

## **Maryland State Care Coordination**

Patients receiving levels III.3, III.5 and III.7 residential treatment supported by Behavioral Health Administration (BHA) funding are eligible to receive Maryland State Care Coordination.

Jurisdictions across Maryland may also identify additional populations, including detention centers and outpatient treatment to participate in care coordination. Other targeted high risk populations may include pregnant women, women with children, HIV positive individuals, and IV drug users.

Maryland State Care Coordinators are based in each jurisdiction at the county health departments. Care Coordinators receive a referral from the residential program while the patient is still in treatment. Care Coordinators assist patients as they transition into the recovery community by providing a connection to community/faith based services and other human services organizations.

The Maryland State Care Coordinator will conduct a face-to-face intake interview with the patient prior to discharge from the residential treatment program. The intake goal is to establish contact with the patient and orientation into Care Coordination. From the initial point of contact, promoting and utilizing positive goals and objectives as well as the establishment of a Recovery plan is a priority.

Ongoing face-to-face or telephone meetings with the patient are conducted bi-monthly or as needed to update the patient's recovery plan. Meeting with the patient will also allow coordination and support to access, participate and continue in services.

State Care Coordination services are designed to help individuals remain engaged in their recovery and to promote independence and self-sufficiency. As a systems navigator, the Care Coordinator identifies health care and recovery support needs with the patient and may initiate referrals to needed services. Common linkages include those with treatment and/or other health care, employment, legal aid, housing, child welfare, social services, and/or peer-support providers.

As the patient progresses through the stages of recovery and becomes acclimated to the recovery community, the need for care coordination begins to subside. The goal is for the patient to establish relationships within in the recovery community to sustain a healthy lifestyle free from substance use.