NATIONAL COUNCIL for Mental Wellbeing

HEALTHY MINDS STRONG COMMUNITIES

CCBHC Care Coordination Strategies and Approaches

March 19, 2025

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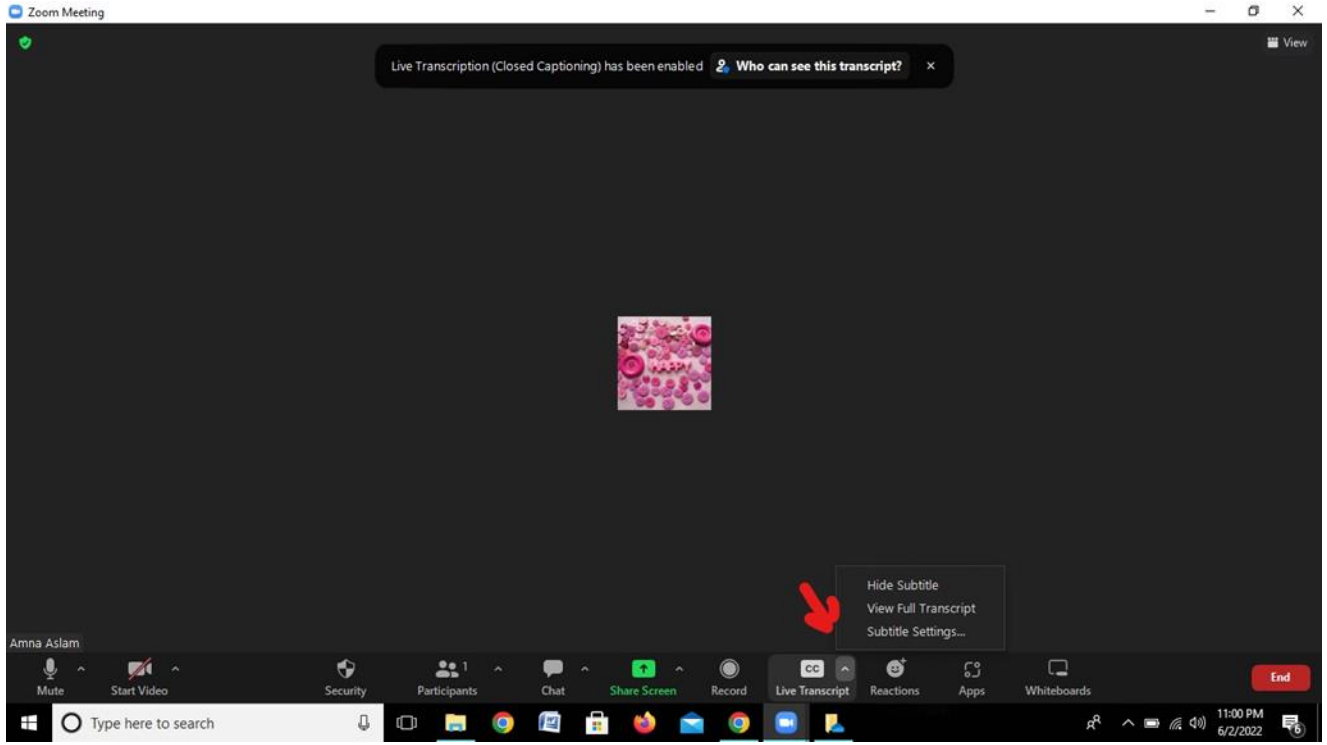

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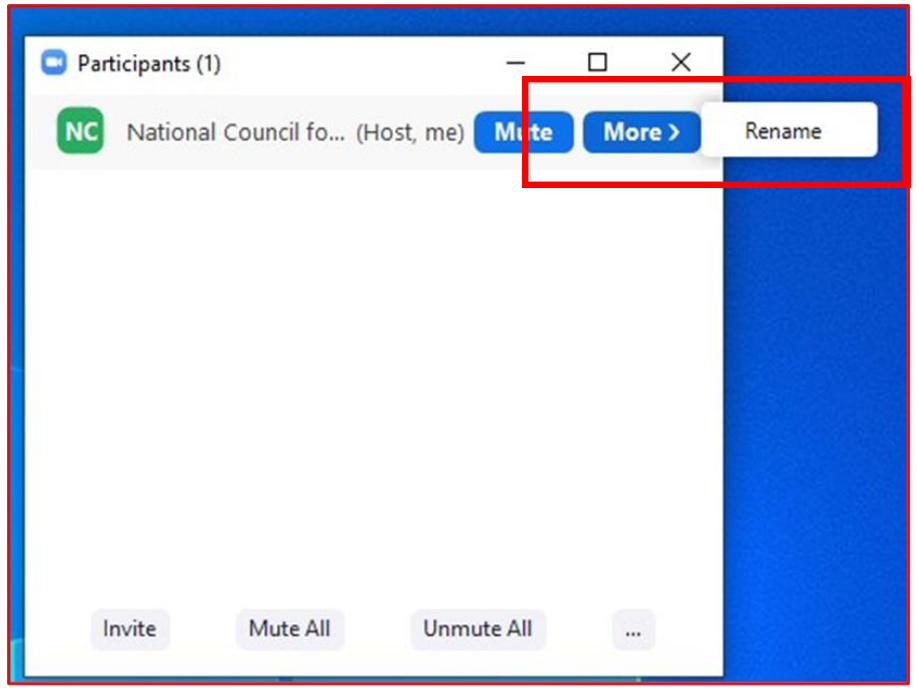

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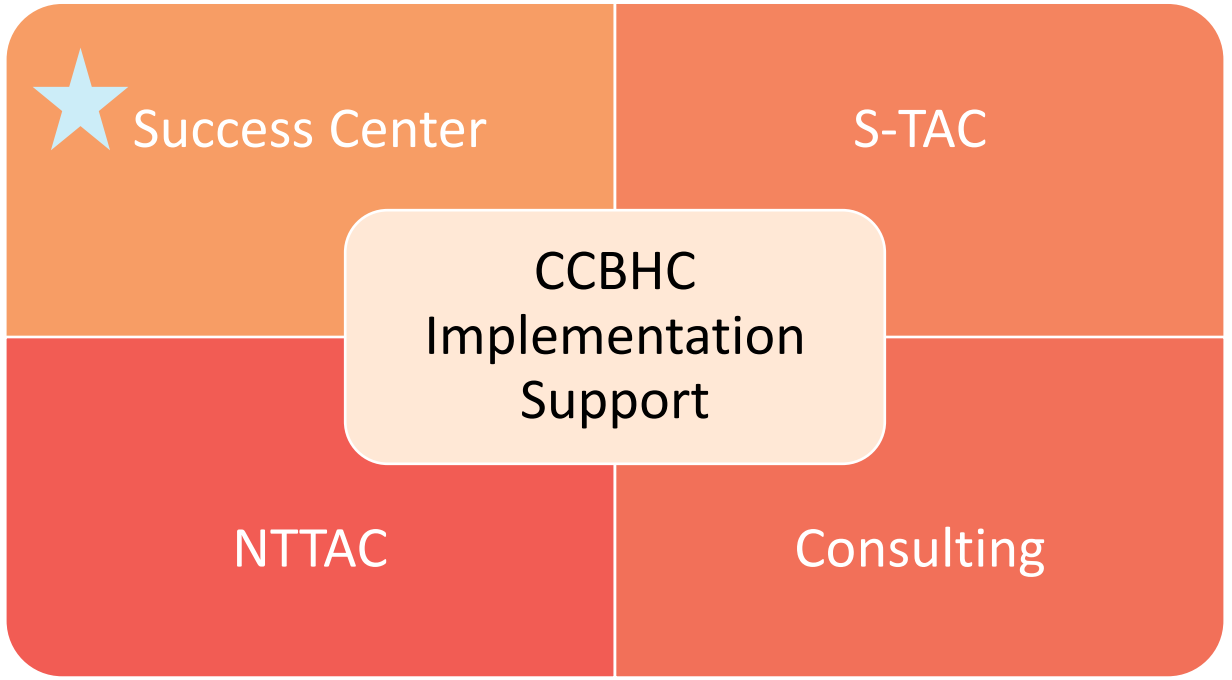
Implementation Support for CCBHCs



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Today's Presenters

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Agenda

- Defining Care Coordination & Criteria Requirements
- Goals, Mechanisms, and Measurement for Care Coordination
- Approaches and Practices for Care Coordination
- CCBHC Showcase: Four County MH Center, Inc.
- Breakout Discussion
- Wrap up

Today's Learning Objectives

- Increase knowledge of CCBHC care coordination criteria and define care coordination within the context of the CCBHC model.
- Identify common mechanisms, strategies and approaches CCBHCs utilize for achieving successful care coordination.
- Recognize different care coordination models employed by CCBHCs.

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Quick Poll

- What is your CCBHC status?
- What is your role at your organization?

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Care Coordination: Definition and Requirements

Defining Care Coordination

Care Coordination is the linchpin of the CCBHC Model

- Care coordination involves deliberately organizing individual care activities and sharing information among all the participants concerned with the individual's care to achieve safer, more effective care.
- The individual'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.

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

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Care Coordination 3.A: General Requirements

Based on a person- and family-centered treatment plan, the CCBHC coordinates care across the spectrum of health services, including access to:

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

- Consistent with privacy and confidentiality requirements, and the preferences and needs of people receiving services, the CCBHC assists people receiving services (including the families of children and youth) referred to external providers or resources in obtaining an appointment and tracking participation in services to ensure coordination and receipt of supports.
- The CCBHC shall coordinate care in keeping with the preferences of the person receiving services and their care needs. To identify the preferences of the person in the event of psychiatric or substance use crisis, the CCBHC develops a crisis plan with each person receiving services.
- People receiving services should be counseled about the use of 988 Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis and stabilization services should a crisis arise when providers are not available. Crisis plans may support the development of a psychiatric advanced directive.
- CCBHC assists people receiving services and families in accessing benefits, including Medicaid, and enrolling in programs or supports that may benefit them.

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

- CCBHC has a health information technology (HIT) system, including electronic health records
- CCBHC uses its HIT to conduct activities, including population health management, quality improvement, reducing disparities, outreach, and research.
- CCBHCs should utilize nationally recognized, HHS-adopted standards, to enable health information exchange (HIE), and technology that has been certified to current criteria under the Office of National Coordinator (ONC) HIT Certification Program for the following required set of capabilities that align with key clinical practice and care delivery requirements:
  - Capture health information, including demographic information
  - Support care coordination, including sending and receiving summary-of-care records
  - Provide individuals receiving services with timely access to their health information using a personal health app of their choice
  - Provide evidence-based clinical decision support; and conduct electronic prescribing

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

- CCBHC will work with designated collaborating organizations (DCOs) to ensure all steps are taken, including obtaining consent from people receiving services and complying with privacy and confidentiality.
- Within two years following CCBHC certification, 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

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Care Coordination 3.C: Partnerships

Additional Recommended Partnerships

- Other specialty and social and human services providers
- Indian Health Service and tribal programs
- Suicide and crisis hotlines and warmlines (in addition to other required crisis services)
- 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 & Care Coordination Activities

- All treatment planning and care coordination activities are person- and family-centered.
- 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 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, 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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Benefits of Care Coordination

Better Patient Outcomes

Improved Patient Satisfaction

Increased Provider Satisfaction

Reduced Healthcare Costs

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Goals, Mechanisms & Measurement for Successful 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 individuals 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: www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/carecoordination.html

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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

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Measuring Effective Care Coordination

- **Transitions of care** (e.g., how long did it take to connect with the individual after inpatient/ED discharge?; was discharge plan communicated and incorporated into care plan)
- **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 client medical information and history between providers)

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

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Approaches and Practices for Care Coordination

Umm… What Management?

- Case Management - time limited assistance for concrete needs and utilization of resources

- Care Management – practice and process over time to achieve person-centered goals and outcomes

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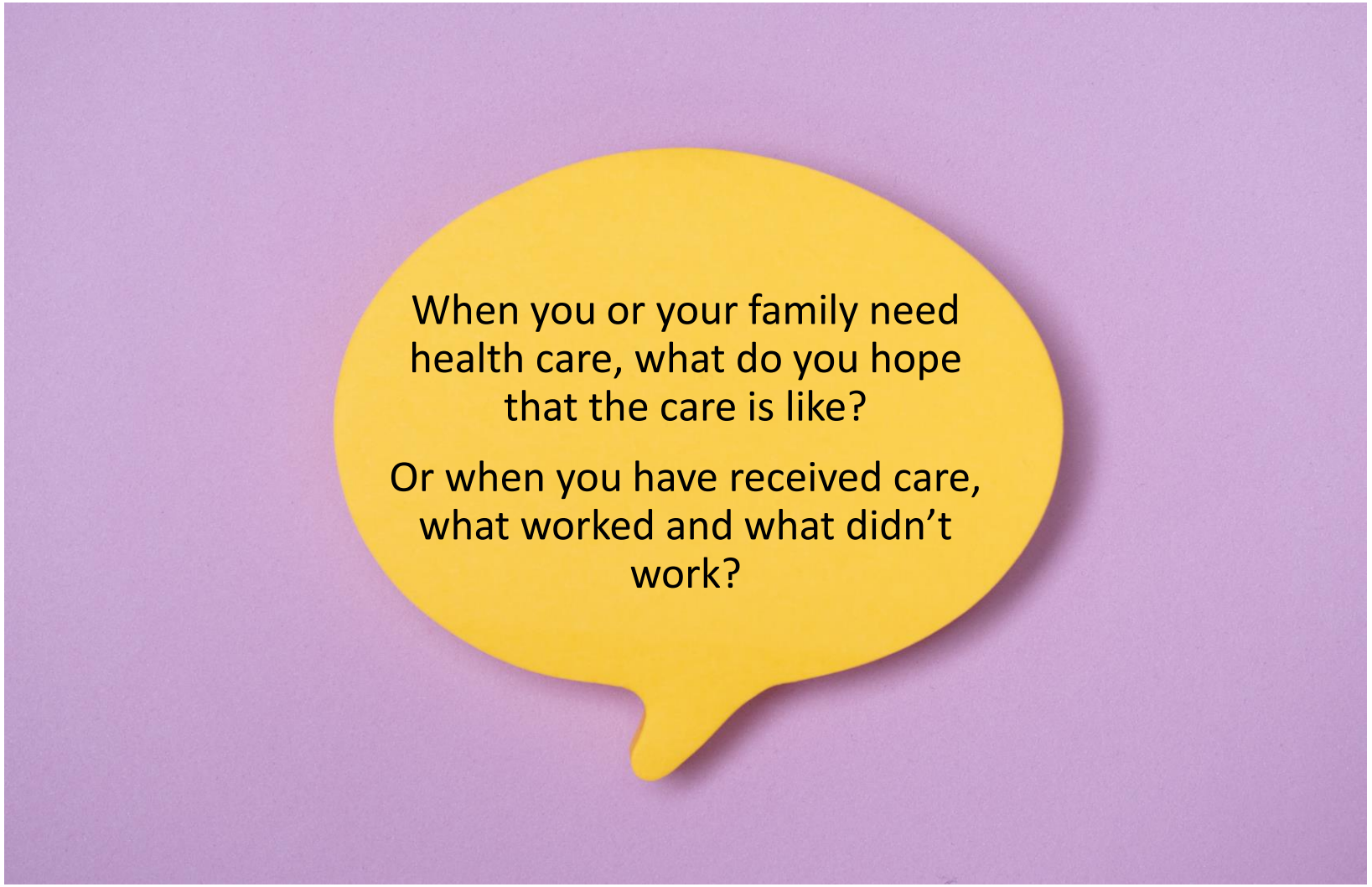
Group Reflection



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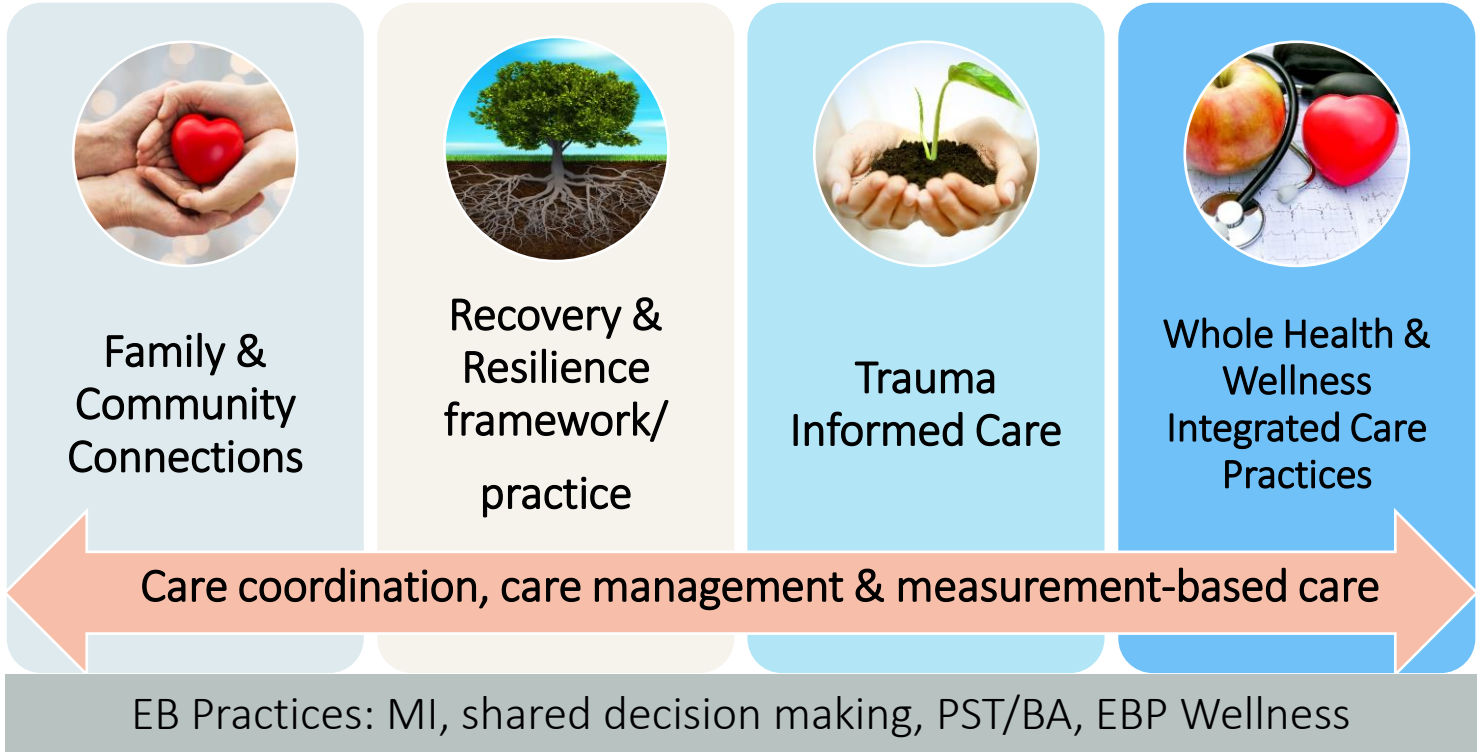
A Blend of Approaches



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Activating Care Management:

- Screening & Assessment using data
- Care planning
- Increasing health literacy through education
- Medication management & adherence support
- Risk stratification
- Population management
- Coordination of care transitions and care coordination

Source: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

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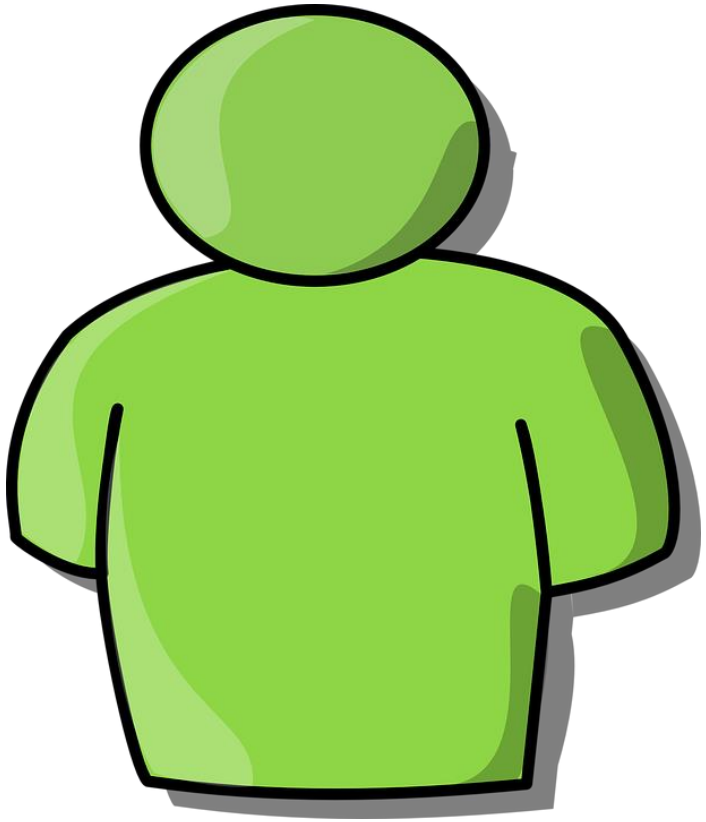
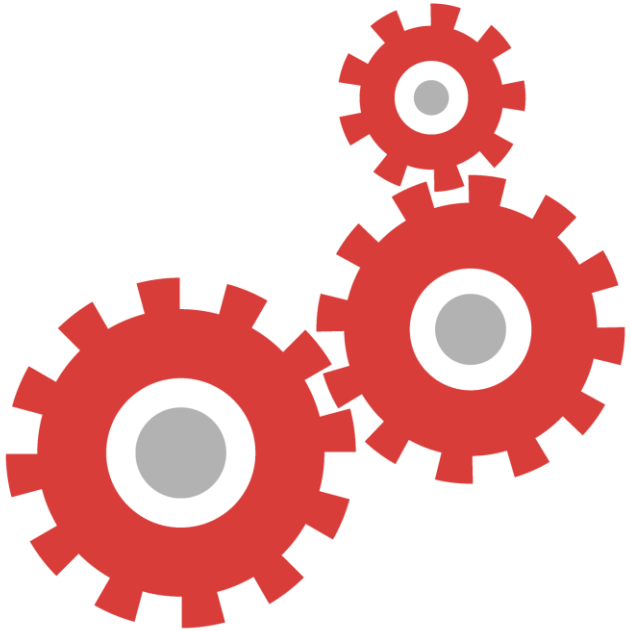
Care Coordination is a ROLE and a FUNCTION





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Care Coordination as the Lynchpin

- Connecting team members and services
- Improving outcomes
- Enhancing client experience
- Cost-efficiency

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Transitions of Care

The movement of patients between health care locations, providers, or different levels of care within the same location, as their conditions and care needs change

Source: NTOCC

- Across health states: e.g., palliative care to hospice, or personal residence to assisted living
- Between providers: e.g., PCP to a psychiatrist, or acute care provider to a palliative care specialist
- Within settings: e.g., primary care to specialty care team, or intensive care unit (ICU) to ward/department
- Between settings: e.g., inpatient hospital to outpatient care, or ambulatory clinic to senior center

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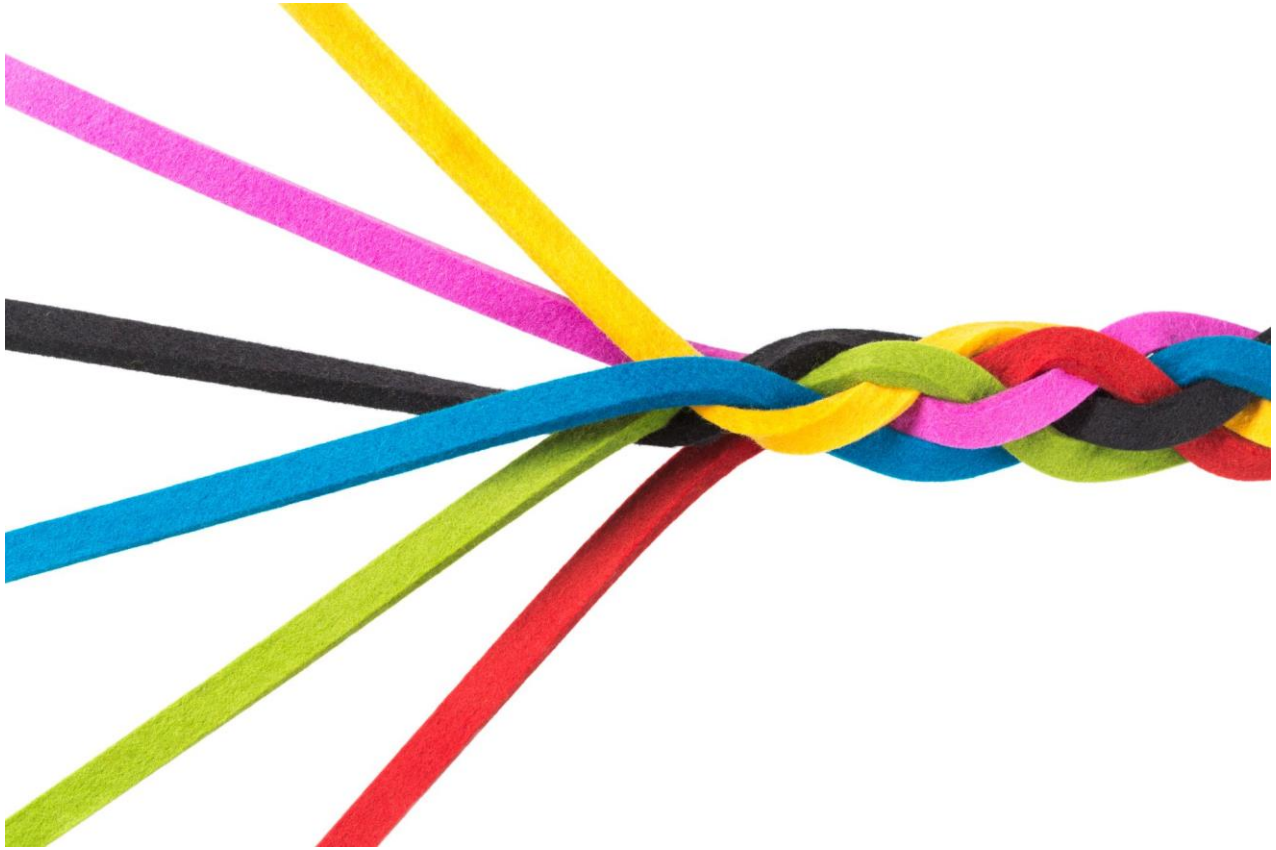
Team Communication & Functioning



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At the End of the Day…

- What is the person's experience—using your advisory group
- What are you tracking to let you know your care coordination is working?
- Pay special attention to:
  - People using the emergency room for behavioral health and physical health care
  - People being hospitalized for either psychiatric and physical health care
  - Discharges---developing a communication plan with people.

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CCBHC Showcase: Four County Mental Health Center, Inc.

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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 original Kansas CCBHCs
- 25-26 CCBHCs in Kansas are now certified

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Care Coordination: Preparation and Ongoing Practices

- Study the criteria – identify gaps
- Develop a dedicated team
- Adopt a universal definition
- Identify what staff (new and existing) that will do the work
- Develop workflow and policy (version 1.0 and beyond)
- **Establish key partnerships**
- Train-Refresh-Train Again
- Develop data management plan
- Integrate into CQI process

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Initial 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, EDs, residential facilities, etc.
- 3.d.1-3.d.3: Integrated treatment teams/planning

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FCMHC: 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.

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Care Coordination Process and Activities

- Staffing/treatment team meetings
- Wrap around 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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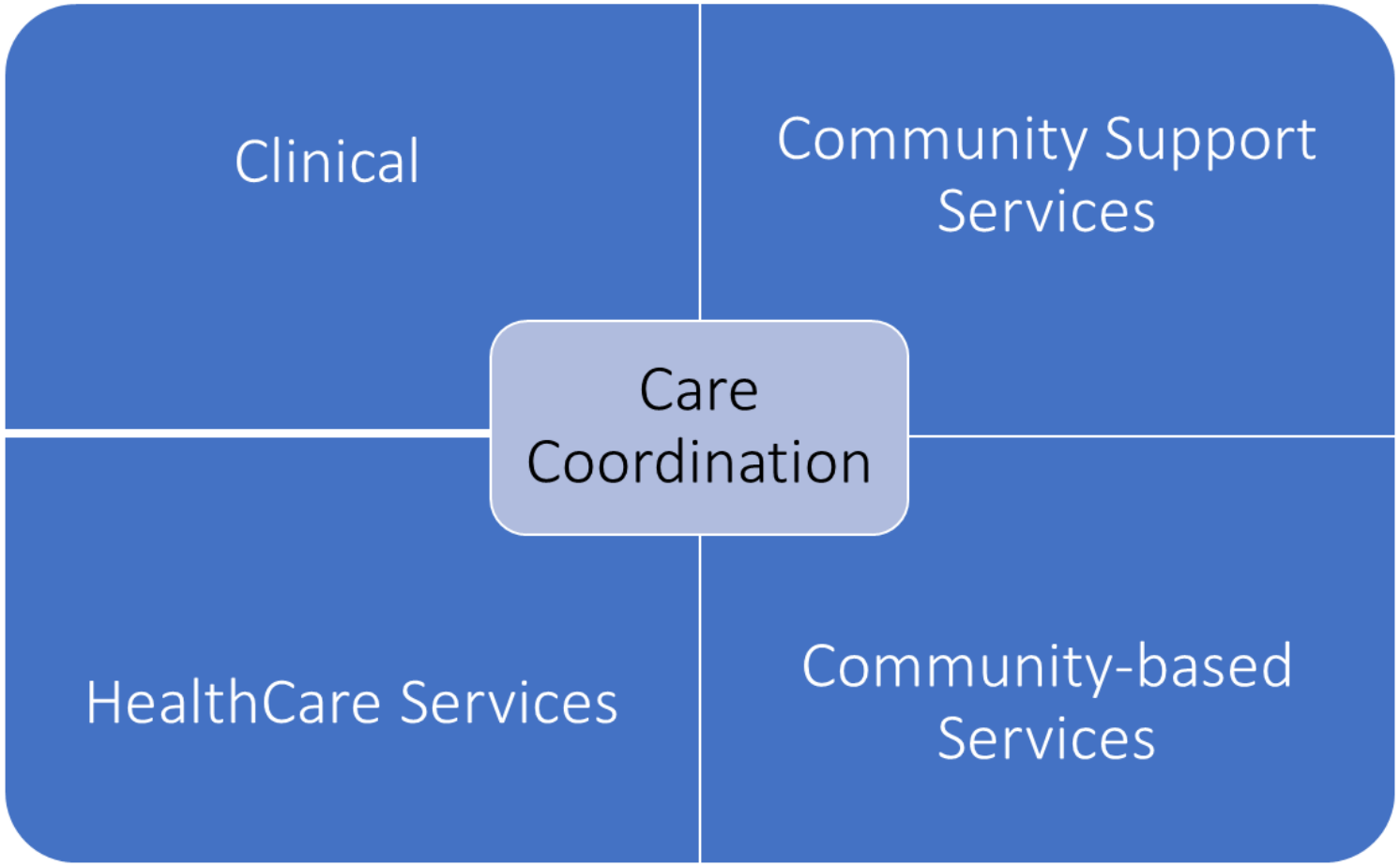
FCMHC: Internal Care Coordination Structure



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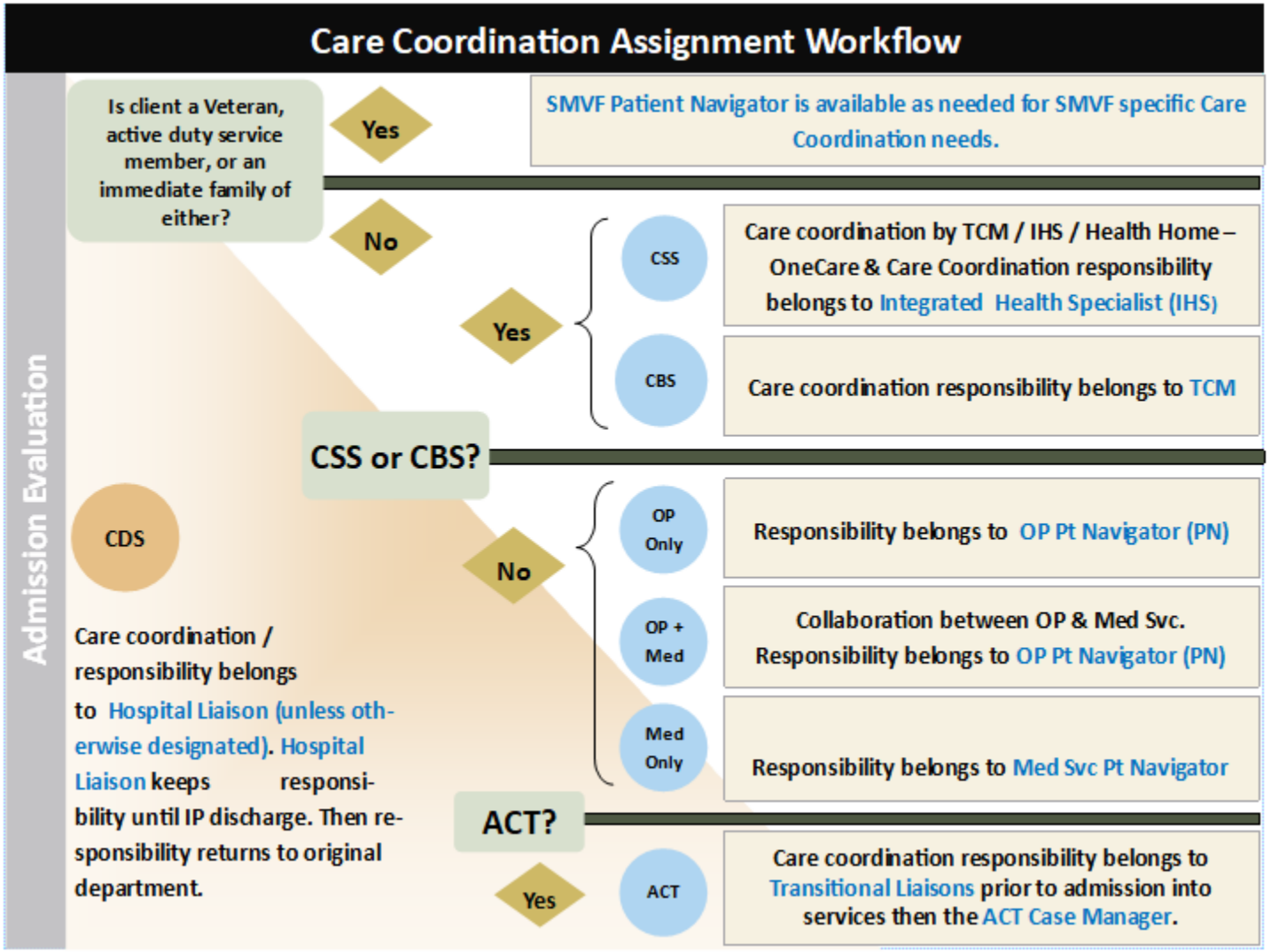
Care Coordination Workflow



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Staff Conceptualization and Training Concepts

- Care Coordination is no longer limited to Target populations
- Care Coordination can occur as an **independent** service/activity (TCM)
- Care Coordination can occur within the context **as part of** another service activity (Traditional Case Management activities)
- Care coordination can be a **primary job** role OR it can be one of the duties expected **as part of** another job role (case management, nursing, therapists, and support staff)
- Treatment planning is a care coordination activity, but care coordination activities **should never be limited** to treatment planning
- Some care coordination activities may need be captured in “non-billable” processes and activities

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Patient Navigation: Care Coordination Specialists

- The "Patient Navigator" position was created to provide "CCBHC" specialized care coordination services and to collect essential data:
  - Outpatient primary screening and referral
  - Caseload management
  - Inpatient/Emergency Room admissions tracking and follow-up
  - Presumptive Eligibility Medicaid applications
- Patient Navigators are assigned to populations that do not currently have assigned Targeted Case Management or a designated care coordinator
  - General Outpatient (by location)
  - "Medication services only" service recipients
  - Service Members Veterans and Families (SMVF) population

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Screening for Social Determinants of Health (SDOH)

- Completed by Patient Navigators, but also Targeted Case Managers (TCM's) with designated target populations at Intake with annual re-screenings
- Originally, FCMHC established an internal tool screening at intake for a variety of SDOH related areas including but not limited to Housing, Transportation, Access to Health Insurance, etc.
- Results from these tools were used in the Community Needs Assessment completed in June of 2024 to help identify need and areas of priority.
- FCMHC has selected a validated tool as defined by the "Quality Measures for Behavioral Health Clinics" Technical specifications manual 2024 (p. 62)
- FCMHC will continue to screen for additional areas not included in the validated tool consistent with needs specific to our client population-Access to Healthcare Insurance; Access to Primary Care; Negative impact of Social Media
- Staff have designated follow-up expectations on all positive screens and document actions taken at the time.

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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
- ***Navigate-*** Focuses on first episode psychosis, includes therapy, employment and education support and medication access for ages 15-35

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Strategic Partnership Considerations

Establishing meaningful agreements

- **Identify the who**: primary care, veterans, law enforcement, hospitals, community populations
- Set up preliminary meetings, identify mutual goals, and establish roles/responsibilities of both partners
- Consider separate agreements for care coordination protocol to allow for flexibility as systems change
- Identify how you will evaluate progress and plan future meetings

The relationship is more important than the document!!!

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Primary Care/FQHC Partnership

- **FQHC**: FCMHC has established partnerships with two FQHCs
  - Co-located services are available in one CCBHC location and one FQHC location
  - Defined referral protocol "both directions" is established and reviewed annually
  - Staff in each facility are cross trained in how to access services (admission, sliding scale fees)
  - Key staff from each system are encouraged to establish meaningful connection
  - Closed loop referral programs are being piloted one community
- **Primary Care Considerations**:
  - Honor patient choice and community connection
  - Patient Navigators establish relationships with all primary care clinics
  - Focus on simple referral and admission procedures
  - Establish protocol on how to communicate on special cases

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Key Performance Indicator Data

- Care Coordination Recipients – Increases over time
- Care Coordination Activities- Ensuring that the full array of care coordination services are being provided
- Screenings- Increasing population screened and developing screening to identify community specific concerns
- Inpatient hospitalization and readmission monitoring and follow up standards
- Closing the referral loop- Appointment confirmation outcomes

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Considerations & Points of Emphasis

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

Points of Emphasis

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

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Lessons Learned

- Start by evaluating where, when, and how care coordination is already happening in your agency-**Memorialize what you are already doing!**
- Develop a **communication plan** and follow up often
- **Written workflows** are essential, but **don't assume** that they will be remembered and universally adopted (Develop retention and feedback loop strategies)
- **Share data** at regular intervals, but not too much data. **Narrative** should always accompany data.
- Integrate Care Coordination into **Continuous Quality Improvement Plan**

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Sharing

- The CCBHC model emphasizes care coordination across the spectrum of health services, including social services. What is your CCBHC's strategy for developing strong care coordination partnerships?
  - How do you identify potential partners?
  - How do you communicate?
  - What data is shared?
- The CCBHC model requires use of health information technology to conduct activities such as population health management, quality improvement, disparity reduction, and outreach. How is your agency engaging in these activities?

Other Questions?

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NEW! Prospective Payment System (PPS) TA Series

This three-part series is intended particularly for operational and programmatic staff at CCBHC Demonstration sites. Participants will learn how to manage PPS funding and gain hands-on financial management and training skills for ensuring sustainability.

- Overview of PPS Rate-setting and Cost Reporting
  March 31, 3– 4 p.m. ET
  Learn how CCBHC PPS cost reporting and PPS rate-setting works, including reimbursement fundamentals, and state-specific implementation options to support efficient and effective service delivery.
- Living Within the PPS Rate
  April 28, 3–4 p.m. ET
  Gain further insight into how service delivery influences PPS rates and discover strategies for planning future services, rebasing the rates, and ensuring CCBHC sustainability and growth.
- Financial Reporting and Management in a PPS Environment
  May 27, 10:30–11:30 a.m. ET
  Engage in hands-on training on the required financial reporting systems for managing a CCBHC PPS rate and identifying its differences from grant funding.

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CCBHC Forum at NatCon25

- **What:** National Council is hosting a **full-day pre-conference CCBHC Forum**
- **When:** Sunday, May 4, 2025
- **Who:** Designed for everyone- state health officials, policymakers, CCBHCs, advocacy groups, researchers and other stakeholders.
- Forum activities include:
  - Joint programming with National Council's Crisis Response Services Summit, exploring how the CCBHC model enhances effective crisis systems
  - Deep-dives into current CCBHC topics such as evaluating statewide impact, DCOs, SUD care, children's services, and more

- Registration is available now! CCBHC E-Grantees will receive a half day registration.

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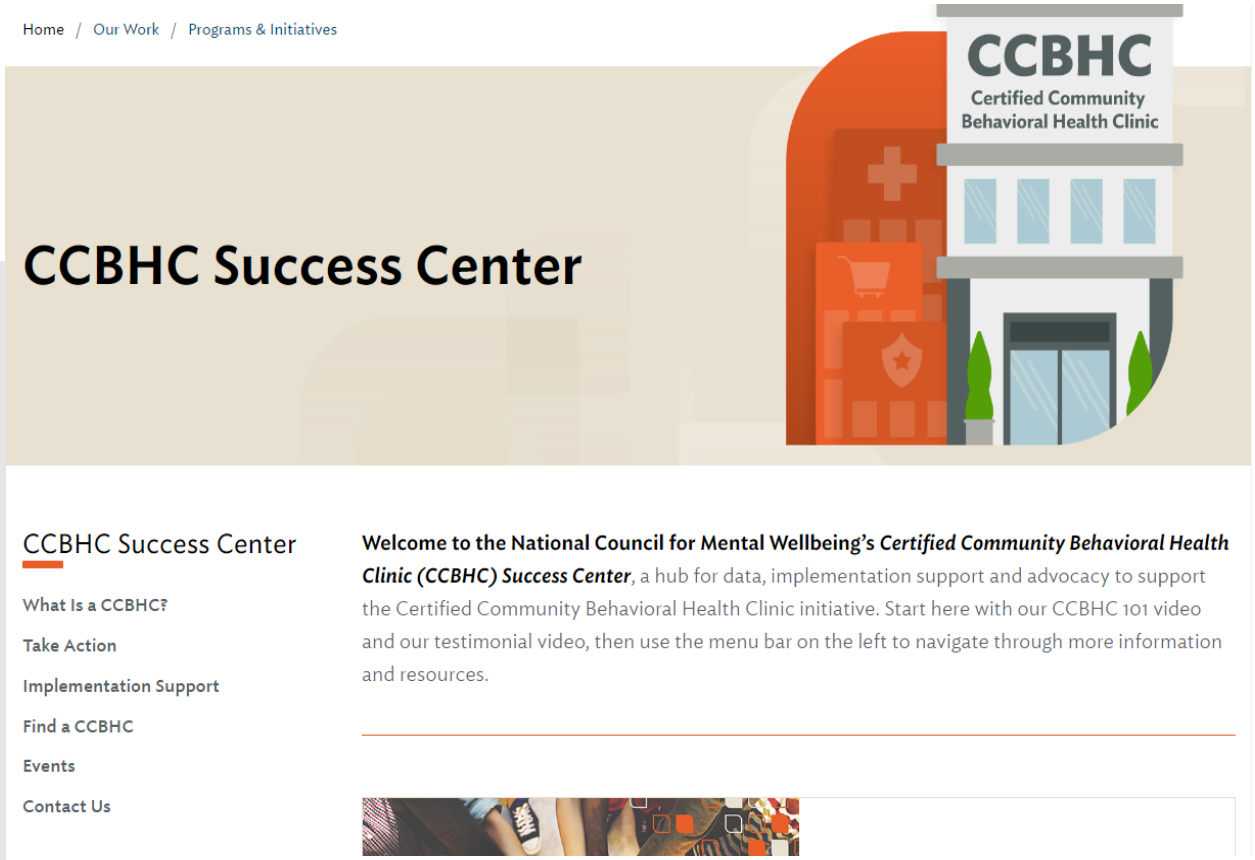
CCBHC Success Center Support

CCBHC Success Center News and Events Subscription Link: https://www.thenationalcouncil.org/program/ccbhc-success-center/implementation-support/#subscribe-form.

Questions? Contact us at: CCBHC@TheNationalCouncil.org

Visit our Success Center website at: https://www.thenationalcouncil.org/program/ccbhc-success-center/



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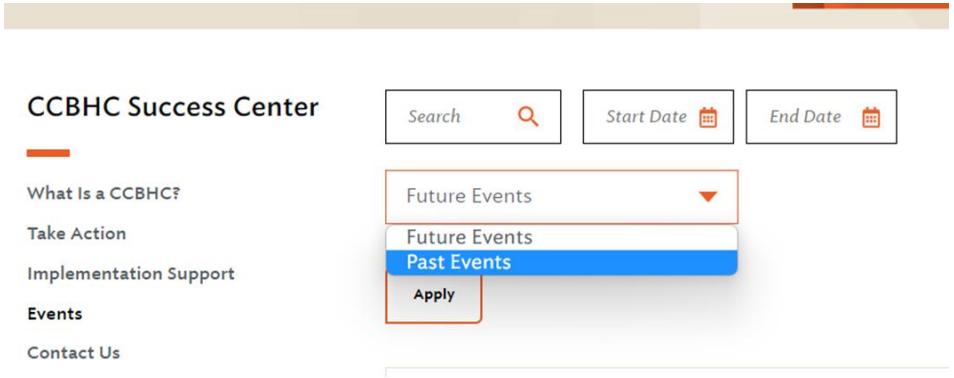
Thank You!

Thank you for attending today's webinar.

Slides and the session recording link will be available on the CCBHC Success Center website under "Events" > "Past Events" within 2 business days.



Your feedback is important to us!

Please complete the brief event survey that will open in a new browser window at the end of the meeting.

You may also scan the QR code (below) to fill out the survey!

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