Community Mental Health Partnership of Southeast Michigan	***Policy*** ***Continuity of Care***
Department: Clinical Performance Team **Author:** Matt Vergith	**Local Policy Number (if used)**
Regional Operations Committee Approval Date 3/16/2017	**Implementation Date 4/1/2017**

I. PURPOSE

Ensure consumers receive care that is appropriate to their specific needs and is continuous and coordinated among agency departments and programs and between agency departments or programs and outside providers.

II. REVISION HISTORY

DATE	REV. NO.	MODIFICATION
11/21/2006	1	
10/2/2013	2	Revised to reflect the new regional entity effective January 1, 2014.
4/1/2017	3	Revised per scheduled review

III. APPLICATION

This policy applies to the Community Mental Health Service Programs (CMHSP), and all network providers within the Community Mental Health Partnership of Southeast Michigan (CMHPSM).

IV. POLICY

It is the policy of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) that consumers will receive continuity of services and care throughout an episode of care, between levels of care, and across an integrated array of services. Additionally, with written consent from consumers, care will be coordinated with other organizations and providers.

V. DEFINITIONS

Community Mental Health Partnership of Southeast Michigan (CMHPSM):
The Prepaid Inpatient Health Plan (Regional Entity) responsible for the oversight entity of Medicaid services for Mental Health and Substance Use Disorder Services.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports.

Community Mental Health Services Program (CMHSP): Community mental health services program means a program operated under chapter 2 of the Michigan Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Providers: Providers provide Mental Health and/or Substance Abuse Services as a CMHSP or under contract with the CMHSPM or any affiliated CMHSP, as an organization or an individual (LIP).

VI. STANDARDS

A. Providers shall ensure that care management is a dynamic process incorporated in systemic, administrative, and clinical functions

B. The system of care ensures access to the appropriate level of care, service providers, programs and services to meet consumers' assessed needs.

C. Organizational barriers to care delivery are reduced and the individual receiving services is viewed as a consumer of the organization not as belonging to separate program elements.

D. Fragmentation of service delivery will be reduced through the development of highly individualized person centered plans and family centered plans that holistically surround a consumer in such a way that the coordination of care enhances the effectiveness of the plan.

E. Staff shall be trained in the principles and practices of care coordination and management.

F. Provider services will be coordinated with services a consumer may receive from other managed care organizations or PIHPs.

G. Results of assessments will be shared with other managed care organizations or PIHPs providing services to jointly served consumers so that services are not duplicated.

H. Plans of care will identify resources that consumers have available, resources available in the community at large, and resources that are needed that will be provided by a CMHSP or network provider.

I. Integrated plans of care will be developed which outline needed services, how services will be provided, who is responsible for providing identified supports and services, and how ongoing coordination of services and supports will occur.

J. Referral, transfer, or discharge of consumers to other levels of care, health professionals, or settings are based on the consumer's assessed needs and the agency's capability to provide needed care.

K. Provider clinical staff is responsible for ensuring continuity and coordination of care.

L. Provider clinical staff will function as advocates for consumers to ensure entitlements, services and supports needed by consumers are available.

M. At times of transitions for consumers such as between program service components, between service providers, to community service providers, and at termination of services, the current service provider is responsible to ensure that the new services have successfully been initiated before withdrawing from the consumer's care.

N. Discharge planning will ensure that all necessary post treatment referrals for services external to the agency have been considered and arrangements for these referrals completed. As desired by the consumer and as appropriate, aftercare plans will be developed.

O. When consumers terminate services according to an agreed upon discharge plan, aftercare services will be provided as described in the discharge plan.

P. At the time of discharge, coordination with the consumer's primary healthcare provider will include a review of medications currently prescribed.

Q. Ethical and professional responsibilities will be met before a consumer is discharged from care if an external entity has denied care, service, or payment.

VII. EXHIBITS

None

VIII. REFERENCES

Reference:	**Check if applies:**	**Standard Numbers:**
42 CFR Parts 400 et al. (Balanced Budget Act)	X	438.208
Michigan Mental Health Code Act 258 of 1974	X	
The Joint Commission- Behavioral Health Standards, 2015	X	CTS.03.01.01, CTS.03.01.07, CTS.04.01.01, CTS.06.01.01, CTS.06.01.03, CTS.06.02.01, CTS.06.02.03, CTS.06.02.05
MDHHS Medicaid Contract	X	6.4.4?
Discharge Planning Policies	X	
CMHPSM Consumer Appeals Policy	X	
CMHPSM Customer Services Policy	X	
CMHPSM Coordination of Integrated Healthcare Policy	X	

CMHPSM Person Centered Planning Policy	X	