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

Cathy Schoen
Senior Vice President
The Commonwealth Fund
www.commonwealthfund.org
cs@cmwf.org

High Cost Beneficiaries: What Can States Do?
19th Princeton Conference: States Role in Health Reform
May 23, 2012

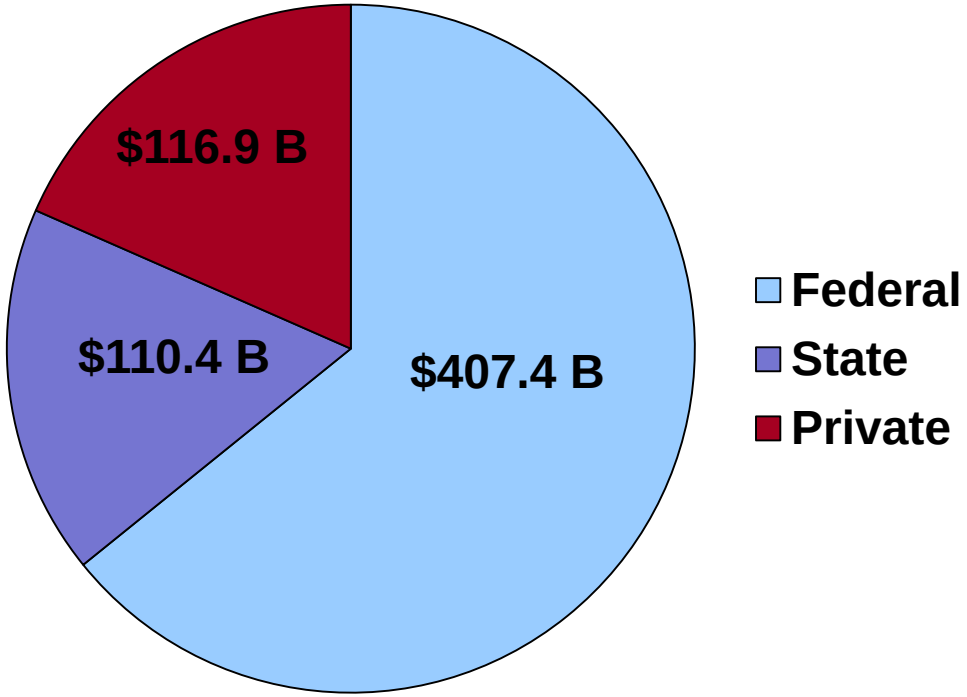
Chronically Ill: Opportunities and Challenges to Achieving Better Outcomes at Lower Costs

- **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**

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

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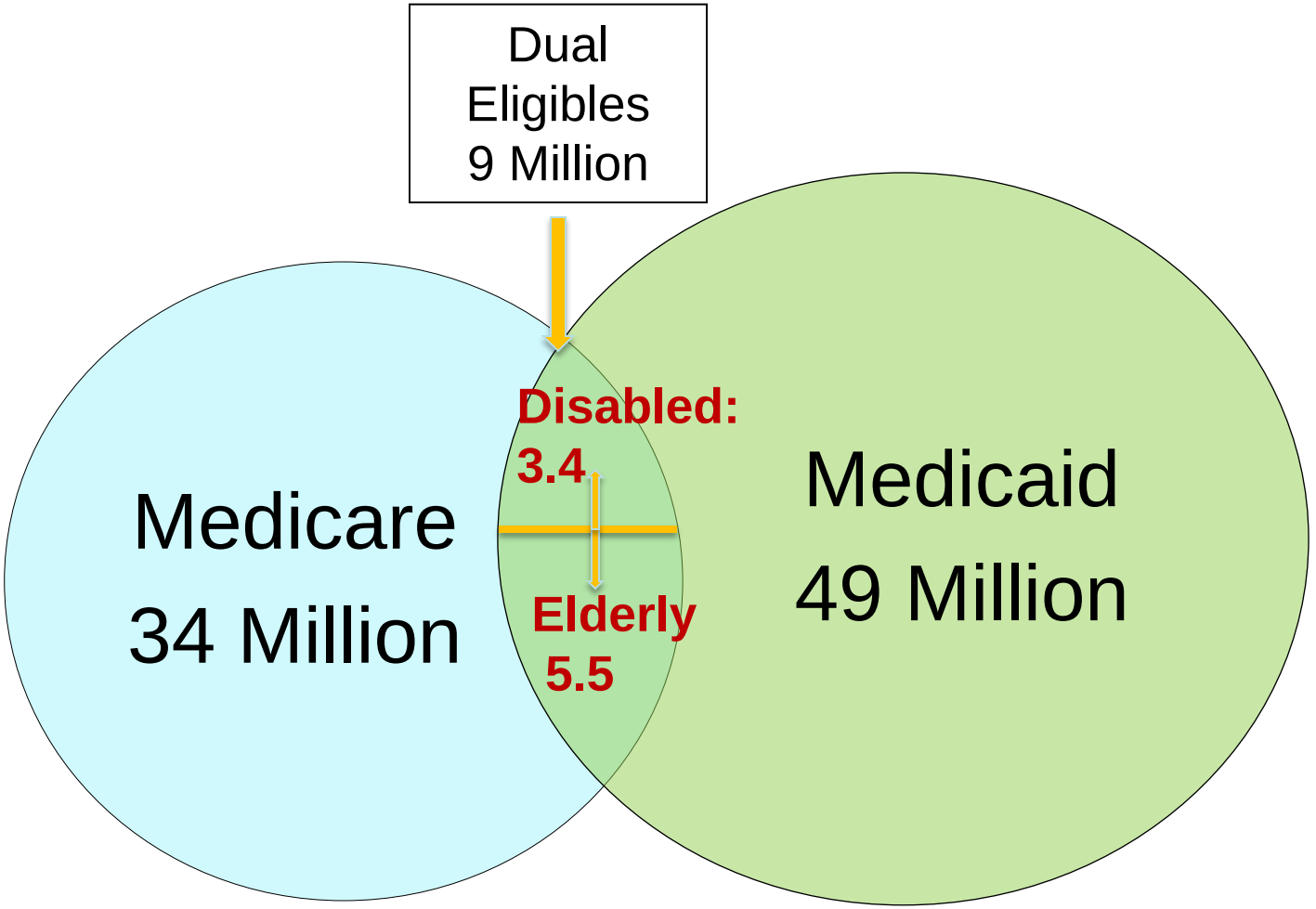
Nine Million People Are Covered by Both Medicare and Medicaid: 10% of Total Population = 38% Total Spending



Total Medicare Beneficiaries, 2007: 43 million

Total Medicaid Beneficiaries, 2007: 58 million

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.

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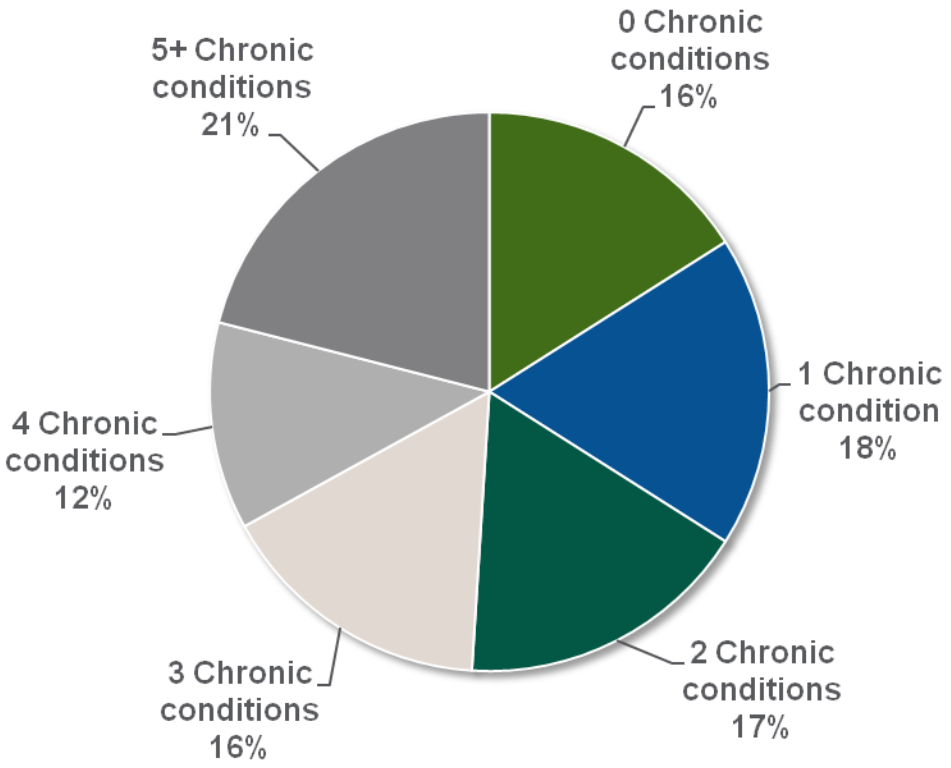
High Share of Health Care Spending Is on Behalf of People With Multiple Chronic Conditions

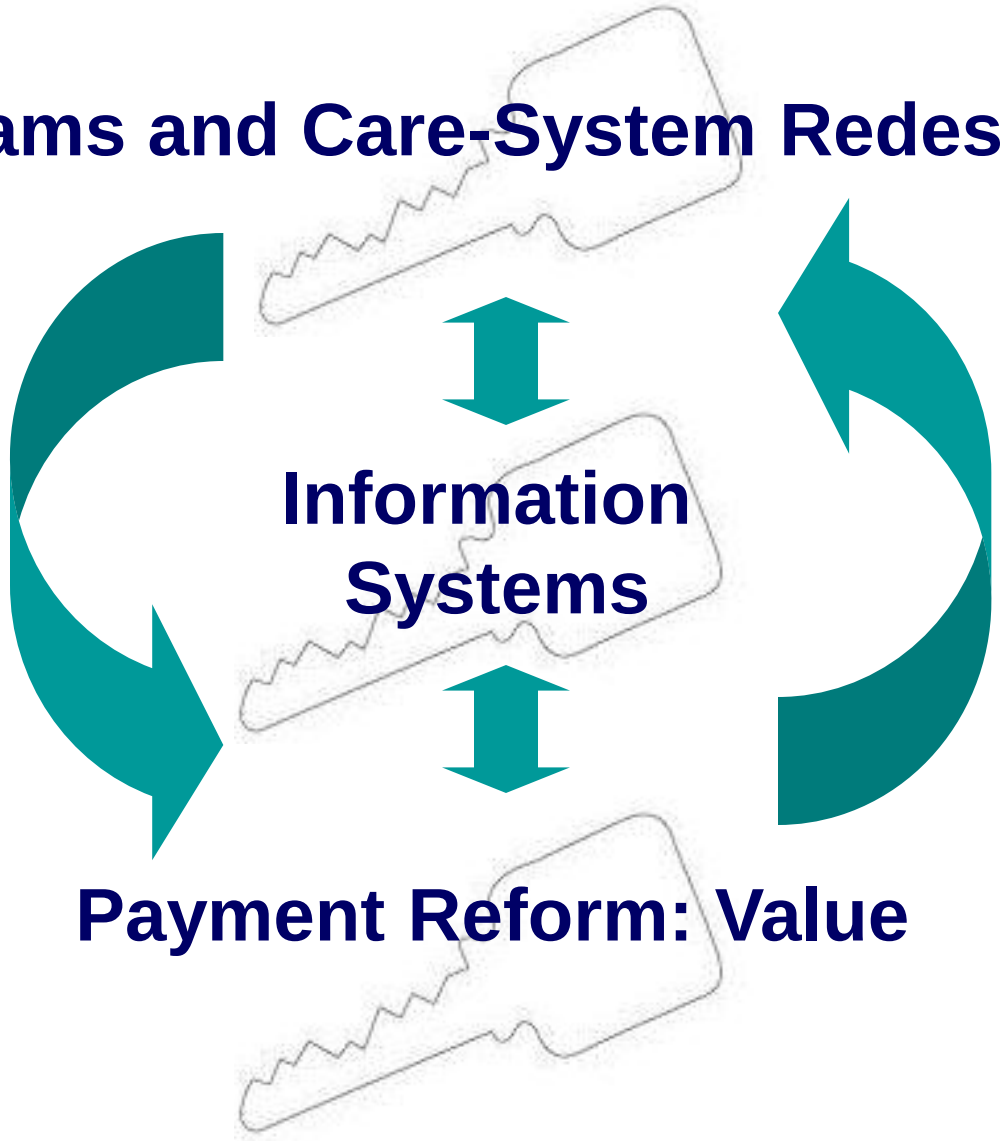
- Eighteen percent of spending is for the 22 percent of the population that has only one chronic condition.
- Seventeen percent of spending is for e 12 percent of the population that has two chronic conditions.
- **Sixteen percent of spending is for the 7 percent of the population that has 3 chronic conditions.**
- **Twelve percent of spending is for the 4 percent of the population that has 4 chronic conditions.**
- **Twenty-one percent of spending is for 5 percent of the population that has 5 or more chronic conditions.**

Percentage of Health Care Total Spending by Number of Chronic Conditions



Source: Medical Expenditure Panel Survey, 2006

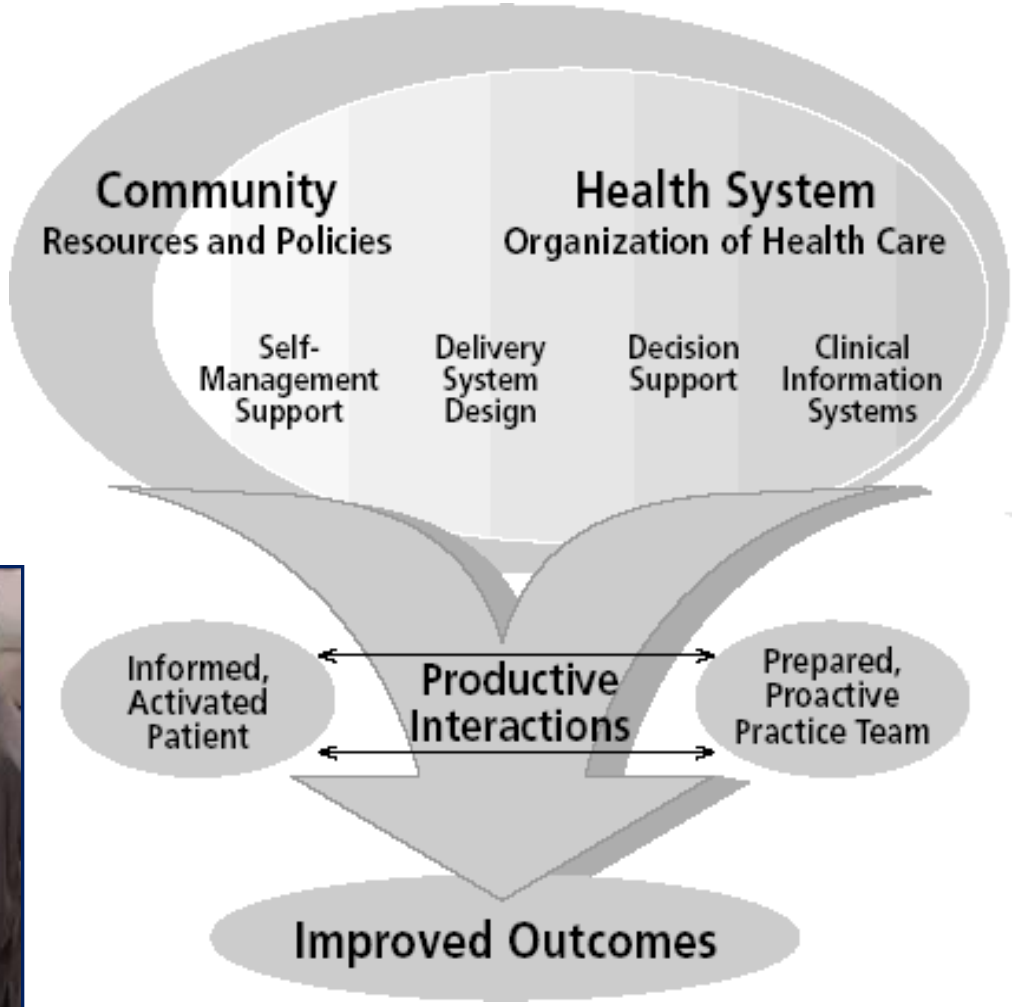
Keys to Rapid Progress



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



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Multiple Models Exist: Opportunity to Spread and Learn

Commonwealth CARE alliance

Cambridge Health Alliance

JOHNS HOPKINS MEDICINE

GUIDED CARE

GroupHealth

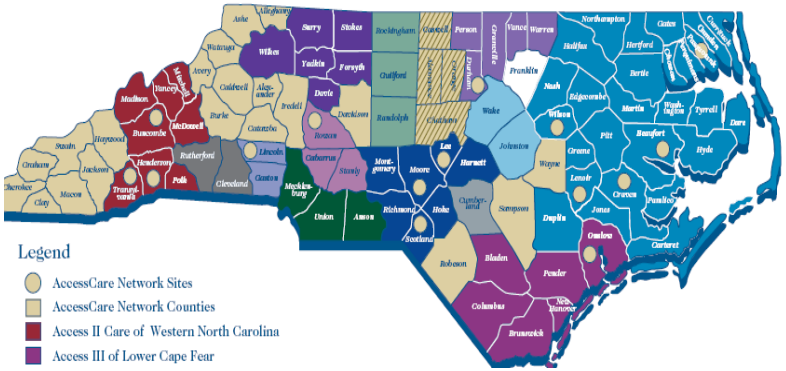
Geisinger Health System

DENVER HEALTH

Level One Care for ALL

MGH 1811 MASSACHUSETTS GENERAL HOSPITAL

PARTNERS HEALTHCARE



Community Care of North Carolina

Minnesota Senior Health options

complete care designed for seniors

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALASKA NATIVE MEDICAL CENTER

SOUTHCENTRAL FOUNDATION

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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***

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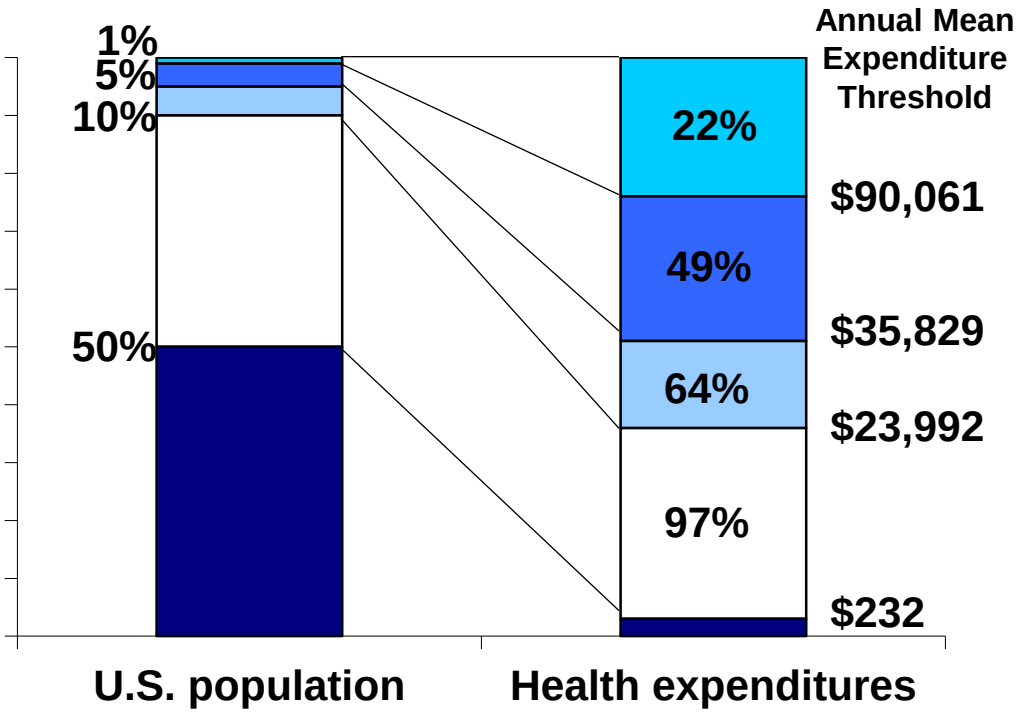
Focusing on High-Cost Patients

- **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**

Distribution of health expenditures for the U.S. population, 2008-09



Source: D. Blumenthal, *The Performance Improvement Imperative*, The Commonwealth Fund, forthcoming; 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).

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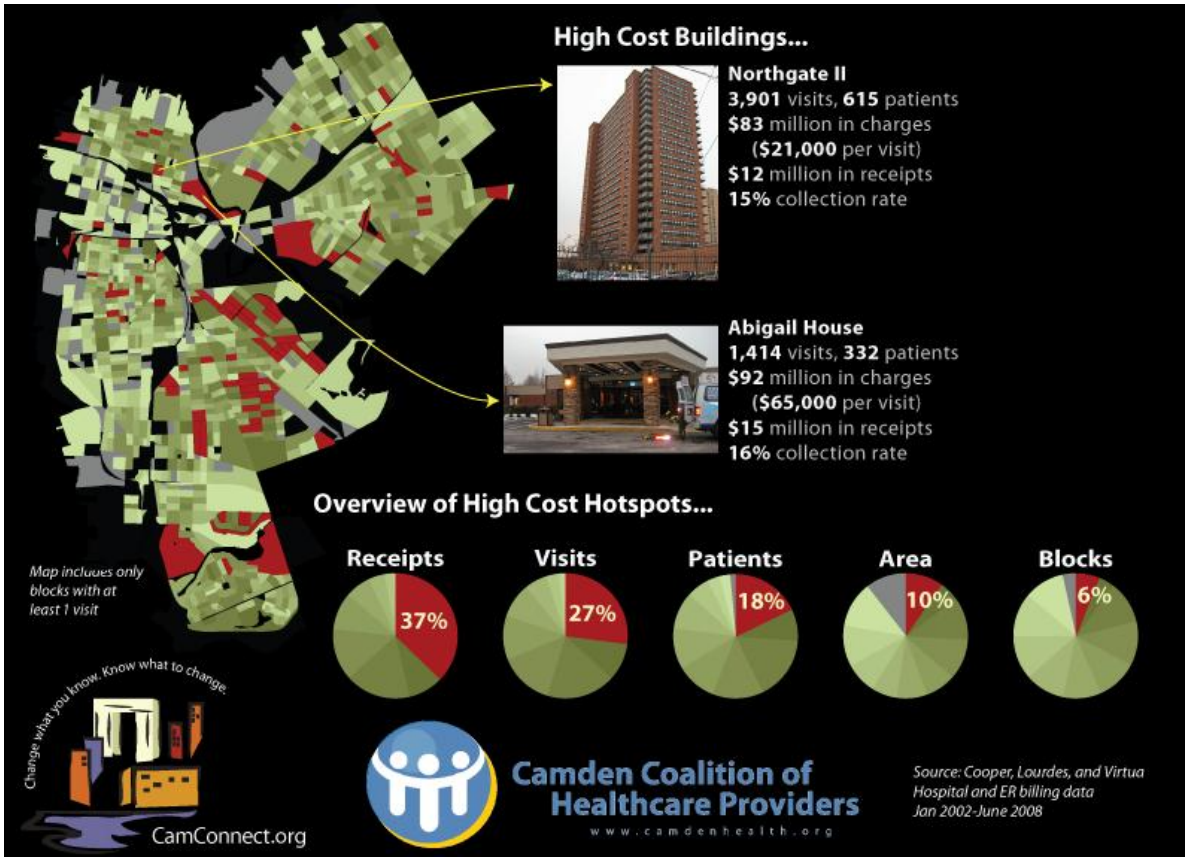
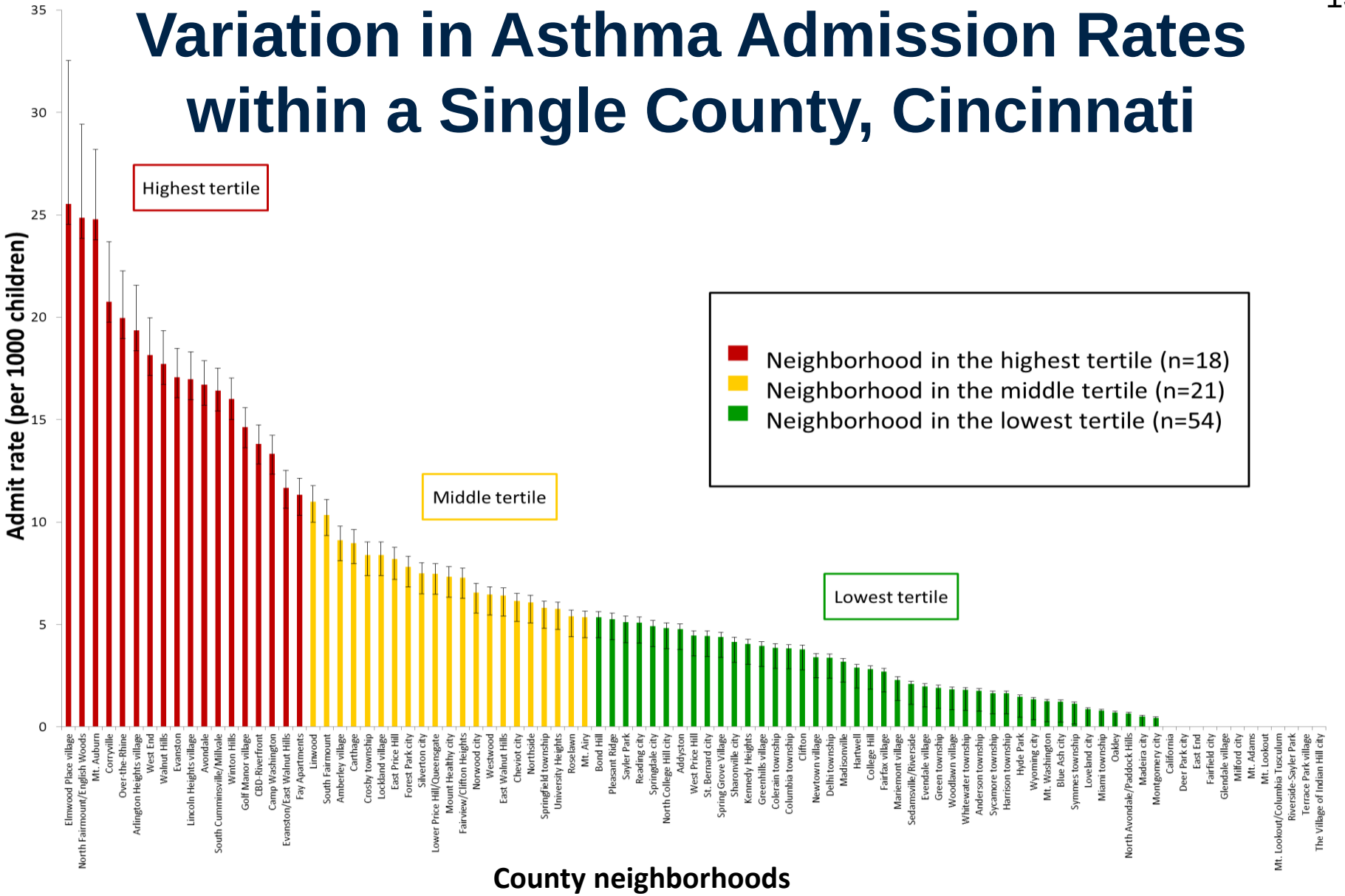
Health Care Cost Hotspots in Camden, NJ



- **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



Electronic Health Records: Meaningful Use
Cincinnati Children's Hospital

Social/Environmental (Questions to ask family during visit)

Child lives with	
* Are you having problems receiving WIC food stamp, daycare vouchers, medical card, or SSI?	Yes / No
* Housing problems (overcrowding, roaches, rodents, utilities, mold, lead)?	Yes / No
* Threatened with eviction or losing your home?	Yes / No
* Over the past 2 weeks, have you felt down, depressed or hopeless?	Yes / No
* 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?	

Benefits

Housing

Depression

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

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

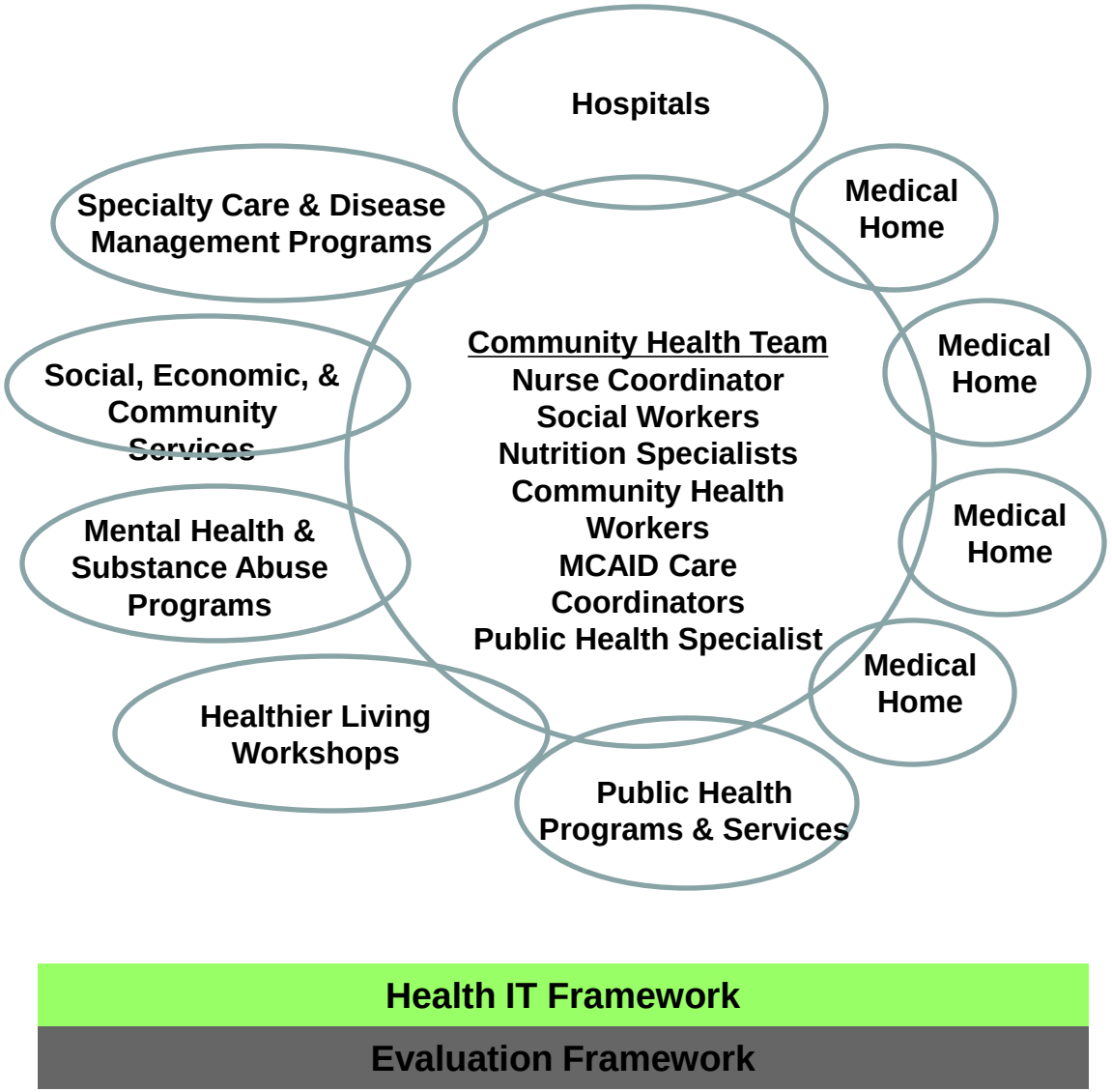
Question	Answer	Comment
Reason for referral?	**Section 8 about to expire, has a new housing application pending but afraid will lose SEc 8; child has bad asthma and current home has mold, roaches and dirty carpets per mom**	
Guardian's name(s)?	MT	
Guardian's primary phone?	513-xxx-xxxx	
Guardian's secondary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

Order Details

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

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

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MASSACHUSETTS GENERAL HOSPITAL

MGH Care Redesign

	Longitudinal Care	Episodic Care	
	Primary Care	Specialty Care	Hospital Care
Access to care	**Patient portal/physician portal**		**Hospital Access Center**
	Extended office hours		**Reduced admits/1000**
	Non face-to-face visits		
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**		
	PMPM, HCI, ACSH, Pharmacy	**Clinical and Patient Reported Outcomes**	**LOS, CMAD, HACs, Re-Admits**

Source: J. Ferris, G. Meyer, P. Slavin, "Challenges and Responses of Academic Health Centers in the Health Care Reform Era," Presentation to Commonwealth Fund Board of Directors, April 2011.

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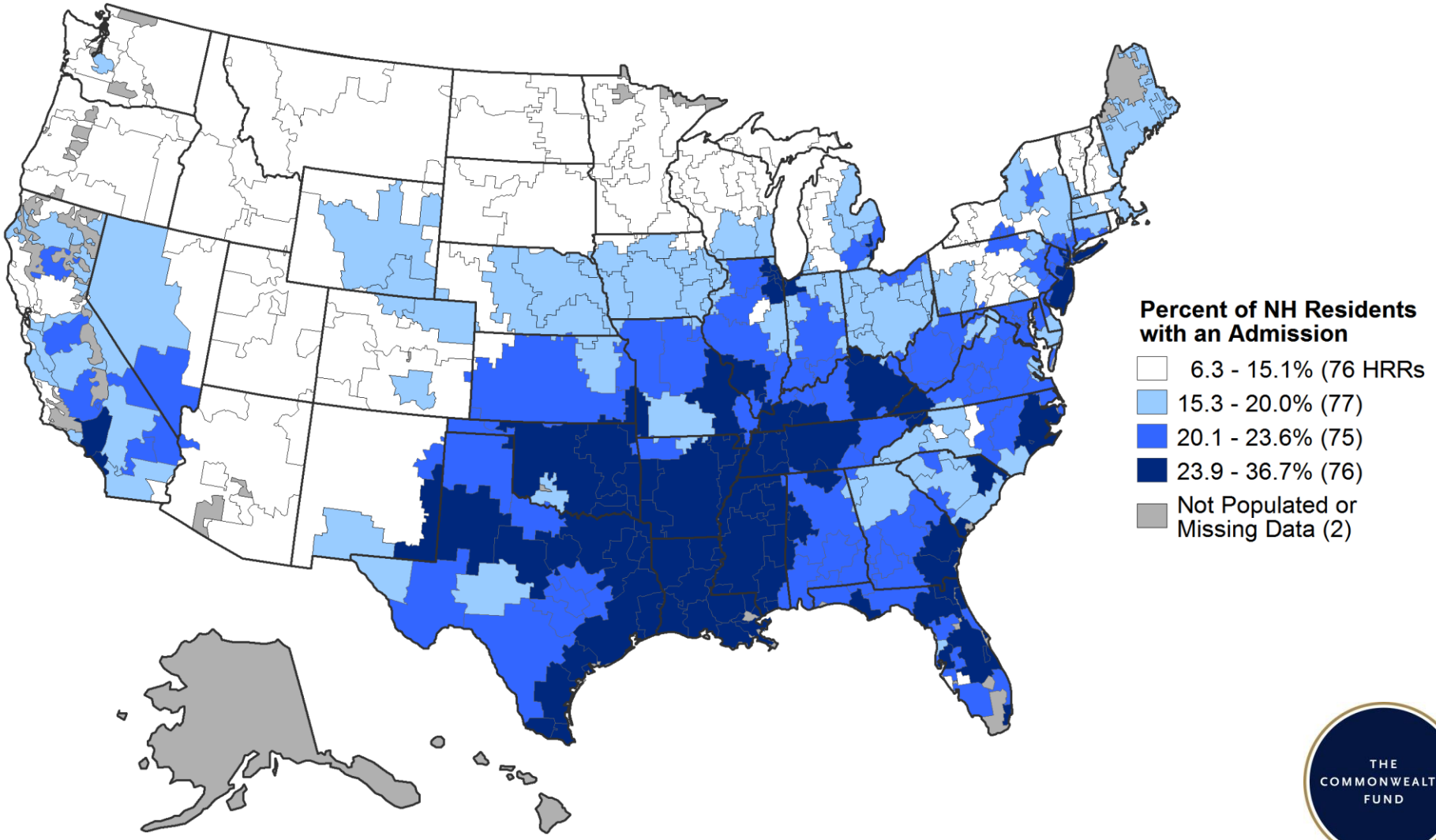
Long-Stay Nursing Home Residents Hospitalized within a Six-Month Period



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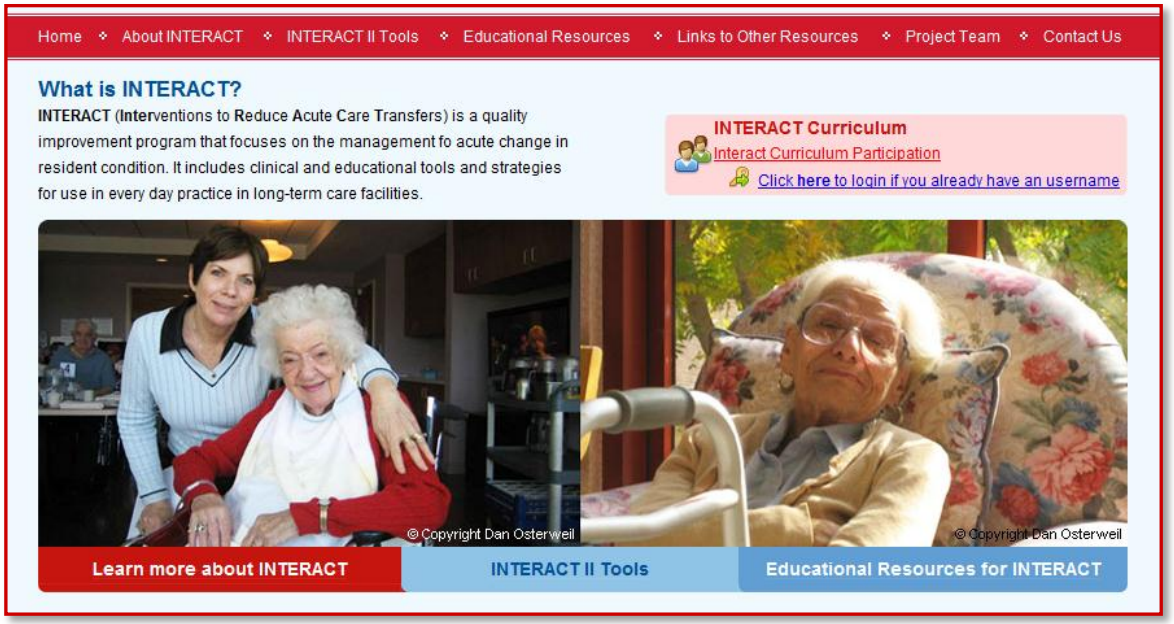
SOURCE: Commonwealth Fund Local Scorecard on Health System Performance, 2012

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 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**

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.

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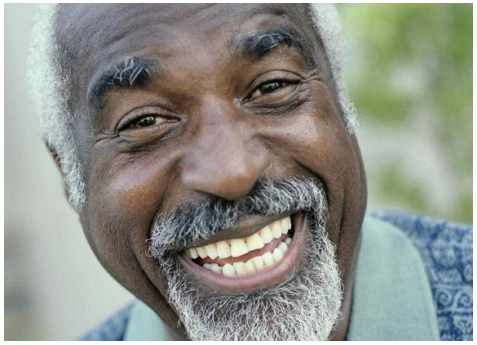
Visiting Nurse Service New York Health Plans

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

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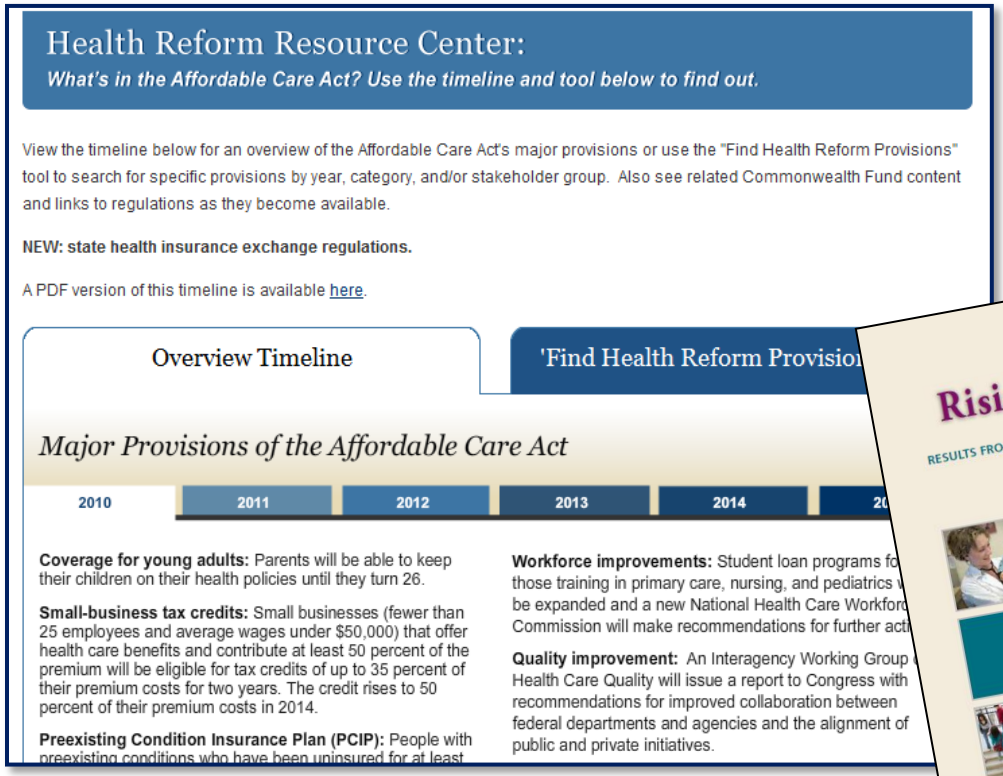
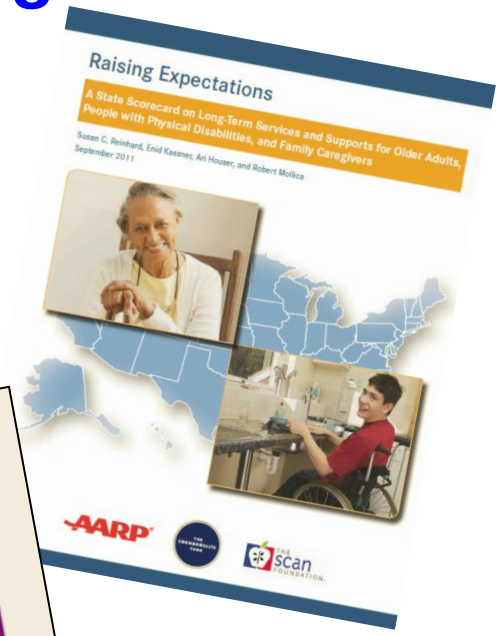
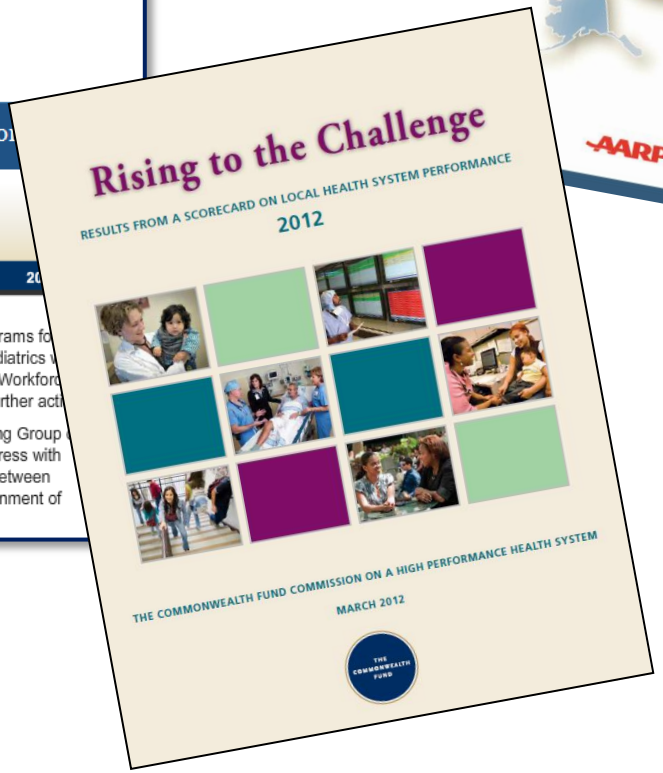
Opportunity and Challenges

- **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







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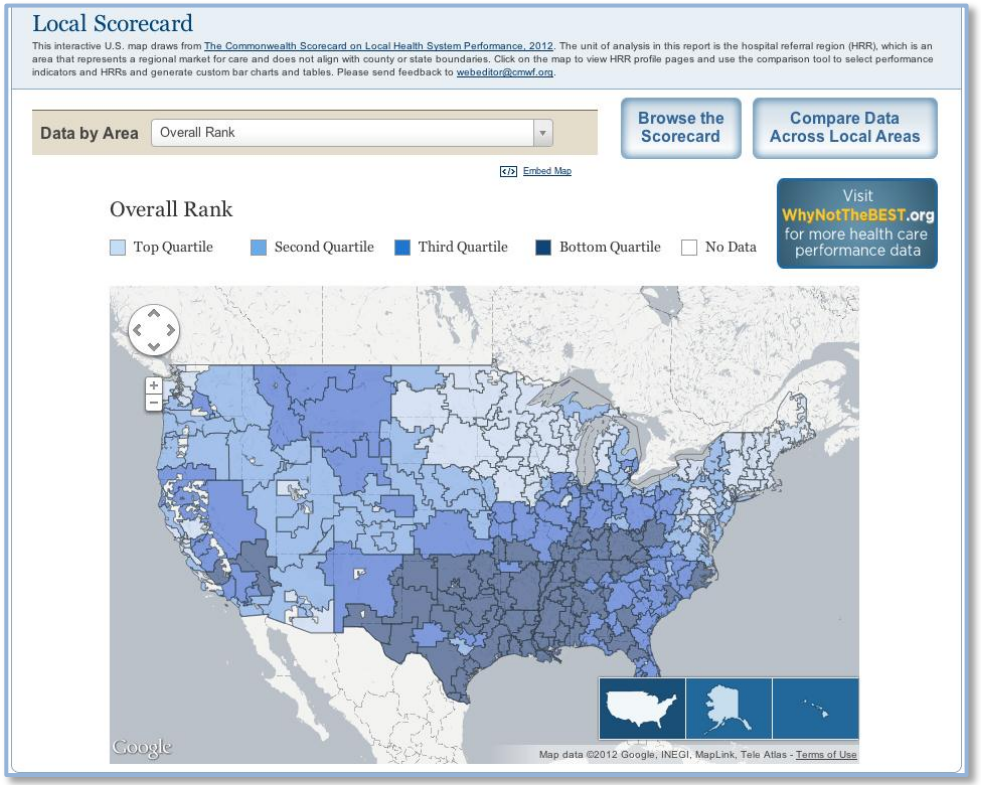
For More Information Visit the Fund's Web site at www.commonwealthfund.org

- 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



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Thank you!

Anne-Marie Audet
Vice President
Health System Quality and Efficiency

Melinda K. Abrams
Vice President
Patient-Centered Coordinated Care

Karen Davis
President

Stu Guterman
Vice President
Payment and System Reform

Mary Jane Koren
Vice President
Long Term Care Quality Improvement