

## CCBHC Care Coordination Chart

Care coordination service	Eligibility Criteria	Required Activities	Care Coordination Provider
<b>CCBHC Care Coordination*</b>	All individuals served by the CCBHC regardless of insurance status.	Coordinate and manage care across the spectrum of health care services, including access to high-quality physical health (both acute and chronic) 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. Care coordination is a required service regardless of whether the care is provided directly by the CCBHC, DCO or referral.	The expectation is that all CCBHC staff are responsible to ensure that care is coordinated for all Individuals served by the CCBHC, and to ensure that eligible Individuals are referred to specialized care coordination teams.
<b>IHH Care Coordination**</b>	<p>Individuals, regardless of Medicaid eligibility who meet the following criteria:</p> <ol style="list-style-type: none"> <li>1. Individuals age 18 and over with an SMI diagnosis that causes significant impairment in daily functioning <b>OR</b></li> <li>2. Individuals age 17 or below with an SED that results in a functional impairment that substantially interfere with or limit the achievement of or maintaining one or more developmentally appropriate social,</li> </ol>	<p><b>Comprehensive Care Management:</b> at least monthly reporting of gaps in care and risks; development and oversight of care management plans.</p> <p><b>Care Coordination:</b> assessment, scheduling appointments, making referrals, follow-up monitoring, etc.</p> <p><b>Health Promotion:</b> health</p>	IHH care coordination team comprised of a nurse case manager, care coordinator, and peer support or family peer support specialist.

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	<p>behavioral, cognitive, communicative or adaptive skills and substantially interfere with or limits functioning in family, school or community activities, difficulties of episodic, recurrent and continuous duration.</p>	<p>goals included in care plans, health education, wrap around planning, etc.  <b>Transitional Care:</b> assist Individual to transition from inpatient to other settings, including follow-up.  <b>Individual and Family Support:</b> assistance to access support services, advocacy, develop support networks, assistance with med and treatment management, etc.  <b>Referral to Community and Social Support:</b> resource referrals or coordination for school, housing, transportation, etc.</p>	
<p><b>IHH Intense Community Service Case Management**</b></p>	<p>Individuals, regardless of Medicaid eligibility, who meet the following criteria:</p> <ol style="list-style-type: none"> <li>1. SMI diagnosis that causes significant impairment in daily functioning and has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care, more than once in a lifetime. The individual has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.</li> </ol> <p style="text-align: center;"><b>OR meets two of the following:</b></p>	<p><b>Includes all activities required for IHH Care Coordination and the following activities:</b></p> <ol style="list-style-type: none"> <li>1. At a minimum meet with the Individual face to face every 90 days. Monthly contact with Individual either in person, by telephone, or by video conferencing.</li> <li>2. Annually complete a standardized assessment that drives the service</li> </ol>	<p>IHH care coordination team comprised of a nurse care manager, care coordinator, and peer support or family peer support specialist.</p>

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	<ul style="list-style-type: none"> <li>• Is unemployed or employed in a sheltered setting or has markedly limited skills and a poor work history.</li> <li>• Requires financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.</li> <li>• The member shows severe inability to establish or maintain a personal social support system.</li> <li>• The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management.</li> <li>• The member exhibits inappropriate social behavior that results in demand for intervention.</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p>2. Meet the criteria of a SED diagnosis that results in a functional impairment and meets hospital level of care or has other demonstrated need for Intensive Community Service Case Management.</p> <p style="text-align: center;"><b>OR</b></p> <p>3. Are at a high risk of suicide.</p> <p style="text-align: center;"><b>OR</b></p> <p>4. Receive CMH waiver or Habilitation services.</p>	<p>plan.</p> <ol style="list-style-type: none"> <li>3. Develop a person-centered service plan annually with the individual and their team and update as needed.</li> <li>4. Receive quarterly updates from service providers on goal progress/barriers.</li> <li>5. Monitor and coordinate all services.</li> <li>6. Make referrals as needed</li> <li>7. Coordinate and follow up on all appointments.</li> </ol>	
<p><b>Substance Use Disorder Case Management***</b></p>	<p>Individuals, regardless of Medicaid eligibility, with a long-term substance use disorder, defined as meeting the Moderate or Severe</p>	<ol style="list-style-type: none"> <li>1. At a minimum meet with the Individual face to face every 90 days. Monthly</li> </ol>	<p>SUD Case Management Team.</p>

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	<p>severity level for one or more of the following disorders as described in the DSM-5:</p> <ul style="list-style-type: none"> <li>• Alcohol Use Disorder</li> <li>• Cannabis Use Disorder</li> <li>• Phencyclidine Use Disorder</li> <li>• Other Hallucinogen Use Disorder</li> <li>• Inhalant Use Disorder</li> <li>• Opioid Use Disorder</li> <li>• Sedative, Hypnotic, or Anxiolytic Use Disorder</li> <li>• Stimulant Use Disorder (Amphetamine, Cocaine)</li> <li>• Other (or Unknown) Substance Use Disorder</li> </ul>	<p>contact with Individual either in person, by telephone, or by video conferencing.</p> <ol style="list-style-type: none"> <li>2. Annually complete a standardized assessment that drives the service plan.</li> <li>3. Develop a person-centered service plan annually with the individual and their team and update as needed.</li> <li>4. Receive quarterly updates from service providers on goal progress/barriers.</li> <li>5. Monitor and coordinate all services.</li> <li>6. Make referrals as needed Coordinate and follow up on all appointments.</li> </ol>	
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\*Refer to CCBHC Clinic Criteria, Program Requirement 3: Care Coordination for complete CCBHC care coordination requirements.

\*\*IHH programs are required to comply with the State Plan Amendment (SPA) for IHH services and any contractual requirements governing Medicaid-funded IHH services. This chart provides a general overview of IHH requirements but does not replace or supersede any requirements for Medicaid-funded IHH services for Medicaid-eligible individuals.

\*\*\*SUD Case Management Criteria document in the Bidder’s Library has additional information about SUD Case Management requirements.