Care Management Case Study

Pacific Business Group on Health's Intensive Outpatient Care Programs

The Pacific Business Group on Health, a not-for-profit 501(c)(3), has led efforts to transform U.S. health care using the combined influence of some of the largest purchasers of health care services in the United States.

Background

As one of its initiatives to drive health care improvements, the Pacific Business Group on Health (PBGH) established Intensive Outpatient Care Programs to serve high-need, high-cost Medicare patients within 23 delivery systems in five states (Arizona, California, Idaho, Nevada, and Washington) over a three-year period ending in 2015.

Program Description

The Intensive Outpatient Care Programs (IOCP) established a dedicated multidisciplinary team closely linked to primary care to address medical, behavioral, and psychosocial needs of patients. Based on a successful pilot for commercial patients, PBGH won a grant from CMS's Innovation Center to expand the IOCP model to the Medicare population and test the scalability of a common care model across many clinical settings.

Care Management Strategies

To identify high-need, high-cost patients for the program, IOCP recommended a combination of predictive risk scoring with clinical judgment. If the delivery system did not have predictive software, IOCP recommended a utilization-based algorithm:

- Two or more admissions, in last year, with one in last six months
- Six or more ED visits in last year

Other stratification criteria include:

- Five or more medications
- Three or more active specialists
- Behavioral health diagnosis
- Three or more chronic conditions

Best practices included sharing the algorithm-based patient list with the PCP and asking which patients from the list they would recommend for intensive care management.

The care model must have elements (referred to as "guardrails") implemented across the 23 delivery systems include:

- *Trained Care Coordinators:* These nurse or social worker-led teams, which can include community health workers and medical assistants, maintain a close, ongoing relationship with the patient, developing trust over time.
- *A face-to-face "supervisit":* This visit, which must occur within one month of enrollment, enables information to be gather gathered with a motivational, open, and flexible approach.

- *Standardized longitudinal assessment:* The assessment includes tools for physical function, mental well-being, and patient engagement in care.
- *Monthly, bi-directional communication between the care coordinator and patient*
- *Shared Action Plan:* A plan created with the patient's own goals at its center.
- *Warm handoffs:* These connect relevant support services (e.g., home health, behavioral health, transportation, drug assistance programs, food banks, and other community services).
- *24/7 access:* Patients are offered a 24/7 access solution, with guaranteed communication to the care coordinator the next business day.

Participating delivery systems were encouraged to adapt implementation to their local environment as long as core requirements (i.e., guardrails) were met.

To participate in the IOCP, all care team members received training, but care coordinators participated in intensive training that helped them develop or sharpen skills in gaining patient trust, maintaining a close relationship, and coaching self-management support and behavior change. In addition, training sessions were directed at organizational leaders to build the organizational systems required for successful implementation such as patient identification, physician and patient engagement, and IT system support.

While the IOCP model has similarities to other new models of care, it is the unique combination of these elements that differentiated it from others.

Findings

PBGH collected data on 15,000 Medicare patients enrolled by the 23 delivery systems over two years.

Patient-Centered Measures

37% of IOCP patients moved to a higher level of activation while in the program (e.g., patient moved from PAM level 3 to level 4). Forty-five percent remained at the same level of activation and 11% moved to a lower level of activation (with the highest level having the greatest decrease). Increased patient activation was associated with patients being more likely to successfully graduate from IOCP.

The Patient Health Questionnaire (PHQ) is a multi-purpose tool for screening, diagnosing, monitoring, and measuring the severity of depression that takes only a few minutes to complete. One-third of people with a serious medical illness experience symptoms of depression, making the IOCP patient population at a higher risk for this condition. On average, patient PHQ scores improved 31%.

The VR-12 is a health-related quality of life survey that summarizes both physical and mental health functioning. Patients in IOCP saw a 4.2% in mental functioning and 3.3% increase in physical functioning. Any increase in these scores are particularly noteworthy as they typically decline in senior populations with a high burden of chronic illnesses.

Cost and Utilization

A program-wide actuarial analysis of a sub-set of patients continuously enrolled for at least nine months showed a significant reduction in inpatient utilization and emergency department use as a result of the program intervention, although actuarial analysis cannot distinguish the proportion due to the intervention versus regression to the mean.

Many of the delivery systems performed their own internal analyses. Perhaps most telling, once the grant program ended, 90 percent of participating delivery systems continued the core elements of the program for Medicare patients and 15 of 23 expanded programs into their commercial populations by July 2015. Some program elements varied, most notably caseloads for care coordinators which averaged 80 – 120 for Medicare patients and 200 for commercial patients.

Scalability

The care model guardrails were successfully adapted across a wide variety of provider settings – from rural IPAs to urban medical centers. The location of care coordinators varied depending on setting, but in all cases, a close working relationship with primary care clinicians supported success of the program.

Patient engagement is crucial to success. The patient engagement rate (defined by completed initial assessments and face-to-face visit) averaged 76%, and varied across the delivery systems from 30%to 99%. Best practices include care coordinators establishing the face-to-face relationship in the hospital prior to discharge, or starting the face-to-face relationship in the office with the PCP.

Ultimately, the program had a lasting impact on changing the way the participating providers practice medicine, and the way patients care for themselves.