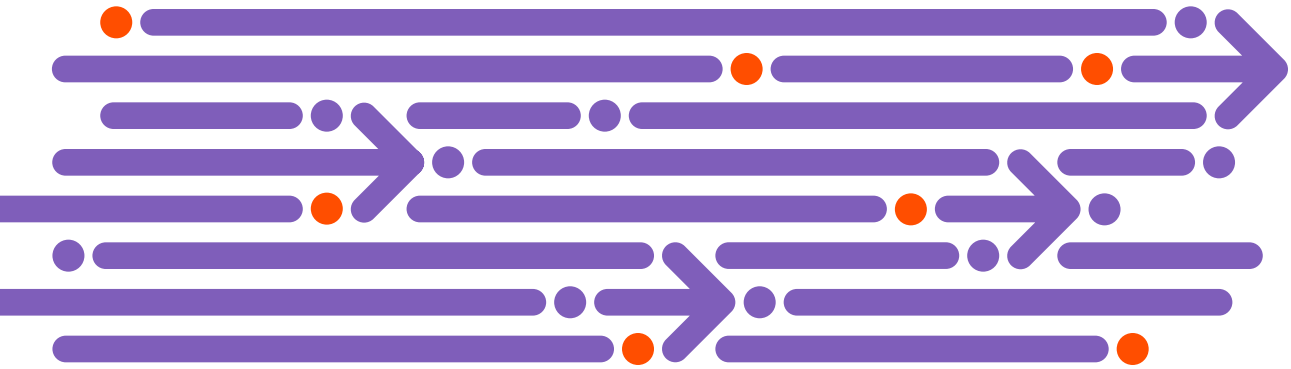
Touch Point

The dangers of fragmented chronic care under longitudinal risk



Patients with chronic disease account for the overwhelming majority of health care spending in the United States. Employers, commercial insurers, and public payers alike are all honing in on the opportunity to generate savings and improve patients' quality of life by developing new models to finance and deliver care for the complex, chronic patient population.

For Medicare, in particular, improving the efficiency of complex, chronic episodes of care is essential to long-term sustainability. Two-thirds of Medicare beneficiaries have two or more chronic conditions. One out of every seven beneficiaries has six or more chronic conditions. Beneficiaries with two or more chronic conditions are estimated to account for more than 90 percent of total Medicare expenditures while more than 45 percent of total expenditures arise from only 14 percent of beneficiaries, those with six or more chronic conditions[1]. Across every major spending category—inpatient hospitalizations, post-acute care (PAC) stays, home health visits, physician visits, and emergency department visits—patients with multiple comorbid chronic conditions are by far the highest utilizers and represent the highest cost cohort of the population.

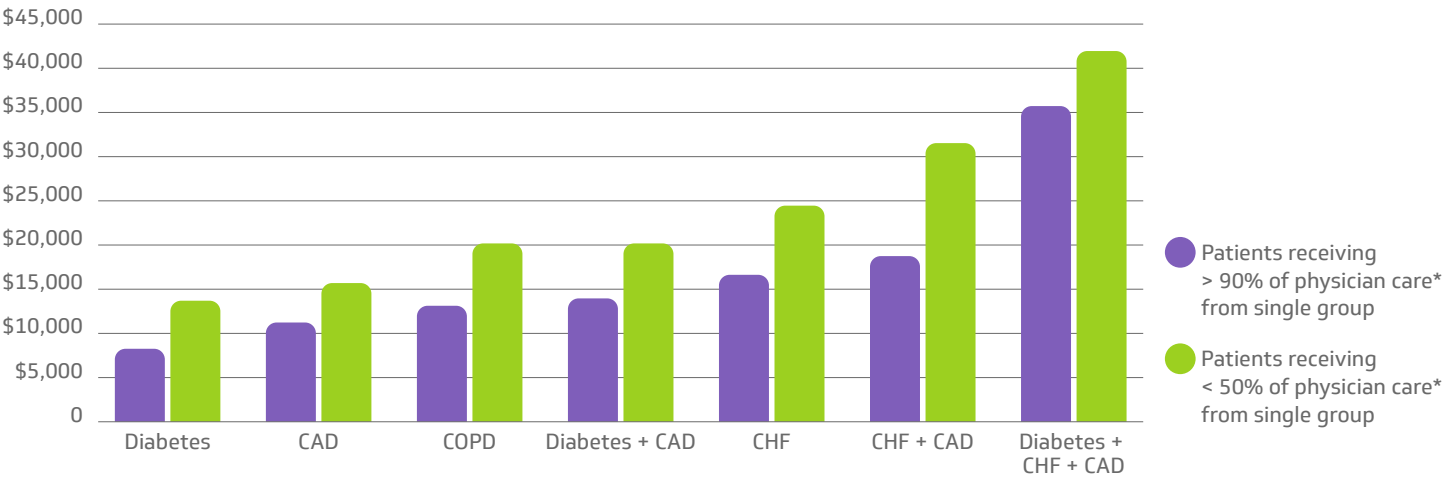
Complex, chronic patients visit multiple subspecialists on a regular basis, requiring numerous, iterative handoffs and the sharing of detailed clinical information among providers. These frequent interactions, when they occur between patients and disconnected providers, can result in unintended redundancies, contraindicated treatments, unnecessary resource consumption, and iatrogenic complications. Fragmented care comes at tremendous cost, with an inconsistent impact on patients' outcomes and quality of life.

Given the increasing assumption of longitudinal risk by providers, we posed an economic question with strategic ramifications for anyone contemplating such risk-sharing arrangements: Do complex, chronic patients who receive their care exclusively or nearly exclusively from a single multispecialty physician practice organization have lower episode costs than patients whose care delivery is fragmented across multiple separate physician practices?

To explore this question, the Vizient Research Institute team used data from the calendar-year 2014 Medicare Quality and Resource Use Reports (QRURs) of selected members in five completely different markets to assess the total cost per attributed beneficiary among patients with congestive heart failure (CHF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and diabetes. The members studied included both academic medical centers (AMCs) and large community health systems.

The analysis found that Medicare incurred substantially lower episode costs for patients who received the overwhelming majority of their care from a single multispecialty physician practice organization compared to patients whose care was fragmented across multiple provider organizations (Figure 1). Within any given member, patients in each of the chronic condition cohorts examined were nearly identical in terms of their clinical complexity, as measured by hierarchical condition categories (HCC) scores assigned by Medicare.

Figure 1: CY2014 total cost per attributed beneficiary, average of five markets



* Physician care defined as outpatient evaluation and management (E&M) services, regardless of the specialty rendering service; referenced in CMS QRURs as primary care services.

Figures 2 and 3 illustrate lower admission rates and lower PAC facility utilization among chronically ill patients who received the bulk of their care from a single multispecialty group compared to clinically similar patients whose care was delivered by multiple physician practices. These differences in utilization were the strongest contributors to overall savings.

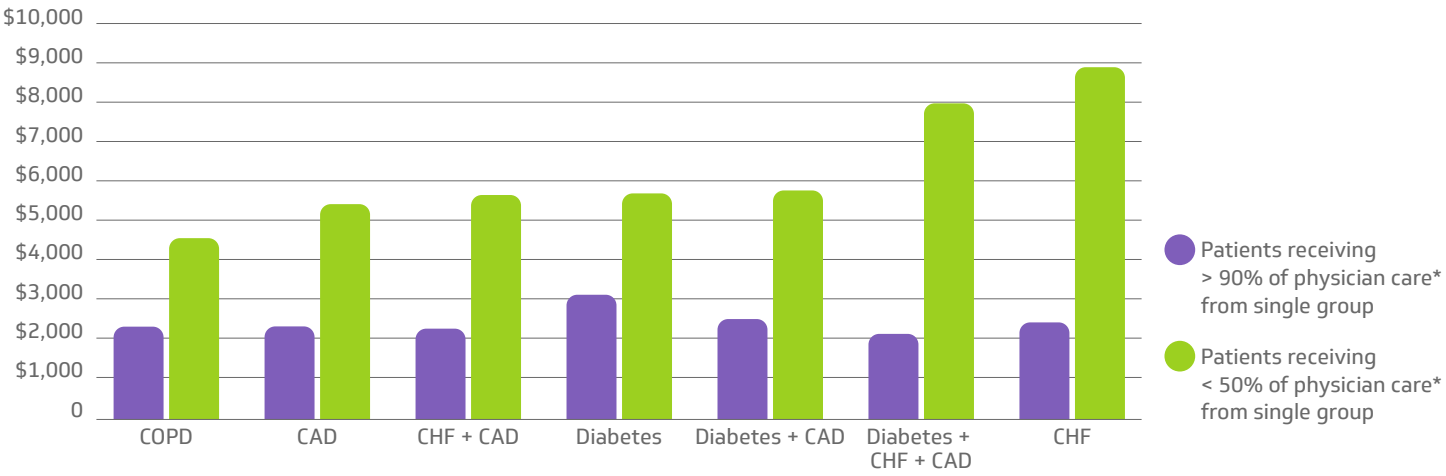
Patients with complex chronic disease account for the overwhelming majority of health care spend in the United States.

Figure 2: Comparison of CY2014 admission rates (fragmented physician care* and single source physician care), average of five markets**

* Fragmented physician care defined as patients receiving <50% of outpatient E&M services, regardless of the specialty rendering service, from single group.

** Single source physician care defined as patients receiving >90% of outpatient E&M services, regardless of the specialty rendering service, from single group

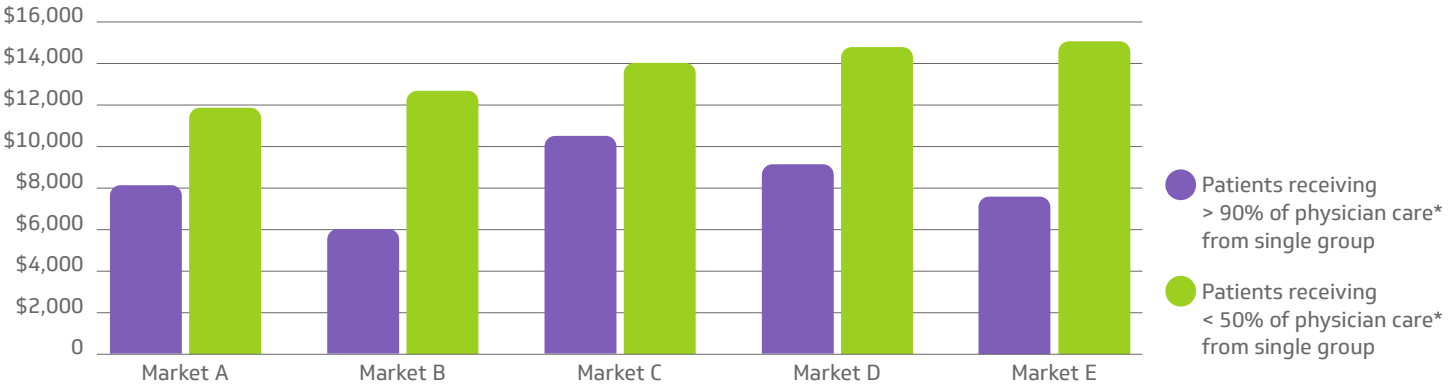
Figure 3: CY2014 post-acute care facility cost per discharge, average of five markets



* Physician care defined as outpatient E&M services, regardless of the specialty rendering service; referenced in CMS QRURs as primary care services.

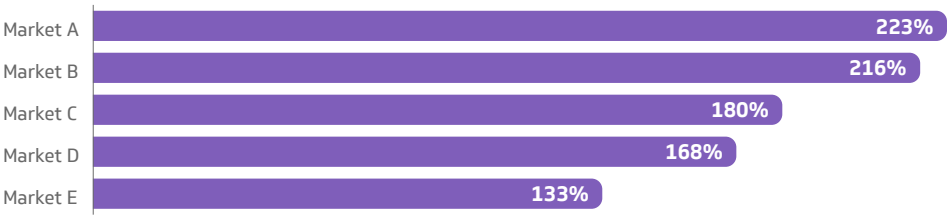
Figures 4 and 5 detail cost and inpatient utilization for diabetes patients, across markets. As observed with diabetes, for the other chronic conditions studied costs and admission rates were consistently higher among patients whose care was fragmented across multiple providers. In rare instances, there were exceptions to the rule, where cost and utilization were a "dead heat" between fragmented and single source physician care for a given condition. Vizient Research Institute staff conducted follow-up interviews during which members said such exceptions were not a surprise and noted known operational challenges for selected clinical services (e.g., poor access to care, individual behavior) that likely prevent the organization from fully tapping the benefits of being the sole care quarterback.

Figure 4: CY2014 total cost per attributed beneficiary, diabetes patients



* Physician care defined as outpatient E&M services, regardless of the specialty rendering service; referenced in CMS QRURs as "primary care services.

Figure 5: Comparison of CY2014 admission rates (fragmented physician care* and single source physician care**), diabetes patients



* Fragmented physician care defined as patients receiving <50% of outpatient E&M services, regardless of the specialty rendering service, from single group.

** Single source physician care defined as patients receiving >90% of outpatient E&M services, regardless of the specialty rendering service, from single group.

Much attention lately focuses on the development of medical homes and other similar vehicles to coordinate and manage care for patients with complex, chronic disease. A review of Medicare episodic spending data reinforces an intuitive belief long held by many health care professionals, namely that the group practice of medicine can be a particularly effective model for delivering high quality, safe and cost-efficient care. Intuition suggests that multispecialty physician groups afford unique opportunities for the development of personal relationships and trust among providers, fluid physician-to-physician communication, teamwork, behavior anchored by shared culture and values, and common standards of care. These characteristics—supported by a single, integrated health information technology and electronic medical record platform—can confer direct benefit to the delivery of cost-efficient, high quality, and safe care. Efficient handoffs, continuous communication, shared values and the elimination of avoidable variation are much harder to achieve among fragmented and independent provider organizations. Our examination of Medicare spending data supports the hypothesis that chronically ill patients treated predominantly by a single multispecialty group incur lower episodic costs than similar patients treated by multiple independent providers.

As Vizient member organizations consider entering risk-bearing contracts for patients with complex, chronic disease, whether in the form of global spending targets such as accountable care organizations or more focused prospective episodic payments that may emerge such as longitudinal DRGs, achieving new levels of efficiency in care delivery will be imperative to their success. A significant opportunity to generate and share in cost savings may lie in transitioning chronically ill patients who have historically received their care from a fragmented set of independent providers to a model where they are cared for comprehensively, either by a single multispecialty physician group or by a patient-centric team of providers organized in such a way as to replicate the inherent communication and coordination advantages of a traditional group practice.

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1 Centers for Medicare & Medicaid Services. Chronic Conditions Among Medicare Beneficiaries Chartbook: 2012 Edition. Baltimore, MD: Centers for Medicare & Medicaid Services; 2012.