Continuity of Care through Strengthened Interagency Collaboration

Julie Lago, MSW, LICSW

Steve Arnault, MA

Center for Life Management

Sarah Snyder, MS

Community Crossroads

Mission and Goals

To create, support, and coordinate team-based health care, integrating continuity of care efforts for mental, physical, and behavioral health needs

- Merge annual meetings and goals to promote continuity of care
- Integrate team members into the clinical setting to reinforce and encourage skill use
- Implement measurement tools with goals for decreased behaviors, hospitalizations, and Emergency Services contacts, as well as increased independence through ADL's, employment, residential stability, etc.
- Integrate physical health needs and medical care through improved communication and monitoring, as evidenced through use of measurement tools to track improved physical health and mental health symptoms, as well as improvements in functioning
- Create and maintain a model that can be replicated by other Community Mental Health Centers and Area Agencies to improve continuity of care for those with co-occurring IDD and mental health needs, creating an expectation of partnership, rather than an exception

Where we came from…

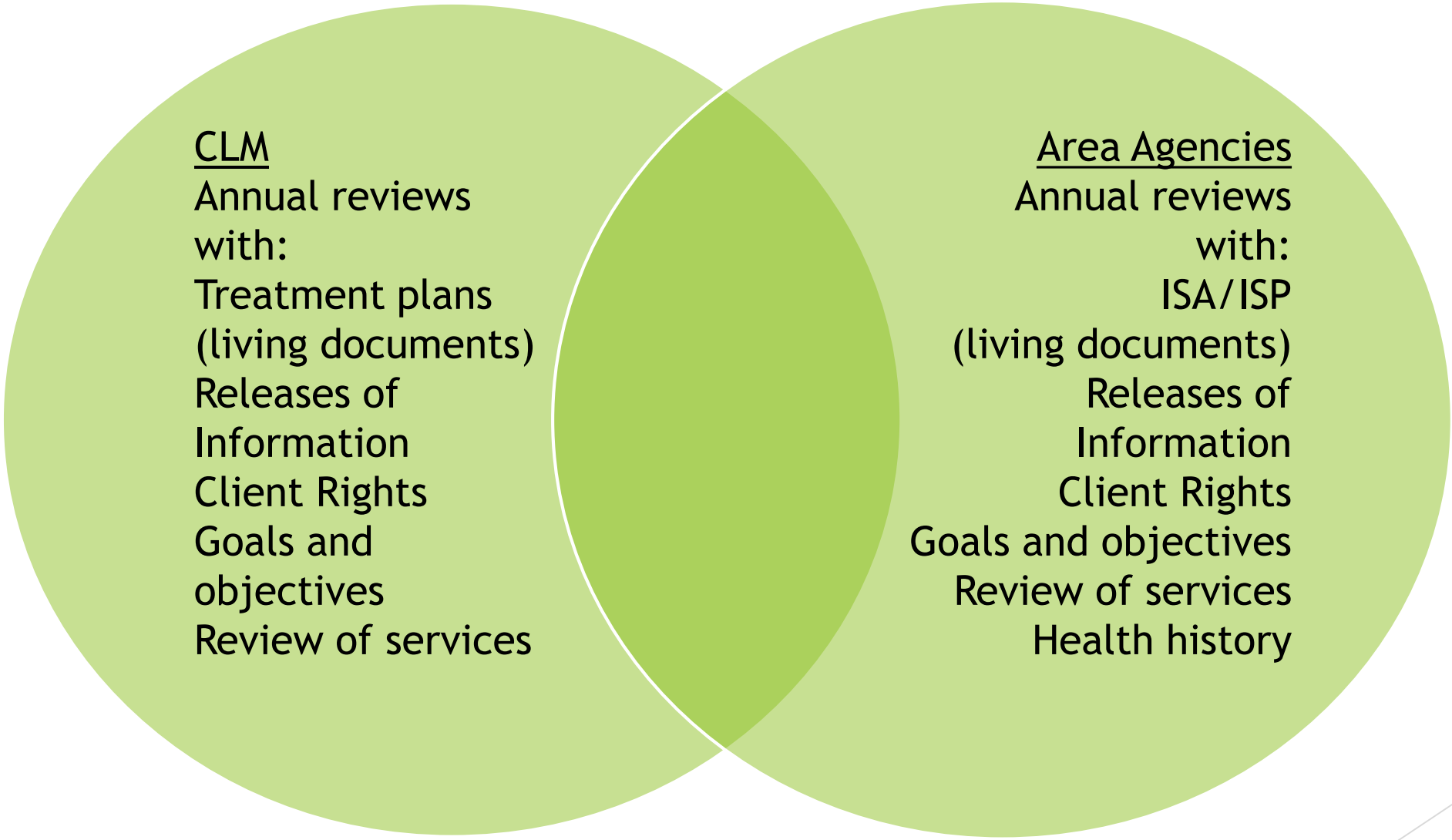
CLM Center for Life Management™

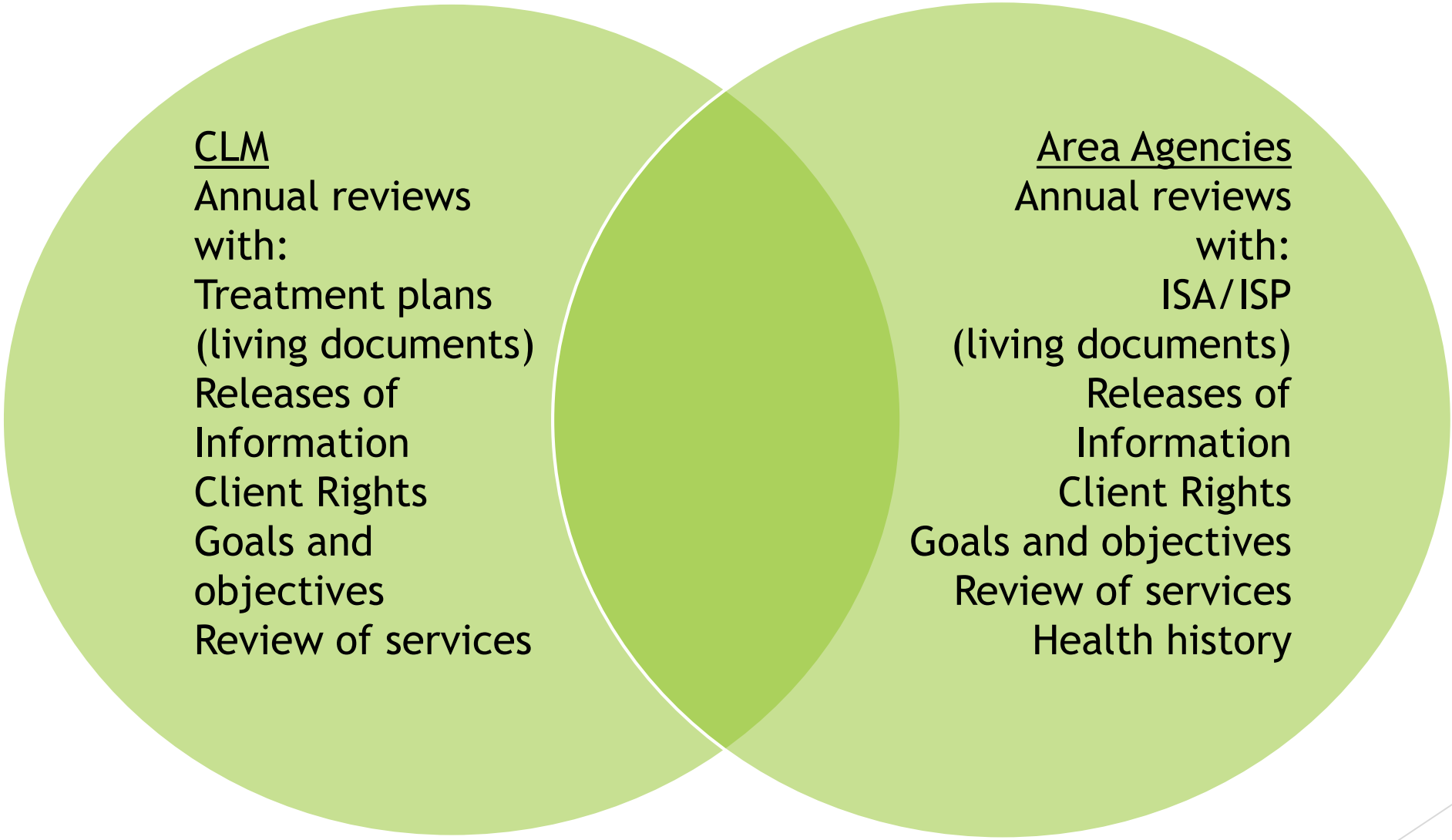
Changing Lives, Saving Lives

Community Crossroads

GUIDANCE. SUPPORT. ADVOCACY.

THE CENTER FOR START SERVICES


CLM
Annual reviews with:
Treatment plans (living documents)
Releases of Information
Client Rights
Goals and objectives
Review of services
Area Agencies
Annual reviews with:
ISA/ISP (living documents)
Releases of Information
Client Rights
Goals and objectives
Review of services
Health history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<u>Interagency Annual Meetings</u>

Annual reviews with:

Treatment plans/ISA's (living documents)

Releases of Information

Client Rights

Merge of goals and objectives

Review of services

Health history review

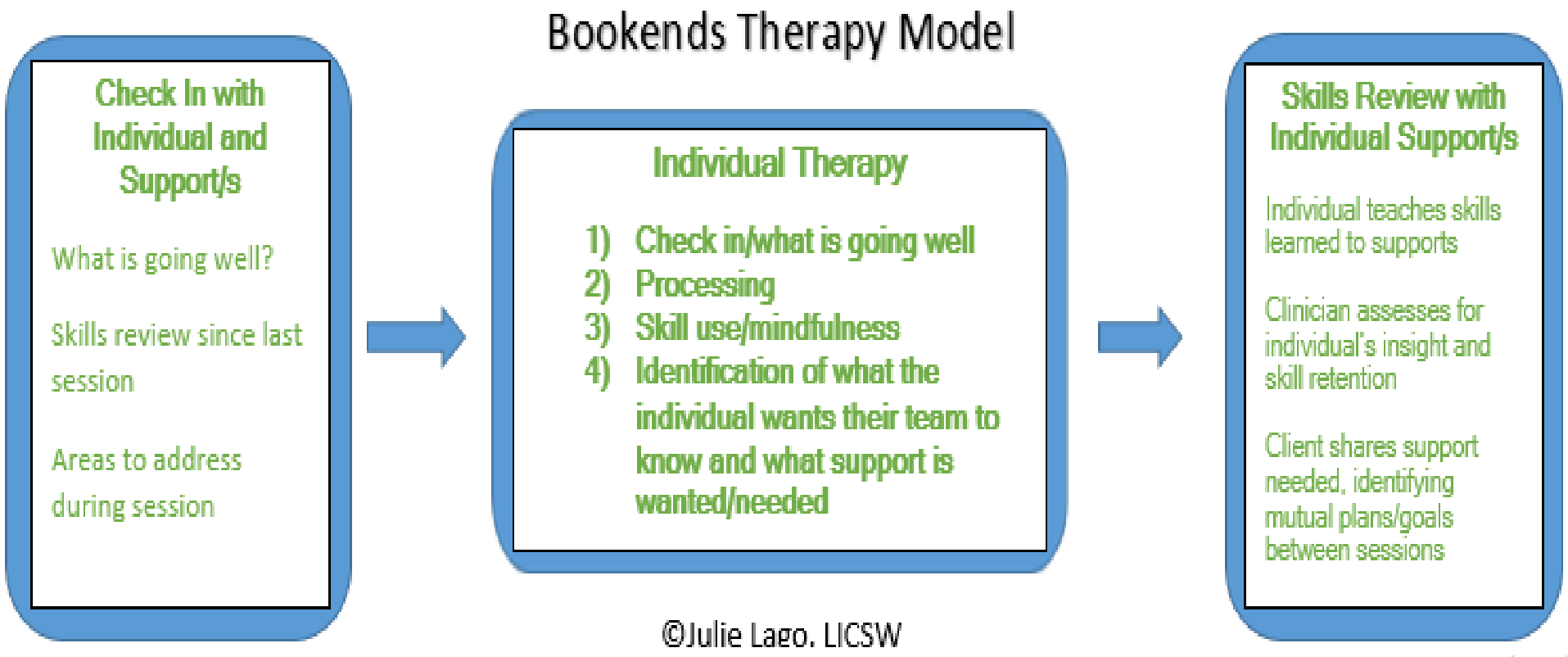
Collaboration of documentation

https://www.corvallisclinic.com/mycc/pebb-medical-home-concepts-principles

Program Concepts

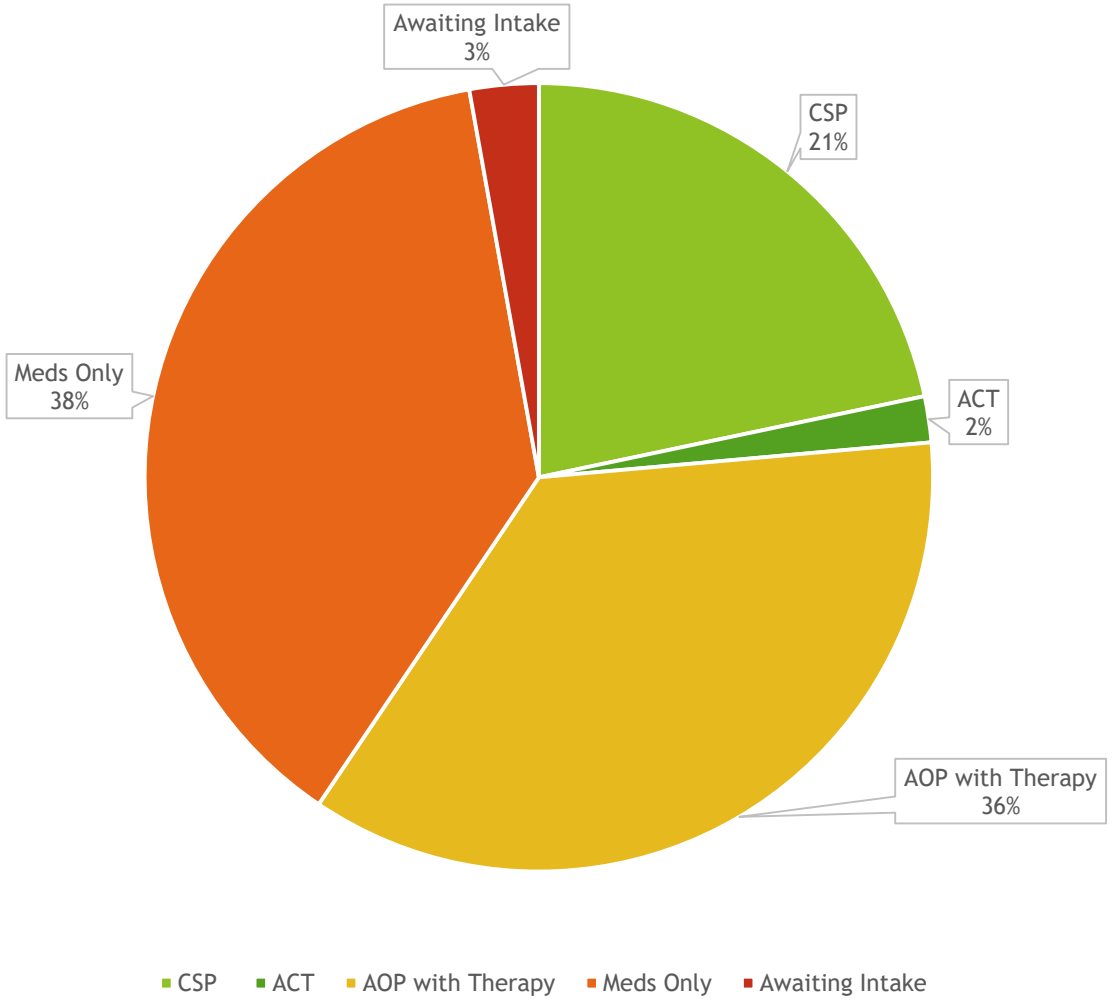
- Intake pre-screening
- Merging of meetings
- Merging of goals and treatment plans
- Continuity of care
- Monitoring of medical needs
- Measurement tools/data collection

Bookends Therapy Model

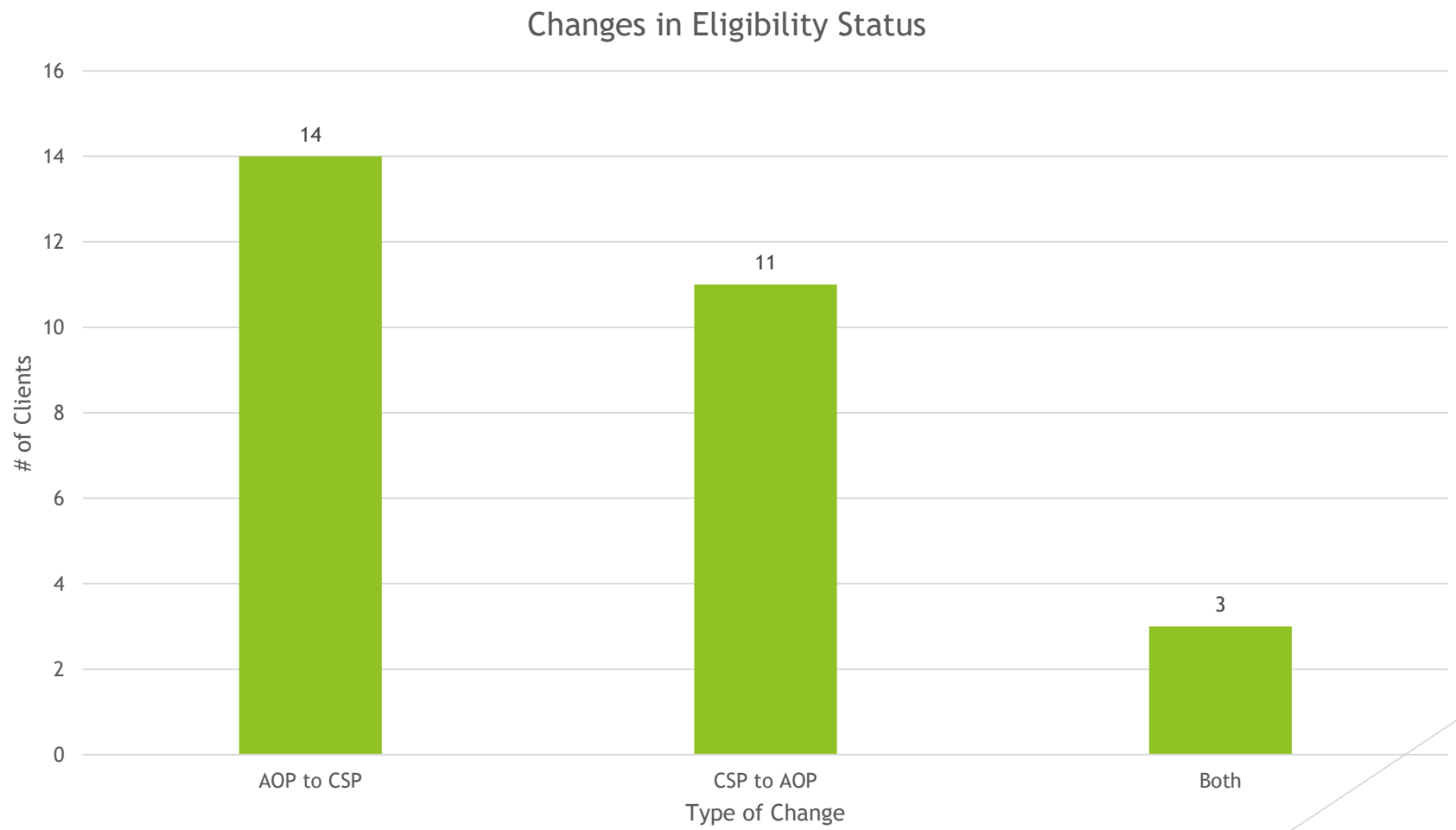


Eligibility of Adult Consumers/Patients

May 2018

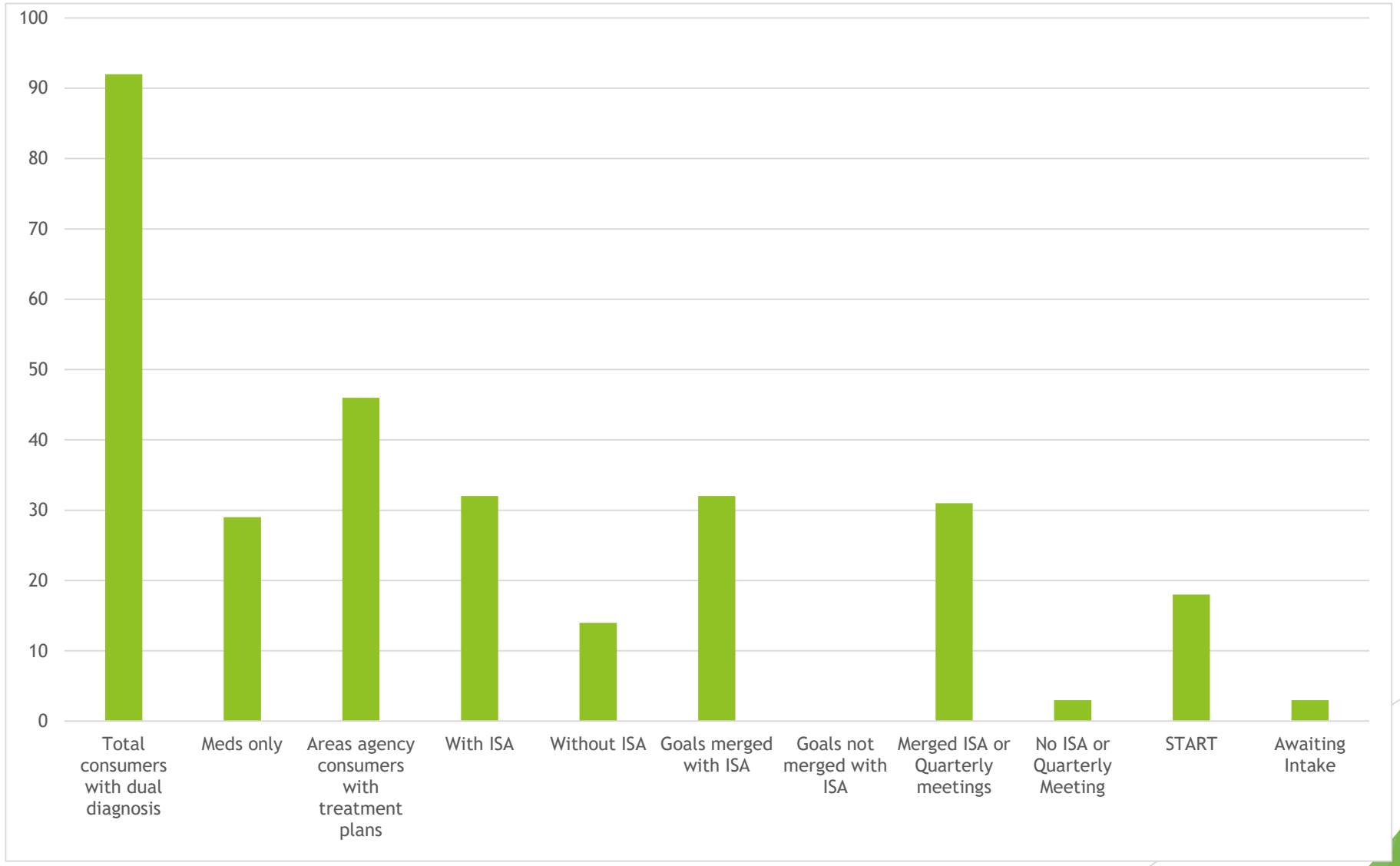


Improved Identification of Consumer Eligibility for Mental Health Services



ISA Collaboration

May 2018



Monthly and Incident Reports

- To review progress on annual goals, including strengths, barriers, and success to ensure consistency of reporting and continuity of care.

- To ensure communication of occurrences outside of consumers' baselines. This will allow for tracking of antecedents, triggers, incident/behavior's impact on functioning and intervention, thus supporting processing with consumer.

Integrating Technology

Ensures continuity of care through identification, organization, and sharing of documentation and interagency status, providing informed and necessary information to staff to support wrap around care.

START Collaboration and Partnership

"…aims to improve the lives of persons with IDD and behavioral health needs and their families through fidelity to the START model with exemplary services and supports that emphasize local, person-centered, positive, multidisciplinary, cost-effective and evidence-informed practices."

- **2016 National START Training Institute Network Partner Award recipient**
- CLM and START agreement was signed in 2014, though collaboration had been occurring for months prior
- Share of documentation to provide integration and continuity of care
- Coordination of care from admission to discharge with START Center stays
  - Monitoring of medications and implementation of changes as needed
  - Review of clinical skills and observations

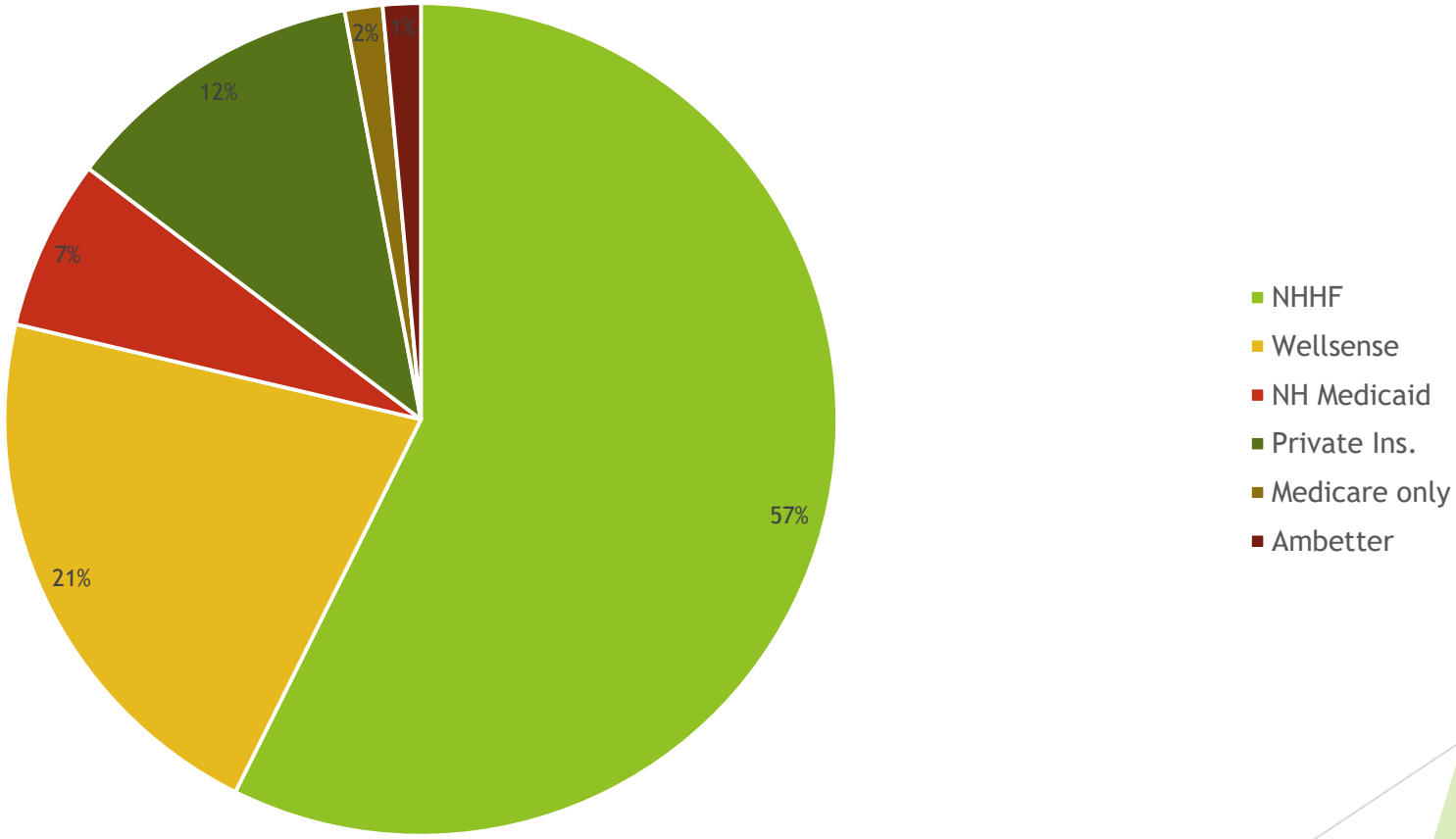
http://centerforstartservices.com/about/missionvalues.aspx

Interagency Multidisciplinary Team Trainings

Regularly scheduled large multidisciplinary team collaboration, integrating case presentations and education to strengthen team communication and relationships to improve client outcomes and supports.

- Requested case presentations are made by completing referral form and submitting to START Coordinator or Clinical Supervisor
  - Request for presentation can also be initiated from case discussion during monthly group consultations
- Includes case presentations and a relevant educational presentation and training
- Recommendations are sent to team and follow up meetings are scheduled to follow-up with progress and implementation of recommendations
- We are approaching 20 consecutive meetings without disruption

Payer Mix


57%
21%
7%
12%
2%
1%
NHHF
Wellsense
NH Medicaid
Private Ins.
Medicare only
Ambetter

Impact

- Promotes education and experience in both macro and micro level for staff and interns
- Provides Collaboration within all agencies involved
  - Office of Public Guardian, area agencies, START, vendor agencies, etc.
- Interagency trainings, staff consultations and educational opportunities
- Bridges gap between self-advocacy skills learned in therapy and implementation of such skills
- Created and implementing new measurement tools
  - Provides data to track and measure progress
- Merging and reducing number of meetings = cost savings and time efficiency
- Improves structure and collaboration during and beyond meetings
- Increases consumer involvement in their treatment

Impact – Crisis Data

- Of the all of those with an IDD/TBI/ASD diagnosis in the patient registry with and without Area Agency affiliation
  - 52/64 (81%) of ER visits, 123/227 (54%) of ES contacts, and 19/19 (100%) of hospitalizations are those not fully integrated into the Continuum of Collaborative Care Model.
- Of those with an IDD/TBI/ASD diagnosis in the patient registry with Area Agency affiliation
  - 41/53 (77%) of ER visits, 83/187 (44%) of ES contacts, and 12/12 (100%) of hospitalizations are those not fully integrated into the Continuum of Collaborative Care Model

It is to be noted that ES contacts are higher due to outliers, including those with goals that include appropriate ES utilization, as well as outliers with frequent guardian contacts.

Impact

There have been **NO** psychiatric hospitalizations for consumers who are fully integrated into this model since the model was first implemented four years ago

Vulnerabilities

- Challenges receiving incident and monthly reports in a timely fashion
  - Important to address incidents as close to occurrence as possible to support identification of triggers and antecedents , as well as helpful interventions
  - Beneficial to have the opportunity to validate progress and identify room for continued skill use
- Limited funding to enhance education for all team members
- Need for increased staff incentive to attend further/ongoing trainings
  - Impact on productivity
  - Decreased incentive for those not needing CEU's
- Cost of meeting
  - Clinicians are unable to bill for interagency annual or quarterly meetings
    - No billable services are available for non-eligible/Adult Outpatient consumers

Next Steps

- Continue with development of an EMR integrated patient registry
- Track medical levels, supporting connection between mental health, physical health, and goal achievement with the support of staff expansion and interns – Using Nurse Care Navigator
- Continue with vendor education regarding dual diagnosis and best practices
- Implementation of group psychoeducation, such as modified DBT and IMR
- Integrate updated START Crisis Plans into ES alerts, as they are updated
- Assess and determine if CMHC's can access HRST data for mutual consumers
- Continued training for professionals, families, and community members regarding dual diagnosis
- Further trainings for CMHC's on appropriate assessment of eligibility for those with IDD and mental health needs
- Improved data tracking: residential stability, job placement, medical hospitalizations, legal involvement, ADL independence

Visions for the Future

"Unity is strength…when there is teamwork and collaboration, wonderful things can be achieved."

- Mattie Stepanek

To be the expectation and not the exception…

- Begin offering multidisciplinary team assessments and recommendations
  - Including: Psychiatry, OT, Behaviorist, and Therapist evaluations and recommendations, as well as available contracted follow up and training
- Be a fully integrated health home
- Continue to implement measurement tools, creating long-term evidence of supports resulting in continuity of care and positive outcomes: Improved data collection
- Have this model be replicated throughout all regions in New Hampshire, requiring continuity of care and improving strength in relationships between mental health centers and area agencies
  - **Provide training and oversight regarding implementation through a consultation model**

“There have been many times when I did not know how to handle my son’s situation or sometimes just felt defeated. The people at CLM and Community Crossroads have encircled our lives and guided us through the process of making my son feel whole with the services he receives from both CLM and Community Crossroads and has been nothing but a true life saver. I am grateful that the communication between our team is so good that everyone is always on the same page in my son’s care. I do not know where we would be without them. I am forever thankful for all of the support we are continually given. You make all the difference in our lives!”

DP, Mother/Legal Guardian

“As a professional, public guardian, I have worked collaboratively with CLM and local area agencies for a few years now and have seen how critical it is to have continuity among the agencies when serving some of the most at-risk and difficult individuals. Having the opportunity to bring all treatment team members to the table on a consistent basis
Have allowed for a more streamlined, efficient and quality service for the individual receiving services, as their treatment goals and services are consistent and complement one another between the multiple agencies. This type of collaboration has proven to be in the best interest of our individual.”

TG, National Certified Guardian