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**Owner:** Harriett Siddiqui  
**Policy Area:** Integrated Health Care  
**References:** [NCQA CC2 Element B, Factor 1](#)

## Integration and Coordination of Care - Data Sharing and Care Coordination

### POLICY

The Detroit Wayne Mental Health Authority (DWMHA) promotes service coordination and integration at the Pre-paid Inpatient Plan (PIHP) and Medicaid Health Plan/Integrated Care Organizations (MHP/ICO) level. The DWMHA has been dedicated to developing and implementing a care coordination/data sharing process with its partners - MHP/ICOs, Manager of Comprehensive Provider Networks (MCPNs) and/or their service providers - that is designed to improve overall health outcomes for individuals receiving integrated care services.

### PURPOSE

This policy will support the PIHP to better manage health care utilization and reduction of unnecessary cost while providing individuals the care they need. The sharing of information will identify systemic opportunities that will encourage an integrated approach to improve behavioral and physical health outcomes and improve overall quality of life.

### APPLICATION

The policy applies to the DWMHA, the MCPNs and their contracted or subcontracted behavioral health providers who are all involved in providing services that directly impact adults and children/youth with behavioral health and/or physical health concerns. These individuals typically carry a designation of intellectual/developmental disabilities (IDD), severely mentally ill (SMI), substance use disorders (SUD), severely emotionally disturbed (SED), Autistic and/or are involved in the juvenile justice system. Individuals involved in the data sharing/care coordination process are beneficiaries of Medicaid and/or Medicare, can be part of the SED waiver, the Autism benefit, or are enrolled in MI Health Link.

### KEY WORDS

1. Co-Occurring Disorders (also known as Co-occurring Issues or Conditions)
2. Coordination of Care
3. Cultural Competence
4. Integrated Health Care
5. Individualized Plan of Service/Treatment Plan (IPOS/Person-Centered Plan)

6. Manager of Comprehensive Provider Networks (MCPN)
7. Medicaid Health Plan (MHP)
8. Primary Health Care

## **STANDARDS**

1. DWMHA will utilize available data sources (i.e., DWMHA data warehouse, CareConnect 360, etc) to identify individuals shared with the PIHP and MCPN/MHP/ICO.
2. DWMHA will partner with the MCPN/MHP/ICO to determine which common individuals are to be shared during the care coordination process. A secure email notification with the list of proposed individuals will be sent to the MCPN and/or MHP/ICO .
3. The MCPN will notify service providers of the care coordination meeting and encourage their participation as appropriate.
4. Integrated Care Coordination Plans will be developed with interventions based on the individual's needs - to include identified individuals who are to support him/her in carrying out these objectives.
5. Care Coordination Plans will be reviewed monthly and amended depending on the individual's needs and achievement of prior interventions.
6. Care Coordination support will be discontinued if the individual's behavioral and/or physical health concerns have stabilized - i.e., regular contact with primary care physician is maintained as appropriate; individual remains compliant with psychotropic and physical health medications; there is evidence of lowered inpatient and ED encounters; and/or the individual declines further intervention.

## **QUALITY ASSURANCE/IMPROVEMENT**

The DWMHA shall review and monitor contractor adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of MCPNs, their subcontractors and direct contractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

## **COMPLIANCE WITH ALL APPLICABLE LAWS**

DWMHA staff, MCPNs, contractors and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

## **LEGAL AUTHORITY**

1. FY 2017 contract between the Michigan Department of Health and Human Services and the DWMHA PIHP

# RELATED POLICIES

# RELATED DEPARTMENTS

Departments that can be impacted by this policy include:

1. Clinical Practice Improvement
2. Compliance
3. Integrated Care
4. Quality Improvement
5. Substance Use Disorders

## CLINICAL POLICY

YES

## INTERNAL/EXTERNAL POLICY

Internal

## EXHIBIT(S)

1. MHP/PIHP Care Coordination Plan

### Attachments:

[Blank CARE COORDINATION PLAN \(2\)-08232016.docx](#)

### Approval Signatures

Approver	Date
Ronald Hocking: Chief Operating Officer	04/2017
Dana Lasenby: Deputy Chief Operating Officer	03/2017
Allison Smith: Project Manager, PMP	03/2017
Darlene Owens: Director, Substance Use Disorders, Initiatives	03/2017
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Kip Kliber: Director, Recipient Rights	03/2017
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Lorraine Taylor-Muhammad: Director, Managed Care Operations	03/2017
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<b>Approver</b>	<b>Date</b>
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Sarah Sharp: Consultant	03/2017
Diana Hallifield: Consultant	02/2017
Julia Kyle: Director of Integrated Care	02/2017
Harriett Siddiqui	02/2017

**MEDICAID HEALTH PLAN AND PRE-PAID INPATIENT HEALTH PLAN CARE COORDINATION PLAN**

**Instructions for completing the CARE COORDINATION PLAN**

- (1)** Please complete each item within the demographic section. Begin date refers to the date the MHP/PIHP agree to open a joint care coordination case. Close date refers to the date the MHP/PIHP agrees to close the joint care coordination case. Status refers to whether the case is open to joint care coordination or closed. The closed date will remain blank when open.
- (2)** Care team refers to the identified MHP/PIHP/CMH individual that is the primary care manager and point of contact for joint care coordination.
- (3)** Individual's service providers refers to providers relevant to the joint care coordination episode.
- (4)** The *Outcome – Goals/ Tasks* section I includes a drop down list of tasks associated with each goal. Letters a-d below each goal can be cut and pasted several times to accommodate multiple tasks. The task list, free text boxes and date boxes will copy and paste, as well.
- (5)** If a goal is not applicable to the individual, it can be deleted from the form.

**DEMOGRAPHIC**

Individual Name:

Date of Birth:

Begin Date:

Referral Source:

Close Date:

Reason:

Status:

**CARE TEAM**

MHP Care Manager:

PIHP Care Manager:

CMH Care Manager (if applicable):

Individual's Service provider (*additional rows may be inserted as needed*):

Professional Name	Profession	Agency	Date Added

**OUTCOME – GOALS/TASKS**

1. **Individual will be provided with education regarding health conditions.** *Delete if not applicable to this individual.*
  - a. Task:
  - b. Status:
  - c. Owner:
  - d. Notes (include author’s name and date for each entry):  
Author’s Name:
  
2. **Individual will be provided with education regarding benefits and covered services.** *Delete if not applicable to this individual.*
  - a. Task:
  - b. Status:
  - c. Owner:
  - d. Notes: (include author’s name and date for each entry):  
Author’s Name:
  
3. **Individual will be provided with resources needed (examples include housing, transportation, benefits, community resources).** *Delete if not applicable to this individual.*
  - a. Task:
  - b. Status:
  - c. Owner:
  - d. Notes: (include author’s name and date for each entry):  
Author’s Name:
  
4. **Individual will be referred to Primary Care Physician (PCP).** *Delete if not applicable to this individual.*
  - a. Task:
  - b. Status:
  - c. Owner:
  - d. Notes: (include author’s name and date for each entry):  
Author’s Name:

5. **Individual will be referred to specialist (providers necessary to treat client's conditions).**

*Delete if not applicable to this individual.*

- a. Task:
- b. Status:
- c. Owner:
- d. Notes: (include author's name and date for each entry):  
Author's Name:

6. **Providers will collaborate as needed to provide cohesive treatment to individual with complex needs.** *Delete if not applicable to this individual.*

- a. Task:
- b. Status:
- c. Owner:
- d. Notes: (include author's name and date for each entry):  
Author's Name:

7. **Other.** *Delete if not applicable to this individual*

- a. Task:
- b. Status:
- c. Owner:
- d. Notes: (include author's name and date for each entry):  
Author's Name: