

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

CCM services are short term and does 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 pihpccm@dwihn.org
- Fax 313-989-9529
- Phone 313-833-2500

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

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



COMPLEX CASE MANAGEMENT

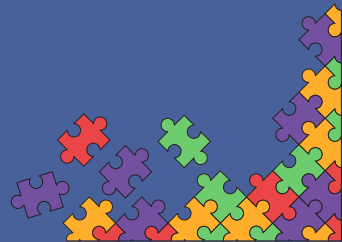
CONTACT US!

Phone: 313-833-2500

Access Helpline: 800-241-4949

Website: dwihn.org

707 W. Milwaukee St. Detroit, MI
48202



What is Complex Case Management?

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.



Criteria to Participate

The DWIHN CCM program has general eligibility criteria for adults and children/youth. CCM is a voluntary program, all active participants have to be willing to participate in the program for at least 90 days.

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:

- Absence of primary care or specialty medical care visits within the last 12 months
- Gaps in care (medication refills, not seeing doctors and etc.)
- Medical Issues (Asthma, Obesity, Chronic Pain, Diabetes, Pregnancy and etc.)
- Frequent ED visits within the last six months
- Missing appointments with behavioral health providers

Children/Youth

Diagnosed with serious emotional disturbances (SED) and autism spectrum disorder (ASD) between the ages of 2-21 years of age and diagnosed with a chronic medical health condition (Asthma, Obesity, Cerebral Palsy, Epilepsy, Pregnancy and etc.) as well as evidence of one or more gaps in services:

- Frequent ED visits related to medical and/or behavioral health in the last 12 months
- Gaps in services and/or care (absence of primary care visit within the last six months, gaps in refilling medications, and etc.)
- Missing appointments within behavioral health providers

