

Behavioral Health Home (BHH) Services

STANDARDS

Provider Standards

1. Population

- A. If you intend to provide BHH services to adults with serious mental illness (SMI) or serious and persistent mental illness (SPMI), you must have the ability to serve and meet the needs of adults with mental health conditions.
- B. If you intend to provide BHH services to youth (14–25 years old) with emotional disturbance (ED) or severe emotional disturbance (SED), you must have the ability to serve and meet the needs of youth with mental health conditions.
- C. If you intend to provide BHH services to children (0–13 years old) with ED or SED, you must have the ability to serve and meet the needs of children with mental health conditions.

Infrastructure Standards

2. Capacity

- A. Utilize an electronic health record (EHR).
- B. Use a patient registry to inform population management strategies, identify and manage care gaps, and facilitate communication among BHH services team members. Required elements include:
 - An indication that you completed the brief needs assessment, initial health wellness assessment and health action plan for each person
 - An indication that the integration specialist reviewed the health action plan for each person before it was finalized and reviewed the health action plan as part of the revision process for each person
 - Date the integration specialist met with the person
 - Primary physical and mental health diagnosis
 - Date of the person’s last physical exam with his or her primary care provider
 - Date of last dental exam
 - Screening dates and results for substance use disorder, alcohol and tobacco use
 - If applicable, referrals made based on substance use disorder and tobacco use screening results (yes/no)
 - If applicable, did the person follow-up on referrals made from substance use or tobacco use screening (yes/no)

2. Capacity

- Admission and discharge information
- Preferred language
- Need for interpreter

C. Meet process, outcome and quality standards developed and specified by the commissioner. The commissioner will collect data from BHH services providers as necessary to monitor compliance with certification standards.

D. Monitor and analyze data in your patient registry, and in the MN Provider Partner Portal, when performing population management.

3. Culture to support integration

A. Ensure administrative support and leadership buy-in across your provider organization to pursue integration, encourage change and remove barriers.

B. Maintain a team-based model of care, including regular coordination and communication between BHH services team members.

The following elements must be captured for every person but may be stored in the patient registry, electronic health record or other case management system. These elements must be accessible by all BHH services team members:

- Referrals based on physical health screening
- Name and contact information for the person's primary physician, mental health professional and, if applicable, specialty providers
- Name and contact information for the person's dentist
- Name and contact information for the family member(s) or supports that are identified by the person or family
- Medications and if applicable, lab results

C. Utilize BHH services team members responsible for the six BHH services and ensure each team member has the state-required credentials. All behavioral health home services must include the following team members:

Team member: Person receiving BHH services

When the person is a child or youth, parents or caregivers are key to the implementation of the BHH services and must be engaged throughout the process.

Team member: Integration specialist

Required Qualifications:

- When BHH services are offered in a mental health setting, the integration specialist must be a registered nurse (including advanced practice registered nurses)
- When BHH services are offered in a primary care setting, the integration specialist must be a mental health professional as defined in Minnesota Statutes, [section 245.4871](#), subdivision 27, clauses (1)–(6) or Minnesota Statutes, [section 245.462](#), subdivision 18, clauses (1)–(6)

Team member: Behavioral health home services systems navigator (care coordination)

3. Culture to support integration

Required Qualifications:

When behavioral health home services are offered in a mental health setting, the systems navigator must meet one of the following qualifications:

- A case manager as defined in Minnesota Statutes, [section 245.4871](#), subdivision 4 (excluding paragraph a), and Minnesota Statutes, [section 245.462](#), subdivision 4 (excluding paragraph a)
- A mental health practitioner as defined in Minnesota Statutes, [section 245.4871](#), subdivision 26 or Minnesota Statutes, [section 245.462](#), subdivision 17

When behavioral health home services are offered in a primary care setting, the systems navigator must meet one of the following qualifications:

- Case manager as defined in Minnesota Statutes, [section 245.4871](#), subdivision 4 (excluding paragraph a), Minnesota Statutes, [section 245.462](#), subdivision 4 (excluding paragraph a)
- Mental health practitioner as defined in Minnesota Statutes, [section 245.4871](#), subdivision 26, or Minnesota Statutes, [section 245.462](#), subdivision 17
- Have three years of experience providing care coordination to adults, youth or children with mental illness, **and either**:
 - Meet Minnesota Statutes, [section 245.4871](#), subdivision 4 (g) and one of the following:
 - subdivision 4 (b, 1-4)
 - subdivision 4 (d)
 - subdivision 4 (m)
 - Meet Minnesota Statutes, [section 245.462](#), subdivision 4 (f) and one of the following:
 - subdivision 4 (b, 1-3)
 - subdivision 4 (c)
 - subdivision 4 (j)

Team member: Qualified health home specialist

Required Qualifications:

The qualified health home specialist must meet one of the following:

- A community health worker as defined in Minnesota Statutes, [section 256B.0625](#), subdivision 49
- A peer support specialist as defined in Minnesota Statutes, [section 256B.0615](#)
- A family peer support specialist as defined in Minnesota Statutes, [section 256B.0616](#)
- A case management associate as defined in Minnesota Statutes, [section 245.462](#), subdivision 4, paragraph (g) or Minnesota Statutes, [section 245.4871](#), subdivision 4, paragraph (j)
- A mental health rehabilitation worker as defined in Minnesota Statutes, [section 256B.0623](#), subdivision 5, clause (4)
- A community paramedic as defined in Minnesota Statutes, [section 144E.28](#), subdivision 9
- A certified health education specialist

D. Establish a continuous quality improvement process for providing BHH services.

4. Approach to integration

- A. Implement one of three integration approaches: 1) an in-house model, 2) a co-located partnership model, or 3) a facilitated referral model. Based on the approach you choose, you must meet the following standards:
- Option 1. In-house model: Ensure communication across providers and coordination of services so that you deliver care that is fully integrated from the person’s perspective.
 - Option 2. Co-located partnership model: When BHH services are offered in a mental health setting, the BHH services team must arrange for health care providers to provide primary care services onsite. Conversely, when BHH services are offered in a primary care setting, the BHH services team must arrange for behavioral health services providers to provide behavioral health services onsite. Put processes in place beyond simple co-location to ensure effective communication and coordination between providers.
 - Option 3. Facilitated referral model: Primary care services are not provided onsite, but the behavioral health agency ensures coordination of care provided offsite. Conversely, behavioral health services are not provided onsite, but the primary care agency ensures coordination of care provided offsite.

For all options, integration specialists are expected to build relationships and facilitate the exchange of information for all care providers.

5. Federally required health home services

- A. Provide all six BHH services as required by the state:

1. [Comprehensive care management](#)
2. [Care coordination](#)
3. [Health and wellness promotion](#)
4. [Comprehensive transitional care](#)
5. [Individual and family support](#)
6. [Referral to community and social supports](#)

- B. Provide state-created materials about BHH services to people, including the consent form and rights and responsibilities document. Provide other information that helps people make an informed choice about whether to participate in BHH services.

- C. Maintain staffing ratios, as set by the state, to ensure BHH services team members adequately provide services to people.

To keep BHH services certification, you must maintain the following shared case-load ratios:

- One full-time equivalent (FTE) integration specialist for every 224 members
- One FTE systems navigator for every 56 members
- One FTE qualified health home specialist for every 56 members

The one FTE integration specialist can be split between two people, at .5 FTE per person. The one FTE for systems navigator can also be split between two people at .5 FTE per person. And, unless DHS approves an alternative staffing model, the one FTE for the qualified health home specialist can be split across up to four people, with a minimum of .25 FTE per person. (Providers can exceed the ratios up to 20 percent and still be in compliance with the standard.)

5. Federally required health home services

Providers must have adequate staff to deliver the required BHH services. The staffing ratios are based on the assumption that providers will implement caseloads on a pro-rated basis depending on the size of the population served. Providers may incrementally increase staffing based on the growth and needs of the population served as long as they meet and maintain the BHH services staffing ratios listed in the bullet points.

Alternative staffing model

Providers can propose an alternative staffing model for the qualified health home specialist role. DHS must review and approve proposals before the model is implemented.

D. Coordinate with the consumers' Minnesota Health Care Programs (MHCP) managed care plan, if applicable. If the person is enrolled in a managed care plan, you must:

- Notify the BHH services contact designated by the managed care plan within 30 days of completing intake
- Adhere to the managed care plan communication and coordination requirements described in the BHH services manual
- Share information with the managed care plan about incidents of hospital admission, discharge and emergency room use

E. Deliver services consistent with state standards for frequency and face-to-face contact.

- During the initial 90-day engagement period, you must meet face-to-face with the person to:
 - Complete the intake process and the brief needs assessment.
 - Complete the initial health wellness assessment within 60 days after intake.
 - Develop the health action plan within 90 days after intake.
- On an ongoing basis after the person's initial 90 days of receiving BHH services, you must:
 - Have personal contact with the person or the person's identified support at least once per month. This contact may include face-to-face, telephone contact or interactive video. A letter, voicemail or text alone does not meet the requirement for monthly personal contact.
 - Conduct a face-to-face visit with the person at least every six months to review the health action plan and update if necessary.

Providers must deliver services consistent with state standards for frequency and face-to-face contact for children and youth consumers as defined in the MHCP Provider Manual.

F. Use evidence-based practices that recognize and are tailored to the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting the person's health and health care choices. Examples include motivational interviewing and ecological modeling.

G. If a provider is no longer a certified behavioral health home, you must ensure that people receive continuity of BHH services by doing the following before terminating your BHH services:

- Provide a 60-day notice of termination of BHH services to all people receiving BHH service, DHS and managed care plans (if applicable)
- Assist your current people that receive BHH services to find a new BHH services provider

6. Comprehensive care management

- A. Have capacity to administer or refer people for physical health screening under national and state guidelines.
- See the [U.S. Preventive Services Task Force recommendations for adults](#)
 - See [Minnesota Child and Teen Checkups \(DHS-3379\) \(PDF\)](#) for children and adolescents up to 21 years old
- B. Follow up with the person to ensure he or she knows about resources appropriate to his or her screening results for physical health issues. Ensure that the BHH services team knows how to conduct referrals about physical health issues and how to ensure referrals are followed through. Demonstrate capacity to integrate physical health into comprehensive care planning.
- C. The integration specialist must review the health action plan for every person before the plan is finalized. The integration specialist must also review the health action plan as part of the revision process.
- D. Systematically use the patient registry to identify specific population subgroups requiring specific levels or types of care.
- E. Track peoples' medications and if applicable, lab results, and then use this data to coordinate recommendations for adjustments to treatment as needed.
- F. Have the capacity to administer required BHH services screenings for substance use disorder, alcohol and tobacco use. Use the CAGE-AID or GAIN-SS, or other tools approved by DHS, for screening for substance use disorder during the health wellness assessment.
- G. Demonstrate efforts to engage area hospitals, primary care practices, and behavioral health providers to collaborate on care coordination.

7. Care coordination

- A. Provide a central point of contact to ensure that people and their families can successfully navigate the array of services that impact their health and well-being.
- B. Deliver services in locations and settings that meet the needs of the person.
- C. Conduct a brief needs assessment at time of intake in collaboration with the person and his or her identified supports. This brief assessment will identify and address immediate safety and transportation needs, and potential barriers to participating in BHH services.
- D. Refer people to resources appropriate to their screening results. Know processes for referrals related to substance use disorder and ensure follow-through with referrals. Demonstrate capacity to integrate a treatment plan for substance use disorder into comprehensive care planning.
- E. Have capacity to assess a person's readiness for change and his or her capacity to integrate new health care or community supports into his or her life.

7. Care coordination

- F. Update the health action plan at least once every six months, or more frequently if there are significant changes to a person's needs or goals.
- G. Help the person set up and prepare for appointments. Accompany the person to appointments as appropriate, and follow up with the person.

8. Health and wellness promotion

- A. Coach people and their identified supports to increase self-efficacy, improve health management, maintain a healthy lifestyle and improve health outcomes.
- B. Offer or facilitate the provision of wellness and prevention education on evidenced-based curriculums specific to the prevention and management of common chronic conditions, the person's specific health conditions and the person's readiness for change.
- C. Support people in recovery and resiliency.

9. Comprehensive transitional care

- A. Ensure that the person and his or her family are included in transition planning.
- B. Access admission and discharge information, health profiles and service information from appropriate entities, as approved by the person and his or her identified supports.
- C. In partnership with the person and his or her identified supports, create a plan to follow after the person's discharge from hospitals, residential treatment and other settings. The plan should include protocols to:
 - Maintain contact between the BHH services team member(s) and the person and his or her identified supports during and after discharge
 - Link people to new resources as needed
 - Re-link people to existing services and community and social supports
 - Follow up with appropriate entities to transfer or obtain the person's service records as necessary for continued care

10. Individual and family support services

- A. Utilize the person's formal and informal supports to help the person's recovery, resilience and progress toward meeting his or her health goals.
- B. Use a person-centered planning approach to ensure the person's health action plan accurately reflects the preferences, goals, resources and optimal outcomes for the person and his or her identified

10. Individual and family support services

supports. Each health action plan must include the following elements:

- The goal(s) of the individual (and parent or guardian)
- Individual's strength(s) related to each goal (internal and external resources)
- Specific services and supports needed by the individual (and parent or guardian)
- Activities or action of applicable BHH services team member(s) to support accomplishing each goal
- Activities or action of the individual (and parent or guardian) for accomplishing each goal
- Names and contact information for BHH services team members
- Names and contact information of key professionals and service providers involved in the individual's care (list may include: primary care physician, medical specialists, mental health provider, school contact, financial worker, etc.)
- Crisis plan in case of an emergency or instances when additional support is urgently needed

- C. Offer or facilitate the provision of direct education and provide support to families, caregivers and other identified supports, related to chronic disease management and how to navigate complex systems of care.

11. Referral to community and social services

- A. Have a process in place to learn about and understand the person's culture, individual preferences and communication needs. Include the person when identifying resources to meet his or her communication needs.

- B. Have adequate knowledge of agencies and resources to connect people and their identified supports to appropriate support services that help them overcome access or service barriers, increase self-sufficiency skills and improve overall health.

This standard requires that you ensure people are aware of resources and are supported in efforts to access resources to address each person's identified goals and needs (i.e., county social services, housing and employment).

- C. Develop and nurture relationships with other community and social support providers to aid in effective referrals and timely access to services.