Care Coordination for Certified Community Behavioral Health Clinics (CCBHCs)

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Case Management vs. Care Coordination

• Case management is a service
  – Helping an individual gain access to needed supports and services
  – Rule 132 service/DASA contracts

• Care coordination is an activity
  – Involves agreements with other providers
  – Entails tracking and follow-up
The case for needing Care Coordination:

- High rates of medical errors.
- Serious unmet needs.
- Poor satisfaction with care.
- High rates of preventable readmissions.

This has resulted in significant cost burden, but more importantly, there is a human cost involved.
CCBHCs are responsible for Care Coordination

- Organize care activities among different services and providers, and across various facilities.

- This deliberate organization of care also requires sharing information among all of the participants concerned with a consumer’s care to achieve safer and more effective care.
In order to effectively coordinate care

• The individual’s needs and preferences must be known ahead of time.
• These must be communicated at the right time to the right people.
• This information can then be used to provide safe, appropriate and effective care to the individual.
Who is Involved?

- FQHCs and rural health clinics
- Inpatient Services
  - psychiatric hospitals
  - detoxification services
  - post-detoxification step-down services
  - residential programs
  - acute care hospitals
  - hospital outpatient clinics
- Schools
- DCFS contracted providers
- Juvenile justice
- Criminal justice
- Department of Veterans Affairs
  - (VA) medical centers
  - independent outpatient clinics
  - drop-in centers
  - other VA facilities.
- Other social and human services
Care Coordination Agreements and Care Transitions

• Ensure quality care.
• Establish protocols for supporting effective care transitions.
• Agreements:
  – Orderly
  – Promote the highest quality of care possible.
Redesign of a health care system...

• Current systems are often disjointed and processes vary among and between primary care and specialty care sites.
• Individuals are often unclear about why they are being referred from primary care to a specialist, how to make appointments and what to do after seeing a specialist.
• Specialists do not consistently receive clear reasons for the referral or adequate information on tests that have already been done.
• Primary care physicians do not often receive information about what happened in a referral visit.
• Referral staff deal with many different processes and lost information, which means that care is less efficient.
Effective Care Coordination Requires Systems To:

- Transfer medical records of services received from those providers, including prescriptions.
- Track admission and discharge.
- Actively follow-up after discharge.
- Coordinate specific services determined by specific risks (e.g. a potential suicide risk).
Specific Care Coordination Activities...

• Establish accountability and agreement on who maintains responsibility.
• Engage each person you’re working with (and their family, when appropriate) in the development of a care plan that reflects their own health care needs and priorities.
• Ensure that the person and his/her team understands their role in the plan and feels equipped to fulfill responsibilities.
Specific Care Coordination Activities (Cont.)

• Identify barriers that affect the person’s ability to adhere to treatment.
• Assemble the appropriate team of health care professionals and team members.
• Assist the individual in navigating the network of providers.
Specific Care Coordination Activities (Cont.)

- Ensure the individual’s electronic health record reflects up-to-date information and is accessible to all care team members.
- Facilitate appropriate and timely communication between care team members.
Specific Care Coordination Activities (Cont.)

- Follow-up with the individual periodically to ensure their needs (and goals) are being met and that circumstances and priorities have not changed.
- Communicate and share knowledge related to care.
- Work to align resources with consumer needs.
Care Coordination ...

• Has the potential to improve the effectiveness, safety and efficiency of the community health care system.

• When well-designed and well-delivered, Care Coordination improves outcomes for everyone: consumers, providers and payers.
First 24 hours post discharge

• Make and document reasonable attempts to contact consumers who are discharged from higher levels of care.

• For all who pose potential risks for suicide:
  – plan for suicide prevention and safety
  – coordinate consent and follow up services
  – Contact attempts continue until the individual is linked to services or assessed to no longer be at-risk.

• Involvement of individuals with lived experience is encouraged in this process.
Medications...

- CCBHC must make and document reasonable attempts to determine medications prescribed by providers for CCBHC consumers.
- With proper consent, the CCBHC should also provide such information to other providers to ensure safe, quality care.
Cornerstones of care:

• Timely sharing of information that supports multiple providers being able to access information and document care plan progress.

• CCBHCs should have a plan that addresses how to improve care coordination with all designated collaborating organizations (DCOs) using health information technology.
  – Must maintain HIPAA compliance!
A High Quality Referral is:

- **Safe** - planned and managed to prevent harm
- **Effective** - based on scientific knowledge and executed well to maximize benefit
- **Timely** - individuals receive needed services without unnecessary delays
- **Person-centered** - responsive to individual and family needs & preferences
- **Efficient** - limited to necessary referral and avoids duplication of services
- **Equitable** - availability and quality do not vary
Individual Support

• The team is organized to optimally provide support to individuals and families during referrals and transitions.

• Referral Coordinator:
  – Tracks all referrals and transitions
  – Provides individuals (and families) with information about referral
  – Addresses barriers to referrals
  – Follows up on missed appointments
Strong Relationships & Agreements

• Relationships with key specialist groups, hospitals and community agencies.
• Formal agreements with these key groups and agencies.
• Opportunities to Document Lessons Learned:
  – Talk through the process for a “typical” person’s experience in the system
  – Work on a global (versus an individual) basis encourages you to focus on the system and not individual people.
Where to Start

• Tracking & following up on lab/imaging results
• Identification & tracking of linkages to community resources
• Guidelines for referral, prior tests, and information;
• Expectations about future care and specialist-to-specialist referral;
• Expectations for information back to CCBHC
• Notification of visit/admission and discharge;
• Medication reconciliation after transition;
• Involvement of CCBHC in post-discharge care.
Care Coordination...

• Complements and improves health care.
• Ensures continuity for improved health.
• Avoids preventable poor outcomes. spending.

• Care Coordination changes lives!