Integrated Care Management Model Overview

Sutter Health
Sutter Center for Integrated Care

Vision

The Integrated Care Management (ICM) model is a person-centered, evidence-based care delivery model that provides care coordination and support across providers, settings, and time. Building on Wagner's Care Model, ICM further defines the requisite practices and competencies needed to engage patients through the provision of person-centered, health literate care. ICM values highly functional teams, with the person at the center, in order to actualize genuine collaboration and facilitate superior health outcomes.

Change Vision

- Person's values, needs and preferences always drive care delivery.
- Partnerships with individuals/families/caregivers to promote informed, activated, and engaged self-management.
- Develop health care provider competencies and practices to support functioning as a prepared, health literate proactive care team.
- Demonstrate innovative leadership in transformational change, hardwiring excellence and creating a learning environment that values multi-disciplinary teams.

Outcomes

- Provide a framework for hardwiring ICM in the provider's operational practice at all levels with specific process measures to ensure model fidelity (e.g., patient goals, use of Situation, Background, Assessment, Recommendation [SBAR], use of teach-back, timely initiation of care).
- Provide a framework for hardwiring ICM supporting the provider's achievement of outcomes of better care, better health, and lower cost (e.g., improvement in clinical quality measures, patient satisfaction, patient engagement, re-hospitalization rates, emergency department utilization).

Core Principles	Core Practices, Tools and Resources
Informed/Activated person • Motivation • Information • Skills • Confidence • Problem solve • Manage health	**Informed/Activated person** • Motivational Interviewing • Universal precaution approach to health literacy • Principles of adult learning/teach-back/patient SBAR • Confidence ruler/pros and cons/SMART goals • Action plan • Personal health record (PHR)/stoplight forms
Prepared, proactive practice team • Person-centered - Person is "expert" - Values, needs, preferences drive care - Person is part of team • Evidence-based - Clinical guidelines for medical management and action planning - Patient engagement: self-management support/health literate care - Transitions of care • Coordinated - Care management - Communication - High functioning teams	**Prepared, proactive practice team** • Person-centered - Open ended questions (OARS) - Things That Are Important to Me - Quality of Life Tools - Person-centered goals • Evidence-based - Best practice cards - Assessment of barriers for self-management support (SMS) (PHQ 2 and 9, health literacy, confidence, self assessment of health) - Medication management, red flags, follow-up, PHR • Coordinated - Referral note, risk assessments, protocols for high risk - SBAR verbal and written meaningful data exchange - Team conferences/huddles utilizing SBAR structure for decision making
Innovative leadership • Transformational change • Accountable for outcomes • Culture of learning that values teams	**Innovative leadership** • Change vision/celebrate short term wins by sharing positive stories/storytelling • Rounding for outcomes to create a learning environment • Utilize behavior change principles with clinical and support staff; tip of the month with challenges for team members