

FUTURE OF NURSING™

Campaign for Action

AT THE CENTER TO CHAMPION NURSING IN AMERICA



Changing the System for Complex Patients:

Nursing Innovation in Action

National Center for Complex Health and Social Needs

Webinar Summary

March 28, 2017

Presenters:

Susan C. Reinhard, PhD, RN, FAAN

Senior Vice President and Director AARP Public Policy Institute, Chief Strategist, Center to Champion Nursing in America

Victoria Sale, BSN, Chief Learning Officer, Camden Coalition of Healthcare Provider

Lauran Hardin MSN, RN-BC, CNL Senior Director, Cross Continuum Transformation, AARP

In this webinar, participants will 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

Also the presenters will examine the role of nurses as leaders and facilitators of interdisciplinary care models.

Bending the cost curve and improving quality for patients who need complex care is a focus of national attention. Today, we'll learn to learn about an innovative model of care and social services that is well-respected and is gaining traction. The model, originating from the Camden Coalition of Healthcare Providers and now expanding

Across the country, there is a movement to advance the field of nursing so that all Americans have access to high quality, patient-centered care in a health care system where nurses contribute as essential partners in achieving success. This national level [Future of Nursing: Campaign for Action](#) is a result of the Institute of Medicine's landmark 2010 report on the [Future of Nursing: Leading Change, Advancing Health](#).

The *Campaign for Action's* field-based teams, the [Action Coalitions](#) (ACs), are leading this movement and are equipping themselves with knowledge gained from technical assistance provided by the Center to Champion Nursing in America (CCNA), a joint initiative of AARP, the AARP Foundation, and the Robert Wood Johnson Foundation. Such technical assistance comes in the form of webinars, face to face interactions, and other facilitated engagements with public policy leaders, content experts, consultants, and Action Coalition peers across the country.

to the National Center for Complex Health & Social Needs, is inter-professional and effectively positions nurses as leaders

Attendees will:

Hear how nurse leader, Lauran Hardin, senior director of Cross-Continuum Transformation at the National Center for Complex Health and Social Needs, and her team used population analysis, interprofessional case conferencing, and process improvements to decrease overuse of health care by high-cost, high-need patients. And,

Discuss how interventions of complex care resource centers achieve the triple aim outcomes of improving the patient's care experience, enhancing the health of populations, and lowering per-capita costs, and Examine the role of nurses as leaders and facilitators of interdisciplinary care models.

AARP is excited to be working with the Camden Coalition as a founding partner of the National Center for Complex Care and Social Needs. Over the past ten years, the Camden Coalition has been a leader in using a holistic, person-centered approach to address communities' health challenges and the social determinants affecting health outcomes. At AARP, we've begun to examine these approaches as well.

The Future of Nursing: *Campaign for Action*, which is run out of the Center to Champion Nursing in America at the AARP Public Policy Institute, has been working to integrate the Robert Wood Johnson Foundation's Culture of Health framework into their work. AARP has also recently launched a Healthy Living Initiative. The National Center for Complex Care and Social Needs is an opportunity for AARP to partner with the Camden Coalition to gain information and data on social determinants of health, workforce, housing, and Medicaid expansion in the communities that need support the most.

AARP is also funding a "scholar-in-residence" program at the Center, which establishes thought leaders and experts on site in communities across the country to direct services aimed specifically at the 50-plus population and their unique needs. Lauran is one of the four scholars who we are funding. In addition to Lauran, we have another nurse and two physicians. We look forward to publishing on the success of the program and, most importantly, convening other leaders to further galvanize the movement toward improved health outcomes.

Today's webinar is being funded and will be posted on our website www.campaignforaction.org/webinars



Victoria Sale is one of the original fifteen members of the Camden Coalition staff and works closely with Jeff Brenner in sharing his philosophy and strategic lens for bending the healthcare cost curve. She has spoken in both large and small forums on both the business and clinical operations of "Healthcare Hotspotting".

A nurse by training, Victoria was instrumental in developing the current care management intervention the Coalition's care teams employ to engage the most complex and vulnerable patients in the city of Camden. Victoria continues to serve as a leader of the Coalition, spreading its mission and vision through national technical assistance as well as growing the Camden Coalition's internal operations to support the one hundred full time staff. Victoria Sale is one of the original fifteen members of the Camden Coalition staff and works closely with Jeff Brenner in sharing his philosophy and strategic lens for bending the healthcare cost curve. She has spoken in both large and small forums on both the business and clinical operations of "Healthcare Hotspotting".

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Lauran Hardin recently joined the Camden Coalition and the National Center for Complex Health and Social Needs as the Senior Director of Cross Continuum Transformation. In this role she continues her past experience providing consulting, co-design and coaching in complex care transformation. Her special interests include the impact of trauma/loss on high frequency healthcare access and the economic potential of stabilizing complex patients through retraining/redesigning existing resources in the healthcare system.

Hardin was previously the Director of a Regional Complex Care Center serving hospitals, multiple providers and more than 1,500 high frequency/complex patients in the Mercy Health System. The Center's model of complex care has resulted in better patient navigation and outcomes, including decreased emergency room visits, hospitalizations, and costs for diverse vulnerable populations. She received an Innovation Grant from Trinity Health, one of the largest multi-institutional Catholic health care delivery systems in the nation, and implemented aspects

of the care model changing the system of care around complex patients in more than twenty Trinity Health ministries across six states.

National Center for Complex Health and Social Needs includes the:



- AARP
- Atlantic Philanthropies
- Robert Wood Johnson Foundation

The goals are to:

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

key stakeholders who are 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)



- AARP Scholar in Residence
- Edge Runner Recognition, American Academy of Nursing (June 2015)
- Former Director of Mercy Health System, Complex Care Center, serving over 1,500 high frequency/complex patients

Bringing Together Friends...



Steph Nothelle,
MD



Corey Waller,
MD



Ken Coburn,
MD, DrPH, FACP



Shelly Virva,
LMSW, CSW

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- Disseminate knowledge and practice
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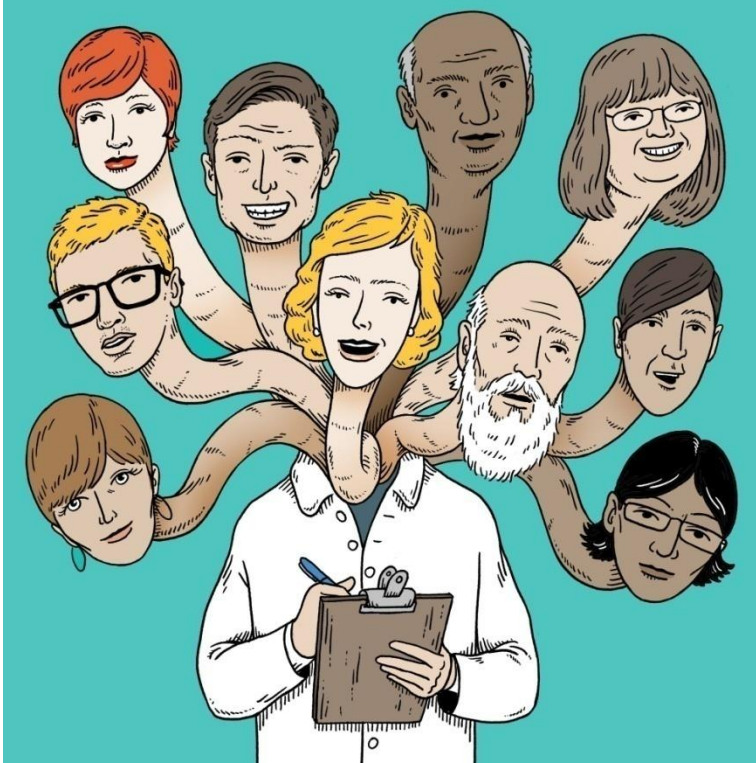
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- National Clinical Nurse Leader Vanguard Award, American Association of Colleges of Nursing (January 2015)
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IAs Hadin says it started with one patient and one phone call...





Transformation

The First Patient Story

Conflict between care providers and mixed messages.

Middle Aged Woman:

- Complex issues in care
- Conflict between care providers
- Care providers across multiple systems

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
- Net Revenue Reduction 42%
- Direct Expense Reduction 47%

- Operating Margin Increase \$632k

Patient Economics

High

Frequency

Population

Management

Admissions Reduction

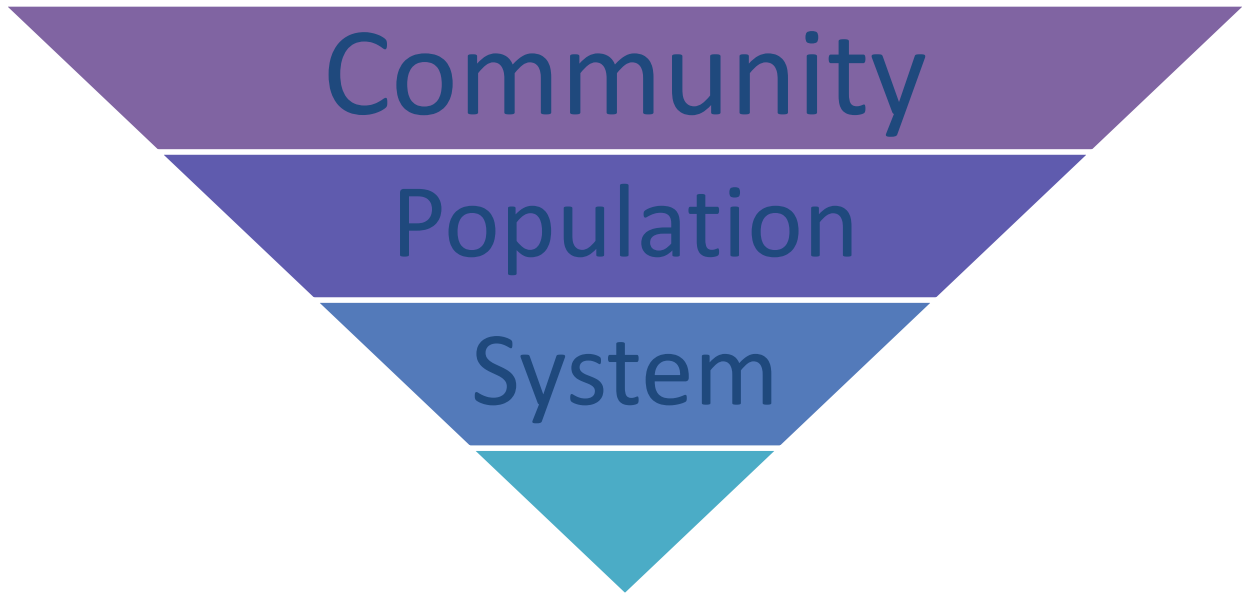
195
44%

Emergency Visit Reduction

1,498
43%

Outpatient Visit Reduction

199
17%



Innovation at all Scales

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



- Discover patient story, which has been lost/buried as different disciplines in notes, through examining 10 years of the medical record for medical, psychiatric, social, and system information.

- Completed by Master's level nurse.
 - Has background in all pertinent content areas, process utilizes nursing skill to see among and between different aspects of a person.
- Result: Deep holistic understanding of patient, knowledge of who to bring together – cross-continuum – to problem solve regarding the patient
- **Root Cause Analysis**
10 year review of the medical record Bring together, even those in different agencies, who work with the patient to determine next steps.
- Nurse facilitates: Extension of role on the hospital floor / applying the skill set in a different context.
- Outcomes:
 - Determine the one person who has the strongest relationship with the patient to be the main point person for the intervention so questions/concerns regarding patient care is streamlined and organized.
 - Capitalize on resource that is already in the room. Not reinventing the wheel.
 - (next slide) Complex Care Maps

Case Conferencing

Carrying the patient story cross continuum



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

- Look at patient frequency because frequency is a sign of system failure and inefficiency. No one should be coming to the emergency department multiple times during the year.
- Often find patterns in the types of patients who are frequent users. These can be organized into sub-populations.
- Knowing common sub-populations, you can design targeted process improvements to better their care while lowering cost.
- The data analysis allows you to make the business case to determine for which types of patients, or subpopulations, will you get the biggest return on investing in a better process or policy.



Data Analysis

“Frequency as systems failure”

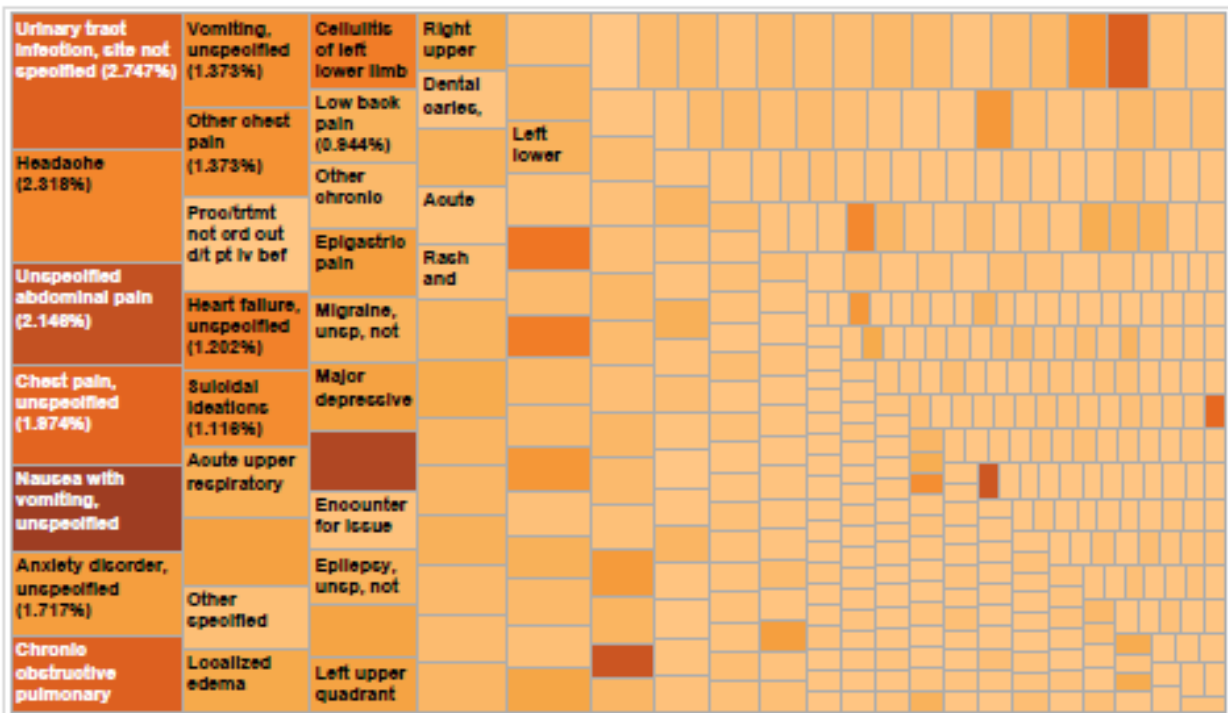
Utilization Matrix

Policy & Process Improvements

Learning from the few to make gains for the many

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

Top 1% of Utilization Patients by ICD 10 Codes



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



- To improve the health of populations often requires partnerships outside the health system; it requires a larger community scale.
- A community collaborative involves partners from across sectors within the community coming together to problem solve how to meet the needs of certain populations.





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- For example... (Perhaps the challenge of alcohol dependence?) I've just shown you the organic growth of the model. The pieces together include:
- Data analysis to find the frequent hospital utilizers the system fails.
- We analyze 10 years of these individuals medical charts, discovering previously unidentified root causes of their frequent utilization.
- We then bring together a cross continuum team to case conference about the individuals to create a shared plan of care, taking the form of a complex care map.
- And from the individuals we discuss, we start to see patterns about how to improve processes and policies to benefit larger groups of patients.

- And for these larger groups, we often reach out to the greater community to work together to problem solve solutions and share resources.

And all this began with one nurse.

- collaborating with existing resources
- to improve patient outcomes
- Model, then, embodies the spirit of nursing's founders like Florence Nightingale and Clara Barton, who saw a need, understood vulnerable populations, saw people holistically and brought others together to improve people's quality of life.



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- See frequency as a quality and safety opportunity.
- Attend to the whole person story. (ex/just because someone has an address in the record, doesn't mean they have housing)
- Notice the impact of trauma
- Utilize the strength of inter-professional collaboration to make a difference. Acknowledge your skill set as a facilitator.
- See the system as your patient
- See the community as your partner

The IOM's recommendations include: the need for more advanced education of registered nurses; nurses leading innovations in health care and being appointed to decision making bodies; all nurses practicing to the full extent of their education and training; a more diverse nursing workforce and faculty; and more inter-professional collaboration among nurses, physicians, and other members of the health care team in the educational and clinical environments.

For more information from the Center to Champion Nursing in America about this webinar, technical assistance or other questions related to the Future of Nursing, Campaign for Action contact Madeline O'Brien at mobrien@aarp.org

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