The Playbook: Better Care for People with Complex Needs

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Perspective

Caring for High-Need, High-Cost Patients — An Urgent Priority

David Blumenthal, M.D., M.P.P., Bruce Chernof, M.D., Terry Fulmer, Ph.D., R.N., John Lumpkin, M.D., M.P.H., and Jeffrey Selberg, M.H.A.

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Improving the performance of America’s health system will require improving care for the patients who use it most: people with multiple chronic conditions that are often complicated by patients’ limited ability to care for themselves independently and by their complex social needs. Focusing on this population makes sense for humanitarian, demographic, and financial reasons.

From a humanitarian standpoint, high-need, high-cost (HNHC) patients deserve heightened attention both because they have major health care problems and because they are more likely than other patients to be affected by preventable health care quality and safety problems, given their frequent contact with the system. Demographically, the aging of our population ensures that the number of older people with multiple chronic conditions will continue to rise. Finally, the costs of care for high-need, high-cost patients will continue to rise, placing the burden on employers, the states, and the federal government. Improving the care for these patients will produce savings for our health care system as a whole.
Playbook Vision & Aim

- **5F Collaborative Vision:** By 2020, 30 percent of Accountable Care Organizations and Medicare Advantage Plans have adopted proven interventions for high-need, high-cost adults that improve person-level outcomes and lower overall costs of care.

- **Playbook Vision:** The Playbook serves as a vital resource and the go-to place for leaders of health systems and health plans to learn about and adopt new practices to ensure the health and care of people with complex needs is better than ever before.

- **Playbook Aim:** The Playbook provides users with the best available knowledge about promising approaches to improve care for people with complex needs, in a format that is engaging, attractive, practical, and useable with the goal of encouraging testing, adoption, implementation, and spread in their care settings.
About the Playbook

- Over 115 highly-curated resources focused on improving care for people with complex needs

- Organized around four key questions facing leaders:
  - Why invest in redesigning care for people with complex needs?
  - Who are people with complex needs?
  - What care models are promising?
  - What are the key elements of redesigning care?

- Play by Play blog featuring content original to the Playbook
Five foundations are partnering with the Institute for Healthcare Improvement to offer you the latest information about improving care for people with complex health and social needs. Visit the User's Guide to learn how to navigate the Playbook.

Key Questions
Find curated resources about promising approaches to improving care for people with complex needs.

- Why invest in redesigning care for people with complex needs?
  - 33 Resources

- Who are people with complex needs?
  - 25 Resources

- What care models are promising?
  - 43 Resources

- What are key elements to redesigning care?
  - 17 Resources
Vital Statistics

Since the launch of The Playbook on December 9th, 2016*:

- 22,975 unique visitors
- 100,655 page views

Users are highly engaged
- 50% of users who visit a resource page click on a link
- Over 4.5 minutes per visit
- On average 45% are return visitors

* Through September 8, 2017
Four priorities for the field
Seek effective care models

Key takeaway: There is no “one size fits all” approach to support people with complex needs.
Who are people with complex needs?

High-need individuals have clinically complex needs, functional limitations, and/or behavioral health conditions, and incur high health care costs or are likely to in the near future. This is a diverse population, ranging from frail older adults to people with behavioral health and social needs.

Rates of hospitalizations, emergency department visits, and home health services are significantly higher for these individuals than the nation at large. However, despite higher utilization and associated spending, they are significantly more likely to report unmet needs.

There is no “one-size-fits-all” approach to support people with complex needs. To effectively meet their needs, the first step is for providers to identify subgroups (or segments) with similar needs and/or service use patterns in order to tailor interventions appropriately.

The population subgroups identified in the Playbook were derived from work by the National Academies of Medicine (NAM).
Five foundations are partnering with the ins... information about improving care for people... to learn how to navigate the Playbook.

Key Questions
Find curated resources... improving care for people...

I Want Better Care For...

- Adults Under 65 with Disabilities
- Frail Older Adults
- People with Multiple Chronic Conditions
- People with Behavioral Health and Social Needs
- People with Advanced Illness

Why invest in redesigning care for people with complex needs?
34 Resources

Who are people with complex needs?
25 Resources

What care models are promising?

What are key elements to redesigning care?
Resources for People with Multiple Chronic Conditions

People with multiple chronic conditions — such as diabetes, heart disease, chronic kidney disease, congestive heart failure, dementia, and stroke — use more hospital and outpatient services than other adults. People with multiple chronic conditions often struggle to cope with and manage their health, which can lead to high out-of-pocket costs, medication complexity, and frustration with an overwhelming number of health system contacts. Most clinical guidelines do not account for multiple conditions and can create conflicting treatment plans when providers do not communicate well. As a result, care for this population needs to be comprehensive, coordinated, and focused on what matters most to the person.
Segmenting High-Need, High-Cost Patients: A Video Presentation by Dr. Jose Figueroa

August 1, 2017

How can health systems improve care for patients with complex needs? They can start by asking, “Who?”

Jose Figueroa, MD, MPH, a hospitalist at Brigham and Women’s Hospital and a health services researcher at Harvard School of Public Health and Harvard Medical School, has been researching this question: Who are patients with complex needs?

Dr. Figueroa was part of a team convened by the National Academies of Medicine (NAM) that created a model for identifying population segments within the broad category of high-need, high-cost patients. Unsurprisingly, they found that high-need, high-cost patients are not a monolithic group. In the following video presentation, Dr. Figueroa explains more. Watch each segment in order for the full presentation, or skip to the bottom to watch the full 16-minute video uninterrupted. You can also browse the segments to find the piece that interests you most. Click here to read the full report from the NAM.

Part 1: Why is it so difficult to improve outcomes and lower costs for patients with complex needs?
Share information on outcomes

Key takeaway: We cannot wait for large-scale, formal evidence to emerge. We must start testing new models and sharing information about success and failure.
What care models are promising?

Many pioneering programs have reduced avoidable utilization while improving health outcomes. The most promising models create interdisciplinary teams that collaborate to meet the person's needs for primary care, transitions after a hospitalization, palliative care for advanced illnesses, and/or long-term services and supports.

Although the evidence base is evolving, many existing models meaningfully improve a person's quality of life. It is therefore important to continue testing promising care models in different settings and contexts, and to develop better measures of person-centered outcomes and effects on total cost of care in order to guide the development of financially sustainable and scalable models.

View the evidence criteria used to determine each resource's "level of evidence."
Which models have the best evidence?

Transitional care models, palliative care programs, and interdisciplinary primary care models have been more extensively studied, corresponding with stronger levels of evidence. The Care Transitions Intervention, The Program of All-Inclusive Care for the Elderly (PACE) model, the Advanced Illness Model, and the Independence at Home Demonstration are among those specific models of care which have shown promising improvements in health and reduced costs.
Coming soon: User-submitted content

- Practical plays
- Case examples
Create payer-provider data collection partnerships

Key takeaway: There is a huge opportunity to test and evaluate payer-provider partnerships to collect and share information on enhanced care management models.
Improving Care for People with Serious Illness Through Innovative Payer-Provider Partnerships

KEY QUESTIONS ANSWERED
- What are the benefits of palliative care?
- How can my organization best deliver palliative care?
- How can my organization create incentives for palliative care?

KEY THEMES AND TAKEAWAYS
Palliative care can lead to longer survival and better quality of life for patients. This resource describes three palliative care delivery models: hospital, home, and hospice.

The Return on Investment (ROI) Calculator: The Business Case and Person-Centered Care

KEY QUESTIONS ANSWERED
- How can my organization quantify the business case for person-centered care (PCC)?
- How does the ROI calculator work?

KEY THEMES AND TAKEAWAYS
This resource describes an ROI calculator designed to assess the business case for PCC programs that serve older adults with complex needs. The resource also provides instructions for using the calculator:
- The calculator can help illuminate the business case for entities that develop and run PCC programs or that are thinking of starting one.
- The user enters data and estimates — such as costs, revenue enhancements, and medical utilization — into the calculator. Once all the needed information is entered, the calculator runs algorithms to determine the ROI.
Promote patient and caregiver engagement

Key takeaway: Enormous opportunity remains to expand contribution and presence of patients and family caregivers in health system design and innovation of service delivery.
Key Ingredients for Successful Trauma-Informed Care Implementation

KEY QUESTIONS ANSWERED

- What are the key steps to establishing a trauma-informed approach to care?
- What are examples of various approaches?
- What are the key opportunities for advancement in this area?

KEY THEMES AND TAKEAWAYS

This resource, based on interviews with experts across the US, summarizes the key features of a trauma-informed approach to care. It includes a chart with descriptions of different approaches.

- Trauma-informed care acknowledges the need to understand a person's life experiences. It can improve patient engagement, treatment adherence, and health outcomes while reducing costs.
- A set of relevant organizational competencies and clinical guidelines is emerging, but more needs to be done to develop an integrated, comprehensive approach.
Thank you and request...

Please share your feedback! playbook@ihi.org

www.bettercareplaybook.org
Person-Centered Care Implementation: What? Where? How?

2017 California Summit on Long-Term Services and Supports (LTSS):
October 26, 2017

Margie Powers
Director, Medically Complex Patients Program
Describe ideal complex care management model.

Identify critical model elements in effective programs.

Review lessons learned from successful medically complex program.
What Do We Mean by Medically Complex Patients?

- Multiple Chronic Conditions
- Behavioral Health
- Frail Elderly
- Healthy with Acute Event
- Under 65 Years Disabled
- Complex Chronic Conditions
- Socially Complex
- Children with Complex Needs
Unmet Needs Signals:

- 45% of patients appear in top spending tier over 2 years
- 67% are under age 65
- 28% of Medicare Spending occurs in last 6 months of life
Response: Intensive Outpatient Care Program (IOCP)

- Built on successful pilots established for commercial patients:
  - Boeing (Seattle area)
  - PG&E and CalPERS (rural northern California)
- 2012 HCIA award to test spread across 23 delivery system in 5 states for 15,000 Medicare patients
- 2016 Provided Technical Assistance for Medi-Cal Health Homes program
- Building Care Solutions (BCS) launch in 2017
IOCP Target Population

ID High Risk Patients* (Multiple Pathways)

Factors to consider:
- 1+ hospital admissions in last 6 months
- 1+ ER visits in last 6 months
- 3+ active specialists
- 3+ diagnosed conditions or a single major condition
- 5+ current medications (Rx)

Factors to consider:
- Total Prospective Risk Score
- Prospective risk score contribution from inpatient, outpatient and prescription
- Prospective risk score contribution by condition
- Year-over-year trend on risk scores

Medical Group and Physician Referral

Case Find Through Data
###Patients
- Top 10-15% predicted high cost

###Services / “Guardrails”
- Longitudinal 1:1 relationship with warm handoff to support services
- Minimum, two-way communication with care coordinator / patient 1x/mo
- Care coordinators host face-to-face “supervisit”
  - Assessment with PAM, PHQ-2; medication reconciliation
  - Support patients’ Shared Action Plan
- 24/7 access, communication to care coordinator next business day
Medically Complex Care Model (cont’d)

Create and support Care Coordinator multi-disciplinary team
- Trained with an emphasis on patient engagement techniques
- Dedicated to the role, and work in teams
- Can be licensed or unlicensed staff, anchored by RN or MSW
- Care coordinator team supervised by physician

Build communication infrastructure
- Direct communication between care coordinator and patient/family
- Secure messaging between care coordinator and all physicians participating in patient’s care
- Regular connection to primary care practices

Manage patient enrollment
- Create patient identification process/algorithm
- Support patient engagement process (Opt-in rates ranged from 33% to 99%)
The **Intensivist** model versus **Distributed**

**Intensivist** – Patient is referred to a specialist primary care practice with co-located care coordinators

**Distributed** – Patient remains in primary care practice and care coordinators travel

**Care Coordinator ratios**

Panel size for Medicare: 80 – 120  
Panel size for Commercial: 180 – 200  
Medicaid: 25 - 80
## IOCP Results*

<table>
<thead>
<tr>
<th>Cost/Utilization</th>
<th>Clinical Outcomes</th>
<th>Patient Engagement</th>
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</thead>
<tbody>
<tr>
<td>✓ Top 10-15% predicted high cost</td>
<td>✓ Longitudinal 1:1 relationship with warm handoff to support services</td>
<td>✓ 3.6% increase in patient engagement</td>
</tr>
<tr>
<td>✓ 55% decrease in emergency department visits for higher risk patients</td>
<td>✓ 33% improvement in depression symptoms</td>
<td></td>
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<tr>
<td>✓ 21% decrease in total cost of care for higher risk patients</td>
<td>✓ 3.4% improvement in mental health functioning</td>
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<td></td>
<td>✓ 4.1% improvement in physical health functioning</td>
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*Statistically significant at p.05 level

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IOCP 2.0: Building Care Solutions

- New program that delivers improved training, support in key areas
  - Assessing readiness & building a business case
  - Identifying right participants for program
  - Strengthening the care model
  - Building the team
  - Engaging providers
  - Measuring & monitoring success
Building Care Solutions Framework

- Target Population: Medically Complex Older Adults
- Timing: September 2017-August 2019
- Participants: Up to 21 California organizations
- Expansion of IOCP Model:
  - ROI & Business Case
  - Person-Centered Care emphasized
## Building Care Solutions

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<tr>
<th>Action Communities</th>
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<tr>
<td>• Three 1-day in-person learning sessions over 9 month period; expert faculty and peer-peer learning sharing strategies on caring for medically complex population; final conference brings all 3 collaboratives together.</td>
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<tr>
<td>• Participation requirements: Leadership teams attend and actively participate in learning sessions and final conference. Set program goals at first LS.</td>
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<th>Coaching Support</th>
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<tr>
<td>• Customized hands-on coaching in clinical, operational and business care development areas.</td>
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<tr>
<td>• Participation requirements: Between meetings, work closely with coach towards goals set in LS1.</td>
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<th>Care Coordinator Training</th>
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<tr>
<td>• One 2-day care coordinator training for patient-facing staff, provided by expert faculty.</td>
</tr>
<tr>
<td>• Participation requirements: Staff working directly with patients attend training.</td>
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<th>Data Collection &amp; Reporting</th>
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<tr>
<td>• Share data monthly with implementation team, leadership</td>
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<tr>
<td>• Share data with Action Community at each learning session</td>
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Lessons Learned #1

• Identifying the **right patients** for the program
• Honing in on **highest needs**; who will benefit
• Creating exit criteria, **transition to step-down** program
• Critical for **providers** to understand referral process, enrollment criteria
• **Behavioral, social issues** can have severe impact on patient engagement, yet are often treated separately
  • **Add team member** with behavioral health, substance abuse expertise; even as consultant
  • **Consider adding home visit**; see environment, family, food, safety
  • **Lack of integration** is a barrier—data sharing, referral tracking.....
Lessons Learned #3

- As programs proliferate, increase in duplication of services/missed opportunities
  - Consider creating umbrella over multiple medically complex programs
  - Create data-sharing, common IT infrastructure
  - Collecting care coordination data is hard-worth investing IT resources in this
Lessons Learned #4

• **Find ROI**
  • Sustainability plan required to **sell to leadership**
  • Competing programs, priorities, vast uncertainty requires **hard facts** about program costs/benefits
  • The SCAN Foundation ROI Calculator Tool
    • Testing now
IOCP Toolkit
(http://www.calquality.org/storage/documents/IOCPPCC_Toolkit_V7_112216.pdf)

The Playbook
(http://www.bettercareplaybook.org/about-playbook)

Health Affairs Blog
(healthaffairs.org/blog/2016/02/02/using-the-intensive-outpatient-care-program-to-lower-costs-and-improve-care-for-high-cost-patients/)
Connect with Us

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Sharp Rees-Stealy Medical Group

- Region’s 1st Multi-Specialty Group Practice
- 23 Locations Throughout San Diego
- Primary and Specialty Care
- 2000 Employees
- 572 Physicians (Foundation Model)
- 1 Million Visits/year

Covered Lives
ACO and PPO  220,000
Next Gen ACO  11,000
Continuum of Care Evolution

- Diabetes Data Analysts
- Pharmacy Benefits
- Center for Health Management
- Primary Care & Complex Case Mgmt
- Asthma
  - CAD
  - CHF
  - Tele
  - COPD
- Triage
  - Asthma
  - Tele
  - Senior Enhanced Care Mgmt
- Texting Programs
  - Diabetes
  - Smoking Cessation
  - Post Hospital Discharge
  - DPP Medication Adherence
  - New Weigh
- Remote Glucose Monitoring
- Behavioral Health
- COC Calls
- Care at Home
- HSFZ
- NextGen ACO

Timeline:
- 2011
- 2012
- 2013
- 2014
- 2015
- 2016
- 2017

IOCP
Expanding Services

- Need for face to face visits
- Value of seeing patients in their environment
- HCC Coding/Quality measures
2013 - Care at Home Program

- Interdisciplinary Team with RN/MSW/NP/MD/MA
- Provides primary care in the home
- Home labs, x-rays, ultrasounds
- Telemedicine and Telepsych visits in the home
- AVOID unnecessary emergency room or urgent care visits and hospitalizations
Behavioral Health

- MSW/LCSWs
- Experts at finding resources
- Act as consultants to care managers
- Carry a caseload where appropriate
- Follow up on referrals where services are carved-out
Senior Readmissions

30 Day All Cause Readmission Rate
SRS Senior HMO Population
(Source: Claims)
Takeaways

• Added the guardrails to our existing programs
• Increased collaboration – Internally & externally
• Allowed development of a non disease-specific program