**Coordination with Systems of Care**

**Facilitator Guide**

*This module has:*

* *Handouts (2):*
* *Common Acronyms used in ACCS*
* *Case Study Activity- Part 1*
* *Case Study Activity- Part 2*
* *Breakout activities (2):*
* *Case Study Activity- Part 1*
* *Case Study Activity- Part 2*
* ***Facilitator Note:*** *This module presents a significant amount of information – trainer should intersperse agency examples whenever possible to concretely illustrate concepts being presented.*

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| Slide 1 | **Slide 1: Title Slide**  *Introduce Trainers*  *Establish any ground rules for discussion* |
| Slide 2 | **Slide 2: Learning Objectives**  **Explain:**  During this module you will:   * Consider agencies and organizations that you will partner with * Apply partnership recommendations to case study * Identify an organization or program in your area to learn more about |
| Slide 3 | **Slide 3: Why Care Coordination and ACCS/ITT Partnership with Care Coordinating Entities is an Essential Function of ACCS Services**  **Explain:**   * ACCS and DMH are part of the overall healthcare delivery system. * People with serious mental health conditions have a lower life expectancy and poorer physical health outcomes than the general population.   + Evidence suggests that this discrepancy is driven by a combination of clinical risk factors, socioeconomic factors, and health system factors Rogers et. al (2016) ACCS is designed to address each of these factors. * Partnerships with other organizations and departments are necessary.   + ACCS/ITT cannot meet all a person’s served mental health and health care needs on its own, so integration and coordinating partnerships are required. |
| Slide 4 | **Slide 4: Activity**  **Ask:**  What are some examples of other organizations and state agencies that ACCS might partner with in your area? (E.g., …) |
| Slide 5 | **Slide 5: Overview of Social Determinants of Health**  **Let us look at why this coordination is important for our persons.**  **Explain:**  Delivery of quality behavioral health services are not as effective unless SAMSHA’s Eight Dimensions of Wellness:   1. Emotional/Mental; 2. Environmental; 3. Financial; 4. Intellectual; 5. Occupational; 6. Physical; 7. Social: and 8. Spiritual.   (SAMSHA <http://www.samhsa.gov/wellness-initiative>)  or the five domains of the social determinants of health are also assessed and addressed:   1. Economic Stability; 2. Education Access and Quality; 3. Healthcare Access and Quality; 4. Neighborhood and Built Environment; 5. Social and Community Context.   The Eight Dimensions of Wellness and the social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which all of us are born, grow up, work, live, and age. Improving these conditions require ACCS programs to partner or collaborate with other systems.  The SDH have an important influence on health inequities - the unfair and avoidable differences in health status seen within and between populations. |
| Slide 6 | **Slide 6: Discussion**  **Explain:**  Let us walk through each of the 5 domains of the social determinants of health and think about what systems or resources ACCS staff will need to partner with in serving our persons.  If you are new to ACCS, please feel free to jump in with what agency or resource comes to mind.  **Facilitator Note:**  *(Use the below examples to fill in the gaps if the trainees do not have examples)*   * Income and social protection (ex. Social Security Disability, Supplemental Social Security) * Education (ex. Massachusetts Rehabilitation Commission-MRC) * Unemployment and job insecurity (Ex. MRC; Career Centers; Unemployment Insurance & Resources) * Food insecurity * Housing, basic amenities and the environment * Early childhood development (Ex. Head Start Programs) * Social inclusion and non-discrimination (Ex. Community/Affinity Groups, Culture-specific mental health centers) * Access to affordable health services of decent quality.   **Explain:** Research shows that the social determinants can be more important than health care or lifestyle choices in influencing health.   * For instance, numerous studies suggest that SDH account for between 30-55% of health outcomes. * In addition, initial estimates show that the contribution of these non-health sectors have a greater impact on population health outcomes than contributions from the healthcare sector. * Therefore, we cannot work to improve or treat behavioral health conditions without also addressing the social determinants of health or the Eight Dimensions of Wellness. |
| Slide 7 | **Slide 7:** **Examples of Partnership Services to Coordinate & Integrate**  **Explain:**  Some examples of partnership services that require coordination and integration:   * Health care:   Persons enrolled in ACCS should have access to the full range of healthcare and service benefits; this requires care coordination.   * Harm Reduction:   Harm reduction is a proactive and evidence-based approach to reduce the negative personal and public health impacts of behavior associated with alcohol and other substance use at both the individual and community levels. Harm reduction services incorporate a spectrum of strategies that meet people “where they are” on their own terms, and may serve as a pathway to additional prevention, treatment, and recovery services. Harm reduction works by coordination and integrating services and addressing broader health and social issues through improved policies, programs, and practices. (SAMSHA, 2020).   * Employment:   Employment is a vital need for persons served receiving ACCS services. ACCS is expected to engage all individuals regarding their desire to work or return to school, and to connect them with educational and vocational services.   * Social engagement:   Social support and community engagement are also key factors in improving well-being and promoting recovery. Coordination by ACCS staff with community resources and services is essential (e.g., day programs, 12 step programs, organized social events and community connections). This includes resources for persons served from diverse cultural backgrounds who would benefit from being connected to specific cultural community groups (e.g., Casa Esperanza, Latino Counseling Center).  **Ask:**   * Do you have other examples of partnership services that may require coordination for ACCS persons served? |
| Slide 8 | **SLIDE 8:** **Why Integrated and Coordinated Care is Important for ACCS persons served**  **Explain:**  Integration breaks down silos and barriers and makes it easier for persons served to access the support they need.  Persons benefit when partners and collaborators in the public mental health service system coordinate and streamline their services and create seamless access to needed services and resources. |
| Slide 9 | **Slide 9: How to Integrate and Coordinate Care**  **Explain:**     * + Providers and clinicians need to be fully informed of all entities and resources in the Person’s service area and cultivate ongoing partnerships with these key collaborators.   + Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care. Multiple studies have identified effective communication as a key feature of collaboration.   + Persons served should have unfettered access to their own medical information and to clinical knowledge. Clinicians and persons served should communicate effectively and share information. |
| Slide 10 | **Slide 10: Breaking Down Barriers**  **Explain:**  Persons served face enough barriers to their recovery; integration reduces bureaucratic barriers so ACCS/ITT can concentrate on clinical and peer support.  Referrals, follow-up, approvals, signoffs, and issues of coverage and reimbursement can create barriers to timely clinical services and peer support.  Understanding the system, integrating services, and staying current on services, and mitigating barriers will:   * + - reduce wait times,     - alleviate the stress on the Person, and     - can prevent the worsening of mental health symptoms and     - improve safety. |
| Slide 11 | **Slide 11: Example: Housing First**  **Explain:**  ***Housing First*** is a good example of breaking down the barriers to services and is premised on the following principles:   * *Housing for ACCS Persons is not a reward for good behavior.* * *Housing is a right.* * *Everyone served by ACCS gets housing.* * *Persons need a place where treatment can be received in a stable, safe, and quiet environment****.*** * Homelessness is first and foremost a housing crisis and can be addressed through the provision of safe and affordable housing. * All people experiencing homelessness, regardless of their housing history and duration of homelessness, can achieve housing stability in permanent housing. Some may need very little support for a brief period, while others may need more intensive and long-term supports. * Everyone is “housing ready.” Sobriety, compliance in treatment, or even criminal histories are not necessary to succeed in housing. Rather, homelessness programs and housing providers must be “consumer ready.” * Many people experience improvements in quality of life, in the areas of health, mental health, substance use, and employment, because of achieving housing. * People experiencing homelessness have the right to self-determination and should be treated with dignity and respect. * The exact configuration of housing and services depends upon the needs and preferences of the person. |
| Slide 12 | **Slide 12: Example: Improving Physical Health**    When compared to the general population, adults with behavioral health conditions have an elevated risk of illness and death.  Care coordination provides referrals and connections to information and services related to medical care and other services as appropriate.  **Explain:**   * For example, adults with mental health and substance use conditions have a higher prevalence of chronic health conditions and co-morbidities (e.g., heart disease, high blood pressure, poor Diabetes management, and certain cancers). ([Katon, 2003](https://www.ncbi.nlm.nih.gov/books/NBK19833/)). * Obesity, poor nutrition, tobacco and substance use, and sedentary lifestyle are pervasive among persons with mental health conditions such as schizophrenia. * Many of these persons are exposed to lithium preparations, increasing odds of related illness like renal disease. * Persons with severe mental health conditions have much higher rates of HIV and hepatitis C than those found in the general population.   + Substance use, particularly injection use, carries an elevated risk of other serious illnesses. |
| Slide 13 | **Slide 13: Example: Improving Physical Health** *(continued)*  **Explain:**   * Ensuring that ACCS persons served have annual primary care and dental health visits is critical toward improving overall health. Integration with preventive healthcare can identify and address the modifiable risk factors before chronic conditions become too difficult and costly to treat. * Most persons served with mental health conditions receive psychiatric services in community mental health systems which offer medication, social and rehabilitative services, but are often isolated from delivery of medical care. * Adults with behavioral health conditions are more likely to visit their BH provider or community mental health agency than a primary care setting. * Some adults with BH conditions may not access preventative and routine healthcare and instead are more likely to access healthcare through Emergency Departments and contact with first responders and law enforcement.   These facts show the need for ACCS to build relationships with and integrate with other healthcare systems. |
| Slide 14 | **Slide 14: Creating Transitions**    ***Read slide:***  Care coordination identifies resources, offers guidance and support, and connects the person to the essential resources needed when making transitions.    **Explain:**  For instance, when a young adult is transitioning from DMH Child, Youth and Family services or other youth serving agencies (e.g., DCF, DYS, DDS), ACCS agencies participate in transition planning activities. Integrating services and the coordination of care during this transition helps to make the transition as seamless as possible for the person served. |
| Slide 15 | **Slide 15: Breakout Exercise - Case Study – Joe – Part 1**  ***(5-minute breakout + discussion)***  *Refer to Handout:*   * *Case Study Activity- Part 1*   ***Facilitator Instructions:***   * ***Explain:*** We are going to introduce you all to Joe and get familiar with his situation. We will come back to Joe later and discuss potential care coordination. * ***Read*** *out loud the scenario on the slide; leave slide up during discussion and refer to handout.* * ***Separate*** *into groups of 3 to 5 and* ***ask each group to pick a recorder & reporter for the later discussion.*** * ***Provide handout:*** *Case Study Activity- Part 1* * ***Instruct groups to discuss***:   + What are Joe’s strengths?   + In what life areas could Joe use assistance?   + Without getting into detail about how to coordinate services, determine what agencies might be important to get involved with Joe’s case? * ***Breakout for approximately 5 minutes*** *to discuss these questions.* * ***Bring the groups back together for discussion and review.*** *Ask them to hang onto their answers about external partner agencies because they will use this list again.* |
| Slide 16 | **Slide 16: Role of ACCS/ITT in Care Coordination for Persons Served**  **Explain:**  ACCS staff are required to collaborate with Care Coordination Entities and be knowledgeable about the systems of care, including systems of care for young adults, Long Term Services and Supports (LTSS) and service systems for older adults.   * Examples of care coordination are:   + DMH Case Managers;   + Behavioral Health Community Partners (co-located with the rest of the team);   + OneCare (a service for those getting both MassHealth and Medicare); or   + another form of care coordination offered through the person’s health care provider or health plan.   ***Facilitator Note:***  *Mention these care coordination entities are co-located with ACCS programs in some agencies. Staff should enquire about what entities exist within their agency.* |
| Slide 17 | **Slide 17: Monitoring**  **Explain:**    ACCS Integrated Treatment Teams (ITT)/Intensive GLEs are responsible for:   * monitoring both the behavioral and physical health statuses of persons served * must have 24/7/365 clinical on-call availability to respond to urgent needs.   These Teams/Intensive GLEs are required to report changes in a person’s health status, including medication and treatment utilization, to the applicable Care Coordination Entities:   * + When changes in a person’s health status or conditions require immediate attention, the applicable Team/Intensive GLE communicates directly with the Persons’ health care providers and seeks alternative resources as indicated (e.g., Primary care Physician office visit, Emergency Department).   **During key times of transition**:  ACCS staff must work with persons served, Care Coordination Entities, and other relevant entities (MRC, hospitals, police, courts, etc.) to address the safety of the Persons, provide Critical Time Interventions, address employment and housing, and adjust service delivery as necessary and communicate changes to Treatment Plans.  ***Facilitator Notes:***  *A few key transitions are listed on the slide.* *Ask* “What are other examples of key transitions?” *Examples for facilitator if responses from group are limited:*   * + - Hospitalization     - Moving from a Supervised GLE to an independent apartment     - Preparing to travel     - Reconnecting with family; starting or ending an important relationship; experiencing loss through death or divorce. |
| Slide 18 | **Slide 18: Example of Other Relevant Coordination with Partner**  **Entities**    **Explain:**  Employment, education, and vocational training/resources are also critically important to lessening mental health symptoms, strengthening self-reliance and confidence, and are key services in mental healthcare delivery systems.  **Massachusetts Rehabilitation Commission (MRC)** is a key partner and coordinator with ACCS services.   * MRC is the state agency in Massachusetts dedicated to employment for people with disabilities.   + MRC provides assistance for persons to go to school, find jobs, consider career goals, determine their interests, manage social security benefits, and learn/practice skills necessary for work or school. * In ACCS, MRC provides a **Vocational Rehabilitation Counselor (VRC)** to each ACCS program.   + ACCS staff should know and refer-to this counselor when a person expresses interest or ambivalence about work.   + The Counselor engages all individuals who are interested in or unsure about work or school (no one has to be “job ready”). MRC services assist with establishing career goals.   + If the person wants to enroll with MRC, the Counselor determines the person eligible and arranges for the services the person needs to reach her/his career-goals.   ***Facilitator Note:***  *DMH considers the VRC (counselor) a member of the Integrated Treatment Team; when both ACCS and the VRC are serving the same person, ACCS staff should communicate openly and frequently with the VRC whenever there is a change that could impact that person’s ability to pursue his/her career-goal.* |
| Slide 19 | **Slide 19: Breakout Activity – Case Study – Joe -Part 2**  ***(10-minute breakout + discussion)***  *Refer to Handout:*   * *Case Study Activity- Part 2*   ***Facilitator Instructions:***   * ***Explain:*** We are returning to Joe to discuss care coordination. * ***Leave*** *participants in same groups with the same recorder and reporter.* * ***Provide handout:*** *Case Study Activity- Part 2, mention that the scenario and questions are found on this handout*. * ***Instruct groups to discuss***: * How will you coordinate Joe’s care, and with what external partners/other systems? * Where would you start in this coordination? * How do you think the integrated team could approach work with Joe to re-engage in services? * ***Breakout for approximately 10 minutes*** to discuss these questions. * ***Bring the groups back for discussion and review.***   ***Facilitator Note:***  *Optional: Facilitator may want to provide an example of their clinical approach to this scenario as well as identify collaborating service partners/systems and community resources that you would engage with to serve this person.* |
| Slide 20 | **Slide 20: Closing Activity**  **Ask:**  Identify one organization or agency discussed to reach out to on your own toward building a community connection. |
| Slide 21 | **Slide 21: References** |