Successful Care Coordination and the ACA

Care Coordination for the Chronically Ill
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1. What do we know about effective care coordination?
2. What ACA provisions are likely to produce savings for Medicare?
3. What can we do to enhance the likelihood of success?
4. What are the major barriers to success?
The Best Evidence on Effective Care Coordination

- Significant favorable effects—only for high risk patients
  - Transitional care (Naylor, Coleman)
  - Medicare Coordinated Care Demonstration—4 sites
  - Care Management Plus model (Dorr; OHSU)
  - Geriatric Resources for Assessment and Care of Elders (GRACE) model (Counsell)
  - Mass. General Hospital high cost program

- Telephonic disease management programs don’t work
What distinguishes successful interventions?

1. **Face-to-face contact with patients**
   - Frequent face-to-face contact with patients (~1/month)

2. **Small enough caseload (e.g., 50-80)**
   - With ongoing training of and feedback to care managers

3. **Rapport with physicians**
   - Face-to-face contact through co-location, regular hospital rounds, accompanying patients on physician visits
   - Use same care coordinator for all of a physician’s patients

4. **Strong patient education**
   - Provide a strong, evidence-based patient education intervention, including how to take RX correctly and adhere to other treatment recommendations
What distinguishes successful interventions?

5. Managing care setting transitions
   • Have a timely, comprehensive response to care setting transitions (most notably from hospitals)

6. Being a communications hub
   • Care coordinators playing an active role as a communications hub among providers and between patients and providers

7. Managing medications
   • Comprehensive Rx management, involving pharmacists and/or physicians

8. Addressing psychosocial issues
   • Staff with expertise in social supports for patients who need it
Proposed Models in the ACA

- 20 models of care suggested in ACA for CMMI to test

- Ones that have promise of improved care coordination:
  - Patient-centered medical homes for high risk patients
  - Advanced payment ACOs
  - Geriatric assessment and comprehensive care plans (GRACE)
  - Care coordination through HIT and telehealth (high risk patients)
  - Community-based health teams to improve self-management
  - Fully integrated care for dual eligibles
  - Home health providers who offer multidisciplinary care teams
  - Coordinated care demonstration to test replicability of successful programs from MCCD for high risk patients

- Success will depend on how implemented

- Bundling models have less promise for chronic illness
require key features of successful past programs

focus on high risk patients

feed back information to programs and physicians

build in studies of operational issues

test dissemination now that core features are known
Potential Barriers to Success

1. Excessive attention to rapid cycle learning
   - Quick answers are often wrong answers (e.g., Guided Care, Wash U)
   - Takes time to learn, train, adapt, build rapport
   - So use intermediate outcomes and build in tests of program implementation issues (Mahoney)
   - Don’t sacrifice rigor of evidence for speed
   - Building on prior successes should shorten time to improvement

2. Lack of political will
   - Failure to withstand pressure from special interests (e.g., hospitals, MA plans) will thwart attempt to save

3. Lack of information and incentives for providers
   - Physicians need data on quality and efficiency—their own and specialists
   - Payment to providers should be tied to both factors
   - Resource use reporting should provide this