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 ≥ $10k/year
Data Sources

Calendar Year 2012

Medicaid Claims

DMHAS
DDaP and Avatar
Identifying Consumers Eligible for Auto Enrollment

Medicaid CY 2012

POOL OF ELIGIBLE MEDICAID ENROLLEES

Enrollees with 1 of 6 identified Diagnoses

+ Enrollees with Medicaid Expenditures >$10K
Identifying Consumers Eligible for Auto Enrollment

Pool of Eligible Medicaid Enrollees

Consumers in DMHAS DDaP & Avatar Data with OP and/or CM services

Projected Eligible and Auto-Enrolled

Projected Eligible but NOT Auto-Enrolled
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
<table>
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<td>Functional Assessment (items 14-15)</td>
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<td>Individualized Recovery Plan (16-19)</td>
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<td>Functional Assessment (item 19)</td>
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| 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

- **MAY 2014**: Provider Learning Collaborative Begins
- **July 2014**: PNP LMHAs prepare for BHH Implementation
- **September 2014**: ASO start date
- **September 2014**: State-operated LMHAs prepare for BHH Implementation
- **October 2014 (proposed)**: Federal Clock starts 8 Quarters for PNP LMHAs
- **January 2015 (proposed)**: Federal Clock starts 8 Quarters for SO LMHAs
Questions?

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