Care Coordination & Authorization Workgroup

July 12, 2021

RHODE ISLAND

Today's Agenda

01 Recap of prior care coordination workgroup feedback

02 Target population for wraparound/care coordination

03 Pathway to access wraparound/care coordination

04 Outcomes and metrics

05 Closing remarks and next steps

Care Coordination

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.*

Wraparound Facilitation in Rhode Island

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.

May 13 Breakout Group Feedback on Care Coordination

System Needs

- One, centralized system and access point (do have KidsLink)
- Culturally and linguistically sensitive services overall
- Ability to know where there is capacity to take referrals
- School involvement
- MCO buy in and involvement
- Front end prevention
- Universal releases
- Services that are not stopped due to time limitswhile still needed
- Really good parent education
- Solutions for workforce challenges

Family engagement

- Based on family voice and choice, not what providers think a family needs
- Culturally and linguistically sensitive
- Must build up natural supports - coach, big brother, etc.
- Must ensure care coordinator is prepared ahead of time.
- Relationship building is critical to discovering what a family really needs
- Need right fit and connection
- Need to avoid overwhelming a family with services
- Helps when families don't have to tell story over and over

Other elements of care coordination

- Care coordination should be provided by whomever is addressing family's biggest need
- More than just case management and arranging for services
- Need quarterback to keep everyone on point when things get complex
- 6 month may be too short to help families with children with serious behavioral health needs
- Need care plan to follow child for an extended period and living documents that can follow family
- Having a lived experience is really useful in providing care coordination
- Need follow through with services
- Need timeliness, proactive not reactive

June 10 Breakout Group Feedback on Care Coordination

Necessary Resources

- Robust knowledge of services and which programs/services are currently taking referrals
- Central repository of info on children and families
- Housing and housing supports
- MCO flexibility in funding
- School participation
- Training on how to effectively engage children and families
- Services that pickup the phone/ respond (e.g., can't call a crisis service and get voicemail)
- Post-crisis response that does not fall off after the initial crisis
- System must be culturally and linguistically sensitive

Additional thoughts on care coor.

- Have the right people at discussions who can make things happen
- Need to be flexible (not fit families to the service)
- Need one point person who understands the family and whom the family trusts and feels supported by
- Everyone involved should have the family's goals in mind
- Must be designed for the long-term
- Must provide assistance early (e.g., intervene through day care to prevent later ED visit)
- Provide training and support for families on how to ask for what they want (not just training for professionals)

Who should access

- Families who are at a crisis level
- Families for whom traditional services are not working
- Any family with intensive needs
- Parents choose if they need care coordination

Discussion Question:

Who should be accessing wraparound/intensive care coordination?

- Family or child/youth who experienced a crisis?
- What types of behavioral health challenges?
- Other family situations?
- Any preference for trying another service first (e.g., mobile crisis response, a more traditional service)?

Workgroup Discussion

Who should access care coordination?

- Experienced a crisis?
- Types of behavioral health challenges?
- Other family situations?
- Tried other services first?
- Additional thoughts?

Comments:

Discussion Question:

How should families access wraparound/intensive care coordination?

- Triage through primary statewide BH access point?
- Contacting wraparound/intensive care coordination provider directly?
- Referral from mobile crisis response?
- Behavioral health provider referral?
- Referral from sources outside of BH system?
  - School
  - Daycare
  - CAP
  - Other?

Workgroup Discussion

How access wrap/care coordination?

- Through primary BH access point?
- Self-referral to wrap/cc provider?
- Referral from …
  - Mobile crisis
  - BH provider
  - School/day care
  - CAP or other?
- Additional pathways?

Comments:

Outcomes for Intensive Care Coordination/Wraparound

What outcomes and metrics do we want to measure?

Rigorous studies on wraparound have shown that, ***when implemented with fidelity***, wraparound facilitation has led to better functional and treatment outcomes:

- being suspended less often
- using more community services
- not running away as frequently
- living in a lower level of restrictiveness
- Living with families permanently more often

Source: rigorous-research-on-wrap-effectiveness.pdf (pdx.edu)

Current FCCP Performance Measures

DCYF works with Family Care Community Partnership (FCCP) providers to monitor a range of process and outcome measures:

- # of referrals and families served
- Referral source
- Family demographics
- Time from referral to first face-to-face contact
- Length of involvement with an FCCP
- % of families closed with all, most or partial wrap goals met
- % of children with subsequent maltreatment
- % of children who subsequently enter out-of-home care
- Results according to race/ethnity
- Compliance with Medicaid requirements

Workgroup Discussion

What outcomes and metrics need to be measured?

- Process measures?
- Outcome measures?
- How will we know if wraparound/intensive care coordination is working?
- How do we capture and address disparities according to race/ethnicity?

Comments:

Next Care Coordination & Authorization Workgroup Meeting

The next workgroup meeting will be …

Monday, August 9, from 3-4pm.

For any questions or additional thoughts, please contact

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Thank you!