The National Center
for Complex Health and Social Needs

Changing the System for Complex Patients: Nursing Innovation in Action

Question & Answer Session

1. **How did they increase the patient housing?**

We found that there were many agencies already working on housing in the community. For each individual patient we would partner with the existing agencies in a shared case conference to address housing. We did not have a strong housing first (housing availability regardless of history of felony record or current substance abuse) program in our community. For some patients, housing through the existing agencies was not an option. We then used the data around the business case (cost of frequent healthcare access versus cost of an investment in a different housing option) to advocate for creative solutions.

2. **What is the name of this type of table shown on slide 27?**

The first table is called a Utilization Matrix. The Matrix was developed by Aaron Truchil at the Camden Coalition. It shows all patients who accessed hospitals in one year in the Camden Coalition HIE (multiple hospitals). It indicates the visits and charges for patients by their frequency of access.

The second table is called a Tableau Tree Map and indicates the number of patients accessing the hospital in one year with a certain ICD 10. The color of the boxes indicates the intensity of the charges for that ICD 10. http://onlinehelp.tableau.com/current/pro/desktop/en-us/buildexamples_treemap.html

3. **Great presentation and model. How have you or others engaged public health and public health programs into your work?**

Public health is an important partner and there are two aspects of integration in the model. If public health was involved with a specific patient, they were invited to the case conference to develop the shared plan of care. In our community there were also several collaborative initiatives for public health issues (mental health, substance abuse) – often led by Public Health. As part of the policy and process improvements, we participated in these initiatives and used the data and individual patient intervention to contribute to solutions for the community.

4. **We are trying to implement behavioral health and primary care integration models in our clinics. We are having trouble with capturing data to show improvements/challenges. Are there any resources out there, or any on pulling data from EHRs such as EPIC?**

Defining the business case for your initiative can be very helpful to support effective data mining. You can pull data from EPIC and also from hospital cost accounting systems. If you are working with a privately insured population you can also pull data from payers. If you are working with patients in an ACO or other risk based payment arrangement – you can get data from the leaders of the ACO. I would answer these questions to define the business case:

Which of the following cost/quality drivers does your intervention impact:

*   Reduction in ED visits
*   Reduction in Inpatient Admissions
*   Reduction in Psych unit admissions
*   Reduction in calls, no shows, or improved efficiency in Primary care visits
*   Reduction in Community Mental Health dollars spent on the population (case management, medications)
*   Patient measured quality of life improvement (evidence based scales or survey developed by your program to measure)

5. **Where can we find out more about the National Center conference taking place November 15-17 in LA?**

On the National Center for Complex Health and Social Needs conference.
http://www.centering.care

6. **Was there a strong collaboration with Social Workers as well in this model in developing the Shared Plan of Care Complex Care map? And also Pharmacists?**

Definitely! Social Workers are part of the team that develops the Care Maps, part of the case conferencing and often consulted for support in resolving complex cases. When the program grew and I had a budget to work with, I had to decide if I would add Social Work positions to the team. I decided not to because most patients had a MSW as part of their cross continuum care team already and adding one from my team would displace an important trusting relationship that the patient had already established. The model could be implemented with Social Work as part of the team depending on the culture and resources in the environment. Pharmacists are a critical part of the team. The article that is coming out in JONA will describe how we integrated Pharmacists in the model and what we hoped to do in the future.

7. **What resources can you recommend to learn more and be comfortable with the business case?**

I learned a lot from the field of Palliative Care regarding building the business case.

https://www.capc.org/search/?q=business+case

We are working on several resources from the National Center that will be specific to building the business case for complex populations. You can sign up for the mailing list here to learn more as the materials are added to the website.

8. Is there a template for your "complex care map"?

Detailed information about the Care Maps can be found in this article:

- 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