Integrating Social Services into Care for the High-Need, High-Cost Population

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Speakers

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Jeff has been the Executive Director of the Task Force since 2015. He previously served as General Counsel for the Federation of American Hospitals.

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Diane has been with PBGH since 2001. She directs the California Quality Collaborative, a statewide program to reengineer quality in outpatient settings.

Katie Clay

Director, Health Home Program
Hudson River HealthCare
Tarrytown, NY

Katie has been working with the Health Home program at HRHCare since its inception in 2011. The Health Home program serves 30,000 patients across 10 counties in New York.

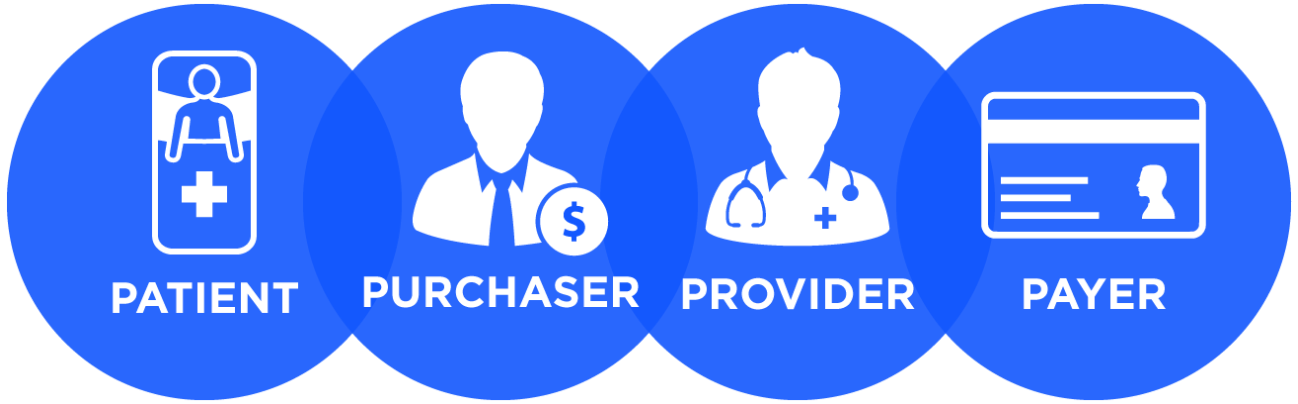
Agenda

- Introduction to the Health Care Transformation Task Force
- Understanding the High-Cost Patient
- Developing a Social Services Integration Framework
- Case Study: Hudson River HealthCare
- Summarizing Thoughts
- Q&A
- Task Force Improving Care to High-Cost Patients Work Group Activities

Who we are: Our mission to achieve results in value-based care

The Health Care Transformation Task Force is an industry consortium that brings together patients, payers, providers, and purchasers to align private and public sector efforts to clear the way for a sweeping transformation of the U.S. health care system. We are committed to rapid, measurable change, both for ourselves and our country.

We aspire to have 75% of our respective businesses operating under value-based payment arrangements by 2020.

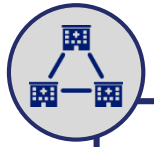


Our Members: Patients, Payers, Providers and Purchasers committed to better value

The Task Force's guiding principles outline a financially and operationally viable and sustainable approach

- **Shift 75% of our respective businesses to be under value-based care contracts by 2020**
- Design programs that provide reasonable returns to deliver the triple aim of better health, better care and reduced total cost of care at or below GDP growth
- Equip market players with all tools necessary to compete in new market focused on people-centered primary care
- Encourage multi-payer participation and alignment to create common targets, metrics, and incentives
- Share cost savings with patients, payers, and providers to ensure adequate investment in new care models
- Foster transparency of quality and cost metrics in a manner that is accessible to, and easily understood by, consumers
- Support the needs of disadvantaged populations and help strengthen the safety net providers who serve them

TF Work Groups drive rapid-cycle product development



Improve the ACO Model

Develop aligned public-private action-steps and recommendations to improve the design and implementation of the ACO model

Develop Common Bundled Payment Framework

Create detailed principles and tools to align and evaluate episode definitions/pricing for public/private payer bundled payment programs.

New Model Development - Improving Care for High-cost Patients

Create, test and recommend a delivery/payment model that allows a wide range of provider organizations, including in rural areas with little to no current MA/ACO penetration, to engage in population health by starting with highest-cost patients (top 5%).

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Understanding the high-cost patient

22% Of total spending by top 1%

90% Of total spending by top 30%

43% Of persistent spenders are 65 or older

40% Of persistent spenders between the ages of 45-64

High-cost patients can be identified by three subtypes:

Can impact with intervention

1) Patients with Advanced Illness

Often nearing end of life, and responsible for some of the highest costs. Patients often die within 1-2 years. Opportunities to provide home and community-based services that cut down on unnecessary hospitalizations.

2) Patients with Persistent High Spending Patterns

Characterized by multiple chronic conditions. Many face psychological and social barriers to care. Many are good candidates for care management/social support services.

3) Patients with Episodic High Spending

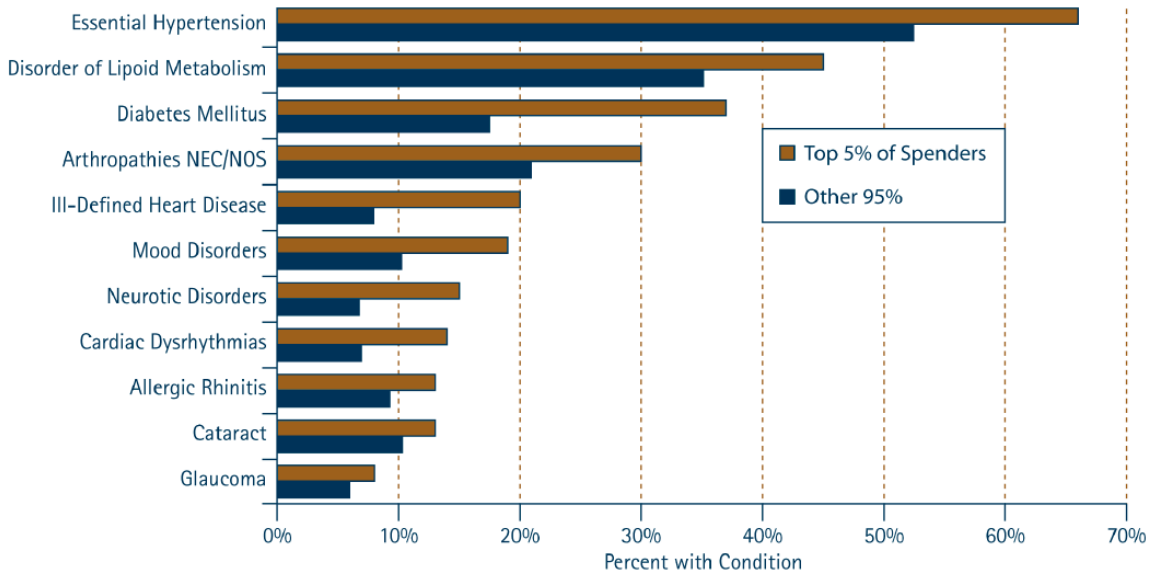
Have increased costs due to a sudden event, but costs decrease as the condition resolves. Difficult to target proactively because cost spikes are usually not predictable.

Sources: Proactively Identifying the High Cost Population. *Health Care Transformation Task Force,* 2015. NIHC Concentration of Health Care Spending. *National Institute for Health Care Management Foundation*, July 2012.

Understanding the high-cost patient: Common conditions

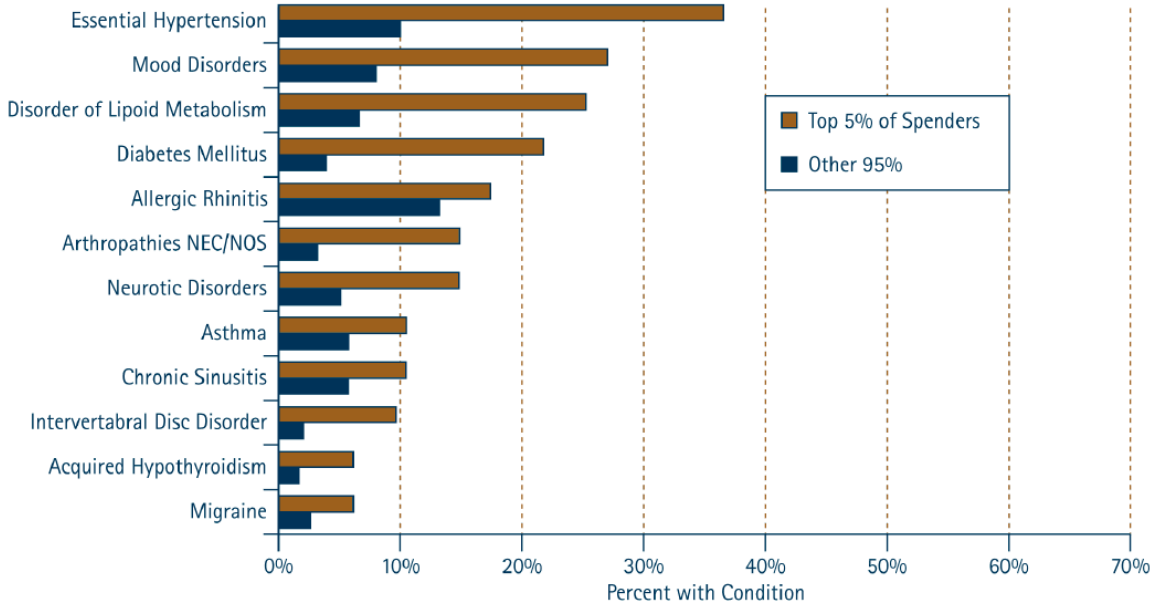
Hypertension, hyperlipidemia, and diabetes are among the top conditions common to both elderly and non-elderly high spenders. While these conditions are not necessarily directly tied to high costs, poor management can lead to unnecessary medical costs – and may be mitigated by robust care management and social support.

Common Conditions Among Elderly High Spenders (2006)



NIHCM Foundation analysis of data in The Lewin Group, "Individuals Living in the Community with Chronic Conditions and Functional Limitations: Closer Look," Jan. 2010. Featured conditions are among the most prevalent for both high and non-high spenders.

Common Conditions Among Non-Elderly High Spenders (2006)



NIHCM Foundation analysis of data in The Lewin Group, "Individuals Living in the Community with Chronic Conditions and Functional Limitations: Closer Look," Jan. 2010. Featured conditions are among the most prevalent for both high and non-high spenders.

Why social services are critical for high-cost patients

- Many conditions can be triggered or worsened by factors such as lack of adequate housing, reliable transportation, food, and strong interpersonal relationships
- Patients may skip necessary medication doses or doctor appointments, leading to a decline in health and subsequent hospitalizations
- If providers are unaware of underlying social challenges, they risk characterizing patients as intentionally noncompliant
- Social services integration enables providers to team with other professionals, such as social workers, to treat patients more proactively and holistically

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Why an integration framework?

- **Identified Need:** Industry stakeholders have identified a need to better identify social services in a given community, and then integrate those services into existing care management programs in order to improve outcomes and lower costs for the most vulnerable populations.
- **The Tool:** This framework offers principles for integration to help organizations assess the needs of their patients and their progress toward integration. It also provides direction on how to proceed through the integration process.
- **Use:** The framework is not intended to detail every process necessary for successful integration of social services. It is meant to assist provider organizations in structuring their thinking around integration, specifically those that are starting from scratch.
- **A Foundation for Further Work:** Various foundations and other organizations provide specific tools, resources, and processes necessary for successful integration of social services. These detailed resources will provide depth to this high-level framework, and further validate this step-wise approach.

Social service integration framework

Integrate social services into broader care delivery and care management process

Identify Target Population

Determine the following:

- How impactable individuals will be identified
- Which events and conditions have potential for highest impact from patient and system financial perspective

Identify Social Needs

Identify areas of highest social service need for the designated population

Resources:

- *Hospital Community Health Needs Assessments*
- *Behavioral Risk Factor Surveillance System*

Assess Community Resources

Assess existing social service providers and capacity to meet priority social service needs:

- Public agencies (federal, state, local)
- Public programs
- Community-based organizations

Develop Social Service Integration Model

Based on available community resources and capacity to engage, determine best governance model and financing structure:

- Joint Venture
- Closed-loop Referral Network
- Delegated Community Partnership

Implement Social Integration Structure

- Define common priorities and specific responsibilities
- Adopt shared measures of success
- Implement systems to coordinate
- Evaluate process
- Refine model

Reference methodologies: Commonwealth Fund State Policy Framework, Institute of Medicine's Community Health Improvement Process

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Background : Hudson River Healthcare (HRHCare)

HRHCare opened over 40 years ago thanks to a group of four African American women who spearheaded efforts to address the lack of accessible and affordable health care services in their hometown of Peekskill, NY.

HRHCare Peekskill, New York

Hudson River HealthCare overview

HRHCare Network

- 28 Federally Qualified Health Centers (FQHCs)
- +175,000 patients
- Health Home Program at HRHCare
  - 5 years
  - 10 counties of the Hudson Valley and Long Island (largest in New York State)
  - Includes urban and rural areas
  - +30,000 patients
  - 45 Care Management Agencies

Federal structure of the Health Home Program

1. States submit state plan amendment (SPA) to Center for Medicare and Medicaid Services (CMS)

2. States choose their target population and service goals

3. Federal Approval

Health Home

A Health Home isn't a place, but an extensive network of services for Medicaid recipients in the community. The Health Home Care Manager coordinates and provides access to all of the services an individual needs to stay healthy, out of the hospital and emergency room.

Health Home population

Target Population

Medicaid recipients with:

- ≥ 2 chronic conditions
- HIV/AIDS
- Any serious mental illness

Sally

Before Health Home Services:

- Health Status: unstable, many hospitalizations
- Social Support: Reliant on her care manager for support on day-to-day tasks

Image sources: © Can Stock Photo / leremy, Hudson River HealthCare

Patient testimony

After Health Homes Services:

- Health Status:
  - Stable
  - No hospitalizations
- Social Support:
  - Independent
  - Working for one our of Care Management Agencies as a Care Manager

Health Home Population

5 core care management services offered

- Comprehensive Care Management
- Care Coordination & Health Promotion
- Comprehensive Transitional Care
- Patient & Family Support
- Referral to Community & Social Support Services

Patients have different avenues to join the program

Two ways patients can become part of the Health Home program:

Community Referrals

- Individual seeks care management services or is referred by someone
- Enrollment is increasingly through these referrals

State Identification

- State identifies Medicaid/Duals patient as a “list case” for outreach based on claims history, utilization data, and diagnostic information
- Health Home program is notified to reach out to patient

Image source: © Can Stock Photo / Aleutie

Identifying the social needs of the target population

- First step is to conduct a comprehensive assessment of medical, behavioral, and social needs
- Next, assessment is used to develop a care plan with the patient
- Care plan encompasses goals and priorities identified by both the patient and the care manager

Strategic partnerships with community resources

- Care management agencies have been working in their field locally for 30-40 years
- We chose providers who had engrained relationships with public agencies, public programs, and community-based non-profit organizations, because they know exactly what resources are in their community

Developing the integration model

- Social services are integrated within broader care management infrastructure
- Governance model best described as Delegated Community Partnership
- Financing model is based on a per-member per-month care management rate funded by shared State and Federal Medicaid dollars

Establishing and implementing the social integration model

- **Defining common priorities and specific responsibilities**
  - Best practices coming out of historic Case Management Agencies in NYS
  - Expertise regarding chronic conditions as a primary care organization
  - Feedback from our Care Management Agencies
- **Adopting shared measures of success**
  - Revise our policies and procedures based on best-practices
  - Quarterly meetings with all contracted Care Management Agencies
  - Evaluate Care Management Agencies using performance

Establishing and implementing the social integration model, cont.

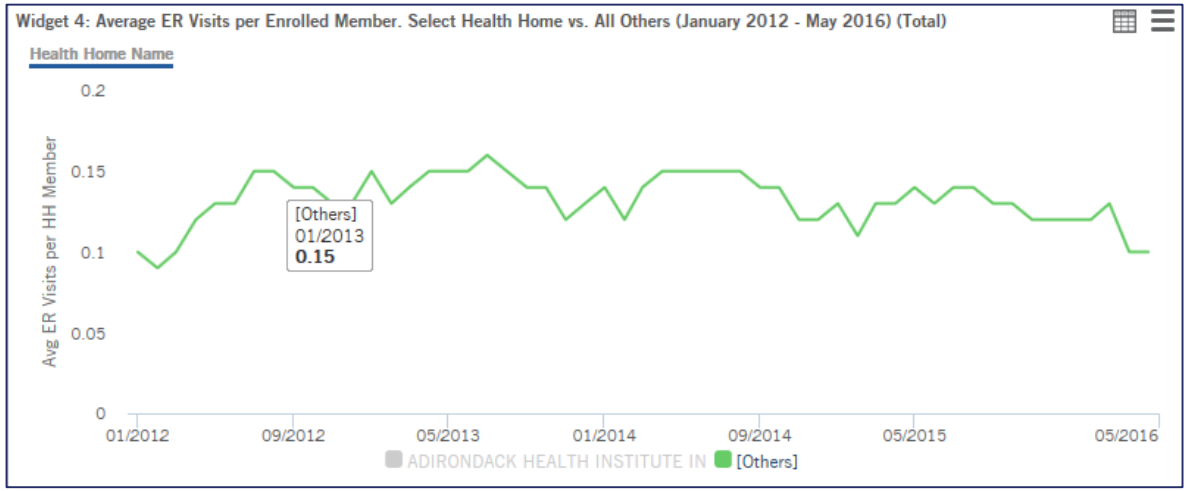
- **Implementing systems to coordinate**
  - Care Management Software
- **Evaluating process**
  - Evaluate process metrics, outcome metrics, claims data
- **Our refinement model is made up of two layers**
  1. Internal
     - Evaluation and adoption of best practices using data and feedback from our Care Management Agencies
  2. External - Coalition of New York State Health Homes
     - Gathers best practices from across the state to provide input to the Department of Health

Seeing results in the Health Home program

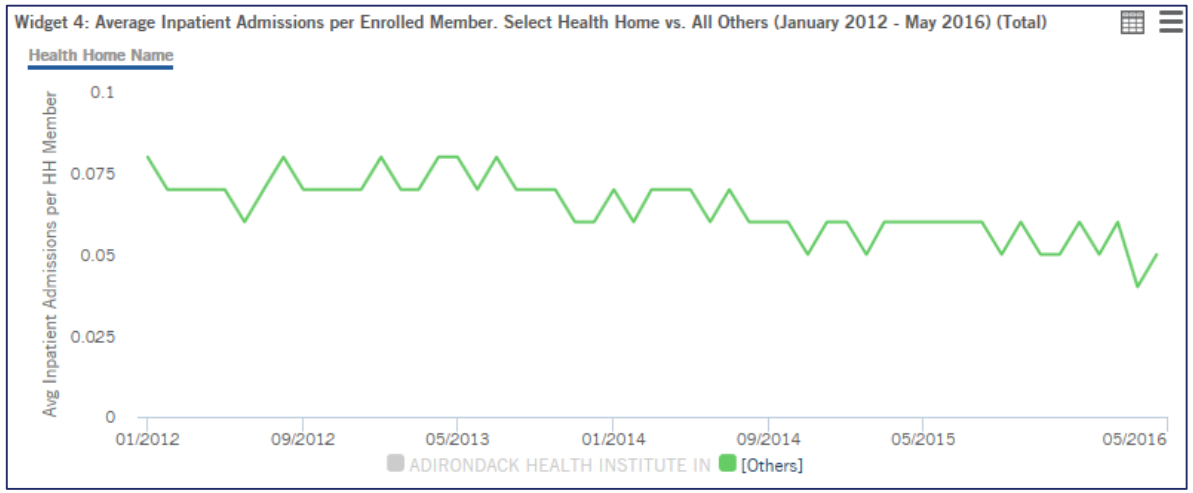
Emergency Room Utilization

ER Utilization Decrease:

The average number of ER visits per Health Home member has decreased by 7.21% for members enrolled in a Health Home over the past 12 months over the previous 12 months.



Inpatient Admissions



Inpatient Utilization Decrease:

The average number of inpatient admissions per Health Home member has decreased by 9.08% in the past 12 months over the previous 12 months.

Source: Medicaid Analytics Performance Portal (MAPP)

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Summarizing thoughts

- While there are ongoing efforts across the public and private sector to integrate social services into health care delivery, much more needs to be done in this space
- Addressing behavioral health and social needs for high-need, high-cost patients is an important part of preventing frequent medical utilization
- Though some organizations are already proving successful at developing integrated, person-centric care management, others need more guidance – hence the need for a robust model for operational integration, and more information on financing models that can support non-medical services

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Thank you!

QUESTIONS?

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HCTTF Improving Care to High-Cost Patients Work Group

About the Work Group

- Comprised of HCTTF members and those with interest/experience in high-need, high-cost patients
- Participants include health systems, commercial payers, foundations, and patient advocacy organizations

Previous Projects

- Whitepapers on:
  - Care management financing models
  - Best practices for care management programs
  - Identification of the high-need, high-cost patient population

Future Topics

- Integration of behavioral health services
- Funding mechanisms for social service and behavioral health integration
- Best practices in care management contracting

To access our materials and the recording of this webinar, please visit: http://hcttf.org/high-need-cost-patients/