

OVERVIEW

Today, 5% of patients account for nearly half of the nation's spending on health care. The needs of this patient population extend beyond care for their physical ailments to social and behavioral services which are often of central importance to their overall well-being.

Improving care management for this population while balancing quality and associated costs is at the forefront of national health care goals. This will require a unified effort from a variety of stakeholders including health systems, payers, policy makers, providers, researchers, patients, and caregivers.

Improving care for high-need patients is not only possible—it also contributes to a more sustainable health system.

What is the role of providers?

The six items listed below are opportunities for action that providers can take to improve and ensure high-quality care for some of our nation's most vulnerable patients.



WHAT PROVIDERS CAN DO

- ✓ Work collaboratively and understand that many successful care models work best when everyone works at the top of their licenses.
- ✓ Engage with patients, care partners, and their caregivers in the design and delivery of care.
- ✓ Meet patients in their communities or connect patients to community and other social resources and accept that much of the care they will need will be delivered by family and unpaid caregivers or professionals outside the health care system.
- ✓ Identify and engage patients' care partners as integrated team participants.
- ✓ Fully adopt the proven practices of health literacy to improve patients' and caregivers' ability to follow care plans developed with their input.
- ✓ Identify and work to change cultural norms that may hinder adoption of successful care models.

DELIVERY FEATURES OF SUCCESSFUL MODELS OF CARE

Teamwork

Multidisciplinary care teams with a single, trained care coordinator as the communication hub and leader.

Medication Management

Provide careful medication management and reconciliation, particularly in the home setting. This could include equipping patients with the tools they need to self-manage their medications.

Follow-Up

Prompt outpatient follow-up after hospital stays and the implementation of standard discharge protocols.

Feedback

Timely clinician feedback and data for remote patient monitoring.

Outreach

The extension of care to the community and home.

Coordination

Extensive outreach and interaction among patient, care coordinator, and care team, with an emphasis on face-to-face encounters among all parties and collocation of teams.

Integration

Work with social workers and other care team members to ensure patients have timely access to the social services they need.

Responsiveness

Speedy provider responsiveness to patients and 24/7 availability.

Explore additional resources at nam.edu/HighNeeds