



FORUM SESSION

Management of Chronic Care Needs: What Will It Really Take to Coordinate Care?

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Chronic care management, including coordination of care among primary and specialty clinicians, has garnered much attention recently from legislators and regulators, particularly where Medicare beneficiaries are concerned. New proposals for reform of Medicare's sustainable growth rate (SGR) payment update formula call for creation of a payment code to encourage the management of care for individuals with chronic conditions. Similarly, the Centers for Medicare & Medicaid Services (CMS) has defined a scope of chronic care management services for which it proposes that additional payment codes be established beginning in 2015.

These proposals reflect a growing recognition that care for many older adults is fragmented and inefficient. People with multiple chronic conditions often see multiple clinicians who do not necessarily communicate, much less work together to develop or follow a shared care plan. Without such collaboration, patients may have to repeat medical histories and tests, be prescribed medication appropriate to one condition but not another, receive inconsistent medical information, and experience poor transitions from one site of care to another. Following disease-by-disease guidelines without reference to their interaction can result in an onerous treatment burden, questionable benefit, and even potential harm to the patient.

The vision of what good care should encompass has broadened to include patient-centered care, involvement of family members and caregivers as appropriate, and the deployment of teams to manage care and care transitions, particularly for older adults. Importance is placed on electronic health records that go beyond a focus on medical record-keeping to support clinical decision making, quality improvement, and information exchange. Different organizations and localities have had varied success in real-

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izing the vision of good care; effort, time, and leadership will still be required to make coordinated care a norm.

The challenges of improving care coordination for the chronically ill are many. Physicians working under fee-for-service contracts increasingly report feeling pressure to see more patients per day. (It may be noted here that over 70 percent of Medicare beneficiaries have their claims paid under fee-for-service.) The growing role of hospitalists and intensivists has reduced the opportunity for informal consultation between primary care physicians and specialists, since many of the former no longer see their patients in the hospital and may not even know they have been admitted. Care coordination requires that change be implemented within a practice, between practices, and in concert with patients, families, and other organizations, potentially including social services not traditionally part of medical practice.

SESSION

Why is it so difficult for clinicians to coordinate patient care? Reasons cited include insufficient time, incentives that assign greater value to other tasks, and a dearth of systems to support communication, records transfer, scheduling, and feedback. Various demonstrations and pilots sponsored by CMS and private sector organizations have shown modest results at best. The June 2012 Medicare Payment Advisory Commission (MedPAC) report, for example, noted that the Medicare care coordination demonstrations had showed “very low rates of improvements in clinical quality measures and intermittent success at reducing hospitalizations and other use of acute care services.” Moreover, most were unable to recoup the care management fees they paid out through lower utilization.¹

Nevertheless, there is a widespread belief that coordinating care is the right thing to do for patients. While some patients may welcome greater opportunity to manage their own care, those who are very ill, frail, or cognitively impaired may not be able to handle their own care coordination. Though much work has been done in some facets of care coordination, such as managing transitions from one site or provider to another and undertaking interprofessional training, the results of that work have not been applied universally. But new concepts in care delivery may be conducive to progress. The patient-centered medical home is increasingly being thought of as part of a medical neighborhood, with improved communication channels and greater mutual accountability between primary and specialty

providers.² In some localities, health information exchange among clinicians and with patients has begun to live up to its promise.

This Forum session explored the factors that make patient-centered, cost-effective care coordination difficult to achieve; considered the tools and strategies being deployed in efforts to improve care coordination and outcomes; and assessed the outlook for further progress.

KEY QUESTIONS

- What has been learned about successful and unsuccessful attempts to make care coordination sustainable? What efforts are now under way that seem promising?
- What kinds of activities or arrangements can facilitate working relationships among clinicians and between clinical and social services in a health system or in a community?
- Can care coordination realistically be expected both to improve outcomes and to save money?
- Should quality measurement move from disease-specific metrics to consider prevention, wellness, and quality of life? How can the interaction of multiple chronic conditions be better reflected in quality measures?
- How can care plans be crafted and implemented to ensure that patient goals and preferences are routinely consulted and reflected?

SPEAKERS

Mary Tinetti, MD, is the Gladys Phillips Crofoot Professor of Medicine and Epidemiology and chief of geriatrics at the Yale School of Medicine was scheduled to speak. [Her slides](#) address the nature of current practice and the primary/specialty care nexus, what can be achieved through improved care coordination, and the importance of starting with patient goals in mind.

Kyle Allen, DO, is the director of geriatric medicine and lifelong health at Riverside Health System in Newport News, Virginia. He discussed innovative models of caring for older adults and the evolution of a health system approach to improving care for this population. Drawing from this experience and recent work with the Institute for Healthcare Improvement, he described efforts to modify quality improvement approaches in order to meet the specific needs of the elderly and those with multiple chronic conditions in particular.

David Kendrick, MD, MPH, is the principal investigator and chief executive officer of the MyHealth Access Network in Tulsa, Oklahoma. An engineer as well as a physician, he discussed how this system was designed and refined over time to support information transfer and the operation of patient-centered medical homes. He demonstrated how MyHealth Access, which began as a Beacon Community, enables practices to connect with one another in ways that measurably improve community health, as well as individual patient outcomes.

ENDNOTES

1. Medicare Payment Advisory Commission, "Care coordination in fee-for-service Medicare," ch. 2 in *Report to Congress: Medicare and the Health Care Delivery System*, June 2012, p. 34, www.medpac.gov/chapters/Jun12_Ch02.pdf.
2. For a detailed discussion, see Neil Kirschner and M. Carol Greenlee, "The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices," a position paper of the American College of Physicians, 2010, www.acponline.org/advocacy/current_policy_papers/assets/pcmh_neighbors.pdf.