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

Presentation to Commission on Long-Term Care Public Hearing
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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?
CBO review of 30+ programs (1/12) 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, Coleman, RED)
- 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
# Estimates from Medicare Care Coordination Demo

<table>
<thead>
<tr>
<th></th>
<th>Number of High-risk Enrollees (and % 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>-.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>-.16</td>
<td>-12</td>
<td>0.07</td>
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<tr>
<td>Mercy Medical Center</td>
<td>904 (79)</td>
<td>1.03</td>
<td>-.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>-.13</td>
<td>-8</td>
<td>0.10</td>
</tr>
<tr>
<td>Combined</td>
<td>4,290 (60)</td>
<td>1.38</td>
<td>-.15</td>
<td>-11</td>
<td>0.001</td>
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</tbody>
</table>
What distinguishes successful interventions?

Care Coordinators:

1. Have frequent face-to-face contact with patients (~1/month)
2. Build strong rapport with patients’ physicians through face-to-face contact at hospital or office
3. Use behavior-change techniques to help patients increase adherence to medications and self-care
4. Know when patients are hospitalized and provide support for transition home
5. Act as a communications hub among providers and between patient and providers
6. Have 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>
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<tbody>
<tr>
<td>In nursing homes</td>
<td>Evercare</td>
<td>INTERACT II</td>
</tr>
<tr>
<td>In community, using LTSS</td>
<td>PACE, CCA</td>
<td>GRACE</td>
</tr>
<tr>
<td>Severe chronic illnesses, no LTSS</td>
<td>CareMore</td>
<td>MCCCD, Mass. Gen.</td>
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<tr>
<td>Less severe chronic illness</td>
<td>??</td>
<td>PGP</td>
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</tbody>
</table>
How Can We Increase Likelihood of Success?

Whether FFS, shared savings, or managed care solutions are tried:

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

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
   - Payments or sharing of savings should focus on high risk patients
   - Physicians need data on quality and efficiency (own and others)
   - Payment to providers should be tied to both factors
Collaborators and Funding

- Co-authors of papers on which this was based:
  - Debbie Peikes, Greg Peterson, Jennifer Schore, Arnold Chen

- Funders
  - CMS
  - Robert Wood Johnson Foundation HCFO Grant
  - National Coalition for Care Coordination
Key References and Contact Information

- **Key papers on which this presentation is based:**
  - Brown, R, D Peikes, G Peterson, J Schore, and C Razafindrakoto. “Six Features of Medicare Coordinated Care Demonstration Programs that Cut Hospital Admissions of High-Risk Patients.” *Health Affairs* June 2012

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