BBHC

BROWARD BEHAVIORAL HEALTH COALITION

2019-2020

# BBHC Care Coordination Manual Child Welfare Families

Care Coordination-CW

2019-2020

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## ABOUT BROWARD BEHAVIORAL HEALTH COALITION

Broward Behavioral Health Coalition, Inc. (BBHC) was created in 2011 and was selected by the Florida Department of Children and Families (DCF) as Broward County's (Circuit 17) managing entity for mental health and substance abuse services. Its purpose is to coordinate and fund services, for and on behalf of adults and children in our community.

The Substance Abuse and Mental Health (SAMH) Program Office of the Department of Children and Families contracts with BBHC to manage the state funded Substance Abuse and Mental Health system of care in Broward County.

BBHC ensures quality and best practices are provided to consumers and families seeking services in Broward County.

***MISSION STATEMENT***

To advocate and ensure that an effective and efficient behavioral health system of care is available in Broward County.

***VISION STATEMENT***

Ensuring a responsive and compassionate behavioral healthcare experience for people in our community.

***VALUE STATEMENT***

Consumer driven, cultural competence, compassionate service, efficient management, innovative system, fiscal integrity.

## BBHC CARE COORDINATION – Child Welfare (CW)

Section 394.4573(1)(a), F.S., defines Care Coordination-CW as "the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individual who are not yet effectively connected with services to ensure service linkage."

Care Coordination-CW is the organization of care activities between two or more participants including the family served (with consent), involved in the family's care to facilitate the effective delivery of behavioral health, primary health care, developmental, and mental health services. The population to be served through Care Coordination-CW will be child welfare families that have experienced a judicial removal episode due to caregiver Substance Use Disorder (SUD). With priority given to caregivers with Opiate Use Disorder (OUD). It offers the opportunity to share information in a timely manner and ensures the families being served are followed and supported as they progress through their recovery process. In child welfare the standard practice has been that once the case is closed, the family may no longer receive the services and support needed to maintain the gains achieved during the life of the case. Due to a lack of support, many of these families cycle through the child welfare system experiencing multiple episodes of removal. In turn, the caregiver's cycle through the mental health/substance abuse system, and

the children experience the repeated trauma of removal and the negative impact of their caregivers(s) SUD. This leads to the de-compensation of the family unit and creates immense costs for multiple publicly funded systems.

**Care Coordination-CW Short-Term Goals:**

- Prioritize the family's wellness and enhance their natural supports within the community.
- Improve transitions from acute and restrictive services mandated by child welfare to; community-based services, family supports, and the maintenance of long-term family and individual recovery.
- Increase overall family stability and wellbeing, while decreasing the likelihood of another removal episode.

**Care Coordination-CW Long-Term Goals:**

- Help service providers shift from an acute care model to a Recovery-Oriented System of Care (ROSC) Model.
- Help communities provide a wide array of services and supports tailored to meet the diverse needs specific to each family and each member within the family unit.

## BBHC Care Coordination Manager

BBHC has a Care Coordination Manager that provides oversight to Care Coordination-CW Teams at local provider agencies. These teams serve individuals and families with complex needs and are involved in multiple systems. Care Coordination-CW is time-limited, with a heavy concentration on educating and empowering the family while providing a single point of contact until the family is adequately connected to care that meets their needs.

The BBHC Care Coordination Manager monitors consumers and their families who are at High-Risk & are High-Utilizers of Mental Health and Substance Abuse Services. Monitoring may include clinical record review, participation in case staffing's, and linkage to services in the community. Additionally, BBHC Care Coordinator Managers will assist Provider Care Coordination-CW Teams in accessing system partner services and breaking through barriers for families on their teams and other high utilizers, as needed.

| Role | Name | Phone | Email |
|---|---|---|---|
| **Director of Operations** | Elida Segrera | 954-622-8121 Ext. 1015 | esegrera@bbhcflorida.org |
| **Project Director** | Skye Cleek | 954-465-4751 | scleek@bbhcflorida.org |
| **Care Coordination Manager** | TBA | 954-622-8121 | |
| **CCT-CW Care Coordinator** | TBA | 954-622-8121 | |

## Care Coordination Teams-CW

Care Coordination Teams (CCT)-CW will provide transitional services to families in the child welfare system, who have experienced one or more episodes of removal due to caregiver SUD, with priority given to OUD. Critical Time Intervention (CTI) will be one of the evidenced-based practices utilized to effectively transition families from the child welfare system. Care Coordination-CW Teams will provide an Intensive Case Management Team approach in conjunction with the BBHC Care Coordination Manager, that will focus on the family's strengths and needs to determine the appropriate level of support needed, and link with existing and newly identified services and supports. The Care Coordination-CW Team will consist of an intensive case manager, and a peer specialist, supervised by a Licensed clinician. The case load of each team will range between 10-15 families. The teams will conduct weekly treatment team meetings and will coordinate for assessment/clinical services, and will directly provide intervention/crisis support, case management, and peer support. The services provided by the Care Coordination-CW Teams are time-limited, with a heavy concentration on educating and empowering the family served, engaging and getting to know the family's strengths, needs and natural supports, and providing a single point of contact until a family is adequately connected to the ongoing support needed to maintain long term recovery. The Care Coordination-CW Teams will be available 24/7 for crisis issues.

## Frequency of Contact

- **Phase 1**: A minimum of three (3) face-to-face contacts/week with at least 75% of total contacts in the community is required.
- **Phase 2**: Most families may still require (3) face-to-face contacts/week. For identified families who are transitioning well, prior approval may be given by the designated BBHC Care Coordination Manager for (2) face-to-face contacts and (1) phone contact for individuals who may ready to transition earlier than the 9 months CTI model.
- **Phase 3**: Gradual decrease to lower level of contacts with an average of 1-2/week prior to discharge planning.

## Inactive Status

Inactive status refers to families enrolled in Care Coordination-CW Team services, who are not able to be seen in the community according to the identified CTI Phase. Inactive status requires a written request from the provider and approval from the BBHC Care Coordination Manager and may be approved for a maximum of 30 days. Examples of reasons for inactive status may include being out of the area visiting family/friends, hospitalization, incarceration or other environment. These families are to remain enrolled on the team, however, they will not be included in the utilization for the time-period.

## Admission Criteria

- Families must have experienced a child welfare removal episode due to caregiver SUD, with priority given to caregivers with OUD.
- Families identified by child welfare with a case plan goal of reunification.
- Child Welfare families who are not effectively connected with services and supports.
- Child Welfare families who are transitioning successfully from mandated child welfare services, to effective community-based care.
- Child Welfare families who are high utilizers of services in behavioral health, primary care, peer, natural supports, housing, education, and vocational.
- Child Welfare family's needs can include at-risk to manageable substance abuse problems with a high recidivism rate into SUD treatment and further episodes of removal due to caregiver SUD/OUD.

## Care Coordination-CW Team Referral Process

If the criteria above are met, follow the process below to have families placed on a Care Coordination-CW Team.

- Complete:
  - Child Welfare Families Application.
  - Consent to Release and Exchange Information & Data Sharing Agreement
  - Authorization for Release of Protected Health Information for Waitlist Participation
  - Write a brief history regarding the family's current status and need for placement on a Care Coordination-CW Team.
  - Provide any relevant documentation i.e., Current Biopsychosocial Assessment, Psychiatric Evaluation, Medication Log, Court Documents, Comprehensive Behavioral Health Assessment, Family Functioning Assessment, etc.
- Email Documents to: CCT-CW Care Coordinator co-located at ChildNet
- CCT-CW Care Coordinator will email the packet to the BBHC Care Coordination Manager to render a disposition of the referral.
- Upon acceptance, BBHC Care Coordination Manager will email the referral source and cc the CCT-CW Care Coordinator an authorization number as well as a start and ending date of authorization, for the first phase of care (90 days).
- BBHC Care Coordination Manager and the CCT-CW Care Coordinator will conduct weekly reviews regarding progress toward family goals.
- At the end of each phase BBHC Care Coordination Manager and the CCT-CW Care Coordinator will conduct quarterly utilization reviews to authorize next phase of care.

## Treatment Model

The primary Treatment Model utilized by the Care Coordination-CW Teams is the evidence-based practice (EBP), Critical Time Intervention (CTI). Critical Time Intervention is used to provide recovery-oriented services to individuals and families receiving Care Coordination-CW. This model is on the SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP) and was "designed as a short-term intervention for people adjusting to a "critical time" of transition in their lives". Within the CTI model, Motivational Interviewing and Family Wellness Recovery Action Planning (F-WRAP) are also utilized to ensure that families receive treatment/ancillary services to meet their needs. The Teams receive training and coaching to ensure program fidelity. More information about CTI can be found on www.criticaltime.org.

**Services Covered Under Care Coordination-CW:**

- Outreach
- Assessment
- Crisis Support/Emergency
- Individual and Family Recovery Support (F-WRAP)
- Intensive Case Management & Case Management
- In-Home and On-Site
- Supportive Housing
- Intervention

**Principles of CTI:**

- Focuses on a critical transition period and is time-limited.
- Enhances continuity of care, aims to prevent recurrent child welfare removal episodes, inpatient facilities, detox, etc.
- Identifies formal and natural community supports to meet the needs of the family.
- Complements rather than duplicates existing services.

**Phases of CTI and Treatment Planning:**

- Pre-CTI: Services begin before Termination of Child Welfare Supervision (TOS) to establish an initial relationship before the transition begins.
- Phase 1: Transition to the Community – Frequent contact with the family in the community, focus on engaging the family with services, identifying and addressing housing-related issues in order to prevent homelessness or housing instability, and identifying and addressing what is needed to support long-term family recovery. A transition plan is implemented while providing emotional support.
    - Complete CTI Phase Plan & Treatment Plan Form – At the beginning of phase 1. Treatment plans should be completed within two weeks of authorization
    - Specify goals, reason and strategies for goals for the corresponding CTI phase
    - Complete ongoing progress notes documenting interactions with the family. Discharge planning discussion should occur throughout the phases.

- Complete the Summary of Goals form within two weeks prior to the second phase indicating status of goals for Phase 1
- Participate in Utilization Review led by BBHC Care Coordination Manager and CCT-CW Care Coordinator

- Phase 2: Tryout – The team encourages families to manage problems independently, with the assistance of natural supports, after connecting them to supportive services.
  - Complete CTI Phase Plan & Treatment for Phase 2
  - Specify goals, reason and strategies for goals for the corresponding CTI phase
  - Complete ongoing progress notes documenting interactions with the family. Discharge planning discussion should occur throughout the phases.
  - Complete the Summary of Goals form within two weeks prior to the third phase indicating status of goals for Phase 2
  - Participate in Utilization Review led by BBHC Care Coordination Manager and CCT-CW Care Coordinator

- Phase 3: Transfer of Care - Promotes transfer from CTI to other formal and informal community supports and termination of CTI services occurs once a family support network is safely in place.
  - Complete CTI Phase Plan & Treatment for Phase 3
  - Specify goals, reason and strategies for goals for the corresponding CTI phase
  - Complete ongoing progress notes documenting interactions with the family
  - Complete the Summary of Family Centered Goals form within two weeks prior to the end of the third phase indicating status of goals for phase 3 and while enrolled in the Care Coordination-CW program
  - Document caregiver and family outcomes and transition from the team including documentation of a warm hand-off meeting at the next level of care
  - Discharge

## Services provided per Treatment Phase

**Phase 1/Months 1-3:**

Using CTI, The Care Coordination-CW Team provides assessments of the family's needs, develops and implements an individualized service plan for the caregiver(s) and family to meet these needs. During this period the Care Coordination-CW Team frequently engages with the family making home visits, providing services such as introducing the family to providers, and helping the family access and connect with service providers that can potentially be a part of their support system. Focus is on meeting the family's immediate needs such as housing, food, primary medical care,

SUD sustained recovery, as well as therapeutic services. The family and/or caregiver(s) are accompanied when connecting to with community providers and receives assistance accessing benefits (Medicaid, Disability, etc.).

Peer Specialists will work with the identified parent with SUD to create an individual WRAP.

**Phase 2/Months 4-6:**

Using CTI, The Care Coordination-CW Team will again asses the family and continue to support the family's engagement and participation in services. The family's ability to use problem solving skills to navigate independently is assessed. As needed, case management, community-based visits and services are provided along with psychoeducation regarding the ability of the family to self-manage and navigate community services and natural recovery supports. The Care Coordination-CW Team begins to decrease the intense level of services provided during months 1-3. There are less frequent meetings, problem solving, and troubleshooting is provided along with crisis interventions as needed.

Peer Specialists will work with the family in creating an F-WRAP, and implementing the individual WRAP.

**Phase 3/Months 7-9:**

Using CTI, The Care Coordination-CW Teams assess the family's level of functioning and readiness for discharge from the Care Coordination-CW Team. The Care Coordination-CW Team continues to remain available to help the family problem solve, utilize providers, and natural support systems. During this period the family along, with their providers and natural supports, will agree on a long-term support system and plan in order to help the individual remain stable in the community (Family WRAP). Prior to discharge a final meeting is held to recognize the family's achievements and reinforce the ongoing plan that has been agreed upon.

Peer Specialists will work with the family in implementing the F-WRAP and the individual WRAP.

## Transitional Vouchers

**Purpose:**

The Transitional Vouchers are designed to help bridge the gap for families with an identified caregiver diagnosed with SUD as they transition from mandated child welfare services to supportive services in order to maintain gains achieved and family recovery. The intent is to provide financial assistance and facilitate the family's ability to live independently in the community with treatment and support services based on need and

choices to help them build a support system and improve their community involvement and, overall quality of life. This will sustain family independence, recovery, and overall well-being. The aim is to also help prevent recurrent episodes of removal due to caregiver SUD, in patient treatment, incarceration, provide safe, affordable, and stable housing opportunities and increase family choice and self-determination in their recovery process.

The transitional voucher provides time limited financial assistance based on the family's needs and care plan objectives. Families who have limited resources available or they have exhausted other financial resources including insurance; and have complex needs which may require multi-agency involvement, may be approved for assistance.

All transitional voucher requests must receive formal agency approval/denial utilizing the authorized form and approval by the designated BBHC Care Coordinator.

Agencies will continue to utilize internal policies and procedures in accordance with Broward Behavioral Health Coalition's (BBHC).

**Eligibility (All funds are time-limited):**
Families must be receiving substance abuse and/or mental health services and be served by a Care Coordination-CW Team funded by BBHC. Other unique requests may be approved by BBHC on a case by case basis.

**Examples for use of Transitional Voucher Funds (If other resources are not available):**
- Employment related expenses
- Housing assistance/subsidies
- Educational/Vocational services
- Transportation
- Day Treatment/Recovery Support
- Medical Care/Services/Pharmaceuticals
- Clothing
- Childcare
- Respite Services
- Other incidentals as approved by BBHC in compliance with Rule 65E-14.021, F.A.C.

**Restrictions and Limitations:**
- Voucher funds are the payer of last resort
- Directly support documented treatment/service goals of the caregiver (s) and family.
- Receipts must be maintained by the agency
- Invoice and treatment plan for requested service must be attached to the Transitional Voucher request form.
- Families should increasingly demonstrate the ability to self-manage and/or transition to other fund sources based on access to disability benefits, insurance, employment, and/or housing vouchers.

**Agency Responsibilities:**

It is the responsibility of the agency to develop an agency-specific policy and procedure to ensure accuracy, accountability, and responsibility for the funds requested and approved.

- The information will include initials or record identifier of families served
- Amount expended, service/item purchased, date of purchase, case manager involved
- The justification for an expenditure should be included in the caregiver(s) and family service plan

**Procedure for Accessing Transitional Voucher Funds:**

- Case Manager/Agency Designee will complete a Transitional Voucher Request/Application Form on behalf of the family being served
- The Transitional Voucher Request/Application will be submitted internally to the agency supervisor or designee for signature
- After being signed by the supervisor or agency designee the following must be submitted to the BBHC Care Coordination Manager overseeing the client's Care Coordination-CW Team:
- Transitional Voucher Request/Application Form
- Copy of the current treatment plan justifying the need for the requested service
- Transitional Voucher Program (TVP) Assessment Scale (due at phase change)
- Copy of Invoice for requested service
- BBHC Care Coordination Manager will approve and return signed form to the Case Manager/Agency Designee within 72 hours.
- Case Manager/Agency Designee is responsible for following their agency's internal policy in order to obtain and disburse the requested funds
- The Agency Designee is responsible for documenting and maintaining records of the Transitional Voucher funds provided on behalf of the families that they serve.
- BBHC Care Coordination Manager will also maintain a monthly tracking log of Transitional Voucher funds that have been approved

● Agency will submit their Care Coordination-CW Team Census and their voucher log/Exhibit O log monthly to BBHC.

## Discharge Planning

**Policy:**

Transition and Discharge planning begins at the initiation of the Care Coordination-CW process and will be discussed with the family, provider Care Coordination-CW Team, BBHC Care Coordination Manager. This planning will include the completion of the CTI service plan and along with the CTI phases of care, the implementation of individual and F-WRAP, and linkage to fellowship. A Transition/Discharge will occur when:

- The family has achieved identified CTI goals and/or has progressed through the phases of care.
- The family/individual has the tools necessary to maintain self-care and family recovery.
- The family may benefit from a lower level of care and/or additional services and supports.
- When clinically justified, families may step down to a less intense treatment phase, requiring less weekly in-person contact with the family.
- The family drops out, disengages, or requests to be discharged.

**Purpose:**

- To ensure coordination and continuity of care based on the needs and desires of the family served.
- To identify additional levels of care required/requested by the family served.
- To ensure follow-up post-discharge services identified by the family served or by the Care Coordination-CW team.
- To provide adequate care through the coordination of services based upon the individualized needs and desires of the family served.
- To address unanticipated service modification, reduction, or transition/discharge precipitated by funding or other resource issues.
- To maintain an accurate record of the service history provided for each family served as they progress between services disciplines and when discharged from the agency.

**Procedure:**

1. Families completing the 9-month program: Provider agency, BBHC Care Coordination Manager, and CCT-CW Care Coordinator will agree to discharge the family served and a discharge date will be determined.
2. The family will meet with the team to review the status of their goals, plans to remain stable in the community, ability to problem solve, and use of their natural support systems.
3. A Transition/Discharge Summary will be completed for all discharges by the designated staff member. Summary will include contact information for the next level of care, appointments and referrals made to internal and outside providers based on level of need and family request. If a family is transferring from program to program within the organization, the case manager will complete their internal agency Transition/Discharge Summary.
4. A copy of the Transition/Discharge Summary will be emailed via secure email to: the provider agency supervisor, BBHC Care Coordination Manager, and the CCT-CW Care Coordinator **within 48 hours of discharge from Care Coordination-CW**.
5. The Care Coordination-CW Team will complete a warm hand-off and transfer families to other formal and informal community supports upon completion of services.
6. A Satisfaction Survey will be offered per internal agency guidelines.
7. A copy of the Transition/Discharge summary will be provided to the family, including but not limited to, the F-WRAP and the individual WRAP.
8. Documentation will be placed in the medical record.

## References

**References**

https://www.criticaltime.org/

DCF Guidance Document Four: Care Coordination

DCF Guidance Document Twenty-Nine: Transitional Vouchers

# Sample Documents

## CONSENT TO RELEASE AND EXCHANGE INFORMATION & DATA SHARING AGREEMENT

I,_____, am aware that_____(hereafter referred to as the Named Agency) is part of a cooperative group of organizations that provide behavioral health treatment services and/or authorize State Funded treatment services. A list of all current Broward Behavioral Health Coalition (BBHC) funded behavioral health treatment providers has been given to me by the named agency. This information will be disclosed for the purposes of referral for behavioral health care, the provision of care, and for the reimbursement for services provided on my behalf.

I agree to allow all members of the BBHC provider network and Concordia Behavioral Health ("Concordia"), to exchange among them the following information: my complete name, date of birth, social security number, gender, race/ethnicity, location of intake, case manager, and treatment site.

In addition, I agree to allow the exchange of any information collected through the assessment process, which may include but is not limited to information about my HIV status, applicable medical records, and service delivery history, including information protected under 42 CFR Part 2, among and between the Named Agency, BBHC, Concordia, and the agency(s) that participate in the provider network - unless you choose specifically to not authorize release to a particular agency - consent to all agencies is granted by this Consent to Release.

I also understand that the network provider's ability to assess and access treatment, payment, enrollment, and/or eligibility for benefits is dependent on whether I sign this form. Refusal to sign consent will not prevent receiving services at a provider member, but may limit referral and/or access into another agency.

I fully understand the provisions of this Consent to Release, my rights to the confidentiality of my records, and I also understand that no other information regarding my treatment program, whereabouts, or any other factor will be released without my express and written consent.

This Consent to Release may be revoked at any time by signing the revocation line below, or by informing the agency holding this original form in writing, except to the extent that action had been taken in reliance thereon, (any information already released cannot be revoked). This Consent to Release shall expire in twelve (12) months from the date of execution below. I understand that any entity receiving information as a result of this release is bound by the following statement and that this Consent to Release shall become part of my record.

## ACKNOWLEDGEMENT OF REQUIRED INFORMATION

I have been informed by_____that the following may be requested for admission into any of the agency(ies) that participate in the provider network (Provider network agencies listed on attachment I): Detoxification Clearances, Medical Clearances, Prescribed Medications, Psychiatric Clearances and/or Evaluations

This is information and/or medication requirements must be provided and/or arranged prior to admission into the provider network agencies. Failure to meet these requirements will delay admission process.

_____ _____
Agency Representative Date

_____ _____
Client Signature Date

_____ _____
Parent, Guardian, or Authorized Representative Date

□ I wish to revoke this release of information, and I understand that I am entitled to a copy of this form.

_____ _____
Client Signature Date

# CTI Phase Plan & Service Plan

| **Phase #:** | **Pre-CTI** ☐ | **Phase 1** ☐ | **Phase 2** ☐ | **Phase 3** ☐ |
|---|---|---|---|---|

Client Name: _____ DOB: _____/_____/_____ Record #: _____

Today's Date: _____/_____/_____ Date Phase starts: _____/_____/_____ Due date for end of phase: _____/_____/_____
(blank for pre-CTI)

**CHECK THE GOALS FOR THIS PHASE: (Choose 1 to 3 areas)**

| | | |
|---|---|---|
| Psychiatric Treatment & Medication Management ☐ | Substance use treatment ☐ | Housing and/or Benefits ☐ |
| Individual Therapy ☐ | Daily living skills training ☐ | Crisis Prevention & Management ☐ |
| Natural supports/social supports intervention ☐ | Money management ☐ | Other (please specify) _____ ☐ |

**Goal # 1:** _____
*(in client's words)*

**Reason for goal:**
_____
*(justification/rationale)*

| **Strategies:** Be ***SMART*** | ***Progress Update 1 (within phase)*** | **Progress Update 2** ***(within phase)*** | **Progress Update 3** ***(within phase)*** |
|---|---|---|---|
| 1. _____ | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS |
| 2. _____ | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS |
| 3. _____ | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS |

| **Phase #:** | **Pre-CTI** ☐ | **Phase 1** ☐ | **Phase 2** ☐ | **Phase 3** ☐ |
|---|---|---|---|---|

Client Name: _____ DOB: _____/_____/_____ Record #: _____

**Goal # 2:** _____
*(in client's words)*

**Reason for goal:**
_____
*(justification/rationale)*

| **Strategies:** Be ***SMART*** | ***Progress Update 1 (within phase)*** | **Progress Update 2** ***(within phase)*** | **Progress Update 3** ***(within phase)*** |
|---|---|---|---|
| 1. _____ | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS |
| 2. _____ | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS |
| 3. _____ | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS |

| **Phase #:** | **Pre-CTI** ☐ | **Phase 1** ☐ | **Phase 2** ☐ | **Phase 3** ☐ |
|---|---|---|---|---|
| Client Name: _____ DOB: ____/____/____ Record #: _____ | | | | |

| **Goal # 3:** _____ *(in client's words)* ☐ Not Applicable | | | |
|---|---|---|---|
| **Reason for goal:** _____ *(justification/rationale)* | | | |
| **Strategies:** Be ***SMART*** | ***Progress Update 1 (within phase)*** | **Progress Update 2** ***(within phase)*** | **Progress Update 3** ***(within phase)*** |
| 1. _____ | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS |
| 2. _____ | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS |
| 3. _____ | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS | _____ ☐ NO PROGRESS |

**Client signature:** _____ **Date:** _____

**Case Manager signature/credentials:** _____ **Date:** _____

**Supervisor signature/credentials:** _____ **Date:** _____

| **Phase Completed:** | **Pre-CTI** ☐ | **Phase 1** ☐ | **Phase 2** ☐ | **Phase 3** ☐ |
|---|---|---|---|---|
| **Date of Completion** | | | | |
| **Comments** | | | | |

## Care Coordination -Temporary Transitional Voucher Request/Approval Form

**Must be submitted for proposed transitional expense, along with treatment plan and invoice.**
**All costs shall be consistent with the requirements of the contract, the State of Florida Reference Guide for State Expenditures, and applicable Florida statutes, rules, and regulations.**

**Case Manager/Requestor:** _____ **Request Date:** _____

**Provider Name:** _____ **Client Name:** _____

**Date of Birth:** _____ **Sex:** ☐ M ☐ F **Soc. Sec. #:** _____

**Consumer is currently receiving DCF/SAMH services at:** _____

**And meets one of the following requirements:**

- ☐ Experiencing Homelessness pursuant to ME Guidance 29
- ☐ Receiving Care Coordination services pursuant to ME Guidance 4
- ☐ Participating in FACT teams and ready to transition to a lower level of care
- ☐ Resides in SMHTF and ready for a lower level of care

| **Transitional Voucher Modifier Codes:** | **Care Coordination Modifier Codes:** | **Alternate Codes, as Directed:** |
|---|---|---|
| ☐ (DS) for MSTRV – Transitional Voucher – SA | ☐ (DV) for MSOCN – Substance Abuse | ☐ MSA11 (BM) |
| ☐ (DM) for MHTRV – Transitional Voucher – MH | ☐ (DO) for MHOCN – Mental Health | ☐ MHA09 (B1) |

| **Transitional Services needed:** | | |
|---|---|---|
| ☐Educational Services (IEL00) | ☐Medical Medications (IE001) | ☐Time-Lim. Transportation (IEE00) |
| ☐Clothing (IEB00) | ☐Psychiatric Medications (IE100) | ☐Medical Care (IEF00) |
| ☐Child Care (IEP00) | ☐Employment/Vocational Services (IEH00) | ☐Housing - -Utilities (IED00) |
| ☐Furniture/Home Equip. (IEK00) | | ☐Other: _____ |
| ☐ Housing Subsidy (IEC00) | Describe how this will support the consumer's treatment plan and recovery efforts: _____ | |

**Housing Provider & Address:** _____

- ☐ ALF Licensed by DCF, AHCA or related professional license
- ☐ Non-Licensed but have applicable professional certification (ie. FARR certified)
- ☐ Independent housing

**Housing Type:** ☐ **Permanent** ☐ **Transitional** ☐ **Supportive**

***Assisted Living Facility (ALF): Prior approval from DCF must be obtained to purchase services from an ALF. When utilizing and ALF, the request must include documentation showing due diligence was exercised in searching for less restrictive housing.*

**Funding request:** Housing $_____ per month x #____ months = $_____

Other Services: _____ $_____ per month x #____ months = $_____

Other Services: _____ $_____ per month x #____ months = $_____

**Anticipated Start Date:** _____ **Total Request $** _____

| Client's Source of Income: _____ | Annual Income: $ _____ |
|---|---|

**Benefit Status:**

☐ Receiving disability benefits (SSI or SSDI) ☐ Receiving insurance, Medicaid and/or Medicare

☐ Receiving food stamps ☐ Receiving veteran's benefits

☐ Receiving TANF ☐ Receiving other financial assistance

**Pending Disability Income Application via SSI/SSDI Outreach, Access Recovery (SOAR):**

☐ YES – Date of Application:_____ Date entered in OAT: _____

Staff assigned to complete: _____

If No, please explain plan for obtaining health insurance and/or disability for the consumer:

_____

_____

**Alternative funding sources explored:** _____

**Sustainability Plan - Post Transitional Voucher:**

_____

_____

_____

_____

_____

_____

**Case Mgr/Care Coordinator signature:**_____**Date:**_____

I certify that due diligence was exercised by my agency in searching for alternative funding sources prior to this request for Transitional Voucher funds. Our agency will continue to provide care coordination for the consumer post transitional voucher assistance.

**Provider Authorized Signature:**_____ **Date:** _____

**Agency Name:** _____

**To be Completed by BBHC**

**Funding decision:** ☐**Approved** ☐ **Denied**

**Approved amount: $**

**Approval Details/Comments:**

_____

_____

_____

**Funding Allocation:** ☐ **DS (MSTRV) - Transition Vouchers – SA** ☐ **DM (MHTRV) - Transition Vouchers – MH**

☐ **MH_MHA09 -BM (Modifier 4)** ☐ **SA: MSA09 (Modifier 4)** **Transition Vouchers - VO**

**Reason for Denial:** _____

_____

**BBHC Care Coordinator Name:**_____**Signature:**_____**Date:** _____

**TVP Assessment Scale**

## Transitional Voucher Program Assessment Scale

### Domains and Definitions - Highlight or Circle Assessed Domains

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **High Risk Behaviors (see page 3)** | None of the 11 high risk behaviors in at least the past year | None of the 8 highest risk behaviors in at least the past year | None of the 11 high risk behaviors in at least the past 6 months | None of the 8 highest risk behaviors in at least the past 6 months | One or more of the 8 highest risk behaviors on the last 6 months. |
| **Activities of Daily Living** | Able to perform self-care tasks (bathing, toileting, cooking, food shopping). Able to use bus independently. | Able to cook food shop for self. May require occasional prompts or assistance with other self-care tasks. Consistent access to reliable transportation (i.e. bus, family, friends). | Able to cook food shop for self. May require occasional prompts or assistance with other self-care tasks. No consistent access to reliable transportation (i.e. bus, family, friends). | Requires frequent prompting, monitoring or step-by-step cueing to perform one or more self-care tasks No consistent access to reliable transportation. | Demonstrates consistent failure to maintain personal hygiene appearance, and self-care near usual standards. No access to reliable transportation. |
| **Community Integration** | Consumer works/volunteers 20 hrs/week or more AND exhibits at least one of the following: 1) Consistent attendance at community groups/clubs/ religious services; 2) Consistent visits with friends/relatives | Consumer works/volunteers 10 – 19 hrs/week AND engages in at least one of the following: 1) Consistent attendance at community groups/clubs/ religious services; 2) Consistent visits with friends/relatives; | Consumer does not work/volunteers (or does so less than 10 hrs/wk) but attends community groups/clubs/ religious services AND/OR visits friends/relatives on a regular basis. | Consumer does not work/volunteers (or does so less than 10 hrs/wk) and sometimes attends groups/clubs/ religious AND/OR sometimes visits with friends/relatives | Consumer does not work, rarely leaves home and has few or no friends |

**Consumer Name:**_____

**Consumer Signature:** _____ **Date:** _____

**Provider Staff Name:** _____

**Provider Staff Signature:** _____ **Date:** _____

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Stable Housing (see page 3)** | Stably housed in the community for more than 12 months | Stably housed in the community for 7 - 12 months | Stably housed in the community for 1 - 6 months | In community living for less than 1 month or in another setting, but not homeless | Homeless living situation or had days homeless in last 6 months |
| **Treatment Participation** | Excellent (independently and appropriately accesses services) | Good (able to partner and can use resources independently) | Fair (No independent use of services or only in extreme need) | Poor (relates poorly to providers, avoids independent contact with providers) | No Participation (no contact with providers, does not participate in services at all) |
| **Psychiatric Medication Use** | Either no medications prescribed or adheres most of the time | For last six months takes meds most of the time but may need some verbal assistance, | Takes meds sometimes and/or may need physical assistance | Takes meds rarely or never as prescribed OR requires substantial help to take meds | Takes meds rarely or never as prescribed OR refuses meds OR level of assistance is unknown |
| **Psychiatric Hospitalization /Crisis management/ Detoxification** | No inpatient admissions, detox or ER visits in previous 12 months. | No inpatient admissions AND less than 3 ER/ Detox visits in previous 12 months. | Up to 1 inpatient admission and no ER/Detox visit OR 4 – 9 ER visits and no inpatient admissions in previous 12 months | No category 4 for this domain | 2 or more inpatient admissions OR 10 or more ER/ Detox visits in previous 12 months |
| **Forensic** | Had no arrests and spent no days incarcerated in past 12 months | Had no arrests and spent no days incarcerated in past 9 months | Had no arrests and spent no days incarcerated in past 6 months | No category 4 for this domain | Arrested or spent days incarcerated in last 6 months |
| **Substance Use Stages of Treatment (see page 4) Please circle the appropriate number in each box** | Consumer assessed at 0 (Client does not abuse drugs or alcohol); OR 8 (In Remission or Recovery) | Consumer assessed at Stage 7 (Relapse Prevention) OR late phase of Stage 6 (Late Active Treatment) | Consumer assessed in early phase of Stage 6 (Late Active Treatment) OR Stage 5 (Early Active Treatment) | Consumer assessed at Stage 4 (Late Persuasion) OR Stage 3 (Early Persuasion) | Consumer assessed at Stage 2 (Engagement) OR Stage 1 (Pre- engagement) |

**Date of Assessment Scale:** _____ **Score:**_____

**Consumer Initials:** _____ **Provider Staff Initials:** _____

## Transitional Voucher Program Assessment Scale

### Instructions:

The Transitional Voucher Program Provider will assess each participant's need for transitional voucher services at the time of referral, quarterly and at discharge from the program, using the attached Transition Assessment Scale. Completion of the scale with the consumer is particularly important at the time of referral, as it will aid in completion of the Transitional Voucher Program Care Plan and help guide conversation with the consumer about their goals. The Transitional Voucher Program Care Plan and the results of this assessment are key to assisting with appropriate services that will promote further recovery, stability, and ensure transition to self-sufficiency. The scale results are meant to be an indicator of success or challenges with reaching Transitional Voucher Care Plan Goals for discharge from the program, and to serve as a tool to assess level of care needed to assist the consumer with successful transition to services and housing that best meets their needs. Participation in the program is time limited as authorized by Broward Behavioral Health Coalition (BBHC)

### Housing

Individual is considered "stably housed in the community" if he/she meets the following criteria:

- Rents or owns a housing unit that is intended for human occupancy and is not defined as a "shelter" or "transitional housing".
- Individual has not moved involuntarily. Consumer's lease has not been involuntarily terminated due to acting out behaviors, failure to pay rent, property destruction, etc
- Individual uses identified housing unit as primary residence. Individual has not wandered or run away from the unit for lengthy periods of time.
- Individual pays rent and utility bills in a consistently timely fashion.

### High Risk Behaviors

1. Verbally assaulted another person
2. Expressed suicidal threat
3. Physically harmed self and/or attempted suicide
4. Threatened assault or physical violence
5. Physically/sexually abused or assaulted another individual
6. Engaged in arson
7. Damaged or destroyed property
8. Pattern of victimization
9. Taken property without permission
10. Created public disturbance
11. Wandered or ran away

## Clinician-rated Substance Abuse Stage of Treatment

| Rating scale | Circle one number below |
|---|---|
| **NOT APPLICABLE – Client does not abuse drugs or alcohol** | 0 |
| **Pre-engagement:** Client does not have contact with a case manager | 1 |
| **Engagement:** Client has had only irregular contact with a case manager or counselor. | 2 |
| **Early Persuasion:** The client has regular contacts with case manager, but has not reduced substance use more than a month. | 3 |
| **Late Persuasion:** The client is engaged in a relationship with case manager, is discussing use or attending a group and shows evidence of reduction in use for at least one month (fewer drugs/smaller quantity). | 4 |
| **Early Active Treatment:** The client is engaged in treatment, is discussing substance use or attending group, has reduced use for at least one month, and is working toward abstinence (or controlled use without associated problems). Abstinence is a goal though may still be using. | 5 |
| **Late Active Treatment:** The person is engaged in treatment, acknowledged substance abuse is a problem, and has achieved abstinence (or controlled use) for less than six months. | 6 |
| **Relapse Prevention:** The client is engaged in treatment, acknowledged problem, has at least six months' abstinence (or controlled use). Occasional lapses or day of problematic use are allowed. | 7 |
| **In Remission or Recovery:** The client has had no problems related to substance use for over one year and is no longer in any type of substance abuse treatment. | 8 |