Behavioral Health Homes

WHOLE PERSON CARE FOR MEDICAID MEMBERS WITH COMPLEX NEEDS

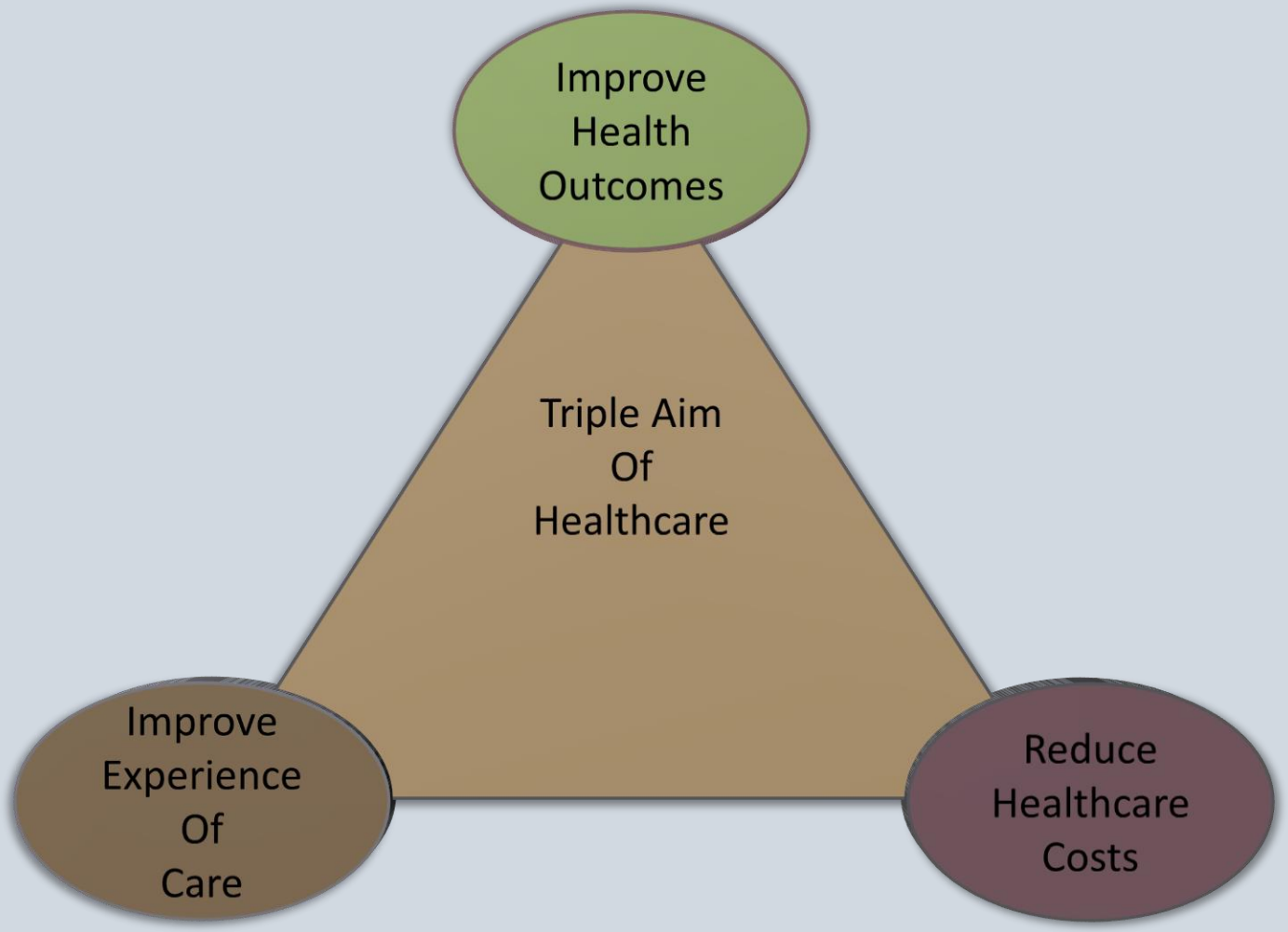
BHPOC – ADULT QUALITY, ACCESS AND POLICY COMMITTEE

SEPTEMBER 2024

What is a Health Home?

The Health Home model aligns with the Institute for Healthcare Improvement's Triple Aim of Healthcare, which became part of a national strategy to address healthcare issues.

The Affordable Care Act (ACA) created an optional Medicaid State Plan benefit to establish Health Homes. Health Homes coordinate care for Medicaid members who have chronic conditions.



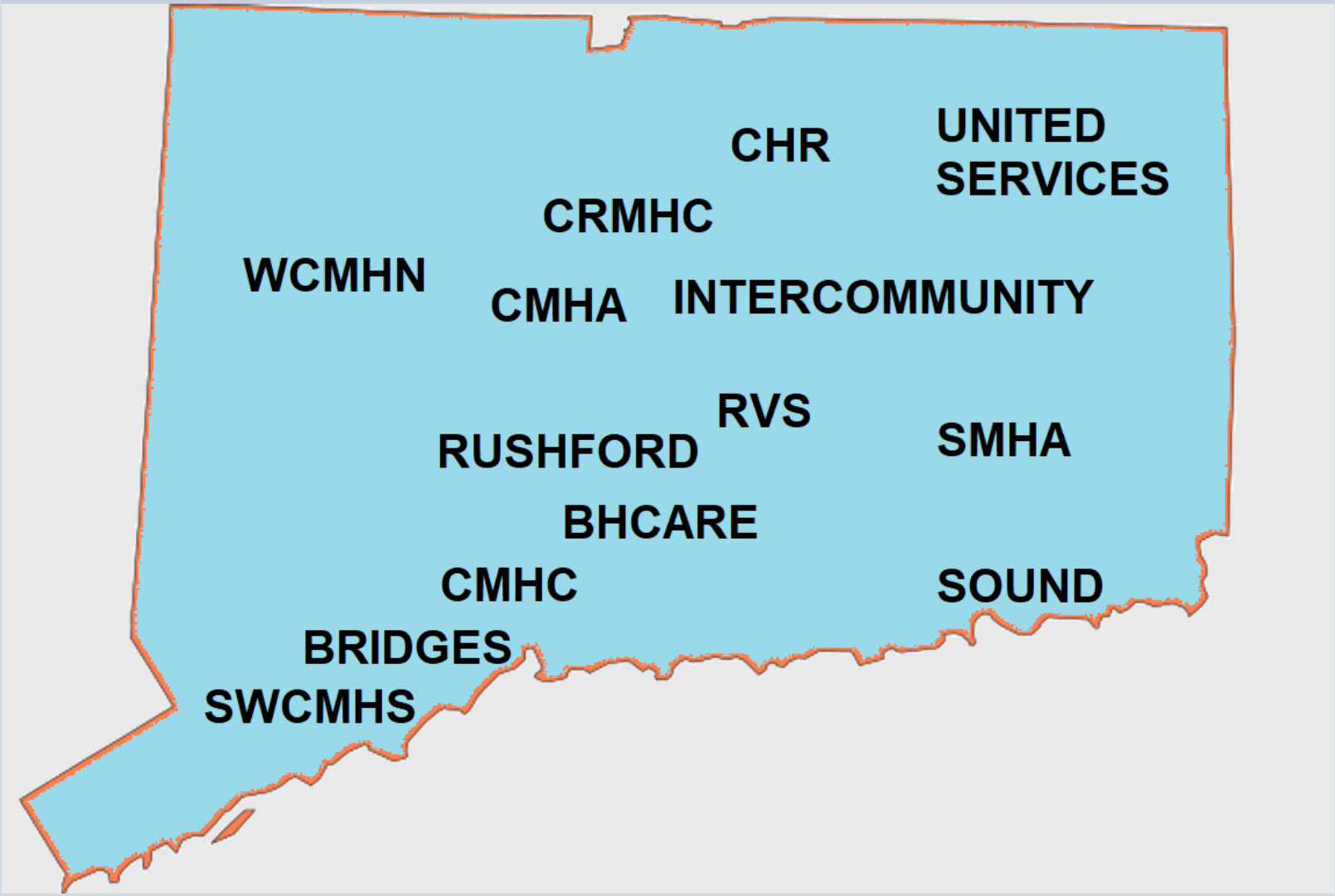
Why a Behavioral Health Home?

Individuals with serious mental illness (SMI):

- Experience at least one co-occurring medical condition at a rate of **50%-80%.** [2-4, as cited in 1]
- Premature mortality with **life expectancies 15-25 years shorter** than the general population. [5-7, as cited in 1]
- Sixty percent of the medical comorbidities observed among persons with SMIs **are non-fatal and preventable.** [8, as cited in 1]
- Largely **underserved** by primary care.
- Experience **barriers** in accessing medical/specialty care.
- Use **behavioral health** as their **primary source of care**.

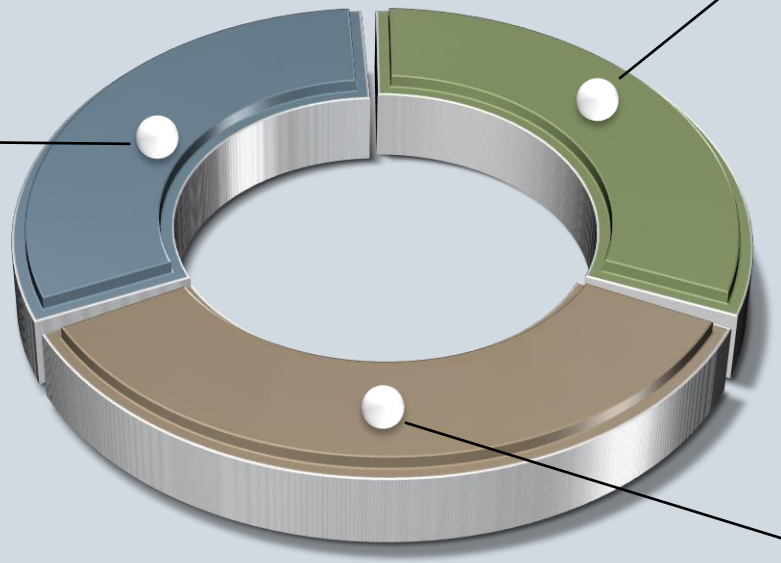
Designated Providers

See slide 30 for full names



Connecticut's Behavioral Health Home (BHH) Network

BHH Providers



State Partner Organizations

- Department of Mental Health and Addiction Services
- Department of Social Services
- Department of Children and Families

Administrative Service Organizations (ASO)

- Carelon
- Advanced Behavioral Health

Connecticut's BHH

The **entire agency** is a Behavioral Health Home (BHH) provider, it is not a separate program. BHH members are enrolled in many different DMHAS programs, and all receive BHH services.

An **integrated team** works together to coordinate the care a BHH member receives

Uses established relationship the Medicaid member has with their behavioral health provider. **Health assessments** collect information on health and wellness.

Incorporates physical health and wellness into a Medicaid member's treatment at behavioral health provider. **Primary care consultant** assists with this.

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BHH Eligibility

SPMI Diagnosis

- Schizophrenia and Psychotic Disorders;
- Mood Disorders;
- Anxiety Disorders;
- Obsessive Compulsive Disorder;
- Post-Traumatic Stress Disorder; Borderline Personality Disorder.

Active Medicaid

- Participants must have active coverage through Medicaid

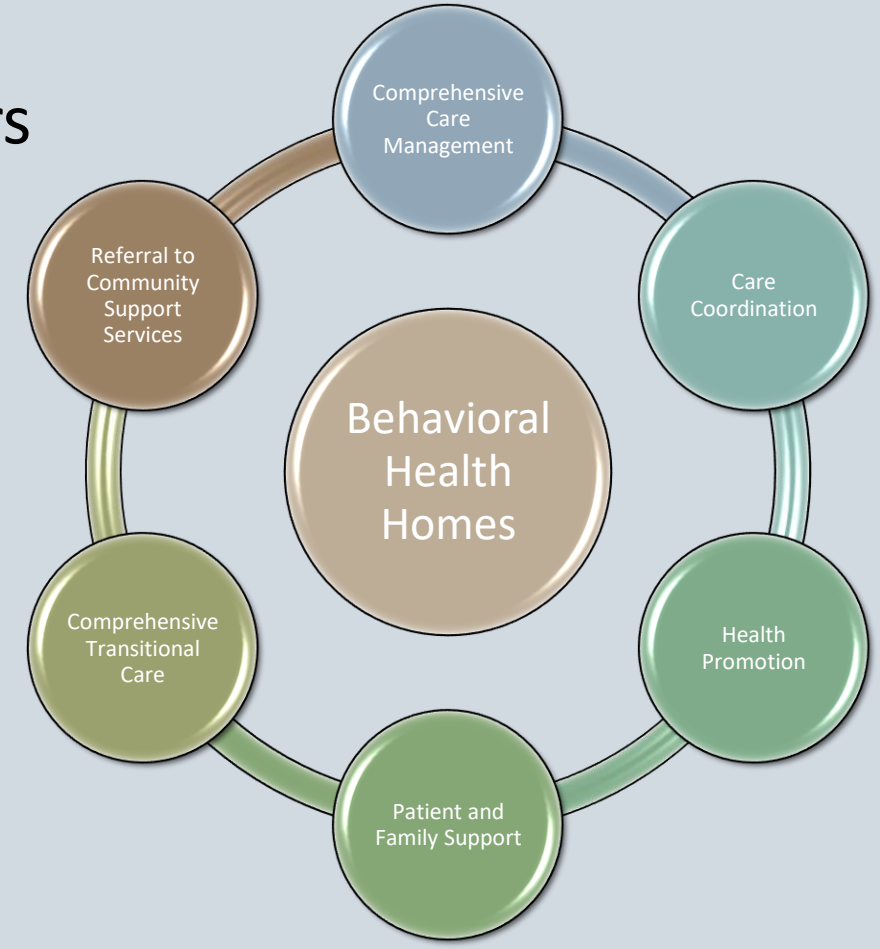
Medicaid claims > $10k/year

- Participants must have Medicaid claims in excess of 10 thousand dollars in a 12 month period

Active at one of the BHH Agencies

BHH Services

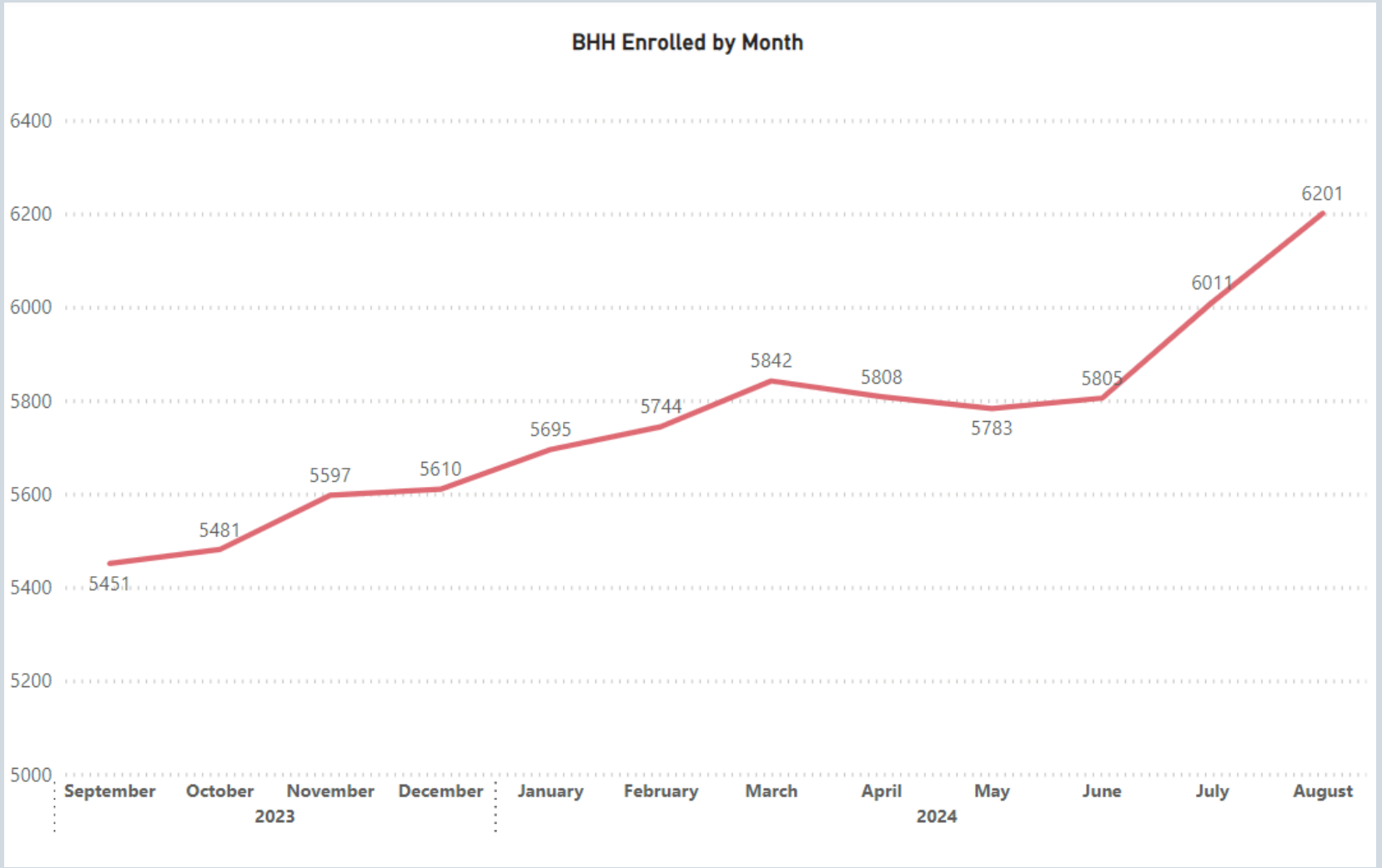
Behavioral Health Home providers enhance existing services to ensure that persons served have access to both behavioral and physical health services.



BHH Enrollment/Service Data

Year	Total Enrollment	Average Enrollment/Month	At Least One Service Provided/ Month	Billed Services
2018-2023	17,316	6,316	384,708	342,040
2018	8,513	6,875	63,175	57,473
2019	8,489	6,599	65,928	58,452
2020	7,897	6,668	71,957	63,482
2021	7,382	6,287	64,948	59,062
2022	7,174	5,884	60,472	54,204
2023	6,706	5,581	58,228	49,367

Focus on Increasing BHH Enrollment



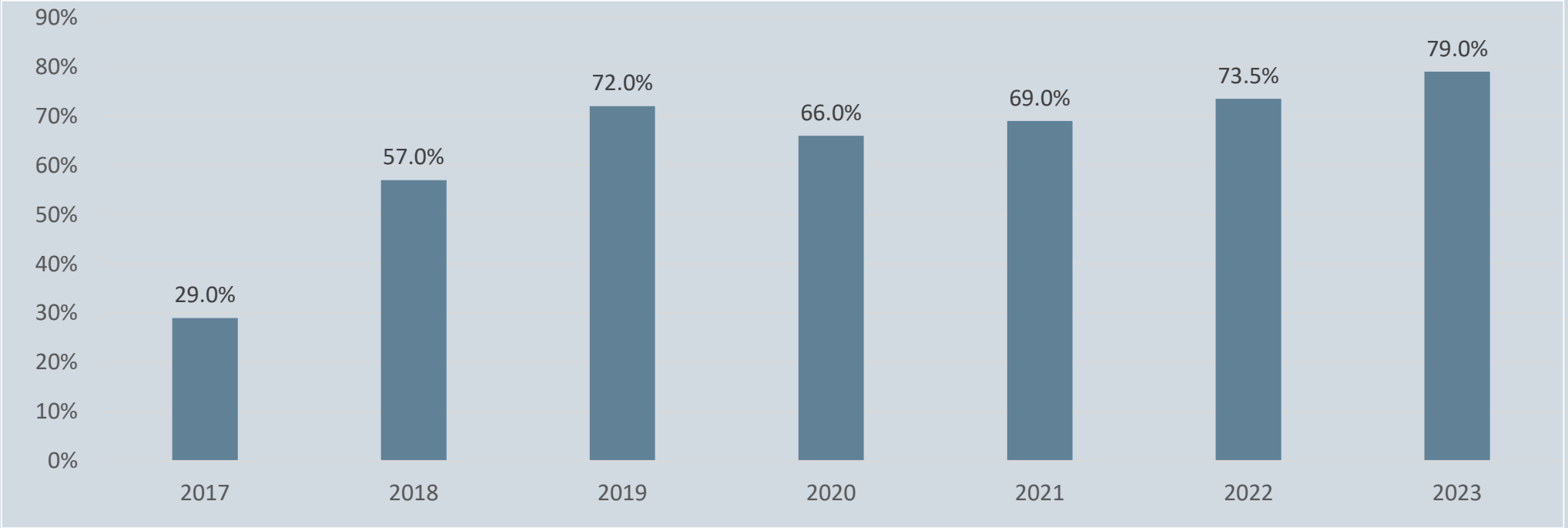
BHH Enrollee Diagnostic Data

Top 3 Chronic Medical Conditions	2020	2021	2022
Rheumatoid Arthritis/ Auto Immune Disorder Rate	50.6%	51.8%	51.7%
Hypertension	42.8%	43.8%	45.7%
Hyperlipidemia	34.8%	36.9%	39.5%

Top 3 Mental Health Diagnoses	2020	2021	2022
Depressive Disorder Rate	52.3%	50.5%	47.5%
Schizophrenia and Psychotic Rate	51.4%	52.3%	54.8%
Anxiety Disorder Rate	44.0%	43.2%	43.2%

Top 3 Substance Use Diagnoses	2020	2021	2022
Nicotine	31.0%	32.1%	29.7%
Alcohol	28.1%	26.4%	23.4%
Cannabis	22.6%	22.8%	21.2%

Health Assessment Completion



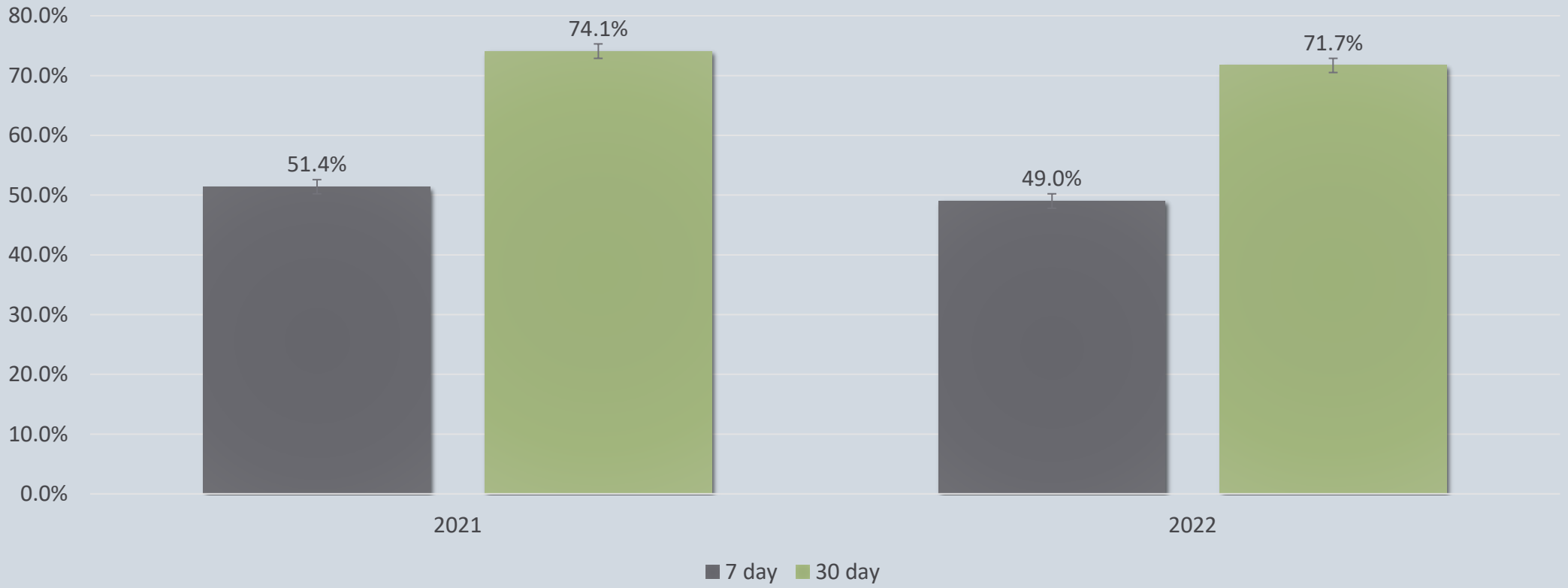
A Complete Health Assessment Consists Of BMI, Blood Pressure, Depression Screen, Tobacco Screen And Cessation. Enrolled at least one day in the Calendar Year.

Population Health

Design specific health and wellness interventions using data.

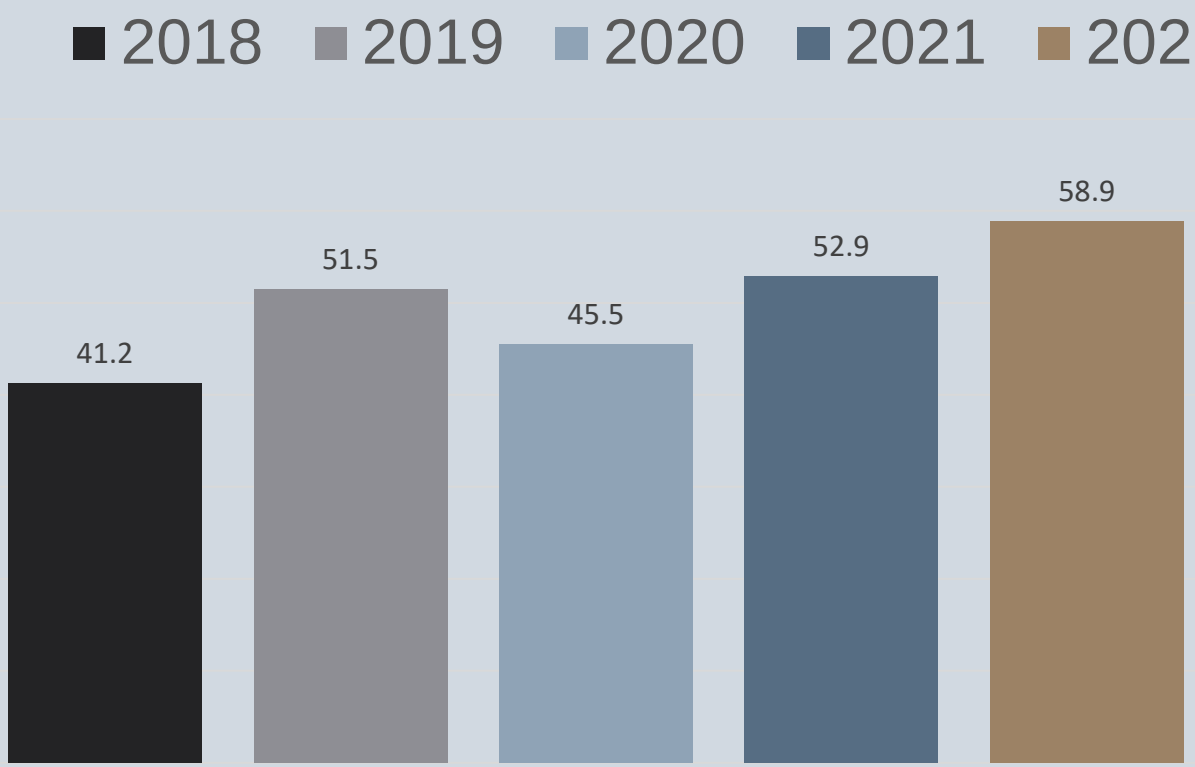
- Which members are due for a wellness exam or a medical screening - such as a mammogram? **CHN gaps in care**
- Which members are on a medication that can raise A1C levels? **Diabetes report**
- What are the most common medical conditions of members? **Population Health Profile**

Follow-up After ED for Mental Illness (FUM-HH)



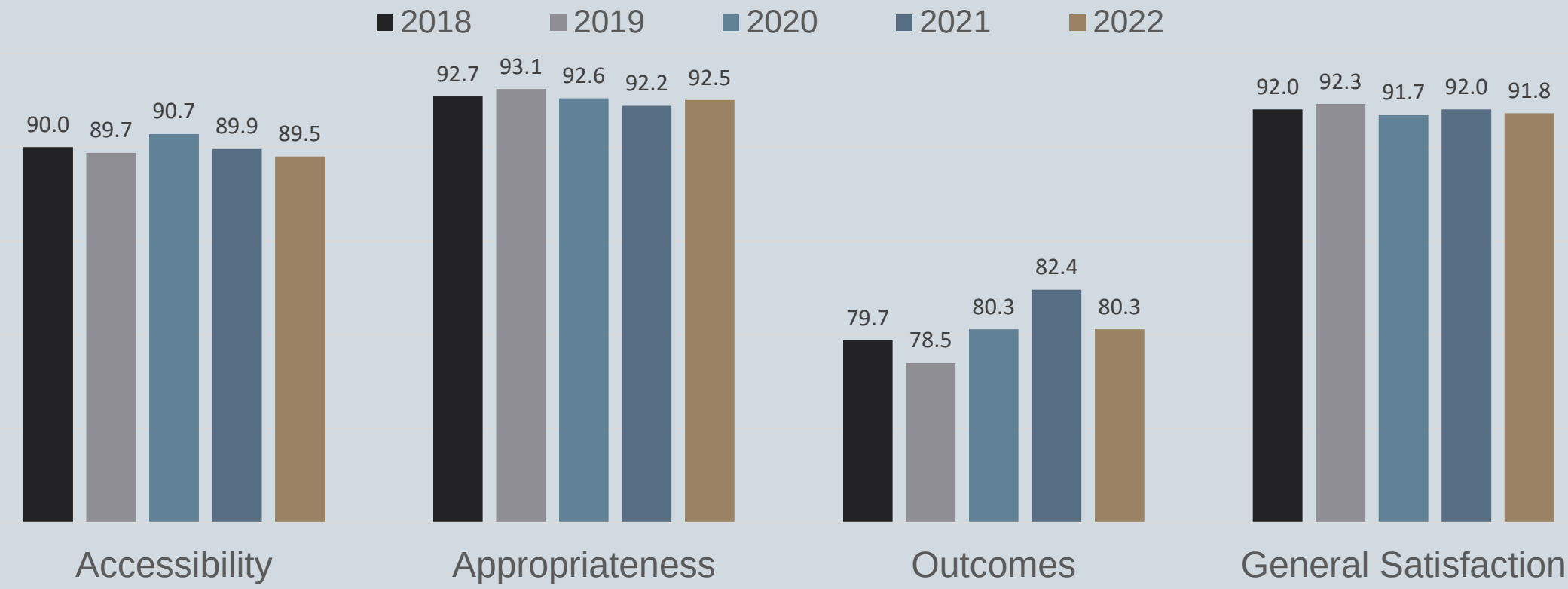
Percentage of emergency department (ED) visits for health home enrollees ages 6 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. ED visits that result in an inpatient stay are excluded. The follow up visit can be with any practitioner, unlike FUH who requires a mental health practitioner, but does require the primary diagnosis be mental health or intentional self harm.

Controlling High Blood Pressure (CBP)



Percentage of health home enrollees ages 18-85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/80 mm Hg) during the measurement year. If a blood pressure is not collected, it is considered uncontrolled.

Client Satisfaction Survey



Percentage of individuals 18 years and older who are enrolled in BHH that report being satisfied (report scores of 2.5 or higher) with care, access, quality, and appropriateness using the DMHAS Consumer Satisfaction Survey.

Health Equity

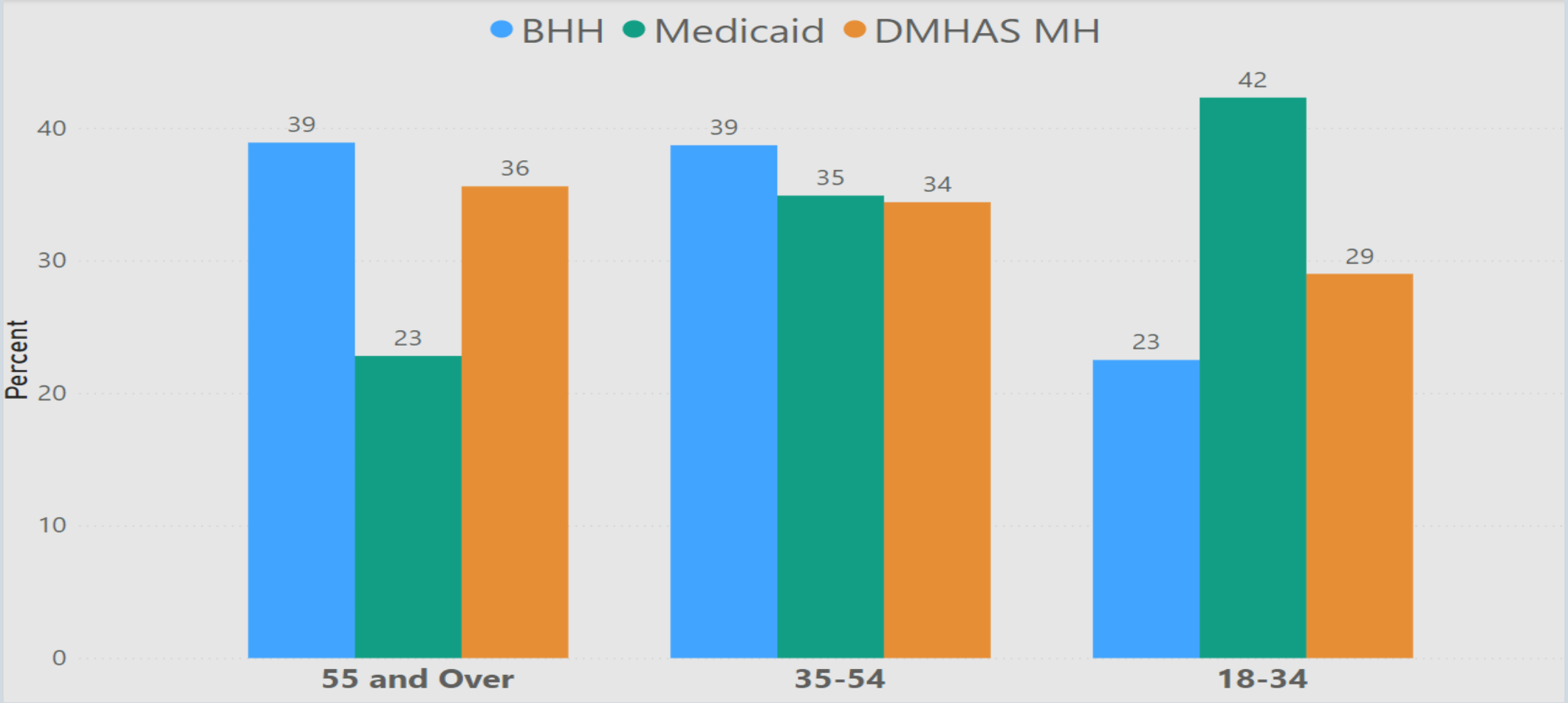
Health Equity Is The State In Which Everyone Has A Fair And Just Opportunity To Attain Their Highest Level Of Health. *CDC OHE*

Factors Affecting Health Equity:

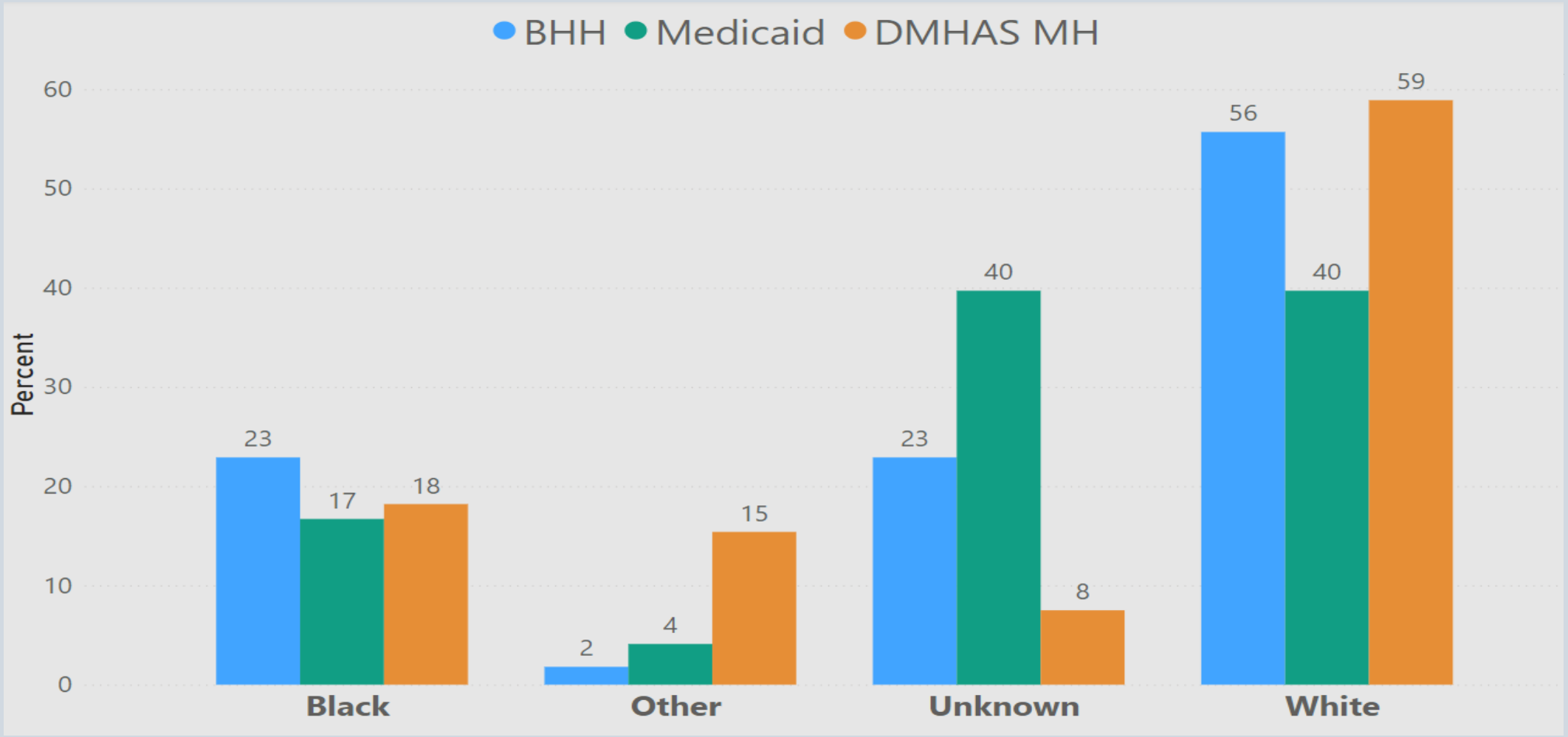
- Social Determinants of Health
- Social and Community Context
- **Healthcare Access and Use**
- Neighborhood and Physical Environment
- Workplace Conditions
- Education
- Income and Wealth Gaps

Selected Demographic Comparisons

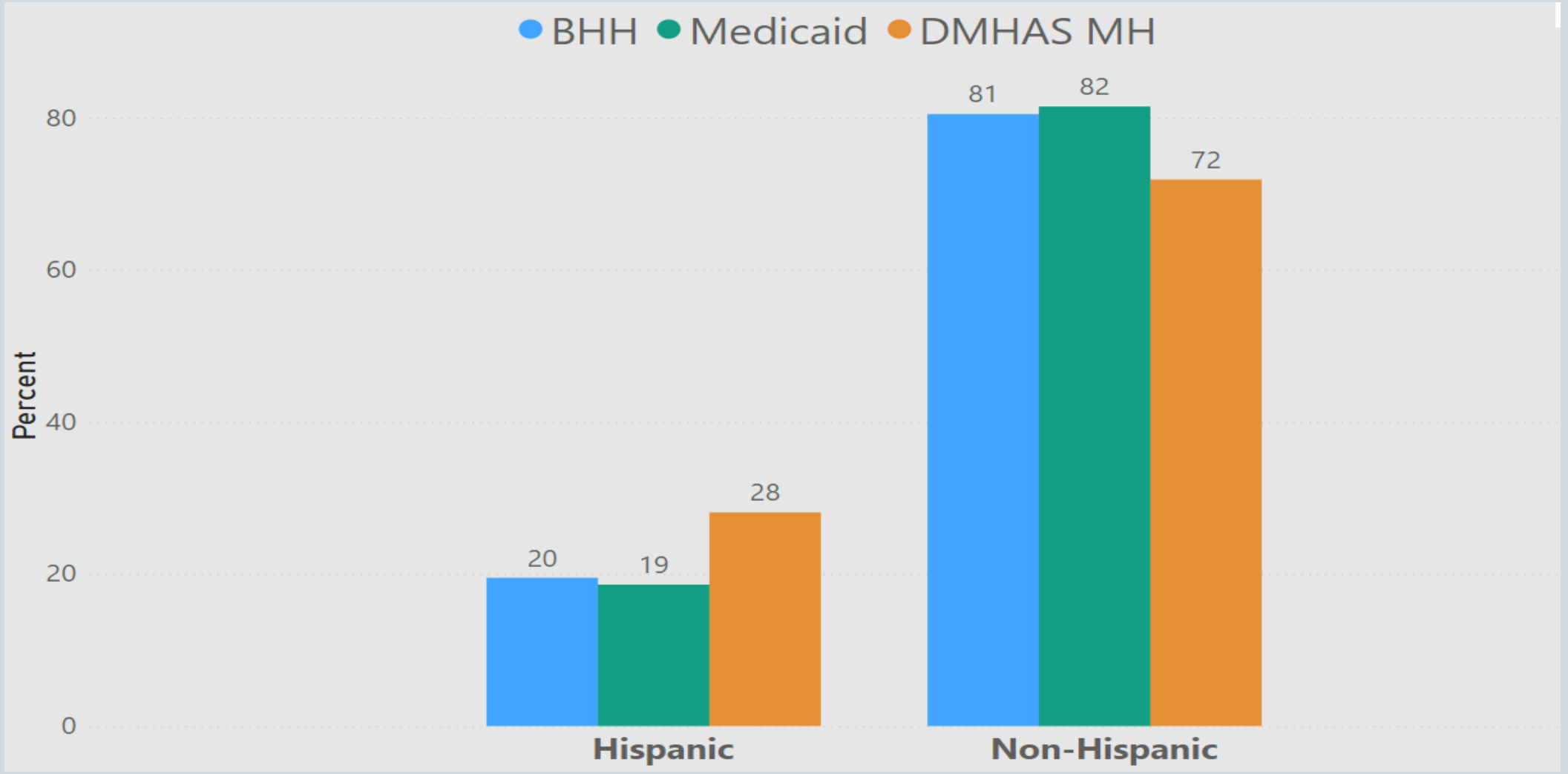
Age


BHH
Medicaid
DMHAS MH
Percent
40
30
20
10
0
39
23
36
39
35
34
23
42
29
55 and Over
35-54
18-34

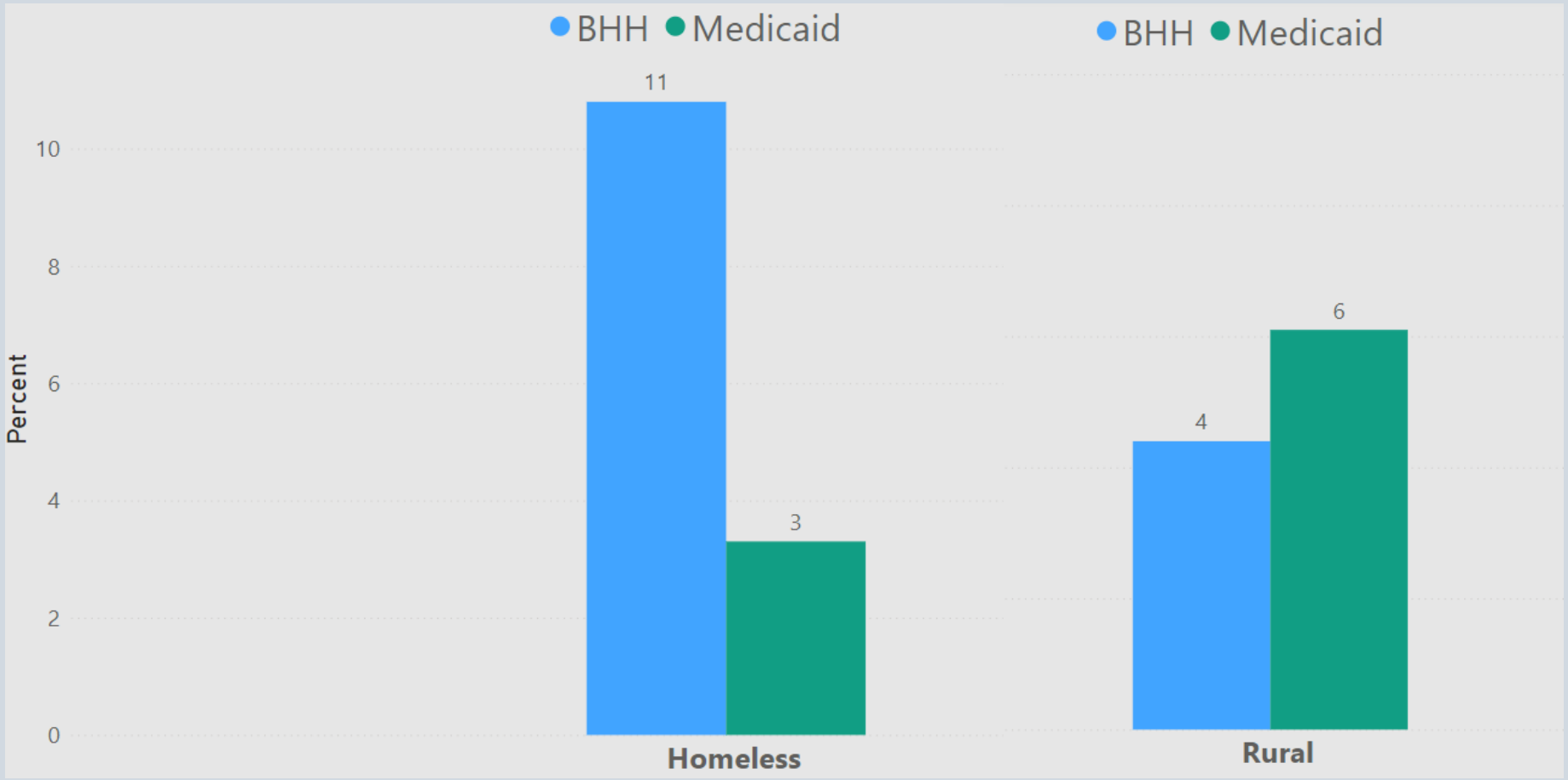
Race


BHH
Medicaid
DMHAS MH
Percent
60
50
40
30
20
10
0
23
17
18
2
4
15
23
40
8
56
40
59
Black
Other
Unknown
White

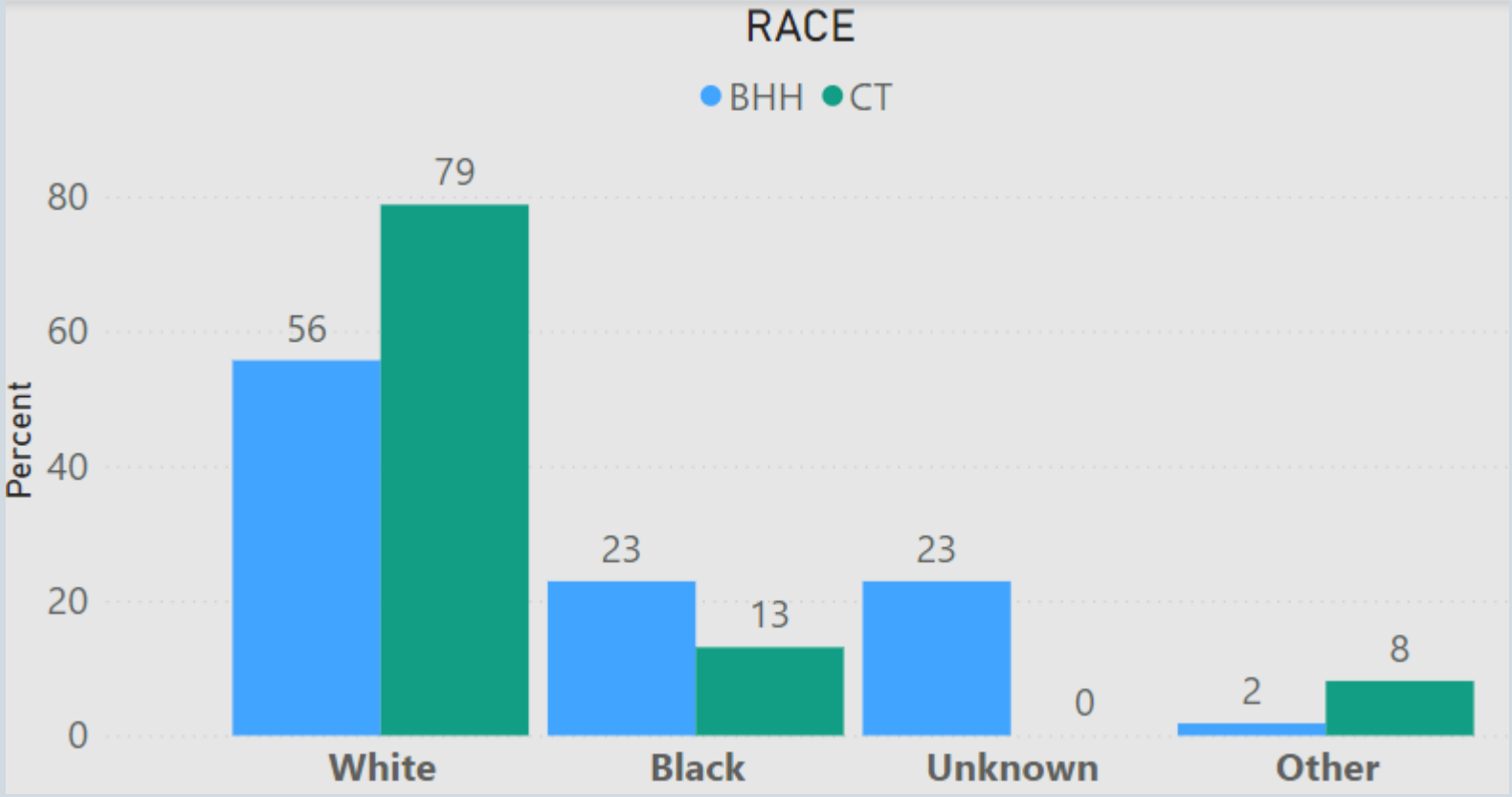
Ethnicity

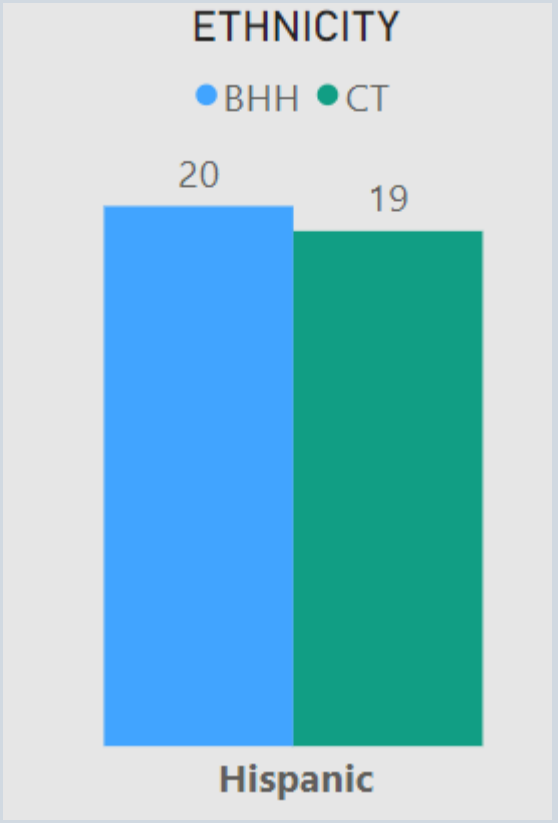

BHH
Medicaid
DMHAS MH
Percent
80
60
40
20
0
20
19
28
81
82
72
Hispanic
Non-Hispanic

Housing Status and Location

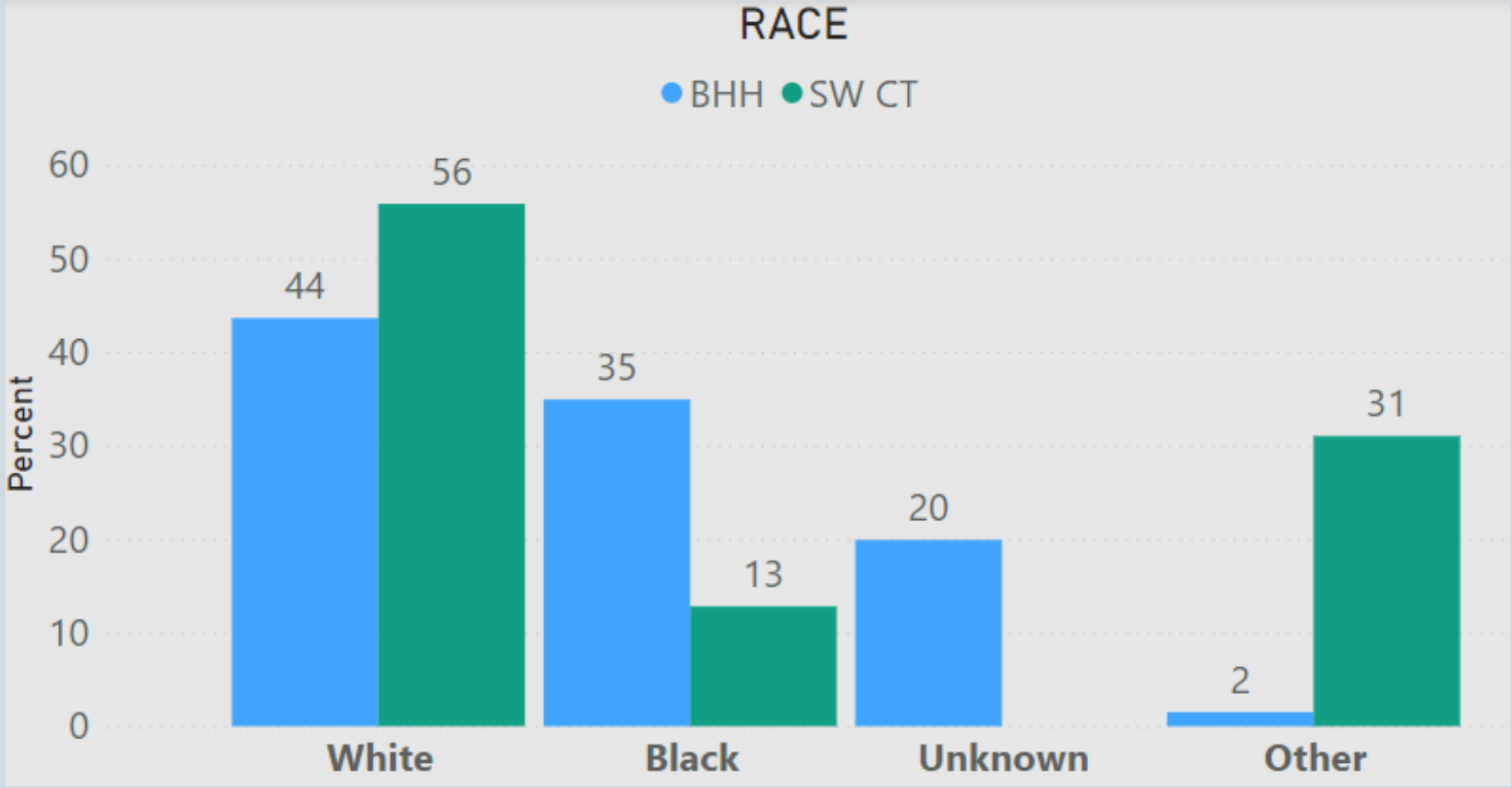


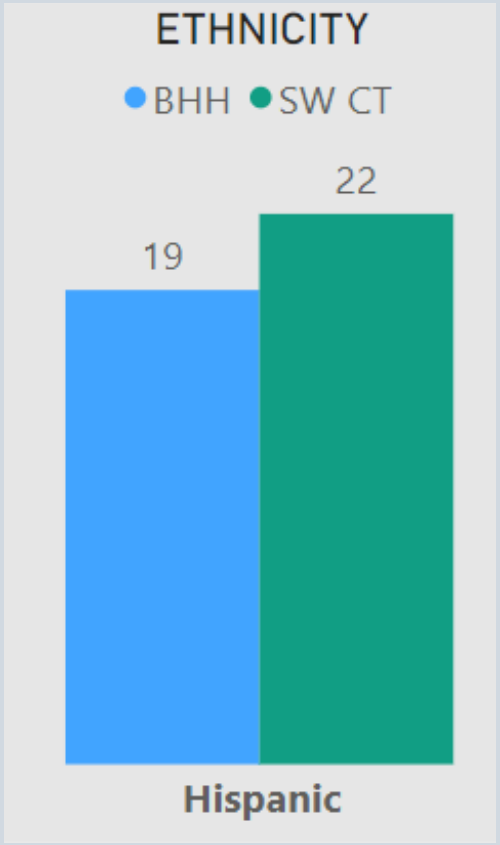
BHH Population/Community Population: State



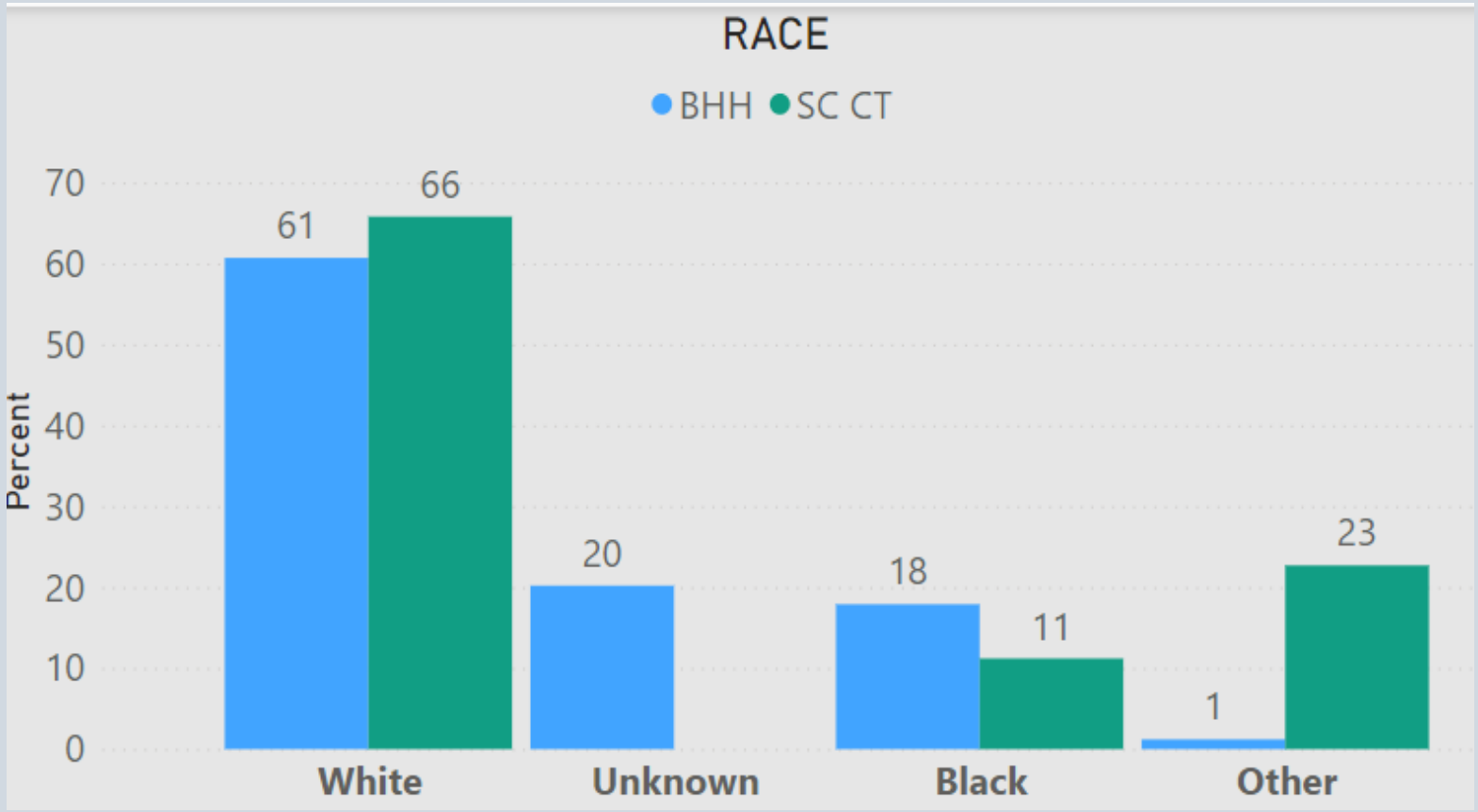


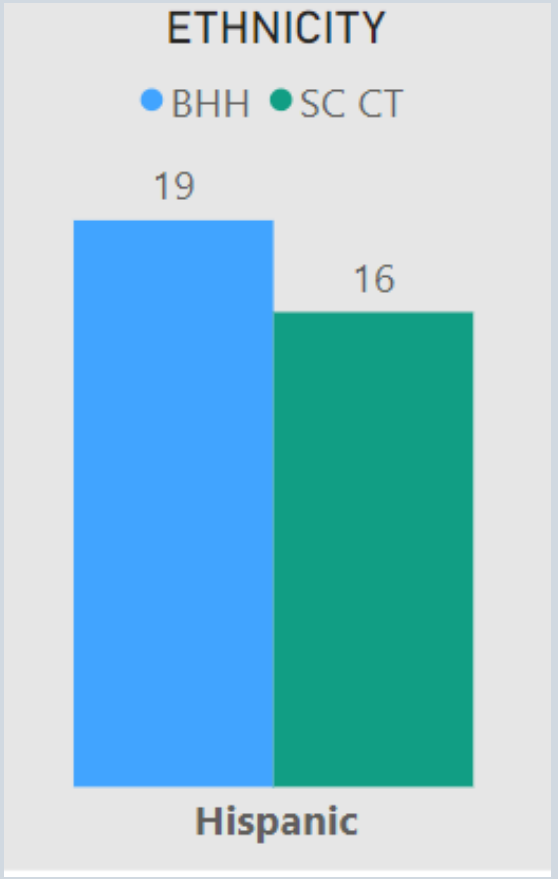
BHH Population/Community Population: SW CT



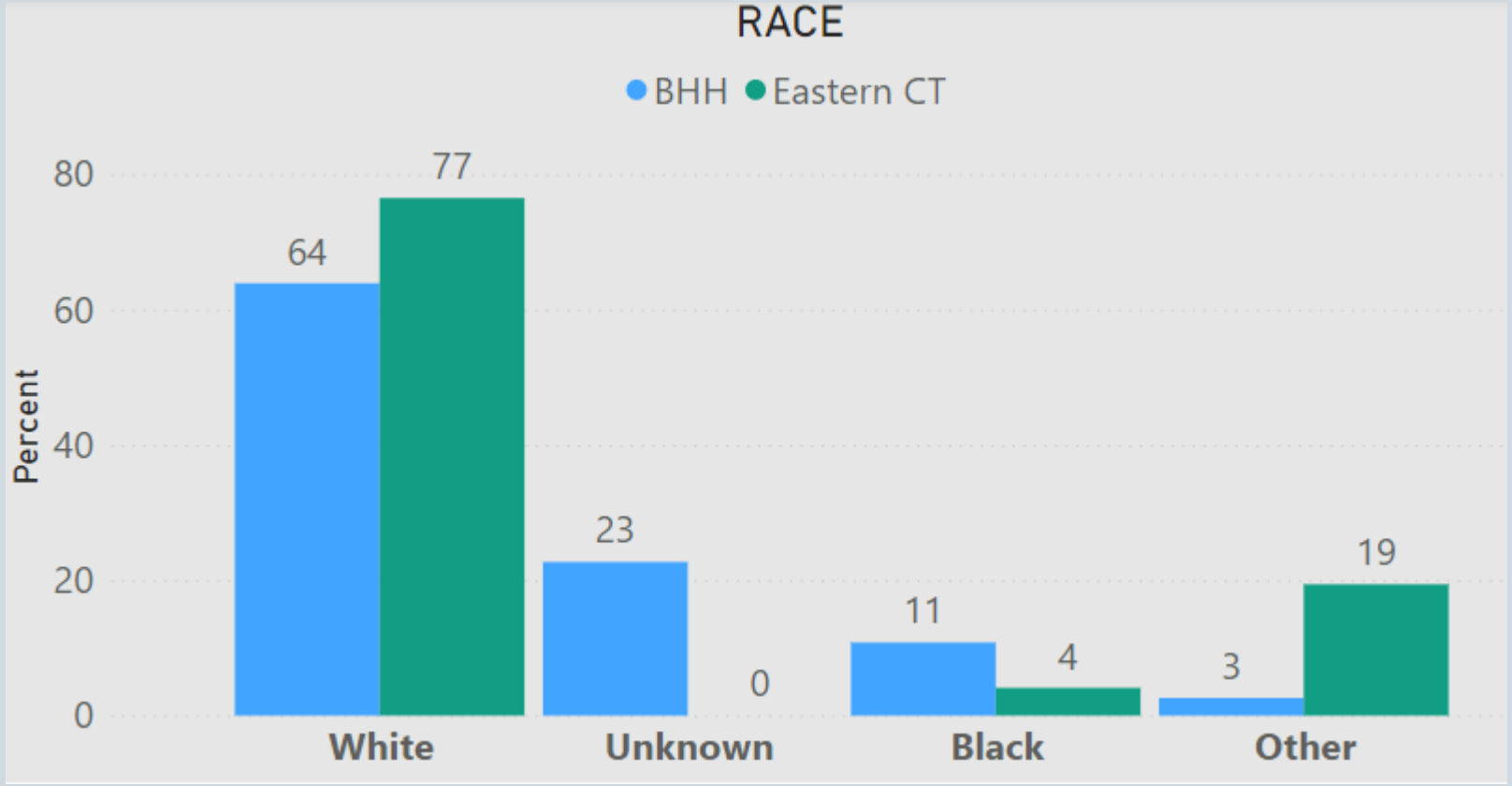


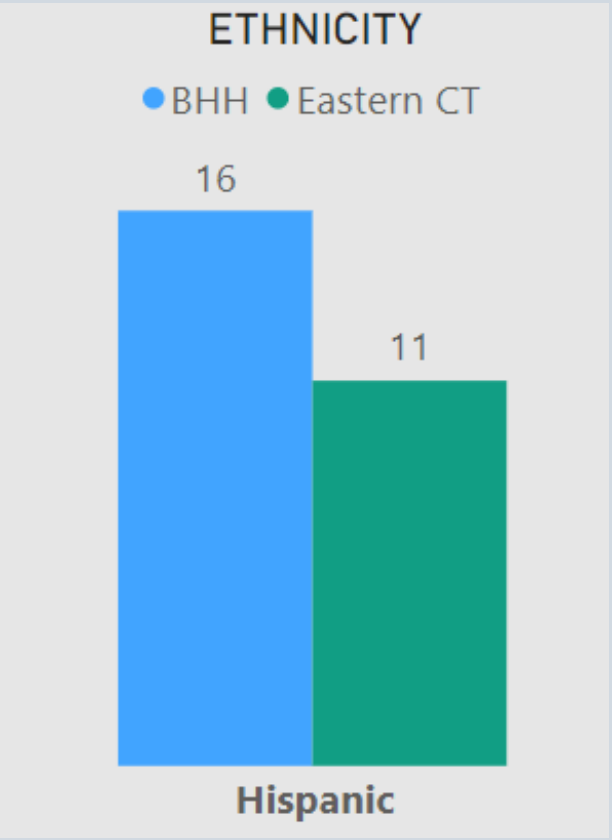
BHH Population/Community Population: SC CT



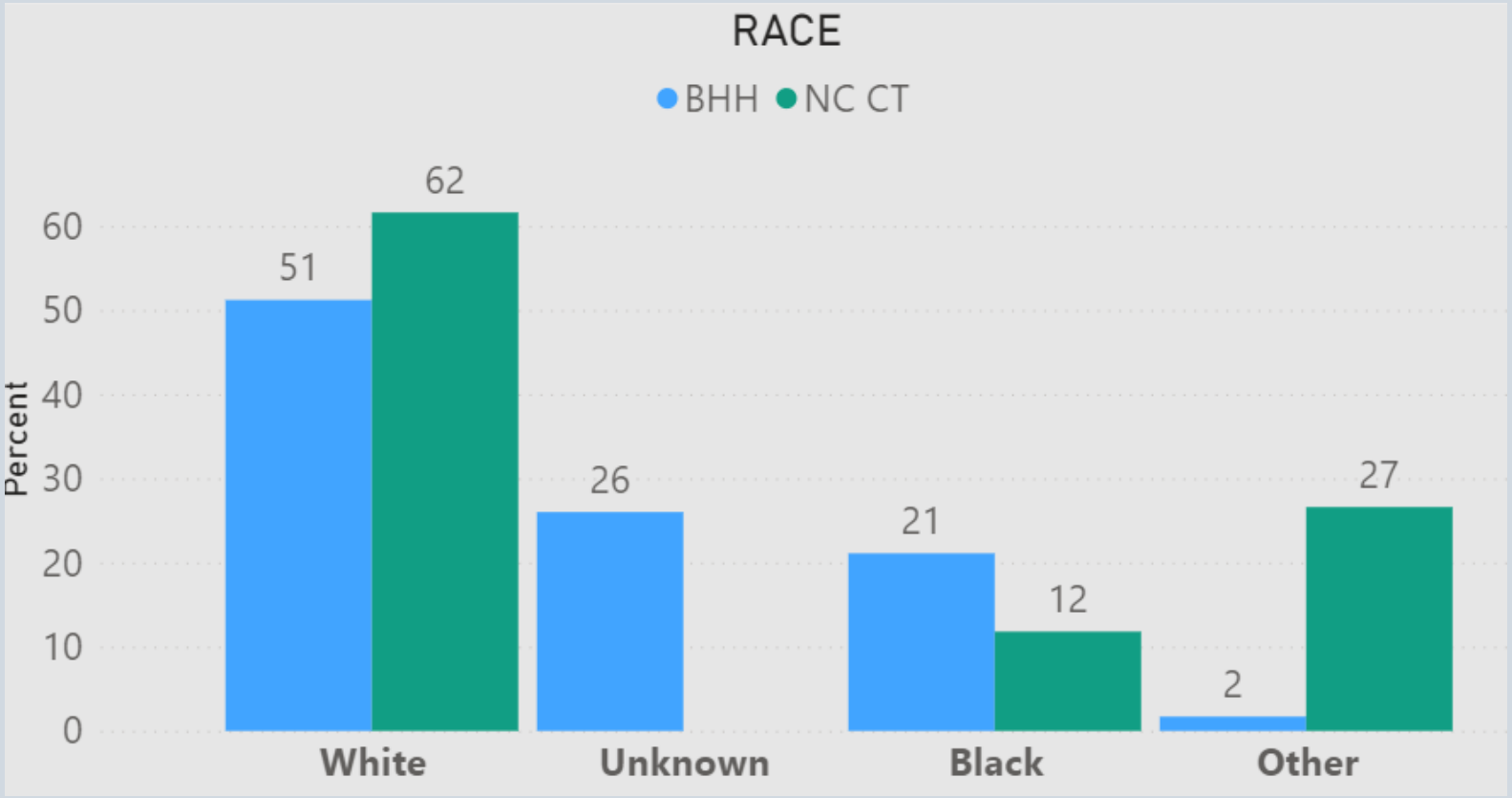


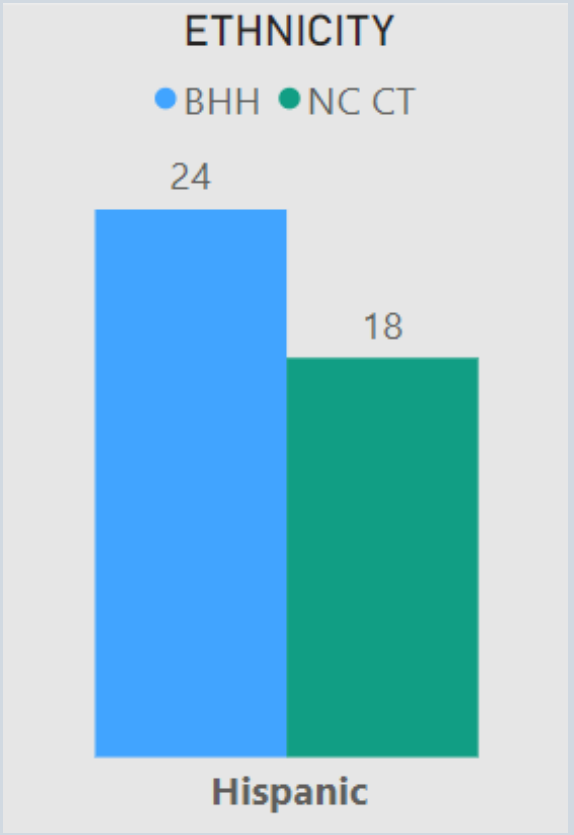
BHH Population/Community Population: Eastern CT



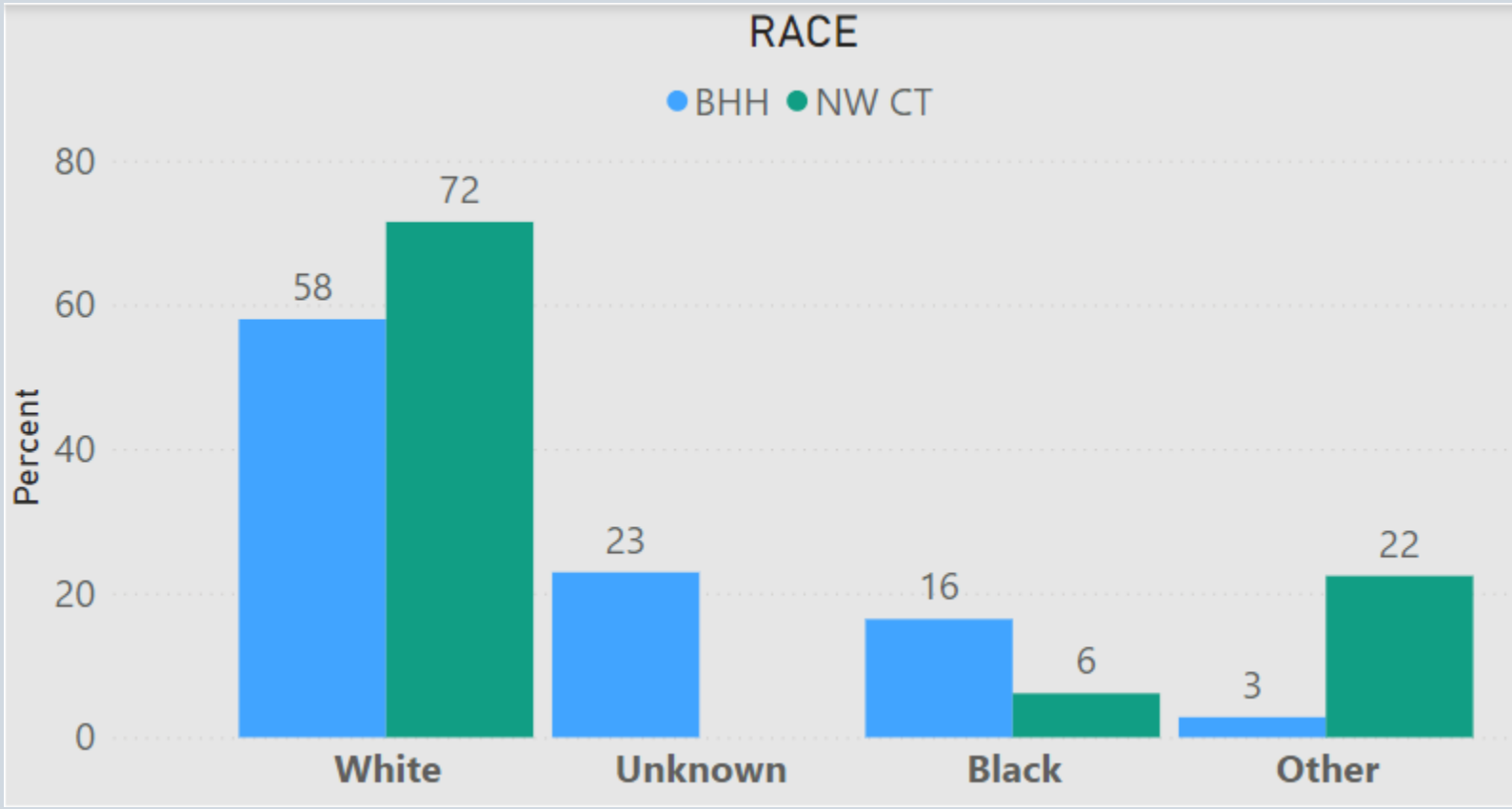


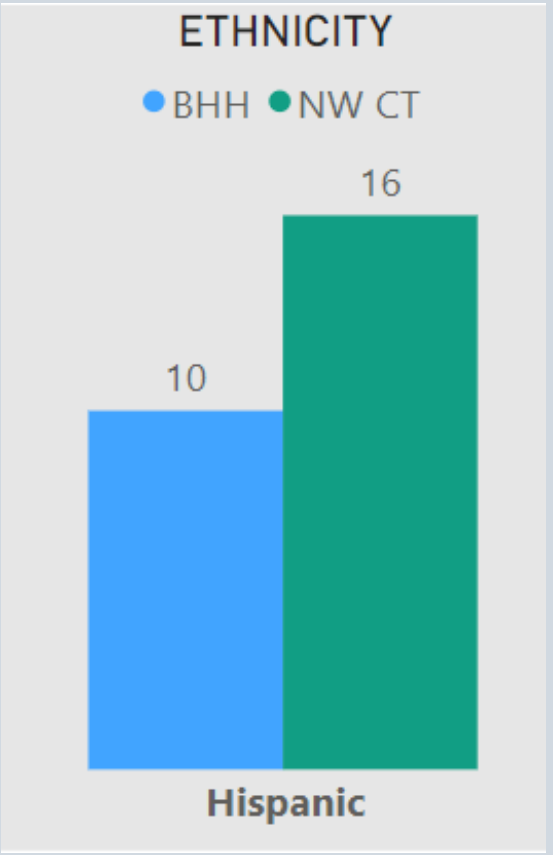
BHH Population/Community Population: NC CT





BHH Population/Community Population: NW CT





Next Steps

- Develop capacity to use DMHAS data to compare BHH agency level population characteristics to overall agency population characteristics.
- Use data to identify underserved populations within each agency.
- Investigate reasons and identify action steps to close gaps (if they exist).
- Continue the focus on increasing enrollment in BHH.

BHH Provider List

BH Care
Bridges Healthcare Inc.
Capitol Region Mental Health Center
Community Health Resources Inc.
Community Mental Health Affiliates
Connecticut Mental Health Center
InterCommunity Inc.
River Valley Services
Rushford Center
Sound Community Services Inc.
Southeastern Mental Health Authority
Southwest Connecticut Mental Health System
United Services Inc.
Western Connecticut Mental Health Network

References

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9. Comparison Population Data: US Census Data (2021 American Community Survey, 5-year estimates); CT Data Collaborative