QUALTITY BEST PRACTICE TIPS

CARE MANAGEMENT

Definition:

Care Management is a **patient-centered approach** designed to assist patients and their caregivers in managing **chronic and complex** medical conditions more effectively. It involves the coordination of a comprehensive **array of services and activities** with goals tailored to the **individual patient's needs.**

Care Management aims to:

- Improve patient's overall health
- Prioritize patient's healthcare needs by guiding them in establishing self-driven goals and in developing a care plan
- Address preventative screenings and assist with closure of Gaps in Care
- Reduce costly medical services such as preventable ER visits and hospitalizations
- Perform medication reconciliation and identify appropriate social determinants of health services
- Enhance collaboration and communication between patients and providers
- Connect patient to community resources and educational materials

The **Interdisciplinary Care Management team** includes: Providers, Behavioral Health Clinician, Nurse Care Advisors, Care Coordinator, Community Health Worker, Health Educator, Medical Director, Pharmacist, and Community-Based Organizations.

Once a patient is enrolled, the practice will get regular updates from **EVOLENT** on the patient's status and improvement.

For inquiries and concerns, please email quality@somosipa.com

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Patients with the following will benefit from Care Management:

- Motivation to make health-related **changes and needing support** to implement those changes
- **Recent inpatient** hospitalization or other intensive-level of care services
- Requiring assistance with **referrals to in-network providers**
- Needing education and coordination around **newly diagnosed conditions**
- With **uncontrolled symptoms** of identified medical conditions
- With **social determinants of health-related** concerns, such as:
    - Housing Insecurity
    - Food Insecurity

Care Management involves the ongoing assessment of a patient's:

- Physical Health
- Behavioral Health
- Social Determinants of Health

Collaboration with Providers:

PCPs are notified when a patient in Care Management:

- Agrees to participate in the program
- Is unable to be reached
- Graduates or ends Care Management services
- Has a hospital admission & discharge
- Has multiple ER visits
- Has a change in medical condition

Referrals should include:

- ✓ Enrollee's Name, DOB, ID Number
- ✓ Reason for referral & diagnosis
- ✓ Any additional pertinent information

Referrals can be made by:

- ✓ Fax: (646)940-9886
- ✓ Email: SOMOSCareManagement@evolenthealth.com
- ✓ Phone: (855)225-3211

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