Complex Case Management: Program Description

This program strives to meet the needs of the most fragile members through clinical intervention(s) and case management services. These members may have multiple chronic medical conditions, fragmented care, difficulty in navigating the health care system, or other challenges that threaten to compromise their well-being if not supported through an individualized care plan (ICP).
Care Coordination staff work to connect members' complex needs through clinical and non-clinical settings, as well as social determinants of health (SDOH).

Typical interventions provided include, but are not limited to:

- Personalized assessments and ICPs
- Motivational interviewing to build on resiliencies
- Emotional support and active listening
- Transitional care services for tailored support across settings, benefit structure, or programs
- Disease specific management support and education (i.e. asthma, diabetes, end-stage renal disease, cardiovascular disease, sickle cell anemia, cystic fibrosis, etc.)
- Teach-back techniques to promote health and support lifestyle choices based on healthy behavior
- Coordination of services (i.e. appointments, referrals, durable medical equipment [DME], transportation, medical supplies, etc.)
- Closed loop referrals to address the needs of physical health, mental health, substance use disorder (SUD), oral health, developmental health, palliative care, community supports, and/or community agencies
- Identification of barriers to established goals or treatment plan adherence
- Review for medical necessity of complex services, such as pediatric shift nursing or residential SUD treatment services
- Collaboration with the multi-disciplinary care team to ensure the member's care needs are expedited, as well as reducing duplication of efforts amongst care team members
- Assisting in access to programs such as Long Term Support Services (LTSS), Women, Infants, and Children (WIC) Program, In Home Support Services (IHSS), or other social supports

Note: Members cannot qualify for complex case management (CCM) if already actively enrolled to enhanced care management (ECM).