The Impact of Care Management on Utilization and Spending

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Purpose of the Report

- Review the research evidence on care management for patients with complex medical conditions
- Identify the ingredients of success
- Establish priorities for HSCRC
- Policy implications and recommendations

Review of Research Evidence

- Medicare care management demonstrations
  - Taken as a whole, no net impact
  - But dissecting the aggregate evidence shows that certain approaches show strong results
- Wide range of other studies show mixed results but also point the way to success

Key Ingredients of Success

- Identification of patients with complex needs
- In-depth health risk assessments
- Early development of care plans
- Implementation of these care plans

Identifying Patients with High Needs

- This can be done on a predictive basis
  - e.g. predictive modeling
- Another approach: actual use/conditions
  - Recent inpatient stay, 3+ ED visits
  - Chronic diseases: CHF, COPD, ESRD, SMI, diabetes, asthma, hypertension
  - Patients with multiple diseases are at high risk
  - Top spenders

Health Risk Assessment

- HRAs include: extended questionnaire, risk scores, face-to-face feedback to patients
- Include physiological data and lifestyle information (exercise, smoking, diet)
- Demographic data
- Estimate a level of risk
- Recommend interventions

Individualized Care Plan

- Key ingredients
  - Individualized, patient/family involvement
  - Effective discharge planning and follow-up
  - Home visits by care managers
  - Medication management
  - Strong linkage between somatic/behavioral health
  - Addressing transportation, nutrition needs
  - Addressing social determinants (e.g. lack of safe housing, poverty, unemployment, air quality)

Delivery System Reforms

- Care managers have direct interactions with their patients' physicians, hospitals
- Care managers embedded in, or employees of primary care practices
- Careful care transitions, smooth hand-offs
- Multi-disciplinary team-based care
- Long-term care facilities treat minor changes in health conditions on site

Complementary Reforms

- HIT that is interoperable and highly interactive
- Meaningful use of HIT by providers in real time
- Care management fees at reasonable levels
- Care management fees at risk

Promising Programs

- INTERACT
- Project RED
- Bridge Model
- Coleman, Naylor models
- Care Improvement Plus
- J-CHiP, Frederick Memorial
- Washington Adventist, Western Maryland

Additional Programs

- Geisinger Diabetes Control
- San Francisco Department of Health
- Hennepin County

HSCRC Priorities

- Reduce hospital admissions
- Reduce hospital readmissions
- Reduce trips to ER, admissions among patients in long-term care facilities

Policy Implications

- HSCRC can play a useful role in support of the All-Payer Model Design goals by:
  - Encourage MD hospitals to adopt best practices in identifying hi-risk patients, conducting HRAs, developing good care plans
  - Use multi-dimensional teams, in-home visits
  - Link behavioral and physical health
  - Embed care managers within physician practices

Policy Implications

- Medication management is critical
- Interdisciplinary, multi-dimensional teams
- PCP has all records of service use
- Social services included in care plan
- Interoperable HIT used in real time by providers
- HSCRC could promote a “checklist” of promising practices for care management