Health Care Appropriations Subcommittee

Meeting Packet

March 20, 2013
1:00 PM—3:00 PM
Webster Hall

Will Weatherford
Speaker

Matt Hudson
Chair

The Florida House of Representatives

Appropriations Committee

Health Care Appropriations Subcommittee

Will Weatherford
Speaker

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AGENDA
March 20, 2013
Webster Hall (212 Knott)

I. Call to Order/Roll Call

II. HB 241 Community Health Workers by Reed

III. Presentation on Adolescent & Young Adult Community Mental Health Action Teams by Mary Ruiz, President/CEO, Manatee Glens Specialty Hospital and Outpatient Practice

IV. Closing Remarks and Adjournment

221 The Capitol, 402 South Monroe Street, Tallahassee, Florida 32399-1300
(850) 717-4814 Fax: (850) 488-9633

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 241 Community Health Workers
SPONSOR(S): Reed
TIED BILLS: **IDEN./SIM. BILLS:** SB 894

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 0 N	Rockowitz	O'Callaghan
2) Health Care Appropriations Subcommittee		Rodriguez	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Community health workers (CHWs) assume a wide range of roles in various settings to assist individuals with health care services, generally by performing patient advocacy, education, and direct care in isolated, underserved, and low socioeconomic neighborhoods. CHWs work as paid or unpaid volunteers within the community in which they live or have strong ties.

House Bill 241 defines the activities CHWs perform in communities and requires the Department of Health (DOH) to create the Community Health Worker Task Force (Task Force). The bill provides for and outlines the requirements of the Task Force. The bill requires the Task Force to develop recommendations for inclusion of CHWs in health care or Medicaid reform, inclusion of CHWs in assisting residents with navigation and with provision of information on preventative health care, and inclusion of CHWs into health care delivery teams. The Task Force will coordinate with The Florida Community Health Worker Coalition, colleges, universities, and other organizations to determine a procedure for standardization of qualifications and skills for CHWs employed by state-supported health care programs.

The bill has an insignificant negative fiscal impact on the DOH that can be absorbed within existing agency resources.

The bill shall take effect upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Community Health Workers (CHWs) serve in local health care systems for pay or as volunteers to help alleviate health care disparities in communities. CHWs deliver health care services with cultural competency, in part through intimate knowledge of the neighborhoods they serve. A report prepared for the U.S. Department of Health and Human Services examined 53 studies between 1980 and 2008 and found evidence that CHWs improve health outcomes.[1] A workgroup under the Center for Disease Control (CDC) reviewed literature on CHWs, and reported the profession is uniquely qualified to strengthen community ties, build partnerships, and foster community action in health care. Research supports that CHWs augment health care utilization, access, and education.[2]

CHWs are recognized under a variety of names, including lay health educators, peer health promoters, community health outreach workers, and in Spanish, promotores de salud.[3] In 2010, CHWs received a Standard Occupational Classification.[4] Texas, Massachusetts, Ohio, and Minnesota have recently officially recognized the job category of CHW.[5] Recently California, New Mexico, Oregon, and Pennsylvania have filed or passed legislation to certify or recognize CHWs.[6] Due to mounting visibility, more organizations including the Institute of Medicine are calling for CHW integration into health care strategies.[7]

CHWs perform a variety of services that include but are not limited to:

- Culturally competent education regarding prevention and disease management;
- Advocating for individuals and health care needs;
- Informal counseling and social support;
- Translation and interpretation of health care encounters;
- Help with health care literacy and accuracy;
- Providing direct services, such as health care screenings;
- Contributing to coordination of care;
- Strengthening of individual and community capacity;[8]
- Providing coaching, follow ups, referrals; and
- Patient navigation, particularly for chronic conditions.[9]

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[1] RTI International-University of North Carolina Evidence-Based Practice Center, Evidence Report/Technology Assessment Number 181, *Outcomes of Community Health Worker Interventions*, June 2009, *available at* www.ahrq.gov/downloads/pub/evidence/pdf/comhealthwork/comhwork.pdf (last viewed on March 8, 2013).

[2] National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, *Community Health Workers/Promotores de Salud: Critical Connections in Communities*, May 20, 2011, *available at* http://www.cdc.gov/diabetes/projects/comm.htm (last viewed on March 8, 2013).

[3] *Id.*

[4] Bureau of Labor Statistics, *Standard Occupational Classification 21-1094 Community Health Workers*, March 11, 2010, *available at* http://www.bls.gov/soc/2010/soc211094.htm (last viewed on March 8, 2013).

[5] Balcazar H., Rosenthal L., Brownstein N., Rush C., Matos S., Lorenza H., American Journal of Public Health, *Community Health Workers Can be a Public Health Force for Change in The United States: Three Actions for a New Paradigm*, December 2011, *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222447/#R19 (last viewed on March 8, 2013).

[6] University of Florida College of Pharmacy, Florida Community Health Worker Coalition, *Materials: Brochure*, *available at* http://www.floridachwn.cop.ufl.edu/ (last viewed on March 8, 2013).

[7] See *supra*, FN 5.

[8] American Public Health Association, *Policy Database, Support for Community Health Workers to Increase Access and Reduce Health Inequities,* 2009, *available at* http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1393 (last viewed on March 8, 2013).

[9] See *supra*, FN 5.

Present Situation

In 2007, it was reported that Florida has 2,640 paid and 1,556 volunteer CHWs for a total of 4,205 CHWs, the fourth highest number in the country.[10] In October 2010, the DOH received the Policy, Environmental and System Change grant from the CDC to assist cancer coalitions.[11] The Florida Cancer Control and Research Advisory Council (CCRAB)[12] called for utilization of CHWs as a priority strategy to facilitate treatment and access to services for minorities.[13] The CDC funds and CCRAB permitted the DOH to develop the Florida Community Health Worker Taskforce initiative in 2010 that evolved into the Florida Community Health Worker Coalition.[14] The all-volunteer group promotes the profession of CHWs. The coalition is composed of five committees: Policy, Curriculum Development, Networking/Sustainability, Research, and Practice.[15]

Effect of Proposed Changes

The bill states that a "community health worker" (CHW) is a front line health care worker who is a trusted member of a community or has close insight into that community, and functions to enhance quality of health care by fostering a bridge between individuals and services in a culturally competent manner. The bill states that a CHW works in "medically underserved community" or a geographic area with a shortage of health care professionals, and a population with income below 185 percent of the federal poverty level who lack health insurance and ability to pay for it.

The bill directs the Department of Health (DOH) to establish the Community Health Worker Task Force (Task Force) within a state college or university and at the request of an elected chair, use available resources to provide administrative support and services. The DOH will collaborate with organizations such as the Florida Community Health Worker Coalition and state colleges and universities to create a process for standardization of qualifications and skills of CHWs who work in state-supported health care programs.

The bill delineates activities CHWs perform in communities to assist local residents with clinical services, education, outreach, advocacy, and data collection in a culturally competent manner. CHWs provide residents information on local resources, give social support and informal counseling, educate and deliver information on wellness and disease prevention, and help administer first aid and blood pressure screenings. CHWs advocate for oral health, mental health, and nutritional needs. CHWs facilitate communication with health care providers by fostering communication skills in residents, and ensuring appropriate coordination of care.

The bill requires the Task Force to determine mechanisms for integrating CHWs into the health care system. Recommendations will include involving CHWs in the effort to increase enrollment into Medicaid Managed Care or other statewide health care programs, deliver information on preventative health care, aid in health care navigation, and participate in health care delivery teams of community health centers and other "safety net" providers.

The bill states that the 12 Task Force members must elect a vice chair and chair, serve without compensation, meet at least quarterly, consist of a quorum of seven, and have a concurring vote by the majority of members to take action. Members will submit a report to the Governor, President of the Senate, and Speaker of the House of Representatives by June 30, 2014.

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[10] U.S. Department of Health and Human Services, Health Resources Services Administration, Bureau of Health Professionals, *Community Health Worker National Workforce Study: March 2007*, available at bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf (last viewed on March 9, 2013).
[11] Department of Health Bill Analysis of HB 241, January 22, 2013, on file with committee staff.
[12] S. 1004.435, F.S.
[13] Florida Cancer Control and Research Advisory Council, Florida Cancer Plan Council: 2012-2013, *available at* http://ccrab.org/ (last viewed on March 8, 2013).
[14] See *supra,* FN 6. *Materials: CHW Year in Review Final.*
[15] See *supra,* FN 6. *Status Update.*

The Task Force is comprised of:

- A member of the Senate appointed by the President of the Senate;
- A member of the House of Representatives appointed by the Speaker of the House of Representatives;
- A state official appointed by the Governor;
- Six culturally and regionally diverse community health workers appointed by the Surgeon General; and
- Three representatives of the Florida Community Health Worker Coalition appointed by the chair of the Florida Community Health Worker Coalition.

B. SECTION DIRECTORY:

Section 1: Creates an unnumbered section of law entitled Community Health Worker Task Force.

Section 2: Provides an effective date upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   No impact.

2. Expenditures:

   The bill has an insignificant negative fiscal impact on the DOH associated with establishing, and providing administrative support and services to the Task Force. These expenditures can be absorbed within existing agency resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   The bill does not appear to have any impact on local governments.

2. Expenditures:

   The bill does not appear to have any impact on local government.

3. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

   The bill does not appear to have any impact on the private sector.

4. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The DOH has appropriate rule-making authority to implement this provision.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to community health workers; providing definitions; specifying the duties and activities of community health workers; creating the Community Health Worker Task Force within a state college or university; requiring the Department of Health to provide administrative support and services; providing membership and duties of the task force; requiring the members of the task force to elect a chair and vice chair; providing that task force members serve without compensation and are not entitled to reimbursement for per diem or travel expenses; requiring that the task force meet at least quarterly; specifying the number of members required for a quorum; requiring the task force to submit a report to the Governor and Legislature by a specified date; providing an effective date.

WHEREAS, Florida faces a number of challenges in providing access to health care services in both urban and rural areas which impair the health and well-being of state residents, and

WHEREAS, Florida continues to experience critical shortages of providers in primary health care, oral health care, and behavioral health care, particularly in rural and inner-city areas, and

WHEREAS, there is substantial evidence that comprehensive coordination of care for individuals who have chronic diseases and the provision of information regarding preventive care can

improve individual health, create a healthier population, reduce the costs of health care, and increase appropriate access to health care, and

WHEREAS, community health workers have demonstrated success in increasing access to health care in underserved communities, providing culturally appropriate education regarding disease prevention and management, providing translating and interpreting services for health care encounters, improving health outcomes through the coordination of care, increasing individual health care literacy and advocacy, and organizing to improve the health care of medically underserved communities while reducing costs in the state's health care system, and

WHEREAS, the Legislature recognizes that community health workers are important members of the health care delivery system in this state, and the Florida Health Worker Coalition has begun to explore options that would allow community health workers to earn a living wage and be part of an integrated health delivery team, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. Community Health Worker Task Force.—

(1) As used in this section, the term:

(a) "Community health worker" means a front-line health care worker who is a trusted member of or has an unusually close understanding of the community that he or she serves and who:

1. Serves as a liaison, link, or intermediary between health care services, social services, and the community in

order to facilitate access to health care services and improve the quality of health care services and the cultural competency of health care providers.

2. Performs the following activities in a community setting:

a. Provides information regarding available resources.

b. Provides social support and informal counseling.

c. Advocates for individuals and their health care needs.

d. Provides services such as first aid and blood pressure screening.

3. Builds individual and community capacity by increasing knowledge regarding wellness, disease prevention, and self-sufficiency through a range of activities, such as community outreach and education and advocacy.

4. Collects data to help identify the health care needs in a medically underserved community by:

a. Enhancing the communication skills of residents in order to assist them in effectively communicating with health care providers.

b. Providing culturally and linguistically appropriate health or nutrition education.

c. Advocating for better individual and community health, including oral health, mental health, and nutritional needs.

d. Providing referral services, followup services, and coordination of care.

(b) "Department" means the Department of Health.

(c) "Medically underserved community" means a geographic area that has a shortage of health care professionals and has a

population that includes persons who do not have public or private health insurance, are unable to pay for health care, and have incomes at or below 185 percent of the federal poverty level.

(d) "Task force" means the Community Health Worker Task Force established by the department under this section.

(2)(a) The department shall establish the Community Health Worker Task Force within a state college or university. The department shall provide administrative support and services to the task force to the extent requested by the chair of the task force and within available resources of the department.

(b) The task force shall consist of the following 12 members:

1. One member of the Senate appointed by the President of the Senate.

2. One member of the House of Representatives appointed by the Speaker of the House of Representatives.

3. One state official appointed by the Governor.

4. Six culturally and regionally diverse community health workers appointed by the State Surgeon General.

5. Three representatives of the Florida Community Health Worker Coalition appointed by the chair of the Florida Community Health Worker Coalition.

(c) The task force shall develop recommendations for:

1. Including community health workers in the development of proposals for health care or Medicaid reform in this state as part of the outreach efforts for enrolling residents of this state in Medicaid managed care programs or other health care

delivery services.

2. Including community health workers in providing assistance to residents in navigating the health care system and providing information and guidance regarding preventive health care.

3. Providing support to community health centers and other "safety net" providers through the integration of community health workers as part of health care delivery teams.

(d) The task force shall also collaborate with the Florida Community Health Worker Coalition, colleges and universities in the state, and other organizations and institutions to recommend a process that leads to the standardization of qualifications and skills of community health workers who are employed in state-supported health care programs.

(e) The members of the task force shall elect a chair and vice chair.

(f) Members of the task force shall serve without compensation and are not entitled to reimbursement for per diem and travel expenses.

(g) The task force shall meet at least quarterly and may meet at other times upon the call of the chair or as determined by a majority of members.

(h) A quorum shall consist of seven members, and the concurring vote of a majority of the members present is required for final action.

(i) The task force shall submit a report by June 30, 2014, to the Governor, the President of the Senate, and the Speaker of the House of Representatives stating the findings, conclusions,

and recommendations of the task force.

Section 2. This act shall take effect upon becoming a law.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Reed offered the following:

Amendment (with title amendment)

Remove line 134 and insert:

by a majority of members. Meetings of the task force may be held in person or by teleconference, or by other electronic means.

T I T L E A M E N D M E N T

Remove line 13 and insert:

force meet at least quarterly and may meet in person, by teleconference, or by other electronic means.

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION	
ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Reed offered the following:

Amendment

Remove line 63 and insert:

b. Provides social support.

Adolescent & Young Adult Community
Mental Health Action Teams

Mental Health & Addictions
Specialty Hospital and Outpatient Practice

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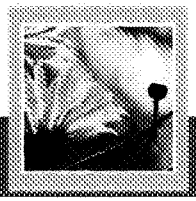
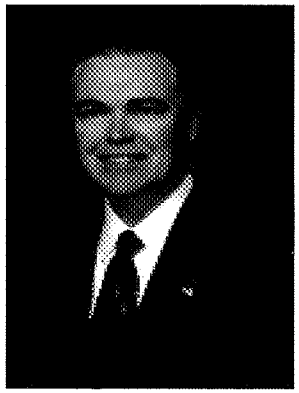
Community Action Team Response for Our Times

Florida House Appropriations Committee

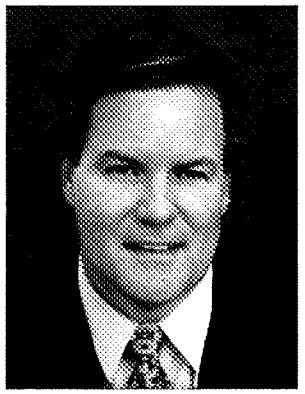
March 20, 2013

MARY RUIZ MBA
CEO MANATEE GLENS

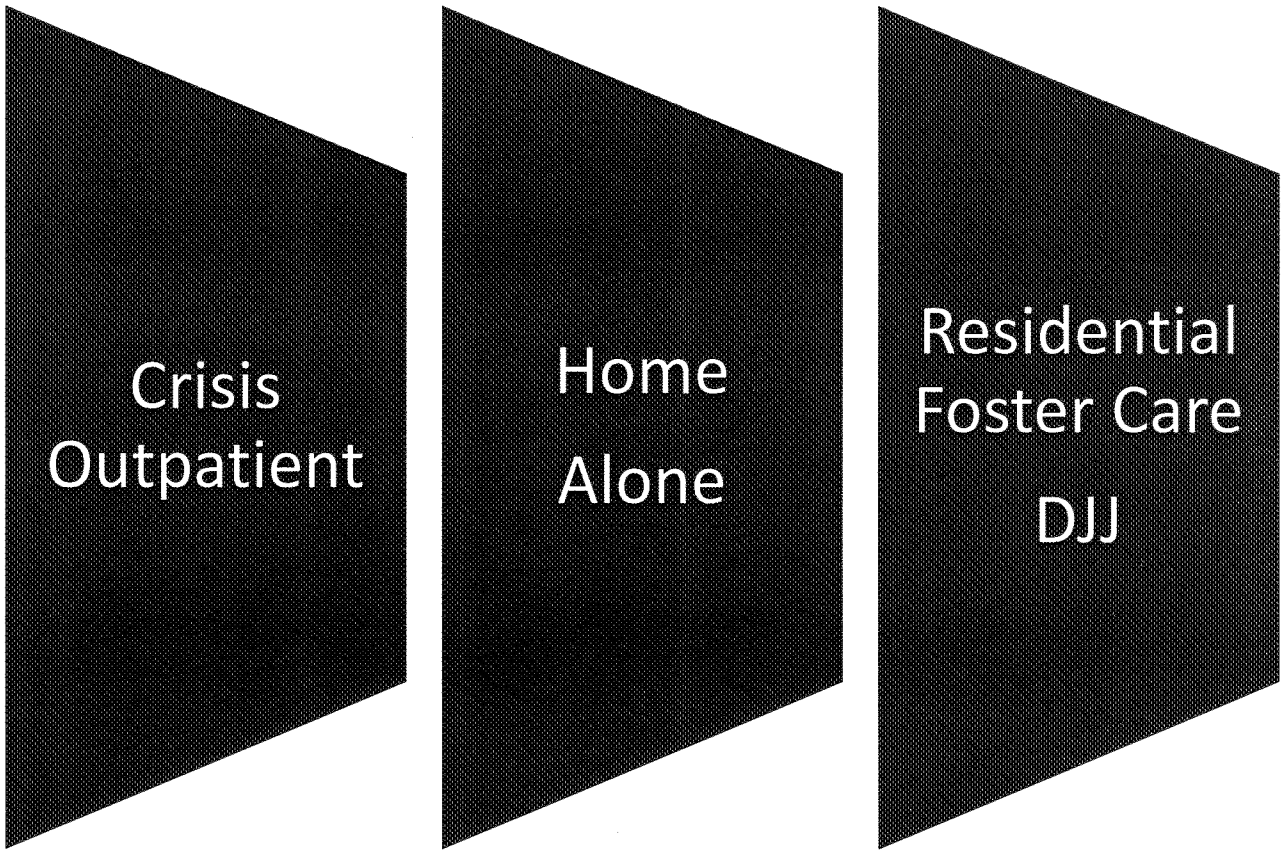



CAT Team History



- **2004** House Speaker pro tempore Ron Reagan seeks community care for 13 year old constituent with Schizophrenia
- **2005** Reps Reagan and Bean champion pilot for Community Action (CAT) Team
- **2009** CAT Team loses state funding and picks up county funding adding co-occurring substance abuse treatment
- **2013** Opportunity to retool CAT Team pilot to respond to current needs for youth, family and community safety

Florida Parents Are Home Alone



Case Studies in Hazard and Heart Ache

- 7-year-old hyper active boy with Tourette's up for adoption as single mom with medical issues can't manage symptoms at home
- 14-year-old rape victim with mood disorder cuts her arms at night and runs away to a gang
- 16 year-old boy explodes into aggression with mom triggered by mood disorder and trauma
- 17-year-old boy hears voices that tell him he is worthless and others are out to kill him

How Did Florida Get Here?

- 3% of young Floridians have challenges so severe they cannot function at home, in school or community
- Florida's behavioral health care for youth was never updated for serious cases such as schizophrenia, bipolar disorder or multiple major diagnoses
- Safety of young people, their siblings and parents and their communities at risk

How Did Florida Get Here?

- 49th in mental health per capita spend
- 27% of youth behavioral needs funded
- Almost half of behavioral health spend on institutions. No other state equals this level.
- Institutionalize seriously disturbed youth more often than offering alternatives to foster care, residential and juvenile justice

Mental Health & Addictions
Specialty Hospital and Outpatient Practice

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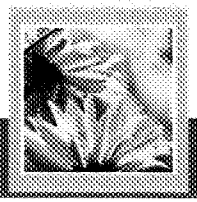
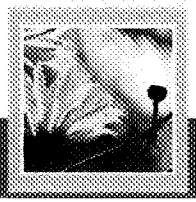
CAT Team Mission

Offer parents and caregivers of seriously, emotionally disturbed youth a safe option for raising their son or daughter at home

Provide lower cost alternative to state-funded foster homes, residential treatment or juvenile justice.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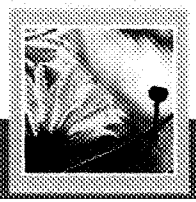
CAT Team

A Hospital Without Walls

- Counselors on 24 hour call
- Availability of daily services in home or school
- One integrated team for multiple problems
- Coaching for parenting of special needs
- Whole family support including counseling, respite, mentoring, tutoring and social services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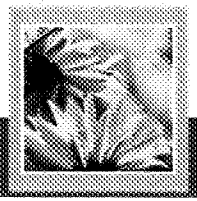
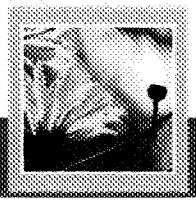
CAT Team Model
State of the Art Care

- Modeled after Florida Assertive Community Treatment Team (FACT) for adults
- "Wraps around" unique challenges of each family
- Whole family approach deals with all persons in the home including siblings
- Social service supports with integrated medical, behavioral, trauma and substance abuse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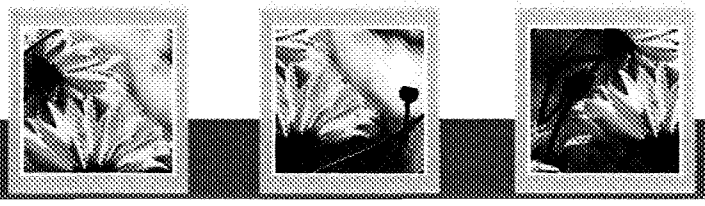
CAT Team Record

3-Year Evaluation Manatee CAT Team

2010-2012

- ✓ Served 244 youth and 955 family members
- ✓ 76% ages 11-18
- ✓ Referred from mental health, foster care, parents, schools, residential and juvenile justice
- ✓ 69% two major diagnoses; 37% three diagnoses



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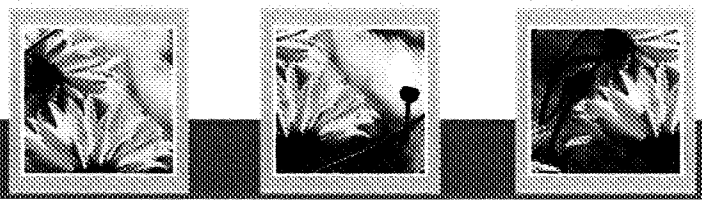
Specialty Hospital and Outpatient Practice

CAT Team Record

3-Year Evaluation Manatee CAT Team

2010-2012

- ✓ 160 at risk of residential; diverted 87.5%
- ✓ 95 at risk of foster care; diverted 93.7%
- ✓ 62 at risk of juvenile justice; diverted 74.2%
- ✓ Readmission to CAT over 3 years 4%



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CAT Team Parents

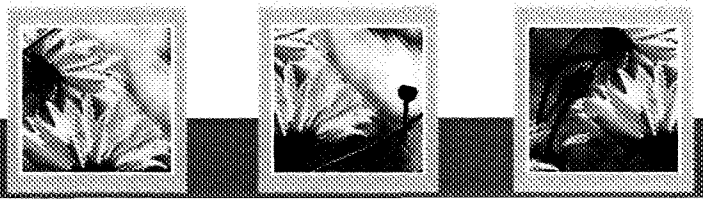
"You would really do this for me?"

"It makes us feel like we are not alone."

"You have put my mind at ease."

"I am so glad to have you guys on my side."

"Thank you, thank you, thank you."



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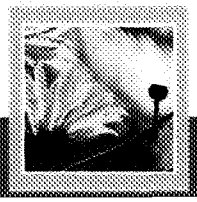
Specialty Hospital and Outpatient Practice

CAT Team Staff

Clinical Director	1.0 FTE
Psychiatrist/ARNP	.25 FTE
RN/LPN	.5 FTE
MA Therapists	2.0 FTE
BA Case Manager	1.0 FTE
Mentors	3.0 FTE
Support	1.0 FTE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Specialty Hospital and Outpatient Practice

CAT Team Services

Crisis response 24/7

Counseling/Medication Therapies

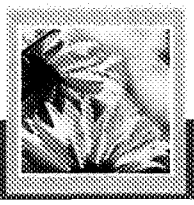
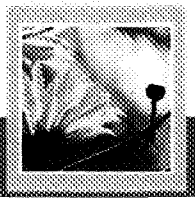
Substance abuse/Trauma/Co-occurring Services

Case Management-community/medical/dental Educational and Legal advocacy/coordination

Parenting /Family Education/Support Systems

Therapeutic mentoring/tutoring/respite

Vocational/Educational Skills


CAT Team Model Costs

- $675,000 annual costs to serve 75 cases plus 300 family members
- Daily rate of $67.50 compared to $350 for residential (40 caseload x 250 days x $67.50)
- Break Even Analysis: Diversion of 9 admissions from residential covers entire annual cost for all 75 cases

Recommendations

- Make CAT a permanent strategy in Florida's Behavioral Health System
- Expand to age 21 with ages 4-10 allowed by exception for acuity
- Launch 30 CAT Teams statewide—attach rural communities to multi-county teams
- Implement start up with cost-based contracts to allow for one-time capital and ramp up

CAT Team
Evaluation

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Children's Community Action Team-CAT Team

Summary Three Year Outcomes and Findings
January 1, 2010-December 31, 2012

Mary Ruiz, MBA
Melissa Larkin-Skinner, LHMC

Introduction

In 2005 the Florida Legislature launched a behavioral healthcare pilot for youth in Manatee County known as the **Community Action Team** or **CAT Team** with the following goals:

Goal 1: **Offer parents and caregivers of seriously, emotionally disturbed youth a safe option for raising their son or daughter at home.**

Goal 2: **Provide a lower cost alternative to state-funded care such as foster homes, residential treatment or juvenile justice.**

The **CAT Team** bridges the gap between home and institutional care by providing families a "hospital without walls" including such features as:

- Counselors on 24 hour call
- Availability of daily services in home or school
- One integrated team of experts addressing multiple problems
- Coaching for effective parenting of special needs
- Family support including counseling, respite, mentoring and social services including expense for incidentals

The **CAT Team** is not a "program" but a service that is unique in "wrapping around" the individual circumstances of each family and the needs of every member in the family. This whole family approach deals with all challenges that might confront the child or the home environment. At the end of six months of **CAT Team** services, the majority of families are able to successfully manage the concerns that brought them to the **CAT Team.**

This summary evaluation was conducted at Manatee Glens, a nonprofit specialty hospital and outpatient practice in Bradenton, Florida. The purpose of the evaluation was to assesses outcomes for the three-year time period from January 2010 to December 2012 when **CAT Team** services were enhanced to address co-occurring alcohol and drug abuse issues along with mental health concerns.

Summary Findings

Goal 1: Offer parents and caregivers of seriously, emotionally disturbed youth a safe option for raising their son or daughter at home

Performance Outcome Measure

Goal: Serve 75 cases and 300 family members per year

Result: Served 81 cases and 332 family members per year

From January 1, 2010 through December 31, 2012, a total of 244 cases and 995 family members were served over three years. The **CAT Team** exceeded the outcome for annual numbers served with an average of 81 cases admitted per year and an average of 332 family members served annually. Most of these cases (76%) fell between the ages of 11 to 17. The majority of family members represent siblings impacted by the behavioral difficulties demonstrated by their brother or sister.

CAT Team January 1, 2010 to December 31, 2012

Age at Admission	Number of Admissions
4 years	2
5 years	6
6 years	6
7 years	12
8 years	11
9 years	10
10 years	11
11 years	23
12 years	28
13 years	33
14 years	24
15 years	26
16 years	32
17 years	20
Total Admissions	**244**

Performance Outcome Measure

Goal: Serve 65% of cases with multiple diagnoses

Result: Served 69% of cases with multiple diagnoses

The **CAT Team** is required to treat the most serious of childhood disorders including schizophrenia, bipolar disorder, post-traumatic stress syndrome, substance abuse and mood disorders. It must also routinely handle complex cases with multiple major diagnoses. Below is a summary of diagnoses for the 244 admissions from January 1, 2010 to December 31, 2012.

CAT Team January 1, 2010 to December 31, 2012

Diagnosis	Number of Clients	Percent of Total
Two Major Diagnoses	169	69%
Three Major Diagnoses	53	37%
Psychotic Disorder/Schizophrenia	16	7%
Bipolar	37	15%
Post-Traumatic Stress	36	15%
Substance Abuse	58	24%

Performance Outcome Measure

Goal: Readmission rate less than 15%

Result: Readmission rate of 4%

Despite the severity and complexity of cases, the **CAT Team** must successfully transition children and their families to less intensive levels of care within less than a year. In the three years from January 1, 2010 to December 31, 2012, the total three-year readmission rate was 4% of total cases. While length of stay varied from three months to just over a year, most cases transitioned in six months or less.

CAT Team January 1, 2010 to December 31, 2012

Readmissions to CAT by Case	Readmissions
One Readmission	8
Two Readmissions	1
Three Readmissions	0
Total Readmissions	**10**

Goal 2: Provide a lower cost alternative to state-funded foster homes, residential treatment or juvenile justice.

Performance Outcome Measure

Goal: Divert 85% at risk of foster care, residential or juvenile justice

Result: Diverted 93.7% foster care, 87.5% residential, 74.2% juvenile justice

Because the youth's behavior poses a threat to the safety of the child, home or community, most cases (66%) admitted to the **CAT Team** from January 1, 2010 to December 31, 2012 were at risk of residential placement. Families themselves are also in jeopardy. Of the total cases admitted during this three year period, more than a third (39%) was at risk of entering the foster care system. Public safety concerns resulted in 25% of cases at risk of incarceration in the juvenile justice system.

The **CAT Team** was most successful in diverting cases from foster care at 93.7%. Diversion from residential placement also exceeded the expected outcome at 87.5%. Diversion from juvenile justice achieved 74.2% which was below the expected outcome of 85%. Many cases were at risk of multiple system admissions with the most typical overlap occurring between foster care and residential treatment.

CAT Team January 1, 2010 to December 31, 2012

At Risk of Admission	Number of Clients	Number Admitted	Diversion Rate
Residential Placement	160	20	87.5%
Foster Care	95	6	93.7%
Juvenile Justice/Detention	62	16	74.2%

The majority of referrals to the **CAT Team** came from the following sources in order of frequency:

- Crisis or outpatient behavioral health services
- Child welfare or child protective services
- Parents and Schools
- Residential (Family Services Planning Team)
- Department of Juvenile Justice

Performance Outcome Measure

Goal: Expenses below daily rate of $100

Result: Expenses at daily rate of $67.43

During the three-year period from January 1, 2010 to December 31, 2012, the CAT Team provided 250 days of service to an average caseload of 47. Average annual operating costs were $792,388 for a daily cost of $67.43 excluding one-time capital and minor durable expenses for computers, desks, vehicles, phones and equipment of about $62,000.

A break-even analysis requires that only 9 of the 244 admissions to the CAT Team need be diverted from a residential treatment stay of six months at $350 a day to offset the entire cost of all families served.

Case Studies

Tom *The seventeen year old was impulsive. His increasing aggression toward his mother and classmates began to alarm his adoptive parents. Tom was grounded at home and suspended from school. Nothing worked. CAT Team helped Tom reestablish self-control. Counseling provided pressure relief, insight into triggers for anger and agreement on ground rules at home. Medication provided Tom enough relief from his symptoms to begin to self-manage his impulsivity and aggression. One-on-one time with the CAT Team mentor helped Tom get back on top of his game at school. Tom's father wrote in gratitude about his son "he is fun to be around and we all laugh together."*

Trina *Her mood swings were severe even for a sixteen year old girl. Trina just couldn't stand herself. She began cutting her arms in secret and openly defying her mother by sexually acting out. The CAT Team psychiatrist was able to stabilize her moods but the damage had been done with Trina's family relationships and her school work. Counselors helped Trina think about consequences before choosing actions and work on positive communication. She is meeting her goal of a 3.0 GPA in school. Trina's mother says, "I am glad to have my daughter back."*

Sandy *The grandparents of this ten- year-old girl knew they were in way over their heads. They finally sought out residential treatment because Sandy was explosive and aggressive without warning. Her poor social skills meant she was always bullied at school. So Sandy refused to go to school and her grades fell. CAT Team went in the home to help the grandparents build structure and consistency. Counselors addressed Sandy's self-esteem and offered ways she could be assertive without being aggressive. Sandy found out about how to cope with the stress of school so she could make friends and get her grades up. Grandmother told the CAT counselor, "We know we can raise our granddaughter at home with us now."*

From Parents

"You would really do this for me?"

"I must be dreaming this is too good to be true."

"It makes me feel like we are not alone."

"I appreciate your help; you have put my mind at ease."

"I am so glad to have you guys on my side."

"This program was needed a long time ago. My son needs all the help he can get."

"Thank you, thank you, thank you."

Recommendations

1. Make CAT Team a permanent strategy in Florida's behavioral health system for youth and young adults. Florida families are too often left "home alone" with seriously emotionally disturbed youth and young adults without adequate support to handle the challenge. Out of desperation, families seek residential placement or even foster care or juvenile justice to keep their children and their families safe.

While families wait for help, Florida's communities risk losing public safety. This three-year summary evaluation concludes that the CAT Team can fill this gap in care for Florida families with great acceptance by families and lower cost for Florida tax payers. Every child should have every chance to be raised at home. No Florida community should have to fear its own children. With only a 4% readmission rate for this difficult population, the CAT Team proves it can answer the call.

2. Add 30 CAT Teams at $20.25 million throughout the state tied to child or adult public receiving facilities. There are 30 full FACT Teams in Florida for adults. A like number of CAT Teams will offer the same level of service for youth and young adults. Tying CAT Team services to crisis centers provides a seamless transition from the crisis center to intensive in home services of the CAT Team. Rural counties are best served as an adjunct to an urban team with an appropriate reduction in required caseload to allow for time and distance of a larger geographic area. The model budget of $675,000 cannot be scaled down as the staffing plan is the minimum required to provide 24 hour coverage. It can be scaled up to provide care for more cases. For example the budget could be doubled to serve 80 cases at a time or 165 a year. CAT Teams are a good investment for the state as they have a proven, positive impact on diversion from foster care, residential treatment and juvenile justice offering a bend in the cost curve for the expansion of these deep end services. CAT Team services are reimbursed at a daily rate of $67.50 vs. $350 for residential care.

3. Update the model for today's challenges. Expand age to 21 for CAT services and admit children under 11 if they meet test of severity of illness. Require co-occurring substance abuse and trauma and care management of medical issues. Young adults up to age 21 years need to be provided transitional care in the youth system before they enter the adult system. Young adults with serious emotional disturbance have unique challenges in this stage of life.

CAT Teams have proven they can address a broad range of ages from four years old to eighteen. Therefore CAT Teams should be allowed to admit young adults up to 21 years old. A new state funding category would be required. While the majority (76%) of youth in this three year study is eleven or older, the flexibility to admit younger children based on the severity of their illness is important to avoid more significant problems later in life.

Given there is a significant rate of co-occurring substance abuse(26%) and trauma, Cat Teams should be required to treat substance abuse as an integrated part of their services. Further CAT Teams should integrate care management of medical issues into their services.

4. Implement and monitor proven outcomes. Performance outcomes measures developed in this study for volumes of service, severity of cases, readmission, diversion and cost containment promote accountability for contracted services. It is recommended that these outcomes be applied to future CAT Team contracted services.

5. Allow cost-based grants for first six months of start-up to cover one-time capital and equipment costs and enrollment ramp up. It is recommended that the first six months of CAT Team operation be on a cost-based grant allowing for hiring and training of staff, purchase of one time equipment including furnishings, computers, phones and automobiles and phase in of cases over time to full caseload. This approach will assure a smooth transition for the CAT Team with a well-prepared clinical staff and adequate start up resources. Start-up capital costs are about $62,000.

Appendix A

Clinical Program Description

The Community Action Team (CAT Team) is a self-contained integrated multi-disciplinary team providing comprehensive, intensive community based treatment to families with children and youth at risk of out-of-home placement due to a mental health disorder. It includes oversight of the primary care needs of the children served.

The CAT Team provides family-centered, culturally competent services focused around the strengths and needs of each child and his/her family with a goal of supporting and sustaining the child in his/her family system and in the community. Medical staff provides psychiatric care, basic health status checks and works with the family to maintain medical records and linkages to community health care practitioners. The whole family is embraced in care and family commitment and participation is essential and expected. The CAT Team assists the family in developing a natural support network, improve interactions with the school system, and develop and use other community resources and supports.

Rationale: Mental disorders are the most prevalent illnesses affecting young people and are the largest single category to contribute to both mental and physical long-term societal costs. More than two-thirds of mental illnesses onset before 25 years of age, and these disorders are mostly chronic with substantial negative impact on multiple personal, interpersonal, social and physical health domains. Early identification and intervention can decrease both short- and long-term morbidity and may substantially improve both physical and mental health outcomes.

Mental health teams have long been the foundation for mental health services provided to children and youth. Changes in professional practices, the emergence of evidence-based care, the importance of integrating mental health and primary health care delivery provides even newer challenges to providing quality mental health care. The CAT Team provides a proven framework to address mental health and physical health care needs where 'traditional' mental health service interventions have not worked.

Target Population: Children ages 11 to 21 years with a mental health diagnosis or co-occurring substance abuse diagnosis, at-risk of out-home placement for whom traditional services have not been adequate as demonstrated by repeated failures at less intensive levels of care, 2 or more hospitalization or repeated failures, involvement with DJJ or multiple episodes involving law enforcement, or poor academic performance and/or suspensions. Also in the target group are adolescents/young adults aging out of the child welfare system or adolescents aging out of the children's system with high treatment needs as demonstrated above as part of their transition into the adult system of care. Children younger than 11 can be accepted into the program if they meet 2 or more of the criteria above.

Staffing/Minimum Qualifications: The CAT Team capable of serving 40 children/young adults consists of: 1) Team Leader who is a licensed mental health professional; 2) 1 licensed or licensed-eligible mental health/substance abuse professionals; 3) 1 non-licensed master's level mental health/substance abuse professionals; 4)1 bachelor's case manager 5) 3 mentors/paraprofessionals; 6) .25 psychiatrist and or .50 ARNP and .5 RN or LPN ; 7) 1 administrative/support staff. Mentoring staff have the ability to assist with educational and vocational skill development as well as other non-clinical activities. The staffing model needs to allow for some flexibility to allow staff to provide the array of services that best meets the needs of the individuals/families. For example it may be more useful to have more psychiatric time or more nursing time or more mentoring.

Service Capacity: 40 children and their families; annual caseload from 75-80.

Length of Stay: Average length of stay per family/child is 6 months although length of stay is determined on a case by case basis.

Services: CAT Team services are provided in the community. Specific services are based on the child and family's strengths and needs. Services provided by the team and/or coordinated by the team include:

- Psychiatric (evaluation and medication management)
- Case Management
- Therapy (individual, group, family)
- Crisis response 24/7
- Community resource coordination including medical/dental
- Transportation (within specific guidelines)
- Educational system advocacy, coordination, tutoring
- Legal system advocacy and coordination
- Substance abuse/co-occurring services
- Parenting skills/Family education/Network Development
- Vocational/Educational Skills
- Therapeutic mentoring, including respite care up to 4 hours
- Coordination of other mainstream behavioral health treatment and support services
- Behavioral management and social skill development

Expected Effects:

- School related outcomes such as improved attendance, grades and graduation rates
- Decrease in out-of-home placements
- Improved family/child functioning
- Decrease in substance use/abuse
- Decrease in psychiatric hospitalizations
- Transition into age appropriate services
- Increase in health and wellness

Discharge Criteria:

1. 21 years old and transitioned to adult treatment services if appropriate
2. Child has functioned well at home and school (or employment if age appropriate) for 6 months

3. Family and team mutually agree to terminate services
4. Parent and/or child refuses to participate after 3 months despite best efforts of team to engage family
5. One year unless a reassessment determines continuation would be of value
6. Family moves
7. The child is placed in foster care, residential care, DJJ facility /or prison
8. The team determines that a different program would be more clinically appropriate

Appendix B
Budget and Staffing Model

Budget Model Narrative

An integrated team of 8.75 Full Time Equivalents representing six different behavioral health disciplines is required to provide services to 40 cases at a time for 250 days a year with 24 hour call, frequent or daily contact, in-home or in-community care, and coordination with schools, child welfare and other agencies.

- **Clinical Director**
- **Psychiatrist/Advanced Registered Nurse Practitioner**
- **Registered or Licensed Nurse**
- **Master's Therapists**
- **Bachelor's Case Manager**
- **Mentors**
- **Support Staff (Records, Reports, Schedules, Reception)**

Other expenses include transportation and family support. Family support expenses while a minor part of the budget play a major part in the **CAT Team** success. Examples of family support expense might be the continuation of activities offered by schools during the summer time, lock boxes for kitchen knives or other dangerous household objects or emergency purchases for health or safety.

Total cost per team is $675,000 a year serving 75-80 cases a year at a cost of $67.50 per day for 250 days a year. One time capital expenses of $62,000 provide for computers, furnishings, vehicles, phones and other start-up costs. These can be addressed in a six-month start up contract that is cost-based to cover these one-time expenses and ramp up of staffing ahead of accepting cases.

Budget Model

POSITION	FTE	ANNUAL SALARY	RATE	ALLOCATED SALARY
Psychiatrist/ARNP	0.25	195,000	93.75	$ 48,750
RN/LPN	0.5	54,080	26.00	27,040
Team Leader/Lic Clinician	1	44,500	21.39	44,500
Licensed Clinician	1	40,560	19.50	40,560
Masters Level Clinician	1	35,360	17.00	35,360
Bachelor's Case Manager	1	32,552	15.65	32,552
Mentor's	3	29,494	14.18	88,483
Admin Assist	1	27,560	13.25	27,560
Total Salary Expense	8.75			$ 344,805
Benefits/Call (24%)				$ 82,072
Subtotal Staffing Expense				$ 426,877
Direct Operating Expense				$ 225,623
Family Incidentals				$ 22,500
Total Expense				$ 675,000

Appendix C Diagnoses

CAT Team January 1, 2010 to December 31, 2012

Principle Diagnosis	Number of Clients
Adjustment Disorder	3
Alcohol Abuse	1
Anxiety Disorder	4
Attention Deficit/Hyperactivity Disorder	73
Bipolar Disorder	30
Cannabis Abuse	15
Conduct Disorder	3
Depression	18
Disruptive Behavior Disorder	5
Impulse Control Disorder	6
Intermittent Explosive Disorder	3
Mood Disorder	49
Obsessive Compulsive Disorder	1
Opioid Dependence	1
Oppositional Defiant Disorder	10
Polysubstance Dependence	1
Post-traumatic Stress Disorder	14
Psychotic Disorder/Schizophrenia	7
Total	**244**

CAT Team January 1, 2010 to December 31, 2012

Secondary Diagnosis	Number of Clients
Adjustment Disorder	2
Alcohol Abuse	1
Anxiety Disorder	8
Asperger's Disorder	4
Attention Deficit/Hyperactivity Disorder	34
Bipolar Disorder	5
Cannabis Abuse	22
Conduct Disorder	1
Depression	5
Disruptive Behavior Disorder	4
Impulse Control Disorder	2
Mood Disorder	31
Opioid Dependence	1
Oppositional Defiant Disorder	13
Polysubstance Dependence	7
Post-traumatic Stress Disorder	20
Reactive Attachment Disorder	3
Psychotic Disorder/Schizophrenia	6
Total with at least two diagnoses	**169**

CAT Team January 1, 2010 to December 31, 2012

Tertiary Diagnosis	Number of Clients
Alcohol Abuse	1
Amphetamine Abuse	1
Anxiety Disorder	7
Asperger's Disorder	1
Attention Deficit Hyperactivity Disorder	12
Bipolar Disorder	2
Cannabis Abuse	6
Conduct Disorder	2
Depression	2
Disruptive Behavior Disorder	1
Impulse Control Disorder	1
Mood Disorder	8
Oppositional Defiant Disorder	3
Polysubstance Dependence	1
Post-traumatic Stress Disorder	2
Psychotic Disorder/Schizophrenia	3
Total with at least three diagnoses	**53**

Appendix D
Manatee Glens

Manatee Glens

Manatee Glens is a nonprofit organization specializing in mental health and addictions so that health and wellness is possible for every family. It was founded in 1955. Manatee Glens specialty hospital and outpatient practice is headquartered in Bradenton on the west coast of Florida. The agency provides care to more than 15,000 persons a year including 4,200 children and teens. Manatee Glens also offers child welfare services focused on family safety and reunification or adoption. Staff of 450 doctors, nurses, counselors and case workers serves one out of every thirty families in our region. Manatee Glens partners with local hospitals, physicians and law enforcement to accept referrals for more than $16 million in charity care a year.

Manatee Glens is able to offer this extraordinary level of service to the community through grants and donations from federal, state and local government as well as foundation and community donations. Our average cost per patient served is less than $2,200 a year. Seventy percent of our inpatients rate Manatee Glens' care as excellent far exceeding average national customer service levels (HCAPS). We achieve these cost efficiencies and high customer satisfaction through compassionate care, community partnerships, disciplined business practice, high productivity and innovation. Manatee Glens has a statewide and national reputation for state of the art care.

Mary Ruiz MBA and Melissa Larkin-Skinner LMHC

Ms. Ruiz is a senior behavioral healthcare executive with 25 years of experience in hospital administration, managed care systems, marketing and business development. For the past 16 years she has been President and CEO of Manatee Glens expanding annual services under her leadership from $12 million to $27 million.

Ms. Larkin-Skinner is a senior clinical manager with 15 years of experience in crisis and trauma services, child welfare, intensive outpatient and inpatient services. Currently she is Vice President of Inpatient and Residential Services responsible for a 78-bed campus offering mental health and addictions care for children and adults.