Coal Mines and Canaries in Humboldt County
by Dr. Mary Meengs

Frequent Flyers. We all know what we mean by this, and if asked, no doubt every ED physician, and likely every PCP as well, could quickly identify patients who always seem to be in the Emergency Room, or admitted to the hospital. And we're not surprised when we hear that the sickest 5% of our patients are responsible for more than 60% of health care costs.

Dr. Jeffrey Brenner, family physician and founder of the Camden Coalition of Healthcare Providers, certainly noticed this phenomenon in his practice in New Jersey. He spent countless hours investigating the demographics and drivers of this "super utilizer" behavior, and subsequently developed care teams to provide intense, one-on-one medical and social support to these individuals. He had impressive results, reducing ER visits for these individuals and dramatically lowering unreimbursed hospital costs. In The New Yorker (1-24-11), Atul Gawande tells the story of Dr. Brenner's work in "The Hot Spotters".

Brenner's innovative work and his successes have had an inspiring ripple effect. The HDN-IPA's Priority Care program began in July, 2011, offering nurse-led care coordination, support, and coaching to patients at risk for overutilization of expensive health care resources. The Robert Wood Johnson Foundation has supported the work of Brenner and the Camden Coalition for some time, and last year they awarded funding for 2-year super utilizer projects to six communities nationwide, including Humboldt County. Our project began in July, 2012, administered by the IPA as part of our work in the larger Aligning Forces for Quality grant.

The Super Utilizer project is based on a community-wide collaborative built on the foundation of two existing programs: Care Transitions at St. Joseph Hospital and Priority Care at the IPA. Our multidisciplinary team, which meets monthly, consists of nurses from those programs, plus providers, nurses, and social workers from both Care Transitions and primary care, the ED, hospitalists, and county mental health, with input from substance abuse providers and 911 personnel. For the first year, patients were identified and selected from the Medicare/Medi-Cal population of Eureka Community Health Center. Frequent huddle-type meetings occurred, involving personnel directly involved in these patients' care. Many strategies were employed as efforts were made to identify needs and to meet these

individuals “where they were”. Encouraging care to be based in the primary care provider’s office rather than the ED, one patient’s frequent drop-in visits were facilitated and she was even provided her favorite soft drink when she showed up. A lot of work has been done to try to improve communication between the PCP office, the ED, and the hospitalists so that common goals and pitfalls can be efficiently recognized.

There have certainly been successes in the first year of the project; many of the super utilizer patients have had significant stabilization of their medical and social situations, as well as reductions in ER visits and inpatient admissions. ED visits have reduced by 50% after enrollment in the program and inpatient admits have reduced by 34%. In some cases, previously unidentified substance abuse issues have been discovered. We have learned, however, that we are not yet equipped to make a marked impact when severe mental illness or substance abuse problems are present.

What has been accomplished in the first year, along with less utilization of the most expensive care by these patients, is recognition of some of the barriers to achieving what the Institute for Healthcare Improvement calls the Triple Aim. This involves improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care. Figuring out how to get busy professionals together for huddles or larger meetings is a challenge. Trying to share data and updates between PCPs, the ED and the hospital, with the limitations of differing EHRs and the balance between confidentiality and expediency is a problem with no quick solution. Identifying and setting up the care needed for these complicated patients in a community with lots of access issues – from PCP offices with few openings, to patients with their own scheduling and transportation problems – is obviously frustrating.

It’s easy to put all the blame for overutilization on these individuals. We label them as noncompliant, not responsible, not engaged, and/or at fault for their own problems and the huge financial burden that ensues. But our health care system, locally and nationally, is very flawed, and is at least partly at fault for not being able to meet the needs of the super utilizers in more efficient and appropriate ways. We can view these difficult patients as the canaries in the coal mines of our well intentioned but fragmented and often ineffectual network of health care providers and organizations.

As we continue in the second year of the Super Utilizer project, we hope to make use of the lessons learned and the collaborations forged. There is potential to improve care for all of our patients. We are opening up the project to appropriate patients from the community, with the caveat that patients not ready to deal with a substance abuse problem are not good candidates. If you would like to nominate one of your patients for consideration by the team, you can find a form on our website www.hdnfmc.com.