GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER		
TITLE: Care Coordination	**POLICY NO.:** CL-AP-18	Page 1 of 4
RESPONSIBILITY: Clinical Programs		
APPROVED BY: _____ for THERESA C. ARRIOLA, DIRECTOR	**DATE OF ORIGINAL APPROVAL:** 7/25/22	
	LAST REVIEWED/REVISED: 7/25/22	

PURPOSE

To provide a structure that defines case management and service coordination activities in partnership and collaboration with the consumer, natural supports, service providers, and healthcare providers. This policy follows Commission on Accreditation of Rehabilitation Facilities (CARF) standard Section 3B and Certified Community Behavioral Health Clinic (CCBHC) Criteria 3 General Requirements of Care Coordination.

POLICY

A. Guam Behavioral Health and Wellness Center (GBHWC) coordinates care across the spectrum of health services, including access to high-quality physical health and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person.

B. GBHWC shall work with partnered agencies and Designated Collaborating Organization (DCO) to ensure all steps are taken, including obtaining consumer consent, to comply with privacy and confidentiality requirements, including but not limited to those of Health Insurance Portability and Accountability Act (HIPAA), 42 CFR part 2, and other federal and state laws, including patient privacy requirements specific to minors.
    1. GBHWC may release information to other treating providers or emergency departments not affiliated with GBHWC if necessary for safe and quality care.
    2. For non-urgent care, GBHWC shall obtain consent from the consumer before the release of information to other treating providers not affiliated with GBHWC.

C. GBHWC provides care coordination to meet the consumer needs and preferences in the delivery of care. A Lead Provider (LP) is identified to coordinate care with other service providers and facilitate treatment planning in addressing both the physical and behavioral health needs of the consumer.
    1. The LP shall provide integrated and coordinated care to the consumers to identify and coordinate all aspects of their health to include but not limited to their medical, psychosocial, emotional, therapeutic, and recovery support needs to include if appropriate, traditional approaches to care.
    2. GBHWC shall form agreements for care coordination with DCOs such as Medical Facilities, Public Health Community Health Centers, and other agency partners to provide healthcare services, to the extent the services are not provided directly by GBHWC.

D. The Lead Provider shall work in collaboration with the consumer, their natural supports, collaborating partnered agencies, and DCO if deemed appropriate to ensure a seamless coordination and/or transition of care to include emergent, urgent, or routine needs.
    1. LP shall document reasonable attempts to determine any medications prescribed by other outside providers for GBHWC consumers.
    2. A warm handoff shall be conducted as appropriate when transitioning individuals between emergency departments, hospitals, inpatient psychiatric stabilization unit, detox unit and residential setting.
    3. Transition to a different level of care shall include transfer of medical records of services received (i.e., prescriptions, clinical summary), active follow up after discharge and, as appropriate, a plan for suicide prevention and safety.
    4. All consumers discharged from GBHWC Inpatient Unit shall have a follow-up care appointment with the LP within 7 days of discharge and follow up at Medication Clinic with a Behavioral Health Provider within 30-45 days of discharge as deemed appropriate.
        a. LP shall make a follow-up call within 24 hours of discharge to consumers who presented as potential suicide risk. LP reviews and check consumer's understanding of the discharge and crisis plan and re-assess risk until the individual is linked to services or assessed to be no longer at risk.

E. Case Management services are provided as part of person-centered treatment planning and is carried out by Social Workers, Direct Care Coordinators, and Direct care Technical Assistance Coordinators
    1. Case management services and its intensity, duration, and frequency will be individually determined based on the assessment tool(s) utilized by the program that a consumer is assigned to. (*Refer to Case Management Scope and Description of Services policy)*
    2. Case Management is provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services.

DEFINITIONS

Agreement	As used in the context of care coordination, an agreement is an arrangement between GBHWC and external entities or Designated Collaborating Organizations with which care is coordinated.
Care Coordination	The deliberate organizing of consumer care activities and sharing of information among all the participants concerned with a consumer's care to achieve safer and more effective care (AHRQ, 2014). Any activities that have the purpose of coordinating and managing the care and services furnished to each consumer including both behavioral and physical health regardless of whether the care and services are provided directly by GBHWC or through referral or other Designated Collaborating Organizations (DCO).
Case Management	A range of services provided to advocate, assist and support individuals in developing their skills to gain access to needed

	medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human needs. This also includes working with families, and significant others in the consumers recovery from mental health issues; providing linkages and training for the consumer, in the use of basic community resources, and monitoring of overall service delivery (NASMHPD, 2014).
Certified Community Behavioral Health Clinic (CCBC)	A specially designated clinic that provides a comprehensive range of mental health and substance use services, to include the integration of primary care screenings and monitoring.
Designated Collaborating Organization	An entity that is not under the direct supervision of GBHWC- CCBHC but has a formal relationship to deliver services under the same requirements as a CCBHC.
Lead Provider	The LP is the primary provider assigned to each consumer. The LP facilitates behavioral health service planning, implementation, and service delivery of the person served to include engagement of family members, natural supports, and agencies/service providers in addressing the needs of the consumer.
Warm Hand-Off	Linkage of services from one service provider to another. This process is conducted in person, between two members of the healthcare team, in front of the consumer so that he or she can hear what was being discussed about the clinical problem, status and plan of care.

RESPONSIBILITES

A. Lead Provider
   1. Shall coordinate treatment planning schedule with the consumer and other treating providers.
   2. Shall collaborate with consumer, parent/legal guardian and other treating providers in planning, implementation, and review of the treatment plan.
   3. Shall write the comprehensive Individualized Treatment Plan in the electronic behavioral health record (EBHR) within 60 days of admission.
   4. Shall coordinate the care of the consumer.
   5. Ensure that other health related information from other medical providers (i.e., primary care) shall be documented in AWARDS and included in the treatment planning.
   6. Collaborate with consumer, parent/legal guardian, family and/or significant other and other services providers if applicable in assessing medications use, health, economic, and psychosocial functioning.
   7. Advocate and refer for needed services on behalf of the consumer.
   8. Make referral linkages to community resources, assessment of psychosocial problems, provide supportive counseling and other supportive services.
   9. Attend court hearing(s) in the interest of the consumer as needed.
   10. Monitor consumer's progress.
   11. Assist in responding and resolving assigned consumers' crisis as it occurs.

REFERENCES

CARF International. (2020). *Behavioral health standards manual 2020.* Tucson: Commission on Accreditation of Rehabilitation Facilities.

National Action Alliance for Suicide Prevention. (2019). *Best Practices in Care Transitios for Individuals wirh Suicide Risk: Inpatient Care to Outpatient Care.*

SAMSHA. (2015). *Certified Community Behavioral Health Clinic Manual.*

SUPERSEDES: Title; Policy No.; Effective Date/Signature Date; Approving Individual's Name

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REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

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Policy No: CL-AP-18
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