



**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!*

Visit [www.ehidc.org](http://www.ehidc.org) for more information.

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# ANNUAL CONFERENCE 2014

THE ROADMAP TO HEALTHCARE DELIVERY TRANSFORMATION



January 28-29, 2014 | Orlando, FL

## Early Bird Rates Expire January 2!

REGISTER NOW



#eHI2014

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Visit [www.ehfdc.org](http://www.ehfdc.org) for more information.



# ANNUAL CONFERENCE 2014

THE ROADMAP TO HEALTHCARE DELIVERY TRANSFORMATION



January 28-29, 2014 | Orlando, FL

**Special Council Discount:**  
**“EHI ANNUAL”** to  
receive \$100 off registration

**REGISTER NOW**



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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.

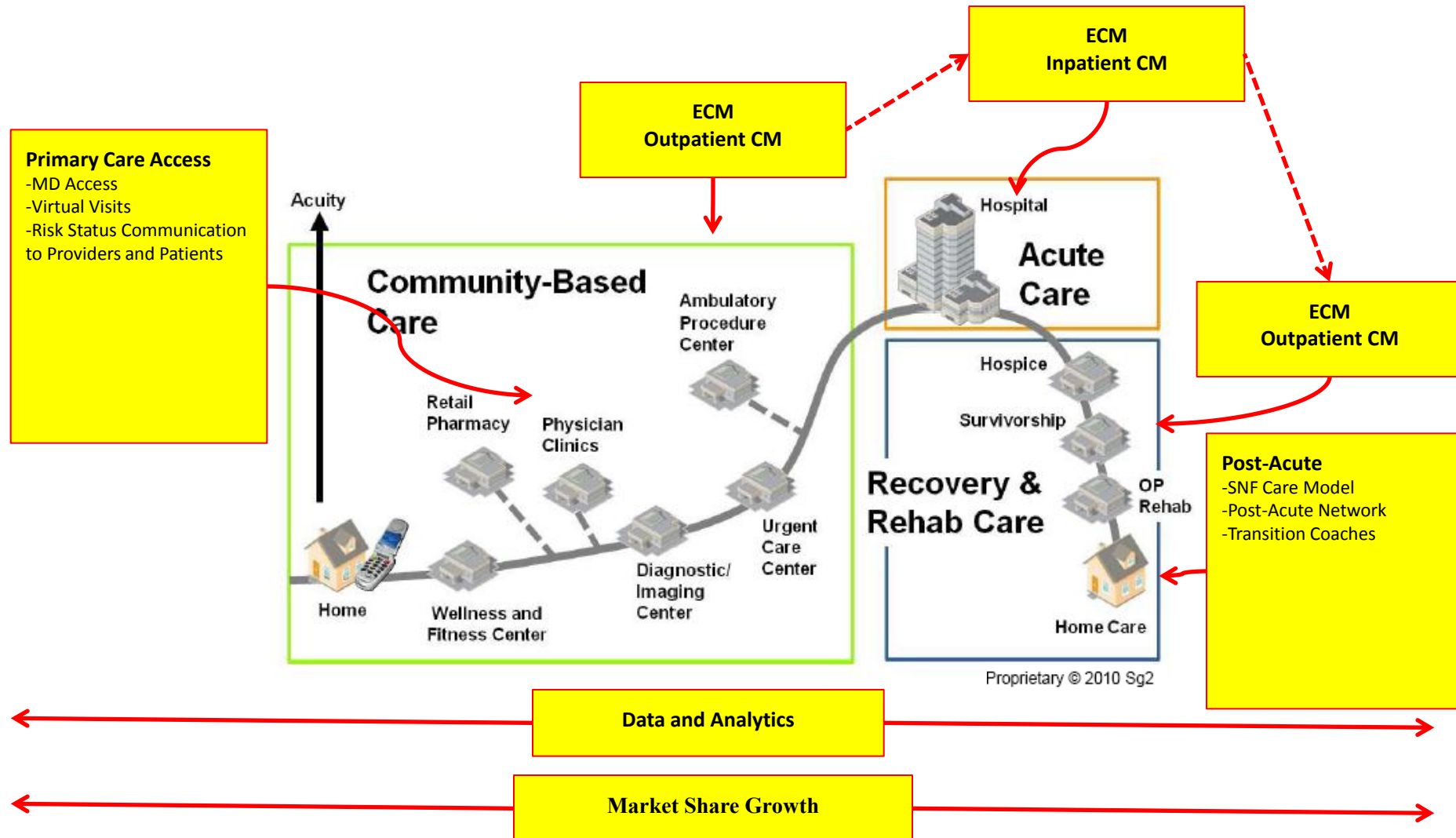
- Patient-centric and wholistic
- Enhances the quality and consistency of care by improving communication amongst the healthcare team members
- Continuity of care

# Changing Paradigms: What Do We Need To Do Differently?

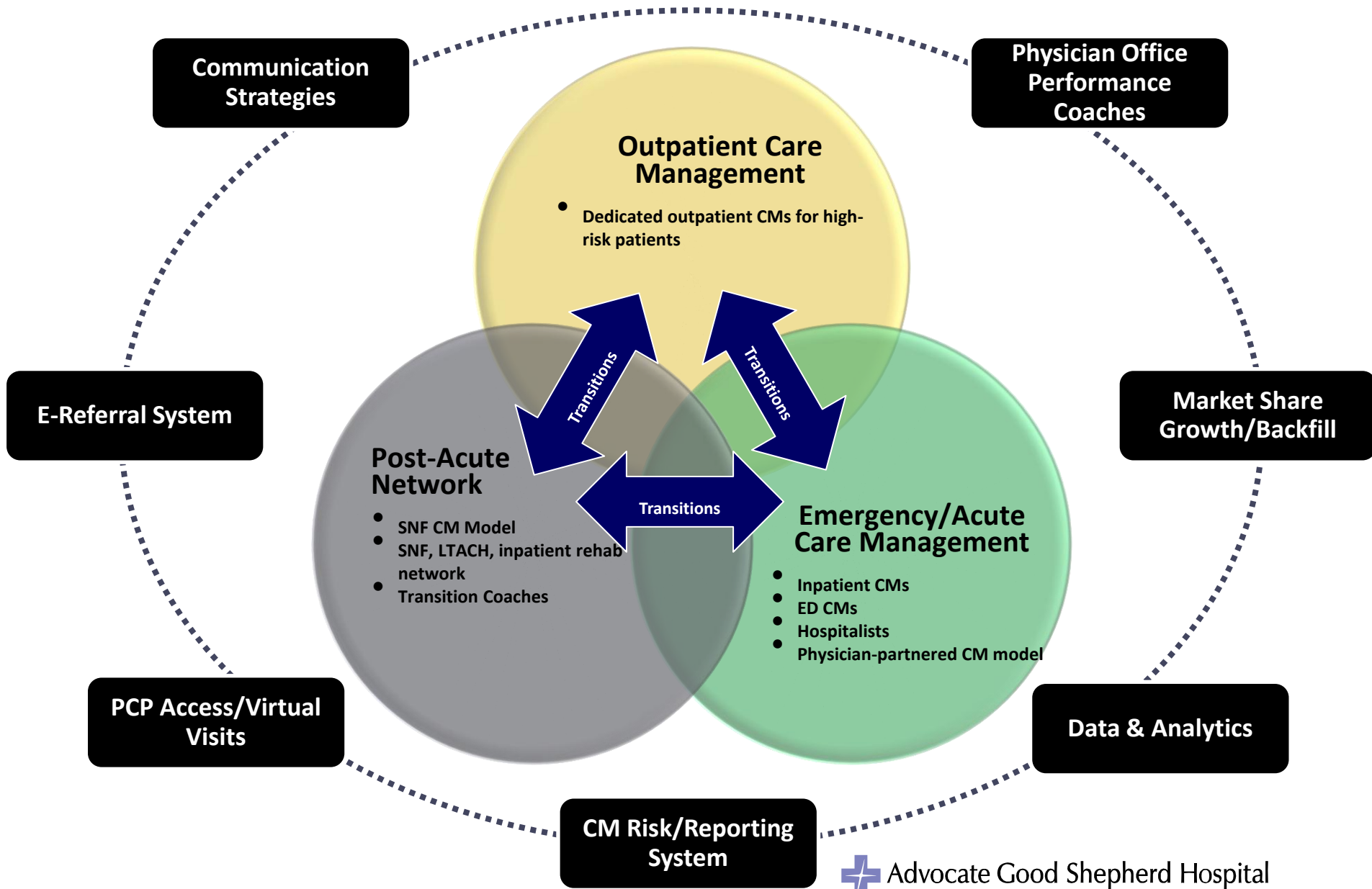
## Enterprise Care Management (ECM)

FROM...	TO...
Silo <b>case</b> management	Enterprise <b>care</b> 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



Advocate Good Shepherd Hospital

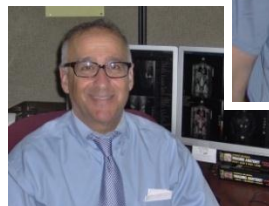
# Team Membership

## ■ 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 based 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 30<sup>th</sup>**  
**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....



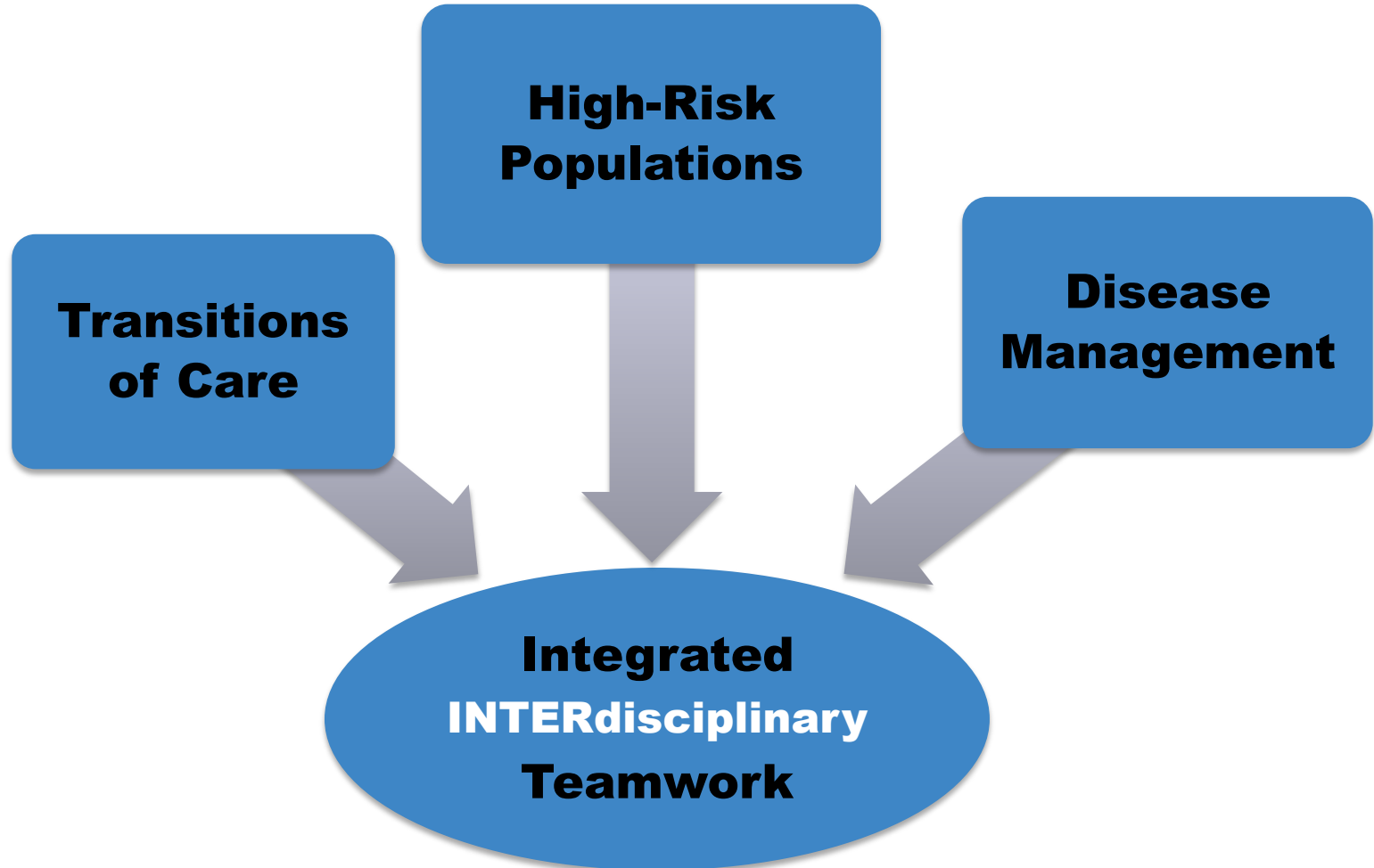
# ICP Team Vision

- 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





# 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. Naxos 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**

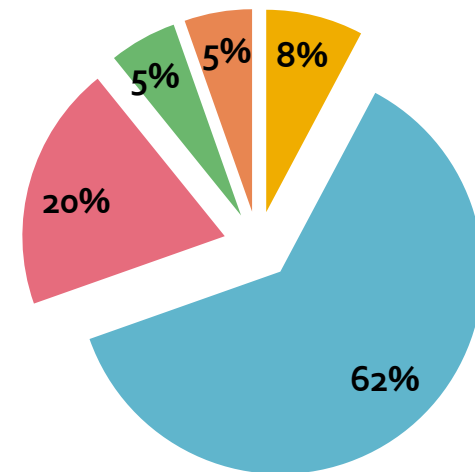
# Identifying Our Patient Population

## ■ (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

■ chronic care / special needs   ■ narcotic dependence  
■ social concern   ■ behavioral related  
■ CT watch list

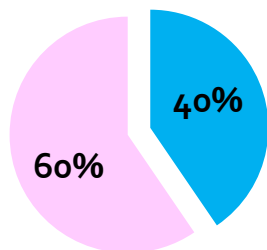


# As of November 2013, Over 300 Patients Enrolled in the GSHP Individualized Care Plan Project

**Male/Female Distribution for Combined Demographic ICP Groups**

N=257

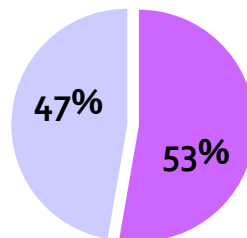
■ male ■ female



**Physician Distribution for Combined Demographic ICP Groups**

N=257

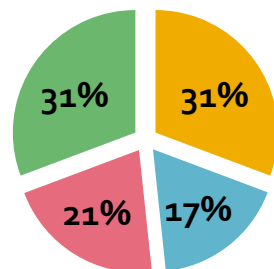
■ PCP ■ No Doctor



**Insurance Distribution for Combined Demographic ICP Groups**

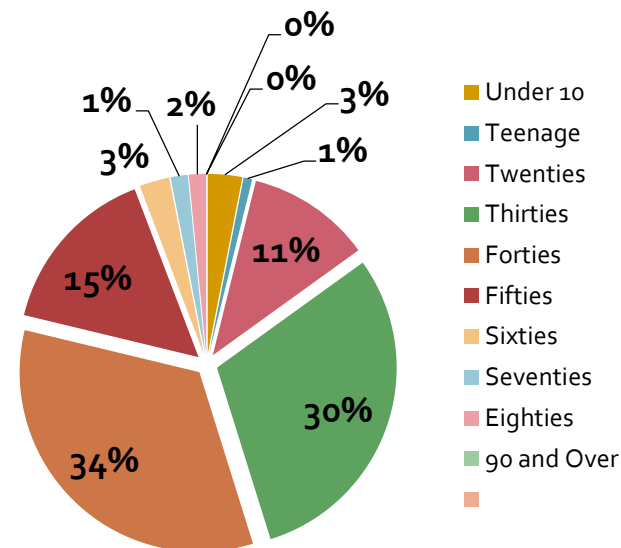
N=257

■ Insured ■ Medicare ■ Medicaid ■ Uninsured



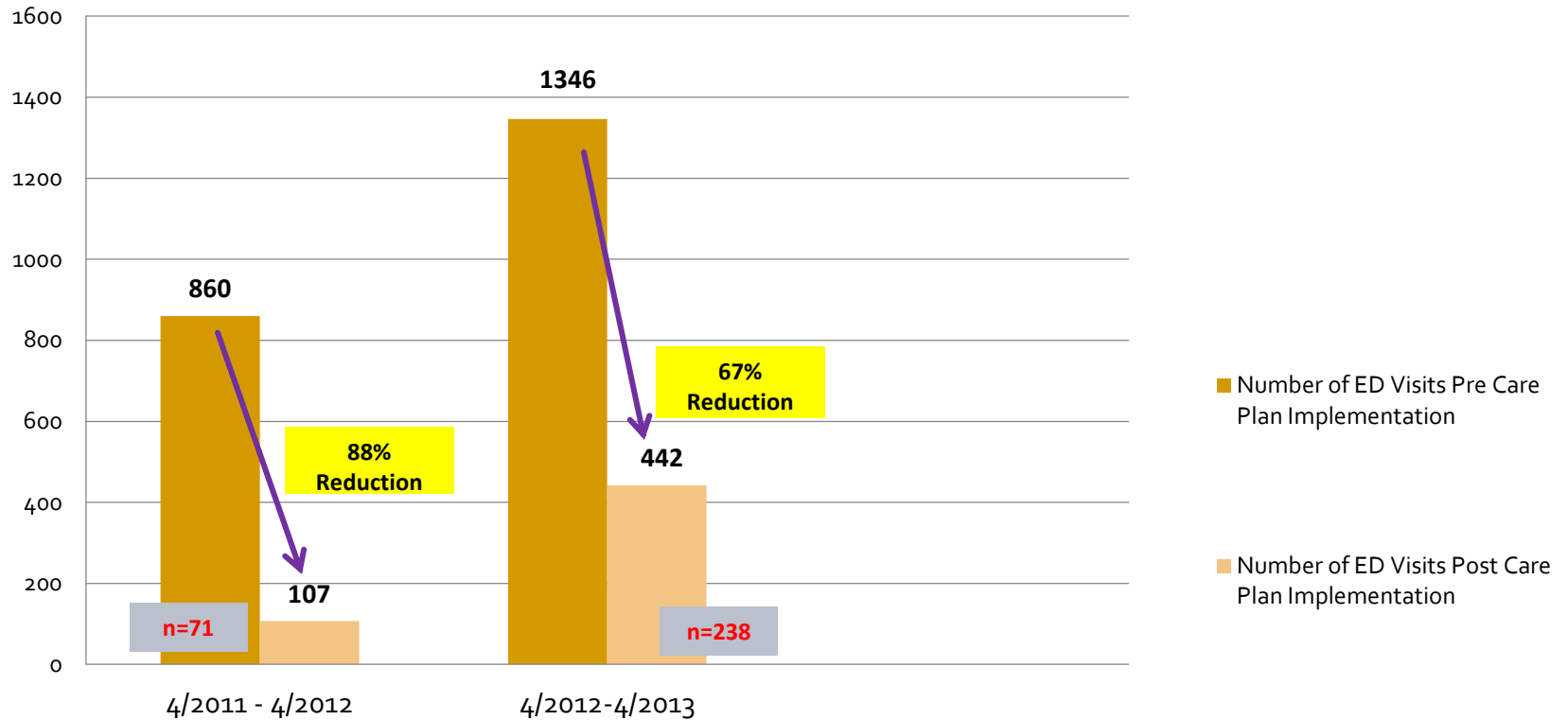
**Age Distribution for Combined Demographic ICP Groups**

N=257



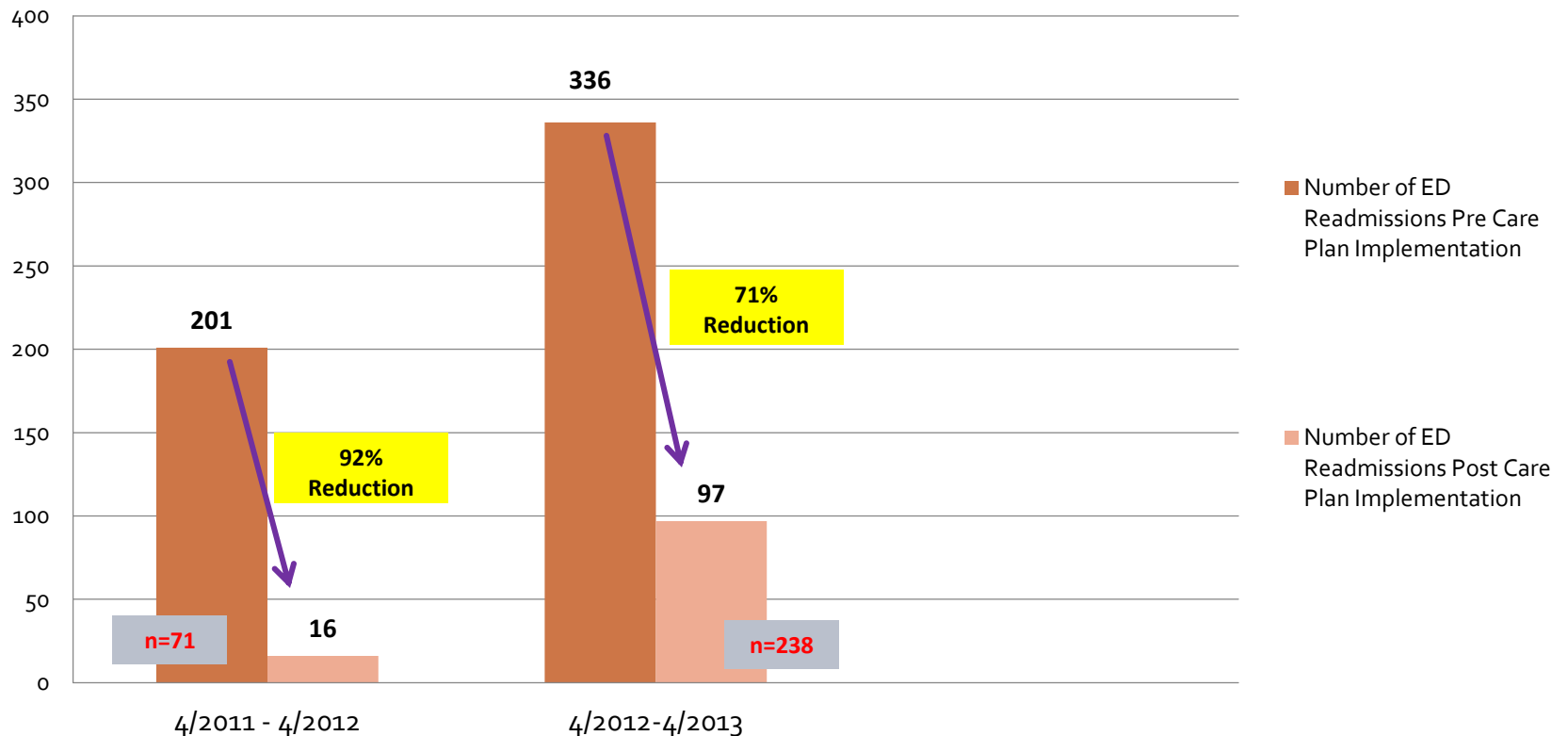
# Positive Impact Seen With Reducing Recidivism

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



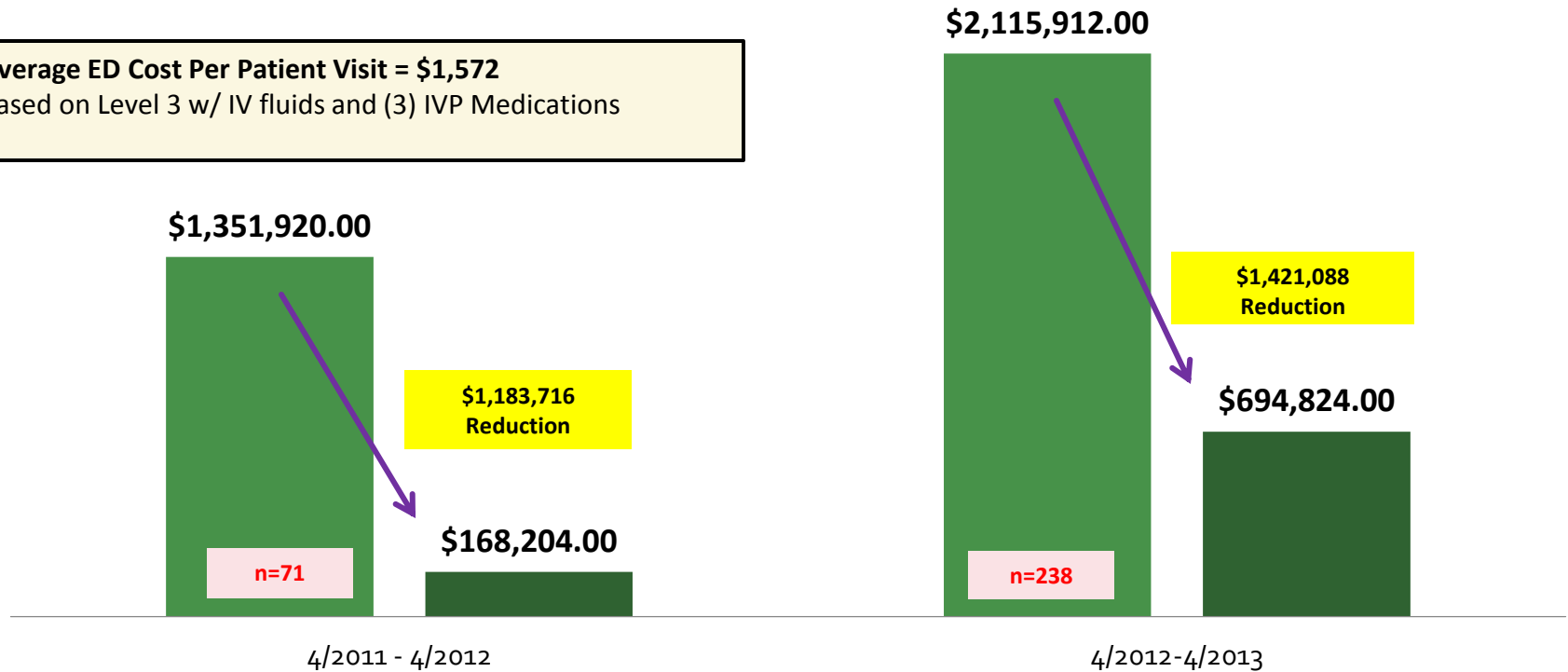
# Cost Analysis on ED Recidivism

## 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

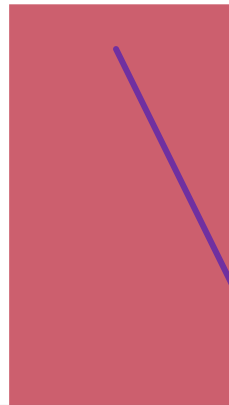
## ED Readmissions Cost Reductions Yearly Trend for Combined Demographic ICP Groups

■ 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

**\$790,488.78**

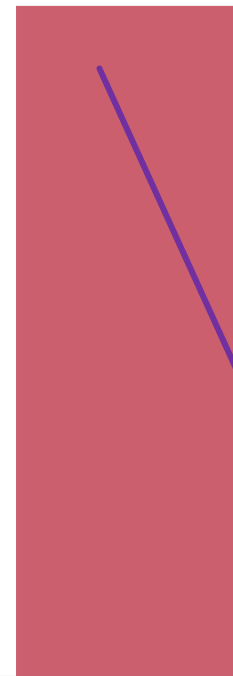


**\$727,564.30  
Reduction**

**\$62,924.48**

4/2011 - 4/2012

**\$1,321,414.08**



**\$939,934.42  
Reduction**

**\$381,479.66**

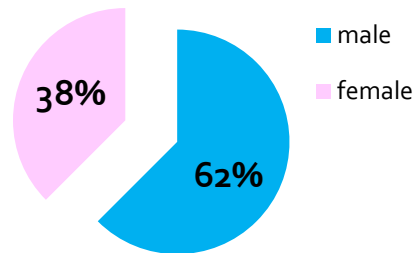
4/2012 - 4/2013



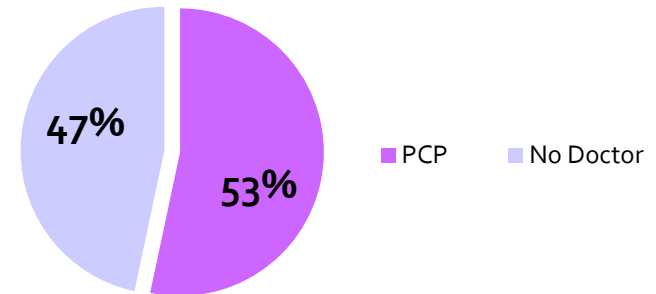
# Social Concerns

## Demographic ICP Group

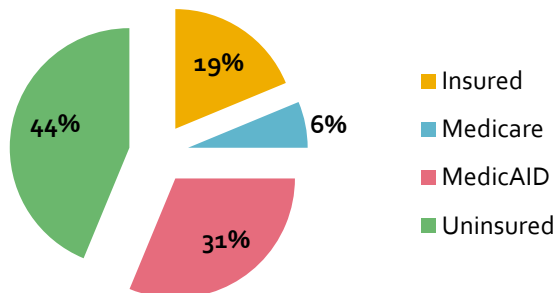
Male/Female Distribution for  
Social Concerns  
N=16



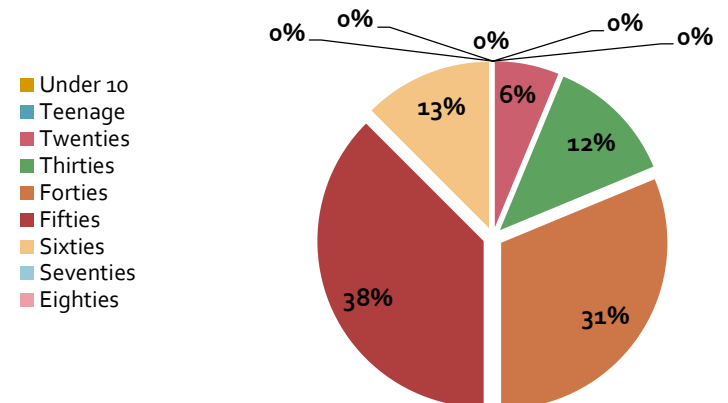
Physician Distribution for Social Concerns  
N=16



Insurance Distribution for  
Social Concerns  
N=16



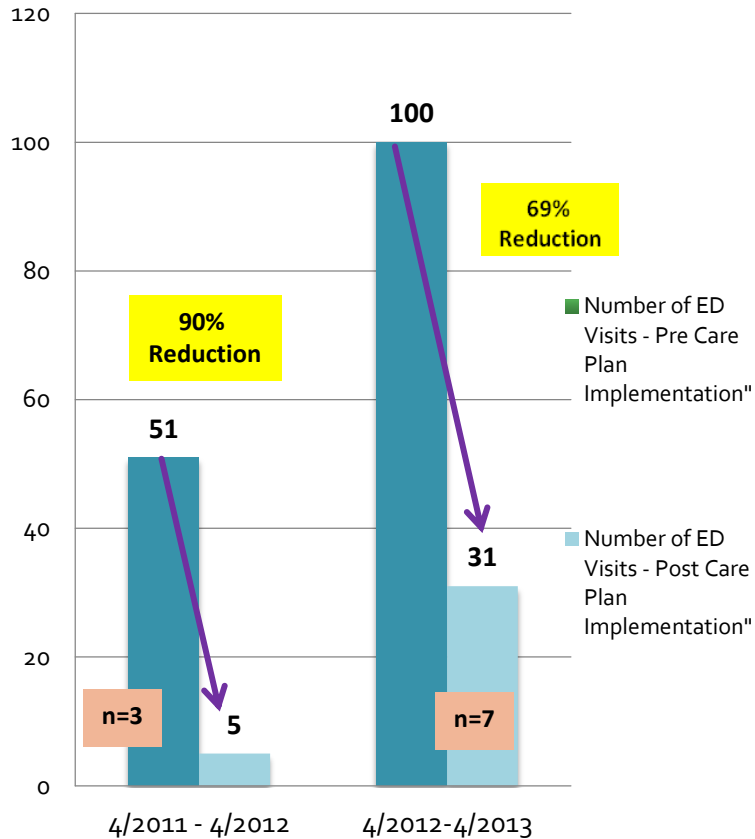
Age Range Distribution for Social Concerns  
N=16



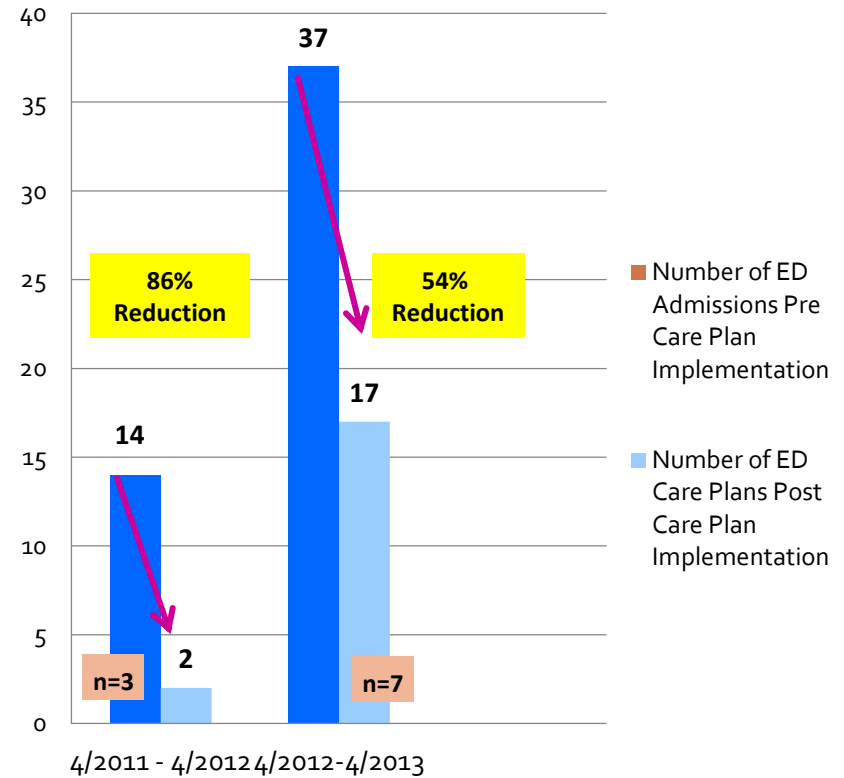
# Social Concerns ICP

## Group Visit Reductions

ED Recidivism Reductions Trend for Social Concerns Demographic ICP Group



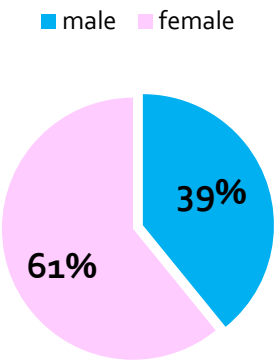
ED Readmissions Reductions Trend for Social Concerns Demographic ICP Group



# Chronic Condition/Special Needs Demographic ICP Group

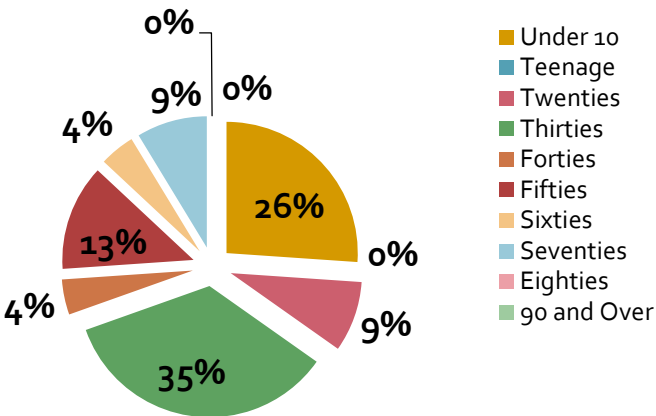
Male/Female Distribution for Chronic Condition and/or Special Needs

N=23



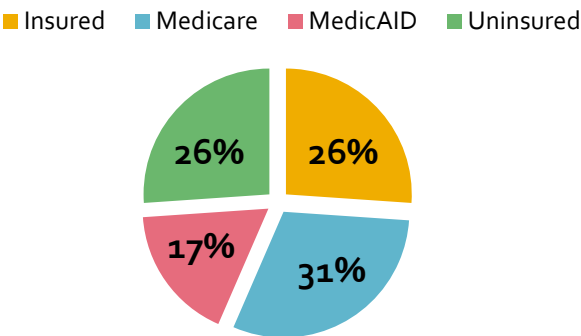
Age Distribution for Chronic Condition and/or Special Needs

N=23



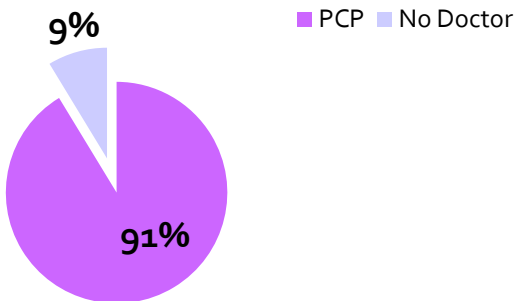
Insurance Type Distribution for Chronic Condition and/or Special Needs

N=23



Physician Distribution for Chronic Care and/or Special Needs

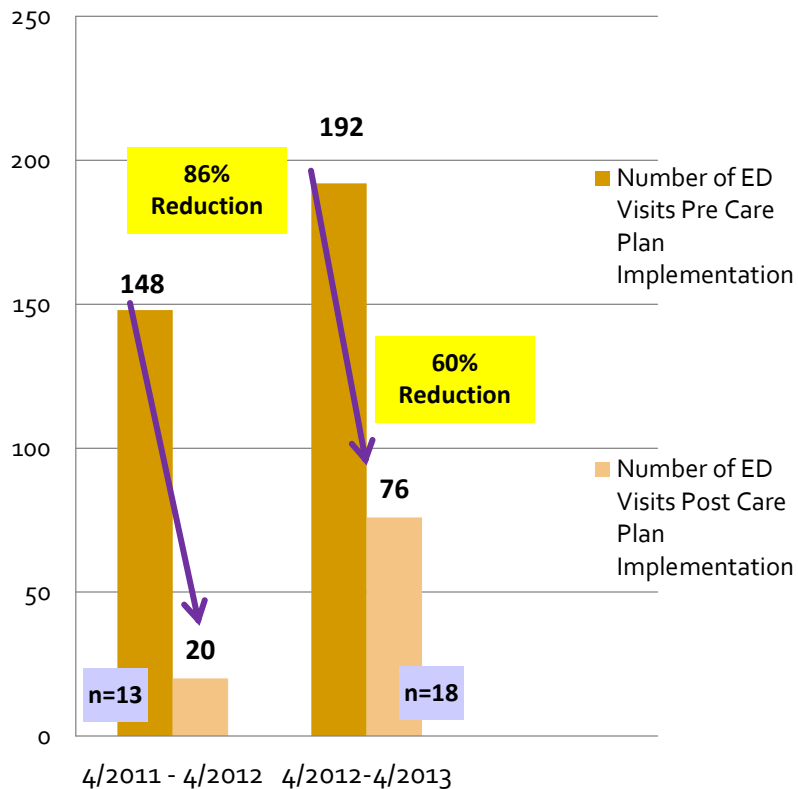
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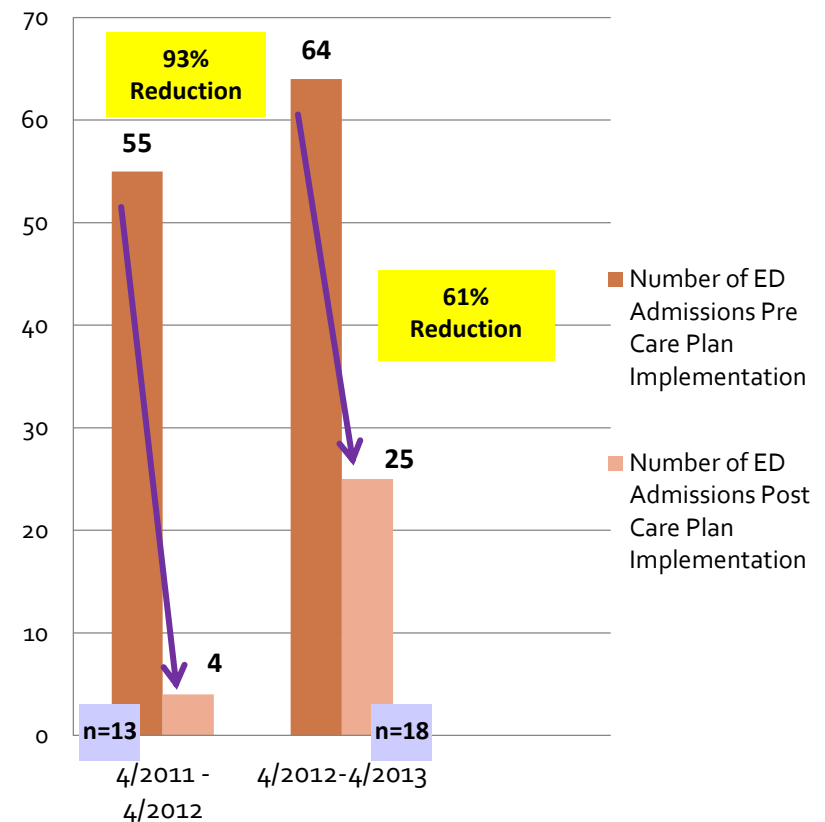
# Chronic Conditions/Special Needs ICP

## 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

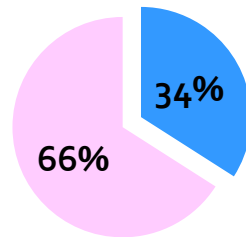


# Behavioral-Related Demographic ICP Group

Male/Female Distribution for Behavioral-Related Issues

N=58

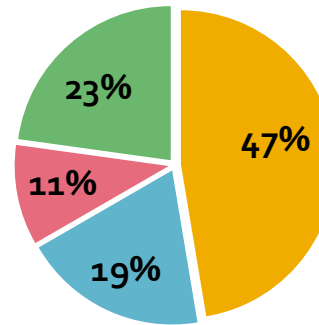
■ male ■ female



Insurance Type Distribution for Behavioral-Related Issues

N=58

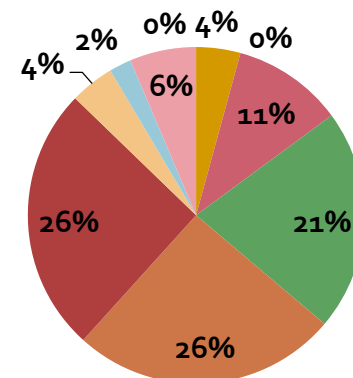
■ Insured ■ Medicare ■ Medicaid ■ Uninsured



Age Distribution for Behavior-Related Issues

N=58

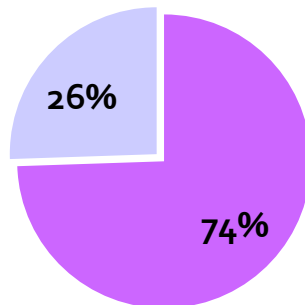
■ Under 10 ■ Teenage ■ Twenties ■ Thirties ■ Forties  
■ Fifties ■ Sixties ■ Seventies ■ Eighties ■ 90 and Over



Physician Distribution for Behavioral-Related Issues

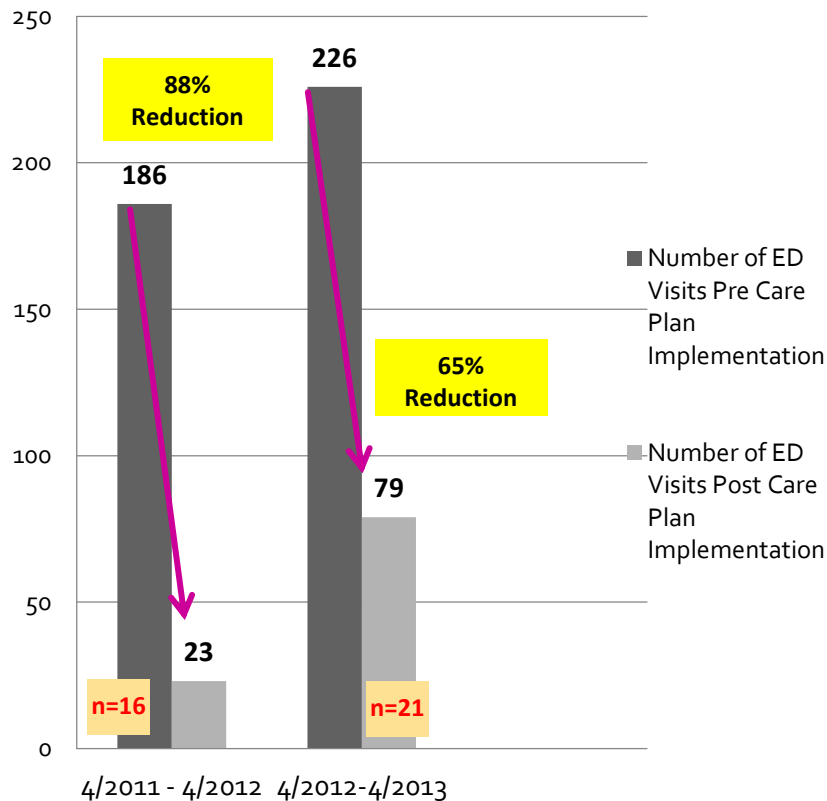
N=58

■ PCP ■ No Doctor

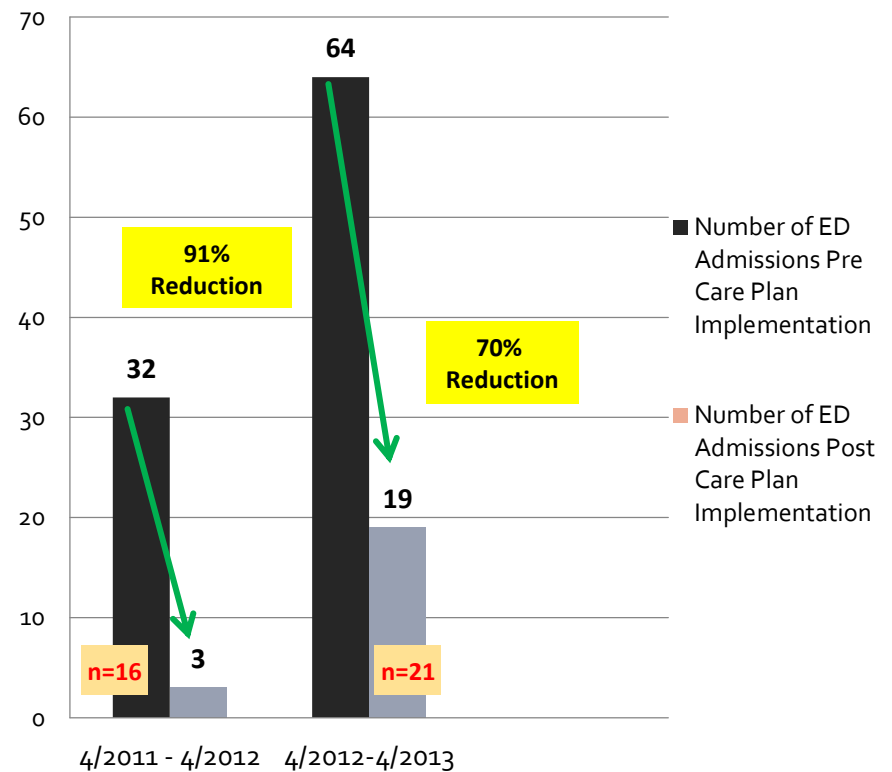


# Behavioral-Related ICP Group Visit Reductions

**ED Recidivism Reduction**  
**Yearly Trend for Behavior-Related Issues**

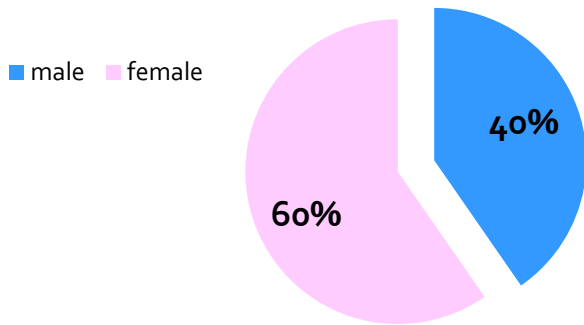


**ED Readmissions Reduction**  
**Yearly Trend for Behavior-Related Issues**

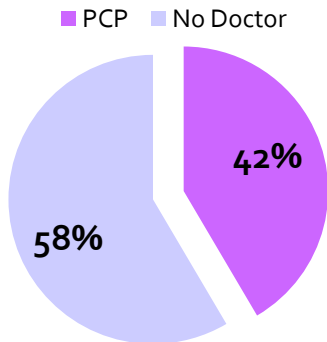


# Narcotic-Dependent Demographic ICP Group

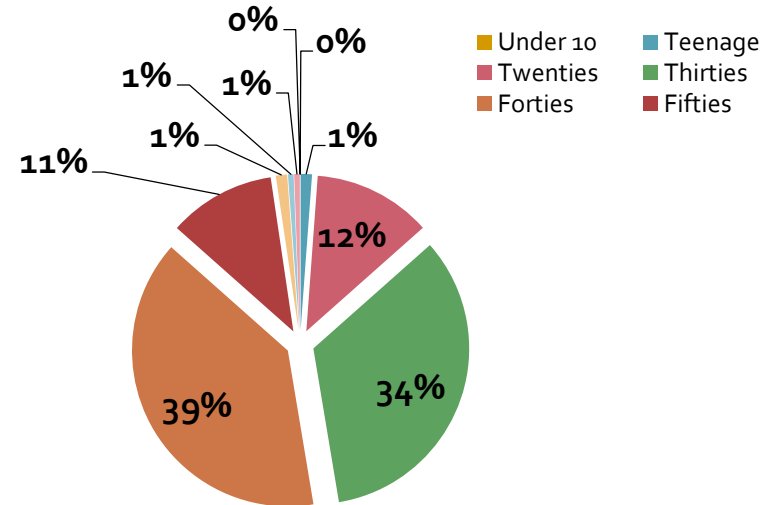
**Male/Female Distribution for Narcotic Dependent**  
N=183



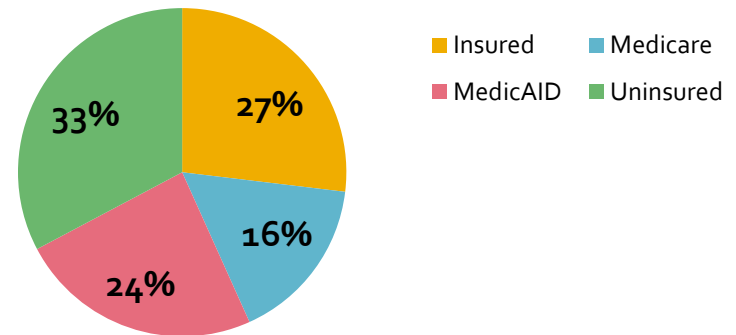
**Physician Distribution for Narcotic-Dependent**  
N=183



**Age Distribution for Narcotic-Dependent**  
N=183

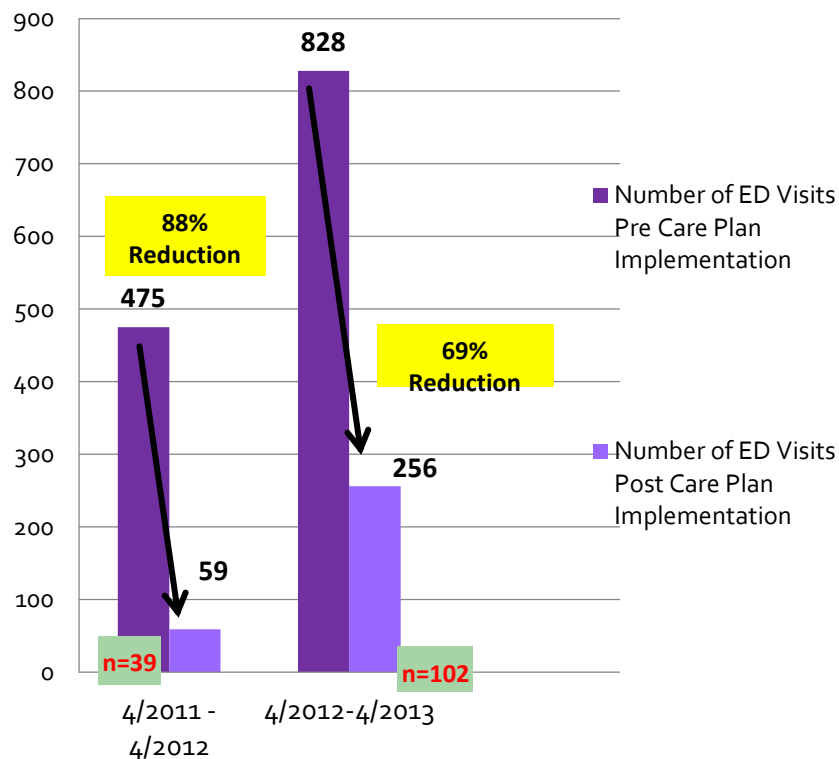


**Insurance Type Distribution for Narcotic-Dependent**  
N=183

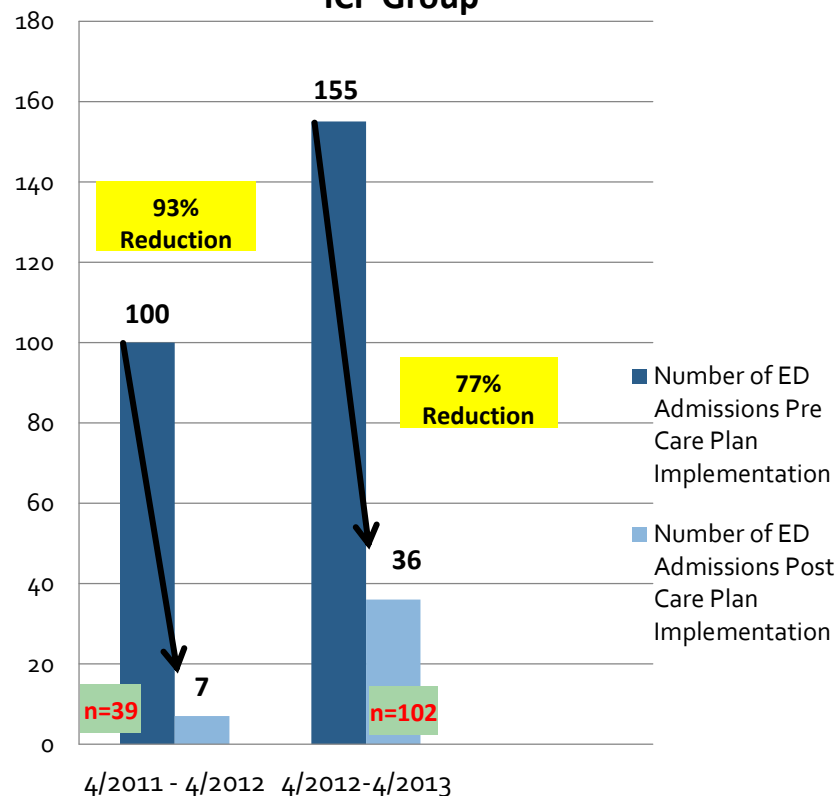


# Narcotic-Dependent ICP Group Visit Reductions

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



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

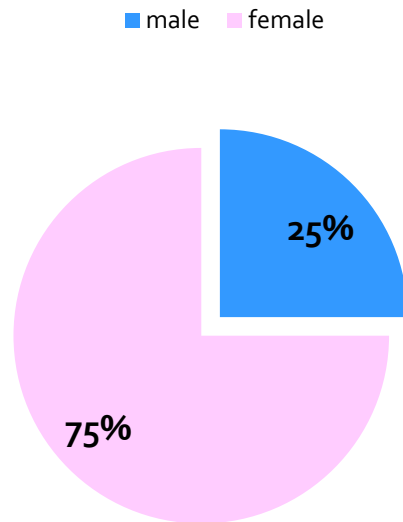




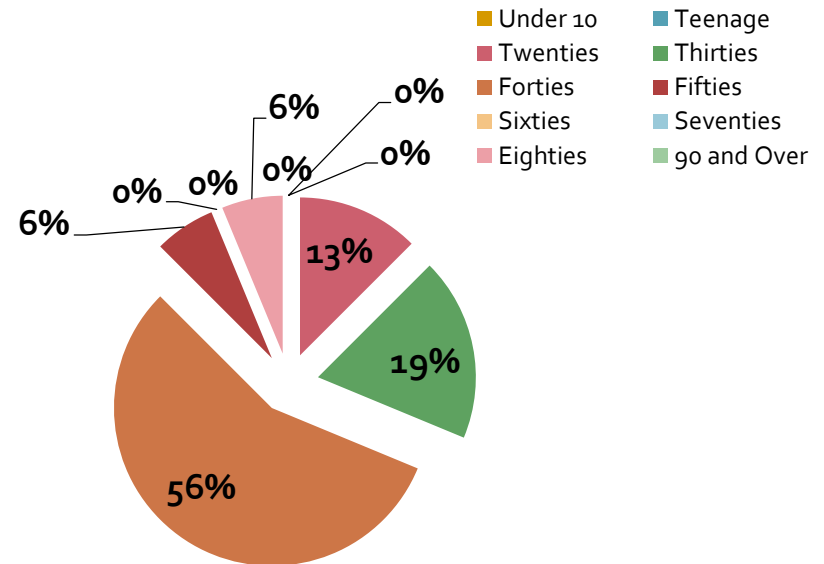
# Cat Scan Watch List

## Demographic ICP Sub-Group

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



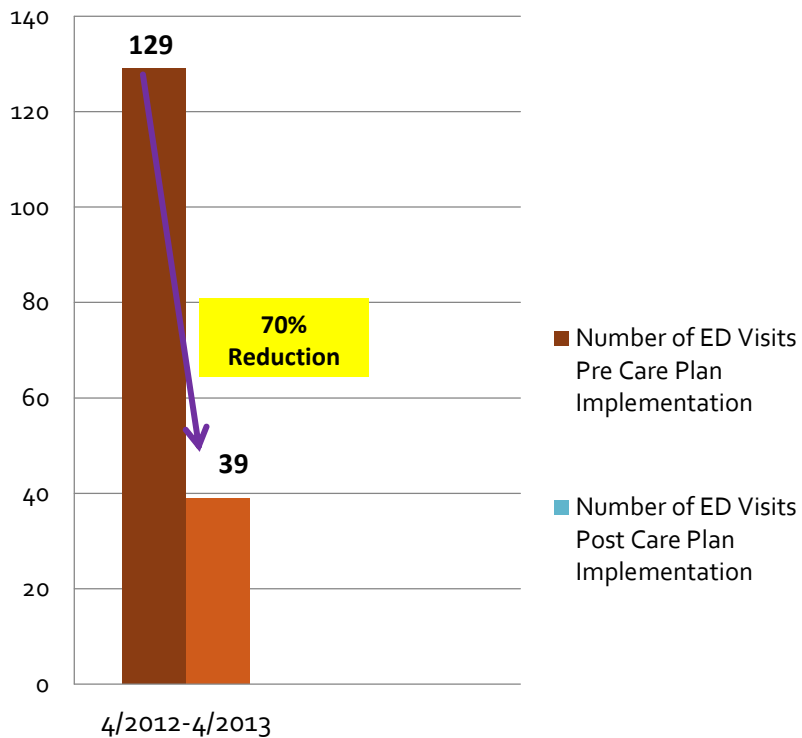
Age Distribution for Cat Scan Watch List  
Demographic ICP Group  
4/2013 N=12



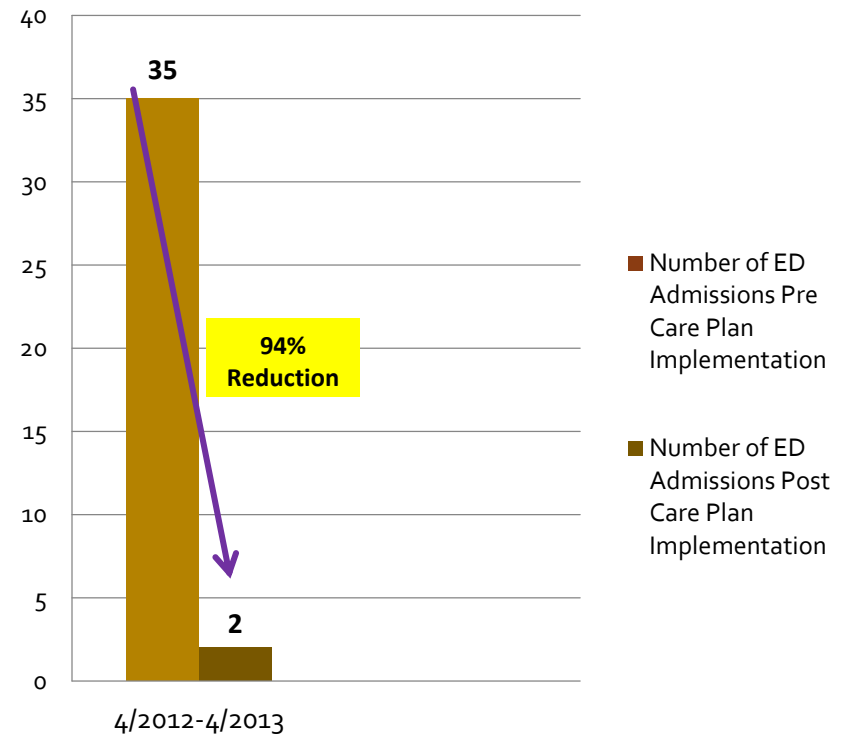
# Cat Scan Watch List

## ICP Sub-Group Visit Reductions

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

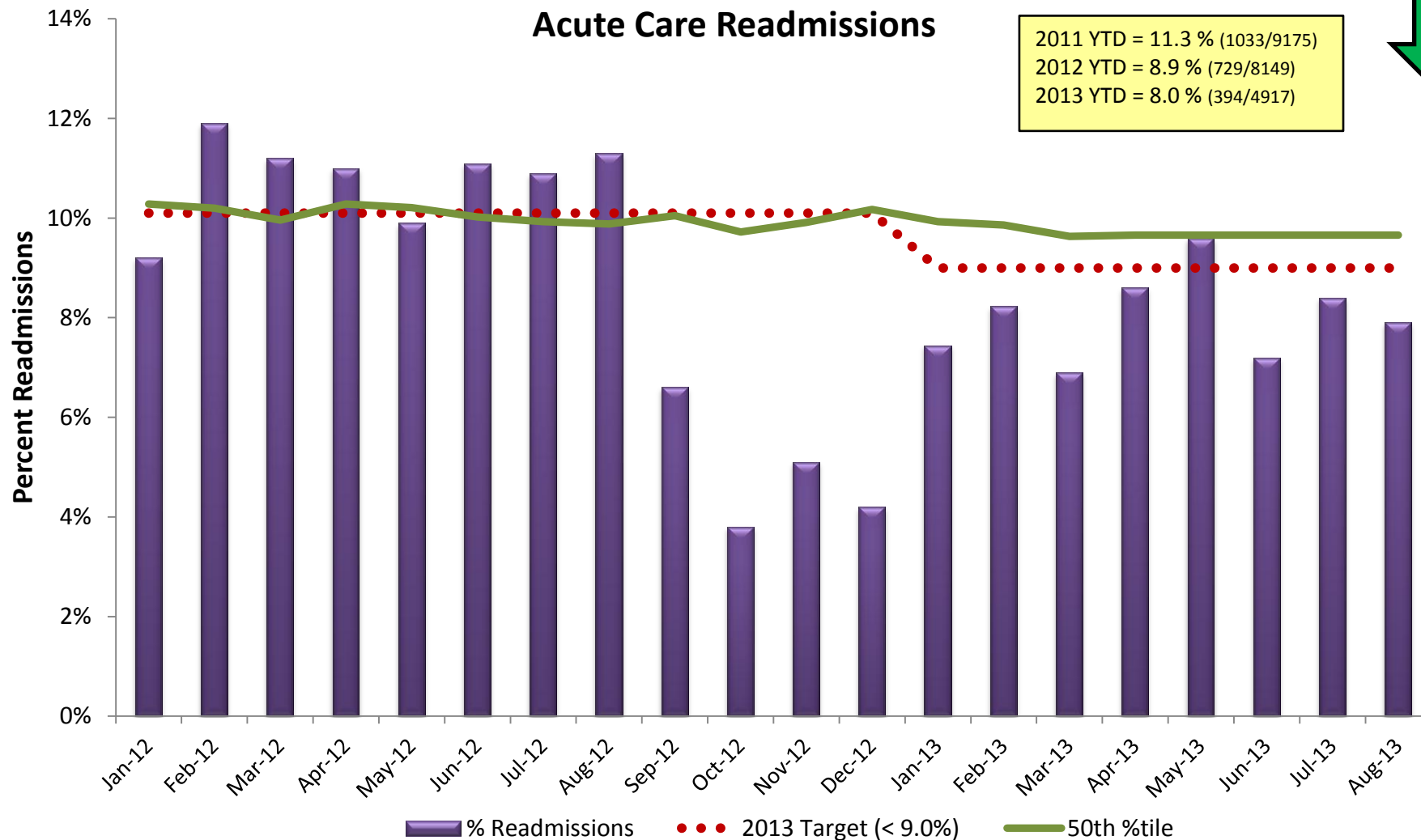
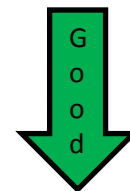


ED Readmissions Reduction in Cat Scan  
Watch List Demographic ICP Group  
4/2013 N=12



## Acute Care Readmissions

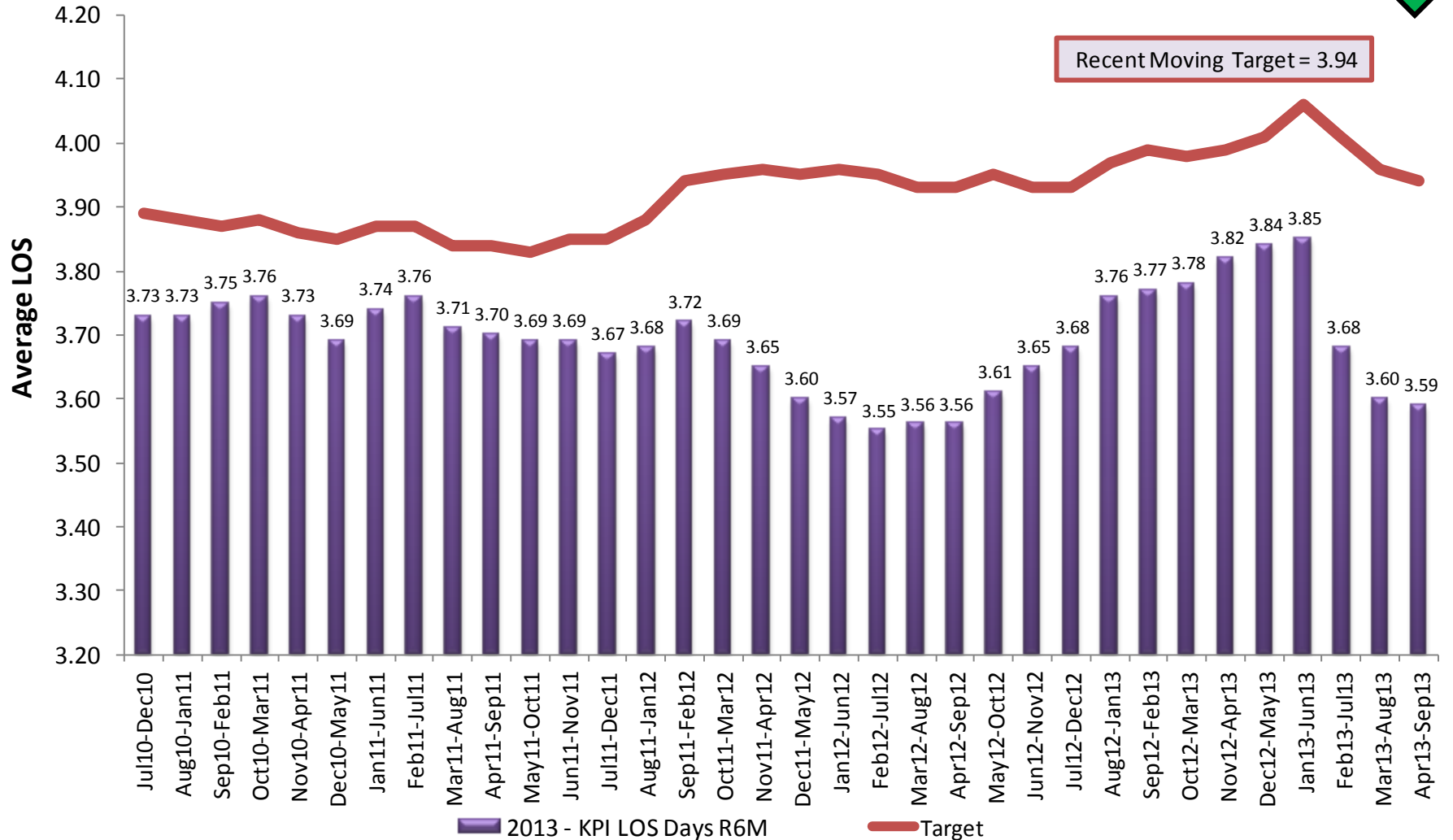
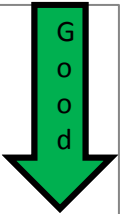
2011 YTD = 11.3 % (1033/9175)  
2012 YTD = 8.9 % (729/8149)  
2013 YTD = 8.0 % (394/4917)



	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



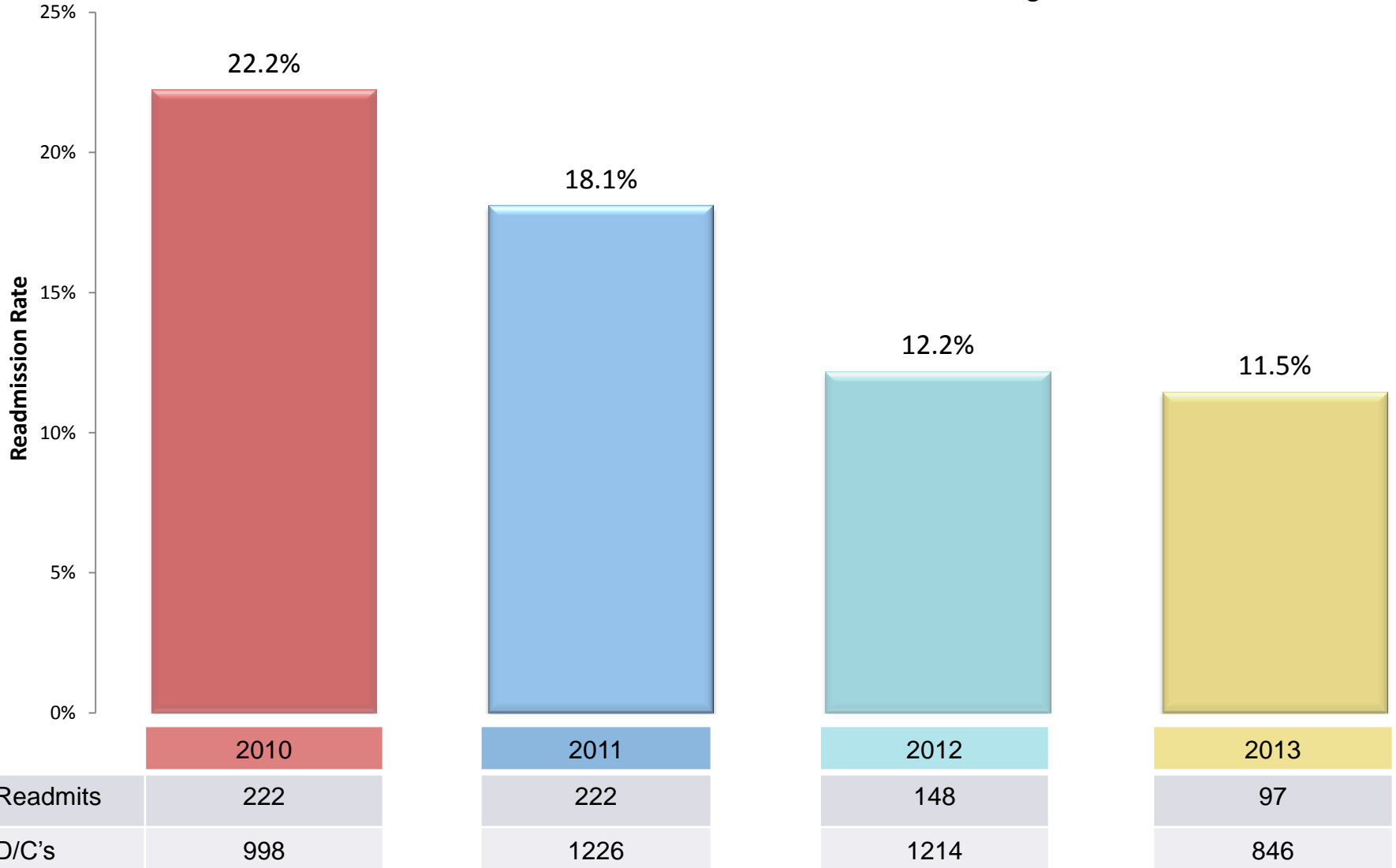
## ECF Readmission Rate Annualized

2010

2011

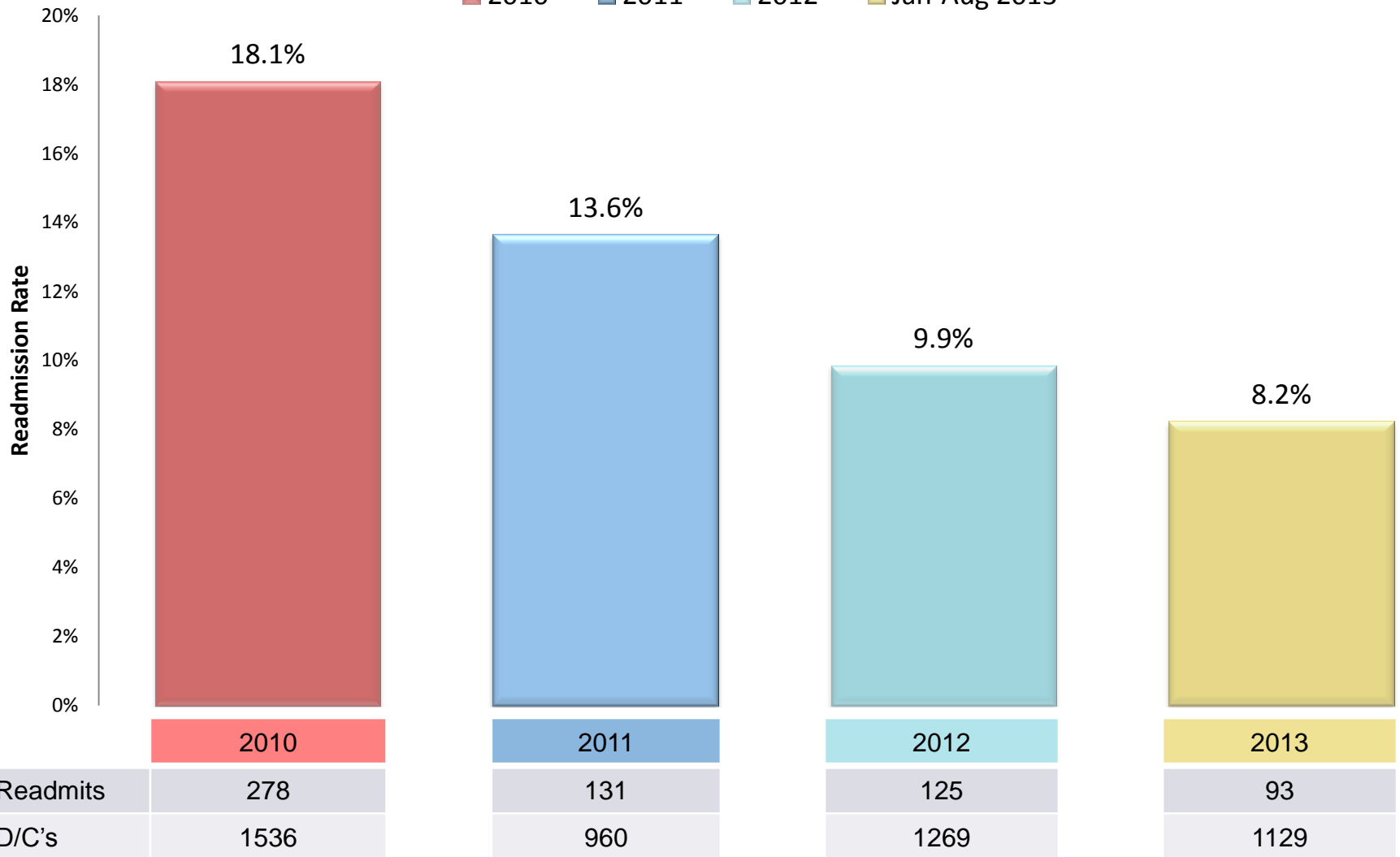
2012

Jan-Aug 2013



## Home Health Readmission Rate Annualized

2010 2011 2012 Jan-Aug 2013



# 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](mailto: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!

