Guidance 4
Care Coordination

Contract Reference:	*Section C-1.2.4*
Authority:	*Section 394.9082, F.S.*
Frequency:	Monthly Care Coordination Report (Template 21)
Due Date:	20th 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 Managing Entities and Network Service Providers, 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,

[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

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 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 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.

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.[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 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 – a standardized level of care assessment provides a common language across providers that can assist in determining service needs.
4. Shared decision-making – family and person-centered, individualized, strength-based plans of care

[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] 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.

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.

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, or
    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.

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

Under OCA MHCAS:

1. 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.

2. Children and adolescents with a mental health diagnosis, SUD, or co-occurring disorders who demonstrate high utilization. For the purposes of this document, high utilization is defined as: children and adolescents under 18 years of age with three (3) or more admissions into a crisis stabilization unit or an inpatient psychiatric hospital within 180 days, including:

    a. 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.

    b. 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.

3. Children not currently receiving services by a CAT Team.

Under OCA MSCAS:

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

The following populations may receive Care Coordination from the remaining balance of OCAs MS0CN and MH0CN allocated funds with Department Regional Office approval.

1. Persons with a 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.
2. Caretakers and parents with an SMI, SUD, or co-occurring disorders considered at risk for involvement with child welfare.
3. Individuals identified by the Department, Managing Entities, or Network Service Providers as potentially high risk due to concerns that warrant Care Coordination.

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. The transition plan shall be designed to ensure a warm hand-off and successful case management engagement.

III. IMPLEMENTATION

A. MANANGING ENTITY RESPONSIBILITIES

Managing Entities are responsible for system level care coordination and supporting Network Service Providers as they coordinate care at the person level. System level coordination includes the following activities:

1. Identify, through data surveillance, individuals eligible for Care Coordination based on the priority populations identified in section II.

2. Subcontract with Network Service Providers for the provision of Care Coordination using the allowable services outlined in section III.C. Network Service Providers must demonstrate a successful history of:

    a. Collaboration and referral mechanisms with other Network Service Providers and community resources, including, but not limited to, behavioral health, primary care, housing, and social supports,

    b. Benefits acquisition,

    c. Consumer and family involvement; and

    d. Availability of 24/7 intervention and support.

3. Track individuals served through Care Coordination to monitor the following outcome metrics:

    a. Readmission rates for individuals served in acute care settings,

    b. Length of time between acute care admissions,

    c. Length of time an individual waits for admission into a SMHTF,

    d. Length of time an individual waits for discharge from a SMHTF; and

    e. Length of time from acute care setting and SMHTF discharge to linkage to services in the community.

4. Manage Care Coordination funds and purchase services based on needs identified by Network Service Providers.
5. Track service needs and gaps and redirect resources as needed, within available resources.
6. Assess and address quality of care issues.
7. Ensure provider network adequacy and effectively manage resources.
8. Develop diversion strategies to prevent individuals who can be effectively treated in the community from entering SMHTFs.
9. Develop partnerships and agreements with community partners (i.e., managed care organizations, criminal and juvenile justice systems, community-based care organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data.
10. Provide technical assistance to Network Service Providers and assist in eliminating system barriers.
11. Work collaboratively with the Department to refine practice.
12. Implement a quality improvement process to establish a root cause analysis when Care Coordination fails.

B. NETWORK SERVICE PROVIDER RESPONSIBILITIES

Network Service Provider 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 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.
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. Free training is available at https://soarworks.samhsa.gov/course/ssissdi-outreach-access-and-recovery-soar-online-training.
10. 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.
11. Coordinate with the managing entity to identify service gaps and request purchase of needed services not available in the existing system of care.
12. 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.
13. Notify the Managing Entity of individuals identified for Care Coordination from the priority population specified in section II.1.c.

C. 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. 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

D. 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
--	MHCAS Children Care Coordination
--	MSCAS NAS/SEN Care Coordination

Only the covered services specified in Section C may be reported using the modifier codes identified for Care Coordination. Service data must be reported on the Network Service Provider detailed expenditure reporting in Templates 12 and 13. The Managing Entity shall submit a monthly Care Coordination Report using Template 21 - Monthly Care Coordination Report as an attachment to the SAMH Managing Entity Monthly Progress Report. Template 21 should include only individuals receiving Care Coordination funded with OCAs MH0CN and MS0CN.

IV. 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]

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

[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.

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 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/

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