



eHEALTH INITIATIVE

Real Solutions. Better Health.

National Council on Data & Analytics

Tackling ED Recidivism & Readmissions

Friday, December 20

11:00am-12:00pm ET

Agenda

- Welcome and introductions
- Roll call
- Council Announcements
- Presentation
 - Tackling ED Recidivism & Readmissions
 - Leah Montoya, MHA, BSN
Director- Clinical Resource Management, Compliant Documentation Management, & Diabetes Care Center
Advocate Good Shepherd Hospital
- Questions / Discussion
- Next Stems



Reminder:

- All Lines Are Open!
- Press *6 to mute, *7 to unmute you line
- This call is being recorded



Are You Missing Out On This?

The **Data & Analytics Council** will meet **IN PERSON** on January 28 before the 2014 Annual Conference in Orlando, FL!

- **Meet and network your fellow council members face to face!**
- **Give us your input on eHI priorities for 2014!**



ANNUAL CONFERENCE 2014

THE ROADMAP TO HEALTHCARE DELIVERY TRANSFORMATION



January 28-29, 2014 | CHAMPIONSGATE FL

Discussion Topics Include:

#eHI2014

- *Disruptive Innovations in Data and Technology: Lessons Learned from Other Industries*
- *Leveraging Analytics to Support Population Health*
- *Privacy and Security: Challenges and Best Practices*
- *Much More!*

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eHI 2014 National Forum on Data & Analytics

- May 21-22, 2014 at the Omni Shoreham in Washington, DC
- We will be seeking input from the Council
- Call for speakers to open in mid-January



Co-Chairs

The Council is chaired by:

- Connie Moser
VP of Performance Analytics
McKesson
- Craig Richardson
VP of Global Business Intelligence
Johnson & Johnson



Tackling ED Recidivism & Readmissions:

Empower and Engage Your Organization



Utilizing An Individualized Care Planning Approach

Leah Montoya, MHA, BSN, RN

Director – Clinical Resource Management, Compliant
Documentation Management, & Diabetes Care Center



Inspiring medicine. Changing lives.

Advocate Good Shepherd Hospital



Community-Based

Barrington, Illinois

- 169 Beds

34,000 ED Visits

11,000+ Inpatient Admissions

7,000+ Procedures

Certifications/Awards:

- 2013 ANCC Magnet Recognition
- Level 2+ Trauma
- Oncology
- Stroke
- Diabetes
- 2013 Richard L. Doyle Award
- Truven Top 50 Cardiovascular Hospital
- EDAP
- Chest Pain Clinic Journey

Advocate Health Care

- Named among the nation's Top 5 largest health systems by Truven Analytics.
- Largest health system in Illinois and one of the largest health care providers in the Midwest.
- Operates more than 250 sites of care, including 12 hospitals that encompass 11 acute care hospitals, the state's largest integrated children's network, five Level I trauma centers (the state's highest designation in trauma care), two Level II trauma centers, one of the area's largest home health care companies, and one of the region's largest medical groups.

Realities of High Recidivism

One of the most important **negative** impacts on patients who have a high ED recidivism is that the care they do receive is potentially:

Inconsistent **nor** High-Quality Care

Realities of High Recidivism

With each ED visit:

- **Lack of communication between ED MDs**
 - The plan of care and treatment can greatly differ from visit to visit even if the symptom presentation is the same
 - Can cause confusion for the patient, ie. differing goals
- **Lack of continuity of care**
 - Using the ED as THE primary care
 - Not promoting healthy outcomes

Realities of High Recidivism

Costs and Over-Utilization of Resources

- Duplication of Diagnostic Exams
 - Labs
 - Cat Scans
- Readmissions
- Reimbursement

Realities of High Recidivism

Managing Chronic Pain

- ED is unable to coordinate or monitor medications
- Prescription practices are also highly variable
 - * One study showed that in identical situations...
10% would prescribe a narcotic and 10% would not
- Over-prescribing risk
- Greater risk of addiction and overdose

Reasons for Initiating the ICP Program (Individualized Care Plans)

- **ED staff and ED MDs feel “hopeless & helpless”**
 - Patient satisfaction concerns
 - Decreased associate morale
 - Patient Fatigue Syndrome
- **Inconsistent and fragmented care**
 - Not addressing the real needs of patients
 - No continuity of care
 - Are we harming or helping the patient?
- **Health Care Reform**
 - Readmissions
 - Reimbursement Concerns

Individual Care Planning Fundamentals

Clinical Question:

Can an inter-disciplinary healthcare team effectively reduce the misuse or overutilization of the Emergency Department while ensuring continuity of high quality, patient-centered care?

Project Purpose:

- **Provide consistent high quality, patient-centered care with each ED visit.**
- **Reduce recidivism rates.**
- **Manage healthcare costs.**
- **Empower patients to become active participants in their own healthcare by providing tools and alternatives to promote healthy lifestyles.**
- **Partner with patient's healthcare providers to create individualized plans of care.**

Individual Care Planning (ICP) Fundamentals

This is **NOT** about denying care but rather facilitating access to appropriate care, treatment, and resources.

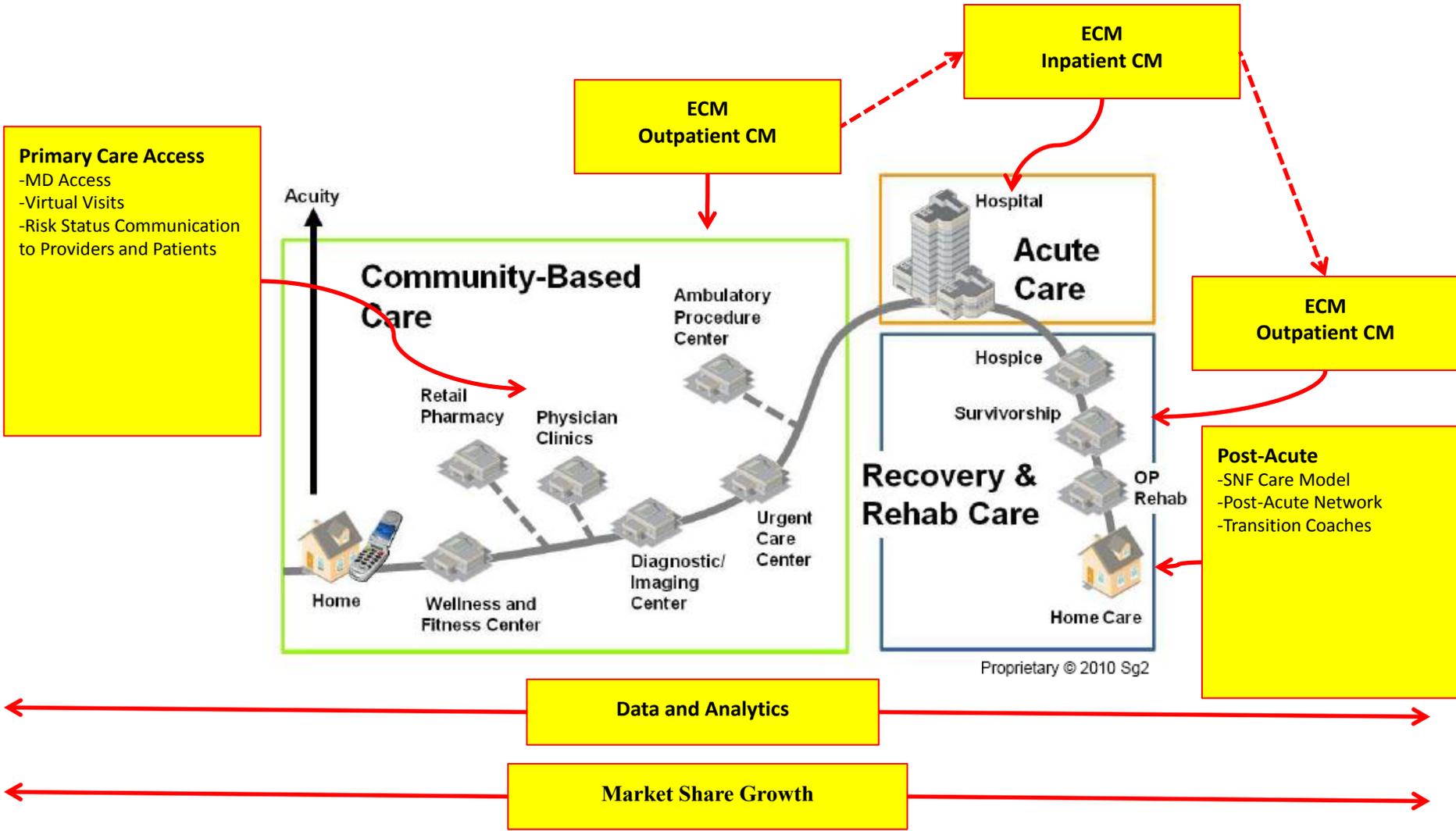
- Patient-centric and wholistic
- Enhances the quality and consistency of care by improving communication amongst the healthcare team members
- Continuity of care

Changing Paradigms: What Do We Need To Do Differently?

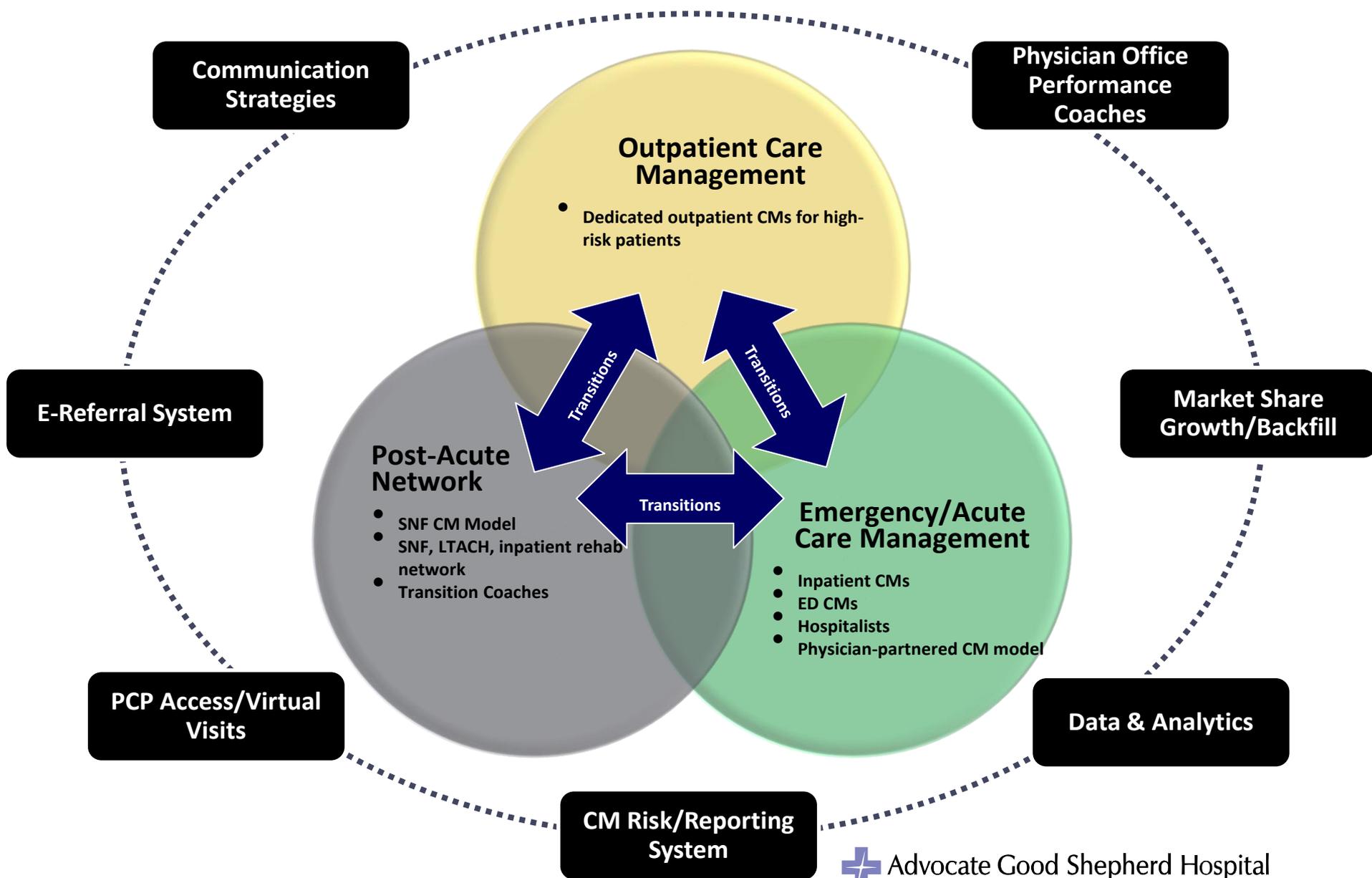
Enterprise Care Management (ECM)

FROM...	TO...
Silo case management	Enterprise care management
Episodes of care	Coordination of care
Discharges	Transitions
Utilization Management	Right care, right place, right time
Caring for the sick	Keeping people well
Production (volume)	Performance (value)

Where Does ECM Strategies Fit In?



2011 ECM Infrastructure & Support



Team Membership

Core Inter-Disciplinary Team

- ED Physicians
- ED RNs
- ED Leadership
- ED Nurse Care Managers
- ED Social Worker
- ED RN/Pediatric Liaison
- Oncology Nurse Navigator
- Chaplain

Ad Hoc Team Members

- Inpatient Nursing Team
- PCPs and Specialists (pain, radiologist,...)
- Inpatient Social Workers
- Inpatient and Outpatient Care Managers
- Hospice/Palliative Care
- Community Resources
- Pre-hospital



Formalized ED Care Planning Begins!

Want to help create plans of care for our patients who are "superusers" or for those who have chronic complicated health issues?



Interdisciplinary Participants needed:
ED MDs, Care Managers, ED RNs, Social Workers

- We will be creating a standardized process
- We will be using evidenced base practices
- We will create an actual policy
- We will design a process in which all members in the ED will be able to "recommend" patients
- We will work collaboratively with pt's PCPs

Friday September 30th
ED Administrative Conference Room
10:00 – 12:00
Participants will agree upon future meeting time and dates.

Foundational Work

- Identify the Patient Population
- ED Recidivism and Readmissions
- Develop Exclusion & Inclusion Criteria
- Enrollment & Referrals of Patients
- Data Collection
- Team Membership and Meeting Schedule
- Creating a Vision and Charter
- Create Operational Guidelines
- Patient Information Accessibility
- Reporting Structure
- Integrating Patient Information into the EMR
- Creating Visual Triggers – Transparency in Communication
- Gaining Organizational & Leadership Support
- Compliance w/ HIPAA, Legal, Risk, HIM....

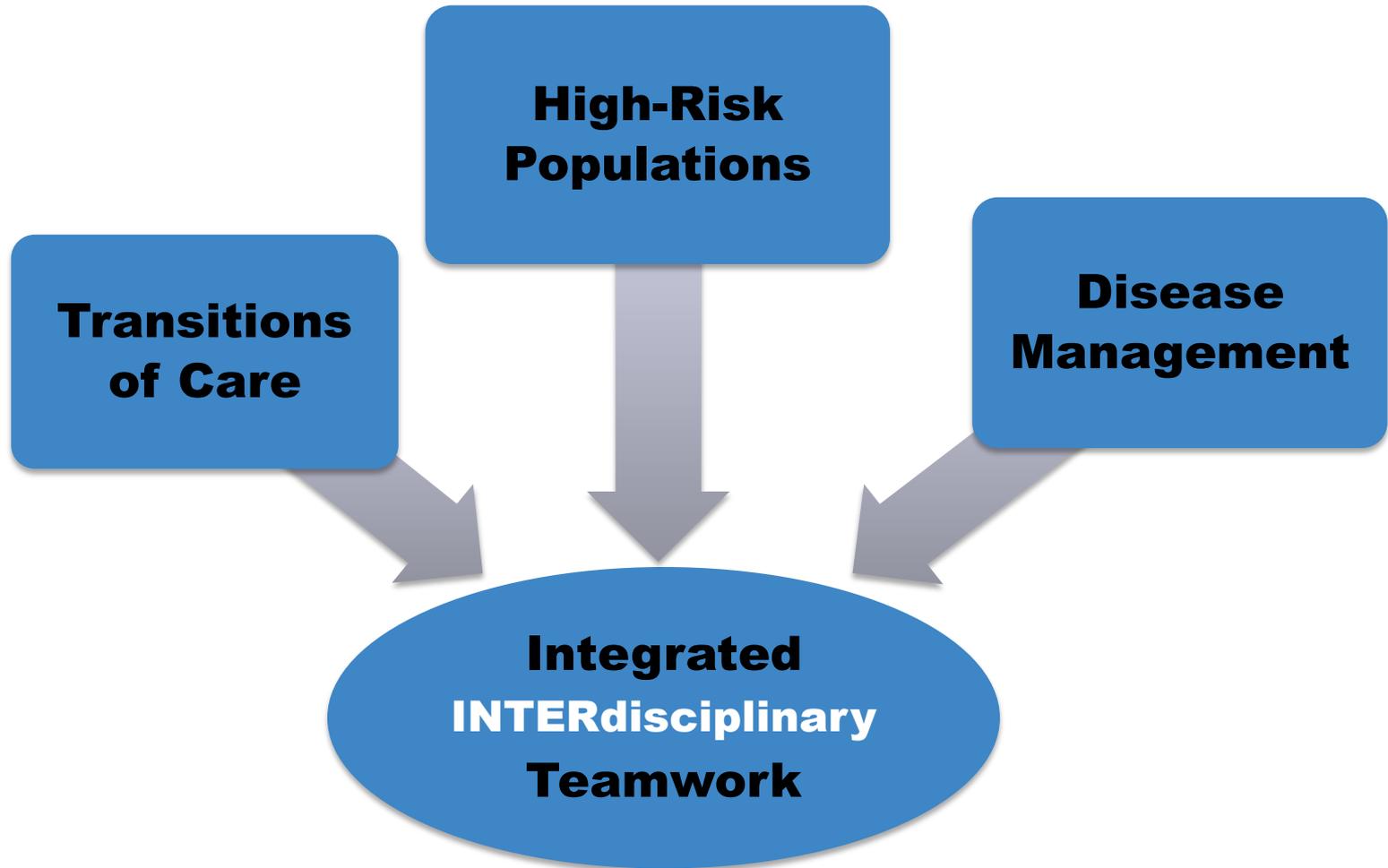
ICP Team Vision

- Our purpose is to re-instate control of the patient's condition back to the patient by creating a degree of wellness that allows the person to function at their highest contributing level.
- The patient is an active member of the team and often the driver of the plan in conjunction with the people who know the patient the best: their family, significant others, and their physician(s).
- By planning and creating options and choices, the plan is **Patient-Driven** and **Inclusive**.

Individualized Care Planning Format

- **Inter-disciplinary ED Care Plan Team**
- **Under direction of ED MD**
- **Engagement & empowerment of ED staff**
- **Provides the tools for the patient to ultimately take responsibility for their own health/wellness**
- **Care Plans are the essence of Care Management**
- **Essentially budget-neutral**

Integrating ED Care Management Model



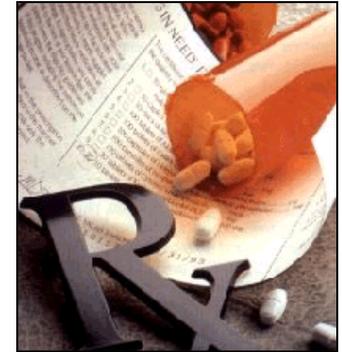
Synergism

The Care Manager and the Social Worker Dyad

- **Care Manager/Social Worker** assesses the patient/family need.
- **Care Manager/Social Worker** tag-teams medical, psycho-social, behavioral, and/or substance abuse issues.
- **Partnership** with patients and families to involve them in the individualized plan of care.

Inclusion / Exclusion Criteria

Identifying Patients



1. One of the three following visit trends:

- More than 6 visits for the same or similar complaint in the last year
- More than 3 visits for the same or similar complaint in the last 6 months
- More than 10 visits for various pain or condition complaints in the last year

2. Evidence on the Illinois Prescription Monitoring Program website (<https://ilpmp.org>) of inappropriately obtaining opioid prescriptions

- Opioid prescriptions written by multiple providers or from different locations
- Overlapping prescriptions
- Patient not forthcoming about when last prescription was filled

3. Other questionable behavior that can be well-documented

- Patient makes no effort or seems dishonest about following-up with their primary doctor or specialist since the last visit
- Subjective pain is significantly out-of-proportion to objective findings
- Concurrent presentation of opioid withdrawal symptoms

4. Other special needs patients such as those with LVADs, hemophilia, et al.

Individualized Care Planning Format

- **Staff and physicians can both refer/recommend patients**
- **Scheduled monthly ICP meetings**
 - Ongoing work throughout the month
- **Case presentation and review**
 - Criteria met?
- **Create a plan of care**
 - Simple versus Complex
 - Formal Care Conferences
- **ICP document generated**
 - Patient “icon” entered in the EMR



Automated EMR Visual Trigger

FirstNet Organizer for Firtik-RN, Dawn

Task Edit View Patient Chart Patient Actions Provider List Help

Tracking Shell Patient List LearningLIVE Non-Physician

CareConnection ED

Tear Off Attach Charges Exit Calculator Message Sender AdHoc Request A Chart Chart Request Maintenance Explorer Menu Encounter Location History Viewer Patient Pharmacy

POKLENKOWSKI, RAFFELA Recent Name

Tracking Shell Print 1 minutes ago

GSH All Patients GSH WR/Triage GSH Admitted Patients GSH 3 Days Back GSH Pending Lab GSH All Beds

Patient: Patient Name WR: 3 Total: 24 Avg LOS: 2:28 Filter: GSH All Pts

Bed	LOS	CP Name	Age	Alk	Greet C	Reason for Visit	Triage Hx	LOC	AcMD	RN	Events	MAR	IV	Stop	Lab	Rad	Comment	Disp
1	0:43	Patient Name	93 y	*	difficulty	1:Abdominal pain	pt reports mid up	3	EC	Amy	🚑 📄 📄 📄 📄 📄				11/0	2/0/0	*	
2	3:32		62 y	*	CHEST	1:Abdominal pain	pt developed pain	3	LD	KAREN	🚑 📄 📄 📄 📄 📄				📄	📄	*US WCB WHEN	
3	5:47		5 y	*	swollen	1:Foot pain-swel	Child developed s	3	EC	KAREN	🚑 📄 📄 📄 📄 📄				📄	📄		
4	0:04		81 y	*	difficulty						🚑 📄 📄 📄 📄 📄							
5	2:17		32 y	*	evaluatic	1:Shortness of br	Pt had an ASD p	3	EC	Patty P	🚑 📄 📄 📄 📄 📄				8/7	2/1/0	trop 0.22	*
6	1:11		20 y	*	evaluatic	1:Alcohol withdra	drinking whisky s	3	EC	KAREN	🚑 📄 📄 📄 📄 📄	1	📄		9/0		inpt detox	
7	3:25		63 y	*	30DIZZIN	1:Dizziness	c/o dizziness on/o	3	EC	Patty P	🚑 📄 📄 📄 📄 📄	2	📄		1/1/0		CT a/p - 1500	
9	2:08		38 y	*	fall	1:Medical proble	increased spacic	3	EC	Patty P	🚑 📄 📄 📄 📄 📄	1	📄		4/1			
10	13:06		15 y	*	evaluatic	1:Alcohol intoxic	Pt (Minor), prese	2	ML, TP	Erika	🚑 📄 📄 📄 📄 📄				📄	📄	transfer-dd	T
11	5:25		16 y	*	evaluatic	1:General medic	Pt is presented ti	2	ML	Erika	🚑 📄 📄 📄 📄 📄	1	📄		📄	📄		
14	0:26		87 y	*	dizziness	1:Dizziness	Pt had sudden or	3		Erika	🚑 📄 📄 📄 📄 📄	1						
16	2:23		78 y	*	anxiety*	1:Anxiety	pts house caught	5	ML	Amy	🚑 📄 📄 📄 📄 📄						dc to family	
21	1:00		12 y	*	syncope	1:Syncope/Near	playing tennis ou	3	LD	EM	🚑 📄 📄 📄 📄 📄				📄			
22	1:32		60 y	*	fall*	1:Closed head in	Pt tripped over th	4	LD	Voytek	🚑 📄 📄 📄 📄 📄					1/0/0	*	
23	2:27		13 y	*	fever	1:Fever	w/d that began 3	3	LD	Amy	🚑 📄 📄 📄 📄 📄				4/2	📄	*	
24	1:37		50 y	*	difficulty	1:Shortness of br	pt used an old ne	2	EC	EM	🚑 📄 📄 📄 📄 📄	1			7/6	1/1/0	*	
25	3:34		10 y	*	VOMITIN	1:Diarhea	Mom and child w	3	LD	EM	🚑 📄 📄 📄 📄 📄				📄			
26	2:58		36 y	*	mvc: aut	1:mvc	restraint driver go	3	LD	EM	🚑 📄 📄 📄 📄 📄				📄	📄		
27	0:31		5 y	*	injury:he	1:Facial laceratio	child was playing	4		Voytek	🚑 📄 📄 📄 📄 📄							
28	2:23		46 y	*	pain:leg	1:Abdominal pain	c/o right hip/leg,	3	EC	Voytek	🚑 📄 📄 📄 📄 📄	1	📄		2/2/0		ct@1505, iv zosy	
29	1:59		15 y	*	fall	1:Closed head in	pt was on a "long	4	ML	Voytek	🚑 📄 📄 📄 📄 📄				1/0/0	*		
WR	0:28		72 y	*	pain:abd	1:Medical proble	1 week of "equilib	3			🚑 📄 📄 📄 📄 📄						15	
WR	0:15		23 y	*	chest pa	1:Flank pain	pt started with fla	3			🚑 📄 📄 📄 📄 📄							
WR	0:12		21 y	*	fever	1:Fever	Spanish speaking	3			🚑 📄 📄 📄 📄 📄							

Individualized Care Planning Format

Emergency Department Care Plan

DOB: 7/7/76 **REVISED 7/17/13. LH**

MR# [REDACTED]

Initiation Date: 1/29/12. Revision 6/1/12 (per Dr. [REDACTED] and Dr. [REDACTED]) Revision 5/15/13 per conversation Dr. [REDACTED] and Dr. [REDACTED]

- Dr. [REDACTED] spoke w/Dr. [REDACTED] 5/15/13 – per Dr. [REDACTED] patient trying to get pregnant – check HCG w/each visit prior to meds.
- If HCG pos. call OB GYN regarding pain meds – will need to get OBGYN info from patient
- Ok to give Dilaudid IM per Dr. [REDACTED] if unable to obtain IV access
- SPOKE W/ DR [REDACTED] 7/17/13, STATES IT IS OK FOR PT TO RECEIVE DILAUDID/STADOL IF PREGNANT

Multiple complaints of pain and cyclical vomiting syndrome

- May use narcotic protocol ONLY 2 times per calendar month.
- If the patient has had 2 visits for the month, then utilize the non-narcotic protocol
- Patient is NOT to receive Ativan or other Benzodiazepines
- DO NOT push Dilaudid fast per pharmacy protocol due to risk for respiratory depression.

Narcotic Protocol

1. Please consider 1-2 liters of IV fluid
2. Dilaudid 1-2 mg SLOW IVP x2 with one hour interval (max dose Dilaudid 4 mg)
3. Zofran 4-8 mg (may possibly repeat Zofran)
4. Phenergan 25 mg IM Only.

Non-Narcotic Protocol

1. Toradol 30mg IV push
And / or
2. Naxflex 30mg IV push

Pt is now taking STADAL NASAL SPRAY TID, AND ZOFRAN ODT TID, PRN

Pain Specialist- [REDACTED] MD
Partner- Dr. [REDACTED]
[REDACTED] Pain Center
[REDACTED] Ave, Suite 230
[REDACTED] IL 6 [REDACTED]
Phone [REDACTED]

- Please contact the pain specialists with any questions/concerns, or if the patient has exceeded the 2 visit per month protocol. Otherwise, contact the physician on a monthly basis for routine collaboration.

Emergency Department Care Plan

DOB 4/[REDACTED]

MR# [REDACTED]

Initiation Date: 5/14/13

PCP: None

Direction of Care:

- Direction of care is to provide a consistent plan of care from ED visit to ED visit
- Daily cannabis use, chronic vomiting and pain
 1. Fits profile of cyclical vomiting and pain syndrome
- Psych social worker to see patient with each visit to support resources and offer counseling and other rehab services as needed
- Patient expresses coping with anxiety and depression
- Patient given written literature on last visit
- Narcotics to manage pain is a decision ED MD will determine with each visit
- Her primary care physician should be managing any narcotic pain prescriptions

Cyclical Vomiting and Pain Syndrome Protocol

Upon arrival, initiate the following:

1. Give one liter bolus of normal saline (0.9NS)
2. Zofran 4mg – 8mg IVP
3. Physician can consider Toradol 15mg – 30mg IVP
4. Physician can consider narcotic medications such as Dilaudid

Why:

- We need to provide a medical screening for every patient that arrives to our ED
- We will provide consistent care and safe care, with each visit, if we all follow the care plan protocol
- We will manage the expectations of the patient and family
- The patient's PCP will be contacted to update him on the number of ED visits and how the care plan protocol is working for the patient, patient compliance with continuing care, and other information as identified by the ED Care Planning team.

Special Need:

- Anxiety can be associated with this syndrome. May utilize ED psych social worker PRN.

Emergency Department Care Plan

DOB: [REDACTED]

MR# 00 [REDACTED]

Initiation Date: 5/14/13

PCP: None

Direction of Care:

- Not truthful when physician has asked about past narcotic prescriptions
- Has an extensive Illinois Prescription Monitoring list
- You may give her any medication that you feel appropriate to manage her pain EXCEPT for addictive medications i.e. Dilaudid, Morphine, Fentanyl, et al.
- Do not write for prescription narcotic medications
- Psych social worker to see patient with each visit to offer drug rehab / counseling

Why:

- We need to provide a good thorough medical screening.
- Review History.
- Review prescription history in Illinois Narc Nanny.

Talking Point Guidelines when speaking to [REDACTED] about her plan of care

1. We, all the physicians here at Good Shepherd Hospital also believe narcotics are worsening your migraines. We will be happy to help manage your pain by using a wide variety of non-addictive medications we have readily available here in the emergency department.
2. (If she complains that we are violating her rights or refusing to care for her)
 - a. We are more than happy to take care of you in our ER but we will no longer give you narcotics as part of your plan of care for migraines.

Care Plan Operational Guidelines

Patient Criteria/Assessment

Plan Development

Implementation

Monitoring

Evaluation

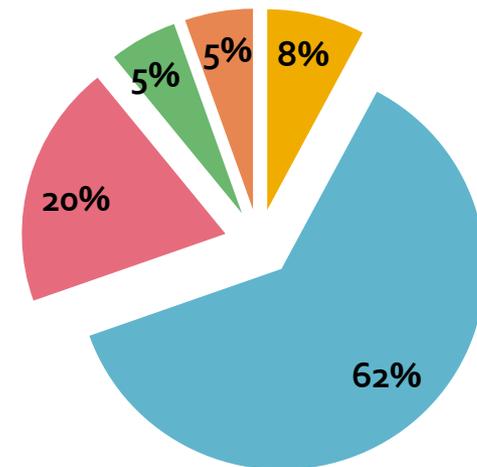
**Re-Assessment/
Refinement**

Identifying Our Patient Population

■ (4) Demographic Groups

- Chronic Care & Special Needs
- Behavioral-Related Issues
- Social Concerns
- Narcotic-Dependent
- (1) Sub-Group
“Cat Scan Watch List”

Distribution of Patients Amongst the
Five Different Demographic ICP Groups
4/2013 N=257

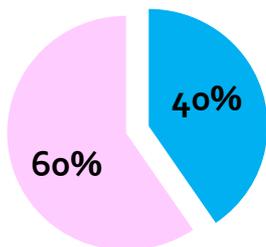


As of November 2013, Over 300 Patients Enrolled in the GSHP Individualized Care Plan Project

Male/Female Distribution for Combined Demographic ICP Groups

N=257

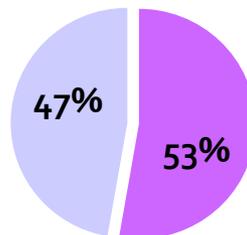
■ male ■ female



Physician Distribution for Combined Demographic ICP Groups

N=257

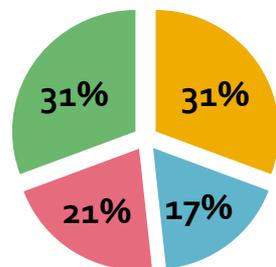
■ PCP ■ No Doctor



Insurance Distribution for Combined Demographic ICP Groups

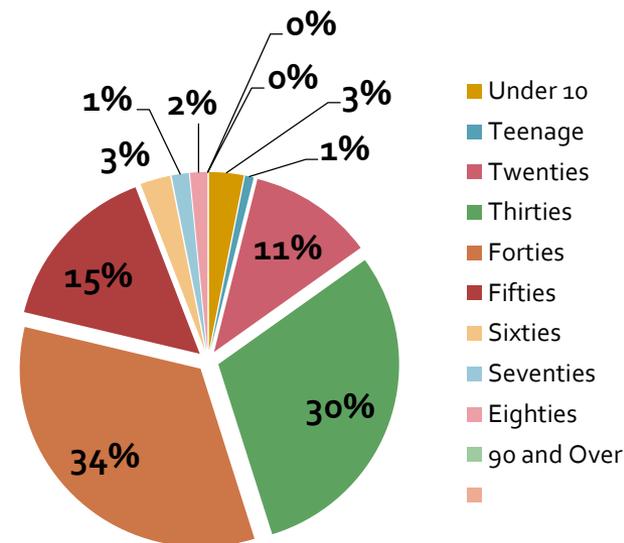
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■ Insured ■ Medicare ■ Medicaid ■ Uninsured



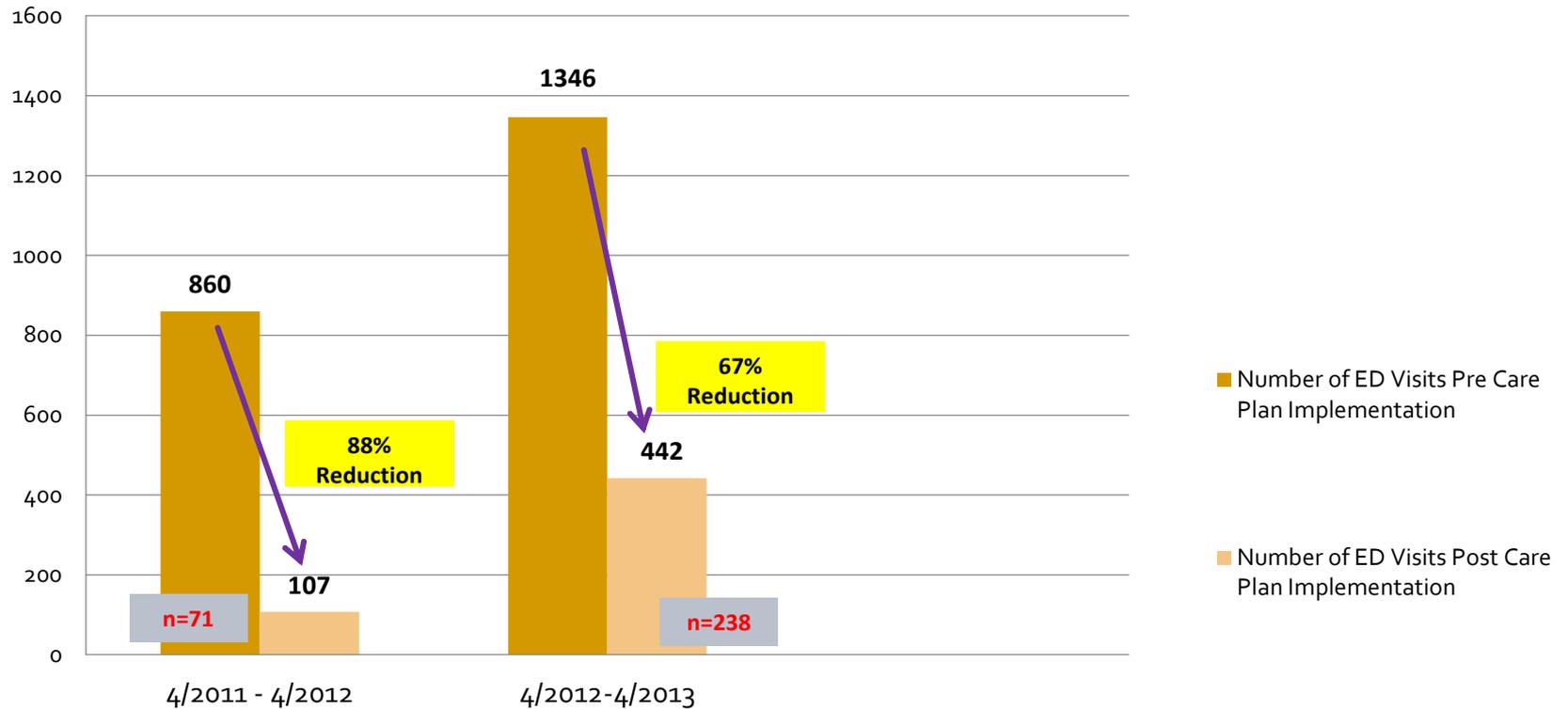
Age Distribution for Combined Demographic ICP Groups

N=257



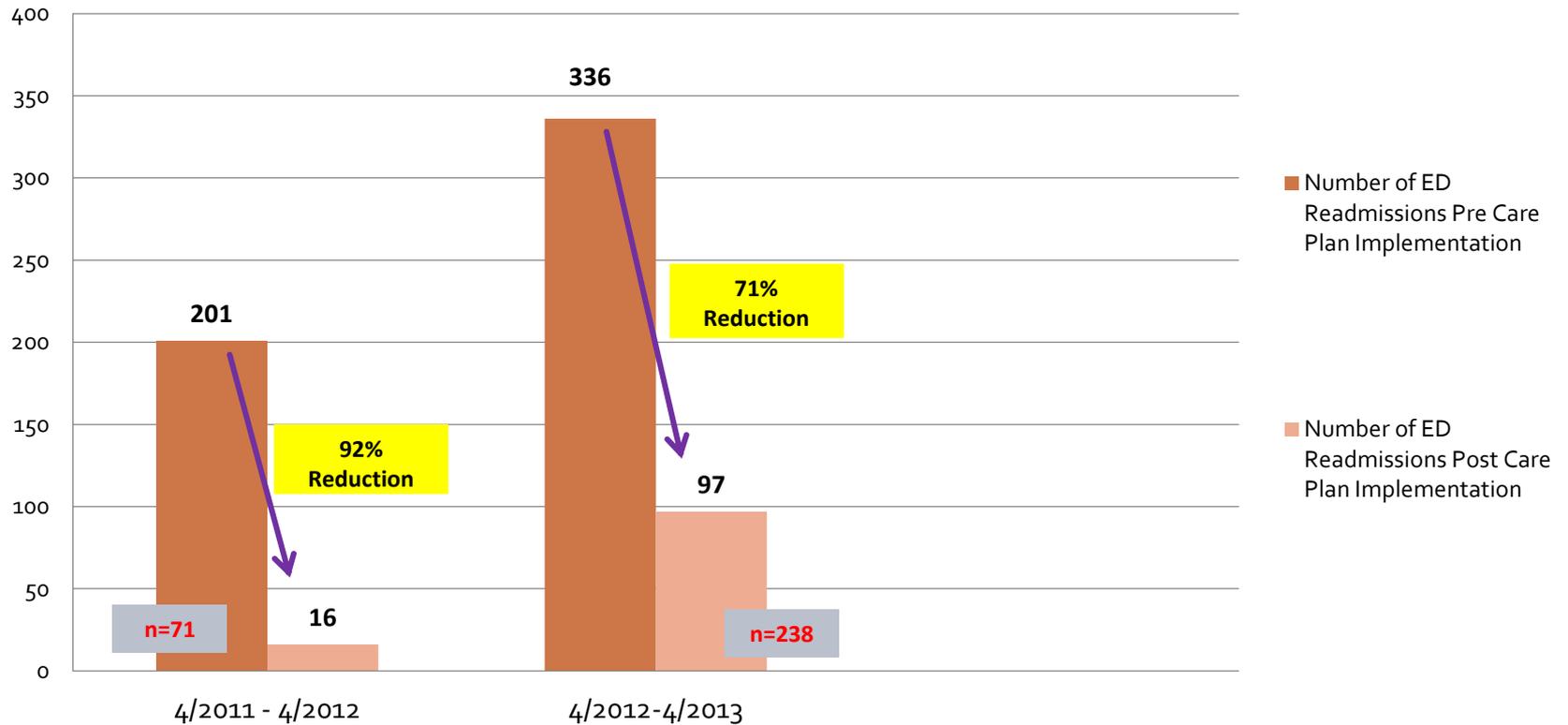
Positive Impact Seen With Reducing Recidivism

ED Recidivism Reduction as seen in Combined Demographic ICP Groups Yearly Trend



Positive Impact Seen With Reducing Readmissions

ED Readmissions Reduction as seen in Combined Demographic ICP Groups Yearly Trend

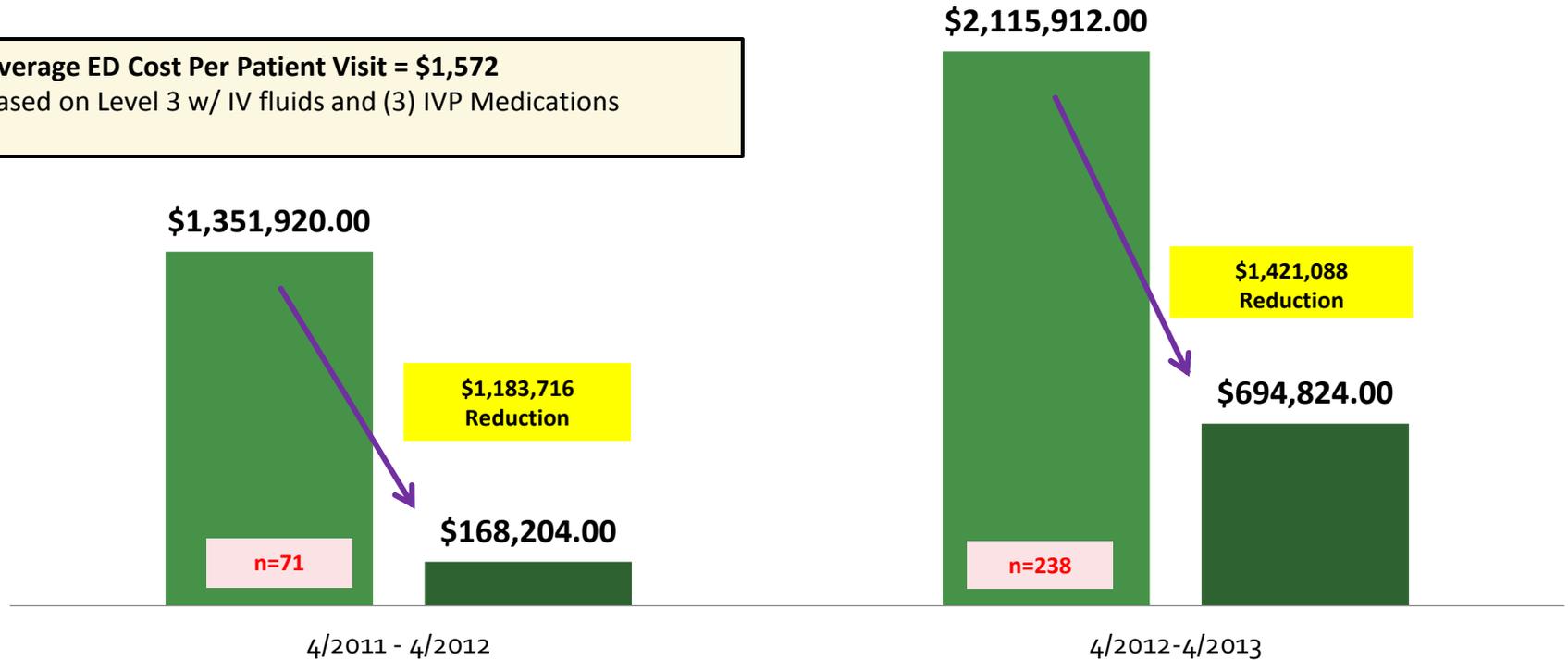


Cost Analysis on ED Recidivism

ED Recidivism Estimated Cost Reductions Yearly Trend for Combined Demographic ICP Groups

■ ED Visit Costs Pre Care Planning Implementation ■ ED Visit Costs Post Care Planning Implementation

Average ED Cost Per Patient Visit = \$1,572
Based on Level 3 w/ IV fluids and (3) IVP Medications

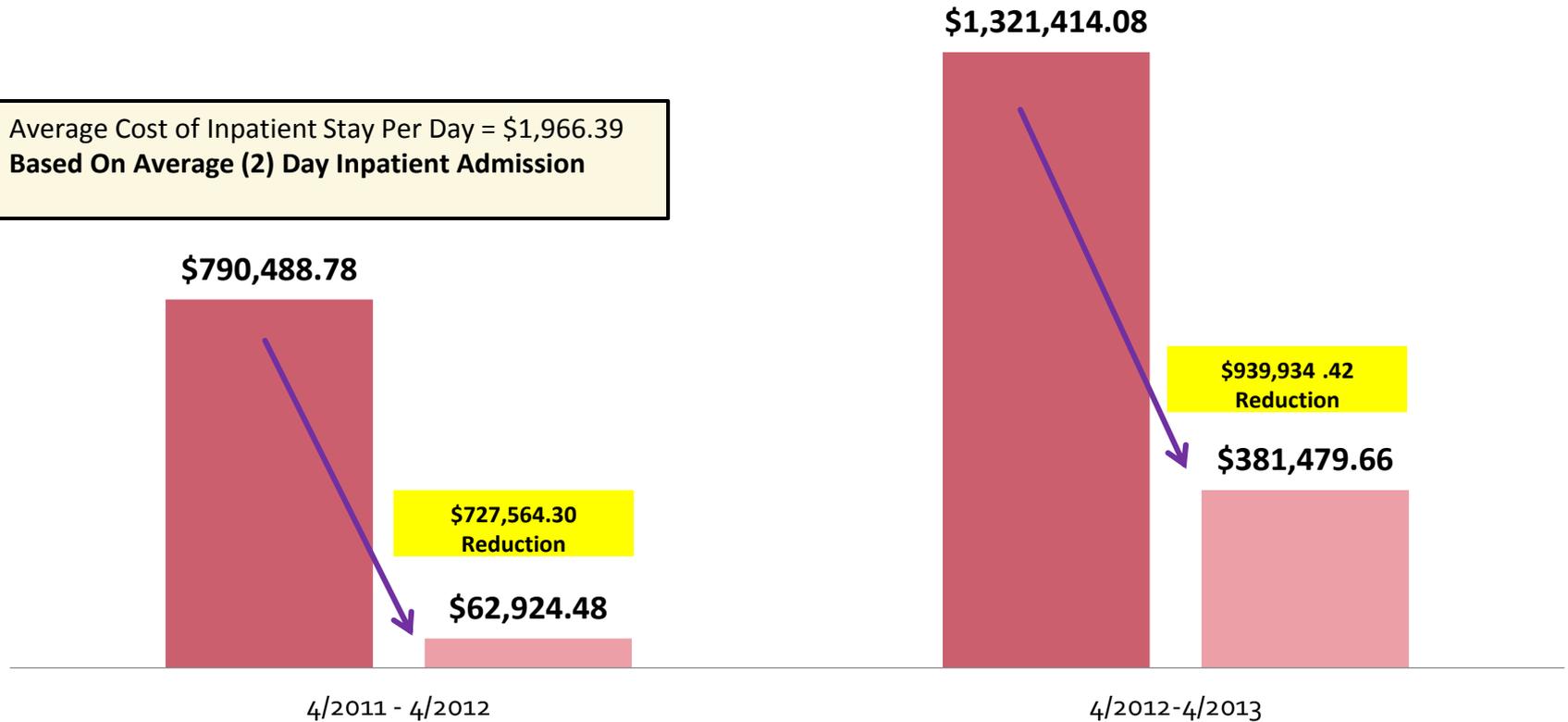


Cost Analysis on ED Readmissions

ED Readmissions Cost Reductions Yearly Trend for Combined Demographic ICP Groups

■ Number of ED Admissions Pre Care Planning Implementation ■ Number of ED Admissions Post Care Planning Implementation

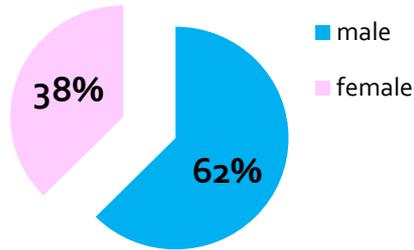
Average Cost of Inpatient Stay Per Day = \$1,966.39
Based On Average (2) Day Inpatient Admission



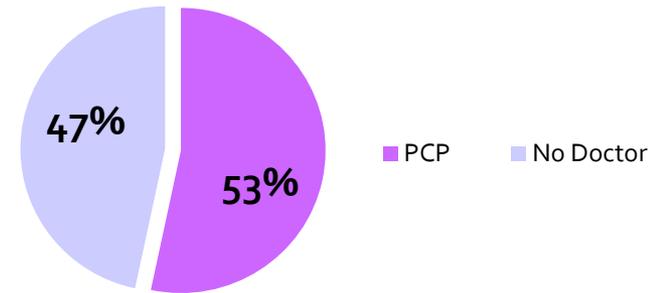
Social Concerns

Demographic ICP Group

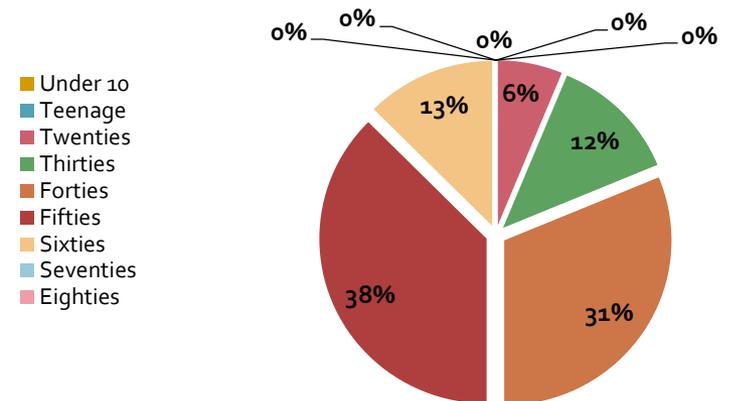
Male/Female Distribution for Social Concerns
N=16



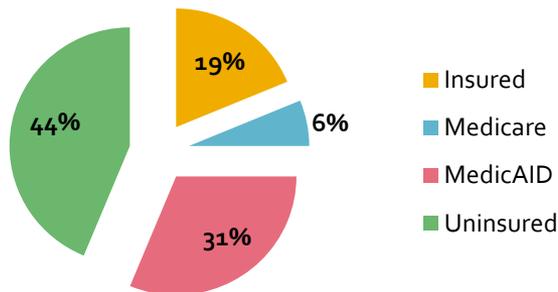
Physician Distribution for Social Concerns
N=16



Age Range Distribution for Social Concerns
N=16

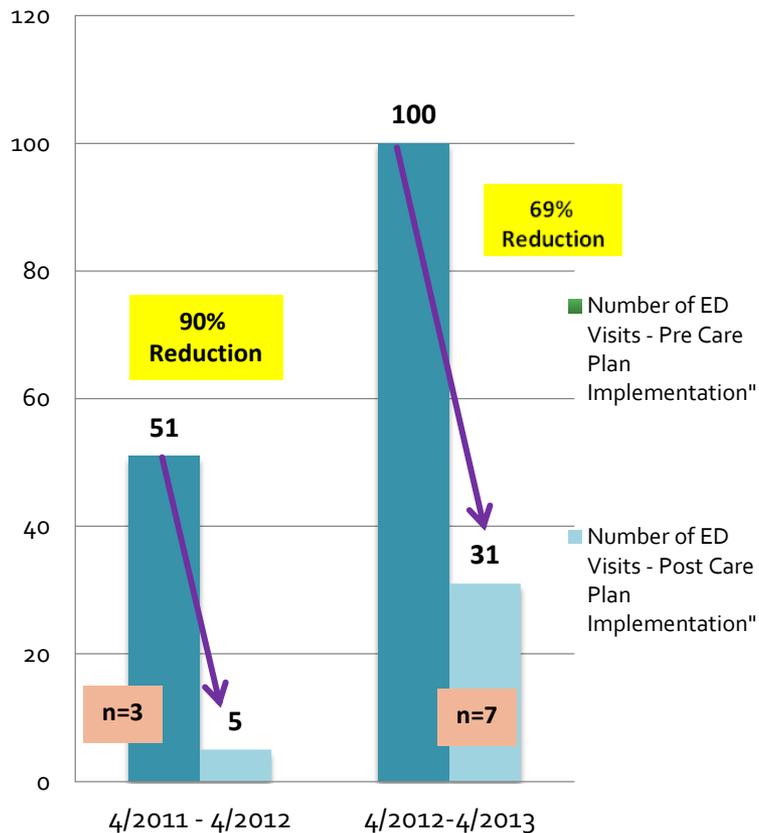


Insurance Distribution for Social Concerns
N=16

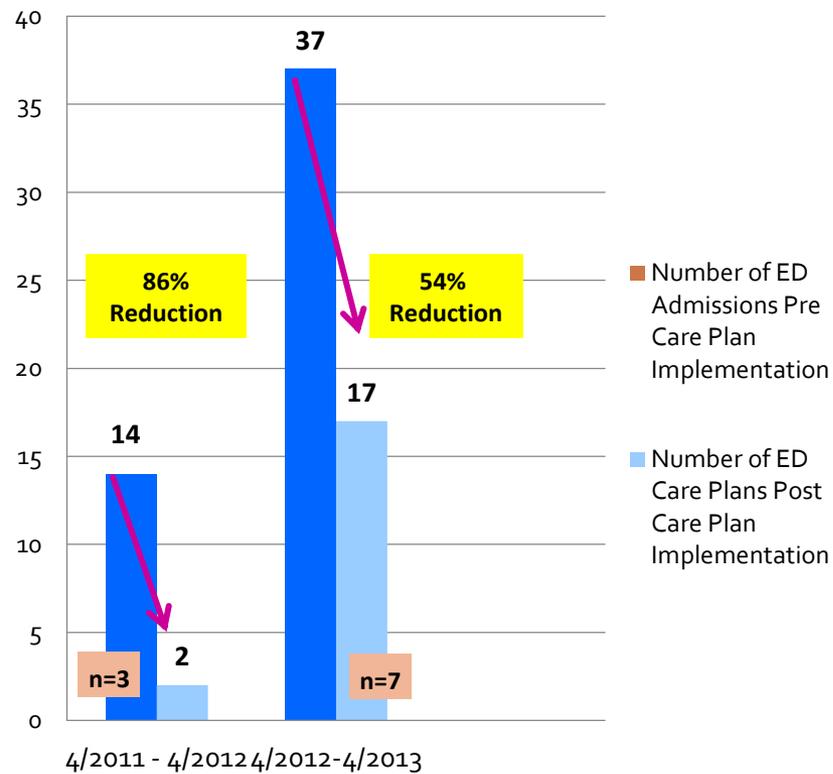


Social Concerns ICP Group Visit Reductions

ED Recidivism Reductions Trend for Social Concerns Demographic ICP Group



ED Readmissions Reductions Trend for Social Concerns Demographic ICP Group

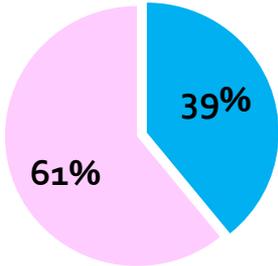


Chronic Condition/Special Needs Demographic ICP Group

Male/Female Distribution for Chronic Condition and/or Special Needs

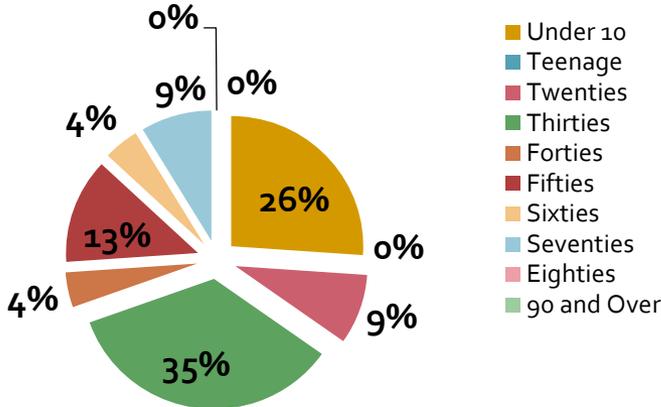
N=23

male female



Age Distribution for Chronic Condition and/or Special Needs

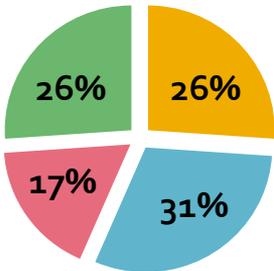
N=23



Insurance Type Distribution for Chronic Condition and/or Special Needs

N=23

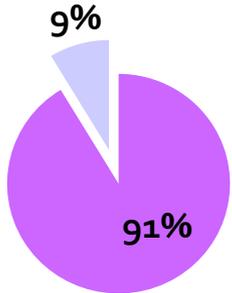
Insured Medicare MedicAID Uninsured



Physician Distribution for Chronic Care and/or Special Needs

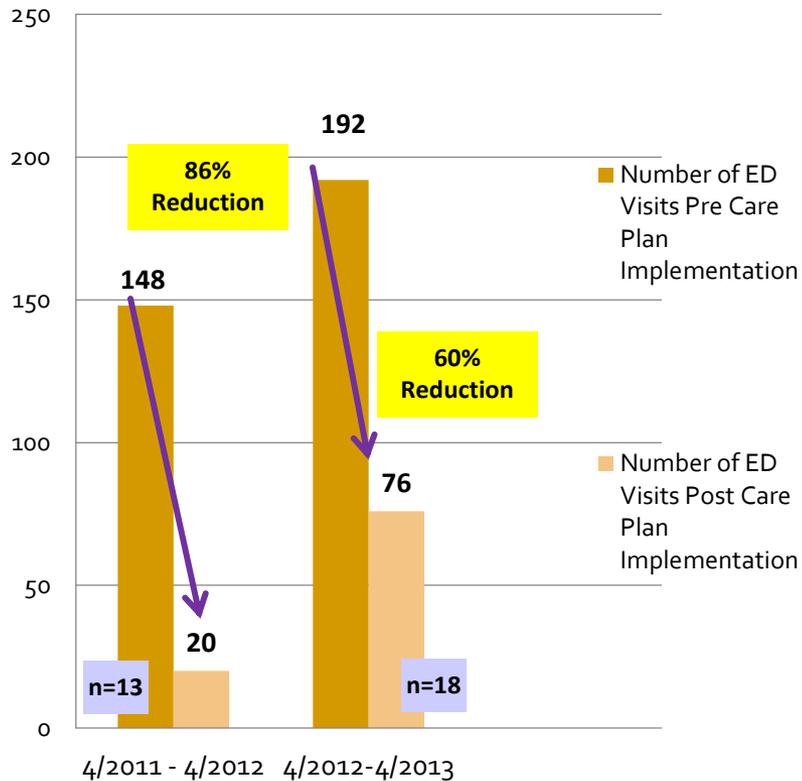
N=23

PCP No Doctor

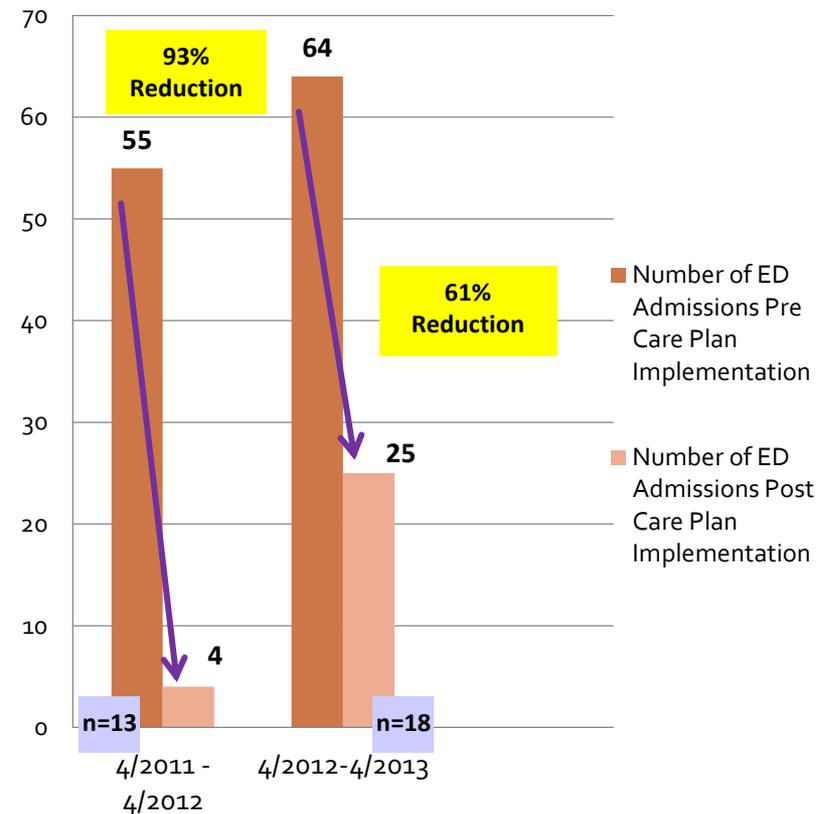


Chronic Conditions/Special Needs ICP Group Visit Reductions

ED Recidivism Reduction Yearly Trend for
Chronic Condition and/or Special Needs
Demographic ICP Group



ED Readmissions Reduction Yearly Trend
for Chronic Condition and/or Special
Needs Demographic ICP Group

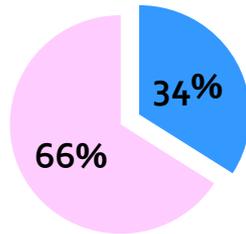


Behavioral-Related Demographic ICP Group

Male/Female Distribution for Behavioral-Related Issues

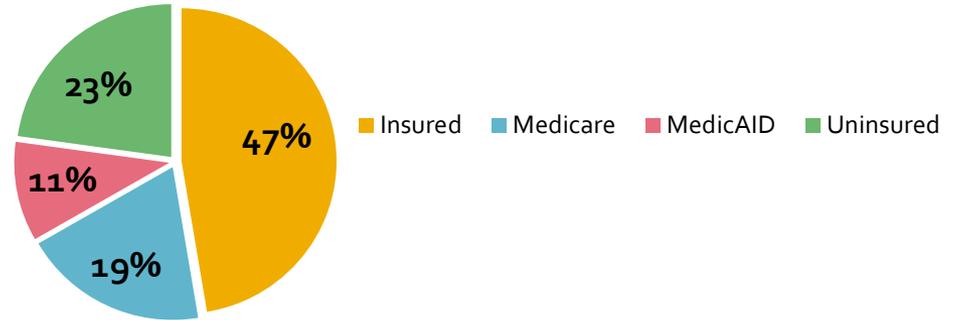
N=58

■ male ■ female



Insurance Type Distribution for Behavioral-Related Issues

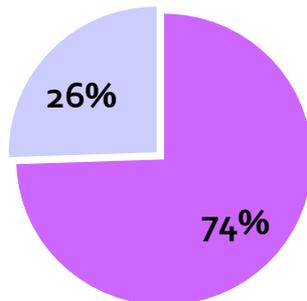
N=58



Physician Distribution for Behavioral-Related Issues

N=58

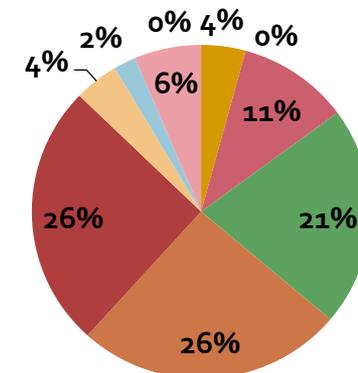
■ PCP ■ No Doctor



Age Distribution for Behavior-Related Issues

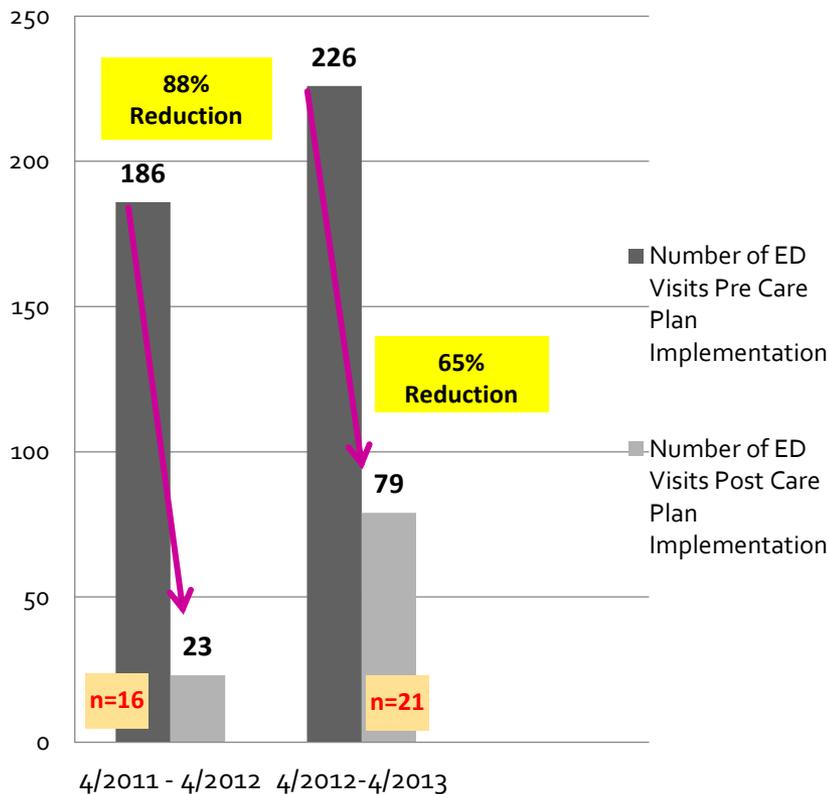
N=58

■ Under 10 ■ Teenage ■ Twenties ■ Thirties ■ Forties
 ■ Fifties ■ Sixties ■ Seventies ■ Eighties ■ go and Over

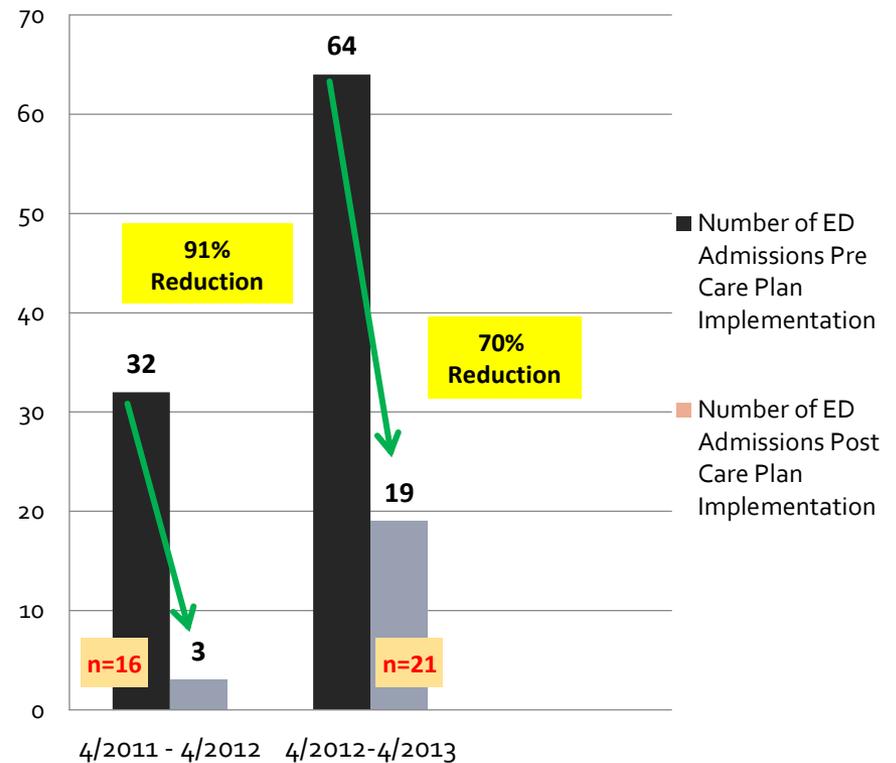


Behavioral-Related ICP Group Visit Reductions

ED Recidivism Reduction
Yearly Trend for Behavior-Related Issues



ED Readmissions Reduction
Yearly Trend for Behavior-Related Issues

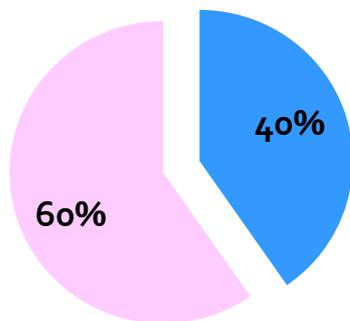


Narcotic-Dependent Demographic ICP Group

Male/Female Distribution for Narcotic Dependent

N=183

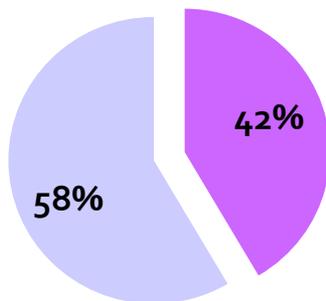
■ male ■ female



Physician Distribution for Narcotic-Dependent

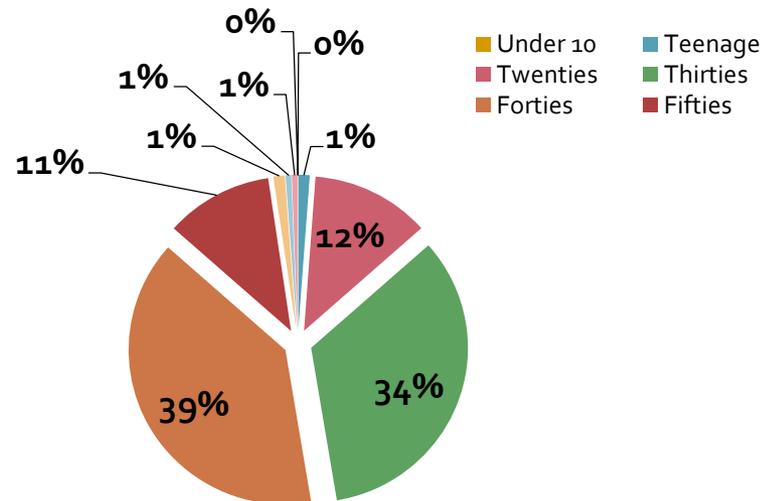
N=183

■ PCP ■ No Doctor



Age Distribution for Narcotic-Dependent

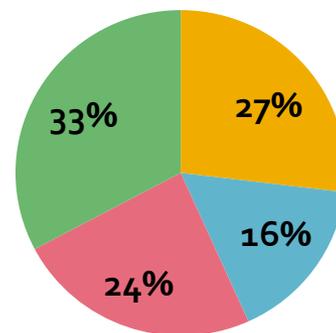
N=183



Insurance Type Distribution for Narcotic-Dependent

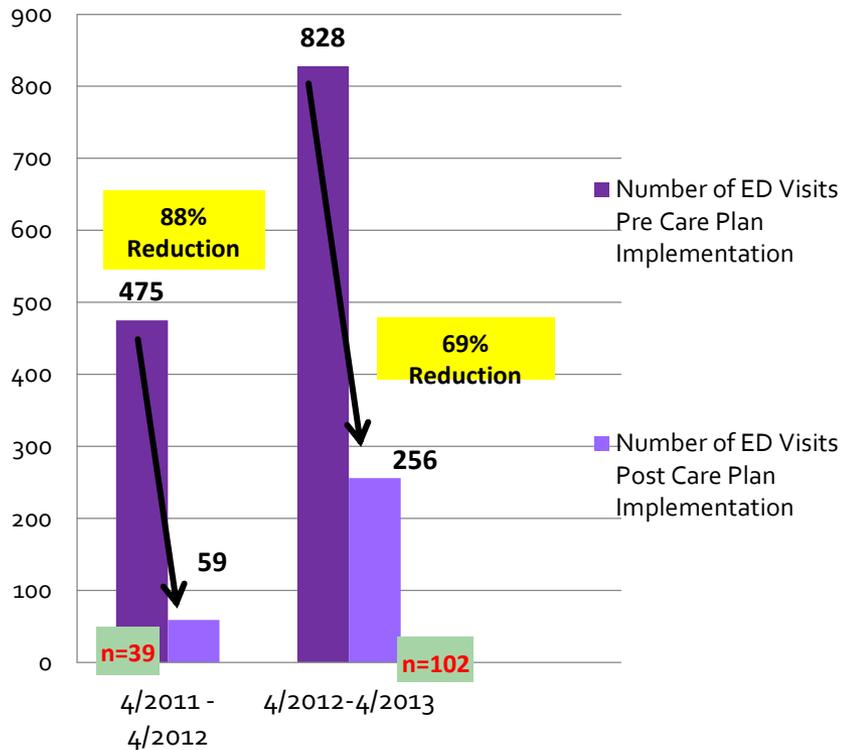
N=183

■ Insured ■ Medicare
■ Medicaid ■ Uninsured

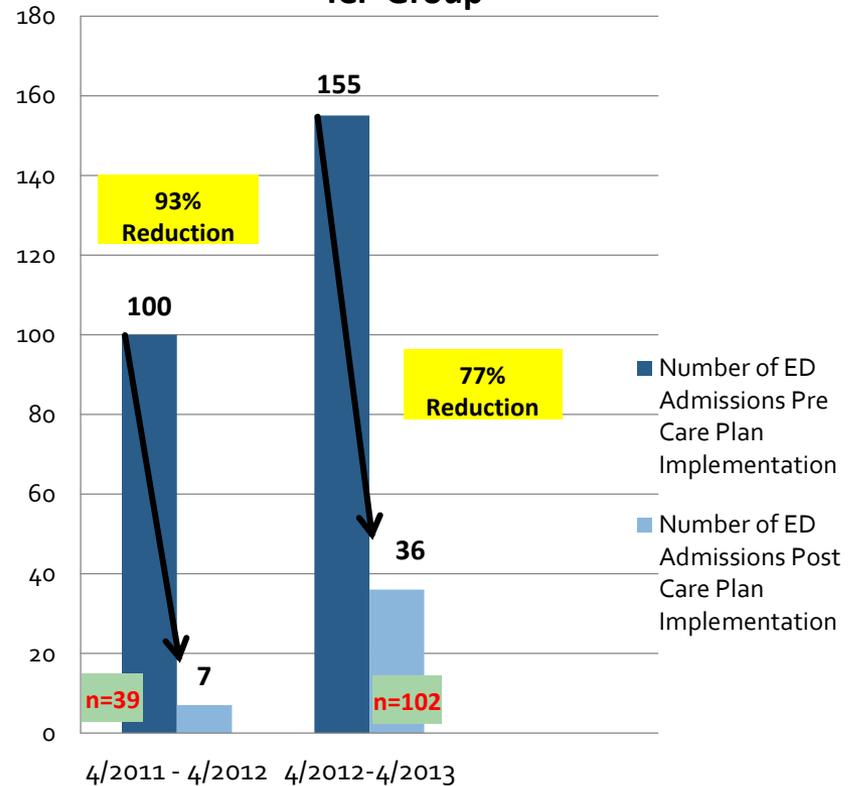


Narcotic-Dependent ICP Group Visit Reductions

ED Recidivism Reduction Yearly Trend for Narcotic-Dependent Demographic ICP Group



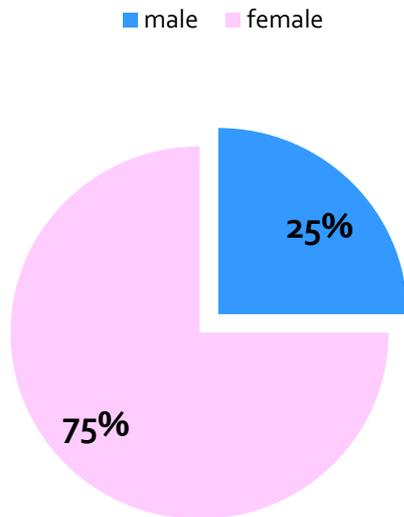
ED Readmissions Reduction Yearly Trend for Narcotic-Dependent Demographic ICP Group



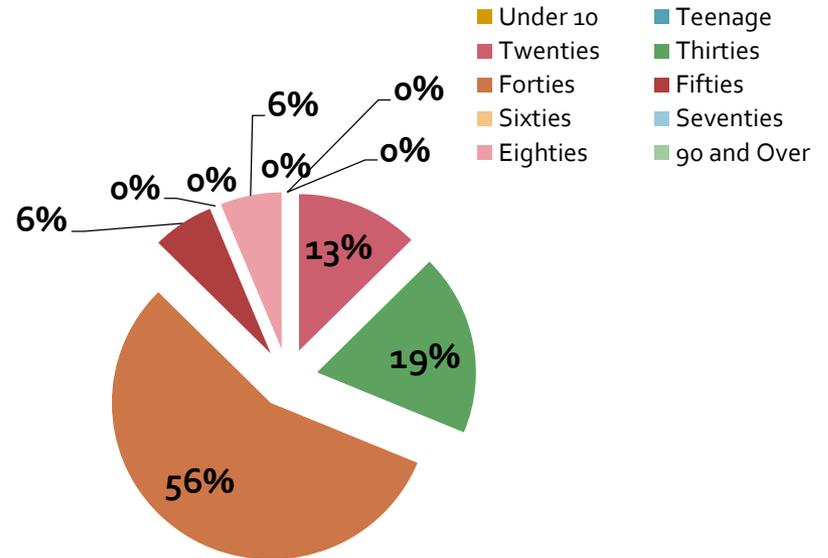
Cat Scan Watch List

Demographic ICP Sub-Group

Male/Female Distribution for Cat Scan
Watch List Demographic ICP Group
4/2013 N=12



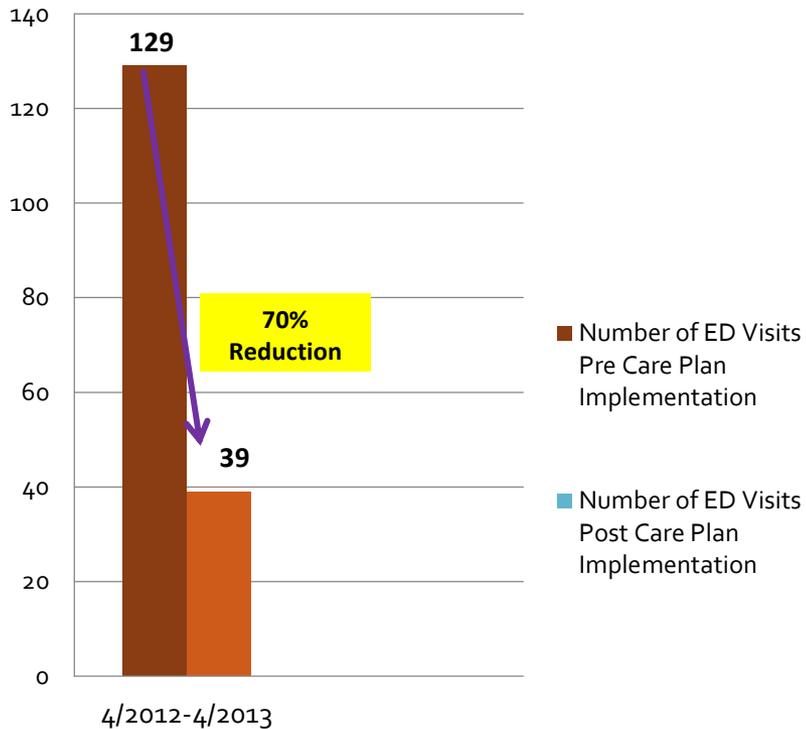
Age Distribution for Cat Scan Watch List
Demographic ICP Group
4/2013 N=12



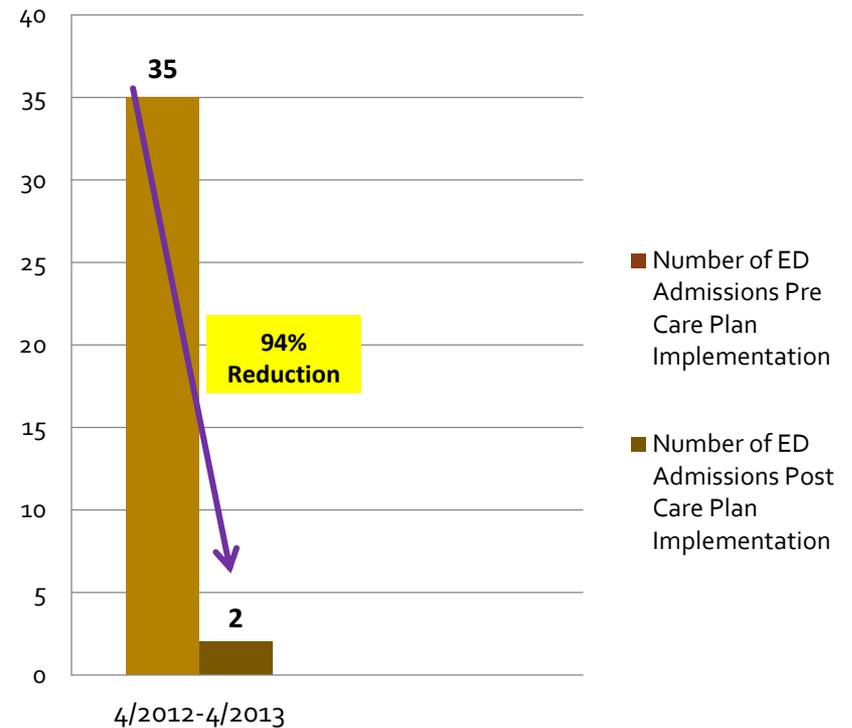
Cat Scan Watch List

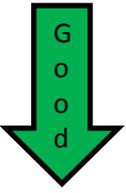
ICP Sub-Group Visit Reductions

ED Recidivism Reduction in Cat Scan Watch List Demographic ICP Group
4/2013 N=12



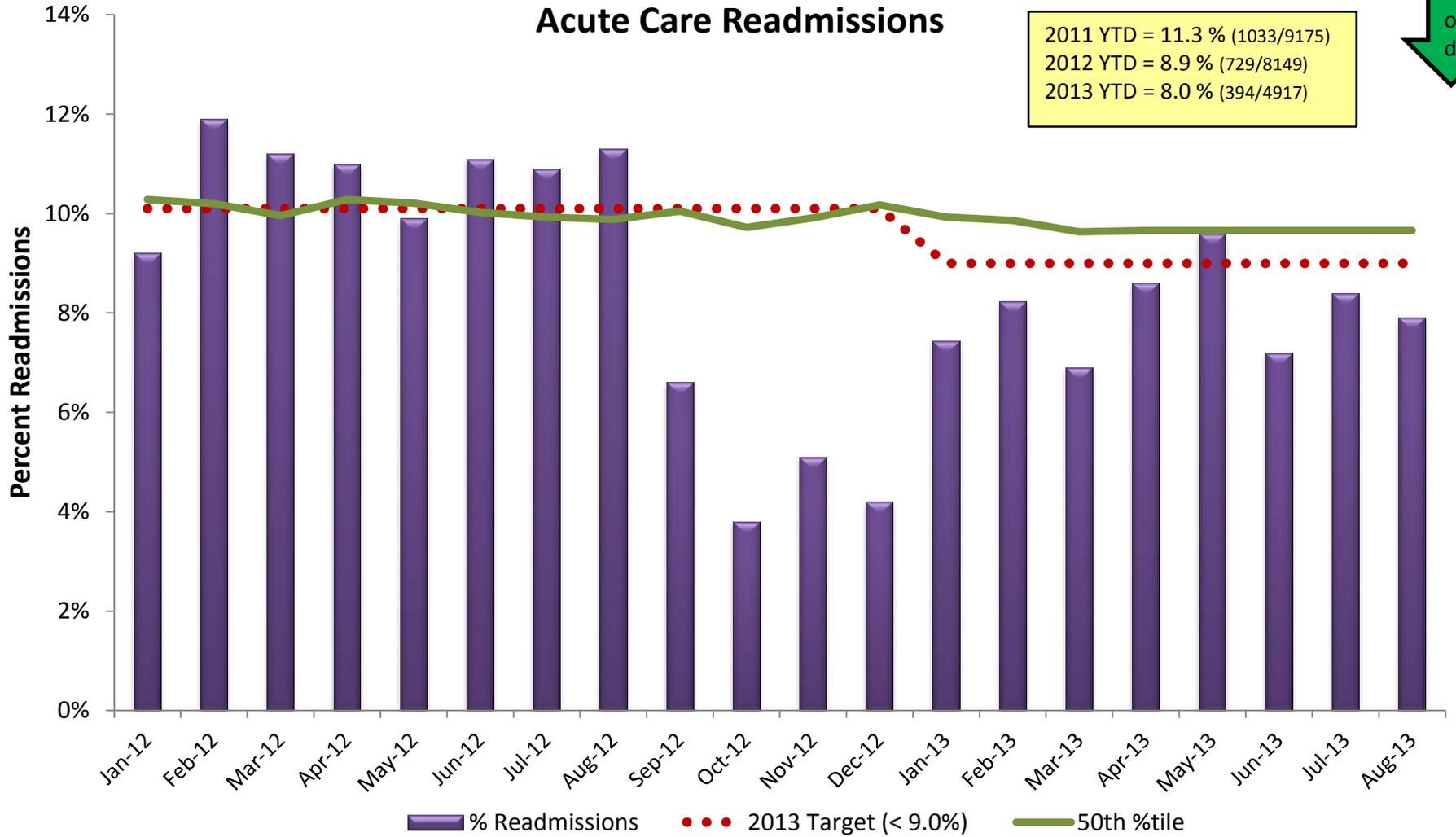
ED Readmissions Reduction in Cat Scan Watch List Demographic ICP Group
4/2013 N=12





Acute Care Readmissions

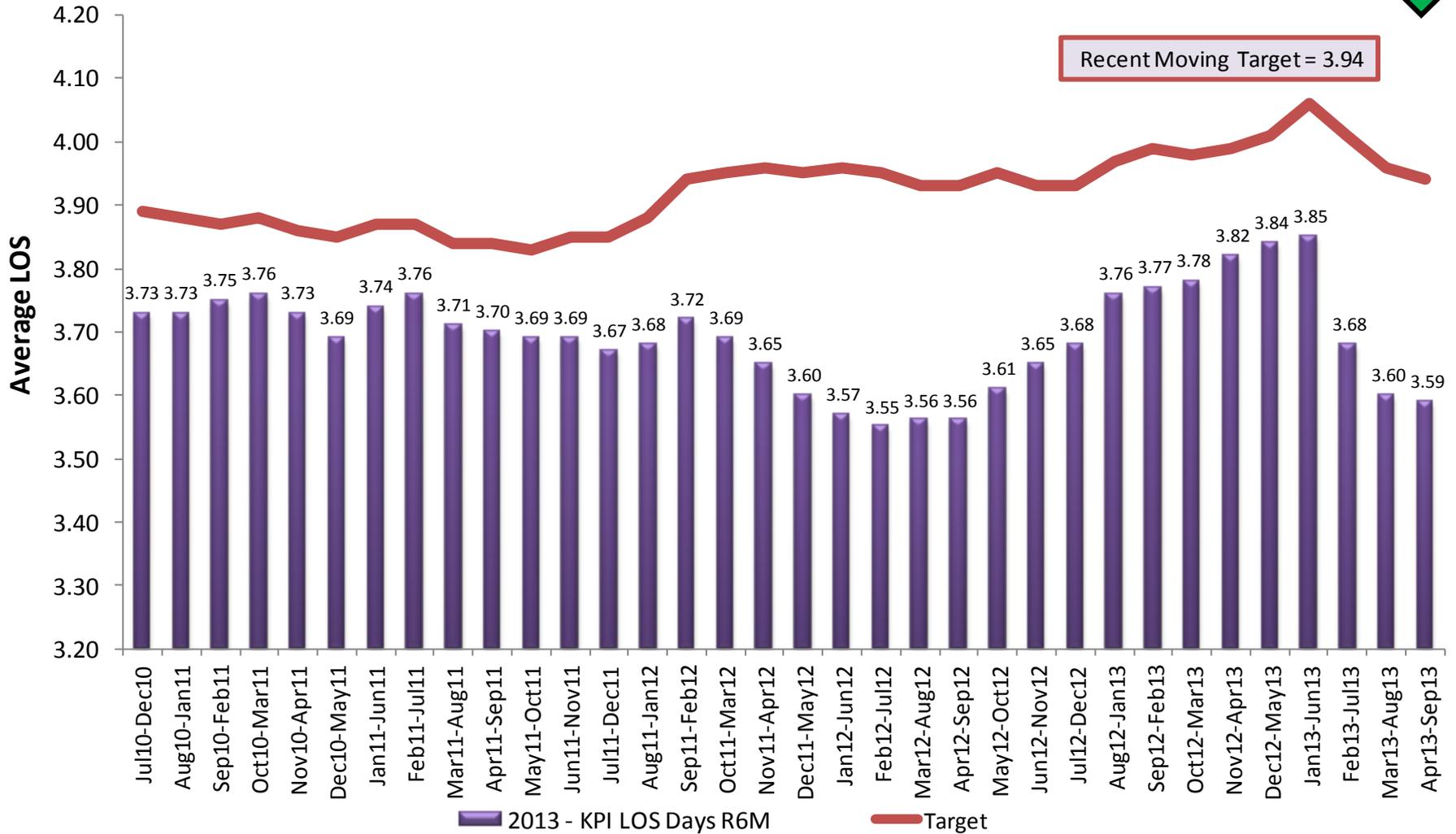
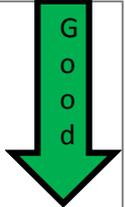
2011 YTD = 11.3 % (1033/9175)
 2012 YTD = 8.9 % (729/8149)
 2013 YTD = 8.0 % (394/4917)



■ % Readmissions
 ●●● 2013 Target (< 9.0%)
 — 50th %tile

	1/12	2/12	3/12	4/12	5/12	6/12	7/12	8/12	9/12	10/12	11/12	12/12	1/13	2/13	3/13	4/13	5/13	6/13	7/13	8/13
%	9.2%	11.9%	11.2%	11.0%	9.9%	11.1%	10.9%	11.3%	6.6%	3.8%	5.1%	4.2%	7.4%	8.2%	6.9%	8.6%	9.6%	7.2%	8.4%	7.9%
#Readm	72	84	79	77	68	72	76	74	45	25	29	28	51	47	42	51	60	45	49	49
#Pts	779	703	704	697	690	648	700	656	686	652	572	662	685	573	605	594	627	628	581	624

 Advocate Good Shepherd Hospital
Length of Stay Days

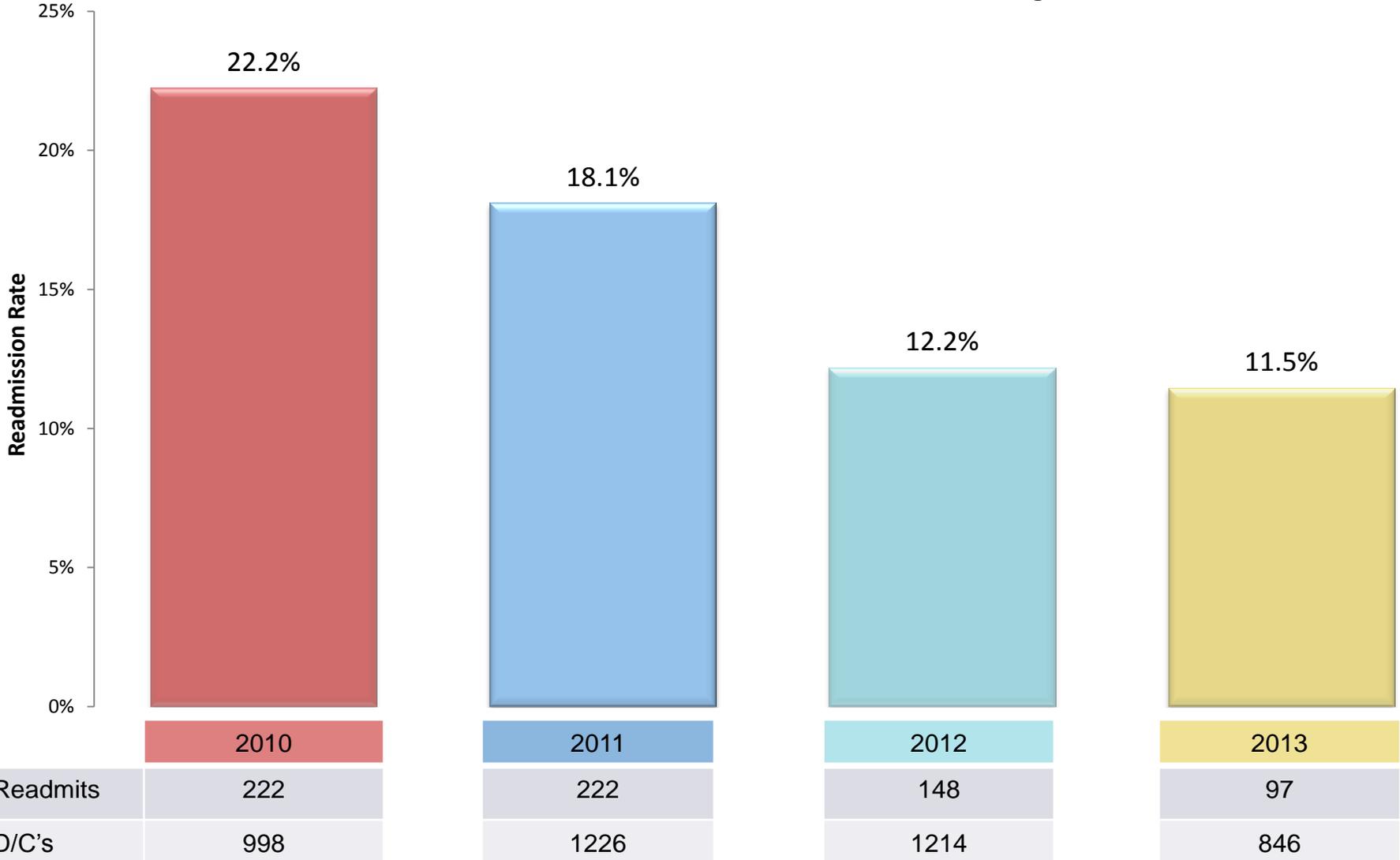


Each data point is reflective of a rolling 6-month;
Target adjusts monthly based on relative case mix

Case mix adjusted using Milliman 2012 National MS-DRG benchmarks

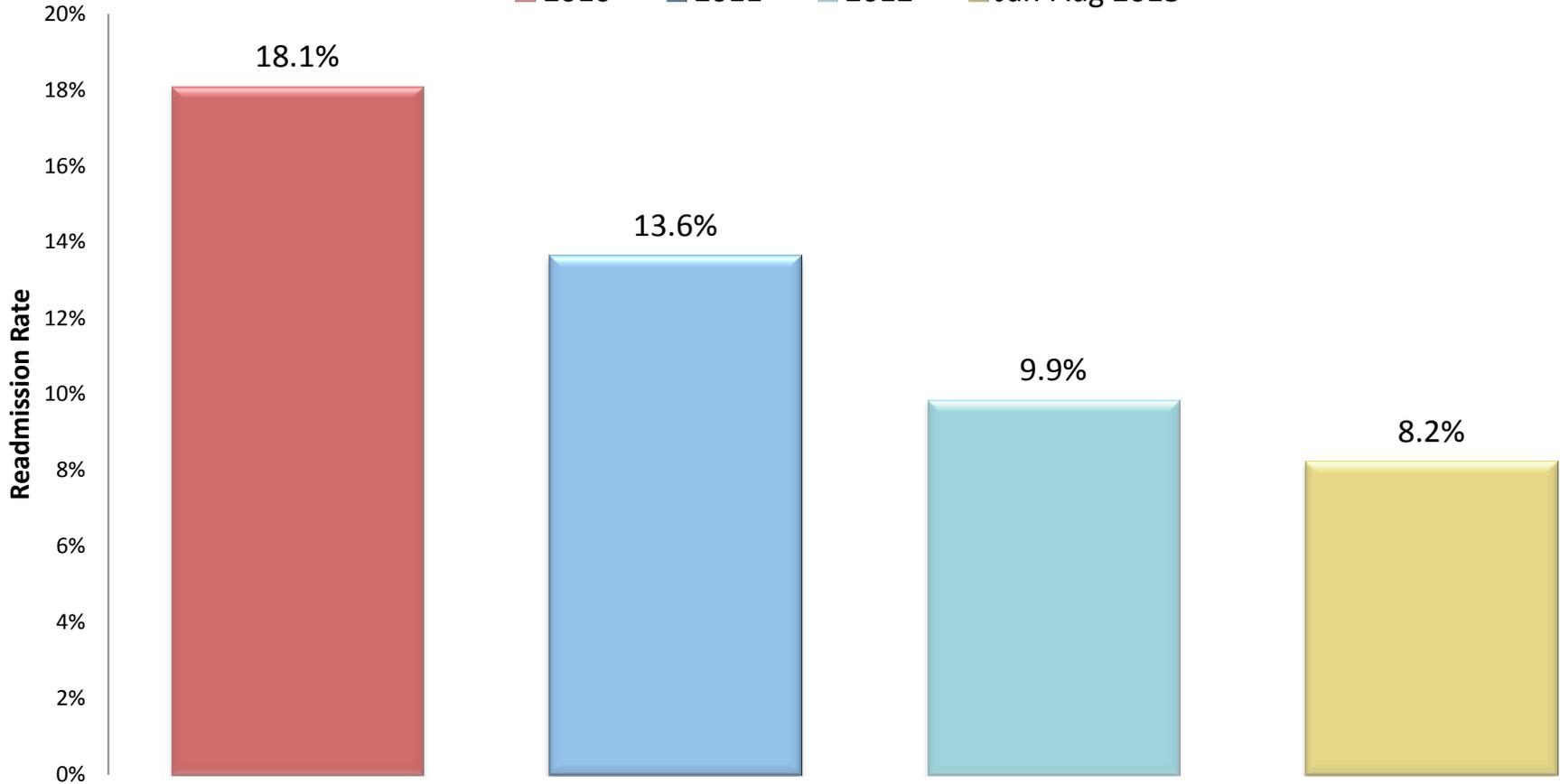
ECF Readmission Rate Annualized

■ 2010
 ■ 2011
 ■ 2012
 ■ Jan-Aug 2013



Home Health Readmission Rate Annualized

■ 2010
 ■ 2011
 ■ 2012
 ■ Jan-Aug 2013



	2010	2011	2012	2013
Readmits	278	131	125	93
D/C's	1536	960	1269	1129

Further ICP Enhancements

System-Wide Implementation

- **Newly-implemented visual icon trigger across system**
 - Each ED and Urgent Care Center can now see icon on tracking board
 - Good Shepherd patient visiting another Advocate Site
- **Offering workshops to our other 10 Advocate Hospital EDs in 2014**
- **Adding “*Abuse and Neglect*” care plan group**
- **Full integration of ICP within the EMR**
 - System-wide access to patient care plans site-to-site

ICP Development: A Viable Option for Everyone

- Educating Patients
- Empowering Staff
- Linkage with Social Workers/Care Managers
- Partnering with Physicians
- Bridging Services to the Community
- Mitigating Addiction and Abuse
- Reduction of Costs
- Reduction of Readmissions
- Enhancing Patient and Associate Safety

**"It is the province of knowledge to speak,
and it is the privilege of wisdom to
listen."**

~ Oliver Wendell Holmes ~



Thank you!

*???***Questions***???*



leah.montoya@advocatehealth.com



Next Steps

- On behalf of eHI, Thank you for your contributions to the Council in 2014!
- See you at the in-person meeting in January
- Happy Holidays!

