When Access Isn’t Enough

DEVELOPING AN AMBULATORY ICU IN A HEALTH CARE FOR THE HOMELESS SETTING

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Michael Everly, CMA
Audrey Wagner, PharmD
MEDITATION
OBJECTIVES

• Describe Old Town Clinic and rationale for developing ambulatory ICU
• Identify target population for the Summit Team (our A-ICU)
• Describe Summit’s team structure/roles
• Breakout discussion
• Review Summit’s initial utilization data
• Discuss challenges in adapting A-ICU model to FQHC/HCH setting
• Highlight future work
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Old Town Clinic

- Portland, OR (Medicaid Expansion State)
- FQHC and designated Health Care for the Homeless program.
- Provide integrated primary and behavioral health care, pharmacy, and co-located specialty mental health and substance use disorder services.
- We serve 5,000 patients per year, who have a high degree of medical, behavioral and social needs:
  - 77% have a mental health disorder
  - 69% have a chronic medical condition
  - 60% have a substance use disorder
  - 60% are experiencing homelessness
- Robust team based care within PCMH model
- Embedded within larger social services agency (Central City Concern)
Old Town Clinic Utilization Estimates 2014

<table>
<thead>
<tr>
<th>Utilization Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No hospitalization/2-5 ED visits</td>
<td>14%</td>
</tr>
<tr>
<td>No hospitalization/6+ ED visits</td>
<td>5%</td>
</tr>
<tr>
<td>1 hospitalization with 0-5 ED visits</td>
<td>9%</td>
</tr>
<tr>
<td>2+ hospitalizations OR 1 hospitalization and 6 + ED visits</td>
<td>11%</td>
</tr>
</tbody>
</table>

25% = “high utilizers”

- ~40% of patients at Old Town Clinic need complex care management outside the hospital/ED
- 450/1200 patients per care team
5% of Patients account for 50% Expenditures
If Camden, New Jersey, becomes the first American community to lower its medical costs, it will have a murder to thank. At nine-fifty on a February night in 2001, a twenty-two-year-old black man was shot while driving his Ford Taurus station wagon through a neighborhood on the edge of the Rutgers University campus. The victim lay motionless in the street beside the open door on the driver’s side, as if the car had ejected him. A neighborhood couple, a physical therapist and a volunteer firefighter, approached to see if they could help,
“The Graying of America’s Homeless”

Nation’s Homeless Growing Older

The surge in older homeless people is driven largely by a single group — younger baby boomers born between 1955 and 1965, according to an analysis by Dennis P. Culhane, a University of Pennsylvania professor who studies homelessness. This group has made up a third of the total homeless population for several decades.

Percentage of male adults in homeless shelters

In 1990

- 18-21: 5%
- 22-24: 10%
- 25-27: 8%
- 28-30: 8%
- 31-33: 8%
- 34-36: 8%
- 37-39: 8%
- 40-42: 8%
- 43-45: 8%
- 46-48: 8%
- 49-51: 8%
- 52-54: 8%
- 55-57: 8%
- 58-59: 8%
- 60-61: 8%
- 62-64: 8%
- 65-74: 8%
- 75+: 5%

In 2000

- 18-21: 5%
- 22-24: 10%
- 25-27: 8%
- 28-30: 8%
- 31-33: 8%
- 34-36: 8%
- 37-39: 8%
- 40-42: 8%
- 43-45: 8%
- 46-48: 8%
- 49-51: 8%
- 52-54: 8%
- 55-57: 8%
- 58-59: 8%
- 60-61: 8%
- 62-64: 8%
- 65-74: 8%
- 75+: 5%

In 2010

- 18-21: 5%
- 22-24: 10%
- 25-27: 8%
- 28-30: 8%
- 31-33: 8%
- 34-36: 8%
- 37-39: 8%
- 40-42: 8%
- 43-45: 8%
- 46-48: 8%
- 49-51: 8%
- 52-54: 8%
- 55-57: 8%
- 58-59: 8%
- 60-61: 8%
- 62-64: 8%
- 65-74: 8%
- 75+: 10%

Sources: Dennis P. Culhane, University of Pennsylvania; U.S. Census Bureau Decennial Census Special
By The New York Times
Adverse Childhood Experiences

Adapted from Felitti, Am J Prev Med. 1998

57 year homeless man recently admitted to a local hospital with respiratory failure discharged to medical respite and establishing with Old Town Clinic.

He has advanced COPD, diastolic heart failure, traumatic brain injury, cognitive impairment, generalized anxiety, opioid dependence on methadone maintenance, sedative/hypnotic use disorder, and partial blindness.

Despite multiple PC and MH visits, an outreach SW, prolonged respite support (6 month beyond target stay), housing assistance and home health/palliative care support, Rickie was poorly engaged and avoidant of prognosis believing if he “just exercised more and lost weight,” he would get better.

He was hospitalized 7 times (total of 43 days) and visited the ED 12 times over the course of one year.
“Rickie” – 2015

“Usual Care” PCP Appointment at Old Town Clinic

Worsening dyspnea, still smoking
Hypoxic: 82% on baseline 4L
Tachycardia 177
Declined recommended transfer to ED
Ongoing illicit benzo use and using heroin while on methadone

Goals of care discussion: patient resistant to accepting that he has a chronic lung disease remains convinced he just needs to “get in shape”

Was “kicked out” of pulmonary rehab due to too many no shows
Adult Protective Services report filed given concern for self neglect

20 minutes!
“Rickie” – Complexity Drives Utilization

**Medical Conditions:**
- End stage COPD
- Chronic diastolic heart failure
- Hepatitis C
- Blindness right eye
- Traumatic Brain Injury
- Cognitive Impairment
- Generalized Anxiety Disorder
- Severe opioid use disorder on MMT
- Sedative/hypnotic use disorder of unclear severity

**Social Complexity:**
- Poor acceptance of condition
- Heavy symptom burden
- High risk substance use benzos + MMT
tobacco + O2 dependent
- Too medically complex to access detox services
- Substance users in social circle
- Lonely, socially isolated
- Poor health literacy worsened by cognitive impairment/TBI
- Goal of independence = mismatch between care needs and resources
- Fragmented systems of care and funding
- Low “patient activation”

**Utilization 2014-2015:**
- 7 hospitalizations (43 days in hospital)
- 12 ED visits
- 26 clinic visits
- Enrolled in respite care program
- Enrolled with health resilience SW
- Palliative care home health
- Home caregiver through ADS
What does this mean for care teams?

- >450 patients with complex care coordination needs
- Lower risk patients crowded out
- High provider burn out
- Patient experience and care quality suffer
High Risk Teams Across Central City Concern

- CORE/ICM (ACT Model)
  - Severe Mental Illness

- Community Engagement Program (Harm Reduction)
  - Severe Substance Use/Mental Illness

- A-ICU
  - Severe Medical Illness

Summit Team
Developing Old Town Clinic’s Ambulatory ICU

• Payer interest in developing “value based” care models
  • Hybrid funding → monthly incentives, capitated per member per month, fee for service with “adjusted” productivity, academic funding for research

• Team Training at Stanford Coordinated Care
  • Refer to handout for details on AICU model

• No best practices for adapting to FQHC/HCH population

• Leadership engaged team members in design
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What does a Summit patient look like?

• Someone with advanced medical illness who has a hard time engaging in primary care
• Someone who may benefit from longer appointments, increased care coordination, and navigation
• Someone who may not go to the ED often, but when they do, they are usually admitted for a medical issues
• Someone who looks like “Rickie”
PATIENT VIDEO
## Target Conditions and Characteristics

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic kidney disease</td>
<td>19.8%</td>
</tr>
<tr>
<td>CHF</td>
<td>42.9%</td>
</tr>
<tr>
<td>COPD</td>
<td>50.5%</td>
</tr>
<tr>
<td>Chronic/severe infections</td>
<td>53.8%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>42.9%</td>
</tr>
<tr>
<td>End stage liver disease</td>
<td>24.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean ±SD, years</td>
<td>57 ±11</td>
</tr>
<tr>
<td>Housing status</td>
<td></td>
</tr>
<tr>
<td>Homeless</td>
<td>23.4%</td>
</tr>
<tr>
<td>Low income housing</td>
<td>63.0%</td>
</tr>
<tr>
<td>Other or unknown</td>
<td>13.7%</td>
</tr>
</tbody>
</table>
## Behavioral Health and Medical Complexity

### Behavioral Health Condition

<table>
<thead>
<tr>
<th>Behavioral Health Condition</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance use disorder</td>
<td>80.2%</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>33.0%</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>19.8%</td>
</tr>
<tr>
<td>Depressive disorder</td>
<td>53.8%</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>16.5%</td>
</tr>
<tr>
<td>Trauma-related disorder</td>
<td>38.5%</td>
</tr>
</tbody>
</table>

### Selected Diagnoses

<table>
<thead>
<tr>
<th>Selected Diagnoses</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any mental health diagnoses</td>
<td>87.3%</td>
</tr>
<tr>
<td>Any substance use disorder</td>
<td>79.7%</td>
</tr>
</tbody>
</table>

### Medical Diagnosis Count

<table>
<thead>
<tr>
<th>Medical Diagnosis Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 diagnoses</td>
<td>8.9%</td>
</tr>
<tr>
<td>3 diagnoses</td>
<td>27.8%</td>
</tr>
<tr>
<td>4 diagnoses</td>
<td>19.0%</td>
</tr>
<tr>
<td>5+ diagnoses</td>
<td>38.0%</td>
</tr>
</tbody>
</table>

87% have a mental health diagnosis

85% have 3+ medical diagnoses
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Summit Team Model

200 patients

Care Coordinator
Provider
Social Worker
Complex Care Nurse
Pharmacist

Allows more time to:
• Build relationships
• Outreach
• Provide timely support
• Increase access to team
• Smooth transitions of care
Summit Team Roles:

- 2 physicians
- 2 care coordinators (medical assistants)
- 2 social workers
- 1 complex care RN
- 1 clinical pharmacist
- 1 team manager
- Data analyst
- Research staff

*refer to handout for specifics about role delineation*
Core Activities: Intensive patient intakes

• Complete comprehensive patient assessment w/ social work, physician, and care coordinator at intake
• Identify social determinants and basic needs from day 1
• Streamline safest treatment plan in accordance with patient centered goals
• Elicit needs that might require pharmacist or RN assistance with warm handoff introductions
• Teach patients about enhanced access to team
  • Care coordinator identified as main point of contact
  • Encourage use of physician “warm line” after hours for telephonic support
• Close follow up with option of outreach
Core Activities: Transitions of Care

- Patient + Team
  - Hospital/ED
  - Specialist Appointments
  - Housing
  - Criminal Justice System
  - Nursing Homes/Home Health
Core Activities: Fostering “Teamness”

• Team discusses use of flexible funds to help with non-traditional care needs as they emerge
• Team trainings in palliative care, motivational interviewing, trauma informed care
• Team wellness and daily group meditation practice
• Team shares and celebrates successes
• Interdisciplinary nature offers real time supports for challenging clinical scenario (warm hand offs)
• Team collaboration happens naturally as issues arise
• Weekly team meetings to reflect on work, participate in quality improvement exercises
Core Activities: Panel Management

Weekly “Speed Dating”
“Rickie” – An Update

• Intensive intake, engagement, outreach
  - Rickie was actively using heroin, buying benzos illicitly
  - Enmeshed in unhealthy relationships
  - Diagnosed with COPD exacerbation and benzo withdrawal versus possible pneumonia at home visit → he declined going to hospital and was treated at home

• Enhanced transitional care planning
  - Declined about 1 month later and more receptive to facilitated hospitalization
  - Care coordination with hospital and stabilized on long acting benzo
  - Illicit substance use stopped

• Collaborative team management
  - Improved symptom burden and advanced care planning
  - Regular pharmacist visits to streamline and reinforce medications/inhalers
  - Daily anxiety reduced with daily CC check in’s and consistent SW support
  - POLST completed and ongoing discussions about end of life goals
"Rickie": Attention and Streamlined Services

<table>
<thead>
<tr>
<th>PRE-SUMMIT</th>
<th>POST-SUMMIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Utilization 10/2014-10/2015:</strong></td>
<td><strong>Utilization 11/2015- Present:</strong></td>
</tr>
<tr>
<td>7 hospitalizations (43 days in hospital)</td>
<td>3 hospitalizations (19 days in hospital)</td>
</tr>
<tr>
<td>12 ED visits</td>
<td>1 ED visit</td>
</tr>
<tr>
<td><strong>Outpatient Activities:</strong></td>
<td><strong>SUMMIT Activities:</strong></td>
</tr>
<tr>
<td>23 primary care visits</td>
<td>28 Summit provider visits 22 in clinic, 6 at home)</td>
</tr>
<tr>
<td>Respite Care program (RCP)</td>
<td>26 Summit pharmacist visits</td>
</tr>
<tr>
<td>Enrolled with Care Oregon Health Resilience Specialist</td>
<td>15 Summit BHOW visits</td>
</tr>
<tr>
<td>Palliative care home health</td>
<td>15 Summit RN visits</td>
</tr>
<tr>
<td>Home caregiver through ADVS</td>
<td>174 Summit phone notes*</td>
</tr>
<tr>
<td>Adult protective services</td>
<td>New in home caregiver</td>
</tr>
</tbody>
</table>
Conceptual Framework

- RELATIONSHIP
- ↓ TREATMENT BURDEN
- ↑ SELF-EFFICACY
- SOCIAL DETERMINANTS OF HEALTH
- ACCESS/UTILIZATION
- PATIENT’S SELF-CARE
- HEALTH OUTCOMES
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“Lee” – A Difficult Case

• Organize into interdisciplinary groups of 5 or more
• Review part 1 of case (page 3 in handout)
• Discuss
  1. How would you approach Lee’s care?
  2. What barriers do you think Lee is encountering when accessing care, particularly at the hospital?
  3. What barriers do you expect to encounter in developing a care plan for Lee?
  4. What safety concerns do you have about his care?
“Lee” – A Difficult Case

• Review part 2 of case (page 4 in handout)

• Discuss
  1. How would you approach better understanding Lee’s goals of care?
  2. How would you advocate to improve Lee’s quality of life?
Safety Net Challenges with Palliative Care

Maslow’s hierarchy of needs
- Unstable housing
- Lack of traditional caregiver supports
- Lack of trust/engagement in the healthcare system
- Isolation and lack of proxy decision makers
- Increased incidence of sudden death
- Fear of anonymity, being forgotten
- Severe persistent mental illness
- Substance use disorders

Adapted from Lauren Land, FNP
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Primary Care Engagement

Minutes in Face-to-Face Visits Per Patient Per Month

Month Relative to Enrollment (0 = Month of Enrollment)

PC Minutes Rate
Avg PC Minutes Rate

49 Minutes

155 Minutes
Primary Care Engagement by Provider Type

Minutes in Face-to-Face Visits Per Patient Per Month

Month Relative to Enrollment (0 = Month of Enrollment)

PCP  Pharm  BH  RN
Hospital Utilization: ED Visits and Inpatient Admissions

- **0.34 ED Visits**
- **0.24 Inpatient Admissions**
- **0.23 ED Visits**
- **0.18 Inpatient Admissions**

Graph showing the variation of hospital visits and inpatient admissions per patient per month relative to enrollment.
Primary Care Engagement vs. Hospital Utilization

- 200% Increase in PC Engagement
- 30% Decrease in Inpatient Days
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Challenges – Systems

• Gaps in care
  • TBI resources
  • Trauma informed settings for respite/long term care
  • Hospice for socially vulnerable patients
  • Substance use disorder treatment services for medically complex individuals

• Compassion fatigue → empathy failure across systems
• Maintaining patient trust across systems
• Retaining team flexibility to accommodate patient needs while growing
• How do you measure success?
  • “Winning” the financial case
Challenges – Clinical

• Relationships are non-linear
• Relationships are intense and often we are sharing risk in a different way
• Controlling what you can control
• What comes with holding a high level of respect for autonomy and self determination?
  • Getting comfortable with allowing people to make “bad” decisions
  • Experiencing the risks and consequences associated with those decisions alongside people
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• **Highlight future work**
The Future...

• Better defining success through patient/provider experiences, outcomes, cost data
• Increased patient activation/self management
• Ongoing team role delineation
• Partnerships with hospitals/care homes
• Building expertise and sharing best practices
• Securing long term funding/payment reform?
• Qualitative and Quantitative research findings
TEAM VIDEO
Questions?
Palliative Care at a Safety Net Clinic

**Principles of Palliative Care**

- Focus on patient’s goals of care rather than disease management.
- Awareness of psychosocial background and personal narrative.
- Build on strengths and optimize coping/resilience.
- Reduce suffering and distress.
- Improve quality-of-life.
- Recognize the power of relationship.

**Person-Centered**

**Trauma-Informed**

**Harm Reduction**

**Relationship-based**

*Adapted from Lauren Land, FNP*