

Academy for Policymakers Podcast Transcript
Care Coordination in Certified Community Behavioral Health Clinics
Recorded by Samuel Shore & Kelsi Urrutia

Announcer: Thank you for visiting the University of Illinois at Chicago's Health & Recovery Academy for Policymakers. The following recording comes to you from the UIC Center on Integrated Health Care and Self-Directed Recovery. Visit our online Academy to obtain free information and resources about policies that promote health, self-direction, and employment for the behavioral health field.

KU: Hello. My name is Kelsi Urrutia. I'm here with Samuel Shore, Director of the Academy for Policymakers at the University of Illinois at Chicago's Center on Integrated Health Care and Self-Directed Recovery. Previously, we spoke about Certified Community Behavioral Health Clinics, or CCBHCs. Today, we'll be talking about a unique aspect of CCBHCs which is care coordination. Thanks for joining me today Sam. Would you please start us off with some background information about what care coordination is?

SS: Certainly. People with complex or co-occurring illnesses often see many different specialty doctors and have numerous points of contact with the health care system. Care is often provided by different professionals in isolation from one another. Unfortunately, this may lead to a disjointed system of care, with poor communication among doctors as well as between doctors and patients. The end result is reduced efficiency, lost information, and poor treatment outcomes. Care coordination involves intentionally organizing patient care activities and sharing information among all of the parties involved in a patient's care to achieve safer and more effective care. This requires that the patient's needs and preferences be known ahead of time and shared at the right time with the right people, and that this information is used to provide safe, evidence-based, and effective care to the patient.

KU: Can you tell our listeners a little more about why care coordination is so important to the operation of CCBHCs?

SS: Care coordination is central to the success of CCBHCs because these Clinics are required to ensure that clients can access a wide variety of mandated services. Some services must be provided by Clinic staff, such as behavioral health assessment and diagnosis, person-centered and family-centered treatment planning, outpatient mental health and substance use disorder services, and crisis services. For other mandated services, Clinics can establish formal relationships with external providers, called designated collaborating organizations or DCOs. In addition, Clinics are required to work with local organizations such as schools, child welfare agencies, Veterans Affairs medical centers, and criminal justice agencies. With all the different organizations that can potentially serve a particular client, care coordination becomes an essential activity, and the CCBHC legislation spells out what this needs to include.

KU: I can certainly see the need to coordinate care between all those different organizations, patients, and their families. Can you tell us what kinds of care coordination activities CCBHCs are expected to engage in?

SS: Sure. First, Clinics are required to have formal care coordination agreements with the organizations they designate as collaborating providers. At a minimum, these agreements must cover how medical records will be transferred between providers, how admission and discharge will be tracked, plans for active follow-up after discharge, and coordination of specific services if the patient is at risk for suicide. Second, Clinics must have protocols in place for tracking and transitioning clients who are admitted to non-designated providers such as emergency departments, inpatient and outpatient hospitals, detoxification programs, and housing programs. Sharing information about prescribed medications between both designated and non-designated agencies also is required for care coordination.

KU: What about the person being served? What is their role, and what about their family members?

SS: I'm glad you asked that, because the client is at the center of this approach. Clinics and their collaborating providers must engage in person- and family-centered treatment planning. This kind of patient-centered care is a collaborative process where care recipients participate with providers in the development of treatment goals and receive help in accessing the services they want and need. One way this is done is through shared decision-making, in which patients and providers make health care decisions together, based on the best available evidence, and the patient's values and preferences. Another way patients direct their care is by learning illness self-management strategies for both medical and behavioral health conditions. It is also recommended that Clinics provide or link clients to peer and family support services as part of care coordination efforts.

KU: This sounds similar to case management. How is care coordination different from what is traditionally provided?

SS: There is some overlap between these terms and case management does include coordination of some parts of a person's care. However, at the center of case management is the case manager, serving as a liaison between various parties. Whereas at the center of care coordination is the individual client, who receives help to determine all the different services they need based on what their goals are.

KU: Could you share an example of what all of this might look like in practice once these Clinics are established?

SS: Sure. This example comes from FamiliesUSA, a nonprofit, nonpartisan organization that promotes high-quality, affordable health care for all Americans. In this case, Julia and Paul live in a two bedroom apartment with their 12 year-old son John who has severe asthma. John ends up in the emergency room at least once a month. The inhalers the doctor prescribes are expensive, and since Julia lost her job and John works part-time, the

family often has to choose between paying for the inhalers and buying other necessities. John senses his condition is forcing his parents to make tough choices, and has started having trouble sleeping at night. Paul thinks their cramped living space and the mold growing in their living room might be exacerbating John's asthma, but the landlord won't return his calls. The primary care practice that John visits for medical care has adopted care coordination. During a visit, a care coordinator sits down with John, Julia, and Paul and assesses all of John's health needs to determine if there are any other services that could help John stay healthy and out of the emergency room. The care coordinator's conversation with John and his parents reveals the significant psychological, social, and economic factors that might be aggravating John's condition. The care coordinator connects John to a behavioral health specialist to discuss why he might be having trouble sleeping, legal services to address the family's trouble with their landlord, a pharmacist to discuss if there are more affordable pharmaceutical interventions, and a social worker to connect the family with other community benefit programs they might qualify for to try to lighten the strain on the family budget. All of these professionals update John's electronic medical record as they make progress assisting the family. The pharmacist sees what medication John had been taking, and sends a secure message to the physician to ask if a particular, more affordable substitute would work. The behavioral health specialist talks with the social worker about enrolling John in an afterschool program in their community that teaches teenagers living with moderate to severe asthma to swim as a form of therapy. The electronic database that stores this information will send reminders to the care coordinator to follow up with John's family and to check on how he is feeling and the progress of these new treatment efforts. You can see how getting help for their son John was made possible using a care coordination approach, which connected them to professionals who worked together to improve his health. You can read more about this example at familiesusa.org.

KU: Thank you, Sam. Where can our listeners go if they want to find out more information about care coordination?

SS: The American College of Physicians offers a resource called the High Value Care Coordination Toolkit which provides ways to facilitate more effective and patient-centered interaction between primary and specialty care providers. You can access it by Googling "American College of Physicians" along with "Care Coordination Toolkit." For more information about care coordination required of Certified Community Behavioral Health Clinics, visit www.samhsa.gov/section-223/care-coordination. Finally, there is some excellent information for policy makers on our Center's website, which is at center4healthandsdc.org. That's center4healthandsdc.org. From there, navigate to the Policy Academy section, and then click on the tools and resources button.

Announcer: Thank you for listening. You can obtain additional recordings, or download a transcript, by visiting the Academy for Policymakers on the Center's web site.