Defining Complex Care

Complex care for high need populations is a relatively new concept, and taxonomy is evolving. A 2014 statistical brief by the Agency for Healthcare Research and Quality reported that 1% of patients accounted for 22.8% of total health care expenditures. (1) As such, many institutions have undertaken efforts to identify these “high need” individuals, with the goal of reducing unnecessary utilization and costs through structured interventions.

The National Academy of Medicine has identified three criteria that may inform identification of high need patients: a) total accrued health care costs, b) intensity of care utilized for a given period of time, and c) functional limitations. (2) A high need population can be fluid, as costs and intensity of care vary over time based on disease activity and psychosocial factors.

Complex care is the framework for taking care of the high need population. Advocated by the Commonwealth Fund and the Robert Wood Johnson Foundation, complex care is a person-centered approach to address the needs of people who experience combinations of medical, behavioral health, and social challenges that result in extreme patterns of healthcare utilization and cost. (3)

References:


The Vanderbilt University Medical Center (VUMC) Population

Vanderbilt University Medical Center has developed the Vanderbilt Familiar Faces (VFF) program to provide complex care for high need patients. The VFF program strives to improve the quality of life, patient experience, and healthcare utilization of chronically ill patients through interdisciplinary collaborative practice and an emphasis on fostering trusting relationships across the continuum of care.

VFF defines the high need population as patients who have had at least 3 ED visits or hospital admissions in the 6 months prior to referral. Based on internal data, this population includes approximately 1% of all patients seen at VUMC in a 6-month period, and represents over 10% of all inpatient admissions and total charges. (1) VFF employs multi-layered, patient-centered strategies to improve clinical care for VUMC’s high need population and seeks to understand which interventions decrease hospital utilization and improve clinical outcomes. Preliminary data demonstrates a 41% decrease in admissions and 38% decrease in ED visits among patients in the VFF program, compared to these patients’ healthcare utilization prior to enrollment. (2)

References:
Patient Stories

1. A patient with uncontrolled Diabetes Mellitus with neuropathy, hypertension, prior CVA with expressive aphasia, history of arterial emboli on lifelong anticoagulation, horseshoe kidney with persistent hydronephrosis and chronic indwelling urinary catheter, recurrent UTI, and chronic pain. This patient had 16 ED visits and hospitalizations in the year preceding VFF enrollment. After joining the VFF program, the patient’s ED visits dropped to 6 visits the following year and the patient has had increased engagement in the VFF outpatient clinic.

2. A patient with moderate persistent asthma and active smoking had 24 ED visits for asthma exacerbations the two years prior to VFF enrollment. After VFF enrollment, the patient has had only 3 visits and is seeing the VFF clinic for same day care for asthma attacks.

Other Complex Care Programs

1. UCLA
   https://www.uclahealth.org/extensivist/
2. Comprehensive Care by University of Chicago
   https://ccpprogram.uchicago.edu/
3. CareMore
   https://www.caremore.com/

Frequently Asked Questions:

1. One of my patients has a VFF flag. What do I do?
   You can send us an eStar InBasket message for any VFF patient you are caring for in the hospital, ED, or clinic setting, directing the message to the Vanderbilt Familiar Faces Clinical pool. You can also page the VFF A provider listed in Synergy. Note that there are some patients with VFF flags that we haven’t yet interacted with, but if you notify us, we can reach out to the patient and schedule a VFF clinic appointment. The flag may have an associated care plan that can provide patient-specific guidance for providers.

2. What is a care plan?
   A care plan is a patient centered plan to help guide providers in different settings who may care for VFF patients. The care plan’s intent is to complement rather than replace physician judgment in making diagnostic and treatment decisions. Where possible, the VFF team collaborates with the patient’s other clinical providers in the creation of this care plan.

3. Does a VFF patient always have to be with the VFF team, or admitted to the round wing?
   If the patient would otherwise be admitted to an general medicine service (e.g., Riven or Morgan), VFF can be the admitting team. Patients needing ICU-level care, surgical care, or inpatient psychiatric care should be admitted to the team and unit that best meets the patient’s needs. Providers should use clinical judgment to determine whether the patient is suitable for admission to the VFF team; our team is always happy to help with triage decisions if you page our VFF A provider.
4. *How do I comanage a patient who is enrolled in the VFF program?*

We want to partner with VFF patients’ primary care and specialty providers to best meet each patient’s needs. We can tailor the extent of the VFF team’s involvement based on input from other care team members, and hope to work together to develop care plans for these high need patients. Contact us at vff@vumc.org or via the VFF Clinical message pool in eStar.