McLaren Physician Partners
MPP NEWS FLASH

April 27, 2018

Care Management Referrals

McLaren Physician Partners and McLaren High Performance Network, LLC continue to build our Care Coordination and Management Program. The services we provide target patients in "risk-based" contracts and Medicare Shared Savings Plans, with the goal of improving overall quality of care and outcomes while reducing avoidable utilization.

Our multi-disciplinary Care Coordinators currently provide Transition of Care and Chronic Care Management services for high-risk patients. The Transition Program allows us to identify patients who are at risk upon discharge and assess and address their healthcare needs while ensuring a smooth transition to the next level of care. The Chronic Care Program identifies patients through analytics using disease classification and utilization patterns. These patients are assessed for ongoing care management that includes: education on self-management techniques, access to care, financial concerns, transportation, home health care or assistance, inadequate housing or food, and other social and medical problems that affect the patient's health.

As we continue to identify those patients who have had hospitalizations, re-admissions within 30 days and frequent Emergency Department visits, we ask that you refer to us any of your Medicare and Medicare Advantage patients who you feel would benefit from these types of services.

For your convenience, referrals can be made using one of the following methods:

- By phone via our secure number 1-844-368-1817
- Fax directly to 248-484-4999 utilizing the attached form.

For additional information or questions, please contact Andrea.Phillips1@mclaren.org or call (248) 484-4947.

McLaren Physician Partners and Mclaren High Performance Network
Care Coordination Referral

Name & DOB:		Address:
Preferred Contact Number:	Emergency Contact & phone number:	Payor (circle one): • Medicare FFS • Medicare Advantage
Primary Care Provider:	PCP's preferred Contact/Time:	Notes:

Reason for Referral

Transitions	Complex Care Management
• Hospitalization • Emergency Visit – High Utilization • Skilled Nursing Facility/Subacute Rehab • Home Health Care	• One or more Chronic conditions -Education • Preventable Screenings - Education • Advanced Care Planning - Education/Support • Community Resources

Diagnosis/Focus Problem

- Asthma
- CHF
- COPD
- Diabetes
- Dementia
- Falls/Safety
- Hypertension
- Mental health/Behavioral Health
- Obesity/Weight Management
- Medication Management

Other_____
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Please send referral to: mppcarecoordination@mclaren.org or fax: 248-484-4999