

Creating a Dialogue on Complex Care:

Hot Spotting and Local Strategies

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5% of Medicaid patients account for 50% of spending...



a patient centered approach to reducing costs.

Hosted By:

UMN Hot Spotters
Breakfast provided by University Catering

**Saturday
11 June**

8:00am-12:00pm
TCF Bank Stadium: Indoor Club Room
420 SE 23rd Ave,
Minneapolis, MN 55455

Events:

Guest Speaker
Eileen Weber, DNP, JD, RN
Clinical Assistant Professor
Population Health and Systems, School of Nursing

Panel Discussions

Ross Owen
Director of Hennepin Health

Kate Vickery, MD
Physician at HCMC Coordinated Care Clinic

Shailey Prasad, MD, MPH
Associate Professor, Department of Family
Medicine and Community Health

Andrew Olson, MD
Assistant Professor of Medicine

World Café (small group discussion)
A small group discussion of approaches that have
increased primary care visits, reduced ED use, and
rapid re-hospitalization.

Exhibit Session

A networking opportunity for faculty, practicing
clinicians, health administration, public health
professionals, and all healthcare students.



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Hotspotting Definition

- ▶ Strategic use of data to target resources to the outliers. A movement for a system of multi-disciplinary, coordinated care that treats the whole patient and attends to the non-medical needs that affect health: housing, mental health, substance abuse, and emotional support

Hotspotting:

- ▶ Conference
 - ▶ Project
 - ▶ Story

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Student Hotspotting Project

- ▶ Goals of Intervention
 - ▶ Patient-defined Goals
 - ▶ Learning the Hot Spotting model
- ▶ Learning about home routines may provide insight into effective interventions

Hotspotting:

- ▶ Conference
 - ▶ Project (Background)
 - ▶ Story

Camden Coalition



- ▶ Patient Interventions: through Care Management Initiatives
 - ▶ Family physician, NP, CHW, social worker
 - ▶ All staff working to top of license
 - ▶ Regular outreach visits

Camden Coalition



- ▶ Origin of 'Hot Spots' - a data-driven model:
 - ▶ Highest healthcare use is often centralized in geographic areas
 - ▶ Often associated with poorer care - often due to underlying causes not being addressed

Camden Coalition



- ▶ Initial results of 36 patients enrolled - costs decreased 56% after intervention (2009)
 - ▶ Randomized Controlled Trial in progress

Many Approaches – Nationwide

- ▶ Brief of 18 effective interventions – a few with RCT data to support effectiveness
- ▶ Approach depends on context – small vs. large practice, rural vs. urban
- ▶ Patient selection – a mix of quantitative and qualitative

ISSUE BRIEF
AUGUST 2014



The
COMMONWEALTH
FUND

**Caring for High-Need, High-Cost Patients:
What Makes for a Successful Care Management
Program?**

Clemens S. Hong, Allison L. Siegel, and Timothy G. Ferris

Many Approaches – Local

- ▶ Additional summary articles that highlight examples of effective strategies in our area
- ▶ Despite different approaches, we observed a common goal

HealthPartners Medical Group BestCare PCMH Model

- 39% decrease in emergency room visits, 24% decrease in hospital admissions
- Overall costs in the PCMH clinics decreased from being 100% of the state network average in 2004 to 92% of the state average in 2008, in a state with costs already well below the national average

Many Approaches – Local

- ▶ Additional summary articles that highlight examples of effective strategies in our area
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Hennepin County: Return on Investment (ROI)

Hennepin County has identified a solid ROI to support the case for investing in its super-utilizer approach:

- One month of housing costs less than two days in the hospital—thus, Hennepin is investing in transitional housing; and
- ED costs decreased by 80 percent for the target population through the Sobering Center—thus the program is sustaining and building on this successful model.

Source: February 12, 2013 presentation by J. DeCubellis

Many Approaches – Local

- ▶ Additional summary articles that highlight examples of effective strategies in our area
- ▶ Despite different approaches, we observed a common goal

Coordinated Care Clinic Hennepin County Medical Center	<ul style="list-style-type: none">▪ 3 or more hospital admits in past year	<ul style="list-style-type: none">▪ Components of broader Hennepin Health model.▪ aICU model using a special clinic that only serves patients who are complex high-utilizers.▪ The aICU team includes a physician, nurse practitioner, licensed clinical social worker, RN coordinator, licensed practical nurse (LPN), alcohol/drug counselor, behaviorist, pharmacist, and office specialist who greets the patient. The office specialist may be the most important person on the team, building close relationships with patients.▪ Most care is in-clinic or telephonic; patients can walk in and get same-day visits. Most home visits are done through a separate home care agency.
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What I believe this common goal is:

- ▶ Social and community factors, such as those below, can have drastic impairments on a person's response to illness. Using an alternative approach that can address these factors can build trust, empowerment, and healing.
- ▶ Examples of these relevant factors:
 - ▶ Transportation issues
 - ▶ Substance abuse / addiction
 - ▶ Low literacy
 - ▶ Mental health conditions
 - ▶ Housing/homelessness
 - ▶ Chronic pain
 - ▶ "Non-compliance"
 - ▶ Sense of self-efficacy in being able to manage the above challenges

Hotspotting:

- ▶ Conference
 - ▶ Project
 - ▶ Story

What We Did - a Conference for Students and Local Professionals

- ▶ Goal: create a space for discussion and collaboration among parties with this shared goal



MINNESOTA ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR MINNESOTA

Student Innovation Grant



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What We Did - a Conference for Students and Local Professionals

- ▶ **Goal:** create a space for discussion and collaboration among parties with this shared goal

Event Consisted of 3 Parts

- ▶ Introduction to Hot Spotting with Presentation by Eileen Weber, DNP, JD, RN
- ▶ Panel Discussion
 - ▶ Ross Owen - HennepinHealth
 - ▶ Kate Vickery, MD - HCMC Coordinated Care Clinic
 - ▶ Shailey Prasad, MD, MPH - Dept of Family Medicine & Community Health
 - ▶ Andrew Olson, MD - Assistant Professor of Medicine at UMN
- ▶ Small Group Discussions

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What We Learned

- ▶ MN has a strong history of collaboration - work being done in our community is gaining recognition nationally

What We Learned

- ▶ Transition from traditional fee-for service to a value-based model
 - ▶ Shared cost savings - these can be used to reinvest in the system
 - ▶ Flexibility in spending is useful for patients with complex care needs
 - ▶ Providing multiple services under one roof

What We Learned

- ▶ Importance of using complementary approaches to target this shared goal
 - ▶ Highest users are a small subset that reflect broader problems in the community
 - ▶ Recognition of limitations of healthcare role - many of the causes of these issues are better solved from stronger communities and social support systems

What We Learned: Considerations for Next Time

- ▶ Importance of expanding the network
 - ▶ More perspectives to include
 - ▶ Patients
 - ▶ Government - MDH, Medicaid, DHS
 - ▶ Hospitals
 - ▶ Financial perspectives - e.g. healthcare economist
 - ▶ Importance of including all relevant stakeholders
 - ▶ Increased promotion

What We Learned: Considerations for Next Time

- ▶ Format

- ▶ What do professionals want to learn?
- ▶ What is the best way to allow for collaboration?

What's Next:

Multiple ongoing student projects

- ▶ MAFP Spring Refresher Presentation
- ▶ Student Hotspotting Learning Collaborative - next year's cohort
- ▶ Subsequent conference

What's Next: Multiple ongoing student projects

Research

We will contribute to and expand the base of knowledge on patients with high utilization and on interventions to improve their care.

Intervention

We will work with patients to promote a patient-centered culture in health care by wielding their personal stories and experiences.

UMN Hot Spotters

provides practical opportunities for professional students to improve the care of patients with high utilization of healthcare resources.

Curriculum

We will create opportunities for professional students to impact current care and create an effective workforce focused on the broad determinants of health.

Policy

We will disseminate our findings, experiences, and recommendations to patients, the general public, health systems, and legislators to influence systemic change.

Resources / References

- ▶ J. Brenner, "Reforming Camden's Health Care System—One Patient at a Time," Prescriptions for Excellence in Health Care Newsletter, 2009 5(Suppl. 1):10.
- ▶ C. Hong, et. al., "Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?"; Commonwealth Fund, 2014 19(1764).
- ▶ K. Grumbach, et. al. "The Outcomes of Implementing Patient-Centered Medical Home Interventions", Patient Centered Primary Care Collaborative, 2009.
- ▶ T. Bodenheimer, "Strategies to Reduce Costs and Improve Care for High-Utilizing Medicaid Patients: Reflections on Pioneering Programs", Center for Health Care Strategies, Inc. 2013.
- ▶ D. Hasselman, "Super-Utilizer Summit: Common Themes from Innovative Complex Care Management Programs", Center for Health Care Strategies, Inc., 2013.

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