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 24-hour Provider Support line at **1-602-402-0003**.

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**
Home health	Professional Health Care Network Optum-NP Services	**1-603-395-5100** **1-866-217-0220**
Infusion	Coram Home Health Infusion	**1-480-240-3200**

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 48–72 hours of discharge notification
- Personalized care planning; support/closures; connect patient back to their PCP
- Connection to community resources, home health, home base, 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 Risk Assessment, Interdisciplinary Care Team Meetings
- Comprehensive TOC provider summary

Disease management services

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

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 to case management; follow up on orders/referrals
- Connection to community resources, home health, social work services, diabetes services, Medicare case management, hospice, palliative care, disease management services
- After-hours outreach to patients

Social work services

- Telephone outreach by a Master Social Worker (MSW)
- Behavioral health needs, substance use (chemical dependency)
- Financial (financial counseling/social welfare)
- Transportation; assess for 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)