Complex Care Transformation

October 9, 2015
Lauran Hardin MSN, RN-BC, CNL
Director Complex Care
hardinlj@mercyhealth.com

Conflict of Interest Disclosure

The presenter indicates:

• No conflict of interest, commercial support, sponsorship, or endorsement of products.
Where it All Began….

Aggregate Patient Story/Real Outcome Numbers/Stock Photo

Middle Aged Woman

- Disruptive Behaviors
- Care Providers across Multiple Systems
- Multiple Procedures and Encounters

Outcome:
- Cross Continuum and Cross System shared plan
- Reduction of $134,826 monthly net operating loss (1.6 million annual) overtreatment/unreimbursed care
- Linked to Comprehensive Care Model

The Invisible Population
Who are the High Risk or Complex Patients?

A Population View

Measuring Risk and Complexity
- Claims Data
- DRG Data
- 30 Day Readmit Data
- Frequency Data
Business Intelligence - Population Analysis

<table>
<thead>
<tr>
<th></th>
<th>Total Visits</th>
<th>ED Visits</th>
<th>UC Visits</th>
<th>IP Admits</th>
<th>OBS Admits</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2011</td>
<td>524</td>
<td>8,200</td>
<td>5,205</td>
<td>256</td>
<td>1,652</td>
</tr>
<tr>
<td>FY 2012</td>
<td>735</td>
<td>8,501</td>
<td>5,590</td>
<td>397</td>
<td>2,073</td>
</tr>
<tr>
<td>FY 2012 % Total Volume 10.5%</td>
<td>2%</td>
<td>10.1%</td>
<td>17.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Population Characteristics of High Frequency Patients

Primary Care Status
- 60% have a medical home

Insurance Status
- 30% Uninsured
- 40% are Dual Eligible

Age
- 70% are <60 yrs old

What Came First.....
What is the root cause of Complex Care?

Patient with COPD and Diabetes with no Insurance: No Care Managers, Emergency Room = PCP

Patient with COPD and ESRD with Insurance: Multiple Care Managers – not connected to each other
Mental Health and Substance Use Disorder

• 8.9 Million persons have co-occurring disorders

• Only 7.4 percent of individuals receive treatment for both conditions with 55.8 percent receiving no treatment at all.

• Untreated mental illness and substance use disorders lead to more deaths than traffic accidents, HIV/AIDS, and breast cancer combined

• Centers for Medicare and Medicaid Services (CMS) data show nearly one in four people with mental or substance use disorders lack health insurance. For those with both mental illness and substance use issues the figure is 30 percent.

What are current themes of innovative Complex Care?
Innovative Complex Care

- Complex Care Navigator/CM
- Integration of Behavioral Health in Primary Care
- Home Based Primary Care
- Community Health Workers/Community Teams
- Ambulatory ICU/High Risk Clinics

Approach Comparison

**Complex Care Manager**
- Patient must opt in
- Exclusion by Payer, Diagnosis, Location
- Patient Intervention
- Change the Patient
- New FTEs/Team to manage patient
- Program
- Usually in one System
- Typically time-limited follow
- 1 FTE: 100 Patients

**Complex Care Center**
- No need to opt in
- No exclusion criteria
- Patient & Provider Intervention
- Change the System
- Minimal new FTEs - Potentiates existing roles
- Process/Standard of Care
- Links Competing Systems
- “Watch” for life
- 1 FTE: 500 Patients
- Intervention occurs whether patient engages or not

What is the Complex Care Center?
National System: Trinity Health

- Regional Health Ministry
- Long-Term Care Senior Living Facility

Complex Care Center Core Services

- Change the Perspective
- Change the Patient Experience
- Change the Population
- Change the System

Business Intelligence
Clinical Intervention
Community Intervention
System Intervention
Intervention Pathway

2.0 Clinical FTEs
- Follow >1,000 Patients
- Add 10 to 20 New Patients/Week
- Add 5 to 10 Complex Care Maps/Week
- Case Find & Proactively Intervene with risk populations (i.e., All Uninsured w/>5 Visits)

Complex Care Consult Order
Complex Care Alert

Patient-Provider-System-Community Intervention

Young Man
- Type I Diabetic
- 7 Hospital Admissions and 15 ED visits
- What might be root cause?

Outcome
- 1 Hospital Admission and 2 ED visits
- What interventions made the difference?

Vulnerable Populations

Male 56 years old
15 ED Visits and 4 Inpatient Admissions in 12 months
Lost to Follow Up.....

(Aggregate Patient Story/Sample Outcome Numbers/Stock Photo)

• 31 year old female
• Many abdominal surgeries
• Substance use
• No engagement with care team post discharge

What is the impact of Complex Care Intervention?

One Patient’s Experience

The impact of changing the system...

*Shared with Patient and Case Manager permission
Complex Care Population Demographics N=248

- Gastroparesis 7%
- Cardiac 1%
- Sickle Cell 1%
- Neuro 1%
- ETOH 15%

Complex Care Patients 12 months from Intervention N=248

Substance Use Disorder 19%
Pain 13%
Multiple Medical 13%
ESRD 3%
Psych 20%
Cancer 1%
COPD 6%

Results (N=210, 12 Months After Intervention)

- Decrease in Total Gross Charges 7 Million
- Reduction in IP/OBS 61%
- Reduction in LOS 61%
- Reduction in ED/UC 39%

Increase in Contribution Margin/Case
$1000/Case 50% Increase/Case

- Decrease in Direct Expenses 2 Million
- Decrease in Patient Self Pay Charges (1 Million)
- Decrease in Uninsured Visits 63%
- Decrease in Patient Self Pay Charges (1 Million)
- Decrease in Uninsured Visits 63%

Complex Care Map Outcomes

Complex Care Patients with Complex Care Maps
- Complex Care Patients with Complex Care Maps
- Complex Care Patients with Complex Care Maps

(c) 2015 Trinity Health/Michigan dba Mercy Health Saint Mary’s. All Rights Reserved. No Reproduction Without Prior Authorization
Complex Care Map
Patients Financial Outcomes

Impact of Intervention
12 mo Before/12 mo After

- Total Gross Charges: 48%
- Direct Expenses: 56%
- Operating Margin Improvement of $368,000

Change is Sustained Over Time

Policy Issues and Complex Care
Policy Issues

- HIPAA/42 CFR
- "Firing" Patients
- Home Bound status
- Criminalization of Mental Health
- Guardianship & Competency
- Care Coordination payment
- Felony Records

Process Improvements for Complex Patients

The Huddle
Process Improvements for Complex Patients

- Dementia with Behaviors Protocol
- Collaborative Partnerships with Psych CM Agencies & Dialysis Units
- Chronic Pain in the ED
- Chronic Pain in PCMH
- Cross Continuum Process for Stabilization of Complex Patients
- Community Partnerships for Alcoholics
- Complex Care Plans on the HIE

Promising Practices for Complex Care

On the Horizon

- Integration of Behavioral Health
- Housing First
- Community Intervention Teams
- Veterans & Mental Health Courts
- Psychiatric Advance Directives
- AIM Models
Questions?

For More Information

Lauran Hardin MSN, RN-BC CNL
Director Complex Care
Phone: 616-685-5253
hardinlj@mercyhealth.com
lauran@octoberday.com
Mercy Health
200 Jefferson SE
Grand Rapids MI  49505

References

The project was conducted as a Clinical QI initiative at Mercy Health and was not formally supervised by the Mercy Health Institutional Review Board for their patients.

48