## NEED MORE INFORMATION ABOUT CARE COORDINATION?

Check out our website at: www.georgiacollaborative.com or call us toll-free at: **855-606-2725**.

## WHAT IS THE GEORGIA COLLABORATIVE ASO?

Together with the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), the Georgia Collaborative Administrative Service Organization (ASO) is a partnership between Beacon Health Options, Behavioral Health Link (BHL), and the Delmarva Foundation.

**OUR MISSION** is to support DBHDD in its mission to lead an accountable and effective continuum of care to support Individuals with behavioral health challenges and intellectual and developmental disabilities in a dynamic healthcare environment.

**OUR VISION** is easy access to high-quality care that leads to a life of sustained recovery and independence for the Individuals we serve.

## HOW CAN I MAKE A REFERRAL?

To refer an individual for Care Coordination, please contact us at **855-606-2725**.


**Website:**

www.georgiacollaborative.com

**Care Coordination email:**

GACARE@beaconhealthoptions.com

**Care Coordination fax:**

855-858-1966

**Care Coordination phone:**

855-606-2725

The Georgia Collaborative ASO
P.O. Box 56324
Atlanta, Georgia 30343

# Care Coordination: Recovery & Advocacy

# Connecting the Unconnected

## WHAT IS CARE COORDINATION?

The Georgia Collaborative's Care Coordination Program is a community-based program designed to support Individuals with behavioral health challenges and co-occurring developmental disabilities. The goal of the Care Coordination program is to ***Connect the Unconnected***, children and adults who:

- Are supported by DBHDD providers
- Have complex care needs or who are in critical transition periods

Being in the community allows the Care Coordination Program to support an Individual in reaching their recovery goals. The program:

- Is optional and elected by the Individual or their guardian
- Provides supports at no charge to the Individual
- Supports care integration

### Community Transition Specialists

The Community Transition Specialists (CTS) provide outreach and discharge appointment coordination to support an Individual's transition from an acute level of care to a community-based provider. Community Transition Specialists are either Certified Peer Specialists (CPS) or Certified Addiction Recovery Empowerment Specialists (CARES).

The role of the CTS is to:

- Utilize their lived experience to facilitate recovery and resiliency
- Support Individuals with their community provider for aftercare appointment(s) within seven (7) days or 30 days of discharge
- Identify barriers for provider aftercare engagement and community tenure (e.g. transportation, child care, location, provider choice, access to medication)
- Identify Individuals who qualify for Specialized Care Coordination

### Specialized Care Coordinators

Specialized Care Coordinators (SCC) are licensed behavioral health clinicians who:

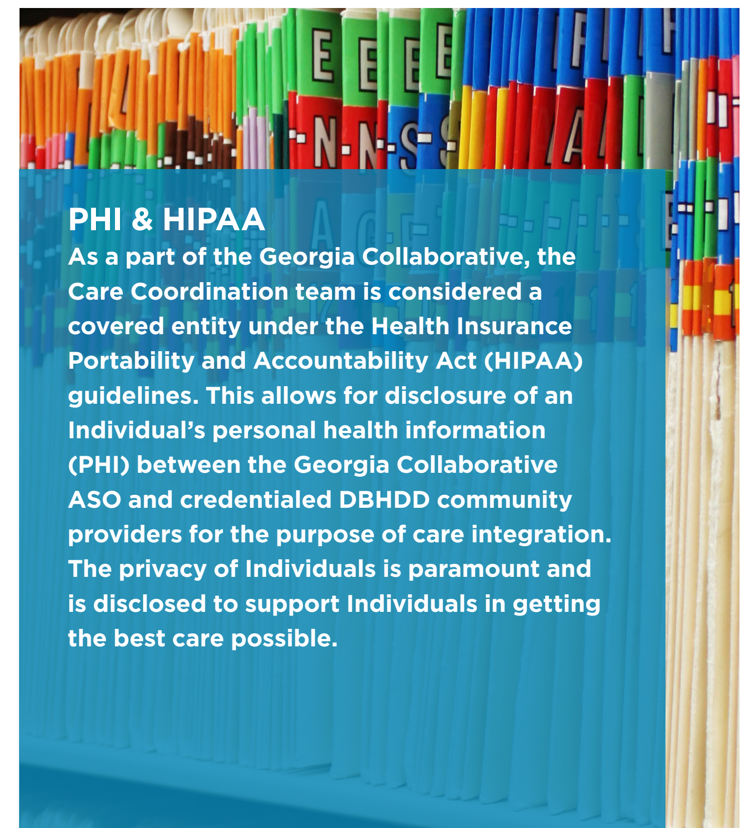
- Provide clinical oversight for Individuals with complex clinical histories and/or multiple hospitalizations
- Outreach and engage the Individual's provider(s), support network, and community-based services in order to best support the entire system of care
- Routinely conduct outreach to support the Individual's treatment and resolve service barriers
- Partner with providers to create innovative ways to maximize an Individual's community tenure
- Provide access or knowledge of critical services that may be missing in the continuum

### Certified Peer Specialists

Certified Peer Specialists are Individuals who have lived experience with a mental illness and/or a substance use challenge which allows them to connect with Individuals, showing by example that long-term recovery is attainable. CPS are trained in principles of recovery and resiliency, wrap-around services, and traditional peer support.

The role of the CPS is to work with the SCC to:

- Assist Individuals with identifying barriers to maintaining community tenure and finding services and/or supports to move through those barriers
- Connect Individuals to community resources and support by identifying both traditional and non-traditional resources based on Individual preferences
- Assist with applications for resources and services
- Encourage Individuals to focus on their strengths and abilities for long range health and wellness
- Coach Individuals about self-care and self-advocacy
- Support Individuals and their support network for continued treatment engagement
- Educate and assist in developing a Whole Health Action Management (WHAM) plan and a Wellness Recovery Action Plan (WRAP)



### PHI & HIPAA

**As a part of the Georgia Collaborative, the Care Coordination team is considered a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) guidelines. This allows for disclosure of an Individual's personal health information (PHI) between the Georgia Collaborative ASO and credentialed DBHDD community providers for the purpose of care integration. The privacy of Individuals is paramount and is disclosed to support Individuals in getting the best care possible.**