NORTHCARE NETWORK

POLICY TITLE: Community Integration Policy	**CATEGORY:** Utilization Management	
EFFECTIVE DATE: 12/4/13	**BOARD APPROVAL DATE:** 12/4/13	
REVIEWED DATE: 9/6/22	**REVISION(S) TO POLICY STATEMENT:** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☐ **Yes** ☒ **No**
RESPONSIBLE PARTY: Senior Clinical Director	**CEO APPROVAL DATE:** 9/6/22 Dr. Tim Kangas, CEO	

APPLIES TO

NorthCare Network Personnel
Member CMHSPs
SUD Provider

POLICY

It is the policy of NorthCare Network that Member CMHSPs (Community Mental Health Service Providers) and providers of SUD (Substance Use Disorder) services have in place mechanisms that assure community integration activities are conducted in compliance with the Title II integration mandate of the Americans with Disabilities Act (ADA).

PURPOSE

To ensure individuals with disabilities, have the opportunity to live, work and receive services in the most integrated settings and are given informed choice as to alternative living arrangements available to them.

DEFINITIONS

1. ***Aftercare Plan/Transition Plan:*** For purposes of this policy is a clinical document that addresses a consumer's treatment and support needs following discharge from an institutional setting. An aftercare plan, also referred to as a Transition Plan is the culmination of the Discharge Planning process.

2. ***Center***: A facility operated by the Michigan Department of Health and Human Services (MDHHS) to admit individuals with developmental disabilities and provide habilitation and treatment services.

3. ***Child-care Institution***: A nonprofit private child-care institution, or a public child-care institution that accommodates no more than twenty-five children, which is licensed by the State in which it is situated, or has been approved by the agency of the State responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing. The term does not include detention

facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.

4. ***Community Integration:*** The opportunity to live in the community and be valued for one's uniqueness and abilities in the same manner as the typical community citizen. Community integration commonly encompasses the areas of employment or other productive/meaningful activities, community living, and participation in social-community activities.

5. ***Community Reintegration:*** The process of transitioning from a setting in which an individual is segregated from mainstream community living and participation to a setting where the individual controls and directs their meaningful activities of daily living and community participation.

6. ***Community Reintegration Activities:*** Activities and tasks performed by community provider staff in collaboration with other community-based providers and facility personnel and designed to assist consumers living in institutional settings to prepare for, establish, and maintain successful community-based living following discharge from the facility/institution.

7. ***Correctional Facility:*** A prison, jail, reformatory, work farm, detention center, or any similar facility maintained by either federal, state, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders, or suspected offenders.

8. ***Dependent Living Setting:*** means all of the following: (a) An adult foster care facility; (b) A nursing home licensed under article 17 of the public health code, 1978 PA 368, MCL 333.20101 to 333.22260; and (c) A home for the aged licensed under article 17 of the public health code, 1978 PA 368, MCL 333.20101 to 333.22260.

9. ***Discharge Planning:*** The process to prepare a person, who has been admitted to a psychiatric hospital, nursing facility, or other institution for community integration. Discharge planning begins at the time of admission, is updated periodically throughout the episode of care, and results in development of an Aftercare Plan.

10. ***Facility:*** A residential facility for the care or treatment of individuals with serious mental illness, serious emotional disturbance, or developmental disability that is either a state facility or a licensed facility.

11. ***Hospital:*** For purposes of this policy means an inpatient program operated by the MDHHS for the treatment of individuals with serious mental illness or serious emotional disturbance or a psychiatric hospital or psychiatric unit licensed under section 137 of the Michigan Mental Health Code (MHC).

12. ***Institution:*** An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

13. ***Institution for Mental Diseases (IMD):*** A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.

14. ***Institutional Settings:*** For purposes of this policy, includes: state operated facilities, nursing facilities, rehabilitation centers, child caring institutions, residential treatment centers, and correctional facilities.

15. ***Long-Term Care/Nursing Facility:*** A facility that primarily provides to resident's skilled nursing care and related services for the rehabilitation of injured, disabled or sick persons, or on a regular basis, health related care services above the level of custodial care to other than individuals with developmental disabilities.

16. ***Psychiatric Residential Treatment Facility:*** A psychiatric facility that is not a hospital and is accredited by an organization with standards that are recognized by the state in which it is located and provides inpatient psychiatric services for individuals under the age of 22 and meets the requirements set forth in section 441.151-441.182 of title 42 of the code of federal regulations.

17. ***Rehabilitation Facility:*** An inpatient facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetic services.

18. ***Residential Treatment Center:*** A facility which houses youth with significant psychiatric or substance abuse problems who have proven to be too ill or have such significant behavioral challenges that they cannot be housed in foster care, day treatment programs, and other non-secure environments but who do not yet merit commitment to a psychiatric hospital or secure correctional facility.

19. ***State Facility:*** A center or a hospital operated by the MDHHS.

20. ***Treatment Team:*** Consumer, institutional and Member CMHSP and SUD providers, family, guardian(s), and other supporting persons as identified by the consumer.

REFERENCES

- Americans with Disabilities Act of 1990
- 42CFR Part 441
- 2013 Application for Participation (AFP) For Specialty Prepaid Inpatient Health Plans
- Michigan Mental Health Code

- MDHHS/PIHP Contract
- Michigan Medicaid Provider Manual
- NorthCare Network Access Policy
- NorthCare Network Utilization Management Plan
- NorthCare Network Level of Care Placement Protocols
- NorthCare Network Level of Care Service Packages
- Block Grant Agreement with MDHHS for Substance Use Disorder Services
- Michigan's Statewide Transition Plan for Home and Community-Based Services

HISTORY

REVISION DATE: 5/14/14, 4/1/16, 12/21/18, 5/28/21
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PROCEDURES

A. Clinical Practice Standards

1. Core Values
    a. Individuals with disabilities should have the opportunity to live, work, and receive services in integrated settings. They should have the opportunity to be engaged in the community with family and friends.
    b. Individuals with disabilities should have control over their own day, including which job, educational, or leisure activities they pursue.
    c. Individuals with disabilities should have control over how and where they live and with whom.

2. General Principles
    a. Community integration activities are person-centered services designed to prepare consumers for and support the establishment of successful community living.
    b. Community integration activities must:
        i. be guided by person centered planning processes that honor consumer preference and choice; and
        ii. assure services, supports, and programs are provided in the most integrated setting appropriate to the needs of the consumer; and
        iii. encourage and support community participation that allows CMHSP consumers to interact with persons who are not CMHSP consumers to the fullest extent possible, participate in integrated settings of their choosing, and do so in a manner that reflects their preferences; and

iv. be driven by consumer needs rather than the availability of resources.

c. For consumers who are being reintegrated into the community from institutional settings:
   i. Consumers must be deemed clinically suitable for discharge from the facility/institution and must not object to being released.
   ii. Activities must be conducted in partnership with institutional/facility personnel and those with primary responsibility for supporting community reintegration

B. Components of Community Reintegration Activities for consumers discharged from institutional settings

1. Transition Planning Team. The Transition Planning Team is established once the consumer is identified as "discharge ready". The composition will vary but at a minimum will be comprised of institutional/facility personnel, the consumer, and/or person acting on their behalf, and the designated Member CMHSP/SUD representative. The Member CMHSP/SUD representative is responsible for assuring the community reintegration process meets the standards set forth in this policy. The team participates in the discharge planning evaluation process and development of a Transition/Aftercare Plan to provide supports and services that enable the consumer to live successfully in the community.

2. Discharge Planning/Evaluation Process. The discharge planning evaluation assesses the consumer's aftercare needs following discharge from the facility. Discharge planning is a collaborative effort involving the consumer, and/or person acting on their behalf, facility personnel and the Member CMHSP/SUD representative. The Member CMHSP/SUD representative is responsible for documenting the findings from the Discharge Planning Evaluation in the Biopsychosocial (BPS) Assessment form in ELMER. The evaluation identifies continuing care needs; appropriate aftercare services and includes an assessment of:

   a. Consumer's bio psychosocial needs; housing, vocational, financial;
   b. The consumers discharge/aftercare environment;
   c. Information obtained from the consumer/family including strengths and needs
   d. The consumer/family understanding of the consumer's discharge needs and capacity for self-care.
   e. eligibility for entitlements, benefits, other resources to be applied for pre-discharge
   f. Anticipated problems after discharge, barriers to success, unresolved issues

g. How services will be accessed and coordinated

3. Aftercare/Transition Plan. The Transition/Aftercare plan is the culmination of the planning meeting which involves an exploration of the consumer's preferences, goals, and needs identified during the discharge planning evaluation process. The meeting incorporates findings from the discharge planning process into an aftercare plan that establishes meaningful goals and measurable objectives that directs the supports and services to be provided through the Member CMHSP/SUD provider system and other community-based organizations to support successful community re-integration. The Aftercare/Transition Plan is documented on the Preliminary Individual Plan of Service (IPOS) form in ELMER. The aftercare/transition plan:

    a. Identification of needed services and supports.
    b. The dates services and supports are expected to commence.
    c. Identification of consumer skills needed and tasks to be completed to transition.
    d. Persons responsible for each service/task.

C. Community Reintegration Process

The community reintegration process begins when the consumer and treatment team determine that the consumer is ready for discharge from the facility/institution. Although discharge planning begins on the day of admission, it is an ongoing process designed to identify and plan for the consumer's aftercare needs, and includes completing essential tasks prior to discharge. All community reintegration activities must be documented in the consumer's medical record which requires the consumer have an active admission in the ELMER system.

1. For consumers with an active NorthCare Network enrollment at the time of admission, the Member CMHSP primary case holder is involved in discharge planning, aftercare development, and is responsible for overseeing the community reintegration process. The following procedures apply when transitioning consumers from the specified institutional settings:

    a. State Facility/Long term Care/Nursing Facility. This includes consumers being released from facilities operated by the MDHHS (center or hospital) and privately operated long term care/Nursing facilities.
        i. The facility treatment team identifies the consumer as ready for discharge and notifies the Member CMHSP primary case holder to activate the community reintegration plan.
        ii. The Member CMHSP primary case holder requests a referral packet from the facility:
            - Assessments: Psychiatric; Social Work; Physical Health; Nursing
            - List of current medications
            - Medical consultation reports

- Other documentation as provided

iii. When received, the Member CMHSP primary case holder will review and initial the materials and submit them to medical records for scanning and upload into ELMER.

iv. The Member CMHSP primary case holder will open a current program assignment, and secure authorizations to support initial reintegration activities (targeted case management, supports coordination services, additional assessments/evaluations as deemed medically necessary).

v. The Member CMHSP primary case holder will meet (by phone or in person) with the consumer and treatment team before release from the facility to collect any additional information necessary to update the consumer's bio psychosocial (BPS) assessment.

2. For consumers without an active admission at the onset of discharge planning and individuals not previously enrolled as NorthCare Network consumers, the following procedures apply when transitioning consumers from the specified institutional settings:

    a. Member CMHSP/SUD providers will refer and link consumers/applicants and/or facility personnel to the NorthCare Network Access unit to determine eligibility before initiating reintegration activities.
    b. The NorthCare Network Access Policy and Procedures will apply in these cases.
    c. For those consumers/applicants who have been determined to meet the eligibility criteria for specialty Mental Health Services by the NorthCare Network Access screening unit, the consumer, facility representative(s), and the Member CMHSP/SUD representative (primary case holder or designee) participate in the discharge planning process.