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

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.	○ ME identifies, through data surveillance, individuals eligible for Care Coordination based on the priority populations identified. ○ ME ensures that there is a single point of accountability identified at the network provider level who is responsible for the coordination of services until the individual is adequately connected to the care that meets their needs. ○ ME ensures one care coordinator follows the individual served from beginning to end, until a warm hand-off is made. ○ ME ensures that the Network Service Provider has adequate staffing of care coordinators.
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.	○ ME ensures that the Network Service Provider is engaging individuals in their current setting *(e.g., crisis stabilization unit (CSU), SMHTF, homeless shelter, detoxification unit, addiction receiving facility, etc.)* to establish a warm hand-off. ○ ME ensures that the Network Service Provider is maintaining frequent contact, ranging from daily to a minimum of three times per week, for at least the first 30 days of services, for those individuals who agree to receive care coordination services. If the individual refuses care coordination services or they are not responding to the attempts made, the ME ensures the provider has documented the information in the individual's clinical record. ○ ME ensures that the Care Coordinator(s) at the Network Service Provider has a process in place that allows for on call services to be available 24 hours, seven days a week.
3. Standardized assessment of level of care determination process – a standardized level of	○ ME ensures that the Network Service Provider 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*

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care assessment provides a common language across providers that can assist in determining service needs.	*of Care Utilization System (CALOCUS) or the American Society of Addiction Medicine (ASAM) Criteria.*
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.	○ ME ensures that the Network Service Provider staff share the 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. ○ ME ensures that the individuals served and their family members are the driver of goals on 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.	○ ME manages care coordination funds and purchases services based on needs identified by Network Service Provider. ○ ME develops diversion strategies to prevent individuals who can be effectively treated in the community from entering SMHTFs. ○ ME ensures provider network adequacy and effectively manages resources. ○ ME provides technical assistance to the Network Service Provider and assists in eliminating system barriers. ○ ME assists in developing a list of community-based services/resources with the Network Service Provider and ensures the list is kept current.
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.	○ ME ensures that the Network Service Provider has assessed their organizational culture and developed mechanisms to incorporate the core values and competencies of Care Coordination into daily practice. ○ ME subcontracts with Network Service Providers for the provision of Care Coordination using the allowable services outlined in the Guidance Document. ○ ME works collaboratively with the Department of Children and Families to refine practice. ○ ME develops partnerships and agreements with community partners *(i.e., managed care organizations, criminal and juvenile justice systems, community based care*

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	organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data. ○ ME tracks service needs and gaps and redirect resources as needed, within available resources. ○ ME makes sure that for individuals who require medications, the Network Service Provider ensures linkage to psychiatric services within 7 days of discharge from higher levels of care. 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. ○ ME ensures that the Network Service Provider assesses the individuals 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. ME ensures that the Network Service Provider uses SOAR when assessing for SSI and SSDI.
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.	○ ME ensures that the Network Service Provider has protocols established and followed for data sharing and releases of information (ROI) that are in compliance with federal and state law. ○ ME ensures that the Network Service Provider has established conditions and infrastructure for quality referrals and transitions. ○ ME ensures that the Network Service Provider is capable of shared Electronic Health Records, web-based e-referrals or has another standardized process in place for the flow of information.
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.	○ ME ensures Network Service Provider has established protocols for effective transitions and warm hand-offs. ○ ME ensures Network Service Provider adheres to established protocols for effective transitions and warm hand-offs. ○ ME ensures Network Service Provider effectively utilizes Peer Specialists in the workplace to promote engagement, warm hand-offs and assist with daily contact in the community.

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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.	○ ME ensures the Network Service Provider considers the values, preferences, beliefs, culture, and identity of the individual served, and their community when providing care coordination. ○ ME ensures that the Network Service Provider has protocols for meeting the linguistic needs of the individuals served. ○ ME ensures that 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.	○ ME assesses and addresses quality of care issues. ○ ME implements a quality improvement process to establish a root cause analysis when Care Coordination fails. ○ ME ensures that the Network Service Provider reviews Care Plans regularly. ○ The ME tracks individuals served through Care Coordination in order to monitor the following outcomes: readmission rates for individuals in acute care settings; length of time between acute care admissions; length of time an individual waits for admission to a SMHTF; length of time an individual waits for discharge from a SMHTF and length of time acute care setting and SMHTF discharge to linkage to services in the community.