Care Coordination Plan FY 2021-22

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Section 1: Care Coordination Plan FY21-22

Overview

The purpose of this document is to provide direction for the implementation, administration, and management of Care Coordination activities. Included is an overview of Care Coordination, definition of priority populations, and delineation of responsibilities for both the Managing Entity, Central Florida Behavioral Health Network (CFBHN) and contracted service providers within the network.

Definitions

Section 394.4573(1)(a), F.S., defines Care Coordination to mean "the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individuals who are not yet effectively connected with services to ensure service linkage. Examples of care coordination activities include development of referral agreements, shared protocols, and information exchange procedures. The purpose of care coordination is to enhance the delivery of treatment services and recovery supports and to improve outcomes among priority populations."

Purpose and Goals

Care Coordination serves to assist individuals who are not effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care. This includes services and supports that affect a person's overall well-being, such as primary physical health care, housing, and social connectedness. Care Coordination connects systems including behavioral health, primary care, peer and natural supports, housing, education, vocation, and the justice systems. Care Coordination is time-limited with a heavy concentration on educating and empowering the person served. Care Coordination provides a single point of contact until a person is adequately connected to the care and services that best meet their needs.

Care Coordination is a collaborative effort to efficiently target treatment resources to identified needs, effectively manage and reduce risk, and promote accurate diagnosis and treatment using both consistent and shared information. It is a process that includes coordination at the funder level through data monitoring, information sharing across regional and system partners, partnerships with community stakeholders (i.e. housing providers, judiciary, primary care, etc.), and purchase of needed services and supports.

At the provider level, this includes a thorough assessment of needs inclusive of a level of care determination, and active linkage and communication with existing and newly identified services and supports. Care Coordination services also facilitate transition between providers, episodes of care, across lifespan changes, and across trajectory of illness.

At the individual level Care Coordination incorporates shared decision making in planning and service determinations by emphasizing self-management. Individuals served by Care Coordination, and their family members, should be the driver of goals and be recognized as the experts on their needs and/or what works for them. Engagement of the individual is essential when identifying and addressing available social supports and identified basic needs and resources such as applying for insurance/disability benefits, housing, food, and work programs.

Care Coordination is not intended to replace Case Management. Based on an individual's needs and wishes, case management may be a service identified in the care plan, which serves to identify which services would best meet the individual's needs. Care Coordination services are not allowed while the individual is receiving Case Management services per Guidance Document 4. Individuals receiving Care Coordination services, once successfully linked with a case manager, will be transitioned to receiving services via their case manager.

Effective Care Coordination must be flexible and respond to the needs of the communities and individuals served by incorporating new clinical research and meeting evolving federal and state requirements. Changes to the Care Coordination processes are driven through the collection and analysis of data. The data used to monitor and inform the Care Coordination processes come from a variety of sources and include treatment outcomes, cost of care, QA/QI monitoring reviews, satisfaction survey information, risk management/incident reporting and information from individuals served, and other stakeholders, including funders. Using data as the catalyst for change transforms the system from reactive to proactive by analyzing data trends, identifying opportunities for improvement and initiating quality improvement activities.

Short-term Goals of Implementing Care Coordination

1. Improve transitions from acute and restrictive to less restrictive community-based levels of care
- Increase post admissions contact to support effective transition and bridge to the next level of care
- Provide frequent 30-day contact (phone, visits, and electronic media) for identified high need/high utilizers daily to 3 times a week.
- Links with continuum of care/natural supports needed to facilitate (medical, substance use/mental health, legal, case management, vocational)

2. Increase diversions from state mental health treatment facility admissions
- Ensure that appropriate referrals are made to the FACT (Florida Assertive Community Treatment) team and insure a FACT screening occurs prior to SMHTF (State Mental Health Treatment Facility) admission
- Use the CFBHN State Hospital Waitlist Notification (disseminated once a month to each receiving facility) to prompt referral of those individuals that are stable to CFBHN residential program(s) options throughout local communities
- Work to implement consistent discharge protocols for civil/forensic individuals returning to the community from the SMHTF

3. Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness
- Work with the provider to implement consistent discharge protocols for civil/forensic individuals returning to the community.
- CFBHN Utilization/Care Managers work closely with acute care providers to assure discharge plans address spectrum of needs (medical, substance use/mental health, legal, case management, vocational)

- Serving the entire fourteen-county area, the CFBHN Supportive Housing Specialist is promoting use of the SOAR process with providers and engaging with community homeless coalitions

4. Focus on an individual's wellness and community integration
    - Provide Recovery Peer Specialist support and certification training, support use of ROSC(Recovery Oriented System of Care) and Wraparound training for consumers and professional staff, and support Mental Health First Aide Training
      Assist with development and implementation of data sharing agreements across funders/stakeholders

Long-term Goals of Implementing Care Coordination

1. Shift from an acute care model of care to a recovery model
    - Increase the use of Peer Specialists and promote use of Evidenced Based Programs (EBP) like ROSC (Recovery Oriented System of Care), and Wraparound to provide consumers with necessary life skills to enable them to thrive while living with a mental illness or co-occurring disorder
    - Promote use of Motivational Enhancement Therapy (MET)
    - Research opportunities for data portals for all available services that would allow CFBHN to connect with other ME's, statewide funders, and other appropriate entities like Law Enforcement (i.e. Sheriff Data Sharing Project)

2. Offer an array of services and supports to meet an individual's chosen pathway to recovery
    - Use voucher funding to pay for identified items and/or services
    - Decrease cost per person of identified individuals in acute care/residential
    - Increase length of time between discharge and next acute care/residential readmission
    - Increase Diversion to alternative community resources

Care Coordination Roles

Provider Care Coordinator

1. Will provide intensive support services to discharged individual(s) from acute care that are high need/high utilizer (HNHU) of services as defined by DCF Guidance Document 4.
2. Will explore community/natural resources to address potential barriers to success.
3. Provide guidance and support to individual and their families/support network as appropriate to Care Coordination.
4. Will provide flexible services i.e. in home-on site, in the community, meet person at appointment, ensure individuals participation in their care i.e. medical, vocational, housing, behavioral, etc.
5. Provide home visits, arranged as appropriate.
6. The provider must develop a Care Coordination plan with the client's involvement.
7. Meet with CFBHN Behavioral Health Utilization Care Manager and maintain communication as needed regarding individual.

CFBHN Behavioral Health Utilization Care Manager

1. Monitor admission and readmission history and assign HNHU status to individuals meeting HNHU criteria.
2. Identify Care Coordination status to those persons with the highest frequency of admissions, high risk presentation or diversion from State Treatment Facility (STF).
3. Notify facilities as soon as possible upon admission of an HNHU identified program participant or Care Coordination program participant to engage Care Coordination activities.
4. Assist **provider** care coordinators with resource planning, searching, and access as needed.
5. Arrange for case conferences with providers for complex cases.
6. Facilitate HNHU/High risk meetings with acute care providers on a regular basis to discuss case presentations with multiple admissions, high risk or complex needs to support effective Care Coordination.
7. Monitor progress of clients engaged in Care Coordination for possible closure. Care Coordination status can close if status improves and acute care admissions reduce or diminish to zero; and/or if Care Coordination is no longer needed.
8. Attend STF discharge planning calls to assist with aftercare placement and discharge planning.

Core Competencies for Managing Entity and Contracted Providers

The following are a set of guidelines for service delivery compiled by the Department intended to be guiding principles for both managing entities and their contracted providers. Services should be recovery-oriented, choice and needs driven, flexible, unconditional, and needs driven.

Single point of accountability

Care Coordination provides for a single entity responsible for coordination of services, supports, and cross system collaboration to ensure the individual's needs are met holistically.

Providers serve as a single point of accountability for the coordination of an individual's care with all involved parties (criminal justice, juvenile justice, child welfare, primary care, behavioral health care, and housing).

Engagement with person served and their natural supports

The provider care coordinator goes to the individual and builds trust and rapport. The provider care coordinator actively seeks out and encourages the full participation of the individual' networks of interpersonal and community relationships. The care plan reflects activities and interventions that draw on sources of natural support.

The provider will support the individual in identifying and utilizing natural supports (family, friends) for the purposes of education, care planning, and establishing supports for treatment and aftercare. CFBHN will offer support and technical assistance through this process. Consumer and Family Affairs (C&FA) department is available to provide consultation by phone and/or email to providers, individuals, and family members to help them connect to natural supports in their local region.

CFBHN Utilization/Care Managers coordinate with agency discharge planners regarding recommended resources in meeting identified needs. CFBHN Network Development and Clinical Services (NDCS) department collaborates with the internal departments of Quality Improvement (QI) and Consumer and Family Affairs (C&FA) as well as the funder the Department of Children and Families (DCF) to identify emerging trends in the behavioral health field and assist providers in implementing and evaluating appropriate Evidence Based Programs and treatment.

Standardized assessment of level of care determination process

A standardized level of care assessment provides a common language across providers that can assist in determining service needs.

Providers will submit annual program descriptions that include any Evidence Based Practices in use, as part of the contract development process.

Providers will reference the level of care assessment tool for mental health and substance use treatment placement. DCF has recommended and CFBHN promotes the use of the ASAM/ LOCUS. These are clinical tools utilized for placement, continued stay, transfer, and discharge from treatment. Level of care assessment tools ensure clinical appropriateness for the current level of care and provide a multi-dimensional assessment of current level of functioning utilized by the provider.

Providers will develop a care plan with individuals based on shared decision making that emphasizes self- management, recovery and wellness. The care plan must include transition to community based services and/or supports.

Shared decision-making

Family and person-centered, individualized, strength-based plans of care drive the Care Coordination process. The perspective of the individuals served are intentionally elicited and prioritized during all phases of the Care Coordination process. The care coordinator provides options and choices such that the care plan reflects the individual's values and preferences.

Providers offer interim services to individuals which may include assessment, case management to assist in securing the placement, and other services as needed to maintain the individual until the appropriate level of care is available.

Providers within a circuit, and across the CFBHN network, collaborate to enhance co-occurring capability of staff and programs. This is accomplished by attending trainings and engaging in technical assistance on methods of implementing the principles of Continuous Comprehensive Integrated Systems of Care (CCISC) and Evidence Based Practices.

The CFBHN Utilization/Care Managers work with providers to identify interim services for individuals waiting for admission and as appropriate aftercare services for individuals being discharged from these programs. The Utilization/Care Managers work with the Program Managers of Children's Services, Forensic, and FACT/State Hospital to address systems issues with providers that impact admission, discharge, and outcomes.

CFBHN Utilization/Care Managers will identify and support effective assessment and treatment of individuals receiving services who have co-occurring disorders. CFBHN Utilization/Care Managers support collaboration between providers within a circuit and across the CFBHN network to enhance co-occurring capability of staff and programs through training and technical assistance in implementing the principles of CCISC and Evidence Based Practices.

Community-based

Services and supports take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible that safely promote an individual's integration into home and community life.

CFBHN's Network Development and Clinical Services Department manages the SunCoast Region and C10's Substance Abuse and Mental Health Wait List. Individuals waiting for services are entered into the web-based electronic waitlist. CFBHN requires subcontractors under the DCF contract to enter individuals seeking services into the DCF Electronic Waitlist according to the DCF Pamphlet. The Care Coordination Provider meeting will develop and implement projects to reduce and, where possible, eliminate waitlists throughout the region. CFBHN staff provides training on the SAMH Waitlist annually and monitors compliance with completing the waitlist monthly.

The Care Coordination Provider/ME meeting occurs monthly. The Care Coordination Provider/ME meeting focuses on review of a wide variety of access issues. This includes review of quarterly waitlist findings, capacity reports, any provider concerns regarding access to care. Through this meeting, CFBHN and its subcontractors effectively link individuals with other appropriate services, funders and community resources. The CFBHN Care Coordination Provider meeting reviews quarterly waitlist reports to identify gaps in services and barriers to access, including cultural/linguistic, age, gender, sexual orientation, spiritual beliefs, socioeconomic, geography, and capability to provide treatment for co-occurring disorders. The provider meeting will generate recommendations to decrease waitlists and increase access.

Priority Populations

When a subcontractor receives a request for services from an individual identified as a priority population and the provider is unable to accommodate the request, the subcontractor is to contact CFBHN for assistance in locating services elsewhere for the individual. If services cannot be located or the individual declines to accept services elsewhere, the subcontractor is expected to provide interim services, as defined by federal regulations, until the appropriate level of care is available.

Mental Health and Forensic Populations

The CFBHN Behavioral Health Utilization Care Managers will collaborate with the assigned CFBHN Program Managers to ensure that subcontractors who serve select populations have consistent procedures to ensure timely access to substance abuse and mental health residential services. These populations include individuals awaiting transfer to the state treatment facility, in-jail services and diversion from the criminal justice system, BNet, Florida Assertive Community Treatment (FACT) services, Juveniles Incompetent to Proceed (JITP), and Statewide Intensive Psychiatric Programs (SIPP). The Utilization Management Specialists will monitor admissions,

discharges, and any waitlists for services for persons in these categories, and report on capacity issues, trends in utilization, and barriers to services. The CFBHN Behavioral Health Utilization Care Managers will work with subcontractors to identify interim services for individuals waiting for admission and, as appropriate, aftercare services for individuals being discharged from these programs. The CFBHN Behavioral Health Utilization Care Managers will work with the Program Managers (Children's Services, Forensic, and FACT/State hospital) to address systems issues with subcontractors that impact admission, discharge, and outcomes, as well as to ensure that individuals waiting for services receive interim services. These services may include assessment, case management to assist in securing the placement, and other services as needed to maintain the individual until the appropriate level of care is available.

Coordination across the spectrum of health care

Coordination of services is to include, but is not limited to, physical health, behavioral health, social services, housing, education, and employment.

Providers collaborate through referral mechanisms with other Network service providers for access to community resources, including, but not limited to, behavioral health, primary care, housing, and social supports; benefits acquisition, consumer and family involvement, and availability of 24/7 intervention and support.

Providers are encouraged to use the multi-agency release form and the CFBHN Care Coordination Authorization to Release Information form that can be utilized across stakeholders/system of care providers for better coordination of care for individuals.
For individuals requiring medications, providers will ensure linkage to psychiatric services within 7 days of discharge from higher levels of care. If linkage is not available within the designated time frame, documentation will be submitted to the medical record and CFBHN will be notified. Providers will outreach to any of the individual's past providers for treatment history and list of medications to support client reports and current treatment recommendations.

Provider works with CFBHN, insurance provider(s) (if applicable), and. the parent/guardian to identify effective solutions to treatment to prevent the child from entering the child welfare system. Receipt of benefits enables individuals to have greater options for treatment, housing and other community resources. Providers assess individuals for eligibility of Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI), Veteran's Administration benefits, housing benefits, and public health benefits. Providers must use the SSI/SSDI Outreach, Access and Recovery (SOAR) application process. Free training is available at: http://soarworks.prainc.com/course/ssissdi-outreach-access-and-recovery-soar-online-training.

When unmet needs are identified, providers will work with CFBHN to identify ways either to expand the services or increase capacity through use of services such as Telehealth.

The CFBHN Utilization/Care Managers work to identify and support initiatives to integrate primary care with behavioral health services. Using a holistic health model which incorporates total need(s) of individuals, they include mental health, substance abuse, physical health, housing, and other supportive service needs in their planning.

CFBHN advocates in a variety of ways to support individuals served through its NDCS Program Managers and Utilization/Care Managers, Contract Managers, Consumer and Family Affairs staff, Finance personnel, IT, and QI departments. In compliance with Guidance Document 29, CFBHN uses a vouchering system for purchasing incidentals and other services based on identified needs.

CFBHN continues to promote reduced utilization of state treatment facility beds by reinforcing diversion efforts in all the SCR/C10 receiving facilities and with TCM/FACT teams providing services for individuals being referred for admission to the SMHTF. The diversion efforts include conference calls as necessary to brainstorm alternatives to state hospital placement, identifying placement alternatives and educating the providers during community based Acute Care Meetings.

The Utilization/Care Managers collaborate with the assigned CFBHN Program Managers to ensure providers who serve select populations have consistent procedures for timely access to substance abuse and mental health residential services. Select populations include individuals awaiting transfer to the SMHTF, in-jail services, diversion from the criminal justice system, BNet, FACT services, Juveniles Incompetent to Proceed (JITP), and Statewide Intensive Psychiatric Programs (SIPP) for children.

Information sharing

Releases of information and data sharing agreements are used as allowed by federal and state laws, to effectively share information among Network Service Providers, natural supports, and system partners involved in the individual's care.

CFBHN continues to work with providers through acute care committees to utilize the multi-agency release form.

Effective transitions and warm hand-offs

Current providers directly introduce the individual to the care coordinator. The "warm hand-off" is both to establish an initial face-to-face contact between the individual and the care coordinator and to confer the trust and rapport the individual has developed with the provider to the care coordinator.

In FY21-22, CFBHN continues to focus on warm hand-offs and engagement for individuals served. These two issues continue to be discussed as needed on the monthly Care Coordination Meeting, conducted via Microsoft Teams. Providers continue to share how their agencies are doing warm-hand offs and engagement strategies to decrease readmissions to acute care and residential levels of care. The belief is that by increasing warm hand-offs and increasing engagement, this will decrease the high need/high utilizers readmissions.

Culturally and linguistically competent

The Care Coordination process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the individual served, and their community

CFBHN continues to work with providers to ensure individuals served are able to access treatment programs. CFBHN reminds providers of Title VI, federal law, about linguistic capability.

Outcome-based

Care Coordination ensures goals and strategies of the care plan are tied to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly

The CFBHN data information system captures admissions and discharges for acute and residential services throughout the network for the uninsured. The system allows CFBHN staff and providers access to information on service availability and allow for daily monitoring to reduce the number waiting for services.

All Providers will use the CFBHN data information system to report all admissions and discharges, and submission of any additional information CFBHN requests for the purpose of data analysis in order to track trends in admissions, length of stays, discharges, and outcomes.

The Utilization/Care Managers use information from the CFBHN data information system to evaluate trends related to admission, such as length of stay, discharge, and service outcomes data. The primary focus, however, is to monitor high frequency readmissions. The Utilization/ Care Managers will verbally provide information to the Chief Clinical Officer, who in turn will communicate results to the CFBHN Management team, QI Oversight Committee, Board of Directors, and other stakeholders upon request.

Priority Populations

Care Coordination

Pursuant to s. 394.9082(3)(c), F.S., the Department has defined several priority populations to potentially benefit from Care Coordination. Persons are identified as eligible for Care Coordination in compliance with eligibility criteria as outlined in the current version of Guidance Document 4.

CFBHN Special Note

Pregnant women continue to be a priority population and are given preference in regards to admissions for behavioral health services. Pregnant women and pregnant IV users must receive treatment within 48 hours. If services are not available, CFBHN must be notified to find other resources.

CFBHN has worked with providers to develop programs which allow post-partum women and women with children to bring their children with them to residential and/or outpatient treatment services. The availability of programs and resources that include opportunities for women to engage in treatment with their children helps with reunification and provides motivation for the women to enter and continue in treatment. CFBHN maintains a current listing of family treatment programs throughout the state and is able to refer women to these programs as needed.

Substance Abuse - Federally Defined Priority Populations

The federal block grant regulations define priority populations for substance abuse services as women who are pregnant and/or IV drug users. Those requesting services that fit the requirements of a priority population are to be given preference for admission. The specific hierarchy is:

1. Pregnant women with intravenous drug use
2. Pregnant Women
3. Intravenous drug users
    a. Intravenous drug users are defined as those individuals who are seeking treatment for IV drug use even if the last use indicates that the individual may not need detoxification services. (Example someone released from jail seeking services.)
4. The SunCoast Region has also established a fourth priority group, which is parents/caregivers and children who are involved with the child welfare system and have substance use disorders.

Ensuring Access for Priority Populations

All efforts will be made to provide the identified services to individuals in these priority populations. In the event a provider is unable to accommodate a request for service, the provider will collaborate with CFBHN in locating the identified or comparable services elsewhere. If services cannot be located, or the individual declines the alternative services, the provider is expected to provide interim services, as defined by federal guideline, until the appropriate service is available.