2016

Care Coordination Framework

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EXECUTIVE SUMMARY

This framework serves to form the basis for practice enhancements to Florida's publically funded behavioral health service system. The Institute of Medicine (IOM) has identified the failure to coordinate care as resulting in gaps in care, miscommunication, and redundancy.[1] Recognizing the need to better coordinate care for individuals with complex needs at the system and person levels, the Department of Children and Families (Department) convened a Project Team inclusive of stakeholders from across the state to develop strategies and recommendations to improve current practice.

There is no universal definition for care coordination. In order to ensure a common understanding of the term, the Project Team started with the Substance Abuse and Mental Health Services (SAMHSA) definition, modified it, and came to consensus on the following definition for the state:

> ***"Care Coordination is the organization of care activities between two or more participants including the person served and family (with consent) involved in an individual's care to facilitate the effective delivery of health care services."***

This paper details the Project Team's recommendations for implementation of Care Coordination in terms of short and long-term goals. It provides a framework demonstrating the role of Care Coordination, including core competencies, roles and responsibilities, performance metrics, and promising practices. The intent is to depict clear expectations in terms of care standards and provide tools for implementation, while allowing ample flexibility for regional needs and practice innovation.

<u>Recommendations</u>

The following are high level recommendations:

- Add Care Coordination as a billable, covered service in ch. 65E-14.021, F.A.C.
- Contract for Care Coordination services with network service providers that are qualified based on the core competencies outlined in this framework.
- Identify standardized level of care assessments and provide the monetary resources necessary for the Managing Entities (MEs) and providers to implement them.
- Implement data sharing agreements across providers and funders to ensure an effective flow of information that follows individuals through their care.
- ME's to link with stakeholders that provide services and supports in the domains of primary care, housing, employment and criminal justice to ensure a holistic approach to care that addresses psychosocial determinants of health and wellness.
- Increase resources to fund a more comprehensive community-based service array that addresses the identified needs of the person served.
- Monitor implementation and outcomes of Care Coordination activities and adjust approaches as needed to maximize effectiveness.
- Implement consistent discharge protocols for individuals returning to the community from state mental health treatment facilities.

[1] Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies- Volume 7- Care Coordination

BACKGROUND

The term "Care Coordination" may be new to Florida's behavioral health system, but the concept is not. In 2001, the IOM indicates individuals receiving services are the ones suffering when there are gaps in care, miscommunication and redundancy. Two years later in 2003, the IOM stated Care Coordination was one of twenty (20) priority health care areas worthy of immediate attention.[2]

Care Coordination is a delivery methodology that is being implemented by health plans around the country, as a way to manage chronic diseases in the primary healthcare setting, away from hospitals. By developing collaborative partnerships between payor and provider, coordinated care offers an opportunity to share information in a timely manner, and to ensure that a person served is being followed as they move through their episode of care.

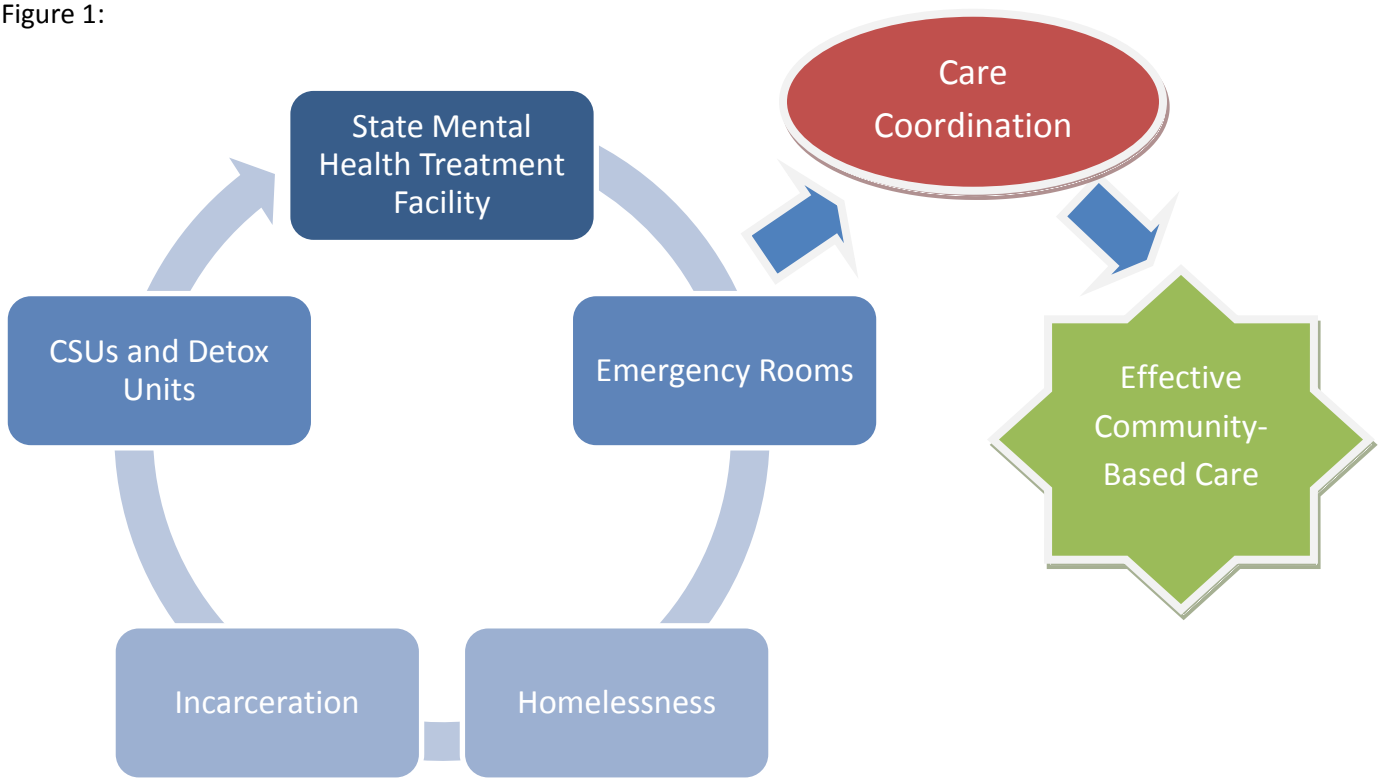
Historically, new and innovative concepts, approaches and treatment modalities have been embraced and implemented throughout the state. These can be highly effective; however, if there is fragmentation and disconnect between systems and services, it has a negative impact on the individual, their family and their community. This is especially true for persons with complex needs who are involved in multiple systems.

Poorly managed care transitions for high-risk, high need individuals from acute services to lower levels of care negatively affect a person's health and well-being, potentially causing additional utilization of acute, crisis services, avoidable re-hospitalization, or re-arrest. A review of behavioral health emergency[3] services reported to the Department,[4] and the connection to community based "primary" behavioral health services demonstrated that there is disconnect between Florida's emergency services, and community-based care. This may be due to a lack of coordination and to a lack of funding for necessary community-based services.

Many of these individuals cycle through jails, emergency rooms, and homeless facilities, leading to de-compensation of the person's mental health and creating immense costs for multiple publically funded systems. Transition from the crisis service, to home, or other post-acute care settings, can be managed to avoid this cycling.

[2] Coordinated Care for Better Mental, Substance Use, and General Health http://www.nap.edu/catalog/11470.html
[3] This is considered to be crisis stabilization units, and residential detoxification.
[4] The review examined those admissions, reported to the Department that could be tied to an individual across FY12-13, and FY13-14.

Figure 1:



CURRENT SYSTEM

To understand the opportunities for improvement, it is helpful to have a conception of the behavioral health system as it presently exists. Florida offers numerous behavioral health services and supports. However, these are funded through multiple funding streams, including general revenue, block grants, Medicaid, other state agencies, local government, private insurance, and others. All have different payment structures, eligible services, medical necessity criteria, service authorization requirements, rules, and data structures. In addition, confidentiality laws to protect an individual's personal health information further deter from information sharing necessary to effectively coordinate across systems and providers. Needless to say, this makes the system incredibly complicated to navigate, and ultimately fragmented.

In terms of the publically funded behavioral health system, funds appropriated to the Department to support community behavioral health services was to develop capacity to provide services, and has continued to be the payment and contract methodology used to date. This results in funding not being targeted directly to people; it is contracted through direct payments to providers. At times this inadvertently results in a person being referred to services a provider has available rather than what the person wants or needs. In the absence of sufficient resources, it has been difficult to change that array and add new practices, unless done so through a discretionary grant or special legislative appropriation.

On the mental health side, the system also lacks a standardized level of care determination which often leaves decision making solely to clinical judgment or community capacity – in other words, what is

available. This makes planning service arrays that are responsive to the actual needs of the individuals we serve difficult, if not impossible.

PRIORITY POPULATIONS

Amidst these challenges, providing holistic care to those with the greatest need has proven to be complicated. Several specific population groups have been identified for whom Care Coordination practices may assist with these challenges. They are:

- Persons with a Serious Mental Illness (SMI) awaiting placement in a civil state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community.
- Individuals with a SMI and/or Substance Use Disorder (SUD) who account for a disproportionate amount of behavioral health expenditures.
- Persons with a SMI and/or SUD who have a history of multiple arrests, involuntary placements, or violations of parole leading to institutionalization or incarceration.
- Caretakers and parents with a SMI and/or SUD involved with child welfare.

Over time, the MEs will have flexibility to add additional priority populations based on needs identified in their respective regions. The Project Team determined that in order to implement Care Coordination practices within the current increases in block grant funds, which are only partly recurring, addressing all four groups initially is not feasible. Hence, the first two groups were chosen to "pilot" this approach. Workgroups were established to address the unique needs of each of these groups.

<u>Persons with SMI awaiting placement in a civil SMHTF or awaiting discharge from a SMHTF</u>

As of December 31, 2015, there were 116 individuals in crisis stabilization units (CSUs) waiting to be admitted into civil state mental health treatment facilities (SMHTFs) and 202 individuals ready to be discharged from SMHTFs. An analysis of individuals discharged from SMHTFs in FY 2013-14 revealed that 12 percent (105 out of 876) were readmitted within 365 days. Of these discharges, individuals discharged to Adult Family Care Homes and Assisted Living Facilities were more likely to be readmitted.

SMHTFs have a need for increased support and fluid transitions between settings to best address the needs of individuals served. A uniform admission and discharge process across SMHTFs, MEs and community providers, is necessary to clearly define roles and responsibilities for each of the system partners. The workgroup developed recommendations that describe how a process can be designed to streamline transitions between SMHTFs and the community, which can be found in Attachment I. The following intercept points and strategies were identified for Care Coordination specific to individuals awaiting placement in or discharge from a SMHTF:

- While awaiting admission to a SMHTF
    - Educate providers and persons served on services in the community that can be accessed to divert the admission to the SMHTF.
    - Increase screening frequency for individuals on the waitlist to ensure they continue to meet inpatient placement criteria.

  - MEs to assist with developing and funding service arrays to divert individuals from hospitalizations.
- While in the SMHTF
  - Improve communication protocols around discharge planning.
  - Increase community participation in discharge planning.
  - Ensure the person has all the needed resources for a successful transition (i.e., benefits, identification documents, etc.)
- During discharge to the community
  - Consider use of Recovery Support Bridger/Navigator models (these are described in the Promising Practices section of this document).
  - Use "warm hand offs" between the SMHTF staff and the community provider to ensure the community provider meets the individual at time of discharge or within 24 hours.
  - Community provider to maintain contact with person served at least 3 times per week for the first 30 days post-discharge.

<u>Individuals who account for a disproportionate amount of behavioral health expenditures</u>

As referenced earlier, a review of the community-based services received by individuals who are treated in CSUs and Inpatient Detoxification Facilities (Detox) found many are discharged and not connected to care. Table 1 shows the unduplicated number of persons served in these acute levels of care and how many received at least one community-based service in FY2014-15, as reported to the Department.

Table 1: Crisis Stabilization Unit (CSU) and Inpatient Detoxification Service Recipients[5]

Number of Persons Receiving Crisis Stabilization Service(s)[6]	Community Services for Persons Receiving Crisis Stabilization Services (Received at least one service)
41,290	22,905 received a crisis support service (i.e., mobile crisis or walk-in clinic)
	11,616 received a medical service
	6,453 received an outpatient service (individual or group)
	5,675 received a case management service
	3,533 received a community team-based service (CCST)
	355 received a recovery support service
Number of Persons Receiving Inpatient Detox Service(s)[7]	Community Services for Persons Receiving Inpatient Detoxification Services (Received at least one service)

[5] Data Source: Department of Children and Families, Substance Abuse and Mental Health Information System (SAMHIS). This only includes individuals whose services were funded by DCF.
[6] Represents unduplicated count of persons served who received at least one crisis stabilization service.
[7] Represents unduplicated count of persons served who received at least one substance abuse inpatient detoxification service.

17,409	3,575 received an intervention service
	2,815 received a medical service
	2,971 received an outpatient service (individual or group)
	2,824 received a case management service
	278 received medication assisted treatment
	521 received a recovery support service

Common practice statewide is once an individual is released from a CSU or Detox, the individual is given referrals to follow up on independently. If the individual does not show up, another appointment is made. After a number of missed appointments, the person will likely be discharged. This presents an opportunity for Care Coordination to have significant impact, by providing the individual support, assessment, planning and coordination that leads to a "warm hand-off" to needed services and supports.

Florida has seen success with pockets of care coordinated initiatives such as Family Intensive Treatment (FIT) teams, Wraparound, Florida Assertive Community Treatment (FACT) Teams, and others. Although the approaches may vary, the general concept of multi-disciplinary/multi-agency engagement, person and family centered focus with purposeful interaction and follow through with service linkage has shown to be effective.

The Project Team identified the following criteria for populations to be served under Care Coordination. However, MEs should have the flexibility to add groups of individuals who have been identified as high risk and having the potential to benefit from this intervention.

- Adults with three (3) or more acute care admissions (CSU, Detox, and inpatient) within 180 days;
- Adults with acute care admissions that last 16 days or longer;
- SMHTF referred individuals;
- Individuals identified by the Department, MEs or network providers as potentially high risk due to concerns that warrant Care Coordination.

ROLE OF CARE COORDINATION

Care Coordination is complex, blended with other theories and models that concentrate on person centered care, quality, service linkage and ultimately manifesting itself as integrated care. 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 contact until a person is adequately connected to care that meets their needs.

When defining the role of Care Coordination, it is important to note what it is not. Care Coordination is not an attempt to replicate or redefine case management. Although many of the functions of care coordination mirror that of case management, they are distinct interventions. **For the purposes of this initiative, Care Coordination serves to assist individuals who are not yet effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care.** That is to say, the right services, at the right time. This includes services and supports that affect a person's overall well-being, such as primary care, housing, and social connectedness. 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 needs to be linked with. Case management may be ongoing for those with chronic needs. Once an individual is successfully linked with a case manager, they would assume the responsibilities of coordinating care. The person may continue to be tracked at the ME level to continue to manage resource utilization and assess progress.

Care Coordination is also not a service in and of itself. 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 needed services and supports. At the person level it incorporates shared decision making in planning and service determinations and emphasizes self-management. Persons served and family members (as appropriate) should be the driver of their goals and recognized as the experts on their needs and what works for them.

In the broadest sense, 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.

Recognizing that this is a multi-year effort that will require multiple system changes as well as additional resources to realize those goals, the Project Team focused on the following goals in the short-term:

- Improve transitions between acute and community-based levels of care;
- Increase diversions from state mental health treatment facility admissions;
- Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness;
- Focus on an individual's wellness and community integration.

At the system level, Care Coordination should be 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. [8]

At the service level, it assesses for and addresses mental health and substance use problems as well as medical, social, housing, interpersonal problems/needs that impact the individual's status. [9] It is a

[8] 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

mechanism for linking providers of different services to enable shared information, joint planning efforts, and coordinated/collaborative treatment to address identified needs.[1] 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.[10] It encompasses self-management support and resources offered to individuals and their families to support their management of their illness[1] Care Coordination also facilitates transitions between providers, episodes of care, across lifespan changes, and across trajectory of illness. [11] Below are the guiding principles and core competencies of Care Coordination agreed upon by the Project Team.

Guiding Principles

- Recovery-oriented
- Choice and needs driven care
- Flexible (when/where/how)
- Unconditional
- Data driven

Core Competencies

- Single point of accountability
- Engagement with person served and their natural supports
- Standardized assessment of level of care determination process
- Shared decision-making with person served
- Family and person centered, individualized, strength-based plan of care
- Coordination across the spectrum of health services (physical health and behavioral health) and social services, housing, education, and employment
- Information sharing - Health Information Technology (HIT)
- Effective transitions and warm hand-offs
- Culturally and linguistically competent

ROLES AND RESPONSIBILITIES

Care Coordination will be provided through collaboration between the ME's and providers. ME's will identify high utilizers with complex needs, and other target populations at the system level and provide relevant data, technical assistance and resource allocation to providers. Network service providers will be designated by MEs to implement Care Coordination at the individual service level. The following delineates the roles and responsibilities of stakeholder across the Care Coordination continuum:

Office of Substance Abuse and Mental Health (Department)

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[9] Closing the quality gap: A critical analysis of quality improvement strategies. Technical Review 9: AHRQ Publication No 04 (07)-0051-7. www.ahrq.gov

[10] Touchstone Mental Health Minneapolis, Care Coordination Program – Program Offerings. http://www.touchstonemh.org/programs-and-services/care-coordination

[11] Care Coordination Measures Atlas. AHRQ Publication. www.ahrq.gov

- State Mental Health Treatment Facilities:
    - Collaborate with MEs and providers to:
        - Improve communication and screening process
        - Implement the LOCUS for improved level of care (LOC) determinations
        - Develop a consistent discharge process across the state
    - Secure benefits for eligible residents prior to discharge
- Community SAMH Program
    - Work with Medicaid to align definition and activities of Care Coordination
    - Add Care Coordination as a billable covered service in ch. 65E-14.021, F.A.C.
    - Increase communication to share expectations, practices, and resources with the field
    - Clarify how funding can work under changes in ch. 65E-14, F.A.C. and
    - Work towards value based contracting within a grants and aids environment
    - Provide guidance and expectations that will carry over with staff changes, including:
        - Guidance for peer-operated services and related best practice
        - Guidance on parameters of data sharing from a legal perspective (HIPAA and 42CFR, Part II)
        - Guidance on change practice
        - Roles and responsibilities of the Planning Council
    - Transparent planning with key partners prior to implementation
        - Coordinate data so that clinical and fiscal information aligns. The system needs to be able to connect a person to services, cost, and outcomes
        - Standardized assessment (incl. co-occurring issues) that leads to treatment planning
        - Standardized LOC/functioning instrument (that can replace FARS/CFARS) and assist with funding licenses and trainings

<u>Families and Persons Served</u>

- Meaningful involvement in policy and plan development, including:
    - Developing a road map for involvement at all levels and developing benchmarks to measure that
    - Define “person-centered care” and how that relates to care planning and choice
- Provide guidance on peer support roles in the workforce
    - Role in engagement
    - Role of Peer Navigators
    - Role in transitions between levels of care – part of transition teams
    - Role in Care Coordination
- Increase involvement of the Planning Council
- Create opportunities for personal responsibility, even in the highest levels of care

<u>Providers</u>

- Contract with the MEs to implement Care Coordination services at the individual service level

- Share information and data across the system
- Agree to use and share standardized assessments and LOC determinations to reduce duplication
- Assess organizational culture and develop mechanisms to incorporate the core values and competencies of Care Coordination into daily practice at every level of the organization
- Transparent feedback to DCF and the MEs on barriers and resource needs:
    - Complete system of care self-assessment with MEs (including housing, transportation, etc.)
    - If services or supports are not available, use Care Coordination service funds to buy and build capacity in local systems (in partnership with MEs).
    - Collect and report on performance measures to evaluate quality of care

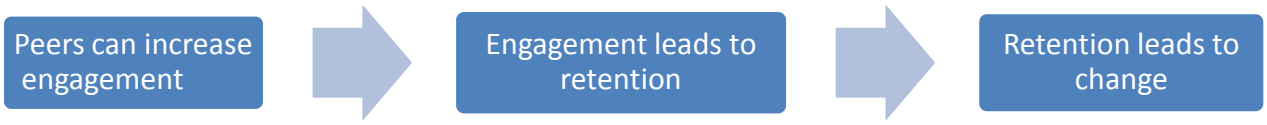
<u>Managing Entities</u>

- Contract with qualified providers for Care Coordination services based on history of community collaboration, consumer involvement, and effective referral systems with other providers and systems (e.g., primary health care, housing, vocational programs, criminal justice, etc.)
- Data portals for all available services so that MEs can connect with each other statewide and in future, other funders
- Monitor the system of care and work with providers and other stakeholders
- Identify high utilizers and individuals with complex, special needs who could benefit from Care Coordination
- Provide relevant data informed monitoring to identify individuals in need of Care Coordination
- Provide technical assistance and resource allocation to providers
- Identify and contract with provider(s) to provide Care Coordination with clear expectation and ongoing monitoring
- Manage and monitor Care Coordination funds for purchases of needed services and supports
- Monitor outliers, target priority populations, and need for additional or different services
- Ensure network adequacy and manage resources
- Assess and address quality of care issues based on established standards of care
- Develop cross system partnerships and agreements for information sharing and coordination
- Assist in eliminating barriers at the systems level to address regional and local behavioral health resources

USE OF CERTIFIED RECOVERY PEER SPECIALISTS (PEER SPECIALISTS)

In a recovery oriented system of care, Peer Specialists play a significant role, working in tandem with other professionals. Often Peer Specialists serve as the one responsible for coordinating the transition of care from one service or level of care to the next. The use of Peer Specialists is a cost-effective, evidence-based practice that improves clinical and social outcomes for individuals with behavioral health diagnoses. Oftentimes, the "initial" meeting for anyone, if overlooked, is a missed opportunity to begin the journey towards recovery. The initial interaction between a Peer Specialist and individuals in need of services could be the difference between failure and instilling a sense of hope. Figure 2 breaks this down to a basic formula;

Figure2:



Peer Specialists are skilled at identifying community resources and other connections. They are capable of providing a level of detail and knowledge that come from experience. For example, below is a list of opportunities to maximize the impact of Peer Specialist services:

- State Mental Health Treatment Facilities:
  Peer Specialists can engage with residents prior to and during transitions from SMHTFs to the community. The use of Peer Specialists could increase the ease and effectiveness of the transition process and identify additional needs along the way.
- Court system and diversion programs:
  Diversion would occur through the use of Peer Specialists, trained to provide forensic peer support in their community.
- Community programs and Crisis Stabilization Units (CSUs):
  Utilizing Peer Specialists at the point of entry into behavioral health services to orient an individual could immediately help to alleviate anxiety and uncertainty, creating opportunity for change.
- Correctional facilities:
  Peer Specialists can be utilized as community liaisons to assist individuals to engage in treatment. The more effectively individuals are engaged, the more likely they are to continue with treatment.

Anticipated outcomes of utilizing Peer Specialists for Care Coordination include:

- Increased sense of empowerment and personal responsibility of persons served as they partner in a process rather than being directed.
- Individualized care plans and increased follow through with identified services.
- Effective service coordination and utilization and engagement in community services and supports.
- Improved social functioning, use of natural supports, and community integration.
- Increased individual benefits including stability, self-efficacy, and self-management.

DETERMINATION OF SERVICE NEEDS

Assessments and standardized service need determinations are essential for successful care planning. This shapes the intensity of services. Placing individuals in a service or level of care that is not indicated can be harmful, even with the best of intentions. Standardized assessment tools that encompass cultural competency are of the utmost importance as individuals navigate through the system.

The Level of Care Utilization System (LOCUS) and the Children and Adolescent Level of Care Utilization System (CALOCUS) are assessments and placement instruments developed by the American Association of Community Psychiatrists (AACP) and the American Academy of Child & Adolescent Psychiatry (AACPA). These instruments are used to determine the needed level of care, they are not intended to be used as a diagnostic tool, nor are they intended to replace sound clinical judgment. The structured interview portion of the assessment includes a review with the person served on the outcome and provides opportunity to negotiate recommendations. Service needs are not stagnant; rather they are fluid. In a person and family-centered behavioral health system, we must be prepared to meet individualized needs. Assessments are a way to help identify those changes. The Department will need to identify and secure funding to provide training, certifications, and licenses for MEs and providers.

KEY CHANGES IN COORDINATING CARE

Changes will be required at all levels. As indicated earlier, Care Coordination will be provided through collaboration between the MEs and providers. ME's will identify high utilizers with complex needs, and other target populations at the system level and provide relevant data, technical assistance and resource allocation to providers. Network service providers will be designated to implement Care Coordination at the individual service level. What qualifies a provider will need to be established through ongoing collaboration with stakeholders.

MEs will need to create sufficient connections between providers and other system partners to allow individuals to move through care seamlessly. This will include working to address barriers such as information sharing and navigating multiple funding streams. They will need to provide data monitoring to ensure individuals receive the right care in the least restrictive setting that addresses their needs holistically. Partnerships with primary care, housing, criminal justice and child welfare will be essential. Network adequacy that provides sufficient community based support will need to be assessed and adjusted regularly. MEs will need to contract with providers that have demonstrated the core competencies of Care Coordination, as outlined earlier in this document, to develop models to implement in their regions.

The individual or team within the network service provider responsible for Care Coordination will be purposeful in their actions with a focus on the person's needs. The following are practices that may be incorporated into the Care Coordination models to be implemented by the selected providers:

- The care coordinator may meet the individual prior to discharge from an acute care or SMHTF setting.
- Following discharge from an acute care or SMHTF setting, the care coordinator will contact the individual by phone (if possible) within 48 hours of discharge.

- Upon discharge from acute care or SMHTF setting, the care coordinator will link the individual to the next treatment appointment within 7 days of discharge.
- Intentional warm handoffs are a time to begin engagement to treatment. For example, instead of only calling and setting up an appointment together, consider doing some of the following; get brochures of the place, set up a virtual meeting with the counselor to whom they are transitioning (or a conference call), research the provider online. Any activity to increase comfort and the likelihood to continue with treatment.
- Assess the individuals psycho-social and medical needs, including:
    - Are they being discharged into safe housing?
    - Are medical needs being addressed in an identified primary care setting?
    - Does the individual have any court dates that they may need support with?
    - Has the individual developed goals for their recovery?
- Assist the person get to the first appointment.
- Follow up on all referrals to ensure successful linkage.

METRICS

In order determine the effectiveness of Care Coordination activities, the following measures are recommended.

Short Term Goals (approach)

- Increase length of time between acute care episodes;
- Reduce readmissions of high utilizers;
- Improve time of linkage to next treatment appointment to within 7 days;
- Reduce wait time for persons awaiting SMHTF admission;
- Reduce length of stay in SMHTFs;
- Reduce wait time for discharge from the SMHTF to the community;
- Reduce readmissions to SMHTFs;
- Increase safe, permanent housing for those who are homeless; and
- Improve perception of care specific to Care Coordination (access/choice/well-being) through satisfaction surveys.

Long Term Goals (concept)

- Develop improved Care Coordination for all populations ;
- Link data and finance together to assess the cost of behavioral health services per person;
- Decrease frequency of persons entering or returning to acute care, child welfare, forensic systems, or SMHTFs;
- Develop communication and information sharing mechanisms across systems; and
- Explore contracting mechanisms that reward good performance.

CHALLENGES

As with any systemic change, Care Coordination will undoubtedly be faced with challenges. The following are areas for potential challenges:

- Lack of understanding or the difference between Care Coordination and case management;
- Continued funding for initiatives started with non-recurring funds;
- Data sharing capabilities across MEs, providers and other agencies;
- Developing and fully integrating the peer specialist workforce;
- Workforce development;
- Organizational culture shifts that require change in the way we operate;
- Safe and affordable housing resources; and
- Availability of needed services and supports that fully support recovery, such as:
    - Recovery Support (provided by Certified Recovery Peer Specialists);
    - Supported Employment;
    - Mobile Crisis;
    - Supportive Housing;
    - Family Support and Education; and
    - Wellness Management and Self-Care

PROMISING PRACTICES

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. The CRPS then supports the individual as they transition to the community.

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.[12]

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.

[12] *See,* http://caretransitions.org/about-the-care-transitions-intervention/, site accessed October 14, 2015.

- 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.[13]

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.

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

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. [14]

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

[13] See, https://pcmh.ahrq.gov/page/defining-pcmh, site accessed October 14, 2015.
[14] IOM (Institute of Medicine). 2010. *The healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary.* Washington, DC: The National Academies Press.

care be community-based and culturally and linguistically competent. Staff to family ratios should not exceed 1 Wraparound facilitator to 10 families. More information on Wraparound may be accessed at: http://nwi.pdx.edu/

Standardization of Care Coordination

Table 2 provides an example of an implementation plan for Care Coordination services at the provider level. This may be utilized as a tool to develop Care Coordination activities.

Table 2: Care Coordination Standardization		
Accountability	• Leadership commits to care coordination.	• Develop a quality improvement (QI) plan to implement changes and measure progress.
		• Develop appropriate measures
	• Develop a tracking system.	• Design the provider's information infrastructure to internally track and manage referrals/ transitions including specialist consults, hospitalizations, ED visits, and community agency referrals.
Client and Family Support	• Organize a multidisciplinary team to support clients and families.	• Delegate/hire and train staff to coordinate referrals and transitions of care, and train them in patient-centered communication, such as motivational interviewing or problem solving.
		• Assess client's clinical, insurance, and logistical needs
		• Provide follow-up post referral or transition.
		• Identify patients with barriers to referrals/transitions and help clients address them.
		• Develop standards for the expected frequency of services for target populations and protocols to address when the desired frequency is not met.
		• Define expectations of peer specialists
		• Develop standards for long-term injectables
Relationships & Agreements	• Identify, develop, and maintain relationships with community partners (i.e. specialist groups, hospitals, and community agencies).	• Complete internal needs assessment to identify key specialist groups and community agencies with which to partner.
	• Develop agreements with these key groups, hospitals, and agencies.	• Initiate conversations with key consultants and community resources.
		• Develop verbal or written agreements that include guidelines and expectations for referral and transition processes.
		• Standardize the information in referral requests and consultation reports to ensure it meets agreed upon expectations.

Connectivity	• Develop and implement an information transfer system.	• Investigate the potential of shared EHR or web-based e-referral systems; if not available, set up another standardized information flow process.
		• Establishing the conditions and infrastructure for ensuring quality referrals and transitions

NEXT STEPS

Next step is to deploy a workgroup that will be tasked with developing an action plan to implement the recommendations outlined in this framework. Specifically, the action plan needs to address the detailed steps necessary for successful implementation in the areas of policy changes, funding, protocol development, and monitoring.