



Promoting Wellness and Recovery

John R. Kasich, Governor
Tracy J. Plouck, Director

Promising Innovations in OHIO: Community Options & Recovery Requires a Community



Mission:

To provide leadership and assistance with the displacement (transition) and deterrence (diversion) of individuals diagnosed with mental illness from nursing facilities (NF's) into the most integrated setting appropriate to their needs.

- A PASRR program
- Proactive vs. regulatory
- Focuses on individuals with the most complex & challenging profiles
- Builds alliances with key State & community stakeholders

Core Values

- Recovery / Resiliency / Strengths based
- Person Centered
 - Individualized Planning
 - Individual Voice & Choice
- Interdisciplinary team (IDT)
 - **Community Options role** is leading through education, coaching, convening, empowering & consulting when barriers to transition are encountered
- Continuous Quality Improvement: Outcomes focused / Data Driven
- Integration of Physical & Behavioral Health



Process Flow

Stakeholders Identified/contacted

Guardian:

Discuss needs, educate on PASRR determination, resources etc., secure approval to proceed; identify family, friends & other natural supports

County Mental Health Authority:

Inform that resident is returning to community; engage participation; empower to engage community providers

State MFP program:

Check on status of application; talk to assigned contractor; empower to coordinate stakeholder group

Nursing Home:

Consult on status of discharge planning; identify barriers; suggest solutions; request team meeting

Multiple Referral Sources

Individual/Guardian
Nursing Facility
Appeals officer
Reviewers
State Disability Advocacy Group
Constituency
Technical assistance call



Referral & Consultation

COMMUNITY
OPTIONS

Follow-up & Additional Activities

- Track recidivism & placement stability at 30, 90, 180 & 360 days
- Collaborate with state & county entities to develop innovative services that
 - Meet the individual's needs
 - Strengthen the County's Mental Health toolkit
 - Can serve as models for other counties
- Develop models for proactive, effective discharge planning in Nursing Homes
- Collect, analyze & report on needs, trends and outcomes that can inform the process of rebalancing long-term care



Team Meeting

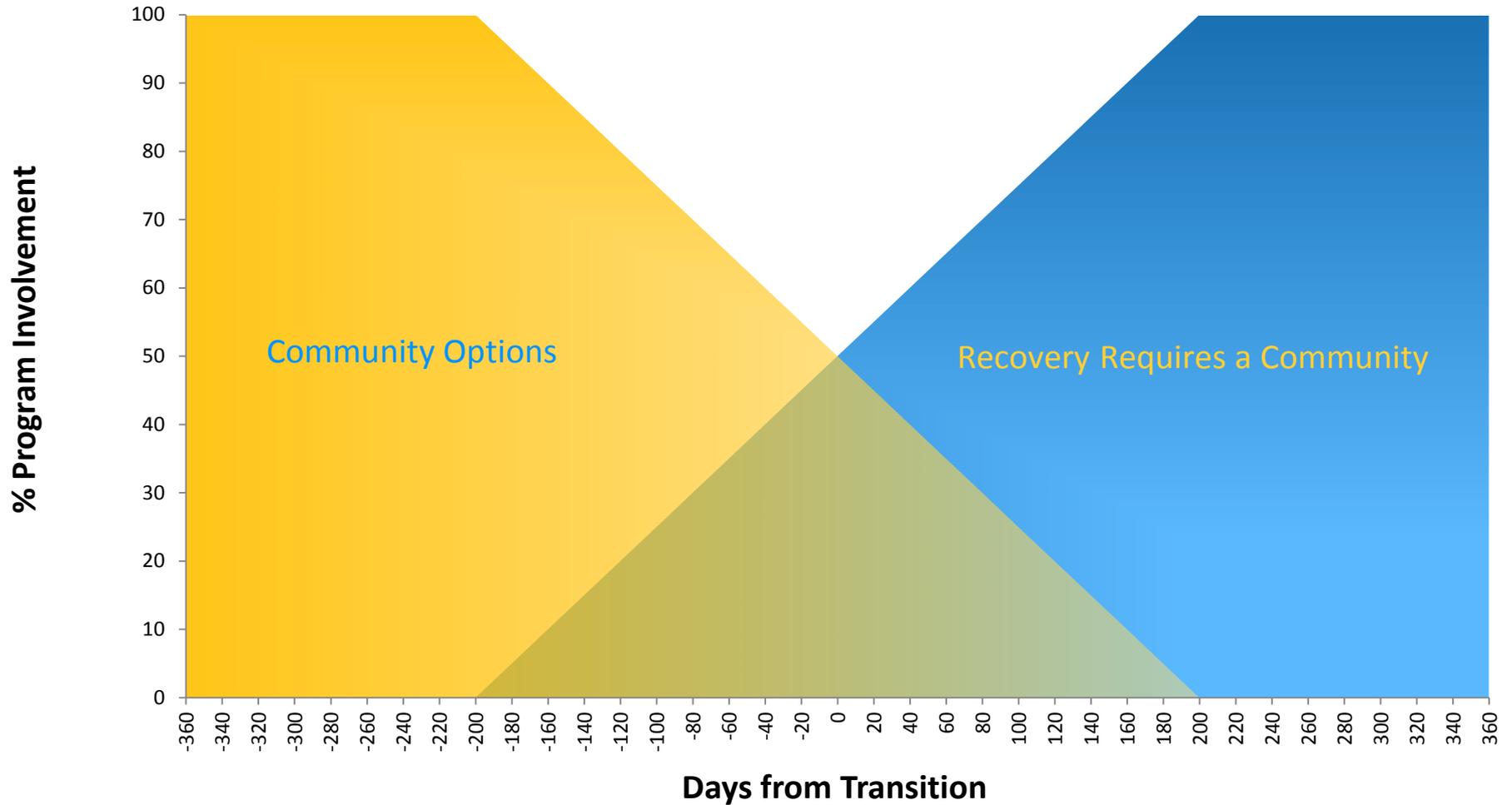
- **RESIDENT PARTICIPATES;** asked to voice their desires; discussion of barriers; assignment of tasks for participants, including resident; follow-up meeting set.
- Team meets periodically (no less than every 2 months) to review progress & adjust plan
- New team members added/drop out as needed

Target Population

- NF residents who were issued an adverse determination and continue to reside in a NF following expiration of their approval period and the exercise of their appeal rights
- NF residents who are represented by the state disability rights advocacy group
- NF residents who experience difficulty with being linked to needed services

Community Options to Recovery Requires a Community

Community Options and Recovery Requires a Community Proportion of Coverage for Transition Cases



What Is Recovery Requires a Community?

- An OhioMHAS budget initiative.
- Provide financial assistance to individuals with mental illness to transition and remain stable in community after an institutional stay.
- Works closely with the Ohio Department of Medicaid's HOME Choice program.
- Helps to enforce the Olmstead decision, reduce service delivery costs to the state and other systems, and increases community linkage while reducing institutional placements.

Referrals

- Coordination between PASRR and Recovery
- Coordination between MFP and Recovery
 - Individuals “Applied, Approved, Not Enrolled”
 - Section Q
 - Individuals in immediate danger of returning to a facility
- Coordination between providers and Recovery

Not an exhaustive list!

Process: Individuals

- Release of Information
- Application
 - The “but-for” item
 - Due diligence and best practice
 - Incorporates the largest and smallest needs, including housing
- Approval and Funding
- Recertification

Process: System Level

- Real-Time data from individuals
- Aggregate and disseminate with recommendation and funding.
- Emphasize creative, evidence based solutions that are cost-effective.
- May impact local, state, or federal level.

Funding

- Analyzed 900 individuals who were in NFs with SPMI
 - Looked at Medicaid claims data 365 days before and after transition (included MFP spending post-transition)
 - Takes a portion of cost savings from NF transition and reinvests it into community supports
- 500 individuals FY 14, 700 individual FY 15

Presenter Contact Information

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