Section 16
Case Management
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Case management is a collaborative process which assesses, plans, implements, monitors, and evaluates the options and services required to meet an individual’s health needs. Education, coordination, and communication of available resources are utilized to promote appropriate, cost-effective outcomes.

The goal of the case management program at CDPHP is to address the needs of the whole person. It may include addressing family needs, emotional problems, financial concerns, or work-related problems that influence the health of the member. It involves effectively communicating with the patient, family, primary care physician, and specialty care provider (when appropriate) as a team.

Case management is available to all CDPHP members. Members are specifically identified for case management through multiple sources, which may include predictive model software, the pre-certification process, inpatient continued stay review, physicians, the disease management program, or retrospective claims review. In addition, members may self-refer for case management services.

A staff of registered professional nurses and licensed masters social work case managers conduct case management via telephonic management. Embedded case management is provided at selected practices participating in the Enhanced Primary Care medical home program. Case managers are also embedded in multiple community-based sites to meet with our Medicaid members.

CDPHP encourages physicians to access the services of our case management department. Physician referrals are very beneficial for the member and can be made by leaving a message on the confidential single-source referral line at 1-888-94-CDPHP (1-888-942-3747). These messages are retrieved daily and will be relayed to the appropriate case manager. Following contact by the case manager, you will receive feedback related to the interaction. Additional information can be located through our website at http://www.cdphp.com/members/case_management.aspx.

In 2009 CDPHP introduced the Health AllySM program which offers a comprehensive care management program specifically designed for Medicare enrollees. The program is offered to participants at no cost. The care model uses a needs-based approach to coordinating care that includes individualized program features. In addition the program will assure that all Medicare enrollees are stratified and referred to a care management program that best meets their individual needs.

Some examples include:

- Wellness programs designed specifically for the senior population.
- Disease management services with access to a health coach 24/7.
- Case management services to provide assistance finding community resources and coordination of complex care.

Physicians can refer Medicare enrollees to the Health Ally program by contacting the single-source referral line at 1-888-94-CDPHP (1-888-942-3747).