Behavioral Health Home Services Summary of Characteristics: Rural 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 seven rural BHH services sites. Rural sites served forty-one of the individuals served who completed interviews. This summary reports data representing more than 10 responses, including the interviews with individuals served and referral tracking, as percentages, and data representing fewer than 10 responses, including the staff interviews and implementation checklist, as numbers. While rural sites and urban 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 rural sites, readers should interpret results with caution.

BHH Services Implementation

Progress in BHH services implementation overall

When asked in the staff interview about the successes they have had so far in implementing the BHH services model, most rural sites reported that they have experienced an increase in the number of referrals they've received or the number of individuals enrolled in BHH services (n=4). Three sites mentioned that they have better processes, such as a quicker or more systematic or integrated processes. Two sites shared they have a clearer understanding of implementing or running the BHH services model (e.g., increased understanding of workflows, policy, procedures, and/or roles; improved ability to identify which individuals would be a good fit). However, rural sites shared some concerns that urban sites did not. Rural sites were more likely to mention financial instability or losing money (2 out of 7 versus 0 out of 12), and that they're receiving slow or few referrals to their BHH services from community partners (3 out of 7 versus 0 out of 12).

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Organizational supports

Rural sites are generally receiving organizational support for BHH services implementation, including technical infrastructure. According to the implementation checklist, all rural sites use the state-developed Mental Health Information System (MHIS) for reporting data to the state and an electronic health record. Most sites indicated that they use a patient registry (n=5). Three sites reported monitoring and analyzing data in the patient registry or in the Minnesota Provider Partner Portal to perform population management. Compared to urban sites, rural sites were more likely to use the MHIS (7 out of 7 versus 9 out of 12) and less likely to use their patient registry or the Minnesota Provider Partner Portal for population management (3 out of 7 versus 10 out of 12).

Most rural sites benefit from additional organizational resources and supports, as they are implementing other models such as Certified Community Behavioral Health Clinics (CCBHC) or Adult Rehabilitative Mental Health Services (ARMHS) or provide other in-house services (n=6). Some sites reported they have received other funding, such as a disability services innovation grant from the Minnesota Department of Human Services (DHS; 29%).

Culture to support integration

The themes from both the self-reported implementation checklist and the staff interview suggest that rural sites' organizational culture supports integration. All rural 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. In addition, all rural sites indicated that they have financial leaders involved in creating the business plan for increased integration, a culture of shared leadership and responsibility, and leaders who engage all staff in integration.

Staff training and capacity

All rural sites agreed in the implementation checklist that they identify and meet staff training needs, hire staff with the skills to work in an integrated environment, and that their staff have a basic understanding of integration principles. All rural sites also reported using evidence-based practices, such as motivational interviewing. Compared to urban sites, fewer staff at rural sites requested additional staff training (1 out of 7 versus 7 out of 12), regular check-ins with DHS (0 out of 7 versus 3 out of 12), and clearer guidelines for BHH services implementation (0 out of 7 versus 3 out of 12). Additionally, rural sites did not identify high caseloads as a challenge, as some urban sites did.

However, three rural sites mentioned in the staff interview that hiring or turnover is a challenge, and that there is a need for more opportunities for BHH services staff to communicate more and share their experiences with one another.

Comprehensive care management

Rural sites generally utilize comprehensive care management strategies. Most rural sites indicated in the implementation checklist that they have the capacity to administer or refer people for physical health screening and a process for following up with screenings (both n=6). Rural sites also commonly reported collecting data on medications and lab results and using this information to coordinate recommendations and treatment (both n=5). Additionally, most sites reported engaging in health and wellness promotion activities, such as health coaching and health education (both n=5).

Care coordination

Rural sites are engaging in a variety of care coordination strategies. According to the implementation checklist, all rural sites reported doing all the activities required for care coordination, 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 rural 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 also reported having access to medications and lab result information (n=5). In addition, rural sites did not identify service delays due to diagnostic assessment requirements as a challenge, as some urban sites did. However, rural sites were more likely to mention other challenges, including avoiding duplicative services and issues related to billing and insurance (both 4 out of 7 versus 2 out of 12).

When asked to describe their care coordination process in the staff interview, most rural sites mentioned that they accompany individuals to appointments (n=6); communicate with outside providers (n=6); have regular team meetings, check-ins, or supervision (n=5); and use electronic records (n=5).

All rural sites communicate with individuals served through phone calls. Other common methods of communication include face-to-face contact (n=6) and meeting in places individuals prefer (n=3). Compared to urban sites, rural sites were less likely to report using email (0 out of 7 versus 5 out of 12) or texting (2 out of 7 versus 5 out of 12).

When asked whether the BHH services team provides different types of help with appointments, most individuals served agreed that they help make appointments (81%), remind individuals served about appointments (81%), provide assistance to get to appointments (51%), and follow up about appointments (95%) at least sometimes (Figure 1). A smaller proportion of individuals served at rural sites reported they did not need assistance getting to their appointments compared to those served at urban sites (37% versus 48%).

1. Appointment assistance received by individuals served by rural sites

Does the BHH services team…	Percentage of individuals served by rural BHH services sites (N=41)			
	Most of the times or always	Sometimes	Never	Not needed
Help you make the appointments you need?	44%	37%	2%	17%
Remind you about the appointments?	54%	27%	2%	17%
Provide assistance to help you get to the appointments?	27%	24%	12%	37%
Follow up with you about the appointments?	68%	27%	0%	5%

Source. Interview with individuals receiving BHH services

Transitional care

Rural sites are providing assistance to individuals transitioning between different care settings. Most rural sites reported in the implementation checklist that they have systematic ways to engage individuals and families in transition planning (n=4); create plans to follow after an individual is discharged (n=5); and access admission and discharge information, health profiles, and service information from appropriate entities (n=6).

When asked whether they've been admitted to a hospital or any other residential setting, about a third of individuals served at rural sites reported that they had (32%; n=13). Of those, about half indicated that the BHH services team helped them move into and out of that care (54%). When asked how the BHH services staff helped with the care transition, individuals most frequently mentioned that the BHH services team accompanied the individual to the hospital or otherwise helped with admission and helped with transportation (31% and 39% respectively).

Individual and family support services

All rural sites reported providing individual and family support services, including using a person-centered approach; asking individuals served to identify formal and informal supports; and learning about individuals' cultures, preferences and communication needs.

Most individuals served at rural sites agreed that they have physical and/or mental health goals they're working on (90%). Most individuals also reported that they worked with the BHH services team to come up with these goals (89%) and create a plan to reach these goals (89%). Almost all individuals served at rural sites shared that the plan or the BHH services team has been helpful to reach their goals (97%).

When asked what goals they've been able to accomplish, individuals served at rural sites most frequently mentioned general improved physical health (12%), increased exercise or activity levels (12%), and general improved mental or behavioral health (10%). When asked how the plan or BHH services team helped them to reach their goals, individuals served at rural sites most often mentioned that they received general emotional support or encouragement (15%), staff attend appointments with them (8%), and they have more coping skills (8%).

Referrals and supports

Rural sites made 1,418 referrals to additional services or supports during the 9-month referral tracking data collection period (Figure 2). The most common referral categories were mental health care (20%), physical health care (18%), and housing (14%; Figure 1). The individuals receiving referrals followed up on most of the referrals (66%), 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 given to individuals receiving BHH services at rural and urban sites

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

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 urban sites, a greater proportion of referrals at rural sites were for dental care (4% versus 3%; p<.05); Medical Assistance (MA), insurance, or MNsure support (4% versus 2%; p<.01); transportation (10% versus 3%; p<.01); and the Supplemental Nutrition Assistance Program (SNAP) or other food support (5% versus 3%; p<.01; Figure 2). Rural sites made proportionally fewer referrals for physical health care (18% versus 22%; p<.01); mental health care (20% versus 26%; p<.01); education (<1% versus 2%; p<.01); the Minnesota Family Investment Program (MFIP) or other financial assistance (95% versus 97%; p<.01); and recreational, social, or cultural services (3% versus 5%; p<.01; Figure 2). Overall, referrals made at rural sites were more likely to be followed up on than referrals given to individuals served at urban sites (66% versus 60%; p<.01).

When asked which community resources individuals receiving BHH services access to meet their needs, rural sites most commonly mentioned housing (n=6); food support (n=4); county support (n=4); recreational, social, or cultural services (n=4); mental health care (n=4); and physical health care (n=4). When asked what resources are needed to better meet the needs of individuals served at their site, rural sites most commonly mentioned transportation resources (n=5); housing (n=4); dental care (n=3); and recreational, social, or cultural services (n=3).

Individuals served by rural sites most commonly cited transportation services (15%) and greater staff availability or capacity (12%) when asked what additional supports would be helpful that they were not receiving or did not receive.

Preliminary outcomes

Rural sites generally reported observing positive changes in the individuals they serve. Most sites mentioned that individuals receiving BHH services have become more independent and have learned how to better advocate for themselves. Four sites shared that individuals served enjoy and are engaged with BHH services, and that they have an increased awareness, knowledge, or skills related to their health condition. Four sites reported that there is greater trust and better communication between individuals served and providers.

When asked whether the BHH services team has helped them learn about their health condition, most individuals served at rural sites responded affirmatively (63%). When asked how the BHH services team helped them learn about their health condition, individuals served at rural sites most commonly mentioned that the BHH services team provided resources or information (12%), helped them understand their symptoms or diagnoses (15%), or explained the treatment for their health condition or how to manage it (15%).

When asked what was most helpful about BHH services, individuals served at rural sites most commonly cited that the BHH services team is reliable, dependable, or responsive (20%) or mentioned another specific positive quality about the staff (17%). When asked what was least helpful about BHH services, individuals most frequently mentioned that they would like an

increase in staff availability, the number of staff, or staff capacity (7%); they would like the staff to follow up more (7%); and that they needed a service BHH services could not provide, such as clothing (7%).

Challenges and additional supports requested

In the staff interview, rural sites shared 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

- BHH services are not well-known, and it can be difficult to help others understand what BHH services are (both n=5)
- Avoiding duplicative services (n=4)
- Billing and insurance (e.g., difficulties receiving payments; type of insurance limits services; n=4)
- Receiving slow or few referrals to their BHH services from community partners (n=3)
- Hiring staff and/or high staff turnover (n=3)
- Communication with outside providers and managed care organizations (e.g., data sharing; n=2)
- Building or navigating the patient registry (n=2)
- Financial instability or expenses (e.g., losing money due to reimbursement rates, high staffing ratio increases costs; n=2)

Additional supports requested

- Outreach from the Minnesota Department of Human Services to outside service providers and the community to educate and advertise BHH services (n=4)
- Opportunities for BHH services staff to come together to share lessons learned and communicate more regularly (n=3)
- Up-to-date information in the Minnesota Provider Partner Portal (n=3)

Conclusion

Rural sites are generally making progress in implementing the BHH services model and experiencing positive benefits. Rural sites report improved processes, organizational support, and organizational cultures conducive to service integration. They're providing comprehensive care management, care coordination, individual and family support services, and some transitional care. Individuals served at rural 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 rural sites are well qualified, and the individuals served at rural sites view BHH services staff positively.

Rural sites also face challenges as they move forward with BHH services implementation. The general lack of awareness and understanding of what BHH services are is a challenge, and rural staff requested outreach from the Minnesota Department of Human Services to outside service providers and the community to better advertise BHH services. Some rural sites also mentioned receiving few referrals to their services or receiving referrals slowly.

In addition, rural sites identified several other challenges, including financial challenges, avoiding duplicative services, billing and insurance, outdated information in the Minnesota Provider Partner Portal, and hiring staff and/or staff turnover.

According to the interviews with BHH services staff and individuals served and/or their caregivers, individuals receiving BHH services at rural sites could benefit from additional housing; transportation; dental services; and recreational, social, or cultural services or support, as well as an increase in the capacity or availability of BHH services staff.