Chronic Care Management: What Works, What Doesn't and How To Be Successful in Medicare's Chronic Care Improvement Program

George Taler, MD

Director, Long Term Care

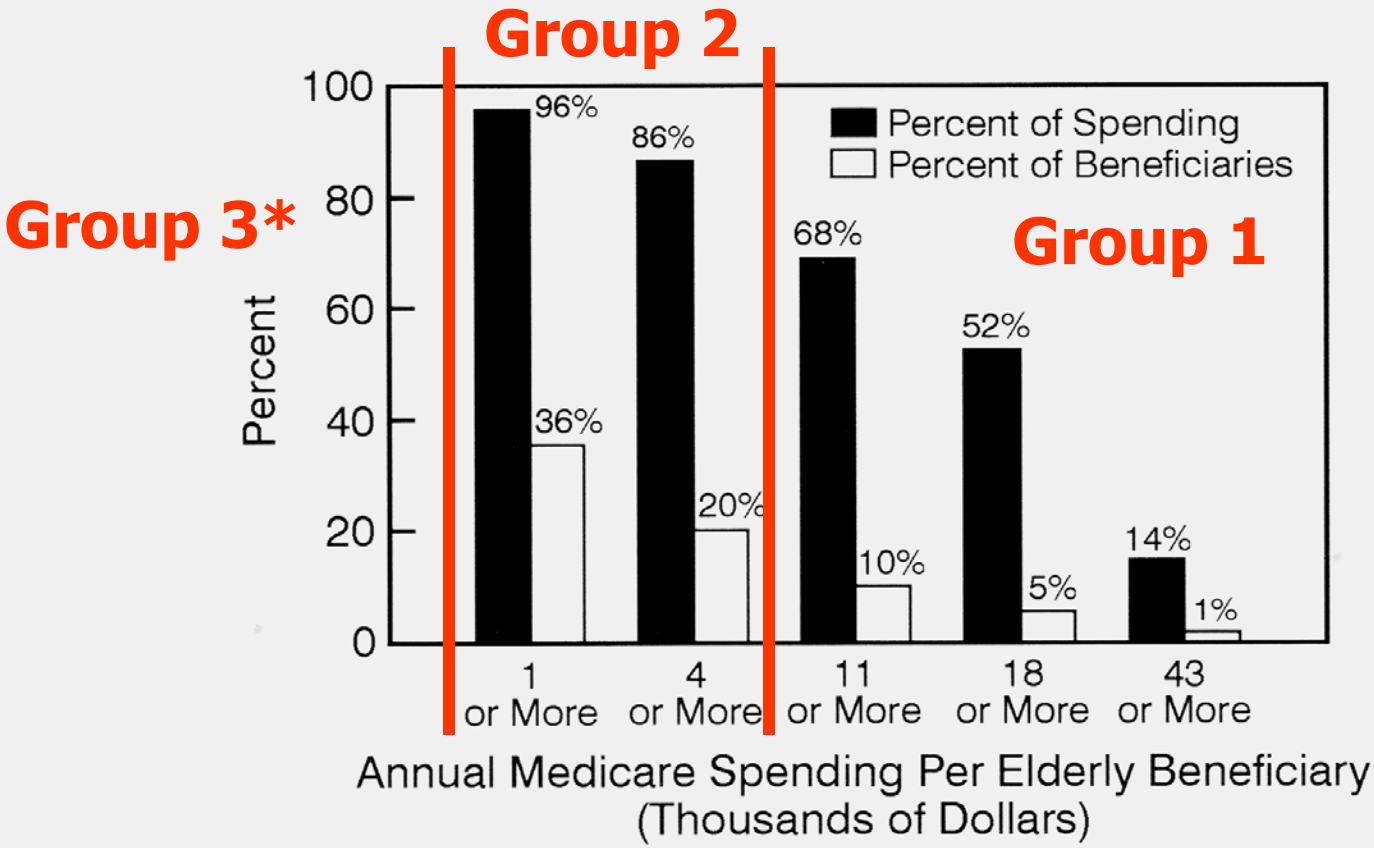
Washington Hospital Center

Key Points

- A small segment of the population is responsible for a disproportionate share of medical costs under Medicare and Medicaid
- These patients are not well served in the current systems of primary and specialty care
- Innovative approaches are required to overcome structural problems inherent in the organization of health care delivery

Distribution of Medicare Spending For Elderly Beneficiaries, 1993

5% Of Beneficiaries Account For 52% Of Spending



Source: HCFA/Office of the Actuary; data from 10% sample from 1993 Continuous Medicare History File (does not include HMO enrollees)

* Group 3 represents the remaining 64% of beneficiaries, using 4% of spending

Dissecting the Demographics

Group 3

- 66% of pop / 4% of costs
- Non-hospital care
- Care needs:
  - 1° Prevention
  - Administrative
  - Episodic urgent care

Group 2

- 24% of pop / 28% of costs
- Non-hospital care
- Care needs:
  - Disease management
  - 1° & 2° Prevention
  - Administrative
  - Episodic urgent care

Who Are The High-Cost Users?

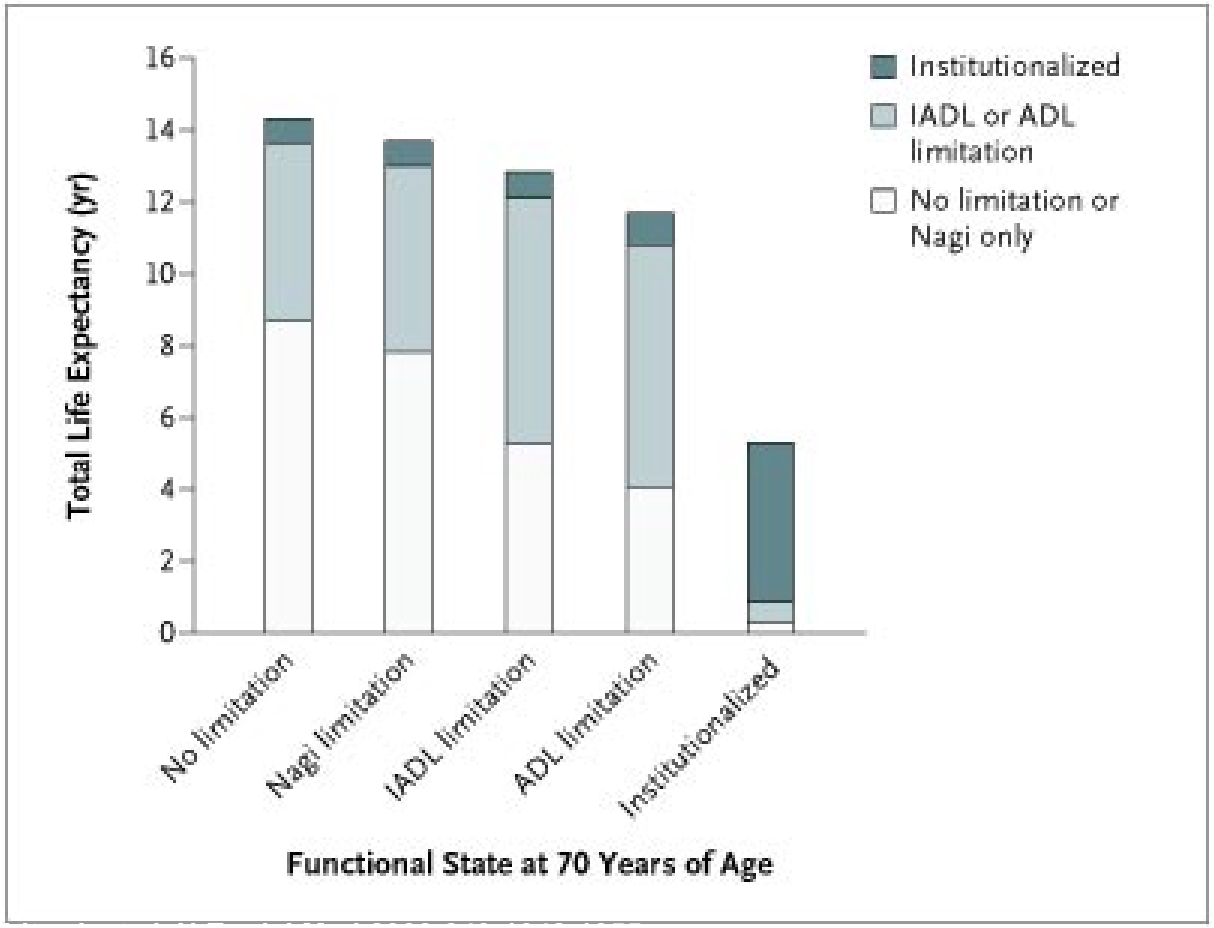
Group 1

- Catastrophic Illness → Dead or well
  - Myocardial Infarction
  - Cancer
  - Stroke
- Major Trauma → Dead, in rehab or well
- Advanced Chronic Illness (80%) → Perpetually at High-Risk for High-Cost Care
  - CHF/CAD
  - DM
  - COPD

Health Care Spending By Age and Service Type

Service	**65-69**	**70-74**	**75-79**	**80-84**	**85+**
Average $	6,711	8,099	9,241	10,683	16,596
In-patient %	37,8	33.1	31.4	29.4	22.1
Out-patient %	37.2	38.5	33.5	27.9	17.4
Cust NH %	4.3	7.9	14.0	21.8	45.5
SNF/HCA %	2.3	4.3	7.0	9.4	9.2
Drugs %	13.3	12.0	10.7	8.8	4.0
Other %	5.2	4.2	3.3	2.7	1.8

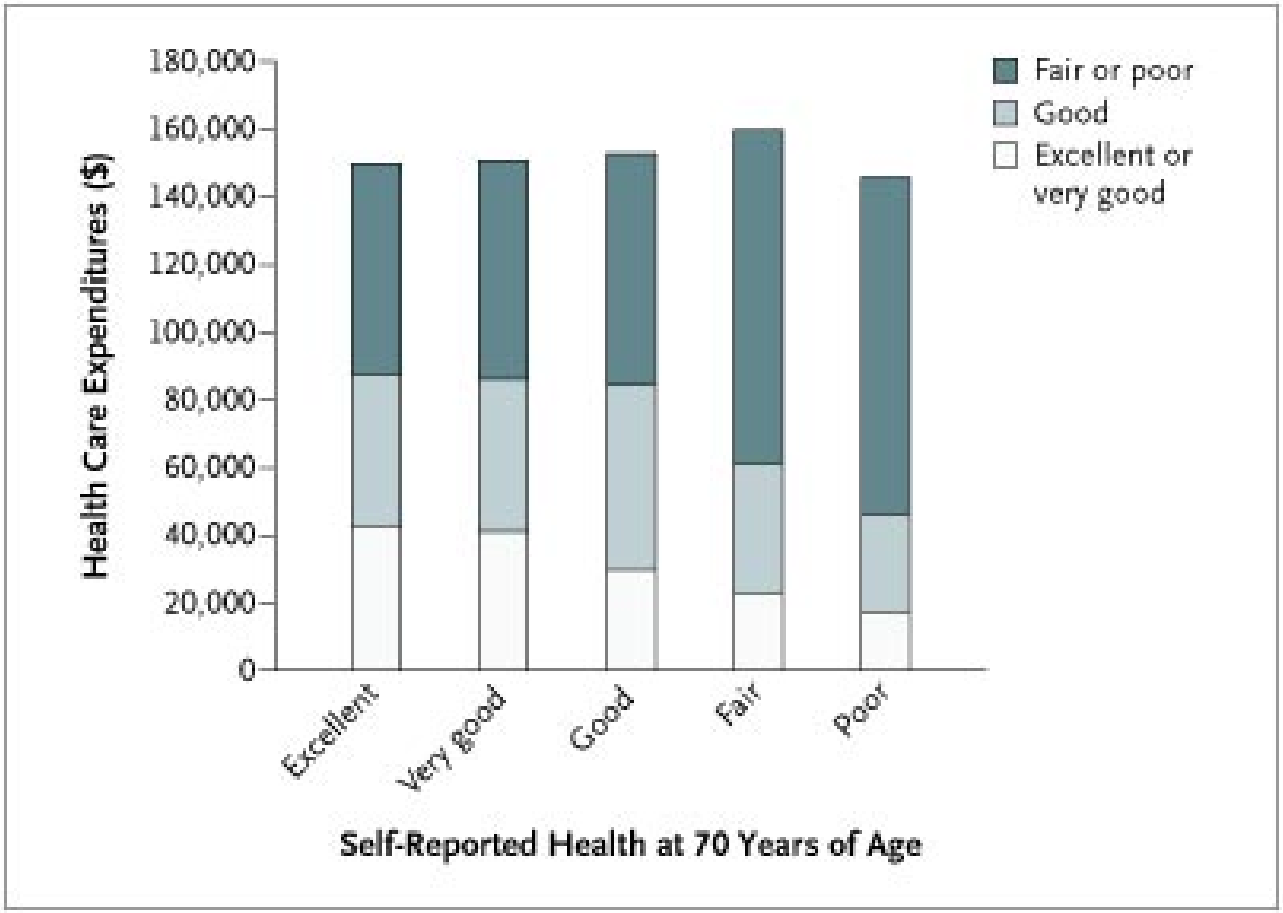
Life Expectancy by Functional Status @ 70



Lubitz J, Cai L, Kramarow E, Lentzner H. Health, Life Expectancy, and Health Care Spending among the Elderly. N Eng J Med 2003;349:1048-1055

The NEW ENGLAND JOURNAL of MEDICINE

Health Care Expenditures by Self-Reported Health Status @ 70



Lubitz J, Cai L, Kramarow E, Lentzner H. Health, Life Expectancy, and Health Care Spending among the Elderly. N Eng J Med 2003;349:1048-1055

The NEW ENGLAND JOURNAL of MEDICINE

High-Cost Users + ↓Fx = Frailty

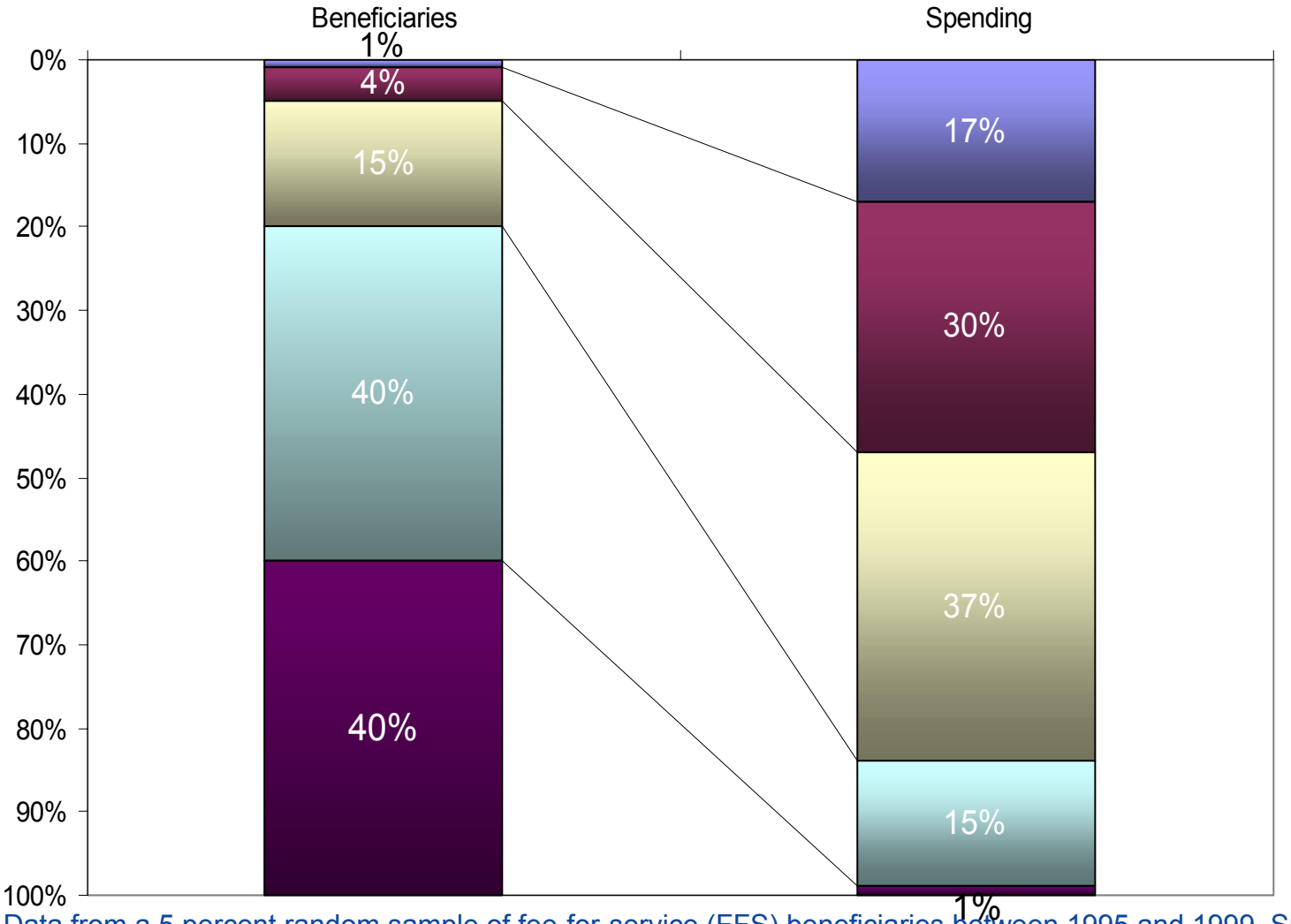
- Multiple, irremediable chronic conditions
- Require ongoing medical management
- Associated with functional impairment
- Frequent hospitalizations
- High-risk of institutionalization
- Transitioning to end-of-life care

Concentration and Persistence of Medicare Spending: Implications for Disease Management

GWU National Health Policy Forum "From Disease Management to Population Health: Steps in the Right Direction?"

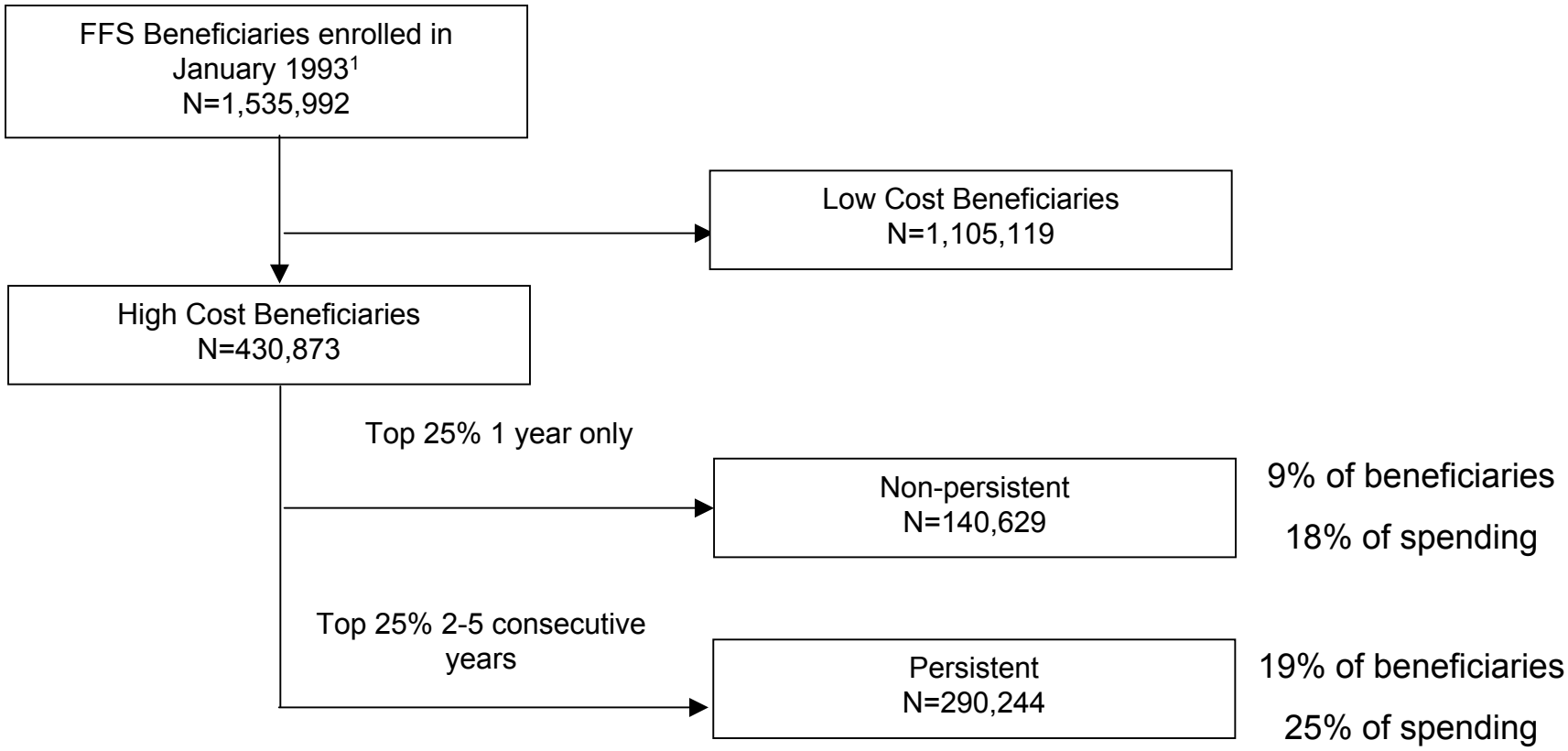
Amber E. Barnato, MD, MPH, MS
Assistant Professor of Medicine and Health Policy and Management
University of Pittsburgh
Visiting Scholar, Congressional Budget Office

Distribution of Medicare Spending and Beneficiaries



Notes: Data from a 5 percent random sample of fee-for-service (FFS) beneficiaries between 1995 and 1999. Spending reported in 1999 dollars. Source: CBO preliminary analysis.

Persistence of Medicare Spending



Notes: "High cost" cohort defined as those beneficiaries who, over the 5 years between 1993 and 1997, consumed 75% of total Medicare resources (this amounted to 28% of all beneficiaries, some of whom were persistently expensive, others who were not). Source: CBO preliminary analysis.

Prevalence of Chronic Conditions

Beneficiary Group (Spending pattern)	All	Low Cost	High Cost (Non-persistent)	High Cost (Persistent)
Coronary Artery Disease	28.2%	19.1%	50.0%	53.7%
COPD	19.6%	13.9%	28.9%	37.5%
Congestive Heart Failure	18.5%	10.1%	33.0%	44.3%
Diabetes	16.7%	12.6%	23.5%	29.5%
Cognitive Impariment	8.8%	5.7%	13.9%	18.7%
Asthma	3.9%	2.9%	4.5%	7.3%
ESRD	2.3%	0.7%	4.2%	7.9%
Mean number of conditions	1.0	0.7	1.6	2.0

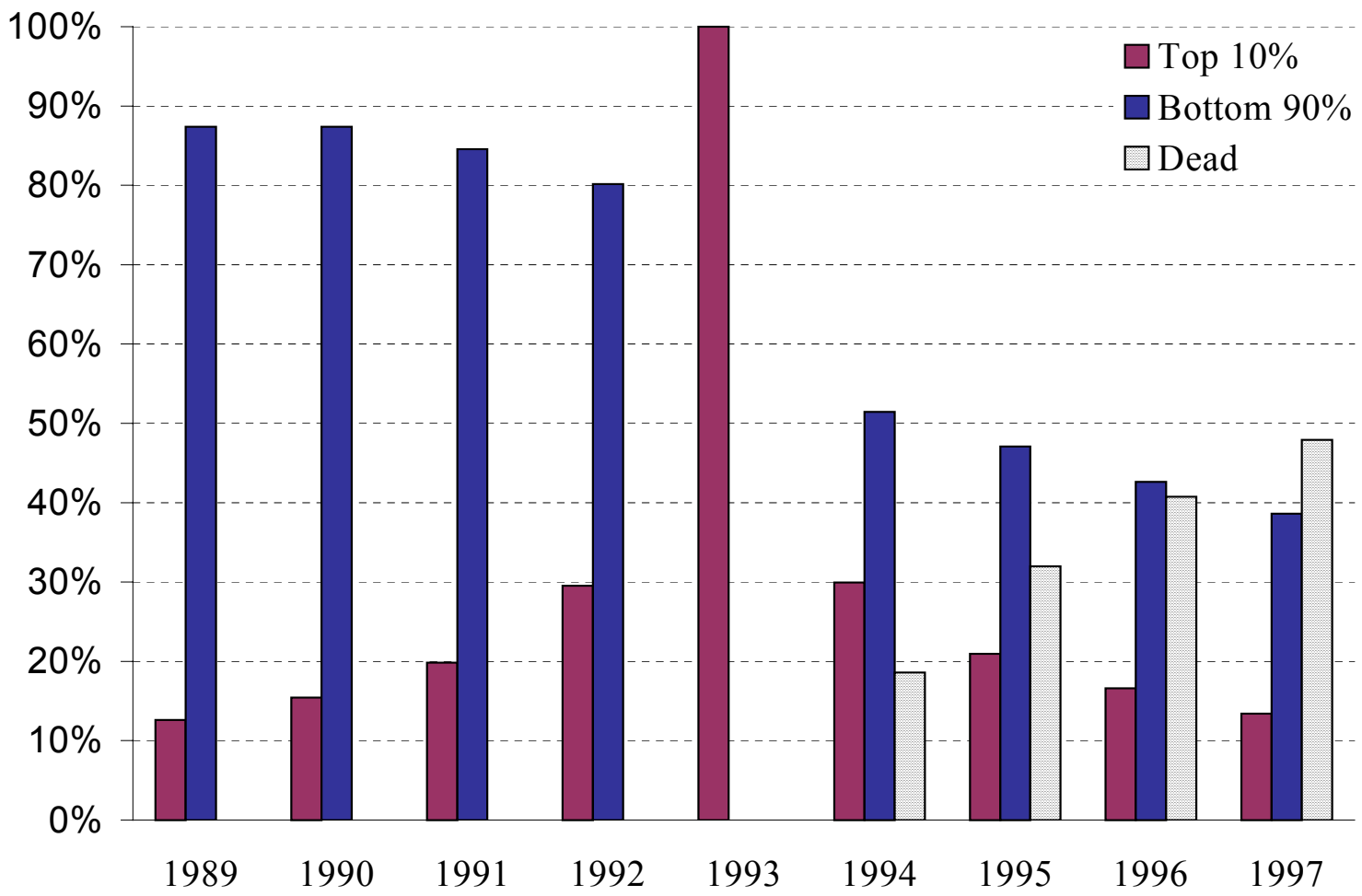
Notes: COPD=Chronic Obstructive Pulmonary Disease, ESRD=End Stage Renal Disease. Data from a 5 percent random sample of fee-for-service (FFS) beneficiaries between 1989 and 1997. Source: CBO preliminary analysis.

Number of Chronic Conditions Predicts High-Cost Status

Beneficiary Group (Spending pattern)	Low Cost	High Cost (Non-persistent)	High Cost (Persistent)
0 of the 7 conditions	89.5%	4.4%	6.1%
1 condition	71.5%	11.1%	17.3%
2 conditions	53.3%	15.0%	31.7%
3 conditions	34.5%	16.1%	49.4%
4 conditions	20.2%	13.8%	66.0%
5 conditions	10.8%	9.9%	79.3%
6 conditions	5.4%	6.0%	88.7%
7 conditions	0.0%	0.0%	100.0%

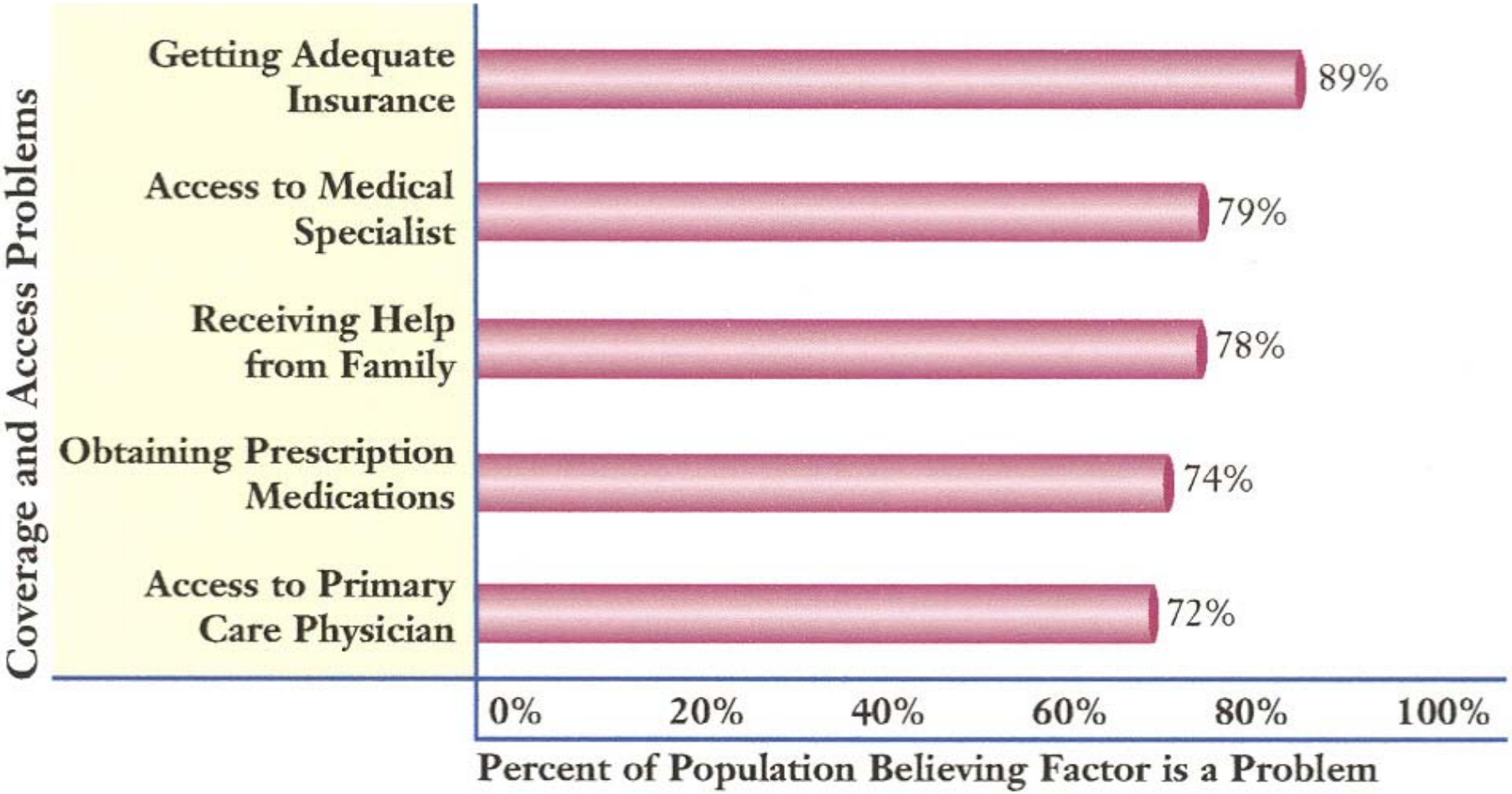
Notes: The 7 conditions considered were: CHF, CAD, COPD, ESRD, Asthma, Diabetes, and Cognitive impairment.
Source: CBO preliminary analysis.

Persistence of Medicare Spending



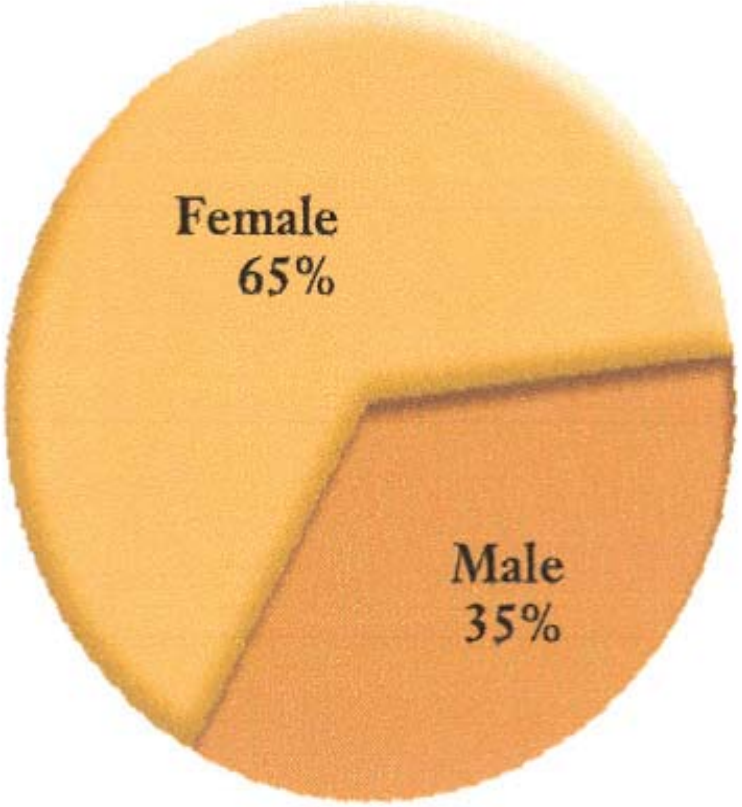
Notes: Data from a 5 percent random sample of fee-for-service (FFS) beneficiaries between 1989 and 1997.
Source: CBO preliminary analysis.

Americans Believe that Coverage and Access to Care Are Problems for People with Chronic Conditions

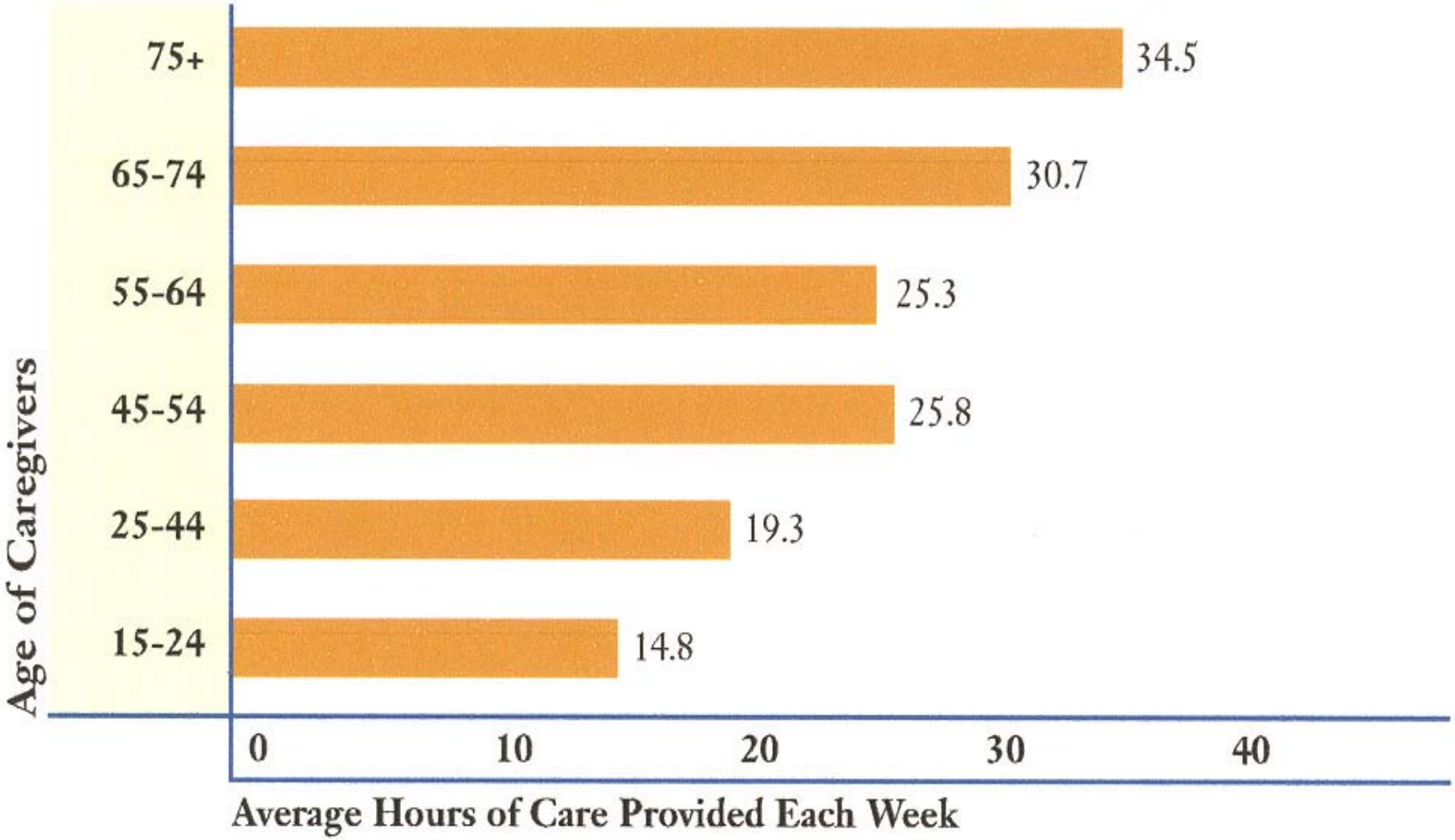


Source: *Chronic Illness and Caregiving*, a survey conducted by Harris Interactive, Inc., 2000.

Family Caregivers by Gender



The Number of Hours Dedicated to Caregiving Increases with the Age of the Family Caregiver



Management of Chronic Diseases

- Medical Care
  - Guidelines (versus Algorithms)
  - Coping to Caring (versus Curing)
- Caregiver/Patient Dyad
  - Education and Training
  - Coaching and Coaxing
- Environment / Functional impairment
- Community supports: formal and informal

What Do High-Cost User Patients Want … and Need?

What Patients Want

(From Donald Berwick MD, IHI)

- Relationship(s)
  - Doctor/Patient: mutual caring and respect
  - Doctor/Team: communication and integration
  - Continuity
    - Time
    - Settings
    - Natural history of the illness

What Patients Want

(From Donald Berwick MD, IHI)

- Science
  - Knowledge
  - Judgment and Perspective
  - Technology

What Patients Want

(From Donald Berwick MD, IHI)

- Access and Availability
  - When they want you
  - Where they want you
  - For however long it takes

Why Office-Based Medicine Fails: Relationships

- Physician- v Patient-Centered Care
- Consultant Care v Population Health
- Lack of continuity:
  - Cross settings: Office, Hospital, NH & Hospice
  - Communication / Continuity of medical records
  - Interdisciplinary team structure

Why Office-Based Medicine Fails: Access, Availability & Technology

- Access hassles and costs
- Unavailable openings when needed
  - "Next available appointment…"
  - "Squeeze them in…"
  - Refer to ER
  - Try to manage over the phone
- Unprepared for urgent care management

Why Office-Based Medicine Fails: Payment and Info Constraints

- Medicare Payment Policies
  - "$/unit time" favors the lower CPT codes
  - No reimbursement for care coordination
- Lack of breadth of information
  - Caregiver
  - Environmental / functional barriers
  - Community resources
  - Compliance

Current State of the Disease Management Industry

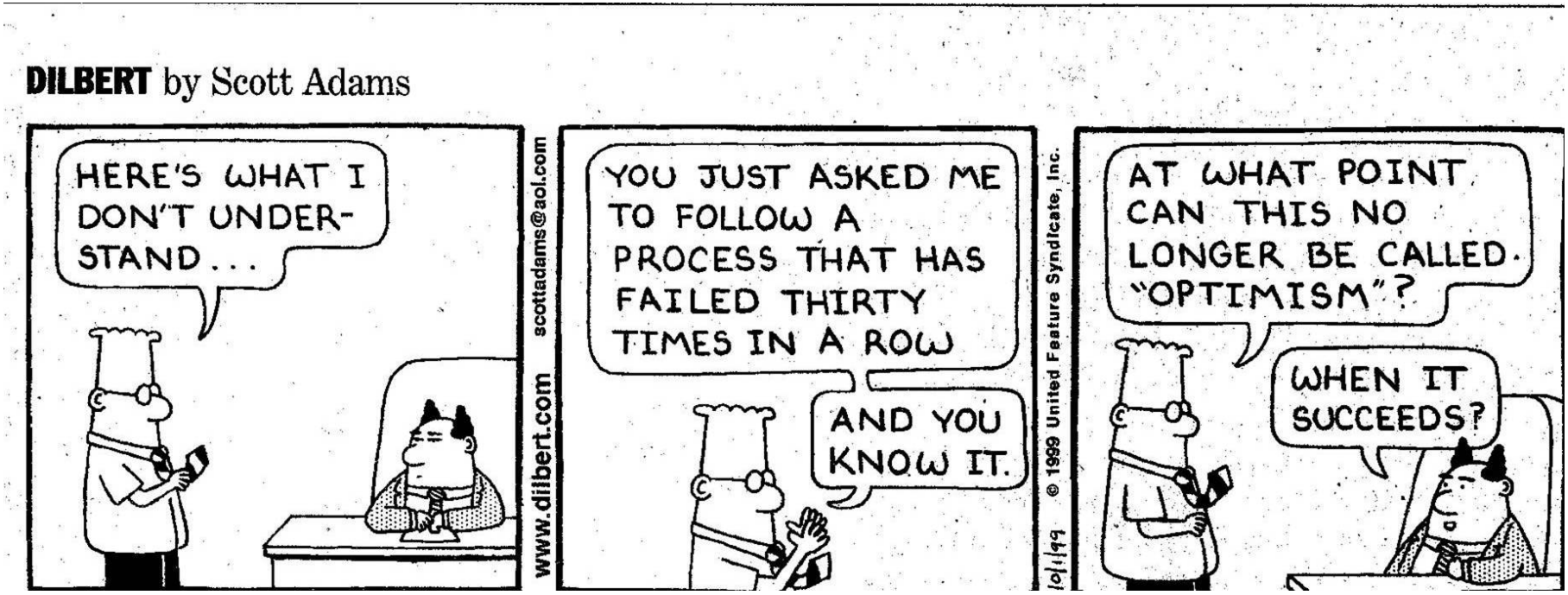
Disease management (DM) is an intervention frequently mentioned in the high-cost beneficiaries approach

- Two models
  - Focus on patients diagnosed with specific diseases, e.g. diabetes
  - Focus on patients with complex combinations of medical conditions who are at high risk for costly medical events
- Two types of DM companies
  - Stand-alone: contracts with a health plan to provide DM services (30% of companies, 60% of covered individuals, 83% of revenues)
  - In-house: operated by an HMO, medical center or health plan directly (60% of companies, 30% of covered individuals, 14% of revenues)

Disease Management Evidence

- Two main questions to be answered
  - Does DM improve *health outcomes*?
  - Does DM save money?
- The Evidence
  - Improvement in health outcomes; demonstrated short-term cost savings among CHF patients.
  - Improvement in some processes of care and *intermediate* outcomes in diabetes; savings not reliably demonstrated.
  - Improvement in some processes of care and *intermediate* outcomes in other heart disease, one study with decreased mortality; savings not reliably demonstrated.
  - CMS demonstration projects have not shown, to date, financial benefits of DM.

A Failure to Understand Health Care Systems



Disease Management

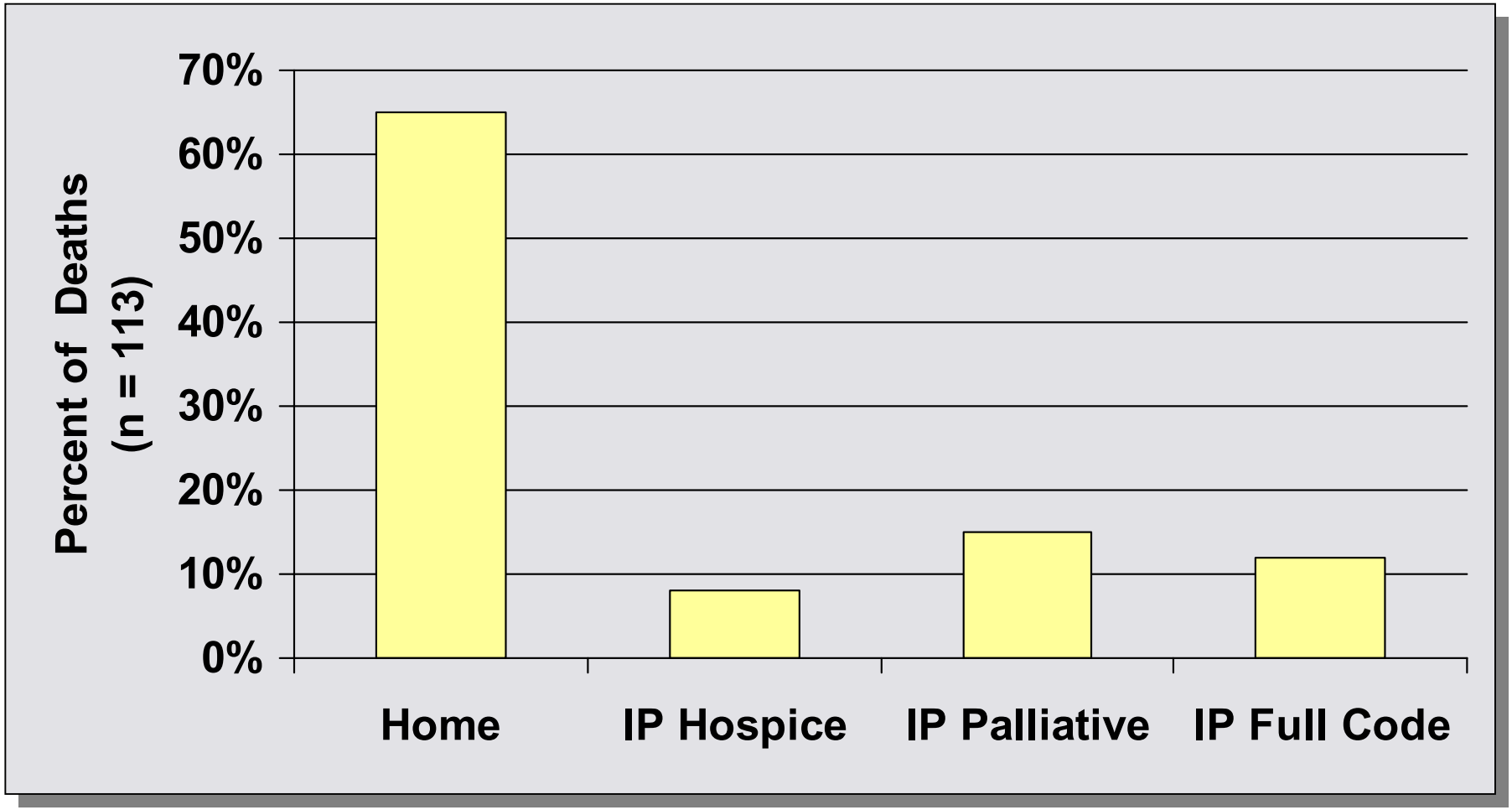
- Actually focused on Group 2 patients with one predominant disease
- Adjuvant service to Primary Care
- Experience with the high-cost user is limited and likely led to the failure to show sustained benefit.

Terminal Care

- Recognizing the transition from chronic to terminal conditions
- Build trust & end of life goals over time
  - Understand value system of patient/family
  - Good primary care is always palliative
- Hospice versus Hospice-Lite

Washington Hospital Center

Site & Mode of Death



Source: WHC MHCP 2003

What's Next

- Enhanced Urgent Care Services
  - Extended hours
  - High tech capabilities: Dx & Tx
  - In-home end-of-life care (vigil services)
- Patient-Centered EMR
  - Single record for out and in-patient care
  - Shared with other providers
    - HHA
    - Pharmacy
- Team Expansion

Chronic Care Coordination Fees

- Layered fee for non-covered services
  - Comprehensive Geriatric Assessment
  - Team meetings
  - Care coordination
  - Enhanced services
  - On-call services
  - Gap-filling fund
- Renewable contingent on performance
  - Adherence to evidence-based guideline targets
  - Patient and caregiver satisfaction targets
  - Reduced costs

Key Elements to System Success

- A physician-led, interdisciplinary primary care team under a fee-for service system of care
  - overcomes the weaknesses of the current Disease/Case Management models and
  - resistance to capitated programs
- Patient-centered design
  - cross settings of care
  - provide continuity over the natural history of illness
- Management requires coordination of services
  - caregiver support
  - advance care planning
  - a restructuring of the payment system

"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."

- Margaret Mead