When Access Isn't Enough

CENTRAL CITY CONCERN

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MEDITATION

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OBJECTIVES

- Describe Old Town Clinic and rationale for developing ambulatory ICU
- Identify target population for the Summit Team (our A-ICU)
- Describe Summit's team structure/roles
- Breakout discussion
- Review Summit's initial utilization data
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Old Town Clinic

- Portland, OR (Medicaid Expansion State)
- FQHC and designated Health Care for the Homeless program.
- Provide integrated primary and behavioral health care, pharmacy, and co-located specialty mental health and substance use disorder services.
- We serve 5,000 patients per year, who have a high degree of

medical, behavioral and social needs:

  - 77% have a mental health disorder
  - 69% have a chronic medical condition
  - 60% have a substance use disorder
  - 60% are experiencing homelessness

- Robust team based care within PCMH model
- Embedded within larger social services agency (Central City Concern)

Old Town Clinic Utilization Estimates 2014

Utilization Category	Percent
No hospitalization/2-5 ED visits	14%
No hospitalization/6+ ED visits	5%
1 hospitalization with 0-5 ED visits	9%
2+ hospitalizations OR 1 hospitalization and 6 + ED visits	11%

25% = “high utilizers”

- ~40% of patients at Old Town Clinic need complex care management outside the hospital/ED
- 450/1200 patients per care team

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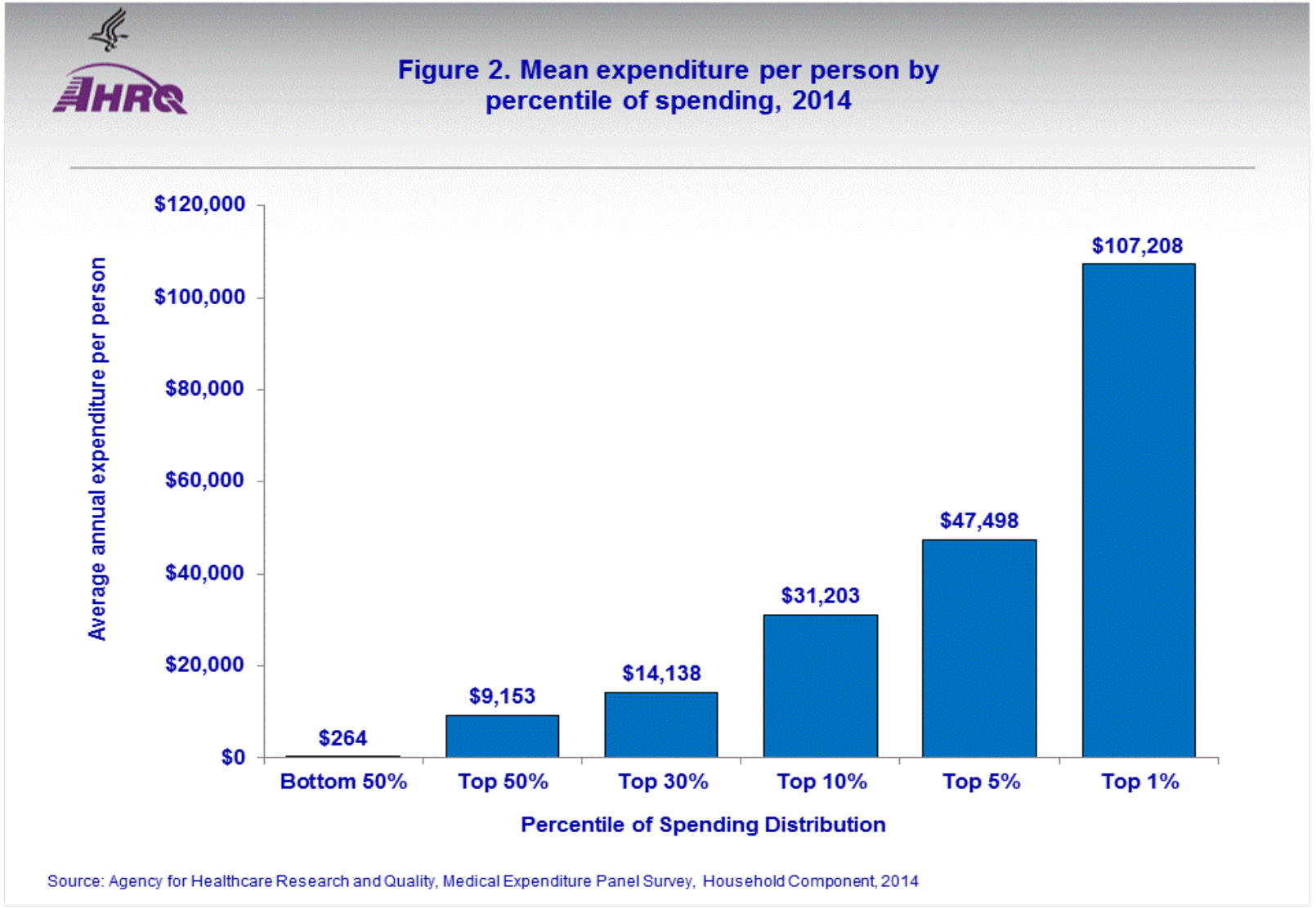
5% of Patients account for 50% Expenditures



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Mitchell E, 2016

THE NEW YORKER

MEDICAL REPORT JANUARY 24, 2011 ISSUE

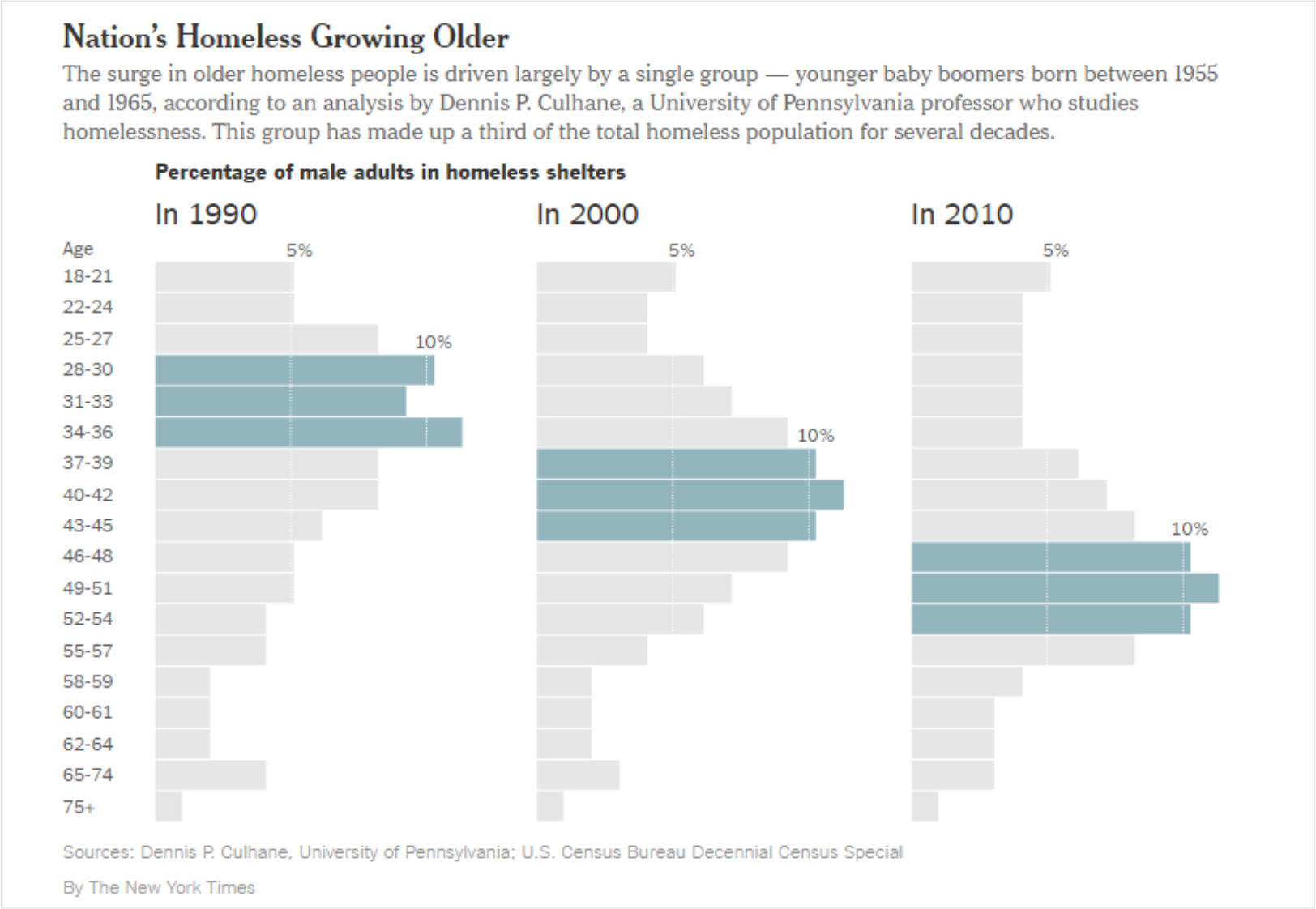
THE HOT SPOTTERS

Can we lower medical costs by giving the neediest patients better care?

By Atul Gawande

If Camden, New Jersey, becomes the first American community to lower its medical costs, it will have a murder to thank. At nine-fifty on a February night in 2001, a twenty-two-year-old black man was shot while driving his Ford Taurus station wagon through a neighborhood on the edge of the Rutgers University campus. The victim lay motionless in the street beside the open door on the driver's side, as if the car had ejected him. A neighborhood couple, a physical therapist and a volunteer firefighter, approached to see if they could help,

“The Graying of America’s Homeless”



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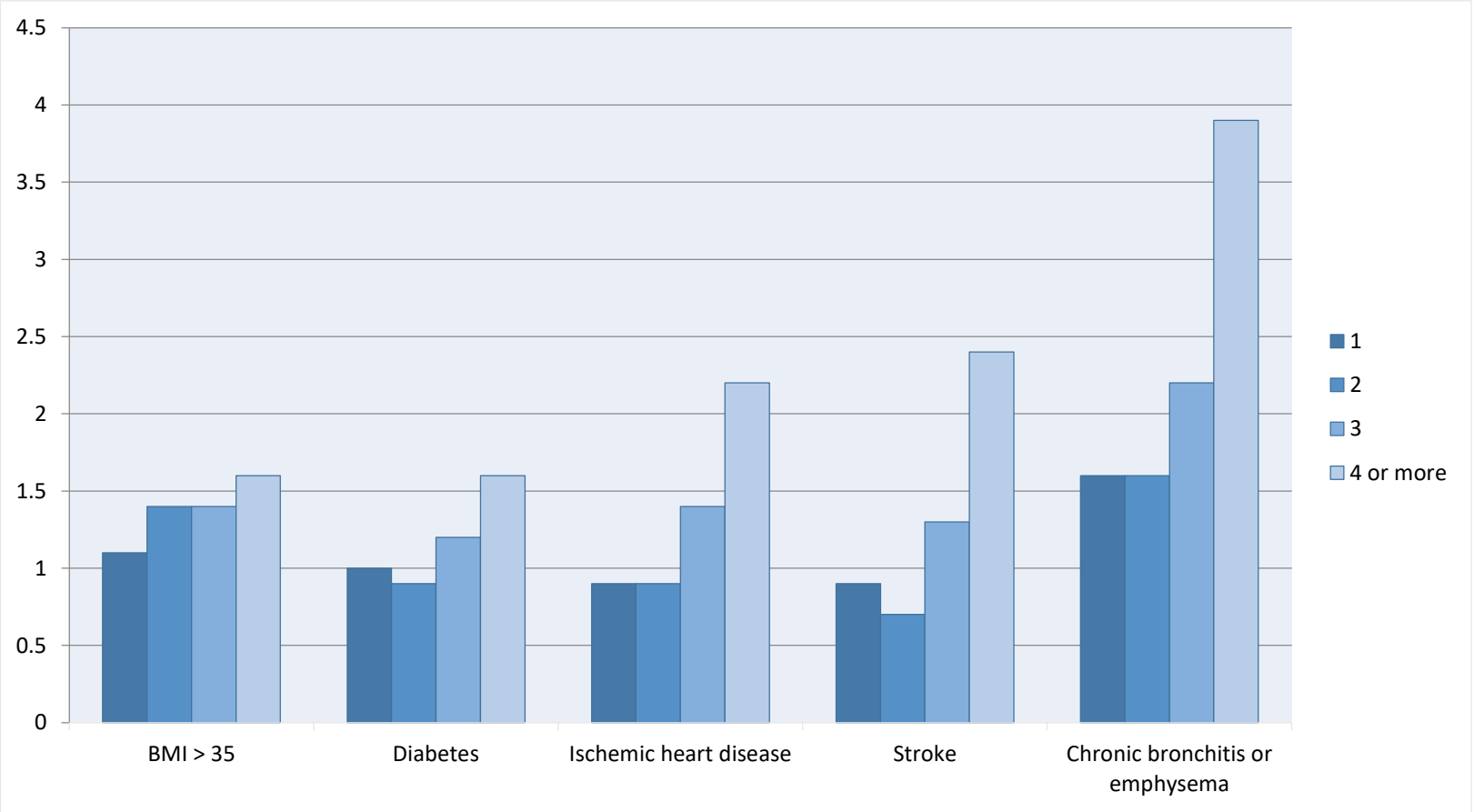
NYTimes, May 2016

Adverse Childhood Experiences



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Adapted from Felitti, Am J Prev Med. 1998

“Rickie” – 2014-2015

57 year homeless man recently admitted to a local hospital with respiratory failure discharged to medical respite and establishing with Old Town Clinic.

He has advanced COPD, diastolic heart failure, traumatic brain injury, cognitive impairment, generalized anxiety, opioid dependence on methadone maintenance, sedative/hypnotic use disorder, and partial blindness.

Despite multiple PC and MH visits, an outreach SW, prolonged respite support (6 month beyond target stay), housing assistance and home health/palliative care support, Rickie was poorly engaged and avoidant of prognosis believing if he “just exercised more and lost weight,” he would get better.

He was hospitalized 7 times (total of 43 days) and visited the ED 12 times over the course of one year.

“Rickie” – 2015

“Usual Care” PCP Appointment at Old Town Clinic

Worsening dyspnea, still smoking

Hypoxic: 82% on baseline 4L

Tachycardia 177

Declined recommended transfer to ED

Ongoing illicit benzo use and using heroin while on methadone

Goals of care discussion: patient resistant to accepting that he has a chronic lung disease remains convinced he just needs to “get in shape”

Was “kicked out” of pulmonary rehab due to too many no shows

Adult Protective Services report filed given concern for self neglect

20 minutes!

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“Rickie” – Complexity Drives Utilization

Medical Conditions:
End stage COPD
Chronic diastolic heart failure
Hepatitis C
Blindness right eye
Traumatic Brain Injury
Cognitive Impairment
Generalized Anxiety Disorder
Severe opioid use disorder on MMT
Sedative/hypnotic use disorder of unclear severity

Social Complexity:
- Poor acceptance of condition
- Heavy symptom burden
- High risk substance use
  - benzos + MMT
  - tobacco + O2 dependent
- Too medically complex to access detox services
- Substance users in social circle
- Lonely, socially isolated
- Poor health literacy worsened by cognitive impairment/TBI
- Goal of independence = mismatch between care needs and resources
- Fragmented systems of care and funding
- Low “patient activation”

Utilization 2014-2015:
7 hospitalizations (43 days in hospital)
12 ED visits
26 clinic visits
Enrolled in respite care program
Enrolled with health resilience SW
Palliative care home health
Home caregiver through ADS

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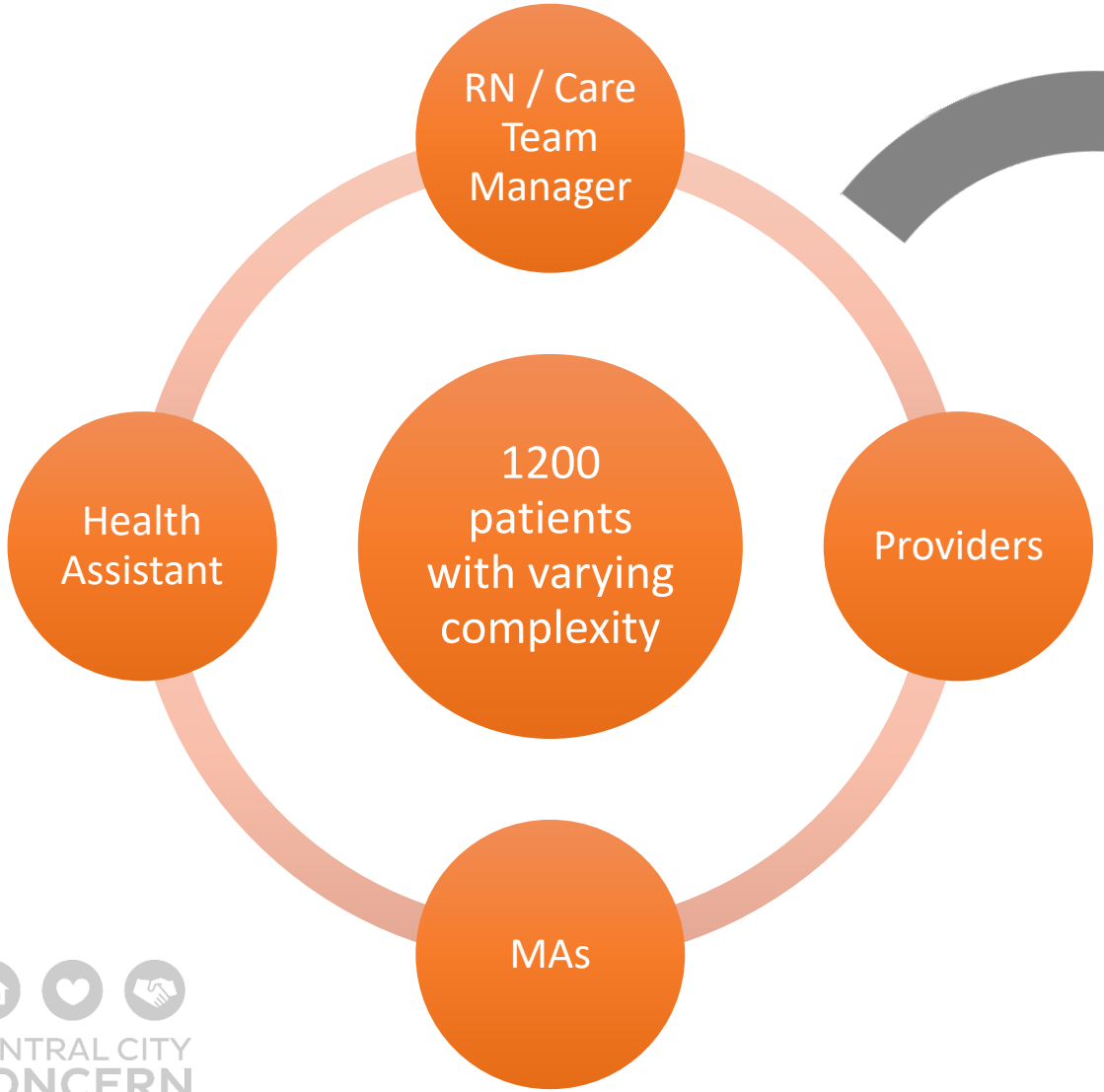
What does this mean for care teams?



- >450 patients with complex care coordination needs
- Lower risk patients crowded out
- High provider burn out
- Patient experience and care quality suffer

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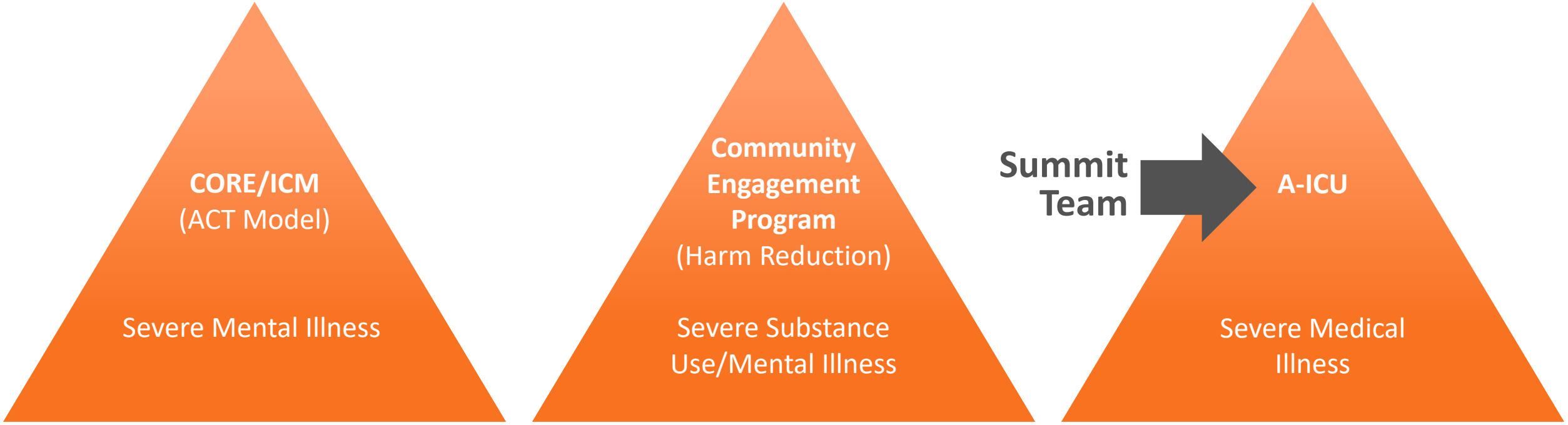
High Risk Teams Across Central City Concern



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Developing Old Town Clinic's Ambulatory ICU

- Payer interest in developing "value based" care models
  - Hybrid funding → monthly incentives, capitated per member per month, fee for service with "adjusted" productivity, academic funding for research
- Team Training at Stanford Coordinated Care
  - Refer to handout for details on AICU model
- No best practices for adapting to FQHC/HCH population
- Leadership engaged team members in design

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What does a Summit patient look like?

- Someone with advanced medical illness who has a hard time engaging in primary care
- Someone who may benefit from longer appointments, increased care coordination, and navigation
- Someone who may not go to the ED often, but when they do, they are usually admitted for a medical issues
- Someone who looks like “Rickie”

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PATIENT VIDEO

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Target Conditions and Characteristics

Medical Condition	Percent
Chronic kidney disease	19.8%
CHF	42.9%
COPD	50.5%
Chronic/severe infections	53.8%
Diabetes	42.9%
End stage liver disease	24.2%

Characteristics	
Age, mean ±SD, years	57 ±11
Housing status	
Homeless	23.4%
Low income housing	63.0%
Other or unknown	13.7%

Behavioral Health and Medical Complexity

Behavioral Health Condition	Percent
Substance use disorder	80.2%
Anxiety disorder	33.0%
Bipolar disorder	19.8%
Depressive disorder	53.8%
Psychotic disorder	16.5%
Trauma-related disorder	38.5%

Selected Diagnoses	Percent
Any mental health diagnoses	87.3%
Any substance use disorder	79.7%

87% have a mental health diagnosis

Medical Diagnosis Count	Percent
2 diagnoses	8.9%
3 diagnoses	27.8%
4 diagnoses	19.0%
5+ diagnoses	38.0%

85% have 3+ medical diagnoses

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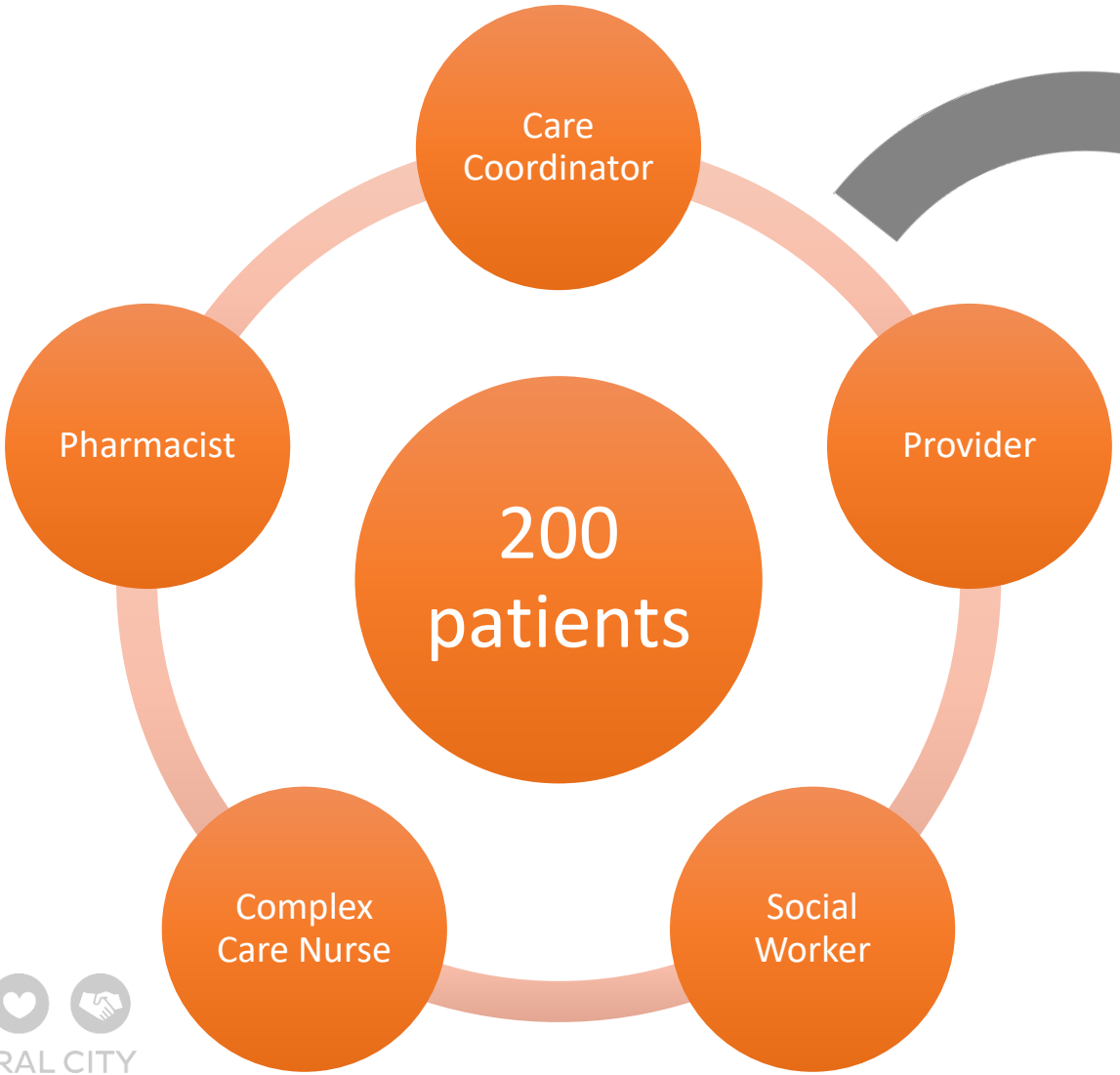
Summit Team Model



Allows more time to:

- **Build relationships**
- Outreach
- Provide timely support
- Increase access to team
- Smooth transitions of care

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Summit Team Roles:

2 physicians
2 care coordinators (medical assistants)
2 social workers

1 complex care RN
1 clinical pharmacist
1 team manager

Data analyst
Research staff

*refer to handout for specifics about role delineation

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Core Activities: Intensive patient intakes

- Complete comprehensive patient assessment w/ social work, physician, and care coordinator at intake
- Identify social determinants and basic needs from day 1
- Streamline safest treatment plan in accordance with patient centered goals
- Elicit needs that might require pharmacist or RN assistance with warm handoff introductions
- Teach patients about enhanced access to team
  - Care coordinator identified as main point of contact
  - Encourage use of physician “warm line” after hours for telephonic support
- Close follow up with option of outreach

Core Activities: Transitions of Care

Hospital/ED

Nursing Homes/ Home Health

Patient +Team

Specialist Appointments

Criminal Justice System

Housing

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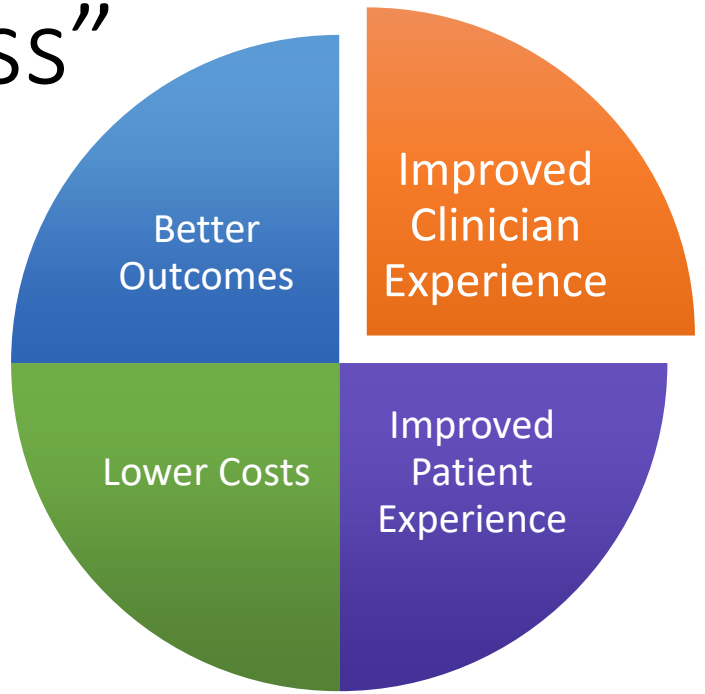
Core Activities: Fostering "Teamness"



- Team discusses use of flexible funds to help with non-traditional care needs as they emerge
- Team trainings in palliative care, motivational interviewing, trauma informed care
- Team wellness and daily group meditation practice
- Team shares and celebrates successes
- Interdisciplinary nature offers real time supports for challenging clinical scenario (warm hand offs)
- Team collaboration happens naturally as issues arise
- Weekly team meetings to reflect on work, participate in quality improvement exercises

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Core Activities: Panel Management

Weekly “Speed Dating”

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“Rickie” – An Update

- Intensive intake, engagement, outreach
  - Rickie was actively using heroin, buying benzos illicitly
  - Enmeshed in unhealthy relationships
  - Diagnosed with COPD exacerbation and benzo withdrawal versus possible pneumonia at home visit → he declined going to hospital and was treated at home
- Enhanced transitional care planning
  - Declined about 1 month later and more receptive to facilitated hospitalization
  - Care coordination with hospital and stabilized on long acting benzo
  - Illicit substance use stopped
- Collaborative team management
  - Improved symptom burden and advanced care planning
  - Regular pharmacist visits to streamline and reinforce medications/inhalers
  - Daily anxiety reduced with daily CC check in’s and consistent SW support
  - POLST completed and ongoing discussions about end of life goals

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“Rickie”: Attention and Streamlined Services

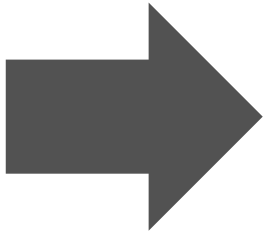
PRE-SUMMIT

Utilization 10/2014-10/2015:
7 hospitalizations (43 days in hospital)
12 ED visits

Outpatient Activities:
23 primary care visits
Respite Care program (RCP)

Enrolled with Care Oregon Health Resilience Specialist

Palliative care home health
Home caregiver through ADVS
Adult protective services



POST-SUMMIT

Utilization 11/2015- Present:
3 hospitalizations (19 days in hospital)
1 ED visit

SUMMIT Activities:
28 Summit provider visits 22 in clinic, 6 at home)

26 Summit pharmacist visits
15 Summit BHOW visits
15 Summit RN visits

174 Summit phone notes*

New in home caregiver

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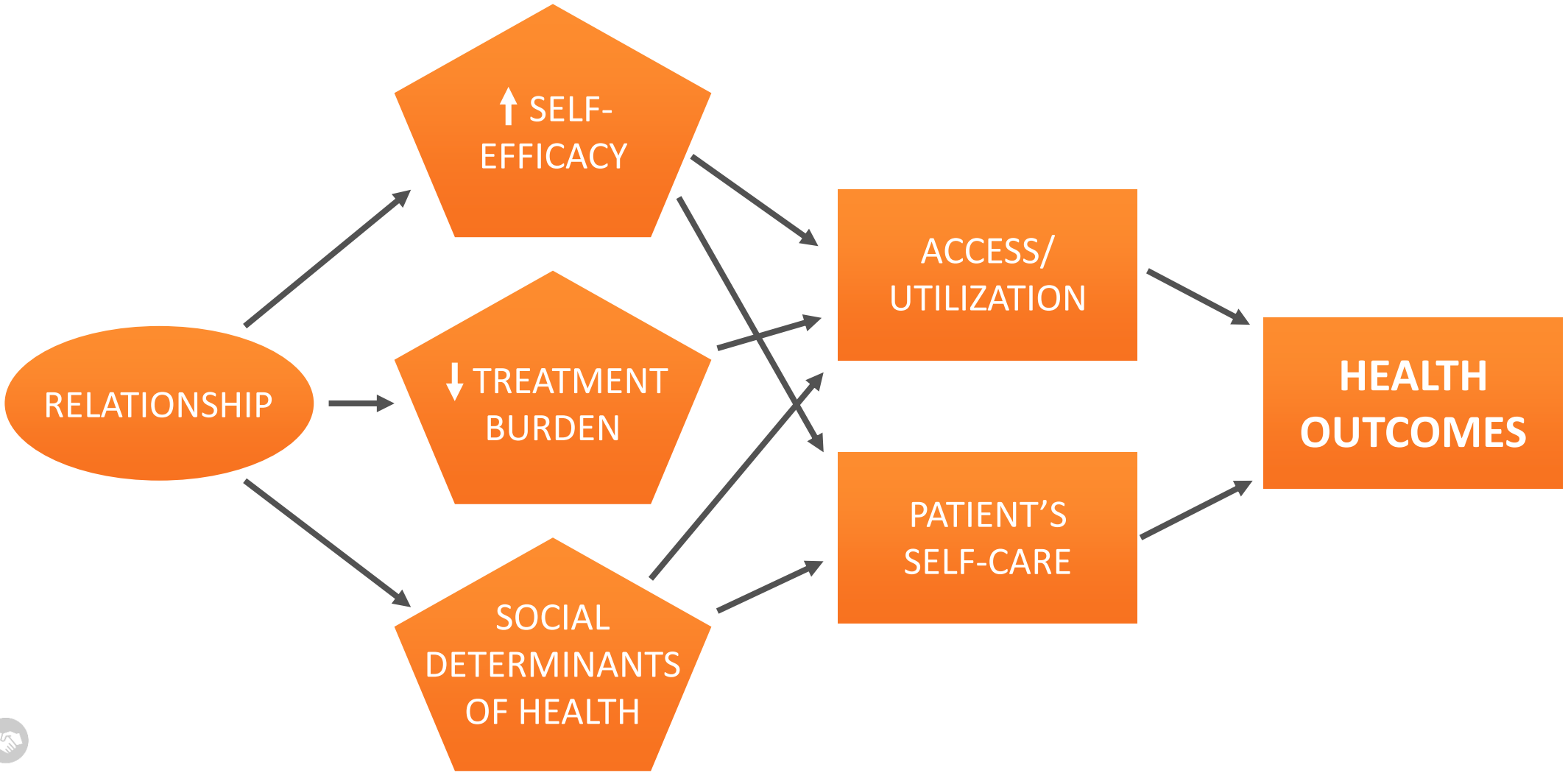
Conceptual Framework



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OBJECTIVES

- Describe C atory ICU
- Identify ta
- Describe S
- **Breakout**
- Review Su
- Discuss ch tting
- Highlight f

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“Lee” – A Difficult Case

- Organize into interdisciplinary groups of 5 or more
- Review part 1 of case (page 3 in handout)
- Discuss
  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?

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“Lee” – A Difficult Case

- Review part 2 of case (page 4 in handout)
- Discuss
  1. How would you approach better understanding Lee’s goals of care?
  2. How would you advocate to improve Lee’s quality of life?

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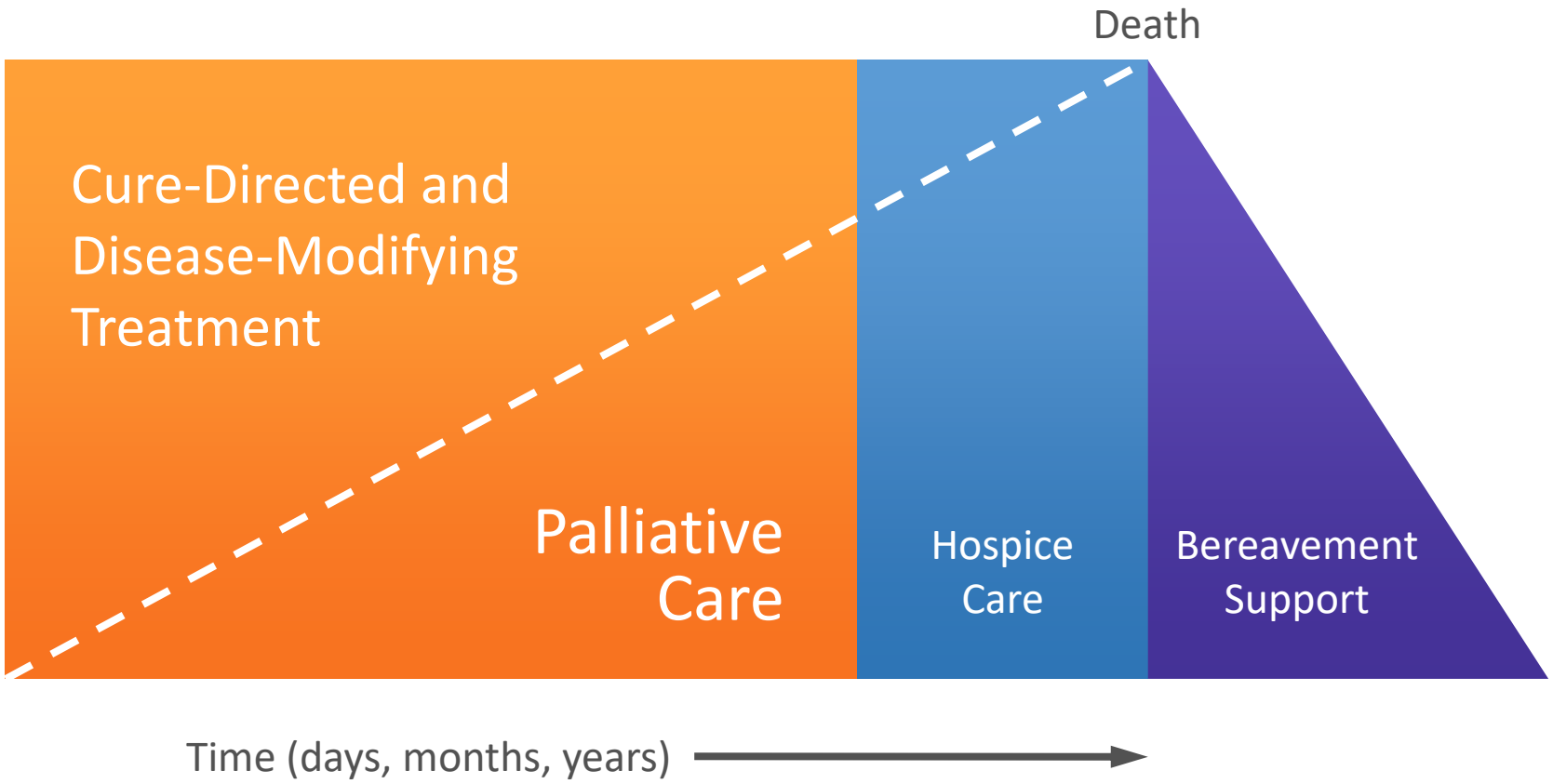
Concurrent Model of Palliative Care



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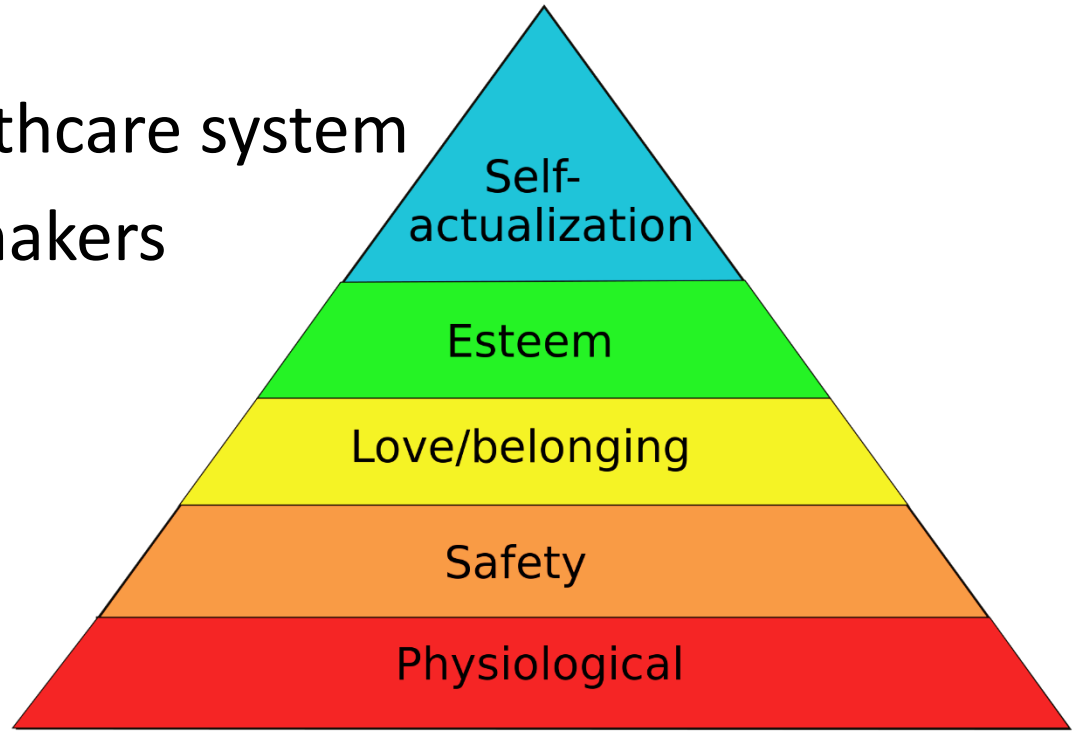
Safety Net Challenges with Palliative Care

Maslow's hierarchy of needs

- Unstable housing
- Lack of traditional caregiver supports
- Lack of trust/engagement in the healthcare system
- Isolation and lack of proxy decision makers
- Increased incidence of sudden death
- Fear of anonymity, being forgotten
- Severe persistent mental illness
- Substance use disorders



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Adapted from Lauren Land, FNP

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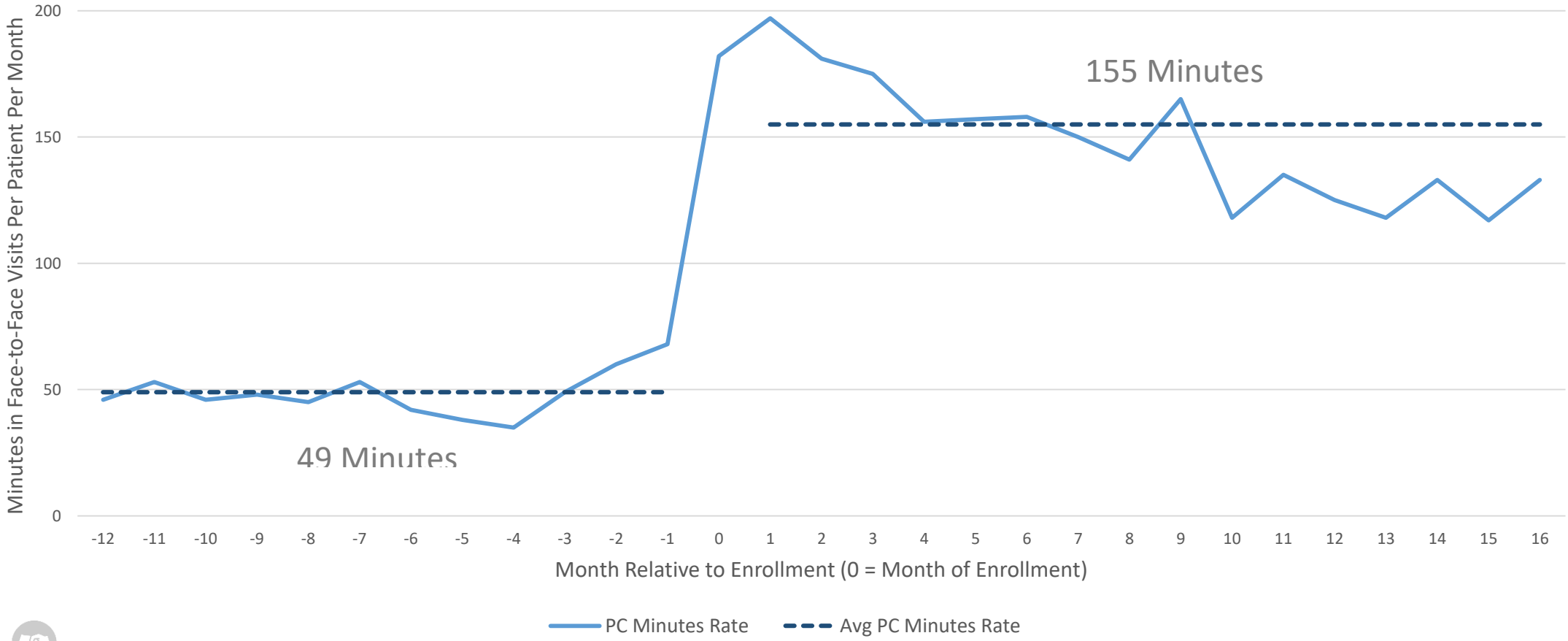
Primary Care Engagement



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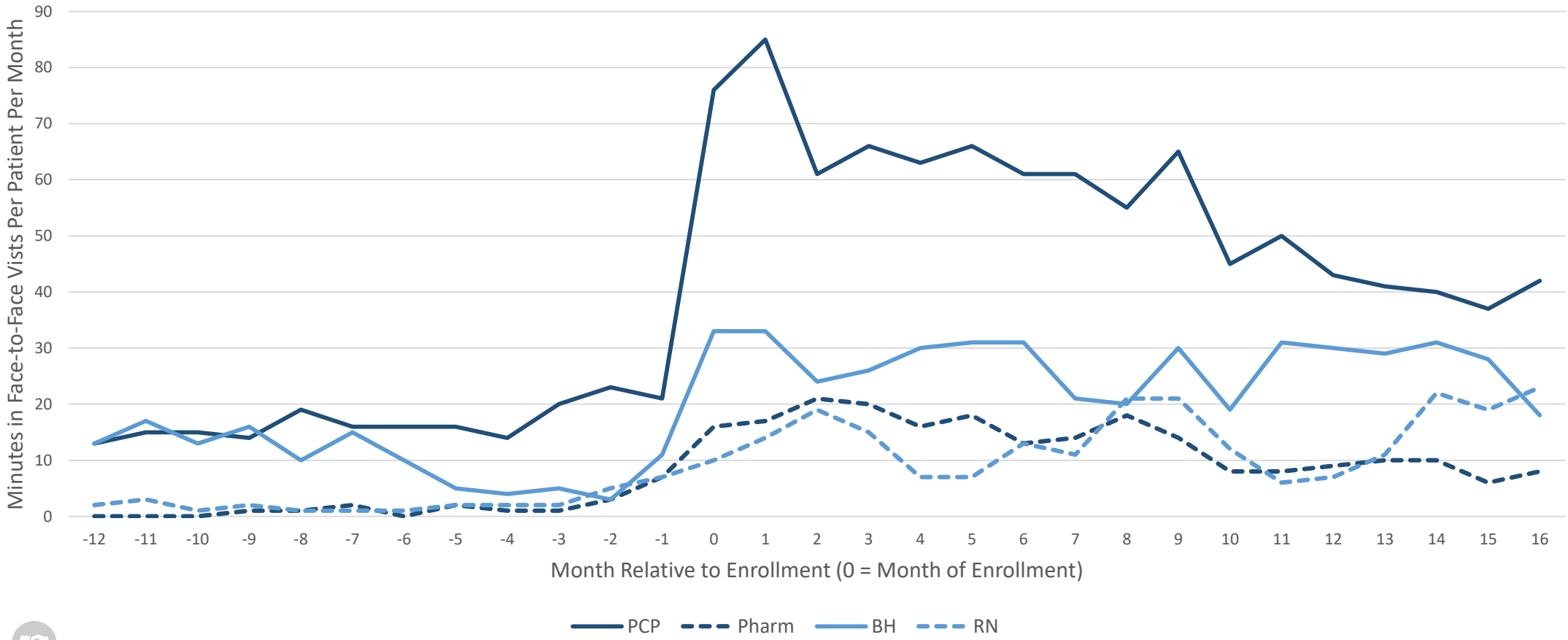
Primary Care Engagement by Provider Type



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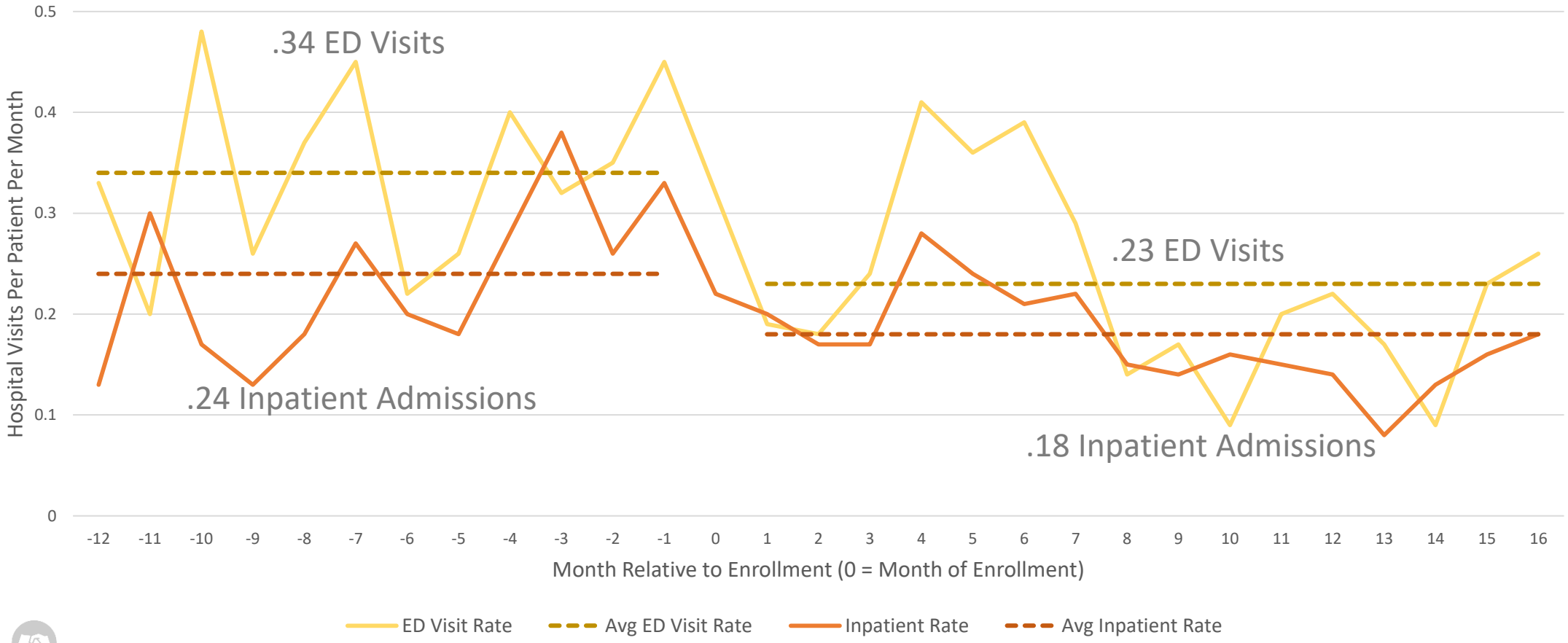
Hospital Utilization: ED Visits and Inpatient Admissions



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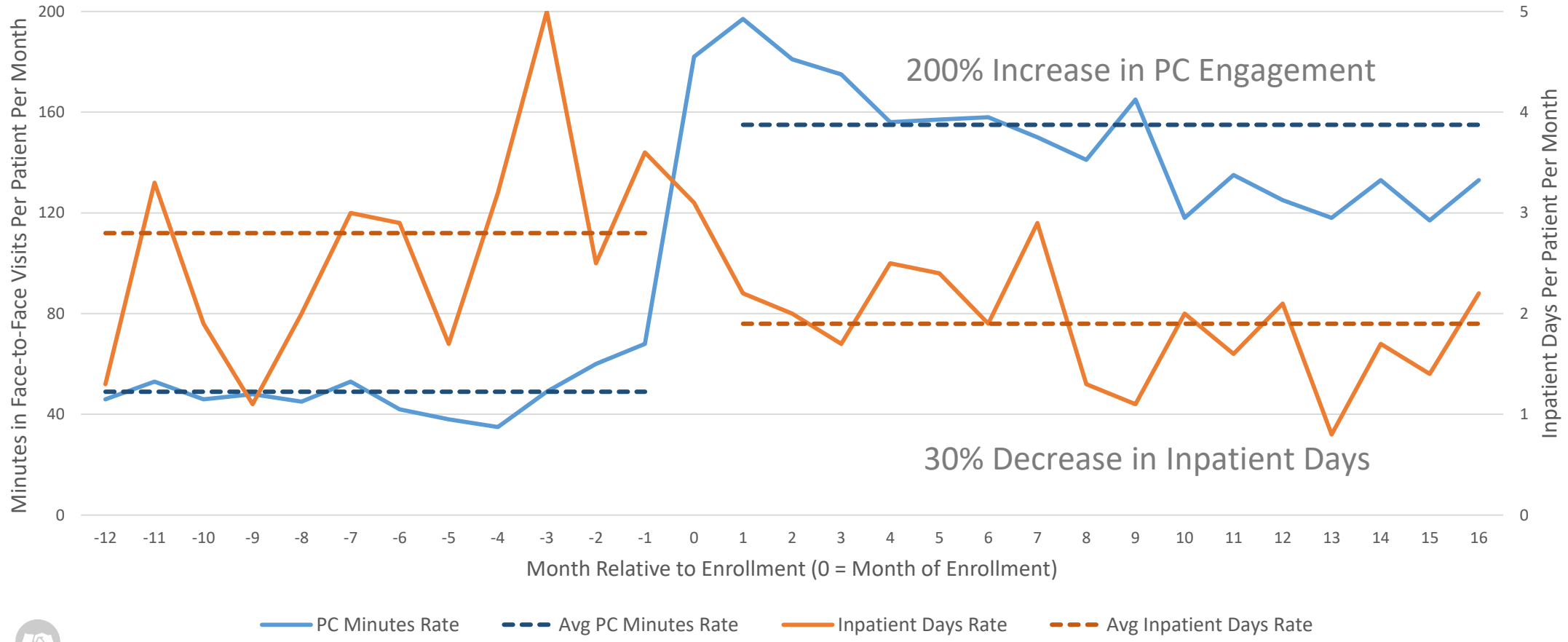
Primary Care Engagement vs. Hospital Utilization



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Challenges – Systems

- Gaps in care
  - TBI resources
  - Trauma informed settings for respite/long term care
  - Hospice for socially vulnerable patients
  - Substance use disorder treatment services for medically complex individuals
- Compassion fatigue → empathy failure across systems
- Maintaining patient trust across systems
- Retaining team flexibility to accommodate patient needs while growing
- How do you measure success?
- “Winning” the financial case

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Challenges – Clinical

- Relationships are non-linear
- Relationships are intense and often we are sharing risk in a different way
- Controlling what you can control
- What comes with holding a high level of respect for autonomy and self determination?
  - Getting comfortable with allowing people to make “bad” decisions
  - Experiencing the risks and consequences associated with those decisions alongside people

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The Future…

- Better defining success through patient/provider experiences, outcomes, cost data
- Increased patient activation/self management
- Ongoing team role delineation
- Partnerships with hospitals/care homes
- Building expertise and sharing best practices
- Securing long term funding/payment reform?
- Qualitative and Quantitative research findings

TEAM VIDEO

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Questions?

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Palliative Care at a Safety Net Clinic

Person-Centered

Trauma-Informed

Harm Reduction

Relationship-based

Principles of Palliative Care

Focus on patient's goals of care rather than disease management.

Awareness of psychosocial background and personal narrative.

Build on strengths and optimize coping/resilience.

Reduce suffering and distress.

Improve quality-of-life.

Recognize the power of relationship.

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Adapted from Lauren Land, FNP