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Health and
Social Care

Designing a High-Performing Health Care
System for Patients with Complex Needs

Ten Recommendations for Policymakers

**The Commonwealth Fund International Experts
Working Group on Patients with Complex Needs**

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Health care costs are heavily concentrated among people with multiple health problems. Often, these are older adults living with frailty, advanced illness, or other complex conditions. In 2014, the New York–based Commonwealth Fund, a private, independent foundation, established the International Experts Working Group on Patients with Complex Needs through a grant to the London School of Economics and Political Science. The group’s purpose was to outline the prerequisites of a high-performing health care system for “high-need, high-cost” patients and to identify promising international innovations in health care delivery for meeting needs of these patients. Drawing on international experience, quantitative and qualitative evidence, and its members’ collective expertise in policy and program design, implementation, and evaluation, the international working group sought to articulate the principles that underpin high performance for this complex population in health systems around the world.

What follows are the group’s top recommendations based on these principles. All 10 present challenges, with some requiring profound paradigm shifts—for instance, away from disease-specific care delivery and toward more patient-centered approaches, or away from the single-provider model and toward cooperation and teamwork. Their implementation, however, has the potential to transform care and quality of life for millions. The selected international models that follow the recommendations represent some of the promising frontline care innovations that illustrate the principles laid out here.

RECOMMENDATION 1

Make care coordination a high priority.

Because patients with complex needs receive treatment from a wide range of providers, their care often becomes fragmented. This can result in more hospitalizations and lower patient satisfaction. What these patients need is a dedicated person who is responsible for coordinating all their care. This could be the patient’s primary care physician, but increasingly health care organizations are employing staff specifically tasked with coordinating treatment for complex patients. Although better coordination should lead to better care, it will less often save money. It is therefore especially important to identify and remove financial disincentives to care coordination.

RECOMMENDATION 2

Identify patients in greatest need of proactive, coordinated care.

Several methods have been developed to identify patients with complex needs. Generally they use data drawn from medical records, sometimes supplemented by professional judgment. The aim is to identify patients at risk for poor outcomes, such as unnecessary hospital admissions, and provided targeted, proactive, team-based care. While a number of validated models exist to predict patients’ health care utilization and costs, individual countries will likely need to adapt these models based on the types of data they have available.

RECOMMENDATION 3

Train more primary care physicians and geriatricians.

In most OECD member countries, the number of subspecialists has increased at a much higher rate than the number of generalists. This trend has led to fragmented care and needs to be reversed. To meet the needs of aging populations, more family physicians and geriatricians, in particular, will be needed. Medical school curricula and training programs should be altered to support this shift.

RECOMMENDATION 4

Facilitate communication between providers—for example, through clinical record integration.

It is important that providers treating a patient with complex needs are able to share important data about that patient; this ensures clinicians have the information they need, when they need it. Ideally, this is accomplished by a single electronic record for all the patient's medical care. Also critical is good and timely provider communication, including the prompt relay of information to the primary care physician following hospitalization and specialist visits and the sharing of care plans with after-hours and emergency services.

RECOMMENDATION 5

Engage patients in decisions about their care.

For the patient with multiple health conditions, treatment that adheres to evidence-based guidelines for each individual condition can lead to an unacceptable burden of treatment, adverse interactions between treatments, and risks from polypharmacy. Patients with complex conditions need to be part of an open discussion of the benefits and risks of individual treatments. Such a process allows them to bring their own needs, preferences, and hopes into the treatment conversation.

RECOMMENDATION 6

Provide better support for caregivers.

Elderly people and those with complex needs often receive care from family members and friends. They are usually unpaid and often provide support around-the-clock. Health services need to take steps to identify and support these informal caregivers. Support might include respite care to provide relief for caregivers and assistance to help them look after their own health.

RECOMMENDATION 7

Redesign funding mechanisms to meet patients' needs.

Current funding mechanisms and payment incentives often exacerbate the problems of fragmented care. For example, fee-for-service encourages the overprovision of specialist services; capitation- and salary-based payments may lead to undertreatment; and quality incentives tend to prioritize only those aspects of care that are most easily measured. Payments systems for complex patients need to be redesigned so that they reduce barriers to collaboration, adequately compensate for the complexity of cases treated, and incentivize hospitals to work with community providers.

RECOMMENDATION 8

Integrate health and social services, and physical and mental health care.

The separation of health and social care fails to recognize some patients' closely related needs for both types of care. Constrained social service spending may also lead directly to inefficient use of health care resources—for example, when patients are unable to be discharged from the hospital because of a lack of support available in the community. Care for patients with complex needs therefore requires close cooperation between the two sectors.

Failure to integrate physical and mental health care also causes problems for patients with complex needs. Care for mental health must be integrated with physical health care, with multidisciplinary teams ensuring that physical and mental health problems are addressed together in a timely fashion.

RECOMMENDATION 9

Engage clinicians in change and train and support clinical leaders.

Implementing these recommendations will challenge notions of professional autonomy, established beliefs, and engrained ways of working. Clinical leadership is key to delivering successful change, and the clinicians leading change need support from local managers to ensure that local administrative systems and budgetary arrangements do not stifle change. Clinicians may also benefit from formal leadership training and opportunities to meet with peers on a regular basis.

RECOMMENDATION 10

Learn from experience and scale up successful projects.

Different solutions will suit different environments. Policymakers and health care managers should provide opportunities for sharing experiences and learning from success as well as failure. It is important to understand that successful projects tend to develop iteratively over time—and sometimes over a long period.

CANADA

Mount Sinai Hospital Acute Care for Elders (ACE) Strategy

LOCATION Toronto, Ontario, Canada

YEAR ESTABLISHED 2010

BACKGROUND Mount Sinai Hospital developed a comprehensive, integrated approach to improve care for hospitalized older adults and older adults at high risk of hospitalization, particularly because of functional, cognitive, social, or other problems.

OBJECTIVE To improve the delivery and quality of care, patient and system outcomes in all older patients, and those older patients at especially high risk of poor outcomes.

PATIENTS TARGETED All patients age 65 and older admitted with an acute medical condition. High-risk patients are identified in emergency department (ED) based on having any three or more of: 1) recent decline in functional abilities; 2) recent change in cognition or behavior; 3) geriatric syndrome (e.g., falls, incontinence, acute or chronic pain); 4) complex social issues; or 5) Identification of Seniors at Risk (ISAR) score ≥ 2 . Complementary community-based programs also identify and support high-risk patients. Program enrolled approximately 10,500 patients between 2010 and 2015.

KEY FEATURES AND INTERVENTIONS

ISAR screening for all older ED patients, with additional support from geriatric emergency management nurses. High-risk medical patients are prioritized to be cared for under Acute Care for Elders (ACE) protocol and, when possible, by designated ACE inpatient medical unit. All older patients have access to hospitalwide consultation liaison services in geriatrics, psychiatry, and palliative medicine and to volunteer-based Hospital Elder Life Program (HELP). All professionals are educated in geriatric care. Additional models strengthen community care and improve care transitions; Integrated Client Care Program provides intensive care coordination for targeted high-risk/high-use patients, while community outreach teams provide short-term home- and community-based supports to patients at risk of

losing independence. ACE strategy integrates these interventions to create seamless, interprofessional, technology-enabled integrated team-based delivery model spanning the care continuum.

INFORMATION SYSTEMS Geriatricized order sets and care protocols to support safer evidence-based care; tracking systems to monitor flow of ACE patients throughout Mount Sinai Hospital in real time and support timely transfer to ACE unit; secure e-mail notification and flagging systems to allow primary care, home care, emergency, and inpatient care providers to communicate effectively; and risk identification tools (ACE Tracker) to support early identification of high-risk patients.

FINANCING AND PAYMENT METHODS

Usual funding through global block payments for hospitals and other community-based agencies. Physicians paid fee-for-service; other professionals are salaried. Hospital budget structures create incentives to reduce admissions and length of stay. No model-specific incentives.

EVALUATION METHODS Ongoing quarterly performance tracking system, using balanced scorecard and regional benchmarking to identify areas for improvement. Pre/post implementation comparisons.

EVALUATION RESULTS Comparing pre-implementation and post-implementation periods, there was 53 percent overall increase in annual admissions of patients age 65 and older within Toronto's fast-growing population (due to trend of increasing ED visits). Mount Sinai has maintained region's lowest admission rate of older patients—25 percent, 18 percent lower than regional admission rate. For those admitted to hospital, there was 28 percent decrease in mean length of stay; 13.4 percent decline in readmissions; reduction in "alternate level of care" ("bed blocker") days per patient of 20 percent; and increase in patients discharged directly to home. Average direct cost of care per patient reduced by 23 percent, and general inpatient medical beds reduced by 18.2 percent.

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FRANCE

Personalized Health Plan for Elderly at Risk of Autonomy Loss (PAERPA)

LOCATION Nine administrative regions across France.

YEAR ESTABLISHED In nine pilot regions across France in 2013–14; seven additional regions in 2016 in order to ensure full deployment on the French territory and provide PAERPA coverage to a total of 550,000 persons

BACKGROUND French residents age 75 or older are 9 percent of the population but accrue 22 percent of health expenditures. The High Council for the Future of Health Insurance identified several shortcomings in elder care: lack of referral pathways from primary care to specialist physicians, burdens on informal caregivers resulting in “respite” hospital admissions, hospitals’ lack of attention to geriatric patients’ needs, insufficient availability of health care professionals in nursing homes, capacity shortfalls in nursing homes delaying hospital discharge, regional disparities in the availability of social support and personal care services, and lack of coordination between hospitals and social service facilities.

OBJECTIVE To improve frail elders’ quality of life, better coordinate their care, and reduce caregiver burdens.

PATIENTS TARGETED Those age 75 or older who: live in long-term care facilities; are admitted to hospital via emergency departments; are frail; take certain prescription drugs; or have one or more chronic condition. Eligibility for a personal care plan is assessed by a primary care physician or care coordinator. Across regions, 6 percent to 14 percent of elders were enrolled.

KEY FEATURES AND INTERVENTIONS Some features, including eligibility criteria, vary by region. Common features include systematic

identification of those at risk; education for elders and their caregivers; professional education on frail elders’ needs; personal care plans; and interventions to reduce the risk of falls. Integrated health and social services are provided through mobile geriatric teams; respite facilities for informal caregivers; telemedicine; a fast-track application for welfare benefits; and temporary stays in long-term care facilities to facilitate transitions from hospital to home. Nurse coordinators coordinate the work.

INFORMATION SYSTEMS A secure e-mail system facilitates communication and web-based systems provide information to patients and professionals. Although special legislation permits data sharing among members of care teams, medical records are not yet widely shared.

FINANCING AND PAYMENT METHODS National funding for information systems, coordination units, financial incentives, and additional services. Regional Health Authorities fund pilot projects through social security and have autonomy in funding local variations. Providers are paid as usual. In addition, an incentive of €100 per elderly patient with a personal care plan is shared between primary care physicians and other involved professionals. Long-term care institutions receive €53 per day for temporary residents in transition out of hospital.

EVALUATION METHODS Pre/post comparisons of process indicators (e.g., number of personal care plans created) are mandatory in local implementations. Qualitative and health economic evaluations are under way at the national level.

EVALUATION RESULTS Not yet available.

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UNITED STATES

Commonwealth Care Alliance “One Care” Program

LOCATION Massachusetts, United States

YEAR ESTABLISHED 2003

BACKGROUND Adults under age 65 who are eligible for both Medicaid and Medicare are a particularly vulnerable group, with complex and often overlooked needs.

OBJECTIVE To provide enhanced primary care and care coordination for dually eligible Medicare and Medicaid beneficiaries through multidisciplinary teams that include physicians, nurses, and mental health and geriatric specialists, and to generate savings from reduced hospitalizations and institutional care.

PATIENTS TARGETED Under Massachusetts’ One Care demonstration, Commonwealth Care Alliance (CCA) provides coverage to more than 11,000 dually eligible, nonelderly beneficiaries—the majority of state of residents enrolled in the demonstration. Roughly 80 percent have multiple chronic health conditions, mental health problems, or functional limitations due to physical and developmental disabilities.

KEY FEATURES AND INTERVENTIONS

Interdisciplinary care teams—nurse practitioners, physician assistants, behavioral health and addiction clinicians, social workers, community health workers, and others—assemble around medically complex patients, helping to identify their unmet medical, behavioral health, and social service needs and deploying resources using flexible benefits. Individualized care plans, developed by clinicians and members, guide resource allocation for long-term care, durable medical equipment, behavioral health services, and other key components. Care delivery innovations, including a community paramedicine program

and community psychiatric respite facilities, shift care from acute settings into the home and the community (where appropriate), at lower cost.

INFORMATION SYSTEMS Web-based and shared electronic medical record.

FINANCING AND PAYMENT METHODS

CCA receives a risk-adjusted, per member per month, capitated blended payment from both Medicare and the state Medicaid program. CCA then bears full financial risk for the total cost of care, including long-term services and supports, acute and postacute care, pharmaceuticals, and primary care. Given the complexity and cost of CCA’s beneficiaries, these payments are substantial: In 2015, CCA received \$386 million from the Medicaid and Medicare programs, and \$273 million for the 15 months ending in December 2014. The state’s Medicaid contribution ranges from a few hundred dollars per member per month for relatively healthy patients to \$9,000 or more for patients with extended stays at long-term care facilities. The base rate for Medicare Part A/B capitation payments are in the range of \$770 to \$960 per member per month.

EVALUATION METHODS A pre/post study of 4,500 CCA One Care enrollees, without control group.

EVALUATION RESULTS Enrollees had 7.5 percent fewer hospital admissions and 6.4 percent fewer emergency department visits than in the prior 12 months and greater use of long-term services and supports. A majority of enrollees said they were satisfied with the program. A preliminary analysis found that use of inpatient facilities and inpatient psychiatric days decreased.

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