International Journal of Integrated Care ISSN 1568-4156

Volume 15, 27 May 2015
Publisher: Uopen Journals
URL: http://www.ijic.org
Cite this as: Int J Integr Care 2015; Annual Conf Suppl; URN:NBN:NL:UI:10-1-117015

Conference Abstract

Using Disruptive Innovation to Improve Patient Care

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Abstract

The project described was supported by Grant Number 1C1CMS331047 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies. The research presented here was conducted by the awardee. Findings might or might not be consistent with or confirmed by the independent evaluation contractor.

The following is a brief description of a U.S.-based primary care redesign initiative funded by the Affordable Care Act. The program described, the Intensive Outpatient Care Program, may have useful lessons and applicability to NHS Scotland.

Background on the Intensive Outpatient Care Program (IOCP): IOCP is a care coordination model focused on Medicare patients (65 years+) with chronic illness and medical and non-medical co-morbidities. Multidisciplinary care teams embed in primary care practices to develop relationships with patients and provide longitudinal 1:1 care coordination. The care teams are based around registered nurses (at least one per team) and, depending on patients' needs, include social workers, medical assistants and unlicensed community health workers. In addition, pharmacists, diabetes educators, nutritionists and other providers are engaged as needed. Each team addresses the medical, psychosocial and behavioral needs of the patient through direct service or a "warm-handoff" to community agencies.

The strata of medically complex patients targeted by IOCP are those whose conditions can be improved through care coordination, self-management and ambulatory care. As a result, this improves clinical outcomes and patient experience, and reduces preventable hospital admissions, readmissions and emergency room use. By providing care coordination and tools that help prevent escalation of conditions, IOCP allows physicians to focus on those patients with more acute needs, as well as become comfortable with this new model of care. As well, the physicians become active participants in the evolution of health care delivery, including the transition from an activity-based model to a value-based model focusing on the whole patient, not just the disease.

To date (January 2015), IOCP has enrolled 11,000 patients in 23 medical groups in five states and has engaged 500 physician practices. The average enrollment rate (those offered IOCP and enroll into the program) is 76%.

The presentation will address the following questions: What are some strategies to engage patients in their care and provide the care team with the information necessary to guide the intensity and direction of services?

One of the fundamental principles of IOCP is that patient accountability stems from activation. IOCP emphasizes patient empowerment through the use of a Shared Action Plan and, to understand the patient's level of engagement in their care, uses the Patient Activation Measure (PAM). Based on the PAM score, the team uses Motivational Interviewing to engage patients and meet them "where they are."

Additionally, all patients participate in a "super-visit" where they are assessed using the Patient Health Questionnaire (PHQ), which screens and monitors for severity of depression, and the Veterans' Rand 12 (VR-12) Survey, which tracks physical and psychological health using a 12 item questionnaire.

How do integrated teams work together in order to meet each patient's needs?
The team:
• Serves as a link to primary, specialty and ancillary services,
• Provides warm handoffs to relevant services (e.g., behavioral, psychosocial, home health, medical equipment, transportation and community agencies),
• Maintains two-way communication with the patient at least once a month,
• Supports the patient to develop a Shared Action Plan and to achieve at least one patient-defined goal per year (an example is "going to my daughter's wedding").
What makes care coordination successful?
To be successful in this model of care, care coordinators' capabilities must go beyond clinical skills to include such attributes as empathy, communication and willingness to maintain a longitudinal relationship with patients. At times we have observed that for nurses, the culture change from inpatient to outpatient care is difficult, and in some cases cannot be overcome.
How are metrics used to measure success?
IOCP uses its assessments as both process and outcomes measures. PAM and PHQ scores are tracked at six-month intervals, and the VR-12 is administered and tracked annually.
Preliminary findings show*
• Activating patients: Improvement in average activation scores of 5.9% as measured by the PAM. The PAM has been widely studied and higher patient activation is associated with lower costs and utilization.
• Improved functioning:
o VR-12 mental health summary score showed a 2.4% improvement
o VR-12 physical health summary score showed a 3% improvement
• Depression: 26% improvement in average PHQ score.
We are in the process of building a data set of the full enrolled cohort, which will generate related to utilization; in addition, a patient satisfaction survey has been put into the field.

*Metrics will be updated and will include additional measures to reflect results as of March, 2015. IOCP is awaiting confirmation by CMS evaluators.

Keywords

care coordination; chronic illness

PowerPoint presentation

http://integratedcarefoundation.org/resource/icic15-presentations