**Vigo County Outpatient Services**

**Mission:**

The mission of Vigo County Outpatient Services (VCOP) coincides with the mission of Hamilton Center Inc (HCI). Our mission is to provide quality behavioral health care that focuses on wellness and human development to the Vigo County community. Our Vision is to advance excellence in behavioral health services through compassion, customer responsiveness, innovation and flexibility.

**Service Description:**

Vigo County Outpatient Services is an outpatient program that provides quality services to persons that experience symptoms of mental illness ranging from mild to severe. Services are provided from a multi-disciplinary team perspective and cover the full spectrum of Community Mental Health Services. The following services are offered:

* Assessment
* Individual Therapy
* Group Therapy
* Family and Marital Therapy
* Psychological Testing
* Crisis Intervention
* Pharmacological Management
* Case Management
* Medication Training and Support
* Skills Training and Development
* Evaluation and Management
* Primary Care

VCOPs goal is to provide services that are innovative and individualized while promoting independence, healthy lifestyle, and the most optimal quality of life. The multi-disciplinary team is as follows:

* **Psychiatrist:** The psychiatrist is the lead physician for all medications prescribed for the consumer. The team members consult with the psychiatrist re: symptoms, crisis intervention, major life changes, etc. Psychiatrists participate in a regular on-call rotation for both our psychiatric inpatient unit and Access Center. They see VCOP consumers every 30-60 days to monitor vital signs, symptoms, lab work, and pharmacological benefit. When a VCOP consumer is in financial need the psychiatrist and medical team link the client to sample medication or various pharmaceutical companies medication assistance programs.
* **Psychiatric Advanced Practice Nurses (APN):**  APNs provide pharmacological management under the supervision of a psychiatrist. They provide the same clinical services as a psychiatrist.
* **Psychologist:** The psychologist is licensed and most often a Health Service Provider in Psychology (HSPP). Psychologists serve many roles on the team. Psychologists see consumers for assessments and individual, family, and group therapy. They also provide crisis intervention to any consumer in need. Psychologists review charts for Medicaid consumers validating diagnostic impression as well as current treatment approach. The psychologist often recommends changes in treatment that are necessary. Psychologists often hold the role of “team leader” on the multi-disciplinary team. They provide supervision to non-licensed clinicians who are actively seeking a license as well as students working to pursue either a PhD or PsyD. Psychologists also provide supervision to Qualified Behavioral Health Professionals (QBHP) and Other Behavioral Health Professionals (OBHP) to meet Medicaid Rehabilitation Options (MRO) guidelines. Psychologists administer various psychological examinations as clinically indicated.
* **Licensed Clinical Social Workers (LCSW):** Licensed Clinical Social Workers are most generally team leaders on the multi-disciplinary outpatient teams. LCSWs see consumers for assessments, individual, family, group therapy and crisis intervention. Some LCSWs provide supervision for non-licensed clinicians that are actively working towards a license, Qualified Behavioral Health Professionals (QBHP) and Other Behavioral Health Professionals (OBHP) to meet Medicaid Rehabilitation Option (MRO) guidelines.
* **Licensed Mental Health Counselor (LMHC):** Licensed Mental Health Counselors like LCSWs are most generally team leaders on the multi-disciplinary outpatient teams. LMHCs see consumers for assessments and individual, family, and group therapy. They also provide crisis intervention to any consumer in need. Some LMHCs provide supervision for non-licensed clinicians that are actively working towards a license, Qualified Behavioral Health Professionals (QBHP) and Other Behavioral Health Professionals (OBHP) to meet Medicaid Rehabilitation Option (MRO) guidelines.
* **Clinical Therapist:** Clinical therapists are Master’s level practitioners that complete all of the above clinical tasks that LCSWs and LMHCs do, however are not independently licensed. They receive weekly supervision with a licensed provider. Clinical therapists are actively pursuing a license to practice independently. They are often placed on a multi-disciplinary team with a licensed clinician to ensure proper supervision at all times.
* **Student Therapists:** Student therapists are Master’s level practitioners that are currently pursuing either a PhD or a PsyD in an HCI approved field. The student therapist is supervised by a licensed psychologist and receives at least 1 hour per week structured supervision. They also complete all clinical tasks that clinical therapists complete. Student therapists administer psychological testing for referring agencies under the supervision of the HSPP.
* **Nurse:** The nurse is either a registered nurse (RN) or licensed practical nurse (LPN) that is supervised by the Director of Nursing. The nurses manage the consumer’s medication to ensure compliance according to physician orders. They also monitor vital signs, and side effects of medication, assess mental status, provide education, and administer injections as needed. Nurses coordinate the needs of the consumers with the pharmacy, oversee tests ordered by the physician, identify consumers that qualify for patient medication assistance programs and report significant lab work to the physicians.
* **Care Manager: Care** managers (CM) are bachelor’s level team members that provide specialized services to consumers to assist them in obtaining resources within the community. The CMs role is to monitor the consumer’s entire care plan that will encompass issues such as mental health, physical health, legal, and social services. CMs provide a variety of tasks such as linking with community resources, referring to services that have been identified in the client’s assessment, monitoring the consumer’s care plan and obtaining services on behalf of the consumer if he/she is unable to obtain them on his/her own. The CM works as an advocate in the community to provide the services that are necessary for consumers to live independently. The Care managers primary role is to provide consumers with MRO services such as skills training and development services that allow clients to live the most independent lifestyle within a community setting. They provide services in a variety of locations such as in the consumer’s home as well as in the community. The focus of the service is to educate the consumer with skills that enhance activities of daily living. Care Managers work in conjunction with the treatment team to assess a consumer’s needs and assist him/her in building strengths to overcome these needs.

In order to meet the needs of the consumers with higher functional deficits VCOP has developed several specialized teams. The specialized teams have the same multi-disciplinary team members as the regular outpatient teams; however have altered their approach to meet the unique needs of the consumers they serve. The specialized teams include the following:

* **Intensive Community Treatment (ICT)** - A specialized team that works with consumers who are on the verge of hospitalization, residential placement or have recently been discharged from a higher level of care. Treatment with ICT generally lasts no longer than 1 year. Consumers receive higher frequencies of both rehabilitative and clinical services than consumers in traditional outpatient teams. This team also provides a lower consumer to staff ratio.
* **Dialectical Behavioral Therapy (DBT)** - A specialized team that primarily serves consumers diagnosed with Borderline Personality Disorder. The treatment is skill based and requires firm guidelines by the practitioner. Consumers generally sign a contract for at least 1 year for this level of treatment. It is required that consumers on this team participate in both individual and group therapy.
* **Psychiatric, Assertive, Identification and Referral (PAIR) Misdemeanor**- A specialized team developed in 1999 as a diversion program for consumers that have DSMIV-TR diagnoses and have been charged by the legal system with a misdemeanor. The PAIR team facilitates interaction with the legal system. The misdemeanor PAIR program generally has about 90 clients enrolled. These consumers are involved in treatment for a time period of 1 year. If compliant with treatment the consumer will have the misdemeanor charge expunged at the end of the one year time period.
* **Adult Mental Health Court or AMHC** – The same specialized team that works with the Misdemeanor PAIR program works with the Felony program. The Felony program was added in 2008 after almost 10 years of success with the Misdemeanor PAIR program. AMHC actively serves approximately 120 clients. All consumers that are referred have been charged with a felony. Length of stay in the program is based on the level of felony the consumer receives. The minimum amount of time in the program is 1 year and the maximum is 4 years. If the consumer is compliant and graduates from the program he/she receives a lesser charge.
* **Department of Child Services (DCS)**- This team specializes in providing services to parents referred for services from the Department of Child Services. A clinician provides office counseling while case managers provide home based casework and supervised visits. The team makes referrals when needed to other services such as medication management, group, ect.
* **Mental Health of America (MHA) YOUnity House, Younity Village, and Liberty Village Outreach** – This is a supportive housing model program. MHA has contracted approximately 120 hours per week of service from three HCI, VCOP care managers at the YOUnity property. MHA has contracted 80 hours per week from 2 care managers. The care manager provides services to all consumers that are in need at the YOUnity House or Village. MHA contractually pays for services provided to consumers that have no payer source at the House. The mission for the case manager at MHA YOUnity House is to keep the residents housed “no matter what.” The case manager tries to access all resources needed for these residents to stay housed, meet necessities, and improve general quality of life. Hamilton Center has provided MHA residents with a Therapist, and Nurse on-site as well when needed.
* **Wabash Valley Health Clinic Outreach** – Formerly known as St. Ann’s Clinic, the Wabash Valley Health Clinic provides a wide range of medical services to members of Vigo County as well as surrounding communities. The clinic has recently been awarded FQHC (Federally Qualified Health Center) status. VCOP has an outreach at the clinic 3 days per week. A clinician is available for 8 hours each day. One psychiatric advanced practice nurse is available 8 hours per week. Consumers are seen for individual therapy and pharmacological management services on the basis of need.
* **Walk-in Clinic-** VCOP has a walk in hours Monday – Friday 8am-4pm. This clinic is provided to consumers that need to just walk in for services for accessibility, for consumers needing inpatient follow up, or for client’s that struggling to meet consistently with clinician during scheduled sessions. The clinician meets with the consumer during walk in to assess then will refer if needed or will coordinate ongoing treatment.

**Service Philosophy**

VCOP staff members embrace and celebrate the uniqueness and value of the individual. We believe that everyone has talents and abilities that need to be developed, nurtured and expressed. We believe that all persons in need of treatment can experience a productive, meaningful life and achieve their personal goals. It is a privilege to participate in their growth and development.

**Admission/Continuing Care/Discharge Criteria**

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| Admission | Continuing Care | Discharge Criteria |
| A consumer is in admission status upon the following:   * An individual must be 18 years of age or older * An individual experiencing, but not limited to the following: stress, life changes, relationship issues, thought disturbances, cognitive disorder, behavioral disruptions or mood disorders * Eligible consumers *usually* have a diagnosis that is congruent with the DSMIV-TR * Eligible consumers must show functional impairment relative to such primary aspects as:   + Interpersonal functioning   + Adaptation to change   + Independent living skills   + Securing the most basic necessities such as housing, food, medical care, etc.   + Employment   + Focus, concentration and pace towards daily tasks | A consumer is in continued care or treatment upon the following:   * Consumer must engage in a partnership with the treatment team providing service * There must be an agreement between the consumer and the treatment team related to the identified problem and goals necessary to reach recovery * The consumer must make realistic progress towards goals * If clinically indicated the consumer must participate in active rehabilitative services to promote independence by increasing his/her functional level of activities in daily living * The consumer is responsible for rendering any payment/co-payment at the time of service. The consumer must agree to pay for any services not provided by the funding. The services provided are agreed upon by both client and provider. | A consumer is discharged from services upon the following:   * A consumer successfully completes treatment * Charts are closed after 2 months of inactivity following HCI Clinical Procedure or the consumer passes away or requires transition into a skilled nursing facility * The consumer is unable to maintain symptoms well enough to reside in the community or in a 24 hour supervised environment and requires referral to a state operated facility * It is clinically indicated that the consumer should be referred for other, more appropriate treatment within the community (i.e. BDDS) * The consumer chooses to relocate to another community * The consumer enters into long-term incarceration * The consumer fails to uphold financial agreement/   obligations to Hamilton Center. VCOP will follow the current HCI procedure in regards to this type of discharge. |

**Enrollment:**

There are a variety of ways that consumers can be referred to VCOP. Referral sources include Primary Care Physicians (PCP’s), HCI’s Access Center via client phone call/walk-in, HCI inpatient unit and other community agencies. Upon referral consumers are given an intake appointment with an appropriate clinician for his/her payer source. Prior to meeting with the clinician support staff in VCOP meet with the client to complete the administrative portion of the intake. The following tasks are completed by the program assistant:

* Consent for care and treatment is reviewed and signed
* HIPPA rights and responsibilities are explained and the consumer signs an agreement that he/she understands the HIPPA rights and responsibilities
* The consumer is given a copy of the “Client Rights”
* The consumer is given a copy of VCOP Consumer Program Orientation
* The consumer signs all appropriate releases of information (ROI)
* A Financial Affidavit/income statement is completed and fees for service are discussed.
* Insurance information is gathered and entered into the electronic medical record.
* The consumer must give general demographic information that is immediately entered into the electronic medical record.
* A copy of the consumer’s photo identification is secured

**Electronic Medical Record (EMR)**

HCI holds all clinical documentation in the consumer’s chart which is part of an Electronic Medical Record. Administrative and clinical documents that require a signature are kept in a small paper chart in the designated locked storage area.

**Assessments, Treatment Planning, and Review:**

**Assessment:**

After the consumer completes the enrollment with the program assistant the consumer meets with a properly certified clinician. The clinician works with the client in several capacities during the first visit. The clinician does an “initial assessment” which includes a combination biopsychosocial history and the Adults Needs and Strengths Assessment (ANSA). This “initial assessment” must be completed by a licensed clinician or a clinician working towards a license that is supervised by a licensed clinician. A bi-annual re-assessment ANSA is done with all Medicaid Rehab Option (MRO) and Hoosier Assurance Plan (HAP) eligible consumers. The reassessment can be completed by a bachelor’s or master’s level provider. An “initial assessment” includes the following:

* The clinician discusses his/her credentials and therapeutic approach.
* The therapist gives an overview of the consumer’s rights and expectations of the consumer for treatment including a basic orientation to VCOP.
* The therapist engages the consumer in an assessment. The Division of Mental Health and Addictions (DMHA) have determined that the Adults Needs and Strengths Assessment (ANSA) is the standardized assessment that will measure success of each Community Mental Health Center (CMHC) in service provision. HCI has chosen to blend the ANSA along with a traditional bio-psycho-social assessment to complete upon first meeting with the new consumer.
* Information can be gathered from not only the consumer but the client’s natural supports, family, friends, church family, primary care physicians, etc. with proper consent to release information.
* The ANSA gathers information on issues related to mental health. Areas addressed are but not limited to the following:
  + General skills, abilities, and interests
  + Educational and vocational interests and history
  + Spiritual Connectedness
  + Community connectedness
  + Family connectedness
  + Social connectedness
  + Medical history
  + Psychiatric history
  + Medication involvement
  + Family dynamics
  + Recreational history
  + Intellectual abilities
  + Sexuality
  + Acculturation
  + Daily living Skills
  + Residential stability
  + Legal issues
  + Sleep habits
  + Self-care
  + Decision making abilities
  + Resiliency, resourcefulness and commitment to recovery
* The therapist explains all possible services in VCOP and makes appropriate referrals for services such as pharmacological management, case management and medication training and support if clinically indicated.
* The therapist explains the use of the EMR and document requirements related to concurrent documentation.
* The therapist explains the HCI Access Center and 24 hour availability for crisis intervention via phone or walk-in.

It is after these referrals are clinically indicated and made that the consumer becomes a member of a treatment team. Consumers requiring services from various disciplines are cared for from a team approach to ensure the most holistic treatment possible. Consumers that do not show clinical indication for services beyond individual or group therapy and or pharmacological management do not require treatment team assignment other than a general outpatient team.

**Treatment Planning:**

VCOP, along with the rest of Hamilton Center Inc. is invested in providing person centered treatment planning and service provision to all clients. The treatment plan is developed in phases by multiple team members. The roles are as follows: The person’s activities, services and supports are based upon his or her dreams, interest, preferences and strengths. Hallmarks of person centered treatment:

* The person and people important to the person are included in the lifestyle planning and have the opportunity to exercise control and make informed decisions.
* The person has meaningful choices, with decisions based on his or her experiences.
* Activities, supports and services foster skills to achieve personal relationships, community inclusion, dignity and respect.
* The person’s opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints.
* Planning is collaborative, recurring and involves an ongoing commitment to the person.
* The person is satisfied with his or her activities, supports and services.

The specialized teams as well as traditional outpatient teams refer consumers to a variety of services within the community as well. These services include but are not limited to the following:

* Vocational Rehabilitation
* Various GED Programs
* Altrusa for Literacy
* Primary Care Physicians
* Various specialty physicians as needed such as podiatrist, OBGYN, dentist, etc.
* Diabetic /Nutritional Education
* Social Security Administration for cash benefits as well as Medicare
* State of Indiana for Medicaid, SNAP, TANF etc.
* Local Housing Authority for assistance with rent
* Medication Assistance programs through various pharmaceutical companies
* Mental Health of America
* Supportive Employment Programs such as Work One, Employment Solutions, and Employment Plus
* Legal services
* Representative payee-ship

VCOP also offers specialized programs for consumers that are unable to meet financial obligations in a variety of settings. These programs are but not limited to the following:

* Semi-Independent Living Program (SILP) - Consumers can receive temporary financial assistance for housing and other basic needs funded by the cost center location.
* Charity care for reduction of account balance or for clinical necessity- Consumers can apply for all or partial forgiveness on outstanding balance or future services to HCI if requirements are met due to financial hardship or due to severe clinical needs.