**Case Management**

Case Management is a collaborative process aimed to connect at risk clients with needs to the available resources, supports and services in the health and social systems and community organizations. It encourages and supports the self management of clients and their chronic conditions.

**Admission Criteria**

* Adults whose primary residence is on PEI, and has or is in the process of obtaining a PEI Provincial Health Number (PHN); and
* Has complex mental and/or physical health needs and/or issues with social determinants of health as demonstrated by:
* frequent hospital admissions, visits to the emergency department and/or visits to primary care or walk-in clinics, longer than usual lengths of stay in hospital;
* difficulty locating community supports/resources, waiting for mental health support/treatment, poor self-management support;
* difficulty securing or maintaining safe/secure housing; and/or,
* difficulty paying bills, e.g. buying food, purchasing prescribed meds/treatments.

**Exclusion Criteria:**

Currently living in or assessed and awaiting long term care placement (ie. on a waiting list)

Already receives similar case management/care coordination from another service area

**Referral Sources:**

Family physicians,

Hospital dischargers,

Primary care network clinicians,

Other government or community agencies

PRIMARY CARE CASE MANAGERS

Bethany MacIsaac RN OR Lindsay Lidstone RN

West Prince Primary Care Network

blmacisaac@ihis.org

lelidstone@ihis.org

Jacqueline Griffith MSW, RSW

Queens West Primary Care Network

jggriffith@ihis.org

 Colleen Murphy RN OR Adrienne Fudge RN

 Queens East Primary Care Network

 afudge@ihis.org

 colmurphy@ihis.org

 Angela Steele RN OR Arlene MacIsaac RN

 Kings Primary Care Network

 asteele@ihis.org

 acmacisaac@ihis.org

**Case Management Referral form**

**PRIMARY CARE NETWORKS**

**Phone 620-3260**

**Fax 620-3267**

|  |  |
| --- | --- |
| **Client Label:** | **Referring Provider:** |
| **Patient Name:** | **Address:**  |
| **Health Number:** |  |
| **Date of Birth:** |  |
| **Home Phone:** | **Phone:** |
| **Work Phone:** | **Fax :** |
| **Gender: Male Female** |  |

Reason for Referral:

Is Patient aware of the referral ? Yes No

Related Medical/ Surgical History:

Socio-economic Issues:

Care Provider’s Signature : Date:

 Phone # and/or e-mail address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**April 24, 2019**