Hot Spotters: Understanding Social Causes to Improve Population Health

Partnership of:

- Camden Coalition
- Primary Care Progress
- Association of American Medical Colleges

Clese Erikson, M.P.Aff.
Senior Director, AAMC
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What is hot spotting?

- Identifying high cost patients – those with multiple hospital and ER visits
- Getting to know the patients and their community and the root causes of the multiple visits
- Identifying strategies/resources improved patient care
- Creating the leadership and business case for supporting the interventions
Medicare, Medicaid, & private payers using multiple payment levers to incentivize move from volume to value

FFS
The more you bill, the more you get paid

Value
Payment tied to lower cost, higher quality and improved population health

PCMH

ACOs

Bundled Payments

Episode-Based Payments

Risk-Based Global Payments
Expanding Scope of Health Care

- Sobering centers
- Vocational aid
- Tackling stressors
- Housing assistance
- Legal counsel
- Paying for transportation
- Paying for exercise equipment/coaches
- Investing in a healthy home
- Paying for a cell phone
- Housing assistance

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Expanding Scope of Health Care
What is the goal?

Better care at lower cost for everyone every day
How is healthcare hotspotting done?

• Data
• Engagement
• Clinical Redesign
Triage
Bedside Triage Engagement Initial Care Planning

Questions for My Care Team...
- Birth certificate
- Social security card
- Non-drivers N.J. I.D.
- * Housing
- * Schooling
- * Employment
- Addictions Support
- Primary Care Physician
- Medication Support
- Transportation
- Phone Communication
- Clothing
- Food/Welfare?
Bedside Engagement
Triage
Planning
Initial Care
Home Visit
Triage Bedside Engagement Initial Care Planning Home Visit Accompany To Appts
Community Partners

- Cooper
- Project H.O.P.E., Inc.
- Loving Care Agency
- Links2Care
- LogistiCare
- Meals On Wheels Association of America
- CLARIFI
- Compassionate Care Hospice
- CareOne
- Innovative Hospice Care
- South Jersey Behavioral Health Resources
- MFC
- Cathedral Kitchen
- Lourdes Health System
- BAYADA Home Health Care
- MANNA
- Joseph’s House
- Volunteers of America
Track
Graduate
Student Learning Collaborative
Project Partners

- Provide students with hands on experience focused on social determinants of health
- Demonstrate value of interprofessional teams
- Demonstrate the value of hot spotting
- Create the next generation of leaders
- Chance for the partners (AAMC, Camden Coalition and Primary Care Progress) to work together on common ground
Sponsor Role

- Convene 6-month student learning collaborative
- Provide funding support
- In-depth training:
  - Motivational interviewing
  - Social determinants of health
  - Team-building
  - Communication
  - Leadership
  - Advocacy
- Monthly Case Conferences
2015 Cohort
Over 100 Students from a diverse mix of health professions

Medicine  Epidemiology
Nursing  Biomedical science
Pharmacy  Occupational Therapy
Dentistry  Health Administration
Social Work  Medical Dietetics
Public Health  Community Health
Physician Assistant  Business

Psychology
Curriculum

Webinars

- Interdisciplinary Teaming
- Patient Engagement
- ACEs & Harm Reduction
- Backwards Planning
- Patient Graduation & Handoff

• Case Conferences
• Skills Application
Student Responsibilities

- Participate in interprofessional teams
- Identify faculty advisors (physician, clinical social worker required)
- Follow 3-5 Superutilizers and really get to know them
- Assist the patients with appointments and better understanding their healthcare needs
- **Work as a team**
- Identify potential interventions to propose
- Commit to spending 3-5 hours per week
- Participate in monthly webinars and case conferences
Student Hotspotting

**Patient Picture and Background**

- GJ is a 58 y/o female with a primary diagnosis of ESRD
- Highest healthcare utilizer at our health system
- Had been dismissed from all dialysis centers in the local area for disruptive behavior.
  - Her only option was to come to the ED whenever she became fluid overloaded
- GJ was homeless at the time we met her. Upon her discharge from the hospital, she began living with her daughter, however their relationship was unstable.
Summary of the Intervention

- GJ was able to obtain stable housing.
- New dialysis clinic and had her sign a treatment agreement.
- Organized all of her medications in a pill counter and counseled her on each medication.
- To date, GJ has made most of her dialysis and PCP appointments.
- We are currently still working on obtaining an emotional support dog for her.
Student Hotspotting

Utilization and Claims Data Before & After

- ED visits pre-intervention from January to June
- 2014: 34
- Post intervention: 1

Intervention

Number of Encounters

Medicine of the Highest Order

University of Rochester Medical Center
Advisory Council

• 10 students and 2 faculty from first cohort

• Mentoring current students

• Shaping the future of the program