



Behavioral health homes overview- draft proposal

Background

Health Homes

The 2010 Patient Protection and Affordable Care Act (ACA) established the “State Option to Provide Coordinated Care through a Health Home for Individuals with Chronic Conditions”, which provides funding for a two-year enhanced (90-percent) federal match for health home services for eligible Medicaid enrollees. This enhanced federal funding gives states critical resources to build provider capacity and provide an additional window of time needed to realize a return on their investment.

The federal health home model expands upon the concept of the more commonly used term, medical homes (in Minnesota referred to as Health Care Homes) by serving the whole person across the primary care, long-term services and supports, and mental health and substance use disorder treatment components of the health care delivery system. Health homes coordinate a variety of services including primary care and specialty care, and ensure referrals to community supports and services are effectively managed. Comprehensive care management, the key feature of health homes, supports the person in managing chronic conditions and achieving their self-management goals by facilitating the provision of clinical services that contribute to improved health outcomes.

Federally, there are minimum criteria that an eligible individual with chronic conditions must meet in order to be eligible for health home services:

- Two chronic conditions
- One chronic condition and “at risk” for another
- Only one chronic condition if it is a serious mental illness (serious emotional disturbance for population 18 years old and under)
 - The other chronic conditions include asthma, diabetes, heart disease, and being overweight as evident by a BMI over 25.

States must establish eligibility criteria and determine which chronic condition(s) to focus on in their health home model. In Minnesota, DHS is starting with the population with serious mental illness because of the known barriers of health care access, high co-occurrence of chronic health conditions, and early mortality. DHS will build on this framework to serve other complex populations in the future.

Health Homes in Minnesota

The Chemical and Mental Health Services and Health Care Administrations of DHS are working together to design a behavioral health home (BHH) model which will operate under a “whole person” philosophy and assure access to and coordinated delivery of primary care and behavioral health services for adults and children with serious mental illness.

A number of recent multi-state studies demonstrate that people served by the public mental health system die, on average, 25 years earlier than the general population. While 30% of the excess mortality burden can be attributed to suicide, 60% of the excess mortality is due to natural causes such as heart disease, cancer, and lung diseases. These conditions are generally associated with modifiable risk factors more prevalent in the adult SMI population including smoking, chemical dependency, and poor nutrition. Children who are exposed to psychological trauma are proven to have a significant risk of poorer physical health as adults and are much more likely to have serious emotional disturbance.

People with serious mental illness often lack access to adequate health care and those with access are less likely to receive care that meets clinical practice guidelines for comorbid chronic conditions. Quality care for people with serious mental illness requires coordination between health care and behavioral health systems and integrated treatment for co-occurring mental health and substance abuse disorders.

DHS is developing a framework that will require a standard of integrated care which encompasses mental, behavioral, physical health conditions and considers the influence of multiple conditions, social factors, social function, and consumer preferences to personalize assessment, treatments, and goals of care.

DHS believes that more integrated care, regardless of setting, contributes to improved health and decreases the risk of adverse outcomes.

Proposal Design

Goals and Guiding Principles

The goals of the health home framework are to:

1. Improve health outcomes (preventative, routine, treatment of health conditions) of individuals enrolled.
2. Improve experience of care for the individual.
3. Improve the quality of life and wellness of the individual.
4. Reduce health care costs.

The guiding principles of behavioral health homes are:

1. BHH services are distinguished by the presence of a multi-disciplinary team that shares information and collaborates to deliver a holistic, coordinated plan of care.

2. BHH services are an opportunity to better meet the needs of individuals experiencing serious mental illness and their families by addressing the individual's physical, mental, behavioral health, and wellness goals.
3. BHH services will take a person-centered approach and will engage and respect the individual and family in their health care and recovery/resiliency.
4. BHH programs and services are to respect, assess and use the cultural values, strengths, languages, and practices of the individual and family in supporting the individual's health goals.

See Appendix A for the design and implementation timeline.

Eligibility

Behavioral health home services will be made available to adults with serious mental illness (SMI) or a serious and persistent mental illness (SPMI), and children and youth experiencing a severe emotional disturbance (ED) as defined in MN Statute 245.462 subdivision 20(a) or 245.4871 subdivision 15 (2) that have a current diagnostic assessment as defined in MN Rule 9505.0372 subpart 1 items B or C, as performed or reviewed by a mental health professional employed or contracted by the behavioral health homes.

Potentially eligible individuals will be identified through the Medicaid claims system. DHS will provide certified behavioral health homes with a list of individuals that they already serve that are eligible for BHH services. Certified behavioral health homes will also recruit and identify potentially eligible individuals. The BHH provider will determine if an individual is eligible for behavioral health home services.

Participation in behavioral health homes is voluntary and eligible individuals will receive state-developed materials to inform them of the choice to participate in a BHH.

After eligibility for BHH services has been determined and information about the services has been provided to the eligible individual, the individual will be given the option to opt in to receiving BHH services. The opt-in process will include an informed consent form created by the state that will include the individual rights and responsibilities as a recipient of these services.

Behavioral health home services may not duplicate services or payments under Targeted Case Management, Health Care Home care coordination, Assertive Community Treatment, Relocation Services Coordination, or Home and Community-Based Waivers when there are case management services provided. Individuals will receive information on the various case management options to determine where their needs are best met.

Services

In a behavioral health home, recipients identified with serious mental illness will have their comprehensive physical and behavioral health needs addressed in a coordinated manner. This includes care planning to address chronic conditions (e.g. addressing steps to meet the recipients health goals), ongoing coordination of care between behavioral and physical health (e.g. comprehensive review of all prescribed medications), and coordination with medical and behavioral specialists not at the BHH site

(e.g. appropriate use and timing of elective surgery). Where appropriate, non-clinical service coordination will be added so that individuals will have health care coordinated with social and community supports. Appropriate family and patient support includes education to improve self-management.

“Health Home Services” as articulated by the Affordable Care Act, Section 2703 and in Minnesota State law (256B.0757) requires:

1. Comprehensive care management, using team-based strategies,
2. Care coordination and health promotion,
3. Comprehensive transitional care between health care and community settings,
4. Individual and family support, including authorized representatives,
5. Referral to community and social support services, and
6. The use of health information technology to link services, as feasible and appropriate.

Several of these services, including health and wellness, direct education and support to family members, and intentional support with transitions, are not traditionally covered under Medicaid and offer an opportunity to provide more person-centered care.

Initial engagement

Behavioral health homes will be responsible to conduct specific activities as part of the initial engagement with clients:

Recruitment

- Take referrals.
- Recruit potential clients.
- Initiate contact with potential clients.
- Schedule intake appointments.
- Engage in community outreach.

Intake

- Check Medicaid eligibility for potential clients.
- Provide clients with BHH program materials, including the rights and responsibilities document, and inform clients about the choice to participate.
- Gather client consent.
- Determine if a diagnostic assessment has occurred within the last 12 months and obtain results. If the diagnostic assessment has not occurred within the last 12 months, assist the client in scheduling an appointment with the licensed mental health professional to complete the updated assessment.
- Set up an appointment with the client for an initial assessment.

A Behavioral health home will be responsible for conducting minimum activities under each of the six federally required services.

Comprehensive Care Management

Comprehensive care management is a collaborative process designed to manage medical, social, and mental health conditions more effectively based on population health data and tailored to the individual patient.

Behavioral health homes will be responsible to conduct the following activities as part of the comprehensive care management services:

(Activities applicable to all patients collectively)

- Design and implement new activities and workflows that increase patient engagement and optimize clinical efficiency.
- Design and implement communication and care coordination tools, to ensure that care is consistent among a client's many providers, as well as between the provider and the BHH.
- Deploy electronic and non-electronic tools to effectively make use of best practices and evidence to guide care efficiently and correctly.

Population Health Management

- Use a searchable electronic health record and patient registry to collect individual and practice-level data that allows providers to identify, track, and segment the population, improve outcomes over time, manage BHH services, provide appropriate follow-up, and identify any gaps in care.
- Select common clinical conditions and target cohorts on which to focus and define the patient population.
- Use the patient registry information to report outcomes to DHS as needed.
- Monitor and analyze data to manage the patient panel
- The integration specialist must review the patient registry regularly to track individuals' medications, lab results, and symptom management and use this data to adjust treatment as needed.
- The registry must contain:
 - (1) for each participant, the name, age, gender, contact information, and identification number assigned by the health care provider, if any
 - (2) sufficient data elements to issue a report that shows any gaps in care for groups of participants with a chronic or complex condition; and
 - 3) additional fields to be determined by DHS.

(Activities specific to an individual patient within targeted populations)

- Meet with each client and evaluate their initial and ongoing needs. Elements to evaluate include the patient's clinical condition, feasibility of completing various interventions, and the patient's values, preferences and readiness to engage in self-management and treatment.
- Utilize care strategies including health information technology and other tools to communicate and coordinate with the patient and with other caregivers to ensure that the care plan is being executed safely and efficiently.

- Measure services and interventions offered, the reason for implementation or non-implementation, and outcomes of each intervention.

Care Coordination

Care coordination is the compilation, implementation, and monitoring of the individualized, holistic health action plan with the client's family or identified supports through appropriate linkages, referrals, coordination and follow-up to needed services and supports. Overarching activities of care coordination include the provision of case management services necessary to ensure individuals and their identified supports have access to medical, behavioral health, pharmacology and recovery support services (e.g. housing, access to benefits, vocational, social, and educational, etc.).

Specific care coordination activities are conducted with individuals and their identified supports, medical, behavioral health and community providers, and across and between care settings.

Behavioral health homes will be responsible to conduct the following activities as part of the care coordination services:

Initial assessment

- Assess the client's immediate safety and transportation needs and identify any barriers to participating in BHH services.
- Develop and implement an immediate needs plan for the client.

Comprehensive wellness assessment

- Conduct a comprehensive wellness assessment. The assessment process must begin within 30 days of intake and be completed within 60 days.
- Include a face-to-face meeting between the client and the systems navigator. The integration specialist must also meet with the client to complete components of the wellness assessment. In a mental health setting, the integration specialist must be an RN and focus on the individual's health care needs. In a primary care setting, the integration specialist must be a mental health professional and focus on the individual's mental health needs.
- Talk with internal and external professionals to gather information for the health action plan and make initial connections to begin establishing relationships required for ongoing care coordination.
- The assessment must include the skills, strengths, current resources, and current needs in the following areas:
 - Review of the diagnostic assessment;
 - Mental health and chemical/substance use and abuse knowledge of symptoms and illness management and treatment resources, and the individual's view of recovery;
 - Screenings for substance abuse using CAGE-AID or GAIN-SS tools, alcohol, and tobacco. A substance abuse screen is not required if a substance abuse disorder is already known and documented.
 - Health as it relates to chronic conditions, health wellness and literacy, lifestyle, self-management, and nutrition, access to health care, including information about the client's primary care doctor, primary care clinic, and dentist;
 - Culture and spiritual beliefs and practices;

- Employment and education;
 - Social functioning, including the use of leisure time;
 - Interpersonal functioning including relationship with family and social support network;
 - Self-care and independent living capacity;
 - Income, financial assistance and legal;
 - Risks and vulnerabilities;
 - Housing;
 - Transportation;
 - Program utilization; (e.g. food support, Minnesota Family Improvement Program, Minnesota Supplemental Aid, Child Care Assistance Program)
 - Access to food;
 - Access to child care;
 - Social services and community supports
 - Self-navigation and self-advocacy skills; and
 - Other domains as appropriate.
- Obtain appropriate releases of information as needed to gather information needed for the comprehensive wellness assessment. DHS will create a release of information template for BHHs to utilize if they do not have such a form already developed. All releases of information must follow Minnesota state privacy laws.
 - Conduct a portion of the assessment in the client's home/living situation. The client has the right to refuse services in their home.

Health action plan development

- Draft an initial health action plan based on the comprehensive assessment within 60 days of intake.
- Talk with the client to ensure that the health action plan is based on their identified needs and goals.
- Demonstrate the client-centered nature of the plan by including the client's goal statement in first person language and the client signature. Provide a copy of the plan to the client.
- Update the comprehensive assessment and health action plan at least every 6 months thereafter.

Ongoing care coordination

- Maintain regular and ongoing contact with the client and/or their identified supports to prevent unnecessary inpatient readmissions, emergency department visits and/or other adverse outcomes such as homelessness, loss of established care/service providers, and loss of employment/schooling.
- Monitor client progress on goals in the health action plan and the need for plan alterations.
- Monitor the use of routine and preventative primary care, dental care, and well-child physician visits.
- Conduct appropriate referrals.
- Assist the client in setting up needed appointments, preparing for appointments, and accompanying the client to appointments as appropriate.
- Assist the client in follow-up care and follow-through on recommendations from the appointment(s).

- Initiate and maintain coordination with client's providers and formal and informal supports to ensure that the client has the resources necessary to follow the health action plan.
- Identify and share individual level information in a timely manner with professionals and providers that are involved in the individual's care.
- Demonstrate engagement of area hospitals, primary care practices and behavioral health providers to collaborate for care coordination.
- Maintain current releases of information as needed for communication with providers that are involved in the client's care.
- Ensure linkages to medication monitoring if it is an identified need.
- Coordinate communication and collaboration within the BHH team on behalf of the client.
- Foster communication with and between the individual, their providers and their identified supports.

Health and Wellness Promotion Services

Health and wellness promotion services encourage and support healthy living and motivate individuals and/or their identified supports to adopt healthy behaviors and promote better management of their health and wellness. Health and wellness promotion services place a strong emphasis on skills development through health education and wellness interventions so individuals and/or their identified supports can monitor and manage their chronic health conditions to improve health outcomes.

Behavioral health homes will be responsible to conduct the following activities as part of the health and wellness promotion services:

- Provide clients with information to increase their understanding of the illnesses/health conditions identified in the comprehensive wellness assessment, and educate clients on how those conditions relate to and impact various facets of their life.
- Work with clients to increase their knowledge of illness-specific management as well as overall daily health maintenance.
- Support clients in activities aimed at increasing their self-management and reaching their health goals.
- Support clients in recovery and resiliency.
- Help clients and/or clients' identified supports to make healthy lifestyle choices within their budget.
- Provide onsite coaching, classes, and information on topics including: wellness and health-promoting lifestyle interventions, substance use prevention/early intervention and harm reduction, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy support, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, increasing physical activity, and promoting independence and skill development related to self-administration of medications.

Comprehensive Transitional Care

Comprehensive transitional care activities are specialized care coordination services that focus on the movement of individuals between or within different levels of care or settings or while shifting from the use of reactive care and treatment to proactive care via health promotion and health management. Transition services are designed to streamline plans of care and crisis management plans, reduce barriers to timely access, reduce inappropriate hospital, residential treatment, and nursing home admissions, interrupt patterns of frequent emergency department use, and prevent gaps in services

which could result in (re)admission to a higher level of care or longer lengths of stay at an unnecessary level of care.

Behavioral health homes will be responsible to conduct the following activities as part of the comprehensive transitional care services:

- Ensure adequate and continuous client services and supports following and in between services and settings such as, hospitalization, homelessness, shelters, domestic violence shelters, residential treatment, prison, juvenile justice, children and family services, treatment foster care, foster care, special education and other settings and services with which the client may be involved.
- Participate in discharge planning in collaboration with the individual and the appropriate facility staff to assist in the development and implementation of the transition of the client to the least restrictive setting possible.
- Advocate with the client to ensure that clients/families are included in transition planning.
- Work with other agencies to ensure that information is shared between agencies regarding a transition.
- Establish a protocol for contacting clients and/or their identified supports and services following discharge from hospitals, residential treatment, and other settings, to assure clients are reconnected to ongoing services and community and social supports.

Referral to Community and Social Support Services

Referral to community and social support services occurs in collaboration with the client and/or their identified supports. The BHH provider identifies and provides referrals to a variety of services and assists clients in setting up appointments, preparing for appointments, and accompanying the client to appointments as appropriate.

Behavioral health homes will be responsible to conduct the following activities as part of the referral to community and social supports services:

- Connect clients to community resources as identified in their comprehensive wellness assessment, including but not limited to, medical and behavioral health care, entitlements and benefits, respite, housing, transportation, legal services, educational and employment services, financial services, wellness and health promotion services, specialized support groups, substance use prevention and treatment, social integration and skill building, and other services as identified by the individual and/or their identified supports.
- Check in with the client and their family after a referral is made in order to confirm if they need further assistance in scheduling or preparing for appointments, or assistance in following up after connecting with community resources.
- Maintain adequate knowledge of agencies and resources in order to connect individuals and/or their caregivers to a wide array of support services to help them overcome access or service barriers, increase self-efficacy skills and improve overall health.

Individual and Family Support Services

Individual and family support services are activities, materials, or services aimed to help clients reduce barriers to achieving goals, increase health literacy and knowledge about chronic condition(s), increase self-efficacy skills, and improve health outcomes.

Behavioral health homes will be responsible to conduct the following activities as part of the individual and family support services:

- Assist clients and families with accessing self-help resources, peer support services, support groups, wellness centers, and other care programs focused on the need of the individuals and their families and/or identified supports.
- Assist clients with obtaining and adhering to prescribed medication and treatments.
- Offer family support and education activities.
- Support clients and/or clients' identified supports in improving their social networks.
- Teach individuals and families how to navigate systems of care in order to identify and utilize resources to attain their highest level of health and functioning within their families and community.

NOTE: Utilization of health information technology is federally required to link services, as possible and appropriate. BHH provider standards may evolve as experience is gained and as permitted by Minnesota law.

Provider Requirements

Federal requirements

Behavioral health home providers must have the capacity to perform the health home functions specified below by Centers for Medicare and Medicaid Services (CMS):

- 1) Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- 2) Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
- 3) Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- 4) Coordinate and provide access to mental health and substance abuse services;
- 5) Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
- 6) Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
- 7) Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
- 8) Coordinate and provide access to long-term care supports and services;
- 9) Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
- 10) Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- 11) Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

State requirements

DHS will certify behavioral health homes and providers must be enrolled as a Medicaid provider. Behavioral health homes must serve as the central point of contact for consumers and ensure person-centered development of a health action plan and implementation of services which improve experience of care, health outcomes and reduce avoidable health care costs.

At a minimum, BHH providers will be expected to:

- Be enrolled as a Medicaid provider and comply with the Medicaid program requirements.
- Successfully complete the State certification process and maintain certification by meeting standards as developed by the State.
- Demonstrate processes that allow them to understand and serve the BHH population.
- Maintain the required BHH team structure as described above and provide the federally required services of comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, referral to community and social support services, and use of health information technology to link services.
- Conduct comprehensive screenings and assessments that address behavioral, medical, and social service and community support needs.
- Create and maintain an individualized health action plan for each consumer that encompasses behavioral and physical health and social services and community supports.
- Use health information technology to link services, identify and manage care gaps; and facilitate communication among health home team members and other providers.
- Use an electronic health record and patient registry to collect individual and practice-level data that allows them to identify, track, and segment the population and improve outcomes over time.
- Establish processes in order to identify and share individual level information in a timely manner with professionals and providers that involved in the individual's care.
- Demonstrate engagement of area hospitals, primary care practices and behavioral health providers to collaborate with the Health Home on care coordination.
- Track individuals' medications, lab results, and symptom management and use this data to adjust treatment as needed.
- Demonstrate commitment by leadership to pursue integration and support practice transformation.
- Establish a continuous quality improvement plan, and collect and report data that will inform state and federal evaluations.

BHH teams will be integrated with both primary care and behavioral health providers:

- In a behavioral health setting, the required integrated team must include a nurse care manager.
- In a primary care setting, the team must include a licensed mental health professional.

Behavioral health home providers must also:

- Directly provide, or subcontract for the provision of, all required health home services.
- Maintain documentation of all team member qualifications in their personnel files.
- Participate in federal and state-required evaluation activities including documentation of behavioral health home services.

- Maintain compliance with all of the terms and conditions of a certified behavioral health home provider or will be discontinued as a provider of services.
- Provide a 60 day notice if they plan to discontinue the delivery of behavioral health home services. Providers must inform consumers that they will no longer provide services and support the individual in finding a new behavioral health home provider.

Team members

BHH services will be administered through a team based approach. The members listed below are the minimum requirements for a behavioral health home team, with the exception of an optional external professional. In order to qualify as one of these team members, a person must meet at least one of the qualifications listed below their title. One person can fill more than one membership roll.

Team Member: Client

Roles and Responsibilities

It is the responsibility of the client to voluntarily choose to participate in the behavioral health home (BHH). They are responsible for voicing their needs, concerns, questions, barriers, strengths, skills, desires and goals to their behavioral health home team with the support and assistance of the qualified health home specialist and the systems navigator as needed. They are responsible for communicating regularly with the behavioral health home team, including reaching out to appropriate team members as needed and returning phone calls, emails, and all other appropriate forms communication. They are responsible for engaging in the planning and implementation processes of their treatments and therapies.

Team Member: Team Leader

Required Qualification

- Clinic manager
- Other executives

Roles and Responsibilities

The team leader provides the BHH with executive leadership as a champion for integration. They determine the size and overall composition of the BHH team. They are responsible for ensuring that needed memorandums of understanding are in place and that the BHH has access to resources and tools including but not limited to overhead, health information technology, protected time on a calendar, support staff, medical records, and screening tools. They serve as the outward facing liaison to the wider community and provide administrative outreach to diverse communities. The team leader determines quality improvement and communication protocols for the BHH and is responsible for overseeing the certification and recertification process, and ensuring that the BHH meets all required reporting and evaluation responsibilities.

Team Member: Integration Specialist (Care Management)

Required Qualification

- Registered Nurse when BHH services are offered in a mental health setting.
- Mental health professional as defined in [M.S. 245.4871](#) Subd. 27, 1-6 or [M.S. 245.462](#) Subd. 18 1-6 when BHH services are offered in a primary care setting.

Roles and Responsibilities

The integration specialist position illustrates the importance that the BHH program places on integration of primary care and mental health. The integration specialist is the reciprocal professional whose required qualifications are contingent on the setting of the BHH. If the BHH is located in a mental health setting, the integration specialist must be a Registered Nurse whereas if the BHH is located in a primary care setting, the integration specialist must be a mental health professional.

With the guidance of their supervisor and in collaboration with the BHH team, the integration specialist is the primary team member responsible for providing the comprehensive care management within the BHH. The integration specialist will utilize the patient registry to manage medical, social, and mental health conditions based on population health data and tailored to the individual patient. The integration specialist is responsible for activities that are applicable to all patients collectively and to individual patients within the targeted populations.

The integration specialist is responsible for individual and family support services in relation to the management of population health. The integration specialist may also contribute to the provision of the other health home services and is also available to run wellness groups for clients as appropriate. In some settings, the integration specialist may serve as the supervisor of systems navigator or the same individual may serve both positions in settings where client populations are small.

Team Member: Behavioral Health Home Systems Navigator (Care Coordination)

Required Qualification

- Case manager as defined in [M.S. 245.4871](#) Subd.4, [M.S 245.462](#) Subd. 4 or
- Mental health practitioner as defined in [M.S. 245.4871](#) Subd. 26. or [M.S 245.462](#) Subd. 17

Roles and Responsibilities

With the guidance of their supervisor and in collaboration with the BHH team, the BHH systems navigator is the primary entity responsible for providing the care coordination within the BHH. The BHH systems navigator may contribute to the provision of health and wellness promotion services. In settings with a large client population, there may be multiple BHH systems navigator within one BHH. Conversely, in settings with small client populations, there may be one individual that fulfills the roles of both integration specialist and systems navigator. They are also available to conduct wellness groups as appropriate contingent on their individual training.

Team Member: Qualified Health Home Specialist

Required Qualification

- Community health worker as defined in [M.S. 256B.0625](#) Subd. 49
- Peer support specialist as defined in [M.S. 256B.0615](#)
- Family peer support specialist (upcoming definition and certification at DHS),
- Case management associate as defined in [M.S. 245.462](#) Subd.4 (g) or [M.S. 245.4871](#) Subd. 4 (j),
- Mental health rehabilitation worker as defined in [M.S. 256B.0623](#) Subd. 5 (4)

Roles and Responsibilities

The qualified health home specialist serves as a coach whose primary focus is to support and assist clients in reaching their goals. They interact with the clients on the phone or in person on a regular basis to build trusting relationships and assist the client with identifying barriers to accessing care. They can meet with a client before appointments, help clients organize health concerns and prioritize issues to discuss with health providers. They can also meet with clients after office visits to review provider instructions and check for client understanding and access to resources to follow provider instructions. They provide ongoing motivation, encouragement, and positive feedback when the client makes constructive changes or progress.

With the guidance of their supervisor and in collaboration with the BHH team, the qualified health home specialist is the primary entity responsible for the health and wellness promotion services and assists the BHH systems navigator in coordinating care, serving as the secondary entity responsible for care coordination services.

The qualified health home specialist is responsible for providing individual and family support services on a regular basis for overall client needs. The qualified health home specialist may contribute to the provision of the comprehensive transitional care and referral to community and social support services. Qualified health home specialists are also available to conduct wellness groups as appropriate contingent on their individual training. There may be multiple qualified health home specialists dependent on the size of the BHH.

Team Member: Consulting Physicians

Required Qualification

- Primary care physician
- Psychiatrist
- Psychologist
- Specialized MD/ therapist

Roles and Responsibilities

The consulting physician is not a required team member but rather an option contingent on the needs of the client. The consulting physician is responsible for ongoing case consultation and recommendations for the health action plan and may contribute to the provision of BHH services through case consultation.

Team Member: External Professionals

Required Qualification

Professionals from organizations that provide:

- Housing
- Food
- Special education
- Criminal/justice system
- Respite care

- Social support services
- Additional community support services

Roles and Responsibilities

The external professional is not a required team member but rather an option contingent on the needs of the client. As needed and appropriate, external professionals will provide recommendations for the health action plan and ongoing consultation, and may contribute to the provision of BHH services through case consultation.

Health Home Monitoring, Quality Improvement and Performance Measures

There are specific state monitoring, quality improvement reporting, and evaluation requirements expected under the federal health home provision. In addition, DHS has identified further performance measures to demonstrate outcomes for those served by BHH and to monitor service providers.

Monitoring

DHS will ensure there is a defined methodology, including data sources and measurement specifications, for:

- tracking avoidable hospital readmissions,
- calculating cost savings that result from improved chronic disease management, and
- tracking the use of health information technology in providing health home services to improve coordination and management of care and adherence to recommendations made by their provider.

Quality Improvement

As part of the continuous quality improvement process, DHS is required to report on a set of CMS quality measures including:

- reduction in hospital admissions,
- emergency room visits, and
- skilled nursing facility admissions.

Evaluation

DHS must provide assurance that it will report to CMS information submitted by behavioral health home providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act as described by CMS. DHS must also assure the completion of a state evaluation that assesses the impact of behavioral health home services on patient and family experience; health care utilization, and costs.

Additional State Performance Measures

DHS must create a set of performance measures specific to the targeted populations of adults and children with serious mental illness. These measures will include:

- Follow-up after hospitalization for mental illness,
- Use of Child and Adolescent Service Intensity Instrument (CASII) and Early Childhood Services Intensity Instrument (ECSII),
- Patient experience of care,
- Use of routine and preventative primary care,

- Use of dental care,
- Well-child physician visits,
- Screening for alcohol and other drug use, and
- Depression remission using PHQ-9 for adults.

Consumer and Stakeholder Engagement to Inform Design

Consumer Engagement

In planning for behavioral health homes, DHS contracted with the National Alliance on Mental Illness (NAMI) Minnesota to engage people living with mental illness across the state in an opportunity to shape policy. Through their participation in focus groups, Medicaid participants from a very wide range of communities provided feedback on topics that will inform the development of Minnesota's behavioral health home model. The focus group questions concentrate on topics such as: accessing physical and mental health care, transition of care experiences, methods of obtaining health information, opinions surrounding the facets of integrated care, and the ways in which individual, cultural, spiritual, and gender values should be incorporated into the care process.

The final NAMI report will be posted on the DHS website.

Stakeholder Engagement

Stakeholder engagement activities to date have included short and longer-term advisory workgroups, a Request for Information, and a learning community.

An initial short-term advisory workgroup for preliminary input on behavioral health home planning was held in the winter of 2013. This group was one of five workgroups providing input to DHS as part of what was called the Adult Mental Health Reform initiatives informing the Reform 2020 report.

A long-term BHH Advisory Group was developed and began meeting in August of 2013 and has met 11 times. The group is scheduled to meet at least quarterly and represents over 26 different stakeholder groups.

A Request for Information (RFI) was issued in April 2013 seeking public input and comments regarding improved integration and coordination of behavioral health and primary care services for Medical Assistance (MA) recipients. Findings were used to inform the design of the health home framework.

DHS has also established a behavioral health home first implementers learning community of providers that are interested in becoming certified behavioral health homes. This group will share best practices about how to best meet person's individual needs including person-centered planning and supporting integrated service delivery. Behavioral health home first implementers will also receive support from DHS in preparation for certification. Thirty-six agencies across the state indicated interest in participating in this group. An initial needs assessment was conducted and will inform the development of curriculum focused on health home certification and on topics related to integration of mental and physical health. The group will use different modalities for sharing information, including regional meetings, webinars around specific health home topics, and group-based technical assistance. The group will begin meeting in February of 2015 and will for 18 months. An analysis will be completed to

determine if the modality is effective in increasing the capacity to provide integrated care; if it is funding will be sought to continue learning community activities.

Interaction with other programs in Minnesota

DHS is federally required to ensure that health home payments will not pay for duplicative services. Therefore, Minnesota will focus outreach to people that are not receiving Targeted Case Management, Assertive Community Treatment, Relocation Services Coordination, or Home and Community Based Waivers.

Health Care Homes

Health homes expand upon the concept of the more commonly used term, medical homes (in Minnesota referred to as Health Care Homes). Health Care Homes serve the general population and are multi-payer, whereas Health Homes serve specific populations and is Medicaid only. We anticipate that several Health Care Homes will move towards dual certification. We expect that if an individual is receiving primary care through a HCH and also wants to receive BHH services that the providers communicate with one another. A client cannot receive care coordination services through a HCH and a BHH.

State Plan Amendment

States are required to submit a State Plan Amendment (SPA) and enter into negotiations the Centers for Medicare and Medicaid Services (CMS). Services may not begin until federal approval is obtained.

The BHH SPA is in draft form and will be posted for public comment by March 2015. DHS is scheduled to submit the SPA in the 2nd quarter of 2015. DHS must also obtain a legislative appropriation to implement the proposal as currently developed. If the legislative proposal does not move forward this legislative session the model, services, and payment must fit under the existing Health Care Program.

Additional resources related to health homes

Websites with additional information:

<http://www.dhs.state.mn.us/>

<http://www.integration.samhsa.gov/integrated-care-models>

<http://www.thenationalcouncil.org/areas-of-expertise/integrated-healthcare/>

For additional information related to Behavioral health homes in Minnesota, please contact Lisa Cariveau Lisa.Cariveau@state.mn.us

Appendix A

