

Behavioral Health Home Services

Summary of Characteristics: Urban Sites

In 2016, the Minnesota Department of Human Services (DHS) established the behavioral health home (BHH) services model. DHS contracted with Wilder Research to conduct an implementation evaluation that will inform a later outcome evaluation, drawing on data from interviews with individuals served and/or their caregivers, staff interviews, service referral records, and an implementation checklist self-administered by providers.

In order to understand how different types of sites are implementing the BHH services model, this summary provides an overview of BHH services implementation among the 12 urban BHH services sites. Urban sites served fifty-two of the individuals served who completed interviews. While urban and rural sites generally reported similar patterns of data, there were several differences; if a difference is not specifically mentioned, it indicates that these two types of sites had similar results. Due to the relatively small number of sites and interview respondents representing urban sites, readers should interpret results with caution.

BHH Services Implementation

Progress in BHH services implementation overall

When asked about the successes they have had so far in implementing the BHH services model, half of urban sites mentioned that they have a clearer understanding of how to implement the BHH services model (e.g., increased understanding of workflows, policy, procedures, roles, and which individuals are a good fit) and improved processes (e.g., standardized workflows; processes are quicker, more systematic, or more integrated). A quarter of urban sites (25%) shared that they are growing or expanding BHH services (e.g., increases in the number of individuals referred to or enrolled in BHH services, broadening services offered). However, compared to rural sites, urban sites were more likely to mention they are serving individuals of higher acuity than reimbursement rates cover or that high caseload expectations are a challenge (33% versus 0%), and they were more likely to request additional funding or greater reimbursement (25% versus 14%).

Organizational supports

Urban sites are generally receiving organizational support for BHH services implementation, including technical infrastructure. According to the implementation checklist, all urban sites use an electronic health record. Most sites (75%) use the state-developed Mental Health Information System (MHIS) to report data to the state and their patient registry or the Minnesota Provider Partner Portal to perform population management. Urban sites were more likely to use their patient registry or the Minnesota Provider Partner Portal for population management (83% versus 43%) and less likely to use the MHIS than rural sites (75% versus 100%).

Most urban sites benefit from additional organizational resources and supports, as they are also implementing other models, such as Certified Community Behavioral Health Clinics (CCBHC) and Adult Rehabilitative Mental Health Services (ARMHS; 83%). Some sites reported they have received other funding, such as a disability services innovation grant from the Minnesota Department of Human Services (33%).

Culture to support integration

The themes from both the self-reported implementation checklist and the staff interview suggest that urban sites' organizational culture supports integration. All urban sites shared in the staff interview that they previously provided services to support integration and reported in the implementation checklist that they have leaders who actively support the concepts of integration. Most urban sites agreed that they have financial leaders involved in creating the business plan for increased integration (92%), a culture of shared leadership and responsibility (83%), and leaders who engage all staff in integration (83%).

Staff training and capacity

All urban sites indicated in the implementation checklist that they identify and meet staff training needs and hire staff who have the qualifications to work in an integrated environment. Almost all urban sites reported that they hire staff who have a basic understanding of integration principles (92%) and use evidence-based practices, such as motivational interviewing (92%).

However, most sites mentioned a need for additional opportunities for BHH services staff to communicate and share lessons learned with one another (58%), and a quarter of sites reported a need for additional training, such as trainings on the Minnesota Provider Partner Portal (25%). Some sites also mentioned that hiring staff or staff turnover was a challenge (25%). Relative to rural sites, staff at urban sites were more likely to request additional staff training (58% versus 14%), regular check-ins with the Minnesota Department of Human Services (DHS; 25% versus 0%), and clearer guidelines for BHH services implementation (25% versus 0%).

Comprehensive care management

Urban sites generally utilize comprehensive care management strategies. Most urban sites indicated in the implementation checklist that they have the capacity to administer or refer individuals for physical health screening (92%) and a process for following up with screenings (83%). Urban sites also commonly reported collecting data on medications and lab results and then using this information to adjust treatment (75% and 92%, respectively). Most urban sites reported engaging in health and wellness promotion activities, such as health coaching and health education (83% and 75%, respectively).

Care coordination

Urban sites are engaging in a variety of care coordination activities. All urban sites reported that they implement all care coordination activities listed in the implementation checklist, such as providing a central point of contact to assist with service navigation, delivering services in locations and settings that meet individuals' needs, and helping with appointments. In addition, all urban sites reported having access to information on referrals based on individuals' health screening, contact information for other health providers, and contact information for family member(s) or other supports. Most sites (92%) reported having access to medications and lab result information. Urban sites were less likely to mention avoiding duplicative services and issues related to billing and insurance as challenges compared to rural sites (both 17% versus 57%). However, several urban sites (33%) mentioned that the diagnostic assessment requirements delay access to needed services for the individuals they serve, a challenge not reported by rural sites.

When asked to describe their care coordination process, all urban sites mentioned that they communicate with outside providers and have regular team meetings, check-ins, or supervision. Most sites also shared that they request records or obtain information releases and use electronic records (67% and 83%, respectively).

Urban sites most commonly reported communicating with individuals served by phone (83%) and face-to-face contact (58%). Relative to rural sites, urban sites were more likely to report using email (42% versus 0%) and texting (42% versus 29%).

When asked whether the BHH services team provides different types of help with appointments, most individuals served agreed that they help make appointments (72%), remind individuals served about appointments (62%), and follow up about appointments (80%) at least sometimes (Figure 1). Almost half of individuals served reported that the BHH services team provides assistance to get to appointments (44%). Individuals served at urban sites were more likely to report that they did not need assistance to get to their appointments than rural sites (48% versus 37%).

1. Appointment assistance received by individuals served by urban sites

Does the BHH services team...	Percentage of individuals served by urban BHH services sites (N=50)			
	Most of the times or always	Sometimes	Never	Not needed
Help you make the appointments you need?	50%	22%	8%	20%
Remind you about the appointments?	48%	14%	6%	32%
Provide assistance to help you get to the appointments?	26%	18%	8%	48%
Follow up with you about the appointments?	56%	24%	6%	14%

Source. Interview with individuals receiving BHH services

Transitional care

Urban sites are assisting individuals transitioning between different care settings. Most urban sites reported in the implementation checklist that they have systematic ways to access admission and discharge information, health profiles, and service information from appropriate entities (67%); create plans after an individual is discharged (83%); and engage individuals and families in transition planning (92%).

When asked whether they've been admitted to a hospital or any other residential setting, about a quarter of individuals served at urban sites said that they had (26%; n=13). Of those, more than a third of individuals reported that the BHH services team helped them move into and out of that care (39%). When asked how the BHH services team helped with care transition, individuals served most commonly mentioned that the team helped with transportation (39%) and accompanied the individual to the hospital or otherwise assisted with admission (31%).

Individual and family support services

Urban sites are generally providing person-centered care and individual and family support services. All or nearly all urban sites reported providing individual and family support services, such as using a person-centered planning approach (100%); learning about the culture, preferences, and communication needs of individuals served (100%); and asking individuals served to identify formal and informal supports (92%).

Most individuals served at urban sites agreed that they have physical and/or mental health goals they're working on (90%), and that they worked with the BHH services team to come up with their goals (89%) and to create a plan to reach their goals (98%). Most individuals also agreed that the plan or the BHH services team has been helpful to reach their goals (91%).

Individuals most frequently reported general improved mental or behavioral health (17%), general improved physical health (15%), and improved socializing skills or decreased isolation (12%) when asked what goals they have been able to accomplish. When asked how the plan or service team helped them to reach their goals, individuals served at urban sites most often cited specific positive qualities about staff (8%) and that the staff are reliable, dependable, or responsive (8%).

Referrals and supports

Urban sites made 2,576 referrals during the 9-month referral tracking data collection period (Figure 2). The most common categories of referrals were mental health care (26%), physical health care (22%), and housing (15%; Figure 2). The individuals receiving referrals followed up on most of the referrals (60%), meaning that they contacted the referral agency to initiate the referral services. Those not followed up on may be because BHH services staff were unable to ask the individual served about referral follow-up, the referral was unavailable, or the individual chose not to follow up on the referral.

2. Referrals made to individuals receiving BHH services at urban sites and rural sites

	Referral tracking results			
	Urban number of referrals	Rural number of referrals	Urban % of all referrals	Rural % of all referrals
Mental health care	681	278	26%**	20%
Physical health care	569	251	22%**	18%
Housing	392	196	15%	14%
Disability services	123	50	5%	4%
Recreational, social, or cultural	119	35	5%**	3%
Chemical health care	84	44	3%	3%
Dental care	80	63	3%*	4%
Transportation	83	144	3%**	10%
SNAP/Food Support	76	77	3%**	5%
MFIP/Financial Assistance	67	75	3%**	5%
Legal assistance	63	31	2%	2%
Other basic needs	51	46	2%*	3%
Other	48	39	2%	3%
Employment	48	23	2%	2%
MA/Insurance/MNsure	43	54	2%**	4%
Education	39	5	2%**	<1%
Child care	10	7	<1%	1%
Total	2,576	1,418		

Source. Referral tracking

Note. Statistical significance was tested using chi-square analysis and statistically significant results are identified as * p<.05 and ** p<.01.

Compared to referrals made at rural sites, a greater proportion of referrals at urban sites were for physical health care (22% versus 18%; $p < .01$); mental health care (26% versus 20%; $p < .01$); education (2% versus $< 1\%$; $p < .01$); the Minnesota Family Investment Program (MFIP) or other financial assistance (3% versus 5%; $p < .01$); and recreational, social, or cultural services (5% versus 3%; $p < .01$; Figure 2). Urban sites made proportionally fewer referrals for dental care (3% versus 4%; $p < .05$); Medical Assistance (MA), insurance, or MNsure support (2% versus 4%; $p < .01$); transportation (3% versus 10%; $p < .01$); and the Supplemental Nutrition Assistance Program (SNAP) or other food support (3% versus 5%; $p < .01$; Figure 2). Overall, referrals made at urban sites were less likely to be followed up on than referrals given to individuals served at rural sites (60% versus 66%; $p < .01$).

When asked which community resources individuals served are accessing to meet their needs, most urban sites mentioned housing (83%), food support (75%), and physical health care (58%). Half of urban sites (50%) also mentioned mental health care and transportation. When asked what resources are needed to better meet the needs of individuals served at their site, sites most commonly mentioned housing (83%) and transportation (42%).

Individuals served at urban sites most frequently mentioned more social support or social interaction (14%) and transportation services (10%) when asked about what additional supports would be helpful.

Preliminary outcomes

Urban sites generally reported positive changes in the individuals they serve. Most sites shared that individuals served have become more independent or confident or have learned how to better advocate for themselves. Most urban sites (58%) also reported that the individuals they serve have increased knowledge, awareness, and skills to better manage their health condition. Half of urban sites (50%) shared that individuals receiving BHH services attend and follow through on their appointments more regularly, and that there is more trust and better communication between individuals served and their providers. Some urban sites (42%) mentioned that individuals receiving BHH services enjoy and are engaged with the services.

When asked whether the BHH services team has helped them learn about their health condition, most individuals served at urban sites agreed that they had (70%). When asked how the BHH services team helped them learn about their health condition, individuals most frequently cited that the BHH services team explained the treatment for their health condition or how to manage it (15%), helped them understand their symptoms or diagnoses (12%), and provided resources or information (12%).

When asked what was most helpful about BHH services, individuals most commonly mentioned specific positive qualities about BHH services staff (29%); the staff are reliable, dependable, or responsive (23%); and the staff work well with the individual (17%).

When asked what was least helpful, individuals said that they would like the staff to be more available or have increased capacity (12%) and that they needed a service BHH services could not provide, such as clothing (8%).

Challenges and additional supports requested

In the staff interview, urban sites staff noted some challenges they've encountered and the types of support or modifications that would be most helpful as they move forward with BHH services implementation.

Challenges

- Communication with outside providers and managed care organizations (e.g., data sharing; 42%)
- Delays in accessing services due to diagnostic assessment requirements (33%)
- Serving individuals with higher acuity than the reimbursement rates cover or high caseload ratio (33%)
- BHH services are not well-known (33%), and it can be difficult to help others understand what BHH services are (25%)
- Hiring staff and/or staff turnover (25%)
- Building or navigating the patient registry (25%)
- Billing and insurance (e.g., difficulties receiving payments; type of insurance limits services; 17%)
- Avoiding duplicative services (17%)

Additional supports requested

- Opportunities for BHH services staff to come together to share lessons and communicate more regularly (58%)
- Outreach from the Minnesota Department of Human Services to outside service providers and the community to educate and advertise BHH services (50%)
- Additional training (e.g., training on the Minnesota Provider Partner Portal; 58%)
- Funding for administrative support, reimbursement for the pre-enrollment process, or higher reimbursement rates (25%)
- Clearer guidelines or expectations for BHH services implementation (25%)
- Regular check-ins with the Minnesota Department of Human Services (25%)

Conclusion

Urban sites are generally making progress in implementing the BHH services model and experiencing positive benefits. Urban sites report improved processes, organizational support, and organizational cultures conducive to service integration. They are providing comprehensive care management, care coordination, individual and family support services, and some transitional care. Individuals served at urban sites have also experienced benefits, such as learning about their health condition, setting and accomplishing health-related goals, and receiving referrals to needed services and supports. Lastly, BHH services staff at urban sites are well qualified, and the individuals served at urban sites view BHH services staff positively.

Urban sites also face challenges as they move forward with BHH services implementation. Urban sites shared that they serve individuals with higher acuity than the reimbursement rates compensate them for and that caseload expectations are high, and they requested additional funding or greater reimbursements. They also identified hiring staff and/or staff turnover as a challenge. Urban sites requested additional trainings for staff, more opportunities for BHH services staff to communicate and share lessons learned with one another, regular check-ins with the Minnesota Department of Human Services, and clearer guidelines or expectations for BHH services implementation.

In addition, urban sites identified other challenges related to communication with outside providers and managed care organizations, diagnostic assessments, the lack of awareness and understanding of BHH services, building or navigating the patient registry, and billing and insurance.

Referrals given to individuals served at urban sites were less likely to be followed up on than referrals given to individuals served at rural sites, and unfortunately, there is no clear explanation for this pattern in the data currently available. Individuals served at urban sites could benefit from additional housing, social interaction, and transportation support or services, as well as an increase in the capacity or availability of BHH services staff.