



# Primary Care Clinician (PCC) Plan Integrated Care Management Program

Partnering with Providers  
to Improve Member Health



## Program Overview

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The Primary Care Clinician (PCC) Plan has implemented the Integrated Care Management Program (ICMP) for Members of all ages. This program is administered by the Massachusetts Behavioral Health Partnership (MBHP). The ICMP is designed to support medical and behavioral health care providers, like you, by providing services to help Members who are in your care to better manage their complex conditions and improve their health.

## Member Eligibility and Identification

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Eligible Members are identified and stratified by complex condition risk levels using historical claims data and clinical information. The ICMP is a voluntary service provided to eligible Members of all ages who have complex health conditions. Those who do not wish to continue in the program can opt out at any time.

The ICMP welcomes referrals from providers for Members in their care whom they believe might benefit from the program. Providers are also urged to encourage eligible Members to participate. Members may also self-refer into the program.

## Provider Benefits

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The ICMP staff will serve as a no-cost extension of your care team. ICMP nurses and social workers collaborate with providers to help Members overcome barriers to improved health. The staff will:

- Conduct assessments while Members are in their home environments
- Identify barriers that impact health
- Coach Members on understanding their conditions and adhering to treatment plans and lifestyle modifications

- Reinforce your treatment plans and recommendations, if available (Staff will not change your prescribed treatment plans without your authorization.)
- Coordinate services among different providers and agencies
- Deliver education related to Members' self-management
- Assist Members in arranging and keeping appointments by providing appointment reminders
- Help with transportation arrangements to decrease appointment no-shows
- Facilitate medication adherence
- Assist Members to overcome any barriers to their ongoing care
- Be available to you and your Members 24 hours a day, 7 days a week

## How it Works

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Once Members are identified as eligible for the program, Members and their PCCs are sent written notification. The ICMP team uses state-of-the-art information systems for providing educational materials, support, and monitoring for Members between visits with their providers. The program follows current, nationally recognized, evidence-based clinical guidelines.

For PCCs with one or more Members in the ICMP, the program will mail monthly correspondence listing their enrolled Member(s). Additionally, after each Member completes his or her care management assessment, the program will send the Member's summary care plan information to the PCC on a monthly basis. A Physician Alert (fax) and/or a phone call by ICMP staff will also be directed to providers for urgent or emergent situations.

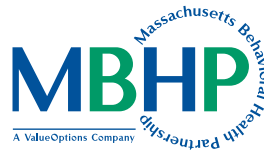
The ICMP gives you, the provider, an extension of your care team, helping to coordinate care for your highest risk, chronically ill Members.



## Referrals and More Information

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To refer Members (children, youth and adults), to request the clinical guidelines the program follows, or to learn more about the program, please contact the ICMP at **1-800-495-0086 Ext. 454165**, or via secure fax line at 1-800-542-8074.



### Integrated Care Management Program

**1-800-495-0086 Ext. 454165**

**[www.masspartnership.com](http://www.masspartnership.com)**