Quick Reference for Targeted Care Coordinators

"I'm a Targeted Care Coordinator. Now what?"

This document is meant to serve as a quick reference for Targeted Care Coordinators as you support youth members and the Youth Empowerment Services (YES) system of care.

As a Targeted Care Coordinator you will:

Step 1: Engagement

- Contact the member and family.
- Share information regarding Targeted Care Coordination (TCC), the Child and Family Team (CFT), Child and Adolescent Needs and Strengths (CANS) and other details.
- Coordinate with the member's existing providers and gather necessary documents including the CANS, comprehensive diagnostic assessment (CDA), any current treatment plans (i.e. CBRS, therapy, etc.), releases of information (ROIs), consent forms and additional forms, as applicable.
- Partner with the member and family to identify CFT members, which may include informal supports. At a minimum, CFT participants include the member, family, the Targeted Care Coordinator and member's clinician. If the member does not already have a master's level treating clinician, the Targeted Care Coordinator links the member to a clinician.
- Organize and schedule a CFT meeting. Date, time and location must be convenient, comfortable and chosen by the family.
- Create an agenda for the first CFT meeting and a strategy for sharing CANS items and family goals with CFT.

NOTE: Services may begin while the person-centered service plan (PCSP) is being developed. The Targeted Care Coordinator should encourage all providers working with the member to participate in the CFT, which all Optum Idaho network providers may bill.

Step 2: Planning and Assessment

- Coordinate and facilitate the initial CFT meeting to develop a PCSP and build consensus around the PCSP (this may take more than one CFT meeting).
- Support prioritization of goals identified in the PCSP and assign action items to appropriate CFT team members (PCSP goals should address CANS needs and strengths items and may only focus on a few at a time).
- Locate and provide linkage to available and agreed upon formal services and informal supports for the member and family, as needed.
- For members in the Youth Empowerment Services (YES) Program, upload the PCSP for Code of Federal Regulation (CFR) review via the Optum Supports and Services Manager (OSSM). If the PCSP is found to not meet CFR requirements, make necessary changes to the PCSP and then resubmit through OSSM.
- Share the PCSP with CFT members who have a signed release once the PCSP is found to meet CFR requirements.

Step 3: Monitoring and Adapting

- Continue checking in with the member and family at least every 30 days.
- Schedule additional CFT meetings, as necessary, based on the member's needs, the request of the family or if there is a change in condition.
- Implement the PCSP by focusing on member's strengths, monitoring goal progress and supporting the member's and family's access to formal services and informal supports. Additionally, support alignment of the PCSP and service treatment plan goals and objectives.
- Gather and/or complete needed documentation including progress notes, CANS, PCSP and additional forms, as applicable. The member and family should receive copies of the CANS and PCSP.
- Monitor member and family success in meeting goals and adapts PCSP goals, as needed.
- Follow up with providers to ensure that specific service treatment plans and the course of treatment are updated to meet the member's and family's needs as well as to align with the updated PCSP. If specific service goals are met, or member is not making progress, new modified goals are created to align with an updated PCSP.

NOTE: The CANS is updated at least every 90 days, and the PCSP is updated at least annually. Both documents can be updated more frequently, as necessary, based on the member's needs, the request of the family or if there is a change in condition.

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Step 4: Transition

- Assist and monitor the member and family in meeting goals and advocate for transitioning from formal services to informal supports as needs are met, strengths are developed and CANS scores improve.
- Develop a plan of transition during a CFT meeting. The plan of transition may include various levels of care and youth systems.
- Coordinate between systems as the youth transitions. This includes updating the CANS and PCSP, as needed.
- Complete needed documentation including a discharge summary.

NOTE: These steps are not concrete but are more fluid. A Targeted Care Coordinator may have to work with the member, family, and other members of the CFT to adjust and/or return to previous tasks in the various steps.

Targeted Care Coordination must be consistent with the YES Practice Model and YES Principles of Care.

YES Practice Model

The YES Practice Model describes the six key components to provide care in the YES system of care.

The six components are:

- **Engagement**: Actively involving children and youth and their families in the creation and implementation of their coordinated care plan
- **Assessment**: Gathering and evaluating information to create a coordinated care plan
- **Care planning and implementation**: Identifying and providing appropriate services and supports in a coordinated care plan
- **Teaming**: Collaborating with children and youth, their families, providers and community partners to create a coordinated care plan
- **Monitoring and adapting**: Evaluating and updating the services and support in the coordinated care plan
- **Transition**: Altering levels of care and support in the coordinated care plan

YES Principles of Care

The YES Principles of Care are applied to all areas of mental health treatment planning, implementation and evaluation, as outlined in the Jeff D. Settlement Agreement. The Principles of Care are 11 values that are applied in all areas of the YES system of care.

The 11 principles are:

- **Family-centered**: Emphasizes each family's strengths and resources
- **Family and youth voice and choice**: Prioritizes the preferences of children and youth and their families in all stages of care
- **Strengths-based**: Identifies and builds on strengths to improve functioning
- **Individualized care**: Customizes care specifically for each child, youth and family
- **Team-based**: Brings families together with professionals and others to create a coordinated care plan
- **Community-based service array**: Provides local services to help families reach the goals identified in their coordinated care plan
- **Collaboration**: Brings families, informal supports, providers and agencies together to meet identified goals
- **Unconditional**: Commits to achieving the goals of the coordinated care plan
- **Culturally competent**: Considers the family's unique needs and preferences
- **Early identification and intervention**: Assesses mental health and provides access to services and supports
- **Outcome-based**: Contains measurable goals to assess change

For additional information, refer to the following: ***Optum Idaho Provider Manual***, ***Optum Idaho Member Handbook***, ***Optum Idaho TCC web page***, ***Optum Idaho TCC Training***, ***Praed Foundation***, and ***Youth Empowerment Services (YES).***

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