Northeast Florida HATS Coalition Update

JUNE 2016

Vision

To develop a system of care for YYASHCNs living in Northeast Florida through a unified community effort. The coalition will work in collaboration with multiple stakeholders to address the complex medical, psychosocial and environmental issues faced by YYASHCNs and assist in developing solutions.

Community Matters

Updated strategic plan to better reflect the views of our coalition with a focus on the following:

- Increased leadership and participation from our community partners.
- Focus on gaps in health care transition identified by our membership.
- Updates at each meeting to learn about representative organizations, foundations and community events.
- Invitation to new members and organizations interested in health care transition to join our coalition and present at upcoming meetings.
- Planning or participate in at least one health care transition related community event each year.

Ongoing -System of Care

Bridging the Gap

- Medical Legal Partnership
- Working group to assess needs of DD community
  - Ongoing efforts to develop a Dental Clinic
- Network/Collaborative Care Models
  - Psychiatry, Hematology
- Education/Vocational needs
  - Networking with college disability services, ADHD group
- Youth council/support groups
- JASMYN/PACE/Foster Care
  - JASMYN Clinic- starting July 2016
- Access Center for DCF
  - Patients may apply for Medicaid, Cash and Food Assistance

Education

Medical Outreach
- Ongoing lectures and presentations to local PCPs and specialists
- ED collaborations
- Inpatient referrals through social work
- Residency Transition Curriculum
- JU/Arc Village Nursing Curriculum
- UNF Practicum
  - Psychology Majors with a concentration in Disability Services

Community Outreach
- Promote and attend events
- Family Care Council- “Connecting the Dots Conference”

Conference Lectures and Presentations (local and national)

Advocacy/Policy

Clinical
- Family Council
  - Parent Liaison

System
- Linkages between pediatric and adult subspecialties
- Increased access to care/overcoming barriers

Legislative
- Presentation for Duval Delegation
- Medicaid/AHCA
  - Billing
- Agency of Persons with Disabilities (APD)
- AAP

Lessons Learned

Collaboration and networking are key features to developing an effective system of care for YYASHCNs, especially in the face of limited resources.

Develop a strategic plan that reflects the views and goals of our many stakeholders.

Continue to advocate for adequate and appropriate support for programs working with YYASHCNs in order to avoid burn out, loss of services and to ensure the best quality of care.

HILLSBOROUGHHATS

2015-2016 Fiscal Year-in-Review

COALITION ACTIVITIES

- November 2015 - Hired new Coalition Coordinator: Katrina Bales
- January 2016 - Coalition reconvened meeting
- February 2016 - Coalition participated at 3rd Annual – Creating a Plan for the Future workshop
- March 2016 - Coalition met to review action plan and discuss goals for 2016
- April 2016 – Coalition participated in "Together we can make a difference" Disability Fair and Family Fun Event hosted by Family Care Council Suncoast Region

ACCOMPLISHMENTS

- Participated in community outreach events to promote and share information about transition planning and tools available to youths and families
- Discussed and received input from coalition membership in identifying prospective goals that the coalition would like to pursue over the course of the year
- Explored opportunity to partner with Florida Healthy Transitions Project
- Encouraged membership growth

CHALLENGES

- Ensuring coalition members remain actively engaged and participate
- Identifying and encouraging pediatric and adult care provider involvement in the transition process
- Obtaining information about the different insurance plans available to youth and young adults

NEXT STEPS

- Meet again via teleconference regarding identified goals from last meeting, identify and prioritize action steps needed in order to move forward with those goals

- Potentially create sub-committees who could be tasked with plan research and/or educational outreach to pediatric providers regarding transition tools and billing tip sheet availability

South Florida HATS

- Review of activities
  - 8 Meetings took place
  - Information distributed at 3 community events
    - Transitions Summit
    - GIFT Conference
    - Unicorn Foundation Transition Panel Discussion

White paper

- Health Care Perspectives Position Paper
  - A South Florida HATS initiative started by Partners in Policy
  - Looking at the issue from multiple perspectives
  - Using the information to inform law makers
  - Using local expertise to create recommendations
- Next steps
  - Survey Distribution
  - Survey analysis
  - Draft paper

Overall health and growth of the taskforce

- Strengths
  - South Florida HATS is growing!
  - It has a strong core of participants!
  - It has gotten people talking and acting!
    - White Paper
    - Mailman Center Forum
- Challenges
  - Small
  - Utilizes many people who are already on many many taskforces
  - Encompasses two large counties
  - Upcoming change in leadership

Recommendations

- Keep current make up (of Miami-Dade and Broward)
- Facilitator should be someone who is already participating in several of the overlapping taskforces and coalitions
- Maintain momentum started with the white paper

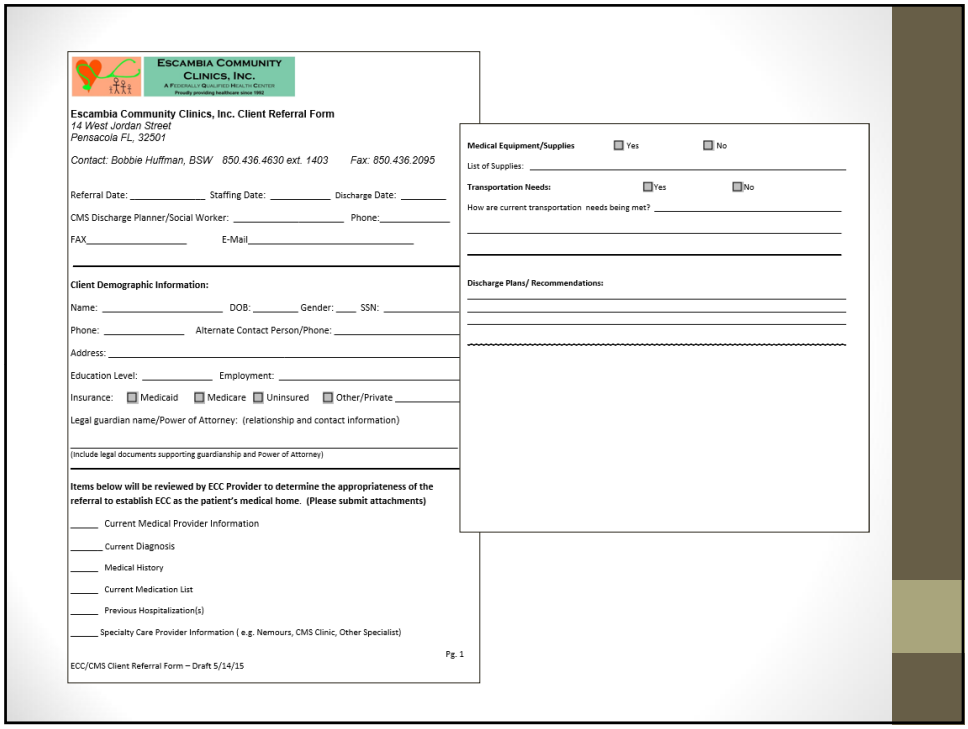
PanhandleHATS Action Plan Review CMS/ECC FQHC Transitions

Vision

The PanhandleHATS Regional Coalition's vision is to assure continuity of health care in order to provide a seamless transition from pediatric to adult life in the Florida Panhandle with a primary focus on those with disabilities or special health care needs.

Barriers, Challenges and Successes for PanhandleHATS 2014-2015

- Expectations of recruiting of new coalition members has been unrealistic given numerous budget cuts and staff changes/cuts in agencies. New approaches identified.
- Reorganization of CMS region offices and leadership has impacted the identification of appropriate staff to attend and represent CMS at PanhandleHATS meetings. Will continue to work with managing staff.
- ECC FQHC has helped to create a transition process and PanhandleHATS and ECC have developed client transition referral form.
- Enhanced collaborative spirit over past year between FQHCs and broadened communication between centers in PanhandleHATS region.



ESCAMBIA COMMUNITY CLINICS, INC.

Escambia Community Clinics, Inc. Client Referral Form
14 West Jordan Street
Pensacola FL, 32501

Contact: Bobbie Huffman, BSW 850.436.4630 ext. 1403 Fax: 850.436.2095

Referral Date: _____ Staffing Date: _____ Discharge Date: _____

CMS Discharge Planner/Social Worker: _____ Phone:_____

FAX_____ E-Mail_____

Client Demographic Information:

Name: _____ DOB: _____ Gender: ____ SSN: _____

Phone: _____ Alternate Contact Person/Phone: _____

Address: _____

Education Level: _____ Employment: _____

Insurance: ☐ Medicaid ☐ Medicare ☐ Uninsured ☐ Other/Private _____

Legal guardian name/Power of Attorney: (relationship and contact information)

_____
(Include legal documents supporting guardianship and Power of Attorney)

Items below will be reviewed by ECC Provider to determine the appropriateness of the referral to establish ECC as the patient's medical home. (Please submit attachments)

_____ Current Medical Provider Information

_____ Current Diagnosis

_____ Medical History

_____ Current Medication List

_____ Previous Hospitalization(s)

_____ Specialty Care Provider Information (e.g. Nemours, CMS Clinic, Other Specialist)

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ECC/CMS Client Referral Form – Draft 5/14/15

Medical Equipment/Supplies ☐ Yes ☐ No

List of Supplies: _____

Transportation Needs: ☐ Yes ☐ No

How are current transportation needs being met? _____

Discharge Plans/ Recommendations: