Behavioral Health Care Coordination

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Learning Objectives

- Understand what behavioral health care coordination is and why it's important
- Recognize the aspects of behavioral health care coordination and how they improve patient experience and outcomes
- Consider strategies to implement behavioral health care coordination in a primary care setting

"Coordination of care across settings permits an integration of services that is centered on the comprehensive needs of the patient and family, leading to decreased health care costs, reduction in fragmented care, and improvement in the patient/family experience of care." (American Academy of Pediatrics, 2014)

Importance of Care Coordination

- Lower healthcare costs (Hibbard, Greene, & Overton, 2013)
- Better patient outcomes (Druss et.al., 2010; Greene & Hibbard, 2012; Salyers et.al., 2009)
- Higher patient satisfaction (Hibbard & Cunningham, 2008)

- Meets multiple aspects of Patient Centered Medical Home standards (National Committee for Quality Assurance, 2017)

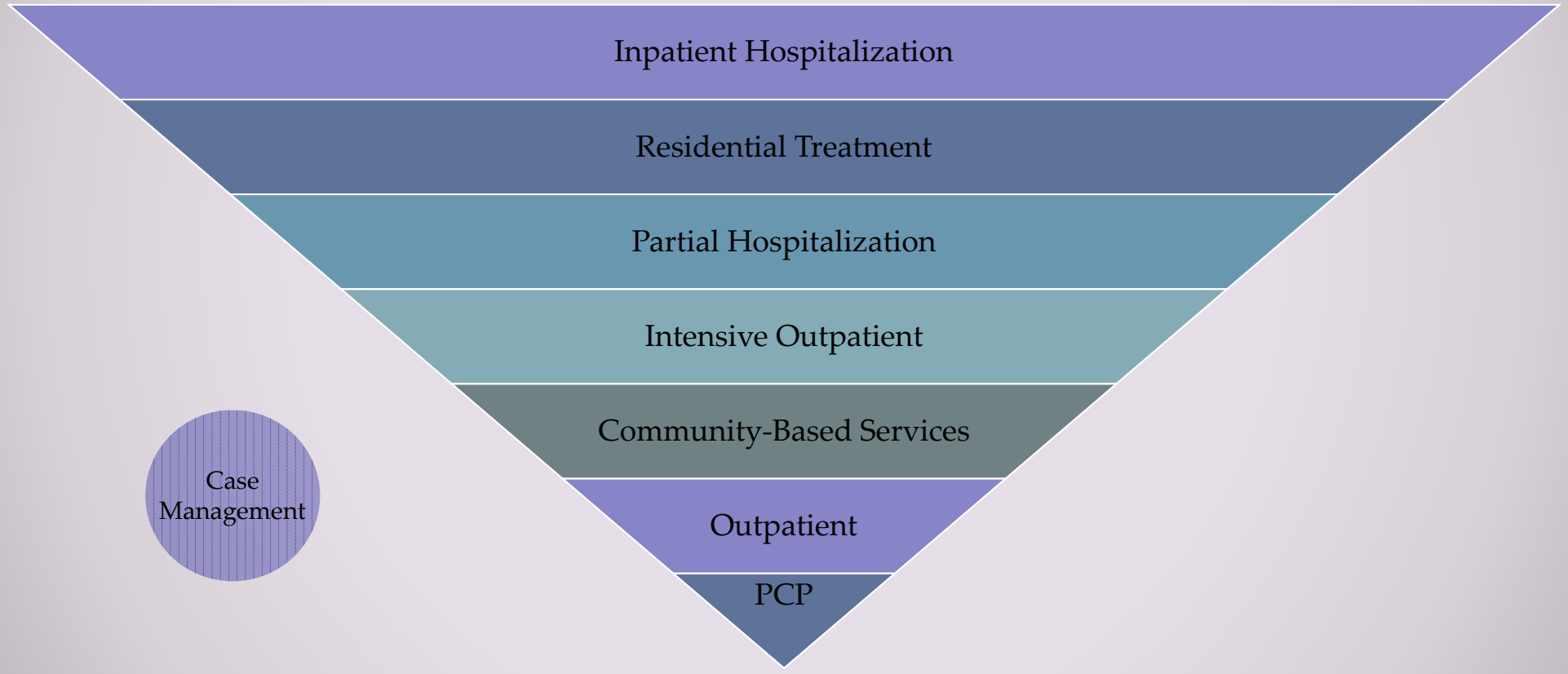
Who are Behavioral Health Care Coordinators?

- No set requirements, however the following may be helpful:
  - Educational background in human service field (social work, psychology, nursing, etc.)
  - Employment experience in behavioral health field
  - Behavioral health license (LSW, LCSW, MFT, LPC, etc.)
- Case management certifications
  - Numerous options (ACM, C-SWCM, CASWCM, CCM, CMC etc.)
  - Significance of certifications
- Training
  - Pediatric Care Coordination Curriculum (Antonelli, Browning, Hackett-Hunter, McAllister, & Risko, 2014)

Office Setting for Care Coordination

- To implement a successful care coordination program in the primary care setting, consider the following:
  - Effective behavioral health care coordination requires dedicated time to interact with patients and families
  - Care coordinators often make phone calls that contain sensitive and confidential behavioral health information
  - Access to certain technology is essential for care coordination (phone, fax, internet, computer, access to EMR, etc)
  - A care coordination program should begin with a database of resources

Behavioral Health Levels of Care



Care Coordinator vs. Case Manager

- Terms are often used interchangeably
- No set definitions / rules

Care Coordinator	Case Manager
Can be phone-based	Usually face-to- face
Less involved with patient and family	More involved with patient and family
Short-Term	Long-Term

Referrals and Accessing Care

- Who can make a referral?

Level of Care	Behavioral Health Team	Primary Care Provider	Patient and/or Guardian
Inpatient Hospitalization*	----- No Referral Needed -----		
Residential Treatment Facility	X		
Partial Hospitalization / Intensive Outpatient	X	X	
Community-Based Services*	X	X	
Outpatient	----- No Referral Needed -----		
Case Management	X	X	X

Did you know?

- If a child has a behavioral health diagnosis, they are eligible for medical assistance, regardless of family income and financial resources. This is known as the “Medicaid Loophole”.
- Families can apply for the Medicaid Loophole through their county assistance office.
- Documentation of the qualifying diagnosis is required.
- Children can have private insurance, with Medicaid as a secondary coverage.
- Medicaid expands access to more behavioral health services.

Release of Information

- Patients 14 years or older must sign a behavioral health release of information
- Must specify if behavioral health and/or drug and alcohol information is to be disclosed
- Dates of treatment must be included
- Valid for 90 days, unless otherwise specified (cannot exceed 1 year)
- Can be withdrawn at any time

Release of Information

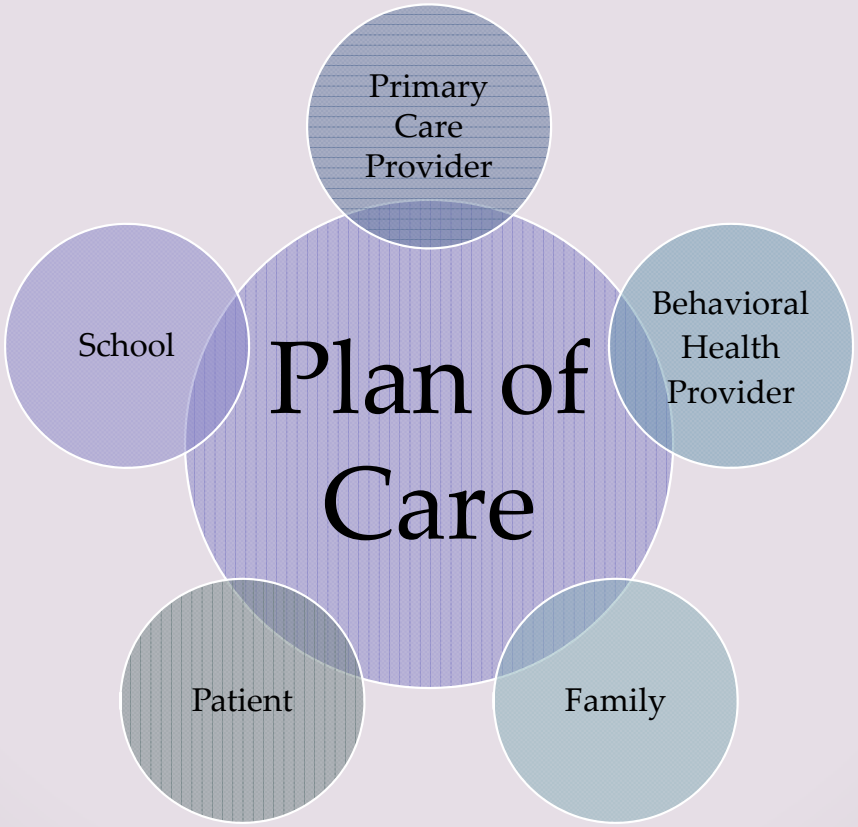
- Not required "when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person." (National Association of Social Workers, 2008)

- If you are ever uncertain about the need for a release of information, consult with your agency's compliance officer.

Aspects of Behavioral Health Care Coordination

- Teamwork
- Education and Guidance
- Engagement of Families
- Productive Communication
- Supporting Self-Management
- Monitoring
- Advocacy

Team Work and the Plan of Care



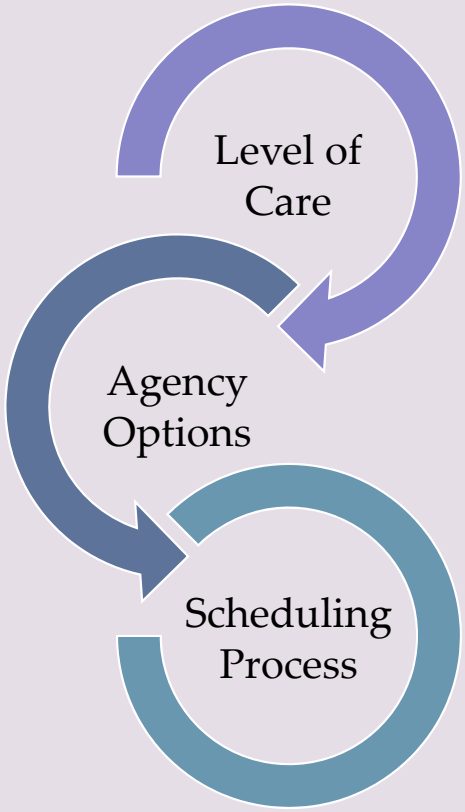
Teamwork Example

- **Patient:** Tom, 16 year-old male
- **Diagnosis:** Depression
- **Presenting Problem:** Continuing passive death wish without plan or intent
- **Barriers to Treatment:** Family does not own a car and has poor follow-though with community resource recommendations.

Teamwork Example

- The PCP obtains consent from Tom and his family, and consults with the care coordinator
- The care coordinator contacts the family and school
- The care coordinator provides the family with a list of resources and assists them with choosing one
- The care coordinator and PCP work together to refer Tom to a partial hospitalization program

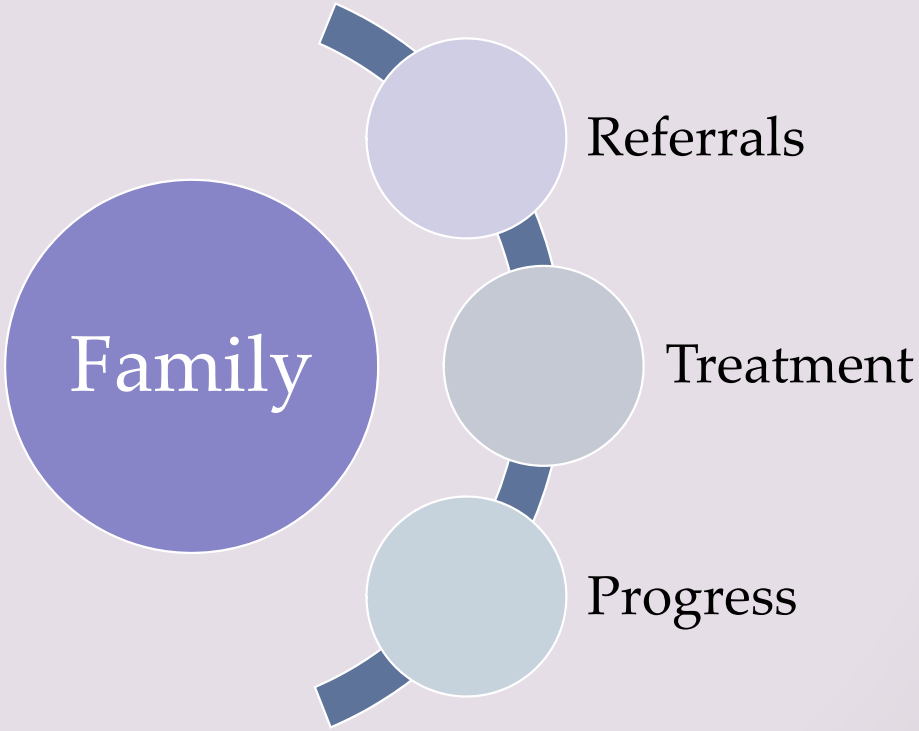
Education and Guidance



Education and Guidance Example

- **Patient:** Alison, 6 year-old female
- **Diagnosis:** Post Traumatic Stress Disorder (PTSD)
- **Presenting Problem:** difficulty sleeping, behavioral issues at home and school
- **Barriers to Treatment:** Family has poor follow-through on recommendations and does not fully understand Alison's diagnosis or the services available

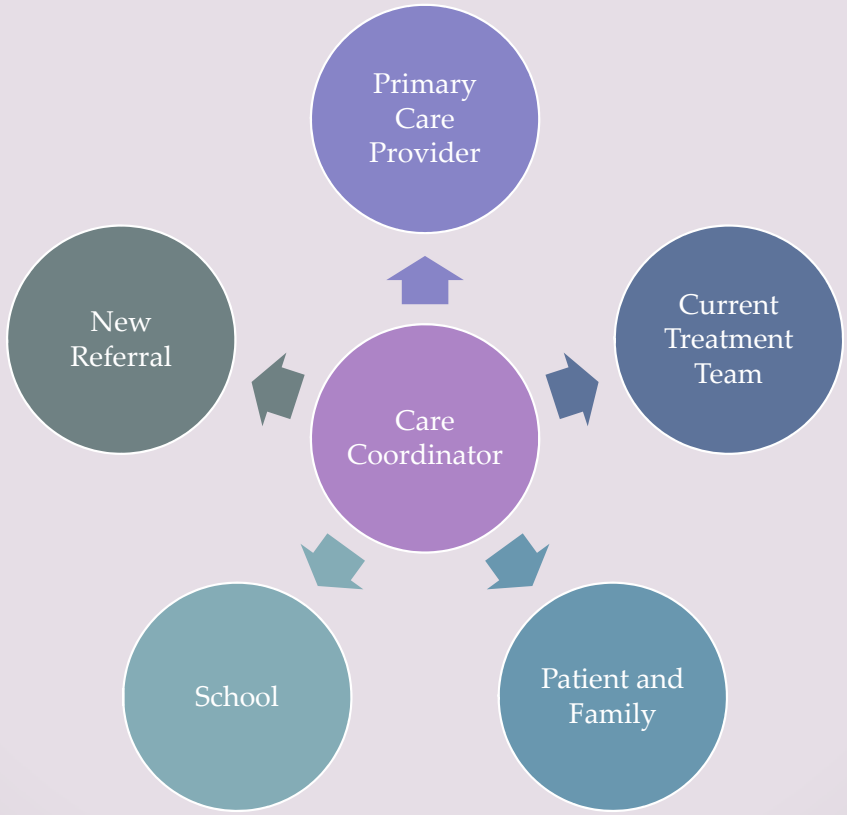
Engagement of Families



Engagement Example

- **Patient:** Karen, 15 year old female
- **Diagnosis:** Obsessive-Compulsive Disorder (OCD)
- **Presenting Problem:** excessive handwashing leading to open wounds
- **Barriers to Treatment:** Family is resistant to behavioral health interventions

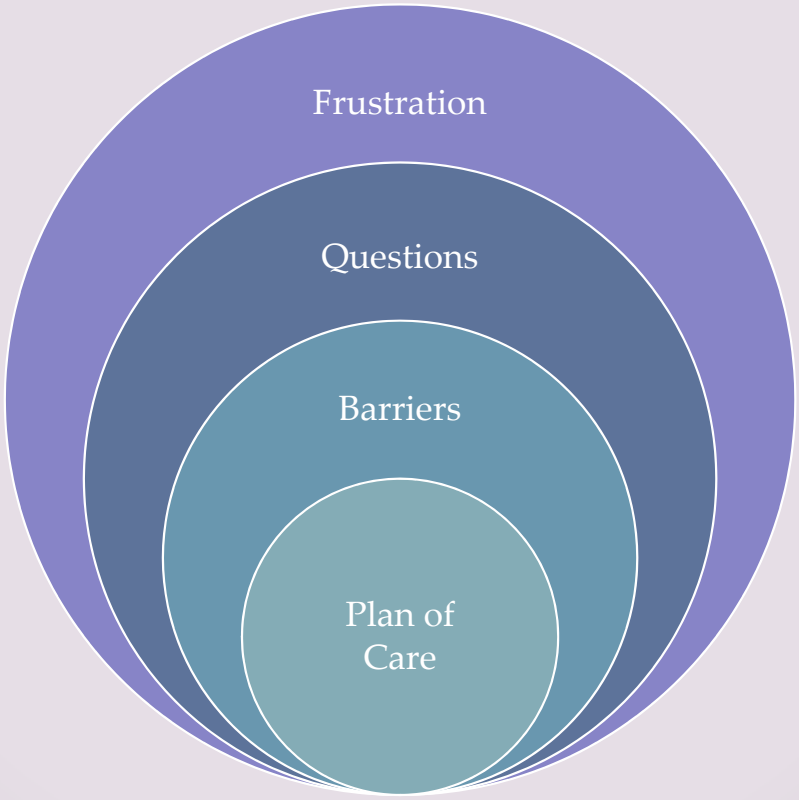
Productive Communication



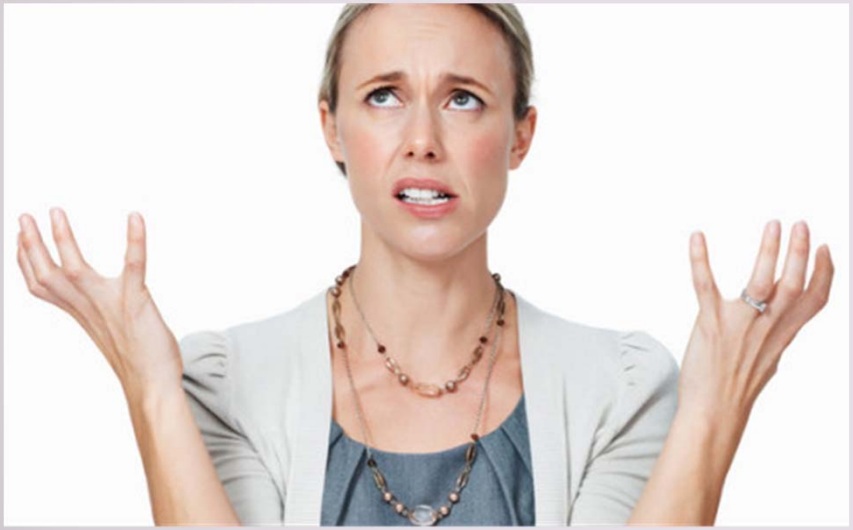
Communication Example

- **Patient:** David, 4 year old male
- **Diagnosis:** Adjustment Disorder
- **Presenting Problem:** Parents are recently separated and having increased difficulty with David's behavior
- **Barriers to Treatment:** No known barriers

Supporting Self-Management



Self-Management Example



- **Patient:** Mary, 10 year old female
- **Diagnosis:** Anxiety and Depression
- **Referred Level of Care:** outpatient therapy
- **Current Issue:** Mom has call the referred agency for intake, and left a voicemail. She has not heard back from them.

Self Management Example

- Acknowledge Mom's frustration
- Confirm she has the correct intake number
- Encourage Mom to call again
- Call the agency to confirm their intake process and let them know that a parent is trying to reach them
- Follow-up with Mom in a few days to see how things are going

Monitoring

- address new barriers
- assess satisfaction with referral
- respond to changes in patient needs
- provide new resources as needed
- answer family/patient questions

Monitoring Example

- **Patient:** Ryan, 8 year old male
- **Diagnosis:** Anxiety
- **Referred Level of Care:** outpatient therapy
- **Current Issue:** Ryan did not like the therapist at the referred agency and Dad had a negative experience with the agency's office staff

Monitoring Example

- Assess for new concerns and confirm that Ryan is safe
- Review the recommendations and reassure Dad that outpatient therapy is the best treatment for Ryan's anxiety at this point
- Offer alternate resources that provide the same level of care and treatment
- Confirm that Dad has crisis phone numbers to use in the event of an emergency
- Follow up again in a few days to see how things are going

Advocacy

- Patient Choice
- Self Determination
- Protection of Privacy
- Access to Adequate Services
- Appropriate and Timely Interventions

Advocacy Example

- **Patient:** Sarah, 7 year old female
- **Diagnosis:** Oppositional Defiant Disorder (ODD)
- **Referred Level of Care:** intensive in-home therapy program
- **Current Issue:** New agency has decided to discharge after 3 visits to the home

Advocacy Example

- Speak with the agency
- Encourage the agency to continue providing in-home services or refer to an agency who will provide the same level of care
- Encourage the agency to consider referring the family to an outpatient provider while continuing the in-home services.
- Offer to coordinate a meeting between the agency and the care team who made the initial referral.
- Contact supervisors, insurance companies, and county mental health officials as necessary.

Thank You

- Questions?

References

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Recommended Reading

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