Practical Approaches to Complex Patients: Learning from Exemplar Ambulatory Practices

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Where have we been?

- What is “complexity?”
- How does it apply to patients and patient care?
- Can it be “managed?”
Where are we going?

• Can it be “managed?”
• Lessons from Project LEAP
Why Focus on Complex Patients?

• That’s where the suffering is.
• That’s where the staff burnout is.
• That’s where the money is.

• Evidence that enhanced services work.
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 interdependence
What Makes Patients Complex?

• 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
Clinicians

Lab Services

Imaging Services

Hospital

Specialist 1

Specialist 2

MAs

Receptionist

PT/OT

Care-Givers

Referral Coord

Mental Health

Complex Patients: Task Inter-dependence

Complex Patient

Givers

MAs
IT TAKES A NEIGHBORHOOD:

- Medical Home
  - State & Local Public Health: *Tobacco control, *Infectious Disease control, *Chronic Disease Prevention
  - Diagnostic Services: *Lab, *Radiology
  - Health Plans: *Engaged, *Aligned Incentives
  - Whole Person Orientation, Safety & Quality, Care Coordination & Integration, Personal Provider, Unbiased Access, Continuity of Care, Capacity & Accountability
## Care Management in the Medical Neighborhood

Providing follow up, clinical management, and self-management support to patients outside of clinic visits.

| Services and intensity of services vary with the severity of the illness. | Provided by a staff person for lower risk patients and by a nurse or other health professional for high-risk patients. | Best when the CM:  
- Is an integral member of the practice team  
- Can influence drugs  
- is supported by clinical expert(s).  
- has face-to-face patient contact |


Relationship between care coordination & care management activities in primary care

- Care Coordination
  - Logistical

- Clinical Follow-up Care
  - Logistical
  - Clinical Monitoring

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

- Care Management Functions

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Learning from Effective Ambulatory Practices
“Project LEAP”

• Robert Wood Johnson Foundation
• 30 “Exemplar” practices
• One week site visits
• Innovations in workforce and teams
Complex Patients: Lesson Learned

• Requires both
  – Changes within the team in the practice
  – Changes in relationships outside the practice
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

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

- Specialist Compacts
- Hospital agreements: notification of ED visits and hospitalization
- Health Information Exchanges
- Linkages to mental/behavioral health
- Linkages to community resources

The Primary Care Team
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

• 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?
Expanded Huddle (cont.)

• Facilitator at White Board draws vertical line on board:
  – Technical Issues: adjust medications, etc.
  – Adaptive Issues: sub-standard housing

• Used to develop “action/care plan”
LEAP Webinar: Models of Complex Care Management

Penobscot Community Health Care
Kathy Bragdon
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

![Graph showing ER Visit Cost per MaineCare patient enrolled in CCT over 3rd Quarter](chart.png)
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-component 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
Discussion

• Where are you on this journey?
• Time and place for sense-making conversations?
• What improvisations are you willing to try next?
Project Leap

• Dissemination and Learning Community Kick-Off in August/September 2014

• Opportunity to participate, contact:
  – Brian Austin: austin.b@ghc.org
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  – Michael Parchman: parchman.m@ghc.org