



Care Coordination at West Michigan Community Mental Health

Lisa Williams, Chief Executive Officer

Keeli Sholtey, Director of Children and Family Services

Nicole Whitman, Director of Health Home Coordination



Care Coordination Internally

- Internal Referral Process in our EMR
 - Records the referral cleanly in the consumer record
 - Allows for identified coordination between teams
 - Allows for data tracking and data driven quality outcome measures
 - Can be utilized across many internal services
 - Psychiatric Services
 - Individual Therapy
 - Community Employment Living Skills Services
 - Peer Support Services
 - Psychological Testing Services
 - Any other services outside of the primary case holder.

Sample of Internal Referral

Type of Referral

- ACT
- WMCMH Internal Autism Testing Referral
- CELSS
- DBT
- Health Screening
- Homebased
- Parent Support Partner
- Peer Recovery Coach
- Peer Support Services
- Psychiatric Evaluation for Medications
- Psychological Testing Evaluation
- SIMPLE
- Smoking Cessation
- Suboxone
- Individual Therapy
- Wraparound
- Youth Peer Support

Clinical Services

- [IPOS - Individual Plan of Service](#)
- [Progress Notes](#)
- [Crisis Plans](#)
- [Internal Referrals](#)
- [External Referrals](#)
- [Long Term Health Care Plans](#)
- [Support/Safety Plans](#)
- [Veteran Navigator Data Collection Forms](#)
- [Health & Safety Warnings](#)
- [Diagnosis Update Forms](#)
- [Death Reports](#)
- [Scanned Clinical Services Documents](#)

NO DISCUSSIONS EXIST

5. Internal Referral Form: Disposition

Check if Referring Staff is the same as Supervisor of Referring Staff (supervisor is making the referral)

Disposition of Referring Staff Supervisor

Approved Denied

Comments

Disposition of Receiving Supervisor

Approved Denied/Not Qualified Redirected **if other, please explain**
 Re-Evaluate Assigned Other


Referred to Staff New Assigned Staff will be Primary Caseholder

Yes No Staff Assignment Effective Date

Comments



Care Coordination Externally

- External Referral Process in our EMR
 - Records the referral cleanly in the consumer record
 - Allows for identified coordination between teams
 - Allows for data tracking and data driven quality outcome measures
 - Can be utilized across many external services
 - Primary Care Physician
 - Specialist
 - Transportation
 - Housing
 - Courts
 - Schools
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EMR Sample of External Referral

Referral Information

Referral Date: 9/5/2023

Referral Purpose: Medical Needs - Other

Follow-Up Required?: Yes No

Referring to: Community Resource Individual Provider

Referral Recipient Information: [lookup](#)

Name: Manatee Family Care-Munson Health

Address: 1391 E Parkdale Ave, Manistee MI 49665

Specialty: General Practice

Requested Services:
establish PCP

Referring Staff: [lookup](#) | [clear](#)
2214 Nicole Whitman

Automatically generate a Transition / Summary of Care CCD upon signature and place it on the release queue

Diagnosis

- (Active) Non-Axial-1: F06.4 - Anxiety disorder due to another medical condition
- (Active) Non-Axial-2: F32.0 - Major depressive disorder, Single episode, Mild
- (Active) Non-Axial-3: F43.10 - Posttraumatic stress disorder
- (Active) Non-Axial-4: F40.10 - Social anxiety disorder (social phobia)
- (Active) Non-Axial-5: F06.8 - Obsessive-compulsive and related disorder due to another medical condition
- (Active) Non-Axial-6: Z56.1 - Change of job

Referral Information

Referral Date: 09/05/2023

Referral Purpose: Employment

Follow-Up Required?: Yes No

Referring to: Community Resource Individual Provider

Referral Recipient Information: [lookup](#)

Name: Michigan Works

Address: 6262 S M-37, Baldwin MI 4930

Specialty:

Requested Services:
establish PCP

Referring Staff: [lookup](#) | [clear](#)
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Automatically generate a Transition / Summary of Care CCD upon signature and place it on the release queue

Instructions:

- Once this document has been signed, it will be copied and sent to all parties listed below. For all documents that are to be sent outside of your agency, please be sure you have a valid Authorization for Release of Information before adding this copy request.
- To notify staff of document completion, click on **Send to Staff**.
- To share a copy of this document with the Client via the patient portal, click on **Send to Patient Portal**.
- To send a copy of this document outside of your agency, click on **Send External Copy**.



Care Coordination Agreements

- Entering into meaningful and simple care coordination agreements with community partner
 - Example COVE (Communities Overcoming Violent Encounters)
 - The WMCMH/COVE Care Coordination Agreement Partnership
 - What's in the Care Coordination Agreement?
 - What does COVE do? How many of COVE's clients are also CMH consumers?
 - What coordination can CMH do to be helpful for COVE Staff and the client?
 - What coordination can COVE do to be helpful for CMH Staff and the client?

CARE COORDINATION AGREEMENT BETWEEN WEST MICHIGAN COMMUNITY MENTAL HEALTH (WCMCHS) AND COVE (Communities Overcoming Violent Encounters)

This Care Coordination Agreement serves to confirm the mutual understandings of West Michigan Community Mental Health System (WCMCHS) and COVE. The purpose of this Agreement is to set forth the parties' understanding regarding Care Coordination for common individuals served by both organizations.


WCMCHS agrees to:

- Refer individuals that WCMCHS serves to COVE when COVE's services are deemed potentially appropriate/beneficial.
- Respond per established timeframes and procedures to requests from COVE for crisis/mobile crisis services for their clients.
- Receive and serve individuals referred by COVE for WCMCHS Services, regardless of their ability to pay.
- With a valid release of information, WCMCHS to provide relevant information to COVE including but not limited to: treatment plans, safety plans, medications prescribed, scheduled appointments, discharges from services, etc. This information may support COVE service provision and their ability to coordinate and support the individual's participation in other beneficial services.

COVE agrees to:

- Refer individuals COVE serves to WCMCHS when WCMCHS services are deemed potentially appropriate/beneficial.
- Receive and serve individuals referred made by WCMCHS for needed COVE Services, regardless of their ability to pay.
- With a valid release of information, provide relevant information to WCMCHS including but not limited to: individualized support plans, safety plans, service logs, case summaries, scheduled appointments, etc. This information may support WCMCHS' service provision and their ability to coordinate and support the individual's participation in other beneficial services.

Both WCMCHS and COVE agree to:

- Meet together, when mutually determined beneficial, to educate on available services, establish, improve, and/or train on relevant procedures, and/or find solutions to barriers to good communication and quality care coordination efforts.
 - Share relevant clinical information, written and/or verbally, for the purpose of care coordination and treatment planning as determined beneficial to the individual's services/care and in full compliance federal or state law governing the privacy and confidentiality of the individually identifiable health information.
 - Ensure that nothing in the arrangement will, or is intended to, impair the exercise of
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Additional Care Coordination Practices



- Representation at community meetings between community partners
 - DDHS/Schools/Juvenile Probation (Monthly Meeting in Each County for coordination)
 - SUD Prevention Collaborative in Each County
 - Inter Systems Framework (School/Health Department Grant)
- Using HIT (Health Information Technology) to guide practice/follow up
 - VIPR
 - CC360
- Embedding Care Coordination principles through efficient and effective communication, adaptive skills training, and supervision/mentoring.
 - Integrated care coordination meetings monthly between med services/teams
 - Case review/case consult in several internal meetings, with our clinical oversight committee, and regional partners
 - Ongoing training/supervision discussions
 - PDCA of care coordination work and processes.
 - Strategic goal planning surrounding embedded care coordination outcomes.

Contact Information

www.wmcmhs.org

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Lake County

231-745-4659

1090 N. Michigan Avenue
Baldwin, MI 49304

[GET DIRECTIONS](#)



Oceana County

231-873-2108

105 Lincoln Street
Hart, MI 49420

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Mason County

231-845-6294

920 Diana Street
Ludington, MI 49431

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