Big Bend Community Based Care
Policy & Procedure

Series:	300: Medical and Behavioral Health Care
Policy Name:	Warm Hand-Offs Between Network Service Providers for Care Coordination Populations
Policy Number:	314
Origination Date:	9/27/2017 **Revised:** Board Meeting of 12/13/2018
Regulation:	394.9082(3)(c), F.S
	Guidance Document 4: Care Coordination.

Referenced Document:

300-314 x 1, Circuit Transfer Form

Policy

The purpose of this document is to define the procedure for warm-hand offs between individuals meeting the care coordination population as outlined in *Guidance Document 4: Care Coordination* who are transferring across counties, circuits or network service providers and, therefore, changing network service providers. A warm handoff is a transition conducted in person between two (2) separate agencies with the knowledge of the individual being served. The warm handoff engages the individual as a team member and partner in his or her care. In warm handoffs, individuals being served hear what is discussed, reinforcing their understanding of the diagnosis and plan of care and allowing them to correct or clarify the information exchanged. Warm handoffs engage the individual through structured communication and improve individual safety by helping prevent communication breakdowns.

Procedure

A. Client Eligibility. This policy is specific to those individuals meeting the care coordination population as outlined in *Guidance Document 4: Care Coordination* which is as follows:

1. 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. For the purposes of this document, high utilization is defined as:

a. Adults with three (3) or more acute care admissions within one hundred eighty (180) days; or

b. Adults with acute care admissions that last sixteen (16) days or longer.

2. Adults with a SMI awaiting placement in a state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community.

3. Populations identified to potentially benefit from Care Coordination that may be served in addition to the two required groups include:

a. Persons with a SMI, SUD, or co-occurring disorders who have a history of multiple arrests, involuntary placements, or violations of parole leading to institutionalization or incarceration.

b. Caretakers and parents with a SMI, SUD, or co-occurring disorders involved with child welfare.

4. Individuals identified by the Department, managing entities, or network providers as potentially high risk due to concerns that warrant Care Coordination, as approved by the Department.

B. Process.

1. When an individual is transferring circuits the following should occur:

a. The sending network service provider and receiving network service provider are connected and sharing information.

b. Sending network service provider completes the Circuit Transfer Form.

c. The Circuit Transfer Form is submitted to the Care Coordination Specialist for the Circuit.

d. The Care Coordination Specialist from the sending Circuit reviews the Circuit Transfer Form and, if appropriate, will send the completed form to the receiving circuit's Care Coordination Specialist.

e. The receiving circuit's Care Coordination Specialist reviews the transfer form. A staffing will be scheduled to discuss the individual and transfer. If appropriate, the transfer is accepted.

f. The individual receiving services is able to participate in the transfer staffing and is fully aware of all communications. The individual receiving services is introduced to the receiving network service provider either in person or via telephone.

2. When an individual is transferring between counties or network service providers the following should occur:

a. The sending network service provider and receiving network service provider are connected and sharing information.

b. A staffing will be scheduled to discuss the individual and transfer with the individual, ME, and both network service providers.

c. The individual receiving services is able to participate in the transfer staffing and is fully aware of all communications. The individual receiving services is introduced to the receiving network service provider either in person or via telephone.

C. Responsibilities.

1. ME Care Coordination Specialist.

a. Review and Approve/Deny Circuit Transfer Forms.

b. Facilitate staffings that need to occur related to the transfer.

2. Network Service Providers.

a. Complete the Circuit Transfer Forms and submit to appropriate Care Coordination Specialist.

b. Attend any staffings related to the transfer request.

c. Ensure communication, introductions, and warm hand-offs occur between sending and receiving network service providers.