DHCS Behavioral Health Forum December 2015 Forum Meeting

December 14th , 2015
9:00 a.m. to 2:30 p.m.

Forum Agenda Overview

9:00 – 9:15	Welcome & Introductions
9:15 – 9:30	CCBHC Overview
9:30 – 10:45	Best Practices in Care Coordination
10:45 – 11:00	Break
11:00 – 12:00	Client and Family Member Forum
12:00 – 1:00	Lunch (on your own)
1:00 – 2:15	Prospective Payment System for CCBHCs
2:15 – 2:30	End of the Date Reflections and Adjourn

Welcome and Introductions

Behavioral Health Forum Leads

Karen Baylor, Ph.D., **LMFT,** Deputy Director
Mental Health and Substance Use Disorder
Services
Department of Health Care Services

Brenda Grealish, Assistant Deputy Director
Mental Health and Substance Use Disorder
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Erika Cristo, Chief
Program Policy & Quality Assurance
Mental Health Services Division
Department of Health Care Services

Rob Maus, Chief
Program Support & Grants Management Branch
SUD - Prevention, Treatment, and Recovery
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Alice Trujillo, Chief
Program Policy Unit, SUD - Prevention,
Treatment, and Recovery Services Division
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Lanette Castleman, Chief
Program Oversight and Compliance Branch
Mental Health Services Division
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Branch, Mental Health Services Division
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Behavioral Health Forum Leads

Minerva Reyes, Research Manager II
Fiscal Management and Outcomes
Reporting Branch
Mental Health Services Division
Department of Health Care Services

Dionne Maxwell, Ph.D., Research Program
Specialist III
Fiscal Management and Outcomes Reporting
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CCBHC Overview and California's CCBHC Grant Proposal

Authorizing Legislation: 2014 Excellence in Mental Health Act

- Protecting Access to Medicare Act (H.R. 4302) created the criteria and authorized the two Phase CCBHC Demonstration Program:
  - **Planning Grant Phase**: Up to $2 million per state (max. 25 states)
    - 1 year grant to plan and develop CCBHC certification and prospective payment system (PPS) reimbursement requirements
    - Certify at least 2 sites
    - Establish the PPS for Medicaid reimbursable BH services
    - Apply to participate in the 2 year demonstration program
  - **Demonstration Phase**: Up to 8 states will be selected to participate in the CCBHC demonstration
    - Bill Medicaid under established PPS approved by CMS under an enhanced Medicaid Federal Medical Assistance Percentages (FMAP)

The Vision:
Certified Community Behavioral Health Clinics

- States improve overall health by:
  - ✓ providing co-located community-based mental health and substance use disorder treatment
  - ✓ integrating with physical health care
  - ✓ utilizing evidence-based practices
  - ✓ establishing/maintaining electronic health records (EHR) to conduct population health management, quality improvement, reducing disparities, and for research and outreach

Care Coordination is the
The "Linchpin" of CCBHC

Minimum Standards

The Act establishes standards in six areas that an organization must meet to achieve CCBHC designation:

1. Staffing
2. Accessibility
3. Care coordination
4. Service scope
5. Quality/reporting
6. Organizational authority

CCBHC Service Requirements

- The CCBHC ensures that the following services are provided directly:
  - Crisis mental health services—24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization (unless a state/county sanctioned systems for crisis services can act as a DCO):
  - Screening, assessment and diagnosis, including risk assessment
  - Person and Family-centered treatment planning
  - Direct provision of outpatient mental health and substance use disorder services

- All CCBHC services, if not available directly through the CCBHC, are provided through a Designated Collaborating Organization (DCO)

- DCO-provided services must meet the same quality standards as those provided by the CCBHC

Planning Phase Activities
October 2015-October 2016

Planning grant recipients must:

- Design the CCBHC services

- Certify a minimum of two CCBHCs—rural and underserved—that will participate in the pilot
  - Create and finalize application process for CCBHCs
  - Support clinics to meet standards (access to training and technical support)

- Establish and Enact the Prospective Payment System (PPS) to reimburse CCBHC services

- Solicit input from a variety of stakeholders

- Apply for the 2-year Demonstration by 10/31/2016

California's
CCBHC Planning Grant Application

- Developed as a result of a collaboration between DHCS, CBHDA and CIBHS

- Multiple Stakeholder Meetings

- Technical Assistance and Support from the National Council for Behavioral Health

- Stakeholder Input (variety of perspectives)

- Submitted on August 5, 2015

- Awarded on October 20, 2015

24 States Awarded Planning Grants for CCBHCs
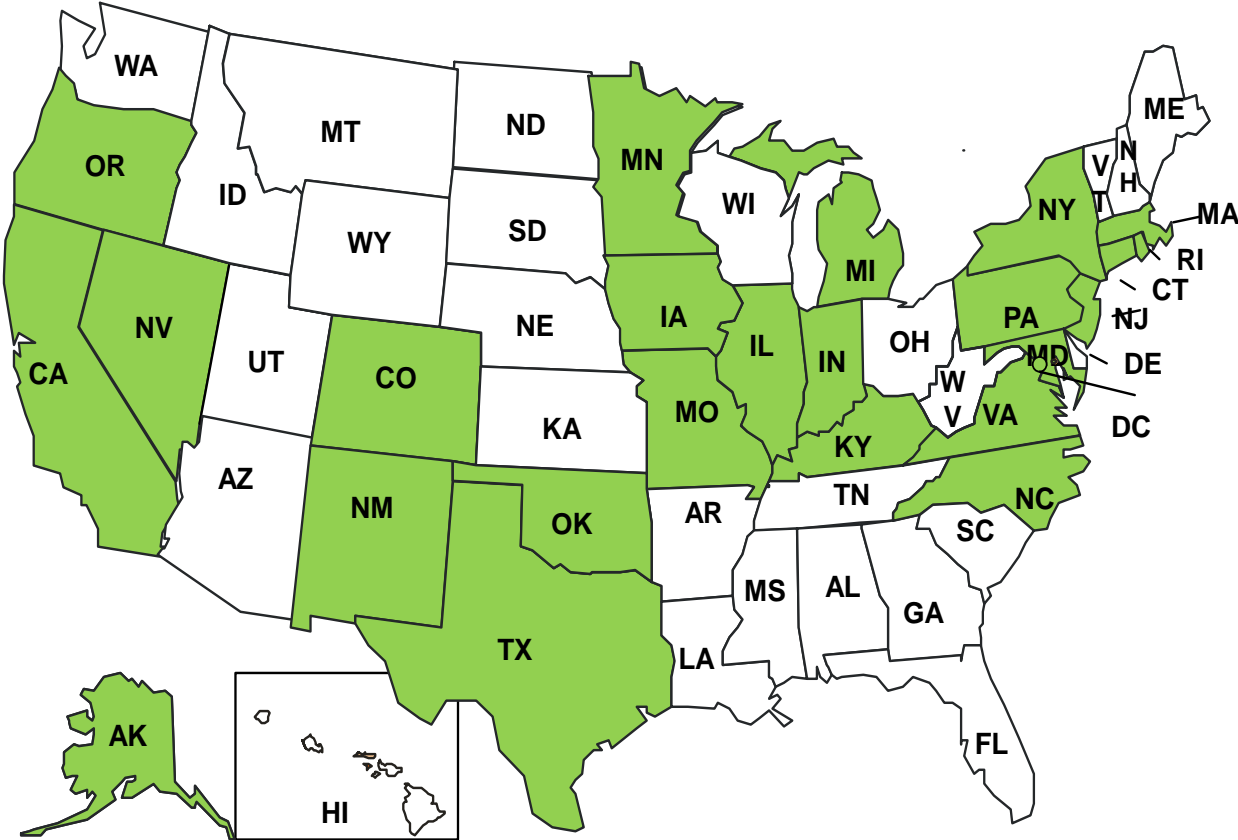
California's
CCBHC Planning Grant Application (continued)

- Focus on "superutilizers," although CCBHC requires that anyone who presents for care be provided services

- Builds off of MHSA

- Multi-system care coordination is a key element

- Comprehensive data collection and reporting is required

SAMHSA's Planning Phase Project Structure

- Four Workgroups
  - State Coordination Planning Group
  - CCBHC Certification Planning Group
  - PPS Planning Group
  - Data Collection and Reporting Planning Group
- Monthly Meetings

DHCS' Planning Phase Project Structure

- Steering Committee

- Workgroups
  - CCHBC Service Design
  - Certification Process Design
  - PPS Rate Development
  - Evaluation

- DHCS Behavioral Health Forum

Role of DHCS
Behavioral Health Forum Participants

- Steering Committee and/or Workgroups will provide status reports and/or present draft deliverables to Behavioral Health Forum Participants via:
  - In-person meetings
  - Email
- Behavioral Health Forum Participants to provide input/feedback

Timeline

- October 2015: Planning grants awarded

- January 2016: Further guidance on the application to participate in the Demonstration program

- October 2016: Grantees submit applications for the Demonstration program AND no-cost extensions

- December 31, 2016: Up to 8 states selected for Demo Program and approved for no-cost extensions

- January 2017: Demo program starts

- Sept. 2017: (9 months after start) 1st Cost Report due

- December 31, 2018: Demonstration Program ends

- December 31, 2021: Final Report Due to Congress

Additional CCBHC Information

- SAMHSA's CCBHC Grant Page: http://www.samhsa.gov/grants/grant-announcements/sm-16-001

- National Council for Behavioral Health Toolkit:

  http://www.thenationalcouncil.org/capitol-connector/2015/06/national-council-hosts-ccbhc-webinar-releases-state-planning-grant-toolkit/

- Department of Health Care Services CCBHC Application:

  http://www.dhcs.ca.gov/services/Documents/CCBHC_Grant_Application_Rev.08.07.15pdf.pdf

Today's CCBHC Presenters

Karin Kalk, California Institute for Behavioral Health Solutions
Best Practices in Care Coordination

Vera Calloway, *Peer Advocate and USC Certified Health Navigator*, Los Angeles County

Cindy Claflin, *The Institute for Parent Leadership Training for United Advocates for Children and Families,* Sacramento County

Vanessa Lopez*, RAIZ Promotores Program,* Stanislaus County

Accessing and Navigating Care

Nina Marshall, MSW, Senior Director, Policy and Practice Improvement, National Council for Behavioral Health
Prospective Payment System for CCBHCs: Policy and Operational Consideration

Contact Information

Behavioral Health Forum Stakeholder Website:

http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-UpcomingMeetings.aspx

Please e-mail questions, comments or concerns to:
MHSUDStakeholderInput@dhcs.ca.gov

DHCS Behavioral Health Forum
Best Practices in Care Coordination

Presenter:

Karin Kalk, California Institute for Behavioral Health Solutions
(CIBHS)

December 14th , 2015
9:30 a.m. to 10:45 a.m.

Topics Today

1. Overview of CCBHC Certification Requirements
2. About Care Coordination
3. Specific Care Coordination Requirements
   – Scope
   – Communication & Documentation
   – Individual's Goals, Preferences
   – Access
   – Treatment Team, Treatment Planning
   – Crisis Prevention/Management
   – Health Information Technology
   – Coordination & Quality Improvement
   – Agreements with DCOs
4. Discussion: Feedback & Recommendations

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Prepare Your Feedback & Guidance – Discussion after Review of Requirements

- In anticipation of the Care Coordination Workgroup convening, what guidance do you have for:
  - The role of peers in care coordination
  - Assuring cultural sensitivity in approaches to care coordination
  - Other important aspects of successful care coordination

CCBHC Certification Requirements

Section I: Staffing
- 1.A: General Staffing Requirements
- 1.B: Licensure And Credentialing Of Providers
- 1.C: Cultural Competence And Other Training
- 1.D: Linguistic Competence

Section 2: Availability And Accessibility Of Services
- 2.A: General Requirements Of Access And Availability
- 2.B: Requirements For Timely Access To Services And Initial And Comprehensive Evaluation For New Consumers
- 2.C: Access To Crisis Management Services
- 2.D: No Refusal Of Services Due To Inability To Pay
- 2.E: Provision Of Services Regardless Of Residence

Section 3: Care Coordination
- 3.A: General Requirements Of Care Coordination
- 3.B: Care Coordination And Other Health Information Systems
- 3.C: Care Coordination Agreements
- 3.D: Treatment Team, Treatment Planning And Care Coordination Activities

Section 4: Scope Of Services
- 4.A: General Service Provisions
- 4.B: Requirement Of Person-centered And Family-centered Care
- 4.C: Crisis Behavioral Health Services
- 4.D: Screening, Assessment, And Diagnosis
- 4.E: Person-centered And Family-centered Treatment Planning
- 4.F: Outpatient Mental Health And Substance Use Services
- 4.G: Outpatient Clinic Primary Care Screening And Monitoring
- 4.H: Targeted Case Management Services
- 4.I: Psychiatric Rehabilitation Services
- 4.J: Peer Supports, Peer Counseling, And Family/Caregiver Supports
- 4.K: Intensive, Community-based Mental Health Care For Members Of The Armed Forces And Veterans

Section 5: Quality And Other Reporting
- 5.A: Data Collection, Reporting, And Tracking
- 5.B: Continuous Quality Improvement (Cqi) Plan

Section 6: Organizational Authority, Governance, And Accreditation
- 6.A: General Requirements Of Organizational Authority And Finances
- 6.B: Governance
- 6.C: Accreditation

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CCBHC Care Coordination Requirements (Section 3)

3.A: General Requirements of Care Coordination

3.B: Care Coordination and Other Health Information Systems

3.C: Care Coordination Agreements

3.D: Treatment Team, Treatment Planning and Care Coordination Activities

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CCBHC Care Coordination Requirements (Section 3)

3.A: General Requirements of Care Coordination

3.D: Treatment Team, Treatment Planning and Care Coordination Activities

3.B: Care Coordination and Other Health Information Systems

3.C: Care Coordination Agreements

CCBHC Care Coordination Requirements

The CCBHC Readiness Assessment will be used to understand each candidate site's progress in this area and identify capability to be developed during the planning year.

Care Coordination: A Central Tenant of CCBHCs

- Involves organizing care activities among different services and providers, and across various facilities.

- CCBHC is responsible for all care coordination, whether it involves coordination within the CCBHC, with a *designated collaborating organization* (DCO), or with another entity identified in the statutory language related to care coordination.

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Agency for Healthcare Research and Quality (AHRQ)

"Deliberately organizing consumer care activities and sharing information among all of the participants concerned with a consumer's care to achieve safer and more effective care.

This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."

DHCS Sponsored Care Coordination Projects

- DHCS funded intensive learning collaboratives:
  - Care Integration Collaborative (CIC)
  - Small County Integration Collaborative (SCCI)
  - Strategies for Integrating Health, Prevention, and Community (SIPHC)
  - Care Coordination Collaborative (CCC)
- Cal MediConnect
  - Supported the creation of a structure to improve coordination of care for dually eligible beneficiaries with serious behavioral health conditions.
- DHCS partnership with Interagency Council on Veterans
  - To participate in SAMHSA-sponsored SUDs Virtual Implementation Academy with other states
  - Began in September 2015.

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Care Coordination Collaborative
(a source of illustrative examples)

- The CCC synthesized care coordination/care integration best practices for individuals with complex health conditions from the medical field with evidence-based and emerging practices from MH/SUD regarding effective treatment and wellness and recovery support for individuals with serious mental illness and/or substance use disorders.

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Care Coordination Collaborative
(a source of illustrative examples)

- 13 Key Care Coordination Processes identified and pursued:

1. Outreaching, engaging, and facilitating clients' access to appropriate services
2. Defining the Care Team (including natural supports) for each client/patient
3. Ensuring and monitoring consent to share clinical information (ROI)
4. Ensuring and monitoring appropriate screening for medical, mental health and substance use conditions
5. Facilitating referrals
6. Entering clinical information into caseload registry tool
7. Conducting multidisciplinary clinical care conferences

8. Ensuring and monitoring routine medication reconciliation
9. Supporting client self-management
10. Ensuring and communicating shared care plan goals among client/patient and providers (primary care, mental health, and substance use providers)
11. Ensuring availability of ad hoc clinical case consultation
12. Ensuring urgent care access to specialty MH, SUD or primary care
13. Monitoring transitions in care

"My Total Health Plan"

The Scope of CCBHC Care Coordination

The Whole Person!

Scope of Care Coordination: *The Whole Person*

Requirement 3.a.1: Coordinates care across the spectrum of health services to facilitate wellness and recovery of the whole person; includes supporting access to:

- High- quality physical health (both acute and chronic) and behavioral health care
- Social services
- Housing
- Educational systems
- Employment opportunities

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CCBHC Care Coordination supports the *Whole Person*

Individual

Behavioral Health

Physical Health

Housing

Education

Employment

Other Social Services

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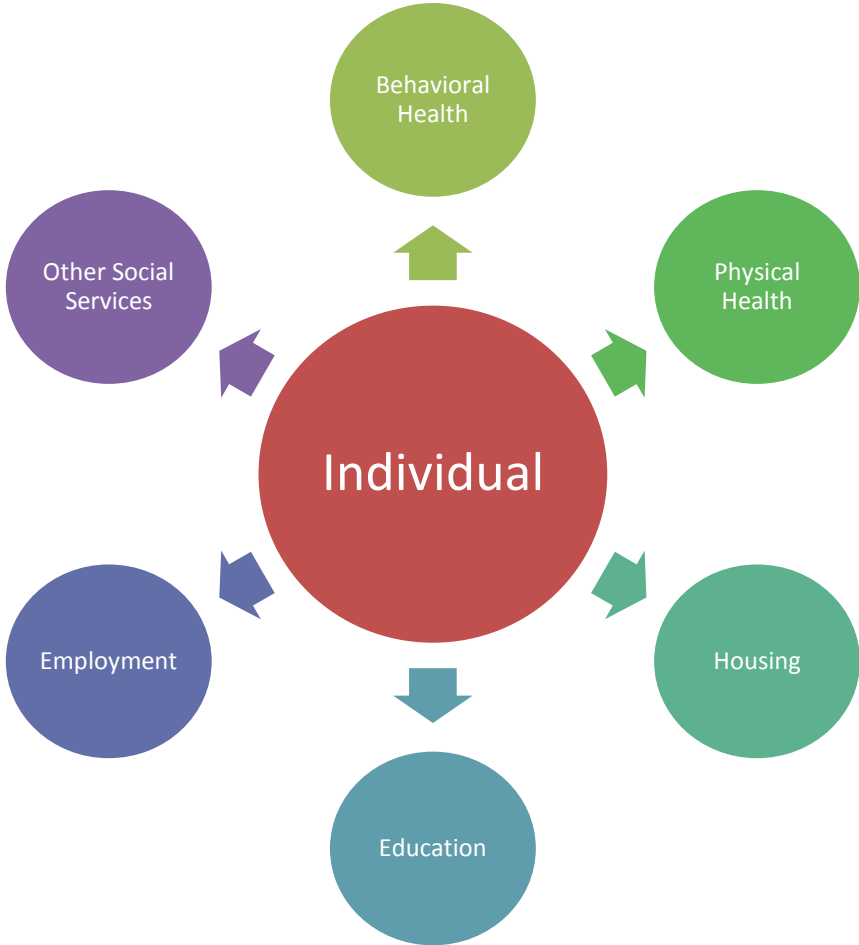
The CCBHC Recovery Focus means we also include *Community* & *Natural Supports*
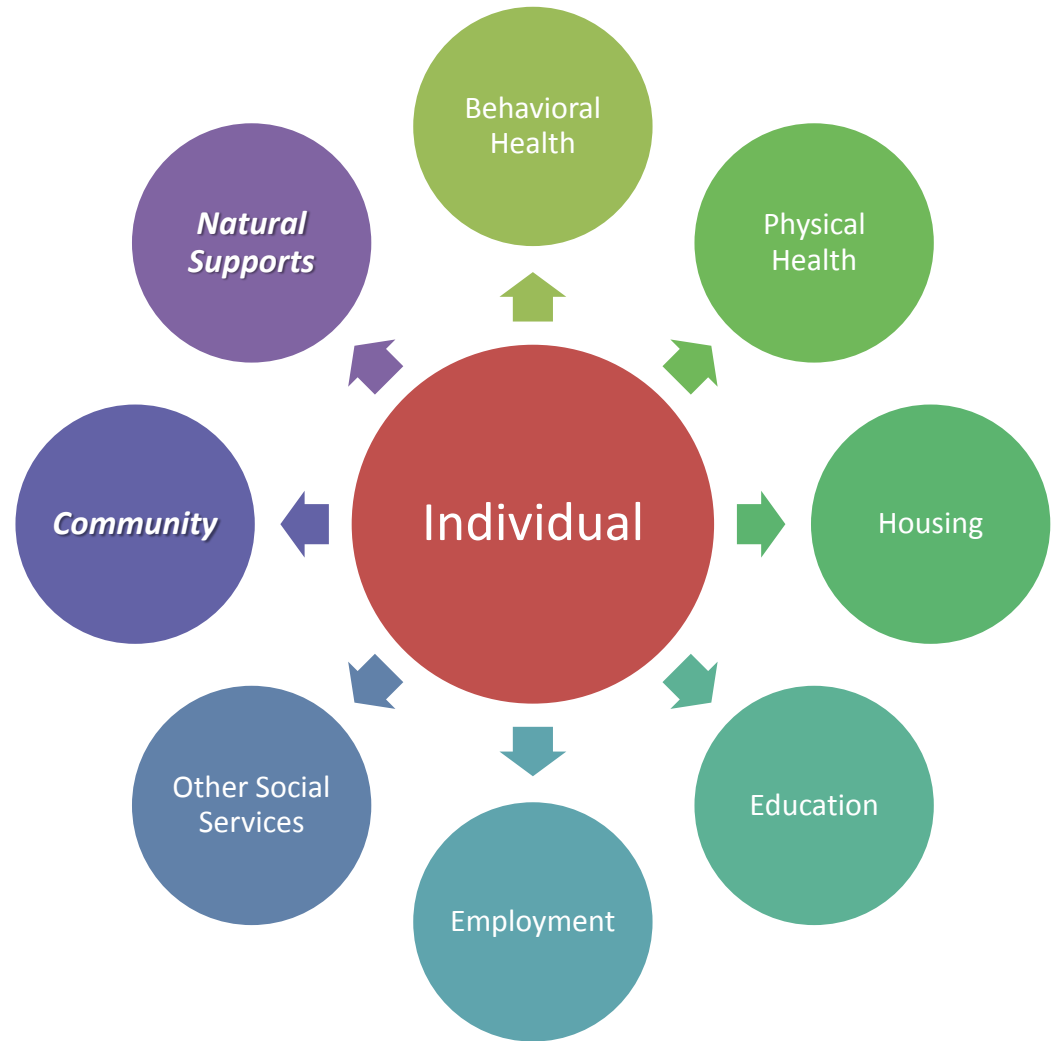
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MY TOTAL-HEALTH PLAN

MY CARE TEAM			
NAME	ROLE / RELATIONSHIP	CLINIC / LOCATION	TELEPHONE

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Communication & Documentation for CCBHC Care Coordination

AHRQ Definition: "….the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient."

Communication and Documentation

- Health care providers may always listen to a consumer's family and friends.
- If a consumer consents and has the capacity to make health care decisions, health care providers may communicate protected health care information to a consumer's family and friends.
- Given this, the CCBHC ensures consumers' preferences, and those of families of children and youth and families of adults, for shared information are adequately documented in clinical records, consistent with the philosophy of person and family-centered care.
- Necessary consent for release of information is obtained from CCBHC consumers for all care coordination relationships.
- If CCBHCs are unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program requirement 3, such attempts must be documented and revisited periodically.

Requirement 3.a.5: Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers for CCBHC consumers and, upon appropriate consent to release of information, to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.

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MY TOTAL-HEALTH PLAN

PHARMACY		
PHARMACY NAME	ADDRESS / LOCATION	TELEPHONE
My Medications		
MEDICATION NAME	DIRECTIONS	REASON FOR TAKING

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Care Coordination & Individual's Goals, Preferences

Whole Person Care and successful communication among providers starts with knowing individuals goals and preferences

Care Coordination and Required Treatment Planning

- Person- and Family-Centered Treatment Planning: A collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible.
    - Strength-based and focuses on individual capacities, preferences, and goals.
    - Individuals and families are core participants in the development of the plans and goals of treatment.
    - Strengthens the voice of the individual, builds resiliency, and fosters recovery.

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MY TOTAL-HEALTH PLAN

INSTRUCTIONS

Use this form for the information that you would like to share with all of your care team -- including your doctor(s), nurses, counselors, or others. Show your providers this information at your visits so that everyone on your team knows about your personal health goals.

THIS PLAN BELONGS TO:

Your Name

.MY HEALTH GOALS

GOAL DESCRIPTION	STEPS I NEED TO TAKE TO MEET THIS GOAL
Goal #1	1.
	2
	3.
Goal #2	1.
	2
	3.
Goal #3	1.
	2
	3.

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Communication is always in the context of individual's goals and preferences – and includes relevant aspects of their community and natural supports

CC & Client Goals, Preferences

Requirement 3.a.4: Care coordination activities are carried out:

- In keeping with the consumer's preferences and needs for care and, to the extent possible and
- In accordance with the consumer's expressed preferences, with the consumer's family/caregiver and other supports identified by the consumer.

Requirement 3.a.6: Nothing about a CCBHC's agreements for care coordination should limit a consumer's freedom to choose their provider with the CCBHC or its DCOs.

Requirement 3.b.4: The CCBHC will work with DCOs to ensure all steps are taken including obtaining consumer consent, to comply with privacy and confidentiality requirements per State and Federal Laws
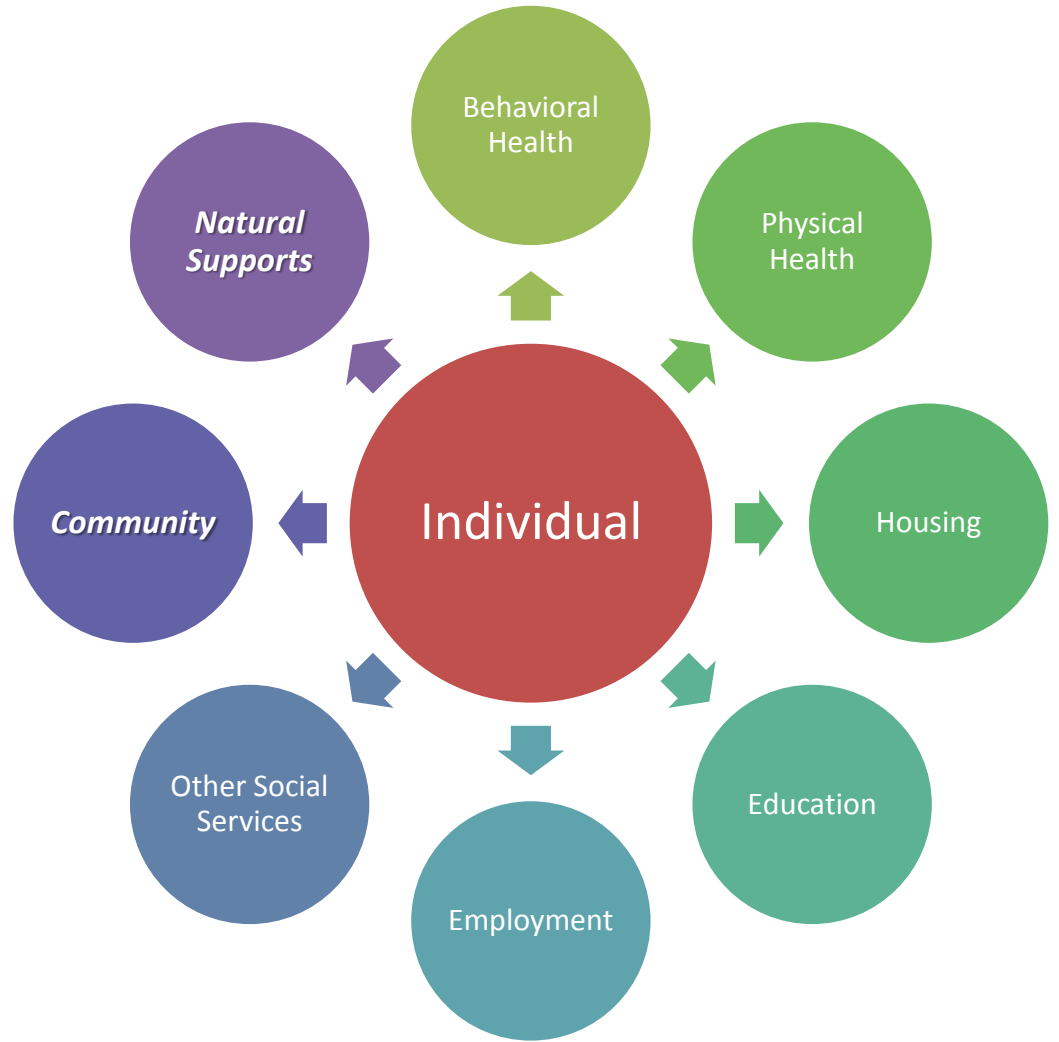
Care Coordination & Access

It's more than just a referral…...

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Care coordination assures timely access to appropriate services

MY TOTAL-HEALTH PLAN

REFERRALS AND OTHER CARE COORDINATION TASKS FOR FOLLOW UP	
TASK	**DATE**

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Care Coordination & Access

Care coordination will drive timely access, reveal new problems in accessibility to be addressed, and generally drive resolution of barriers to access;

Requirement 3.a.3:   Consistent with requirements of privacy, confidentiality, and consumer preference and need, the CCBHC assists consumers and families of children and youth, referred to external providers or resources, in obtaining an appointment and confirms the appointment was kept.

Treatment Team, Treatment Planning And Care Coordination Activities

The heart of care coordination

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The CCBHC treatment team includes the individual, the family/caregiver of child consumers, the adult consumer's family to the extent the consumer does not object, and any other person the consumer chooses

The CCBHC interdisciplinary team is composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of CCBHC consumers,

MY TOTAL-HEALTH PLAN

MY CARE TEAM			
NAME	ROLE / RELATIONSHIP	CLINIC / LOCATION	TELEPHONE

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Treatment Team, Treatment Planning And Care Coordination Activities

Requirement 3.d.1: The CCBHC treatment team includes the consumer, the family/caregiver of child consumers, the adult consumer's family to the extent the consumer does not object, and any other person the consumer chooses.

- All treatment planning and care coordination activities are person-centered and family-centered and aligned with the requirements of
- All treatment planning and care coordination activities are subject to HIPAA and other federal and state laws, including patient privacy requirements specific to the care of minors.
- The HIPAA Privacy Rule does not cut off all communication between health care professionals and the families and friends of consumers. As long as the consumer consents, health care professionals covered by HIPAA may provide information to a consumer's family, friends, or anyone else identified by a consumer as involved in their care.

Requirement 3.d.2: As appropriate for the individual's needs, the CCBHC designates an interdisciplinary treatment team that is

- responsible, with the consumer or family/caregiver, for directing, coordinating, and managing care and services for the consumer.
- The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of CCBHC consumers,
- including, as appropriate, traditional approaches to care for consumers who may be American Indian or Alaska Native.

Requirement 3.d.3: The CCBHC coordinates care and services provided by DCOs in accordance with the current treatment plan

MY TOTAL-HEALTH PLAN

INSTRUCTIONS

Use this form for the information that you would like to share with all of your care team -- including your doctor(s), nurses, counselors, or others. Show your providers this information at your visits so that everyone on your team knows about your personal health goals.

THIS PLAN BELONGS TO:

Your Name

.MY HEALTH GOALS

GOAL DESCRIPTION	STEPS I NEED TO TAKE TO MEET THIS GOAL
Goal #1	1.
	2
	3.
Goal #2	1.
	2
	3.
Goal #3	1.
	2
	3.

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MY TOTAL-HEALTH PLAN

CARE COORDINATION PLAN

Patient Name	DOB	MR Number

GOAL #1			
Date Opened		Date Closed	Closed Reason
Problem or Need			
Goal			

What Will You Do To Help The Patient To Achieve This Goal?

Who Is Responsible For Action?	Activity Description	
How do you plan to measure progress toward this goal?	What is the target? (Example: PHQ -9 score, number of days per week of walking, etc.)	**WHEN do you anticipate meeting this target measure?**

Progress In Achieving Goal

Date of Update	Measure or Description of Progress/Status	Date of Update	Measure or Description of Progress/Status
1		4	
2		5	
3		6	

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Care Coordination & Crisis Prevention/Management

Coordination will be designed to prevent crisis, assure its accessibility when unavoidable, assure post-crisis continuity of care, etc.;

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Care Coordination & Crisis Prevention/Management

Requirement 3.a.4:

- So as to ascertain in advance the consumer's preferences in the event of psychiatric or substance use crisis, CCBHCs develop a crisis plan with each consumer.

- Examples of crisis plans may include a Psychiatric Advanced Directive or Wellness Recovery Action Plan.

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Care Coordination & Health Information Technology

All of these requirements and processes depend on robust HIT

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Care Coordination and HIT

Requirement 3.b.1: **T**he CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records.

- The health IT system has the capability to capture structured information in consumer records (including demographic information, diagnoses, and medication lists), provide clinical decision support, and electronically transmit prescriptions to the pharmacy.
- To the extent possible, the CCBHC will use the health IT system to report on data and quality measures as required by program requirement 5.

Requirement 3.b.3: If the CCBHC is establishing a health IT system, the system will have the capability to capture structured information in the health IT system (including demographic information, problem lists, and medication lists).

- CCBHCs establishing a health IT system will adopt a product certified to meet requirements in 3.b.1, to send and receive the full common data set for all summary of care records and be certified to support capabilities including transitions of care and privacy and security.
- CCBHCs establishing health IT systems will adopt a health IT system that is certified to meet the "Patient List Creation" criterion (45 CFR §170.314(a)(14)) established by the Office of the National Coordinator (ONC) for ONC's Health IT Certification Program.

Care Coordination and HIT

Requirement 3.b.5: Whether a CCBHC has an existing health IT system or is establishing a new health IT system, the CCBHC will develop a plan to be produced within the two-year demonstration program time frame to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system.

- This plan shall include information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care.

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Care Coordination & Quality Improvement

CCBHC development and management will rely on continuous quality improvement processes and techniques

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Care Coordination & Quality Improvement

Requirement 3.b.2: **T**he CCBHC uses its existing or newly established health IT system to conduct activities such as population health management, quality improvement, reducing disparities, and for research and outreach.

- Quality improvement activities will be designed to support care coordination, including data collection and tracking to reveal when it is not sufficiently effective and where there are opportunities for improvement.

Care Coordination Agreements with DCOs

CCBHC is responsible for all care coordination, whether it involves coordination within the CCBHC, with a *designated collaborating organization* (DCO), or with another entity identified in the statutory language related to care coordination

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Care Coordination is supported by formal agreements with array of DCOs to support the full scope of Whole Person care

CCBHC

Behavioral Health (if needed)

Primary Care

Housing & Residential Care

Educational Institutions

Employment Support Services

Other Social Services

Urgent & Emergency Care

Inpatient Services

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Care Coordination Agreements

Requirement 3.c.1: The CCBHC has an agreement establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics [RHCs]) to provide health care services, to the extent the services are not provided directly through the CCBHC.

- For consumers who are served by other primary care providers, including but not limited to FQHC Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination.

Requirement 3.c.2: The CCBHC has an agreement establishing care coordination expectations

- with programs that can provide inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down services, and residential programs
- to provide those services for CCBHC consumers.
- The CCHBC is able to track when consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non- CCBHC entity.
- The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric, detoxification, and residential settings to a safe community setting.
- This includes transfer of medical records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for suicide prevention and safety, and provision for peer services.

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Care Coordination Agreements

Requirement 3.c.3 The CCBHC has an agreement establishing care coordination expectations with a variety of community or regional services, supports, and providers. Services and supports to collaborate with which are identified by statute include:

- Schools;
- Child welfare agencies;
- Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts);
- 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 CCBHC has, to the extent necessary given the population served and the needs of individual consumers, an agreement with such other community or regional services, supports, and providers as may be necessary, such as the following:

- Specialty providers of medications for treatment of opioid and alcohol dependence;
- Suicide/crisis hotlines and warmlines;
- Indian Health Service or other tribal programs;
- Homeless shelters;
- Housing agencies;
- Employment services systems;
- Services for older adults, such as Aging and Disability Resource Centers; and
- Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs)

Care Coordination Agreements

Requirement 3.c.4 The CCBHC has an agreement establishing care coordination expectations with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department.

- To the extent multiple Department facilities of different types are located nearby, the CCBHC should explore care coordination agreements with facilities of each type.

Care Coordination Agreements

3.c.5   The CCBHC has an agreement establishing care coordination expectations with inpatient acute care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers, in the area served by the CCBHC, to address the needs of CCBHC consumers.

- This includes procedures and services, such as peer bridgers, to help transition individuals from the ED or hospital to CCBHC care and shortened time lag between assessment and treatment.
- The agreement is such that the CCBHC can track when their consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to another entity. The agreement also provides for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge.

The CCBHC will make and document reasonable attempts to contact all CCBHC consumers who are discharged from these settings within 24 hours of discharge.

- For all CCBHC consumers being discharged from such facilities who presented to the facilities as a potential suicide risk,
- the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the consumer within 24 hours of discharge, and continues until the individual is linked to services or assessed to be no longer at risk.

CCBHC Care Coordination Requirements (Section 3)

3.A: General Requirements of Care Coordination

3.B: Care Coordination and Other Health Information Systems

3.C: Care Coordination Agreements

3.D: Treatment Team, Treatment Planning and Care Coordination Activities

Where We Go From Here

- CCBHC Workgroups will develop statewide standards for care coordination in California
  - To meet the Federal CCBHC requirements
  - To build on the successes already in place around the state
  - To reflect the unique needs of a state as large and diverse as ours

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Feedback & Guidance

- In anticipation of the Care Coordination Workgroup convening, what guidance do you have for:
  - The role of peers in care coordination
  - Assuring cultural sensitivity in approaches to care coordination
  - Other important aspects of successful care coordination

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EVALUATION
AND RESEARCH

Thank You!

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OPEN DISCUSSION

Evaluation

Your feedback is important to us.

In your packet there is an evaluation form for this Forum.

Please complete the evaluation form now.

Return your evaluation before you leave.

Contact Information

Please e-mail questions, comments or concerns to:
MHSUDStakeholderInput@dhcs.ca.gov

Break
Please return at 11:00am

DHCS Behavioral Health Forum Client and Family Member Forum

December 14th , 2015
11:00 a.m. to 12:00 p.m.

Client and Family Member Forum

Jane Adcock, Executive Director
California Mental Health Planning Council

Today's Panelist

Vera Calloway, *Peer Advocate and USC Certified Health Navigator*, Los Angeles County

Cindy Claflin, *The Institute for Parent Leadership Training for United Advocates for Children and Families,* Sacramento County

Vanessa Lopez*, RAIZ Promotores Program,* Stanislaus County

Yesenia Garcia, *Community Promotora, Stanislaus County*

Rossy Gomar, *RAIZ Promotora, Stanislaus County*

OPEN DISCUSSION

Discussion

How has the CHW/Navigator/Promotores services helped from the consumers' perspective? What are the biggest barriers and common issues faced by consumers and family members in accessing and navigating care?

LUNCH BREAK
12:00 p.m. – 1:00 p.m.

DHCS Behavioral Health Forum
Prospective Payment System for CCBHCs:
Policy and Operational Consideration

Presenter: Nina Marshall, MSW,
Senior Director, Policy and Practice Improvement, National Council for Behavioral
Health

December 14th , 2015
1:00 p.m. to 2:15 p.m.

1. Inside medical homes
2. Behavioral health specialty centers of excellence

CCBHC:

Certified Community

Behavioral Health Clinics

Think but don't **say** FQ**B**HC
- Paid for actual costs of providing services
- Have common scope of services
- Have common quality metrics
- A federal definition – commonality across state provider networks

H.R. 4302: passed March 2014
- $1.1 billion investment in behavioral health
- Certified Community Behavioral Health Clinic framework
- Two phases:
  - ✓ Planning grant phase
  - ✓ Demonstration phase

Proposed:

- ✓ Target Medicaid population
- ✓ Site selection process
- ✓ EBPs to be required of CCBHCs
- ✓ PPS option → California chose PPS-2

Required activities October 2015-October 2016

1. Solicit input
2. Certify clinics (at least two, can be all)
3. Establish a PPS
4. Develop capacity to provide CCBHC services
5. Develop or enhance data collection and reporting capability
6. Prepare for participation in national evaluation
7. Submit a demonstration proposal

Federal Match for States

- Federal Match (FMAP) follows beneficiary eligibility:
  - ✓ Regular Medicaid: Enhanced FMAP (**65%** instead of 50% in CA)
  - ✓ Expansion population: 100% now, down to 90% by 2020
  - ✓ Medicaid CHIP Expansion: Enhanced FMAP +23%
  - ✓ Served by Indian Health Services Clinics: 100%
- **State plan authority not necessary for payment** for CCBHC services delivered by certified clinics
- States may claim administrative expenditures that support the development and implementation of the demonstration

Minimum Standards

Areas that an organization must meet to achieve CCBHC designation:

1. Staffing
2. Accessibility
3. Care coordination
4. Service scope
5. Quality/reporting
6. Organizational authority

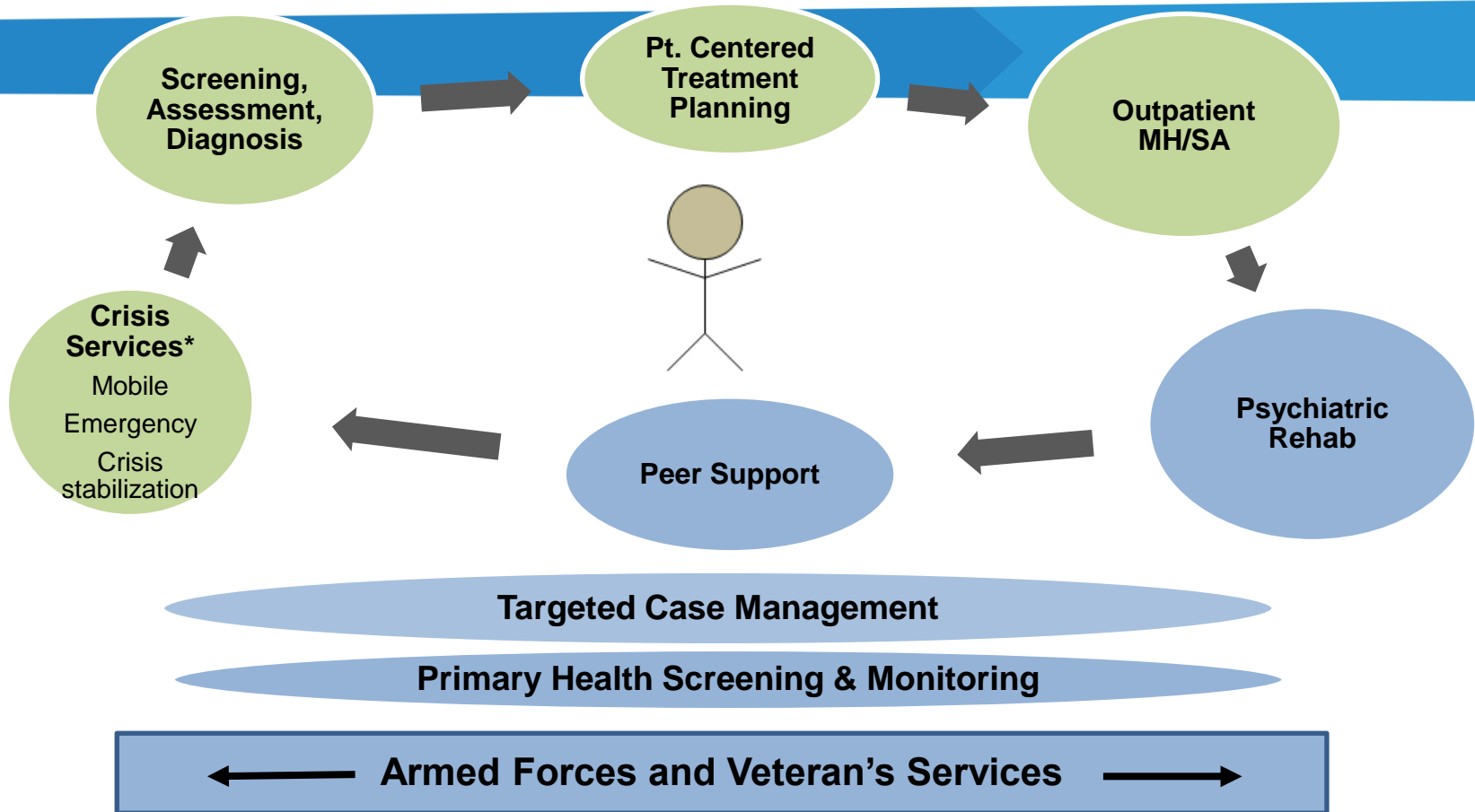*See MTM's Certification Criteria Readiness Tool for detail

Partnerships (MOA, MOU) or care coordination agreements required with:

- ✓ FQHCs/rural health clinics, unless the CCBHC provides comprehensive healthcare services
- ✓ Inpatient psychiatry and detoxification
- ✓ Post-detoxification step-down services
- ✓ Residential programs
- ✓ Other social services providers, including
    - Schools
    - Child welfare agencies
    - Juvenile and criminal justice agencies and facilities
    - Indian Health Service youth regional treatment centers
    - Child placing agencies for therapeutic foster care service
- ✓ Department of Veterans Affairs facilities
- ✓ Inpatient acute care hospitals and hospital outpatient clinics

- CCBHC coordinates care across the spectrum of health services, including physical and behavioral health and other social services

- CCBHC establishes or maintains electronic health records (EHR)
  - ✓ Health IT system is used to conduct population health management, quality improvement, reducing disparities, and for research and outreach

CCBHC Scope of Services

Screening, Assessment, Diagnosis

Pt. Centered Treatment Planning

Outpatient MH/SA

Crisis Services*
Mobile
Emergency
Crisis stabilization

Peer Support

Psychiatric Rehab

Targeted Case Management

Primary Health Screening & Monitoring

Armed Forces and Veteran's Services

○ Delivered directly by CCBHC
○ Delivered by CCBHC or a Designated Collaborating Organization (DCO)

- Formal relationship, not direct supervision
- Delivers services under "same requirements" – up for interpretation
- Payment included in PPS
- DCO encounter = CCBHC encounter
- CCBHC is clinically responsible
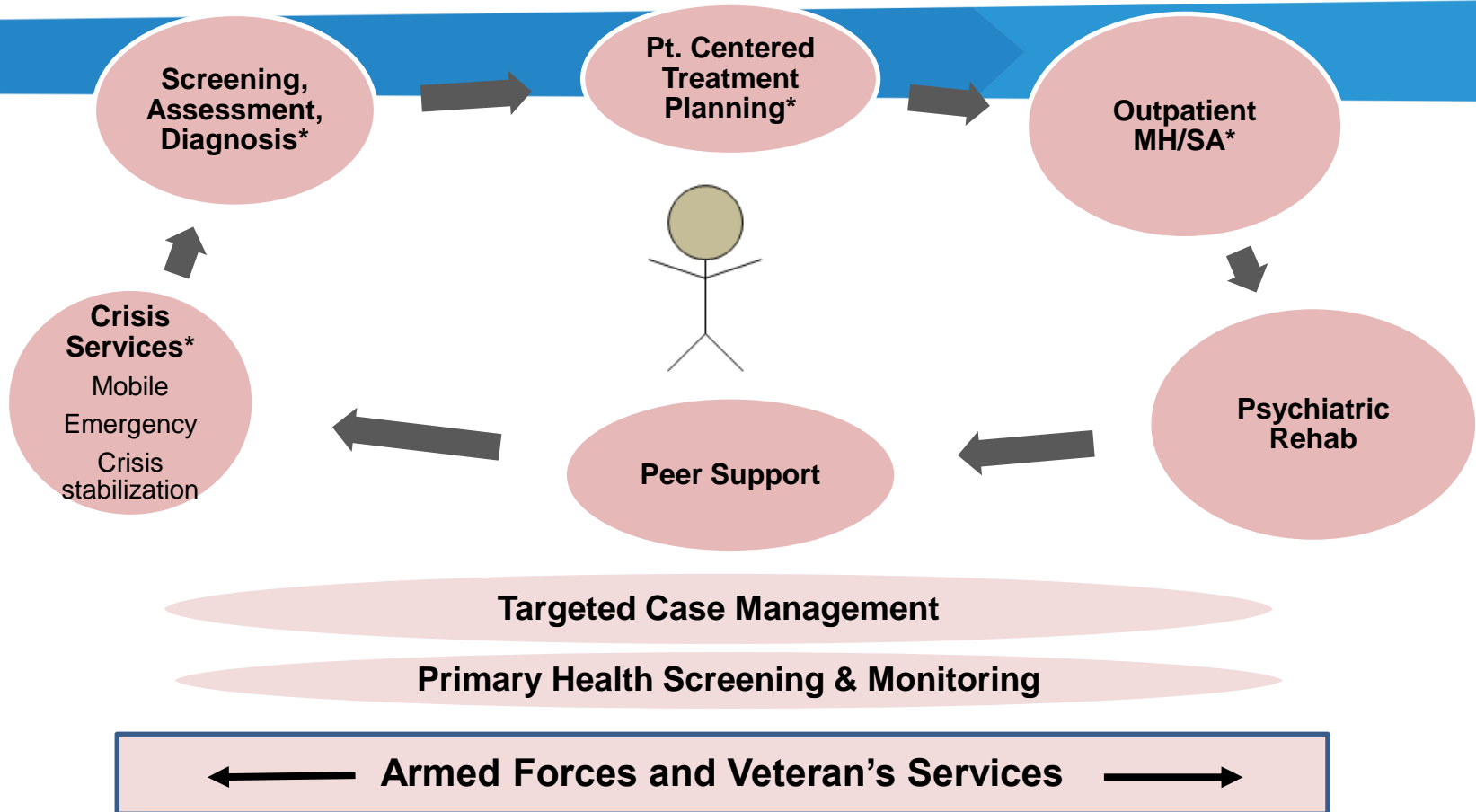
- States select 1 of 2 PPS rates
  1. FQHC-like PPS
     - Reimbursement of cost on daily basis
  2. CC PPS Alternative
     - Reimbursement of cost on monthly basis
     - Layered payments for clients with certain conditions
     - Outlier payments

- PPS Rate will include cost of DCO services

- Quality **Bonus** Payments – On top of PPS
  - ✓ Optional for FQHC-like PPS Option
  - ✓ Required for Alternative PPS Option

Required Measures for Quality Bonus Payments:
1. Follow-Up after Hospitalization for Mental Illness (adult age groups)
2. Follow-Up after Hospitalization for Mental Illness (child/adolescents)
3. Adherence to Antipsychotics for Individuals with Schizophrenia
4. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
5. Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
6. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Eligible Measures for Quality Bonus Payments:

1. Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication
2. Screening for Clinical Depression and Follow-Up Plan
3. Antidepressant Medication Management
4. Plan All-Cause Readmission Rate
5. Depression Remission at Twelve Months-Adults

States may propose quality measures for QBP; however, CMS approval is required.

- # Demonstration Year 1 Rates
  - Cost and visit data gathered during planning phase;
  - May include **estimated costs** for services/items projected for demo phase
  - Updated by Medicare Economic Index (MEI)

- # Demonstration Year 2 Rates
  - Update of DY1 rates with MEI

    Or

  - Rebasing

CCBHC PPS payments trump all

- FQHCs

- Clinics

- Tribal Facilities

Excluded services:

- Inpatient care

- Residential treatment

- Room and board expenses

State Options

1. Fully incorporate the PPS payment into the managed care capitation rate;

or

2. Year-end reconciliation process to make a wraparound supplemental payment to ensure that the total payment is equivalent to CCBHC PPS.

$$\frac{\text{Total } \textit{Anticipated} \text{ Cost of Services}}{\text{Total } \textit{Anticipated} \text{ \# Visits}} = \textbf{Encounter Rate}$$

$$\frac{\text{Total } \textit{Anticipated } \text{Cost of Services}}{\text{Total } \textit{Anticipated } \text{\# Visits}} = \textbf{Encounter Rate}$$

- Know your costs of <u>CCBHC</u> Services (no residential)
- Know your <u>DCO's</u> costs
- Know your <u>number</u> of <u>visits</u>

$$\frac{\text{Total } \textbf{\textit{Anticipated}} \text{ Cost of Services}}{\text{Total } \textbf{\textit{Anticipated}} \text{ \# Visits}} = \textbf{Encounter Rate}$$

- Know your costs of <u>CCBHC</u> Services (no residential)
- Know your <u>DCO's</u> costs
- Know your <u>number</u> of <u>visits</u>
- Know utilization patterns for clients
- Know utilization patterns for clients with certain conditions
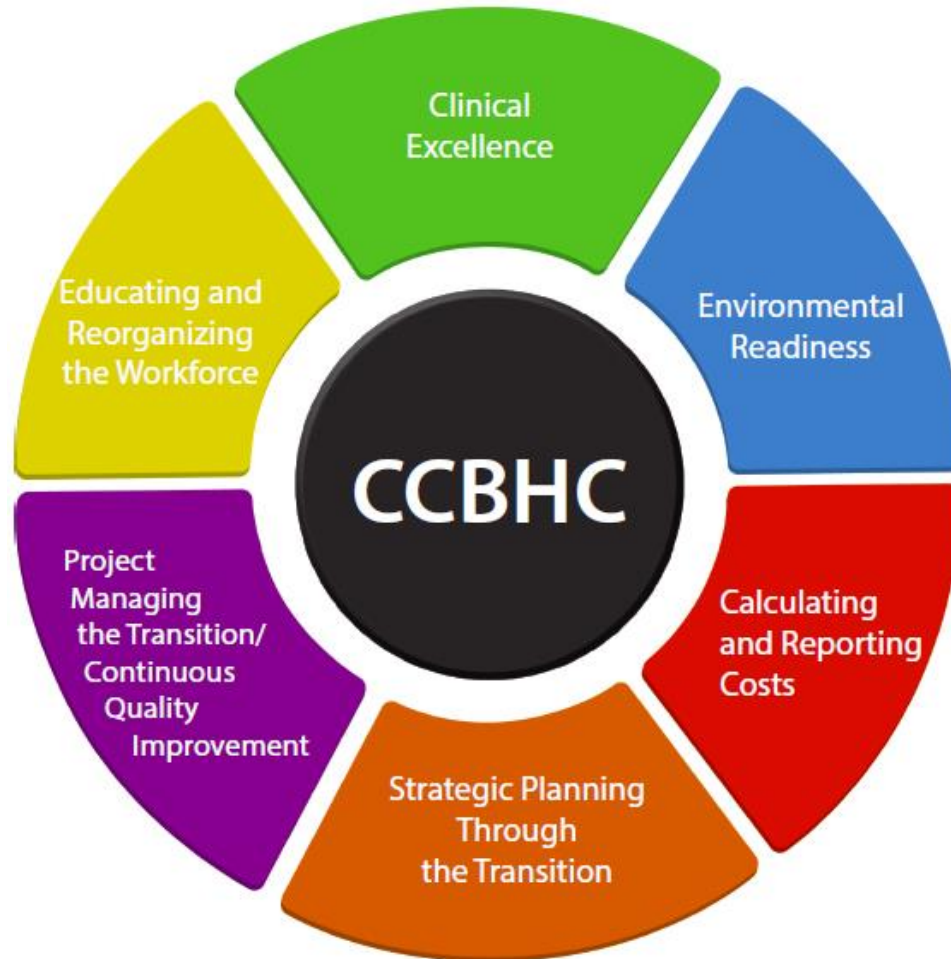
Thank you!

Nina Marshall, MSW
Senior Director, Policy and Practice Improvement
NinaM@thenationalcouncil.org
National Council for Behavioral Health

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Contact Information

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End of the Day Reflections and Next Steps

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Next Forum Meeting Date

Behavioral Health Forum Forums will be meeting on:

February 1st , 2016