How can this program help my patient?

We help patients with:

- navigational issues/ care coordination
- medication adherence
- appropriate utilization of resources
- self- management
- health education
- connection to services for, e.g. income support, disability support, pension support, drug & oxygen programs, chronic disease management programs and self-management supports

Note: *Please only refer your top 2-3 patients in need. We are currently a small program and want to ensure we are taking the highest-risk patients*

Who should I refer to case management?

We take referrals of patients who have had ≥ 3 hospital admissions and/or ≥ 5 emergency department visits or ≥ 15 primary care or walk-in clinic visits within the past year OR have difficulty securing or maintaining safe and secure housing OR have difficulty paying bills or paying for medications.

If you feel that your patient is at high-risk for inpatient admissions in the coming year, they are probably an appropriate referral.

How do I refer a patient?

That's easy! Please fax a completed referral form or email our Case Managers with the following:

(1) Name, MRN & contact info.
(2) Reason for referral,
(3) Goals/issues for your patient, and
(4) Brief background information.

Primary Care Case Management Program

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Case Management - Frequently Asked Questions

Why do we need case management?

The serious and growing burden of chronic disease and social determinants of health are challenging the sustainability of the health system. A small number of Islanders, *familiar faces*, (~7550 or 5%) have accounted for ~$81M in total inpatient, outpatient and physician costs within a 12-month period. This amount is ~12% of Health PEIs est'd expenditure for FY 2016/17.

Studies show that providing focused care and support for high risk patients decreases costs and improves health outcomes.

Case Management goals:

1) Improve patient health and experience
2) Reduce the number of preventable hospitalizations
3) Lower health system costs

What happens after I refer my patient?

A case manager will:

1) Contact your patient by phone;
2) Complete a comprehensive assessment as appropriate (may include a PHQ-9, GAD 7, physical health check-in (BP, wt), and medication review);
3) Help your patient identify their needs and goals;
4) Develop a patient-centered care plan with the patient;
5) Help your patient manage their complex health (physical and/or mental) and/or social issues;
6) Facilitate care coordination, health education, and appropriate use of resources.

Please expect to wait 1-2 weeks before your patient is contacted.

How will you communicate with me about my patient?

A letter is sent to you about the patient's identified goals and interventions, referrals made and information/education provided on social and community resources. We will collaborate with you as needed.

What are some things that the care team does not do?

- Schedule health provider/specialist visits
- Attend health provider visits
- Take the place of an NP or FP visit
- Find people a primary care provider

Is this a home-health program?

No. We <u>do not</u> visit the patient's home. We <u>do</u> coordinate with home care as appropriate.