Health Home Population Criteria and Enrollment	
Geographic Area (Describe whether statewide or targeted. If targeted, describe if targeted by county, city, region, or other)	Statewide *-Need to determine if a phased-in approach will be used or if all will be implemented at once*
Population Criteria (Indicate if State will be using 2 or more chronic conditions, 1 and being at risk for another or 1 serious and persistent mental illness and include the targeted chronic conditions list.)	1 serious and persistent mental illness, defined as Schizophrenia and Psychotic Disorders (295.1-295.35, 295.60-295.75, 295.9x, and 297.1, Mood Disorders (296.0x, 296.3-296.6, 296.89), Anxiety (300.21-300.23), Obsessive Compulsive Disorder (300.3), Post-Traumatic Stress Disorder (309.81), and Borderline Personality Disorder (301.83),
Enrollment of Participants (Describe how the individuals will be assigned to the health home, including whether eligible individuals can opt-in to a Health Home or are auto-assigned with an option to opt-out):	Individuals who meet eligibility criteria and who are existing service users of a Behavioral Health Home will be auto-assigned to the provider from which they are currently receiving behavioral health services. Upon enrollment and notification, individuals will have the opportunity to choose another Behavioral Health Home provider or opt out of the Behavioral Health Home program completely without jeopardizing their existing services. *-CT plans to target initial enrollment to eligible individuals who are currently receiving behavioral health services at a Behavioral Health Home provider and who have Medicaid costs (behavioral, medical and pharmacological) greater than $10,000 in the previous year.*
Health Home Provider Requirements	
Provider Infrastructure (Indicate whether designated providers, team of health care professionals or health team)	Designated Providers
Types of Providers (Indicate the types of providers to be included, such as those listed in Section 1945(a)(5), 1945(a)(6), and 1945(a)(7). For each type, indicate provider qualifications and standards.)	Local Mental Health Authorities (LMHA) and LMHA contracted affiliate providers (Affiliates) will serve as designated providers of behavioral health home services. LMHAs are designated by the Department of Mental Health and Addiction Services and each has the specific responsibility for one or more catchment areas assuring statewide coverage. Many LMHAs have contracted Affiliates which are part of the LMHA system of care. These affiliated providers play a critical role in the overall system of care and provide system diversity, enhanced local geographic access to underserved populations and contribute to a comprehensive network of care. All designated providers will be required to meet state certification requirements, must have the demonstrated ability to provide the six core health home services, and must have substantial percentage of individuals eligible for enrollment in behavioral health homes as determined by the state.

	-Should providers have to have access to CSP and/or ACT services?
Provider Standards (Describe the State's minimum requirements and expectations for Health Homes providers)	In addition to being a state designated LMHA or Affiliate, all behavioral health homes will be required to meet the following state certification conditions, which may be amended from time-to-time as necessary and appropriate: 1. Meet state licensure requirements; 2. Be accredited by either The Commission on Accreditation of Rehabilitation Facilities or The Joint Commission; 3. Be an eligible member of the CT Medicaid Program; 4. Have capacity to serve individuals on Medicaid who are eligible for behavioral health home services in the designated service area; 5. Meet staffing requirements to ensure behavioral health home team composition and roles; 6. Meet enhanced access requirements including enhanced enrollee access to the health home team and 24/7 access to crisis intervention and other needed services; 7. Have a strong, engaged leadership committed and capable of leading the provider through the transformation process as demonstrated by the agreement to participate in learning collaboratives and other technical assistance; 8. Conduct a standardized assessment and complete status reports to document enrollees' living arrangement, employment, education, legal, entitlement, custody, etc.; 9. Develop and maintain a single person-centered care plan that coordinated and integrates all behavioral health, primary care, and other needed services and supports with documentation to demonstrate that behavioral health home services are being delivered in accordance with program rules and requirements; 10. Conduct wellness interventions as indicated based on enrollees' level of risk; 11. Agree to convene regular documented behavioral health home team meetings for case consultation and implementation of practice transformation; 12. Within three months of implementation, develop a contract or MOU with regional hospitals or provider systems to ensure a formalized relationship for transitional care planning, to include communication of inpatient admissions as well as identification of individuals seeking Emergency Department (ED) services (for children, these MOUs should build upon those executed between EDs and emergency mobile psychiatric service providers); 13. Within threes months of implementation, develop and maintain referral agreements with regional primary care practices or federally qualified health centers; 14. Have a comprehensive data collection system capable of communicating with the state's data system; 15. Have the capacity to collect and report data in the form and manner specified by the state on implementation progress, staffing, services, time/activities, outcomes, etc.; 16. Agree to participate in CMS and state-required evaluation activities; 17. Agree to site visits and auditing of records by the state, and develop quality improvement plans to address identified issues; 18. Maintain compliance with all terms and conditions as a behavioral health home provider or face termination; and 19. Implement a behavioral health home model that the state determines has a reasonable likelihood of being cost-effective. Improvement on outcome measures will be used to determine cost effectiveness prior to the calculation of return on investment.

Supports for Providers (Describe the methods by which the State will support health homes providers in meeting requirements for the service)	Providers will be supported in transforming service delivery by participating in statewide learning collaboratives. The state will assess providers' learning needs, as it is expected that there will be varying levels of experience with organizational change, transformation approaches, and knowledge on health home services. Behavioral health home providers will be required to participate in learning collaboratives specifically designed to aid in implementation. Learning collaboratives will be supplemented with provider specific technical assistance both on-site and via telephone. These learning activities will support providers to address the following components: 1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services utilizing a whole person approach to integrate behavioral health, primary care, and other necessary support 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 use 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/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.
Health Home Service Delivery System	
Type of Service Delivery System (Indicate whether services are provided Fee for Service, using Primary Care Case Management, using Risk-Based Managed Care, or	-*Ongoing conversations between DMHAS, DCF, and DSS. DMHAS would like to build upon current grant funded services with an additional payment for new BHH services.*

another service delivery system)	
Payment Methodology	
Type of Payment Methodology (Indicate whether services are provided Fee for Service, using Primary Care Case Management, using Risk-Based Managed Care, or another model)	*-Ongoing conversations between DMHAS, DCF, and DSS. DMHAS would like to build upon current grant funded services with an additional payment for new BHH services.*

Mandatory BHH Staff

Job Title	Payment Methodology	Sample Job Duties	Staff:Individual Ratio
BHH Director	*All TBD*	a. Provides leadership to the implementation and coordination of Healthcare Home activities b. Champions practice transformation based on Healthcare Home principles c. Develops and maintains working relationships with primary and specialty care providers including inpatient facilities d. Monitors & reports performance, outcomes, and leads improvement efforts e. Designs and develops administrative and clinical policies and procedures f. Provides training and supervision to BHH team members	1:600
Primary Care Nurse Care Manager		a. Develops wellness, health promotion & prevention initiatives b. Facilitates health education groups c. Participates in the initial treatment plan development for all BHH enrollees d. Assists in developing treatment plan health care goals for individuals with co-occurring chronic diseases e. Consults with BHH Specialists about identified health conditions f. Assists in contacting medical providers & hospitals for admission/discharge g. Provides training on medical diseases, treatments & medications h. Tracks required assessments and screenings i. Monitors HIT tools & reports for treatment, medication alerts & hospital admissions/discharges	1:200
PCP Consultant		a. Participates in treatment planning b. Consults with psychiatrist/APRN c. Consults regarding specific consumer health issues	1 hour/ind/year

		d. Assists coordination with external medical providers	
BHH Administrative System Specialist		a. Referral tracking b. Training and technical assistance c. Data management and reporting d. Scheduling for Health Home Team and enrollees e. Chart audits for compliance f. Reminding enrollees regarding keeping appointments, filling prescriptions, etc. g. Requesting and sending medical records for care coordination	1:600
Peer Recovery Specialist		a. Helps individuals recognize their capacity for recovery and resilience b. Models successful recovery strategies c. Assists individuals with identifying strengths and personal resources to aid in their recovery d. Helps individuals set and achieve recovery goals e. Assists individuals in setting goals and following through on wellness and health activities f. Conducts wellness and health promotion activities	1:200
Transition Coordinator		a. Maintains good working relationships with hospital inpatient unit and emergency departments b. Engages individuals upon admission to the hospital and visits regularly to assist in discharge planning c. Engages individuals and their families in their discharge plan by providing needed resources and tools to ensure a smooth transition d. Upon discharge, ensures scheduling of follow-up appointments, medication reconciliation, schedules transportation, coordinates other needed services, etc.	1:600
BHH Specialists		a. Continues to fulfill current CSP or ACT responsibilities b. Collaborates with Primary Care Nurse Care Manager and other team members to provide individualized services and supports c. Improves their skills in assisting individuals in meeting wellness and recovery goals and managing chronic illnesses\ d. Assists in the scheduling and coordination of medical appointments	1:75
MA Level Clinician		-*Under consideration*	
Psychiatrist/APRN		-*Under consideration*	

Health Home Services

Service Definition	BHH Staff Involved
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. 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.	**Comprehensive Care Management** Conducted by BHH Director and or Nurse Care Managerwith the participation of other health team members as appropriate.
Care Coordination 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.).	**Care Coordination** Team based approach with tasks being completed under the direction of the Nurse Care Manager by BHH Specialists and or Peer Recovery Specialists

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	
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.	**Health Promotion Services** Provided by any member of the Health Home Team under the direction of the Care Manager or other Team Lead

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. 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.	**Individual and Family Support Services** Provided by BHH Specialists and or Peer Specialists under the direction of the Nurse Care Manager
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.	**Comprehensive Transitional Care** Provided by Transitional Care Coordinator under the direction of the Nurse Care Manager

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.	**Referral to Community and Social Support Services** Provided by BHH Specialists and or Peer Specialists under the direction of the Nurse Care Manager

Evaluations – Describe how the state will collect information from health home providers for the purpose of determining the effects of this program on reducing:

Recommended Connecticut-Specific Health Home Measures

Below is a list of proposed DMHAS Health Home outcome goals and quality measures. The measures are listed under each specific goal and include alignment with other quality measurement initiatives, desired clinical outcome, data source, and a description of the overall measure, the numerator and the denominator.

GOAL 1: IMPROVE QUALITY BY REDUCING UNECCESSARY HOSPITAL ADMISSIONS AND READMISSIONS

A. **Plan All-Cause Readmissions:** (CMS Core Health Home Set, Medicaid Adult Core Set Measure, HEDIS, National Quality Forum (NQF))
Desired Clinical Outcome: Decrease the readmission rate within 30 days of an acute hospital stay for individuals aged 18 years of age and older.
Data Source: Claims data

B. **Ambulatory Care-Sensitive Conditions Admissions:** (CMS Core Health Home Set)
Desired Clinical Outcome: To decrease the rate of Ambulatory Care- Sensitive Admissions for conditions where appropriate ambulatory care prevents or

reduces the need for inpatient admission to a hospital.
Data Source: Claims data

C. **Emergency Department Visits: (**algorithm from SAMHSA National Outcome Measures)
Desired Clinical Outcome: To reduce ambulatory care-sensitive emergency room visits.
Data Source: Claims data

GOAL 2: REDUCE SUBSTANCE USE

A. **Tobacco Cessation Intervention** (Collected as part of HEDIS CAHPS Supplemental Survey, Medicaid Adult Core Set, NQF)
Desired Quality Outcome: Increase the number of tobacco users who received cessation intervention.
Data Source: Paper Record, HIT

B. **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment** (CMS Health Home Core Set , Meaningful Use 1 and 2, Medicaid Adult Core Set, HEDIS, NQF)
Desired Quality Outcome: Increase the percent of adolescents and adults with a new episode of alcohol or other drug dependence (AOD) who initiated AOD treatment or engaged in AOD treatment.
Data Source: Claims data

GOAL 3: IMPROVE TRANSITIONS OF CARE

A. **Transition Record Transmitted to Health Care Professional (**CMS Health Home Core Set, Medicaid Adult Core Set, NQF)
Desired Clinical Outcome: Increase the percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.
Data Source: Paper records, HIT

B. **Follow-up After Hospitalization for Mental Illness** (CMS Health Home Core Set, Medicaid Adult Core Set, HEDIS, NQF)

Desired Clinical Outcome: Increase the percentage individuals who have a follow up visit within 7 days of discharge from an acute hospitalization for mental health.
Data Source: Claims

GOAL 4: IMPROVE THE PERCENT OF INDIVIDUALS WITH MENTAL ILLNESS WHO RECEIVE PREVENTIVE CARE

A. **Adult Body Mass Index (BMI) Assessment (**CMS Health Home Core Set, Medicaid Adult Core Set, HEDIS)
Desired Clinical Outcome: Improve BMI education and health promotion for enrolled individuals.
Data Source: Claims, Paper Records

B. Screening for Clinical Depression and Follow-up (CMS Health Home Core Set, PQRS, CMS QIP, Medicare Shared Savings Program, Medicaid Adult Core Set, Meaningful Use 2, NQF)
Desired Clinical Outcome: Early intervention for individuals diagnosed with depression
Data Source: Claims data

GOAL 5: IMPROVE CHRONIC CARE DELIVERY FOR INDIVIDUALS WITH SPMI

A. Adult Asthma Control (Medicaid Adult Core Set, AHRQ Quality Indicator)
Desired Clinical Outcome: Increase the percentage of individuals 18-64 years of age who identified as having persistent asthma during the measurement year and the year prior to the measurement year and who were dispensed a prescription for either an inhaled corticosteroid or acceptable alternative medication during the measurement year
Data Source: Claims data

B. Controlling High Blood Pressure (CMS Health Home Core Set, Medicaid Adult Core Set, NQF, Meaningful Use 2)
Desired Clinical Outcome: Increase the percentage of individuals 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year
Data Source: Claims

C. HbA1c Level Screening (Medicaid Adult Core Set, NQF)

Desired Clinical Outcome: Increase the percentage of adults, age 18 to 75, with diabetes whose Hemoglobin HbA1c was within a normal range during the measurement period.
Data Source: Claims, Medical Record, HIT

D. Improve Cardiovascular Care for Individuals with CAD (Medicaid Adult Core Set, NQF)
Desired Clinical Outcome: Increase the percentage of adults, over age 18, with coronary artery disease (CAD**)** whose LDL was within a normal range during the measurement period.
Data Source: Claims, Medical Record, HIT

Goal 6: INCREASE PERSON-CENTEREDNESS AND SATISFACTION WITH CARE DELIVERY

A. General Satisfaction With Care, Access, Quality and Appropriateness (SAMHSA National Outcome Measures (NOMS)
Desired Quality Outcome: Increase general satisfaction with care; access to care; quality and appropriateness of care; participation in treatment; cultural competence
Data Source: Satisfaction survey, HIT

Goal 7: INCREASE CONNECTION TO RECOVERY SUPPORT SERVICES

A. Decrease Homelessness
Desired Outcome: To decrease the number of individuals who experienced homelessness *and* increase housing stability
Data Source: Medical Record, HIT

B. Increase Employment and Education Opportunities
Desired Clinical Outcome: Increase the number of individuals who become involved in employment and/or educational activities
Data Source: Medical Record, HIT