Behavioral Health Home: Primary Care 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 co-morbidity concerns. Care is coordinated over time across providers, functions, activities, and sites to maximize the value and effectiveness of services delivered to persons served. Team Wellness Center 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. 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 physical health, 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 primary care (including ensuring that members have a primary care physician), prevention, and specialty healthcare services
- Support member's in the self-management of chronic health conditions

- Assist members with treating symptoms of physical illness with, the latest in evidence-based practices, including addressing a history of trauma, emotional disturbances and independent life management.
- Provide member with strategies and coping skills to become stable and reduce the impact of chronic 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):

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

All services and frequency will be complemented 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.

Eligibility/Admissions Criteria

All members receiving services from TWC for Primary Care issues will be considered members of the Health Home. TWC receives referrals in a variety of ways, including walk-ins, hospital referrals, Internal referrals, or crisis referrals. 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 Primary Care Services is determined by the following:

- Member is identified as eligible to be defaulted into care with a Primary Care physician via a PPO insurance contract (or direct Medicaid)
- Member is identified as eligible and elects one of TWC's Primary Care providers via an HMO insurance contract (including Medicaid)
- Internal Referral from Jail Diversion or Psychiatric Urgent Care
- Referred by other Rehabilitation Facilities
- Member is able to manage behavior in such a way as not to be of harm to themselves or others
- TWC also accepts self-referrals

Modalities of Treatment

Our treatment modalities are based on Evidence-Based Practices
The most commonly utilized treatment modalities are:

- Evaluation and Management
- Physical Examination
- Specific Scopes
- Office-based Services
- X-ray

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.

Comprehensive Care Management

I. Communicating with other primary and specialty care providers: TWC asks all members to complete and 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. Primary Care Provider (MD, DO, PA or NP)
   c. Therapist (LMSW, LLMSW, LLPC, or LPC)
   d. 2 care coordinators (LLBSW or LBSW) – 1 will be assigned as "primary"
   e. Peer Support Staff
   f. RN
   g. Psychiatric Provider (Psychiatrist or NP)

Referral Source

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

Setting

TWC Primary Care 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, licensed MD, DO, NP, PA, Podiatrist, RN or Certified X-ray Technician will provide Primary Care treatment.

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
- Evaluation and Management assessment
- 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 Primary Care program is open from 9am - 5pm, Monday - Friday, unless otherwise noted (i.e., some days are open until 8:00 PM). Toll free number for all locations: (888) 813-8326

Primary Care Program ensures that one or more of the following medical staff, legally able to independently provide the services offered, is on site during hours in which medical services are offered: Physician, Physician Assistant or Nurse Practitioner.

Psychiatric Provider (Psychiatrist or NP) and other behavioral health providers are available for collaboration and consultation during hours that Primary Care program is open.

Location

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

Transition/Discharge Criteria

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

- The member/guardian requests to be discharged
- Member has met all goals in their care plan and new goals have not been established. Member is able to function on his/her own.
- Member is not making additional recovery gains or there has been a persistent regression in recovery, 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 external treatment 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 external treatment program within the community will be made.
- Member fails to respond to contact attempts (see discharge policy)

Payer/Funding Source

Funding is provided by the insurance coverage that the member has, self-pay or self-pay with sliding fee scale. 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.

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