Serious Mental Illness (SMI)

Provider Training

Community Care Plan
The Health Plan with a Heart

Overview

As a provider, your role in the Serious Mental Illness (SMI) program is crucial in addressing the complex needs of Medicaid recipients with significant mental health conditions. The SMI program focuses on supporting individuals diagnosed with severe psychiatric conditions, including schizophrenia, bipolar disorder, major depressive disorder, and other serious mental health disorders.

Serious Mental Illness Program Specialty Plan

Community Care Plan (CCP) is dedicated to supporting members with serious mental illness (SMI) by offering integrated care through the SMI Specialty Plan. This plan combines behavioral, medical, and pharmacy services through a collaborative, team-based approach, ensuring coordination among behavioral health providers, medical providers, licensed clinicians, and pharmacists.

Key Features

The program’s goal is to ensure patients receive comprehensive mental health. This holistic approach empowers members to manage their health more effectively and enhances overall care outcomes.

Care Coordination: Seamless integration of medical and behavioral health services.

Social Support Services: Assistance with access to healthy food, secure housing, and reliable transportation.

Additional Benefits: Extra resources that extend beyond traditional healthcare to support overall well-being.

Serious Mental Illness (SMI) Plan

The Serious Mental Illness (SMI) Plan is tailored to support members aged 6 and older who have one or more of the following conditions:

- Psychotic Disorders
- Bipolar Disorders
- Major Depression
- Schizoaffective Disorder
- Delusional Disorders
- Obsessive-Compulsive Disorder (OCD)

PCP Criteria

Identifying mental health or substance use conditions and referring members to appropriate behavioral health providers is crucial to delivering integrated care for all Community Care Plan members. To support primary care physicians in recognizing members with potential behavioral health needs, the following evidence-based screening tools are recommended:

- PHQ9: Depression screening tool for adults (PDF)
- PHQ-A: Depression screening tool for adolescents (PDF)
- CRAFFT: Screening tool for adolescent substance abuse (PDF)
- CAGE: Screening tool for identifying potential alcohol abuse (PDF)
- CAGE questionnaire (PDF)
- SBIRT: Screening, Brief Intervention, and Referral to Treatment for those with unhealthy alcohol and drug use (PDF)
- Edinburgh Postnatal Depression Scale – Microlearning External Link

Case Management

Providers play a key role in CCP's Concierge Care Coordination Model, which prioritizes personalized, concierge-level services for enrollees and providers. CCP supports providers by offering customized services, reporting, and tools to enhance enrollee care. The goal is to facilitate better outcomes by ensuring providers have the necessary data and resources.

- **Collaborative Case Management:** Work with providers to improve case management and care coordination processes.
- **Care Initiatives:** Develop and coordinate interventions and alternative care plans with the enrollee, providers, and care team.
- **Support Treatment Plans:** Reinforce physician-recommended treatments and facilitate referrals for comprehensive care.

Case Management

- **Enhanced Communication:** Facilitate communication among enrollees, families, providers, and the community to meet healthcare needs.
- **Self-Management Plans:** Collaborate with provider office staff and physicians to create and communicate self-management plans.
- **Provider Communication:** Providers can refer enrollees to case management (CM) programs through various channels (phone, email, fax, or in-person).
- **C3 Care Coordination:** Care Coordinators interact with healthcare professionals to complete assessments and care plans, coordinating to prevent complications. Care plans and program notifications are shared with the care team via fax or email.

Concierge Care Coordination Model (C3)

Care managers collaborate closely with the concierge care coordination team to address member needs and achieve personalized health goals. A care coordinator plays a central role, engaging promptly with new members upon enrollment to complete a comprehensive initial assessment.

Key responsibilities include:

- Developing a person-centered care plan in collaboration with the member, their family, PCP, and both network and non-network providers.
- Tailoring the care plan based on the member’s strengths, needs, preferences, and informal supports.
- Monitoring and adjusting the care plan in response to changes in the member's condition or medical necessity.
- Evaluating and discussing the quality of care and member satisfaction during every interaction.

This model ensures a holistic approach to care, integrating input from all stakeholders to support member-centered outcomes effectively.

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Referral to Services

Referrals include services beyond the Specialty product's covered offerings, as well as those provided through interagency agreements. CCP Care Coordinators are available to assist enrollees in accessing all necessary services, even those outside the Specialty product's coverage or provided through interagency agreements. Examples of these services and agencies include, but are not limited to:

- Department of Children and Families (DCF)
- Department of Veteran Affairs (VA)
- Department of Education for School-Based Services
- Department of Juvenile Justice
- Department of Corrections
- Department of Elder Affairs
- Alzheimer's Disease Initiative
- Homecare for the Elderly Program
- Federal Older Americans Act Program
    - Agency for Persons with Disabilities
    - Department of Health Title XXI: Children's Medical Services

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THANK YOU