

Integrated Chronic Care Management (ICCM)

The Integrated Chronic Care Model was developed by healthcare providers. This model evolved from the Home-Based Chronic Care Model™ (HBCCM) via continued research and application, resulting in a refined concept of true patient-centered, high quality chronic care delivery. The implementation of this refined model in a large home health and hospice agency in Little Rock, Arkansas successfully netted positive patient experiences, excellent clinical and financial outcomes, and improved employee engagement. The ICCM has received national recognition from the National Association of Home Care and Hospice and Modern Health Care due to the realization of excellence in patient-centered care.

Recent healthcare reform legislation calls for transformational change across our healthcare delivery systems, with the goals of achieving positive patient experiences, high quality care for individuals and populations, and bending the cost curve in healthcare spending. The Integrated Chronic Care Model was designed to take lessons learned from homecare and hospice delivery reform in order to apply those lessons to healthcare practices across the provider continuum. Multiple providers across the nation seeking viable solutions for care transitions, patient centered medial home, and ACOs have adopted this model.

Key principles of the ICCM Model

1. Healthcare should be patient-centered and evidenced-based.
2. Management of chronic conditions is 1% medical management and 99% behavior change/self- management.
3. Delivery system redesign needs to support behavior change/self-management in the environment where that battle is won or lost: in the home and community.
4. Redesigning care delivery should be designed by healthcare providers who are patient-centered.
5. True patient centered care will not be realized until patients/families/caregivers, healthcare providers, payors, and policymakers have a “change vision” for their roles and responsibilities. It starts with innovative leadership and financing.
6. The spring board for redesigned care starts with behavior change on the part of the healthcare provider.
7. Provider focus is on the interpersonal relationship with patient. All care is planned, viewed, provided based on patient’s goals.
8. Goal of care is to engage and activate the patient/care giver and promote patient autonomy.
9. Responsibility for patient outcomes is shared between healthcare professionals and patient/family.
10. In the ICCM model this standard of “patient-centered” care is delivered to all patients throughout the condition trajectory (hospitalized, homecare, palliative care, hospice care), by all providers in the healthcare continuum (physicians, case coordinators, transition coaches, hospital – homecare- hospice nurses, therapists, social workers, etc.) and across all settings (community, MD practice, acute care, rehab, long term care, Home Health & Hospice, palliative care).
11. Sustainable delivery redesign must have providers working at the “top of their license”, to fully empower patients/families/caregivers/volunteers, while making full use of community resources.
12. Delivery redesign should be a process of transformational change with a foundation of continuous improvement as its base.

Metrics: Demonstrate a patient and healthcare team that is value driven, engaged, activated, goal oriented, and coordinated. Specific metrics include:

1. Quality of care: patient experience / goal attainment / evidenced based guidelines
2. Cost of Care: start with re-hospitalizations/ ED use/ end of life care
3. Provider engagement: measure of team engagement / turnover

Integrated Chronic Care Management: The Four Model Tenets

I. Patient Centered/ Relationship Based

1. All patients are treated with dignity and respect
2. Trusting interpersonal relationship is sought
3. Each contact starts with patient needs/concerns
4. Holistic assessment conducted to identify and remove patient barriers for optimal health
5. Recognizes role of caregiver / family/ support system
6. Single most important predictor of whether patient will change behavior – a relationship with caregiver who is concerned about their well-being.

2. Self-Management Support / Behavior Change

1. In order for individuals to be “informed and activated “ they need motivation, information, skills and confidence to effectively make decisions about their health and manage it (Wagner)
2. Communication /collaborative provider skill competency is imperative
3. Competent healthcare providers can assist an individual to become “informed and activated” utilizing tools and techniques in motivational interviewing, confidence building , problem solving, health literacy, adult education, and disease specific signs & symptoms requiring problem solving to self-manage
4. Collaborative relationship is essential for behavior change; collaborative relationship should not end when patient transitions from one venue of healthcare delivery to the next. (The concept of “partner for life”).

3. Expertise / Evidenced Based Care

1. Patient is the expert of their life, their goals and aspirations
2. Healthcare provider is expert in evidenced based care , techniques to support individuals self- management / behavior change, and assisting patient to navigate and transition among providers and provider settings
3. Team approach is valued – no one is as smart as all of us
4. Work at the top of our licenses
5. Right provider / right time/right place
6. Care coordination and collaboration across *all* care settings by *all* providers

4. Technology / Decision Support

1. Technology is a tool in a delivery system
2. Technology can help “make the right thing to do the easy thing to do”
3. The right patient information is accessed by the provider at the point of care
4. Decision support built into EMR/PHR/telemonitoring
5. Decision support includes patient-centered goals and evidenced based guidelines
6. Personal data should be used to engage the patient and establish relevance
7. Data in NOT information; meaningful information is data collected/organized/presented such that pt and provider has easy access to make decisions and problem solve, see results of their goal attainment.
8. Data needs to be organized both on an individual level and a population level
9. Meaningful data should be shared across sectors
10. Data needs to point to new “bottlenecks” and opportunities for continuous improvement