The Playbook: Better Care for People with Complex Needs

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Agenda

- Overview of The Playbook
- Lessons learned: Priorities for the Field
- Q&A
The Better Care Playbook is supported by a funders collaborative that includes The Commonwealth Fund, The John A. Hartford Foundation, the Peterson Center on Healthcare, the Robert Wood Johnson Foundation and The SCAN Foundation.
Caring for High-Need, High-Cost Patients — An Urgent Priority

David Blumenthal, M.D., M.P.P., Bruce Chernew, 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
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 140 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 practical tools can I use to redesign 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.
Vital Statistics:

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

- 30,482 unique visitors
- 135,163 page views
- 1,309 registered users

Users are highly engaged
- 50% of users who visit a resource page click on a link
- Over 4.5 minutes per visit
- On average 3 pages per visit
- On average 45% are return visitors

* Through January 23, 2018
Lessons Learned: Priorities for the Field
Make the case for value-based care

Key takeaway: We need more evidence to support the business and humanitarian case for better care for individuals with complex needs.
Why invest in redesigning care for people with complex needs?

When people with complex needs require medical services, they often encounter a health care system that is poorly coordinated, inefficient, and expensive. They face many challenges such as chronic conditions, behavioral health issues, trauma history, food insecurity, and homelessness. High-need patients often experience poor outcomes due to avoidable emergency department visits and hospital stays that do not improve their health.

Meeting the needs of these people is an economic necessity. Health plans, accountable care organizations, and providers cannot achieve their quality and cost goals without improving care for people with complex needs. The broader implementation of promising care models is critical to improve outcomes, lower overall costs of care, and build further evidence for the most effective approaches.
Making the human case
Build evidence for effective care models

Key takeaway: There is no “one size fits all” approach to support people with complex needs.
Case studies and practical guidance

CareMore: Improving Outcomes and Controlling Health Care Spending for High-Needs Patients

**KEY QUESTIONS ANSWERED**
- What's an example of a successful approach to reducing costs for Medicare Advantage patients?
- How does the CareMore model work?
- What have the results been, and what are the plans for spread?

**KEY THEMES AND TAKEAWAYS**
This resource is a case study of CareMore, a Medicare Advantage plan and medical provider based in Cerritos, California, that serves 130,000 enrollees in Medicare and Medicaid managed care plans across six states.

- CareMore’s business model is to identify high-risk patients and surround them with coordinated services. It invests capitated payments from Medicare in prevention and early intervention programs for all members, and provides supplemental benefits such as patient education programs and transportation to its Care Centers.

- CareMore partners with independent primary care physicians in its networks to refer high-risk patients to its Care Centers, where multidisciplinary teams deliver and coordinate care.

The Hospital at Home Model: Bringing Hospital-Level Care to the Patient

**KEY QUESTIONS ANSWERED**
- What are the benefits and challenges of providing hospital-level care in the home?
- What are the results of this kind of program?

**KEY THEMES AND TAKEAWAYS**
This resource is a case study of the Hospital at Home program at Presbyterian Healthcare Services in Albuquerque, New Mexico, which offers patients who require hospitalization for conditions with well-defined treatment protocols the option of receiving care at home.

- Teams of physicians, nurses, and other clinical staff make house calls to administer medications, arrange for lab tests, and provide education to patients with congestive heart failure, chronic obstructive pulmonary disease, and other conditions that can be safely treated at home. Patients must live in metropolitan Albuquerque and be covered by the system’s health plans.

- Physicians visit once daily and may spend up to an hour with patients. Nurses and home health aides also spend significant time with patients. When needed, Presbyterian also sends social workers and rehabilitation specialists.

- Patients benefit from being in a familiar environment, and providers gain an understanding of the challenges patients face at home, related to anything from following treatment recommendations to maintaining a healthy diet.

- Presbyterian's commercial and Medicare Advantage health plans pay a bundled rate for each program admission.
Promote authentic 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.
Engaging Family Caregivers in Programs for People with Complex Needs

December 12, 2017

Research has shown that many people with complex health needs are assisted by family members, who often operate as de facto care coordinators.

Yet most care delivery systems don’t proactively identify and meaningfully engage or support family caregivers in visits or care plans.

Jennifer Wolff, PhD, is a gerontologist and health services researcher who studies family caregiving and optimal models of care delivery for adults with complex health needs. We asked her a few questions to learn how complex care programs can better engage families in care for patients with complex needs.

How did you get started working on family engagement for patients with complex needs?

This is not something that I dreamed up myself. Initially, I was very interested in care delivery for individuals with complex health needs and disabilities. It was through my work as a health services researcher that I saw that individuals who have the most complex care needs are often the heaviest users of health services. And the quality of their care is notably poor.
Provide structured support for implementers

Key takeaway: There is an appetite for some sort of structured learning and technical assistance in support of redesign care systems.
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 Academy 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 10-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?

How Partners HealthCare Uses Predictive Analytics to Identify Patients with Complex Needs (Part 1 of 2)

November 1, 2017

One of the challenges in identifying patients with complex needs to enroll in an enhanced care program is that past health care utilization doesn’t necessarily predict future utilization.

Successful programs develop and refine criteria to enroll patients for care management. At Partners HealthCare, the Integrated Care Management Program (ICMP) has used an evolving algorithm to identify patients using claims data and information from the electronic medical record. The program also allows primary care providers to offer their insights as to which patients would most benefit from the program, taking into account the diversity of services available at various Partners sites.

The Better Care Playbook spoke with Christine Yergel, PhD, Director of Evaluation and Research, Partners HealthCare Center for Population Health, to better understand how the ICMP uses predictive analytics to identify patients to enroll. (To learn more about how the program is managed, please visit Part 2 of this interview.)

How does Partners HealthCare use predictive analytics in the ICMP?
Play: Define the Care Management Team

**Play Strategy**

Most complex care programs use a team approach to provide multiple services to people with complex needs while also trying to control costs. While many programs invest their resources in high-facility patients, a team-based delivery model can help control costs by allowing medical providers to focus on the top of the care pyramid. The integration of non-medical services to other team members such as community health workers or case managers.

The goal of this playbook is to develop and develop your care model.

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**FOR MORE INFORMATION**

- For an in-depth discussion on staffing, review the Care Redesign Guide's recommendations on developing and staffing a care model.
- View slides from the Cambridge Health Alliance about staffing a complex care management program.
- Learn more in these resources in the Playbook:
  - To learn more about the community health worker role, please read "Diffusion of Community Health Workers Within Medicaid Managed Care: A Strategy to Address Social Determinants of Health."
  - To learn more about the care manager role, please read "Care Management Plus: Strengthening Primary Care for Patients with Multiple Chronic Conditions."
  - Learn how to effectively partner with community resources.
  - Learn how to use a Three-Part Data Review to understand the root causes of High health care utilization among your patients.

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**TIPS AND TRICKS**

- Try making a list of the tasks that need to be done, and a list of all the team members who might be available to do the work. Then, mix and match. Challenge yourself to think, "Do I really need a medical professional to do that? Would a community health worker do it even better?"
- In addition to the core care team, you may consider staffing in these roles: behavioral health specialist, pharmacist, dietitian, and case management specialist.
- While many complex care programs aim to reduce costs, it's important not to try to cut costs by overloading team members with patients. Caseloads that are too large can lead to staff turnover and lower quality of care.
- Consider team members that may be outside your organization, working in community resources. Could you meet some patient needs through partnerships with other services, rather than providing them yourself?
Designing a blueprint for complex care at Putting Care at the Center

Putting Care at the Center 2017 will be more than just an educational and networking opportunity for attendees. With the brightest minds in health care innovation and transformation at the Los Angeles Westin Bonaventure November 15-17, the National Center for Complex Health and Social Needs (National Center) is working to harness the energy of the conference into defining the field of complex care.

At the conference’s interactive Beehive, attendees will have the opportunity to be “field designers,” helping to create the Complex Care Blueprint, a joint project of the National Center, the Center for Health Care Strategies (CHCS), and the Institute for Healthcare Improvement (IHI). The Complex Care Blueprint will be a deep dive into the current and potential players complex care field, and a distillation of the priorities and goals of the movement.