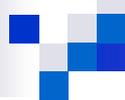


Intensive Care Management – Member Care Planning

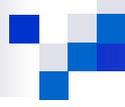
September 23, 2016





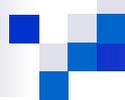
Presenters

- Venice F. Churilov, RN, MA, CCM
Director, Intensive Care Management
- Margy Roberts, LCSW
Manager, Community Support Services
- Aiveen Iovanna MSN, RN, CCM
Team Lead, Training and Auditing, Intensive Care Management
- Anna Luna
Community Health Worker, Intensive Care Management



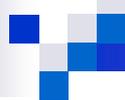
Agenda

- Objectives
- Overview of Intensive Care Management
- Development of Care Plans
- Collaboration
- Integrated Role of Community Health Workers
- Questions and Answers



Presentation Objectives

- Explain when a care plan is developed, and how often is it updated/reviewed
- Describe the role of the member in the care plan
- Clarify where the care plan actually exists in the system
- Explain how are goals established, measured, & accomplished
- Identify who is in charge of the care plan
- Describe how the ASO coordinates and collaborates with providers or others involved in the members care



Intensive Care Management Program

- Intensive Care Management (ICM) is a voluntary program developed to help HUSKY Health members manage their social, medical, financial and behavioral health needs
- The Intensive Care Manager and the member interact through face-to-face visits, phone calls, and/or video conferencing sessions
- Referrals are received from a variety of sources, including hospital reports, hospital staff, providers, CHNCT's Member Engagement Services, state agencies, data analytic reporting, and more

Who ICM Serves?

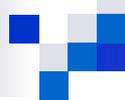
The program works with members who have:

- Multi Chronic Conditions (MCC) such as coronary heart disease, heart failure, COPD, chronic pain, children and youth with special healthcare needs and substance abuse
- Coexisting medical and behavioral health conditions Serious and Persistent Mental Illness [SPMI]
- Need for coordination of services for organ transplant authorizations, transgender procedures, pain management services
- Need for condition care management:
 - Asthma
 - Diabetes
 - Sickle Cell
 - Perinatal, postpartum, and newborn needs

Goals of the ICM Program

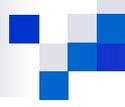
- Assist with identifying barriers and strengths
- Encourage participation with provider treatment plans
- Empower members to take control of their conditions
- Promote health and wellness





What is a Care Plan?

- A Care Plan is developed with the member and/or Head of Household [HOH] to serve as a road map for the member to be able to manage their own care
- The Care Plan is a part of the ICM Assessment
- ICM develops a Care Plan within 14 days of completing a member's assessment
- The Care Plan is reviewed and updated during each interaction with the member
 - At minimum every 90 days, usually every few weeks



The 5 Parts of a Care Plan

1. Assessment
2. Problems
3. Interventions
4. Goals
5. Coordination & Collaboration

Assessment

The member and/or head of household and nurse have a conversation to identify the member's strengths and barriers, including:

Basic and Social Needs

- Food Security
- Safety of Living Environment
- Social Determinants of Health
 - Poverty, socioeconomic status, etc.

Conditions and Diagnoses

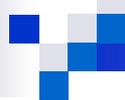
- Assess Condition Management
- Impact of Condition on Member's Life

Stress & Behavioral Health Needs

- Perceived Stress Scale
- Depression Screening
- Domestic Violence Screening
- Risk Taking Behaviors

Ability to Care for Themselves

- Acquire Medical Care
- Follow Treatment Plans
- Take Medications as Prescribed
- Manage Conditions on a Day-to-Day Basis



Problems & Interventions

- Care Plan Problems

- Problems are identified with the member or head of household from the answers to the questions asked by the nurse in the assessment

- Care Plan Interventions

- Interventions are identified by the nurse
- Nurses help the member resolve and/or address the care plan problems and achieve goals

Goals

ICM works with members to identify new ways in which members can take care of themselves by posing questions such as:

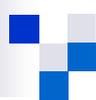
What is most important to you?

What do you think might get in the way?

What would you like to work on first?

When do you think you can start?

What steps do you want to take next?



Goals – SMART Format

- **Specific**: The goal is specific to what action or behavior will take place to achieve the goal
- **Measurable**: The goal can be measured
- **Attainable/Agreed Upon**: The goal is achievable, relevant to the problem, and agreed upon
- **Realistic**: The goal is reasonable, not out of reach for the member
- **Time Bound**: The goal has a deadline or “achieve by” date (i.e. by 5/1/16, within 1 month, etc.)

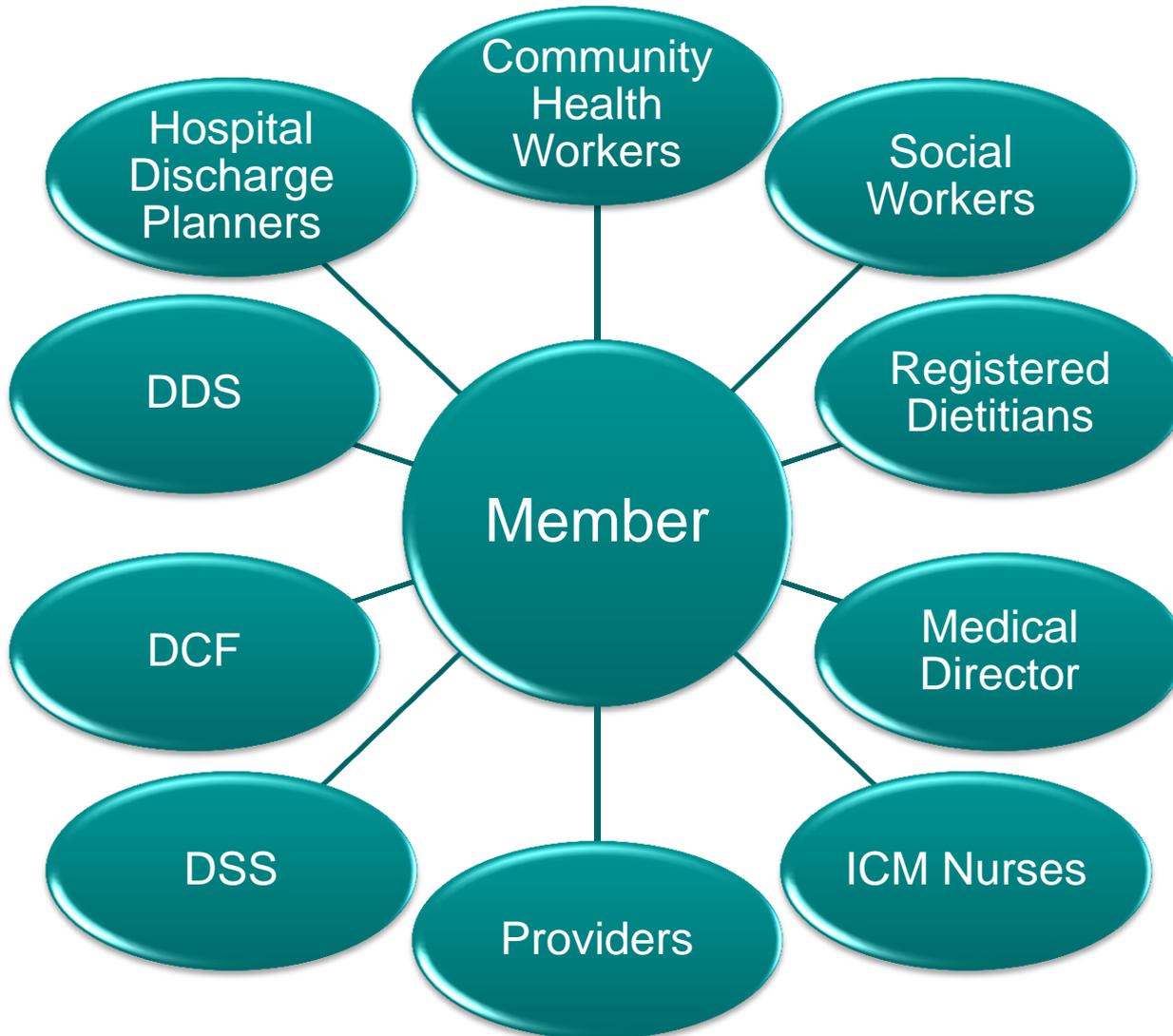
Goals - Example

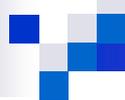
Member stated goal, “I want to lose weight”

- STG #1: The member will verbalize 2 - 3 positive dietary changes (i.e. low fat dairy, increase daily fruits and vegetables, drink water instead of soda) by {date}
- STG #2: The member will report walking 20 minutes per day, 3 - 5 times per week for two months by {date}
- LTG #1: The member will report a loss of 20 lbs. within 6 months or by {date}

Collaboration & Coordination

ICM nurses work as part of a team comprised of, but not limited to...





Collaboration & Coordination

- The Care Plan is shared with the member's providers if member agrees
- A Plan of Care letter is sent, which includes the member's problems, medications, barriers, strengths, interventions, and goals
- The provider may respond back with any suggestions to the member's plan of care

Provider Care Plan Letter Sample



11 Fairfield Blvd., Suite 1 • Wallingford, CT 06492
1.800.440.5071 • www.huskyhealth.com

<<today_date_mmmmm_dd_yyyy>>

<<provider_name>>
<<provider_street_address>>
<<provider_city_state_zipcode>>

Dear Colleague:

Our HUSKY Health Program Intensive Care Management (ICM) program has conducted a needs assessment of your patient.

The Intensive Care Management (ICM) program's registered nurse will work collaboratively with you to help your patients achieve optimal health and self-management skills; our registered nurses cannot initiate treatment changes or take verbal or written treatment orders.

We have attached a copy of your patient's care plan which identifies problems, care management interventions to minimize identified problems, the patient's activation level, and person-centered SMART goals. We welcome your input to further develop your patient's care plan. If you have questions or concerns regarding the ICM program, please call <<case_manager>> at 1.800.859.9889, <<x0000>>.

Sincerely,

<<ccms_nurse_name>>
HUSKY Health ICM nurse

0316



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Member Name:	<<member_full_name>>
Date of Birth:	<<MM/DD/YY>>
Medicaid ID Number:	<<00000000>>
ICM Initial Assessment Date:	<<MM/DD/YY>>
Care Manager Name:	<<care_manager>>
Care Manager Contact Information:	1.800.859.9889, <<x0000>>
Activation Level: <i>Assessment of their knowledge, skills, ability, and willingness to manage their health.</i>	Patient's current level of activation is:
Goals:	
Barriers:	Strengths:
Medication Reconciliation Your patient reported taking the following medications:	
The member appears to have additional unmet needs, learning needs and/or would benefit from reinforcement related to:	
Problems and Opportunities:	Care Management Interventions:
Action Planning	
Action Planning, Asthma	
Action Planning, COPD	
Action Planning, Diabetes	
Action Planning, Heart Failure	
Action Planning, Managing Environmental Triggers	
Action Planning, Sickle Cell Disease	
Action Planning, Wellness and Preventative Care	
Action Planning, Wellness and	

Provider Care Plan Letter Sample



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Preventative Care	
Being Active	
Care Coordination, DME supplier	
Care Coordination, Home Care Services	
Care Coordination, Specialty Care	
Food Insecurity May Be Causing Variability in Glycemic Control	
Gap In Care, Diabetes Screenings	
Gap In Care, Keeping Perinatal Appointments	
Gap In Care, Keeping Preventative Care Visits	
Gap In Care, Needs Post Inpatient or ED Follow Up	
Healthy Eating	
Healthy Eating with Diabetes	
Healthy Eating, Perinatal	
Managing Pain	
Monitoring	
Monitoring, Asthma Control	
Monitoring, Diabetes	
Preconception/Interconception Planning	
Risk Reduction, Smoking	
Risk Reduction, Smoking Intention	
Taking Asthma Meds as Prescribed	
Taking Diabetes Meds as Prescribed	
Taking Meds as Prescribed	
Unmet Basic Needs	
Unmet Needs, Basic Utilities	
Unmet Needs, Food Insecurity	
Unmet Needs, Homelessness	



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Member Name:	<<member_name>>
Medicaid ID Number:	<<00000000>>
Provider Collaboration:	
Please review, sign, and fax this page with your recommendations to 1.866.361.7242 (secure fax line).	

Would you like any of the following collaborative interventions?

- Patient had missed several appointments; focus interventions to minimize missed appointments
- I would like a care manager to attend my patient's next appointment
- Referral to Community Health Worker for _____
- Patient has a language barrier; arrange for translation services

Focus interventions to minimize barriers to:

- Healthy Eating
- Healthy Coping
- Monitoring
- Risk Reduction
- Action Planning
- Taking Meds as prescribed

Please check all of the following that apply. If you need more space, fax an additional sheet with additional comments or recommendations.

- _____ This is not my patient.
- _____ I am in agreement with this patient's plan of care.
- _____ I am providing the following additional information, comments, or recommendations below.

Provider comments or recommendations:

Provider Signature: _____
Date: _____

<<provider_name>>
<<provider_street_address>>
<<provider_city_state_zipcode>>

NOTICE: This message is intended only for the use of the individual or entity to which it is addressed. It may contain information that is privileged, confidential, and/or exempt from disclosure under law. If the recipient of this message is neither the intended recipient nor the employee or agent responsible for delivering the message, please be notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please call 1.800.440.5071 to notify sender of error, and then destroy the documents. Thank you.

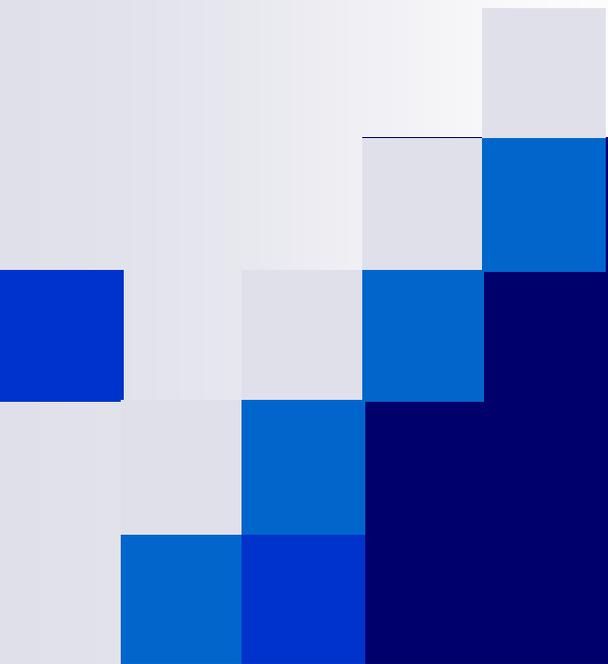
Next Steps

- ICM and the member have follow up conversations, usually every few weeks, to review the Plan of Care:
 - Goals may be revised or new ones set as needed
 - Problems can be resolved and/or new ones added
 - New interventions may be identified
 - New conditions may be identified
- ICM will follow up and revise care plan, if needed, after inpatient or ED utilization
- Assessment is repeated every 6 months
- When the goals are met and the member is able to manage his/her care, the case is closed

ICM Referral Process

Providers may refer members to ICM through the following methods:

- Call 1.800.440.5071, extension 2024
- Fax completed ICM Referral Form to 1.866.361.7242
 - To download the ICM Referral Form, go to www.huskyhealth.com, click “**For Providers,**” “**Provider Bulletins & Forms,**” then “**ICM Referral Form**”



Questions/Comments