



Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health

SUCCESSFUL MODELS OF CARE:

Focus of Service, Care Attributes, Delivery Features,
and Organizational Culture

Focus of Service

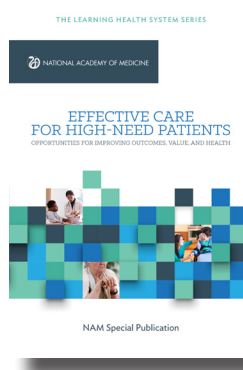
Enhanced primary care. Programs in the primary care setting defined by the use of supplemental health-related services that enhance traditional primary care and/or employ a team-based approach, with a provider and at least one other person

- **Interdisciplinary primary care.** A team comprising a primary care provider and one or more other health care professionals (e.g., nurse, social worker, rehabilitation therapist) who communicate frequently and provide comprehensive primary care
E.g., Guided Care, GRACE, IMPACT, PACE, or Care Management Plus
- **Care and case management.** Collaborative models in which a nurse or social worker helps patients with multiple chronic conditions and their families assess problems, communicate with providers, and navigate the health care system
E.g., Mass General Hospital Physicians Organization Care Management Program
- **Chronic disease self-management.** Structured, time-limited interventions designed to provide health information to patients and engage them in actively managing their chronic conditions
E.g., Chronic Disease Self-Management program at Stanford

Transitional care. Facilitate safe and efficient transitions from the hospital to the next site of care (e.g., alternative health care setting or home). Interventions are usually led by a nurse, known as a “transition coach,” who provides patient education about self-care, coaches the patient and caregiver about communicating with providers, performs a home visit, and monitors the patient
E.g., Naylor Transitional Care Model

Integrated care. Cross-disciplinary models which engage or focus on social risk interventions and behavioral health services in addition to medical care and functional assistance.
E.g., IMPACT or Camden Coalition

Note: Categories are not mutually exclusive.



Care Attributes of Successful Care Models

- **Assessment.** Multidimensional (medical, functional, and social) patient assessment
- **Targeting.** Targeting those most likely to benefit
- **Planning.** Evidence-based care planning
- **Alignment.** Care match with patient goals and functional needs
- **Training.** Patient and care partner engagement, education, and coaching
- **Communication.** Coordination of care and communication among and between patient and care team
- **Monitoring.** Patient monitoring
- **Linking.** Facilitation of transitions

Delivery Features of Successful Care Models

- **Teamwork.** Multidisciplinary care teams with a single, trained care coordinator as the communication hub and leader
- **Coordination.** Extensive outreach and interaction among patient, care coordinator, and care team, with an emphasis on face-to-face encounters among all parties and collocation of teams
- **Responsiveness.** Speedy provider responsiveness to patients and 24/7 availability
- **Feedback.** Timely clinician feedback and data for remote patient monitoring
- **Medication management.** Careful medication management and reconciliation, particularly in the home setting
- **Outreach.** The extension of care to the community and home
- **Integration.** Linkage to social services
- **Follow-up.** Prompt outpatient follow-up after hospital stays and the implementation of standard discharge protocols

Organizational Culture of Successful Care Models



Leadership across levels



Customization to context



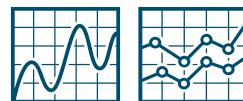
Strong relationships



Training appropriate to circumstances



Continuous assessment with effective metrics



Use of multiple sources of data

Read the full publication online at nam.edu/HighNeeds.