SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

CLINICAL POLICY

NUMBER: BC008

NAME: CARE COORDINATION

INITIAL APPROVAL DATE:	10/04/2000	BY: Administrative Committee
STAKEHOLDER REVIEW:	09/06/2023	BY: Consumer Advisory Board
(LAST) REVISION DATE:	11/21/2024	BY: COO
(LAST) REVIEW DATE:	12/12/2024	BY: Policy Committee
DISCONTINUED DATE:	N/A	REPLACED BY: N/A

I. PURPOSE

To establish a uniform policy that ensures coordination of care with other behavioral health care providers, physical health care providers (acute and chronic), social services, educational systems, employment related services and veterans services, among others, that relate to a shared individual base in appropriate situations.

II. APPLICATION

Populations: **ALL**
Programs: Direct **- ALL**
Contracted **- ALL**

III. POLICY

It is the policy of the Sanilac County Community Mental Health Authority (Sanilac CMH), that whenever consent can be obtained, to ensure that coordination of care with other behavioral health care providers, physical health care providers (acute and chronic), social services, educational systems, employment related services and veterans services, among others, is occurring, as appropriate, between Sanilac CMH, its provider network, and other providers. This policy applies to those individuals of Sanilac CMH for whom supports are expected to be provided for an extended period of time (e.g., persons receiving case management).

IV. DEFINITIONS

Beneficiary – An individual who is receiving or may qualify to receive services through Sanilac CMH.

Collaboration – Formal partnered agreements among service providers/practitioners that result in coordinated systems of care, as detailed within an individual's comprehensive plan of service.

Integration – To bring together providers to the individual being served to coordinate to provide the best and appropriate treatment and avoid duplication of services.

Provider – An individual or organization that provides a specific service to the individual/ beneficiary, including but not limited to the areas of behavioral health, physical health (acute and chronic), social services, educational systems, employment-related services, or any others as appropriate.

V. STANDARDS

A. Services shall be integrated for all individuals served by Sanilac CMH.

B. Based on the needs of the individual it will be determined if a patient-centered team approach will be the best treatment method. The criteria for determining if an interdisciplinary team is needed will include, but not be limited to, assessment findings, diagnosis and severity level, treatment needs, and the individual's preferences. The team will consist of staff from medical services, therapy services, care management, and peer support with other disciplines being added as appropriate. The team will be responsible, with the individual and/or family/caregiver, for directing, coordinating, and managing care and services for the individual. When appropriate, traditional approaches to care for individuals who are American Indian or Alaska Native will be included within treatment planning.

C. Beneficiaries shall have access to an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating services. Individuals who do not have a primary care physical health provider will be provided (1) a service goal to obtain a primary care medical practitioner or (2) a risk vs. choice goal to educate the individual about health risks associated with a behavioral health condition and the advantages of having a primary care physical health provider.

D. Providers shall share clinical information with those identified in the person's plan of service to facilitate care and avoid duplication of services, while also ensuring the beneficiary's privacy in accordance with privacy requirements. This can include coordination with Managed Care Organizations (MCO) and other Prepaid Inpatient Health Plans (PIHP) which includes the sharing of enrollee assessment(s) results.

E. Sanilac CMH clinical staff will assist the identified individual, or parent/caregiver for an identified individual, in obtaining and keeping primary care and other key health/human service appointments, subject to privacy and confidentiality requirements and consistent with the individual's preference and need. Sanilac CMH will also provide physical health resources and referrals as needed to ensure that identified individuals and families have options to physical health care.

F. Sanilac CMH shall ensure that local standards and monitoring mechanisms are in place delineating the contingencies under which behavioral health practitioners communicate with the primary physical health practitioner. Primary caseholders shall utilize CareConnect 360, admission, discharge, and transfer (ADT) data and the Waiver Support Application (WSA) to monitor their individual's engagement with primary health care providers, emergency room usage and medications prescribed. The caseholder will monitor on a monthly basis and use this information when completing plans of service or reviews.

G. In partnership with the Medicaid Health Plans, Sanilac CMH will participate in integrated care meetings facilitated by the PIHP. A designated staff member will assist the primary caseholder with the coordination of the meetings and with documenting in Care Connect 360 the action steps from the discussion. The notes must be entered into Care Connect 360 within 2 business days of the meeting.

H. The following protocols shall be utilized for MiCAL and CCBHC:

1. Crisis Alerts
   Sanilac CMH will utilize the crisis alert function in MiCAL if deemed necessary to best facilitate crisis care for our individuals. The Care Manager will ensure that the clerical staff have all the relevant information for the crisis alert to include: first and last name, if they receive ACT, DBT or Homebased services, suggested action plan, significant information, expiration date of crisis alert, and if a release of information has been obtained.

2. Daily Activity Reports/Exchange of Information
   Clerical staff will check the daily activity reports in MiCAL to ensure that information is passed on to the responsible party. The exchange of information between relevant parties will be coordinated among clerical staff, Hospital Program Coordinator and Data Management staff to guarantee timely and accurate exchange of information.

3. Crisis Services, Handoffs and Referrals to Treatment
   Crisis Services will be coordinated as directed in MiCAL. MiCAL staff will call Sanilac CMH during normal business hours and the Region 10 Access Center during non-business hours. Hand-offs and referrals to treatment will be checked daily by clerical staff and coordinated with the applicable department.

VI. PROCEDURES

Primary Care

A. Upon intake, and annually thereafter, all individuals to whom this policy applies will be asked to sign a release of information permitting the sharing and disclosure of pertinent information between their Primary Physical Health Provider and Sanilac CMH. If the individual does not have a Primary Physical Health Provider, this is to be indicated on the release of information form and filed with all other releases.

B. With the appropriate consents to release information in place, information exchanged amongst clinic providers and other providers who prescribe medications shall include a list of all prescribed medications with diagnosis, dosage, strength, and frequency as well as laboratory work and any significant change in condition.

C. At Intake and Annual Assessment or Change in Condition
   At the time of intake, the annual assessment or when a change in an individual's condition occurs, the primary caseholder will be responsible for completing the Coordination of Care form in OASIS which will be sent to the Primary Physical Health Provider.

   Care coordination activities are carried out in keeping with the individual's preferences and needs for care and, to the extent possible and in accordance with the individual's expressed preferences, with the individual's family/caregiver and other supports identified by the individual and activity in the treatment planning process.

   Nothing about Sanilac CMH's care coordination process or documents will limit an individual's freedom to choose their service provider(s) with Sanilac CMH or with any of its contracted partners including Designated Care Organizations (DCOs).

D. At initiation of and for on-going Psychiatric Services or when there is a change in Primary Physical Health Provider
Upon initiation of psychiatric services and at each medication review or with any change in the Primary Care Provider, the psychiatrist/nurse practitioner will be responsible for completing the Coordination of Care form in OASIS, which will be sent to the Primary Physical Health Provider.

E. It will be the responsibility of the Primary Staff at Sanilac CMH (i.e., Nurse, Care Manager, or Therapist) to ensure that information regarding medications and/or significant change in condition is solicited regularly from the individual and/or caretaker as part of the periodic review or medication monitoring process. This information then is coordinated with the Primary Physical Health Provider.

F. Sanilac CMH will obtain individual and specific authorization to release information to other service organizations prior to sharing medication and other service-related information. This would include requests from other providers beyond primary physical health, court system, etc. to the extent necessary for safe and quality care and within the parameters of HIPAA (42 CFR) and Sanilac CMH's guidelines.

G. When an individual is being discharged from services, the Primary Staff at Sanilac CMH will coordinate with the individual's primary physical health provider and any other services/community supports/MCOs to ensure that they understand the discharge plan and the role they play.

H. When an individual is being discharged from short-term or long-term hospitalizations or placements, the Primary Staff at Sanilac CMH will coordinate with the individual's primary physical health provider and any other services/community supports/MCOs to ensure that they understand the discharge plan and the role they play.

I. If appropriate, assessments/results of assessments will be shared with primary physical health providers and any other services/community supports/MCOs to help coordinate level of care needs in regard to their role with the individuals.

J. The Sanilac CMH worker will work with the individual to develop a crisis plan. If the individual chooses not to participate in creating a crisis plan, the worker will document this decision in the individual's chart in the EHR. The worker will readdress and encourage the development of a crisis plan with the individual at a minimum annually.

Community Collaboration
Sanilac CMH will coordinate with entities through participation in multi-purpose collaborative bodies.

Public and Private Organizations
Sanilac CMH will develop service coordination agreements with each of the pertinent public and private community-based organizations and providers to address issues that relate to a shared consumer base. Per the agreements, the Care Coordination Referral Form will be utilized when a provider is referring to Sanilac CMH.

VII. ATTACHMENTS

VIII. **REFERENCES**

(In OASIS) – Form #0373 -Coordination of Care
(In OASIS) - Form #0234 - Psychiatric Services Letter to Physician
Form #0587 - Care Coordination Referral