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NEW PERSPECTIVES

Hot Spotting, So Hot Right Now

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The population health theme of the 2016 SGIM Annual Meeting showcased the myriad ways generalists are targeting high-risk groups to improve outcomes and reduce costs. Ever since Jeffrey Brenner's Camden Coalition was recognized for its innovative care of "super-utilizers," the term and practice of hot spotting have found their way into every payer system and a variety of care venues.

But what is hot spotting, really? For one, it isn't entirely new. We are reminded by sage SGIM colleagues that practice and research on the topic date back decades. After all, taking care of vulnerable patients with complex medical and social needs is not new to the field of primary care. We have long known that the sickest patients often are tangled in a web of multiple chronic conditions and social and economic barriers to accessing the medical care they need. We have also known that improving the health of these patients is not easy work. Health systems—in particular safety net hospitals and clinics—have long bolstered medical care with case management and social services to improve the health and lives of these patients. We also know that the care of these patients is costly, particularly when they receive care in the acute care setting.

Herein lies the core of what fuels the current hot spotting explosion. Reducing the cost of care for these patients is a major economic imperative for the future of health care. The looming health care economic crisis has spurred payment reform and a growing interest in population health. Pair this with the burgeoning field of big data, and the time is ripe for hot spotting programs. Identifying the patients that cost the most and targeting interventions to improve their health and lower total expenditures are the goals of hot spotting.

At the SGIM annual meeting, we saw examples of hot spotting programs along the entire care continuum, from hospital discharge to long-term home-based care. Our plenary sessions showcased a program using medical students as patient navigators for high-risk patients and highlighted two home-based primary care hot spotting programs. Workshops highlighted VA programs targeting the highest-risk patients using a risk prediction score and VA homeless programs that are using risk prediction models to anticipate acute care utilization and eviction among recently housed veterans. Yet another workshop highlighted case-based strategies to optimize hot spotting interventions. More than a dozen posters and presented abstracts highlighted strategies to implement and evaluate hot spotting programs.

Our plenary lecturer, Tim Ferris, provided the population health management perspective on hot spotting with a poignant case. He asserted that while the ideal configuration and implementation of hot spotting programs may require ongoing investigation, there is no uncertainty as to the necessity of the expansion of such programs to improve care and reduce acute care utilization.

Future research will continue to delineate just how to craft the best risk prediction models, target resources to the high-risk patients most likely to benefit from intensive management programs, build an intervention team, and set a time frame for providing intensive management. The billion-dollar question remains: Will these programs reduce total health care costs?

As we look ahead to next year's meeting theme of resilience we may ask increasingly about the impact hot spotting programs have on primary care providers. Are effectively crafted teams that help manage the most challenging patients improving the job satisfaction of busy practitioners?

As I reflected on the countless ways we saw hot spotting being incorporated into patient care, a colleague jokingly added, "It sounds like Green Eggs and Ham!" We do hot spotting in the home, in the clinic, and on the phone. It's in our research, education, and care. I see hot spotting everywhere. I'd say my colleague's observation is true. I like hot spotting. How about you?

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