Transition Age Youth: A Managed Care Approach

Georgia Families 360°

A Collaboration Between Georgia Medicaid and Managed Care

Amerigroup Community Care

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Georgia Department of Community Health

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Georgia Families 360°

Georgia's managed care program for approximately 27,000 children, youth, and young adults in foster care, children and youth receiving adoption assistance, and select youth involved in the juvenile justice system. Launched on March 3, 2014. Amerigroup Community Care of Georgia, exclusively provides health care coverage for this population.

Georgia Families 360° program goals are to:

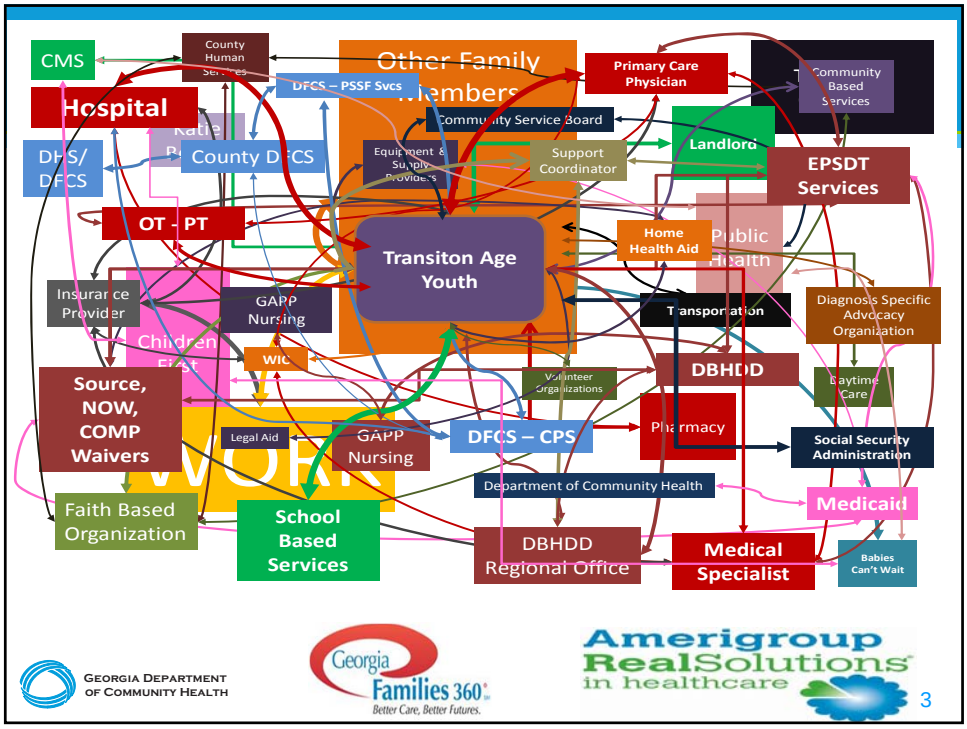
- ✓ Improve access to health care services, particularly for physical and behavioral health services covered by the Medicaid program.
- ✓ Increase continuity of care, including when members transition in and out of foster care and to the adult care system.
- ✓ Enhance health outcomes by providing additional care coordination, and improved physical and behavioral health oversight.

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CMS
County Human Services
Other Family Members
Primary Care Physician
Community Based Services
Hospital
DFCS – PSSF Svcs
Community Service Board
DHS/ DFCS
County DFCS
Equipment & Supply Providers
Support Coordinator
Landlord
EPSDT Services
OT - PT
Transiton Age Youth
Home Health Aid
Public Health
Insurance Provider
GAPP Nursing
Transportation
Diagnosis Specific Advocacy Organization
Children First
WIC
DBHDD
Volunteer Organizations
Daytime Care
Source, NOW, COMP Waivers
Legal Aid
GAPP Nursing
DFCS – CPS
Pharmacy
Social Security Administration
Department of Community Health
Medicaid
Faith Based Organization
School Based Services
DBHDD Regional Office
Medical Specialist
Babies Can't Wait
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GF 360° Key Model Features
Coordinated System of Care Culture and Wrap Around Principles
Advisory Groups and Community Engagement
Specialty and Non-traditional Provider Network
Medical and Dental Home
Care Coordination with Subpopulation Specialty Programs
Pioneering Unique Population Innovation
Medication Management Program
Training and Community Outreach
Peer Support and Ombudsman
Specialized Call /Navigation Center
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Value of Care Coordination

- Key bridge to health using a primary point of contact for service coordination; each member is assigned to a care coordination team
- Comprehensive care coordination; coordination of physical, behavioral, functional, and social support needs with an emphasis on voice and choice to the extent members choose.
- Comprehensive ongoing needs assessment and person-centered care planning
- Management of chronic conditions and seamless care transition across settings, leading to avoidance of the need for potentially more expensive health services.
- On the ground and face-to-face visits with minimum contact requirements
- Promotion of independence and quality of life

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Specialized Care Coordination Model

Key components that differentiate this model from traditional models of care



Transition To Adulthood

- Objective
  - Members gain self-sufficiency
  - Members assume primary responsibility for managing all aspects of their overall wellbeing
- Population
  - Existing Members
  - Potential Members, currently unknown to GF360°
  - Process begins at age 14 in collaboration with Child Welfare Transition Age Youth Teams
  - Intensive focus for 17 to 25 year olds

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Self Sufficiency Matrix

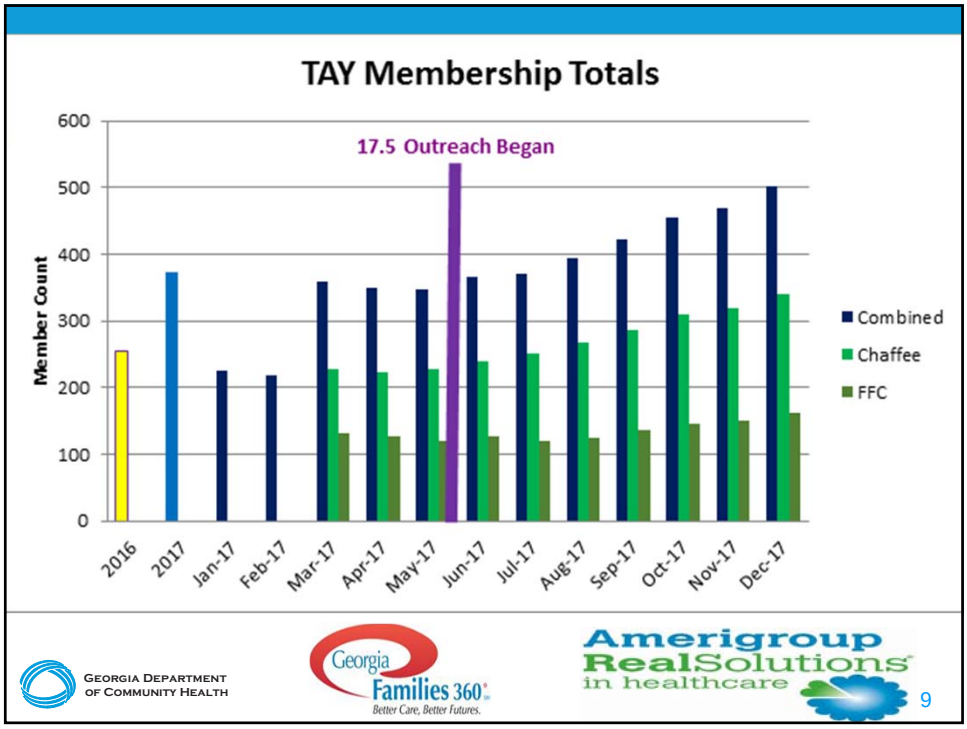
- Transportation/Mobility
- Legal and Criminal History
- Non-criminal Legal Issues
- Domestic Violence History
- Child Welfare Status
- Parenting Skills
- Community Involvement
- Welfare/TANF Status
- Food
- Job training/Vocational Rehab

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Transition to Adult Healthcare

- TAY 2018 Workgroup
- Planning for Adult Healthcare, Georgia Department of Public Health (DPH)

  -A guide for parents and caregivers
- Transitioning Youth from Pediatric to Adult care, DPH

  -Taking Charge of My Healthcare

  -A guide for young adults

  -Ages 17-25. At age 17 ½, work on how to maintain your Medicaid
- Got Transition 6 Core Elements

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Relationships and Mentoring

Young adults exiting foster care need emotional support as they navigate the transition to independent adulthood. Without the social and emotional skills to manage the stresses of emerging adulthood, youth often struggle to maximize the medical, housing, education, and employment resources that are available to them.

Adult mentors who stay connected with foster care youth as they transition to adulthood provide the emotional supports necessary for youth to achieve positive adult outcomes. Mentorships formed through informal connections (within the youth's life) or through formal programs will increase the likelihood of successful transitions to adulthood. Lifelong connections with positive adults are critical to success as youth begin to make decisions that affect their future







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For Additional Information

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спасибо
dank je
thank you
gracias
tapadh leat
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mauruuru
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go raibh maith agat
obrigado
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