



# Case Management Programs

To connect members with the right resources at the right time, we offer case management services to all members with complex or high-risk health conditions. Our services help members better understand their health while coordinating their care to develop and implement a care plan that's focused on their goals and health needs.

**Complex case management:** Members with multiple chronic conditions, catastrophic events, complex or uncontrolled health conditions.

## Specialty case management

**Transplant:** Members undergoing transplant evaluation or currently on a list for a transplant.

**Oncology:** Members with an active or complicated cancer diagnosis.

**NICU:** Newborns with complications or conditions requiring a neonatal intensive care stay.

**Kidney care:** Members with an active diagnosis of chronic kidney disease or undergoing dialysis.

**Specialized pregnancy care:** Expectant mothers with a high-risk pregnancy due to carrying multiples or complicated medical conditions.

**Mental wellness:** Members with substance-use disorders, depression, anxiety, bipolar disorder, schizophrenia or personality disorders with admissions or emergency room use.

**Care transitions – medical or behavioral health:** Members with inpatient hospitalizations for a medical or behavioral health need that is managed for 30 days.

**Social work:** To address psychosocial needs, members with identified social determinants of health are referred to a social worker for assistance to connect with community resources.



### Care Transitions – Post-Inpatient Admission (medical and behavioral health) and Emergency Room Visit

Support for healthy transitions and care coordination

### Complex Case Management

Support for managing chronic diseases and other health conditions, and health care services to create positive outcomes

### Specialty Case Management Programs

Specialized case management for members undergoing transplant services, kidney care, oncology treatment, specialized pregnancy care, NICU admission or mental wellness needs

### Social Worker Support

Support and connection to community resources to address social determinants of health needs

## Team members

- ✓ **Case Managers:** The case manager role for medical case management programs is a registered nurse and a licensed counselor or a master's level social worker for behavioral health programs.
- ✓ **Social Worker:** The social worker role addresses social determinants of health identified through our assessments. They assist with coordination of community resources and support for psychosocial needs.
- ✓ **Intake Coordinator:** The intake coordinator is an administrative role and assists with outbound calls to enroll in case management and provides department support for mailings, surveys and file management.

## Program Identification and Referrals

- Members are identified for case management programs based on criteria and rules that look at claims and authorization information. Once identified for the program, a risk score is used to rank individuals by highest risk to prioritize the highest risk members for outreach.
- Referrals to the programs can be made by the member, family members, providers or other Sanford Health Plan teams.

## To refer a patient, contact the case management team at:

📞 **Phone: (888) 315-0884**

✉️ **Email: [shpcasemanagement@sanfordhealth.org](mailto:shpcasemanagement@sanfordhealth.org)**