psycho-education (F2F, group, Phone)

BHH Clients



BHH Clients Medicaid Statuses & BHH Enrollment

Un-Enroll	Un-Enroll after 6 months	Keep Enrolled
• No longer eligible for Medicaid- Over income • No Medicaid -Private Insurance	• Qualified Medicare Beneficiary (QMB)	• Medicaid Only (all Husky Types) • Medicaid and Medicare • Spend-down

BHH Services

IN RELATION TO THE TRIPLE AIM/OVERARCHING GOALS

BHH Services and Service Codes

- Whole person approach
  - Comprehensive Assessment – physical, mental, social needs
  - Recovery Plan Goals related to physical health conditions and wellness
  - Interventions/Services to Support Whole Person-Not Just Mental Health
- No separate BHH program or service codes
  - Use of existing TCM and case management codes (see handout)
  - Screenings and psycho-education options

BHH Services and Service Codes

- Phone and collateral contacts are billable
- Depth vs. Breadth
  - Don't need to provide additional hours or services – services count for BHH and program they were provided under
  - A minimum 1 hour/month services should look like integrated care and align with BHH service descriptions – services must be at least 8 minutes to be billable
  - Random Moment Time Study

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Core Services

Comprehensive Care Management

- **Assessing** physical and mental health
- **Monitoring** goals and objectives
- Treatment **Planning**

Care Coordination

- Implementing plan
- **Linking** to services
- **Coordinating** care
- **Collaborating** with external providers

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Core Services

Health Promotion

- **Educating** on health and wellness topics
- Educating on **Preventive** measures
- Intervening to **Promote** healthy living

Patient and Family Support

- **Supporting** to overcome barriers
- **Involving** family members/other supports
- **Assisting** with identifying resources to support attaining highest level of wellness

Core Services

Comprehensive Transitional Care

- **Monitoring** access to follow-up care
- **Coordinating** post-discharge care
- **Collaborating** with hospitals and inpatient facilities

Referral to Community Support Services

- **Referring** to resources for community support
- **Linking** to community supports
- **Confirming** appointments kept

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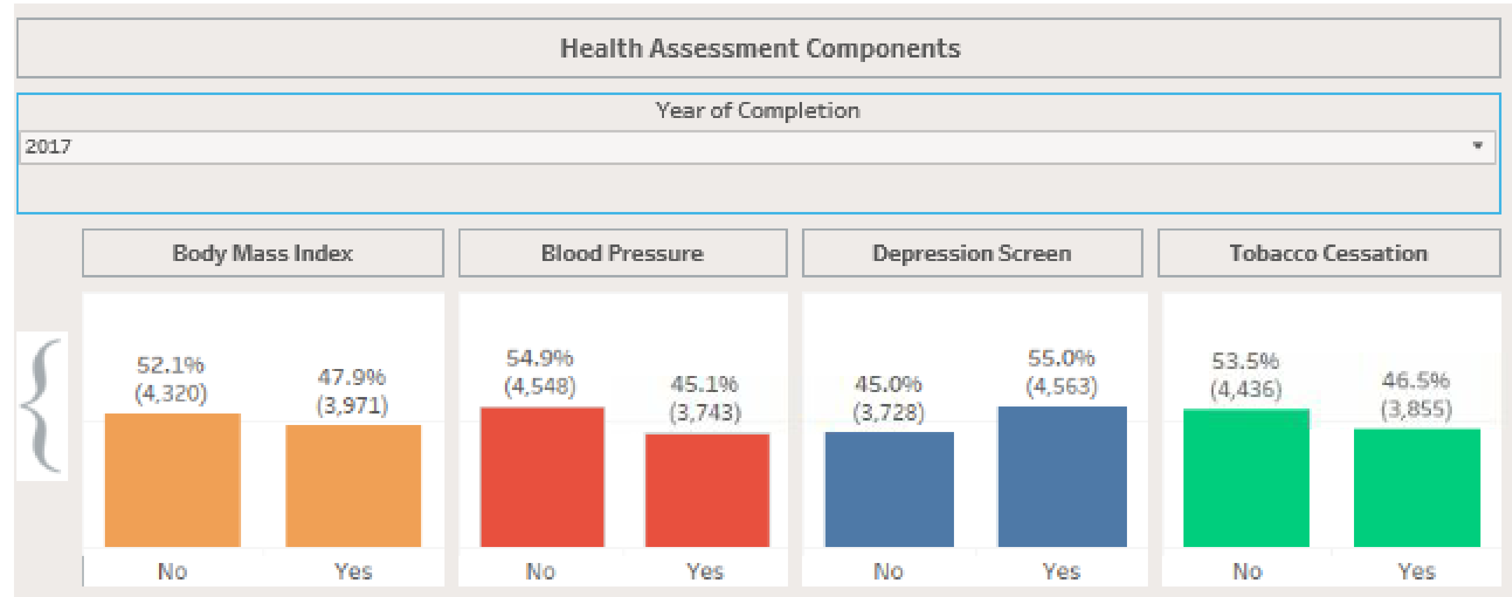
BHH Documentation Requirements

- **Specify the BHH service/Include description of service delivered**
- TCM Requirements Apply to all BHH Billable Services
  - Document the service & show its relationship to the treatment plan
  - Date, time, duration & location 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

Service Example: Health Assessments

BMI, BP, DS, and TC assessment can be used to develop goals, monitor health, and determine which additional services need to be provided

Not just data collection!



- Completing a health **assessment** is a **TCM** service that should documented.
- The BHH service to be mentioned in the note – **Comprehensive Care Management**.

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Service Example:
Diabetes Testing Education

- In reviewing the diabetes gaps in care report you see your client hasn’t had 2 important tests to monitor his diabetes.
- You meet with him to review the tests, what they involve, what he can expect, and educate him on why they are important.
- Reviewing this information with the client **Psycho-Education** face to face service that should documented.
- The BHH service to be mentioned in the note – **Health Promotion**.

Service Example:
Connecting Client to Appointments

- Your client has several appointments in the community: 1) a doctor's appointment and 2) an appointment to see a new apartment.
- You contact the doctor's office to ensure they have the needed paperwork.
- You review the bus schedule with the client and discuss the stops, tips for getting on and off the bus and strategies to remain calm on the ride.
- Contacting the doctor's office=**TCM with Collateral** that should documented.
- The BHH service to be mentioned in the note – **Care Coordination.**
- Reviewing the bus schedule – **CM face to face** and **Patient and Family Support.**

BHH Tools/Resources

BHH Website www.ctintegratedcare.com

Connecticut Behavioral Health Homes

Welcome to the CT Behavioral Health Home website. You can use this site for providing and accessing services to improve your health.

For Providers For Enrollees

In the Spotlight

- Behavioral Health Home Video – I'm a Whole Person
- Behavioral Health Home 101 Presentation
- Health and Wellness Observances

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Beacon’s Tableau Dashboards

provides a more in-depth look at BHH population

Annual HEDIS Measures

Health Assessment Tracking and Health Statuses

Employment and Living

Medical Gaps in Care Reports

Enrollee Services

Annual Population Health Data

Inpatient Tracking

Lapse in Medicaid Report

Beacon's Spectrum

a Medicaid claims data warehouse

Demographics

Health Conditions and Services

Medications/Labs

Prescribers

External Providers

To gain access you need:

- A Beacon ProviderConnect Account
- Specific Spectrum Consent Form

BHH Health Observances

- Monthly Health Observance Topics
- ASO administers packets and sends link with additional resources
- Can be used to:
  - Teach health promotion classes
  - Provide handouts and brochures to clients
  - Offer preventative advice to clients

Questions and Technical Assistance

BHH Customer Service Line at:

1-844-551-2736