Florida Department of Children and Families
Office of Substance Abuse and Mental Health
Care Coordination Rating System (Provider)

Instructions: The checklist examines the core competencies of Care Coordination activities. This document is intended to be used in partnership with the Care Coordination Technical Assistance Document. This checklist/rating system is a resource that can be used by the Network Service Provider as a self-assessment tool or by the Managing Entity (ME) and SAMH Regional Office as a progress monitoring tool.

Review the key elements for each core competency and indicate if the key elements are present by using the following scale:

0 – There is *no evidence*
1 – There is *minimal evidence*
2 – The evidence identified is *average*
3 – The evidence identified is *above average*
4 – The evidence identified is *exceptional*

For each item, a description of evidence is required.

KEY ELEMENTS	STATUS	EXPLAIN EVIDENCE
SINGLE POINT OF ACCOUNTABILITY		
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).*	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Assign one care coordinator to follow the individual served from beginning to end, until a warm-hand off is made.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Ensure adequate staffing of care coordinators to meet the demand of the target population groups.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
ENGAGEMENT WITH PERSON SERVED AND THEIR NATURAL SUPPORT(S)		

KEY ELEMENTS	STATUS	EXPLAIN EVIDENCE
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.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
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.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
On call services are available 24 hours, seven days a week.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
STANDARDIZED ASSESSMENT		
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.*	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
SHARED DECISION-MAKING		
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.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
The individual served and family members are the driver of goals of the Care Plan.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	

KEY ELEMENTS	STATUS	EXPLAIN EVIDENCE
COMMUNITY-BASED SERVICES		
Coordinates with the ME to identify service gaps and request purchase of needed services not available in the existing system of care.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Care Coordinator assists with access to the least restrictive level of care in the community.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Helps to remove barriers to access to care.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Maintains an up to date list of community-based services/resources to inform staff and individuals served as well as their families.	☐ 0 1 ☐ 2 ☐ 3 ☐ 4	
COORDINATION ACROSS THE SPECTRUM OF HEALTH CARE		
Network Service Provider has assessed the organizational culture and developed mechanisms to incorporate the core values and competencies of Care Coordination into daily practice.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
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.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
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.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
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	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	

KEY ELEMENTS	STATUS	EXPLAIN EVIDENCE
obtaining eligible benefits. Providers must use SOAR when assessing for SSI and SSDI.		
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.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
INFORMATION SHARING		
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.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
The conditions and infrastructure for ensuring quality referrals and transitions have been established.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Protocols are established for handling data sharing and releases of information (ROI).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
EFFECTIVE TRANSITIONS AND WARM HAND-OFFS		
Protocols are established and followed for transitions.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Individuals served meet the provider at the time of discharge or within 24 hours of referral to ensure a warm-hand off when possible.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Follow-up post-referral or transition is provided.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
The role of peer specialists is defined as it relates to engagement, warm hand-offs and daily contact in the community.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
CULTURALLY AND LINGUISTICALLY COMPETENT		
Practices reflect respect for and builds on the values, preferences, beliefs, culture, and identity of the individual served, and their community.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Staff are trained to work effectively in a cross-cultural environment.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Linguistic needs of the individuals served are assessed and met.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	

KEY ELEMENTS	STATUS	EXPLAIN EVIDENCE
Quality improvement efforts include reviewing cultural and linguistic competence.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
OUTCOME-BASED		
The goals and strategies of the Care Plan are clearly written and observable or measurable.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Care Plans include steps for eventual transition to community-based services and supports when feasible.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Resources are in place to support individual self-care goals.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Care Plans have clearly identified target dates and are reviewed regularly to monitor for success or the need for revisions.	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
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).	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	