**Brief overview of “Pathways to Wellness”: Case Management for Medical and Mental Health**Behavioral Health Home (Northland Counseling)

Behavioral Health Home (BHH) is a program designed to help people with serious mental illnesses as well as chronic health conditions. It aims to improve health outcomes, improve experience of care, reduce health care costs, and improve quality of life for the individual. It is person-centered and 100% voluntary. BHH will provide clients with care coordination, skill development, education, activities, services, and referrals to community supports, among other things. We focus on a team approach, and try to communicate between all levels of care on each client’s team.

**Insurances accepted:**

Any form of Medical Assistance (Medicaid) which does include managed care organizations such as Imcare, Ucare, Health Partners, Blue Plus, Medica.

**Who is eligible?**

* Children, Youth, and Adults (ages 3 and up) who have been diagnosed with a SMI, SPMI, ED, or SED.
* Must have a diagnostic assessment completed in the last 12 months with qualifying diagnosis present.
* Must have Medical Assistance.

**Proper Referral Process:**

Have client fill out the BHH Rights, Responsibilities, and Consent form. Inform them that this is only to be used to verify eligibility. Let them know that someone from the BHH team will be contacting them to discuss program or answer any questions.

**BHH Phone number:** 218-326-5114

**Difference between BHH and Case Management:**

It is a team approach. Case Management is more 1:1. It is integrated, so it can help you reach your goals for both mental health and physical health. TCM focuses only on mental health. It is a partnership with primary care: your behavioral health home team and your primary care provider work together to better coordinate care. It includes consumer and family supports and education, so you can get information and support when you need it.

**Features of Behavioral Health Home**

Care Management:

* Managing medical, social, and mental health conditions.
* Increase patient engagement.
* Target groups to focus on.
* Evaluate patients routinely and create written recommendations. (Health and Wellness Assessment, Brief Needs Assessment, Health Action Plan)

Care Coordination:

* Central point of contact for referrals and coordination, follow up as needed.
* Ongoing contact with individuals and their supports.
* Engage hospitals to collaborate, conduct referrals, follow through with referrals.
* Assist in setting up appointments, going along if needed, following up with discharge instructions.
* Med monitoring if needed.

Health and Wellness Promotion:

* Skill development so consumer is able to monitor and manage their illness by understanding it.
* Educate on how those illnesses impact all around well-being.
* Support participation and recovery.
* On-site coaching, classes, information as needed.

Comprehensive Transition Care:

* Coordinate between different levels of care.
* Make crisis management more efficient.
* Reduce barriers to timely care access.
* Reduce admission and remissions to the hospital.
* Follow discharge from service involved.
* Transition planning.

Individual and Family Supports:

* Activities, materials, or services to help reduce barriers to achieving goals.
* Increase knowledge of condition.
* Person centered.
* Assist with obtaining and adhering to meds and treatment.

Referral to Community Supports:

* Ensuring clients access to resources so they can achieve their person centered goals.
* Connecting to community resources.
* Learn and understand their preference and culture.
* Check in with them and their supports to confirm if they need further assistance.
* Go with to resources if needed