Patients with Complex Health Care Needs: Community Health Ecosystems

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Where are we going?

- Who are patients with “complex health care needs?”
- Ecosystems: climbing fitness peaks
- Fitness peak climbing by “exemplar” primary care practices
- Challenges and Opportunities
Why do we perceive some patients as complex?

- A clear gap between what they need and what we can provide
- A constellation of interacting conditions, needs and environmental context
- Care requires high level of task inter-dependence
Who is a patient with complex health care needs?

- Multiple Chronic Conditions
  - AND
  - Frailty
  - Complex medication regimens
  - Chronic pain/opioid use
  - Functional impairments
  - Mental impairments & dementia
  - Substance Abuse
  - Mental/Behavioral health
  - Lack of social support
  - Finances/Insurance coverage
  - Language/culture
  - Housing/transportation
The 'Kaiser Triangle', illustrating different levels of chronic care

- **Supported self care**: 70-80% of people with chronic conditions
- **Disease management**: High-risk patients
- **Case manage**: Highly complex patients (5%)

**Population-wide prevention**

Source: NHS and University of Birmingham.
IT TAKES A NEIGHBORHOOD:

State & Local Public Health
* Tobacco control
* Infectious Disease control
* Chronic Disease Prevention

Acute and post-acute care
* Inpatient hospital
* Rehabilitation
* Emergency Dept

Medical Home

Ambulatory Services
* Specialists
* Mental Health
  • Podiatry
  • PT/OT
  • Dental

Diagnostic Services
* Lab
* Radiology

Community Resources
* Education
* Transportation
* Food
* Job Training

Health Plans
* Engaged
* Aligned Incentives
Complex Patients: Task Inter-dependence
Task Inter-dependency

- For every 100 Medicare FFS patients a typical primary care office must coordinate care with
  - 99 specialists
  - 53 other clinic locations
- A fundamental issue of task inter-dependency

Pham HH, Ann Intern Med 2009
Care coordination & Care Management in the Medical Neighborhood

Care Management
- Medication management
- Self-management Support
- Logistical
- Clinical Monitoring

Clinical Follow-up Care
- Logistical
- Clinical Monitoring

Care Coordination
- Logistical

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Relational Coordination and Chronic Illness Care

• Communication that is
  – Frequent
  – Accurate
  – Timely
  – Problem-Solving

• Relationships with
  – Shared Goals
  – Understanding of roles
  – Respectful

• Within the primary care team predicts:
  – Better chronic illness care
  – Better patient experiences of care

Complex Care: Ecosystems & Fitness Landscapes

• Stuart Kauffman *At Home in the Universe*
  – Capacity of an organism to break down a protein

• Agents climb toward “fitness peaks”

• Peaks bestow considerable survival advantages
Climb Every Mountain

- Fitness Peak Climbing
- To move from one mountain top to the next you must go downhill
- Yikes! the care system may be less “fit” for a time until they reach the next peak
Implications for Patients with Complex Health Care Needs

• Fitness landscapes
  – Internal to their primary care team
  – External to their primary care team

• Internal Dimensions
  – Resources
  – Composition of the team
  – Mission, Values and Culture

• External
  – Payment systems
  – Ability to share information across silos
  – Etc.
Fitness in the Medical Neighborhood

• What is “fitness?”
• Mastery of a set of competencies to provide care for a patient with complex health care needs?
• Implies a minimum “altitude”
Challenges to Continuous Quality Improvement

• We want everyone to adapt and survive on the fitness landscape (can we afford to lose primary care capacity?)

• How create a fitness landscape to insure this?
  – Create diversity in location and verticality of fitness peaks with many peaks and diverse paths to reach the top
  – Provide “Sherpas” to guide the way?
    • Practice “coach” or “facilitator”
Changing the Fitness Landscape

• Internal “fitness”
  – Team-based primary care
  – Clinical information systems

• External “fitness”
  – Affordable Care Act

• Can have unanticipated results: emergence and surprise
  – Small changes: big results
  – Big changes: small results
Fitness Peak Climbing: Learning from Effective Ambulatory Practices “Project LEAP”

- Robert Wood Johnson Foundation
- 31 “Exemplar” practices
- One week site visits
- Innovations in workforce and teams
31 LEAP Sites
Complex Patients: Internal and External Ecosystems

• Requires both
  – Changes within the team in the practice
  – Changes in relationships outside the practice
What have successful organizations done to create effective teams?

• Hire bright, energetic folks with good interpersonal skills.
• Define key roles and tasks and distribute them among the team members.
• Train staff to perform tasks and monitor performance.
• Use protocols and standing orders to enable staff to operate independently.
• Give teams time to meet.
Team-Based Care in the Practice:

- Proactive use of a registry
- Delegation and standing orders
- Extensive Cross-training
- Internal MA training and competency assessment: “career ladders”
- Mapping workflows
- Extended “huddles”
Project LEAP Roles for Patients with Complex Health Care Needs

• Patient Navigators (lay-roles)
• Care Coordinators/Managers
• Referral coordinators
• Dept of Care Coordination
• Health Coaches/Care Managers
External Changes within the Medical Neighborhood

• Specialist Compacts
• Hospital agreements: notification of ED visits and hospitalization
• Health Information Exchanges
• Integrating mental/behavioral health
• Linkages to community resources
Caring for Complex Patients

Craig Robinson, Executive Director
Amber Crist, Director of Education and Program Development
Cabin Creek Health System
Become as Complex as the Patients?

Add to the care team and more tightly coordinate the roles of team members.

Team now includes:
MDs, NPs/PAs, MAs, BHC, Pharmacist, Health Coach, administrators.

And engage in much more conversation.
Addressing Complexity Means Lots of Conversations
What are the Team Roles?

- **Health coaches** (MAs or MSWs): assess home and family, home visits, connect with resources, self-care support, correct the EMR.
- **Pharmacists** – drug utilization reviews
- **BHCs** – psych. assessments, short term therapy, coordinate with specialty BH care, facilitate meetings.
- **Administrators** – make meeting time, organize training, f/u on systems barriers.
How to identify complex patients?
It is evolving over past 5 years.

First: focused on high risk groups that we identified:
  • frail elders,
  • expanded to elders with chronic conditions
  • Medicaid/SSI disabled population
  • Dual eligibles

Second: PCPs/MAs identified complex patients in weekly team huddles – assessment and care planning.

Third: Obtaining lists of high risk/high cost patients from insurers: Quality Blue, PEIA, Medicaid (coming), online hospital service reports (new).
The Expanded Team Huddle: Sense-Making Conversations

- One hour once/week
- All clinic staff attend: front desk, pharmacy, MA, behavioral health consultants, etc
- Clinician presents patient (chart open on EMR projected on screen)
- Front desk staff and MA who live in community asked what do they know?
- Health Coaches asked what do they know?
LEAP Webinar: Models of Complex Care Management

Penobscot Community Health Care

Kathy Bragdon
Complex Care at PCHC

- Embedded Care Management
- Community Care Team
- Transitions Care Management
- Panel Management
Transitions Care Manager

- Practice Based RN
- Rounds at facilities daily
- Clinical decision making skills crucial
- Meets with people planning the Discharge
- Meets with patients in the hospital/facility
- Empowered to make referrals to Care Management, SW, or CCT based on information obtained during rounding
Embedded Care Management

- Teams consist of RN’s, MA Health Coaches, and LSW’s
- Goal is to improve self management skills, decrease hospitalizations & readmissions, and improve quality of care
- Use face to face visits and phone calls for education, coaching, and monitoring.
- INCREASED FOCUS ON HOSPITAL FOLLOW UP
- Try to identify and help overcome psychosocial barriers to self management (transportation, cost of meds, etc.)
Embedded Care Management

• Use risk stratification (Modified LACE tool) to determine who makes the Hospital F/U call.
  – HIGH Risk-Call is made by RN, automatic referral to Care Management or CCT, F/U visit with PCP in 2 to 3 days
  – MODERATE Risk-Call is made by RN or MA Health Coach, automatic referral to Care Management, F/U visit in clinic within 3 to 5 days
  – LOW Risk-Call made by MA Health Coach, F/U visit in 7 days. MA Health Coach makes a “touch base call” in a week after F/U
Community Care Team (CCT)

- Offers same supports as Embedded Care Management **BUT ALSO CAN**
  - Meet patients where they are at (home, shelter, Dunkin Donuts, or in clinic)
  - Designed to be more intense for a shorter period of time (Care Management on Steroids)

- Grant Funded through 2014
- Focused on highest utilizers of health care dollars

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**CCT Implemented**

**ER Visit Cost per MaineCare patient enrolled in CCT**

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<th>Time Period</th>
<th>Before CCT</th>
<th>ED 6 mo</th>
<th>ED 5 mo</th>
<th>ED 4 mo</th>
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<th>ED 1 mo after CCT</th>
<th>ED 2 mo after CCT</th>
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Leadership’s role in success of Care Management

• Recognition of importance of Role Protection
• Supports efforts to protect the role

• Validation that Care Management is important
  – Adding Care Management Director to Senior Leadership Meetings
  – Including Care Management in New Employee Orientation
  – Care Management has a spot on the agenda at each clinic’s Provider Meeting
Conclusions

• Complex patients require multi-level approaches
  – Within clinic
  – Within medical neighborhood

• Time for sense-making conversations
  – Continual tweaking & improving

• Leadership support is critical
  – Communicate its value
  – Support improvisation
  – Creative financing

• Multi-disciplinary teams are key
  – Especially mental/behavioral health
Challenges for Discussion

• Observing a multi-level dynamic phenomenon
• How define the important constructs that describe the ecosystem/landscape of care for patients with complex needs
• The role of patients and care-givers as change agents in the complex network/landscape
• Keeping it real
  – Tools for improvement
  – Resources for change