

Intensive Care Management Program

Intensive Care Management

- Intensive Care Management provides Care Coordination to high risk Husky Health and Charter Oak members
- Intensive Care Managers partner with you, the Provider, to facilitate a smooth transition of care across settings.
- Promote Wellness and Preventive Care

Program Goals

- Assist the patient to follow through on your recommended treatment plan
- Promote Medication knowledge, safety and adherence
- Coordinate care by assisting you and your patient to access medically necessary services.
- Empower members in self care through education, self-help coaching and patient centered care planning.

Role of ICM Care Manager

- Collaborates with the interdisciplinary team, member and provider
- Assess, develop and coordinate a member centric integrated care plan
- Offers a hybrid model of “face to face” and telephonic communication
- Work collaboratively with external regulatory agencies, waiver programs and ASO partners

Referral Process

Contact Provider Line - **1.800.440.5071** and when prompted dial **EXT 2011** to request ICM services

ICM Contacts

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Community Support Services Program

Presenter:

Tiffany Huntoon, MBA

Manager, Community Support Services Program

Philosophy and Goals

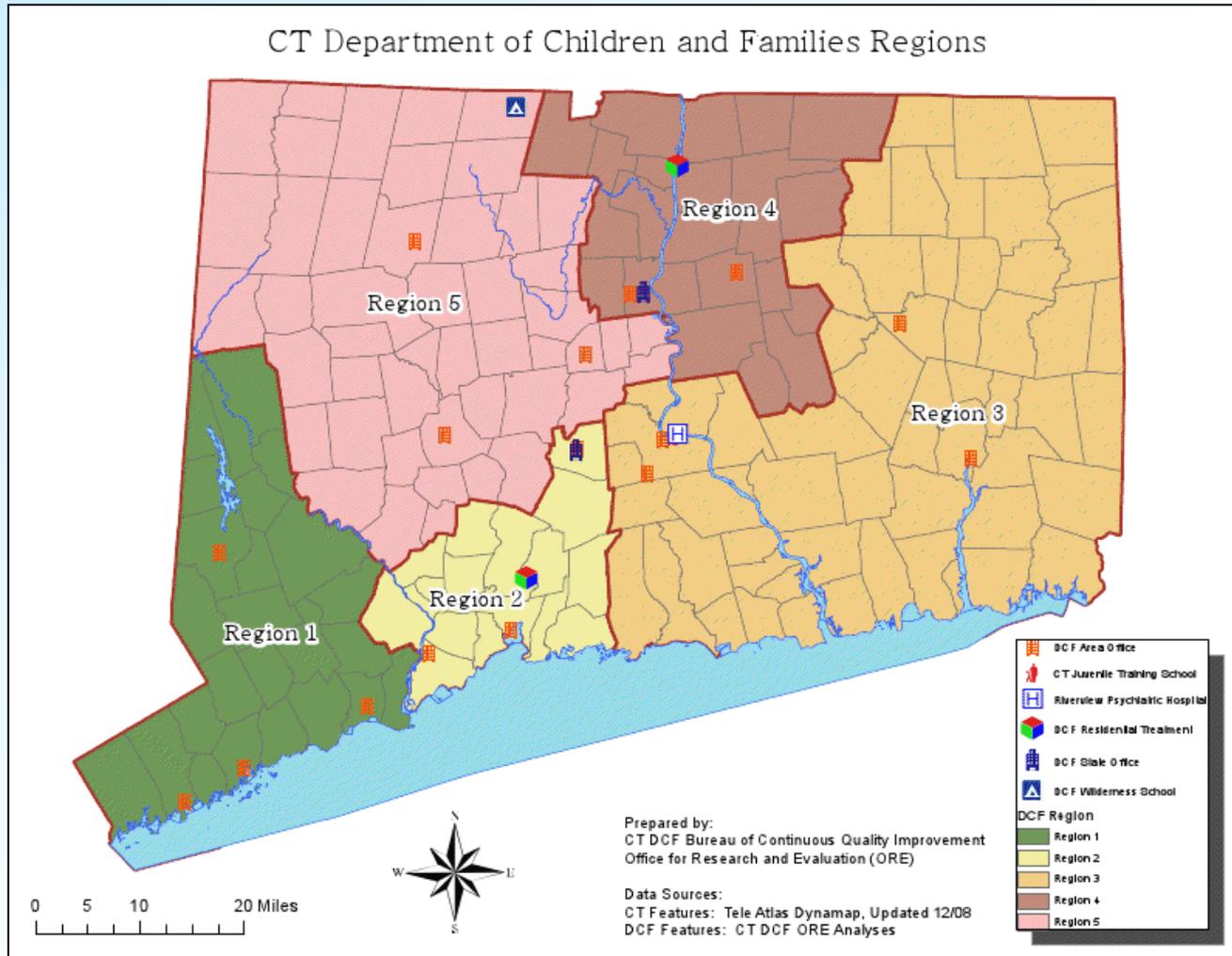
Member-Centered

- Assist Members in meeting their basic life necessities
- Help members identify and access resources within the community
- Utilize a wraparound approach, encourage information sharing and treat all participants with dignity and respect
- Empower members to reduce barriers to maintaining a healthy lifestyle
- Encourage members to be active participants in their own plans of care

Community Support Services Team

- Director of Community Support Services
- Manager of Community Support Services
- 11 Human Services Specialists
 - Regionalized (5 Regions)
 - Bilingual Staff
 - Language Line
- 1 Community Support Services Clerk

Community Support Services Team: Regions



What does a Human Services Specialist do?

- Empowers members to improve their healthcare
 - Addresses barriers and assists in resolve
 - Collaborates with all participants coordinating the member's care
- Refers to community organizations and providers
 - Attends statewide collaborative meetings
 - Acts as a liaison to ensure successful engagement
- Assists in Identifying Natural Supports
 - Identifies existing connections and relationships
 - Builds new relationships
- Encourages Self Advocacy
 - Teaches basic life skills
 - Empowers and supports throughout the process

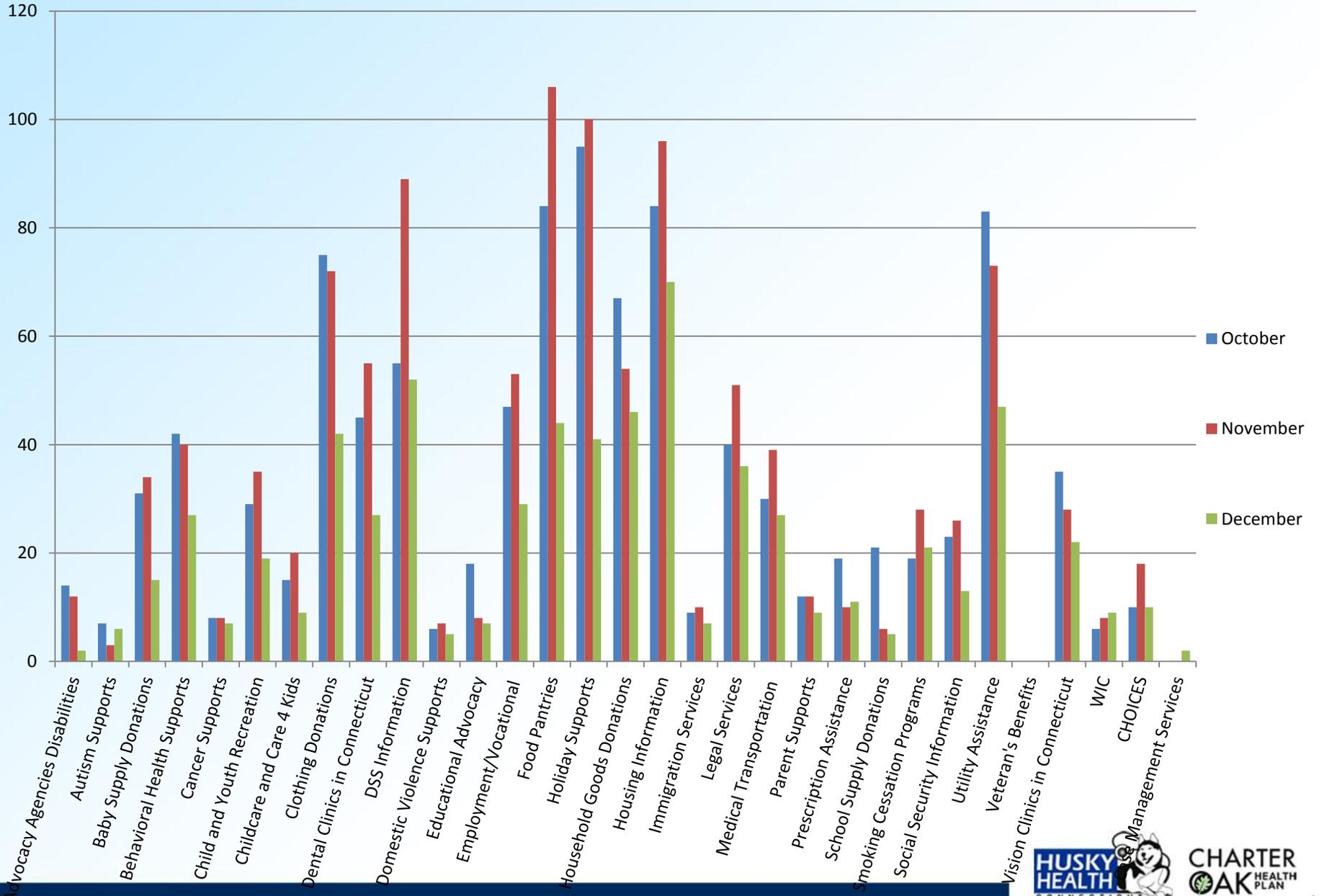
Program Structure

- Hybrid Model of Care Coordination
 - Face-to-face home visits
 - Face-to-face community visits
 - Telephonic intervention
- Individualized Services Provided: “Meet Members Where They Are”
 - Conduct intakes that assess:
 - Social Service and community resource needs
 - Emotional and behavioral health care needs
 - Physical health care needs
- Resources are Provided to Alleviate Barriers
 - Local and accessible
 - Culturally- and linguistically-appropriate

Community Resource Assistance

- Housing
- Food
- Clothing
- Utility Assistance
- Childcare
- Behavioral Health Services
- Dental Services
- State Benefits
- Disability Services
- Employment Services
- Parenting Supports
- Holiday Supports
- Educational Supports
- Youth Programs
- Cancer Supports
- Domestic Violence Supports
- Legal Services
- Vision Services

Community Resources Provided 4th Quarter 2012



Early Identification: Children Ages Birth to 5 ½

- Assessment identifies children with developmental and/or behavioral concerns
- Ages and Stages questionnaires utilized as an early identification tool

Ages and Stages

Screen Five Major Developmental Areas:

- Communication
- Gross Motor Skills
- Fine Motor Skills
- Problem Solving
- Personal-Social

Risk Factors Associated with Poor Developmental Outcomes

Medical:

- Low birth weight
- Prematurity
- Seizures
- Serious illnesses

Environmental:

- Poverty
- Parents with cognitive impairments
- History of abuse/neglect
- Teenage parents

Referrals Based on Ages and Stages Questionnaire Results

- CT Birth to Three Program
- Nurturing Families Network
- Child Development Infoline
- Pediatrician
- ICM RN at the ASO

Key Points:

- Care Coordination is essential
- Duplication of services is avoided

Program Follow Up

- Continued Availability for Ongoing Support
 - Members are encouraged to contact Human Services Specialists any time they are facing barriers
- Post-Intervention Assessment
 - Conducted 90 days after face-to-face visit or telephonic contact
 - Assure successful connections were made
 - Address new or unmet needs
- Satisfaction Surveys
 - Provided after face-to-face visits and telephonic contact
 - Assure quality of services

Provider Outreach and Collaboration

- Statewide Outreach Presentations
 - On-Site Collaboration with Providers to Ensure Access to Community Support Services
- Direct Referrals from Providers
 - Establish Open Lines of Communication Regarding Patient Needs
 - Continual Updates Provided to Enhance Coordination of Services

Supporting Person-Centered Medical Home

NCQA Standard 4: Provide Self-Care Support and Community Resources

4A: Support Self-Care Process

4B: Referrals to Community Resources

National Quality Strategy: Triple Aim

- Promote Access
- Reign in Cost
- Achieve Quality

Supporting Person-Centered Medical Home

<p style="text-align: center;"><u>Provider Benefits</u></p> <p style="text-align: center;">Enhanced Reimbursements</p> <p style="text-align: center;">Higher Levels of Intrinsic Motivation</p> <p style="text-align: center;">Improved Communication</p> <p style="text-align: center;">Increased Knowledge-EHR</p> <p style="text-align: center;">Investment for Increased Profitability</p> <p style="text-align: center;">NCQA Recognition</p>	<p style="text-align: center;"><u>PCMH Structure</u></p> <p style="text-align: center;"><u>Conformity with NCQA Standards</u></p> <p style="text-align: center;">Provide Access/Continuity of Care</p> <p style="text-align: center;">Identify/Manage Patient Populations</p> <p style="text-align: center;">Plan and Manage Care</p> <p style="text-align: center;">Self-Care Support & Resources</p> <p style="text-align: center;">Track and Coordinate Care</p> <p style="text-align: center;">Measure and Improve Efficiency</p> <p style="text-align: center;">Electronic Health Record Utilization</p> <p style="text-align: center;">Team-Based Care Coordination</p> <p style="text-align: center;">Service Oriented</p>
<p style="text-align: center;"><u>Patient Benefits</u></p> <p style="text-align: center;">Improved Quality of Care</p> <p style="text-align: center;">Person-Centered Care Plan Goals</p> <p style="text-align: center;">Improved Communication</p> <p style="text-align: center;">Patient Self-Management</p> <p style="text-align: center;">Ownership of Your Healthcare</p> <p style="text-align: center;">24/7 Access to Care</p> <p style="text-align: center;">Access to Your Medical Information</p> <p style="text-align: center;">Enhanced Trust in Providers</p> <p style="text-align: center;">Intensive Care Management</p>	<p style="text-align: center;"><u>Outcomes</u></p> <p style="text-align: center;">Savings in Healthcare Costs</p> <p style="text-align: center;">Reduction in Duplicate Services</p> <p style="text-align: center;">Decreased Racial/Ethnic Disparities</p> <p style="text-align: center;">Healthier Outcomes</p> <p style="text-align: center;">Improved Standards of Life</p> <p style="text-align: center;">Quality Improvement Initiatives</p> <p style="text-align: center;">Develop Evidence-Based Practices</p> <p style="text-align: center;">Catalyst for Payment Reform</p> <p style="text-align: center;">Catalyst for Delivery System Reform</p>

Making a Referral

Manager of Community Support Services

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For more information about Health Services, please visit the
HUSKY Health Website:

www.huskyhealthct.org

Toll-Free:

1.800.859.9889

Fax:

1.203.265.7948

Community Support Services Referral Form



Member Name:

Member ID Number:

Member Address:

Member Telephone Number:

Referring Person's Name and Department/Company:

Referring Person's Contact Information:

Reason for Referral: Assistance with the following Community Supports

- | | |
|---|--|
| <input type="checkbox"/> Advocacy for Persons with Disabilities | <input type="checkbox"/> Household Goods Donations |
| <input type="checkbox"/> Autism Supports | <input type="checkbox"/> Housing Information |
| <input type="checkbox"/> Baby Supply Donations | <input type="checkbox"/> Immigration Services |
| <input type="checkbox"/> Behavioral Health Supports | <input type="checkbox"/> Legal Services |
| <input type="checkbox"/> Cancer Supports | <input type="checkbox"/> Medical Transportation Assistance |
| <input type="checkbox"/> Childcare and Care 4 Kids | <input type="checkbox"/> Parent Supports |
| <input type="checkbox"/> Child and Youth Recreation | <input type="checkbox"/> Prescription Assistance |
| <input type="checkbox"/> Clothing Donations | <input type="checkbox"/> School Supply Donations |
| <input type="checkbox"/> Dental Clinics in Connecticut | <input type="checkbox"/> Smoking Cessation Programs |
| <input type="checkbox"/> Dept. of Social Service Information | <input type="checkbox"/> Social Security Information |
| <input type="checkbox"/> Domestic Violence Supports | <input type="checkbox"/> Utility Assistance |
| <input type="checkbox"/> Educational Advocacy | <input type="checkbox"/> Veterans Benefits |
| <input type="checkbox"/> Employment and Vocational services | <input type="checkbox"/> Vision Clinics in Connecticut |
| <input type="checkbox"/> Food Pantries | <input type="checkbox"/> WIC |
| <input type="checkbox"/> Holiday Supports | |