Caring for High-Need, High-Cost Aging Populations

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The Commonwealth Fund

Disclaimer: the views are the presenters’ and not necessarily those of The Commonwealth Fund or its officers, directors, or staff.
Outline of Today’s Talk

- Who are high-need high-cost adults?
- How does the health system perform for older high-need high-cost adults?
- What are common features of effective care models for high-need high-cost adults?
- What are some benefits of exemplary care models for aging adults?
- What policy and system changes are needed to enable the spread of effective care models?
Who are high-need, high-cost adults?

- People with 3 or more chronic conditions plus a functional limitation in their activities of daily living or instrumental activities of daily living

- Incur much higher health care spending

- Make much greater use of health care services

- Differ on key socio-demographic characteristics

- Experience gaps in access to and quality of care
Older adults with high needs more often report problems with access to and quality of care

<table>
<thead>
<tr>
<th>Problem</th>
<th>High-need U.S. older adults</th>
<th>Other U.S. older adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost-related access problem in past year</td>
<td>22</td>
<td>16</td>
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<tr>
<td>Went to ED for condition that could have been treated by regular doctor</td>
<td>19</td>
<td>9</td>
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<tr>
<td>Had a coordination problem in the past two years</td>
<td>44</td>
<td>27</td>
</tr>
<tr>
<td>Medical mistake in treatment or care in past two years</td>
<td>13</td>
<td>6</td>
</tr>
</tbody>
</table>

Most older adults with high needs have a treatment plan, but follow-up is not common

Some comprehensive care models exhibit promising evidence of impact, but few have been widely spread

<table>
<thead>
<tr>
<th>CATEGORIES</th>
<th>MODELS OR EXAMPLES†</th>
<th>EVIDENCE OF POSITIVE IMPACT††</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>QoC</td>
</tr>
<tr>
<td>1. Interdisciplinary Primary Care</td>
<td>Guided Care, GRACE, IMPACT, PACE</td>
<td>X</td>
</tr>
<tr>
<td>2. Enhanced Primary Care</td>
<td>Care and case management</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Disease management</td>
<td>X</td>
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<td></td>
<td>Preventive home visits</td>
<td></td>
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<tr>
<td></td>
<td>Geriatric evaluation and management</td>
<td>X</td>
</tr>
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<td></td>
<td>Pharmaceutical care</td>
<td>X</td>
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<tr>
<td></td>
<td>Chronic disease self-management</td>
<td>X</td>
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<tr>
<td></td>
<td>Proactive rehabilitation</td>
<td>X</td>
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<tr>
<td></td>
<td>Caregiver education and support</td>
<td>X</td>
</tr>
<tr>
<td>3. Transitional Care</td>
<td>Hospital to home</td>
<td></td>
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<tr>
<td>4. Acute Care in Patients’ Homes</td>
<td>Substitutive hospital-at-home</td>
<td>X</td>
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<td></td>
<td>Early-discharge hospital-at-home</td>
<td></td>
</tr>
<tr>
<td>5. Team Care in Nursing Homes</td>
<td>Minn. Senior Health Options, Evercare</td>
<td>X</td>
</tr>
<tr>
<td>6. Comprehensive Care in Hospitals</td>
<td>Prevention/management of delirium</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Comprehensive inpatient care</td>
<td>X</td>
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Source: adapted from C. Boult et al. *Journal of the American Geriatrics Society* 2009;57:2328-37. †Examples: GRACE = Geriatric Resources for Assessment and Care of Elders; IMPACT = Improving Mood: Promoting Access to Collaborative Treatment; PACE = Program of All-Inclusive Care for the Elderly. ††Impact: QoC = quality of care; QoL = quality of life; FA = functional autonomy; Surv = survival; LOS = length of stay; M = mixed evidence.
“You can always count on Americans to do the right thing...after they’ve tried everything else.”

--Winston Churchill
Caring for high-need, high-cost patients

WHAT WORKS

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

Case Example: Kaiser Permanente’s Care Groups for the Senior Population

<table>
<thead>
<tr>
<th>Group</th>
<th>Health Status</th>
<th>Risk*</th>
<th>Potential Optimization</th>
</tr>
</thead>
</table>
| 1     | Robust with no chronic conditions      | LOW 1% hospitalized <1% 1-yr mortality | -Disease prevention  
                                                -Screening  
                                                -Health promotion services |
| 2     | One or more chronic conditions         | MODERATE 2% hospitalized 1.2% 1-yr mortality 2X cost of Group 1 | -Disease management |
| 3     | Advanced illness and/or end-organ failure (e.g., heart failure, COPD) | 6% hospitalized 5.5% 1-yr mortality 4X cost of Group 1 | -Complex case management  
                                                        -Advanced illness coordinated care  
                                                        -Transitional care  
                                                        -Geriatric consultation |
| 4     | Extreme frailty or near end of life    | HIGH 12% hospitalized 28% 1-yr mortality 8X cost of Group 1 | -Home-based care  
                                                        -Social work outreach  
                                                        -Palliative care  
                                                        -Hospice care |

*Hospital discharge in quarter after segmentation. For Group 3, members are those not identified for other groups.
Source: Adapted from Table 1 in Y. Y. Zhou, W. Wong, and H. Li, “Improving Care for Older Adults: A Model to Segment the Senior Population,” The Permanente Journal 2014, 18(3): 18-21.
Case Example: Medstar Washington Medical Center’s Medical House Call Program

2 Assess patients’ health-related risks and needs
3 *Develop* evidence-based care plans centered around patients’ needs and preferences
4 *Engage* patients and family members in managing care

Case Example: Commonwealth Care Alliance
Massachusetts Senior Care Options

5 Connect patients to appropriate follow-up & support services following hospital discharge

Co-locate care managers within hospitals to facilitate communications and placement of members back into community settings

Built a preferred network of post-acute care facilities: care transition nurses make weekly visits for evaluation and liaison

Deploy specially trained paramedics to patients’ homes to provide diagnosis & management for acute physical & behavioral health ailments

Source: Toyin Ajayi, M.D., M.Phil., Chief Medical Officer, Commonwealth Care Alliance
TWO CARE MODELS FOR ELDERS

PACE
• Medicare/Medicaid managed care plans and medical & long-term care providers
• 118 programs; 39,000 served
• Enrollment up 40% in last three years

CAREMore
• Medicare managed care plan and medical provider
• 85,000 served across 6 states
• Expanding to Medicaid

PACE and CareMore members tend to be poorer, sicker, frailer than general Medicare population – but models lead to fewer hospitalizations
Would make clear the models lead to fewer hospitalizations b/c might be confused with baseline characteristics of population
Douglas McCarthy, 6/23/2016
A SHARED APPROACH

- Flexibility of capitation
- Dedicated care centers
- Care coordination; close monitoring
- Embedded behavioral health providers
- Wellness, exercise
- Multidisciplinary care teams
ELDER CARE AS A TEAM SPORT

PACE
- Personal Care Attendants
- Home Care Workers
- Transportation Workers

CareMore
- MDs, NPs, RNs
- Social Workers & counselors
- PT, OT, and Rec Therapists
- Dieticians

Medical Assistants
Psychiatrists & Psych. RNs
Pharmacists
Case Managers
KEEPING MINDS AND BODIES ACTIVE

Dianne Boggs  Age 75, enrolled in PACE Mountain Empire in rural Virginia

Bad fall landed her in a wheelchair

Transit service brings to day center for socializing, exercise, checkups

After 3 years, regained enough strength to use cardio machine for mile; do most self-care

*If it wasn’t for PACE, I would just sit home and dry up.*
—Dianne Boggs
Challenges

- Operationally complex
- Need support from provider community
- Reductions in Medicare Advantage rates (CareMore)

The Future

- Expanding to other high-need populations (PACE to disabled; CareMore to Medicaid)
- Greater use of technology
Success depends on implementation...

• Effective **interdisciplinary teamwork** (e.g., defined roles, trusting relationships, team meetings)

• Specially trained **care managers build rapport** through **face-to-face contact** with patients and **collaborative relationship** with physicians

• **Coaching** and **behavior-change techniques** to teach self-care skills (e.g., motivational interviewing)

• **Standardized processes** for medication management, advanced care planning, etc.

• Effective use of **health information technology** to provide timely and reliable information

# Barriers and Possible Solutions to Sustainability and Spread

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<th>Barrier</th>
<th>Possible Solutions</th>
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<tr>
<td>Financial incentives</td>
<td>Incentives for care coordination &amp; supportive services</td>
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<tr>
<td>Capacity to change</td>
<td>Technical support; collaborative learning</td>
</tr>
<tr>
<td>Culture &amp; workforce</td>
<td>Leadership; skills training (e.g., Guided Care)</td>
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<tr>
<td>Infrastructure</td>
<td>Information tools (e.g., Care Management Plus)</td>
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<tr>
<td>Evidence translation</td>
<td>Adaptive change principles; rapid-cycle evaluation</td>
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Fostering a High-Performance Health System That Serves Our Nation’s Sickest and Frailest

<table>
<thead>
<tr>
<th>Goal</th>
<th>Description</th>
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<tbody>
<tr>
<td>Identify subgroups of patients with similar needs and challenges</td>
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<tr>
<td>Shift the delivery of care for high-need patients from institutional</td>
<td>settings to home and community settings whenever possible</td>
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<tr>
<td>Build the capacity to assess and actively manage social and</td>
<td>behavioral health needs in addition to medical needs</td>
</tr>
<tr>
<td>Make it easier for patients, caregivers, and professionals to work</td>
<td>in close coordination with one another</td>
</tr>
<tr>
<td>Design and deliver services that meet goals set collaboratively by</td>
<td>patients, caregivers, and providers</td>
</tr>
<tr>
<td>Allocate resources based on the potential to have a positive impact</td>
<td>on the quality of life of patients and caregivers</td>
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