MANAGING HIGH-COST HIGH-NEED INDIVIDUALS

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DHCF
Department of Health Care Finance

Medicaid Business Transformation DC
Prepping for Value

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AGENDA

I. Define high-cost, high-need (complex) populations
II. How we identify complex populations
III. Successful care models

Learning Objectives

1. Recognize the characteristics and unique challenges faced by high-cost, high-need patients to be better equipped to identify within their patient populations.
2. Describe patient-centered approaches, multidisciplinary care coordination, and leveraging community resources to address the complex needs of high-cost, high-need patients.

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DEFINING HIGH-COST, HIGH-NEED (COMPLEX) POPULATIONS

WHO ARE PEOPLE WITH COMPLEX NEEDS?

- A heterogenous group of people with:
  - Complex medical, behavioral health and health-related social needs
  - May also include sub populations such as children with special health care needs

Adults under 65 with physical or developmental disabilities →

People with multiple chronic conditions →

People with serious behavioral health needs →

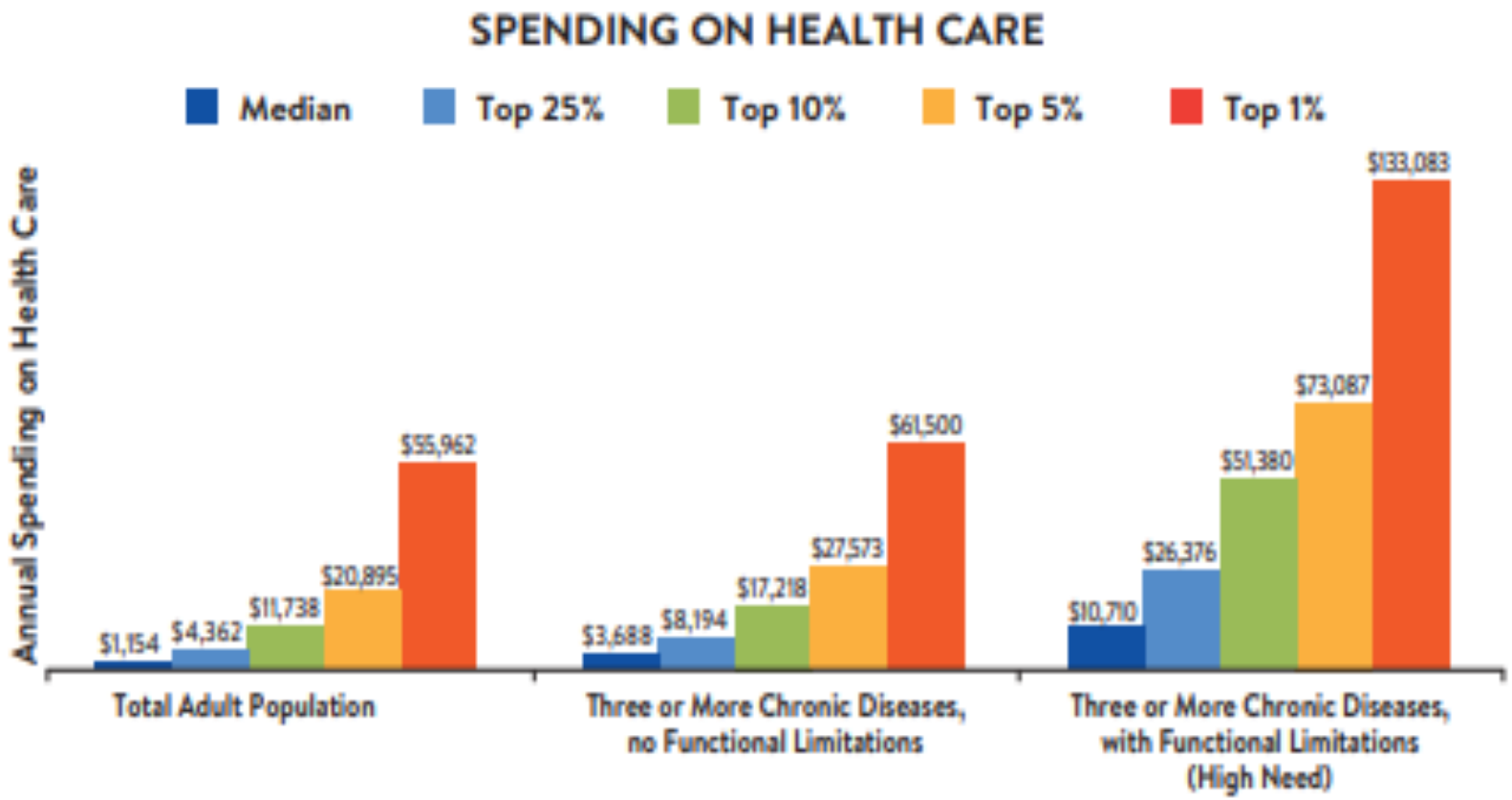
Frail older adults →

People with serious illness →

A TAXONOMY OF COMPLEX POPULATIONS

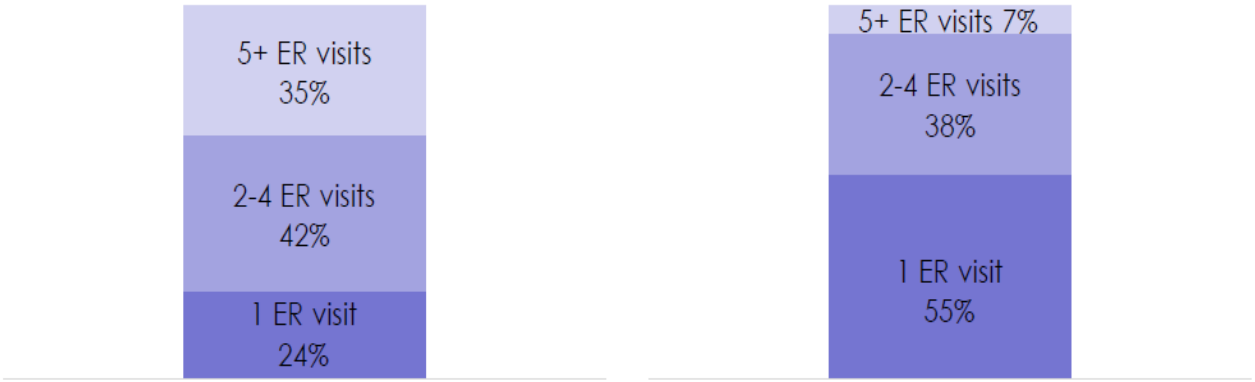
Source: Adapted and reproduced with permission from the National Academy of Sciences (*Effective Care for High-Need Patients: Opportunities for Improving Outcomes, Value, and Health*)[20] and from Abrams (*Matching Patients to Tailored Care Models: A Strategy to Enhance Care, Improve Outcomes, and Curb Costs*).[182]

SPENDING ON HEALTH CARE



National Academy of Medicine Effective Care for High Need Patients: https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients.pdf

DHCF MEDICAID BENEFICIARIES WITH ER VISITS FOR BH IN FY 2019



Total ER users with BH primary diagnosis on ER claim (5,904)

Total ER users with no BH primary diagnosis on ER claim (94,634)

- Individuals who had an ER visit with a BH primary diagnosis were five times as likely to have had 5+ ER visits in a year than those seen for non-BH reasons (35% versus 7% with 5+ visits).
- Individuals with a dual diagnosis were most likely to be seen 5+ times (data not shown above):
  - 34% who had an ER visit with a MH primary diagnosis were seen 5+ times.
  - 44% who had an ER visit with an SUD primary diagnosis were seen 5+ times.
  - 49% who had an ER visit a MH/SUD dual diagnosis were seen 5+ times.

Source: DHCF Medicaid Management Information System data extracted June 9, 2020 and July 16, 2020.
Note: Reflects Medicaid fee-for-service claims and managed care organization encounters. Includes outpatient ER visits and those that led to an inpatient admission. *Does not sum to 100% due to rounding.

SUCCESSFUL CARE MODELS

SUCCESSFUL CARE MODELS

Assessment. Multidimensional (medical, functional, and social) patient assessment

Targeting. Targeting those most likely to benefit

Planning. Evidence-based care planning

Alignment. Care match with patient goals and functional needs

Training. Patient and care partner engagement, education, and coaching

Communication. Coordination and communication among and between patient and care team

Continuity. Seamless transitions across time and setting

Monitoring. Proactive tracking of the health status and adherence to care plans

Centers for Disease Control and Prevention, 2023

Anderson et al., 2015; Bodenheimer and Berry-Millett, 2009; Boult and Wieland, 2010; Brown et al., 2012; McCarthy et al., 2015; Nelson, 2012)

ASSESSMENT

ASSESSMENT

1. Universal health risk screening including SDoH screening
2. Who are the **populations** that require a special intervention?
   - » Aggregate data
   - » Claims, Frequent ED/Hospital users
   - » Challenges with adherence to treatment
   - » Medical/pharmacy claims
   - » Demographic data: age/gender/zip code
   - » Area Deprivation Index

SCREENING TOOLS FOR SOCIAL DETERMINANTS OF HEALTH

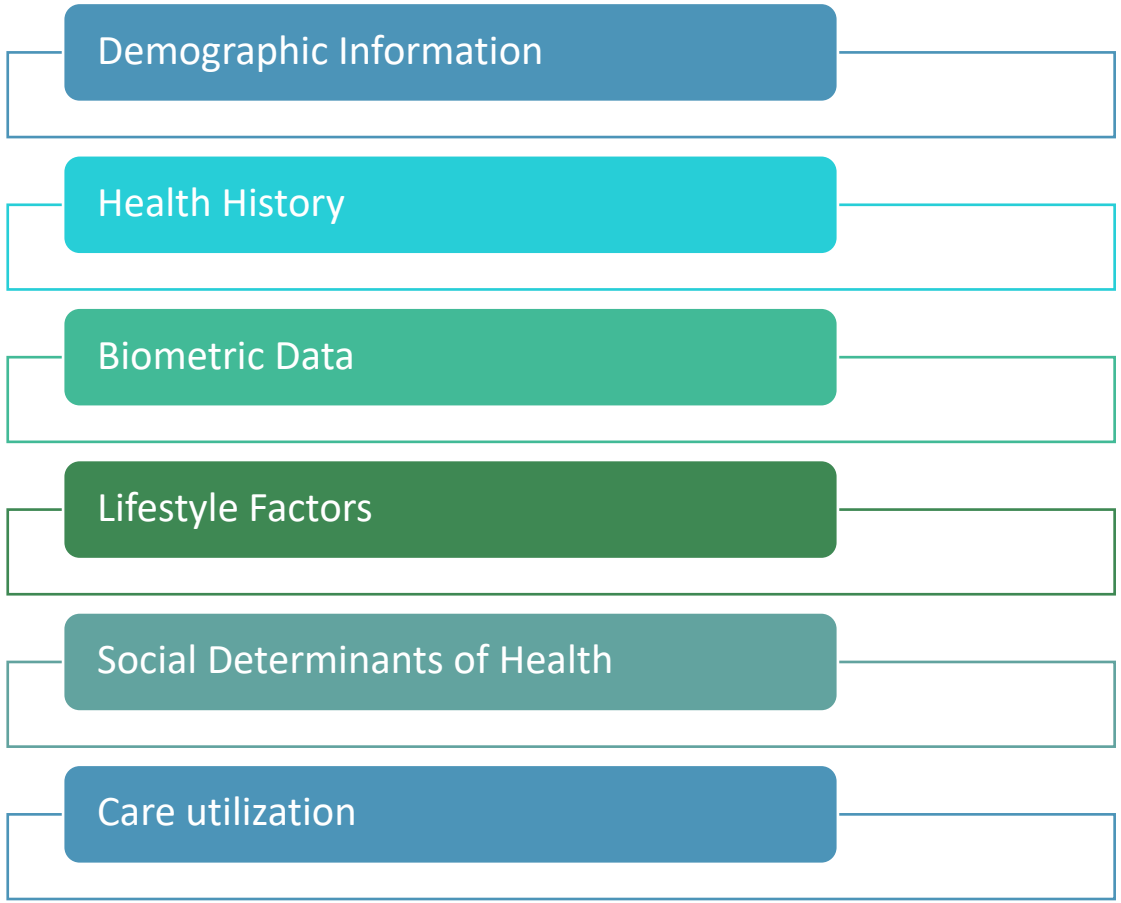
Three screening tools can aid physicians in addressing multiple social determinants of health in a primary care setting.

Screening tool	Number of questions	Source
The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	15 core, 5 supplemental	http://www.nachc.org/research-and-data/prapare/toolkit/
The American Academy of Family Physicians Social Needs Screening Tool	11 (short form) 15 (long form)	Short: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf Long: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-long-print.pdf
The Accountable Health Communities Health-Related Social Needs (AHC-HRSN) Screening Tool	10 core, 13 supplemental	https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

Sample screening tools:Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool - National Academy of Medicine (nam.edu)

TARGETING

TARGETING



- Low Risk: Routine preventive care and healthy lifestyle recommendations.
- Moderate Risk: Closer monitoring, targeted interventions, and education about managing their risks.
- High Risk: Intensive management, regular medical assessments, and more aggressive interventions.
- Very High Risk: Extensive medical management, frequent monitoring, and comprehensive interventions to prevent complications.

PLANNING

PLANNING

Involve consumers in the design of programs.

Apply lessons from research-based and practice-based evidence. Examples may include:

Transitional Care Model for hospitalized, high-risk adults with chronic conditions.	Commonwealth Care Alliance for non-elderly people with complex needs.	Partners HealthCare Integrated Care Management Program for children with special needs.

Identify the costs of upfront investments in infrastructure, staffing and using evidence-based practices.

ALIGNMENT

ALIGNMENT

Potential opportunities for aligning care with patients' personal values include:

1. Acknowledging patient values and providing care that supports these values

2. Providing access to non-physician providers who have different care delivery methods, such as nurses, chiropractors, dietitians, acupuncturists, and counselors

3. Offering mental health support

4. Connecting patients to community-based social resources that align with personal values, such as transportation to church or volunteering; and

5. Supporting families and caregivers.

Aligning Care with the Personal Values of Patients with Complex Care Needs | Playbook (bettercareplaybook.org)

TRAINING

TRAINING

- Train staff in critical areas, including:
  - Engagement
  - Assessment
  - Person-centered care
  - Collaboration
  - Evidence-based care

SAMPLE COMPLEX CARE MANAGEMENT PROGRAMS: RESEARCH & PRACTICE INFORMED COMPLEX CARE INTERVENTIONS

Program	Intervention	Outcomes
Camden Coalition	Targeted patient enrollment during hospital admission, primary care practice engagement, patient incentives to overcome barriers to keeping an appointment, and reimbursements to practices for prioritizing patients recently discharged from the hospital.	Medicaid beneficiaries who had primary care appointments within seven days of discharge had significantly lower rates of 30- and 90-day hospital readmissions (a 5 percent and 11 percent decrease, respectively).
CareMore Health	Program was staffed by a multidisciplinary care team consisting of a community health worker (CHW), a social worker (SW), and a PCP. CHWs and other nontraditional healthcare workers. The CHW conducts outreach, engagement, activation, and accompaniment. The SW provides counseling and brief interventions for patients with behavioral health needs and for coordinating referrals to social service agencies and other medical providers.	Reduced total medical expenditures by 37% and inpatient utilization by 59%. Compared with patients randomized to usual care, patients randomized to complex care management had lower costs, fewer IP bed days , fewer IP admissions, and fewer specialist visits.
Health Hennepin County Medical Center's Coordinated Care Center	Ambulatory intensive care unit, providing primary care and behavioral health services through multidisciplinary teams that includes a nurse care coordinator, advanced practice provider, and a social worker supported by psychologists, addiction counselors, and a physician.	Emergency department visits decreased by 9.1 percent between 2012 and 2013, while hospital admissions remained stable. Over the same period, outpatient visits increased by 3.3 percent.

Outcomes of a Citywide Campaign to Reduce Medicaid Hospital Readmissions With Connection to Primary Care Within 7 Days of Hospital Discharge | Health Care Economics, Insurance, Payment | JAMA Network Open | JAMA Network

Hennepin Health: A Care Delivery Paradigm for New Medicaid Beneficiaries | Commonwealth Fund

Impact of Complex Care Management on Spending and Utilization for High-Need, High-Cost Medicaid Patients (ajmc.com)

COMMUNICATION

COMMUNICATION

- Prioritize ongoing communication and coordination among and between the interdisciplinary care team and patient. This can include:
  - Text message alerts, e-portals, regular remote patient monitoring, video chats, huddles, case conferences
- Successful complex care models have a dedicated care coordinator who serves as the information hub and develops ongoing trusting relationships with the patient, their supports, and the healthcare team.

Unsplash

COMMUNICATION: CARE TEAM CONFERENCES

Crucial for improving the quality of care, reducing healthcare costs, and enhancing patient outcomes

Key points about care team conferences with high-cost, high-need patients include:

- Multidisciplinary approach care team conferences facilitate the sharing of information and insights from different specialties
- Coordination of effort
- Regular review and adjustments
- Comprehensive, person-centered care planning
- Data-driven approach

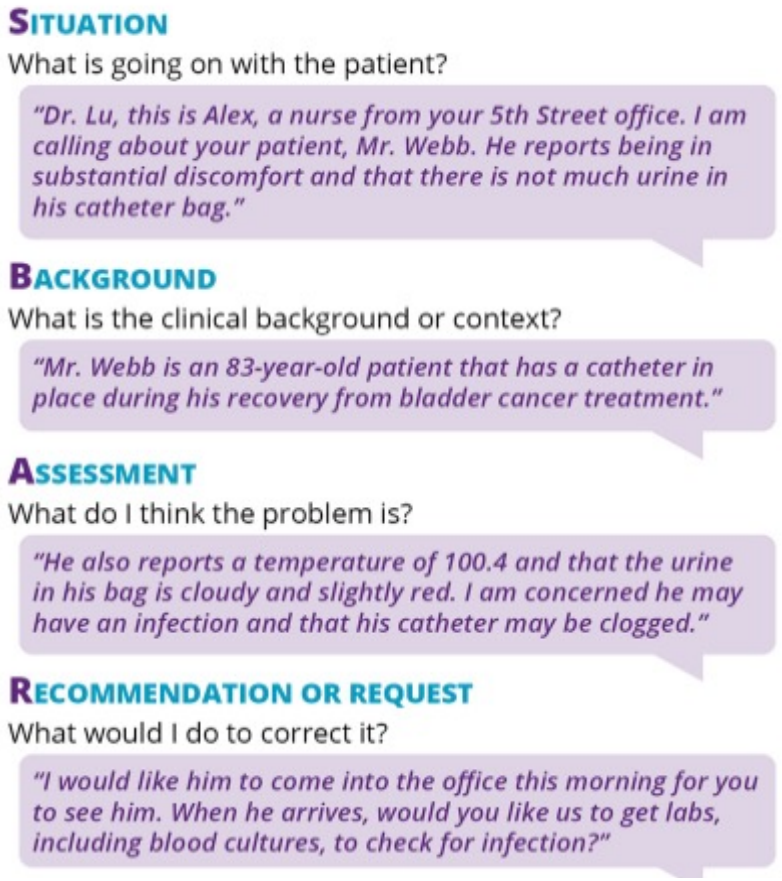
The case review must include, but is not limited to:

- A Provider Champion, PCP
- A behavioral health provider
- Care manager
- Peer, CHW, health navigator
- Other members of the healthcare team

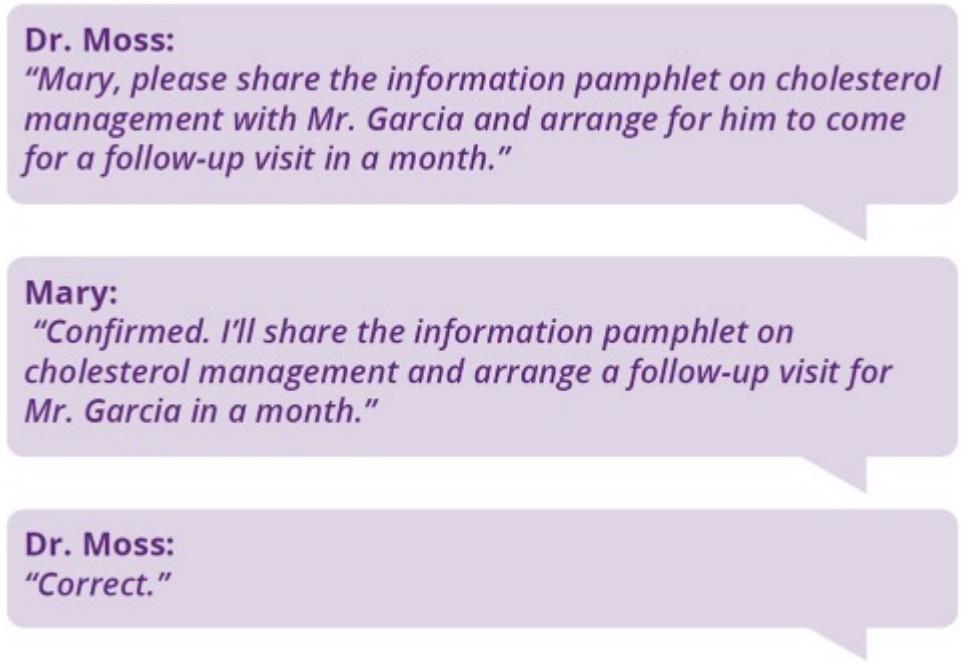
Source: Quality-measure-brief-final.pdf (camdenhealth.org)

COMMUNICATION TOOLS: TEAMSTEPPS

SBAR
A technique for communicating critical information concerning the condition of a patient or another issue affecting the team that requires immediate attention and action.



Check-Back
A closed-loop communication strategy used to ensure that information shared by one team member is correctly understood by another team member.

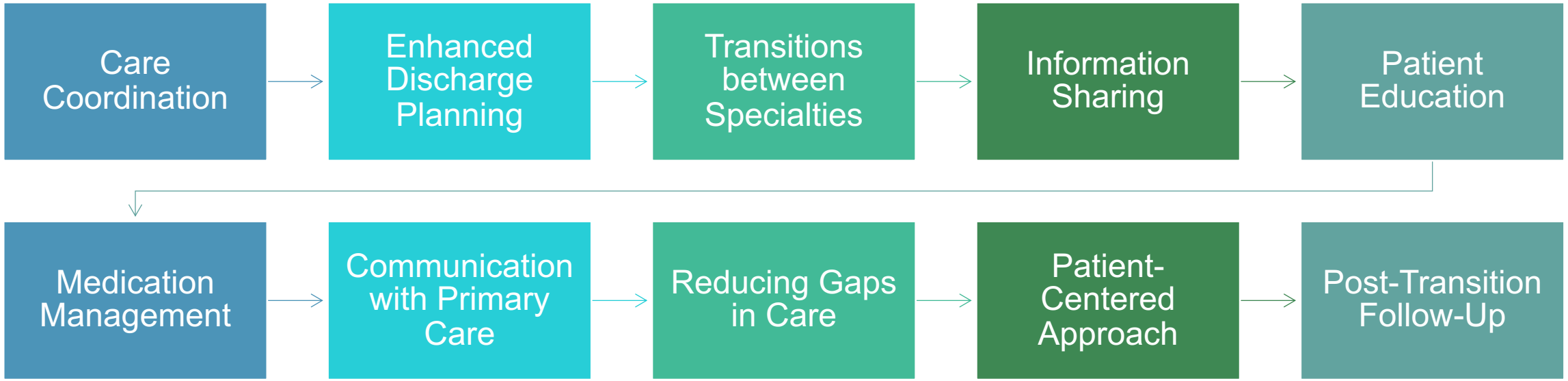


Section 1: Overview of Key Concepts and Tools | Agency for Healthcare Research and Quality (ahrq.gov)

CONTINUITY OF CARE

CONTINUITY

Seamless transitions across time and settings. Key elements include:



MONITORING

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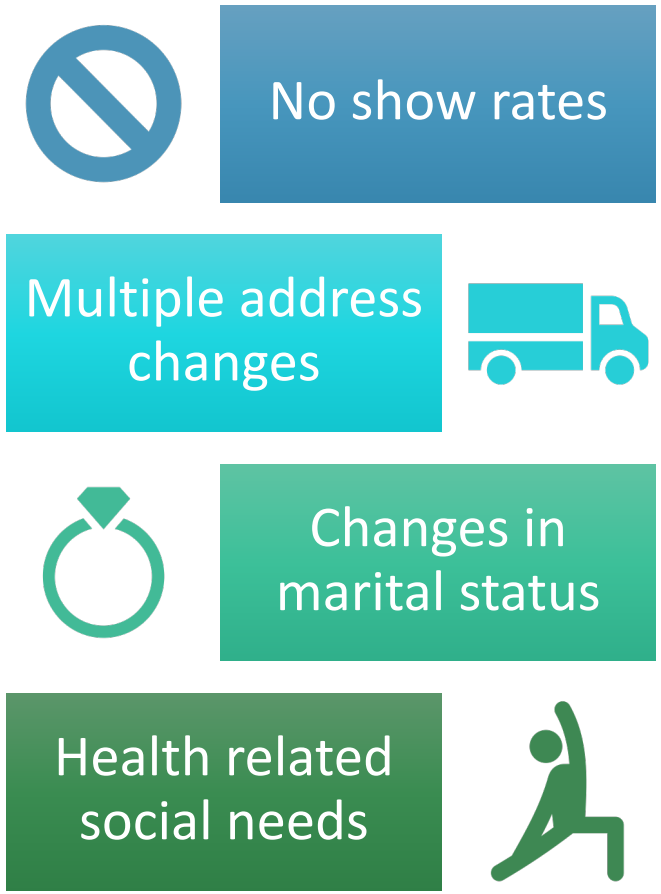
Care team monitoring using dashboards, Admission, Discharge, Transfer (ADT) feeds, SDoH closed loop referrals. Consider proxy measures, such as:



MONITORING

Measure effectiveness/quality of services

- Admissions/readmissions
- Function
- Community tenure
- Medication adherence
- Experience with care
- Retention
- Follow-up
- Social needs
- Goal-concordant care and goal attainment
- Patient-reported outcome measures

Equity: equity can be assessed by stratifying and comparing data by measures like race/ethnicity, gender, insurance status, income or education, neighborhood, and other factors.

SUMMARY

Caring for high-cost, high-need patients requires a comprehensive and collaborative approach that identifies and addresses medical, social, and psychological aspects of care.

Successful programs incorporate

Multidisciplinary team	Comprehensive assessment and risk stratification	Data-driven care	Patient engagement and empowerment	Personalized care plans and patient-centered approach	Care coordination and continuity of care	Medication management

WRAP-UP/NEXT STEPS

BRIEF EVALUATION

1. Overall rating:

1. Poor 2. Fair 3. Average 4. Good 5. Excellent

2. Content Level:

1. Too Easy 2. Just Right 3. Too Advanced

3. Which TA modalities are you interested in for additional TA? *(Select all that apply)*

1. Webinars 2. Individual Coaching 3. Group Coaching

4. Which domains are you interested in receiving additional TA in? *(Select all that apply)*

1. Financial 2. Clinical 3. Legal 4. Business

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UPCOMING SESSIONS & MORE INFORMATION

Upcoming Cohort Sessions:

- Key Considerations for Value Based Payment Arrangements – *Tuesday, Sept. 19 (12-1 PM ET)*

Visit the Medicaid Business Transformation DC web page for more information and upcoming events:

www.integratedcaredc.com/medicaid-business-transformation-dc/

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September 21st

VBP Virtual Learning Collaborative

HMA

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