MCCMH MCO Policy 2-042

(was MCCMH Policy 7-02-130)

Chapter: **CLINICAL PRACTICE**
Title: **COORDINATION OF CARE**

Prior Approval Date: 3/27/2013
Current Approval Date: 7/13/2015

Approved by: _____ 07/13/15
Executive Director Date

I. Abstract

This policy establishes the standards of the Macomb County Community Mental Health Board (MCCMH) for service coordination between MCCMH behavioral health providers, including providers of substance use disorder services, and external providers of primary and specialized health care.

II. Application

This policy shall apply to directly-operated and contracted network providers of the MCCMH Board.

III. Policy

It is the policy of the MCCMH Board to ensure that services provided to consumers of the MCCMH Board shall be coordinated with their primary care and other medical service providers. The goal is to ensure that appropriate and effective coordination of care and collaboration occurs between the PIHP, its contractors, and all relevant providers of services so that information regarding behavioral and medical healthcare can be exchanged and used in the provision of care. Care is coordinated across persons, functions, activities, and sites over time to maximize the value of services delivered to consumers.

IV. Definitions

A. **Primary Care Physician (PCP)**
A consumer-selected physical health care professional that provides and directs the primary health care.

B. **Specialized Health Care Provider**
A consumer selected physician that acts as a medical specialist. Examples include, but are not limited to, neurologist, psychiatrist, endocrinologist, cardiologist.

C. **Medicaid Health Plan (MHP) Qualified Health Plan (QHP)**
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 consumers.

D. **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, and enrolled in MI Health Link.

E. **MI Health Link**
A program for adults aged 21 and older who are enrolled in both Medicare and Medicaid. The goal of the program is to provide seamless access to high quality care that reduces costs. The program offers a broad range of medical and behavioral health services, pharmacy, home and community-based services and nursing home care in a single program that is designed to meet the individual needs of the consumer.

F. **Integrated Care Team (ICT)**
A service for MI Health Link members that provides a team that works with a MI Health Link enrollee to develop, implement, and maintain the IICSP and to coordinate the delivery of services and benefits as needed for the MI Health Link enrollee. The membership in the team includes the enrollee and their chosen allies or legal representative, Primary Care Physician, ICO Care Coordinator, and the Long Term Support Services Coordinator or PIHP Supports Coordinator (as applicable) and others as needed.

G. **Care Coordination Platform**
The Care Coordination Platform is an electronic platform supported by web based technology which is used in the MI Health Link Demonstration and allows secure access to information and enables all MI Health Link enrollees and ICT members to use and update information.

H. **Integrated Care Bridge Record (ICBR)**
The ICBR is the individualized MI Health Link enrollee record generated and maintained within the electronic Care coordination platform. It allows secure access for enrollees and the ICT to use and, where appropriate, update information.

I. **Individual Integrated Care and Supports Plan (IICSP)**
The plan of care developed by a MI Health Link enrollee, ICO Care Coordinator, and the enrollee's ICT members develop a comprehensive person-centered written IICSP for each consumer. The IICSP is maintained in the ICBR.

J. **ICO Care Coordinator**
An ICO employee who is accountable for providing MI Health Link enrollees with care coordination services.

K. **Primary Case Holder**
PIHP Supports Coordinator, Clinician or Case Manager who is the primary care coordinator of behavioral health services.

L. **Care Coordinator**
Care Coordinator is the Primary Case Holder responsible for the integrated coordination and management of all aspects of a consumer's care (for example: providing information to multiple providers, seeing that services are received by the consumer in a timely manner, behavioral and physical health services, etc.) to maximize improvement and stabilize the health status of consumers receiving services from Macomb County Community Mental Health PIHP.

M. **Care Coordination**
A process used by a person or team to assist consumers 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.

VI. Standards/Procedures

A. **MCCMH Primary Case Holder Responsibilities**
The MCCMH Primary Case Holder is responsible for coordination of physical and behavioral health care services. This includes individuals with mental illness, developmental disabilities, substance abuse disorders and co-occurring mental health and substance abuse disorders. These activities are based on the completion of current and valid release of information authorized by the patient/consumer and/or legal guardian. (See MCCMH MCO Policy 6-001, "Release of Confidential Information – General," for standards and procedures related to releases of information.) Refusals of release shall be documented in the electronic medical record.

1. The Primary Case Holder is responsible for:
   a. Coordinating psychiatric, psychopharmacological, rehabilitative, and habilitative services and supports in response to the needs identified by the assessments, individual plan of service and the IICSP, as applicable.
   b. Assisting the consumer receiving urgent and emergent care due to an exacerbation **of behavioral health, substance use disorder, and or intellectual/ developmental disability**.
   c. Assisting the consumer with managing transitions between psychiatric acute and sub-acute levels of care and within the community.
   d. If applicable: to coordinate, monitor, collaborate, and consult with the ICO Care Coordinator regarding health, wellness, and preventive services as well as health-related behavioral conditions.

2. Coordination of Care shall be completed at least annually, and when:
   a. The level of care changes;
   b. In-patient hospitalization occurs;
   c. Change in psychiatric medications if necessary per psychiatrist;
   d. Change in Primary Case Holder or provider.
   e. Determined by a psychiatrist, physician assistant, nurse practitioner or nurse to be necessary to reduce potential harm to the individual.

B. **Initiation of Coordination**

To initiate coordination, the MCCMH Primary Case Holder will confirm the consumer has a PCP. If the consumer does not have a Primary Care Physician (PCP), the MCCMH Primary Case Holder will:

1. Assist the consumer in selecting a PCP by contacting applicable insurance providers.

2. If the consumer has no insurance, assist the consumer in applying for applicable insurances, such as Medicaid; or refer to available community resources such as a Federally Qualified Health Center or free/low cost clinic.

3. If applicable, a goal will be identified in the Plan of Service addressing the need for a PCP.

C. **Coordination of Care Document**

If the consumer has an identified Primary Care Provider, the MCCMH Primary Case Holder will:

1. Complete the Coordination of Care document (Exhibit A), or compatible form, in the electronic health record for primary care providers and specialists. Information shall include:
   a. Service start date;
   b. Psychiatric Diagnosis;
   c. Level of care currently received by the consumer from MCCMH;
   d. Current Psychiatric Medication(s);
   e. Result of screening disposition for inpatient;
   f. Date of most recent psychiatric hospitalization;
   g. Identification of current Primary Case Holder and prescribing psychiatrist.

2. The MCCMH Primary Case Holder will send the Coordination of Care document with appropriate valid release of information to the identified Primary Care Provider. The Coordination of Care document will request the following information from the PCP;
   a. Date of last medical appointment;
   b. Current medical diagnoses;
   c. Current medication(s);
   d. Allergies;
   e Major health issues;
   f. Other concerns.

3. The MCCMH Primary Case Holder will ensure the consumer's health related needs, desires and preferences are reflected in the individual plan of service. These needs shall identify the consumer's level of need for primary care services. The Primary Case Holder will consult with physicians and nurses to assist in identifying any medical issues that require linking and coordinating.

4. Efforts will be made to include the need for specialty care in the assessment and re-assessment process. The Primary Case Holder will contact the PCP to determine who will coordinate care with the specialty health care practitioner.

5. Integration between behavioral health and substance use disorder services will include the coordination of care process with an appropriate, valid release of information.

D. MI Health Link Coordination of Care

1. The ICO will identify an ICO Care Coordinator as the primary coordinator of care unless the consumer requests their current Primary Case Holder to provide care coordination.

2. As a member of the Integrated Care Team (ICT), the PIHP Supports Coordinator will be responsible to:
   a. Participate in IICSP development, implementation, and revision according to the Person-Centered Planning Process or Individualized Treatment Planning Process, and the Enrollee's stated goals;
   b. Update the ICBR as needed pertinent to the ICT member's role on the ICT;
   c. Review assessment, test results, and other pertinent information in the ICBR;
   d. Address transitions of care when a change between care settings occur;
   e. Ensure continuity of care requirements are met; and
   f. Monitor for issues related to quality of care and quality of life.

E. Hospital Coordination of Care

The Primary Case Holder shall meet with consumer within one (1) business day of admission to a psychiatric in-patient facility (excluding the Assertive Community Treatment program which follows requirements specific to that program). The purpose of this contact includes, but is not limited to:

1. Initiate discharge planning;
2. Coordinate aftercare services;
3. Consult with hospital staff regarding treatment planning;
4. Support consumer and family; and
5. Facilitation of consumer transfer back to the community.

VII. References / Legal Authority

A. MCL 330.1206(c)

B. MDHHS/MCCMH Managed Mental Health Specialty Supports and Services Contract, FY 15

C. MCCMH/Medicaid QHP Agreements

D. Commission on Accreditation of Rehabilitation Facilities (CARF) 2011 Behavioral Health Standards Manual, §3N., "Integrated Behavioral Health/Primary Care," pp. 177-181

E. OAG, 1979-1980, No 5709 (May 20, 1980)

F. 42 CFR 438.208

G. MI Health Link Three Way Contract Between CMS, MDHHS, and Health Plan

VIIII. Exhibits

A. Coordination of Care Form (example)
B. MI Health Link Care Coordination: Assessment Process Flow BH, I/DD, SUD Needs and Multiple Needs