Advising the Congress on Medicare issues

Care coordination in fee-for-service Medicare

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April 6, 2012

MEDPAC

Today's presentation

- Definition of care coordination
- Further detail on Medicare demonstrations
- Improving communication between beneficiaries and providers
- Quality measures

Definition of care coordination

- A conscious effort between two or more participants involved in a patient's care to facilitate appropriate delivery of health care services (AHRQ)
  - Beneficiary-centered with a holistic orientation
  - Focusing on beneficiaries with a high disease burden

- Care coordination can encompass different models
  - Care management: Coordinating care across different providers
  - Transitional care: Facilitating transitions for patients at risk of poor outcomes
  - Case management: Helping patients access social supports
  - Chronic care management: Helping medical practices manage patients with chronic conditions
  - Disease management: Ensuring compliance with guidelines for specific conditions

Case studies from the demonstrations

- Promising models were not always able to recruit enough participants or be financially viable
- Lower hospitalizations do not necessarily lead to lower program spending
- Findings from the Medicare demonstrations can shape future interventions for the Medicare population
- Programs changed over time to improve results for later groups

Features of the most successful Medicare care coordination program to date

- Extensive planning
  - Established a pilot in a health center to identify problems
- Beneficiary enrollment
  - Patients enrolled in the demonstration must have established ties to the physicians' organization
- Relationships with physician groups
  - Each physician was paired with only one care manager
  - Physicians were paid a fee for interacting with the care manager
- Links between care manager, hospital and medical practices
  - Interoperable IT and communications protocols
  - Common resources (e.g., mental health services)

Key ideas from the demonstration findings

- Programs often seem similar, incorporating the same key elements, but are quite different on the ground
- There is mixed evidence on which elements are critical to success
- Good interventions installed in a system that isn't redesigned to accommodate them are unlikely to be successful

Improving communication between providers and beneficiaries

- Improving communication when many providers are involved
  - Interoperable information systems
  - Formal process changes to encourage the exchange of information
- Improving communication when a beneficiary's condition worsens
  - Beneficiary has other options to access care
  - Care manager knows when the beneficiary shows up at the hospital

Quality measures for evaluating care coordination

- Outcome measures: ED visits and preventable admissions
- Survey-based measures
  - "Hassles" scale
  - 3-Item Care Transitions Measure
- Claims- and medical record- based process measures
  - Tracking referrals and follow-up visits
  - Continuity of care index

Conclusion

- Questions
- Comments about the chapter
- Next steps