## Care Coordination Resources

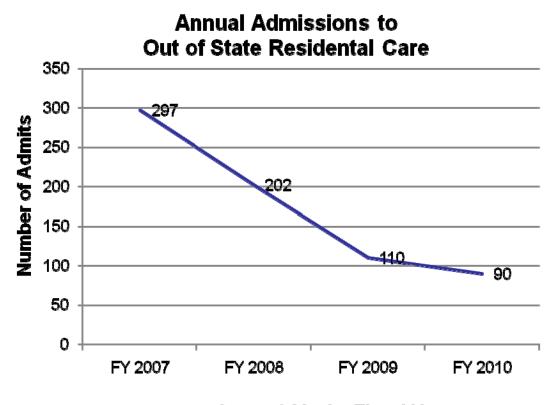
# Betty M. Robards, MS, LTPA Qualis Health

Manager, Alaska Medicaid Behavioral Health
April 27, 2011



Advancing Healthcare Improving Health

### Bring the Kids Home Progress



Annual Admissions Peak in FY 2004 with 752

State of Alaska Fiscal Years



### FY 2010 Updates

- Out of State Medicaid expenses
  - decreased by 22%
- FY 2010 Recidivism rate was 8.6% (35 cases)
  - Clients returning to RPTC within 365 days of discharge
  - Highest rates found in Clients who are in custody and discharging from Out of State placements (19%)

http://www.hss.state.ak.us/commissioner/btkh/pdf/BTKH-SFY10%20Datav4DRAFT.pdf

### New Look to Qualis Health Website

#### Click on:

Health Care Professionals

#### Then select:

Alaska Medicaid – Behavioral Health





# Find iExchange Help



- Provider Education includes:
  - Training manual with screen shots



### Find Resources on Qualis Website



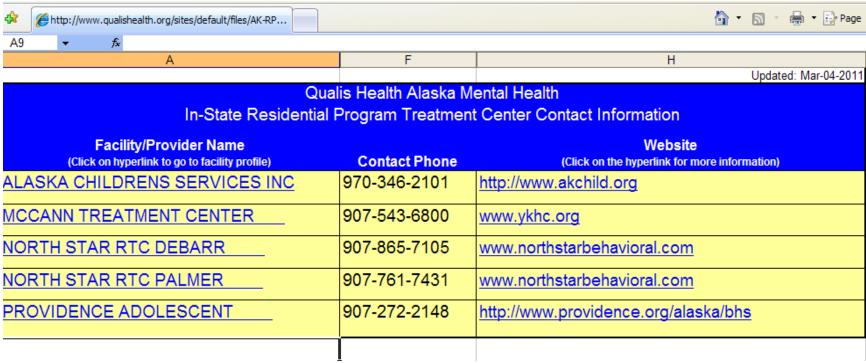
Click on: Provider Resources

You will find our list of resources including:

- Provider Manual
- Incident Report Forms
- Bed availability
- Lists of Providers
- •Regional Information
- Questionnaires



#### **Check Your Information**

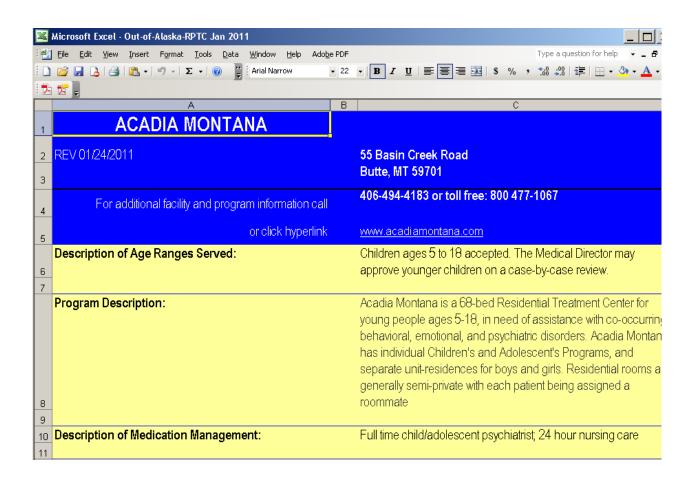


Check your information and website links

Out of Alaska and Instate Residential Programs are listed.

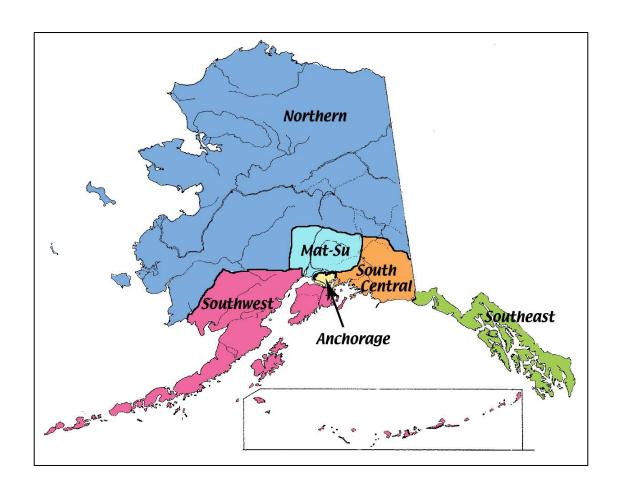


# Check your Individual Page





### Alaska Regions for Admit Questionnaire

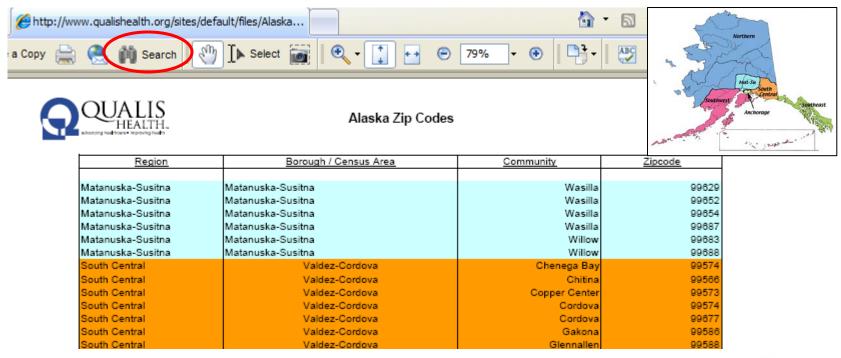




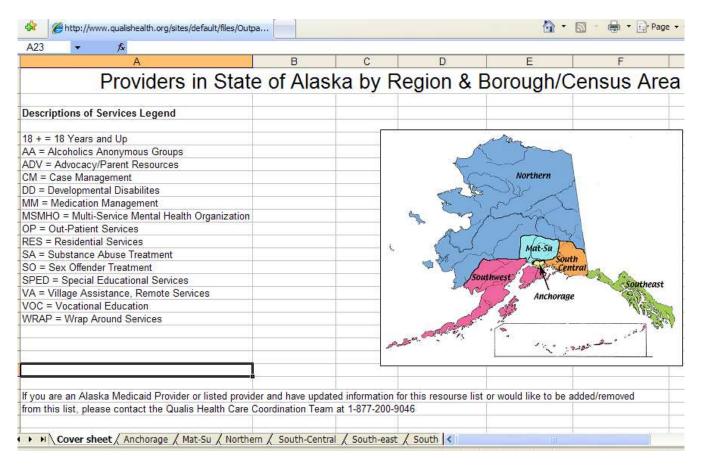
# Search by Zip Code

Click on Binoculars – then enter city name or zip code in search

Results are color coded to match the regional map



### Search for Alaskan Providers by Region





# Search for Providers by Region

A	В	С	D	E
	& Statewide Resources			
Type of services	Provider Name	Phone number	Fax number	Website address
CM	Co-Occurring Disorders Institute, Inc	907-745-2634	907-745-4897	www.codi-ak.org
DD. VOC	Access Alaska - Mat-Su	907-357-2588	907-357-5585	www.accessalaska.org
SPED .	Special Education Service Agency	907-334-1314	907-569-0546	www.sesa.org
ADV	Alaska Youth and Family Network	907-770-4979	907-770-4997	www.ayfn.org
DD, Respite	ReadyCare	907-357-5627	907-357-5628	www.readycareak.com
DD, TFH, CM, DD, MM	Hope Community Resources	907-357-3750	907-564-7495	www.hopealaska.org
DD, 1111, OW, DD, WIW	Trope community resources	307 337 3730	307 304 7433	www.nopediasku.org
Palmer				
Type of services	Provider Name	Phone number	Fax number	Website address
SA, MSMHO	Alaska Family Services	907-357-6817	907-373-1135	www.akafs.org
CM, 18 +	Daybreak, Inc	907-746-6019	907-745-6146	
OP, TFH, WRAP, MM	Denali Family Services	907-222-2347	907-274-0455	www.denalifs.org
Crisis, Preventative	Dorothy Saxton Shelter - AK Family Services	907-376-7233	907-376-7233	www.akafs.org
OP, MM	Holladay and Associates	907-745-7080	907 745-6263	
OP, SPED	Mat-Su Day School - AK Family Services	907-376-0459		
SPED	Mat-Su Day School - Mat-Su School District	907-376-0459		www.matsuk12.us
OP, CM, MM	Mat-Su Health Services, Inc.	907-376-2411	907-352-3363	www.bhs-mat-su.com
Psych ER, Crisis	Mat-Su Regional Hosptial	907-861-6000		www.matsuregional.com
SPED	Mat-Su School District	907-746-9233		www.matsuk12.us
DD, CM, FASD Team	Mat-Su Services for Children & Adults	907-352-1200	907-352-1249	www.mssca.org
Talkeetna				
Type of services	Provider Name	Phone number	Fax number	Website address
OP, MM	Sunshine Community Health Center	907-733-2273		



### Overview of Care Coordination

- Review of Qualis Health Care Coordination role
  - Assessment/Identification of client's needs
  - Provider/Facility collaboration
  - Discharge planning to promote continuity of care
  - Access to community/resources/service
- Assist clients with complex and difficult needs
  - Viable services in remote communities
  - Service limitations
  - Access to resources

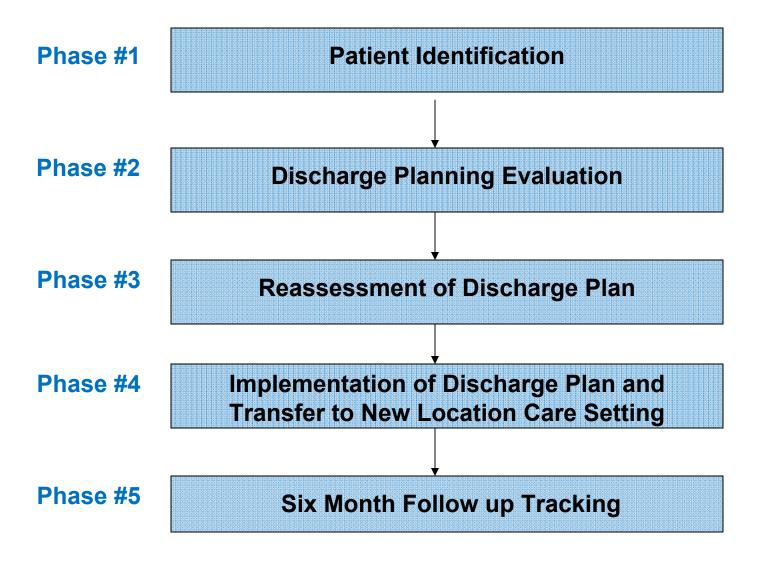
#### **Care Coordination Goals**

- Support information sharing
  - between providers to facilitate continued care for clients placed in residential treatment out of Alaska
- Facilitate discharge planning across continuum of care
- Facilitate access to community resources/availability

#### Additional Goals of Care Coordination

- Promote continuity of care
- Track length of stay at out-of-state facilities
- Track client's services and status in treatment upon return to Alaska

### **Five Phase Process**



### Moving Through the Phases

- Care Coordinators identify clients admitted to out-of-state RPTC and confirm demographics
  - Admit date
  - Custody status of client
  - Service providers (Therapist, UR contact, former in-state providers, etc.)
  - Contact information for guardians (names, address, phone numbers)

### Moving Toward Discharge

#### Providers

- Report any updates and changes
- Request assistance with identification of possible providers
- Document discharge plans in client charts
- Make accurate reports for utilization review process

#### Care Coordinators

- Offer assistance
- Request clarification

# Confirm/Reassess Discharge Plan

- Encourage collaboration and dialog regarding client's updated needs
- Assist Out of State Providers understand limitations and need for continuous follow up
- Encourage development of wrap-around, community based, and wavier based services
- Secure that In-State Providers have updated information and applications

# Moving To Discharge

- Out of Alaska Provider roles
  - Identify any previous providers that may be able to provider services and stay engaged with client during treatment (beginning at admit!)
  - Re-evaluate initial plan on a regular bases
  - Contact providers early and often
  - Provide updates regarding treatment progress
- Care Coordinator will be checking in often
  - Ask for updates and newly identified client needs

### **Evaluating and Reassessment**

#### Care Coordinators

- Communication with Out of State providers regarding timeline for discharge and planning
- Confirms Availability of Services
- Validity of Plan
- Application and updated clinical has been received by in State provider in timely manner
- Checks with In and Out of State providers

### Implementation of Discharge Plan

- Out of State Provider finalizes
  - Services needed
    - Include considerations regarding medication management, housing, family, and educational services in addition to IT, FT, GT and other identified therapeutic interventions.
  - Identified providers
    - Secures providers for all services across the care continuum based on client needs.
  - Discharge date

# Confirmation of Discharge Plan

- Prior to discharge Care Coordinator confirms:
  - In State Provider/Facilities admission of client
  - Appointment are set for follow up care
  - Client's access to services and providers
- Provider also secures above information and retains responsibility for discharge planning
- Discharge Confirmed

# **Business Associate Agreement**

 Letter of Agreement of Disclosure of Health Insurance Portability and Accountability Act (HIPAA):

"As a business Associate, Qualis Health is permitted to receive Protected Health Information (PHI) in order to conduct their contracted work."

### Six Month Tracking Phase

- Care Coordinator confirms:
  - Actual discharge and date return to Alaska
  - Actual admit to aftercare services
- Alaskan Provider
  - Confirms admit
  - Provides month update on client status
  - Reports level of engagement/compliance

#### **Desired Outcomes**

- Bring the Kids Home Initiative is to keep youth in their local communities
- Reduce the length of stay in out-of-state programs
- Improved sequencing of services that meet the individual patient's needs
- Improved patient satisfaction
- Avoidance of readmissions to OOS services

### Care Coordination Timeframes

- Discharge planning must begin at time of admit
- Need to report names of mental health providers no later than 90 days into treatment or risk shortened review period
- Confirmation of actual appointments must be complete prior to discharge
- Planning for services once provider is identified can take six to ten months

#### **Trial Home Pass**

- Trial home passes can be planned as part of twelve annual nights out of program
- Travel should be arranged two weeks in advance
- Client should see lower level of care providers
- Should be based on specific treatment plan needs and documented in client's chart and reported via iExchange (in review)

#### **Case Consultations**

- Care Coordinators network with:
  - Office of Children's Services
  - Juvenile Justice
  - Behavioral Health Utilization Review Staff
  - Senior and Disability Services
  - Local Providers
  - Family Advocates
  - Educational Services (SESA & Anchorage School District)

#### Identification of Resources

- Care Coordinators participate in Alaska Regional Provider meetings with Alaska Behavioral Health Team to:
  - Maintain information on community services
  - Review capacity issues
  - Build greater understanding of placement issues and barriers

#### Additional Alaskan Resources

- RPTC/FASD Wavier
  - Requirements:
    - Under 21
    - Suspected of Prenatal Alcohol Exposure
    - Serious Emotional Disturbance (SED)
    - Meet Criteria for Residential Psychiatric Treatment
  - To enroll a youth (or to get clinical support) contact:
    - Shannon Cross, LCSW (907) 269-3619

#### More on the RPTC/FASD Waiver

- Additional Requirements
  - Requires mental health clinical support
  - Need must be identified in treatment plan
- Benefits
  - Residential Habilitation
  - Day Habilitation
  - Supported Employment
  - Community Transition Services
  - Training and Consultation
  - Daily and Hourly Respite
  - Mentor

#### **DD Wavier Based Services**

- Requires time to process
  - Selection process (FSIQ below 70)
  - Waiting lists
  - Assessment process
    - Care Coordination
      - Care Coordination Authorization Number (CCAN) is issued
      - Changes must be processed
    - ICAP = Inventory for Client & Agency Planning
      - Reviewed by Arbitre Consulting Inc.
    - LOC = Level of Care

### MR/DD Waiver Implementation

- Once Level of Care is approved
  - Care Coordinator must submit plan of care
    - Including provider, services, needs
    - the waiver is then submitted to The Division of Senior and Disabilities Services and reviewed by a Regional Program Specialist.
  - Once approved by the Regional Program Specialist, the waiver is referred for prior authorized for payment

This process takes months!

#### **Find Out More**

- MR/DD Waiver:
  - http://www.hss.state.ak.us/dsds/ carecoordinationtraining/segmentE.htm
  - South Central Region
    - (907) 269-3666
  - Northern Region
    - (907) 451-5045
  - Southeast Region
    - 1-800-465-3165

#### **FASD Waiver**

- Alaska State Behavioral Heath
  - Shannon Cross, LCSW
  - -(907)269-3619
- http://www.alaskachd.org/workforce/3m/ documents/FASDProjectOverview.ppt

### Questions

- Qualis Health Care Coordination Team
  - Carrie Triplett, MS
    - 907-550-7628
    - 1-800-949-7539 x 7628
  - Kimberley Lawerence, LCSW
    - 907-550-7629
    - 1-800-949-7536 x 7626
  - Linda Rasmussen, LCSW
    - 907-550-7622