Care Coordination & Authorization Workgroup

May 13, 2021
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<td>Introductions and review of overall System of Care approach in RI</td>
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Introductions

- Introductions: Please put your name and your organization and/or role in the chat.
- General overview of scope and goals of Care Coordination and Authorization Workgroup
- Identification of Care Coordination and Authorization Workgroup Co-lead
- Tracking any “parking lot” issues that need to be fed to other groups
Review: Children’s Behavioral Health in Rhode Island Today

**Lack of Clarity for Parents**

Navigating the children’s behavioral healthcare system in Rhode Island can be daunting, particularly when a child experiences a behavioral health crisis, especially for families of color. Parents may not know what to do, or who is available to help meet their child’s needs in a culturally and linguistically competent manner.

**Lack of Alignment within the System**

Our current system is siloed. Responsibility for children’s behavioral health services is fragmented across different state agencies. This makes it difficult for the system to deliver effective behavioral healthcare to all of our children and families in Rhode Island.

**Need for a More Organized System**

Rhode Island needs an integrated, culturally and linguistically competent continuum of behavioral health care for all children in the state that will provide an organized pathway to services and supports, in contrast to the multiple, typically confusing paths that are in existence today.
Key of SOC Elements

- **Exists** (although capacity may be below need)
- **Partially exists**
- **Doesn’t exist**

**Examples of Current Point(s) of Access (not a full list)**
- Kids’ Link RI
- FCCPs
- Medicaid MCOs
- Commercial Insurance
- Pediatrics
- Community: Schools, Hospitals, CBOs

**Examples of Current Point(s) of Access (not a full list)**
- Broad array of home, school and community-based services
- Culturally relevant intervention programs
- Linguistic and culturally competent workers
- Pedi-PRN, Peds, Psych
- FQHCs
- Telehealth

**Examples of Current Point(s) of Access (not a full list)**
- FCCPs with Wraparound
- Traditional case mgmt.
- MCO care coordination
- Health Homes
- Family Home Visiting

**Examples of Current Point(s) of Access (not a full list)**
- Two (of 8) CMHCs received recent grants for children’s mobile crisis response.
- Intensive in-home services
- Respite

**Examples of Current Point(s) of Access (not a full list)**
- Psychiatric Hospitals
- Acute Residential Treatment Services
- PRTF
- Group homes
- Specialized foster care
- Adolescent Substance
Goals of Care Coordination Workgroup over the next four months

• Identify short-term priority areas and solutions to address care coordination needs for children, youth and families.

• Identify challenges with care authorization and services involved

• Assess budget and other resource needs for care coordination. Consider SAMSHA grant, American Rescue Act Funds, and/or FY23 budget and non-financial resources.

• Create an implementation plan to improve care coordination and address short-term and long-term gaps and needs with measurable objectives.
Meeting schedule for Care Coordination Workgroup

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<td>May 13</td>
<td>Introduction to workgroup and care coordination</td>
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<td>June 10</td>
<td>Options for care coordination and building collaboration</td>
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<td>July 8</td>
<td>Care authorization</td>
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<td>Aug. 12</td>
<td>Implementation plan and next steps</td>
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Many children and families will have easily identified needs and they can be quickly and directly referred to service providers. However, other children will have serious emotional and/or behavioral disturbances and multiple system involvement and will require intensive coordination of services and supports. High fidelity Wraparound is a care management model considered a best practice model for Systems of Care. Traditional case management, MCO care coordination, or health home approaches are often not sufficient for children and youth with significant behavioral health challenges.

Proposal for Action:

- Expand the capacity of our family-driven Wraparound approaches to service planning and delivery through the Family Care Community Partnerships (FCCP) to ensure that services meet the family and youth’s identified strengths and needs and works to eliminate racial and ethnic disparities in the current system. This will allow for a care-planning approach for children with complex needs that is intensive, individualized, comprehensive, coordinated across child-serving systems, culturally and linguistically appropriate, and carried out in partnership with children and their families.
In 2009, DCYF created the Family Care Community Partnerships (FCCPs):

- Five regional FCCPs serve children and families who are not involved with DCYF.
- They serve children and youth with behavioral health challenges, youth involved with juvenile justice, as well as children at risk for involvement with child welfare.
- The FCCPs utilize wraparound as their care management model, a best practice model for Systems of Care. The FCCPs facilitate a defined, team-based service planning and coordination process that ensures that there is one coordinated plan of care for the child and family. Wraparound principles include family voice and choice, as well as cultural and linguistic competency.

The National Wraparound Initiative defines wraparound as the following:

Wraparound differs from many service delivery strategies, in that it provides a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. Wraparound puts the child or youth and family at the center. With support from a team of professionals and natural supports, the family’s ideas and perspectives about what they need and what will be helpful drive all of the work in Wraparound.

The young person and their family members work with a Wraparound facilitator to build their Wraparound team, which can include the family’s friends and people from the wider community, as well as providers of services and supports.

With the help of the team, the family and young person take the lead in deciding team vision and goals and in developing creative and individualized services and supports that will help them achieve the goals and vision. Team members work together to put the plan into action, monitor how well it’s working, and change it as needed.
Breakout Group Questions on Care Coordination

• What are the needs that care coordination should address?
• What are the elements of effective care coordination?
• Who is providing care coordination now and what are the needs that are not being addressed?

Please keep track of any big questions that come up about care coordination.
## Focus Group Report Outs

What are the three biggest points from the small group discussion that each group would like to mention?

What is one question that came up in the small group discussion that should be answered?

## Focus of Next Session

The next session will focus on ...

- Who should be receiving FCCP wraparound or another enhanced care coordination service
- Strengths we can build on in the system to provide enhanced care coordination
- Care coordination resource needs other than funding
- Strategies to build collaboration and cooperation with other systems/organizations to support care coordination

## Homework

For the next session, please come prepared to discuss....

- Additional thoughts on the elements of effective care coordination
- Who needs enhanced care coordination
- How we can build better partnerships to support care coordination
The next workgroup meeting will be ...

Thursday, June 10, from 2-3pm.

For any questions or additional thoughts, please contact

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Thank you!