

UHC Care Coordination Model Overview

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Overview of the Care Coordinator Role

The Care Coordinator is the care team quarterback with a primary focus on:

- Completion of annual comprehensive assessments and intercurrent assessments as needed (e.g., post-discharge)
- Creation of a member-centered individualized care plan (ICP)
- Ensuring access to the interdisciplinary care team (ICT) and communicating with the ICT
- Mitigating and addressing social determinants of health (SDoH) through appropriate referrals to internal and external supports
- Regular rounding with care team including LTS-Cs and community-based organizations
- Ongoing monitoring of member and regular follow-up
- Finding members who are unable to reach
- Supporting gaps in care closure
- Collaborate with members of the ICT including primary care, behavioral health, advocates, and LTS-C

Aspects already in alignment with CMFI

- Care Coordinator as a single point of contact
- A care team that includes the member, their family, their doctor(s), their One Care plan, and anyone else they want to help make health care decisions
- Annual assessment and development of an individualized care plan
- The care plan is developed by the member with the help of their care coordinator with input from the member's ICT
- The care plan may be adjusted during the year if the member's status changes
- In addition to medical, behavioral health and equipment needs, the member may also receive services related to food insecurity, housing, transportation, and employment
- A 24-hour medical advice line to help with questions and concerns
- Flexible Benefit when traditional coverage and benefits do not cover the member's needs as documented in the care plan

Training and Oversight

- Implementation of the care coordinator role in the care team
 - The Care Coordinator works in conjunction with the member to identify actionable goals that the member wants to address in their care. Identified needs are addressed with the Care Coordinator, who then engages with any resources available to help support the member.
- How are care coordinators trained to identify and meet each member's unique and specific needs?
 - Care Coordinators have an extensive 6-week training from the health plan, as well as through the One Care specific trainings. Additionally, we have hired staff with diverse backgrounds. As staff progress in their role, we are able to identify subject matter experts who consult on particular topics and assist with ongoing trainings.
- How will you measure care coordinator quality in areas including the advancement of equity and responsiveness to individualized needs?
 - Care Coordinators have the support of their managers, who they meet with regularly to review caseloads and individual member issues that arise. Our team culture fosters open communication not only with managers and members of the ICT, but also with the medical director to talk through cases that need more individualized care and support. Our team also relies on reporting metrics to ensure regular touchpoints and outreach to those who may need more frequent interventions. We ensure equity for our members by providing access to translation services, ensuring all ethnic and cultural groups receive routine screening and preventative care, as well as meeting accessibility and independence needs of people with disabilities.

Aspects that have been revitalized & any new processes

- Advocacy Role clarifications
 - In addition to the care coordinator, there is a dedicated One Care navigator team in Member Services that functions as a member advocate
 - Care coordinators actively promote inclusion of LTS-Cs in care planning and execution
 - The UHC Consumer Advocacy Team convenes a quarterly Consumer Advisory Board to solicit member feedback on the UHC model and services. This team consists of specialists in housing, employment and caregiver support. The team also helps members and caregivers navigate prior authorization, appeals and other health plan processes.
- Role in UM / What can the Care Coordinator Authorize
 - Care Coordinators can approve home and community-based services (HCBS) based on the functional assessment. All denials require medical director review.
 - Care Coordinators assess and present flexible benefits requests with the medical director at weekly rounds. Requests that are consistent with the care plan and not covered under another benefit are approved. Examples include bedding, dehumidifiers, small kitchen appliances (microwave, mini-fridge).
 - Care coordinators facilitate DME requests by providing complete clinical information but cannot authorize these requests.
- Care Coordinator role
 - The Care Management team directly supports the members and consists of cultural and linguistically diverse Behavioral Care Coordinators and RN Care Coordinators.

Care Coordinator (CC) Role	Responsibilities
<p>-RN (RNCC) – Licensed RN</p> <p>BH Care Coordinator (BHCC) -BH Care Coordinators have licenses and/or background in behavioral health, social work, etc.</p>	<p>-Care planning</p> <p>-Service plan development</p> <p>-Supporting members in meeting their goals</p> <p>-Monitoring members for ongoing changes needed to their goals or services</p> <p>-Referral and collaboration with additional care team members as appropriate</p> <p>- Support proactive discharge planning and manage/coordinate Care Transition following ER visit, inpatient or Skilled Nursing Facility (SNF) admission (RNCC)</p> <p>-Support proactive discharge planning and manage/coordinate care transition following inpatient BH ER visits or admissions. (BHCC)</p>

Member Examples

- One of our members needed better medication management, the assigned Care Coordinator was able to order a pill organizing box through the Flexible Benefit. Member also needed ramps for both his front and back doors to safely get in and out of his home with use of his wheelchair. The Care Coordinator and the members of the ICT are working currently to assist in getting this for the member. The member has had to alter his diet due to poor fitting dentures. The Care Coordinator has connected the member with a dental provider to obtain new dentures which has improved the member's diet and ability to eat the food he wants to.
- One member was referred to our Housing Advocate by our Care Coordinator to find new housing. The member's landlord was not keeping up with appropriate maintenance and it was affecting the member's overall health. Compounding the situation, the member and her children had PTSD due to past domestic violence. Our Housing Advocate was able to assist with connecting the member with a RAFT caseworker as well as locating additional financial assistance programs in the region. As the member had a Section 8 voucher, our Housing Advocate was also able to educate her on housing resources available to her. By working in collaboration, the care coordinator and the housing advocate were able to identify resources and locate a new apartment to meet the members needs within 2 weeks.