I - Care Coordination Duties of DMC-ODS Providers

DMC-ODS SUD programs shall designate primary case managers for each beneficiary who implement the following procedures to deliver and coordinate care for as follows:

1. Assess each beneficiary's needs and ensure that each beneficiary has an ongoing source of care appropriate to his or her needs. It is the primary case manager's responsibility to coordinate services accessed by the beneficiary, and to inform the beneficiary of their care coordination role and how to contact them.
    a. Collaborates with MCP staff to support transitions from any referral source with emphasis on those that are ASAM driven LOC changes, or stepping from an ASAM treatment level.
2. Coordinates services provided to the beneficiary as follows:
    a. Between settings of care, including appropriate discharge planning for short term and long-term hospital, acute care settings, skilled nursing facilities, institutional stays, different SUD programs, with county MHP programs, or other community-based settings. Primary case manager will initiate coordination of care transfer as follows:
        I. Inform beneficiary of referral, reasons, and address concerns
        II. Prepare referral information including the following electronic health record elements as applicable:
            i. beneficiary information
            ii. Transition of Care Tool (as applicable)
            iii. Assessment Documents (ANSA, CANS, ASAM)
            iv. Diagnosis Document
            v. Risk Assessment Documents
            vi. Recent Service Notes
        III. Assemble referral packet and send to identified recipient at new care setting.
        IV. Obtain written consent from beneficiary as a requirement for any disclosure
        V. Confirm services scheduled with recipient at new care setting
        VI. Facilitate a "warm handoff" whenever possible including:
            i. Communication though emails or phone calls, transportation or other practical supports, and is contingent upon beneficiary written consent to share the information.
        VII. Confirm beneficiary attended initial appointment at new care setting
        VIII. If applicable, close to services at previous care setting
            i. Completes any required discharge summary and planning materials
            ii. Sends copies as authorized to new care settings
            iii. Coordinate and communicate with other care providers or care managers serving the beneficiary for the purpose of facilitating a "smooth landing" and to prevent negative outcomes such as victimization, crisis, or homelessness
    b. With the services the beneficiary receives or is eligible to receive from any other managed care organization (e.g. Sonoma County Behavioral Health Mental Health Plan, Partnership Health Plan, Kaiser Health Plan) including but not limited to communication and coordination at minimum monthly or as medically necessary frequency for all of the following:
        I. Collaborative Treatment Planning

i. Including exchange of medical information when clinically indicated as authorized, and upon request in accordance with authorized information sharing.
ii. Making efforts to include beneficiaries, caregivers, and providers in development of planning activities. As evident by discussion and encouraged inclusion at outset of treatment planning, monthly, or as clinically indicated.
iii. Services coordinated outside of business ours for any DMC-ODS program will be through 24/7 access line (non crisis), or Crisis Stabilization Unit / Mobile Support Team (Crisis Only).
iv. Making efforts with beneficiaries to engage in persons centered culturally appropriate care.

II. Clinical Consultation: coordinating clinical consultation, including consultation on medications, and assisting with navigation support for beneficiaries and caregivers.
III. Coordinate the following with MCP contacts including prescribing and refilling of medications, labs, radiological and radioisotope service.
IV. Enhanced Care Management (ECM)
V. Complex Care Management (CCM)
VI. Community Supports (CS)
i. Work with MCP identified point of contact for initiating, providing, and maintaining ongoing coordination
ii. Work with MCP identified point of contact to discuss applicable community supports for beneficiary
iii. Make referrals as agreed upon with each Community Supports service provider.
VII. Transportation Services
VIII. Home Health Services
IX. Residential SUD Treatment
i. Notify MCP by phone, secure email, or fax within 24 hours of admission an discharges
ii. Make efforts to coordinate appropriate follow up services with MCP contact.
X. Treatment discharges
i. Send copies of any discharge summary and planning materials
ii. Coordinate and communicate with MCP providers or care managers serving the beneficiary for the purpose of facilitating a "smooth landing" and to prevent negative outcomes such as victimization, crisis, or homelessness
XI. Tracking referrals
i. Will track referrals using county spreadsheet or identified EHR tool.

c. With the services the beneficiary receives in FFS Medicaid.
d. With the services the beneficiary receives from community and social support providers.
e. Updates problem list within 72 hours of changes in beneficiary status for regular items and 24 hours for crisis items.
f. Ensures all care coordination efforts and services coordinated are non-duplicative

3. Conduct initial screening within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if initial attempts to contact the beneficiary are unsuccessful.
4. Share with the Sonoma County Behavioral Health, DHCS, or other managed care organizations (e.g. Partnership Health Plan, Kaiser Health Plan) serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.
5. Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.
6. Ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extant that they are applicable.
7. SUD Crisis Services
    a. All SUD crisis services shall be accompanied by a follow up within 24 hours to any care providers including MCP to share and support relapse prevention or relapse support depending on nature of crisis event.
8. All SUD treatment programs will provide or coordinate care for MAT services.
    a. When MAT needs are identified during screening or assessment processes coordination:
        I. Will coordinate a secure email or fax, and follow up phone call to refer any MAT services and NTP programs.
        II. Confirm scheduled appointments
        III. Assist with coordinating transportation including providing transportable if unable to arrange a transportation resource.
        IV. Will make timely referrals for MAT services within 24 hours of request

II. Monitoring Plan for Care Coordination

a. In order to monitor care coordination across the DMC-ODS, Sonoma County Behavioral Health will require all SUD service providers (with the exception of Opioid Treatment Programs, and certain out-of-county providers who serve small amounts of beneficiaries as needed) to enter beneficiary clinical service information into SmartCare, the county's centralized electronic health record system (EHR) for substance use and mental health services. The following elements within the EHR will be used to evaluate and monitor care coordination activities:
    a. Completion of Coordinated Care Consent
    b. Completion of DHS-BHD SUD ROI and any other agency ROI as applicable
    c. Progress Notes review with evidence of providing the beneficiary with information on how to contact the person responsible for coordinating their care.
    d. Review Primary Care Provider Detail section for completion
    e. Progress Notes review with evidence of care coordination between settings of care (e.g. detox, residential, outpatient, intensive outpatient) in accordance with Section I and Section II procedures.
b. Language on Care Coordination requirements is included in the DMC-ODS provider contracts, and the DMC-ODS practice guidelines.
c. Sonoma County Quality Assessment Performance Improvement (QAPI) staff review progress on performance standards through review of Treatment Perception Survey, timely transitions in level of care, evidence of follow-up post-discharge from DMC-ODS levels of care.