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# Integrated Care Services Care Coordination

*April 23, 2025*

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

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# Acknowledgements and Disclaimer

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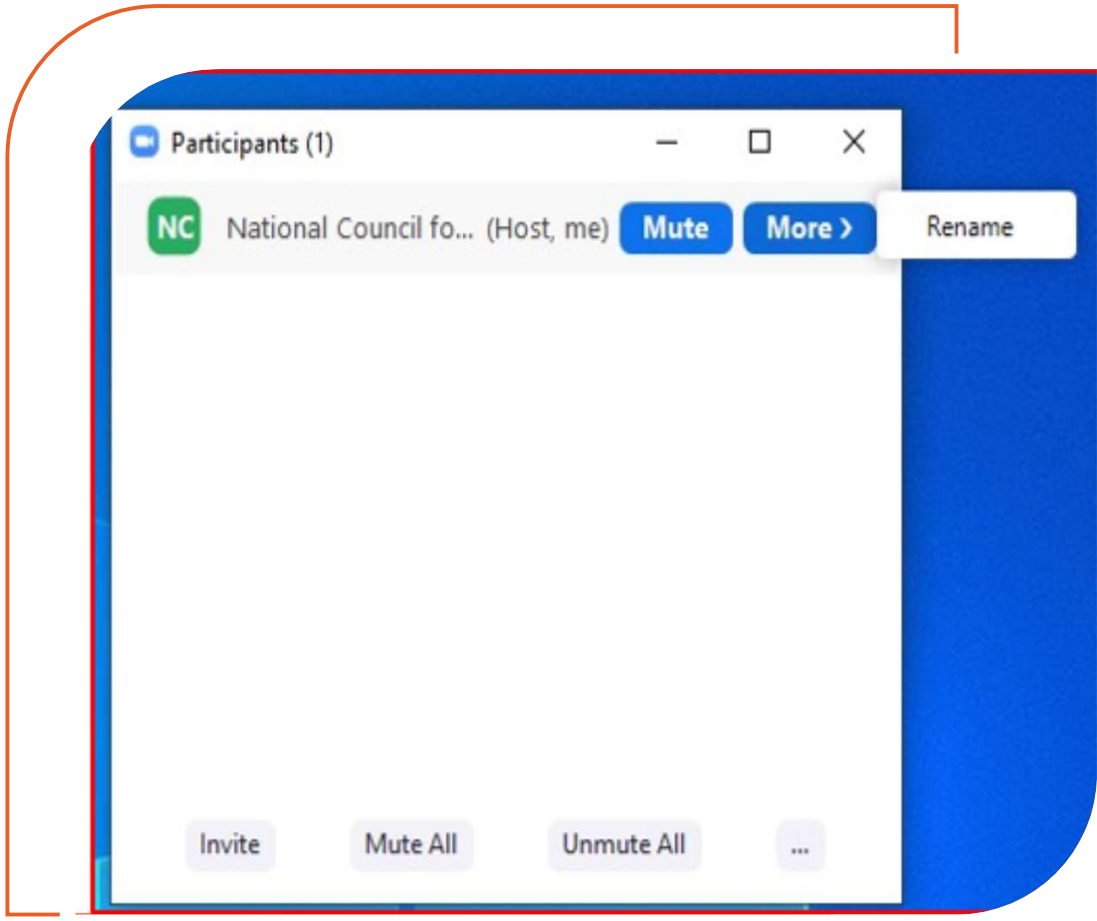
# Logistics

- Please rename yourself so your name includes your organization
  - *For example:*
    - **Roara Michael, National Council**
  - *To rename yourself:*
    - Click on the **Participants** icon at the bottom of the screen
    - Find your name and hover your mouse over it
    - Click **Rename**
  - If you are having any issues, please send a Zoom chat message to **Danielle Foster, National Council**



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# How to Enable Closed Captions (Live Transcript)

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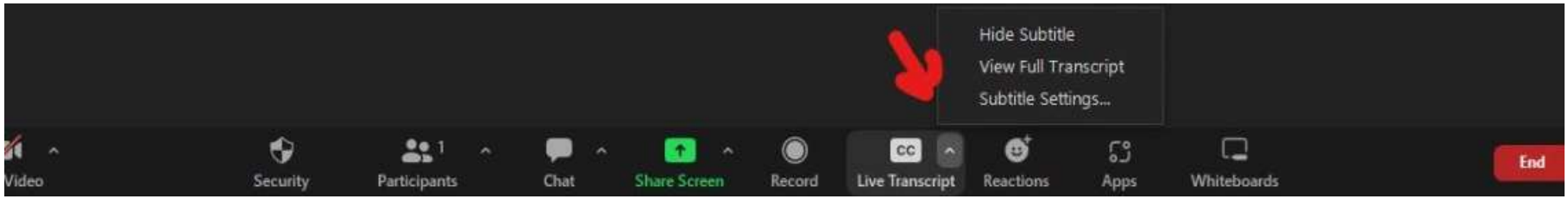




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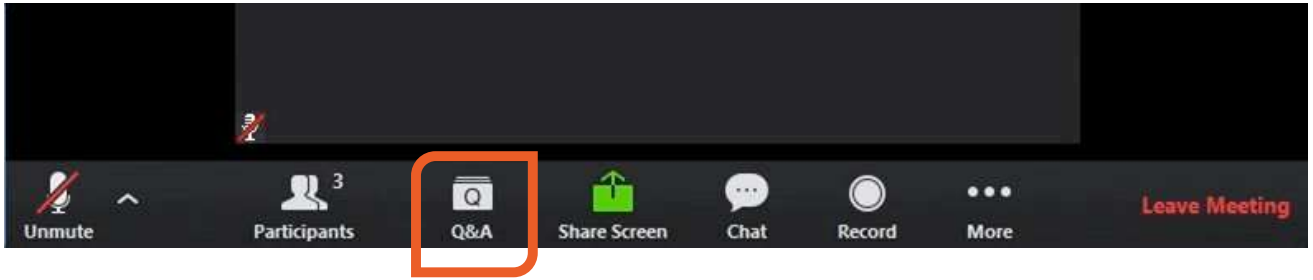
# How to Use the Q&A Feature



# NTTAC Learning & Action Series Team

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# Session Presenters

**Katie Lipp, LICSW, PMP**
Principal, Bowling Business Strategies

**Lauren Moyer, LSCSW, LCSW**
Executive VP of Clinical Innovation, Compass Health Network

# Learning Series Curriculum

| Date | Topic |
|---|---|
| **April 23rd** | Care Coordination |
| **May 28th** | Data Points & Metrics |

# Learning Objectives

Participants will learn:

- How CCBHC care coordination differs from ‘practice as usual’
- Practical strategies for developing effective internal and external coordination
- Case studies and examples from existing CCBHCs

# Integrated Care Session 2:  Polling Questions

Does your CCBHC have designated Care Coordinators, or is the function of care coordination built into other positions?

Designated Care Coordinators

Care coordination is built into other position(s)

Does your CCBHC able to demonstrate how much care coordination is being provided?

Yes

No

Does your CCBHC know which primary care provider(s) have the largest population of shared clients?

Yes

No

# Definitions and Core Concepts

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# Excerpts From CCBHC Certification Criteria

| Care Coordination Function | Associated Objectives | Criteria |
|---|---|---|
| **Coordinates care across the spectrum of health services** | Individuals and families receiving services have access to acute and chronic physical health and behavioral health care, social services, housing, educational systems, and employment opportunities. | 3.a.1 |
| **Tracks participation and coordinates referrals and appointments** | Staff assist clients and the families of children and youth referred to external providers or resources to secure needed support. | 3.a.3 |
| **Determines any medications prescribed by other providers** | The PDMP is checked before prescribing and, with consent, prescription information is provided to other providers to prevent opioid misuse. | 3.a.5 |
| **Supports enrollment in benefits** | Help clients and families to obtain needed benefits | 3.a.7 |

Adapted from National Council for Well Being CCBHC Care Coordination Toolkit, Table 2

# Excerpts From CCBHC Certification Criteria

| Care Coordination Function | Associated Objectives | Criteria |
|---|---|---|
| **Uses HIT in support of care coordination activities** | Outreach and care coordination support is documented and summarized by sending and receiving a summary of care records | 3.b.1<br>3.b.2<br>3.b.3 |
| **Seeks ways to improve care coordination through HIT** | HIT is used to improve care transitions within, to, and from the CCBHC and also to support integrated evaluation planning, treatment, and care coordination by integrating clinically relevant treatment records | 3.b.5 |
| **Includes person- and family-centered treatment planning** | A designated interdisciplinary team coordinates the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the people receiving services | 3.a.4<br>3.d.1<br>3.d.2 |

Adapted from National Council for Well Being CCBHC Care Coordination Toolkit, Table 2

# Care Coordination

- Care coordination is an organized set of activities, systems, and tools incorporated into management, service delivery, and treatment.
- It is not a distinct service, but a way of delivering care that ensures:
  - Care is systematically integrated
  - Necessary communication with other providers is routinely provided in a timely manner
  - Barriers to care are actively identified and mitigated
  - Data and EHRs are used effectively

*Care coordination activities serve the entire CCBHC population*

# Person-Centered vs. Community Care Coordination

| Person-Centered | Community |
| --- | --- |
| • Inform the person's treatment plan | • Inform program design and development of care pathways |

# Person-Centered Care Coordination Activities

UNDERSTANDING PERSON'S NEEDS AND GOALS

ALERTING TEAM MEMBERS TO CARE NEEDS

COORDINATING REFERRALS



SCHEDULING APPOINTMENTS

DOCUMENTING RELEVANT UPDATES

UPDATING THE TREATMENT PLAN

# Community Care Coordination Activities

Reviewing ADT data to understand care patterns and clients needing f/u and/or increased support

Reviewing referral data to determine rate of completion

Meeting with partners to discuss ways to strengthen connections in referral and follow-up.



Making improvements to workflows and processes

# Staffing Considerations

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# Staffing Approaches

## Embedded multidisciplinary

- Wide range of client-facing staff coordinate within their roles
- No single person designated as care coordinator

## Concentrated Teams

- Team-based, with a range of roles assigned depending on the team's needs (e.g. those with co-morbid medical needs receive nurse care coordination)

## CM/CC Partnership

- Case managers and care coordinators collaborate to provide consistent support and address internal and external referrals

## Dedicated Care Coordinator

- One care coordinator is lead point of contact for the person served

# Every Role Supports Care Coordination!

**Intake staff**

- Complete assessments, identify existing services/providers/supports, flag needed services, initiate records requests

**Front Desk**

- Appointment reminders, may identify issues (e.g. physical presentation) and alert clinician

**Peers**

- Identify barriers to care, identify preferences, provide support at appointments

**Case Managers**

- Serve as hub, identify and monitor referrals

# Every Role Supports Care Coordination!

## Clinicians

- Observe changes that raise need for additional supports, help increase motivation, ensure clinical needs are addressed in the context of care coordination

## Psychiatrist

- Checks PDMP, reviews screens and discusses results with person served, identifies medical needs for follow up

## Administrators

- Meets with key partners to establish and maintain collaboration, identifies organizational needs and finds ways to address

# A Case Study: Angie

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# Angie

## SDOH

- 47yo
- Living in multigenerational house in a rural area
- Family has 5 adults and one vehicle
- Part-time employment at the local dairy farm

## Physical Health

- Cardiovascular disease: sees cardiologist 2x/yr
- Pre-diabetes: established with PCP

## Behavioral Health

- Bipolar I: established with outpatient therapist, sees psychiatrist every 3 mos
- Possible alcohol use disorder- binge drinks on weekends: working with peer support

# Angie: Intake

**Pregnancy status**

- Angie reports she is perimenopausal and declines a pregnancy test.

**Relevant medical history and major health conditions**

- Therapist requests medical records, including medication list, from cardiologist and PCP

**Substance use**

- Therapist gets Angie's self report and Angie signs an ROI for all CCBHC staff to talk with her physical health providers, including about SUD

**Medication list**

- LPN pulls Angie's records from the Prescription Monitoring Program and adds it to the medical record

**Assessment for Physical Health Referral**

- Since Angie is already connected with physical health providers and signed ROIs for CCBHC staff to talk with them, no other referral is needed

# Angie: Care Coordination

| Psychiatrist | Therapist | Peer support | LPN | PCP & Cardiologist |
|---|---|---|---|---|
| • Considered medications Angie was prescribed for heart disease when prescribing a mood stabilizer | • Provides psychoeducation about connection between trauma and increased risk for heart disease | • Supports Angie to discuss binge drinking with her cardiologist | • Takes Angie's blood pressure and weight each visits and sends results to PCP and cardiologist. | • Shares more extensive tests and medication changes with CCBHC |

# Care Pathways

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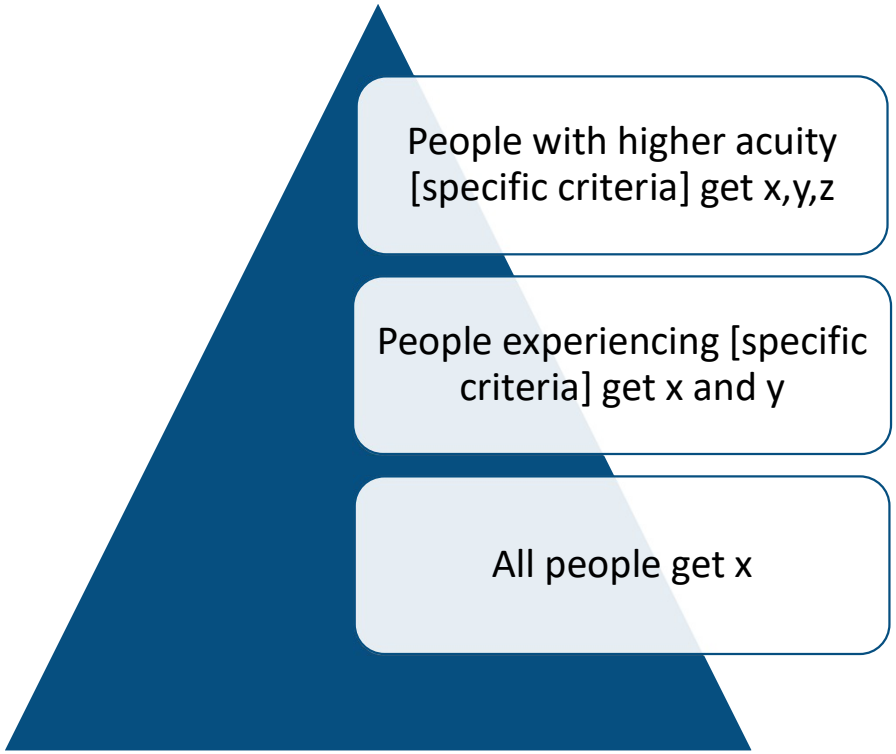
# Care Pathways



# Care Pathway Clinical Protocols

- Steps for conducting intake biopsychosocial assessment including identification of barriers to engaging in treatment
- Steps for developing treatment plans
- Decision trees for matching evidence-based or best practice interventions to identified needs of individual served
- Steps for prescribing medications/medication algorithm

# Care Pathway Administrative Protocols

- Screening and assessment data entry
- Biopsychosocial documentation and/or progress notes
- Care coordination data entry (e.g., referral, scheduling, data sharing)
- Team huddles
- Team meetings where data are reviewed and risk stratification conducted
- Individual and group supervision
- Billing and revenue cycle
- MOUs and/or relationship development with partners

# Sample Workflow Planning Questions

- Who receives the outreach/referral?
- Who is responsible for initial screening?
  - Who interprets the screen results?
  - How are the screening results recorded in the EHR? Who records them?
- What is the protocol and workflow if an immediate need for intervention is identified?
- When and how are other care partners brought into the assessment process?
- Who is responsible for informing who?
- How is it determined whether a psychiatric evaluation and consultation with other specialists is warranted?

# Internal Care Coordination

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# Documentation

- Effective and timely documentation and follow up facilitates care coordination
- Do not rely on narrative; develop radio buttons and other reportable fields to capture client preferences, referral submission, etc.

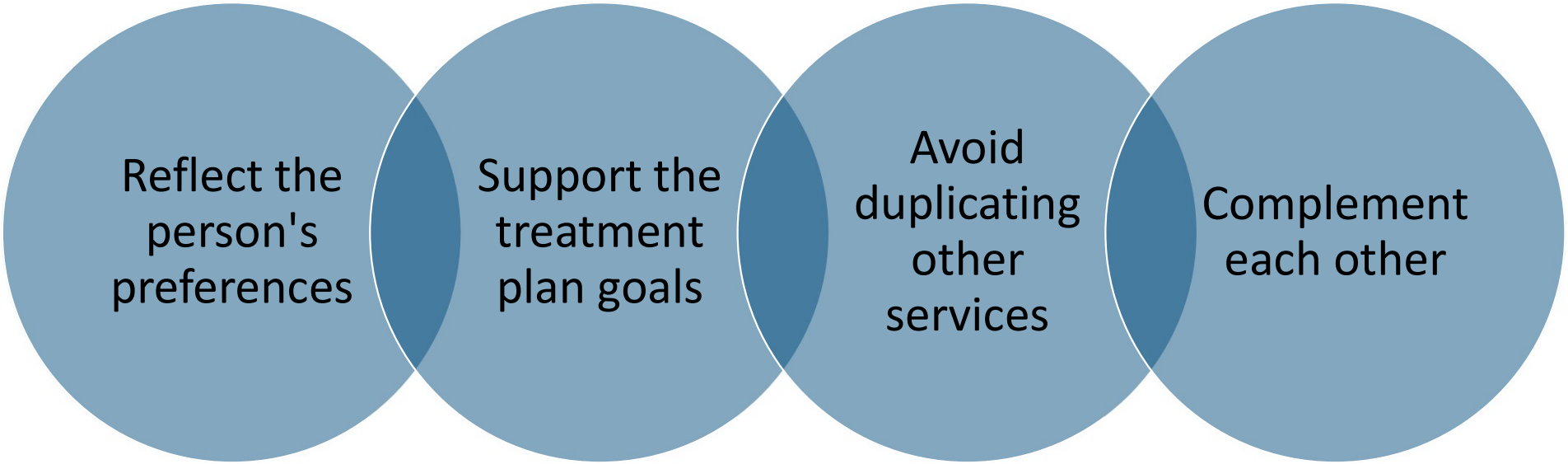
# Stratifying/Coding Clients

Uses a number of indicators to categorize levels of care or flag specific care needs.

- Clinical indicators (acuity, comorbidities)
- Utilization patterns
- SDoH
- Behavioral factors (medication adherence, engagement in therapy)

# Team Meetings

Support the CCBHC's efforts to ensure the services provided:



# What strategies have you implemented to support internal coordination?

Please enter in the chat.

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# Coordination with External Partners

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# Liaison

1. Use data from your Community Needs Assessment, EHR, and staff feedback to identify priority partnerships
2. Identify a staff member with a history of working with priority partners to serve as point of contact for regular communication and more timely concerns.
3. Initiate standing meetings, based on organizational needs:
    - Provide updates to staffing/back door numbers/changes in points of contact
    - Troubleshoot procedural or client-specific issues
    - Share programmatic or other changes across each organization
    - Identify training needs

# Written Agreements

- Written agreements help to outline the shared expectations of each organization with respect to timeliness, points of contact, points of escalation, etc.
- MOU: establishes agreement (not legally binding) which outlines the expectations of each of the parties
- BAA: establishes legally binding relationship between HIPAA covered entities and business associates to ensure protection of PHI.

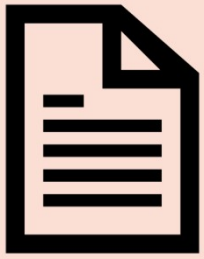
EXAMPLE

- BAA between hospital system and CCBHC that facilitates read-only EHR access to key staff

# Notification Triggers

EXAMPLE

- Develop client-level EHR report that pulls out key elements to share with PCP, sent on quarterly basis.



- Positive screens
- Medication changes
- Engagement with crisis services, ED, or hospitalization
- Result outside of normal range
- Discontinuation of any key services
- Significant changes in housing or other SDoH

# Example: Coordination with Corrections

- Assistant Director of Community Support Program (CSP) for adults with SMI serves as liaison to county correctional facility (CCF).
  - CSP provides updated organizational charts and back-door numbers
  - CCF provides weekly census reports
  - Hold monthly meeting to collaborate:
    - Review programmatic/organizational changes
    - Troubleshoot concerns
      - Clinical
      - Workflow
      - Relational

# What strategies have you implemented to coordinate with external partners?

Please enter in the chat.

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# Spotlight on Children & Adolescents

- Schools and pediatricians are the front door- empower and nurture these relationships!
  - Ex: Child Psychiatry Access Lines (NNCPAP National Network of Child Psychiatry Access Programs), School-Based Health Centers, co-location, integration
- Provide coaching to caregivers to help them get the support they need
  - Ex: Well Visit Planner (Well Visit Planner) for engaging with primary care, family peer support, collaborating with school-based clinicians, participation in IEP meetings, collaborating with child protection and juvenile justice
- Consider unique needs of blended and co-parenting families
- Address caregiver mental health and substance use needs
- Be mindful of varying ages of consent for transition aged-youth

# Lessons From a Leader

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# Lessons From a Leader

- Tell us about the change management process your CCBHC went through in incorporating care coordination. What were the biggest challenges and opportunities?
- Are there specific conditions you have targeted for care coordination? How did you make that decision and what does the care pathway look like?
- Are there specific strategies for internal or external care coordination that have been particularly successful?

# Questions?

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