Care Coordination And What Police Officers Should Know About It.

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Centennial Care…a Community-based Member-centric Approach to Care

Overview

- Care coordination.
- What police know about program this program.
- We take referrals for any voluntary person who is on Medicaid.

Care Coordination as the Heart and Soul of Centennial Care

- Goal is advancing wellness and quality of life
- Promoting:
  - Independence, resiliency
  - Healthy living, health literacy
  - Active participation

Care Management – the "Heart and Soul of Centennial Care"

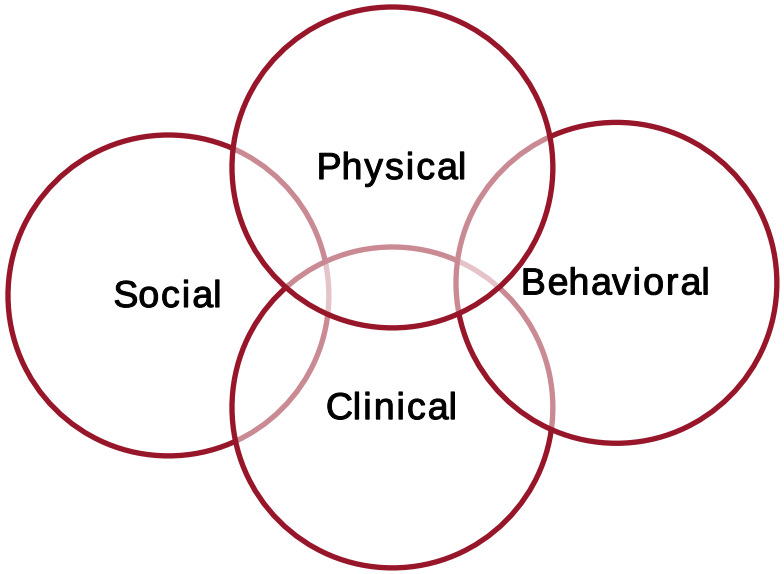
Care Coordination

- Service through which the Interdisciplinary Care Plan is executed
- Linking recipient to needed services
- Integrating treatments, services and supports
- Increasing recipient's motivation to understand and actively manage his/her chronic medical and behavioral health conditions

Care Management – the "Heart and Soul of Centennial Care"

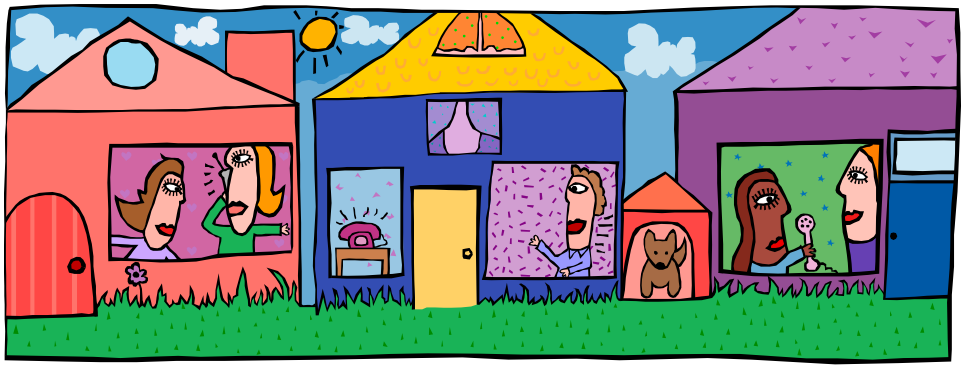
Interdisciplinary Care Plan

- Individualized and culturally sensitive
- Health Assessment to identify high-need recipients
- Medical and Behavioral services
- Evaluate for effectiveness & modification as needed



Care Coordination Model Focus

- Relationship building model
  - Building a strong relationship will minimize disagreements between member and plan.
  - Intent is to keep members as safe as possible in community with supports available



How First Responders Can Use the Program

- How police can access this program
- Phone number
- Website
- Medicaid vs Non-Medicaid

What we do when a referral comes in …

- Contact patient
- Conduct Evaluation
- Triage the need level … 1, 2, 3, and Nursing Care.

Requirements for Level 1

- Annual Health Assessment
- Minimum quarterly review of claims and utilization data to determine if Member is in need of a Comprehensive Needs Assessment and possible level of care coordination
- Hospital/Emergency Department visits reviewed in real time to determine if a level of care change is needed
- Not assigned an individual Care Coordinator

Indicators for Comprehensive Needs Assessment Completion - Level 2/3

- High cost user
- Medically frail
- High emergency room use
- Readmitted to hospital within 30 days
- Out of state medical placements
- Dependent child in out-of-home placements
- Transplant patient
- High risk pregnancy
- Behavioral Health diagnosis including Substance Abuse that adversely affects the Member's life

Minimal Touch Points by Level

Level 2

- Annual Health Assessment
- Annual In person Comprehensive Needs Assessment
- Annual Nursing Facility Level of Care (if approp)
- Semi Annual In Person visit
- Quarterly Phone Contact

Level 3

- Annual Health Assessment
- Annual Nursing Facility Level of Care (if approp)
- Semi Annual In Person Comprehensive Needs Assessment
- Quarterly In Person Visit
- Monthly Phone calls

Nursing Facility Level of Care

- Evaluation conducted as part of the Comprehensive Needs Assessment
- Must require assistance with 2 or more Activities of Daily Living
- Provides additional benefits once meets Nursing Facility Level of Care
- Long Term Care Benefits

Care Coordination Teams

- Inpatient Team
- Residential Treatment Centers/Treatment Foster care
- Juvenile Corrections
- Adult SMI
- Child SED
- High Risk Maternal team
- ABA Team

Thank You

Questions?