Improving Care for High-Need Patients

Featuring Health Quality Partners

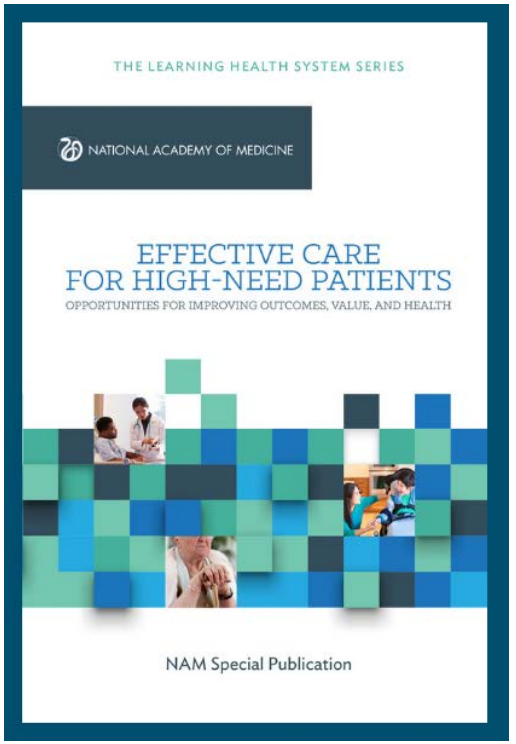
Webinar Series

March 29, 2018 | 2:00 – 3:00PM ET

nam.edu/HighNeeds

Share your thoughts!

@theNAMedicine | #HighNeeds



NATIONAL ACADEMY OF MEDICINE

Leadership • Innovation • Impact | *for a healthier future*

PETERSON CENTER ON HEALTHCARE

AGENDA

WELCOME & OVERVIEW OF PUBLICATION 2:00 – 2:05

Henrietta Awo Osei-Anto, National Academy of Medicine

Emily Zyborowicz, Peterson Center on Healthcare

MODEL DEVELOPMENT & IMPLEMENTATION 2:05 – 2:45

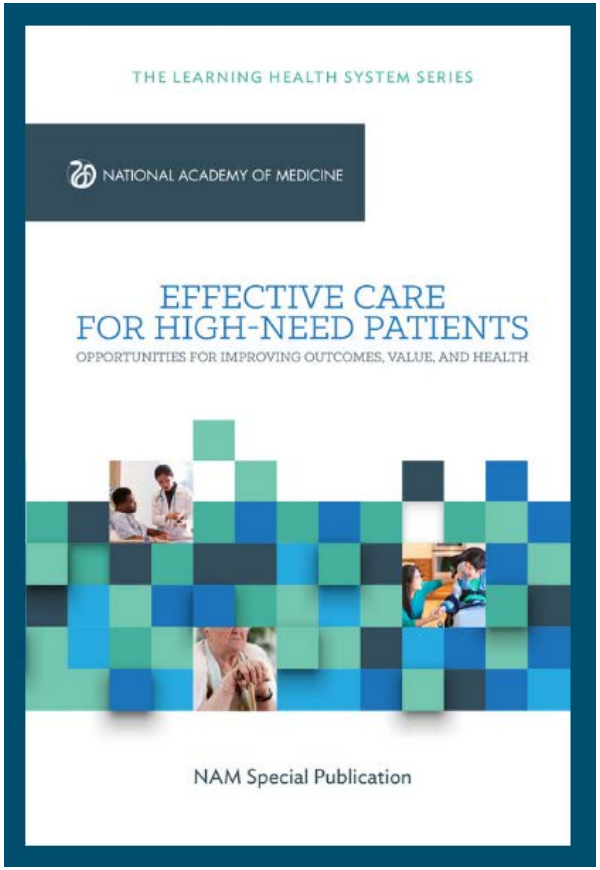
Ken Coburn, Health Quality Partners
Conception, design, and implementation of Advanced Preventive Care model

Jonathan Harvey, Martin's Point Health Care
Implementation of Advanced Preventive Care model

AUDIENCE Q&A 2:45 – 3:00

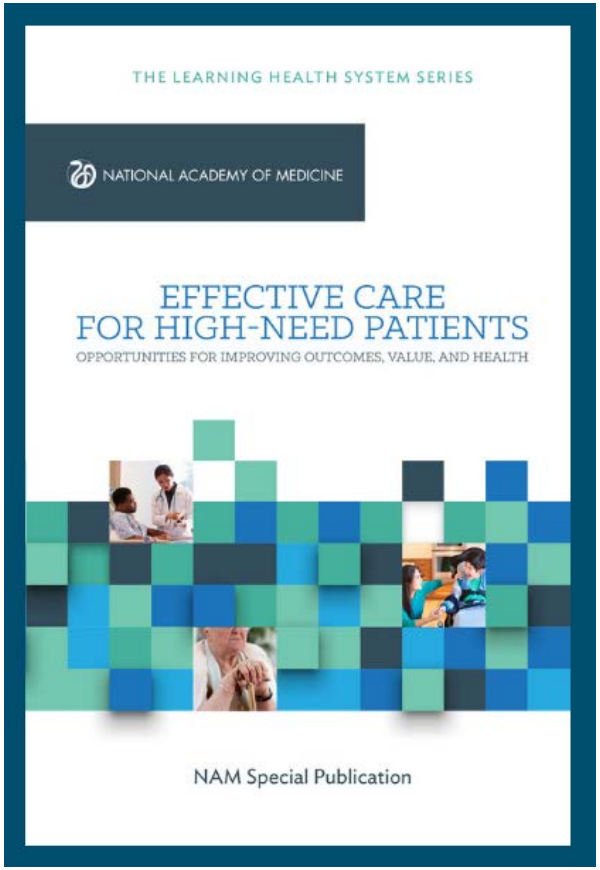
Welcome & Introduction

Henrietta Awo Osei-Anto
Senior Program Officer
National Academy of Medicine



Overview of Publication

Emily Zyborowicz
Associate Director, Research and Grants
Peterson Center on Healthcare

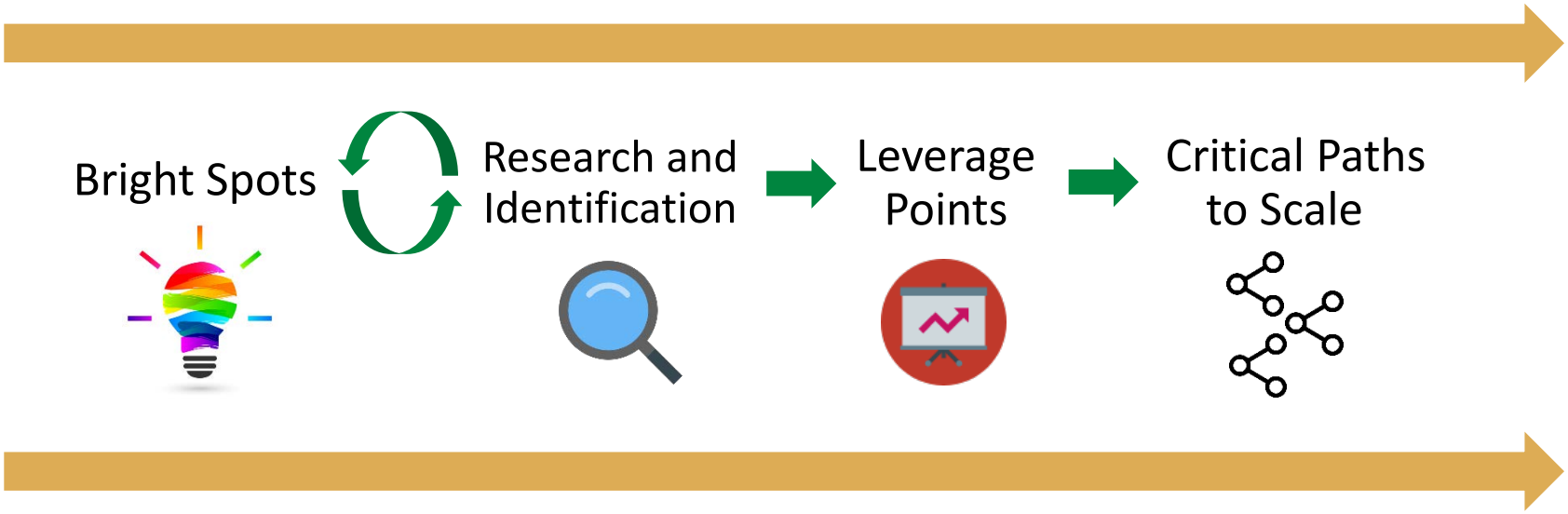


The Peterson Center on Healthcare

Mission: To transform U.S. healthcare into a high-performance system by finding innovative solutions that improve quality and lower costs and accelerate their adoption on a national scale.

Areas of Focus

- Health System Transformation
- Facilitating Conditions for Change
- Monitoring System Performance



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Overview of the Special Publication Process

- In 2015, partnered with the National Academy of Medicine, Bipartisan Policy Center, Harvard School of Public Health, and the Commonwealth Fund, to advance the field's understanding of how to better manage the health of high-need patients.

- Convened stakeholders and experts over the course of three workshops as well as in taxonomy and policy working groups to understand:
  - Who are high-need patients?
  - What care delivery models and attributes can improve the quality and lower the costs of care for high-need patient segments?
  - What policy levers can accelerate the adoption of effective care delivery models?

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Planning Committee

PETER V. LONG (*Chair*), President and Chief Executive Officer, Blue Shield of California Foundation
MELINDA K. ABRAMS, Vice President, Delivery System Reform, The Commonwealth Fund
GERARD F. ANDERSON, Director, Center for Hospital Finance and Management, Johns Hopkins Bloomberg School of Public Health
TIM ENGELHARDT, Acting Director, Federal Coordinated Health Care Office, Centers for Medicare & Medicaid Services
JOSE FIGUEROA, Instructor of Medicine, Harvard Medical School; Associate Physician, Brigham and Women's Hospital
KATHERINE HAYES, Director, Health Policy, Bipartisan Policy Center
FREDERICK ISASI, Executive Director, Families USA; former Health Division Director, National Governors Association
ASHISH K. JHA, K. T. Li Professor of International Health & Health Policy, Director, Harvard Global Health Institute, Harvard T.H. Chan School of Public Health
DAVID MEYERS, Chief Medical Officer, Agency for Healthcare Research and Quality
ARNOLD S. MILSTEIN, Professor of Medicine, Director, Clinical Excellence Research Center, Center for Advanced Study in the Behavioral Sciences; Stanford University
DIANE STEWART, Senior Director, Pacific Business Group on Health
SANDRA WILKNISS, Health Division Program Director, National Governors Association Center for Best Practices

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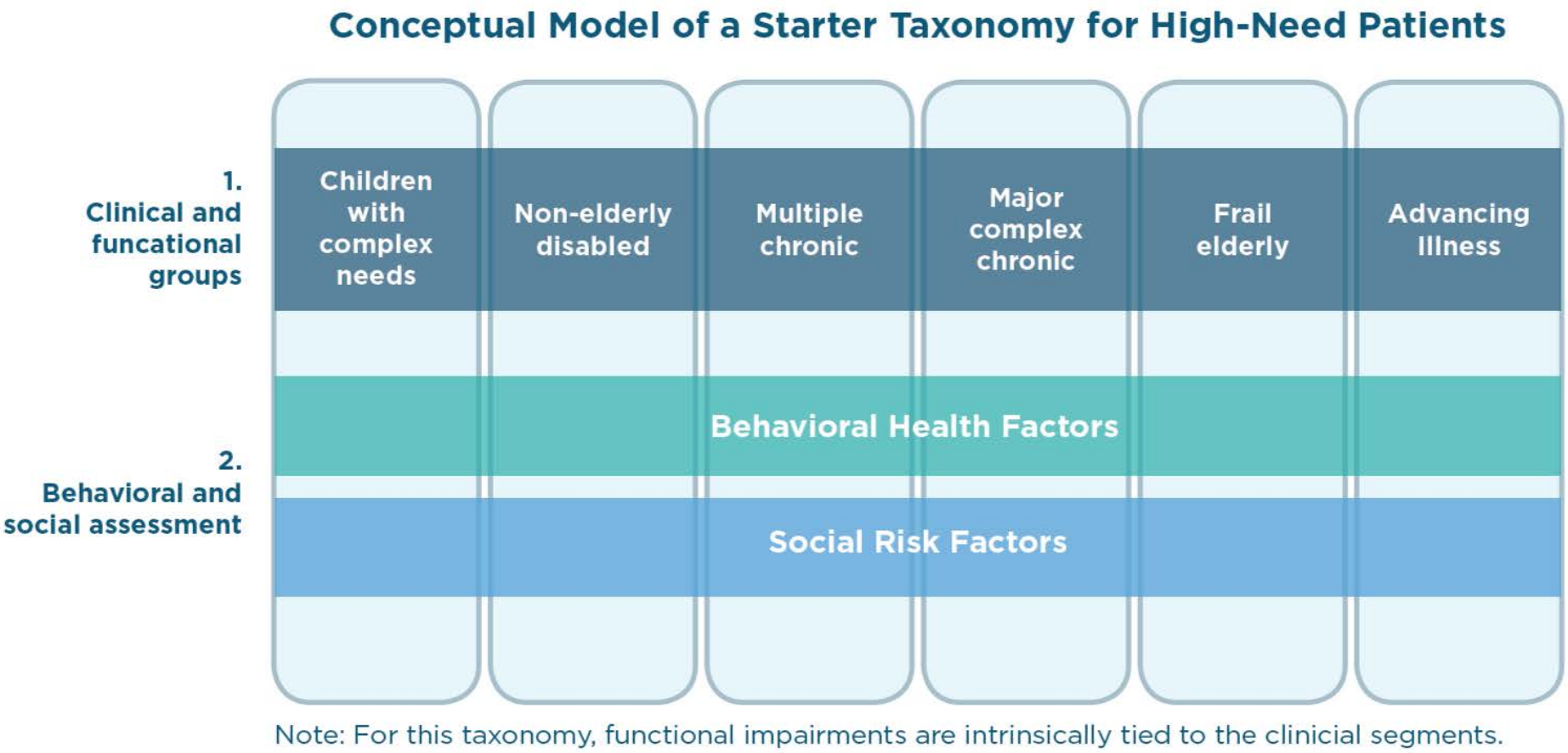
What Have We Learned?



Note: For this taxonomy, functional impairments are intrinsically tied to the clinicial segments.

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What Have We Learned?

Program \ Segment	Children w/ complex needs	Non-elderly disabled	Multiple chronic	Major complex chronic	Frail elderly	Advancing illness
Care Management Plus				*		*
Commonwealth Care Alliance						
Complex Care Program at Children's National Health System						
GRACE				*		
Guided Care						
Health Quality Partners						
Health Services for Children with Special Needs	*					
Hospital at Home						
H-PACT		*				
IMPACT			*		*	
Massachusetts General Physicians Organization Care Management Program						
MIND at home					*	
Naylor Transitional Care Model (Penn)						
PACE						

Taxonomy Crosswalk

Successful care models cross-referenced to patient segment(s) that could be served if needs of patients are matched to appropriate models.

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How Do We Spread Effective Care Models?

- The Center is collaborating with the Commonwealth Fund, the John A. Hartford Foundation, The Milbank Memorial Fund, the Robert Wood Johnson Foundation, and the SCAN Foundation to accelerate health system transformation for high-need patients.

- Together with the Institute for Healthcare Improvement, we launched the Better Care Playbook (bettercareplaybook.org) to provide users with the best available knowledge and resources to improve care for people with complex needs.

- The Center is also working with partners to scale up proven models of care and increase the know-how and resources needed to help providers effectively change how they deliver care.

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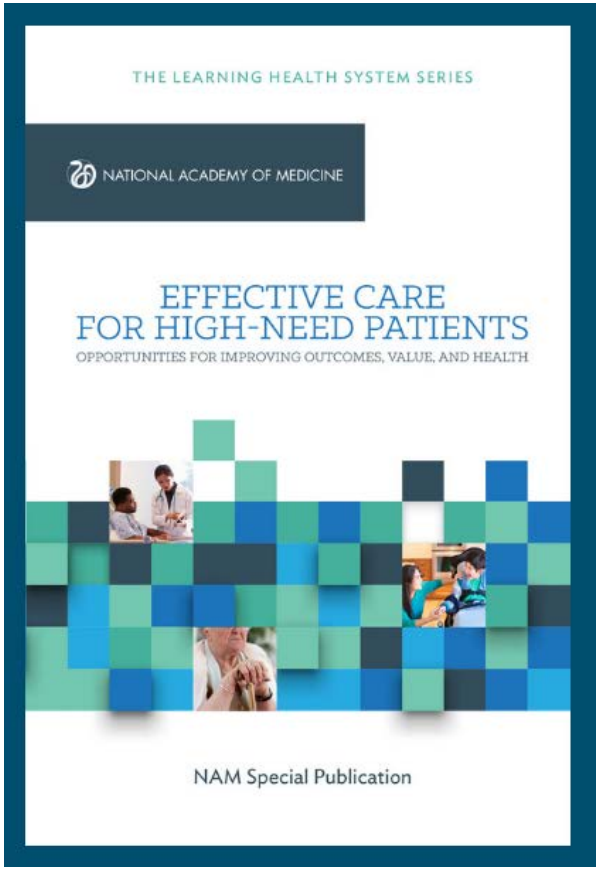
Today's Featured Program

Advanced Preventive Care

Health Quality Partners

www.hqp.org



Model Development & Implementation

Ken Coburn
President & CEO
Health Quality Partners

Improving Care for High-Need Patients:

Developing and Scaling **Advanced Preventive Care**

Ken Coburn, MD, DrPH, FACP
CEO, Medical Director
Health Quality Partners (HQP) hqp.org

Health Quality Partners (HQP)

- 501(c)3, non-profit in Doylestown, PA since 2001
- Discover and apply practical knowledge and insights through R&D to **design systems**
  - that improve the health of vulnerable populations
  - by preventing avoidable complications of aging, chronic disease, other (social / non-medical) risks to health
- Implement, evaluate, improve, and scale these systems through collaborative partnerships

HQP's Applied R&D Work in Population Health and Prevention

- Medicare Advantage – Martin's Point Health Care, Portland, ME
- Health system population health redesign - Doylestown Health
- Design / Replication collaboration – Camden Coalition of Healthcare Providers and the National Center for Complex Health and Social Needs
- StLukesHealth / Salveo – a secondary health plan in Tasmania, Australia
- Research - U Penn, NewCourtland Center for Transitions and Health
- IT tool development – SPERO® platform, supported by hMetrix

----- past projects …

- MSSP ACO – Advanced Preventive Care (replication consultancy)
- Bundled Payment (BPCI) – Heart failure, Model 2, 90-day
- Medicare Advantage - Aetna, high-risk members, southeast PA
- Traditional Medicare - CMS, Medicare Coordinated Care Demo
- State Innovation Model planning - consultant for Maryland (2013)

A SYSTEM OF ADVANCED PREVENTIVE CARE

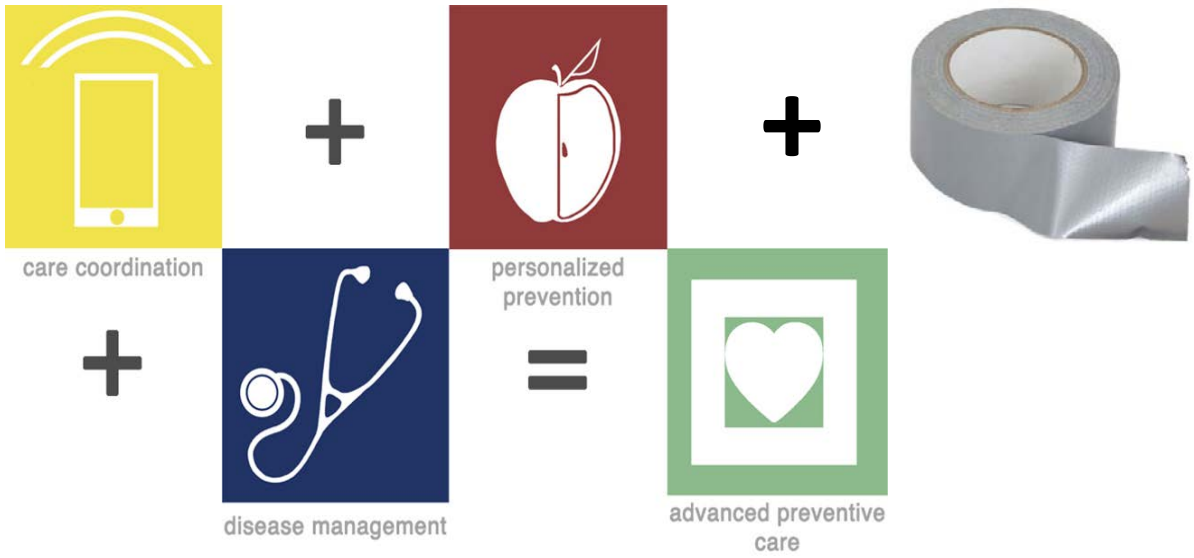

Aim:
Improve health and relieve suffering

Framework:
Advanced Preventive Care

- Key Concepts
  - Improve health and relieve human suffering – Why / Aim
  - Applied systems and design thinking – How / Principles
  - Reliably and proactively deliver a set of preventive interventions for health risks that are under-reported or inadequately-addressed, in a manner that is valued by the participant, builds a positive relationship, and improves health outcomes – What / Logic Model
- Basic Elements
- Design Principles
- Interventions
- Operational Domains

Framework:
Advanced Preventive Care

- Key Concepts
- **Basic Elements**
  - Care coordination + Chronic disease management + Personalized prevention + System failure duct tape
- Design Principles
- Interventions
- Operational Domains



Framework:
Advanced Preventive Care

- Key Concepts
- Basic Elements
- Design Principles
  - Person-centered
  - Population-relevant
  - Reliable
  - Robust
  - Anticipatory
  - Accountable
- Interventions
- Operational Domains

Framework:
Advanced Preventive Care

- Key Concepts
- Basic Elements
- Design Principles
- Interventions
  - portfolio of 30-35 interventions to mitigate health risks prevalent in the target population
    - best-in-class: assessments, monitoring, health literacy, chronic disease self-management, medication adherence, lifestyle behavior change, weight management, seated chair exercise, nutrition, home safety, harnessing community resources, advanced care planning, etc. all in collaboration with PCPs and specialists
- Operational Domains

interventions:
use everything
that can help

design
principle:
robust

Framework:
Advanced Preventive Care

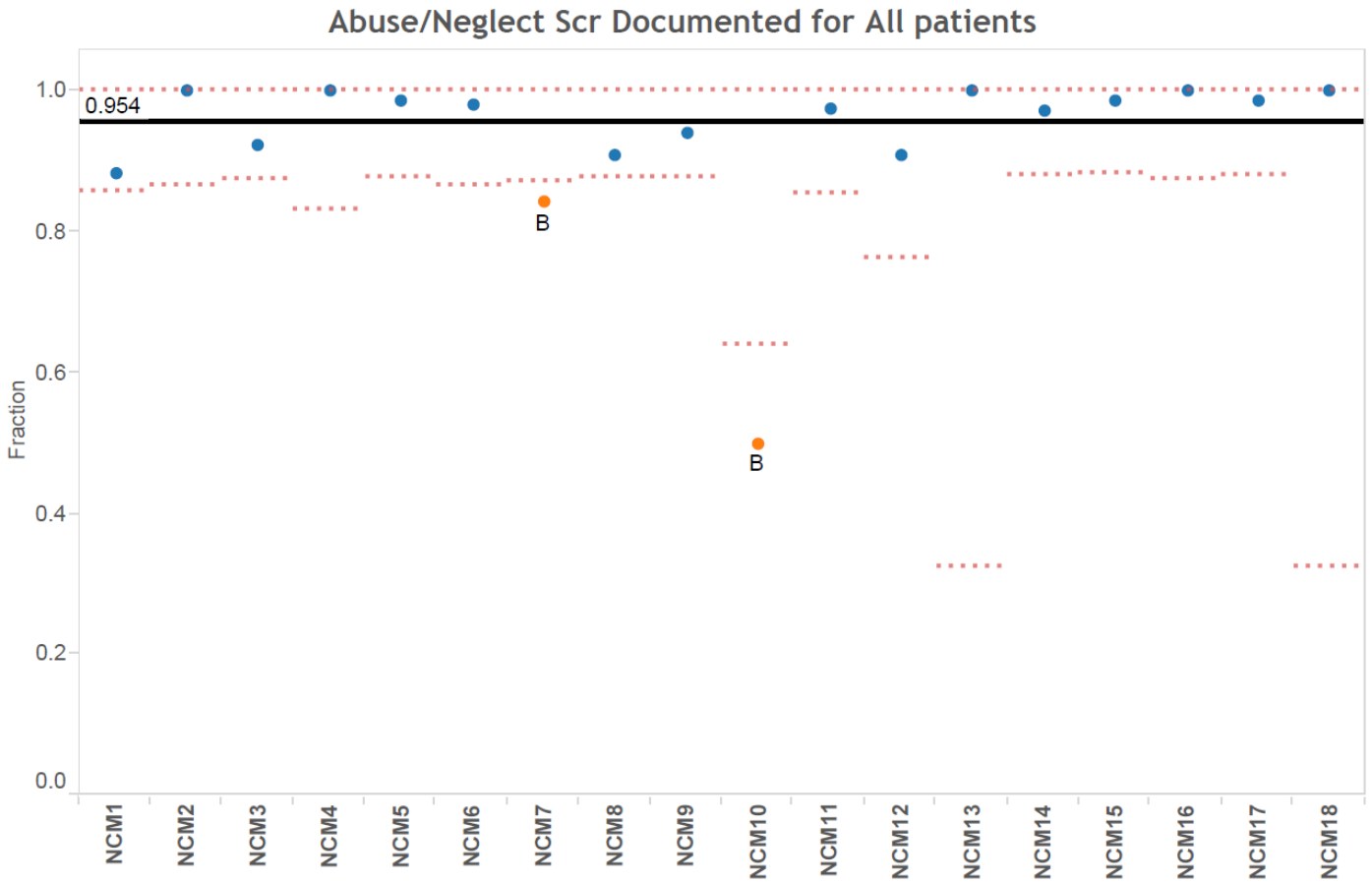
- Key Concepts
- Basic Elements
- Design Principles
- Interventions
- Operational Domains
  - Policies, Procedures, and Protocols
  - Staff Education and Training
  - Participant Education
  - Care Data
  - Analytics

IT systems that support care model-specific operational domains are extremely helpful tools

SPERO®

HQP has developed a scalable IT platform designed specifically to support all 5 operational domains of Advanced Preventive Care

Reports and Analytics
understanding variation



Cross-sectional p-chart comparing the fraction of each nurse care manager's participant cohort having had a timely abuse and neglect screen completed

Results for Advanced Preventive Care

CMS - Medicare Coordinated Care Demonstration

- Randomized, controlled prospective trial analyzed on an intention-to-treat basis

  12 years 9 months duration (April 2002-Dec 2014)

  3,073 chronically ill older adults enrolled
- Overall: -25% deaths ($p<0.05$, NNT=29)
- For those at 'higher-risk' (HF, CAD, or COPD & 1+ admit in prior year):

  -39% hospital admissions

  -37% ER visits

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

  n=248, average follow-up 42 months, all outcomes $p\leq0.05$

Sources: Coburn et al, PLoS Medicine, July 2012

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

Publications

JAMA®

Online article and related content current as of February 10, 2009.

Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials

Deborah Peikes; Arnold Chen; Jennifer Schore; et al.

JAMA. 2009;301(6):603-618 (doi:10.1001/jama.2009.126)

http://jama.ama-assn.org/cgi/content/full/301/6/603

"… HQP, also showed promise, … for this subgroup [highest severity cases] both differences were large (-29% for hospitalizations and -20% for expenditures) and statistically significant (P=.009 and P=.07, respectively)."

HEALTH AFFAIRS JUNE 2012 31:6

AVOIDABLE ADMISSIONS

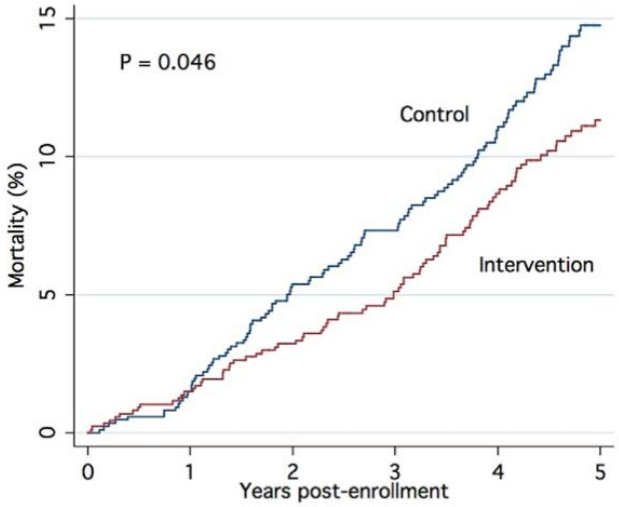
DOI: 10.1377/hlthaff.2012.0393
HEALTH AFFAIRS 31,
NO. 6 (2012): 1156–1166

By Randall S. Brown, Deborah Peikes, Greg Peterson, Jennifer Schore, and Carol M. Razafindrakoto

Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients

"… Health Quality Partners, reduced hospitalizations by 30 per 100 beneficiaries (33 percent; *p*=0.02)"

" … The demonstration program with the largest effects, at Health Quality Partners, was very data-driven, tracking care coordinators' performance and continually assessing the effectiveness of newly introduced interventions component and refinements to existing ones …"



OPEN ACCESS Freely available online PLoS MEDICINE

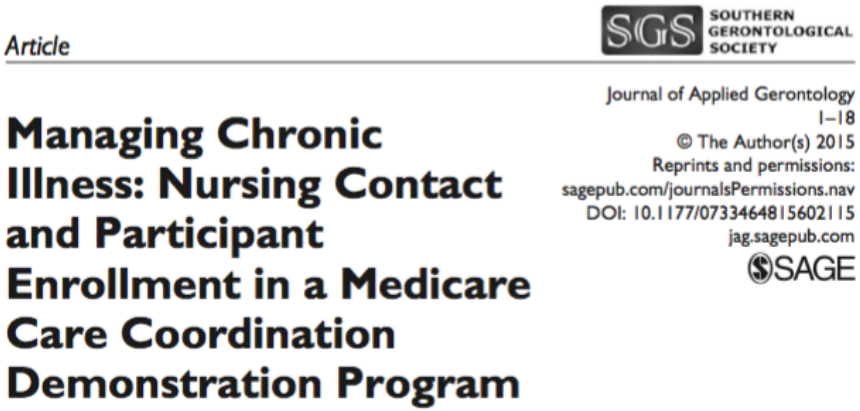
Effect of a Community-Based Nursing Intervention on Mortality in Chronically Ill Older Adults: A Randomized Controlled Trial

Kenneth D. Coburn*, Sherry Marcantonio, Robert Lazansky, Maryellen Keller, Nancy Davis

Health Quality Partners, Doylestown, Pennsylvania, United States of America

"… Overall, a 25% lower relative risk of death (hazard ratio [HR] 0.75 … the adjusted HR was 0.73 (95% CI 0.55-0.98, *p*=0.033)."

Recent Publications



Article

SGS SOUTHERN GERONTOLOGICAL SOCIETY

Journal of Applied Gerontology
1–18
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DOI: 10.1177/0733464815602115
jag.sagepub.com
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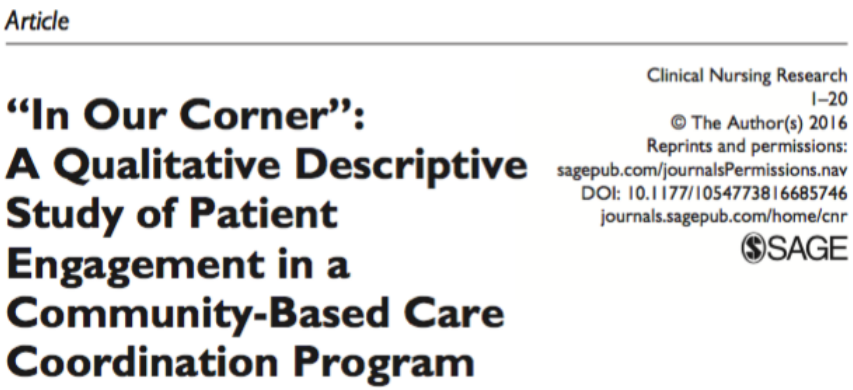
Managing Chronic Illness: Nursing Contact and Participant Enrollment in a Medicare Care Coordination Demonstration Program

Toles M, et al; Journal of Applied Gerontology, Aug 2015

"… A lower risk of voluntary disenrollment was associated with a **greater proportion of in-person (vs. telephonic) nursing contact** (Hazard Ratio [HR] 0.137, confidence interval [CI] [0.050, 0.376]). A higher risk of voluntary disenrollment was associated with lower **continuity of nurses who provided care** (HR 1.964, CI [1.724, 2.238]) …"



Article

Clinical Nursing Research
1–20
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sagepub.com/journalsPermissions.nav
DOI: 10.1177/1054773816685746
journals.sagepub.com/home/cnr
SAGE

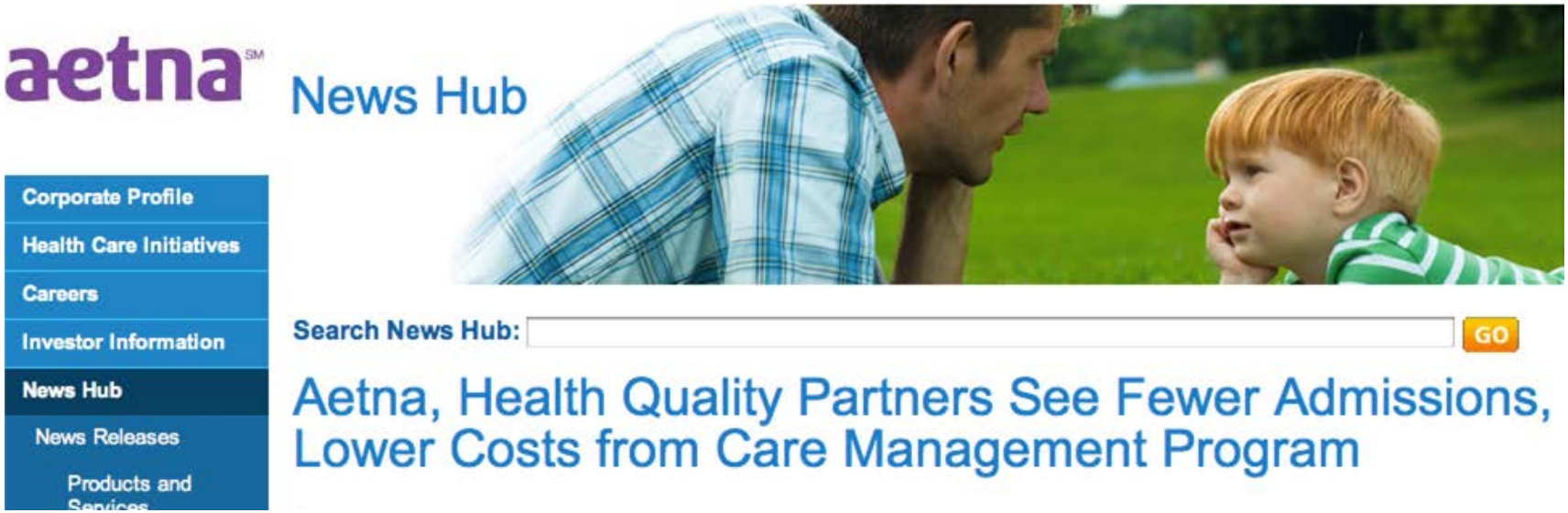
"In Our Corner": A Qualitative Descriptive Study of Patient Engagement in a Community-Based Care Coordination Program

Sefcik J, et al; Clinical Nursing Research, Dec 2016

"… The overarching theme resulting from the analysis was **"in our corner,"** with subthemes **"opportunities to learn and socialize"** and **"dedicated nurses,"** suggesting that these are the primary contributing factors to engagement in HQP's Care Coordination Program …"

Medicare Advantage - Aetna

- Recently completed 7-yr collaboration
- Higher risk Medicare Advantage members in counties of SE PA: approx. 2,500 chronically ill older adults
- Difference-in-differences evaluations done by Aetna's medical economics unit
- Results:
  - Hospitalizations reduced 15-20%
  - Hospital costs reduced 16-18%
  - Gain share bonus to HQP for 5 out of 7 years



Update on longer-term mortality impact:

For higher-risk participants per CMS, from 2002-2014:

- **-34% fewer deaths thru 2yr follow-up**
  (6.9% vs 10.5%) (p=0.02) n=1,160; NNT=28

- **-22% fewer deaths thru 5yr follow-up**
  (18.1% vs 23.3%) (p=0.03) n=912; NNT=19

Source: Supplement to 5th Report to Congress

Understanding what doesn't work is key

- Our two trials within the MCCD did not demonstrate the same impact on utilization and cost
- Differences between trials 1 (worked) and 2 (didn't work) help shed light on critical success factors; target population, model fidelity, operations

Attribute	Trial 1 (2002-10) - WORKED	Trial 2 (2011-14) –DIDN'T WORK
Eligibility criteria	HQP defined – Dx and HRA based	CMS defined – Dx and utilization requirements
Case-finding method	PCP billing list and primary care practice collaboration	Hospital discharge data only
Risk Band Enrolled	Moderate to High	Higher than "high risk" subgroup in Trial 1
Services Offered	Preventive Group Programs	No Preventive Group Programs
Administrative Disruptions	Modest	Significant discontinuity of service

Related reference; Petersen, GG, et al. Health Services Research, Dec 2016

“DIFFUSION OF INNOVATION” CHALLENGE IN HEALTH CARE:
INNOVATING REPLICATION AND SCALING

SEARCH FOR A PRACTICAL STRATEGY TO DISSEMINATE MODELS OF ADVANCED PREVENTIVE CARE THAT IMPROVE THE HEALTH OF CHRONICALLY ILL OLDER ADULTS

Kenneth D. Coburn

A dissertation submitted to the faculty at the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Doctor of Public Health in the Department of Health Policy and Management in the UNC Gillings School of Global Public Health.

Replication Consultancy: Walking with adopter-partners

- Provided by original developers of Advanced Preventive Care at HQP
- Intensively develops the people, processes, and capabilities within the adopting organization in accordance with original system specs, including; design principles, operational domains, culture, and IT support platform.
  - Analyses for identifying target population
  - Geo-mapping target population
  - Modeling staffing patterns, recruitment, hiring, training
  - IT platform, data integration, and QC
  - Ongoing support, monitoring, and impact analyses
- Direct support progressively weaned over time as measurable evidence of adoption and assimilation with fidelity and critical adaptation (“replidaption”) is achieved

Implementation

Jonathan Harvey

Chief Medical Officer
Martin's Point Health Care

Innovation in Complex Care Management at Martin's Point

Presented By:

Dr. Jonathan Harvey

Martin's Point® Health Care

Overview

- Martin's Point –Mission, Membership, Geography
- Care Management Definition and Strategy
- Highlights of experience to date in adopting and replicating HQP's Advanced Preventive Care model.

Martin's Point's Mission

Leading our communities to better health through relationships built on trust

The Power of Integrated Health Care

Primary Care

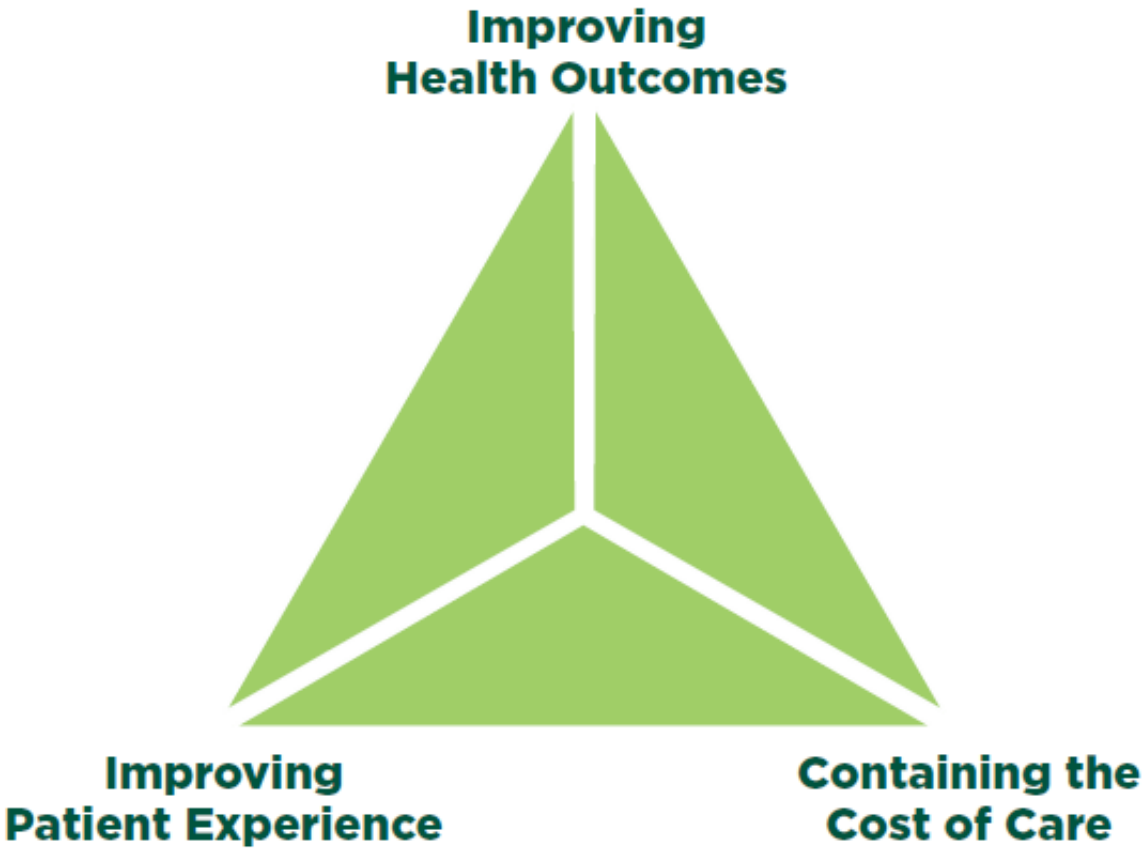
- Takes Broad view
- Establishes relationship – high level of trust
- High levels of access
- No economic conflict with offering procedures – proactive care

Health Plans

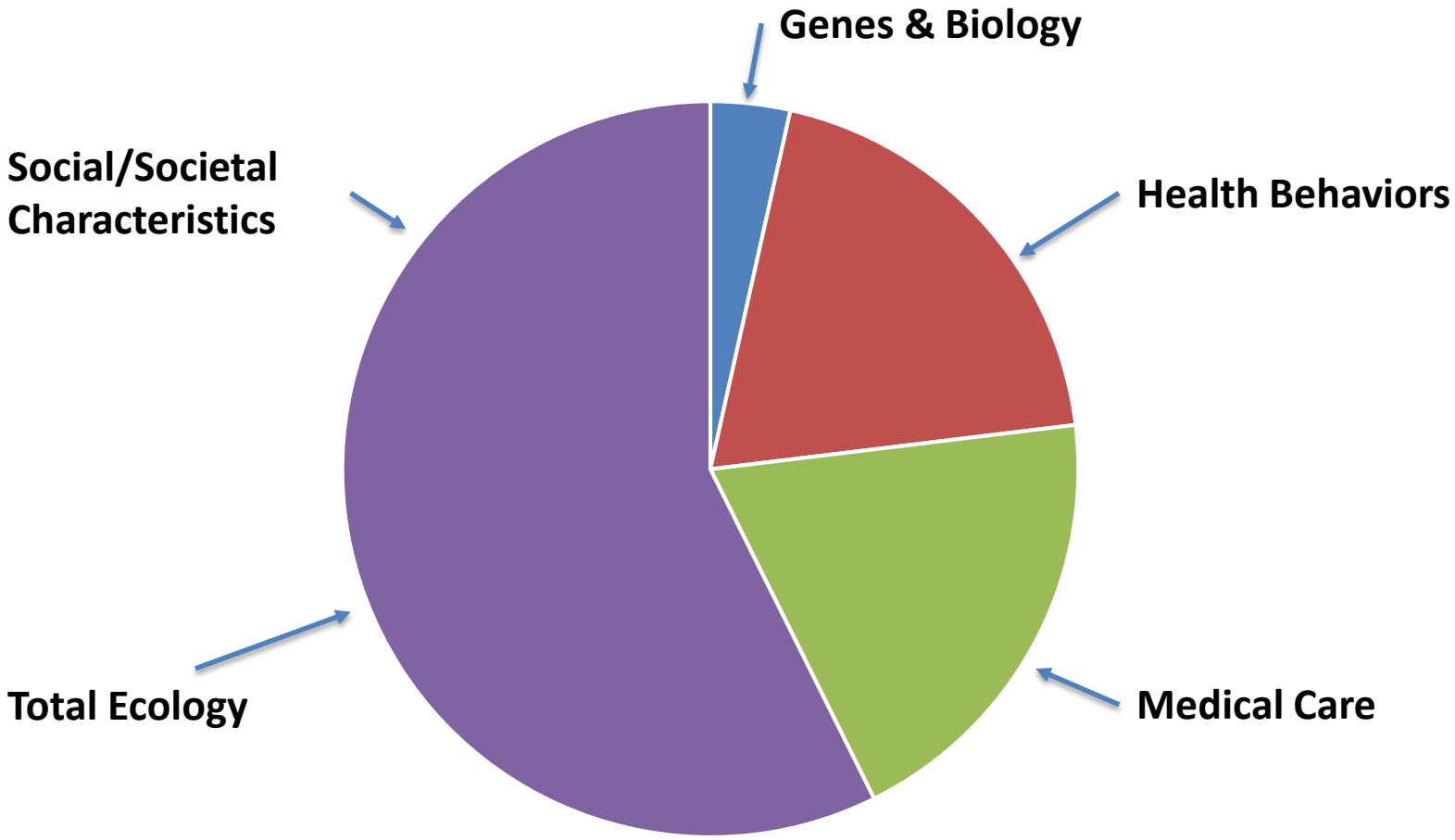
- Provides financial protection
- Creates relationships on behalf of members with physicians and hospitals
- Supports coordination of care and services

Both succeed when they meet the Triple Aim

Foundationally – Rooted in the Triple Aim



Social Determinants of Health



Reference: https://www.cdc.gov/nchhstp/socialdeterminants/faq.html

Our Care Management Strategy

Highlights of a "Replication Model" with Health Quality Partners—Our Comprehensive Care Program

1. Reason(s) for adopting the model
2. Population targeted (high-level descriptive)
3. Clinical or outcome challenges MPHC aims to improve
4. How data analysis is used to implement the model has provided new insights.
5. How you achieved leadership buy-in for this transformation.
6. Key learnings, insights, challenges, in adopting and assimilating the model.

Q & A

- Please type your questions in the Q & A box at the lower right-hand corner.
- Provide your name and organization.
- If possible, please specify who you are directing your question to.

Register for April 25 Webinar

Improving Care for High-Need Patients

Featuring

Health Share of Oregon

April 25, 2018 | 2:00 – 3:00 PM ET

Register at NAM.edu/HighNeedsWebinar

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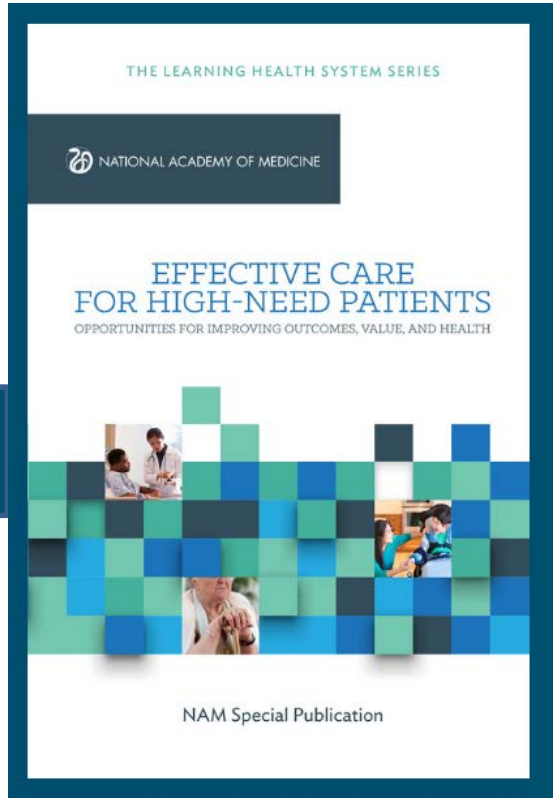


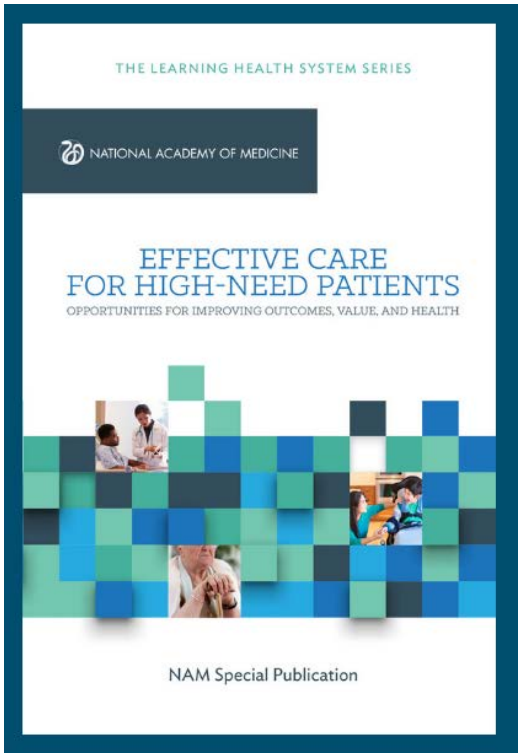
This webinar series is produced in partnership with the Peterson Center on Healthcare.

Thank you for joining!

A recording of today's webinar will be posted online at nam.edu/HighNeeds.

For more information about the National Academy of Medicine's initiative on high-need patients, please visit:

nam.edu/HighNeeds



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