Individualized Placement & Supports: Supportive Employment Program Description

Program Description

Team Wellness Center's Individualized Placement & Supports/Supportive Employment Program (IPS) is a healthcare delivery approach that focuses on the whole person and integrates and coordinates primary care, behavioral health, other healthcare, community, social, and employment support services. IPS allows for individual choice and is capable of assessing the various physical and behavioral health needs of persons served. The programming demonstrates the capacity to address, either directly or through linkage or referral to external resources, behavioral health employment barriers, such as mental illness and substance use disorders, and physical health conditions. IPS may also serve persons who have intellectual or other developmental disabilities and physical health needs or those who are at risk for or exhibiting behavioral disorders. Care is coordinated over time across providers, functions, activities, and sites to maximize the value and effectiveness of services delivered to persons served. TWC serves as a Behavioral Health Home for members receiving co-occurring services. It is designed to increase improved mental and physical health, self-sufficiency, and quality of life for individuals who have been diagnosed with a severe and persistent mental illness or developmental disability. Individuals are offered a comprehensive array of services, including supportive employment, geared towards their individual needs. Activities are carried out in collaboration with the member and participation of family members and natural supports is strongly encouraged.

Program Philosophy

Our approach to service delivery promotes care for the *whole* person, integrating aspects of physical, mental/emotional, and spiritual health. 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 meaningful/sustainable employment, optimum health, quality of life, continuous improvement and social awareness. The member's desires, needs, preferences and identified goals are paramount in determining the degree to which they will receive available services. With creative, compassionate, and efficient care: we are dedicated to making a difference in the lives of those we service.

Program Goals

- Obtain meaningful employment
- Sustain meaningful employment
- Support overall health and wellness
- Address psychiatric, substance abuse, and other healthcare barriers to employment
- Embody a recovery-focused model of care that respects and promotes independence and responsibility
- Promote healthy lifestyles and provide prevention and education services that focus on wellness and self-care

- 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.
- Promote the member's involvement (role and responsibilities) in making decisions about their employment
- 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, job related tasks, family relationships, inter-personal relationships, life-span indicators, psychiatric illness, substance abuse and other addictive behaviors.
- 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.

Specific Services Offered

Employment planning services:

- Confirm that employment exploration sites (e.g., Indeed, Zip Recruiter, etc.) utilized for the person seeking employment are appropriate to obtain desired information
- Job-readiness assessments:
  - Job skills
  - Hours and availability to work
  - Interest in a particular job
  - Work-related behaviors
  - Need for potential job accommodations
  - Other pertinent information related to the job seeker
- A person seeking employment is informed of job opportunities and requirements in the employment market consistent with his or her interests and abilities
- Employment planning analysis and report:
  - Employment exploration results
  - Relevant jobs available in the employment market
  - Strengths of the person evidenced during exploration
  - Barriers to the achievement and maintenance of employment
  - Transportation and other support needs
  - Self-evaluation by the person of the employment exploration experience, if possible

- Individualized environmental, assistive technology, or job-task accommodations used
- Recommendations for community resources and/or services, as needed, to assist in addressing employment barriers
- The person's employment planning report is shared in an understandable manner with the person seeking employment
- The person's employment planning report is disseminated in a timely manner to the care coordinator or referring agency's individual responsible for implementing recommendations in the report

Organizational employment services:

- The following information is provided to the person served
  - The conditions of maintaining employment
  - Benefits provided by the organization
  - Responsibilities of the organization
  - Responsibilities of the person served
  - Wage payment practices
  - Rate of pay, including methods of performance measurement and methods to increase earnings
  - Work rules and customs
  - Nondiscrimination practices
  - Civil rights practices
  - Policies for transfer
  - Employee classifications in the organization
  - Health and safety practices
  - Potential for advancement opportunities
  - Conditions for advancement
  - Employment options available in the organization
  - Opportunities for training on other jobs
  - How the individual can move to community integrated employment
- Training activities address, as needed:
  - Job performance and progress
  - Increasing individual performance
  - Work-site job modifications, if needed
  - Strategies for resolving job-related issues
  - Safe workplace practices
- Based on the needs and choices of the person served, the organization provides or refers the person to resources for addressing, as relevant to job support:
  - Basic academic skills
  - Basic self-skills

    - Communication skills
    - Computer literacy
    - Work attitudes
    - Tools and equipment related to the person's job
    - Mobility and travel training
    - Interpersonal relationships with coworkers
    - Job-site safety practices
    - Career planning
    - Problem-solving and decision-making skills
    - Health maintenance and medication management
    - Knowledge of governmental and community service agencies
    - Management of legal affairs
    - Management of benefits and financial resources
    - Recreational and leisure time activities
    - Use of phone and computer resources
    - Use of community services and resources
    - Accommodations or assistive technology needs, if identified
    - Other issues or barrier to success, as identified
- At least annually, persons are provided informed choices for exploration of other work opportunities, as desired, within the organization and within the community
- Relevant training activities are available during periods of reduced work activity

Community employment services:

- Job development planning uses a strengths-based approach that considers, as appropriate to the person served:
    - The person's preferences
    - Successful aspects of work history
    - Noted strengths and abilities from volunteer experience or hobbies
    - Successful aspects of previous training, education, and life experiences
    - The management and planning of benefits the person is receiving
    - Resources for career planning and advancement
    - Transportation availability
- Individual service plans for job development are individualized to the person seeking employment and involve his or her input and approval
    - Are tracked in a systematic manner to ensure ongoing monitoring until employment is achieved
    - Are revised periodically, as necessary
- Job development activities include, depending on the needs of the individual served:

- Contacting employers and building networks to develop and/or identify job opportunities
- Providing access to information about current job openings
- Work-site analysis, as needed
- Supports that assist the person served in an individual site, including:
  - Job-site consultation to identify or modify barriers to employment
  - Negotiating job carving, job accommodations and job and job sharing
- Natural supports in the workplace
- Assisting the job applicants in finding jobs and employers well matched to their employment goals
- Education and supports in self-directed job search, when appropriate, and ADA rights and EEOC
- Disability awareness education to the employer, when indicated
- The services ensure that the new employee is provided information needed to be appropriately oriented to the job and work culture
- As is available to all employees

➢ If the person served has authorized disclosure, the organization provides the employer with information about or access to resources as needed regarding:
- Job modifications and/or reasonable accommodations
- Federal, state, provincial, or employer tax credits, if applicable
- Supports available from the organization, including a staff contact person

All services and frequency will be guided by the member's Individual Plan of Service (IPOS).

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 IPS program serves adults with mental health, substance abuse and developmental disabilities.

Eligibility/Admissions Criteria

All members receiving services from TWC for behavioral health, substance abuse, and/or development disabilities will be considered members of the Health Home and are eligible for IPS services. TWC receives referrals in a variety of ways, including the Detroit Wayne Integrated Care Network (DWIHN) referrals, hospital referrals, or self-referrals. Poor health, credit, housing, incarceration, or other histories will not automatically disqualify a member for IPS services.

Eligibility and admission to TWC's IPS Services is determined by the following:

- Member is identified as eligible to be defaulted into a contracted payer by DWIHN's Central Access Department
- Member is identified as being a part of a contracted payer
- Member is covered under a contracted private insurance
- Referred by MPRI
- Referred by other Rehabilitation Facilities
- Member is deemed medically stable or is under the care of a physician
- Member is psychologically stable enough to work (not in need of hospitalization to treat illness)
- Member is able to manage behavior in such a way as not to be of harm to themselves or others
- Member is in need of access to a comprehensive array of mental health or developmental disability services to meet their needs
- TWC also accepts self-referrals

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:

- Supportive employment
- 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

Individual Placement Support Services follow best practices in healthcare, 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, Supportive Employment 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, Employment Specialist, Housing Specialist, and a peer support specialist. 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, employment 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, employment program 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), including but not limited to:

- Implementation of the person-centered plan
- Ongoing monitoring of the person-centered plan, including revisions as needed
- Providing or arranging for primary care, behavioral healthcare, hospital care, medical specialty care, substance abuse, employment services, community and/or social support services and other services, as appropriate
- Monitoring of critical chronic disease indicators
- Comprehensive transitional care
- Sharing information about the person served (actively and during transition), including strengths, needs, abilities, preferences, treatment history, health status, current medications, identified goals, Identified gaps in treatment, when applicable; inpatient, other outpatient providers, levels of care and when transitioning between systems of care (when the member agrees to share such information with potential employers or others)

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 employment programming, primary care services, or follow-up care upon discharge.

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 IPS Team:
   a. Member
   b. Program Director
   c. Employment Supervisor
   d. Employment Specialist (ration 1:20)
   e. Peer Support Specialist

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 obtain/maintain employment, 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 employment, housing, case management and peer services are performed away from the clinic, in the home or community.

Staffing

Only a credentialed, qualified Mental Health Professional will provide treatment. Staff will be employed based on the following minimum criteria:

- Case Managers: Bachelor's Degree in Human Services related field (Licensure must be obtained LLBSW, LBSW, SST)
- Clinical Therapist: Licensed or Limited Licensed Master's Degree in Social Work, LLP, LLPC, MFT
- Employment Specialists: High School diploma
- Housing Specialist: High School diploma
- Nurse: Associate's Degree in Nursing (RN)
- Psychiatrist: MD, DO, or FNP and licensed to provide psychiatric services in the state of Michigan
- Peer Support: Certified Peer Support Specialists
- Primary Care Provider: MD, DO, PA, or FNP licensed to practice in the state of Michigan.

Documentation

The following documents are general in nature and are in no way inclusive of all documents which may be located/required in an individual's Medical Record:

- Employment Referral
- Consent for Treatment
- Employment self-assessment
- Vocational Profile
- Intake Paperwork
- Psychiatric Evaluation, Psychosocial Assessment, Nursing, and Case Management Assessments
- History and Physical
- Lethality Assessment
- IPOS
- Individual Progress Notes from each discipline
- Authorization to Release/Request Information
- Crisis Plan
- Medication consent
- Notice of Hearing Rights

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. Employment specialist will assist member's as needed, after 5pm and on weekends.

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

Transition/Discharge Criteria

A member may be discharged from IPS Services for the following reasons:

- The member/guardian requests to be discharged
- Member has obtained employment and met all goals as written in the IPOS and new functional goals cannot be established.
- Member is able to function on his/her own, is community integrated and has established independence
- Member is not making additional functional gains or there has been a persistent regression in performance, which has a negative impact on the member's ability to obtain employment or meet goals established. Discharge will be administered due to lack of progress and inability to successfully complete individual member goals. A referral to a more appropriate TWC program or a program within the community will be made.
- Member has behavioral challenges that make treatment in their current level of care unsafe or ineffective. A referral to a more appropriate TWC program or a program within the community will be made.
- 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 rules and regulations established for member rights (see Recipient 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 members to these services, when appropriate.
TWC will maintain an up to date Resource Manual that can be conveniently accessed and used by TWC staff.
All eligible members shall be offered case management, as well as an informed choice of case managers.
Personnel must respond to phone calls within 24 hours, to enhance access to the health home.

IPS and outpatient services are provided to individuals enrolled in contracted payers or are private pay.