REACH (BHH Program)
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Referrals, Education, Accessing Care, Coordinating, Healthy Outcomes
Integrating Behavioral Health and Physical Health

Resources → Activities → Outputs → Outcomes

Staffing:
-.5 RN (20hr/week)
-.1 MA (4hrs/week)
-Team based care with multidisciplinary teams Individual consumer caseholders/advocates
-Medical/Psychiatric Consultants
-Program evaluator

Outcome Tools:
-Completed nursing assessments
-PHQ9/SDoH/CSSRS/LOCUS
-Cardiovascular Risk
-ADTs
-Consents to exchange information
-BHH Careplan

Other Resources:
-Team based care dash-board
-HEDIS indicators for benchmarking
-CIGMMO (electronic health record) for data and treatment documentation
-Primary Care physicians, specialists, medical facilities and office staff
-CMHCM org structure

Pre-Program:
-Program readiness and start up tasks (post RN position, arrange training on BHH referrals and documentation)
-Identify best collection of outcome measures
-Inform case holders and consumers
-Identify consumers

Enrollment and Onboarding:
-Hire RN Care manager and program evaluator
-Identify and enroll consumers
-Outcome measures completed
-Continuous collaboration with clinical teams

Evaluation:
-Benchmark outcomes to state and national averages
-Collect patient satisfaction, program feedback and outcome data (pre/post/follow up)

Consumer:
-# of BHH enrollees
-# of BHH contacts
-# of nursing assessments
-# of careplans
-% of consumers with primary care consents

CMHCM and Community System of Care:
-Billable encounters and number of enrollments meet volume expectations
-RN care manager and consultants in place
-Completed outcome measures for minimum 80% of BHH consumers
-Care coordination activity on behalf of consumers - regarding physical health/behavioral health

Evaluation
-Feedback gained on program (acceptability, satisfaction, quality improvement opportunities) from consumers and stakeholders
-Process for referrals, and preliminary outcomes

Short-term:
-CMHCM is better able to serve consumers by having the BHH leading the behavioral/physical care coordination allowing case holders additional capacity for other interventions
-CMHCM is better able to implement Evidence Based Practices with BHH an important focus of integrated care teaming
-Enhanced and integrated evaluation activities

Long-term:
-CMHCM is better able to serve consumers through building capacity
-CMHCM will build financial organizational sustainability through the reimbursement for each enrollee that has a delivered BHH service each month
-CMHCM will have increased financial contributions directly resulting from the BHH enrollment that are an identified revenue stream unable to access without BHH structure