



# 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

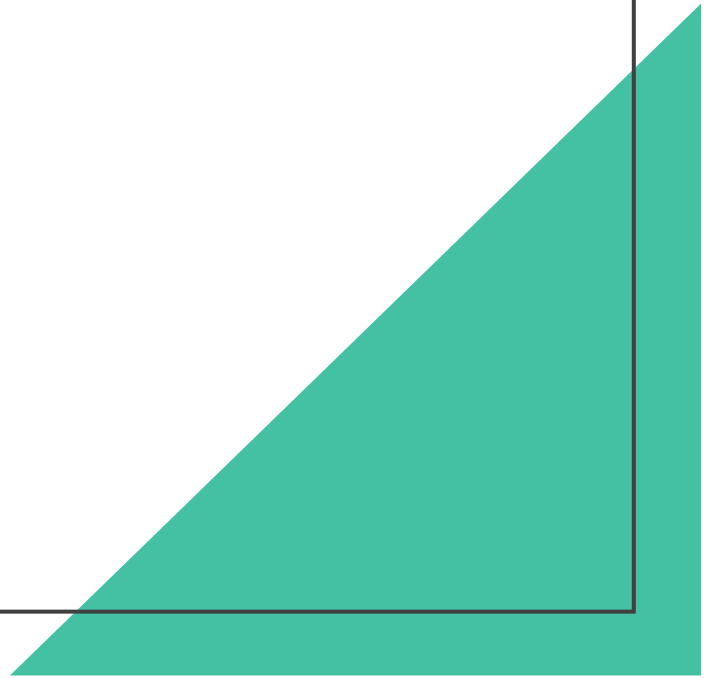
- Patients we see for Substance Use Disorders (SUD), Mental Health (MH), Primary Care and Specialty HIV Care often have not had their medical needs addressed when they first enter treatment.
- They may not have seen a medical provider for months or years, which means our role as a BHH is to address the 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

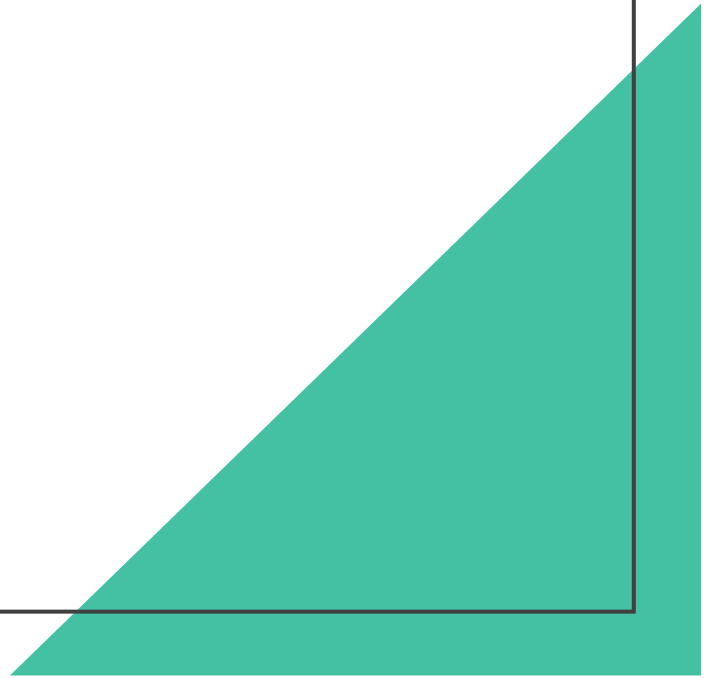
## **COPD**

- 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.

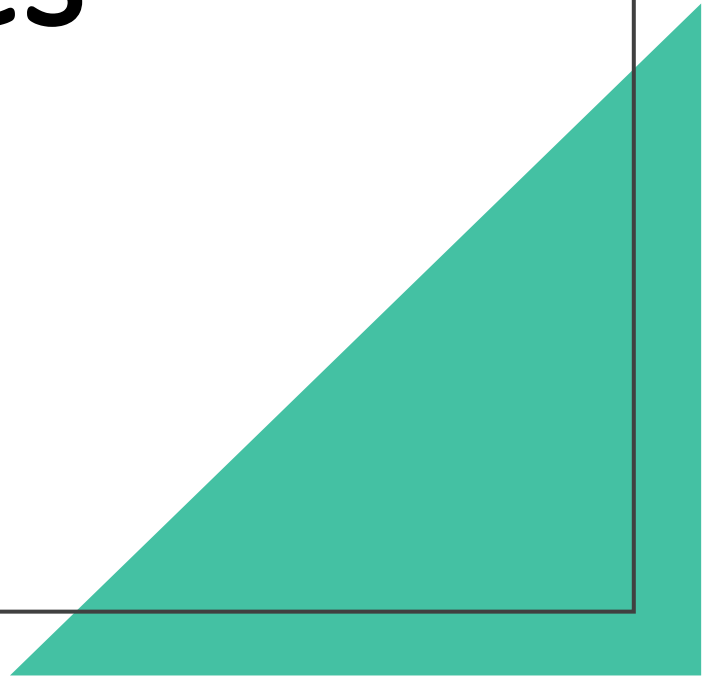
# HIV/AIDS

## 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

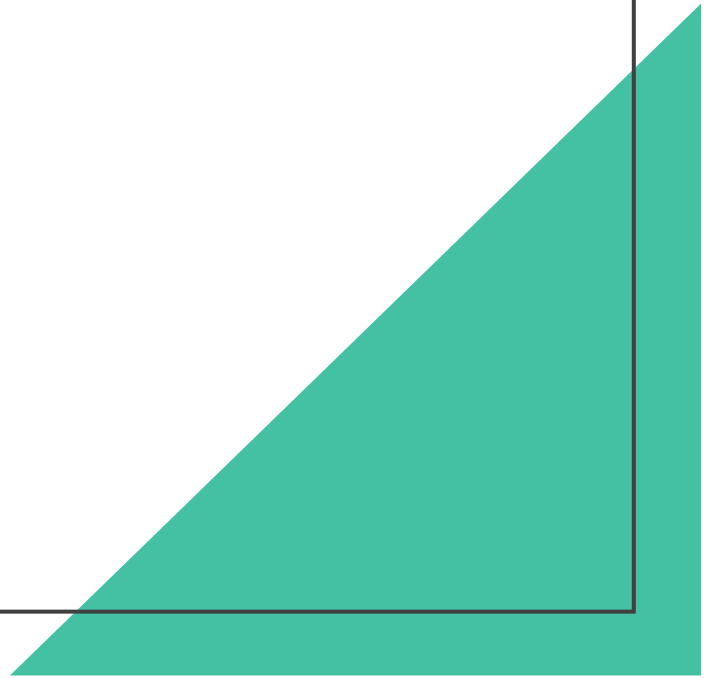
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Screenings: Self-Medical History	Assessment	Treatment Plan	Treatment	Case/Care Management	Whole Person Care
<ul style="list-style-type: none"><li>• Review chronic diseases</li><li>• Review medications</li><li>• Assess if patient is receiving medical care of chronic diseases</li></ul>	<ul style="list-style-type: none"><li>• Note Chronic Diseases identified in Self-Medical History form</li><li>• Identify how these chronic diseases impact SUD and MH issues</li></ul>	<ul style="list-style-type: none"><li>• Add chronic disease as a problem</li><li>• Add problem page for chronic disease with goals, objectives and interventions</li></ul>	<ul style="list-style-type: none"><li>• Address chronic diseases as part of your overall care with the patient</li><li>• Follow the objectives and interventions on the treatment plan and document progress in the medical record</li><li>• Reinforce medical provider orders and recommended treatment</li></ul>	<ul style="list-style-type: none"><li>• Communicate with the primary care provider</li><li>• Monitor and assess if patient is seeing the medical provider and following the medical provider's care plan</li><li>• Coordinate care as needed with primary care provider</li></ul>	<ul style="list-style-type: none"><li>• Emphasize that managing chronic diseases is similar to managing addiction and mental health disorders</li><li>• Point out the similarities in terms of how taking better care of oneself promotes recovery and improved health</li></ul>

# 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

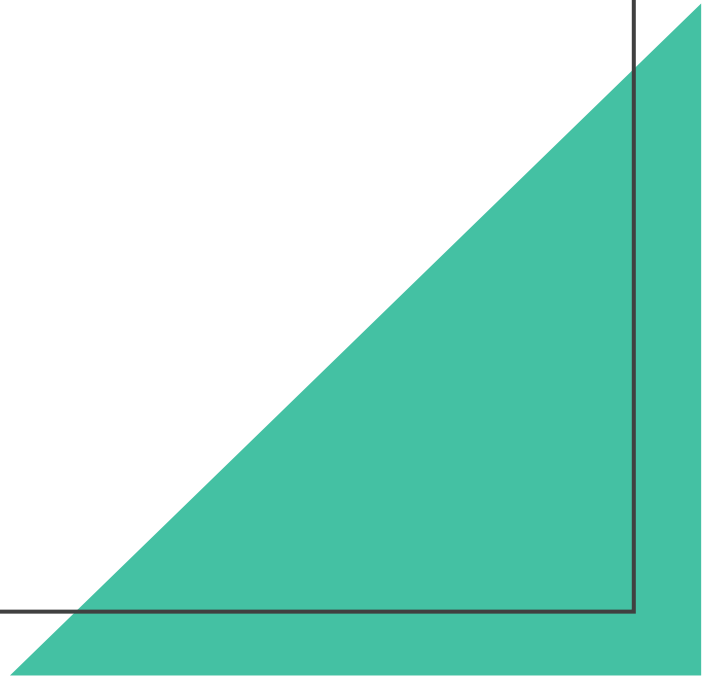
- Behavioral Health team members are not expected to provide medical care or be experts in medical care; rather, they are to coordinate care and make sure each patient has their medical and other BH needs met.
- For patients who have an existing primary care provider TTC team members coordinate with 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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