6 steps to better care management

By Lia Novotny | May 31, 2018

A 66-year old patient — let's call him Lewis — was in and out of the hospital battling symptoms of his uncontrolled COPD. He was severely depressed — scoring at 20 out of 27 on the PHQ-9 questionnaire that screens for depression. And he hadn't traveled in five years.

Nevertheless, Lewis desperately wanted to cross the country for his granddaughter's birthday party in three months.

Chances are, his condition would have remained unstable, and he would have continued to cycle in and out of the hospital, making it impossible for him to travel. Instead, Lewis was offered the opportunity to enroll in the Intensive Outpatient Care Program (IOCP) offered by his healthcare provider, Innovation Care Partners, a 1,600-physician clinically integrated network in Arizona.

An IOCP-trained care coordinator found Lewis a pulmonologist he liked, worked out a new medical regime, got him on home breathing classes, and called him twice a week to check in.

The patient's depression score went down to a 7 within weeks – well within the normal range. Best of all, he was able to drive to the birthday party – his care coordinator having arranged for fresh oxygen tanks all along the way.

Lewis was elated, and so was Innovation Care Partners, which calculated savings of $70,000 in hospital costs on this one case alone.

Care management for complex patients

How did Innovation Care Partners come to be able to offer IOCP to Lewis and its other patients?

In 2012, the Pacific Business Group on Health (PBGH), a

not-for profit coalition of 60+ large employers in California, received a grant from the Center for Medicare & Medicaid Innovation to create a care management program for complex patients like Lewis, with the goal of reducing emergency department visits, hospitalizations, and complications, while improving clinical outcomes and patient experience.

PBGH modeled the outpatient care program after one offered at Boeing, one of its member employers, and piloted IOCP for Medicare patients in 23 healthcare delivery systems across five states.

IOCP provides a clear blueprint for how to support the 5 to 15 percent of patients who are at highest risk, improving their outcomes and reducing their total cost of care.

Diane Stewart, former senior director at PBGH, describes the six "guardrails" that make up the core of IOCP:

- Care coordinators trained in person-centered care techniques such as motivational interviewing and medication management who focus solely on building close relationships with high-risk patients.
- A face-to-face initial "super-visit" within a month of enrollment to gather medical information but also understand the patient's life and goals.
- Monthly or more frequent two-way communication between the patient and the care coordinator.
- A shared action plan that includes at least one goal chosen by the patient.
- Warm handoffs to all relevant support services for behavioral health, social services, or community programs.
- Patient ability to contact the practice 24/7 with next-day follow-up by the care coordinator on any issues arising from such calls.

Says Stewart, "The key is switching from a medical care coordination role to a patient-centered care coordination role, which is really about detective work and building a trusting relationship with patients."

Patient-centered care coordination

Sharp Rees-Stealy Medical Centers (SRS), a 500-physician medical group in San Diego and pilot IOCP member, quickly enrolled more than 3,500 patients and began to rethink the way care coordination worked throughout the organization.

According to Scott Heimer, project manager at SRS, "The guardrails apply whatever the department is: You assess the patient, you find out their needs, you find out their goals, and you work on those."

Those needs are varied and many. SRS case managers make sure patients are properly enrolled in insurance and they can afford and use their medical supplies and equipment. Case managers address issues of transportation, food, home healthcare, and safety – and they coach family caregivers, connecting them too with vital community resources.

In short, case managers are charged with addressing virtually all of the barriers that prevent chronically ill patients from managing their own care, barriers which often result in hospitalization.

Clear results

The model appears to be working.

Between 2012 and 2015, SRS saw a 14 percent reduction in admissions among its target senior patients. SRS now takes a similar approach not just with Medicare patients, but with all its patients.

Innovation Care Partners' 3,000 moderate to high-risk patients are supported by IOCP-trained care coordinators across all lines of business – ACO, Medicare Advantage, and commercial. The organization currently has a 5.7 percent readmission rate for patients enrolled in the program as compared to the national average of just under 18 percent.

And both organizations have seen substantial improvement in patient engagement, as measured by the Patient Activation Measure (PAM) – a leading indicator for overall health improvement.

Innovation Care Partners has seen a 16 percent increase in patient engagement, while at SRS, nearly 20 percent of patients with the lowest engagement scores improved one or more level(s) – with SRS data showing that moving

low-scoring patients up even one level results in savings of more than $1,100 per patient.

With results like that, it's of little surprise that clinics are eager to adopt intensive outpatient care models like IOCP. Karen Varnaskie, chief clinical officer at Innovation Care Partners, says, "Very quickly we hear from practices saying, 'I don't know what we did without a care coordinator!'"

Lia Novotny is a contributing writer for athenaInsight.