TARZANA TREATMENT CENTERS
Integrated Healthcare

Behavioral Health Home:
Providing Integrated Medical and Behavioral Health Services

Tarzana Treatment Centers is a Behavioral Health Home

- In addition to our accreditation with The Joint Commission (TJC), TTC also obtained certification as a Behavioral Health Home (BHH) with TJC.
- The Joint Commission's Behavioral Health Home standards are consistent with the vision of integrated behavioral healthcare that TTC has been pursuing since 1995.

About Behavioral Health Homes

- **The Behavioral Health Home** model requires agency team members at all levels to coordinate and provide integrated behavioral and physical health to our patients.
- **Behavioral Health Homes** are important to supporting a whole-person approach to care for our patients.
- **Behavioral Health Homes** additionally rely on strong coordination of care, treatment, and services in order to *effectively decrease high rates of morbidity and mortality* found in patients with serious mental health needs and other behavioral health concerns.

Behavioral Health at TTC

- Patients we see for Substance Use Disorders (SUD), Mental Health (MH), Primary Care and Specialty HIV Care often have not had their medical needs addressed when they first enter treatment.
- They may not have seen a medical provider for months or years, which means our role as a BHH is to address the gaps in treatment our patient have experienced.
- Behavioral Health team members see patients more frequently than medical providers and they often have developed a trusting and therapeutic relationship with patients.
- This results in patients more likely to discuss sensitive issues with them, including their chronic medical diseases.

Behavioral Health at TTC

As a Behavioral Health Home Provider:

- It is important that all team members understand behavioral health and primary care approaches to providing services to our patients in order to truly implement integrated care.
- It is important that all team members *understand behavioral health conditions* most prevalent within the populations we serve.

Behavioral Health Conditions

Section 1

Tarzana Treatment Centers Populations of Focus

- Our patients generally have lived-experience within at least one of the following special populations:
  - **Substance Use Disorders (SUD)**
  - **Mental Health Needs (MH)**
  - **HIV/AIDS**
  - **Homelessness**

Each of these special populations have specific significant behavioral and physical needs related to their condition(s).

Common Behavioral Health Conditions

Substance Use Disorders

- Clinical diagnoses for patients who use or depend on substances with the following common behavioral needs:
  - Decision making
  - Impulsivity
  - Social Withdrawal
  - Irritability
  - Anger Outbursts

Common Behavioral Health Conditions

Mental Health Disorders

- A wide array of mental health conditions that affect a patient's mood, thinking and behavior with some of the following common behavioral needs:
  - Mood changes
  - Withdrawal from friends
  - Withdrawal from activities
  - Lethargy
  - Inability to cope with daily problems/stress
  - Changes in eating habits
  - Suicidal thinking
  - Excessive anger, hostility, or violence

Common Behavioral Health Conditions

HIV/AIDS

- Patients living with a chronic medical condition transmitted from a person living with HIV who has a detectable viral load producing common behavioral health needs like:
  - Feelings of Helplessness
  - Complicated existing Mental Health Conditions
  - Risky sexual behavior
  - Substance Use Disorder

Common Behavioral Health Conditions

Homelessness

- The situation where a patient is currently or at risk of living without stable, safe, permanent, and/or appropriate housing which bring the following common behavioral health needs:
  - Loss of Structure and Safety
  - Mental Health Disorders
  - Substance Use Disorders
  - Increased risk of experiencing domestic or sexual violence
  - Legal and/or criminal justice issues
  - Lack of social support
  - Inadequate job preparation

Areas for Behavioral Interventions

Substance Use

- Maintenance of abstinence
- Supportive behaviors and drug-free activities
- Maintain supportive contact
- Set new short- and long-term goals for MH and SU

Diabetes

- Blood sugar monitoring and control
- Identify and support dietary changes
- Promote self management
- Enhance mood stability
- Stress reduction

Areas for Behavioral Interventions

Obesity

- Monitoring food/diet
- Goal identification and attainment
- Exercise goal identification and tracking

COPD

- Identifying triggers
- Smoking cessation (medical and behavioral)
- Medication compliance
- Daily Monitoring, Action planning

Social Support

- Identify drug free activities including 12-step, church and recreation

Common Chronic Physical Health Conditions

Section 2

Screening for Chronic Health

- Our patients are generally screened for variety of different chronic physical health conditions which are most common with our communities
  - Diabetes
  - Hypertension
  - Hyperlipidemia (LDL greater than 200)
  - Heart Disease
  - Asthma
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Hepatitis C
  - HIV/AIDS

Diabetes

- Type 1: Diagnosed in children and young adults where the body does not produce insulin. Also known Insulin-dependent diabetes mellitus (IDDM)
- Type 2: Most common with our populations. Body either does not produce enough insulin or the cells ignore the insulin. Also known as Non-insulin-dependent diabetes mellitus (NIDDM)
- Typical Screenings involving blood work up where “Fasting Glucose Levels” and HbA1C levels are evaluated to be normal or abnormal ranges.

Diabetes

- Diabetes can lead to blindness, heart & blood vessel disease, stroke, kidney, failure, amputations, and nerve damage.
- Most common symptoms include:
  - Blurred vision
  - Erectile dysfunction
  - Fatigue
  - Frequent or slow-healing infections
  - Increased appetite
  - Increased thirst
  - Increased urination

High Blood Pressure & Cholesterol

Hypertension

- Hypertension is when blood pressure is too high
- Signs of Hypertension: severe headaches, nosebleed, fatigue or confusion, vision problems, chest pain, difficulty breathing.
- Increased risk of:
  - Stroke
  - Blood vessel damage (arteriosclerosis)
  - Heart attack
  - Tearing of heart's inner wall (aortic dissection)
  - Vision loss
  - Brain damage

Hyperlipidemia

- High Cholesterol
- Typical Screening is a blood work up. Where they look at: total cholesterol, low density lipoprotein (LDL) cholesterol, high-density lipoprotein (HDL) cholesterol, triglycerides
- LDL "bad" cholesterol levels are higher than 200

Asthma

- Condition in which your airways narrow, swell and may produce extra mucus. This can make breathing difficult and trigger coughing, a whistling sound (wheezing) when you breathe out and shortness of breath.
- Asthma signs and symptoms include:
  - Shortness of breath
  - Chest tightness/pain
  - Wheezing when exhaling
  - Trouble sleeping

COPD

- Chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Emphysema(destroyed air sacs) and chronic bronchitis (inflammation of air tube).

- Signs and symptoms of COPD may include:
  - Shortness of breath, especially during physical activities
  - Wheezing
  - Chest tightness
  - A chronic cough that may produce mucus (sputum) that may be clear, white, yellow or greenish
  - Frequent respiratory infections
  - Lack of energy
  - Unintended weight loss (in later stages)
  - Swelling in ankles, feet or legs

Hepatitis C

- Liver infection that can lead to serious liver damage
- Symptoms:
  - Bleeding easily
  - Bruising easily
  - Fatigue
  - Poor appetite
  - Yellow discoloration of the skin and eyes (jaundice)
  - Itchy skin
- Screening for Hepatitis C: Blood work that searches for the “Anti-HCV antibodies”

HIV/AIDS

Human immunodeficiency virus infection and acquired immunodeficiency syndrome (HIV/AIDS) is a spectrum of conditions.

Stage 1: Acute HIV Infection

- Within 2 to 4 weeks after infection with HIV, about two-thirds of people will have a flu-like illness. This is the body's natural response to HIV infection. Flu-like symptoms can include –fever, chills, rash, night sweats, muscle aches, sore throat, fatigue, swollen lymph nodes, mouth ulcers

Stage 2: Clinical Latency

- People in this stage may not feel sick or have any symptoms

Stage 3 : AIDS:

- Rapid weight loss, Recurring fever or profuse night sweats, extreme and unexplained tiredness, swollen lymph glands, Diarrhea that lasts for more than a week, sores of the mouth, anus, or genitals , pneumonia, blotches on or under the skin, memory loss, depression, and other neurologic disorders.

HIV/AIDS

Stage 3: AIDS:

- Rapid weight loss
- Recurring fever or profuse night sweats
- Extreme and unexplained tiredness
- Prolonged swelling of the lymph glands in the armpits, groin, or neck
- Diarrhea that lasts for more than a week
- Sores of the mouth, anus, or genitals
- Pneumonia
- Red, brown, pink, or purplish blotches on or under the skin or inside the mouth, nose, or eyelids
- Memory loss, depression, and other neurologic disorders

Patient-Centered Care, Treatment, and Services

Section 3

Why Integrated Care?

- Mental health and substance use services are integral to health care services.
- Goals:
  - Ensure positive experiences of care
  - Enhance customer services
- Ensure care is effective
  - Develop multi-directional care and “no wrong” door policy that treats patients as whole people
  - Implement data outcomes system to enable monitoring of client progress

Why Integrated Care?

- Patients we see in SUD, MH, primary care and specialty HIV care often have not had their medical needs addressed when they enter treatment. They may not have seen a medical provider for months or years.
- Control/reduce costs
  - Develop strategies to extend care
  - Develop strategies to reduce readmission and preventable hospitalizations

No Wrong “Door” to Integrated Care

- Screenings-staying in scope and referring to other systems of care internally (MH, SUD, HIV/AIDS specialty care, Primary Care, Housing, etc.)
- Educational presentation that educate on the link between chronic health conditions and mental health/substance use
- Motivational Interviewing techniques/Brief Interventions that engage patients in discussions about changes and linkages to SUD/MH/Primary Care and other services
- Behavioral health providers follow up on referrals and ensuring “warm hand off” to all systems of care (MH, SUD, Primary Care, Housing, etc.)
- Behavioral health providers developed a trusting, therapeutic relationships with patients. This results in patients more likely to discuss sensitive issues with them, including their chronic medical diseases.

Integrated Care Approach

Screenings: Self-Medical History	Assessment	Treatment Plan	Treatment	Case/Care Management	Whole Person Care
• Review chronic diseases • Review medications • Assess if patient is receiving medical care of chronic diseases	• Note Chronic Diseases identified in Self-Medical History form • Identify how these chronic diseases impact SUD and MH issues	• Add chronic disease as a problem • Add problem page for chronic disease with goals, objectives and interventions	• Address chronic diseases as part of your overall care with the patient • Follow the objectives and interventions on the treatment plan and document progress in the medical record • Reinforce medical provider orders and recommended treatment	• Communicate with the primary care provider • Monitor and assess if patient is seeing the medical provider and following the medical provider's care plan • Coordinate care as needed with primary care provider	• Emphasize that managing chronic diseases is similar to managing addiction and mental health disorders • Point out the similarities in terms of how taking better care of oneself promotes recovery and improved health

Strategies for Successful Communication

- It is important to understand the system with which you are working
- Learn about the medical conditions that bring people to primary care
- Expand your vocabulary to facilitate communication
- Stay within your scope of practice in your interactions
- Make yourself visible and helpful
- Be accessible and available

Strategies for Engagement in Care

Section 4

Strategies for Engagement in Care

Referrals to Treatment and Systems Navigation

- Patients with serious behavioral health conditions are much more likely to be admitted to hospitals via the emergency department or to be readmitted within 30 days of discharge.
- TTC reduces the likelihood of hospital admission or readmission by engaging our Hospital Navigation Teams (many of whom are co-located in Los Angeles County Hospitals) to ensure patients have access to treatment.

Strategies for Engagement in Care

Assessment and Treatment Planning

- When an individual comes to TTC seeking behavioral health services, TTC team members assess for and include in the treatment plan the other chronic medical conditions that a patient may have.
- When screening a patient, chronic medical conditions and other serious medical issues can be identified through a review of the **Self-Medical History Form**. Once these problems have been confirmed with the patient, they should be included on the treatment plan and reviewed on a regular basis.
    - It is important to note how these chronic diseases impact SUD and MH issues for the patient.

Strategies for Engagement in Care

Treatment

- Address chronic diseases as part of your overall care with the patient.
- Follow the objectives and interventions on the treatment plan and document progress in the medical record.
- Reinforce medical provider orders and recommend treatment.

Case Management

- Communicate with the primary care provider as needed for the patient.
- Monitor and assess if the patient is seeing the medical provider and following the medical provider’s care plan.
- Coordinate care as needed with primary care provider.

Strategies for Engagement in Care

Care Coordination

- Behavioral Health team members are not expected to provide medical care or be experts in medical care; rather, they are to coordinate care and make sure each patient has their medical and other BH needs met.
- For patients who have an existing primary care provider TTC team members coordinate with the provider to assure continuity of care.
- If a patient lacks a current primary care provider, TTC primary care providers address the patient's physical health needs at one of our clinics.

Strategies for Engagement in Care

Whole Person Care

- All TTC team members are expected to promote the values of whole-person care.
- Managing chronic diseases is similar to managing SUD and MH disorders.
- When working with patients, it is important to identify the similarities in terms of how taking better care of oneself promotes recovery and improved health.

Technology and Equipment to Support Primary Health Care

Section 5

Technology and Equipment to Support Primary Health Care

- **TTC's Electronic Health Record.**
  - My Patient Portal communicates important labs and provides real time health education to patients.
  - It encourages patients to be involved with their care.
  - The Patient portal can be accessed through computers, cell phones, and tablets.

Technology and Equipment to Support Primary Health Care

- **Hypertension:**
  - Provide educational materials through My Patient Portal.
  - Provide educational materials after visit plan.
  - Provide automated blood pressure equipment to patients.
  - Properly educate patient on the use of automated home blood pressure equipment.
- **Diabetes Mellitus**
  - Provide educational materials through My Patient Portal.
  - Provide education materials after visit plan.
  - Provide glucometer equipment to patients.
  - Properly educate patient on the use of glucometers.

Technology and Equipment to Support Primary Health Care

- **Hepatitis patients**
  - Provide educational materials through My Patient Portal.
  - Provide education materials after visit plan.
- **HIV/AIDS**
  - Provide educational materials through My Patient Portal.
  - Provide educational and safe sex materials after visits.
- **Asthma**
  - Provide educational materials through My Patient Portal.
  - Provide education materials after visit plan
  - Possibly provide Nebulizer equipment to patients and properly teach them how to utilize the equipment.

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