	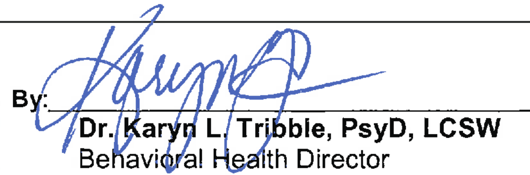 By: Dr. Karyn L. Tribble, PsyD, LCSW Behavioral Health Director
Adult and Older Adult System of Care Coordination Medi-Cal Specialty Mental Health Services	**Policy No: 100-2-5** **Date of Original Approval**: 12/16/19 **Date(s) of Revision(s):**

PURPOSE

This policy outlines the responsibilities of the Adult/Older Adult System of Care (AOASOC) of Alameda County Behavioral Health (ACBH) to coordinate Medi-Cal Specialty Mental Health Services (SMHS), Substance Use Disorder (SUD) and Primary Care Services (PCS) for ACBH clients, and to ensure continuity of care.

AUTHORITY

- 42 CFR § 438.208 Coordination and continuity of care
- 42 CFR § 438.62(b)(1)-(2) Continued services to beneficiaries
- 42 CFR § 438.3(l) Choice of Provider
- 42 CFR § 438.114(d)(3) Emergency and Post stabilization Services
- 42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records
- 45 C.F.R. § 160 and §164 Health Insurance Portability and Accountability Act
- CCR § 1810.370. Memorandum of Understanding (MOU) with Medi-Cal Managed Care Plans
- 9 CCR §1810.425. Hospital Selection Criteria
- 9 CCR §1810.415
- DHCS-MHP contract, Ex. A, att.10

SCOPE

All ACBH Adult and Older Adult System of Care county-operated programs in addition to entities, individuals, and programs providing behavioral health services under a contract or sub-contract with ACBH.

POLICY

This policy establishes that beneficiaries of ACBH Adult/Older Adult System of Care will be assessed and have access to a full continuum of mental health services with an emphasis on engaging the beneficiary in the right care, at the right time, with the right provider. Beneficiaries will be linked to all levels of outpatient mental health care through ACBH ACCESS.

PROCEDURE

I. Care Coordination Services will occur:

a. Between service providers both within ACBH and service providers outside of ACBH. This includes coordination between settings of care, appropriate discharge planning for short and long term hospital stays, substance use withdrawal management, residential treatment stays, hospital stays, institutional stays, and all levels of outpatient care (see Adult and Older Adult Specialty Mental Health Consumer Care Transition Policy).
b. With services a beneficiary receives from any Managed Care Plan (MCP).
c. With services a beneficiary receives from any Fee for Service (FFS) providers.
d. With services a beneficiary receives from community and social support providers.

II. Care Coordination Efforts will Ensure:

a. That the beneficiary's privacy is protected according to all state and federal regulations.

III. Care Coordination Actions Required of Each Responsible Party:

Responsible Party	Action Required
ACBH	Ensures each beneficiary has an ongoing source of behavioral health care appropriate to his/her/their needs (see Adult/Older Adult Level of Care and Eligibility Criteria Draft Policy). Ensures a person or entity is formally designated as primarily responsible for coordinating services accessed by the beneficiary. Ensures the beneficiary is provided information on how to contact their person or entity formally designated as primarily responsible for coordinating their services. Maintains, distributes and shares a Behavioral Health Service Provider Directory, which includes information about providers within the plan, contact information, languages served, alternatives and other cultural options and the populations served, to all providers and beneficiaries. Posts Provider Directory on the ACBH website. Maintains and provides oversight to contracted and designated providers to ensure they meet the care coordination and continuity of care requirements.

	Develops and implements a transition of care policy that is consistent with Federal and State requirements.
ACCESS	Reviews electronic health record information to determine if the beneficiary has a person or entity formally designated as primarily responsible for care coordination (provider). Conducts initial screening to identify the beneficiary's needs. Staff will make subsequent attempts to conduct initial screening if initial attempt is unsuccessful. Refers beneficiaries to a provider if they do not have one assigned. Refers to other provider if beneficiary does not meet medical necessity for specialty mental health services.
Assigned Providers	Provides the Provider Directory to all beneficiaries. Provider Directory is available in threshold languages on ACBH's website. Upon referral or receipt of referral, identifies the designated person or entity primarily responsible for care coordination and provide the designated contact information. If client/guardaian is agreeable, obtains consent from the clent/guardian for ongoing communications relating to their treatment and care coordination using an appropriate Release of Protected Health Information form. Coordinates services with physical health primary care and specialty physical health care providers. Coordinates substance use disorder treatment for beneficiaries identified as having a need for substance use treatment services. Determines any biomedical, behavioral health, and community and social support needs as a part of the assessment. Assessments must include any special provisions for the target population such as age, gender, developmental appropriateness, culture, and type of systems or program involvement. Documents care coordination needs and goals in the client's care plan (aka Treatment Plan) including goals that are achievable with objectives that are specific, measurable, and attainable with specific timelines for completion. Initiates the coordination of care needed, including linkage with other providers and institutions that serve the client population as appropriate.

	Provides coordination for transitions between all settings and levels of care, including collaborative discharge planning. Follows the Adult and Older Adult Specialty Mental Health Consumer Care Transition Policy for client transfers between SMHS providers. As appropriate, shares and communicates beneficiary's needs, relevant information for treatment, services, and referrals, and coordinates follow-up with other providers, in order to prevent duplication of services. Documents referrals, progress toward the care plan goals and objectives, and coordination of care in progress notes using the appropriate service codes. In conjunction with ACBH ACCESS, provider will make every attempt to link beneficiaries to another network provider, when a beneficiary requests a change or transfer of providers, and the change is deemed clinically appropriate. Provides supports based on client preferences, needs and strengths identified by the comprehensive assessment, including: mental health, SUD, primary care, housing, employment, education, socialization, spiritual, and other.
Utilization Management Program	MH MCP, Psychiatric Hospitals, and Institutions: • Contacts ACCESS or utilize the ACBH Electronic Health Record to identify if the beneficiary has an existing provider or requires a referral. • Coordinates between settings of care, including discharge planning consistent with the State and Federal requirements and Memorandum of Understanding with Alameda County Medi-Cal Managed Care Plans. SUD MCP QI, Medical Hospitals, and Ambulatory Care: • Hospital and Ambulatory Care social workers coordinate care by contacting the Substance Use Treatment and Referral Helpline if an individual needs substance use treatment and prevention resources. • Provides training to and consultation for network providers to improve efforts to coordinate care

IV. Weekly Care Coordination Meeting

a. In addition to the care coordination actions of the responsible parties identified above, ACBH and its partners conduct a weekly care coordination meeting described below:
   i. The purpose of the Weekly Care Coordination meeting is to:
      1. Plan for consumers across acute, sub-acute, crisis residential and outpatient care settings.
      2. Provide a venue for determining facility capacity to accommodate movement of clients between appropriate levels of care.
      3. Serve as a place for system level problem solving for "high utilizers" of our services.
      4. Convene from 8:30 am to 10:00 am every Wednesday at the ACBH Offices.
      5. Consist of the following sections; Facility Report Outs and Individual Care Coordination Parts I and II.
   ii. The process of the Weekly Care Coordination is as follows:
      1. Acknowledge successes
      2. Announcements
      3. Facility Report Outs: review of census, open beds, capacity updates provided by each facility.
      4. Individual Care Coordination – Part 1
         a. Brief summary and discussion of the needs of a specific list of clients that are high profile, complex clients requiring high level of care coordination.
         b. Decision on next steps for clients.
      5. Individual care coordination – Part II
         a. Brief summary and discussion of 3 clients selected from the ACBH High Utilizer list. These clients are intentionally selected by ACBH leadership and are followed for a full year.
         b. Discussion of care coordination and intervention options and identification of next steps for clients.
      6. Notes on the decisions made are maintained by Program Specialist.
      7. Critical Care Managers are the "eyes and ears" providing oversight, addressing barriers at the system and treatment levels, ensuring follow through on recommended coordination efforts/care transitions.
      8. ACBH Adult and Older Adult System of Care tracks dispositions of the case conference across time maintained by Program Specialist.

9. ACBH Adult and Older Adult System of Care tracks number of successful linkages/transitions as a result of this meeting to determine if care coordination is successful.
10. This group will use data from the Community Health Record in coordinating care and analyzing progress.

NON-COMPLIANCE

I. Failure to comply with this policy may result in formal actions including and up to formal sanctions as outlined in ACBH Policy# 1302-1-1 "Contract Compliance and Sanctions for BHCS Contracted Providers."

II. Procedures to be completed in the event of a policy non-compliance:
   a. When a provider is not abiding by the procedural requirements of the policy, the appropriate ACBH office will be notified of the situation.
   b. Reports of non-compliance can be made in writing or verbally to supervisors, and staff shall not face retribution for reporting non-compliance.
   c. Reports of non-compliance shall be communicated to supervisors and to the appropriate ACBH office within 72 hours to ensure timely response and corrective action.
   d. Any communication that contains protected health information or otherwise confidential information should be sent through secure methods such as email with secure encryption.

CONTACT

BHCS Office	Current as of	Email
Adult/Older Adult System of Care	12/2/2019	Katherine.Jones@acgov.org

DISTRIBUTION

This policy will be distributed to the following:
- ACBH Staff
- ACBH County and Contract Providers
- Public

ISSUANCE AND REVISION HISTORY

Original Authors: Kate Jones
Original Date of Approval: 12/16/19
Date of Revision:

Revise Author	Reason for Revise	Date of Approval by (Name)

DEFINITIONS

Term	Definition
ACBH	Alameda County Behavioral Health
AOASOC	Adult Older Adult System of Care
SMHS	Specialty Mental Health Services
SUD	Substance Use Disorder
PCS	Primary Care Services
MCP	Managed Care Plan
FFS	Fee for Service