

Care Management

The Care Management Department at **Physician Health Partners** (PHP) offers a variety of services to our primary care clients. The care management approach is through a multidisciplinary team made up of nurses, social workers, triage coordinators, and census coordinators.



The Care Management Department works together with the physicians, patients, and families to:

- Support efficient transitions between settings — home, acute care facilities, skilled nursing facilities, home healthcare, and doctor visits.
- Coach patients and families utilizing a systematic approach that promotes knowledge and self-management skills.

The following triggers will activate the PHP Care Management team for any patient across the continuum:

- Acute facility stay for the diagnosis of COPD, CHF, pneumonia, or acute MI.
- All patients admitted to a skilled nursing facility.
- All patients with frequent rehospitalizations.
- Patients with complex acute and skilled facility discharge planning needs.
- Psychosocial issues, such as decreased social support, financial needs, Alzheimer's, or dementia.
- Requests directly from the offices of the primary care physician (PCP) for a care manager.

Services Provided by PHP's Care Management Department

Services to Primary Care Physicians and their staff:

- Each PCP practice has a care manager assigned as their single point of contact for all care management needs or questions.
- Standardized process of informing each practice of admits, current inpatients, discharges, and prior authorized inpatient procedures.
- Care management assessment reports faxed to the practice for each patient seen by a PHP care manager.

Facility Management:

- Monitor patient's daily progress.
- Coordinate with the hospital physician to assure the member has the right care at the right time.
- Facilitate authorizations for the services needed when leaving the hospital.

Transitions of Care Program

(based on program developed by Eric Coleman, MD at the University of Colorado):

- Support during transitions between hospital or skilled facility and home.
- Patient receives: hospital and skilled facility visits, home visit, and follow-up phone calls.
- Focuses on the Four Pillars: medication reconciliation, red flags, follow-up with PCP, and completion of a personal health record.

Hip/Knee Replacement Program:

- All patients with a prior authorized hip or knee replacement are eligible for program.
- Home visit completed prior to surgery to discuss pre-op appointments, discharge plan, Lovenox set-up and teaching, and red flags following surgery.
- Post-operative hospital visit, and follow-up phone calls are made to patient.

General Care Management:

- Social worker available to assist patients and their families.
- Long-term RN care management.

Direct Admit to Skilled Nursing Facilities:

- Assist with admitting a patient directly to a skilled nursing facility without the need for a hospital stay or emergency room visit.

Personal Health Picture:

- PHP has utilized the Personal Health Record developed by Eric Coleman, MD, MPH (www.caretransitions.org), and has designed a Personal Health Picture for patients.
- The Personal Health Picture is a tool to assist patients, families, and their healthcare team to organize their past and current health issues, including conditions, medications, advanced directives, immunizations, hospitalizations, and more.
- Patients who receive a Personal Health Picture are encouraged to bring it to all their healthcare appointments and hospitalizations.

To access services, or if you have any questions, please contact your assigned care management single point of contact, or our main Care Management Department number at 303.605.1530 — Option 2.



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