

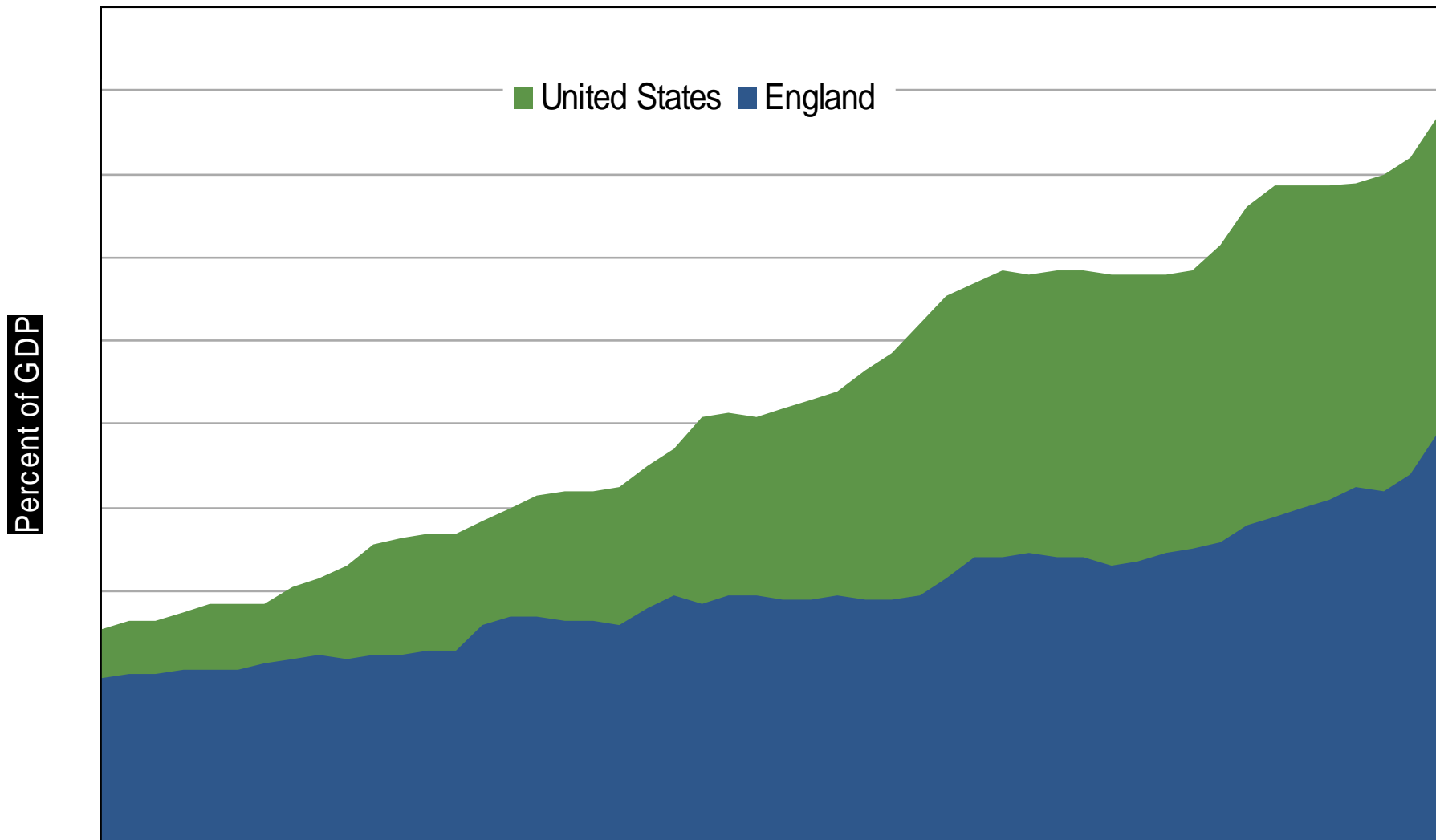
**Managing patient complexity: Chronic Disease  
Management, PCMH, and the Ambulatory  
Intensive Caring Unit  
Models for improving care**

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# Goals

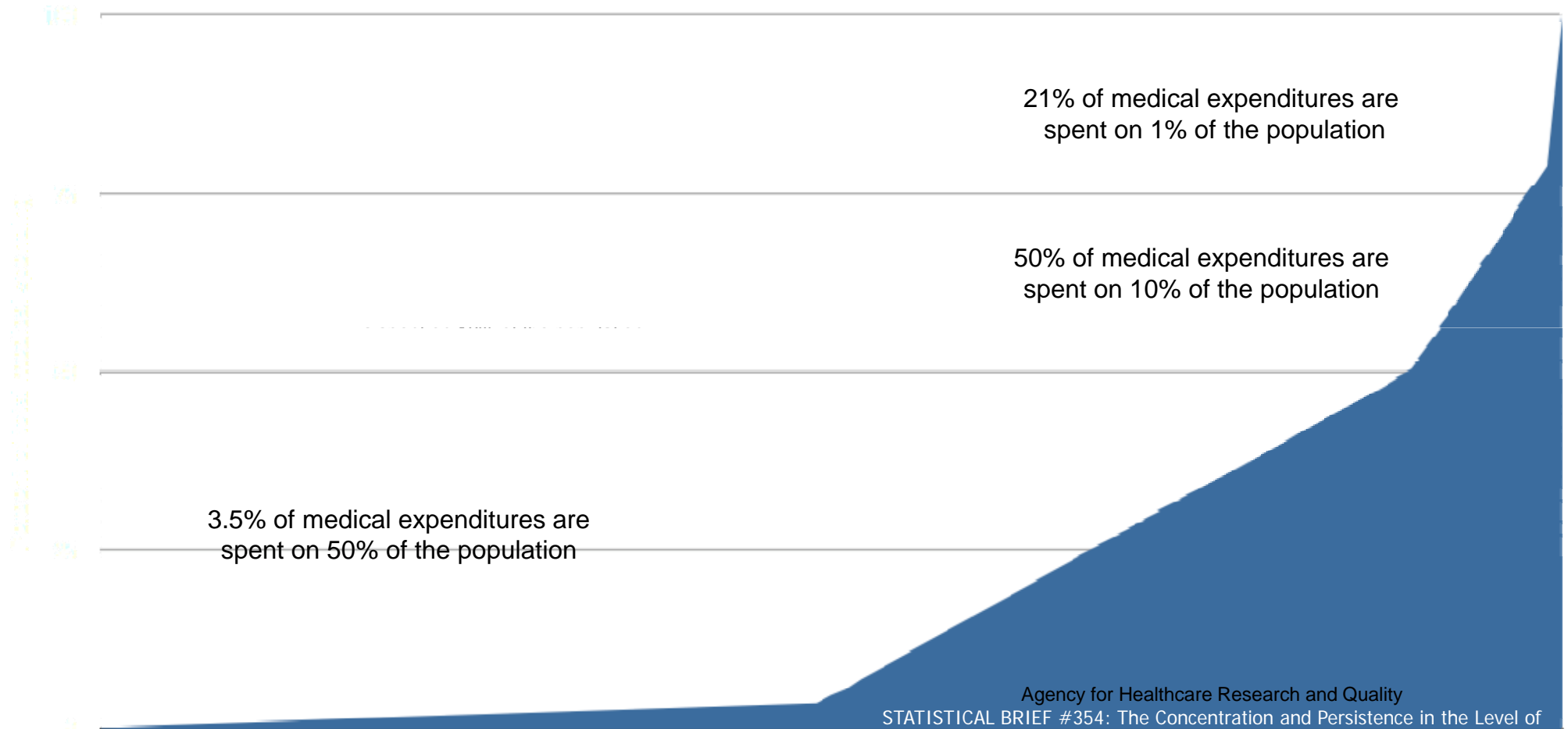
- Understand the impact of complex patients on national medical expenditures
- Understand tools available to identify complex patients, as well as some of the shortcomings with these tools
- Understand the strengths and weaknesses of different models for care of complex patients

# Scope of medical expenditures



# What amount of money is spent on different members of the population?

Chart 15



[http://meps.ahrq.gov/mepsweb/data\\_files/publications/st354/stat354.shtml](http://meps.ahrq.gov/mepsweb/data_files/publications/st354/stat354.shtml)

It may make sense to target our healthcare quality reforms towards those who are already consuming resources, in order to prevent high cost complications and hospitalizations.

The challenge then becomes, how do we identify the high risk patients

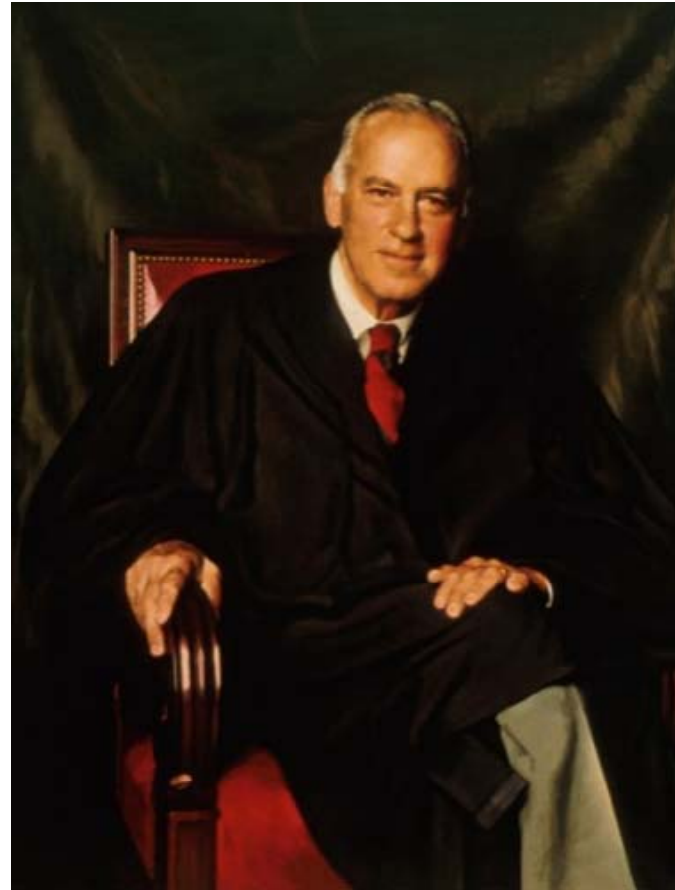
# How do policy makers and insurance companies assess patient complexity?

- Policy makers and insurance companies rely on strict actuarial models of complexity. These models are usually based on:
  - number of ICD 9 diagnostic codes for a specific patient
  - Specific high risk diagnostic codes, such as renal failure or diabetes
  - Claims data

- The Centers for Medicare and Medicaid Services uses Ambulatory Care Groups: ICD9 diagnostic codes are grouped into 1 of 32 blocks, generally organ based.
- Elderly patients with chronic diagnoses in 4 or more blocks are at a 99 fold increased risk of hospitalization compared to elderly patients without a chronic diagnosis

# How do PCP's assess patient complexity?

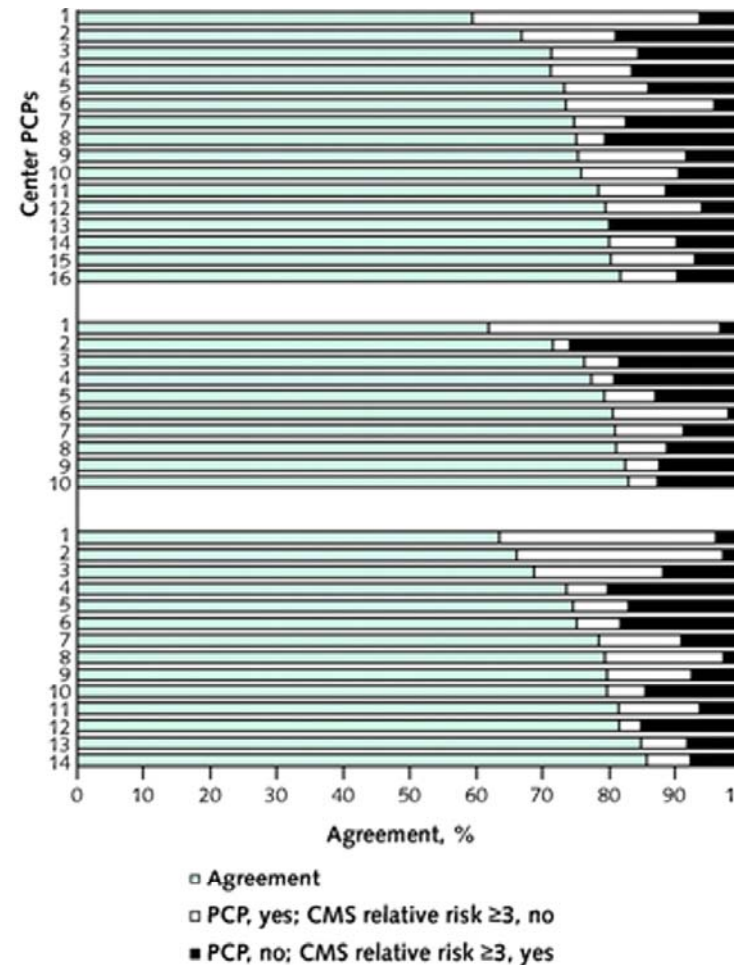
- We typically use the “Potter Rule.”
- “I know it when I see it.”



# How do actuarial measures of complexity compare to clinicians perceptions of complexity?

There can be large discrepancies in the perception of complexity between actuarial databases and physician assessments of complexity.

I would describe these discrepancies as “False Positive Complex Patients,” and “False Negative Complex Patients.”



What care models are available to facilitate care of complex patients?

What are each model's strengths and weaknesses?

# Three models for improving patient care

- Chronic Disease Management
- Patient Centered Medical Home
- Ambulatory Intensive Caring Unit

# Chronic Disease Management

- programs began initially in the early 1990's, and focused on specific diseases.
- CDM programs have been very successful in improving and standardizing care for patients with single complex care processes such as dialysis or complex care needs such as mental illness.
- CDM programs are often run by health insurers or by national healthcare companies, and focus on improving care and reducing costs for their patients.
- Communication with PCP's is often paternalistic.

# Patient Centered Medical Home

- Pediatricians initially envisioned the Medical Home as a model to provide comprehensive coordinated compassionate care for children.
- The AAFP, in 2002, and the ACP, in 2005, embraced the PCMH model as a means of improving primary care.
- In 2007, the AAFP, AAP, ACP, and the AOA released the “Joint Principals of the Patient Centered Medical Home.”

# Joint Principals of the Patient Centered Medical Home

- A Personal Physician to provide continuity of care
- Physician led multidisciplinary care team of providers
- Whole Person Orientation
- Integrated and coordinated care across specialist and hospital care
- Quality and Safety assured through use of EBM, linked electronic records and performance measures
- Enhanced access to care through open access, new forms of communication (e-visits, e-mail)

# The Ambulatory Intensive Caring Unit

- First described in 2003 by a group of researchers at Stanford as a tool for caring for high risk patients.
- Patients are referred to the AICU , and undergo an intensive review of their current health as well as a 360 degree assessment of their current health status.
- A personalized plan is developed, and may include intensive phone contact with trained RN's or PharmD regarding medical management and close follow-up of clinical status.

# The Ambulatory Intensive Caring Unit

- Social challenges may be recognized, and dealt with through Social Worker interventions.
- Diagnoses that add substantially to patient complexity, but that may be missed by actuarial assessments, are taken into account, and addressed.
- Potential exists for a broader range of medical issues to be addressed in a holistic manner in a way that may be missed through traditional CDM.
- Patients can be discharged from the AICU, returning to PCMH care, when their condition improves.

# What are the major differences between the three models?

Chronic Disease Management	PCMH	Ambulatory Intensive Caring Unit
<ul style="list-style-type: none"> <li>-Nationally or regionally directed</li> <li>-Focus on an single diagnosis or type of disease spread over many different practices</li> <li>-Process improvement comes from the CDM group</li> </ul>	<ul style="list-style-type: none"> <li>-Practice directed</li> <li>-All patients in the practice are part of the process: many diagnoses/processes</li> <li>-Process improvement developed within the practice</li> </ul>	<ul style="list-style-type: none"> <li>-Office or provider directed</li> <li>-Patients selected by the provider based on need</li> <li>-Process improvement developed within the practice.</li> </ul>

# What are the respective strengths of each type of program?

CDM	PCMH	AICU
<ul style="list-style-type: none"> <li>-National reach</li> <li>-National consensus about goals of care</li> <li>-Process improvements are directed towards high risk patients</li> <li>-May have the support of payers, depending on the CDM</li> </ul>	<ul style="list-style-type: none"> <li>-Local control</li> <li>-Practices will begin collecting quality of care data, preparing the practice for MC billing changes upcoming under PPAC</li> <li>-improved patient satisfaction.</li> </ul>	<ul style="list-style-type: none"> <li>-The same benefits described under the PCMH.</li> <li>-More intensive use of multidisciplinary teams.</li> <li>-Process improvements are directed toward the highest risk patents.</li> </ul>

# What are the respective weaknesses of each of the models?

CDM	PCMH	AICU
<ul style="list-style-type: none"><li>-Top down approach may not be successful unless incentives are aligned</li><li>-Positive results from CDM in terms of improved patient outcome may increase total cost if patients live longer</li></ul>	<ul style="list-style-type: none"><li>-Process for achieving PCMH certification can be difficult</li></ul>	<ul style="list-style-type: none"><li>-Intensive work to develop protocols for patient care</li><li>-Changes in support team mix may be difficult to achieve</li><li>-Time frame to demonstrate success may be long</li></ul>

# Are there projects in our practices currently that have aspects of the AICU?

- Anticoagulation Clinic
- POCO Clinic
- PharmD medication consultations
- Multidisciplinary Team Model of care
- CICP Social Work consultations

# What steps would it be required to expand the concept of the AICU across our entire practice?

- Decide on groups diagnoses for our initial focus
- Work to develop protocols that could be utilized by our Multidisciplinary Teams to improve patient compliance and disease control.
- Increased Social Worker availability.

# Conclusions

- Identifying complex, high risk patients in a large practice requires a multifaceted approach.
- Once patients are identified, each patient's needs must be addressed, and appropriate goals are set
- There are a variety of models for providing care to these patients.
- The AICU, in conjunction with a PCMH may be a very effective model of primary Care Practices.