HOME AGAIN

HUDDLING UP AROUND HIGH-NEEDS PATIENTS

BY ELAINE VITONE

PHOTOGRAPHY BY JOHN ALTDORFER
Each patient’s case is the kind most primary care docs would call their most challenging. At 8:30 a.m., they’re just halfway through the list, and they’ve already covered: a trauma survivor who is so terrified of her (male) orthopaedist that someone she trusts has to go with her; a man who’s working two jobs so his girlfriend, who’s in a federal prison, can buy palatable food from the commissary; and a mother of two who, since her husband’s deployment, has been too depressed to take her antidepressants, let alone keep up with her pulmonary rehab.

Welcome to the “huddle meeting.”

This morning ritual is a staple of the UPMC Enhanced Care Program (ECP), a suite of services based out of Montefiore’s General Internal Medicine Clinic. The brainchild of a University of Pittsburgh faculty member, ECP was designed for people with complex medical and psychosocial needs—“super utilizers,” as they’re known in the literature for their frequent visits to the emergency department. These patients’ advocates often cite that 5 percent of Medicaid enrollees account for half of all Medicaid spending.

Among these advocates is Jodie Bryk (MD ’09, Res ’12, Fel ’14), medical director and architect of ECP, and clinical instructor of medicine at the University of Pittsburgh. She sees her unique patient load as a window into issues that affect public health on a grand scale.

Bryk ticks through the list of names. Some are a quick mention (“Audrey Lane… Jack Lee…”). Others become the focus for several minutes’ worth of round-tabling. (We’ve changed patient names and details.)

“Cheryl Leyden,” Bryk says—a woman in her 50s, I later learn, who has severe chronic obstructive pulmonary disease (COPD), among other illnesses. “She was doing excellent yesterday.” Bryk adds that she gave Leyden tips for quitting smoking, like switching to an e-cigarette first. “And I told her husband on the phone that he has to do it, too.”

“I mean, Cheryl gets it,” says social worker Jeanette Valentine. “She repeats it back to you! It really seems like she’s gonna do it.” Everyone agrees.

“Wayne Lowe,” says Bryk.

“He just got discharged yesterday,” says Patricia Englert, an RN. She knew the moment this patient left the hospital, thanks to Augr, an app that UPMC developed to buzz the ECP staff every time one of their patients checks in or out. Augr makes timely follow-up—which keeps readmissions down—much easier. It’s helpful when patients are admitted, too. For example, Bryk once had a patient who was so petrified of having a second heart attack that he went to the hospital every time he sneezed—267 emergency department visits in one year. So she started...
intercepting him in the waiting area and bringing him upstairs for an EKG in the clinic instead. It took a few months to reassure him—but it worked.

“Dana Moore,” says Bryk. “She did great yesterday. All her health maintenance is up to date: mammogram, colonoscopy …”

“That’s my patient,” says Theresa Goldston, a BSN and RN.

Everyone laughs.


“Yaaaay Danny!” says Engler—he’s her patient. But everyone at the table knows what a big deal it is that his blood pressure is stable. And that’s the whole point of the huddle. If a team member is out sick or on vacation, patients don’t lose ground.

“Stephanie Nowak,” says Bryk.

Across the table, Kim Kunkle, an RN, takes a deep breath. Yesterday, she says, she was reviewing paperwork and, after a little investigating, figured out that the 30-something-year-old had finagled a way to double-dip opioid scrips.

The room tenses.

“I had a long talk with her on the phone yesterday,” says Bryk. “These were the options I gave her: Self-taper—and I’ll give you those instructions; or detox at Mercy; or rehab at Western Psych. She voted none of the above and said she needs the medication.”

Anita Leon-Jhong, an MD, laments, “Chronic opioids are not shown to improve chronic pain. They don’t work. They can make you tolerant and more sensitive to pain, and then some people get really addicted.”

Bryk continues. “Stephanie was like, You gotta understand, I didn’t know what to do. I said, ‘Hey, we gave you a whole plan for what to do: physical therapy, behavioral health.’ And she hasn’t followed through.”

“What did she say to that?” asks Kunkle.

“She got really quiet,” says Bryk. “She said she wanted to come in. I told her I’m not dismissing her. I’ll still treat her, but on the right treatment. And then she asked to move up her appointment. So if you want to be there…”


“Absolutely, you will,” Kunkle says. “Because her parents! They mean well, but they’re making excuses for her!”

And the whole room answers in chorus, “Yeah!”

This is a team that notices things: Which patient has a dad with a cancer diagnosis and just might be diverting his painkillers. Whose housing just fell through because now the landlord suddenly wants more money up front. Who is grieving. Who has gone back to her abusive boyfriend—again—and needs to hear that the safety net is still here for her. Who always sounds like he’s at death’s door, but 9 times out of 10 is just calling because he’s having a bad day. Who is still in the ICU and, in the professional opinion of her nurse (Englert), “needs a hug.”

The team knows, because in addition to scheduled clinic visits—which can be arranged same-day, as needed—they regularly see patients in their homes. Because patients are able to reach them directly, 24/7. Because every new ECP enrollee gets a 90-minute intake, a detailed medical-history report dating all the way back to the earliest appointment on record, and a comprehensive plan for the way forward. And because the whole hivemind huddles up and downloads around the status of that plan every day.

At this moment, Stephanie Nowak is on the precipice of falling headlong into opioid addiction. The ECP team will put everything they’ve got into saving her from this modern epidemic, but the approach they use looks surprisingly … old school. It’s not a battery of tests, a clinical trial, a new pill, a million data points, (though statistical tools certainly help—more on those later). Most of all, it’s building relationships, noticing things, and following up. It’s a throwback to the very start of Western medicine:

The house call.

Bryk speaks with a Cleveland accent, but she grew up on a dairy farm 50 miles outside of the city. Her dad, who trained as both a veterinarian and an MD, and her mom, an RN, did outreach in rural areas and convinced Amish bishops to implement vaccination programs. After that, families who’d never felt comfortable going to a hospital would buggy up to the Bryk farm with sawed-off fingers. “My dad would suture them up and stabilize them to get them to the right place,” she says. “It was kind of fun.”

Bryk learned to work with people’s belief systems: Yes, you should pray—for the surgeon who is going to operate on you. She came to see trust as something that did not come easy—but it was absolutely worth the ride.

Bryk found a comfortable fit at Pitt, where the medical school and its clinical partner,
other is doing. And cruelly, "the system" proves the picture. One hand doesn't know what the difficulties, diagnoses multiply. Specialists enter sema, and heart disease on top of those dif homelessness. language barriers, inadequate housing, and functional illiteracy, transportation difficulty, domestic violence, financial strain, hunger, determinants of health: childhood trauma, contending with what experts call the social Program is a better fit.) ECP patients are often for those patients, UPMC's Advanced Illness of the program's scope, Bryk notes, adding that complex needs in end-of-life care are outside that are largely preventable. (Patients with emergency department visits and hospital stays done the same. since noted the promise of this approach and spot" in geographic areas. Brenner created found that high-cost care tended to "hot N.J., physician who studied billing data and Yorker Internist and Public Service Psychiatry. consecutive fellowships in Psychiatry for the internal medicine residency, then stayed for human health. She completed her MD and rooting the biology of the brain firmly in UPMC, have a long and storied history of rooting the biology of the brain firmly in human health. She completed her MD and internal medicine residency, then stayed for concurrent fellowships in Psychiatry for the Internist and Public Service Psychiatry.

Around this time, a new movement was gaining steam. Atul Gawande wrote a New Yorker piece about Jeffrey Brenner, a Camden, N.J., physician who studied billing data and found that high-cost care tended to "hot spot" in geographic areas. Brenner created wraparound services for high-needs patients. Health care systems across the country have since noted the promise of this approach and done the same.

Three years ago, Bryk designed ECP for patients caught in a revolving door of emergency department visits and hospital stays that are largely preventable. (Patients with complex needs in end-of-life care are outside of the program's scope, Bryk notes, adding that for those patients, UPMC's Advanced Illness Program is a better fit.) ECP patients are often contending with what experts call the social determinants of health: childhood trauma, domestic violence, financial strain, hunger, functional illiteracy, transportation difficulty, language barriers, inadequate housing, and homelessness.

With conditions like renal disease, emphysema, and heart disease on top of those difficulties, diagnoses multiply. Specialists enter the picture. One hand doesn't know what the other is doing. And cruelly, "the system" proves most complicated for those who have the most barriers to navigating it.

So ECP helps break those barriers down. "They'll have 15 meds on the table," says Bryk, "and I'm like, 'I could not reliably take all these!'" On day one, ECP switches each new patient's scripts to a single, centralized pharmacy that presorts the doses and delivers "med packs" to the patient's door. The ECP team also helps patients manage the cost: by switching to generics, hunting down coupons, calling the pharmacy to ask if they'll waive the copays Medicaid won't cover.

If a patient has diabetes, for example, ECP staff can make a house call to watch him run through his glucose-monitoring and insulin-injection routine to ensure he's got it down pat. They can bring a podiatrist to perform a foot exam. They can even use a telemedicine-enabled camera to have an eye doc back in Oakland perform a retinal exam remotely.

On a recent fall morning, as Bryk and I drive to a patient's home, she tells me about other needs that don't typically make it onto a medical chart. ECP team members have packed up and loaded moving boxes. They've reconnected patients with long-lost loved ones. They've held patients' hands as they've made the first unsteady steps outside after a long illness. For Cheryl Leyden—the woman we're on the way to see now—her nurse once made a trip for the express purpose of taking her, finally, back to church. And then, to bingo.

We arrive at a brick house with a flower bed full of toys. "Hi! Have a seat if you can find one!" Leyden says, standing to greet us, tethered by tubes pumping oxygen into her nostrils via an air compressor that hums loudly from the back of the house. Apart from the fleet of oxygen tanks in the corner, it's a typical old Pittsburgh home: hardwood floors, a piano in the front room. Leyden's grown daughter curls up on the couch with her own preschool-age girl, brushing her hair; the youngest, 15 months old and wearing a Minnie Mouse shirt, toddles at our feet.

"You're walking already!" says Bryk, and the moms talk milestones. Bryk has a little girl, too.

It's been a week since the huddle meeting with the encouraging progress report from Bryk regarding Leyden. Then, three days later, Leyden had a scare: severe headache, hand tremors, spikes in her blood pressure. Most emergency physicians would've admitted her on the spot, but Bryk was able to rule out worst-case scenarios with lab work in the clinic. Those tests also showed a possible explanation for the symptoms: Leyden's phosphorus level was low.

Bryk explains she’s here to draw some blood to check it again and to administer a flu shot, in addition to the usual home-visit routine: a chat on the couch about nutrition and other behavioral factors, and a check-in on how well Leyden is keeping up with her pulmonary rehab and medications. Bryk can see the latter at a glance, simply by looking at the med packs. These kinds of preventive and vitals monitoring visits are crucial to keeping Leyden in the clear—but it’s not easy for Leyden to get to the clinic at Montefiore. From Leyden’s home, it’s 90 minutes on the bus each way; and that’s with oxygen in tow.

“How’s that tremor?” Bryk asks.

“I’ve still got it,” Leyden says, showing us her shaking hands.

“We’re setting up an appointment with the neurologist at UPMC. I mean, it could be from the steroids you’re on; but we should definitely get that checked out, because it’s getting worse.”

“It is, it is,” says Leyden.

“And how are you doing on the smoking?” Bryk says.

“About five to seven” cigarettes per day, she says—an improvement.

“I’m telling everyone: the e-cigarette!” says Bryk. “You don’t miss the habit, because it’s not like you don’t have anything in your hand anymore. And it’s gonna be cheaper. We’ve gotta get your husband to do it, too.” Leyden nods “yes” and says it all back—she
really does seem like she’s going to do it.

We watch the baby play as Bryk gets to work with her blood pressure cuff, stethoscope, and syringes. Leyden’s blood pressure is much better today, urbano, and no signs of new trouble in her lungs, either. After last week’s scare, Bryk is relieved, she says—and so happy with how things are going.

“I remember when you first started the program, you had that swelling in your legs,” says Bryk. Back then, Leyden was in and out of the emergency department every month. “They were telling you that you had to go to a nursing home. You showed them. You worked hard.”

“Sure did. They said I’m gonna be on this oxygen for the rest of my life. I said, ‘No, I’m not! God is gonna heal my lungs. I’m gonna get off this oxygen!’”

“I think if anybody is able to do it, it’s you,” Bryk says, smiling. “I think you’ve got what it takes.” But the hardest part will be the smoking, she says—pray for the strength to quit smoking.

In a paper published in Population Health Management in September, the ECP team shows that in the program’s first 30 months, their patients’ emergency department visits decreased by half, and unplanned care overall significantly decreased. The program has also shown improvements in quality metrics for diabetes and hypertension care, cancer screenings, connection with mental health providers, and weaning off opioids.

Supporting the old-school house calls is a wealth of data, courtesy of UPMC’s services division, which funds ECP. They’re in constant cross-talk with the team, brainstorming new services. As an academic health care center and one of the largest payer/providers in the country, UPMC Health Plan has a treasure trove of population data—a powerful complement to the on-the-ground insights of Bryk’s team, says Marion McGowan, the division’s chief clinical officer and senior vice president for population health. By comparing patients who share similarities, and having them know who you are. … They want to walk into a clinic and feel like they’re at home.”

Back at Montefiore, Bryk and Kunkle, the RN who spotted the coming storm in Nowak’s opioid use, sit down for a heart-to-heart with Nowak and her father. Taking controlled medications in an unauthorized manner is serious—the risk of overdose is high, Bryk says. “I’m no longer comfortable prescribing them.” And then she takes it from the top one more time: self-taper, detox, or rehab. Bryk strongly recommends detox.

Nowak is scared—of a lot of things. But right now, mostly the stigma of addiction, and the looming threat of pain, which was once a constant companion. She doesn’t want to go back to it.

So they make a compromise.

Bryk reaches out to a pharmacist and comes up with a plan to taper down the painkillers, as well as alleviate the racing heart and wrenching anxiety that might follow. Then she calls the UPMC Pain Medicine Program and gets Nowak an appointment that very day.

Nowak’s dad pulls Bryk aside. “Thank you for doing this,” he says, and fesses up—this has been an intervention for him, too. “I try to advocate for her,” he says, “but I know what I’m really doing is enabling her.”

One week in, Nowak calls Bryk and says she’s doing well. Granted, these are early days yet, and the future is far from certain. Still, there’s plenty to celebrate at the next huddle. Nowak didn’t simply fire Bryk and look for another doc, another scrip. This patient is putting in the work.

And actually, she feels better off the opioids, she says. Finally clear again, and here again. Back to her real life, and family, and home.