Improving Care for High-Need, High Cost Patients

Extensivist Model Development

Background. Every year ten percent of the population accounts for nearly 70 percent of health care spending. In most communities the care for these frail complex patients is fragmented and disorganized with patients receiving care from multiple physicians in multiple settings with very limited communication or coordination. Healthcare systems are increasingly responsible for managing the total cost of defined populations such as under the Medicare Shared Savings and Next Generation ACO programs. Some have begun initiatives to identify their most complex patients and "surround them with services" through approaches called "extensivist" models.

Extensivist models take many forms but generally include multi-disciplinary care teams that provide intensive outpatient management for frail patients with complex chronic conditions. The care teams include extensivist physicians that manage inpatient and post-discharge care for designated patients. The most well know extensivist program is run by Medicare Advantage operator CareMore which reports lower hospitalization rates and lower spending for its beneficiaries than for Medicare patients with similar risk profiles.

Six national health foundations have undertaken a major initiative to improve care for high-need, high-cost individuals. The foundations have identified accountable care organizations (ACOs) as an important venue for implementing evidenced-based programs that address the needs of this population. The ACO financial model includes incentives to actively manage complex populations while the ACO structure provides a platform to do so effectively. Three of the foundations have partnered with the Institute for Accountable Care in a planning effort to design initiatives that will engage ACOs efforts to improve care for high-need, high-cost individuals. The planning process identified extensivist models as a promising intervention. Therefore, the Institute will implement a ***learning collaborative*** for ACOs that are planning or implementing extensivist programs.

The Learning Collaborative: We will invite up to 10 ACOs to participate in an extensivist clinic learning collaborative that will be 9– 12 months in duration. It will include 2 in-person learning sessions and monthly webinars. The content will ultimately be driven by the interests and needs of participants. The learning sessions will be guided by expert faculty including executive and operational ACO staff that have successfully implemented extensivist models. ACOs will make presentations on their own model development in order to facilitate group problem solving. By sharing the experience of planning and launching extensivist programs, ACOs will have the opportunity to learn from their peers which should facilitate faster problem resolution and adoption of best practices.

Program objectives: The objective of the learning collaborative is to support ACOs in the development and implementation of extensivist programs that deliver timely well-integrated care to the ACOs' most complex patients that improves clinical outcomes, reduces potentially avoidable acute and post-acute utilization and enhances patients' ability to remain independent.

Extensivist model options. There are a variety of models that ACOs might could consider. The Institute's ACO Advisory Group identified five distinct approaches:

1. **Extensivist Clinics** based on the CareMore approach with multi-disciplinary care teams that enroll and care for high-risk patients until their condition stabilizes and they meet disease specific targets (e.g., HBA1C below 7.5%).
2. **Post-discharge clinics** that enroll high-risk patients for a limited time period following discharge from the hospital.
3. **Clinic within a clinic**. An extensivist clinic located inside a larger primary practice where the patients' own primary care provider supervises care delivered by a specialized extensivist team.
4. **Virtual clinic** that lacks a designated physical space but with a care team that sees patients at a variety of venues with particular emphasis on care provided in the home.
5. **Clinic offering hospital-level acute care**. A clinic where patients with conditions that would qualify for inpatient hospitalization (e.g., heart failure exacerbation, dehydration, urinary tract infection), can instead elect to receive care in an outpatient setting. These clinics are proximate to a hospital and staffed with hospitalist physicians and nurses with ER or critical care experience. When the clinic closes at night patients can elect to go home or be admitted to the hospital overnight. Such a model has been implemented by the Holston Medical Group in Tennessee.

Follow-up programs: Once the initial Learning Collaborative is underway, we will work with interested sites to acquire funding for a formal demonstration program that includes technical support and a rigorous evaluation of outcomes and return on investment.