

PHC Complex Case Management Program (CCM)

Staff for Program:

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Care Coordination Email: CareCoordination@Partnershiphp.org

Care Coordination Provider Phone Number: 707-863-4276

Criteria:

- 2 chronic diseases (e.g. COPD, CHF, DM, HTN, Hyperlipidemia)
- Modifiable behaviors
- 8 or more medications
- Poor access to care or lack of awareness to community resources
- In need of specialty care or currently seeing multiple specialists
- Poor support network; limited or no family assistance
- Poor understanding/education of medical illnesses
- “High dollar” patients (inpatient/outpatient costs) (reports are available)
- Partnership Advantage or Partnership only members
- Other insurance as primary do **not** qualify

Referral Process:

- Call PHC Care Coordination Department and give general info (name, CIN, DOB, DX’s), current care plan and why the member would benefit from case management
- Request that an update be given on what is being done with the referral (please specify the format in which you would like the updates given (phone, fax or email)
- Member’s/Member’s families can self refer (**For Member: 800-809-1350**)

General Info:

- 6 month “high touch” program; weekly/biweekly calls to patient based on participation
- Voluntary program: member can dis-enroll at any time for any reason
- Care plan is faxed to PCP office when opened to CCM (PCP is encouraged to make changes or add to care plan)
- Case Management is done telephonically
- Interview performed to determine medical history, social history and home environment in order to identify areas of improvement
- RN/health coordinator calls patient to establish short and long term goals with the patient based on what they are willing to work on
- RN begins involvement if patient has been identified as needing health education, medication education, or if the patient has many health related questions
- For 6 months the care plan is worked and adjusted to maintain a continuum of care in conjunction with the PCP
- While in CCM we assist in the coordination of all aspects of care including barriers to access to care (e.g. transportation)
- The multidisciplinary team convenes at 3 and 6 months to assure all goals are met; when met a survey is performed patient is called by a non affiliated staff member for PHC