NATIONAL COUNCIL for Mental Wellbeing

CCBHC-E National Training and Technical Assistance Center

Care Coordination Learning Community

Session 4: Partnership with Emergency Departments and Hospitals

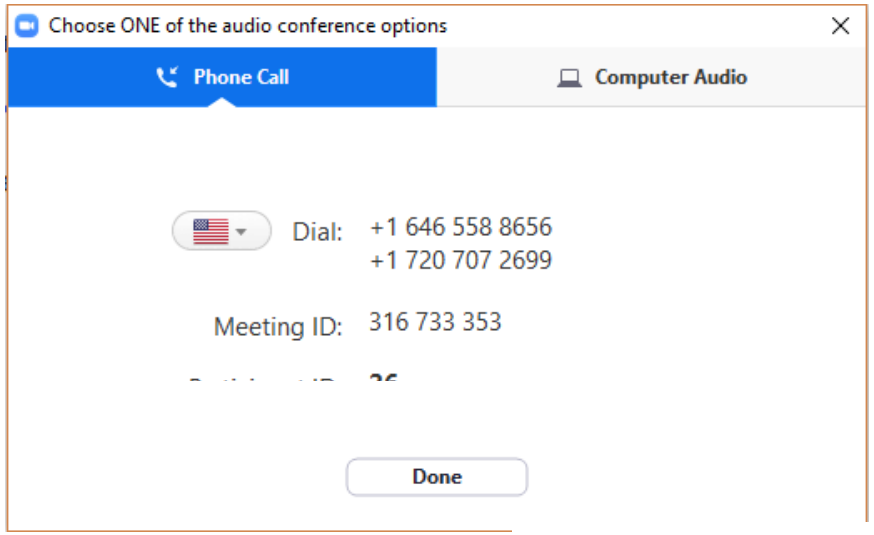
September 29, 2022

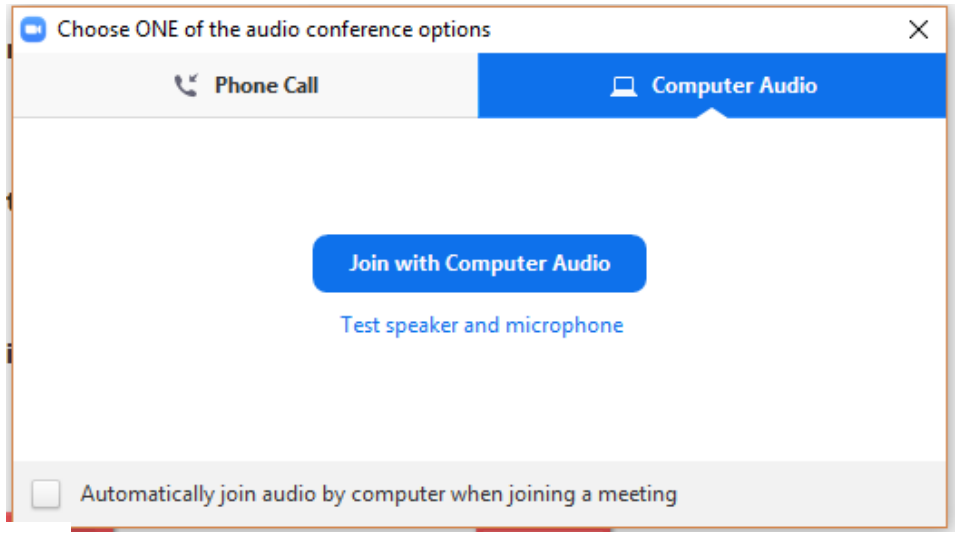
CCBHC-E National Training and Technical Assistance Center

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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Today's Presenters

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Agenda

- Today's Objectives
- Sharing: CCBHC Success Stories
- Overview of care coordination partnerships with hospitals and emergency departments and how to leverage health information technology
- CCBHC Provider Showcase
  - Acacia Network
  - LifeWorks NW
- Breakout discussion
- Wrap-up and next steps

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Learning Objectives

Increase	Increase knowledge of care coordination strategies with hospitals and emergency departments
Identify	Identify technology options and approaches for leveraging technology to support care coordination

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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.

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Care Coordination with Hospitals and Emergency Departments

Criteria 3.C

- The CCBHC has procedures and services for transitioning consumers from EDs and these other settings to CCBHC care, for shortened lag time between assessment and treatment, and for transfer of medical records, prescriptions, active follow-up.
- The CCBHC has established care coordination expectations with hospitals, EDs and other providers, that includes procedures and services, such as peer bridgers, to help transition individuals from the ED or hospital to CCBHC care and shortened time lag between assessment and treatment.
- The CCBHC can track when their consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to another entity, and provides transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge.
- The CCBHC has care coordination agreements that require coordination of consent and follow-up within 24 hours, continuing until the consumer is linked to services or is assessed as being no longer at risk, for consumers presenting to the facility at risk for suicide.
- The CCBHC makes and documents reasonable attempts to contact all consumers discharged from these settings within 24 hours of discharge.

Leveraging Health Information Technology

Criteria 3.B

- The CCBHC has health information technology (HIT) systems in place that (1) include EHRs; (2) can capture demographic information, diagnoses, and medication lists; (3) provide clinical decision support; and (4) can electronically transmit prescriptions to the pharmacy.
- CCBHC HIT systems allow reporting on required data.
- The CCBHC has plans in place to use the HIT system to conduct activities such as population health management, quality improvement, disparity reduction, outreach and research.
- The CCBHC has a plan in place to improve care coordination between the CCBHC and DCOs using HIT. The plan should include how the CCBHC can support electronic health information exchange to improve care transitions to and from the CCBHC using the HIT system they have or are developing related to transitions of care.

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Acacia Network

Bronx, NY

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About Acacia Network

For over 50 years, Acacia Network and its affiliates have been committed to improving the quality-of-life and wellbeing of underserved communities in New York City and beyond. We are one of the leading social services organizations in New York City and the largest Hispanic-led nonprofit in the State.

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Acacia Values

Excellence: Our focus on excellence ensures that individuals, families, and communities consistently receive quality driven care

Commitment: The talented and dedicated members of the Acacia family are the foundation of our success. We go the extra mile to meet the needs and expectations of individuals, families, and our communities.

Customer: We promote a culture that consistently exceeds customer's expectations. We affirm the unique identify of those we serve, treating each with friendliness, dignity, respect, care and compassion.

Leadership: We nurture partnerships, inspire others, instill ownership, engender trust and provide solutions toward our common goal to lead change and provide the highest quality of care.

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Our Integrated Care Model

We provide **integrated**, **culturally-competent**, and **trauma-informed** services to over 150,000 individuals of all ages through:

- Primary Care;
- Behavioral Health & Addiction Services;
- Affordable and Supportive Housing;
- Transitional Housing & Homeless Services;
- Early Childhood Education;
- Afterschool Programs and Youth Development;
- Services for Older Adults (60+);
- Workforce Development;
- Arts and Culture, and more.

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2020 Impact at a Glance

- 12,000+ unique patients of all ages served through our health centers, in addition to 100+ adults living with HIV/AIDS at our residential skilled nursing facility
- 4,200 households served through our Affordable and Supportive Housing Developments, and over 15,000 social service encounters rendered
- 11,000+ unique patients annually through Outpatient Mental Health Services, Outpatient Substance Use Services, Detox & Rehab, and Residential Care
- Over 7,000 individuals served throughout 57 shelters for single adults and for families with children across four boroughs in New York City
- 3,550+ participants served through our Youth Development & Family Engagement initiatives, and 300+ kids ages 3-5 through our Daycare & Preschool Programs
- 6,000+ individuals served and 100+ community partners engaged through our workforce development & benefits access programs
- 2,500 mature adults ages 60 and older served through six (6) Senior Centers, with 900 participants attending daily activities
- Approximately 2,000 individuals of all ages engaged through our in-house and virtual arts and culture programming
- Over 200,000 meals & groceries distributed through our food pantries & soup kitchens in NYC, and over 23,000 in Upstate New York
- 15,000+ individuals reached through our initiatives in Puerto Rico & we provided 4,000+ meals, 1,000+ emergency supplies, 100+ units of housing & more

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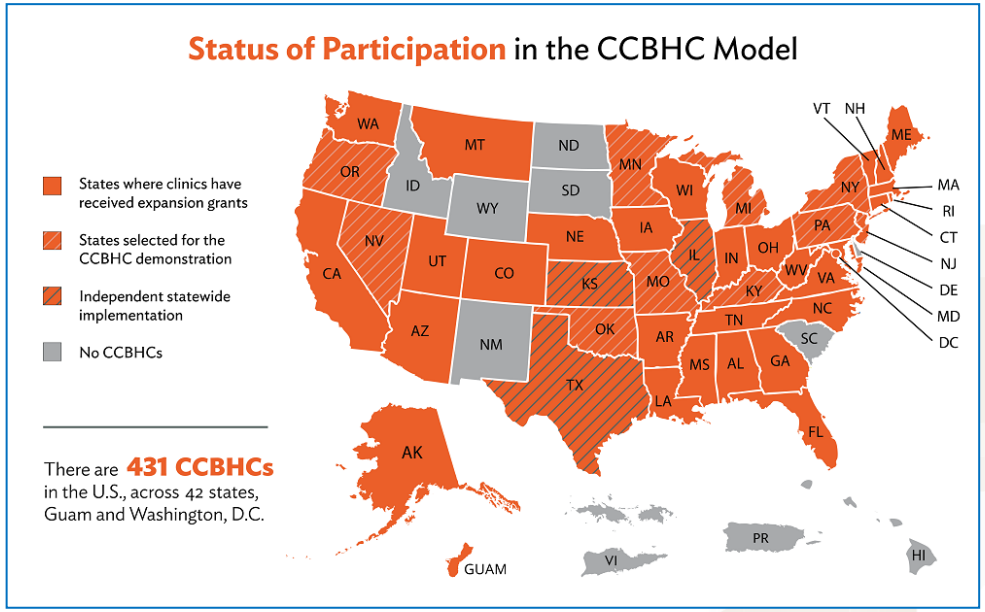
Behavioral Health: CCBHC Model

- New York was one of the first eight states selected to be implement a Certified Community Behavioral Health Clinics (CCBHC) demonstration program, which launched in 2017. Acacia Network (through PROMESA) was one of the first five providers in NYC to operate a CCBHC.
- The CCBHC model has enabled us to meet rising behavioral health needs. Since March 2020, we served over 1,500 unique clients at our clinic, a 21 percent increase since 2017.
- The CCBHC model has translated into extended hours, more clinicians and case managers, 24/7 crisis response, increased access to diverse services including medication-assisted treatment, and improved population health for people who might require additional, specialized services, such as children and veterans.



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Care Coordination Strategies

- **What is care coordination?**
  - The purpose of organizing the clients care activities by sharing information amongst appropriate individuals concerned with clients care to achieve safer and more effective care
- **What are the benefits of care coordination?**
  - Care coordination reduces hospital admissions and improves quality of mental health symptom management & adherence. It also improves client satisfaction due to having better access to mental health services and care.
- **What are the limitations?**
  - Insufficient community resources; lack of consistent inclusion from support system (family, legal guardian, etc.); client's self-determination and motivation to treatment; & lack of awareness to CCBHC services.

CCBHC Populations Served

What populations do we serve?

- Acacia CCBHC programs are based in NYC: Bronx and Manhattan locations
  - Populations:
    - Minority groups (Latinx & African-American/Black)
    - Clients with co-occurring disorders (substance use)
    - Children/Families
    - Couples
    - Undocumented clients
    - Consumers of long-term behavioral health treatment
    - Mandated clients (Assisted Outpatient Treatment; Parolees)

CCBHC Collaborations

- **What are the partnerships in place?**
  - Linkages are formed with hospitals within the community
    - Manhattan: NY Presbyterian Hospital
    - Bronx: Lincoln Hospital
- **How does the collaboration work?**
  - Initial hospitals were identified based on the proximity and accessibility to the clinic
  - Established clients are referred to partnered hospitals as appropriate for emergency services
  - New clients are referred to CCBHC clinic as part of discharge planning for continuity of care
  - Meetings to discuss need of the clients and how the CCBHC clinic can assist as appropriate

CCBHC Collaborations

- Example of the success of care coordination & implementation of CCBHC services
  - *New Intakes*: Case conferences are held prior to client completing intake to ensure appropriateness for the client. Hospitals are contacted and informed if client is appropriate for the clinic. If not an appropriate referral, recommendations for other appropriate settings are provided.
  - ***Established Clients:*** Collaboration consists of providing a fact sheet with CCBHC staff contact information for hospital staff to connect for care coordination.
    - If consent is provided for client or underage clients, support system is included during the discharge planning in the hospital and intake process at CCBHC clinic.
    - Follow up is conducted within one business day with the hospital to confirm of client's attendance to follow up appointments with the consent from client.

Success Stories of Care Coordination

- Client YY – Monolingual speaking female in late 50s diagnosed with schizophrenia
- Frequent hospital admission due to noncompliance to medication
  - Client had presented at the emergency department twice within 30 days due to increase in auditory hallucinations.
- Once discharged, a collaborative meeting took place within the week. The CCBHC staff, discharge planning social worker and client met to discuss medications prescribed and side effects expressed by client.
  - Client was given the opportunity to discuss concerns for side effects and create a safety plan.
- After meeting, CCBHC services were put in place (case management, peer supports, psychiatric rehabilitation services). It was agreed upon to have a follow up meeting with all parties involved within 30 days to monitor progress.
- A decrease in symptoms was noted within progress notes with the therapist during the first month since post discharge. Hospital reported no re-admission within 30 days.
- The same success was noted 90 days later and continues to be an active client within the CCBHC clinic.

Success Stories of Care Coordination

- Client KH – Monolingual African American male diagnosed with Schizoaffective disorder, with Cocaine use, in his 50s.
  - Client was hospitalized from September 2018 – October 2018 due to suicidal and homicidal ideation with intent. Hospital was not one of our routine participating hospitals.
  - Part of the discharge planning, referral was made to CCBHC clinic.
  - A collaborative meeting was held within a week of discharge. Introduction and explanation of CCBHC services were provided. Input from the hospital was given on client's identified needs and client was able to express his future goals and progress he would like to make.
  - Client was then connected to CCBHC services (CASAC, case management, peer services)
  - Within 90 days, there was a reduction of substance use , SI/HI and in depressive symptoms. Client was able to apply for entitlement benefits (Social Security, SNAP, etc.)
  - Within 6 months (March 2019), client was able to obtain stable supportive housing in Brooklyn.
  - KH now participates in our consumer advisory board and is an active member within his community.

Strategies for Building Strong Partnerships

- **What strategies ensure effective collaboration?**
  - Identifying a point of contact within hospitals to discuss shared clients such as social worker for intake and discharge planning.
  - Ensure all members within partnerships has all necessities to be successful in their role within partnerships.
  - Managing expectations and longevity of client care.
  - Have quarterly meetings to review workflows and discuss any barriers that may have come up within the quarter.
  - Conduct two CCBHC informational refreshers yearly for hospital staff to learn of our services for appropriate referrals to the clinic.
  - Celebrate success stories within partnerships.

How Are Decisions Made?

- Consensus of client's follow up treatment from all partners and client
  - Understanding the clinic's & hospital's agenda while ensuring clients wellbeing and safety.
  - Following established workflows for effective collaboration such as referral process, contact person, etc.

How is Data Shared?

- During quarterly meetings, number of shared clients are reviewed such as:
  - How many established clients have been hospitalized within the last 3 months?
  - How many hospital discharges were referred to CCBHC within the last 3 months?
    - With consent PSYCKES data is utilized to support any recidivism or treatment received from hospital or CCBHC clinic
- PowerBI internal data system informs of client's management of symptoms based on screenings such as C-SSRS, PHQ-9, GAD-7, Audit-10, DAST, MSSI, CRAFT, ACE, & PEARLS for changes within the last 3 months.
  - Upon discharge from hospital, client completes above screenings and is assessed monthly for improvements or barriers in symptom management and services used for appropriate treatment planning.

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LifeWorks NW

Portland, Oregon

CCBHC-E National Training and Technical Assistance Center

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About LifeWorks NW

A non-profit behavioral healthcare company serving the greater Portland metro area

- Offer outpatient and limited residential services
- Staff of nearly 700
- Primarily serve Medicare, Medicaid, and Uninsured

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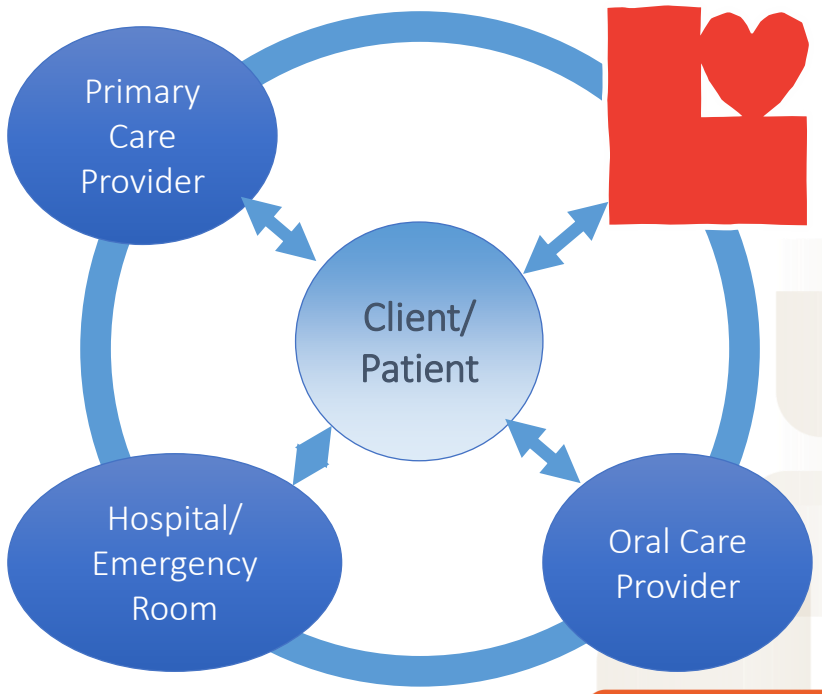
Integrated Care Model

"People with mental and substance use disorders may die decades earlier than the average person"

The systematic coordination of general and behavioral healthcare.

Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.



Source: What is Integrated Care? SAMHSA-HRSA Center for Integrated Health Solutions

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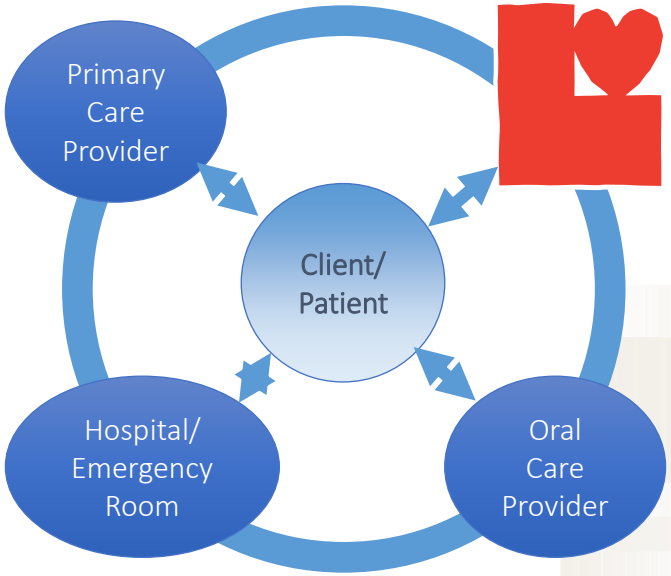
Integrated Care Principles

- Increase the access to care
- Improved patient/consumer health/mental health status & clinical outcomes
- Improved patient/consumer satisfaction
- Improved cost management and cost savings
- Administrative simplification



LifeWorks NW Integrated Care

Our Focus is on Partnerships

Coordinated	Co-Located	Integrated
• Separate Facilities • Communicate as Necessary	• Same Facilities • Transitioning to shared systems/data • Face-to-face communications	• Same Facilities • Shared/Highly Integrated systems and data • Blended Operations
✔	✔	✔
• Phone • Paper • Fax • Email • Secure Messaging • Manual Processes	• Shared System Access • Connected Systems • Push/Pull Shared Data (CCD/CCDA) • Coordinated Processes	• Shared Care Plans • Integrated Business Processes and Systems • Team Based Care "One Team"

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LifeWorks NW Integrated Health

Clinical Model

Rapid Response Team	Integrated Healthcare Team	Psychiatric Services
• Enrolled LifeWorks NW Consumers • ED Diversion • Transition of Care • Utilizes Care Everywhere • Focus on Behavioral Health ED/IP visits	• Enrolled Lifeworks NW Consumers • Physical and Dental Healthcare Coordination • ED Diversion • Population Health	• Enrolled LifeWorks NW Consumers • Medication Management • Collaboration with IHCT and RRT for both psychiatric and physical health needs

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Key Successes

- ED Diversion Workflow
  - Rapid Response Team receives Collective Medical notifications in real time from Emergency Departments and other Acute inpatient facilities in order to collaboratively discharge plan
  - Care Coordinators at each site review physical health notifications and utilize workflows based on Population Health/Risk Stratification
  - Workflows connect consumers with PCP/Specialty physical healthcare for follow up as well as encourage engagement with LWNW clinicians, referrals as needed for SUD and psychiatry services
- Wellness Assessments
  - Allow for increased care coordination
  - Early identification of supports (I.e., Established care team, family, etc.) and needs/barriers (I.e., social determinants of health review, Health history/Chronic health conditions)
- Collaboration with Managed Care/Coordinated Care Organization
  - Utilizing CareOregon Population Health/Risk Stratification for targeted interventions
  - Regular check ins to promote improvement processes and development

Key Challenges

- Network of Connectivity
  - Integrate with multiple EHRs, HIEs
  - Integrate with multiple extended service providers (i.e., laboratories)
  - Integrate with multiple Collaboratives, Collectives
- Blending of Medical and Behavioral Health Worlds
  - Nomenclature/Vocabulary
  - Business Processes
- Variance in Data Definition, Collection, and Reporting
- Covid
  - RRT previously co-located at Unity Psychiatric Emergency Department now Telehealth coordination
  - Healthcare workforce shortages create additional lag time in coordination
- Evolving Policy Changes at Federal, State levels
  - Funding and Incentives
  - Metrics and Reporting

Innovation – What's Needed

- Data Exchange Standards
  - Data Definitions
  - Common key identifiers for record matching
- Flexibility & Configurability Designed into Data Exchange
  - Design to support the network of connectivity
  - Design to support integrating business processes across different organizations
    - Role based, Rule based, Triggers, Escalation Policies, Data Selection
- Integrated sign-on/system authentication
- Codes

LifeWorks NW - What's Next?

- Continue to work to innovate data exchange mechanisms to increase efficiency
- Continue to partner with CCO to develop codes that capture integration efforts
- Continue to utilize partnerships to develop collaborative workflows across systems to reduce duplicative processes for metrics
- Continue to utilize full-capability of available technology within Collective Medical (i.e., Care Guidelines)
- Develop/Refine Predictive Algorithms to identify high-risk groups who will receive coordinated care protocols across service providers to prevent need for acute care.

Breakout Discussion

1. What are some of the current challenges your agency is experiencing in coordinating care with your local emergency department?
2. What data points or information would be helpful to your agency in coordinating care with the emergency department?

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Keep the Conversation Going!

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

Review your data and look for trends in diagnoses (mental health, substance use disorder, or physical health) to learn who is accessing the ED and consider population level interventions and supports

- Determine what opportunities may exist to address any health disparities (either in health outcomes or utilization of services/ED)

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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.

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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]

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