High Utilization of Crisis Stabilization Services: Children and Adolescents

Second Quarter Report: October - December 2020

Department of Children and Families

and

Agency for Health Care Administration

February 1, 2021

The Office of Substance Abuse and Mental Health within the Florida Department of Children and Families (department) is the state's legislatively designated mental health authority. In that capacity, the office is governed by Chapter 394 of the Florida Statutes (F.S.), has responsibility for the oversight of statewide prevention, treatment, and recovery services for children and adults with mental illness, and for the designation of Baker Act receiving facilities. The Agency for Health Care Administration (Agency) directs the state's health policy and planning. The Agency is responsible for the licensure of health care facilities including crisis stabilization units and inpatient psychiatric hospitals and administration of the Medicaid program.

On June 27, 2020, Governor Ron DeSantis signed House Bill 945 to revise s. 394.493, F.S., requiring the identification of children and adolescents who are the highest utilizers of crisis stabilization services (CSU). The agencies define high utilization as children and adolescents under 18 years of age with three or more admissions into a crisis stabilization unit or an inpatient psychiatric hospital within 180 days. The agencies are required to jointly submit quarterly reports to the Legislature that lists the actions taken to meet the behavioral health needs of these children until Fiscal Year 2022.

The department and Agency continued bi-weekly internal agency meetings and joint agency workgroup meetings. The department and the Agency created a 2020-2021 project plan (See Appendix A) during this quarter in order to identify goals. The overall goal for the project is to identify children who meet the high utilizer definition and work with the health plan or the Managing Entity to coordinate care and reduce utilization of crisis stabilization services. Below are the strategies and the corresponding actions taken during the quarter. These quarterly strategies also work toward the overall recommendations of previous reports, addressed in Appendix B. These recommendations and follow-up from the data sharing agreement will guide the objectives and strategies of the next reporting quarter.

Goal: The Department of Children and Families and the Agency for Health Care Administration will focus on decreasing the number of children who are high utilizers of crisis stabilization services.		
Objective: Identify children who meet the high utilizer definition and work with the health plan or the Managing Entity to coordinate care and reduce future utilization of crisis stabilization services.		
Strategies:	Status:	Next Steps:
1. By January 21, 2021 identify current review processes used at the local, regional, and state level.	Complete	– Streamline existing multidisciplinary staffing processes – Address barriers identified by health plans
2. By February 11, 2021 identify children by obtaining 2019 baseline data and 2020 data.	In progress	– The inter-agency data sharing agreement has been executed. It will now be used to compare the agencies' baseline data and identify a shared list of children and move forward in the process to coordinate care with the respective health plan or managing entity.
3. By February 28, 2021 arrange meetings with the managing entities, additional state agencies and health plans to begin coordinating care for identified children and develop strategies.	In progress	– Identify areas of improvement to current processes – Assist and support implementation of the Managing Entities Organization Framework to develop a children's behavioral health system of care. – Identify ways to leverage current community resources – Identify ways to increase interagency collaboration on the children that fall within the high utilizer definition

Strategy 1. By January 2021 identify current review processes used at the local, regional, and state level.

There are different staffing processes around the state that could be leveraged to address the specific needs of individuals identified through data analysis as high utilizers of crisis stabilization services. The department identified existing staffing processes and the system partners to include when developing strategies to address the needs of high utilizers. The following statewide processes were identified:

- Multidisciplinary team Baker Act staffings: Coordinated by the Community Based Care (CBC) Lead Agency; sometimes coordinated by the department (when there is an open child protective investigation) and sometimes led by CSUs. This staffing is required by the department's Office of Child Welfare under CFOP 170-1 and conducted after a child involved with the child welfare system is admitted to an inpatient unit under a Baker Act.
- Child Advocacy Center - Multidisciplinary team staffings: Coordinated by the Child Advocacy Center. These staffings are for children with an open child protective investigation with at least one other factor that increases risk of dependency and mental health issues. Authorized in s. 39.3035 F. S.
- Family Services Planning Team (FSPT)/Child Specific Staffing Team (CCST)/Youth At Risk (YAR) staffing: Managing Entities may contract with providers, coordinate, or participate in a local staffing process for children with multiple behavioral health needs. The managing entity may contract funds to the team to purchase behavioral health services and supports. The YAR staffings are generally focused on identifying children with emerging behavioral health needs. When a parent or guardian is seeking residential treatment for a child or adolescent, they may be referred to a YAR team.
- Multidisciplinary team staffings for children/youth involved in child welfare and in therapeutic placement: Coordinated by the CBC Lead Agency. These staffings are conducted when children involved in the dependency system are in or being considered for therapeutic placement.
- The 2017-2022 Interagency Agreement between child serving state agencies to coordinate services for children served by more than one agency describes a tiered level of staffings as described below:
  - Circuit Level/Local Review Team: Coordinated by the Department Circuit Community Development Office (Local Review Team lead). Anyone can refer a child or adolescent to the Local Review Team. The team includes the parent or guardian, service providers, Medicaid Managed Medical Assistance Plans, school, and other involved agencies. The team develops a plan for services and supports and conducts follow up staffings. If the team is unable to resolve the situation, they may refer the case to the Regional Review Team.

- Regional Level/Regional Review Team: Coordinated by the Department Circuit Community Development Office (Regional review team lead). The team includes the Local review team and representatives from the department's regional office and other regional state agency leadership. The Regional Review Team makes recommendations to the Local Review Team for services and supports and other actions. If unable to resolve the situation, they may refer the case to the State Review Team.
- State Level/State Review Team: Coordinated by the Department's Office of the Assistant Secretary for Operations. The State Review Team participants include the Local Review Team and state level representatives from the agencies involved with the child. The team makes recommendations to the Local and Regional Review Teams. Depending on the situation, recommendations may involve engaging agency leadership. Generally, these cases involve placement and or funding issues.

These processes appear to be tied to involvement in child welfare, but not all of the processes are limited to those that come to the attention to the department or CBC Lead Agency through child welfare. Using the definition of high utilization established by the agencies, the department can ensure CSUs are aware of the existing staffing processes locally and streamline the types of multidisciplinary teams to assist with meeting the needs of high utilizers at the community level. This will be a focus of effort in the Third Quarter reporting period.

In October of 2020, the Agency added to the Statewide Medicaid Managed Care (SMMC) contract requirements for health plans to assign a care coordinator to all enrollees under the age of twenty-one (21) with special health care needs and is in need of out-of-home/residential treatment services to ensure timely placement and access to care. The health plan's care coordinator is required to remain lead in the enrollees' care coordination even if the child is involved in multiple state agencies to ensure the enrollees' needs are met, must maintain routine contact with other state agencies, and must document all efforts to find placement in the enrollees' records. This addition to the SMMC contracts ensures enrollees with special health care needs are provided the necessary care coordination to receive the services needed and to help prevent future CSU or behavioral health inpatient admissions.

The Agency confirmed with a sample of Medicaid health plans that they have processes to identify high utilizers of CSUs and behavioral health inpatient admissions. The health plans sampled consider any child with two or more behavioral health admissions within six months as complex cases. Through the use of behavioral health utilization management teams, health plans are able to identify these children quickly and begin making contact to ensure the needed services are rendered, caregivers have additional

supports (e.g., medication management, therapeutic services, family counseling, peer support services, and mobile crisis stabilization units) and frequent contact is made with providers and caregivers. Specific health plan measures identified in the preliminary sample include the following:

- Assigning a clinical case manager to all enrollees who fit the definition of high utilizer so each can receive intensive and targeted case management.
- Conducting daily, weekly, and monthly rounds on the children with the most complex issues. These rounds include the health plan case managers, health plan medical teams, hospitals, and community providers. The frequency of the rounds is dependent on each case and the level of severity.
- Working with community providers, Florida Assertive Community Treatment teams, CAT teams, hospitals and caregivers to provide these enrollees with the necessary services needed to treat their diagnoses.
- Conducting pilots with particular hospitals to address the readmission rates of these children by placing a licensed clinical utilization management staff, such as a licensed mental health professional, within the hospital to begin the process of authorizing services immediately, working with the enrollee to provide the care they need, speak with their providers to alert them of recent admissions and begin discussing plans for discharge.
- Health plans in the sample identified the following barriers to reducing CSU and behavioral health inpatient admissions:
  - Caregivers denying additional case management services or unable to be reached. Health plans make frequent attempts to contact, at a minimum of five attempts within a quarter, via phone calls and letters.
  - When the Department of Juvenile Justice (DJJ) is involved, caregivers sometimes reach out to them before reaching out to the health plans, which makes it difficult for health plans to intervene and prevent readmissions and offer alternative services.
  - Admissions and Baker Acts are also coming from schools where law enforcement is involved, which leaves the health plans without notice of the admission until after the child is in the CSU or hospital.
  - Enrollees are involved with several other agencies (e.g., Agency for Persons with Disabilities, the Department, and DJJ) that are providing or mandating services which makes enrollees' compliance to services and communication with caregivers a barrier. Caregivers have a hard time complying with communication for all different agencies and navigating the systems.
  - Limited community resources in certain areas due to wait lists, providers at maximum capacity for programs, and lack of providers in areas. Health plans identify providers, where available, in areas with limited Medicaid providers for

particular services and enter into single case agreements so enrollees can receive needed services.
    - Enrollee non-compliance with plan of care.
    - COVID-19 has reduced face to face visits and check-ins with enrollees and has contributed to enrollee non-compliance.
- The Agency is conducting a thorough case file review of a sample of the children identified as high utilizers of CSUs and behavioral health inpatient admissions.
- The Agency is working with health plans to identify best practices, areas of improvement, and ways additional entities or stakeholders can be included in discussions to help reduce high utilizer readmissions of CSUs and behavioral health inpatient admissions for children 18 years of age and younger.
- The Agency and the department are working together to identify opportunities for improvement at the state, regional, and local levels that will address barriers identified by health plans and include teams from the various levels to standardize escalation protocols for high utilizers.

Strategy 2. By February 2021 identify children by obtaining 2019 baseline data and 2020 data.

The Agency analyzed 2019 data and identified approximately 2,300 children with high admissions to CSUs and behavioral health inpatient admissions for calendar year 2019. Top utilizers were identified and case discussions with five health plans on the highest utilizing recipients were conducted in December 2020. Further analysis of this data will be presented next quarter.

Strategy 3. By February 2021 arrange meetings with the managing entities and health plans to begin coordinating care for identified children and develop strategies.

The Agency initiated meetings with the health plans. The Agency and the department met with the Florida Association of Managing Entities on January 8, 2021 to discuss progress toward the requirement to develop a behavioral health system of care for children in Florida. The Managing Entities have worked together to develop an Organizational Framework, including a reporting template, to guide their activities for developing a coordinated system of care planning process. The managing entity planning process has accomplished the following:

- A review of MRT subcontracts to identify gaps
- Trained child welfare professionals around MRT
- Engaged and educated school districts about the MRT protocol
- Established a Steering Committee comprised of key stakeholders

Future activities include:

- Establish a board of directors and steering committee

- Leverage behavioral health workgroups already in place
- Identify system problems and potential solutions

Other work of note related to the project includes:

Report on Involuntary Examination of Minors, 2019

Standards of Care in Facilities Providing Crisis Stabilization Services for Children and Adolescents

The Baker Act, Florida Mental Health Act, Fiscal Year 2018-2019 Annual Report

Quarterly Summary

Pursuant to Section 394. 493 (4), F.S., the Department and Agency's second quarter actions included identifying and taking action on project goals, analyzing 2019 data, and meeting with system partners.

Appendix A: 2020-2022 Plan to Decrease High Utilizers of Crisis Stabilization Services

Goal: The Department of Children and Families and the Agency for Health Care Administration will focus on decreasing the number children who are high utilizers of crisis stabilization services.

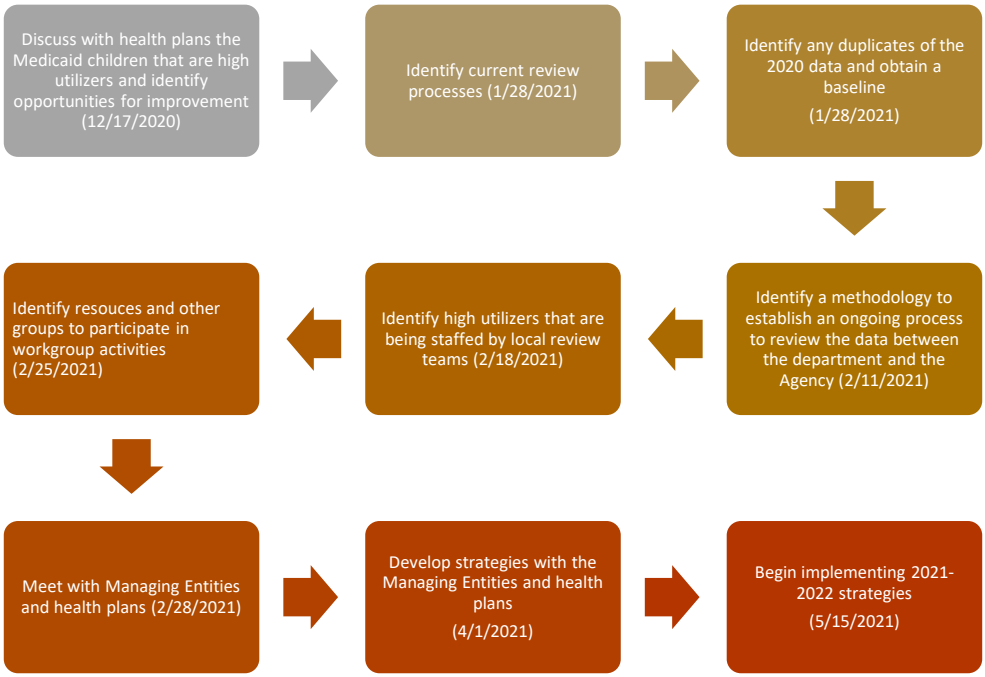
Objective:

Identify children who meet the high utilizer definition and work with the health plan or the Managing Entity to coordinate care and reduce future utilization of crisis stabilization services.

Strategies:

1. By January 21, 2021 identify current review processes used at the local, regional, and state level.
2. By February 11, 2021 identify children by obtaining 2019 baseline data and 2020 data.
3. By February 28, 2021 arrange meetings with the managing entities and health plans to begin coordinating care for identified children and develop strategies.

Action Steps



Appendix B: Progress toward the recommendations from the 2019 *Report on Involuntary Evaluation of Minors* and the November 2020 report on *Standards of Care in Facilities Providing Crisis Stabilization Services for Children and Adolescents*

Recommendation	Action This Quarter	Next Steps	Percent Complete
Increase care coordination for minors with multiple involuntary examination or crisis stabilization admissions.	Increasing capacity for high intensity children's care coordination and Community Action Treatment (CAT) teams through the CARES Act funding.	– Implement funding to provide children's care coordination and expansion of CAT services. – Plan for sustainability through Legislative Budget Requests and utilization of Community Mental Health Block Grant.	85%
Rule Development to Amend Administrative Rule 65E-5.	In addition to language regarding discharge planning processes discussed in the First Quarter report, the department drafted language to revise administrative rule 65E-5 requiring crisis stabilization unit providers to implement policies and procedures that comprehensively address the needs of children and adolescents who are high utilizers to avoid or reduce their future use of crisis stabilization services. The policies and procedures will include a warm hand-off for intensive service delivery through a care coordinator or mental health targeted case manager.	– Rule promulgation and adoption. – Regional SAMH designation staff to work with designated receiving facilities on implementing enhanced discharge planning.	45%

Support Baker Act technical assistance by funding a position in the Office of Substance Abuse and Mental Health (SAMH).	While no additional funding was allocated to the department, this recommendation has been fulfilled by re-assigning a SAMH employee to a position working with Baker Act and Marchman Act policy to assist with efforts related to HB945.	– Continue to advocate for full-time support of these functions. – Utilize newly re-established Children's Behavioral Health Unit to support activities related to high utilizing children.	80%
Ensure that parents and guardians receive information about local Mobile Response Team (MRT) upon discharge from Crisis Stabilization Services.	In addition to amending the managing entity contracts to require contact information of the MRT in the area to parents and caregivers of children receiving behavioral health services during the First Quarter reporting period, the department has continued efforts to promote awareness of MRT services during the Second Quarter reporting period through the following actions: • Reviewed and provided feedback to the draft *Best Practices Response Protocol for Schools to Use Mobile Response Teams* submitted by the Florida Mental Health Institute (FMHI) within the University of South Florida. • Provided a presentation to the Department of Education and school districts about working with MRTs and utilizing the MRTs within schools.	– Implement FMHI's *Best Practices Response Protocol for Schools to Use Mobile Response Teams* with school districts, managing entities, and providers. – Utilize Regional SAMH designation staff to work with designated receiving facilities to ensure information on MRT is provided as part of the discharge process.	50%

	• Monthly meetings are held with the Department of Education to work toward resolving any issues that arise between schools and MRTs. • Established a workgroup to review the Substance Abuse and Mental Health Services Administration's *National Guidelines for Crisis Care Best Practice Toolkit* published in February 2020. The toolkit identifies best practices for MRTs in relation to crisis care services.		