CARE COORDINATION FOR CHILDREN WITH BEHAVIORAL HEALTH NEEDS

BRIDGING GAPS FOR YOUTH

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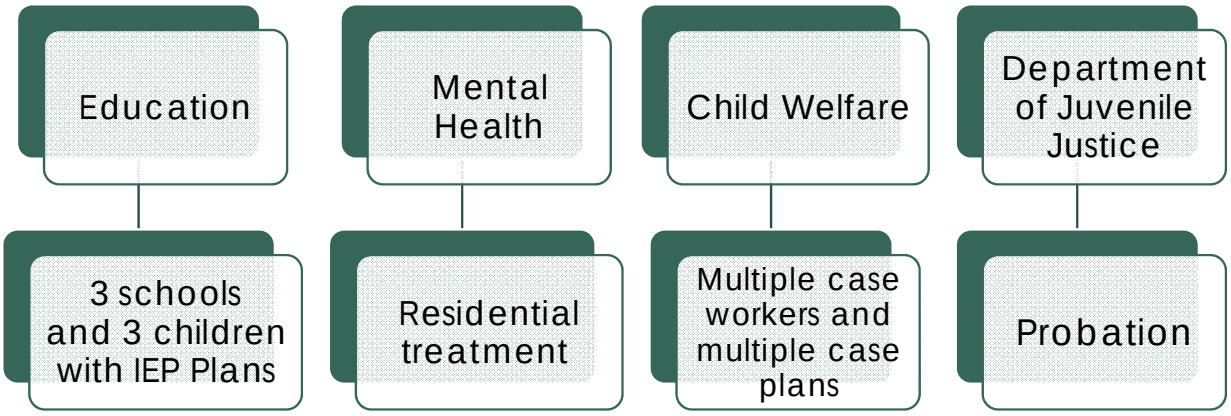
OBJECTIVES

1. Recognize that children's care coordination should be **individualized** and include **team-based communication** across multiple systems.
2. Understand care coordination should include **youth and family engagement** including in assessment and **shared plans of care** and include how to **connect the child and family to recovery and peer supports**.
3. **Identify social determinants of health** and recovery support domains and strategies to help families **develop the knowledge and skills** needed to **navigate systems of care** and manage recovery.
4. Develop skills to facilitate **effective care transitions** and **warm handoffs** between and within the multiple systems youth and family cross.
5. Pinpoint best practices for preparing youth for **transitions from pediatric to adult care**.
6. Become familiar with the **role of recovery community organizations**, recovery management and community support for children and youth.

FAMILY STORY

Working single mom	Grandmother	5 children
Teenager arrested for shoplifting	1 child placed in psychiatric residential treatment	3 children removed by child welfare

FAMILY'S ECOGRAM OF FORMAL SUPPORTS



LANGUAGE MATTERS

DO
- Put people first
- Emphasize abilities

DO
- Ask how to address someone
- Validate a person's experiences

DO
- Use language that promotes hope and the culture of recovery
- Reflect "unconditional positive regard" for people

RECOVERY-ORIENTED-LANGUAGE-GUIDE_2019ED_V1_20190809-WEB.PDF (MHCC.ORG.AU)

HIPAA AND CARE COORDINATION COMMUNICATION

3014-HIPAA and Health Plans – Uses and Disclosures for Care Coordination and Continuity of Care | HHS.gov

3007-Does HIPAA permit health care providers to share protected health information (PHI) about an individual who has mental illness with other health care providers who are treating the same individual for care coordination/continuity of care purposes? | HHS.gov

HIPAA ALLOWANCE FOR COMMUNICATION

MYTH

- A health plan or mental health treatment provider may not share information without a signed release of information.

FACT

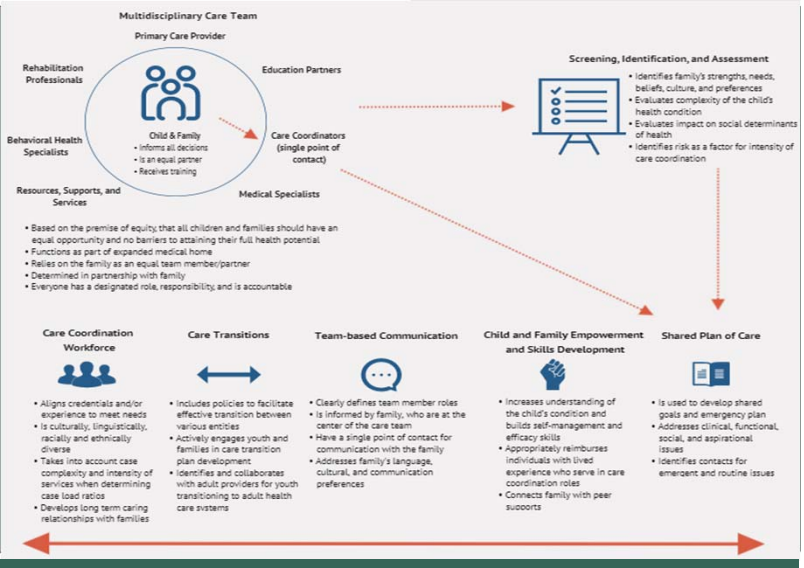
- Health plans and covered entities (including providers) may share person-specific information for continuity of care purposes i.e., treatment, case management or care coordination.

NATIONAL STANDARDS FOR CHILDREN AND YOUTH WITH SPECIAL HEALTH NEEDS

There are six (6) Domains linked to best practices for Care Coordination

- Screening, Identification, and Assessment
- Shared Plan of Care
- Team-Based Communication
- Child and Family Empowerment and Skills Development
- Care Coordination Workforce
- Care Transitions

NASHP
NATIONAL ACADEMY FOR STATE HEALTH POLICY



NATIONAL CARE COORDINATION (CC) FOUNDATIONAL STANDARDS

CC is based on the premise of health equity, that all children and families should have an **equal opportunity to attain their full health potential.**	CC addresses the full range of **social, behavioral, environmental, and healthcare needs.**	Families are co-creators of CC processes and are **active, core partners in decision making.**	Families, and care coordinators work together to **build trusting relationships.**
CC is **evidence-based where possible, and evidence-informed and/or based on promising practices.**	CC is implemented and delivered in a **culturally humble, linguistically competent manner.**	Insurance coverage of CC allowing for it to be **accessible, affordable, and comprehensive**.	**Performance activities** with outcome measures evaluating; ***Process *Experience *Quality *Reduction in service utilization**

STANDARDS FOR CARE COORDINATION: DOMAIN 1 – *SCREENING, IDENTIFICATION AND ASSESSMENT*

A systematic, timely, and clearly documented screening process is in place to identify all children and families who need care coordination. Policies and procedures should highlight an agency's, or system's, alignment with Care Coordination services within the System of Care.

The process of screening a child to identify need for care coordination uses information and data from multiple sources, including providers, medical records, claims, hospital admission, discharge, and transfer records, families and youth, education records, and records from other child-serving systems.

Care Coordination assessments should be the result of a collaborative conversations with families to identify needs and strengths. Care coordination assessments should be conducted in addition to, or in alignment with, other initial assessments upon enrollment in a health plan or other service delivery system.

STANDARDS FOR CARE COORDINATION:
DOMAIN 2 - *SHARED CARE OF PLAN*

The shared plan of care is a dynamic document that addresses the clinical, functional, and social service needs identified in the assessment. The shared plan of care considers and builds on the child's and family's strengths, and it describes delivery and coordination of all needed services.

The shared plan of care is reviewed and updated at least every six months or more frequently as needed, depending on the intensity of care coordination and/or in response to a triggering event. Care coordinators and members of the care team track progress toward goals and make updates to the shared plan.

The shared plan of care is accessible within a centralized electronic health record (EHR) to all members of the care team, including the family. With the family's consent and pursuant to applicable laws and regulations, the shared plan of care is shared with other providers and child-serving systems.

STANDARDS FOR CARE COORDINATION:
DOMAIN 3 – *TEAM-BASED COMMUNICATION*

Care team members remain in regular communication with each other and with any other providers serving the child using electronic tools, to the extent possible, to address challenges, and discuss solutions in a timely and efficient manner.

Care coordinators have policies and procedures in place to identify any other care coordinators who are serving the child, and to facilitate communication and coordination between them.

The care coordinator communicates and has referral arrangements with community-based organizations and agencies to address the child's medical, financial, educational, and social needs.

STANDARDS FOR CARE COORDINATION:
DOMAINS 4, 5,& 6 – *CHILD/FAMILY EMPOWERMENT, WORKFORCE TRAINING AND CARE TRANSITIONS*

The care coordinator and other members of the care team connect the child and family to peer supports.

Care coordinators should have the competencies needed for successful navigation across health, behavioral health, social service, and other child-serving systems.

Updated records from the health care, social service, education, behavioral health, and justice systems, including the most recently updated shared plan of care, are made available to youth and families to support successful transitions

Best Practices for Care Coordination Policies Should Involve….

- Assessment for screening for eligibility for Care Coordination
- Recovery-oriented, strengths-based language and approach (ROSC)
- Culturally humble and linguistically appropriate
- Outcomes-based and performance driven
- Training for staff and education for youth and families
- Commitment to individuals being served in the least restrictive level of care possible
- Shared choices, expectations, and decision-making throughout the process
- Use of natural supports
- Effective transitions and warm hand-offs
- Youth and family voice and choice

FLORIDA STATE LAWS

Chapter 2020-107 (also known as House Bill 945)

Children's Mental Health

MOBILE RESPONSE TEAMS

COORDINATED SYSTEM OF CARE PLANNING

CARE COORDINATION FRAMEWORK

DCF GUIDANCE DOCUMENT #4: CARE COORDINATION

- Single point of accountability
- Standardized assessment of level of care determination process
- Shared decision-making – family and person-centered, individualized, strength-based plans of care
- Community-based – services and supports take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible
- Engagement with person served and their natural supports
- Outcome based – Care Coordination ensures goals and strategies of the care plan are tied to observable or measurable indicators of success
- Information sharing – releases of information and data sharing agreements are used as allowed by federal and state laws
- Culturally (humble) and linguistically competent
- Coordination across the spectrum of health care
- Effective transitions and warm hand-offs
- Care Coordination should incorporate a recovery oriented, strengths-based approach (ROSC)

Managing Entities - Florida Department of Children and Families (myflfamilies.com)

CHILDREN'S PRIORITY POPULATIONS

- Children and adolescents in the child welfare system with behavioral health needs, who require assistance in transitioning to services provided in the adult system of care.
- Children and adolescents with a mental health diagnosis, substance use disorder, or co-occurring disorders who demonstrate high utilization.

HIGH UTILIZATION

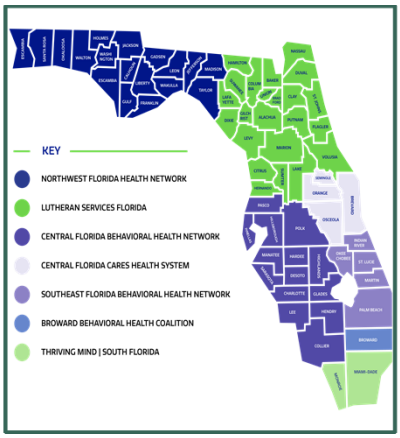
Acute Care (AC)

- Person with three (3) or more acute care admissions within 180 days.

Others Identified

- Individuals identified by the Department, Managing Entities or network providers as potentially high risk due to concerns that warrant Care Coordination.

FLORIDA'S MANAGING ENTITIES



Provide **oversight** of behavioral health (mental health and substance use) services for children and adults.

Managing Entities funding is primarily for the **uninsured and indigent.** However, for children's care coordination **it is used for underinsured**, as well.

Oversee contracted network of service providers ensuring **quality services** and **best practices** creating **regional systems of care.**

Review data and **modify system needs** accordingly.

Managing Entities - Florida Department of Children and Families (myflfamilies.com)

PROVIDERS

- Assess organizational culture
- Utilize a standardized level of care tool
- Provide 24/7 on-call availability.
- Serve as single point of accountability
- Assess the individual for eligibility of benefits
- Develop a care plan with the individual based on shared decision making
- Coordinate care across systems that impact the social determinants of health.
- Provide frequent contact for the first 30 days of services, ranging from daily to a minimum of three times per week.
- For individuals who require medications, ensure linkage to psychiatric services within 7 days of discharge from higher levels of care.
- Engage the individual in their current setting…to facilitate a warm hand off.
- Coordinate with the managing entity to identify service gaps and request purchase of needed services not available in the existing system of care.
- Develop partnerships and agreements with community partners to leverage resources and share data.
- Notify the Managing Entity of individuals identified for Care Coordination.

YOUTH AND FAMILIES

Family-centeredness	Relationship and trust building	Guiding the development and implementation of care coordination programs
• In alignment with family beliefs, values, strengths and hopes • Needs and preferences should guide decision making processes *(including how they want to communicate among team members)*	• Aim to build trust • Shared goals	• Using youth and family voice to guide system change

Level-Specific Roles within Care Coordination Model...
It's SYSTEMIC!

Funder

- Through data surveillance, information sharing across regional and system partners, partnerships with community stakeholders (i.e., housing providers, law enforcement, judiciary, primary care, etc.), and purchase of needed services and supports.

Provider

- Thorough assessment of needs, inclusive of a level of care determination, and active linkage, planning and communication with existing and needed services and supports.

Person

- 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.

RECOVERY-ORIENTED SYSTEM OF CARE

Florida's Department of Children and Families defines Recovery-Oriented System of Care as
" a network of clinical and nonclinical services and supports that sustain long-term, community-based recovery."

Goals:

*Promote good quality of life, community health and well-being for all.
* Prevent the development of behavioral health conditions.
* Intervene earlier in the progression of illnesses.
* Reduce the harm caused by substance use disorders and mental health conditions in individuals, families and communities and provide resources to assist people with behavioral health conditions to achieve and sustain their wellness and build meaningful lives for themselves in their community.*

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES HTTPS://WWW.MYFLFAMILIES.COM/SERVICE-PROGRAMS/SAMH/ROSC/INDEX.SHTML

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM

WRAPAROUND

- Focus on strengths, needs and culture
- Individualized planning process
- Team of the family's choosing
- Teaches skills and builds confidence

WRAPAROUND 101 TRAINING, THE RONIK-RADLAUER GROUP, INC. FUNDED BY THE FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES, OFFICE OF SUBSTANCE ABUSE AND MENTAL HEALTH; WRAPAROUND | SOUTHEAST FLORIDA BEHAVIORAL HEALTH NETWORK (SEFBHN.ORG)

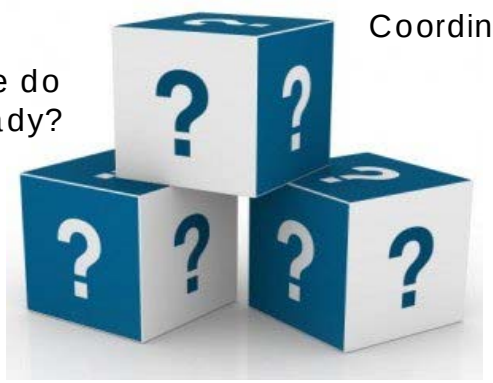
CARE COORDINATION?

Questions you may still be asking yourselves…

Is this just Case Management with a trendy new name?

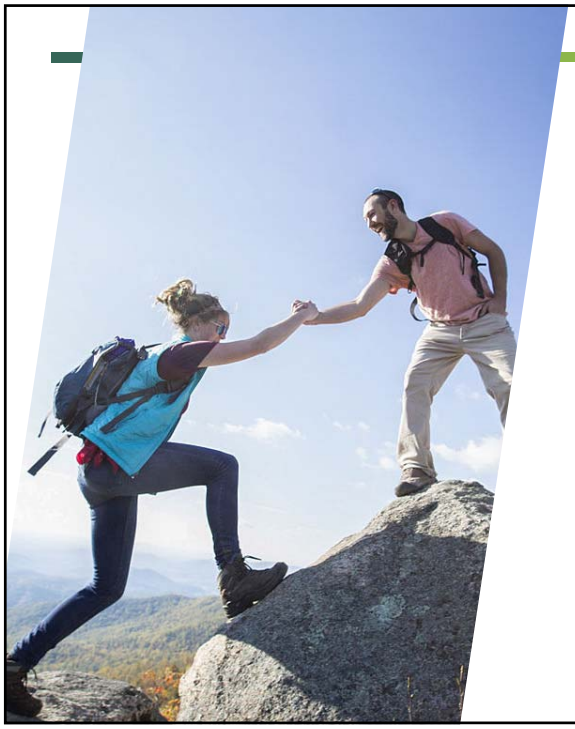
What is Care Coordination?

Don't we do this already?



ALL VALID QUESTIONS!

SO, WHAT EXACTLY IS CARE COORDINATION?



DEFINING CARE COORDINATION

There is no universal definition for care coordination. In 2016 the Florida Department of Children and Families convened a Project Team to develop strategies and recommendations to improve current practices. In order to ensure a common understanding of the term, they started with the Substance Abuse and Mental Health Services (SAMHSA) definition, modified it, and came to consensus on the following definition:

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

Care Coordination Project Team; Ute Gazioch Department of Children and Families 2/1/2016

ALL ABOUT TRANSITIONS

Case Management

- Referrals may be made to other services and then case is closed.
- A formal transition plan is developed.
- Typically, a discharge summary is completed with or without the individual's participation.

Case Coordination

- Transition is when the individual is linked to the most appropriate services that will meet the individuals immediate and long-term needs.
- There are warm hand-offs between services.
- There is no formal transition plan completed.

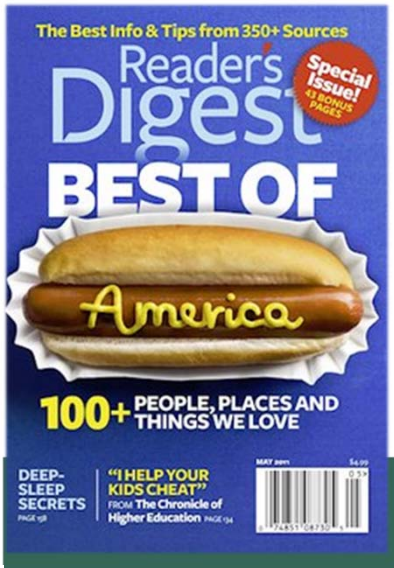
WHAT CARE COORDINATION IS… AND WHAT IT ISN'T

IS…

- An activity not a service
- Provided by a single point of contact (SPOC) for high utilizers transition to lower level of care
- Primarily implemented during transition phase(s)
- Time-limited

IS NOT….

- An attempt to replicate or redefine case management
- A service in and of itself
- Long-term



- Effectively connect persons with the services and supports especially at times of transition.
- Assess and consider the social determinants of health impacting a person's life.
- Engage and build upon social supports.
- Facilitate transitions between providers, episodes of care, across lifespan changes, and across trajectory of illness.
- Share information and data.

READER'S DIGEST VERSION

CASE MANAGEMENT

What is it?

Case Managers help people….

- identify their needs,
- plan their services,
- link them to the service system,
- coordinate the various system components,
- monitor service delivery, and
- evaluate the efficacy of the services received.

Sounds like Care Coordination?

You're right! Let's look at these similarities, shall we?

SIMILARITIES BETWEEN CASE MANAGEMENT AND CARE COORDINATION

Engage and gather information to assess.

Offer support, guidance and advocacy to help stabilize immediate needs.

Create a plan of action and maintain communication with each other to monitor.

Link individuals to the most appropriate services.

Transition when the individual is linked and stability is reached.

LOOKING AT THE **DIFFERENCES**…

Case Management

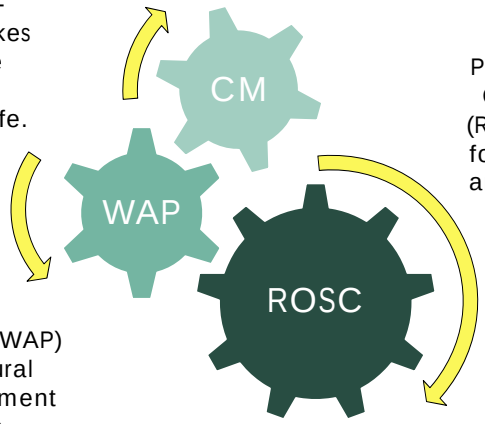
- Longer-term service
- Referral provision followed by monitoring of other services
- Formulation of care plan
- Data collection to determine efficacy of service provision

Care Coordination

- Shorter-term activities
- Referral provision/no monitoring
- Short-term plan to assist with transition.
- Warm hand-offs with no follow-up once individual engages in referred service(s)

THE GOLDEN THREAD

Case Management (CM)-specific service provision takes place for CC-appropriate consumers during pivotal transitions in a consumer's life.



Principles of the Recovery-Oriented System of Care (ROSC) lay the groundwork for Care Coordination and are referenced throughout the Care Coordination Framework.

The Wraparound Process (WAP) may guide the procedural process of Case Management or Care Coordination

FOUNDATIONS OF CARE COORDINATION

Principles

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

Competencies

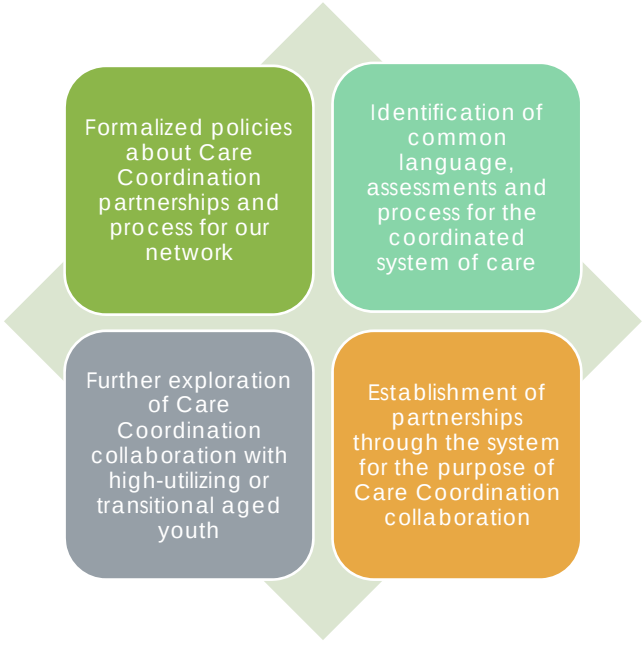
- Single point of accountability*
- Engagement with person served and their natural supports
- Standardized assessment of level of care determination process
- Shared decision-making with person served
- Family and person centered, individualized, strength-based plan of care
- Coordination across the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

GOALS OF CARE COORDINATION: *INDIVIDUAL – SHORT-TERM*

- 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
- Increase safe, permanent housing for those who are homeless
- Improve perception of care specific to Care Coordination (access/choice/well-being) through satisfaction surveys

GOALS OF CARE COORDINATION: *SYSTEMIC – LONG-TERM*

- 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, residential psychiatric or substance misuse treatment, child welfare and juvenile justice programs;
- Develop policies and procedures to support system change;
- Improve integration with primary care;
- Develop communication and information sharing mechanisms across systems; and
- Explore contracting mechanisms that reward good performance.



CHILDREN'S CARE COORDINATION

OPPORTUNITIES FOR GROWTH

COMMUNITY SUPPORT FOR YOUTH AND FAMILIES

Consider our family at the beginning of the presentation….

- How could community support for youth and families improve their lives?
- What can our communities offer and how can care coordination provide linkage to these supports?
  - System navigation/knowledge about local resources/communication with MEs
  - Connect to youth peer support groups
  - Parent support groups
  - Respite (formal programs or informal supports)
  - Recovery community organizations

CONTACT INFORMATION

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- Florida Department of Children and Families: Guidance Document 4 Care Coordination
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- Wraparound | Southeast Florida Behavioral Health Network (sefbhn.org)