DBHDD

The Georgia Collaborative ASO

Behavioral Health Symposium Presentation

Person-Centered Care

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Atlanta Engagement Center

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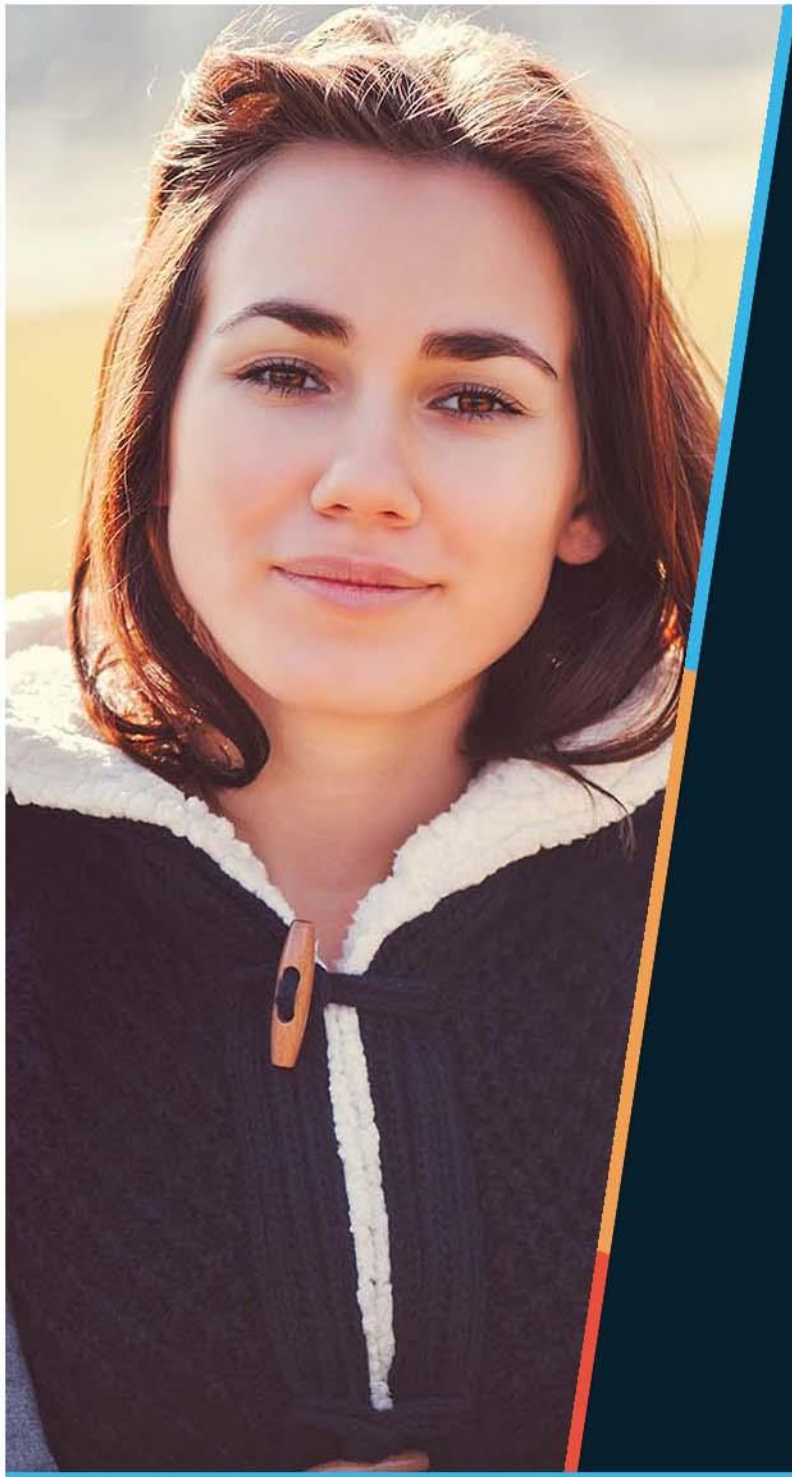
beacon health options



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- The right service
- In the right amount
- For the right individuals
- At the right time

Care Coordination

Overview - Definition

What is Care Coordination?

The Georgia Collaborative ASO's Care Coordination Program is a ***community based*** program designed to monitor, support, and serve individuals within the behavioral health and developmental disability population. The program ***uniquely targets*** individuals with the most complex care needs or during critical transition periods to best ***support care coordination*** with all community based providers.

Overview – Varying Levels of Support

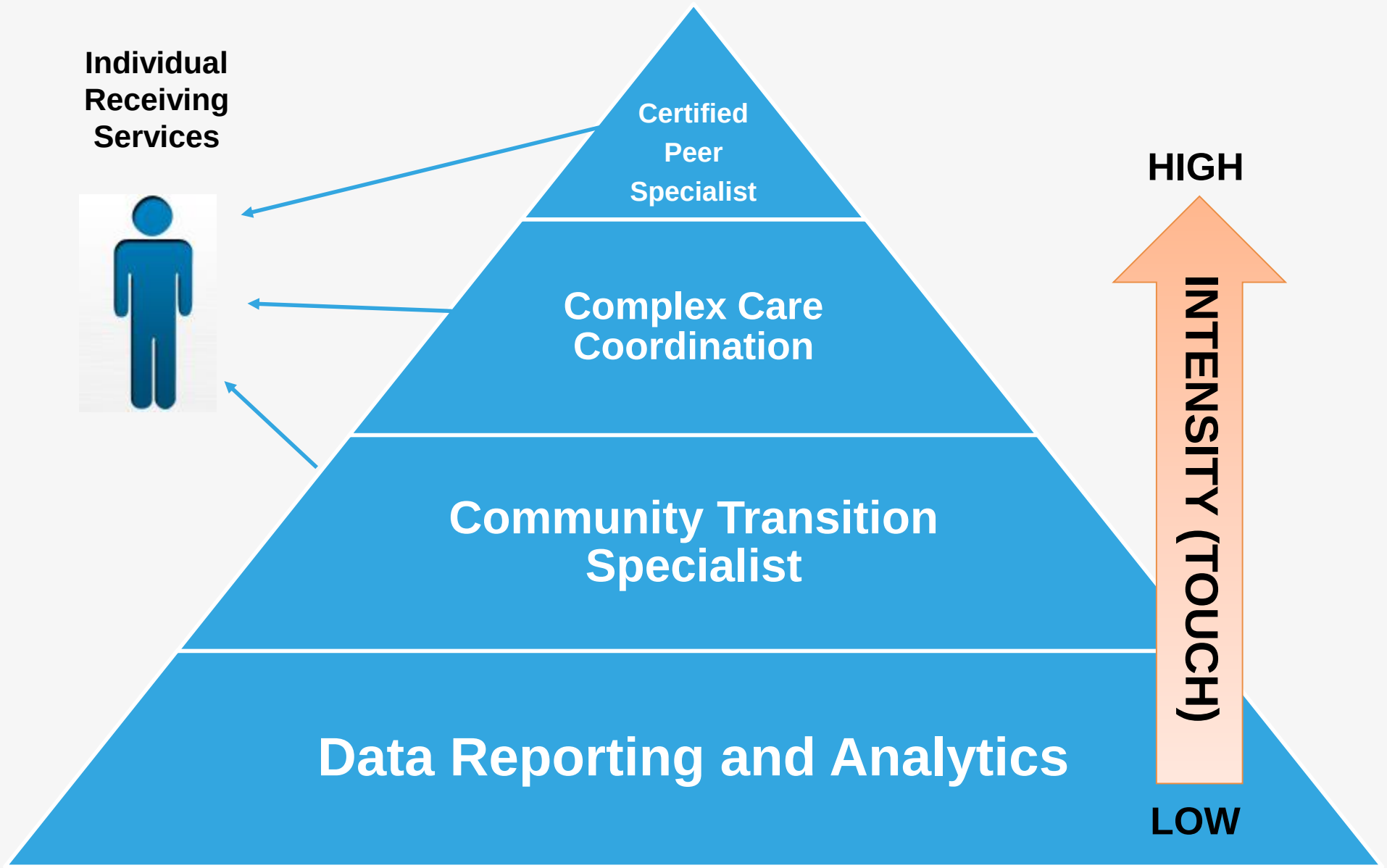
Care Coordination Program is

uniquely targeted to the individual

The Georgia Collaborative ASO provides four types of Care Coordination

1. Data Reporting and Analytics
2. Community Transition Specialists
3. Complex Care Coordination
4. Certified Peer Specialists

Care Coordination Program Overview



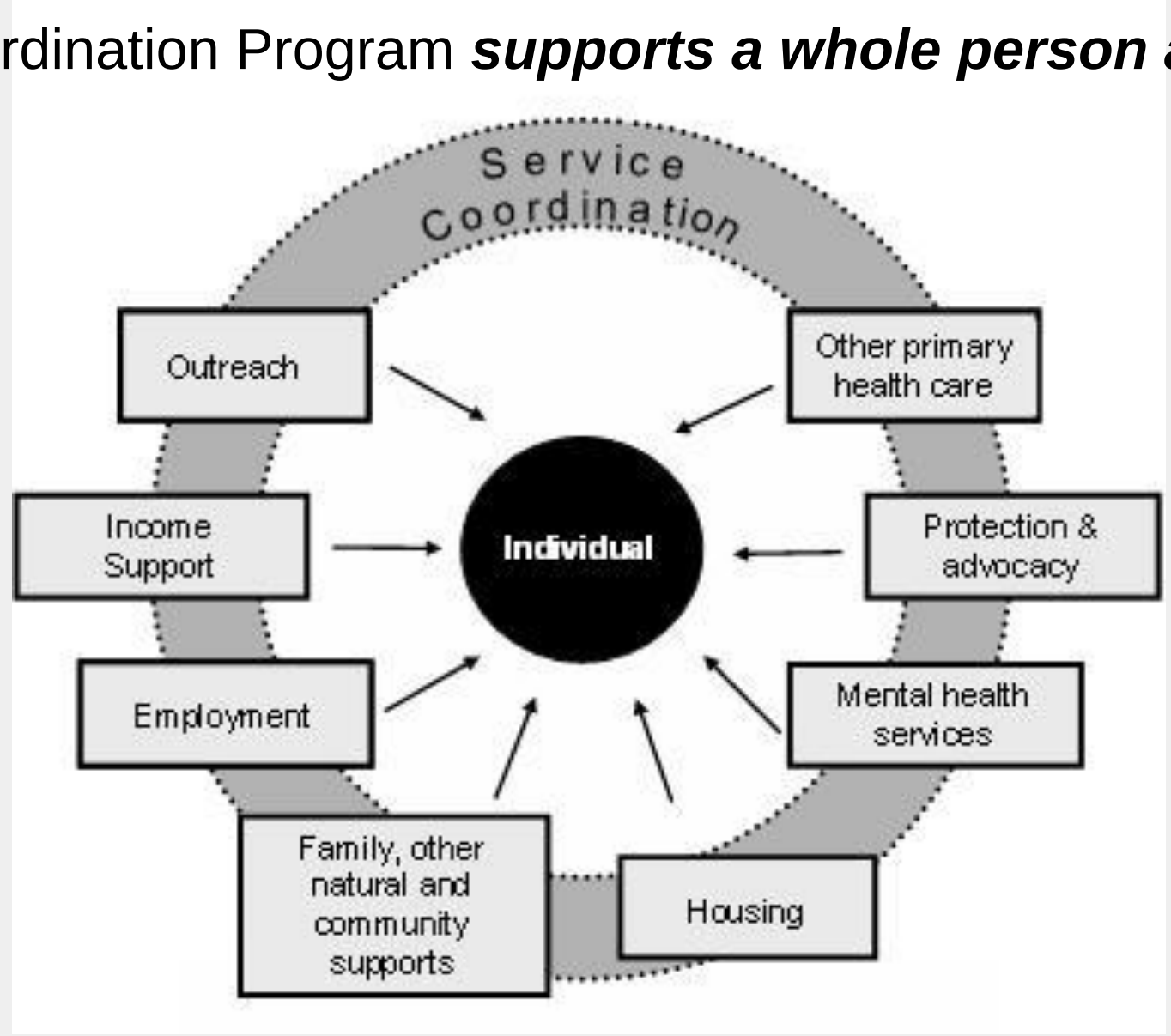
Collaboration with Community Based Providers

The ASO's Care Coordination Team consists of individualized care coordination types to uniquely target an individuals needs.

- Community Transition Specialists provides outreach and discharge appointment coordination to support the *transition from a High Level of Care* to a community based provider
- Specialized Care Coordinators are licensed clinicians that provide clinical oversight to vulnerable individuals with complex diagnostic histories and/or multiple hospitalizations.
- Certified Peer Specialists are mental health/substance abuse individuals certified in Georgia who have "lived life experience" which allow them to uniquely connect, in a meaningful way with individuals, showing by example that long-term recovery is attainable.

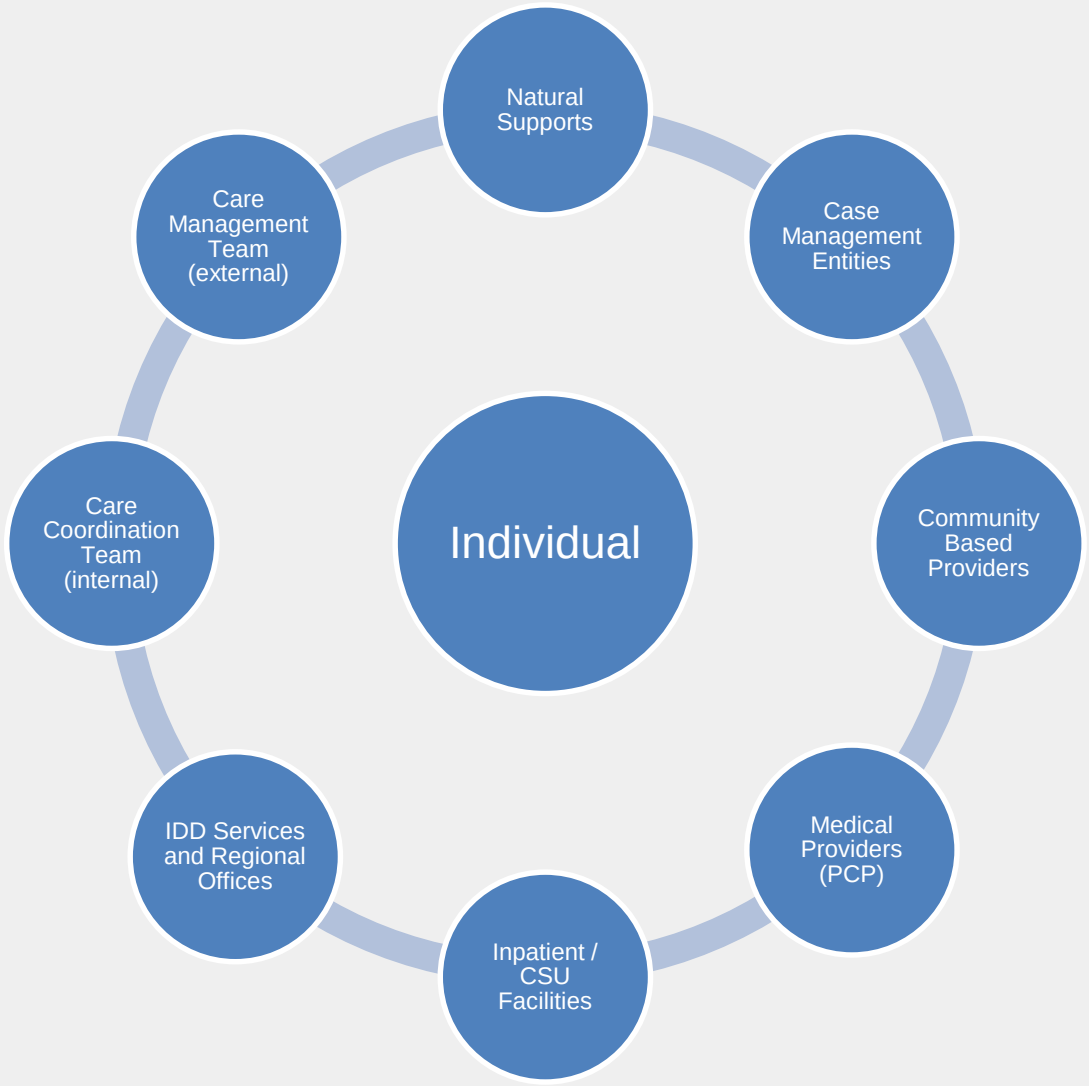
Care Coordination

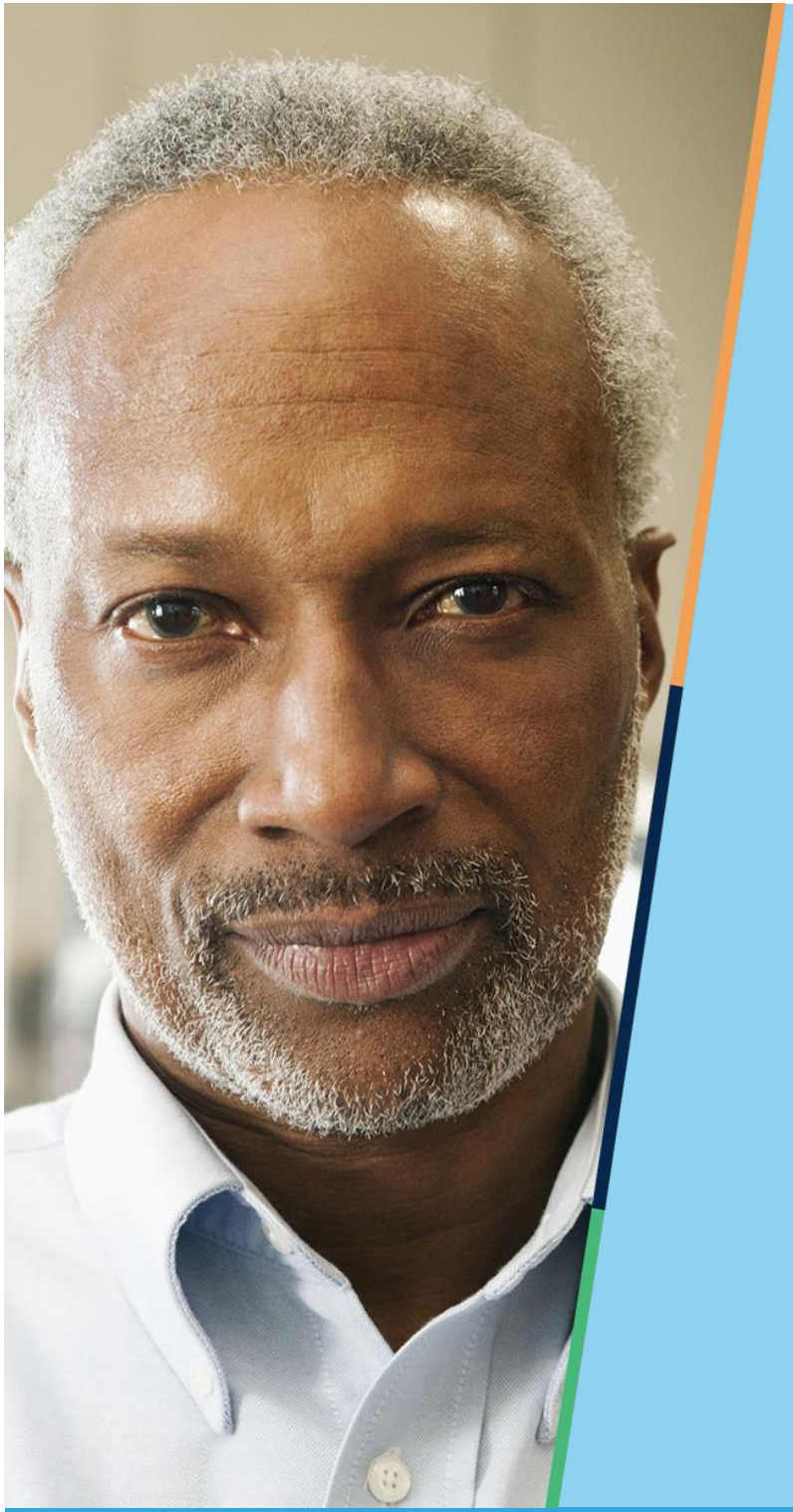
Care Coordination Program ***supports a whole person approach***



Care Coordination Program

Uniquely Supportive Care Coordination





Recovery Presentation

Recovery Presentation

Presentation: “No one listens to me and what I need!”

- 42 year old male
- Who presents during an inpatient stay
- Suicidal ideations and depression

High Utilization Pattern:

- 20+ acute hospital or crisis stabilization admissions in the past year
- 139 days out of hospital setting in last year

Recovery Presentation

Environmental:

- Identified as homeless, with little or no community support and ongoing substance use issues

Complex Comorbid Issues:

- SPMI, substance use and medical complexity
- Person-Centered: Unrealized Recovery Needs

Collaboration Response

Care Coordination July 2015:

- SCC/Peer Support Wrap-Around Approach
- Meeting the individual “where they are”

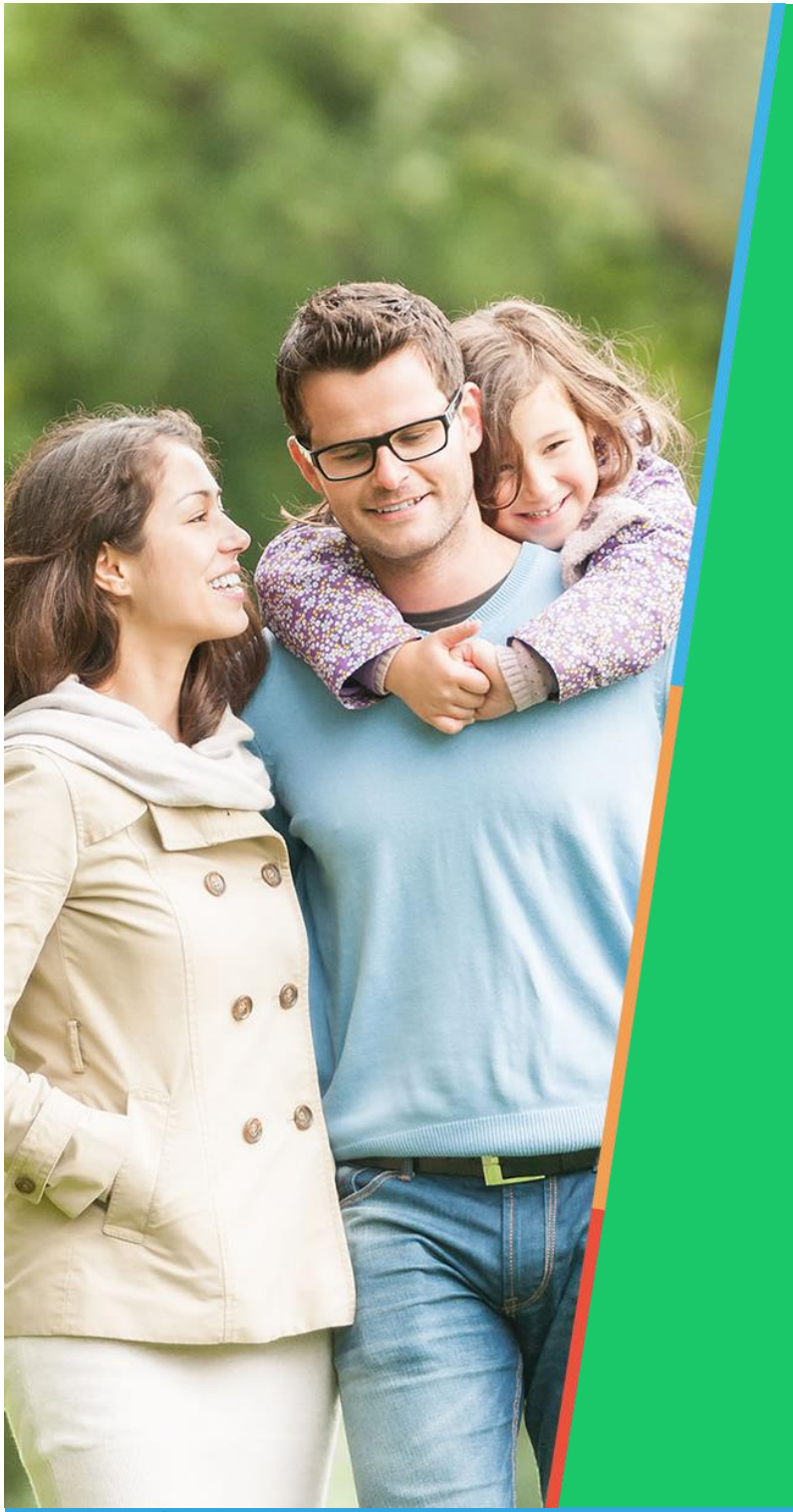
Success Within Recovery

- Engaged with his Georgia Collaborative (Beacon Health Options) Recovery Team
  - His Specialized Care Coordinator (SCC); and
  - His Certified Peer Specialist
- He made his first intake appointment
- He attended his first psychiatric appointment and has scheduled follow-up medical appointments
- He takes his medications as recommended and has refilled his prescriptions

- He routinely engages with his ACT Team
- He has not been readmitted to a psychiatric inpatient unit in over 30 days
- He has had no need for contact with Crisis Stabilization/ Emergency Mobile Services
- He has been free of substance use since his discharge and is now off Naltrexone

Lessons Learned & Takeaways

Patient Centered Approach: Listen	Identifying patient's need from a patient-centered approach and removing obstacles to optimize recovery.
Coordinating Transitions of Care with Collaboration	Both the care coordinator and the CPS met with the individual while in the hospital. This face to face intervention quickly built rapport and engagement. SCC and Peer Support presence at the inpatient facility allowed for close collaboration with facility staff and strong discharge planning. While the individual was in an inpatient facility, Care Coordination team identified and facilitated outpatient resources to engage the individual in optimal recovery.
Substance Use Medication Assisted Treatment	With the support of the medical director, medication assisted substance treatment methodologies were recommended to the provider and started in the acute environment. Care coordinator supported continuity of care to community providers in an outpatient setting including ambulatory detox.
Valued Certified Peer Specialist Involvement	As a member of the care coordination team, the CPS was able to share unique "lived experience" with the individual that challenged set ideas and strengthened his motivation for change



Quality Management

Platforms for Effectiveness

The evaluation focus of the Care Collaboration program includes, but is not limited to:

- Individual Engagement
- Overall Clinical Improvement
- Achievement towards goals/satisfaction
- Length of stay in the facility
- Follow–up post discharge
- Length of time in the community following discharge
- Re-admission to psychiatric facilities

Cross Pollination of Best Practices

Behavioral Health (BH)	⟷	Intellectual/ Developmental Disabilities (IDD)
Incorporate Compliance and Program Integrity	→	
Offer Reviews More Often	→	
Provide Overall Score	→	
←		Incorporate Individual Interviews
←		Incorporate Staff Interviews
←		Offer Technical Assistance/Consultations
←		Incorporate Focused Outcome Areas

GA Collaborative BHQR Tool – Individual Interview Section

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FY15-16 Behavioral Health Individual Interview

Item Number	Reference To		Definition/Element of Review	Yes	No	N/A	Comments
	Category	Expectation					
Individual Interview							
1	Whole Health	Health related needs have been addressed.	☐ The person has seen a primary care physician in the last 12 months.				
2			☐ The person receives routine preventative screenings (based upon age, gender, diagnosis).				
3			☐ The person has seen a dentist in the last 12 months – if they so choose.				
4			☐ Person has been offered and provided assistance, if requested, in accessing needed health and wellness supports and services to address whole health needs.				
5			☐ Person indicates staff followed up on any expressed needs and assistance (including referrals with other providers) to ensure these were addressed.				
6		Person is managing his/her own health.	☐ Person is aware of his/her diagnoses.				
7			☐ When applicable, person is aware of (educated about or provided options related to) medication alternatives.				
8			☐ Person is aware of why physical health medications and/or psychotropic medications are prescribed/taken (if applicable).				
9			☐ Person is aware of the medications' side effects.				
10			☐ Person feels they can talk to their MD about prescribed medications and that their opinions/feedback are taken into account and valued.				
11			☐ Person is offered needed education and resources/tools to help them manage his/her own health.				

Overall Goal: Assure strong incorporation of individual's goals/choices/ideas.

GA Collaborative BHQR Tool – Staff Interview Section

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FY15-16 Behavioral Health Staff Interview

Item Number	Reference To: Category	Reference To: Expectation	Definition/Element of Review	Yes	No	N/A	Comments
			Staff Interview and Assessment				
1	Whole Health	Health related needs have been addressed.	☐ Staff have been educated or provided information on person's medical and psychiatric diagnoses.				
2			☐ Staff is aware of the person's current diagnoses.				
3			☐ Staff is aware of how the person is managing personal health.				
4			☐ Staff is able to describe how the whole health of the person is addressed through coordination of services				
5			☐ Staff is aware of self-management tools and teaches/supports the individual in using them.				
6			☐ Staff is able to indicate how they ensure any referrals and coordination of services are addressed to completion.				
7			☐ Staff are communicating with other providers of care to ensure good communication in coordination of services.				
8		Medications are administered and managed as required. (Mark N/A if	☐ Staff is aware of where to find/identify current medications the person is taking.				
9			☐ Staff support and assist people with overcoming barriers to accessing medications when needed.				
10			☐ Staff evaluate whether or not the individual needs support in taking medications correctly, particularly with low health				

Overall Goal: Assure strong support of individual from staff's perspective.

Questions and Feedback

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Thank you

For Georgia Collaborative ASO general inquiry or questions please email:

GACollaborativePR@valueoptions.com

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