Chapter: **CLINICAL PRACTICE**

Title: **INTEGRATION OF BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES**

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Chief Executive Officer Date

I. ABSTRACT

This policy establishes the position statement of the Macomb County Community Mental Health Board (MCCMH) regarding its adherence to and compliance with the legal requirements for the public behavioral health Prepaid Inpatient Health Plan (PIHP). This policy establishes the standards and procedures for addressing the implementation of joint care management of physical and mental health services provided by the Macomb County Community Mental Health Board (MCCMH Board) as a Prepaid Inpatient Health Plan (PIHP) with its regional Medicaid Health Plans (MHP) and Integrated Care Organizations (ICO). The implementation of joint care management is intended to improve the health status and experience of care for Medicaid enrollees, and reduce unnecessary costs.

II. APPLICATION

This policy shall apply to the administrative offices, directly-operated and contract network providers of the MCCMH Board, workforce members, including but not limited to, administrative and directly-operated network provider employees, independent contractors, and volunteers; and MCCMH board contracted network provider workforce members, including but not limited to, employees, independent contractors, and volunteers.

III. POLICY

A. It is the policy of the MCCMH Board that:
Macomb County Community Mental Health (MCCMH), as Region 9 PIHP, provides co-located and coordinated integrated behavioral and primary healthcare services for Medicaid and Medicare beneficiaries throughout the behavioral health provider network.

It is further the policy of MCCMH to work cooperatively with Medicaid Health Plans (MHP) and Integrated Care Organizations (ICO) to jointly identify priority need populations for purposes of care coordination. In support of this policy, MCCMH shall secure appropriate consents, share necessary electronic data, and conduct routine care coordination activities. The fully executed consent of information will determine the information that is approved to be shared internally and externally for the coordination of integrated care services. All persons served have the right to decline care coordination services and to be provided with referrals to meet their medical needs.

IV. DEFINITIONS

A. Admission, Discharge, Transfer Record (ADT)
A MiHIN Use Case that assists organizations in leveraging existing or establishing new capabilities to share transitions of care information by sending and/or receiving hospital Admission, Discharge, and Transfer events to those organizations that desire to be notified of such events.

B. Active Care Relationship Service (ACRS)
A MiHIN Use Case that contains information about organizations and health professionals who use MiHIN and have an existing relationship with a person served.

C. Care Connect 360 (CC360)
A web portal to support care coordination of Medicaid Enrollees' physical and behavioral health conditions. The portal provides PIHPs and MHPs access to Medicaid claims information in the MDHHS Data Warehouse related to both physical and behavioral health care.

D. Federally Qualified Healthcare Center (FQHC)
An FQHC is a community-based organization that provides comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status

E. Generalized Anxiety Disorder 7-item (GAD-7)
A self-reported questionnaire for screening and severity measuring of generalized anxiety disorder (GAD). GAD-7 has seven items, which measure severity of various signs of GAD according to reported response categories with assigned points (see below). Assessment is indicated by the total score, which made up by adding together the scores for the scale all seven items.

F. Health Information Network (HIN)
A Health Information Network is a set of standards, services, legal agreements, and governance that enable the internet to be used for a secure and meaningful exchange of health information to improve health care.

G. Health Information Technology (HIT)
Information technology to support health information management across computerized systems and the secure exchange of health information between persons served, providers, payers, and quality monitors.

H. Integrated Care Organization (ICO)
Insurance based or provider-based health organization contracted to and accountable for providing integrated care to people eligible for both Medicaid and Medicare, enrolled in MI Health Link.

I. Integrated Care Team (ICT)
A team of professionals including, but not limited to Primary Care Physician, Psychiatrist, Nurse Practitioner, Care Coordinator, Therapist, and Case Manager who provide and coordinate behavioral health and physical health services to meet the needs of the person served as identified in the primary care plan.

J. Information Exchange
1. Send and receive information from multiple electronic sources, including CareConnect 360 (CC360) export lists and other affordable health information exchanges that are pertinent to the coordination plan process
2. Accept CC360 extracts that are generated at monthly intervals to update or refresh information about shared members and coordination planning.

K. Medicaid Health Plan (MHP)
A managed health care organization under contract with the State of Michigan to enroll primary care providers and specialty providers and provide for the health care of persons served.

L. Michigan Health Information Network (MiHIN)
A Health Information Exchange (HIE) organization providing services to enable the electronic sharing of health-related information. MiHIN is the Michigan network use for sharing electronic health information statewide.

M. Modified Checklist for Autism in Toddlers, Revised with Follow-up (M-CHAT-R/F)
A two-stage parent-report screening tool to assess risk of Autism Spectrum Disorder.

N. Parents' Evaluation of Developmental Status (PEDS)
The evidence-based screen that elicits and addresses parents' concerns about children's language, motor, self-help, early academic skills, behavior and social-emotional/mental health. PEDS tells you when parents' concerns suggest problems requiring referral and which concerns are best responded to with advice or reassurance.

O. Patient Health Questionnaire (PHQ-9)
A questionnaire consisting of nine questions to measure the severity of depression in an individual.

P. Shared Member List
An MDHHS generated report identifying members assigned to a specific PIHP that have received services through a specific MHP.

Q. UNCOPE
A six-part screening instrument used to identify dependence on alcohol and or drugs.

R. Use Case
Specifications that prescribe the data content, technical, and security requirements that an organization must follow to use the specified feature of the HIE Platform.

V. STANDARDS

A. Joint Care Management

1. MCCMH provides integrated behavioral health and primary health services for persons served that have a chronic condition such as a severe and persistent mental health illness, co-occurring substance use disorder, or developmental disability and who have been determined by MCCMH to be eligible for Medicaid/Medicare services.

2. MCCMH ensures that primary health care screening, including height, weight, blood pressure, and blood glucose levels is performed on persons served who have not visited a primary care physician for more than twelve (12) months. The results of all screening information will be reviewed with the persons served.

3. MCCMH ensures that all persons served will be referred to the MHP/ICO for health services to identify the primary healthcare

provider and to receive a physical health assessment for the medical and medication history. In addition, the internal and external services/referrals for integrated care will be identified in each initial assessment performed.

B. Co-located

1. MCCMH operates a behavioral health care team in primary health care settings to enable persons served to obtain both primary care and behavioral health services.

2. MCCMH exercises reasonable efforts to assist Medicaid and Medicare enrollees in understanding the role and contact information for the MHP/ICO. MCCMH shall exercise reasonable efforts to support the Medicaid/Medicare enrollees in selecting and coordinating services with the Primary Care Practitioners (Reference MCCMH MCO Policy 2-042, "Coordination of Care," for standards and procedures related to care coordination requirements).

3. MCCMH develops one integrated treatment plan addressing both the physical and behavioral health goals and objectives based on the strengths, needs, opportunities, abilities, and preferences of the person served.

C. Care Coordination

MCCMH implements care coordination efforts with MHP/ICO organizations by conducting monthly case reviews and demonstrating that joint care plans exist for members with appropriate severity/risk that have been identified as receiving services from both entities that have consented to a joint care plan.

1. Monthly, MCCMH identifies joint members with MHP/ICO who are active and have Medicaid/Medicare. The following data elements should include the following: name, date of birth, Medicaid ID/Medicare ID number, and name of providers recently seen, medication, and diagnosis.

    a. Receive information from electronic sources such as CareConnect 360 (CC360) or Health Information Technology (HIT)/Health Information Exchange (HIE), including which reports are received at the indicated interval, including customizable extracts, and how this information is shared between the MCCMH and MHP/ICO.

b. Participants with MiHIN, including which Use Cases they are participating, Active Care Relationships are being established for shared members, Admission, Discharge, Transfer Record (ADT) messaging is being received and appropriately shared.

2. MCCMH conducts monthly meetings between the MHP to develop a care coordination plan in CC360, which the goals and objectives are documented in FOCUS on the Person-Centered Plan for all persons served receiving integrated care services.

D. Confidentiality

The release of personal health information from records of the person served shall only be made pursuant to valid release authorizations from the person served or for specific and limited purposes as established by law or administrative rules. MCCMH will comply with all confidentiality laws including the Michigan Mental Health Code, 42 C.F.R. Part 2, HIPAA, and HITECH, and adherence to MCCMH MCO Polices 6-001, 6-002, 6-003, 6-006, and 6-100.

VI. PROCEDURES

A. Co-located Internal Primary Care Services

1. MyCare Health Center provide accessible satellite primary care services at the MCCMH North location for residents and non-residents of Macomb County.

2. The Integrated Care Team (ICT) is comprised of licensed professionals such as, a Physician, Psychiatrist, Nurse Practitioner, Medical Assistant, and a Master level Therapist/Wellness Coordinator. A licensed Psychologist is available for consultation during the hours of operation.

3. Referrals to MyCare Health Center services are acquired by a Medical Assistant, clinical team member, or an individual who can access services by walk-in during office hours.

4. All individuals seeking services are required to provide the following documentation to assist with the primary care screening process:
   a. Medical history and diagnosis
   b. Behavioral health history and diagnosis
   c. List of all prescribed current medications, name of prescriber, and last date seen
   d. List of all known allergies

5. Medical Assistant completes the new patient paperwork and the following three behavioral health screenings: PHQ-9, GAD-7, and

UNCOPE based on the specific needs and presenting conditions of the person served. An appointment with the Physician is then scheduled for the individual.

6. Wellness/Care Coordinator reviews and scores the PHQ-9, GAD-7, and UNCOPE to determine if behavioral health services are needed for the individual served.

7. Wellness/Care Coordinator consults and collaborates with an existing medical and behavioral health treatment team and provides on-site assistance for the individual to assist to access medications and to provide education on the MHPs and ICOs available services.

B. Co-located External Primary Care Services

1. Behavioral Health services are embedded at the MyCare Health Center Clinic in Centerline and Mt. Clemens, FQHC Community First Health Center, Judson Center, and Northpointe Pediatrics.

2. The Integrated Care Team (ICT) at each site is comprised of licensed professionals such as, a Physician, Psychiatrist, Nurse Practitioner, Medical Assistant, and a Master level Therapist/Wellness Coordinator. A licensed Psychologist is available for consultation during the hours of operation.

3. Care Coordinator obtains referral(s) from the medical facility staff members and secures a consent from the individual/guardian for ongoing treatment coordination needs.

4. Care Coordinator/Clinical Therapist conducts the on-site screening tools such as M-CHAT-R/F and PEDS based on the specific needs and presenting conditions of the person served to determine the behavioral health, community resources, and social support needed.

5. Care Coordinator contacts Macomb County Access Center/Open Access to set an appointment for an initial assessment and/or schedule a psychiatric consultation.

6. Treatment team participates in consultations regarding the monitoring and follow-up services for individuals referred for behavioral health services and coordinates with other providers to prevent duplication of services.

C. Integrated MCCMH and MHP/ICO Care Coordination

1. Region 9 will identify staff members responsible for using Michigan.gov CareConnect (CC360). A Shared Member List between MCCMH and

   MHP will be generated by a CC360 search through a risk stratification filter and/or by direct recommendation of a MCCMH/MHP team member.

2. Any exchange of lists or specific PHI will be handled using encrypted email or secure messaging.

3. The person served who is selected will have at least one chronic behavioral health diagnosis and one chronic medical diagnosis.

4. Monthly care coordination meetings between MCCMH, contracted network providers, and MHP team members are held to discuss the identification of care coordination responsibilities regarding self-management planning, determination of services needed regarding supports and availability, medication, and treatment adherence.

5. The team members responsible for care coordination include, but are not limited to the MCCMH care coordinator, MCCMH case manager and primary therapist, contracted network provider team members, PIHP administrator, MHP nurse practitioner, case managers, and administrator.

6. The primary case manager/therapist will attend the monthly care coordination meetings and provide an update on the goals and tasks and reassess the needs of the person served. Additionally, the Admission, Discharge, and Transfer (ADT) information will be reviewed and shared in the coordination of care process.

7. The primary case manager/therapist is required to obtain a release of information on every person served for the MHP/ICO.

8. The primary case manager/therapist is responsible to ensure all care coordination activities regarding linkages and referrals between the Primary Care Physician, MHP, and other Managed Care Organizations (MCO) are conducted and documented in the EMR-FOCUS system.

9. The CMHSP care coordinator will ensure that the goals and tasks assigned to the primary case manager/therapist are updated within the CC360 after each care coordination meeting.

D. Declining Integrated Care Services

1. If the person served decides to decline integrated care services, then behavioral health services will only be provided, as requested.

a. The Person-Centered Plan will only reflect the behavioral health goals.

b. The person served will be provided with the MHP/ICO contact information to obtain physical health services as evidenced by documentation in the chart.

2. If the person served initially agreed to receive integrated care services, signed a consent of information for a MHP or ICO, and decided to decline services, the consent will be revoked.

E. Documentation Requirements

1. Initial Assessment/Reassessment is required to have documentation that identifies the medical conditions, needs of the person served, and updated, as required.

2. The diagnosis is required to be documented and updated to reflect the medical condition(s) identified in the Initial Assessment/Reassessment.

3. Person-Centered Plan is required to have at least one integrated healthcare goal for the person served with an identified medical condition. The integrated care goals and objectives should be developed based on the needs of the person served.

4. The progress notes are required to include communication among interdisciplinary team members, person served, and family members. Collaboration with external service providers and the need for documentation of communication of the care coordination efforts with the medical providers, MHP, ICO, etc.

5. Vital signs are required to be taken and documented on a regular basis as identified by the treatment team.

6. A current release of information the Primary Care Physician, MHP, ICO, or documented refusal to release information, should always be in the record.

VII. REFERENCES / LEGAL AUTHORITY

A. Commission on Accreditation of Rehabilitative Facilities (CARF), 2020 Behavioral Health Standards Manual, § 3.K Integrated Behavioral Health/Primary Care (IBHPC)

B. MDHHS-MCCMH Medicaid Managed Specialty Supports and Services, FY20

C. Parents' Evaluation of Developmental Status definition at www.pedstest.com

D. MI Health Link Glossary at www.michigan.gov/documents

E. MCCMH MCO Policy 2-042, Coordination of Care

F. MCCMH MCO Policy 6-001, Release of Confidential Information – General

G. MCCMH MCO Policy 6-002, Release of Confidential Information – Substance Use Disorder Treatment

H. MCCMH MCO Policy 6-003, Release of Confidential Information – Court Orders and Subpoenas

I. MCCMH MCO Policy 6-006, Notice of Confidential Information

J. MCCMH MCO Policy 6-100, Notice of Privacy Practices

K. MCCMH MCO Policy 2-048, Telehealth/Telemedicine

L. MCCMH MCO Policy 2-018, Clinical Practice – Correction, Supplementation, or Deletion of Information from Electronic Medical Record

M. MCCMH MCO Policy 2-010, Clinical Practice – Standards for Clinical Service Documentation

N. MCCMH MCO Policy 10-200, Directly-Operated Program Management – Service Planning and Review

O. Medical Services Administration (MSA) 2015 Medicaid Provider L Letter 15-71

VII. EXHIBITS

A. None.