Hot Spotting Medically Complex At-Risk Patients in an Urban Primary Care Residency Clinic

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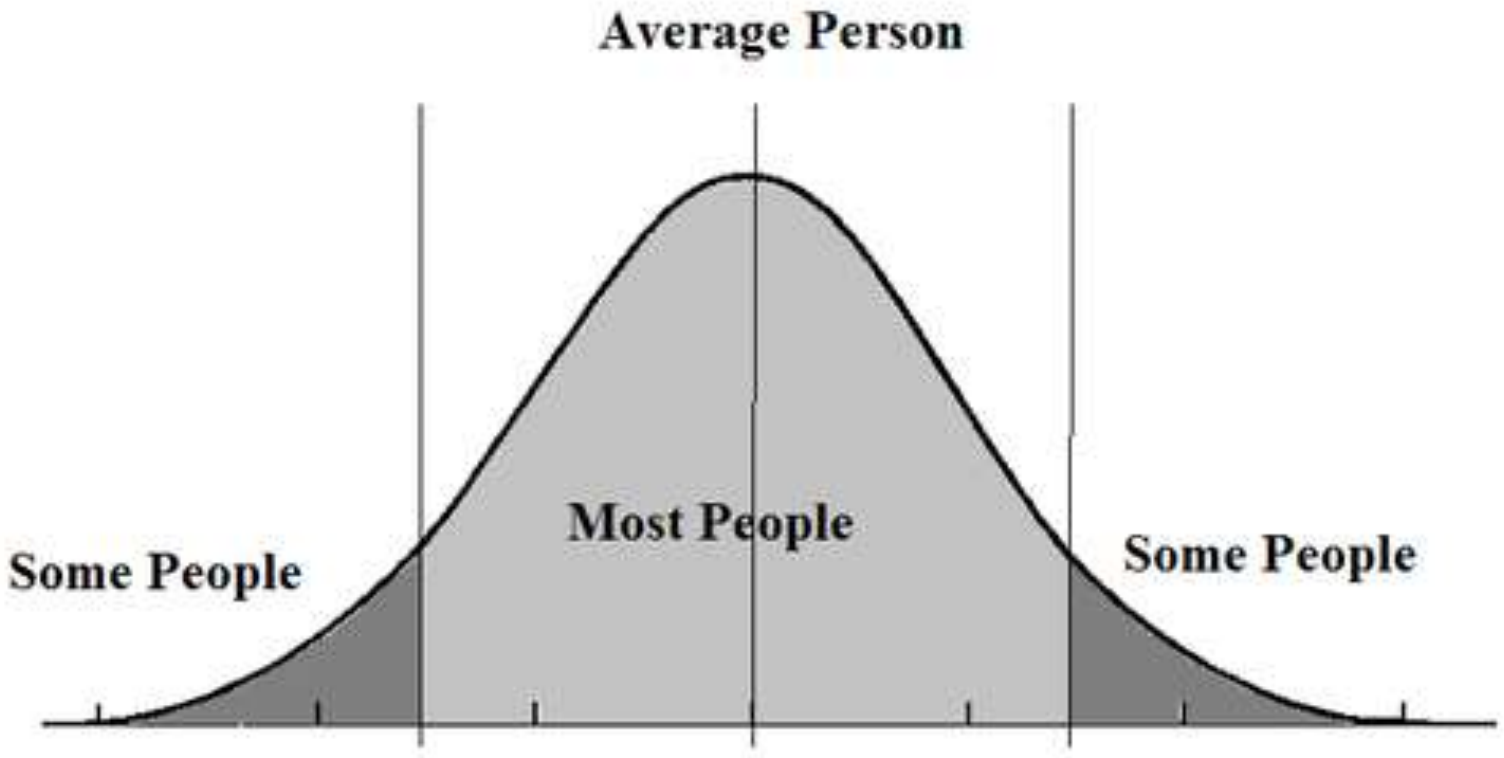
Outliers need more



Why Hot Spot?

Our healthcare system is not designed for the outliers; 5% of the patients incur 50% of the healthcare cost according to research.

Definition of Hot Spotting

"The collaborative care approach put into place in hopes of improving outcomes and decreasing costs."

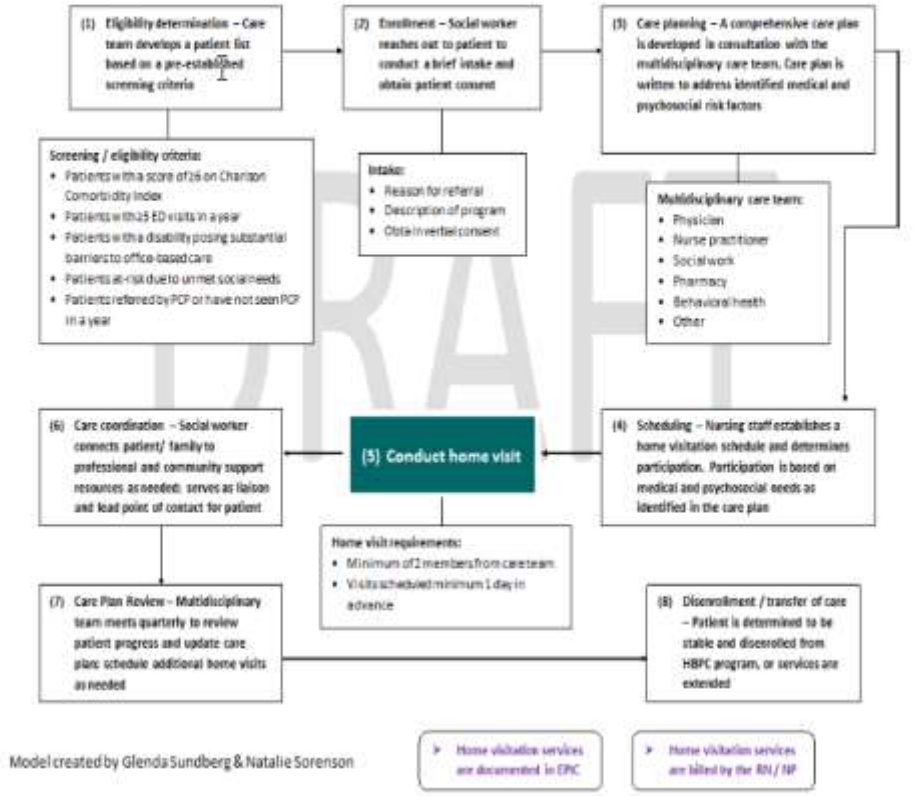
What does hot spotting a patient mean?

- Each patient receives:
  - A discussion and extensive chart review at the 2 hour interactive team meeting 4 times per year
  - A comprehensive care plan with goals and updates placed on the problem list in the EMR to help enhance care.
  - At least one home visit per patient.
  - More frequent calls from nursing and social work

Mapping it out!

Home-Based Primary Care for Medically and Socially Complex Patients

A Population-Based Health Approach for Patients At-Risk



Model created by Glenda Sundberg & Natalie Sorenson

Roles for the Hot spotting Team

Nurse Practioner:

- Gathers patient names from primary care provider to be hot spotted
- Organizes patients to be hot spotted and maintains the list
- Works with the team to do the pre and post surveying for the project of participants and patients
- Schedules the interactive meeting times (2 hours 4 times per year)
- Keeps team updated on progress meeting times etc.
- Hold team accountable for their contribution.
- Conducts and bills all home visits
- Keeps and distributes an ongoing spread sheet with team input

Social work:

- Calles and gets acceptance into the hot spotting program from the patients nominated by their primary care provider
- Communicated w the team the status of the patients who have accepted and who they are still reaching or other issues the team should be aware of
- Attends some home visits as available and as necessary
- Attends all interactive meetings

Nursing:

- Calls patients at least twice during the year to help support
- Types care plans during the integrative team meetings.
- Attends all 4 interactive team meetings

Pharmacy:

- Monitors and makes team aware of all medication concerns
- Attends all interactive team meetings
- Responds to issues or interventions from interactive meetings or home visits re any medication concerns or discoveries.

Resident:

- Helps conduct home visits
- Attends interactive team meeting when available
- Helps w project management and write up

Faculty Physician:

- Attends the 4 interactive team meetings
- Supports the project

Other members:

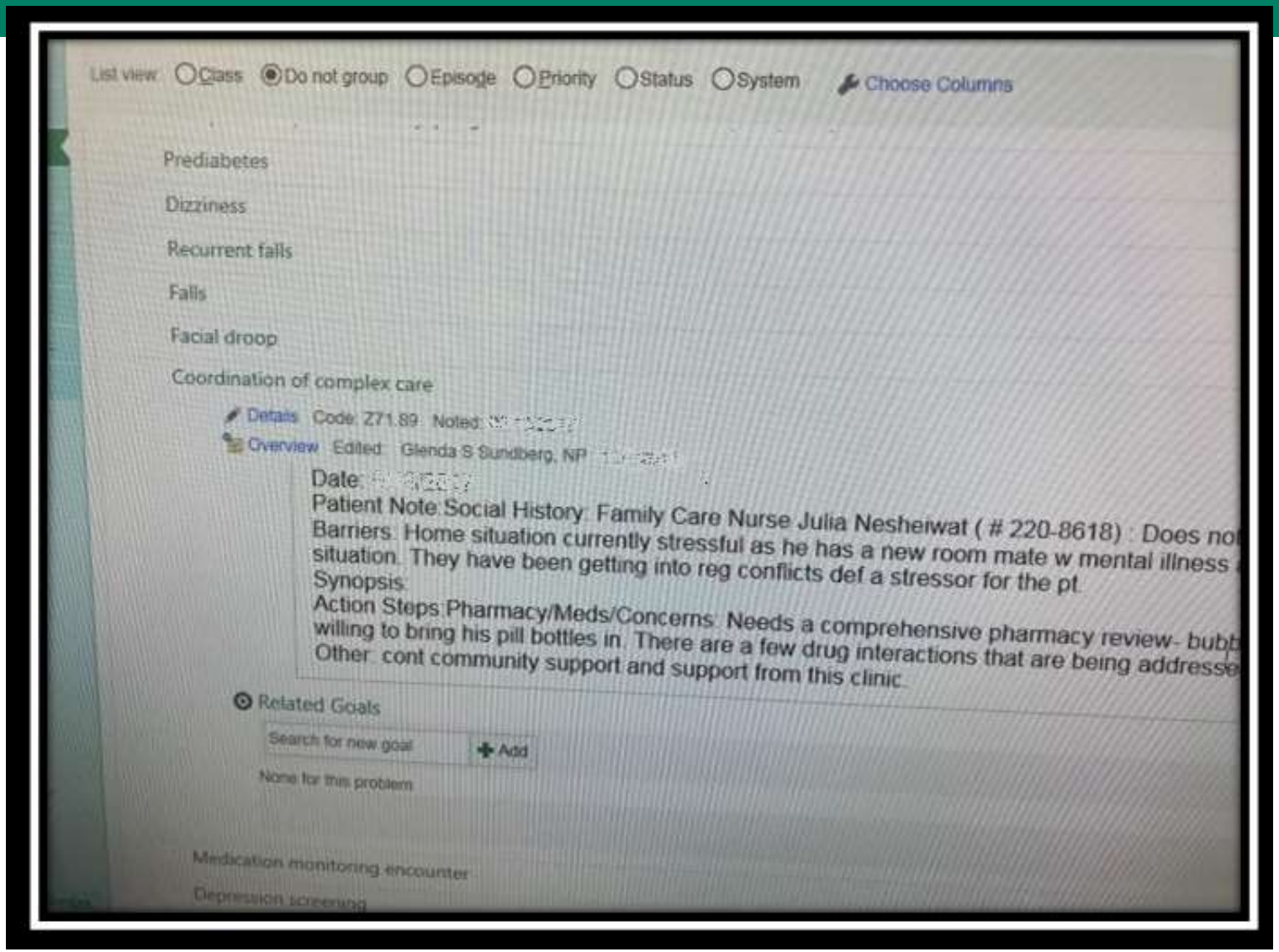
- All team players are an active player in communication to the team and primary care provider new developments on the patients or any changes that occur so that the team can respond appropriately. We as a team have regular communication with the primary care provider about our goals for the patient and updates. Home visits are set up through the help of clinic staff.

25 Patients were chosen to hotspot!

2 hour Interactive Team Meeting

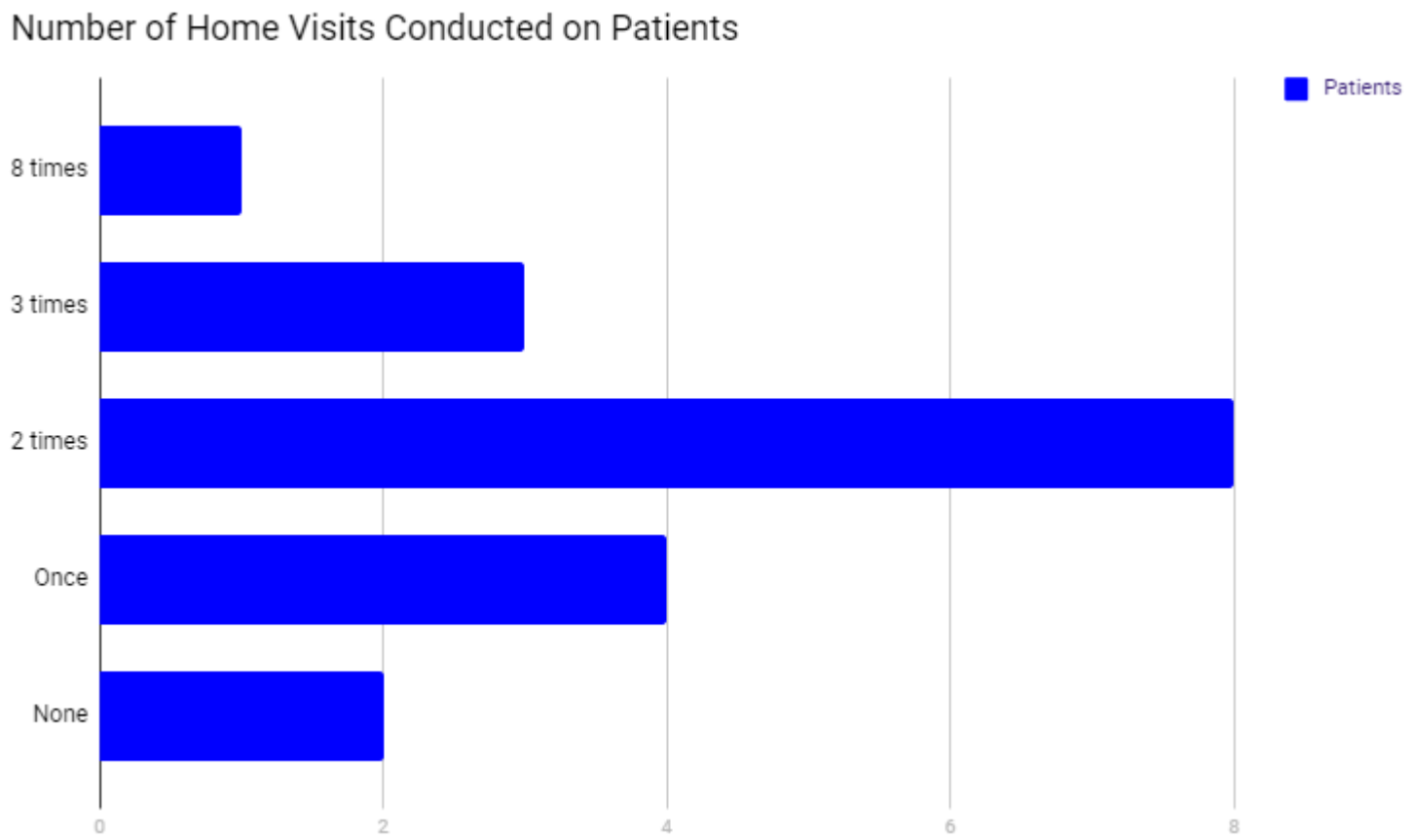
Care Planning

During the interactive meeting



Home visits begin!

Number of Home Visits Conducted



Home Visit Billing

Home Visit Codes – Established Patient:

- 93347 Self-limited or minor problem, 15 min.
- 99348 Low to moderate problem, 25 min.
- 99349 Moderate to high problem, 40 min.
- 99350 Patient unstable or significant new problem requiring immediate physician attention, 60 min.

Home Visit vs Clinic Charges:

Level 4 office visit (99214) charge =$374

Level 3 Home visit (99349) charge= $341

The mean distance of the hot spot patients was 3.1 miles and median was 2.7 miles from the clinic.

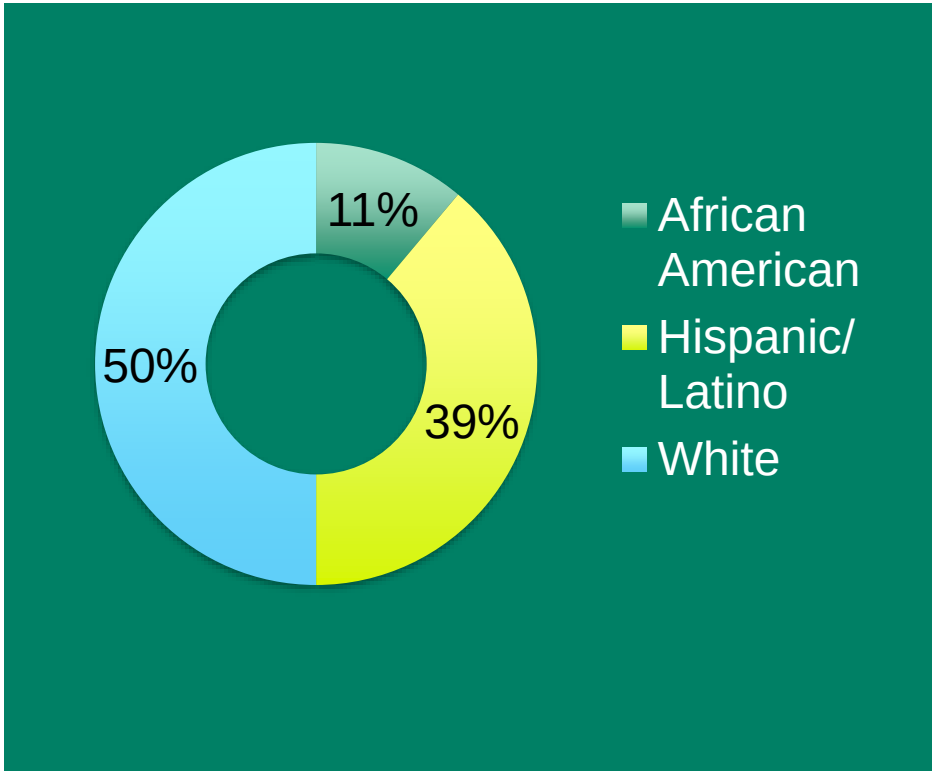
Demographics of the Hot Spots

62.4 average age

7 Male and 13 Female

Insurance:

- **Medicare- 13 of the 20 (65%)**
  - Humana-3
  - United Health Care-2
  - Independent Health Care-4
  - AARP Medicare-1
- **Medicaid- 18 of 20 (90%)**
  - My Choice Family Care-6
  - Medicaid T19-2
  - Independent Care Medicaid-2
  - UHC Community and State-1
  - Community Care Family Care-5
  - T19 Anthem BCBS Medicaid-1
  - Icare Medicaid-1

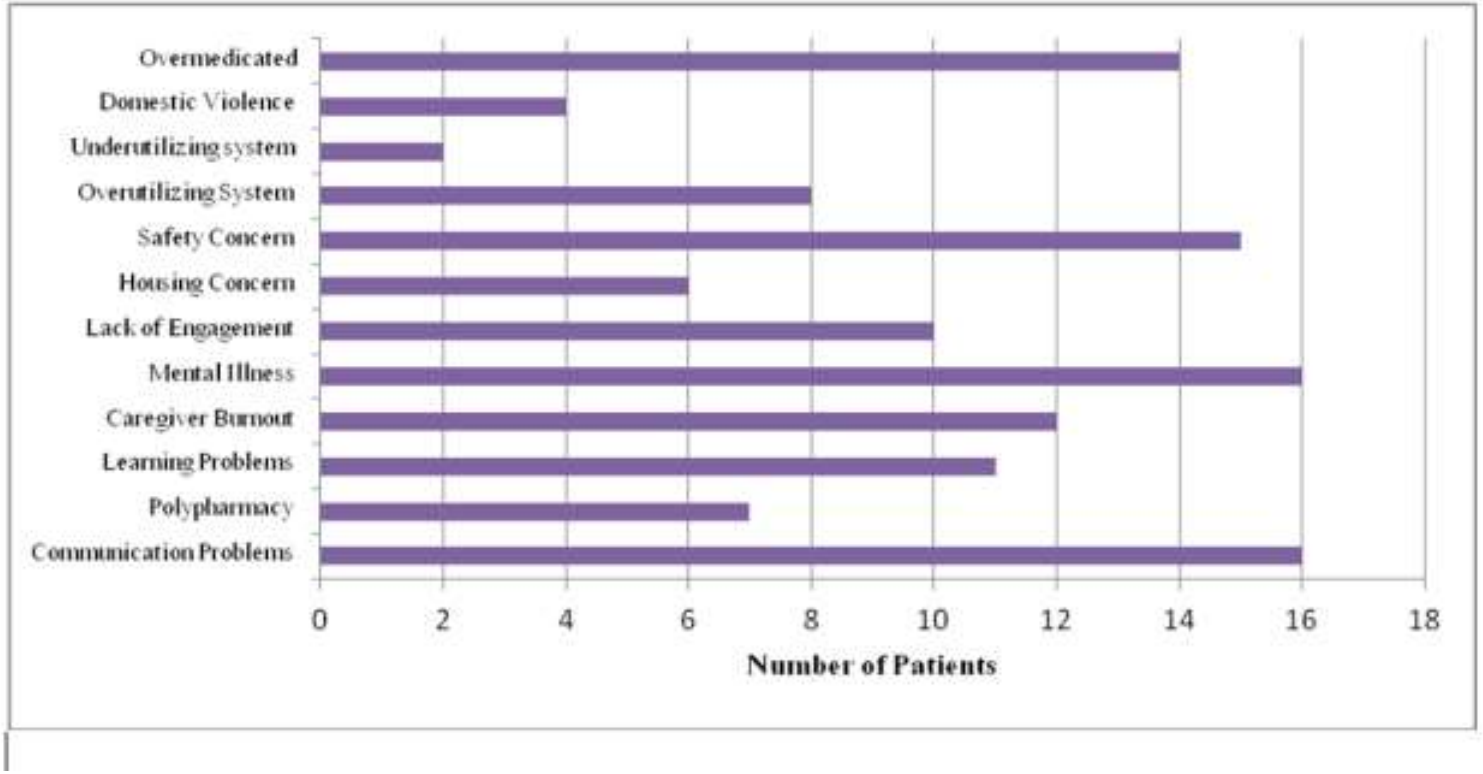


Charleson Scoring for acuity

- The average score for the patients was 6.2 with a median of 6.

- A score of 6 equates to a 10 year mortality rate of 98%

>14 were overmedicated, had safety concerns, mental illness and communication problems.



Key Findings

- Reasons for noncompliance discovered
- Home visits revealed barriers to care
- Violence in the home was discovered and managed
- Increased communication with community workers and sharing insight helped
- Community workers not always willing to stand up and advocate for the patients needs
- Medications were not being taken correctly
- Team in place to care for patient not always functioning well
- Compliance got better with increased communication and care
- Critical caregiver information not always easily available in EMR

SAVINGS!

33%

20%

COST SAVINGS!

Total (ER+IP) Direct Cost Savings = **$186,825**

$186,825 / 17 patients = **$10,990** saved per patient

$186,825 / $21,035 investment = **9:1 ROI**

** Investment
NP and Social Worker 0.1 FTE
RN 0.05 FTE
Plus Miscellaneous

How to make Hot spotting thrive?

- Keep fine-tuning and reinforcing good communication patterns on the team
- Everyone on the team needs to do their role for the intervention to be a success.
- You need buy-in and support from all team members
- Support from administration and resources

What's Next?

- Hot spotting in two settings
  - St. Luke's
  - Sinai
- Goal is to track 35 patients in 2018

VISION:

- Hot spotting would be present in all clinics
- All clinicians would be able to doing some home visits


Impact

Acknowledgements

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