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CARE COORDINATION

Care Coordination

The Certified Community Behavioral Health Clinic (CCBHC) must provide care coordination across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems and employment opportunities necessary to facilitate wellness and recovery of the whole person. Care coordination activities are the foundation of the CCBHC program, and should guide all aspects of treatment to seamlessly integrate care and support effective partnerships among the client, family/other natural supports, and service providers.

These activities are carried out in accordance with the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2, and other confidentiality standards, as well as the client's needs and preferences. The CCBHC documents the client consent, preferably in an electronic format, and any attempts made to obtain consent.

General requirements include the following:

1. The CCBHC assists clients referred to external providers in obtaining an appointment, and tracks their participation in services to ensure coordination and receipt of services;
2. The CCBHC shall not limit client's freedom of choice (FOC) to choose their provider within the CCBHC, with its designated collaborating organizations (DCOs), or with any other provider;
3. The CCBHC assists clients receiving services to access benefits, including Medicaid, and enroll in programs or supports which may benefit them; and
4. The CCBHC ensures there is integration or coordination between the care of substance use disorders (SUDs) and other mental health conditions for those clients who experience both, and for integration or coordination between care for behavioral health conditions and other components of health care for all clients.

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Care Coordination Partnerships

The CCBHC is required to secure and maintain formal relationships with the following care settings for care coordination purposes:

1. Federally-Qualified Health Centers (FQHCs), including Rural Health Clinics (RHCs);
2. Emergency departments (EDs);
3. Inpatient acute care hospitals and hospital outpatient clinics;
4. Inpatient psychiatric facilities;
5. Substance use withdrawal management, post-withdrawal management step-down services, and residential programs;
6. Opioid Treatment Programs (OTPs);
7. Other community supports such as:
 - a. Schools;
 - b. Child welfare agencies;
 - c. Juvenile and criminal justice agencies and facilities;
 - d. Indian Health Service youth regional treatment centers;
 - e. State licensed and nationally accredited child placing agencies for therapeutic foster care service; and
 - f. Other social and human services.
8. Department of Veterans Affairs medical centers, independent outpatient clinics, drop in centers, and other facilities of the Department;
9. Early Childhood Supports and Services (ECSS) clinics (unless there is a DCO with an ECSS provider);
10. Coordinated System of Care (CSoC) Wraparound Agencies; and

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11. 988 Suicide & Crisis Lifeline.

For EDs, inpatient facilities, hospital outpatient clinics, and residential crisis settings, the partnership shall support tracking when clients receiving CCBHC services are admitted and discharged, preferably through the Admission-Discharge-Transfer (ADT) system.

To support transitions of care, CCBHCs must establish protocols for transitioning clients from EDs, inpatient facilities, psychiatric facilities/programs, withdrawal management services, and residential facilities to community settings to reduce delays in starting services and after a mental health or substance use crisis. This includes the following:

1. Transferring health records including prescriptions;
2. Coordinating services such as peer recovery specialists to support transitions from the ED or hospital to the CCBHC and community care;
3. Ensuring service continuity; and
4. Active follow-up post discharge.

The CCBHC must attempt to contact all clients receiving CCBHC services who are discharged from EDs, inpatient hospitals, or residential treatment facilities within 24 hours of discharge. After a psychiatric emergency, CCBHC must work with clients to develop/update and follow a crisis plan to prevent and manage future crisis.

Interagency Coordination Team

The CCBHC designates an interagency coordination team, which includes external providers. The team includes the client and their family/caregivers, to the extent the client desires their involvement or when they are legal guardians, and is responsible for directing, coordinating, and managing care and services. The interagency coordination team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the clients. When appropriate and desired by the client, this includes traditional approaches to care for clients who are American Indian or Alaska Native or from other cultural and ethnic groups.