



How High-Need Patients Experience Health Care in the United States

Findings from the 2016 Commonwealth Fund Survey of High-Need Patients

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ABSTRACT

Issue: Health care costs are highly concentrated among people with multiple chronic conditions, behavioral health problems, and those with physical limitations or disabilities. With a better understanding of these patients' challenges, health care systems and providers can address patients' complex social, behavioral, and medical needs more effectively and efficiently. **Goal:** To investigate how the challenges faced by this population affect their experiences with the health care system and examine potential opportunities for improvement. **Methods:** Analysis of the 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016. **Key findings and conclusions:** The health care system is currently failing to meet the complex needs of these patients. High-need patients have greater unmet behavioral health and social issues than do other adults and require greater support to help manage their complex medical and nonmedical requirements. Results indicate that with better access to care and good patient–provider communication, high-need patients are less likely to delay essential care and less likely to go to the emergency department for nonurgent care, and thus less likely to accrue avoidable costs. For health systems to improve outcomes and lower costs, they must assess patients' comprehensive needs, increase access to care, and improve how they communicate with patients.

INTRODUCTION

In the United States, patients with clinically complex conditions, cognitive or physical limitations, or behavioral health problems use a disproportionate amount of health care services.¹ In any given year, 10 percent of patients account for 65 percent of the nation's health care expenditures.² Moreover, many patients with high needs—that is, people with two or more major chronic conditions like diabetes or heart failure—also have unmet social needs that may exacerbate their medical conditions.³

With a better understanding of this patient population, health care providers would be more equipped to develop strategies for addressing behavioral health problems and unmet social needs. These, in turn, could lead to improved medical outcomes and potentially lower health care costs.

Previous studies by The Commonwealth Fund have examined this population's demographics and their high use of health care services, but we require

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additional information about their medical and nonmedical needs, as well as recommendations that could assist health systems to improve outcomes and curb costs.⁴ The 2016 Commonwealth Fund Survey of High-Need Patients sampled 3,009 U.S. adults, including 1,805 high-need adults and 1,204 other adults without high needs, to investigate how the challenges faced by this patient population affect their experiences with the health care system and where there might be opportunities for improvement. For additional information on the sampling strategy and population breakdown, see [How This Study Was Conducted](#).

FINDINGS

This survey confirms prior studies that examined the demographic characteristics of the high-need population.⁵ Compared with the general population, the high-need population is older, has lower levels of education and income, and includes more women and African Americans (Table 1). High-need patients use more health care services than other adults, as has been reported in previous analyses (Table 2).⁶ Nearly half (48%) of high-need respondents were hospitalized overnight in the past two years; a similar percentage (47%) went to the emergency department multiple times in the past two years. Approximately one of five (19%) used the emergency department for a condition that could have been treated in a doctor's office or a clinic.

Many High-Need Patients Report Social Isolation and Other Unmet Social Needs

Adults with high medical needs often have unmet emotional and social needs. The survey results indicate that this group is more likely than the general population to report experiencing emotional distress that was difficult to cope with on their own in the past two years. Nearly four of 10 (37%) high-need respondents reported often feeling socially isolated, including lacking companionship, feeling left out, or feeling lonely or isolated from others, compared with 15 percent of other adults (Exhibit 1). Almost two-thirds (62%) of high-need respondents report stress or worry about material hardships, such as being unable to pay for housing, utilities, or nutritious meals, compared to only one-third of other adults (32%). Furthermore, six of 10 (59%) high-need adults report being somewhat or very concerned about being a burden to family or friends (Table 3).

Nearly Half of High-Need Patients Delay Care and Report Access Problems

High-need patients report problems with access to care (Exhibit 2). More than two-fifths (44%) reported delaying care in the past year because of an access problem such as lack of transportation to the doctor's office, limited office hours, or an inability to get an appointment quickly enough. Nearly one-quarter (22%) of high-need respondents specifically reported a lack of transportation as a reason for delaying care, compared with only 4 percent of other adults. Three of 10 (29%) high-need respondents reported delaying care specifically as a result of not being able to get an appointment soon enough with their regular provider.

WHO WE SURVEYED



High-need patients are adults with *two or more major chronic conditions* like heart failure, stroke, or diabetes requiring insulin.

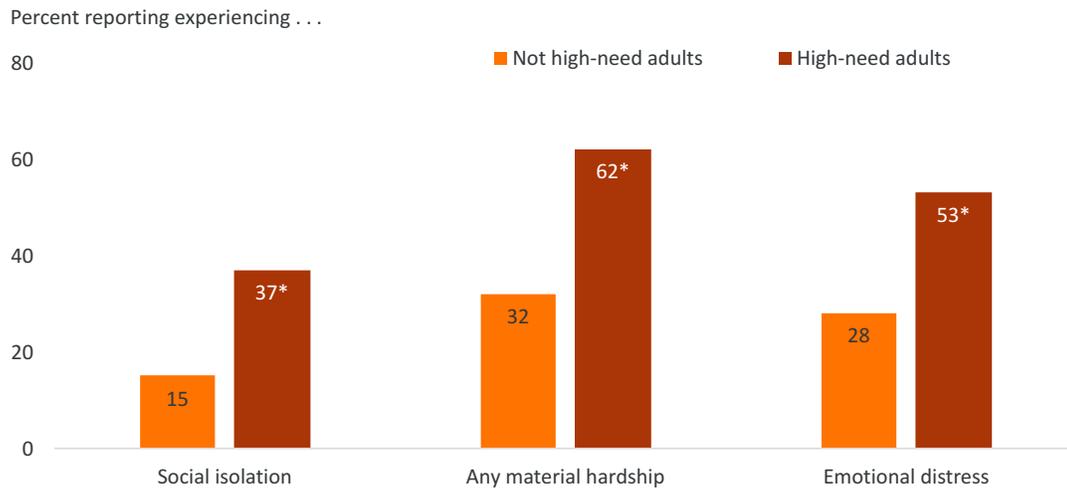
High-need patients *may or may not have functional limitations* in their ability to perform daily tasks like meal preparation, dressing, or bathing.

Some are *under age 65 with a disability*.

Others are *elderly with multiple functional limitations*.

Exhibit 1

Poverty and Social Isolation Are More Prevalent Among High-Need Patients



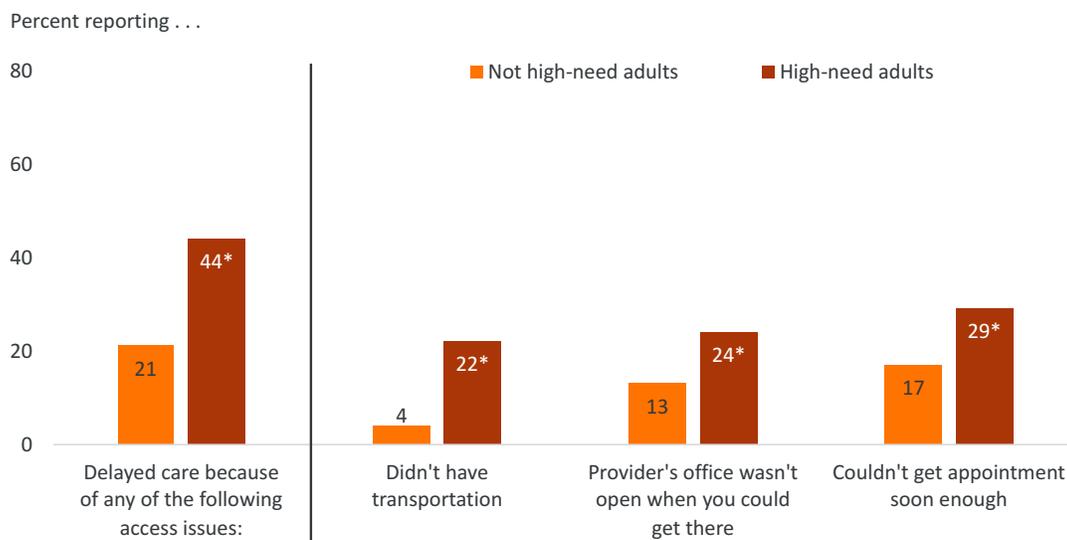
Notes: Social isolation = Reported often feeling left out, lacking companionship, or feeling isolated from others. Any material hardship = Reported worry or stress about having enough money to pay rent/mortgage, pay gas/oil/electric, or buy nutritious meals in the past year.

* Significantly different from not high-need adults at the p<0.05 level.

Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

Exhibit 2

High-Need Patients Experience Disparities in Timely Access to Care



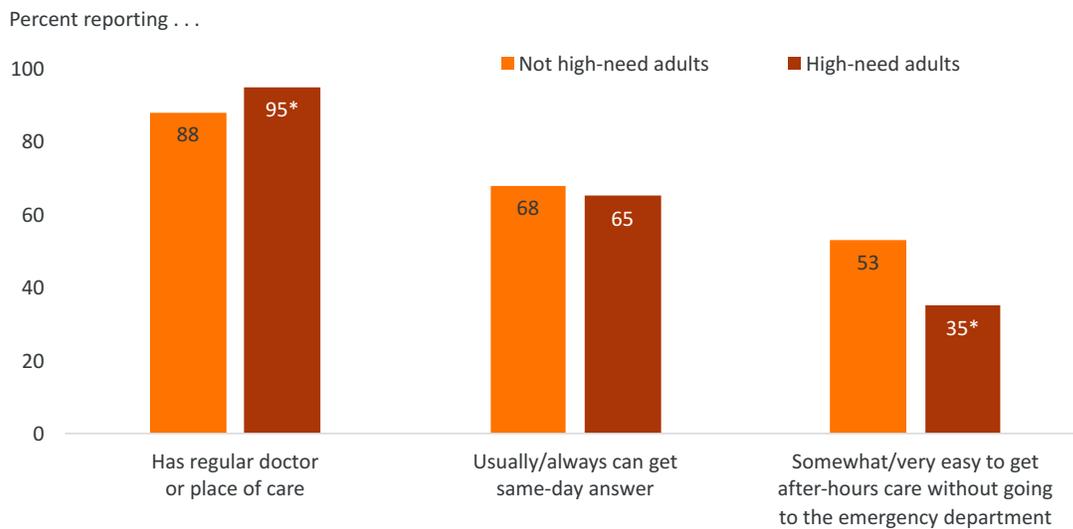
* Significantly different from not high-need adults at the p<0.05 level.

Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

Nearly all high-need respondents (95%) reported having a regular doctor or place of care (Exhibit 3). Yet, only two-thirds of adults (65% of high-need and 68% of other adults) report being able to get an answer the same day when they contact their doctor's office with a medical question, in line with similar analyses.⁷ In particular, high-need respondents report difficulty being able to get after-hours medical care on weekends, evenings, or holidays. Only one-third (35%) of high-need respondents reported it was somewhat or very easy to get medical care after-hours without going to the emergency room, compared with more than half (53%) of other adults.

Exhibit 3

High-Need Patients Report Problems with Convenient Access to Care



* Significantly different from not high-need adults at the $p < 0.05$ level.
Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

Less Than Half of High-Need Adults Receive Assistance in Managing Conditions

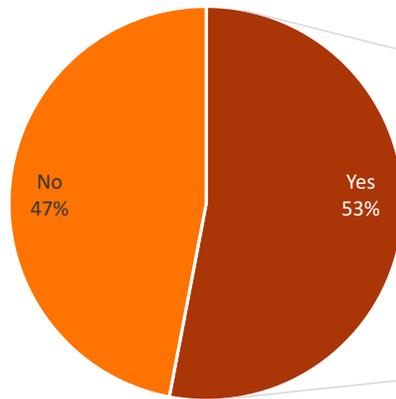
High-need patients are somewhat less likely than others to report receiving care that is accessible, efficient, and high quality. They are also unlikely to have convenient and timely access to key services or supports that can help them manage their conditions outside hospitals or emergency departments.

- Half of high-need respondents reported experiencing emotional distress that they found difficult to cope with alone. Of these, fewer than four of 10 (39%) could get counseling as soon as they wanted (Exhibit 4).
- Of the 53 percent of high-need respondents who reported seeing multiple doctors or using multiple health care services in the past year, less than half (43%) reported having an informed and up-to-date care coordinator (Exhibit 5).
- Of the 57 percent of high-need respondents who have trouble with activities of daily living, fewer than four of 10 (38%) usually or always have someone to help them (Exhibit 6). Among respondents who received help, about three-quarters said it came from family members or relatives (data not shown).

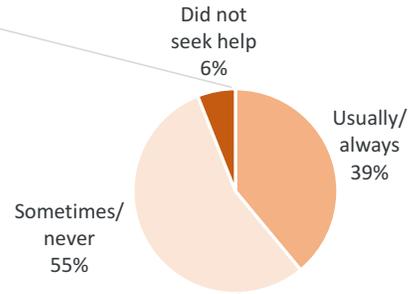
Exhibit 4

Less Than Half of Distressed High-Need Patients Can Usually or Always Get an Appointment for Emotional Counseling as Soon as Needed

In the past two years, experienced emotional distress that was difficult to cope with alone



Can get an appointment for counseling as soon as needed

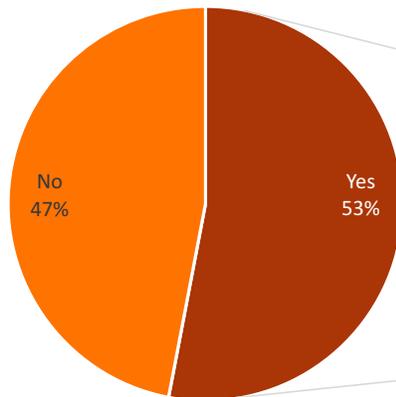


Base: High-need adults.
Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

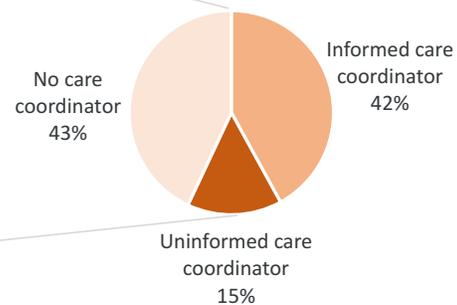
Exhibit 5

Less Than Half of High-Need Patients Who Might Need One Have an Informed Care Coordinator

In the past two years, visited multiple doctors' offices or used multiple health care services



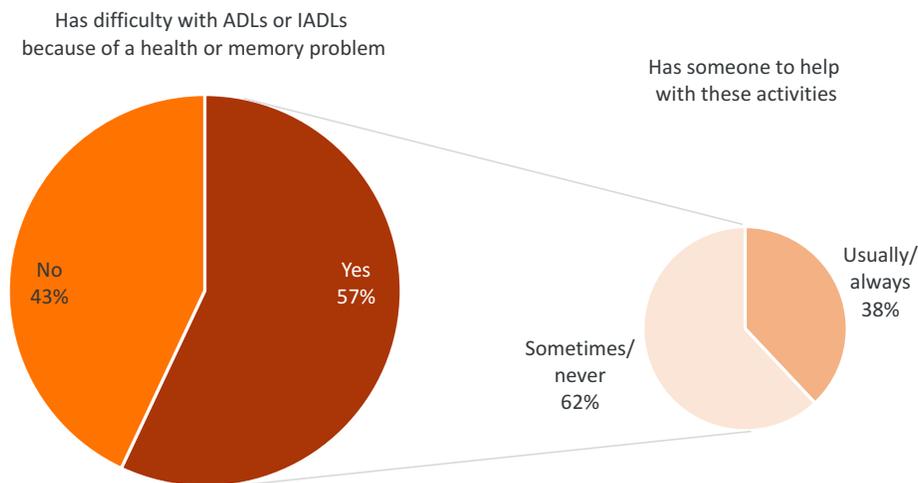
Has a care coordinator



Base: High-need adults.
Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

Exhibit 6

Few High-Need Patients with Functional Limitations Have Adequate Help with Activities of Daily Living



Base: High-need adults.

Note: ADLs = activities of daily living (e.g., eating, bathing, dressing); IADLs = instrumental activities of daily living (e.g., housework, preparing meals).

Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

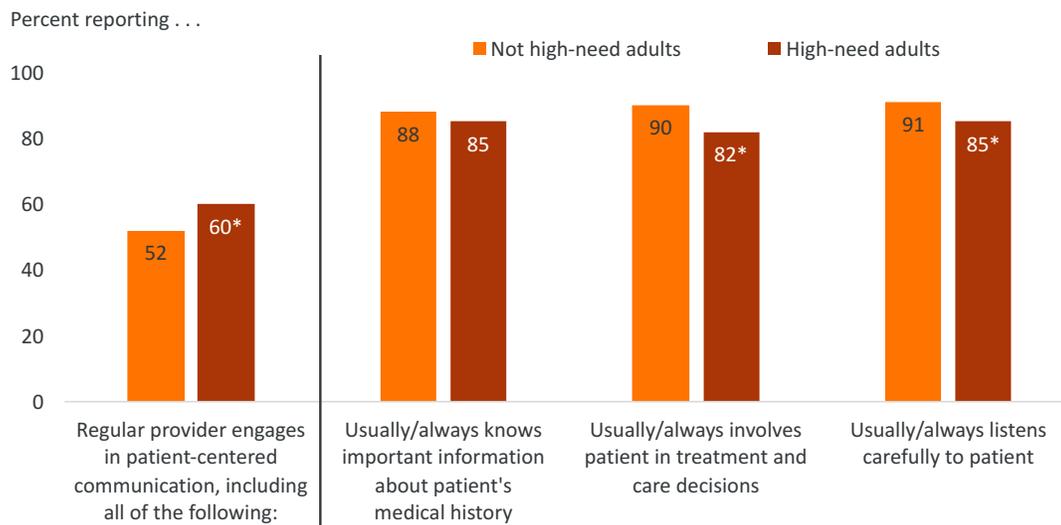
Some high-need respondents are more adversely affected by access issues than others. Among high-need respondents, those who were socially isolated or had low incomes were less likely than respondents without these issues to report having support to manage their conditions, such as easy access to counseling for emotional distress, an informed care coordinator, access to after-hours care, or adequate help for functional limitations (Table 4). Another important factor was their insurance status. High-need adults with employer-sponsored insurance reported a greater likelihood of having these aforementioned resources to help manage their care, while those who are uninsured are less likely to have these resources. Additionally, high-need Medicare and dual Medicare–Medicaid beneficiaries typically had greater access to these resources than the uninsured. While 87 percent of uninsured high-need patients reported having a regular doctor or place of care, less than half reported having an informed care coordinator, adequate help with their functional limitations, patient-centered communication with their regular provider, easy access to emotional counseling, or easy access to after-hours care.

Good Patient–Provider Communication Is Critical for High-Need Population

Patient-centered communication—when patients report that their health care provider listens carefully and involves them in decisions as much as they would like—is critical to high-quality care, especially for high-need patients.⁸ More high-need patients (60%) than other adults (52%) have doctors or providers who fully engage in patient-centered communication (Exhibit 7). However, high-need adults are less likely to report that their providers specifically involve them in treatment decisions (82% of high-need adults vs. 90% of others) or listen carefully to them (85% of high-need adults vs. 91% of others).

Exhibit 7

There Is Room for Improvement in Patient-Centered Communication for High-Need Patients



* Significantly different from not high-need adults at the $p < 0.05$ level.

Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

With Good Access and Communication, High-Need Patients Are Less Likely to Delay Care and Visit the Emergency Department

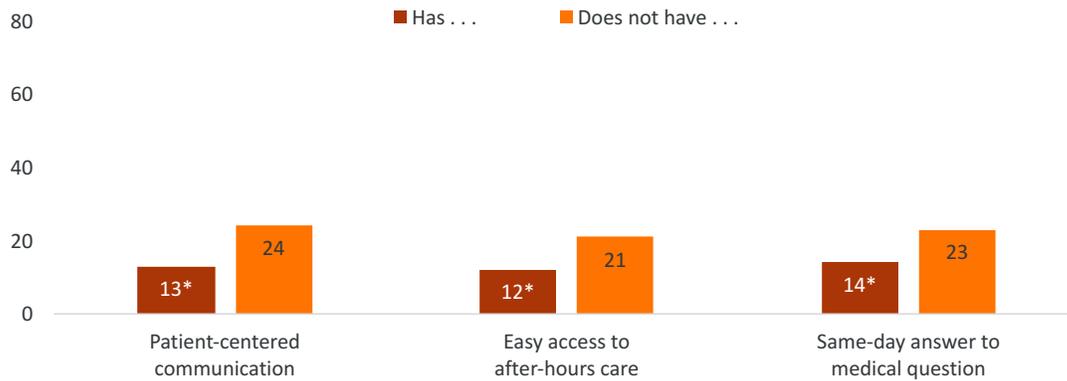
Survey findings suggest tangible strategies to reduce nonurgent emergency department use and to help high-need adults avoid delaying care (Table 2). For high-need patients, having accessible after-hours care, being able to get a same-day answer to a medical question, and having a good relationship with their regular health care provider through patient-centered communication are associated with lower rates of nonurgent emergency department visits for conditions that could have been handled by a regular doctor if one had been available (Exhibit 8). Additionally, having accessible after-hours care is associated with less frequent total emergency department use (both urgent and nonurgent) among high-need patients. While the analysis suggests a relationship between access and communication and a reduction in emergency department visits, there was no similar association with inpatient hospitalizations (Table 5).

For high-need adults, having good communication with their regular provider and good access to care are associated with lower rates of delaying care because of the following reasons: not having transportation, the office not being open when the patient could get there, and not being able to get an appointment soon enough (Exhibit 9). Being able to access care and information in a timely manner are also associated with decreased emotional distress among high-need adults.

Exhibit 8

For High-Need Patients, Good Access to Care and Communication with Provider Are Associated with Fewer Nonurgent Emergency Department Visits

Percent of high-need patients who reported using the emergency department for a condition that could have been treated in the doctor's office



Base: High-need adults.

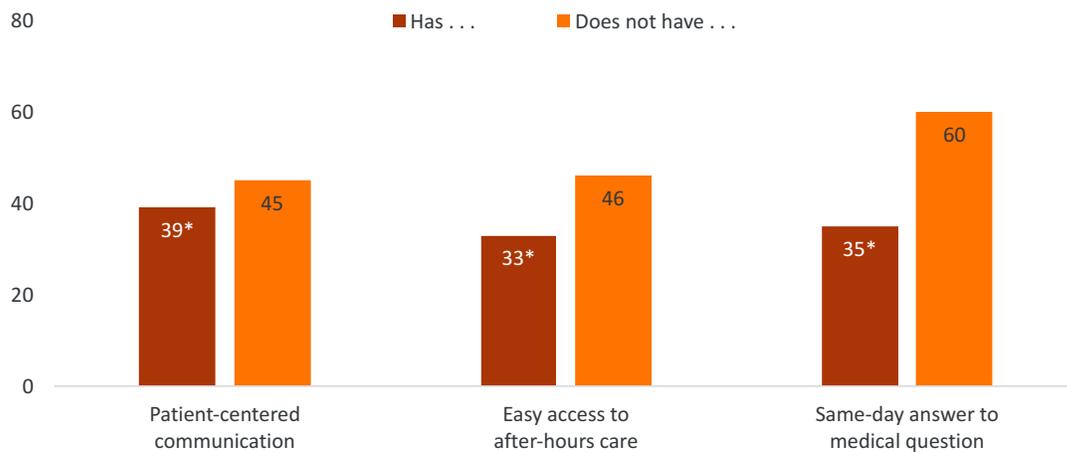
* Significantly different at the p<0.05 level.

Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

Exhibit 9

High-Need Patients with Good Physician Communication and Timely Access to Care Have Lower Rates of Delaying Care

Percent of high-need patients who reported delaying care in past year because of access issue



Base: High-need adults.

* Significantly different at the p<0.05 level.

Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

IMPLICATIONS

By examining the unique challenges and needs of this patient population, we can identify and develop innovative interventions to meet their needs. In doing this, we should consider the following:

Understand patients' social and behavioral needs in addition to their medical conditions

The survey findings show the range of social and behavioral health challenges facing these patients in addition to their complex medical conditions. Social isolation and material hardship, for example, have been shown to aggravate medical conditions.⁹ For health systems, payers, and programs to improve outcomes for high-need adults, providers must consider multiple factors—individuals may have multiple chronic diseases, functional limitations, behavioral health conditions, and material hardships.¹⁰ To help people who most need resources, the interventions must be more comprehensive and creative than just a standard set of doctor visits.¹¹ Health care providers should build relationships and collaborate with social service agencies, community-based organizations, and behavioral health providers to deliver better outcomes and avoid high-cost care for this population.

Ensure patients obtain much-needed assistance to manage their health

The results suggest that the health care system is largely failing to meet the complex needs of these patients. Although high-need adults report they are more likely to have—and enjoy good communication with—a regular doctor or place of care, these patients do not receive the services and supports they need. In particular, high-need patients report limited access to known effective supports and services, such as transportation services, emotional counseling, assistance in managing functional limitations, and care coordinators.¹² Of patients who have high needs and functional limitations, as well as financial stress, those who had an informed care coordinator or had patient-centered communication with their provider were less likely to use the emergency department for a nonurgent condition (data not shown).

Improve outcomes while potentially lowering costs of care

Health systems are increasingly focused on targeting high utilizers of care as a way to simultaneously improve outcomes and save money. Our analysis suggests two key strategies for improving patient care while potentially curbing costs: increasing patient-centered communication and enabling easier access to appropriate care and information, both of which would support patients in managing their conditions.¹³ Having timely access to care—by phone, or in person after hours—and good provider–patient communication could potentially reduce nonurgent emergency department visits and help patients avoid delays in needed care.¹⁴ Increasing the health care system's responsiveness to patients in this way could help avoid unnecessary care that drives up the nation's health care costs.

HOW THIS STUDY WAS CONDUCTED

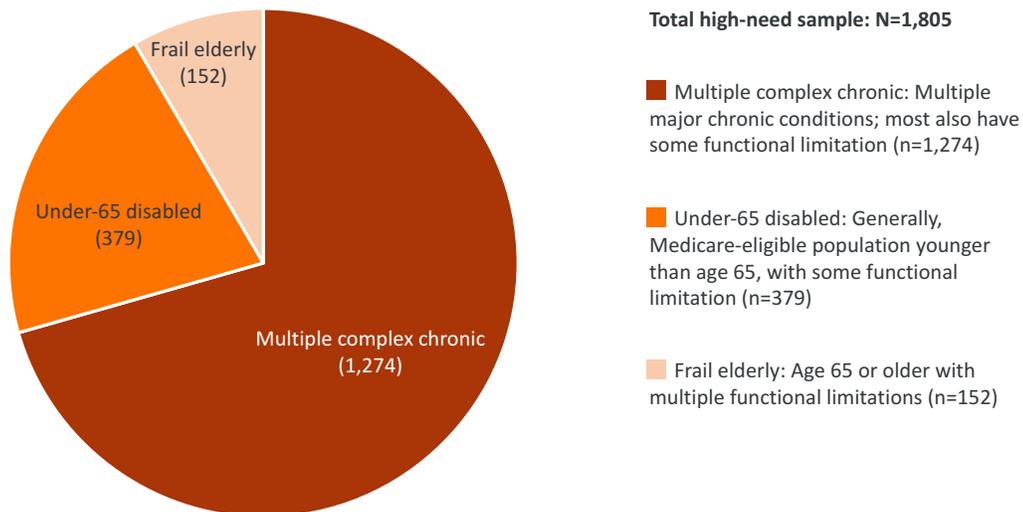
The 2016 Commonwealth Fund Survey of High-Need Patients was conducted by SSRS from June 22 to September 14, 2016, as a part of SSRS's weekly, nationally representative omnibus survey. The survey consisted of 15-minute telephone interviews in English or Spanish, conducted among 3,009 adults age 18 and older living in the United States. Of these, 1,805 were completed with respondents who qualified as high-need based on screening questions (Exhibit M1). Respondents were screened into the high-need group based on combinations of major chronic conditions, functional limitations, age, and insurance status (Exhibit M2). The remaining 1,204 interviews were conducted among respondents who did not qualify as high-need. Overall, 1,323 interviews were conducted with respondents on landline telephones, including 31 in Spanish; 1,686 interviews were conducted on cellular phones, including 61 in Spanish.

Data were weighted by age, race, sex, region, education, and phone status to provide nationally representative estimates of the U.S. adult population age 18 and older. The weighting process takes into account the disproportionate probabilities of household and respondent selection as a result of the number of separate telephone landlines and cellphones answered by respondents and their households, as well as the probability associated with the random selection of an individual household member.

Accounting for sample size and design effect, the margin of sampling error for this study was ± 3 percent. The response rates for this study were calculated using AAPOR's RR3. The landline portion of the survey achieved a 10 percent response rate and the cellular phone component achieved a 5 percent response rate. The overall response rate was 7 percent.

Exhibit M1

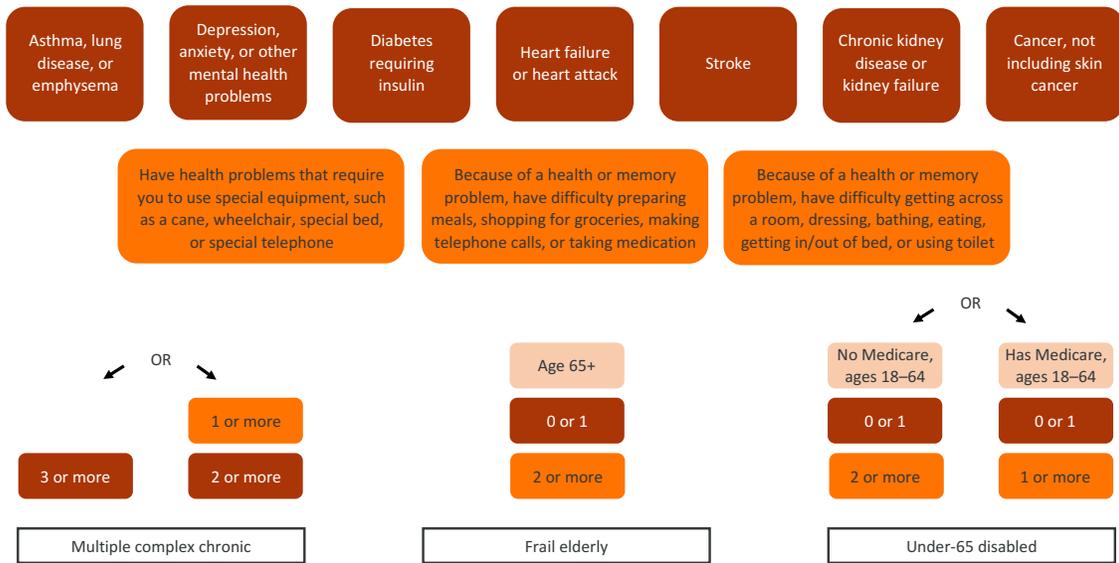
Distribution of Survey Respondents with High Needs



Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

Exhibit M2

Distribution of Survey Respondents with High Needs by Chronic Conditions, Functional Limitations, and Insurance Status



Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

NOTES

- ¹ U.S. Department of Health and Human Services, *Multiple Chronic Conditions: A Strategic Framework—Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions* (DHHS, Dec. 2010); and S. Goodell, B. G. Druss, and E. R. Walker, *Mental Disorders and Medical Comorbidity* (Robert Wood Johnson Foundation, Feb. 2011).
- ² S. B. Cohen, *Differentials in the Concentration of Health Expenditures Across Population Subgroups in the U.S., 2013*, MEPS Statistical Brief #480 (Agency for Healthcare Research and Quality, Sept. 2015).
- ³ D. Bachrach, H. Pfister, K. Wallis et al., *Addressing Patients’ Social Needs: An Emerging Business Case for Provider Investment* (The Commonwealth Fund, May 2014); and J. M. McGinnis, P. Williams-Russo, and J. R. Knickman, “The Case for More Active Policy Attention to Health Promotion,” *Health Affairs*, March 2002 21(2):78–93; and S. A. Schroeder, “We Can Do Better—Improving the Health of the American People,” *New England Journal of Medicine*, Sept. 20, 2007 357(12):1221–28.
- ⁴ 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); and C. A. Salzberg, S. L. Hayes, D. McCarthy, D. C. Radley, M. K. Abrams, T. Shah, and G. F. Anderson, *Health System Performance for the High-Need Patient: A Look at Access to Care and Patient Care Experiences* (The Commonwealth Fund, Aug. 2016).
- ⁵ Survey patient population has a similar demographic profile to those identified in recently published analyses of federal surveys. See 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); and S. B. Cohen, *Differentials in the Concentration of Health Expenditures Across Population Subgroups in the U.S., 2013*, MEPS Statistical Brief #480 (Agency for Healthcare Research and Quality, Sept. 2015).
- ⁶ 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).
- ⁷ R. Osborn, D. Squires, M. M. Doty, D. O. Sarnak and E. C. Schneider, “In New Survey of 11 Countries, U.S. Adults Still Struggle with Access to and Affordability of Health Care,” *Health Affairs* Web First, published online Nov. 16, 2016.
- ⁸ M. A. Stewart, “Effective Physician–Patient Communication and Health Outcomes: A Review,” *Canadian Medical Association Journal*, May 1, 1995 152(9):1423–33; and D. G. Safran, M. Karp, K. Coltin et al., “Measuring Patients’ Experiences with Individual Primary Care Physicians: Results of a Statewide Demonstration Project,” *Journal of General Internal Medicine*, Jan. 2006 21(1):13–21.

- ⁹ L. C. Hawkey and J. T. Cacioppo, “Loneliness Matters: A Theoretical and Empirical Review of Consequences and Mechanisms,” *Annals of Behavioral Medicine*, Oct. 2010 40(2):218–27; J. Holt-Lunstad, T. B. Smith, and J. B. Layton, “Social Relationships and Mortality Risk: A Meta-Analytic Review,” *PLoS Medicine*, July 2010 7(7):e1000316; E. Y. Cornwell and L. J. Waite, “Social Disconnectedness, Perceived Isolation, and Health Among Older Adults,” *Journal of Health and Social Behavior*, March 2009 50(1):31–48; L. F. Berkman and T. Glass, “Social Integration, Social Networks, Social Support, and Health,” in *Social Epidemiology*, ed. L. F. Berkman and I. Kawachi (Oxford University Press, 2000), 137–73; B. McCarthy, A. Carter, M. Jansson et al., *Material Hardship Shows a Clearer Picture of Mental Health Among Low-Wage Workers* (Center for Poverty Research, University of California, Davis, Sept. 2015); and C. M. Heflin and J. Iceland, “Poverty, Material Hardship, and Depression,” *Social Science Quarterly*, Oct. 2009 90(5):1051–71.
- ¹⁰ S. L. Hayes, D. McCarthy, and D. C. Radley, “The Impact of a Behavioral Health Condition on High-Need Adults,” *To the Point*, The Commonwealth Fund, Nov. 22, 2016; and E. H. Bradley, M. Canavan, E. Rogan et al., “Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care, 2000–09,” *Health Affairs*, May 2016 35(5):760–68.
- ¹¹ J. M. McGinnis, P. Williams-Russo, and J. R. Knickman, “The Case for More Active Policy Attention to Health Promotion,” *Health Affairs*, March 2002 21(2):78–93.
- ¹² C. S. Hong, A. L. Siegel, and T. G. Ferris, *Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?* (The Commonwealth Fund, Aug. 2014).
- ¹³ A. Shih, K. Davis, S. C. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (The Commonwealth Fund, Aug. 2008).
- ¹⁴ J. S. Weissman, R. Stern, S. L. Fielding et al., “Delayed Access to Health Care: Risk Factors, Reasons, and Consequences,” *Annals of Internal Medicine*, Feb. 15, 1991 114(4):325–31.

Table 1. Demographic Characteristics of Survey Respondents

	Total	Not high-need	High-need
Unweighted N=	3,009	1,204	1,805
	%	%	%
Age			
19-29	18	19	4*
30-49	18	35	25*
50-64	25	24	40*
65 or older	19	18	29*
75 or older	8	7	13*
Insurance status			
Publicly insured	32	28	71*
Medicare only	4	3	10*
Medicare and Medicaid (dual)	8	6	29*
Medicare and employer-sponsored insurance	3	3	5*
Medicaid only	5	5	7
Employer-sponsored insurance only	36	39	9*
Race/Ethnicity			
White, non-Hispanic	64	65	63
Black, non-Hispanic	10	10	15*
Hispanic	15	16	12*
Income status			
<\$30,000/year	36	32	66*
Education status			
Less than high school	12	11	24*
High school diploma	31	31	33
Some college or two-year degree	25	25	25
Bachelor's degree or higher	31	32	17*
Employment status			
Employed full- or part-time (under age 65)	67	71	18*
Gender			
Female	52	51	58*

* Significantly different from not high-need at the $p < 0.05$ level.

Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

Table 2. Health Care Utilization and Promising Interventions

	Total	Not high-need	High-need
Unweighted N=	3,009	1,204	1,805
	%	%	%
Health care utilization			
Hospitalized overnight in past two years	18	15	48*
Used ER multiple times in past two years	18	15	47*
Used ER for a condition that could have been treated in doctor's office	14	13	19*
Access barriers			
Delayed care because of an access issue:	23	21	44*
Didn't have transportation	6	4	22*
Place of care wasn't open when you could get there	14	13	24*
Couldn't get an appointment soon enough	18	17	29*
Promising interventions			
Has a regular doctor or place of care	88	88	95*
Usually/always can get same-day answer when contacted doctor's office with medical question	68	68	65
Somewhat or very easy to get after-hours care without going to the emergency department	51	53	35*
Usually/always can get an appointment for emotional counseling or treatment as soon as needed	30	29	39*
Has informed and up-to-date care coordinator (base: saw multiple doctors or used multiple services in past year)	–	–	42
Usually/always has adequate help for trouble with ADLs/IADLs	34	–	38
Person-centered communication			
Regular doctor or place of care engages in patient-centered communication by doing all of the following:	53	52	60*
Usually/always knows important information about patient's medical history	87	88	85
Usually/always involves patient in treatment and care decisions	89	90	82*
Usually/always listens carefully to patient	90	91	85*

* Significantly different from not high-need at the $p < 0.05$ level.

– N/A.

Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

Table 3. Concerns and Vulnerabilities of High-Need Patients

	Total	Not high-need	High-need
Unweighted N=	3,009	1,204	1,805
	%	%	%
Loneliness and social isolation	17	15	37*
Often feel that you lack companionship	12	11	23*
Often feel left out	6	5	21*
Often feel isolated from others	8	7	22*
Material hardships			
Was stressed or worried in the past 12 months about having enough money to:	35	32	62*
Pay rent or mortgage	26	24	45*
Pay gas, oil, or electric bill	25	22	51*
Buy nutritious meals	21	18	44*
Functional limitations			
Has any trouble with ADLs and/or IADLs	7	2	57*
ADLs: Because of a health or memory problem, has any difficulty getting across a room, dressing, bathing, eating, getting in and out of bed, or using the toilet	5	1	38*
IADLs: Because of a health or memory problem, has any difficulty preparing meals, shopping for groceries, making telephone calls, or taking medication	5	1	43*
Usually/always has adequate help with above activities	34	–	38
Emotional health			
Somewhat or very concerned about being a burden to family or friends	–	–	59
Experienced emotional distress which was difficult to cope with alone	30	28	53*
Confident or very confident they can control or manage health problems	–	–	79

* Significantly different from not high-need at the $p < 0.05$ level.

– N/A.

Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

Table 4. Potential Resources Available to High-Need Patients
(base: high-need respondents)

	N=	Informed care coordinator (Base: Used multiple services)		Adequate help for ADLs/IADLs (Base: Has ADL/IADL)		Patient-centered communication		Easy access to emotional counseling (Base: Experienced emotional distress)		Regular doctor or place of care	Easy access to after-hours care		Same-day answer to medical question (Base: Has regular doctor/place of care)		
		Has	Does not have	Has	Does not have	Has	Does not have	Has	Does not have	Has	Does not have	Has	Does not have	Can get	Cannot get
		%	%	%	%	%	%	%	%	%	%	%	%	%	%
Total	1,805	42	58	38	62	60	40	39	61	95	5	35	65	65	35
Insurance															
Medicare	952	42	58	38	62	63	37	43	57	98	2	36	64	67	33
Medicare + Medicaid (Dual)	533	45	55	35	65	57	43	46	54	98	2	38	62	65	35
Medicaid	132	38	62	38	62	56	44	34	66	94	6	29	71	53	47
Employer-sponsored insurance	452	46	54	41	59	68	32	47	53	95	5	43	57	73	27
Uninsured	175	39	61	35	65	42	58	22	78	87	13	19	81	54	46
Income															
<\$30,000/year	984	41	59	34	66	58	42	36	64	94	6	30	70	63	37
\$30,000/year+	537	43	57	43	57	67	33	46	54	97	3	42	58	70	31
Race/Ethnicity															
White, non-Hispanic	1,216	43	57	38	62	66	34	41	59	97	3	34	66	66	34
Black, non-Hispanic	255	45	55	40	60	58	42	30	70	94	6	40	60	69	31
Hispanic	169	35	65	35	65	41	59	38	62	90	10	36	64	55	45
Social isolation															
Socially isolated	622	40	60	30	70	50	50	36	65	93	7	28	72	57	43
Not socially isolated	1,183	44	56	45	55	66	34	42	58	97	3	39	61	70	30
Material hardship															
Has bill stress/worry	983	41	59	36	64	54	46	37	63	94	6	28	72	59	41
Does not have bill stress/worry	822	44	56	46	54	71	29	46	54	98	2	45	55	75	25
Functional limitations															
Has functional limitations	972	43	57	38	62	58	42	37	63	94	6	30	70	61	39
Does not have functional limitations	833	41	59			63	37	42	58	96	4	41	59	71	29

Note: ADLs = activities of daily living (e.g., eating, bathing, dressing); IADLs = instrumental activities of daily living (e.g., housework, preparing meals).

Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

Table 5. Interventions for High-Need Patients
(base: high-need respondents)

	Used emergency department multiple times in past two years	Went to emergency department for condition that could be treated in office	Hospitalized in past two years	Experienced emotional distress in past year	Delayed care because of an access issue in past year
	%	%	%	%	%
Among total population:	18	14	18	30	23
Among not high-need population	15	13	15	28	21
Among high-need population	47	19	48	53	44
Among high-need population:					
Has informed care coordinator	46	15	60	51	43
Does not have informed care coordinator	51	18	56	53	48
Has adequate help with ADLs/IADLs	54	17	50	54	48
Does not have adequate help with ADLs/IADLs	47	21	48	58	49
Has patient-centered communication	45	13*	51	49	39*
Does not have patient-centered communication	46	24	45	49	45
Has easy access to counseling	51	21	51		49
Does not have easy access to counseling	56	23	53		53
Has regular doctor or place of care	45	17	49	49	
Does not have regular doctor or place of care	42	25	35	52	
Has easy access to after-hours care	38*	12*	47	42*	33*
Does not have easy access to after-hours care	49	21	50	53	46
Can get same-day answer	44	14*	52*	46*	35*
Cannot get same-day answer	46	23	43	56	60

* Significantly different at the $p < 0.05$ level.

Note: ADLs = activities of daily living (e.g., eating, bathing, dressing); IADLs = instrumental activities of daily living (e.g., housework, preparing meals).

Data: The 2016 Commonwealth Fund Survey of High-Need Patients, June–September 2016.

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