DEPARTMENT OF HUMAN SERVICES

Memo

Date: 1/31/2020

To: Behavioral health home (BHH) services providers

From: Vimbai Madzura, Integration Reform Manager

RE: Updates to behavioral health home (BHH) services standards

This memo addresses revisions to the BHH services standards. These revisions are due to legislative changes to the Minnesota Statute 256B.0757 Coordinated Care Through a Health Home, which authorizes BHH services. The legislative changes were approved in May 2019 by the Minnesota State Legislature and became effective upon Centers for Medicare and Medicaid Services (CMS) approval on December 10, 2019. DHS anticipates these changes will strengthen the existing framework of BHH services to support the capacity of providers delivering BHH services and to increase access for individuals with mental illness and co-occurring medical conditions.

The revised statute includes revisions to current service delivery and certification standards, and the addition of the following certification standards:

- training requirements for providers;
- establishment of discharge criteria for when an individual receiving BHH services is no longer actively engaged and working towards their identified goals for health and wellness; and
- authority for the Department of Human Services (DHS) to issue a variance to standards to allow flexibility when appropriate.

Changes also include:

- Addition of the qualification of a community health worker (CHW) to the role of systems navigator. This addition provides the opportunity for BHH services providers to better reach and serve diverse populations facing increased disparities in care.
- Addition to the qualification of a peer recovery recovery specialist as defined in section 245G.07, subdivision 1, clause (5). This addition allows additional flexibility for providers to utilize staff that meet the needs of the populations they serve.
- Removal of the diagnostic assessment (DA) for eligibility criteria. The revised statute removes the requirement that an individual must have a current diagnostic assessment (DA) to be eligible to receive BHH services. Instead, an individual must have a current diagnosis from a qualified health professional of a condition that meets the definition of mental illness as described in section 245.462, subdivision 20, paragraph (a), or emotional disturbance as defined in section 245.4871, subdivision 15, clause (2). This change seeks to increase access to BHH services by removing the requirement that providers identified as a barrier to engaging individuals in BHH services.

BHH Services Webinar – February 13, 2020, at noon.

DHS will host a webinar on Thursday, February 13, 2020, to review this memo and the changes in BHH services policy. During the webinar, DHS will review the revised statute from this memo and allow time for questions from providers.

Summary of behavioral health home (BHH) services standards updates

DHS has highlighted the changes to the BHH services standards in the following sections. You will also find more information in table 1 beginning on page 6.

1. **Population**

   Standard 1A. Capacity of providers to serve identified populations

   DHS merged the previous population standards 1A, 1B and 1C, which outlined the requirements for providers to have the ability to meet and serve the needs of individuals within specific age ranges they intend to serve. Instead, DHS expects providers to describe their organization's ability to meet the needs of the people with mental health conditions they intend to serve.

   Standard 1B. Minnesota Health Care Plan (MHCP) enrollment requirement

   This standard incorporates the legislative requirement for BHH services providers to be a Minnesota Health Care Plan (MHCP) enrolled provider into the BHH services standards.

2. **Infrastructure and Population Health Management (formerly titled *Capacity*)**

   Standard 2B. Patient Registry

   This standard was moved from 3B to 2B and the language was revised for clarity.

   Standard 2C. Monitoring and Evaluation of BHH services

   DHS revised the language in this standard to align with legislative language on the monitoring and evaluation of BHH services.

   Standard 2D. Use of the Partner Portal

   DHS revised this standard to provide more specific language to capture the primary goals of population health management and providers use of the MN Partner Portal.

   Standard 2E. Use of evidence-informed practices

   This standard was moved from 5F to 2E.

3. **Culture to Support Integration**

   Standard 3A. Culture to support integration

   DHS revised this language for clarity on how providers must ensure a capacity to establish and maintain processes that support the integration and coordination of an individual's comprehensive care.

   Standard 3B. Quality Improvement

   This standard was moved from 3D to 3B.

   Standard 3C. Team-based model of care

   This standard was moved from 3B to to 3C. The language in this standard was also simplified to remove duplicative language about required elements.

   Standard 3D. Required six core services

   This standard was moved from 5A to 3C.

Standard 3E. Team member qualifications

This standard was moved from 5C to 3E and incorporates the addition of the qualification of a community health worker to the role of the systems navigator.

Standard 3F. Staffing ratios

This standard was moved from 5C to 3F.

4. Training and Practice Transformation (formerly titled *Approach to Integration*)

Standard 4A. Preservice and ongoing training

The previous standard was incorporated into 3A. The new language in this standard was added to align with legislative language around expectation for providers to ensure staff providing BHH services receive adequate preservice and ongoing training.

Standard 4B. Ability to implement culturally responsive services

This standard was added to align with legislative language around expectation for providers to ensure staff providing BHH services are capable of implementing culturally responsive services.

Standard 4C. Participation in DHS practice transformation activities

This standard was added to align with legislative language around expectation for BHH services providers to ensure their staff participate in DHS' practice transformation activities. This supports continued skill and competency development in the provision of integrated medical, behavioral health, and social services.

5. Timeline Requirements

Standard 5A. Provide state-created materials about BHH services

This standard was moved from 5B to 5A.

Standard 5B. Requirement to obtain Diagnostic Assessment (DA) within six months of receiving services

This standard adds the legislative requirement for BHH services providers to ensure that a diagnostic assessment is completed for each individual within six months of the start of BHH services.

Standard 5C. Coordination with Managed Care Organizations (MCOs)

This standard was moved from 5D to 5C.

Standard 5D. State Standards for frequency and face-to-face contact

This standard was moved from 5E to 5D.

Standard 5E. Discharge criteria

This standard adds language that outlines the discharge criteria for BHH services, and aligns with new legislative language approving discharge criteria for BHH services.

Standard 5F. Notice of termination of BHH services

This standard was moved from 5G to 5F.

6. Comprehensive Care Management

Standard 6A. Capacity to administer or refer people for physical health screenings.

The language in this standard was revised for clarity.

Standard 6B. Educating individuals and identified supports about resources to meet their needs and goals

The language in this standard was revised for clarity.

Standard 6C. Ability to conduct, track and follow up on referrals

This standard was changed to move standard 7D into this section, and combine expectations related to providers' abilities to conduct, track and follow up on referrals.

Standard 6D. Review of Health Action Plan (HAP) by Integration Specialist

This standard was moved from 6C to 6D.

Standard 6E. Capacity to administer required substance use disorder screenings

This standard was moved from 6F to 6E and adds language specific to screening for commercial tobacco use if it is not specifically addressed as part of substance-use disorder screenings.

Standard 6F. Coordination with area hospitals, primary care providers and behavioral health providers

This standard was moved from 6G to 6F and the language was revised for clarity.

7. **Care Coordination**

Standard 7C. Brief needs assessment

The language in this standard was revised for clarity.

Standard 7D. Assessing readiness for change

This standard was moved from 7E to 7D.

Standard 7E. Helping individual set up and prepare for appointments

This standard was moved from 7G to 7E.

8. **Health and Wellness Promotion**

Standard 8A. Follow up with resources related to health promotion and wellness

needs The language in this standard was revised for clarity.

Standard 8B. Offer or facilitate wellness and prevention education

The language in this standard was revised for clarity.

9. **Comprehensive Transitional Care**

Standard 9A

This standard was moved from 9B to 9A.

Standard 9B

DHS revised this standard to combine the previous 9A and 9C standards.

10. **Individual and Family Support Services**

Standard 10A

The language in this standard was revised for clarity.

Standard 10B

The language in this standard was revised for clarity and to simplify the elements of the health action plan.

Standard 10C

The language in this standard was revised for clarity.

11. Referral to Community and Social Services

Standard 11A

This standard was revised for clarity and to incorporate language from the previous standard 11B.

Standard 11B

This standard was moved from 11C to 11B.

Variance guidelines

Variance guidelines were added to the standards to reflect new legislative language that gives DHS the authority to grant a variance to specific requirements outlined under 256B.0757, subd. 4a, 4b, 4c, or 4d, in order to allow flexibility in program models when appropriate.

***See Table 1** for further detail on all the recent changes and updates to the BHH services standards.

We want to take this opportunity to thank you for your feedback in regards to BHH services. We value provider feedback as we continue to support implementation of BHH services. If you have any questions about this memo, please contact Michaelyn Bruer at michaelyn.bruer@state.mn.us or 651-421-2852.

Table 1. Behavioral Health Home (BHH) Services Standards Updates

Updated Standard	Related Previous Standard(s)
1A. You must have the ability to serve and meet the needs of the people you serve with mental health conditions.	1A. If you intend to provide BHH services to adults with serious mental illness (SMI) or serious and persistent mental illness (SPMI), you must have the ability to serve and meet the needs of adults with mental health conditions. 1B. If you intend to provide BHH services to youth (14–25 years old) with emotional disturbance (ED) or severe emotional disturbance (SED), you must have the ability to serve and meet the needs of youth with mental health conditions. 1C. If you intend to provide BHH services to children (0–13 years old) with ED or SED, you must have the ability to serve and meet the needs of children with mental health conditions.
1B. BHH services providers must provide a medical assistance covered primary care or behavioral health service.	None
2B. Use a patient registry to inform population management strategies, identify and manage care gaps, and facilitate communication among BHH services team members. Systematically use the patient registry to identify specific population subgroups requiring specific levels or types of care. The BHH services patient registry must contain sufficient elements to issue a report that show gaps in care and needs for individuals and populations or population subgroups.	3B. Use a patient registry to inform population management strategies, identify and manage care gaps, and facilitate communication among BHH services team members. Required elements include: • An indication that you completed the brief needs assessment, initial health wellness assessment and health action plan for each person • An indication that the integration specialist reviewed the health action plan for each person before it was finalized and reviewed the health action plan as part of the revision process for each person • Date the integration specialist met with the person • Primary physical and mental health diagnosis • Date of the person's last physical exam with his or her primary care provider • Date of last dental exam • Screening dates and results for substance use disorder, alcohol and tobacco use • If applicable, referrals made based on substance use disorder and tobacco use screening results (yes/no) • If applicable, did the person follow-up on referrals made from substance use or tobacco use screening (yes/no) • Admission and discharge information

Updated Standard	Related Previous Standard(s)
	• Preferred language • Need for interpreter
2C. Agree to participate in the state's monitoring and evaluation of BHH services.	2C. Meet process, outcome and quality standards developed and specified by the commissioner. The commissioner will collect data from BHH services providers as necessary to monitor compliance with certification standards.
2D. Utilize the DHS Partner Portal to identify the following at an individual and population level: • past and current treatment or healthcare services; • utilization of resources and cost of care; and • complexity and risk for fragmented care, or gaps in care. BHH services teams should be utilizing the Partner Portal in an attempt to identify the above listed information at an individual and population level.	2D. Monitor and analyze data in your patient registry, and in the MN Provider Partner Portal, when performing population management.
2E. Use evidence-informed practices that recognize and are tailored to the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting the individual's health and health care choices.	None
3A. BHH services providers must establish and maintain processes that support the integration and coordination of an individual's primary care, behavioral health, and dental care. Providers must ensure administrative support and leadership buy-in across their organizations to pursue integrated care.	3A. Ensure administrative support and leadership buy-in across your provider organization to pursue integration, encourage change and remove barriers. 4A. Implement one of three integration approaches: 1) an in-house model, 2) a co-located partnership model, or 3) a facilitated referral model. Based on the approach you choose, you must meet the following standards: • Option 1. In-house model: Ensure communication across providers and coordination of services so that you deliver care that is fully integrated from the person's perspective. • Option 2. Co-located partnership model: When BHH services are offered in a mental health setting, the BHH services team must arrange for health care providers to provide primary care services onsite. Conversely, when BHH services are offered in a primary care setting, the BHH services team must arrange for behavioral health services providers to provide behavioral health services onsite. Put processes in place beyond simple co-location to ensure effective communication and coordination between providers. • Option 3. Facilitated referral model: Primary care services are not provided onsite, but the behavioral health agency ensures coordination of care provided offsite. Conversely, behavioral health services are not provided onsite, but the primary care agency ensures coordination of care provided offsite.

Updated Standard	Related Previous Standard(s)
	For all options, integration specialists are expected to build relationships and facilitate the exchange of information for all care providers.
3B. Establish a continuous quality improvement process for providing BHH services.	3D. Establish a continuous quality improvement process for providing BHH services.
3C. Maintain a team-based model of care, including regular coordination and communication between BHH services team members.	3B. Maintain a team-based model of care, including regular coordination and communication between BHH services team members. The following elements must be captured for every person but may be stored in the patient registry, electronic health record or other case management system. These elements must be accessible by all BHH services team members: • Referrals based on physical health screening • Name and contact information for the person's primary physician, mental health professional and, if applicable, specialty providers • Name and contact information for the person's dentist • Name and contact information for the family member(s) or supports that are identified by the person or family • Medications and, if applicable, lab results
3D. You must have the ability to meet the unique needs of people with mental health conditions while ensuring your BHH services team can provide all six federally required core services. • Comprehensive care management • Care coordination • Health and wellness promotion • Comprehensive transitional care • Individual and family support • Referral to community and social supports	5A. Provide all six BHH services as required by the state: 1. Comprehensive care management 2. Care coordination 3. Health and wellness promotion 4. Comprehensive transitional care 5. Individual and family support 6. Referral to community and social supports
3E. Ensure each team member has the state-required credentials. All BHH services teams must include the following team members: **Team member: Person receiving BHH services** When the person is a child or youth, parents or caregivers are key to the implementation of the BHH services and must be engaged throughout the process. **Team member: Integration specialist** Required Qualifications: • If BHH services are offered in a mental health setting, the integration specialist must be a registered nurse licensed under the [Minnesota Nurse Practice Act](), sections 148.171 to 148. • If BHH services are offered in a primary care setting, the integration specialist must be a mental health professional as defined in section	3C. Utilize BHH services team members responsible for the six BHH services and ensure each team member has the state-required credentials. All behavioral health home services must include the following team members: **Team member: Person receiving BHH services** When the person is a child or youth, parents or caregivers are key to the implementation of the BHH services and must be engaged throughout the process. **Team member: Integration specialist Required Qualifications:** • When BHH services are offered in a mental health setting, the integration specialist must be a registered nurse (including advanced practice registered nurses)

Updated Standard	Related Previous Standard(s)

245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6).
 	
Team member: BHH services systems navigator
Required Qualifications:
If BHH services are offered in either a primary care setting or mental health setting, the systems navigator must meet one of the following qualifications:
• A mental *health practitioner* as defined in Minnesota Statutes, section 245.4871, subdivision 26 or Minnesota Statutes, section 245.462, subdivision 17.
• A *community health worker* as defined in section 256B.0625, subdivision 49.
 	
Team member: Qualified health home specialist
Required Qualifications:
If BHH services are offered in either a primary care setting or mental health setting, the quaified health home specialist must meet one of the following qaulifications:
 	
• A peer *support specialist* as defined in Minnesota Statutes, section 256B.0615
• A *family peer support specialist* as defined in Minnesota Statutes, section 256B.0616
• A *case management associate* as defined in Minnesota Statutes, section 245.462, subdivision 4, paragraph (g) or 245.4871, subdivision 4, paragraph (j)
• A *mental health rehabilitation worker* as defined in Minnesota Statutes, section 256B.0623, subdivision 5, clause (4)
• A *community paramedic* as defined in Minnesota Statutes, section 144E.28, subdivision 9
• A *peer recovery specialist* as defined in section 245G.07, subdivision 1, clause (5)
• A community *health worker* as defined in Minnesota Statutes, section 256B.0625, subdivision 49
	• When BHH services are offered in a primary care setting, the integration specialist must be a mental health professional as defined in Minnesota Statutes, section 245.4871, subdivision 27, clauses (1)–(6) or Minnesota Statutes, section 245.462, subdivision 18, clauses (1)–(6)
	
	Team member: Behavioral health home services systems navigator (care coordination)
	When behavioral health home services are offered in a mental health setting, the systems navigator must meet one of the following qualifications:
	• A case manager as defined in Minnesota Statutes, section 245.4871, subdivision 4 (excluding paragraph a), and Minnesota Statutes, section 245.462, subdivision 4 (excluding paragraph a)
	• A mental health practitioner as defined in Minnesota Statutes, section 245.4871, subdivision 26 or Minnesota Statutes, section 245.462, subdivision 17
	
	When behavioral health home services are offered in a primary care setting, the systems navigator must meet one of the following qualifications:
	• Case manager as defined in Minnesota Statutes, section 245.4871, subdivision 4 (excluding paragraph a), Minnesota Statutes, section 245.462, subdivision 4 (excluding paragraph a)
	• Mental health practitioner as defined in Minnesota Statutes, section 245.4871, subdivision 26, or Minnesota Statutes, section 245.462, subdivision 17
	• Have three years of experience providing care coordination to adults, youth or children with mental illness, and either:
	  o Meet Minnesota Statutes, section 245.4871, subdivision 4 (g) and one of the following:
	    ▪ subdivision 4 (b, 1-4)
	    ▪ subdivision 4 (d)
	    ▪ subdivision 4 (m)
	  o Meet Minnesota Statutes, section 245.462, subdivision 4 (f) and one of the following:
	    ▪ subdivision 4 (b, 1-3)
	    ▪ subdivision 4 (c)
	    ▪ subdivision 4 (j)
	
	Team member: Qualified health home specialist
	Required Qualifications:
	The qualified health home specialist must meet one of the following:

Updated Standard	Related Previous Standard(s)
	• A community health worker as defined in Minnesota Statutes, , section 256B.0625, subdivision 49 • A peer support specialist as defined in Minnesota Statutes, section 256B.0615 • A family peer support specialist as defined in Minnesota Statutes, section 256B.0616 • A case management associate as defined in Minnesota Statutes, section 245.462, subdivision 4, paragraph (g) or Minnesota Statutes, section 245.4871, subdivision 4, paragraph (j) • A mental health rehabilitation worker as defined in Minnesota Statutes, section 256B.0623, subdivision 5, clause (4) • A community paramedic as defined in Minnesota Statutes, section 144E.28, subdivision 9 • A certified health education specialist
3F. Maintain staffing ratios, as set by the state, to ensure BHH services team members adequately provide services to people. To keep BHH services certification, you must maintain the following shared caseload ratios: • One full-time equivalent (FTE) integration specialist for every 224 members • One FTE systems navigator for every 56 members • One FTE qualified health home specialist for every 56 members The one FTE integration specialist can be split between two people, at .5 FTE per person. The one FTE for systems navigator can also be split between two people at .5 FTE per person. The one FTE for the qualified health home specialist can be split across up to four people, with a minimum of .25 FTE per person. (Providers can exceed the ratios up to 25 percent and still be in compliance with the standard.) Providers must have adequate staff to deliver the required BHH services. The staffing ratios are based on the assumption that providers will implement caseloads on a pro-rated basis depending on the size of the population served. Providers may incrementally increase staffing based on the growth and needs of the population served as long as they meet and maintain the BHH services staffing ratios listed in the bullet points.	5C. Maintain staffing ratios, as set by the state, to ensure BHH services team members adequately provide services to people. To keep BHH services certification, you must maintain the following shared case-load ratios: • One full-time equivalent (FTE) integration specialist for every 224 members • One FTE systems navigator for every 56 members • One FTE qualified health home specialist for every 56 members The one FTE integration specialist can be split between two people, at .5 FTE per person. The one FTE for systems navigator can also be split between two people at .5 FTE per person. And, unless DHS approves an alternative staffing model, the one FTE for the qualified health home specialist can be split across up to four people, with a minimum of .25 FTE per person. (Providers can exceed the ratios up to 20 percent and still be in compliance with the standard.) Providers must have adequate staff to deliver the required BHH services. The staffing ratios are based on the assumption that providers will implement caseloads on a pro-rated basis depending on the size of the population served. Providers may incrementally increase staffing based on the growth and needs of the population served as long as they meet and maintain the BHH services staffing ratios listed in the bullet points.

Updated Standard	Related Previous Standard(s)
	Alternative staffing model Providers can propose an alternative staffing model for the qualified health home specialist role. DHS must review and approve proposals before the model is implemented.
4A. Ensure that all staff delivering behavioral health home services receive adequate preservice and ongoing training, including: • training approved by the commissioner that describes the goals and principles of behavioral health home services; and • training on evidence-informed practices to promote an individual's ability to successfully engage with medical, behavioral health, and social services to achieve the individual's health and wellness goals.	None
4B. Ensure that staff are capable of implementing culturally responsive services, as determined by the individual's culture, beliefs, values, and language as identified in the individual's health wellness assessment.	None
4C. Participate in the department's practice transformation activities to support continued skill and competency development in the provision of integrated medical, behavioral health, and social services.	None
5A. Obtain the individual's written consent to begin receiving BHH services using a form approved by the commissioner. Provide other information that helps people make an informed choice about whether or not to participate in BHH services.	5B. Provide state-created materials about BHH services to people, including the consent form and rights and responsibilities document. Provide other information that helps people make an informed choice about whether to participate in BHH services.
5B. Ensure that a diagnostic assessment is completed for each individual receiving BHH services within six months of the start of behavioral health home services.	None
5C. If the individual is enrolled in a managed care plan, a BHH services provider must: • Notify the BHH services contact designated by the managed care plan within 30 days of of when the individual begins BHH services • Adhere to the managed care plan communication and coordination requirements described in the BHH services manual	5D. Coordinate with the consumers' Minnesota Health Care Programs (MHCP) managed care plan, if applicable. If the person is enrolled in a managed care plan, you must: • Notify the BHH services contact designated by the managed care plan within 30 days of completing intake • Adhere to the managed care plan communication and coordination requirements described in the BHH services manual • Share information with the managed care plan about incidents of hospital admission, discharge and emergency room use
5D. Deliver services consistent with the standards for frequency and face-to-face contact required by the commissioner. • During the initial 90-day engagement period, you must meet face-to-face with the person to: ○ Complete the intake process and the brief needs assessment. ○ Complete the initial health wellness assessment within 60 days after intake.	5E. Deliver services consistent with state standards for frequency and face-to-face contact. • During the initial 90-day engagement period, you must meet face-to-face with the person to: o Complete the intake process and the brief needs assessment. o Complete the initial health wellness assessment within 60 days after intake.

Updated Standard	Related Previous Standard(s)
○ Develop the health action plan within 90 days after intake. • On an ongoing basis after the person's initial 90 days of receiving BHH services, you must: ○ Have personal contact with the person or person's identified support at least once per month. This may include face-to-face or telephone contact or interactive video. A letter, voicemail or text alone does not meet the requirement for monthly personal contact. ○ Conduct a face-to-face visit with the person at least every six months to review the health action plan and update if necessary. Providers must deliver services consistent with state standards for frequency and face-to-face contact for children and youth consumers as defined in the MHCP Provider Manual.	o Develop the health action plan within 90 days after intake. • On an ongoing basis after the person's initial 90 days of receiving BHH services, you must: o Have personal contact with the person or the person's identified support at least once per month. This contact may include face-to-face, telephone contact or interactive video. A letter, voicemail or text alone does not meet the requirement for monthly personal contact. o Conduct a face-to-face visit with the person at least every six months to review the health action plan and update if necessary. Providers must deliver services consistent with state standards for frequency and face-to-face contact for children and youth consumers as defined in the MHCP Provider Manual.
5E. Include use of the following criteria when developing policies and procedures for discharging individuals from BHH services: (a) An individual may be discharged from BHH services if: • the BHH services provider is unable to locate, contact, and engage the individual for a period of greater than three months after persistent efforts by the behavioral health home services provider; or • the individual is unwilling to participate in BHH services as demonstrated by the individual's refusal to meet with the BHH services provider, or refusal to identify the individual's health and wellness goals or the activities or support necessary to achieve these goals. (b) Before discharge from BHH services, the BHH services provider must offer a face-to-face meeting with the individual, the individual's identified supports, and the BHH services provider to discuss options available to the individual, including maintaining BHH services.	None
5F. If a provider is no longer a certified behavioral health home, you must ensure that people receive continuity of BHH services by doing the following before terminating your BHH services: • Provide a 60-day notice of termination of BHH services to all people receiving BHH services, DHS and managed care plans (if applicable) • Refer individuals receiving BHHservices to a new BHH services provider or other appropriate service (if available).	5G. If a provider is no longer a certified behavioral health home, you must ensure that people receive continuity of BHH services by doing the following before terminating your BHH services: • Provide a 60-day notice of termination of BHH services to all people receiving BHH service, DHS and managed care plans (if applicable) • Assist your current people that receive BHH services to find a new BHH services provider
6A. Have capacity to administer or refer people for physical health care services under national and state guidelines.	6A. Have capacity to administer or refer people for physical health screening under national and state guidelines.

Updated Standard	Related Previous Standard(s)
	• See the U.S. Preventive Services Task Force recommendations for adults • See Minnesota Child and Teen Checkups (DHS-3379) (PDF) for children and adolescents up to 21 years old
6B. Ensure that the person and their identified supports know about resources appropriate to their physical and mental health needs, including resources appropriate to substance use disorder results. If applicable, resources appropriate to substance use disorder results should include resources for addressing a person's tobacco use disorder.	6B. Follow up with the person to ensure he or she knows about resources appropriate to his or her screening results for physical health issues. Ensure that the BHH services team knows how to conduct referrals about physical health issues and how to ensure referrals are followed through. Demonstrate capacity to integrate physical health into comprehensive care planning.
6C. Ensure that the BHH services team knows how to conduct referrals and uses policies and procedures to track referrals and follow-up to ensure that the referral met the individual's needs.	7D. Refer people to resources appropriate to their screening results. Know processes for referrals related to substance use disorder and ensure follow-through with referrals. Demonstrate capacity to integrate a treatment plan for substance use disorder into comprehensive care planning.
6D. The integration specialist must review the health action plan for every person before the initial plan is finalized and as part of the review process.	6C. The integration specialist must review the health action plan for every person before the plan is finalized. The integration specialist must also review the health action plan as part of the revision process.
6E. Have the capacity to administer required substance use disorder screenings approved by the commissioner. Use the CAGE-AID, Kiddie-CAGE or GAIN-SS, or other tools approved by DHS, to screen for substance use disorder during the health wellness assessment. Screen for the use of commercial tobacco if this substance is not specifically addressed when administering the above-mentioned required substance use disorder screenings. Currently, there is no DHS-approved screening tool specific to the use of commercial tobacco.	6F. Have the capacity to administer required BHH services screenings for substance use disorder, alcohol and tobacco use. Use the CAGE-AID or GAIN-SS, or other tools approved by DHS, for screening for substance use disorder during the health wellness assessment.
6F. Ensure efforts to engage area hospitals, primary care practices, and behavioral health providers to build relationships, facilitate the exchange of information, and collaborate on care coordination.	6G. Demonstrate efforts to engage area hospitals, primary care practices, and behavioral health providers to collaborate on care coordination.
7A. Provide a central point of contact to ensure that individuals and the individual's identified supports can successfully navigate the array of services that impact the individual's health and well-being.	7A. Provide a central point of contact to ensure that people and their families can successfully navigate the array of services that impact their health and well-being.
7B. Deliver services in locations and settings that meet the needs of the person.	7B. Deliver services in locations and settings that meet the needs of the person.
7C. Conduct a brief needs assessment when an individual begins receiving BHH services. The brief needs assessment must be completed with input from the individual and the individual's identified supports. The brief needs assessment must address the individual's immediate safety and transportation needs and potential barriers to participating in behavioral health home services	7C. Conduct a brief needs assessment at time of intake in collaboration with the person and his or her identified supports. This brief assessment will identify and address immediate safety and transportation needs, and potential barriers to participating in BHH services.

Updated Standard	Related Previous Standard(s)
7D. Have capacity to assess a individual's readiness for change and that individual's capacity to integrate new health care or community supports into the individual's life.	7E. Have capacity to assess a person's readiness for change and his or her capacity to integrate new health care or community supports into his or her life.
7E. Help an individual set up and prepare for medical, behavioral health, social service, or community support appointments, including accompanying the individual to appointments as appropriate, and providing follow-up with the individual after these appointments	7G. Help the person set up and prepare for appointments. Accompany the person to appointments as appropriate, and follow up with the person.
8A. Follow up with the person and/or their identified supports to ensure they know about resources appropriate to identified health promotion and wellness needs.	8A. Coach people and their identified supports to increase self-efficacy, improve health management, maintain a healthy lifestyle and improve health outcomes.
8B. Offer or facilitate the provision of wellness and prevention education using evidenced-informed curriculums specific to the prevention and management of common chronic conditions, the person's specific health conditions and other determinants of health, and the person's readiness for change.	8B. Offer or facilitate the provision of wellness and prevention education on evidenced-based curriculums specific to the prevention and management of common chronic conditions, the person's specific health conditions and the person's readiness for change.
9A. Access admission and discharge information, health profiles and service information from appropriate entities, as approved by the person and his or her identified supports.	9B. Access admission and discharge information, health profiles and service information from appropriate entities, as approved by the person and his or her identified supports.
9B. In partnership with the person and the person's identified supports, create a plan to follow after the person's discharge from hospitals, residential treatment and other settings. The plan must include protocols to: • Ensure that the person and his or her family are included in transition planning. • Maintain contact between the BHH services team member(s) and the person and the person's identified supports during and after discharge • Link the person to new resources as needed • Re-establish the individual to any existing services and community and social supports • Follow up with appropriate entities to transfer or obtain the person's service records as necessary for continued care	9A. Ensure that the person and his or her family are included in transition planning. 9C. In partnership with the person and his or her identified supports, create a plan to follow after the person's discharge from hospitals, residential treatment and other settings. The plan should include protocols to: • Maintain contact between the BHH services team member(s) and the person and his or her identified supports during and after discharge • Link people to new resources as needed • Re-link people to existing services and community and social supports • Follow up with appropriate entities to transfer or obtain the person's service records as necessary for continued care
10A. Support the person's recovery, resilience, and progress toward meeting his or her health goals via identification and rapport building with formal and informal supports.	8C. Support people in recovery and resiliency. 10A. Utilize the person's formal and informal supports to help the person's recovery, resilience and progress toward meeting his or her health goals.
10B. Use a person-centered planning approach to ensure the person's health action plan accurately reflects the preferences, goals, resources and optimal outcomes for the person and his or her identified supports. Each health action plan must include the following elements: • The goal(s) of the individual (and parent or guardian)	10B. Use a person-centered planning approach to ensure the person's health action plan accurately reflects the preferences, goals, resources and optimal outcomes for the person and his or her identified supports. Each health action plan must include the following elements: • The goal(s) of the individual (and parent or guardian)

Updated Standard	Related Previous Standard(s)
• Individual's strength(s) that will help them reach their goal. (Internal and external resources that should be listed for each goal) • Specific services and supports the individual (and legal guardian) wants to receive to help reach goal (if different than goal) • Names and contact information for BHH services team members • Names and contact information of key professionals and service providers involved in the individual's care (list may include: primary care physician, medical specialists, mental health provider, school contact, or financial worker, etc.) • Brief crisis plan in case of an emergency or instances when additional support is urgently needed	• Individual's strength(s) related to each goal (internal and external resources) • Specific services and supports needed by the individual (and parent or guardian) • Activities or action of applicable BHH services team member(s) to support accomplishing each goal • Activities or action of the individual (and parent or guardian) for accomplishing each goal • Names and contact information for BHH services team members • Names and contact information of key professionals and service providers involved in the individual's care (list may include: primary care physician, medical specialists, mental health provider, school contact, financial worker, etc.) • Crisis plan in case of an emergency or instances when additional support is urgently needed
10C. Offer or facilitate the provision of education, coaching, and support related to chronic disease management and how to navigate complex systems of care to the individual, the individual's family, and identified supports.	10C. Offer or facilitate the provision of direct education and provide support to families, caregivers and other identified supports, related to chronic disease management and how to navigate complex systems of care.
11A. Have adequate knowledge of agencies and resources to connect people and their identified supports to appropriate support services that help them overcome access or service barriers, increase self-sufficiency skills and improve overall health. Connect an individual, the individual's family, and identified supports to appropriate support services that help the individual overcome access or service barriers, increase self-sufficiency skills, and improve overall health. This standard requires that you have adequate knowledge of agencies and resources or networks to access this information to ensure people are aware of resources and are supported in efforts to access resources to address each person's identified goals and needs (such as county social services, housing and employment).	11B. Have adequate knowledge of agencies and resources to connect people and their identified supports to appropriate support services that help them overcome access or service barriers, increase self-sufficiency skills and improve overall health. This standard requires that you ensure people are aware of resources and are supported in efforts to access resources to address each person's identified goals and needs (i.e., county social services, housing and employment).
11B. Develop and nurture relationships with other community and social support providers to aid in effective referrals and timely access to services.	11C. Develop and nurture relationships with other community and social support providers to aid in effective referrals and timely access to services.
Variance Guidelines The Commissioner may grant a variance for specific requirements of behavioral health home services providers to an applicant or certified behavioral health home services provider that demonstrates good cause. The commissioner may grant a variance if the commissioner finds that:	None

Updated Standard	Related Previous Standard(s)
1. Failure to grant the variance would result in hardship or injustice to the provider organization; 2. The variance would be consistent with the public interest; and 3. The variance would not reduce the level of services provided to individuals served by the organization. 4. The commissioner may grant a variance from one or more requirements to permit an applicant to offer behavioral health home services of a type or in a manner that is innovative, if the commissioner finds that the variance does not impede the achievement of the criteria in subdivisions 4a, 4b, 4c, or 4d and may improve the behavioral health home services provided by the provider organization. The commissioner's decision to grant or deny a variance request is final and not subject to appeal. To request a variance, providers will need to complete a request.	