

HEALTH CARE FOR THE NEEDIEST: The Critical Transformation

INTRODUCTION

The United States now stands on the cusp of important expansion in access to affordable health insurance coverage that was promised in the enactment of federal health reform legislation in 2010. As actors and stakeholders throughout the health system prepare for a surge in the insured population, leaders are looking ahead to the looming challenges that will move to center stage as the crisis of the uninsured recedes: How can we reduce the heavy burden of health care cost growth on our nation's families, employers, state budgets, and federal health care programs? And, in the face of significant disparities in health outcomes across population groups and between the United States and other developed nations, how can we strengthen our health system to provide better care and better health for all?

One intriguing perspective on these challenges comes in taking a close look at how those who are the sickest, neediest, and most vulnerable fare in today's health care system. Could changes to make the health care system work more effectively and efficiently for those in greatest need serve to make the health care system stronger and more sustainable for all?

The rationale for adopting this perspective rests on the fact that use of the health care system is not evenly distributed across the population. In fact, a relatively small share of the population constitutes the "heavy users" of health care services at any given time. According to research using data from the U.S. Agency for Healthcare Research and Quality, just 5 percent of the population is responsible for almost half of all health care spending in this country, while the top 1 percent alone accounts for more than 20 percent of all health care expenditures (Stanton 2006; National Institute for Health Care Management 2012). In 2009, annual health spending per person stood at more than \$90,000 for those in the costliest 1 percent and nearly \$41,000 per patient in the highest 5 percent. By contrast, spending for those in the lowest half of the spending distribution was just \$236 per person (National Institute for Health Care Management 2012). Redesigning our health care system to reflect a better understanding of the needs and unmet needs of those who are using the system most intensively could help ensure that resources are targeted most efficiently to achieve the best possible outcomes.

At the 2012 Grantmakers In Health *Fall Forum*, members of the health philanthropy community engaged with leaders from the frontlines of health care delivery to tackle the problem of how to produce better health and health care for the neediest and most vulnerable patients. This monograph distills some of the main messages, ideas, and arguments presented in discussions at the forum.

WHO ARE THE HEAVY USERS OF OUR HEALTH CARE SYSTEM?

Not surprisingly, those who use health services most intensively tend to be older and in relatively poor health. They are more likely to have multiple chronic conditions and long-term care needs requiring care from a range of health care providers (National Institute for Health Care Management 2012). They include residents of nursing homes and persons who are dually eligible for Medicare and Medicaid due to their advanced age or disability and low-income status (Jacobson et al. 2010; Bella 2012). Those with the most resource-intensive health care needs also include patients with physical, mental, and behavioral health conditions that are exacerbated by social problems associated with poverty or homelessness (Baggett 2009).

For many individuals who are part of these and other vulnerable population groups, the health care system fails to meet their needs in that services are not available and accessible when and where needed, at the most appropriate time and place. Such failures result in suboptimal outcomes from care that is not always timely or appropriate, as well as excess costs from hospitalizations that could be avoided with appropriate care for chronic conditions or readmissions resulting from inadequate post-hospital care.

A HEALTH CARE SYSTEM THAT MEETS PATIENTS ON THEIR OWN TERMS

Dr. Jeffrey Brenner's groundbreaking work in Camden, New Jersey, set a new benchmark for what can be done to improve care and outcomes for the most vulnerable patients in the face of significant resource constraints. As a physician serving poor and disadvantaged patients in one of the country's poorest urban centers, Dr. Brenner saw a health care system that failed to understand and anticipate the needs of the patients it served. Patients with inadequate access to primary care services were frequent return visitors to the emergency room, racking up large bills for treatment of health problems that could have been averted. Case management efforts consisting of a nurse phoning patients whose phones were out of service or unanswered fell far short of meeting patient needs. Hospital-based efforts to reconcile patients' medication regimes could not succeed in the face of incomplete documentation and patients who had lost track of the array of different pill bottles at home (Brenner 2012).

The innovations that proved so successful in Camden involved two main thrusts. First, Dr. Brenner dug deeply into locally available hospital utilization data to determine who the high-cost, high-intensity users of hospital services were and to look for patterns in their health care needs. He learned that just 1 percent of patients accounted for 30 percent of costs accrued in Camden between 2002 and 2011, and that just 13 percent of patients accounted for an astonishing 80 percent of costs. He was able to identify where the heaviest users of emergency and hospital services lived, pinpointing not just neighborhoods but the apartment buildings where frequently hospitalized patients lived, and learned that the top diagnoses responsible for emergency room visits included conditions such as head colds, sore throats, and headaches, along with flare-ups of chronic conditions, such as asthma, that were not being adequately managed. Second, he developed a strategy for meeting the patients' needs on their own terms, establishing a clinic in the low-income housing unit where a disproportionate share of needy patients resided. He also fielded health coaches (AmeriCorps volunteers) to visit patients at their homes and to work with them to manage their health conditions and their interactions with the health care system, as well as to address factors in their home environment that cause or exacerbate health problems. To help make local health care provision more reflective of patients' needs and preferences, Dr. Brenner's coalition also worked to train local residents to participate in decision-making about health care resources and to promote collaboration between providers and the community they serve (Brenner 2012).

KEY CHALLENGES

As a result of these initiatives, supported by relatively modest grants from funders, including the Robert Wood Johnson Foundation and the Merck Foundation, Dr. Brenner's work has dramatically reduced inpatient stays and emergency room visits for the highest-cost patients, incurring savings for the Medicaid and Medicare programs. But if the Camden experience illustrates the enormous potential impact of redesigning delivery systems to serve the neediest patients, it also highlights significant obstacles to replicating that experience in other communities.

- ***Misaligned Incentives*** – Under the current fee-for-service payment system, keeping patients healthier and out of the hospital means lost revenue to providers. Similar barriers of misaligned incentives can thwart action to improve quality and reduce costs elsewhere. For instance, efforts to reduce inappropriate or unnecessary hospital admissions among dually eligible nursing home residents hold potential for significant savings to Medicare, but the costs of such initiatives are normally borne by the nursing homes that are financed primarily by Medicaid.
- ***Fragmented Approach to Health and Social Service Supports*** – The move toward establishing accountable care organizations that can take a holistic and population-based view of patient health, and that are incentivized to maintain and improve health rather than on the basis of number of visits and admissions, is seen as a structural change that may help foster more innovations in care for vulnerable patients. But ultimately, breaking down the boundaries that separate health care providers from each other may not be sufficient to achieve the transformation that is needed. A fragmented and uncoordinated approach to health and social service support strains the fabric of our health care system. Experimentation with programs, such as ones designed to provide a place for homeless patients to stay and recuperate from an

Investments outside the health sector may offer the biggest value in terms of impact on patient health and health care costs. There is growing acknowledgment among health care experts that social and behavioral determinants of health strongly influence health and likely outweigh the role of health care services as determinants. The U.S. Department of Health and Human Services issued a set of goals and approaches to population health improvement in *Healthy People 2020*. It describes factors such as income; education; transportation; food insecurity; environment; and personal habits such as smoking, drug and alcohol abuse, poor nutrition, and sedentary lifestyles as highly influential on health, and calls for an emphasis on “health in all policies” that focuses on how factors that influence safety and individual behaviors can result in better population health.

illness or following a hospitalization (so-called respite care programs), have achieved promising results in terms of impact on health outcomes, including rates of readmission, and costs (Buchanan et al. 2006). Similar initiatives that address patients’ health care needs indirectly, by addressing problems that keep them from getting or staying healthy, will require creative efforts to cross boundaries between programs, sectors, and systems.

ROLES OF FEDERAL AND STATE POLICY IN TRANSFORMING DELIVERY OF CARE FOR THE NEEDIEST

The Patient Protection and Affordable Care Act of 2010 (ACA) launched new mechanisms to encourage and support innovation in health care delivery through federal financing for demonstrations and evaluations of new approaches to caring for patients, such as patient-centered medical homes, more holistically-oriented “health homes,” and accountable care organizations. The ACA also facilitates rapid incorporation by the Medicare program of models that are demonstrated to be effective.

State governments, however, may ultimately prove to have an even larger role to play in driving change. The strong pressure that Medicaid and state employee health insurance costs place on state budgets has increased the appetite for experimenting with changes that can slow the rate of health cost growth, as evidenced by ambitious programs in states like Washington, which is pursuing complementary strategies in benefit design, delivery system reform, and payment policies, and Michigan, which is working to strengthen primary care and promoting the patient-centered medical home. At the same time, expanded enrollment in Medicaid will make the state-based programs even more prominent actors driving change in care. Attention to health and health care costs at the state level is also promising in that states have both the incentive and the means to adopt a more holistic approach to addressing their residents’ health through multisectoral approaches involving education, family support, public transportation, and other factors that can enhance and support changes in health care delivery.

An issue of considerable controversy, with challenges and opportunities for care of the most vulnerable patients, is emerging in the matter of care for patients who are dually eligible for both Medicare and Medicaid. Many are low-income elderly or disabled people, including a sizeable share who are residents of long-term care institutions. Up until recently, these so-called dually eligible beneficiaries were exempt from most state initiatives to manage care for Medicaid enrollees, as the federal Medicare program serves as the first-line payer for health care services for patients who are dually eligible. State budget shortfalls, however, combined with health and long-term care cost growth have increased interest at the state level in taking on the challenge of finding more efficient ways to care for the dually eligible population, and the federal government has taken steps that will allow for more state program management of care for this population in the future.

WHAT IS THE ROLE FOR PHILANTHROPY?

There is much that health foundations can do and are doing to spur and foster a critical transformation in health care for the neediest and most vulnerable patients. Promising directions for action include the following:

- Make the case for delivery system transformation and increase public awareness of the problems to be addressed. Help increase demand for the truly transformational, “disruptive” innovation that is required to make a paradigm shift on behalf of patients not well-served by the hospital-oriented model of health care delivery.
- Contribute to work to define the vision of success (What does effective and efficient health care delivery look like? What is required to better meet the needs of a community’s patients?) and to share the vision with those in a position to make needed changes.
- Advocate for the needs of vulnerable patients to be taken into account in the next phase of health reform implementation where the focus of attention will be at the state level.
- Support the development of data and health information systems, as well as the analysis of patient utilization data, that can serve to focus delivery system transformation on problem “hot spots.”
- Convene local stakeholders to identify and implement changes in local delivery systems.
- Support efforts at the state level to target resources effectively in efforts to improve health care delivery.
- Support efforts by safety net providers to transform in the direction of more patient-centered care, including by providing technical assistance as needed.
- Work cross-sectorally to collaborate in the interest of public health with organizations focusing on community development, early childhood development, education, environment, and other fields.

CONCLUSION

As a nation and as a community of health foundations, it is a time of refocusing and reprioritizing to meet emerging challenges. Achieving broader access to health insurance coverage is an accomplishment that has been a long time coming. At the same time, making headway toward more sustainable and effective health care delivery systems is essential to ensure that coverage expansion will result in better care and better health for all. Examples such as the successful reforms in Camden offer exciting promise for what can be achieved, but widespread changes will require addressing obstacles such as realigning payment incentives and adopting more holistic approaches to meeting patient needs.

FOR FURTHER READING

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