NATIONAL COUNCIL for Mental Wellbeing

CCBHC-E National Training and Technical Assistance Center

CCBHC New Grantee Learning Community

Session 7: Care Coordination

May 21, 2024

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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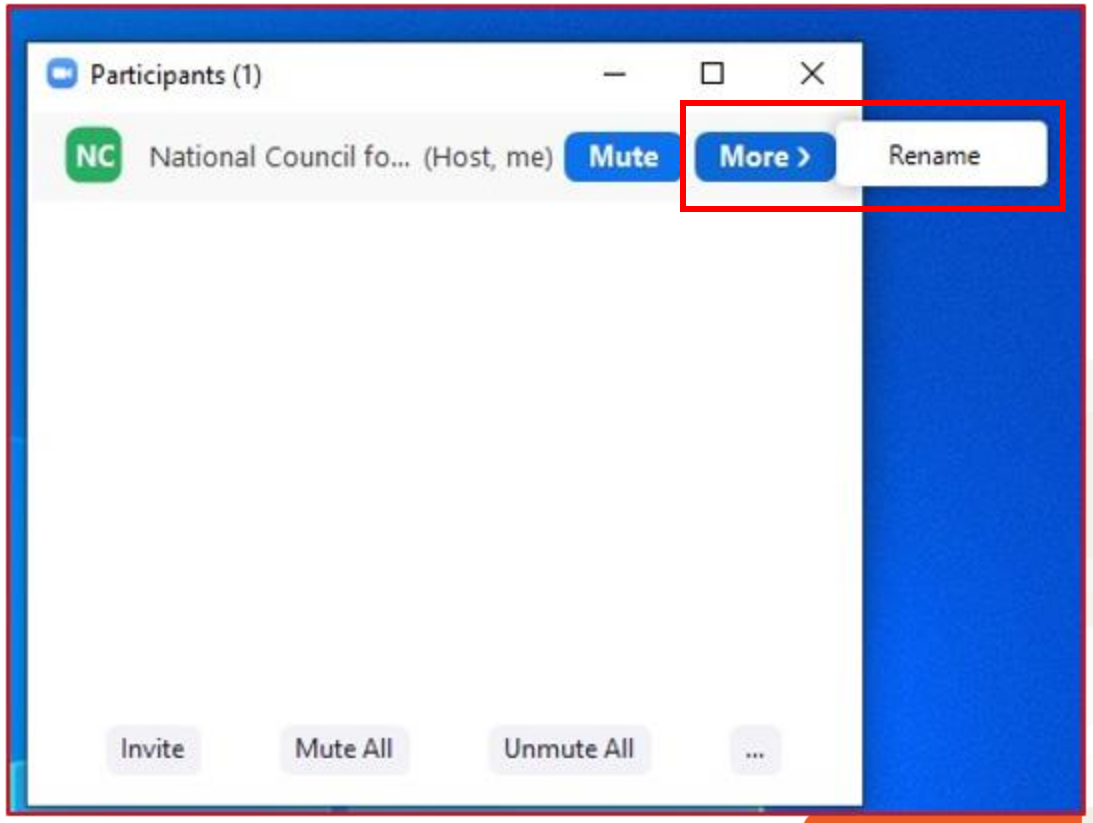
Logistics

- **Please rename yourself so your name includes your organization.**
- *For example:*
  - D’ara Lemon, 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 **D’ara Lemon, National Council**



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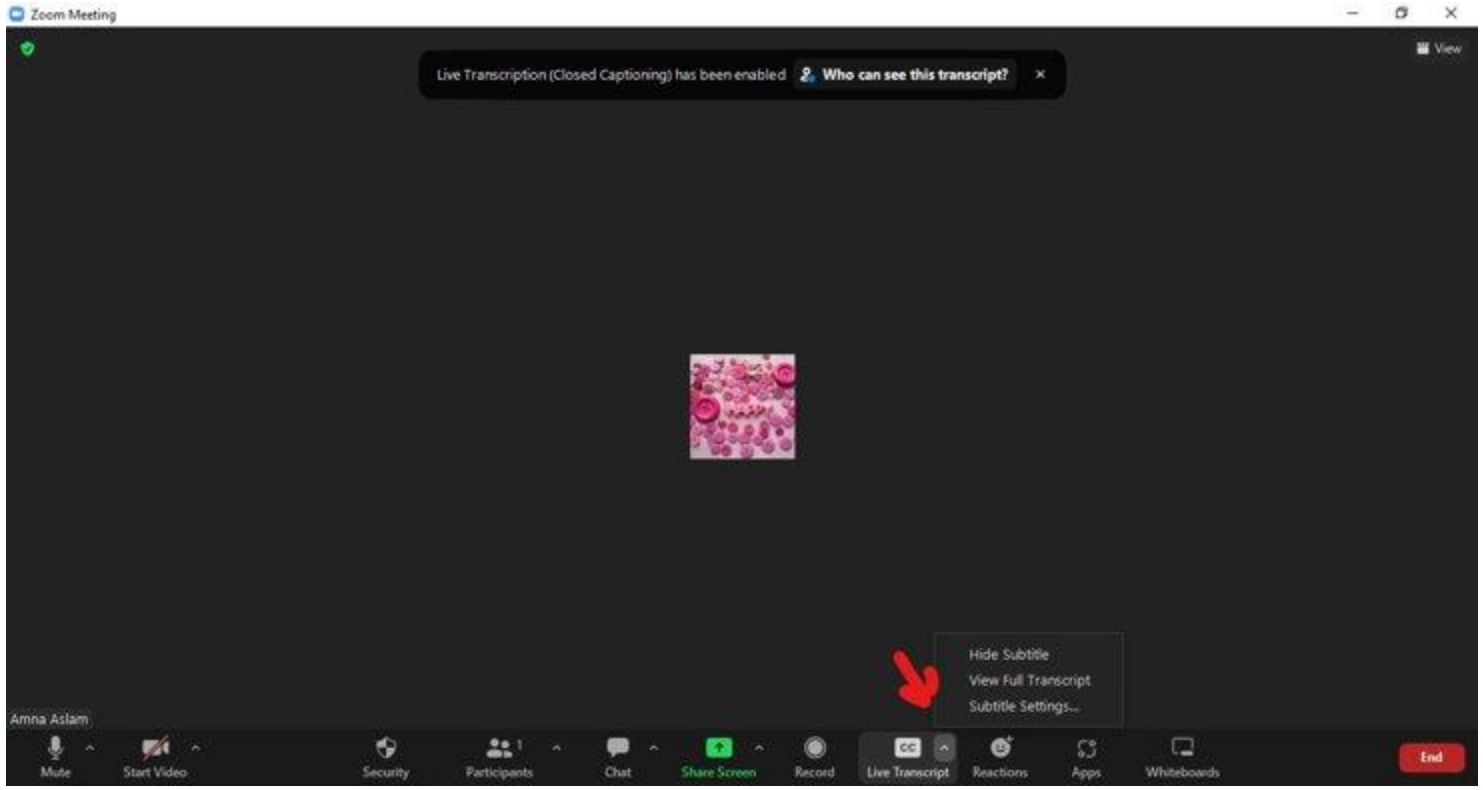
How to Enable Closed Captions (Live Transcript)



Next to “Live Transcript,” click the arrow button for options on closed captioning and live transcript.

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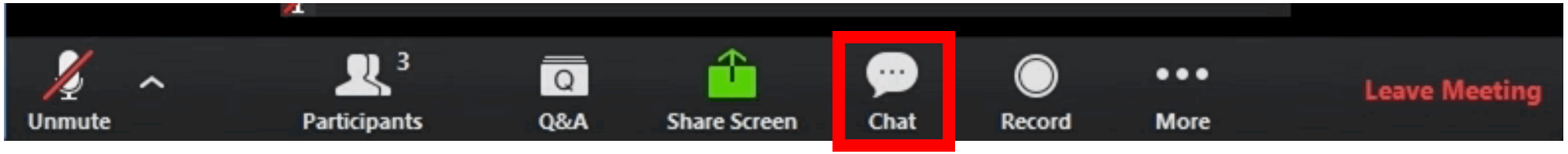
How to Ask a Question



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

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Today's Agenda

1. CCBHC overview
2. Definitions and requirements
3. Best practices for care coordination
4. Case study
5. Breakout discussion

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Learning Objectives

- Increase knowledge and understanding of CCBHC care coordination criteria and implications for clinic and organizational changes
- Identify strategies and approaches CCBHCs can employ to effectively develop partnerships and models to coordinate care
- Improve understanding of HIT and other strategies for sharing data

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Your Learning Community Team

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Consultant and Subject Matter Expert
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Nichelle Ward, LCSW
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Community Pulse Check

New Grantee Deliverables

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Community Check-In

What is the status of your **needs assessment**?

- Haven't begun needs assessment
- Have begun design but have not started data collection
- In the process of collecting data
- Have completed the needs assessment
- Have questions

How many of the **9 required services** are you currently providing either directly or through a Designated Collaborating Organization (DCO)?

- 1-4
- 5-8
- All 9

Where are you on the **staffing and training plans**? *(select all that apply)*

- ❑ Waiting for completion of needs assessment
- ❑ Have begun the staffing plan
- ❑ Making good progress
- ❑ Have completed the staffing plan
- ❑ Have questions

Where are you on the **delivery of services plan?** *(select all that apply)*

- ❑ Waiting for the completion of the needs assessment
- ❑ Have begun the service plan
- ❑ Making good progress
- ❑ Have completed the service plan
- ❑ Have questions

Where are you on the **sustainability plan**? *(select all that apply)*

- ❑ Haven't begun the sustainability plan
- ❑ Have begun the sustainability plan
- ❑ Making good progress
- ❑ Have completed the sustainability plan
- ❑ Have questions

Where are you on **attestation**? *(select all that apply)*

- ❑ Haven't begun preparing for attestation
- ❑ Have begun preparing for attestation
- ❑ Making good progress
- ❑ Have submitted attestation
- ❑ Have questions

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Care Coordination: Requirements

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What Is a CCBHC?

An integrated community behavioral health clinic model of care that aims to improve service quality and accessibility, a CCBHC:

- Provides integrated, evidence-based, trauma-informed, recovery-oriented and person-and-family-centered care.
- Offers the full array of CCBHC-required mental health and substance use disorder (SUD) services and primary care screening.
- Has established collaborative relationships with other providers and health care systems to ensure coordination of care.

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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

- The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA, 42 CFR Part 2, and other federal and state privacy laws.
- The CCBHC obtains necessary consents for sharing information with community partners where information is not able to be shared under HIPAA and other federal and state laws and regulations.
- 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.

Note: CCBHCs are encouraged to explore options for documenting consent electronically where it's feasible and responds to the needs and capabilities of the person receiving services.

Care Coordination 3.A: General Requirements

- The CCBHC shall coordinate care in keeping with the preferences of the person receiving services and their care needs. To the extent possible, care coordination should be provided, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by the person. 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.
- At minimum, people receiving services should be counseled about the use of the 988 Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis and stabilization services should a crisis arise when providers are not in their offices. Crisis plans may support the development of a psychiatric advance directive.

Care Coordination 3.A: General Requirements

- Nothing about a CCBHC's agreements for care coordination should limit the freedom of a person receiving services to choose their provider within the CCBHC, with its designated collaborating organizations (DCOs) or with any other provider.
- Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers.
- To the extent that state laws allow, the state prescription drug monitoring program (PDMP) must be consulted before prescribing medications and during the comprehensive evaluation.
- Upon appropriate consent to release of information, the CCBHC is also required to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.
- The CCBHC assists people receiving services and families in accessing benefits, including Medicaid, and enrolling in programs or supports that may benefit them.

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

- The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records (EHR).
- The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as:
  - Population health management
  - Quality improvement, quality measurement and reporting
  - Reducing disparities
  - Outreach
  - Research
- When CCBHCs use federal funding to acquire, upgrade or implement technology to support these activities, systems should utilize nationally recognized, HHS-adopted standards, where available, to enable health information exchange.

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

- The CCBHC uses technology that has been certified to current criteria under the Office of the National Coordinator (ONC) Health IT Certification Program for the following required core set of certified health IT capabilities that align with key clinical practice and care delivery requirements for CCBHCs:
  - Capture health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity and disability status (as feasible).
  - At a minimum, support care coordination by sending and receiving Summary-of-Care records.
  - Provide people receiving services with timely electronic access to view, download or transmit their health information or to access their health information using a personal health app of their choice.
  - Provide evidence-based clinical decision support.
  - Conduct electronic prescribing.

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

- The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consent from people receiving services and complying with privacy and confidentiality requirements.
- Within two years following CCBHC certification or submission of attestation, 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.

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

Additional Recommended Partnerships

- Other specialty and social and human services providers
- Indian Health Service and tribal programs
- Suicide and crisis hotlines and warmlines
- 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 and Care Coordination Activities

- All treatment planning and care coordination activities are person- and family-centered.
- All treatment planning and care coordination activities align with the requirements of Section 2402(a) of the Affordable Care Act. All treatment planning and care coordination activities are subject to HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.
  - 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 – with the person receiving services and their family/caregivers (to the extent the person receiving services desires their involvement or when they are legal guardians) – 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, as appropriate and desired by the person receiving services, traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups.

Approaches and Practices for Care Coordination

Joan King
Practice Improvement and Consulting
National Council for Mental Wellbeing

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Reflection question:

When you or your family need health care, what do you hope that care is like?

Or when you have received care, what worked and what didn't work?

5-minute Breakout Discussion

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Care Coordination as the Lynchpin

- Systems, discrimination, symptoms and complexity all get in the way of people receiving care.
- Care coordination can provide needed expertise, support, guidance and advocacy to help with this navigation and understanding.
- For too long, even within our organizations we have been siloed and the left hand hasn’t known what the right hand was doing

Approaches to Care Coordination: Function and Role

- Care coordination as the “front door."
- Team based care coordination: Who is accountable?"
- Care coordination as a specialty, layered approach.
- Care coordination for medical, physical health care needs.

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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 both psychiatric 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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Case Study

Nichelle Ward
CCBHC Program Director
Tessie Cleveland Community Services

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Tessie Cleveland Community Services Corp.

- Established 2005
- Located in Los Angeles, California
- Service North, South and East Los Angeles County and Riverside County
- CCBHC since 2021

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Our Care Coordination Model

Outreach

Clients/ Partnerships

Linkages

Referrals

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Intakes

INTAKE PAPERWORK

RISK ASSESSMENTS

TREATMENT PLANS

SAFETY PLANS

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Needs Assessments

- ✓ Housing
- ✓ Income
- ✓ Access to food
- ✓ Clothing
- ✓ Health
- ✓ Transportation
- ✓ Employment
- ✓ Education
- ✓ Legal
- ✓ Care (child/ adult/ elder)
- ✓ Support systems
- ✓ Purpose/ Meaningful Use of Time

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Care Coordination Throughout Treatment

- Services are based on acuity of needs
- Care coordination is provided throughout treatment
- A single designated point of contact
- Needs are reassessed every 90 days

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Benefits

- Needs are addressed at intake
- Addresses barriers to services
- Reduces workload for clinician
- Provides a single point of contact

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Questions?

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Breakout Discussion

In each room, each participant will share:

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

During the breakout room, assign someone to take notes. Upon returning to the large group, these questions can then be entered into the chat and become part of the question log.

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Closing: Sharing and Preparing

Brave Volunteers: What did you hear from others in terms of questions and needs?

QUESTION LOG: Take 2-3 minutes to put any questions you generated in the chat to continue to add to our question log

Next Session: June 12th, 2:30-4pm ET

Topic: Partnerships

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Upcoming Events

Event Type	Title	Date + Time	Registration Link
Webinar	CCBHCs and Housing: Clinic and Housing Provider Partnership Possibilities	Wednesday, May 29th 3:30pm – 5:00pm ET	Register Here

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Monthly Cohort Calls

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!

Event Type	Date + Time	Registration Link
Executives	The **last Friday** of each month from **12:00-1:00pm E.T.**	Register here
Program Directors	The **first Wednesday** of each month from **12:00-1:00pm E.T.**	Register here
Evaluators/CQI Leads	The **first Tuesday** of each month from **3:30-4:30 pm E.T.**	Register here

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Questions or Looking for Support?

Visit our website
and complete the [CCBHC-E NTTAC Request Form]

Slides, recordings and session resources will be available on our [New Grantee Learning Community webpage] approximately 2 days following each session

thenationalcouncil.org/program/ccbhc-e-national-training-and-technical-assistance-center/request-training-assistance/

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