Changing the System for Complex Patients: Nursing Innovation in Action

March 28, 2017

Susan Reinhard, PhD, RN, FAAN

Victoria Sale, BSN

Lauran Hardin, MSN, RN, CNL

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The National Center for Complex Health and Social Needs

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Webinar Overview

Learn about an innovative nurse-led model of care that:

- Decreases overuse of health care by high-cost, high-need patients
- Improves patient care experience
- Enhances population health
- Lowers per-capita costs

Examine the role of nurses as leaders and facilitators of interdisciplinary care models

Susan C. Reinhard, PhD, RN, FAAN
Senior Vice President and Director AARP Public Policy Institute
Chief Strategist
Center to Champion Nursing in America

Speakers

Victoria Sale, BSN

Chief Learning Officer

Camden Coalition of Healthcare Providers

Lauran Hardin MSN, RN-BC, CNL

Senior Director

Cross Continuum Transformation

AARP Scholar

The National Center for Complex Care and Social Needs

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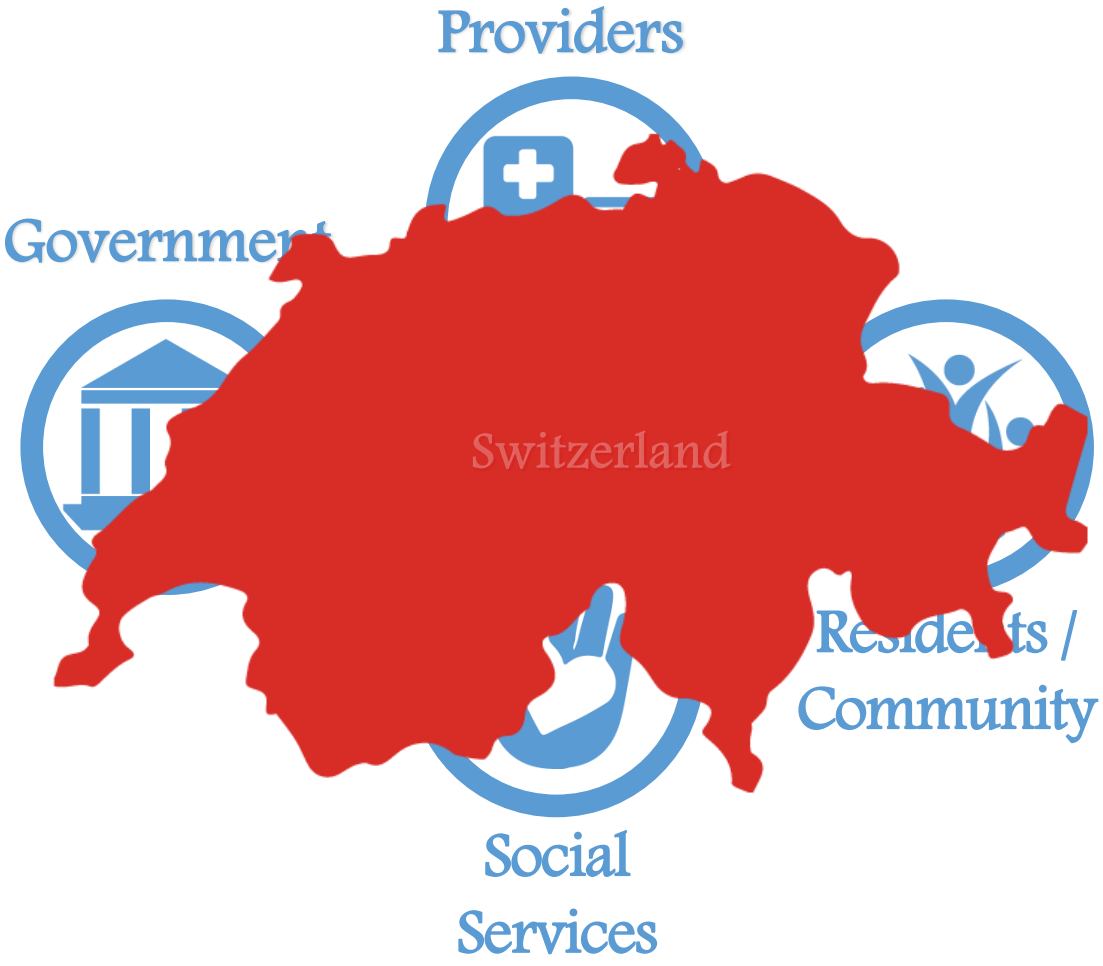
Providers
Switzerland
Social
Services

Bringing Together Friends…

Steph Nothelle,
MD

Corey Waller,
MD

Lauran Hardin,
MSN, RN-BC, CNL

Ken Coburn,
MD, DrPH, FACP

Shelly Virva,
LMSW, CSW

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…And Funders

- AARP
- Atlantic Philanthropies
- Robert Wood Johnson Foundation

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Purpose

- Convene and engage those in the field
- Disseminate knowledge and practice
- Support research and field development

Key Stakeholders

innovators, clinicians, consumers, families, educators, students, researchers, data scientists, government and policy advocates

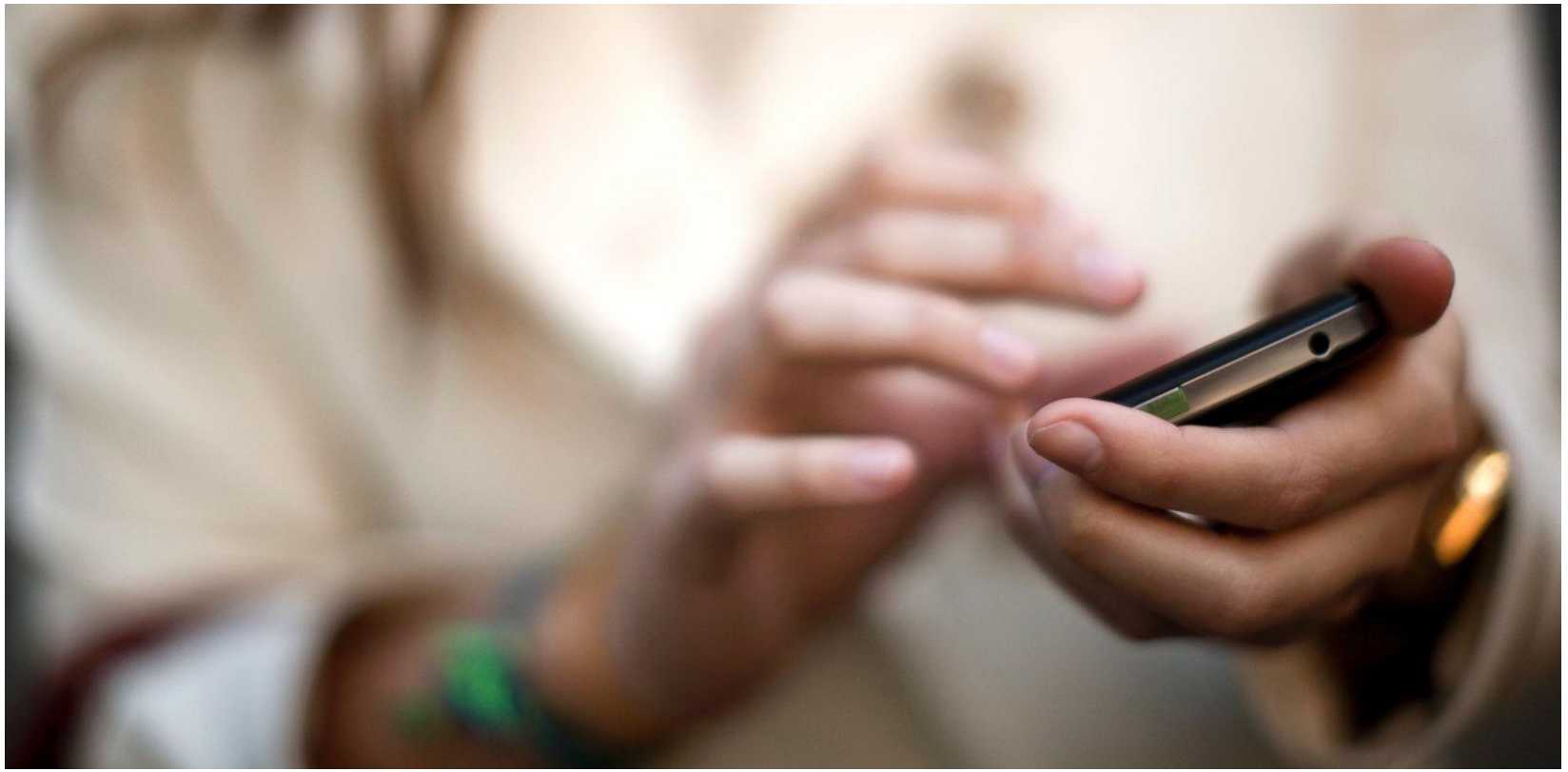
Key Initiatives

- Student Hotspotting
- Complex.care
- Technical Assistance to Health Systems
- Expanding Partnerships
- Consumer Engagement
- National Center Conference (Nov. 15-17, 2017)

Lauran Hardin MSN, RN-BC, CNL

- AARP Scholar in Residence
- Edge Runner Recognition, American Academy of Nursing (June 2015)
- National Clinical Nurse Leader Vanguard Award, American Association of Colleges of Nursing (January 2015)
- Former Director of Mercy Health System, Complex Care Center, serving over 1,500 high frequency/complex patients

It started with one patient and one phone call…



The First Patient Story

Andrew Rae. "The Tangle of Coordinated Care." New York Times. April 13, 2015.

Transformation

$1.6 million reduction in unreimbursed care

How much better care could we provide at lower costs for other complex patients?

Outcomes - 339 patients in 24 months

Hospital Utilization

Admissions Reduction	Emergency Visit Reduction	Outpatient Visit Reduction
195 ↓ 44%	1,498 ↓ 43%	199 ↓ 17%

Patient Economics

High Frequency Population Management

- Net Revenue Reduction 42% ↓
- Direct Expense Reduction 47% ↓
- Operating Margin Increase $632k ↑

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Outcomes - 339 patients in 24 months

Quality Measurements

Patient Housing	Primary Care Physician	Insured
14% ↑	15% ↑	16% ↑

Patient Utilization

High Frequency Population Management

- Length of Stay 41% ↓
- CAT Scans 62% ↓
- ED/Urgent Care Minutes 49% ↓

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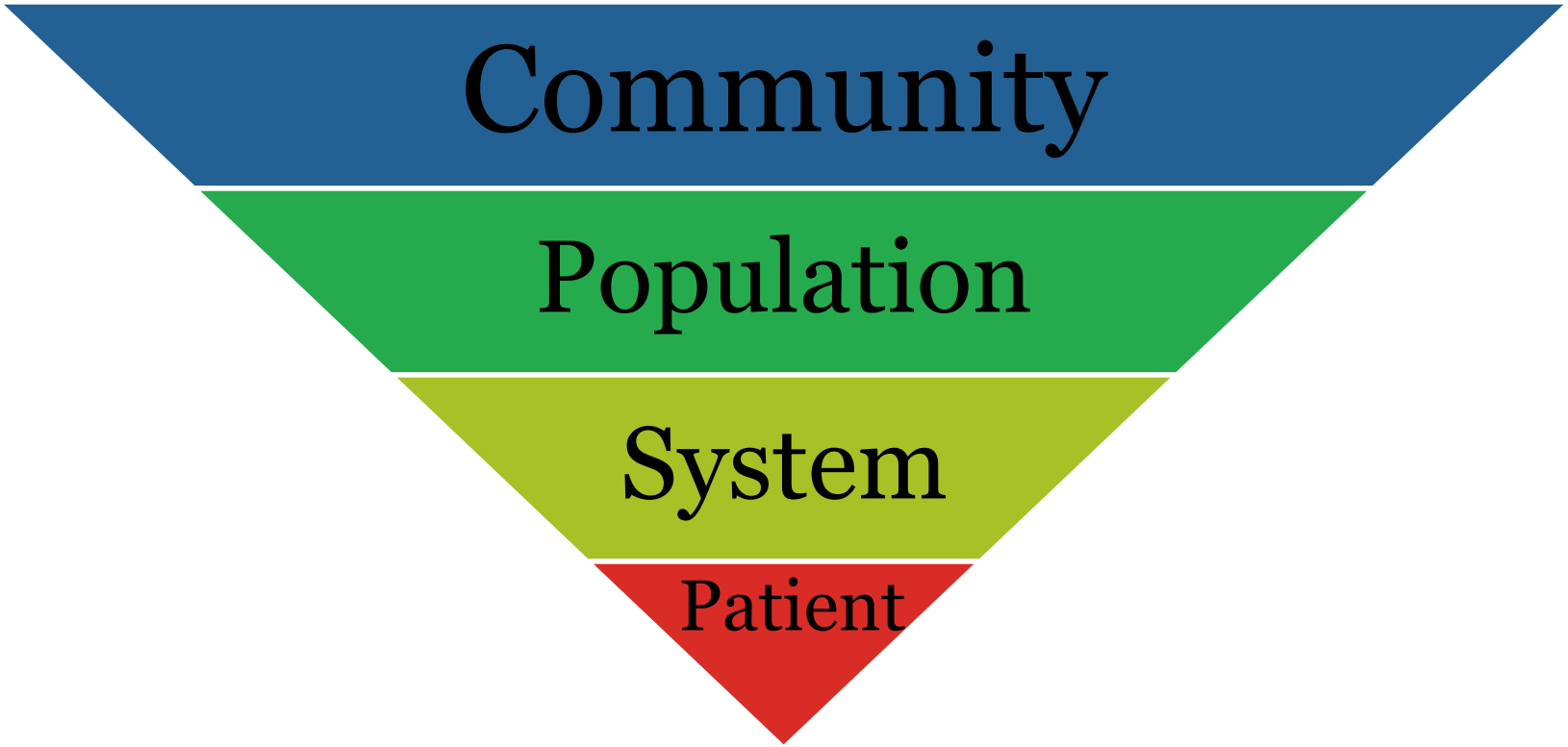
Innovation at all Scales



But what impact can you have as one nurse, with no resources or budget?

Root Cause Analysis

10 year review of the medical record

Case Conferencing

Carrying the patient story cross continuum

Complex Care Map©

Plan of care linked to EMR pop-up alert

This intervention works on a patient level, but can we take it to a system's scale?

Data Analysis

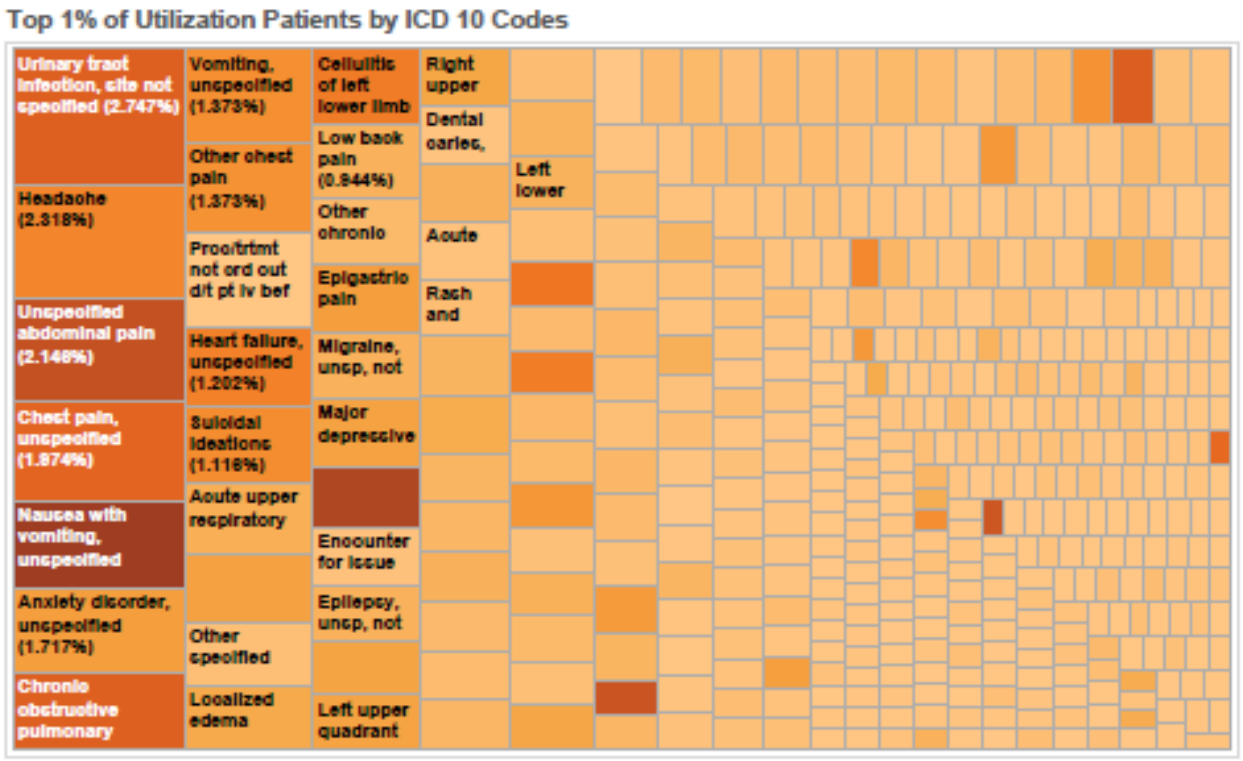
"Frequency as systems failure"

Utilization Matrix

<table>
<tr><td>ED Visits (2014)</td><td colspan="5">Inpatient Visits (2014)</td></tr>
<tr><td>0</td><td>0</td><td>1</td><td>2</td><td>3 to 4</td><td>5+</td></tr>
<tr><td>1
2 to 3</td><td colspan="2">41,752 (83%) patients
54,926 ED Visits (53%)
6,106 INP Visits (45%)
$69 million (44%) hospital receipts</td><td rowspan="3">1,279 (2%) patients
3,743 (4%) ED Visits
2,558 (19%) INP Visits
$25 million (16%) hospital receipts</td><td colspan="2" rowspan="3">886 (2%) patients
4,005 (4%) ED Visits
3,720 (28%) INP Visits
$40 million (26%) hospital receipts</td></tr>
<tr><td>4 to 5
6 to 7
8 to 9
10+</td><td>5,792 (11%) patients
34,076 (33%) ED Visits
0 INP Visits
$13 million (8%) hospital receipts</td><td>1,058 (2%) patients
7,175 (7%) ED Visits
1,058 (8%) INP Visits
$9 million (6%) hospital receipts</td></tr>
</table>

Policy & Process Improvements

Learning from the few to make gains for the many



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What if patient population needs are greater than what one hospital system or multiple systems can offer?

Community Collaborative

Solving complex problems with shared resources

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Summary

And all this began with one nurse collaborating with existing resources to improve patient outcomes.

What Can Nurses Do?

Publications

- Hardin, L., Kilian, A., Muller, L., Callison, K., & Olgren, M. (2016). Cross-Continuum Tool Is Associated with Reduced Utilization and Cost for Frequent High-Need Users. *The Western Journal of Emergency Medicine*, *18*(2), 189–200. doi:10.5811/westjem.2016.11.31916

- Hardin, L., Kilian, A., & Olgren, M. (2016). Perspectives on Root Causes of High Utilization that Extend Beyond the Patient. *Population Health Management*. doi:10.1089/pop.2016.0088

- Hardin, L. (2016). Restoring Dignity for Vulnerable Populations: Changing the System for Complex Patients. *Health Progress, January-February*, 28-32.

Thank You

A Conversation with Lauran

Susan C. Reinhard, PhD, RN, FAAN
Senior Vice President and Director AARP Public Policy Institute
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Questions or Comments?

Press *1 on your telephone key pad to ask a question

OR

Use the “chat” feature to send “everyone” a question.

Additional Resources

- The National Center for Complex Health and Social Needs Newsletter Sign-Up
- Campaign for Action Newsletter sign up
- Campaign for Action Resources