Care Coordination

Requirement: Contract
Section 394.9082, F.S**.**
Frequency: Monthly Care Coordination Spreadsheet
Due Date: 10th day of the month following service delivery

Discussion: The purpose of this document is to provide direction for the implementation, administration and management of Care Coordination activities. The document describes an overview of Care Coordination, defines the priority populations, delineates responsibilities of the provider agencies, and provides resources regarding promising practices.

I. OVERVIEW

A. 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."

B. 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. It is time-limited, with a heavy concentration on educating and empowering the person served and provides a single point of contact until a person is adequately connected to the care that meets their needs.

Care Coordination is not a service in and of itself, it is a collaborative effort to efficiently target treatment resources to needs, effectively manage and reduce risk, and promote accurate diagnosis and treatment due to consistency of information and shared information.[1] It is an approach that includes coordination at the funder level, through data surveillance, 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, it 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 assesses for and addresses behavioral health issues as well as medical, social, housing, interpersonal problems/needs that impact the individual's status. [2] It is a mechanism for linking providers of different services to enable shared information, joint planning efforts, and

[1] Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Washington (DC): National Academies Press (US); 2006
[2] Closing the quality gap: A critical analysis of quality improvement strategies. Technical Review 9: AHRQ Publication No 04 (07)-0051-7. www.ahrq.gov

coordinated/collaborative treatment. Engagement of available social supports to address identified basic needs for resources such as applying for insurance/disability benefits, housing, food, and work programs is essential.[3] Care Coordination also facilitates transitions between providers, episodes of care, across lifespan changes, and across trajectory of illness.[4]

At the person level, it incorporates shared decision making in planning and service determinations and emphasizes self-management. Persons served and family members should be the driver of their goals and recognized as the experts on their needs and what works for them.

Care Coordination is not intended to replace case management. Based on the person's needs and wishes, case management may be a service identified in the person's care plan that he or she will be referred to. Case management may be ongoing for those determined eligible for this service based on current standards. Once an individual is successfully linked with a case manager, they would assume the responsibilities of coordinating care.

The short-term goals of implementing Care Coordination are to:

- Improve transitions from acute and restrictive to less restrictive community-based levels of care;
- Increase diversions from state mental health treatment facility admissions;
- Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness; and
- Focus on an individual's wellness and community integration.
- Decrease the amount of time individuals spend awaiting discharge from a state mental health treatment facility.

The long-term goals of implementing Care Coordination are to:

- Shift from an acute care model of care to a recovery model; and
- Offer an array of services and supports to meet an individual's chosen pathway to recovery.

C. CORE COMPETENCIES

The Department has compiled a set of guiding principles and core competencies that must be considered in service design.[5] The guiding principles stipulate that service delivery is recovery-oriented, choice and needs driven, flexible, unconditional, and data driven. Core competencies of Care Coordination include:[6]

1. 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.

2. Engagement with person served and their natural supports - the care coordinator goes to the individual and builds trust and rapport. The care coordinator actively seeks out and encourages

[3] Touchstone Mental Health Minneapolis, Care Coordination Program – Program Offerings. http://www.touchstonemh.org/programs-and-services/care-coordination
[4] Care Coordination Measures Atlas. AHRQ Publication. www.ahrq.gov

[5] See, http://www.dcf.state.fl.us/programs/samh/publications/Care%20Coord%20Framework.pdf, site accessed July 8, 2016.
[6] Many of the definitions of core competencies are based on the guiding principles of Wraparound as described in: Bruns, E. J., Walker, J. S., & The National Wraparound Initiative Advisory Group. (2008). Ten principles of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

the full participation of the individual's networks of interpersonal and community relationships. The care plan reflects activities and interventions that draw on sources of natural support.

3. Standardized assessment of level of care determination process – The LOCUS , CALOCUS and ASAM will be used to determine level of care.

4. 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.

5. 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.

6. Coordination across the spectrum of health care - this includes, but is not limited to, physical health, behavioral health, social services, housing, education, and employment.

7. 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.

8. 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.

9. 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.

10. 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.

II. PRIORITY POPULATIONS

Pursuant to s. 394.9082(3)(c), F.S., the Department has defined several priority populations to potentially benefit from Care Coordination. Managing entities and provider agencies are expected to minimally serve the following two populations:

1. Adults with a serious mental illness (SMI), substance use disorder (SUD), or co-occurring disorders who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, and inpatient detoxification services. For the purposes of this document, high utilization is defined as:

a. Adults with three (3) or more acute care admissions within 180 days; or

b. Adults with acute care admissions that last 16 days or longer.

c. Adults with three (3) or more evaluations at an acute care facility within 180 days, regardless of admission

2. Adults with a SMI awaiting placement in a state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community. Also see Incorporated Document 8 regarding SMHTF admissions and discharges.

Populations identified to potentially benefit from the remaining allocated funds for Care Coordination may include:

1. Individuals identified by the Department, managing entities, or Network Service Providers as potentially high risk due to concerns that warrant Care Coordination.

If deemed necessary, Managing Entities and provider agencies may implement a time-limited transition plan for individuals who are connecting to a case manager or a team that includes case managers during which both the case manager and the care coordinator work with the individual. The transition should not exceed 90 days. A time-limited transition involving the individual (and family if present) will ensure a warm hand-off and that engagement is established.

III. IMPLEMENTATION

A. NETWORK SERVICE PROVIDER RESPONSIBILITIES

Network Service Providers provide direct Care Coordination services for individuals and their responsibilities include:

1. Assess organizational culture and develop mechanisms to incorporate the core values and competencies of Care Coordination into daily practice.

2. Utilize a standardized level of care tool (the LOCUS, CALOCUS, and ASAM) and assessments to identify service needs and choice of the individual served.

3. Serve as single point of accountability for the coordination of an individual's care with all involved parties (i.e., criminal or juvenile justice, child welfare, primary care, behavioral health care, housing, etc.).

4. Engage the individual in their current setting, (e.g., crisis stabilization unit (CSU), SMHTF, homeless shelter, detoxification unit, addiction receiving facility, etc.) to facilitate a warm hand off. Individuals served should not be expected to come to the care coordinator.

5. Develop a care plan with the individual based on shared decision making that emphasizes self-management, recovery and wellness, including transition to community-based services and/or supports. The care coordination care plan must include the initiation of SSI/SSDI Outreach, Access, and Recovery (SOAR) and application for government benefits or entitlements when the client is eligible.

6. Provide frequent contact for the first 30 days of services, ranging from daily to a minimum of three times per week. Care coordinators should consider the individual's safety needs, level of independence, and their wishes when establishing the optimal contact schedule. This includes telephone contact or face-to-face contact (which may be conducted electronically). Leaving a voicemail is not considered contact. If the individual served is not responding to attempted contacts, the provider must document this in the clinical record and make active attempts to locate and engage the individual.

7. Provide 24/7 on-call availability.

8. Coordinate care across systems, to include behavioral and primary health care as well as other services and supports that impact the social determinants of health.

9. Assess the individual for eligibility of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Veteran's Administration benefits, housing benefits, and public benefits, and assist them in obtaining eligible benefits. When applying for SSI or SSDI benefits, providers must use the SSI/SSDI Outreach, Access, and Recovery (SOAR) application process. Individuals enrolled in care coordination should be prioritized for the SOAR process. The client must have an initial appointment with a SOAR processor within 60 days of enrollment into Care Coordination services. Progress towards obtaining benefits should be reported to the Managing Entity Care Coordinator on a bi-weekly basis.

Free training is available at: https://soarworks.prainc.com/course/ssissdi-outreach-access-and-recovery-soar-online-training

10. Complete applications for government benefits or entitlements when the client is eligible (i.e. Supplemental Nutrition Assistance Program or Food Stamps, Medicaid, Medicare, Unemployment Benefits and Temporary Assistance for Needy Families) within 60 days of enrollment into Care Coordination services.

11. For individuals who require medications, ensure linkage to psychiatric services within 7 days of discharge from higher levels of care. If no appointments are available, document this in the medical record and notify the managing entity.

12. For individuals admitted to a CSU whose length of stay exceeds 30 days, a staffing with the ME will be required.

13. Coordinate with the managing entity to identify service gaps and request purchase of needed services not available in the existing system of care. A signed approval of a voucher from LSFHS must be obtained before incurring expense for a client that is to be reimbursed through the LSFHS voucher funds. Vouchers submitted after the fact, may be denied.

14. Develop partnerships and agreements with community partners (i.e., managed care organizations, criminal and juvenile justice, community-based care organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data.

15. Complete and submit within 10 business days to the Managing Entity a Root Cause Analysis and Action Plan (See Appendix A) when Care Coordination fails.

B. CARE COORDINATION ALLOWABLE COVERED SERVICES

Pursuant to ch. 65E-14.014, F.A.C., providers may not bill for services for individuals who have third party insurance, Medicaid, or another publicly funded health benefit coverage when the services provided are **paid** by said program. Providers shall follow 65E-4.014, F.A.C. and 65D-30.004, F.A.C. statutes related to the allowable covered services. When billing for incidental expenses, the Network Service Provider shall follow F.A.C. 65E-14.021(4)(k)4.b.(V). The following is a list of allowable covered services as defined in ch. 65E-14.021, F.A.C.:

1. Outreach

2. Assessment

3. Crisis Support/Emergency

4. Recovery Support

5. Case Management

6. Intensive Case Management
7. In-Home and On-Site
8. Supportive Housing
9. Intervention
10. Incidental Expenses

C. DATA COLLECTION AND MANAGEMENT

Care Coordination is a bundled service approach that is reported through an expenditure Other Cost Accumulator in accordance with the DCF Data System Guidelines and using the following modifier codes in the Modifier 2 field:

Modifier Code	Short Description
DO	MH0CN Care Coordination MH
DV	MS0CN Care Coordination SA

Only the covered services specified in Section B may be reported using the modifier codes identified for Care Coordination. Service data must be reported into the Managing Entity's Data System.

D. REQUIRED REPORTS

Network Service Provider are required to submit the following reports by the 10th of each month:

- **Care Coordination Spreadsheet**: Encrypted submission to the Network Manager, Care Coordination Specialist and Director of Program Operations. **The Template for this report is incorporated herein.**

IV. PERFORMANCE OUTCOMES

The following outcomes are expected for those consumers enrolled in Care Coordination.

1. Individuals enrolled in care coordination are expected to have a reduction in admissions to acute levels care. Providers are expected to maintain a recidivism rate for acute levels of care at or below 8.2% for consumers enrolled in care coordination.

2. State Mental Health Treatment Facility Discharges (SMHTF) will be discharged from the SMHTF to the community within 30 days of being placed on the seeking placement list (SPL).

3. For individuals who require medications, ensure linkage to psychiatric services within 7 days of discharge from higher levels of care. If no appointments are available, document this in the medical record and notify the managing entity.

4. Monthly, Providers will report numbers on successful engagement and enrollment versus referral, to the Managing Entity utilizing the Care Coordination Spreadsheet.

5. Providers will submit data regarding successful versus unsuccessful discharges to the managing entity, monthly utilizing the Care Coordination Spreadsheet.

V. RESOURCES

MEs and providers are encouraged to research the following list of promising practices in Care Coordination as examples of effective implementation.

1. Recovery Support Bridgers/Navigators

Certified Recovery Peer Specialists (CRPS) are utilized to assist individuals successfully transition back into the community following discharge from a SMHTF, CSU or Detox. The CRPS engages the individual while still inpatient and provides support and information on discharge options. They participate in discharge planning and assist the person in identifying community-based service and support needs and build self-directed recovery tools, such as a Wellness Recovery Action Plan (WRAP). The CRPS then supports the individual as they transition to the community. More information on WRAP may be accessed at: http://mentalhealthrecovery.com/

2. Care Transition Programs®

This intervention utilizes a Transition Coach to preferably meet an individual in the acute care setting to engage them and their family (as appropriate) and sets up in-home follow up visits and phone calls designated to increase self-management skills, personal goal attainment, and provide continuity across the transition.[7] More information on the Care Transition Programs may be accessed at: http://caretransitions.org/

3. Medical Homes

The Agency for Healthcare Research and Quality defines the medical home as a model of the organization of primary care that delivers the functions of primary health care with the following attributes:

- Comprehensive Care – the medical home is accountable for meeting the individual's physical and mental health needs, which requires a team of care providers.
- Patient-Centered – the medical home partners with patients and their families, respecting each person's unique needs, culture, values, and preferences.
- Coordinated Care – the medical home coordinates care across all elements of the broader health system, including community services and supports.
- Accessible Services – a medical home delivers services in shorter wait times, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team.
- Quality and Safety - a medical home uses evidence-based medicine and clinical decision support tools to guide shared decision making with patients and families, engaging in performance and improvement.[8]

[7] See, http://caretransitions.org/about-the-care-transitions-intervention/, site accessed October 14, 2015.
[8] See, https://pcmh.ahrq.gov/page/defining-pcmh, site accessed October 14, 2015.

In Indiana, WellPoint Health Plan medical homes for persons with high-service use decreased emergency department utilization by 72% and decreased controlled substance prescriptions by 38% in the 6 months pre- and post-program. Medical homes for people with substance use issues can also be a key intervention for super-utilizer programs – in Michigan, an integrated medicine clinic addressing super-utilizers with mental health and substance abuse needs decreased emergency department visits by over 50% among highest utilizers.

4. Behavioral Health Homes

The SAMHSA – HRSA Center for Integrated Health Solutions has proposed a set of core clinical features of a behavioral health-based health home that serves people with mental health and substance use disorders, with the belief that application of these features will help organizations succeed as health homes. This resource may be accessed at: http://www.integration.samhsa.gov/clinical-practice/CIHS_Health_Homes_Core_Clinical_Features.pdf

5. Reducing Avoidable Readmissions Effectively

The RARE Campaign in Minnesota was established to improve the quality of care for persons transitioning across care systems and to reduce avoidable readmissions by 20%. Five areas were identified as a focus of these efforts:

- Patient/Family Engagement and Activation,
- Medication Management,
- Comprehensive Transition Planning,
- Care Transition Support, and
- Transition Communication

For more detail, the RARE Campaign published recommendations on actions to address the above areas of focus which can be accessed at: http://www.rarereadmissions.org/documents/Recommended_Actions_Mental_Health.pdf

6. Telehealth

The use of technology presents another promising practice in coordinating care, specifically as it related to access. As an example, the Department of Veterans Affairs (VA) piloted a care coordination/home telehealth initiative that continually monitored veterans with chronic health conditions. Vital signs and other disease management data was transmitted to clinicians remotely located. The pilot reported reductions in hospital admissions and length of stay.[9]

7. Wraparound

Wraparound is an intensive, individualized care planning and management process for individuals with complex needs, most typically children, youth, and their families. The Wraparound approach provides a structured, holistic and highly individualized team planning process which includes meeting the needs of the entire family. The philosophy of care begins with the principal of "voice and choice", which stipulates the child and family perspective and drives the planning. The values further stipulate that care be community-based and culturally and linguistically competent. The

[9] IOM (Institute of Medicine). 2010. The healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington, DC: The National Academies Press

staff to family ratio typically does not exceed one Wraparound facilitator to ten families. More information on Wraparound may be accessed at: http://nwi.pdx.edu/

Care Coordination will be administered according to DCF Guidance 4, which can be found at following link using the applicable fiscal year: http://www.myflfamilies.com/service-programs/samh/managing-entities/.

APPENDIX A

Root Cause Analysis and Action Plan

This template is provided as an aid in identifying unsuccessful discharges, the potential factors affecting discharge, and to recognize and implement action plans as a means to prevent future unsuccessful discharges and promote enrollment retention.

This template will need to be completed within 10 business days for each unsuccessful discharge from care coordination.

Client Name	Date Enrolled	Date Discharged	Reason for Discharge

Possible Factors for Discharge	Preventive Methods Used	Action Plan: What Can Be Done Differently in the Future