OREGON HEALTH AUTHORITY

May 26, 2026

CCBHC Learning Collaborative:

Program Requirement 3

Care Coordination

Virtual Meeting Housekeeping

This presentation is being recorded. Slides and recording will be posted on the CCBHC website following the learning collaborative.

Please raise your hand within Teams features.

When speaking, please identify yourself and your program/business.

You may put questions in the chat.

Meet the Team

BHD Program, Policy, & Certification

- Chelsea Holcomb
- Katie Rosenthal
- Mali Ross
- Cissie Bollinger
- Mary Stone

Data Reporting

- Erin Macauley
- Gina Turrini
- Katy Holmquist

Rate Setting & Billing

- Richelle Murray
- Rebecca Level
- Wassa DosReis
- Jon Wu
- Kate Tallman
- Kevin Thomas

Project Management & Program Support

- Rafia Razzaque
- Kristy Alberty

Agenda

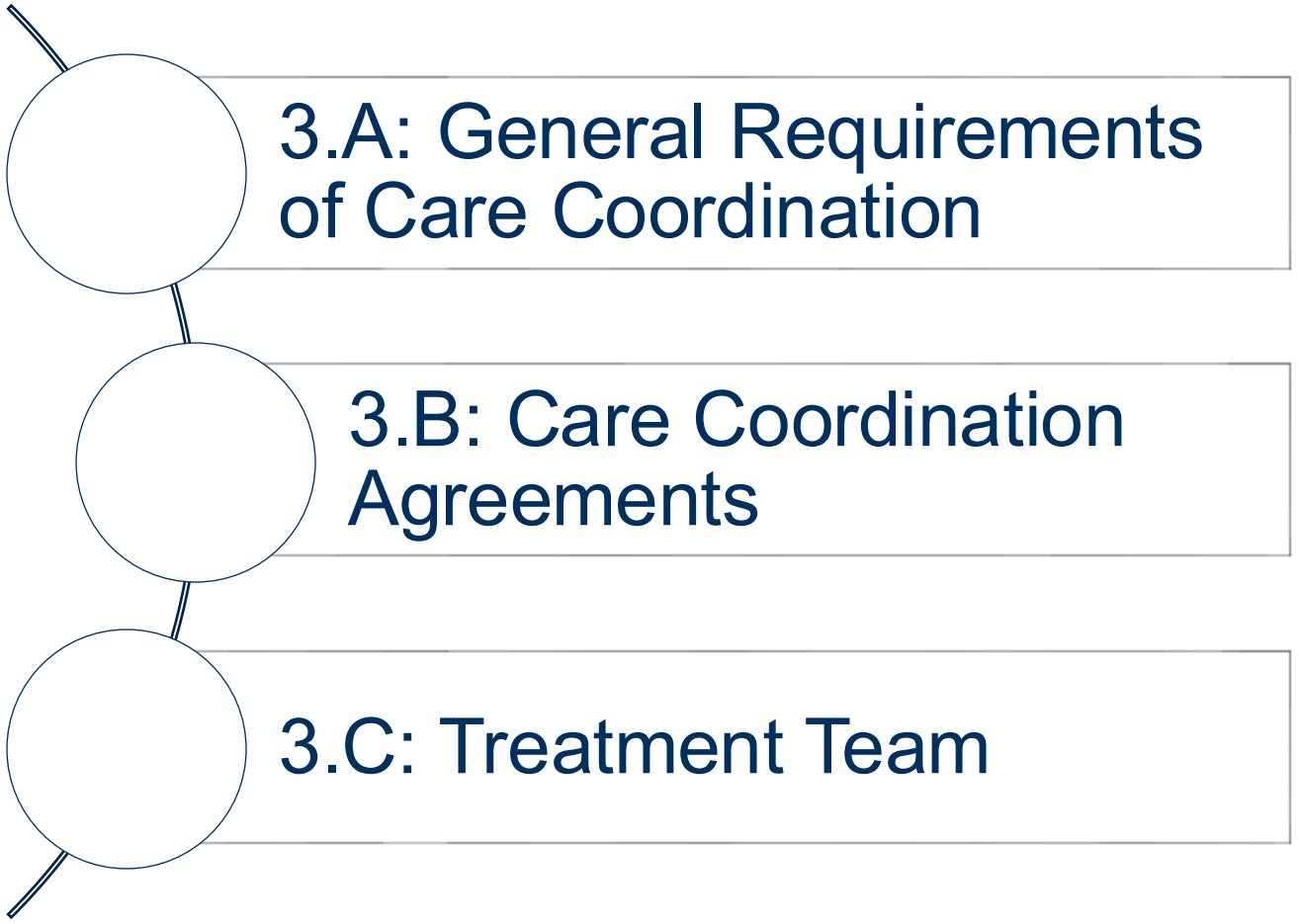
Program Requirement 3: Care Coordination

- ❑ Overview of Criteria
- ❑ Clinic Spotlight: Symmetry Care, Inc.
- ❑ Readiness Considerations
- ❑ Q & A

Care Coordination (22 Criteria)

CCBHCs play a central and essential role in coordinating care, including:

- Assisting with access to the full spectrum of health and wellness supports, including physical and behavioral health care, social services, public benefits, and other resources
- Ensuring information is tracked and shared between providers to facilitate continuity and consistency of care and positive outcomes in treatment
- Designating an interdisciplinary care team to cooperatively support the holistic recovery needs of each individual



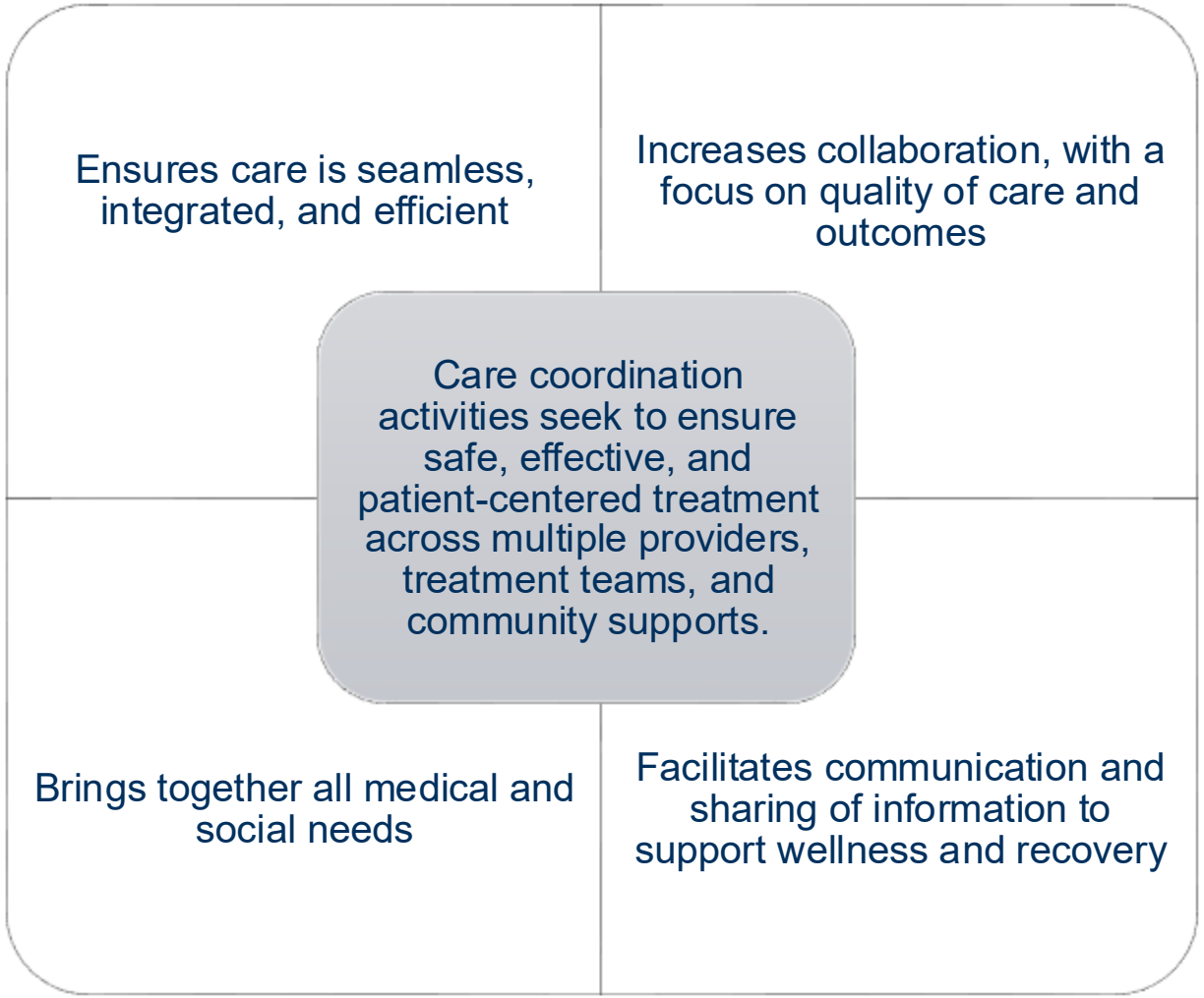
What is Care Coordination?

OAR 309-019-0105(28): “Care coordination means a **process-oriented activity** to facilitate ongoing communication and collaboration to meet **multiple** needs. Care coordination includes:

Facilitating communication between the person or family served, natural supports, community resources, and involved providers and agencies;

Organizing, facilitating, and participating in team meetings;

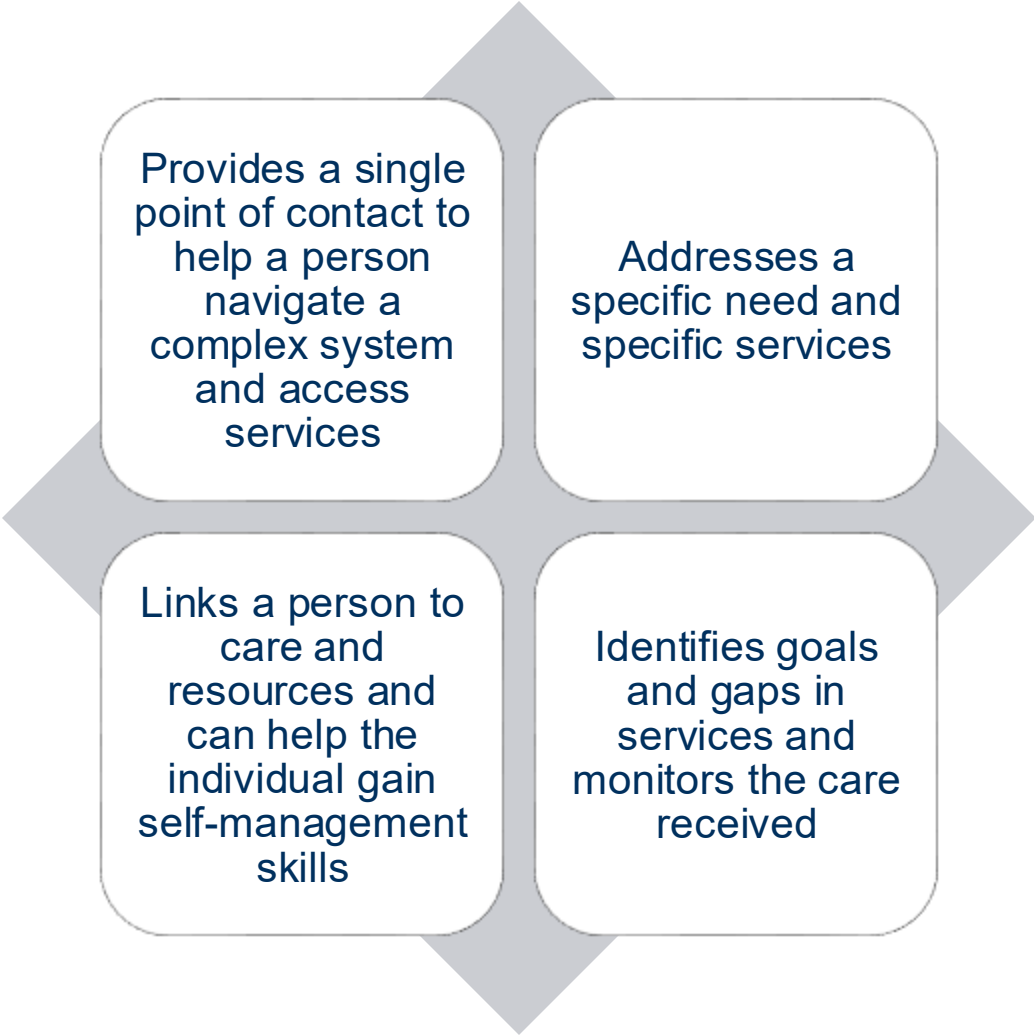
And providing for continuity of care by creating linkages to and managing transitions between levels of care and transitions for young adults in transition to adult services.”



What is Case Management?

Case management is a coordinated, individualized approach that links patients with appropriate services to address their **specific** needs and help them achieve their stated goals.

OAR 309-019-0105(29): “Case management means services provided to assist individuals who reside in a community setting or are transitioning to a community setting in gaining access to desired medical, social, educational, entitlement, and other applicable services.”



Reimbursement for Care Coordination in CCBHC

Care coordination is not a billable service in which a CCBHC may receive their prospective payment system rate (PPS).

However, CCBHCs may capture the cost of care coordination within their cost report by including staffing costs and health information technology costs associated with provision of care coordination.

3.A: General Requirements of Care Coordination

Care Coordination Partnerships

- Written agreements or protocols establishing expectations for coordination of care with a variety of community partners are required.

Access to Services

- Care is coordinated across the spectrum of services facilitating wellness and recovery, including physical and behavioral health care, housing, education, and employment opportunities.

Access to Resources

- CCBHCs assist with access to Medicaid, Social Security benefits, Supplemental Nutrition Assistance Program, and other social services and public benefits.

Children, Youth, and Families

- CCBHCs collaborate with systems serving children and families, such as juvenile justice, child welfare, and schools.
- CCBHCs assist with enrollment in Fidelity Wraparound, as appropriate.

Medications

- CCBHCs attempt to determine medications prescribed by other providers, including accessing the Prescription Drug Monitoring Program.
- CCBHCs have procedures in place to pursue medication reconciliation.

Freedom to Choose

- The freedom of a person to choose their provider within a CCBHC, its DCOs, or an unaffiliated entity is not limited by the CCBHC's care coordination agreements.

Referrals

- A CCBHC may provide a referral for a specific service outside of the CCBHCs scope or to another provider entirely if the CCBHC is unable to serve a person. CCBHCs are responsible for the coordination of care during a referral and must meet all referral requirements.

3.a.6 & 3.a.7: Referrals

For Services Outside of CCBHC's Scope

When referring a person to an external provider for a service, the CCBHC must assist the person in obtaining an appointment and document attempts to confirm the outcome of the referral, as well as document ongoing care coordination.

Ongoing care coordination with a referral partner can be documented through records requests, consultation requests, and other coordination services.

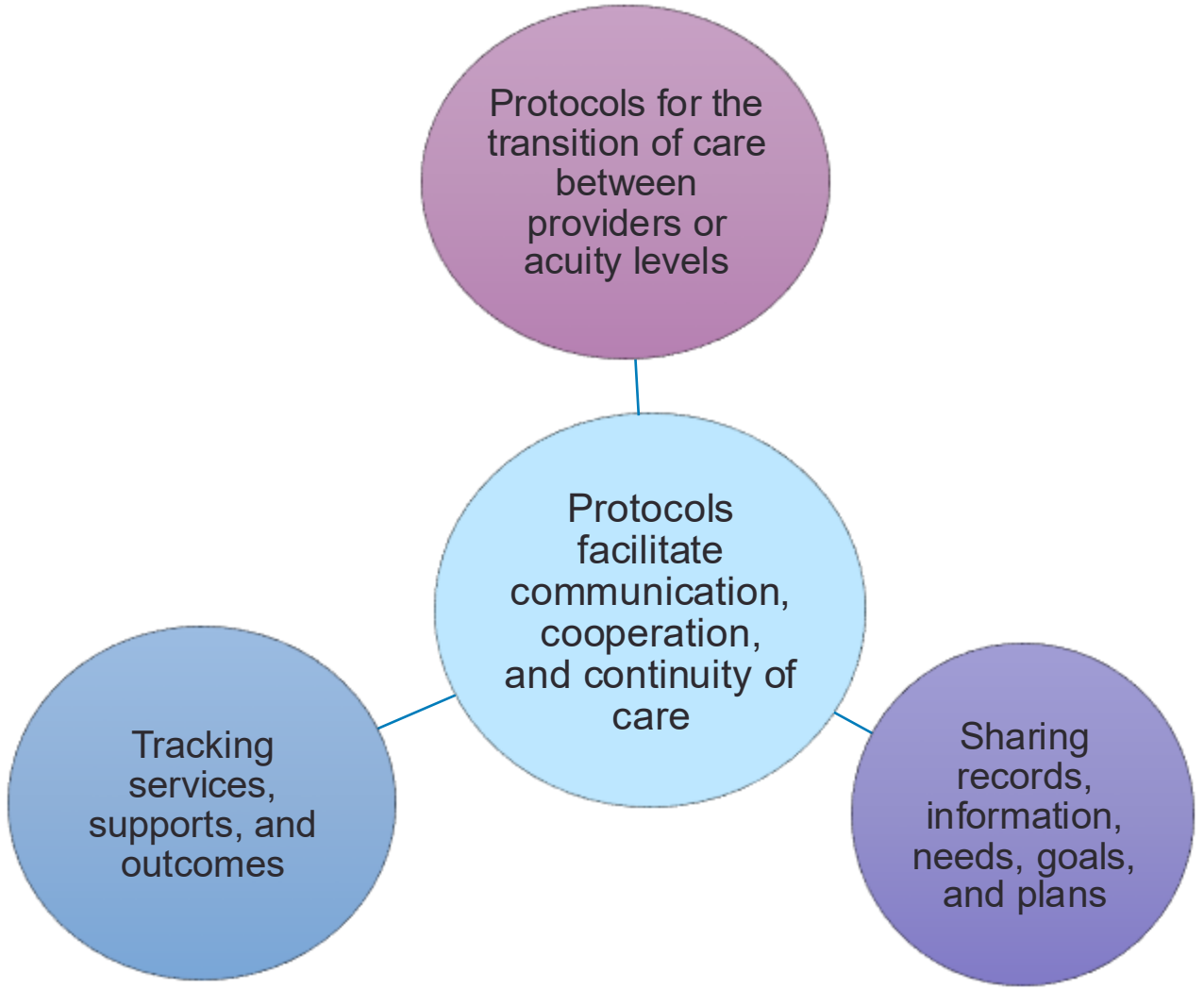
When a CCBHC is Unable to Serve a Person

A CCBHC may refer an individual to another provider if the person requires specialized or intensive care outside of the CCBHC's capability or if the person chooses to move their care elsewhere.

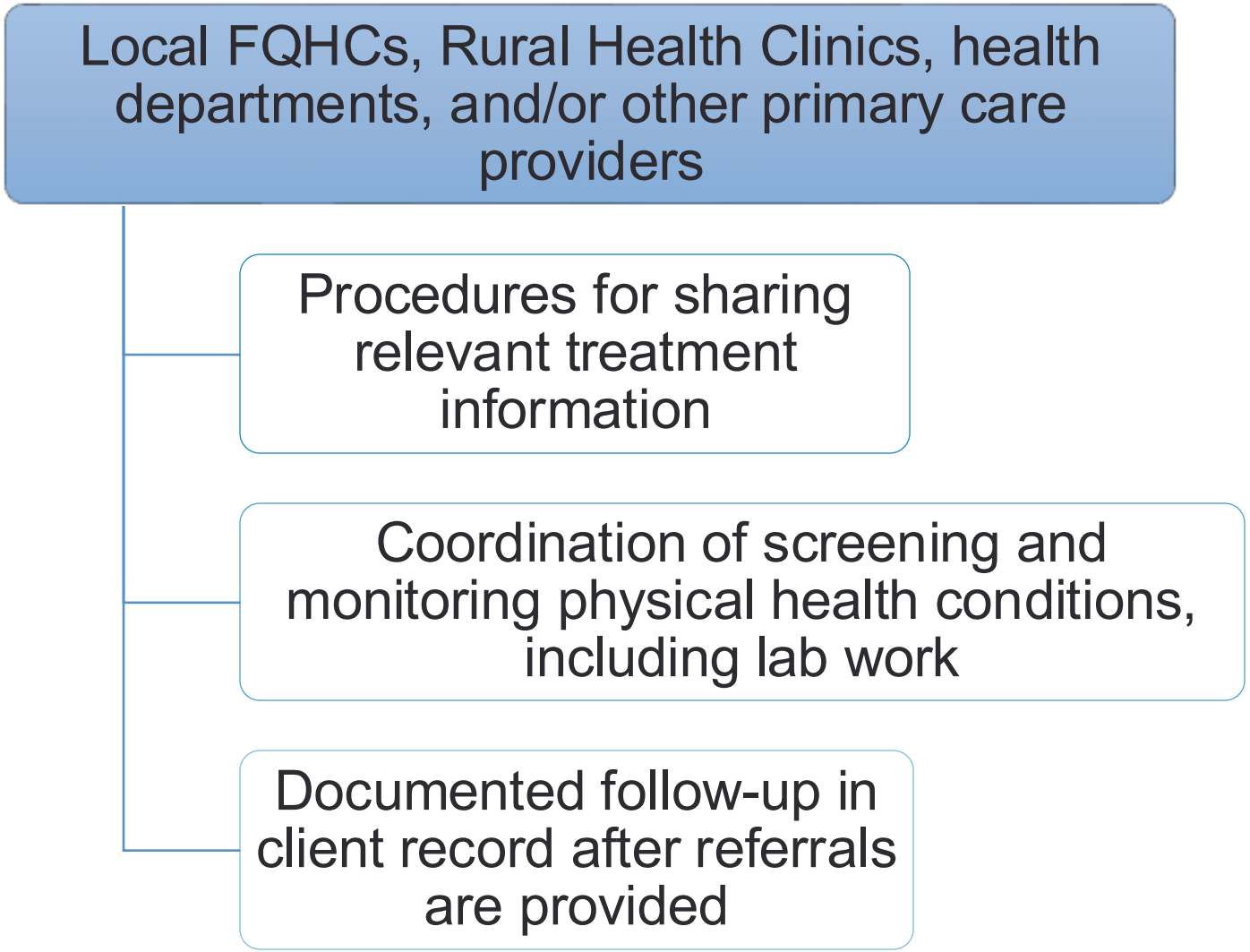
The CCBHC must document follow-up with the provider or the person attempting to confirm that they are established in care following a referral. Coordination of care remains the responsibility of the CCBHC until the person has established care with the referred provider or the person disengages from participation.

3.B: Care Coordination Agreements

CCBHCs must have written agreements or written protocols that establish care coordination expectations with a variety of community partners. The required elements of these protocols vary by partner type and are detailed in 3.b.1 - 3.b.5.



Written Protocols: Primary Care (3.b.1)



Written Protocols: SUD Providers (3.b.2)

Local opioid treatment programs, medical withdrawal management facilities and providers, and tribally operated mental health and SUD providers.

- Procedures for transitioning individuals between levels of care
- Sharing relevant treatment information such as prescriptions
- Follow-up procedures after discharge from higher levels of care
- A plan for suicide prevention and/or overdose prevention plan

Written Protocols: Hospitals and Facilities (3.b.3)

Emergency departments, acute care hospitals, inpatient and residential psychiatric and SUD facilities, and children and youth psychiatric residential treatment facilities, including Indian Health Service Youth Regional Treatment Centers

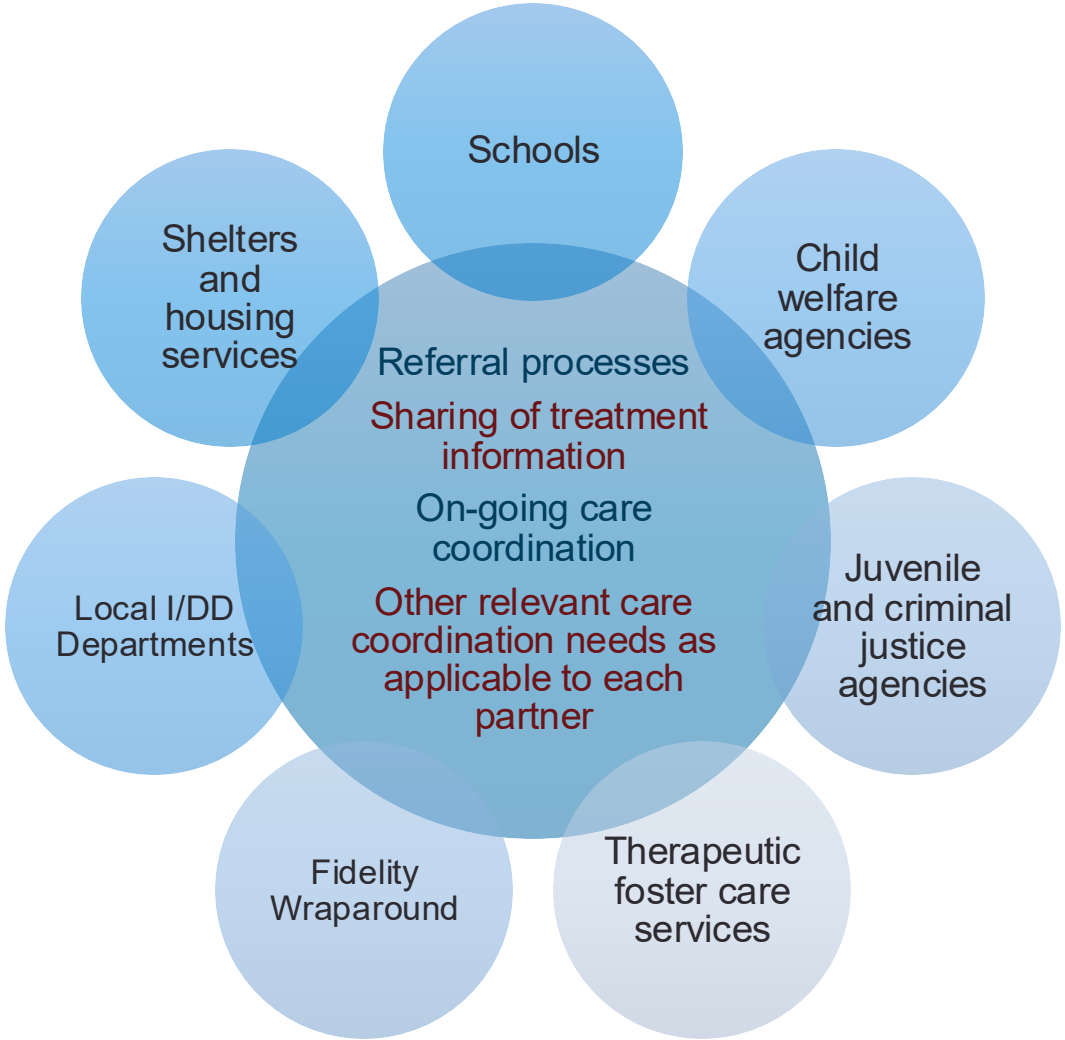
- Tracking admittance and discharge and active follow-up after discharge
- A plan to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge
- The transfer of health records for services received
- A plan for suicide prevention and safety and/or overdose prevention
- A plan for provision of peer support services or other supports to help facilitate transition of care
- Notification of relevant inpatient and outpatient facilities through Emergency Department Information Exchange (EDIE)/Collective Platform

Written Protocols: Veterans Services (3.b.4)

Veteran Affairs medical centers, independent clinics, drop-in centers, other facilities of the Department of Veterans Affairs, or other community services and/or providers serving members of the U.S. Armed Forces and Veterans

- Processes for identifying/assigning the Principle Behavioral Health Provider and coordinating with the PBHP
- Processes for sharing information in accordance with the person receiving services
- Protocols for tracking referrals

Written Protocols: Community Partners (3.b.5)



3.C: Treatment Team

The CCBHC must designate an interdisciplinary team for all people who receive services.

The team is responsible for directing, coordinating, and managing care and services.

These services include, but are not limited to, the medical, psychiatric, therapeutic, psychosocial, and recovery supports needed.

The team supports the person's needs in a culturally and linguistically appropriate manner, including facilitating traditional approaches, as appropriate.

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Program Requirement Q&A

Clinic Spotlight:

Welcome, Symmetry Care!

Readiness Considerations

Care is coordinated across the spectrum of health and social services and supports (3.A) and CCBHC has necessary protocols and policies in place to facilitate care coordination with community partners (3.B)

- ❑ Clinic is aware of the local providers, agencies, and resources available (medical and non-medical)
- ❑ All required community partners have been identified with whom a care coordination protocol is needed and protocols are written
- ❑ Procedures are in place to allow for family/caregiver involvement in care coordination
- ❑ Clinic can complete and document referral follow-up in the EHR to CCBHC standards
- ❑ Policies are in place to ensure HIPAA and 42 CFR requirements are met and that necessary consents can be obtained and documented
- ❑ Clinic has access to the Prescription Drug Monitoring Program
- ❑ Policies are in place for medication reconciliation

Readiness Considerations

3.C: People receiving services are supported by an interdisciplinary team

- ❑ Staffing plan includes sufficient staff numbers and staff types to comprise interdisciplinary teams
- ❑ Clinic is prepared to provide culturally and linguistically appropriate care, including required trainings for staff and translation/interpretation services
- ❑ Clinic is aware of the sources of traditional approaches to care in their community

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Readiness Considerations Q&A

Resources

- CCBHC Website
- CCBHC Provider Resources Website
- Oregon CCBHC Program Requirements Manual
- Main Inbox: CCBHC@oha.oregon.gov
- Cost Reporting Inbox: CCBHCCostReporting@oha.oregon.gov

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the OHA CCBHC team at CCBHC@oha.oregon.gov.

Oregon Health Authority
Certified Community Behavioral Health Clinics
CCBHC@oha.oregon.gov
OHA CCBHC Website