Integrated Care Partners
A Hartford HealthCare Partner

Community Care Management Team

Who We Are:

ICP's Community Care Management Team is made up of registered nurses, social workers and health coaches – all focused on the patient's well-being and on helping the patient meet his or her health goals. Our team is designed and dedicated to improving the patient experience and patient satisfaction by extending the traditional reach of providers to the patient's home and to the community, where patients are most comfortable receiving care. Our team is nationally certified in Chronic Disease Care Management, a growing specialty of Case Management.

How Can We Help Primary Care Providers and Their Patients?

Our outreach program is intended to extend the reach of your services by supporting your patients in achieving their health goals. Our team can provide health education, coaching, and connection to social services and programs, as well as facilitate home care and provide caregiver assistance and support. Our team also will assist inpatient care coordinators with discharge planning if your patient is hospitalized. Our goal is to facilitate transitions of care throughout our system by providing the link between the community and the acute-care phases of care for better communication of patients' goals and needs, while providing quality care.

Who Should I Refer to the Community Care Management Team?

- Patients you believe are high risk for declining health or hospital readmission
- Patients with complex chronic medical conditions (congestive heart failure, diabetes, COPD, pneumonia, depression)
- Patients with multiple health care providers
- Patients who require complex care but have little or no family or caregiver support
- Patients with poor adherence to their medical plan of care
- Patients with complex social needs
- Patients who may benefit from additional health education or coaching
- Patients who may require behavioral health services
- Patients who may use emergency department services instead of the appropriate level of care

Our Nurse Care Manager Competencies:

- Chronic disease education and management
- Coordination of patient transitions from the hospital or skilled-nursing facility to home care
- Medication review and education
- Comprehensive patient assessments
- Clinical support and outreach for home-bound patients
- Community resource referrals
- Motivational interviewing
- Assistance with end-of–life care and planning
- Assistance with non-adherence behavior management
- Identification of behavioral health and poly-pharmacy concerns

Our Social Work Care Manager Competencies:

- Cognitive assessment and competency screening
- Geriatric risk assessments
- Depression and anxiety screening
- Legal and financial assistance
- Assistance with power of attorney and living wills
- Knowledge of state and federal entitlement programs and application assistance
- Behavioral health referrals
- Substance-use care referrals
- Caregiver support and resources, including respite care
- Coordination of home care and community social services
- Access to town and state social service programs
- Assistance with transportation
- Long-term care planning and resources
- Assistance with end-of-life planning and transitions

Our Health Coach Competencies:

- Motivational interviewing and health coaching to help patients achieve goals and self-efficacy
- Identification of patient barriers to engagement
- Support of and celebration with patients making positive changes
- Assisting physicians with closing gaps in care through patient outreach
- Assisting patients with scheduling appointments and coordinating services