FACT SHEET

Complex Care Management (CCM)

What
SCAN provides episodic telephonic ambulatory case management for members at high-risk for poor health outcomes and hospitalizations. Delivered by registered nurses, social workers and gerontologists the program team is interdisciplinary and includes a Board Certified Geriatrician, Clinical Pharmacist and Behavioral Health Specialist.

Who
SCAN provides case management to high-risk Special Needs Plan members, dually eligible (Medicare/Medi-Cal) members and Medicare members at risk for inpatient events who belong to shared risk medical groups with high utilization performance identified through predictive modeling (risk stratification). Referrals are also received by member self-referral, physicians, and hospital discharge planners.

Why
- To improve self-management of chronic conditions through education and coaching
- To support medical providers in member adherence to treatment plans
- To assist members in navigating the health care/medical system
- To provide members with community resource information
- To increase member satisfaction and retention

How
The program includes completion of a robust bio-psychosocial geriatric assessment to identify and help members with chronic condition self-management, medication management, function and mobility, address barriers to treatment plan adherence, address access to care issues, provide community resource needs and advance care planning. A collaborative, individualized care plan based on issues identified during assessment and appropriate to member's readiness to change is developed for each member. Interventions may include:
- Coaching to improve adherence to treatment plan and communication with MD
- Member/caregiver education on common geriatric conditions, preventive health guidelines, and advance care planning
- Referral to geriatric-focused community resources
- Communication to MD on specific actionable findings and recommendations
- Clinical pharmacy review
- Interdisciplinary team conference

When
For members identified through risk stratification or who are referred to case management, contact is initiated within 10 business days. For urgent referrals, case management is initiated within 2 business days. Cases are closed when members have no actionable problems, are transferred to another SCAN care management program, or are transitioned to a medical group case manager.

Please send completed referral form via e-mail to CMReferral@scanhealthplan.com. Please use file encryption that is password protected or fax form to (562) 989-5212. For questions regarding case management enrollment please contact our referral coordinator at (562) 308-4373.

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