Department of Children and Families
Office of Substance Abuse and Mental Health
**Care Coordination Technical Assistance Document (Provider)**

**Purpose:** The purpose of this document is to provide guidance and technical assistance for the implementation, administration and management of Care Coordination activities.

| Core Competencies | Key Elements |
|---|---|
| **1.** Single point of accountability – Care Coordination provides for a single point of accountability responsible for coordination of services, supports, and cross system collaboration to ensure the individual's needs are met holistically. | ○ Serves as single point of accountability for the coordination of an individual's care with all involved parties *(i.e. criminal or juvenile justice, child welfare, primary care, housing, etc).*<br>○ Assign one care coordinator to follow the individual served from beginning to end, until a warm-hand off is made.<br>○ Ensure adequate staffing of care coordinators to meet the demand of the target population groups. |
| **2.** Engagement with person served and their natural supports - the care coordinator goes to the individual and builds trust and rapport. The care coordinator actively seeks out and encourages the full participation of the individual' networks of interpersonal and community relationships. The care plan reflects activities and interventions that draw on sources of natural support. | ○ Network Service Provider engages the individual in their current setting *(e.g., crisis stabilization unit (CSU), State Mental Health Treatment Facility (SMHTF), homeless shelter, detoxification unit, addiction receiving facility, etc.)* to establish the warm hand-off.<br>○ Provides frequent contact for the first 30 days of services, ranging from daily to a minimum of three times per week. The individual's safety needs, level of independence and their wishes should be considered when establishing the optimal contact schedule. If the individual is not responding to these attempts, the provider must document this in the clinical record and make active attempts to locate and engage the individual. If the individual refuses care coordination services, this is documented in the record.<br>○ On call services are available 24 hours, seven days a week. |
| **3.** Standardized assessment of level of care determination process – a standardized level of care assessment provides a common language | ○ Utilizes standardized level of care tools and assessments to identify service needs and choice of the individual served. For example the Level of Care Utilization System (LOCUS), the Children and Adolescent Level of Care Utilization System (CALOCUS) or the American Society of Addiction Medicine (ASAM) Criteria. |

| | |
|---|---|
| across providers that can assist in determining service needs. | |
| **4.** Shared decision-making – family and person-centered, individualized, strength-based plans of care drive the Care Coordination process. The perspective of the individuals served are intentionally elicited and prioritized during all phases of the Care Coordination process. The care coordinator provides options and choices such that the care plan reflects the individual's values and preferences. | ○ Develops a care plan with the individual based on shared decision-making in care planning and service determination with the individual and family members (where applicable) and emphasizes self-management, recovery and wellness, including transition to community based services and/or supports.<br>○ The individual served and family members are the driver of goals of the Care Plan. |
| **5.** Community-based – services and supports take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible that safely promote an individual's integration into home and community life. | ○ Coordinates with the ME to identify service gaps and request purchase of needed services not available in the existing system of care.<br>○ Care Coordinator assists with access to the least restrictive level of care in the community.<br>○ Helps to remove barriers to access to care.<br>○ Maintains an up to date list of community-based services/resources to inform staff and individuals served as well as their families. |
| **6.** Coordination across the spectrum of health care - this includes, but is not limited to, physical health, behavioral health, social services, housing, education, and employment. | ○ Network Service Provider has assessed the organizational culture and developed mechanisms to incorporate the core values and competencies of Care Coordination into daily practice.<br>○ Develops partnerships and agreements with community partners *(i.e., managed care organizations, criminal and juvenile justice systems, community based care organizations, housing providers, federally qualified health centers, etc.)* to leverage resources and share data.<br>○ For individuals who require medications, linkage to psychiatric services within 7 days of discharge from higher levels of care are ensured. If no appointments are available, this is documented in the medical record and the ME is notified. If the individual refuses services, this is documented in the record.<br>○ Assesses the individual for eligibility of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Veteran's Administration benefits, housing benefits, |

| | |
|---|---|
| | and public benefits, and assist them in obtaining eligible benefits. Providers must use SOAR when assessing for SSI and SSDI.<br>o Coordinates care across systems, to include behavioral and primary health care as well as other services and supports that impact the social determinants of health. |
| **7.** Information sharing – releases of information and data sharing agreements are used as allowed by federal and state laws, to effectively share information among Network Service Providers, natural supports, and system partners involved in the individual's care. | o The potential of shared Electronic Health Records (EHRs) or web-based e-referral systems have been investigated. If not available, another standardized information flow process has been set up.<br>o The conditions and infrastructure for ensuring quality referrals and transitions have been established.<br>o Protocols are established for handling data sharing and releases of information (ROI). |
| **8.** Effective transitions and warm hand-offs - current providers directly introduce the individual to the care coordinator. The "warm hand-off" is both to establish an initial face-to-face contact between the individual and the care coordinator and to confer the trust and rapport the individual has developed with the provider to the care coordinator. | o Protocols are established and followed for transitions.<br>o Individuals served meet the provider at the time of discharge or within 24 hours of referral to ensure a warm-hand off when possible.<br>o Follow-up post-referral or transition is provided.<br>o The role of peer specialists is defined as it relates to engagement, warm hand-offs and daily contact in the community. |
| **9.** Culturally and linguistically competent - the Care Coordination process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the individual served, and their community. | o Practices reflect respect for and builds on the values, preferences, beliefs, culture, and identity of the individual served, and their community.<br>o Staff are trained to work effectively in a cross-cultural environment.<br>o Linguistic needs of the individuals served are assessed and met.<br>o Quality improvement efforts include reviewing cultural and linguistic competence. |
| **10.** Outcome based – Care Coordination ensures goals and strategies of the care plan are tied to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. | o The goals and strategies of the Care Plan are clearly written and observable or measurable.<br>o Care Plans include steps for eventual transition to community-based services and supports when feasible.<br>o Resources are in place to support individual self-care goals. |

| | |
|---|---|
| | ○ Care Plans have clearly identified target dates and are reviewed regularly to monitor for success or the need for revisions.<br>○ Care Coordination specific outcomes have been created based on the goals of the program to be analyzed for continuous quality improvement (i.e. reduction in readmission rates to acute care services). |