
Behavioral Health Homes
in Connecticut

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 facilitate access to an inter-disciplinary array of behavioral health care, medical care, and community-based social services and supports for adults with chronic conditions

Background

- Section 2703 of the Affordable Care Act
- “State Option to Provide Health Homes for [Medicaid] Enrollees with Chronic Conditions”
- Application to the Centers for Medicaid and Medicare Services (CMS) via a Medicaid State Plan Amendment
- 90% Federal match (FMAP) for the first 8 quarters (as compared to the standard 50% match)

CMS Health Home Initiative Goals

- **Improve Experience in Care** – use care coordination and universal care plans and ongoing measurement of outcomes to continually enhance integration and coordination of behavioral health, primary, acute, and long-term services and supports
- **Improve Overall Health** – operate under a "whole-person" philosophy by providing a comprehensive array of early intervention, clinical and recovery support services across an inter-disciplinary team of primary care, behavioral health care, and community-based services and supports that promote health and recovery and improve lives
- **Reduce Per Capita Costs of Health Care** - while delivering high quality, integrated services (without harm whatsoever to individuals, families, or communities)

Why Develop a Specific Behavioral Health Home Model?

- Access to appropriate primary health care for individuals diagnosed with chronic behavioral health conditions - who are traditionally underserved in primary health care and often experience barriers in accessing appropriate care
- Mortality rate/age—People living with SPMI are dying 25 years 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

Behavioral Health Homes in CT

- The CT Behavioral Health Home model has been developed by the Department of Mental Health and Addiction Services (DMHAS) in collaboration with the Department of Social Services (DSS)
- The CT Behavioral Health Home model includes input from a CT BHH Workgroup with participants from various stakeholder groups, including the Connecticut Behavioral Health Partnership (CT BHP) Oversight Council and individuals in recovery and their families

The CT BHH Workgroup

Established parameters for defining **Eligibility** for BHH

- Established **Service Definitions**
- Identified **Provider Standards**
- Identified CT's BHH **Outcome Measures**
- Reviewed Medicaid and DMHAS enrollment **Data**

Connecticut's BHH Service Delivery Model

- Facilitates access to:
  - Inter-disciplinary behavioral health services,
  - Medical care, and
  - Community-based social services and supports for individuals with serious and persistent mental illness (SPMI).

Connecticut's BHH Service Delivery Model

- Builds on DMHAS' existing behavioral health infrastructure using LMHAs and their affiliates as designated providers to implement BHH services statewide in a targeted manner

BHH Provider Standards

- Meet state certification requirements
- Have capacity to serve individuals on Medicaid who are eligible for BHH services in the designated service area
- Have a substantial percentage of individuals eligible for enrollment in behavioral health home services
- Be an eligible member of the CT Medicaid Program

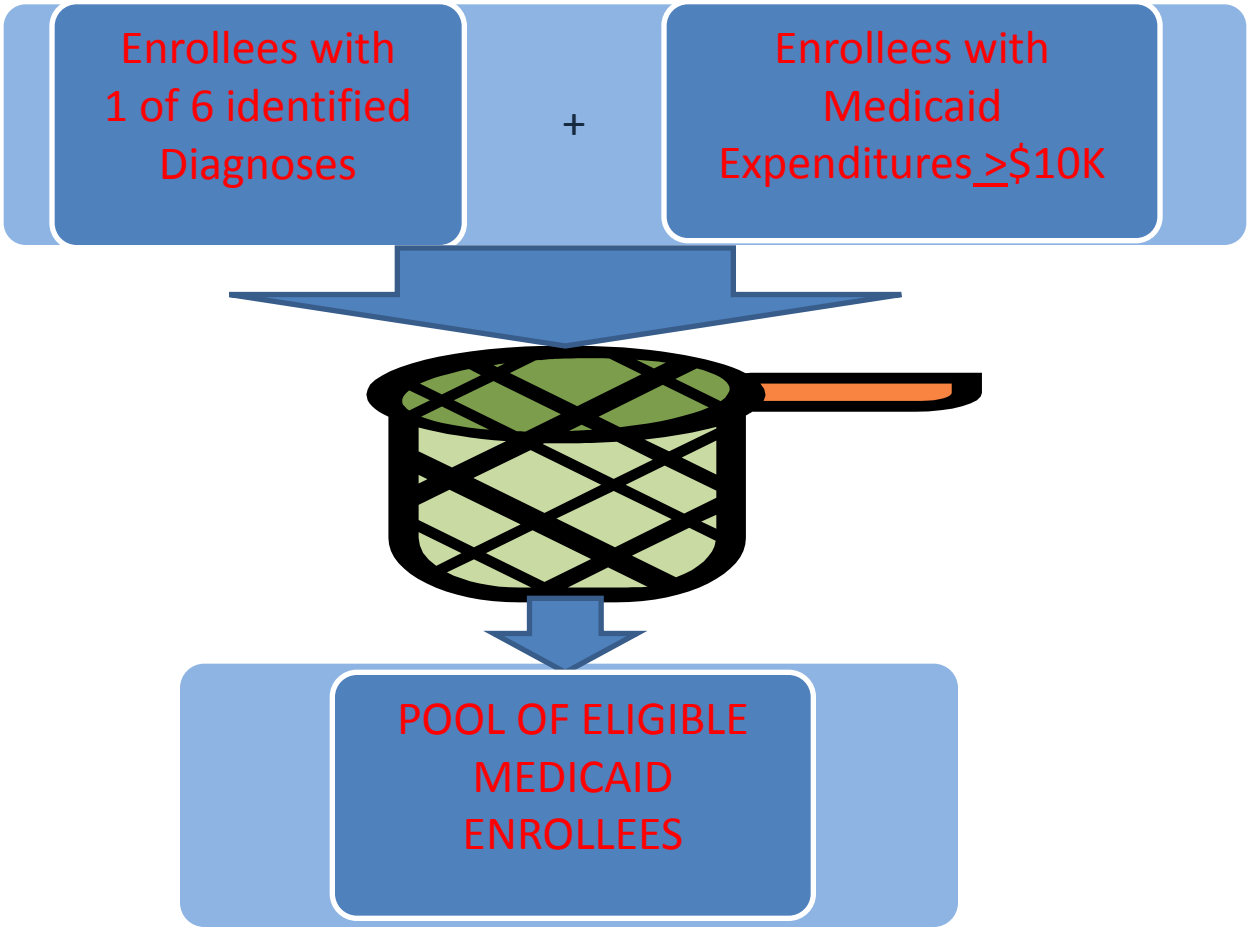
Connecticut BHH Eligibility

- Auto-Enrolled Mental Health Consumers include those with:
  - SPMI
    - Schizophrenia and Psychotic Disorders;
    - Mood Disorders;
    - Anxiety Disorders;
    - Obsessive Compulsive Disorder;
    - Post-Traumatic Stress Disorder; and
    - Borderline Personality Disorder.
  - Medicaid Eligibility
  - Medicaid claims $\geq$ $10k/year

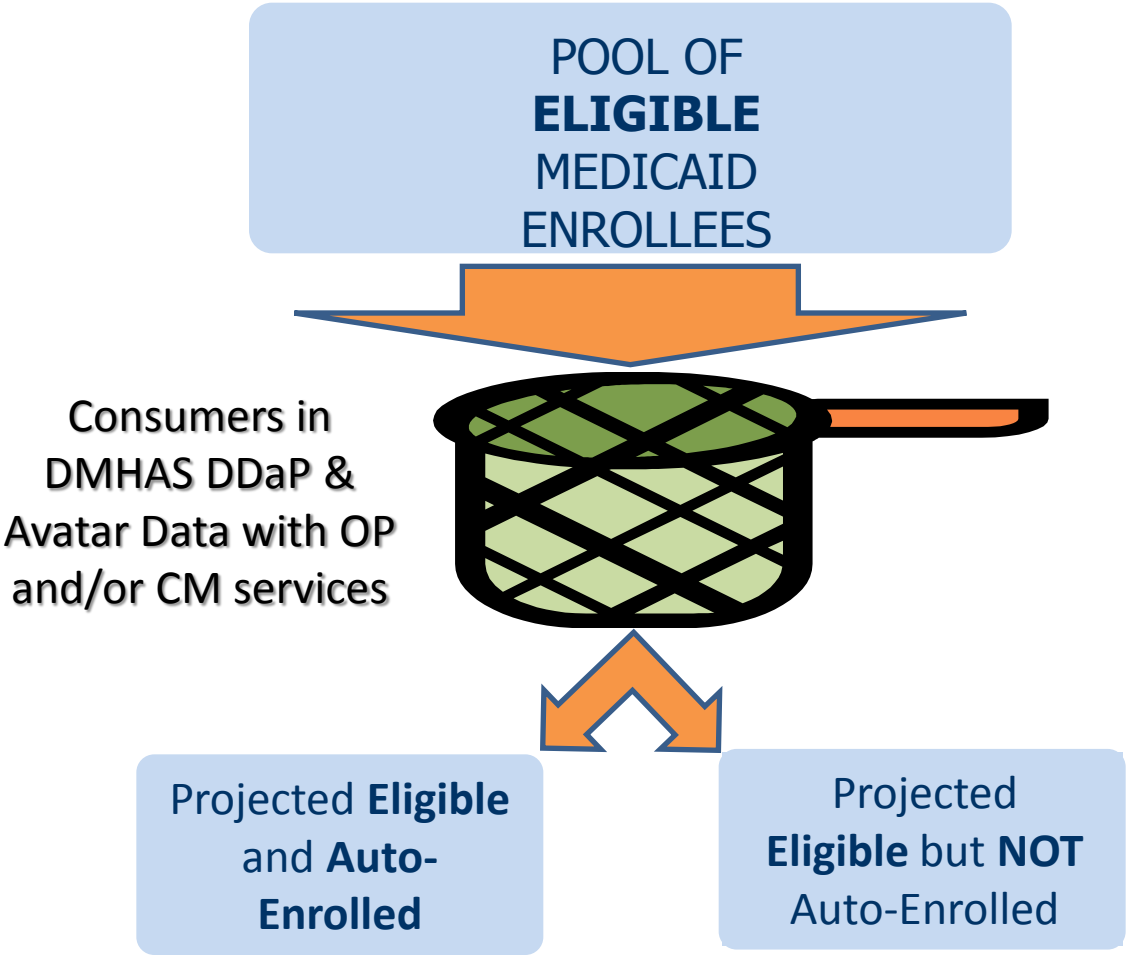
Data Sources

Identifying Consumers Eligible for Auto Enrollment

Medicaid CY 2012



Identifying Consumers Eligible for Auto Enrollment



Participation is Voluntary

- All individuals meeting eligibility criteria for BHH services will be auto-enrolled with their Behavioral Health provider of record
- Individuals may choose another designated BHH service provider or opt out of BHH services entirely

Behavioral Health Home Core Services

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Patient and family support
- Referral to community support services

Comprehensive Care Management

- Assessment of service needs
- Development of a treatment and recovery plan with the individual
- Assignment of health home team roles
- Monitoring of progress

Care Coordination

- Implementation of the treatment and recovery plan in collaboration with the individual to include linkages
- Ensuring appropriate referrals, coordination and follow-up to needed services and supports
- Ensuring access to medical, behavioral health, pharmacological and recover support services

Health Promotion

- Health education specific to an individual's chronic condition(s)
- Assistance with self-management plans
- Education regarding the importance of preventative medicine and screenings
- Support for improving natural supports/social networks
- Interventions which promote wellness and a healthy lifestyle

Comprehensive Transitional Care

- Specialized care coordination focusing on the movement of individuals between or within different levels of care
- Care coordination services designed to
  - Streamline plans of care
  - Reduce hospital admissions
  - Interrupt patterns of frequent Emergency Department use

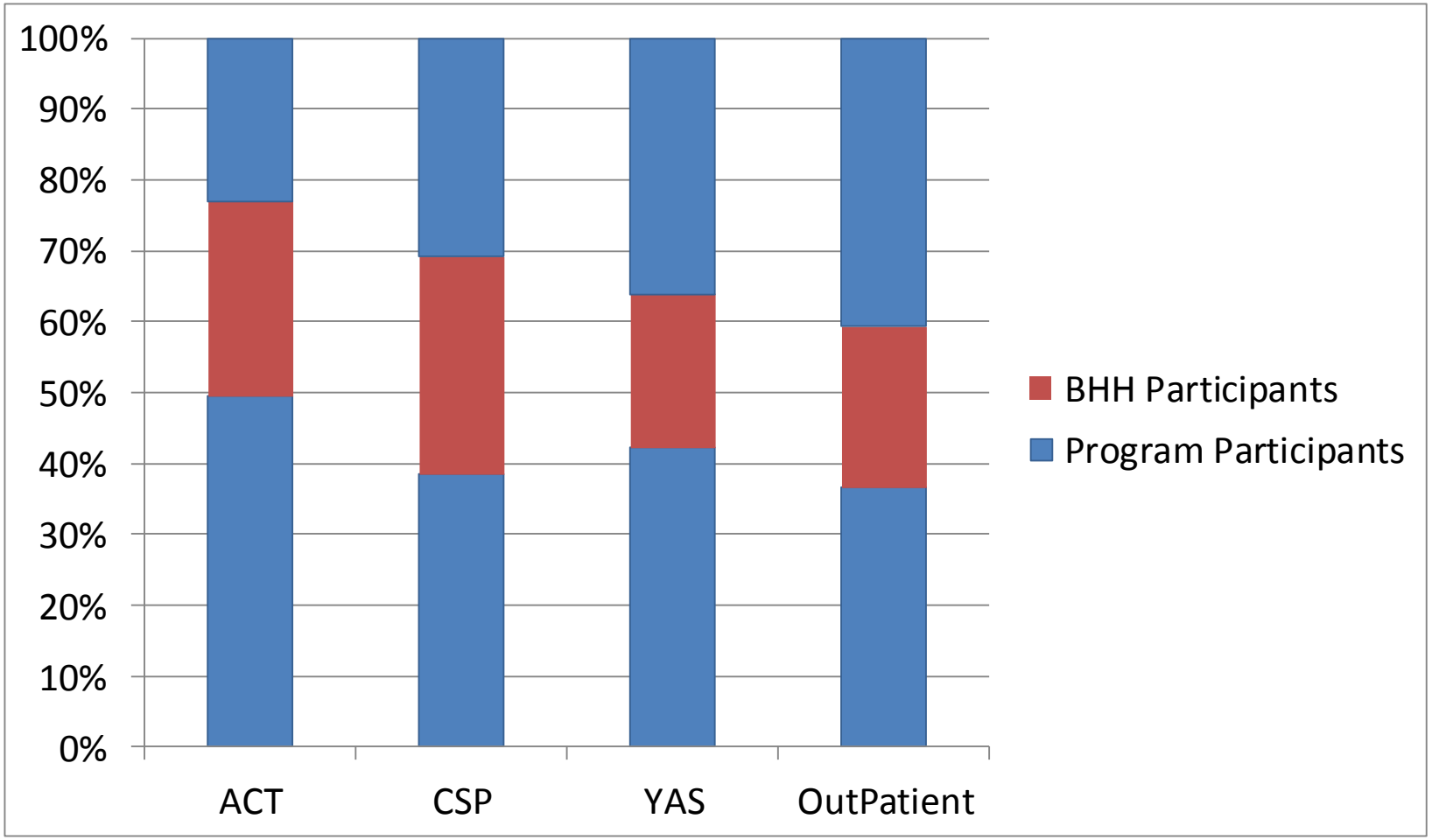
Patient and Family Support

- Services aimed at helping individuals to
  - Reducing barriers to achieving goals
  - Increasing health literacy and knowledge about chronic conditions
  - Increasing self-management skills
- Identifying resources to support individuals in attaining their highest level of wellness and functioning within their families and communities

Referral to Community Support Services

- Ensuring access to formal and informal resources which address social, environmental and community factors
- Assisting individuals to
  - overcome access or service barriers,
  - increase self-management skills and
  - improve overall health

BHH services will be provided within existing programs



BHH Services are consistent with CSP/RP and ACT

CSP/RP **(as defined by DMHAS)**	**BHH Services** **(as defined by CMS & CT BHH Workgroup)**
Functional Assessment (items 14-15)	Comprehensive Care Management
Individualized Recovery Plan (16-19) Skill-building interventions (22) Encounter notes (20)	Care Coordination
Skill-building interventions (22) Wellness Recovery Groups (24)	Health Promotion
TCM	Comprehensive Transitional Care
Peer specialist (1) Family education/support groups (25) Team has regular contact with family members (26)	Individual and Family Support
TCM	Referral to Community and Support Services

ACT **(as defined by DMHAS)**	**BHH Services** **(as defined by CMS and BHH Workgroup)**
Functional Assessment (item 19)	Comprehensive Care Management
Individualized Recovery Plan (20-21) Stages of change (23) Skill-building interventions (22)	Care Coordination
Skill-building interventions (22, 27) SA specialist (7) SA groups (24)	Health Promotion
TCM	Comprehensive Transitional Care
Peer Specialist (8) SA Specialist (7) Team has regular contact with family members (25) Family education/support groups (26)	Individual and Family Support
TCM	Referral to Community and Support Services

Health Home Expectations

- Increase care navigation, health promotion, wellness and recovery
- Person-centered care that improves health and recovery outcomes and individual experience in care
- Reduce unnecessary inpatient hospitalization and emergency room visits
- Reduce reliance on long-term care and improve quality of life in the community
- Enhance transitional care between inpatient settings and the community
- Reduce overall health costs

GOAL 1:

Improve Quality By Reducing Unnecessary Hospital Admissions And Readmissions

- Decrease the readmission rate within 30 days of an acute hospital stay
- Decrease the rate of ambulatory care-sensitive admissions
- Reduce ambulatory care-sensitive emergency room visits

GOAL 2:

REDUCE SUBSTANCE USE

- Increase the number of tobacco users who received cessation intervention
- Increase the percentage of adolescents and adults with a new episode of alcohol or other drug dependence (AOD) who initiated AOD treatment or engaged in AOD treatment

GOAL 3:

IMPROVE TRANSITIONS OF CARE

- Increase the percentage of those discharged from an inpatient facility for whom a transition record was transmitted for follow-up care within 24 hours of discharge
- Increase the percentage of individuals who have a follow up visit within 7 days of discharge from an acute hospitalization for mental health

GOAL 4:

IMPROVE THE PERCENT OF INDIVIDUALS WITH MENTAL ILLNESS WHO RECEIVE PREVENTIVE CARE

- Improve BMI education and health promotion for enrolled individuals
- Early intervention for individuals diagnosed with depression

GOAL 5:

IMPROVE CHRONIC CARE DELIVERY FOR INDIVIDUALS WITH SPMI

- Increase the percentage of individuals with a diagnosis of hypertension (HTN) whose blood pressure (BP) is adequately controlled
- Increase the percentage of individuals with asthma and who were dispensed a prescription for medication
- Increase the percentage of adults with diabetes, whose Hemoglobin HbA1c is within a normal range
- Increase the percentage of adults with coronary artery disease (CAD) whose LDL is within a normal range

GOAL 6:

INCREASE PERSON-CENTEREDNESS AND SATISFACTION WITH CARE DELIVERY

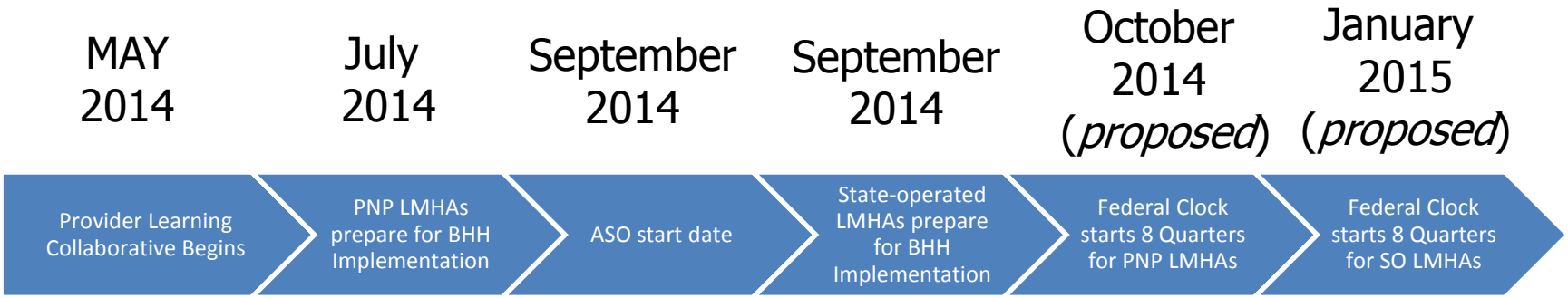
- Increase general satisfaction with care including:
  - access to care;
  - quality and appropriateness of care;
  - participation in treatment; and
  - cultural competence.

GOAL 7:

INCREASE CONNECTION TO RECOVERY SUPPORT SERVICES

- Decrease the number of individuals who experienced homelessness and increase housing stability
- Increase the number of individuals who become involved in employment and/or educational activities

CT BHH TIMELINE



Questions?

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www.ct.gov/dmhas/BHH