

Patient Perspective is Critical in Developing Interventions for Frequently Admitted Patients

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In the context of rapidly rising healthcare costs and increasing disparities in health outcomes in the United States, there has been increasing interest in identifying and addressing the needs of our country's most frequently admitted patients. These patients account for a disproportionate percentage of healthcare expenditures¹⁻³; they also represent a vulnerable and high-risk population. Finding solutions to address the needs of these patients is important for the patients themselves and for the systems in which they receive care. The last 10-15 years have seen a proliferation of programs working to address the needs and contain the costs of frequently admitted patients,^{2,4-6} as well as increased interest in understanding the risk factors and drivers that lead to high utilization.

In this edition of the *Journal of Hospital Medicine*, O'Leary et al. report on their study of patients enrolled in the CHAMP program at Northwestern University, in which the authors elicit patients' perceptions of factors contributing to the onset and continuation of high hospital use.⁷ The authors identify several themes, including the important role of psychological, social, and economic factors in course fluctuation, the perception of acute illness as uncontrollable and unpredictable, and a strong desire to avoid hospitalization. As a group, the themes suggest multiple strategies that may be of use in developing individualized plans for patients.

Several of the most commonly cited risk factors for high utilization—including mental health issues, housing insecurity or homelessness, and substance use^{2,3,8,9}—did not emerge as themes identified by patients in this study as contributing to high hospital utilization. Although identified themes such as social support and psychological stress could certainly be related to these underlying risk factors, the risk factors themselves did not emerge. This is particularly notable in a population whose utilization is in line with other studies (participants had at least two unplanned 30-day inpatient readmissions within 12 months, and one readmission in the last six months, a referral, or at least three observation visits). In contrast to prior qualitative work with complex, high-needs patients,¹⁰ patients in this study did not identify difficult (or positive) relationships with care provider teams, or a history of early life trauma, as factors related to current utilization.

These findings raise several important questions. To what extent are frequently hospitalized patient populations comparable with each other? This is both a question about how populations are defined and a question about the inherent variability between populations (including geographic, social, socioeconomic, and other factors). It is not evident from the demographic information provided whether this population is fundamentally different from others that have been studied, or whether risk factors such as mental health issues, housing insecurity, substance abuse, and trauma history are present, but are just not identified by patients here as proximal contributors to their utilization. In either case, the findings raise important questions about the development of effective interventions for these patients. The discrepancies also highlight the utility of ascertaining and reporting the prevalence of these risk factors among study populations, ideally both among patients who opt in and those who opt out. Although obtaining this information adds an additional layer of complexity to data collection, this history, along with extended demographic data, would significantly improve our ability to assess the comparability of populations across studies. It would also help us understand whether perspectives of any specific groups of patients are not represented, due to frequent opting out of the study.

The fact that commonly identified risk factors for high utilization are not identified by patients in this study as contributing to their high hospital use highlights the importance of (1) including the patient perspective as an integral part of care plan and intervention development and (2) continuing local work aimed at understanding the risk factors and drivers of high utilization in specific populations. Many programs, including CHAMP at Northwestern and our own hospitalist-run program at Penn Medicine, work closely with patients to develop individualized care plans that aim to address the underlying drivers of high utilization. In our experience, a multidisciplinary committee reviewing patient cases has identified mental health conditions as likely drivers of frequent admissions in over 95% of program patients. In line with the findings here, however, patients themselves often do not see mental health as a significant contributor. If patients do not see factors such as mental health as important, this has significant implications for the development of interventions around these factors as part of a solution to high hospital use.

Patients are unlikely to respond to interventions targeting problems that they themselves do not identify as important. This is not to say that drivers such as mental health, housing instability, substance abuse, and behaviors rooted in childhood

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trauma cannot be addressed if they are not identified by a patient as problems. Rather, interventions must be sensitive to and developed within the context of the patient's own perceptions and priorities. For any program aimed at addressing the underlying drivers of high utilization, therefore, it is critical to elicit individual patient perspectives and to incorporate them in the development of interventions tailored to a specific patient's needs. This process not only informs the creation of an individualized care plan but also promotes engagement and builds trust.

In prior work,⁶ O'Leary et al. have joined others throughout the field in calling for standardized definitions of "high utilizers"; this is critical for our ability to compare study results across programs. However, standardizing definitions is just the first step. Individual site studies such as this are needed to help us understand which themes are universal, versus those that are population- and site-specific. They are also important for individual institutions in targeting, developing, and refining local interventions. As a whole, the results will help guide the development of best practices within the field and allow providers to better understand the needs of specific populations. This work is essential to our ability as providers, hospitals, and systems to develop effective interventions for individual patients in this heterogeneous, vulnerable, and high-risk population.

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