Service Name	**COORDINATED SPECIALITY CARE**
Funding Source	Behavioral Health
Setting	Community- based setting, including individual's home
Facility or Professional License	As required by DHHS Division of Public Health

Basic Definition: Coordinated Specialty Cre is a comprehensive, recovery-oriented team based approach to treating early psychosis that promotes easy access to care, shared decision-making, strengths and resiliency, motivational enhancement skills, psychoeducational teaching skills, and collaboration with natural support. It targets individuals aged 14 to 35 and their families for early intervention, restoration of age-appropriate activities, resiliency, and recovery.

Service Expectations:

- A mental health assessment must be completed, if one has not been completed within the previous 12 months of admission to the service, within 24 hours of the initiation of treatment interventions. The mental health assessment must establish the need for this service. The mental health assessment must meet the requirements as noted in the mental health assessment service definition.
    - If the mental health assessment was completed within the previous 12 months of admission to the service, a licensed clinician who is able to diagnose and treat major mental illness within their scope of practice, must review the mental health assessment to determine if the diagnosis and treatment, recovery, and rehabilitation plan are still applicable. If there is new information available, including changes in the treatment, recovery, and rehabilitation plan, an update to the mental health assessment must be documented in the form of an mental health assessment addendum. The mental health assessment addendum must reflect the individual's current functional status
- This mental health assessment will serve as a temporary assessment until additional assessments are completed by the Coordinated Specialty Care team. These include: recovery and resiliency, mental health (including symptoms and functioning), illness management, physical health, family and other supports, and basic living needs.
- Development of a treatment/recovery team including formal and informal supports as chosen by the individual in addition to the Coordinated Specialty Care team members.
- An initial treatment, recovery, and rehabilitation plan must be developed within 24 hours to guide the first 30 days of treatment.
- An individualized treatment plan is developed by the team within 30 days of admission that integrates individual strengths and needs, formal and informal supports, measurable goals, and a documented discharge and relapse prevention plan/safety plan.

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- Review the individualized treatment plan and discharge plan with the individual's team, including the individual, every 90 days, or as clinically indicated. Each review should be signed by members of the team and the individual served.
- The multi-disciplinary team is expected to provide psychotherapy, family support and education, supported education, medication management, care coordination, and peer support (if the team has access to a certified peer). Supported employment should be coordinated with Vocational Rehabilitation and Extended Services with the Division of Behavioral Health.
- The multi-disciplinary team is expected to meet regularly to discuss referral, review consumer progress towards treatment goals and discuss care coordination needs.
- Care coordination activities include: coordination or assistance in accessing medical, psychiatric, psychopharmacological, psychological, social, education, housing, employment, transportation or other appropriate treatment/support services as well as linkage to other community services identified.
- Provision of active rehabilitation and support interventions with focus on vocational/education, social skills, and/or activities of daily living, and other independent living skills that enable the individual to reside in the community.
- The Coordinated Specialty Care team meets on a weekly basis, are led by the Program Director and usually last 60 minutes, depending on the number of individuals in the program and the complexity of their treatment/recovery needs.
- Outreach, primarily by team lead, to community for education, referrals, and resources.
- Referrals to crisis assistance must be available 24 hours a day, 7 days a week.
- Service must be trauma-informed and culturally sensitive.
- Supervision of service as required by the practitioner's license.
- All psychotherapy and substance use disorder practitioners are to provide services within their scope of practice.

Lengths of Services:

Length of service is individualized and based on clinical criteria for admission and continuing stay.

Staffing:

- Program Director: A bachelor's degree or higher in psychology, sociology or a related human service field is required. Demonstrated experience, skills, and competencies in behavioral health management. A master's degree in a human service field preferred.
- The coordinated specialty care team includes the following:
    - MD, PA, or APRN who serves as the team prescriber
    - Licensed Mental Health Practitioners (LIMHP, LMHP, PLMHP, Psychologist, Provisional Psychologist) in role of Individual Resiliency Trainer
    - Licensed mental health practitioners (LIMHP, LMHP, PLMHP, Psychologist, Provisional Psychologist) in role of Family Education Clinician. The Program director may also take the role of the Family Clinician on the team but must be a

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licensed mental health practitioner (LIMHP, Psychologist, Provisional Psychologist).
    - If individual is using Extended Services, Supported Employment Specialist: High school with minimum of 2 years of experience in the field and training, preferably in the Individual Placement and Support (IPS) model, with evaluation of course competency. Supported Employment and Education Specialists must be capable of performing all phases of supported employment and education services (engagement, assessment, job development, job placement, job coaching, and follow-along supports)
- Team may also include a Certified Peer Support Specialist (optional)
- The coordinated specialty care team will be trained in either the NAVIGATE or ON-TRACK model.

Staffing Ratio:

Up to 25 individuals per team

Hours of Operation:

Typical business hours with evening and weekend hours available by appointment, with 24/7 access to a crisis intervention services

Individual Desired Outcome:

- Successful transition to a less intensive level of care
- Individualized goals and objectives substantially met
- Crisis/safety/relapse prevention plan is in place
- Active and ongoing engagement in educational or volunteer activities or is competitively employed and maintaining job of choice
- Formal and informal support system in place
- Stable in the community environment of choice

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UTILIZATION GUIDELINES

I. Admission Guidelines

Individual must meet all of the following admission guidelines to be admitted to this service.

1. Individuals ages 14 through 35 with a primary diagnosis of psychosis listed below, including individuals with co-occurring disorders:
    a. F20.0 Paranoid schizophrenia
    b. F20.1 Disorganized schizophrenia
    c. F20.2 Catatonic schizophrenia
    d. F20.3 Undifferentiated schizophrenia
    e. F20.5 Residual schizophrenia
    f. F20.81 Schizophreniform disorder
    g. F20.89 Other schizophrenia
    h. F20.9 Schizophrenia, unspecified
    i. F21 Schizotypal disorder
    j. F22 Delusional disorders
    k. F23 Brief psychotic disorder
    l. F24 Shared psychotic disorder
    m. F25.0 Schizoaffective disorder, bipolar type
    n. F25.1 Schizoaffective disorder, depressive type
    o. F25.8 Other schizoaffective disorders
    p. F25.9 Schizoaffective disorder, unspecified
    q. F28 Other psych disorder not due to a sub or known physical cond.
    r. F29 Unspecified psychosis not due to a substance or known physical condition
2. Presence of functional deficits in two of three functional areas: Vocational/Education, Social Skills, and Activities of Daily Living.
    a. Vocational/Education: inability to be employed or an ability to be employed only with extensive supports; or deterioration or decompensation resulting in inability to establish or pursue educational goals within normal time frame or without extensive supports; or inability to consistently and independently carry out home management tasks.
    b. Social Skills: repeated inappropriate or inadequate social behavior or ability to behave appropriately only with extensive supports; or consistent participation in adult activities only with extensive supports or when involvement is mostly limited to special activities established for persons with mental illness; or history of dangerousness to self/others.
    c. Activities of Daily Living: Inability to consistently perform the range of practical daily living tasks required for basic adult functioning.
3. Individual can reasonably be expected to benefit from the Coordinated Specialty Care model.

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II. Continued Stay Guidelines:

Individual must meet all of the following continued stay guidelines to continue receiving this service.

1. Individual's condition continues to meet Admission Guidelines at this level of care.
2. Individual's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
3. There is reasonable likelihood of substantial benefits as demonstrated by objective behavioral measurements of improvement in functional areas.
4. Individual demonstrates progress in relation to specific symptoms or impairments, but goals of treatment/rehabilitation/recovery plan have not yet been achieved.

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