1040 OUTREACH, ENGAGEMENT, AND REENGAGEMENT FOR BEHAVIORAL HEALTH

REVISION DATE: 10/28/2020
EFFECTIVE DATE: October 01, 2018
REFERENCES: AMPM Policy 320-R, AMPM Policy 320-U

Overview

The Division of Developmental Disabilities (Division) develops and implements outreach, engagement, and reengagement activities for members seeking and receiving behavioral health services. The Division develops and makes available to providers its policies and procedures regarding outreach, engagement, and reengagement, including any additional information specific to their operations.

Outreach includes activities designed to inform individuals of behavioral health services availability and to engage or refer those individuals who may need services. The activities described within this section are essential elements of clinical practice. Outreach to vulnerable populations, establishing an inviting and non-threatening environment, and re-establishing contact with persons who have become temporarily disconnected from services are critical to the success of any therapeutic relationship.

Definitions

Engagement - For purposes of this policy, the establishment of a trusting relationship, rapport and therapeutic alliance based on personal attributes, including empathy, respect, genuineness, and warmth.

Outreach activities - For purposes of this policy, activities designed to inform individuals of behavioral health services availability and to engage or refer those individuals who may need services.

Reengagement - For purposes of this policy, activities by providers designed to encourage the individual to continue participating in services.

Policy

The Division will incorporate the following critical activities regarding service delivery within the AHCCCS System of Care:

A. Establish expectations for the engagement of members seeking or receiving behavioral health services,

B. Determine procedures to reengage members who have withdrawn from participation in the behavioral health treatment process,

C. Describe conditions necessary to end reengagement activities for members who have withdrawn from participation in the treatment process, and

D. Determine procedures to minimize barriers for serving members who are attempting to reengage with behavioral health services.

Community Outreach

The Division provides and participates in community outreach activities to inform members of the benefits and availability of behavioral health services and how to access them. Outreach activities conducted by the Division may include the following:

A. Participation in local health fairs or health promotion activities;

B. Involvement with local schools;

C. Involvement with outreach activities for military veterans, such as Arizona Veterans Stand Down Coalition events;

D. Development of outreach programs and activities for first responders (i.e. police, fire, EMT);

E. Regular contact with AHCCCS contractor behavioral health coordinators and primary care providers, especially the Division's Administrative Services Subcontractors;

F. Development of outreach programs to members experiencing homelessness;

G. Development of outreach programs to persons who are at risk, identified as a group with high incidence or prevalence of behavioral health issues, or underserved;

H. Publication and distribution of informational materials;

I. Liaison activities with local, county, and tribal jails, prisons, county detention facilities, and local and county Department of Child Safety (DCS) offices and programs;

J. Regular interaction with agencies that have contact with substance abusing pregnant women/teenagers;

K. Development and implementation of outreach programs to identify members with co-morbid medical and behavioral health disorders and those who have been determined to have Serious Mental Illness (SMI) within the contractor's geographic service area; including persons who reside in jails, homeless shelters, county detention facilities or other settings;

L. Provision of information to behavioral health advocacy organizations; and

M. Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members.

Behavioral health providers shall participate in engagement, reengagement, and follow-up processes as described in this policy.

Engagement

The Support Coordinator and/or Case Manager of the TRBHA, IHS, Tribally Operated 638, or Urban Native Health Facility must ensure active engagement by providers in the treatment planning process with the following:

A. The member and/or member's legal guardian;

B. The member's family or significant others, if applicable and amenable to the person;

C. Other agencies or providers, as applicable; and

D. For persons with a SMI who are receiving Special Assistance (see AMPM Policy 320-R), the person (guardian, family member, advocate or other) designated to provide Special Assistance.

Reengagement

The Support Coordinator takes the lead in the coordination with the TRBHA, IHS, Tribally Operated 638, or Urban Native Health Facilities to ensure reengagement attempts are made with members who have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services, or failed to appear for a scheduled service based on a clinical assessment of need. Provider Case Managers are available to assist Support Coordinators with reengaging members as deemed beneficial to their care. All attempts to reengage members must be documented in the member's file.

A. The behavioral health provider shall attempt to reengage the member by:

1. Communicating in the member's preferred language.

2. Contacting the member/guardian/designated representative by telephone at times when the member may reasonably be expected to be available (e.g. after work or school).

3. When possible, contacting the member/guardian/designated representative face-to-face if telephone contact is insufficient to locate the member or determine acuity and risk.

4. Sending a letter to the current or most recent address requesting contact if all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g. domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record.

5. Contacting the person designated to provide Special Assistance for his/her involvement in reengagement efforts for members determined to have a SMI who are receiving Special Assistance (see AMPM Policy 320-R).

B. If attempts to engage the member are unsuccessful, the Support Coordinator must ensure further attempts are made to reengage the member. Further attempts must include at a minimum, contacting the member or member's responsible person face to-face and contacting natural supports for whom the member has given permission to contact. All attempts to reengage members must be clearly documented in the member's case file.

C. If face-to-face contact with the member is successful and the member appears to be a danger to self, danger to others, persistently and acutely disabled, or gravely

disabled, the Support Coordinator must determine whether it is appropriate to engage the person to seek inpatient care voluntarily. If the member declines voluntary admission, the Support Coordinator must initiate the pre-petition screening or petition for treatment process described in AMPM Policy 320-U.

Follow-up After Significant and/or Critical Events

Discharge planning must begin upon notification that the member has been hospitalized. The Support Coordinator must ensure activities are documented in the member's case file and follow-up activities are conducted to maintain engagement within the following timeframes.

District nurses are available to assist Support Coordinators as considered beneficial to optimally meeting the needs of the individual member during their care transition:

A. Discharged from inpatient services, in accordance with the discharge plan and within seven days of the member's release to ensure member stabilization, medication adherence, and to avoid re-hospitalization;

B. Involved in a behavioral health crisis within timeframes based upon the member's clinical needs, but no later than seven days;

C. Refusing prescribed psychotropic medications within timeframes based upon the member's clinical needs and individual history; and

D. Changes in the level of care.