

Care Coordination Collaborative Change Package Visual

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Care Coordination Collaborative Change Themes

DEVELOP EFFECTIVE COLLABORATIVE CARE RELATIONSHIPS

ENGAGE CLIENTS/PATIENTS IN THEIR WHOLE HEALTH

DELIVER COORDINATED SERVICES

CARE COORDINATION INFRASTRUCTURE

Seamless experience of care that is person-centered, cost effective, and improves health and wellness for individuals and populations

Care Coordination Collaborative Changes

DEVELOP EFFECTIVE COLLABORATIVE CARE RELATIONSHIPS

1. Convene agencies that have a shared aim of improving the health status of individuals
2. Define the client/patient population
3. Engage and strengthen relationships between the provider organizations convened
4. Increase knowledge of the roles peer and family member providers
5. Develop the role of the Convener Organization
6. Establish the Care Coordination Team and individual agency roles and responsibilities
7. Develop the role of the Care Coordinator
8. Build the Business Case for ongoing support of the care coordination effort

ENGAGE CLIENTS IN THEIR WHOLE HEALTH NEEDS

1. Do outreach
2. Actively engage each client/patient in his/her Care Coordination
3. Screen clients/patients' whole health
4. Follow up with more in-depth assessments
5. Actively engage client/patient in Care Planning
6. Actively engage client/patient in Self Mgmt.
7. Develop the roles of peers
8. Collaborate with the client/patient/family to develop a whole health service plan
9. Promote health literacy
10. Match level/intensity of care coordination

DELIVER COORDINATED SERVICES

1. Assign Care Coordinator to identified clients/patients
2. Make Clinical Care Managers available
3. Use a universal release of information (ROI)
4. Develop and use standard referral processes and protocol
5. Create processes and workflows to achieve coordinated care
6. Conduct regular multi-disciplinary meetings,
7. Require multidisciplinary team meetings
8. Perform monthly medication reconciliation
9. Care Coordinator insures clients/patients have a single medication list
10. Design a single page Care Coordination Service Plan

Seamless experience of care that is person-centered, cost effective, and improves health and wellness for individuals and populations

CARE COORDINATION INFRASTRUCTURE

- Address mental health and substance use stigma
- Integrate Peer Providers into all agencies that are part of the Partnership Team
- Integrate Family Member Providers into all agencies that are part of the Partnership Team
- Use clinical information systems to coordinate and monitor services for individuals and populations
- Measure coordination of care and outcomes