Improving Care and Managing Costs: Team-Based Care for the Chronically Ill

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High Cost Beneficiaries: What Can States Do?
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Chronically Ill: Opportunities and Challenges to Achieving Better Outcomes at Lower Costs

• Complex-chronically ill account for a high proportion of national spending

• Care needs span health care system
  – Diverse population groups: risk groups
  – Cared for by multiple clinicians, sites of care
  – Need for patient-centered care “teams”

• Potential to improve outcomes and lower costs
  – Teams and information systems
  – More integrated systems with accountability

• Affordable Care Act has elements to build on
Chronically Ill Complex and Expensive: Care Often Spans Multiple Providers and Sites of Care

Estimated 30% of National Spending

Total $635 Billion Spending on disabled and chronically ill, 2010

- Duals – Medicare: $164.2B
- Non-dual Medicare with 5+ Chronic Conditions: $145.3B
- Medicaid Duals: $140.3B
- Medicaid Non-dual Disabled: $116.5B
- Employer Coverage: $68.4B

Nine Million People Are Covered by Both Medicare and Medicaid: 10% of Total Population = 38% Total Spending

Total Medicare Beneficiaries, 2007: 43 million

Total Medicaid Beneficiaries, 2007: 58 million

Medicare
34 Million

Medicaid
49 Million

Disabled: 3.4
Elderly: 5.5

Dual Eligibles 9 Million

Source: Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey, 2007, and Urban Institute estimates based on data from the 2007 MSIS and CMS Form 64.
High Share of Health Care Spending Is on Behalf of People With Multiple Chronic Conditions

- Eighteen percent of spending is for the 22 percent of the population that has only one chronic condition.
- Seventeen percent of spending is for the 12 percent of the population that has two chronic conditions.
- Sixteen percent of spending is for the 7 percent of the population that has three chronic conditions.
- Twelve percent of spending is for the 4 percent of the population that has four chronic conditions.
- Twenty-one percent of spending is for the 5 percent of the population that has five or more chronic conditions.

Source: Medical Expenditure Panel Survey, 2006
Keys to Rapid Progress

Teams and Care-System Redesign

Information Systems

Payment Reform: Value
Payment, Teams and System Innovation Key to Better Outcomes and Lower Costs

- Payment
  - Patient-centered health “homes”: payment for team
    - Move away from “visits” alone: pay for value
    - Care from multi-disciplinary teams, time and skills for high risk patients
    - Multiple access points: e-mail/web, phone, tele-health
  - More bundled payments: accountability for transitions
  - Sharing savings to reinvest, with accountability

- Multi-payer coherence and aligned incentives

- Teams that span sites of care, with accountability
  - Multiple models; including “community” shared teams

- Information systems to communicate, inform, guide
  - Registries and Electronic Health records
  - Feedback information from payers/claims
Accessible Patient-Centered Primary Care Foundation – Teams Connected to Care System

- Community Resources and Policies
  - Self-Management Support
- Health System Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

- Informed, Activated Patient
- Productive Interactions
- Prepared, Proactive Practice Team

Improved Outcomes
Multiple Models Exist: Opportunity to Spread and Learn

Community Care of North Carolina
Examples of Cost and Quality Outcomes: High Cost Care, Primary Care Teams and Care Systems

Geisinger Health System (Pennsylvania)
• 18 percent reduction in all-cause hospital admissions; 36% lower readmissions
• 7 percent total medical cost savings

Mass General High-Cost Medicare Chronic Care Demo (Massachusetts)
• 20 percent lower hospital admissions; 25% lower ED use
• Mortality-decline: 16 percent compared to 20% in control group
• 7% net savings annual

Guided Care - Geriatric Patients (Baltimore, Maryland)
• 24 percent reduction in total hospital inpatient days; 15% fewer ER visits
• 37 percent decrease in skilled-nursing facility days
• Annual net Medicare savings of $1,364 per patient

Group Health Cooperative of Puget Sound (Seattle, Washington)
• 29% reduction in ER visits; 11% reduction ambulatory sensitive admissions

Health Partners (Minnesota)
• 29% decrease ED visits; 24% decrease hospital admissions

Intermountain Healthcare (Utah)
• Lower mortality; 10% relative reduction in hospitalization
• Highest $ savings for high-risk patients
Focusing on High-Cost Patients

- Atul Gawande – The Hot Spotters, New Yorker, January 24, 2011
- 10% of patients account for 64% of costs
- Focus efforts on patients with highest costs including frail elderly and disabled
- Population-based payment
- New teams and care management focused on highest-risk patients
- Across sites of care

Health Care Cost Hotspots in Camden, NJ

- New clinics located in buildings where high-utilizers reside (led by Nurse Practitioners)
- Outreach teams to high utilizers
- Medical home based care coordinators
- Same day scheduling (e.g., “open access”)
- Medicaid ACO eligible for shared savings

Source: J. Brenner, presentation to Commonwealth Fund Congressional Retreat, January 2012.
Variation in Asthma Admission Rates within a Single County, Cincinnati

County neighborhoods

- Highest tertile
  - Neighborhood in the highest tertile (n=18)
- Middle tertile
  - Neighborhood in the middle tertile (n=21)
- Lowest tertile
  - Neighborhood in the lowest tertile (n=54)

Robert Kahn
Cincinnati Children’s Hospital System Presentation April 2012
Benefits

Housing

Depression

Source: Presentation by R. Kahn Cincinnati Children’s Hospital James M. Anderson Center, April 2012.
A foundation of medical homes and community health teams that can support coordinated care and linkages with a broad range of services

- Multi Insurer Payment Reform that supports a foundation of medical homes and community health teams

- A health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized registry

- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact
## MGH Care Redesign

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| Design of care | Defined process standards in priority conditions (multidisciplinary teams)       | High risk care management                                                    | Shared decision making                                                      | Re-admissions |
|                |                                                                              | 100% preventive services                                                      | Appropriateness                                                             | Hand-off standards |
|                |                                                                              |                                                                              |                                                                              | Continuity visit   |
|                | EHR with decision support and order entry                                        |                                                                              |                                                                              |                   |
|                | Incentive programs                                                              |                                                                              |                                                                              |                   |

| Measurement    | Variance reporting/performance dashboards                                        | Clinical and Patient Reported Outcomes                                         | LOS, CMAD, HACs, Re-Admits                                                  |
|                | PMPM, HCI, ACSH, Pharmacy                                                         |                                                                              |                                                                              |

Long-Stay Nursing Home Residents Hospitalized within a Six-Month Period

SOURCE: Commonwealth Fund Local Scorecard on Health System Performance, 2012
Interventions to Reduce Acute Care Transfers (INTERACT) helps nursing-home staff manage residents’ health status:

- 17-25% decline in hospital admissions in pilot
- Spreading to 300+ homes

Three strategies:

- Identify, assess, communicate, document, and manage conditions to prevent hospitalization
- Manage selected conditions, such as respiratory and urinary tract infections, in the nursing home itself
- Improved advance care planning

Visiting Nurse Service New York Health Plans
Patient-Centered Care Teams for High-Cost Chronically Ill Medicare and Medicaid – Special Needs and Long Term Care

- Interdisciplinary teams; home and community care; transition care
- Care and assist with navigating complex health care systems
- Patient-centered: targets and customizes interventions
- Strong health information technology and EHR; Support team
- Positive results
  - Improved primary care access; high quality and patient ratings
  - Reduce hospital admissions, readmissions, ER use (17 to 27%)
  - Links primary, specialist and long term care
  - Patient and family preferences

Summary of presentation by Carol Raphael, Pres and CEO, NY Visiting Nurse Assn., 6/2011
Tele-Health and Electronic Communication
Enhanced Access and Care Teams

• Veteran’s Administration: serving 31,000 frail at home; aim to serve 92,000 by 2012
  – High patient-ratings; Link to care teams – home visits
  – 40 percent reduction in “bed-days” (nursing home and hospital) by 2010 compared to start

• U. Tennessee Memphis: Remote specialist consultations with patients, local clinicians. Center serves 3 state region
  – Reduce heart failure admission and readmissions by 80%
  – “real-time” diabetic retinopathy (digital) report results

• Primary care to Specialist e-consultations and referral
  – Mayo, SF General, Group Health Puget Sound

• Kaiser: Web access, e-visits/consultation - outreach
Opportunity and Challenges

• Requires multi-payer approach to hold care-systems accountable and provide incentives to innovate
  – Need to partner Medicare to span care-continuum
  – Collaborative care-systems

• Care-systems and teams take time to develop
  – Teams: flexibility and multi-discipline approach
  – Feedback data on performance
  – Policies to hold accountable for outcomes

• Vulnerable populations: health and income
  – Capitation puts at risk; Need to monitor – risk-adjust
  – Requires robust data-systems and benchmarks
  – Criteria for care-teams eligible for new payment
  – Provisions for “exit” if fail to perform
For More Information Visit the Fund’s website at www.commonwealthfund.org

Health Reform Resource Center:
What’s in the Affordable Care Act? Use the timeline and tool below to find out.

View the timeline below for an overview of the Affordable Care Act’s major provisions or use the “Find Health Reform Provisions” tool to search for specific provisions by year, category, and/or stakeholder group. Also see related Commonwealth Fund content and links to regulations as they become available.

NEW: state health insurance exchange regulations.

A PDF version of this timeline is available here.

Overview Timeline

Major Provisions of the Affordable Care Act

- **Coverage for young adults**: Parents will be able to keep their children on their health policies until they turn 26.
- **Small-business tax credits**: Small businesses (fewer than 25 employees and average wages under $50,000) that offer health care benefits and contribute at least 50 percent of the premium will be eligible for tax credits of up to 35 percent of their premium costs for two years. The credit rises to 50 percent of their premium costs in 2014.
- **Preexisting Condition Insurance Plan (PCIP)**: People with preexisting conditions who have been uninsured for at least

Workforce improvements: Student loan programs for those training in primary care, nursing, and pediatrics will be expanded and a new National Health Care Workforce Commission will make recommendations for further action.

Quality improvement: An Intergroupy Working Group on Health Care Quality will issue a report to Congress with recommendations for improved collaboration between federal departments and agencies and the alignment of public and private initiatives.
For More Information Visit the Fund’s Web site at www.commonwealthfund.org

- Rising to the Challenge: Scorecard on Local Health System Performance, 2012
- Raising Expectations: Performance, State Scorecard on Long Term Services and Support, 2011
- Aiming Higher: State Scorecard on Health System Performance, 2009
- Also www.WhyNottheBest.org Website
Thank you!

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