High Need Patients

An NAM Discussion Series

NIHCM Foundation Webinar

May 19, 2017
Series Planning Committee

Chair
Peter Long, PhD, Blue Shield of California Foundation

Members
Melinda Abrams, MS, The Commonwealth Fund
Gerard Anderson, PhD, Johns Hopkins Bloomberg School of Public Health
Tim Engelhardt, Centers for Medicare & Medicaid Services
Jose Figueroa, MD, Harvard School of Public Health
Katherine Hayes, JD, Bipartisan Policy Center
Frederick Isasi, JD, MPH, Families USA
Ashish K. Jha, MD, MPH, Harvard School of Public Health
David Meyers, MD, Agency for Healthcare Research and Quality
Arnold S. Milstein, MD, MPH, Stanford University
Diane Stewart, MBA, Pacific Business Group on Health
Sandra Wilkniss, PhD, National Governors Association
Cooperating foundations

- Peterson Center on Healthcare *(series sponsor)*
- Commonwealth Fund
- John A. Hartford Foundation
- Robert Wood Johnson Foundation
- Scan Foundation
Who are high need patients?
High cost?

e.g...

• Top 1% accounting for 20% of costs
• Top 5% accounting for 50% of costs

but...

...among highest 10% of spenders in a year, 60% didn’t have persistently high spending over a 2 year period.
Long term?

*e.g.*…
...those with serious chronic conditions or multiple co-occurring conditions

*but*…
...a significant number of patients are only transiently high need—the nature and level of needs change over time
Functional status?

A central determinant of nature/level of need

e.g. variation in physical, mental, emotional needs with

- Recovery from acute injury or surgery
- Condition requiring intensive therapy
- Chronic addiction-related impairment
- Long-term mobility impairment
- Long-term cognitive impairment
- Needs at the end of life
Successful models?

- Targeting according to level and nature of function
- Tailoring requirements: care attributes, service setting, delivery features, organizational culture
- Social services factored centrally into patient and care-partner specific needs
- Service linkages among health care system, social, economic, and behavioral programs
- Payment alignment
Sample crosswalk

<table>
<thead>
<tr>
<th>Program</th>
<th>Matched Group</th>
<th>Non-elderly disabled</th>
<th>Advancing illness</th>
<th>Frail elderly</th>
<th>Major complex chronic</th>
<th>Multiple chronic</th>
<th>Children w/ complex needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Management Plus</td>
<td></td>
<td>w/Social &amp; Behavioral Factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commonwealth Care Alliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex Care Program at Children’s National Health System</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GRACE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guided Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Quality Partners</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Services for Children with Special Needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital at Home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H-PACT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMPACT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massachusetts General Physicians Organization Care Management Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIND at home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naylor Transitional Care Model (Penn)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PACE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Next steps?

• Spread and scale successful care models
• Integration of social support and medical care
• Train clinicians on the unique challenges of high-need patients
• Promote value-based payment & measure for quality
• Create opportunities for and action from stakeholders