4) ntegrated Care Management Program (ICMP)

Emerson Hospital

Georgia Feuer, MPH, Project Manager; gfeuer@emersonhosp.org

PROJECT DESCRIPTION

The ICMP Program is a Care Manager collaborative created to ensure the transition of patient care across various settings. When an ICMP patient enters the emergency department, they are flagged in our computer system so that the Care Manager (CM) is notified. Once notified, the CM then informs the patient's Primary Care Physician of their hospital visit. Post-discharge, the CM schedules follow up appointments with Primary Care Physicians and Specialists within seven days to provide a smooth transition from inpatient to outpatient. Patients also have access to a variety of resources such as a social worker, pharmacist, and community resource specialist. Once a patient has been discharged from the hospital, a CM conducts a follow up call to make sure that their needs are being met. They continue to follow them in the community to provide patients with the best care.

OUTCOMES ACHIEVED

- Reduction in hospital stays
- Qualitative improvements in patient experience with the healthcare system
- Primary care physicians have a greater appreciation of the impact an integrated care manager can have to their patient's goals and engagements in their disease states.

LESSONS LEARNED

- Physicians and their staffs buy in of the program are crucial. The patients are more likely to participate if the request is coming from their physician.
- The care manager's patient load needs to be realistic of the patient population they are managing. There is no universal number that applies to all care managers.
- Electronic records and registries that have the ability to communicate to one another greatly improve productivity and patient outcomes.