Welcome

Hot Spotters in the HCH Setting: Managing Patients with Complex Comorbidities

June 26, 2012

We will begin promptly at 12:00pm EDT

Event Host

Molly Meinbresse, MPH

National Health Care for the Homeless Council, Inc.

This publication was supported by Grant/Cooperative Agreement Number U30CS09746-04-00 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.
Hot Spotters in the HCH Setting: Managing Patients with Complex Comorbidities

June 26, 2012
+ Presenters

**Judith Mealey**, MS, ANP, RN, 
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Health Care for the Homeless 
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Director of Services for Homeless People, United Neighborhood Health Services

**Crystal Carey**, Clinical Director, United Neighborhood Health Services
Overview

- Background of Complex Comorbidities Project
- Review of the Literature
- Results of HCH field interviews
- Project Highlight - Mercy Medical HCH
  - Hot Spotter Program
- Project Highlight – United Neighborhood Health Services
  - Encouraging Routine Care
- Q & A
Approach

- Clinicians expressed challenge in providing care to patients with complex comorbidities
- Limited clinical guidance available
- Desire to explore promising practices
- Conducted HCH field interviews to learn what others are doing
Review of Literature – General Population

- Measuring multiple chronic conditions (MCC)
  - Simple count vs count + severity

Top 5 Comorbidities in Veterans (Lee, 2007)
1. Diabetes + hypertension (n=47,568)
2. Ischemic heart disease + hypertension (n=28,154)
3. Depression + osteoarthritis (n=23,692)
4. COPD + hypertension (n=11,883)
5. COPD + ischemic heart disease (n=7,235)

Highest 5-year Mortality Rates
1. Cancer + COPD (40%)
2. Cancer + diabetes (25%)
3. Cancer + ischemic heart disease (23%)
4. Diabetes + COPD (17%)
5. Cancer + hypertension (15%)
Review of Literature (continued)

- MCC in general population
  - Extremely prevalent
  - Care is expensive
  - Associated with negative health outcomes
  - Care coordination difficult
  - Medication management complicated
Review of Literature - Homelessness

- **Prevalence (Goldstein, 2008)**
  - Drug abuse + alcohol abuse (78%)
  - Tuberculosis + alcohol abuse (73%)
  - Hepatic + alcohol abuse (71%)
  - Heart/cardiovascular + hypertension (70%)
  - Tuberculosis + drug abuse (68%)
  - Gastrointestinal + alcohol abuse (66%)
  - Gastrointestinal + orthopedic (65%)
  - Hepatic + drug abuse, orthopedic + alcohol abuse, alcohol abuse + drug abuse (63%)

- **Gaps in Literature**
  - Prevalence data
  - Mortality rates
  - Focused mostly on dual diagnoses

- **Management recommendations**
  - Integrated care
  - Community partnerships
  - Effective clinician communication
Review of Literature - Homelessness

- Strategies for Dual Diagnoses (Foster, 2009)
  - Stabilize patients – provide housing, basic needs, support for “daily living activities”
  - Thorough medical history before engaging in interventions
  - Increase access to services – medical, mental health and substance abuse
  - Utilize motivational approaches to encourage participation in care
  - Trauma-informed care
  - Provide opportunities for peer support and group treatment
  - Integrated mental health and substance abuse services
  - Interdisciplinary teams and regular treatment planning meetings, cross-training, multiple service locations, and partnerships with other community agencies
Review of Literature - Homelessness

- Challenges (Foster, 2009)
  - Client behavior problematic and hindrance to success of program
  - Providers need more time to build relationships with clients.
  - Projects experienced staff and community resource limitations
  - Local communities not necessarily supportive of integrating mental health and substance abuse into treatment
Literature Review - Federal Recommendations

Multiple Chronic Conditions: A Strategic Framework (U.S. Department of Health and Human Services, 2010)

- Foster health care and public health system changes to improve the health of individuals with MCC
- Maximize the use of proven self-care management and other services by individuals with MCC
- Provide better tools and information to health care, public health, and social service workers who deliver care to individuals with MCC
- Facilitate research to fill knowledge gaps about, and interventions and systems to benefit, individuals with MCC
Field Interviews – HCH Projects

- Mercy Medical Center HCH program (Springfield, MA)
- Peak Vista Community Health Centers HCH project (Colorado Springs, CO)
- Outside In (Portland, OR)
- Franklin Primary Care H.E. Savage Memorial Center HCH project (Mobile, AL)
Field Interview Results

- **Staffing & services**
  - Short-staffed, social services and SA/MH staff in particular
  - Lack of specialty care, advanced labs and diagnostics
  - Presence of chronic disease management programs and health education, but none specific to comorbidities
  - Difficulty in referring patients to specialists and coordinating care

- **Identifying & tracking**
  - Informal tracking of complex comorbidities, inconsistent across sites
  - Case conferences with integrated care teams utilized
Field Interview Results

- Top cluster of complex comorbidities reported for each site:
  - Mercy Medical
    - Mental health, substance abuse, tobacco abuse
  - Peak Vista
    - Chronic pain, mental health, tobacco
  - Outside In
    - COPD, mental health, chronic liver disease, substance abuse, tobacco use, dental issues
  - H.E. Savage of Franklin Primary
    - Diabetes, mental health, cardiovascular disease
Field Interview Results

- Models of care
  - Patient-Centered Medical Home model, or the Primary Care Home Model
  - Chronic Care Model

- Guidelines
  - Specific chronic disease guidelines (e.g. asthma, hypertension)

- Evidence based practices
  - Motivational interviewing
  - Harm reduction
  - Comprehensive care management
  - Trauma-informed care

- Care coordination
  - Case conferences
  - EMR “ticklers”
Recommendations

- Share HCH models for increasing capacity to identify and treat patients with complex comorbidities
  - Evaluating outcomes
- Develop method for measuring complex comorbidities, or MCC
  - Test tracking system
- Provide assistance to better utilize EMR for tracking and following up on care
Identifying & Managing Hot Spotters in the HCH Setting

Judy Mealey
Mercy Medical HCH
Springfield, MA
Hot Spotters in Health Care for the Homeless Program – We Do That!

- High medical cost does not equal good health outcomes
- Complex social needs have a negative impact on health outcomes
HCH Programs Well-Suited to Address Complex Comorbidities

- Gift of time
- Team approach
- Flexibility
- True patient-centered care
- Belief that everyone deserves quality care
- We never give up on people
- We do what needs to be done
Key to Success

Weekly team meetings
Who are our hot spotters?
Tools

- Patient engagement
- Motivational interviewing
- Patient centered goals
The Chronic Care Model

**Community**
- Resources and Policies
- Self-Management Support

**Health Systems**
- Organization of Health Care
- Delivery System Design
- Decision Support
- Clinical Information Systems

**Improved Outcomes**
- Informed, Activated Patient
- Productive Interactions
- Prepared, Proactive Practice Team
National HCH Council Publication (June 2007)

Self-Management Support: Helping Clients Set Goals to Improve Their Health

by Sharon Morrison
Measuring Success

- Engagement
- HRSA measures/Chronic disease guidelines
- Patient identifies improved quality of life
- Meeting patient goal
Strengths

- EMR
- Imbedded mental health
- Strong outreach component
- Team approach and respect of all disciplines
Weaknesses & Barriers

- EMR
- Community barriers
- Chronicity of chronic disease
Case Study - Richard

- 49 Yr. Old Homeless Man
- Discharged from MH unit after suicide attempt
- Medical issues
  - Chronic alcoholism
  - Depression with multiple suicide attempts
  - Avascular necrosis – both hips
  - Chronic pain
  - Neurogenic/hypotonic bladder
  - Diabetes
  - Tobacco use
Case Study - Richard

- Social Problems
  - No social support
  - Shelter tenuous
  - Poor social skills
  - Functionally illiterate
The 10-Month Journey

Successes

- Engaged
- Bilateral hip replacement
- Sober 5 months (one time relapse)
- Stable on mental health meds

Work in progress

- High relapse risk
- No permanent housing
Encouraging Routine Care

- United Neighborhood Health Services - Nashville, TN
  - Creating a welcoming environment
  - The role of self-management
National HCH Council Resources

- **Adapted Clinical Guidelines**
  - General Recommendations for the Care of Homeless Patients (2010)
  - Chronic Pain Adaptive Guidelines (2011)

- **Healing Hands Articles**
  - Caring for Clients with Comorbid Psychiatric & Medical Illnesses (2009)
  - Meeting the Challenges of Comorbid Mental Illness & Substance-Related Disorders (2009)
  - Integrating Primary & Behavioral Health Care for Homeless People (2006)

- **Monographs**
  - Key Elements of Integrated Care for Persons Experiencing Homelessness (2011)
  - Health Care Delivery Strategies: Addressing Key Preventive Health Measures in the HCH Setting (2011)
What do you need?

- What resources do you need in your practice to help you provide care to patients with complex comorbidities?

- What resources could you share that your project uses to provide care to patients with complex comorbidities?
Questions & Answers