MERCY HEALTH
SAINT MARY'S

The Power of the Patient's Story to Transform Health Care

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Interprofessional Value and the Patient Story…. Where it all Began

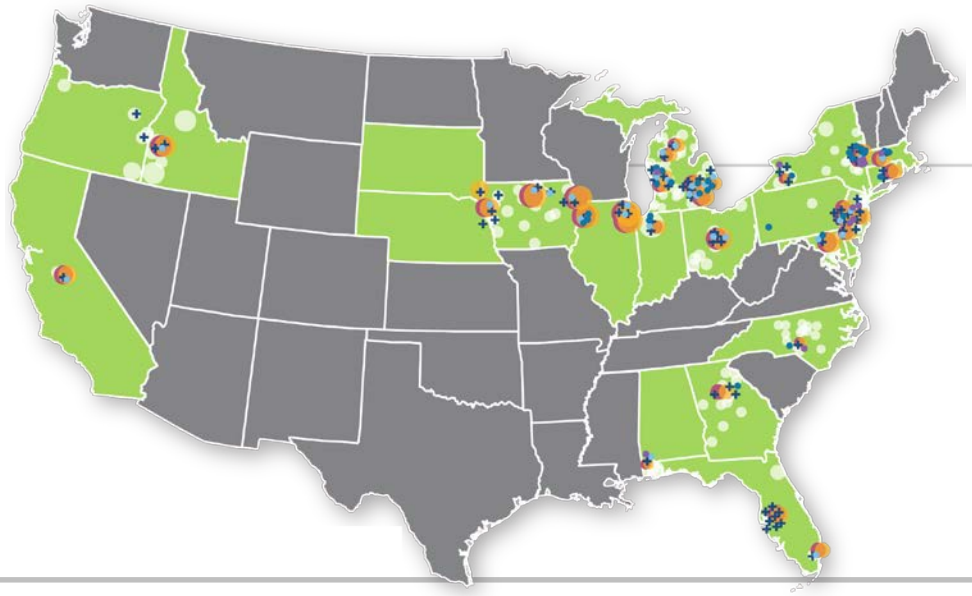
CPM: The Core Beliefs™

- Each person has the right to safe, individualized healthcare which promotes wholeness of body, mind and spirit.
- A healthy culture begins with each person and is enhanced by self-work, healthy relationships and system supports.
- Continuous learning, diverse thinking and evidence-based actions are essential to maintain and improve health.
- Partnerships are essential to plan, coordinate, integrate, deliver and evaluate healthcare across the continuum.
- Each person is accountable to communicate and integrate his/her contribution to healthcare.
- Quality exists where shared purpose, vision, values and healthy relationships are lived.

Trinity Health

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

MERCY HEALTH SAINT MARY'S



Our diversified network extends across the full continuum of care

- Hospital
- Home Care Agency
- Counties served by Home Care Agencies
- PACE Center
- Other Continuing Care Facility
- Employed Physicians
- Affiliated Physicians

- 86* Hospitals in 21 states
- 128 Long-term care, assisted, independent living and affordable housing communities
  - 44 Home Care Agencies
  - 14 PACE Centers
  - 70 Other Continuing Care Facilities
- Nearly 2.8 million home health/ hospice visits

- $13.6 billion in revenue
- Almost $900 million in community benefit ministry
- 89,000 full-time employees
- 3,300 employed physicians
- 22,890 affiliated physicians

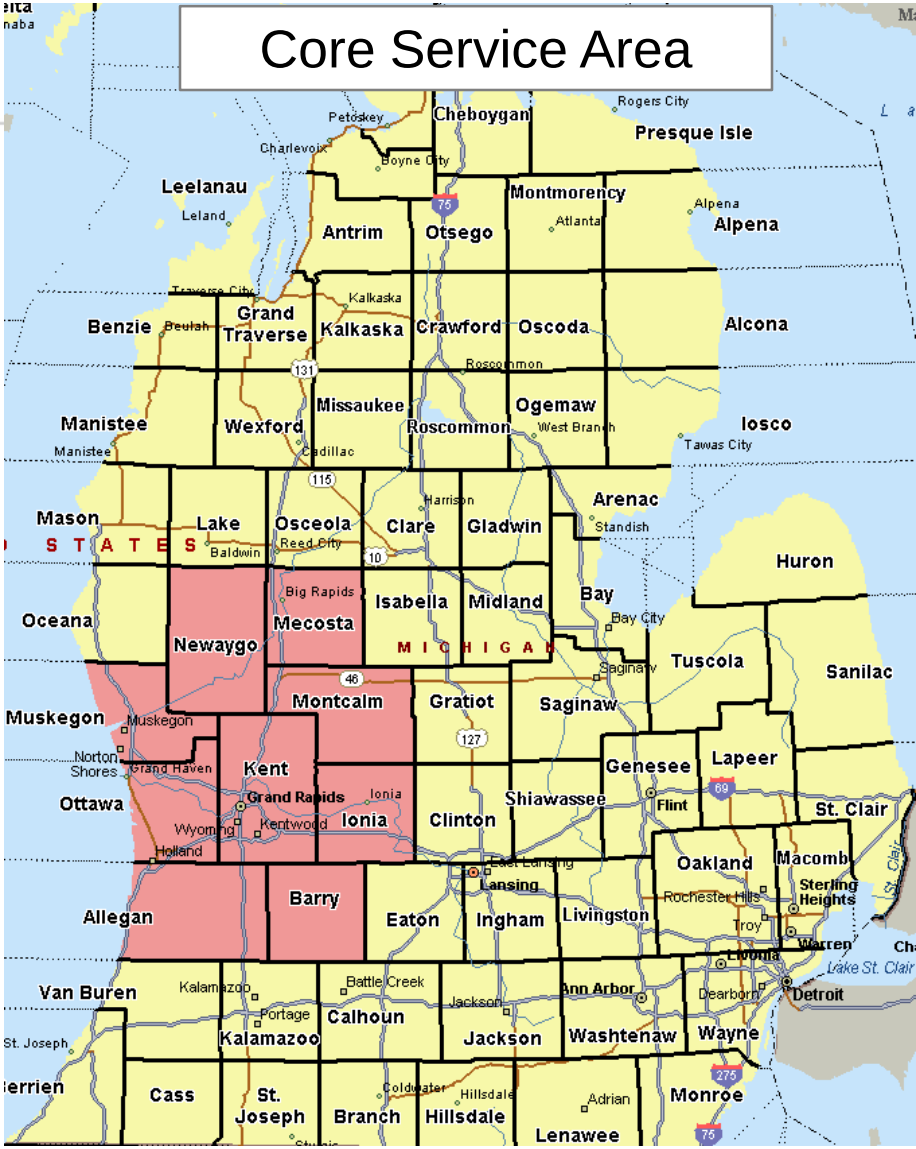
Mercy Health Saint Mary's Today

An integrated health care system in west Michigan:

- 2nd largest integrated health care system in Kent county with $450M annual net revenue
- Achieved Magnet® designation on May 15, 2013
- Top Hospitals for Leapfrog 2013 - 2015
- Teaching hospital - 371 beds with ~ 4,500 colleagues - - including 116 psychiatric, and 15 neonatal ICU beds
- 20 operating rooms between main campus and ASC with 2 da Vinci surgical systems
- Progressive leader in cancer care, neurosciences, orthopedics, kidney transplant, diabetes and endocrine care, and behavioral health
- Comprehensive clinical integration model aligning more than 500 employed and independent providers into Clinically Integrated System with at risk contracts
  - Mercy Health Physician Partners – employed group of 250+ primary and specialty care physicians and APPs
  - Affinia Health Partners – a membership organization unifying employed and independent physicians in the community

Mercy Health Saint Mary's – FY2015

- Serve residents in 15 counties
- ~22,000 inpatient discharges
- ~2200 births
- ~20,000 surgeries
- 80,000+ emergency department visits
- 23,500+ urgent care visits
- 1.1+ million outpatient visits
- Top quartile in national peer group in H-CAHPS patient satisfaction for:
  - Rate Hospital
  - Would Recommend Hospital



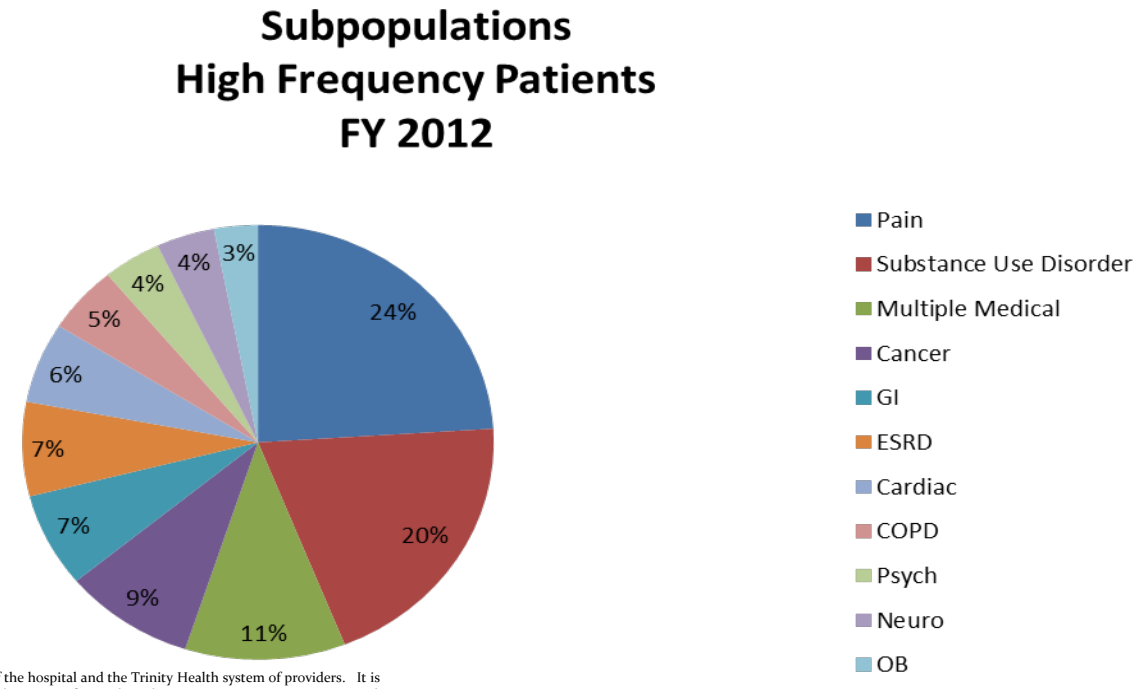
Source: Mercy Health Saint Mary's financial reporting and Press Ganey

The Situation

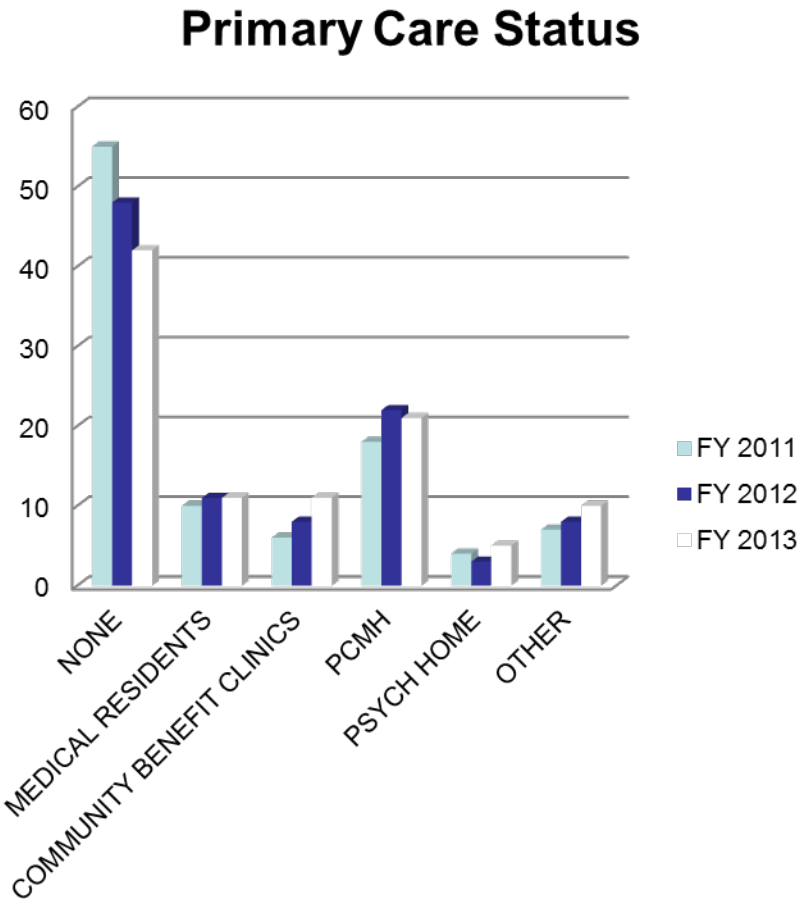
- Robert Wood Johnson Foundation reports 5% of the population uses nearly half of total healthcare spending (http://www.rwjf.org/en/topics/rwjf-topic-areas/health-policy/health-care-costs/HealthCareCostsFastFacts.html
- Recent analysis identifies “High frequency Patients” or “Super Utilizers” – who they are is poorly understood
- Successful Population Health strategies include management of these high risk patients

High Frequency Patients – Population Approach

≥10 ED Visits &/or ≥ 4 Admits in 12 months	Total Pts	Total Visits	ED Visits	UC Visits	IP Admits	OBS Admits
FY 2011	613	7,307	5,205	256	1,652	194
FY 2012	735	8,501	5,590	397	2,073	441
FY 2012 % Total Volume			10.5%	2%	10.1%	17.8%



Population Characteristics of High Frequency Patients (≥10 ED Visits &/or ≥4 Inpatient Admissions in 12 months)



Primary Care Status

- 60% have a medical home

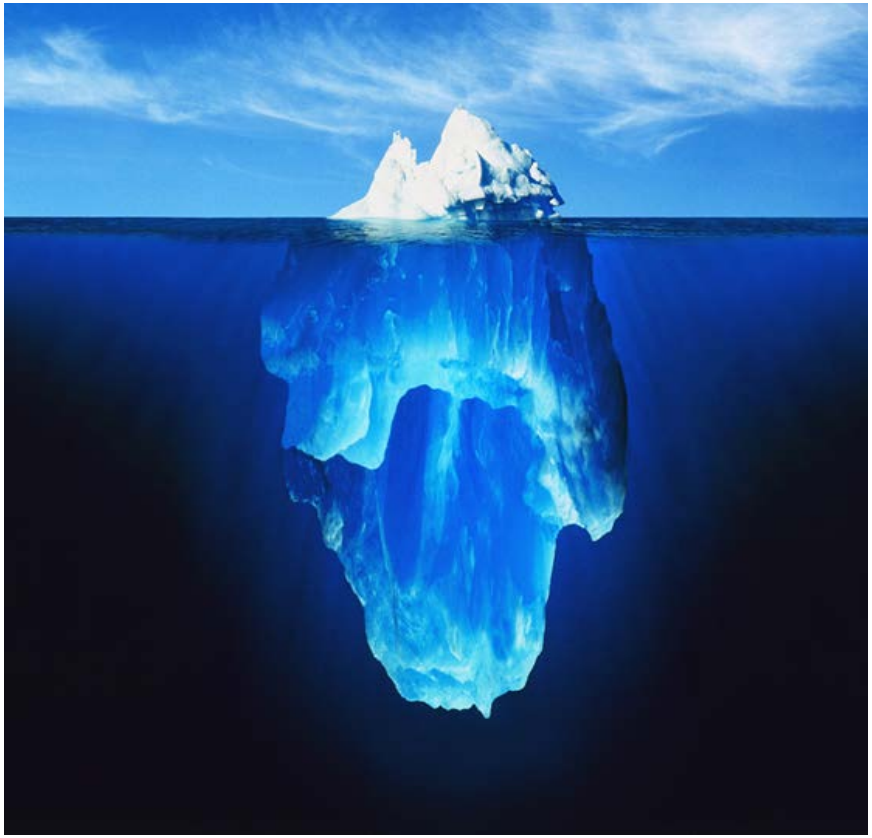
Insurance Status

- 30% Uninsured
- 40% are Dual Eligible

Age

- 70% are <60 yrs. old

The Invisible Population



- Mental Illness
- Substance Abuse
- Social Determinant of Health Issues
- Trauma
- Fragility

The First Patient Story….

(Aggregate Patient Story/Stock Photo)

Middle Aged Woman

- Complex issues in care
- Conflict amongst providers
- Care Providers across Multiple Systems
- Multiple Procedures and Encounters

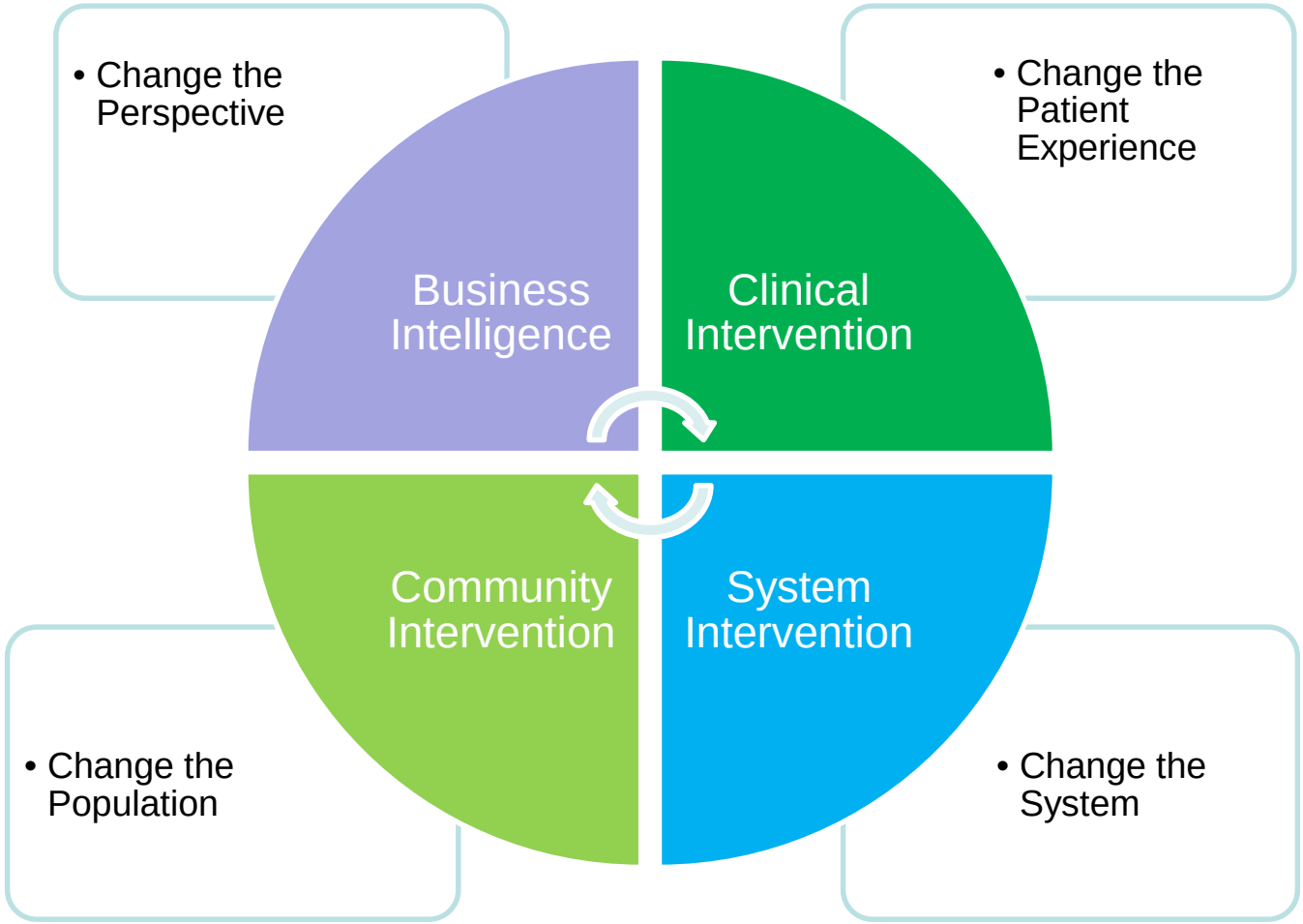
Transformation….

(Aggregate Patient Story/Stock Photo)

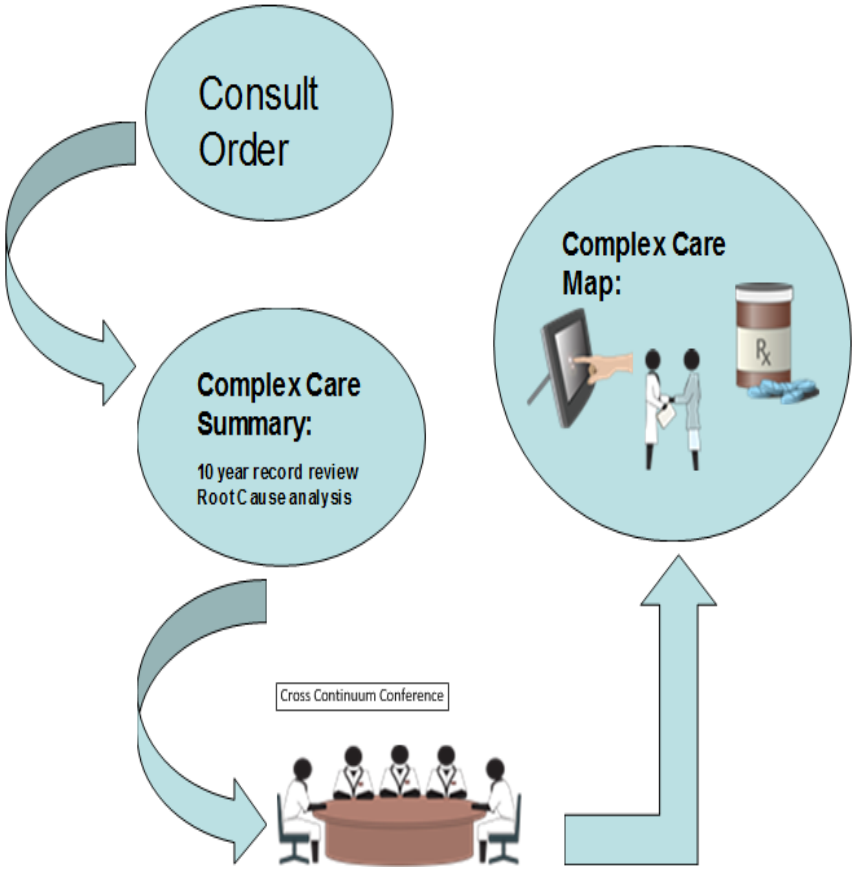
Middle Aged Woman

- Root Cause Patient story
- Interprofessional Collaboration
- Interagency Collaboration
- Shared plan of care
- Holistic Patient Intervention
- System Intervention

Complex Care Center Core Services



Intervention Pathway



2.0 Clinical FTEs

- Follow >1,000 Patients
- Add 5 to 10 New Patients/Week
- Add 5 to 10 Complex Care Maps/Week
- Case Find & Proactively Intervene with risk populations

(i.e. All Uninsured w/>5 Visits)

Approach Comparison

Complex Care Manager

- Patient must opt in
- Exclusion by Payer, Diagnosis, Location
- Patient Intervention
- Change the Patient
- New FTEs/Team to manage patient

- Program
- Usually in one System
- Typically time-limited follow
- 1 FTE :100 Patients

Complex Care Center

- No need to opt in
- No exclusion criteria
- Patient & Provider Intervention
- Change the System
- Minimal new FTEs - Potentiates existing roles
- Process/Standard of Care
- Links Competing Systems
- “Watch” for life
- 1 FTE: 500 Patients
- Intervention occurs whether patient engages or not

Hong CS, Siegel AL & Ferris T (2014) Caring for high-need high-cost patients: what makes for a successful care management program? Retrieved January 12, 2015 from http://www.commonwealthfund.org/publications/issue-briefs/2014/aug/high-need-high-cost-patients)

The Second Patient Story…..

(Aggregate Patient Story/Stock Photo)

24 yr. old Young Man

- Type I Diabetic
- Not Following diet recommendations
- Multiple Hospital Admissions and ED visits

Transformation…..

(Aggregate Patient Story/Stock Photo)

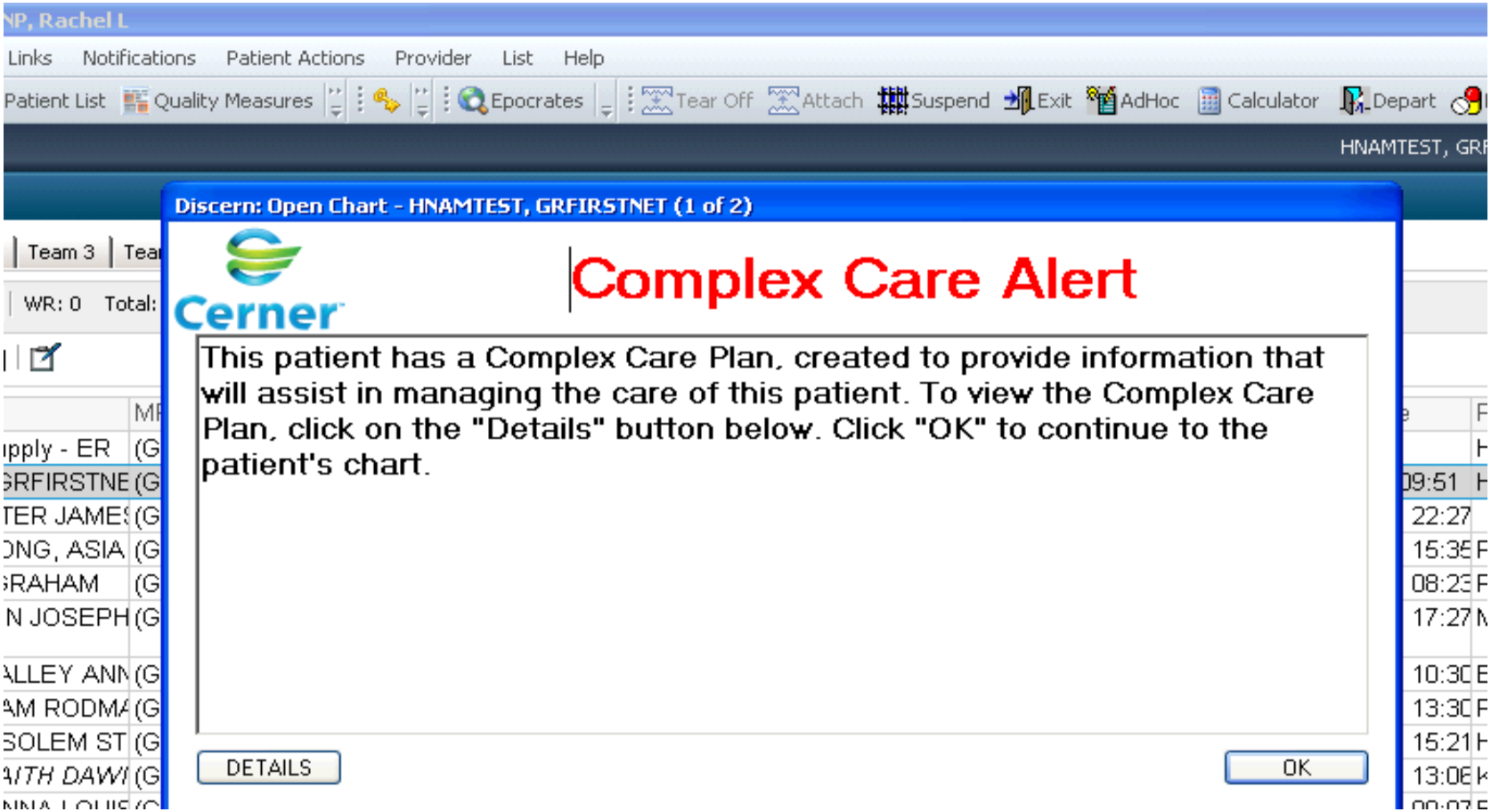
24 yr. old Young Man

- Holistic Plan of care
- Interprofessional evidence based tools
- Evidence based Complex Care Map
- Population Intervention

Complex Care Maps

- SBAC Format
- Translates Patient story from a root cause framework
- Identifies key relationships in the Cross Continuum Team
- Integrates Evidence Based Recommendations for care

Complex Care Alert



Complex Care Team – Interprofessional Collaboration

- Meets weekly for 1 hour
- Standard Evidence Based Complex Care Maps
- Process Improvements
- Toolkit for Implementation
- Implementation in 17 Trinity Health Hospitals

The Third Patient Story….

(Aggregate Patient Story/Stock Photo)

Male 48 years old

- High frequency ED and inpatient visits
- Cancer and ESLD
- Alcoholism and Substance Use Disorder
- Significant Psychiatric Issues
- Fragile life circumstances

Transformation….

(Aggregate Patient Story/Stock Photo)

Male 48 years old

- Inter-organizational Collaboration
- Embedded Shared plan of Care
- Bi-weekly Interprofessional Rounds
- Shared patient conferences
- Community Wide Collaboration

Inter-organizational Collaboration - Rounds

One Final Story….

The impact of changing the system…

*Shared with Patient and Case Manager permission

RWJ: Promising Practices to Implement and Promote Interprofessional Collaboration

- Put patients first
- Demonstrate leadership commitment to interprofessional collaboration as an organizational priority through words and actions
- Create a level playing field that enables team members to work at the top of their license, know their roles, and understand the value they contribute
- Cultivate effective team communication
- Explore the use of organizational structure to hardwire interprofessional practice
- Train different disciplines together so they learn how to work together

Core Competencies for Complex Care

- Holistic Patient Story
- Integration of Behavioral Health, Social Determinants of Health & Trauma Informed Care
- Root Case Analysis
- Cross Continuum/Cross System View
- Evidence based intervention
- Facilitation skills in Interprofessional Collaboration
- Teaching in Teams
- Shared Plans of Care
- Integration of Technology
- Point of Care view applied to Populations

For More Information

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The project was undertaken as a Clinical QI initiative at Mercy Health and as such was not formally supervised by the Mercy Health Institutional Review Board per their policies.