Complex Care Transformation

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Conflict of Interest Disclosure

The presenter indicates:

- No conflict of interest, commercial support, sponsorship, or endorsement of products.

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- 2nd largest integrated health care system in Kent county with $450M annual net revenue
- Teaching hospital with 379 licensed beds – 248 acute care, 116 psychiatric, and 15 NICU
- Progressive leader in cancer care, neurosciences, orthopedics, kidney transplants, diabetes and endocrine care, and behavioral health serving residents of 15 counties
- Annually: 22,000+ inpatient admissions; 17,000+ surgeries; 75,000+ emergency visits; 25,000+ urgent care visits, 1M + outpatient visits
- Mercy Health Physician Partners – 350 Physicians - Patient Centered Medical Homes
- Unique Test Market for Innovation – Integrated Health Network, Psychiatric Patient Population, ESRD, Neuroscience, 5 Community Benefit Clinics

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

Where it All Began….

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

Middle Aged Woman

- Psychiatric Root Cause
- Care Providers across Multiple Systems
- Multiple Procedures and Encounters

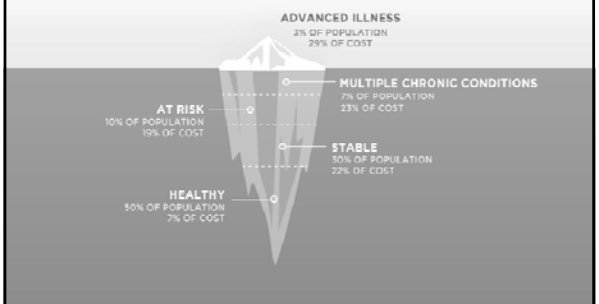
Outcome:

- 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



Source: Healthcare Risk Adjustment and Predictive Modeling by Ian Duncan

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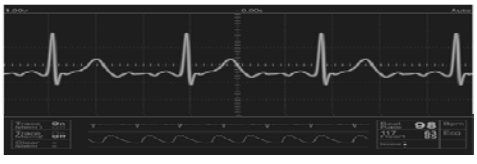
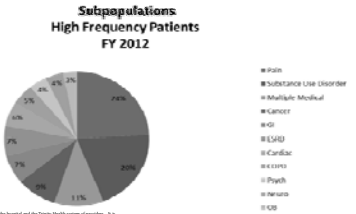
Measuring Risk and Complexity



- Claims Data
- DRG Data
- 30 Day Readmit Data
- Frequency Data

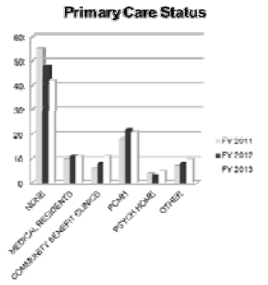
Business Intelligence - Population Analysis

≥10 ED Visits &/or ≥ 4 Admits in 12 months	Total Pts	Total Visits	ED Visits	UC Visits	IP Admits	OBS Admits
FY 2011	613	7,307	5,205	256	1,652	194
FY 2012	735	8,501	5,590	397	2,073	441
FY 2012 % Total Volume			10.5%	2%	10.1%	17.8%



Population Characteristics of High Frequency Patients

(≥10 ED Visits &/or ≥4 Inpatient Admissions in 12 months)



Primary Care Status

- 60% have a medical home

Insurance Status

- 30% Uninsured
- 40% are Dual Eligible

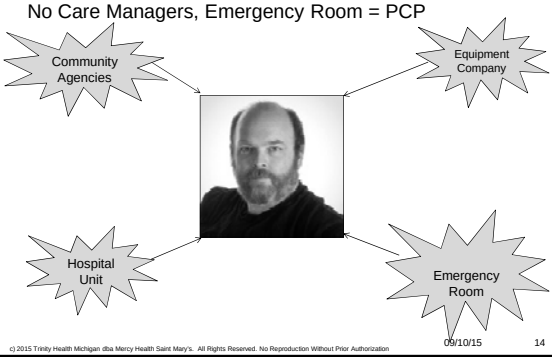
Age

- 70% are <60 yrs old

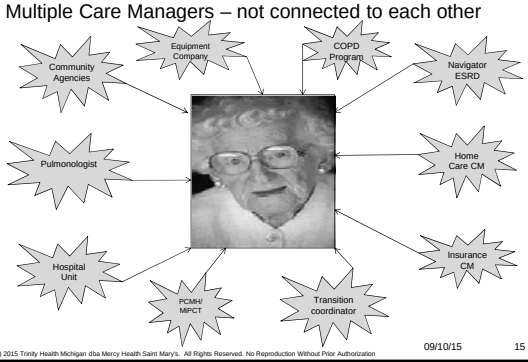
What Came First…..

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



Trauma Informed Care

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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
- (SAMHSA retrieved January 7, 2014 from http://www.samhsa.gov/co-occurring/topics/data/disorders.aspx)

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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

(CHCS, 2013; CMMS, 2013; Stamy & MacKinney, 2013,
The Commonwealth Fund retrieved January 12, 2015 from http://www.commonwealthfund.org/publications/issue-briefs/2014/aug/high-need-high-cost-patients)

Approach Comparison

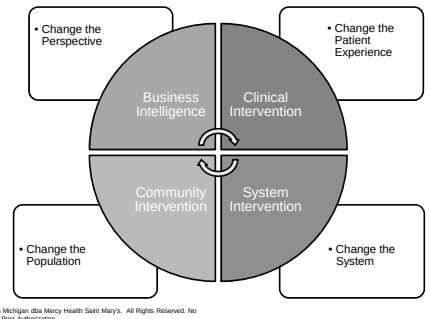
Complex Care Manager	Complex Care Center
• Patient must opt in	• No need to opt in
• Exclusion by Payer, Diagnosis, Location	• No exclusion criteria
• Patient Intervention	• Patient & Provider Intervention
• Change the Patient	• Change the System
• New FTEs/Team to manage patient	• Minimal new FTEs - Potentiates existing roles
• Program	• Process/Standard of Care
• Usually in one System	• Links Competing Systems
• Typically time-limited follow	• "Watch" for life
• 1 FTE :100 Patients	• 1 FTE: 500 Patients
	• Intervention occurs whether patient engages or not

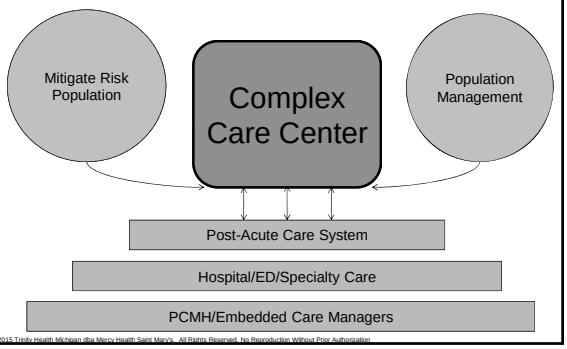
Hong CS, Siegel AL & Ferris T (2014) Caring for high-need high-cost patients: what makes for a successful care management program? Retrieved January 12, 2015 from http://www.commonwealthfund.org/publications/issue-briefs/2014/aug/high-need-high-cost-patients)

What is the Complex Care Center?

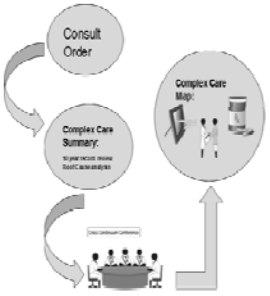
National System: Trinity Health (>80 Hospitals, >24 States)

Complex Care Center Core Services





Intervention Pathway

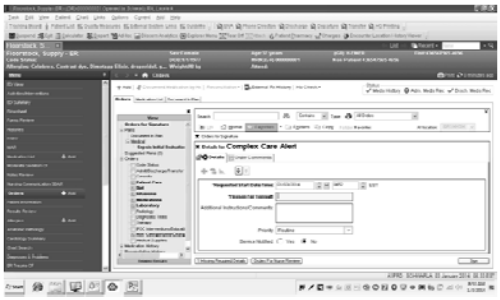


2.0 Clinical FTEs

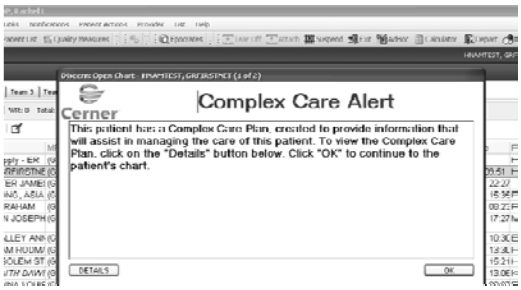
- Follow >1,000 Patients
- Add 10 to 20 New Patients/Week
- Add 5 to 10 Complex Care Maps/Week
- Case Find & Proactively Intervene with risk populations

(i.e. All Uninsured w/>5 Visits)

Complex Care Consult Order



Complex Care Alert



Patient-Provider-System-Community Intervention

(Aggregate Patient Story/Stock Photo)

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

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

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?

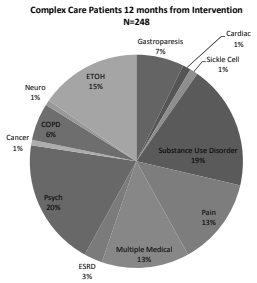
The project was undertaken as a Clinical QI initiative at Mercy Health and as such was not formally supervised by the Mercy Health Institutional Review Board per their policies.

One Patient's Experience

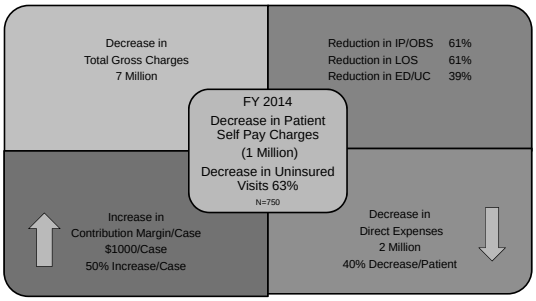
The impact of changing the system…

*Shared with Patient and Case Manager permission

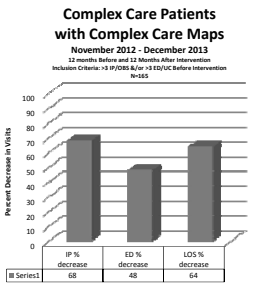
Complex Care Population Demographics N=248

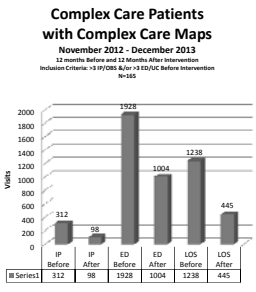


Results (N=210, 12 Months After Intervention)



Complex Care Map Outcomes





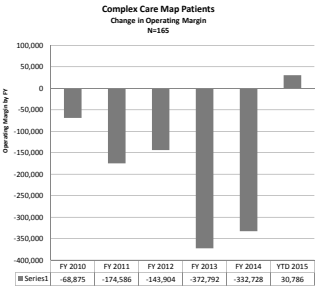
Complex Care Map Patients Financial Outcomes

Impact of Intervention
12 mo Before/12 mo After

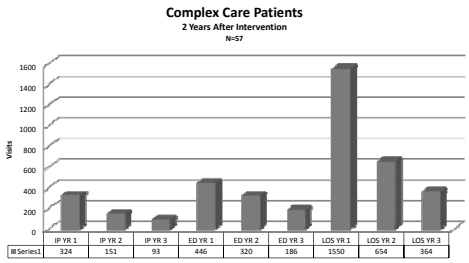
Total Gross Charges 48%

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

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