NATIONAL COUNCIL *for* Mental Wellbeing

CCBHC
Care Coordination Toolkit

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CCBHC-E National Training & 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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Overview

This toolkit is a resource for Certified Community Behavioral Health Clinics (CCBHCs), including Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC expansion (CCBHC-E) grantees, to use in planning, designing and implementing care coordination, as well as in continuous quality improvement (CQI). It highlights practical guidance, strategies for meeting CCBHC requirements, resources and tools that CCBHCs can use to coordinate care within their organizations and in their local communities.

Goals

The goals of this toolkit are to:

- Increase understanding of the requirements and role of care coordination in a CCBHC, as outlined in the CCBHC certification criteria issued by SAMHSA in March 2023.
- Support CCBHC organizations in the planning, design and implementation of care coordination, including coordination roles and CQI efforts.
- Describe ways CCBHCs can develop and incorporate an effective care coordination approach, drawing on existing models and current CCBHC practices.
- Consider how CCBHCs can leverage health information technology to support care coordination.

How to use this toolkit

Care coordination is the linchpin of the CCBHC. There are many ways to engage in care coordination. CCBHCs can choose an approach that makes the most sense for the community served and reflects the community needs assessment. While many staff roles may have elements of care coordination, this toolkit offers guidance on aligning your care coordination approach with the SAMHSA CCBHC certification criteria and shares strategies that have been effective in meeting community needs and CCBHC requirements.

For additional resources and support

The National Council for Mental Wellbeing's CCBHC-E National Training and Technical Assistance Center is committed to advancing CCBHCs by providing SAMHSA CCBHC expansion programs (including CCBHC-E, CCBHC-PDI and CCBHC-IA grantees) with training and technical assistance related to implementation and sustainability, including efforts that support access to care and evidence-based practices. For additional information, to learn about upcoming events and to request technical assistance, visit the CCBHC-E National Training and Technical Assistance Center.

Acknowledgments

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Table of Contents

Care Coordination: The Linchpin of the CCBHC Model

Care coordination as the keystone of CCBHC

As the linchpin of the Certified Community Behavioral Health Clinic (CCBHC) (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023 — see page 16), care coordination supports the provision of all required services, ensures individual and population health care outcomes are being met, and makes connections with and between service entities to address individual needs regardless of intensity. Examples of care coordination activities include (Agency for Healthcare Research and Quality, 2018):

> **"Care coordination involves deliberately organizing patient care activities and sharing information among all the participants concerned with a patient's care to achieve safer and more effective care."**
>
> **Agency for Healthcare Research and Quality**

- Sharing knowledge and information with internal and external care partners.
- Helping with transitions of care.
- Creating a proactive care plan.
- Monitoring and follow-up, including responding to changes in client needs.
- Working to align resources with client and population needs.

Often, current or aspiring CCBHCs recognize the importance of care coordination but struggle to define and implement it, since they must explore several strategic and operational considerations during the planning process. They must understand the needs of their client populations in order to design a customized, community- and client-responsive care coordination approach that is anchored in the SAMHSA CCBHC criteria. CCBHCs must also identify how care coordination will be staffed, structured, documented and delivered, including how to match the level and intensity of care coordination services to client acuity and needs. This toolkit provides an overview of the components of care coordination, strategies to build and operationalize it across the CCBHC, and real-world examples to support a strong foundation for the CCBHC.

As outlined in the CCBHC certification criteria issued by SAMHSA in March 2023, CCBHCs establish activities within their organization and with care coordination partners that promote clear and timely communication, deliberate coordination and seamless transition. This may include:

- Establishing accountability and agreeing on responsibilities between care coordination partners.
- Engaging and supporting people receiving services and, subject to appropriate consent, their family and caregivers to participate in care planning and delivery, and ensuring that the supports and services that they receive are provided in the most seamless manner that is practical.
- Communicating and sharing knowledge and information, including the transfer of health records and prescriptions, within care teams and other care coordination partners, as allowable and agreed upon with the person being served.

- Coordinating and supporting transitions of care that include tracking of admission and discharge and coordination of specific services if the person receiving services presents as a potential suicide or overdose risk.
- Assessment of the person's needs and goals to create a proactive treatment plan and linkage to community resources.
- Monitoring and follow-up, including adapting supports and treatment plans as needed to respond to changes in the needs and preferences of people being served.
- Coordinating directly with external providers for appointment scheduling, and following up after the appointment for any prescription changes or care needs, thereby "closing the loop."
- Communicating and sharing knowledge and information to the full extent permissible under HIPAA, 42 CFR part 2, and ONC and CMS interoperability regulations on information blocking, without additional requirements unless based on state law.

Like most CCBHC efforts, starting with a foundational community needs assessment (CNA) is key. Understanding the population you serve and any additional unmet needs in your community will help your CCBHC define the elements of its care coordination model and highlight partnership opportunities with other community providers. Table 1 identifies key questions to include in the CNA. People needing any combination of the CCBHC's required services often benefit greatly from coordinated services within the organization (internal) and in the community (external). The best care happens when internal and external services are aligned, which begins with the CNA.

Table 1. Select care coordination planning questions

Designing an approach	■ What are the care coordination needs identified through our CNA? ■ Based on our CNA and other data/information, what subpopulations may need customized care coordination approaches, including culturally informed care? ■ What levels of care coordination are we building into our CCBHC? ■ How will we determine the appropriate care coordination level for each client?
Staffing and training	■ How will care coordination be staffed? ■ How many care coordination staff do we need to address our client volume? ■ What training is needed for care coordinators to do their jobs well? ■ What expectations do we have of care coordinators in terms of frequency and nature of engagements, and how does that change based on care coordination level?
Internal and external communication	■ What processes do we need to establish to ensure communication and collaboration between care coordinators and *internal* staff or programs? ■ What processes do we need to establish to ensure communication and collaboration between care coordinators and *external* staff or programs?
Documentation and data	■ What documentation will be required of care coordinators, and how does that change based on care coordination level? ■ What internal and external data access will care coordinators need to do their jobs well? ■ What data will show us that care coordination is working well? How will we collect, report and review that data?

The person served is the central focus of care coordination. Many people seeking services at a CCBHC have complex needs that go beyond a single presenting issue, and most can benefit from care coordination, though the appropriate amount, frequency and intensity vary. The person served should be engaged in care coordination activities through informed consent and shared decision-making. The people served must understand the importance and benefits of care coordination and how their input will help shape its use to improve their outcomes and achieve their goals. Ensuring their wishes are taken into consideration aligns with the CCBHC requirement 3.a.4: "The CCBHC shall coordinate care in keeping with the preferences of the person receiving services and their care needs." Given that person-centered care is foundational to the CCBHC model, staff should explain to clients the desired objectives of care coordination and how care coordination occurs, what is involved, who will be included, what releases need to be signed and what information will be shared. Understanding how care coordination works will help a client drive their own care.

Since other external service entities and existing internal programs may conduct care coordination activities, it is important to work collaboratively to ensure care coordination supports existing services and is efficient, organized and cohesive. Effective care coordination improves how services interact, enhancing the benefits of each, while siloed care leads to competing or conflicting efforts. Through care coordination, your CCBHC can provide comprehensive, congruent care with designated partners, which allows you to recognize and address needs and the associated gaps in services more easily. The overarching goal is to understand and address a client's needs and achieve the best possible outcomes.

Care coordination also helps you understand and address broader population health needs. Since care coordination activities enable staff to assess a variety of needs, internal resources and community resources, your CCBHC is well-positioned to identify gaps and opportunities, as well as population measures to better assess impact. With the knowledge that care coordination brings forward, your CCBHC can develop resources and establish new relationships with community partners. While care coordination is focused on the needs and goals of individuals, having a view of the needs of multiple clients enables CCBHCs to improve broader population health.

> **"Our care coordinators meet you at the front door, hold you in services and beyond to other levels of care or other services. How you say hello is most important, and how you say goodbye second most important."**
>
> **Pat McKenzie, Administrator of Outpatient and SUD Services, Kennebec Behavioral Health**

> **"Don't get stuck on one idea of what care coordination is. It's going to grow, change, look different. The client always has to be at the forefront. When considering changes, if they don't support the client, they are not worth doing."**
>
> **Marisol Guevara, Clinical Care Coordinator, Berks Counseling Center**

> **"[We] see [care coordination] as a way to provide services that address all levels of need, the need to partner with organizations in the community to better target the gaps and rise to meet those needs."**
>
> **Dianeth Rodriguez, CCBHC Project Director, Tropical Texas Behavioral Health**

SAMHSA care coordination requirements

SAMHSA's requirements for care coordination are in Section 3 of the CCBHC certification criteria (SAMHSA, 2023). Organizations are encouraged to review the full criteria before determining their care coordination approach. All CCBHCs should be prepared to attest to their compliance with the updated criteria by July 1, 2024.

Since care coordination is core to the CCBHC model, the Section 3 criteria speak to general requirements and how coordinated care should be connected to health information systems, support partnerships and be integrated into treatment planning. Table 2 provides excerpts from the criteria.

Table 2. Care coordination excerpts from the CCBHC certification criteria

Care coordination function	Associated objectives	Criteria
Coordinates care across the spectrum of health services	Individuals and families receiving services have access to acute and chronic physical health and behavioral health care, social services, housing, educational systems and employment opportunities.	3.a.1
Tracks participation and coordinates referrals and appointments	Staff assist clients and the families of children and youth referred to external providers or resources to secure needed support.	3.a.3
Determines any medications prescribed by other providers	The Prescription Drug Monitoring Program is checked before prescribing and, with consent, prescription information is provided to other providers to prevent opioid misuse.	3.a.5
Supports enrollment in benefits	Help clients and families to obtain needed benefits.	3.a.7
Uses health information technology (HIT) in support of care coordination activities	Outreach and care coordination support is documented and summarized by sending and receiving a summary of care records.	3.b.1 3.b.2 3.b.3
Seeks ways to improve care coordination through HIT	HIT is used to improve care transitions within, to and from the CCBHC and also to support integrated evaluation planning, treatment and care coordination by integrating clinically relevant treatment records.	3.b.5
Includes person- and family-centered treatment planning	A designated interdisciplinary team coordinates the medical, psychiatric, psychosocial, emotional, therapeutic and recovery support needs of the people receiving services.	3.a.4 3.d.1 3.d.2

In sections 3.c.1 to 3.c.5, the criteria identify required partnerships or formal agreements with:

- "Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to provide health care services, to the extent the services are not provided directly through the CCBHC."
- Inpatient psychiatric facilities and substance use detoxification, post detoxification 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."
- "The nearest Department of Veterans Affairs medical center, independent [outpatient] clinic, drop-in center, or other facility of the Department."
- Inpatient acute care hospitals and hospital outpatient clinics.

Aims and impacts of care coordination

Impact for people receiving services

People receiving services are at the heart of care coordination. The impact of care coordination on each person serves as the compass for defining and evolving the services and support they receive and includes the following:

> **"Care coordinators introduce 'Ask Me 3' [Institute for Healthcare Improvement, n.d.] with each person served. It helps them become their own advocate; responding to the three questions helps them take charge of communications with providers. [We've found it] really important to keep a focus on empowering clients."**
>
> **Celerina Cervantes, Integrated Health RN, Tropical Texas Behavioral Health**

- **More effective services, improving treatment engagement and retention.** When people can share their needs in their own words, especially in the context of their cultural framework, providers gain a clearer understanding of how to best address those needs. By sharing people's perspectives with internal and external care teams, as appropriate and with consent, their voices help shape and enhance the impact of the care that providers deliver.
- **More time receiving effective services.** When care is coordinated, service providers don't have to reinvent the wheel, allowing them to address needs more directly. People experience better continuity of care and less of the "treatment fatigue" that comes from having to tell their story repeatedly or having to seek multiple care pathways to address unmet needs. This approach also respects the person's preferences and time spent receiving care.
- **Reduced engagement in duplicative services.** Services that address the same need should be complementary rather than duplicative, to avoid wasting both the person's and the service system's time and resources.
- **Enhanced relationships with providers and the treatment system.** People receiving behavioral health services often feel marginally involved in their own care. When a person is afforded the opportunity to share their voice, have an active role in making decisions about their care, and advocate for their needs, they are more likely to engage in their care. This also establishes trust with the provider system and increases the likelihood that they will share additional insights about their needs. Direct engagement in care, especially for parents, can help address multigenerational needs and prevent the deepening of needs across the family. Effective care coordination seeks to understand the person's physical, social and environmental contexts

Ultimately, these care coordination elements lead to overall improved outcomes related to behavioral health, physical health and social drivers. Achieving these positive outcomes is more feasible when providers move from delivering services independently to implementing a coordinated approach that centers the person receiving care.

Impact for CCBHC providers

Care coordination creates positive impacts for providers, as well. Consistently improved patient outcomes help to increase job satisfaction, reduce turnover and create a culture of results-driven care. Key impacts for providers include:

- **Overarching understanding of beneficial strategies and services**. Understanding individuals' perspectives allows their input to inform the delivery of care and ensures that the service array is responsive to individual needs, rather than relying only on providers' beliefs.
- **Improved staff satisfaction**. Including people in shared decision-making about the services they receive gives them a more active role in their own care. For providers, seeing positive impacts on the people they serve can lead to improved job satisfaction, diminished burnout and compassion fatigue, and reduced staff turnover.
- **Efficient service delivery through streamlined and targeted approaches**. Through care coordination, providers are more likely to identify which services are most impactful and complementary and recognize duplications. Through collaboration and input from people being served, providers can implement targeted interventions that effectively and efficiently address needs.
- **Multidisciplinary, team-based approach to care**. Care coordination recognizes comprehensive needs, aligns services and ensures a team-based approach to care, where each member of the multidisciplinary team brings value to their distinct role. This allows team members to operate at the top of their license and provide the care that they are best equipped to deliver.
- **Efficient staffing models**. When services are aligned and redundancies are reduced, CCBHCs can implement staffing models that use resources appropriately and enable staff to do their jobs effectively, rather than being stretched thin from taking on additional responsibilities.
- **Improved return on investment**. The efficient use of resources leads to better return on investment and improved value-based payment or incentive programs. Care coordination allows people to access appropriate evidence-based practices promptly and receive care that enables them to lead healthy lives, and it helps CCBHCs use resources efficiently and sustain high-quality services.
- **Additional support for culturally responsive care**. Care coordination partnerships with organizations that represent specific groups (e.g., the Hispanic Cultural Alliance) can inform and support culturally responsive care.

Care coordination creates a bridge between various behavioral health services, and with physical health and social services. Prioritizing this level of coordination leads to better overall health and provides support at the intersection of health care and social drivers, underscoring their impact on behavioral health. Care coordination is the linchpin of the nine core CCBHC services and other internal and external care or support services, including these foundational aims:

- **Link and support all comprehensive services** inside and outside the CCBHC, working in concert with each other.
- **Recognize and address complex behavioral health needs** that are intensified by physical health and social drivers. This leads to the right services at the right time and a more correct "dose" driven treatment planning approach.
- **Reflect person-centered approaches**. This is core to the CCBHC model and encourages people to have a voice and more actively participate in their care. Care coordination supports people as decision-makers on priorities, types of services, delivery methods and provider options that are tailored to their needs and preferences.

- **Improve access and prevent gaps in care**. Care coordinators pay attention to the services being provided in various settings, which prevents disruptions in care, because barriers to access and engagement can be addressed in real time. Improved access is particularly important to achieving health equity, where everyone has an opportunity to attain their highest level of health.
- **Reduce fragmentation** by increasing communication, systematic documentation and collaboration between services and entities. It is an opportunity to leverage HIT in recording and reporting on care coordination activities.
- **Measure and report outcomes** to increase the effectiveness of services through continuous quality improvement (CQI). Tracking outcomes at the individual and population levels can help identify which services are effective and elevate needs in the community more quickly.
- **Engage in community partnerships** to address health care and social drivers. Establishing effective partnerships can result in positive health outcomes for the people served and more proactive upstream efforts to address and manage the population's needs.

Working in collaboration on the care of individuals and the broader population will make all partners, both internal and external, more effective in their roles. Spending time establishing and maintaining those working relationships is critical to the success of care coordination.

Example from the field: CHR

CHR, a CCBHC in Connecticut, takes a whole-organization approach to care coordination, incorporating principles in its orientation, staff roles, policies, procedures and processes. Care coordination is ingrained in the culture of the organization. This approach is reflected in regularly held, multidisciplinary team meetings, where staff come together from across the CCBHC to discuss clients who have experienced some form of crisis. The focus is to track people from an event (e.g., emergency department visit, crisis call, hospitalization) to resolution by reviewing patterns, events and linkages. Agency-wide meetings, which include staff with lived experience, are learning opportunities across disciplines and systems, with the wellbeing of the people served as the shared focus. These reviews influence care by shedding light on challenges, such as breakdowns in communication between systems and/or providers, and can reveal the root causes and lead to new strategies. CHR's example shows the impact of care coordination on an individual and across an organization, which can feed into a CQI plan as the CCBHC reviews progress and improves its care coordination approach.

Designing a person- and family-centered approach

In a person-centered approach, care coordination supports a person to achieve their desired lifestyle and quality of life. Family-centered care is important for the person served, particularly for children and youth. It is grounded in the philosophy that:

- Support is most effective when you understand each family's goals, values and expectations.
- All families have strengths, and we learn and grow when we build on them.
- Family wellbeing is elevated by the quality of informal and formal supports and services.

Person- and family-centered care also prioritizes access and engagement. Staff ask about each person's supports and barriers to getting care and reaching their goals, and then incorporate them into the care they provide. This approach fosters:

- Meeting treatment plan goals.
- Precision in care.
- Avoiding duplicative or "cluttered" care.
- New, creative access points to care, informed by the person served and/or their family.
- Engagement by those served and their families.
- A customer service orientation among providers.
- In-home and community-based care.

Care coordination can reflect a person's goals and preferences, the family and/or friends who support them, their desired experiences and services, and the individual-, provider- and community-level barriers that keep them from driving their own care. In other words, care coordination can respond proactively to each person and their needs and preferences. SAMHSA's CCBHC certification criteria describe the role of person- and family-centered care as it relates to care coordination in Sections 3.a.3, 3.a.4 and 3.a.6.

> **"When the coal mines closed, the coal mine-specific laundromats decreased services, and some public housing sites don't have laundry facilities either. Egyptian substance use program has partnered with laundry facilities in other counties to provide free laundry services. ... One laundromat has also offered their shower for homeless clients or those who work in uniforms (e.g., McDonald's) and will help wash their uniforms until their situation is stable. We would not have known about laundry challenges without asking clients directly about their needs."**
>
> **Staff member, Egyptian Health Department**

Common elements across care coordination models

CCBHCs can learn effective approaches from existing care coordination models. A review of several models found that each tailors its approach to the unique needs of a specific population. Below are notable elements and themes that CCBHCs can draw from when defining their approach. Appendix C includes a table with each model, a brief description and its target population, which CCBHCs also can use to inform care coordination design. Key takeaways and examples across these models include:

- **Provide critical connections to align a continuum of care**. These models share a recognition that the current system of care is fragmented, with different entry points, processes and requirements in a mix of ever-evolving services. These models assess the full needs of the person served and coordinate across the system to facilitate connections with services and confirm service completion. They pay particular attention to care transitions from locations such as inpatient treatment, partial hospitalization and emergency departments. One example is the Health Homes model, which aims to integrate care for people with two or more chronic conditions. When people have multiple chronic conditions (e.g., an opioid use disorder, anxiety and a hepatitis C infection), the Health Homes model combines comprehensive care management and transitional care to provide opioid treatment, counseling and health care.

- **Engage and empower people by giving them a choice in their own care**. CCBHC criteria require person-centered care, so choice plays an important role in these models. The person served helps to determine care plans, such as in wraparound models (for children with complex needs and their families) and Supportive Housing models (for people experiencing chronic housing instability and health challenges). In Supportive Housing models, tenants live independently and receive rental assistance and intensive support services. Tenants can come and go as they please, control their daily schedule and direct their goals and services.
- **Establish and maintain partnerships that provide community supports**. When managing behavioral and physical health challenges, support for social and basic needs can help people reach and continue services and improve their health. The Community HUB model (HUB) identifies people at greatest risk and assesses their physical, social and behavioral health risk factors. The HUB then assigns the person to a specific pathway to address the greatest risk factors, working with a wide range of stakeholders through partnerships that provide health care and community supports (e.g., housing, food, clothing, specialty care, parenting education). Like CCBHCs, HUBs are required to offer primary care screening and monitoring to address risk factors and the whole health needs of the person.
- **Improve access by offering or co-locating multiple services in one site**. Through access to multiple services and multidisciplinary staff in one visit, many care needs can be met. The Program of All-inclusive Care for the Elderly (PACE) model provides 24-hour care delivery and coordination to help older adults receive health monitoring, dental care, counseling, meals and social engagement in an adult day health center, supplemented by home visits.
- **Incorporate staff with similar experiences to those served**. It is valuable to hire staff who have had experiences similar to those of the population served, and to do so at every level of the organization. Meaningfully including these staff on care teams, in service decisions and in planning can strengthen the CCBHC's ability to understand and meet people's needs. In the Community Health Worker (CHW) model, the CHW plays an important coordination role, building trust with people with complex health conditions in communities where they may share ethnicity, language, socioeconomic status or life experiences. CHWs serve as a bridge between the clinic and community and often receive in-depth training, including clinical content, motivational interviewing and behavioral change approaches.
- **Extend care into communities and homes**. An effective care system extends beyond a clinic's walls and may include home visiting, mobile units and support provided directly in the community, improving access and engagement. In the Nurse-Family Partnership model, nurses meet with pregnant and new parents in their homes, to support and share information on topics such as child development, breastfeeding and self-care. The Mobile Units model also supports people who struggle to access health care and other services, meeting them where they live.

Operationalizing CCBHC Care Coordination

Defining your CCBHC's approach to care coordination entails many considerations, including populations of focus, needs, staff roles and capacity, current CCBHC services and supports, services in the community, existing and potential partnerships, possible care pathways, levels of need, client preferences, their access and capacity, documentation and communication.

Staffing structures

Staffing structures for care coordination will vary by CCBHC based on capacity, available resources and client needs, among other factors. Each CCBHC interviewed for this toolkit structured their care coordination model uniquely. Their staffing strategies fall into four distinct approaches:

1

Embedded multidisciplinary approach: A wide range of client-facing staff coordinate care within their roles, and no single person is designated as the care coordinator (except when serving children and youth, who have a dedicated lead coordinator).

2

Population-specific team approach: Care coordination is team-based, with a range of roles (e.g., registered nurses, primary care managers, CHWs, peer specialists, outreach staff) assigned as care coordinators depending on the population served. For example, a team including both primary care and behavioral health clinicians coordinates care for people with comorbid conditions.

3

Case manager/care coordinator partnership approach: Case managers and care coordinators work collaboratively to provide consistent support to the person served and address internal and external referrals.

4

Dedicated care coordinator approach: One care coordinator is the lead point of contact for the person served through internal and (to varying extents) external coordination.

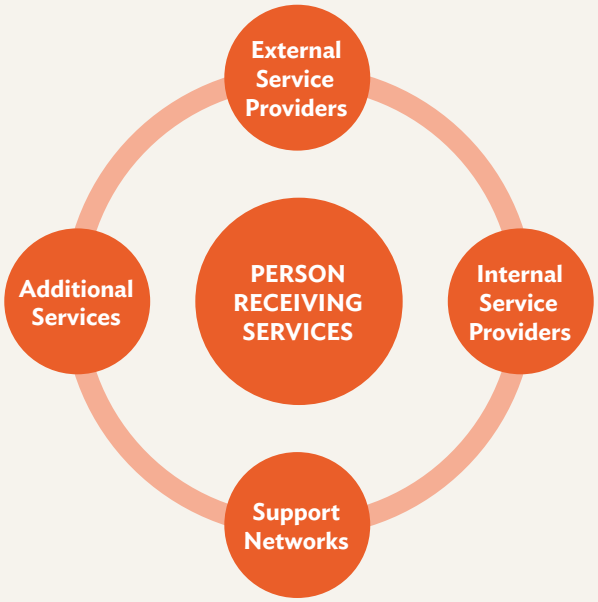
Regardless of how care coordination is structured, it is critical to delineate who is responsible for which coordination activities and to engage and empower clients in shared decision-making.

Among CCBHCs interviewed, some adapted case manager roles to become care coordinator roles, while others incorporated care coordination responsibilities into existing roles, such as registered nurses or primary care managers. Care coordinators may be responsible for helping a client develop a treatment plan, communicating with internal and external providers, overseeing referrals and coordinating with other service providers. Some may also bring clients to partner sites for a warm handoff, educate partners on care coordination, conduct intake assessments with new clients to determine needs, or assess currently available partner programs to which clients can be referred. Depending on staff capacity and client need, care coordinators may focus solely on substance use disorders (SUDs) or mental health care or serve in specific settings (e.g., hospitals, jails). A designated care coordinator can help build trust with clients, streamline communications and increase efficiency of workflows by clearly defining each team member's responsibilities, to reduce overburdening any one staff member.

Example from the field: Tropical Texas Behavioral Health

At Tropical Texas Behavioral Health (TTBH), care coordinators (also referred to as primary case managers) carry out a variety of duties to ensure that clients can access the services they need. They provide case management, retrieve medical records, coordinate care across the organization and work with other specialists to streamline services, including employment, housing and peer supports. Care coordinators need to know what groups and programs are available for clients to attend, as well. Externally, care coordinators help clients access care, maintain relationships with provider agencies through phone calls and in-person visits, and provide education on their services and the agencies' partnership responsibilities. TTBH care coordinators also created a "live" resource that tracks changes to partner agencies' programming, which is used to inform and guide clients using the most up-to-date information.

Dedicated care coordinator represented by the line connecting the various services and supports.



For CCBHCs that use a team structure, the team is composed of a care coordinator and behavioral health clinician, at a minimum, as well as other providers, such as medical and psychiatric clinicians, SUD counselors, case managers, family and social service providers or wellness coaches. While the care coordinator may still lead client communications, care coordination teams will meet regularly to discuss cases with the various providers who interact with the client. Teams may divide care coordination responsibilities between internal and external referrals or different levels of care. For example, at one CCBHC, the behavioral health clinician manages internal referrals and clients needing a higher level of care, while the care coordinator manages external referrals and clients needing a lower level of care. In smaller teams, the lead clinician may supervise other team members, while larger teams may prefer to adhere to their organizational supervision structure. This team-based approach can provide a more holistic view of clients' medical, psychiatric and social needs, as well as improve multidisciplinary communications and enhance the integrated care model.

Example from the field: Egyptian Health Department

Every day a team of case managers, case workers, wellness coaches, SUD coordinators, peer support roles and nurses meets for a morning huddle to discuss ongoing client cases and coordinate care across the agency. Each team member is responsible for different aspects of a client's care. For example, nursing staff attend all medical appointments with clients, help them understand their diagnoses and prescriptions, and ensure the provider is made aware of any relevant behavioral health history. Case managers may take clients to other appointments and maintain relationships with external providers, particularly in cases where in-person coordination is more efficient (e.g., with partners who are not using electronic records). It is important that staff know who to contact for what information. Building strong relationships with partners can also expedite care for clients or provide more leniency in complex or challenging cases.

When hiring care coordinators, CCBHCs often expect candidates to hold a bachelor's degree and have case management experience. One CCBHC's care coordinator job description required some familiarity with integrated care or the CCBHC model. This emphasized the importance of multidisciplinary collaboration and a commitment to holistic health and integrated care. In addition to familiarity with integrated care, care coordinators should be able to engage clients effectively, not only ensuring they understand what providers have told them — particularly for those with lower health literacy — but also empowering them to advocate for their needs. Motivational interviewing is a key skill for care coordinators, and some CCBHCs may also provide education and programming to equip clients with the skills to advocate for their own health.

Though the staffing structure will vary across CCBHCs, several interviewees noted that the CCBHC model enabled them to hire new positions, including care coordinators, outreach workers and data managers. CCBHCs should assess their organizational capacity, needs of people receiving care and external partnerships to determine what staffing structure best fits their program, and to ensure that all involved staff are properly trained to deliver holistic, integrated care.

Table 3. Examples of considerations for designing a care coordination structure

Multidisciplinary team providing care coordination	Considerations
■ Client-facing staff play a key role in care coordination. ■ The organization clearly identifies the additional care coordination responsibilities. ■ Staff identify a lead care coordinator for each person receiving services or divide responsibilities based on expertise. ■ The organization sees care coordination as a fluid activity that happens within each interaction and, where indicated, with community partners.	■ Cross-agency communication will be critical. Structures for regular multidisciplinary staff communication will be needed, as well. ■ Ensure all staff are trained on care coordination and their role in supporting it. ■ Design team workflows with clear roles and communication processes that are centered on the person served. ■ Consider the roles of supervisor, case manager and other points of contact to provide support for the care coordinator. ■ A more fluid model may work when different members of the team take on different coordination activities, depending on needs.

One staff member providing care coordination	Considerations
■ The care coordinator is accountable for regular communication with a wide range of staff and partners. ■ The care coordinator serves as the point of contact for external partners. ■ Care coordination is viewed as a specific activity that has distinct start and stop points. ■ The care coordinator has a deep skill set that aligns well with other staff roles. ■ Care coordination is provided to all clients but is focused on specific populations that show a greater need for it.	■ A single care coordinator may be beneficial for developing deeper relationships with key point of contact at partner organizations. ■ A single position may be more clearly defined than when the role is shared across multiple staff. ■ Job descriptions should clearly articulate the skillset required to provide care coordination. ■ Consider the roles of supervisor, case manager and other points of contact to provide support for the care coordinator. ■ The CNA identifies a population with multiple intense needs that would be best served by a single care coordinator for (e.g., people who are homeless).

As reflected in Table 3, there is no single best approach to care coordination. It may be necessary for CCBHCs to provide both team-based and individual care coordination. The most important considerations include the CNA findings, CCBHC requirements for care coordination, staffing models that have proven beneficial to people receiving services, available staff, and training and supervision to maintain an effective model. Another important consideration is that staff with care coordination responsibilities benefit from supervision that includes a case consultation component, regardless of the model implemented.

> **"Care coordinators 'carry a lot' of information and need a range of skills and competencies. They can have compassion fatigue. Every care coordinator gets individual supervision and group supervision through weekly meetings. They have access to an intake clinician and a lead clinician for triage and consulting on cases."**
>
> **Carla Stockdale, Clinical Director, Kennebec Behavioral Health**

Training approach

SAMHSA requires all CCBHCs to provide certain trainings to staff, but each CCBHC should provide additional training that is tailored for its unique setting, population served, staffing model and available resources. For example, a CCBHC that serves a large refugee community may benefit from training on refugees' mental health and best practices when working with refugees. At a minimum, your CCBHC should provide training on:

- Risk assessment, suicide prevention and response.
- Roles of families and peers.
- Cultural competence.
- Person- and family-centered care.
- Recovery-oriented, evidence-based, trauma-informed care.
- Integration of primary care and behavioral health.
- Continuity planning.

As care coordination is a CCBHC requirement, new staff orientation should include training in care coordination, and the training should be revised and repeated as needed to ensure all staff are aware of current processes. CCBHCs also should clearly document training completion and demonstration of care coordination competencies. Examples of competencies include communication skills, interdisciplinary collaboration, planning, cultural competence, advocacy skills, resource management, problem solving/critical thinking and ethics knowledge. Training topics may include the philosophy of care coordination, roles and responsibilities, partnerships and referral networks, communication, documentation, and internal and external workflows. It is essential that all staff, not just care coordinators, understand and embed care coordination in their roles to provide effective care and enhance outcomes for clients. In particular, staff should be able to document care coordination activities clearly to comply with CCBHC requirements. (Strategies for effective documentation are discussed in "Documenting, Analyzing, Reporting and Care Coordination" on page 23).

Training also should include practical elements, such as shadowing seasoned staff and participating in staff meetings to review client cases. Some CCBHCs may provide practical training primarily during an orientation period, while others may offer ongoing training, such as a year-long mentorship program pairing new and experienced staff. Strategies to enhance care coordination activities may be discussed during regular supervision and later elevated to the care teams, or you may establish regular meetings to review and revise workflows with key staff. Care coordination should not be a static protocol. Instead, it should be improved through an iterative process as staff gain experience and insight through implementation.

> **"[After new employees receive care coordination training], care coordinators will 'staff cases' with one-on-one support from supervisors and other team members. They dissect the chart to identify all aspects of care to put the full picture together, then take observations back to the client to collaborate on solutions."**
>
> **Dianeth Rodriguez, CCBHC Project Director, Tropical Texas Behavioral Health**

Care coordinators play an integral role liaising between clients and providers, so the ability to communicate effectively with diverse stakeholders is key. Training should emphasize the need to include clients in decision-making and understand their priorities, rather than solely acting on what providers identify as needs. For example, a care coordinator may review a client's chart with the providers and identify potential needs, then share this with the client for their feedback and input before collaboratively developing a comprehensive treatment plan. Through collaboration with clients and providers, care coordinators can help clients more effectively navigate systems of care, whether they are related to behavioral health, medical care or social drivers of health, and empower them to advocate for themselves using motivational interviewing or person-centered goal planning.

Care coordinators work with various types of internal and external providers. Within CCBHCs, cross-training between care coordinators, behavioral health clinicians and medical staff helps care teams understand each role and how to communicate with one another to best support clients in achieving their goals. Care coordinators relay critical information about clients to external partners, and partners should expect that communications will come from them. In some situations, care coordinators may feel unsure if they have the authority needed to share information. When this happens, care coordinators should be encouraged to seek supervision or guidance. Your CCBHC should ensure that regular training includes guidance on the sharing of information. Additionally, the care team may benefit from training on each member's role, and the care coordinator may need support and training on how to communicate information with partners.

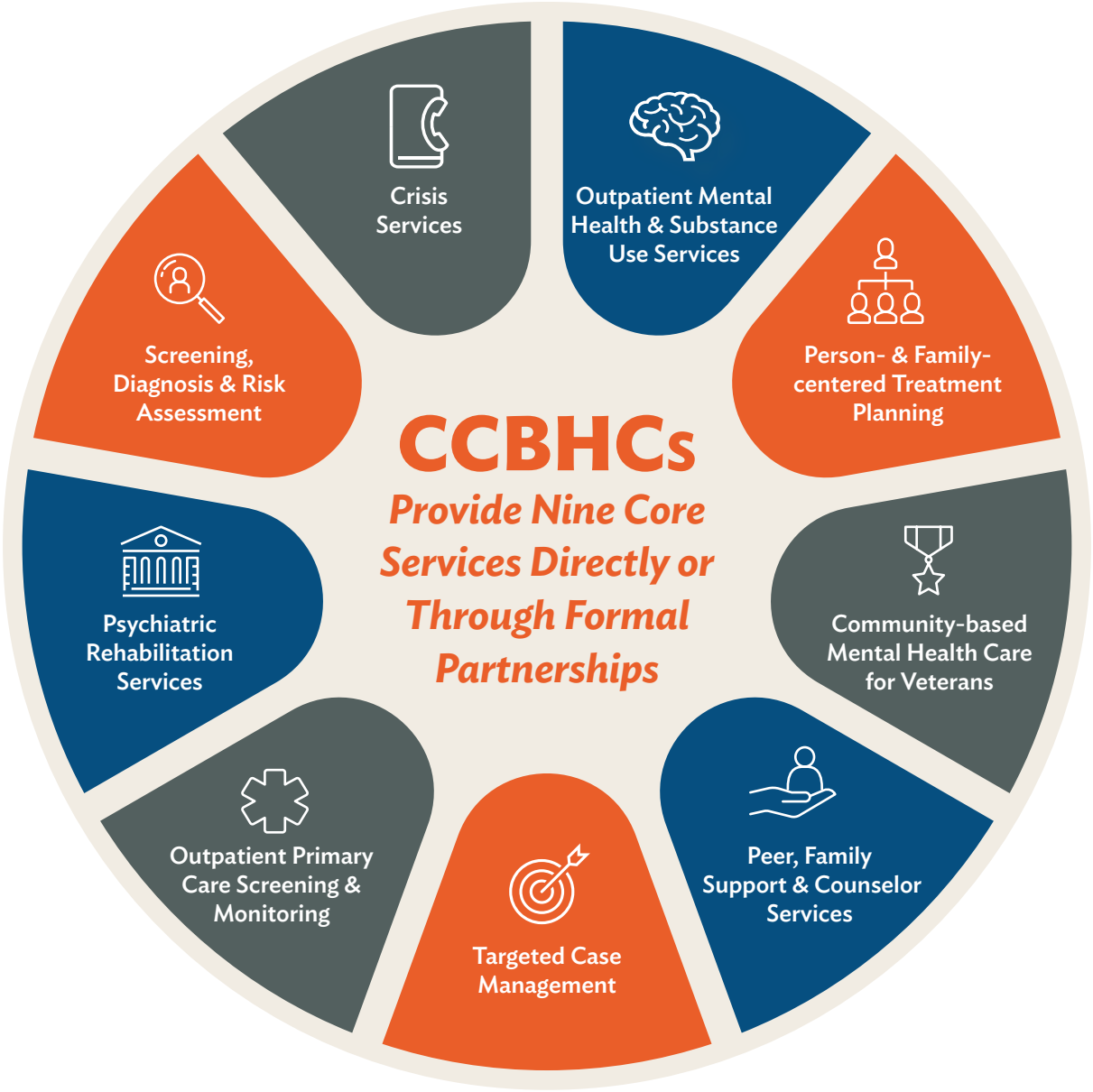
Example from the field: NorthCare

Leadership at NorthCare identified one of their barriers to effective care coordination: Care coordinators and peer specialists struggled to contact external providers about their clients, feeling that they did not have the knowledge or authority to do so. Yet NorthCare also recognized that these staff are the best-equipped to advocate for their clients' needs. Through formal training and informal engagements, NorthCare now empowers care coordinators and peer specialists to take ownership of their role and provides them with supports to do so. Additionally, partners are made aware that these staff will lead communications about clients, reiterating the importance of their role externally.

Partnership and relationship development

Internal partnerships

Care coordination makes connections with internal services. It supports the CCBHC's efforts to ensure the services provided support the treatment plan goals, avoid duplicating other services and complement each other. Care coordinators communicate important updates to each team member, including progress toward goals and changes in needs. They are the "team captains" who want the efforts of each team member to contribute to the ultimate "win" — where the client's needs are met and goals achieved. Some CCBHCs have not assigned a specific care coordinator and instead incorporate coordination into the roles of all staff who engage the client. In this approach, each staff member is committed to understanding the client's care priorities, recognizing the level of care that has been received and is needed and communicating updates across the care team.



> **"Our Inreach Coordinator supports clients transitioning from residential treatment to outpatient. When a client now had to sustain sobriety 'in the real world,' it became immediately challenging. The Inreach Coordinator will physically facilitate that transition, introduce them to outpatient programs and get them to care, while minimizing their anxiety and resistance. It really reduces the challenges for staff and enables clients to make the transition as seamlessly as possible."**
>
> **Melissa Espinoza, CCBHC Program Director, HealthRIGHT 360**

External partnerships

CCBHCs should have relationships with multiple outside entities through partnership agreements, like formal memoranda of understanding (MOUs) or other informal arrangements. Regardless of the relationship model, it is important to articulate the role of care coordination both within the CCBHC and through collaborative efforts with other provider agencies. The CNA can be used to identify which entities would be the most important and effective partners, often including:

> **"We develop good community relationships to get referrals [for the people we serve]. To measure community engagement — i.e., the right people at the right time — we developed a dashboard that shows every community partner and the number of contacts with that partner (based on the type of engagement). Our Clinical Directors and Operations Directors meet with the partner and follow with steps for strengthening that relationship."**
>
> **Josh Cantwell, Chief Operating Officer, GRAND Mental Health**

- FQHCs
- Other primary care providers
- Indian Health Services
- Providers of social driver supports
- Veteran services
- Criminal justice/specialty courts
- Child- and youth-focused entities, such as schools, child welfare, therapeutic foster care, treatment centers and juvenile justice

It is important to discuss how and when information will be shared formally through a release of information and establish regular meetings to continue building strong relationships.

Through this relationship development process, the differences and benefits of care coordination versus other types of care/case management services will become clearer. When care coordination is seen in action, its positive impact becomes apparent. Where applicable, it is particularly important to formalize a Designated Collaborating Organization (DCO) relationship, especially since the CCBHC is ultimately responsible for the clinical outcomes. DCOs are legally authorized providers that may furnish one or more of the nine core CCBHC services under arrangement with the CCBHC. More details regarding partnership development can be found in the National Council's Certified Community Behavioral Health Clinics Contracting and Community Partnerships Toolkit (Gopalan & Riley, 2024).

CCBHCs also have an opportunity to educate stakeholders on the needs of community members and how best to address those needs, especially through collaborative efforts. One example is CarePlus NJ, which identified through their CNA that about 75% of mothers who experience perinatal mood and anxiety disorders (PMADs) go untreated. In response, the CarePlus Maternal and Family Center (MFC) team built community awareness through education and outreach efforts to local health care providers, community groups and faith-based organizations to educate them about maternal mental health. The MFC community engagement model includes:

- Providing community training and education to increase awareness of PMADs among anyone who engages with the perinatal population.
- Sharing information about MFC services and referral pathways.
- Developing partnerships with primary care, social services, child welfare, criminal justice, faith-based communities, hospitals and housing service providers.

In addition to building understanding, this approach leads to increased screening and referrals for appropriate treatment and supports.

Sharing referrals with external partners can provide more opportunities for collaboration and lead to care coordination relationships that improve outcomes for clients. For example, Wallowa Valley Center for Wellness refers clients to community partners using Unite Us, a secure platform that allows for more real-time referrals, supporting timely access to needed resources.

At TTBH, staff regularly meet with contacts at external partners to stay connected on how best to guide people receiving services. TTBH conducts regular presentations to external or potential partners to explain their services and educate them on care coordination. This includes explaining how their collaborative relationship is a shared responsibility to support of the people seeking care.

With an understanding of the context of the population's needs and what types of relationships can meet those needs, it is then important to consider the various care coordination models, their common elements and how to design the most effective model for your CCBHC.

Recognizing when more intensive care coordination is needed

Significant events — such as a call to a 988 Suicide & Crisis Lifeline call center, an emergency department visit or a hospitalization — are clear signals that more intensive care coordination is warranted. Responding quickly in these vulnerable moments is critical to avoid admissions or readmissions, prevent adverse events, reduce the likelihood of medication errors, and adjust the comprehensive treatment plan as appropriate to address the needs that may have contributed to the event. It is an opportunity to increase the intensity of the care coordination to meet new needs. Section 3.c.5 of SAMHSA's CCBHC certification criteria speaks to addressing these transitions seamlessly and quickly to reduce risks for the person served. These criteria establish expectations for partnerships with:

- Inpatient acute-care hospitals
- Their associated services/facilities, including:
  - Emergency departments
  - Hospital outpatient clinics
  - Urgent care centers
  - Residential crisis settings

These partnerships allow for tracking people receiving CCBHC services when they are admitted to these facilities, as well as at discharge. Expectations also include transferring records of services received (e.g., prescriptions) and active follow-up after discharge, with notifications provided through the Admission Discharge Transfer System (ADTS). Contact must occur within 24 hours of discharge from these settings, providing coordination and follow-up until the person is linked to services or assessed to be no longer at risk.

> **"Determining the level of care coordination occurs on a day-by-day basis. For those who have been in care for a long time, we know the services needed. With new clients, it takes time to understand their needs. Daily 'huddle' meetings are helpful. We are able to gather various perspectives from all staff who see a client to get a more holistic view of their needs (including medical, psychiatric, personal and social), rather than just hear from one case worker."**
>
> **Staff member, Egyptian Health Department**

To determine the intensity (how often, how much, etc.) of care coordination that is right for each person, it is beneficial to engage multiple staff across the CCBHC and include partner perspectives, in line with client and caregiver preferences. The type, amount and frequency of support generally changes over time.

Documenting and Reporting

Documenting care coordination

Documenting and summarizing CCBHC care coordination activities takes diligence, and it ultimately will help capture progress, challenges and the client's own voice. It is important to provide the right amount of information when documenting coordination efforts, and to summarize the intent and outcome of these efforts. Additionally, the connection between care coordination activities and a person's individualized treatment plan should be evident in action and documentation. Working across different services and with various team members is central to making progress and meeting the goals of a treatment plan. Documentation of internal and external coordination activities, referrals and follow-up should reflect the activities of these care team members, including clinical and administrative staff across the organization and other local providers and services.

HIT also captures engagements with roles like CHWs and peer recovery specialists, such as ensuring appointments are attended or conducting in-home or school visits. Documentation should note the preferences and potential involvement of natural supports from family and friends. In addition, as noted in the certification criteria (see 3.a.2), documentation must include appropriate consents that satisfy the requirements of HIPAA, 42 CFR Part 2 and other federal and state privacy laws. Most importantly, it should capture the voice of the person receiving services, to reflect current input and provide insight for the other team members.

Informed consent and any required legal consents are essential components of the care coordination process that can further support person- and family-centered care. While CCBHC staff must follow HIPAA and 42 CFR Part 2 in establishing consent, it is possible to share client data while adhering to privacy requirements. (See these resources on sharing and protecting records from the Center of Excellence for Protected Health Information for further details [Focus: PHI, 2024].)

In one example, a CCBHC used their consent form to support maintaining connections through transitions of care. The person served completes a blanket consent (i.e., allowing the CCBHC to communicate with any of the client's providers) and, if they need an emergency department visit or hospitalization, takes this consent with them for the receiving entity to review and retain. This allows communication between the CCBHC and the external provider, and therefore a greater understanding of care needs and less repeated or contradictory care. External providers also appreciate the open line of communication with the CCBHC point of contact, who can shed light on the person's current and past care history and, upon discharge, follow up with appropriate outpatient services.

Through well-documented care coordination, staff can support the full range of a person's needs, starting with what the person sees as their primary goals. Looking at referrals made and completed or not completed, staff can follow up with the person receiving services and their care team members to check on outcomes, make clinical adjustments, discuss progress with partners and report on related measures. Care coordination documentation can capture adjustments to approach and goals, celebrations of outcomes achieved and newfound ways to continue making progress.

> **"Documentation takes commitment. Since care coordination is not billable, staff don't automatically think to put [activities] in the EHR (electronic health record). But they are extremely important — in some cases the most important activities we are doing. To get them into the record, we built a specific care coordination note. Now it's easy to look at record to see what is happening. It helps the person and helps the staff. Saying what work you did helps the clinician with follow-up in their session. We all help each other."**
>
> **Bonnie Triebig, Clinic Director, Berks Counseling Center**

Documenting care coordination activities also supports CCBHC sustainability. It enables staff to reflect on the role of care coordination in achieving outcomes. Documenting care coordination should be a priority in your CCBHC's cost reporting where it supports current and anticipated service needs, resource allocation and the costs of meeting those needs. In addition, you can share data on how care coordination is increasing access to care, thereby demonstrating its value to partners, funders, decision-makers and, most importantly, the people you serve.

Health information technology and care coordination

CCBHCs are required to establish or maintain an HIT[1] system per Section 3.B of the certification criteria. It is critical to use HIT to document, analyze and report on care coordination. Staff can develop a coordination plan through their interactions with clients and information derived through preliminary triage, intake, screenings, crisis plans, initial evaluations and treatment plans. To ensure that all members of a care team can access reliable documentation, the organization's HIT must use standardized templates and forms, such as check boxes to click for relevant choices, to create structured data on encounters, referrals and follow-up for analysis. Allowing for additional unstructured data in the form of notes also provides critical context.

HIT can support your CQI efforts (see "Continuous Quality Improvement" on page 25) and reporting on measures such as clinical outcomes (e.g., improved health outcomes), utilization (e.g., group attendance, primary/specialty care visits) and assessing success in closing the loop on referrals.

The role of the care coordinator and care team includes efficiently sharing electronic information among all the participants supporting the client's care, including providers within the CCBHC and external partners. To provide efficient and effective care coordination, the team needs a specialized view of the health information stored in the electronic health record (EHR), including:

- A high-level or dashboard view of all assigned clients, with the ability to view client-level information.
- Access to client-level information, including information collected in client registration fields (e.g., family relationships, preferences for language and communication, pronouns) and behavioral health and physical health activities.
- A display of the client's care team members (e.g., behavioral health providers, physical health providers, care coordinators, social workers, peer support team members).

The care coordination team also needs the ability to view and incorporate electronic health information provided by external organizations. Care coordinators may need to identify gaps in care, make reasonable attempts to fill these gaps, and document when they have been closed.

Partnering with a health information exchange (HIE) enables your CCBHC to track and respond to key events and transitions for the people served. A core service of HIEs is to provide hospital encounter notifications. HIEs receive ADTS information from hospitals and then use this to provide notifications to users who have subscribed to receive these notifications for their patients. The HIE enables your CCBHC to meet key requirements and measures (e.g., "follow-up after hospitalization for mental illness"). Developing a workflow for incorporating these notifications makes them actionable. For example, staff at Kennebec Behavioral Health in Maine receive alerts every morning from their HIE. Alerts are shared with the care coordinator, case manager and nurse care managers for follow-up with the client.

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1 Health information technology refers to how health information is stored, shared, and analyzed, and to the electronic systems used by health physical and behavioral health care professionals and the people they serve.

Documentation and billing

Although care coordination is not a billable activity in and of itself, it generally involves staff time in completing activities, some of which may be associated with procedure codes in your state. As you develop your CCBHC, staff should crosswalk CCBHC services with allowable Current Procedural Terminology (CPT) codes within the state and assess current billing practices to maximize billable costs. It is important to identify all CPT procedure codes for services you are providing directly in each core service category, as well as all types of licensed or unlicensed providers you may be using for each service. This allows you to manage claims properly, minimize coding errors and handle rejected claims promptly. When preparing for CCBHC certification, develop a cost report to capture all costs (incurred and anticipated) related to CCBHC activities, including those of care coordination, to inform prospective payment system (PPS) negotiations and to assess rate adequacy. Detailed records of incurred or anticipated costs are important for negotiating alternative payment arrangements, as well.

Consider staffing costs and how staff time and effort related to the CCBHC program are tracked and captured. In one example, providers took one week each year to complete a time study to capture more accurately how their time was spent. Documenting time will enable your CCBHC to more easily determine the true cost of the program. For other direct CCBHC costs, update your accounting systems to assign codes for future capturing and monitoring. If other direct costs (such as telehealth infrastructure) are shared across several programs including the CCBHC, consider developing an allocation methodology that captures and assesses these costs. More details regarding sustainability can be found in the National Council's Approaches to Sustainability for CCBHCs: An Environmental Scan and Guidance for Grantees (2023).

Continuous quality improvement

Care coordination is an evolving practice, often described as a journey or process, not a final destination. Interviewees noted they are still learning, working on and improving their approach. At the same time, the outcomes care coordination can produce are striking: increasing access, improving behavioral health and connecting people to the most appropriate array of services and support when they need them. Care coordination involves identifying activities with the people served, marshaling staff resources to support internal and external coordination, defining information flow (e.g., documentation and data sharing) and engaging with a wide range of partners. Care coordination benefits from a strong CQI focus to support its development and direct resources to the most effective practices.

CQI is a deliberate, defined, ongoing process to achieve measurable improvements in indicators of quality, including efficiency, effectiveness, performance, accountability and outcomes. CQI focuses on three key questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Examples of qualitative and quantitative data that can inform CQI for care coordination include the CNA, service utilization data, interviews with stakeholders, client data (via screening results, satisfaction surveys and input from advisory groups), staff feedback (via surveys, focus groups, and interviews) and input from partners, funders and system leaders. Through a CQI process, such as the Institute for Health Improvement's Plan-Do-Study-Act (PDSA) cycle, staff can adjust their approach by, for example, changing staff roles and workflows for defining internal processes and how best to work with partners and their services.

Plan

Your CNA can be instrumental in identifying priority areas for care coordination within the CCBHC and with external partners. When designing a care coordination approach, your CCBHC must make decisions on roles and responsibilities, communication, documentation, establishing the coordination plan and monitoring, revising and updating coordination needs. For example, if connecting children and their families to partial hospitalization services is a priority identified in your CNA, staff involved in this coordination can develop a CQI cycle that tests an approach for making and receiving referrals and follow-up with key partners. As another example, administrative, clinical and IT staff may collaborate to change how they document referrals and follow-up in their EHR.

Implement

Care coordination continually needs to adjust based on needs, services and supports. Staff can use CQI processes to:

- Determine what is working well and where adjustments to the approach are needed.
- Define appropriate levels, amount and frequency of care to apply with clients.
- Determine how to share data with partners and coordinate outcomes monitoring.

Given care coordination's many moving parts, assessing the strengths and challenges in your CCBHC through CQI processes is important.

To drive new services, staff at GRAND Mental Health (GMH) start with specific outcomes in mind. GMH's staff includes a CQI specialist whose sole job is to look at the control panel of outcomes, complete an analysis of why an outcome is out of range, and work to move the outcome into normal range. When choosing to address three outcomes — reduction in overdoses, reduction in a return to using substances and increased days in recovery (e.g., for six months and one year) — GMH established a co-occurring crisis center where people could have same-day access to SUD treatment. Through assessing their progress, they started giving iPads to people in need (e.g., in emergency departments, law enforcement vehicles, people's homes) to enable immediate contact with CCBHC staff aimed at reducing a return to using substances. With this success, today GMH provides iPads more broadly to support access to care.

Evaluate and report

To learn what works best, you must regularly evaluate how well your care coordination approach is working. One element of effective coordinated care is accessibility to the person served. Accessibility includes:

- Affordability
- Availability
- Accommodation
- Acceptability

The staff member responsible for coordinating care can assess these characteristics when determining a plan. Addressing these elements of accessibility could help mitigate social, economic or environmental disadvantages that people may experience based on broader inequities.

HIT can systematically track measures of care coordination effectiveness. For example, staff can document and review referral completion, client satisfaction, staff feedback and board member feedback, then perform CQI processes that look at populations and outcomes.

To understand the impact of your care coordination on the people you serve and report on state and federal measures where coordination is critical, use CQI to:

- Measure care coordination's impact on achieving care goals.
- Review significant events, such as those noted in the SAMHSA CCBHC certification criteria that involve care coordination (e.g., integration with primary care, 30-day readmissions for psychiatric or substance use reasons).
- Measure outcomes for care delivered by partners.

Special Considerations

Four key topics within care coordination warrant additional attention, planning and monitoring: care transitions, the difference between care coordination and case management, reaching special populations and the need to focus on children and youth.

Care transitions

People are particularly vulnerable during transitions of care. Transitions may be planned or unexpected and (possibly) uncommunicated with the CCBHC. Identifying when a transition has occurred can be challenging. CCBHCs and care coordination staff must prepare for potential transitions by developing strong partnerships with medical and psychiatric hospitals, emergency departments, other specialty behavioral health providers and primary care providers, so they can share critical information and provide timely follow-up. CCBHC staff have reported learning of transitions through the client themself, a family member, hospital staff and other providers. Interviewees shared that building strong relationships with each provider was the most effective approach to maintaining open communication with staff. Hospital staff often appreciate that the CCBHC reduces the number of repeat visits and connects the person to ongoing care and support.

Transitions also can be due to a move to a new living situation, working with a new provider or making progress and requiring fewer services. CCBHC staff who help people navigate these transitions must work closely with the site the person is moving to or from, as well as involved providers, to communicate information about the person and track the care received.

Care coordination in these critical periods requires intensive communication and tracking. When possible, the care coordinator will need to get records and discharge summaries, make appointments and address related socially driven needs. CCBHCs benefit from communication and tracking protocols for transitions within each area of the CCBHC (e.g., mobile crisis, adult outpatient). For example, CHR has a 30-day post-hospitalization tracking protocol to avoid rehospitalization for people served, with staff following each person in a registry.

> **"That means a lot of care coordination here internally between teams, and externally with other providers in the community. Sometimes those are hospitals, primary care providers, medical specialists, or outside psychiatric care. People stay on this registry 'open until linkage' to care. In our agency-wide, weekly care coordination meeting, we track any client sent to the ED or hospital, either psychiatrically or medically, to ensure we have eyes on or hands on each of those cases, hopefully connecting them to whatever services they need."**
>
> **Jason Boucher, Clinical Program Director, CHR**

Care coordination intensity can be based on factors that increase risk for further complications or new conditions. At GMH in Oklahoma, the registered nurse care managers monitor the progress of those with comorbid conditions, such as diabetes and psychosis. Working closely with primary care providers, the care managers ensure that people with comorbidities receive chronic disease management, including more laboratory blood draws and connections with specialists.

The differences between care coordination and case management

It's important to note that care coordination is different from case management or targeted case management (one of the nine required services). Care coordination provides a context for seamless and integrated care across various domains, including health care and social drivers, while case management (both general and targeted) covers a specific need and specific services. The act of coordinating (or "bringing together") is different from managing. While both may be necessary for a specific individual, the overarching nature of care coordination makes it distinct.

Care coordination is an activity that brings together all health-related care and social needs that are being provided or proposed to be provided. It ensures a person's care is seamless and integrated and supports efficient use of resources. Care coordination increases collaboration, due to its primary focus on enhancing quality of care and the associated outcomes. Care coordination should consider a person's preferences and all settings in which care is delivered, and it should incorporate the full spectrum of health in an integrated manner. Activities include referrals and exchange of information on needs addressed, including crisis, to support the wellness and recovery of the person.

Case management comprises an array of activities that help a person gain access to behavioral and physical health services and other social supports, such as education, legal counsel, housing and transportation. These activities include planned referrals and linkage to other care. Case managers serve as the conduit to that care and the identified point of contact to help the client identify goals and gaps in services, and they monitor the care being delivered. Case management helps a person access services within a complex system and gain the skills to do so independently, increasing self-sufficiency, wellness and recovery, and it monitors the delivered services to ensure goals are met.

Reaching special/underserved populations

Populations that have historically faced health disparities and barriers to care, including Black, Indigenous and people of color (BIPOC) and LGBTQ+ communities, may warrant a particularly considered and creative approach to care coordination. Specific barriers include geography (e.g., rural communities with fewer behavioral health resources), culture and language, socioeconomic status, discrimination, bias and experiences of domestic violence or abuse. By understanding the community's service barriers and gaps, your CCBHC can coordinate care to address them creatively.

In Eldorado, Illinois, few dentists accept Medicaid. Recognizing the significant and often urgent oral health needs of the people they serve, particularly those with SUDs, staff at the Egyptian Health Department developed an arrangement

> **"Has this changed the police understanding of behavioral health? Absolutely. We provide law enforcement with trainings, both formal and brief, during their roll calls. The police are also able to ask the embedded clinicians questions, such as 'Is this an appropriate referral? How do I help this person?' Having a clinician on site in the police department has been a really positive influence."**
>
> **Elizabeth Smith, Clinical Program Director, CHR**

with the only dentist in the area who accepts Medicaid, to increase access to care. In their arrangement, when a client is admitted to the emergency room for dental pain, this dentist will provide them with a next-day appointment, avoiding a lengthy and harmful wait for oral health care.

You also can address barriers by expanding to other settings. When the police respond to a 911 call, there is an opportunity to reach people who may be having a behavioral health crisis and offer access to care. At CHR, a staff member is embedded in the police department to triage and address cases where a behavioral health evaluation may be needed. By working with the police to address the Police Requests for Emergency Evaluation (PREEs), staff can divert people from the judicial system and provide follow-up care. This benefits the people served, the CCBHC and the police themselves. In at least one town CHR serves, data shows that PREEs have been reduced dramatically, as officers collaborate with the embedded clinician and consider other options.

Children and youth

The youth and young adult populations also have specific barriers to accessing and staying engaged in care. At NorthCare, staff recognized that transition-age youth (TAY, defined as 16 to 24 years old) often do not have the necessary support systems, especially if they have aged out of foster care. NorthCare used a portion of their 2018 CCBHC expansion grant to provide additional support through a team of TAY liaisons. These liaisons identify child welfare system-involved youth and youth/young adults who are homeless or at risk of homelessness. They run groups to help these youth and young adults learn about available resources and life skills, with the goal of ongoing engagement. The TAY liaisons also work individually to coordinate with the entire system of care for each client, including counseling, peer supports and assistance getting access to employment, education, housing and primary care.

At CHR, staff work in and with the school systems through their wraparound model. The CCBHC works with Connecticut's system of care to support a "no wrong door" referral system to its integrated care coordinator (ICC), who leads child and family engagement. The ICC works to minimize school disruptions and caregiver strain, providing preventive services and same-day access to psychiatric evaluations. Care coordination continues to be an opportunity for CCBHCs to build and incorporate new models to increase impact on children, youth and their families.

Conclusion

Care coordination, as one interviewee noted, is "woven throughout everything" in the CCBHC. It is a means to achieving care goals. It helps you meet the needs and preferences of the people you serve and facilitates the delivery of high-quality care based on the needs and preferences of the people you currently serve and those you seek to serve. Taking a thoughtful and reflective approach in defining and refining the care coordination strategy is critical to the success of your CCBHC.

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Appendices

Appendix A. Resources

Title	Source	Description
Capturing Value: Care Coordination Measurement Tool	Boston Children's Hospital	A measurement tool to document care coordination activities and outcomes, and an implementation guide to tailor the tool for use with various settings and populations.
CCBHC Contracting and Community Partnerships Toolkit: Expansion Grantee Edition	National Council for Mental Wellbeing	An overview of DCO and care coordination relationships required under the CCBHC model and resources to effectively establish and strengthen these relationships.
Intellectual and Developmental Disabilities and Behavioral Health: Leveraging Person-centered Approaches	Resources for Integrated Care	A one-hour webinar recording that discusses strategies to coordinate care across siloes and implement holistic, person-centered approaches to care.
Intensive Care Coordination for Children and Youth With Complex Mental and Substance Use Disorders: State and Community Profiles	Substance Use and Mental Health Services Administration	Inventory of the implementation of intensive care coordination in 40 states, with an emphasis on using wraparound and evidence-based screening tools and practices, financing and more.
Medical Home Care Coordination Resources	American Academy of Pediatrics	A collection of tools and resources to support pediatric care coordination, including multidisciplinary education, measurement tools and real-world examples of care coordination.
National Care Coordination Standards for Children and Youth With Special Health Care Needs	National Academy for State Health Policy	An outline of national standards for care coordination for children, to help state officials and other stakeholders develop and strengthen high-quality care coordination.

Title	Source	Description
Promising Practices for Promoting Person-centered Communication and Care Coordination	Resources for Integrated Care	A one-hour webinar recording that presents strategies for promoting person-centered care coordination and communication, particularly for people who are Medicare-Medicaid dual eligible or have language barriers.
Quality Improvement Toolkit	National Council for Mental Wellbeing	Strategies and tools to implement continuous quality improvement.
Resource Library	The Center of Excellence for Protected Health Information	A resource library on federal health privacy laws and regulations related to accessing and providing SUD and mental health services.
Rural Care Coordination Toolkit	Rural Health Information Hub	Best practices and considerations for implementing care coordination in rural settings.

Appendix B. Glossary of terms

ADTS	Admission Discharge Transfer System
BIPOC	Black, Indigenous and people of color
Case management	A process that assesses, plans, implements, coordinates, monitors and evaluates to improve outcomes, experiences and value (Commission for Case Manager Certification, 2024). Case management typically addresses a specific need or condition.
CCBHC	Certified Community Behavioral Health Clinic
CCBHC certification criteria	A set of minimum standards providers must meet in order to be a CCBHC, including staffing, availability and accessibility of services, care coordination, scope of services, quality and other reporting, and organizational authority and governance.
CHW	community health worker
CMS	Centers for Medicare and Medicaid Services
CNA	community needs assessment
CPT	Current Procedural Terminology
CQI	continuous quality improvement
DCO	Designated Collaborating Organization
EHR	electronic health record

FQHC	Federally Qualified Health Center
GMH	GRAND Mental Health
HIE/HIT	health information exchange/technology
HIPAA	Health Insurance Portability and Accountability Act: Federal law that required the creation of national standards (HIPAA Privacy Rule) to protect sensitive patient health information from being disclosed without patient knowledge or consent.
HUB	Community HUB model
ICC	integrated care coordinator
LGBTQ+	lesbian, gay, bisexual, transgender, queer
MFC	Careplus NJ Maternal and Family Center
MOU	memorandum of understanding
NFP	Nurse-Family Partnership
ONC	Office of the National Coordinator for Health Information Technology
PACE	Program of All-inclusive Care for the Elderly
PAMA	Protecting Access to Medicare Act
PDSA	Plan-Do-Study-Act
PMAD	perinatal mood and anxiety disorder
PPS	prospective payment system
PREE	Police Request for Emergency Evaluation
RHC	Rural Health Clinic
SAMHSA	Substance Abuse and Mental Health Services Administration
TAY	transition-age youth
SUD	substance use disorder
Transitional care	A set of services and activities designed to ensure the coordination and continuity of healthcare when patients transition between different levels of care or different sites.
TTBH	Tropical Texas Behavioral Health
42 CFR Part 2	Federal regulations that protect the confidentiality of substance use disorder treatment records.

Appendix C. Existing care coordination models

Care coordination model brief overview	Special population(s)
Program of All-inclusive Care for the Elderly (PACE)	
Integrated physical and behavioral health care for frail older adults. PACE provides 24-hour care delivery and coordination, including social services.	Older adults who are Medicare-Medicaid dual eligible
Wraparound	
Coordinated health care, particularly behavioral health and social services for children with complex needs and their families. An initial care plan, including crisis/safety planning, is developed and provides support through the transition out of the formal wraparound program.	Children with complex care needs and their families
Community HUB	
The HUB serves as a central agency coordinating with regional health and social service providers, conducting the intake and referrals for clients. Risk factors are assigned to a pathway with an evidence-based or best practice intervention. The HUB ensures completion of each pathway.	Individuals experiencing or at risk of health and social services challenges
Community Health Worker (CHW)	
Coordinated health, human and social services for people with complex health conditions. CHWs typically are community members who share social, cultural and economic characteristics with the priority population. CHWs work with people in their community.	People with complex health conditions
Nurse-Family Partnership (NFP)	
NFP provides one-on-one home visits by a nurse to promote healthy pregnancies, child development and economic self-sufficiency. Nurses conduct visits for approximately 2 1/2 years, from the beginning of pregnancy through when the child turns two years old.	First-time, low-income mothers
Health Homes	
Integrated physical, behavioral health and social services for people with chronic conditions. Aims to reduce fragmentation of care through person-centered care planning and coordination of services.	Individuals with two or more chronic health conditions who are Medicare-Medicaid dual eligible
Mobile Unit	
Mobile units extend the reach of health clinics, health departments or other providers by delivering care and services outside of a fixed setting. Mobile units can operate outside of business hours and travel to meet people where they are.	Hard-to-reach populations (e.g., people who have transportation barriers, live in isolated areas or have unstable housing)

Care coordination model brief overview	Special population(s)
Supportive Housing	
Integrated affordable housing and intensive coordinated services for those with chronic physical and behavioral health issues and housing instability. Services are multidisciplinary, low-barrier and voluntary.	People experiencing chronic housing instability and health challenges

Appendix D. Sample job descriptions

NorthCare (Oklahoma)

DEFINITION:

Position will serve as the facilitator of the child and family teams, advocate for families in the program, provide linkage with needed community resources, assist in treatment and education to families, and provide crisis support and safety planning under the clinical supervision of licensed staff.

SUPERVISION:

The SOC Project Director supervises this position.

FUNCTIONS AND ROLES OF THE CARE COORDINATOR:

- Facilitates implementation of the phases and activities of wraparound. Ensures the team is moving the children, youth and family toward long-term stability through the wraparound process.
- Ensures all team members contribute and are active partners in the wraparound process.
- Partners with all professional and natural supports on the family team to promote appropriate and integrated services.
- Respects the integrity and confidentiality of the persons receiving wraparound services.

EXAMPLES OF WORK PERFORMED:

- Conducts strengths, needs, cultural discoveries and crisis plans for each family. Prepares written report and gives to family according to the wraparound model. Develops strength-based family guided wraparound plan for each child and family team based on their individual needs.
- Coordinates and facilitates the wraparound process with the child/youth and family team to keep children/youth in the home and avoid out of home placements of the children/youth.
- Empowers the child, youth and family through general modeling, advocacy, coaching, follow up, and support. Teaches the children, youth and family how to effectively advocate within various child-serving agencies to include DHS, Juvenile Justice, and the education system.
- Develops and maintains positive relationships with community partners. Serves as a liaison between SOC, the Logan County referral team, and other community services and groups as directed. Participates in community consultation and educational activities. Promotes child, youth and family involvement at the individual and community levels.

- Carries a differentiated caseload involving highly complex and difficult situations requiring the coordination of services through the wraparound process.
- Maintains records in a timely manner as required by agency, state or federal funding sources and accreditation authorities. Completes all required forms and maintains same in a manner consistent with requirements. Documents all activities directly or indirectly related to serving children, youth and families in the program on a daily basis. Obtains clinical and non-clinical information from children, youth and families for continuing needs assessment. Collects data for evaluation and research of program effectiveness.
- To maintain position status, must spend at least 55% of work hours providing services to children, youth and families. Direct service provision must account for a minimum of 35%. Indirect service provision (travel and billable documentation) can account for up to 20% of the service requirement. Ensures effective and consistent delivery of services. Demonstrates flexibility in scheduling to accommodate children, youth and family needs for evening appointments and 24-hour crisis diversion and/or intervention. Returns phone calls, text messages and pages promptly. Checks and responds to emails daily.
- Participates in team meetings, clinical consultations, group and individual supervisions/coaching. Participates in trainings/workshops related to the wraparound process and in expanding knowledge base in children's mental health.
- Abides by agency policy and program procedures at all times.
- Performs other duties as required and/or assigned by supervisor and/or executive staff.

Every NorthCare employee is responsible for adhering to any and all laws, professional standards and ethical codes that apply to his/her job responsibilities.

POSITION REQUIREMENTS:

Position requires a Bachelor's Degree in Social Work or related human services field and two (2) years experience or Master's Degree in Social Work or related human services field and one (1) year experience. Must display proficiency in the MS Word processing software and intermediate general computer skills. Excellent written and oral skills are essential, along with strong organizational skills. Must demonstrate good interpersonal skills and the ability to effectively communicate verbally and in writing with English speaking consumers. Casual professional dress is required. Local travel required.

Must possess and provide verification of valid Oklahoma driver's license during employment with NorthCare. Must maintain and provide verification of current automobile liability insurance including uninsured motorist coverage. Must have and/or complete Core Level Co-Occurring Training and Trauma Informed Training via NetSmart University within 60 days of employment with NorthCare. Must possess and maintain current Behavioral Health Case Manager certification through the Oklahoma Department of Mental Health and Substance Abuse Services. If not current upon hire, must obtain CM certification within 30 days of employment with NorthCare. Must participate in on-site coaching to achieve credentialing as a High Fidelity Wraparound Facilitator within 9 months of employment with NorthCare. Must have TB test within 12 months prior to employment with NorthCare, or obtain within 30 days of employment with NorthCare. Must possess and maintain current certification in CPR, First Aid and CAPE certifications. If not current upon hire, must obtain CPR, First Aid and CAPE certifications within 30 days of employment with NorthCare. Must be able to move about facilities freely and sit for extended periods.

COMHAR (Pennsylvania)

JOB TYPE: Full-time

DESCRIPTION

Effective October 15, 2021, all employees/contractors/interns/volunteers are required to provide our office with proof of COVID vaccination.*

Shift: Monday-Friday 8:30AM-4:00PM
Openings: One (1) Opening
Care Coordinator Salary: $XX,XXX

CARE COORDINATOR POSITION SUMMARY

COMHAR is a nonprofit community based organization. Our mission is to provide health, and human services that empower individuals, families and communities to live healthier self-determined lives.

IBHS is designed for young people who are exhibiting more serious emotional and mental health symptoms. Children receive intensive services in the home, school, or community in order to help them reduce or replace problem behaviors with more positive, socially appropriate behaviors. Group mobile-therapeutic services are available.

We have an immediate opening for a Care Coordinator in our Children Services department. The Care Coordinator provides coordination for services for children within the Intensive Behavioral Health Services (IBHS) program.

Care Coordinator Responsibilities:

The Care Coordinator works in collaboration and continuous partnership with children, their family/caregiver, school/specialty providers and staff, and community resources in a team approach to:

Coordinate Services:

- Meet with families for completion of intake.
- Communicate with and coordinate the services. Schedule and confirm evaluation/re-evaluation appointments.
- Assist families with providing them information for – Medication, Outpatient, Neurology, etc.
- Attend evaluations (Complete Biopsychosocial Evaluation/Re-evaluation [CBE/CBR]).
- Arrange for referrals and placement to Partial Hospitalization Programs, Residential Programs, and inpatient

Advocacy:

- Collaborate with service providers such as Department of Human Services (DHS) STS Programs.

Other Responsibilities:

- Complete packets to be submitted to Community Behavioral Health.
- Respond to, and follow up on issues leading to insufficient responses (from CBH) to packet submission.
- Requesting addendum.
- Home visits, as needed.

Full Time Employees are eligible for generous benefit options including but not limited to:

- Medical, Vision and Dental Insurance with plan options to fit your needs
- Life and Long Term Disability Insurance
- 403B Retirement Savings Plan
- Paid Time Off (Holiday, sick, PTO, vacation)
- Tuition Reimbursement
- Employee Assistance Program
- Additional supplemental voluntary insurance options including Disability, Accident and Pet Insurance

Care Coordinator Job Requirements:

- Minimum of a Bachelor's degree in social work, counseling, psychology, sociology, gerontology, counseling education or related degree
- At least 1-year experience in the health or human service field (behavioral health or substance use field preferred).
- Driver's license required.

Care Coordinator Skills:

- Understanding and respect for each individual's unique path to recovery. Able to provide trauma-informed, strength based support
- Working knowledge of the recovery/treatment system
- Demonstrate professionalism and ethical service at all times
- Able to work well independently and on teams
- Must have good verbal and written communication skills. Bi-lingual (Spanish & English) a plus.
- Be flexible and adaptive in handling changing priorities in a fast paced environment
- Computer literacy is essential. Must be able to effectively use electronic health record, video conferencing, email, Office products, and any other technology needed to meet job responsibilities

https://comhar.org/job-details/?jobID=1125272

Comprehensive Healthcare (Washington)
Care Coordinator – Youth Mobile Outreach

JOB DETAILS

Job Location: Walla Walla, WA **Job Shift:** Day
Position Type: Full Time Education **Level:** Bachelor's degree

DESCRIPTION

Who is Comprehensive Healthcare?

Comprehensive Healthcare provides innovative behavioral health and integrated healthcare services to clients of all ages. We take pride in our creative and collaborative work environment and in delivering clinically excellent, trauma-informed, recovery-oriented services.

What are we looking for in a Care Coordinator?

Care Coordinators on the Youth Mobile Outreach Team respond in the community to support youth are experiencing a mental health crisis. The goal of the Youth Mobile Outreach Team is to reduce the use of emergency departments, hospitals, and detention centers for young people experiencing a crisis by offering an alternative for support and access to services in the community when a mental health emergency does occur. Care Coordinators offer supportive counseling to help youth stabilize and then assist clients with connecting to appropriate community services and treatment. To be successful in this role, Care Coordinators must enjoy variety in their day, possess exceptional communication skills, and be able to solve problems creatively. The schedule for this position is Monday – Friday, 8am – 5pm.

Care Coordinator duties may include:

- Meeting with youth who are experiencing a crisis to assist with de-escalating, stabilizing, and providing initial support
- Assisting the client with developing skills for self-advocacy and illness management
- Participating in crisis and safety planning with the youth and their family
- Coordinating with other service providers and treatment teams to expedite services and advocate on the client's behalf
- Assessing clients for safety and risk to self or others and taking appropriate crisis intervention steps when indicated
- Completing all required progress notes in a client-centered, timely manner
- Participating in the rotation for after-hours-on-call coverage

QUALIFICATIONS

- Bachelor's degree in social work, psychology, or related field
- Must be eligible for registration as Agency Affiliated Counselor
- Must have valid driver's license and vehicle liability insurance

NATIONAL COUNCIL *for* Mental Wellbeing

TheNationalCouncil.org

CCBHC-E National Training & Technical Assistance Center

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing