HOW TO REFER YOUR HIGH-RISK PATIENTS FOR SPECIAL CARE

Population Health Management (PHM)

Q How do I refer my high-risk patients to PHM services?
A Email completed referral form to **PHMReferrals@Cigna.com**.

Q Who do I call if I have questions about referring patients to PHM services?
A Call our Provider Support line at **1-602-282-9662**.

Q What services are included under PHM?
A PHM includes a range of prevention and wellness services in four categories.

1. Transition of Care
2. Disease Management
3. Care Coordination
4. Social Work

NOTE: For detailed information regarding these services, turn to the flip side.

Q What if my patient needs in-home assistance?
A In certain circumstances, PHM Social Work services include in-home care. Cigna partners with the following contracted specialists.

Behavioral health	Cigna Behavioral Health	**1-800-627-7534**
Durable medical equipment (DME)	Preferred Home Health (DME)	**1-480-446-9010** **1-800-636-2123** **http://preferredhomecare.com**
Home health	Professional Health Care Network Optum – NP Services	**1-602-395-5100** **1-866-217-0220**
Infusion	Coram Home Health Infusion	**1-480-240-3200**
Central Clinical Labs	Mobile Labs	**1-480-990-1335** **ccllabs.com**

Together, all the way.®

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Transition of Care (TOC) services

- Review and monitor while patient is inpatient
- Telephone hospital and SNF follow-up within 48 to 72 hours of discharge notification
- Personalized care planning; support/closures; connect patient back with their PCP
- Connection with community resources, home health, home base services, social work services, Medicare case management, hospice, palliative care, diabetes services
- Utilization of advanced assessment tools (LACE scoring, 4 Domains, HRA)
- Medication and utilization review, Health Assessment, Interdisciplinary Care Team Meetings
- Comprehensive TOC provider summary

Disease Management (DM) services

- Telephone teaching facilitated by an LPN or RN focusing on specific chronic diseases (CHF, COPD, diabetes)
- Utilization of the teach-back method; personalized goal setting, Healthwise evidence-based teaching eight standardized teaching modules; outcome and goal-driven program; discharge transition support
- Provider summary and communication about program progress and patient updates
- Enrollment criteria: Spirometry testing preferred, but not required, for COPD program; COPD, CHF or DM diagnosis, consent from patient prior to referral; patient is willing to learn and engage; frequent utilization related to COPD, CHF or DM
- Program exclusions: Dementia, learning disorders, hospice, patient is currently in another program for COPD or CHF

Care Coordination services

- Telephone outreach by an LPN or RN Care Team member
- Appointment reminders; review and clarify discharge instructions
- Follow-up on outstanding gaps in care; wellness check; support HEDIS/STAR quality gap closures
- Schedule appointments; assistance navigating the health care system; connecting with case management; follow-up on orders/referrals
- Connection with community resources, home health, social work services, diabetes services, Medicare case management, hospice, palliative care, disease management services

Social Work services

- Telephone outreach by a Master Social Worker (MSW)
- Behavioral health needs, substance use (chemical dependency)
- Financial (financial community resources/social welfare)
- Transportation; access to adequate social support; grief support
- Advanced Directives and other legal services
- Home visits to evaluate cognitive declines or identify advocate or family member
- Evaluate and coordinate services when abuse or neglect is identified
- Veteran services; assist in maneuvering long-term care placement systems
- In-home service providers (ALTCS and other for-profit organizations)

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