When Access Isn't Enough:
Developing an Ambulatory ICU in a Healthcare for the Homeless Setting

Complex Care Program Comparisons:

Type	Features	Cons
Health plan model added to regular primary care (complex care management through insurance)	– Targeted populations based on claims data	– Not well integrated with provider practice – Often telephonic supports without in-person contact
Hospital Discharge Model	– Engages patients when they are sickest as "teachable moment" – Provides case mgt, nursing & pharmacy support that wrap around primary care – Uses hospital admin data	– Mixed evidence of efficacy. – Not long term – If no primary care linkage, may not be effective
ED Case Management Model	– Similar to Hospital D/C model – Designed to curb inappropriate use of ED services	– Similar to Hospital D/C models. – Focus is on ED use, not chronic disease mgt, hospitalization or primary care
Ambulatory ICU	– Transfer to "stand alone" primary care team with reduced patient load and increased staffing ration	– Expensive/high resources. – Unclear efficacy as of yet – Potential limitation in accessing population health/claims data
Home Based Primary Care	– Providers or care team conduct outreach visits to patients' homes	– Often limited to home-bound patients – Lack of availability

Key Features of an Ambulatory ICU:

- Holistic patient assessment (including psychosocial issues)
- Face-to-face contact/engagement with patients
- Close interaction with primary care physician
- Tightly managed care transitions: Hospital, ED, specialists
- Emphasis on self-management support (coaching behavior change & enhancing self-efficacy)
- Iterative quality improvement processes

Summit Team Roles

Role	Characteristics
1 physician (2 x 0.5 FTE)	- Boarded in Addictions and Internal Medicine - >5 year experience with population - Practice hospital based addictions care
2 Care Coordinators	- "Up skilled" Medical Assistants manage their own panel (goal ~100 patients each) - Main point of contact for patient - Help support/guide patient through healthcare system - Scribe during provider visits - Follow up with patient between visit - Provide wound care
2 Social Workers	- QMHP/LCSW also manage their own panel - Outreach/engagement - Case management/assistance with basic needs - Substance use assessments - Harm reduction education and treatment (both working on CADC) - Mental health support/treatment - Skill building
1 Complex Care Nurse	- RN with hospital and clinic experience - Transitions of care - Outreach (home, hospital, community) - Triage crises and walk ins - Accompany patients to specialist appointments
1 Clinical Pharmacist	- Transitions of care - Collaborative drug therapy management (diabetes, HTN, COPD, HLD) - Specialty medication packaging/plans - Complex medication management - Adherence support - Medication education - Supports physicians in learning about new drug therapies and incorporating them into practice
1 Team Manager	- Bachelor's Degree, >1 year experience at clinic - Track patient referrals - Supervisory and administrative support - Quality improvement project development/tracking - Zen Buddha Master/Team coach - Monitors team wellness and cohesiveness
1 Data Analyst	- Facilitate team discussions to inform metrics - Track clinical data to feed back to team to help with process development and quality improvement
2 Research staff	- Design and study longitudinal evaluation of Summit intervention over 3 years - Non-clinical staff administers patient surveys to track research

Summit Transitional Care Supports Across Systems

System	Supports
Hospital / ED	– Immediate care coordination – Med reconciliation – RN case management with hospital – SW support of complex behavioral needs – Patient support
Nursing Homes / Home Health	– Complex care support for caregivers – Behavioral support and trauma informed care modeling – Setting realistic expectations for caregivers
Specialist Appointments	– RN/CC/SW accompany patient to specialists – Transportation support – Care coordination enhances value of specialty appointments
Housing / Homelessness	– Intensive case management to help secure housing – Flexible funds to cover rent and keep people housed – Advocacy with ADS/APS to support independence
Incarceration / Depart. of Criminal Justice	– Support/advocacy with warrants – Support with expunging felony records

Breakout Session

Case: Part 1

Lee is a 52 year old man establishing with your complex care team. He was incarcerated for manslaughter 2000-2011 and subsequently homeless until a recent hospitalization for congestive heart failure and atrial fibrillation (a fast and abnormal heart rhythm) related to severe alcohol use disorder. He was recently discharged from a medical respite program where he was supported in securing social security income and food stamps.

- He now lives in a single room occupancy hotel and is waitlisted for more permanent housing
- He is prescribed 15 medications all with different dosing frequency and some up to 4 times per day
- He has no interest in quitting beer or smoking marijuana
- He is estranged from his family who live in the South
- He has low health literacy

He develops light headedness, racing heart, breathlessness, swelling of his legs, and abdominal bloating which are symptoms of decompensated heart failure. He has gone to the hospital 4 times with these symptoms and each hospitalization, he stays for 2-3 days, and then leaves against medical advice.

1. How would you approach Lee's care?
2. What barriers do you think Lee is encountering when accessing care, particularly at the hospital?
3. What barriers do you expect to encounter in developing a care plan for Lee?
4. What safety concerns do you have about his care?

Breakout Session

Case: Part 2

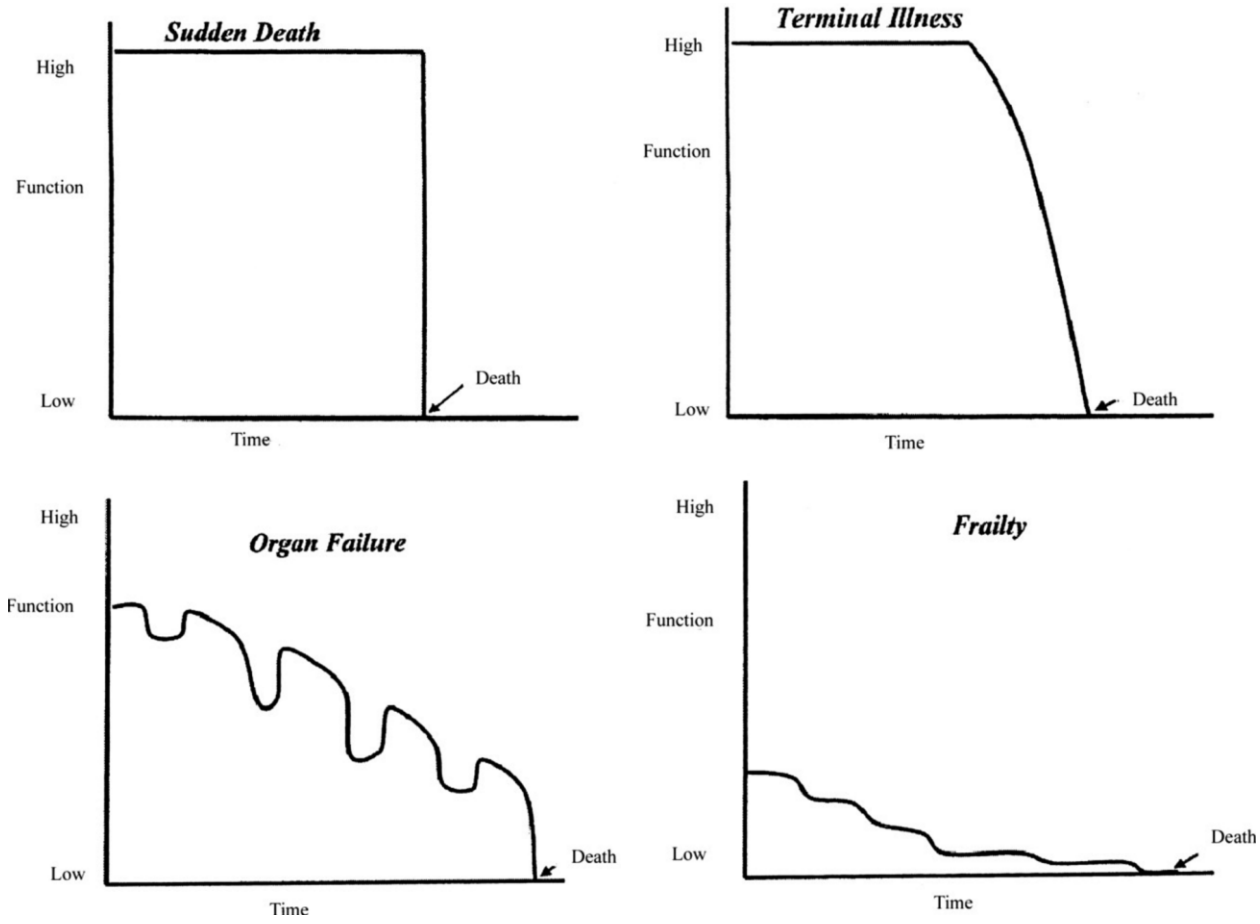
Care coordinator, physician, and social worker arrange a 60 minute home visit with Lee after hospitalization. He is mildly intoxicated and remains quite ill. He expresses a desire to live as long as he can but understands he has a life-limiting illness stating, "I think God pulled my card, but he ain't punched my ticket yet."

He adamantly refuses to return to the hospital as it reminds him too much of jail. He states that he would just as soon die in his room before returning to the hospital. The physician describes hospice and Lee states, "That would be superman great." During this visit, the team notes that Lee has numerous medication packages and bottles and appears to be taking only 2 medicines regularly that he finds helpful for his symptoms.

Summit pharmacist does a medication review and a hospice referral is placed. During hospice consultation, Lee expressed a desire to live as long as he could and stated he wanted everything done. Hospice declined to work with Lee given inconsistencies in expressing his goals of care and also highlighted safety concerns. Hospice expressed concern about social isolation, medication safety, the lack of a lock on his door, and inability to access Lee's building reliably since he didn't have a phone. Summit SW learns that patient does not have enough money to cover food expenses or rent for the last week of the month at SRO ($176).

1. How would you approach getting a better understanding Lee's goals of care?
2. How would you advocate to improve Lee's quality of life?

Decline Trajectories



These are patterns of decline in chronically ill people.

What do you think end stage social determinants of health looks like?