**PCMH 2022 Summer Sessions: Integrated Care Plan Workshop Key Take-aways**

**Define an Integrated Care Plan**

* + Why is an ICP needed?
	+ What criteria qualify a patient for an ICP?

 ▪ What if an ICP is initiated and other party does not agree criteria was met to have an ICP?

* + What are the similarities and differences between an ICP (MCOs focus) and a care plan (PCMHs focus)?

**Define Roles and Expectations: Standard Workflow**

* Who is the ICP for?
	+ - Patient? What is their role in the plan?
		- MCO? Focused on high utilizers/cost reduction?
		- PCMH? Patient-centered focus *(receive a significant volume of information from the MCOs- how prioritize? “what do I do with the ICP?”)*
	+ Who owns the ICP?
		- Who is responsible for maintaining the accuracy to ensure the information is relevant and current? Are there consistent check ins with the patient and/or PCMH?
		- MCO initiates but do they update the information and revise if there are changes to the plan?
		- Who and how is the ICP loop closed?
	+ What is the role of the MCOs, the role of the PCMHs, and role of patient?
		- MCOs initiate ICP, what is the PCMH expected to do with the plan?
		- Are there ICP team meetings across MCO and PCMH entities? For example, in case of severe mental illness, service coordinator from PH MCO/BH MCO care management or nurse care manager can initiate meeting.
		- Specify point of contact for information from the MCO to PCMH and vice versa, including consents/release of information

**Define Bidirectional Communication**

* Interoperability to share ICP
	+ - * *Could PA Rise tool be used to facilitate sharing and coordination of the ICP between MCOs and PCMHs?*
			* Could there be a standard template used by all MCOs to share with PCMHs?
				+ Each MCO has a different format and different method to communicate with the PCMHs (verbal and/or electronic)
				+ MCOs acknowledged the variability
		- Does the patient receive the plan? If so, how? *This could help with the issues of getting consents across entities.*
			* *MCOs shared when they have trouble reaching members, they reach out to PCMHs for help since they have a relationship with the patient. However, patient not come in to PCMH so also rely on MCOs to make connection.*



 **Education**

* What are the services provided by the MCO for the ICP to support member and PCMH?
	+ - * Avoid duplication of services; for example, PCMH developed their own resources because were unaware of MCO’s
				+ Need to make best use and availability of resources
		- Use of terminology (Dr. Ken Thompson): Primary Health Services vs. Primary Care and Behavioral Health Care and Social Needs Care
			* Patient will likely need all these services- could be way to align agendas and delivery across MCOs and PCMHs to focus thinking on integration
			* Overall cost reduction