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CARE COORDINATION OVERVIEW IN THE CERTIFIED COMMUNITY BEHAVIORAL HEALTH CARE (CCBHC) MODEL

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Committing our professional lives to the behavioral health field requires that we carry out our role with a combination of empathy, knowledge, and skills as we strive to help individuals who live, work, and seek services within multiple complex systems. Care coordination allows us to honor those complexities by deepening our understanding of an individual's strengths, clinical needs and goals; by leveraging each person's existing environmental resources; by collaborating with others who bring specific knowledge and skills to the helping relationship; and by monitoring performance through key indicators.

As a hallmark of the certified community behavioral health clinic (CCBHC) model, coordinating care respects client input and choice while reducing burden through providing help in what is often viewed as a difficult-to-navigate behavioral health care system. It provides an opportunity to include physical health care so that co-occurring conditions are treated simultaneously, preventing the worsening of some symptoms while others are addressed. Finally, social determinants of health can be enhanced through care coordination within the CCBHC, resulting in fewer duplicative or ineffective services. It is through this whole person approach that we reduce inefficient and ineffective care and work toward helping those we serve to achieve and sustain wellness and recovery.

Healthcare's Quadruple Aim, targeting improved clinical outcomes, enhanced client experience, improved work life of healthcare providers, and reduced costs, positions CCBHCs as key drivers of care coordination implementation at the clinic and client service levels. Care coordination as both an embedded structure and function within the organization has the potential to improve the effectiveness, safety, efficiency, and healthcare team well-being of the CCBHC system of care.

Defining Care Coordination

The concept of coordinating care for individuals (clients, consumers, patients) is not a novel concept. It spans many segments within healthcare including medicine, nursing, social work, pharmacy and peer support, and involves persons from various professional backgrounds comprising an interdisciplinary team. In short, care coordination organizes and synthesizes the seemingly disparate parts of an individual's care into one care experience. According to the Agency for Healthcare Quality and Research (AHRQ), care coordination is *deliberately*

organizing patient care activities and sharing information among all participants concerned with a patient's care to achieve safer and more effective care.[1]

Deeply entrenched in an outdated system built upon singular responses to multiple and multifaceted conditions, behavioral healthcare (BH), including mental health (severe mental illness [SMI] and any mental illness [AMI]) and substance use disorders (SUD), stands in need of a paradigmatic shift charged with reducing fragmentation and increasing individualized, evidence-based care. This shift will transform the BH field to one redesigned to reflect measurement-based performance by advancing organizations' strategy, operations, and financial models. One such way to do so is by implementing care coordination.

Clients with BH issues often have co-occurring mental health and SUD challenges, physical health issues, and social determinant deficits that are interconnected and need attention simultaneously. According to the most recent release of the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH), in 2020, 40.3 million people aged 12 or older (14.5%) had an SUD in the past year, including 28.3 million with alcohol use disorder, 18.4 million with an illicit drug use disorder, and 6.5 million with both alcohol use disorder and an illicit drug use disorder. In that same year, 52.9 million adults aged 18 or older (21%) had AMI, while 14.2 million people (5.6%) had serious mental illness (SMI) over the past year. Further, an estimated 17.0 million people aged 18 or older (6.7%) had co-occurring AMI and an SUD, and 5.7 million people (2.2%) had co-occurring SMI and an SUD in the past year.[2]

Not addressing these factors puts the client at greater risk of gaps in care or duplication of services, which can lead to insufficient care, client burden, staff fatigue, and excessive cost. Organizations and their staff cannot provide all services to everyone. CCBHCs rely on designated collaborating organizations (DCO) with specific expertise to be helpful, but reaching out for that expertise must be facilitated by the CCBHC.[3]

Broad inter-and intra-organizational care coordination *approaches* include: inter-disciplinary teamwork, medication management, health information technology, and the behavioral health home or patient-centered medical home[1] that address service needs within areas such as primary care, specialty medical care, psychiatric or medical hospitals, schools, housing authorities, and probation departments. Within these areas, specific care coordination *activities* may include:

- Establishing accountability and agreeing on responsibility
- Communicating/sharing knowledge
- Helping with transitions of care
- Assessing client needs and goals
- Creating a proactive care plan
- Monitoring and follow-up, including responding to changes in clients' needs

- Supporting client's self-management goals
- Linking to community resources
- Working to align resources with client and population needs
- Helping and staying with the client throughout referral as long as they are client[2]

Care Coordination within the CCBHC Model

The service providing organization (i.e., the clinic) and its designated collaborating organizations form the CCBHC. While clinics typically have sufficient experience with successful case management, care coordination extends beyond the case management role. Case managers, specific to the parent organization itself, provide direct care by supporting access to resources to support wellness and recovery. In contrast, care coordinators work with the client's treatment providers (internal and external the CCBHC) to organize and coordinate services to minimize confusion for clients who seek services beyond the CCBHC's walls. Generally, case management is condition-specific and operates at the individual client level, while care coordination functions across all needs and conditions often delivering both client-centered and family-centered care. Finally, case managers will make referrals and in some cases provide warm handoffs, but care coordinators will "deliver" that client to the DCO, engage in ongoing communication with the client and provider, and make adjustments when clinically relevant. Managing transitions of care and retaining clients until they are discharged from services completely are two key characteristics that distinguish case management from care coordination within the CCBHC model.

Population Health Management and Care Coordination

Population health management (PHM) involves addressing health through an equitable lens which includes understanding health disparities via community needs assessments; managing chronic conditions through integrated care and community partnerships; and measuring progress through data analytics. Successful PHM uses data to identify care pathways that align with unique client needs. PHM involves evaluating data from the community within which the CCBHC is situated, screening and assessing clients, and combining what is known from the community with the results of screens and assessments to develop individualized care with the strongest probability of successful outcomes, positive client and provider experience, at the best possible cost.

Care coordination activities are connected to PHM through:

- Stratifying clients by utilizing risk scores and applying preventive interventions
- Tracking clinical outcomes and progress at both the individual client level and overall caseload level for the target population
- Identifying clients not improving to prioritize for treatment adjustment or psychiatric case review
- Tracking longitudinally the entire client panel across multiple integrated care programs

Strategies and Tactics for Successful Care Coordination Implementation

Care coordination for people seeking BH services is critical to meeting the comprehensive needs of the client and family while providing connected and integrated care for better outcomes and experience in a cost-effective way. The opportunity to be planful and forward-thinking with care coordination occurs whether you are working within an existing CCBHC or working toward establishing the model in your organization. Below are five strategic opportunities with questions for consideration as you build your CCBHC.

Opportunity 1: Staff Education and Training

- What relevant and formal trainings are in place for care coordinators and other staff?
- How are supervisors involved in these trainings, or are there sessions for supervisors only?

Opportunity 2: Policies and Procedures

- Are policies and procedures in place to drive client choice and to encourage family participation in care coordination processes and activities?

Opportunity 3: Client Engagement

- How is PHM utilized to target groups of clients?
- Are service offerings tailored to meet the unique needs of these groups?
- How do staff explain care coordination to clients?

Opportunity 4: Marketing Materials

- What content is included on your website and in other materials to explain care coordination to a variety of audiences?
- With what frequency are marketing materials refreshed and shared with a variety of audiences?

Opportunity 5: Electronic Health Record Capabilities

- To what degree do care coordinators use the EHR? What is needed to bring them to a level of proficiency?
- Are the necessary consent forms available electronically to be able to proceed with effective care coordination?
- How are outcomes (service and clinical) extracted from your EHR?
- Consider interoperability – how well does your system connect to others to allow for the easy exchange of information?

Conclusion

The need for carefully embedded and executed care coordination is clear, and the implications to the CCBHC and the clients it serves rests in the Quadruple Aim. A streamlined and data-informed approach to care coordination is not without barriers, yet its implementation is likely to reap benefits for all involved - clients, families, providers, and payers. With careful planning, training, supervision, and ongoing evaluation, care coordination will strengthen overall service delivery and contribute substantially to improving fully integrated behavioral healthcare.

References

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