POLICY AND PROCEDURE

POLICY NAME: Continuity & Coordination Between Medical and Behavioral Health Care	**POLICY ID**: LA.QI.10
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA**: Quality
EFFECTIVE DATE: 05/09/2023	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE:4/24	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
This policy outlines the collaboratives efforts between medical and behavioral health practitioners.

PURPOSE:
To foster collaboration between medical and behavioral health providers in order to monitor and improve coordination between medical and behavioral health care. To ensure seamless, continuous, and appropriate care for members (i.e., member and/or beneficiary) and to facilitate continuity between all elements of the medical/care delivery system, including primary care providers, specialists, and behavioral health providers. Communication between providers fosters comprehensive and all-inclusive care and facilitates positive outcomes.

SCOPE:
Louisiana Healthcare Connections (Plan) Quality and Population Health & Clinical Operations departments.

DEFINITIONS:
Coordination of Care: Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.
Behavioral Health Provider: Specialists/settings who serve people who seek help for a variety of mental health and substance abuse needs such as, but not limited to: Psychiatrists, Clinical Psychologists, Licensed Clinical Social Workers, Community Mental Health Centers, and Psychiatric Inpatient Facilities
Qualitative Analysis: An examination of deficiencies or processes that may present barriers to improvement or cause failure to reach a stated goal. Also called a *causal, root cause* or *barrier* analysis. The analysis involves those responsible for the execution of the program.
Quantitative Analysis: A comparison of numeric results against a standard or benchmark trended over time using charts, graphs, or tables. Unless specified, tests of statistical significance are not required, but may be useful when analyzing trends.

POLICY:
The health plan facilitates collaboration between medical and behavioral health practitioners to evaluate the continuity and coordination of care between these provider types. The health plan analyzes results, develops interventions, and implements interventions when opportunities for improvement are identified. The health plan also assesses the effectiveness of interventions implemented to improve continuity and coordination of care.

PROCEDURE:

I. Data Collection

A. At least annually, the health plan collects data about opportunities for collaboration between medical and behavioral health care in the following six (6) areas. The results of any HEDIS measure may only be used for one area below (i.e., the same HEDIS measure cannot be used for more than one area):

1. Exchange of information (between behavioral health providers and primary care providers, medical/surgical specialists, organizational providers, or other relevant medical delivery systems). Communication between medical and behavioral health practitioners must be bi-directional. For example:
   - Medical care practitioner satisfaction (i.e., satisfaction regarding the timeliness and the frequency of communication) with behavioral health practitioner communication as assessed through the annual provider satisfaction survey
   - Behavioral health care practitioner satisfaction (i.e., satisfaction regarding the timeliness and frequency of communication) with medical care practitioner communications as assessed through the annual provider satisfaction survey

- Evaluation of solicited or unsolicited practitioner reports on communication between behavioral healthcare practitioners and medical practitioners, including protection of privacy

2. Appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care settings. For example:
   - Results of the HEDIS measure *Antidepressant Medication Management* (AMM)
   - Results of the HEDIS measures *Follow-up Care for Children Prescribed ADHD Medication* (ADD)
   - Data on the use of primary care guidelines for assessment of behavioral health disorders in at-risk individuals (e.g., eating disorders in adolescents or depression in the elderly) and referral to behavioral health providers
3. Appropriate use of psychotropic medications. For example:
   - Results of the HEDIS measure *Antidepressant Medication Management* (AMM)
   - Results of the HEDIS measures *Follow-up Care for Children Prescribed ADHD Medication* (ADD)
   - ~~Results of HEDIS measure *Potentially Harmful Drug-Disease Interactions in Older Adults* (DDE)~~
   - Pharmaceutical utilization data for appropriateness of a psychotropic medication
4. Management of treatment access and follow-up for members with co-existing medical and behavioral health conditions. For example:
   - Results of the HEDIS measure *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia* (SMC)
   - Results of the HEDIS measure *Diabetes Monitoring for People with Cardiovascular Disease and Schizophrenia* (SMD)
   - Pharmacy data on medication interactions to assess coordination of co-existing medical and behavioral problems
   - Results of the HEDIS measure *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (APM)
5. Primary or secondary preventive behavioral healthcare program implementation. For example:
   - Data on the SSFB (Start Smart for Baby) Perinatal Depression Screening Program
   - Health Risk Screening/Health Risk Assessment PHQ-2 depression screening and referral
6. Special needs of members with severe mental illness or serious emotional disturbance. For example:
   - Results of the HEDIS measure *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (SSD)
   - Results of the HEDIS measure *Diabetes Monitoring for People with Diabetes and Schizophrenia* (SMD)
   - Results of the HEDIS measure *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia* (SMC)
   - Data on frequency of assessment of substance use disorders
   - Results of the HEDIS measure *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (APM)

B. The health plan facilitates and participates at least annually in collaborative discussions involving behavioral health and medical practitioners on the data collected as described above. The health plan collects evidence of the collaboration (e.g., joint committee minutes, agendas, etc.).

II. Collaborative Activities

A. The health plan annually conducts quantitative and qualitative/causal analysis of data and collaborates with medical and behavioral health care practitioners to identify at least two (2) opportunities for improvement, such as:
   - Improve the process for members to authorize sharing of behavioral health information with PCPs, specialists, and other relevant nonbehavioral healthcare practitioners
   - Develop or implement primary care guidelines for screening, assessing, diagnosing, treating, and referring common behavioral problems
   - Increase nonbehavioral healthcare practitioner satisfaction with feedback from behavioral health practitioners and other specialists
   - Increase behavioral healthcare practitioner satisfaction with feedback from nonbehavioral health practitioners and other specialists
   - Improve procedures for screening and managing with co-existing medical and behavioral health conditions
   - Improve identification and management of elderly members with multiple behavioral health medications and potentially inappropriate dosages
   - Improve procedures for communication about medications between PCPs and behavioral health providers

- Educate PCPs about appropriate indications for referring patients with hyperactivity disorder or depression to behavioral healthcare specialists
- Provide tools to facilitate communication between a medical practitioner and the behavioral healthcare practitioner who is treating the medical practitioner's patient
- Hold Quarterly meetings with the behavioral healthcare organization to develop coordination activities

B. Where areas for improvement have been identified, the health plan also collaborates with medical and behavioral health practitioners to implement at least two (2) interventions to address the identified opportunities for improvement. Collaborative actions may include but are not limited to the following:
   - Work with behavioral health providers to establish a system for communicating members' prescribed medications to their PCPs
   - Develop and implement a clinical practice guideline for a behavioral health disorder that is commonly managed in the primary care setting, e.g., depression, ADHD
   - Place behavioral health providers in high volume or key primary care settings
   - Develop and implement a clinical practice guideline that includes the evaluation of appropriate psychopharmacological use for a given disorder
   - Evaluate exchange of information data for accuracy, sufficiency, timeliness, frequency, and clarity

C. The health plan annually measures the effectiveness of the interventions taken for at least two (2) identified opportunities.
   - Well-defined measures are used which may include activities, events, occurrences, or outcomes for which the health plan collects data to assess performance for the areas of collaboration identified.
   - HEDIS measures are used and ensure sound methodology; for measures outside of HEDIS, the health plan ensures valid measurement methodologies are utilized, and defines the numerator and denominator, sampling methodology, sample size calculations, measurement period and seasonality effects, if applicable.
   - Measurement and analysis occur no less than annually and includes comparison of results against a goal or benchmark as well as a barrier analysis.
   - The health plan must measure the effectiveness of the actions (i.e., re-measure) twice, and analyze the results of each re-measurement. A baseline measurement, analysis, and interventions must precede the first measurement. For each opportunity, two (2) full cycles of measurement are included with analysis and interventions.

D. Collaboration with medical and behavioral health practitioners, which may include data analysis, interventions selection, and review of outcomes, must be effectively documented. Documentation may include but is not limited to: minutes demonstrating Quality Committee evaluation of collaborative activities during the quality evaluation process; participation of behavioral health practitioners in the Quality Committee, subcommittees of the Quality Committee, Quality teams, or external work group meetings involving health plan staff and behavioral health practitioners; annual written evaluation/report, etc.

REFERENCES: Current NCQA Standards and Guidelines for the Accreditation of Health Plans

ATTACHMENTS: n/a

ROLES & RESPONSIBILITIES: n/a

REGULATORY REPORTING REQUIREMENTS~~:~~

~~HB 434, Act 319~~La R.S. 46:460.54 applies to material changes of this policy

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy	New policy created to align with corporate policy CC.QI.10	07/11/2023
Annual Review	Updated to align with corporate policy	04/09/2024

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.