Journal of Interprofessional Education & Practice 7 (2017) 5–10

Contents lists available at ScienceDirect

Journal of Interprofessional Education & Practice

journal homepage: http://www.jieponline.com

Competing health care systems and complex patients: An inter-professional collaboration to improve outcomes and reduce health care costs

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ARTICLE INFO

Article history:
Received 10 July 2016
Accepted 20 January 2017

Keywords:
Cross continuum care collaboration
Competing health systems
Integrated care
High need patient
High frequency patient
Complex patient
Chronic patient
Emergency department
Individualized care
Decrease readmissions
Preventable hospitalization
Cost reduction
Root cause
Inter-professional team
Interorganizational team
Integrated behavioral health
Overuse
Overutilization
Super utilizers

ABSTRACT

Background: High-need, high-frequency patients overutilize acute care services, a pattern of behavior associated with many poor outcomes that disproportionately contributes to US healthcare costs.
Purpose: Our objective was to reduce healthcare costs while improving clinical outcomes through optimizing healthcare delivery and inter-professional collaboration for complex patients.
Method: To do so, we partnered with a competing health care system to address fragmentation in the patients' plans of care contributing to patterns of high utilization.
Discussion: Our collaborative approach was associated with a reduction in healthcare utilization and costs for this population, as well as an increase in operating margin.
Conclusion: Collaboration between neighboring competing health systems that share a select group of complex patients is an effective way to stabilize care, decrease health care system overutilization, improve healthcare delivery, and reduce the costs of associated care. Our intervention model provides a useful model for inter-organizational collaboration in healthcare.

Introduction

Background

Interest in high-need, high-cost (HNHC) patients has intensified in recent years as healthcare systems increasingly focus limited resources on high-risk patients to prevent the unnecessary use of costly services.[1,2] To meet the needs of HNHC patients, many organizations are developing specialized intensive management programs, offering enhanced clinical access, care coordination, medication reconciliation, support during transitions from hospital to home, and referrals to social and community services.[3–6]

Funding: This work is supported by an Innovation Grant funded by Trinity Health. The funding organization(s) had no role in the design and conduct of the study; in the collection, analysis, and interpretation of the data; or in the preparation, review, or approval of the manuscript.

Conflicts of interest: The authors declare that they have no conflicts of interest.
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http://dx.doi.org/10.1016/j.xjep.2017.01.002

The most complex HNHC patients have a constellation of chronic disease, psychiatric diagnoses and substance use disorder. Patients in this group are often dually eligible, having both Medicare and Medicaid, and they represent one of the highest cost groups in the healthcare system.[7] The complex needs of the population are often beyond the management capabilities of a typical primary care practice. Stabilization in the population requires an integration of disciplines traditionally separated by specialty and regulations that divide medical, psychiatric, and substance use information into disconnected documentation systems.[7–9]

Rationale for our intervention

In response to the needs of this population, the Cherry Health Durham Clinic (CHDC) – part of the Cherry Health System – created an integrated Primary Care and Behavioral Health Medical Home (BHMH) specifically designed to meet the needs of patients with co-occurring disorders. The CHDC opened in 2011 and includes a Primary Care Physician, Physician Assistant, Psychiatrist, Nurses, Health Coaches, and Supports Coordinator all in one office. Patients are able to receive services in one location with integration of psychiatric and medical records. Health Coaches provide support for on-going chronic disease management including evidence-based therapies for psychiatric and substance use disorders. The Supports Coordinator addresses housing, insurance, and access issues for further stabilization. Due to the comprehensive nature of services, the clinic receives some of the most complex patients in the city including patients with extreme healthcare utilization (>100 visits per year), complex psychiatric conditions such as Munchausen Syndrome, and very complex social situations such as homelessness, active domestic violence, and significant trauma.

In 2012, Mercy Health Saint Mary's (MHSM) – part of the Mercy Health System – began to investigate the HNHC population accessing the hospital system. A Complex Care Center was created by a Clinical Nurse Leader (CNL) to provide clinical intervention, process improvements, and analysis of patients accessing the hospital. Population analysis of high frequency patients in the system revealed an unexpected finding of patients assigned a medical home with a competing healthcare system but utilizing the Mercy Health hospital system for care. One group included the Cherry Health System patients and this led to a new approach to care coordination. We realized that to stabilize their care we would need to collaborate with our competitors.

Rather than focusing solely on improving care within the four walls of our own organization, we began to look at how we could collaborate across systems to bring the best of both organizations to the table to serve the needs of patients.[10] The general aim of our model for inter-organizational collaboration was to create a continuum of care across organizational boundaries to deliver integrated healthcare to HNHC patients to reduce their need to overutilize healthcare resources. Just as previously addressed by Loehrer et al, creating an effective linkage across the care continuum required “overcoming challenges related to the historic fragmentation of healthcare service delivery, in which provider organizations may not share a common mission, orientation to the goals of care, or information exchange platform.” Although we initially faced significant challenges to create the partnership, focusing first on the patients helped build bridges to improve outcomes for both organizations.

Challenges of inter-organizational collaboration

Collaboration between organizations is often problematic due to different organizational logics and cultures,[11] conflicting legislation, knowledge and value bases, and conflicting economic and other interests of the organizations involved.[11–16] Yet, increased collaboration among different healthcare systems to prevent and manage chronic disease has been recognized as being critical for successful care of these patients.[17–20] The Centers for Disease Control and Prevention (CDC) and the Public Health Accreditation Board (PHAB) have reinforced the vision for more unified chronic disease approaches across healthcare systems: two of CDC's four key chronic disease practice domains call on public health to improve the services provided by health care systems,[18] and health care system collaboration is now required by PHAB for health departments' accreditation, and the movement toward collaborative chronic care continues to grow.[19] In spite of the existence of many integrated care programs worldwide, ample literature published about inter-professional team-based care,[21–24] and growing emphasis on these issues, there has been little published on inter-organizational team-based care in the setting of competing health systems.

Specific aims

The objective of this article is to describe our approach to inter-organizational collaboration on a shared population of HNHC patients, illuminate challenges involved and how to overcome them, share findings from the clinical impact of our collaboration, and describe the model that has been successful in our area. The purpose of this article is to share the framework of our model, thereby providing a guide for facilitating inter-organizational collaborative practice among competing health care systems to improve patient outcomes and quality of patient care.

Process of collaboration with a competing health system

Here we outline the inter-organizational infrastructure and practices that we considered integral for facilitating effective cross continuum collaboration between competing health systems to help shared HNHC patients (Fig. 1). Details on patient identification and root cause analysis are described in a separate article.[8]

Patient identification and root cause analysis

Data analysis of the HNHC patients in the Mercy Health system built the case for collaboration by highlighting the need for improved care in the population. The Complex Care Center utilizes a tool called a Complex Care Summary to analyze root causes contributing to patient destabilization.[8] Collecting information about the patient's cross continuum team identified natural partners for collaboration including the CHDC. Reviewing root causes beyond the medical diagnoses (including psychiatric, social determinants of health and system barriers) enabled us to build a comprehensive foundation on which to create the person-centered plan of care. Organizing our collaboration around patient specific situations gave us the opportunity to build the collaboration around shared purpose. Both organizations wanted to improve outcomes; however, the complexity of the patients made it difficult to achieve this in isolation.

Engagement of the clinical partnership

Patient-centered collaboration proved essential. Many models of inter-organizational collaboration begin with system leadership meetings and organizational infrastructure. We found that by starting with the patient and their individual story we were able to quickly develop a shared sense of purpose to improve outcomes across organizations. Rather than getting delayed by organizational