Care/Case Management Model Cover Sheet

Program Name: Mental Health Care Coordination

Population Focus:

Mental Health Care Coordination Services will be provided to both children and adults who have a qualifying Medicaid mental health diagnosis. Individuals participating are those who require supports beyond traditional outpatient therapy setting including those who are at risk of being placed in a facility other than the home, loss of employment, low school attendance, and legal/court involvement.

Program Objectives:

To promote service engagement that encourages and promotes individual's independence for adults and children living with a mental illness.

Program Description:

This model of Care Coordination provides referral/follow-up and monitoring for participants who are accessing at least 2 care systems, which includes but is not limited to: mental health, educational, law enforcement, medical, employment, housing, transportation, etc. Given the remote and rural nature of Montana, this model supports an open enrollment care coordination system that allows for flexibility in service delivery to foster independence and meet the individual's needs. A major focus is placed on linkages to needed community services and the ultimate fading of care coordination interventions while simultaneously increasing independence and non-paid natural and community supports. Community care services include those which promote health and well-being and aims to reduce the need for paid professional supports. Participants will be supported in engaging in these community care services and guided by the care coordination service plan, which is created in conjunction with the individual and their team to promote individual responsibility. Outcomes will be measured through attendance and individualized goals as designated in the care coordination service plan.

This focus will encompass all aspects of the individual’s life/needs and place the measurement of a quality and meaningful care coordination program in the

ability of the care coordinator to engage the individual in service participation.

Required Care/Case Management Staff:

This program would employ and train bachelors (or equivalent) level care coordinators who demonstrate the following skill set: time management, relationship building, effective written and verbal communication, meeting facilitation, culturally competent, and professionally empathetic. The care coordinator position would not require clinical oversight but would be supervised by an experienced bachelors level manager.

Program Demographics

Monthly member count: determined by DPHHS - see population focus above

Average monthly program cost per member: $269

Average monthly total benefit cost per population member: determined by DPHHS

Monthly provider count: determined by DPHHS - depends on total enrollment

Average # of members per provider: 25 individuals served per care coordinator

Average monthly provider program revenue: $6725

Program Measurements

The program is measured based on the outcomes of individuals' service plan goals. Overall program success is measured by assessing individuals' progress in the below listed core areas. Agencies will collect baseline scores in the first year. Following year one, DPHHS will set thresholds for agencies using baseline data reported.

1. Engagement with Services
2. Promotion of Independence
3. Promotion of Health and Wellbeing

Reviews of individual services will be reviewed by the interdisciplinary team quarterly.
Reviews of agency performance outcomes of the care coordination program will be provided to the state annually.