The IOCP Care Model
The Care Model

Key Features of the IOCP and Successful Medicare Demonstrations:

1. Target the right patients
   - Predicted high cost: Multiple medical conditions, at risk for hospitalization

2. Provide the right services
   - Patient assessment (including socio-behavioral issues)
   - Face-to-face contact with patients
   - Team-based care
     - Direct access to dedicated care manager
     - Patient-Centered Shared Action Plan
     - Regular, planned, rules-based proactive contact
   - Close interaction with physician(s)
   - Manage care transitions and medications

3. Supported by an organizational infrastructure
   - Timely information on hospital and ED admissions
The Care Model

- “Intensivist” and “Distributed” models
- Patients identified using risk-stratified list, plus care team’s subjective judgment.
- PCP referral OK
- IOCP exclusions: already in hospice; partners may add others

Care Team functions:
- Vet high-risk patient list (based on current and predicted costs)
- Make sure patients are attributed to a PCP
- Complete a face-to-face patient intake within 1 month of enrollment, and maintain two-way communication at least monthly
- Use the PAM, PHQ-2, and VR-12 tools to assess patients; Work with patients to develop a Shared Action Plan, and work towards at least one goal per year
- Develop a 24/7 access solution for patients to avoid emergency room visits. This could be a call service where a clinician has access to the medical record and can notify the designated Care Coordinator within 24 hours
- Participate in Care Coordinator trainings
Patient Assessment: What the patient faces

The Team = Patient, Providers, RN Care Manager, patient’s support network
Patient Assessment: What the patient brings

The Patient Activation Measure® (PAM®) assessment gauges the knowledge, skills and confidence essential to managing one’s own health and healthcare.

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
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<tbody>
<tr>
<td>Starting to take a role.</td>
<td>Building knowledge and confidence</td>
<td>Taking action</td>
<td>Maintaining behaviors</td>
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Two Staffing Model Options

<table>
<thead>
<tr>
<th>“Intensivist”</th>
<th>“Distributed”</th>
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<tbody>
<tr>
<td>Patient referred into specialized primary care practice</td>
<td>Patient remains with current primary care practice</td>
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<tr>
<td>1 MD for every 500 patients</td>
<td>3 Team Members for 375 patients</td>
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<tr>
<td>3 Team Members for every MD</td>
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<td>➢ 1 RN as the Care Team Lead</td>
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<td>+ 2 Care Coordinators with specialized skills per clinic needs (ex: NP, PA, MA, MSW, LVN)</td>
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➢ Considerations for your organization…
Dedicated Care Manager Role

• Establishes Trusting Relationship(s)
  o Trust created during face-to-face visit
  o Continuous engagement of patients and providers
  o Direct access via email and phone

• Takes a longitudinal view (weeks, months, years) toward patient problem solving and patient self-management skills

• Creates the shared action plan
  o “What bothers you the most?”

• Ensures continuity of care and explores overuse
  o Medication management
  o Transitions, including specialists
What it Comes Down to…

Building relationships

Patient-centered action planning

Increase patient wellbeing