Better Health and Lower Costs for Patients With Complex Needs

An IHI Triple Aim Collaborative

Informational Call
May 12, 2015
Faculty on Informational Call Today

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Goals Of Call Today

- Answer your questions about the Better Health and Lower Costs for Patients With Complex Needs Collaborative
- Describe the IHI methods and content to be used in the Collaborative
- Describe the activities of the Collaborative
Why This, Why Now?

Why Focus On Patients With Complex Needs whose Care is Costly? Why Now?
BHLC: A Triple Aim Initiative

The Triple Aim is a guiding concept to simultaneously improve three dimensions:

- Improve the health of the populations;
- Improve the patient experience of care (including quality and satisfaction);
- and
- Reduce the per capita cost of health care

BHLC Collaborative will help you:

- Redesign and implement comprehensive care designs to serve your patients with complex needs (who are at high risk of driving high costs in the future)
- Establish measures and build a portfolio that will result in better health outcomes, a better care experience, and lower total cost
- Whether your organization has already established a program or is just starting this work, our goal is to help you make a positive and sustainable difference for this population
Distribution of Health Expenditures for the U.S. Population, by Magnitude of Expenditure, 2009

Source: Agency for Healthcare Research and Quality - analysis of 2009 Medical Expenditure Panel Survey
Cost Concentration in Canada

Health Care Cost Concentration:
Distribution of Health expenditure for ON, 2007

On average, healthcare spending is highly concentrated, with the top 5% of the population (ranked by cost) accounting for the 60% of expenditure.
Persistence in Spending

Figure 1. Persistence in the level of health care expenditures, U.S. civilian noninstitutionalized population, 2008 to 2009

Percentage of population with same percentile rank in 2009

Top 1%: 20.0%
Top 5%: 38.0%
Top 10%: 44.8%
Top 20%: 54.4%
Top 30%: 63.1%
Top 50%: 75.0%
Lower 50%: 73.9%

Percentile rank by health care expenditures, 2008

Guiding Principles

1. Identification of individuals at high risk for future cost
2. Impactability of the identified individuals
3. Cost effectiveness of your intervention or redesign – must understand the cost drivers in your population and region
4. Potential interventions or redesign – what we are currently doing isn’t working, so how can we change it?
5. Build your program to reach all who will benefit - plan for financial and operational sustainability
Roadmap

Choose your macro population and learn its segments
Identify individuals who are good candidates for your enhanced care design
Develop a care model to fit the needs and strengths of the target population
Recruit people into care
Engage people in care
Partner within and outside of your organization

Learn to operate sustainably at full scale: 5 to 25 then 5x
Act for the Individual, Learn for the Population

Chronic Heart Failure

COPD

Schizoaffective Disorder

History of Addiction to IV Drugs and Alcohol

Developmental Disorder

Hepatitis C

Type 2 Diabetes

October 2011:
Admitted to the hospital for almost a month for acute complications of his Chronic Heart Failure. Had a previous 25 day admission 5 months earlier.

66 Year Old African American Man
Learn your way to an effective model

Patient-Driven Care
- Learn the target populations’ needs, strengths, and preferences
- Align services to meet needs, build on strengths, and respond directly to patient preferences

Refine care using 5X approach: 5 → 25 → 125
- Conserves resources
- Pacing is realistic
- Try out strategies: Failure is a teacher
- Develop work processes to ensure consistency
- Cultivate ROI
Common Care Models

- A high-cost intensive model that is supported by nurse care management (among other resources) and primary care, usually serving a relatively small panel of patients.

- A model that primarily focuses on the redesign and retraining of the primary care team to provide wraparound care.

- A model that enhances good primary care with a new skill set: non-traditional health care workers who assist patients in the community and align social determinants.
New Methods for This Population

- Engagement methods tailored to this population
- Very high functioning, responsive and proactive primary care
- New resources: health education, integrated behavioral health, care coordinators, community health workers, co-located pharmacy, strong links to community programs

Integrated teams with strong workforce support, including:
- Intensive onboarding of new team members
- Attention to signs of burn-out
- Stress management techniques built into team huddles
- Very clear job tasks and deliberate role delineation
## San Francisco Health Network Population

<table>
<thead>
<tr>
<th>Total TA Population</th>
<th>Size</th>
<th>Complex Population</th>
<th>Size</th>
<th>% of total costs</th>
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</thead>
<tbody>
<tr>
<td>Low income San Franciscans who receive primary care in San Francisco Health Network. All have Medicare and/or Medicaid, or are uninsured.</td>
<td>80,000</td>
<td>Patients receiving primary care in San Francisco Health Network who have been hospitalized 3 or more times in the last year or whose primary care provider thinks they will have many hospitalizations in the coming year</td>
<td>468</td>
<td>49% of total hospital days in the TA population</td>
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<tr>
<td>Team member</td>
<td>Roles</td>
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<tr>
<td>RN Care Manager</td>
<td>Initial assessment and Care Plan</td>
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<td></td>
<td>Complex clinical issues and medication issues</td>
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<td></td>
<td>Clinical back-up for Health Coach</td>
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<td>Health Coach (Medical assistant or</td>
<td>Outreach to patients</td>
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<tr>
<td>health worker)</td>
<td>Coaching toward care plan goals</td>
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<td></td>
<td>Focus on self-management</td>
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<td></td>
<td>Primary point of contact for patients</td>
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<td>Primary Care Provider</td>
<td>Refer patients</td>
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<td></td>
<td>Collaborate with CM team</td>
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<tr>
<td></td>
<td>Titrate medications, plan diagnostic work ups</td>
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<tr>
<td>Data Analyst</td>
<td>Manages referrals, data tracking and analysis, reporting</td>
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<tr>
<td>Social Worker</td>
<td>Consultant to team about referrals (entitlements and community-based programs), mental health, and addiction</td>
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<td></td>
<td>If &gt;0.5FTE, case load with primary behavioral health issues</td>
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<tr>
<td>Nurse Manager</td>
<td>Ensure CCM model is utilized by the teams</td>
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<td></td>
<td>Track progress toward program goals</td>
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<td></td>
<td>Day to day supervision</td>
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<tr>
<td>Medical Director</td>
<td>Program development and evaluation</td>
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<td>Lead quality improvement</td>
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**Care Management Program: Enrollment and Levels of Care**

**ASSESSMENT:** The team RN and health coach conduct a comprehensive assessment, either in the home, in clinic, or by phone. From this information, they develop a care plan and assign the patient a level of care.

**LEVELS OF CARE:** The assigned level of care determines the intensity of our care management for each patient. Patients can move up and down the levels of care at any time depending on need.
Hospital Days & ED Visits

Hosp days/ED Visits per Patients

Hosp days
ED

-12 mos -11 mos -10 mos -9 mos -8 mos -7 mos -6 mos -5 mos -4 mos -3 mos -2 mos -1 mos +1 mos +2 mos +3 mos +4 mos +5 mos +6 mos +7 mos +8 mos +9 mos +10 mos +11 mos +12 mos
<table>
<thead>
<tr>
<th>Total TA Population</th>
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<th>Complex Population</th>
<th>Size</th>
<th>% of total costs</th>
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<tbody>
<tr>
<td>Islanders in the top 1% of health care spending within a select group of chronic conditions who present in Community Health* for Health PEI services with an intervention identified for hypertension, anxiety and/or diabetes.</td>
<td>10,266</td>
<td>Islanders in Community Health with hypertension + anxiety + diabetes.</td>
<td>1,678</td>
<td>$11M</td>
</tr>
</tbody>
</table>

*Community Health involves majority of community-based services in the province.
Target Population: Islanders who utilize Health PEI services identified for Diabetes + Hypertension + Anxiety interventions

- About 1% of total PEI population
- On average, each patient utilizes Health PEI’s physician services 18 times a year (for any condition), which include:
  - Family physician visits 12 times a year
  - Walk-in clinic visits once a year
  - Specialty clinic visits twice a year
  - Emergency department visits 2 to 3 times a year
  - Hospital admissions 0.4 times per year
- In the past 3 years:
  - 44% of these patients have been admitted to the hospitals
- Average length of stay is 12 days

(The above utilization statistics are based on 277 samples of the 1678 patients whose family physicians are located in the Queens East region of PEI.) Y2011/12 – FY2013/14 (Data source: Health PEI Medicare Office, Cactus Inpatient Data)
Care Model & Elements
A designated care coordinator in a distributed model

Health PEI has developed care delivery processes to ensure consistent care

1. In conjunction with family physicians, a designated care coordinator contacts ‘patients with familiar faces’ via phone first, then face-to-face

2. The visit includes a physical health check-in and a medication review and a PHQ 4 and/or GAD 7 assessment if indicated

3. Using a minimal intervention approach during the visit, the care coordinator assists the patients to identify their priority for lifestyle health behavior change including an assessment of readiness for change

4. Education/information provided to patients on available social and community resources relevant to needs

5. Direct referrals are made via phone by the care coordinator, or by the patient during their visit
   - Ie: income support, diabetes education centre (social worker, registered nurse or dietitian), COPD clinic, Living a Healthy Life, hypertension clinic, community mental health or a community support organization (cancer society, arthritis society)

5. A letter is sent to the family physician informing them of the patient’s identified goal and interventions, referrals made and information/education provided on social and community resources

6. A follow-up phone call/face-to-face meeting is arranged with/by the care coordinator
# Chronological List of Key Interventions Tested for Our Care Model

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Intervention</th>
<th>Step in Framework*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 27/14</td>
<td>Health/services survey developed and pre-tested with 3 people.</td>
<td>Identification</td>
</tr>
<tr>
<td>Dec 15/14</td>
<td>First 5 Islanders identified from list of high utilization and existing electronic records reviewed. Family physician contacted about participation after 5 chosen. Phone call surveys completed.</td>
<td>Recruitment</td>
</tr>
<tr>
<td>Dec 18/14</td>
<td>Results of phone call surveys reviewed/analyzed. Plan developed for follow-up with the 5 patients in a face-to-face meeting. Decision made to test Shared Collaborative MH Care algorithm in meeting needs.</td>
<td>Recruitment</td>
</tr>
<tr>
<td>Jan 16/15</td>
<td>Plan to ramp up to 25 patients with follow-up of initial 5 patients. Decision made to test including family physician in initial identification of patients to participate. Decision made to test contact 5 patients by phone and request a face-to-face, and another 5 to do survey and then request a face-to-face.</td>
<td>Engagement</td>
</tr>
<tr>
<td>Jan 26/15</td>
<td>5 patients participating to date; one declined. Awaiting names of patients to connect with family physicians for their identified top 5 patients.</td>
<td>Engagement/partnering w/ referrals, family physicians, community orgs</td>
</tr>
<tr>
<td>March 26/15</td>
<td>No case coordinator in place x 1 month – new coordinator recruited.</td>
<td></td>
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<tr>
<td>April 17/15</td>
<td>7 patients participating to date. In collaboration with family physicians, continue to identify top 5 patients.</td>
<td>Engagement/partnering w/ referrals, family physicians, community orgs</td>
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</tbody>
</table>
# Measurement Plan

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Measures</th>
<th>Data Sources / Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population Health</strong></td>
<td><strong>Self-rated health status</strong></td>
<td></td>
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<tr>
<td></td>
<td>- In general, would you rate your physical health is...</td>
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<tr>
<td></td>
<td>- In general, would you rate your mental health is...</td>
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</tr>
<tr>
<td></td>
<td>(Poor, Fair, Good, Very Good, Excellent)</td>
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<td></td>
<td><strong>Functional status</strong></td>
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<td>- During the past 30 days, for how many days did poor physical and mental</td>
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<td>health keep you from doing your usual activities, such as self-care,</td>
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<td></td>
<td>work, or recreation?</td>
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<td><strong>Experience of Care</strong></td>
<td><strong>Patient evaluation of health services</strong></td>
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<tr>
<td></td>
<td>- <strong>Quality:</strong> Rate the health services you received in the past 12</td>
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<tr>
<td></td>
<td>months</td>
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<td></td>
<td>- <strong>Access:</strong> In the past 12 months, how satisfied were you with the</td>
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<td>amount of time you waited to receive health services?</td>
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<td>- <strong>Efficiency:</strong> In the past 12 months, how well do you think the health</td>
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<td>services you used were arranged to meet your needs?</td>
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<tr>
<td></td>
<td><strong>Patient evaluation of self-efficacy</strong></td>
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<tr>
<td></td>
<td>- How well do you think you manage your health?</td>
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<td></td>
<td>- How confident are you that you can carry out your plan?</td>
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<tr>
<td><strong>Per Capita Cost</strong></td>
<td><strong>Provider Claims per Patient ($)</strong></td>
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<td></td>
<td><strong>Process</strong></td>
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<tr>
<td></td>
<td><strong># Clients Engaged with a Case Coordinator</strong></td>
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<tr>
<td></td>
<td><strong>Client Engagement rate</strong></td>
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</table>

**Data Sources / Reporting Frequency**

- Patient Survey [Annual]
- Patient Survey [Semi-Annual]
- Patient Assessment [Quarterly]
- Provider Claims Data [Quarterly]
- Case Managers [Monthly]
Questions
Learning Collaborative Benefits

- Practical methods to redesign care to achieve better health outcomes at lower costs
- Consistent attention to sustainability and return on investment
- Access to and ongoing support from expert faculty
- Joining a community of practice to support teams through complex systems change
- Access to a host of practical tools and resources
- Guest speakers on cutting-edge topics related to enhanced care design

**Investment: $20,000 per team (covers all team members)**
Collaborative Faculty

Cory Sevin
IHI Director

Catherine Craig
Faculty

Kevin Nolan
Improvement Advisor

Alan Glaseroff
Faculty

Ann Lindsay
Faculty

Eleni Carr
Faculty
### SCC Triple Aim Results

<table>
<thead>
<tr>
<th>Inpatient Admissions</th>
<th>ER Visits</th>
<th>Patient Experience</th>
<th>HEDIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>-39%</td>
<td>-25%</td>
<td>99&lt;sup&gt;th&lt;/sup&gt; percentile</td>
<td>&gt;90&lt;sup&gt;th&lt;/sup&gt; percentile</td>
</tr>
</tbody>
</table>

271 patients with at least 6 months enrollment
Hospital Utilization Rates for HRP cohort

non-OB Inpt Stays PMPY

12 mos PRE: 1.7 PMPY
4+ mos POST: 1.1 PMPY
35% ↓

n= 424 clients engaged in program on or before 9/1/13
ED Utilization Rates for HRP cohort

ED Visits - PMPY

12 mos PRE: 8.5 PMPY
4+ mos POST: 5.6 PMPY
34% ↓

n= 424 clients engaged in program on or before 9/1/13

CareOregon
better together
Learning Collaborative Structure

- 12 month learning collaborative beginning July 2015
- 30-40 organizations
- Building the Triple Aim Infrastructure call series for new teams
- Two core tracks with monthly webinar sessions
  - Foundations of Care Redesign
  - Scale-up and Sustainability
- Additional tracks to support your work
  - Leadership
  - Measurement
- Three Learning Sessions, one will be face-to-face
- Use of QI methods and rapid, iterative learning
- Access to continuing education credits (physician, nursing, social work) for learning sessions

All Teach, All Learn
Track 1: Foundations of Care Redesign

Goals within 12 months:

- Identify a specific high-risk population that will be the focus of your work
- Deeply understand the assets and needs of your target population to inform the services needed to improve outcomes
- Develop and execute new care designs to test for impact and cost savings
- Increase the scale and reach of successful care designs
- Learn what is needed for operational and financial sustainability
- Establish process and outcome measures to use available data to track health, patient experience, and cost savings
Track 2: Scale-up and Sustainability

Goals within 12 months:

- Achieve scale-up of enhanced care designs and approach full scale, i.e., reach all individuals who would benefit from the care model.
- Develop reliable work processes to support effective delivery of enhanced care to the target population at scale.
- Develop robust learning systems during scale-up to support operationally and financially sustainable enhanced care programs for the target population.
- Demonstrate positive outcomes in at least two of the three prongs of the Triple Aim: health outcomes, patient experience, and costs.
Participants May Include

- Integrated systems of health delivery and financing operating anywhere in the world
- Accountable Care Organizations (ACOs) or integrated delivery systems that are pursuing other new payment models
- Physician group ACOs
- Private or publicly funded health plans committed to improving value
- Primary care or multi-specialty physician groups interested in risk sharing and cost savings arrangements
- Organizations embarking on innovative, population-focused designs
- Safety-net health care systems facing rising demands and flat budgets
- Regional coalitions collaborating on a community-wide health issue or working to ensure access for all while controlling costs
- Public health departments or social agencies focused on populations with complex health issues
- Private or public employers seeking better health and value for employees
Questions and Discussion
July 2015

“Better Health and Lower Costs for Patients with Complex Needs-Year 2
An IHI Triple Aim Offering”

Contact:
BetterHealthLowerCosts@IHI.org