SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

M E M O R A N D U M

Date: September 17, 2019

To: All Clinical staff

From: QCM, Ana Vicuna, Division Chief for Clinical Operations

Subject: Care Coordination through Team Based Care (TBC)

CC: Pam Fisher, Deputy Director for Clinical Operations

Team Based Care (TBC) is an approach where consumers in our system are supported by an integrated team all working together. Behavioral Wellness integrated TBC into their practices in 2016-17. Since that time, Supervisors and Managers have been required to oversee and ensure that the teams within the clinics run effective team-based meetings that focus on client centered care and ensure that case coordination and continuity of care occur.

With the additional NACT requirements mandated by the state, it is imperative that each clinic continue TBC and ensure that every client has an assigned care coordinator and be informed of the name of their assigned care coordinator. As such, the department has created a Care Coordinator brochure to give to each client in order to assist them with understanding TBC and identifying their Care Coordinator. It is imperative that each client is provided with a brochure so that they have this information in writing.

This memo is to ensure that staff understand the importance of this need and that each clinic staff also knows the process and tools to document Team Based Care. Coordination, collaboration, and communication are vital components when multiple providers and various agencies are serving the same client. To achieve this, it crucial to identify one person to take the lead in providing general oversight and coordination of all necessary service components for the client as well as to ensure that clients are aware of how services are planned and added when needs are identified. This coordination creates the best opportunity to ensure positive outcomes while avoiding the pitfalls of unnecessary or wasteful duplication of services, or providers working at cross purposes resulting in clients not getting the support they need to keep them engaged and connected.

DEFINITION

Care Coordinator (CC) – the designated person to oversee and appropriately manage a client's behavioral health service needs. This may be a Licensed/Waivered Mental Health Professional (LMHP), a Behavioral Wellness Case Worker. Individuals working for Community Based Organizations (CBOs) may also serve as the Care Coordinators.

EXPECTATION

The Care Coordinator will manage the services between the current treatment providers, other managed care organizations, and other human service agencies including community and social support providers, as appropriate. This will include all Behavioral Wellness clients—both in children's and adult services. The Care Coordinator may or may not be the lead clinician, depending on program needs. The Care Coordinator will facilitate the TBC approach to communicate and collaborate between service providers to ensure quality of care without duplication of services. Releases of Information (ROIs) must be in place for ongoing coordination of care. This will be true whether the provider is a Behavioral Wellness staff member or staff with a contracted CBO provider. The overall point of establishing a Care Coordinator is to ensure clients are aware of the name of the person to call and who is in charge of their coordinated care. ROIs will be in place for ALL ongoing coordination efforts.

In TBC meetings, Care Coordination is key in order to discuss and plan appropriate treatment and how services are planned for/added when needs are identified.

CARE COORDINATION ACTIVITIES

The Care Coordinator (CC) will monitor services between settings of care and other managed care organizations and other human services agencies including community and social support providers, as appropriate. In addition to monitoring, the CC will ensure this is shared at TBC meetings and documented.

Examples:

1. Between settings of mental health care (including Fee-For-Service Providers)
2. Physical Health Organizations (e.g. Medi-Cal Managed Care Plan, CenCal/Holman)
3. Department of Children's Services (CWS)
4. Other Human Service Agencies (e.g. Public Health, FQHC's)
5. Community and Social Support Providers
6. Education Programs
7. Housing
8. Rehabilitative Services

The Care Coordinator will ensure that, in the course of coordinating care, the privacy of each beneficiary is protected in accordance with all federal and state privacy laws.

The CC will communicate and coordinate with all mental health providers on a routine basis to establish and monitor mutual client goals. At a minimum, the CC will document

monthly contacts with all individuals providing direct mental health services and incorporate the other services and coordination discussed into the Team Based Care Progress Note template as well as ensure the services are part of the Client Plan. More frequent contacts/communication with the treatment team to coordinate care may be necessary when a client is receiving more intensive services (i.e. TBS, Wraparound, ICC, IHBS or ACT or when multiple providers are involved in the treatment). There is a Care Coordination brochure that you will give to your client when the CC is established.

SPECIAL NOTE

The Care Coordinator is NOT liable for the failure of other agencies responsible for non-mental health services to provide indicated services or to ensure the agency participates in coordination efforts. However, any breakdown in participation must be documented in progress notes.

To Document in the Electronic Health Record (Gateway)

When the CC is established with the client, please enter the CC into the TBC Progress Note Template for tracking purposes and any time the CC changes and a new CC is established.

References: Contract with DHCS citing WIC 14683, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code) and the Child Health and Disability Prevention Program (Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code.