

Transitional Case Management and Complex Case Management

Transitional Case Management (TCM) and Complex Case Management (CCM) programs support participating members in a variety of care settings, going beyond traditional medical coverage and preventive services.

Using medical, pharmacy and health claims information, Case Managers can identify members at risk and direct them to programs and services to help improve and maximize their care. Through the use of coordinated systems and advanced software, Case Managers are able to identify members in need, and provide education and care coordination to assist them in obtaining needed treatment while removing barriers to service.

Goals of the TCM and CCM programs include:

- ▶ Reduce the member's hospital admissions and readmissions for preventable treatment and disease complications
- ▶ Verify that a workable discharge plan is in place for the member
- ▶ Encourage discharge plan adherence
- ▶ Assist in coordination of physician's treatment plan, consistent with the member's benefits
- ▶ Help improve the member's overall satisfaction with his/her health care
- ▶ Refer members to the appropriate Case Management (CM)/Disease Management (DM) program(s)

The Transitional Case Management (TCM) program supports members in transition from an inpatient setting to a home setting. In an effort to prevent avoidable readmissions, TCM consists of discharge follow-up and case management. The TCM team works closely with members and their physicians to support and reinforce treatment plans, emphasizing symptom management and patient empowerment.

Discharge follow-up calls are made to assist the member with:

- ▶ Treatment plan adherence
- ▶ Medication adherence
- ▶ Physician follow-up
- ▶ Disease process education
- ▶ Caregiver availability information
- ▶ Homecare evaluation and resources
- ▶ Referrals to other CM/DM programs (i.e., Active Care EngagementSM and Transplant)
- ▶ For Medicare members, we also have case stabilization available (i.e., homecare, resources)

Our outbound call programs also use evidence-based guidelines to identify high-risk members for gaps in care. At the core of these programs is health education as well as a focus on self-care, close follow-up with the treating physician and medication management. Members have access to information and resources that focus on education, prevention and health reminders. Programs also include potential medical director peer-to-peer conversations that allow physicians to discuss gaps in care and review best practices.

Who is eligible for the TCM program?

Fully insured and self-funded commercial Oxford plan (group) members, based on a readmission risk-scoring process that helps identify which hospitalized members would benefit most from discharge follow-up support.

Members who are participating in another Oxford clinical program, such as our Active Care EngagementSM, Rare Chronic Care or Transplant program, and members who have secondary coverage through an Oxford plan are not eligible for TCM.



The Complex Case Management (CCM) program provides access to specialized nurses as well as other resources that can assist in better managing a member's health and coordinate the member's health care needs. By collaborating with members and their physicians, or other health care professionals, the nurses are able to facilitate access to health care services and provide support for health-related decisions, which may allow members to obtain the highest quality of care, maximize their health care coverage, and potentially save money.

A CCM Nurse will:

- ▶ Provide one-on-one health care information, guidance and support
- ▶ Help coordinate care with physicians and health care professionals
- ▶ Provide support in understanding and following a physician's treatment plan
- ▶ Help provide education to support self-care skills
- ▶ Provide guidance in obtaining the right equipment and self-care supplies
- ▶ Provide support to assure medication compliance

More than 23 high-risk conditions are supported through the CCM program, with referrals to transplant and neonatology resource services, programs and specialists in these complex areas. In addition to health information and care support, screening for depression is provided to help those who may have behavioral health needs get directed to the appropriate behavioral health resources.

When a member is identified for these programs, he or she is assessed to determine the appropriate level of intervention. A Case Management Registered Nurse will contact the member by phone to explain the program details and help enroll the member in the program.

Who is eligible for the CCM program?

Eligibility is determined when certain health events occur that require medical attention, or by physician referral. Case management is available to commercial plan members who meet eligibility criteria. We proactively identify these members based on the member's overall health status, complexity of the member's issue(s) (i.e., medical, psychosocial or financial) and the member's risk of future hospitalization.

Members who are participating in another Oxford clinical program, such as our Active Care Engagement, Rare Chronic Care or Transplant program, and members who have secondary coverage through an Oxford plan are not eligible for CCM.

Physicians may refer covered individuals to any of the Case Management programs by calling the toll-free service telephone number, **1-800-666-1353**, and speaking with a representative to initiate a referral to the appropriate program. Members can also be identified at the time of hospital discharge, referred from *Oxford On-Call*[®], through self-referral, and through direct referrals, by physicians or other practitioners. Members may opt out of a program at any time.



Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc., Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Administrative services provided by Oxford Health Plans LLC.