



**SANDHILLS
CENTER**



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**MH/SA Care Coordination
Units
Overview of Functions**

The MH/SA Care Coordination Section has four units:

- They are: MH/SA Care Coordination for Adults and Children, Specialized Children's System of Care, Transitions to Community Living Program, and the Care Coordination Specialty Unit.

MH/SA Care Coordination for Adults and Children

- Responsible for providing education to high risk/high need members, their families, and stakeholders.
- Provides linkage to providers, community resources, natural supports, primary care physicians etc.
- Ensures that the high risk/high need members receive appropriate assessments (psychiatric, psychological, medical etc.) and that a Person Centered Plan based on the findings of the comprehensive assessment is developed and implemented.
- Care Coordinators maintain involvement in these high risk cases until a member in the case has reached a maximum state of stability as evidenced by low risk of harm, the presence of an actively engaged supportive environment, and at least moderate recovery has been maintained for a period of time, and/or there has been a decrease in the LOCUS/CALOCUS score



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Specialized Children's System of Care

- Responsible for:
 - Coordinating member transition from one level of care to another.
 - Periodically attending member-focused staffings and meetings.
 - Participating in inter-agency meetings.
 - Ensuring quality service provision.
 - Ensuring care coordination when multiple providers are involved in one case.
 - Ensuring that members have an integrated and coordinated Service Plan.
 - Assisting with eligibility screenings needs assessments.
 - Working with children identified by schools and other county service-based agencies as being at high risk for out of home placement and/or school suspension.



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Transitions to Community Living

- ❖ Responsible for assisting willing target population members in transitioning to the community. Eligible Sandhills Center members include members with serious mental illnesses who: Reside in Adult Care Homes, or who have had extended stays in state hospitals, or who are at risk of being placed into Adult Care Homes.
- Transition to Community Living staff assists eligible members access components of
- this initiative including:
- In Reach, Transition Planning, and Transition.
- Ensures that any individuals wishing to move from an adult care home to more integrated settings are provided with the necessary services and supports.
- Ensures that discharge/transition plans are developed and implemented through
- person centered planning processes.
- Coordinates with individuals, family, and supports to identify and secure community resources necessary to transition.
- Educates, informs, and connects, target population with services including but not limited to Supported Employment, Assertive Community Team, Community Support Team, Psychosocial Rehabilitation, and Peer Support.

Care Coordination Specialty Unit

- Responsible for :
 - Coordinating and monitoring activities related to hospital emergency departments' transition efforts.
 - Providing specialized consultation and interface with all state hospitals, crisis services providers, hospital transition team providers, stakeholders, and LME staff, regarding hospital resources, admissions, and discharge planning.
 - Establishing and maintaining communication with housing agencies, programs, initiatives, and landlords.
 - Providing information and referral to issues related to housing.
 - Tracking and disseminating information related to housing resources.

The Purpose of Care Coordination

- Care Coordination is an administrative function of the LME-MCO that does not provide direct services to recipients.
- The overall goal of Care Coordination at Sandhills Center--across identified targeted populations--is to improve member outcomes while preventing the use of services of unwarranted intensity and restrictions.
- The work of the Care Coordination department is appropriately integrated with the operations of the Sandhills Center Medical Director, the Clinical Operations Leadership Team, the Customer Services Program, Utilization Management Program, Network Operations, and the Quality Management Program.



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