



Understanding the Referral Criteria and Process to MH/SUD Care

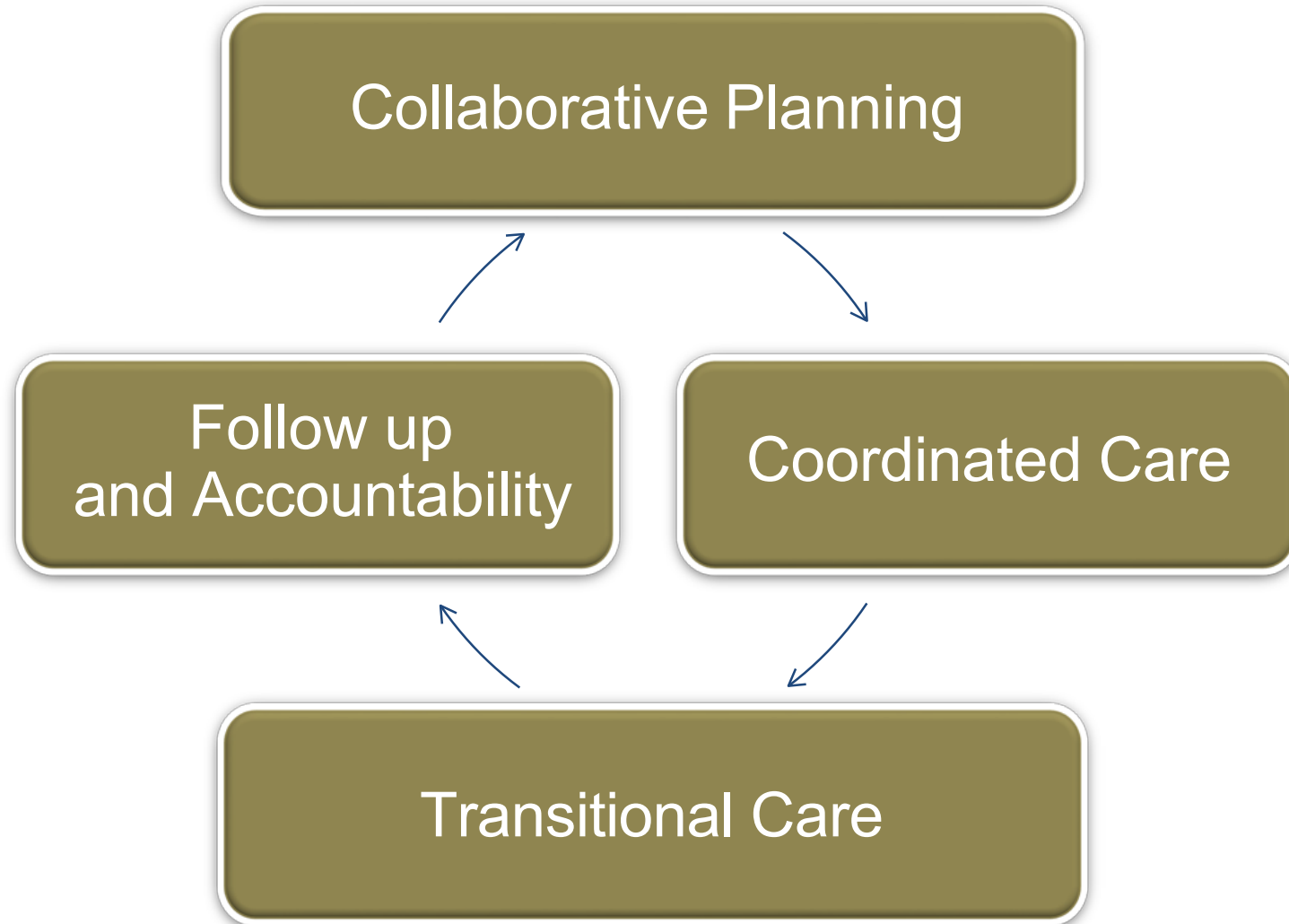
Overview

- What is MH/SUD care coordination?
- What are the eligibility criteria for care coordination?
- What is the role of a care coordinator?
- What is the role of the liaison?
- What is the referral process to care coordination?

Alliance MH/SUD Care Coordination

- Ensures appropriate services and supports are present and functional, accomplished through direct contact with both the individual and the service provider to address barriers to engagement in appropriate, quality care
- Assessing, linking or reconnecting to services
- Assuring accountability of the service provider through follow-up activities to monitor and track progress of treatment plans, appropriateness of services and other key indicators

Alliance MH/SUD Care Coordination



Enrollees Potentially Eligible

- Special healthcare needs population
- At-risk crisis enrollees
- Other populations defined by Alliance
- Care coordination supervisors assess other referrals for appropriateness

Medicaid Eligibility

Special Healthcare Populations

- Adults and children
 - Substance use – substance use dependence and an ASAM of III.7 or higher
 - Dual diagnosis (MH/SUD) – diagnoses falling in both categories (not limited to substance dependence) and either a LOCUS/CALOCUS of V or higher and ASAM of III.5 or higher
- Children that qualify as Children with Complex Needs

Medicaid Eligibility

Dual Diagnosis

- (IDD/MH): Diagnoses falling in both categories and a LOCUS/CALOCUS of IV or higher
- (IDD/SUD): Diagnoses falling in both categories and an ASAM of III.3 or higher
- Not everyone in these categories will have an unmet need or barrier to quality care that needs to be addressed by care coordination

Medicaid Eligibility

Transitions to Community Living

- Individuals transitioning to the community receive care coordination for at least 90 days following transition
- After the initial 90 days, care coordination should continue if needs are still unmet and the individual meets other special health care needs criteria
- Not everyone in these categories will have an unmet need or barrier to quality care that needs to be addressed by care coordination

Medicaid Eligibility

At-Risk for Crisis Population

- Missed appointments – adults or children who are at-risk for emergency or inpatient treatment and do not appear for scheduled appointments
- First service as crisis – adults or children for whom a crisis service is their first interaction with the MH/SUD/IDD system

Medicaid Eligibility

At-Risk for Crisis Population

- Adults or children discharged from a psychiatric inpatient facility/hospital, ADATC, psychiatric residential treatment facility (children), facility-based crisis center, or a general hospital unit after admission for MH, SUD or IDD conditions
- Not everyone in this category will have an unmet need or barrier to quality care that needs to be addressed by care coordination

Non-Medicaid Eligibility

- Department of Health and Human Services defines specific uninsured or under-insured (non-Medicaid) populations to be considered eligible for care coordination up to available resources
- Alliance has prioritized populations within the eligible categories for the non-Medicaid population residing in the Alliance catchment area

Non-Medicaid Eligibility

- Not everyone eligible for care coordination will receive full care coordination from Alliance because providers are expected to provide case management services for many of the enhanced services (per enhanced service definitions)

Role of the Care Coordinator

- Maximize positive outcomes, decrease utilization of emergency services and ensure quality community-based care
- Develop and build relationships with the provider and community resources to assure appropriate array of services are being delivered
- Encourage linkage and communication with primary care provider to address medical needs

Role of the Care Coordinator

- Encourage and facilitate involvement of providers and family
- Ensure strong engagement between individuals and treating providers or other wellness supports by working with providers and sharing resources and information
- Ensure quality person-centered plans
- Assess appropriateness of treatment for individuals with difficulty progressing or engaging in treatment

Role of the Liaison

- Collaborates with the social worker(s) and hospital team to develop proactive discharge community plans
- Provides education to natural supports about different levels of care
- Provides support to the hospital team to link consumers to appropriate services and resources within Alliance community network

Role of the Liaison

- May attend on-site or off-site treatment team meetings to provide consultation, community treatment options, and resources for a least restrictive setting
- Ensure individuals discharging from 24-hour treatment facilities have effective discharge plans and address barriers to attending aftercare appointment

To make a referral to Care Management
please call
Member and Recipient Services
at (800) 510-9132

Resources

- Alliance Health
Locate a provider, upcoming training, and updates
www.AllianceHealthPlan.org
- NC Department of Health and Human Services
<https://www.ncdhhs.gov/>
- Division of Medical Assistance
<https://dma.ncdhhs.gov/>