Care Coordination for Older Adults with Complex Chronic Illness

Written Testimony to the

Senate Special Committee on Aging
Senator Herb Kohl, Chairman

May 9, 2007

Washington, D.C.

David A. Dorr, MD, MS

Principal Investigator, Care Management Plus

Asst. Professor, Medical Informatics and Clinical Epidemiology / General Internal Medicine and Geriatrics, Oregon Health & Science University

Good afternoon. My name is Dr. David Dorr and I am honored to present testimony today. I am an internal medicine physician in a primary care clinic. I am also a medical informatics researcher on the faculty of Oregon Health & Science University. My work has focused on the use of information technology to improve care coordination for older adults with complex chronic illnesses in a program called Care Management Plus.

There is a crisis in chronic illness care. Consider Ms. Viera, a 75 year old patient with 5 chronic illnesses. In most clinics, coordination of the care for her multiple chronic illnesses would be limited, leading to worsening of her conditions, unnecessary hospitalizations, and significant cost. Guidelines of care for her illnesses may conflict, and she and her husband may struggle to integrate the sometimes conflicting recommendations of 6 different physicians with their own values. With careful care coordination as in Care Management Plus, a care manager can help educate and guide the Vieras through their options. Care coordination for people with these complex illnesses can help limit these costs, improve health, and provide better quality of life for the growing number of older adults in our country.

Care Management Plus is the integration of a tested information technology (IT) system with trained Care Managers in primary care clinics to treat older adults with complicated conditions respectfully and effectively. In its initial testing, Care Management Plus saved lives and improved health care outcomes by reducing hospitalizations by 24%, improving patients' experience with care, and improving disease status. Savings were estimated at **more than a quarter of a million dollars annually per clinic**. If 2% of the nation's primary care providers adopted care coordination programs like Care Management Plus, Medicare would potentially save over $100 million each year.

We are in the process of disseminating the Care Management Plus model from 7 clinics to more than 40 primary care clinics through a grant from The John A. Hartford Foundation, and we have discovered three significant challenges. First, clinicians want to provide care coordination services but – especially in small and rural clinics – face significant, unreimbursed costs as they do so. For instance, having a care manager is essential to many such models but services by the care manager such as providing education, motivation, coaching, and monitoring do not receive adequate payment. Second, the use of information technology is essential but must be adapted to the needs of coordinating care. Current incentives have compelled most practices to use electronic health records to better capture billing documentation, rather than address the needs of coordination over time. Third,

models like ours and Eric Coleman's Care Transitions nurse coaching require time and effort to learn and implement. Incentives must reflect these costs.

We are heartened that the Senate Special Committee on Aging is holding these hearings today. With your help we can make sure all persons with multiple chronic illnesses get health care that meets their essential needs in the most cost-effective way possible. Thank you for the opportunity to share some of our exciting work with you today.

The Challenges of Managing Chronic Illnesses

Caring for patients with chronic illnesses is not easy. Consider the case of Ms. Viera. She is 75 years old, has diabetes, high blood pressure, mild congestive heart failure, arthritis and recently has had difficulty remembering to pay her bills and to take her pills. Her family practitioner is Dr. Smith, but she also sees 5 other physicians sporadically for her various illnesses. Ms. Viera and her caregiver husband come to clinic to see Dr. Smith and have several new issues to discuss, including hip and knee pain, questions about her 12 medicines, dizziness, low blood sugars, and a recent fall. Dr. Smith knows there are separate guidelines that apply to many of her individual conditions, but he also knows that the studies behind this evidence often excluded patients like Ms. Viera. In addition, the caregiver often is exhausted. In a typical primary care physician's office, the ability to track these multiple concerns is limited. Likely, Dr. Smith, a busy practitioner, will focus on her joint pain, and have limited time to address other issues. Without a thorough care plan and follow-through, Ms. Viera's diseases are likely to cause frequent hospitalizations and emergency visits. In addition, her 6 physicians may not communicate about her plan, give conflicting recommendations, or order medications that interact, raising the risk of problems down the road. Without incentives to coordinate her care, Ms. Viera is a serious risk of avoidable complications.

Our care model, Care Management Plus (caremanagementplus.org) attempts to comprehensively address Ms. Viera's health and quality of life. Once in Care Management Plus, a specifically trained nurse or social worker care manager assesses Ms. Viera's needs, co-creates a plan of care with her, acts as a catalyst to ensure the care plan takes place, and is a single point of contact for Ms. Viera's health care needs. The model focuses three themes: self-management and navigation over time; prevention of illness and disability; and information technology. For the Vieras, the care manager may assess home safety, connect them to community resources that provide services to help the caregivers cope, use assessment protocols for chronic illnesses, and facilitate discussions with providers and other

specialists. The information technology will track the progress of the Vieras and others over time to ensure they will not be forgotten.

The Benefits of Care Management Plus

The clinical and cost outcomes of the Care Management Plus approach are significant and positive. In our initial research and testing of Care Management Plus, care managers in 7 clinics cared for more than 23,000 patients over five years, rendering more than 100,000 services. In the program, people with diabetes have better control of their blood sugars and are more likely to be tested, which corresponded to 15-25% fewer long term complications, which translates into significant savings in medical costs, social service costs, and allows patients like the Vieras to live independently far longer. Seniors with diabetes had a 20% reduction in mortality and a 24% reduction in hospitalizations, saving Medicare up to $274,000 per clinic. Perhaps most importantly, patients and health care providers are extremely satisfied, referring to the program as a "lifesaver" and a "dramatic improvement in healthcare."

Looking Ahead: The Challenges of Dissemination, the Need for Reimbursement

We now are disseminating the Care Management Plus model with our coordinating center at Oregon Health & Science University, increasing seven pilot clinics to more than 40 clinics nationwide. In this effort, we see a number of challenges as we translate our research into broader practice.

First, these models provide cost savings but the services are minimally reimbursed. Smaller clinics run a serious risk of a net loss by providing coordination. Second, the ability to track and coordinate care requires a system currently in place in few clinics. Use of information technology is essential, but even with an electronic health record, the specific needs of care managers – care plan creation, best practices reminders and tracking, and facilitation of communication with the entire team – are not met. Understanding these information technology needs, encouraging their further development, and helping clinics implement them was crucial to our success and should be encouraged.

Finally, and most salient to the discussion today, is that we found significant variation in the goals of the patients and the roles of the care managers. In developing Care Management Plus, we created protocols for and focused on the management of specific diseases. But patients have more holistic concerns about the overall quality of their life and health, as well as the interactions among their multiple conditions. We found that care managers' ability to spend face-to-face time with patients and offer a variety of services (e.g.,

education, motivation, addressing barriers) was strongly correlated with better disease and health outcomes. Not every patient's trajectory was changeable, but thoughtful, experienced care managers improved most patients' quality of life and care.

Continued work on our capacity to care for older adults is required. In recent testimony to the Institute of Medicine, Corinne Rieder, the executive director of The John A. Hartford Foundation, highlighted the ongoing issues to build capacity to care for our vulnerable elders. She discusses three strategies that are pertinent to our discussion today. First, the numbers of our geriatrics specialists – physicians, social workers, nurses, pharmacists, and others – are insufficient to meet current and future needs. Second, creating capacity to deliver better care to older adults also requires investment in research in models like Care Management Plus. Research and development in such models has not developed through traditional business models and requires support by the government and foundations to support. Third, excellent researchers need to be encouraged to pursue research in efficiently, effectively provide care for older adults.

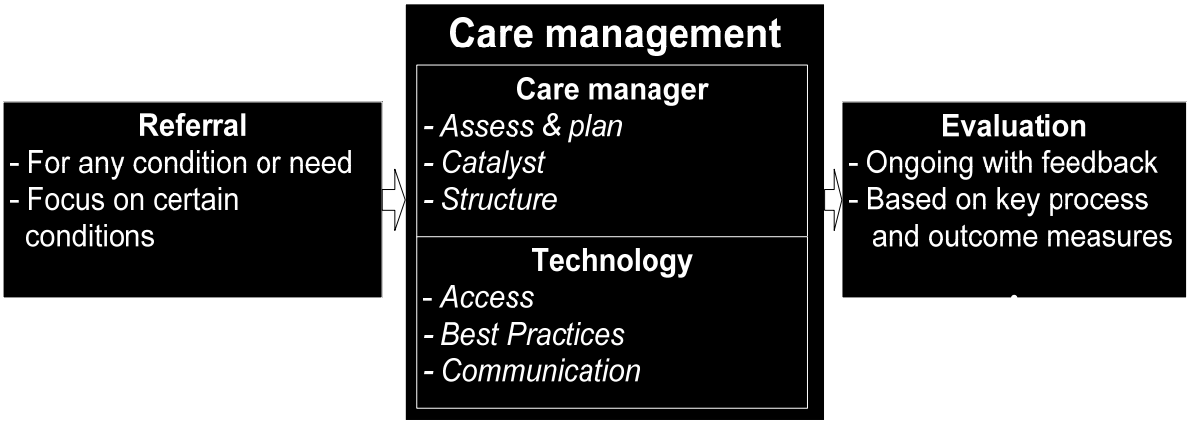
Care Management Plus

Care Management Plus uses IT and care managers to help patients and caregivers 1) self-manage their conditions; 2) prioritize health care needs and prevent complications through structured protocols; and 3) navigate an increasingly complex health care system. Specialized Information Technology includes the care manager tracking database, patient summary sheet and messaging systems to help providers access care plans, remind providers about best practices, and facilitate communication among the health care team.

The positive results of this model have caused many stakeholders to take notice. However, adoption of Care Management Plus requires primary care clinics to make a substantial investment: hiring a care manager, upgrading or acquiring Information Technology, and devoting the time and resources of other staff members to training and protocol implementation. In all, each clinic's investment is about $100,000 over the first year of the program. In addition, Care Management Plus was estimated to save Medicare $274,000 per year per clinic by comparing care managed patients with diabetes and other illnesses with matched controls.

Programs that use care management techniques, such as the Chronic Care Model, use team-based approaches to reorganize care. Information technology may also be used to remind physicians about best care for conditions. However, previous uses of information technology and care management only address part of the issue; with the complexity of a

patient's needs, information technology alone may provide too many alerts without a clear plan.



Care Management Plus focuses on three areas. First, care managers enhance a patient's and caregiver's *self-management* ability. The program has adapted other models to focus on needs of the elderly and patients with multiple chronic illnesses, for whom self-management is most difficult. It uses both computer-based tools and trained clinicians to enhance primary care. The primary information technology tool - the Care Management Tracking database - organizes the delivery of care and tracks tasks and outcomes. This enables both the patient and family and the primary care team to proactively identify the patient's disease status, to help them receive recommended care, and to meet specific goals. For those patients who have greater barriers to self-management, care managers work collaboratively with them and with their physicians to develop strategies to overcome these barriers, and then monitor progress. Physicians can refer patients in high numbers since the IT tools remind the care manager about the complex care plans and needs of patients.

Some patients have substantial challenges that can interfere with their self-management ability and overall health. The care manager partners with patients to help them overcome these challenges. For example, patients who have multiple chronic diseases or lack sufficient confidence or social support to manage the diseases may have a difficult time following through on a doctor's counsel without extra help. The care manager empowers such patients to organize and prioritize their tasks, and then monitors their progress. The care manager collaborates with the patient, the family and their physician(s) to

adjust the plan as needed. The benefits of improved self-management persist beyond the time that the care manager is involved accounting for better outcomes even years later.

Second, *prevention and early recognition is key* in Care Management Plus. The primary care team treats patients' chronic diseases early, trying to prevent problems rather than treating them after they occur. Information technology tools help monitor the status and needs of an entire population of patients, and remind the team of what needs to be done. A Patient Summary Sheet (known as the patient worksheet) also identifies which patients may not be getting monitored or treated appropriately; lab work that is due, and indicated medications that should be prescribed. It can be used as a reminder and to reinforce these goals when it is sent home with the patient. Third, many patients seek care from urgent locations (the emergency room, the hospital) because *the health care system can be complex and difficult to access*. The care managers help patients and caregivers navigate the system, providing links to community resources, helping compile care plans from multiple different providers, and taking the time to ensure patients at high risk receive best practice care. For example, if Mr. Viera were exhausted, the care manager could arrange for respite care and caregiver support classes to help him cope. If Ms. Viera were extremely depressed, the care manager would assure that the patient was seen by a counselor and/or a psychiatrist, and then communicate changes back to the primary care team.

The combination of the integration of these care managers into the primary care team with these tools has led to improvement of health of thousands of persons and significant decreases in the exacerbations of illness for seniors. Seniors with complex diabetes cared for under the program had a 20% reduction in mortality, 24% reduction in hospitalizations (including a 40% reduction in preventable hospitalizations), and up to 42% improvement in control of disease.

Other models

The Care Transitions Model, developed by Eric Coleman, has shown significant reductions in costs and significant improvements in patient-centered outcomes. During a 4-week program, patients with complex care needs and family caregivers receive specific tools and work with a "Transition Coach," to learn self-management skills that will ensure their needs are met during the transition from hospital to home. Patients who received this program were also more likely to achieve self-identified personal goals around symptom management and functional recovery. These patients were also significantly less likely to be readmitted to the hospital, and the benefits were sustained for five months after the end of

the one-month intervention. Anticipated cost savings for 350 chronically ill adults with an initial hospitalization over 12 months is $ 295,594.

To date, the Care Transitions Program team has collaborated with 16 leading health care delivery organizations to adapt the model to their unique environments and this number will exceed 50 by September 2007. Please visit www.caretransitions.org where you can learn more about the model and its evidence.

Senior Health and Wellness Centers, like that developed by Ron Stock at PeaceHealth in Oregon, use interdisciplinary team approaches to coordinate care for the frail elderly. Such centers have been shown to improve function of patients, an important quality outcome. Other models, such as the Virtual Integrated Practice team model from Steven Rothschild at Rush University in Chicago, the IMPACT model by Jürgen Unutzer from the University of Washington, and many others have great promise for delivering the kind of chronic disease coordination that brings benefits to patients. Developing the expertise in care coordination takes time and effort; any reimbursement changes and health care reform initiatives should take into account the dissemination of expertise required to successfully implement them.