Smoky Mountain Center LME-MCO Care Coordination

Care Coordination activities include the identification, coordination and monitoring of, linkage to behavioral health treatment services and/or habilitative services and supports depending on the consumer's individual needs and funding source. SMC provides Care Management for two populations: **special healthcare needs** and **high risk high cost** consumers.

Special Health Care Needs

The Division of Medical Assistance (DMA) defines individuals with special health care needs as the following:

Intellectual and/or Developmental Disabilities:

Individuals who are functionally eligible for, but not enrolled in, the Innovations waiver, who are not living in an ICF-MR facility or individuals with an intellectual or developmental disability diagnosis who are currently, or have been within the past 30 days, in a facility operated by the Department of Correction (DOC) or the Department of Juvenile Justice and Delinquency Prevention (DJJDP) for whom SMC has received notification of discharge.

Child Mental Health:

Children who have a diagnosis within the diagnostic ranges defined below:

Diagnostic Range	Diagnosis or Disorder Classification
293-297.99	Disorders due to General Medical Condition
298.8-298.9	Psychotic Disorder, Psychotic Disorder NOS
300-300.99	Mood Disorders, Anxiety Disorders, Dissociative Disorders, Factitious Disorders, Somataform Disorders, Unspecified Mental Disorder
302-302.6, 302.8-302.9	Sexual & Gender Identity Disorders
307-307.99	Eating Disorders, Tic Disorders, Sleeping Disorders
308.3	Acute Stress Disorder
309.81	PTSD
311-312.99	Depressive Disorder NOS, Impulse-Control Disorders Not Elsewhere Classified
313.81	Oppositional Defiant Disorder
313.89	Reactive Attachment Disorder
995.5-995.59	Neglect, Physical or Sexual Abuse of Child (victim)
V61.21	Physical or Sexual Abuse of Child (perpetrator)

And a current CALOCUS Level of VI, or who are currently, or have been within the past 30 days, in a facility (including a Youth Development Center and Youth Detention Center) operated by the DJJDP or DOC for whom SMC has received notification of discharge.

Adult Mental Health:
Adults who have a diagnosis within the diagnostic ranges of:

Diagnostic Range	Diagnosis or Disorder Classification
295-295.99	Schizophrenic & Schizoaffective Disorders
296-296.99	Major Depressive, Bipolar & Mood Disorders
298.9	Brief Psychotic Disorder
309.81	PTSD

And a current LOCUS Level of VI.

Substance Dependent:
Individuals with a substance dependence diagnosis and current ASAM PPC Level of III.7 or II.2-D or higher.

Opioid Dependent:
Individuals with an opioid dependence diagnosis and who have reported to have used drugs by injection within the past 30 days.

Co-occurring Diagnoses:
Individuals with co-occurring diagnosis may be a combination of mental health, substance abuse and/or intellectual or developmental disability. The following criteria are required to be considered special health care needs:

a. Individuals with both a mental illness diagnosis and a substance abuse diagnosis and a current LOCUS/CALOCUS of V or higher, or current ASAM PPC Level of III.5 or higher;
b. Individuals with both a mental illness diagnosis and an intellectual or developmental disability diagnosis and current LOCUS/CALOCUS of IV or higher; or
c. Individuals with both an intellectual or developmental disability diagnosis and a substance abuse diagnosis and current ASAM PPC Level of III.3 or higher.

High Risk & High Cost Consumers
High Risk High Cost Individuals are defined by NC General Statute 122C and NC Division of MH/DD/SA Scope of Service Contract and DMH/DD/SAS Implementation Updates.

Per NC General Statute 122C, a High Risk Consumer has been assessed as needing emergent crisis services 3 or more times in the previous 12 months. Emergency services=Mobile Crisis Intervention or ED primary behavioral health intervention. A High Cost Consumer is an individual whose treatment plan is expected to incur costs in the top 20% for all consumers in a disability group.

Consumers without a Behavioral Health Home:

DMH/DD/SAS also identifies high risk consumers for whom Care Coordination (CC) activities should occur. These populations include consumers without a behavioral health home who are being discharged from state facilities, hospitals, or emergency services that are not engaged with a behavioral health provider. A Behavioral Health Home may be a licensed independent practitioner, enhanced service provider, direct care provider or CABHA. Care Coordination is not designed to usurp the role of the Behavioral Healt Home. CC activities may include participating in on-site in discharge planning for consumers being discharged from state hospitals and alcohol and drug abuse treatment centers and other important community partner providers and agencies continuing to work with the consumer and CCNC / medical home until the consumer is connected to a clinical behavioral health home. SMC CC staff is to be available for participation at the annual Plan of Care meetings for consumers from their catchment area who reside in a Developmental Center and are appropriate for community placement. Individuals who are being discharged from DHHS state facilities and community inpatient hospital services, detoxification facilities, and facility based crisis centers are to be seen by a community provider within 7 calendar days of discharge and ensure that consumers who do not attend scheduled appointments are contacted to reschedule services within 5 calendar days.

Outpatient Commitments:

SMC shall provide care coordination services for its consumers who are under an Outpatient Commitment (OPC) order. This includes maintaining up-to-date records on each consumer in the catchment area with an OPC order including the name or names of their treatment provider(s) and documentation of SMC CC contacts to verify the consumer's compliance with the outpatient commitment order. If the Care Coordinator determines that the consumer has failed to comply or clearly refuses to comply with all or part of the prescribed treatment, the CC shall report such failure as required by law and take action as necessary to assure the safety of the consumer and the public.

Specialty Populations:

Specialty populations include:

a. Consumers who are deaf and hard of hearing and/or visually impaired
b. Consumers with TBI
c. Veterans and members of the military and their families
d. Consumers exposed to trauma
e. Offender populations
f. Consumers with Fetal Alcohol Spectrum Disorders and their families
g. Underserved racial, cultural and linguistic minorities

CC will be provided to these individuals as identified to ensure at a minimum that consumers within these populations have access to linguistically appropriate and culturally competent provision of services. In cases where the consumers have service needs related to their specialty population (ex. TBI, FASD, need for treatment for trauma or offender released with MH/SA disorder and/or intellectual or developmental disability), the Care Coordinator will determine the level of CC supports needed and either provide the necessary supports or link the consumer to the appropriate services.

CCNC:
Consumers who are enrolled with Community Care of NC Networks may require CC services. Particular emphasis should be placed on consumers who have high behavioral health/high physical health needs and high behavioral health/low physical health needs (Quadrants II & IV). SMC Care managers will coordinate with CCNC Case Managers to ensure consumers are linked to both behavioral health supports as well as a medical health home.
Additional DMH/DD/SAS populations include:

a. Adjudicated youth involved with DJJDP or TASC;
b. Youth being admitted to or discharged from mental health or substance abuse residential level III and IV group homes;
c. Individuals who currently reside in an ICF-MR home who could be successfully transitioned to a community setting.

Identification of Individuals Needing Care Coordination
Care Coordination referrals occur in a number of different ways. Referral sources include but are not limited to:

a. Consumer self-identification;
b. Daily reports;
c. Utilization Review or Quality Management Cases of Concern;
d. Customer Service referrals;
e. CCNC Referrals;
f. External agency referrals.

Care Coordination Role:
For individuals who fall into Care Coordination Populations, Care Coordinators will be available at times convenient to the consumer and their family for telephonic consultation and face to face meetings. Care Coordinatorss will provide the following:

a. Determine which Behavioral Health Services are Medically Necessary for each individual;
b. Coordinate and monitor Behavioral Health hospital and institutional admissions and discharges, including discharge planning;
c. Ensure the coordination of care with each individuals' primary care Provider/CCNC physician;
d. Provide follow-up activities to high risk individuals who do not appear for scheduled appointments; to individuals for whom a crisis service has been provided as the first service, in order to facilitate engagement with ongoing care; and to individuals discharged from 24/7 facilities.
e. For individuals enrolled in Medicaid, CM will also provide 24/7 telephonic assessment and support in accordance with SMC policy.

Cases will be triaged in the following ways:
Triage Questions

1. Is the individual in an appropriate level of care?
2. Is the individual in an appropriate level of care but intervention is not being implemented effectively?

3. Is the individual engaged in appropriate level of care but readmitting with 30 days of inpatient discharge?
4. Is the individual engaged in appropriate level of care but readmitting 3 times within past 12 months?
5. Is the individual a priority treatment population (Mental Health or Substance Abuse Block Grant requirements)?
6. Does the individual need additional formal and informal services/supports?
7. Does this case require clinical staffing?
8. Are there any HIPPA or 42CFR Restrictions impeding care?

If no to all questions, the Care Management Review is complete.

If yes, the following activities may occur:

a. Additional record review;
b. Consumer/Provider Consultation;
c. Consultation with key providers;
d. Team Meeting(s);
e. ISP or PCP development;
f. Coordination of Assessments;
g. Linkage to Behavioral Health or Medical Health Home;
h. Linkage to informal supports (unpaid supports, community resources, etc.);
i. Short or moderate term tracking to ensure engagement to services and stabilization;
j. Long-term Tracking/Monitoring Required (Exception): The consumer has very complex behavioral health and medical issues that result in periodic inpatient placements despite having appropriate services/supports in place.

A consumer is discharged from the MH/SA Care Management Team when:
The services have been determined to be effective and the consumer is stable or stabilizing as evidenced by:

a. No behavioral health inpatient placements within 90 days;
b. Is engaged with a behavioral health provider (Individual can identify provider(s), has participated in their plan development and has attended 4 appointments within 45 days);
c. Has not required a Crisis Service from Mobile Crisis within last 90 days;
d. The Outpatient Commitment requirements have been met;
e. Despite multiple attempts to engage the consumer continues to refuse CM services.

A consumer with an intellectual or developmental disability participating in Innovations Waiver services will not be discharged from the IDD Care Coordination Team. Other consumers with IDD who do not meet ICF-MR level of care will be discharged from the IDD Care Coordination Team when:

a. No behavioral health inpatient placements within 90 days;
b. Is engaged with a behavioral health, residential or habilitative service provider or has service needs being met (Consumer or legally responsible person can identify provider(s), has participated in their plan development and has attended a minimum 4 appointments within 45 days);
c. Has not required a Crisis Service from NC START or Mobile Crisis within last 90 days;
d. The Outpatient Commitment requirements have been met.

e. Despite multiple attempts to engage the consumer or legally responsible person continues to refuse CC services.