# BHH Work Group:

# BHH Overview & Services/Codes Refresher

May 2021

# Training Goals

In this training you will learn:

- why the integration of physical health and behavioral health is important
- what the Behavioral Health Home (BHH) model for healthcare delivery is
- what services are part of the BHH model
- how to document and code BHH services

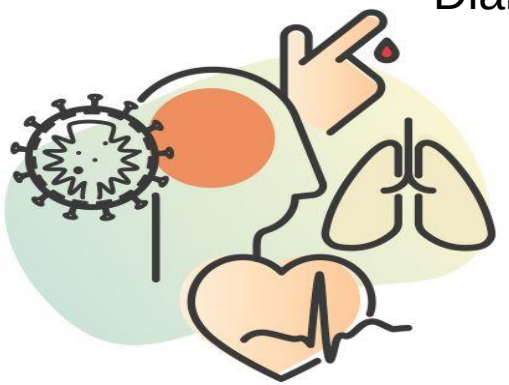
# Why is Integration Important?

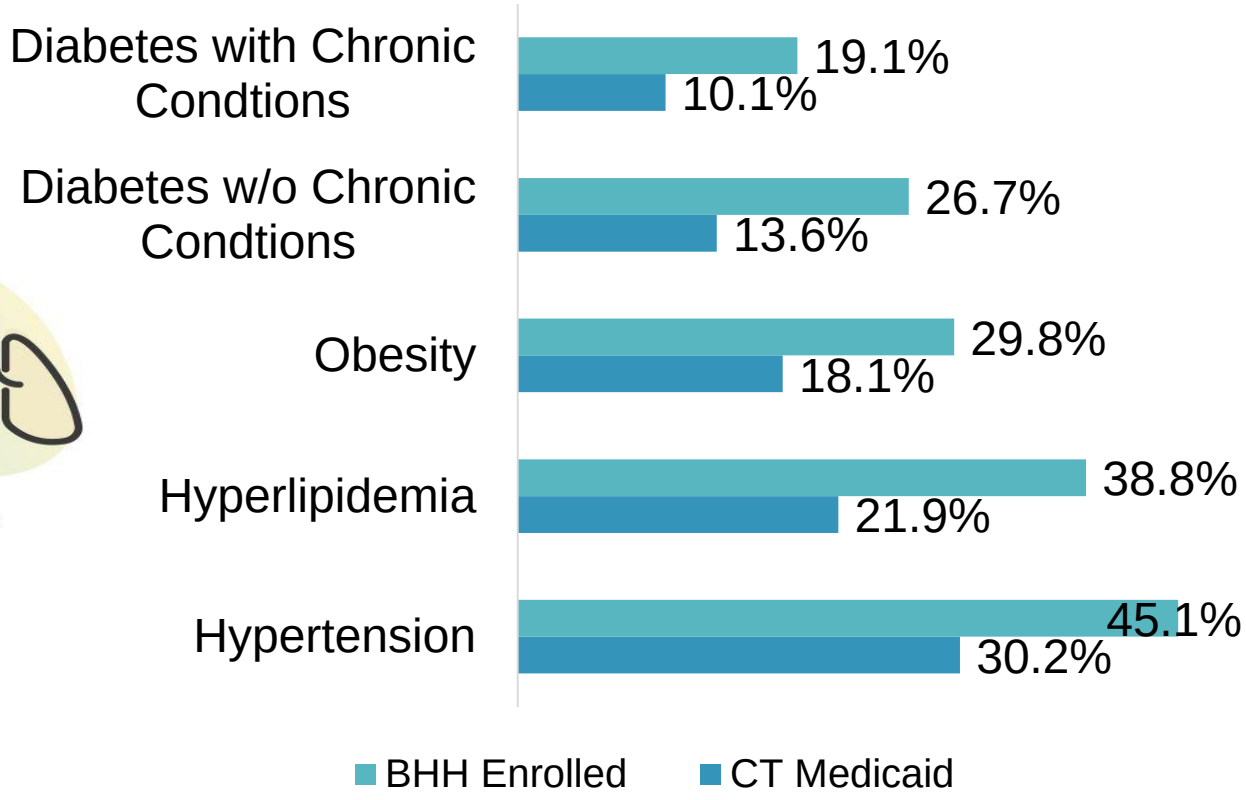
- The lifespan of people with severe mental illness (SMI) is shorter compared to the general population. Life expectancy estimates for adults with SMI range from 8-30 years lower than for the general population. (Chang et al., 2011)

- Approximately half of these deaths result from preventable natural causes or modifiable risk factors (Parks et al. 2006; Piatt et al. 2010; Sterling et al. 2010; Walker et al. 2015).

- Having a mental health condition is a risk factor for developing a chronic physical health condition

# Comorbid & Co-occurring Prevalence BHH Population CY2019





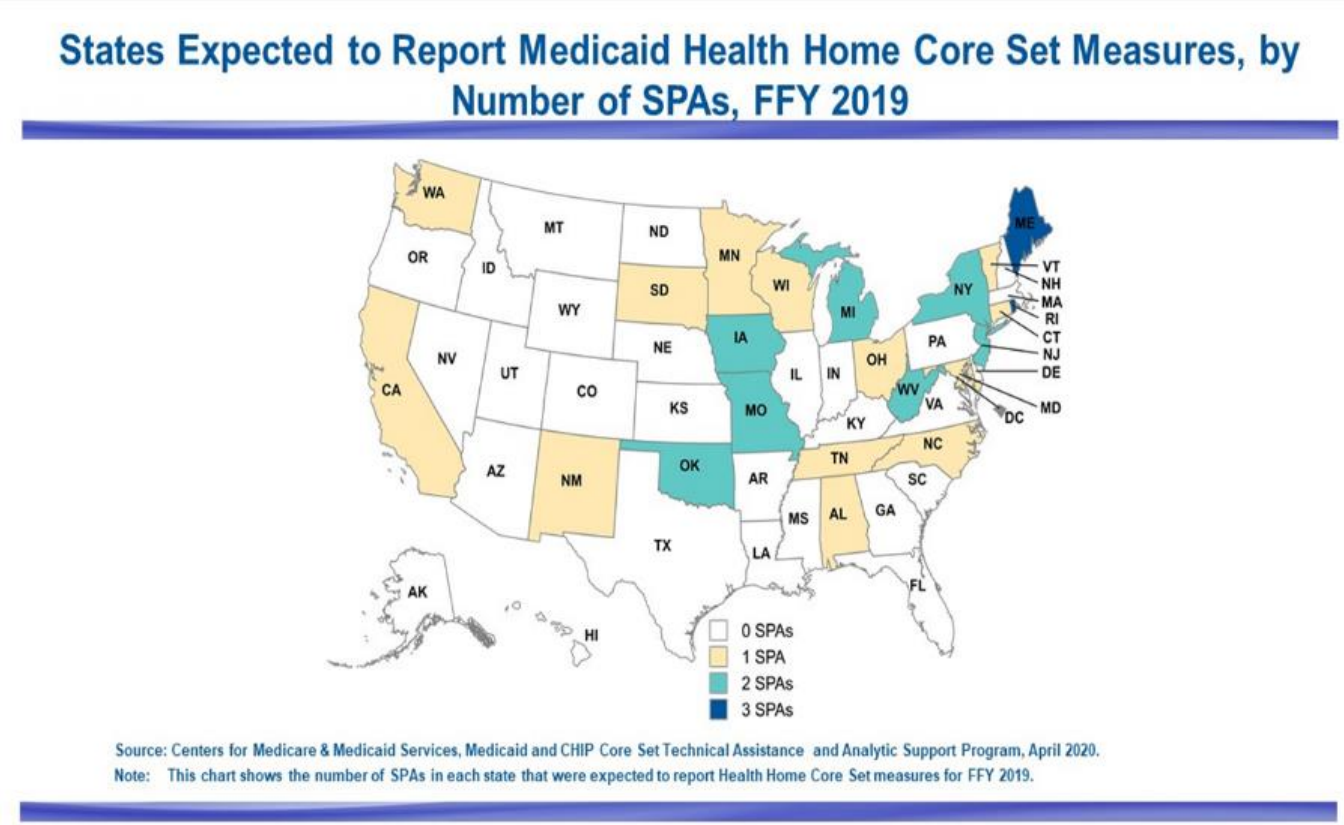
# What is the Behavioral Health Home model?

- A model to bring primary care services into the community behavioral health setting
- A model that focuses on whole person care with a team of providers working together to deliver care
- A model that seeks to achieve the Triple Aim of healthcare
  - Improve health outcomes
  - Improve client experiences with healthcare
  - Reduce healthcare costs

# Behavioral Health Homes Nationally

States with 2 or more Health Homes:

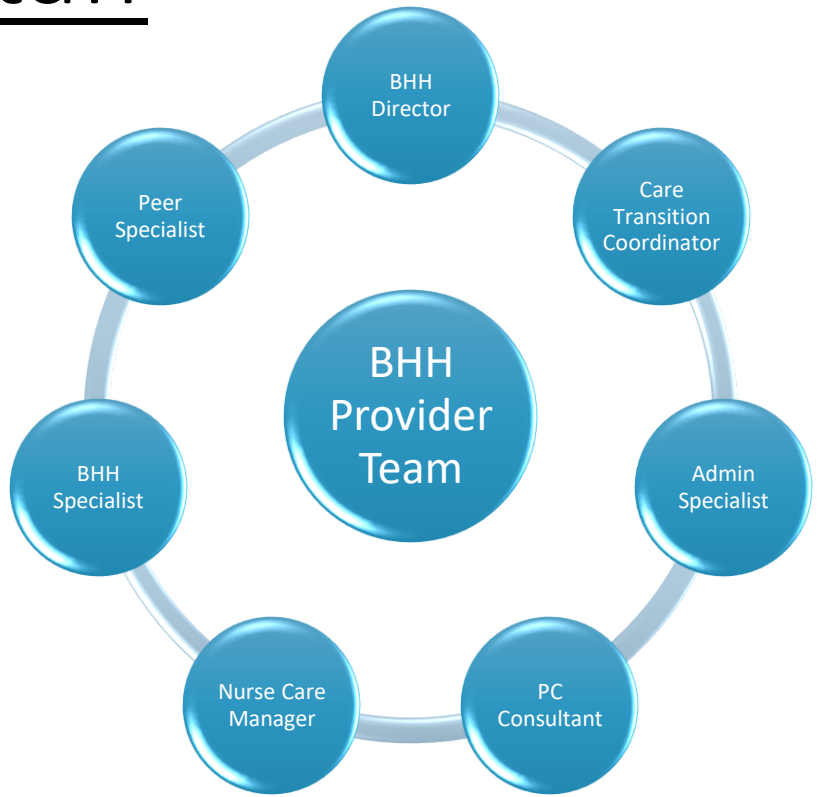
- DC (2)
- Iowa (2)
- Maine (3)
- Michigan (2)
- Missouri (2)
- New Jersey (2)
- Oklahoma (2)
- Rhode Island (3)
- West Virginia (2



# How Do We Serve Our Population:

## Staff

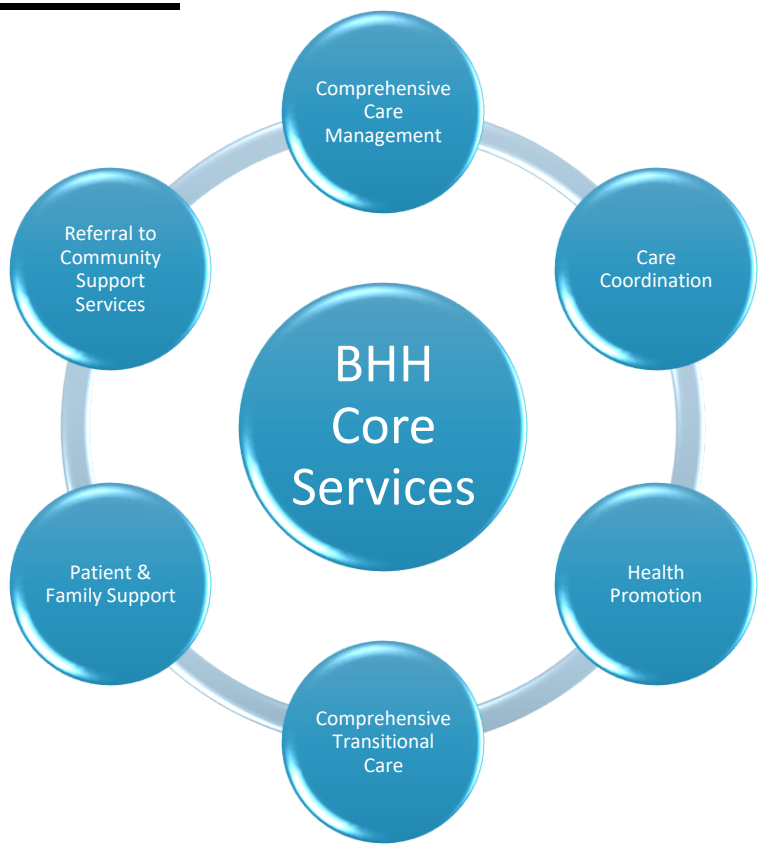




# How Do We Serve Our Population:

## Services





**Behavioral Health Homes Initiative**

**Service Code Crosswalk**

The following DDaP and WITS codes can be used to capture BHH services provided to any person with a BHH insurance payor code.

| DDaP Code | WITS Code* | Current Service | Standard Description | Units | BHH Service | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Care Management | Care Coordination | Health Promotion | Patient and Family Support | Comprehensive Transitional Care | Referral to Community Support Services |
| TCM01 | 2023T1 | TCM with Client Face to Face | The continuum of activities with a client concerned with assessment, planning, linkage support and advocacy. Includes assisting and enabling a client to gain access to needed medical, clinical, social, educational, wellness and other services.[1] | 8-15 minute increment | X | X | | X | | X |
| TCM02 | 2023T2 | TCM with Client By Telephone | The continuum of activities with a client concerned with assessment, planning, linkage support and advocacy. Includes assisting and enabling a client to gain access to needed medical, clinical, social, educational, wellness and other services. Reflects phone contacts with the client. | 8-15 minute increment | X | X | | X | | X |
| TCM03 | 2023T3 | TCM with Collateral | The continuum of activities with a collateral contact on behalf of a client concerned with assessment, planning, linkage support and advocacy. May include phone contacts. Includes assisting and enabling a client to gain access to needed medical, clinical, social, educational, wellness and other services. | 8-15 minute increment | X | X | | X | | X |
| TCM04 | 2023T4 | TCM with Client Audio and Visual | The continuum of activities with a client concerned with assessment, planning, linkage support and advocacy. Includes assisting and enabling a client to gain access to needed medical, clinical, social, educational, wellness and other services. Reflects audio and visual (virtual) contact with the client. | 8-15 minute increment | X | X | | X | | X |
| T1016 | T1016 | Case Mgmt with Client Face to Face | The continuum of activities provided to assist and support clients in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services.[2] | 8-15 minute increment | X | X | | X | X | X |
| T116A | T1016A | Case Mgmt with Client Audio and Visual | The continuum of activities provided to assist and support clients in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services. Reflects audio and visual (virtual) contact with the client. | 8-15 minute increment | X | X | | X | X | X |
| T116B | T1016B | Case Mgmt with Collateral | Interaction with a collateral contact on behalf of a client to assist and support clients in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services. | 8-15 minute increment | X | X | | X | X | X |
| T116C | T1016C | Case Mgmt with Client By Telephone | The continuum of activities provided to assist and support clients in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and | 8-15 minute increment | X | X | | X | X | X |

12.02.2020

**Behavioral Health Homes Initiative**

**Service Code Crosswalk**

**The following DDaP and WITS codes can be used to capture BHH services provided to any person with a BHH insurance payor code.**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| H2027 | H2027 | Psycho-Education Individual Face to Face | The educational process for mental health, addictive disorders, wellness and medical conditions to provide insight and promote lifestyle changes. Manner of contact is face to face with client.[3] | 8-15 minute increment | | | X | X | | |
| H2027B | H2027B | Psycho-Education Individual By Telephone | The educational process for mental health, addictive disorders, wellness and medical conditions to provide insight and promote lifestyle changes. Manner of contact is always by phone with client. | 8-15 minute increment | | | X | | | |
| H227A | H2027A | Psycho-Education Group | The educational process for mental health, addictive disorders, wellness and medical conditions to provide insight and promote lifestyle changes. Manner of contact is face to face in a group setting. | 8-15 minute increment | | | X | | | |
| H227V | H2027V | Psycho-Education Individual Audio and Visual | The educational process for mental health, addictive disorders, wellness and medical conditions to provide insight and promote lifestyle changes. Manner of contact is always audio and visual (virtual) with client. | 8-15 minute increment | | | X | | | |
| H227G | H2027G | Psycho-Education Group Audio and Visual | The educational process for mental health, addictive disorders, wellness and medical conditions to provide insight and promote lifestyle changes. Manner of contact is audio and visual (virtual) in a group setting. | 8-15 minute increment | | | X | | | |
| G8431 | G8431 | Positive Screen for Depression** | Positive screen for clinical depression using a standardized tool and follow-up plan is documented on the date of the screen | 8-15 minute increment | X | | | | | * |
| G8510 | G8510 | Negative Screen for Depression | Negative screen for clinical depression using a standardized tool | 8-15 minute increment | X | | | | | |

**WITS codes displayed are the codes a staff member would choose when documenting a service. This code may be different than the code that displays on reports in the EDW for the same service. Example: a staff person will choose 2023T1 for Face-to-Face TCM, but the BHH client summary report will show 2023T for Face-to-Face TCM.*

*[1]The definition of targeted case management is from the CT Department of Mental Health and Addiction Services (DMHAS) TCM training materials: https://portal.ct.gov/DMHAS/Initiatives/DMHAS-Initiatives/TCM*

*[2]The definition of case management was created by the National Association of State Mental Health Program Directors (NASMHPD): https://www.nasmhpd.org/node/1394#C*

*[3]The updated definition of Psycho-Education was approved by DMHAS and created by the Behavioral Health Homes Health Literacy Committee*

***All clients who screen positive for depression should have a referral for follow-up clinical services documented and coded according to the type of case management or TCM service provided.*

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# Case Management vs Targeted Case Management

- CMS approved the following definitions:
  - **Case Management** – "consists of services which help beneficiaries gain access to needed medical, social, educational, and other services." (www.cms.gov)
  - **Targeted Case Management** – "services aimed specifically at special groups of enrollees such as those with chronic mental illness" (www.cms.gov)

Examples of

| Case Management | Targeted Case Management |
|---|---|
| Counseled | Coordinated |
| Assisted | Linked |
| Practiced | Accessed |
| Supported | Monitored |
| Supervised | Planned |
| Role-Played | Advocated |

*Based on ICD-10 Diagnoses

# Services not Billable as TCM

- Doing ADL and personal care tasks or assisting with activities of daily living e.g., assisting with budgeting, cooking, shopping, laundry, moving residences, payee services, etc.
- Performing routine services including courier services, e.g., running errands or picking up and delivering food stamps or entitlement checks, etc.
- Medication delivery
- Medication supervision/observation
- Skill building activities
- Providing other services that are billable through other Medicaid mechanisms, e.g., medical exams, treatment, therapy, etc.
- Helping a client move to a new apartment
- Transporting a client or family member
- Unsuccessfully attempting to provide a service such as calling and leaving a message; no shows, cancellations, etc. – These do not constitute engagement or outreach

# Putting it All Together

## Case Example 1

You are working with an individual, Melissa, with the following person-centered goal:
"I want to have a nice place to live"

Melissa also has the following 3 objectives:

1. Better manage her diabetes as evidenced by taking her insulin as directed over the next 30 days
2. Improve her housekeeping skills as evidenced by her ability to clean her house twice a week over the next 30 days
3. Manage her anxiety better as evidenced by her ability to speak with the housing assistance coordinator within the next 30 days

What types of BHH services can you offer Melissa around the above goal and objectives?

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# Putting it All Together

## Case Example 2

You just found out Bob, a man in your CSP program, is BHH eligible. Below is some information about Bob:

- 36 years old
- Has a sister named Mary he is close to
- Has active diagnoses of PTSD & Anxiety
- Is considered overweight
- Is currently pre-diabetic and pre-hypertension
- Smokes cigarettes
- Does not have a current primary care physician
- Utilizes urgent care for medical concerns
- Is not employed, but able to work
- Is on a fixed income
- Has section 8 housing
- Inconsistently attends medical and behavioral health appointments

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# How Can BHH Support Bob?

| Assist with Physical Health Care Needs | Coordinate Care | Empower to Live a Healthier Lifestyle |
| --- | --- | --- |
| • Help control blood pressure<br>• Manage/help prevent progression of diabetes | • Identify a PCP<br>• Ensure Bob attends appointments | • Tips and tools to lose weight<br>• Tips and encouragement to quit smoking |

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# Comprehensive Care Management

- Starts with the initial engagement with Bob.
- Includes providing him with information, education, and support necessary to make fully informed decisions about his care options.
- Allows him to actively participate in his care planning.
- The end goal is to develop a person-centered care plan
- Monitoring progress is a key component

## How Do We Provide Comprehensive Care Management to Bob?:

- Perfect opportunity to re-assess Bob and update goals, objectives, and interventions
  - Is the plan person-centered?
  - Does it include medical information?
  - Does Bob understand his plan?
    - Is the goal in his own words?
- Schedule time for everyone involved in Bob's plan (including Bob and his natural supports) to meet
- Periodically meet with Bob and those working with Bob to confirm plan still works for Bob

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# Example of Comprehensive Care Management Note and Coding

*BHH Comprehensive Care Management-"3/17/21, 11:00 am. Case Manager met with Bob via Microsoft Teams to review results of most recent functional assessment. Bob determined he wanted to change his goal to improve his physical health. We made a plan to increase his physical activity. I will schedule a group meeting with Bob, his sister Mary, and his clinician Darla so we may update his plan."*

| Service Code | Service Description | Service Location |
| --- | --- | --- |
| • TCM04/2023T4 | • TCM Audio & Visual | • Audio & Visual |

# Comprehensive Care Management Services: Beyond the Initial Assessment/Planning

**How can we provide this service to Bob after a year of participation?**

- Continually discuss recovery plan with Bob
  - Update goals and objectives as needed
  - Focus on ways to help Bob become more independent
  - Identify relevant health goals to meet the BHH standards
  - Ensure cultural/personal preferences are included in treatment plan
  - When appropriate, create a discharge plan with Bob
- Meet regularly with those involved in Bob's treatment plan
- Take advantage of opportunities to educate Bob on his diagnoses, health needs, and his plan so he is empowered to make informed decisions towards his recovery 

# Care Coordination

- Is linking individuals to external supports
- It includes the referral process and coordinating care to support individuals gain access to providers they may otherwise miss out on
- Also includes assistance with appointment scheduling and fostering communication between individual and provider

## How Do We Provide Care Coordination to Bob?:

- Bob needs a primary care physician
  - Use agency's onsite primary care service
  - Identify a community provider
- Once an external PCP is identified, meet with Bob and provider to discuss Bob's needs
  - He was diagnosed with pre diabetes
  - He has stage 1 hypertension
- If specialists are needed to support Bob, help him find providers and ensure proper transportation is in place.

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# Example of Care Coordination Note and Coding

*BHH Care Coordination-"4/10/21, 11:00 am. Case Manager coordinated care on behalf of Bob with a community physician. Bob was too anxious to make the call to set up the appointment on his own. Case manager was able to schedule an appointment with the new doctor in two weeks. After the call, Bob was still antsy, but happy he had an appointment. CM gave Bob the name, address, and telephone number for his new doctor. Case Manager will check in prior to his appointment."*

| Service Code | Service Description | Service Location |
|---|---|---|
| • TCM03/2023T3 | • TCM w/ Collateral | • Office |

# Health Promotion

- Services encourage and support healthy living concepts
- The goal should be to motivate individuals to adopt healthy behaviors
- It includes promoting self-management of health and wellness

## How Do We Provide Health Promotion to Bob?

- Bob would benefit from education around the harmful effects of tobacco use
  - Includes financial, physical, social, and emotional consequences
- BHH staff can focus on hypertension and ways to self-manage and monitor blood pressure
- Education around staying active and eating healthy would also benefit bob
  - Help lose weight
  - Help with medical conditions

# Example of Health Promotion Note and Coding

*BHH Health Promotion -"4/16/21, 11:00 am. BHH Nurse Care Manager hosted an hour long onsite educational group on the harmful effects of tobacco use. Bob attended this training and learned the impact tobacco use has on all aspects of his life, including his physical health. Bob shared with the group when he started smoking cigarettes and why he continues to do so. Bob also shared he knows it is not good for him, but he does not know how to stop. Although Bob is not ready to quit, I requested he take home some informational brochures to review and he agreed. I asked Bob if we can meet 1-on-1 next month to take a deeper dive into his personal experience with tobacco use. Bob agreed to meet with me."*

| Service Code | Service Description | Service Location |
|---|---|---|
| • H227A/H2027A | • Psycho-Education Group | • Office |

# A Deeper Dive into Psycho-education

**Are there limits around what type of "education" can be billed under psychoeducation?**

- Within the CT BHH initiative, psycho-education is defined as:
  - The educational process for mental health, addictive disorders, wellness, and medical conditions to provide insight and promote lifestyle changes.

| Billable Service | BHH Service | Encounter Note |
|---|---|---|
| Psycho-education | Health Promotion | *Hosted an hour long onsite educational group on the harmful effects of tobacco use. Bob attended this training and learned the impact tobacco use has on all aspects of his life. Bob shared with the group when he started smoking cigarettes and why he continues to do so….* |
| Case management | Patient & Family Support<br>Comprehensive Care Management | *Met with Bob to discuss the different types of tobacco cessation programs. Answered questions Bob had around the different options. Bob will review the information and let me know if he'd like to give any of them a try.* |

# Patient and Family Support

- Services help individuals achieve their goals
- It includes providing individuals with advocacy skills so they may actively participate in their health plans
- The goal of this support is to improve their overall health outcomes

## How Do We Provide Patient and Family Support to Bob?

- Include and educate Bob's sister Mary as appropriate
- Help Bob identify barriers to improving his health
  - Then work with Bob to overcome them
    - What's stopping him from losing weight?
    - What's preventing him from eating healthy?
    - Why doesn't he have a primary care doctor?
    - Why isn't he working?
- Help Bob access and use technology as appropriate
  - View electronic health record
  - Schedule a ride

# Example of Patient & Family Support Note and Coding

*BHH Patient & Family Support-4/22/21, 11:00 am. Bob called his recovery specialist and said he wanted to cancel his appointment with the new PCP because he can't understand what the doctor tells him. The specialist listened to his concerns and shared his own experience. Then, he spent 15 minutes role playing what might happen at his doctor's appointment. He also encouraged Bob to ask questions and request take home documents. At the end of the call, Bob agreed to see his doctor tomorrow. He said he will call RS after his appointment to let him know how it went.*

| Service Code | Service Description | Service Location |
|---|---|---|
| • T116C/T1016C | • Case Management w/ client by phone | • Office |

# Comprehensive Transitional Care

- Activities are specialized care coordination services that are proactive rather than reactive
- They ensure seamless transitions of care for individuals
- The goal is to reduce unnecessary hospital admissions and interrupt patterns of frequent visits

## How Do We Provide Comprehensive Transitional Care to Bob?

- Focus on Bob's movement between different levels of care
- Ensure you are able to receive notification if Bob is admitted into a hospital or inpatient setting
- Set up a system in which you are notified if Bob visits the emergency room

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# Example of Comprehensive Transition of Care Note and Coding

*BHH Comprehensive Transition of Care - "5/10/21, 11:00 am. BHH Transition Coordinator received notification via Project Notify that Bob was in the hospital. He went to the ER because of chest pains and light-headedness and is staying for two nights for observations. In response, TC met with the hospital social worker to monitor his progress and discuss what needs to be done once released. As requested by Bob, I spoke with his sister Mary to plan for his discharge. Mary will pick Bob up when he gets out and she agreed he can stay with her for a week. The social worker is going to send me a copy of Bob's hospital record. Mary is going to give me a call once Bob is released so I can visit with his case manager."*

| Service Code | Service Description | Service Location |
|---|---|---|
| • TCM03/2023T3 | • TCM w/ Collateral | • Office |

# Referral to Community Support Services

- Ensure individuals have access to a myriad of formal and informal resources
- These resources should address the 6 dimensions of wellness beyond physical and mental health:
  1. Financial support
  2. Social support
  3. Spiritual support
  4. Occupational support
  5. Intellectual support
  6. Environmental support

## How Do We Provide Referral to Community Support Services to Bob?

- Bob is able to work, but not employed
  - We can encourage Bob to seek employment
    - Identify job coach
    - Identify entry level/no skills needed positions
- If Bob is not happy with his living situation, we can help improve his environmental wellness
  - Housing services
  - Rent assistance programs
- Great opportunity to use Bob's interest to find social group for him
  - Does he have hobbies?
  - Is there something he wants to learn?
  - Is there any support group that would benefit Bob?

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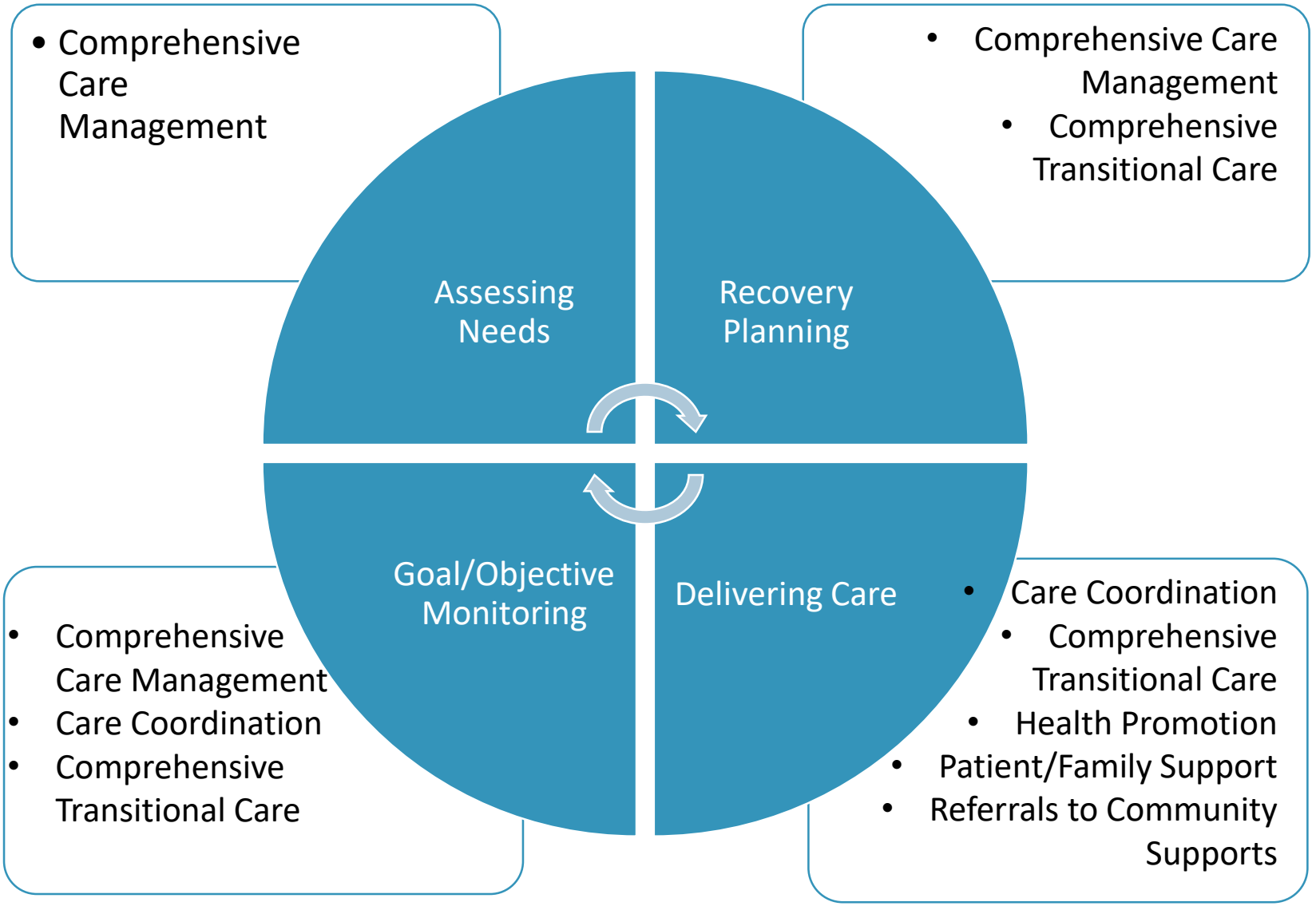
# Example of Referral to Community Support Services Care Note and Coding

*BHH Referral to Community Support Services- "5/24/21, 11:00 am. As a follow up to last month's meeting where Bob stated he'd like to find a job, I met with Bob today to go over the CT State Job Center. I called the Hartford location, linked Bob to a job coach, and coordinated a time for Bob to go over his work history with the job coach. Bob shared with me he was embarrassed that he hasn't worked for over 14 years and felt he would not be able to land a job.*

| Service Code | Service Description | Service Location |
|---|---|---|
| • TCM01/2023T1 | • TCM face-to-face | • Office |

# Complete View of BHH Services



# THANK YOU!

For more information visit:

www.ctintegratedcare.com

Questions? Comments?

Call 1-844-551-2736

OR

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