PtC^3: Patient-Centered Coordinated Care

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A significant percentage of Medicare beneficiaries have at least one chronic condition. Two-thirds of these older adults have several chronic conditions with almost a quarter dealing with four or more.[1]

The cost of fragmented, inefficient chronic care is high. Medicare beneficiaries with four or more chronic conditions account for 80% of Medicare spending,[1] which totaled $402 billion in 2006. American medicine stands at a worrisome crossroads as the first baby boomers near retirement age. Without prompt transformation, chronic care in America will soon become unsustainably expensive (Box 1).[2]

The answer may be Patient-Centered Coordinated Care (PtC^3). PtC^3 is an assessment-based interdisciplinary approach to integrating health care and social support services in which a patient's individual needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored through a high touch approach.

Core Principles

Medicare has been interested for some time in identifying successful models of care. The Medicare Coordinated Care Demonstration (MCCD) was initiated in 2002 and for a few select programs continues today to identify coordinated care programs with improved outcomes. However, despite enormous efforts, only 3 of the 15 programs in the MCCD were effective in reducing hospitalizations and costs over the first 4 years of operations. In-depth analysis of program details has revealed that six key components distinguished the successful MCCD programs from the ineffective ones[3]:

1. Targeting
2. In-person contact
3. Access to timely information on hospital and emergency room admissions
4. Close interaction between care coordinators and primary care physicians
5. Services provided
   a. Assessing
   b. Care planning
   c. Educating
   d. Monitoring
   e. Coaching patients on self-management
6. Interdisciplinary team (IDT) staffing
   a. Nurse
   b. Social workers
   c. Nutritionists
   d. Therapists
   e. Pharmacist
   f. Physician / nurse practitioner

Targeting

Screening the enrolled population identifies individuals with special needs. Plans should use valid and reliable instruments to screen their enrollees regularly. They should assess the clinical needs of high-risk enrollees for both functional status and quality of life. About 10% to 15% of beneficiaries, most of whom have several chronic conditions, account for 70% to 80% of Medicare's annual payments for health care. Early identification of those who are at highest risk for requiring expensive care—and assessing their clinical needs—would facilitate coordination of care and timely preventive interventions designed to improve the clinical and financial outcomes of care.[4]

IDT Staffing

The IDT approach allows for comprehensive, coordinated assessment and management of beneficiaries' medical, psychological, social, and functional needs—and those of their unpaid caregivers.[5] Making available the services of health care professionals from several disci-

plines, including physicians, nurses, social workers, pharmacists, and rehabilitation therapists, enables all to function as an interdisciplinary team in managing not only the medical conditions but also the social factors that affect high-risk beneficiaries' well-being.

Part of the IDT approach includes providing geriatric expertise for designing and administering geriatric programs and for consultation with primary care physicians, case managers, and other providers. Managed care organizations (MCOs) would be well served to use a geriatrician in a medical director role to help guide the development and management of programs necessary for success in caring for seniors. Geriatricians have the background necessary to efficiently and effectively manage patients in teams, as well as manage the care of complex patients with multiple problems across the continuum of care.[6]

Coordinating Actions

Coordinating the actions of all providers across the continuum of enrolled beneficiaries' care improves the quality and the outcomes of health care, including safety, cost, and satisfaction with care. The coordination of care can be made more efficient and effective by utilizing integrated medical records as well as improved communication tools.

Preventive Care

Offering effective health promotion, disease prevention, and self-management programs can prevent or delay the progression of disease, resulting in better patient outcomes and lower costs of health care. In addition, programs that provide education of patients and their caregivers with regard to their conditions and self-management initiatives empower them to be proactive and choose wise alternatives.[7]

Box 1. The Root Problem: Fragmentation

- Incentives and accountability are not aligned
  - Fiduciary is separated from clinical responsibility
  - Medical care model is focused on single disease states
  - Cannot count future benefits against today's costs
- Information does not exist or is not available
  - Medical records are still largely paper-based
  - Clinical decision support lacks an evidence base
  - Real-time communication is lacking between providers
- Private and public solutions are hard to implement
  - Patients and insurers cannot act unilaterally
  - Public payers invariably pick access over cost containment
  - Desire to protect status quo confuses problem with solution

Medicare Advantage Funding

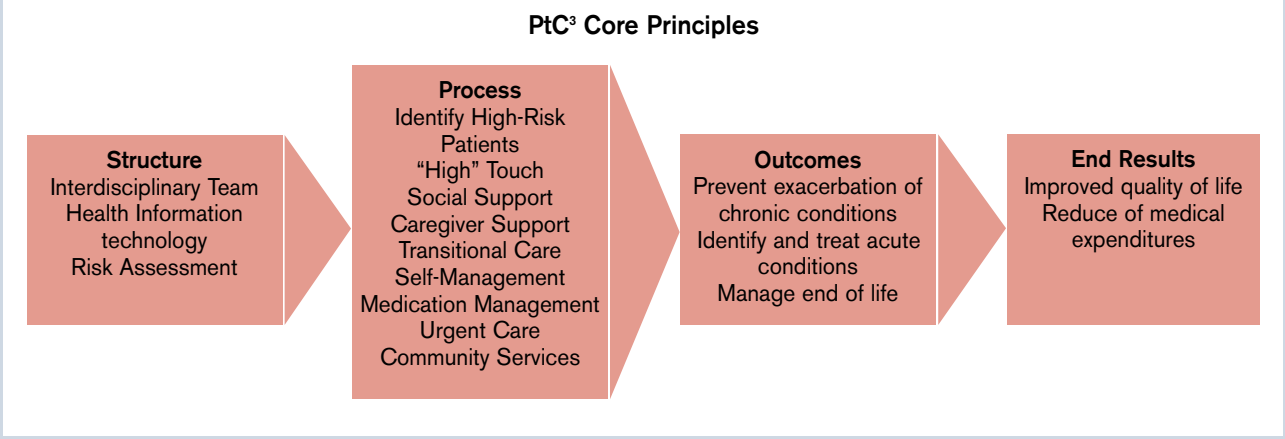
According to the September 2006 report of the Institute of Medicine, *Rewarding Provider Performance: Aligning Incentives in Medicare,* this method "does little to encourage coordinated, preventive, and primary care that could save money and produce better health outcomes."[8] Instead the core principles themselves of PtC^3 itself must be promoted. And one of the ways to promote PtC^3 is through Medicare Advantage (MA).

Today, there are more than 10 million Medicare beneficiaries enrolled in MA plans that include:

- PACE—Program for All inclusive Care for the Elderly
- SNP—Special Needs Plans
- HMOs—Health Maintenance Organizations
- PFFS—Private Fee For Service

Medicare Advantage plans provide enrollees with access to increased benefits over fee-for-service (FFS) under original Medicare. Specifically, MA programs have the potential to add care coordination for Medicare patients who are particularly vulnerable. Nonprivate FFS MA plans add value to Medicare patients by providing a payment mechanism to enhance care coordination and quality reporting and performance. While it cannot be said for every Medicare Advantage HMO, an effective MA program provides enrollees with increased value and benefits, including lower member cost-sharing, vision and dental coverage, wellness programs, prescription drug coverage at little to no extra cost, and a cap on out-of pocket medical expenses. Additionally, plans that incorporate a coordinated approach to health care delivery utilize a team of health care professionals whose focus is on maintaining health and wellness as well as managing chronic conditions. Patients participating in these programs often receive consistent preventive care, are satisfied with their coverage, and are less

Figure 1. Core Principles of PtC³



likely than FFS beneficiaries to report trouble receiving care.

The findings of a 2007 survey by America's Health Insurance Plans (AHIP), regarding the important role MA plans play in providing health security to Medicare beneficiaries, found that 90% of beneficiaries enrolled in these plans are satisfied with their overall coverage. Other findings show that most beneficiaries are satisfied with the quality of care they receive (93%), the number of doctors from which they can choose (92%), the benefits they receive (89%), the coverage they receive for preventive care (87%), their out-of-pocket costs (80%), and the coverage they receive for prescription drugs (76%).

Another survey in 2007 by the Blue Cross and Blue Shield Association found that MA provides valuable benefits and coordinated care. More than 8 out of 10 survey respondents (84%) said they are happy with their health care coverage, and nearly all survey respondents said it is important for Congress to work to maintain adequate funding for the program. In addition, many beneficiaries worry that Medicare cuts could mean they could not afford to pay the bill for an unexpected illness (48%) or afford prescription drugs (45%). Finally, three-quarters of MA beneficiaries said their health plan is better than traditional Medicare and while many beneficiaries ranked health care coverage in this country as fair or poor (65%), most ranked their own health plan coverage in MA as good or excellent (67%).

Lastly, the 2005 Medicare Current Beneficiary Survey (MCBS) shows that MA beneficiaries are less likely than FFS beneficiaries to report trouble in receiving care, and more likely to receive necessary preventative services such as those for pneumococcal and influenza immunizations, mammography, colorectal screening, and prostate screening.

The American Geriatrics Society (AGS) has stated that the coordinated care approach, found under many MA plans, results not only in higher quality of care but also beneficiary savings, access to care, and additional benefits and satisfaction. As a result, AGS in a policy brief has endorsed prepaid capitation as an efficient approach for Medicare to finance high-quality, cost-effective geriatric care that supports care models for frail elders. In advocating for effective care delivery models, appropriate quality, and fair payment systems, the AGS recognizes the role that many MA programs play in offering capitated funding for several heterogeneous MCOs. Regardless of organizational type, however, the AGS has urged policymakers, administrators, health care professionals, and consumers to understand what core elements of care are required to meet the unique needs of older adults.

The quality of the health care provided to beneficiaries by MCOs should be measured consistently and reported regularly to the plans' executives and providers, to CMS, and to the public. New instruments designed to measure the quality of outpatient care and coordination of care must be developed and tested for reliability and validity.

Credible, understandable information about the quality of health care is essential to organizations' processes for improving quality and to consumers' efforts to make informed choices from among the available health plans and providers.[9]

Capitation rates in all regions of the country should be sufficient for

providing high-quality health care for all Medicare beneficiaries, regardless of the intensity of their clinical needs. Specifically, CMS should provide capitation that reflects the probable cost of caring for each enrolled beneficiary. This should be accomplished by risk-adjusting capitation payments according to individual beneficiaries' diagnosis, functional status, and utilization.

Capitation payments that acknowledge that beneficiaries with chronic conditions require more health care than those who are healthy would encourage MCOs to enroll beneficiaries who have chronic conditions and to provide them with special services designed to address their needs for complex care. In contrast, inadequate risk-adjustment of capitation payments is a disincentive for plans to enroll frail or medically complex beneficiaries or to offer special services that might encourage such beneficiaries to enroll.[10]

Provider Action

Impact to You

Because of the aging baby boomers and medical innovations, chronic care management is becoming unsustainable. The cost of fragmented, inefficient chronic care is high. Medicare beneficiaries with four or more chronic conditions account for 80% of Medicare spending, which totaled $402 billion in 2006. A transformation of chronic care management is inevitable.

What You Need to Know

Patient-Centered Coordinated Care (PtC^3) is based on core principles involving structure, process, and outcome that ultimately results in improved quality of life and reduced medical expenditures. PtC^3 is founded on an assessment-based interdisciplinary approach to integrating health care and social support services in which a patient's individual needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored through a high-touch approach.

What You Need to Do

One should start with the development of a practice based on the PtC^3 core principles. If that is not possible, physicians should identify those systems that utilize the PtC^3 core principles and refer not only their patients but themselves as well—looking to become an active part of the IDT managing these systems. In addition, physicians will need to be politically active to ensure the growth and development of PtC^3 models of care.

Models That Work

PACE: Program of All-Inclusive Care for the Elderly

PACE is a managed-care program that was developed to enable individuals to live independently in the community and with a high quality of life. In 2007, there were 42 PACE programs active in 22 states. Founded on the premise that it is better for the well-being of frail older adults and their families if services are provided in the community, PACE was modeled after an innovative initiative in San Francisco, On Lok, which was designed to help the Asian American community care for older adults in their homes.

The program centerpiece is an adult daycare center, where older adults receive primary care therapies, meals, and social work and other services. In Texas, PACE enrollees have had fewer hospital admissions than the overall Medicare population (2399 per 1000 per year vs 2448) even though PACE enrollees are far more frail than the average Medicare patient. More information on the program is available at www.npaonline.org/website/article.asp?id=12.

Evercare

Evercare is one of the nation's largest care coordination programs for people who have long-term or advanced illnesses, are older, or have disabilities. These MA plans enhance the health and independence of older Americans by providing a nurse practitioner or care manager to guide beneficiaries through the complex world of health care. Evercare provides health plans for people who have long-term or advanced illness, are older, or have disabilities, including those in nursing homes. The plans target individuals with specific long-term illnesses, including heart disease, respiratory disease, high blood pressure, diabetes, or dementia. More information is available at: http://evercarehealthplans.com.

Future

While most models of PtC^3 come from MA, there are some that are emerging from the FFS side of Medicare. Perhaps the most promising, if not the most heavily promoted, is the Patient-Centered Medical Home (PCMH),[11] a concept developed under the joint auspices of the American College of Physicians, the American Academy of Family Practice, the American Academic of Pediatrics, and the American Osteopathic Association. Criteria have been developing by which primary care practices can qualify to be "medical homes," and a number of private insurers and Medicare are launch-

ing demonstrations to test the feasibility of the concept. The beneficiary eligibility criteria for the Medicare demonstration currently include 86% of all beneficiaries in FFS Medicare. Evidence suggests that if "medical homes" participating in the Medicare demonstration are expected to generate savings that equal or exceed the monthly fee paid, they are unlikely to be successful because they will be serving a population that is too broad-based.

In the end it will be the programs that are able to best provide all the core principles required of a PtC^3 program that will succeed. And by successfully delivering on these principles, patients, caregivers, providers, and payers will be much better off as a result. MPM

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