Care Coordination and Case Conferencing Policy

Effective Date: 08/15/2025

Approved By: Director of Medical and Clinical Services

Review Schedule: Annually or as Needed

Applies To: PHP, Residential and Integrated Primary Care/Behavioral Health

Policy Statement
The organization is committed to a coordinated, team-based approach that integrates medical, behavioral, and social services to ensure continuity, quality, and efficiency of care. Through structured care coordination and regular case conferencing, providers will collaborate to address the holistic needs of each individual, support recovery, and achieve optimal outcomes.

Purpose
To establish standardized procedures for interdisciplinary coordination of care and case conferencing to promote person-centered, integrated service delivery and reduce fragmentation between disciplines.

Scope
This policy applies to all providers and staff engaged in direct client care, including medical providers, behavioral health clinicians, case managers, and other support personnel participating in the integrated care model.

Definitions
- Care Coordination: The deliberate organization of client care activities between multiple providers and services involved in a client's care to facilitate appropriate delivery of healthcare services.
- Case Conferencing: A structured, multidisciplinary meeting to review client progress, adjust care plans, address barriers, and ensure communication among the care team.
- Interdisciplinary Team (IDT): A collaborative group including primary care providers, behavioral health staff, case managers, and others involved in the client's care.

Procedure

1. Care Coordination Process
- Each client's care shall be guided by a shared, integrated plan of care developed collaboratively among the interdisciplinary team.
- The designated Care Coordinator (typically the case manager or primary clinician) shall serve as the primary point of contact for all coordination efforts.
- Coordination activities include:

- Communication between internal and external providers
- Scheduling and follow-up of appointments
- Exchange of relevant clinical information
- Ensuring implementation of referrals, lab results, and specialist recommendations
- Addressing social determinants of health that affect treatment adherence

2. Frequency and Format of Case Conferences
- Case conferences shall occur at least monthly for active clients, and more frequently as clinically indicated.
- Urgent case conferences may be convened at any time to address safety concerns, clinical crises, or significant changes in condition.
- Meetings may occur in person, by phone, or through secure video conference.
- All case conferences shall be documented in the client's electronic health record (EHR) or designated system.

3. Participants
Case conferences will include, as applicable:
- Primary care provider or nurse practitioner
- Behavioral health clinician
- Case manager or care coordinator
- Medical assistant or nursing staff
- Peer support or other specialists, as appropriate
- The client and/or family/natural supports, if clinically appropriate and with consent

4. Discussion Topics
Each case conference shall address:
- Review of the client's integrated plan of care
- Current clinical status and progress toward goals
- Medication adherence and potential side effects
- Recent laboratory or diagnostic results
- Barriers to engagement or treatment adherence
- Social or environmental concerns (e.g., housing, employment, family dynamics)
- Risk or safety issues and mitigation plans
- Coordination of upcoming appointments, referrals, or community supports

5. Documentation
- The Care Coordinator or designee will document:
  - Date and participants of the case conference
  - Summary of discussion and decisions made
  - Updates or changes to the plan of care
  - Follow-up tasks, responsible parties, and timelines
- The record shall be signed or initialed by the responsible staff and stored in the client's chart.

6. Communication and Confidentiality
- Information shared during case conferencing must comply with HIPAA and 42 CFR Part 2.
- Signed consents for information sharing will be obtained before discussing cases involving multiple providers or agencies.
- Only team members directly involved in the client's care shall participate in case discussions.

7. Quality Assurance and Performance Monitoring
- The Quality Improvement (QI) Committee will review documentation of case conferences quarterly to monitor compliance and assess care coordination outcomes.
- Metrics reviewed may include:
  - Timeliness of case conferencing
  - Interdisciplinary participation rates
  - Documentation completeness
  - Client outcomes and satisfaction measures
- Findings will be used to inform staff training and program improvement initiatives.

8. Staff Responsibilities
- Care Coordinator/Case Manager: Organize and document case conferences; communicate updates to all team members.
- Primary and Behavioral Health Providers: Participate in conferences and contribute updates, insights, and recommendations.
- Supervisors/Clinical Leadership: Ensure consistent implementation of care coordination standards and provide guidance on complex cases.
- Quality Improvement Staff: Audit records and track performance indicators.

Performance Indicators
- Percentage of clients with documented interdisciplinary case conferences
- Evidence of updated care plans following case conferences
- Timeliness of communication between disciplines
- Client engagement and retention in care
- Reduction in avoidable hospitalizations or missed appointments

Review and Revision
This policy shall be reviewed annually as part of the organization's Quality Improvement and CARF compliance activities, and revised as needed to reflect best practices in integrated care and evolving regulatory standards.