



## Coordinating Care for Adults with Multiple Chronic Conditions: Searching for the Holy Grail

## FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

**Gerald Anderson, PhD**

*Professor of Health Policy and Management and International Health  
Bloomberg School of Public Health  
Johns Hopkins University*

**David B. Reuben, MD**

*Director  
Multicampus Program in Geriatrics Medicine and Gerontology  
Chief  
Division of Geriatrics  
UCLA Center for Health Sciences*

**Randall S. Brown, PhD**

*Senior Fellow  
Mathematica Policy Research, Inc.*

**Robert Berenson, MD**

*Senior Fellow  
The Urban Institute*

FRIDAY, MARCH 27, 2009  
11:45AM–12:15PM—Lunch  
12:15–2:00PM—Discussion

LOCATION

Reserve Officers Association  
One Constitution Avenue, NE  
Congressional Hall of Honor  
Fifth Floor  
*(Across from the Dirksen  
Senate Office Building)*

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## National Health Policy Forum

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## OVERVIEW

*Chronic care is currently a hot topic of conversation among daily news programs, research journals, health care professionals, and patients. Health care analysts worry about the costs and quality of care, physicians worry about how to manage care, and patients worry about their health. Both the government and the private sector have tried a variety of chronic care interventions to remedy what many see as a failed system of care, characterized by a lack of coordination among providers, patient confusion, and poor outcomes. Two Forum sessions will focus on efforts to improve chronic care quality and control costs through care coordination. At this first session, speakers will discuss the prevalence and demographics of chronic care needs, their impact on delivery and financing patterns, and research and demonstration efforts that have tested ways to better coordinate and manage patient care. At the second session (April 3), speakers will offer perspectives on selected models that offer promise for future federal policy.*

## SESSION ONE

For many years, health care practitioners and researchers have struggled to develop models to improve chronic care while controlling costs. Various approaches have been tried: disease management, care coordination, case management, transitional care, patient self-management, accountable care organizations, and, recently, medical homes.

It's not surprising that policymakers are concerned as well, given the increasing number of people with chronic conditions and the amount of care they need. People with five or more chronic conditions see about 14 physicians and fill 57 prescriptions on average annually.<sup>1</sup> And because three-quarters of Medicare spending goes to beneficiaries needing this level of care, the volume of patients and services significantly affects the Medicare program.<sup>2</sup>

The Medicare delivery system is oriented toward acute, episodic care, and geriatricians and other experts say that it should be modified to coordinate and manage chronic care.<sup>3</sup> Lack of coordination among providers leads to fragmented care, poor patient outcomes, and higher costs, often due to avoidable hospital admissions and emergency room visits. To ensure better patient outcomes and control costs, some say the health care system needs to take into account medical, health, functional, and supportive care needs and become more "patient-centered";

provide continuity and coordination of services and high-quality transitional care for patients as they move among various sites or teams of care; encourage close collaboration between physicians and care coordination staff; use an interdisciplinary team approach, evidence-based care guidelines, and methods to provide patient education and self-management skills; and involve caregivers and supportive community services to assist patients, as appropriate.<sup>4</sup>

Efforts to improve patient outcomes and control chronic care costs include a number of care models that have been developed over the years. They target patients according to the severity of their conditions, and the intensity of intervention ranges from high-intensity for patients with multiple and complex chronic conditions to less intensive for those with fewer and less complex conditions.<sup>5</sup> Some programs focus on people with a specific chronic condition, others on people with multiple and complex conditions and/or those who have had one or more hospitalizations in the previous year.

The methods of patient intervention used vary by model. Some provide geriatric assessment and ongoing case management using interdisciplinary teams of physicians, nurses, social workers, and other professionals; some help patients make transitions from one care setting to another, for example through specialized hospital discharge planning and ongoing patient support services. Others are designed to improve communications among providers and patients, for example through telephone contact with patients and their physicians by disease management organizations. Still others enlist patients to participate in patient education and self-care approaches as the sole intervention. Programs may be operated by various types of providers, such as integrated delivery systems, physician group practices, disease management organizations, and community-based providers.<sup>6</sup> The Chronic Care Model (CCM), developed more than a decade ago, envisions effective chronic care management as the product of providers working with complementary community resources, including organizational leadership to promote an environment to improve care, patient self-management programs, and team approaches.<sup>7</sup>

### CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) DEMONSTRATION EFFORTS

Over the past decade, CMS has sponsored seven Medicare research and demonstration studies on models that used various interventions. (CMS refers to these various models under the term “disease management.”) The demonstrations took place in 35 programs in

fee-for-service Medicare, involving about 300,000 beneficiaries. Interventions varied among the projects, ranging from telephone monitoring by case managers to a more comprehensive approach that included physician, nurse home visits; in-home monitoring devices; and caregiver support and education. Generally, the interventions were provided by nurses targeting patient education and behavior, with little physician involvement. Some of the demonstrations targeted specific diseases, while others focused on high-cost or high-risk Medicare beneficiaries, regardless of diagnosis. The interventions were not conceived to address the full range of care coordination and case management across settings and providers that is sometimes needed by patients with chronic conditions.<sup>8</sup>

In general, the results of the CMS-sponsored efforts have not been encouraging; only a few of the programs produced net financial savings.<sup>9</sup> Even so, research on the Medicare Care Coordination Demonstration (MCCD), one of the major CMS demonstration efforts, shows that certain interventions hold promise of improving patient outcomes and reducing costs. These interventions include direct, person-to-person contact of care coordination staff with patients as well as frequent interaction with physicians; appropriate targeting of patients; and management of patients who are transitioning from one provider to another.<sup>10</sup> A key challenge for policymakers is to distill and understand the successes as well as failures in order to move both policy and practice forward.

### KEY QUESTIONS

- What is the burden of chronic conditions, and how is it changing?
- What are the key factors that can lead to successful interventions, improve patient outcomes, and reduce or contain costs? What components have been ineffective? Is there an optimal model?
- Which patients should be targeted for specialized chronic care interventions? Which interventions work for what patients?
- What role does an interdisciplinary team approach play in outcomes?
- How effective are chronic disease self-management programs?
- Are there key structural and organizational mechanisms that can be put in place to ensure positive outcomes?
- What barriers and opportunities does Medicare face in financing improvements to chronic care coordination and management?

## SPEAKERS

**Gerald Anderson, PhD**, will discuss the burden of chronic conditions and its effect on health care delivery and financing. He is a professor of health policy and management, professor of international health at the Johns Hopkins University Bloomberg School of Public Health, professor of medicine at the Johns Hopkins University School of Medicine, director of the Johns Hopkins Center for Hospital Finance and Management, and co-director of the Johns Hopkins Program for Medical Technology and Practice Assessment. **David B. Reuben, MD**, will discuss the benefits of care coordination and the challenges faced by physicians and patients. He is the director of the Multicampus Program in Geriatrics Medicine and Gerontology (MPGMG); chief of the division of Geriatrics at University of California at Los Angeles (UCLA) Center for Health Sciences, the Archstone Foundation chair and professor at the David Geffen School of Medicine, UCLA; and director of the UCLA Claude D. Pepper Older Americans Independence Center. **Randall S. Brown, PhD**, will discuss research findings on chronic care interventions. He is a senior fellow at Mathematica Policy Research, Inc., and an expert in health care policy issues related to care for the chronically ill, long-term care, managed care, and quality of care. He is nationally known for his evaluations of care coordination and disease management programs for Medicare beneficiaries. **Robert Berenson, MD**, will serve as a reactor to the other panelists and will comment on the challenges faced by Medicare in improving chronic care. He is a senior fellow at the Urban Institute. Dr. Berenson is an expert in health care policy, particularly Medicare, with experience practicing medicine, serving in senior positions in two administrations, and helping organize and manage a successful preferred provider organization. From 1998 to 2000, he was in charge of Medicare payment policy and managed care contracting in the Health Care Financing Administration (now CMS).

## ENDNOTES

1. Gerard Anderson, "Chronic Conditions: Making the Case for Ongoing Care," chart book, Johns Hopkins University, November 2007; available at [www.fightchronicdisease.com/news/pfcd/documents/ChronicCareChartbook\\_FINAL.pdf](http://www.fightchronicdisease.com/news/pfcd/documents/ChronicCareChartbook_FINAL.pdf).
2. Congressional Budget Office (CBO), *Budget Options Volume 1: Health Care*, December 2008, p. 77; available at [www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf](http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf).
3. Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, March 2001, release information at [www.iom.edu/Object.File/](http://www.iom.edu/Object.File/)

- [Master/27/184/Chasm-8pager.pdf](#); and David B. Reuben, "Better Care for Older People with Chronic Diseases," *Journal of the American Medical Association*, 298, no. 22 (December 12, 2007): pp. 2673–2674, available at (subscription required) <http://jama.ama-assn.org/cgi/content/full/298/22/2673>.
4. Reuben, "Better Care for Older People with Chronic Diseases"; CBO, *Budget Options Volume 1*; Eric A. Coleman and Chad Boulton, "Improving the Quality of Transitional Care for Persons with Complex Care Needs: Position Statement of the American Geriatrics Society Health Care Systems Committee," *Journal of the American Geriatrics Society*, 51 (April 2003): pp. 556–557, available at (subscription required) <http://www3.interscience.wiley.com/cgi-bin/fulltext/118861912/PDFSTART>; Jennifer L. Wolff and Chad Boulton, "Moving Beyond Round Pegs and Square Holes: Restructuring Medicare to Improve Chronic Care," *Annals of Internal Medicine*, 143, no. 6 (September 20, 2005): pp. 439–445, available at [www.annals.org/cgi/reprint/143/6/439.pdf](http://www.annals.org/cgi/reprint/143/6/439.pdf); and Jack Meyer and Barbara Markham Smith, "Chronic Disease Management: Evidence of Predictable Savings," Health Management Associates, November 2008, available at [www.idph.state.ia.us/hcr\\_committees/common/pdf/clinicians/savings\\_report.pdf](http://www.idph.state.ia.us/hcr_committees/common/pdf/clinicians/savings_report.pdf).
  5. Soeren Mattke, Michael Seid, and Sai Ma, "Evidence for the Effect of Disease Management: Is \$1 Billion a Year a Good Investment?" *American Journal of Managed Care*, 123, no. 12 (December 2007): pp. 670–676. The authors group the range of interventions under the term "disease management." Here, this typology refers to models of care, rather than just disease management.
  6. Medicare Payment Advisory Commission (MedPAC), "The Medicare Modernization Act and chronic care improvement," chap. 2 of *Report to Congress: New Approaches in Medicare*, June 2004; available at [www.medpac.gov/publications/congressional\\_reports/June04\\_ch2.pdf](http://www.medpac.gov/publications/congressional_reports/June04_ch2.pdf).
  7. Thomas Bodenheimer, Edward H. Wagner, and Kevin Grumbach, "Improving Primary Care for Patients with Chronic Illness," *Journal of the American Medical Association*, 288, no. 14 (October 9, 2002): pp. 1775–1779; and Edward H. Wagner *et al.*, "Improving Chronic Illness Care: Translating Evidence into Action," *Health Affairs*, 20, no. 6 (November/December 2001): pp. 64–78, available at <http://content.healthaffairs.org/cgi/reprint/20/6/64.pdf>.
  8. David M. Bott *et al.*, "Disease Management for Chronically Ill Beneficiaries in Traditional Medicare," *Health Affairs*, 28, no. 1 (January/February 2009): pp. 86–98, available at (subscription required) <http://content.healthaffairs.org/cgi/content/full/28/1/86>.
  9. Bott *et al.* "Disease Management for Chronically Ill Beneficiaries in Traditional Medicare."
  10. Deborah Peikes *et al.*, "Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries, 15 Randomized Trials," *Journal of the American Medical Association*, 301, no. 6 (February 11, 2009): pp. 603–618.

## COMPANION SESSION

April 3 (9:15 to 11 AM)

### Promising Models of Care Coordination for Adults with Multiple Chronic Conditions: Getting Closer to the Holy Grail?

This meeting, the second of two, will focus on selected models that offer promise of coordinating care for people with multiple chronic conditions, improving patient outcomes, and controlling costs.

**Speakers:** **Chad Boulton, MD**, is the Eugene and Mildred Lipitz Professor of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health and principal investigator of a multi-site, cluster-randomized controlled trial of Guided Care. **Eric A. Coleman, MD**, is professor of medicine in the Divisions of Health Care Policy and Research and Geriatric Medicine at the University of Colorado at Denver and Health Sciences Center and director of the Care Transitions Program. **Mary Naylor, PhD, FAAN**, is the Marian S. Ware Professor in Gerontology and director of the NewCourtland Center for Transitions and Health at the University of Pennsylvania, School of Nursing and is the leader of Transitional Care. **Kenneth Coburn, MD**, is president and chief executive officer and founder of Health Quality Partners, a not-for-profit health care quality research and development organization, and principal investigator for its participation in the Medicare Care Coordination Demonstration program of CMS.