

Behavioral Health Home (BHH) Services

Provider STANDARDS

1. Population

- A. You must have the ability to serve and meet the needs of the people you serve with mental health conditions.
- B. BHH services providers must provide a medical assistance covered primary care or behavioral health service.

2. Infrastructure and population health management

- 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. Systematically use the patient registry to identify specific population subgroups requiring specific levels or types of care. The BHH services patient registry must contain sufficient elements to issue a report that shows gaps in care and needs for individuals and populations or population subgroups.
- C. Agree to participate in the state's monitoring and evaluation of behavioral health home services.
- D. Utilize the Department of Human Services Partner Portal to identify the following at an individual and population level:
 - past and current treatment or health care services;
 - utilization of resources and cost of care; and
 - complexity and risk for fragmented care or gaps in care.

BHH services teams should use the Partner Portal to identify the information in the bulleted list at an individual and population level.
- E. Use evidence-informed practices that recognize and are tailored to the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting the individual's health and health care choices.

3. Culture to support integration

A. BHH services providers must establish and maintain processes that support the integration and coordination of an individual's primary care, behavioral health, and dental care. Providers must ensure organization-wide administrative support and leadership buy-in to pursue integrated care.

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

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

D. You must have the ability to meet the unique needs of people with mental health conditions while ensuring your BHH services team can provide all six federally required core services.

- A. [Comprehensive care management](#)
- B. [Care coordination](#)
- C. [Health and wellness promotion](#)
- D. [Comprehensive transitional care](#)
- E. [Individual and family support](#)
- F. [Referral to community and social supports](#)

E. Ensure each team member has the required credentials. All BHH services teams 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:

- If BHH services are offered in a mental health setting, the integration specialist must be a registered nurse licensed under the Minnesota Nurse Practice Act, sections 148.171 to 148.
- If BHH services are offered in a primary care setting, the integration specialist must be a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6).

Team member: BHH services systems navigator

Required Qualifications:

If BHH services are offered in either a primary care setting or mental health setting, the systems navigator must meet one of the following qualifications:

- A mental *health practitioner* as defined in Minnesota Statutes, [section 245.4871](#), subdivision 26 or Minnesota Statutes, [section 245.462](#), subdivision 17
- A community *health worker* as defined in [section 256B.0625](#), subdivision 49.

Team member: Qualified health home specialist

3. Culture to support integration

Required Qualifications:

If BHH services are offered in either a primary care setting or mental health setting, the qualified health home specialist must meet one of the following qualifications:

- 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 [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 9A
- A *peer recovery specialist* as defined in [section 245G.07](#), subdivision 1, clause (5)
- A *community health worker* as defined in Minnesota Statutes, [section 256B.0625](#), subdivision 49

- F.** 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 caseload 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. 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 25 percent and still be in compliance with the standard.)

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 staffing ratios listed in the bullet points.

4. Training and practice transformation

- A.** Ensure that all staff delivering BHH services receive adequate preservice and ongoing training, including:
- training approved by the commissioner that describes the goals and principles of BHH services, and
 - training on evidence-informed practices to promote an individual's ability to successfully engage with medical, behavioral health, and social services to achieve health and wellness goals.

4. Training and practice transformation

- B. Ensure that staff are capable of implementing culturally responsive services, as determined by the individual's culture, beliefs, values, and language as identified in the individual's health wellness assessment.
- C. Participate in the department's practice transformation activities to support continued skill and competency development in the provision of integrated medical, behavioral health, and social services.

5. Timeline requirements

- A. Obtain the individual's written consent to begin receiving behavioral health home services using a form approved by the commissioner. Provide other information that helps people make an informed choice about whether or not to participate in BHH services.
- B. Ensure that a diagnostic assessment is completed for each individual receiving BHH services within six months of the start of BHH services.
- C. If the individual is enrolled in a managed care plan, a BHH services provider must:
 - Notify the BHH services contact designated by the managed care plan within 30 days of when the individual begins BHH services; and
 - Adhere to the managed care plan communication and coordination requirements described in the BHH services manual.
- D. Deliver services consistent with state standards for frequency and face-to-face contact.
 - During the initial 90-day engagement period, you must meet 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.
 - Review the health action plan and update if necessary every six months.
 - 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.

5. Timeline requirements

- E.** Include use of the following criteria when developing policies and procedures for discharging individuals from BHH services:
 - (a) An individual may be discharged from BHH services if:
 - the BHH services provider is unable to locate, contact, and engage the individual for longer than three months after persistent efforts by the BHH services provider; or
 - the individual is unwilling to participate in BHH services as demonstrated by the individual's refusal to meet with the BHH services provider, or refusal to identify the individual's health and wellness goals or the activities or support necessary to achieve these goals.
 - (b) Before discharge from BHH services, the BHH services provider must offer a face-to-face meeting with the individual, the individual's identified supports, and the BHH services provider to discuss options available to the individual, including maintaining BHH services.
- F.** 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:
 - a. Provide a 60-day notice of termination of BHH services to all people receiving BHH service, DHS and managed care plans (if applicable)
 - b. Refer individuals receiving behavioral health home services to a new behavioral health home services provider or other appropriate service (if available).

6. Comprehensive care management

- A.** Have capacity to administer or refer people for physical health care services under national and state guidelines.
- B.** Ensure that the person and/or their identified supports know about resources appropriate to their physical and mental health needs , including resources appropriate to substance use disorder results. If applicable, resources appropriate to substance use disorder results should include resources for addressing a person's tobacco use disorder.
- C.** Ensure that the BHH services team knows how to conduct referrals and uses policies and procedures to track referrals and follow-up to ensure that the referral met the individual's needs.
- D.** The integration specialist must review the health action plan for every person before the plan is finalized and as part of the review process.
- E.** Have the capacity to administer required substance use disorder screenings approved by the commissioner. Use the CAGE-AID, Kiddie-CAGE or GAIN-SS, or other tools approved by DHS, to screen for substance use disorder during the health wellness assessment.

6. Comprehensive care management

- F. Screen for the use of commercial tobacco if this substance is not specifically addressed when administering the previously mentioned required substance use disorder screenings. Currently, there is no DHS-approved screening tool for commercial tobacco.
- G. Ensure efforts to engage area hospitals, primary care practices, and behavioral health providers to build relationships, facilitate the exchange of information, and collaborate on care coordination.

7. Care coordination

- A. Provide a central point of contact to ensure that individual and the individual's identified supports can successfully navigate the services that impact the individual's health and well-being.
- B. Deliver services in locations and settings that meet the needs of the person.
- C. Conduct a brief needs assessment when an individual begins receiving behavioral health home services. The brief needs assessment must be completed with input from the individual and the individual's identified supports. The brief needs assessment must address the individual's immediate safety and transportation needs and potential barriers to participating in behavioral health home services.
- D. Have capacity to assess an individual's readiness for change and their capacity to integrate new health care or community supports into their life.
- E. Help an individual set up and prepare for medical, behavioral health, social service, or community support appointments, including accompanying the individual to appointments as appropriate, and providing follow-up with the individual after these appointments.

8. Health and wellness promotion

- A. Follow up with the person and their identified support to ensure that they know about resources appropriate to identified health promotion and wellness needs.
- B. Offer or facilitate the provision of wellness and prevention education using evidenced informed curriculums specific to the prevention and management of common chronic conditions, the person's specific health conditions, other determinants of health and the person's readiness for change.

9. Comprehensive transitional care

- A. Access admission and discharge information, health profiles and service information from appropriate entities, as approved by the person and his or her identified supports.

9. Comprehensive transitional care

- B.** In partnership with the individual and their identified supports, create a plan to follow after the individual's discharge from the hospital, residential treatment and other settings. The plan must include protocols to:
- Ensure that the person and his or her family are included in transition planning.
 - Maintain contact between the BHH services team member(s) and the individual and their identified supports during and after discharge.
 - Link the individual to new resources as needed.
 - Re-establish the individual to any 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.** Support the person's recovery, resilience, and progress toward meeting his or her health goals via identification and rapport building with formal and informal supports.
- 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 supports. Each health action plan must include the following elements:
- The goal(s) of the individual (and parent or guardian)
 - Individual's strength(s) that will help them reach their goal. (internal and/or external resources that should be listed for each goal)
 - Specific services and/or supports the individual (and legal guardian) wants to receive to help reach goal (if different than 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.)
 - Brief crisis plan in case of an emergency or instances when additional support is urgently needed
- C.** Offer or facilitate the provision of education, coaching, and support related to chronic disease management and how to navigate complex systems of care to the individual, the individual's family, and identified supports.

11. Referral to community and social services

- A.** 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. Connect an individual, the individual's family, and identified supports to appropriate support services that help the individual overcome access or service barriers, increase self-sufficiency skills, and improve overall health;

This standard requires that you have adequate knowledge of 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 (i.e., county social services, housing and employment).

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

Variance Guidelines

The Commissioner may grant a variance for specific requirements of behavioral health home services providers to an applicant or certified behavioral health home services provider that demonstrates good cause. The commissioner may grant a variance if the commissioner finds that:

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.
4. 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 a request.