Increased adoption of complex care management can help meet cost savings, quality goals

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The care of patients with complex medical needs is widely regarded as one of the key factors driving increased U.S. health costs, and it is generally accepted that 10 to 15 percent of Medicare patients account for 65 to 75 percent of all Medicare spending. Many of the country's leading health care organizations have been adopting the strategy of complex care management – assembling multidisciplinary teams of physicians, nurses, pharmacists, mental health professionals and others, with services being coordinated by care managers who work closely with patients and their family members.

In a Perspective article in the August 7 *New England Journal of Medicine* and a issue brief from the Commonwealth Fund being released today, two Massachusetts General Hospital (MGH) physicians and their co-authors outline best practices based on interviews with the leaders of 18 complex care management programs, discuss barriers to wider adoption of complex care management and describe potential strategies to surmount those barriers.

"Not only can fully addressing the needs of complex care patients keep them healthier, but it also can reduce costs by avoiding emergency departments visits and unnecessary hospitalizations," says Clemens Hong, MD, MPH, of the MGH Division of General Medicine, corresponding author of the NEJM article. "In our Perspective piece, we wanted to spell out some of the needs and challenges inherent in

establishing complex care management and review potential solutions whether you are working in a large integrated health system in Boston or a small one-doctor practice in rural Arkansas."

In the Commonwealth Fund report, Hong and his co-authors – Timothy Ferris, MD, MPH, vice president, Population Health Management, at MGH and Partners HealthCare System and Allison Siegel, MPH, formerly with the Stoeckle Center for Primary Care Innovation at MGH – review characteristics of successful care management programs. Foremost among these are close collaboration of care managers with all the providers taking care of a complex patient. They note that small, one- and two-physician primary care practices may lack the resources required for complex care management. In cases like that, regional organizations – either public or private – can provide the infrastructure for care management that remains closely tied to patients' known providers.

In the NEJM article, Hong, Ferris and Melinda Abrams, vice president, Delivery System Reform, at the Commonwealth Fund note that the primary barrier to broader adoption of care management is the fee-for-service payment system, which provides little or no support for essential care management functions. Instead, reimbursement systems that provide global payments covering all services a complex patient requires or those that share cost savings among both payers and providers may be better options. Another option that provides a monthly, per-patient care management fee might encourage the participation of providers unable to take on the financial risks involved in global payment contracts. Other barriers include the start-up costs associated with staff training and new information technology, which could be covered by supplemental payments. Unrealistic expectations for a rapid return on investment could be addressed by increasing the duration of payer-provider contracts.

The MGH embarked on care management in 2006, with a Center for Medicare and Medicaid Services (CMS)-sponsored demonstration project that enrolled 2,500 high-risk patients in its first phase. Through the coordination of nurse care managers who worked closely with enrolled patients and their physicians, the program achieved annual net savings of 7 percent and a return on investment of at least $2.65 for every dollar spent. CMS renewed the project in 2009, and now over 10,000 complex patients in Eastern Massachusetts have a care manager under the Partners HealthCare Integrated Care Management Program.

"We have many small practices within the Partners system that often do not have enough complex patients to invest in complex care management resources themselves," says Hong "As an integrated delivery system, Partners has the ability to support these practices by providing care managers who may work two or three days a week in several different practices. Not every complex patient needs every service, so sharing resources that are deployed only when and where needed can achieve important economies of scale."

He and his co-authors also note the need for more information on how best to match program design with different practice environments; for training programs and standards; and for advanced analytics and information technology to help identify appropriate patients, provide real-time data and improve workflow. Increased evidence about the savings provided by complex care management should increase its adoption, as the programs not only pay for themselves but also improve health outcomes and reduce fragmentation of patient care.

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