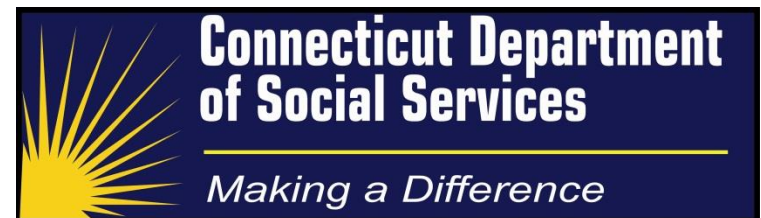


Intensive Care Management (ICM) Rare Disease Task Force Presentation

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Presenters

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Intensive Care Management Program

- Intensive Care Management (ICM) is a voluntary program developed to help HUSKY Health members manage their medical, behavioral, functional, and social health needs
- The program meets the unique needs of members and encompasses a broad scope of services to promote active member participation to achieve their highest possible outcomes



Leading ICM Program Goals

- Provide members* with information, education, and support to make informed decisions about their care options to foster active participation in their self-care, including participation with provider treatment plans
- Coordinate care in partnership with the member that is consistent with the member's personal preferences, cultural values, strengths
- Ensure care is implemented in the most integrated setting
- Minimize gaps in care, and social determinants of health, while promoting health and wellness

* The term “members” in the presentation may also refer to the member's caregiver or the head of household

Social Determinants of Health

There are many factors that can impact a person's ability to successfully manage his or her health

**Social Support
Networks**



**Working
Conditions**



**Physical
Environment**



**Cultural
Background**



**Income &
Social Status**



Education



**Genetic
Endowment**



**Coping
Skills**



**Health
Services**



ICM Care Teams

Care Teams address the unique needs of members with:

- Multi-chronic conditions such as coronary heart disease, chronic pain, gender dysphoria, substance misuse, progressive health disorders, and children and youth with special healthcare needs
- Coexisting medical and behavioral health conditions including Serious and Persistent Mental Illness (SPMI)
- Need for condition care management:
 - Asthma, Chronic Obstructive Pulmonary Disease (COPD)
 - Diabetes
 - Heart failure
 - Sickle cell disease
 - Perinatal, postpartum, and newborn needs
- Need for coordination of services for transplant authorizations, gender dysphoria treatment, and pain management

ICM Care Team Members

ICM utilizes a multidisciplinary approach that consists of the following groups:

Nurse
(RN, LPN, APRN)

**Certified
Specialty
Educator**
(Diabetes, Childbirth,
Lactation Consultant)

**Community
Health
Worker
(CHW)**

**Registered
Dietitian**

**Administrative
Care Coordinator**
(Non-licensed,
Non-clinical
support staff)

**Medical
Director**

**Integrated
Behavioral
Health Care
Coordinator**

**Certified Case
Manager
(CCM)**

**Pharmacy
Consultant**

ICM Outreach

ICM uses a person-centered approach to provide support and education to HUSKY Health members based on their specific needs.

- How member outreach is conducted
 - **Face-to-Face** - ICM meets with members in the community, such as in their home, shelter, hospital (inpatient or ED), skilled nursing facility (if nearing discharge), provider's office, or community settings
 - **Phone Support** - ICM communicates with members telephonically according to their needs and acuity
 - **Video Conferencing** - ICM uses a video conferencing application and engages with members via Wi-Fi connections and follows up with members at home as well as during hospitalizations



ICM Approach

CHNCT's approach is non-prescriptive. Care managers do not prescribe or dictate treatment plans of care. We support the member's activation and willingness to manage their individual health to foster participation in the provider's treatment plan by:

- Developing person-centered care plans and utilizing evidence-based clinical guidelines
- Facilitating access to culturally and linguistically appropriate services that take into consideration the member's beliefs and traditions, as these may impact self-management needs such as diet and provider recommendations

Care Coordination

- Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care¹
- In care coordination, the primary care practice acts as the hub for managing the member's care. The member's care is coordinated not only within the practice, but also between the practice, ICM, specialists, and hospitals



¹<https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html>

Collaboration with Practices

- To help educate practices on the support CHNCT provides, ICM and other internal departments, such as provider and member engagement and the utilization management team, meet with providers, discuss the role of each area, and address provider inquiries
- ICM works with the CHNCT Community Practice Transformation Specialists (CPTS) to assist practices, clinics, and Federally Qualified Health Centers (FQHC) with obtaining PCMH recognition from either the National Committee for Quality Assurance (NCQA) or The Joint Commission
- ICM collaborates with the PCMH practices and in-network providers to support members in need of medical home assignment



ICM and Rare Diseases

- A rare disease, also referred to as an “orphan disease,” is any disease that affects a small percentage of the population. Most rare diseases are genetic and affect multiple parts of the body
- Individuals with these conditions require complex care from a range of different health professionals
- ICM helps families coordinate services in which varied medical services are provided by multiple agencies to coordinate the needs and strengths of each child, adolescent, or family
- ICM engages members and reinforces provider plans of care and provides education to help improve member participation and follow-through on coaching recommendations given



Support for Members with Rare Diseases

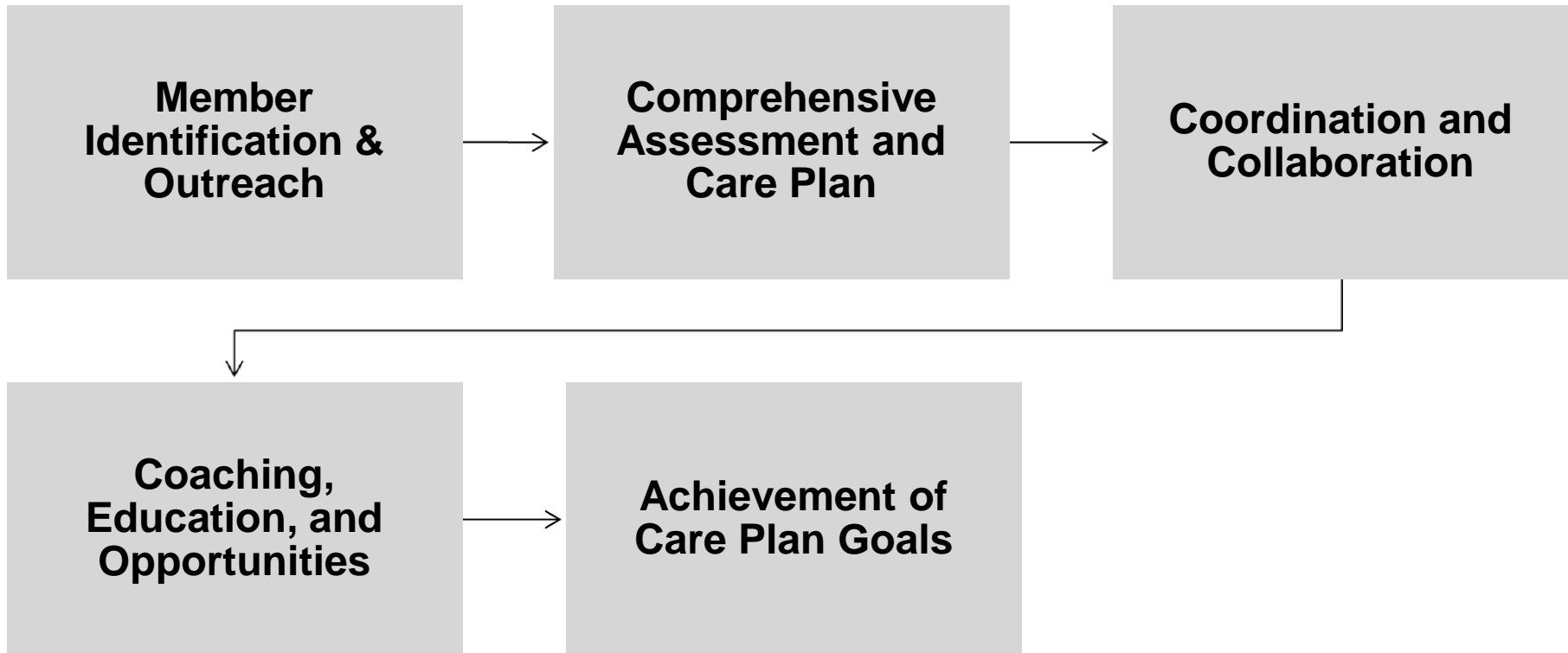
- ICM collaborates with support and advocacy groups to enable connection with other patients and families. Many support groups develop patient-centered information and are the driving force behind research for better treatments and possible cures
- Support and advocacy groups provide valuable services and can help members connect with other patients and families. Support groups develop patient-centered information and are the driving force behind research for better treatments and possible cures
- ICM has worked with members with Krabbe disease, PKU, Rett syndrome, Duchenne muscular dystrophy, as well as chronic granulomatous disease



The ICM Process

ICM Process

ICM uses a multi-pronged approach designed to identify members and work with them to achieve their health goals.





Member Identification & Outreach

- 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
- ICM identifies, stratifies, and outreaches to members based on their health condition and pattern of service utilization

ICM Assessment Components

The member and nurse have a conversation to identify the member's strengths and barriers including:

Basic and Social Needs

- Food insecurity
- Safety of living environment
- Social determinants of health

Conditions and Diagnoses

- Assess member's driving condition and develop person-centered goals with the member
- Assess the impact of physical condition on member's quality of 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

Coordination & Collaboration

- Individual member plan of care is shared with the providers if the member agrees. It includes the member's problems/opportunities, medications, barriers, strengths, interventions, and SMART goals
- The provider has the opportunity to respond back with any suggestions to the member's plan of care



Follow-up and Case Closure

- ICM and the member have follow-up conversations every few weeks to review the existing plan of care, during which, the following can occur:
 - Goals may be revised or new ones set as needed
 - Problems can be resolved and/or new ones added
 - New conditions and interventions may be identified
 - ICM follows up and revises care plans if needed, such as after inpatient or ED visits, and conducts a re-assessment of member's current status every 6 months
- Case is closed when the goals are met and the member is able to manage their care

Coaching & Education

ICM works with members to reinforce provider plans of care and to provide education to help improve member self-reliance.

Chronic Condition Coaching

- Knowing Numbers
 - Blood pressure
 - Blood glucose
 - Cholesterol
 - Weight
 - Peak flows
- Knowing targets and triggers
- Action planning (“What would you do if...?”)
- Knowing who to call and when

Preventative Care Coaching

- Knowing the “when, where, and why”:
 - When do you schedule?
 - Where do you call/go?
 - Why is it important?
- Well-care visits
- Screenings and preventive care
- Immunizations/flu shots
- Dental and vision



Opportunities & Interventions

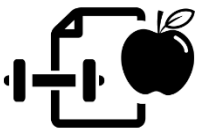
- Care plan opportunities
 - Opportunities are identified based on the member's responses to clinical, behavioral, social, and cultural questions asked by the nurse in the assessment
- Care plan interventions
 - Interventions are identified by the nurse
 - Nurses help the member resolve and/or address the care plan problems and achieve goals

Opportunities & Interventions

Examples of interventions include:



- Working with providers and members in relation to member's rare disease or other conditions to develop action plans with members
- Sharing care plans with providers to promote collaboration and understanding of the member's needs
- Facilitating the coordination of behavioral health services as needed
- Assisting members with obtaining specialist referrals, if needed
- Coaching members on healthy eating and other preventive care measures specific to their condition
- Treatment participation and appointment follow-up education
- Providing members/caregivers with information related to self-advocacy to obtain needed services (504 Plans & IEP at school, disability issues, legal issues)
- Providing educational resources



Achieving Care Plan Goals

ICM members graduate from the program when:

- The member, caregiver, and provider agree that the member's healthcare goals have been met and the member:
 - Demonstrates self-advocacy
 - Expresses understanding of appropriate care and resources
 - Successfully manages his/her condition(s)

Upon case closure and graduation:

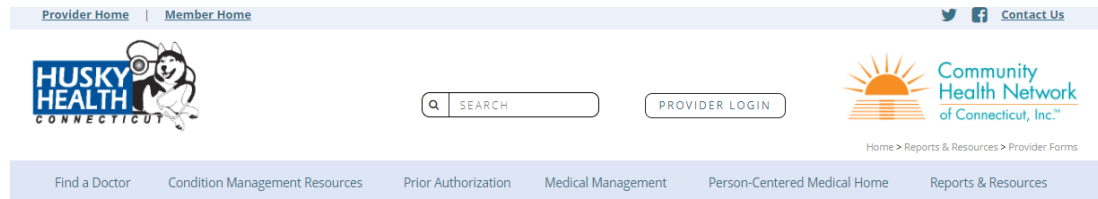
- Members can seek ICM services for changes in their health status or conditions
- Members have continued access to other services including:
 - 24/7 Nurse Helpline
 - Health reminders
 - Appointment scheduling assistance (medical, dental, transportation)

ICM Referral Process

Call Provider Engagement Services at **1.800.440.5071**. When prompted, dial **extension 2024** to request ICM services.

OR

Go to www.ct.gov/husky, click “**For Providers,**” “**Provider Forms**” under the “**Reports & Resources**” menu item, then “**ICM Referral Form**”



Provider Forms

Find all forms available for provider use below. Some forms may also be found in related sections of the provider website.

Forms

- **ICM Referral Form**
- **Escalation Referral Form**
For help locating a specialist, other provider, or community resources for your HUSKY patients. Please fax to 203.265.3197 or e-mail to reachforescalation@chnct.org
- **Advanced Imaging Prior Authorization Request Form**
- **Outpatient Prior Authorization Request Form**
Authorization requests for home care must be submitted through the Medical Authorization Portal. Outpatient hospital-based therapy may be requested via fax to 203.265.3994.
- **Palivizumab (Synagis®) Request Form**
For use by clinics and private practices.
- **Palivizumab (Synagis®) Outpatient Hospital Request Form**
For information on the coverage guidelines and procedures for requesting authorization for Palivizumab (Synagis®), please refer to the clinical policy located on our **Policies, Procedures & Guidelines** page.
- **Spinraza™ (nusinersen) Prior Authorization Request Form**
For information on the coverage guidelines and procedures for requesting authorization for Spinraza™ (nusinersen) please refer to the clinical policy located on our **Policies, Procedures & Guidelines** page.



Questions/Comments