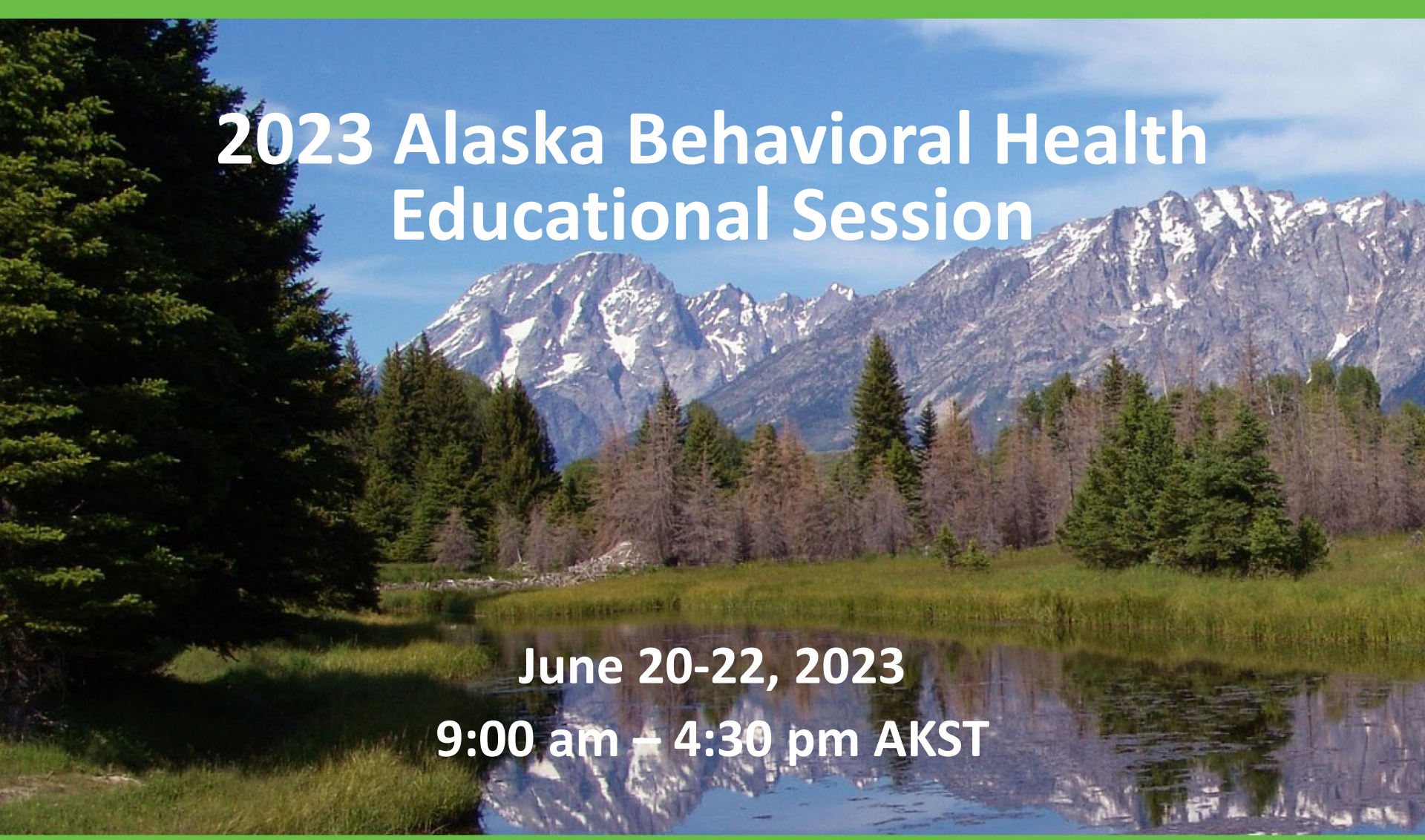


2023 Alaska Behavioral Health Educational Session

June 20-22, 2023

9:00 am – 4:30 pm AKST

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Welcome and Introduction

Yvette Stratton, RN, BSN, CCM

Executive Director, Care Management, Comagine Health

Welcome to Forging Partnerships to Provide Optimum Behavioral Health Services for Alaska's Youth

Approved Provider Statements:

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, this activity has been planned and implemented by Alaska Native Medical Center (ANMC) and UAA Alaska Center for Rural Health and Health Workforce - Alaska's AHEC. ANMC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

CPE Credit will be posted to the online CPE Monitor system within 60 days following completion of each activity when applicable.

Contact Hours:

ANMC designates this activity for a maximum of 11.75 contact hours, commensurate with participation.

Financial Disclosures:

None of the presenters and planners for this educational activity have any relevant relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Requirements for Successful Completion:

To receive CE credit please make sure your attendance is recorded, actively engaged in the entire activity, and completed the course evaluation form.

For more information contact
jlfielder@anthc.org or (907) 229-1185

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Care Coordination and Discharge Planning

Kimberley Lawrence, MS, LCSW
Lead Care Coordinator, Comagine Health

Objectives

- Describe role of Comagine Health Care Coordinators
- Share goals of care coordination services
- Describe the four phases of care coordination work
- Increase understanding of transition process and potential barriers
- Share information regarding available resources

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Overview of Care Coordination Role

Comagine 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

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Care Coordination Goals

- Support information sharing
- Provide updates to providers
- Facilitate discharge planning and access to community resources

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Care Coordination Goals (cont.)

- 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

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Case Consultations

- Care Coordinators network with
  - Office of Children's Services
  - Division of Juvenile Justice
  - Division of Behavioral Health Medicaid Provider Assistance Services team
  - Senior and Disabilities Services
  - Local behavioral health providers
  - Family advocates
  - Educational services

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Identification of Resources

Meetings with Division of Behavioral Health Medicaid Provider Assistance Services team and OCS representative:

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

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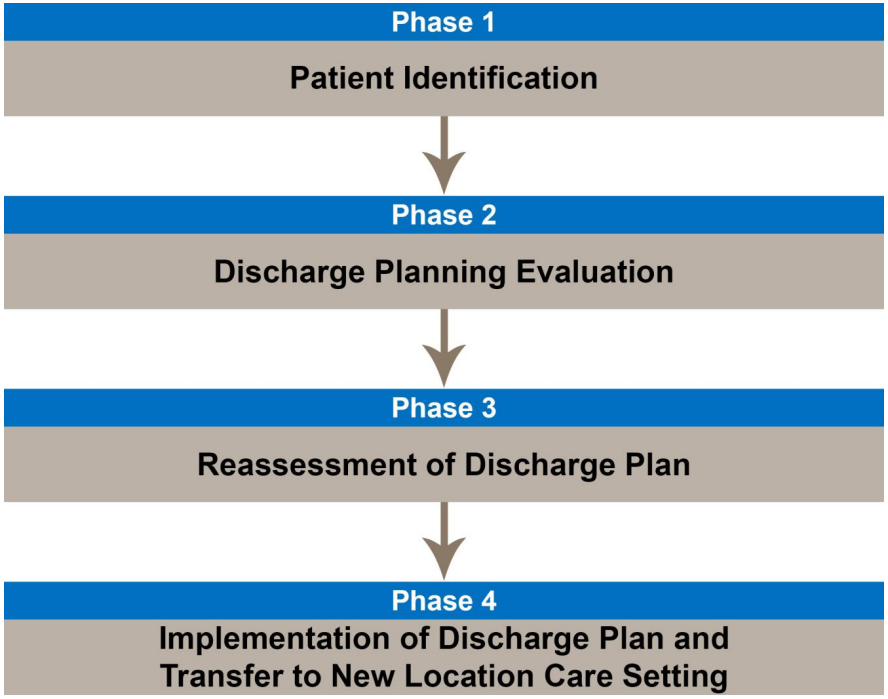
Business Associate Agreement

Letter of agreement of disclosure of Health Insurance Portability and Accountability Act (HIPAA):

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

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Four-Phase Process



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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 (cont.)

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

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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

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Phase 3: Reassessment of Discharge Plan (cont.)

Care Coordinators

- 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

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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

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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 4 to 6 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

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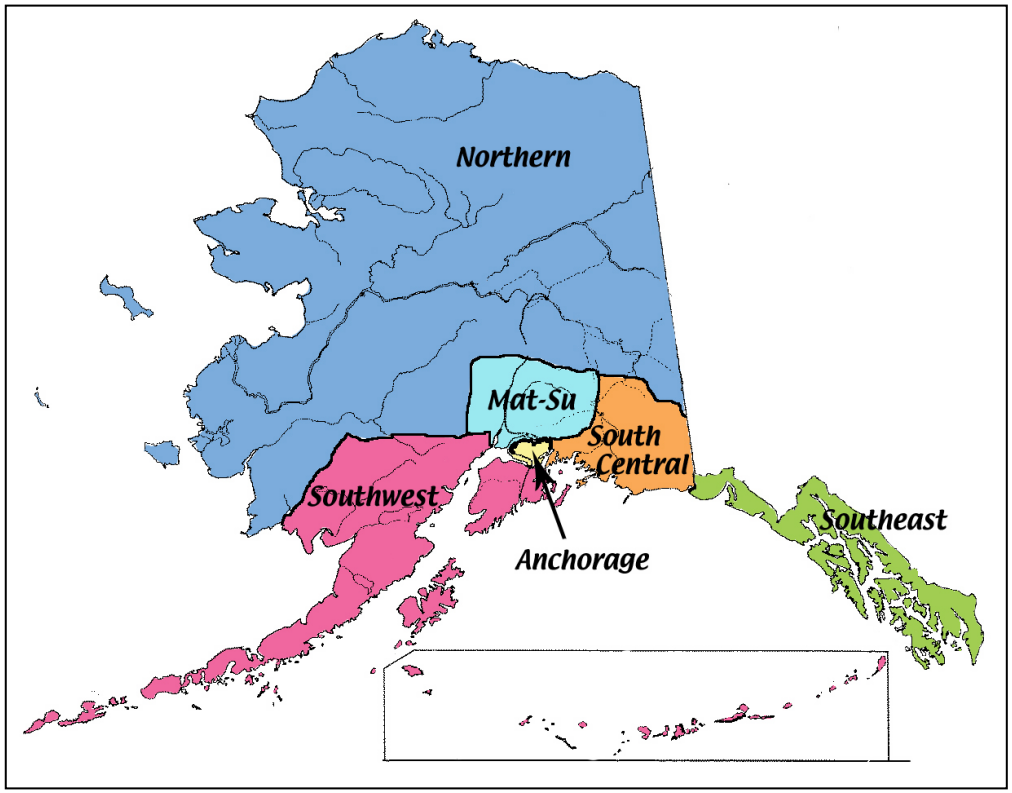
Intellectual & Developmental Disabilities

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

- If you suspect a youth may fit this criteria, please immediately notify the care coordinator so the process of applying for developmental disability and possibly a Waiver can be discussed.
- The care coordinator can assist with getting you in contact with the appropriate people to explore this further.

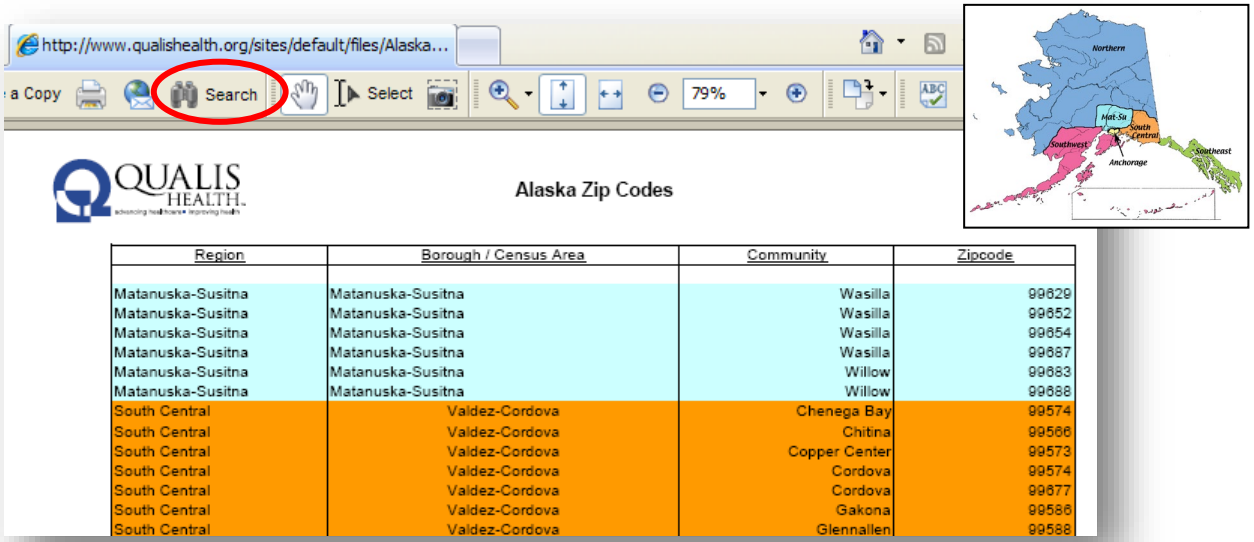
Alaska Regions



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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

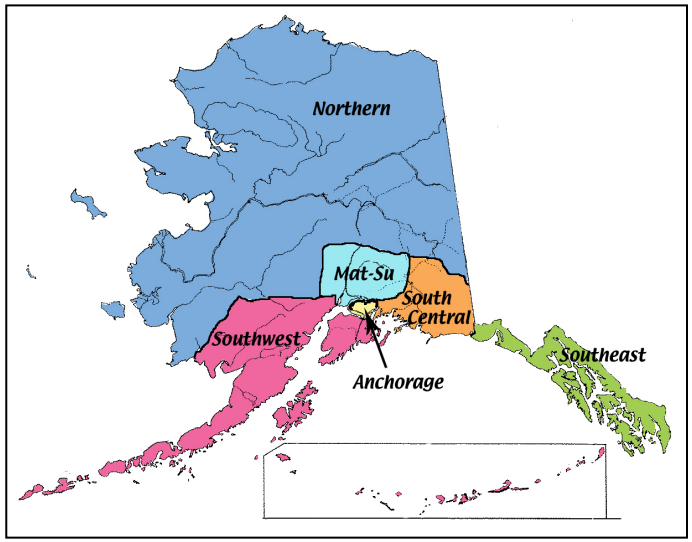


Region	Borough / Census Area	Community	Zipcode
Matanuska-Susitna	Matanuska-Susitna	Wasilla	99629
Matanuska-Susitna	Matanuska-Susitna	Wasilla	99652
Matanuska-Susitna	Matanuska-Susitna	Wasilla	99654
Matanuska-Susitna	Matanuska-Susitna	Wasilla	99687
Matanuska-Susitna	Matanuska-Susitna	Willow	99683
Matanuska-Susitna	Matanuska-Susitna	Willow	99688
South Central	Valdez-Cordova	Chenega Bay	99574
South Central	Valdez-Cordova	Chitina	99566
South Central	Valdez-Cordova	Copper Center	99573
South Central	Valdez-Cordova	Cordova	99574
South Central	Valdez-Cordova	Cordova	99677
South Central	Valdez-Cordova	Gakona	99586
South Central	Valdez-Cordova	Glennallen	99588

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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



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Comagine Health Care Coordination Team

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Break

Back in 15 minutes

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Panel Discussion Fostering an Improved System of Care for Alaskans with Eating Disorders

Sarah McCutcheon, MD, FAPA, BCPA

Regional Medical Director, Comagine Health



https://www.surveymonkey.com/r/RMVLSFP

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Lunch break

Back in one hour

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Alaska Blanket Experience

Cultural Event

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Closing Remarks – Conference Wrap Up

Yvette Stratton, RN, BSN, CCM

Executive Director, Care Management

Thank you for the services you provide to Alaska Medicaid recipients, and for your continued efforts on their behalf.

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Thank you for attending!

You will be receiving an email from UAA with instructions about a survey.

This will be related to the conference presentations you have attended.

Please complete the survey if you would like to receive continuing education units.

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