

Policy 5.6

POLICY TITLE:	INTEGRATIVE CARE COORDINATION	POLICY # 5.6	REVIEW DATES	
Topic Area:	UTILIZATION MANAGEMENT	ISSUED BY: Chief Executive Officer APPROVED BY: Chief Executive Officer	8/21/14	10/7/2020
Applies to:	LRE staff and operations, Member CMHSPs, and contracted Providers		10/1/2021	5/8/2023
Review Cycle:	Annually			
Developed and Maintained by:	CEO and Designee			
Supersedes:	N/A			
		Effective Date: January 1, 2014	Revised Date: 6/16/2022	

I. PURPOSE

Integrated healthcare 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.

II. POLICY

- A. The LRE is committed to local health care for local communities. Across our region, the people that the LRE serves receive care from a broad array of hospital providers and an even broader array of primary care providers. While the 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. The 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). The LRE will participate in the state-wide data analytics process and will work with Member 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 SUD, behavioral and physical health care providers.
- C. Within communities served by the 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 the

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 employed across the region. The various models share in common an emphasis on training staff, building relationships with hospital systems and primary care providers, sharing information, and enhanced care coordination.
- E. CMHSP members of the LRE 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.
- F. LRE shall work cooperatively with other MHPs and 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 Contracted Providers.

IV. MONITORING AND REVIEW

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

V. DEFINITIONS

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.

VI. RELATED POLICIES AND PROCEDURES

- A. LRE UM policies and procedures

B. LRE 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