Connecticut Behavioral Health Homes
Service Definitions

Health Promotion Services

Health Promotion Services encourage and support healthy living concepts to motivate individuals to adopt healthy behaviors and promote self-management of their health and wellness. Health Promotion Services place a strong emphasis on self-direction and skills development through health education and wellness interventions so individuals can monitor and manage their chronic health conditions to improve health outcomes. SAMHSA has defined the eight dimensions of wellness as Financial, Social, Spiritual, Health, Environmental, Emotional, Occupational and Intellectual which provides a helpful framework for Health Promotion Services.

Activities related to Health Promotion should look at individuals from holistic perspective and service shall include, but not be limited to:

- Health education and wellness interventions specific to individuals' chronic condition(s);
- Development of self-management with the individual;
- Education regarding the importance of immunizations and promotion of health screenings;
- Healthy lifestyle choices within one's budget;
- Health education about chronic conditions to family members and other natural supports;
- Support for improving social networks; and
- Wellness and health-promoting lifestyle interventions such as, but not limited to, substance use prevention/early intervention and harm reduction, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy, 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.

Care Coordination

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Care Coordination is the implementation and monitoring of the individualized person-centered care plan with active individual involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports, including referral and linkages to long-term services and supports to achieve outcomes consistent with individual needs, strengths and preferences.

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, across and between care settings to ensure all services are coordinated. Specific activities include, but are not limited to:

- Fostering communication with and amongst the individual, her/his providers and her/his identified supports
- Assistance in follow up care and follow through on recommendations
- Assistance with appointment scheduling and accessing and coordinating necessary health care and recovery support services as defined in the care plan, including transportation,
- Skill building and teaching/coaching to help individuals maximize independence in the community;
- Conducting referrals and follow-up monitoring
- Participating in hospital discharge processes and other care transition
- Outreach to engage, support and promote continuity of care to individual
- Ensuring linkage to medication monitoring if it is an identified need

Comprehensive Care Management

The goal of Comprehensive Care Management is the initial engagement to provide individuals with the needed information, education, and support necessary for them to make fully informed decisions about their care options so they may actively participate in their care planning.

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Individuals and their identified supports work with their identified care manager(s) and behavioral health, medical health and other community providers to identify and obtain the necessary supports and services to assist individuals to achieve and maintain their highest level of health and success. To that end, a comprehensive needs assessment is completed with each individual to help to identify their medical, behavioral health, pharmacology, housing and recovery and social support needs, as well as their current expectations, providers, benefits, preferences, choices, strengths, resources, motivation, and barriers.

Based on the completed comprehensive needs assessment, individuals and their identified supports will develop a person-centered care plan which prioritizes goals, identifies optimal outcomes and determines the assignment of the roles and responsibilities of health team members. Individuals and their identified supports will periodically reassess (no less than annually) the person-centered care plan by reviewing needs and goals, identifying the progress made toward meeting those goals to achieve positive outcomes and determine the individuals' satisfaction with services. Adjustments are made in the plan accordingly each time the plan is reassessed.

Comprehensive Care Management services include outreach and engagement to support and promote continuity of care to individual and follow a tiered approach (high, medium, low) based on individuals' assessment of needs, plan of care, and desired participation in health home services. Service guidelines will be available for care management teams to follow as the health conditions and risk levels of individuals change, and outcome reports that indicate progress toward meeting outcomes for individual satisfaction, health status, service delivery and costs will be developed and disseminated to all health home participants.

Individual and Family Support Services

Individual and Family Support Services are aimed to help individuals reduce barriers to achieving goals, increase health literacy and knowledge about chronic condition(s), increase self-management skills such as advocacy, and improve health outcomes. Care Coordinators must ensure that individual care plans accurately reflect the preferences, goals, resources, and optimal outcomes of the individual and her/his identified supports. All communication and information shared with individuals and their identified supports must be language, literacy, and culturally appropriate and executed in a location and time convenient to the individual and her/his identified supports.

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Services can include, but are not limited to:

- Assistance in accessing self-help, peer support services, technology such as smart phones, support groups, wellness centers, and other self-care programs;
- Teaching and coaching self-advocacy for individuals and families;
- Health education, wellness promotion, and prevention and early intervention services;
- Assistance in identifying and developing social support networks;
- Assistance with obtaining and adhering to prescribed medication and treatments; and
- Helping to identify new resources to aid in reduction of barriers to help support individuals attain their highest level of health and functioning within their families and community, including non-medical recovery supports such as transportation and housing.

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 (medical, behavioral health, long-term care, home, prison, other community settings, e.g, shelter) while shifting from the use of reactive care and treatment to proactive care via health promotion and self management. Services are designed to streamline plans of care and crisis management plans, reduce barriers to timely access, reduce inappropriate hospital 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.

Collaboration and real time notification of admissions and discharges to and from acute and other care settings is crucial to facilitate interdisciplinary collaboration among providers (physicians, nurses, social workers, discharge planners, pharmacists, etc.). Therefore, the health home team must maintain collaborative relationships with hospital emergency departments, housing providers, psychiatric units of local hospitals, long-term care, detox providers and other applicable settings.

The ensure seamless transitional care to the least restrictive setting, the care coordinator will collaborate with the individual and appropriate facility staff to assist in the development and implementation of a discharge or transition plan. The care coordinator will also develop and implement a systematic follow-up protocol with individuals, as they change levels of care or providers within the same level of care, to ensure timely access to follow-up care, medication education and reconciliation, and other needed services/supports.

Referral to Community and Social Support Services

Referrals to community and socials support services ensure individuals will have access to a myriad of formal and informal resources which address social, environmental and community factors all of which impact overall holistic health. Local agency and resource knowledge is required to connect individuals to a wide array of support services to help individuals overcome access or service barriers, increase self-management skills and improve overall health. The Health Home Team must develop and nurture relationships with other community-based providers to aid in effective individual referrals and timely access to services.

The types of community and social support services to which individuals will be referred may include, but are not limited to: medical and behavioral health care, entitlements/benefits, housing, transportation, legal services, educational and employment services, financial services, wellness and health promotion services, specialized support groups, substance use treatment, self-help, social integration and skill building, and other services as identified by the individual.