The goal of CCBHC care coordination is to facilitate the appropriate and efficient delivery of health care services both within and across systems for individuals defined as eligible for CCBHC\(^1\). It is the deliberate organization of care that requires sharing information among all of the participants concerned with an individual’s care to achieve safer and more effective treatment. At this time, there is not a reimbursement mechanism for this type of care coordination for Community Centers. The Texas Council is actively promoting that the costs for care coordination be included in the rate methodology for the CCBHC model.

Unlike Care Coordination, targeted mental health case management (MH-TCM) is a service such as helping an individual gain access to needed supports and services. Under Texas Medicaid rules, MH-TCM is a reimbursable service when the session is the provision of a case management activity during a face-to-face meeting with the individual authorized to receive case management. Collateral contacts are allowed but they are only payable when the client or legally authorized representative is also present during the case management session.\(^2\)

Care coordination assumes accountability for the outcomes for the patient, regardless of who provides the service. All providers must collaborate but the CCBHC is taking the responsibility for establishing the framework and assuring quality referrals and transitions are occurring. The benefit for the individual receiving care coordination is a seamless transition across a full spectrum of health care services, in what has and continues to be a complicated service delivery system.

All levels of care coordination require:

- Closing the loop on referrals
- Transferring medical records of services among providers
- Tracking transitions of care including admissions to and discharge from high levels of care

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\(^1\) Although CCBHC organizations can provide services to the IDD population, these services are not part of the CCBHC certified services and are not included in the federally-defined CCBHC payment system.

• Actively follow-up after discharge
• Engagement of the MCO service coordinator to address barriers in access
• Formal agreements with key groups and agencies who serve a Center’s members

Closing the loop on referrals and transition management may be electronic or paper, depending on the Center’s structure.
• Referral tracking systems will include: member name, member ID number, diagnosis, brief reason for referral, provider name, insurance status, referral request status (sent, received), appointment date (if made), required pre-appointment tests, appointment completion, consultation note received, post-consultation care (e.g., consultant follow-up visits, specialist-to-specialist referral, return to primary care)
• Transition tracking includes receiving timely information about its members’ admissions and discharges from hospitals, emergency rooms, and other institutions. Transition tracking should in most cases include early CCBHC contact with the recently hospitalized patient and/or patients’ family.
A CCBHC must have care coordination agreements\(^3\) in place establishing care coordination expectations. Referrals are more likely to be successful if providers understand each other’s expectations, preferences and needs. Individuals and their families can play a more active role in engaging in the referral process if they are informed and supported.

A CCBHC executive management team member will need to lead the process for the initial discussions with the key organizations requiring agreements. Establishing leadership priority and agreement is critical in the beginning of this process. Once leaders in both organizations have agreed to key concepts, staff can begin working through the details and completing the agreement documents.

CCBHC care coordination agreements include:

1. Federally-Qualified Health Centers (FQHCs) to provide health care services, to the extent the services are not provided directly through the CCBHC.
2. Other primary care providers serving Center members
3. Programs that provide inpatient psychiatric treatment, ambulatory and medical detoxification, post-detoxification step-down services and residential programs.
4. Inpatient acute-care hospitals, including
   a. emergency departments
   b. hospital outpatient clinics
   c. urgent care centers
   d. residential crisis settings
   e. medical detoxification inpatient facilities and ambulatory detoxification providers
5. Schools
6. Child welfare agencies

\(^3\) CCBHC specifically requires Memorandum of Understanding (MOU) and depending on the relationship with the provider, patient release forms. Coordination agreements should include policies and procedures for data exchange. For an overview of the legal requirements and checklist for terms, see https://www.thenationalcouncil.org/wp-content/uploads/2016/05/Care-Coordination-Agreements.pdf
7. Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts)
8. State licensed and nationally accredited child placing agencies for therapeutic foster care service
9. Other social and human services
10. Nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department

The CCBHC must have established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric, detoxification, and residential settings to a safe community setting. For low volume providers, single case releases may be used rather than a formal Memorandum of Understanding (MOU).
Care Coordination Tiers

One way to operationalize care coordination is to design a system of tiers, which systematically assigns care coordination based on level of need. This concept is known as risk stratification\(^4\). The goal of risk stratification is to group individuals with similar complexity and care needs, then provide the appropriate level of intensity of coordination. Care coordination tiers will not necessarily align with the current Levels of Care used in the Community Center system.

**Tier 1: Care Coordination**

All attributed members in the Center’s services who are involved in referrals or transitions of care. Tier 1 Care Coordination is an activity, not a service, that involves agreements with other providers, entails tracking outcomes of referrals and identifying gaps in care. This is the least intensive level of service coordination, therefore care coordinators in this tier have the highest caseloads. For example, caseloads might be in the range of 500-750 members or more.

The primary functions are:

- **Logistical**
  - Tracks all referrals and transitions
  - Addresses barrier to referrals
  - Follows up on missed appointments
  - Engages the MCO service coordinator

Tier 1 members receive at least two telephonic contacts per year. The contacts may be by any Center Care Coordinator or the treatment team. The majority of the work done by the Care Coordinator is done through data analysis and engagement of other healthcare organizations.

Education Requirement of Care Coordinator:

- High school diploma, sometimes combined with medical assistant certification or additional training

Skills

- Data analysis

The Texas Council also has several documents related to risk stratification posted with CCBHC resources.
• Excel or other database applications and Electronic Health Record
• Healthcare system in the community
• Strong customer service skills, primarily over the phone but also in person
• Resourceful in problem solving
• Experience with individuals with chronic health conditions or disabilities is helpful but may not be required

**Tier 2: Clinical Care Coordination**

All attributed members in the Center’s services who have more than one common chronic illness such as hypertension, diabetes, serious mental illness, substance use disorder, homelessness. This is the moderate level of service coordination, therefore care coordinators in this tier have lower caseloads than Tier 1 but can still manage a significant number of members. For example, caseloads might be in the range of 100-200 members.

The primary functions are:

- **Logistical**
  - Tracks all referrals and transitions
  - Addresses barrier to referrals
  - Follows up on missed appointments
  - Engages the MCO service coordinator
  - Relationships with a broader range of specialists

- **Clinical Monitoring**
  - Tracking and follow up on lab/imaging results
  - Tracking indicators related to CCBHC quality metrics

- **Self-Management Support**
  - Referrals to Center programs or community groups teaching self-management for specified conditions

Members in Tier 2 must have a single identified person assigned as a Care Coordinator. These members receive at least one telephonic and 1 face-to-face visit annually which may include care planning or other interdisciplinary team meetings.

**Education Requirement of Care Coordinator:**
• must have an undergraduate or graduate degree in social work or a related field or be an LVN, RN, NP, or physician’s assistant (PA); or have a minimum of a high school diploma or GED and direct experience with individuals with disabilities in three of the last five years.

**Tier 3: High Risk, High Need Care Coordination**

All attributed members in the Center’s services who are high-risk/high need with multiple health conditions, high severity of symptoms and significant use of higher levels of care. A CCBHC has clearly defined criteria for engagement into Tier 3 care coordination (see Tarrant MHMR sample referral form). This is the highest intensity of members and requires the most intervention out of all tiers of service coordination. Care coordinators in this tier have small caseloads, and care coordination may be handled through an intensive treatment team. For example, caseloads might be in the range of 25-50 members or be individuals served through the Assertive Community Treatment team.

The primary functions are:

- **Logistical**
  - Tracks all referrals and transitions
  - Addresses barrier to referrals
  - Follows up on missed appointments
  - Engages the MCO service coordinator
  - Relationships with a broader range of specialists and inpatient facilities

- **Clinical Monitoring**
  - Tracking and follow up on lab/imaging results
  - Tracking indicators related to CCBHC quality metrics
  - Hospital discharge planning and follow up

- **Self-Management Support**
  - Referrals to Center programs or community groups teaching self-management for specified conditions

- **Medication Management**
  - Medication reconciliation after transition
  - Ongoing medication management across systems
Members in Tier 3 must have a single identified person assigned as a Care Coordinator. The Care Coordinator may also function as the intensive care manager for this population. These members receive at least one telephonic and 2 face-to-face visits annually which may include care planning or other interdisciplinary team meetings.

Education Requirement of Care Coordinator:
- Must be a registered nurse (RN), nurse practitioner (NP), Masters-level Social Worker or Professional Counselor, Licensed Bachelor of Social Work (LBSW), Provisionally Licensed Psychologist (PLP), or Licensed Psychological Associate licensed to practice in Texas.
Care Coordination Team Referral

Referrer Name: ___________________________     Date: _____________
Referrer Phone: ___________________________     Chart Review Completed:  □ Yes  □ No
Prescriber’s Name: ___________________________
Clinic Name: _____________________________     Clinic Nurse: ___________________________
Other Information: __________________________

Individual Information

DOB: ___________________________     Age: ___________________________     Phone #: ___________________________
Street Address: ___________________________     City: ___________________________     Zip: ___________________________
PCP: ___________________________     PCP Phone: ___________________________
Guardian/LAR: ___________________________     Guardian/LAR Phone: ___________________________

Minimum Screening Criteria:
Individual has a chronic condition. All identified conditions must be documented in Avatar:
Chronic Conditions documented per chart (mark all that apply):

☐ Hypertension 140/90 or greater     Most current reading: Unknown
☐ Obesity (BMI of 30 or greater)     BMI: Unknown
☐ Underweight (BMI < 18.5)     BMI: 
☐ Lipids – Abnormal Range     Value:
☐ PHQ 9 Score 9 or higher     Current Score:
☐ COPD
☐ Asthma

Must have 2 or more of the following:
☐ 1 or more Inpatient admissions within the past 6 months
☐ 3 or more ED within the past 6 months
☐ 6 or more prescriptions currently
☐ 3 or more outpatient providers over the past 6 months
☐ No PCP visit within the past year

**Wellness Team Use Only**

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<th>Well Linked</th>
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