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Health System Performance for the High-Need Patient: A Look at Access to Care and Patient Care Experiences

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ABSTRACT

Issue: Achieving a high-performing health system will require improving outcomes and reducing costs for high-need, high-cost patients–those who use the most health care services and account for a disproportionately large share of health care spending. **Goal:** To compare the health care experiences of adults with high needs–those with three or more chronic diseases and a functional limitation in the ability to care for themselves or perform routine daily tasks–to all adults and to those with multiple chronic diseases but no functional limitations. **Methods:** Analysis of data from the 2009–2011 Medical Expenditure Panel Survey. **Key findings:** High-need adults were more likely to report having an unmet medical need and less likely to report having good patient–provider communication. High-need adults reported roughly similar ease of obtaining specialist referrals as other adults and greater likelihood of having a medical home. While adults with private health insurance reported the fewest unmet needs overall, privately insured high-need adults reported the greatest difficulties having their needs met. **Conclusion:** The health care system needs to work better for the highest-need, most-complex patients. This study's findings highlight the importance of tailoring interventions to address their needs.

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INTRODUCTION

Patients with multiple chronic diseases along with cognitive and physical limitations have the greatest sustained health care needs. As a group, they use the most health care services and account for a disproportionately large share of health care spending.[1] To strengthen our health care system, it is critical that we improve outcomes and reduce costs for these high-need patients.

This brief—the second in a series—examines the characteristics and health care experiences of adults with high needs, defined as people with three or more chronic diseases and a functional limitation in their ability to care for themselves or perform routine daily tasks (see How This Study Was Conducted). Using nationally representative data from the 2009–2011 Medical Expenditure Panel Survey, we found that one of 20 U.S. adults (5%) age 18 and older—or about 12 million people—met this definition.

Our first brief found that average annual health spending for this group was much higher than for all adults. In this brief, we explore whether this higher spending

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Commonwealth Fund pub. 1898
Vol. 27

was associated with better care experiences. We examined experiences with care using the following self-reported measures:

- unmet medical need
- easy access to specialists
- good patient–provider communication
- having a medical home—a usual source of care that provides comprehensive, accessible, and responsive care.

We examined our results by insurance type because differences in benefits, payment design, and regulations may affect patients' experience with care or the health system's ability to meet their needs. The vast majority of high-need adults are insured but are much more likely than the overall adult population to be covered by Medicare alone or to be dually eligible for Medicare and Medicaid (Appendix Table 1a). Therefore, we investigated how high-need adults with Medicare or Medicare–Medicaid coverage experienced care compared with their counterparts covered by private insurance or Medicaid alone. This information can help to identify potential barriers or policy changes to consider to improve care for high-need patients.

As in the first brief in this series—which examined sociodemographic characteristics, health care spending, and the use of services among adults with high needs—we compare the experiences of the high-need group to adults with multiple chronic diseases but no functional limitations as well as to all adults living in the community.

KEY FINDINGS

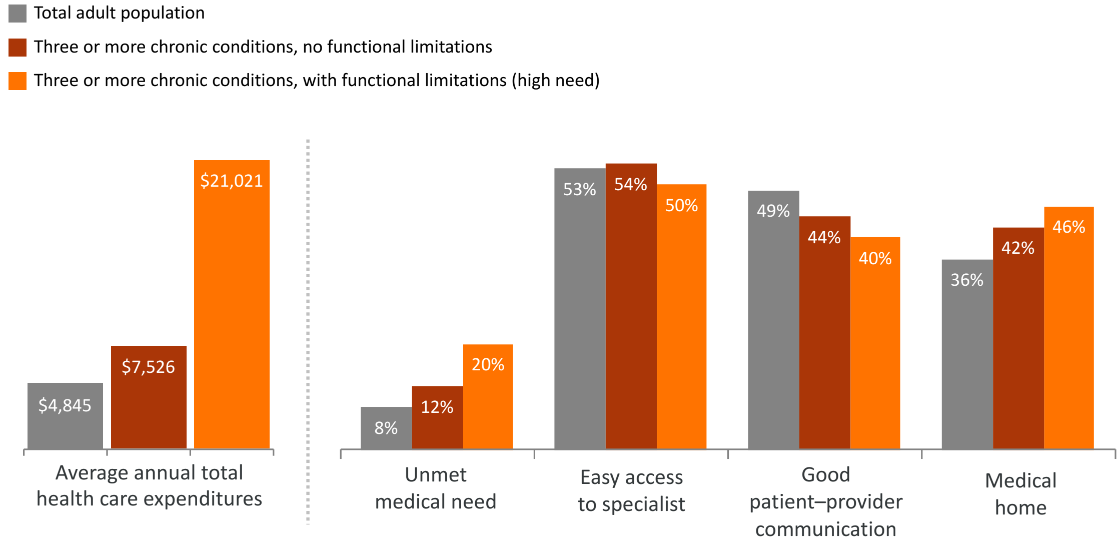
Greater Spending Does Not Equal Better Care

Patients with a high level of clinical complexity generally have a commensurately high rate of health care use and spending.[2] Average annual health care spending for high-need adults exceeded $21,000 per person, nearly three times the average for adults with multiple chronic diseases only ($7,526) and more than four times that of all adults ($4,845). Our previous analysis found that high-need adults are also more likely than other adults to continue to have high costs over two years.

However, this much higher level of spending care does not appear to buy consistently better access and care experiences. Compared with all adults or adults with multiple chronic diseases only, adults with high needs were more likely to report having an unmet medical need and less likely to report having good patient–provider communication. Roughly half of the high-need and the comparison groups were able to access specialists easily. In contrast to their experiences on other measures, high-need adults were more likely than adults with multiple chronic diseases only or adults overall to report having a usual source of care that provides comprehensive, accessible, and responsive care consistent with a medical home (Exhibit 1).

Exhibit 1

Despite Much Greater Health Care Spending, High-Need Adults Reported More Unmet Needs and Mixed Care Experiences



Note: Noninstitutionalized civilian population age 18 and older.
Data: 2009–2011 Medical Expenditure Panel Survey (MEPS). Analysis by C. A. Salzberg, Johns Hopkins University.

Unmet Medical Need

Despite much greater health care spending, one of five high-need adults (20%) reported having an unmet medical need—defined as forgoing or delaying needed medical care or prescription medication in the past year—compared to one of eight adults with multiple chronic diseases only (12%) and about one of 13 adults (8%) in the total population (Exhibit 1, Appendix Table 2).[3]

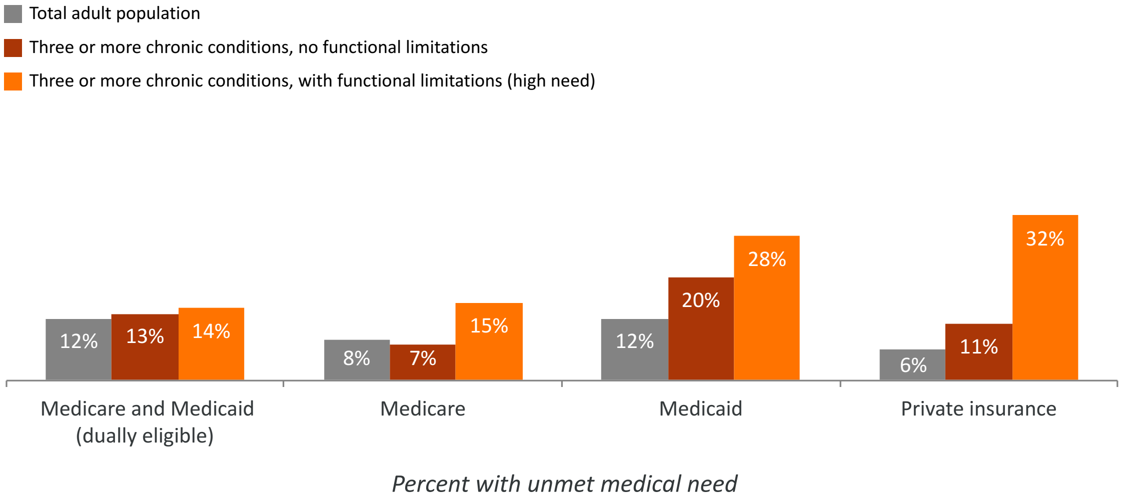
The problem does not seem to be a lack of health insurance: only 4 percent of the high-need population was uninsured at the time of the survey, before the Affordable Care Act's major coverage expansions took effect (Appendix Table 1a). The extent of unmet need varies by insurance type. Unmet needs were greatest among high-need adults with private insurance (32%) followed by those with Medicaid alone (28%). In contrast, unmet need was about half as great among high-need adults with Medicare (15%) or with Medicare and Medicaid (14%) (Exhibit 2, Appendix Table 2).

Ease of Access to Specialists

Roughly half the people in each group reported they had no problem getting a referral to a specialist when they believed they needed to see one (Exhibit 1, Appendix Table 3). There was variation across insurance types, however. Among high-need adults, those with Medicare (alone or in combination with Medicaid) were the most likely to report easy access to specialists while those covered by Medicaid alone were the least likely to have easy access (Exhibit 3, Appendix Table 3). These data, collected in 2009–2011, before the Affordable Care Act's major coverage expansions took effect, may reflect the challenges that Medicaid patients have historically faced finding specialists to treat them in a timely manner because of reimbursement rates that are lower than those offered by Medicare or commercial insurers, among other factors.[4]

Exhibit 2

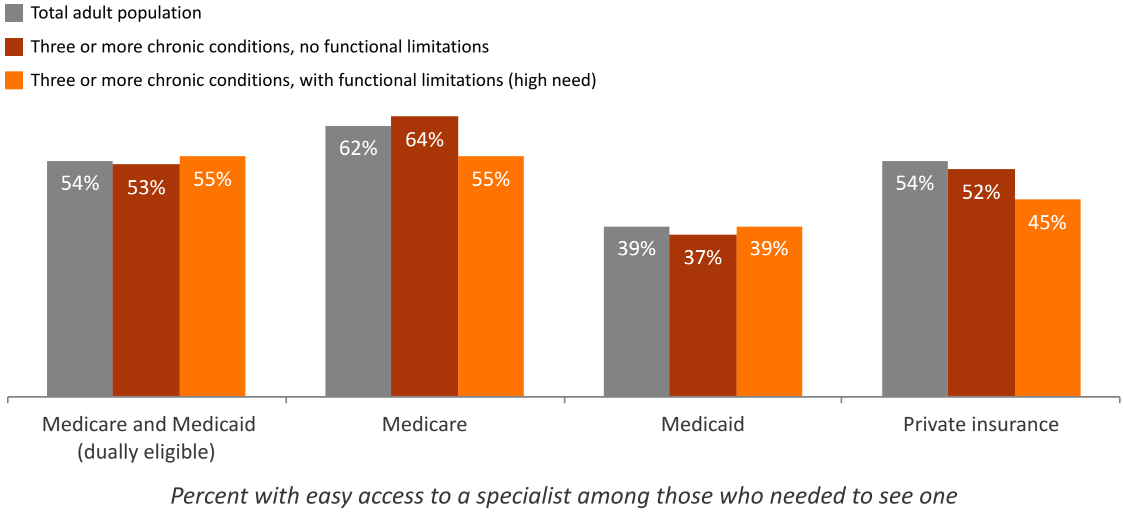
Unmet Medical Need Was Greatest Among High-Need Adults with Private Insurance



Notes: Noninstitutionalized civilian population age 18 and older. Unmet medical need means the respondent reported they needed necessary health care or prescription medicine but were unable to receive it or were delayed in receiving it during the past 12 months.
Data: 2009–2011 Medical Expenditure Panel Survey (MEPS). Analysis by C. A. Salzberg, Johns Hopkins University.

Exhibit 3

High-Need Adults with Medicare Were Most Likely to Report Easy Access to Specialists



Notes: Noninstitutionalized civilian population age 18 and older. Easy access to specialist means the respondent reported they needed to see a specialist and that it was always easy to get a specialist referral.
Data: 2009–2011 Medical Expenditure Panel Survey (MEPS). Analysis by C. A. Salzberg, Johns Hopkins University.

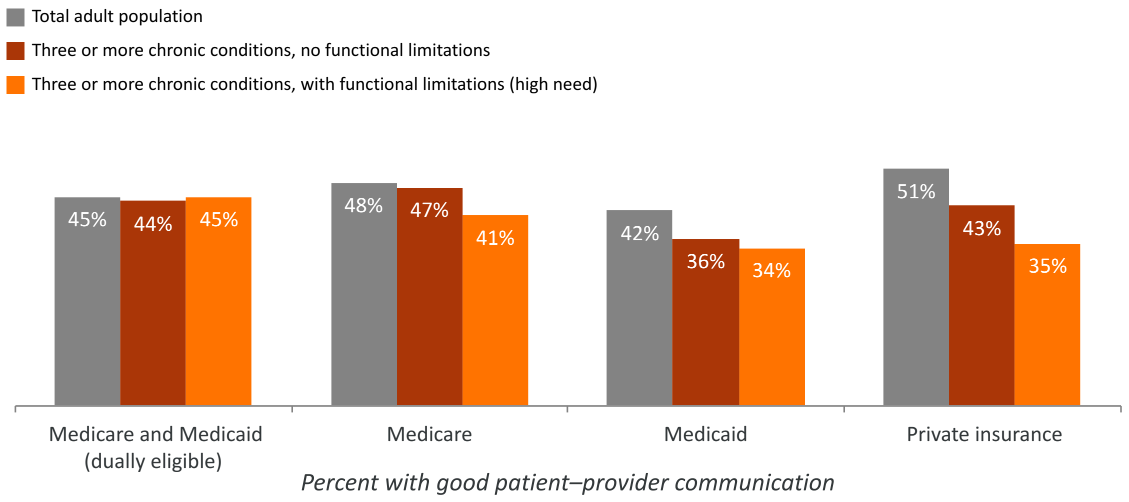
Good Patient–Provider Communication

Prior research has found that patients who report having good communication with their provider follow their treatment regimens more diligently, have better health outcomes, and experience increased satisfaction with care.[5] For patients with multiple chronic diseases, positive interpersonal exchanges with physicians are associated with higher levels of patient activation.[6]

Yet our analysis finds that only two of five high-need adults (40%) who received care at a doctor's office or clinic reported having "good" patient–provider communication (Exhibit 1, Appendix Table 4). We define this as having a provider who always: 1) spent enough time, 2) showed respect, 3) listened carefully, and 4) explained things in a way that was easy to understand. The rate among adults overall was higher (49%). This gap between high-need adults and all adults on having good patient–provider communication was widest when those high-need adults were covered by private insurance. For those who were dually insured by Medicare and Medicaid, there was little difference between high-need adults and other adults (Exhibit 4, Appendix Table 4).

Exhibit 4

High-Need Adults Were Less Likely to Report Good Patient–Provider Communication



Notes: Noninstitutionalized civilian population age 18 and older. This composite is restricted to respondents who went to a doctor's office or clinic to get care and reported that health providers always: listened carefully; explained things in a way that was easy to understand; showed respect for what the patient had to say; and spent enough time with the patient.
Data: 2009–2011 Medical Expenditure Panel Survey (MEPS). Analysis by C. A. Salzberg, Johns Hopkins University.

Usual Source of Care and Medical Home

Medical homes provide comprehensive, coordinated, patient-centered care that can benefit all patients and may especially help high-need patients improve outcomes and reduce spending. Building on previously reported metrics, we created the following medical home measure: a usual source of care that is comprehensive, accessible, and responsive to patients.[7]

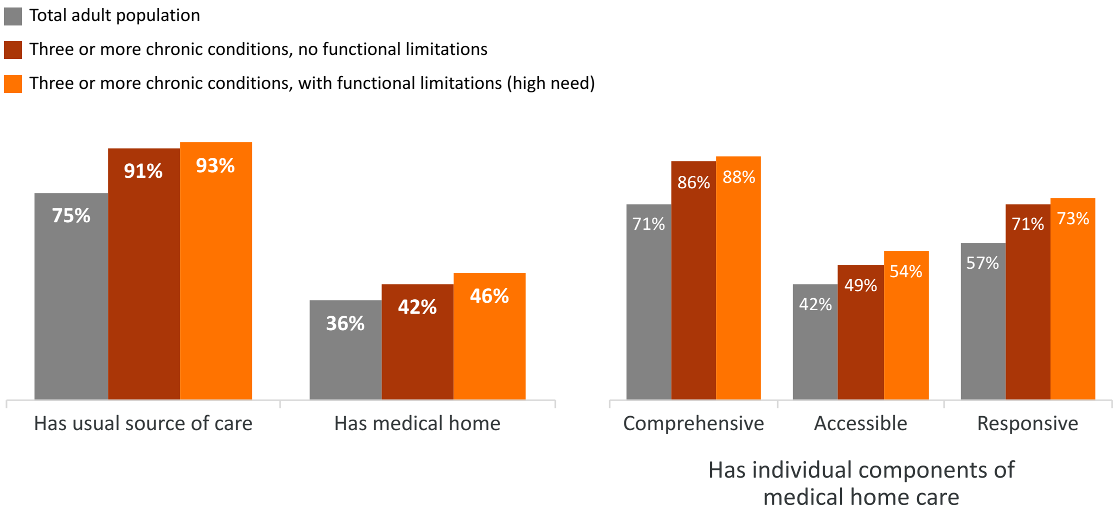
Because they have complex medical needs, it is important that high-need adults have a usual source of care and nearly all (93%) reported they did, compared with three-quarters of all adults (Exhibit 5). However, fewer than half (46%) of adults with high needs reported they had a usual source of care that met our medical home definition. Even so, this was a higher rate than found in the total adult population (36%) and suggests that efforts to target high-need populations who may benefit most from care management programs are having some success (Exhibit 5, Appendix Table 5).

To understand which of the three components that make up our medical home measure—comprehensive care, accessible care, and responsive care—were most or least likely to be available to high-need patients, we looked at each component individually. In general, whether looking at comprehensive care, accessible care, or responsive care, high-need patients were more likely than patients in other groups to report their usual provider offered such care. Across all three groups, patients were most likely to report their usual source of care provided comprehensive care (i.e., care for routine or minor health problems as well as ongoing health problems, preventive care, and referrals to other health providers). Also across all groups, off-hours access to care—meaning their usual provider offers office hours at night or the weekend, or can be contacted without difficulty by phone during regular hours or after hours—remains a considerable challenge (Exhibit 5, Appendix Table 7).

The better performance on our medical home measure among high-need adults was true across insurance types, with the highest rates among high-need Medicaid enrollees (Appendix Table 5). This promising finding may reflect the efforts of numerous states beginning in the early 2000s to spread the medical home model to their Medicaid population.[8]

Exhibit 5

High-Need Adults Were More Likely to Have Comprehensive, Accessible, and Responsive Care, Consistent with a Medical Home



Notes: Noninstitutionalized civilian population age 18 and older. Medical home means the respondent had a usual source of care that provided comprehensive, accessible, and responsive care (i.e., engaged the patient in his/her own care). See How This Study Was Conducted for definitions of components.
Data: 2009–2011 Medical Expenditure Panel Survey (MEPS). Analysis by C. A. Salzberg, Johns Hopkins University.

IMPLICATIONS

These findings suggest the health care system is not optimally configured to serve adults with high needs. Our findings reinforce other research that shows that having a functional limitation in combination with multiple chronic diseases imposes a greater burden on patients than multiple chronic diseases alone. This additive burden must be taken into account when designing care systems for high-need patients.[9]

It is reassuring that high-need adults covered by Medicare or dually enrolled in Medicare and Medicaid—who represent the majority (70%) of high-need adults—reported better care experiences and relatively low rates of unmet need. Private insurers will need to consider how they might improve benefit and network design to reduce unmet needs among high-need patients covered by commercial insurance. State policymakers should consider how to ensure adequate specialty care for high-need adults enrolled in Medicaid programs.

A number of care models aim to improve outcomes for high-need patients, some of which have shown promising results.[10] Their experience indicates the importance of targeting and tailoring initiatives to serve the unique characteristics and needs within this population so as to enable more efficient use of resources and promote better patient experiences and outcomes.[11]

HOW THIS STUDY WAS CONDUCTED

We conducted a retrospective cohort analysis of the 2009–2011 Medical Expenditure Panel Survey (MEPS)–Household Component. MEPS is representative of the noninstitutionalized civilian U.S. population; we focused our analysis on adults age 18 and older.

MEPS respondents were classified into four mutually exclusive cohorts. The cohorts were defined hierarchically, first among persons with and without functional limitation and then by the presence of fewer than three, or three or more, chronic diseases. Chronic diseases were identified using a previously described approach that assigns ICD–9 diagnosis codes (first three digits) to the Agency for Healthcare Research and Quality's Clinical Classification System.[12] Functional status was based on respondents' self-reported limitations in activities of daily living (i.e., basic personal care tasks) or instrumental activities of daily living, such as shopping, preparing food, managing medications, and performing routine household tasks. Reporting in this brief excludes the cohorts with fewer than three chronic diseases, with or without functional limitations, except to the extent they are reflected in the total adult population.

We defined adults with three or more chronic diseases and a functional limitation as "high need," and compared this cohort to adults with three or more chronic diseases and no functional limitations and the total adult population on per capita total health care spending, which includes expenditures for services provided by hospitals, physicians, and other health providers, as well for prescribed medicines, dental care, and medical equipment, and on four self-reported measures defined as follows:

1. *Unmet medical need:* respondents reported they needed necessary health care or prescription medicine but were unable to receive it or were delayed in receiving it during the past 12 months.
2. *Easy access to specialists:* respondents reported they needed to see a specialist and that it was always easy to get a referral.
3. *Good patient–provider relationship:* composite restricted to respondents who went to a doctor's office or clinic to get care and reported that health providers always listened carefully, explained things in a way that was easy to understand, showed respect for what the patient had to say, and spent enough time with the patient.
4. *Medical home:* the respondent had a usual source of care that provided comprehensive, accessible, and responsive care, defined as follows:

   Comprehensive care means the usual provider offered care for routine or minor health problems and ongoing health problems, preventive health care, and referrals to other health providers.

   Accessible care means the usual provider offered office hours at night or the weekend, or the respondent had no difficulty contacting the provider by phone during regular hours or after hours.

   Responsive care means the usual provider usually asks about prescription medications and treatments prescribed by other doctors or usually asks the patient to help decide among a choice of treatments.

Limitations. We did not analyze the interaction between insurance type and age or other sociodemographic factors; some differences in performance by insurance type may reflect differences in the composition of enrollees in particular insurance types. Those who face financial or other barriers to care, or who are less likely to seek care when medically needed, may be underrepresented in counts of chronic diseases because they have not had the opportunity to be medically evaluated and diagnosed.

All authors contributed to data interpretation. Data analysis was conducted by Claudia A. Salzberg under the supervision of Gerard F. Anderson at the Johns Hopkins Bloomberg School of Public Health under a grant from The Commonwealth Fund. This brief builds on a prior analysis by Eric T. Roberts also under a grant to the Johns Hopkins Bloomberg School of Public Health.

NOTES

[1] M. K. Abrams and E. C. Schneider, "Fostering a High-Performance Health System That Serves Our Nation's Sickest and Frailest," *To The Point,* The Commonwealth Fund, Oct. 29 2015.

[2] S. L. Hayes, C. A. Salzberg, D. McCarthy, D. C. Radley, M. K. Abrams, T. Shah, and G. F. Anderson, *High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care? A Population-Based Comparison of Demographics, Health Care Use, and Expenditures* (The Commonwealth Fund, Aug. 2016).

[3] Additional analysis of those reporting that they did not receive needed health care found that the majority cited cost, followed by their insurer's refusal to cover the treatment, as the reason. Thus it seems likely that, for some high-need adults, out-of-pocket expenses along with insurance design may be barriers to meeting perceived needs for medical care.

[4] L. E. Felland, A. E. Lechner, and A. Sommers, *Improving Access to Specialty Care for Medicaid Patients: Policy Issues and Options* (The Commonwealth Fund, June 2013).

[5] J. F. Ha and N. Longnecker, "Doctor–Patient Communication: A Review," *The Ochsner Journal,* Spring 2010 10(1):38–43; and S. H. Kaplan, S. Greenfield, and J. E. Ware, Jr., "Assessing the Effects of Physician–Patient Interactions on the Outcomes of Chronic Disease," *Medical Care,* March 1989 27(3 Suppl.):S110–S127.

[6] J. A. Alexander, L. R. Hearld, J. N. Mittler et al., "Patient–Physician Role Relationships and Patient Activation Among Individuals with Chronic Illness," *Health Services Research,* June 2012 47(3 Pt. 1):1201–23.

[7] The definition for our proxy, or composite measure, of a medical home is adapted from A. C. Beal, S. E. Hernandez, and M. M. Doty, "Latino Access to the Patient-Centered Medical Home," *Journal of General Internal Medicine,* Nov. 2009 24(Suppl. 3):514–20. We defined comprehensive, accessible, and responsive care as follows: comprehensive care means the usual provider offered care for routine or minor health problems and ongoing health problems, preventive health care, and referrals to other health providers; accessible care means the usual provider offered office hours at night or the weekend, or the respondent had no difficulty contacting the provider by phone during regular hours or after hours; responsive care means the usual provider usually asks about prescription medications and treatments prescribed by other doctors or usually asks the patient to help decide among a choice of treatments.

[8] N. Kaye, J. Buxbaum, and M. Takach, *Building Medical Homes: Lessons from Eight States with Emerging Programs* (The Commonwealth Fund and the National Academy for State Health Policy, Dec. 2011); and N. Kaye and M. Takach, *Building Medical Homes in State Medicaid and CHIP Programs* (National Academy for State Health Policy and The Commonwealth Fund, June 2009).

[9] S. M. Koroukian, N. Schiltz, D. F. Warner et al., "Combinations of Chronic Conditions, Functional Limitations, and Geriatric Syndromes That Predict Health Outcomes," *Journal of General Internal Medicine,* June 2016 31(6):630–37.

[10] D. McCarthy, J. Ryan, and S. Klein, *Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis* (The Commonwealth Fund, Oct. 2015); and G. F. Anderson, J. Ballreich, S. Bleich et al., "Attributes Common to Programs That Successfully Treat High-Need, High-Cost Individuals," *American Journal of Managed Care,* published online Nov. 10, 2015.

[11] G. Anderson and J. R. Knickman, "Changing the Chronic Care System to Meet People's Needs," *Health Affairs,* Nov. 2001 20(6):146–60.

[12] W. Hwang, W. Weller, H. Ireys et al., "Out-of-Pocket Medical Spending for Care of Chronic Conditions," *Health Affairs,* Nov. 2001 20(6):267–78; and K. A. Paez, L. Zhao, and W. Hwang, "Rising Out-of-Pocket Spending for Chronic Conditions: A Ten-Year Trend," *Health Affairs,* Jan./Feb. 2009 28(1):15–25.

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