

Intensive Outpatient Care Program: A Care Model for the Medically Complex Piloted by Employers

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PROGRAM AT A GLANCE

KEY FEATURES: Multidisciplinary team-based approach to addressing patients' medical, behavioral, and social needs. At the heart of the Intensive Outpatient Care Program (IOCP) is the care coordinator, who links patients to primary, specialty, and ancillary services; provides tools for effective self-management; guides participants through development of a shared action plan; and provides connections to behavioral, psychosocial, and community services.

TARGET POPULATION: Medically complex patients at high risk for hospitalization. Risk factors considered include recent hospitalizations or emergency department use, three or more chronic conditions, eight or more medications, and demonstrated fragmentation of care. IOCP participants also are directly referred from primary care physicians or transferred from existing care management programs.

WHY IT'S IMPORTANT: The model has been tested and proven in three populations: the commercially insured (employer-sponsored coverage), Medicare beneficiaries, and Medicaid enrollees.

BENEFITS: IOCP data in commercial populations show up to a 20 percent reduction in per member, per month spending for medically complex patients. External analysis of a two-year federally funded IOCP study showed improvements in patient activation, mental health, and physical functioning.

CHALLENGES: Receiving timely data from participating medical groups to produce a standard risk score, used to identify patients appropriate for IOCP. Recruiting patients requires going beyond conventional methods, such as phone calls and letters, in favor of face-to-face invitations by primary care physicians, which may include an introduction to an IOCP care coordinator.

KEY TAKEAWAYS

- ▶ **The Pacific Business Group on Health's Intensive Outpatient Care Program (IOCP) is a multidisciplinary team-based model that addresses patients' medical, behavioral, and social needs, with care coordinators at the heart of the program.**
- ▶ **IOCP has reduced costs among commercially insured, medically complex patients by up to 20 percent.**
- ▶ **External analysis of a two-year IOCP study showed improvements in patient activation, mental health, and physical functioning.**



BACKGROUND

Improving care for high-need, high-cost patients has long been a priority for both public and private sector purchasers of health care. In 2009, the Pacific Business Group on Health (PBGH) partnered with Boeing to implement a care management initiative that Boeing had successfully piloted with about 700 of its employees, retirees, and dependents. Called the Intensive Outpatient Care Program (IOCP),¹ the initiative aims to improve outcomes for medically complex patients and prevent unnecessary hospital use by providing care coordination, self-management support, and effective ambulatory care. The overall goal of IOCP is to keep participants at home and in their communities by providing intensive, person-centered outpatient care.

Shortly after IOCP was introduced, the California Public Employees' Retirement System (CalPERS) and Pacific Gas and Electric Company (PG&E) followed suit with a pilot in Northern California. From 2013 to 2015, PBGH, with a \$19.1 million Health Care Innovation Award from the federal Centers for Medicare and Medicaid Services (CMS), expanded the IOCP model to 23 medical groups in five states.² The grant enabled PBGH to implement IOCP in primary care practice sites in Arizona, California, Idaho, Nevada, and Washington, serving some 15,000 participants, including those enrolled in Medicare Advantage or Medicare fee-for-service, those dually eligible for Medicare and Medicaid, and a small number of Medicaid-only beneficiaries. In 2016 and 2017, PBGH has continued to provide technical assistance and training on the IOCP model to additional providers. Moreover, Boeing has incorporated aspects of the IOCP model in its accountable care organization (ACO) contracts by including specific intervention guidelines and performance guarantees for medically complex patient populations.

While the CMS grant provided an important source of funding for initial training, after the grant period 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.

KEY PROGRAM FEATURES

The IOCP model calls for embedding dedicated care coordinators in primary care physician practices and medical groups. These care coordinators build relationships with patients and work closely with them to stabilize their health. While IOCP is similar to other models for complex patients, it is differentiated by a unique combination of elements — called the IOCP Guardrails — and close coordination with primary care providers. Participating delivery systems are expected to adhere to the Guardrails (described below), but may adapt implementation to their local environment.

IOCP Guardrails

Six necessary elements have been identified as Guardrails in IOCP:

1. A care coordinator (who could be a nurse, social worker, community health worker, or medical assistant), trained in person-centered care techniques, maintains a close, ongoing relationship with the participant over time and across the care continuum.
2. Within one month of enrollment, the care coordinator visits the participant at home for up to 90 minutes to review the patient's medical history, complete a needs assessment, establish treatment goals, and develop a shared action plan.
3. The care coordinator and participant communicate regularly, monthly or more frequently.
4. The participant and care coordinator together create a shared action plan that includes at least one goal chosen by the patient.
5. In-person introductions — known as “warm hand-offs” — are made to workers from relevant support services (e.g., home health, behavioral health, transportation, drug assistance programs, food banks, and other community services).
6. Patients have access to a non-emergency department care provider 24 hours a day, seven days a week, with follow-up communication to the care coordinator on the next business day.

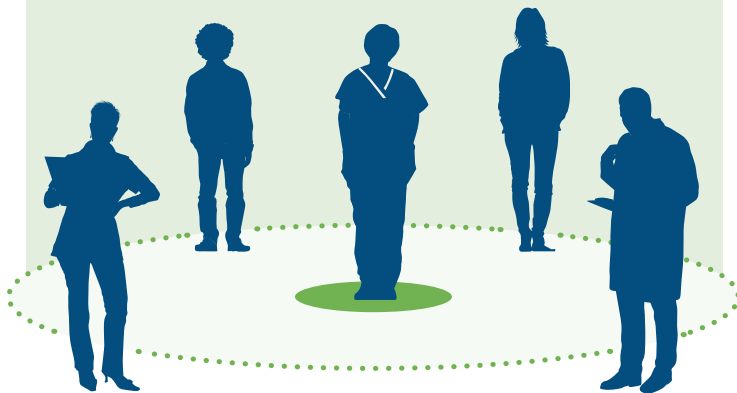
FINANCING

In the initial pilot, Boeing paid participating clinicians an additional monthly fee based on the severity of the patient's condition and the number of patients being managed. Anthem also used this model in its ACO contracts in California: Medical groups are given a higher per member, per month fee for members with more than two chronic condition diagnoses.

STRUCTURING THE CARE COORDINATOR ROLE FOR SUCCESS

Several factors are key to the care coordinator's success. He or she should be:

- Dedicated to the role, with no responsibilities beyond managing a panel of IOCP participants.
- Part of a team. A registered nurse is often at the center of the team of care coordinators. Other staff, such as medical assistants or medical social workers, are team members. All should receive the same training for the role. Using lower-level staff, along with nurses, improves the financial sustainability of the program.
- Able to rely on medical supervision, either from the primary care provider or another physician supervising the program.



Funding from the CMS Innovation grant involved both a uniform infrastructure payment per medical group and a per member, per month payment. This allowed participating medical groups to hire more than 200 full-time care coordinators across approximately 600 clinical sites. The grant also funded technical assistance and training, including attendance at a three-day in-person training for care coordinators and periodic webinars on topics such as end-of-life care and motivational interviewing.

Implementing the IOCP model requires up-front investment in staff training, baseline infrastructure (e.g., electronic medical records), and delivery system capacity (e.g., after-hours access to non-emergency department care). Sustainable financing for the program is best accomplished within population-based, accountable care systems, which can offset initial outlays with long-term reductions in per member, per month spending for medically complex patients. Delivery systems that operate in traditional fee-for-service payment environments can support transformation work through per member, per month care coordination fees.

CHALLENGES

Identifying eligible patients was an initial challenge in the CMS-funded program. Initially, it was thought that patients could be identified through Medicare fee-for-service claims data and Medicare Advantage encounter data. However, the standard risk score reports produced by the program's third-party data vendor used data that were three to six months old, and medical groups found the data too outdated to help identify suitable IOCP patients. Medical groups devised several alternative methods for identifying patients:

1. **Direct referral from PCPs.** Once primary care physicians (PCPs) became familiar with the program, they could refer patients who were good candidates.
2. **Transfer from an existing care management program.** Often patients enrolled in disease-specific care management programs were identified as patients who could benefit from a more intensive, comprehensive program, like IOCP.

Features of the Intensive Outpatient Care Program

 <p>Targeting the population most likely to benefit</p>	<p>Patients for the Intensive Outpatient Care Program (IOCP) are identified through a combination of predictive risk modeling and retrospective utilization review. Crucially, both types of patient identification are used in tandem with clinical review by a physician or nurse, preferably one who knows the patient. Primary care physicians also are encouraged to refer patients who do not appear on predictive or retrospective lists, but may still benefit from the intervention.</p>
 <p>Assessing patients' health-related risks and needs</p>	<p>IOCP encourages the use of standardized longitudinal assessment tools for physical function, mental well-being, and patient engagement in care.</p>
 <p>Developing patient-centered care plans</p>	<p>The Shared Action Plan is one of the “Guardrails” of IOCP. The plan includes at least one goal chosen by the patient.</p>
 <p>Engaging patients and family in managing care</p>	<p>IOCP includes a face-to-face visit in the participant’s home within one month of enrollment that allows the care coordinator to assess the home environment and family support.</p>
 <p>Transitioning patients following hospital discharge</p>	<p>IOCP found that patients are generally willing to enroll in the program when introduced to the care coordinator during a hospital stay. A face-to-face encounter during a crucial time facilitates the transition back to primary care.</p>
 <p>Coordinating care and facilitating communication among providers</p>	<p>The care coordinator is the link among primary, specialty, and ancillary services.</p>
 <p>Integrating physical/behavioral health care</p>	<p>IOCP uses the PHQ-9 to track depression in patients over time. Those enrolled in the program for at least nine months experienced an average reduction in depression symptoms of 33 percent.</p>
 <p>Integrating health and social services</p>	<p>IOCP goes beyond referral to social services by having the care coordinator facilitate a “warm hand-off” to any support service.</p>
 <p>Making care or services more accessible</p>	<p>A central tenet of IOCP is 24/7 access to care, with follow-up communication to the care coordinator on the next business day.</p>
 <p>Monitoring patients' progress</p>	<p>The care coordinator is required to contact patients at least monthly; most are in contact much more frequently.</p>

Note: This exhibit describes common features of effective care models for high-need, high-cost patients; see: D. McCarthy, J. Ryan, and S. Klein, *Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis* (The Commonwealth Fund, Oct. 2015).

3. **Identification from hospital records.** Some groups had access to hospital EHRs in integrated delivery systems and could use those data to refer patients to IOCP.
4. **Identification from internal reporting.** Some groups had their own reporting systems or risk stratification methods that they used to identify patients for IOCP.

Recruiting patients into the program also proved initially challenging. During the first few months of program operations, care coordinators contacted eligible patients through cold calls and letters, but patients were not receptive to these approaches. Medical groups were more successful when they modified their strategies to incorporate “warm hand-offs.” This involved PCPs introducing the care coordinator during a visit or approaching eligible patients during a hospital or skilled nursing facility stay. Eventually, the warm hand-off approach was incorporated not only in patient recruitment, but in all relevant referral services.

RESULTS

Previously released data from IOCP in commercial populations show a reduction in costs among medically complex patients by up to 20 percent.³ PBGH used several metrics to measure success in patient-reported outcomes, utilization, and cost for the CMS-funded program over the 30-month period between July 1, 2012, and December 31, 2014. The results on patient-reported health status surveys — including the Veterans Rand 12 Item Health Survey (VR12), Patient Health Questionnaire (PHQ), and Patient Activation Measure (PAM) — show statistically significant ($p \leq .05$ levels) improvements in patients’ engagement in their own care and in physical and mental health. An actuarial analysis by Milliman shows reduced cost of care. Specifically, the program achieved a:

- 3.6 percent increase in patient engagement
- 33 percent reduction in depression symptoms
- 3.4 percent improvement in mental health functioning
- 4.1 percent improvement in physical health functioning
- 21 percent reduction in the cost of care for high-risk patients enrolled for at least nine months.

LESSONS

The IOCP model has been successfully implemented in varied settings with different populations. This has enabled analysts to identify several common factors that contribute to the program’s success:

- strong senior leadership support, including a dedicated physician champion
- a commitment to the IOCP Guardrails
- staff who can work collaboratively in a team-based care model
- rigorous performance measurement and quality improvement processes
- modern health IT infrastructure
- in-person care coordinator training.

NEXT STEPS

The Intensive Outpatient Care Program model continues to evolve, and the Pacific Business Group on Health is training additional providers to implement it. In 2016, elements of the IOCP model were included in technical assistance and training that PBGH led for California Medicaid providers under the Health Homes Program.⁴ In 2017 and 2018, with support from The SCAN Foundation, PBGH will provide training to 21 health systems providing care to 250,000 Medicare beneficiaries under its Building Care Solutions program, which builds upon the IOCP model. This work will update the model to ensure it incorporates the most recent patient-centered care principles (such as those used by the National Committee for Quality Assurance’s Patient-Centered Medical Home Recognition Program), and provide training to delivery systems on developing a business case for medically complex care programs like IOCP.

NOTES

- ¹ B. Schilling, “Boeing’s Nurse Case Managers Cut Per Capita Costs by 20 Percent,” *Purchasing High Performance*, The Commonwealth Fund, March 25, 2011.
- ² The project described was supported by Grant No. 1C1CMS331047 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. The contents of this publication are solely the responsibility of the author and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies. The analysis presented was conducted by the awardee. Findings might or might not be consistent with or confirmed by the findings of the independent evaluation contractor.
- ³ A. Milstein and P. P. Kothari, “Are Higher-Value Care Models Replicable?” *Health Affairs Blog*, Oct. 20, 2009.
- ⁴ *Health Homes Program* (California Quality Collaborative, n.d.).

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