

# Care Coordination Process Mapping:

## Simple Case - (Matthew)

Assessment

Creation of Care Plan

Referrals / Interventions

Monitoring / Reassessment

Referral  
START

Initial Contact

Assessment

Referrals / Interventions

Creation of Care Plan

Referrals / Interventions

Outreach

Assessment

Creation of Care Plan

Referrals / Interventions

Creation of Care Plan

Monitoring / Reassessment

Outreach

Monitoring / Reassessment

Creation of Care Plan

CC follows up with member after initial behavioral health visit and re-assesses member. CC updates care plan. Member has no other needs at this time.

Member agrees to assessment and scheduling follow up. Member communicates need for behavioral health. CC updates care plan and start process of connecting member to behavioral health services..

Member states they are in need of food, clothing, and utility assistance.

CC outreaches member to schedule follow up, complete assessment leading to care plan.

CC updates care plan and schedules a time to follow up after their initial behavioral health visit. CC monitors member between contacts.

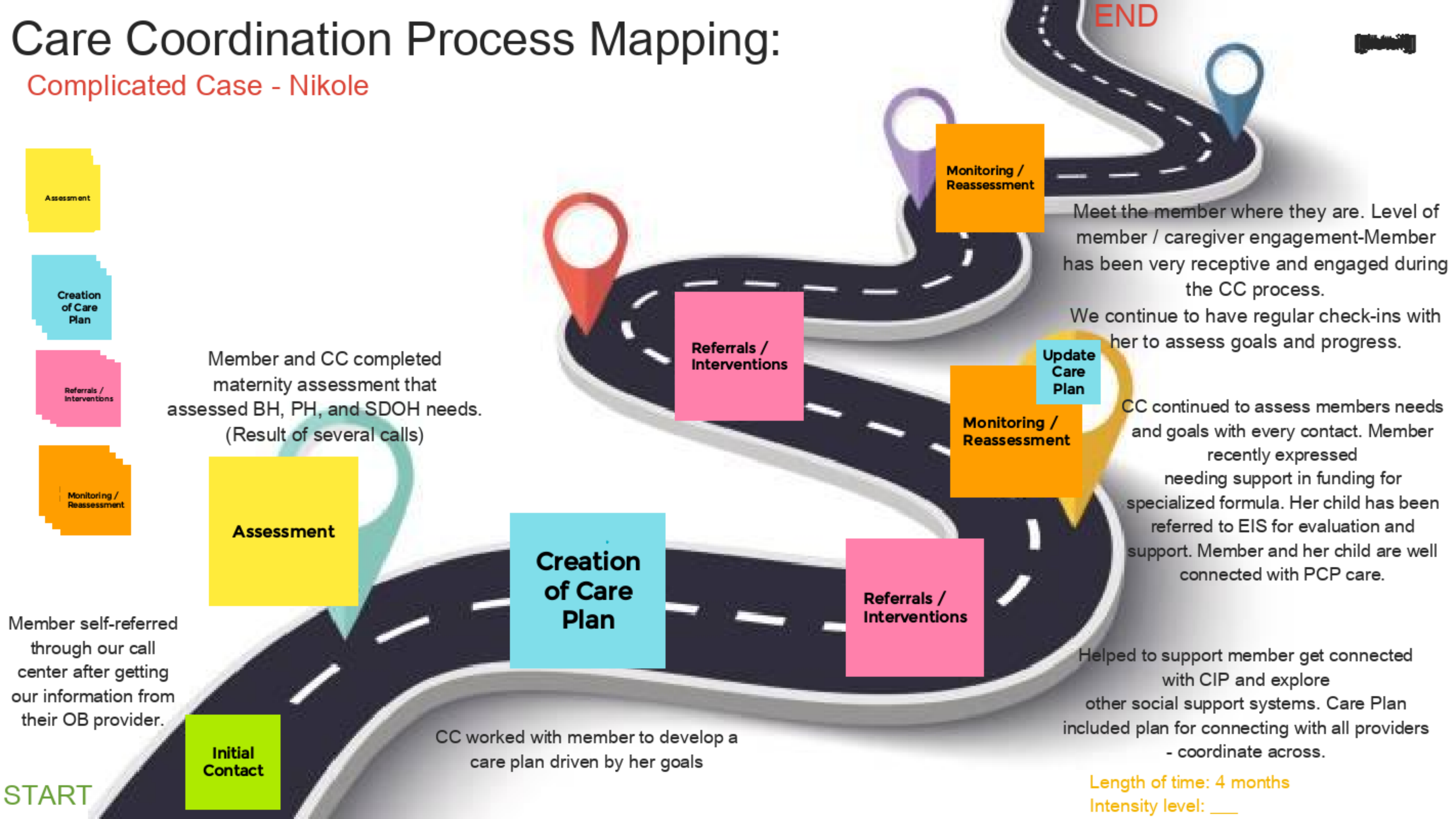
Goals met

END

Length of time: 2-3 months  
Intensity level: \_\_\_

# Care Coordination Process Mapping:

## Complicated Case - Nikole



Assessment

Creation of Care Plan

Referrals / Interventions

Monitoring / Reassessment

Member self-referred through our call center after getting our information from their OB provider.

Initial Contact

Member and CC completed maternity assessment that assessed BH, PH, and SDOH needs. (Result of several calls)

Assessment

Creation of Care Plan

CC worked with member to develop a care plan driven by her goals

Referrals / Interventions

Referrals / Interventions

Update Care Plan

Monitoring / Reassessment

Monitoring / Reassessment

Meet the member where they are. Level of member / caregiver engagement-Member has been very receptive and engaged during the CC process.

We continue to have regular check-ins with her to assess goals and progress.

CC continued to assess members needs and goals with every contact. Member recently expressed needing support in funding for specialized formula. Her child has been referred to EIS for evaluation and support. Member and her child are well connected with PCP care.

Helped to support member get connected with CIP and explore other social support systems. Care Plan included plan for connecting with all providers - coordinate across.

Length of time: 4 months

Intensity level: \_\_\_\_

START

END