NSP Care Coordination

Provider Care Coordination Assessment Cx (LSF Contract ID) Utilized a standardized level of care tool (the LOCUS, CALOCUS, and ASAM) and assessments to identify service needs and choice of the individual served.

Provider Care Coordination Community Srvs Cx (DCF CC Rating System) Care Coordinator helps to remove barriers to access to care.

Provider Care Coordination Community Srvs Cx (LSF Contract ID) Coordination with the managing entity to identify service gaps and request purchase of needed services not available in the existing system of care. A signed approval of a voucher from LSFHS must be obtained before incurring expense for a client that is to be reimbursed through the LSFHS voucher funds. Vouchers submitted after the fact, may be denied.

Provider Care Coordination Community Srvs Cx (LSF Contract ID) Care Coordinator assists with access to the least restrictive level of care in the community.

Provider Care Coordination Coord of Care Cx (LSF Contract ID) 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.

Provider Care Coordination Coord of Care Cx (LSF Contract ID) Assess 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. When applying for SSI or SSDI benefits, providers must use the SSI/SSDI Outreach, Access, and Recovery (SOAR) application process. Individuals enrolled in care coordination should be prioritized for the SOAR process. The client must have an initial appointment with a SOAR processor within 60 days of enrollment into Care Coordination services. Progress towards obtaining benefits should be reported to the Managing Entity Care Coordinator on a bi- weekly basis.

Provider Care Coordination Coord of Care Cx (LSF Contract ID) 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.

Provider Care Coordination Cx (LSF Contract ID) Complete applications for government benefits or entitlements when the client is eligible (i.e. Supplemental Nutrition Assistance Program or Food Stamps, Medicaid, Medicare, Unemployment Benefits and Temporary Assistance for Needy Families) within 60 days of enrollment into Care Coordination services.

Provider Care Coordination Cx Cx (LSF Contract ID) Complete applications for government benefits or entitlements when the client is eligible (i.e. Supplemental Nutrition Assistance Program or Food Stamps, Medicaid, Medicare, Unemployment Benefits and Temporary Assistance for Needy Families) within 60 days of enrollment into Care Coordination services.

Provider Care Coordination Cx Trans Voucher (ID 34) Was the client either currently experiencing homelessness, receiving care coordination services (pursuant to DCF Guidance Document 4), or Participating in FACT and ready to transition to a lower level of care?

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Provider Care Coordination Cx Trans Voucher (ID 34) Is the provider keeping accurate records that reflect the specific services offered to each client?

Provider Care Coordination Cx Trans Voucher (ID 34) If the client is receiving ongoing funds, was their progress reviewed every 90 days to ensure progress (Exhibit A-1)?

Provider Care Coordination Cx Trans Voucher (ID 34) Were services documented on the Transitional Voucher Assistance Purchase Request Form (Exhibit A) and/or in the progress notes?

Provider Care Coordination Cx Trans Voucher (DCF Guidance Document 29, Incorporated Document 34) Were services documented on the
Transitional Voucher Assistance Purchase Request Form (Exhibit A) and/or in the progress notes?

Provider Care Coordination Cx Trans Voucher (ID 34) Is the provider using the SOAR model to assist clients in applying for SSI/SSDI?

Provider Care Coordination Eligibility Cx (LSF Contract ID) 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.

Provider Care Coordination Engagement Cx (LSF Contract ID) Assigned one care coordinator to follow the individual served from beginning to end, until a warm-hand off is made.

Provider Care Coordination Engagement Cx (LSF Contract ID) Care Coordinator 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, behavioral health care, housing, etc.).

Provider Care Coordination Engagement Cx (LSF Contract ID) Individual engaged 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.

Provider Care Coordination Plan of Care Cx (DCF CC Rating System) Care Plans have clearly identified target dates and are reviewed regularly to monitor for success or the need for revisions.

Provider Care Coordination Plan of Care Cx (LSF Contract ID) Plan of care developed with the individual based on shared decision making that emphasizes self-management, recovery and wellness, including transition to community based services and/or supports.The individual served and family members are the driver of goals of the Care Plan. The care coordination care plan must include initiation of SSI/SSDI Outreach, Access, and Recovery (SOAR) and application for government benefits or entitlements when the client is eligible. The care coordination care plan must include initiation of SSI/SSDI Outreach, Access, and Recovery (SOAR) and application for government benefits or entitlements when the client is eligible.

Provider Care Coordination Plan of Care Cx (LSF Contract ID) 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.

Provider Care Coordination Plan of Care Cx (DCF CC Rating System) The goals and strategies of the Care Plan are clearly written and observable or measurable.

Provider Care Coordination Plan of Care Cx (DCF CC Rating System) Care Plans include steps for eventual transition to community-based services and supports when feasible.

Provider Care Coordination Plan of Care Cx (DCF CC Rating System) Resources are in place to support individual self-care goals.

Provider Care Coordination Plan of Care Cx (DCF CC Rating System) Practices reflect respect for and builds on the values, preferences, beliefs, culture, and identity of the individual served, and their community.

Provider Care Coordination SMHTF Req cx (LSF Contract ID) Secure community placement and services in cooperation with SMHTF social worker or discharge planner.

Provider Care Coordination SMHTF Req Cx (LSF Contract ID) Share relevant information with the SMHTF staff.

Provider Care Coordination SMHTF Req Cx (LSF Contract ID) Participate in the discharge meeting and assist in the development of a service plan which addresses the individual's needs in the community.

Provider Care Coordination SMHTF Req Cx (LSF Contract ID) Actively carry out linkage and brokerage activities in the community prior to the individual's discharge in order to implement the service plan.

Provider Care Coordination SMHTF Req Cx (LSF Contract ID) Have a face-to-face contact with the client in the community within 2 working days of discharge from the SMHTF.

Provider Care Coordination SMHTF Req Cx (LSF Contract ID) Maintain progress notes in the client record reflecting all meetings and communications with state treatment facility staff, the client, the family or significant others.

Provider Care Coordination SMHTF Req Cx (LSF Contract ID) Ensure recommended services are received after the individual's discharge.

Provider Care Coordination SMHTF Req Cx (LSF Contract ID) Maintain at least monthly contact with state treatment facility staff concerning the status of the individual.

Provider Care Coordination SMHTF Req Cx (LSF Contract ID) Participation in the development of a SMHTF treatment plan.

Provider Care Coordination SMHTF Req Cx (LSF Contract ID) Maintain contact with the individual's family consistent with Chapter 394, F.S.

Provider Care Coordination Transitions Cx (DCF CC Rating System) The role of peer specialists is defined as it relates to engagement, warm hand-offs and daily contact in the community. (as applicable)

Provider Care Coordination Transitions Cx (DCF CC Rating System) Follow-up post-referral or transition is provided.

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Provider Care Coordination Transitions Cx (DCF CC Rating System) Individuals served meet the provider at the time of discharge or within 24 hours of referral to ensure a warm-hand off when possible.

Provider Care Coordination Transitions Cx (LSF Contract ID) Individuals served meet the provider at the time of discharge or within 24 hours of referral to ensure a warm-hand off when possible.

Provider Care Coordination Transitions Cx (LSF Contract ID) For individuals admitted to a CSU whose length of stay exceeds 30 days, a staffing with the ME will be required.

Provider Care Coordination Transitions Cx (LSF Contract ID) 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.