



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

FORUM SESSION  
ANNOUNCEMENT

A DISCUSSION FEATURING:

**Chad Boulton, MD**

*Director*

Roger C. Lipitz Center for Integrated Health Care  
Bloomberg School of Public Health  
Johns Hopkins University

**Eric A. Coleman, MD**

*Professor of Medicine*

Divisions of Health Care Policy and Research and Geriatric Medicine  
University of Colorado and Health Sciences Center  
*Director*  
Care Transitions Program

**Mary Naylor, PhD, FAAN**

*Marian S. Ware Professor in Gerontology*  
University of Pennsylvania

**Kenneth Coburn, MD**

*President and Chief Executive Officer*  
Health Quality Partners

FRIDAY, APRIL 3, 2009

8:45–9:15AM—Breakfast

9:15–11:00AM—Discussion

LOCATION

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

**REGISTER NOW**

Space is limited. Please  
respond as soon as possible.

Send your contact information  
by e-mail to:

[nhpfmeet@gwu.edu](mailto:nhpfmeet@gwu.edu)

**National Health Policy Forum**

2131 K Street, NW  
Suite 500  
Washington, DC 20037

**T** 202/872-1390  
**F** 202/862-9837  
**E** [nhpf@gwu.edu](mailto:nhpf@gwu.edu)  
[www.nhpf.org](http://www.nhpf.org)

Judith Miller Jones  
*Director*

Sally Coberly, PhD  
*Deputy Director*

Monique Martineau  
*Publications Director*

**Forum Session Manager**  
Carol V. O'Shaughnessy  
*Principal Policy Analyst*

The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at [www.nhpf.org](http://www.nhpf.org).

**OVERVIEW**

*Recent press reports about research on Medicare chronic care demonstrations suggest that few of the demonstration approaches have been successful. However, moving beyond the headlines and digging deeper and wider, it appears that some chronic care models—within and outside Medicare—have indeed been able to coordinate care and offer promise for future policy on chronic care improvement. The challenge for policymakers is to understand the characteristics of these models and what elements could be incorporated into future policy directions. This Forum session, the second of two, will focus on a discussion of selected models that have improved patient outcomes while reducing or controlling costs.*

*The companion meeting on March 27, “Coordinating Care for Adults with Multiple Chronic Conditions: Searching for the Holy Grail,” will look at the prevalence and demographics associated with chronic care, its impact on delivery and financing patterns, and major federal research and demonstration efforts that have tested ways to better coordinate and manage patient care.*

**SESSION TWO**

Trying to “fit a square peg into a round hole” is how some describe the experience of patients with multiple chronic conditions in the current health care system. Medicare is oriented toward acute, episodic care, but geriatricians and other experts say that it should be modified to focus on chronic care, which is a significant driver of the program’s costs. About three-quarters of Medicare spending goes to care for patients with multiple chronic conditions.<sup>1</sup> These patients see many providers on a continuous basis; often, when transitioning among providers, care suffers and leads to poor patient outcomes. Fragmented care leads to higher costs, often due to avoidable hospital admissions and emergency room visits.

Geriatricians and other experts say care of patients with chronic conditions can improve. Their vision is to create a system that takes into account medical, health, functional, and supportive care needs and is “patient-centered”; ensures continuity of services for patients as they move among various sites and teams of care; encourages close collaboration between physicians and care coordination staff; uses an interdisciplinary team approach, evidence-based care guidelines,

and methods to provide patient education and self-management skills; and involves caregivers and supportive community services to assist patients, as appropriate.<sup>2</sup>

Efforts to improve patient outcomes and control costs abound. Although the Centers for Medicare & Medicaid Services (CMS) has tested a number of Medicare demonstration projects over the years, they have had limited success. But some programs outside the Medicare demonstrations have been able to improve care and reduce costs through fewer hospitalizations, readmissions, and/or emergency room visits.

This Forum session will explore several of these models, as well as one of the programs in CMS's Medicare Care Coordination Demonstration (MCCD). Each model focuses on an interdisciplinary team approach to patient-centered care, smoothing transitions among multiple providers and settings, and patient education, among other things.

- **Guided Care** is a patient-centered medical home model that uses an interdisciplinary team approach to coordinating care for older adults with complex chronic conditions.<sup>3</sup> Guided Care nurses, based in primary care physician practices, are responsible for coordinating care among health care providers; completing standardized comprehensive home assessments; and collaborating with physicians, patients, and caregivers to create evidence-based care guides and action plans, among other things. Guided Care nurses work on a long-term basis with clients, provide transitional care, and assist patients with self-management skills and accessing necessary community-based services. Program results to date show improved quality of care and reduced health care costs from fewer hospital admissions, hospital days, and emergency room visits.<sup>4</sup>
- The **Care Transitions Program**<sup>5M</sup> is designed to improve care of patients as they move among health care practitioners and settings during the course of a chronic or acute illness.<sup>5</sup> Patients and caregivers receive assistance from a nurse transition coach, who coordinates care across settings and encourages patients to take an active role in their care through self-management skills. Patients who participated in this program were significantly less likely to be readmitted to the hospital, and the benefits were sustained for five months after the end of the one-month intervention.<sup>6</sup>
- **Transitional Care** is aimed at improving the post-discharge outcomes for high-risk, high-cost elderly patients.<sup>7</sup> Advanced practice nurses (APNs) coordinate discharge planning while the patient is hospitalized and provide home care follow-up. The APNs individualize patient care in collaboration with physicians. Patients who

participated in the program had fewer hospital readmissions and days rehospitalized, which resulted in lower Medicare costs.<sup>8</sup>

- One of the sites studied under the MCCC, **Health Quality Partners (HQP)**, is a not-for-profit health care quality improvement organization that uses a nurse-led case management approach and provides patient education and self-care management. The program achieved positive effects on patient satisfaction and achieved net cost savings through reduced hospitalizations.<sup>9</sup>

### KEY QUESTIONS

- What impact do these models have on patient outcome, quality of care, and costs? How do these models pay for care coordination?
- Which key components of care coordination and care transition models have proven successful? What factors have led to their success? Are the results idiosyncratic (for example, the result of dynamic leadership), or could they be replicated?
- What role does the interdisciplinary team play, and how effective are patient education and empowerment strategies?
- Which patients should be targeted for intensive care coordination and management?
- Are these programs ready to be adopted on a wider scale in Medicare? Are there barriers to dissemination? And if so, can these barriers be overcome without compromising the models' effectiveness?

### 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. He directs the Roger C. Lipitz Center for Integrated Health Care and holds joint appointments on the faculties of the Johns Hopkins University Schools of Medicine and Nursing. Dr. Boulton is the principal investigator of a multi-site, cluster-randomized controlled trial of Guided Care. **Eric A. Coleman, MD**, is professor of medicine within the Divisions of Health Care Policy and Research and Geriatric Medicine at the University of Colorado at Denver and Health Sciences Center. Dr. Coleman is the director of the Care Transitions Program, and the executive director of the Practice Change Fellows 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. Since 1990, Dr. Naylor has led

an interdisciplinary program of research designed to improve the quality of care, decrease unnecessary hospitalizations and reduce health care costs for vulnerable community-based elders. **Kenneth Coburn, MD**, is president and chief executive officer of Health Quality Partners, a not-for-profit health care quality research and development organization, and principal investigator for its participation in the MCCD program of CMS.

## ENDNOTES

1. 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).
2. 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>; 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. 439–435, 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).
3. For more information on the Guided Care model, see [www.guidedcare.org](http://www.guidedcare.org).
4. Martha L. Sylvia *et al.*, "Guided Care: Cost and Utilization Outcomes in a Pilot Study," *Disease Management*, 11, no. 1 (February 2008): pp. 29–36. The researchers point out that these results are based on a small sample size.
5. Care Transition Program Web site, "Care Transitions," available at [www.caretransitions.org/definitions.asp](http://www.caretransitions.org/definitions.asp); "Program Structure," available at [www.caretransitions.org/structure.asp](http://www.caretransitions.org/structure.asp).
6. Eric A. Coleman, Carla Parry, and Sandra Chalmers, "The Care Transition Intervention: Results of a Randomized Controlled Trial," *Archives of Internal Medicine*, 166, no. 17 (September 25, 2006): pp. 1822–1828; and Eric A. Coleman, "Person-Centered Models for Assuring Quality and Safety During Transitions Across Care Settings," testimony before the United States Senate Special Committee on Aging, July 23, 2008, available at [www.caretransitions.org/documents/Coleman%20Senate%20Aging%20Testimony%20July%202008.pdf](http://www.caretransitions.org/documents/Coleman%20Senate%20Aging%20Testimony%20July%202008.pdf).
7. Mary D. Naylor, PhD, FAAN, "Transitional Care," Hartford Center of Geriatric Nursing Excellence, University of Pennsylvania; available at [www.nursing.upenn.edu/centers/hcgne/TransitionalCare.htm](http://www.nursing.upenn.edu/centers/hcgne/TransitionalCare.htm).

8. Mary D. Naylor, "A Decade of Transitional Care Research with Vulnerable Elders," *Journal of Cardiovascular Nursing*, 14, no. 3 (April 2000): pp. 1–14.
9. 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

March 27 (12:15 to 2PM)

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

This meeting will focus on the prevalence and demographics associated with chronic care, its effect on delivery and financing patterns, and major research and demonstration efforts that have tested ways to better coordinate and manage patient care.

**Speakers:** **Gerald Anderson, PhD**, is a professor of health policy and management; professor of international health at the Johns Hopkins University Bloomberg School of Public Health; **David Reuben, MD**, is the director of the Multicampus Program in Geriatrics Medicine and Gerontology (MPGMG); and chief, Division of Geriatrics at UCLA Center for Health Sciences. **Randall Brown, PhD**, 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. **Robert Berenson, MD**, is a senior fellow at the Urban Institute. He is an expert in health care policy, particularly Medicare, with experience practicing medicine, and serving in senior positions in two administrations.