

Hawai'i Health Partners News

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Complex care: a sophisticated new effort to save lives

Dale Glenn, MD, Medical Director

I'd like to introduce you to Robert. Robert has diabetes. He lost two toes last April. That was after he noticed the blind spots in his vision. Living alone, he found it difficult to get food that met his prescribed diet so he ate out a lot. He has no phone because "it costs too much" and he didn't have anyone he needed to call. Unfortunately, this made it difficult to contact him about his lab tests.

His health was slowly deteriorating. He knew it, but he felt powerless to stop it. He didn't really understand his disease, and though he knew he was supposed to take his shots, the glucose readings didn't make much sense to him and his pills gave him diarrhea. The 15 minutes he spent every three months in the doctor's office weren't enough to change his direction. His diabetes was out of control, and repeated warnings from his physician did not change his situation.

Managing patients with complex health care needs

One of the greatest challenges we face as physicians is managing patients with complex medical conditions. This is especially true when their challenges are exacerbated by psychosocial or economic issues outside the office or hospital. Medical therapy for these patients is often difficult, with multiple medications, specialists, tubes, drains, therapies, and procedures.

Is it any wonder that things as basic as language difficulties, transportation, finances, or scheduling problems get in the way of successful healing? The average clinical practice is not equipped to assist patients in dealing with these issues. As a result, many of our sickest patients are constantly at risk of readmission, complications and even death.

Complex care services to support HHP physicians

One of the great advantages of an effective accountable care organization such as Hawai'i Health Partners is the holistic view we take of health care needs. We understand that poor health leads to personal tragedy as well as higher costs for our patients and our economy.

To address this, Hawai'i Health Partners is investing a large portion of our available funding to address the challenges faced by physicians who care for patients with complex needs. We are also working with several



different groups in the community including Project Hope, Healthways, HMSA and Ho'okele.

Complex care nurse navigators are available to visit with patients at home or during their appointment at the physician's office, and will provide various forms of assistance, such as:

- Helping to identify specific issues and needs that may help improve the patient's care, such as better diabetes education, monitoring medication compliance, transportation issues, or durable medical equipment;
- Providing home monitoring equipment to help patients monitor their weight, blood sugar, and blood pressure;
- Managing patients recently discharged from the hospital or those with short term acute needs at home;
- Referral for home care for patients with more specific needs; and
- Serving as a bridge to the PCP by ensuring the care plan is being followed and monitoring the patient for issues, such as a CHF patient who is suddenly gaining weight or a patient with diabetes who has very high blood sugars.

continued

Complex care, continued

We are currently working to enable all of these groups to document directly in Epic. By doing so, a shared care plan will be visible to all who are caring for the patient. We will also ensure those care plans are shared with PCPs who are not on the Epic system.

Extending complex care services to more patients

Our goal as an organization is to identify the top one percent of our patients who are at risk of serious complications and invite them to have their own personal complex care navigator. Not all patients will consent to receive services, and that is their choice.

We would appreciate comments from all of our HHP physicians on the effectiveness of these services. We have

just started this program and have 50 patients enrolled. We are now expanding the program to enroll more patients in order to help our high-risk patients stay well.

What is the outcome we hope to achieve? Let's get back to Robert.

Robert now meets regularly with a health coach and receives home visits. He has lost weight. His glucose is monitored remotely and shared with his PCP who adjusts his medication when needed. We may even find a way to get him a phone.

Read on to learn more about how the HHP Population Analytics team is helping to identify more patients like Robert.

New data system used to aid in delivery of clinical care

Hawai'i Health Partners is using a sophisticated risk management and analytics system from McKesson. Though it's usually used by insurance companies to manage risk, HHP is using the system to deliver clinical care.

The McKesson system is able to combine cost information from HMSA's claims records and clinical data from Epic to provide a panoramic view of the nearly 80,000 patients that HHP is beginning to manage as a team.

The goal is to find the needle in the haystack—to determine in advance the patients who are most likely to run into trouble. Certain characteristics, such as frequent ED visits, high utilization of health care resources, and recurrent hospitalization, help to identify patients who are at greatest risk. Unfortunately, most of these characteristics are retrospective and not predictive of what may happen in the future.

To address this, an additional layer of analysis involves identifying patients with multiple diagnoses or high risk scenarios. For example, patients who may be flagged include patients on dialysis, those with complicated diabetes, history of amputation, diabetic retinopathy, congestive heart failure or COPD.



Pictured are (back row) David Chow, Ky Lao, Chase Nielsen, Allan Toh, (front row) Martie Tibayan and Joanna Dima.

Population Analytics Director Ky Lao oversees the HHP analytics team under Hawai'i Pacific Health's HealthAdvantage Support Services unit. The team has gone through extensive training on the new system in order to create reports and analytics to help HHP physicians identify patients who need complex care services.

SAVE THE DATE!

NOVEMBER CME: COMPLEX CARE

Friday, November 21

12:30 p.m.

Straub Doctor's Dining Room or via WebEx