LAPEER COUNTY COMMUNITY MENTAL HEALTH **Date Issued** 05/28/2009
Date Revised 03/20/12; 8/13/14; 06/25/15, 7/08/19; 08/23/22

CHAPTER Health/Medical	**CHAPTER** 03	**SECTION** 002	**SUBJECT** 15
SECTION Health Care	**DESCRIPTION** Coordination with Health Care		
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APPLICATION:

☒CMH Staff	☐Board Members	☐Provider Network	☒Employment Services Providers
☐Employment Services Provider Agencies	☒Independent Contractors	☒Students	☒Interns
☒Volunteers	☒Persons Served		

POLICY:

Lapeer County Community Mental Health (LCCMH) coordinates services with the primary health care providers.

STANDARDS:

A. Primary care and behavioral health care services are integrated for Medicaid beneficiaries with focused coordination of care efforts.

B. LCCMH shall develop service coordination agreements with organizations and providers, public or private to address needs of a shared population of persons served.

C. Coordination of Care with the primary care physician is a function of the primary case holder and shall be incorporated into the plan of service.

D. Coordination with Medicaid Health Plans (MHP's) or any other health care providers identified shall be incorporated into the plan of service.

E. Care Connect 360 (CC360) is used for secure data sharing and storage of Interactive Care Plans with the MHP's for shared persons served with identified severity/risk conditions in accordance with the Michigan Department of Health and Human Services joint care management requirements.

F. Lapeer County Community Mental Health (LCCMH) and its provider network, in accordance with Michigan Department of Health and Human Services (MDHHS) and Region 10 Pre-paid Inpatient Health Plan (PIHP) contracts use, accept and honor the standard consent form MDHHS-5515 and the Coordination of Care form in the electronic health record to serve as a valid consent and release to share certain types of health information.

G. "Consent to Exchange Health Information (MDHHS Consent)" Form MDHHS-5515 and the Coordination of Care form in the OASIS electronic health record are the two standard consent forms used for sharing specially protected health information related to mental health and substance use disorder. Privacy shall be maintained in accordance with 45 CFR parts 160 and 164, subparts A and E.

H. Public and private agencies, departments, corporations or individuals, involved with treatment of the individual receiving behavioral health and/or substance use disorder service listed on the consent form can share information amongst each other.

I. These forms may be used to allow disclosure of behavioral health and/or substance use disorder information by listing members and friends of the individual on the form.

J. A minor may not complete form MDHHS-5515 and consent to the sharing of information without parental consent under Michigan law unless emancipated. MCL722.1-722.6.

K. Persons served or their guardians have the right to revoke their consent through verbal or written means at any time.

L. Persons served or their guardians must renew the forms MDHHS-5515 or Coordination of Care annually.

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PROCEDURES:

1. LCCMH ensures an initial screening of the persons needs is completed within 90 days of the enrollment date for new person served, and document if attempts to contact the person served are unsuccessful (42 CFR. 438.208)

2. The primary case holder identifies the primary care physician (PCP) of the person served at intake.

3. Persons served who do not have a primary care physician are provided:
    a. A service goal to obtain a primary care provider
    b. A risk vs. choice goal to educate the person served about health risks associated with their behavioral health condition and the advantages of having a primary care physician

4. The primary case holder obtains the signatures at the time of service for consent to coordinate care.

5. The primary case holder ensures the consent is completed correctly, copied, given to the appropriate parties. The originals are electronically signed or signed and scanned into the electronic health record.

6. Primary case holders assist persons served with scheduling appointments with the PCP and case managers may accompany persons served to their appointment with a primary care physician when needed.

7. At the time of the psychiatric evaluation, if the person served is recently discharged from the hospital, a physical is obtained and reviewed by the agency prescriber. The agency nurse completes a Wellness Check, documented in the Nursing Progress note at the time of the psychiatric evaluation and at medication reviews. Results found outside of accepted parameters are shared with the person served (guardian and/or parent if applicable), the primary case holder, the primary care physician, and the treating prescriber.

8. LCCMH notifies the primary care physician on record whenever a person is prescribed psychotropic medication, when there is a change in psychotropic

medication, or when a person is admitted to a psychiatric inpatient unit. If other medical concerns arise throughout treatment, the physician is contacted and efforts made to coordinate care.

9. Agency nurses shall monitor blood work ordered by agency prescribers. The nurse and prescriber review the results of the requested blood work. If there are any abnormal findings not related to the medications prescribed by the prescriber or are indicative of a medical problem, the primary care physician is made aware of the findings, generally by the agency nurse who then does any follow-up on coordination of care needed or directed by the physician and/or LCCMH prescriber.

10. LCCMH participates in monthly joint meetings with the MHP's and the PIHP for coordination of care.

11. Case holders share clinical information, as appropriate to those identified in the plan of service, to facilitate care and avoid duplication of services.

DEFINITIONS:

Coordination of Care: A set of activities designed to ensure needed, appropriate and cost-effective care for persons served. As a component of overall case management, care coordination activities focus on ensuring timely information, communication, and collaboration across a care team and between responsible services providers. Major priorities of coordination of care in the context of case management include:

- Outreach and contacts/communication to support engagement of the person served
- Conduct screening, record review and documentation as part of the evaluation and assessment
- Tracking and facilitating follow-up on lab tests and referrals
- Care planning
- Managing transitions of care activities to support continuity of care
- Address social supports and make linkages to services
- Monitoring, reporting and documentation

REFERENCES:

Michigan Department of Health and Human Services Consent to Exchange Health Information Form 5515.

42 CFR. 438.208 Coordination and Continuity of Care

45 CFR Part 160 Subparts A and E

45 CFR Part 164, Subparts A and E

BS:lr

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This policy supersedes
#05/09012 dated 05/28/2009.
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