Effective Care Coordination

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

National Health Policy Forum

March 27, 2009

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Goals of Presentation

- Identify proven interventions for beneficiaries with chronic illness
- Describe key distinguishing features
- Outline model with maximum potential
- Suggest policy implications

The Problem

- Most Medicare dollars are spent on small percent of beneficiaries with *chronic conditions*
- Causes:
  - Inadequate care
  - Poor communications among primary providers, specialists, and patients
  - Weak adherence by patients
  - Failure to catch problems early

What Is “Effective” Care Coordination?

- Reduces total Medicare expenditures for participating beneficiaries
- Maintains or improves beneficiary outcomes
- Savings require reduced hospitalizations

Credible Evidence of Effectiveness

- Most "evidence" showing impacts is unreliable
- 3 types of interventions have been effective:
  1. Transitional care interventions (Naylor and Coleman)
  2. Self-management education interventions (Lorig and Wheeler)
  3. Coordinated care interventions (Select sites from the Medicare Coordinated Care Demonstration)

Transitional Care : Key Components

- Patients first engaged while hospitalized
- Followed intensively post-discharge
- Receive comprehensive post-discharge instructions on medications, self-care, and symptom recognition and management
- Reminded/encouraged to keep follow-up physician appointments

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Effective Transitional Care Intervention: Naylor et al. (2004)

- Targeted patients hospitalized for CHF
- Used advanced practice nurses (APNs)
- 12-week intervention; highly structured protocols
- RCT (118 treatment, 121 control)
- 1 year post-discharge followup
- Intervention patients had:
  - 34% fewer rehospitalizations per patient
  - Lower proportion rehospitalized (45% vs. 55%)
  - 39% lower average total costs ($7,636 vs. $12,481)

Effective Transitional Care Intervention: Coleman et al. (2006)

- Used APNs as transition coaches
- Targeted patients hospitalized for various conditions
- Patients received (1) tools to promote cross-site communication, (2) encouragement to take a more active role in their care, (3) continuity/guidance from transition coach
- RCT (379 treatment, 371 control)
- Lowered rehospitalization rates at 90 days:
  - For any reason (17% vs. 23%)
  - For initial condition (5% vs. 10%)
- Lowered hospital costs 19% over 180 days ($2,058 vs. $2,546)

Self-Management Education: Key Components

- Staff collaborate with patients and families to:
  - Identify individualized patient goals
  - Improve self-management skills
  - Expand sense of self-efficacy
  - Assess mastery of these skills
- Uses group sessions
- Limited duration

Effective Self-Management Education Intervention: Lorig et al. (1999, 2001)

- People age 40+ with heart disease, lung disease, stroke, arthritis
- 7 weekly group sessions on exercise, symptom management techniques, nutrition, fatigue and sleep management, use of medications, dealing with emotions, communication, problem-solving
- RCT (664 treatment, 476 control)
- One-third fewer hospital stays per person (0.17 vs. 0.25)
- Savings of $820 per person over 6 months

Effective Self-Management Education Intervention: Wheeler (2003)

- Women age 60+ with cardiac disease
- 4 weekly group sessions with health educators teaching diet, exercise, and medication management specific to cardiac disease
- RCT (308 treatment, 260 control)
- Intervention group findings over 21 months:
  - 39% fewer inpatient days
  - 43% lower inpatient cost

Features of Coordinated Care Programs

- These programs typically:
  - Teach patients about proper self-care, medications, how to communicate with providers
  - Monitor patients' symptoms, well-being, and adherence between office visits
  - Advise patients on when to see their physician
  - Apprise patients' physician of important symptoms or changes
  - Arrange for needed social support services
- Goal: reduce need for any hospitalization
  - Don't wait for the train wreck
  - Need ongoing contact for chronic illnesses

Medicare Coordinated Care Demonstration (MCCD) Programs

- Peikes, Chen, Schore, Brown; *JAMA* 2/11/09
- RCT in 15 sites:
  - Varied populations
  - Varied interventions
- Samples ranged from 934 to 2,657 for 12 sites
- Only 2 reduced hospitalizations

Key Components of Effective Care Coordination Models

- Target high risk patients
- Frequent in-person contacts by care coordinator
- Timely information on hospital/ER admissions
- Colocation of care coordinators and physicians
- Same care coordinator for all of physician's patients
- Strong patient education, guidance on taking Rx's
- Social supports for those who need it

The “Optimal” Care Coordination Model?

- Augment effective ongoing care coordination with transitional care
- *Offer* group education on self-management
- It's not just what you do, but how well:
  - Incorporate key features identified in MCCD
  - Use protocols to detail effective interventions
  - Focus on individual patients’ goals/needs

Possible Implications for Medicare

- Lessons for medical homes:
  - Several features associated with success, but…
  - Needs tighter targeting to save money
  - Not easy; adapt protocols of effective programs
  - Needs strong transitional care component
- Small practices will need other options for effective care coordination
- Create incentives for hospitals to adopt transitional care programs

Ongoing Research Issues

- What is the optimal target population?
- Episodic vs. continuous enrollment
- How best to provide transitional care
- How to provide care coordination effectively
- How to provide care coordination efficiently
- How best to target and provide social service supports

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