TEAM WELLNESS CENTER

Case Management Services Program Description

Program Description

Case management/services coordination provides goal-oriented and individualized supports focusing on improved self-sufficiency for the persons served through assessment, planning, linkage, advocacy, coordination, and monitoring activities. Case management focuses on increasing the independence of each member and enhancing their quality of life. This is used to enhance the independence of members who have been diagnosed with a severe and persistent mental illness. Services are tailored to meet the needs of the individuals through Person-Centered-Planning. Activities are carried out in collaboration with the member and participation of family members and natural supports is strongly encouraged.

Program Philosophy

We believe that the member is the most important member of the treatment team. The philosophy of this program is built on the premise that by enhancing independence and supporting the recovery process for individuals and families; they will be able to obtain optimum health and quality of life. The member's desires, needs, preferences and identified goals are paramount in determining the degree to which they will receive Case Management Services. With creative, compassionate, and efficient care; we are dedicated to making a difference in the lives of those we service while providing effective care.

Program Goals

- Support overall health and wellness
- Assess and diagnose psychiatric, substance abuse, and other healthcare issues
- Embody a recovery-focused model of care that respects and promotes independence and responsibility
- Successful case management/service coordination results in community opportunities and increased independence for the persons served.
- Promote healthy lifestyles and provide prevention and education services that focus on wellness and self-care
- Ensure access to and coordination of care across prevention, primary care (including ensuring that members have a primary care physician), and specialty healthcare services
- Support member's in the self-management of chronic health conditions
- Assist member with controlling symptoms of mental illness with, individual/group/family therapy, pharmacotherapy and supportive services to reduce negative behaviors, emotional disturbances and independent life management.

- Provide member with strategies and coping skills to become stable and reduce the impact of severe mental illness, co-occurring disorders and other trauma (past/present).
- Develop resources for each member to strengthen the support systems available to them, within their community.
- Empower the member to successfully manage situational stressors, family relationships, inter-personal relationships, life-span indicators, psychiatric illness, substance abuse and other addictive behaviors.
- Monitor critical health indicators:
    - Diabetes
    - Hypertension
    - Obesity
    - Current Smoker
    - Depression
- Coordinate/monitor/reduce emergency room visits and hospitalizations, including participation in transition/discharge planning and follow up
- Collect, aggregate, and analyze individual healthcare data across the population or persons served by the program and uses that data and analysis to manage and improve outcomes for the persons served.

Support and facilitate improved outcomes (even when TWC is not the actual provider) by providing disease management supports and care coordination with other providers (CRSP)

Specific Services Offered:

Based on the Person Centered Plan, the following Case Management services may be provided:

- ➢ Assist individuals/families with obtaining entitlements and utilizing other local, state, and federal resources.
- ➢ Make referrals and coordinate services within and outside of TWC, including community and enhanced social support networks.
- ➢ Monitor medication compliance and efficacy.
- ➢ Monitor participation and level of satisfaction with services.
- ➢ Assist with skill development related to enhancing independence and quality of life.
- ➢ Provide options for low cost/free health care.
- ➢ Provide information and referrals to community resources and supports.
- ➢ Assist members with transportation; including assistance in becoming more self sufficient regarding transportation issues.
- ➢ Assist individuals/families in obtaining safe and affordable housing.
- ➢ Provide assistance related to securing employment and/or other meaningful activities.
- ➢ Coordinate and assist in activities related to crisis intervention/planning.
- ➢ Ensure that individuals/families understand their rights when receiving services.

- With the permission of the persons served, personnel provide advocacy by sharing feedback regarding the services received with the agencies and organizations providing the services
- Ensure the health and safety of members
- Coordinate with Primary Care Physician
- Participate in the Person Centered Planning Process
- Assessment of member family need for other services;
- Referral to the other needed services within or outside of TWC;
- Coordination and linkage to other services within or outside of TWC;
- Monthly monitoring (minimally) of members'/family's progress.
- Re-engagement of member's who have been unable to contact.

Components of the disease management program include:

- Population Identification: The above conditions and health behaviors are assessed during the intake process and flagged in the member's chart.
- Evidence-Based Practice Guidelines: The physicians, RN's, and member treatment teams are critical to educating members on an ongoing basis about how to better manage their conditions. TWC staff are educated on practice guidelines and utilize the "Paths to Improved Outcomes" manual to ensure Evidence-Based Care is provided to members with the targeted chronic conditions.
- Collaboration: The Paths to Improved Outcomes employ a collaborative and interdisciplinary approach to care, including care coordination with outside agencies.
- Self-Management Education: TWC recognizes that individuals who are better educated about how to manage and control their condition receive better care.
- Outcomes Measurement: The Chronic Conditions are monitored on a regular basis to ensure disease management interventions and approaches are effective.

Population Served

TWC Adult and Children's program serves adult, children/adolescents and families with mental health, substance abuse and developmental disabilities.

Individuals who reside in Adult Foster Care Homes will be provided with Case Managers who have been trained to specifically meet the needs of these individuals; including documentation and reporting requirements necessary to maintain the individual's placement in the Adult Foster Care Home.

In the event that we have members who require an interpreter, we have employees who are able to provide translation services to assist in the effective treatment of these individuals. In the event that a translator is not available within the agency, TWC will provide interpreter services from an outside source to ensure quality care is provided.

Eligibility/Admission

Eligibility and admission to TWC Case Management services is determined by the following:

- Member is identified as belonging to the Gateway MCPN or is eligible to be defaulted in to this MCPN
- Determination of member/family need based on Case Management Assessment.

Once a referral is received from the Intake Specialist, Nurse, or Clinical Therapist, a Case Manager is assigned to meet with the member/family and complete a Case Management Assessment. If the Case Management Assessment determines that Case Management services are appropriate, such services will be initiated.

Modalities of Treatment

Our treatment modalities are based on Evidence-Based Practices and research in the arena of Mental Health

The most commonly utilized treatment modalities are:

- Cognitive Behavior Therapy
- Brief Solution Focused Therapy
- Group Therapy
- Family Therapy
- Crisis Intervention/Stabilization
- Stages of Change/Motivational Interviewing
- Behavior Modification
- Relapse Prevention
- DBT
- Peer Support Specialists/Recovery Coaches

Primary care services that are provided internally follow best practices in medicine, as defined by the U.S. Preventive Services Task Force (USPSTF). Health Indicators are based on recommendations by the USPSTF and the National Council for Behavioral Health.

Adequate Services

A single entrance will be used for accessing all services. Primary care, behavioral health, and SUD services are provided seamlessly in the clinic. Upon admissions into the program, members will be assigned a Health Home Team. The Health Home Team consists of a therapist, a primary care coordinator, a back-up care coordinator, and a peer support specialist (see Program Description section on Staffing). The Health Home Team is responsible for performing intake and annual assessments with the member, assisting the member in articulating goals, developing a person-centered plan of care, and providing the member with necessary support, assistance, and referrals.

Members will also be assigned to a psychiatrist and a primary care provider (unless an external PCP has already been assigned). Care Coordinators ensure coordination between the behavioral, primary care, and specialty providers, regardless of whether a member receives primary care services internally or externally.

Care Coordinators maintain contact with members at least monthly (more if determined by the IPOS). Therapists and peer support specialists maintain contact with the member as determined by the IPOS, typically 1-4 times per month. Members receiving psychiatric medications will receive an initial psychiatric evaluation (as well as annually) and will be scheduled for follow-up with the psychiatrist on a monthly basis for a medication review. Some members may be scheduled more frequently with the psychiatrist if it is determined to be clinically necessary. Primary Care Providers will examine members at least annually (if receiving PCP services internally). Members with chronic health conditions will be monitored by a PCP at least quarterly, or more often if deemed clinically appropriate.

Members are typically discharged from the behavioral health home when they have met all of the goals outlined in their IPOS, or at their own discretion. TWC care coordinators will ensure a smooth transition into subsequent programming, primary care services, or follow-up care upon discharge.

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Comprehensive Care Management

I. Communicating with other primary and specialty care providers: TWC asks all members to complete provide authorization/ROI to communicate with other providers. The care coordinators are responsible for ensuring that all communication between providers occurs and is documented. Types of information shared will include physical health assessments, medication updates and change, lab results, hospitalization status, and data related to current HEDIS measures. This information will be shared for both members who have a TWC PCP and members who do not.

II. Integrated IPOS: Following a psycho-social assessment, case management assessment, health assessment (and H&P if receiving primary care at TWC), and psychiatric evaluation, the care coordinator will assist members with constructing an IPOS, which outlines interdisciplinary member needs and goals. Interdisciplinary interventions will be included, which will assist member in meeting their goals.

III. Composition of Health Home Team:
   a. Member
   b. Therapist (LMSW, LLMSW, LLPC, or LPC)
   c. 2 care coordinators (LLBSW or LBSW) – 1 will be assigned as “primary”
   d. Peer Support Staff
   e. RN
   f. Psychiatric Provider (psychiatrist or NP)
   g. Primary Care Provider (optional)

Referral Source

Consumers are referred by parent(s), legal guardian(s), PCP or external entities when member is experiencing episodes of mental health decompensation, behavioral or emotional crisis that interferes with their ability to exists independently and safe, without risk of harm to themselves or others.

Setting

Most TWC outpatient Behavioral Health services are provided in a healthcare office setting that is relevant and comfortable with bright colors and welcoming décor. Free coffee, reading material and televisions are made available while waiting for the treatment team. Some case management and peer services may be performed away from the clinic, in the home or community.

Staffing

Only a credentialed, qualified, mental Health Professional will provide treatment to individuals/families. Case Managers will be employed based on the following minimum criteria:

- Bachelor's Degree in Human Services related field.
- Licensure for the State of Michigan

Documentation

The documents listed below reflect minimum case management documentation requirements:

- Case Management Assessment
- Individualized Plan of Service
- Case Management Progress Note
- Communication with Primary Care Physician
- Authorization to release information for various outside referrals and agencies based on need

Hours of Operation/Frequency

TWC Outpatient Behavioral Health programs are open from 9am - 5pm, Monday - Friday, unless otherwise noted (i.e., some locations are open until 8:00 PM; some have weekend hours; and some are open 24 hours). Toll free number for all locations: (888) 813-8326

Locations

Eastern Market Clinic
2925 Russell
Detroit MI 48207

Southgate Clinic
14799 Dix-Toledo Rd
Southgate MI 48195

Team East
6309 Mack/3646 Mt. Elliott
Detroit, MI 48207

Team Jefferson
11105 E. Jefferson
Detroit, MI 48202

Discharge

A member may be discharged from Case Management services for the following reasons:

- Case Management goals have been met.
- Member is exhibiting a need for a higher level of treatment; i.e. ACT
- The member/guardian requests to be discharged.
- Member requires long term hospitalization.
- Member has been using/abusing drugs and/or alcohol while in program and has been non-compliant with substance abuse treatment portion of the treatment plan.
- Member commits an act of physical violence or aggression towards a TWC staff member, a recipient of TWC services, or any other individual on TWC premises.
- Verbally threatening to cause bodily harm to a TWC staff member or recipient of TWC services.
- Having in your possession while on the premises of TWC, any of the following: weapon, ammunition, alcohol, or illegal drugs.
- Member fails to respond to contact attempts (see discharge policy)

Payer/Funding Source

Funding is provided by Detroit Wayne Mental Health Authority (DWMHA), Michigan Department of Health and Human Services (MDHHS), and private insurances.

Fees

Fee For Service
Contracted bundled rates

Additional Information

All services provided by TWC abide by Person Centered Planning guidelines (see Person Centered Planning Policy).

All services provided by TWC abide by the rules and regulations established for member rights (see Member Rights policy).

All Members age 21 or under with Medicaid insurance shall be notified of the availability of EPSDT services and shall link the member and his or her family member to these services, when appropriate.

TWC will maintain an up-to-date resource manual that can be conveniently accessed and used by the case managers.

All eligible members shall be offered a choice of case management, as well as an informed choice of case managers.