Empower Healthcare Solutions

Care Coordination Program

August 2019

Agenda

- The Care Coordination Program
- Continuity and Transitions of Care
- Person Centered Service Plans
- Coordination and Communication with Providers
- Contacts
- Questions

The Care Coordination Program

Care Coordination

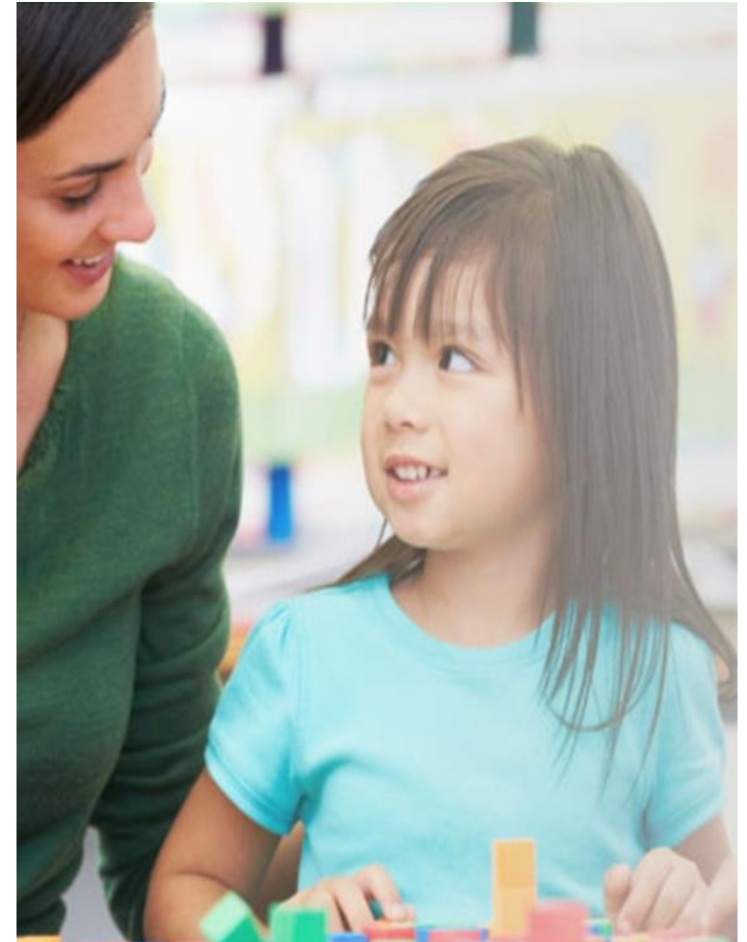
- Every member of Empower is part of the Care Coordination Program
- Care Coordinators (CC) are the single point of contact for all the member's providers including medical, pharmacy, behavioral health, intellectual and developmental disability, and long term support services
- The CC works to proactively integrate service delivery based on the member's Person Centered Service Plan (PCSP)
- The PCSP captures all needs of a member to ensure providers are coordinating care

Care Coordination

- CC's monitor the delivery of integrated services through regular contacts with members and providers, establishing linkages to family service agencies, community service organizations, court systems, schools, and other appropriate resources
- The goal of Care Coordination is to collaborate with the member, their PCP, and all providers to achieve the highest possible levels of wellness, functioning, and quality of life
- This model is designed to help members obtain needed services and assist them in coordination of their healthcare and other needs
- Care Coordination includes member and family education and connects the member to providers and supportive services

Care Coordination Programs

- 3 Care Coordination Programs
  - Child and Adolescent Behavioral Health
  - Adult Behavioral Health
  - Intellectual/Developmental Disability
- Specialty Populations
  - Foster Care
  - Child and Adolescent Inpatient
  - Adult SMI
  - DD Waiver



Continuity and Transitions of Care

Continuity of Care

- Empower's Care Coordination Program will ensure all services are coordinated and appropriately delivered by providers:
  - Empower complies with Conflict Free Case Management (42 CFR 441.330)
  - CC's are responsible for assisting the member when moving between service settings and ensures the member is placed in or remains at the most appropriate and least restrictive setting that meets the member's needs
  - CC's will assist when a new member joins Empower from another PASSE to ensure that services continue without disruption
    - The Member will have 90 days of transition when moving from another PASSE
  - CC's assist members with changing PCP or accessing Specialty Providers

Person Centered Service Plans

Person Centered Service Plans

- All members will have a Person Centered Service Plan (PCSP) completed annually
- Care Coordinators will include members in development of the PSCP and provide choices for members in this process
- Members choose who attends the PCSP meeting
- Care Coordinators will ensure compliance with the PCSP and will assist with any resources needed or barriers to accessing treatment
- Member and Provider will receive a copy of the PCSP
- If a member has a question or needs a revision for their PCSP, they will contact the assigned Care Coordinator

The PCSP will include:

- Relevant medical and mental health diagnoses
- Relevant medical and social history
- The individual who has legal authority to make decisions on behalf of the member
- Indication of whether or not an Advance Directive has been created
- Member's goals and objectives
- All services necessary for the member including the provider of service
- Member's needs, strengths, preferences
- A crisis plan

The PCSP Process

- The member's goals on the PCSP are chosen by the member. Providers will continue to develop the MTP/IPP for each member you serve
- The member choses who attends the PCSP meeting. The CC will send an invite to the provider via email/phone
- Attend PCSP meetings when possible. Your feedback is important to the process
- Let us know how the process is going

PCSP Contact

- Please designate a point of contact(s) at your facility/clinic to receive Person Centered Service Plans via email
  - You can send this information to CareCoordination@empowerhcs.com

PCSP and UM

- Care Coordinators assist with the development and coordination of the PCSP
- The UM Team reviews for medical necessity for services listed on the PCSP
- Providers will continue to submit supporting documentation when requesting prior authorizations for services

Coordination and Communication with Providers

Communication with CC and Providers

- Empower encourages all healthcare providers to collaborate with the CC's to ensure our members receive the care he/she needs
- Providers have extensive knowledge of the member's medical condition, mental status, psychosocial functioning, and family situation
- Communication of this information to the CC and other healthcare providers during the course of treatment is encouraged with member consent when required

Coordination with CC and Providers

- BH and DD providers should initiate communication with and coordinate with a member's Care Coordinator and/or Specialty Providers when there is a problem that can affect the member's condition or treatment being provided.
- Examples include:
  - A significant change in status that would necessitate an update to the PCSP
  - To request assistance in identifying resources or recommend resources
  - Hospital admissions
  - Emergency room visits

Provider Responsibilities

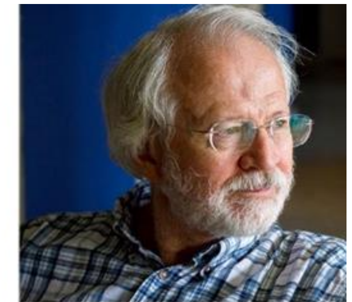
- Empower encourages providers to report specific clinical information to the member's CC in order to preserve the continuity of the treatment process
- With appropriate written consent from the member, it is the provider's responsibility to keep the member's CC abreast of treatment status and progress by including the following:
  - A copy of the current treatment plan
  - Any updates on progress/regression
  - Results of functional assessments
  - Notification of member's noncompliance with treatment plan (if applicable)

Contacts

To Reach a Care Coordinator

Contact us at:

- Email: CareCoordination@empowerhcs.com
- Phone: 866-261-1286



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HEALTHCARE SOLUTIONS

Care Coordinator Supervisors by Program

Care Coordinator Supervisors	Program	Email	Phone
Micah Pryor, LPC	Child BH	Micah.Pryor@empowerhcs.com	501.351.4598
April Bale, LCSW	Child BH	April.Bale@empowerhcs.com	501.519.5420
Lindsay Lisemby, LCSW	Child BH	Lindsay.Lisemby@empowerhcs.com	501.813.7104
Joey Gardner, LCSW	Child BH	Joey.Gardner@empowerhcs.com	501.813.7784
Kirsten Bird, RN	Child BH	Kirsten.Bird@empowerhcs.com	501.607.7797
Heather Hoggard, LMSW	Child BH	Heather.Hoggard@empowerhcs.com	501.607.7968
Liz Deere, LCSW	Child BH	Elizabeth.Deere@empowerhcs.com	501.680.6135
Lauren Pickens, LCSW	Child BH	Lauren.Pickens@empowerhcs.com	501.607.8243
Julie Rial, LPC	Child BH	Julie.Rial@empowerhcs.com	501.813.5821
Jennifer Mercy, LPC	Child BH	Jennifer.Mercy@empowerhcs.com	501.515.7810
JoVann Leek, RN	Adult BH	JoVann.Leek@empowerhcs.com	501.366.0018
Kim Robinson, LCSW	Adult BH	Kimberly.Robinson@empowerhcs.com	501.680.2554
Lance White, LPC	Adult BH	Lance.White@empowerhcs.com	501.607.1320
Stacy Crawford, LCSW	Adult BH	Stacy.Crawford@empowerhcs.com	501.813.5736
Jennifer Hennessee	DD	Jennifer.Hennessee@empowerhcs.com	501.607.8246
Christie Green	DD	Christie.Green@empowerhc.com	501.353.7218

Contact Us

Clinical Directors	Program	Email	Phone
Jamie Ables, LCSW	Child and Adolescent Behavioral Health	Jamie.Ables@empowerhcs.com	501.607.8261
Stacie Williams, LPC	Adult Behavioral Health	Stacie.Williams@empowerhcs.com	501.607.8269
Harold Watts	Developmental Disability	Harold.Watts@empowerhcs.com	501.350.6598

Questions

Thank you!

from

getempowerhealth.com