Increasing the Focus on Complex Care

November 16, 2022

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Please chat in…

Who is on the webinar with us today?

- What organization you are with,
- Where are you located, and
- What is your role in reducing utilization?

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Poll Question

What is your care setting?

Overview

- Structure of the 9-session series
- Defining complex care and multi-visit patients
- Reviewing data
- Introducing your assignment
- Open forum

Increasing the Focus on Complex Care

9-Session Series

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Participating organizations will implement a process to:

- Identify individuals at high-risk by using internal methods such as population health data and known drivers of utilization
- Recognize individuals who have had multiple hospital visits
- Map a plan to develop and integrate processes and interventions to assist in meeting the needs of identified patients

Complex Care Learning Activities

1. Conduct a deep dive into your data to see if methods used to identify multi visit patients (or those at high risk) are effective
2. Assess how communication of risk is shared with team members
3. Apply an internal management process to identify multi-visit patients (e.g., via EHR, direct screening, interdisciplinary rounds)
4. Share the population data and utilization drivers across the team
5. Pilot a process to use specific interventions for identified patients

Complex Care, 9 Session Schedule

Date	Time	Activity	Registration
12/01/2022	12- 12:30pm	Learning Circle - Data Review, Check- in	(Placeholder for website link for registration)
12/15/2022	12-1pm	**Screening, Referral, and the Data Loop**	
01/05/2023	12-12:30pm	Learning Circle: Screening Review, Check-in	
01/19/2023	12-1pm	**Understanding and Addressing Drivers of Complex Care**	
02/02/2023	12-12:30	Learning Circle - Best Practice	
02/09/2023	12-12:30pm	Learning Circle - Best Practice	
02/16/2023	12-12:30pm	Learning Circle - Best Practice	
02/24/2023	12-1pm	**Wrap-up and Celebrate**	

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Today's Learning Objectives

Upon completion of this event participants will be able to:

1. Define complex care and multi-visit patients,
2. Analyze your data to identify who your multi-visit patients are, the reasons they are returning to the hospital, and from what care setting, and
3. Identify your initial key team members to support your high-risk patient needs.

Today's Speaker

Dr. Rebekah Gardner

Senior Medical Scientist, Healthcentric Advisors

Associate Professor of Medicine, Brown University

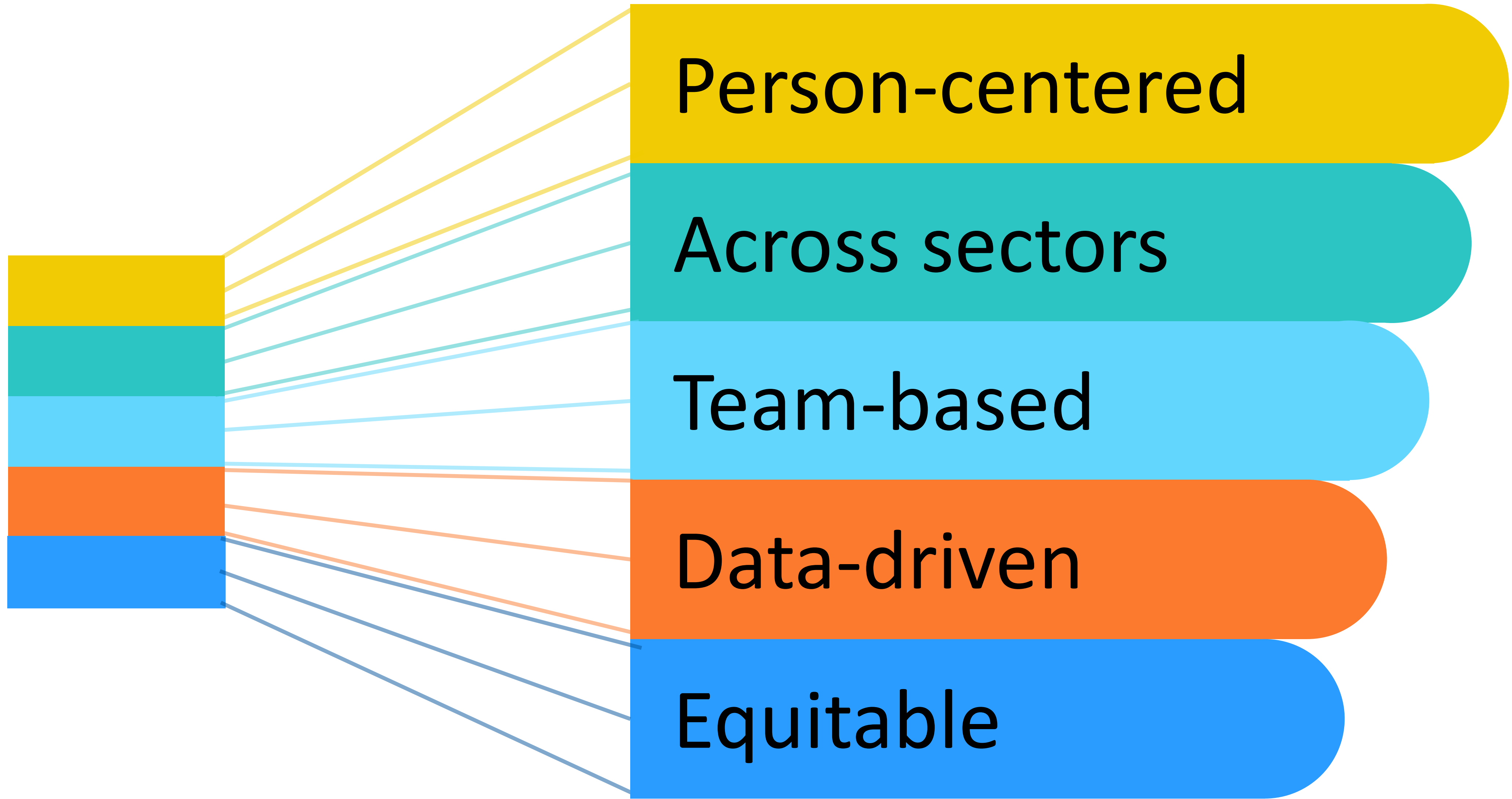
Internist practicing inpatient and outpatient medicine

Patient Story

Defining Complex Care

"Person-centered approach, brings together patients, families, community, and healthcare system to collaboratively improve health outcomes and wellbeing for people with complex health and social needs."

Source: The National Center for Complex Health & Social Needs – An initiative of the Camden Coalition
https://www.nationalcomplex.care



Source: Humowiecki, et al. Blueprint for complex care, Dec 2018.
www.nationalcomplex.care/blueprint

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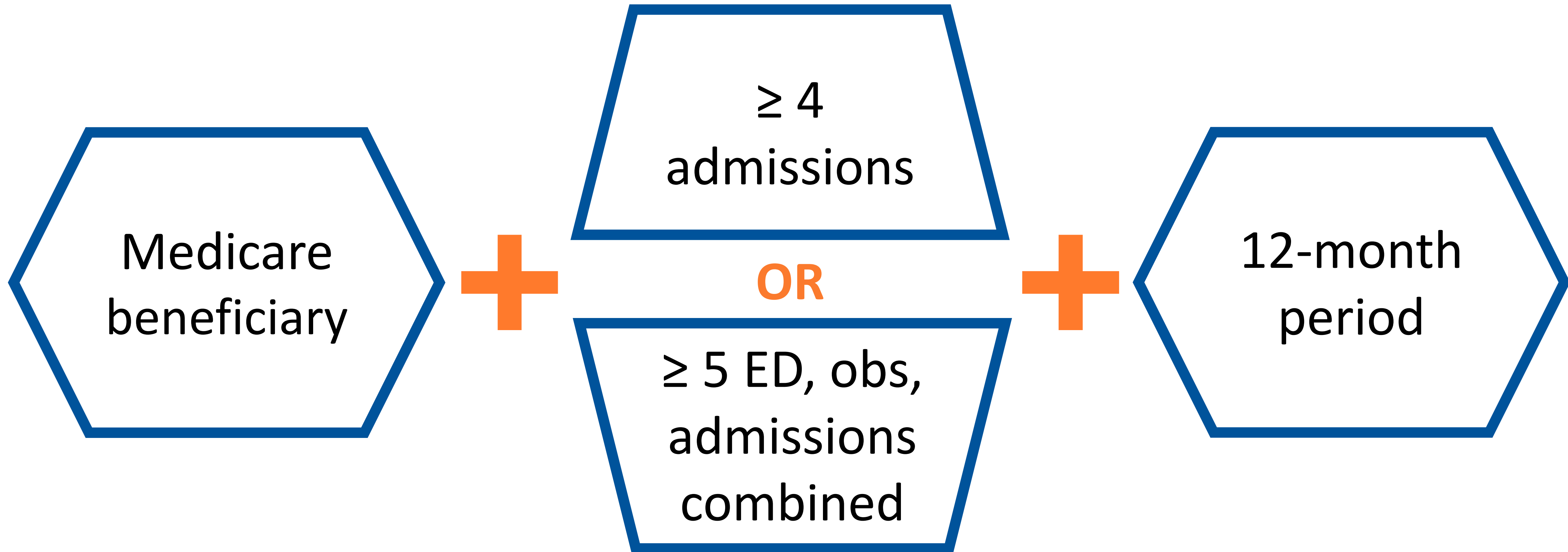
Complex care brings together entities across the health ecosystem to address barriers at the [individual, community, and system] levels. Through these efforts, there is a greater ability to … care for the population in need.

Director of Integrated Care Management for a clinically integrated network

Source: Humowiecki, et al. Blueprint for complex care, Dec 2018. www.nationalcomplex.care/blueprint

Our Definition: Multi-Visit Patient



Poll Question

Have you heard the term Multi-Visit Patient (MVP)?

Please chat in…

How are you defining Multi-Visit Patients in your organization and by what term do you typically refer to them?

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65-year-old man

History of alcohol use disorder, depression, atrial fibrillation, and heart failure

Admitted with HF exacerbation

Hospital course complicated by alcohol withdrawal and afib with RVR

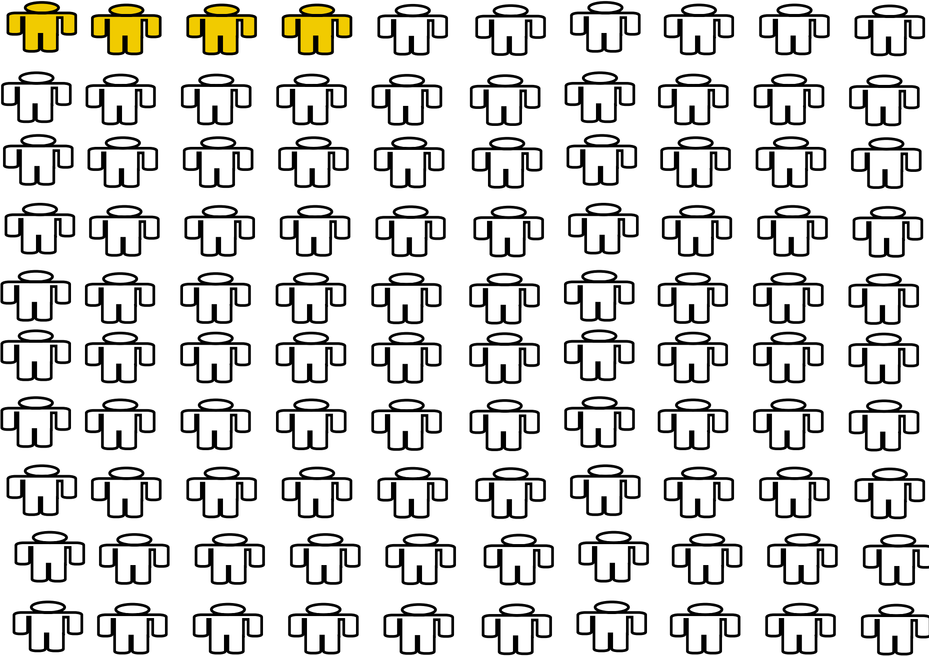
> 6 different ED visits and hospital admissions in past year

Multi-Visit Patient

Please chat in…

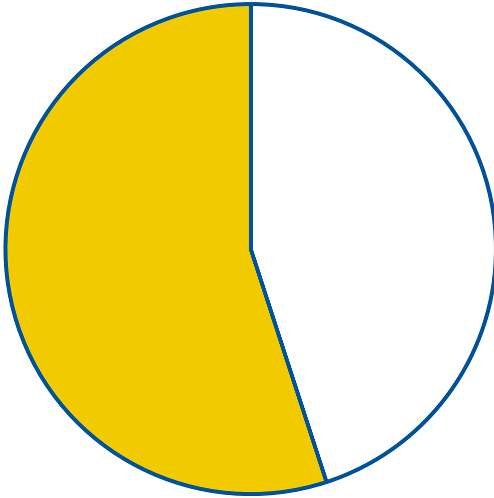
What do you think are some reasons patients return to the ED multiple times?

Multi-Visit Patients



4% drive

55% of readmissions



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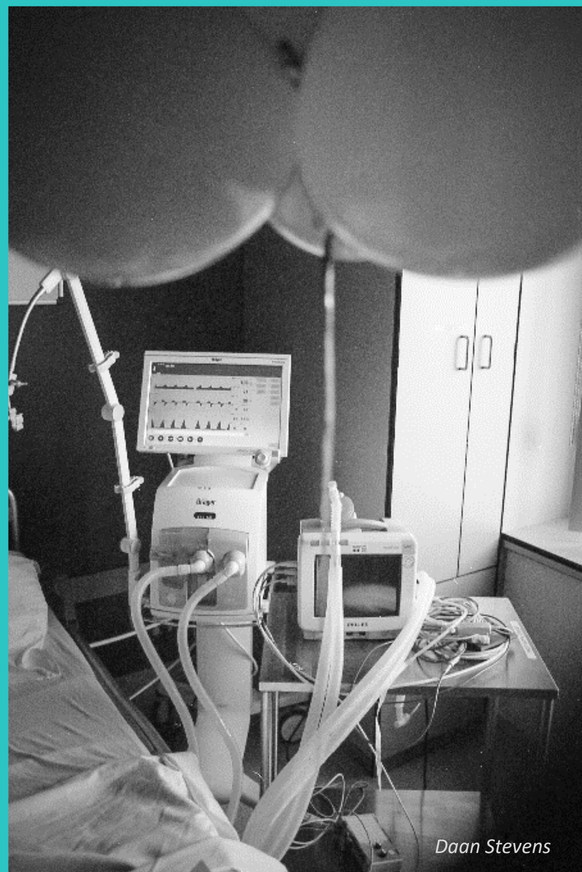
Potential Contributing Factors

Medical

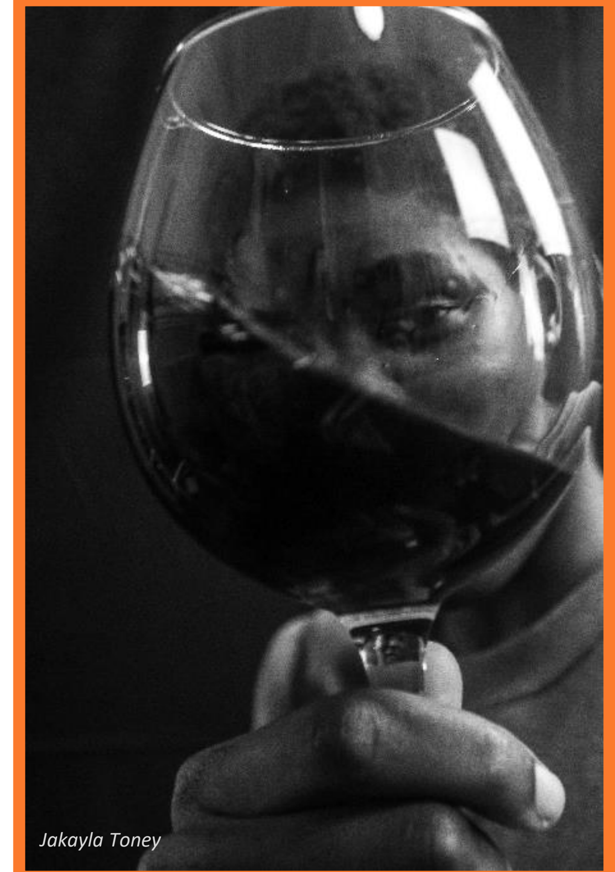


Daan Stevens

Social

Vitaly

Behavioral



Jakayla Toney

Medical factors

Atrial fibrillation, heart failure, med difficulties

Social factors

Marginally housed, couch at a friend's apartment, food access

Behavioral factors

Depression, alcohol use disorder

Identifying, Analyzing, and Interpreting the Data

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Poll Question

Does your organization currently have a method to track multi-visit patients?

- If yes, please **chat in** what tracking methods you use

Please chat in…

Who is reviewing the data on your team?

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Explore Your Organization’s Processes

Does your facility have a method to **identify** and **track** multi-visit patients with **complex care** needs?	**Options** Readmission reports, hospital ADT notifications, Medicare claims

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Explore Your Organization's Processes

Who is reviewing this data? When and with whom do they **share** it?	**Options** Quality group, admissions director, case or care manager, nurse, social worker; share with stakeholders

Explore Your Organization’s Processes

What are the **triggers** to identify multi-visit patients?	**Options** Food or housing instability, substance use disorders, behavioral health diagnoses, chronic disease

Resources for Hospitals

- Reduces preventable readmissions
- Improves workflow
- Reduces med errors
- Prepares and empowers patients and families
- Requires understanding current barriers, adaptation, institutional commitment

Resources for Hospitals & Nursing Homes

- ✓ Reduces readmissions
- ✓ Improves patient satisfaction
- ✓ Works in diverse populations
- ✓ Includes 12 discrete mutually reinforcing components
- ✓ Requires understanding current barriers, adaptation, institutional commitment

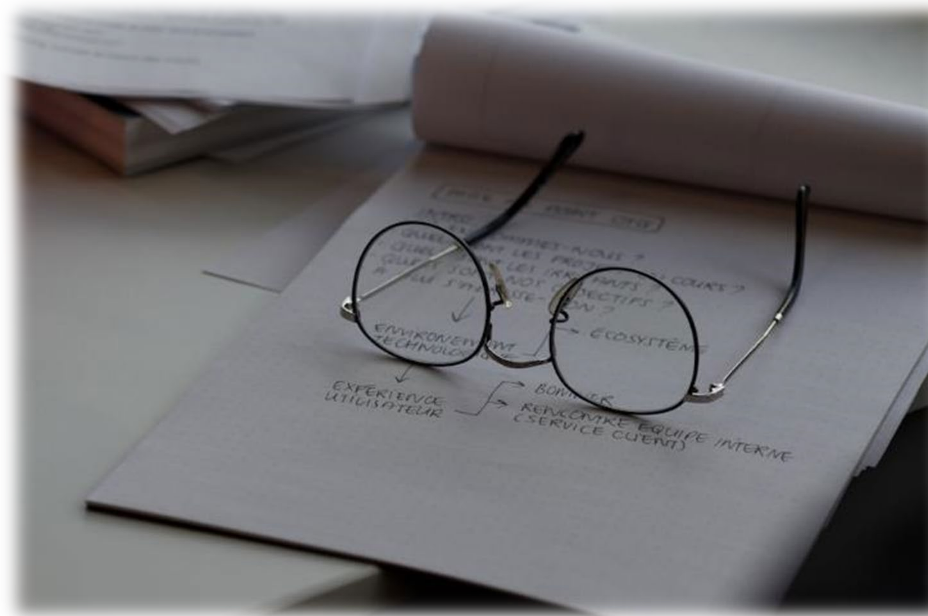
Resources for Nursing Homes

- Reduces acute care transfers
- Helps identify and evaluate changes in resident condition
- Uses tools to improve communication among care teams
- Facilitates advance care planning
- Requires understanding current barriers, adaptation, institutional commitment

Resources for Community Settings

- Uses healthcare “hotspotting”
- Provides community-based care management
- May reduce readmissions
- Facilitates patient link to primary care and social services
- Requires understanding current barriers, adaptation, institutional commitment

Assignment: Finding the root cause



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1. Identify multi-disciplinary team
2. Review ≥5 multi-visit patients
3. Define the problem clearly
   - Coming from which care setting?
   - Why seeking care in ED?
4. Discuss different pilot options

Why?

Why was this patient admitted again?
Heart failure exacerbation

Why did he have a heart failure exacerbation?
Not taking his meds or adhering to the recommended diet

Why not?
No access to kitchen to store or cook his own food, has to eat prepared food, which is high in salt

Why else?
Limited bathroom access during the day so afraid to take his diuretic and risk incontinence

Why no housing?
Past criminal conviction makes it hard to get a job or an apartment

Open Forum

- What will be the biggest challenge in looking at your data and finding out the reasons patients are returning to the hospital?
- What are you hoping to gain from attending the next few sessions?
- Additional questions?

Next Steps

- Work on assignment tool and share key findings
- December 1st Learning Circle
  - Opportunity to share current findings and discuss
  - Brainstorm around barriers when looking at your data
  - Sign-up for the next session here: https://healthcentricadvisors.zoom.us/meeting/register/tZcqcu6gpzIpGtbeGcY52bXi35a7PvZW9Mpt
- December 15th Screening tools, referrals, and data loop
  - https://healthcentricadvisors.zoom.us/meeting/register/tZMrcu6spzsoG9LCInGV_LKa1L-88zXK5Pit

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Want to learn more?

- Check out the Complex Care Compendium which highlights select models and practices related to complex care:
  - https://drive.google.com/file/d/14qKTeQSpr1DR420n6xSH4e9XDSXSOXay/view