Shared Health

Where knowledge meets need

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Shared Health

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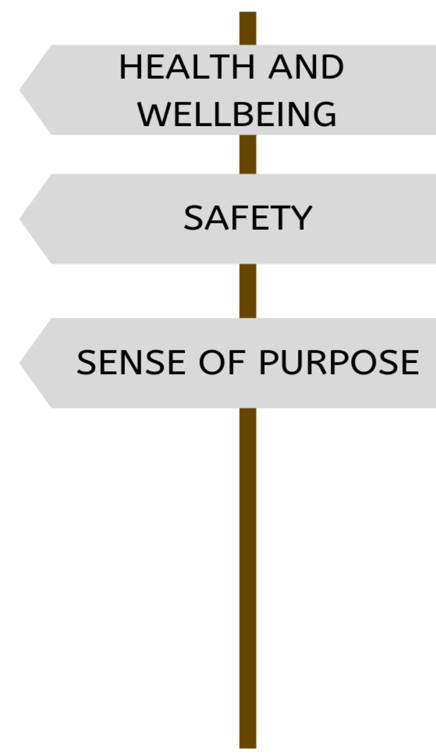
Secret Sauce: Separating Clinical from Administrative Tasks

Objectives

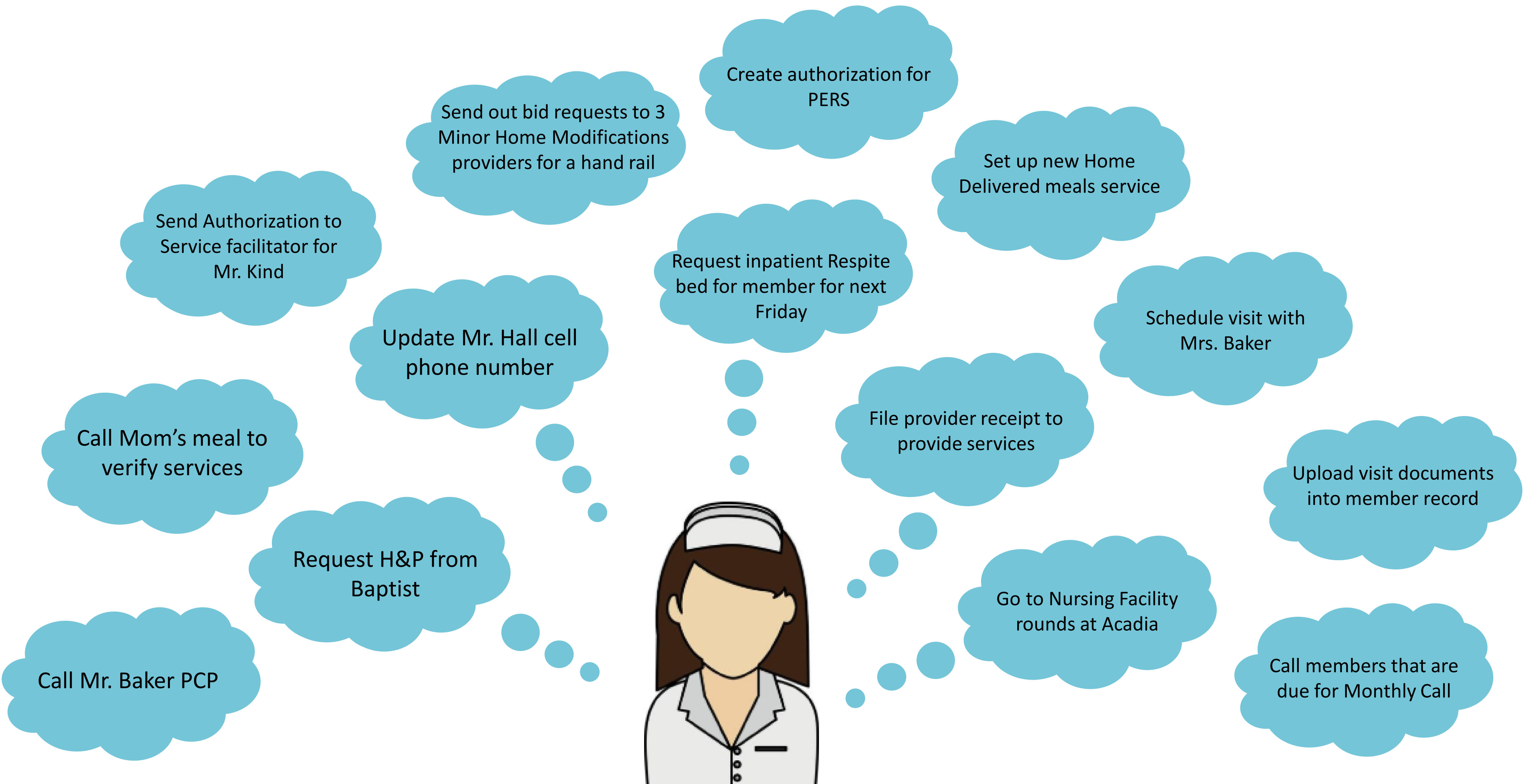
- Role of administrative staff in Care Coordination
- Part of the Care Coordination team
- Point of Contact for Members and Providers
- Outcomes
  - Adequacy and impact of services
  - Coordination of care
  - Quality of life
  - Safety
  - Community integration and participation
- Care Coordinator Outcomes
- MCO Outcomes

- Scheduler
- Researcher
- Single Point of Contact
- Member Advocate
- Trusted Resource
- Confidant
- Liaison

Part of the Care Coordination Team


HEALTH AND WELLBEING
SAFETY
SENSE OF PURPOSE

Members, Caregivers, Healthcare Providers, Family, Community, etc.
Case Manager
Support Center



Care Coordinator

Shared Health

Send out bid requests to 3 Minor Home Modifications providers for a hand rail

Update Mr. Hall cell phone number

Send Authorization to Service facilitator for Mr. Kind

Request inpatient Respite bed for member for next Friday

Call Mom’s meal to verify services

Create authorization for PERS

Request H&P from Baptist

Set up new Home Delivered meals service

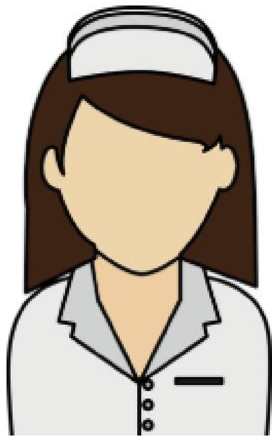
Call Mr. Baker PCP

File provider receipt to provide services

Member Associate

Shared Health

- Schedule visit with Mrs. Baker
- Go to Nursing Facility rounds at Acadia
- Upload visit documents into member record
- Call members that are due for Monthly Call



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Member Outcomes

- Adequacy and Impact of Services
- Coordination of Care
- Quality of Life
- Liability
- Community Integration and Participation

Adequacy and Impact of Services

- Completes non-clinical pathways
- Completes non-clinical screenings
- Assists with referral process
- Performs audits and assists with the quality process
- Reviews paperwork submissions to ensure accuracy and communicates to appropriate staff
- Schedules missed appointments
- Reports missed and late visits
- Sets up initial services for members

Liability

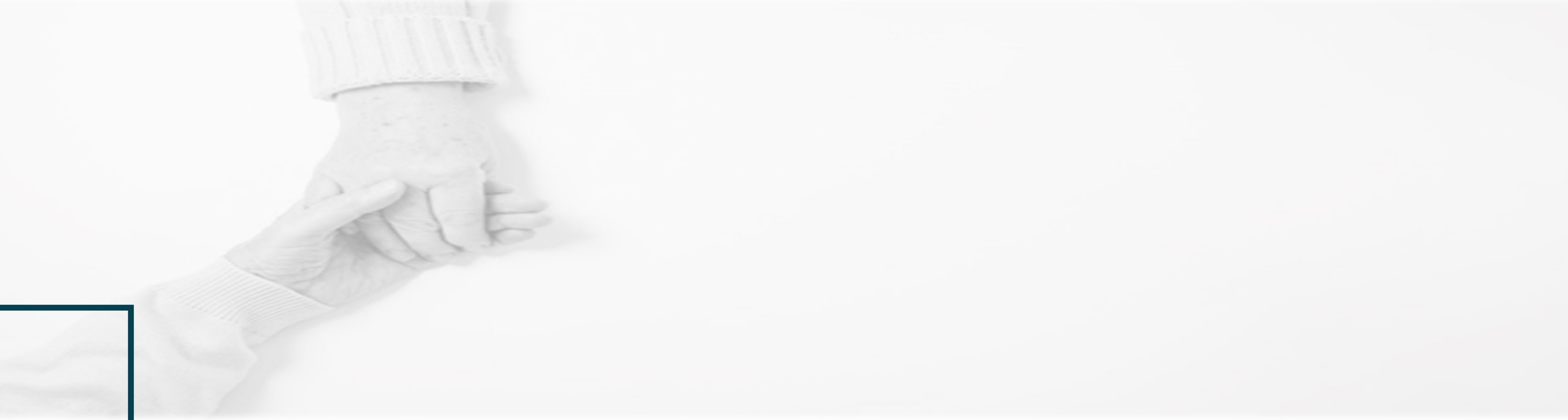
- Analyzes data and reports ER visits to Care Coordination team
- Logs trends and reports Incidents to Care Coordination team
- Assists Care Coordinators with calls to members and updates Care Coordinators if any intervention is needed
- Finds and coordinates community resources to ensure the safety of members

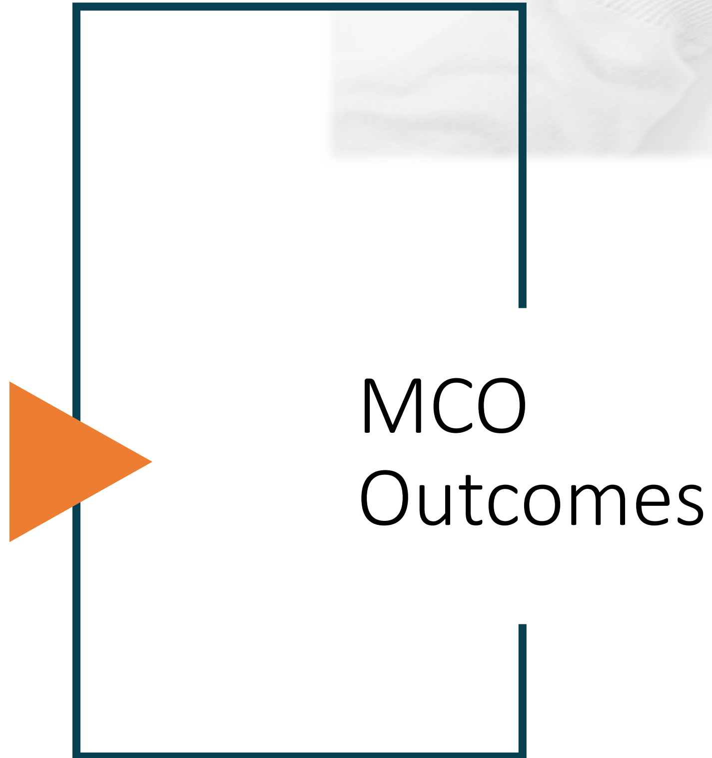
Community Integration and Participation

- Coordinates community integration activities for members such as:
  - Referral to life skill classes
  - Assisting with applications for housing
  - Suggesting community resources for independent living skills
  - Coordinates with community referrals for delivery of services
  - Assists with job placement
  - Aids in the logistics of scheduling transportation

Case Manager Outcomes

- More time to
  - Spend with the member
  - Listen to care givers concerns
- Better focus on
  - Patient centered care planning
  - Interventions and treatment plans
  - Management of chronic care and complex medical members
- Reduced hospital admissions





MCO Outcomes

- Reduced claim expenses
- Lesser CM/CC turnover
- Increase in quality of Case Management
- Better management of chronic and complex conditions
- Reduced ER visits

Conclusion

- Part of the Care Coordination team
- Dedicated point of contact for members and providers
- Improves Outcomes for Members, Care Coordinators, and MCOs

Questions?