Achieving the Triple Aim: Evidence from the MGH CMS Demo

Weitzman Symposium
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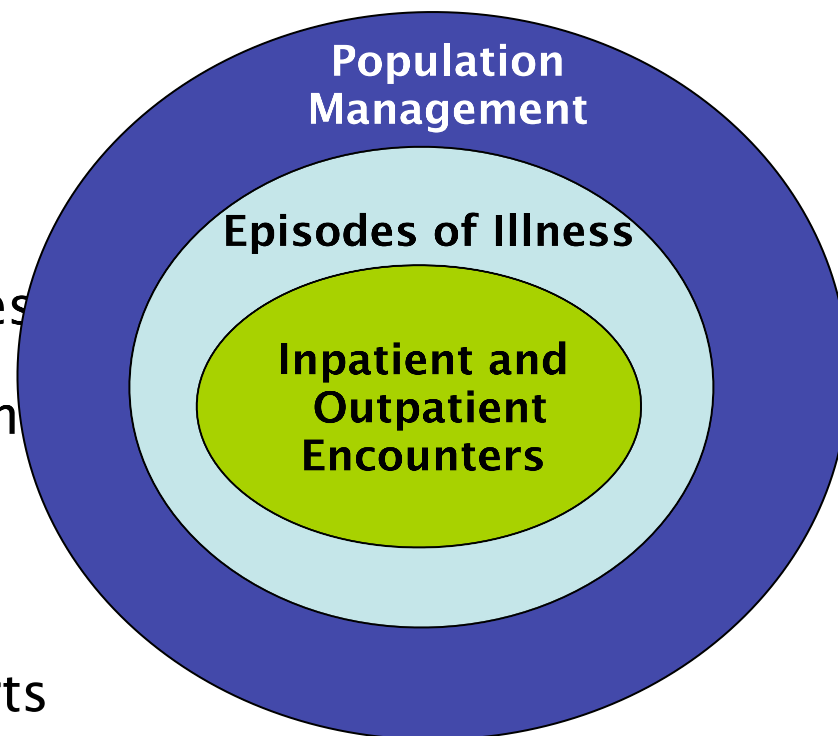
Overview

Goals
- Demonstrably higher quality
- Decreased unit cost
- Savings to purchasers

Approach
- Improve quality (patient outcomes
- Reduce unit costs
- Redesign care (fewer units/patien
- Improve access (more patients)

Process
- Set goals
- Integrate Partners and MGH efforts
- Support implementation teams
- Monitor progress (measurement)



Care Redesign Tactics

	Longitudinal Care	Episodic Care	
	Primary Care	Specialty Care	Hospital Care
Access to care	Patient portal/physician portal		Hospital Access Center
	Extended hours/same day appointments		Reduced low acuity admissions
	Expand virtual visit options		
Design of care	Defined process standards in priority conditions (multidisciplinary teams)		
	High risk care management	Shared decision making	Re-admissions
			Hospital Acquired Conditions
	100% preventive services	Appropriateness	Hand-off standards
			Continuity visit
	EHR with decision support and order entry		
	Incentive programs		
Measurement	Variance reporting/performance dashboards		
	Quality metrics: clinical outcomes, satisfaction		
	Costs/population	Costs/episode	

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Four Observations, One Implication

- **Small fraction of pts responsible for large fraction of costs**
  MedPac, June 2006 Data Book
- **Most high cost patients have multiple chronic conditions**
  Thorpe et al, Health Affairs, 2006
- **Outcomes for these patients depend on quality of care**
  Higashi et al, Ann Int Med. 2005
- **Outcomes also depend on patient's self-management**
  Lorig et al, Med Care, 2001
- **Implication:**
  - Improved delivery of care and better self-management should improve quality and reduce costs

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Definitions in Population Management

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- Disease management (500+ pts/nurse)

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- **Case management (50+ pts/nurse)**

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Approaches to Population Management

	Low Engagement	High Engagement
Traditional	**Population Screening** Target patients by disease and age group **Patient Education** Distribute brochures on how to manage chronic disease	**Call Center** Centralized case managers call patients to monitor progress **Guidelines / Support** Promote best practices among providers
Emerging	**Risk Screening** Stratify patients for different program interventions based upon medical criteria	**Remote Monitoring** Use devices to monitor patients at home **Practice Based Case Managers** Supported by real-time alerts, workflow software, clinical decision support

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Based on California HealthCare Foundation Report, 2006

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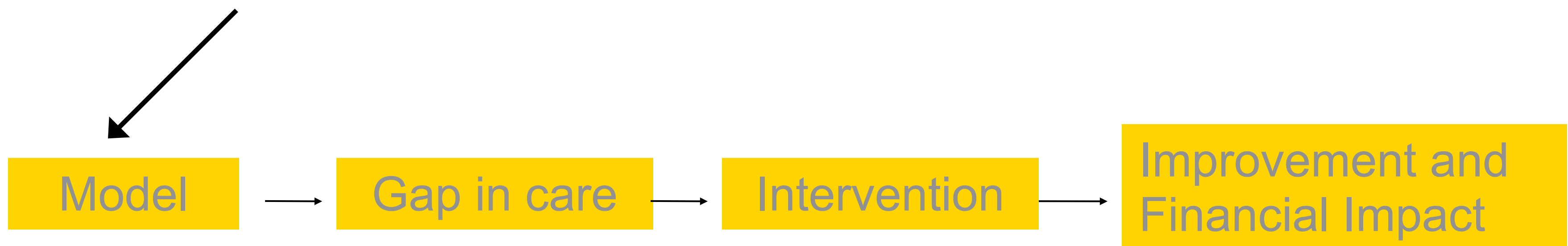
Identifying Patients

- Predictive Models: Ideal and Real
- Medical Claims Data
- Pharmacy Claims Data
- Demographics
- Patient Reported Information (Health Risk Assessment)*
- Medical records*
- Laboratory Data*



Most programs model "risk" and not "opportunity"

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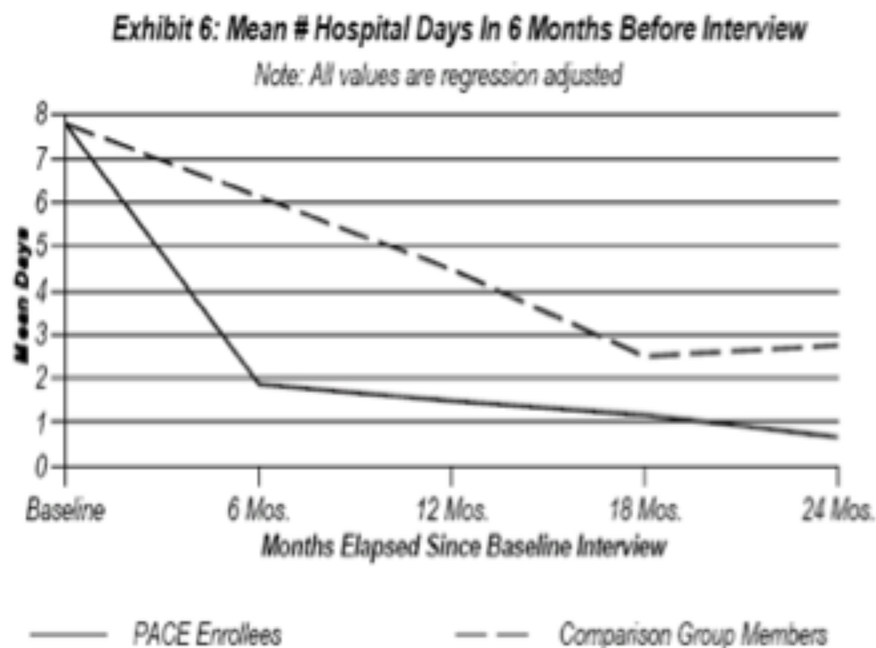
Exemplars in Population Management

- **Disease specific: Heart Failure (HF)**
  - CBO reports cites HF as the only consistent example of savings
  - Comprehensive discharge planning plus post-discharge support reduced readmission increasing costs.



- **High risk programs**
  - Not disease specific
  - PACE program

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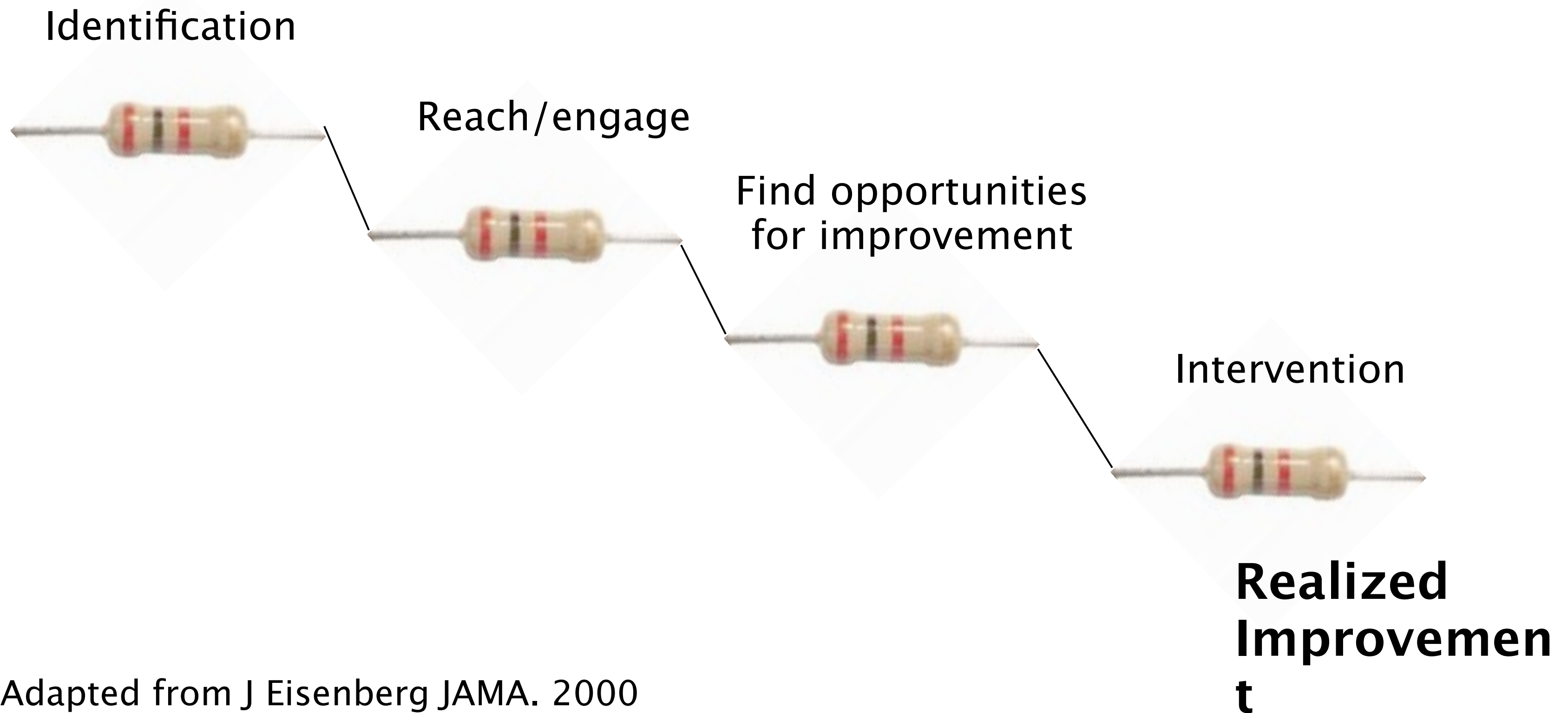
Why Have Care Management Results Been So Modest?

1. **Flaws in Concept**
   - Expected big results rapidly (programs require maturation, CQI)
   - Intervention differed little from usual care
   - Participants not the ones with high costs (selection)
   - Limits to patients' "self management" of complex illness (esp. psych)
2. **Flaws in Design**
   - Interventions were not sufficiently standardized or robust
     - Targeting of appropriate patients
     - Low prevalence of some outcomes
   - Programs more effective if patient choices are constrained
   - Neuro-psych issues not sufficiently accounted for
3. **Flaws in Implementation**
   - Internal approval processes took too long
   - Challenges in recruiting patients quickly

Gold M et al. Health Affairs. 2005;W5-199

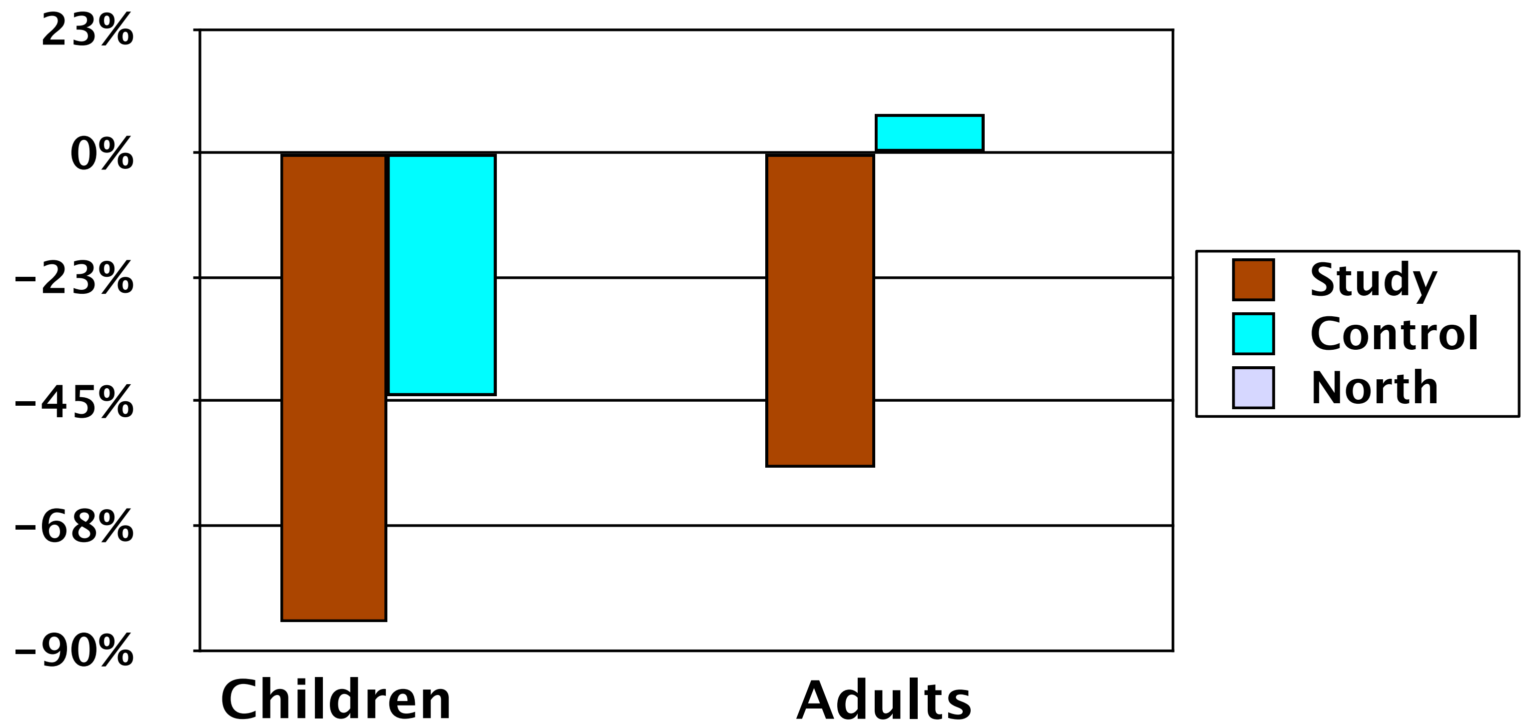
Drops in Potential for Care Management

Potential Opportunity



Adapted from J Eisenberg JAMA. 2000

Chelsea Asthma Management Program



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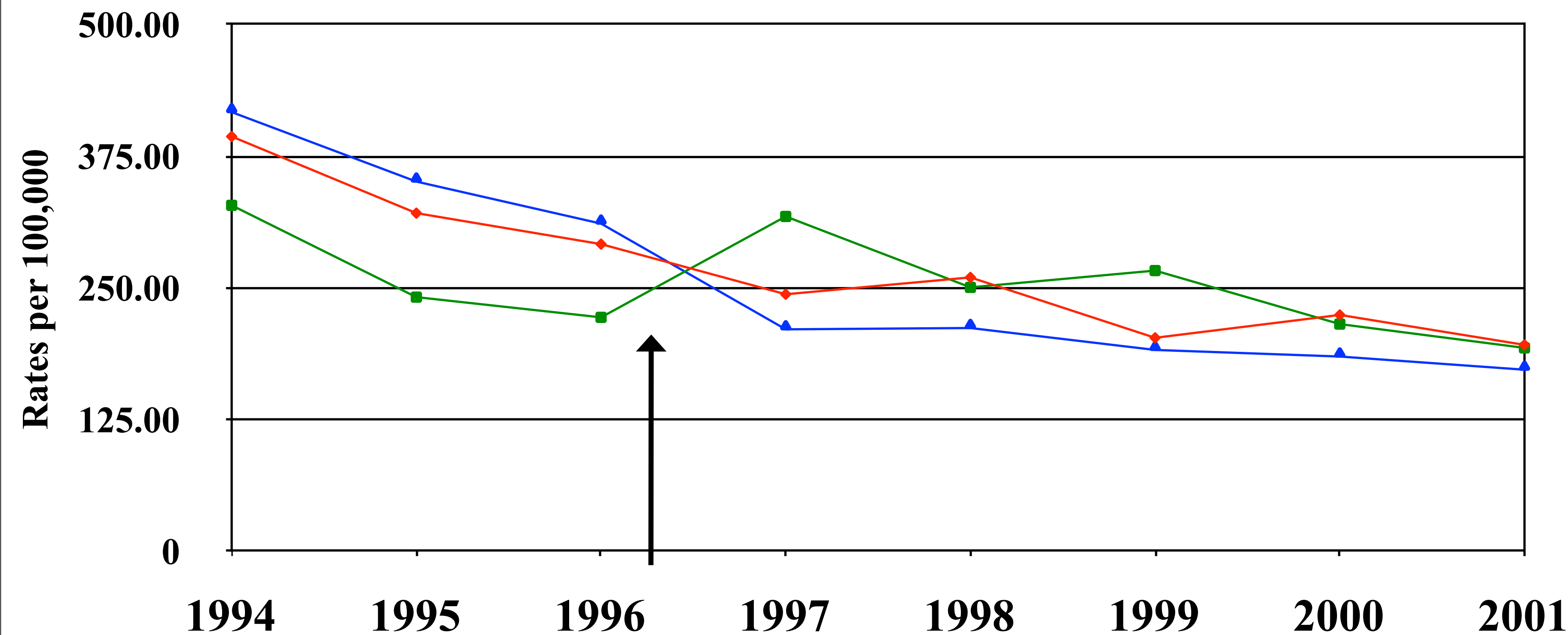

Tuesday, June 14, 2011

MGH Medicare Demo:
Care Management for High Cost Beneficiaries

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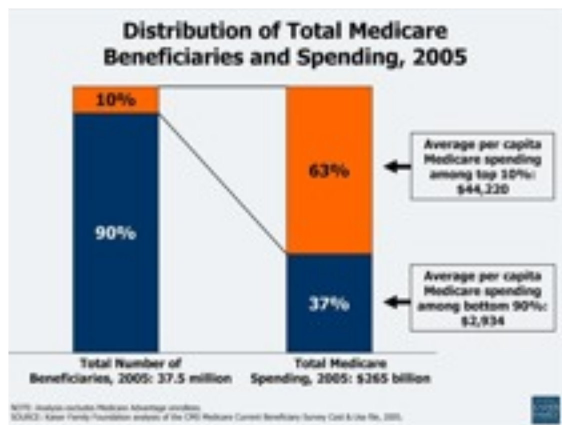
Care Management for High Cost Beneficiaries

The Opportunity

- **10% of Medicare patients account for nearly 70% of spending**



- **20% of Medicare patients have 5 or more chronic conditions**
  - Congestive heart failure
  - Chronic pulmonary disease
  - Coronary disease
  - Diabetes
  - Depression

The Demonstration

- **3-year Medicare demonstration**
  - MGH one of 6 participating sites
  - Focus is on high-cost beneficiaries
- **Goal**
  - Test strategies to improve coordination of Medicare services for high-cost FFS beneficiaries
- **Paid monthly fee based on # patients enrolled**
- **Success determined using prospective control**
- **Cost Outcomes**
  - Required to cover program costs + 5%
- **Quality Outcomes**
  - Hospitalizations, Mortality

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High Cost Beneficiaries: The Patients

Selection
- **All primary care practices (19); 190+ PCPs**
- **Risk & cost criteria applied to PCP claims**
- **Inclusion:** chronic illnesses
- **Exclusions:** ESRD, HMO, geography

Utilization
- **2500 patients (top 2.5%)**
  - Average # Meds = 12.6
  - Average # hospitalizations/year = 3.4
  - Average annual costs = $24,000

Total Costs
- **Annual cost of enrolled patients = $60M**

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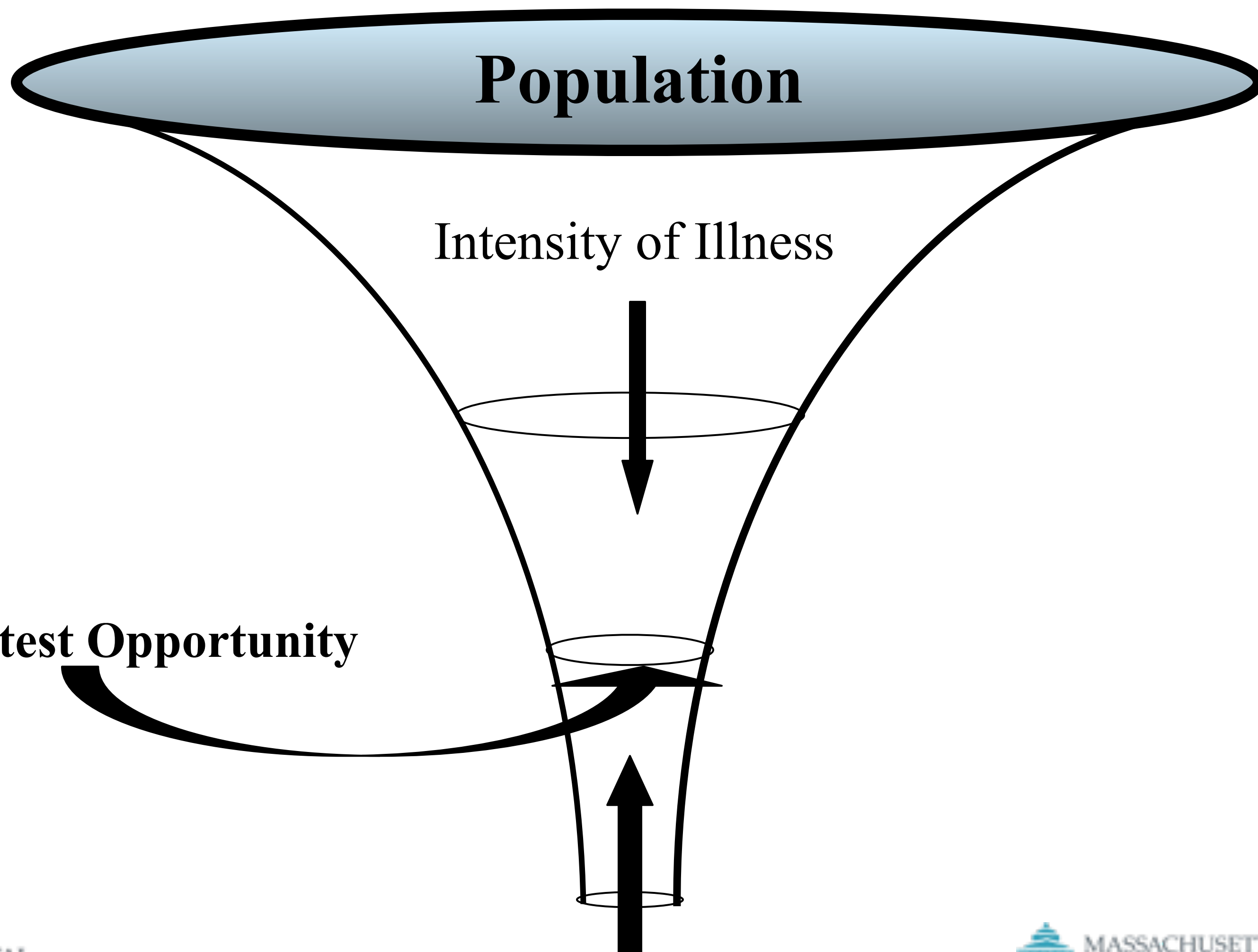
Effective Targeting of Care Management



Intensity and Specificity of Intervention

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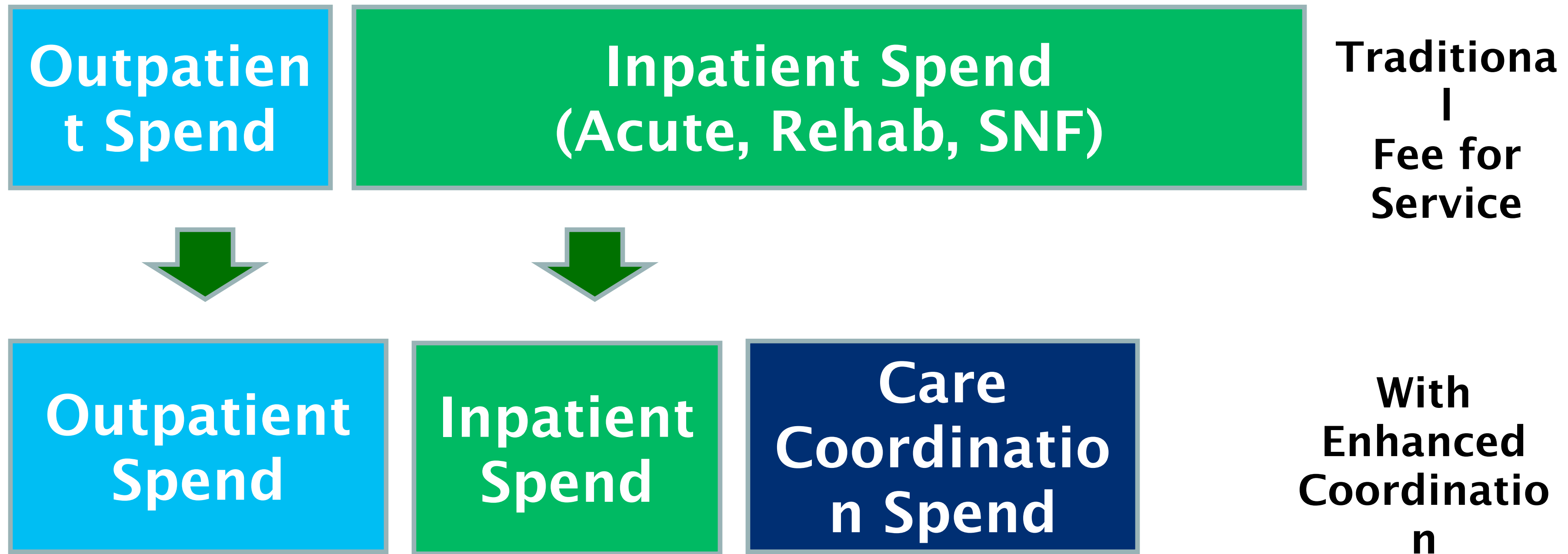
Care Management Program: Strategy

Strategy:
To improve patient care and outcomes with enhanced management resources and care coordination for the sickest patients in our practices



SCHEMATIC: NOT DRAWN TO SCALE

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Care Management Program: Design

- **Primary Care practice based**
- **Heavy reliance on IT/real-time data**
- **Mass customization: services to fit patient needs**
  - End-of-life management
  - Psych/social evaluations & interventions
  - Focus on transitions: home-hospital-home
  - Provider fee encourages participation
  - Flexible: modifications based on experience

- **Care managers are integrated into all Primary Care practices**
  - 12 Care Managers (approx 200 patients/Care Manager)
  - Assess Patients: Identifying risks for poor outcome
  - Coordinate care between providers, services
  - Facilitate better communication / transitions
  - Specialized training and ongoing team based learning

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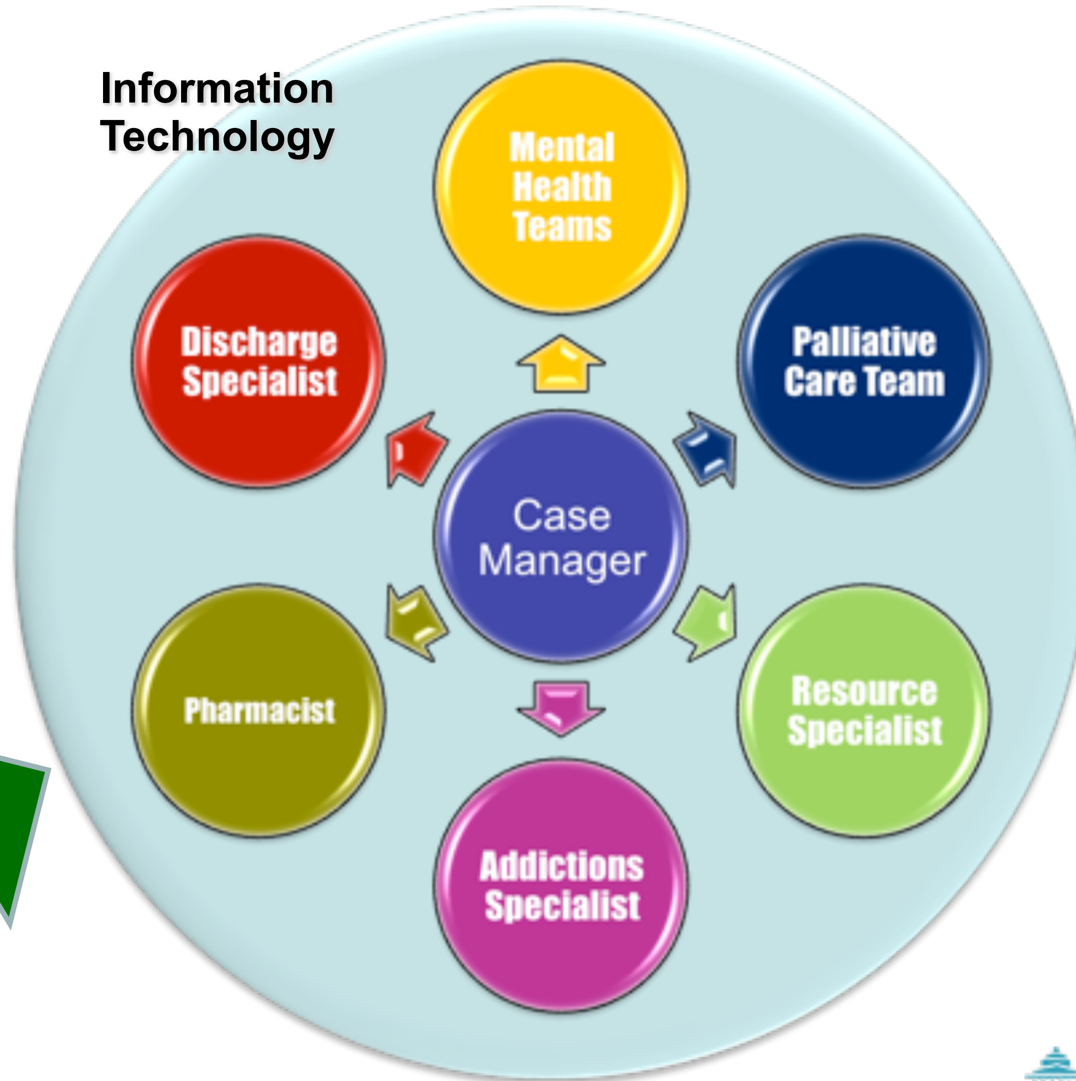
Delivery Model Incorporates Other Specialized Services to Manage Specific Needs



Care Team

Milestones

- **Phase I completed July 2009**
- **Expanded for an additional three years**
  - 1500 new patients enrolled at MGH
  - Program expanded to
    - North Shore Medical Center,
    - Brigham and Women's Hospital
  - 3000 additional patients
- **Total Program Size: 8000 Patients**

MGH Medicare Demonstration Project: Outcomes

Results from Independent Evaluator (RTI)

- **Successful Enrollment**
  - 87% of eligible beneficiaries enrolled
- **Successful Targeting of Interventions**
  - Interventions focused on the enrolled patients with the greatest opportunity
- **Successful Communication**
  - Improved communication between patients and health care team
  - High patient and physician satisfaction
- **Successful Outcomes**
  - Hospitalization rate among enrolled patients was 20% lower than comparison*
    - ED visit rates were 25% lower for enrolled patients*
  - Annual mortality 16% among enrolled and 20% among comparison
- **Successful Savings**
  - 7.1% net savings (12.1% gross) for enrolled patients
  - Approximately 4% annual savings for total population
  - For every $1 spent, the program saved at least $2.65

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*Based on difference in differences analysis

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Care Management Program: Implications

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Care Management Program: Implications

- **Demonstrates positive impacts on <u>total costs</u> to the healthcare system with <u>improved outcomes</u> through <u>well implemented care coordination</u>**

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  - Highlights the value of strong Primary Care

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Care Management Program: Implications

- **New payment systems hold promise for reducing health care costs**
- **Programs like the MGH Care Management Program can be a piece of the solution**

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