

# **Minnesota Health Care Programs Behavioral Health Home (BHH) Services**

## **Certification Process and Application Guide**

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September 2020

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# Introduction

DHS must certify organizations before they can provide behavioral health home (BHH) services to individuals. There are no fees charged by DHS in the certification process. The application and certification process is designed to validate that BHH services standards and requirements are met and to create opportunities for meaningful discussions with prospective providers before, during, and after the certification site visit. The initial certification process involves the following steps:

- Request to apply by requesting a BHH Services ID
- Submit application for certification
- Complete site visit

The request to apply for BHH services, the online certification application and this policies and procedures certification process guide should provide all of the information necessary to successfully complete the initial certification process. However, please contact the DHS BHH services team at [dhs.bhh.certification@state.mn.us](mailto:dhs.bhh.certification@state.mn.us) with any questions.

## Request to Apply

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The [Request to Apply for a BHH services ID](#) form is designed to gather information about how and where your organization intends to provide BHH services. The answers on the form provide DHS with the preliminary information needed to determine if your organization will be required to complete more than one application. DHS will contact your organization after you complete and submit the Request to Apply form. Within that correspondence, DHS will notify your organization whether or not you need to submit additional applications.

The [Request to Apply for a BHH services ID form](#) is available online.

### ***BHH services ID***

The [Request to Apply](#) for a BHH services ID form is how your organization is assigned a BHH services ID. The BHH services ID is a password assigned by DHS to Minnesota Health Care Programs (MHCP) enrolled providers who want to apply for certification to provide BHH services. DHS will assign a BHH services ID once we receive the completed form. We will send an encrypted email with your BHH services ID within three business days of the request.

### ***Person Responsible for the Oversight of BHH Services Team Operating Out of the Location Identified***

Please identify the executive-level leader within the organization who is responsible for ensuring that BHH services are integrated into the organization's operations, and that the BHH services team has the resources necessary to deliver BHH services in accordance with BHH services certification requirements.

### ***BHH Services Offered in Additional Locations***

The BHH services delivery model allows and encourages BHH services providers to deliver services in a setting of the person's choice. In some cases, organizations will deliver services from additional clinic or

agency locations. Certified BHH services providers must ensure that all sites operated by the organization where BHH services are delivered are enrolled as an MHCP provider. Go to the provider enrollment page on the [DHS website](#) to access forms and information on the MHCP enrollment process.

DHS may contact applicants that indicate multiple locations for additional information before being assigned a BHH services ID.

### ***Authorized Representative***

Your organization's authorized representative for BHH services is the person responsible for communication with DHS about the certification process and ongoing BHH services operations. The authorized representative does not need to be a member of the BHH services team.

## **Initial Certification Application**

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The application outlines the information that you must submit before a site visit. For the initial certification application, DHS will review the completed application, the required application attachments and possibly other information. DHS will respond with feedback if other information is needed to complete the application. Once the application is complete, we will schedule a certification site visit.

### **PRINT/PDF INSTRUCTIONS**

Please email a copy of your application to [dhs.bhh.certification@state.mn.us](mailto:dhs.bhh.certification@state.mn.us). Save a copy of the application for your records, including all attachments for future reference.

Once a complete application has been received, a DHS Care Integration Liaison will be assigned to begin evaluating the application and the evaluation process will begin.

Please anticipate that it will take DHS up to 45 business days after receipt of a completed application for DHS to schedule a site visit. A completed application includes all required documents that complies with all applicable BHH services standards. If DHS determines your application is incomplete and the submitted documents do not meet behavioral health home services certification standards, DHS will send you a written notice that the application is incomplete. The written notice will identify the information that is missing and provide you with 45 days to resubmit additional documentation.

### **ONLINE INSTRUCTIONS**

Along with this guide you should have received a link to the application.

You will need the link received from DHS with your BHH services ID to continue with the certification application.

**Step 1.** Select "Apply for Certification."

**Step 2.** Enter the BHH services ID that you received.

**Step 3.** Click on the “Lookup” button. This will pull up the information in your request for a BHH services ID.

## Step 1

## Step 2

## Step 3

*SELECT THE APPLICATION YOU WOULD LIKE TO SUBMIT <b>Apply for Certification</b>	BHH ID test6767	<b>Lookup</b>
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**Important:** After step 3 you must save the online application as a PDF to your desktop or network drive before entering information.

**After saving the application, close your browser and open the PDF you saved to your computer.**

**Complete the application, SAVE it again, THEN click submit at the bottom of the application.**

### *Application Guide*

This application guide will assist you in completing the application. We strongly recommended that you read through this information prior to completing the application as it will assist you in understanding the BHH services standards and requirements. The application guide follows the application section by section and application questions align with corresponding BHH services standards.

## **1: Population**

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1A) Briefly describe your organization’s capacity and history of working with the age group you intend to serve. Include the following:

- the population of people you intend to serve (such as age, conditions, and specific communities)
- the history of working with people who have mental illness
- any specific competencies to deliver services to this population
- the steps your organization has taken to begin providing BHH services, if your organization has not previously provided services to any of the following:
  - people with mental illness
  - the population you intend to serve

1B) Briefly describe the services you currently provide. DHS requests this information to further assess your organization’s capacity to meet the needs of this population.

## **2: Infrastructure and Population Health Management**

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BHH services providers must demonstrate a capacity to use health information technology per the federal requirements. Health information technology supports communication and care coordination among team members, providers and people receiving services (including their supports). At minimum, we expect every BHH services provider has an electronic health record (EHR) and patient registry.

2A) EHRs are an essential part of this health information technology infrastructure. They are defined as a longitudinal electronic record of patient health information generated in a care delivery setting. There are multiple vendors that provide EHR software of varying capacities, flexibilities, user support and cost. Although an EHR is required to meet BHH services certification requirements, it is up to each individual organization to determine which vendor and software best meets the organization's needs ([Standard 2A](#))

2B) The patient registry is an electronic, sortable tool that supports population and care management strategies, and allows data tracking and monitoring over time to help improve quality.

- Supporting care management strategies: The BHH services team shares a caseload of a defined group of people who are tracked in a registry to ensure no one “falls through the cracks.” The BHH services team must assign someone to actively monitor and maintain the registry as part of the person's position description. The registry, or the registry in conjunction with other tools, will be used to develop a comprehensive picture of overall care received and current care gaps for each individual person. This allows the BHH services team to determine which people need immediate attention to remedy gaps in care relative to a comprehensive set of needs, and who on the team is best positioned to intervene regarding identified gaps ([Standard 2B](#)).
- Supporting population health strategies: In addition to using the registry as a person-centered care management tool, the registry also supports population-based care by providing a tool that can assist in tracking and managing a group's health conditions and response to services. These are often based on a particular diagnosis or chronic condition, or other set of characteristics (such as age, gender identity, demographics, use of specific services, and more) allowing the BHH services team to identify needs or disparities of a particular subgroup of people. Describe how the organization anticipates using the patient registry to conduct panel management and improve population health to meet the requirements in [Standard 2B](#).
- Supporting quality improvement strategies: A patient registry will allow you to track characteristics about the population you serve over time so that you can monitor the impact your improvement activities have had. Organizations can add specific data elements to their registry that align with their quality improvement efforts if they find that is a helpful way to track and monitor that data.

Not all EHRs have built-in registry functions. Building a registry outside of the EHR will require data to be pulled from the EHR and put into a separate database, such as an Excel spreadsheet. For either approach, workflows and processes — including designated staff to maintain the registry — are necessary so that the tool is meaningful and accurate. Registries need to contain enough information to track and manage care so that key data about a target population is organized in one place for increased effectiveness and efficiency.

To identify individuals for care management strategies and groups of individuals for population health strategies, there must be sufficient demographic and health data elements in the patient registry. DHS outlined [required data elements](#) for the registry to meet the BHH services

certification requirements ([Standard 2B](#)). Over time, organizations may further develop these registries, adding data elements to better meet their needs for population and care management. Additional information about some of the required data elements is provided below:

- Lesbian, gay, bisexual, transgender or queer (LGBTQ+) people include all races and ethnicities, all ages, and all socioeconomic statuses. The LGBTQ+ population experiences a number of health disparities, including a disproportionate rate of infection with HIV/AIDS.<sup>i</sup> Sex assigned at birth and gender identity are required patient registry elements to identify and address disparities for the population you serve. Your organization is encouraged to learn about intersection of health status and identity in order to identify appropriate responses for these elements. As an example, responses for the “Gender Identity” field within an individual’s profile could include: Agender, Androgynous, Bigender, Demiboy, Demigirl, Female, Gender Fluid, Gender Nonconforming, Gender Queer, Gender Questioning, Male, Non-binary, Pangender, Third Gender, Transgender, Transsexual, Two Spirit.
- Minnesota is one of the healthiest states in the country, but it has some of the worst health disparities. All communities can experience poor health outcomes, but due to systemic inequities, they disproportionately occur in communities of color and the American Indian community. This results in a much higher risk for health conditions like cancer, diabetes, heart disease and other preventable diseases for these communities — despite no biological reason for this to be the case.<sup>ii</sup> Race, ethnicity, and preferred language are required patient registry elements to identify and address disparities for the population you serve. Making inequities visible brings them to the forefront for identifying potential solutions.
- Housing status and educational attainment are factors that largely impact a person’s health and wellness. Understanding the rates of housing instability and overall educational status of the population you serve will help you in prioritizing community partnerships and referral resources. Your organization will also have important data to inform communities and systems of care about gaps and their impact.
- Common co-occurring physical health conditions experienced by individuals being served in BHH services include diabetes, asthma, seizures and other conditions. These are examples of specific physical health diagnoses that your organization may choose to develop population health or quality improvement strategies around. The elements in a patient registry can track the rate at which these diagnoses affect the population you serve.

Please note, during the site visit you will be asked to demonstrate how you intend to use the patient registry. The site visit will provide an opportunity to discuss with DHS staff potential implementation challenges, technical assistance needs, and other questions and concerns.

2C) The MN DHS Partner Portal gives providers access to Medicaid claim and enrollment data reports. We

expect providers to use the portal information to understand how service recipients are accessing care and utilizing services such as inpatient admissions, emergency department visits, names and locations of these facilities and primary reasons for admission or visit. The portal can also be a resource to help inform organizations about the use of duplicative services, cost of care, and risk levels of the individuals they serve. Providers must sign a data-sharing agreement with DHS to use the MN DHS Partner Portal.

### **3: Culture to Support Integration**

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3A) Building and sustaining integrated care means all facets of the organization must reflect the values of whole health, collaborative care and the understanding that successful outcomes are everyone’s responsibility.<sup>iii</sup> In order to change organizational culture to support the integration and coordination of a person’s care, it is essential that senior leadership is involved. Senior leadership must understand and support such a culture shift while also keeping in mind that there is often an underlying force to do things the way they have always been done. The Substance Abuse and Mental Health Supports Administration (SAMHSA) states that “buy-in has to be obtained from primary care medical staff and mental health staff. Intense collaboration requires rethinking of everything — warm handoffs, billing, screening tools, staff training, staffing, accreditation and adapting services to make a good fit for both agencies.”<sup>iv</sup> Examples of an organizational culture that supports integration may include:

- a shared vision of an integrated program,
- an increased sense of shared work,
- newly developed goals and roles and responsibilities reflecting the culture shift,
- enlisted boards that can influence and support strong ties to healthcare partners in the community, and
- ongoing efforts to keep momentum alive.

3B) Part of the infrastructure that needs to be in place to promote a culture of integration includes a formalized continuous quality improvement process. The BHH services standards were developed to ensure that designated providers deliver care using a “whole person” approach with a culture of continuous quality improvement. Continuous quality improvement planning is critical to the success of BHH services and essential to improving outcomes. This type of planning guides the work in a strategic, data-supported, evidenced-based way. Communication is an important part of the continuous quality improvement process and structure because it allows all team members to remain engaged in the work.

The ideal quality team structure includes staff involved in direct BHH services provision and administrative leadership as well as representation from people currently receiving services or who previously received services. Person- and family-centered services rely on people or their representatives to support and provide input to the BHH services provider’s quality activities.

3C) Provide a written description that adheres to [Standard 3B](#). The policy will include how the BHH services

team members will communicate and coordinate around a shared caseload. The policy should also support and align with how the patient registry is used to facilitate communication among BHH services team members.

- 3D) The BHH services team is to meet the needs of the people they are serving and provide the federally required core services. Organizations are expected to develop position descriptions (PDs) for the required BHH services team members at the point of application to demonstrate where they meet these requirements. It is not expected that an organization has identified or hired staff to fill these roles. However, prior to final certification, an organization will need to submit proof of hire for required staff members, including documentation that they have met required certification standards.

Submit position descriptions for the integration specialist, system navigator and qualified health home specialist in accordance with [Standard 3D](#).

The following outlines the components DHS expects to see in one or more PDs to demonstrate standards are met:

- Responsibilities for inputting information into the patient registry and communicating updates in the patient registry ([Standard 2B](#))
- Expectations for how to use and maintain the patient registry ([Standard 2B](#))
- Identify which member of the BHH team will ensure that the person receives information about the purpose and the services of the BHH and the person's rights and responsibilities ([Standard 5B](#))
- The integration specialist PD must include responsibilities for using the patient registry to conduct panel management ([Standard 6D](#))
- The integration specialist PD must include responsibility for aid and review of each health action plan ([Standard 6C](#))
- Dedicated time for conducting the initial needs assessment and developing the preliminary action plan ([Standard 7C](#))
- Responsibilities for assisting the member in setting up and preparing for appointments, accompanying the member to appointments as appropriate and following up with the member ([Standard 7G](#))
- Responsibilities for providing coaching to members and their identified supports ([Standard 8A](#))
- Responsibilities for ensuring that members are aware of resources and are supported in efforts to access resources in order to address the member's identified goals and needs (for example, county social services, housing, and employment) ([Standard 11B](#))
- Responsibilities for developing and nurturing relationships with other community and social support providers to aid in effective referrals and timely access to services ([Standard 11C](#))

## **4: Training and Practice Transformation**

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- 4A) BHH services providers are expected to use evidence-informed 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. An example of such an approach is

motivational interviewing. For more information about [motivational interviewing](#), visit the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) website under their Clinical Practice tab.

It is necessary that all BHH services staff receive training on the goals and principles of BHH services. DHS will provide online and in-person trainings to support providers in learning about the goals and principles of BHH services. BHH services applicants must have a plan to ensure that all BHH services team members receive appropriate pre-service training and onboarding. Once certified and delivering BHH services to individuals, providers will need to continue to participate in ongoing learning activities provided by DHS. Communication about these learning activities will be done through the authorized representatives for BHH services at your organization.

- 4B) An organization must ensure that staff are capable of implementing culturally responsive services. These services must recognize and be tailored to the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting the person's health and health care choices.

## **5: Timeline Requirements**

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- 5A) BHH services providers are expected to provide state-created materials about BHH services. Describe the organization's policy to meet the requirements, including who on the team you anticipate will review the requirement materials with the individual receiving BHH services.

### **Required Materials:**

1. [BHH Services Rights, Responsibilities, and Consent form \(DHS-4797B-ENG\)](#)

BHH services providers are required to document that a person has voluntarily chosen to receive BHH services. BHH services providers must use the BHH Services Rights, Responsibilities, and Consent form to document that a person understands what BHH services are, and that he or she has agreed to receive them.

Please note that even if a referring provider outside of the BHH services team reviews this form with the person, DHS requires a BHH services team member to also review and complete this form with the person.

2. [Notification of Eligibility for Behavioral Health Home \(BHH\) Services \(DHS-4797-ENG\)](#)

This document is used to notify a person's managed care organization (MCO) if he or she has begun receiving BHH services. This form is required for people enrolled in managed care. If a person's Medicaid (MA) coverage is on a fee-for-service basis, this form is not required ([Standard 5D](#)).

### **Optional State-Created Materials:**

1. [Authorization for Release of Protected Health Information \(DHS-4797C-ENG\)](#)

Providers may choose to use this release form to gather protected health information for a person receiving BHH services. However, providers can also use release forms developed by their organization.

2. [BHH services community providers flyer \(DHS-7405\)](#)

This flyer is an informational handout intended for service providers of all types who are interested in a broad overview of BHH services.

3. [BHH services consumer flyer \(DHS-7405A\)](#)

This flyer is an informational handout for people who want to learn some basics about the service, including potential benefits, eligibility and how to get started. This handout may also be helpful for support persons of people who may potentially benefit from BHH services.

5B) Providers must ensure that a diagnostic assessment is completed for each individual receiving behavioral health home services within six months of the start of behavioral health home services. The diagnostic assessment will only need to be completed once for the purpose of receiving BHH services.

5C) If a person who has been determined eligible for BHH services is enrolled in managed care, the BHH services provider is required to communicate and coordinate with MCOs to ensure that services and activities are coordinated to most effectively meet the goals of the person and to avoid duplication between the MCO and the BHH services provider.

5D) Providers will need to meet requirements around frequency and face to face contacts in order to bill for BHH services and to meet the requirements of [Standard 5D](#).

DHS' requirements include conducting comprehensive assessments that address behavioral, medical, social service and community support needs. DHS does not require the use of a standard assessment form, knowing that organizations already have processes in place to gather information. Instead, DHS allows organizations to identify how their current assessments meet the requirements of the BHH services health wellness assessment.

The guiding principles of the health wellness assessment include a systems view that everything is connected, and a foundational importance of bio-physiological, psychologic, sociocultural and spiritual domains.

This assessment can:

- Help determine desired future state by inclusion of the person's voice and perception
- Identify the person's access to health care, mental health, substance use and social services
- Foster mutual understanding of the described needs or barriers to engagement
- Provide an opportunity to identify strengths
- Set the stage for the development of the health action plan

DHS will crosswalk the assessment form or supporting documents provided by an organization with the assessment elements required by DHS. Each organization is required to provide DHS with a copy of the health wellness assessment form or other assessments as a component of the interim application. Please review the health wellness assessment element requirements in the [required data elements](#) document.

If DHS is unable to locate all the required elements in your documentation, you will receive an email outlining the missing elements. DHS will request that the organization do one of the following:

- Provide an updated copy of the health wellness assessment form that includes the missing elements
- Explain how the information related to each missing element will be gathered (if not gathered through a specific “health wellness assessment”)

The following table is an example of how organizations may respond to DHS about missing elements that are required for the initial health wellness assessment.

Missing Health Wellness Assessment Element	Form or process you will use to gather this information*
Preferred name	Added to existing health wellness assessment form
Emergency contact	Asked during our intake process or on intake form

\* The form or process you use to gather information related to the required elements is not the same as where you store the information in your electronic health record.

5E) It is important to ensure persons served by BHH services have notice and receive support or assistance in the transition if the provider decides to discontinue BHH services. [Standard 5F](#) also provides guidance in implementing criteria for when an individual may be discharged from behavioral health home services, should the BHH services provider wish to use it.

## **6: Comprehensive Care Management**

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Comprehensive care management is a collaborative process designed to manage medical, social and behavioral health conditions more effectively. It is based on population health data and tailored to the person receiving services.

6A) The BHH services team must have the capacity to refer [children](#) and [adults](#) for physical health care services under national and state guidelines to meet the requirements in [Standard 6A](#).

6B) The BHH services team will collect enough data about physical, mental health needs (including addressing commercial tobacco and other substance use as appropriate) and health promotion and wellness needs as part of a “whole person approach” to identify needs or gaps in care that should be addressed. The BHH services team should identify and develop relationships with organizations and referral sources to support the ability to do this work seamlessly.

- 6C) The BHH services team must have the ability to track referrals and ensure their successful completion; Policies and procedures must be in place that describe the infrastructure that supports how referrals and their outcomes are tracked and managed (such as workflows, information systems and tracking tools). Another key component of referral work is supporting people and their families. This component should be incorporated with a whole-person approach that includes logistical support (such as insurance and transportation), education to better understand the need for the referral, identification of barriers related to the referral and helping to address them, and post-referral follow-up with changes that may be needed in the health action plan or other related goals. Provide written policies and procedures that “close the loop” on referrals to ensure people have the necessary support to access services to meet the requirements in Standard 6C.
- 6D) The integration specialist will utilize their scope of expertise to provide as needed recommendations to the health action plan. These recommendations are meant to support incorporation of best practices for achieving optimal health and wellness outcomes while balancing the person’s unique circumstances and preferences.
- 6E) It is essential that people are screened for the use of commercial tobacco use. Commercial tobacco use is the number one cause of death in people with mental illness according to the American Lung Association.<sup>v</sup> Moreover, it affects people with mental illness at alarmingly disparate rates compared to the general population.

The status of a person’s commercial tobacco use often goes unaddressed in common substance use disorder screens. DHS requests that all BHH services providers have a protocol for screening someone’s commercial tobacco use status.

DHS expects that BHH services providers are providing continuous health education to people regarding the use of commercial tobacco use. In addition, DHS also encourages the use of motivational interviewing techniques to provide people with the appropriate support according to their current stage of readiness to quite or reduce their use.

Please note, DHS does not require BHH services providers to complete a commercial tobacco use screen every six months if, at the time of the six-month screening due date, the person is currently receiving adequate treatment services for their use (“adequate” as defined by the person receiving treatment).

- 6F) Describe how your organization will engage area health care providers (hospitals, primary care practices, behavioral health providers and others) in collaborating on care coordination as outlined in Standard 6G. This can include workflows for coordinating with other providers, obtaining release of information or consent, and receiving referral reports or outcomes, etc.

## **7: Care Coordination**

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- 7A) The service delivery model for BHH services requires the BHH services team to act as the “central point of contact” for the person and their family or other identified supports. This means that the BHH services team is responsible for answering questions and ensuring that communication about the person is shared as appropriate. If a person or their identified supports asks a question or has a need, the expectation is that the BHH services team will work to find the answer and connect the person to the requested resource or service.
- 7B) Provide a written description for how the organization plans to deliver services in locations and settings that meet the needs of the person to meet the requirements of [Standard 7B](#). We expect that BHH services providers will adjust scheduling and meeting venues to meet the person’s needs and circumstances. Access to BHH services should not be limited due to a person’s inability to meet on-site.
- 7C) The brief needs assessment must address the individual's immediate safety and transportation needs and potential barriers to participating in BHH services. The brief needs assessment must be completed with input from the individual and the individual's identified supports.
- 7D) Assessing readiness to change will be an important part of the BHH services provider’s role. Knowing how ready a person is to change particular behaviors will allow BHH services team members to help the person choose health action plan goals that are realistic and individualized, as well as inform the BHH services team’s approaches and interactions with the person. Assessing readiness to change also provides an opportunity to begin a discussion with the person (and his or her identified supports) about his or her confidence and motivation to make certain changes and whether or not additional barriers exist. These components, which are key to the person’s active participation in the care, also comprise what is referred to as “patient activation.”

The Transtheoretical Model, also known as The Stages of Change Model, theorizes that behavior change involves a progression through five stages of change: precontemplation, contemplation, preparation, action and maintenance. Per SAMHSA, “These stages can be conceptualized as a cycle through which clients move back and forth. The stages are not viewed as linear, such that clients enter into one stage and then directly progress to the next. Framing client treatment within the stages of change can help the clinician better understand client treatment progress.”

A specific tool inspired by The Stages of Change Model is the Readiness-to-Change Ruler, a simple assessment tool that can help people evaluate their readiness to change. Its use of a continuum to measure a person’s position in the change process may be used for any health action goal requiring a behavioral change (such as smoking cessation, sleep hygiene, increased physical activity, or others). Please note that DHS does not require any specific model or tool for assessing readiness to change. As part of the certification process, the BHH services team will need to describe the organization’s capacity and skill in assessing a person’s readiness and how this information is used when adjusting plans of care and providing supports as outlined in [Standard 7D](#). A possible approach is [motivational interviewing](#),

found to be effective in supporting people making changes and working towards better health.

## **8: Health and Wellness Promotion**

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Health and wellness promotion services encourage and support healthy living and motivate people and their identified supports to adopt healthy behaviors and better manage their health and wellness. They emphasize skills development so people and their identified supports can monitor and manage their chronic health conditions to improve health outcomes. SAMHSA identifies eight dimensions of wellness:

- Emotional
- Environmental
- Financial
- Intellectual
- Occupational
- Physical
- Social
- Spiritual

## **9: Comprehensive Transitional Care**

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9A) When possible, BHH services providers will also be expected to access admission and discharge information as approved by the person and his or her identified supports. Access to this information may involve, but is not limited to, the following:

- Self-report from persons involved in transition (person receiving BHH services or identified support[s])
  - It is recommended that people receiving BHH services and their identified supports are educated early on about the importance of notifying the BHH services team about transitions. This will likely increase the chances that people or their identified supports will contact you when they are experiencing a transition.
  - Organizations will be expected to discuss at their certification site visit how they will proactively prepare people and their identified supports for transitions and related planning.
- Data from the Minnesota Department of Human Services Partner Portal
  - The partner portal is a secure, web-based reporting tool which enables access to information that providers can use to help coordinate care, and manage cost and quality.
  - You will learn more about the partner portal during and after your certification site visit with DHS.
- Reports from key professionals and service providers involved in the person's care

- DHS expects BHH services providers to develop relationships with local hospitals, as well as other key professionals and service providers involved in the person’s care, and inform them of the opportunity to connect existing in-reach services to BHH services. The more proactive efforts that are made to develop these relationships with other service professionals, the more likely it is that BHH services providers are to receive information about transitions. Describe how the organization will develop, maintain or improve the relationship with hospitals and other providers in planning for transitions. Include a description of potential barriers to meeting the requirements in [Standard 9B](#).
- BHH services providers may also be interested in using the [MN Encounter Alert Service \(EAS\)](#) to support their efforts in providing comprehensive transitional care. The MN EAS enables providers to receive alerts for individuals who have been admitted, discharged or transferred from an EAS-participating hospital, emergency department, long-term and post-acute care facility, or other provider organization in real time. Any Medicaid-enrolled provider can participate.

9B) It is important to establish a transition plan in partnership with the person and his or her identified supports for any transfers between settings of care or following a discharge from hospitals, residential treatment, and other settings. Effective care transitions are key to improved outcomes for persons and populations with higher risk. Poorly coordinated care transitions result in higher costs, poor health outcomes and adverse events such as medication errors and complications.

Please note: When the person receiving BHH services is a child or youth, all transitional care activities should include the person’s family or other identified supports. DHS understands that there may be times when a BHH services provider cannot include a family member or identified support when working with a child or youth. The reasoning for why a transitional care activity did not include the child or youth’s family or other identified supports should be documented.

## **10: Individual and Family Support Services**

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10A) Recovery-oriented principles are an important component of self-management and wellness strategies for this population and should be integrated into a person’s health action plan as appropriate. For the application, organizations are asked to briefly describe how their BHH services team plans to utilize “peer support” services and “recovery support” resources in their region. Ensure this aligns with your policies and procedures for effective and timely referrals to SUD treatment as outlined in [Standard 10A](#).

10B) DHS expects an organization to ensure the following in the development of a health action plan:

- utilize a person-centered format in order to encourage informed choice and creativity (for more information on person-centered practices, visit the MN DHS [person-centered practices website](#))
- use plain language
- include the person’s own words when applicable
- avoid having more than three goals at one time so the person is able to give better attention to each one

Each organization is also required to provide DHS with a copy of the health action plan when submitting the application. There is no specific health action plan form required by DHS; however, DHS will crosswalk the health action plan form that an organization creates with the health action plan elements required by DHS as outlined in [Standard 10B](#).

During the time of the certification site visit, organizations will be expected to describe how the BHH services team will ensure the involvement of the person's identified supports in the development and maintenance of the health action plan. Please remember that DHS expects providers to use a person-centered planning approach with the health action plan. Therefore, providers should only involve identified supports when desired by the person. Please note that parents or caregivers are key to the implementation of this service and the development of the health action plan if the person is a child or youth.

- 10C) BHH services providers have the ability to work directly with family, caregivers or other identified supports as a covered service. This work supports the whole-person approach by involving the person's identified supports and could include education, skill development, support groups or other strategies that support progress towards meeting the person's health goals. It is expected that an organization will offer or facilitate the provision of education, coaching, and support related to chronic disease management and how to navigate complex systems of care.

## **11: Referral to Community and Social Services**

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- 11A) Social and economic factors, such as income, education, employment, safety, and social supports, significantly affect a person's health and wellness. These factors affect a person's ability to make healthy choices, afford medical care and housing, manage stress, and more. In fact, it is estimated that approximately 40% or more of what determines a person's health are social and economic factors.<sup>vi</sup> Efforts to improve a person's health and wellness must address these factors. BHH services providers are required to have adequate knowledge of community and social services agencies and resources, or networks to access this information, to ensure people are aware of resources and are supported in efforts to access resources to address each person's identified goals and needs (such as county social services, housing and employment).
- 11B) Established relationships between BHH services providers, other healthcare providers, county human services, and other relevant community and social support providers make it easier to connect people with their desired resources. Those relationships not only improve bidirectional referral relationships, but they also improve the ability of all providers involved to maintain successful coordination of the person's chosen supports and services (such as timely access to services). Therefore, it is essential that the BHH services team develop and nurture relationships with community and social support providers.

Organizations are expected to explain to DHS how they intend to establish and maintain these relationships as part of the BHH services certification process. DHS does not expect a BHH services to have an established relationship with every possible provider. At minimum, DHS expects that each organization applying for BHH services describe a general plan for how they will start to establish and

nurture relationships for the purpose of BHH services (such as = a general plan for reaching out and establishing and sustaining relationships with local hospitals or common referral source(s) social service needs in your area. Sometimes organizations already have an established relationship with another organization (such as a local hospital). In this case, the BHH services applicant may also decide to describe their plan to increase awareness of BHH services among hospital staff.

## **Completing your Application**

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### ***Certification Application Process and Attestations***

Please check the two boxes under this section in the application to acknowledge that your organization has reviewed and understand the applicable standards and statutory requirements for the delivery of behavioral health home services and understand that you must be compliant with all applicable BHH services certification standards and laws at the time of the certification site visit or a certification letter will not be issued.

### **ONLINE/AEM INSTRUCTIONS**

#### ***Agreement and Signature***

Check box to acknowledge that by doing so you are electronically signing the application, then type name and date in the Electronic Signature field.

#### **\*\*IMPORTANT\*\*:**

**After the application is completed, SAVE the form to a location where this application can be stored on your computer (either to your desktop or a shared networked folder).**

#### ***Submitting the completed Application***

Click on “SUBMIT” at the bottom of the application. If there are any fields that were not completed, you will get a prompt to complete those fields before submitting.

Once a complete application has been received, a DHS Care Integration Liaison will be assigned to begin evaluating the application and the evaluation process will begin.

Please anticipate that it will take DHS up to 45 business days after receipt of a completed application to schedule a site visit. A completed application includes all required documents that complies with all applicable BHH services standards. If DHS determines your application is incomplete and the submitted documents do not meet behavioral health home services certification standards, DHS will send you a written notice that the application is incomplete. The written notice will identify the information that is missing and provide you with

45 days to resubmit a completed second application.

## Variance

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Please note: Providers have the ability to request a variance for specific requirements of BHH services. Providers may be granted a variance if they can demonstrate the following:

1. Failure to grant the variance would result in hardship or injustice to the provider organization;
2. The variance would be consistent with the public interest; and
3. The variance would not reduce the level of services provided to individuals served by the organization.

The commissioner may grant a variance from one or more requirements to permit an applicant to offer behavioral health home services of a type or in a manner that is innovative, if the commissioner finds that the variance does not impede the achievement of the criteria in subdivisions 4a, 4b, 4c, or 4d and may improve the behavioral health home services provided by the provider organization.

The commissioner's decision to grant or deny a variance request is final and not subject to appeal.

To request a variance, providers will need to complete the BHH services variance request form.

## Conclusion

BHH services staff at DHS are dedicated to assisting organizations with the application process. For more information about the BHH services certification process, please visit the [BHH Services](#) website or contact the DHS BHH services team at [dhs.bhh.certification@state.mn.us](mailto:dhs.bhh.certification@state.mn.us) with any questions.

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<sup>i</sup> [Advancing Health Equity in Minnesota: Report to the Legislature, 2014](#)

<sup>ii</sup> [Advancing Health Equity in Minnesota: Report to the Legislature, 2014](#) and [2018 The Cost of Health Inequities in Minnesota](#)

<sup>iii</sup> [A Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers](#)

<sup>iv</sup> [A Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers](#)

<sup>v</sup> [How to Address Tobacco Use in Minnesota's Mental Health and Substance Use Disorder Services: TIPS FROM THE FIELD](#)

<sup>vi</sup> [What is Health? County Health Rankings and Roadmaps](#)