High-Risk Care Management at Partners Population Health

The Integrated Care Management Program (iCMP) cares for chronically ill patients with multiple medical conditions. The goal of the program is to help patients stay healthier longer by providing the specialized care and services they need to prevent complications and avoid hospitalizations.

Who is an iCMP Patient?

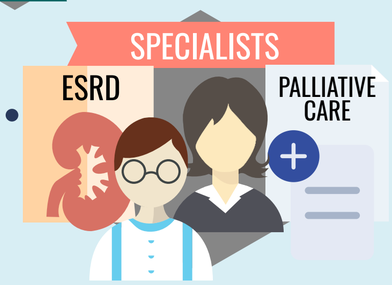
- Age ranges from pediatric patients to senior
- Multiple medical conditions
- Mental health, behavioral health, or substance use worsening existing medical conditions
- Lack of socioeconomic resources to manage illnesses
- Patients who are at risk of becoming high utilizers of care

With iCMP, patients are supported by a team of professionals.

Primary Care Physicians (PCPs) help review the list of potential iCMP patients and determine who enrolls in the program.

PCPs can also refer patients outside of the identified list they feel will benefit from iCMP, a process called Patient Opt in.

Care Coordinator Leads can be a nurse, social worker or community health worker depending on the patient profile.



Care Coordinator Leads also help coordinate services such as tests, transportation, social services, and appointments with specialists.

The iCMP program matches high-risk patients with a **Care Coordinator Lead** who works closely with them and their family to develop a customized health care plan to address their specific health care needs.

By coordinating all of the care that some of our sickest patients require and monitoring their health, we are able to avoid unnecessary, costly hospitalizations and keep patients at home, where they are happiest.