GUIDELINES FOR CARE COORDINATION

Revised 9/2021

CENTRAL FLORIDA CARES HEALTH SYSTEM
GUIDELINES FOR CARE COORDINATION

PROGRAM GOAL

Care Coordination serves to assist individuals who are not effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care. This includes services and supports that affect a person's overall well-being, such as primary physical health care, housing, and social connectedness. Care Coordination connects systems including behavioral health, primary care, peer and natural supports, housing, education, vocation and the justice systems. It is time-limited, with a heavy concentration on educating and empowering the person served, and provides a single point of contact until a person is adequately connected to the care that meets their needs.

The overall goal of the Care Coordination program is to reduce the need for crisis stabilization, inpatient detoxification treatment, psychiatric hospitalizations, and to assist individuals in obtaining and maintaining placement in the least restrictive community environment. It is the desired outcome that persons served receive sufficient treatment and education to remain in the least restrictive setting within the community, enhance their psychological wellbeing, and reach an optimum level of functioning in the community.

The short-term goals of implementing Care Coordination are to:

- Improve transitions from acute and restrictive to less restrictive community-based levels of care;
- Increase diversions from state mental health treatment facility admissions;
- Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness; and
- Focus on an individual's wellness and community integration.

The long-term goals of implementing Care Coordination are to:

- Shift from an acute care model of care to a recovery model; and
- Offer an array of services and supports to meet an individual's chosen pathway to recovery.

POPULATION SERVED/ELIGIBILITY CRITERIA

Pursuant to s. 394.9082(3)(c), F.S., the Department has defined priority populations to potentially benefit from Care Coordination. Managing entities and provider agencies are expected to minimally serve the following priority populations:

ADULTS

1) Adults with a serious mental illness (SMI), substance use disorder (SUD), or co-occurring disorders who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, and inpatient detoxification services. High utilization is defined as:

a) Adults with three (3) or more acute care admissions within 180 days; or

b) Adults with acute care admissions that last 16 days or longer.

c) Adults with three (3) or more evaluations at an acute care facility within 180 days, regardless of admission.

2) Adults with a SMI awaiting placement in a state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community.

CHILDREN/ADOLESCENTS

1) Children and parents or caretakers in the child welfare system with behavioral health needs, including adolescents, as defined in s. 394.492, who require assistance in transitioning to services provided in the adult system of care.

2) Children and adolescents with a mental health diagnosis, SUD, or co-occurring disorders who demonstrate high utilization. High utilization is defined as:

a) Children and adolescents under 18 years of age with three (3) or more admissions into a crisis stabilization unit or an inpatient psychiatric hospital within 180 days

b) Children being discharged from Baker Act Receiving Facilities, Emergency Rooms, jails, or juvenile justice facilities at least one time, who are at risk of re-entry into these institutions or of high utilization for crisis stabilization.

c) Children and adolescents who have recently resided in, or are currently awaiting admission to or discharge from, a treatment facility for children and adolescents as defined in s. 394.455, which includes facilities (hospital, community facility, public or private facility, or receiving or treatment facility) and residential facilities for mental health, or co-occurring disorders.

3) Children not currently receiving services by a CAT Team.

4) Families with infants experiencing or at risk for Neonatal Abstinence Syndrome or Substance Exposed Newborn.

Populations identified to potentially benefit from Care Coordination that may be served dependent on available funding:

1. Persons with a SED, SMI, SUD, or co-occurring disorders who are involved with the criminal justice system, including: a history of multiple arrests, involuntary placements, or violations of parole leading to institutionalization or incarceration.
2. Caretakers and parents with a SMI, SUD, or co-occurring disorders considered at risk for involvement with child welfare.
3. Individuals identified by the Department, Managing Entities, or Network Service Providers as potentially high risk due to concerns that warrant Care Coordination.

Discharge Criteria

- Individual was successfully discharged from program due to completing Service Plan goals and/or maintaining community-based living
- Individual disengaged from Care Coordination services (i.e., no contact for 30 days or after three attempts to contact)
- Individual was admitted to higher level of care (i.e. state mental health treatment facility, residential treatment facility)
- Individual moves out of the service area
- Individual was transitioned to a case management program, including any of these programs: Florida Assertive Community Treatment (FACT), First-Episode Psychosis (Aspire Health Partner-INSYPTE), Community Action Treatment (CAT), Family Intensive Treatment (FIT), Forensic Multidisciplinary team (FMT), and any other local multidisciplinary treatment teams that include case management.
- Following one incident of violent behavior in which the safety of one or more individuals is compromised
- Adult has been incarcerated
- Death

Care Coordinator Role and Credentials

Overall, the care coordinator is expected to provide outreach services, assessment of behavioral health needs, including medical, social, housing needs, linkage to community resources and assist in transitions between providers and levels of care. The maximum caseload is 15 individuals.

The Care Coordinator must have a bachelor's degree in Human Services Field or a minimum of 2 years of experience in a behavioral health field.

Care Coordinator responsibilities per DCF Guidance 4 for Managing Entities Contracts include:

1) Assess organizational culture and develop mechanisms to incorporate the core values and competencies of Care Coordination into daily practice.
2) Utilize a standardized level of care tool and assessments to identify service needs and choice of the individual served.
3) Serve as single point of contact for the coordination of an individual's care with all involved parties (i.e., criminal or juvenile justice, child welfare, primary care, behavioral health care, housing, etc.).
4) Engage the individual in their current setting, (e.g., crisis stabilization unit (CSU), SMHTF, homeless shelter, detoxification unit, addiction receiving facility, etc.) to facilitate a warm hand off. Individuals served should not be expected to come to the care coordinator.

5) Develop a care plan with the individual based on shared decision making that emphasizes self- management, recovery, and wellness, including transition to community-based services and/or supports.

6) Provide frequent contact for the first 30 days of services, ranging from daily to a minimum of three times per week. Care coordinators should consider the individual's safety needs, level of independence, and their wishes when establishing the optimal contact schedule. This includes telephone contact or face-to-face contact (which may be conducted electronically). Leaving a voicemail is not considered contact. If the individual served is not responding to attempted contacts, the provider must document this in the clinical record and make active attempts to locate and engage the individual.

7) Provide 24/7 on-call availability.

8) Coordinate care across systems, to include behavioral and primary health care as well as other services and supports that impact the social determinants of health.

9) Assess the individual for eligibility of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Veteran's Administration (VA) benefits, housing benefits, and public benefits, and assist them in obtaining eligible benefits. When applying for SSI or SSDI benefits, providers must use the SSI/SSDI Outreach, Access, and Recovery (SOAR) application process. Free training is available at https://soarworks.samhsa.gov/course/ssissdi-outreach-access-and-recovery-soar-online-training.

10) For individuals who require medications, ensure linkage to psychiatric services within 7 days of discharge from higher levels of care. If no appointments are available, document this in the medical record and notify the managing entity.

11) Coordinate with the managing entity to identify service gaps and request purchase of needed services not available in the existing system of care.

12) Develop partnerships and agreements with community partners (i.e., managed care organizations, criminal and juvenile justice, community-based care organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data.

In addition to the responsibilities outlined above:

1) The Care Coordinator will complete an orientation with each individual and ensure a Consent for Treatment/Service is signed by the individual and parent when a minor. The official date of enrollment into the care coordination program is the date that the provider's consent form was signed.

2) The Care Coordinator will make significant attempts to contact (via phone and/or face-to-face) individuals who received Care Coordination within 48 hours of discharge from the CSU/inpatient detox facility (In the event the individual is discharged on Friday, Care Coordinator must contact the individual on Monday).

3) Individuals will be linked to community services within 5 days of enrollment into the care coordination program.

4) Assessment of needs must be completed within 30 days after completion of intake. The assessment must, with input from the client, include:

a) Description and evaluation of presenting problem;

b) Information from the intake and evaluation; and,

c) Description of the individual's current and potential strengths and problems, the client's family and other social supports, pertinent service agencies with whom the client has been involved, and other social support systems that may contribute to the course of treatment.

5) Progress of the client is monitored and evaluated during each contact with the individual. Progress notes, activity notes or status reports shall be prepared at least monthly for clients having a service plan or treatment plan unless the plan indicates less frequent need. Progress note content shall include:
   a) Dates of contact with client, and as needed, client's family, friends, and involved service or resource agencies;

   b) Description of client progress, or lack thereof, relative to the service plan or Treatment Plan; and

   c) Description of any modification to the service plan or Treatment Plan resulting from such factors as changes in client's needs, changes in resources and new assessment findings.

6) The Care Coordinator will be trained in and will utilize the SOAR model in order to increase access to SSI/SSDI for eligible persons.

7) The Care Coordination program provides intensive support services for a period of about 6 months. Continuation past the 6 months will be evaluated on a case by case basis with CFCHS System of Care designee.

8) Individuals who obtain Medicaid during Care Coordination services will be transitioned to a case management program within 60 days of notification. The Care Coordinator will complete and submit a referral to a Targeted Case Management agency. The transition plan shall be designed to ensure a warm hand-off and successful case management engagement.

9) Supervisors/Managers will notify CFCHS of any significant program changes, including staff changes or caseload transfers, within 2 business days.

REPORTING

The Network Service Provider is required to submit a weekly report no later than Tuesday of each week. The report template, along with a copy of this guideline can be found at: https://centralfloridacares.org/providers/guidelines-templates-forms/service-programs/

Outcome metrics that will be tracked by CFCHS:

- Number of individuals served
- Referral Sources-CSU, Detoxification, SMHTF, Diverted from SMHTF, Other
- Reasons for Discharge
- Housing Status
- Employment or Entitlement benefits Status
- Average Days in the community
- Engagement of individual while in a CSU/Detoxification facility