Behavioral Health Home: Outpatient Program Description

Program Description

Team Wellness Center's Behavioral Health Home/Outpatient Program is a healthcare delivery approach that focuses on the whole person and integrates and coordinates primary care, behavioral health, other healthcare, and community and social support services. A health home 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 with or referral to external resources, behavioral health conditions, such as mental illness and substance use disorders, and physical health conditions. Programs 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 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 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

- 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
- 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

Health Home/Outpatient services (on site):

- Individual therapy
- Family Therapy
- Group Therapy
- Case Management/Care Coordination (linkage to external services)
- Psychiatric and Medication Management services
- Primary Care Services
- Dental Services
- Optometry Services
- Nursing
- Peer Support
- Podiatry
- Co-occurring substance abuse treatment
- Member advocacy
- Activities associated with Crisis Intervention (including suicidal threats or attempts)

- Response to Trauma (past/present)
- Psychiatric Urgent Care
- Jail Diversion

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

Eligibility/Admissions Criteria

All members receiving services from TWC for behavioral health issues will be considered members of the Health Home. TWC receives referrals in a variety of ways, including MCPN referral, hospital referral, or self-referral. Members that decline to participate in the Health Home will be required to sign-off on the declination, and this will be noted in the member's chart. Members can decide to enroll in the Health Home at any time following the declination.

Eligibility and admission to TWC's Outpatient 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 participate in individual and/or group therapy (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
- A member/family may be referred to Outpatient Services by a hospital, School Social Worker, Primary Care Physician, or the MCPN
- 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:

- Cognitive Behavior Therapy:

  Note: CBT is a specialized level of care and merits the following expansion in explanation of the approach to treatment:

  Cognitive Restructuring — One of the core components of Cognitive Behavioral Therapy. Cognitive restructuring operates on the assumption that it's not what happens to us that makes us unhappy, anxious, or depressed — rather, it's how we *think about* what happens to us.

  Cognitive restructuring techniques focus on increasing awareness, challenging the accuracy of troublesome thoughts, and developing a more mindful awareness with the goal of lessening the frequency and intensity of difficult emotions.

  Our Therapists guides the participants and teaches them about cognitive distortions. Often, people are unaware of these unhealthy patterns of thinking until we learn about how they impact our lives in a negative way, and at that point, we can change the way we think about things.

  We invite the participant's families, friends, and other natural supports, to participate in individual and group sessions where the following cognitive distortions are addressed for correcting:

  1. Filtering
  2. "Black and White" thinking
  3. Overgeneralization
  4. Jumping to Conclusions/Mind Reading

5. Catastrophizing
6. Personalization
7. Control Fallacies
8. Fallacy of Fairness
9. Blaming
10. "Should" statements
11. Emotional Reasoning
12. Fallacy of Change
13. Labeling
14. Always Being Right
15. Heaven's Reward Fallacy

Other commonly utilized treatment modalities are:

- 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), 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, 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.

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.

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. Medical Assistant
   g. Psychiatric Provider (psychiatrist or NP)
   h. Primary Care Provider (optional)

IV. The program addresses the needs of the persons served in the following areas:
   a. Triage based on acuity (with nursing and medical assistants)
   b. Assessment of service needs
   c. Identification of gaps in treatment
   d. Appropriate testing to monitor health status
   e. Medication reconciliation at admission to the health home program, at appropriate intervals, and upon discharge from hospitalization
   f. Assignment of health home team roles and responsibilities
   g. Development of relations ships with community and/or social support services

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 children/families. 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
- 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:

- 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

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 Outpatient Services for the following reasons:

- The member/guardian requests to be discharged
- Member has 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 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.

Outpatient services are provided to individuals enrolled in contracted payers or are private pay.