Southwest Michigan BEHAVIORAL HEALTH

Section: **Clinical Practices**	Procedure Name: **Integrated Care Team Procedure**	Procedure #: **P12.02.01**
Overarching Policy: **12.02 Integrated Healthcare**		
Owner: **Director of Quality Management and Clinical Outcomes**	Reviewed By: **Alena Lacey, MA, LPC and Jeannette Bayyapuneedi, MA, LPC, CAADC**	Total Pages: **6**
Required By: ☐ **BBA** ☒ **MDHHS** ☐ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: Alena Lacey Jeannette Bayyapuneedi Jeannette Bayyapuneedi (May 17, 2024 13:56 EDT)	Date Approved: May 17, 2024
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Other (please specify):** ☒ **Healthy Michigan** **1115 Waiver** ☐ **Specialty Waiver (B/C)** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☒ **MI Health Link**	Effective Date: **6/29/2020**

Policy: 12.02 Integrated Healthcare

Purpose: The purpose of the Integrated Care Team meeting is to improve health outcomes by providing care coordination between behavioral and physical health providers while promoting patient centered care to reduce high Emergency Department (ED) use and inpatient (IP) admissions for members identified for Integrated Healthcare Team (ICT) enrollment in compliance with the Michigan Department of Health and Human Services (MDHHS) 1915 Waiver Program contract requirements.

Scope: The scope of this procedure includes all aspects of ICT Meetings to include meeting preparation, conduct and follow up on action items. SWMBH ICT staff may include a Registered Nurse (RN), Integrated Healthcare Specialist, Case Manager II or Case Manager III.

Responsibilities: Southwest Michigan Behavioral Health (SWMBH) ICT Staff i.e. Registered Nurse (RN), Integrated Healthcare Specialist, Case Manager II or Case Manager III are responsible for ICT meeting preparation and conduct, however as the pre-eminent Prepaid Inpatient Health Plan (PIHP), SWMBH staff will facilitate ICT meetings with a proactive approach to integrated care and when applicable, patient centered planning.
SWMBH ICT staff will attend the designated Workgroup meetings and follow directives agreed upon by the workgroup to the extent that they are aligned with SWMBH policies and mission statement. ICT staff will work toward a resolution of differences between

MHP and the Workgroup and seek to clarify differentiation between Workgroup suggestions and State mandated activities.

All ICT activities will adhere to CFR 42, Part 2, Michigan Mental Health Code, and HIPAA, and will aim to direct coordinated care utilizing best practices, and as directed by the SWMBH P12.02.01 ICT Procedure, and other SWMBH policy as applicable.

Definitions: Integrated Care Team (ICT): The Integrated Care Team may include staff from, but is not limited to SWMBH, Michigan Health Plan (MHP), Community Mental Health (CMH) and primary care physician (PCP) staff participating in monthly care coordination with a shared goal of person-centered planning toward improved health outcomes. Accommodations may be made to include a member as part of their own ICT meeting upon request or can be facilitated if needed to improve an individual's health outcomes.

Procedure:

A. ICT Staff Responsibilities for ICT Meeting Preparation:

1. Run the risk stratification list utilizing Care Connect 360 for each MHP two weeks prior to the ICT meeting date. If no MHP member is identified on the Easy Tab, refine the member search using the Filter Tab.
2. Adjust the Filtered Tab options as needed to identify one new member per MHP, per month in the following order:
   a. Reduce chronic conditions
   b. Reduce ED visits
   c. Increase number of months to six months
3. Prioritize member selection based on Workgroup priorities.
   a. High emergency room (ER) use and high IP admissions
   b. Non-emergent ED use
   c. SPMI diagnoses
   d. Active with PIHP
   e. Recent behavioral health (BH) claims and physical health (PH) claims
4. Share selected member with MHP via encrypted email to seek agreement on member selection.
5. Consider adding more than one member per month:
   a. If both PIHP and MHP have identified a high use member
   b. If the total number of active members is ≤ 4.
   c. If more than one high use member was identified (≥ 6 ED use in three months).
6. Will email or call Community Mental Health (CMH) contact for Behavioral Health Consent assistance and for member updates regarding member individuals who are active in treatment, one week prior to ICT meetings.
   a. Enter CMH informational updates in the next meeting minutes.
   b. Enter the date of CMH contact and CMH response date on the Member Tracker.
7. Mail a consent letter for members not in active BH treatment. The consent will include SWMBH, MHP, and any other known treatment providers, or reasonably anticipated treatment providers entered on the form.

a. All new or anticipated treatment providers added to the BH consent form should be identified in the consent cover letter.
b. Print the letter to mail and save E-signature letter to scan file.

8. Call members as needed for:
   a. Member notification of mailed consent letter.
   b. Offer BH services and warm transfer if indicated.
   c. Identify unmet needs such as housing and transportation.
9. Complete member call attempts as follows:
   a. A minimum of three attempts each month (between monthly ICT meetings)
   b. On three different days of the week
   c. At three different times of day
   d. For three consecutive months for members with a substance use disorder (SUD) history, until the consent with all care coordinating agencies, is signed.
10. Process the receipt of signed consent forms by:
    a. Review signed consent to ensure completeness including a marked check box.
    b. Fax signed consent to MHP, CMH as indicated and any other providers included on the form.
    c. Scan and save signed consent in the Utilization Management (UM) Scan file for uploading to SmartCare.
11. Prepare the ICT meeting minutes as follows:
    a. Save last meeting minutes with new version date
    b. Move completed action items to previous action items
    c. Add CC360 updates since the last ICT meeting, enter as "per claims".
    d. Add member call attempts and/or member contact updates.
    e. Add CMH contact attempts and updates by date
    f. Add follow up on all action items from previous month
    g. Add new member and enter all available information.
    h. Review SmartCare for SUD updates for members with a signed SUD consent.

B. Responsibilities for ICT Meeting Conduct:

1. ICT Staff will prioritize members and adhere to the scheduled ICT meeting time.
   a. If there are more than six members on the agenda ICT Staff will decide along with the MHP if there is flexibility to meet longer than the scheduled time, or quickly identify members with currently met needs, reduced ED use and continuing ICT for 3 months of ED use reduction, to table until the next month's meeting.
2. ICT Staff will provide ICT meeting facilitation to ensure the identification of members' needs and any barriers to meeting those needs with a focus on improved health outcomes.
   a. The SWMBH facilitator will confirm the previous month's meeting minutes are approved, or document requested edits or updates.
   b. The SWMBH facilitator will be watchful of the time spent on each member and keep the conversation focused on primary ICT goals to include but not limited to:
      i. Adherence to SWMBH, Michigan Mental Health Code and 42CFR, Part 2, protected health information guidelines. No SUD information will be shared during the ICT meetings without a signed SUD consent form.

ii. Active connection to CMH and CMH updates
iii. Active connection with Primary Care Provider (PCP) and PCP and medical updates
iv. Need for and completion of HRA
v. Housing and transportation needs
vi. Reasons for continued ED use or IP admission and facilitation of referrals to specialists as needed.
vii. Follow up on the previous months action items to document completion or the identification of barriers
viii. Discuss any newly identified barriers to care and potential action items to address barriers.
ix. Identify high ED users with frequent narcotic Rx claims for potential Medication Adherence Program (MAP) monitoring
x. Identify members for potential patient management referral and / or Complex Case Management (CCM) referral.

3. ICT meeting minutes will be documented to reflect accurate descriptions and timing of all items discussed.
   a. Meeting minutes will be taken to document the status of all items listed above as well as any other identified physical or behavioral health needs, and planned MHP and PIHP action items.
4. Decisions to close Care Coordination Plan (CCP) for completion will be made based on the following criteria.
   a. Stable for 3 months, meaning no chronic ED or IP visits
   b. Active and/or stable with BH care or discharged from BH treatment.
   c. Active with PCP
5. Closing CCP criteria for difficult to reach members will include inability to contact or engage the member after the required phone and U.S. Mail contacts.
   a. Phone contact attempts will meet the minimum requirements:
      i. A minimum of three call attempts will be made each month for three months (between monthly ICT meetings)
      ii. Member calls will be made on three different days of the week.
      iii. Member calls will be made at three different times of day.
      iv. U.S. Mail attempts will be completed for unable to reach members with one mailed letter per month for three consecutive months. All mailed member letters will include an E-signature and be uploaded into SmartCare as noted above.

C. Responsibilities for ICT Meeting Conclusions:
1. Confirm the next meeting date and time is still acceptable to all ICT Staff. Review action items if not documented or are unclear.
2. Send ICT Meeting Minutes for internal review within 5 days to allow time for review and edits and send to the MHP within 7 days.
3. Send email approval for meeting minutes to be uploaded to SmartCare.
4. Enter notes and tasks into CC360 CCP for each member discussed within 3 business days of the ICT meeting date.

5. Follow up on all PIHP action items within 5 business days of the ICT meeting date.
6. Send communications to MHP as needed (i.e., for dis-enrollments, relocated members, SNF placements, and updated contact information).

Effectiveness Criteria: SWMBH will use metrics established in the contract to measure effectiveness. In addition, SWMBH will analyze ED and IP utilization pre-ICT meetings, during ICT meetings and post-ICT meetings.

References:

A. SWMBH 12.02 Integrated Healthcare
B. SWMBH 12.11 Clinical Documentation
C. MHL 12.7 Complex Case Management
D. SWMBH 19.2 Protected Health Information -Minimum Necessary
E. HIPAA
F. 42CFR, Part 2

Attachments:

P12.02.01A ICT Meetings Template
P12.02.01B MDHHS 5515 Consent to Share Behavioral Health Information

Southwest Michigan
BEHAVIORAL HEALTH

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	8/22/2017	N/A: New Template	N/A: New Template	
1	TBD	Formatted Integrated Collaborative Care to New Template; added Scope and Responsibilities	Annual Review	Moira Kean Doug Stewart Sarah Green
2	9/23/2022	Updated name of overarching policy and referenced policies	Annual Review	Alena Lacey Jeannette Bayyapuneedi
3	4/19/2024	Labeled the procedure attachments	Annual Review	Alena Lacey

P12.02.01 Integrated Care Team

Final Audit Report 2024-05-17

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Southwest Michigan
BEHAVIORAL HEALTH

Meeting Name:	MiHealth Link ICT (IPs & Cold Calls)		
Date of Meeting:	January 8, 2020	**Time Scheduled:**	830am-930am
Conference Call Information:			

1. Meeting Objective

MHL Member Coordination (focus on recent behavioral health IP admits).

2. Administration

Call to order/Roll Call:	**Attendance:**
Approval of Agenda/Additions noted:	**Notes:**

3. Members to Discuss

IP admit date/ ICO CM name	Member Name/Notes	MCD ID
Cold Calls		

4. Other Members/Items of Discussion

Medicaid ID/Name	Agenda Topic/Discussion

6. Next Meeting

Date:		**Time:**	
Location:			

CONSENT TO SHARE BEHAVIORAL HEALTH INFORMATION

Michigan Department of Health and Human Services

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout this form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

Why This Form Is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

- To **give** consent, fill out Sections 1, 2, 3, and 4.
- To **take** away consent, fill out Sections 5.
- Sign the completed form, then give it to your health care provider. They can make a copy for you.

Section 1: About You

First Name	Middle Initial	Last Name	Date of Birth	Date Signed

Section 2: Who Can See Your Information and How They Can Share It

Section 2a: Sharing Information Between Individuals and Organizations

Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

1. SWMBH
2. _____
3. _____
4. _____
5. _____
6. _____
7.
8.

Section 2b: Sharing Information Electronically

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

Choose only one option:

☐ Share my information through the organizations listed below. This information will be shared with the individuals and organizations listed under Section 2a.

☐ Do not share my information through the organizations listed below.

☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

For Health Care Provider or Health Plan Use Only. List all health information exchanges or networks:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Section 3: What Information You Want to Share

Choose one option:

☐ Share **all** my behavioral health and substance use disorder records. This does not include "psychotherapy notes."

☐ Share **only** the types of behavioral health and substance use disorder records listed below. For example, what I am being treated for, my medications, lab results, etc.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Section 4: Your Consent and Signature

Read the statements below, then sign and date the form.

By signing this form below, I understand:

- I am giving consent to share my behavioral health and substance use disorder records. This includes referrals and services for alcohol and substance use disorders, but other information may also be shared.
- I do not have to fill out this form. If I do not fill it out, I can still get treatment, health insurance or benefits. But, without this form, my provider or health plan may not have all the information needed to treat me.
- My records listed above in Section 3 will be shared to help diagnose, treat, manage, and pay for my health needs.

- My records may be shared with the people or organizations as stated in Section 2.
- Other types of my health information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes".
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form. Or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.
- This signature is good for **1 year** from the date signed. Or I can choose an earlier date or have it end after the event or condition listed below. (For example, at the end of my treatment.)

  Date, event, or condition: _____

State your relationship to the person giving consent and then sign and date below:

☐ Self

☐ Parent (Print Name) _____

☐ Guardian (Print Name) _____ Please include proof of guardianship

☐ Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Appropriate)	Date

TAKE AWAY YOUR CONSENT

Complete Section 5 if you no longer want to share your records listed above in Section 3.

Section 5: Who Can No Longer See Your Information

I no longer want to share my records with those listed in Sections 2a and 2b. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

☐ Self

☐ Parent (Print Name) _____

☐ Guardian (Print Name) _____

☐ Authorized Representative (Print Name) _____

Signature	Date
Witness Signature (If Appropriate)	Date

FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

Verbal Withdrawal of Consent

☐ The individual listed above in Section 1 has taken away his/her consent.

List the individual who requested the withdrawal below, then sign and date below.

☐ Individual listed above in Section 1.

☐ Parent (Print Name) _____

☐ Guardian (Print Name) _____

☐ Authorized Representative (Print Name) _____

Signature of Person Who Received the Verbal Withdrawal	Print Name	Date

Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at michigan.gov/bhconsent.

Additional Identifiers (Optional)

Medicaid Last 4 of the Social Security Number

Form Copy (Optional, Choose One Option)

☐ The individual in Section 1 **received** a copy of this form.

☐ The individual in Section 1 **declined** a copy of this form.

AUTHORITY:	This form is acceptable to the Michigan Department of Health and Human Services as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq. and PA 129 of 2014, MCL 330.1141a.
COMPLETION:	Is Voluntary, but required if disclosure is requested.

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