Care Coordination and Care Management Tasks

Steven Constantino made a good point in the discussion of 02122019 of the importance of defining care coordination and care management. That is particularly important if we are to recommend paying PCPs for these services. One standard we could use is that established for Health Homes by CMS under Section 2703 of the Patient Protection and Affordable Care Act. It broadly identifies health home services as including comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up from inpatient to other settings; patient and family support; and referral to community and support services. Although there are no federal regulations that define these core components, some tasks that could be included under each are listed for each.

Comprehensive Care Management

- Identifying individuals potentially eligible to receive care management services; although this responsibility often lies predominantly with either the Medicaid agency or the managed care health plans through claims, primary care practices (PCP) may identify individuals missed through that screening process and should refer them for consideration to the entity responsible for final eligibility determination;
- Engaging individuals and families with explanation as to the benefits of participation in care management; although responsibility for enrollment may also rest with the Medicaid agency or health plan, the PCP often can capitalize on existing trusting relationship with the individual to explain the benefit of care management services and facility enrollment;
- Completing a comprehensive assessment of the individual's physical health, behavioral health, and social needs;
- Developing a single, integrated, person-centered care plan that reflects input from the entire health care team including the individual and family;
- Developing a communication plan to ensure routine information exchange among the full care team (including the enrollee, pertinent family members, care givers, care manager, PCP, BH provider, and specialist) as well as with any health plan care manager involved with the individual;
- Implementing the care plan;
- Monitoring the care plan to assess the individual's progress, barriers to care, and services provided relative to the desired outcomes and goals; modifying the care plan as appropriate.

2. Care Coordination

- Working with the health plan to identify gaps in preventive services and chronic disease management;
- Providing assistance with obtaining health care services including making appointments; facilitating communication between the PCP and specialists to enhance patient safety and reduce unnecessary duplication of services;
- Facilitating transportation as needed to those appointments;

- Accompanying the enrollee to the appointment if necessary;
- Validating that services were received and facilitating rescheduling when appointments are missed;
- Tracking tests and referrals with necessary follow-up;
- Performing medication management and reconciliation;
- Coordinating prevention, management, and stabilization of crises, including post-crisis follow-up care;
- Making referrals to community, social, and recovery supports as clinically indicated.

3. Comprehensive Transitional Care

- Developing arrangements with inpatient facilities, emergency departments and residential facilities for prompt notification of admission and discharge;
- Participating in discharge planning including developing coordinated, comprehensive discharge plans and/or transition plans and arranging timely ambulatory follow-up appointments with the PCP, BH provider and/or appropriate specialist;
- Timely and appropriate follow-up with the enrollee post-discharge;
- Facilitating timely transmission of clinical information.

4. Health Promotion

- Providing health education about wellness and health lifestyle choices;
- Referring individuals and families to evidence based wellness programs;
- Providing condition-specific education to promote self-management skills;
- Connecting individuals and families to peer supports as clinically appropriate.

5. Referral to Community and Social Support Services

- Identifying and providing referrals to community, social or recovery support services including legal assistance and housing;
- Providing assistance in making appointments, facilitating transportation, validating that service was received, and completing any follow-up.

6. Individual and Family Support Services

- Providing access and availability of services to the individual, family, and care team;
- Supporting the delivery of person-centered care;
- Performing outreach and advocacy for the individual and family to obtain needed resources;
- Educating the individual and family on self-management techniques;
- Facilitating individual and family engagement in care planning and providing access to clinical information and the care plan;
- Referring individuals and family members to community/social/recovery supports.