

## Provider Benefits *(continued)*

- Identify barriers that impact health and help Members eliminate these barriers
- Coordinate with other care management efforts within your practice
- Coach Members on understanding their conditions and adhering to treatment plans and lifestyle modifications
- Coordinate services among different providers and community agencies
- Deliver education related to Members' self-management
- Assist Members in arranging and keeping appointments by providing appointment reminders
- Facilitate medication adherence
- Are readily available to you, your clinical team, and your Members

## Referrals and More Information

To refer Members (children, youth, and adults), to request the clinical guidelines the program follows, or to learn more about the program, please contact us directly at:

### Integrated Care Management Program (ICMP)

1-800-495-0086, Ext. 454165

(617) 790-4165 (Direct)

1-855-895-9758 (secure fax)

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



## Integrated Care Management Program (ICMP)

*Partnering with Providers  
to Improve Member Health*



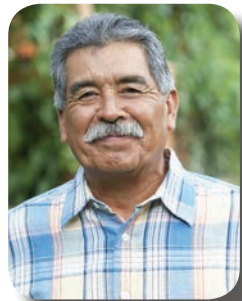
“I’ve often wished that the mental health services that MBHP offers their Members were available to all my clients! I feel the same way about the ICMP!”  
- Boston region provider

The **Integrated Care Management Program (ICMP)** addresses “hands-on” the complex needs of MassHealth Primary Care Clinician (PCC Plan)/MBHP Members. These are often Members who have many challenging social issues (food insecurity, violence, housing needs, etc.), making it difficult to focus on the medical and/or behavioral health treatment plans outlined by their providers. Examples of conditions that qualify Members for the ICMP include:

- **Asthma**
- **Obesity-related conditions**
- **Schizophrenia**
- **Diabetes**
- **Substance Use Disorders**
- **Depression**
- **Hepatitis C**
- **and many more!**

Our ICMP team of nurses, community health workers, peer specialists, social workers, and other mental health professionals **supports both PCC Plan/MBHP Members and providers** by providing telephonic and face-to-face care management.

This support helps Members connect to services in the community to alleviate many of their social issues, resulting in **better management** of all complex conditions and **improvement** in their overall wellbeing.



## How it Works

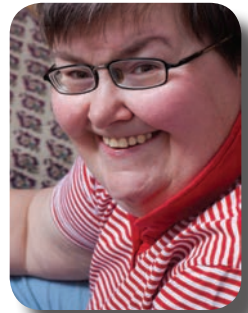
Members can enter the ICMP through:

- Provider referral
- Self referral
- Being identified by the MBHP risk-stratification algorithm that uses historical claims data

“...having this additional support, especially the face-to-face component, has been so extremely helpful...”  
- Central region provider

Once Members are identified for the program (and their behavioral health home or medical home does not have a care management program of their own), the ICMP provides outreach to the Member to encourage him or her to participate in the program.

The ICMP is a **free** service for PCC Plan/MBHP Members that is voluntary. Our staff monitors Members’ goals and care management plans through **regular contact** to reassess their progress and need for care plan updates. All are shared regularly with the Members’ providers, which **strengthens the coordinated and integrated circle of care**. ICMP staff will alert providers directly for urgent or emergent situations. Input and guidance from the provider and his/her team is always a welcome component of the care management plan.



## Provider Benefits

**ICMP is a no-cost extension of your care team!**

ICMP staff:

- Collaborate with providers to help Members overcome barriers to improve their health
- Listen to your Members concerns and help with accessing housing, transportation and other daily needs
- Conduct face-to-face and/or telephonic assessments and monitoring, including visits to Members’ home environments

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