InnOVATIONS:
Recognizing Advances in Health Care
An Issue Brief from the St. Louis Area Business Health Coaltion

Strengthening primary care: a team approach

Abstract *The Triple Aim has been a unifying strategy for health care reform implementation. This concept was first envisioned by Donald Berwick, MD and the Institute for Healthcare Improvement in 2008. The approach strives to optimize health system performance by simultaneously improving the experience of care, population health, and lowering per-capita costs. To fulfill the Triple Aim requires strong leadership and innovation at the community level from primary care teams armed with the skills and infrastructure to manage patients' health and coordinate their care.*

This issue brief illustrates an innovative benefit design and high-intensity primary care delivery model for patients with severe chronic illness called the Intensive Outpatient Care Program (IOCP); a collaborative effort of private purchasers, health plans and providers. A key feature of IOCP is active engagement of patient and family as members of the health care team. A successful IOCP pilot in Seattle simultaneously improved patients' experience, health outcomes and reduced costs – achieving the Triple Aim one patient at a time. This model has been expanded to the St. Louis metropolitan area. Other primary care innovations, such as Patient-Centered Medical Home initiatives are also underway in the St. Louis region.

For Doug McLaren, an engineer and business analyst from Seattle, WA, managing his chronic lung disease had been a challenge for many years. It was tough to keep up with all the things he needed to do to stay well, thus his illness was not well-controlled. "With chronic disease, it doesn't involve just the specific organ; it affects everything else in your life pretty much," he said. "If you get a cold, you have to worry." Yet his condition stabilized thanks to an innovative model of care delivery, the Intensive Outpatient Care Program (IOCP). His employer, The Boeing Company offered IOCP in partnership with health plan and physician groups.

IOCP aims to improve care quality, the patient experience and reduce spending using a primary care-led, high-intensity care model for people with severe chronic illness. Employees and dependents of participating medical groups were invited to enroll if they were likely to benefit from the IOCP program.[1] "The key for us was to try to make the transition as seamless as possible for patients by selecting medical groups as partners that already had a high number of our employees so no one had to switch doctors," said Theresa Helle, Manager, Health Care Quality and Efficiency Initiatives at Boeing.[2]

For a patient, the introduction to IOCP starts with a comprehensive interview, examination and testing. The physician, nurse care manager and patient use the examination and diagnostic findings to establish goals and design a customized plan of self-care. Nurse care managers know patients personally, help them manage their conditions by staying in frequent contact, and are available for consultation 24 hours a day. They ensure rapid access to primary care and coordinate care with hospitals and other clinicians. IOCP's framework and strategies also foster the inclusion of patients' families as active members of the health care team.

The most effective aspect of the program according to McLaren was periodic e-mails from his nurse Connie Horton

[1] A Milstein, P Kothari, R Fernandopulle, T Helle, "Are High-Value Care Models Replicable?" http://content.healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/

[2] B Schilling, Purchasing High Performance, Boeing's Nurse Case Managers Cut Per Capita Costs by 20 Percent, *The Commonwealth Fund*, March 29, 2011.

that simply asked, **"How are things going?" Since Doug and Connie were engaging informally on a frequent basis, he would tell her things he might otherwise delay, wait or try to ignore.** This changed his interaction with the health care system. Connie became his first point of contact for questions about his health and thus reduced the frequency of his contact with specialists. "A program like this helps patients manage their own condition by enabling them to more quickly and effectively access the resources of the clinic," he said. "It also enables the clinic to do their job better. Thankfully my condition is relatively stable now and this program has been helpful for me in this regard."

Results Boeing focused on offering IOCP to the sickest 15% of its employees. Results are summarized in the table below. Due to reduced emergency room visits and hospitalizations, annual cost savings reached 20% per-capita, even after accounting for additional fees paid to participating clinics.[3] Boeing is self-insured and bears the financial risk of health benefits.

Boeing IOCP Pilot, January 2007 – July 2009[4]

Measure Compared to Baseline	Result
Health care costs of pilot participants vs. control group	-20%
Hospital admissions	-28%
Improvement in mental functioning of pilot participants	+16.1%
Participants felt care was "received as soon as needed"	+17.6%

St. Louis Expansion In 2010, Esse Health, SSM Medical Group, Mercy Clinic, SLUCare, and St. Anthony's Physician Organization physician groups partnered with Boeing, United HealthCare of the Midwest (UHC) and other employers, such as General Electric and Monsanto, to expand the pilot to St. Louis. Monsanto's leadership approved IOCP participation in late 2010 and the pilot launched in mid-2011. "The IOCP program complements our robust wellness and disease management programs," said Carolyn Plummer, Health and Welfare Benefits Lead, Monsanto. Physician groups oversee patient recruitment while Monsanto assumes a supportive role. UHC continued to expand IOCP and by the end of 2012, around 2,700 people were enrolled in the St. Louis Pilot.

[3] B Schilling, "Purchasing High Performance, Boeing's Nurse Case Managers Cut Per Capita Costs by 20 Percent", *The Commonwealth Fund*, March 29, 2011.

[4] A Milstein, P Kothari, R Fernandopulle, T Helle, "Are High-Value Care Models Replicable?" http://content.healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/

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Tom Hanley, MD
(Photo courtesy SSM Health Care)

SSM Medical Group In April 2011, Boeing and UHC approached SSM Medical Group (SSMMG) to partner in IOCP. "The timing was perfect. We had been considering medical home and population management models for a few years," according to Tom Hanley, MD, Chief Medical Officer of SSMMG. "The shortage of primary care physicians makes it tough to address every aspect of care. IOCP is attractive because it is a team effort focused on maintaining health, addressing care gaps and coordination of care." UHC sent a list of people that met program criteria who were existing SSMMG patients. Physicians contacted them and more than 800 patients, or approximately 75% said yes.

Renaissance Health provided training to SSMMG physicians and nurse care managers in motivational interviewing techniques to build rapport and foster behavior change in patients. Nurses also receive training focused on the management of chronic conditions such as diabetes and mental health, and development of effective patient problem lists and care plans using SSM's electronic health record (EHR). "**RN care managers are the backbone of the program,**" Hanley said. "They establish a relationship, understand patient priorities, and develop a high level of trust." SSMMG employs 10 nurse care managers who cover 28 clinic sites and take part in monthly multidisciplinary care manager meetings to share best practices.

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For care manager Monica Maaks, RN, IOCP is a good fit since it combines nursing and education. She manages a panel of 160 patients, which continues to grow. "For the most part, patients know what they need to do. I spend the time needed to find what motivates them," Maaks said. This has made a significant impact on the life and health of one of her patients and his family, as told below.

Sarah, whose husband has mental illness and Type 1 diabetes, appreciates how the IOCP has improved his health. **"This has been the best thing Boeing has ever done,"** she said. "Before he entered this program, he had more episodes of mental illness which affected his diabetes resulting in more frequent hospitalizations and medication changes." Her husband agrees, "I feel I am at the point of a remission, and this has helped me build confidence in myself." Monica designed an individualized plan and stayed in frequent contact to help him self-manage his conditions. In the past, his wife had to attend every physician visit with her husband to assist him in understanding complex medical terms. "Monica speaks to him in language he can understand and helps him communicate with his other doctors," she said. "Now I no longer have to attend every visit. Monica has also helped him maintain a routine and improve his communication skills. When he has a bad day or episode of delusions, he contacts Monica who helps him to dispel his delusional thinking and resolve issues. Her attention to my husband's combination of diabetes and mental health conditions have proved tremendous for our family."

The IOCP was a good fit for Esse Health, an independent, organized group of predominantly primary care physicians with practices across the St. Louis region. Esse Health's philosophy is to improve the overall well-being of its patients through patient education, lifestyle modification and prevention, to keep patients at home, not in the hospital. **"The program was just a natural extension of our current practice,"** said Susan Adams, MD. "The IOCP training fine-tuned what we already did." The IOCP pilot started at Esse Health's Florissant Internal Medicine office in December 2011. "Esse saw this as an opportunity and since then has expanded the program practice-wide," said Rob Richman, VP of Contracting and Planning. Potential patients were identified by UHC. Yet, Esse Health physicians were not always in agreement about patient selection. "In some instances, physicians would have identified other patients as having higher medical needs," Adams said.

Monica Maaks, RN
(Photo courtesy SSM Health Care)

Esse Health has been using an electronic medical record (EMR) system for more than a decade. Integrated physician-nurse notes in the EMR work well for IOCP, yet certain process changes were made to better integrate their documentation on the identified IOCP patients. Nurse practitioners serve as IOCP care managers for Esse Health. "We do not replace the doctor but develop relationships with patients where we are available to answer questions about their medicine and health," said Terri Morris, ANP. "The program makes it easier for them to get access to care when they need it." Joyce Boehmer, MD agrees, "The program design helps chronic care patients get their immediate issues addressed."

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Susan Adams, MD

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Joyce Boehmer, MD

Photos courtesy of Esse Health

Compensation and Expansion The IOCP places high demands on physician and staff time. Practices are required to do more reporting on a regular basis and staff meet regularly to discuss patient issues. To compensate, practices receive monthly payments per enrollee to cover the cost of care managers and other resources needed to help patients manage their chronic conditions as well as fee-for-service payments.

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Moving Toward the Triple Aim Significant attention is being focused on achieving the Triple Aim, a strategy to improve the experience of care, the health of populations, and reduce per capita health care costs. Boeing's IOCP pilot in Seattle has validated that patients, providers and health plans working in partnership can improve health outcomes for some of the sickest patients, improve employee productivity and reduce health care spending. Central to these efforts is the idea that primary care teams engaging patients and families as active team members improves patient experience, improves health outcomes and reduces health care costs. Through the IOCP and other primary care initiatives noted in the next section, the Triple Aim is becoming a reality from the ground up.

> *"This has been the best thing Boeing has ever done"*
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> **– Sarah, wife of Boeing employee and IOCP patient**

Other Primary Care Innovations The Missouri Medical Home Collaborative is a patient-centered medical home pilot organized by the Missouri Foundation for Health, where providers and payers are working together to improve the affordability of quality health care. Practices are paid by an alternative payment method presently funded by Anthem Blue Cross and Blue Shield in Missouri and MO HealthNet. The collaborative uses various techniques to improve care coordination and population health management. In some cases, readmissions fell 18 percent and unnecessary emergency department visits fell 15 percent.

Anthem Blue Cross and Blue Shield has conducted several patient-centered models including medical home and ACO pilots across the nation over the last four years which saw measurable improvements in quality and cost. Based on the most successful components of each pilot, Anthem is expanding its efforts. Their Patient-Centered Primary Care program will align incentives by replacing fee for service payments with fixed per member per month (PMPM) fees that compensate physicians for important clinical interventions that occur outside of a patient visit and support population health management. Any primary care physician willing to follow the program terms can participate, whether they practice within a small independent group or within a larger organization such as a multi-specialty physician group, integrated delivery system or accountable care organization.

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