Community-based nurse care management; an emerging innovation for chronically ill older adults

Leveraging it in the service of patients
(and the community-based primary care medical home concept)

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Community-based nurse care management (HQP’s model)

• *A carefully crafted, tightly integrated portfolio of*
  – Evidence-based care management interventions
  – Care coordination activities
  – Proactive and ongoing assessments and monitoring
  – Preventive interventions designed for chronically ill older adults
  – Delivered
    • in the community
    • by nurses
      – through well-developed relationships
    • over extended time periods
    • in partnership with primary care and specialist physicians, local hospitals, home care, long term care, and community services and agencies
Key attributes

- Person-centered (relationship-based)
  - Proactive engagement of patient and family
- Grounded in collaborative problem-solving
  - Motivational interviewing … the next generation
- Rigorous monitoring and feedback of care manager processes
- Ongoing care manager mentoring, training and supervision
- Attention to providing high-value, as-needed collaboration with primary care, and other health / behavioral care and community service providers
Benefits

• Patient / family
  – Easily accessible, personally tailored ongoing support for a wide range of health, prevention, and planning related needs
  – Fewer complications of chronic illness & aging
  – Longer life

• Primary care provider
  – Help managing chronically needful patients & families
  – Ease of use, low hassle factor; ‘background’ support service
  – Help improving process and outcome performance

• Feds / State / Local government and health authorities
  – A chance to offer better care at no/low cost or net savings

• Health Insurance Plans
  – A chance to offer better care at no/low cost or net savings
  – Grow or maintain membership
Benefits from a health system design perspective

- Fluid deployment across a geography provides for
  - Optimization of resource use by flexibly redirecting them to wherever they are needed most
  - Efficient support to any size physician practice in any stage of office process transformation
  - Critical mass of team members in a region allows for central support, training, and flexible staff coverage to that area
  - Ready reserve force for public health emergencies
  - Relatively modest capital requirements or start-up costs
Highlights of results to date

- **High Satisfaction** -
  - Overall experience rating ...72% Excellent, 26% Good, 0% Average, Fair, or Poor (1)
- **Decreased Utilization** -
  - Budget neutral at 29 months mean follow-up including all risk levels (low, med, high) (2)
  - -29% hospitalizations, -20% expenditures for “high risk” group identified on enrollment (3)
  - Fewer hospitalizations and net savings across a variety of population subgroups (4)
- **Improved Health Outcomes** -
  - 26% decrease in all cause mortality (p=0.036) (4)

(1) Mailed anonymous participant survey performed by HQP in 2009, results from 647 responses
(3) Peikes, et al., Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries: 15 randomized trials, JAMA, 2009
(4) Peikes, et al., Analyses of the Medicare Coordinated Care Demonstration for the Medicare Chronic Care Practice Research Network (MCCPRN), Report June 24, 2009
Sustainability & Next Steps

• Medicare Coordinated Care Demonstration
  – Ongoing for 8 years - that’s 1,2,3,4,5,6,7,8

• “Deep dive” into data now underway at CMS
  – Potential to refine targeting to those benefiting most while optimizing long term financial impact

• Replicable? - important question that needs testing
  – Big advantage: a single regional “install” can serve a large geography and many patients and providers
Looking for supporters, partners and kindred spirits

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