



Coordination of Care Procedures

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Related Policy: 7.1.12 Coordination of Care

I. Care Coordination Duties of DMC-ODS Providers

The Drug Medi-Cal Organized Delivery System (DMC-ODS) Substance Use Disorder (SUD) programs shall designate primary case managers for each member who implement the following procedures to deliver and coordinate care for as follows:

1. Assess each member's needs and ensure that each member has an ongoing source of care appropriate to their needs. It is the primary case manager's responsibility to coordinate services accessed by the member, and to inform the member of their care coordination role and how to contact them.
 - a. Collaborates with Managed Care Plan (MCP) staff to support transitions from any referral source with emphasis on those that are American Society of Addiction Medicine (ASAM) driven Levels of Care (LOC) changes, or stepping from an ASAM treatment level.
2. Coordinates services provided to the member as follows:
 - a. Between settings of care, including appropriate discharge planning for short term and long-term hospital, acute care settings, skilled nursing facilities, institutional stays, different SUD programs, with county Mental Health Plan (MHP) programs, or other community-based settings. Primary case manager will initiate coordination of care transfer as follows:
 - i. Inform member of referral, reasons, and address concerns.
 - ii. Prepare referral information including the following electronic health record elements as applicable:
 - (1) Member information
 - (2) Transition of Care Tool (as applicable)
 - (3) Assessment Documents (Adult Needs and Strengths Assessment (ANSA), Child and Adolescent Needs and Strengths (CANS), and ASAM)

- (4) Diagnosis Document
- (5) Risk Assessment Documents
- (6) Recent Service Notes
- iii. Assemble referral packet and send to identified recipient at new care setting.
- iv. Obtain written consent from member as a requirement for any disclosure.
- v. Confirm services scheduled with recipient at new care setting.
- vi. Facilitate a “warm handoff” whenever possible including:
 - (1) Communication through emails or phone calls, transportation or other practical supports, and is contingent upon member written consent to share the information.
- vii. Confirm member attended initial appointment at new care setting.
- viii. If applicable, close to services at previous care setting.
 - (1) Completes any required discharge summary and planning materials.
 - (2) Sends copies as authorized to new care settings.
 - (3) Coordinate and communicate with other care providers or care managers serving the member for the purpose of facilitating a "smooth landing" and to prevent negative outcomes such as victimization, crisis, or homelessness.
- b. With the services the member receives, or is eligible to receive, from any other managed care organization (e.g. Sonoma County Behavioral Health Mental Health Plan, Partnership Health Plan, Kaiser Health Plan), including but not limited to, communication and coordination at a minimum of monthly, or more frequently, as medically necessary, for all of the following:
 - i. Collaborative Treatment Planning.
 - (1) Including exchange of medical information when clinically indicated as authorized, and upon request, in accordance with authorized information sharing.
 - (2) Making efforts to include members, caregivers, and providers in the development of planning activities, as evidenced by discussions

and encouraged inclusion at the outset of treatment planning, monthly, or as clinically indicated.

- (3) Services coordinated outside of business hours for any DMC-ODS program will be through the 24/7 Access Line (non-crisis), or the Crisis Stabilization Unit (CSU) / Mobile Support Team (MST) (crisis only).
 - (4) Making efforts with members to engage in person-centered culturally appropriate care.
- ii. Clinical Consultation: Coordinating clinical consultation, including medication-related consultation, and assisting with navigation support for members and caregivers.
 - iii. Coordinate the following with MCP contacts, including the prescribing and refilling of medications, labs, radiological, and radioisotope services.
 - iv. Enhanced Care Management (ECM).
 - v. Complex Care Management (CCM).
 - vi. Community Supports (CS).
 - (1) Work with the MCP identified point of contact for initiating, providing, and maintaining ongoing coordination.
 - (2) Work with the MCP identified point of contact to discuss applicable community supports for member.
 - (3) Make referrals, as agreed upon, with each CS service provider.
 - vii. Transportation Services.
 - viii. Home Health Services.
 - ix. Residential SUD Treatment.
 - (1) Notify the MCP by phone, secure email, or fax, within 24 hours of admissions and discharges.
 - (2) Make efforts to coordinate appropriate follow up services with the MCP contact.
 - x. Treatment Discharges.
 - (1) Send copies of any discharge summary and planning materials.

- (2) Coordinate and communicate with the MCP providers or care managers serving the member, for the purpose of facilitating a "smooth landing" and to prevent negative outcomes such as victimization, crisis, or homelessness.

xi. Tracking Referrals.

- (1) Will track referrals using county spreadsheet or identified Electronic Health Record (EHR) tool.
- c. With the services the member receives from Fee-For-Service (FFS) Medicaid.
 - d. With the services the member receives from community and social support providers.
 - e. Updates problem list within 72 hours of changes in member status for regular items and 24 hours for crisis items.
 - f. Ensures all care coordination efforts and services coordinated are non-duplicative.
3. Conduct initial screening within 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if initial attempts to contact the member are unsuccessful.
 4. Share with Sonoma County Behavioral Health (SCBH), Department of Health Services (DHCS), or other managed care organizations (e.g. Partnership Health Plan, Kaiser Health Plan) serving the member, the results of any identification and assessment of that member's needs, in order to prevent duplication of those activities.
 5. Ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards.
 6. Ensure that in the process of coordinating care, each member's privacy is protected in accordance with privacy requirements in 45 CFR parts 160, and 164 subparts A and E, and 42 CFR Part 2, to the extent that they are applicable.
 7. SUD Crisis Services
 - a. All SUD crisis services shall be accompanied by a follow up within 24 hours to any care providers, including the MCP, to share and support relapse prevention or relapse support, depending on nature of crisis event.

8. All SUD treatment programs will provide or coordinate care for Medication-Assisted Treatment (MAT) services.
 - a. When MAT needs are identified during screening or assessment processes coordination:
 - i. Will coordinate a secure email or fax, and follow up phone call to refer any MAT services and Narcotic Treatment Programs (NTP).
 - ii. Confirm scheduled appointments.
 - iii. Assist with coordinating transportation, including providing transportation if unable to arrange a transportation resource.
 - iv. Will make timely referrals for MAT services within 24 hours of request.

II. Monitoring Plan for Care Coordination

1. In order to monitor care coordination across the DMC-ODS, SCBH will require all SUD service providers (with the exception of Opioid Treatment Programs, and certain out-of-county providers who serve small amounts of members as needed), to enter member clinical service information into SmartCare, the county's centralized EHR for substance use and mental health services. The following elements within the EHR will be used to evaluate and monitor care coordination activities:
 - a. Completion of Coordinated Care Consent.
 - b. Completion of DHS-BHD SUD Release of Information (ROI), and any other agency ROI as applicable.
 - c. Progress Notes review with evidence of providing the member with information on how to contact the person responsible for coordinating their care.
 - d. Review Primary Care Provider (PCP) Detail section for completion.
 - e. Progress Notes review with evidence of care coordination between settings of care (e.g. detox, residential, outpatient, intensive outpatient) in accordance with Section I and Section II procedures.
2. Language on Care Coordination requirements is included in the DMC-ODS provider contracts, and the DMC-ODS practice guidelines.
3. Sonoma County Quality Assessment and Performance Improvement (QAPI) staff review progress on performance standards through review of Treatment Perception Survey, timely transitions in level of care, evidence of follow-up post-discharge from DMC-ODS levels of care.