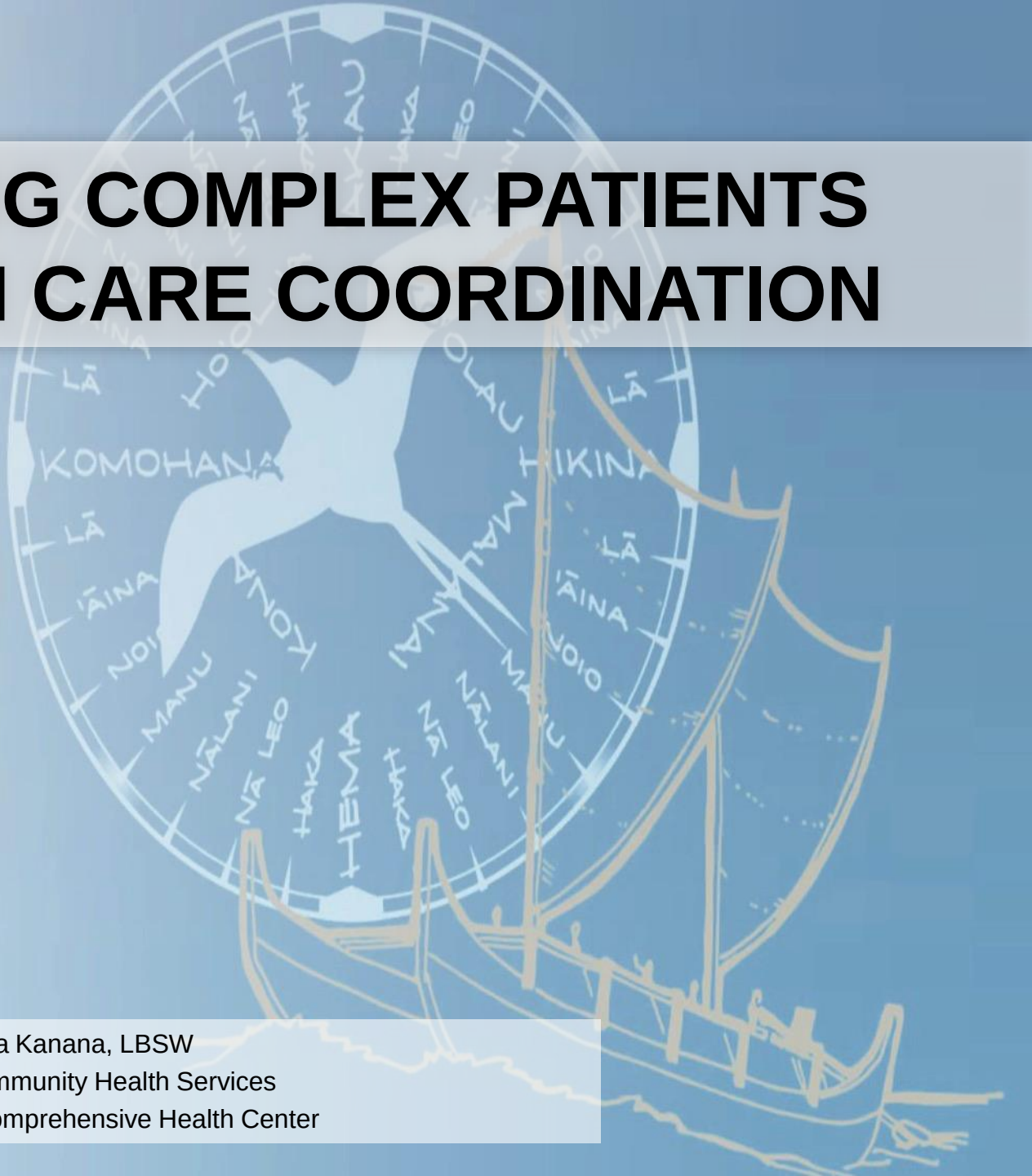
MANAGING COMPLEX PATIENTS THROUGH CARE COORDINATION



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COMPLEX NATION

- As Americans live longer with multiple conditions, managing their care is becoming increasingly challenging.
- Being able to define and measure patient complexity has important implications for how care is organized, how physicians and health systems are paid, and how resources are allocated.

THE WAIANAE COAST PRIMARY SERVICE AREA

- Highest number of households in the state receiving financial aid and food stamps
- Highest percent of individuals on Oahu living below the Federal Poverty Level
- Highest number of obese adults, adults with diabetes, and adult smokers.

2016 State of Hawaii Primary Care Needs Assessment Data Book (Hawaii State Department of Health, May 2016)

AN ALL TOO FAMILIAR STORY

Sheila was **chronically homeless** and lived at Ma'ili Beach for two years while managing a leg wound as best as she could.

Sheila's leg does not heal properly due to her housing situation.

Leads Sheila to the ER multiple times. She is finally admitted to the hospital for treatment.

While in the hospital, Sheila completes multiple tests and imaging studies. She is discharged to a skilled nursing facility to complete several courses of antibiotics, after which...

Sheila is discharged right back to homelessness which means....

Forbes "What Person the Disease Has" Damon Francis M.D.

CHANGING OUR HEALTH CARE STORY

Homeless outreach team partners with **care** coordinators who help Sheila keep her appointments with primary care. Her medical issues are addressed in the context of her **social issues.**

Staff link Sheila with a **housing first program** who finds her a place to stay with rent subsidies

Through transportation services, Sheila keeps primary care appointments for would care and medication management

Sheila is now stably housed; her leg wound has dramatically improved.

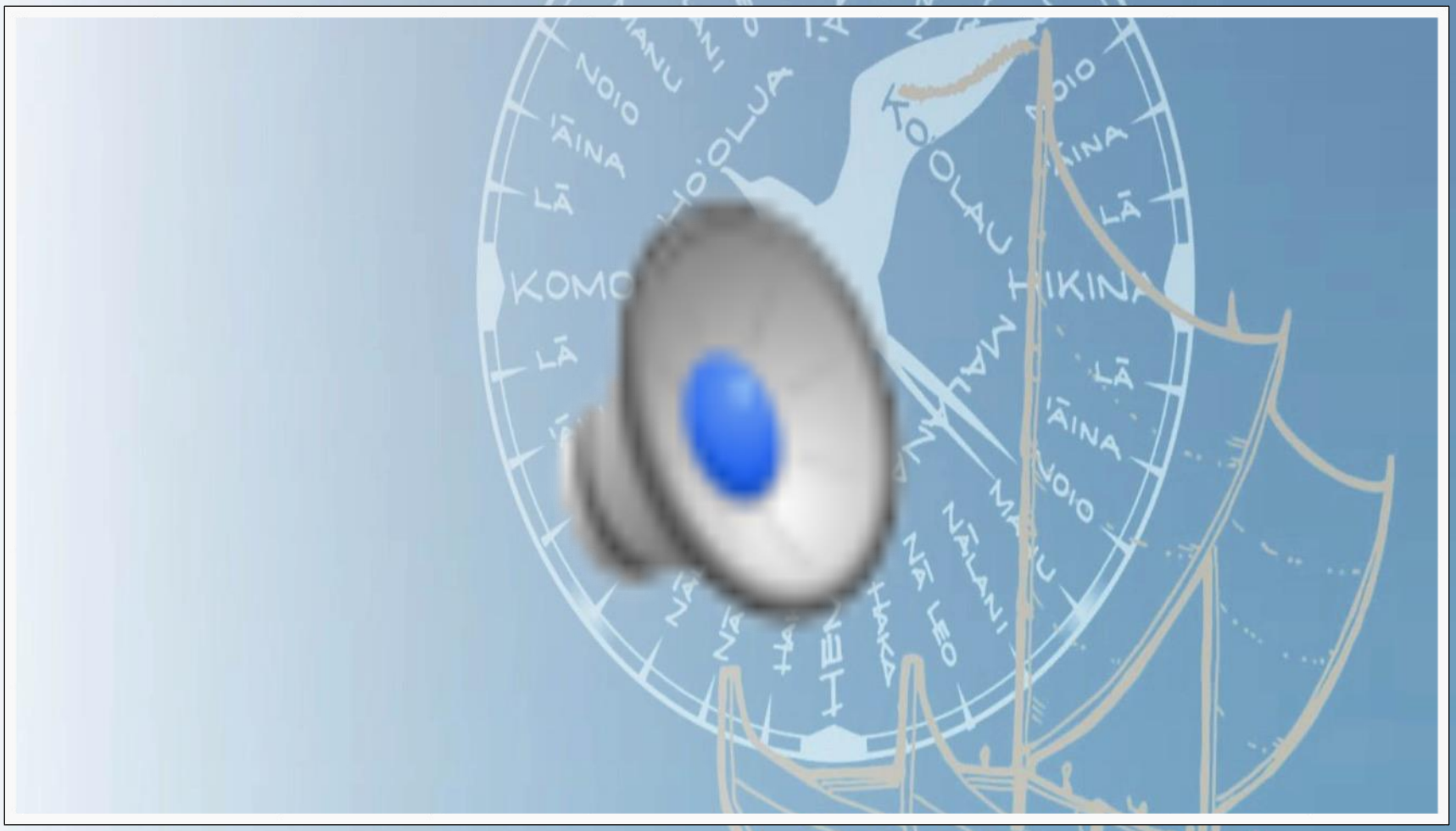
OUR VALUE IS IN PROVIDING COMPREHENSIVE, INTEGRATED MEDICAL CARE TO OUR PATIENTS

- Highly complex patients receive fragmented medical care at best and over-utilize emergency rooms and hospitals.
- They consume more resources, take more time to manage effectively and contribute to decreased quality of care.
- CHCs are best for ideal patient-centered healthcare home because of the integrated services we provide.

RELATIONSHIPS, CONNECTIONS & TRUST

- Relationships are key to establishing mutual respect and positive outcomes
- Seek out common interests
- Cultural diversity
- Encourage patients to be their own change agents
- Patients perspective
- Active listening and positive body language

VIDEO: Prapare To Be Interrogated



WORKFLOW TO CAPTURE SDoH DATA

- Capture data without having to develop another tool
- EHR-Social and family history templates and ICD10 codes
- Use of enabling codes
- “No wrong door” approach
- Pull SDoH information from existing EHR data

PRAPARE

- Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
- Initial plans were to expand our ‘no wrong door’ approach to data collection.
- Every ‘door’ a patient enters contributes to the understanding of who we serve.
- However, resulted in incomplete data.
- Recognized need to develop a standardized method of data collection.

PRAPARE IMPLEMENTATION

- Initially implemented survey into care coordinators' workflow.
- Found to be too time consuming.
- Adapted process to create a 'talk story' environment.
- This process allowed care coordinators a 'foot in the door'.

PRAPARE EXPERIENCES

- Resistance noted on some questions, especially regarding household income and incarceration.
- Expand certain categories to include assessing:
  - Stability of housing situation.
  - Access to health care.
  - Work situation.
  - Legal concerns and rights.
  - Social and emotional health to include screening for depression and domestic violence.

TODAY'S PRAPARE, TOMORROWS SOLUTIONS

- Tested the tool with three provider panels in Adult Medicine
- Created workflow conducive to clinic practices
- Developed a patient mode of PRAPARE to allow patients the ability to self administer the survey.
- Triage patients to appropriate workforce for social support

LESSONS LEARNED & FUTURE PLANS

- Strong leadership in disseminating the tool
- Accountability of staff
- Stronger network of community partners
- Future dissemination to all clinics
- Use of patient portal to disseminate the tool prior to the appointment
- Ultimately develop a holistic risk score, incorporating SDoH with claims based data, to better define the complex patients we serve.

CARE COORDINATION PROGRAM

CONSISTS OF THREE GROUPS OF STAFF

- **Care Enabling Worker**
  - Assure the patient receives appropriate and timely follow up after discharge from an ER/hospital.
- **Care Coordinator**
  - Works with a targeted population to help achieve optimal wellness.
- **Service Coordinator**
  - Intensive case management to high risk patients referred by their PCP or other provider within the health center.

OUR MODEL

- Team approach
- “Talk story”
- **Health Risk Assessment**
  - Patient’s future “trajectory” to higher risk categories
  - Paints a picture of the whole person
  - Creation of a Self-Management plan
- Regular patient contact
- Patient is at the helm (hoe uli)

CARE PLANNING & PATIENT MONITORING

- Contacts based on activation level
- In-person interactions done in office or home setting
- Utilize mental health and substance abuse screens
- Tract test results, communicate to patient and/or PCP.
- Care plans and self-management goals created

SELF-MANAGEMENT ACTION PLAN

WAIANAE COAST COMPREHENSIVE HEALTH CENTER

Self-Management Action Plan

Date_____ DOB_____

I _____ and _____ have agreed that to improve my health I will:
(Name) (Care Coordinator)

My goal this week:

☐ **Be Physically Active**

- ◊ Go to the gym
- ◊ Walk more often
- ◊ Walk longer
- ◊ Go swimming
- ◊ Other

☐ **Improve my Food Choices**

- ◊ Portion control
- ◊ Limit fat intake
- ◊ Minimize salt
- ◊ Read food label
- ◊ Other

☐ **Take my Medications**

- ◊ Fill prescriptions
- ◊ Medicine reminder
- ◊ Medicine log
- ◊ Use pillbox
- ◊ Other

☐ **Check my Blood Pressure**

- ◊ Check as recommended
- ◊ Record log in
- ◊ Bring log to doctor appointment
- ◊ Other

☐ **Check my Blood Sugar**

- ◊ Get testing supplies
- ◊ Record daily log in
- ◊ Set up alarm for reminder
- ◊ Other

☐ **Reduce my Stress**

- ◊ Identify support
- ◊ Talk therapy
- ◊ Stress therapy
- ◊ Daily Meditation
- ◊ Get enough sleep
- ◊ Native Hawaiian Healing Center
- ◊ Other

☐ **Stop Tobacco Use**

- ◊ Set a quit date
- ◊ Talk to PCP about quit smoking
- ◊ Begin a quit smoking program
- ◊ Other

☐ **Limit Alcohol Use**

- ◊ Malama Recovery
- ◊ Drink less
- ◊ Attend AA meetings
- ◊ Attend inpatient program
- ◊ Other

☐ **Other**

SELF-MANAGEMENT ACTION PLAN

WAIANAE COAST COMPREHENSIVE HEALTH CENTER

Self-Management Action Plan

Date_____DOB_____

I _____and _____have agreed that to improve my health I will:
(Name) (Care Coordinator)

A way I can improve my health is: _____.

What will my goal for this week be? _____.

How often will I do it? _____.

What might get in the way of my goal? _____.

What can I do about it? _____.

Commitment Scale:

On a scale of 1 to 10 (1 being not at all and 10 being most possible), my commitment to follow this self-management plan is a: _____.

I gave this number because_____.

Client Signature_____ Date_____

Care Coordinator Signature_____ Date_____

PROMOTE PATIENT, FAMILY, AND TEAM ENGAGEMENT

- Engage patient in their own health care decisions.
- Seek patients values and preferences.
- Health education and completion of Advanced Directives and POLST.
- Use of case conferences as appropriate.
- Collaborate with pharmacist, monitor medication adherence. Weekly return to stock lists.

FACILITATE TRANSITIONS OF CARE

- Receive daily ADT feeds
- Assess low-acuity ER visits
- Provide linkage to primary care
- View discharge summaries
  - Follow up post-discharge to ensure patients understand discharge instructions, recognize symptoms, keep follow-up appointments

SUCCESS STORY

- Rose, 58y.o. Native Hawaiian female
- DMII, Obesity, Asthmatic, Hyperthyroidism, HTN & mixed hyperlipidemia
- Non adherent with all appointments
- Lack of transportation, primary caregiver to 3y.o. grandchild

GOING BEYOND OUR REEF

We can't care for something we don't understand. This is the purpose of why we explore and why we voyage.

~ Nainoa Thompson