Restoring Dignity for Vulnerable Populations

Changing the System for Complex Patients

By LAURAN HARDIN, MSN, RN-BC, CNL

Everything changed the day I met "David." His case manager called to ask if I would attend a meeting to discuss his care. When I arrived, the room was full; there were more than 20 health care providers representing three hospital systems and multiple community agencies. David — not his real name, but he and his case manager agreed to share details of his story — had accessed all of them in the previous two years. David is under 30 years old and has no chronic medical diseases, but he has an array of complex social issues and heartbreaking life circumstances that led to a high degree of vulnerability.

He started the meeting by reading a letter, "Why I Went to the Emergency Room," in which he identified:

Loneliness and desperation.

Attention — "Felt like I was safe and in a safe place."

Homelessness — "People on the street know to use the 'crazy card' by using the word suicide. I knew people would listen and admit me to the hospital."

"I don't have anyone to tell me to do the right thing and to actually care for me."

He read on, describing the emergency room as a safe place that was always open and that served a very important purpose in his life. "The ER provided comfort like going to Grandma's house where everything is good and will be OK. I didn't know what the right choice to make was and where I should go. I knew you would be working to make that choice for me," he read.

Everything coalesced in that moment, for me.

In all of our busyness and focus on expertise in treating medical trauma and complex disease, we may be missing a very important point. The emergency room also is a social trauma center. Every time someone accesses the health care system, it's an opportunity to attend to more than the medical complexity of the situation. David's letter changed everything about how I approach my work with complex patients.

THE COMPLEX CARE CENTER

As a nurse at Mercy Health Saint Mary's in Grand Rapids, Michigan, a member of Trinity Health, I lead a program dedicated to serving complex patients.[1] The center provides four key services: population analysis of high frequency patients, clinical intervention, process improvements and community partnerships to improve care.

When I began the work in 2012, I was surprised by the first population analysis. For patients with frequent access to the health care system — defined as more than nine visits to the emergency department and/or more than three inpatient admissions in one year — more than 70 percent were under 60 years of age.

I had expected to find a population of elderly
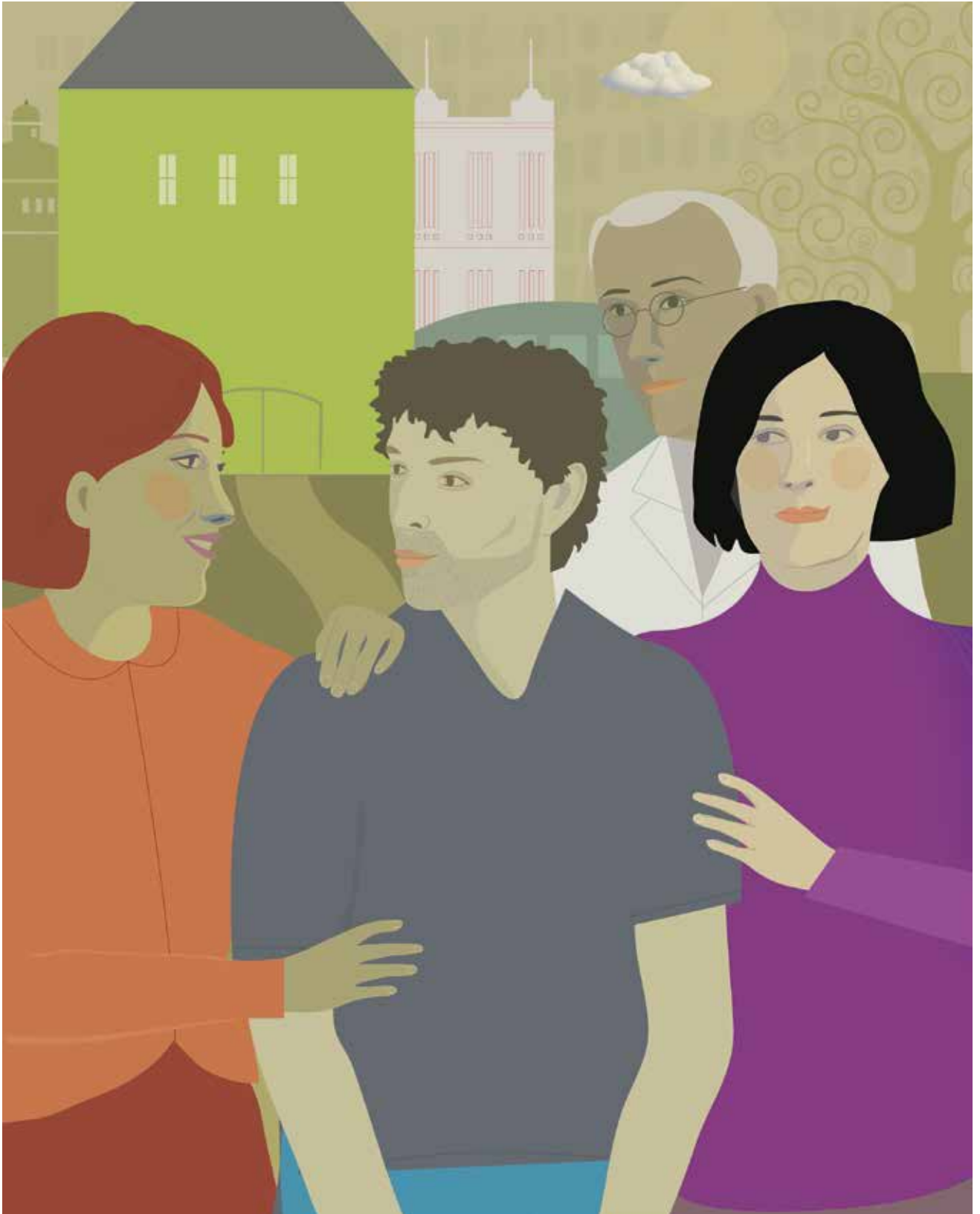
people with multiple chronic diseases. Instead, I found a population that was previously invisible to me — people mostly under age 50, with complex psychosocial issues.

HONORING THE PATIENT STORY

We now have served more than 1,000 patients, and each one has taught us about the importance of looking deeper than medical diagnoses. The first step of our clinical intervention is a 10-year analysis of the patient's medical record plus reviewing it for root causes of instability. Persistent themes can include a prevalence of untreated mental health issues, substance abuse, social issues and history of or current trauma. Those kinds of themes form a constellation that requires deeper intervention than just addressing medical disease.

What we also found in each of these complex cases was the absence of a holistic, team-based approach to care. The result was no management of the psychosocial aspects of the individuals' health care that were at the root of their medical treatment challenges.

We are missing important infrastructure to integrate this view into our daily care. By looking deeper in the record, we have seen how people have shared important aspects of their stories,

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details that have gotten lost in subsequent visits. We don't consistently assess important drivers of instability like housing status, transportation, cross-continuum providers or important trauma, grief and loss issues that affect stability just as much, if not more, than medical treatment or prescriptions.

A recent policy brief from the American Academy of Nursing calls for integration of social and behavioral determinants of health in the electronic health record. Cheryl Sullivan, CEO of the organization, stated, "There is strong evidence that social and behavioral factors influence health; however, they may not be addressed

in clinical care for shared decision-making. It is imperative that all stakeholders in health care collaborate to include this information in electronic records, including [electronic health record] vendors, health systems, providers and funders."[2]

At Mercy Health Saint Mary's, we are trying to close the gap by integrating this information in our intervention and approach from the complex care center.

INTEGRATE THE PATIENT STORY

One of the most effective interventions for David was to translate his story and helpful details into the medical record in such a way that providers, regardless of discipline or time of day, could access key information about his care. Michael Olgren, MD, former emergency medical director of Mercy Health Saint Mary's, championed development of an alert and a tool in the medical record to allow immediate and easy access to a comprehensive view of the patient's story.

The complex care center leads an interprofessional committee that translates the 10-year record review into a concise, one-page analysis. Called a complex care map, it is part of the medical record, and its presence is marked by a pop-up alert. When a provider first opens the record and sees the alert, one click takes him or her directly to the complex care map that includes medical, psychiatric and social root causes driving the case's complexity. It identifies the patient's cross-continuum team and evidence-based recommendations for care.

The map highlights strengths in the patient story to help providers see beyond prejudices — like the label "frequent flyer" given to people who repeatedly use the emergency department. Social issues may be what's really behind someone's frequent visits to the ER or lack of follow-through on medical plans of care. The map refers to important notes in the medical record in order to direct busy providers to parts of the patient story that help them to be more effective during the clinical encounter.

The complex care map changed things for David. Once a map was placed in his record, "I knew right away. Everything was different. It was tailored to me," he said. "There was compassion behind it. They were more organized. They called my case manager from the ED. They

stopped prescribing narcotics. It helped me get to treatment."

PARTNERING TO CHANGE THE SYSTEM

Changing complex issues requires us to step out of our silos and look at things from the patient's perspective. As our population with intervention grew, and we continued to identify the cross-continuum team for patients, we identified trends and connections with agencies and services. Many were not part of our health care system, and several were our competitors. But to really affect population health, we needed to build community partnerships that transcended competition.

We signed a business associates agreement with David's case management agency so we could identify the population of shared patients accessing our health care system, and we developed a process to proactively collaborate to improve patient outcomes. By seeing things from the patient's perspective, we were able to create new connections that honor the person's established relationships, rather than displacing them in a siloed approach. We have found that consistency in care and reduction of fragmentation across systems have been critical elements to restore dignity to vulnerable populations in complex situations.

Here's how David described it:

"What helps: Compassion and relating. Positive feedback and encouragement — This is really important. The lady who actually followed through with her promise."

COLLABORATING WITH THE COMMUNITY

Identifying trends in the population with intervention helped us to see new opportunities to improve care. We found many people who were frequently accessing the health care system because their established providers and the emergency department were over-prescribing narcotics. To have an impact on this practice, we needed to collaborate across the community.

By forming a group with representation from hospitals, mental health agencies and others interested in improving complex care, we were able to create and share a change in practice to affect prescribing from the emergency room. We developed a teaching tool to educate patients about

safe practice with narcotics, offer resources for chronic pain management and explain that there would be a record check with the state prescription monitoring system to facilitate safe and coordinated prescribing practices.

The tool was just implemented, and there is no outcome data yet from the intervention, but our

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collaborative group has begun to look at how we could come together in other areas to affect population health.

THE IMPACT OF CHANGING THE SYSTEM

A year after implementation, the first population of 165 patients with complex care maps had a 68 percent reduction in inpatient admissions, a 48 percent reduction in emergency department visits and a 64 percent reduction in length-of-stay days.

Total gross charges for this population, 12 months after the map, decreased by 48 percent, and direct expenses decreased by 56 percent. Of note: Many of the patients in the group had established a pattern of frequency — more than three emergency department visits and/or more than three inpatient admissions in 12 months — for multiple years prior to intervention.

Although the results are promising, it is challenging to interpret the numbers in the context of such a diverse population, with so many providers and other factors affecting their lives and outcomes. However, we see the impact directly in the patient story.

For example, David hasn't been back in the ED for more than a year. We didn't need to hire an army of care managers to achieve this. We did have to change how the entire team, both within

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the health system and within the community, behaved, and we needed to change how our system responded to the message he was trying to give us.

Doing the right thing saved significant dollars to the health care system. Most importantly, collaborative efforts across systems contributed to a change in a young man's life that could have an effect for many years to come.

I think the most important outcome is how David described the restoration of his dignity in the health care system. He told a story about a health care provider sitting with him in the ED and asking him about his children and what was important to him. She shared her situation with her own son, and she wanted to know the "why" behind David's story. He described himself as being seen as a person, with an important story of his own.

That's real value-based care.

LAURAN HARDIN is director of the complex care center at Mercy Health Saint Mary's in Grand Rapids, Michigan, and leads an innovation grant for Trinity Health to develop tools and processes for intervention with complex patients. She recently was awarded the National Clinical Nurse Leader Vanguard award from the American Association of Colleges of Nursing and the National Edge Runners award from the American Academy of Nursing.

NOTES

1. This project was undertaken as a Clinical Quality Improvement initiative at Mercy Health and as such was not formally supervised by the Mercy Health Institutional Review Board per its policies.
2. American Academy of Nursing, "American Academy of Nursing Calls for Collective Action to Include Social and Behavioral Determinants of Health in the Electronic Health Record," news release, Sept. 14, 2015. www.aan-net.org/index.php?option=com_content&view=article&id=889:american-academy-of-nursing-calls-for-collective-action-to-include-social-and-behavioral-determinants-of-health-in-the-electronic-health-record&catid=23:news&Itemid=133.

RESOURCES

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