Our Approach to **Case Management**

PacificSource Nurse Case Managers will work with your health system to coach and empower members with complex health needs. The goal of our intervention is to improve care transitions by promoting knowledge and self-management of patients and their caregivers. Together, we can help members achieve maximum healthcare benefits and outcomes.

**Identification of High Risk Members**

We have several ways of identifying members who may benefit from case management. These include:

- Prior authorization reviews and concurrent reviews of hospitalizations
- Facility referrals from discharge planners, social workers, and nurse case managers
- HCC risk scores
- 30-day hospital readmissions
- Member, caregiver, and provider referrals
- Referrals from the our 24-Hour NurseLine and condition support staff

**Support in Action**

PacificSource Nurse Case Managers are embedded at St. Alphonsus, St. Luke's hospitals in both Boise and Meridian, Vibra LTAC, and Southwest Complex Care Hospital LTAC.

Our case management begins while the member is in the hospital and continues to provide support after they are discharged.

**Prior to Hospital Discharge**

24 to 48 hours before facility discharge

- Coordinate discharge planning and member engagement. Ensure necessary resources are in place.
- Evaluate medications and discuss importance and drug reactions.

### The Four Pillars of the Care Transitions Approach

1. Medication self-management
2. Use of a patient-centered personal health record (PHR)
3. PCP/specialist follow-up and preventive care measures
4. “Red Flag” indicators of a worsening condition and appropriate next steps

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**PacificSource**

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• Explain the personal health record (PHR).
• Confirm follow-up visit(s) with primary care provider/specialists.
• Discuss symptoms (“red flags”) of worsening condition.

Follow-Up Phone Call #1
24 to 48 hours post acute care discharge
• Reconcile pre- and post-hospitalization medication lists; identify discrepancies.
• Discuss medication side effects and/or adverse reactions.
• Review and update PHR, review discharge summary.
• Emphasize importance of follow-up visit and ensure appointment is made.
• Encourage questions for PCP and specialists.
• Discuss red flags.

Follow-up Phone Call #2
7 to 10 days post acute care discharge
• Answer any remaining medication questions.
• Discuss outcome of follow-up visit(s) with PCP and/or specialist(s).
• Provide advocacy in getting appointment, if necessary.
• Reinforce when/if PCP should be called (“red flags”).

Follow-Up Phone Calls #3 and #4
Three weeks post acute care discharge
• Continue to reinforce the four pillars of care transitions.
• Provide ongoing assessment of healthcare needs and community resources.
• Assess need for ongoing focused intervention.

Ongoing Monthly Communication
• Continue to reinforce the four-pillars.
• Continue to encourage appropriate prevention and screenings.
• Provide ongoing assessment of healthcare needs and community resources.

Additional Member Support
• PacificSource has a Clinical Pharmacist who is available for medication therapy management (MTM).
• Our Behavioral Health Certified RN Case Manager is available for members identified with complex mental health needs.
• Our two Member Support Specialists are available for assistance with community resource needs, coordination with community outreach programs, applications for government programs, transportation, finding a PCP or mental health provider, and maximizing healthcare benefits.

How We Measure Success
• Re-hospitalization rates
• Follow-up member surveys at 30 days
• Compliance with preventive services and screenings
• Five Star and HEDIS quality measures
• Patient activation and self-management

If you have any questions, you’re welcome to contact one of our Health Services Representatives toll-free at (888) 862-9725.

PacificSource Community Health Plans, Inc. is an HMO/PPO plan with a Medicare contract.