Innovating Care for Chronically Ill Patients

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Grantmakers In Health
Webinar
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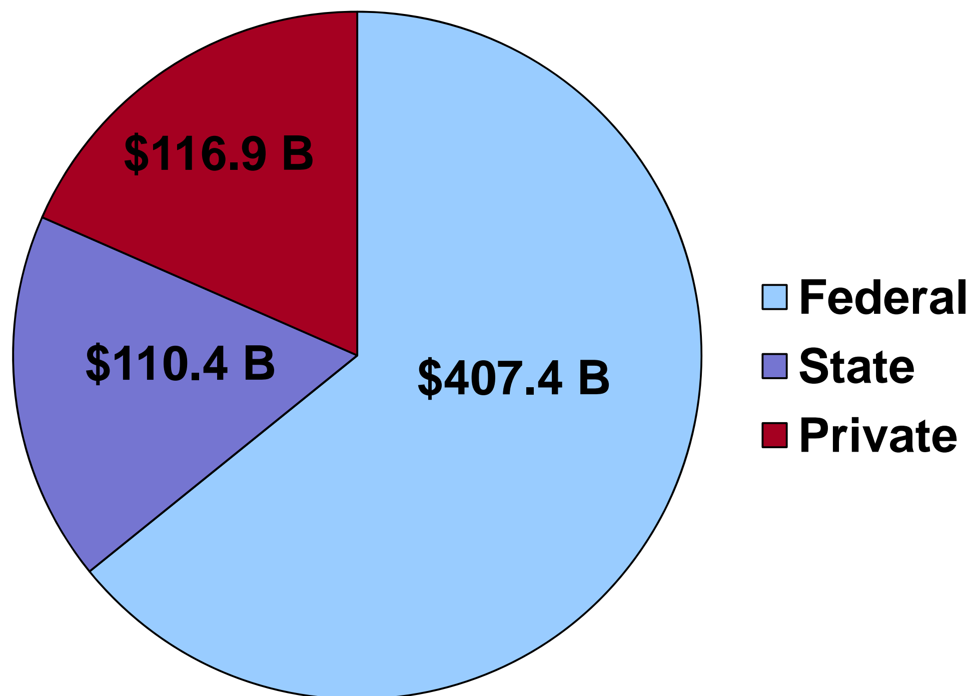
Chronically Ill: Opportunities and Challenges to Achieving Better Outcomes at Lower Costs

- 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
- Rich opportunities for foundation support

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**

Source: Urban Institute Estimates. J. Holahan, C. Schoen, S. McMorrow, "The Potential Savings from Enhanced Chronic Care Management Policies" Urban Institute*, November 2011.*

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

Dual Eligibles 9 Million

Medicare
34 Million

Disabled: 3.4

Elderly 5.5

Medicaid
49 Million

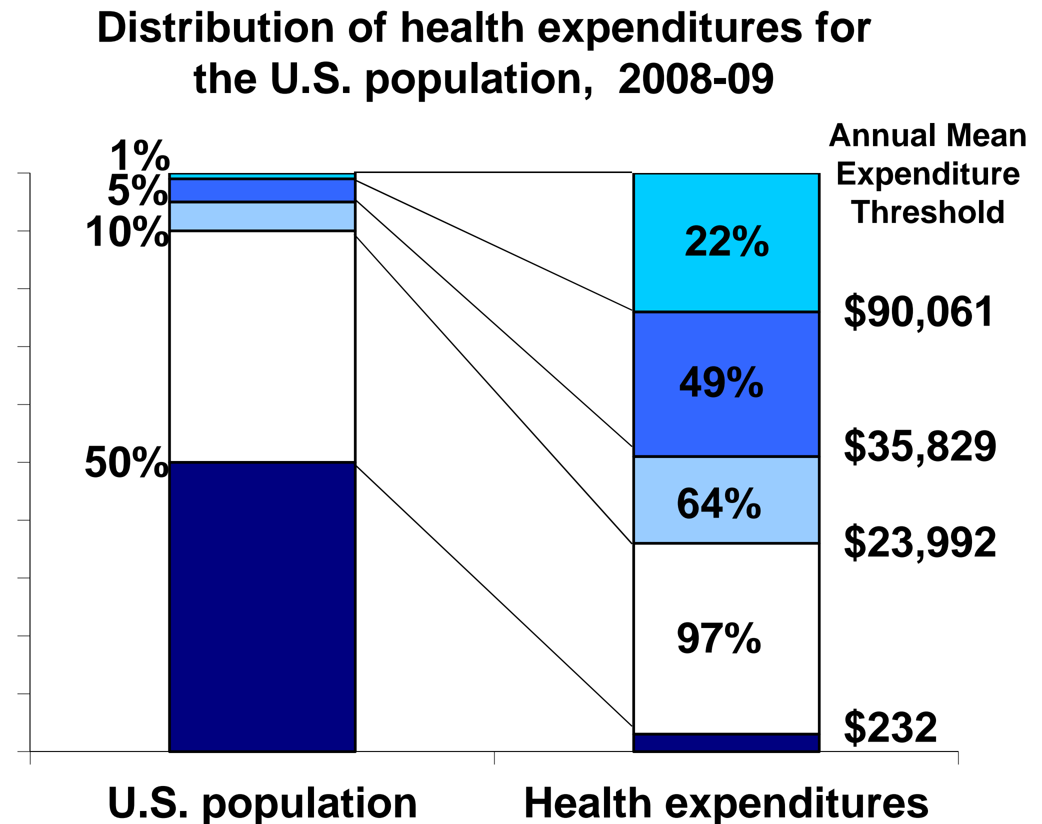
Total Medicare Beneficiaries, 2007: 43 million

Total Medicaid Beneficiaries, 2007: 58 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.

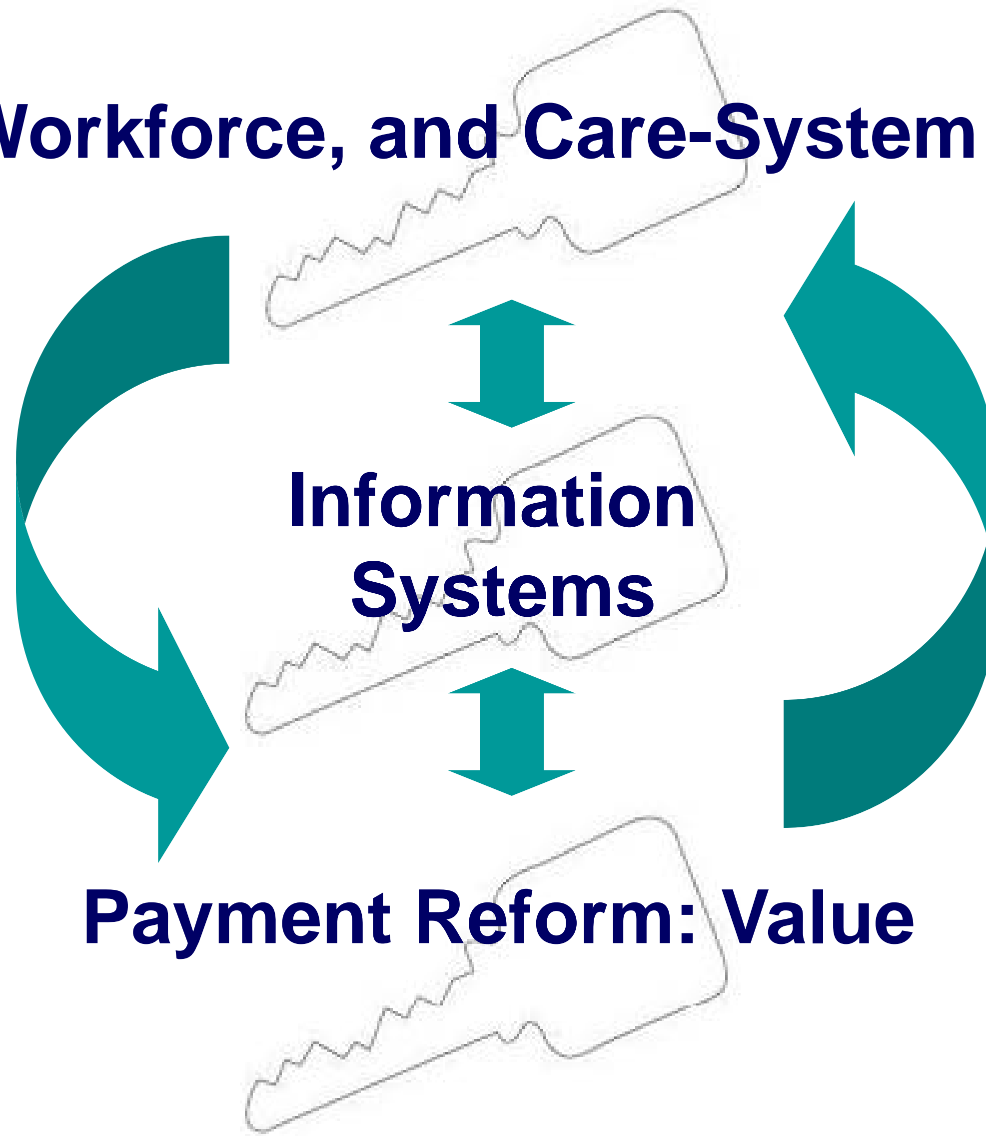
Focusing on High-Cost Patients

- 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



Source: D. Blumenthal, *The Performance Improvement Imperative*, The Commonwealth Fund, 2012. Chart drawn from S. Cohen and W. Yu, *The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008-2009*, (Washington: AHRQ, January 2011).

Keys to Rapid Progress



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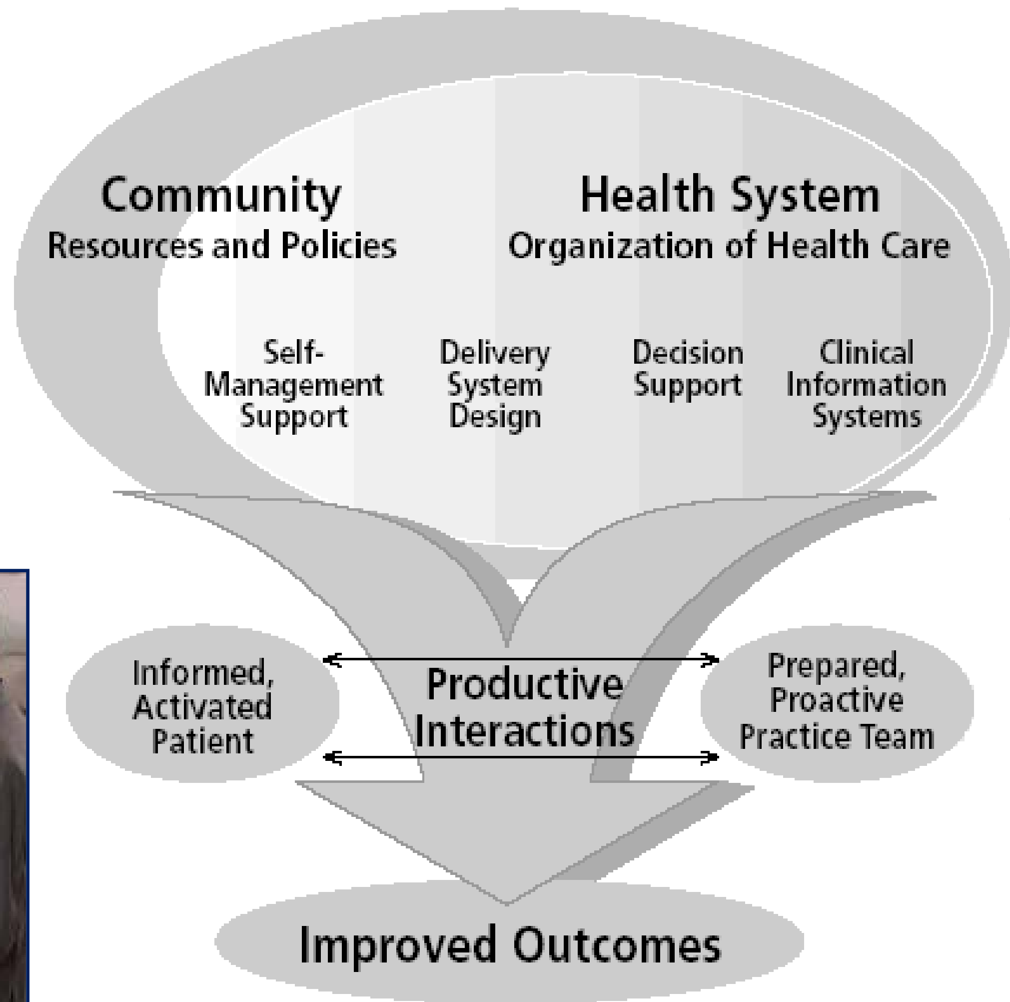
Teams and System Innovation Plus Payment Reform Key to Better Outcomes and Lower Costs

- Teams that span sites of care, with accountability
  - Multiple models; including “community” shared teams
  - Care from multi-disciplinary teams; cross-training
  - Time and skills for high risk patients
  - Multiple access points: e-mail/web, phone, tele-health
- Information systems to communicate, inform, guide
  - Registries, telehealth, electronic records, communication
  - Feedback information from payers/claims
- Payment
  - Patient-centered health “homes”: pay for team
    - Move away from “visits” alone: pay for value
  - More bundled payments: accountability for transitions
  - Multi-payer coherence and aligned incentives

Accessible Patient-Centered Primary Care Foundation – Teams Connected to Care System



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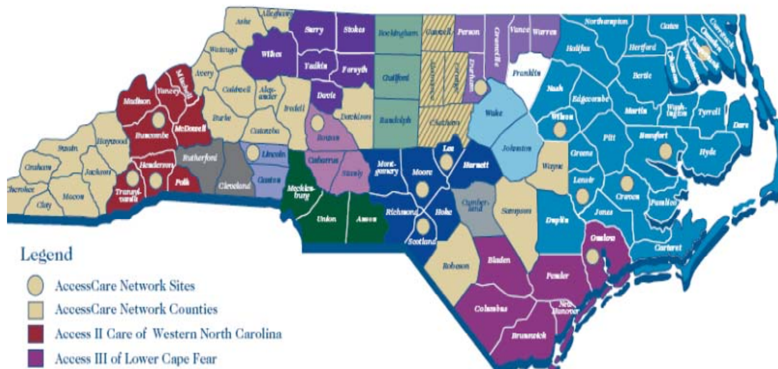
Multiple Models Exist: Opportunity to Spread and Learn

Cambridge Health Alliance

GroupHealth

MASSACHUSETTS GENERAL HOSPITAL



Community Care of North Carolina

Minnesota Senior Health options
complete care designed for seniors

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

Geisinger Health System (Pennsylvania)

- **18% reduction in all-cause hospital admissions; 36% lower readmissions**
- **7% total medical cost savings**

Mass General High-Cost Medicare Chronic Care Demo (Massachusetts)

- **20% lower hospital admissions; 25% lower ED use**
- **Mortality-decline: 16% compared to 20% in control group**
- **7% net savings annual**

Guided Care - Geriatric Patients (Baltimore, Maryland-Washington, DC, area)

Among patients in an integrated care delivery system:

- **47% reduction in skilled-nursing facility admissions**
- **52% reduction in skilled-nursing facility days**

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**

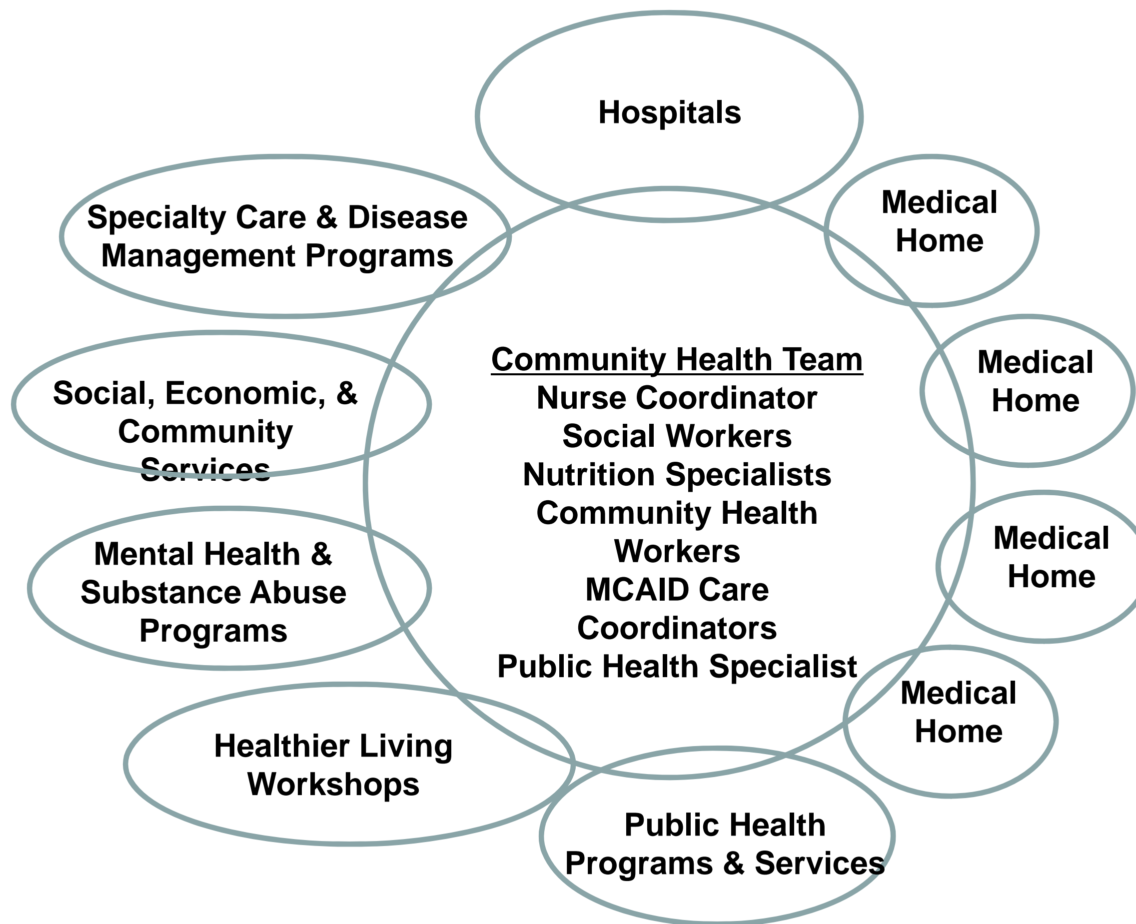
Intermountain Healthcare (Utah)

- **Lower mortality; 10% relative reduction in hospitalization**
- ***Highest $ savings for high-risk patients***

Vermont: Shared Resources Community Teams

VERMONT Blueprint for Health

Smart choices. Powerful tools.



- 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

Redesigning Care and Skills: A Team Effort

Grand+Aides

Who they are: Mature community members who are well-trained and certified in medical care (CNA or CMA)

Where they are or being considered: 13 states, including Texas, where Scott & White Healthcare is hiring 16,000 Grande Aides

What they do: Provide simple primary care or transitional/chronic care via phone or in-home visit, under nurse supervision

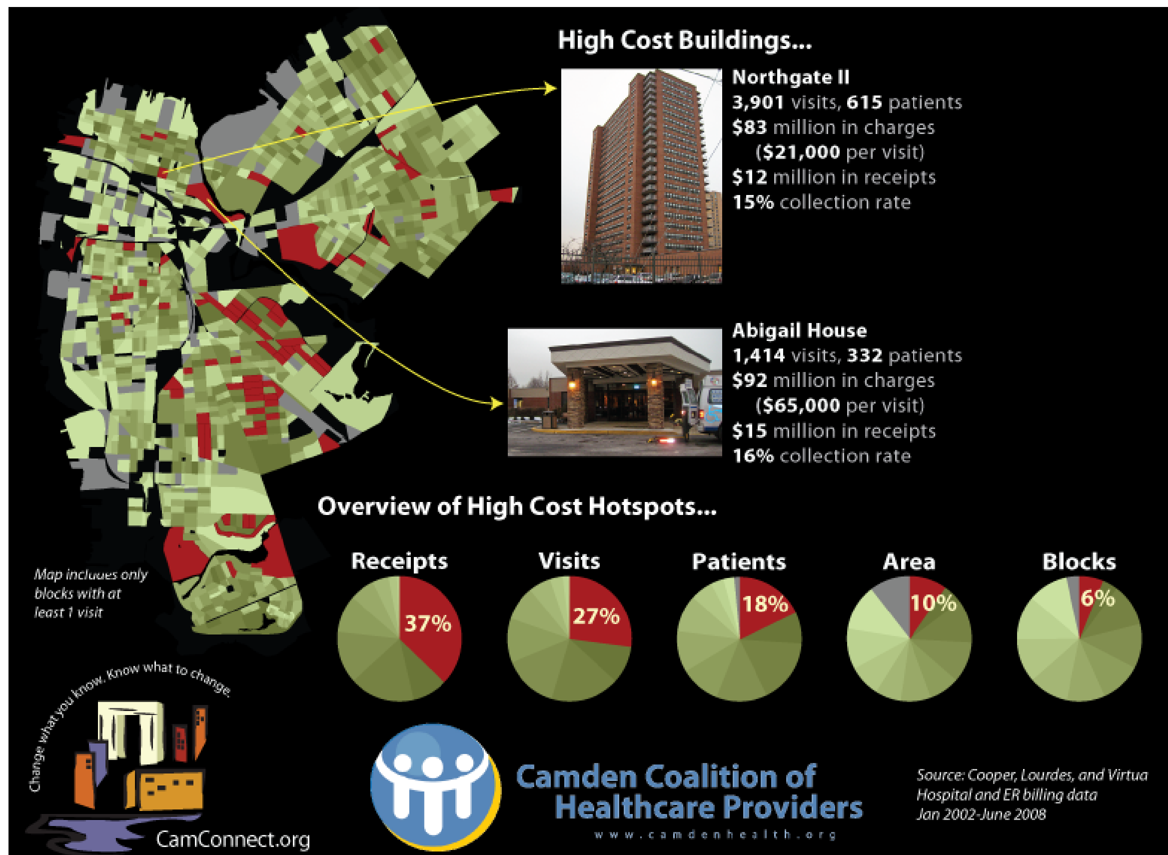
- Free up physicians and nurses
- Reduce congestion in clinics and ERs
- New roles, training, protocols

Two pilot tests suggest the Grand-Aides could have:

- Averted 62% of walk-in visits at an urban clinic site
- Eliminated 74% of visits at a semi-rural ER site
- Saved Medicaid $158 to $183 per visit avoided

Source: A. Garson et al., "A New Corps of Trained Grande-Aides Has the Potential to Extend Reach of Primary Care Workforce and Save Money," *Health Affairs*, May 2012.

Social, Economic Health Risk: Health Care Cost Hotspots in Camden, NJ



- New clinics located in buildings where high-utilizers reside (led by Nurse Practitioners)
- Outreach teams
- Medical home based care coordinators
- Same day scheduling
- 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

Admit rate (per 1000 children)

0 5 10 15 20 25 30 35

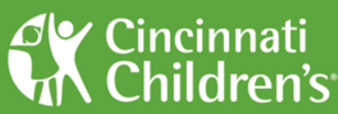
Highest tertile

Middle tertile

Lowest tertile

Neighborhood in the highest tertile (n=18)
Neighborhood in the middle tertile (n=21)
Neighborhood in the lowest tertile (n=54)

County neighborhoods



Electronic Health Records: Meaningful Use High Risk Children, *Cincinnati Children's Hospital*

Social/Environmental (Questions to ask family during visit)

Question	Response	
Child lives with		
* Are you having problems receiving WIC food stamp, daycare vouchers, medical card, or SSI?	Yes / No	**Benefits**
* Housing problems (overcrowding, roaches, rodents, utilities, mold, lead)?	Yes / No	**Housing**
* Threatened with eviction or losing your home?	Yes / No	
* Over the past 2 weeks, have you felt down, depressed or hopeless?	Yes / No	**Depression**
* Over the past 2 weeks, have you felt little interest or pleasure in doing things?		
* Do you feel that you and/or your children are unsafe in your relationships?		
* Would you like to speak with a social worker or legal advocate in the clinic about these issues?		

y | 1 View Pane 1 | 2 View Pane 2 | Split Up/Down | Split Left/Right | Detach Window

1 Child Help (Health Law Partnership)<-12/13/2011 Office Visit Gen Ped CCM

Back

Child Help (Health Law Partnership) (Order 32946709)
Nursing
Order: **32946709**

Date: **12/13/2011**
Ordering User: **Robert S. Kahn, MD**
Department: **Ccm Gen/Commun Peds**

Order Information

Order Date/Time	Release Date/Time	Start Date/Time	End
12/13/2011 4:23 PM	None	12/13/2011	Non

Order Questions

Question	Answer	Comment
Reason for referral?	**Section 8 about to expire, has a new housing application pending but afraid will lose SEc 8; child has bad asthma and current home has mold, roaches and dirty carpets per mom**	
Guardian's name(s)?	MT	
Guardian's primary phone?	513-xxx-xxxx	
Guardian's secondary phone?	513-xxx-xxxx	

Order Details

Source: Presentation by R. Kahn Cincinnati Children's HospitalJames M. Anderson Center, April 2012.

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

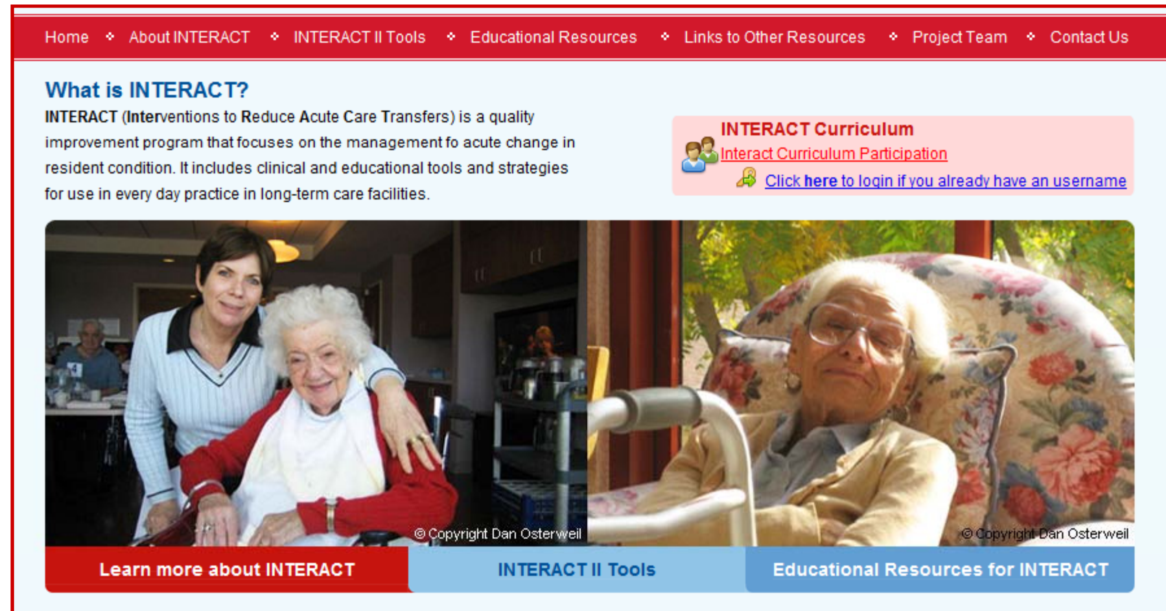
Percent of NH Residents with an Admission

- 6.3 - 15.1% (76 HRRs
- 15.3 - 20.0% (77)
- 20.1 - 23.6% (75)
- 23.9 - 36.7% (76)
- Not Populated or Missing Data (2)

SOURCE: Commonwealth Fund Local Scorecard on Health System Performance, 2012

INTERACT Collaborative Quality Improvement for Nursing Homes

Interventions to Reduce Acute Care Transfers (INTERACT) helps nursing-home staff manage residents' health status



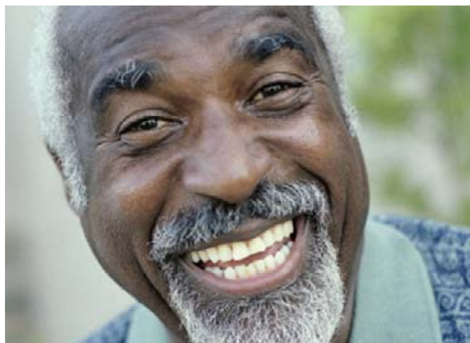
- 17-25% decline in hospital admissions in pilot
- Spreading to 400+ homes
- Three strategies:
  - Identify, assess, and manage conditions to prevent hospitalization
  - Document and communicate critical information
  - Improve advance care planning and develop palliative care plans

Source: J. G. Ouslander, G. Lamb, R. Tappen et al., "Interventions to Reduce Hospitalizations from Nursing Homes: Evaluation of the INTERACT II Collaborative Quality Improvement Project," Journal of the American Geriatrics Society, April 2011.

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: Access and 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
- At the beginning of learning the potential as tool to innovate

Affordable Care Act: Strategic Policies to Build On

- Payment and Care Systems
  - Enhanced primary care and medical home
  - Medicaid "Health Home" for chronically ill
  - Bundled payment: hospital/subacute 30 days
  - Community based transition program: complex chronic
  - Accountable Care Organizations and Shared Savings
- Innovation Center and Pilots/Demonstrations
  - Chronic disease teams for high risk beneficiaries
  - Care systems for dually eligible and disabled
  - In-home care for high-need Medicare/Medicaid patients
  - Medicare authorized to join state initiatives
- Workforce, technical assistance; information exchange
- New "tool box" – need to use strategically

Opportunities for Foundations to Make a Difference

- **Collaboratives to share and learn**
  - **Teams learn from each other**
  - **Workforce cross-training**
  - **Multi-community actions**
- **Diverse population: target areas**
  - **Mental health, disabled, frail, multiple chronic**
  - **Long term care, home and transitions, homebound**
- **Accountability: vulnerable due to health and income**
  - **Requires robust data-systems and benchmarks**
  - **Strong criteria for care systems eligible for new payment *AND* "exit" provisions if fail to perform**
  - **Patient and family voice**

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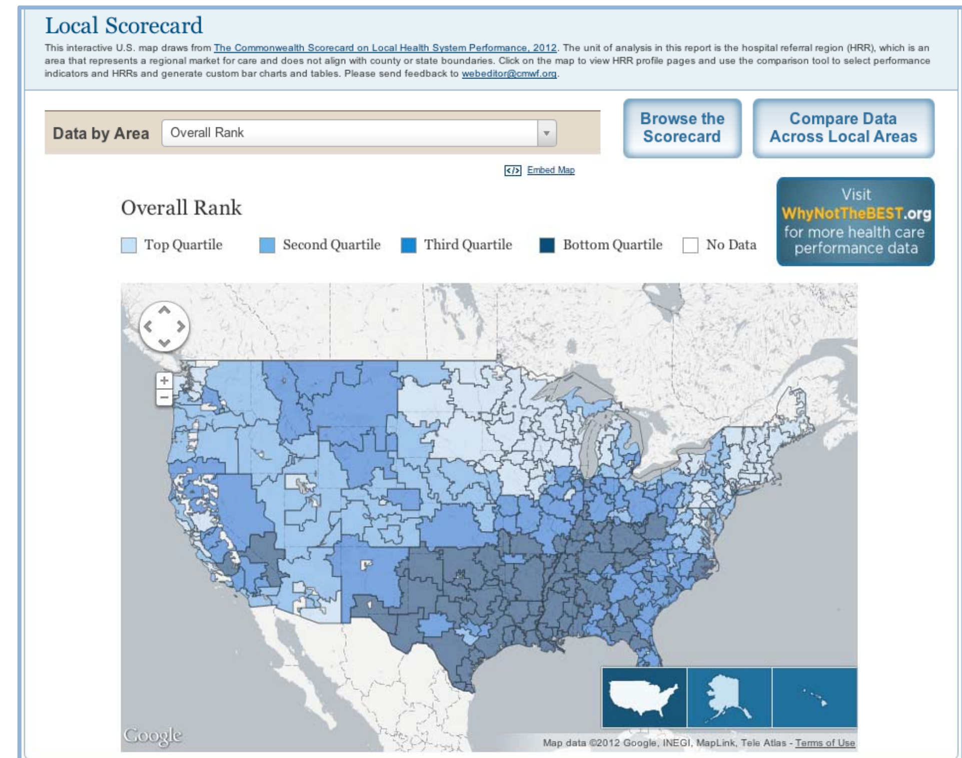
Further Reading and Resources

- **The Performance Improvement Imperative...for Chronically Ill Patients, Commonwealth Fund 2012**
- **The Potential Savings from Enhanced Chronic Care Management Policies, Urban Institute, 2011**
- **Rising to the Challenge: Scorecard on Local Health System Performance, Commonwealth Fund, 2012**
- **Raising Expectations: State Scorecard on Long Term Services and Support, AARP/SCAN, Commonwealth Fund, 2011**
- **For case studies, ACA, and other information visit the Fund's website**



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