Policy Name:	ENSURING CARE COORDINATION FOR INDIVIDUALS	**Policy Number:** CL201

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POLICY

SBH-ASO ensures the provision of Care Coordination to individuals who come in contact with the crisis system or other SBH-ASO funded services within the Salish regional service area. SBH-ASO Care Coordination activities promote the coordination, continuity and quality of care.

PROCEDURE

1. SBH-ASO Care Coordination activities are focused on ensuring:

    a) Crisis Services are delivered in a coordinated manner including access to crisis safety plans to assist with coordination of information for individuals in crisis.
        i. SBH-ASO ensures its Crisis Providers share crisis safety plans with the Salish Regional Crisis Line, when releases of information are obtained from individuals.

        ii. SBH-ASO implements strategies to reduce unnecessary crisis system utilization through the review of crisis logs to identify Individuals accessing excessive crisis services with the intent of engaging the Individuals in the development and implementation of crisis prevention plans to enhance the Individual's stability.
            a. Define excessive crisis services
            b. Crisis Providers will assist SBH-ASO in identifying Individuals who would benefit from additional coordination or for whom non-crisis services may be appropriate.

iii. SBH-ASO Care Managers collaborate with MCOs to develop and implement strategies to coordinate care with community behavioral health providers for Medicaid enrollees with a history of frequent crisis system utilization.
    a. SBH-ASO provides each MCO with daily logs of their respective members contact with Regional Crisis System.
    b. Upon MCO request, SBH-ASO Care Managers participate in care coordination activities for MCO enrollees.
    c. SBH-ASO coordinates the sharing of crisis related documentation between Agencies and MCOs upon request.

b) Care transitions are supported by the sharing of information among jails, prisons, inpatient settings, residential treatment centers, detoxification and sobering centers, homeless shelters and service providers for Individuals with complex behavioral health and medical needs.

    i. SBH-ASO participates in meetings across the region to maintain connection to the community, provide information and support, and assist in identifying Individuals requiring additional resources.

c) Continuity of Care for Individuals in an active course of treatment for an acute or chronic behavioral health condition, including preserving Individual-Provider relationships through transitions.
    i. SBH-ASO Care Managers provide care coordination, in partnership with existing providers, for individuals accessing SBH-ASO funded services.

d) Care strategies are evaluated and implemented to reduce unnecessary utilization of crisis services by promoting relapse/crisis prevention planning and early intervention and outreach that addresses the development and incorporation of recovery-based interventions and mental health advance directives in treatment planning consistent with requirements of contracts.
    i. Examples of these efforts include but are not limited to:
        a. SBH-ASO Leadership facilitate Crisis Providers meetings to review utilization trends, highlight community resources, and facilitate collaborative conversations.
        b. SBH-ASO Care Managers outreach Providers to coordinate and schedule care coordination meetings.
        c. SBH-ASO Care Managers directly engage Individuals in care coordination in instances where Individual/Provider relationships have not been effectively established.

2. SBH-ASO subcontractors screen individuals for Medicaid eligibility and assist in Medicaid enrollment on site or by referral, as appropriate.

3. SBH-ASO collaborates with external entities to address barriers to high-risk non-Medicaid individuals accessing non-crisis behavioral health services. At a minimum,

Individuals identified in SBH-ASO Priority Populations and Waiting Lists Policy are provided with clinically relevant and coordinated care.

a. Individuals also include those referred by community entities such as law enforcement, emergency department or first responders.
b. These individuals are identified at multiple points during clinical contact, including but not limited to intake/assessment, authorization/notification requests, assessment for discharge readiness and/or through direct referral to SBH-ASO.

4. SBH-ASO and its subcontractors work to address barriers to appropriate and coordinated care, if such issues surface. Such barriers may be identified through SBH-ASO Customer Service, SBH-ASO and/or subcontractor care coordination activities, SBH-ASO community engagement, SBH-ASO Quality Assurance and Compliance Committee (QACC), and Regional Ombuds activities.

5. SBH-ASO's subcontractors engage individuals in the development and implementation of crisis prevention plans to reduce unnecessary crisis system utilization and to maintain the individual's stability.
    a. Crisis plans are available to each crisis team through their respective agency's respective EHR. All crisis team members have access to this information within their respective catchment area.
    b. Crisis plans submitted to the Salish Regional Crisis Line (SCRL) are added to the individual's record and are available to crisis line staff upon contact with the individual. This information may be shared with another crisis team as indicated.
    c. Additionally, Crisis Alerts may be submitted to the SCRL through the Crisis Alert Platform, fax, or by calling directly. These alerts may be generated by community members, family members, and professionals. Crisis Alerts are accessible to all SCRL staff.

6. SBH-ASO has the capacity to receive Care Coordination referrals from internal and external entities. Upon receipt of a Care Coordination referral:

    a. SBH-ASO Care Managers identify existing providers and supports.
    b. SBH-ASO Care Managers contact the Individual and Provider Agency, in coordination with any appropriate internal and external entities, to maintain continuity of care.
    c. Service-related decisions will be based on individual clinical presentation, risk, and within available resources, in coordination with current established providers.

7. SBH-ASO Care Managers review notification and authorization requests submitted through the Salish Notification and Authorization Program (SNAP). Upon notification of specific services being initiated, such as inpatient treatment, SBH-ASO Care Managers:
    a. Contact the provider to initiate care planning
    b. Seek information related to existing treatment providers

c. Engage the treatment team in care planning

8. SBH-ASO Care Managers coordinate the transfer of Individual information, including initial assessments, care plans, and mental health advanced directives with other BH-ASOs and MCOs as needed when an Individual moves between regions or gains or loses Medicaid eligibility, to reduce duplication of services and unnecessary delays in service provision, within all applicable privacy regulations.

    a. SBH-ASO subcontractors assist with coordination of service to an individual including collection of releases of information for formal information and/or document sharing.
        i. Adherence to this requirement will be reviewed as per the SBH-ASO Policy Provider Network Selection, Retention, Management, and Monitoring.
    b. SBH-ASO will assist with coordinating care when barriers regarding facilitating of information arise. Subcontractors or outside entities may contact SBH-ASO Care Managers to assist.
        i. SBH-ASO Care Managers will contact all necessary entities/parties to ensure transfer of information occurs in a timely manner, within appropriate privacy regulations, to ensure continuity of care across levels of care or between care settings.

    c. The transfer of this information may be conducted via secure written or oral communication

9. The SBH-ASO collaborates with Child and Transition Age Youth (TAY) service systems as follows:
    a. Convening the regional Children's Long Term Inpatient Program (CLIP) Committee
    b. If requested by a Wraparound Intensive Services (WISe) provider, CLIP facility or other program in the behavioral health system served by the SBH-ASO
    c. Referring potentially CLIP-eligible children to the CLIP Administration
    d. Facilitation of Family Youth System Partnership Roundtable (FYSPRT)
    e. Participation in Regional WISe Managers Meetings.

10. SBH-ASO utilizes GFS/FBG funds to care for Individuals in alternative settings such as, but not limited to, homeless shelters, permanent supported housing, nursing homes, or group homes.
    a. SBH-ASO participates in and/or convenes community meetings to address serving individuals needing services in alternative settings
    b. SBH-ASO participates in meetings across the region to maintain connection to the community, provide information and support, and assist in identifying Individuals requiring additional resources

c. SBH-ASO Care Managers provide case-by case coordination with existing providers to individuals needing care in alternative settings to ensure continuity of care

11. SBH-ASO is responsible for the coordination of assigned Individuals from admission to inpatient care, transfer to a State Hospital, and through discharge. Additional information can be found the SBH-ASO State Hospital Coordination Policy.

12. SBH-ASO shall participate in disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by HCA, county, or local public health jurisdiction. The SBH-ASO shall attend state-sponsored training and participate in emergency/disaster preparedness planning when requested by HCA, the county or local public health jurisdiction in the region and provide Disaster Outreach and post-Disaster Outreach in the event of a disaster/emergency.

MONITORING

SBH-ASO Leadership Team and QACC monitor, develop, and implement strategies to assess and improve the care coordination system over time.