MN Behavioral Health Home Services &
MN Accountable Health Models

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Behavioral Health Home Services

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What models will share

All behavioral health homes will:

• Provide quality-driven, cost-effective, culturally appropriate, person-centered services;

• Build linkages to other community and social supports to aid patients in complying with their care or treatment plans;

• Develop person-centered health action plan;

• Establish a continuous quality improvement program; and

• Use electronic health records, patient registries and communicate across teams.
Models will be distinguished by

How staff coordinate or provide access to:

• Comprehensive care coordination and care management across behavioral health and primary care settings;

• High-quality and evidence-based preventive, health wellness services;

• Comprehensive transitional care and follow-up;

• Individual and family supports; and

• Referral to and coordination with social services and long-term care services.
Behavioral Health Home Services Guiding Principles

BHH services are distinguished by the presence of a multi-disciplinary team that shares information and collaborates to deliver a holistic, coordinated plan of care.
Behavioral Health Home Services Guiding Principles

BHH services create an opportunity to meet the needs of individuals experiencing serious mental illness and their families by addressing the individual’s goals for physical health, mental health, substance use, and wellness.
Providers will deliver BHH services using a strength based approach and will respect, assess, and use the cultural values, strengths, languages, and practices of the consumer and family in supporting the individual’s health and wellness goals.
Providers will deliver BHH services with a person-centered ecological perspective, considering the varying social factors that ultimately impact a person’s health, and will engage and respect the individual and family in their health care and recovery and resiliency.
The guiding principles are met in how the services are delivered and the standards are how the guiding principles come to life.
Primary Drivers

Driver One
Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement.

HIT/HIE

Driver Two
Providers have analytic tools to manage cost/risk and improve quality.

Data Analytics

Driver Three
Expanded numbers of patients are served by team-based integrated/ coordinated care.

Practice Transformation

Information: SIM MN Website, www.mn.gov/sim
Contact: SIM MN Email, sim@state.mn.us
Primary Drivers

Driver Four
Provider organizations partner with communities and engage consumers, to identify health and cost goals, and take on accountability for population health.

ACH

Driver Five
ACO performance measurement, competencies, and payment methodologies are standardized, and focus on complex populations.

ACO Alignment