Caring for High-Need, High-Cost Aging Populations

Presentation to the Health Policy Institute of Ohio

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Outline of Today's Talk

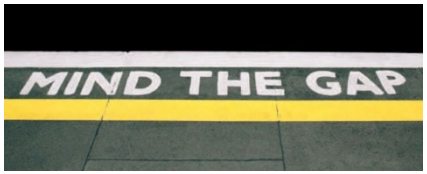
- Who are **high-need high-cost adults**?
- How does the **health system perform** for older high-need high-cost adults?
- What are **common features** of effective care models for high-need high-cost adults?
- What are some **benefits of exemplary care models** for aging adults?
- What **policy and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



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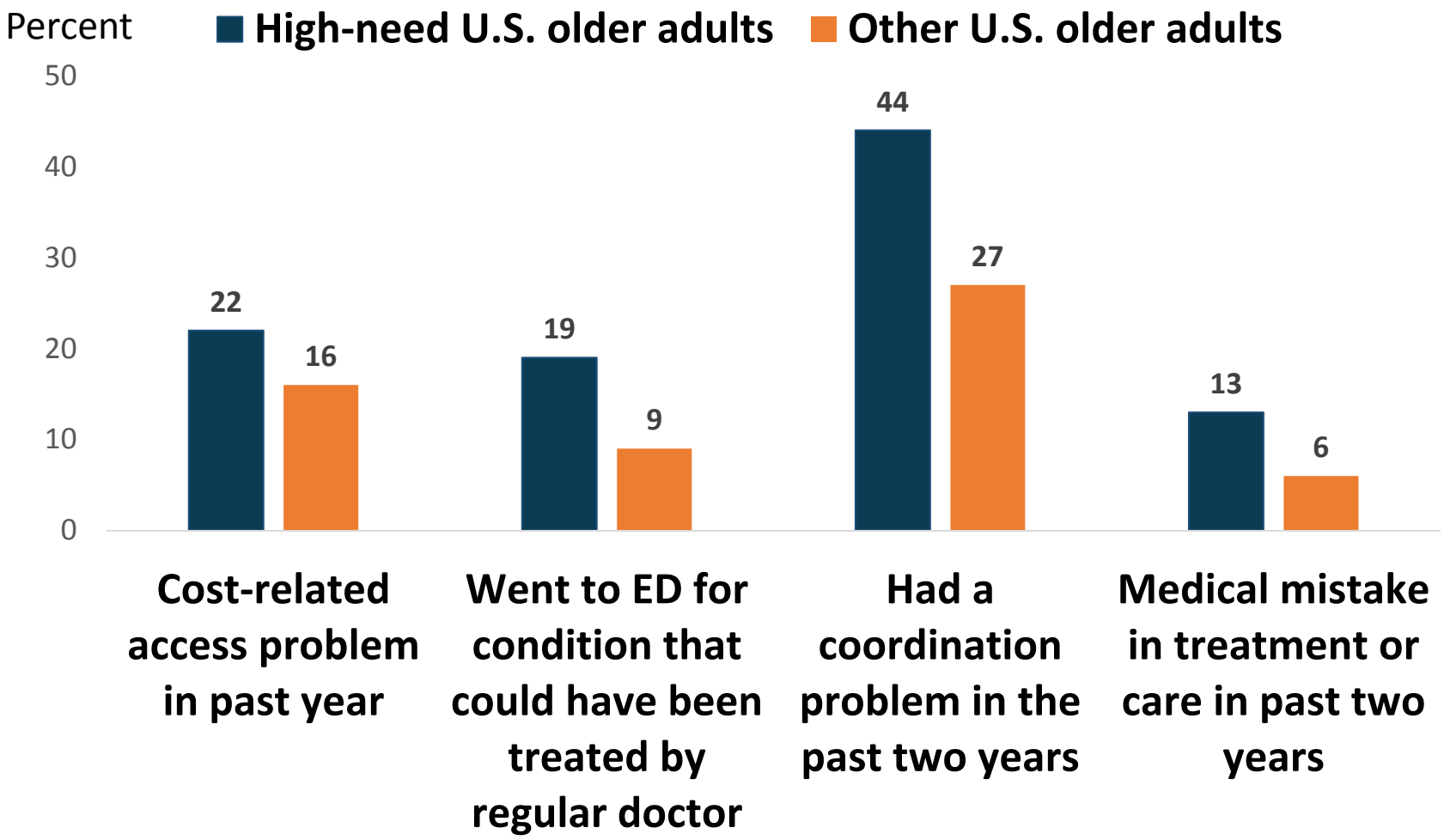
Older adults with high needs more often report problems with access to and quality of care



Source: D. O. Sarnak and J. Ryan, How High-Need Patients Experience the Health Care System in Nine Countries, The Commonwealth Fund, January 2016. Data: U.S. respondents (ages 65 and older) to the Commonwealth Fund 2014 International Health Policy Survey of Older Adults.

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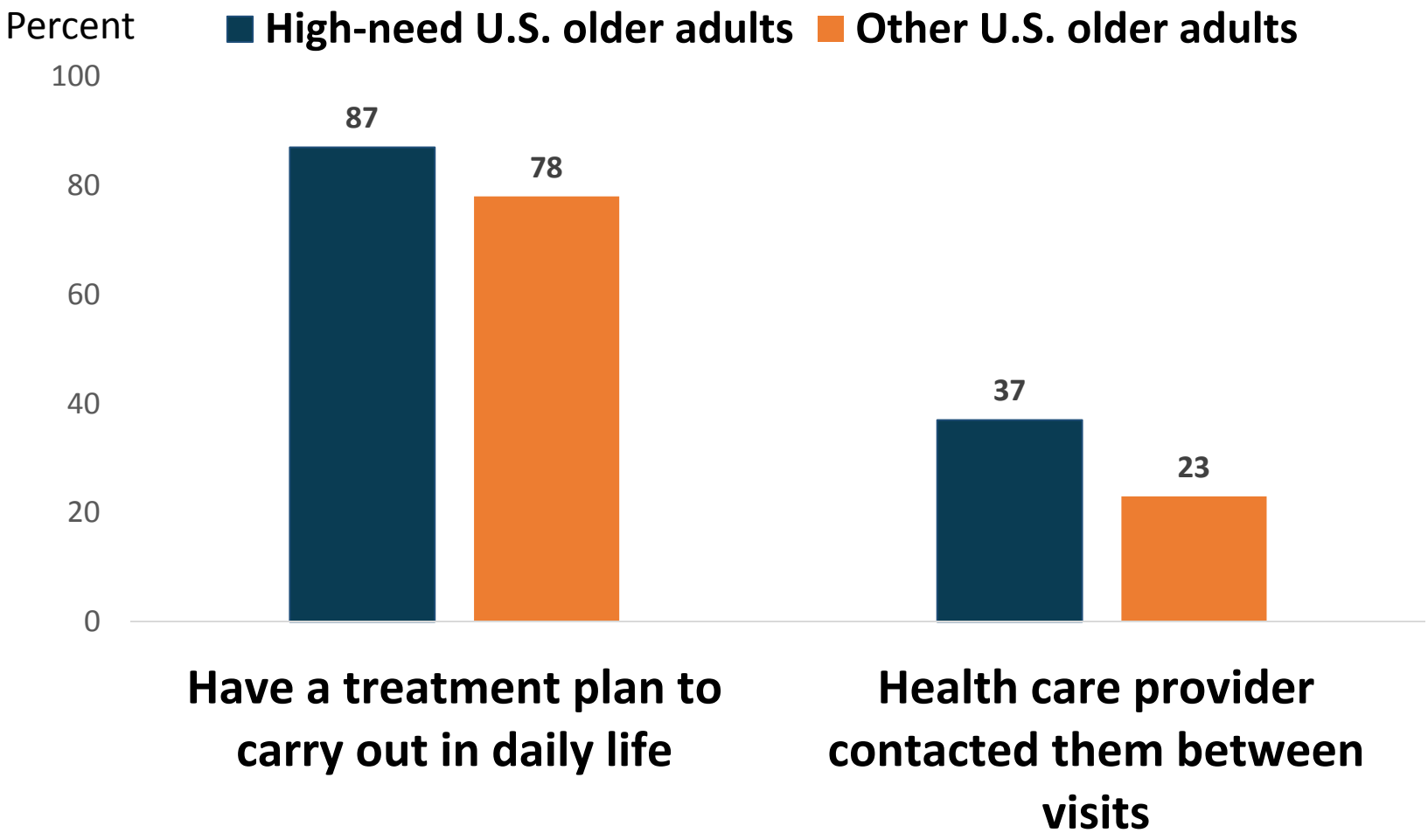
Most older adults with high needs have a treatment plan, but follow-up is not common



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

CATEGORIES	MODELS OR EXAMPLES†	EVIDENCE OF POSITIVE IMPACT††					
		QoC	QoL	FA	Surv	Use	Cost
1. Interdisciplinary Primary Care	Guided Care, GRACE, IMPACT, PACE	X	X	X	X	X	M
2. Enhanced Primary Care	Care and case management	X	X			M	
	Disease management		X			X	
	Preventive home visits			X	X	X	
	Geriatric evaluation and management	X	X	X		M	
	Pharmaceutical care	X				X	
	Chronic disease self-management		X	X		X	
	Proactive rehabilitation		X	X			
	Caregiver education and support		X			X	
3. Transitional Care	Hospital to home		X			X	X
4. Acute Care in Patients' Homes	Substitutive hospital-at-home		X			LOS	X
	Early-discharge hospital-at-home					X	
5. Team Care in Nursing Homes	Minn. Senior Health Options, Evercare	X				M	
6. Comprehensive Care in Hospitals	Prevention/management of delirium		X			LOS	
	Comprehensive inpatient care		X	X	X		

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

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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Case Example: Kaiser Permanente's Care Groups for the Senior Population ❶ *Targeting*

Group	Health Status	Risk*	Potential Optimization
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

Photo credit: Medstar House Call Program Annual Report, http://ct1.medstarhealth.org/content/uploads/sites/116/2015/04/MWHC-House-Call-Program.pdf

Case Example: Commonwealth Care Alliance Massachusetts Senior Care Options

❺ *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

Slide 12

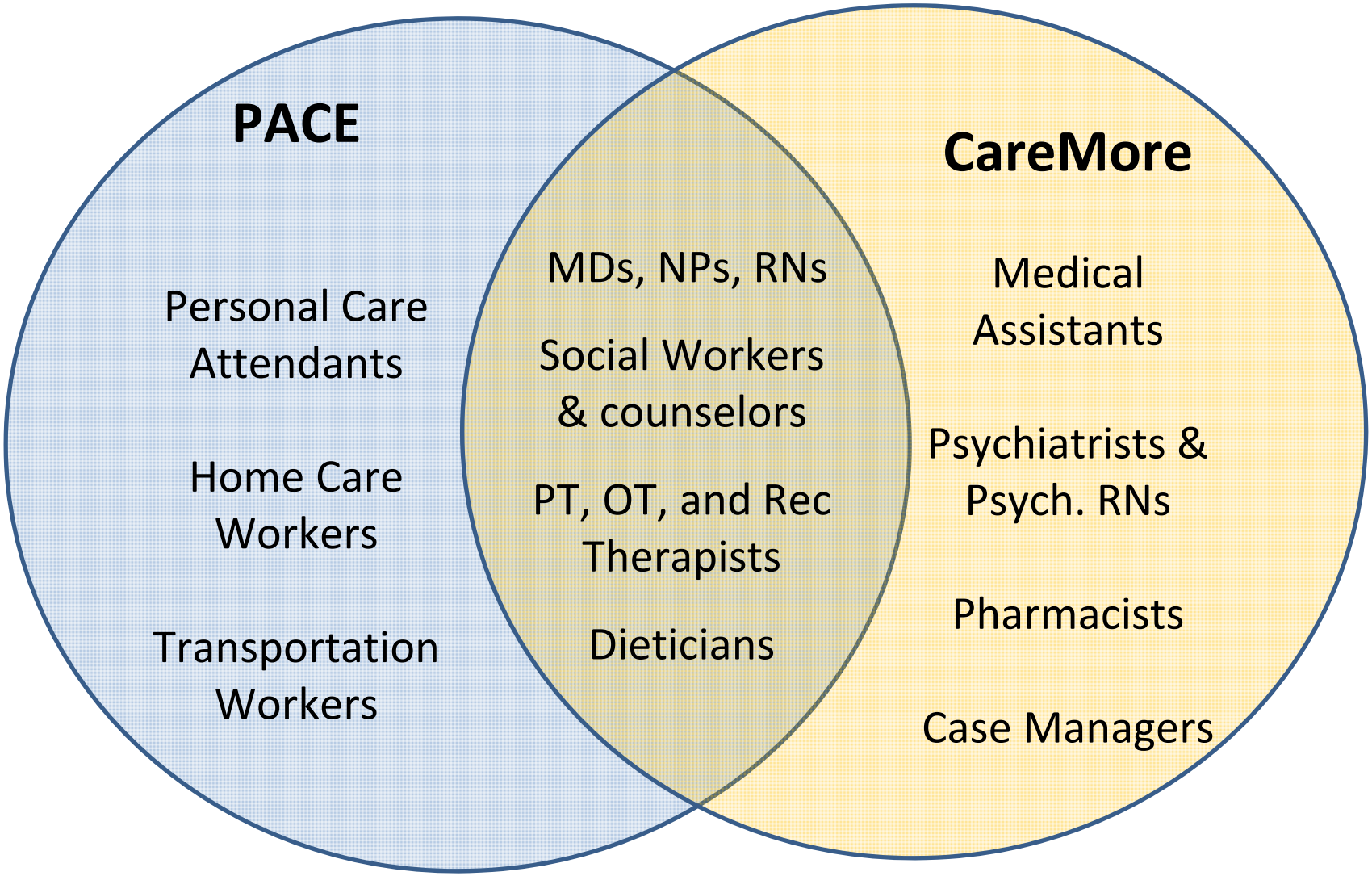
DM1 Would make clear the models lead to fewer hospitalizations b/c might be confused with baseline characteristics of population

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



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

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.

Barriers and Possible Solutions to Sustainability and Spread

Barrier		Possible Solutions
Financial incentives		Incentives for care coordination & supportive services
Capacity to change		Technical support; collaborative learning
Culture & workforce		Leadership; skills training (e.g., Guided Care)
Infrastructure		Information tools (e.g., Care Management Plus)
Evidence translation		Adaptive change principles; rapid-cycle evaluation

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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Fostering a High-Performance Health System That Serves Our Nation's Sickest and Frailest

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

Source: M. Abrams and E. Schneider, "Fostering a High-Performance Health System That Serves Our Nation's Sickest and Frailest," *The Commonwealth Fund Blog*, Oct. 29, 2015.

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