Practice Guidelines for Care Coordination

Purpose:

To ensure the health needs of individuals and families in the King County Behavioral Health and Recovery Division (BHRD) region are met through the coordination and provision of high-quality health care. A Care Coordinator organizes activities and information across service teams in alignment with the needs and preferences of the individuals receiving services to ensure the best possible outcomes.

Coordination of Care:

Coordination of care involves organization and collaboration of a client's care and involves two or more people who are a part of the client's care team. This can be individuals internal to the organization as well as external. Care coordination is a set of activities whereby every person served by the system has an individualized coordinated plan.

A. Care Coordination ensures the health needs of individuals in the region are met by:

   1. Monitoring engagement and service activities of individuals;

   2. Facilitating communication and collaboration between members of service teams. Ensuring the needs and preferences of the individual in services needs are known and met;

   3. Engaging allied systems to address service gaps and resource shortages;

   4. Providing discharge planning support to psychiatric inpatient units when barriers are encountered; and

   5. Clearly documenting the coordination activity by way of consent, coordination log.

B. Activities include, but are not limited to:

   1. Participation in meetings with allied systems, including collaboration on projects intended to address barriers which interfere with recovery efforts;

   2. Data gathering, including review of treatment records and contact with members of service teams;

   3. Consultation with KC BHRD staff and formal and informal supports; and

   4. Provide service recommendations.