Care Coordination

Requirement: Contract
Section 394.9082, F.S**.**
Frequency: Monthly Care Coordination Spreadsheet
Due Date: 8th day of the month following service delivery

Discussion: The purpose of this document is to provide direction for the 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

Care Coordination is a time-limited service that assists individuals with behavioral health conditions who are not effectively engaged with case management or other behavioral health services and supports.

Care Coordination is intended for individuals who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, and inpatient detoxification services. However, Care Coordination is also intended to avert high utilization of such services. Therefore, Care Coordination can be uniquely tailored to serve a broad spectrum of individuals from both a system level and provider level.

High Utilization includes individuals with a serious mental illness (SMI), substance use disorder (SUD), serious emotional disturbance, or co-occurring disorders who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, Statewide Inpatient Psychiatric Program services (or equivalent out of state treatment), and inpatient detoxification services that experience:

1. Three (3) or more acute care admissions or evaluations at an acute care facility within 180 days, or
2. Acute care admissions that last 16 days or longer, or
3. Are awaiting placement in a state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community.

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 an individual'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 individuals served and provides a single point of contact until an individual is adequately connected to the care that meets their needs.

At a system level, Care Coordination 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 a provider level, Care Coordination 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]

Care Coordination is a mechanism for linking providers of different services to enable shared information, joint planning efforts, and 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] By definition, there is currently no equivalent, reimbursable service by Florida Medicaid or any other commercial insurance.

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

Children's Care Coordination is accomplished at two levels: Tier 1 and Tier 2. Tier 1 is implemented by the Department at the regional and state level. Tier 2 is implemented at the Managing Entity and provider level.

Children's Care Coordination should adhere to the National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN)[5] which outlines the core, system-level components of high-quality care coordination. These standards are designed to help stakeholders develop and strengthen high-quality care coordination for children with the goal of engaging families in the care coordination process and developing team-based communication processes to better serve children and families.

CYSHCN standards are grouped into six domains identified as key for effective care coordination and include:

- Screening, identification and assessment;
- Shared plans of care;
- Team-based communication;

[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
[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] National Care Coordination Standards for Children and Youth with Special Health Care Needs. National Academy for State Health Policy. www.nashp.org/national-care-coordination-standards-for-children-and-youth-with-special-health-care-needs/

- Child and family empowerment and skills development;
- Care coordination workforce; and
- Care transitions.

Care Coordination is not intended to replace case management. Based on the individual's needs and wishes, case management may be a service identified in the individual's care plan for which they will be referred. Case management may be ongoing for those determined eligible for this service based on current standards.

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, physical health, and community integration.
- reducing entry into the child welfare system, and
- Increase knowledge of, and access to, community-based services and supports.

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

- Shift from an acute care model of care to a recovery model of well-being, 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.[6] 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:[7]

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 individual 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 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.

[6] See, https://www.myflfamilies.com/service-programs/samh/publications/docs/Care%20Coord%20Framework.pdf site accessed April 6, 2022
[7] 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.

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.

11. Care Coordination should incorporate a recovery oriented, strengths-based approach to an individual's pathway to recovery.

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 utilize at least 50% of allocated funds in OCAs MH0CN and MS0CN to serve the following populations:

A. 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.

B. Adults with a SMI, SUD, or co-occurring disorders who are at risk of re-entry into crisis stabilization, and inpatient detoxification services.

C. 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.

The following populations may receive Care Coordination from the remaining balance of OCAS MS0CN and MH0CN allocated funds.

A. Individuals with a serious emotional disturbance (SED), SMI, SUD, or co-occurring disorders who are involved with the criminal justice system, including: a history of multiple arrests,

involuntary placements, or violations of parole leading to institutionalization or incarceration.

B. Caretakers and parents at risk for involvement with child welfare.

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

The Department has defined additional populations to benefit from Care Coordination using funds in OCAs MSCS2 and MSCS3.

A. Children and parents or caretakers in the child welfare system with behavioral health needs, including Adolescents, as defined in s. 394.492, who require assistance in transitioning to services provided in the adult system of care,

B. Children and adolescents with a mental health diagnosis, SUD, or co-occurring disorder, including:

1. Children being discharged from Baker Act Receiving Facilities, Emergency Rooms, jails, or juvenile justice facilities at least one time, who are at risk of re-entry into these institutions or of high utilization for crisis stabilization.

2. Children and adolescents who have recently resided in, or are currently awaiting admission to or discharge from, a treatment facility for children and adolescents as defined in s. 394.455, which includes facilities (hospital, community facility, public or private facility, or receiving or treatment facility) and residential facilities for mental health, or co-occurring disorders.

C. Children who do not qualify for services provided by CAT Teams.

D. Families with infants experiencing or at risk for Neonatal Abstinence Syndrome or Substance Exposed Newborn.

Care Coordination under these OCAs cannot be provided to individuals enrolled in the following team-based services: FACT, Coordinated Specialty Care for Early Mental Illness, CAT, FIT, Comprehensive Community Service Teams, Forensic Multidisciplinary Teams, and any other local multidisciplinary treatment teams that include case management.

If necessary, Managing Entities and Network Service Providers may implement a time-limited transition plan for individuals in the process of connecting to a case manager or team-based services that includes case managers (excluding Dependency Case Management and medical case management). The transition must ensure Care Coordination may not exceed 90 days during which time both a case manager and a care coordinator may provide services to the same individual unless a longer duration is specifically approved by the Department. A transition plan shall be designed to ensure a warm hand-off and successful case management engagement.

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 (VA) 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.samhsa.gov/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 expenses 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 Pamphlet 155-2, or project code, and using the following service modifiers:

Modifier Code	Short Description
DO	MH0CN Care Coordination MH
DV	MS0CN Care Coordination SA
--	MSCS2/MSCS3 NAS/SEN Care Coordination

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 8th of each month:

- **Care Coordination Spreadsheet**: Encrypted submission to the Network Manager, Care Coordination Team Lead, and Director of Program Operations. **The Template for this report is incorporated herein.**
    - Applicable OCA(s):
        - MH0CN Care Coordination MH
        - MS0CN Care Coordination SA
        - MSCS2/MSCS3 NAS/SEN Care Coordination
- **Children's Crisis Stabilization Unit (CCSU) Care Coordination Report:** Encrypted submission to the Network Manager, Children's System of Care Manager, and Director of Program Operations. **The Template for this report is incorporated herein.**
    - Applicable OCA(s):
        - MH0CN -> MHCCN Care Coordination MH for Children
- **Substance Exposed Newborn (SEN) Prevention Program Report:** Encrypted submission to the Network Manager, Clinical Care Team Lead, and Director of Program Operations. **The Template for this report is incorporated herein.**
    - Applicable OCA(s):
        - MSCS2/MSCS3 NAS/SEN Care Coordination

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. 50% of all individuals who are engaged by care coordinators will be enrolled.

5. Providers will submit data regarding successful versus unsuccessful discharges to the managing entity, monthly utilizing the Care Coordination Spreadsheet. 75% of all discharges from care coordination will be successful.

V. RESOURCES

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

A. National Care Coordination Standards for Children and Youth with Special Health Care Needs

The National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN) outline the core, system-level components of high-quality care coordination for CYSHCN. These standards are designed to help stakeholders develop and strengthen high-quality care coordination for children with the goal of engaging families in the care coordination process, building a strong and supportive care coordination workforce, and developing team-based communication processes to better serve children and families.

More information about National Care Coordination Standards for Children and Youth with Special Health Care Needs may be accessed at: https://www.nashp.org/national-care-coordination-standards-for-children-and-youth-with-special-health-care-needs/

B. The Wraparound Model

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.
More information on Wraparound may be accessed at: http://nwi.pdx.edu/

C. 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 individual 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/

D. 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.[8] More information on the Care Transition Programs may be accessed at: http://caretransitions.org

E. 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 individual'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.[9]

In Indiana, WellPoint Health Plan medical homes for individuals 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.

F. 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

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

substance use disorders, with the belief that application of these features will help organizations succeed as health homes. This resource may be accessed at: www.thenationalcouncil.org

G. Reducing Avoidable Readmissions Effectively

The RARE Campaign in Minnesota was established to improve the quality of care for individuals 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: https://www.mnhospitals.org/newsroom/news/id/183/rare-campaign-prevents-4570-avoidable-hospital-readmissions

H. 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.[10]

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

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

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