Engaging Communities to Influence Culture of Care and Outcomes

Care Culture and Decision-making Innovation Collaborative

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• Who are high-need, high-cost adults and what are their major challenges?

• What works in caring for high-need adults?

• What are some challenges and policy option to help spreading these models?
Meet Sam: Patient struggling with multiple chronic conditions

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As a patient struggling, I...
- Feel dismissed, abandoned when doctors will not take the time to help me
- Feel overwhelmed by all the appointments

As a person struggling, I...
- Feel frustrated people don’t recognize the progress I’ve made so far
- Grieve for what I’ve lost
- Feel embarrassed I can’t afford my meds
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“It was like they weren’t even interested in what was going on with me. I was just another person and they were just telling me something to get me out of the office in the few little minutes they had to work with me… Like I wasn’t a real person.”

High-need Adults Tend to be Older, Have Low Socioeconomic Status, and Have Public Insurance

- **All adults**
- **High-need adults**
  (3+ chronic conditions & functional limitations)

<table>
<thead>
<tr>
<th>Category</th>
<th>All Adults</th>
<th>High-need Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 65+</td>
<td>17%</td>
<td>55%</td>
</tr>
<tr>
<td>No high school degree</td>
<td>16%</td>
<td>28%</td>
</tr>
<tr>
<td>Income below 200% FPL</td>
<td>30%</td>
<td>52%</td>
</tr>
<tr>
<td>Public insurance</td>
<td>28%</td>
<td>83%</td>
</tr>
</tbody>
</table>

Functional Limitations are a Key Predictor of High Costs

Average Annual Health Expenditures Among U.S. Adults

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Adult Population</th>
<th>3+ Chronic Diseases, No Functional Limitations</th>
<th>3+ Chronic Diseases, with Functional Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>231.7 million</td>
<td>79.0 million</td>
<td>11.8 million</td>
</tr>
<tr>
<td></td>
<td>$4,845</td>
<td>$7,526</td>
<td>$21,021</td>
</tr>
</tbody>
</table>

Data: 2009–2011 MEPS. Noninstitutionalized civilian population age 18 and older.
As Are Behavioral Health Issues

Average Annual Health Expenditures Among a Medicaid Population

What Challenges Face High-Need, High-Cost Patients?

- **Social needs**
  - More than one-third are socially isolated
  - 62% report material hardship

- **Mental health needs**
  - 53% experience emotional distress
  - Multiple chronic conditions are often risk factors for depression and anxiety

- **Lack of integration and coordination**
  - Communication among multiple providers
  - Transitions between hospital and post-acute care
  - Physical and behavioral health
  - Medical and social services

High-need, high-cost patients are a heterogeneous population
Segments of High-Cost Patients in Medicare

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frail Elderly</td>
<td>39.5%</td>
</tr>
<tr>
<td>Under 65 Disabled</td>
<td>25.6%</td>
</tr>
<tr>
<td>Major Complex Chronic</td>
<td>20.1%</td>
</tr>
<tr>
<td>Minor Complex Chronic</td>
<td>10.2%</td>
</tr>
<tr>
<td>Simple Chronic</td>
<td>3.6%</td>
</tr>
<tr>
<td>Relatively Healthy</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

Source: Ashish Jha, analysis of Medicare data.
A high performing health system must perform for high-need, high-cost patients. Promising, evidence-based models exist.
Services of Successful Models:
- Enhanced primary care
- Interdisciplinary care teams
- Care and case management
- Chronic disease self-management
- Transitional care
- Integration of medical, social, and behavioral services

Common Attributes:
1. Medical and social patient assessment
2. Targeting
3. Evidence-based care planning
4. Goal-oriented care
5. Patient and caregiver engagement
6. Coordination of care and communication among and between patient and care team
7. Patient monitoring
8. Facilitation of transitions

Delivery Features of Successful Models:
- Teamwork
- Coordination
- Responsiveness
- Feedback
- Medication management
- Outreach (to community and home)
- Integration with social services
- Prompt follow up

*not mutually exclusive categories

Operational Practices and Tools:
- Leadership across levels
- Customization to context
- Strong relationships
- Specialized training
- Effective use of metrics
- Use of multiple sources of data
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Commonwealth Care Alliance
Commonwealth Care Alliance

Program
• For disabled adults and frail elderly.
• Began in 2003; currently 60+ sites serving 17,000+ patients.

Key elements
• Interdisciplinary primary care team, with emphasis on nurse practitioner and social worker home visits.
• Individualized care plans, including for behavioral health needs.
• Capitated funding for total cost of care.

Results
• Reduces hospitalizations, nursing home utilization, and costs.
• Readmission rate top 99th percentile of MA plans.
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Commonwealth Care Alliance
Program of All-Inclusive Care for the Elderly (PACE)

Program
• Help frail elderly remain in their communities.
• Began in 1971; currently 120 PACE programs, 38,000+ enrollees.

Key elements
• Structured around day care center.
• Interdisciplinary care team, with a focus on care coordination.
• Flexible funding model, including for non-medical services.

Results
• Reduces hospitalizations and mortality.
• Cost-neutral for Medicare; may increase costs for Medicaid.
• 93% of PACE participants would recommend the program.
Independence at Home Demonstration

Program
• CMMI demonstration began in 2012.
• ~10,000 patients enrolled at 15 provider sites.

Key elements
• Home-based primary care for Medicare beneficiaries with multiple chronic conditions and functional limitations.

Results
• $35 million in savings in first two years.
• Reduced readmissions and preventable hospitalizations/ED visits.
Key Questions
Find curated resources about promising approaches to improving care for people with complex needs.

- Why invest in redesigning care for people with complex needs?
  - 26 Resources

- Who are people with complex needs?
  - 21 Resources

- What care models are promising?
  - 28 Resources

- What are key elements to redesigning care?
  - 11 Resources

Visit: http://www.bettercareplaybook.org
What are some challenges to spreading these models?

- Misaligned payment system
- The move to value-based payment
- Culture: team-based care
- Need for social investment and supportive policies

For health system leaders, no need to reinvent the wheel
Suggested Policy Improvements

• Promote value-based payment
• Improve value-based payment design and implementation
• Allow payments for non-medical services
• Assist clinicians in adopting best practices
• Prioritize health information exchange
• Support ongoing experimentation

Thank you!

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