CiBHS Care Coordination Collaborative
Description of Key Care Coordination Processes

Introduction: The Care Coordinator serves as the single point of contact for complex clients needing care coordination, and for the providers working with these clients. Below is a list of processes that comprise care coordination. Some of these are performed by the individual Care Coordinator while others are monitored by the Care Coordinator. While the care coordination processes that the Care Coordinator monitors (rather than doing themselves) must occur within each provider agency, it is the responsibility of the Care Coordinator to ensure the care coordination is occurring and to routinely reconcile data associated with those processes in an electronic clinical information system. In order to ensure seamless care that leads to positive health outcomes for *complex clients*, there is generally a single individual serving as the Care Coordinator for a maximum of 65 clients.

Process	Description
1. Outreaching, engaging, and facilitating clients' access to appropriate services	The process of reaching out to persons (especially those persons who are difficult to engage), enlisting their participation in care, and ensuring their access to needed services.
2. Defining the Care Team (including natural supports) for each client/patient	The process of identifying and entering into the registry, all of the key members of an individual patient's care team.
3. Ensuring and monitoring consent to share clinical information (ROI)	The process of ensuring that all consents for treatment and sharing information has been obtained prior to the sharing of clinical information (PHI).
4. Ensuring and monitoring appropriate screening for medical, mental health and substance use conditions	The process of systematic planning, administering, interpreting, and adjusting care based on standardized screening tools and measures.
5. Facilitating referrals	The process of facilitating referral, performing "warm handoffs", monitoring receipt of referral materials from other providers, and tracking completion of referrals. Intra-team referrals are streamlined.
6. Entering clinical information into caseload registry tool	The process of serving as primary "custodian" of the clinical registry data, and routinely up dating information to ensure its accuracy.
7. Conducting multidisciplinary clinical care conferences	The process of performing systematic, population-based caseload review.
8. Ensuring and monitoring routine medication reconciliation	The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

Process	Description
9. Supporting client self-management	The process of engaging the patient, family, and other natural supports in developing skills and abilities for self-care.
10. Ensuring and communicating shared care plan goals among client/patient and providers (primary care, mental health, and substance use providers)	The process of communicating for high-level goals shared by all providers in a coordinated care team.
11. Ensuring availability of ad hoc clinical case consultation	The process of ensuring availability of ongoing, as needed, impromptu consultations between all providers, but especially to primary care provider by specialty providers.
12. Ensuring urgent care access to specialty MH, SUD or primary care	The process of ensuring that patients have access to appropriate urgent care services as clinically needed.
13. Monitoring transitions in care	The process of monitoring critical healthcare transitions (such as discharge from a hospital) so that patients don't "fall through the cracks".