Guidance 4
Care Coordination

I. Level Of Care Description

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 as they transition from higher levels of care to community-based care. Care Coordination concentrates on educating and empowering individuals while providing a single point of contact until they are adequately connected to the care that meets their needs. Care Coordination connects systems including behavioral health, physical health, peer and natural supports, housing, education, vocation, and the justice system. Care coordination may also include discharge planning activities.

II. Eligibility

Care Coordination serves individuals diagnosed with serious mental illness (SMI), substance use disorder (SUD), serious emotional disturbance (SED), or co-occurring disorders who demonstrate high utilization of acute care services, including: crisis stabilization, inpatient, substance abuse inpatient detoxification, and the Statewide Inpatient Psychiatric Program (or equivalent out of state treatment).

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 that:

- experience three (3) or more acute care admissions or evaluations at an acute care facility within 180 days
- have had an acute care admission that lasted 16 days or longer
- are awaiting placement in a state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community

Pursuant to s. 394.9082(3)(c), F.S., the Department has defined several priority populations to benefit from Care Coordination to serve the following:

- Individuals diagnosed with SMI, SUD, SED or co-occurring disorders who demonstrate high utilization.

- Individuals diagnosed with SMI, SUD, SED or co-occurring disorders at risk of re-entry to crisis stabilization, inpatient, and substance abuse inpatient detoxification.
- Individuals under court ordered involuntary outpatient services.
- Adults diagnosed with SMI awaiting placement in a state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community.
- Individuals diagnosed with 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.
- Caretakers and parents at risk for involvement with child welfare.
- 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.

- 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.
- Children and adolescents diagnosed with a mental health, SUD, or co-occurring disorder, including:
    - 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.
    - 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.
- Children on a waiting list to receive Community Action Treatment (CAT) Team services.
- 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: Florida Assertive Community Treatment (FACT), Coordinated Specialty Care for Early Mental Illness, CAT, Family Intensive Treatment (FIT), Comprehensive Community Service Teams (CCST), 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 does 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. Service Description

Care Coordination is implemented by both community behavioral health providers and Managing Entities. Care Coordination:

- Links providers of different services to enable shared information, joint planning, and coordinated/collaborative treatment.
- Engages available social supports to address identified basic needs for resources, such as applying for insurance/disability benefits, housing, food, and work programs.
- Facilitates the transition between providers, episodes of care across lifespan changes, and the trajectory of illness.
- Assists with or coordinates discharge planning efforts for individuals admitted to acute care and residential treatment settings.

By definition, there is currently no equivalent, reimbursable service by Florida Medicaid or any other commercial insurance. 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 can be referred. Case management may be ongoing for those determined eligible for this service based on current standards.

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

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,
- Focus on an individual's wellness, physical health, and community integration,
- Reduce 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.

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.

[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

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, and interpersonal problems/needs that impact the individual's status.[2]

Children's Care Coordination is accomplished at two levels; the Managing Entity level 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)[3] 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;
- Child and family empowerment and skills development;
- Care coordination workforce; and
- Care transitions.

Core Competencies

The Department has compiled a set of guiding principles and core competencies that must be considered in service design. 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[4]:

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 individuals 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 drive the Care Coordination process. The perspectives of the individuals served are intentionally elicited and prioritized during all phases of the Care Coordination process. The care coordinator provides options and

[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] 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/

[4] 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.

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 humble 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.

IV. Reporting Requirements

Care Coordination is a bundled service approach that is reported through an expenditure OCA or project code and using service modifiers as specified in Pamphlet 155-2. Only the covered services specified in Section C may be reported using the modifier codes identified for Care Coordination.

Project Code C4 captures expenditures appropriated to implement the provisions of Chapter 2024-245, Laws of Florida (HB7021). These expenditures should be coded to the following OCAs as appropriate: MHOCB, MSOCB, MHMDT, MH0CN, MS0CN. Allowable covered services must be reported in FASAMS as the actual covered service (i.e., case management, incidentals, etc.).

The intent of Chapter 2024-25, Laws of Florida (HB7021) is to provide enhanced discharge planning and ensure individuals are effectively connected to outpatient, community-based behavioral health services.

In addition to 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 - Care Coordination Report.

V. Managing Entity Responsibilities and Expectations

Managing Entities shall conduct system-level care coordination and support Network Service Providers as they coordinate care at the individual level. System-level coordination includes the following activities:

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

- 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:
    - Collaboration and referral mechanisms with other Network Service Providers and community resources, including, but not limited to, behavioral health, primary care, housing, and social support,
    - Benefits acquisition,
    - Consumer and family involvement; and
    - Availability of 24/7 intervention and support.
- Track individuals served through Care Coordination to monitor the following outcome metrics:
    - Readmission rates for individuals served in acute care settings,
    - Length of time between acute care admissions,
    - Length of time an individual waits for admission into a SMHTF,
    - Length of time an individual waits for discharge from a SMHTF; and
    - Length of time from acute care setting and SMHTF discharge to linkage to services in the community.
- Manage Care Coordination funds and purchase services based on needs identified by Network Service Providers.
- Track service needs and gaps and redirect resources as needed, within available resources.
- Assess and address quality of care issues.
- Ensure provider network adequacy and effectively manage resources.
- Develop diversion strategies to prevent individuals who can be effectively treated in the community from entering SMHTFs.
- 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.
- Provide technical assistance to Network Service Providers and assist in eliminating system barriers.
- Work collaboratively with the Department to refine practice.
- Implement a quality improvement process to establish a root cause analysis when Care Coordination fails.

Managing Entity Care Coordinator Responsibilities

Managing Entities with care coordinator funded positions shall coordinate care at the individual level with the following activities:

- Identify individuals eligible for Care Coordination through data surveillance.
- Track individuals served through Care Coordination to monitor the following outcome metrics:
    - Readmission rates for individuals served in acute care settings,

    - Length of time between acute care admissions,
    - Length of time an individual waits for admission into a Statewide Psychiatric Program (SIPP); and
    - Length of time from acute care setting and SIPP discharge to linkage to services in the community.
- Serve as a 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.).
- 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.
- Identify service gaps and purchase needed services not available in the existing system of care.
- Assess and address quality of care issues.
- Develop diversion strategies to prevent individuals who can be effectively treated in the community from entering a SIPP.
- 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.
- Assist in eliminating system barriers.
- Work collaboratively with the Department to refine practice.

Network Service Provider Responsibilities

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

- Assess organizational culture and develop mechanisms to incorporate the core values and competencies of Care Coordination into daily practice.
- Utilize a standardized level of care tool and assessments to identify service needs and choice of the individual served.
- Serve as a 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.).
- 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 handoff. Individuals served should not be expected to come to the care coordinator.
- 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.
- 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 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. This requirement does not apply to

discharge planning activities or positions funded under the C4 project code as those activities do not continue after the individual is discharged from the acute care or residential treatment setting.

- Provide 24/7 on-call availability.
- 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.
- Assess the individual for eligibility for 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.
- 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.
- Coordinate with the managing entity to identify service gaps and request the purchase of needed services not available in the existing system of care.
- 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.

VI. Incidental Expenses

Pursuant to chapter 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.

Incidental expenses pursuant to chapter 65E-14.021, Florida Administrative Code, are allowable under this program Network Service Providers must follow state purchasing guidelines and any established process for review and approval and must consult the Managing Entity regarding allowable purchases.

Before utilizing Incidentals, other resources must be explored, including eligibility for food, cash, and medical assistance through the Department of Children and Families Automated Community Connection to Economic Self Sufficiency (ACCESS) program. More information on ACCESS can be found at http://www.myflorida.com/accessflorida/.

APPENDIX A – RESOURCES

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

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/

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/

Recovery Support Bridgers/Navigators

Certified Recovery Peer Specialists (CRPS) are utilized to assist individuals successfully transitioning 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/

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 set up in-home follow-up visits and phone calls designated to increase self-management skills, and personal goal attainment, and provide continuity across the transition. More information on the Care Transition Programs may be accessed at: http://caretransitions.org

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 support.
- Accessible Services – a medical home delivers services in shorter wait times, enhanced in-person hours, and 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.[5]

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 the highest utilizers.

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 the application of these features will help organizations succeed as health homes. The *Behavioral Health Homes for People with Mental Health & Substance Use Conditions The Core Clinical Features* resource may be accessed at: www.thenationalcouncil.org/

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: www.mnhospitals.org/newsroom/news/id/183/rare-campaign-prevents-4570-avoidable-hospital-readmissions

[5] https://pcmh.ahrq.gov/page/defining-pcmh, site accessed March 4, 2024

Telehealth

The use of technology presents another promising practice in coordinating care, specifically as it relates 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 were transmitted to clinicians remotely located. The pilot reported reductions in hospital admissions and length of stay.[6]

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