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What Really Works for High-Risk, High-Cost Patients?

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Need to Define High-Need, High-Cost Patients and Identify Settings and Payers

- Very heterogeneous group, with different needs and goals
  - Multiple chronic, physical illnesses
  - Mental illness (with or without substance abuse)
  - Both physical and behavioral/cognitive problems
  - Frail elderly with functional impairments
  - Working-age people with disabilities
  - Children with special needs
- Best model depends on the particular needs and goals
- Also depends on settings and payers
  - Community or institution
  - Fee-for-service (Medicare, Medicaid, private) or managed care
  - ACO, etc.
- Needs and goals vary even *within* these groupings

Some Dual Eligibles Are High Need

Beneficiaries	Percentage of dual eligibles	Effective managed care models	Effective fee-for-service models
In nursing homes	18%	Evercare	INTERACT II
In community, using LTSS	18%	PACE, CCA	GRACE, IAH
Severe chronic illnesses, no LTSS	26%	CareMore	MCCD, Mass. Gen.
Less severe or no chronic illness	38%	??	PGP

Little Solid Evidence About Optimal Targeting and Key Components of Effective Programs

- Good evidence (RCTs) on transitional care interventions to reduce readmissions
  - Naylor, Coleman, RED, Bridge, others
- Good evidence (RCTs) on Medicare fee-for-service interventions
  - Medicare Coordinated Care Demonstrations
- Weaker evidence for claims by various managed care providers

Importance of Detailed Patient Targeting

- Medicare Coordinated Care Demonstration (MCCD): 2002–2008
  - External organizations provided care management
  - Only 2 of 11 programs reduced hospitalizations for all (already high-risk) enrollees
  - But 4 did so (by 11% per year from 2002 to 2008) for higher-risk enrollees, defined as those who had:
    - CAD, CHF, or COPD and one or more hospitalization in prior year, OR
    - Two or more hospitalizations in prior two years (and one or more of 12 chronic conditions)
- Most other studies also found effects limited to high-risk subset
  - Care Management Plus model (Dorr; OHSU)
  - Geriatric Resources for Assessment and Care of Elders (GRACE) model (Counsell)
  - Mass. General Hospital high-cost program

Key Components of Effective Care Coordination in Medicare Fee-for-Service

Care coordinators:

1. Have monthly face-to-face contact with patients
2. Build strong rapport with patients' physicians through face-to-face contact at hospital or office
3. Use behavior-change techniques to help patients adhere to medication and self-care plans
4. Know when patients are hospitalized and provide support for the transition home
5. Act as a communications hub for providers and between patient and providers
6. Have reliable information about patients' prescriptions and access to pharmacists or medical directors

Other factors necessary, too, but only the effective programs include these.

Key Components of Effective Care Coordination in Managed Care Programs

Many of these same features are present in managed care plans' models

- **Geisinger's ProvenHealth Navigator Patient Centered Medical Home (Maeng et al. 2015)**
  - **Embedded care managers for high-risk patients**
  - **Work with primary care physicians to identify truly high-risk cases on high-risk list**
  - **Each medical home links to "acting" physicians at other care sites**
  - **Shared savings**

- **Comprehensive Care Physicians' Model (Meltzer et al. 2014)**
  - **Moves away from hospitalists to improve continuity**
  - **Allocates high-risk patients to specific physicians**
  - **Limits panel size to increase interaction with patients**
  - **Interdisciplinary team and frequent, data-driven meetings**
  - **Shared savings financial incentives**

Has the Problem Already Been Solved?

- Recent studies show dramatic decline nationally in Medicare hospitalizations (Daughtridge et al. 2014; Krumholz et al. 2015)
  - 10% decline from 2011 to 2013
  - Medicare expenditure increases have also slowed
  - Recent paper shows areas with low Medicare expenditures differ from low-cost commercial areas (http://www.healthcarepricingproject.org/)
- Continued success requires ongoing improvement and innovation as the bar rises
  - The case of Health Quality Partners

Can Reduce Hospitalizations, But Costs Are Harder to Reduce

- Care coordination costs money; need to find efficient and effective ways to provide it
- Much is still unknown about optimal design and tailoring
  - Duration of intervention; triaging
  - Care coordinator training and qualifications
  - Location of care coordinators
  - Frequency and mode of visits
  - Most effective behavior change models
  - Optimal coaching models (e.g., “teach-back”)
  - Fall risk screening and treatment or referral
  - Depression screening and treatment or referral
  - Usability of electronic health records
  - Financial incentives
- Need efficient orthogonal designs to learn more quickly what works in different settings

Thank You

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