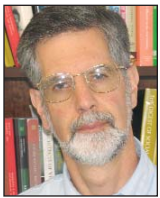


Coordinating Care: An Elusive but Critical Goal

Managing Chronic Illnesses during Transitions Presents Tough Challenges



**BY HOWARD
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More than almost anyone, the frail elderly desperately need well coordinated health care.

Yet, they may be the very people who have the most trouble getting it.

More than half of Americans 65 and older suffer from at least two chronic diseases, and nearly one-fifth of those 75 and older suffer from five or more.¹ More than half of them are living with high blood pressure, more than 40 percent have arthritis and other joint diseases, one in three suffers from heart disease, and one in five lives with diabetes.

Treating these patients is enormously challenging. Nearly two-thirds of those with three or more chronic conditions visit at least 10 different doctors per year.² By some estimates, more than half of all elderly patients admitted to the hospital are taking at least seven prescription drugs. Of those on five drugs or more, at least half will take them incorrectly. Among those taking 12 or more medications, nearly one in five is likely to have an adverse reaction.³

To add to the challenge, many of these patients will go from home to hospital to skilled nursing facility and back again. Managing transitions from one care setting to another is difficult in the simplest of cases. It can be a deadly nightmare for those who suffer multiple chronic illnesses. And the problem is compounded if a patient suffers from dementia, has an elderly spouse or long-distance child as a primary caregiver, or has no caregiver at all.

For decades, policymakers and health providers have recognized the need for more coordinated care for all, and especially the chronically ill. Yet solutions remain elusive. Financial disincentives, poor communications, a desperate shortage of medical professionals with the necessary skills to manage these patients, memories of the failed experiment with Health Maintenance

Organizations of the 1990s, and conflicts among multiple payers (especially for those dual eligibles receiving both Medicare and Medicaid benefits) have all conspired to defeat most attempts to coordinate patient care.

Yet, despite numerous false starts, we may finally be making some progress towards successful care management designs. And while disagreement remains about how much cost savings can be achieved through coordinated care, studies seem to show that this model can at the very least improve patient outcomes without costing more money.

As an organization dedicated to improving medical outcomes, the Institute for Healthcare Improvement, Cambridge, Mass., has identified several practice changes that have the potential to improve patient care at all levels of the health care system, including long-term care. All involve better communication and cooperation among providers and special attention as patients move from unit to unit or during staff changes. These include:

- Multidisciplinary rounds by a full range of professionals, including nurse managers, staff nurses, pharmacists, social workers, case managers, discharge planners and chaplains as well as physicians,
- Rapid response teams — critical care teams ready to respond immediately to a crisis,
- Care teams to work closely with patients on self-care goals, working with patients to set targets, such as sitting in a chair or walking down the hall. Goals are often posted in patients' rooms, and team members are available to assist patients in meeting daily goals.

One sign that the message is being heard can be seen in the health reform legislation now being debated in Washington. Doing a better job of managing care for all is one of the legislation's goals. Medical homes that assure comprehensive

primary care, the new focus on outcomes rather than numbers of procedures, and reformed payment models where providers are compensated based on episodes of care rather than on a per-treatment, fee-for-service design, should all help encourage care coordination. But rather than awaiting fundamental reform, a growing number of modest programs have been surfacing in recent years — some of which may help point the way to broader change.

There are many variations: The Program of All-Inclusive Care for the Elderly combines adult day care services with hands-on medical care. The Johns Hopkins University's Guided Care program uses registered nurses to assess, plan, and manage the care of chronically ill seniors. The University of Pennsylvania's Transitional Care Model uses similar techniques but focuses on seniors being discharged from hospitals. Case management programs such as Minnesota's Senior Health Options attempt to coordinate care for those very poor and sick seniors enrolled both in Medicare and Medicaid.

In many ways, all of these new models for care coordination build upon an old design: hospice, where care for the dying is intensely coordinated among teams of doctors, nurses, social workers and chaplains. New care models extend that concept to those who are chronically, but not terminally, ill.

For decades, hospice has managed medical, social and personal care for the dying. Medicare has paid for these services since 1982. Skilled nurses serve as the fulcrum—managing medications, coordinating physicians and keeping a trained eye on changes in the patient's health status. Social workers, chaplains and volunteers all serve critical, non-medical roles. Rather than being paid by the visit or the procedure, Medicare pays hospices a fixed daily rate—about \$130 for each patient living at home, for example. That structure encourages hospices to carefully coordinate this assistance, since the organizations are at financial risk if they do a poor job managing care.

But hospice is available only to those whose doctors expect them to live for six months or less. Dr. Joanne Lynn, for many years a hospice physician, has developed the concept of Bridges to Care,⁴ in which teams of physicians, nurses, social workers, and others are available to help all patients as they move through the continuum of care. Why not, reformers have asked, at least expand the model to everyone with chronic care needs?

Her idea has been adopted in some recent experiments. Yet, saving money while improving

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patient outcomes is not easy. A recent study by Randall Brown of Mathematica Policy Research Inc., Princeton, N.J., found that of 15 Medicare-coordinated care demonstration programs, just three succeeded in reducing both hospitalizations and costs over a four-year period.⁵

What separated successful programs from failures? Brown identifies six elements: targeting care to those patients at highest risk for hospitalization in the coming year; person-to-person contact between patients and care coordinators;

STEPS TOWARD SUCCESS IN COORDINATING CARE

Researcher Randall Brown identified six elements of successful Medicare demonstration programs:

Targeting care to patients at highest risk for hospitalization in the coming year

Person-to-person contact between patients and care coordinators

A close relationship between care coordinators and primary care doctors

Use of RNs as the lead coordinators

Rapid access by the care team to information about a medical crisis

The right mix of services for patients.

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a close relationship between care coordinators and primary care doctors; use of nurses as the lead coordinators; rapid access by the care team to information about a medical crisis; and the right mix of services for patients.

This package should include not only assessments and development of a care plan, but intensive education and training of patients and caregivers that allows families to successfully self-manage care. Teaching how and when to take medications is critical. Finally, services should include non-medical assistance, such as arranging transportation and other social services.

Coordinating care for the 7.5 million people who are enrolled in both Medicare and Medicaid may be the toughest challenge of all. They are often the poorest and sickest patients whose care needs are the most complex.

One model that shows great promise was designed by Chad Boulton and colleagues at Johns Hopkins Bloomberg School of Public Health. Called Guided Care,⁶ the program is built around nurses, each working with three to four doctors to care for 50 to 60 chronically ill patients. The nurse does a comprehensive assessment of each patient's needs, develops a care plan and monitors the patient's health status with a monthly visit. The nurse helps the patients through the difficult transitions among hospitals, nursing facilities and home, educating and supporting both patients and family caregivers as they learn to take responsibility for much of their routine care. Finally, the nurse coordinates treatments that may be provided by many different physicians.

Early evidence for the first eight months of the trial suggests Guided Care significantly reduced emergency room visits and nursing home stays, and cut overall costs by 11 percent.

The University of Pennsylvania's Transitional Care Model is a variation on the nurse-led team model.⁷ The model focuses on a critical, but too often ignored piece of care management — the transition from hospital to home. Discharge planning for those leaving hospitals or nursing facilities has long been a broken link in the continuum of care. Numerous studies report that barely half of patients understand the instructions they receive as they leave the hospital, even though

90 percent of doctors think they do.

Now, under growing pressure to reduce readmissions, hospitals are looking at new ways to better prepare patients and their families for life after they go home. But because hospitals are not compensated for discharge planning by Medicare or private insurance, this critical service often gets little attention. Discharge planners, usually social workers, are overworked, and they rarely meet patients and their families more than a few hours before they leave the hospital. They have little information on the home environment to which a patient is being discharged, or on whether the patient or a caregiver is even capable of managing the often-complex care. The result: nearly one-fifth of patients are readmitted to the hospital within a month of discharge, and up to a third of these round-trips may be preventable.

Penn's model attempts to reforge that broken link between hospitalization and home care, especially for seniors with multiple chronic conditions. A specially trained transitional care nurse begins to work with a patient even before discharge to develop a care plan. The nurse follows up with regular home visits and works closely with doctors and other providers to be sure care is well-managed. Like Guided Care, this program also focuses on engaging patients and families in the care plan.

Coordinating care for the 7.5 million people who are enrolled in both Medicare and Medicaid may be the toughest challenge of all. They are often the poorest and sickest patients whose care needs are the most complex. And they must navigate an impossible maze of multiple payers and often-conflicting rules.

These patients account for roughly one-quarter of all Medicare spending and more than 40 percent of Medicaid costs. Yet they are less likely to receive important care than typical Medicare beneficiaries. For instance, only one-quarter of dual-eligible women receive regular mammograms compared with 40 percent of Medicare-only patients.⁸

One long-standing effort to coordinate care for this population, the Program of All-Inclusive Care for the Elderly, melds adult day care with easily accessible geriatric medical care and other supportive services. The program began in the early 1970s as a local project in San Francisco's Chinatown. Today, more than 60 such programs operate in 29 states.

While the program gets high marks from researchers and participants, only about 25,000 seniors use its services. Because it relies on high-

quality geriatric care, it is hard to scale up in the face of severe shortages of these specialists. In addition, some seniors have been reluctant to give up their own doctors in order to participate. And states have been reluctant to fully fund the programs.

The reason for the reluctance is endemic to all dual-eligible programs. The upfront Medicaid payments to the program are high — often more than \$2,000 per patient per month — and roughly half is borne by the states. However, a major financial benefit of the program is the reduction of hospitalizations, whose cost is paid entirely by Medicare. Thus, states pay a significant share of the expense, while the cost savings benefits only the federal government.

Special Needs Plans are another attempt to coordinate care of dual-eligible patients. These are variations of the Medicare Advantage plans, managed care plans operated by private insurers. The insurers are paid a fixed monthly fee (roughly \$900-\$1,000 per enrollee) to provide full coordinated care.

The plans have been slow to catch on but in some states have become the dominant form of care for dual-eligible patients. Minnesota's Senior Health Options, for instance, covers more than 37,000 seniors, about 70 percent of those eligible. The state also operates similar programs for adults with disabilities aged 18-64. The program provides primary and preventive care, a comprehensive drug benefit and other integrated services. However, while patient satisfaction is high, there is little evidence that the program as yet saves money or improves patient outcomes.⁹

Coordinating care, especially for chronically ill seniors, is generating more interest than it has in years. Congress is likely to take some modest steps to create new financial incentives for well-

managed chronic care. And researchers, providers and insurers are exploring new designs aimed at achieving this goal. But despite the positive signs, even the experts still have a lot to learn about how to do this difficult job well. ■

Howard Gleckman's book, *Caring for Our Parents*, is reviewed in this issue of *Health Progress*.



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NOTES

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