CT BEHAVIORAL HEALTH HOMES

BHH LEARNING COLLABORATIVE

DATE: THURSDAY, JUNE 16, 2022
TIME: 10:00AM – 12:00PM
VIRTUAL MEETING

Diabetes Prevention and Management:

A Population Health Approach

1. What is Diabetes (used as an example for this workgroup)
    a. Information included to educate about the chosen topic
    b. Educate about topic and include self-monitoring
    c. Treatment with diet, medication or both
    d. Reduce complications
    e. Decrease specific risks
    f. Blood sugar control
2. BHH Population Initiative
    1. Step One:
        a. Identify a population using data:
            i. Prevalence at your agency
            ii. High need/Staff time
            iii. High Cost
            iv. At Risk
    2. Step Two
        a. Create a plan to outreach and engage identified individuals
        b. Design Interventions (All members of care team)
            i. EXAMPLE: Target clients with diabetes. Start a diabetes education group that emphasizes the recommended annual exams. In addition to group, CM/BHH Specialist and nurse care manager work 1:1 with clients. Assess barriers to receiving recommended care
    3. Step Three
        a. Identify staff roles: What each person can do
            i. Primary Care Consultant-Provide staff with information on any health conditions that are part of the initiative. Consult on individual client cases.
            ii. BHH Director- drive the effort to identify target population and the design of the interventions. Communicate plan to staff.
            iii. Case Manager/BHH Specialist-work with client and staff to develop goals and objectives. Assess progress on plan, provide services as outlined in plan, and update as needed.

iv. Admin Specialist- Work with BHH director to identify target population. Provide staff with data regarding target population.
v. Nurse care manager- Collaborate with the Primary Care Consultant on staff education. Work with client and staff to develop goals and objectives. Assess progress on plan, provide services as outlined in plan, and update as needed.
vi. Transition Coordinator- work with hospitals, if warranted, and provide insights into community resources.
vii. Behavioral Clinician- work with staff and client to develop goals and objectives. Assess progress on plan, provide services as outlined in plan, and update as needed.

4. Step 4:
    a. Track and Monitor progress
        i. How will you know it is working?
        ii. Develop both short and long-term goals and the steps needed to achieve goals.

Attendee	Agency
Denise Perez	ABH
Paul Zakarian	ABH
Ginny Murdoch	ABH
Jeannie Wigglesworth	Beacon Health Options
Zach Kelley	Beacon Health Options
Anthony Lawson	BHcare
Jennifer Anziano	BHcare
Justine Compton	Bridges
Patricia Bennett	Bridges
Trish Bridges	Bridges
Valerie Mallard	Bridges
James Morro	CHR
Christopher Porcher	CMHA
Ed Ford	CMHA
Lisa Daley	CMHA
Sean Rowland	CMHA
Velvet Yusko	CMHC
Ellen Severn	CRMHC
Mary Germano	CRMHC
Heta Desai	DMHAS
Katharine Willis	DMHAS
Lauren Staiger	DMHAS
Alicia Reid	InterCommunity
Ryan MacDonough	InterCommunity
Kimberly Whipple	Rushford
Kimberly Crabbe	RVS
Tracey Creighton	RVS
Michelle Veilleux	RVS
Jesus Silva	SMHA
Lisa Goyette	SMHA
Alix O'Neil	Sound
Marcia Beebe	Sound
Natalie Crino	Sound
Tyischa Mcintear	Sound
Alicia Edwards	SWCMHS
Elizabeth Vasquez	SWCMHS
Victoria Hoey	SWCMHS
Joe Trzaska	SWCMHS
Migdalia Guzman	SWCMHS

Angela Richards	SWCMHS
Diane Sheehan	SWCMHS
Shellina Taylor	SWCMHS
David Horowitz	United Services
Jennifer Johnson	United Services
Kaitlyn Butler	United Services
Kimberly Solomakos	United Services
Krystin Tetreault	United Services
Melissa Abrams	United Services
Virgendalis Cruz	United Services
Kaitlyn Hankins	United Services
Ali LaBarca	WCMHN
Debra Deptula	WCMHN
Man-Ching Yeh	WCMHN
cpomar-nichols	Unknown
Danaija Lewis	Unknown
emenla	Unknown
Isabel Barrett	Unknown
odigboe	Unknown