

The Role of Payors in Catalyzing New Care Models for High-Risk Patients

“Despite a range of efforts to reform the U.S. health care system, most delivery models are not designed to effectively care for the most vulnerable patients.”

- Kent Thiry

Executive Chairman of the Board of Directors at DaVita Inc.

Introduction

Managing high-risk, medically complex patients poses a challenge for providers, health systems and insurers alike. Patients with multiple chronic conditions require a high-touch, tailored care model, but the size of the population—less than 5 percent of all patients—is typically not large enough for any one provider, group or health system to justify the significant investments required to manage them appropriately.

Payors, however, have a unique opportunity to leverage the scale they have across a geographic area and align incentives for new entrants to create the necessary care models, driving quality and cost improvements for their entire market.

So what is the role of payors in addressing this challenging issue? How should the care model be designed? What are the financial implications?

This white paper covers the unique characteristics of medically complex patients and the specific capabilities required to manage their conditions. By delving into proven care and financial models, it will help provide the context necessary for payors and risk-bearing organizations to respond to the above questions and, ultimately, to make an informed decision about how to move forward in support of new care models and new entrants for high-risk, high-cost patients.

Overview of Medically Complex Patients

About 100 million Americans have more than one chronic condition,¹ a population expected to grow to 171 million—almost half of the U.S. population—by 2030.² However, the highest-risk patients, those with multiple chronic conditions who also have high rates of health care utilization, represent a relatively small portion of the population (less than 5%), which may explain why care models for high-risk patients are rarely differentiated from what's used for the majority of patients.

While small, this population is disproportionately costly. More than 70 percent of the \$2.7 trillion spent on health care is for people with multiple chronic conditions.³

Medically complex patients often suffer from several of the costliest conditions: heart disease, kidney disease, diabetes, hypertension, stroke, many types of cancers, behavioral disorders and chronic obstructive pulmonary disease. As a result, high-risk patients often require care from multiple clinical and non-clinical providers, as well as numerous medications—far more than the general population. For example, on average, patients with five or more chronic conditions use nearly six times as many drugs and see doctors three times more often, compared to those with one or two conditions.⁴

Management Challenges

Although medically complex patients have unique and greater needs, the current system is not designed to adequately manage their care—neither from a clinical nor a business perspective. Several factors have slowed the implementation of new care models.

The inherent risk and expected cost of this population can present significant challenges to providers and payors. Accountable providers have entire panels of patients to manage, all with heterogeneous needs and risk profiles. It's natural—and even logical—for them to build and manage to the 95%, not the 5%. And considering the most vulnerable patients—those with several chronic conditions and frequent health care needs—health systems are working with a relatively small subset of patients, making it challenging to manage cost and utilization. Large payors, on the other hand, often have scale in a market. However, they are far removed from the point of care and have historically been less equipped to manage complex care needs and utilization.

From a clinical perspective, we know more than 70 percent of all hospital discharges are of patients with multiple chronic conditions.⁵

In addition to higher rates of hospitalization, the existence of comorbidities also leads to higher mortality rates, longer stays and higher average hospital costs.⁶ This population is also more likely to overuse the emergency department. Between 2007 and 2012, non-urgent ED visits made by adults with multiple chronic conditions grew about 35 percent, compared with 8 percent for adults without a chronic condition.⁷

Beyond clinical challenges, medically complex patients also often encounter other difficulties, including navigating and coordinating their care. With up to a dozen different providers, patients and their family members face the difficult task of remembering and following each provider's instructions, as well as identifying those treatments or medications that may be incompatible.

High-touch intervention and heavy care coordination are paramount. However, the average primary care visit lasts just 15 minutes,⁸ an insufficient amount of time to cover all the bases, especially when considering the follow-up phone calls and other consultation required, and the small (and flat) reimbursement per visit.

24 percent of surveyed U.S. primary care doctors said that their practices are not well prepared to manage care for patients with multiple chronic conditions.⁹

In addition to more time, the same survey found there is an opportunity to improve communication across providers. Many primary care doctors are often not notified when patients are discharged from the hospital or ER department. Only about half of primary care physicians regularly communicate with patients' home care providers; a smaller percentage frequently communicate with social service providers.

Home care and social service providers can play an important role in patient outcomes, especially considering some patients with multiple chronic conditions have difficulty getting to office visits. Patients may lack reliable transportation; others have impairments that keep them from leaving their home. In fact, in 2011, nearly 2 million Medicare beneficiaries were completely or mostly homebound.¹⁰

Integrating primary care and social services into a single, home-based model also helps identify factors that are often overlooked yet strongly influence patients' health. In addition to the transportation issues mentioned above, these social, emotional and environment factors include everything from stress, job insecurity and lack of familial support to home tripping hazards, poor hygiene and unhealthy meals. These factors often can't be identified during a typical office visit; they can more easily be identified in the home and with the help of a social worker or behavioral specialist.

A Path Forward

New care models are emerging that have proven to have an extraordinary impact among medically complex patients. There are four elements that should be carefully considered in implementing a successful approach.

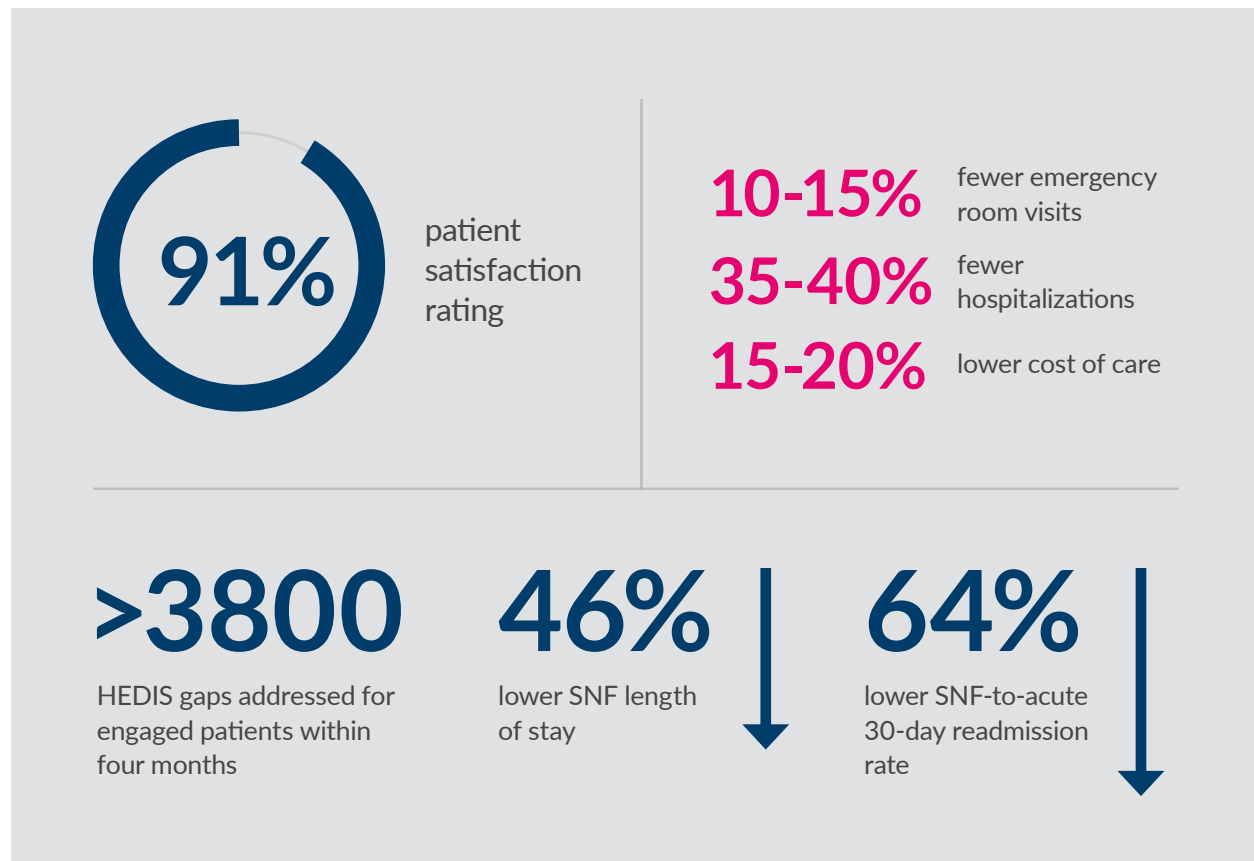
The Right Care Model

As discussed earlier, our health care system is in need of a new care model to address the unique needs and characteristics of high-risk patients. While traditional approaches can be ineffective, providing comprehensive, team-based primary care in a home-based setting has been shown to improve patients' health while reducing costs. According to the Centers for Medicare & Medicaid Services, its house call pilot program for 8,400 beneficiaries with two or more chronic conditions saved \$25 million its first year.¹¹

Much different from non-clinically based home health services, “house calls” programs utilize a multi-disciplinary team led by physicians and nurse practitioners with full prescriptive authority, who can quickly adjust patients’ medications, order tests, refer patients to specialists and coordinate care. In addition, palliative care and behavioral health specialists, social workers, pharmacists and dietitians are available to provide specialized services to patients. With regular contact with patients in their homes, team members have the opportunity to spend more time with patients and to provide education about chronic diseases and ways to more effectively manage conditions and symptoms. They are also uniquely positioned to identify non-clinical factors negatively impacting patients’ health, commonly referred to as social determinants of health. This regular contact and comprehensive care delivery helps prevent hospitalizations and unnecessary trips to the emergency department.

In cases where a patient requires post-acute care, employed clinicians and care managers can be deployed to oversee care within the skilled nursing facility from day one and coordinate care during that patient’s discharge home.

A model tailored to high-risk patients can have a significant impact. Vively Health™, formerly known as DaVita Health Solutions, launched such a program with a large regional health plan, and during the first 12 months (through 2017) posted the following results:¹²



These results are in line with a survey by the Commonwealth Fund, which showed that both good access and communication are associated with lower rates of using emergency departments for non-urgent issues.¹³

These home-based care teams, which spend substantial time with patients, also have unique opportunities to facilitate conversations about palliative and end-of-life care, topics that too often go unaddressed in a traditional care model. These conversations and the subsequent planning that results can help ensure patients' wishes are followed and reduce the costs associated with end-of-life care. According to Kaiser Family Foundation, spending on Medicare beneficiaries in last year of life accounts for about 25 percent of total Medicare spending on beneficiaries age 65 or older.¹⁴

Key Tools to Support This Care Model

The care provided by home-based, multi-disciplinary teams should be guided by tools that help providers identify patients likely to require a hospital stay or other medical care.

They include basic, yet effective, approaches like conducting an annual comprehensive health assessment to help identify gaps in care and establish a plan of care. Analytic tools examine and predict factors like recent hospital or ER admissions or readmissions; the number and type of chronic diseases; and length of stay in an acute setting. There are also studies that indicate that variables such as functional status, illness severity, behavioral health status and social determinants of health are important for accurately identifying individuals with the greatest risk.¹⁵

While difficult to gather in a traditional office setting, this type of information can more easily be collected during a home-based visit.

Aligning Incentives

There are demonstrable benefits to implementing an intensive, high-touch model for medically complex patients. Because this approach requires significant additional investment into technology, analytics, care teams and other innovations, it is imperative to allow providers to participate in savings on the total cost of care for patients. An effective model is full global capitation, which holds providers accountable to providing efficient, quality care and allows for upside when they are successful. Additional quality metrics can be put in place for important indicators such as BMI monitoring, hypertension control, falls risk assessment, diabetes test and control, nephropathy testing, breast and colon cancer screening, etc. The extent to which providers take on risk (e.g., global capitation vs. shared savings upside only) will vary, depending on the needs and capabilities of individual providers and insurers and the nature of the population (e.g., Medicare vs. commercial).

Identifying Effective Care Partners

In addition to rethinking care and financial models, it is important to select the right provider partner and provide the scale necessary to justify the infrastructure needed to care for this unique population. Given that the highest-risk patients comprise such a small percentage of the population and the significant investment required—for technology, analytic tools, specialized practitioners, etc.—it is rarely practical for individual health systems and physician groups to fully create this model for their own patients. However, consolidating care with one specialized provider can deliver the scale and expertise necessary to achieve improved clinical and quality outcomes, as well as savings.

Conclusion

When partnering with specialized providers, payors are uniquely positioned to take on an active role in supporting the management of medically complex patients. Together, and under the care model described above, they have the level of scale in a market and ability to align incentives to support this complex population.

This approach holds great promise for patients, health plans and the health care system as a whole. Patients benefit from receiving better access to quality care from experienced providers, and health plans better serve the most vulnerable patients while reducing overall costs.

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