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

1987: 52%
1997: 65%
2002: 76%

Percent of total Medicare spending

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

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