Intensive Outpatient Care Team: An extra layer of care for complex patients

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Aims and objectives

To design, implement and evaluate a team approach within a primary care clinic and to identify, assess, and provide needed care for the sickest patients enrolled in a federal, managed-care insurance. Impact outcome measures included hospitalizations, emergency room use, quality death, and social support. Process outcomes included member's perception of working as a team

Background

Five percent of the population accounts for half of health care expenses. Patients with multiple chronic conditions cost 7 times as much as a patient with one chronic condition. The use of multidisciplinary teams has become more common in health care due to the complexity of care, demands of technology and the need to coordinate multiple patient and family needs. The team approach is effective in populations with high utilization rates and complex conditions. However, team members have not been trained to work effectively outside their own disciplines.

Synthesis of Evidence

The Chronic Care Disease Model (Wagner 1995, 2001) emphasizes system changes and interdisciplinary team approaches to chronic illness.
Interdisciplinary teams including nurse case managers, social work, and clinical coaches have been used to coordinate care in targeted high utilization populations with variable success rates of cost reduction and quality improvement. These teams have all been outside of the primary care service settings where patients would normally receive their care.

Methodology

An Intensive Outpatient Care Team (IOCT) was created within a busy primary care clinic with an aging managed care population. The team consisted of the PCP, the outpatient nurse, the insurance nurse case manager and an administrative aid. The group identified criteria for patient inclusion, member roles, and the rules for effective communication. Care plans were documented in the EMR and in a quick note format reviewed at each meeting. Meetings were weekly, short (15 minutes) and focused. Seventy-eight patients were enrolled in IOCT over the 16-month study period (1/12-4/13) Quantitative information was obtained through review of insurance data claims, the chart and nurse-scored social support. Qualitative information was collected by member survey, structured interviews and participant observation at IOCT meetings.

Conceptual Model for Process Evaluation

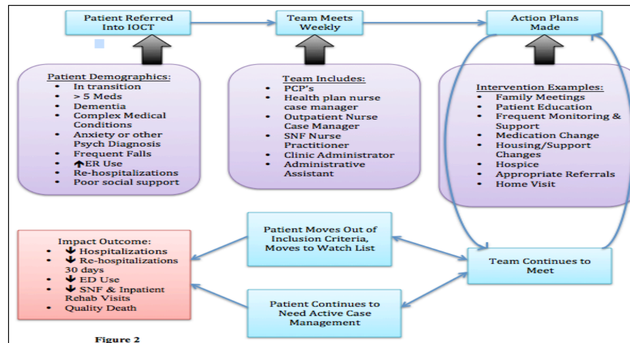


Figure 2

Meet George

- Numerous ER visits for abdominal pain
- Repeated CT scans
- Frequent office follow up
- Frequent hospitalization
- Complex family dynamics
- Daughter as caretaker

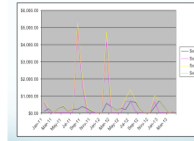
George: Interventions

- Medication de-escalation
- Dedicated nurse contact with weekly calls
- Care management with plan NCM.
- Supported family coping
- Identified need for residential placement

George: Outcomes

- Placed in Adult Family home together with his wife
- "Thriving" with increased socialization
- No ER admits or hospitalizations
- Took 6 months, 26 nurse calls and 4 NCM calls
- Office visits and weekly discussions

George: Cost Data

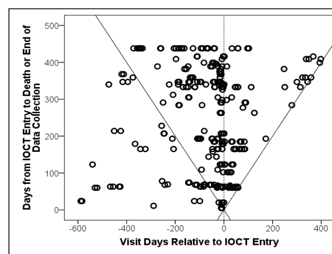


Population Characteristics During 16 Month Study Period (N=78)

Age: Mean 84 (Range 64 to 99)
Gender: 62% Female 38% Male
Medications: Mean 11 (Range 5 to 31)
Top 4 Diagnoses: (1) Cardiovascular disease (2) Frailty – DJD, osteoporosis, Parkinson (3) Anxiety / Depression (4) Dementia

Prior to Study	End of Study
Living Situation 73% Lived at home 23% Assisted Living (ALF) 3% Adult Family Home (AFH)	Living Situation 13% moved from home to ALF or AFH
Social Support 29% Low (lives alone no support) 33% Medium (lives alone weekly check in) 36% High (lives with family, ALF/AFH)	Social Support 23% changed from low to High Death 26% died with 75% of these in their own home
Discreet Hosp/Rehab visits: 138	Discreet Hosp/Rehab visits: 70

All-Type Patient Hospitalizations Relative to IOCT Entry Date



P-Value Paired Sample Significance 0.024, Confidence Interval 95%

Outcomes

Care of complex and chronically ill patients can be applied to a target population in an outpatient primary care setting with little cost to the organization.
- Out of network hospitalization costs were reduced by half
- Patient quality of life improved
- The team enjoyed the work

What did the team members think

- The work was important
  - *"Finally a meeting that matters!"*
- IOCT supported professional growth and decreased provider isolation
  - *"I have a greater sense of satisfaction that my work is part of a bigger body of work that is more influential, more helpful."*
  - *"I enjoy the camaraderie"*
- Members enjoyed working in teams
  - *"I like the interdisciplinary approach. It's not multidisciplinary but INTERdisciplinary. I am working across all lines of disciplines."*
- Small but significant time commitment with no compensation
  - *"I probably put in 15 to 20 minutes getting ready for IOCT, time that is not easy to find but not all that much really*

Recommendations

- Test implementation of this model to other primary care settings
- Nursing skill standards including Motivational Interviewing and case management must be adopted by the organization for program sustainability
- Start with provider champions to improve broad provider adoption
- Measure cost outcomes and quality of life outcomes
- Innovative use of insurance based nurse case managers embedded in primary care settings should be actively tested in other settings

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- Statement of the problem (PICOT format)
- Synthesis of Evidence
- Description of any innovation and resulting change/Practice Change
- Implementation Framework
- Evaluation (Process and Outcomes)
- Implications and significance of the project findings for DNP research, practice, leadership or education;
- Recommendations or future problems/questions.