POLICY TITLE:	INTEGRATED CARE COORDINATION	POLICY # 5.6	REVIEW DATES	
Topic Area:	**UTILIZATION MANAGEMENT**		8/21/14	10/7/2020
Applies to:	LRE staff and operations, Member CMHSPs, and contracted Providers	**ISSUED BY:** Chief Executive Officer	10/1/2021	5/8/2023
			8/14/2024	
Review Cycle:	Annually	**APPROVED BY:** Chief Executive Officer		
Developed and Maintained by:	CEO and Designee			
Supersedes:	N/A	**Effective Date:** January 1, 2014	**Revised Date:** 8/14/24	

I. PURPOSE

Integrated Care Coordination aims to improve the quality of care, improve outcomes and control costs by moving beyond care coordination, in which primary and specialty providers inform each other regarding their treatment of an individual, to actual collaboration regarding the needs of the patient/individual and acting together to develop and implement a plan and ongoing care in a manner that eliminates barriers to and duplication of services.

A. Lakeshore Regional Entity (LRE) is committed to local health care for local communities. Across the region, individuals served receive care from a broad array of hospital providers and an even broader array of primary care providers. While LRE will set guidelines and expectations for coordinated care, the delivery of coordinated care will look different in different communities. Individuals receiving services will obtain health care that is specifically tailored to their needs and optimizes the unique resources offered by health care providers in their communities.

B. The foundation of care coordination is timely communication of relevant health information among providers. LRE will establish guidelines for bi-directional information sharing, that is, the types of information to be shared and collected at specified points in care (including but not limited to notification of Emergency Room (ER) visits and hospitalizations). LRE will participate in the state-wide data analytics process and will work with Member Community Mental Health Service Programs (CMHSPs) to ensure access to meaningful integrated healthcare data to enhance the quality of care for consumers across the region. The common goal is real-time sharing of useful health information across Substance Use Disorder (SUD), behavioral and physical health care providers.

C. Within communities served by LRE, Member CMHSPs will pilot or plan integrated care models ranging from facilitated referral to fully integrated co-located services. All models share the common element of enhanced communication between SUD

providers, behavioral health and physical health providers, which will be guided by LRE guidelines mentioned above. Care will be coordinated between the provider network and primary care practitioners to assure that appropriate preventative and ambulatory care are provided, and existing health care conditions are treated and monitored by the health care team. Follow up care after ER visits and hospitalizations will be coordinated among health team members.

D. Strategies to reduce and prevent avoidable ER visits and hospitalizations (both for physical health and mental health treatment) will be implemented across the region. The various models share an emphasis on training staff, building relationships with hospital systems and primary care providers, sharing information, and enhanced care coordination.

E. LRE Member CMHSPs will implement various strategies for educating the primary care community on approaching and treating the people we serve. Several CMHSPs provide psychiatric consultations to community prescribers on an as-needed basis. Other strategies include offering informative lectures and dinners to members of the medical community. Education occurs back and forth in informal settings such as the professional interactions that go along with our relationship-building efforts, the process of care coordination, and simply doing our work in a shared space in the instance of co-located services.

II. POLICY

A. LRE shall work cooperatively with Medicaid Health Plans (MHPs) and other PIHPs to jointly identify priority need populations for purposes of care coordination and population health activities including but not limited to:
   1. Development of individualized care plans for persons with complex physical and behavioral health needs.
   2. Partnering with MHPs to manage transitions of care between hospital and community-based settings and prevent avoidable hospital readmissions.
   3. Identifying health disparities and engaging in practices that promote health equity for all Medicaid enrollees.
   4. Implementing and monitoring joint quality health metrics.

III. APPLICABILITY AND RESPONSIBILITY

This policy applies to Lakeshore Regional Entity, Member CMHSPs and their Network Providers.

IV. MONITORING AND REVIEW

This policy will be reviewed annually by the Chief Clinical Officer or Designee.

V. DEFINITIONS

Active Care Relationship Services (ACRS): The Health Information Network Service that contains information on those participating organizations and health professionals who have an Active Care Relationship with a patient.

Admission/Discharge/Transfer (ADT): A type of message generated by healthcare systems based upon event triggers; patient is admitted on, discharged from, or transferred within or from the hospital to another care setting or to the patient's home.

Care Connect 360 (CC360): An online, claims-based health record platform supported by MDHHS for the coordination of physical and behavioral healthcare to enhance and expand the exchange of electronic health records. It is a software tool developed by Optum for the State of Michigan to query and report from encounters submitted by fee for service providers, MHPs and PIHPs. Common tool used by MHPs, PIHPs and State of Michigan employees and contractors.

CMHSP: Community Mental Health Service Programs

Comma Separated Values (CSV): A simple file format used to store tabular data, such as a spreadsheet or database. Files in the CSV format can be imported to and exported from programs that store data in tables, such as Microsoft Excel.

Customers/Consumers: Individuals who are eligible to receive specialty mental health and substance use disorder services, as well as those currently receiving such services and their families/guardians. For the purpose of LRE policy, these terms are used interchangeably.

Integrated Care Coordination: A process used by a person or team to assist beneficiaries in gaining access to necessary Medicare, Medicaid, and waiver services, as well as social, educational, and other support services, regardless of the funding source for the services.

MiHIN: Michigan Health Information Network provides real-time clinical information across physical and behavioral healthcare providers.

SSO: Single Sign On; uses uniquely identified credentials to gain access to approved systems and datasets secured by the State of Michigan.

VI. RELATED POLICIES AND PROCEDURES

A. 5.6a Care Coordination with Medicaid Health Plans Procedure

VII. REFERENCES/LEGAL AUTHORITY

A. Medicaid Managed Specialty Supports and Services Contract

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
1/1/2014	New Policy	Chief Clinical Officer
10/7/2020	Annual Review	Chief Clinical Officer
6/16/2022	Annual Review	CEO and Designee
5/8/2023	Annual Review	CEO and Designee
8/14/2024	Annual Review - Updated Purpose and Policy, added definitions	CEO and Designee