# *REDUCING AVOIDABLE HOSPITAL UTILIZATION*

*Best practices and promising strategies for Medicaid patients*


Amy E. Boutwell, MD, MPP


New York DSRIP Learning Symposium

September 18, 2015


COLLABORATIVE
HEALTHCARE STRATEGIES

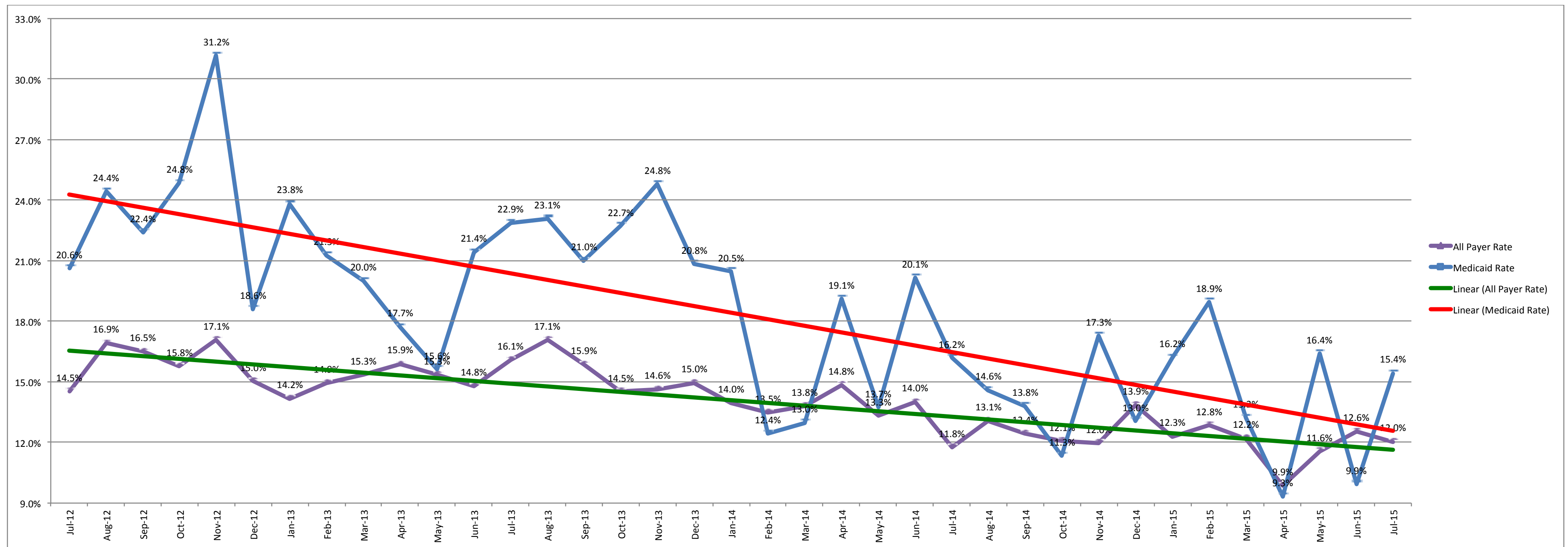
# Agenda

- This *can* be done
- What are hospitals with hospital-wide results doing?
- Key Messages

# Key Messages

- Medicaid adults have high readmission rates
- Medicaid patients need to be specifically identified as high-risk of readmission
- Readmission reduction efforts must include the ED
- Don't over-medicalize

# All Cause 30-day Readmissions

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## AHRQ Reducing Medicaid Readmissions Project

- Identify the similarities & differences in readmission patterns for Medicare v. Medicaid patients
- Explore whether the "best practices" to reduce readmissions apply to the Medicaid population as well
- Create a guide for hospitals to increase awareness of the unique issues in reducing Medicaid readmissions

CONTENTS:

- Why focus on Medicaid Readmissions?
- Know Your Data
- Inventory Readmission Efforts
- Develop a Portfolio of Strategies
- Improve Hospital-based Transitional Care
- Collaborate with Cross Setting Partners
- Provide Enhanced Services
- 13 new Tools

http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/

Hospital Guide to Reducing Medicaid Readmissions

Toolbox

**Tools**

1. Readmission Data Analysis
2. Readmission Interview
3. Data Analysis Synthesis
4. Hospital Inventory
5. Cross-Continuum Team Inventory
6. Conditions of Participation Checklist
7. Portfolio Design
8. Readmission Reduction Impact
9. Readmission Risk
10. Whole-Person Assessment
11. Discharge Information Checklist
12. Forming a Cross-Continuum Team
13. Community Resource Guide

http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/

# Key Actions

1. *Know* your data
2. *Ask* your patients, their caregivers and providers, “why”
3. *Develop* a portfolio of strategies
4. *Improve* hospital-based transitional care for all
5. *Collaborate* with cross setting providers & payers
6. *Provide* enhanced services for high risk patients

# Hospitals with hospital-wide results

- Know their data –

  *Analyze, trend, track, display, share, post*

- Broad concept of “readmission risk”

  *Way beyond case finding for diagnoses*

- Multifaceted strategy

  *Improve standard care, collaborate across settings, enhanced care*

- Use technology to make this better, quicker, automated

  *Automated notifications, implementation tracking, dashboards*

# KNOW YOUR (OWN) DATA

*Analyze, track, trend, raw unadjusted data to identify opportunities*

CENTER FOR HEALTH
INFORMATION AND ANALYSIS

## HOSPITAL-WIDE ADULT ALL-PAYER READMISSIONS IN MASSACHUSETTS: 2011-2

JUNE 2015

H·CUP HEALTHCARE COST AND UTILIZATION PROJECT — AHRQ Agency for Healthcare Research and Quality

## STATISTICAL BRIEF #153

April 2013

### Readmissions to U.S. Hospitals by Diagnosis, 2010

*Anne Elixhauser, Ph.D. and Claudia Steiner, M.D., M.P.H.*

Introduction

The problem of readmissions to the hospital is receiving increased attention as a potential way to address problems quality of care, cost of care, and care transitions.[1,2] Medica reports 30-day hospital readmissions for acute myocardial infarction, congestive failure, and pneumonia for individual hospitals across the country.[3] Interventions are underway t reduce hospital readmissions at the state and national level.[4,5]

Prior research reports have focused on readmissions for specific conditions such as congestive heart failure, pneumonia, chronic obstructive pulmonary disease (COPD) and psychoses.[6,7,8] This Statistical Brief provides an overview of 30-day all-payer, all-cause readmissions to U.S hospitals for a range of conditions in 2010, thereby presenti the most comprehensive national estimates on readmission by condition.

In this Statistical Brief, *readmission* was defined as a subsequent hospital admission within 30 days following an original admission (or index stay) that occurred from Januar through November 2010. All-cause readmissions were examined; thus, readmissions may or may not include conditions that were listed as the principal diagnosis during the index stay. Readmissions were tracked across the sam

[1] Boutwell A, Jencks S. It's Not Six of One, Half-Dozen of the Other: A Cor Measurement Systems for Massachusetts. 2011 AcademyHealth Annual F www.qualityforum.org. Accessed March 21, 2013.
[2] 3M Health Information Systems. Potentially Preventable Readmissions C number GRP-139, May, 2008.
[3] Hospital Compare. Medicare Web site. http://hospitalcompare.hhs.gov/
[4] Boutwell AE, Johnson MB, Rutherford P, Watson SR, Vecchioni N, Auert An early look at a four-state initiative to reduce avoidable hospital readmis
[5] Partnership for Patients: Better Care, Lower Costs. April, 2011.
[6] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patient 2009;360:1418-28.
[7] Stranges E, Barrett ML, Wier LM, Andrews RM. Readmissions for Heart Agency for Healthcare Research and Quality, Rockville, MD. March 21, 2013.
[8] Elixhauser A, Au D, Podulka J. *Readmissions for Chronic Obstructive Pu* September, 2011. Agency for Healthcare Research and Quality, Rockville, us.ahrq.gov/reports/statbriefs/sb121.pdf. Accessed March 21, 2013.

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## STATISTICAL BRIEF #189

May 2015

### Hospital Readmissions Involving Psychiatric Disorders, 2012

*Kevin C. Heslin, Ph.D. and Audrey J. Weiss, Ph.D.*

Introduction

In 2012, nearly one-fourth of adults in the United States experienced some form of mental or substance use disc (M/SUD).[1] Many patients who experience M/SUDs are hospitalized for those conditions. Between 2003 and 20 hospitalization for mental disorders increased at a faster for any other type of hospitalization (i.e., medical, surgic maternal/neonatal).[2]

Mood disorders and schizophrenia (and other psychotic were the two most frequent principal diagnoses among hospitalizations involving M/SUD conditions in 2011.[3] A hospitalizations in 2011, the sixth most common diagno mood disorders, accounting for nearly 900,000 hospital addition, mood disorders was the most common reason hospitalization among children aged 1–17 years.[5]

Mental disorders such as schizophrenia, bipolar disorde mood disorders are especially prevalent among Medicai beneficiaries who are under age 65 and eligible for Med based on their disability. In 2011, approximately 37 per disabled Medicare beneficiaries had a severe mental di

Hospital readmission within 30 days of discharge usuall represents a negative clinical outcome for patients with disorders and may be due to factors such as poor acces adequate community-based aftercare and challenges in

[1] SAMHSA. Mental and substance use disorders. Updated October 9, http://www.samhsa.gov/disorders. Accessed March 13, 2015.
[2] Weiss AJ, Barrett ML, Steiner C. Trends and projections in inpatient and utilization, 2003–2013. HCUP Statistical Brief #175. July 2014. A Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb175-Hospital-Cost-Utilization-Project Accessed March 13, 2015.
[3] Agency for Healthcare Research and Quality. HCUPnet Web site. http://hcupnet.ahrq.gov. Accessed March 13, 2015.
[4] Pfuntner A, Wier LM, Stocks C. Most frequent conditions in U.S. hos HCUP Statistical Brief #162. September 2013. Agency for Healthcare Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs Accessed March 13, 2015.
[5] Ibid.
[6] Social Security Administration. SSI Annual Statistical Report, 2011. SSA Publication No. 13-11827. Released September 2012. http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2011/ssi_asr11.pdf 14, 2015.

H·CUP HEALTHCARE COST AND UTILIZATION PROJECT — AHRQ Agency for Healthcare Research and Quality

## STATISTICAL BRIEF #184

November 2014

### Characteristics of Hospital Stays for Nonelderly Medicaid Super-Utilizers, 2012

*H. Joanna Jiang, Ph.D., Marguerite L. Barrett, M.S., and Minya Sheng, M.S.*

Introduction

With over 67 million beneficiaries, Medicaid has emerged as the largest health insurance program in the United States.[1] The Medicaid population includes infants, children, young mothers, homeless adults, individuals with disabilities, and individuals who are dually eligible for Medicare and Medicaid. The considerable diversity among patients covered by Medicaid in age, race/ethnicity, and type of health conditions poses great challenges for managing the use of health services by this population. Specifically, among patients with physical or behavioral chronic conditions, Medicaid patients have been shown to experience higher hospital readmission rates than privately insured patients,[2] suggesting that a relatively small group of patients may account for a disproportionately large share of utilization and costs. Understanding the characteristics and patterns of hospitalization for high-utilizing patients can help policymakers and clinicians develop interventions to address the special needs of these patients and reduce their risks for multiple hospitalizations.

This Healthcare Cost and Utilization Project (HCUP) Statistical Brief presents data on patient demographics and characteristics of hospital stays for Medicaid super-utilizers compared with stays for other Medicaid patients. For this report, *super-utilizers* are defined as patients who had four or more hospital admissions[3] during 2012. The most common principal diagnoses for hospital stays are also identified for these super-utilizers.

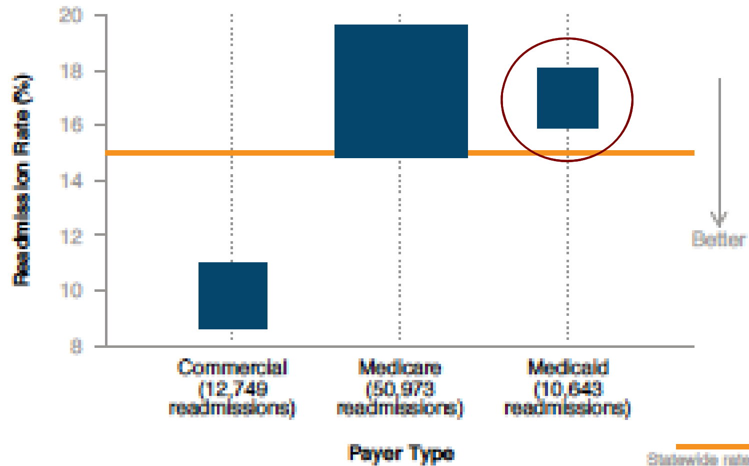
Weighted national estimates are produced from 18 HCUP State Inpatient Databases (SID) that capture hospital discharge data from both fee-for-service and managed care Medicaid enrollees and allow for examination of readmissions because they include a valid encrypted patient identifier that allows for tracking across

Highlights

- In 2012, on average compared with other Medicaid patients, Medicaid super-utilizers had more hospital stays (5.9 vs. 1.3 stays), longer length of stay (6.1 vs. 4.5 days), and higher hospital costs per stay ($11,766 vs. $9,032).
- Medicaid super-utilizers accounted for 14 percent of Medicaid hospital stays and 18 percent of Medicaid hospital costs.
- Medicaid super-utilizers were more likely than other Medicaid patients to be male and to be aged 45–64 years.
- The 30-day all-cause readmission rate for super-utilizers was nearly six times higher than for other Medicaid patients (52.4 vs. 8.8 percent). Half of all 30-day readmissions for the Medicaid population were attributable to super-utilizers.
- *Mood disorders* and *schizophrenia and other psychotic disorders* were the two most common reasons for hospitalization among Medicaid super-utilizers. *Alcohol-related disorders* ranked number six.
- Other common conditions among super-utilizers included diabetes; cancer treatment; sickle cell anemia; septicemia; congestive heart failure; chronic obstructive pulmonary disease; and complications of devices, implants and grafts.

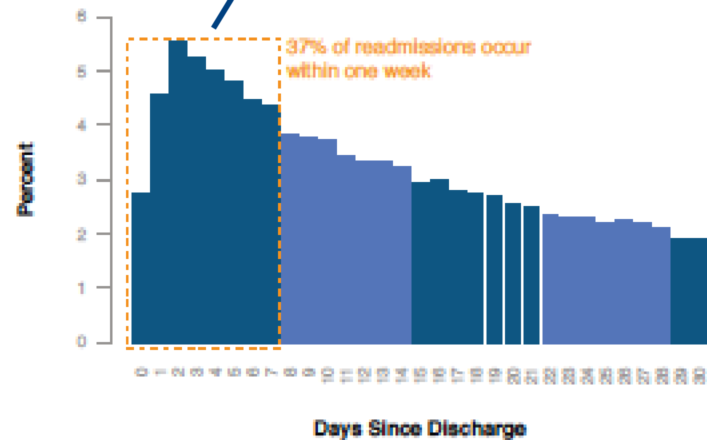
[1] Centers for Medicare & Medicaid Services. Medicaid & CHIP: August 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report. http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/August-2014-Enrollment-Report.pdf. Accessed October 30, 2014.
[2] Jiang HJ, Wier LM. *All-Cause Hospital Readmissions Among Non-Elderly Medicaid Patients, 2007.* HCUP Statistical Brief #89. April 2010. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb89.pdf. Accessed August 20, 2014.
[3] Four or more stays is above two standard deviations of the average number of stays for Medicaid patients aged 1 to 64 years.

1




*Medicaid can be used a singular risk factor*

37% readmissions < 7 days!

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## 3. READMISSIONS BY DISCHARGE SETTING

**Figure 3: All-Payer Readmission Rates by Discharge Setting, July 2012 to June 2013**

Patients discharged to home (without home health agency care) and hospice have lower readmission rates than those discharged to post-acute care.

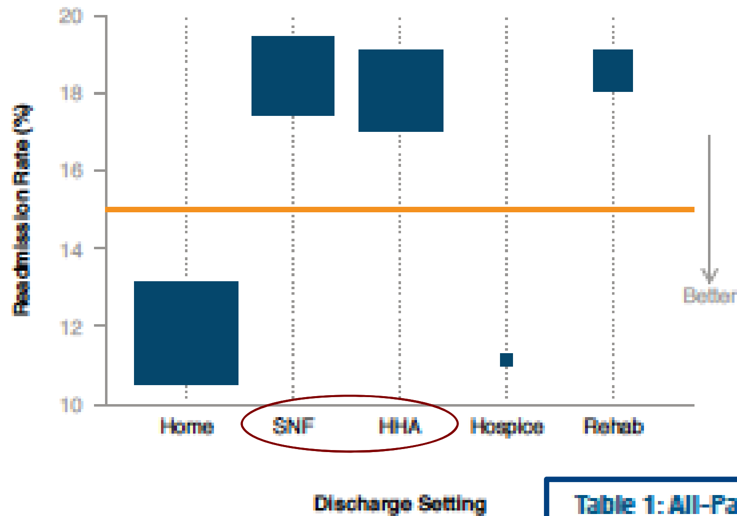


**Table 1: All-Payer Readmissions by Discharge Setting, July 2012 to June 2013**

| | Number of Discharges | Percentage of Discharges | Number of Readmissions | Percentage of Readmissions | Readmission Rate |
|---|---|---|---|---|---|
| **Home** | 258,860 | 50.9% | 30,541 | 39.9% | 11.8% |
| **SNF** | 99,346 | 19.5% | 18,335 | 24.0% | 18.5% |
| **HHA** | 110,419 | 21.7% | 19,946 | 26.1% | 18.1% |
| **Hospice** | 3,851 | 0.8% | 429 | 0.6% | 11.1% |
| **Rehab** | 22,988 | 4.5% | 4,273 | 5.6% | 18.6% |
| **Total** | 508,354 | 100.0% | 76,481 | 100.0% | 15.0% |

Note: Figures do not sum to those in the total row because the table excludes "other" discharge settings and missing values.

Data source: Massachusetts Hospital Inpatient Discharge Databases, July 2012 – June 2013.

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AHRQ Agency for Healthcare Research and Quality

# STATISTICAL BRIEF #172

April 2014

## Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011

*Anika L. Hines, Ph.D., M.P.H., Marguerite L. Barrett, M.S., H. Joanna Jiang, Ph.D., and Claudia A. Steiner, M.D., M.P.H.*

*Methods:*
*- Used CCS groupers*
*- Included OB*

Top 10 Medicaid Dx:

1. Mood disorder
2. Schizophrenia
3. Diabetes complications
4. Comp. of pregnancy
5. Alcohol-related
6. Early labor
7. CHF
8. Sepsis
9. COPD
10. Substance-use related

Top 10 Medicare Dx:

1. CHF
2. Sepsis
3. Pneumonia
4. COPD
5. Arrythmia
6. UTI
7. Acute renal failure
8. AMI
9. Complication of device
10. Stroke

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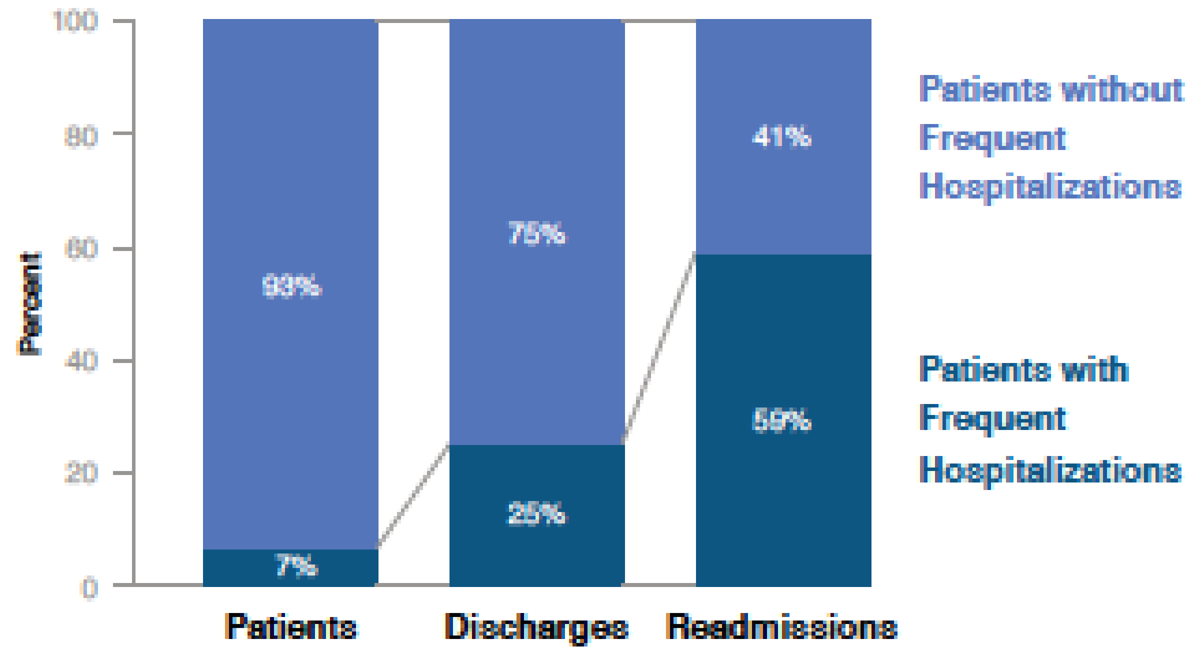
# Figure 1. All-cause 30-day readmission rates for congestive heart failure by age and insurance status, U.S. hospitals, 2010



Source: Weighted national estimates from a readmissions analysis file derived from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID), 2010, Agency for Healthcare Research and Quality (AHRQ).

-- Indicates too few cases to report.




HU Readmission Rate = 40%
Non-HU Readmission Rate = 8%

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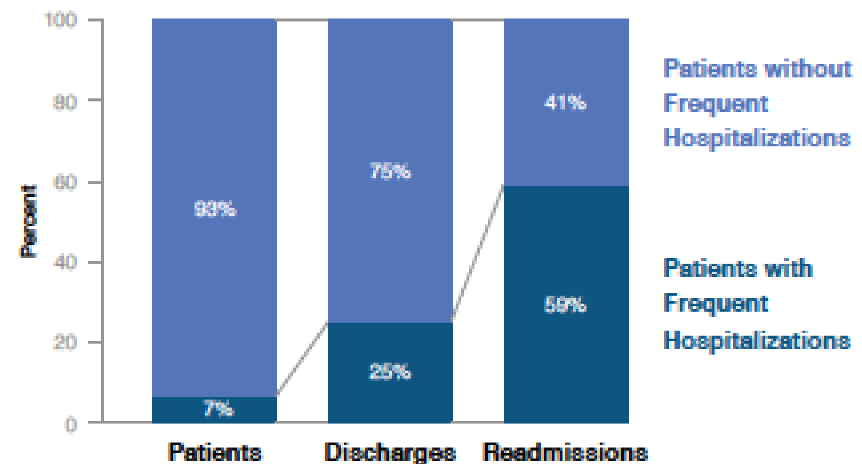
# High Utilizers

- 4+ hospitalizations/year
- 6 hospitalizations /year v. 1.3
- LOS 6.1 days v. 4.5
- $11,600 v. $9,000
- Readmission rate 52% v. 8%
- 74% of high utilizers d/c to home
- Top Dx: mood disorders, schizophrenia, DM, chemo, sickle cell, ETOH, sepsis, CHF, COPD

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Jiang et al. HCUP Statistical Brief #184 Nov 2014

# ASK YOUR PATIENTS "WHY"

*Patient-centered assessment to get the story behind the "cc"*

# Understand the “story behind the chief complaint”

- 61M with 8 hospitalizations this year for shortness of breath returns to the hospital 10 days after discharge with shortness of breath.

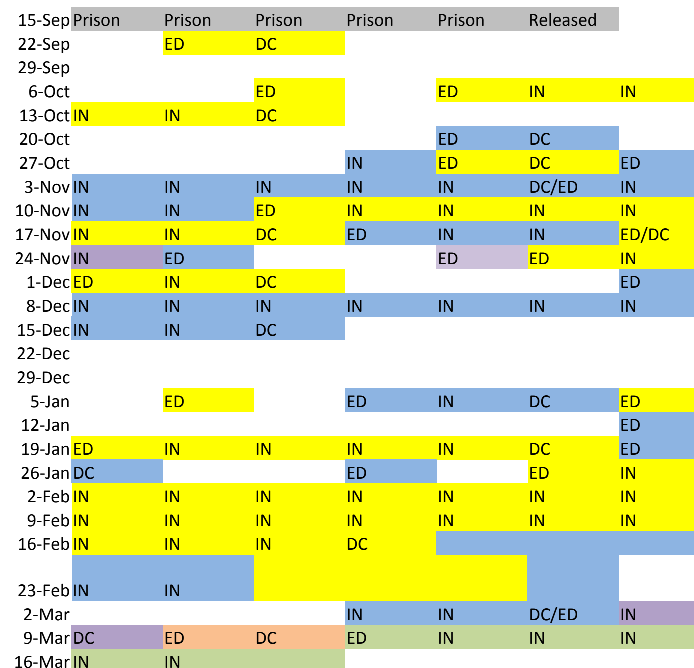
- 32M with uncontrolled DM, cognitive limitations, bipolar disorder, active substance use, homeless presents with flank pain to one hospital, readmitted with chest pain to another hospital

***Chart reviews and checklists will NOT reveal what we need to know: we must talk to patients, their families and caregivers & providers***

# Root Cause of Chest Pain Admission: Shelter

*"I need housing, not a shelter. I need someone to help make sure I take my medicines. In a shelter they don't do that and they kick you out every morning. I need a stable residence and no one is able to help with that."*

Acute Care Utilization over 180 days of freedom



| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 15-Sep | Prison | Prison | Prison | Prison | Prison | Released | |
| 22-Sep | | ED | DC | | | | |
| 29-Sep | | | | | | | |
| 6-Oct | | | ED | | ED | IN | IN |
| 13-Oct | IN | IN | DC | | | | |
| 20-Oct | | | | | ED | DC | |
| 27-Oct | | | | IN | ED | DC | ED |
| 3-Nov | IN | IN | IN | IN | IN | DC/ED | IN |
| 10-Nov | IN | IN | ED | IN | IN | IN | IN |
| 17-Nov | IN | IN | DC | ED | IN | IN | ED/DC |
| 24-Nov | IN | ED | | | ED | ED | IN |
| 1-Dec | ED | IN | DC | | | | ED |
| 8-Dec | IN | IN | IN | IN | IN | IN | IN |
| 15-Dec | IN | IN | DC | | | | |
| 22-Dec | | | | | | | |
| 29-Dec | | | | | | | |
| 5-Jan | | ED | | ED | IN | DC | ED |
| 12-Jan | | | | | | | ED |
| 19-Jan | ED | IN | IN | IN | IN | DC | ED |
| 26-Jan | DC | | | ED | | ED | IN |
| 2-Feb | IN | IN | IN | IN | IN | IN | IN |
| 9-Feb | IN | IN | IN | IN | IN | IN | IN |
| 16-Feb | IN | IN | IN | DC | | | |
| 23-Feb | IN | IN | | | | | |
| 2-Mar | | | | IN | IN | DC/ED | IN |
| 9-Mar | DC | ED | DC | ED | IN | IN | IN |
| 16-Mar | IN | IN | | | | | |

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| Interview Findings and Lessons Learned |
|---|
| 1. Nearly all the patients interviewed currently are ***receiving services*** through the Department of Mental Health, Community Based Flexible Services (CBFS), outpatient community mental health services, supportive housing services, etc. Through increased care navigation our program will ensure collaboration and communication with these programs so as not to duplicate referrals and to come to some agreement with the patient on what would be the best approach to care. |
| 2. Lack of healthy ***daily structure*** appears to be a common theme. Patients often report not having enough to keep them busy, feeling lonely, unsupported, and a general sense of disconnection. Increased rapid access to day treatment programs, partial hospitalization programs, peer-based support programs, etc. will be an importance component of our program. |
| 3. Sometimes ***referrals to appropriate services are not enough***, especially for the patient with substance abuse concerns***. Intensive follow-up is needed*** to ensure that patients stay consistent with their goals of treatment and continue to be engaged throughout the treatment process. Often the treatment system ***navigation requires the assistance of a skilled clinician***, because the system can be too confusing for patients to manage on their own. |

# There is Never One Reason for Readmission…..

- KP team reviewed 523 readmissions across ~14 hospitals:
  - 250 (47%) deemed potentially preventable
  - Found an average ***of 9 factors*** contributed to each readmission

- Assessed factors related to 5 domains:
  - 73% - care transitions planning & care coordination
  - 80% - clinical care
  - 49% - logistics of follow up care
  - 41% - advanced care planning & end of life
  - 28% - medications

- 250 readmissions identified 1,867 factors!



Feingenbaum et al Medical Care 50(7): July 2012

# Return Visits to the Emergency Department: The Patient Perspective

Kristin L. Rising, MD, MS*; Kevin A. Padrez, BA; Meghan O'Brien, MD, MBE; Judd E. Hollander, MD; Brendan G. Carr, MD, MA; Judy A. Shea, PhD

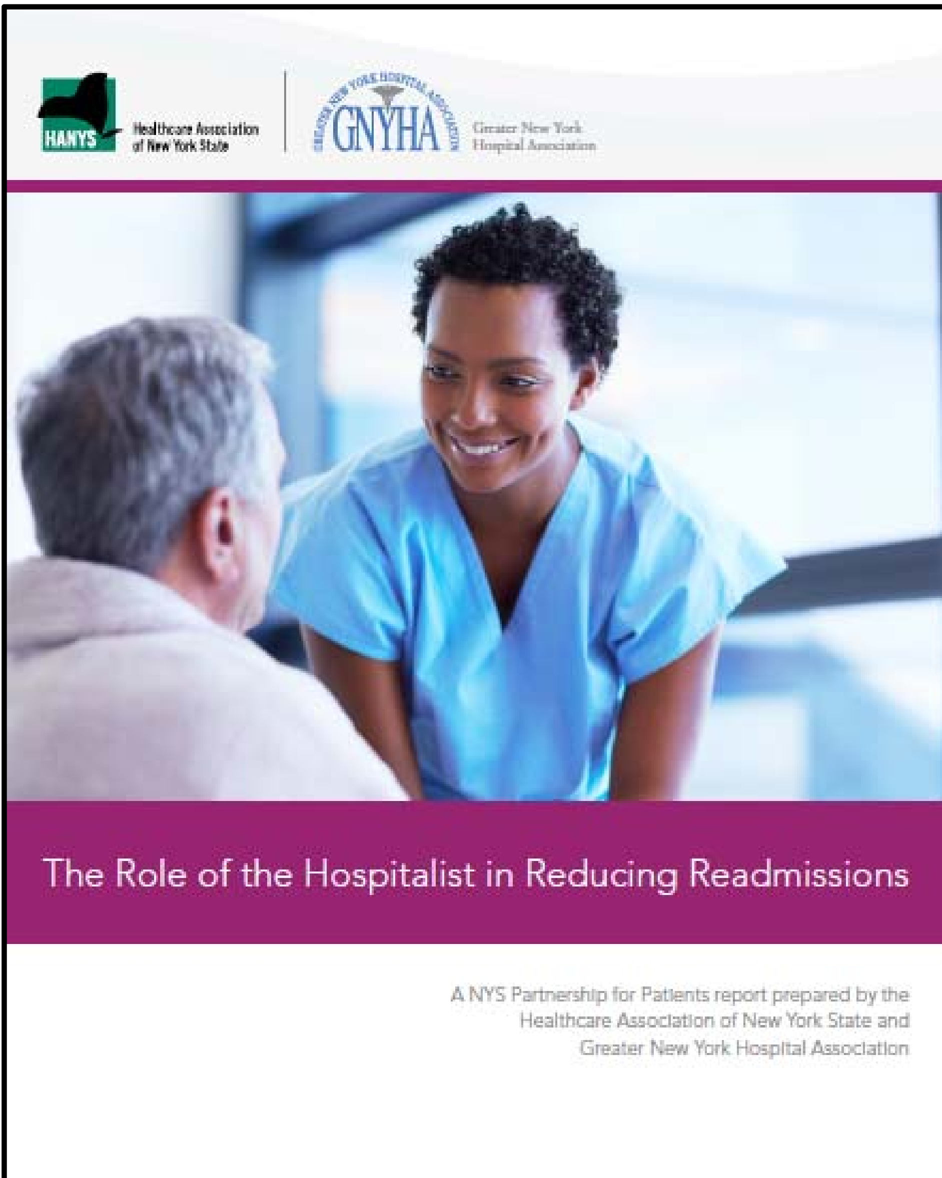
- Interviewed 60 patients who returned to ED after d/c from ED <9days
  - Average age 43 (19-75)
  - Majority had a PCP,
  - Preferred the ED: more tests, quicker answers, ED more likely to treat symptoms
  - Most reported no problem filling medications
  - 19//60 thought they didn't get prescribed the medications they needed (pain)
  - 24/60 expressed concerns about clinical evaluation and diagnosis

- Primary reason for returning: ***fear and uncertainty about their condition***

- Patients need more reassurance during and after episodes of care
- Patients need access to advice between visits



*Annals of Emergency Medicine*




## NY Hospitalist-Generated Ideas:

1. Flag 30-day returns in the ED record
2. Promote collaboration between Emergency Medicine and Hospital Medicine on the decision to admit
3. Encourage Hospital Medicine see the patient in the ED
4. Collaborate with referring providers, especially SNFs
5. Capture the “story behind the story”
6. Form a joint quality review committee of EM and Hospital Medicine to review low-acuity admissions and readmissions

*Boutwell et al, New York State Partnership for Patients 2014*

https://www.nyspfp.org/Materials/NYSPFP_Hospitalist_Readmission_Report.pdf

# DESIGN A PORTFOLIO OF STRATEGIES

*(Re)admission reduction = System transformation*

# Develop A Multifaceted Portfolio of Efforts

## Improve hospital-based transitional care processes for ALL patients

1. Flag discharge <30d in chart
2. ED-based efforts to treat & return
3. Broaden view of readmission risks; assess "whole-person" needs
4. Develop transitional care plans that consider needs over 30 days
5. Ask patients & support persons why they returned, if readmitted
6. Ask patient & support persons what help they need; share with them their needs/risk assessment
7. Use teach-back, target the appropriate "learner"
8. Customize information
9. Arrange for post-hospital follow up
10. Use a check-list for all patients

## Collaborate with cross-setting partners

1. Use ADT notifications with medical and behavioral health providers
2. Ask community providers what they need and how they want to receive it
3. Collaborate to arrange timely follow up
4. Perform "warm" handoffs, and opportunity for clarification
5. Form a cross-continuum team that can access resources your staff are unaware of
6. Constantly refresh your awareness of social and behavioral health resources
7. Broaden partners to include Medicaid health plans and their care managers
8. Identify community partners with social work and behavioral health competencies

## Provide enhanced services for high risk

1. Segment "high risk" – varying types of service & levels of intensity
2. Strategy for high utilizers
3. Strategy for navigating care
4. Strategy for accessing resources
5. Strategy for self-management
6. Strategy for frailty/medically complex
7. Strategy for end-of-life trajectory
8. Strategy for recurrent stable symptoms, etc individual care plans

*Use data, analytics, flags, workflow prompts, automation, dashboards to support continuous improvement, ensure reliability, drive to results*

- Reduce Readmissions by 25% for all patients
  - Improve Standard "Transition" Services for all, based on needs
    - Screen ED high risk patients** for alternatives to admission (ED case management)
    - Secure medications, transportation as needed
    - Ensure all unassigned (ED) patients have PCP, ensure all BH patients have PCP and psych f/u
    - Offer post-discharge clinic to facilitate early follow up for any patient who cant get appt <10d
  - Provide enhanced transitional care for patients who have been RA <30d
    - Navigator provides enhanced needs assessment prior to discharge
    - Navigator ensures comprehensive plan in place prior to d/c
    - Navigator provides telephonic follow up to ensure linkage to care & services
  - Proactively coordinate with other hospitals & SNFs
    - Use HIE to identify cross-hospital RA
    - Navigator led proactive outreach to inpatient team at other hospital to collaborate on plan
    - Collaborate with area SNFs to improve SNF-ED transitions and possible returns
  - Develop & Utilize Care Plans for HU
    - Use internal data to identify top HU
    - Develop efficient process for developing care plans
    - Engage ED & inpatient clinicians in using plans
    - Engage/inform patient about purpose of care plan

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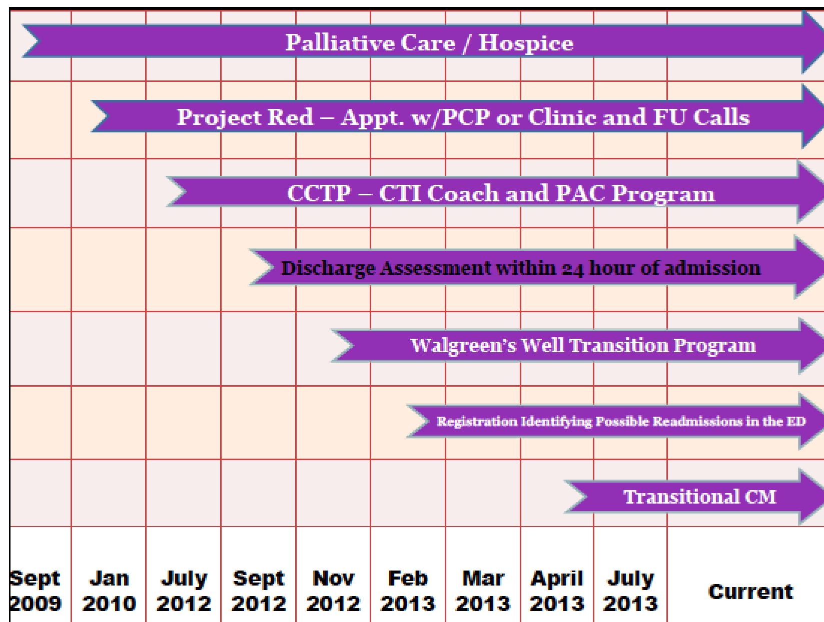
# 2 Hospitals' Multifaceted Portfolios

## Valley Baptist (TX)




## Frederick Memorial (MD)

- **Improve Standard Hospital-based Processes**
  - ED-based SW/CM – identify patients at point of entry
  - CM screen for all patients – move from 8P to "behavioral interview"
- **Collaborate with Providers**
  - 25-member cross continuum team, meets monthly
  - Track and trend H-SNF readmissions, review each, INTERACT
  - Track and trend H-HH patients, weekly "co-management" virtual rounds (move up the continuum from HH to direct SNF if needed)
  - Warm handoffs, points of contact with community BH provider
  - Use off-site urgent care center for post-d/c appointments if needed
- **Provide Enhanced Services to High Risk**
  - CM refer via order entry to Care Transitions Team
  - Multi-disciplinary team "works the case" x 30+ days
  - Cardiology NP "Heart Bridge Clinic"

*Courtesy of Angela Blackford and Heather Kirby*

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# Hospital-wide Results

## Valley Baptist (TX)

All Cause Readmission Rate:

- FY 2011: 28%
- FY 2013: 21%
- FY 2014: 14%

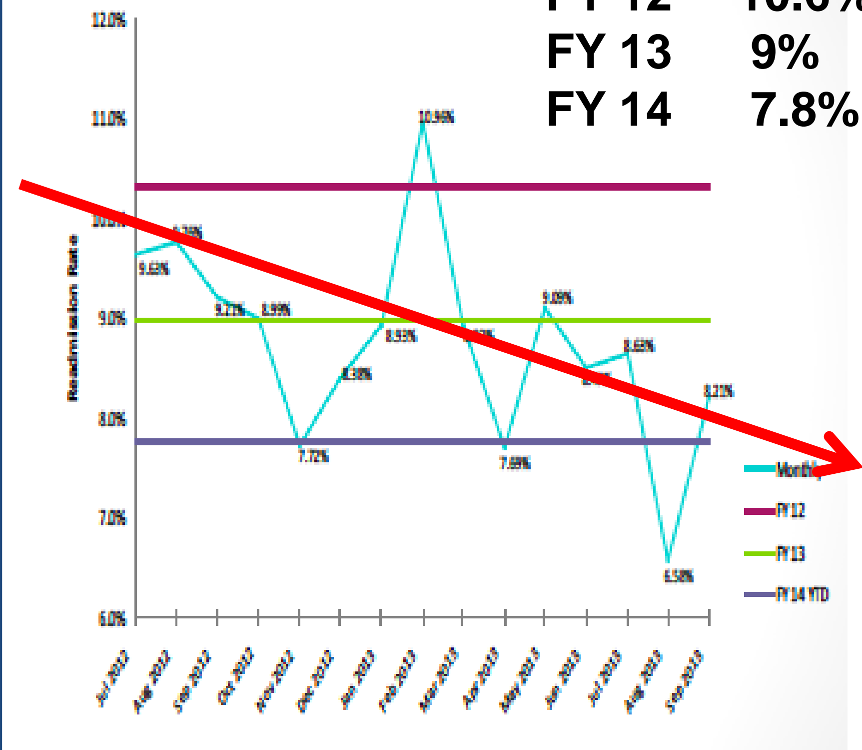
CMS Penalty:

Year 1: 0.8% (of possible 1%)

Year 2: 0.2% (of possible 2%)

Year 3 0.04% (of possible 3%)

## Frederick Memorial (MD)




*Courtesy of Angela Blackford and Heather Kirby*

# 46-study Meta-Analysis: What Works?

**Preventing 30-Day Hospital Readmissions**

*A Systematic Review and Meta-analysis of Randomized Trials*

Leppin et al; JAMA Internal Medicine (online first) May 12 2014

- Review of 42 published studies of discharge interventions
- Found that multi-faceted interventions were 1.4 times more effective
  - Many components
  - More people
  - Support patient self-care
- Interventions published more recently had fewer components are were found to be less effective

http://archinte.jamanetwork.com/article.aspx?articleid=1868538

COLLABORATIVE HEALTHCARE STRATEGIES

# COLLABORATE ACROSS SETTINGS

*Not just a handoff; a purposeful, measured, managed collaboration*

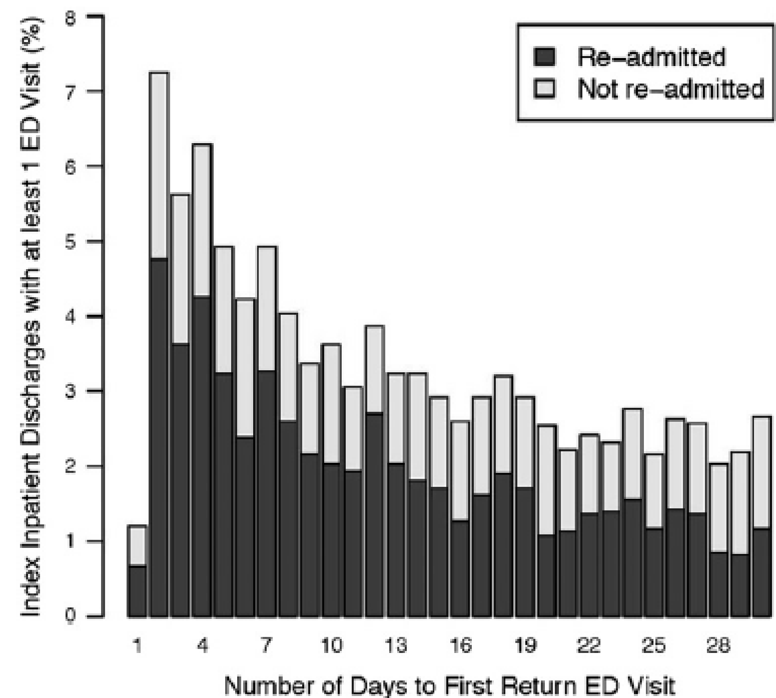
# START IN THE EMERGENCY DEPARTMENT

*ED is the hub of many effective strategies*

# Emergency Department Visits After Hospital Discharge: A Missing Part of the Equation

Kristin L. Rising, MD; Laura F. White, PhD; William G. Fernandez, MD, MPH; Amy E. Boutwell, MD, MPP

- Inpatient discharge - ED revisit
- 24% of inpatient discharges returned to ED <30days
- 46% of revisits were readmitted
- 54% of revisits were d/c






*Annals of Emergency Medicine 2013*

# Top 10 Discharge Diagnoses Leading to ED Return

| Diagnosis | Post d/c ED Revisit | Post d/c ED - Readmit |
|---|---|---|
| CHF | 115/362 = 32% | 95/115 = 83% |
| DM with complications | 97/315 = 31% | 67/97 = 69% |
| Complications of device | 91/316 = 29% | 66/91 = 73% |
| Pneumonia | 89/406 = 22% | 52/89 = 58% |
| Sickle cell anemia | 82/399 = 21% | 58/82 = 71% |
| Nonspecific chest pain | 184/984 = 19% | 109/184 = 59% |
| Cellulitis | 79/432 = 18% | 37/79 = 47% |
| Asthma | 80 / 536 = 15% | 47/80 = 59% |
| Abdominal pain | 73/550 = 13% | 51/73 = 70% |
| Live-born | 102/929 = 11% | 39/102 = 38% |

COLLABORATIVE HEALTHCARE STRATEGIES

*Rising, White, Fernandez, Boutwell. Annals of Emergency Medicine 2013.*

# Experience from state-wide SNF-ED efforts

"The biggest barrier was engaging the EDs. We sent them more focused, standardized information. We gave them contact information to call us. We let them know what our facility can do and indicated we would be willing to take the patient back. It turns out the packets we sent ended up in the recycling bin and never really looked at."

- *Leader of a 300+ site avoidable admission from SNF effort*

# Hallmark Health System Treat-and-Return to SNF

- Hallmark Health System
  - 2 hospital system, 20 ED docs, 17 PAs
  - "Why are almost all SNF patients admitted?"
  - "Patients only seen once a month"; "can't do IVs", etc
  - "If they send them here they can't take care of them"

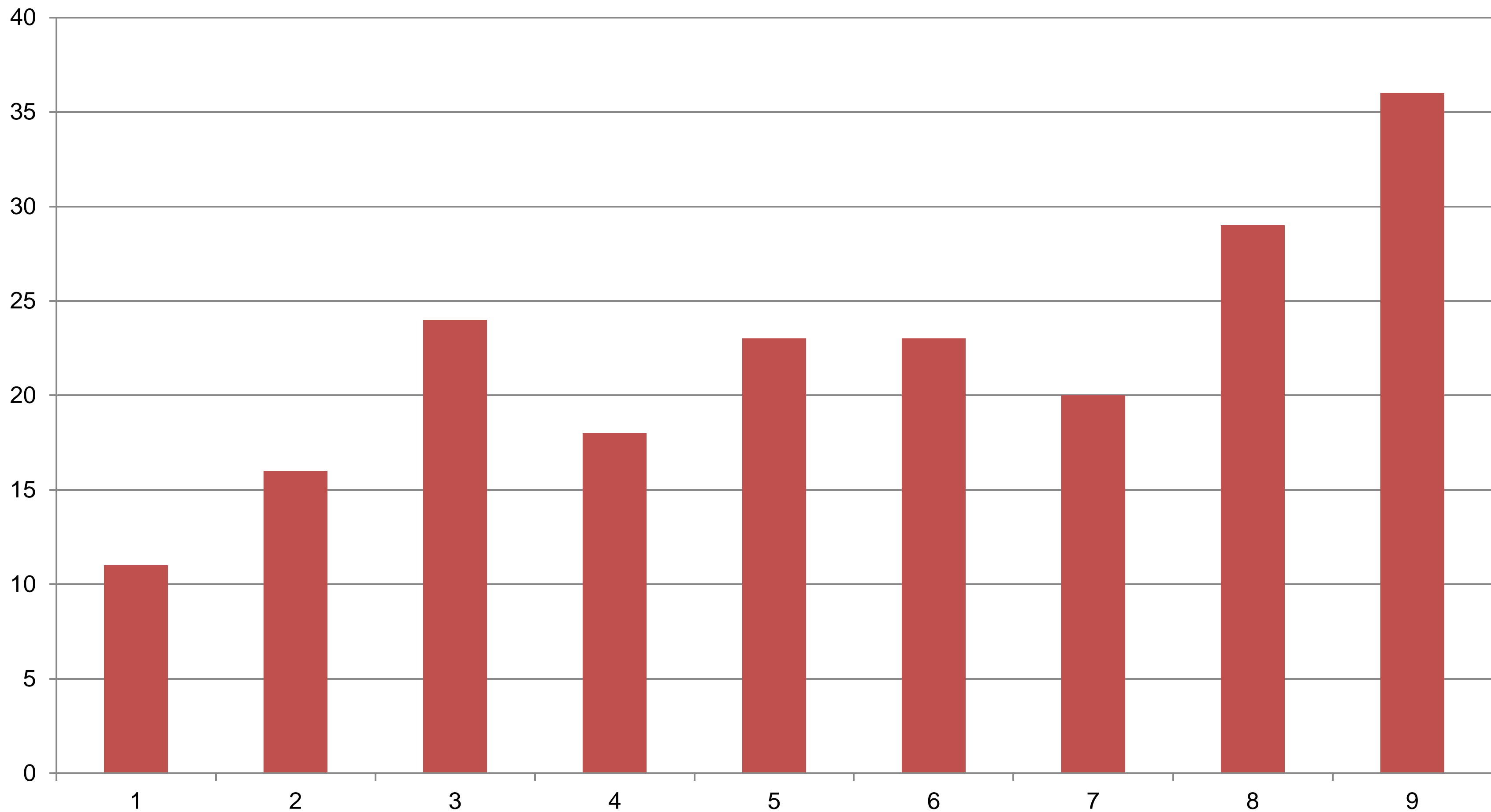
- Actions:
  - Asked ED clinicians "5 whys"
  - Education: posted INTERACT SNF capacity sheets in ED
  - Simplicity : establish contacts, standard transfer information

- Results: increase in number of patients transferred from ED to SNF



*Source: Dr Steven Sbardella, CMO and Chief of ED*
*Hallmark Health System Melrose, MA*

# 9-month results: Treat-and-Return to SNF




January through September

COLLABORATIVE HEALTHCARE STRATEGIES

*Courtesy of Dr Steven Sbardella, Hallmark Health*

# Sinai Hospital of Baltimore-Social Service Agency

- Looked at data**, identified frequent users** of the ED
- **Needs** of frequent users were **not well met** in ED
- Really needed connection to **other resources**
- **Partnered** with community agency- HealthCare Access Maryland
- Identify patients with >4 visits in 4 months **– automated flag**
- Conducted **weekly in-service sessions** to engage / education ED staff
- 3 care coordinators in the ED – contracted staff, have access to EMR
- **Home visits <1 week** of ED visit; **follow for 90days**
- Comprehensive **whole person needs** assessment
- **Link** patients to medical homes and other resources
- **Educate** patient re: when to call PCP rather than go to ED
- “We **partner with** many mental health organizations in the city”
- **Addresses housing** needs
- **80% reduction** in ED visits!

Source: ED Management October 2014

# ED Collaboration with County Public Health

- Carroll County, Maryland
- County and Hospital have a **formal partnership** arrangement
- Health Department deployed **BH peer navigators** in ED
- Navigators **directly connected with** & followed patients
- ~**30% reduction** in utilization for high utilizing BH patients



*Carroll County Health Department*

# MGH High Cost Beneficiary Demo

- Target population: 2500 most expensive Medicare pts at MGH ($68M)
- Opportunity: **Identify** in ED, **intervene** to avoid hospitalization
- Intervention: **Flag** in record to identify patient by registration in ED
  - Patients' full care team (SW, PCP, specialists) paged
  - Expectation clinicians will **"reach in" to ED and avert admission**
- Impact: 20% reduction in hospitalization, 13% reduction in ED visits
  - 12% gross, 7% net savings: for every $1 spend, $2.65 saved
- Lessons learned:
  - May not stop patients from behavior of going to ED
  - These patients always "look bad" (physically, or labs)
  - Clinicians who know the patient know what baseline is
  - Partner with ED doc to reassure no substantial change is present and to assure that close follow up will occur



http://www.massgeneral.org/News/assets/pdf/CMS_project_phase1FactSheet.pdf

# Promote ED – Hospitalist Collaboration

State-wide focus group, part of NY Partnership for Patients:

1. Flag 30-day returns in the ED record
2. Promote collaboration between Emergency Medicine and Hospital Medicine on the decision to admit
3. Encourage Hospital Medicine see the patient in the ED
4. Collaborate with referring providers, especially SNFs
5. Capture the "story behind the story"
6. Form a joint quality review committee of EM and Hospital Medicine to review low-acuity admissions and readmissions



*Boutwell, New York State Partnership for Patients 2014*

# PROVIDE ENHANCED SERVICES

*Best "transition out" of the hospital will not suffice for some patients*

“There’s always going to be a group of folks that’s going to need somebody to help them. That’s never going to change.”

*~ Social Worker, North Philadelphia*

*"It's always been about social work fundamentals: meeting the patient where they are, counseling, teaching, educating. To expect people who are already working and living at a deficit to be able to readily navigate these systems is just unrealistic. "*

*~ Care Transitions Program Manager*

# Transitional Care: Actively Address Social Complexity

## Social Work Transitional Care

- Assess "person in context"
- Employ motivational interviewing
- Connect, assess, reassess
- Needs change over time
- Navigate clinical follow up
- Ensure linkage to services
- Don't over medicalize complexity

*www.transitionalcare.org*

## Multi-Disciplinary Care Teams

- NP, RN, SW, Pharm, Navigator
- Address full complement of medical, social, logistical needs
- Navigator position particularly valuable for outreach, relationships
- Fluid teamwork – problem solving

*Courtesy of Maia White, Highland Hospital*

# Alameda Health System, Oakland CA

- 8 FTE -member transitional care team
- Pharmacist, CHF RN, COPD RN, Social Worker, 2 community health outreach workers (CHOW)
- ***CHOW came from background of detox center workers***
- Program manager, data analyst
- CHOW screen inpatient units for patients with HF, COPD, HIV
- Establish rapport in-house, arrange for follow up quickly
- ***"Acknowledge reality" of marginal housing, poverty, instability***
- ***Specifically inquire about and discuss substance use***
- Accompany, support, touch base, follow up
- RN hold "group visits" as ***"drop in"*** in outpatient conference room
- ***All members of team do home visits***



*Courtesy of Maia White, Highland Hospital*

# St Agnes Hospital, Baltimore MD

- 11-member transitional care staff
- ED-based team
  - 2 RN, 2 SW
  - Staffed 16 hours daily
- Inpatient-based team
  - 4 RN + 1 SW “navigators + pharmacist + LPN educator
  - Adjunct to floor nurses, case managers
  - Enhanced comprehensive care planning and follow-up
  - Bedside delivery of medicines
  - Establish relationship in inpatient setting sets stage for telephonic follow up
  - Telephonic follow up for at least 30days, sometimes more
  - Flexible, proactive, persistent, address all needs
  - ***“Incredible interpersonal skills”***
- Navigators get HIE alerts when patients admitted to other hospitals
  - Navigators call the floors of the other hospitals to share care plans
  - Called a meeting to develop template for care plans to share on the HIE

# NEWEST TOOL : INDIVIDUAL CARE PLANS

*Help us help you….make your all your work readily accessible!*

# Individual Care Plans

- ED- or “Acute” care plans
- Individual, or “Comprehensive” care plans

# ED or “Acute” Care Plan

## What is it useful for?

- Written to influence decisions in ED
- Common symptomatic presentations
- Guide ED-based treatment (avoidance – meds, scans)
- Promotes consistency across providers
- Creates “institutional memory”

## What’s in it?

- Summary of relevant active Issues (not comprehensive history)
- Pattern of utilization (x visits in past y months)
- De-escalation plan
- Symptom or pain management plan
- Behavioral management plan
- Medical clearance plan
- Care Team with contact information

## High Risk Patient Assessment

**Clinical Background**

- History of HIV and gastroporesis with frequent ED visits for abdominal pain, nausea, and vomiting. Attends Smart Pain Management.
- Allergies: Morphine, MSG, Reglan, Shellfish, Vancomycin

**Clinical Challenge**

- 17 inpatient admissions at Northwest Hospital in one year
- Requests IV opioids and Benadryl for pain. Declines other pain medication alternatives
- Per CRISP, seen numerous times at GBMC, St. Agnes, UMMC and Northwest Hospital from June 2014 to April 2015.
- Not compliant with NPO status despite complaints of nausea and vomiting often ordering a guest tray. Witnessed self-induced vomiting.

| | |
|---|---|
| Date of Birth: | |
| Age: | |
| Medical Record: | |
| Gender | |

**Standards of Care:**

1. Narcotics have a high potential for abuse, especially for patients with a hx of chronic pain and liver disease which affects medication metabolization.
2. Medical ethics do not require prescribing a medication when you judge the risks to be greater than the benefits, even if the patient demands the medication.
3. Consider adjunctive pain medications for ongoing chronic pain management (including antidepressants, anticonvulsants, and muscle relaxants) in appropriate patients.
4. Consider alternative therapies to address the affective pain symptoms such as Cognitive-Behavioral therapy
5. When narcotics are used, consider long-acting agents which can be provided/refilled by an identified single provider.
6. An oral or written agreement/contract for appropriate pain medication use may be useful in some cases.

**Recommended Interventions - Emergency Department**

1. Rule out any emergency medical conditions or life-threatening conditions. Attempt to treat pain without use of IV narcotics.
2. Due to self-induced vomiting, place in a room with sitter to monitor patient, as appropriate
3. Complete basic labs to rule out dehydration or infection. Obtain an x-ray as clinically indicated by exam to rule out obstruction.
4. Attempt to control nausea. If you feel pain medication is clinically indicated treat with IV Zofran, wait 15 minutes then give the patient 5 mg PO oxycodone. If patient vomits medication, give 0.5 mg IV Dilaudid mixed in a 100 ML solution for IVPB. Do not give IV push Dilaudid. Do not give IV push Benadryl, unless an anaphylactic reaction occurs.
5. Contact Case Management with patient to ensure appropriate discharge follow up.
6. If no need for ongoing hospital care is present, provide follow up information for **Chase Brexton Clinic.**
7. Consider referral a **Pain Management Specialist.**

**Recommended Interventions - Attending Physician**

1. If patient cannot be safely discharged from the ED and must be kept in the hospital, consider observation status.
2. Attempt to treat with non-narcotic agents. Again, if narcotics are required consider oral agents. Attempt to control nausea. If you feel pain medication is clinically indicated treat with IV Zofran, wait 15 minutes then give the patient 5 mg PO oxycodone. If patient vomits medication, give 0.5 mg IV Dilaudid mixed in a 100 ML solution for IVPB. Do not give IV push dilaudid. Do not give IV push Benadryl, unless an anaphylactic reaction occurs.
3. Make a referral to Case Management/Social Work and consider Pain Management as part of discharge plan.
4. Please provide follow up information for Chase Brexton Clinic.
5. Consider referral a **Pain Management Specialist.**

**Recent Studies**

- 14 XR-Abd/EWPA Chest at NWH from 11/2014 through 5/2015 with no significant findings
- 4 XR Abd Flat & Erect from 11/2014 through 4/2015 at NWH with no significant findings
- Diagnostic Imaging at St. Agnes x4 from 11/2014 through 4/2015
- 3 CT abdomen and pelvis on Jan 2015, March 2015, April 2015 at NWH unremarkable
- XR Chest 2V at NWH in Jan and Feb 2015 unremarkable
- Stress Thallium in Jan 2015 at NWH no significant finding

**For help with High Risk Case Management call:**

Dr. Susan Mani
Dr. Tanveer Gaibi
Maria Manna
Krystal Howard
Kimberly Knipp

Baltimore Hospitals

- Multiple hospitals collaborating
- Develop 1 page Summary
- Background
- Challenge
- Recommendations – staff, MDs
- Recent studies
- Care Management contact

# Comprehensive Care Plan

- Intended to facilitate care management
- Across settings (hospital, SNF, HH, ambulatory care)
- Over time
- Across clinical and non-clinical entities (medical – social – familial)
- Transparent and/or shared by patient & family/caregiver
- Lives in shared care management platform, medical record, other
- Shared broadly for care coordination

# BI-Plymouth Example

- Community Care Plan
- Focus on BH patients
- 4 pages



BID-Plymouth
Community Case Management Individualized Patient Care Plan

**Patient Name:** **DOB:** **Medical Record #:**
**Patient Address:**
**Patient Phone Number:**

**Health Goal:**

*What would you like to change/improve about your current*

*Do you think you are healthy?*

**Team Members:**

| | Agency/ Formal Support | Primary N |
|---|---|---|
| ☐ | BID-P Community Case Manager | |
| ☐ | BID-P Community Social Worker | |
| ☐ | BID-P Community NP | |
| ☐ | BAYADA Home Health Care VNA<br>Liaison-Carolyn Scofield<br>xxx-xxx-xxxx | |
| ☐ | VNA of Cape Cod<br>Liaison-Kathy Balint<br>xxx-xxx-xxxx | |
| ☐ | Gentiva Home Healthcare<br>Liaison-Jackie Lawrence<br>xxx-xxx-xxxx | |
| ☐ | Norwell VNA (NVNA) and Hospice<br>Liaison-Michelle Razzaboni<br>xxx-xxx-xxxx | |
| ☐ | Oxygen Vendor,<br>Contact Person<br>Phone Number | |
| ☐ | Foster Care | |
| ☐ | Group Home | |
| ☐ | Vinfen | |
| ☐ | OCES | |
| ☐ | OCES (Frail Elder Program) | |
| ☐ | Private Duty Care | |
| ☐ | Meals on Wheels | |
| ☐ | Other | |

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**PCP Team:**

| | Select the PCP Team | PCP Name |
|---|---|---|
| ☐ | Plymouth Medical Group (PMG) | (drop down list- to be created wh obtained) |
| ☐ | Affiliated Physicians Group (APG) | |
| ☐ | Plymouth Bay Medical Associates (PBMA) | |
| ☐ | Atrius | |

**Health care proxy**

☐ Yes
☐ No

*If so, please list relationship, name, contact information:*

**Legal guardian**

☐ Yes
☐ No

*If so, please list relationship, name, contact information:*

**Recent/pertinent medical information/history:**
*Fill in information here:*

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**Individual Patient Care plan**

| | Problems | Additional Details/notes |
|---|---|---|
| ☐ | Homebound (explain) | |
| ☐ | Limited or no transportation to PCP office/medical appointments | |
| ☐ | Limited or no caregiver | |
| ☐ | Fall Risk | |
| ☐ | Difficulty Paying for Medication | |
| ☐ | Lives Alone | |
| ☐ | Hoarder/ Hoarding Tendencies | |
| ☐ | Difficulty with Communication | |
| ☐ | Sensory Limitations | ☐ Vision ☐ Hearing |

| | Goals |
|---|---|
| ☐ | Access/ Availability to Homebound Team |
| ☐ | Secure Home Support |
| ☐ | Secure VNA Falls Program |
| ☐ | Secure medications |
| ☐ | Secure social worker intervention |
| ☐ | Confirm best communication modality |

| | Interventions |
|---|---|
| ☐ | Coordinate Homebound Team appointment(s) |
| ☐ | Initiate VNA referral w/provider |
| ☐ | Initiate OCES referral |
| ☐ | Complete social work referral |
| ☐ | Identify resources for medication procurement, e.g., low cost pharmacy, assistance programs |

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| Social History | | | |
|---|---|---|---|
| Smoker | ☐ Yes ☐ No | | |
| Living Situation | ☐ Own | ☐ Staying with Family | ☐ Shelter |
| | ☐ Rent | ☐ Staying with Friends | ☐ Homeless |
| | ☐ Residential Care | ☐ Unstable | ☐ Foster Care |
| | ☐ Other | | |
| Pets | | | |
| Diet | | | |
| Hobbies | | | |
| Alcohol | ☐ Yes ☐ No<br>Amount: | | |
| Drug Use | | | |
| Marital Status | ☐ Married ☐ Single ☐ Widowed ☐ Divorced | | |
| Children | | | |
| Occupation | | | |
| Exercise | ☐ None ☐ 1-3x/week ☐ 4-5x/week ☐ 5+ x/week<br>What type (explain): | | |
| Caffeine | ☐ Yes ☐ No | | |
| Other Notes | | | |

**Functional status:**

**Pertinent Community Case Management Information:**

DRAFT

# Summary

- Know your data – use it as a powerful tool
- Constantly work to understand why patients return to the hospital
- Successful efforts include multiple efforts: In the ED, Improved Standard Care, Purposeful Collaboration, Delivering New Services
- Deploy care teams that actively “do for” – navigate, advocate, support
- Don’t over-medicalize utilization: view through social / behavioral lens
- Leverage the ED as a valuable setting for engagement & linkage

# *THANK YOU*

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