

Optum Alaska April 3, 2020

Wroksie Jackson, LCSW Eula Crippen, PhD



Snapshot





Wroksie Jackson, LCSW Director of Clinical Operations, Optum Alaska ASO





25+ YEARS in **Behavioral Health**





IF I WERE NOT DOING THIS JOB / CHILDHOOD DREAM

MUSICOLOGIST

Favorite Quote:

Relationships "They may forget what you said, but they will never forget how you made them feel."

Carl W Buechner



Outside of Work 1. Like to dance

2. Like live Music

3. Travel



Dr. Eula Crippen, PhD – Chief Psychologist



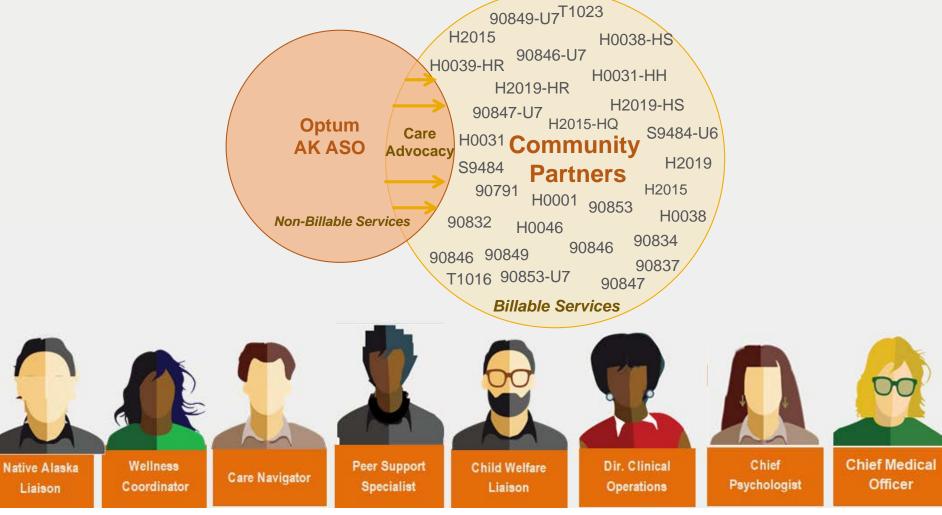


Care Coordination and Advocacy Overview





Dedicated Clinical Operations





Behavioral Health Care Advocates

Master's level licensed clinicians will typically initiate CCA services with a participant, conducting assessment and plan of care;

Care Advocates will refer participant to health providers and community resources;

Through assessment and person-centered planning, help participants identify goals and make steps in their own recovery;

Advocate for participants at every level of service delivery, working directly with participants, family members, health care providers and community agencies.



Behavioral Health Care Coordinators

Skilled and compassionate professionals who offer non-clinical assistance, identify and assess gaps and barriers, and coordinate services and resources that assist with the recipient's needs.

- Assists with searching for/selecting health care providers based on the recipient's needs and preferences; also assists with scheduling appointments (as needed)
- Assists with identifying and resolving clinical gaps for lower risk participants
- Locates community-based resources and services that are available to provide assistance and support to help address the recipient's medical, behavioral, and social gaps or concerns
- Engages with the Participant to assess his/her needs and identify those who may require a higher level of assistance and support from a clinician



Care Navigators

The Behavioral Health Care Navigator can provides critical care management to Medicaid recipients at every level of care. They can assist clients to access peer support, along with other forms of rehabilitation, and all forms of clinical care. Behavioral Health Navigators allow us to offer more robust Care Management.

Navigators may be a professional with a minimum of a Master's degree with preferred clinical license or may work under the supervision of a licensed, Master's-level clinician.



Trained, certified professionals with lived experience. He provides education, support and encouragement to individuals in recovery from substance use or mental health disorders;

Help individuals access resources within their home community that will support their recovery

Help develop Wellness Recovery Action Plan (WRAP);

Teach, encourage and practice life skills with respect for each participant's cultural frame

Build relationships with participant's family whenever possible to strengthen natural supports

Collaborate with BH team to help participant prevent escalation of symptoms that leads to crisis

Help participant cope when they are in crisis



Avele works collaboratively with Optum Alaska Care
Advocates and Medicaid Providers to support
Participants as they transition between levels of care
(typically from residential or inpatient to lower levels of care)

Work with Participants to identify and access resources, traditional and non-traditional, that will support their recovery and mental health rehabilitation)

Works on cross-functional teams, projects and initiatives, process improvement activities, and typically requires previous health insurance experience



Native Alaskan Liaison

Andrew Tooyak, MPH, MJEL



Andrew Helps Native Alaskan participants identify the most appropriate and accessible treatment options, both traditional and non-traditional.

Directly advocates, schedules appointments and otherwise supports tribal participants in accessing care;

Support behavioral health tribal directors and providers navigate the behavioral health delivery system;

Provides cultural perspective, training and support to rural providers;

Documents and communicates gaps in behavioral health services by region.



Child Welfare Liaison

Involved in all aspects of Clinical Services: UM, CM, & Provider Relations;

Foster relationships with Child Welfare agencies statewide, developing familiarity with key staff, and providing support for staff retention;

Provide linkage between OCS caseworkers and behavioral health resources;

Help OCS advocate for child placement, especially when child is facing adverse benefit determinations with Medicaid;

Provide assistance to family as needed to coordinate child's eligibility for services.



Care Coordination and Advocacy (CCA)

Care Coordination and Advocacy (CCA), often referred to as Case Management (CM), embraces a whole person approach to wellness by focusing on all aspects of participant's health and wellbeing.

Optum CCA strives to:

- Work closely with participants to understand all aspects of their health and well-being, including: physical, behavioral and social/environmental needs
- Put the participant front and center. We use our expertise and resources to tailor solutions that provide better care, better health and better consumer experience



Referral Windows

Care coordination can enhance treatment continuity across all levels of care and between behavioral and medical treatment modalities

Initiation of Treatment

Gather the appropriate and necessary information to coordinate care with other treating professionals, especially when complex conditions are disclosed.

During Treatment

Coordinate care periodically, paying particular attention when a medication is initiated, discontinued or changed, when treatment needs escalate or when a participant's condition has altered significantly.

At Discharge

When a participant is discharged, transferred, or referred to another or different treating professional or level of care.



Care Coordination (CCA) Team Functions

- Identify and anticipate high-risk Medicaid participants who need our help, ideally before a substance use, mental health, physical health crisis or adverse event occurs;
- Link Medicaid participants with the medical, psychological, pharmacological care and community resources they need to support their overall health;
- Communicate across systems of care, collaborating closely with participant, participant's family, Medicaid providers, state partners and community resources;
- Develop person-centered Plans of Care using our accessible online platform. Participants can choose to share their Plan of Care with family members, providers or anyone on whom they rely for support.

Reference #1 & #4



Why Care Coordination and Advocacy Matters

Increase Life Expectancy

- Individuals who are treated for serious mental illnesses in public mental health systems die 25 years earlier on average than members of the general population.
- About 60% of these premature deaths are from treatable medical conditions such as cardiovascular and pulmonary disease, diabetes, respiratory and infectious diseases.
- Individuals with mental illness also have higher rates of smoking, alcohol and drug use, poor nutrition, obesity and unsafe sexual behavior.
- Treatment of mental health and substance use issues should not occur in isolation from the treatment of ongoing general health issues.

Reference #1 & #4



Why Care Coordination and Advocacy Matters (Cont.)

Improve Efficiency in Care, Effectiveness of Treatment

- Individuals with mental health and substance use disorders rely on many organizations to provide their care
- These individuals have complex and sometimes competing medical and psychosocial needs, notably among patients with severe and persistent mental health and/or substance use disorders
- A substantial number of patients with serious medical illnesses also have behavioral health conditions
- Sharing treatment information among health care providers supports greater safety and improved outcomes for consumers
- Effective coordination of care can lead to improved health outcomes
- Improved outcomes frequently result in reduced healthcare costs



Why Care Coordination and Advocacy Matters (Cont.)

Improve Medication Management

- Coordination of care is especially important when medications are prescribed, when there are co-existing medical/psychiatric conditions, and whenever patients are hospitalized with coexisting conditions
- Communication between treating providers can minimize the risk of adverse medication interactions for patients being prescribed psychotropic medications
- Coordination of care can help to reduce the risk of relapse for patients with substance abuse disorders or psychiatric conditions



Case Background

Bonnie is a 47-year old woman with a history of Substance Use Disorder, as well as prior SUD-related hospitalizations. Bonnie's substance misuse has been further complicated by:

- Marital stress Separated from her husband
- Grief recent death of her father
- Temporarily living with her sister
- Does not know how to drive
- She has not seen her psychiatrist in over two months due proximity
- Transport limitations



Care Coordination and Advocacy Continuum











One unified segmentation / identification process based on Medicaid-appropriate triggers

Connecting

- Outbound Call
- Occurs at discharge
- Levers best practice
- Clinical call center
- Focus to close gaps in care
- Action Campaign warm transfers
- ER Census calls (until integration)

Assessment

- Care Advocate & Peer Support
- Integrated clinical & non-clinical services
- Manage chronic conditions
- Health education referrals

Plan of Care

- Integrated use of referrals
- Direct referral to comprehensive High Risk Program
- depression & wellchild focus

Action Campaign

- Two-pronged communication
- Encouraging participants to use the right care at right time (providers instead of ED where appropriate)

Readmissions

Focus on reducing readmissions by reaching out to participants at highest risk for readmission, supporting them in accessing supports & resources within their communities.

Person-Centric approach to guiding participants to appropriate level interventions



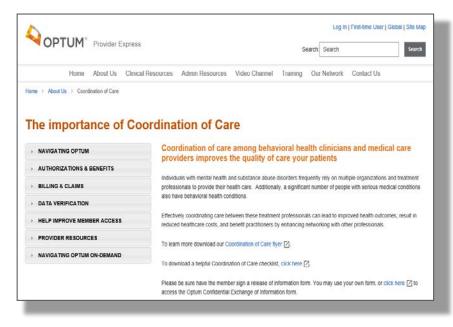
Outliers



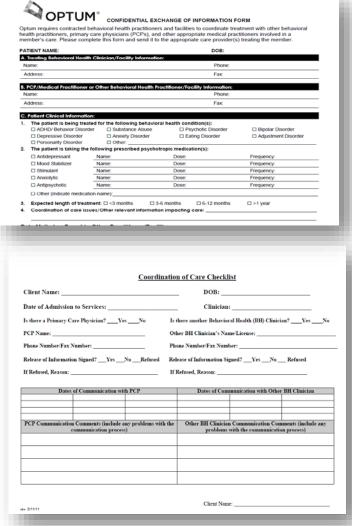


Resources – *Provider Express*

Providerexpress.com

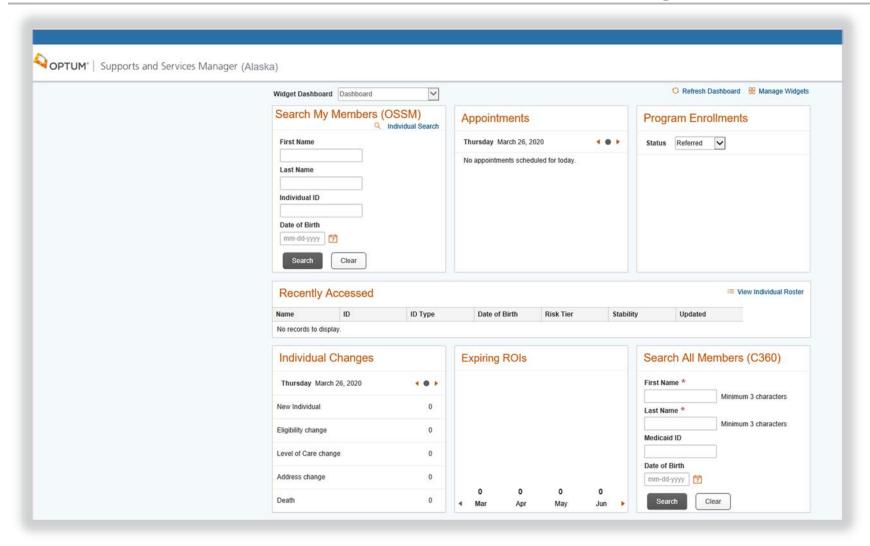


Confidential Exchange of Information





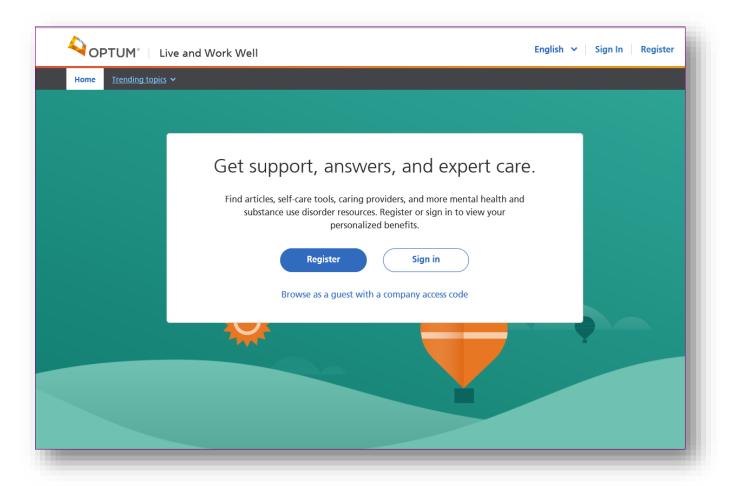
Optum Supports and Services Manager (OSSM)





Resource - Live and Work Well

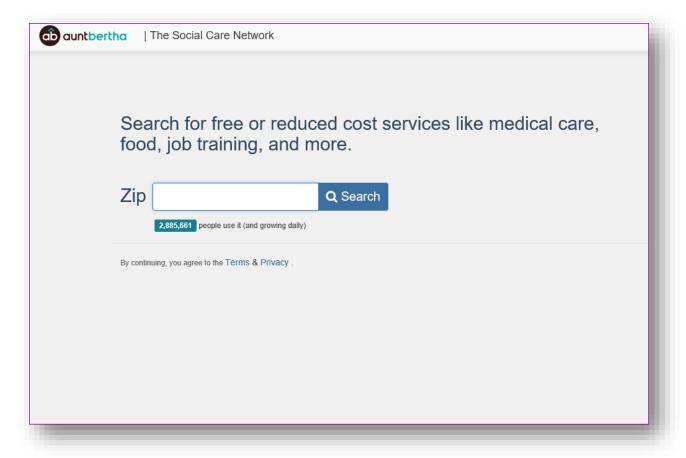
liveandworkwell.com





Resource – auntbertha | The Social Care Network

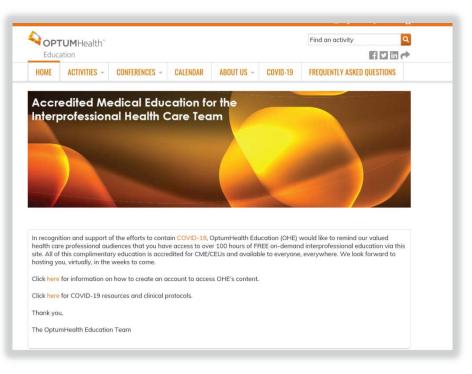
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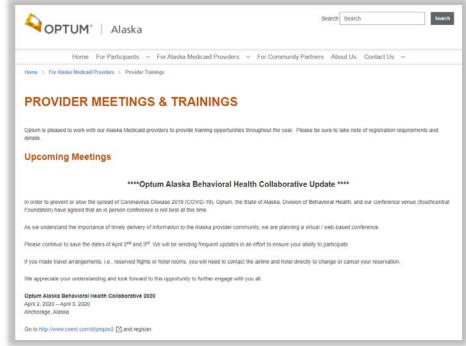


Additional Resources

OptumHealth Education



Technical Assistance





Q & A





References

- Morbidity and Mortality in People with Serious Mental Illness. National Association of State Mental Health Program Directors Parks, J MD; Svendsen, D MD; Singer, P MD; Foti, ME MD; Mauer, B MSW. October, 2006. Pages 1-87
- President's New Freedom Commission Report, 2003
 Coordinating care is the right thing to do and is an expected standard of practice
- 3. Collaboration between primary physicians and behavioral health clinicians makes a difference. UnitedHealthcare Network Bulletin. May, 2012. *Page 42*
- 4. No health without mental health. NIMH website: nimh.nih.gov/about/director/2011/no-health-without-mental-health.shtml



Thank you

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