Introduction

DMC-ODS Care Coordination

Care Coordination services within the DMC-ODS network were formerly referred to as case management. Care coordination is an important component of substance use disorder treatment and consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the person in care with linkage to services and supports designed to restore them to their best possible functional level. *Care Coordination activities are to occur throughout treatment and includes following up with the person in care and other care providers regarding referrals made to ensure linkage has occurred.*

Providers are to work alongside the client throughout their health care journey to develop treatment recommendations that support a person-centered approach that is mindful of the need for access to a variety of resources. It is recommended that providers discuss care coordination with the person in care at the beginning, and throughout treatment. Included in this discussion is the importance of collaboration between service providers. Clients are to be educated about information sharing amongst providers, and that the ability to share health information will facilitate improvements to the quality of care they receive by allowing for ease of care coordination among providers. When a person in care does not sequester their SUD treatment this allows for ease of information sharing and increased ability to obtain important information in a timely manner. Providers must have the person in care sign a request authorization to share information (ROI) when coordinating care with any other providers if their chart is sequestered. If the chart is not sequestered, an ROI is only required when coordinating care with another provider that is outside of Avatar, our electronic health record.

For NTP treatment, there are no changes. Care coordination services will continue to be included in the treatment plan.

Definition: Care Coordination

Care Coordination includes the following components:

- Coordinating with mental health and medical care providers to monitor and support comorbid health conditions
- Discharge planning, including coordination with SUD treatment providers to support transitions between levels of care and to recovery services, referrals to mental health providers and referrals to primary or specialty medical providers
- Coordinating with ancillary services including individualized connection, referral and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, child-care, child development, family/marriage education, cultural sources and mutual aid support groups

- Care Coordination activities include following up with the person in care and other care providers regarding referrals made to ensure linkage has occurred

Care Coordination Guidance

Care coordination services may be ***provided*** by both LPHA & SUD certified / registered Counselors operating within their scope of practice throughout treatment whenever care coordination services are clinically indicated. The provision of care coordination is to be overseen by an LPHA. The LPHA will document that care coordination services are clinically indicated and will oversee and guide care coordination services. It is expected that all persons in care will have care coordination needs. Therefore, for each person in care, the LPHA is to document the need / clinical indication for care coordination in a progress note at the time of the medical necessity determination and at Continued Service Justification (CSJ).

Clients Opened to Services *after July 1, 2022*:

- The LPHA is to document clinical indication for care coordination services at the start of treatment in the medical necessity progress note and when documenting continued service justification (CSJ) **(Service Code= Assessment)**

Clients Opened to Services *prior to July 1, 2022*:
Progress note indicating clinical indication for care coordination is to be completed as soon as possible, definitely before discharge.

- Document in client medical record that care coordination is clinically indicated by LPHA
  - SUD counselor consults with LPHA and completes progress note which states that care coordination is indicated as per LPHA guidance
  - LPHA completes a progress note stating that care coordination is indicated
  - At next CSJ, LPHA documents on-going clinical indication for care coordination
    Service Code for all above = Assessment

Care Coordination Progress Note Content

DIRP format is not required. However, we are still working under the current restraints of the Avatar progress note form until it is updated. Until that update, the current Avatar progress note form will be used.

What to include in ***current*** Avatar progress note fields:

Presentation: Not required, however Avatar will force you to write something.
You may write a brief client presentation here or write, “see intervention section below.”

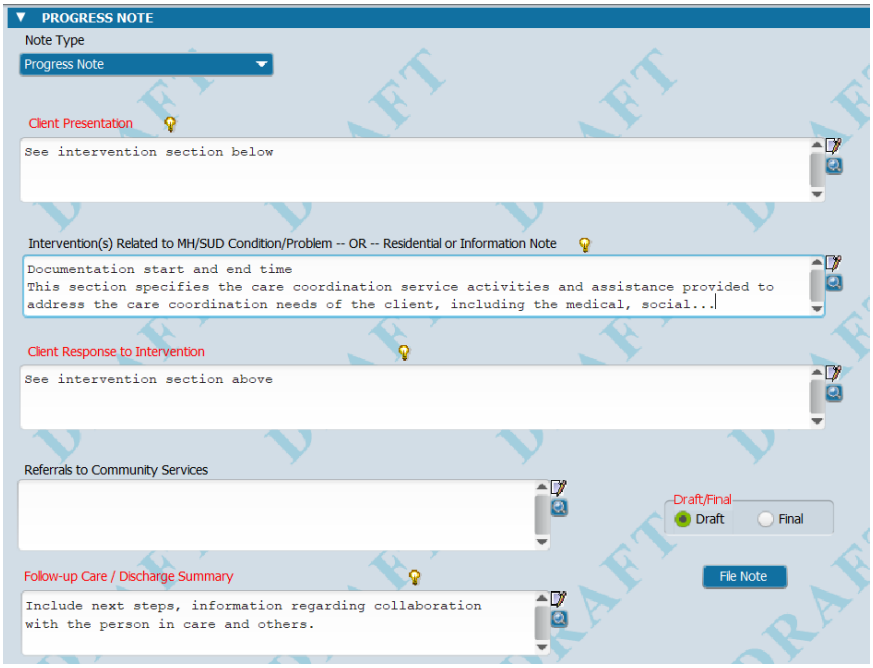
Intervention (Narrative Description of Service):
Documentation start and end time.

This section specifies the care coordination service activities, linkage and assistance provided to address the care coordination needs of the client, including the medical, social, educational, and other services needed by the person in care. Include how the person in care was included and participated and how the service addresses the person's behavioral health / SUD related needs.

Response: Not required, however Avatar will force you to write something.
You may write a brief client response here or write, "see intervention section above."

Referrals to Community Services: Not required.
You may include brief referrals provided.

Follow up Care/ Discharge Summary:
Include next steps, information regarding collaboration with the person in care and others.
Include any updates to the problem list or RSS plan.



Progress Note Examples

Example: Documenting clinical indication for Care Coordination for person who entered services ***after*** July 1, 2022 (Medical Necessity/ CSJ):

Billable Service Code: Assessment (use code associated with program LOC)

Presentation:
See intervention section below.

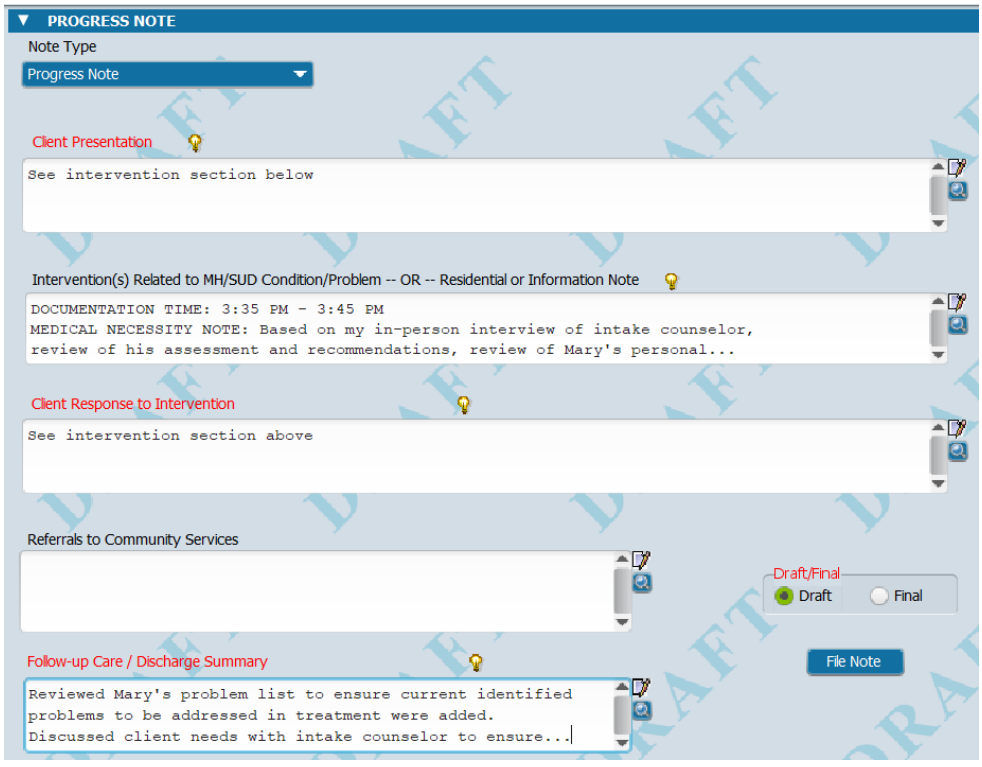
Intervention (Narrative Description of Service):
DOCUMENTATION TIME: 3:35 PM - 3:45 PM

MEDICAL NECESSITY NOTE: Based on my in-person interview of intake counselor, review of his assessment and recommendations, review of Mary's personal, medical, psychiatric and substance use history, most recent health questionnaire, and current ASAM assessment, I have determined that Mary meets medical necessity for Drug Medi-Cal services under the diagnosis of: Alcohol Use Disorder, severe (F10.20) based on the following impairments: increased use of alcohol; poor insight of substance use triggers/craving; reports negative consequences of use as family estrangement, unemployment, homelessness and exacerbated physical health issues. Mary demonstrates minimal coping skills for recovery; and is at high risk for continued use without external prompts and interventions. In addition, to ensure Mary's identified needs are being adequately addressed the provision of on-going care coordination services are clinically indicated including coordinated services with Mary's other care providers and connecting her to resources in the community. Care coordination services were explained to Mary. She agreed to the services and signed an ROI for her health care provider.

Response:
See intervention section above.

Referrals to Community Services:
(blank)

Follow up Care/ Discharge Summary: Reviewed Mary's problem list to ensure current identified problems to be addressed in treatment were added.



Example: LPHA Documenting clinical indication for Care Coordination for person who entered services ***before*** July 1, 2022:

Billable Service Code: Assessment

Presentation:
See intervention section below.

Intervention (Narrative Description of Service):

Documentation time: 1:45-2pm
LPHA met with client's primary counselor during supervision to discuss client's needs identified in the ASAM, on client problem list and over the course of treatment including how to best address identified on-going care coordination needs during treatment. The client has identified continued housing and medical needs, this LPHA determined that it is clinically indicated to provide on-going care coordination to adequately address client needs. Discussed strategies for how to best address client's identified care coordination needs.

Response:
See intervention section above.

Referrals to Community Services:
(blank)

Follow up Care/ Discharge Summary:
Client's primary counselor will continue to meet with client and explain how care coordination services will be used to help address client's identified needs. Primary counselor will obtain ROI's as appropriate in order to facilitate care coordination. Primary counselor will provide on-going care coordination and will consult with LPHA when needed.

Example: Care Coordination Progress Note / Met with person in care

Billable Service Code: Care Coordination (use code associated with program LOC)

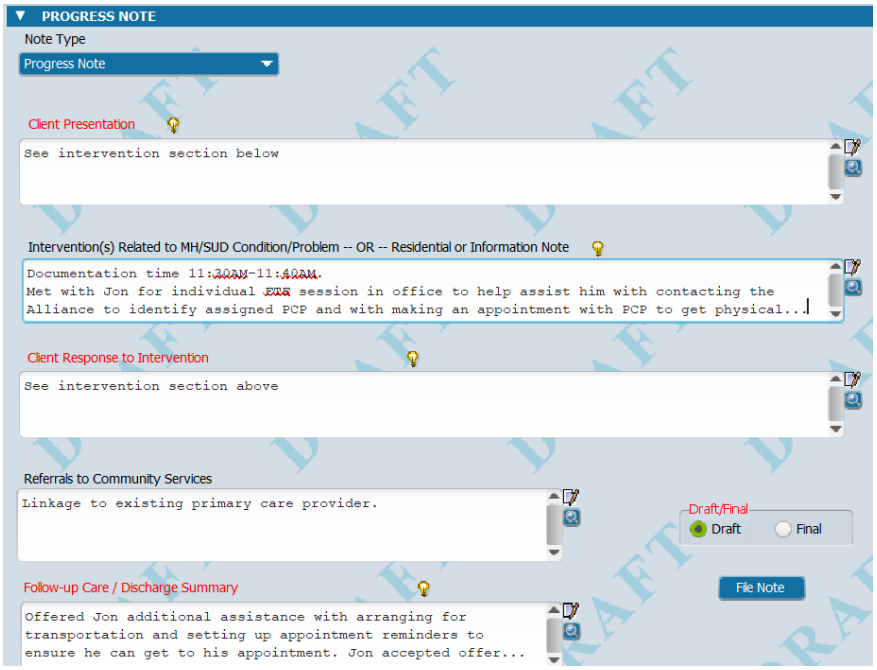
Presentation:
See intervention section below.

Intervention (Narrative Description of Service):
Documentation time 11:30AM-11:40AM.
Met with Jon for individual FTF session in office to help assist him with contacting the Alliance to identify assigned PCP and with making an appointment with PCP to get physical examination. Not having a recent physical examination was included on his problem list. Verified ROI for Jon's PCP is on file. Jon was agreeable to following through and attending his scheduled physical examination appointment.

Response:
See intervention section above.

Follow up Care/ Discharge Summary:

Offered Jon additional assistance with arranging for transportation and setting up appointment reminders to ensure he can get to his appointment. Jon accepted offer of additional assistance and agreed to follow up phone session to confirm transportation logistics prior to appointment.



Example: Care Coordination Progress Note / Person in care not present

Billable Service Code: Care Coordination (use code associated with program LOC)

Presentation:
See intervention section below.

Intervention (Narrative Description of Service):
Documentation time 9:00AM-9:10AM.
Contact was made with Alice's probation officer (PO). PO confirmed that last two drug screens had been random and were positive for both alcohol and marijuana. PO expressed concern that Alice was not taking treatment seriously and was in danger of being remanded to Juvenile Hall if a third test was positive. PO also conveyed that he has been in contact with Alice's mother and has found her cooperative and wanting to help Alice in any way she can. ROI on file to talk with PO and Alice's mother.

Response:
See intervention section above.

Follow up Care/ Discharge Summary:

Will meet with Alice and her mom to explore potential for Mom to act in supportive role. Will follow-up with Alice regarding recent drug screens and possible consequences.

Resources

- CalMHSA Documentation Guides: HERE
- Santa Cruz County CalAIM Information Page: HERE
- DHCS BH Information Notice 21-075: DMC-ODS Requirements for 2022-2026: HERE
- DMC-ODS Care Coordination Training Slides for More Information
  (presented in spring 2022 and can be provided again upon request via email)