Care Coordination Programs for Improving Outcomes for High-Need Beneficiaries: What’s the Evidence?

Presentation to the Commission on Long-Term Care
Public Hearing
July 17th, 2013
Randy Brown
Overview

1. What does the evidence tell us about likely care coordination effects in fee-for-service Medicare?
2. What can we do to enhance the likelihood of success?
3. What are the major barriers to success?
The Best Evidence on Effective Care Coordination

- CBO review of 30+ programs (Jan 2012) found little favorable evidence
  - Telephonic-only disease management programs didn’t work
  - More personal care coordination programs didn’t save enough
  - Value-based purchasing yielded little or no savings

- Other studies show some significant favorable effects—but only for high-risk patients
  - Transitional care (Naylor and Coleman)
  - Medicare Coordinated Care Demonstration—four sites
  - Care Management Plus model (Dorr, OHSU)
  - Geriatric Resources for Assessment and Care of Elders (GRACE) model (Counsell)
  - Mass. General Hospital high-cost program
<table>
<thead>
<tr>
<th></th>
<th>Number of High-Risk Enrollees (% of all enrollees)</th>
<th>Control-Group Mean</th>
<th>Treatment-Control Difference</th>
<th>% Difference</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Quality Partners</td>
<td>273 (17)</td>
<td>0.90</td>
<td>-0.30</td>
<td>-33</td>
<td>0.02</td>
</tr>
<tr>
<td>Hospice of the Valley</td>
<td>1,138 (71)</td>
<td>1.34</td>
<td>-0.16</td>
<td>-12</td>
<td>0.07</td>
</tr>
<tr>
<td>Mercy Medical Center</td>
<td>904 (79)</td>
<td>1.03</td>
<td>-0.15</td>
<td>-15</td>
<td>0.02</td>
</tr>
<tr>
<td>Washington University</td>
<td>1,975 (71)</td>
<td>1.64</td>
<td>-0.13</td>
<td>-8</td>
<td>0.10</td>
</tr>
<tr>
<td>Combined</td>
<td>4,290 (60)</td>
<td>1.38</td>
<td>-0.15</td>
<td>-11</td>
<td>0.001</td>
</tr>
</tbody>
</table>
In Successful Interventions, Care Coordinators…

1. Had frequent face-to-face contact with patients (~ once/month)

2. Built strong rapport with patients’ physicians through face-to-face contact at hospital or office

3. Used behavior-change techniques to help patients increase adherence to medications and self-care

4. Knew when patients are hospitalized and provide support for transition home

5. Acted as a communications hub among providers and between patient and providers

6. Had reliable information about patients’ Rx and access to pharmacists or medical director
Best Approach Varies Across Subpopulations

- Different solutions, based on type of needs
- Need both managed care and fee-for-service models

<table>
<thead>
<tr>
<th>Beneficiaries</th>
<th>Managed Care</th>
<th>Fee-for-Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>In nursing homes</td>
<td>Evercare</td>
<td>INTERACT II</td>
</tr>
<tr>
<td>In community, using LTSS</td>
<td>PACE, and Commonwealth Care Alliance (CCA)</td>
<td>GRACE</td>
</tr>
<tr>
<td>Severe chronic illnesses, no LTSS</td>
<td>CareMore</td>
<td>MCCD, Mass. Gen.</td>
</tr>
<tr>
<td>Less severe chronic illness</td>
<td>High cost areas only</td>
<td>Physician Group Practice (PGP)</td>
</tr>
</tbody>
</table>
Whether the intervention is a medical home, accountable care organization, or comprehensive practice reform, it should incorporate these lessons:

- Require key features of successful past programs
- Focus effort on high-risk patients
- Feed information back to programs and physicians
- Build in studies of operational issues
- Test replicability of proven core features in other settings
Potential Barriers to Success (1)

1. Excessive attention to rapid cycle learning
   - Quick answers are often wrong answers
   - 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 will thwart attempt to save—fees/premiums have to be set low enough

3. Lack of information and incentives for providers
   - Physicians need data on quality and efficiency (own and others)
   - Payment to providers should be tied to both factors
   - Resource use reporting should provide this
Collaborators and Funding

- **Co-authors**
  - Debbie Peikes
  - Greg Peterson
  - Jennifer Schore
  - Arnold Chen

- **Funders**
  - Centers for Medicare & Medicaid Services
  - Robert Wood Johnson Foundation Health Care Financing and Organization (HCFO) grant
  - National Coalition for Care Coordination
Key Papers This Presentation Is Based On


For More Information

- Please contact
  - Randy Brown
    - rbrown@mathematica-mpr.com