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**

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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.

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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.

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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.

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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

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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.

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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.

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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).

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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!

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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

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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

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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.

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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.

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Care Coordination…

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

- **Care Coordination changes lives!**

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