

CASE IN POINT

Leading the Care Coordination Team with Knowledge, News and Learning

TRANSITIONS OF CARE

High-Tech Patient Transition Management for High-Risk ED Patients

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Effective patient transition management is a key priority for hospitals seeking to improve patient outcomes, avoid readmissions, and reduce the overall cost of patient care. As the first point of entry for the lion's share of patients who are treated by the hospital and for patients with the highest risk for readmission, the emergency department (ED) should be a primary focus of any patient transition management initiative.

For Cox Medical Center Branson ("Cox Branson"), the need to focus on the ED is imperative. The average hospital ED treats and discharges 80 percent of its patients, and the 20 percent who are admitted constitute about half of the hospital's overall admissions. At the facility, which has a total annual ED volume of about 40,000 patient visits, the ED impact is even higher – approximately 80 percent of inpatient admissions originate in the ED. Cox Branson's ED treats a high percentage of patients who are covered by Medicaid or are self-pay. An estimated 30 percent of the patients who visit the ED are enrolled in Medicaid and almost one-fourth are designated as "self-pays," which includes uninsured and underinsured individuals. These patients present more commonly with chronic and higher acuity conditions than privately insured patients do and carry a much higher risk for readmission.

SOLVING INVERSE PROPORTIONS

Recent research shows that 5 percent

of patients account for nearly half of all healthcare costs and the 15 most expensive health conditions account for 44 percent of total healthcare expenses. Care for chronically ill patients is costly, and as they tend to have high ED use along with a high readmission risk, we set out to improve the management of

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care for this patient population. Our ultimate goals are to reduce costs, establish more consistent care for the patients, and decrease avoidable readmissions by 20 percent by year-end. Like all U.S. hospitals, Cox Branson is subject to a 1 percent reduction in Medicare reimbursement if it exceeds the Centers for Medicare and Medicaid Services' 30-day readmission levels.

Last year, Cox Branson agreed to participate as a primary care health home in Missouri's MO HealthNet Home program, which is a patient-centered medical home model focusing on the needs of low-income patients with chronic medical conditions. We were given approxi-

mately 250 patients to manage, and one of our first steps was to develop a process for notifying a patient's primary care provider (PCP) when the patient obtains hospital services. We also instituted a process for ensuring that patients have access to affordable post-discharge care.

During the first few months of 2012, Cox Branson's readmission rate was in line with the state's average of 11.5 percent. After we began working more closely with PCPs to coordinate care for patients with chronic conditions, such as diabetes, chronic heart failure, chronic obstructive pulmonary disease and coronary artery disease, our readmissions dropped. By December, our rate for all-cause readmissions was 7.7 percent.

Many uninsured and underinsured individuals use the ED for primary care treatment, and each year Cox Branson writes off about \$19 million for uncompensated care provided in the ED. We expect to realize significant savings and better patient outcomes by shifting care for these patients to one of our medical home clinics.

ACTIVE PATIENT TRANSITION MANAGEMENT

Technology can facilitate management of patients with chronic conditions and prevent setbacks that might lead to readmission. As we noted, the ED is the point of entry to the hospital for a large proportion of this patient population, making it a crucial component in

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the process to improve the transition of care. Identifying these patients in the ED allows us to address two important objectives. First, for those with acute episodes who were previously admitted and are at high risk for readmission, we have an opportunity to help them access better ongoing care in the most clinically appropriate and cost-effective setting and possibly avoid readmission. Second, we can help patients with nonemergent needs find a more appropriate source of future care.

Last November, Cox Branson launched a web-based patient transition management tool – T-System Care Continuity – to connect the ED to our 19 affiliated primary and specialty care clinics. This tool has made it much easier for us to manage patients at high risk for readmission and to put in place newly automated processes for care transition at discharge. It also has improved communication and access to clinical data between the hospital and clinics.

It automatically flags patients for intervention on their third visit to the ED. In nearly all cases, these repeat patients can be treated effectively in a more cost-effective setting, such as one of our clinics, where they can receive holistic rather than episodic care. Ongoing medical care can prevent their illness from worsening to the point where they need to return to the hospital.

If a patient is one we have been assigned to manage under the health home program, our social worker contacts the patient and initiates the case management process. For those who are not in the health home program but are enrolled in Medicaid, we find out if they are eligible for the program and, if so, ask that they be added.

Our case managers educate patients about their chronic medical condition(s) and discuss measures they can take to improve their health and quality of life. They also refer patients to community resources, if indicated. Once patients are better informed and have access to convenient, more affordable primary care, they can become more proactive in their own health.

BOOSTING CARE COORDINATION

T-System Care Continuity is accessible via a shared platform hosted in the cloud, so it is accessible to authorized physicians, nurses, case managers, discharge planners, social workers, admissions employees and administrators.

An essential feature is the notification system. When patients arrive at Cox Branson, their name is automatically entered into the database. Subsequently, they are assigned to one of several work queues, depending on whether they have a PCP and whether they're discharged from the ED or admitted for inpatient services.

The patient's medical home or PCP is notified by email or text message at key intervals during the hospital visit or stay. Providers can log in and access aggregated patient data, including lab and radiology results.

Before the patient leaves the hospital or ED, the program issues an accept/decline referral to the provider for the patient's aftercare. If providers accept, they contact the patient to schedule a follow-up appointment. If providers decline, we put the patient's name back into the work queue to be matched with a different provider. We can also assist patients with referrals to specialists and other community health resources. Continuity of care after a patient leaves the hospital is crucial to preventing the patient from falling through the cracks and winding up back in the ED or being readmitted.

We match patients without a medical home to a provider based on location, insurance coverage and other criteria, and an accept/decline referral is sent. The process is repeated until we find a provider that accepts the patient.

By helping these patients access more complete and consistent care, we also make substantial inroads toward reducing the hospital's cost of care. When we initiated this process, we had an average of 150 to 200 ED visits per week by patients who did not have a PCP. Now, we can easily identify these patients and transition them to a more appropriate care setting.

HOW TO: TIPS FOR TRANSITION MANAGEMENT

If you are contemplating introducing a patient transition management system into the workflow at your facility, you can expect to change some of your management processes and modify your workflow to achieve maximum effectiveness. Based on our experience, we suggest:

- Evaluating your current system and what challenges you want to address.
- Deciding and prioritizing which patient populations to manage.
- Identifying hospital and ED employees who will be responsible for managing those patients and then implementing new support processes to support them.
- Creating a strategy to engage and secure buy-in from affiliated and independent physicians at community clinics.

We chose to include only a small group of patients initially and will gradually expand our new processes to other patient populations. In addition, we'll soon be connecting to independent groups in our service area to improve physician alignment and enhance patient care communitywide.

Although we launched the patient transition management system less than six months ago, we are already seeing results. Staff members at our clinics appreciate having a tangible patient list to facilitate their workflow, and we have much greater visibility into our referral processes. Along with providing infor-

Quoteworthy

"The most effective interventions will depend on changes in the processes of care at a community level that engage more than one provider (including hospitals, home health agencies, dialysis facilities, nursing homes, and physician offices), as well as patients, families, and community health care stakeholders."

—Florida Medical Quality Assurance, a Quality Improvement Organization (www.fmqa.com)

mation on physician review and patient assignment status, the system tracks referrals and reports on providers' referral participation and rejection levels and turnaround times for visit requests. We're learning more about our patients' use of the ED, as well. All of this information is useful in guiding our path forward and helping us achieve our goals. 



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