



# Care Management of Patients with Complex Health Care Needs

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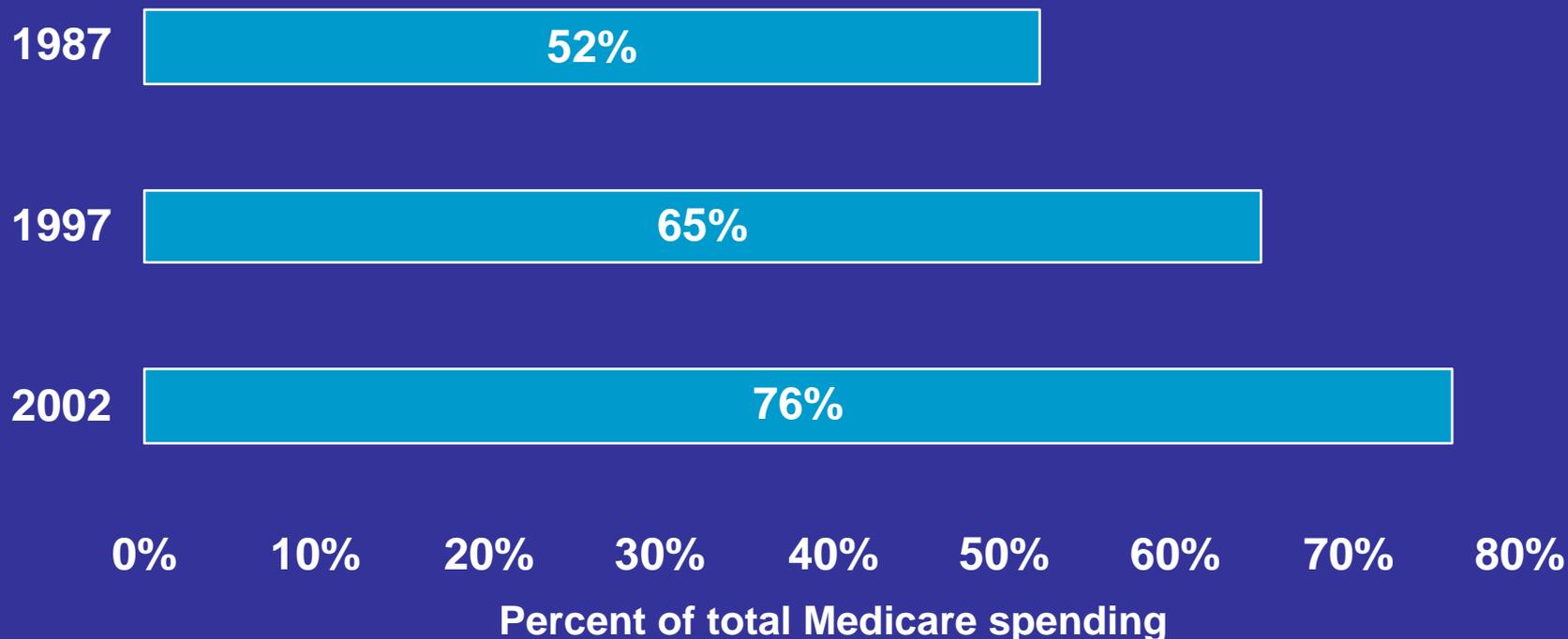


## Who are patients with complex health care needs?

- Multiple chronic conditions
- Frequent hospitalizations
- Many prescription medications
- Many care providers
- Limitation of daily functions
- High costs



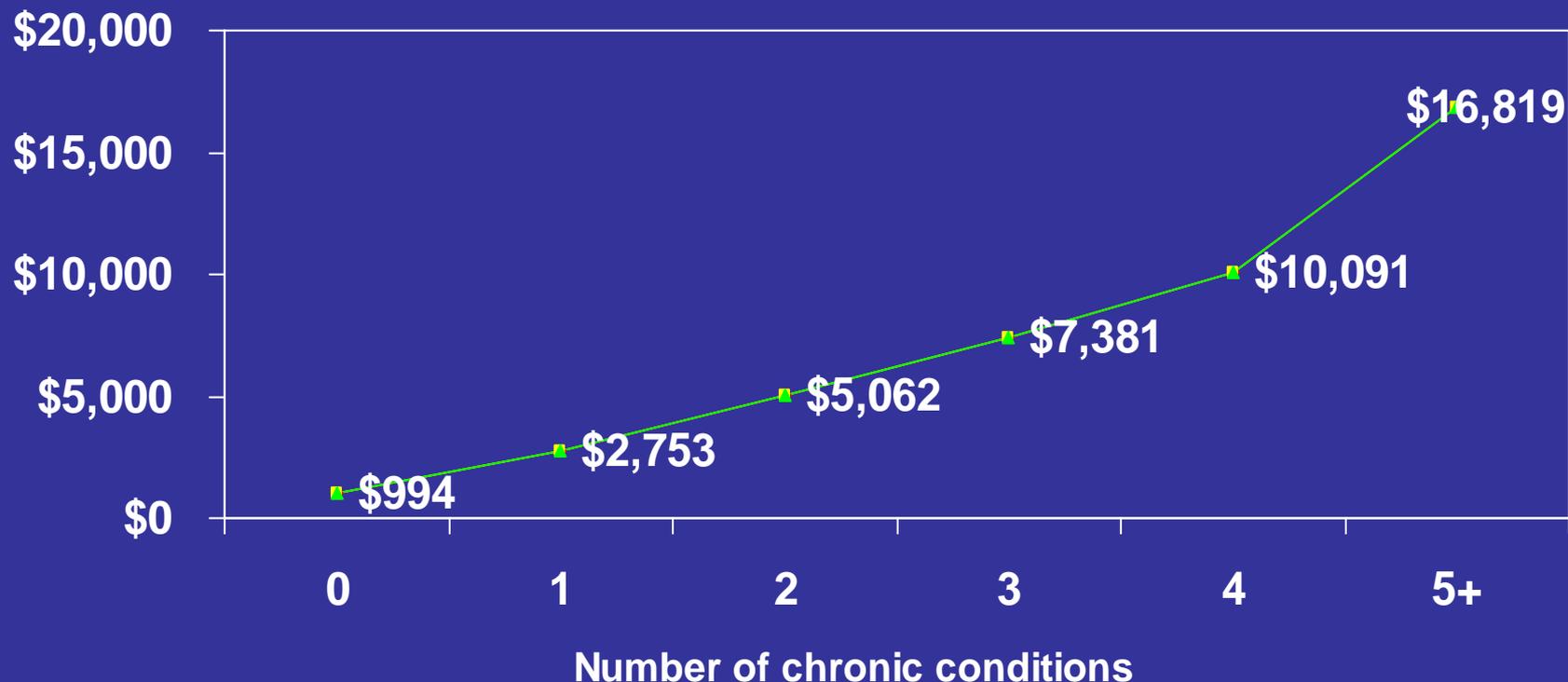
# Medicare spending for beneficiaries with 5 or more chronic conditions



Thorpe and Howard, Health Affairs Aug 22, 2006



# Average per capita spending by number of chronic conditions (2004)



Anderson, "Chronic conditions" Johns Hopkins, 2007



## How we did this study

- Literature reviewed since 1990 on care management and complex patients, excluding single chronic conditions
- Interviews with key researchers
- Interviews with leaders of organizations who have implemented innovative programs for complex, high-cost patients



## Questions addressed

- What is care management?
- How are patients identified?
- Do research-based care management programs enhance quality and reduce costs?
- How have research-based programs been adapted to real-world settings?
- How do payment policies influence care management programs?



## What is care management?

- Activities that assist patients and their support systems to manage medical and psychosocial problems with the aim of improving health and reducing the need for expensive medical services
- Care management is generally performed by RNs, sometimes with interdisciplinary teams



## Care management settings

- Primary care
- Vendor supported
- Integrated multispecialty group
- Hospital-to-home
- Home-based



## How are patients identified?

- Care management is an intensive, costly process requiring highly skilled personnel
- Care management shouldn't be offered to people who are too healthy or too sick to benefit
- Some predictive models:
  - Charlson Comorbidity Index
  - Chronic disease score
  - Hierarchical Condition Categories (HCC)
  - Adjusted Clinical Groups (ACG)
- Models work best if there is discussion with physician



## Do research-based care management programs improve quality and reduce costs?

- Primary care studies:
  - 7/9 studies: improved quality
  - 3/8 studies: reduced hospital use
- Hospital-to-home studies:
  - Many studies: improved quality, reduced re-hospitalization, reduced costs
- Inconclusive evidence:
  - Vendor supported
  - Integrated multispecialty group
  - Home-based



## Care management in primary care

- Three key studies:
  - Geriatric Resources for Assessment and Care of Elders (GRACE) (Counsel)
  - Care Management Plus (Dorr)
  - Guided Care (Boult)
- Common characteristics among studies:
  - Clinic visits, home visits, phone calls
  - Care management teams with extensive training led by RNs
  - Small case loads
- Reduced hospitalization for higher-risk subgroups participating in care management compared to control groups



# Hospital-to-home care management

- Two key studies:
  - Transitional Care Model (Naylor)
  - Care Transitions Intervention (Coleman)
- Key similarities:
  - Nurse care managers with extensive training
  - Patients visited during hospitalization and at home post-discharge
- Key differences:
  - Intensity of the intervention
  - Use of coaching
- Reduced hospital use compared to control groups



## Characteristics of successful care management programs

- Patient selection
- In-person encounters including home visits
- Specially trained care managers with low case loads
- Multidisciplinary teams including physicians
- Informal caregivers/family assisting the patient
- Use of coaching



## Limitations of research studies

### ■ Money:

- Studies provide research-funded personnel
- Studies provide funding for extensive care manager training

### ■ Patient mix:

- Usually patients with dementia are excluded, but they are prevalent among patients with complex health care needs
- Studies mix more and less complex patients



## How have care management programs been adapted to real-world settings?

- Medicare demonstrations: few show cost savings
- Program of All-Inclusive Care for the Elderly (PACE): hospital and nursing home utilization greatly reduced but it has been difficult to prove overall cost savings
- Hospital-to-home programs have been successful in real-world settings, but have required significant modifications
- High risk clinics have potential, examples include Kaiser Permanente Ohio region, VA geriatric primary care program, Urban Medical Group



## How do payment policies influence care management?

- Hospitals making more money from re-admissions have less of an incentive to have care management programs
- Primary care practices often are not reimbursed for RN care managers
- Integrated care systems and payers (Medicare, Medicaid, private insurers) have a financial incentive to implement care management for complex patients

## Policy implications

- Payment reform may improve the feasibility of care management by:
  - Providing incentives to hospitals to reduce readmissions
  - Reimbursing primary care practices for care management
  - Encouraging global payment approaches
- Primary care practices that are too small to support a RN care manager could aggregate (e.g. N Carolina Medicaid)



## Policy implications

- The nursing shortage will impact the success of care management
- Care manager training programs may be needed as care management programs increase
- Incentives for high-risk clinics may be an effective way to improve quality and reduce costs for complex patients



# Project Information

Web site: [www.policysynthesis.org](http://www.policysynthesis.org)

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