Appendix A. Primary Sources

Source	Evidence reviewed	Models studied
C. Boult, A. F. Green, L. B. Boult et al., "Successful Models of Comprehensive Care for Older Adults with Chronic Conditions: Evidence for the Institute of Medicine's 'Retooling for an Aging America' Report," *Journal of the American Geriatrics Society,* Dec. 2009 57(12):2328–37.	123 high-quality studies published between 1987 and 2008 reporting at least one statistically significant positive outcome (quality, health, or efficiency) compared with usual care. Studies were considered high-quality if they had a strong design, adequate sample, valid measures, reliable data collection, and rigorous data analysis.	15 clinical models staffed primarily by health care professionals and intended to "address several health-related needs of older persons, such as care for several chronic conditions, several aspects of one chronic condition, or persons receiving care from several health care providers" (see Supplement Tables A-O of the Boult paper.)
T. Bodenheimer and R. Berry-Millett, *Care Management of Patients with Complex Health Care Needs,* Research Synthesis Report No. 19 (Princeton, N.J.: Robert Wood Johnson Foundation, Dec. 2009).	Controlled and observational studies of care management programs for patients with complex care needs (e.g., multiple chronic conditions, many providers, polypharmacy, frequent hospitalizations, functional limitations) published since 1990, as well as interviews with health care leaders who implemented these programs.	Care management programs defined as "a set of activities designed to assist patients and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aim of improving patients' health status and reducing the need for medical services (see Appendices III and IV of the Bodenheimer paper).
L. Nelson, *Lessons from Medicare's Demonstration Projects on Disease Management and Care Coordination,* Working Paper 2012-01 (Washington, D.C. Congressional Budget Office, Jan. 2012); and L. Nelson, *Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment,* Issue Brief (Washington, D.C.: Congressional Budget Office, Jan. 2012).	20 commissioned and peer-reviewed evaluations of programs targeting Medicare fee-for-service beneficiaries, including high-cost beneficiaries with multiple chronic conditions and dually eligible beneficiaries.	34 disease management and care coordination programs from six major Medicare demonstrations "aimed at improving the care of beneficiaries with chronic conditions or high expected health care costs." The demonstrations included the: • Demonstration of Care Management for High-Cost Beneficiaries (6 sites); • Medicare Coordinated Care Demonstration (15 sites); • Medicare Health Support Pilot Program (8 sites); • Demonstration of Disease Management for Dual Eligible Beneficiaries (1 site); • Demonstration of Informatics for Diabetes Education and Telemedicine (1 site); and • Demonstration of Disease Management for Severely Chronically Ill Beneficiaries (3 sites).
R. S. Brown, D. Peikes, G. Peterson et al., "Six Features of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions of High-Risk Patients," *Health Affairs,* June 2012 31(6):1156–66	Written reports, telephone interviews, and site visits with programs from the Medicare Coordinated Care Demonstration, covering fee-for-service beneficiaries with at least one chronic condition. The high-risk subgroup associated with significant reductions in hospital use across the four programs was defined as patients with coronary artery disease, chronic heart failure, and/or chronic obstructive pulmonary disease and at least one hospitalization in the prior year; or those with any of 12 conditions and at least two hospitalizations in the prior two years.	11 diverse care coordination programs, of which four demonstrated reduced hospitalizations: • Health Quality Partners (a health care quality improvement service provider in suburban and rural southeastern Pennsylvania), • Hospice of the Valley (a hospice and home health agency in the Phoenix area), • Mercy Medical Center (a hospital within an integrated delivery system in rural Iowa), • Washington University (a safety-net academic medical center in St. Louis).

Source	Evidence reviewed	Models studied
R. S. Brown, A. Ghosh, C. Schraeder et al., "Promising Practices in Acute/Primary Care," in C. Schraeder and P. Shelton, eds., *Comprehensive Care Coordination for Chronically Ill Adults* (Wiley, 2011).	Evidence and lessons from rigorously evaluated primary and acute care coordination programs that reduced hospitalizations and expenditures.	Care coordination defined as "a set of activities that assist patients and their families in self-managing their health conditions and related psychosocial problems more effectively; coordinating their care among multiple health and community providers; bridging gaps in care; and receiving the appropriate levels of care."
C. S. Hong, A. L. Siegel, and T. G. Ferris, *Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?* (New York: The Commonwealth Fund, Aug. 2014).	Key informant interviews, review of published manuscripts and program materials for each program serving complex patients with multiple chronic conditions or advanced illness.	18 successful primary care-integrated complex care management programs "in which specially trained, multidisciplinary teams coordinate closely with primary care teams to meet the needs of patients with multiple chronic conditions or advanced illness, many of whom face social or economic barriers in accessing services" (see Appendix Table 1 of Hong paper).
Coalition to Transform Advanced Care, *Advanced Care: A Model for Person-Centered, Integrated Care for Late Stage Chronic Illness,* http://advancedcarecoalition.org.	Best practices derived from interdisciplinary care coordination models.	Interdisciplinary care coordination models "tightly linking inpatient, ambulatory and home/ community settings" for those with advanced illness, which "occurs when a person with one or more chronic diseases begins to decline in health status and ability to function."