NATIONAL ACADEMY OF MEDICINE

PETERSON CENTER ON HEALTHCARE

EFFECTIVE CARE FOR HIGH-NEED PATIENTS

Opportunities for Improving Outcomes, Value, and Health

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NATIONAL ACADEMY OF MEDICINE

- Formerly the Institute of Medicine, established in 1970

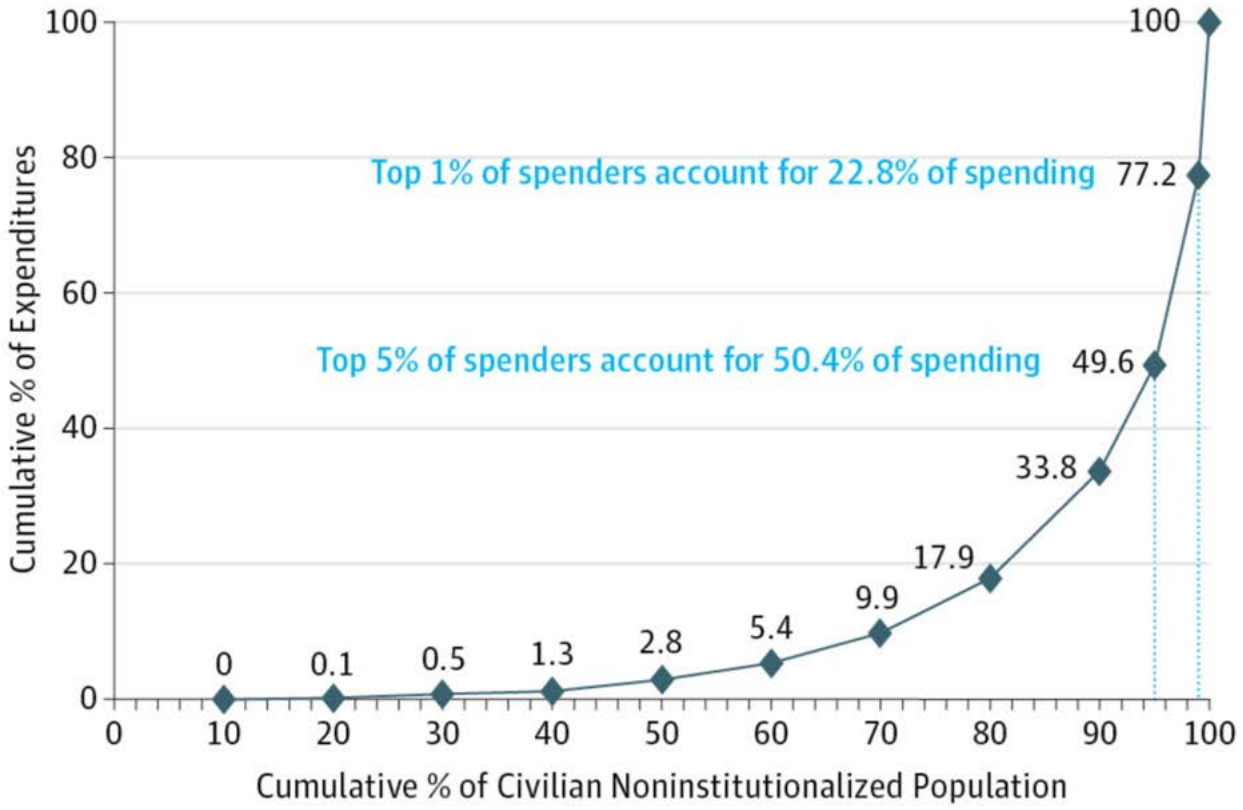
- Provides independent, objective analysis and advice to the nation and conducts activities to solve complex problems and inform public policy decisions

Leadership Consortium for a Value & Science-Driven Health System

- Provides a trusted venue for national leaders in health and health care to work cooperatively toward their common commitment to effective, innovative care that consistently adds value to patients and society.

- Members are leaders from core stakeholder communities brought together by their common commitment to steward the advances in science, value and culture necessary for a health system that continuously learns and improves in fostering healthier people.

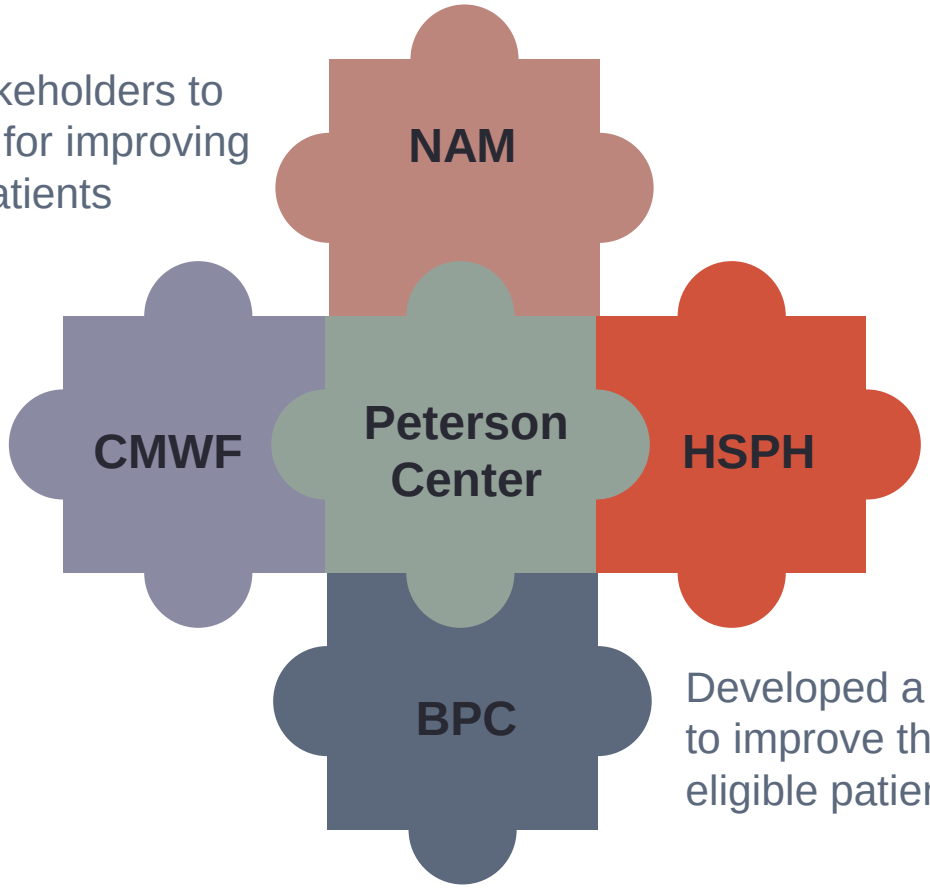
High-Need Patients



Source: Dzau, V. J., M. B. McClellan, J. McGinnis, and et al. 2017. Vital directions for health and health care: Priorities from a national academy of medicine initiative. *JAMA* 317(14):1461-1470.

Where we started?

Brought together stakeholders to reflect on key issues for improving care for high-need patients



Strategic partners and advisor

Data analyses to identify high-cost patients and subgroups

Developed a set of recommendations to improve the value of care for dual eligible patients

Collective goal: Advance our understanding of how to better manage health of high-need patients through exploration of patient characteristics and groupings, promising care models and attributes, and policy solutions to sustain and scale care models.

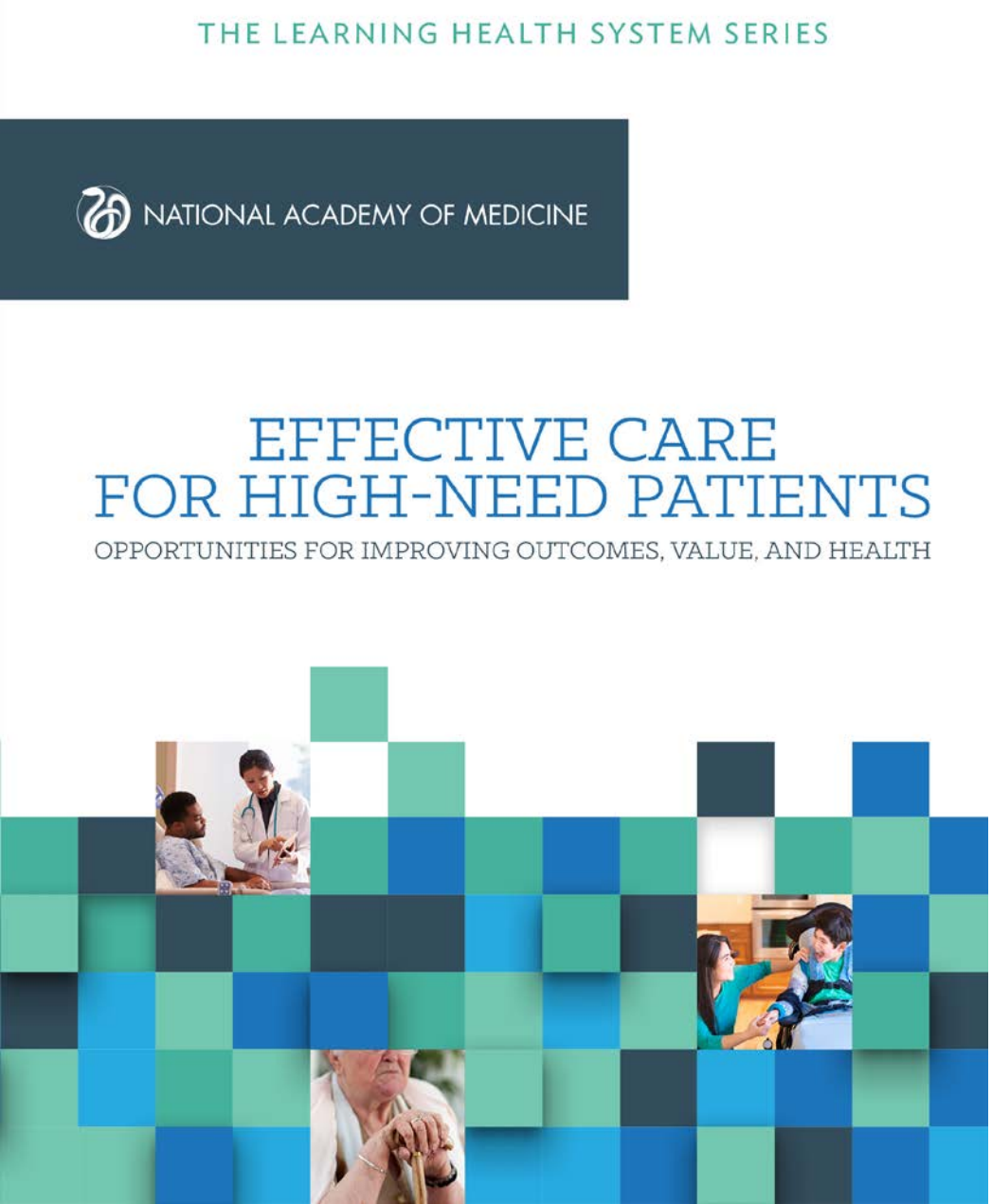
Planning Committee

PETER V. LONG (*Chair*), President and Chief Executive Officer, Blue Shield of California Foundation

MELINDA K. ABRAMS, Vice President, Delivery System Reform, The Commonwealth Fund
GERARD F. ANDERSON, Director, Center for Hospital Finance and Management, Johns Hopkins Bloomberg School of Public Health
TIM ENGELHARDT, Acting Director, Federal Coordinated Health Care Office, Centers for Medicare & Medicaid Services
JOSE FIGUEROA, Instructor of Medicine, Harvard Medical School; Associate Physician, Brigham and Women's Hospital
KATHERINE HAYES, Director, Health Policy, Bipartisan Policy Center
FREDERICK ISASI, Executive Director, Families USA; former Health Division Director, National Governors Association
ASHISH K. JHA, K. T. Li Professor of International Health & Health Policy, Director, Harvard Global Health Institute, Harvard T.H. Chan School of Public Health
DAVID MEYERS, Chief Medical Officer, Agency for Healthcare Research and Quality
ARNOLD S. MILSTEIN, Professor of Medicine, Director, Clinical Excellence Research Center, Center for Advanced Study in the Behavioral Sciences; Stanford University
DIANE STEWART, Senior Director, Pacific Business Group on Health
SANDRA WILKNISS, Health Division Program Director, National Governors Association Center for Best Practices

Process

- Convened experts over the course of three workshops:
  - Workshop 1: Who are high-need patients, and what does successful care for these patients look like?
  - Workshop 2: What data exists on this population and what can it tell us? How do we segment high-need patients for best care?
  - Workshop 3: How can we match patient segments to the best fitting care? What are the policy barriers?
- Convened taxonomy and policy work groups



Topics Covered:

- Key characteristics of HN patients
- The use of a patient taxonomy to inform and target care
- Promising care models for HN patients
- Areas of opportunity for policy-level action

CHARACTERISTICS OF HIGH-NEED PATIENTS

Characteristics of High-Need Patients

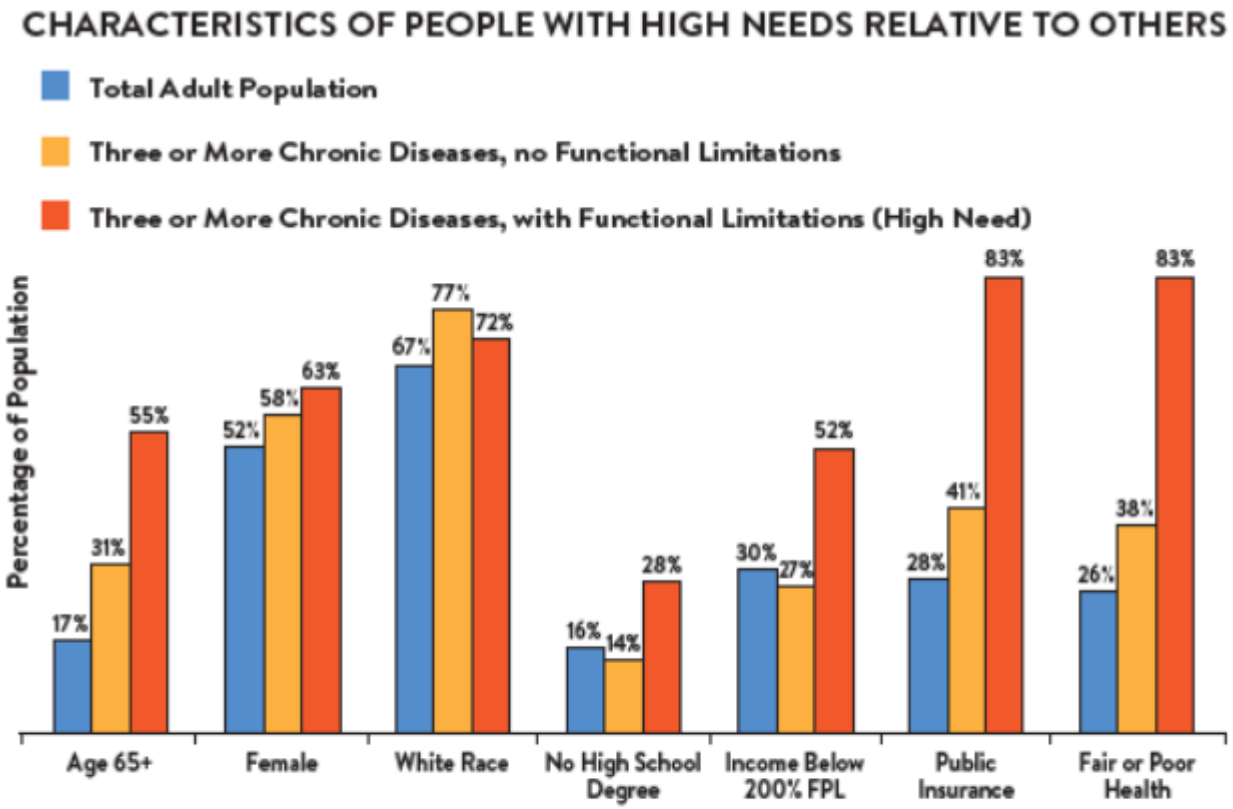


FIGURE 2–6 | Demographic characteristics of high-need adults.
NOTE: FPL = federal poverty line.

SOURCE: Reproduced from (Hayes et al., 2016c).

Characteristics of High-Need Patients

- High-need patients are diverse and have varying needs
- Variables that could form a basis for defining this patient population include:
  - Total accrued health care costs
  - Intensity of care utilized over a given time
  - Functional limitations
- The needs of this population often extend beyond their medical needs to social and behavioral services

Functional Limitations

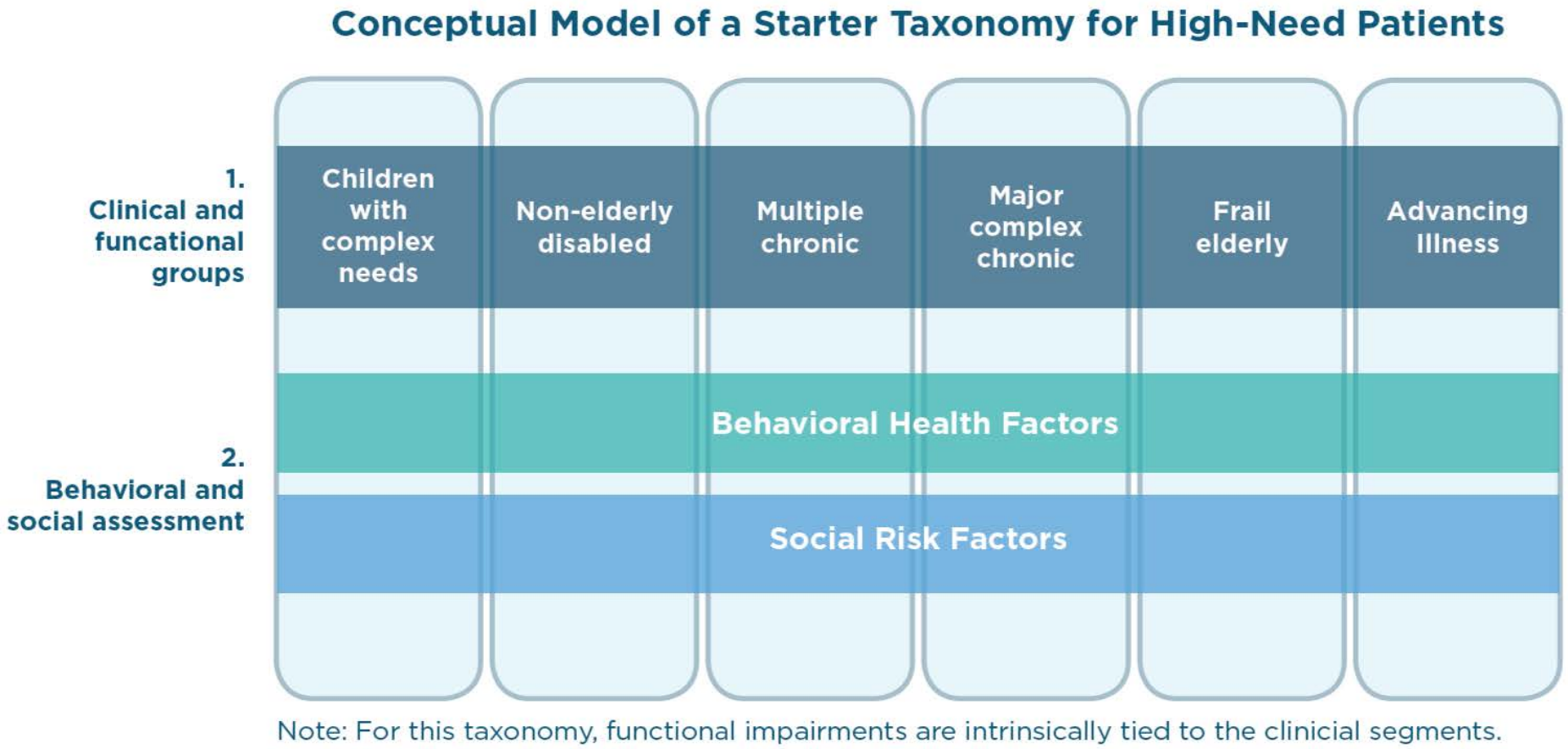
- Limitations in activities of daily living
  - EG: dressing, bathing or showering, ambulating, self-feeding, grooming, and toileting
- Limitations in instrumental activities of daily living that support an independent lifestyle
  - EG: housework, shopping, managing money, taking medications, using a telephone, or being able to use transportation

A STARTER HIGH-NEED PATIENT TAXONOMY

A Starter High-Need Patient Taxonomy

- Using a taxonomy to segment patients can lead to better, more-tailored care
- Segments should group patients based on the care they need and how often they might need it
- A taxonomy workgroup built on existing efforts to develop a starter taxonomy that incorporates functional, social, and behavioral factors into a medically oriented taxonomy

A Starter High-Need Patient Taxonomy



Note: For this taxonomy, functional impairments are intrinsically tied to the clinicial segments.

Taxonomy Clinical Group Features

Clinical Group	Features
Children with complex needs	Have sustained severe impairment in at least four categories together with enteral/parenteral feeding or sustained severe impairment in at least two categories and requiring ventilation or continuous positive airway pressure[a]
Non-elderly disabled	Under 65 years and with end-stage renal disease or disability based on receiving Supplemental Security Income
Multiple chronic	Only one complex condition and/or between one and five noncomplex conditions[b,c]
Major complex chronic	Two or more complex conditions or at least six noncomplex conditions [b,c]
Frail elderly	Over 65 years and with two or more frailty indicators[d]
Advancing illness	Other terminal illness, or end of life

[a] Categories for children with complex needs are: learning and mental functions, communication, motor skills, self-care, hearing, vision

[b] Complex conditions, as defined in (Joynt et al., 2016), are listed in Table 2-1.

[c] Noncomplex conditions, as defined in (Joynt et al., 2016), are listed in Table 2-1.

[d] Frailty indicators, as defined in (Joynt et al., 2016), are gait abnormality, malnutrition, failure to thrive, cachexia, debility, difficulty walking, history of fall, muscle wasting, muscle weakness, decubitus ulcer, senility, or durable medical equipment use.

High-Impact Social Variables

Variable	Criteria/Measurement
Low socioeconomic status	Income and/or education
Social isolation	Marital/relationship status and whether living alone
Community deprivation	Median household income by census tract; proximity to pharmacies and other health care services
Housing insecurity	Homelessness; recent eviction

High-Impact Behavioral Variables

Variable	Criteria/Measurement
Substance abuse	Excessive alcohol, tobacco, prescription and/or illegal drug use
Serious mental illness	Schizophrenia and other psychotic disorders, bipolar, major depression
Cognitive decline	Dementia disorders (Alzheimer's, Parkinson's, vascular dementia)
Chronic toxic stress	Functionally impairing psychological disorders or conditions (e.g., PTSD, adverse childhood experiences, anxiety)

SUCCESSFUL CARE MODELS FOR HIGH-NEED PATIENTS

Attributes of Successful Care Models

- The success of any model depends of the needs of the patient population that the model intends to serve
- Successful models should foster effectiveness across 3 domains: health and well-being, care utilization, and costs
- Common attributes of successful care models can be organized in a framework with four dimensions:
  - Focus on service setting
  - Care and condition attributes
  - Delivery features
  - Organizational features

Service Setting

BOX 4-1
Service Setting and Focus of Successful Care Models

Enhanced primary care. Programs in the primary care setting defined by the use of supplemental health-related services that enhance traditional primary care and/or employ a team-based approach, with a provider and at least one other person

Transitional care. Facilitate safe and efficient transitions from the hospital to the next site of care (e.g., alternative health care setting or home). Interventions are usually led by a nurse, known as a "transition coach," who provides patient education about self-care, coaches the patient and caregiver about communicating with providers, performs a home visit, and monitors the patient

Integrated care. Cross-disciplinary models which engage or focus on social risk interventions and behavioral health services in addition to medical care and functional assistance.

NOTE: Categories are not mutually exclusive.

Care and condition attributes

BOX 4-2
Care and Condition Attributes of Successful Care Models

Assessment. Multidimensional (medical, functional, and social) patient assessment
Targeting. Targeting those most likely to benefit
Planning. Evidence-based care planning
Alignment. Care match with patient goals and functional needs
Training. Patient and care partner engagement, education, and coaching
Communication. Coordination and communication among and between patient and care team
Monitoring. Proactive tracking of the health status and adherence to care plans
Continuity. Seamless transitions across time and settings

Delivery features

BOX 4-3
Delivery Features of Successful Care Models

Teamwork. Multidisciplinary care teams with a single, trained care coordinator as the communication hub and leader
Coordination. Extensive outreach and interaction among patient, care coordinator, and care team, with an emphasis on face-to-face encounters among all parties and collocation of teams
Responsiveness. Speedy provider responsiveness to patients and 24/7 availability
Feedback. Timely clinician feedback and data for remote patient monitoring
Medication management. Careful medication management and reconciliation, particularly in the home setting
Outreach. The extension of care to the community and home
Integration. Linkage to social services
Follow-up. Prompt outpatient follow-up after hospital stays and the implementation of standard discharge protocols

Organizational culture

BOX 4-4
Organizational Culture of Successful Care Models

Leadership across levels
Customization to context
Strong team relationships, including patients and care partners
Training appropriate to circumstances
Continuous assessment with effective metrics
Use of multiple sources of data

Taxonomy Crosswalk

Successful care models cross-referenced to patient segment(s) that could be served if needs of patients are matched to appropriate models

Program \ Segment	Children w/ complex needs	Non-elderly disabled	Multiple chronic	Major complex chronic	Frail elderly	Advancing illness
Care Management Plus				*		*
Commonwealth Care Alliance		■				
Complex Care Program at Children's National Health System	■					
GRACE				*		
Guided Care				■		
Health Quality Partners			■	■		
Health Services for Children with Special Needs	*					
Hospital at Home						■
H-PACT		*				
IMPACT			*		*	
Massachusetts General Physicians Organization Care Management Program	■			■		
MIND at home					*	
Naylor Transitional Care Model (Penn)					■	
PACE					■	

A subset of these care models also target social and/or behavioral risk factors faced by high-need patients and are marked with an (*).

POLICIES TO SUPPORT SUCCESSFUL CARE MODELS

Policies to Support Successful Care Models

Barriers	Proposed policy solutions
Misalignment between financial incentives and the services necessary to care for high-need patients	• Efforts must focus on combining Medicare and Medicaid funding streams for dual-eligible patients into an integrated benefit and care delivery structure • Value based payment models should support the seamless integration of medical, behavioral, and social services
Health system fragmentation	• Federal, state, and local governments must engage in a strategy coordinated to incentivize the provision of social supports in conjunction with necessary medical services
Workforce training issues	• New training and certification opportunities focused on high-need patients and care coordination must be developed as well as credentialing programs for nontraditional health workers
Disparate data systems that cannot easily share data	• Coordinated federal, state, and local government initiatives must identify barriers to data flow and work to address those barriers while respecting patient privacy and data security

Opportunities for Action

All stakeholders have a role to play in improving care for high-need patients.

- Refine taxonomy based on real-world use and experience
- Integrate and coordinate delivery of medical, social, and behavioral services in a way that reduces the burdens on patients and caregivers
- Develop approaches for spreading and scaling successful programs and for training the workforce
- Promote payment reform efforts that further incentivize the adoption of successful care models and the integration of medical and social services
- Establish a small set of proven quality measures appropriate for assessing outcomes, including ROI, and continuously improving programs for high-need individuals
- Create road maps and tools to help organizations adopt models of care suitable for their particular patient populations

Questions?

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www.nam.edu/highneeds