

# Transforming Care Coordination at Alliance

The coordination of care is central to Alliance's whole person approach to creating more satisfying lives for the people we serve. In 2017 we began transforming the way we think about and provide care coordination, moving in a direction that aligns squarely with Alliance Complete Care, employing standard interventions and multidisciplinary care teams working alongside providers to address the broad range of an individual's health needs.

Meet Jiva, the new cutting-edge Alliance care management tool. Jiva works with our other data analytics platforms to help us identify individuals in need of care coordination prior to a crisis event, and to more effectively prioritize populations of people who are at high risk for poor health outcomes. Data in Jiva automatically recommends care plans based on common problems encountered by these populations and generates goals and interventions to help care coordinators engage individuals in appropriate treatment.

We're using motivational interviewing to encourage people to become linked with a provider, and supporting them in self-directing their own care. Once that link is made, Jiva allows us to transition an individual's care plan to the provider, and to share information efficiently between the provider and Alliance going forward.

## Complex Integrated Care Team

The Complex Integrated Care team is a collaboration between MH/SUD and I/DD care coordination to address the needs of individuals who are in crisis or need higher levels of support to engage with providers. The team of licensed behavioral health clinicians and care coordinators provided consultation and short-term care coordination to 80 people in 2017, and facilitated proactive clinical case consultations with Alliance's medical team as part of the Disability Rights Complex Children's Settlement. Using data analytics and cross-departmental communication, the team identifies children and addresses the needs of children at greatest risk of entering institutional levels of care.

The Complex Integrated Care team is also piloting a new model called Care Teams. Instead of a single care coordinator working to support an individual with all aspects of their care, the Complex Integrated Care team, alongside a registered nurse and others, work together using a cross-disciplinary approach to customize the care coordination approach to match the needs of the person served.

## Using Predictive Analytics

We have continued our pioneering work of applying predictive analytics to behavioral healthcare in North Carolina. In a partnership with Duke, we are using data analytics to identify young people who may need early intervention with community-based mental health services to help them avoid the need for crisis services. Our Cumberland County Care Coordination team began participating in the predictive analytics project in November 2017. Along with identifying gaps in care, this has given us an opportunity to track children's progress from higher levels of care. Working with this project helps us to focus on a set of kids who may require linkage to primary health care, behavioral health, and/or school intervention based on case review.

## National Recognition for the I/DD Team

Thirty I/DD Care Coordinators received the prestigious National Academy of Certified Care Managers certification in 2017, demonstrating competency in key work areas including assessment of client strengths, needs and preferences, writing goals and implementing a plan of care, and managing and monitoring services and ongoing care needs.

Other members of the team are nationally-certified or working towards certification as Brain Injury Specialists and Dual Diagnosis Specialists.

## Welcome Home

Alliance unveiled a fully furnished apartment outfitted with special monitoring technology that allows men and women with an intellectual/developmental disability to try out living for up to two weeks in a safe, secure home at no cost, one of the first of its kind in the country. This way they can determine if this service can eliminate the need for overnight staff and ultimately, help them to live more independently.

Remote monitoring also reduces the total cost of an individual's care, using wireless sensors, two-way communication devices, and professional remote staff to address their needs and monitor their wellbeing during unstaffed hours. If a resident does have the need for in-person staffing support from time to time, they can learn to use the technology to call a trained staff member to come to the apartment to assist them.

## Living and Thriving in the Community

The 1999 U.S. Supreme Court ruling called the Olmstead Decision mandated that people with intellectual disabilities have the right to live in the community rather than in institutions. The Alliance Olmstead Team of qualified I/DD professionals focused its efforts on identifying individuals in institutional settings who are ready to transition to life in their communities. The team helps design service plans and supports to meet the unique needs of each person, allowing them to create a self-determined life of their choice, integrated in the community at a significantly less cost.

Alliance is also working to develop an alternative service definition to serve individuals with the highest and most intensive behavioral support needs who want to live in the community. This new service will create a gradual step down from State-operated Intermediate Care Facilities (ICFs) to community-based options, and will offer short-term crisis stabilization for those in need.



## A parent shares about his son's experience with the Remote Monitoring Home:

The Alliance apartment allowed Joshua to truly experience what living on his own will be like. The monitoring equipment allowed for this experience to occur in a safe and comfortable setting, and at a pace that was comfortable to Joshua. Overall, the experience was great for everyone. It really opened our eyes to the fact that Joshua is happier living in his own space. We're so glad that our case manager suggested this apartment to us and that Alliance offers this solution.

15 people with an intellectual/developmental disability transitioned from institutional settings to living arrangements in their communities in 2017, allowing them to live more self-directed lives and resulting in anticipated annual savings of

# \$1.2 MILLION

# 6500 PEOPLE IN 2017

The Alliance MH/SUD Care Coordination team worked closely with over 6500 people in 2017.

# 2000 OTHERS

supported by the I/DD Care Coordination Team.

## Learn More

ABOUT ALLIANCE'S INNOVATIVE SCHOOL-BASED CARE COORDINATION PROGRAM ON PAGE 11.