NORTHCARE NETWORK

POLICY TITLE: Coordination and Integrated Care and Treatment	**CATEGORY:** Network Management	
EFFECTIVE DATE: 2/12/20	**BOARD APPROVAL DATE:** 2/12/20	
REVIEW DATE: 12/5/23	**REVISION(S) TO POLICY STATEMENT:** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☒ **Yes** ☐ **No**
RESPONSIBLE PARTY: Clinical Practices Coordinator/SUD Clinical Director	**CEO APPROVAL DATE:** 1/4/24 Megan Rooney, CEO	

APPLIES TO

NorthCare Network Personnel
Network Providers

POLICY

NorthCare Network requires that all persons served by network providers receive coordinated care across all systems of care the person utilizes. Network providers must coordinate an individual's care with their primary care physician, specialist physicians, community services and supports, medical facilities, and with the individual's health care payer which includes NorthCare Network, Medicaid Health Plans (MHP), and the Michigan Department of Health and Human Services (MDHHS) as applicable. Coordinated care is necessary to ensure that persons served receive holistic and effective care to enhance recovery across all domains of an individual's life.

The Person-Centered Planning Process is required to identify care coordination needs. The Individual Plan of Service (IPOS) must document the goals and objectives of the consumer, incorporate physical and social domain of health goals, and outline the coordination plan to address health and safety concerns or document consumer refusal. If a person served chooses not to incorporate physical health goals, this must be documented in the individual's record.

PURPOSE

To assure that persons served receive coordinated care to maximize their opportunities for recovering (or establishing) critical life functions they wish to pursue. Coordinated care-requires assessment and coordination (a) at the system-level between NorthCare Network, the Integrated Care Organization (ICO), Medicaid Health Plan (MHP) and Network Providers; (b) at the service-level between the Integrated Care Team members, primary care physician, and associated providers; and (c) within NorthCare functional areas as necessary.

DEFINITIONS

Consent: A written agreement executed by a person served, a minor's parent, or a person served legal representative with authority to execute a consent, or for mental health records a verbal agreement of a person served that is witnessed and documented by an individual other than the individual providing treatment.

Behavioral Health Services: A general term that encompasses the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for mental and/or substance use disorders. (SAMHSA)

Care Coordination: the systematic coordination of medical/physical and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.

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

- Outreach and contacts/communication to support patient engagement,
- Conducting screening, record review and documentation as part of 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 making linkages to services addressing social determinants of health such as: housing, food, education, employment, etc., and
- Monitoring, Reporting and Documentation.

Individual*:* refers to an adult or, if the individual is under the age of 18, the child and family/guardian.

Integrated Care Organization (ICO): A Health Insuring Corporation (HIC) contracted with MDHHS (Michigan Department of Health and Human Services) and CMS (Centers for Medicare and Medicaid) to comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid Enrollees including Long Term Supports and Services as needed and desired by the enrollee. The Upper Peninsula has one ICO which is the Upper Peninsula Health Plan (UPHP).

Integrated Treatment for Co-occurring Disorders: When substance use disorder and psychiatric disorder co-exist, each disorder receives appropriately intensive diagnosis-specific treatment.

Mental Health (SAMHSA): A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Person-centered planning (PCP): is part of the process for guiding the development of the individual plan of service (IPOS). The process builds upon the individual's capacity to engage in activities to promote participation in community life and respects the individual's preferences, choices, and abilities. Person-centered planning may involve families, friends, and professionals as the individual desires or requires. If receiving services at a community mental health agency, the planning may be directed by an Independent Facilitator chosen by the consumer. If the consumer is under the age of 18, the Member CMHSP will develop the IPOS utilizing a family centered planning process. Any adult recipient of mental health services and supports may then choose to have their plan implemented through the process of Self-Determination.

Recovery: Recovery based services will reflect the basic tenets of hope, respect, empowerment, and personal responsibility. Behavioral health services will support the four key dimensions of recovery outlined by the Substance Abuse and Mental Health Service Administration (SAMHSA):

- **Health:** Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way
- **Home:** A stable and safe place to live
- **Purpose:** Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- **Community:** Relationships and social networks that provide support, friendship, love and hope

Recovery Oriented System of Care: supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life enhancing recovery and wellness for individuals, families and communities. (ROSC TSC 2010)

Trauma Informed System of Care: assumes trauma is the expectation rather than the exception among the individuals who receive services from community mental health providers and SUD providers. The culture of care includes a safe and calm environment and asks, "what happened to you?" not what is wrong with you.

Substance Use Disorder*:* A chronic disorder in which repeated use of alcohol, drugs, or both, results in adverse consequences.

REFERENCES

- MDHHS/PIHP Contract, as amended
  https://www.michigan.gov/mdhhs/doing-business/contractor
- MDHHS Policies and Practice Guidelines
  https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4900---,00.html
- Michigan Mental Health Code, PA 258
- Public Act 129 of 2014
- Public Act 559 of 2016
- Information regarding MDHHS Standard Consent Form can be found at:
  http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_58005-343686--,00.html
- SAMHSA Coordination of Care Guideline
- Applicable NorthCare Network Policies
- NorthCare Coordination of Co-occurring Services Procedure.

HISTORY

Previously part of Coordination Communication Consent to Share Information Policy, Treatment Planning for Integrated Healthcare Policy
NEW POLICY: 2/12/20
REVISION DATE: 12/15/20, 12/6/21, 10/21/22, 2/21/23, 12/5/23
REVIEW DATE: 12/15/20, 12/6/21, 10/21/22, 2/21/23. 12/5/23
CEO APPROVAL DATE: 1/5/21, 12/6/21, 11/1/22, 6/5/23, 1/4/24
BOARD APPROVAL DATE: 2/12/20

PROCEDURES

TREATMENT PLANNING

NorthCare Network adopts in entirety the current Michigan Department of Health and Human Services (MDHHS) policies and guidelines to assure the spirit and form of the implementation of meaningful person-centered planning which leads to effective treatment and coordination:

- Person-Centered Planning Practice Guideline
- Self-Directed Services Technical Requirement
- Family Driven and Youth Guided Policy and Practice Guideline
- MDHHS PIHP-MHP Model Agreement

The Member CMHSPs will be responsible for implementing treatment planning according to the MDHHS guidelines in a recovery-oriented way. Each Member CMHSP is responsible to ensure the clinical documentation reflects person centered planning through their internal chart review processes. Documentation in the individual's health record must include, but not be limited to, the following:

- Name and contact information for the primary care physician, other health care providers, community supports and resources, and any individual health care and social supports.
- A plan for how care will be coordinated must be documented in the Individual Plan of Service (IPOS) Treatment Plan.
- The provider will document any refusal by the individual to coordinate care and each attempt to address coordination of care activities as well as actual coordination of care activities.

The Member Substance Use Disorder Providers are required to complete a Biopsychosocial assessment using the ASAM Continuum assessment tool for all adults admitted to their program/agency. For individuals under the age of 18 the GAIN assessment tool is used for biopsychosocial assessment. Treatment planning will include services identified as appropriate based on the assessment. The SUD provider is required to obtain a release of information including all community resources and medical providers involved in a person's care identified during treatment planning to facilitate coordination of care. If the individual refuses coordinated care, this must be documented in the client record.

COORDINATING CARE

NorthCare Network maintains coordination agreements with the regional Medicaid Health Plan, Upper Peninsula Health Plan (UPHP), to facilitate coordination of care. NorthCare Network monitors the Network Providers for their implementation of the key requirements outlined in policy as well as requirements in the NorthCare Network site review protocols. NorthCare Network may assist individuals and Member CMHSPs by providing a choice of Independent Facilitators for IPOS creation when requested by a consumer.

Coordination of care is required for all individuals receiving specialty services and supports.

Coordination with Medicaid Health Plan

- NorthCare Network will identify priority need populations/individuals enrolled in UPHP and receiving PIHP services at least monthly utilizing claims and encounter data.

- As an established Qualified Data Sharing Organization, NorthCare Network will receive information from electronic sources to support care coordination as permitted through Use Case Agreements with those electronic sources.
- NorthCare Network and/or Network Providers will inform the Medicaid Health Plan when an individual receiving services has reported any of the following:
    - they do not have a Primary Care Physician
    - they have not had a basic health screening within the last 12 months; or
    - they have not visited their Primary Care Physician for more than 12 months.
- NorthCare Network will also inform UPHP within 5 business days when a mutual member experiences a psychiatric inpatient admission.

Coordination with the Primary and Other Health Care Providers

- Providers ask for the person served primary care physician's name at the time of intake and document this in the clinical record.
- If no primary care physician is identified, the primary clinician shall make efforts to help the individual obtain one, and document accordingly.
- Persons served are encouraged to include their primary care physician, and any other health care providers, community resources, and social supports they deem appropriate, in their person-centered planning process.
- When specialty services or supports are no longer medically necessary, as determined through the person-centered planning process, and with proper consent/authorization from the person served or their legal representative, a copy of the discharge summary may be provided to the individual's primary care physician and/or medical health plan.