



Mental Health and Substance Use Care Coordination

Care Coordination is an administrative function, not a service. Mental Health and Substance Use (MH/SU) Care Coordination activities involve identifying the needs of the consumers then coordinating and linking to behavioral health/rehabilitative treatment services and supports.

Within the Care Coordination Department there is Care Coordination, Dual Diagnosis Youth with Complex Needs, and Transition to Community Living

Care Coordination:

- Connects consumers, who are currently hospitalized or at high risk for hospitalization and not engaged in treatment, to a behavioral health/clinical provider in the community.
- Participates in discharge planning for consumers in state hospitals, community hospitals, facility based crisis, psychiatric residential treatment facility (PRTF), child and adolescent residential level III, alcohol and drug use treatment centers, and detox.
- Ensures that consumers discharged from inpatient/residential facilities have a scheduled appointment with a community provider within seven calendar days of discharge.
- Contacts consumers who do not attend scheduled follow up appointments to reschedule services within five calendar days.
- Verifies compliance with Outpatient and Substance Use Commitment Orders.
- Links consumers to needed psychological, behavioral, education, and physical evaluations.
- Connects consumers to medical care and review consumers' assessments/evaluations, health history, Person Centered Plan (PCP) and crisis plan to reinforce that consumers receive an appropriate clinical assessment; collaborative and individualized treatment planning; and access to clinical and medical specialists.
- Facilitates warm hand-off and good rapport between Providers and consumers and organizes Providers and other key stakeholders to address the special needs of consumers to create and maintain proactive plans of care.
- Identifies the gaps in needed services and intervene to ensure the consumer receives appropriate care, as well as align resources with consumer's needs and preferences.
- Measures results of intervention and treatment, including reduction in high-risk events and use of high cost services.

Dual Diagnosis Youth with Complex Needs are Medicaid eligible children ages 5 and under 21; and who have been diagnosed with a developmental disability (including Intellectual Disability and/or Autism Spectrum Disorder) and a mental health disorder; and who are at risk of not being able to return to or maintain placement in a community setting; and exhibit one or more of the following risk factors:

- Exhibiting behaviors that are a danger to self or others now; and/or
- Been expelled or is at risk of expulsion from school due to disruptive or dangerous behaviors; and/or
- Experienced incidents for crisis such as frequent ED visits, out of home placements, involvement with criminal justice system, or involuntary commitments.

Transitions to Community Living (TCL) focuses on “transition planning” and Care Coordination follow along for the TCL-identified population, which includes:

- Consumers who are living in adult care homes who have a diagnosis of serious and persistent mental illness; and
- Consumers who are referred to adult care homes with a diagnosis of serious mental illness

Frequently Asked Questions and Answers

Q. How are consumers identified and referred for MH/SU Care Coordination?

A. Consumers are identified by reviewing data reports. Referrals – both internal and external – may be made using the [Care Coordination Referral Form](#).

Q. Do all consumers active to MH/SU Care Coordination receive the same level or intensity of intervention/activities?

A. The prioritization and level of intervention for Care Coordination activity determines caseload assignment and ratios. There are three levels of intervention/intensity of Care Coordination activities: light, medium, and high.

Q. How is MH/SU Care Coordination structured?

A. Partners' has an implementation plan with specific strategies. The team is varied with licensed and qualified (non-licensed) behavioral health professionals. There is clearly defined role delineation between licensed MH/SU Care Coordinator and qualified professionals (QP). All cases are assigned by the MH/SU Care Coordination supervisor or Lead Care Coordinator.

Q. How long is MH/SU Care Coordination involved with a consumer?

A. The average length of involvement for most consumers in Care Coordination is 90 days. The goal is for MH/SU Care Coordination to intervene, ensure consumer is connected and receiving the right treatment in the right amount and the right time, then step out.

Q. How do I know if a consumer has a Care Coordinator?

A. The Provider may contact MH/SU Care Coordination or Access to Care staff to search AlphaMCS for assignment. In addition, Providers may send inquiries to MHSA_CC@partnersbhm.org.

Q. When should Providers expect contact from a Care Coordinator?

A. MH/SU Care Coordinators are likely to contact the Provider soon after the initial appointment to ensure the consumer attended the appointment. Other reasons Care Coordinator may contact the Provider include convening a treatment team meeting, inquiring about the status of a consumer, following up on compliance with Outpatient Commitment Order/Substance Use Commitment Order, coordinating treatment with other Providers, etc. The MH/SU Care Coordinator is mindful of the Provider's schedule and time. Partners CC staff contact Providers by telephone first, face to face when convenient or schedule time in advance.

Who to Contact in MH/SU Care Coordination

To learn more about MH/SU Care Coordination please visit

<https://providers.partnersbhm.org/category/care-coordination/> or email MHSA_CC@partnersbhm.org