Care Coordination and Discharge Planning

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Care Coordinator

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Objectives

• Describe role of Qualis Health Care Coordinators
• Share goals of care coordination services
• Increase understanding of transition process and resources
• Share information regarding available resources
Overview of Care Coordination Role

Qualis Health Care Coordinators

• Work directly with psychiatric residential treatment facility (PRTF) providers to facilitate discharge planning
  – Work with both in-state and out-of-state PRTFs

• Assess and identify needs related to discharge planning

• Encourage collaboration between PRTF and lower level of care providers

• Facilitate access to community/resources/services
  – Identify viable services in remote communities
  – Identify service limitations
Care Coordination Goals

• Support information sharing
• Provide updates to providers
• Facilitate discharge planning and access to community resources
Care Coordination Goals

- Promote continuity of care
- Track length of stay in psychiatric residential treatment facilities
- Complete resource assessments to help successfully transition youth back to their home community
- Confirm discharge and admission to lower level of care services
Desired Outcomes

• Keep youth in their local community
• Reduce the length of stay for youth in psychiatric residential treatment facilities
• Improve sequencing of services that meet the individual youth’s needs
• Increase youth satisfaction
• Reduce readmissions to psychiatric residential treatment facilities
Case Consultations

• Care Coordinators network with
  – Office of Children’s Services
  – Division of Juvenile Justice
  – Division of Behavioral Health utilization review team
  – Senior and Disabilities Services
  – Local behavioral health providers
  – Family advocates
  – Educational services
Identification of Resources

Alaska regional provider meetings with Division of Behavioral Health utilization review team:

- Maintain information on community services
- Review capacity issues
- Build greater understanding of placement issues and barriers
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.
Four-Phase Process

Phase 1
Patient Identification

Phase 2
Discharge Planning Evaluation

Phase 3
Reassessment of Discharge Plan

Phase 4
Implementation of Discharge Plan and Transfer to New Location Care Setting
Phase 1: Patient Identification

Care Coordinators

• Identify youth admitted to psychiatric residential treatment facilities
• Confirm demographics
• Review Care Coordinator role related to discharge planning
• Offer assistance with identification of possible providers and resources
Phase 2: Discharge Planning Evaluation

PRTF providers

• Identify any previous providers that may be able to offer services

• Develop initial discharge plan
  – Include considerations regarding medication management, housing, family and educational services, in addition to individual, family and group therapies and other identified therapeutic interventions.
Phase 2: Discharge Planning Evaluation

Care Coordinators

• Check in often regarding updates and newly identified needs
• Encourage collaboration with providers identified for discharge
• Assist PRTF providers in understanding resource limitations
• Encourage development of comprehensive discharge plan
• Encourage PRTF providers to obtain ROIs as soon as discharge providers are identified
• Complete Family Resource Needs Assessment (FRNA) within 45 days of admission
Family Resource Needs Assessment (FRNA)

• Structured set of questions Care Coordinator asks the parent/legal guardian

• Completed within 45 business days of admission

• Focus is to gain information to help identify
  – Barriers to receiving community-based services
  – Family concerns to be addressed during treatment
  – Need for case management and family education
  – Supports necessary to successfully transition youth back to their home community
Phase 3: Reassessment of Discharge Plan

PRTF providers

• Re-evaluate initial discharge plan on a regular basis
  – Identify possible barriers to discharge

• Maintain contact with lower level of care providers to verify service availability and referral/application process

• Organize trial discharge home pass (if appropriate)
  – See Behavioral Health Inpatient Psychiatric Review Provider Manual for additional information
Phase 3: Reassessment of Discharge Plan

• Confirm timeline for discharge with PRTF providers
• Confirm availability of services and validity of plan with lower level of care providers
• Confirm lower level of care providers have received application and updated clinical information
• Regularly check in with PRTF and lower level of care providers regarding progress on discharge planning
• Complete Family Discharge Readiness Assessment (FDRA) prior to discharge
Family Discharge Readiness Assessment (FDRA)

- Structured set of questions the Care Coordinator asks the parent/legal guardian
- Completed prior to discharge
- Focus is to gain information to help identify
  - Continued barriers to receiving community-based services
  - Ongoing needs for case management and family education
  - Supports accessed to successfully transition youth back to their home community
  - Gaps in available services
Phase 4: Implementation of Discharge Plan

- **PRTF providers**
  - Finalize discharge plan for services with identified lower level of care providers
  - Confirm discharge date and plans for transition

- **Care Coordinators**
  - Confirm lower level of care provider’s acceptance of youth
  - Confirm appointments are set for follow-up care
  - Confirm actual discharge from PRTF
Summary and Reminders

• Discharge planning must begin at time of admission
• Must report names of lower level of care providers for discharge no later than 90 days into treatment or risk shortened review period
• Must confirm actual appointments prior to discharge
• Once lower level of care provider is identified, planning for services can take 6 to 10 months
Don’t Forget, Care Coordinators Can…

Work with providers to find
• Web-based provider information
• Availability of services
• Agency contact information
• Alaska-specific resources
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

Providers in State of Alaska by Region & Borough/Census Area

Descriptions of Services Legend

18+  18 Years and Up
AA  Alcoholics Anonymous Groups
ADV  Advocacy/Parent Resources
CM  Case Management
DD  Developmental Disabilities
MM  Medication Management
MSMHO  Multi-Service Mental Health Organization
OP  Out-Patient Services
RES  Residential Services
SA  Substance Abuse Treatment
SO  Sex Offender Treatment
SPED  Special Educational Services
VA  Village Assistance, Remote Services
VOC  Vocational Education
WRAP  Wrap Around Services

Click on Region Heading for Specific Providers

ANCHORAGE
MAT-SU
NORTHERN
SOUTH-CENTRAL
SOUTHEAST
SOUTHWEST

*If you are an Alaska Medicaid Provider or listed provider and have updated information for this resource list or would like to be added/removed from this list, please contact the Qualis Health Care Coordination Team at 1-877-200-9048.
## Search for Alaskan Providers by Region

### Mat-Su Regional & Statewide Resources

<table>
<thead>
<tr>
<th>Type of services</th>
<th>Provider Name</th>
<th>Phone number</th>
<th>Fax number</th>
<th>Website address</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD, VOC</td>
<td>Access Alaska - Mat-Su</td>
<td>907-357-2568</td>
<td>907-357-5555</td>
<td><a href="http://www.accessalaska.org">www.accessalaska.org</a></td>
</tr>
<tr>
<td>SPED</td>
<td>Special Education Service Agency</td>
<td>907-334-1914</td>
<td>907-563-0546</td>
<td><a href="http://www.sesa.org">www.sesa.org</a></td>
</tr>
<tr>
<td>ADV</td>
<td>Alaska Youth and Family Network</td>
<td>907-770-4979</td>
<td>907-772-4927</td>
<td><a href="http://www.aayfn.org">www.aayfn.org</a></td>
</tr>
<tr>
<td>DD, Respite</td>
<td>ReadyCare</td>
<td>907-357-5627</td>
<td>907-357-5628</td>
<td><a href="http://www.resycareak.com">www.resycareak.com</a></td>
</tr>
<tr>
<td>DD, TFH, CM, DD, MM</td>
<td>Hope Community Resources</td>
<td>907-357-3750</td>
<td>907-564-7485</td>
<td><a href="http://www.hopealaska.org">www.hopealaska.org</a></td>
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### Palmer

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<th>Fax number</th>
<th>Website address</th>
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</thead>
<tbody>
<tr>
<td>OP, PLL</td>
<td>Co-Occurring Disorder Institute</td>
<td>907-745-2634</td>
<td>907-745-4607</td>
<td><a href="http://www.dolditaku.org">www.dolditaku.org</a></td>
</tr>
<tr>
<td>CM, 18 +</td>
<td>Daybreak, Inc</td>
<td>907-745-6161</td>
<td>907-745-6161</td>
<td><a href="http://www.denalis.org">www.denalis.org</a></td>
</tr>
<tr>
<td>Psych ER, Crisis</td>
<td>Mat-Su Regional Hospital</td>
<td>907-861-8000</td>
<td>907-861-8000</td>
<td><a href="http://www.matsuk12.us">www.matsuk12.us</a></td>
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### Talkeetna

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</tr>
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<tbody>
<tr>
<td>OP, MM</td>
<td>Sunshine Community Health Center</td>
<td>907-733-2273</td>
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### Wasilla

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<th>Fax number</th>
<th>Website address</th>
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</thead>
<tbody>
<tr>
<td>SA, 18 +</td>
<td>Ascent Treatment Counseling Services</td>
<td>907-357-5805</td>
<td>907-357-5805</td>
<td><a href="http://www.ascenttreatment.com">www.ascenttreatment.com</a></td>
</tr>
<tr>
<td>OP, CM, MM</td>
<td>Mat-Su Health Services, Inc.</td>
<td>907-376-2411</td>
<td>907-352-3373</td>
<td><a href="http://www.mshsi.org">www.mshsi.org</a></td>
</tr>
<tr>
<td>DD, CM, FASD Team</td>
<td>Mat-Su Services for Children &amp; Adults</td>
<td>907-352-1200</td>
<td>907-352-1249</td>
<td><a href="http://www.msasa.org">www.msasa.org</a></td>
</tr>
<tr>
<td>OP, MM</td>
<td>Providence Hospital</td>
<td>907-357-6445</td>
<td>907-357-6445</td>
<td><a href="http://providence.org/alaska">http://providence.org/alaska</a></td>
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### Willow

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<th>Fax number</th>
<th>Website address</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP, MM</td>
<td>Sunshine Community Health Center</td>
<td>907-495-4100</td>
<td>907-495-4100</td>
<td></td>
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</table>
Online Tools and Resources

• Understanding regions
  – Anchorage: Urban (Girdwood)
  – Northern: Urban to remote
  – Southwest: Remote
  – Mat-Su: Rural (road access)
  – Southeast: Remote (Juneau)
  – South Central: Rural and remote

• Ask your client and/or Care Coordinator
Intellectual & Developmental Disabilities (IDD) Waiver

In order for a person with a suspected intellectual and developmental disability to receive help through the State of Alaska, they must be determined developmentally disabled as defined by state law.

Alaska Statute AS 47.80.900
IDD Waiver

DD Statute

One who experiences a severe, chronic developmental or intellectual disability that is attributable to a mental or physical impairment or combination of mental and physical impairments that manifested before the person is age 22, is likely to continue indefinitely, and results in substantial functional limitation in three or more major life activities including self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.
IDD Waiver

Five-step process

1. Submit a DD Determination Application

   http://dhss.alaska.gov/dsds/Documents/pdfs/DD_Determination_Application.pdf

   Contact a STAR (Short-Term Assistance and Referral) provider for free assistance with filling out the application.


2. Once DD eligibility is approved, fill out the DDRR (Developmental Disabilities Registry and Review) form to get on the DD Registry to wait to be pulled for the ISW or the IDD waiver.

IDD Waiver

DD eligibility and IDD waiver steps, cont:

3. Wait to be pulled from the DD Registry. When pulled from the Registry, you must then select a Care Coordinator. Get the Statewide Care Coordinator List from the IDD Unit webpage.

   http://dhss.alaska.gov/dsds/Pages/dd/default.aspx

4. Care Coordinator submits ICAP (Inventory for Client and Agency Planning). SDS proceeds to a Level of Care determination.

5. Once Level of Care is approved, the Care Coordinator works with the family to submit a Plan of Care to SDS for review. See the IDD Unit webpage for more detail on the process.

   http://dhss.alaska.gov/dsds/Pages/dd/default.aspx
The IDD waiver offers a choice between home and community-based services and institutional care for people who meet waiver service criteria. Possible services available for select persons on the IDD waiver include respite care, community inclusion supports, residential supported-living, nursing oversight, care coordination and various other services.
Individualized Supports Waiver (ISW)

• The new Individualized Supports Waiver (ISW) is replacing the Community Developmental Disabilities Grant program, which ends on June 30, 2018.
• The ISW will extend supports to individuals who were not covered by the grant program.
• For more information, see the Frequently Asked Questions.

ISW

Differences between the ISW and the IDD waiver

• ISW participants have an individual cost limit (a budget), while there is no individual cost limit for IDD waiver participants.

• The ISW includes fewer services.

• Out-of-home residential habilitation services (group home and family habilitation services) are not available for ISW participants.
ISW applicants are expected to have services and supports available from other sources that, in combination with waiver services, are sufficient to assure their health and safety within the individual cost limit. The applicant will not qualify for the ISW if the applicant’s needs or desired supports exceed the scope or cost limit of the waiver.
ISW

- The application process and eligibility criteria for the ISW are the same as for the IDD waiver.
  - The individual must be determined to have a developmental disability.
  - The individual must be on the Developmental Disabilities Registration and Review.
  - The individual must meet level of care criteria for Intermediate Care Facility for Individuals with Intellectual Disabilities.
  - The individual must be enrolled in Medicaid.

- Care coordination services are required for ISW participants.
ISW

Services offered on the ISW include:

- Chore services
- Day habilitation
- Intensive active treatment for adults
- Non-medical transportation
- In-home supports for ages < 18
- Supported living for ages > 18
- Respite
- Supported employment (including pre-employment activities)
ISW and IDD Waiver Contacts

Senior and Disabilities Services

Anchorage Office
550 West 8th Avenue
Anchorage, AK 99501-3574
Phone: (907) 269-3666
(800) 478-9996
Fax: (907) 269-3639

Fairbanks Office
751 Old Richardson Highway
Suite 100-A
Fairbanks, AK 99701
Phone: (907) 451-5045
(800) 770-1672
Fax: (907) 451-5046

IDD Waiver Unit Contact List

http://dhss.alaska.gov/dsds/Documents/dd/IDD-StaffContactList.pdf
Qualis Health Care Coordination Team

Dana Hall, MS, LPA
(907) 550-7612
(800) 949-7536 ext. 7612

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(907) 550-7623
(800) 949-7536 ext. 7623

Kimberley Lawrence, MS, LCSW, CCM
(907) 550-7629
(800) 949-7536 ext. 7629