

# High-Need, High-Cost Patients: Challenges and Promising Models

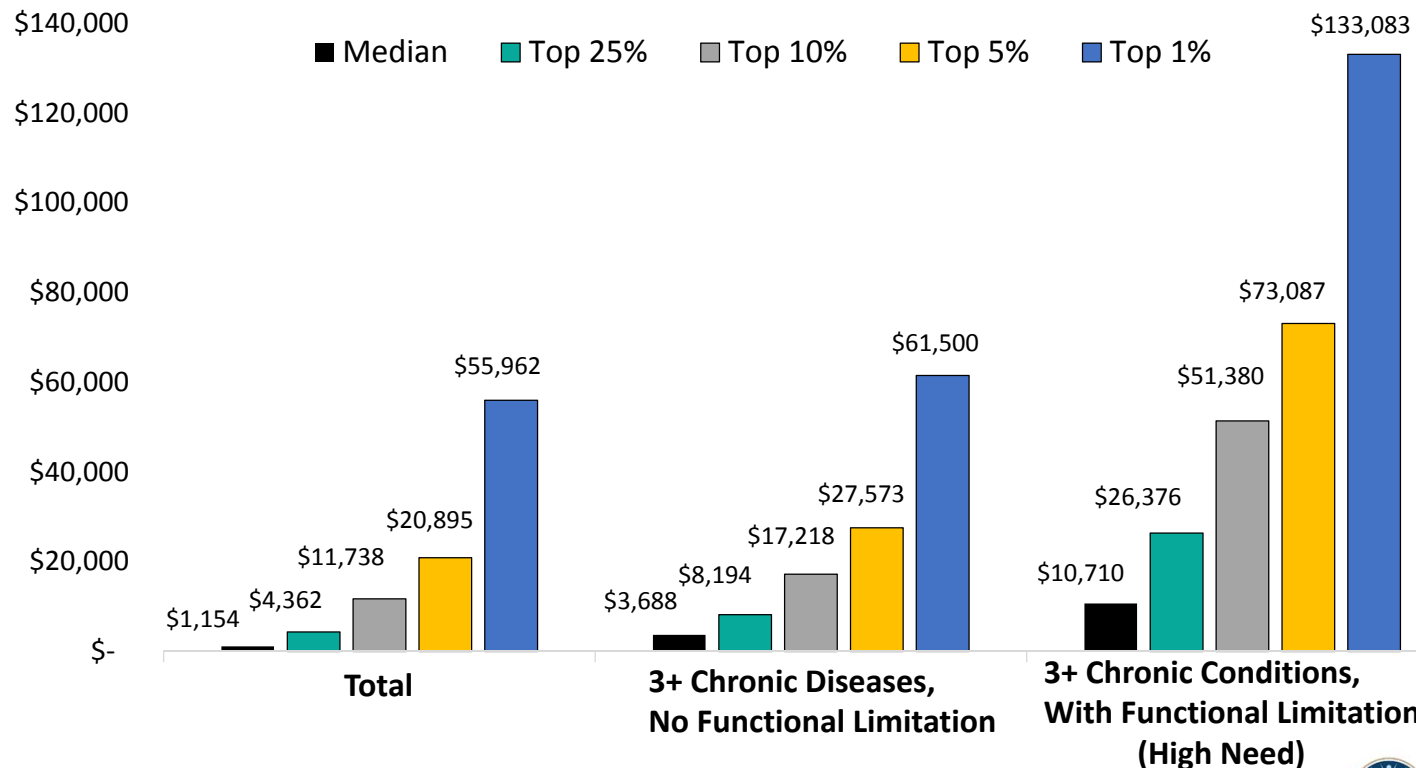
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August 29, 2016



## Who Are High-Need, High-Cost Patients?

- High-need, high-cost adults = 3+ chronic diseases and a functional limitation, affecting their ability to care for themselves or perform routine daily tasks
- HNHC adults are more likely than the total adult population to:
  - be age 65 or older
  - have low incomes
  - have public insurance
  - use hospital emergency department (3x more often)
  - be hospitalized (5x more often)

# Health Care Spending Is Higher at Every Level for Adults with High Needs than for Adults with Multiple Chronic Conditions Only

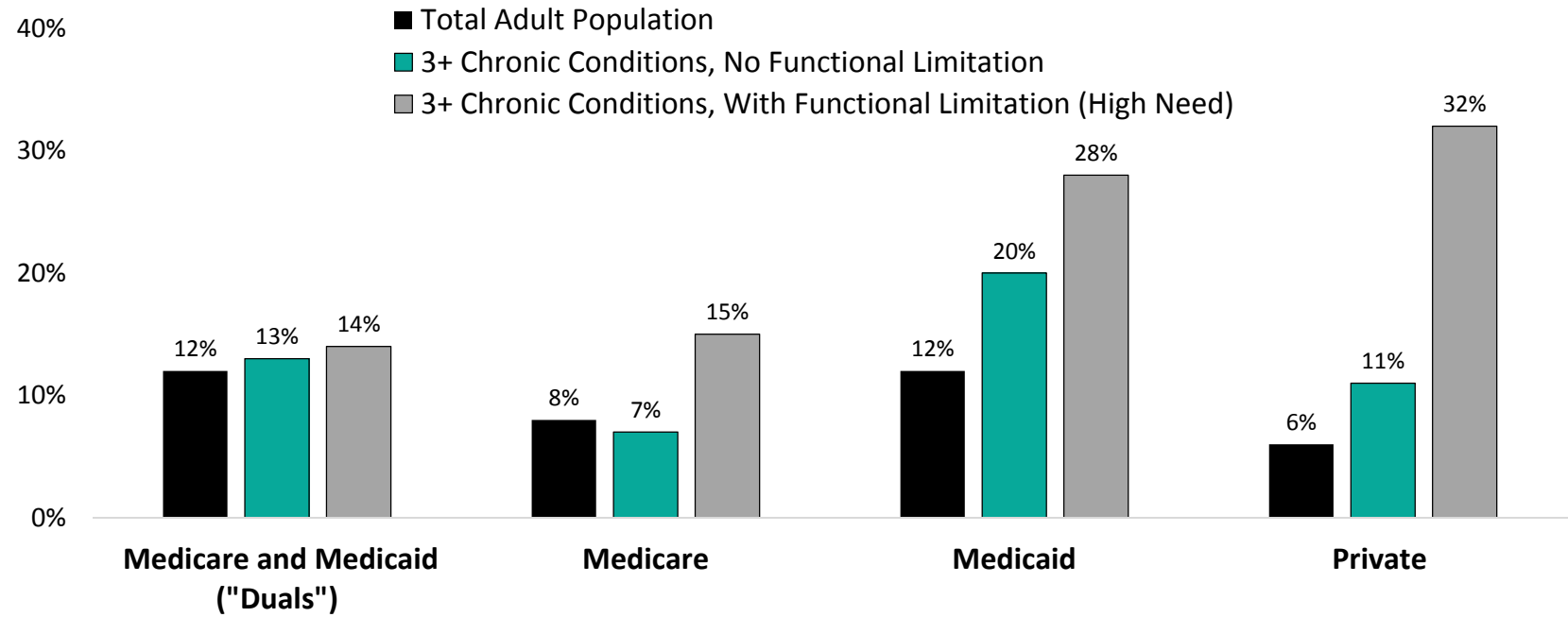


Notes: Non-institutionalized civilian population ages 18+. Data: 2009-2011 Medical Panel Expenditure Survey (MEPS). Analysis by C. Salzberg, John's Hopkins University.



# Despite High Utilization, This Population Still Has Unmet Needs

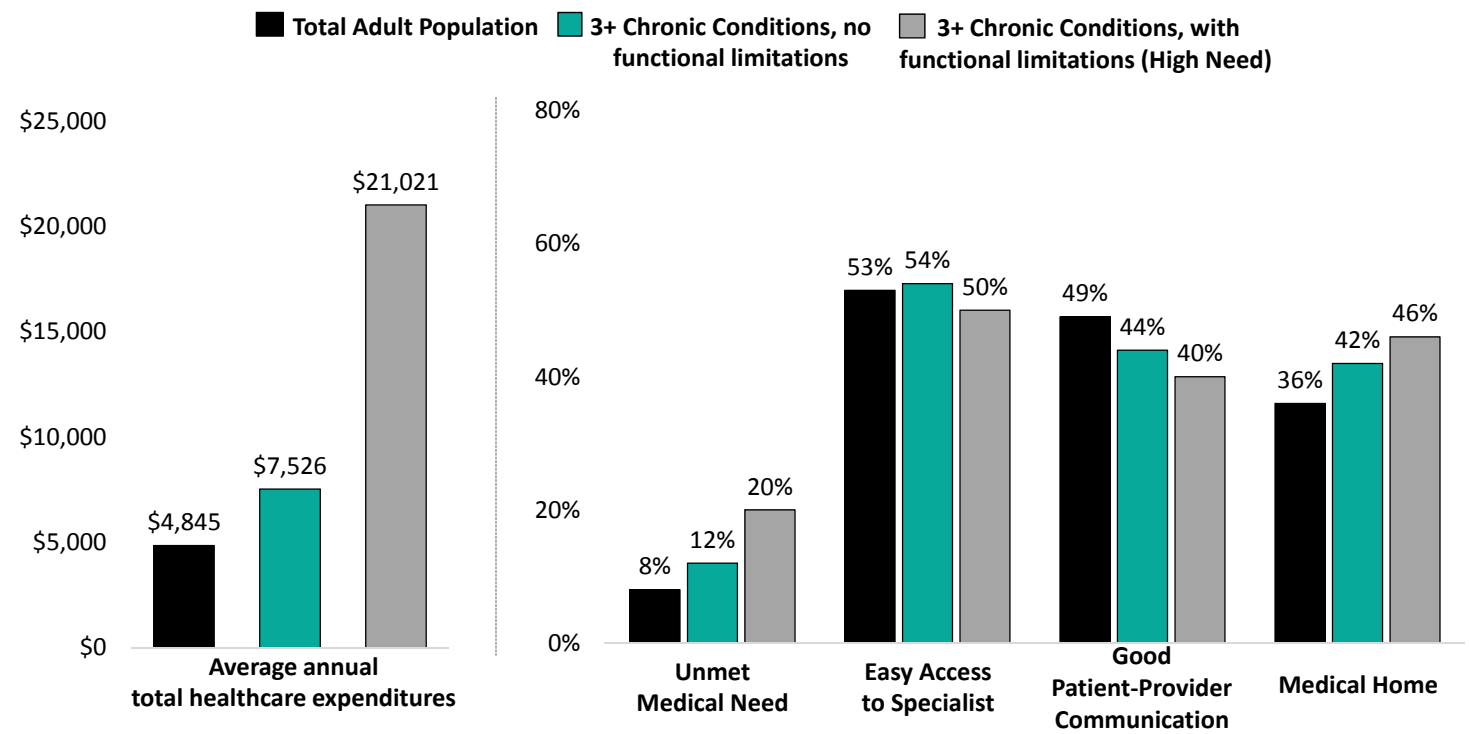
Percent with unmet medical need:



Notes: Non-institutionalized civilian population ages 18+. Unmet medical need means the respondent reported they needed necessary health care or prescription medicine but were unable to receive it or were delayed in receiving it during the past 12 months.  
 Data: 2009-2011 Medical Panel Expenditure Survey (MEPS). Analysis by C. Salzberg, John's Hopkins University.  
 Source: C. Salzberg, S. Hayes, D. McCarthy, et al. *Health System Performance for the High-Need Patient: A Look at Access to Care and Patient Care Experiences*. The Commonwealth Fund, August 2016.



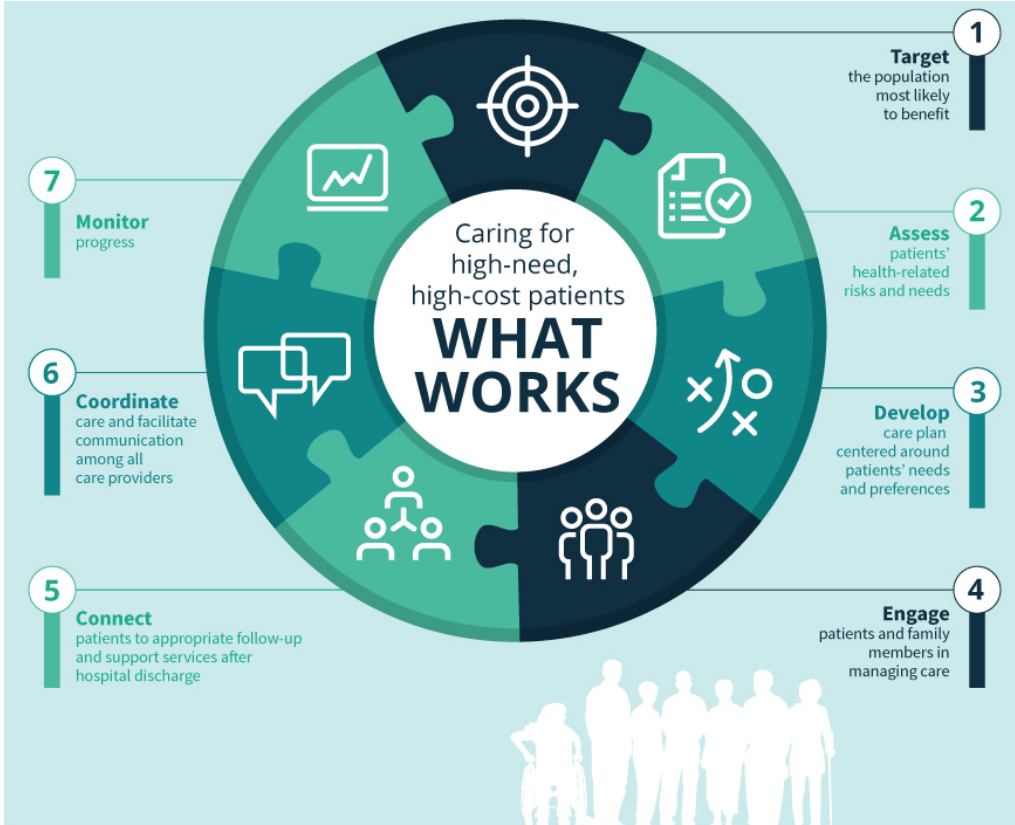
# High-Need Adults Spent More on Health Care But Were Less Likely to Report That the Health System Works for Them



Notes: Non-institutionalized civilian population ages 18+.  
 Data: 2009-2011 Medical Panel Expenditure Survey (MEPS). Analysis by C. Salzberg, John's Hopkins University.



# Caring for High-Need, High-Cost Patients: What Works



Source: D. McCarthy, J. Ryan, and S. Klein. *Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis*. The Commonwealth Fund, October 2015.



## Barriers to Spread and Scale of Promising Programs

- **Misalignment of financial incentives**—few programs align value-based payment with value-based physician compensation; financial incentives do not always accrue to the party that undertakes the investment
- **Lack of flexibility to cover nonmedical services** – unaddressed personal and social needs can adversely affect health, utilization and costs
- **Lack of interoperable electronic health record systems**—coordination among disparate sites is difficult
- **Professional uncertainty and lack of training to take on new roles** – technical assistance need for care management and coordination
- **Limited evidence from multisite interventions**—without further testing, it can be difficult to make the case for scaling up



## Five Foundation Collaborative

- **Goal:** To support health care organizations participating in value-based payment models adopt evidence-based interventions for high-need, high-cost adults that improve person-level outcomes and lower overall costs of care.
- **Playbook:** Foundations have partnered with the Institute for Healthcare Improvement to create a dynamic, online resource to assist risk-bearing organizations (e.g., ACOs, Medicare Advantage plans) implement evidence-based interventions to meet the needs of this complex population.
- **NEJM Perspective** published July 27, 2016



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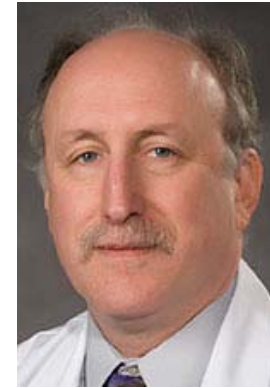
## Today's Panelists



Karen Davis, Ph.D.  
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Katherine Hayes, J.D.  
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Virginia Commonwealth  
University Medical Center



## Questions

- TBD and can be added on Monday morning (e.g., not circulated in advance)
- This slide would appear at end of all four decks.