The Business Case for Addressing the Health of Highly Vulnerable Populations

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This webinar is sponsored by the AHLA Public Interest Committee

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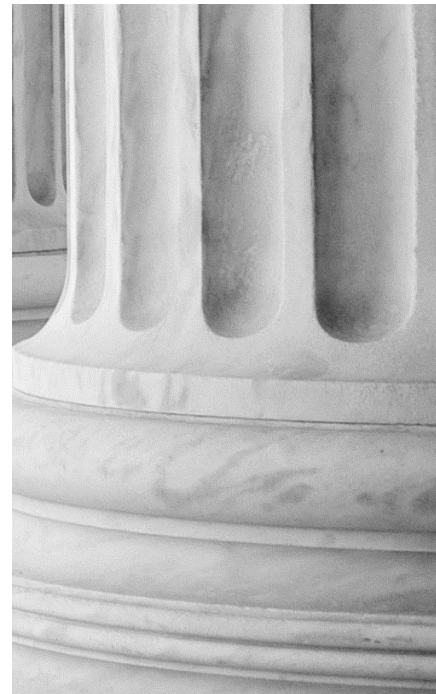
The Business Case for Addressing the Health of Highly Vulnerable Populations
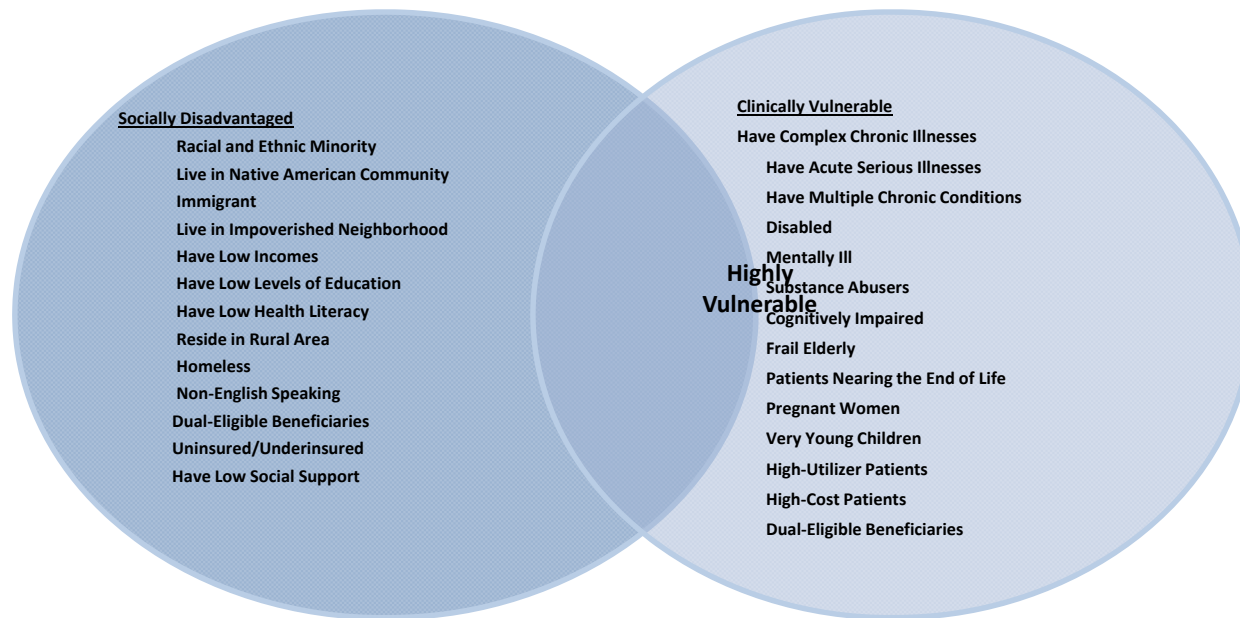
Doug Hastings, JD
Chair Emeritus
Epstein Becker Green

What are Vulnerable Populations?

- 15% of population = 85% of health care costs; 5% = 50%

- Multiple chronic conditions

- "Super Utilizers", especially of ED

- Includes socially disadvantaged and clinically vulnerable

- As baby boomers cross into old age, virtually all are at risk of becoming highly vulnerable; for them, the distinctions between insurance coverage, entitlements, and charity care may become irrelevant

Socially and Clinically Vulnerable Populations

Socially Disadvantaged
- Racial and Ethnic Minority
- Live in Native American Community
- Immigrant
- Live in Impoverished Neighborhood
- Have Low Incomes
- Have Low Levels of Education
- Have Low Health Literacy
- Reside in Rural Area
- Homeless
- Non-English Speaking
- Dual-Eligible Beneficiaries
- Uninsured/Underinsured
- Have Low Social Support

Clinically Vulnerable
- Have Complex Chronic Illnesses
- Have Acute Serious Illnesses
- Have Multiple Chronic Conditions
- Disabled
- Mentally Ill
- Substance Abusers
- Cognitively Impaired
- Frail Elderly
- Patients Nearing the End of Life
- Pregnant Women
- Very Young Children
- High-Utilizer Patients
- High-Cost Patients
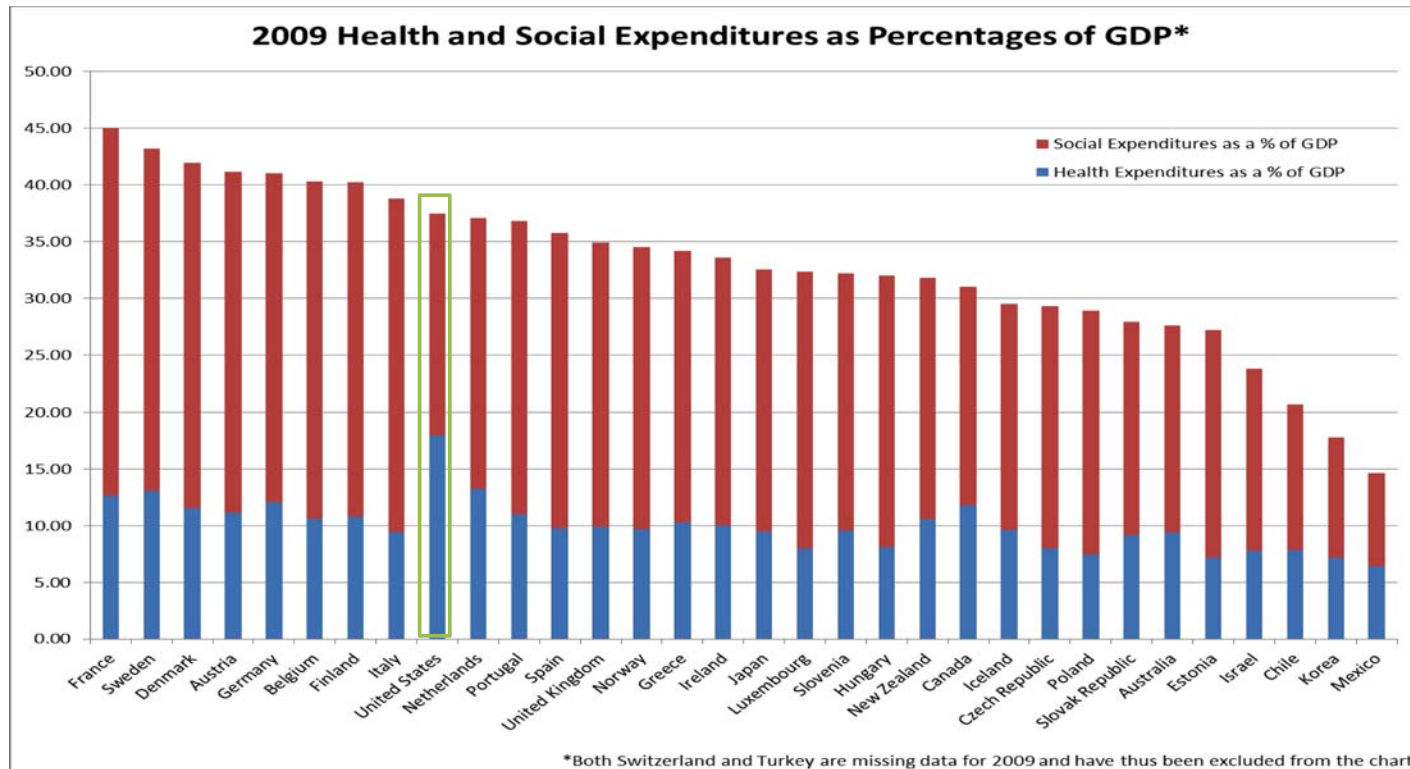- Dual-Eligible Beneficiaries

Highly Vulnerable

"It is with this highly vulnerable group that ACOs may have the most potential to make notable gains in cost and quality and to reduce overall disparities."

Lewis V, Larson B, McClurg A, Boswell R, Fisher E. The Promise and Peril of Accountable Care for Vulnerable Populations: a framework for overcoming obstacles. *Health Affairs (Millwood)*. 2012;31(8):1778.
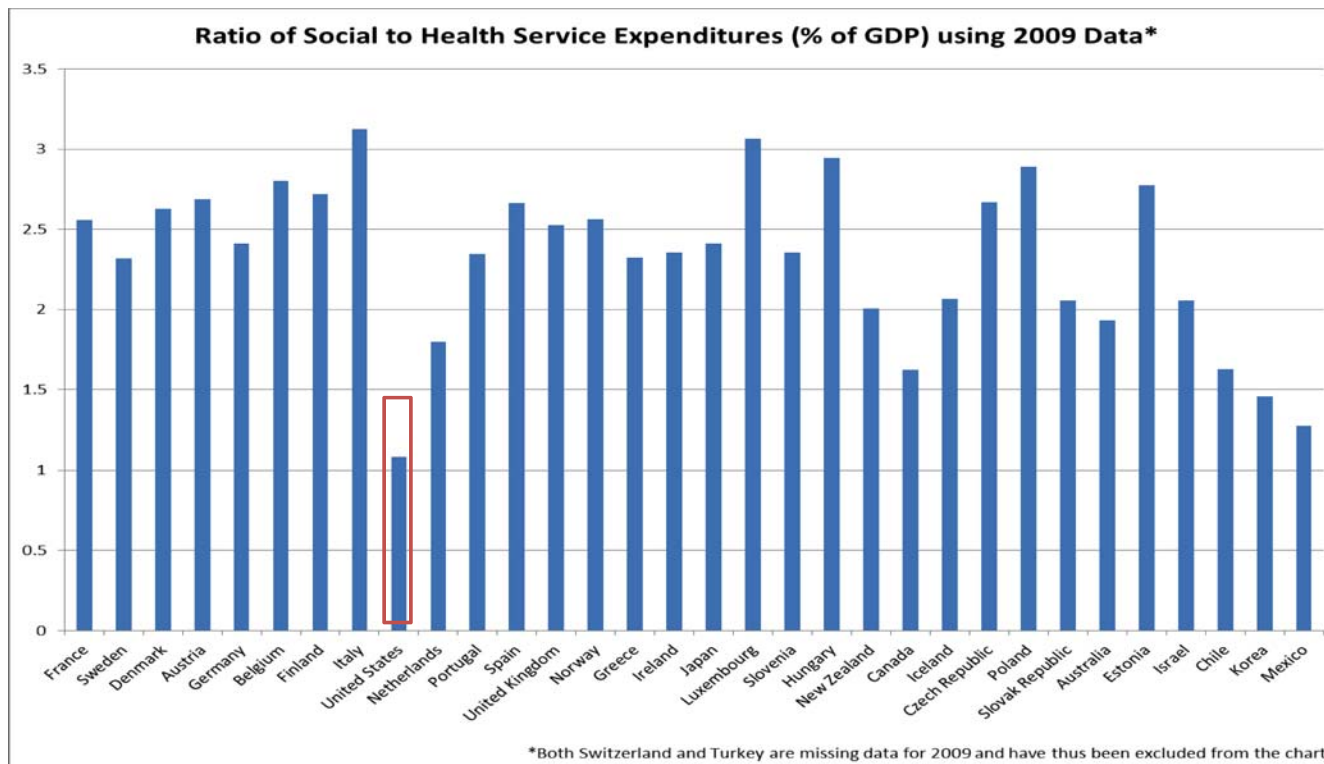
The American Health Care Paradox

2009 Health and Social Expenditures as Percentages of GDP*

Legend:
- Social Expenditures as a % of GDP
- Health Expenditures as a % of GDP

*Both Switzerland and Turkey are missing data for 2009 and have thus been excluded from the chart.

Source: Bradley and Taylor, The American Health Care Paradox, 2013

The American Health Care Paradox

Ratio of Social to Health Service Expenditures (% of GDP) using 2009 Data*

*Both Switzerland and Turkey are missing data for 2009 and have thus been excluded from the chart.

Source: Bradley and Taylor, The American Health Care Paradox, 2013

Crossing the Quality Chasm – IOM, 2001

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- Between the health care we have and the care we could have lies not just a gap, but a chasm. The need for leadership in health care has never been greater."

- **"Health care should be safe, effective, efficient, <u>patient-centered</u>, <u>timely</u>, and <u>equitable</u>."**

- "What is perhaps most disturbing is the absence of real progress toward restructuring health care systems to address both quality and cost concerns, or toward applying advances in information technology to improve administrative and clinical processes."

The Affordable Care Act – 2010

Reduced Payments for
Avoidable Complications

Value Based
Purchasing

Medicare
Advantage Plan
Bonuses

Accountable Care
Organizations

Title III

Hospital Inpatient
Quality Reporting

Bundled Payments

Readmissions
Penalties

Physician Quality
Reporting System

Meaningful Use

Medical Homes
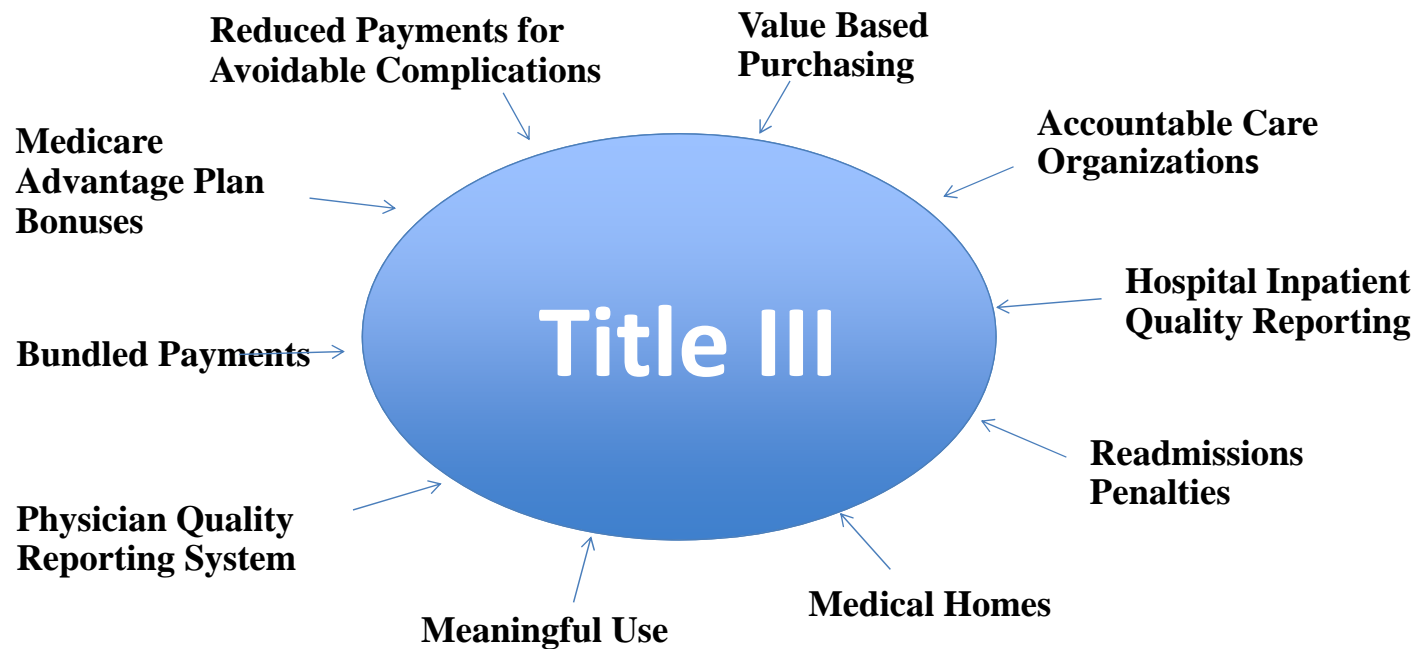
Time to Act – 2014

Report Issued By Committee Led By Economists Mark McClellan and Alice Rivlin

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- Our nation is unhealthy, and it is costing us all through poorer quality of life and lost productivity. Health in America is worse than in other developed nations on more than 100 measures.

- To become healthier and reduce the growth of spending on both public and private medical care, we must create **A SEISMIC SHIFT** in how we approach health and the actions we take.

- As a country, we need to expand our focus to address how to stay healthy in the first place.

- This will take a revolution in the mindset of individuals, community planners and leaders, and health professionals.

- It will take new perspectives, actors, and policies, and will require seamless integration and coordination of a range of sectors and their work.

- This shift is critical for both the health and economic well-being of our country.

Time to Act – Key Data Points

Nearly **1 in 3** three children is overweight or obese

3 in 4 Americans ages 17 to 24 are ineligible to serve in the U.S. military, because they are inadequately educated, have criminal records, or are physically unfit

Poor health results in the U.S. economy losing **$576 billion** a year, with 39 percent, or $227 billion, of those losses due to lost productivity from those who are ill

Medicare would save billions of dollars on preventable hospitalizations and re-admissions if every state performed as well as the top-performing states in key measures of health

More than **one-fifth** of all U.S. children live in poor families, and nearly half of Black children live in particularly unhealthy areas of concentrated poverty

1 in 5 Americans live in unhealthy neighborhoods that are marked by limited job opportunities, low-quality housing, pollution, limited access to healthy food, and few opportunities for physical activities

Caring for Vulnerable Populations – AHA
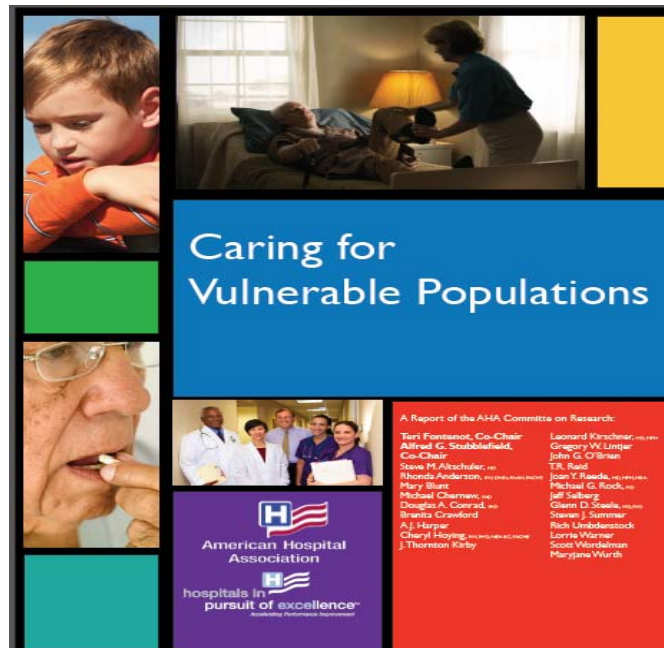
- Community health needs assessment requirement of IRC Section 501(r), set forth in the ACA, is an important opportunity for hospitals to gain better information to serve vulnerable populations

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What Should We Do?

Time to Act	Accountable Care for Vulnerable Populations	Caring for Vulnerable Populations
• Invest in early childhood development for all children • Revitalize neighborhoods and fully integrate health into community development • Incent healthcare professionals and institutions to broaden their missions from treating illness only to helping people lead healthy lives	• Encourage the development of ACOs with the financial and social service capability to serve vulnerable populations • Work with public and private payers to develop contractual arrangements that recognize the start-up challenges, but back-end rewards of success in working with vulnerable populations • Promote rural and regional collaborations	• Hospitals should develop community partnerships with public health departments • Providers should make regular comprehensive assessments of each individual's life circumstances • Providers should adopt cultural competency and equity of care standards
Robert Wood Johnson Foundation	**Dartmouth Institute**	**AHA**

The Population Health/Vulnerable Populations Business Case

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- Improves Lives

- Expands access to the healthcare system

- Saves billions of dollars; potential return to payers, providers, and consumers

- Reduces the cost of coverage for all

- Creates opportunities for new products and services for multiple customer segments

- Enhances employee productivity

Advanced Preventive Care

A System Design for Population Health

Ken Coburn, MD, MPH
CEO and Medical Director
Health Quality Partners (hqp.org)
coburn@hqp.org

Orientation to HQP

- Health Quality Partners (HQP) hqp.org

- Design, test, and disseminate models of care that improve the health of vulnerable populations – *Applied R&D*

- 27-member team based in Doylestown, PA

- Incorporated in 2000, non-profit 501(c)3

Our Work and Supporters

- Traditional Medicare – Medicare Coordinated Care Demonstration

- Medicare Advantage – higher-risk members of Aetna plans

- Bundled Payment (BPCI) – St. Mary Medical Center

- State Innovation Model planning – lead consultant for Maryland (2013)

- Research with NewCourtland Center for Transitions and Health

- Design Innovation – Camden Coalition of Healthcare Providers (CCHP)

Additional support generously provided by Doylestown Hospital

HQP's Advanced Preventive Care

Person centered: freq. contacts, anywhere, listen, respect, care, adapt to changing risks and needs

Population relevant: address a broad array of risks

Robust: 30-35 interventions in our 'portfolio'

Reliable: process specs, training, data system, decision support, and analytics with over 200 process measures

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CMS – Medicare Coordinated Care Demo

- 12 years, 2 months, 5 days

- 3,000+ chronically ill older adults enrolled

- Community-based nursing designed to provide advanced preventive care

- *Randomized, controlled research trial*

- 25% fewer deaths ($p < 0.05$)

- People (participants, families, doctors) like it

- No known adverse events or side effects

Coburn et al, PLoS Medicine, July 2012

Fourth Report to Congress, Mathematica Policy Research, Inc., March, 2011

For those at 'higher-risk':

39% fewer hospital admissions

37% fewer ER visits

28% lower net health care cost ($397 PPPM)

(all p≤0.05)

Fourth Report to Congress, Mathematica Policy Research, Inc., March, 2011

HQP Advanced Preventive Service - Outcomes

Population	N	Control PPPM	Deaths	Hospital admissions	ER visits	Part A & B expenditures; excl prgm fees	Part A & B expenditures; incl prgm fees	SNF cost
Medicare Coordinated Care Demonstration (randomized, controlled trial versus usual care)								
All risk levels (low, mod & high)	1,464			-14%		-14% *	Neutral	
	1,721	$731	-25% **	-7 %		-4%	+9%	
Higher-risk 1	502	$900	-30% **	-29% **		-20% *		
Higher-risk 2	248	$1,441	-18%	-39% **	-37% **	-36% **	-28% **	-64% **
Higher-risk 3	695	$1,108		-25% **		-20% **	-10%	
Higher-risk 4	273	$1,363		-33% **		-30% **	-22%	
Aetna Medicare Advantage (difference-in-differences analysis trended over time against a like comparison group; multiple eval. cycles)								
	N			Hospital adms			Hospital cost	
Higher-risk 5	1,200			-20%, -17%, °			-18%, -16%, °	

For more information go to http://hqp.org/index.php/results

The Washington Post

BUSINESS

The nurse's house call:

If this were a pill, you'd do anything to get it

AMANDA VOISARD FOR THE WASHINGTON POST

DELIVERING CARE: Patty Graefe, a nurse with Health Quality Partners, makes her weekly visit to Paul and Betty Bradfield at their home near Doylestown, Pa.

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SE Pennsylvania
HQP participants by zip code of residence

scalable

856 active participants

6+ counties

100+ physician practices

7+ health systems

Maryland estimate ≈
490 nurses

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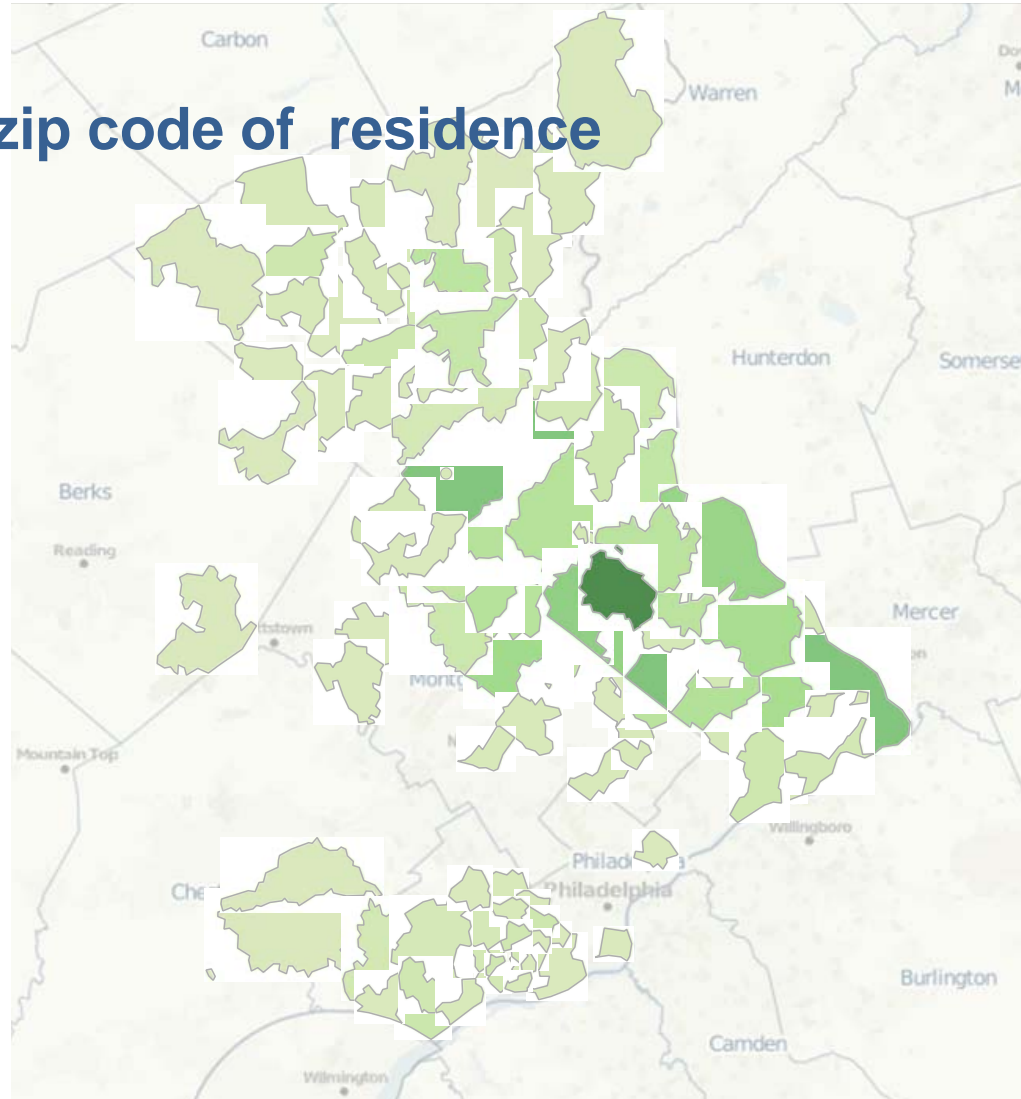
HQP's model can be used with(in) other initiatives

Evidence of population health impact still accruing for;

1. patient centered medical homes (Friedberg et al, JAMA 2014; Jackson et al, Annals Int Med 2013; Boult et al, Arch Int Med 2011, etc.)

2. ACO's, MSSP's, BPCI, …

HQP's design framework has *promising attributes;*

-- rigorously evaluated (RCT) with + outcomes

-- adaptable to populations, settings, and delivery systems

-- scalable with fidelity and the aid of new tools (PaaS)

Excellent, Sustainable Frail Elder Care: MediCaring

**Joanne Lynn, MD, MA, MS
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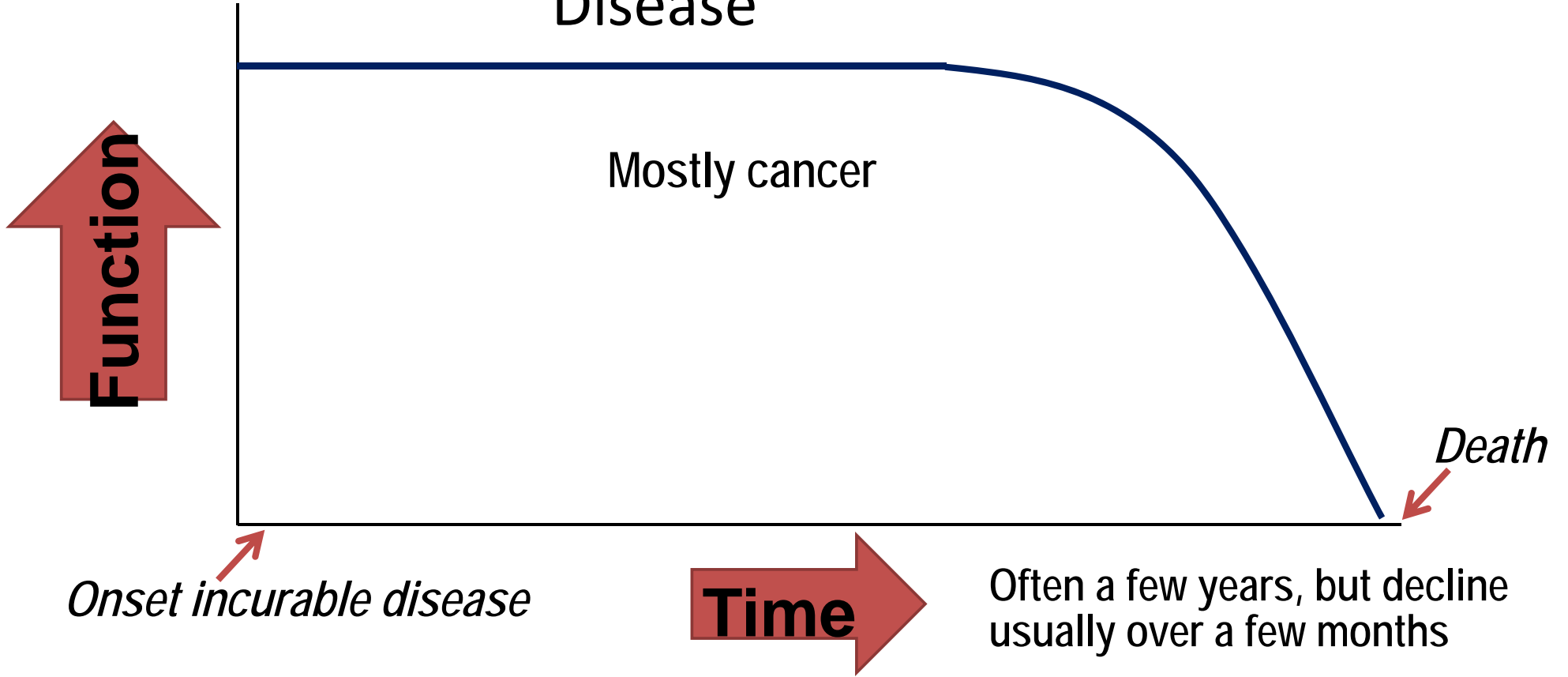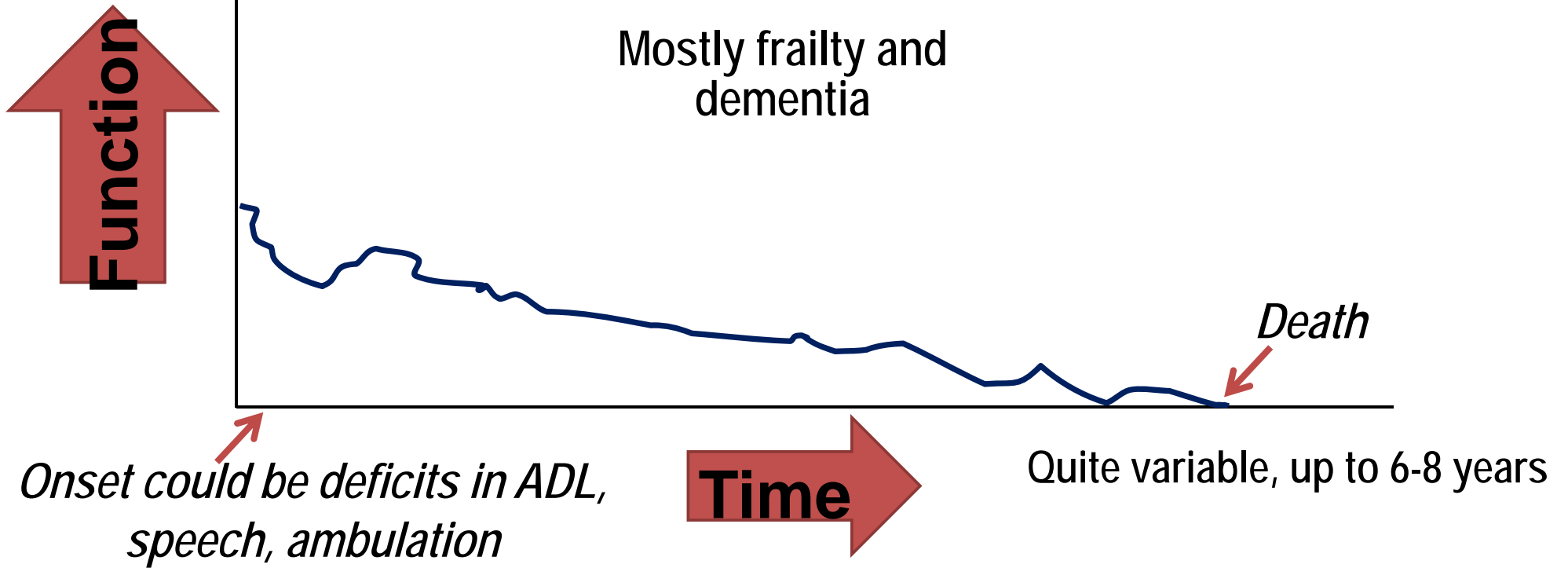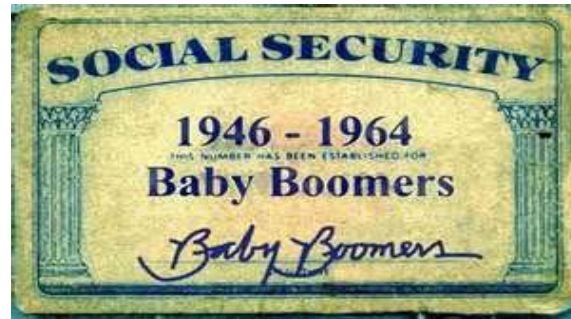
- Post-WWII "baby boom"
- Since Jan 1, 2011 turning 65 at a rate of 10,000 per day
- By 2030 in the U.S. ~20% of population will be >65 - and
- Twice as many people will be frail, compared with 2010
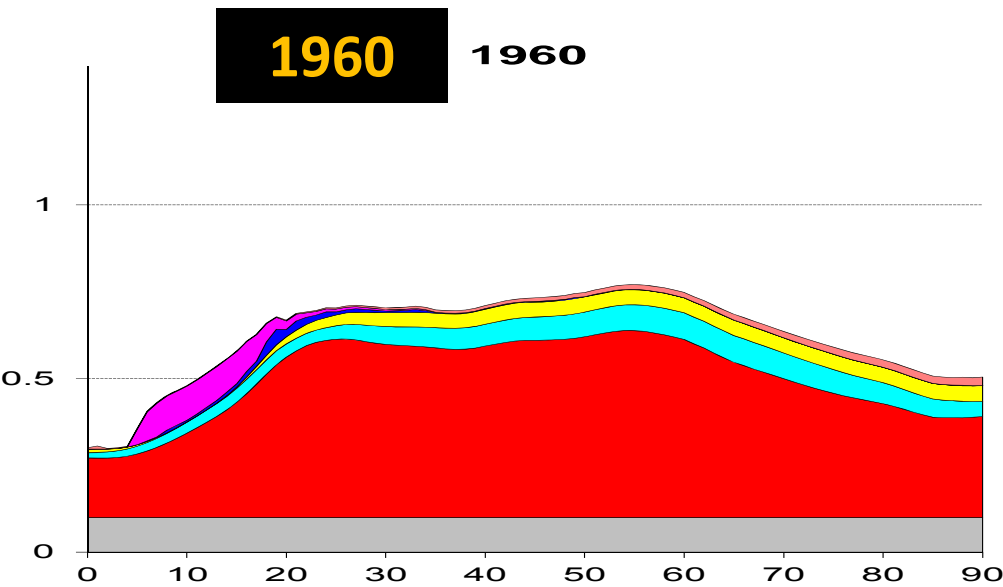- By 2040, frail proportion will double again

U.S. consumption
(Y axis: 1 = average labor income, ages 3...

Public $ towards Health Care   **Private $ towards Health Care**
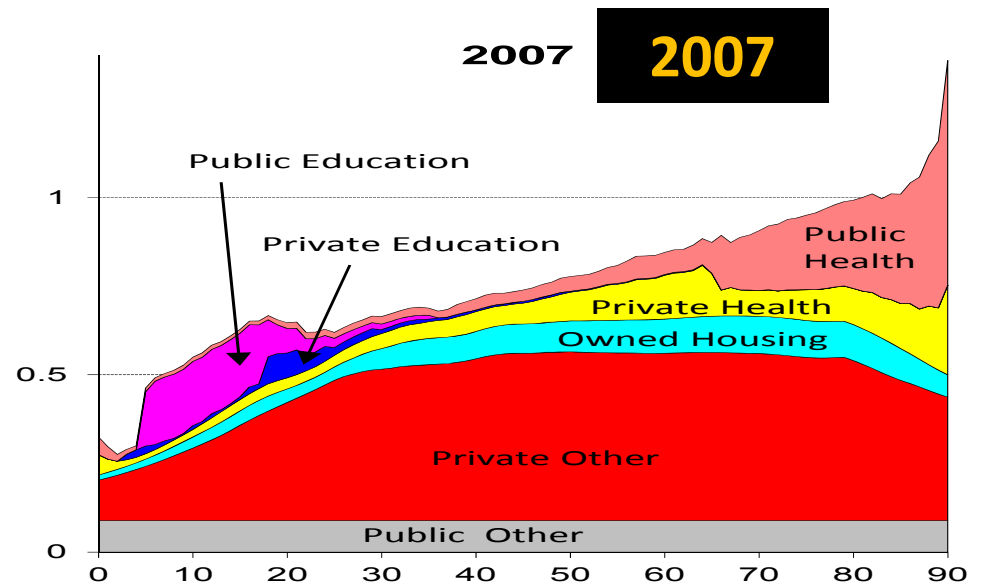
Source: U.S. National Transfer Accounts, Lee and Donehower, 2011.
Also in Aging and the Macroeconomy, National Academy of Sciences, 2013

How are we going to avoid big trouble?

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MediCaring™! *Key Components of Ref*

1. **Customize services for frail elderly**
2. **Generate care plans**
3. **Geriatricize medical care**
4. **Include long-term services and supports**
5. **Develop local monitoring and management**
6. **Fund added services and management, for now, from medical efficiency**

Channel the public's fear and frustration

into the will to change

Identification of Frail Elders in Need of MediCaring™

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Age ≥65 →

AND one of the following:
≥1 ADL deficit or
Requires constant supervision *OR*
Expected to meet criteria in 1-2Y
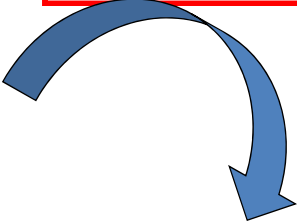
Age ≥80 →

Want a sensible care system

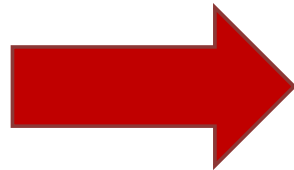Unless Opt Out
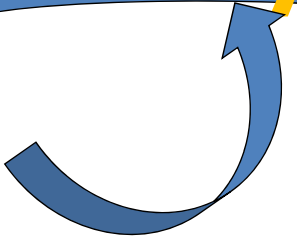
Frail Elderly

With Opt In

COMPREHENSIVE EVALUATION

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PERSON-CENTERED CARE PLAN

Disaster for the Frail Elderly: A Root Cause

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Social Services
- Funded as safety net
- Under-measured
- Many programs, many gaps

Medical Services
- Open-ended funding
- Inappropriate "standard" goals
- Dysfx quality measures

No Integrator

Inappropriate

Unreliable

Unmanaged

Wasteful "care"

What will a local manager need? **AHLA**

- Tools for monitoring – data, metrics
- Skills in coalition-building and governance
- Visibility, value to local residents
- Funding – perhaps shared savings (unless harvested in BACPAC and other private enterprise initiatives)
- Some authority to speak out, cajole, create incentives and costs of various sorts
- A commitment to efficiency as well as quality
- A workable interface on geographic concentration

My Mother's Broken Back

"The Cost of a Collapsed Vertebra in Medicare"

Financing via MediCaring ACOs, MediCaring Bundles…

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- Four geographic communities - 15,000 frail elders as steady caseload
- Conservative estimates of potential savings from published literature on better care models for frail elders
- **Yields $23 million ROI in first 3 years**

Net Savings for CMS Beneficiaries	Yr 1	Yr 2	Yr 3	3-Yr
Before Deducting In-Kind Costs	-$2,449,889	$10,245,353	$19,567,328	$27,362,791
After Deducting In-Kind Costs	-$3,478,025	$8,463,101	$17,629,209	$22,614,284

For more on financial estimates, see http://medicaring.org/2013/08/20/medicaring4life/

We can have what we want and need
When we are old and frail

**But only if we
deliberately build that future!**

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Introduction to Montefiore's Accountable Delivery System and Vulnerable Populations

- **Stephen Rosenthal**
- **Corporate Vice President, Network Management**
- **President & COO, CMO The Care Management Company**

The Bronx

- **1.4 million residents in the poorest urban county in the nation**

- **Median household income $34,000**

- **54% Hispanic, 37% African-American**

- **High burden of chronic disease**

- **Per capita health expenditures 22% higher than national average**

- **80% of health care costs paid by government payers**

Integrated Delivery System

Our Locations

1,930 Beds Across 6 Hospitals

– Including 120 beds at CHAM

– 86 NICU/PICU beds

150 Skilled Nursing Beds

154 Sites Including

64 Primary Care Sites

– 21 Montefiore Medical Group Sites

21 School Health Clinics

12 Mental Health/Substance Abuse Treatment Clinics

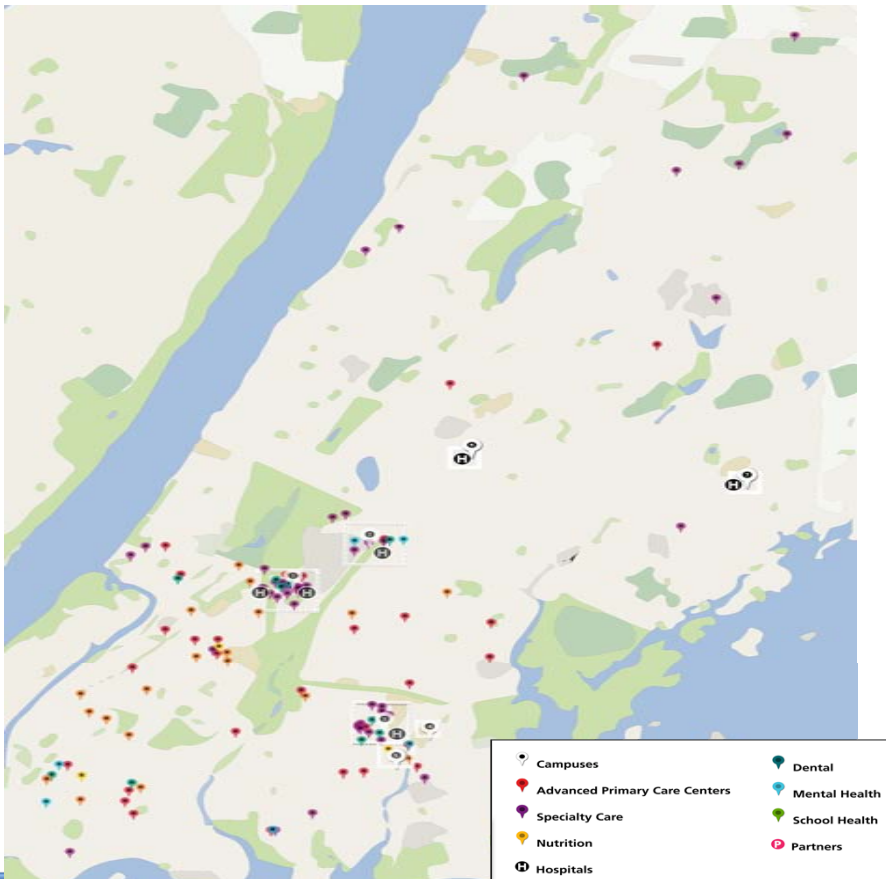**65 Specialty Care Sites**
– 2 Multi-Specialty Centers
– 6 Pediatric Specialty Centers

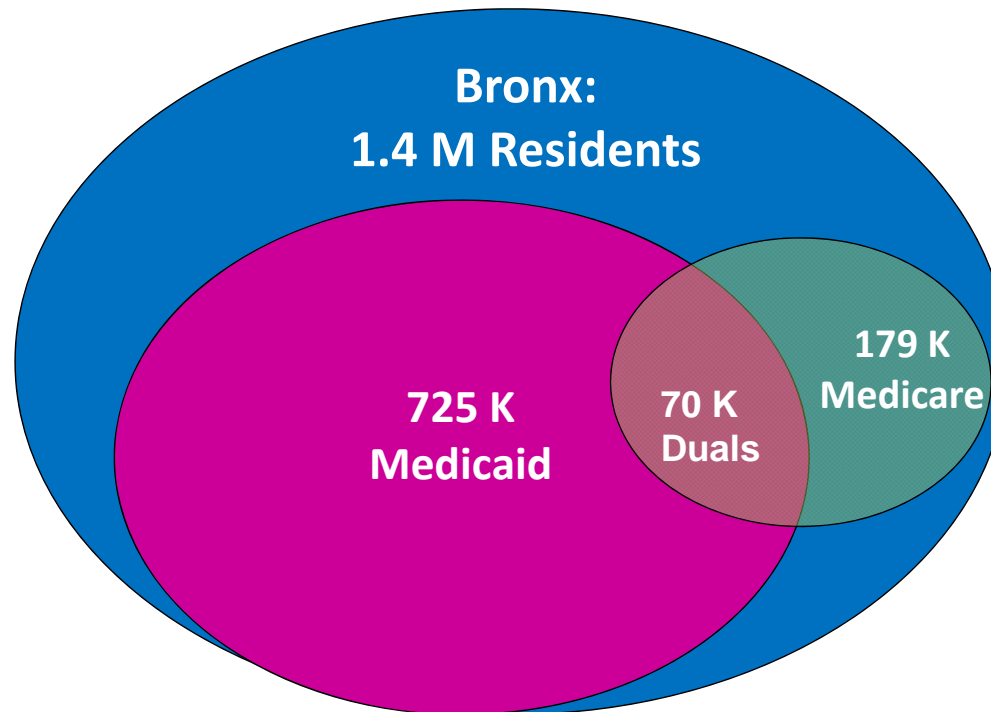– 12 Women's Health Centers

1 Freestanding Emergency Department

10 Dental Centers

5 Imaging Centers

Legend:
- Campuses
- Advanced Primary Care Centers
- Specialty Care
- Nutrition
- Hospitals
- Dental
- Mental Health
- School Health
- Partners

Large Government Payer Base

**Bronx:
1.4 M Residents**

**725 K
Medicaid**

**70 K
Duals**

**179 K
Medicare**

**Current Bronx Total Health Care Spend = $12 B
80% of Medical Expense paid by Medicare and Medicaid**

• CMO "Air Traffic Control" Ensures Seamless Patient Experience

Source: Health Care Advisory Board Interviews and Analysis

Care Guidance Components:
Deployable in any context, intensity may vary depending on population

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Patient Centered Medical Home (PCMH) Team

Individualized Care Plans

Accountable Care Management Team

- Accountable Care Manager
- Nurse
- Social Worker
- Patient Educator
- Behavioral Care Manager

Supporting Role:
- Pharmacist
- Physician

CMO Program Offerings

- Intensive Case Management
- Chronic Care Management
- Palliative/ End of Life Care
- Behavioral Care
- SNF Management
- Telemonitoring
- Medical House Calls
- Pharmacist Review
- Care Transitions
- ED Case Management

Montefiore

Initiatives to Support Vulnerable Populations

Targeted Programs and Community-Based Partnerships Essential for Success

- **PCMH activities:** Enhance staffing and systems to address patients' mix of medical and psychosocial issues

- **CKD; End Stage Renal Disease:** Flagging of individuals who present in data and referral, as well as while in Dialysis.

- **Frail Elderly Program:** Identified through provider referrals and case manager recommendations – Telemonitoring tools

- **Synergy Program:** An evidence-based model for treatment of depression and/or alcohol abuse with chronic medical conditions

- **Key Partnerships:** have cultivated partnerships with regional delivery systems, range of CBOs related to behavioral health, social support services, like housing

Community Programs Promote Wrap-around Care

Montefiore's Community Health Initiatives

Homeless Care PCP

- Works with street homeless population in the community
- Specializes in care for this population
- Internally flags patients she cares for, and is notified if one presents to the hospital

Respite Housing Organization

- Montefiore contracts with organization for a set number of beds annually
- Will provide housing for medically stable, homeless patients post-discharge
- Housing organization works to determine patient's long-term solution to lack of housing

Other Community Organizations

- Legal aid organizations
- Transportation organizations
- Financial services organizations

> **"Graduating" a High-Risk Patient**
>
> Prior to getting him into our Housing at Risk program, one of our patients had 16 admissions. Since we put him in that program, he has been to the emergency room once, has now received his green card, he has Medicaid, and should be moving into a transitional program next month. There is a significant savings to the institution through a reduction in readmissions.
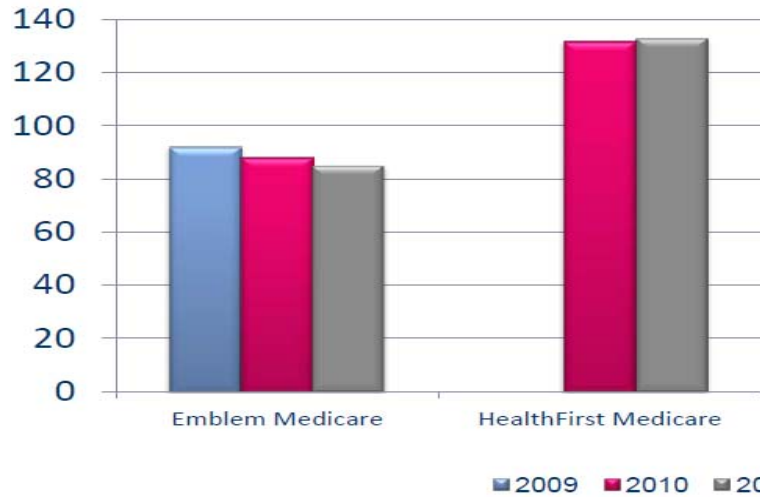>
> *Director, CMO, Montefiore Care Management*

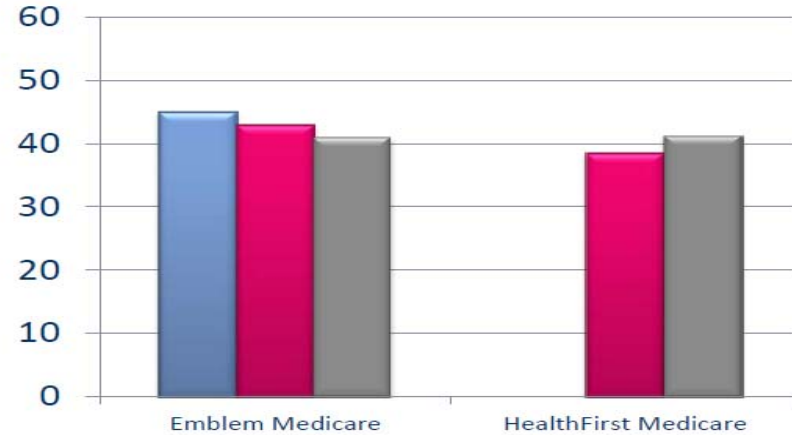Source: Health Care Advisory Board interviews and analysis.

•Potentially preventable admissions and readmissions decline for two of our managed populations

Potentially Preventable Admissions (PPA) PKPY

PPA
Emblem Medicare 3 year trend = -8%
Healthfirst Medicare 3 year trend = 1%

Potentially Preventable Readmissions (PPR) PKPY

PPR
Emblem Medicare 3 year trend = -9%
Healthfirst Medicare 3 year trend = 7%

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