



HEALTH
SYSTEMS

INTEGRATED CARE TEAMS: AN ESSENTIAL MODEL FOR REDUCING RECIDIVISM AND IMPROVING CLIENT OUTCOMES

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LSF Health Systems

WHO WE ARE:

- LSF Health Systems (LSFHS) is a not-for-profit health care organization headquartered in Jacksonville, Florida (USA).
- LSF Health Systems (LSFHS) is the second largest of the seven (7) Managing Entities serving the state-funded behavioral health care system in Florida.

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WHO WE ARE (contd.):

- LSFHS serves approximately 150,000 people per year with an annual budget of \$93 million through 35 contracted behavioral health care providers in Northeast and North Central Florida.
- Florida is the 4th most populated of the 50 states with nearly 19 million residents.
- Florida has 2nd highest rate of uninsured individuals in the USA (25%).

The State of Florida - USA

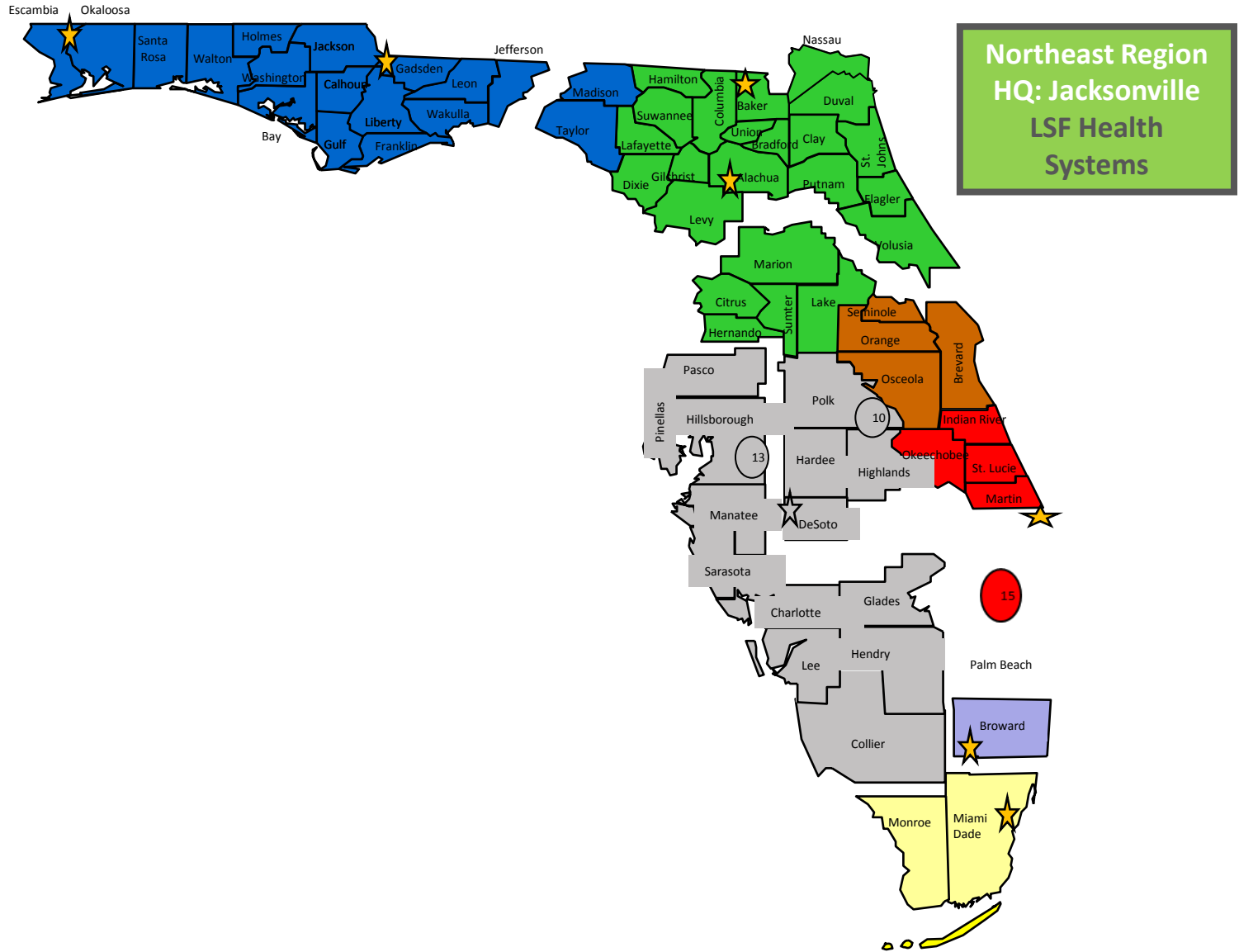


What is a Managing Entity?

- **Florida Statute 394.9082 (2008):**

“The Legislature finds that a management structure that places the responsibility for publicly financed behavioral health treatment and prevention services within a single, private, nonprofit entity at the local level will:

- Promote improved access to care
- Promote service continuity; and
- Provide for more efficient and effective delivery of substance abuse and mental health services.”



Managing Entity Funding

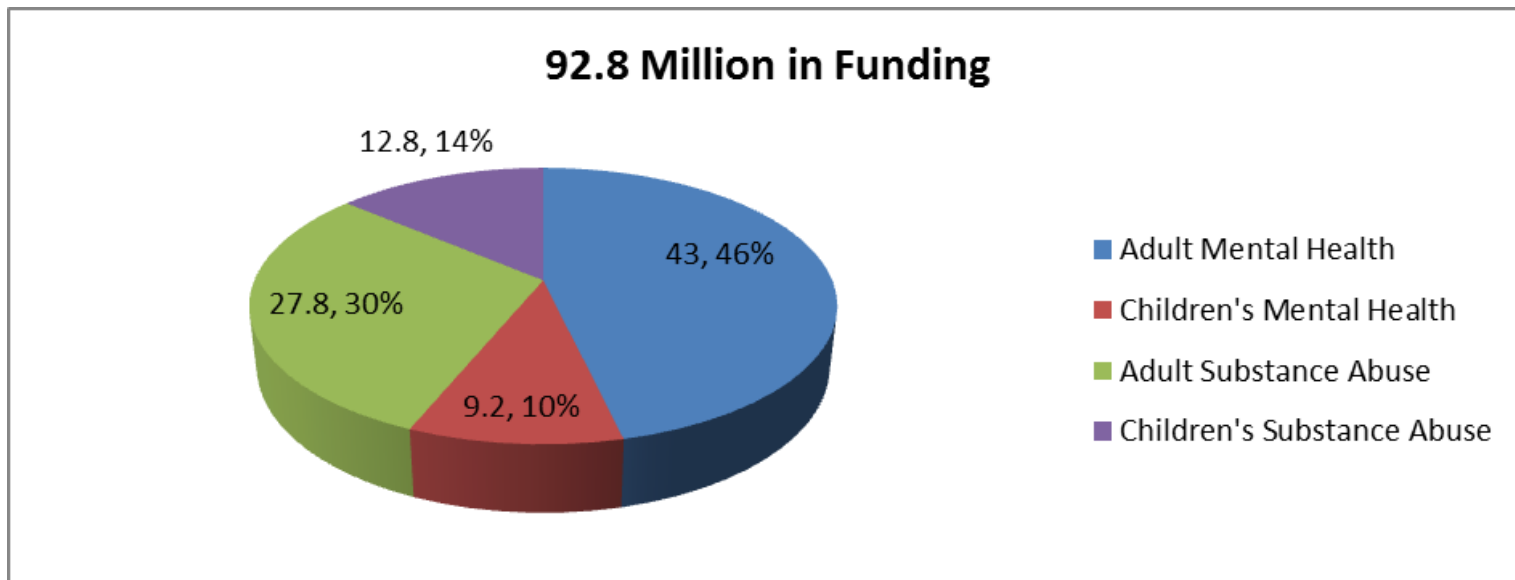
Funding for Managing Entities:

- State General Revenue
- Non-Competitive Federal Dollars Awarded to States to Serve Uninsured, Indigent Population

Florida ranks
49th out of 50 States
in USA for per capita funding for
mental health and substance
abuse services

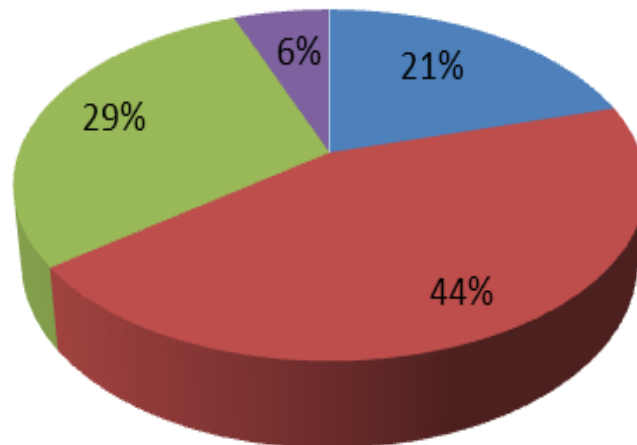
FL = **\$39.50**
US average = **\$120.56**

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35 Regional Service Providers



- Substance Abuse Agencies
- Mental Health Agencies
- Co-Occurring Agencies
- Prevention Agencies

Services Provided through Contracted Agencies

- Aftercare
- Assessment
- Behavioral Health Network - BNet
- Case Management
- Crisis Stabilization (adult/youth)
- Crisis Support
- Day/Night Treatment
- Drop-In, Self-Help Centers
- Florida Assertive Community Treatment (FACT) Teams
- Incidental Expenses
- Information and Referral
- In-Home and On-Site
- Inpatient
- Intervention
- Psychiatric Services

WHO WE SERVE:

- Most vulnerable and neediest individuals
- Special populations include:
 - ✓ Veterans
 - ✓ Older Adults
 - ✓ Incarcerated Individuals
 - ✓ Chronically Homeless Individuals
 - ✓ Children in the Foster Care System
 - ✓ Youth in the Juvenile Justice System
 - ✓ Individuals with a Serious Mental Illness

WHAT WE DO:

Management of State-Funded Behavioral Healthcare Services in 23-County Region:

- ✓ Contract Management and Performance Monitoring
- ✓ Consumer Advocacy
- ✓ 24/7 Access to Care Line
- ✓ Care Coordination
- ✓ Community Partnerships
- ✓ Needs Assessments
- ✓ Performance Monitoring
- ✓ System Development & Integration
- ✓ Training and Dissemination of Evidence Based Practices

LSF Health Systems

- **OUR VISION:** We envision communities where every child, adult, and family has access to the behavioral health care services they need to live well and be well.
- **OUR MISSION:** Our mission is to develop and sustain an integrated system of behavioral health care through a network of services built on integrity, innovation, and collaboration.

TWO MODELS *Operating Simultaneously*

Goal: *The Right Service, at the Right Time, in the Right Setting*

- SYSTEM-LEVEL: CARE COORDINATION TEAMS
 - PROVIDER-LEVEL: INTEGRATED CARE TEAMS

SYSTEM-LEVEL CARE COORDINATION TEAMS

Why Care Coordination?

- Several high-level crises had occurred in the State due to untreated Mental Health conditions
- Underfunded systems and fragmentation of care have contributed to these incidents
- Care Coordination leads to better outcomes for clients and lower costs

What is Care Coordination?

- “Community-Based Care Coordination” to identify emergent cases before they become crises
- Differs from Managed Care interventions as it is highly Community-Based, involving all systems of care
- Interdisciplinary teams within LSFHS to address high-need, high-utilizers of the system
- Teams target region-specific needs identified in the LSFHS Needs Assessment and resulting Strategic Plan

Three Essential Elements to Guide the Initiative:

- Blended Data Sets
- Interdisciplinary Teams
- Quantification of Value to the System

Essential Element #1

- **Blended Data Sets**
 - Substance Abuse and Mental Health
 - Criminal Justice Systems
 - School Systems
 - Homeless Management Information Systems
 - Hospital Systems

Essential Element #2

- **Interdisciplinary Team Approach**
 - **Community Engagement:** to engage stakeholders outside the Network to participate in Care Coordination
 - **Network Management:** to engage and hold contracted Providers accountable
 - **Clinical:** to provide individual Care Coordination services with clinical oversight

Essential Element #3

- Quantification of Value Added to the System
 - Each data set is quantified to represent a dollar amount
 - Monthly Reports show the impact to the System both in terms of lives touched and dollars saved

Make-up of Interdisciplinary Teams

- Network Manager
- Clinician
- Community Engagement staff member
- Management Representative

Team Meetings

- Weekly Meetings
- Teams led by Clinical staff
- Management participation to provide direction/answer questions

Target Populations

Four Target Populations by Need by Circuit

- Circuit 4 – Repeat Misdemeanor Offenders
- Circuit 5 – Children’s Baker Act population
- Circuit 7 – Homeless population
- Circuit 3/8 – SAMH Higher Levels of Care

Care Coordination Monthly Report

- Quantification of the Value
- Transformational stories of individuals and families whose lives have improved
- Publication of report to the State, Providers and Community Stakeholders
- Value is tracked over time to show gains

Impact

- 145 consumers are currently receiving Care Coordination services
- **Care Coordination Teams:**
 - improve communication between providers
 - align resources with consumer needs
 - establish accountability
 - facilitate transitions
 - support self-management goals
 - respond to change

PROVIDER-LEVEL INTEGRATED CARE TEAMS

Integrated Care Grants – January 2015

- Funding provided by LSF Health Systems (LSFHS) to local providers through competitive procurement process.
- Teams address needs identified in LSFHS Needs Assessment, the Circuit-specific priorities identified, and the state 's *Vision for the Future of Behavioral Health in Florida*.



15 proposals submitted

5 selected

Objective of the Teams:

- Reduce the use of high-end, high-cost services;
- Promote the stabilization of high-need, high-cost individual consumers;
- Eliminate the use of acute, crisis services as the primary source of behavioral health care for those clients identified;
- Support long-term recovery and resiliency;
- Reduce or prevent the adverse effects of substance abuse and mental illness; and
- Effectively and efficiently manage available funds ensuring that LSF Health Systems is the payor of last resort.

#1: St. Augustine Youth Services: Mobile Crisis Response Team (MCRT)

- Provides mobile crisis response based on Wraparound process with the goal of diversion from Crisis Stabilization Units.
- Creates a seamless continuum of care for clients and their families.
- The MCRT team consists of three licensed clinicians, a targeted case manager and a nurse.

Services:

- The three licensed clinicians provide in depth assessments and respond to calls from the schools, law enforcement and community agencies.
- In addition, each of the clinicians have a case load of youths to which they provide individual and family therapy.
- The targeted case manager provides services to youths referred from community agencies and the schools in St. Johns County.

Successes:

- Reduced the excessive number of Baker Acts being initiated in St. Johns County by 87 percent.
- Satisfaction surveys praise the team and the availability of the services.
- Youth and families in St. Johns County now able to access services they had not in the past. Several youths are currently receiving therapy for sexual abuse, self injurious behaviors and emotional regulation difficulties. These youths are now stable and many have been able to obtain money for summer camps, tutoring and therapeutic friends.

#2: The Sulzbacher Center for Duval County- Chronically Homeless Offenders Project (CHOP)

- Focuses on the homeless repeat misdemeanor offenders by breaking the cycle of arrest of individuals.
- Provides housing placement, medical, dental, behavioral healthcare and intensive case management.

Successes:

- To date, 100% of the clients enrolled in CHOP were assisted in applying for mainstream benefits within 60 days of entering the program.
- 100% of clients permanently housed since 02/01/15 have remained in stable housing once housed.
- 93% of all clients, regardless of housing date, have remained in stable housing once housed. Previous number of hospitalizations is not available at this time.
- Currently, 93% of CHOP clients enrolled since 02/01/15 have made no emergency room visits for behavioral health care.

#3: Stewart Marchman Act for Volusia County-Behavioral Wellness Project

- Focuses on high utilizers of mental health crisis services who meet the criteria for Involuntary Outpatient placement of the Baker Act.
- Incorporates elements of diversion programs, Assertive Community Treatment (ACT), and a Mental Health Court to improve the outcomes of mental health crisis services.

#4: LifeStream Behavioral Center for Lake County-Wellness Integration Network (WIN)

- Team focuses on providing integrated services to adults with serious mental illness and or substance abuse disorder living in Lake County.
- Expansion of WIN clinic to provide a primary care service and medical home to individuals who do not have access to care.
- Goal: Increase access to primary care, increase cost effectiveness and decrease use of acute care services.

#5: The Centers for Citrus and Marion Counties- Consumer-Centered Integrated Care Team

- Targets adults diagnosed with or at risk for heart disease, COPD, and/or diabetes and children in the child welfare program and their families diagnosed with or at risk for heart disease, COPD and/or diabetes. Both populations are also high-need, high-utilizers of behavioral healthcare.
- Prevents the progression and cycling of the high-need, high-utilizer to the acute level of care.
- Decreases cost of care and provides a more successful transition into the wellness community through the implementation of a comprehensive consumer navigation system.

INNOVATION IS KEY IN PROVIDING DIVERSIONARY PROGRAMS TO TREAT INDIVIDUALS IN THE LEAST RESTRICTIVE SETTING.

- ◆ **CARE COORDINATION** teams target high utilizing, high risk population groups to ensure clients are not "falling through the cracks" and are receiving the services necessary to reduce risk of recidivism.

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- ◆ **INTEGRATED CARE TEAM MODELS** ensure clients are treated in a holistic, strength-based, recovery-oriented manner to enhance their ability to lead productive lives.

PARTNERSHIPS AND COLLABORATIONS



Best-Practice Programs and Resources

THANK YOU!

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