Care Coordination Program

The Care Coordination program offered to patients who have a serious mental illness (SMI), two chronic conditions, or one chronic condition and are at risk of developing a second. Patients are identified for eligibility through a variety of sources, including claims data, referrals from providers, referrals from community agencies and referrals from state agencies.

At the initial visit, members of the Care Coordination team gather UDS data which is used by the medical team to develop a plan of care. Members of the Care Coordination team also determine the patient's level of service delivery through risk stratification. This assessment evaluates that patient's behavioral health, medical, long-term services and supports (LTSS) and social needs. Patients are stratified into three groups: Low, Medium, and High.

Low risk patients receive population management services, including access to relevant program offerings such as disease management and education groups. A patient may receive a new risk stratification following a critical event, such as a new diagnosis or hospitalization.

Patients stratified medium or high risk receive an in-depth Health and Psychosocial Assessment, which drives their individual Care Plan. Care Coordinators work closely with members of the patient's medical team, legal representatives, and family or caregivers, when appropriate, to develop, implement, and assess the patient's Care Plan and goals. All contact is based on the patient's preferred method of contact and a contact schedule based on the patient's needs.

Goals of the Program

- Patients with chronic conditions and complex care needs regain optimum health or improve functional capability in an efficient and cost effective manner.
- Patients receive the appropriate care in the least restrictive environment.
- Patients with complex health conditions have access to and receive appropriate services by identifying and removing barriers to services and coordinating care among patients who receive multiple services.
- Care impacting multiple treatment and support services is coordinated. Services include those from providers, primary care physicians and clinics, and community resources including housing, benefits, and education.

Services Provided

Care Coordination

Care management coordinates care and assists patients in navigating the system to facilitate appropriate the delivery of appropriate care and services in a culturally competent manner with regard to race, ethnicity, language preference and other cultural factors. Care coordinators are trained in principles of both behavioral health and general medical conditions and focus on the current needs of the patient across domains. Care Coordinators are knowledgeable about local social service resources available to help patients with a variety of needs, including but not limited to, housing, support services, transportation.

Care coordinators:

- Increase patient participation and engagement in care. This can include telephone reminders about appointments, lab work, and tests; assisting patients in preparing a list of questions or concerns to discuss with physicians at appointments; or even attending appointments with patients.
- Increase compliance with medication. This includes medication management for high-risk patients, telephone reminders about prescriptions and refills, and follow-up calls with patients to identify barriers to medication compliance.
- Review of member progress through participation in treatment team meetings.
- Document coordination with different program agencies to ensure movement throughout the continuum of care.
- Develop plans of action with the treatment team in order to address individualized needs to improve health outcomes and reduce the need for higher levels of care. Care coordinators use warm hand-offs when referring patients for other services and follow-up with patients and providers to prevent gaps in care.
- Support patients following inpatient hospitalizations. This includes, but is not limited to, ensuring the outpatient medical team has access to inpatient records to support continuity of care and assisting patients in making follow-up appointments with primary and, when indicated, specialty providers.
- Communicate with behavioral, medical, and specialty providers to help ensure continuity of care and prevent duplication of services.
- Provide direct psychoeducational and motivational skill-building and brief solution-focused therapy
- Maintain and refine self-management toolkits and resources to share with patients and their families, when appropriate

Patient and Family Education

Care Coordinators use a variety of evidence-based best practices to achieve goals.

- Individual health coaching related to specific illness or illnesses using Motivational Interviewing techniques
- Health and safety education provided individually through educational groups, home visits, and telephone interventions based on Prime Health Solutions and Stanford Chronic Disease Self-Management
- Online educational tools and resources provided to patients and families

Community Resource Guide

Care Coordinators identify community, social, and recovery support services that are available and develop and maintain a resource guide. The resource guide contains a listing of support service agencies, services provided, hours of operation, address, contact information and any eligibility information. The Community Resources Guide is kept up-to-date and is available to all Care Coordination staff. The Community Resource Guide is available to patients upon request.

Staffing

Care Coordination Specialists serve as a liaison between the primary medical provider, pharmacist, and patient/family. Care Coordinators are bachelors-level Registered Nurses or staff with bachelor's degrees in a social science field. Care Coordinators complete Targeted Case Management Training approved by the Alabama Department of Mental Health. Responsibilities include conducting initial and follow-up assessments, collecting sufficient data to make appropriate referrals, creating Care Plans, and measuring patient progress. Care Coordinators coordinate with multiple providers and other care managers to assure continuity of care; facilitate self-care groups and activities for co-morbid population; and evaluate needs for services and makes appropriate referrals throughout the continuum. These services are provided in a range of community settings including, but not limited to, hospitals, outpatient offices, and patients' homes.