7.1.12 COORDINATION OF CARE

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References: Sonoma County's Mental Health Plan Contract with Department of Health Care Services, Sonoma County's Drug Medi-Cal Organized Delivery System Contract with Department of Health Care Services, Exhibit A, Attachment I, BHIN 23-054, BHIN 23-056, BHIN 23-057, BHIN 24-001.

Policy Owner: Behavioral Health Division – Quality Assessment and Performance Improvement (QAPI), Quality Assurance (QA) Manager

Director Signature: **Signature on File**

I. Policy Statement

The purpose of this policy is to ensure timely coordination of care for members served in Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) directly operated programs and contracted agencies. These requirements apply to any treatment transition between service systems, between county operated programs, and between county operated programs and contracted agencies. Additionally, this policy sets standards for engaging members who miss appointments or withdraw from services.

II. Scope

This policy applies to all DHS-BHD network providers, including county employed staff, independent contract providers and contracted organizational providers that render specialty mental health services or substance use treatment to Medi-Cal beneficiaries served by the Sonoma County Mental Health Plan (MHP) or the Drug Medi-Cal Organized Delivery System (DMC-ODS).

III. Definitions

A. Adult Needs and Strengths Assessment (ANSA): A multi-purpose tool developed for adult's behavioral health services to support decision making, including level

of care and service planning, to facilitate quality improvement initiatives and to allow for the monitoring of outcomes of services.

B. American Society of Addiction Medicine (ASAM) Assessment: A comprehensive biopsychosocial assessment for placement, continued service, and transfer of patients with addiction and co-occurring conditions. Includes risk ratings for each dimension and determines the least intensive appropriate level of care.

C. Care Coordination: Consists of activities to provide coordination of Substance Use Disorder (SUD) care, mental health care, and medical care, and to support the member with linkages to services and supports designed to restore the member to their best possible functional level.

D. Child and Adolescent Needs and Strengths (CANS): A multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

E. On-going Treatment: Services to address a member's mental health or SUD needs that go beyond one-time assessment and/or crisis intervention.

F. Primary Contact: An individual practitioner assigned to a member as a provider and designated for care coordination.

G. Pediatric Symptom Checklist (PSC-35): A psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible.

H. Treatment Team: Practitioners assigned to members to provide services, coordinate services and monitor the health and well-being of the member.

I. Uniform Method of Determining Ability to Pay (UMDAP): A sliding scale of liabilities based on the member's or responsible party's ability to pay for the costs of mental health services provided.

IV. Policy

A. All members receiving ongoing treatment shall have an identified primary contact and be provided information on how to contact that individual.

B. Each member of the members treatment team is responsible for coordinating services within their respective area of expertise.

C. Services to be coordinated include but are not limited to the following:

1. Services from other settings of care such as inpatient or residential services.

2. Services the member receives from other mental health, substance use, or medical providers.

3. Services the member receives from community and social support providers.

D. Coordination of Care includes:

1. Contacting other involved current service providers during the initial stages of treatment and periodically thereafter as clinically appropriate.

2. Contacting previous providers for relevant clinical information as clinically appropriate.

3. Sharing results of any assessment or evaluation of member needs with other currently involved service providers to prevent duplication of those activities.

4. Sharing progress notes and other documentation in the clinical record pertinent to the member's treatment with other currently involved service providers.

   a. Coordination of services must be in accordance with all applicable laws and Departmental policies to ensure the privacy of the member.

   b. Transitions between treatment teams shall be facilitated in accordance with established timeliness standards to minimize disruptions to continuity of care.

   c. Treatment teams shall not terminate services with disengaged members without taking steps to engage them prior to ending services.

5. For members who do not attend scheduled appointments, treatment teams shall document attempts to engage the individual, identify any barriers to the members continued participation in services and inform the member of the ramifications of withdrawing from services.

6. For members who choose to withdraw from services, treatment teams shall inform them of their options to re-engage services in the future, and coordinate referrals to other providers through the step-down procedures outlined below.

V. Procedures

A. Transitions between Treatment Teams or Levels of Care

1. Treatment transitions may occur due to a change in level of care based upon re-assessment, or due to treatment completion.

2. At treatment transition, the primary contact from the existing treatment team will coordinate with the “new” treatment team to help facilitate a seamless transfer of care without disruption in service.

3. The primary contact will initiate the transfer referral by:

    a. Informing the member of the referral, discussing the reasons for the referral and addressing any concerns the member raises concerning the referral;

    b. Preparing the referral information by ensuring the following elements of the member record are current in the Electronic Health Record:

        i. Member Information;

        ii. Consents (Treatment, Telehealth, Email, Text, etc.);

        iii. Assessment Documents (ANSA, CANS, PSC-35, ASAM);

        iv. Diagnosis Document;

        v. UMDAP;

        vi. Risk Assessment Documents;

        vii. Recent Service Notes.

4. Notifying the receiving treatment team of the referral.

5. For SUD treatment team referrals, the primary contact will also obtain written consent from the member to share the referral information with the receiving provider.

    a. For SUD MAT services the primary contact will make the referral **within 24 hours** of service request.

6. The receiving treatment team manager will review the referral and assign a primary contact on the new team within **2 business days** of accepting the referral.

7. The referring and receiving primary contacts will complete a clinical consultation call within **10 business days** to review current service needs and facilitate the transfer of care.

8. Upon completion of the clinical consultation, the receiving primary contact will initiate contact with the member within **10 business days** to engage services.

    a. The receiving primary contact shall document attempts to engage within the Electronic Health Record.

9. Upon successful engagement of the member the receiving primary contact will enroll the member onto the treatment team and inform the referring primary contact who will then close services with the referring treatment team.

10. Until the transfer is complete the referring treatment team is responsible for providing on-going care.

B. Transfers of Care to the Managed Care Plan Service System (Treatment Step-Downs/Add-On Services)

1. Treatment step-downs may occur due to a change in level of care based upon re-assessment, treatment completion or member request.

2. Coordinating additional services may occur when the MCP is or will be providing physical healthcare, mental healthcare, MAT services, Enhanced Care Management (ECM), Complex Case Management (CCM), and/or Community Supports (CS) and these services are non-duplicative with services provided by the MHP or DMC-ODS.

   a. DHS-BHD and the MCP will coordinate the care provided by each other, addressing barriers to care coordination, and ensuring the ongoing monitoring and improving of such care coordination.

   b. This includes coordinating provision of medically necessary services, treatment planning, clinical consultation, Enhanced Care Management (ECM), Community Supports and eating disorder services. DHS-BHD and the MCP will agree in writing how the parties will coordinate care and monitor whether those processes are working and improve the processes as necessary.

   c. DHS-BHD and the MCP will provide clinical consultations to each other regarding a member's mental illness including consultation on diagnosis, treatment and medications.

   d. Clinical consultation by DHS-BHD may include training to MCP clinicians and/or staff on various topics as requested and mutually agreed upon, including but not limited to the following:

      i. Recommended health care-based treatment for diagnosed conditions;

      ii. Complex diagnostic assessment of mental disorders (e.g., multiple co-occurring diagnoses; atypical symptoms patterns);

      iii. Treatment of stabilized but serious and debilitating mental disorders;

      iv. Complex psychotropic medications practices (medication interactions, polypharmacy, use of new psychotropic medications);

v. Treatment of complicated sub-syndrome psychiatric symptoms;

vi. Treatment of psychiatric symptoms precipitated by medications used to treat medical conditions;

vii. Treatment of mental disorders that are the responsibility of the MCP.

e. Clinical consultation and training may be arranged by the DHS-BHD Medical Director or Clinician Designee in collaboration and consultation with the MCP's Clinical Behavioral Health Director or Clinician Designee and may include conferencing in-person or by telephone as arranged between the parties.

f. Coordinating additional services includes clinical consultation on medications and clinical navigation support for members and caregivers.

g. MAT services referrals will be made **within 24 hours** of request for services.

3. At treatment step-down (or add-on request), the primary contact from the existing treatment team will coordinate with the Managed Care Plan to help facilitate a seamless transfer of care without disruption in service.

4. The primary contact will initiate the step-down referral by:

a. Informing the member of the referral, discussing the reasons for the referral, and addressing any concerns the member raises concerning the referral.

b. Preparing the referral information by ensuring the following elements of the member record are current in the Electronic Health Record:

i. Member Information;

ii. Transition of Care Tool;

iii. Assessment Documents (ANSA, CANS, ASAM);

iv. Diagnosis Document;

v. Risk Assessment Documents;

vi. Recent Service Notes.

c. Assembling the referral packet and transmitting it to the Managed Care Plan or receiving community provider.

5. For SUD community referrals, the primary contact will also obtain written consent from the member to share the referral information with the receiving provider.

6. The primary contact will verify with the receiving provider that services have been scheduled with the member.

7. The primary contact will subsequently verify that the member attended the first service with the new provider at which point services will be closed with the County.

8. Until the member has attended the first service appointment with the new provider the referring treatment team is responsible for providing on-going care which includes on-going psychiatry care.

C. Member Disengagement from Services

1. When a member shows a pattern or history of missing appointments with their psychiatrists, case-managers, or other service providers, the primary contact will attempt to meet with the member to identify any barriers that have an impact on their participation in these activities.

    a. The primary contact will develop strategies to address any identified barriers, including phone call reminders, distribution of bus passes, direct provision of transportation services, home visits, etc.

    b. Once a member has missed at least two consecutive psychiatry appointments, or three consecutive service appointments with their primary contact, and whose motivation to participate in services might be in doubt, the primary contact will initiate the following disengagement steps:

        i. Two phone calls to the member or their family;

        ii. One missed-appointment letter to the member informing them of the possibility of having services withdrawn if they continue to miss appointments. This letter shall also include:

            (1) Dates of phone calls and home visit attempts;

            (2) Other types of communications attempted (mail, email, etc.);

            (3) The possible clinical ramifications of withdrawal from continued treatment;

            (4) The fact that inability to pay for services is not a barrier for continuing treatment;

(5) The notice to the member that they have **30 days** to respond to the letter or other written communication.

c. After **30 days**, a subsequent formal "termination of services" letter signed by the treatment team Program Manager, which shall inform the member of:

i. The clinical ramifications of withdrawal from continued treatment;

ii. The fact that inability to pay for services is not a barrier for continuing treatment.

d. If the member is unhoused, or does not have a known fixed or mailing address, the following steps shall be taken to locate and communicate with the member that we are closing services; in lieu of sending letters:

i. Checking for Current Hospitalization;

ii. Checking for Current Incarceration;

iii. Checking with the IMDT Team for Recent Contact;

iv. Leaving a message with the Peer Centers;

v. Leaving a message with the Homeless Service Centers.

e. All attempts to contact and inform the member of the above shall be documented in the member's medical record.

f. Letters (or other written forms of communication) to the member are scanned into the Electronic Health Record and filed in the Correspondence folder.

g. The primary contact will document reasons for failure to contact the member due to unhoused status, no known fixed or mailing address, or valid phone numbers.

h. Treatment teams may develop additional standards regarding responding to missed appointments; consideration should be given to each member's unique circumstances, abilities, and motivation for treatment.

i. The service closing shall be completed once the termination letter (or other alternate communication) is sent.

D. Member Withdrawal from Services

1. Upon member request to withdraw from services, the primary contact shall attempt to engage the step-down procedure above in collaboration with the member.

2. If the member refuses to engage the step-down process, the primary contact shall send a letter formally terminating the member's services, signed by the treatment team Program Manager; the letter shall contain:

    a. The date of the member's decision to withdrew from service;

    b. The possible clinical ramifications of withdrawal from continued treatment;

    c. The fact that inability to pay for services is not a barrier for continuing treatment;

    d. An invitation to resume services and a contact number for doing so;

    e. An offer of assistance in finding other providers in the community, or sending records to a new provider, and/or coordinating with any newly identified providers.

    f. When a member is unhoused, or does not have a known fixed or mailing address, other forms of communication may be used.

    g. All attempts to contact and inform the member of the above shall be documented in the member's medical record.

    h. Letters (or other written forms of communication) to the member are scanned into the Electronic Health Record and filed in the Correspondence folder.

    i. The primary contact will document reasons for failure to contact the member due to unhoused status, no known fixed or mailing address, or valid phone numbers.

    j. The service closing shall be completed once the termination letter (or other alternate communication) is sent.

VI. Forms

A. BHD 615 Letter for Missed Appointment for Adults (English & Spanish)
B. BHD 616 Letter from MH to Adult to End MH Service (English & Spanish)
C. BHD 617 Letter for Adult Member's Decision to End MH Services (English & Spanish)
D. BHD 831 Letter for Missed Appointment for Youth (English & Spanish)
E. BHD 832 Letter from MH to Youth to End MH Service (English & Spanish)
F. BHD 833 Letter for Parent's Decision to End MH Services (English & Spanish)

VII. Attachments

#1: Care Coordination Procedures