

# MAKING CASE MANAGEMENT WORK IN GOVERNMENT PROGRAMS

Highlights of a Workshop for Practitioners and Policymakers  
Institute for Medicare Practice  
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## THE INSTITUTE FOR MEDICARE PRACTICE

The Institute for Medicare Practice is the only applied Medicare policy center in the country addressing Medicare issues from the base of a major clinical enterprise; the Institute is housed at Mount Sinai School of Medicine and Mount Sinai NYU Health. Led by Bruce C. Vladeck, PhD, former Administrator of the Health Care Financing Administration (HCFA), the Institute's mission includes integrating health policy and practice by bringing together and working collaboratively with researchers, practitioners, educators and consumers to improve Medicare and the services provided to Medicare beneficiaries.

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## CASE MANAGEMENT TODAY: A CRITICAL LOOK

**MODERATOR** BRUCE C. VLADECK, PH.D.

Today, more than 125 million Americans suffer from chronic health problems. Formal care for these mostly older patients accounts for 70% of the nation's direct medical costs. In the next 25 years, as the population ages, the number of people with chronic illness could grow to as many as 81 million. The care required and the resources needed by this population will increase dramatically as well.

It has long been conventional wisdom among students of the health system that high quality "case management"—defined as a method to ensure that people with serious and persistent health conditions received needed services in a timely fashion—is an important part of the solution to the growing need for services. Less attention has been paid to the state of case management in the current system, or to understanding how it needs to evolve in order to help us meet the challenges of the 21st Century.

To grapple with these and related questions, the Institute for Medicare Practice convened a workshop of policymakers, practitioners, and researchers, many with multiple decades of experience working with issues of long-term care and case management. Not surprisingly, given the group, whose members are listed on the inside back cover of this report, the ensuing dialogue was spirited and provocative. We prepared this document to share some of what we learned and to begin, or perhaps more accurately, continue, a discussion about the merits and limitations of case management as a strategy for managing and improving care for people with significant chronic illnesses.

The Institute for Medicare Practice had two broad agendas for the workshop. The first was to recognize that in so many different sectors and areas of activity, there is a great deal of "talk" about case management. But if one is actively struggling with the problems of serving people with significant chronic illness, it is quickly apparent that case management means a lot of different things to different people in different settings. Related to this notion is the reality that case management, however it is understood, is difficult to do and do well—even when there are sufficient resources, and people have good intentions. So, in this workshop, we wanted to find a way to get past some of the rhetoric, to talk in a critical and focused way about what good case management is or is not, and why it is so challenging to put into practice.

Second, we wanted to find a mechanism through which we could bring together policymakers and clinicians engaged on a day-to-day basis in providing services to people with chronic illness. We wanted this interdisciplinary group to explore how public policy might encourage more "good" case management, however that might be defined.

Not surprisingly, this forum raised more questions than answers. The most difficult of these issues are described in the last section of this report. They range from important semantic concerns about the definition of case management to perhaps the strategy's most essential tension: Is case management about providing the best care for often extremely sick patients or is it about containing the cost of care for these patients who often need extremely expensive care?

And while the workshop was not designed to build consensus or develop a set of recommendations, some thinking about future work did emerge. For example, there is clearly a pressing need to foster better, multi-disciplinary teamwork and communications to make case management more effective. The case managers' role as an advocate not only for a set of clients, but for needed systems change should be explored and elaborated more fully. Finally, we need to think much longer and harder about how to ensure that case management is more responsive to clients' needs, and to understand the implications and opportunities presented by client-directed case management services.

We hope that the discussion reported here will be helpful in framing future discussions that seek not simply to describe these complex issues, but to develop strategies, interventions, and perhaps even an agenda that can improve case management and help the health care and social services systems improve their ability to make a positive difference in the lives of the rapidly growing number of older, frail adults.

**Bruce C. Vladeck, Ph.D.,**  
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## PUBLIC POLICY AND THE EVOLUTION OF CASE MANAGEMENT

**PRESENTER** A.E. TED BENJAMIN, PH.D.

A.E. "Ted" Benjamin, Ph.D., Chairman of the Department of Social Welfare at UCLA, kicked off the workshop with a keynote address, describing the evolution of case management and outlining a set of key issues that would help guide the day's discussion.

As early as the 1920s, Benjamin reported, the concept of case management received attention as a means of addressing "the multiple needs of people with chronic health problems"—challenges that extended beyond direct medical care into necessities such as food, shelter, transportation, educational and vocational programs, and more.

Later, in the 1960s, he said, case management received new attention with the explosion of categorical programs that provided specific services for specific populations (e.g., those with mental health problems), many of whom had been "de-institutionalized." Now in the community, these patients required a different kind of individualized care not provided in hospitals or by other institutions. Without increased patient access to these new, expanded services, however, community-based programs struggled—not least with the bureaucratic barriers created by the new network of services.

"As the menu of services grew more fragmented, duplicative and uncoordinated," said Benjamin, "a movement began in the 1970s to reform service systems and organizations through better service coordination and integration." These efforts to "fix the system" were also unsatisfactory. And a decade later, a quest began for a mechanism, embodied in the case manager, who would, he said, "serve as an advocate and guide to steer clients through the flawed service maze." This, too, proved problematic, and as concerns over the rising costs of health and other care grew, the case manager became seen as an organizational and system agent asked to limit costs and inefficiencies.

"We began by defining case managers as advocates for clients," said Benjamin. And case managers have evolved into agents charged with containing client demands on services. The 'bureaucratic guide' has become the bureaucratic 'watchdog.' The contradictions inherent in these accreted and competing set of definitions continued to resonate with the group as the day continued.

One thing is certain, Benjamin reflected: the issues that case management was designed to address are still around. Further, people with chronic health problems today must deal with long-term service systems that, he said, "are difficult to navigate, lack critical information about existing services, have varying eligibility standards, require huge time demands to access services, respond slowly to crisis, and fre-

## FIVE BARRIERS TO GOOD CASE MANAGEMENT

### ONE: CONFUSING LANGUAGE

quently exact daunting costs to users and third-party payers.” In response to these serious challenges, case management has become the “centerpiece” for much acute and long-term program design for those with chronic health conditions. Today, case management, he noted, is paid for as part of various federal and state Medicaid waiver programs and legislation.

This historical and contemporary perspective set up Benjamin’s analysis of why “good” case management today is so hard to do. He laid out five major stumbling blocks.

The first issue, he said, is confusing language. The sheer number of labels used to describe case management is so extensive that it muddies the definition and prevents a common understanding of the term. In addition to case or care management (which have different orientations of their own), there is “service coordination” and “case advocacy,” just to name two. Competing with the notion of case or care manager is “personal agent” and “peer counselor,” among other terms used. And not surprisingly, each label is loaded with different connotations, suggesting different priorities, and in many cases, different activities.

### TWO: “CASE MANAGEMENT” MAY EMBODY CONFLICTING GOALS

These semantic issues are often symbolic of the conflicting goals that today characterize case management. At its best, “case management is supposed to improve quality of care, enhance quality-of-life and contain cost,” said Benjamin. But over time, as was noted above, the shift toward home and community-based services and managed care, he said, has changed case management’s overall function from “resource finding, generating and coordinating” to “resource limiting.” As a result, the essential character of case management can be significantly different in different places.

### THREE: TECHNOLOGY

The third issue is what Benjamin called “technology.” “There are no systemic practice guidelines or standards,” he said, “to follow for case management.” This “technological uncertainty” means that the experience and judgment of individual case managers is crucial. It also helps explain why there is a shortage of case managers with sufficient clinical and service system knowledge, skills and experience. “By most accounts,” he noted, “effective case management is probably more art than science.”

### FOUR: COMPETING PROFESSIONAL CLAIMS

### FIVE: ONE SIZE DOES NOT FIT ALL

## THOUGHTS ON STRENGTHENING CASE MANAGEMENT

The fourth challenge involves competing professional claims. “All professional long-term service providers—particularly physicians, nurses and social workers—say they do case management,” said Benjamin, “but we don’t have research that sets out definitively who is best able to play this role and under what conditions. And what is probably needed is a team approach,” he said, “which rarely happens.”

Finally, said Benjamin, diverse populations exist for which case management is needed, and one size does not fit all. The resource framework within which case managers work and the level of systems integration they encounter are very different in different settings. Similarly, the level of available resources varies, as does the comprehensiveness of these resources and even the types of teams that are used. All of this variability makes outcomes harder to measure and best practices harder to define across populations and contexts.

After outlining these challenges, Benjamin shared his ideas for reinvigorating case management. He pointed to the need to better define specific interventions that make up the case management process, as well as the need to generate more comparative research across populations in order to create “a more coherent typology.” He recommended paying more attention to newer models that “incorporate consumer preferences and consumer-driven planning,” rather than relying solely on professional judgment. He called for a renewed focus on outreach among program priorities, that case management initiatives “should work on bringing people into the service system.”

Most broadly, he said, we should attempt to revive the “advocacy goal,” so often linked to case management. This means both bolstering case managers’ ability to conduct client advocacy within and across systems and, importantly, connecting case management programs and case managers with larger conversations designed to find systemic/policy/ financing solutions. “Case management,” said Benjamin, “should include a systems change goal (that is, one that ties professional feedback to advocacy) and at least some forms of case management need to have a community- and system-change orientation.”

## WHY GOOD CARE MANAGEMENT IS SO HARD TO DO: A VIEW FROM THE FIELD

PRESENTER RICK SURPIN

Few understand the day-to-day challenges of performing case management (or “care management” as he prefers to call it) more intimately than Rick Surpin, President and CEO of Independence Care System (ICS), a prepaid health service plan in New York City. His organization serves physically disabled adults, considered by the fee-for-service world as “problem” consumers because they have more problems and require more resources than most others.

After a lengthy, six-year planning process, ICS opened its doors in 2000 with a robust, team-based case management model. This approach, says Surpin, includes:

- A comprehensive range of health and social services coordinated in a flexible manner, including consumer-directed personal care and home modifications;
- Full member participation in care planning and management of his or her own health care and social supports;
- A tailored system of medical and social care for each member, based on his or her choices and providers (e.g. physicians, home care aides, and others on the health care team); and
- An interdisciplinary care management team, led by a nurse-social worker pair, which focuses on coordinating services and providers and identifying gaps in needed services.

In its first year of operation, ICS has encountered some significant barriers to providing appropriate care. Most striking, according to Surpin, is that health care funding silos and regulatory requirements of the fee-for-service system have created an environment in which professionals typically inform consumers what they can or are going to do within a specific set of benefits and standards. According to Surpin, this mindset, “makes it difficult to imagine and develop a flexible, consumer-driven system.” In practice, he said, professionals are slow to consider alternative, rather than traditional, therapies and responses, even when there is a compelling logic for doing them.

There is also the absence of a common understanding of how to lead and/or participate in an interdisciplinary team. Professionals, said Surpin, have difficulty collaborating with one another because they work out of very different “mental models.” Particularly on the ICS care management leadership teams, he said, nurses and social workers often have strikingly different views on what is “realistic” for patients. And paraprofessional staff, whom patients may trust more than professionals and who are often considered a lifeline, may not be well integrated into the team at all—resulting in a loss of critical knowledge and skills.

In addition to these team issues, the relatively woeful state of service availability for ICS clients challenges effective care management. Some services that ICS patients need, he said, are not available or easily accessible, such as adequate transportation, adult day care centers, social and recreational programs, and some preventive health services such as dentistry and mammography screening. Further, the systemic turbulence caused by Medicare and Medicaid budget cutbacks, changes in reimbursement systems, and agency consolidation have increased concerns about who gets paid for what, further dampening the inter-agency cooperation crucial to care management.

The final challenge, said Surpin, is cost. ICS members “receive more appropriate services—and higher levels when they needed it—than they would get in the fee-for-service Medicaid system.” While overall contracted medical costs are about the same as in the fee-for-service system, the cost of care management and administration makes the entire package more expensive. Cost effectiveness has come to mean cost savings. “Shouldn’t we be talking about value rather than cost savings?” he asked. While ICS has lowered costs during its first year of operation, Surpin was not overly optimistic about significant cost reduction in the future.

## BEST PRACTICES IN CHRONIC ILLNESS CARE COORDINATION

**PRESENTERS** RANDALL S. BROWN, PH.D., ARNOLD CHEN, M.D.

For obvious reasons, the Health Care Financing Administration (HCFA), the agency that administers the Medicare and Medicaid programs (since renamed, subsequent to the date of the Workshop, the Centers for Medicare and Medicaid Services [CMS]), has been looking for some time for ways to reduce costs and improve care for the chronically ill—the area where most of today’s health care dollars are spent. Randy Brown, Ph.D., Senior Fellow at Mathematica Policy Research Inc., has been directly involved with this HCFA-sponsored research, some of the findings of which he presented to the workshop.

Dr. Brown’s work in this area began with the evaluation of three Medicare case management demonstrations done in the mid-1990s. These took place in distinct settings (an insurer, a peer review organization, and a teaching hospital), each with different case management interventions of their own design, but with the common goal of reducing Medicare costs for high-risk cases. “They were hoping,” he said, “to improve people’s lives along the way, but the major focus was—Can you keep people out of the hospital by giving them better care?”

In fact, the evaluation revealed that none of the programs decreased costs or reduced hospital usage. Dr. Brown suggested several reasons, including a lack of physician support, which limited case managers’ ability to modify care plans and gain patient acceptance; poorly defined interventions and goals; and inadequate staff skills needed to design and implement service plans. Additionally, the programs had no financial or other incentives to drive down hospitalization rates or other costs, and no feedback on how they were doing.

Given the poor results of this demonstration, HCFA initiated the Medicare Coordinated Care Study to examine best practices within the managed care world and create a demonstration project to test them in the Medicare fee-for-service setting. Brown’s colleague, Arnold Chen, M.D., a senior clinician researcher at Mathematica Policy Research, Inc., described the work done to date on this study.

After an extensive search that identified nearly 400 programs for the study, Chen and his colleagues selected 24 and interviewed them for best practices. “There were some features common to most successful programs,” he said, “including strong care planning, patient education, a proactive case manager as patient advocate, the use of evidence-based guidelines, and nurses as staff. However, there were no clear answers regarding best practices. There were many different ways of improving care coordination and outcomes,” he said. And importantly (and hopefully), there was “really nothing in these programs that prevented them from being implemented in fee-for-service Medicare.”

Based on these findings, Mathematica designed the Care Coordination Demonstration for HCFA. “Our recommendations,” said Brown, “were to be fairly flexible in terms of program features, to avoid the trap of more is better or that you have to do certain things. Ultimately, we’ll be testing whether interventions that were effective in other settings can be adapted successfully for Medicare.”

The demonstration will take place in 15 sites, beginning later in the year. HCFA will provide the structure and the payment mechanism. Mathematica’s final report will describe the interventions implemented, the effects of each program on patient outcomes and costs, the types of interventions that work best, organizational factors that influence outcomes, types of patients that benefited most, and other cost and financing information.

# CASE MANAGEMENT FOR THE 21ST CENTURY: KEY CHALLENGES AHEAD

## DISCUSSION

### DEFINITION: WHAT CONSTITUTES CASE MANAGEMENT?

In response to the presentations, the workshop's participants struggled with a variety of issues raised about case management. At the core of the discussion is a staggering challenge—how to best care for millions of chronically ill patients in a cost-conscious health care environment that will likely become more cost-conscious in the future. As a first step towards seeking concrete strategies in this broader effort, the workshop participants identified several questions that must be addressed to more effectively shape future program and policy directions.

Depending on the population and the setting, case management may include any combination of needs assessment, service planning, patient education, service facilitation and coordination, crisis response, patient support and advocacy, quality assurance and/or cost containment. A single case manager (a doctor, nurse, social worker, paraprofessional or patient advocate) or an interdisciplinary or even multi-disciplinary team may oversee the patient and his or her care. The services actually provided and/or facilitated will likely vary broadly. Rural, suburban and urban environments and care systems may each pose special problems and create special opportunities for what case management will look like in practice. Pile on top of this variability the multiple terms used to describe case management, and you begin to understand that the term case management, as Ted Benjamin noted, “is potentially so broad a term as to be meaningless.”

This confusion about case management is a powerful impediment to its improvement. In particular, it limits the development of useful training approaches, practice benchmarks and recommendations, as well as the planning and conduct of a broader research agenda that could ensure that case management achieves its service provision and cost-containment objectives. Efforts to clarify what case management is, therefore, are crucial.

### STRUCTURE: WHO IS THE OPTIMAL CASE MANAGER?

A variety of health care professionals perform case management. Different disciplines bring very different perspectives and tools to managing “cases” or patients. This issue is often framed as a question of what profession is best qualified to perform case management, but that is clearly the wrong question. Rather, the issues are how to best mobilize diverse skills and orientations to best meet the diverse needs of clients, and how to get individuals from different professional backgrounds to work together more effectively. Further, clients may often be best served if case management is closely integrated with the work of nonprofessional case workers, many of whom help patients with their very real and sometimes very basic, daily needs, and whom patients

### COORDINATION: HOW DO WE RESOLVE TEAM ISSUES AND OPTIMIZE RELATION- SHIPS BETWEEN AND AMONG PROFES- SIONS?

often see as the most valuable and trusted of all the caregivers with whom they interact.

Discussion in the workshop also pointed to the potential for family members or other concerned lay people to serve as case managers. Intuitively, it makes sense that the best advocates for patients could be those people who have a vested interest in caring for them. As some participants suggested, resources might even be directed to train family members to be case managers. At the very least, we should find mechanisms for supporting those who are already wielding metaphorical “crowbars,” as one workshop participant put it, to open doors to needed services and provide comfort and care for their loved ones.

Chronically ill patients have multi-dimensional needs and, therefore, benefit from the services of people with different skills and expertise. No one person can provide all of the care and knowledge required, so a multidisciplinary team approach is often warranted, especially in complex cases. Unfortunately, “expert” team members representing different disciplines are not always “expert” in communicating with one another and performing effectively in collaborative settings. As Rick Surpin put it, developing strong, self-directed teams is an “organizational development process that needs care and investment.”

Traditional hierarchical roles may also interfere with needed communication. Doctors may have trouble working collegially with nurses and social workers and even non-professionals who are asked to manage cases and exert authority over a team. “Some doctors don’t even call other doctors back,” said one workshop participant. “For example, it’s often difficult for a specialist to take instructions regarding a patient’s care from a primary care physician, much less someone even lower in the traditional hierarchical pecking order.” To do good team-based case management, noted Bruce Vladeck, “you may have to re-socialize folks and undo a lot of past training and experience.”

Labor-intensive, logistical issues further complicate team-based (and indeed all) case management. Most professionals say they do not have time or do not wish to perform the countless, time-consuming and mundane tasks necessary to address all the needs of the patient—things like calling taxis, food shopping, keeping track of appointments, and other day-to-day concerns. Of course, good patient outcomes may depend heavily on the execution of these unglamorous duties.

## CLIENTS: HOW CAN CASE MANAGEMENT BE MORE CONSUMER- DRIVEN?

Once we've determined who needs case management, participants asked, how do we handle the patient who says, "I'm not a case, and I don't want to be managed"? To this point, there was consensus that there's a need to incorporate patients' wants and needs more effectively into the case management process. But even this idea has its challenges. As one expert pointed out, "If you have a consumer-driven process, you need consumer-driven standards."

Despite the need to focus on consumers, noted some participants, developing objective, evidence-based best practices for case management is still important. Health care professionals who work from a scientific, medical model may not easily or willingly get behind what they see as idiosyncratic responses to health or social concerns. This is important to ensure the buy-in, participation, and use of the real and needed skills of these professionals in case management. It is also likely to be critical for financial/political reasons. Without rigorous, scientific analysis, politicians and policymakers may be unwilling to support reimbursement for patient-driven case or care management arrangements.

This problem is exacerbated by the "legitimizing" role professionals currently play in the system. Our financing systems largely delegate to health professionals the function of determining whether a patient's needs fall into a reimbursable service category. Consumer-driven case management perhaps unavoidably leads, by contrast, in the direction of vouchers or defined contributions, a very slippery slope indeed.

Too often, as one participant noted, "case management is what we talk about when we feel inadequate in talking about tough system and resource issues." Indeed, in the short- and especially in the long-term, chronic care presents significant, often overwhelming challenges. Problems including poor system and funding stream coordination, limited access to services (particularly among low-income and other vulnerable populations), serious workforce shortages, and growing recognition of quality problems—all seem to dwarf (and also exacerbate) concerns about case management's efficacy. Participants agreed that case management should not be used as a Band-Aid for more serious, fundamental problems. "Case management connects people to services, but if the system is broken," Bruce Vladeck asked, "do we really want people in it?"

One response supported by many in the workshop is to build on Ted Benjamin's observation that case management should include a systems change role, in addition to coordinating client services. As professionals on the front lines in a variety of care settings, case managers have an informed perspective on both their clients' needs and on how the sys-

## ADVOCACY: HOW CAN CASE MANAGEMENT AND CASE MANAGERS SERVE AS ADVO- CATES FOR IMPROV- ING SERVICE AND SYSTEMS?

## FUNDAMENTALS: CAN CASE MANAGEMENT SUC- CEED IF IT FOCUSES ON THE QUALITY OF PATIENT CARE RATHER THAN COST CONTAINMENT?

tem is or is not responding. Initiatives to "amplify" the voice of case managers in any number of system/policy/finance discussions could place this perspective in the service of broad changes benefiting large numbers of chronically ill patients.

"Case management's 'best friend' and 'mortal enemy,'" said Ted Benjamin, "is cost-containment." Why? That case management offers the prospect of cost savings is one reason it has drawn and continues to draw significant interest from wide range of public and private policy-makers, systems and institutions. Indeed, among the frail elderly, case management may limit excessive service utilization, prevent accidents, lead to more sensible drug prescription, and avoid hospitalizations and nursing home admissions—all of which suggest opportunities for reducing chronic care costs.

But as one workshop participant put it, "good case management may not be cost-saving." Research to date in this area continues to be equivocal or negative about case management's ability to contain costs. And according to some, today's chronically ill patients (and particularly those who are not the most frail or at-risk) may actually need more and better services than they are currently receiving. Our health care system may in fact be under-funding care for this vulnerable population. From this perspective, improving access to services through case management or using case management as a mechanism for advocating for more adequate services will likely cost more, not less.

Most in the workshop suggested that we should re-orient current and future policy debates around case management away from containing costs towards improving care. "Our health care system is willing to pay more to avoid death and cure disease, but how about increasing patients' quality of life? If we can show better outcomes for patients through successful case management," asked Vladeck, "Shouldn't we advocate for that, no matter the cost?" Outcomes-based research that studies case management in this manner could help make this important "patient care-focused" case.

The appropriate future role and design of case management in government programs can only be addressed, in other words, in the context of broader issues about the goals and expectations of those programs. Additional discussion and debate, further research, and new models are needed—sooner, rather than later. Delivering appropriate care to patients with complex and multi-dimensional needs is a difficult challenge, and one that, given the rapid aging of our population and the accelerating pace of technological change, will only become more serious in the decades ahead.



## ENDNOTE: AN OVERVIEW ON PARTNERSHIP FOR SOLUTIONS

**PRESENTER** GERARD F. ANDERSON, PH.D.

Jerry Anderson gave the workshop participants an overview of the project, Partnership for Solutions, Better Lives for People with Chronic Conditions, the primary source of support for the workshop. It is a national program of the Robert Wood Johnson Foundation. “We recognized when we started the project that people with chronic conditions are basically not on the public agenda,” said Anderson. “We did a survey of policymakers in Washington, and people said, ‘chronic conditions—what’s that?’ Policymakers know about prescription drug coverage,” says Anderson, “but people with chronic conditions are just not on the policymakers’ map.”

In fact, Anderson’s research showed that policymakers in Washington tend to think of chronic care primarily as a Medicaid issue.

Anderson and his research team first set about defining the term, “chronic conditions.” The working definition they settled on is: “A chronic condition is one that lasts or is expected to last a year or longer, limits what you can do and may require ongoing care.” Based on this definition, there are some 125 million people in America with chronic conditions. People with chronic conditions can require significant health care expenditures. “If you don’t have a chronic condition, it costs about \$1,000 in total direct national cost; as soon as you develop one chronic condition, now you’re up to \$6,000 on average,” said Anderson. “People with chronic conditions and a functional limitation average \$17,000.” A Rand Corporation study projects that by 2020, some 157 million Americans will have a chronic condition and some 81 million will have two or more chronic conditions.

Given this projection, one of the questions that Partnership for Solutions is asking is “What are the ways for people with chronic conditions to get better care?” One focus is people with two or more chronic conditions—who are thus, presumably, working with two or more doctors.

In fact, Anderson said, they are looking specifically at three issues:

- What does the benefit package look like for people in employer-based systems (specifically, in Fortune 100 companies)? How can it become more responsive to those with chronic conditions?
- How can health professionals and institutions get paid for providing ongoing care for people with chronic conditions?
- How can we “break down” government silos to make it easier for people with chronic conditions to receive all the services they need?

In terms of solutions, Anderson and his team are working “in baby steps,” or incrementally, to change the status quo. For example, people with chronic conditions typically see many different doctors. One estimate is that a Medicare beneficiary with a chronic condition sees some eight different physicians in a year. In one example of thinking innovatively about solutions to coordination of care, Anderson and his Partnership team are looking to see if there are ways in which patients’ physicians might receive reimbursement for consultations with one another.

As for the goals of Partnership for Better Solutions on the policy side, the group is seeking to have Congress focus on the needs of people with chronic disease, especially within the Medicare program, at least initially.

Says Anderson in summation, “We recognize that people with different illnesses have common problems, and we are looking towards common solutions to these problems.”

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## CREDITS

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