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Competencies for engaging high-needs patients in primary care

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A B S T R A C T

Background: Patients who heavily utilize hospitals and emergency departments frequently have complex needs requiring services spanning medical, behavioral, and social service sectors. This study identifies essential competencies for caring for high-needs patients and highlights their importance to primary care delivery.

Methods: Transcripts of in-depth interviews with 30 clinical and administrative staff at 23 complex care programs across the United States were analyzed using standard qualitative techniques. Selected programs had several years of experience in serving patients with multiple chronic conditions, serious mental illness, substance use disorders, severe poverty, and homelessness. These programs exemplified diverse models (assertive community treatment, housing first, behavioral health, high utilizer), and all of them shared the common element of integrating primary care into their services.

Results: Competencies, including those known and taught in other fields, have distinctive application to informing delivery of high quality primary care to populations with complex needs, including: motivational interviewing for establishing patients' priorities and helping them improve their health on their own terms; trauma-informed care for modifying primary care procedures to mitigate the ill-effects of prior trauma prevalent in this population; and harm reduction for altering medical regimens to accommodate constraints on what patients are able or willing to do. Other capabilities, cultivated by these programs, include empathizing with patients, promoted by exposure to simulations of patient experiences (e.g., hearing voices); as well as withholding judgment and counteracting patient passivity to foster open discussion of treatment plans.

Conclusions: Absence of deliberate attention to equipping providers with specific competencies for caring for high-needs patients may contribute to lack of patient engagement and sub-optimal outcomes, ultimately undermining the success of programs serving these populations.

1. Introduction

Patients who heavily utilize hospitals and emergency departments for routine care often have complex health challenges including multiple chronic conditions, mental illness and substance use disorder, and frequently suffer from severe deprivation including homelessness, hunger, and other sequelae of poverty.[1,2] These patterns of utilization generate high costs; it is well established that the most costly 5% of all patients account for nearly 50% of health expenditures,[3] and high-needs populations are often represented in this high-cost cohort.[4] Given the socio-demographic background of this population, the burden of these costs is often borne by state Medicaid programs, by charity care programs, and by hospitals, clinics and other providers.[5]

Policymakers have responded by exploring financing mechanisms intended to enable primary care providers to devote time and resources to serve the broad spectrum of needs of these populations, with the aim of reducing costs and increasing quality of care. For example, the Centers for Medicare and Medicaid Services (CMS) have created flexible payment methodologies to support Medicaid health homes[6] which are designed to broaden the scope of needs addressed for people with chronic conditions; several states have initiated demonstrations of Medicaid Accountable Care Organizations offering shared savings arrangements as incentives to reduce costs and improve quality[7]; CMS has supported payment redesign to give primary care practices resources for investing in care coordination strategies for increasing quality and reducing delivery of unnecessary services[8]; and the National Committee for Quality Assurance (NCQA) has set up an accreditation process to recognize superior performance of patient-centered medical homes with regard to quality, costs, and patient experiences.[9] All of these initiatives seek to address the needs of patients with complex needs.

Accounts of the experiences of high-utilizing patients suggest that they often seek treatment when they are in crisis, may not follow through with referrals, frequently have difficulties adhering to treatment regimens, and lack sustained relationships with primary care providers.[1,2,10] These common attributes co-exist in a patient's experience at one of the research sites studied here, quoted from a provider

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interview in the textbox below. The significance of these challenges underscores the importance of preparing providers with appropriate expertise to more successfully engage these patients in care and effectively address their needs.

> Account of the Experiences of a Patient Cared for at a High Utilizer Program Quoted from a Provider Interview from this Study
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> Max (a pseudonym) was a heroin addict, and had COPD and was homeless. He was 58, and every time he came in to the hospital or ED, he'd get put in the ICU because his oxygen levels were so low. As he'd get better, he would start demanding things. He loved chocolate Ensure on ice. But he wasn't [asking for] it in a very nice way. And then, as soon as he could get up and walk, he'd — walk out, not having follow up care, not picking up his discharge medications and not caring what was going on with his health because he was going to look for his next fix.
>
> So I helped Max to get housed first. That was the first thing he wanted to work on. I also, upon discharge, helped him pick up his medications. It took another couple times to figure out where he was going to keep them, so that he didn't keep losing them and how he was actually going to take them. Because some of them required things like—they wanted him to take Lasix and he was like, "I'm not going to take that. Because I don't have a bathroom close enough to me all the time, so I'm just not going to take it." And [I had to] help the providers understand that that wasn't an option and they'd have to come up with a plan B.
>
> And so we went to primary care appointments with each other. We went to housing meetings. We got all the things together that he needed for housing, like ID, and all that sort of thing. He expressed at one point that his fondest wish was to be back in contact with his family. And that they would not speak to him while he was still using. So over time, he decided that it would be worth his while to get on Methadone. So as he got housed, he also went to his intake for his Methadone and started with that. And the doctors had told him over and over again that he wasn't going to live another two years because of how often he was here and how low his O_2 stats were. And he made it five years. And his family was here when he passed. But he was housed and he was happy, and he was back in contact with his family before he passed away. So, I think that's terribly successful.

This study was designed to identify necessary competencies for effectively engaging patients with complex needs in primary care. The research strategy was premised on the assumption that expertise developed and applied in varied fields has relevance for providing high quality primary care for these populations. Programs were selected for study that exemplified a wide range of care models to assure varied perspectives and disciplinary backgrounds of providers. All programs shared the common element of primary care integration.

2. Methods

A qualitative methodological approach was dictated by the purpose of the study – to learn about competencies essential to the roles of providers in programs with extensive experience in serving high-needs patients. Data were collected through extended, open-ended interviews with clinical and administrative staff of 23 systematically selected programs. The sampling strategy reflected the dual emphasis on identifying relevant expertise from diverse disciplines and understanding its application in delivery of primary care. A broad net was cast in identifying types of programs for study. Sampling criteria and associated rationale are detailed in Table 1.

The 23 programs selected for study are identified in Table 2. They are roughly characterized as originating in a behavioral health environment integrating primary care (7 programs); building on a housing program and integrating primary care and behavioral health (4 programs); and originating in a primary care program and integrating behavioral health and other services (12 programs).

Thirty interviews were conducted, averaging 65 min in duration; respondents were encouraged to be as expansive as necessary to address the questions. Questions were sequenced to suit the inductive analytic approach, asking respondents initially to identify care functions critical to delivering services to this population, followed by questions on what they needed to know to perform them. The aim was to elucidate key competencies grounded in the care functions that compel their application. Topics focused on major care tasks and the expertise required for performing them, stories of successful and not-so-successful encounters with patients and factors that determined or impeded success, preparation and training of staff, and background information on characteristics of the patients they served and the composition of their care team(s). Additional items focused on support for staff and avoidance of burnout, topics that are not the focus of this study. A copy of the interview questionnaire is included in the Appendix. The study was approved by the Institutional Review Board at Rutgers University.

All of the interviews were audio-recorded and fully transcribed. Analysis of the transcripts relied upon standard qualitative

Table 1
Sampling strategy for selecting programs for study.

Inclusion criteria	Rationale
The program was equipped to care for people with multiple chronic illnesses, serious mental illness, substance use disorder, severe poverty, homelessness or housing insecurity; and legal, language, and/or cultural barriers.	Needs associated with these conditions are frequently those experienced by complex patients.
The program embraced a broad spectrum of models including assertive community treatment, housing first, behavioral health, and high user programs.	These models rely upon diverse disciplines and associated expertise, which is suited to detecting a broad scope of competencies relevant to caring for these patients.
The program integrated delivery of primary care services as central to its purpose.	The study is designed to make explicit the relevance of competencies to engaging patients in primary care.
The program offered documentation of extensive experience in serving the scope of needs outlined above.	The practices of successful programs have promise in yielding lessons worthy of broader application.
The program had sufficient longevity (at least 5 years) to suggest a stable model and had survived any initial challenges with respect to staffing and training.	Perspectives and patient-care strategies are grounded in sustained and varied experience.