THE KEY TO ACCOUNTABILITY: High-Need, High-Cost Patients

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Affordable, quality health care. For everyone.

Agenda

1. Why worry about high-need, high-cost patients?
2. Who are they?
3. What works?
4. What are the challenges?
5. What is the Commonwealth Fund doing?

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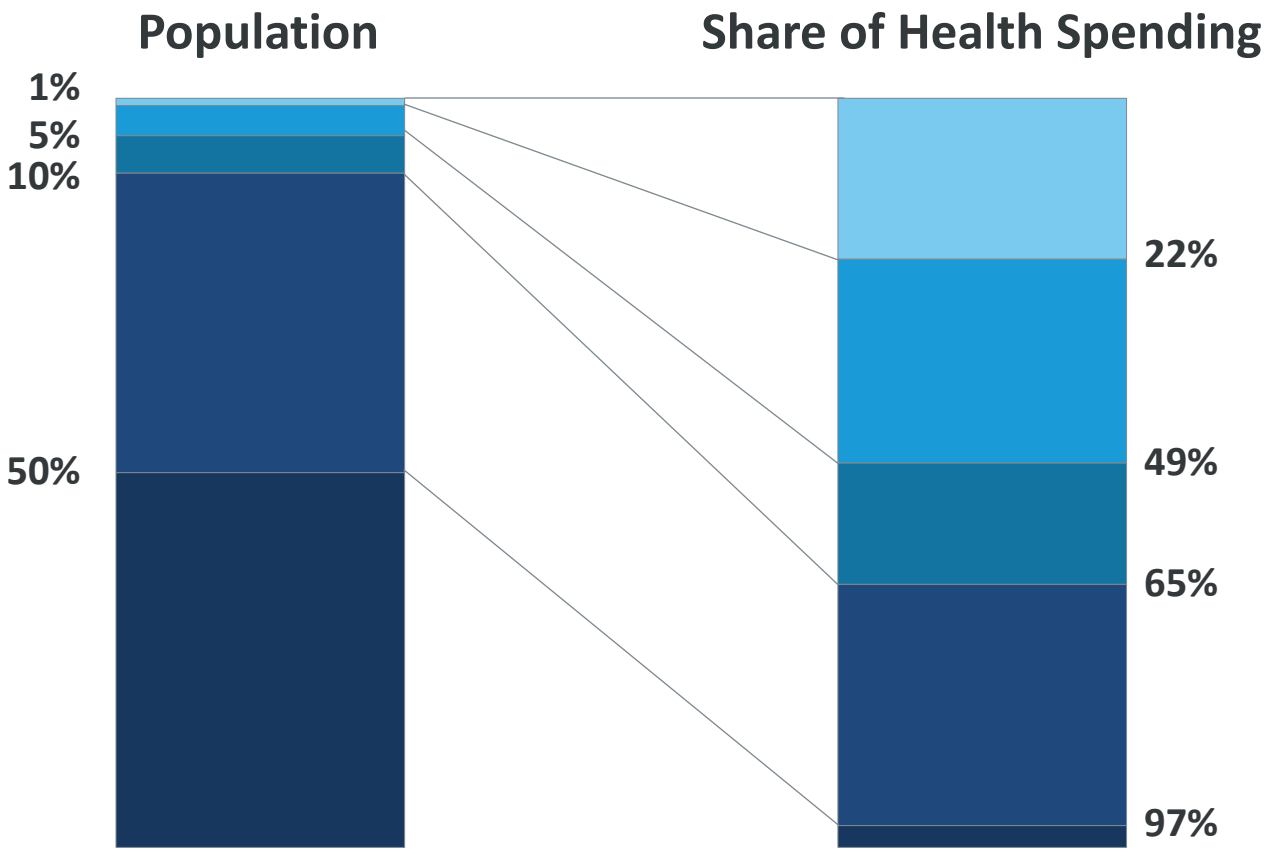
Why worry about high-need, high-cost patients?

Health Care Costs Concentrated in Sick Few—Sickest 5% Account for 49% of Expenses

Distribution of health expenditures for the U.S. population, by magnitude of expenditure, 2013



Source: Agency for Healthcare Research and Quality analysis of 2013 Medical Expenditure Panel Survey; MEPS Statistical Brief 480.

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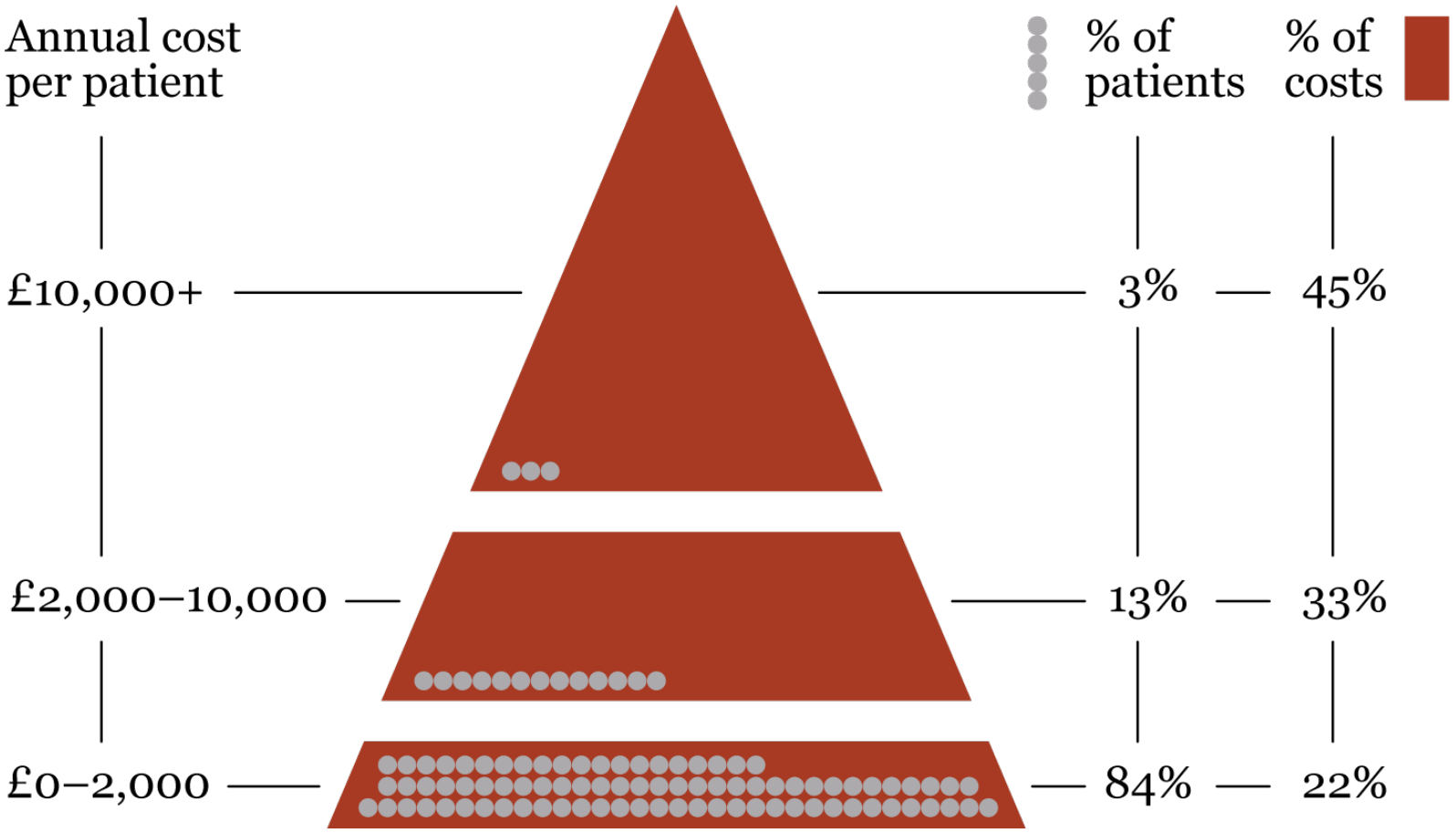
Sickest 3% Account for 45% of Costs at a Major English Teaching Hospital



Note: Costs are for inpatient, outpatient, day-case, and A&E services only.

Source: Blunt I, Bardsley M, "Use of patient-level costing to increase efficiency in NHS trusts," Nuffield Trust, 2012.

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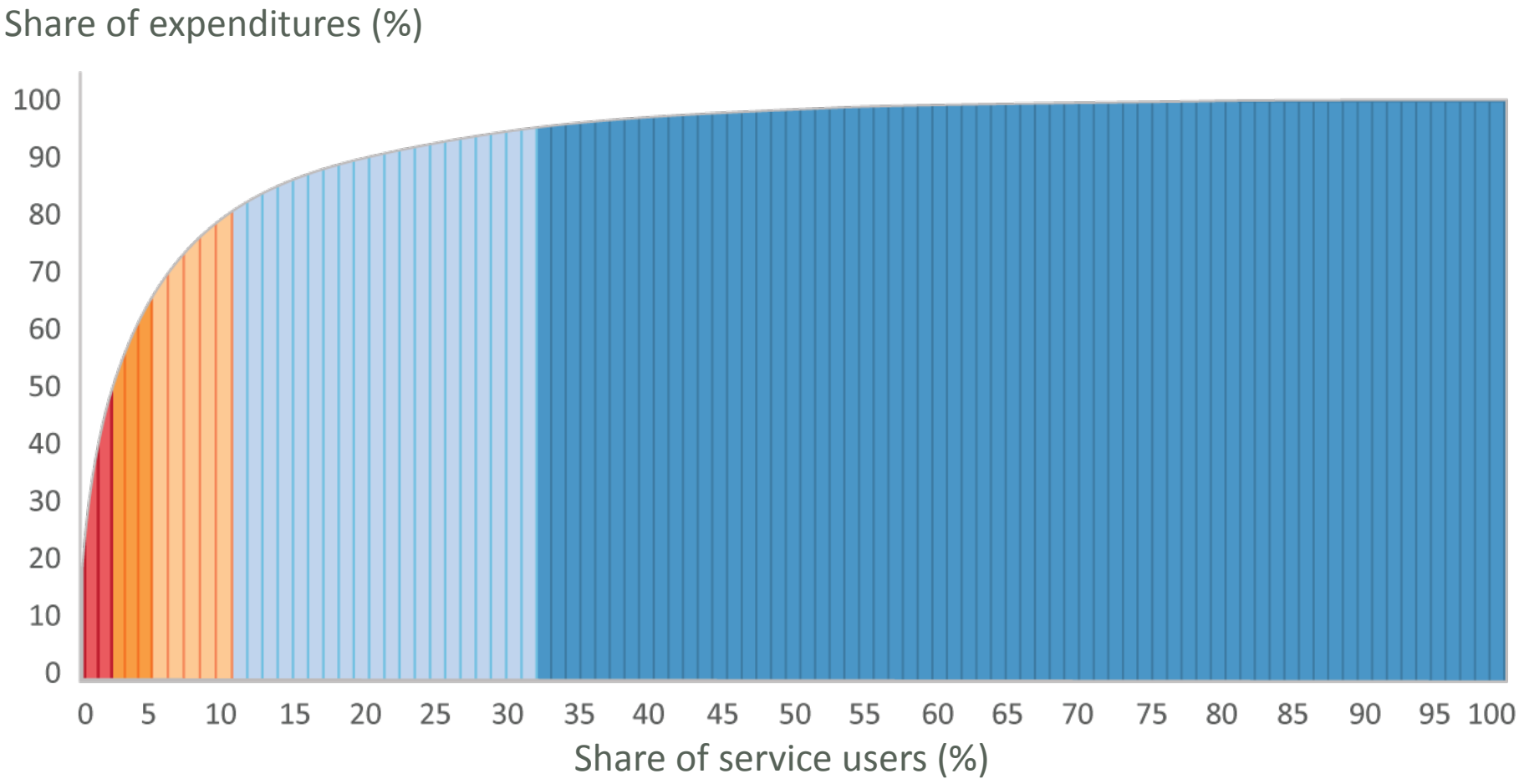
In Scotland, Sickest 2% Account for 50% of Hospital and Pharmacy Resources



Note: Costs are for hospital and community pharmacy services only.

Source: Correspondence with Christine McGregor, Health and Social Care Analytical Services.

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A high performing health system must perform for high-need, high-cost patients.

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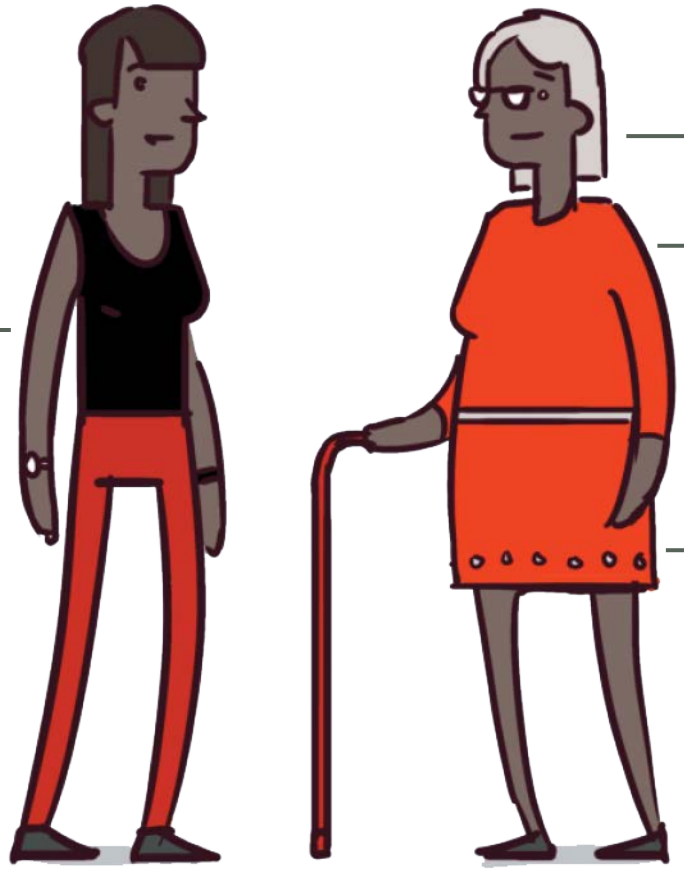
Who Are High-Need, High-Cost Patients?

Lisa, 45

Married with two children (15, 18), has a part time job and provides financial support for her mom. Usually visits 3 times a week.

Primary caregiver for her mom with some help from her two siblings.



Elizabeth, 70

Lives alone in a low-income senior apartment, near her daughter.

On Medicaid

Heart failure

Grade 3 COPD

Needs to visit the ER several times a year for COPD attacks

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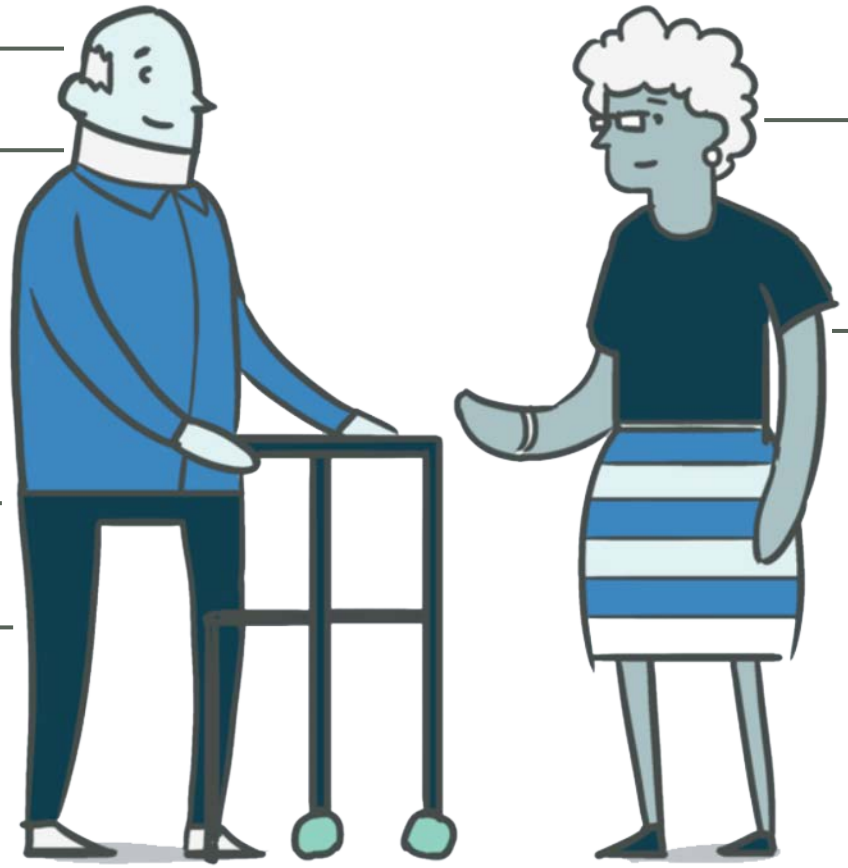
John, 87

Lives at home with his wife, Beth, as his primary caregiver, with support from their daughter.

- A little forgetful
- Unnecessary neck brace (he just likes it!)
- Hypertension
- Mild arthritis
- In decent shape but recently feeling tired, anxious, and uncoordinated



Beth, 79

Lives at home with John and functions as his primary caregiver.

- Usually tired
- Generally healthier and more active than her husband

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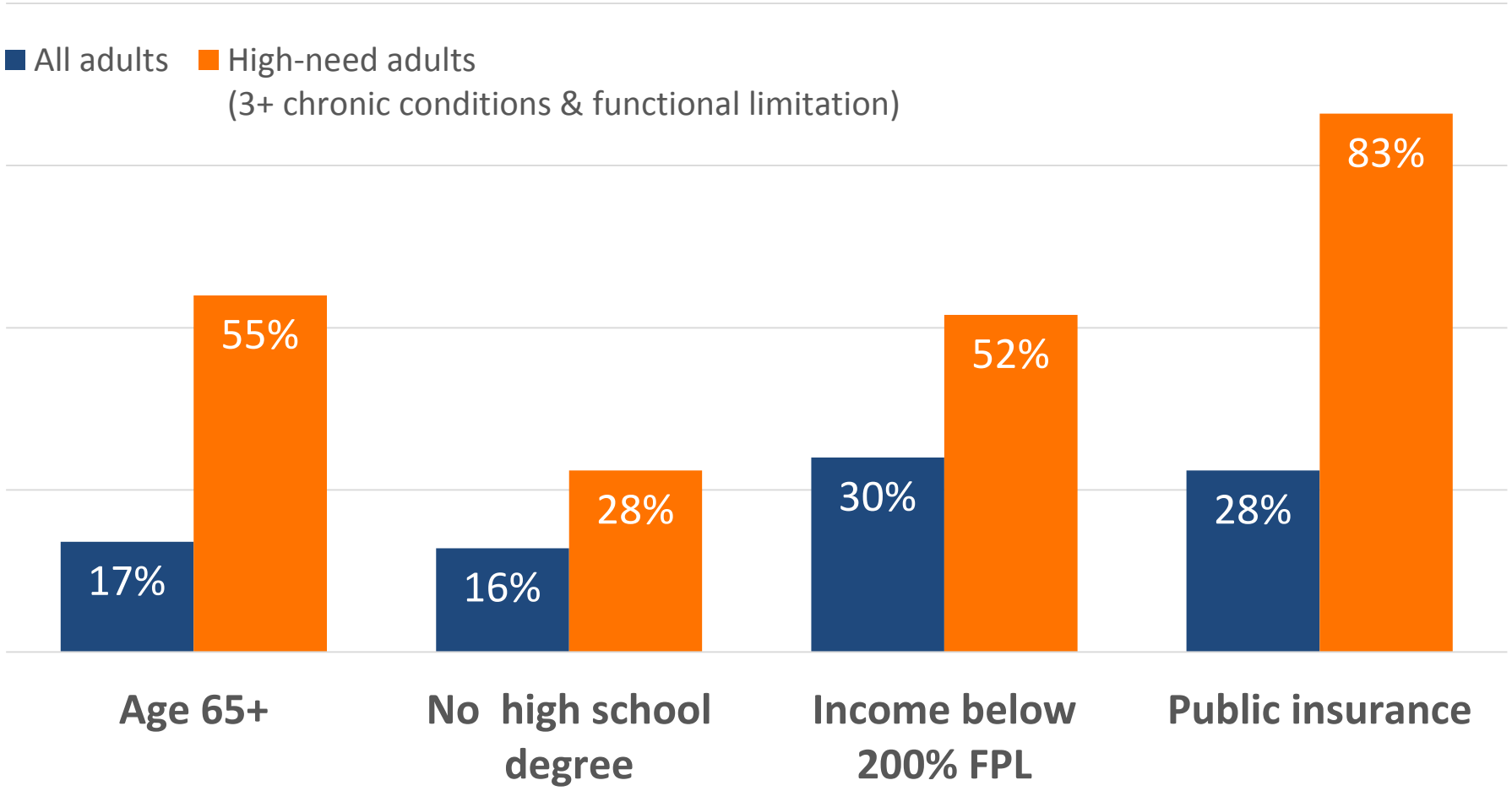
High-Need Adults Tend to be Older, Have Low Socioeconomic Status, and Have Public Insurance



Data: 2009–2011 Medical Expenditure Panel Survey (MEPS).

Source: S. L. Hayes, et al., *High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care?* The Commonwealth Fund, August 2016.

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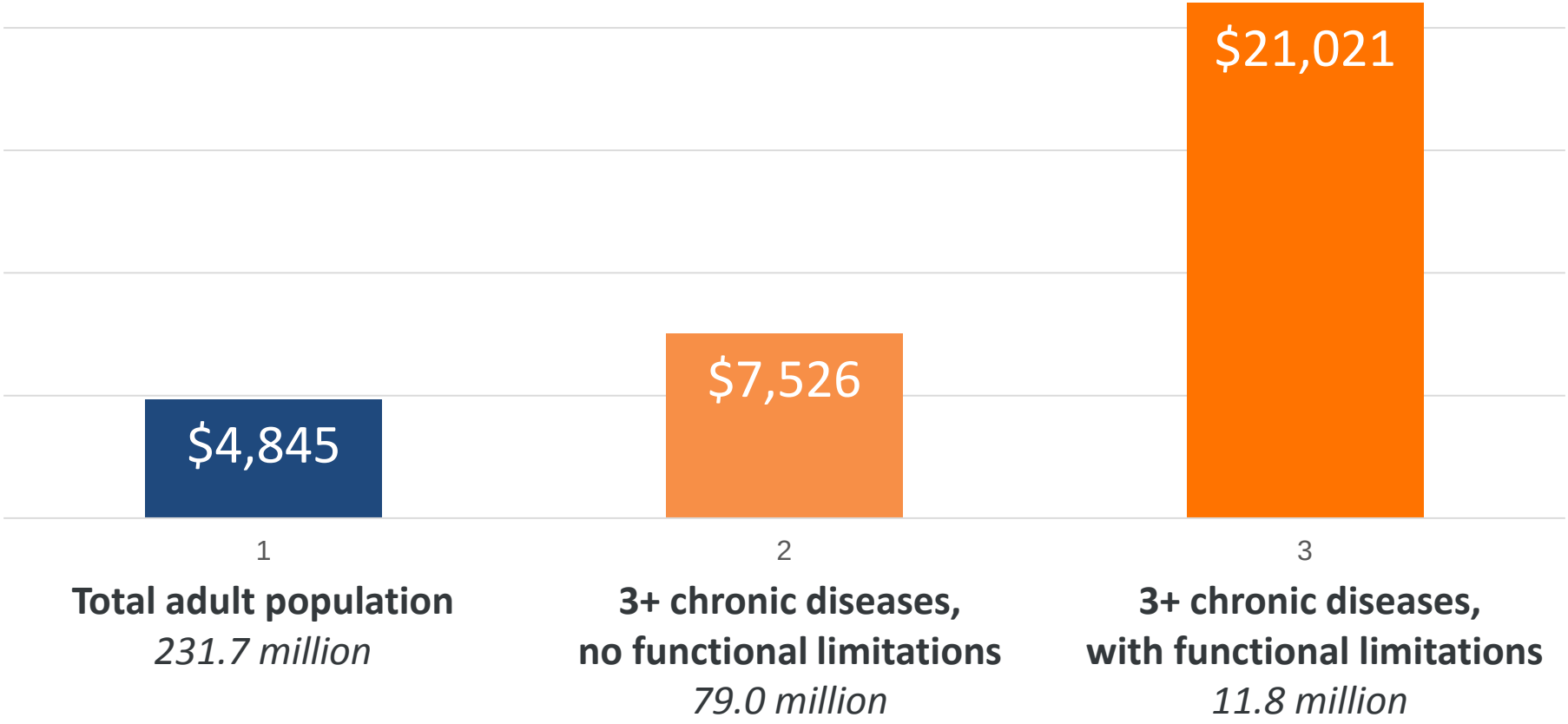
Functional Limitations are a Key Predictor of High Costs

Average Annual Health Expenditures Among U.S. Adults



Data: 2009–2011 MEPS. Noninstitutionalized civilian population age 18 and older.

Source: S. L. Hayes, C. A. Salzberg, D. McCarthy, D. C. Radley, M. K. Abrams, T. Shah, and G. F. Anderson, *High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care?* The Commonwealth Fund, August 2016.

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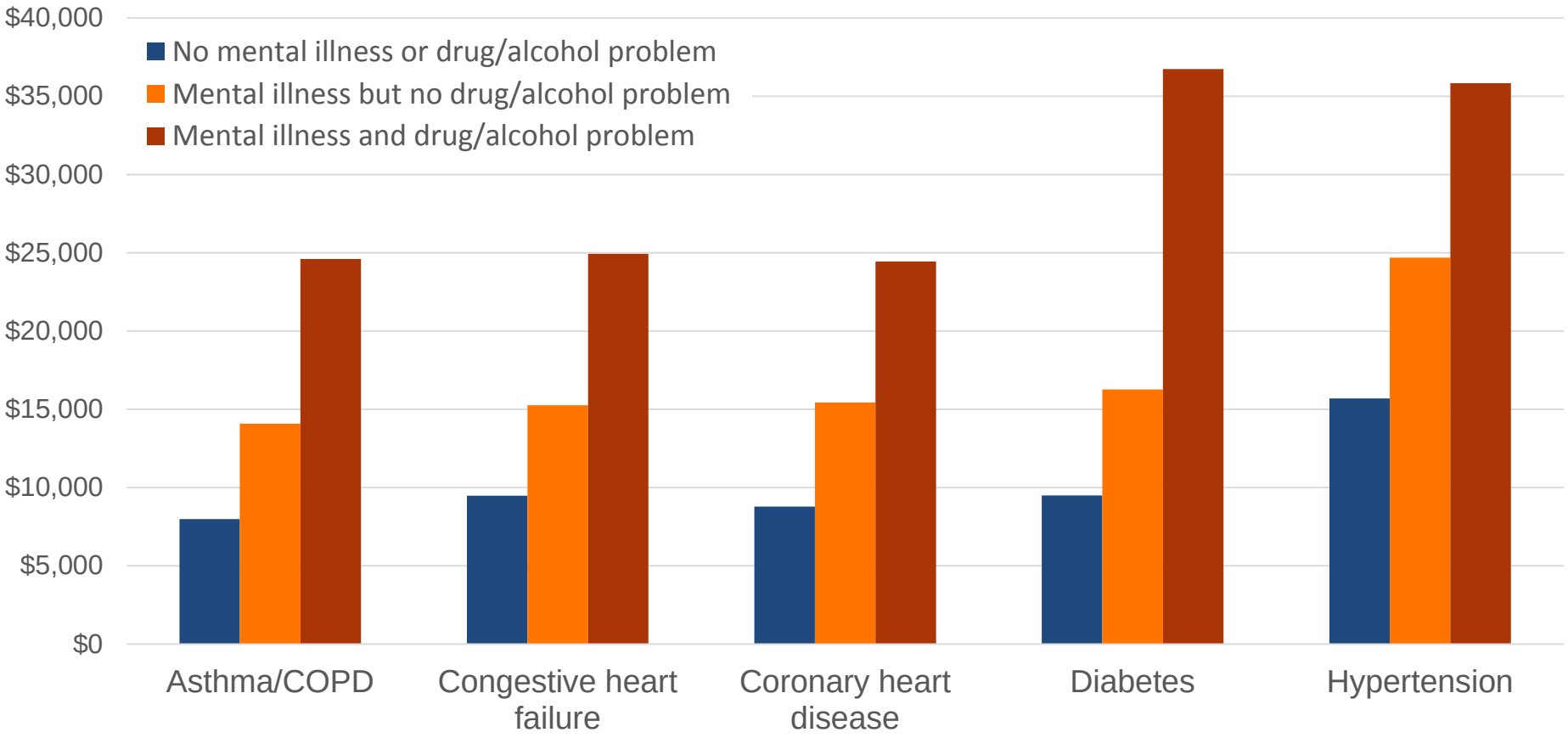
…As Are Behavioral Health Issues

Average Annual Health Expenditures Among a Medicaid Population



Source: C. Boyd et al. Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations. Center for Healthcare Strategies Data Brief, December 2010.

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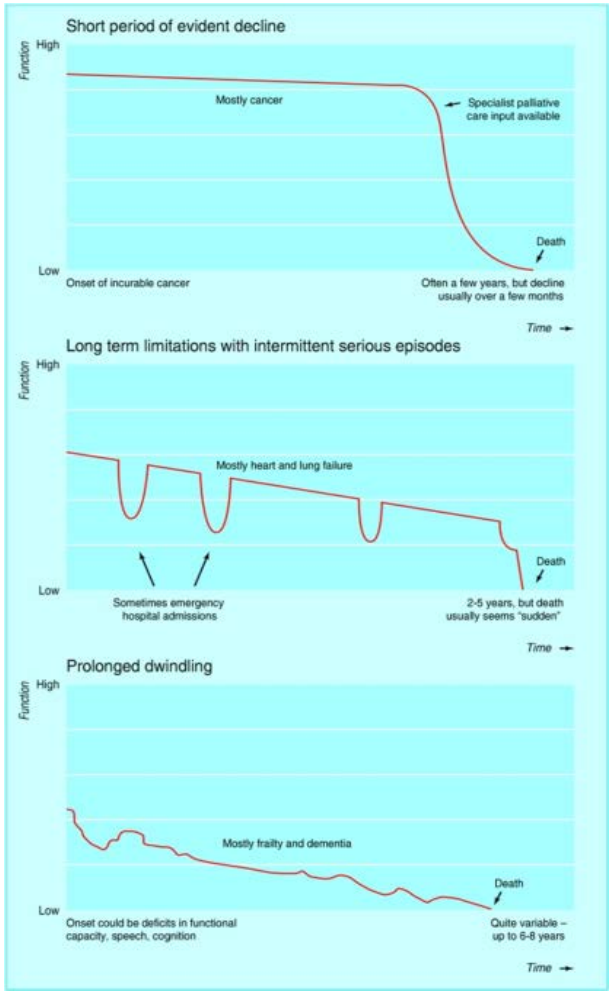
Patients at End of Life are Often High-Need, High-Cost, But Disease Trajectories Vary

"Dying" after short period of decline

Multiple chronic with serious exacerbation, organ failure, "advanced illness"

Long course of decline from dementia and frailty



Source: Lynn, Adamson, "Adapting Health Care to Serious Chronic Illness in Old Age," RAND 2003.

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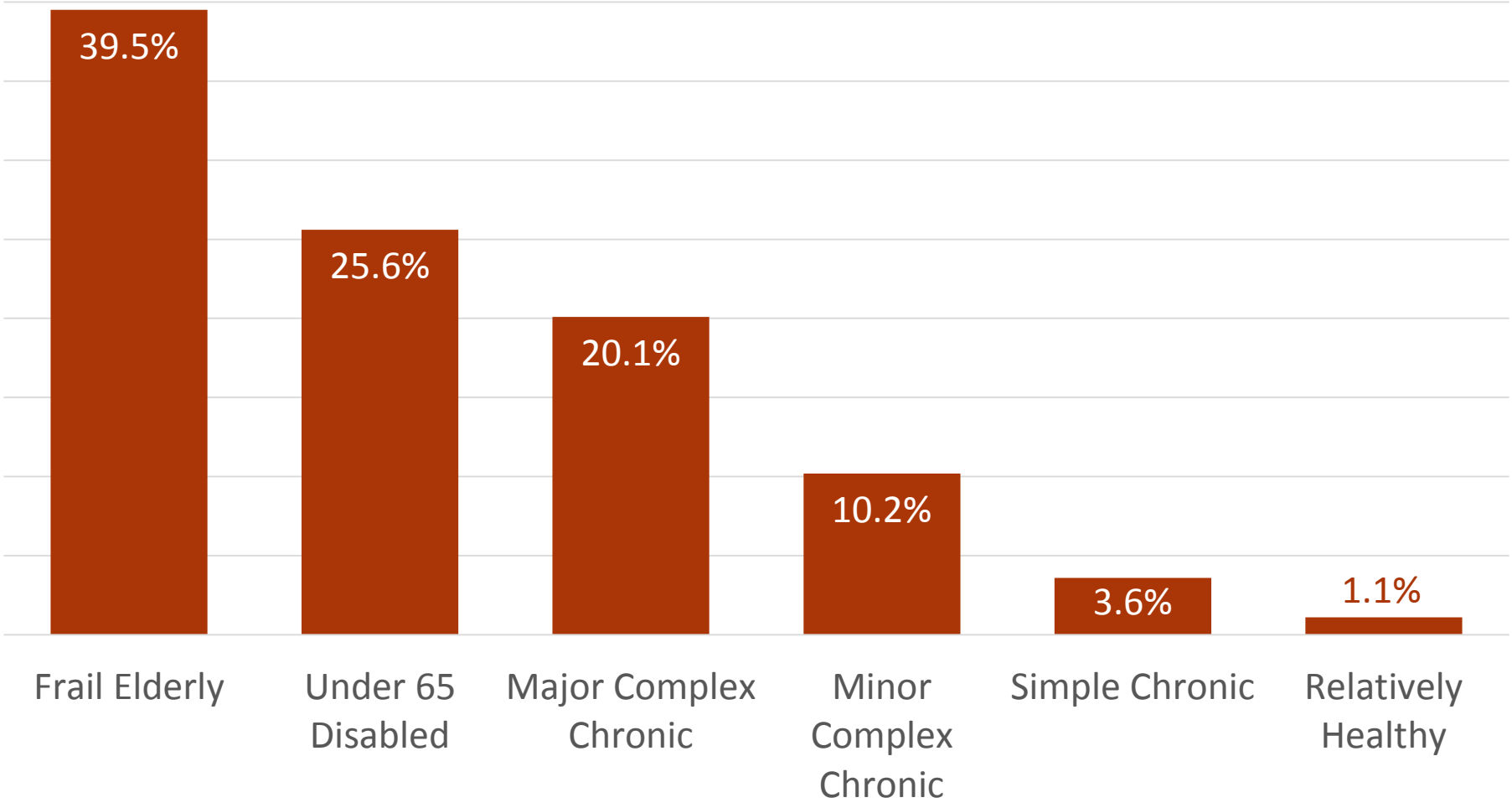
Segments of High-Cost Patients in Medicare



Source: Ashish Jha, analysis of Medicare data.

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What Works in Caring for High-Need, High Cost Patients?

What Have We Learned?

1. Targeted interventions towards patients most likely to benefit.
2. Comprehensive assessments of patients' needs.
3. Trained care managers to facilitate coordination among care team members.
4. Strong health IT.
5. Promotion of patient and caregiver engagement.
6. Partner with social services addressing non-clinical needs.

1 **Target** the population most likely to benefit

2 **Assess** patients' health-related risks and needs

3 **Develop** care plan centered around patients' needs and preferences

4 **Engage** patients and family members in managing care

5 **Connect** patients to appropriate follow-up and support services after hospital discharge

6 **Coordinate** care and facilitate communication among all care providers

7 **Monitor** progress

Source: D. McCarthy, J. Ryan, and S. Klein. *Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis*. The Commonwealth Fund, October 2015.

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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.

CareMore

Program

- Founded in 1993; acquired by Anthem in 2011.
- HMO operating MA plans and delivery sites in 6 states.
- Care management system being piloted by health system, two Medicaid programs.

Key elements

- “Extensivists” lead care team for high-risk patients, including during hospitalization and follow-up.
- Adopt innovative technologies (e.g., partnership with Lyft).

Results

- Reduced hospital readmissions, ~50% fewer SNF days.
- Preliminary analysis shows lower costs.

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.

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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.

For health system leaders, no need to reinvent the wheel.

ACOs' Experiences with High-Need, High-Cost Patients

- Medicare ACOs savings are mostly concentrated among clinically vulnerable beneficiaries (3+ chronic conditions).
  - Savings achieved through reduced use of institutional settings.
    - 4.1 fewer ED visits and 2.9 fewer hospitalizations per 1,000 vulnerable beneficiaries per quarter.
    - 5% reduction in SNF spending.
- Common ACOs tactics to improve care for HNHC patients:
  - Risk-stratification
  - Targeted care management
  - Improved access to primary care teams
  - Management of post-acute care services

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What are the Challenges in Caring for High-Need, High-Cost Patients?

Misaligned Payment System

Moving to Value-Based Payment

Goals for Medicare by 2018

90% of payments linked to quality and value.

50% of payments in alternative payment models.

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Culture: Team-Based Care

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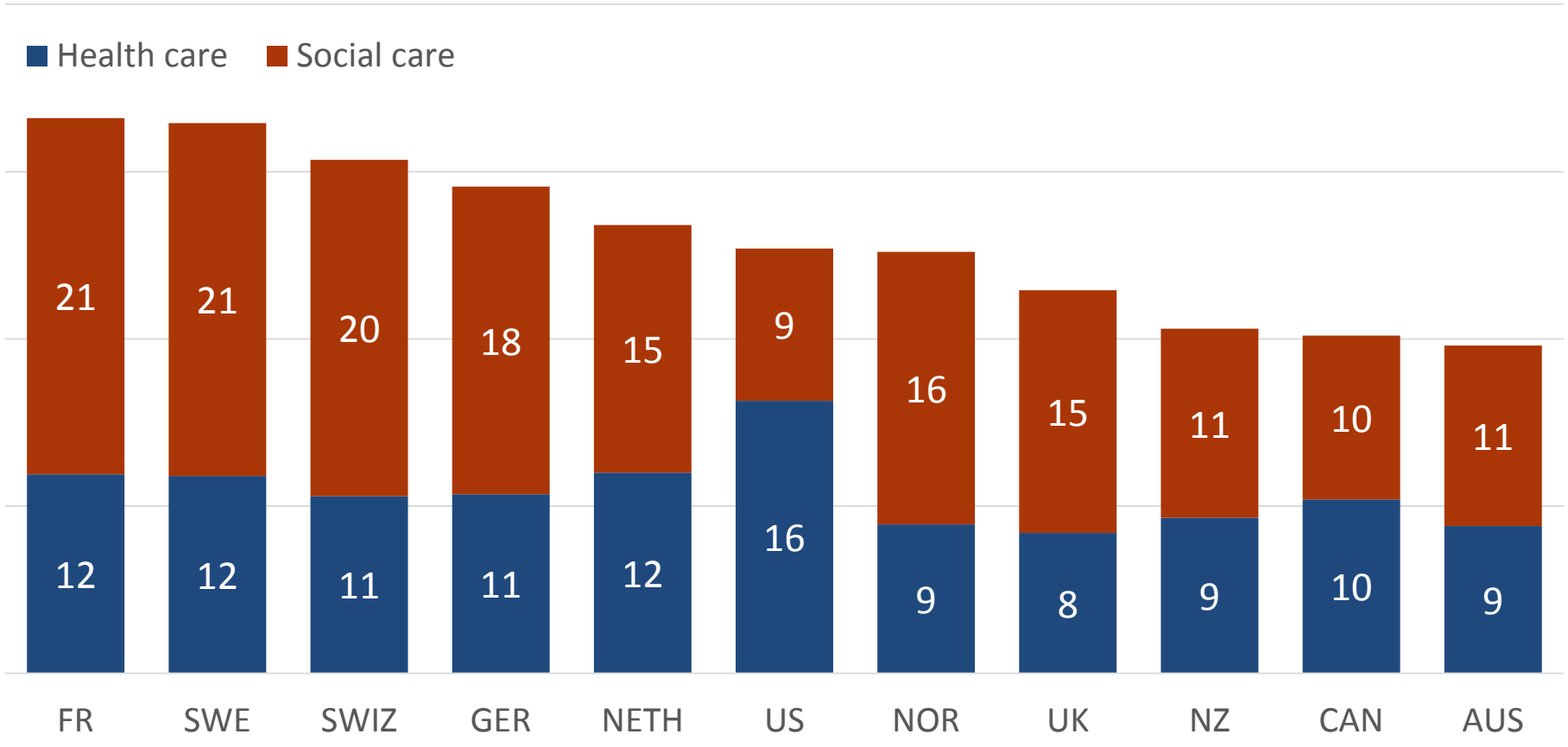
Need for Social Investment and Supportive Policies

Percent of GDP spent on:



Source: E. H. Bradley, L. A. Taylor, and H. V. Fineberg, *The American Health Care Paradox: Why Spending More is Getting Us Less*, Public Affairs, 2013.

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What is the Commonwealth Fund Doing?

The Five Foundation Collaborative

Robert Wood Johnson Foundation

PETERSON CENTER ON HEALTHCARE

THE scan FOUNDATION

The NEW ENGLAND JOURNAL of MEDICINE

Caring for High-Need, High-Cost Patients — An Urgent Priority

David Blumenthal, M.D., M.P.P., Bruce Chernof, M.D., Terry Fulmer, Ph.D., R.N., John Lumpkin, M.D., M.P.H., and Jeffrey Selberg, M.H.A.

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Developing a "Playbook" for Serving High-Need, High-Cost Patients

Goal

Explain challenges facing key high-need, high cost patient segments and how to select evidence-based practices and models to meet their needs.

Core Content

- Value proposition
- Segmentation framework
- Patient profiles
- Case studies of proven models
- ROI data and calculator
- Policy & payment reform opportunities

Target Audience

- Health system leaders, payers, and policymakers

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Getting Incentives Right Inside ACOs

MEDICINE AND PUBLIC ISSUES

Annals of Internal Medicine

Using Behavioral Economics to Design Physician Incentives That Deliver High-Value Care

Ezekiel J. Emanuel, MD; Peter A. Ubel, MD; Judd B. Kessler, PhD; Gregg Meyer, MD, MSc; Ralph W. Muller, MA; Amol S. Navathe, MD, PhD; Pankaj Patel, MD, MSc; Robert Pearl, MD; Meredith B. Rosenthal, PhD; Lee Sacks, MD; Aditi P. Sen, PhD; Paul Sherman, MD; and Kevin G. Volpp, MD, PhD

Behavioral economics provides insights about the development of effective incentives for physicians to deliver high-value care. It suggests that the structure and delivery of incentives can shape behavior, as can thoughtful design of the decision-making environment. This article discusses several principles of behavioral economics, including inertia, loss aversion, choice overload, and relative social ranking. Whereas these principles have been applied to motivate personal health decisions, retirement planning, and savings behavior, they have been largely ignored in the design of physician incentive programs. Applying these principles to physician incentives can improve their effectiveness through better alignment with performance goals. Anecdotal examples of successful incentive programs that apply behavioral economics principles are provided, even as the authors recognize that its application to the design of physician incentives is largely untested, and many outstanding questions exist. Application and rigorous evaluation of infrastructure changes and incentives are needed to design payment systems that incentivize high-quality, cost-conscious care.

Ann Intern Med. 2016;164:114-119. doi:10.7326/M15-1330 **www.annals.org**

For author affiliations, see end of text.

This article was published at www.annals.org on 24 November 2015.

The U.S. health care system is undergoing tremendous change aimed at controlling costs while maintaining or improving quality of care. Payment reform is a fundamental aspect of the transition. Recent years

As organizations strive to reduce costs and improve quality, incorporation of behavioral economics principles into the design of physician incentives has the potential to make these programs more effective.

International Working Group on High-Need, High-Cost Patients

- Scan industrialized countries for care models for high-need, high-cost patients.
- Report on most promising models to health ministers.
- Select models to be piloted in the U.S. and disseminated.

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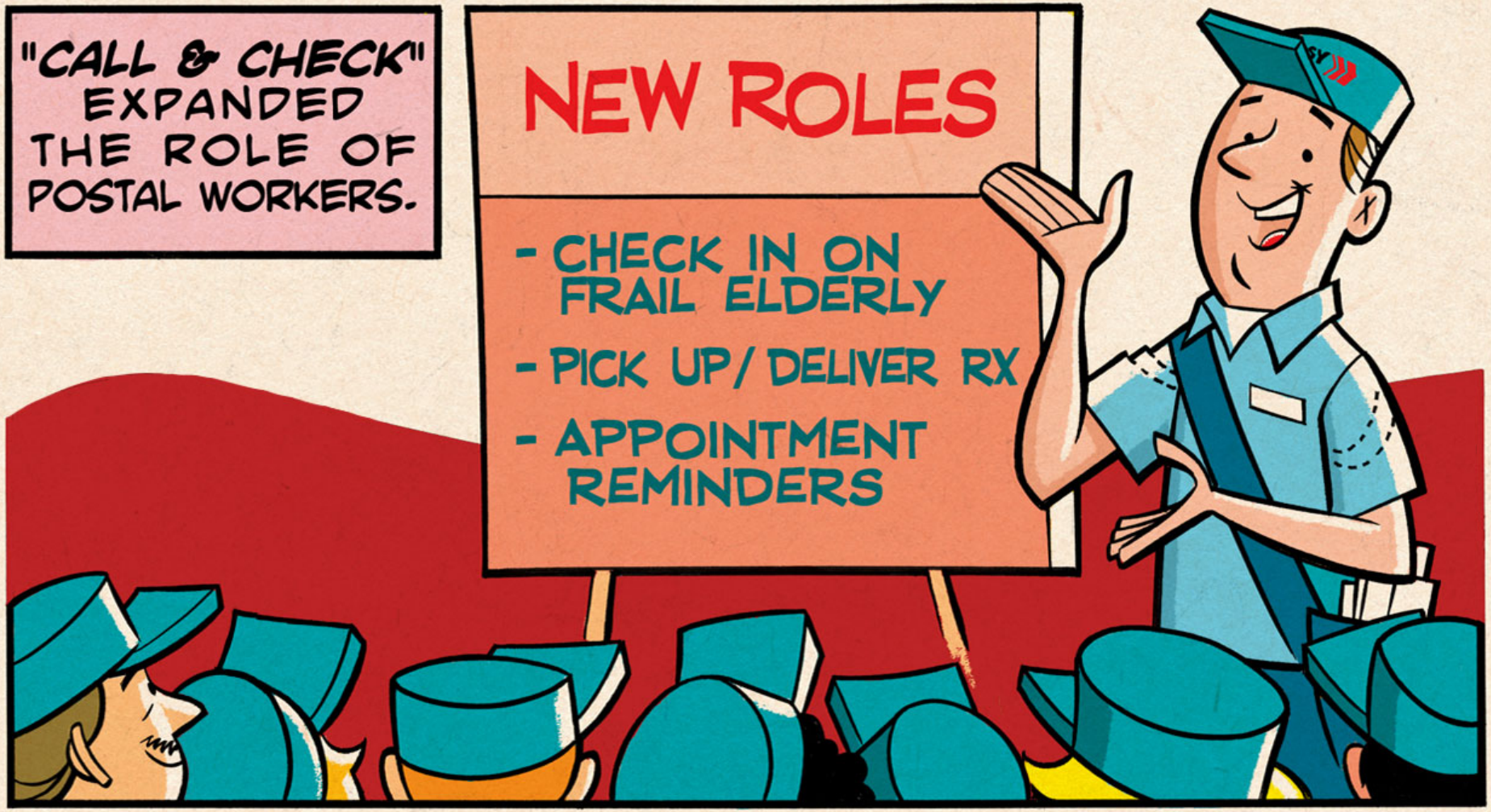
Learning From International Innovations



The ACO challenge is to focus relentlessly on high-need, high-cost patients and execute on their care.

Thank You

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David Squires
Senior Researcher to the President

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Question and Answer