ALL ABOARD! DESTINATION: HEALTH REFORM

THE NATIONAL ACADEMY FOR STATE HEALTH POLICY 22ND ANNUAL STATE HEALTH POLICY CONFERENCE

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Promising Models of Care Coordination in Medicare: Lessons for Medicaid Beneficiaries with Chronic Illnesses

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Roadmap

I. **The Problem**

II. **Successful Interventions for People with Chronic Illnesses**
- **Transitional care**
- **Self-management education**
- **Coordinated care**
- **Model that has maximum potential**

III. **Lessons for Medicaid**

I. The Problem

- **Most health dollars are spent on a small percentage of people with multiple, complex chronic conditions.**
- **Causes of high utilization and costs:**
  - **Deviations from evidence-based care**
  - **Poor communications among primary providers, specialists, other providers, and patients**
  - **Poor adherence by patients**
  - **Failure to catch problems early**
  - **Psychosocial issues**

What is effective care coordination?

Rigorous evidence of:

- **Improves patient outcomes**
- **Reduces total expenditures for recipients**
  - **Improved satisfaction or clinical indicators not sufficient**
- **Savings require reduced hospitalizations**

II. Promising Interventions

- **3 types of interventions have been proven effective for chronically ill adults:**
  1. **Transitional care interventions (Naylor et al. 2004 and Coleman et al. 2006)**
  2. **Self-care management interventions (Lorig et al. 1999, 2001 and Wheeler 2003)**
  3. **Coordinated care interventions (select sites from the Medicare Coordinated Care Demonstration, Peikes, Chen, Schore, Brown 2009)**

1. Transitional Care

- **Patients with chronic illnesses first engaged by APNs 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**
- **Naylor and Coleman approaches differ**
  - **Coleman empowers/coaches patients how to self manage (1 month) vs. more active care manager role in Naylor model (3 months)**

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

- Targeted patients age 65+ hospitalized for CHF
- Used advanced practice nurses (APNs)
- 12-week intervention; highly structured protocols: patient centered, medication reconciliation, early symptom recognition, symptom management, attend some physician visits, coordinate across providers
- 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 for 1 month
- Targeted patients aged 65+ hospitalized for various conditions
- Patients received (1) tools to promote cross-provider communication, (2) encouragement to take a more active role in their care, (3) continuity/guidance from transition coach, (4) medication review
- Nurses do not coordinate or manage care; they empower the patient/family to do so
- 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)

2. Self-Care Education

- **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 led by peers or educators**
- **Limited duration (typically 1-2 months)**

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

3. Care Coordination

- **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 health-related support services**
  - **Coordinate communication among physicians**
- **Goal: reduce need for hospitalizations**
  - **Don't wait for the train wreck**
  - **Need ongoing contact for chronic illnesses and more intensive contacts around acute events**

Medicare Coordinated Care Demonstration (MCCD) Programs

- **RCT in 15 programs:**
  - **Varied populations (only 7 percent were under age 65)**
  - **Varied interventions**
- **Samples ranged from 934 to 2,657 for 12 programs**
- **Only 2 programs reduced annualized hospitalizations (by 0.17 or 17% and 0.49 or 24%) (Peikes, Chen, Schore, Brown, JAMA 2/11/09)**
- **Subsequent work shows 4 programs reduced hospitalizations for higher-risk patients by 0.14 to 0.22/year**
  - **High risk patients-CAD, CHF, or COPD and a hospitalization in the prior year, or 2+ hospitalizations in the prior 2 years**

Keys to Success:
The Right Program to the Right People

1. **Targeting of patients at high risk of hospitalization**
2. **Staffing primarily by experienced registered nurses, with social supports available**
3. **Building rapport**
   - **With patients via some (~monthly) in-person contacts, not just by telephone**
   - **With physicians using different strategies:**
     - Colocation, past work together, accompanying patients to doctors visits, contacts during hospital rounds, linking 1 nurse with each doctor
4. **Early, comprehensive, and consistent response to hospitalizations**
   - **Access to timely information on hospital and ER admissions**

Keys to Success

5. **Medication management**
   - **Check for adverse interactions, polypharmacy, patient filling and taking RX. Obain assistance from a pharmacist or physician.**
6. **Strong self-care education**
   - **Support adherence to treatment recommendations, educate about early warning signs and when to call the doctor**
7. **Provide support services to patients when needed**
8. **Serve as communications hub between patients and providers**
   - **Share patient RX lists, reconcile RXs**
   - **Provide hospital staff with relevant patient information upon admission and assist patients following discharge**
   - **Make sure tests recommended by evidence-based guidelines are ordered on schedule and that providers have the results when they see the patient**

III. Lessons for Medicaid: The "Optimal" Care Coordination Model?

- **Lessons Need to be Adapted to Medicaid Recipients, Who Differ from Medicare Beneficiaries:**
  - **Younger**
  - **Generally have lower education and income levels**
  - **Fewer family and community supports**
  - **More substance abuse problems**
  - **More housing problems**
  - **Different mix of conditions:**
    - Higher prevalence of psychiatric conditions
    - Most MCCD sites excluded people with cognitive or psychological problems that would interfere with learning

The “Optimal” Model

- **Augment effective ongoing care coordination with transitional care**
- ***Offer* group education on self-management**
  - **Tailor educational materials to people with lower educational levels**
  - **Assess comprehension**
  - **(Not realistic in rural areas)**
- **Introduce proactive behavioral health screening and, if needed, treatment (including for substance abuse and alcohol addiction)**
- **Address social needs, such as housing, food, transportation**

Coordinate the Team

- **Multi-specialty service team**
  - **Nurse**
  - **Social worker**
  - **Pharmacist**
  - **Physician**
  - **Psychiatrist**
  - **Substance Abuse Treatment Provider**
- **How to coordinate?**
  - **Triage lead selects team leader, members based on patient needs**
  - **Regular, joint case reviews, plus ad hoc consultations**
  - **Electronic data sharing system**

The “Optimal” Model

- **It's not just what you do, but how well:**
  - **Incorporate key features identified in Naylor, Coleman, Lorig, Wheeler, and MCCD**
  - **Use protocols to detail effective interventions**
  - **Focus on individual patients’ goals/needs**
  - **Quality of patient interactions; education**
  - **Degree of physician trust**

How to Fit Care Coordination Into Medicaid Reform Options?

- **Who should provide it, and what are the challenges?**
  - **Medicaid FFS, HMO's--like MCCD, as a wrap-around service**
  - **Primary care practices, a la medical homes (like Chad Boult's Guided Care, which is for larger practices)**
  - **Hospitals (if hospitalization is "under warranty")**
  - **Accountable care organizations**
- **How much should Medicaid pay for it?**

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