Building a Primary Care Medical Home for High-Risk Super-Utilizer Patients: UCLA Extensivist Program

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Learning Objectives

1. Review strategies to identify and understand high risk and high utilizer patient populations
2. Describe development of a system-wide value program targeted at improving access and delivery of primary care for medically and socially complex patients
3. Identify key data and metrics for program measurement
THE HOT SPOTTERS

Can we lower medical costs by giving the neediest patients better care?

By Atul Gawande
Healthcare’s 1% account for disproportionate spending and utilization

The Top 1% account for 21% of health expenditures
The Top 5% account for 50% of health expenditures

Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2010
Media Attention: “High Utilizers” are the problem

Super-utilizers place huge burden on health-care system

The Atlantic

How We Spend
$3,400,000,000,000

Why more than half of America's healthcare spending goes to five percent of patients

T.R. Reid | Jun 15, 2017 | Health
The Actual Problem: fragmentation of care

Press MJ, NEJM, 2014 “Instant Replay—A Quarterback’s View of Care Coordination”
Creating a customized model for our system
Building a Primary Care Medical Home for Complex Patients

- Medical Care Coordination
- Authentic, Trusting Relationships
- Ambulatory ICU
- Continuity across the spectrum
- Improved ACCESS

Extensivist MD
Extensivist RN Clinical Advisor
Patient Service Rep (PSR)
Extensivist Care Coordinator
Patient
MyMeds Pharmacist
Social Worker
Follow across the care spectrum & ANCHOR to primary care

- Inpatient
- SNF
- Home

Monitor real-time daily admission reports
Inpatient Extensivist consultations
Finding our target high-risk population

High Risk

High Utilizer

Highest Risk Definition:
- Advanced cancer patient
- Cirrhosis with MELD > 30
- GFR < 30
- Heart failure
- High Opioid Equivalent Use

High Utilizer Definition:
- In past 12 months
  - 4 or more ED visits
  - 2 or more emergent inpatient admissions

Department of Medicine Extensivist Clinic

- Care Coordination
- Connect with Primary Care
Patient Enrollment

**Identify**
- PMD referrals
- Hospitalist referrals
- Subspecialty referrals
- Clarity Reports
- Value Analytics
- Care Coordinators

**Outreach**
- Phone Call
- Mychart
- Meeting patient in ED
- Inpatient consultation

**Enroll**
- Enrollment at time of clinic visit
Comprehensive Care Coordinator Intake

• **Utilization and Access Review**
  - Number of ED and inpatient admissions
  - Number of PCP no shows

• **Patient contact information**
  - Reconfirm all contact information
  - Preferred Method of Contact

• **Barriers to care**
  - Transportation barriers
  - Housing insecurity
  - Financial barriers
  - Food insecurity
  - Home/family support

• **Patient’s perspective on reasons for hospitalizations**
• **Patient’s Health and Life Goals**
• **Review of Extensivist Program, ED Alternatives**
• **Make Focused Referrals**
  - LCSW, Mymeds Pharmacist, Behavioral Health, CKD Care Coordinator
Extensivist MD Intake

• Review problem list & confirm diagnoses using objective data
• Review current list of providers (PCP, subspecialists)
• Determine and document baseline (e.g., dry weight, blood pressure, BNP, etc.)
• Further assess patient goals (health, life)
• Motivational Interviewing
• Advance Care Planning
• Create personalized care plan and review it with the patient; shared medical decision making
• Share care plan in Epic with all team members, seek input
• Review next steps and follow up appointment(s)
Core Features of the Extensivist Program

• Medical care coordination by Extensivist MD

• Comprehensive care coordinator intake exploring drivers of utilization: behavioral and social barriers

• Enhanced Patient Access:
  - Direct line to Extensivist patient service representative (PSR) and CCC
  - Same day provider availability and walk-ins
  - Alternative visits: prolonged care services, video visits, home visits
  - IV Fluids, IV antibiotics, volume management
  - After hours availability

• Continuity across the care spectrum: improved transitions of care, coordination with the inpatient team & subspecialists

• Daily huddles, weekly interdisciplinary rounds (Extensivist team members, pertinent subspecialists, Da Vita Representation)
Medical Interventions

• Acute medical interventions
  - IV therapy: antibiotics, fluids, lasix
  - Cancer pain and symptom control
  - Connect patient with dialysis center for additional HD session

• PCP care coordination
  - Re-evaluate diagnoses, objective data/studies, and overall medical care plan
  - Interdisciplinary conference with subspecialists

• Access
  - Same day appointments
  - After hours MD availability on nights and weekends: 24/7/365

• Remote Monitoring
  - Weights, medical adherence (collaboration with Home Health)
  - Adherence with dialysis (collaboration with CKD CCC, Davita)
  - Medical phone check-ins MD and RN Clinical Advisor
Home Visits & Inter-professional Education

- Polypharmacy
- Safety Screening
- Social Isolation Screening
- Enhanced Patient Education
Improving Access and Transitions of Care: Standardizing the Post Discharge Pathway

- Hospital Discharge
- Post DC: 0-7 days
- Post DC: 8-14 days
- Post DC: 15-30 days

High risk patients
Ongoing symptoms
Complex medical coordination

Inpatient Provider

PCP Post DC Appointment

Extensivist Post Discharge Clinic

Care Coordination Expanded Outreach

UCLA Health
Resource Matching

• Leverage and mobilize existing resources
• Keep teams lean, avoid duplication of services
• If medically complex, match patient to Extensivist MD
• If primary driver of utilization related to substance use or mental health, connect them with appropriate UCLA resources – addiction medicine, psychiatry, behavioral health
• Understand system resources – strengths and limitations
• Fostering innovations in primary care delivery
  - Extensivist East West Medicine
  - Palliative care embedded in Westwood primary care
  - Post Discharge Video Visits
  - Home Visits
  - Remote monitoring
  - Interprofessional education of trainees: residents and medical students
Individualized Care Plans & Trusting Relationships

- Same day clinic availability
- Ability to reach a provider 24/7/365
- Continuity of care across settings, across the spectrum
- Understanding and tailoring to patient preferences
- Building therapeutic relationships with clinic team
Extensivist Expansion

**NORTHWEST**
- Ventura
- Simi Valley
- Thousand Oaks
- Westlake Village

**WEST**
- Woodland Hills
- Encino
- Northridge
- Porter Ranch
- Santa Clarita
- Malibu

**SOUTHWEST**
- Marina Del Rey
- Manhattan Beach
- Hermosa Beach
- Redondo Beach
- Rancho Palos Verdes

**SANTA MONICA EXTENSIVIST**

**WESTWOOD EXTENSIVIST**

**EAST**
- Arcadia
- West Covina
- West Puente Valley
- Rowland Heights

**SOUTH**
- Arcadia
- West Covina
- West Puente Valley
- Rowland Heights

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[Map showing various cities and regions in Southern California, with extensivist regions marked.]
UCLA Health

Quadruple Aim
Equity
Provider Satisfaction:
Raising joy in work