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
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
The National Center for Complex Health and Social Needs

Victoria Sale BSN
Chief Learning Officer
Bringing Together Friends...

Steph Nothelle, MD

Corey Waller, MD

Ken Coburn, MD, DrPH, FACP

Shelly Virva, LMSW, CSW

Lauran Hardin, MSN, RN-BC, CNL
...And Funders

- AARP
- Atlantic Philanthropies
- Robert Wood Johnson Foundation
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)
Lauren 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

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

<table>
<thead>
<tr>
<th>Hospital Utilization</th>
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<tbody>
<tr>
<td>Admissions Reduction</td>
<td>195</td>
<td>1,498</td>
<td>199</td>
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<tr>
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<td>44%</td>
<td>43%</td>
<td>17%</td>
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<table>
<thead>
<tr>
<th>Patient Economics</th>
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<tbody>
<tr>
<td>High Frequency</td>
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<tr>
<td>Population Management</td>
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<tr>
<td>Net Revenue Reduction</td>
<td>42%</td>
<td></td>
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<tr>
<td>Direct Expense</td>
<td>47%</td>
<td></td>
<td></td>
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<tr>
<td>Operating Margin</td>
<td>$632k</td>
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# Outcomes - 339 patients in 24 months

## Quality Measurements

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<tr>
<th></th>
<th>Patient Housing</th>
<th>Primary Care Physician</th>
<th>Insured</th>
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<tbody>
<tr>
<td><strong>Percent</strong></td>
<td>14%</td>
<td>15%</td>
<td>16%</td>
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## Patient Utilization

- **High Frequency Population Management**
  - Length of Stay 41%
  - CAT Scans 62%
  - ED/Urgent Care Minutes 49%
Innovation at all Scales

- Community
- Population
- System
- Patient
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

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<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3 to 4</td>
<td>5+</td>
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<tr>
<td>0</td>
<td>0</td>
<td>41,752 (83%) patients</td>
<td>54,926 ED Visits (53%)</td>
<td>6,106 INP Visits (45%)</td>
<td>$69 million (44%) hospital receipts</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>1,279 (2%) patients</td>
<td>3,743 (4%) ED Visits</td>
<td>2,558 (19%) INP Visits</td>
<td>$25 million (16%) hospital receipts</td>
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<tr>
<td>2 to 3</td>
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<td>886 (2%) patients</td>
<td>4,005 (4%) ED Visits</td>
<td>3,720 (28%) INP Visits</td>
<td>$40 million (26%) hospital receipts</td>
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<tr>
<td>4 to 5</td>
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<td>5,792 (11%) patients</td>
<td>34,076 (33%) ED Visits</td>
<td>0 INP Visits</td>
<td>$13 million (8%) hospital receipts</td>
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<td>6 to 7</td>
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<td>1,058 (2%) patients</td>
<td>7,175 (7%) ED Visits</td>
<td>1,058 (8%) INP Visits</td>
<td>$9 million (6%) hospital receipts</td>
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<td>8 to 9</td>
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<td>10+</td>
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Policy & Process Improvements
Learning from the few to make gains for the many
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
Summary
And all this began with one nurse collaborating with existing resources to improve patient outcomes.
What Can Nurses Do?
Publications


Thank You
A Conversation with Lauran

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The National Center for Complex Care and Social Needs
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](#)