



To refer patients call  
308.568.7312.

Care Coordination Services  
FOR PROVIDERS



**Care Coordination Services**

601 West Leota St.  
North Platte, NE 69103  
308.568.7312  
gphealth.org



[gphealth.org/gphin](http://gphealth.org/gphin)

# Care Coordination Services can help high-risk patients take charge of their health.

Care Coordination Services, part of Great Plains Health Innovation Network (GPHIN), includes complex care management and disease management across the continuum of care. The Care Management and Disease Management programs support the patient-provider relationship and plan of care.

Emphasis is placed on preventing disease exacerbations and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies, such as self-management tools. Patients receive Care Coordination Services to help improve their overall health status, satisfaction with the healthcare system, knowledge of their disease and use of resources.

## Care Management Program

### What is Care Management?

Care Management is a free program for high-risk patients requiring extra assistance because of ongoing medical and psychosocial needs. The goal is to make sure these individuals get the right care at the right time in the right place. Eligible patients must be part of a population in which GPHIN is at risk for their care.

### What is the care manager's role?

A care manager is a nurse or social worker who works with a patient's primary care provider to develop, implement and monitor a customized care plan addressing the patient's ongoing medical and psychosocial needs. The care manager can identify and remove barriers to care, as well as provide support and encouragement to help patients take an active role in managing their health.

### How does the program work?

A care manager meets with a patient one-on-one to complete a comprehensive assessment and discuss health

needs and goals. The care manager then develops a personalized care plan to share with the patient and patient's provider. Once the plan is in place, the care manager will regularly follow up in person or by phone to see how the patient is doing and what help is needed.

### Why partner with care managers?

By collaborating to help patients achieve optimal health, the healthcare team can improve outcomes, reduce costs and enhance the patient experience. For example, care managers can help your staff manage care gaps and adhere to evidence-based guidelines and protocols. They also can help decrease avoidable inpatient admissions, readmissions and emergency department visits by facilitating compliance with the care plan.

## Disease Management Program

What is Disease Management?

Disease management is a free program for all eligible health plan members who already have one or more of these six chronic conditions:

- Diabetes
- Congestive heart failure
- Chronic obstructive pulmonary disease
- Asthma
- Hypertension
- Hyperlipidemia
- Other mental health/substance abuse

This program works with the member's treating providers to provide well-coordinated care by identifying opportunities for prevention or intervention.

### What is the health coach's role?

A health coach helps participants develop a plan of care based on evidence-based guidelines and interventions specific to identified conditions or risks related to the following:

- Screenings
- Immunizations
- Self-management education and support
- Medication adherence
- Goal setting

Health coaches engage members through phone calls, in-person meetings and distribution of educational materials. In addition, they assist patients with referrals to weight management, smoking cessation, and alcohol and depression programs as well as support groups.

### How does the program work?

Through messages in the electronic medical record, a health coach will partner with the patient's provider on the care plan, provide scheduled and unscheduled updates on member enrollment, include opportunities for collaboration and note member's progress. Unscheduled communication between the health coach and treating provider will occur when immediate concerns arise about the patient's safety or well-being, the member presents a clinical question that requires provider input, questions or concerns occur about the patient's medications, or any other reason is identified that needs a treating provider's input.

## How are patients identified for Care Management and/or Disease Management?

Patients are selected for Care Coordination Services through diagnosis complexity, identification of barriers to improved health, compliance with treatment plan and high use of resources. Claims and electronic medical record data, predictive risk stratification tools, and provider referrals are the primary means for identifying eligible patients.

## What happens once patients are identified for program inclusion?

Once identified, individuals are automatically enrolled. They are sent a welcome packet with detailed information about Care Coordination Services.

Note that participation is voluntary, so enrollees can opt out if they prefer.

Also, people who think they may qualify to participate but have not received a welcome packet may self-refer for further eligibility review.