Improving Care and Managing Costs: Team-Based Care of the Chronically Ill

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Chronically Ill: Opportunities and Challenges to Achieve Better Outcomes at Lower Costs

- Complex chronically ill account for a high proportion of national spending
- Care needs span health care system
  - Diverse population groups: risk groups
  - Cared for by multiple clinicians, sites of care
  - Need for patient-centered, care “teams”
- Potential to improve outcomes and lower costs
  - Teams and information systems
  - More integrated systems with accountability
- Affordable Care Act has elements to build on
Ch预先anically Ill Complex and Expensive: Care Often Spans Multiple Providers and Sites of Care

Estimated 30% of National Spending

Total $635 Billion Spending on disabled and chronically ill, 2010

- Duals – Medicare: $164.2B
- Non-dual Medicare with 5+ Chronic Conditions: $145.3B
- Medicaid Duals: $140.3B
- Medicaid Non-dual Disabled: $116.5B
- Employer Coverage: $68.4B

Nine Million People Are Covered by Both Medicare and Medicaid: 10% of Total Population = 38% Total Spending

Medicare
34 Million

Medicaid
49 Million

Total Medicare Beneficiaries, 2007: 
43 million

Total Medicaid Beneficiaries, 2007: 
58 million

Dual Eligibles 
9 Million

Disabled: 
3.4

Elderly: 
5.5

Source: Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey, 2007, and Urban Institute estimates based on data from the 2007 MSIS and CMS Form 64.
Section 2 – The Impact of Chronic Conditions on Health Care Financing and Service Delivery

High Share of Health Care Spending Is on Behalf of People With Multiple Chronic Conditions

- Sixteen percent of spending is for 50 percent of the population that has no chronic conditions.
- Eighteen percent of spending is for the 22 percent of the population that has only one chronic condition.
- Seventeen percent of spending is for the 12 percent of the population that has two chronic conditions.
- Sixteen percent of spending is for the 7 percent of the population that has 3 chronic conditions.
- Twelve percent of spending is for the 4 percent of the population that has 4 chronic conditions.
- Twenty-one percent of spending is for the 5 percent of the population that has 5 or more chronic conditions.

Source: Medical Expenditure Panel Survey, 2006
Payment, Teams and System Innovation Key to Better Outcomes and Lower Costs

• Payment
  – Patient-centered health “home”: new ways of paying
    • Move away from “visits” alone
    • Support teams, time with high risk patients
    • Multiple access points: email/web, phone, tele-health
  – More bundled payments: accountability for transitions
  – Sharing savings, with accountability
  – Multi-payer coherence

• Teams that span sites of care, with accountability
  – Multiple models; including “community” shared teams

• Information systems to communicate, inform, guide
  – Registries and Electronic Health records
  – Feedback information from payers/claims
Multiple Models Exist: Opportunity to Spread and Learn

Community Care of North Carolina
Affordable Care Act: Strategic Policies to Build On

• Payment and Care
  – Enhanced primary care $: Medicare and Medicaid
  – Medicaid “Health Home” for chronically ill
  – Bundled payment: hospital/subacute 30 days
  – Community based transition program: complex chronic
  – Community-based Collaborative Networks
  – Accountable Care Organizations and Shared Savings

• Innovation Center and Pilots/Demonstrations
  – Chronic disease teams for high risk beneficiaries
  – Innovations to improve outcome/lower costs: Value
  – In-home care for high-need Medicare patients
  – Medicare authorized to join multi-payer initiatives

• Information: Quality Metrics and Feedback
  – 10 specific to acute/chronic diseases; Long term care
  – Medicare data for local initiatives
Panel Discussion

• What works? Care system strategies to build on
• Teams, models and variations: results and challenges
• Strategic policies that would make a difference

Panel

– Randall Brown, Mathematica Policy Research Vice President; Director, Health Research Division

– Pamela Parker, Minnesota Department of Human Services Manager of Special Needs Purchasing in Health Care Administration Managed Care and Payment Policy Division

– Lois Simon, Commonwealth Care Alliance Chief Operating Officer
Multiple Models: Examples of Cost and Quality Outcomes

Group Health Cooperative of Puget Sound (Seattle, Washington)
- 29 percent reduction in ER visits; 11% reduction ambulatory sensitive admissions

Geisinger Health System: “Navigator” Elderly (Pennsylvania)
- 18 percent reduction in all-cause hospital admissions; 36% lower readmissions
- 7 percent total medical cost savings

Mass General High-Cost Medicare Chronic Care Demo (Massachusetts)
- 20 percent lower hospital admissions; 25% lower ED uses
- Mortality decline: 16 percent compared to 20% in control group
- 7% net savings annual

Guided Care Teams – Results in Integrated Care System (Baltimore/DC)
- High risk geriatric group. Kaiser achieved significant change
- Reduced nursing home days 52%, hospital admissions 15%; readmissions 48.7%; ER visits 17.4%

Health Partners (Minnesota)
- 29% decrease ED visits; 24% decrease hospital admissions

Intermountain Healthcare (Utah)
- Lower mortality; 10% relative reduction in hospitalization
- Highest $ savings for high-risk patients