

Chapter 10

Community Care Connector

Fundamental to the Integrated Care Management Model is the development and utilization of the Community Care Connector.

The Community Care Connector is unique to South Country Health Alliance (SCHA) whereby SCHA has a:

- Delegation Agreement with each county within the 14 county service area and:
- Commitment to establish a Community Care Connector to service each of the 14 county service areas.

The Community Care Connector will serve as the primary link between South Country Health Alliance (SCHA) and the County.

The Community Care Connector will work toward transparent communication among members, providers, County and Plan staff and other outside organizations to support the mission and vision of South Country Health Alliance.

The primary goals of the Community Care Connector are to assure that SCHA members receive the most appropriate service necessary to meet their needs, that they experience smooth transitions between settings of care, that communication between SCHA, county staff and providers occur when needed in support of members and that desired outcomes are attained through collaborative problem solving approaches.

The Community Care Connector will coordinate community care services at the local level when the member is determined to be in need of such services. Existing case management services will be used whenever possible to reduce the potential of duplication of services. A care plan may be developed to assist a member in meeting their integrated care needs.

The duties and responsibilities of the Community Care Connector include:

- Clinical
 - Assist with Care Coordination as needed.
 - Assist with follow-up hospital calls and specific non-urgent Emergency visits for members who do not have an assigned Care Coordinator.
 - Refer moderate to complex members to SCHA Clinical Facilitator or the member's Care Coordinator.

- Provide case management during a transition until delegated to SCHA's Case Manger or County Care Coordinator.
- Provide face-to-face visits with members under direction by the Clinical Facilitators or Care Coordinator for assessment purposes.
- Visit members and discharge planners and/or appropriate facility staff to assist with transitions.
- Refer members' issues to county staff as needed to assure member's access to community services.
- Promote early intervention and preventative services to members.
- Administrative/Operations
 - Schedule and facilitate county care coordination meetings. Work with Clinical Facilitators and County Supervisor to develop agenda, assure participation of key staff and identify additional support when needed. Document outcomes of meetings in Client Care Manager (CCM).
 - Help assure compliance of the transition of care policy and procedures.
 - Help assure care plans are being used and updated as needed due to a medical or social event.
 - Coordinate a range of activities and information flow with the County Supervisor.
 - Organize and attend care conferences as needed.
- Communications
 - Assist with transitions of care for members, by either communicating with the member's county Care Coordinator or performing assigned duties assisting members from one care setting to another and to their permanent home.
 - Assist as needed with communication between member/member's family, provider, hospital and/or county case manager to assure understanding of treatment decisions and care plans.
 - Communicates on a regular basis with County Manager (re: transition, waivers and identify county staff involved with member).
 - Build relationships with key providers in the community (physicians/clinics, hospitals, nursing facilities, etc.); problem solve on specific member issues; provide SCHA process information, be on-site routinely for larger or key sites.
 - Communicates on a routine basis with the regional-Clinical Facilitators, case managers, and care coordinators.