Frequently Asked Questions for Physicians

1. What is the Intensive Outpatient Care Program (IOCP)?
IOCP is a program designed to improve ambulatory care for high risk and high cost patients in the western U.S. IOCP was created based on clinical evidence that some patients can benefit from enhanced care coordination by a team of care coordinators supporting a patient’s primary care physician. IOCP is made possible through the Pacific Business Group on Health (PBGH), a non-profit organization representing 60 companies that purchase health coverage for 10 million employees and dependents, and works to improve the quality and availability of health care.

2. What does it mean for my practice?
Physicians may be asked to participate in the IOCP if your practice has a significant number of Medicare patients with chronic conditions and multiple comorbidities, and some have been identified as being at high risk of hospitalization and emergency room visits.

3. How would it affect my practice?
- Physicians work as part of the care coordination team which will include having regular interaction with your patients enrolled in the IOCP and may involve phone or in-person updates with the care coordinator.
- The IOCP will reduce unnecessary or avoidable visits that are quite challenging to manage and might be a source of frustration for you, allowing you to focus on (or more easily accommodate) patients that are new and/or need urgent attention.
- Patients will come more prepared for their visit (with their labs, etc.) letting you provide a better quality of care.

4. How are patients selected?
Patients are initially identified as potentially benefitting from additional care management support due to having a high prospective risk score based on claims, including admissions, emergency department visits, outpatient and prescription drug claims, where available. The prospective risk score addresses future likelihood of medical services, compared to a concurrent risk score, which weights prior events.

The predictive risk modeling conducted by Milliman, our data warehouse and analytics vendor, includes scoring of the likelihood of inpatient, outpatient and prescription drug use (e.g., polypharmacy).

Next, practices with a significant number of eligible patients are invited to participate. Your practice may be familiar with these patients because they receive regular and ongoing care for a persistent health condition, or they may receive most care through specialists and need a primary care physician. In addition, if you have patients who are not on the list of eligible patients, yet you believe they may be a candidate, you can refer them into the program. Patient outreach includes a letter from the primary physician; your support of the program and positive response to their questions means they are more likely to participate. Since patients
are also more likely to agree to participate during or after an emergency room visit or hospitalization, care coordinators will outreach directly to patients after such an event. It should be noted that Company Name and the primary care physician may elect to exclude individual patients if they are already under case management with established protocols (e.g., transplant or ESRD).

5. **Will I still be involved in my patient’s care plan?**
   Yes. The care coordinator will be available to help with patient assessment to develop a shared action plan with the patient, or can manage that process if your schedule does not allow. You will remain the patient’s physician and will see the patient as needed. The care coordinator will routinely follow-up to motivate patients to achieve their goals, provide tools for self-management, educate the patient to recognize signs and symptoms of exacerbation of illness, and provide support for psycho-behavioral and social needs.

6. **How does this program differ from the way I currently provide care?**
   The new program will focus on patients who can benefit from care coordination: they have multiple medical comorbidities, often have depression and other issues that you may not be aware of, may not adhere to treatment plans or clearly understand their conditions, and may not identify as “sick.” As a result, they may not seek medical care and advice as often as they need it, or, conversely, may present in your office more often than needed.

7. **Does this mean that I will have less time to see my patients?**
   No. The IOCP will help reduce your redundant visits and the care coordinator will work closely with your patients to ensure adherence to your recommendations.

8. **What is the role of the Care Coordinator?**
   The care coordinator will:
   - Manage data for patient identification and program tracking.
   - Know benefits of patient’s insurance plan.
   - Develop trusting, long-term relationships with patients.
   - Coordinate the various services needed by the patients, and potentially attend specialist visits to help with interpretation of and adherence to clinical information.
   - Ensure patients are prepared prior to visiting your office. Facilitate the pre-visit planning and the entire intake process.
   - Connect patients to community and social services as needed.
   - Provide ongoing care coordination, including follow-up to overnight and weekend medical support (e.g., advice lines and on-call) needed by patients through in-person visits, phone and email.
10. What are my responsibilities if I participate in the IOCP?
Once you have agreed to participate in the IOCP, your responsibilities include:

- Meeting the care coordinator working with your patients to get to know each other.
- Provide clinical judgment about suitability of your patients for enrollment to the IOCP.
- Support use of your letterhead/signature since physicians are the best patient recruiter; follow-up phone calls are best.
- Participate in the patient assessment with the care coordinator, when possible.
- Engage other physicians to the IOCP.

11. How long can I participate in the IOCP?
Your participation in the IOCP is completely voluntary. You can end your participation at any time.