Spokane Crisis Collaborative

9/20/19

Spokane Health District
Recovery Oriented System of Care

CHPW’s organizational philosophy and framework that involves collaboration and partnership with families, members, behavioral health providers, community health centers and cross system partners for the purpose of improving services and access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for members and families.
Whole Person Care and Peer Support

• Peer support and peer workforce is an integral part of the whole person care model.

• CHPW built and implemented trainings for all internal staff in the Guiding Principles of Recovery and peer support services as part of our overall staff training plan.

• We are committed to embedding within the overall integrated care delivery model the fundamental components of recovery that embraces the recognition that mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.
Peer Services Overview

Peer Specialists are now the fastest growing workforce in Behavioral Health nationwide.

- First workforce to emerge after national shift in behavioral health to recovery vision
- Some 15,000 peer specialists trained over last 15 years
- State certification programs are growing for youth, family members, wellness coaches and addiction recovery coaches

With the integration of peer services in Managed Care Organizations, Managed Care Organizations are able to:

- Decrease use of crisis and emergency services
- Provide more “face time” with client
- Facilitate similar or better outcomes at lower cost
- Bring different insights, attitudes and motivations to treatment encounters
- Reduce depression and negative health behaviors
- Promote mastery of self-care behaviors.
- Support adherence to medication, diet and exercise
- Escalate social support (linked to decreased mortality and morbidity)
- Support chronic disease management
A peer provider (e.g., certified peer specialist, peer support specialist, recovery coach) is a person who uses his or her lived experience of recovery from mental illness and/or addiction, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency.

By focusing on resiliency and whole health, peer providers can activate self-management of prevention factors, such as stress management, to promote health and longevity.
Our Wellness & Recovery Coordinator engages members daily to assist them in initiating and maintaining engagement in the recovery process and reduce the likelihood of relapse. We also address whole health by:

- Advocating for people in recovery
- Sharing resources and building skills
- Building community and relationships
- Mentoring and setting goals

In addition to working with members, our Wellness & Recovery Coordinator educates and informs CHPW staff, team members, and various workgroups on best practices for Integrated Behavioral Health Peer Services.
Transitions of Care

Transitions of care (TOC) provides proactive support to members as they move from one level of care to another. The team is staffed by medical and behavioral nurses, pharmacists, and social workers.

Program Functions:

- Provide referrals to case management and other community-based programs and services as appropriate
- Ensure coordination of services and prevent unnecessary readmissions or complications
- Support transfers to rehab, skilled, and long-term care
- Ensure home health and DME are in place
- Assist members/caregivers in understanding care plans

Diagram:

- Post DC call team:
  - Outreach within 3 days to any member who has been in a facility
  - Follows up on discharge orders, makes sure follow-up appointments are made and prescriptions are picked up, and that the member doesn’t have any unmet needs.
  - Care coordination occurs when needed.

- Difficult to DC team:
  - Works with the inpatient facility and the member to assist with facilitating the discharge when the member is medically stable to go to a lower level of care but there is a barrier to that discharge.

- Jail Transitions team:
  - Coordinates with the jail and the inmate who is close to release, or has recently been released from jail.
  - The TOC staff assists with coordinating transportation, provider appointments, or other needs either independently or with other Care Management teams.
Community Linkages

CHPW’s Community Linkages (CL) Program addresses social determinants that have an impact on member health.

Program Functions:

• This team of community-based workers provides support to members, providers and caregivers.
• CL provides Care Coordination: transportation, housing, food, medical appointments, caregivers and more.
• CL staff are embedded into the community and identify regional resources, connect the member to those services, and ensure continued support and access.
Case Management

CHPW’s case management (CM) programs work with members, caregivers and care teams to develop and manage a plan of care that ensures access to quality care and the social support members need. These programs address the needs of our most complex and vulnerable members.

Program Functions:

- Provide referrals to community-based programs and services as appropriate
- Ensure coordination of services and prevent unnecessary readmissions, complications or ER visits or complications
- Assist members/caregivers in understanding their plan of care
- Supporting independence, self-determination and care and working on what they deem the focus/goal should be.
- Understand members needs, meeting them where they are and support them in the appropriate program (medical, social, behavioral, or integrated across these domains).
- Encourage establishing and support adherence to appointments and medications
**Program Functions:**

- Coordinate communication for patient when admitted to, or leaving, the state hospital
- Participate in weekly discharge planning meetings for patients at the state hospital that are deemed ‘clinically ready to discharge’
- Engage in aftercare process by reviewing with the patient and/or community partner the patient’s presence in mental health, SUD, medical, and other appointments following discharge from the state hospital
- Regularly coordinate with community providers to assess the member’s progress, identify barriers, and work collaboratively to prevent readmission to the hospital and ensure member’s success in the community
- There are 2 hospital liaisons: One who oversees the Spokane & Greater Columbia regions; the other liaison oversees North Sound and SWWA regions
- Works closely with Case Management and Community Linkages as seen appropriate
Enrollment in services

▪ Free to the member
▪ Opt in/out program at member’s discretion
▪ Built around the needs of the member and the service(s) requested
▪ Can support other community partners as part of the larger care team
▪ Referrals can come from variety of sources:
  ○ Community-based organizations
  ○ Providers
  ○ Hospital discharge planner/CM
  ○ Member, Family member or Caregiver
  ○ Population Analytics/Risk Stratification
  ○ Customer Service – to support members calling in with questions
  ○ Health Care Authority directly
  ○ Transitions of Care Team
Community Linkages CHW  
Case Manager  
Eastern State Hospital & Civil Commitment Liaison

- **Goal:**  
  - Support community partners and CHPW Case Managers to improve the overall wellness of our members

- **Focus:**  
  - Increase presence in community  
  - Increase our ability to connect with members that are hard to reach or high utilizers of the care systems  
  - Address gaps that occurs with telephonic case management  
  - Identify gatekeepers, increase collaboration and build partnerships with local partners  
  - Identifying gaps in community  
  - Leverage community relationships to improve the knowledge for our larger Care Management teams
Program specific staff can be reached by phone and email:

- Case Management: 866-418-7004 or Case.Management@chpw.org
- SNP Case Management: 866-418-7005 or Case.Management@chpw.org
- Community Linkages: 866-418-7006 or CareCoordCommLinkage@chpw.org
- Transitions of Care: 866-418-7009 or TOCRequests@chpw.org

Spokane Regional Staff:

- Case Manager: Ashley Kleinjans, BSN
  - 206-731-7724 or Ashley.Kleinjans@chpw.org
- Community Linkages: Alli Lance
  - 206-731-7703 or Alli.Lance@chpw.org
- Eastern State Hospital & Civil Commitment Liaison: Melissa Guerra-Rushing, LMFT, CDP
  - 206-652-7471 or Melissa.GuerraRushing@chpw.org