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Care Coordination Program

Spill The Tea Cafe (STTC) Care Coordination Program is founded in the Collaborative Care Model (CoCM), an evidenced-based model of integrated care developed by University of Washington, a team-based approach that places emphasis on communication between physicians, clients, care coordinator, and other care team members, to support best clinical outcomes by improving rates of remission and decreasing frequency of relapse.

Clients referred to the program are assigned a care coordinator (CC) who collaborates directly with them to address their interrelated medical, social, educational, and behavioral needs to improve their overall health and wellbeing. Clients are registered and tracked in Simple Practice EMR to ensure timely connection to care and appointment attendance. CCs engage in routine monitoring of clients to track progress in care, provide ongoing education and support to break down barriers to care, and assist clients in accessing appropriate services, while collaborating with the overall care team to inform and adjust the care plan as needed. While CCs at STTC **do not provide direct clinical services,** CCs facilitate client engagement, provide ongoing education and support, and ensure timely and appropriate connection to community-based services.

1.1 Referral Process

Referrals for care coordination may come directly from a Spill the Tea Cafe clinician, administrative staff, or directly from clients and families who present during drop-in centers hours.

1.1.1. Case Assignment

Case assignment is determined by the STTC Clinical Leadership Team based on the individual CC case load and specialty area, although criteria is subject to change based on programmatic needs.

1.1.2. Administrative Requirements

CCs should confirm receipt of referral or request for care coordination services from referral source within **3 calendar days**. CCs should update their STTC client list to reflect new referral and update the administrative note in Simple Practice EMR to include their title, name, and date of case assignment (CC: Boba Tea Active 1/9/2025).

1.2 Intake

1.2.1. Pre-Intake Requirements

Prior to completion of the initial intake for services, CCs must ensure the following pre-intake documents are completed within Simple Practice EMR:

- Consent for Psychotherapy
- Consent for Telehealth
- Intake Form
- Demographic Form
- Practice Policies
- Notice of Privacy Policies
- Copy of Health Insurance (Back/Front

1.2.2. Timeline

High acuity and urgent clients must be contacted *immediately*, **within 24 hours** of receipt of referral. Otherwise, clients assigned for care coordination should be contacted within **72 hours** of case assignment to facilitate care coordination services.

CC should contact the client to schedule an intake **within 1 week** of referral assignment.

1.2.3. Intake Packet

Client intake should be conducted in-person at STTC, unless approved to complete in the community setting. The following documentation is required for all intakes:

1. Care Coordination Agreement Form
2. Biopsychosocial Assessment
3. Initial Care Plan
4. PHQ-9/PHQ-A and GAD-7
5. Safety Plan

Additional screening for neurodevelopmental disorders, mood disorders, trauma-related disorders, eating disorders, or substance use disorders may be initiated, if necessary.

A Release of Information (ROI) should be completed, as necessary, to streamline communication and ensure appropriate collaboration with all members of the interdisciplinary health team, including but not limited, their primary care provider, health care specialist, psychiatrist, or school.

1.2.4. Documentation

All client encounters following best practice standards. Clear, concise and throughout documentation is crucial to the provision of quality client care and effective collaboration with interdisciplinary team members.

It is mandatory that all client-related activities are documented within Simple Practice EMR within **72-hours** from the occurring event in the format of a DAP note:

Data: Specific, objective information, including information regarding client's current mental health status, current symptoms and functioning, client's direct or indirect quotes, results of screeners/other measures (PHQ-9, GAD-7, etc), and interventions and interventions used (e.g., psychoeducation, MI).

Assessment: Analyze the data, including client's progress, including improvement or setbacks as it relates to their treatment goals, assessing for risk (SI/HI/Self-Harm), and any additional resource needs (e.g., medication management, DOE IEP/504, HRT, etc.) that may benefit their treatment plan.

Plan: Detail the specific next steps, including date and time of next client phone call/meeting, resource navigation needs, or communication with care team members.

CCs are subject to routine chart audits to ensure the quality and timeliness of documentation. Please see STTC Documentation Guidelines for further support and examples of charting in Simple Practice EHR in DAP note format.

1.3. Continuum of Care

1.3.1. Role of Care Coordinator

Care Coordinators work directly with clients in collaboration with their care team to identify their concerns, develop a care plan to achieve their goals, provide education on available healthcare and community-based services, complete regular check-ins to monitor progress in treatment, and update their care plan as needed. All care coordination activities should be

appropriately and accurately documented with Simple Practice EHR in DAP note format within **72 hours** of event occurrence.

1.3.1. Routine Monitoring

Care Coordinators should contact assigned clients on a regular basis (e.g., weekly, bi-weekly, monthly) to track and discuss symptoms, administer and review PHQ-9/PHQ-A and GAD-7 screeners, provide ongoing psychoeducation to help clients understand and manage their mental health symptoms, and utilize motivational interviewing and other evidence-based techniques to address ambivalence and encourage relapse prevention.

1.3.2. Resource Navigation

Care Coordinators assist clients in connecting to community-based services that are well-matched to client's needs, preference, and commitment to LGBTQIA support (if consent to disclose if provided). Resource navigation needs are determined by initial intake and client monitoring in collaboration with STTC clinician and overall care team.

Care Coordinators are responsible for completing outreach calls to community-based providers to confirm availability, insurance coverage, and intake process and timeline within **1 calendar week** of request. All resource navigation calls should be appropriately documented as a chart note in DAP format in Simple Practice EHR within **72 hours** of occurring event.

1.3.3. Medication Management

CCs assist clients in connection to medication management services when requested. CCs actively monitor client's adjustment to new medication by assessing for side-effects, adherence, and overall effectiveness. This includes providing psychoeducation on mental health conditions and treatment, potential side effects, and encouraging routine follow-up with their psychiatrist, psychotherapist, and facilitating communication between other health care professionals to ensure client safety and optimal care outcomes.

CCs should accurately chart current medication(s), including dosage, adherence, challenges with access, or side-effects. CCs provides **daily** checks for the first three days, then shifts to **weekly** checks to ensure safety and adherence when a client starts or changes dosage of a psychotropic medication.

1.3.1. Community Visits

A majority of care coordination activities occur on-site at STTC. Community visits may be appropriate in cases where a client and their family have barriers to receiving services in-person at STTC. CCs should review and follow the Community Visits Guidelines to ensure safe and ethical service provision in community settings.

1.3.3. Safety Concerns

Suicidality

Clients who screen positive for suicidal ideation receive a Comprehensive Safety Plan. The safety plan should be reviewed, monitored, and adjusted as needed to ensure the safety and well-being of the client. Care Coordinators should appropriately collaborate with the client's collaborative care team to ensure appropriate support is provided across all-settings. The safety plan should be reviewed and updated **every 90 days**, or sooner, if there is a significant change in mood, stressors, or environment.

If a client is an imminent risk or danger to themselves or others, the care coordinator should inform STTC Leadership immediately. CCs should review the Crisis Intervention Guidelines for further guidance on program requirements to maintain our legal and ethical requirements to clients experiencing a mental health crisis.

Abuse or Neglect

CCs are mandated to report abuse and neglect concerns to Child Welfare Services (CWS) or Adult Provided Services (APS) as soon as possible once information regarding suspected abuse or neglect is received.

CWS/APS

Care Coordinators at STTC should contact a clinical supervisor ***immediately*** to receive consultation and determine the appropriateness of reporting. If a report is deemed necessary, the care coordination should contact the relevant agency CWS (808-832-5300) or APS (808-832-5115) to report suspected abuse or neglect.

Care Coordinators should be prepared to provide all information relevant to reporting, such as reason for referral, relevant information from the biopsychosocial history, summary of past events with specific dates, patient demographic information, such as name, date of birth, address, and parent/legal guardian contact information.

1.3.3. Case Closure

Case Closure is the formal termination of services for a client which occurs when either a client's goal(s) have been met, they are no longer engaged in services, or client chooses to terminate services.

Care Coordinators **must** seek approval to terminate services at clinical supervision.

Care Coordinators are required to complete a termination note in DAP format in Sharepoint EMR within **72 hours** of approved case closure.

Care Coordinator should update their STTC client list and the Simple Practice EHR Administrative Note to reflect the date of case closure.