



Comprehensive Care Management: Critical Components Knowledge of the service delivery system Use of communication strategies that meet the member's skills and needs Ability to address other barriers to success Monitoring and follow-up to ensure that needed

care and services are offered and accessed

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- · Assists in the attainment of the member's goals in timely and relevant ways
- · Engages members in chronic condition self-care to support treatment adherence
- · Involves coordination and collaboration with other providers
- · Engages members and their chosen supports in decision-making
- · Monitoring progress

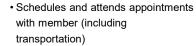


Care Coordination



Key Staff: Nurse Care Coordinator, Social Worker/Care Coordinator

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- Provides follow-up
- Shares information with the member and all members of the care team
- · Monitors ED and Inpatient admissions
- · Monitors progress

- · Encourages and supports healthy ideas and behavior
- Places a strong emphasis on self-direction and skills development
- · Ensures all health action goals are included in person centered care plans
- · Provides health education and coaching
- · Offers prevention education to members





Key Staff: Physician, Nurse Care Coordinator, Social Worker/Care Coordinator

- · Assist in developing the skills and confidence to seek supports to manage their condition(s) and prevent other chronic conditions
- · Assessment of member's understanding of their condition (including health literacy)
- · Provide health education regarding chronic conditions
- · Assist in the development of a self-management plan
- · Conduct medication review and education
- · Promote lifestyle interventions





Comprehensive Transitional Care: Plan Elements

Goals

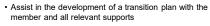
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- · Home visit(s) to determine safety at home, work, or the
- · Timeframes related to appointments and discharge paperwork
- · Follow-up appointment information
- Medication list to allow providers to reconcile medications and make informed decisions about care
- Therapy needs, e.g., occupational, physical, speech, etc.
- · Transportation needs
- Community supports needed post-discharge

Key Staff: Physician, Nurse Care Coordinator, Social Worker/Care Coordinator

- · Specialized care coordination designed to facilitate transition of treatment plans from: Hospitals

 - Emergency Departments
 In-member units



- · Address understanding of rehab activities, LTSS, selfmanagement, and medication
- · Appointment scheduling and follow-up

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Member and Family Support: Critical Components

- Involves ability to determine when members, and their support persons are ready to receive and act upon information provided, and assist them with making informed choices
- Involves an awareness of complexities of family dynamics, and an ability to respond to member needs when complex relationships come into play





Member and Family Support: Critical Components

Key Staff: Nurse Care Coordinator, Social Worker/Care Coordinator, Peer Support Specialist/Peer Mentor

- Promotes engagement of members, family/support persons and guardians
- Promotes self-management capabilities of members
- · Assistance with paperwork
- Member advocacy





Referral to Community Supports & Services



- Determine services needed for the member to achieve the most successful outcome(s)
- Identify available community resources
- · Identify natural supports



Referral to Community Supports & Services: Critical Components

Key Staff: Nurse Care Coordinator, Social Worker/Care Coordinator, Peer Support Specialist/Peer

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systemEngagement with community and social

· Thorough knowledge of the service delivery

- Engagement with community and social supports
- Establishing and maintaining relationships with community service providers
- Fostering communication and collaborating with social supports
- Knowledge of the eligibility criteria for services
- Identifying sources for comprehensive resource guide

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OCK Cores Services in Action

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