

Vermont Chronic Care Initiative **Care Coordination Services**

Indicators for Referring to DVHA Care Coordination:

- Intensive care coordination, one on one intervention required (e.g. complex management, home visits)
- Limited health literacy with respect to condition(s)
- Medical, behavioral, and/or psychosocial instability, leading to gaps in care
- Emerging needs identified that could destabilize future plans for health improvement

Eligibility Criteria:

- Be enrolled in a Medicaid program
- Individuals who have co-occurring conditions of substance abuse and/or mental health diagnoses may be especially good candidates
- High ER utilization, frequent hospitalizations, poly pharmacy and/or high predictability of future health care complications
- Not currently receiving other case management services (e.g. CMS covered case management such as CRT, Choices for Care/PACE and/or other waivers)
- Not currently residents of nursing homes or assisted living facilities
- Not have Medicare or Catamount Health Plan or be incarcerated.

Care Coordination Role: Overall responsibilities include: Advocacy, Assessment, Planning, Implementation, Coordination, Monitoring, Evaluation, and Outcome analysis. The care coordinators are Registered Nurses, Licensed Clinical Social Workers or Licensed Alcohol and Drug Abuse Counselors and non-licensed Medical Social Workers with direct and relevant experience in clinical delivery as well as case management experience in the community setting. The care coordinators will:

- Facilitate access to a medical home and coordination among service providers.
- Develop a plan of care for case management based on complexity, priority of both the provider and beneficiary, and social factors impacting health outcomes.
- Facilitate communication and coordination among beneficiary, PCP and specialty providers - including mental health and substance abuse- to support the treatment plan.
- Support development of skill and confidence required for effective self-management of chronic condition via coaching, education, and/or referral to programs and/or services (Certified Diabetic Educators, Healthier Living Workshops).
- Refer to appropriate resources to reduce the socioeconomic barriers to health and health care, including access to safe and affordable housing, employment, food stamps, fuel assistance and transportation to health care providers for eligible beneficiaries.