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Innovations in Care Coordination

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What is a Certified Community Behavioral Health Clinic (CCBHC)?

CCBHC is a model of care that aims to improve service quality and accessibility. CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence or age – including developmentally appropriate care for children and youth. CCBHCs do the following:

- Provide integrated, evidence-based, trauma-informed, recovery-oriented and person- and family-centered care.
- Offer the full array of CCBHC-required mental health, substance use and primary care screening services.
- Coordinate care with other behavioral health, physical health, and social services systems in the community.

The primary goal of the CCBHC program is to increase access to mental health and substance use care for underserved communities.

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Care Coordination in the CCBHC Model

As the linchpin of the Certified Community Behavioral Health Clinic (CCBHC) model, care coordination supports the provision of all the required services, ensures individual and population health care outcomes are being met and that connections between service entities are robust and supportive of peoples needs.

- High-quality physical health care (acute and chronic) and behavioral health care
- Social services, housing, educational systems and employment opportunities as necessary to facilitate wellness and recovery of the whole person
- Other systems necessary to meet the needs of the people they serve, including criminal and juvenile justice and child welfare

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Care Coordination 3.A: General Requirements

- The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA, 42 CFR Part 2, and other federal and state privacy laws.
- At minimum, people receiving services should be counseled about the use of the 988 Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis and stabilization services should a crisis arise when providers are not in their offices. Crisis plans may support the development of a psychiatric advance directive.
- Nothing about a CCBHC's agreements for care coordination should limit the freedom of a person receiving services to choose their provider within the CCBHC, with its designated collaborating organizations (DCOs) or with any other provider.

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Care Coordination 3.B: Care Coordination and Other Health Information Systems

- The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records (EHR).
- The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as:
  - Population health management
  - Quality improvement, quality measurement and reporting
  - Reducing disparities
  - Outreach
  - Research
- When CCBHCs use federal funding to acquire, upgrade or implement technology to support these activities, systems should utilize nationally recognized, HHS-adopted standards, where available, to enable health information exchange.

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Care Coordination 3.B: Care Coordination and Other Health Information Systems

- The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consent from people receiving services and complying with privacy and confidentiality requirements.
- Within two years following CCBHC certification or submission of attestation, the CCBHC develops and implements a plan to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan includes information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system it has in place or is implementing for transitions of care.
- To support integrated evaluation planning, treatment and care coordination, the CCBHC works with DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record.

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Care Coordination 3.C: Partnerships

Required Partnerships

- Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers and other facilities
- Federally qualified health centers (FQHCs)/Rural Health Centers/primary care
- Hospitals/Emergency Departments (EDs)
- Inpatient acute care hospitals and hospital outpatient clinics
- Inpatient psychiatric facilities, substance use detox, post-detox step-down services and residential programs
- Other community or regional services, supports and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, state-licensed and nationally accredited child-placing agencies for therapeutic foster care service and other social and human services

Additional Recommended Partnerships

- Other specialty and social and human services providers
- Indian Health Service and tribal programs
- Suicide and crisis hotlines and warmlines
- Shelters and housing agencies
- Employment services systems
- Peer-operated programs
- Developmental disabilities agencies and resource centers
- Substance use prevention and harm reduction programs
- Programs and services for families with young children

Any health care organization or social service provider supporting CCBHC clients.

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Care Coordination 3.D: Care Treatment Team, Treatment Planning and Care Coordination Activities

- The CCBHC treatment team includes:
  - The person receiving services.
  - Family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians.
  - Any other people the person receiving services desires to be involved in their care.
- The CCBHC designates an interdisciplinary treatment team that is responsible – with the person receiving services and their family/caregivers (to the extent the person receiving services desires their involvement or when they are legal guardians) – for directing, coordinating and managing care and services. The interdisciplinary team comprises individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic and recovery support needs of the people receiving services, including, as appropriate and desired by the person receiving services, traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups.

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Care Coordination Considerations

- Work cross-collaboratively internally and externally with other care coordinators to ensure care coordination is additive and cohesive
- Define levels of care, amount and frequency to apply with the people you serve
- Determine how to share data with partners and coordinate outcomes monitoring
- Focus on key moments:
  - Intake, Care transitions, Age transitions, Increased crisis or service utilization, Reaching underserved and special populations

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Care Coordination Considerations

- Potential staffing structures:
  - Responsibilities shared across a range of staff, team-based, case managers, dedicated care coordinators
- Training:
  - Care coordination elements, coordination with primary care, evaluation, CQI, population health
- Documentation:
  - Importance even when non-billable, tracking deadlines, accessible to all staff

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Care Coordination Evolution

- Care coordination is an evolving practice that continually needs to adjust based on needs and evolving services and supports
- Staff can use CQI processes to determine what is working well and where adjustments to the approach are needed
- Given care coordination's many moving parts, assessing the strengths and challenges in your CCBHC through CQI processes is important

"Don't get stuck in one idea of what care coordination is. It's going to grow, change, look different. The client must always be in the forefront. When considering changes, if they don't support the client, they are not worth doing."
- *Marisol Guevara, Clinical Care Coordinator, Berks Counseling Center*

These concepts are from the Care Coordination Toolkit available on the CCBHC NTTAC website here: CCBHC-Care-Coordination-Toolkit-24.07.02.pdf (thenationalcouncil.org)

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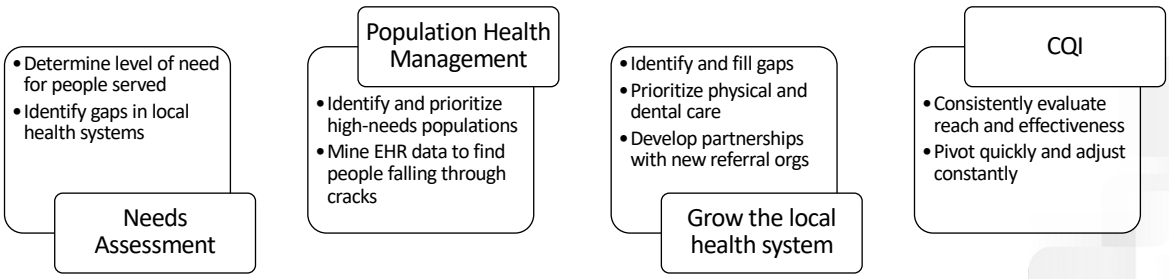
A "Learning" Care Coordination Program



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CCBHC Community Needs Assessment Toolkit (thenationalcouncil.org)

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Example from the Guidance Center in Rural Pennsylvania

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Takeaways

- **Cast a wide net & Be creative**
- **Don't be afraid to ask for partnerships.**
- **Be a good partner**. Show up to their events, refer to their services, cross-promote on your social media, etc.
- **Join everything possible**. Health fairs, back to school nights, etc. Be visible in your community.
- **Get staff on boards, collectives, etc.** Ask staff from a wide range of positions to participate in these types of things, not just management.
- **Know your staff.** You never know who might know someone who knows someone. Don't limit opportunities to only those in leadership roles.
- **Don't lose sight of the WHY**. The correct answer is NEVER, "it's just something we have to do." Ask your staff what they need, for suggestions, and for feedback on changes. Never add until you can figure out what to remove.
- **Develop a system to track MOUs** and make sure you renew those agreements

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	Charting	Quality/Fidelity	Screenings/ Assessments	Treatment Considerations	Programs & Services
Pre-CCBHC	• Paper charts = Difficult to share information, No capability for "big picture" • "Siloed" departments = not a lot of communication	• No centralized oversight • Each Dept. responsible for own quality control/audits	• Limited standardization of screenings • Providers were free to use whichever tool they preferred and all were done on paper		
Demonstration (2017-2019)	• Adoption of the EHR = Much easier to share/access/analyze information • Electronic Prescriptions • Charts of screening scores over time	• HEDIS measures to report to state • Evaluator hired but not given much autonomy • Collection was clunky, few had access, focus more on collection	• Additional Screenings, Processes & resources developed for clients in response to screening outcomes • Standardized screening expectations	• Wellness goals integrated into every TXP • TXPs revised - include goals from all services received • Crisis Plans revised	Programs/Services Created: • Drug & Alcohol • Mobile Psych Rehab
CCBHC – E (2020-2022)	• Medical Profile permissions expanded • NOMs	• Quality Dept. created • Quality Advisory Board • Client Advisory Board • Using data in decision-making	• Additional follow-ups in EHR • NOMs, Additional health metrics • Using EHR for more reporting	• Therapy group supervisions changed format to include prescribers Crisis Plans revised again	Programs/Services Created: • Tobacco Cessation • ACT • Wellness Assessment • Forensic Case Mgmt. • Focus Room
CCBHC – IA (2022-2026)	• Referrals & Follow-Ups tracking • Patient Portal	• Credible BI used regularly • Streamlining processes, audits • Population Health Registry	• Reviewing assessments to ensure they continue to be relevant and up-to-date • Increased focus on SDOH	• Collaborative Documentation • Measurement Informed Care & Care Pathways *coming soon*	• Genoa pharmacy embedded in main clinic • Same Day Access • Scheduling Dept. • Crisis publicity increased

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	Staffing	Training	Partnerships/ Collaborations	Transparency
Pre-CCBHC	• Minimum staffing levels • Lots of burnout, turnover	• Basic requirements only • Clinician paid for any additional training • Confusing, laborious	• Inconsistent coordination with outside providers • Releases difficult to confirm • No time allowances	• A lot of things happening behind closed doors
Demo (2017-2019)	• Trauma-Informed Committee • More clinicians hired • Resistance, skepticism continued • Staff-appreciation events	• Increased education & training for EBPs, training for non-clinical staff • Agency funded	• PCP contact form & expectations standardized • Increased community partnerships (PA Thrive, UPB)	• Trauma-Informed Care Newsletter starts
CCBHC – E (2020-2022)	• More nurses added to staff • Wellness Committee • Training/Development Coord. • Dir. Of Comm/Provider Relations • Pay scales evaluated/improved • More staff appreciation, bonuses, PTO, EAP	• Relias • Additional EBPs • Health data collection increased, supplies provided	• Walk with a Doc • Increased collaboration with PCPs/Specialists • Improved communication with law enforcement/parole/jails • Interns welcomed, increased partnerships with colleges	• All-Agency Meetings • More staff events ("The Great Coworker," Lunch & Learns, committee-sponsored events, etc.) • Increased information dissemination/sharing
CCBHC – IA (2022-2026)	• Client Navigator (SDA) • Schedulers • Care Navigator for Veterans & Military Families *coming soon*	• Additional EBPs & EB Specialized training: *Geriatric, LGBTQIA+ Youth, Military* • Poverty Simulator • Training Center Opens • MHFA	• Improved coordination with county and law enforcement • FHQC CEO joined Board • MOU with 988 • Collaborative Board to address housing needs/problems • Partnership with Court System to provide support to jurors • Removing barriers, providing services in non-traditional locations	• Sharepoint • Annual Report available to all • Inspire for Mgmt. staff

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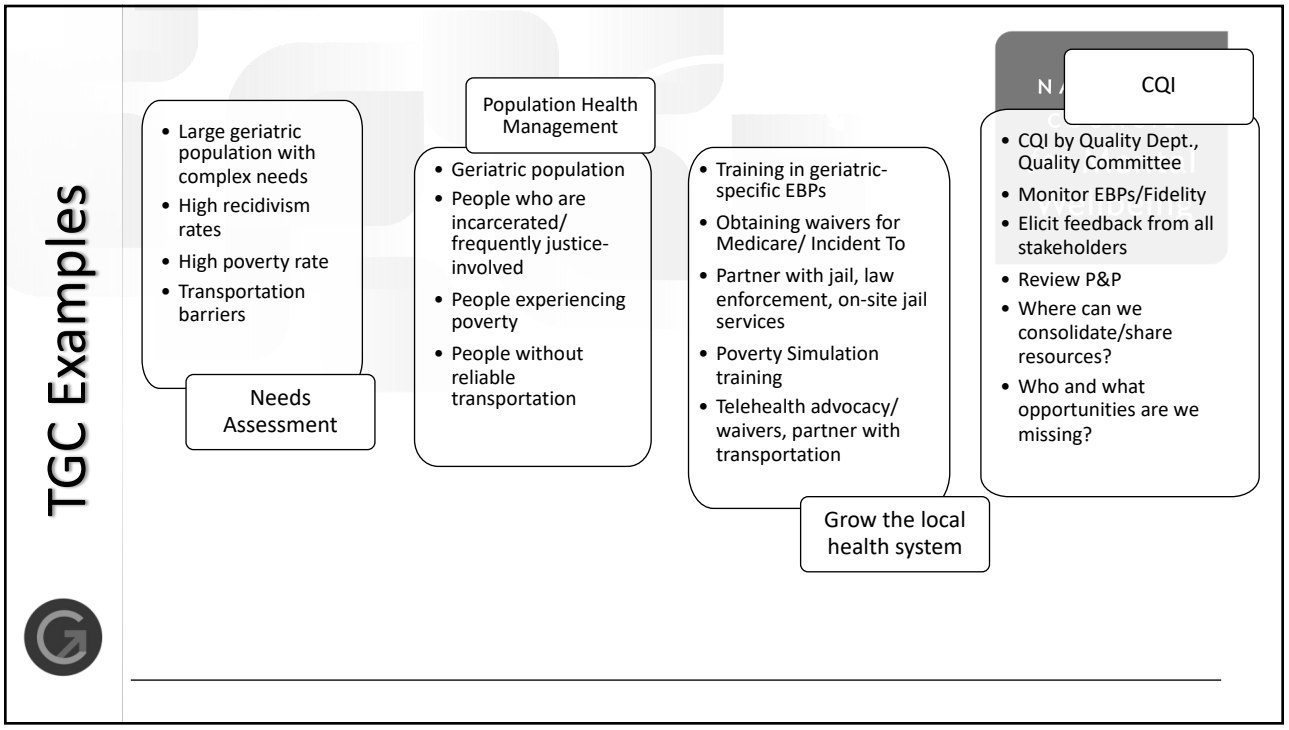

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Now its your turn…..

Please share examples from your clinic of how you have advanced your care coordination program within these categories….

- Needs Assessment
  - Determine level of need for people served
  - Identify gaps in local health systems
- Population Health Management
  - Identify and prioritize high-needs populations
  - Mine EHR data to find people falling through cracks
- Grow the local health system
  - Identify and fill gaps
  - Prioritize physical and dental care
  - Develop partnerships with new referral orgs
- CQI
  - Consistently evaluate reach and effectiveness
  - Pivot quickly and adjust constantly

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CCBHC-Expansion Grantee National Training and Technical Assistance Center

We offer CCBHC grantees…

Virtual Learning Communities, Webinars and Office Hours

Regular monthly offerings that are determined based on grantees expressed needs.

Opportunities for Collaboration with Other Grantees

Monthly Peer Cohort Calls for CCBHC Program Directors, Executives, Evaluators and Medical Directors.

Direct Consultation

Request individual support through our website requesting system and receive 1:1 consultation.

On-demand Resource Library

Includes toolkits, guidance documents, and on-demand learning modules.

On-Demand Modules/Lessons - National Council for Mental Wellbeing (thenationalcouncil.org)

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