



Intensive Outpatient Care Program (IOCP)

PACIFIC BUSINESS GROUP ON HEALTH

Toolkit

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California Quality Collaborative
Breakthroughs for Better Healthcare

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Includes lessons from the 2012 – 2015 IOCP initiative, Person-Centered Care principles, and a focus on business case and sustainability

It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has.

– William Osler



Introduction

Purpose of this toolkit

The resources assembled here are meant to equip the managers and the staff of primary care programs that have been created specifically to serve adults aged 65 and over with the greatest health care needs. These programs should have the explicit goal of achieving high-quality, reliable, person-centered care that supports the individuals being served in meeting their own individual goals for their health and well-being.

The toolkit was developed initially for the use of the twenty-three medical groups that participated in the Pacific Business Group on Health (PBGH) and the California Quality Collaborative's 2012 – 2015 Intensive Outpatient Care Program initiative (IOCP). This toolkit will be most effective if used systematically in a developmental process where the program's goal is to learn the best services and care processes, and to scale this new care model for a defined population of older adults.

Person-centered care

The guiding principle for this toolkit is person-centered care, as championed by The SCAN Foundation – an approach that starts with the knowledge that for complex care interventions to succeed, care must be driven by each person's values and needs. The definition of person-centered care that guides this toolkit is from the American Geriatrics Society Expert Panel on Person-Centered Care, which was grounded in interviews with community-based healthcare and social service organizations, as well as other research:

Person-centered care means that individuals' values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals. Person-centered care is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers. This collaboration informs decision-making to the extent that the individual desires.

Introduction

PBGH's Intensive Outpatient Care Program

Based on a successful pilot for commercial patients¹, the 2012 – 2015 Intensive Outpatient Care Program (IOCP) used a multidisciplinary team-based approach to address medical, behavioral and social needs of older adults. At the heart of the IOCP model is a care coordinator who:

- Serves as a link to primary, specialty and ancillary services,
- Provides tools for effective self-management,
- Guides participants through the development of a shared action plan, and
- Provides connections to behavioral, psychosocial and community services.

The IOCP model focuses specifically on older adults whose outcomes could be improved and whose preventable hospital use can be reduced through care coordination, self-management support and provision of ambulatory care. The overall goal of IOCP is to keep participants at home and in their communities by providing intensive, person-centered outpatient care.

IOCP's clinical advisors identified key "guardrails" (required elements) that distinguish IOCP from other programs for medically complex patients. Delivery systems can adapt the model to their local environment. The guardrails include:

- **Care Coordinator** (includes nurses, social workers, community health workers and medical assistants), trained in person-centered care techniques, maintains a close, ongoing relationship with the participant over time and across the care continuum,
- **Face-to-face Super-visit** in the participant's home within one month of enrollment, where information is gathered with a motivational, open, and flexible approach to establish a trusting relationship with the participant,
- **Bi-directional communication**, monthly or more frequently, between the Care Coordinator and participant,
- **Shared action plan** created with the participant, including at least one goal chosen by the older adult,

- **Warm handoffs** to relevant support services (e.g., home health, behavioral health, transportation, drug assistance programs, food banks and other community services) and
- **24/7 access** solution, with communication to the Care Coordinator on the next business day.

In addition, the Care Coordinator role is structured to achieve program goals:

- The Care Coordinator was dedicated to this role, and did not have other responsibilities beyond managing their panel of IOCP participants.
- The Care Coordinators worked in teams. A registered nurse was most often at the center of the team of Care Coordinators. Other staff, such as medical assistants or medical social workers, were team members. All received the same training for the role. Using lower-level staff, along with nurses, improved the financial sustainability of the program.
- Finally, in all cases, the Care Coordinators relied on medical supervision, either from the primary care provider or other physician supervising the program.

Essential Elements of Person-Centered Care in the IOCP include:

- An individualized, goal-oriented care plan based on the person's preferences.
- Ongoing review of the person's goals and care plan.
- Care supported by a interprofessional team in which the person is an integral team member.
- One primary or lead point of contact on the healthcare team.
- Active coordination among all healthcare and supportive service providers.
- Continual information sharing and integrated communication.
- Education and training for providers and, when appropriate, the person and those important to the person.
- Performance measurement and quality improvement using feedback from the person and caregivers.

For more information on person-centered care, go [here](#).

¹ Milstein A and Kothari P, Health Affairs Blog, "Are Higher Value Care Models Replicable?" Accessed at <http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable>.

Introduction

Delivery systems chose one of two implementation models:

The **Intensivist model** is built around a primary care physician dedicated to IOCP. Participants switch their primary care provider (PCP) until graduation from IOCP, and receive all their care from the Intensivist team. It is well-suited for centralized locations accessible to defined groups or populations.

The **Distributed model** has participants remain with their current PCP and Care Coordinators develop strong working relationships with multiple primary care practices. The Distributed model is well-suited for smaller practices spread over a wide geographic area.

Results

PBGH used several metrics to measure success in patient-reported outcomes, utilization and cost. The results on patient reported outcomes – VR12, PHQ and the Patient Activation Measure (PAM) – showed improvements in patients' engagement in their own care, and in physical and mental health. The results of the three patient assessments were as follows (with statistical significance at p.05 levels):

- 3.6% increase in patient engagement
- 33% improvement in depression symptoms
- 3.4% improvement in mental health functioning
- 4.1% improvement in physical health functioning

The increase in physical health functioning is particularly noteworthy, as physical functioning declines in populations of older adults with high chronic illness burden. Also, the large improvement in the PHQ is encouraging for the management of depression in IOCP. Analysis also showed that the biggest improvements occur in the first year of enrollment. Additionally, participants with an increased score on the Patient Activation Measure (referenced on page 12 in this toolkit) were 30% more likely to graduate because they no longer needed the intervention.

The results of the actuarial analysis by Milliman show a positive impact on cost of care:

- 21%² reduction in cost of care for high-risk patients enrolled for at least nine months

Actuarial analysis confirms that these reductions are attributed to improved care coordination, although the magnitude of change attributable to the program could not be distinguished from regression to the mean.

² Stremikis, Hoo and Stewart, Health Affairs Blog "Using The Intensive Outpatient Care Program To Lower Costs And Improve Care For High-Cost Patients"
Available at: <http://healthaffairs.org/blog/2016/02/02/using-the-intensive-outpatient-care-program-to-lower-costs-and-improve-care-for-high-cost-patients/>

Development Criteria Process for Intensive Outpatient Care Program



1. Assess Readiness and the Business Case

Page 5

- Assess readiness for IOCP based on current capabilities and gaps.
- Understand opportunities and barriers to funding a sustainable care model to support better health of older adults.



2. Identify IOCP Potential Participants & Stratify by Risk

Page 7

- Understand the care needs of older-adult population served.
- Develop process for identifying potential participants for IOCP care, using information from candidates, providers as well as other data.



3. Develop the Care Model

Page 9

- Use a person-centered approach to build the care model.
- Change the care paradigm to meet participants' priorities.
- Engage IOCP participants and caregivers.
- Choose a program model.



4. Build IOCP Team for Older Adults' Goals

Page 13

- Identify champions and project management support.
- Determine care team members.
- Define the Care Coordinator role, hire carefully, provide training.
- Support care team in this challenging work.



5. Engage Providers

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- Develop strategy for provider engagement.
- Demonstrate benefits of IOCP to providers and to their older adult patients.



6. Create a Measurement Plan to Monitor Successes

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- Develop a measures set to monitor IOCP performance.
- Use quality improvement methods and IOCP participant input to continuously improve your IOCP.

Throughout the toolkit, **IOCP tools** are listed with an icon  and included either in the appendices starting on page 17 or as external links. On page 38, **Appendix O: Additional Key Terms and Resources** includes concepts that are not easily packaged as stand-alone tools, or are less specific to the IOCP model. Terms seen in ***bold italics*** throughout the toolkit can be found in this document.



1. Assess Readiness and the Business Case

Most primary care organizations already provide some level of complex care services, with the two most common programs being those that support care transitions from hospital to home and provide care coordination for chronic illness care. Use this checklist-style discussion guide in program planning meetings to help you identify where existing programs stand and where you want to focus your efforts as you build an effective and person-centered IOCP. The ideal group to plan an IOCP includes the program staff team (primary care provider/s, Care Coordinators if hired, medical assistants and/or nursing staff), program managers, a data analytics lead, and a finance manager or analyst.

Questions about organizational readiness and business plan for IOCP

- Can the organization define how an intensive outpatient care program would improve the *lives of older adults and their families and caregivers*?
 - Can the organization define how an intensive outpatient care program would improve the *lives of providers and care team members*?
 - Is your workforce for IOCP ready and equipped to do this work with older adults? What supports do providers, nursing staff, behavioral health providers, and others need to participate fully in providing high-value care in an IOCP?
 - Are sufficient financial and staff resources committed to build the program as needed over the next year? Is there a process established for securing additional support for further program growth if needed to achieve scale for the full population of older adults who would benefit from IOCP services?
 - Are the necessary partners aligned, including payers, hospitals, and specialists? Do you have what you need from these partners, such as frequent and accurate data for care coordination and identification of eligible older adults?
- Does your organization have a clear business plan for a sustainable IOCP? If so, does the business plan include a predictive model for financial return on the investment required to take the program to full scale? Also if so, does your business plan incorporate the changes in Medicare payments through the Medicare Access & CHIP Reauthorization Act (MACRA)/Merit-Based Incentive Payment System (MIPS)?
 - Do you have a measurement system in place to monitor effectiveness of the program, including financial and utilization measures to understand return on investment?

Questions about person-centered care and understanding of older adults' care needs

- Are potential program participants involved in the design of the program?
- Have you conducted focus groups or one-on-one customer interviews with older adults with complex care needs, to understand what they want from your IOCP program?
- Is there a process in place to get feedback from older adults and their families/caregivers on an ongoing basis?
- Do you use a design thinking approach to develop services and processes that are person-centered and designed to ensure a positive therapeutic experience?
- Do you have eligibility criteria established to help you identify the older adults who are most in need of your program's support and services? If so, do your eligibility criteria include all of the following: past care utilization, a prediction of future utilization, and a list of specific medical and behavioral health conditions and functional support needs?



1. Assess Readiness and the Business Case

Questions about the existing or proposed complex care model and program operations

- Do all care team members and management staff understand the definition of person-centered care and its implications for engaging older adults, developing care plans, and delivering effective services?
- Do all care team members and management staff understand trauma and trauma-informed care (which is distinct from the direct treatment of trauma symptoms)?
- Do all care team members and management staff understand the long-term impacts of adverse childhood events on a person's health, regardless of a person's age?
- Do your complex care program workflows, team communication protocols, and electronic documentation include and respond to older adults' priorities, strengths and needs as the main drivers of their care?
- Do primary care providers understand the program and their role in its success with older adults? Do they see IOCP as a way to improve care and decrease their own stress?
- Is there expertise in mental health and addiction in your care team to serve older adults with these needs? Is there a psychiatrist on the team or available?
- Is there adequate primary care capacity in your organization to serve the needs of older adults whose health and preferences make them ready to "graduate" out of complex care services?
- Are you able to track the performance data you need to monitor weekly and monthly progress on your population-level goals for your IOCP work? Do you have the performance improvement knowledge and leadership you need for IOCP to succeed?



Return on Investment (ROI) Calculator from The SCAN Foundation

See IOCP summary above for the model's success in impacting cost and utilization. To enhance this focus and IOCP's potential in cost control, the free ROI Calculator from The SCAN Foundation is a new addition to this toolkit. The user of the ROI Calculator enters estimates of independent variables such as number of people served, expected care utilization patterns, and the costs of staff salaries and program resources. The tool allows the user to tailor the calculations, including segmentation of the target patient population by risk categories and estimating potential revenue through pay-for-performance or risk-sharing.

[Download the ROI Calculator and its embedded user guide here.](#)



2. Identify IOCP Participants & Stratify by Risk

Develop an algorithm or criteria to generate an initial list of candidates from historical data.

If your organization has access to claims data, there are several off-the-shelf claims-based tools that produce a prospective risk score based on some combination of the following: demographics, utilization, diagnoses, medication/prescription fill information, existence of co-morbidities, and prior and current costs. These tools are objective but imperfect, in part because past high utilization does not in itself predict future high utilization and because of all the important information missing from claims data, such as individuals' functional status with activities of daily living (ADLs).

In order to reach out to the potential participants who would benefit the most from IOCP, including people who predictive analytics may miss altogether, consider a list generated from historical data as a starting point, and combine that with two other sources of data: qualitative input from providers and from patients themselves.

- **Primary care providers' assessment:** Apply clinical input – for example, send a PCP his/her list of potential participants and ask the physician: "Identify patients who you would not be surprised if they were in the emergency department or hospital in the next 6 months." Or for Medicare beneficiaries, the above question and: "Identify patients who you would not be surprised if they became seriously ill or died in the next 12 months." Clinical review by providers is a validated approach (see the work of Clemens Hong and others) to predicting which patients will have high care needs in the future.

- **Older adults' own assessment:** Ask your patients about their care needs. In a 1999 study published in *Effective Clinical Practice*, Medicare enrollees who reported their health status as "poor" in response to the question "*In general, compared to other people your age, would you say your health is: excellent, very good, good, fair or poor?*" were found to have higher Medicare expenditures and higher hospitalization rates. Other valuable questions to ask include the number of prescription medications, the number of people available to support the person with his or her health needs, and questions about functional status with ADLs.



Appendix A: Patient Selection Criteria Guidelines

Stratify the list into different levels of care and outreach intensity.

Stratifying a list of IOCP candidates helps the program be effective and person-centered in three ways:

1. Prioritizing the work of initial outreach and engagement
2. Guiding the level of contact and support needed for each IOCP participant once engaged
3. Managing and balancing Care Coordinators caseloads.

In determining levels within your program, develop a risk stratification tool that includes elements not readily available in the data, such as social support, functional status, health assessment scores, and patient activation.



2. Identify IOCP Participants & Stratify by Risk

Refine your identification and risk stratification processes as you gain experience and information.

- Test your approach against your data: Does your algorithm produce a list of potential participants with persistent, actionable and costly health problems?
- Review potential participants that you thought your program should serve but who were not identified as being eligible: Are there common characteristics that define these patients that could be added to your identification or risk stratification algorithms?
- Review potential participants who matched your initial criteria, but were not a good fit for IOCP: Are there common characteristics that define these patients that might be removed from your identification or risk stratification algorithms?
- Compare initial risk scores to actual costs over time. Are any changes needed to your risk algorithm?

Re-assess participants enrolled in the IOCP on an ongoing basis.

- Assess the total panel of people being served for those who are ready to graduate to regular primary care or a lower level of IOCP intervention.
- Find new older adults who are in need of IOCP care. (See recommendations in Section 3: "Develop the Care Model" for establishing tiers of participants based on engagement and needs.)
- Carry out your IOCP participant identification process at least quarterly to find new older adults to serve. Lower acuity patients may have changing risk factors that make them eligible for IOCP.
- When deciding whether to transition patients between levels of care, factors that have been found to be useful are: stages of disease, psychosocial evaluations, assessment of functional status (including **Activities of Daily Living (ADLs)** and **Vulnerable Elders Survey, known as VES13**), and clinical input from the care team.
- When graduating a patient to a lower acuity level, an interdisciplinary care team meeting may be useful to reach consensus.



3. Develop the Care Model

Use a co-design approach to ensure your IOCP is truly person-centered.

Use the best practice of customer interviewing, established in complex care programs by the Institute for Healthcare Improvement and Stanford Coordinated Care, to learn what is important to the people you plan to serve in your IOCP. Find five IOCP participants who are willing to be interviewed about their wishes and needs for their health and well-being. Use these four questions from Stanford Coordinated Care to uncover patient priorities and the root causes for high care utilization. Analyze this important input as you develop your care model.

- What is the worst thing about your health situation?
- What in your life helps to make it better?
- What does medical care do that helps make the situation better?
- What does medical care do that doesn't help or makes the situation worse?

Establish the core value of person-centered engagement in the care team and its processes.

The success of the IOCP model depends on person-centered care, trust, and a longitudinal relationship between the person, their support system and the care team. All program services should be built using these guiding principles.

- Develop a person-centered relationship with the person from the beginning of IOCP. Ideally, the primary care provider with whom the person has a relationship should offer IOCP to each potential participant initially, and offer a warm (in-person) hand-off to the Care Coordinator for those older adults interested in learning more.
- One-on-one interaction following initial engagement may be by phone, email and in-person, as appropriate and as agreed by the older adult and Care Coordinator.
- In the Intensivist model, older adults may have to switch primary care providers. The IOCP care team must work with referring physicians to make this change as comfortable as possible for the older adult, their families and caregivers, and for referring providers.

- As desired by the IOCP participant, engage the older adult's family members and caregivers in plans and activities of IOCP that support the older adult's goals for his or her health and well-being.
- Ensure care that integrates behavioral health care with medical care, and also focuses on functional, social and environmental needs of older adults. Trauma-informed care is an important goal in complex care work, as it requires a true partnership with patients.

Develop a robust, multi-step approach to IOCP candidate outreach, engagement and enrollment.

Build engagement and trust with potential IOCP participants through existing relationships with care providers. A personal, in-person invitation from a primary care provider to join the IOCP is the most effective first step for engagement in IOCP, particularly when it leads to a live, in-person introduction (aka "warm handoff") to an IOCP Care Coordinator. To facilitate this first step, Care Coordinators can identify potential IOCP participants with previously scheduled PCP appointments, and have the PCP introduce the program and the Care Coordinator at the visit. If there is not a visit scheduled in the near term, an outreach call from the provider (ideally) or the Care Coordinator to the older adult at home can initiate the offer of IOCP. A follow-up letter from the PCP can be supportive but may have very limited yield when used as the only recruitment method.

Multiple conversations with both the older adult and his or her family members and caregivers can be expected as part of engagement. The techniques of **Motivational Interviewing** are helpful in demonstrating to IOCP participants and the people important to them that the IOCP model of care is truly different and person-centered care.



Appendix B: Sample Patient Outreach Letter

Appendix C: Frequently Asked Questions for Patients



3. Develop the Care Model

Start the IOCP relationship with an in-depth Super-visit.

The Care Coordinator will begin to develop a collaborative relationship with the IOCP participant, introduce the program and learn the participant's priorities and needs in an initial face-to-face Super-visit in the home. Super-visits may take up to 90 minutes but do not have to be done in one sitting. Include family members and/or caregivers if the participant desires. The Super-visit should be accomplished within the first month of recruitment and, ideally, within the first two weeks. Needs assessment tools central to the IOCP model should be covered in the Super-visit, particularly the Patient Activation Measure, PHQ-9, and VR-12 (included as tools in this toolkit). Even so, these assessment tools should be used to support a therapeutic conversation, not as checklists to be completed as quickly as possible. The Super-visit can be divided into the following three sections (see Appendix D):

Part I: Care Coordinator and Participant (prior to meeting PCP): Care Coordinator greets the older adult and explains the goal of meeting and time allocated and gets agreement before proceeding. Builds rapport with older adult; provides agenda for the visit; addresses any immediate concerns; asks about goals (medical and quality of life); reviews and reconciles medication list; updates allergies; reviews and reconciles health maintenance; assesses and records vital signs. Depending on licensure, another team member may need to join the Care Coordinator to perform tasks such as medication reconciliation.

Part II: Care Coordinator, PCP and Participant: Care Coordinator summarizes the visit thus far, with a focus on the participant's goals (if identified) and includes the PCP to address any medical concerns and promote self-management. If requested or when necessary, the PCP and participant meet briefly without the Care Coordinator.

Part III: Care Coordinator and Participant (after meeting PCP) – Care Coordinator discusses broader health and quality of life goals; continues creating action plan (identify one specific action step); provides a copy of the action plan to the older adult; reviews contact methods (patient portal, phone, etc.); reviews Shared Action Plan

(see Appendix G); discusses any remaining questions and schedule next follow-up visit.

When the Super-visit is done in one meeting, it is critical to stick to the time limit agreed, since these long meetings can tire the IOCP participant.

At the end of the Super-visit, and at subsequent care encounters, it is important to provide a simple printed document to the IOCP participant of what was discussed and what decisions were made about the person's care. This serves as a reference for self-management and for caregivers or family members the participant may choose to involve in his or her care. It also serves as a reference for follow-up contact by the Care Coordinator to check status of action plans and supports needed from the care team.



Appendix D: Care Coordinator Checklist for a Super-visit

Appendix E: PHQ-9 Questionnaire

Appendix F: Domain Assessment

Patient Activation Measure (not included in appendix; license from Insignia Health [here](#))

VR-12 (not included in appendix; request access from Boston University [here](#))



3. Develop the Care Model

Support IOCP participants as the leaders of their needs assessment and shared action plans.

- A face-to-face assessment must be conducted within a month of the IOCP participant's decision to enroll, using one or two initial IOCP visits to conduct the Super-visit.
- Every participant must have a Shared Action Plan with yearly goal(s) reflecting the older adult's personal priorities and goals.
- Every IOCP participant must have at least one goal per year, though several goals are recommended and shorter-term goals can be effective for motivation and engagement. All goals must be the older adult's own, for his or her health and well-being. Using brief action planning (included in Sample Shared Action Plan appendix) to create short-term action steps from longer-term goals.
- In the Super-visit, as part of the initial assessment, use validated patient assessment tools to discover health status and needs, and to monitor progress. IOCP tools include PHQ-2, Patient Activation Measure (PAM) and VR-12.
- Additional assessment tools that are useful in IOCP work with older adults include assessments of pain, particularly back pain (using the 0 – 10 pain rating scale or one of the many available tools to help assess pain relative to medication), and tools that help establish **advanced care plans**.



Appendix G: Sample Shared Action Plan

Develop and support the key role of Care Coordinator with slow caseload growth and a dedicated training program.

- Ramp up the responsibilities and caseload of the Care Coordinator over time.
- Provide training on topics that are central to person-centered care.
 - > Elements of person-centered care
 - > Motivational Interviewing
 - > Effective team communication
 - > Clinical best practices in care transitions and behavioral health – primary medical care integration
 - > Trauma-informed care and the long-term effects of adverse childhood events.
- Provide regular supervision meetings with Care Coordinators, both one-to-one and in peer consultation-style groups. Ensure Care Coordinators are working in a person-centered way that is effective and resourceful to meet IOCP participants' needs and goals.
- Provide Care Coordinators with support to prevent the fatigue and burnout that is common when working in complex care delivery systems with people who have high needs and multiple chronic conditions.



Appendix H: Training and competencies checklist for new Care Coordinators



3. Develop the Care Model

Build a comprehensive list of resources to support patients' goals and to address medical, functional, social and behavioral health needs.

- Develop a comprehensive resource list of support services that may be needed by older adults. Include services and resources for all needs, not simply medical needs.
 - > Medical needs, e.g. home health, behavioral health, substance abuse, Meals on Wheels, personal assistance services to meet ADL needs;
 - > Social needs, e.g. senior centers, Area Agencies on Aging, faith-based resources (church, synagogue, mosque), legal services, housing.
- Address transportation needs, as transportation can be a significant barrier to a persons' ability to achieve goals, access to care, and/or maintain independent living.
- Develop relationships and partnerships with the agencies who provide these resources that will support IOCP participants. Regular meetings with participants to assess specific goals in their health is an extension of care coordination that can help them meet their goals in care more easily with unified support of a team that extends across organizations.

Promote IOCP patient education and self-management approaches.

- Provide training to care team staff on **Motivational Interviewing, trauma-informed care**, and shared action planning.
- Train Care Coordinators and all care team staff on person-centered approaches to the key IOCP assessment tools: Patient Activation Measure, PHQ-2/PHQ-9, VR-12.

Manage Care Coordinator panels frequently, using tiers to meet different levels of need.

- Panel size: IOCP caseloads vary, depending on the level of needs of the target population and the IOCP care team model. 125 to 150 participants per Care Coordinator is the high end of the range, and 90 the low end. Caseloads naturally fluctuate at the individual Care Coordinator level and the care team level.
- Establish tiers of participants within the IOCP, to help manage caseloads and to focus team attention and resources where they are needed most each week or month. Three or four tiers are common in IOCPs, and can be based on a combination of data and information from staff:
 - > Level of engagement, including frequency of contact with Care Coordinators
 - > Number of recent emergency department and hospital admissions
 - > Number of chronic conditions
 - > Level of support needed, based on scores on Patient Activation Measure, VR-12, Domain Assessment (see Appendix F), or assessment of the care team
- See examples of tiered levels of care in **Appendix F: Domain Assessment tool**, which are based on the results of that comprehensive patient assessment tool.
- Assign a level to each older person upon enrollment, then assess monthly or more frequently as needed when a participant's situation changes. One tier should be for participants who are ready to graduate to a lower level of care.
- As part of person-centered care, accommodate in your tiered system the fact that many IOCP participants' goals change. Participants need the freedom to be less engaged when their goals or situation changes, and then more engaged if they choose in the future.
- Review caseloads and participants' change in need and activation monthly or more frequently. Consider using Patient Activation Measure scores in this calculation.



4. Build IOCP Team for Older Adults' Priorities & Needs

Build a person-centered care team that is always available to patients, family and caregivers.

- Develop the care model as you go, using the expertise of the providers and staff of the program and quality improvement and design thinking principles to learn the most effective processes and care activities.
- Consider the IOCP participants, particularly the first few enrolled, as expert guides in developing your care model. In order to be person-centered, the care model must follow person's priorities and goals.
- A successful IOCP has a dedicated Care Coordinator role as the key person on the care team. The Care Coordinator maintains a longitudinal one-on-one relationship with a panel or caseload of patients. See separate toolkit section below dedicated to the Care Coordinator role.
- Participants should have a single point of contact on the care team they can contact at any time of day or night. This point of contact should have access to the patient's medical record and notification of the contact, the participant's concern and the action taken should be made to the Care Coordinator as soon as possible or on the next business day.
- Secure messaging should be available to Care Coordinators during working hours.
- At a minimum, two-way interaction between the Care Coordinator and the IOCP participant should happen once per month.
- Select one of two basic program models, or create a hybrid of the two.
 - > In the **Intensivist Model**, participants are referred into a specialized primary care practice. Each IOCP participant is assigned to the IOCP primary care provider and to his or her dedicated Care Coordinator.
 - > In the **Distributed Model**, participants remain with their current primary care practice. A typical IOCP staff team includes two RN Care Coordinators who partner with primary care provider-based teams. Additional staff may come from a variety of disciplines and may be licensed or unlicensed.

Develop the Care Coordinator role expectations and clarify the requirements of the position in the job description.

The central role of the Care Coordinator includes the following:

- Support older adults' success in achieving their own goals for life, health and well-being
- Address health care and social needs through trusting relationships
- Manage data for identification and program tracking
- Develop and implement engagement strategies
- Know the benefits of the participant's Medicare insurance plan, and any supplemental health care coverage
- Partner with the primary provider to complete the Super-visit assessment and shared action plan development
- Track and monitor daily care needs of the population
- Support progress and follow-up on each participant's shared action plan
- Coordinate the services needed by the participant
- When needed, attend specialist visits to help with interpretation of clinical information and with integration of recommendations into shared action plan
- Attend regular (virtual or in-person) huddles with IOCP care team to review active issues, transfer information, and refine the shared care plan
- Engage with participants to support care transitions between levels of care
- Connect participants to community and social services as needed



Appendix I: Care Coordinator job description

Appendix J: Pre-Visit planning checklist

Appendix K: Care Coordinator daily prioritization and weekly activity checklists



4. Build IOCP Team for Older Adults' Priorities & Needs

Recruit Care Coordinators through multiple means and make the position attractive.

- Create a career path option by recruiting medical assistants (or other skill sets) whereby less experienced staff can work into higher-level roles as ready.
- Host an open house or recruit via a virtual open house opportunity.
- Work with professional organization networks, websites and social media that interface with case/care managers, especially where care managers browse for jobs and employers post job openings.
- Consider job sharing, telecommuting or other position reconfigurations.

Conduct thorough interviews for Care Coordinators, using best hiring practices.

- Use a behavioral interviewing approach, which seeks examples of past behaviors to understand how the person will approach the current work, such as the following:
 - > "Give an example of what you did in a stressful work situation."
 - > "Talk about a time when you learned something new about a different culture."
 - > "Tell us how you solved a difficult communication challenge with a colleague."
- Include the whole care team in in-person interviews, particularly Care Coordinators and primary care providers. Give each team member a scorecard to rate the applicant on key personality requirements and duties of the position.
- If possible, include one or two IOCP participants in the interviews. Support their role in the interviews with a similar scorecard as for other team members.
- Use case scenarios to learn about the applicants' problem-solving skills and approach to coordinating care. Challenging situations from care team members' experience work well. Do not expect perfect knowledge of local resources or your IOCP care pathways, rather look for the applicant's approach to person-centered collaboration with patients and with the approach to

colleagues across the continuum of medical, behavioral and social services.

- Ask the applicant to develop a short plan of care from a case scenario. Assess how well it includes the older adult's goals and priorities.
- Using behavioral interviewing, the whole care team and participants, and case scenarios, assess for these attributes:
 - > Person-centeredness, including collaborative, patient-directed care
 - > Theoretical knowledge of **care management** and **Motivational Interviewing** (Formal knowledge of these models should not be required, but the values and approach to patient care of these person-centered modalities should be expressed clearly by applicants.)
 - > Interest in working with older adults, without a paternalistic attitude
 - > Ability to and personality for collaborating with other providers, as part of a team and in ways that change based on unique needs of IOCP participants
 - > A harm reduction approach to substance abuse and addiction
 - > Problem solving skills
 - > (If your IOCP is new or growing) Interest in new program development and comfort in an uncertain and evolving environment
 - > Cultural literacy and the implications of personal culture and family background for effective collaborative work with IOCP participants
 - > Interpersonal skills such as negotiation, cooperation, conflict resolution, priority setting, leadership, open-mindedness, patience, risk taking. Ensure balance within your organization and IOCP goals



Appendix L: Tips on overcoming common challenges of Care Coordinators



5. Engage Providers

Recognize the importance and challenges of physician and office staff engagement.

The IOCP Care Coordinator must be seen by providers and other care team staff as a benefit to them as well as to their shared IOCP participants. Enthusiasm for IOCP service drives engagement. Providers will commit to IOCP if the following conditions are in place:

- A clear understanding of the purpose of IOCP, for both individual patient care and for the overall efficiency of care delivery
- Clear evidence (anecdotal or population-level) that IOCP does provide a clear benefit for participants
- Peer buy-in from fellow providers
- Personal experience that IOCP provides relief for providers from worrying about their patients who have multiple care needs

Understand key drivers and strategies of engagement.

- Establish strong physician champion for IOCP and use this leader to communicate with other referring providers (for intensivist-model IOCP) or providers supported by new IOCP care team members (in a distributed-model IOCP).
- Support a communication plan for the physician champion which includes presentations at provider meetings, success stories from patients helped by IOCP, use of data that shows quality of care and patient experience improving as a result of IOCP.
- Create IOCP program description information as in **Appendix M: Frequently Asked Questions for Providers**, for other provider office staff.
- Dispel the myth that IOCP will take more physician time.
- Dispel the feeling that IOCP is an indictment of their ability to take care of their patients: IOCP extends care that is already good care.
- Clarify roles, of the Care Coordinator, other IOCP team members and managers, and of other partners in the

work such as health plans. Clarify that IOCP is not home health nursing, so IOCP team does not do wound care, for example.

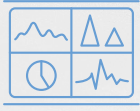
- Establish a service-style relationship of the Care Coordinator for the provider and his/her care team: IOCP is here to help them as well as their patients.

Develop specific engagement strategies for your organization.

- Ensure transparency of purpose and clear articulation of the IOCP, benefits to physicians and physicians' role in its success.
- Involve the physicians and office staff early in the implementation of the IOCP through outreach, relationship building with the Care Coordinators and continued positive messaging.
- Provide training on the elements of person-centered care and the IOCP model to all involved providers and care teams. Offer a meet-and-greet session with the Care Coordinator team.
- Include IOCP participant, family members and caregivers in meet-and-greet sessions with Care Coordinators and other IOCP leaders, so that those people important to IOCP participant understand the supports and goals of IOCP.
- Include provider office staff in engagement efforts, along with clinical staff and providers.
- Leverage local leadership and physician champions in promoting the benefits of IOCP.
- Sustain momentum by sharing IOCP success stories with physicians and office staff so they see progress – such as patient activation, data that shows improvement in quality outcomes or positive patient feedback.
- Be humble and ask for help from referring and/or participating providers, to support engagement and continuous improvement for the IOCP.



Appendix M: Frequently Asked Questions for Providers



6. Create a Measurement Plan to Monitor Successes

It is important to monitor program processes and how they impact the health and well-being of IOCP participants. Are participants meeting their own goals in the program? Is engagement in medical care and health status improving?

Develop and implement a practical dashboard of performance, outcome and quality, measures for IOCP.

- Build a set of measures which includes a balanced mix that represents the three dimensions of the **Triple Aim** for health care improvement: patient experience, population health and cost/utilization control.
 - Measure staff and provider satisfaction, as IOCP leaders need to monitor staff for burnout, and because often providers find their work satisfaction improves because of the improved care being provided for the patients about whom they are most concerned.
 - Use available data from claims, electronic health records systems and from patients, from their families and caregivers and from care team members, to track the progress of the IOCP overall as well as the progress of individual patients in meeting their person goals.
 - Aim for 8 to 10 measures for frequent (monthly, weekly) capture, for use in frequent IOCP care team decision-making. A larger set of measures should be used by program managers for program operations, in separate discussions from the full frontline IOCP care teams' use of performance data.
- Develop data agreements and improve health information exchange with key partners, including hospitals and health plans, to achieve better data more frequently. Educate these partners about what data you need and how you need it, in an iterative process. Many engaged partners of complex care programs, such as health plans, send high volumes of data that are not useful to the receiving program.
 - Use quality improvement principles and practices, including frequent measurements and the use of data for learning in order to improve processes of care for older adults with complex care needs.



Appendix N: Program performance measures to consider

Patient Selection Criteria Guidelines

Many complex care programs begin and end patient identification with data and a predictive modeling process. Because no predictive model using historical data is perfectly effective at forecasting future care needs, IOCP recommends a hybrid approach to identifying potential participants for the program: Start with a list using a risk assessment algorithm and/or utilization and clinical data, then add provider input and, if possible, patients' assessments of their own health status. (The work of Clemens Hong and others informs this approach.)

I. Data on utilization and current care needs

Patients meeting the criteria in 1 OR more are potential IOCP participants.

1. Risk assessment score (your own methodology)
2. Exclusion criteria – patients who should NOT be enrolled in IOCP: In Hospice
3. Number of hospital admissions in the last [6] months: Threshold 1 or more
4. Number of ER visits in the last [6] months: Threshold 1 or more
5. Number of [active specialists] that the IOCP participant is seeing:
 - > Threshold 3 or more
 - > "Active" refers to a scheduled follow-up visit (e.g., the patient has a scheduled visit with a rheumatologist in 1 year)
6. Number of diagnosed [active conditions] that IOCP participant is being monitored by the participant's physician(s).
 - > Threshold 3 or more
 - > The participant may have a single major condition that makes him/her a good fit for IOCP
7. Number of current medications (Rx) the participant is taking
 - > Threshold is 5 or more

II. Older adult's own assessment of health status and needs

Asking the following questions of the patient will open up key areas of risk. Further discussion should occur when responses indicate the need.

1. In general, how would you rate your current health? Excellent/Very Good/Good/Fair/Poor
2. How many prescription medications are you currently taking every day?
 - a. (If medications prescribed) During the past week, how often did you forget to take or decide not to take one or more of these medications?
 - b. (If medications prescribed) How sure are you that you understand the reason you are taking each of these medications?
3. Think about your usual daily activities, such as bathing, toileting, dressing, grooming, feeding, housework, family or leisure activities. Which of the following best describes your situation in the last month?
 - I have no problems with performing my usual activities.
 - I have some problems with performing my usual activities without assistance.
 - I am unable to perform my usual activities without assistance.

4. In the last month, how often did you have trouble with remembering or thinking clearly?
Never/Sometimes/Usually/Always
5. If you needed immediate help for a health problem, how many friends or relatives do you feel close to such that you could call on them for help?
6. Think about your current medical conditions. How confident are you that you can manage these medical conditions day-to-day?
7. During the past 6 months, how many times did you go to the emergency room?
8. Do you think it is likely you will need to go to the emergency room in the next 6 months?
9. During the past 6 months, how many times did you stay in the hospital overnight as a patient?
10. Do you think it is likely you will need to be hospitalized in the next 6 months?

III. Primary care provider assessment

From a list of his or her Medicare patients, prompt the provider:

1. "Identify patients who you would not be surprised if they were in the emergency department or hospital in the next 6 months."
2. "Identify patients who you would not be surprised if they became seriously ill or died in the next 12 months."

Appendix B

Sample Patient Engagement Letter

Note: Depending on your patient population, letters and written materials for patients and families may need to be at a lower literacy level to be effective and person-centered.

Insert Date

Dear *Patient Name*,

Do you sometimes feel stressed when trying to get your health needs met?

Do you feel like your health care could be better organized, but you are not sure how to do it?

If you think that a different kind of health care team could help you, I invite you to consider our **Intensive Outpatient Care Program (IOCP)**.

The main difference from regular care in IOCP is a larger care team. In addition to the primary care doctor, IOCP has a team of Care Coordinators who help our patients achieve their own health-related goals.

IOCP services include:

- Confidential, personal care to help you meet your health and life goals
- Access to a 24-hour advice line or on-call doctor at any time
- Contact with your care team through email, phone, in-person visits including home visits
- Same-day office appointments
- No changes to current medical benefits.

We know that our care is more successful when it is led by each person's specific wants and needs, and tailored to his or her life goals. That's what IOCP intends to do.

There is no additional cost to join IOCP. Your health benefits will remain the same. You can try IOCP out and end your participation at any time if it does not suit you.

A Care Coordinator from my office will call you to answer any questions or address any concerns that you might have about this option. If you like, please call me at phone number. For more information on the program, please see the enclosed **Frequently Asked Questions**.

Sincerely,

Physician Name

Frequently Asked Questions For Patients

Note: Depending on your population, letters and written materials for participants and families may need to be at a lower literacy level to be effective and person-centered.

1. What is the Intensive Outpatient Care Program (IOCP)?

IOCP helps older adults with more health care needs, with a larger health care team that includes a Care Coordinator who will get to know you and support your goals in your health and well-being. People who join the IOCP will be part of a specialized care team that includes your primary care physician (PCP), Care Coordinators (nurses and other professionals) and other team members. This team will provide 24/7 support to you via in-person visits, phone and email.

IOCP starts with each person's own concerns and goals related to their health and well-being. Traditional health care often fails to focus on what people want and need in their lives outside the doctor's office. We know that health care is more successful when it is led by each patient's specific wants and needs, and tailored to his or her life situation.

The IOCP care team is a great resource for understanding health care services, finding your way around the health care system, and communicating with different providers to improve your health and keep you healthy.

IOCP is free. There is no charge to add IOCP to your health care with us.

2. What are the goals of the Intensive Outpatient Care Program?

- Deliver personalized, quality health care
- Improve IOCP participants' health, help them stay healthier, and increase their happiness with the health care they get
- Create a health care program that can be expanded to help more older adults over time.

3. How are patients selected for IOCP?

Patients are selected by the IOCP clinic where you may have been seen and by other care providers who think a person may benefit from IOCP. We ask you to join IOCP based on one or more of these things:

- A long-term health condition
- Your doctor or other provider thought you would benefit from IOCP
- A recent serious health care event, like an emergency room visit or being in the hospital.

If you have a regular doctor or primary provider, he or she knows that you are being invited to IOCP and thinks it may help you.

4. Do I have to participate in IOCP?

No. Participation is voluntary. We hope you meet with us to see if IOCP is a good fit for you.

5. Can anyone participate in IOCP?

No, you must be invited to participate in IOCP based upon specific health needs.

6. Why should I participate in IOCP?

We hope that participation in the IOCP will help your health and how happy you are with health care services. IOCP provides person-centered care, which means we work to meet your goals and expectations for your health and your life. We know our IOCP participants' lives are more than their medical needs.

7. Will my health care coverage and benefits change if I participate?

No. Your health benefits will not change.

8. If I agree to participate, what happens next?

You will:

- Receive a call to set an appointment time to meet your Care Coordinator
- Have a personalized discussion about your care needs
- Have an extended office visit with your PCP and your Care Coordinator.

9. What can I expect if I participate in the IOCP?

You can expect:

- A dedicated Care Coordinator
- At least monthly contact from your Care Coordinator
- Access to the IOCP Care Team 24/7 via secure email or phone
- Promptly returned phone calls for urgent questions and issues
- Same day appointments
- Personalized support for your health goals.

10. How long can I participate in the IOCP?

Your participation in the IOCP is completely voluntary. You can end your participation at any time.

11. Do other clinic patients know about IOCP?

Your medical treatment is confidential. Only you, your PCP and your IOCP Care Team know you have been invited to participate and are now in the program.

12. How much do I have to pay to participate?

It is free. There is no cost to participate in the IOCP.

13. What are my responsibilities if I participate?

Once you have enrolled, your responsibilities include:

- Meeting with your Care Coordinator to get to know each other and determine what your health and life goals may be
- Regular check-ins by phone or email to determine how things are going

- Keeping your Care Team aware of changes in your health or well-being, or calling with updates and questions
- Coming to visits prepared
- Getting labs before visits
- Calling the Care Team before trips to ED
- Signing an agreement for participation if you choose to enroll.

14. Will I continue to see my current Primary Care Physician (PCP)?

In most cases, you will continue to see your PCP. Some clinics are selecting a designated physician known as an 'Intensivist' to provide care to IOCP patients.

15. What happens if my health gets worse?

As always, if your situation is life threatening, call 911 or seek medical care immediately. Otherwise, call your Care Team. All IOCP participants have a dedicated Care Coordinator who helps make plans for health care needs when these needs change.

16. Can my family members join?

This program is for Medicare patients who have been invited to participate. If you have questions about eligibility, please check with your current Care Team.

17. How will my privacy be maintained?

Your privacy is guaranteed just as it is for all other healthcare encounters. Reporting of all IOCP information will follow all state and federal privacy laws.

Care Coordinator Super-Visit Checklist

- ☐ Care Coordinator greets IOCP participant
- ☐ Participant and Care Coordinator discussion, part 1
 - Establish agenda for visit
 - Build rapport with the older person (hobbies, social supports, health goals)
 - Discover concerns
 - Review and reconcile medication list
 - Update/confirm allergies
 - Health maintenance reviewed and reconciled
 - Vital signs
- ☐ PCP enters the visit
 - Care Coordinator summarizes visit so far including goals, any acute concerns
 - PCP validates discussion and focuses upon cited concerns
 - Review of labs, medications, health maintenance
 - Focused physical exam, if necessary
 - PCP advocates for follow-up visit and/or Care Coordinator engagement
 - Discuss rationale behind action plan; RN or patient fills in action plan
 - PCP and patient have alone time (if requested)
- ☐ PCP exits room and Care Coordinator and older person resume the visit
- ☐ Participant and Care Coordinator discussion, Part 2
 - Discuss health goals
 - Discuss advanced care plans/advanced directive status, wishes
 - Continue creating Shared Action Plan – identify one specific action step
 - Given participant a copy of Shared Action Plan
 - Scheduled follow-up visit or phone contact
 - What to do when the Care Coordinator is not in the office
 - Review contact methods, e.g. portal, drop-in or scheduled in-person, phone
 - Review Shared Action Plan
 - Discuss any remaining questions

PHQ-9 Depression Screening Tool

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
--	--	--	---

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Domain Assessment

This tool should not be used as a checklist in a patient visit. The topics covered in these domains of health and well-being are many, and should be covered in a series of conversations at the initiation of IOCP care. The team at Stanford Coordinated Care uses this tool to document face-to-face conversations after they occur. This allows in-depth discussions with their patients that are person-centered and gather more information than a checklist-driven interview, and also helps their staff build a trusting relationship during the important first patient meetings.

	0 Points	1 Point	2 Points	3 Points
Domain: Medical Neighborhood				
Access to care	Adequate access to care	Some limitations: refer to barriers above	Difficulties in accessing care: refer to barriers above	No adequate access to care: refer to barriers above
Experience with Providers	No problem with health care providers	Negative experience with providers (either personally or family member)	Dissatisfaction or distrust: multiple providers for same condition	Repeated major conflicts with providers, distrust of doctors: Frequent ER visits/admissions: Preferred provider out of plan
Getting Needed Services	Practitioners and health care settings readily accessible: money for Rx and medical equipment	Some difficulties in getting appointments, needed services	Routine difficulties in getting in, coordinating, getting appts, services	Inability to coordinate, get appts, needed services
Coordination of care	Complete provider communication with good coordination of care	Limited provider communication and coordination of care: Has PCP that coordinates Medical and Mental Health services	Poor provider communication and coordination of care: No routine PCP	No communication and coordination of care among providers: evidence of ER use for non-urgent health needs
Medical Home/ Medical Services Risk	No risk of impediments to coordinated physical and mental health	Mild risk of impediments to care, such as insurance restrictions, distance to services, limited provider communication or coordination	Moderate risk of impediments to care, such as potential loss of insurance, inconsistent providers, communication barriers, poor care coordination	Severe risk of impediments such as little or no insurance, resistant to communication, disruptive processes that lead to poor care coordination
Medical Neighborhood Total Score				
	0 Points	1 Point	2 Points	3 Points
Domain: Social Support				
Home Environment	Stable housing: Able to maintain independent living	Stable housing with support of others (family, facility, other)	Unstable housing (no support, living in a shelter, etc.)	No satisfactory housing: immediate change necessary
Job & Leisure	Has job and participates in leisure activities	Has job: no participation in leisure activities	Unemployed now for at least 6 months and participates in leisure activities	Unemployed now for at least 6 months and no participation in leisure activities
Social Support	Assistance readily available	Assistance generally available: possible delays	Limited assistance available	No assistance available at any time
Social Relationships	No social disturbance	Mild social dysfunction: interpersonal issues	Moderate social dysfunction such as not able to initiate or maintain	Severe social dysfunction: disruptive or in isolation
Social Support Risk	No risk, or need, for changes in living situation, social relationships and support or job/leisure	Mild risk	Risk of need in foreseeable future	Risk now → Intervene
Social Support Total Score				

	0 Points	1 Point	2 Points	3 Points
Domain: Self-Management				
Engagement/ Coping/ "Change Talk"	Ability to manage stresses/ life and health challenges	Restricted coping skills, such as need for control, illness denial, irritability	Impaired coping skills, such as non-productive complaining or substance abuse but without serious impact on medical condition, mental health, or social situation	Minimal coping skills → destructive behaviors, such as substance dependence, psychiatric illness, self-mutilation, suicide attempts
Adherence/ Resistance to Treatment	Interested in receiving treatment and willing to actively participate/ cooperate	Some ambivalence but willing to cooperate with treatment	Considerable resistance: hostility or indifference to providers and/or treatments	Active resistance to important medical care
Mental Health History	No history of mental health problems/conditions	History of mental health problems/conditions now resolved: no effects on daily function	Mental health conditions with clear effects on daily function (needing medications, therapy, day treatment, etc.)	Psychiatric admissions and/ or persistent effect on daily function
Mental Health Symptoms	No mental health symptoms	Mild symptoms (problems with concentration/feeling tense, etc.) that do not interfere with current function	Moderate mental symptoms (anxiety, signs of depression, mild cognitive impairment) that interfere with functioning	Severe psychiatric symptoms and/or behavioral disturbances (violence, self-inflicted harm, delirium, criminal behavior, psychosis, mania, etc.)
Self-Management and Mental Health Risk	No mental health concerns	Risk of mild worsening of mental health symptoms, such as stress, anxiety, feeling "blue", substance abuse	Moderate risk of mental health disorder requiring additional mental health care: moderate risk for treatment resistance/ non-adherence	Severe risk for psychiatric disorder requiring frequent ER visits and/or inpatient admissions: risk of treatment refusal for serious disorder
Self-Management Total Score				
	0 Points	1 Point	2 Points	3 Points
Domain: Medical Status				
Chronicity	Acute condition: Less than 3 months of physical symptoms/ dysfunction	More than 3 months of physical symptoms/ dysfunction or several periods of less than 3 mos.	A chronic disease	Several chronic diseases
Symptoms Severity/ Condition Factors	No physical symptoms, or symptoms resolve with treatment	Mild symptoms which do not interfere with current functioning	Moderate symptoms which interfere with current functioning	Severe symptoms leading to inability to perform many functional activities
Diagnostic/ Therapeutic Challenges	Clear diagnosis and/or uncomplicated treatments	Clear differential diagnosis and/or diagnosis expected with clear treatments	Difficult to diagnose and treat: physical cause/ origin and treatment expected	Difficult to diagnose or treat: other issues than physical causes interfering with diagnostic and therapeutic process
Utilization Factors	No unscheduled/elective admissions: no ED use (past 12 months)	Elective admission (1): no ED use or <2 visits in 12 months	Multiple elective and/or emergent admissions >2 <4 in 12 months	Frequent elective and/or emergent admissions >4: multiple ED visits >4 in 12 months
Medical Status Total Score				
Domain Score Total				
Patient Level (See Below)				

Level 1: total score 20 or less

Minimal involvement: focus areas wellness, health maintenance/coaching, patient education, placement assistance, etc.

Time involvement: days or less. Clinical Example: recent inpatient stay with rapid recovery anticipated, minimal follow-up care: resolved illness or mental health illness/issues

Level 2: total score 21–27

Brief involvement: focus area disease management, patient education, placement assistance, referrals, return to work, community resources, etc.

Time involvement: days to weeks. Clinical example: coming out of recent high cost healthcare activity, recent inpatient stay with anticipated persistent need for support to prevent delayed/pronged recovery or poor outcome

Level 3: total score 28–34

Standard care management involvement: patient needs in multiple domains, action plan development indicated by variable scores or 2 or 3, assistance to patient to understand illness and health system, assistance with providers, referrals, placement, systematic development and completion of action plan.

Time involvement: weeks to months.

Clinical example: persistent use of inpatient and outpatient services, poorly treated mental health co morbidity in the face of medical and or mental illness/needs, chronic general medical illnesses.

Level 4: total score 35 or greater

Extended care management involvement: care as in Level 3 however problems are persistent, complex, and multiple with long-term high service use or anticipated risk for: patient needs in multiple domains, action plan development indicated by variable scores of 2 or 3, assistance to patient to understand illness and health system, assistance with providers, referrals, placement, systematic development and completion of action plan.

Time involvement: months or longer.

Clinical example: complex, concurrent physical and mental conditions with high service use

Shared Action Plan Template

Use this example as a model for an action plan that can be reviewed frequently and updated monthly. Some information will remain static, like allergies. Goals will change for many IOCP participants and need regular review in a person-centered conversation using a Motivational Interviewing approach. Expect that IOCP participants will achieve some goals and set others. Long-term goals may need to be revised or parsed to support achievement, particularly as health status and other circumstances change.

Patient Name:

DOB:

Medical Record:

Date Updated:

I. About me

Best contact phone #:

Email address:

My main sources of support are:

Things I enjoy:

Today: How I am currently feeling:

My advanced directives:

Full code:

II. Brief Action Planning (from the [Centre for Collaboration, Motivation and Innovation](#))

Question #1 elicits ideas for change: "Is there anything you would like to do for your health in the next week or two?"

Question #2 assesses confidence in carrying out plan: "I wonder how confident you feel about carrying out your plan. Considering a scale of 0 to 10, where '0' means you are not at all confident or sure and '10' means you are very confident or very sure, how confident are you about completing your plan?" (Based on response, explore the number given, using Motivational Interviewing techniques to help increase confidence, e.g. by scaling back the size of the change the person has in mind.)

Question #3 seeks permission to follow up on the plan later: "Would it be useful to check later on how it is going with your plan?"

Time for review, if agreed by participant:

III. My Medications and Allergies

Time	Name	Dosage	# of Pills	Date, Notes

Allergies:

IV. My Care Team

Name	Affiliation	Phone #	E-mail Address
Care Manager			
Primary Care Doctor			
Dentist			
Specialist			
Specialist			

V. My Active Health Issues

Issue:

Current state:

Goal:

Accomplishments:

Barriers:

Plan:

Review date:

Issue:

Current state:

Goal:

Accomplishments:

Barriers:

Plan:

Review date:

VII. My Family, Caregivers and Other Supports

Name	Relationship	Contact Information

Training And Competencies Checklist For New Care Coordinators

General	
<input type="checkbox"/> Continuum of Care (COC)	<input type="checkbox"/> PHQ - what to do for positive screening, review Depression Screening Guideline
<input type="checkbox"/> Outlook - how to set up your calendar	<input type="checkbox"/> Medication Reconciliation
<input type="checkbox"/> Outlook - how share your calendar	<input type="checkbox"/> Consent Assessment
<input type="checkbox"/> EHR - training	Processes
<input type="checkbox"/> EHR - managing and sharing tasks	<input type="checkbox"/> What to enter when closing cases - task, reasons
<input type="checkbox"/> EHR - how to view other people's tasks	<input type="checkbox"/> Difference between referred, in process and engaged
<input type="checkbox"/> EHR - how to review hospital/ED discharge info	<input type="checkbox"/> Changing case from referred to in process upon beginning to work on case
<input type="checkbox"/> Care management software - how to open a new case	<input type="checkbox"/> Care management software - Initial Case Charting smart tasks
<input type="checkbox"/> Care management software - how to change case info	<input type="checkbox"/> Care management software - how to attach documents
<input type="checkbox"/> Care management software - how to enter Referral Notes	<input type="checkbox"/> Care management software - how to use linked library
<input type="checkbox"/> Patient portal - request access	<input type="checkbox"/> Care management software - viewing list of overdue calls
<input type="checkbox"/> eReferrals - COC, Diabetes Education	<input type="checkbox"/> POLST
Programs	<input type="checkbox"/> Advanced Directives
<input type="checkbox"/> Review Program Criteria for all programs	<input type="checkbox"/> Biweekly productivity report - includes overdue contacts, referred/in process lists
<input type="checkbox"/> Disease Management Diabetes	<input type="checkbox"/> SNFs - how to admit a patient
<input type="checkbox"/> Disease Management Heart Failure	<input type="checkbox"/> Caregiver Resources
<input type="checkbox"/> Disease Management COPD	<input type="checkbox"/> Requesting PTO, arranging for coverage
<input type="checkbox"/> Cardio-com - BP and CHF biometric devices	Outside Programs
<input type="checkbox"/> Behavioral Health Program - how to refer	<input type="checkbox"/> Healthier Living - what is it and how to enter referral
<input type="checkbox"/> HTN Program	<input type="checkbox"/> Sharp Transitions Program - guidelines and how to refer, see website
<input type="checkbox"/> Care at Home NP program - what it is and how to refer	<input type="checkbox"/> Sharp Hospice Program - guidelines and how to refer, see website
<input type="checkbox"/> Home visits - MSW/RN role	<input type="checkbox"/> Advanced Care Planning and how to refer
<input type="checkbox"/> Pharmacy Referrals - initial screening process, referrals for financial assistance	<input type="checkbox"/> Adult Protective Services
<input type="checkbox"/> Suicidal Ideation Guidelines	
Case Management Processes	
<input type="checkbox"/> Preparing and Sending Shared Action Plan	
<input type="checkbox"/> PAM - what is it and how to utilize into planning care	
<input type="checkbox"/> PAM - review 2 presentations on Sharepoint	
<input type="checkbox"/> VR12 - review presentation on Sharepoint	

Partial list, adapted from Sharp Rees-Stealy Medical Centers

Sample Care Coordinator Job Description

Job Title: Care Coordinator

Reports to:

Schedule:

Summary of Position

The Care Coordinator works in collaboration and continuous partnership with chronically ill or "high-risk" older persons and their family/caregiver(s), in a team approach with the IOCP care team, other clinic/hospital/specialty providers and staff, and community resources, to perform the following role:

- Support achievement of IOCP participants' goals in an ongoing collaborative relationship
- Help IOCP participants develop their shared care plan and update the participants' goals regularly, in coordination with the patient, primary care provider, and family/caregiver(s)
- Increase patients' ability for self-management and shared decision-making
- Increase health literacy through culturally and linguistically appropriate education
- Promote timely access to appropriate care
- Increase utilization of preventative care
- Reduce emergency room utilization and hospital readmissions
- Increase continuity of care by managing relationships with tertiary care providers, transitions-in-care, and referrals
- Provide medication reconciliation (if Care Coordinator is appropriately licensed)
- Connect patients to relevant community resources, with the goal of enhancing patient health and well-being, increasing patient satisfaction, and reducing health care costs
- Celebrate successes with patients and their families/caregivers

A typical day for the Care Coordinator includes half of the day conducting one-on-one extended patient meetings (approximately 30–45 minutes long). The other half of the day is spent on follow-up with patients, family and caregiver(s), providers, and community resources via secure email, phone calls, text messages, and other communications.

Success in this position will lead to improved health for the patient and reduced health care costs for the managed population of patients.

Essential Duties & Responsibilities

- Serve as the contact point, advocate, and informational resource for patients, care team, family/caregiver(s), payers, and community resources
- Work with patients to plan and monitor care:
 - > Assess patient's unmet health and social needs
 - > Develop a care plan with the patient, family/caregiver(s) and providers (emergency plan, health management plan, medical summary, and ongoing action plan, as appropriate)
 - > Monitor patient progress with care plans and facilitate changes as needed
 - > Create ongoing processes for patient and family/caregiver(s) to determine and request the level of care coordination support they desire at any given point in time

- Facilitate patient access to appropriate medical and specialty providers
- Educate patient and family/caregiver(s) about relevant community resources
- Facilitate and attend meetings between patient, family/caregiver(s), care team, payers, and community resources, as needed
- Cultivate and support primary care and specialty provider co-management with timely communication, inquiry, follow-up, and integration of information into the care plan regarding transitions-in-care and referrals
- Assist with the identification of "high-risk" patients (the chronically ill and those with special health care needs), and add these to the patient registry (or flag in EHR)
- Attend all Care Coordinator training courses/webinars and meetings
- Provide feedback for the improvement of the Care Coordination Program

Education / Experience

- Licensed and credentialed [*Registered Nurse / Nurse Practitioner / Physician's Assistant with prescribing privileges / Social Worker / Community Health Worker / Other*]
- Experience in clinical or community resource settings
- Care coordination and/or case management experience is desirable
- Experience providing patient or client support in community and home settings is desirable
- Evidence of essential leadership, communication, education, and counseling skills
- Proficiency in communication technologies (email, cell phone, etc.)
- Highly organized with ability to keep accurate notes and records
- Experience with health IT systems and reports is desirable
- Local knowledge about and connections to community health care and social welfare resources is desirable
- Ability to speak a relevant second language is desirable

Special Skill Requirements

- Core values consistent with a person- and family-centered approach to care, including appreciation of patients' internal strengths and resources and ability to direct his or her own care
- Demonstrates professional, appropriate, effective, and tactful communication skills, including written, verbal and nonverbal
- Demonstrates a positive attitude and respectful, professional customer service
- Acknowledges patient's rights on confidentiality issues, maintains patient confidentiality at all times, and follows HIPAA guidelines and regulations
- Proactively acts as patient advocate, responding with empathy and respect to resolve patient and family concerns, and recognizes opportunities for improvement to meeting patient concerns
- Proactively continues to educate self on providing quality care and improving professional skills

Salary:

Adapted from Stratis Health

Care Coordinator Pre-Visit Planning Checklist

- ☐ Chart review
 - Pre-populate Shared Action Plan
 - Health maintenance review (recommended for patient's age and risk profile)
 - Medication review - questions to pharmacist, as necessary
- ☐ Consult with patient specialists, as needed
- ☐ Obtain assessments (PHQ-2, VR-12, PAM) you will need to administer during the visit, or at least have them available to administer at a future time if the visit does not allow for you to complete them at this time
- ☐ Develop visit agenda
 - +/- Pre-visit call with patient
 - > Order basic pre-visit labs if clinically indicated (HbA1C, Lipid Panel)

Appendix K

Care Coordinator Daily Prioritization Checklist

Start Of Day

- ☐ Review of patients who are in the office today
- ☐ Review of admissions, discharges, ED visits from last 24 hours
- ☐ Review of overnight call activity
- ☐ Review of Red Tier patients and follow-up needs
- ☐ Schedule day

Ongoing Care Management

- ☐ Schedule outreach
- ☐ Response to daily inbound calls/emails (~ 5 % of panel)
- ☐ Organization of panel / reporting
- ☐ Evaluation of processes, reporting of successes
- ☐ Follow-up specialist visits, diagnostics, etc.
- ☐ Updating care plans
- ☐ Provide critical updates to PCP

Close of Day

- ☐ Review active issues requiring closure
- ☐ Review next day's in-office appointments
- ☐ Let on-call PCP know of any anticipated issues
- ☐ Sketch out next day's schedule

Care Coordinator Weekly Activity Checklist

- ☐ Outgoing Super-visit / engagement calls (< 5 – 20 minutes per patient reached and < 1 minute for patients not reached)
 - Need to plan number of calls per day and block time
- ☐ Chart reviews for upcoming Super-visit (Target: 15 minutes)
- ☐ Super-visit process (75 – 90 minutes)
 - Need to plan number of Super-visits per week and track ongoing
- ☐ Proactive check-in calls (5 – 15 minutes per patient)
 - If call is extending beyond expected time, consider setting another time moving to asynchronous format or in-person (if complicated)
- ☐ Care rounds with PCP and extended team (for Red Tier patients)
- ☐ Updating care plans
- ☐ Data collection / management (will vary per medical group)
- ☐ Project meetings, collaboration and team huddles

Tips on Overcoming Common Challenges of Care Coordinators

- **Lack of role clarity**
 - > Identify tasks and responsibilities that are not clear.
 - > Meet with IOCP care team including PCPs to assign individual or shared responsibilities. Document decisions. Consider using workflow diagrams.
- **Coverage for Care Coordinators (sick or vacations)**
 - > Document coverage protocols and communicate these expectations frequently.
 - > Be proactive. Assign coverage duties well ahead of the days it will be needed.
- **Care Coordinators feeling isolated with sole responsibility for complex care**
 - > Establish frequent communication within and across care teams.
 - > Celebrate positive stories and results.
 - > Encourage communication about specific support needs.
- **Working with uncertainty and concern for participants' many challenges**
 - > Care Coordinator case conferences to support each other, develop solutions.
 - > Encourage Care Coordinators to trust their expertise.
 - > Engage PCPs as supports and coaches for Care Coordinators, where appropriate.
 - > If a participant seems too dependent, reflect as a team on self-efficacy principles of PAM and Motivational Interviewing. Create a plan.
- **Feeling overwhelmed by trying to do everything – how to prioritize**
 - > Determine likelihood of participants' near term risk of hospitalization or ED use.
 - > Know that it's not just the Care Coordinator's responsibility – engage the clinic via leadership or medical director.

Frequently Asked Questions for Providers

1. What is the Intensive Outpatient Care Program (IOCP)?

IOCP is a program to improve care for patients based on clinical evidence that some people can benefit from enhanced care coordination from their physician and a team of Care Coordinators. Patients who choose to enroll in the IOCP will be part of a specialized care team that includes your primary care physician (PCP), Care Coordinators (nurses and other professionals) and support team members. This team will provide 24/7 support to providers and their participating patients via in-person visits, phone and email. The care team will be a new resource for you in coordinating the health services of your medically complex patients. Providers in IOCPs across the United States report improved job satisfaction and feeling better about the care their patients receive with these additional resources.

IOCP is designed specifically to address each participating person's own concerns and goals related to their health and well-being. The added staff resources of the IOCP team allow for in-depth conversations with patients and their families and caregivers, to develop deep understanding of their priorities and to maintain frequent contact with patients through the key role of the Care Coordinator.

2. What are the goals of the Intensive Outpatient Care Program?

- Deliver personalized, quality health care;
- Improve the health of participants, help them maintain their health and increase satisfaction with care;
- Design a health care model that can be expanded to provide affordable, quality care to additional patients.

3. What does it mean for my practice?

You may be asked to participate in the IOCP if your practice has a significant number of patients with chronic conditions and multiple comorbidities, and some have been identified as being at high risk of hospitalization and emergency room visits.

4. How would it affect my practice?

- You will 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.

5. How are patients selected?

Patients are initially identified by 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. Providers are able to refer patients who may benefit from IOCP but do not appear on the list. IOCP also takes referrals from patients themselves and from family members and caregivers.

6. Will I still be involved in my patient's care plan?

Yes. The Care Coordinator can help you 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 maintain contact to help patients to achieve their goals, provide tools for self-management, educate the patient to recognize signs of exacerbation of illness, and provide support for behavioral and social needs.

7. Are you saying that I'm doing a bad job?

Not at all. The new program will focus on patients who can benefit from care coordination: they have multiple medical comorbidities, often have depression and other issues, 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.

8. 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 support your care recommendations.

9. 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 follow-through of clinical recommendations.
- Ensure patients are prepared prior to visiting your office. Facilitate the pre-visit planning.
- Connect patients to community and social services as needed.
- Provide ongoing care coordination, including overnight and weekend medical support (e.g., advice lines and on-call) needed by patients.

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.

Program Performance Measures to Consider

Measures listed below include established IOCP care measures, additional person-centered measures, and measures from the Institute for Healthcare Improvement's Better Health at Lower Costs program.

Quality

- HbA1c control
- Blood pressure control
- Lipid control
- Influenza Vaccination
- Proportion of days covered by therapeutic category (prescription medications)
- Annual monitoring for patients on persistent medications

Care Coordination and Program Operations

- Shared care/action plan established
- Follow-up after Emergency Department visit
- Follow-up after hospitalization

Patient Experience

- Patient Activation Measure (PAM)
- Health status survey (VR-12)
- US Consumer Assessment of Healthcare Providers and Services (CAHPS) Survey of patient experience
- Depression screening (PHQ-9)
- Self-efficacy question for patients (referenced above for IOCP participant identification): *"How confident are you that you can control and manage most of your health problems?" Response options: very confident, somewhat confident, not very confident*
- Two- to three-question brief surveys of patients to ask about provider and Care Coordinator communication, quality of services in IOCP

Utilization and Cost

- Hospital admission rate
- Ambulatory care sensitive admissions
- Hospital readmissions
- Emergency Department Visit Rate
- Average length of stay
- Total per-capita cost of care

Operations

- Patient enrollment rate
- Number of dis-enrollments from program
- Percentage of patients receiving outreach call within 48 hours of emergency department discharge or hospital admission
- Time interval from referral to intake visit

Appendix 0

Additional Key Terms and Resources

These terms and resources are mentioned in the narrative sections of the toolkit, and are important to the work of IOCP but are not tools, or are not central components of the IOCP model. For terms that are important for IOCP participants to understand, the language here has been chosen to support those direct conversations with IOCP participants and their families and caregivers.

Activities of Daily Living (ADLs)

Activities of daily living (ADLs) are basic self-care tasks, including bathing, getting dressed, eating, toileting, maintaining continence and moving through walking and/or transferring between bed and wheelchair.

Instrumental activities of daily living (IADLs) are a set of more complex skills that are required to live independently. These include shopping, preparing meals, managing personal finances, using the telephone, and doing housework and basic home maintenance.

Find a description of ADLs and IADLs in simple language suitable for communicating with IOCP participants and their families and caregivers [here](#).

Advanced Care Planning and Advance Directive

Advance care planning means making healthcare plans for the future, even when doctors and family members are making the decisions for you. Advanced care planning involves learning about the types of decisions that might need to be made, considering those decisions ahead of time, and then letting others know about your preferences, often by putting them into an advance directive.

An advance directive is a legal document that goes into effect only if you are incapacitated and unable to speak for yourself. This could be the result of disease or severe injury—no matter how old you are. It helps others know what type of medical care you want. It also allows you to express your values and desires related to end-of-life care. You might think of an advance directive as a living document—one that you can adjust as your situation changes because of new information or a change in your health.

This definition was adapted from educational materials and resources from the National Institute on Aging. Find more resources, including person-centered information for IOCP participants, [here](#).

Care Coordination and Care Management

These two important terms have multiple overlapping definitions across health care organizations, payers, and policymakers. Hallmarks of both approaches include facilitation of care services between multiple providers and locations (e.g. hospital, specialty, primary care, pharmacy) and direct engagement with patients to ensure effective care and support improved health. Often, care management implies a more active role, or primary responsibility, in determining plans of care. In IOCP and other complex care programs, care coordination is more commonly used than care management, though both terms appear in this toolkit, and of course the central IOCP staff role is Care Coordinator, as defined and described above.

Motivational Interviewing

Motivational Interviewing (MI) is a communication approach that is person-centered and goal-oriented, where the health care provider or counselor explores an individual's own interests and motivations for change. MI includes deep listening and the respectful exploration of a person's goals. MI maintains the individual's ownership of his or her commitment to change, or ambivalence or resistance toward change, at any given time.

There are many books and training programs available in Motivational Interviewing. <http://www.motivationalinterviewing.org/> is a good place to find expert trainers and more information.

Trauma-Informed Care

Trauma-informed care (TIC) is an approach to clinical care that recognizes that trauma experiences have effects on physical health, behavior patterns, and the physiological ways that information is processed in the brain. Trauma-informed care seeks to avoid re-traumatizing people through working with them more skillfully. TIC is a systematic approach practiced by teams and whole organizations. TIC is not the same as individual treatment for trauma symptoms or conditions like Post-Traumatic Stress Disorder.

[The Center for Health Care Strategies](#) and the [National Council on Behavioral Health](#) both provide information about TIC and related resources.

Triple Aim

Promoted by the Institute for Healthcare Improvement, the Triple Aim is a single, three-part framework to focus health care organizations on optimizing health for individuals and populations. The three elements are the health of the population, the experience and outcomes of the patient, and reducing per capita costs of care for the benefit of communities.

Case studies, a guide to measuring the Triple Aim, and a self-assessment tool are among the many [resources from IHI](#).

Vulnerable Elders Survey (VES13)

Developed by RAND, “the Vulnerable Elders Survey (VES-13) is a simple function-based tool for screening community-dwelling populations to identify older persons at risk for health deterioration. The VES considers age, self-rated health, limitations in physical function, and functional disabilities.”

Access and use is free. The tool is described in detail and can be downloaded [here](#).