Super Utilizers and the Center for Integrative Medicine Model

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**Super Utilizer SU**- person with greater than 10 visits to SH system ED’s in one year

**System Super Utilizer (SSU)**- person with greater than 10 visits to any ED in one year

**Primary Psych**- patient who’s use of the ED revolves around their psychiatric diagnosis

**Primary Medical**- patient who’s use of the ED revolves around their medical issues

**Primary SUD**- patient who’s use of the ED revolves around their substance use issues

**Direct Cost**- money actually paid for the patient
Subtypes of Super Utilizers

- The “pre” Super Utilizer
  - Unborn children of mothers with unstable SUD/MI

- The ED Super Utilizer
  - Patients in the ED greater than 10 x year

- The Ambulatory Complicated Medical Patient
  - Patients with poorly controlled medical conditions who live outside a long-term care facility
  - Moderate to low ED use, but high admission and testing rate

- The Non-Ambulatory Complicated Medical Patient
  - Permanently in a LTC facility
“Pre” Super Utilizer

- High cost of care secondary to needed NICU stay
  - $3500/day

- CPS, Foster Care and Judiciary involvement
  - Difficult to calculate total cost

- Coordinated care and BIO-Psycho-Social intervention with aggressive outpatient SUD and MI treatment significantly decrease total cost of care
ED Super Utilizer

- **SU’s**
  - 950 individuals per year
  - 20,000 visits per year
  - $50,000,000 in direct cost per year (includes MH/SUD treatment)

- **SSU’s**
  - 2000 individuals per year (Kent County)
  - 35,000 visits per year
  - $87,500,000 in direct cost per year (includes MH/SUD treatment)

- State wide extrapolation based on population
  - 29,000 individuals per year
  - 600,000 ED visits per year (total state ED visits 4,493,665, 455/1000 pts)
  - $1,500,000,000 in direct cost per year (includes MH/SUD treatment)
The Break Down of ED Super Utilizer

- 10-19 visits per year
  - Mostly medical
  - 70% are transient HFUs (1 year only)

- 20-29 visits per year
  - Mostly combination of medical, SUD and Psych
  - However, trends toward SUD
  - 85% are consistent HFUs (more than 1 out of every 4 years)

- 30 or greater visits per year
  - Mostly psychiatric
  - 95% are consistent HFUs (more than 1 out of every 4 years)
ED Super Utilizers

- Assertive ED policies on opioid use for Super Utilizers
- ED Screening and referral ± brief intervention
- Ambulatory ICU intervention (short term)
- Ambulatory ICU intervention (medical home)
- Focus factory approach to disease state
- Housing, transportation, food and communication
- New payment models needed
Ambulatory Complicated Medical SU

- CHF, COPD, Diabetes, Sickle-Cell, chronic pain, MI and SUD
- Greater than 3 admits per year
- Housing, transportation, food and disease education are issues
- Fired from PCP’s not trained in complicated social disease
- Camden Coalition like programs, Community Hub
  - Evaluation in hospital and use aggressive home based wrap around services
- Ambulatory ICU (medical home model)
Non-Ambulatory Complicated Medical SU

- Dementia, Elder-care, Ventilated and Poly-trauma (mostly SUD related)
- Aggressive end of life decision making
  - Living will
  - Family education
- Relatively fixed cost unless patient transferred home with care
- Can decrease hospital admissions with better infection control and educated power of attorney
Common SU traits

- The diagnosis of destitution
  - Lack of housing, transportation, nutrition, education and safety

- SUD
  - This includes all forms contributing to current medical issues (tobacco, alcohol, MJ, opioid etc.)

- Mental Illness including exposure to early life trauma
  - Rarely identified or treated in an evidence based fashion

- Poor coping skills and little to no support system
Unstable → Stable → Functional

Fear
Intimidation
Violence
Immediate gratification

Anxiety
Desire to belong
Education

Independence
What Next?

- Truly Integrated behavioral and medical care
- Payment System Reform
- Payment coverage for increased value-added service lines
- Standards of care for the treatment of MI and SUD
- A cohesive non-punitive, evidence based approach to the diagnosis of destitution
- Robust performance and quality measures that show improved function and/or ROI