Behavioral Health Homes

Focus on Service Delivery and Client Impact

Whole Person Care for Medicaid Members with Complex Needs
Behavioral Health Partnership Oversight Council
Adult Quality and Access Subcommittee
May 2026

CONNECTICUT
Mental Health and Addiction Services

What is a Behavioral Health Home (BHH)?

A service integration model that incorporates a focus on physical health needs into a behavioral health setting.

BHH is not direct primary or specialty care.

Allows for greater coordination with primary and specialty care in the community.

Client care focuses on coordinating and facilitating client connection to services and supports to meet their healthcare needs.

Is about the service provided, not the person providing the service.

The Need for Behavioral Health Homes

People with Serious and Persistent Mental Illness (SPMI):

- Have a higher mortality rate with an average life expectancy 15-25 years less than those without an SPMI.
- Experience at least one medical comorbidity at a rate of 50%-80%.
- Are largely underserved by primary care and lack a Primary Care Provider.
- Experience barriers in accessing medical/specialty care.
- Sixty (60) % of the co-occurring medical conditions among persons with SPMI are non-fatal and preventable.

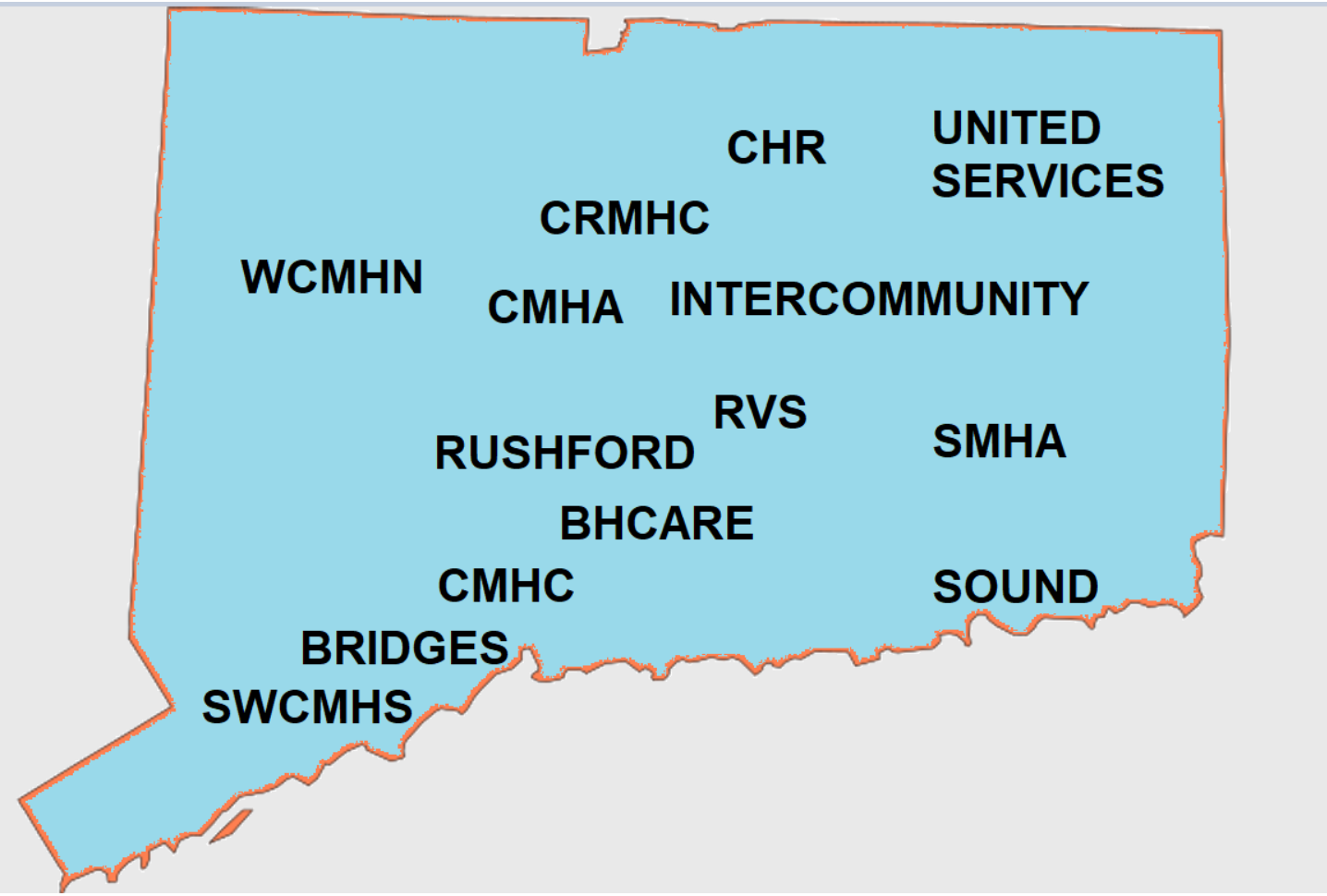
BHH Eligibility

SPMI Diagnosis	• BHH members are required to be diagnosed with an SPMI diagnosis that is outlined on the Medicaid State Plan Amendment.
Active Medicaid coverage	• BHH members must have active Husky Health coverage at time of enrollment.
Medicaid claim threshold	• BHH members must have medical claims that exceed $10,000 in the previous 12-month period
Served by BHH Agency	• BHH members must be an active client of an enrolled BHH agency.

Common Diagnoses for BHH Participants

Top Ten SMI Diagnoses		
F419	Anxiety disorder, unspecified	1
F4310	Post-traumatic stress disorder, unspecified	2
F411	Generalized anxiety disorder	3
F4312	Post-traumatic stress disorder, chronic	4
F32A	Depression, unspecified	5
F331	Major depressive disorder, recurrent, moderate	6
F418	Other specified anxiety disorders	7
F603	Borderline personality disorder	8
F319	Bipolar disorder, unspecified	9
F329	Major depressive disorder, single episode, unspecified	10

BHH Designated Providers



- 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

- Carelon: ASO
- Advanced Behavioral Health: Provider Relations

Goals of BHH

- Improve health and well-being of clients.
- Improve treatment of acute and chronic health conditions and prevent new chronic diseases and conditions.
- Improve client experience.
- Coordinate healthcare transitions.
- Reduce healthcare costs.
- Decrease in the use of emergency departments

BHH Implementation

- While BHH has specific staff members assigned to support and manage BHH, anyone working with a client who is enrolled in BHH is supporting BHH and BHH activities.
- BHH is about the services provided, not the person providing the service.
    - BHH Director
    - Primary Care Nurse Manager/Coordinator
    - Primary Care Physician (PCP) Consultant
    - Administrative Support Specialist
    - BHH Specialist
    - Care Transition Coordinator
    - Recovery and Peer Support Specialist

BHH Core Services

BHH Services

These scenarios only provide a small picture of the complex and diverse services and supports provided to BHH clients.

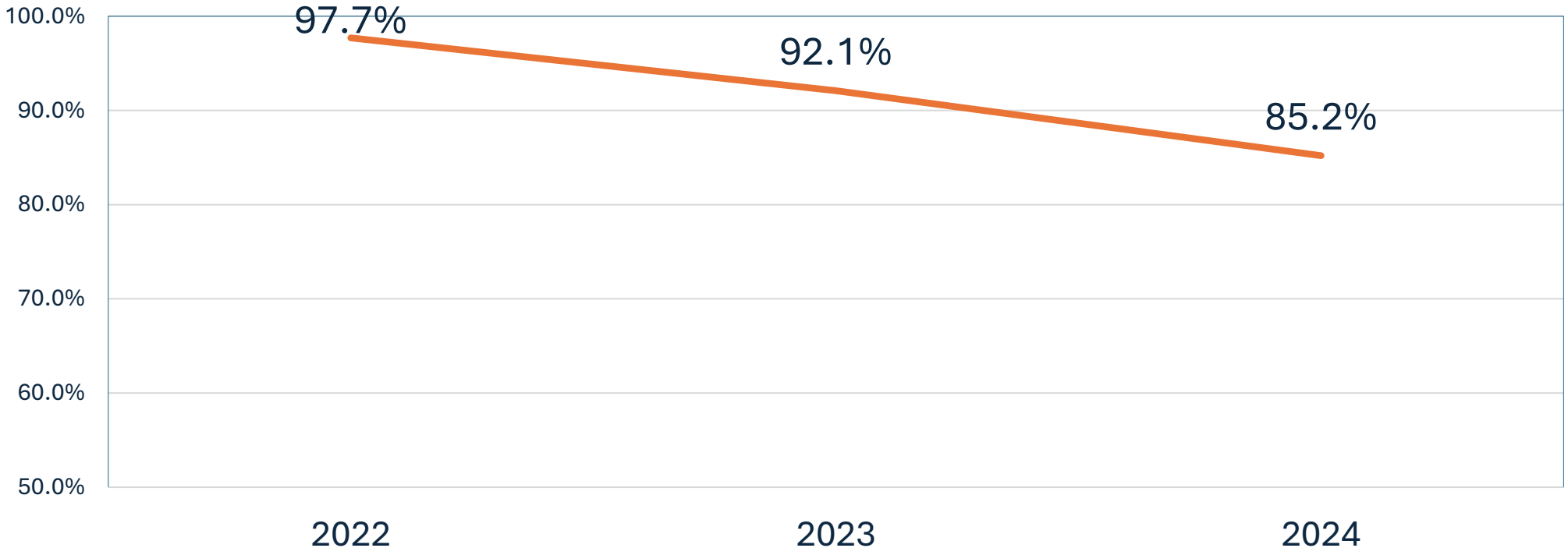
BHH Services

Care Coordination: Diabetes

- Confirm times and dates of client's appointments with endocrinologist, primary care provider and other medical providers within client's care team.
- Remind client of any upcoming appointments to ensure follow-up care.
- If needed and/or requested, attend appointments with the client to provide support and to increase collaboration and coordination of care.
- Refer to Gaps in Care report in BHH Tableau to ensure that standards related to diabetes care have been met.
- Coordinate referral to endocrinologist to ensure the client's specialized needs are met related to diabetes diagnosis.

BHH Services

Care Coordination: Diabetes Care Poor Glycemic Control Individuals with Diabetes



Note: Lower is Better

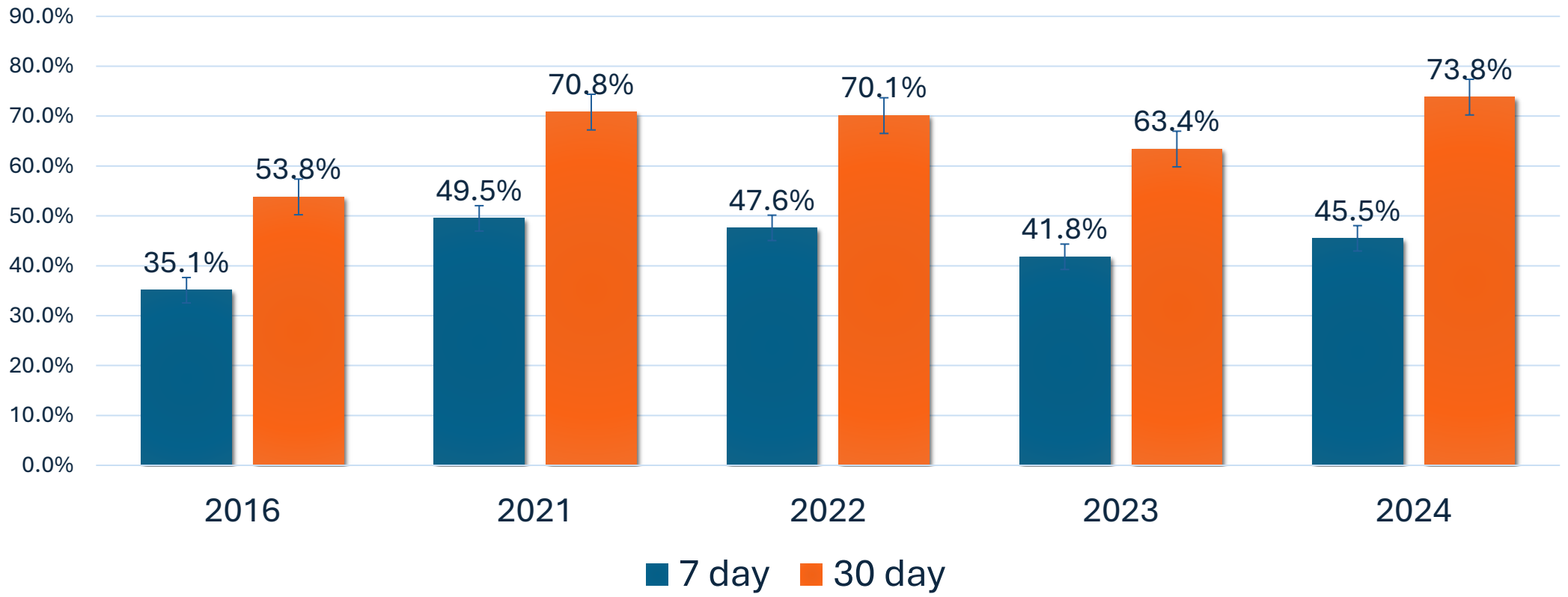
BHH Services

Comprehensive Transitional Care: Chronic Kidney Disease

- Participate in case consultations with hospital staff and/or other members of care team to determine if the client is able to manage their chronic kidney disease.
- Provide support to the client to help communicate with discharge team regarding health concerns prior to discharge.
- Collaborate with client's care team to review any potential medication side effects before transition from current setting to next level of care.
- Work with the client to help the client understand medication side effects.
- Ensure appropriate medications are prescribed and ready for pick up prior to discharge from hospital setting. .
- Work with the discharge team to ensure that the client has the necessary supports to live safely at home.

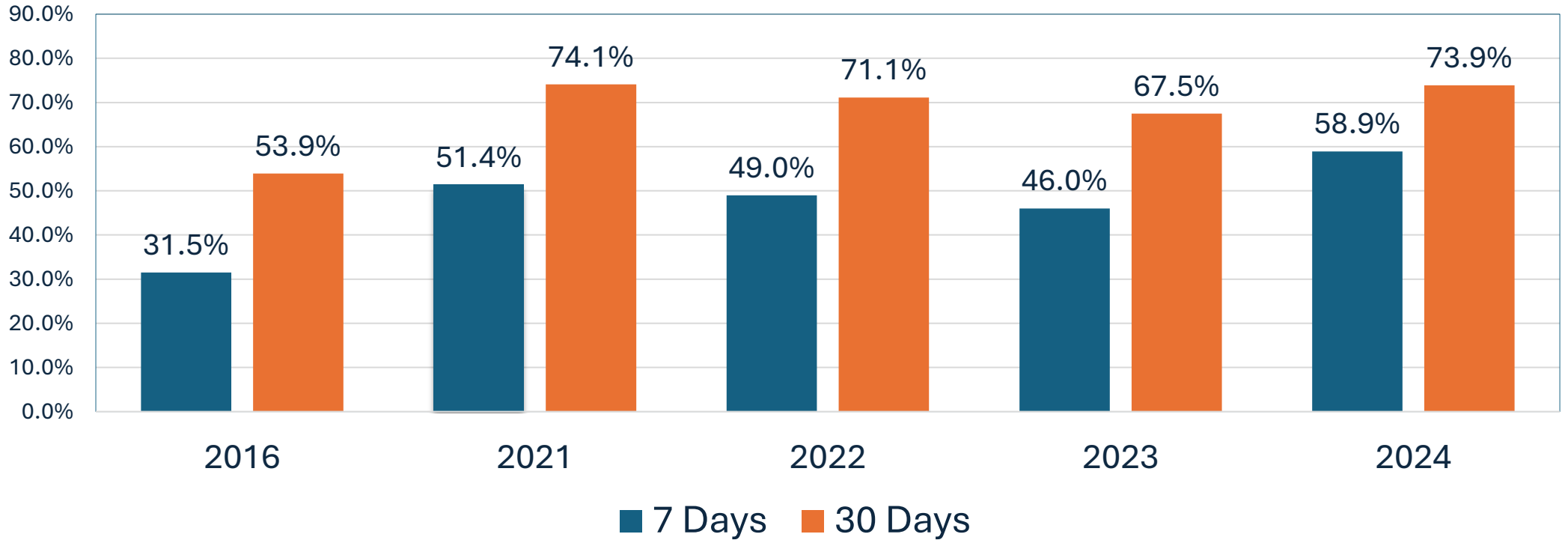
BHH Services

Comprehensive Transitional Care: Follow-up After Hospitalization for Mental Health



BHH Services

Comprehensive Transitional Care: Follow-up after ED Visit for Mental Health



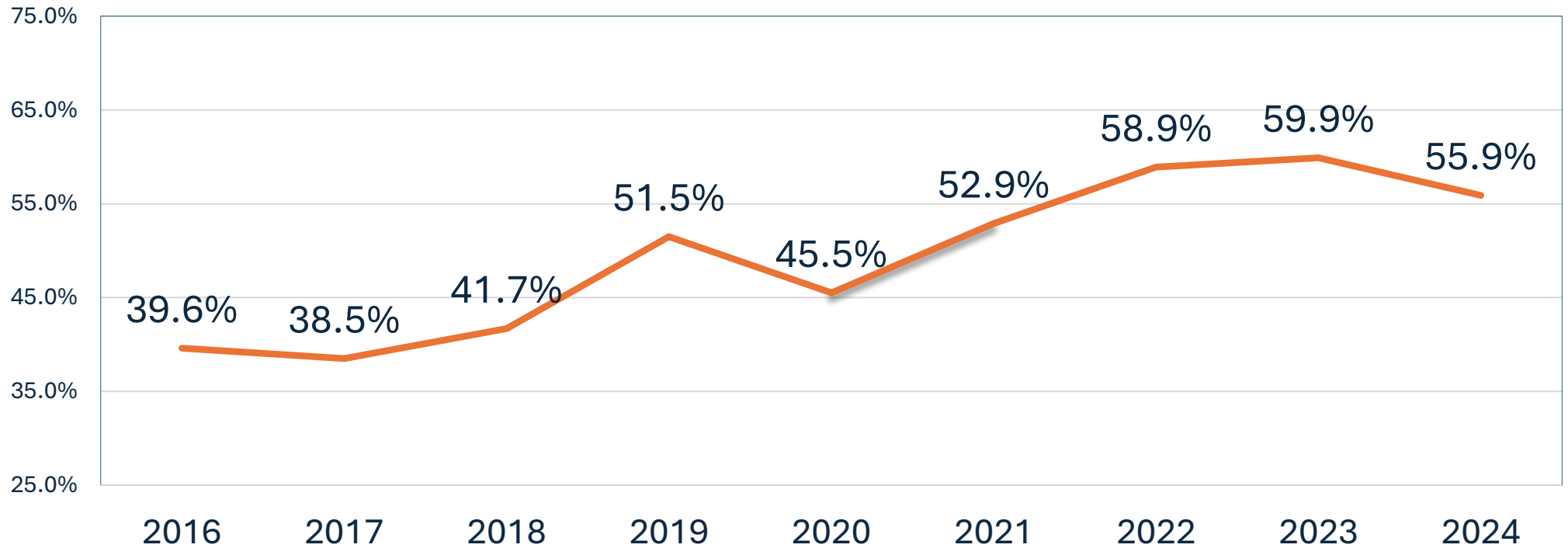
BHH Services

Comprehensive Care Management : High Blood Pressure (Hypertension)

- Conduct health assessment and discuss medical history and make referral to an MD, APRN or PA for further evaluation if warranted.
- If a client is identified as having high blood pressure by an MD, APRN or PA, work with the client to create goals and objectives on their care plan that address high blood pressure.
- Meet regularly with client to monitor progress toward reducing blood pressure.
- Review client's health needs and concerns as they relate to hypertension and verify that these needs/concerns are being addressed in the care plan.
- Include blood pressure management in treatment plan goals for any client diagnosed with hypertension.

BHH Outcomes

Comprehensive Care Management : Controlled High Blood Pressure (Hypertension)



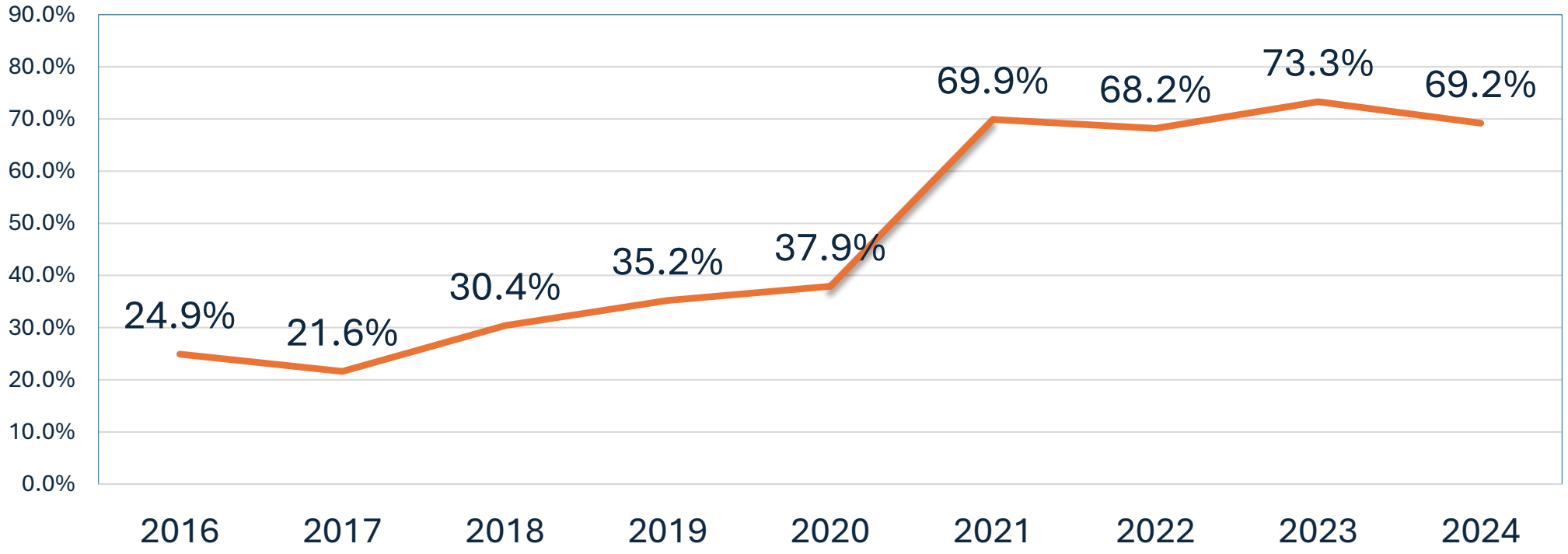
BHH Services

Referral to Community Support Services: Thyroid Disease/Autoimmune Disorder

- Ensure that the client has the resources to obtain food items that support thyroid health.
- Link the client to resources including food pantries and grocery stores to ensure access to food items that support good nutrition and thyroid health.
- Confirm that the client's insurance is active and monitor completion of time sensitive forms to ensure insurance remains active.
- Assist the client in identifying support groups, local events, or community organizations that can provide support and education for individuals with thyroid disease.

BHH Services

Referral to Community Support Services: Depression Screen and Follow-up



Individuals without a diagnosis of MDD or BPD

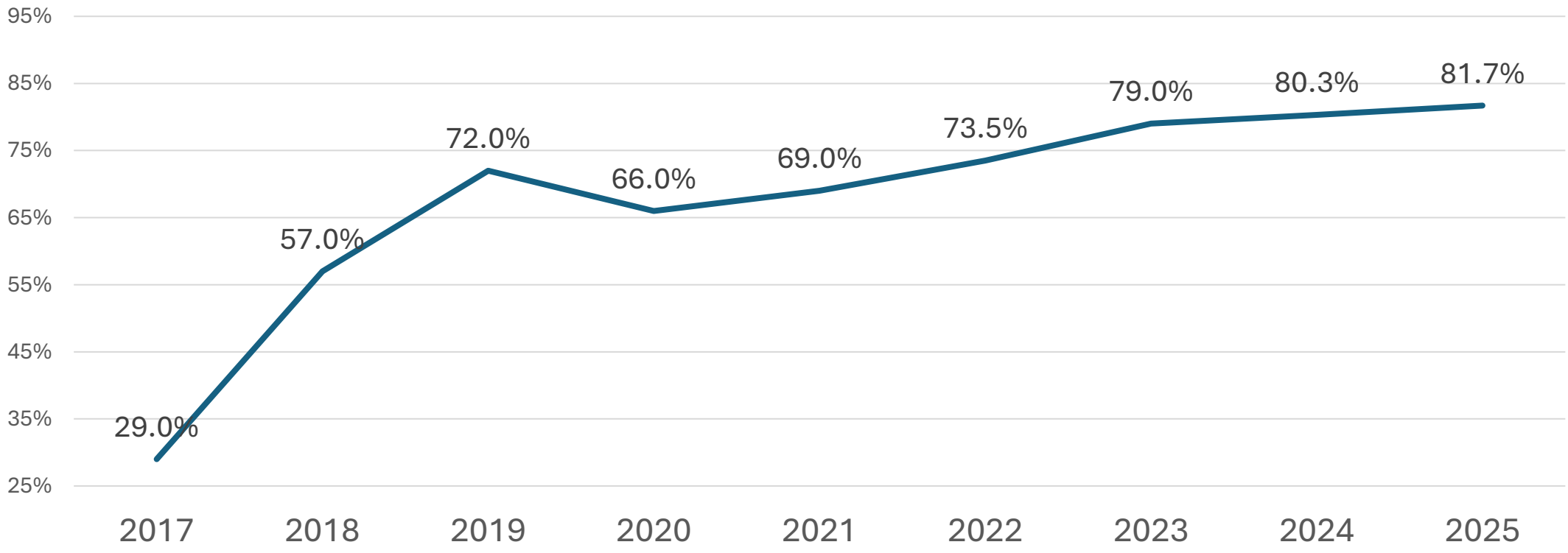
BHH Services

Health Promotion: Obesity

- Provide health education groups focusing on achieving and maintaining a healthy weight and health conditions related to obesity.
- Educate clients about nutrition including the benefits of eating a balanced diet, meal planning, and preparing healthy meals and snacks.
- Encourage clients to consult with their primary care provider or other members of their care team if they would like to change their diet to improve their health and/or lose weight.
- Provide available resources to support increased physical activity.
- Provide education to clients that are prescribed medications that may cause weight gain.

BHH Outcomes

Health Promotion: Health Assessment Completion



BHH Outcomes

Client and Family Support: Asthma

- Identify individuals within a client's support system that may also have or be at risk for asthma and invite them to a group to learn about asthma, how to lessen asthma symptoms and effective asthma treatments.
- Identify an individual who can assist a client in properly managing their asthma and taking asthma medication.
- Invite family supports to attend educational groups about how to manage asthma diagnosis.
- With client permission, discuss the individual's asthma diagnosis, treatment options, and medications with formal/informal support system.
- Collaborate with external supports about how to easily access asthma medications including Epi-pen.

Provider Perspectives

Statewide Provider Relations

What are the greatest impacts that BHH has had on agencies and clients?

What are the most important lessons/insights agencies have learned about providing integrated care?

What are some of the challenges agencies face in providing whole person integrated care?

Provider Perspectives

Agency Perspective

What are the greatest impacts that BHH has had on your agency and on clients at your agency?

What are the most important lessons/insights you/your agency has learned about providing integrated care?

What are some of the challenges you face in providing whole person integrated care?