Community based care and care management6

Patients with multiple providers/complex care5

High risk care coordination team

Site-based Care Management1

Features of effective care management:

Commonwealth Fund (2015)

* Target patients who are most likely to benefit
* Base interventions on comprehensive assessment of risks and needs
* Use evidence-based approaches to care planning and patient monitoring
* Promote appropriate care consistent with patient preferences
* Coordinate care and communication
* Facilitate referral to community resources
* Facilitate transitions (especially from hospital care)
* Promote patient and family engagement in self-care
* Include contact with providers as relevant
* Include in-person contact as relevant
* Build trusting relationships with patients and family
* Like CSA for adults: care teaming (vs. technology-supported communication, coordination, and shared care planning and support)

Medical needs in behavioral health populations3

Nurse Care Managers and medical care management programs

(Medical screening and evaluation: on-site Nurse Practitioners)

Mental health/substance use needs in primary care populations2

IMPACT and similar behavioral health care management models

Behavioral health screening and evaluation (behavioral health clinician)

Behavioral medicine (health-related

behaviors; behavioral medicine

clinician)

Integrated1c

Shared

Coordinated

Behavioral health practice1b

High need clients with access to the practice

Focus: chronic mental health/substance use disorders and poorly managed mental health needs

Care Managers (with peers, community mental health workers attached?)

Primary care practice1a

High need patients with access to the practice

Focus: chronic disease and poorly managed medical needs

Nurse Care Managers (NCM)/

Care Manager, Care Coordinator, NCM teams (with peers, community health workers attached?)

All patients transitioning from hospital care or receiving care in high risk/high need situations (such as Emergency Departments)7

High risk/transition coordination team

Total outpatient primary and behavioral health care population: Proactive population management, preventive support/health promotion, monitoring, & self-care promotion4

High need/high cost patients not engaged by various other case management services8

Payer-based identification, active engagement, and management

Patients not reached by site-based teams (including those unable to access care)

* Community Health Workers/ Peer Supports
* Community Health Teams
* In home outpatient therapy
* VNA

Social Determinants of health

Mental Health & Substance Use Disorders

Care Management Continuum