Goals of CCM

- Connect to appropriate community resources
- Develop teams that include family, medical, and behavioral health professionals
- Improve quality of life
- Provide early intervention to prevent crisis

CMM services do not take the place of current services but are integrated with the clinically responsible service provider's case management services.

Referral Process

The DWIHN CCM staff may receive referrals for services via :

- E-mail
- Fax
- Phone

A referral form is available on the DWIHN website on the Integrated Health Care page.

Referrals can be faxed to 313-989-9529 or e-mailed to pihpccm@dwihn.org.

Along with the referral form please send current bio Psychosocial assessment , LOCUS/SIS assessment and any other relevant clinical documents.

Detroit Wayne Integrated Health Network

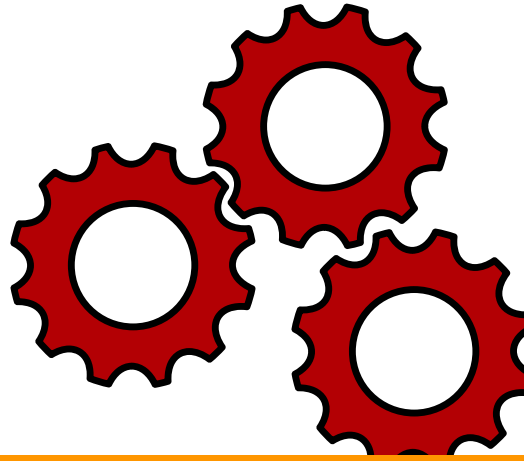
707 W. Milwaukee Street
Detroit, MI 48202
313-833-2500
www.dwihn.org

24-Hour Access Center

800-241-4949

Detroit Wayne Integrated Health Network
DWIHN
Your Link to Holistic Healthcare

COMPLEX CASE MANAGEMENT



What is Complex Case Management (CCM)?

CCM is a collaborative process that includes assessment, planning, facilitation, and advocacy. It explores options and services to meet a person's identified needs with the ultimate goal of promoting high quality, person-friendly and cost effective outcomes.

CCM does not take the place of services already being received - it compliments them. Participation is not dependent upon the health benefit available to enrollee.

CRITERIA TO PARTICIPATE IN CCM

The DWIHN CCM program has general eligibility criteria for adults and children/youth.

ADULTS

- An active member of outpatient behavioral health services with a disability designation of SMI, DD/IDD, or SUD as evidenced by at least one visit within the quarter with a DWIHN provider AND
- Evidence of one or more gaps in services, i.e., absence of primary care or specialty medical care visits within the last 12 months, or gaps in medication refills for behavioral health and/or medical chronic conditions AND
- One or more of the following chronic medical health conditions: hypertension, diabetes, asthma, COPD, heart disease and obesity as well as ten or more visits to the ED in the last six months OR
- Willingness to be an active participant in the program for at least 90 days.

CHILDREN/YOUTH

- Diagnosed with serious emotional disturbances (SED) and seen for services at a DWIHN provider at least once in the last quarter AND
- Should range between the ages of 2-21 years of age - those enrollees in this cohort that are 18-21 are usually designated as youth with learning disabilities, court wards, I/DD, etc. - AND
- Diagnosed with chronic asthma AND
- 4 or more ED visits related to asthma or behavioral health in the last 12 months OR
- Gaps in service/care - i.e., absence of primary care visit within the last six months and gaps in refilling prescriptions for asthma controller medication and/or behavioral health medication AND
- Willingness of child/youth and/or parents/guardian to be active participants in the program for at least 90 days.