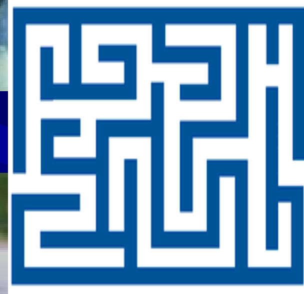
Fostering Better Care Coordination



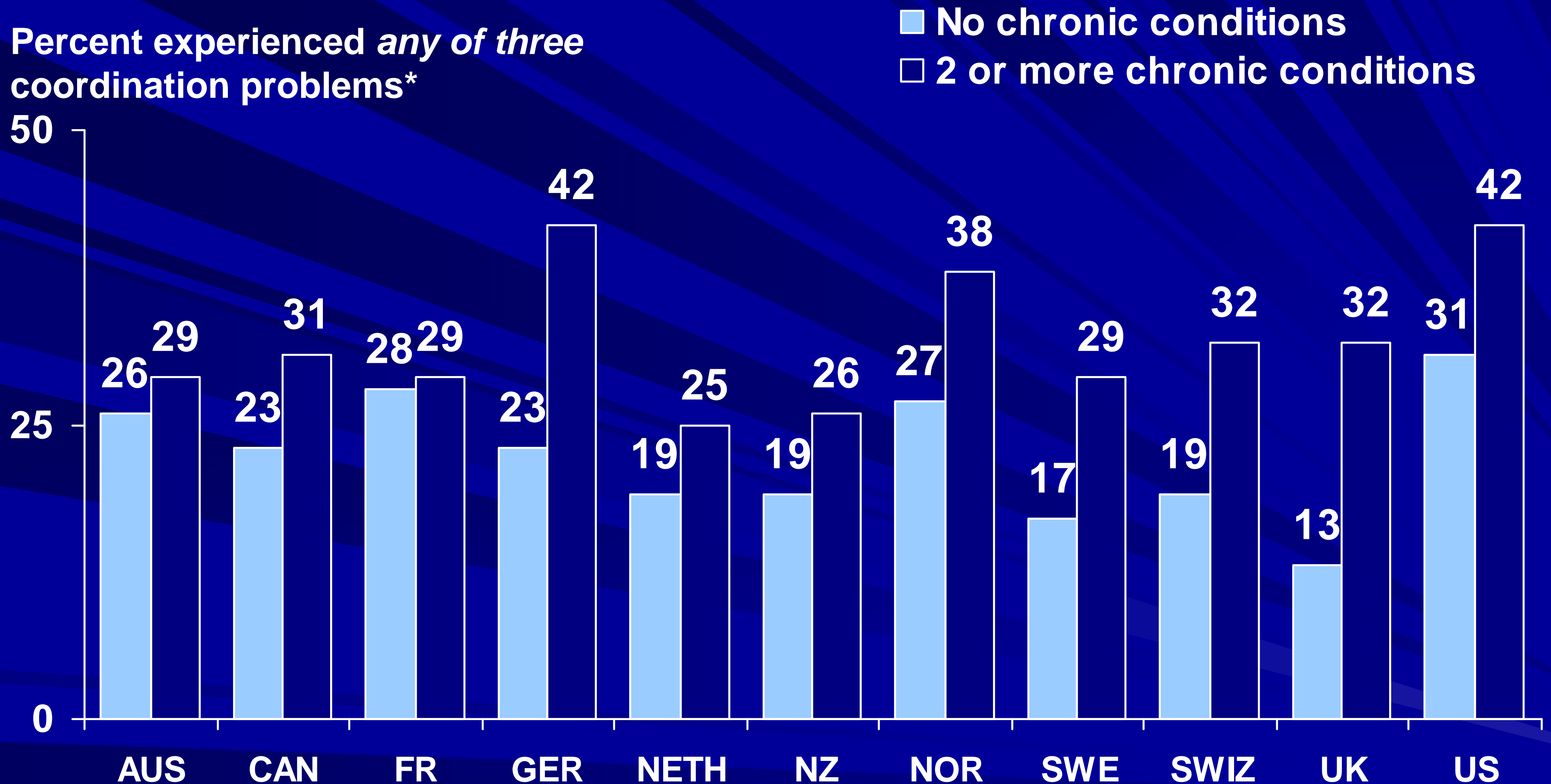
By Susan Dentzer
Editor-in-Chief, *Health Affairs*
The National ACO Summit
June 28, 2011

This presentation at a glance

- If it were easy, everyone would do it: the global deficit in care coordination
- Emerging models and older models with newer names
- Issues to overcome: How culture eats strategy for breakfast, and well-intended people for lunch
- Introductions to our panelists

The Global Deficit in Care Coordination

Patients Reporting Coordination Problems in the Past Two Years, by Number of Chronic Conditions

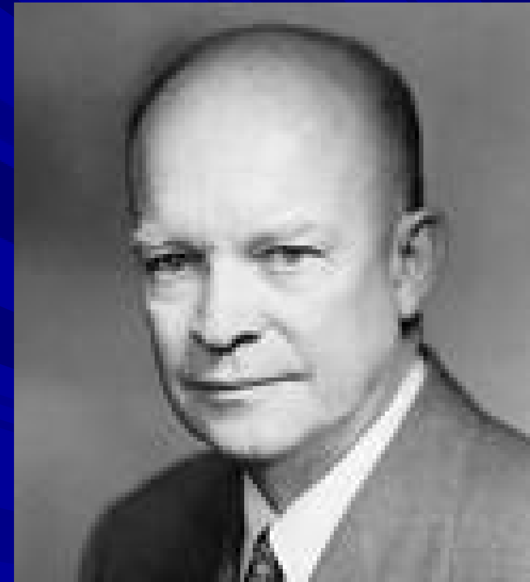


* Test results/records not available at time of appointment, received conflicting information from different health professionals, and/or doctors ordered test that had already been done.

Source: 2010 Commonwealth Fund International Health Policy Survey in Eleven Countries; *Health Affairs*, Nov. 2010

Once upon a time in America…

- We thought about admissions and hospitals, or outpatient care from doctors, and not so much about everything else
- Much disease acute
- Long lengths of stay (LOS) were the norm
- President Eisenhower and his 1955 heart attack; was hospitalized for 7 weeks
- Cost-based “reimbursement”



Then, times changed….

- Medical technology improved, so interventions worked
- People survived acute illness and went on to develop chronic disease; chronic illness now accounts for 75% of US health spending
- System shifted from cost-based reimbursement for hospital care to prospective payment/DRGs
- LOS fell and relatively rapid discharges became the norm
- Health-care delivery system remained siloed and fragmented, so that there was little integration between hospital care and care in the community
- Other issues, including poor medication adherence
- "Readmissions" result

Americans and Chronic Illness

- **Chronic disease is the #1 cause of death and disability in the US**
- **More Americans suffer from chronic illness than voted in the last Presidential election**
- **Expenditures on chronic illness account for 75% of total US health spending**
- **About 2/3 of the rise in spending over the past 20 years is linked to rising prevalence of chronic disease**

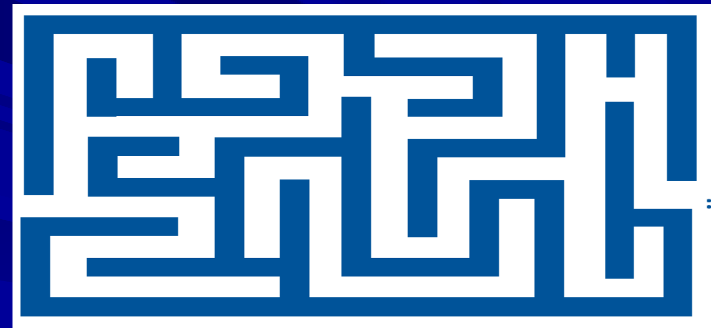
Source: Partnership to Fight Chronic Disease, Policy Platform, September 2007

Rising Prevalence of Multiple Chronic Conditions

- In 2000, 60 million Americans had multiple chronic conditions; 81 million projected by 2020*
- Prevalence increases with age
- Among those 65 and older, 62% have two or more chronic conditions; by 80, 73 percent have two or more
- *Sources: Johns Hopkins University, Partnership for Solutions, and Medical Expenditure Panel Survey, 2001

The "complexity consequences" of chronic illness

- Hoangmai H. Pham, MD, MPH (then of Center for Studying Health Systems Change, now of CMMI) and colleagues looked at care patterns for 1.79 million Medicare beneficiaries
- Over a given year, average patient saw two primary care physicians and five specialists working in a median of 4 practices
- For patients with chronic conditions, even more physicians and practices
- Over a two year period, almost ½ of beneficiaries were assigned to a new physician
- Source: Pham HH et al, "Care patterns in Medicare and their implications for pay for performance," NEJM 2007; 356: 1130-1139



The lack of care coordination is in part the legacy of these huge systemic changes and non-adaptations

The "ad-hoc-racy" comes home

- David M Lawrence, former Chairman and CEO, Kaiser Permanente
- "My Mother And The Medical Care Ad-Hoc-Racy"
- Narrative Matters in *Health Affairs*, March/April 2003; 22(2): 238-242.

What happened

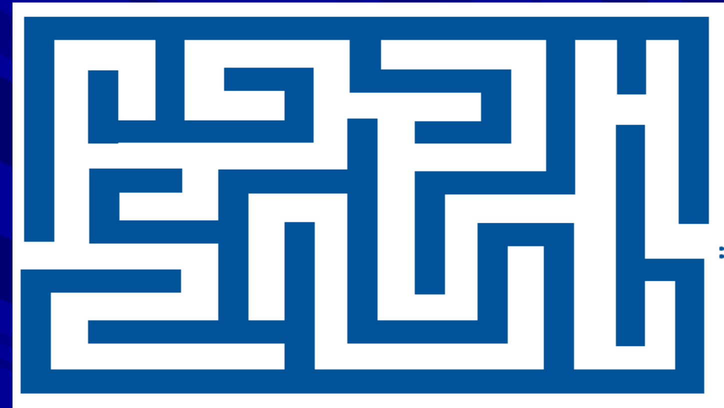
- Lawrence's mother, at the time an 88 year-old widow, falls at friend's home and breaks femur just below hip
- Waits 30 minutes for ambulance; several hours in ED
- Two hour operation followed by 3 days in hospital; then discharged to a skilled nursing facility for intensive physical therapy
- Five months later, she moves home

What really happened:
The “complex web of care”

- Ten different doctors cared for her during hospitalization and nursing home stay
- At least 50 different nurses and a host of nurses’ aides (from Ethiopia, Eritrea, El Salvador, Brazil, Cambodia and Vietnam)
- Ten physical and occupational therapists
- Four social workers
- Grand total: More than 80 different providers

Gaps and disconnects in care

- Hospital had electronic health record system but records had to be printed out and carried to the nursing home
- One physical therapist insisted patient could walk one week post-surgery even though surgeon had ordered otherwise
- Nurses disagreed about how to give her heparin injections and argued about it in her presence



Sub-optimal quality and communication

- Lawrence's mother had previously had a cancerous growth removed from foot by dermatologist
- Wound had not healed and bled during physical therapy
- Dermatologist was on vacation and his records inaccessible

What Happens Next…

- She is taken to wound care clinic where specialists discover that treatment dermatologist had given her was out of date and retarded healing process

- She begins proper treatment, having lost a week of physical therapy on top of unnecessary months of suffering

“Pick-up soccer”

- “At times mom’s care seemed like a pick-up soccer game in which the participants were playing together for the first time, didn’t know each other’s names, and wore earmuffs so they couldn’t hear each other.”
- “Her care seemed like an ‘ad-hoc-racy’ that involved well-trained and well-intentioned people, state-of-the-art facilities, and remarkable technologies –but was not joined into a coherent whole for the benefit of her or her family.”

"Crossing the Quality Chasm: A New Health System for the 21st Century"*

- **Health care should be**

  - **Safe**
  - **Effective**
  - **Patient Centered**
  - **Timely**
  - **Efficient**
  - **Equitable**

  i.e., Coordinated!

*Source: Institute of Medicine, 2001

“Still Crossing the Quality Chasm”

- April 2011 issue of *Health Affairs*
- Much progress; much remains to be done

Reducing avoidable readmissions

- **In an analysis of 2003–2004 Medicare claims data, 20% of hospitalized patients were re-hospitalized within 30 days after discharge.**

- **34% readmitted within 90 days**

- **Nearly half of the Medicare patients who are rehospitalized within 30 days did not have a physician visit between the time of discharge and readmission.**

- Source: Jencks S.F., Williams M.V., Coleman E.A.
  N Engl J Med 2009; 360:1418 - 1428

Now, a fork in the road

Fork in the Road

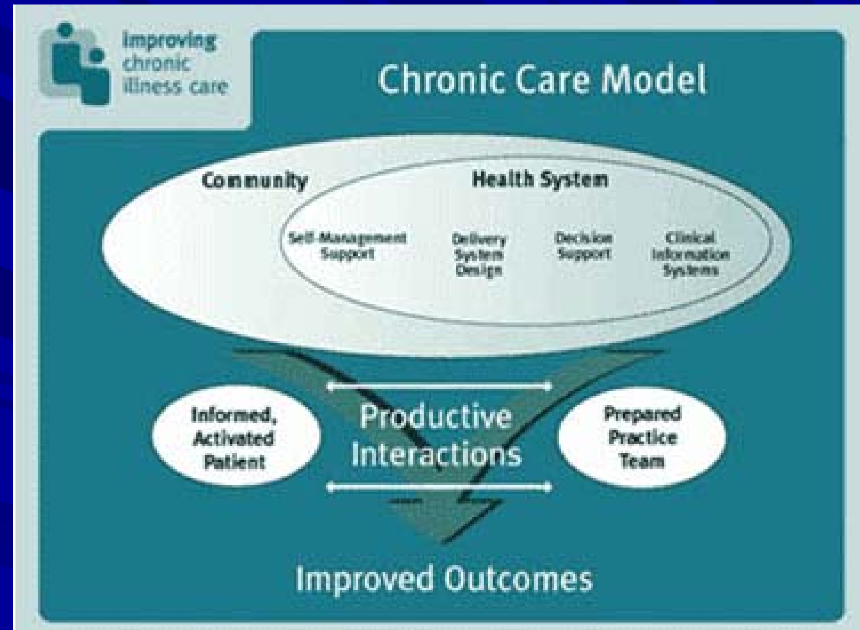
- Down one route:
  - Stick largely with the current payment (FFS-PPS) and delivery (fragmented) systems
  - Try to "hammer" coordination into it; figure out some way to compensate organizations for care coordination even though separate
- Down the other route:
  - Move to more integrated delivery systems and new payment (population-based, modified capitation)
  - Put the reengineered systems in charge of being "coordinated" within their walls

Fork #1 Tools

- Readmissions program
- Medical homes
- Community-based care transitions program
- Federal coordinated care office to better coordinate care of dual eligibles
- Medicare Shared Savings Program

The Solutions?

- **Chronic Care Model**
- **Includes:**
  - **organizational support**
  - **clinical information services and disease registries**
  - **team-based care**
  - **case management**
  - **regular follow-up**
  - **For patient: decision support, self-management support, community resources**



The Solutions?

- The “Patient-Centered Medical Home”*
- Based on ongoing personal relationship with physician who provides and coordinates continuous and comprehensive health care through team of health care professionals
- Care is coordinated across health care system (hospitals, home health agencies, nursing homes, consultants etc.
- *Source: American Academy of Pediatrics, American Academy of Family Physicians, American Osteopathic Association, American College of Physicians joint statement of principles, February 2007

The Patient-Centered Medical Home

- Evidence-based medicine and clinical decision-support tools
- Physician accountability for continuous quality improvement through voluntary performance measurement
- Information technology supports optimal patient care, enhanced communication
- Open scheduling, expanded hours
- Now: the Medicare Advanced Primary Care Practice Demonstration

Community-based Care Transitions Program

- Mandated by section 3026 of ACA; unveiled as Part of Partnership for Patients
- Goal: Improve transitions of beneficiaries from inpatient to other care settings; improve quality of care; reduce readmissions; document savings to Medicare
- Eligible entities = hospitals with high readmission rates (e.g., above 20% for AMI and above 27% for heart failure)
- Hospitals must partner with community-based organizations that provide care transition services

Multi-Payer Advanced Primary Care Practice Demonstration

- 8 states now participating
- Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota
- Demonstration will ultimately include up to approximately 1,200 medical homes serving up to one million Medicare beneficiaries
- Health professionals to receive “more coordinated” payment from Medicare, Medicaid and private health plans

Medicaid “Health Homes”

- New State plan option allows patients enrolled in Medicaid with at least two chronic conditions to designate a provider as a “health home” to help coordinate treatments for the patient
- States that implement will receive enhanced financial resources from the federal government to support “health homes” in their Medicaid programs
- The Innovation Center to assist with learning, technical assistance and evaluation activities

Reducing avoidable readmissions

- Under Affordable Care Act, beginning in FY 2013, PPS hospitals with higher-than-expected readmissions rates will experience decreased Medicare payments
- In FY 2013, the reduction cannot be greater than 1 percent. In FY 2014, it cannot be larger than 2 percent, and in FY 2015 and beyond, it cannot be greater than 3 percent.
- Hospital performance will be evaluated based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program and reported on Hospital Compare
- The ACA requires the Centers for Medicare & Medicaid Services to modify the measures to exclude planned readmissions, as well readmissions that are unrelated to the first admission
- CMS Office of the Actuary (OAct) projects that this provision, when fully implemented, will reduce Medicare costs by $8.2 billion from implementation through 2019.
- CMS has not indicated when it will publish proposed rule

State Demonstrations to Integrate Care for Dual Eligible Individuals

- Dual eligibles = approximately 9 million; account for about $300 billion annually in Medicare and Medicaid spending
- In Medicaid, duals = 15% of enrollment but account for 39% of costs
- 15 states awarded contracts of up to $1 million to support development of new integrated care models that can be rapidly tested and, upon successful demonstration, replicated in other states.
- Aimed at improving care quality, care coordination, cost-effectiveness and overall experience of beneficiaries eligible for both Medicare and Medicaid and CHIP
- States selected: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, Wisconsin.

Comparable Actions,

Private Sector

- WellPoint: In recent years, has raised payments to hospitals in 14 states that serve its Blue Cross Blue Shield plans, which cover 34 million people, by an average 8%
- Replacing with pay-for-value system
- Will pay increases only to hospitals that score high enough on 51 indicators
- Include whether hospital is working to prevent unnecessary readmissions, follows surgical safety checklist ; patients satisfaction (CAHPS)

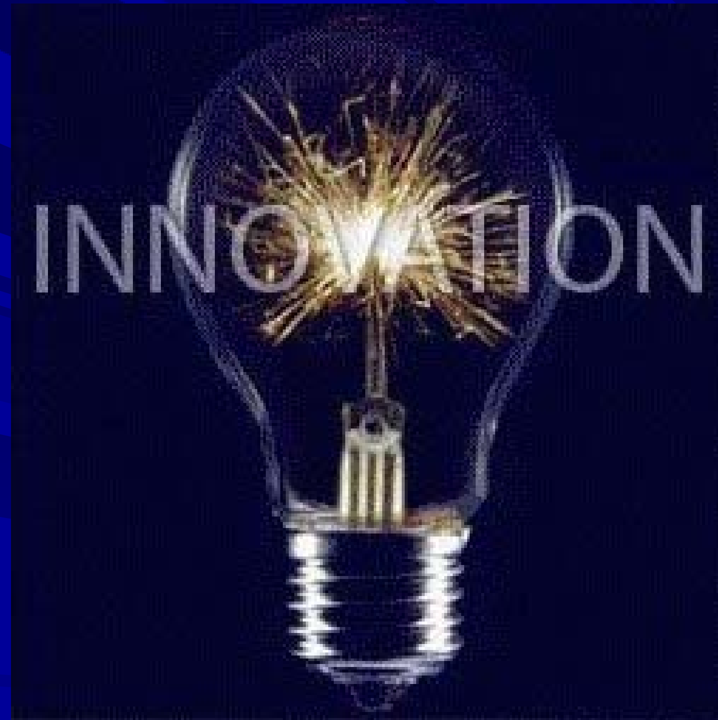
Fork # 2 Tools

- Accountable care organizations – Pioneer program version
- Fact that, if any pilots or tests (including ACO program) achieves stated goals of improving or not reducing quality and reducing spending, Secretary can expand across entire Medicare program

"When you come to a fork in the road, take it."

--Yogi Berra

Innovations Under Way



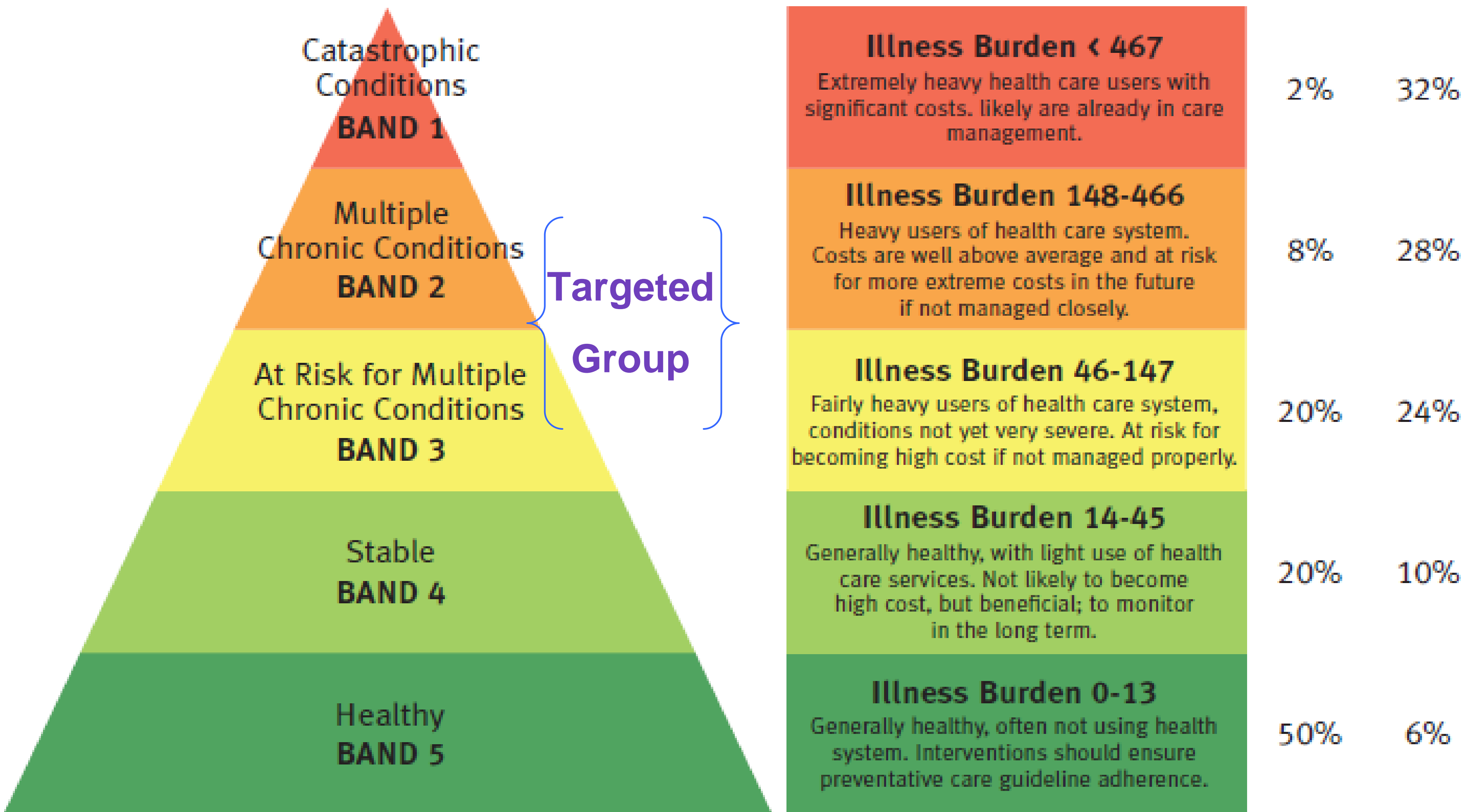
What Participants Said

- **From government: Make Medicare claims data available in real time**
- **Give providers data on “attributable” patients**
- **Support expansion of infrastructure – e.g., HIT**
- **From themselves: Time for them to “get outside the building” and form relationships with others in community who promote health and deliver care**

"A Model For Integrating Independent Physicians Into Accountable Care Organizations"

- Advocate Physician Partners, affiliated organization to Advocate Health System, largest hospital system in Illinois
- Author Mark C. Shields, vice president for medical management of Advocate Health Care and senior medical director of Advocate Physician Partners, in Mt. Prospect, Illinois; et al.
- Model for organizing independent physicians into partnerships with hospitals to improve care, cut costs, and be held accountable for the results.
- Signed its first commercial ACO contract effective January 1, 2011, with the largest insurer in Illinois, Blue Cross Blue Shield
- Other commercial contracts are expected to follow
- Source: Health Aff January 2011 30:1161172; published ahead of print December 16, 2010, 10.1377/hlthaff.2010.0824

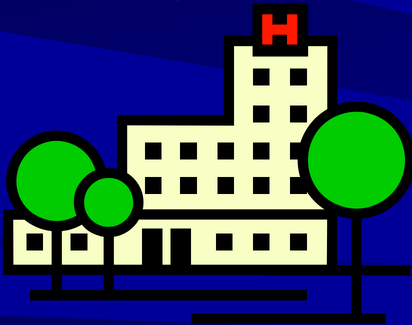
CareFirst Blue Cross/Blue Shield:
Focusing on High-Risk Patients



Advanced Illness Management (AIM)

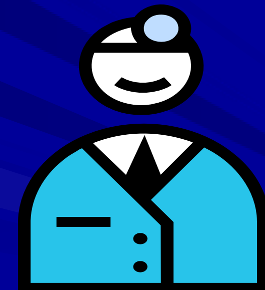
Integrated Care for Patients With Late-Stage Chronic Illness

Brad Stuart, M.D.
Senior Medical Director
Sutter VNA & Hospice
Fairfield, CA



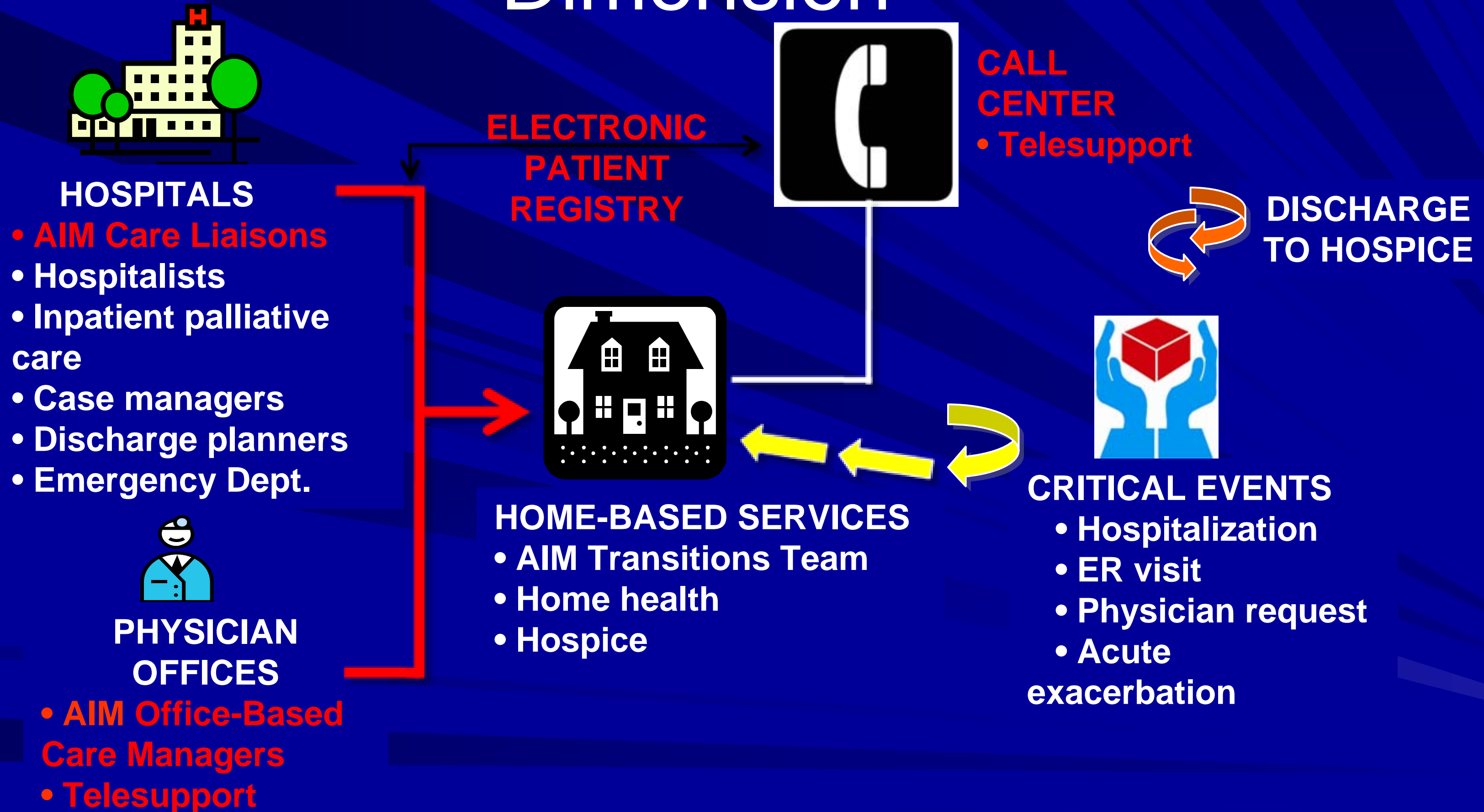
Hospitals

Home-Based Services



Medical Foundations & Groups

Sutter VNA & Hospice: Care Coordination, Spatial Dimension



Sutter VNA & Hospice: AIM 2.0 Preliminary Outcomes Sample period: 11/9/09-9/30/2010

	Days Pre/Post AIM Enrollment		
	30	60	90
N	185	121	96
Δ Hospitalizations	-68%	-59%	-63%
Total Direct Cost Savings*	$394,326	$475,305	$573,581
Savings/Enrollee/Month*	$2131	$1964	$1992
Excellent patient satisfaction			
Excellent physician satisfaction			

*Includes savings from reduction in Emergency Department and hospital-based outpatient services

By Glenn D. Steele, Jean A. Haynes, Duane E. Davis, Janet Tomcavage, Walter F. Stewart, Tom R. Graf, Ronald A. Paulus, Karena Weikel, and Janet Shikles

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ANALYSIS & COMMENTARY

How Geisinger's Advanced Medical Home Model Argues The Case For Rapid-Cycle Innovation

ABSTRACT The Patient Protection and Affordable Care Act of 2010 provides for a number of major payment and delivery system initiatives. These potential changes need to be tested, scaled, and adapted with an urgency not evident in previous demonstration projects of the Centers for Medicare and Medicaid Services. We discuss lessons learned from our iterative tests of care reengineering at Geisinger—specifically, through our advanced medical home model, ProvenHealth Navigator℠, and the way we continuously modified the model to improve quality and value. We hypothesize that the most important ingredient in our model has been the embedding of nurse case managers into our community practices and the real-time feedback of data on the use of health services by the most complex patients.

Glenn D. Steele (gsteele@geisinger.edu) is president and chief executive officer of Geisinger Health System, in Danville, Pennsylvania.

Jean A. Haynes is president and chief executive officer of Geisinger Health Plan, in Danville.

Duane E. Davis is vice president and chief medical officer of Geisinger Health Plan.

Janet Tomcavage is vice president of health services for Geisinger Health Plan.

Walter F. Stewart is director of Geisinger Health System Center for Health Research, in Danville.

Tom R. Graf is chairman of community practice for Geisinger Health System.

Ronald A. Paulus is president

The Patient Protection and Affordable Care Act of 2010 contains a large portfolio of major payment and delivery system reengineering initiatives recently summarized by Stuart Guterman and colleagues at the Commonwealth care shared savings program or accountable care organization provisions of the Affordable Care Act in January 2012 (personal communication from Stuart Guterman to Glenn D. Steele, July 7, 2010).

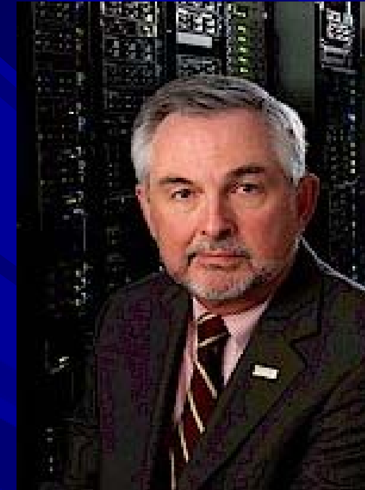
The nation simply cannot afford another

"We hypothesize that the most important ingredient in our model has been the embedding of nurse case managers into our community practices and the real-time feedback of data on the use of health services by the most complex patients."

Source:
***Health Affairs*,**
2010 Nov; 29(11):2047-53.

Geisinger's ProvenHealth Navigator

- Chronic care management, Medical Home, and Patient-Centered Primary Care
- 360-degree, 24/7 continuum of care
- System-wide EHR
- "Embedded" nurses in primary care practices
- Assured easy phone access
- Telephonic monitoring/case management
- Personalized tools (e.g., chronic disease report cards)



Glenn Steele, CEO Geisinger

Geisinger
Health System

Geisinger Health System: Hospital Admission Rates For Patients in Medical Home

Source:
Health Affairs,
2010 Nov; 29(11):2047-53.

Forthcoming in *Health Affairs*, July 2011

- State Action on Avoidable Rehospitalizations (STAAR) initiative
- Project of the Institute for Healthcare Improvement
- 148 hospitals and more than 500 “cross-continuum” team partners in four states (Massachusetts, Michigan, Washington, and Ohio)
- “Cross-continuum teams” =hospitals partnering with home health agencies, nursing facilities, office practices, community-based support services, and patients
- Multistakeholder state-level steering committees
- Source: Amy Boutwell et al, Health Affairs, forthcoming

The “Human Element”

- “Physician Practices To Patient-Centered Medical Homes: Lessons From The National Demonstration Project”

- Report on the country’s first national medical home demonstration, June 1, 2006, to May 31, 2008
- 36 practices
- Conclusions: Transformation can be lengthy and complex
- Requires an internal capability for organizational learning and development
- Requires changes in the way primary care clinicians think about themselves and their relationships with patients as well as other clinicians on the care team
- Practices may require three to five years of external

  assistance” to change
- *Source: Paul Nutting et al, Health Affairs, March 2011 30:3439; 10.1377/hlthaff.2010.0159*

The challenge of complexity in health care

- **Paul E. Plsek and Trisha Greenhalgh: Health care is a "complex adaptive system," not a "clockwork universe"***
- **Complex adaptive systems characterized by collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions change the context for other agents**
- *Source: *British Medical Journal* 2001; 323:625-628

The challenge of complexity in health care

- **Plsek and Greenhalgh: Complex adaptive systems characterized by fuzzy boundaries between agents; membership can change; relationships are non-linear**

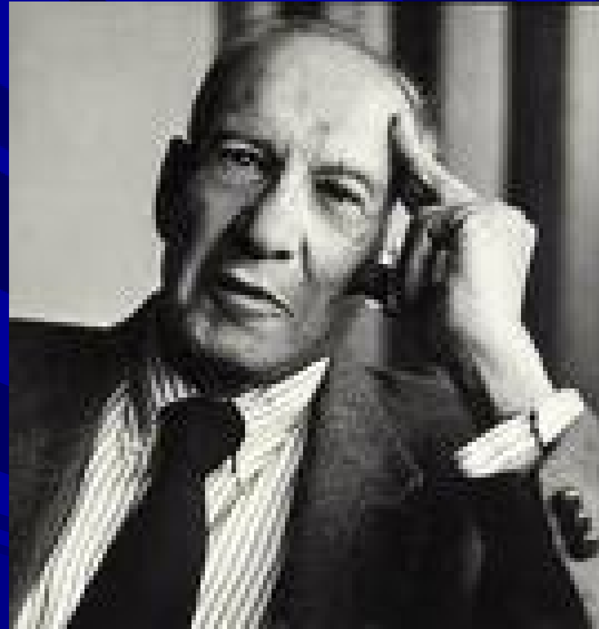
- **Like a termite colony; typical colony of 60,000 termites construct highest structures on planet relative to size of their builders, but there's no "chief executive termite" and no blueprint**

Size of termite:
Up to ¼ inch

Size of colony:
average 8.2 feet

The challenge of complexity in health care

- Our instinct is “to troubleshoot and fix things – in essence to break down the ambiguity, resolve any paradox, achieve more certainty and agreement and move into the simple system zone/”
- “Complexity science suggests that it is often better to try multiple approaches.”



“ Culture eats strategy for breakfast.”

[Addendum: “And well-intentioned people for lunch.”]

--attributed to management expert
Peter Drucker, 1909-2005

“It's *supposed* to be hard. If it *wasn't* hard, everyone would do it!”

-- Actor Tom Hanks as baseball coach Jimmy Dugan In *A League Of Their Own*, 1992

“There has never been a better time to be an Innovator in health care.”

--Don Berwick, administrator, CMS
Military Health System conference
January 2011

“We always need to remember that behind almost every great moment in history, there are heroic people doing really boring and frustrating things for a prolonged period of time.”

– Gail Collins, *The New York Times*, August 13, 2010

The End