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<b>Signature:</b> 	<b>Date:</b> 12-18-19

## I. POLICY

The policy of the ACCESS Community Health and Research Center (CHRC) is to Ensure that mental health services shall be coordinated with primary health care services, Medicaid Health Plans (MHPs), Substance Abuse Coordinating Agencies, individual practitioners, public health agencies, and other General healthcare providers, utilizing the Person-Centered Planning (PCP) process.

## II. PURPOSE

It is the purpose of this policy to provide ACCESS CHRC staff the guidelines and expectations of care coordination to developing a service delivery system that coordinates and integrates care that is welcoming, recovery-focused, trauma informed, and co-occurring disorders capable to meet the individuals'/families' needs and inspire the hope of recovery.

## III. APPLICATIONS

This policy applies to all ACCESS CHRC employees, interns and volunteers.

## IV. DEFINITIONS

**Co-Occurring Disorders:** When used in the context of substance abuse, this term refers to co-occurring psychiatric and substance abuse disorders.

**Coordination of Care:** Collaboration between physicians, other clinical professionals and their designees within the MCPN's array of contractors and sub-contractors, MHP's, and substance abuse providers, in the provision of services to persons mutually served: This coordination of care includes sharing of relevant information such as diagnosis, course of treatment, medication and side effects and recommendations regarding treatment/services/supports for a specific person who is receiving services.

**Early and Periodic Screening, Diagnosis and Treatment Programs (EPSDT):** Medicaid's comprehensive and preventive child health program for beneficiaries under age 21

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**Individualized Plan of Service Treatment Plan (IPOS):** The document that identifies the needs and goals of the individual beneficiary and the amount, duration, and scope of the services and supports to be provided: For beneficiaries receiving mental health services or developmental disabilities services, the Individualized Plan of Services must be developed through a Person-Centered Planning (PCP) process. In the case of minors with developmental disabilities, serious emotional disturbances or mental illness, the child and family are the focus of service planning, and family members are an integral part of the planning process.

**Manager of Comprehensive Provider Network (MCPN):** A business contracting entity established to develop and manage a comprehensive network of providers that can meet the needs of adults with or at risk of developing severe mental illness; children and adolescents with serious emotional disturbances; persons with developmental disabilities; and persons with severe mental illness and substance abuse disorders.

**Medicaid Health Plan (MHP):** A healthcare organization (HMO) under contract with the Michigan Department of Community Health to provide or arrange for the delivery of covered services set forth in the DCH/MHP contract for comprehensive healthcare services to Persons enrolled in Medicaid [Exhibit A]

**Mental Health Specialty Services and Supports Program Covered Services:** Limited to State Plan Services, the services described in the Habilitation/Supports Waiver for persons with developmental disabilities, and the alternative services described in the MDCH/Prepaid Inpatient Health Program (PHIP) contract

**Person:** An individual who is currently receiving or in the past has received treatment/services/supports within the agency's MCPNs, their affiliates, or other entities contracted with the agency

**Person-Centered Planning (PCP):** A process for planning and supporting the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities: The Person-Centered Planning process involves families, friends, and professionals as the individual desires or requires.

**Primary Health Care Providers (PHCP):** Medical doctors and other clinical professionals, including those in MHPs and in non-MHP healthcare organizations, e. g., individual, group and

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clinic practitioners, Indian services, and public health agencies that provide general medical treatment, services, and supports

**Reasonable Access (Geographic Access Standard):** Services are available within 30 miles or 30 minutes in urban areas or within 60 miles or 60 minutes in rural areas.

**Substance Abuse Coordinating Agency (CA):** A legal entity designated under the Michigan Public Health Code, (PA 368 of 1978, as amended) to oversee substance abuse services

**Substance Use Disorder:** Substance use disorders include substance dependence and substance abuse, according to selected specific diagnostic criteria given in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.

## V. PROCEDURES

- 1) It is the expectation that all ACCESS staff educate customers and promote **integration of care**
  - a) Ensure the availability and access to a broad, flexible array of effective, community-based services and supports for adults, children and their families that address emotional, social, educational/vocational, and physical/behavioral health/SUD needs, utilizing traditional and non-traditional services/resources – engaging natural and informal support systems.
  - b) Ensure services are delivered in an integrated and coordinated manner with effective linkages between agencies and programs.
  - c) Ensure the use of ACCESS’s integrated screening and assessment that is comprehensive is addressing the physical/behavioral health, SUD, and IDD concerns of the individual while still being recovery-focused.
  - d) Ensure that the biopsychosocial assessment identifies the individual’s needs in an integrated, holistic manner. These needs, with the individual’s consent, become part of the person-centered plan and identify any physical and behavioral health, substance use disorder, and/or IDD concerns, as well as any other life area needs.
  - e) Ensure the Individual Plan of Service (IPOS) is developed using a person-centered process, as the document that directs the supports and services.
    - i) The IPOS enables individuals to achieve their personally defined outcomes and supports individual choice and control.
    - ii) The IPOS also defines the respective responsibilities of the individual’s care team members – health care providers, behavioral health/SUD providers, natural supports, individual, etc.
  - f) Ensure that processes and technology are developed and implemented to facilitate the sharing of assessments, treatment plans and other pertinent information related to any

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changes in an individual's care needs between internal and external members of the individual's care team.

- g) Ensure that policies and procedures are in place to allow for individuals and/or families to receive information related to their rights and the health information protections already in place.
  - h) Ensure that individuals sign all appropriate consent forms for exchange of protected health information – utilizing the State of Michigan's Consent to Share Information (DCH-3927-12/14) that includes SUD information that is protected under 42CFR, Part 2.
  - i) Provide information to individuals receiving services or their guardians about the availability of family planning and health information. This information shall include a statement that receiving mental health services do not in any way depend upon requesting family planning services or health information services.
  - j) Ensure procedures are developed and implemented for notifying MHP, consulting MHP practitioners and other PCPs regarding the continuation and/or prescribing of new medication, particularly if there are significant co-occurring physical and behavioral health issues that are being addressed, maintaining ongoing communication and sharing completed and updated information.
  - k) Ensure full access to complaint, grievance, and appeals processes that enforce each individual's IPOS/PCP Master Treatment Plan rights.
  - l) Ensure the development and implementation of policy and procedures related to competency with regard to cultural diversity – including ethnic, cultural, gender, and/or community values, etc.
  - m) Identify the development, implementation and monitoring of procedures to coordinate care with SUD treatment facilities and all coordinating contractors – i.e., individual practitioners, public agencies and/or their designees – for individuals and families receiving ongoing services and supports.
  - n) Provide care management at the practice level to ensure and monitor that multiple services are delivered in a coordinated and therapeutic manner; that allows the individual and families to move through the system in accordance with changing needs and without obstacles/barriers.
  - o) Refer the individual and/or family to community-based resources should the services requested not be available on-site or within network; coordination of care with the referral source would be provided.
  - p) Promote the rights of individuals and their families and provide effective and ongoing advocacy.
- 2) ACCESS shall ensure **coordination of care** by:
- a) Referring adults or children/adolescents with definite or probable serious mental illness, SUD and/or intellectual/developmental disabilities to the centralized access center for screening

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and eligibility determination for specialized behavioral services. Exhausting the plan benefit is not necessary prior to referral.

- b) Ensuring processes of screening and assessment are comprehensive in addressing the physical/behavioral health, SUD, and IDD concerns of the individual.
  - c) Communicating significant diagnoses, treatments, laboratory and other examination results to behavioral health and/or SUD service providers.
  - d) Obtaining any necessary signed releases of information from the individual served and/or the guardian to ensure treatment is shared without impediment between the individuals/entities noted on the consent.
  - e) Ensure the provision of all appropriate clinical information for the provision of effective integrated care, which includes:
    - i) Screening assessment, and intake disposition
    - ii) Any at risk behaviors (suicidal or homicidal) and physical
    - iii) Pertinent past psychiatric history, including recent utilization of residential, hospital or other community services
    - iv) Medication regime, including psychotropic medication history and blood levels, as indicated.
    - v) All relevant treatment information based upon the current updated IPOS/PCP.
    - vi) Ensures that staff is adequately trained and knowledgeable of the elements of the coordination of service agreements and the requirements of collaboration.
- 3) ACCESS shall ensure appropriate referrals and referral tracking
- a) ACCESS staff provides referrals for care that cannot be provided at ACCESS, or care for which it is appropriate to continue elsewhere.
  - b) In the case of potentially serious clinical problems that are being referred out of ACCESS, the referring staff may designate the referral to be tracked by the Peer Specialist will monitor referrals designated for tracking and communicate their status to the referring staff in a timely manner if the consultation note is not received in 30 days or by the time requested by the staff.
  - c) Referring staff initiates outside referral in the electronic medical record or on paper and indicates the request for tracking assistance by a peer specialist.
  - d) Referring staff sends the client/patient to the peer specialist who reviews the following: basic information on insurance coverage for specialty care, process of sending referral to appropriate specialists, how the patient/client and the specialist will communicate and expected time-line for specialty appointment.
  - e) Peer Specialist track referrals in the following way:
    - i) Four weeks after the referral is generated checks for a report of visit from the specialist.
    - ii) If the outside consultation report has been scanned into the medical records document section and acknowledged, no further tracking is required.

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- iii) If the report has been scanned but the clinician has not acknowledged the report, an instant message is sent to the referring staff indicating that the report has come in. Once the referring staff is notified of the referral report, no further tracking is required.
- iv) If after 4 weeks no report is found in the EMR, the peer specialist will call the student to confirm that the consultation/test has been completed.
- v) If the consultation occurred but no report is received then the Peer Specialist will phone or fax the consultant, requesting that the written report be faxed to ACCESS. The Peer will call or fax a request once a week for three weeks to try to obtain the report. The Peer Specialist can fax a "Continuity of Care" Medical Records Request as a reminder. If three attempts at contacting consultant office have failed to produce report, the referring ACCESS Staff is notified of no response from consultant. No further tracking is indicated.
- vi) If no consultation occurred because the client/patient has not been seen, then the Peer Specialist will offer to assist the client/patient with scheduling the consultation. If three attempts to assist the client/patient to access services have been attempted (by the insurance office or the specialist offices) and the student has still not followed through, the referring staff is notified, and no further tracking is indicated. Peer Specialist should document conversations with client/patient via contact notes and IM the referring staff if client/patient has not scheduled or completed recommended referral services.

## **VI. QUALITY ASSURANCE/IMPROVEMENT**

ACCESS Quality Assessment and Performance Improvement Program (QAPIP) must include measures for both monitoring of and for the continuous improvement in quality of the program or process described in this policy.

## **VII. COMPLIANCE WITH ALL APPLICABLE LAWS**

ACCESS Employees, interns and volunteers are bound by all applicable local, state, and federal laws, rules, regulations, and policies, all federal waiver requirements, state, and county contractual requirements, policies, and administrative directives in effect and as amended.

## **VIII. LEGAL AUTHORITY AND REFERENCES**

1. Cross, T., Bazron, B, Dennis, K., Isaacs, M. (1989). Towards a culturally competent system of care, Volume 1, Washington DC: Georgetown University Child development Centre, CASSP Technical Assistance Center.
2. Detroit Wayne Mental Health Authority Coordinating Agreements FY2011 – FY2016

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3. Detroit Wayne County Community Mental Health Coordination and Integration of Care Policy. (2013)

4. D. Goode, T, Jones, W. (2004). National Center for Cultural Competence, Linguistic Competence Definitions. Retrieved January 13, 2009 from <http://gucchd.georgetown.edu/nccc>

5. Substance Abuse and Mental Health Services Administration (SAMHSA), Strategies for Developing Treatment Programs for People with Co-Occurring Substance Abuse and Mental Disorders, SAMHSA Publication No 3782, Rockville MD: SAMHSA 2003.

## **IX. EXHIBITS**

Appendix A: Internal Referral form

Appendix B: Coordination of care consent