INTENSIVE CASE MANAGEMENT PROGRAM

Intensive Case Management (ICM) is defined as a collaborative process for assessing, planning, implementing, coordinating, monitoring and evaluating options and services to meet an individual's behavioral health needs. Communications and available resources are used in conjunction with other strategies to achieve optimum member outcomes.

The ICM Program offers the member with assistance pre and post-discharge in coordination with medical managed care delivery system, individualized case management services including patient safety education and monitoring, and disease specific educational materials.

The ICM team targets members based on high-risk criterion or diagnostic categories. Conditions identified with high-risk safety needs include those adults and children with the following criteria:

Admission Criteria include:

- Multiple Inpatient admissions and/or multiple Emergency Room visits; also look at multiple admissions in other High Levels of Care and rapid re-admits.
- Members with a diagnosis of bipolar disorder or major depressive disorder and/or have a co-occurring medical condition.
- Members with a history of non-compliance, including outpatient.
- Complex co-morbid behavioral and medical health conditions, including but not limited to diabetes, asthma, heart disease/cardiac issue, obesity, HIV, pregnancy at risk for or diagnosed with postpartum depression or psychosis.
- Special vulnerable population segments (with no evidence of ongoing treatment support to resolve potential issues associated with their condition):
    i. Pregnant women with substance abuse disorders
    ii. Child 5 yrs. old or younger with Bipolar diagnosis
    iii. Child 10 yrs. old or younger with Inpatient admit

- High utilizers – Member in the top 1 to 5 percent of overall behavioral health service utilization for service population.
- New and/or Unstable High Risk Diagnosis (Eating Disorder, Schizophrenia, Schizoaffective, Dissociative Identity Disorder) "unstable" defined as recent (past 6 months) admission to inpatient / higher level of care or a new diagnosis, and no indication of ongoing treatment or supportive services subsequent to the discharge or the indication of a new diagnosis.
- Medical Care Coordination/Integrated Care – Members with health issues including chronic pain and possible behavioral health concerns are referred for screening and service coordination as needed.
- Members hospitalized for a medical condition that have a co-existing substance abuse/use disorder when referred by the Health Plans clinical staff.

Cases are referred from a variety of sources, including medical rounds, health plans, providers, Beacons data mining, or member/family self-referrals.

If you have a patient that you would like to refer to case management you may do so via ProviderConnect utilizing the “Enter Case Management Referral” link on the home page and then following the prompts to complete a brief referral. Beacon clinicians will review the request and follow-up with the member as appropriate.