Best Practices – Care Coordination

Updated 3-27-2020

Best Practices

To be eligible for care coordination services through the HOPE Consortium, individuals must have a diagnosis of an opioid and/or methamphetamine use disorder, be 18 years of age or older, and reside in the HOPE Consortium service area. In addition, clients must consent to enrollment in the HOPE Consortium and be receiving substance use disorder treatment services (e.g., AODA counseling) from an area provider. Care coordination services are available to all HOPE Consortium clients at no cost to the individual or his or her insurance and should be offered to any eligible individual. Services are provided using the coordinated service teams (CST) model described below.

Collaborative systems of care known as CSTs are designed to address complex behavioral health needs and support community-based options for care. Such teams consist of family members, services providers, and others that work to carry out a coordinated service plan.

All collaborative care systems rely on a shared set of core values including:

- Consumer involvement
- Family-centered
- Build on natural and community supports
- Strength-based
- Unconditional care
- Collaboration across systems
- Team approach across agencies
- Ensuring safety
- Gender/age/culturally responsive treatment
- Self-sufficiency
- Education and work focus
- Belief in growth, learning, and recovery
- Outcome oriented

The wraparound model of care that is established by the CST is not a specific treatment, but rather provides a structured, individualized, team planning process to promote positive outcomes. The CST helps an individual to refine and improve his or her problem solving skills, coping skills, and belief in his or her ability to complete tasks and reach goals. Although originally developed for children with complex behavioral problems, CSTs have been successfully used to support recovery in the context of substance use disorders in the HOPE Consortium service area for nearly 20 years.

Upon initial contact, basic information about the participant is collected using the *Initial Contact Form*, which walks the participant through eligibility criteria, demographic information, high level treatment objectives, information about drug(s) of choice and frequency of use, and services involved. Within 30 days of enrollment, an in depth collaborative systems of care summary of strengths and needs is completed. The 13 page strengths and needs evaluation captures information regarding the participant and his or her immediate family members and rates numerous categories important for the provision of collaborative, coordinated care, including crisis situations, trauma history, living situation, family, basic needs/financial, mental health, medical, alcohol and other drug abuse (AODA), social and recreational, cultural, spiritual, educational/employment, legal, and miscellaneous. For each category, a rating is assigned on a scale from 0 (No problem – no action needed) to 3 (Severe problem – help is needed now). The potential for team members to assist in the area and whether the area is a goal of the participant is also noted. In addition to the detailed form, a one page summary of strengths and needs,

including numerical ratings, is generated. For additional information regarding these tools, please see *Collaborative Systems of Care Summary of Strengths & Needs* and *Summary of Strengths and Needs*. Each time a HOPE Consortium client's strengths and needs are assessed, the care coordinator enters ratings into the REDCap database for each domain.

Using information captured about strengths and needs and recommendations from team wraparound meetings, the care coordinator generates and maintains a service plan for each goal. The service plan details tasks and activities related to a particular goal and assigns a responsible person and target date for completion. Open, close, and review dates are recorded as is associated cost.

Care coordinators also assess quality of life for all clients at baseline and every 6 months thereafter using the WHOQOL-BREF if assessment has not already been completed elsewhere. Results are entered into the REDCap database each time the questionnaire is completed.

Support

The HOPE Consortium is committed to providing care coordination services to all individuals with an opioid and/or methamphetamine use disorder over the age of 18 that reside in the HOPE Consortium service area. At present, all costs associated with care coordination are covered by HOPE Consortium grant funds. There is no cost to the client or to his or her insurance. HOPE Consortium care coordinators are employed by the Marshfield Clinic Health System – Center for Community Health Advancement and managed by Dottie Moffat of DLM Consulting, LLC. Care coordination services are available by request from any Consortium provider. Services are similar to those provided to participants in the Human Service Center's Tri-County Women's Outreach Program. Should service availability become limited, priority will be given to pregnant women.

Referrals **Providers and/or agency staff may refer clients to the HOPE Consortium care coordinators:**	
REDCap	1. Click the "Refer to Care Coordination" button on the patient dashboard 2. Enter the indicated information 3. Upload signed release 4. Click "Submit" to send referral
Fax	Complete ***Referral Form*** Fax completed form and signed release to 715-358-9539
Releases	Clients may sign a standard agency release to HOPE Consortium Care Coordinators or complete the **HOPE Consortium Care Coordination Release of Information Authorization**.
Timeline	Care coordinators will contact referred clients following assignment of new referrals on a weekly basis.