MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Guidelines for Coordination of Care Documentation		
Last Updated: 03/08/2022	**Owner:** MCCMH Nursing Administrator	**Pages:** 2

I. PURPOSE:

The purpose of these established guidelines is to describe the role of Nursing in the development of Coordination of Care documentation.

II. DEFINITIONS:

Care Coordination:
A process used by a person or team to assist persons served in accessing services, as well as social, educational, and other support services. It is characterized by advocacy, communication and resource management to promote quality, cost effectiveness and positive outcomes.

Coordination of Care:
The Document completed to facilitate Care Coordination; in FOCUS this is located under the Medical Section.

III. RECOMMENDED BEST PRACTICES:

A. All persons served should be linked to insurance, a primary care provider and specialists as referred by physicians. Assistance in the linking process shall be provided.

B. Coordination of care (COC) documentation should be completed:

1. If level of care changes.

2. After inpatient hospitalization occurs.

3. Psychiatrist orders a change in psychiatric medications.

4. Change in primary case holder or provider.

5. If determined by a psychiatrist, physician assistant, nurse practitioner or nurse that COC is necessary to reduce potential harm to the individual by sharing vital information (Examples: share concerns, update allergies, inform other providers of side effects and symptoms and prevent multi-drug interactions).

6. When a Specialized Nursing Assessment (SNA) is completed, COC should be done to obtain current medications and additional health information. Any information obtained during the SNA will be shared with treating physicians.

7. If none of the above apply, at least annually.

C. All coordination of care documentation must be sent with current release of information documentation so information can be returned.

D. When coordination of care documentation is returned to the primary case holder or the nurse that initiated the COC, the return will be communicated with the treatment team.

E. As part of an appropriate coordination of care, medication reconciliation should be completed as soon as the coordination of care document is returned to the agency by a nurse or designee of the Licensed Prescriber. The updated medication lists in the EMR chart may auto-populate into: Specialized Nursing Assessment document, Psychiatric Evaluation document, and the "Face Sheet" located in the Consumer Information Section of EMR.

F. The RN may also need to remind Licensed Prescribers of any allergy or multi-drug interaction in the case the EMR does not flag a potential concern.

IV. TRAINING:

None.

V. MONITORING:

None.

VI. EXHIBITS:

None.

VII. REFERENCES:

MCCMH Policy 2-042, "Service Referrals/Recommendations, Coordination of Care, and Follow-Up / Advance Directive"

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	02/21/2022	Development of Guidelines	Jeffrey Clark
2	02/14/2023	Review	Jeffrey Clark