Health Quality Partners' Model of Community-based Care Management:

An Innovation that Improves Health Care Delivery, Outcomes, and Cost in Chronically Ill Older Adults

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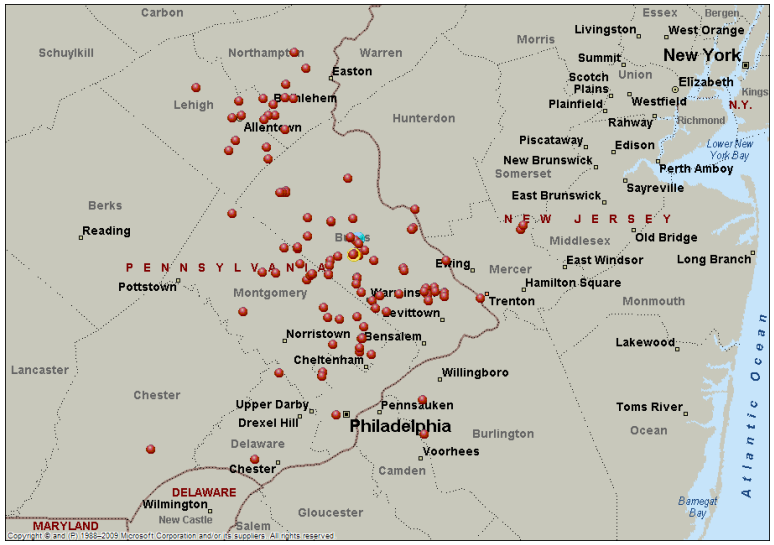
HQP community-based care management

AIM: *Improve health, promote independence, and relieve suffering of chronically ill older adults by providing a comprehensive and highly-effective preventive service.*

- **Longitudinal** – continuous service until death or out-of-area relocation
- **Person-centered** – prioritize concerns of patients & caregivers, adapt care intensity and contact frequency to changing needs
- **Community-based** – participants are seen individually and in groups at accessible locations throughout the community, including at home
- **Nurse care managers** – clinically experienced RNs receive model-specific training and ongoing support and management
- **Collaborate & coordinate** – with primary care, specialist, hospitals, and other health care and community service providers
- **Robust portfolio of preventive interventions** – broad set of best in class interventions adopted with fidelity and delivered directly by nurse care managers
- **Process measurement and visual information displays** - drive performance management, process improvement, and organizational learning

Program Implementation & Evaluation: A Decade of R&D



- **Medicare Coordinated Care Demonstration**
  - Randomized, controlled trial; HQP model vs. usual care
  - Implemented in 90+ practices in 4 counties of eastern PA
  - April 2002 to present, 2,600+ traditional Medicare beneficiaries
  - Low, moderate, and high risk patients served during first 8 years
  - Serving higher-risk patients since late 2010
    - HF, CAD, DM, COPD and 1+ hospitalizations in prior year
- **Aetna Medicare Advantage**
  - Difference-in-differences analysis; trend of HQP cohort vs. like comparison
  - 50+ practices in eastern PA, started 2010
  - Serving higher-risk patients selected by diagnoses, utilization, and Aetna proprietary risk scoring methodology

HQP Program Results Demonstrate that 3-part Aim is Achievable

Better health care: Person-centered prevention, support, education, and coordination

Better health: Lives saved and suffering relieved

Reduced cost through improvement: Lower net cost among higher-risk subgroups

Population	*N*	*Deaths*	*Part A & B expenditures*	*Net Cost*	*Hospital admissions*	*ER visits*	*SNF cost*
MCCD All-in risk (low, mod, high)	1,464		-14% *	Neutral	-14%		
	1,721	-25% **	-4%	+9%	-7 %		
Higher-risk 1	502	-30% **	-20% *		-29% **		
Higher-risk 2	248	-18%	-36% **	-28% **	-39% **	-37% **	-64% **
Aetna Higher-risk 3	942			-18% °	-20% °		

** P ≤ 0.05, * P ≤ 0.1

° statistics not reported

-$511 per person per month
-$6,132 per person per year

Third Report to Congress, Deborah Peikes, et al., Jan 1, 2008, Mathematica Policy Research, Inc. (MPR)

Fourth Report to Congress, Jennifer Schore, et al., March 2011, MPR

JAMA, Deborah Peikes, et al., Feb 2009;301(6):603-618 (doi:10.1001/jama.2009.126)

MPR report shared with HQP with CMS permission, 2011 (unpublished)

Aetna Medical Economics Team Report (unpublished)

HQP Participant Survey (from Peikes et al, JAMA eTables) n=675, 98% response rate	*Treatment*	*Control*	*Difference*
Received help in arranging care	76%	4%	+72% **
Pain interferes with usual activities	66%	75%	-9% *
Primary condition a burden on family	40%	53%	-13% **
Health care clinicians keep in touch with each other (excellent rating)	44%	36%	+8% *

Insights gained and future opportunities

- **Variables that significantly impact savings**
  - Target population, effectiveness in improving health outcomes, program cost (start-up, scale, and demonstration-related overhead), and time frame
- **Access to Data on diagnoses, health service utilization, and clinical tests**
  - Would significantly improve efficiency (case-finding), and effectiveness (better monitoring)
- **Incentives for hospitals and PCPs** to partner with effective providers of this model could
  - Accelerate dissemination
  - Optimize efficiency and fidelity to program implementation to preserve effectiveness
- **Complementary to / synergistic with emerging primary care models**
  - Interface can be designed to minimize redundancy of work and be mutually reinforcing
- **HQP's Replication and Reliability Platform**
  - An integrated suite of tools to support training, decision support, performance analysis, and program monitoring and guidance would boost scalability and enhance reliability
- **Robust and sustained research & development effort seems warranted**
  - Design, adapt, and test variations of the HQP model to serve other vulnerable, at-risk populations
- **Scale it up! The next frontier …**
  - Supporting scalability R&D could fit portfolio of CMMI, other HHS agencies, and/or foundations
  - Unique opportunity for ACO's and consortia of health systems, physician groups, and health plans