| Section:<br>**Clinical Practices** | Policy Name:<br>**Integrated Healthcare** | Policy Number:<br>**MHL 12.09** |
|---|---|---|
| Owner:<br>**Director of Clinical Quality** | Reviewed By:<br>**Moira Kean**<br>**Sarah Green** | Total Pages:<br>**4** |
| Required By:<br>☐ **BBA** ☐ **MDHHS** ☒ **NCQA**<br>☐ **Other (please specify):**<br>_____ | Final Approval By:<br>*Moira Kean* | Date Approved:<br>Jul 10, 2020 |
| Application:<br>☐ **SWMBH Staff/Ops**<br>☐ **Participant CMHSPs**<br>☐ **SUD Providers**<br>☐ **MH/IDD Providers**<br>☐ **Other (please specify):**<br>_____ | Line of Business:<br>☐ **Medicaid**<br>☐ **Healthy Michigan**<br>☐ **SUD Block Grant**<br>☐ **SUD Medicaid**<br>☒ **MI Health Link**<br>☐ **Other (please specify):**<br>_____ | Effective Date:<br>**6/17/2020** |

**Policy:**
It shall be the policy of Southwest Michigan Behavioral Health (SWMBH) to provide Integrated Healthcare services which meet the contractual and regulatory requirements of the Michigan Department of Health and Human Services (MDHHS) contract and Center for Medicare and Medicaid Services (CMS) Code of Federal Regulations (CFR) and advances the recovery of Region 4 customers. This will be accomplished by collaborating with Medicaid Health Plans (MHP), Community Mental Health Service Providers (CMHSPs), Primary Care Providers (PCP) and other providers as needed.

**Purpose:**
The purpose of SWMBH's Integrated Healthcare program is to assist in improving member health outcomes, improve functional capacity, and support self-management by eliminating barriers and providing care coordination between behavioral and physical health providers while promoting patient centered care. Goals for Integrated Care include but are not limited to reducing high Emergency Department (ED) use and inpatient (IP) admissions for members identified as high risk in compliance with the MDHHS/Integrated Care Organization (ICO)/Prepaid Inpatient Health Plan (PIHP) 3-way contract requirements. In addition, Integrated Healthcare aims to eliminate duplication of services and reduce healthcare costs while encouraging use of appropriate services in the behavioral health system.

**Scope:** SWMBH's Integrated Healthcare Specialists are responsible for this policy.

**Responsibilities:**
Integrated Healthcare Specialists will establish tasks and roles based on contracts and regulations.

Integrated Healthcare Specialists will work with MHPs to organize and perform Integrated Care Team (ICT) meetings with a focus of improving health outcomes and lowering ED and IP utilization.

**Definitions:**

A. **Integrated Healthcare**- The integration of physical healthcare, mental healthcare and substance use disorder treatment, which is facilitated by an Integrated Healthcare Team. The goal of Integrated Healthcare is to maximize functional capacity and self-management by optimizing the overall health and well-being of members, while avoiding duplication of services and reducing healthcare costs.

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

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

D. **Community Support Services** - Services that promote disease management, wellness, and independent living, and that help avert unnecessary medical interventions (e.g., avoidable or preventable emergency department visits and facility admissions).

**Standards and Guidelines:**

A. SWMBH and participant CMHSPs will work to eliminate barriers to communication and coordination of care between Substance Use Disorder providers and other providers. In this regard obtaining signed State of Michigan form 5515 for coordination with all providers the member is willing to allow will be an expectation and will allow sharing of treatment plans and information between authorized providers.

B. SWMBH staff (including RN, Care Manger II and/or Care Manager I), will coordinate with participant CMHSP's Case Managers, Licensed Therapists, RNs, PCP and Recovery Coaches to coordinate members' care by improved communication to all current and recent providers, identifying barriers, connecting members to community resources and avoiding duplication of services.

C. CMHSP staff will assist the SWMBH Integrated Healthcare Team (ICT) by providing member updates, and information about community support services (CSS) or by facilitating access to services by ICT members.

D. SWMBH ICT Staff are jointly (along with ICO staff) responsible for ICT meeting preparation and conduct. SWMBH staff will take a proactive approach for collaboration and integrated care and when applicable, patient centered planning.

E. SWMBH ICT staff will attend the appropriate MDHHS/ICO 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 ICO and the Workgroup and seek to clarify differences between Workgroup suggestions and State mandated activities.

F. 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 MHL 12.9.2 Integrated Healthcare Procedure, and other SWMBH policy as applicable.

**Effectiveness Criteria:** SWMBH will use metrics established in the contract to measure effectiveness.

**References:**

A. MDHHS / ICO / PIHP 3-Way Contract
B. MHL 12.9.2 Integrated Healthcare Procedure
C. SWMBH 19.2 Protected Health Information Authority and Responsibility of Individual Staff
D. Michigan Mental Health Code
E. HIPAA
F. 42CFR, Part 2

**Attachments:**

A. SWMBH 12.02A State of Michigan Consent to Share Behavioral Health Information (form 5515)

Southwest Michigan BEHAVIORAL HEALTH

**Revision History**

| Revision # | Revision Date | Revision Location | Revision Summary | Revisor |
|---|---|---|---|---|
| 3 | 6/17/20 | Throughout the document | Utilize new P&P template; update procedure number; edit some terminology | Sarah Green |
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# MHL 12.09 Integrated Healthcare

Final Audit Report 2020-07-10

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# 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. |

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.



REQUIRED: RETURN ALL FOUR PAGES TO MEET COMPLIANCE STANDARDS