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CCBHC-E National Training and Technical Assistance Center

Care Coordination Learning Community
Session 2: Strategies and Considerations for Care Coordination in a CCBHC

August 18, 2022

CCBHC-E National Training and Technical Assistance Center
Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

Zoom Logistics

- Call in on your telephone, or use your computer audio option
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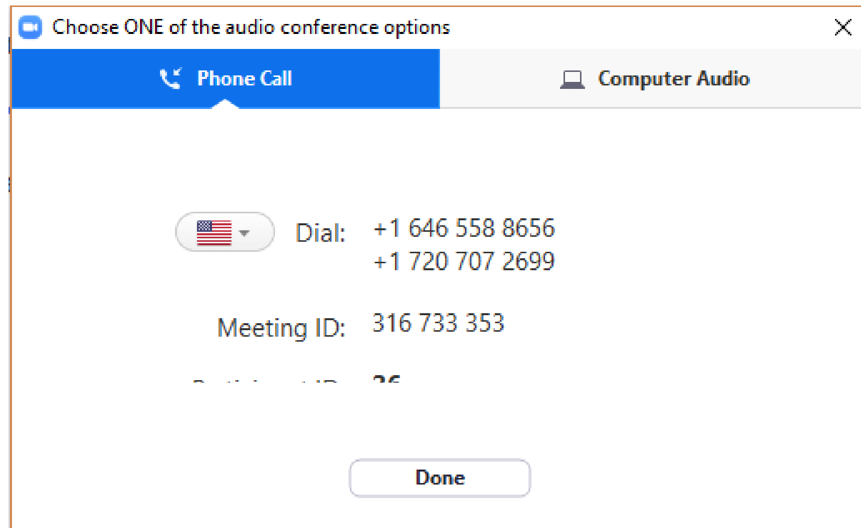

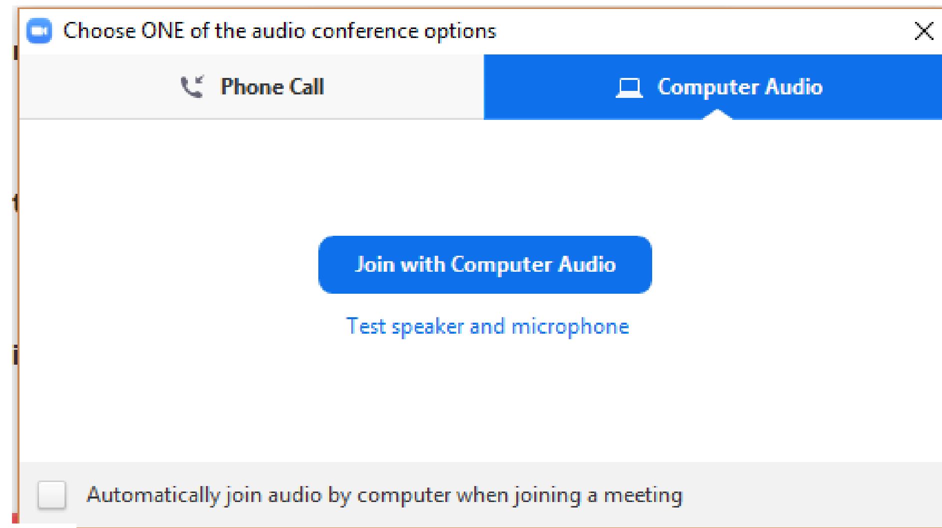

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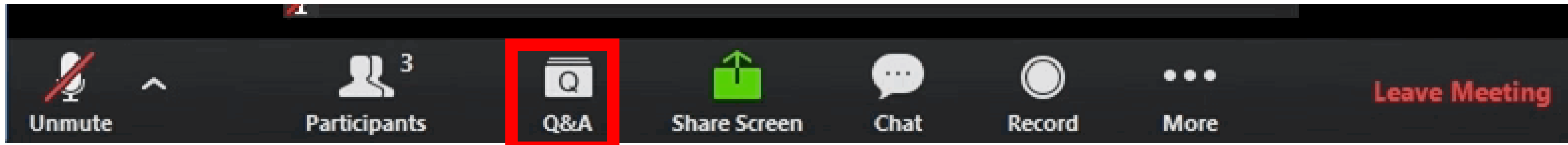
How to Ask a Question



Please share questions throughout today's session using the **Q&A Feature** on your Zoom toolbar.
We'll answer as many questions as we can throughout today's session.

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Acknowledgements and Disclaimer

This event/publication was made possible by Grant Number 1H79SM085856 from the Substance Abuse and Mental Health Services Administration (SAMHSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views, opinions, or policies of SAMHSA, or the U.S. Department of Health and Human Services (HHS).

Today's Presenters

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Agenda

- Today's objectives
- Sharing: CCBHC success stories
- Overview of Care Coordination within the Context of CCBHC and National Landscape
- CCBHC Model Showcase
  - Four County Mental Health Center, Inc.
  - Grand Health
- Breakout discussion
- Wrap up and next steps

Learning Objectives

Define	Define care coordination within the context of the CCBHC model and key requirements
Identify	Identify common mechanisms for achieving successful care coordination
Recognize	Recognize different care coordination models employed successfully by CCBHCs leveraging their population and community context

CCBHC Success Stories

Share a success you've achieved related to care coordination at your CCBHC. It could be an individual's experience of care, collective impact, a process change, or a culture change.

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Defining Care Coordination

Care Coordination is the linchpin of the CCBHC model.

"Care coordination involves ***deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care***. This means that the ***patient's needs and preferences are known ahead of time and communicated at the right time to the right people***, and that this ***information is used to provide safe, appropriate, and effective care to the patient***." Agency for Healthcare Research and Quality (AHRQ)

Source: https://www.ahrq.gov/ncepcr/care/coordination.html

CCBHC Program Requirement 3: Care Coordination

Section 223 (a)(2)(C) of PAMA requires: “Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts with the following:

- Federally-qualified health centers (and as applicable, rural health clinics) to provide Federally-qualified health center services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the CCBHC.
- Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs.
- Other community or regional services, supports, and providers, including schools, child welfare agencies, and 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.
- Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the Department as defined in section 1801 of title 38, United States Code.
- Inpatient acute care hospitals and hospital outpatient clinics.

Source: https://www.samhsa.gov/section-223/care-coordination

Goals for Achieving Care Coordination

The goal of care coordination is to ***create a delivery system that is less fragmented and more organized****, where* ***handoffs are clear****, and* ***patients and clinicians have the information they need to optimize the patient-clinician partnership*** *(National Quality Strategy, 2011)*

National Quality Strategy has identified three long-term goals related to care coordination:

- Improve the quality-of-care transitions and communications across care settings.
- Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status.
- Establish shared accountability and integration of communities and health care systems to improve quality of care and reduce health disparities.

Source: https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/carecoordination.html

Mechanisms for Achieving Successful Care Coordination

Core Care Coordination Activities

- Establish accountability or negotiate responsibility
- Communicate team roles and commitments
- Facilitate transitions
- Assess needs and goals
- Create a proactive plan of care
- Monitor, follow up, and respond to change
- Support self-management goals
- Link to community resources
- Align resources with patient and population needs

Broad Care Coordination Activities

- Teamwork focused on coordination
- Health Care Home
- Care management
- Medication management
- Health IT-enabled coordination

Source: https://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter3.html

Measuring Effective Care Coordination

- *Transitions of care* (e.g., how long did it take to connect with a patient after inpatient/ED discharge?; was discharge plan communicated and incorporated into care plan, etc.)
- *Preventable emergency department visits* (e.g., principal ED diagnosis related to mental health, substance use, etc.)
- *Potentially avoidable hospitalizations* (e.g., lower hospitalization rates related mental health and substance use conditions)
- *Integration of medication information* (e.g., electronic exchange of information and alerts)
- *Use of electronic health records* (e.g., electronic share of patient medical information and history between providers)

Source: https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/trends.html

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Care Coordination Development and Continuous Improvement at Four County Mental Health Center, Inc.

Steve Denny

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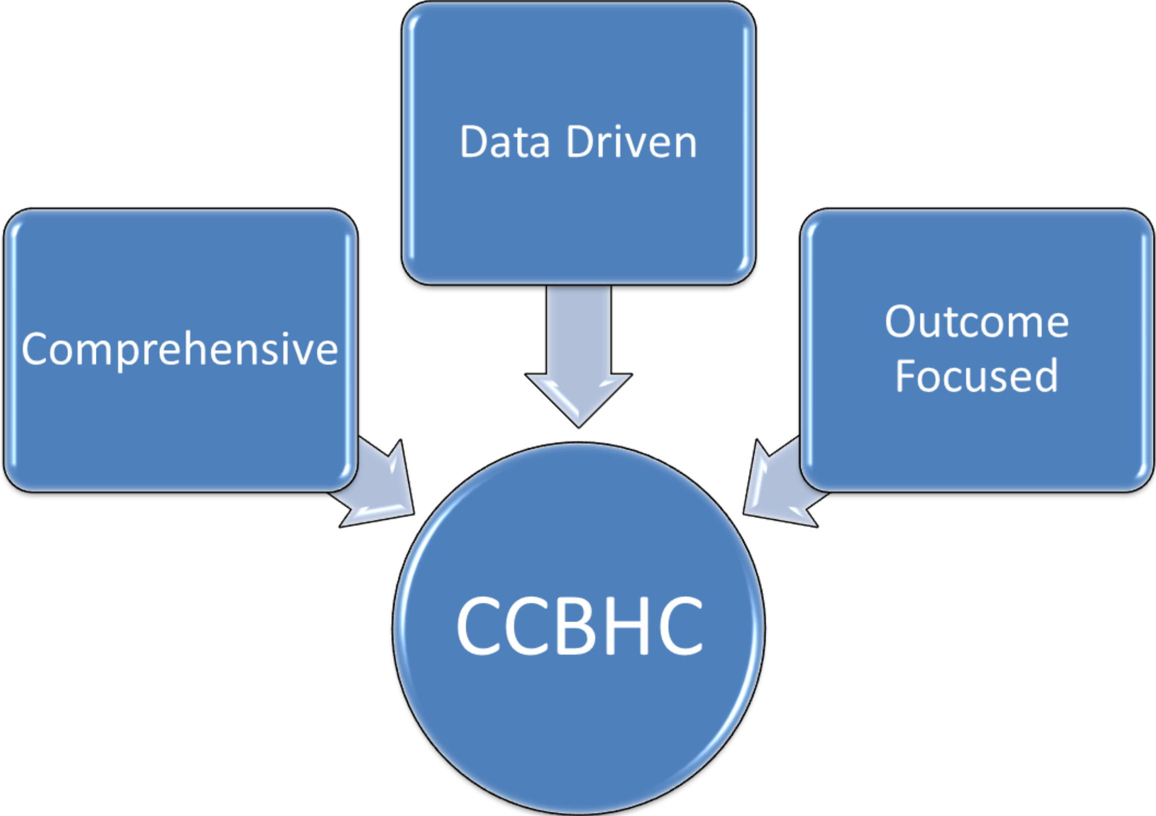
Four County Mental Health Center (FCMHC): Quick Facts

- Located in Southeast Kansas serving both rural and frontier areas across 5 counties
- Awarded CCBHC expansion grant in summer of 2020-Closed in May of 2022
- Kansas passed CCBHC legislation in spring of 2021
- FCMHC is currently 1 of 9 provisionally certified CCBHC's in Kansas

CCBHC: 3 Key Ingredients



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Four County Mental Health Center Expansion Grant Goals

- Increase in number of patient's served
- Serve 100 Veterans through coordination of care
- 50% of patients have Primary Care Provider identified in Electronic Health Record
- 50 clients receive ACT services in year 1
- Key Health Indicators tracked for 75% of patients enrolled in year 1
- Fill and retain vacant positions!
- 150 staff received Psycharmor Training in Year 1

Key Care Coordination Approaches

- Study the criteria – identify gaps
- Develop a dedicated team
- Adopt a definition
- Develop a workflow (Version 1.0 and beyond)
- Train-Refresh-Train Again
- Develop data management plan
- Integrate into CQI process

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Adopting a Care Coordination Definition

- Is timely, addresses whole-person needs, improves chronic conditions, and assists in the attainment of the patient’s goals
- Supports adherence to treatment recommendations, engages patients in chronic condition self-care, and encourages continued engagement in a variety of wellness initiatives
- Involves coordination and collaboration with other providers to monitor the patient’s conditions, health status, and medications and side effects
- Engages patients and family/support persons/guardians in decisions, including decisions related to pain management, palliative care, and end of life decisions and supports
- Implements and manages treatment plans through quality metrics, assessment survey results and service utilization to monitor and evaluate intervention impact
- Creates and promotes linkages to other agencies, services, and supports.

Care Coordination Components

Clinical

Community Support Services

Care Coordination

HealthCare Services

Community-based Services

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Strategy Considerations

- Primary care partnerships
- Veterans – SMVF activities
- Acknowledging the work already being done
- Enhance existing partnerships (hospitals, law enforcement, foster care, etc.)
- Connecting with disparate populations

Possible Gaps

- 3.c.1-3.c.2: FQHC/Inpatient-Care Coordination Protocol
- 3.c.4: Veterans Affairs Agreement/MOU
- 3.c.5: Follow up protocol related to inpatient, ED's, residential facilities, etc.
- 3.d.1-3.d.3: Integrated treatment teams/planning.

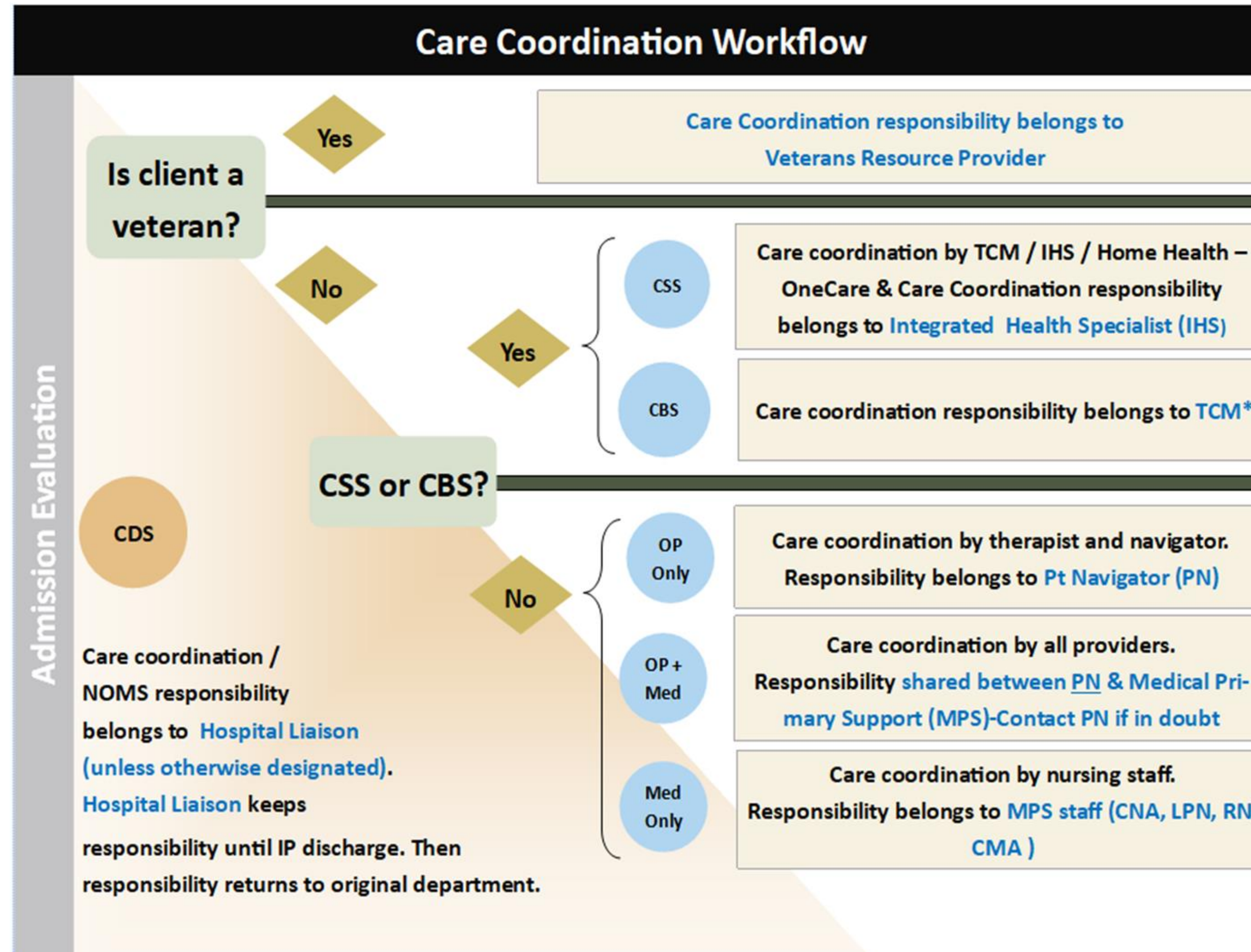
CCBHC Points of Emphasis

- Coordinate care across spectrum of health services including social services
  - Healthcare
  - Housing
  - Transportation
- Inpatient Psychiatric and Emergency Department admissions - 24-hour contact upon discharge expectation
- Referral and confirmation of appointments
- Veterans Services and benefits

Care Coordination is not limited to……

- Target populations
- Health home program(s)
- Writing good treatment plans
- Compliance activities (signatures and more)

Care Coordination Workflow



Integrated Teams Roles

GP	SUD	SED-SMI
Patient Navigator (CC)	Counselor (CC)	TCM (CC)
Therapist	Case Manager	Case Manager
Medication Provider (IA)	Peer Support (IA)	Therapist
		Medication Provider
		Peer, Youth, Family
		Supported Employment (IA)

Integrated Teams – Special Populations

- *Assertive Community Treatment (ACT):* Traditional ACT model with some integration from other programs
- *Service Members Veterans and Families (SMVF):* SMVF navigator is available for a variety of care coordination issues across multiple programs
- *Early Childhood Program:* Early childhood teams include therapy, case management, and family-based resources.

Care Coordination Process/Activities

- Staffing/treatment team meetings
- Integrated treatment planning (includes tiered protocol)
- No contact – engagement activities
- Internal EHR communication (multiple methods)
- Inpatient admission/discharge notifications
- Caseload review and assessment
- Referral and follow up activities
- Primary care screening and follow up

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Documentation Integration Strategy

- Progress notes
- General notes
- Referral notes
- OP therapy notes

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Sample Care Coordination Progress Note

Was a Care Coordination activity provided?

- (●) Yes

If YES, check all activities provided below

- [ ] Scheduled an appointment with
- [ ] Confirmed an Appointment was kept
- [ ] Provided Health Information and/or Education
- [ ] Identified and addressed health care barriers
- [ ] Shared key healthcare information with another healthcare provider or community partner with proper consent
- [ ] Monitored admission with Emergency Department, inpatient psychiatric facility, residential or other acute care facility
- [ ] Coordinated discharge and communicated with all relevant parties involved
- [ ] Provided 24 hour contact after an admission to an Emergency Department, inpatient psychiatric, residential, or other acute care facility
- [ ] Provided referral to external provider including long-term services and supports for specialty care
- [ ] Monitored a member's progress towards achieving goals and revising treatment plans and modalities as necessary to reflect the patient needs
- [ ] Obtained or reviewed records to inform treatment

Is follow-up required?

- ( ) Yes (please explain)
- ( ) No

Sample Quarterly Care Coordination Report

Distinct clients with at least one "yes, care coordination provided" within this quarter	1290
Scheduled an appointment	720
Confirmed an Appointment was kept	295
Provided Health Information and/or Education	140
Identified and addressed health care barriers	180
Shared key healthcare information with another healthcare provider or community partner with proper consent	277
Monitored admission with Emergency Department, inpatient psychiatric facility, residential or other acute care facility	10
Coordinated discharge and communicated with all relevant parties involved	71
Provided 24 hour contact after an admission to an Emergency Department, inpatient psychiatric, residential, or other acute care facility	6
Provided referral to external provider including long-term services and supports for specialty care	7
Monitored a member's progress towards achieving goals and revising treatment plans and modalities as necessary to reflect the patient needs	1372
Obtained or reviewed records to inform treatment	92

Key Performance Indicator Data

Care Coordination Recipients

	Q1	Q2	Q3	FY Average
FY 2021	0	1057	1393	1349
FY 2022	1613	1620	2018	1750

Care Coordination "Related" Goals Achieved Through Grant Period

- 208 SMVF (veterans/families) received care coordination service-Goal 100
- 74% of FCMHC clients had PCP identified-goal 50%
- Developed/implemented new treatment plan
- Developed CQI process for inpatient admissions/readmissions
- Developed tobacco screening and referral protocol

Closing the Referral Loop

- FY 21 Appointment Confirmation Ratio: 45%
- FY 22 Appointment Confirmation Ratio: 54%
- Last Quarter: 61.62% - ***New Milestone!!***

Lessons Learned

- Start simple – you are already doing much of this work
- Develop a communication plan and follow up often
- Written workflows are essential, but don't assume that they will be remembered
- Share stories!

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The Evolution of Care Coordination at Grand

Larry Smith, CEO
Josh Cantwell, COO
GRAND Mental Health

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History of Care Coordination at GRAND

- Early on, each treatment location had certified case managers and worked from a case management needs assessment
- There was no real coordination and case management was provided on a case-by-case basis
- Focus was primarily on internal case management and referral
- Limited contact with external community partners

History of Care Coordination at GRAND

- The advent of Health Homes in 2015 began the transition from case management to care management to care coordination and were assigned to each county in our service area
- GRAND began to specialize in various types of care coordination with the utilization of RN Case Managers to provide healthcare coordination with PCPs and specialized care (dentistry, optometry, etc.)

CCBHC Increased Access to Care Coordination

- We began to recruit and hire care coordinators to focus on specific populations and who could specialize in various domains of care coordination
- Decisions were made based on the volume of need for a specific type of resource (Housing, Employment, medical) and by unique needs held by certain populations (veterans, court involved populations, youth)
- Onboarded RN case managers to improve communication with client's primary care physicians
- RN case managers also worked to ensure client's attendance with lab work, dental, vision, and psychiatry appointments…aimed at improving client health outcomes and reduce duplication of services

Purposeful Outreach to Community Partners

- GRAND seeks to have MOUs with partnering entities which outline care-coordination responsibilities for each party
- Relationships are paramount
    - Frequent communication and process review helps to keep the lines of communication open, and everyone focused on the health of those being served

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Care Coordination on the Treatment Team

- Core Treatment Team serves caseload of 40 individuals
- Team consists of:
  - Integrated Team Manager (LMHP)
  - Care Coordinator
  - Peer Recovery Support Specialist/ Family Support Provider
- Care Coordinator responsible for internal and external care coordination activities

Care Coordination Process Examples

- RN care coordinators assigned to each client and are required to do monthly care coordination calls with PCPs
- Able to identify and communicate new needs arising from either party's communications with client
- Multidisciplinary team meetings occur monthly in each school. Care coordinators discuss with school personnel (principals, counselors, social workers) what is working and barriers to students' success

New Positions Dedicated to Care Coordination

- Additional levels of oversight to ensure the highest quality of care coordination
- Law Enforcement Engagement Director
- Housing Coordinator to grow the housing program and offer additional levels of support to consumers including better relationships with homeless shelters, sober living, section 8 housing and local landlords
- Veterans Outreach Coordinators
- Dedicated care coordinators for "most in need" and PACT

Focus on Youth

- In the early 2000s youth in our service area were being placed in institutional settings at an alarming rate. We decided to focus our resources on treating children and their families to keep them in their homes and receiving high quality services in their own communities
- In 2004 GRAND began implementing component of wraparound for youth. Each youth and family were assigned a team that consisted of a therapist, case manager and family support provider. There was a formalized process of coordinating care with schools, DHS, OJA, family and other natural supports within the community

Focus on Youth

- GRAND has developed close partnerships with 66 school districts comprised of 215 individual schools to provide imbedded mental health and/or substance use services
- Currently serving 4,847 children throughout the 12 county CCBHC service area
- Employ 457 staff devoted to serving children
  - 165 Integrated Team Managers
  - 156 Care Coordinators
  - 91 Behavioral Health Coaches
  - 45 Family Support Providers

Using Technology to Increase Care Coordination

- Mobile devices equipped with the MyCare application provided to
  - All law enforcement in our service area
  - Hospitals
  - Schools
  - PCP offices
  - Health Departments
  - Libraries, Museums
  - Health Departments
  - Most in need clients

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Next Steps

- Fully integrating RN care coordinators into our team-based treatment approach with an Integrated Team Manager guiding the team
- An engagement team focused on reducing readmission to hospitals, residential treatment, and jails by coordinating services before and after discharge
- Ensure every client in services has an iPad equipped with the MyCare App and place iPads in the community at additional high needs areas

Breakout Discussion

- The CCBHC model emphasizes care coordination across the spectrum of health services, including social services. What are some of your agency's strategies for developing strong care coordination partnerships (how do you identify potential partners, how do you communicate, what data is shared)?

- The CCBHC Expansion grant requires that CCBHCs have plans in place to use their HIT system(s) to conduct activities such as population health management work, quality improvement work, disparity reduction and outreach. How is your agency engaging in these activities?

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Keep the Conversation Going!

Take the information learned today and bring it back to your agency to continue the conversation.

- Consider how your agency is currently providing care coordination - does it match up with what the agency needs (per your needs assessment or other data)?
- Is the Care Coordinator job description up to date or does it need to be updated with additional tasks or duties?
- How do your Care Coordinators engage with technology? What are some of their most time-consuming tasks and are there opportunities for efficiency?

Upcoming Events

- **Monthly cohort calls** from the CCBHC-E NTTAC give CCBHC staff members a regular space for sharing with peers, generating solutions and cross-collaboration. Participate as often as you like. Sign up today and share this opportunity with other members of your team!
- **CCBHC-E executives** meet the last Friday of each month from 12-1 p.m. ET. Register here.
- **CCBHC-E program directors** meet the first Wednesday of each month from 12-1 p.m. ET. Register here.
- **CCBHC-E evaluators or CQI leads** meet the first Tuesday of each month from 3:30-4:30 p.m. ET. Register here.
- **CCBHC-E medical directors** meet the first Monday of each month from 12-1:00 p.m. ET. Register here.

- **CCCBHC Care Coordination Learning Community Session 3:** Wednesday, September 7, 2p.m.-3:30p.m. ET

  During session 3 we will cover:
  - Identifying care coordination strategies CCBHCs are employing with FQHCs/primary care and specialty care
  - Identifying characteristics and practices of agencies with effective care coordination relationships

CCBHC-E TTA Center Website

Access our ever-growing resource library, upcoming trainings and events, and request for individualized support.

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