Working With High Health Care Utilizing Patients: The Hot Spotting Team

John-Marc Austin, Andrew Baccari, Nadia Eshraghi, Julian Goding

UMass Memorial ACO: Target Demographics

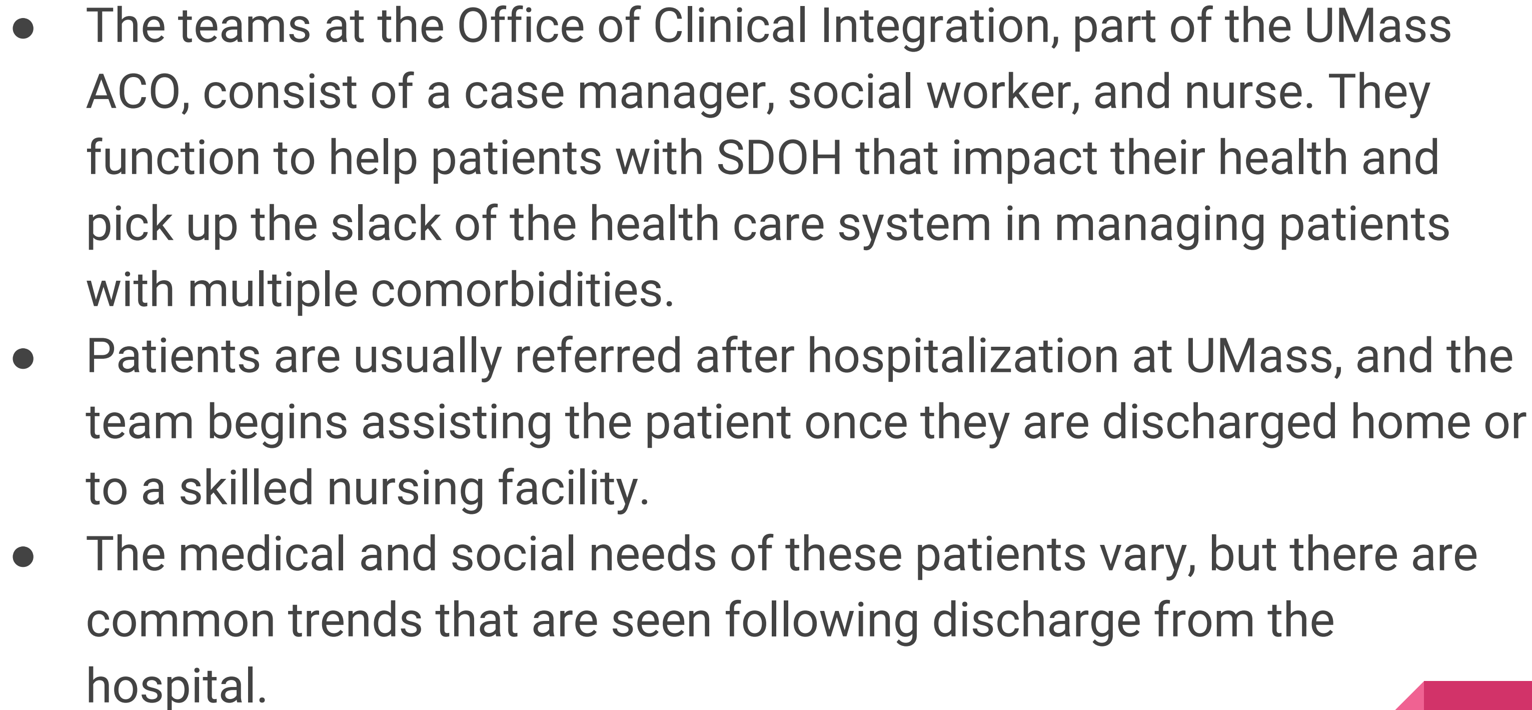
- The population of interest in this clerkship is high healthcare utilizing patients. Below are the demographics of the patients that the organization we worked with targets:
- Medicare patients, which are patients >65, or those under 65 with a disability.
- Patients of UMass, which come from primarily Worcester and the surrounding counties.
- Patients with certain target medical conditions, including CHF, COPD, Renal Diseases and other chronic conditions with high morbidity.
- Patients with SDOH that impact the management of their conditions, including low SES, living alone without significant familial support, homelessness, substance abuse disorders, etc.

UMass Memorial Medicare Accountable Care Organization (ACO)

Our doctors work hard to provide you with high-quality care, but it can be a challenge to manage all of patients' health care needs and information. That's why we have developed the UMass Memorial Medicare Accountable Care Organization (ACO).

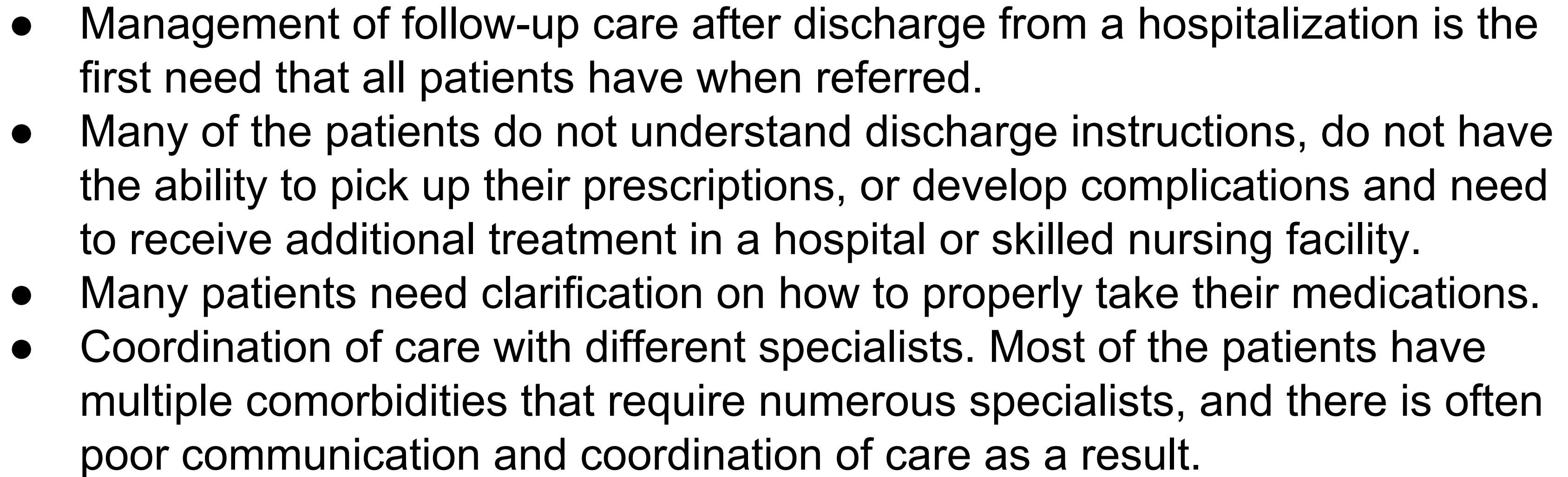
An ACO is a group of doctors, hospitals and health care providers that work together to provide you with better, more coordinated care. Our doctors and hospitals in the UMass Memorial ACO communicate with you and with each other to make sure that you get the care you need when you're sick and the support you need to stay healthy and well.

The Office of Clinical Integration



- The teams at the Office of Clinical Integration, part of the UMass ACO, consist of a case manager, social worker, and nurse. They function to help patients with SDOH that impact their health and pick up the slack of the health care system in managing patients with multiple comorbidities.
- Patients are usually referred after hospitalization at UMass, and the team begins assisting the patient once they are discharged home or to a skilled nursing facility.
- The medical and social needs of these patients vary, but there are common trends that are seen following discharge from the hospital.

Medical needs of high-health care utilizing patients following discharge



- Management of follow-up care after discharge from a hospitalization is the first need that all patients have when referred.
- Many of the patients do not understand discharge instructions, do not have the ability to pick up their prescriptions, or develop complications and need to receive additional treatment in a hospital or skilled nursing facility.
- Many patients need clarification on how to properly take their medications.
- Coordination of care with different specialists. Most of the patients have multiple comorbidities that require numerous specialists, and there is often poor communication and coordination of care as a result.

Social needs

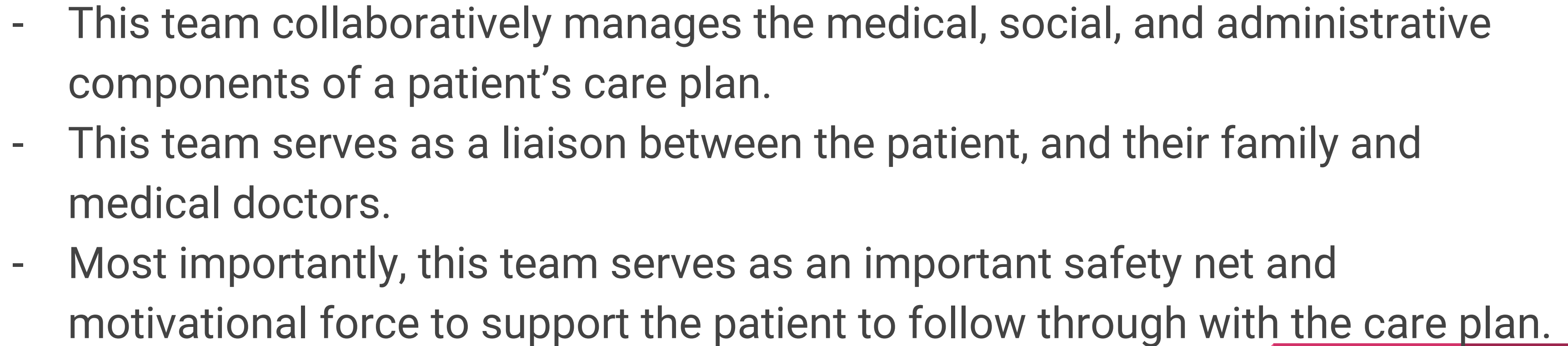
- Assistance in applying for insurance or other social programs, such as SNAP, housing applications, elder services, disability services, etc.
- Assistance with finding transportation services to & from doctor's appointments
- Substance abuse treatment referral
- Assistance with getting admitted into skilled nursing facilities
- Finding services for getting help around the home. This is especially important for patients with chronic medical conditions that limit their mobility and do not have family to help them on a regular basis.

Sample Case to Demonstrate Medical Needs

- 73 y/o male patient with a history of alcoholism, portal hypertension, and a new diagnosis of cirrhosis recently started on lactulose for prevention of portal systemic encephalopathy (PSE), which is caused by accumulating ammonia levels in cirrhosis
- The protocol is as follows: Oral: 20 to 30 g (30 to 45 mL) 3 to 4 times daily; adjust dose every 1 to 2 days to produce 2 to 3 soft stools/day
- The patient was taking 3-4 times daily every single day, causing severe diarrhea & dehydration. He then had such a bad experience that he refused to continue taking the medication. His GI team & pharmacy both failed to make sure he understood how to properly take his medication.

Interprofessionalism within the Accountable Care Organization (ACO)

Each patient is assigned to a 3-person team consisting of a nurse, social worker, and case manager.

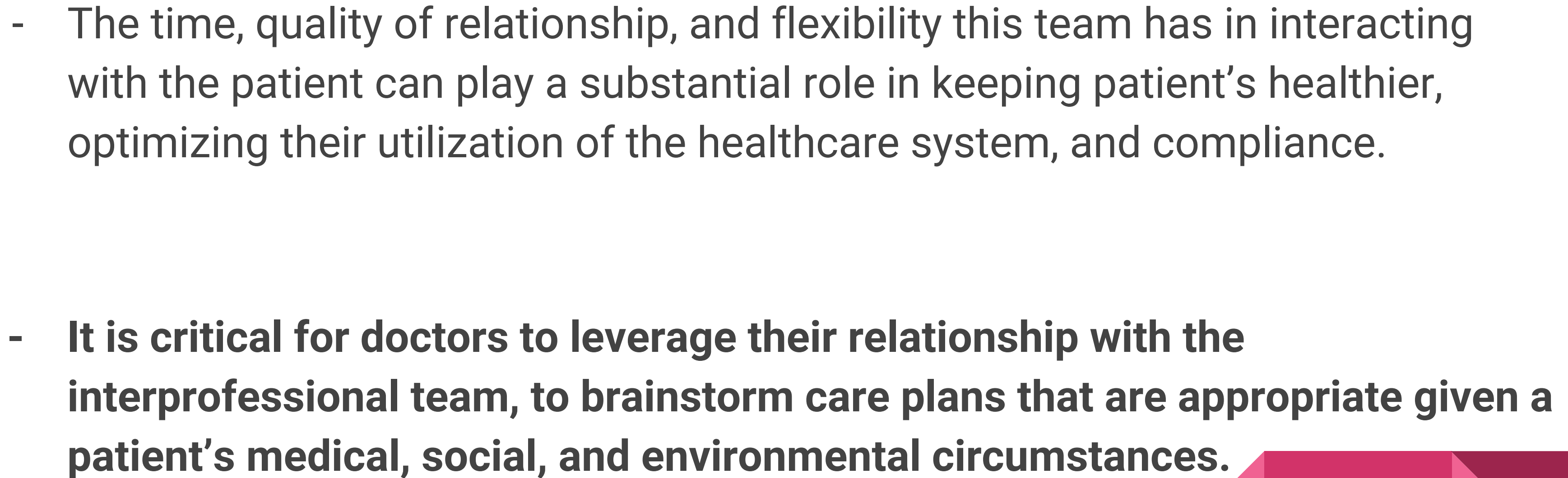


- This team collaboratively manages the medical, social, and administrative components of a patient’s care plan.
- This team serves as a liaison between the patient, and their family and medical doctors.
- Most importantly, this team serves as an important safety net and motivational force to support the patient to follow through with the care plan.

Interprofessionalism (2)

	Social Worker	Nurse	Case Manager
Education	Master's of Social Work (MSW)	RN, BSN	Bachelor's, Master's
Scope of Practice	Involved in the social aspects of a patient's care plan, including: housing, transportation, social relationships, and so forth.	Oversees the medical aspects of a patient's care plan: including health literacy, medical appointments, rehab/therapy options, etc.	Provides administrative support as required by the patient's care plan.
Location of Service	Office-based with occasional home visits to to the patient.		Office Based
Strengths/ Limitations	The team has a lot of agency to access many resources available to eligible patients. However, patients may be non-compliant and not always interested in accessing the resources available to them, even at the expense of their health. The strength of the team's relationship with the patient is important when making recommendations to patients and supporting their compliance.		

Takeaways from the Interprofessional Team



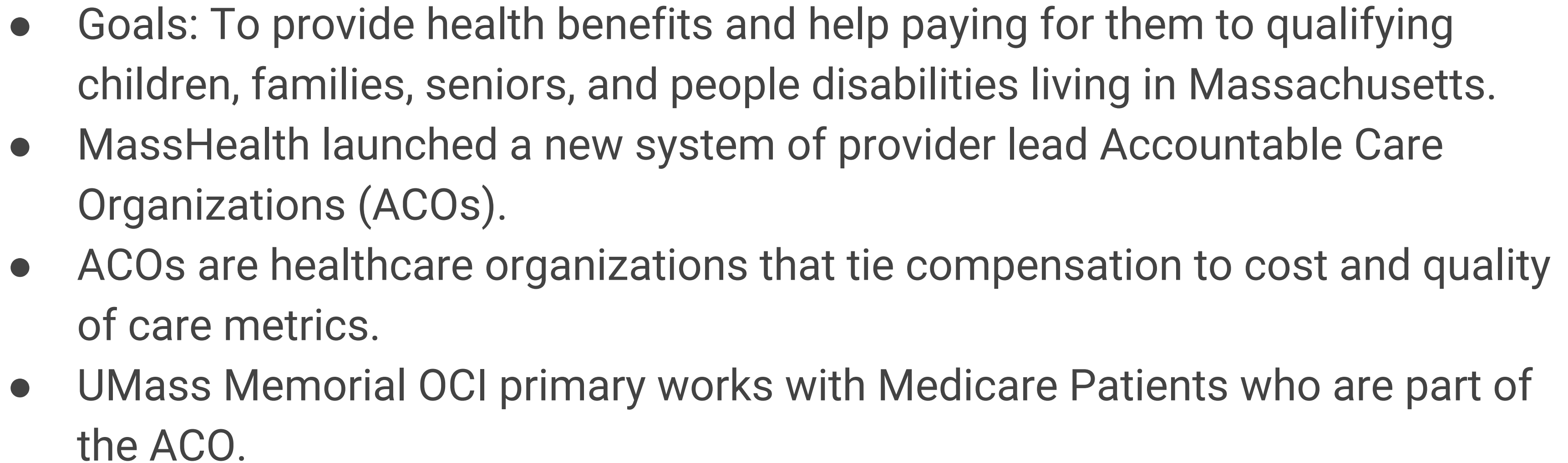
- The time, quality of relationship, and flexibility this team has in interacting with the patient can play a substantial role in keeping patient’s healthier, optimizing their utilization of the healthcare system, and compliance.

- **It is critical for doctors to leverage their relationship with the interprofessional team, to brainstorm care plans that are appropriate given a patient’s medical, social, and environmental circumstances.**

Health Advocacy: UMass Memorial Office of Clinical Integration

- Goal: Connecting super utilizers with services to improve their health.
- Helping find disadvantaged patients who may navigate the healthcare system/insurance/outside resources safe places to live, free wheelchairs, pick up medications, schedule follow ups etc.

Health Advocacy: MassHealth

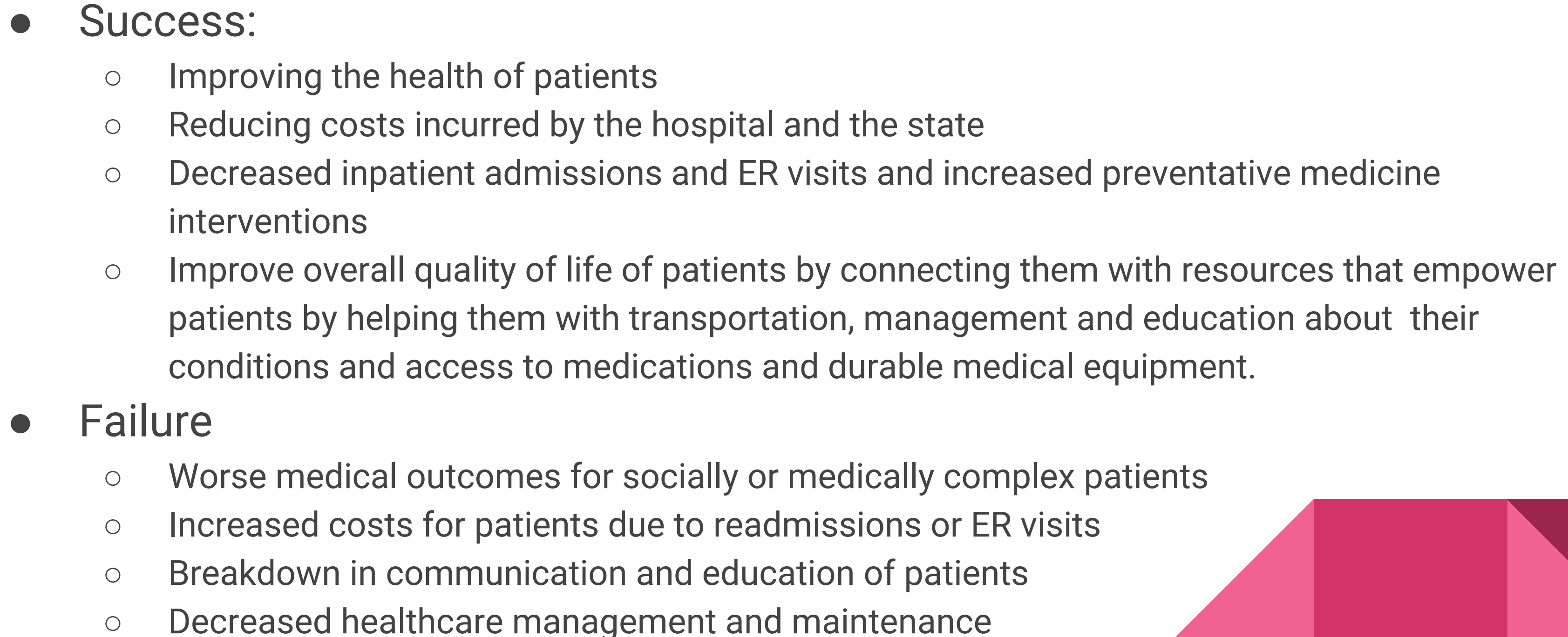


- Goals: To provide health benefits and help paying for them to qualifying children, families, seniors, and people disabilities living in Massachusetts.
- MassHealth launched a new system of provider lead Accountable Care Organizations (ACOs).
- ACOs are healthcare organizations that tie compensation to cost and quality of care metrics.
- UMass Memorial OCI primary works with Medicare Patients who are part of the ACO.

Health Advocacy: Robert Woods Johnson Foundation

- Goals: The largest Philanthropic fund dedicated solely to promoting a culture of health in the United States.
- Funded the Camden Coalition which was created in 2002 with the goal of improving the health of patients who face the most complex medical and social challenges.
    - This is the study that created the idea of Hotspotting and showed care.
    - “Hotspotting uses data to discover the outliers, understand the problem, dedicate resources, and design effective interventions. It is a movement for a new 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, emotional support.”

What’s at Stake?



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