NATIONAL COUNCIL for Mental Wellbeing

# CCBHC-E National Training and Technical Assistance Center

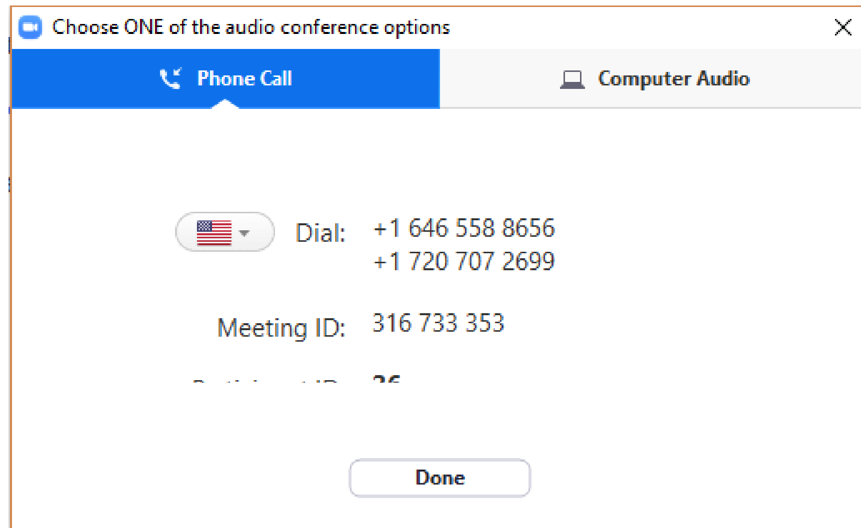
*Care Coordination Learning Community*
*Session 3: Partnerships*

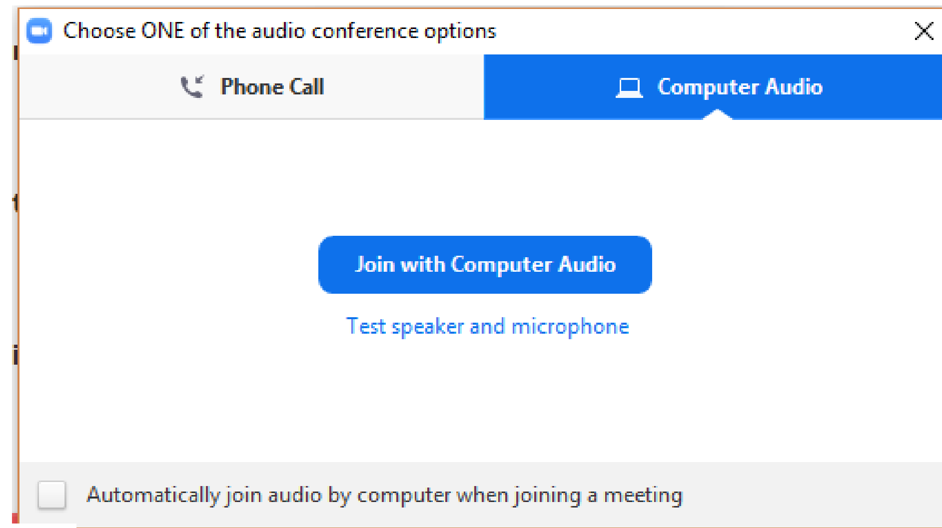
September 7, 2022

**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
- If you are on the phone, remember to enter your Audio PIN so your audio and computer logins are linked



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# Acknowledgements and Disclaimer

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# Today's Presenters

**Renee Boak, MPH**

Consultant

National Council for Mental Wellbeing

**Erin Ralston, LPC**

Clinical Director for Access, Homeless, Forensics, and Residential Services

Aurora Mental Health Center

**Ashleigh Kirk, LSW**

Perinatal and Youth Oral Health Manager

Colorado Department of Public Health and Environment

**Denise Bean, Ph.D.**

Executive Director

The Guidance Center

**Claudette Johnson, RN**

Director of Wellness Services

The Guidance Center

# Agenda

- Today's objectives
- Sharing: CCBHC success stories
- Overview of care coordination partnerships with FQHCs and primary/specialty care
- CCBHC Model Showcase
  - Aurora Mental Health Center
  - The Guidance Center
- Breakout discussion
- Wrap-up and next steps

# Learning Objectives

| Identify | Identify care coordination strategies CCBHCs are employing with FQHCs/primary care and specialty care |
| --- | --- |
| Identify | Identify characteristics and practices of agencies with effective care coordination relationships |

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# 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.

# Care Coordination with FQHCs/Primary Care and Specialty Care

Criteria 3.C

- The CCBHC has an agreement in place with Federally Qualified Health Centers (FQHCs) and, where relevant, Rural Health Clinics (RHCs), unless health care services are provided by the CCBHC.
- The CCBHC has provisions for tracking consumers admitted to and discharged from these facilities (unless there is a formal transfer of care).
- The CCBHC has protocols for transitioning consumers from emergency departments and these other settings to a safe community setting, including transfer of medical records, prescriptions, active follow-up, and, where appropriate, a plan for suicide prevention and safety, and for provision of peer services.

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

# Aurora Mental Health Center & Colorado Department of Public Health and Environment

*Aurora, Colorado*

# Dental-Behavioral Health Bidirectional Referral Project

Project Goals established

- Create a focus on comprehensive care, needs of the whole patient
- Create bidirectional referral process that creates a "no wrong door" to needed health services

Desired Outcome

- Decreased health disparities in prioritized population by increasing access to needed oral health and behavioral health care



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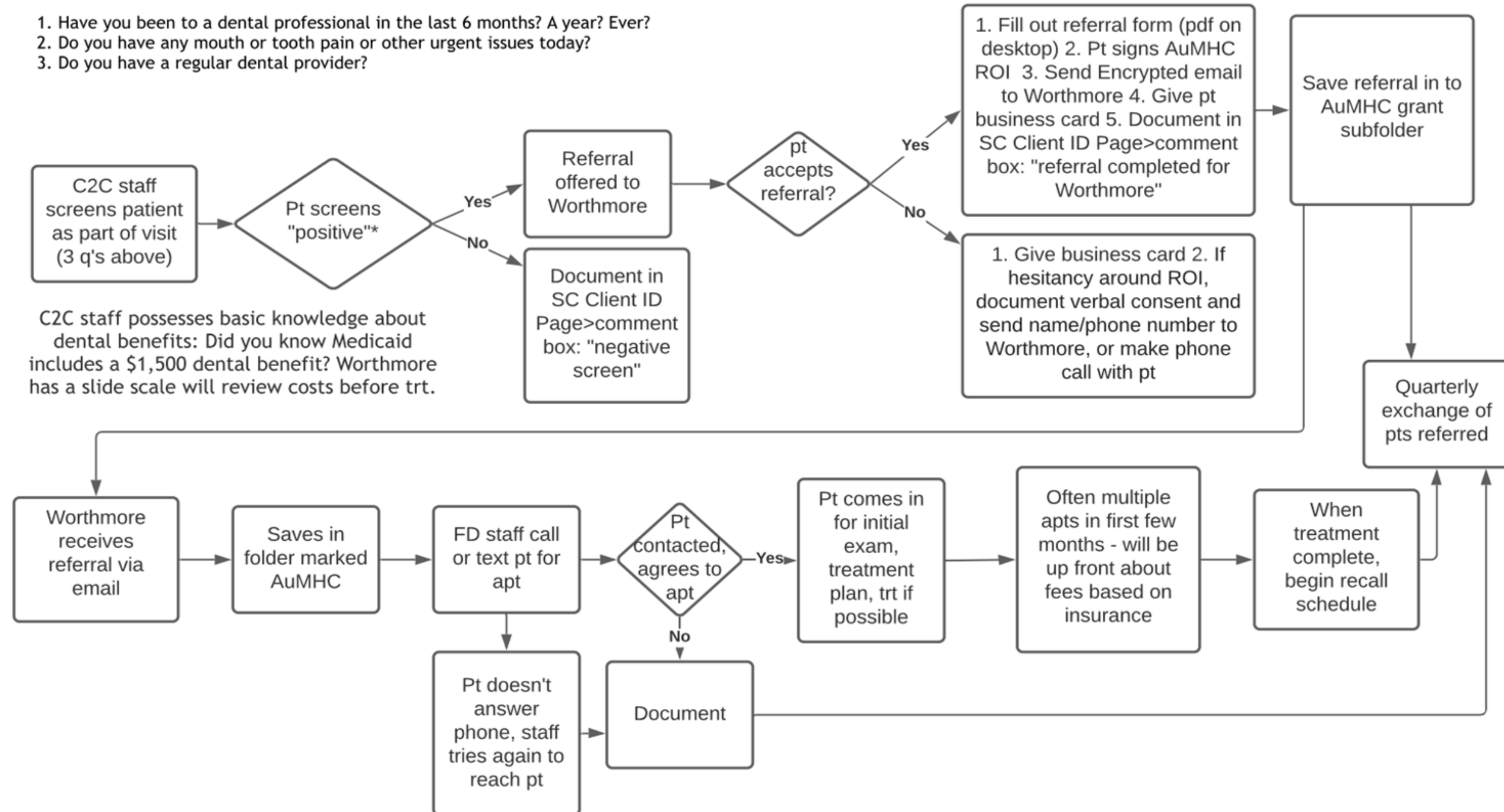
# Dental-Behavioral Health Bidirectional Referral Project

*Environmental Scan*
Connect to Care Clinic and Worthmore population match (refugee, immigrant), and a focus on safety-net clinic services

*Comprehensive Staff Training*
"Behavioral Health Basics in the Dental Office"

"Oral Health and Behavioral Health Connections"

Draft Referral Process: Connect 2 Care (C2C) to Worthmore Dental Clinic



# Referral to Worthmore Dental Clinic

Worthmore Clinic
1666 Elmira Street
Aurora, CO 80010
O: 720.460.0995
F: 877.434.7701

REFERRAL FORM FOR DENTAL CARE

*Aurora Mental Health Center*

Instructions: 1) Complete AuMHC ROI for Project Worthmore. 2) Complete Referral Form. 3) Fax or email (encrypted) both forms to 877.434.7701 or Dentalclinic@projectworthmore.org. 4) Document Referral in BH Screening Note in Smartcare. 5) Save completed referral form to grants subfolder.

Date of Referral: Click here to enter a date. Referring Clinician: Click here to enter text.

**Patient Name:** Click here to enter text. **DOB:** Click here to enter text. **Sex:** ☐ M ☐ F ☐ Trans* ☐ NC/NB

**Language(s):** Click here to enter text. **English Language Proficiency:** ☐ Low ☐ Mid ☐ High

**Patient/Guardian Phone:** Click here to enter text. **Guardian Name:** Click here to enter text. ☐ N/A

**OK to text:** ☐ Y ☐ N **OK to leave VM:** ☐ Y ☐ N

**Insurance Type/Number:** Click here to enter text.

**PCP or Medical Clinic Name:** Click here to enter text.

**Current Medication:** Click here to enter text.

**SCREENING INFORMATION** (select all that apply):

Is the patient in pain today?

☐ Yes

☐ No

Has the patient ever had dental care before?

☐ Yes

☐ No

If YES, when : Click here to enter text.

**OTHER COMMENTS: (Other medical concerns, fear/anxiety, patient questions, etc.)**

Click here to enter text.

## Referral Process Steps

1. Screening completed by staff
   - hygiene kit, bus passes
2. Email form “confidential” to front desk/intake coordinator
3. Saved in client files at AuMHC
4. Added to shared tracking spreadsheet

## Follow-up Process

- Care Coordinator assigned to track progress on spreadsheet, follow-up with Worthmore intake, and connect with client to address any barriers to completion of dental services

## Outcomes:

- In the first 4 months of the project at AUMHC:

  779 client intakes

  390 oral health screenings

  18 confirmed dental appts

  90 OH hygiene kits distributed



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# Referral to AuMHC

## Referral Process Steps

1. Screening complete by staff
   a. Intake form PHQ-2
   b. Clinician/patient conversation (motivational interviewing)
2. Email form "confidential" to lead referral coordinator at AuMHC
3. Saved in patient chart
4. Added to shared tracking spreadsheet

## Follow-up Process

1. Discussed during monthly Project Call between AuMHC and Worthmore
2. follow-up contact by Worthmore clinic staff to AuMHC Care Coordinator

Aurora Mental Health Center Live Life to the Fullest

1290 Chambers Road
Aurora, CO 80011
303.617.2300
aumhc.org

Please utilize the following instructions when referring a client for services at Aurora Mental Health. Connect to Care can be your point of contact for any program within the AuMHC system and is here to answer questions you have about AuMHC services.

When referring a client for services, please email (encrypted) the following referral form to C2CReferrals@aumhc.org. This information can also be provided over the phone, by calling 303-617-2656, or faxed to 303-923-6356 Attn: Connect to Care.

| Client Name | |
|---|---|
| Date of Birth | |
| Primary Contact Phone Number | |
| Back up or Additional Contact Information | |
| Language | |
| Insurance Type | |
| Check the documents that are included with this referral: | ☐ Release of Information<br>☐ Records<br>☐ Other |
| If the referral is sent with a release of information, we will respond with the date and time of the appointment, please put the name and phone number or email of the person to receive this information: | |
| Comments | |

The client is welcome to call us directly to initiate services and we will outreach them based on the referral information provided. The client is also welcome to call from Salud while still there or present at the 791 Chambers Road office to being services in person.

If you have any questions or concerns, please contact Connect to Care. If those options do not resolve your question or concern, please contact Erin Ralston, C2C Program Manager, at 303-627-2011 or by email at erinralston@aumhc.org.



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# The Guidance Center

*Bradford, Pennsylvania*

# The Guidance Center

- 2016 – CCBHC Demonstration Site
  2020 – CCBHC Expansion Grantee Recipient

- The Guidance Center (TGC) is located in rural Northwest Pennsylvania and offers a wide variety of community based behavioral health, prevention, education and crisis services to individuals of all ages. Established in 1984, TGC employs a staff of approximately 200. The majority of services are based in McKean County with some specialized programs offered in seven neighboring counties.

# Care Coordination: Who & Why

WHO

- McKean County has a population of 41,000.
  - 75% are individuals over the age of 18
  - 94% are Caucasian
  - Adult Obesity rate is 36%
- TGC serves individuals of all ages.

WHY

- *Community Needs Assessment* data indicated that McKean County ranked 53/67 counties in overall health factors.
- The ratio of primary care providers per person is 1,862:1; and mental health providers is 923:1.
- Screenings identified high number of individuals with significant mental illness & medical complications
- Limited transportation
- Staff lack of knowledge regarding physical health concerns
- Inability to share medical information in a timely manner

# Care Coordination Strategies

**Community Partnership Relationships**

- Be VISIBLE – face-to-face visits to providers
- Bi-yearly letters to local providers/primary care providers
- On-site coordination of services with PA Thrive: hepatitis, STD & HIV screens
- In-person visits with clients
- Walk With a Doc
- Care Coordination Agreements: be specific about what you offer and expectations

**Tactics**

- Incorporating physical health goals into every individual's treatment plan
- Development of wellness assessment and care coordination documents

# Care Coordination Strategies, cont'd

**Increase staff members' understanding**

- Provide training to staff on the expectations of care coordination
- Wellness nurse meets with all new staff during orientation

**Proactive processes**

- Include PCP consent/specialty providers in intake packets
- Send report following visit
- If client does not have a PCP, have a nurse/staff work with client in the moment at setting up an appointment
- Create processes for the utilization of collaborative documentation for care team

# Identified Care Coordination Goal

- Increase care coordination agreements with providers
- Increase communication with and referral to physical health providers
- Increase the number of staff receiving more comprehensive training on PH/BH topics
- Develop processes for tracking BMI, tobacco dependence and hypertension, waist circumference
- Develop population health registry to identify those most at risk

# Outcomes

- 42 % increase in care coordination agreements with PCPs , specialty providers and an additional FQHC in the service area
- Since initiation of CCBHC, we have had over 60% increase in provider communication
- Staff have been trained in Wellness Coaching, Motivational Interviewing, blood pressure, tobacco, and BMI monitoring. Staff also received training in HIV, TB and HEP C
- 100 % of all clients are assessed for BMI and preventative care upon admission and routinely
- Central data base (medical profile) has been established for all clients and population health registry is in development

# Breakout Discussion

1. Which data from your FQHC partner has been most useful to your CCBHC?
2. What role does your CCBHC take in supporting clients with preparing/planning for appointments with their primary care providers?

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# Keep the Conversation Going!

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

- Identify 1-2 primary care or specialty care partners where there is a high number of individuals receiving care from both organizations- are there any trends in diagnoses or needs? What opportunities might exist for both organizations to collaborate and support their clients/patients?

# 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.

# CCBHC-E TTA Center Website

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

CCBHC-E National Training and Technical Assistance Center