CORE

Community Outreach Recovery Empowerment

Phases of Treatment

The focus of the phased model is on transitioning to a lower level of service intensity over time as a result of an increase in client functioning and natural supports. Level of service intensity can increase or decrease at any time based on client need. Any decision to increase or decrease services shall be made in agreement with the client and the rationale documented in the client's electronic health record. Services shall be provided in the home, community, or office depending on the needs of the client.

Engagement & Planning Phase

Description: In this phase, direct service staff begins engagement and rapport building while gathering Releases of Information, assessment information from the client, as well as collateral information from involved natural supports and involved systems in order to initiate referrals and linkages based on immediate and basic needs. Once the comprehensive biopsychosocial assessment is completed, the Client Plan is developed in collaboration with the client and identified natural supports.

Contact: At minimum, 1 time per week and a maximum of multiple times per day, 7 days per week, as needed to provide mental health services for the purpose of stabilization.

Services: Engagement, assessment, plan development, safety planning, and safety plan monitoring.

Monitoring and Adapting Phase

Description: During this phase, direct service staff monitor progress on the Client Plan and make individualized adaptations or revisions as needed to support progress toward meeting the goals of the plan. The CORE provider shall meet regularly with the client and natural supports to acknowledge milestones and celebrate successes, problem solve challenges, and hold client and members accountable for task completion associated with the Client Plan. Service intensity may increase for stabilization as necessary.

Contact: At minimum, 30 minutes per week to provide Mental Health services for the purpose of ongoing stabilization and working on progress in recovery.

Services: Individual and group social rehabilitation for skills building, enhancing relationships and community connections, case management, safety plan monitoring, and any other service that aids in wellness and recovery.

Transition Phase

Description: In the Transition Phase, the client takes a more active role and the Transition Plan developed shall ensure needed services and supports are in place to support a step-down to a lower level of care. Service intensity may increase for stabilization as necessary.

Contact: At minimum, 30 minutes per month to provide Mental Health services for the purpose of transition readiness. The transition phase should not exceed 3 months without documented, clinical justification.

Services: Case management that supports discharge planning from the Mental Health Plan to a lower level of care, such as the CORE Community Wellness Center, a Managed Care Plan, and/or other community resources based on need.