Section: **Clinical Practices**	Procedure Name: **MHL Integrated Care Team Meeting Procedure**	Procedure #: **MHL P12.09.02**
Overarching Policy: **MHL 12.09 Integrated Healthcare**		
Owner: **Director of Clinical Quality**	Reviewed By: **Moira Kean** **Sarah Green**	Total Pages: **3**
Required By: ☐ **BBA** ☐ **MDHHS** ☒ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: *Moira Kean*	Date Approved: Jul 10, 2020
Application: ☐ **SWMBH Staff/Ops** ☐ **Participant CMHSPs** ☐ **SUD Providers** ☐ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☐ **Medicaid** ☐ **Other (please specify):** ☐ **Healthy Michigan** _____ ☐ **SUD Block Grant** ☐ **SUD Medicaid** ☒ **MI Health Link**	Effective Date: **6/17/2020**

Policy:
Southwest Michigan Behavioral Health (SWMBH) will collaborate with Integrated Care Organizations (ICOs), Community Mental Health Service Providers (CMHSPs), Primary Care Providers (PCPs) and others to provide Integrated Healthcare Services for members according to contractual and regulatory requirements.

Purpose:
The purpose of the Integrated Healthcare team meeting is to improve health outcomes by providing care coordination between behavioral and physical health providers while promoting patient centered care where possible 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)/ICO/Prepaid Inpatient Health Plan (PIHP) 3-way 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:
SWMBH Integrated Healthcare Specialist will engage in Integrated Care Team meeting activities.

Definitions:

A. Integrated Healthcare Team (ICT): The Integrated Healthcare Team may include staff from, but is not limited to SWMBH, ICO, CMH and 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. SWMBH will collect behavioral health inpatient admissions when notified by hospitals.
B. SWMBH will collect behavioral health cold calls. This is when there has been no recent contact with a member who reaches out to SWMBH for authorization of services.
C. SWMBH will compile the week's IP admits and cold calls and email to each ICO weekly. The list will include all IPs/cold calls that we were notified of since the last week.
D. The ICO will confirm the agenda of which members are due to be discussed at the next ICT meeting by 2 days prior to the meeting. This will be in the form of an emailed agenda to SWMBH. The agenda template attached to this procedure may be used.
E. SWMBH will present IP admit notes and any continuous review notes and/or discharge plan notes with ICO staff at the remote meeting. The ICO will engage in conversation and collaborative care is encouraged. Information discussed between both teams may include but not be limited to:
    1. Name, date of birth (DOB), date of admission, admission reason, placement location, residence and any issues with current residence, phone number, legal status, diagnoses (medical and behavioral), complex care management (CCM) status (SMWBH), discharge plan from instructions, discharge medications, planned follow-up visits, any contact or notes/history from either team and any plans or actions that either team can do to assist with compliance with follow-up visits or other post-discharge plan.
    2. If a release of information is available, it will be shared between the PIHP and ICO. If not, there will be an attempt to obtain a release of information as necessary.
F. Members will remain on the agenda until they have followed-up with scheduled provider and/or it has been more than 30 days past discharge date without confirmed follow up.
G. After each meeting, the ICO and SWMBH will document notes in respective internal documentation systems.
H. Any cold call members or other discussion may be addressed in the meeting if time allows.

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 P12.09A State of Michigan Consent to Share Behavioral Health Information (form 5515)
B. SWMBH P12.09.02A MHL ICT Agenda Template

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	6/17/20	Whole document	Create procedure	Sarah Green

MHL P12.09.02 Integrated Care Team Meeting Procedure

Final Audit Report 2020-07-10

Created:	2020-07-10
By:	Erin Peruchietti (erin.peruchietti@swmbh.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAA3n_1X7ktD-cAF7S1xzFwMPVv3VHn9WDF

"MHL P12.09.02 Integrated Care Team Meeting Procedure" History

Document created by Erin Peruchietti (erin.peruchietti@swmbh.org)
2020-07-10 - 6:43:08 PM GMT- IP address: 104.159.231.26

Document emailed to Moira Kean (moira.kean@swmbh.org) for signature
2020-07-10 - 6:43:27 PM GMT

Email viewed by Moira Kean (moira.kean@swmbh.org)
2020-07-10 - 7:23:26 PM GMT- IP address: 104.47.37.254

Document e-signed by Moira Kean (moira.kean@swmbh.org)
Signature Date: 2020-07-10 - 7:23:32 PM GMT - Time Source: server- IP address: 108.203.175.2

Signed document emailed to Moira Kean (moira.kean@swmbh.org) and Erin Peruchietti (erin.peruchietti@swmbh.org)
2020-07-10 - 7:23:32 PM GMT

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