Risk Stratification for ED follow-up interventions - Category of Submission: Reducing Utilization

Contact Information

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Physician Organization Name: Ascension Medical Group ProMed
Practice Name: PO
Practice Address: 1535 Gull Road, Kalamazoo, MI 49048
How many physicians in practice: 42 (PO)
Description of care team:
RN Care Coordinators - Longitudinal: 17
RN Care Coordinators – Transitions of Care: 2
Coord Population Health (no degree requirements, medical practice experience (MA/front office staff)): 5
ED Patient Navigator (no degree requirements, medical practice experience): 1

Executive Summary

Our goal was to implement a strategy to reduce ED utilization. Previous strategies tested were not successful. By introducing a tiered/risk-stratified approach to define follow-up we were able to right-size our staff and approach. ED volume/day is higher than IP volume, and sites and Care Managers were struggling to find time in the day. Having our Population Health Coordinators review and triage each patient allowed us to reach more patients with the appropriate information/follow-up. Our data shows this has decreased our non-emergent ED utilization and percentage of patients without a PCP and increased our ED follow-up rates and patients enrolled in longitudinal care management.

When did the intervention start and end?
Started on 10/8/18 with one Population Health Coordinator, work realigned and expanded to all 5 Population Health Coordinators on 4/19/19. Ongoing – no end date.

Goal of the Program/Intervention:
The goal of the intervention was to reduce non-emergent ED utilization, educate patients on alternative/appropriate access to care, and engage high-utilizers and patients with disease exacerbation with longitudinal care management.

Who developed the program/intervention, and how?
The program was developed by the Population Health team (Director/Coordinators). It was designed in response to the realization that RN Care Coordinators did not have the capacity to handle ER follow-up for all patients. We were also focused on ensuring that staff were working at the top of their license. Many ER follow-ups did not need longitudinal RN care management.

Description of the Program/Intervention (2-3 paragraphs):
Population Health Coordinators review the ER ADT feeds daily in WellCentive. Each patient's discharge summary is reviewed, and follow-up is determined based on the risk stratification criteria. Patients with non-emergent diagnoses are mailed a letter outlining patient education on emergent symptoms (based on their diagnosis) and options for alternative access to care (including 24 hr. call at PCP office, virtual visits, and urgent care). Patients with acute emergent diagnoses are called and a PCP visit is scheduled within 7 days. Patients with disease exacerbation emergencies or frequent ER visits are connected with a care manager for longitudinal care management. In addition, our ED patient navigator assists in scheduling primary care follow-up for patients that did not previously have a PCP.

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How were patients identified for the program/intervention?

All primary care attributed patients are included in the program. ED notifications are received in our population health registry from the state-wide MiHIN ADT feed.

The ED providers are evaluating if a patient has a primary care provider. If not, they are placing an electronic referral in our EMR.

How was success measured? Please delineate whether metrics were process-based or outcome-based

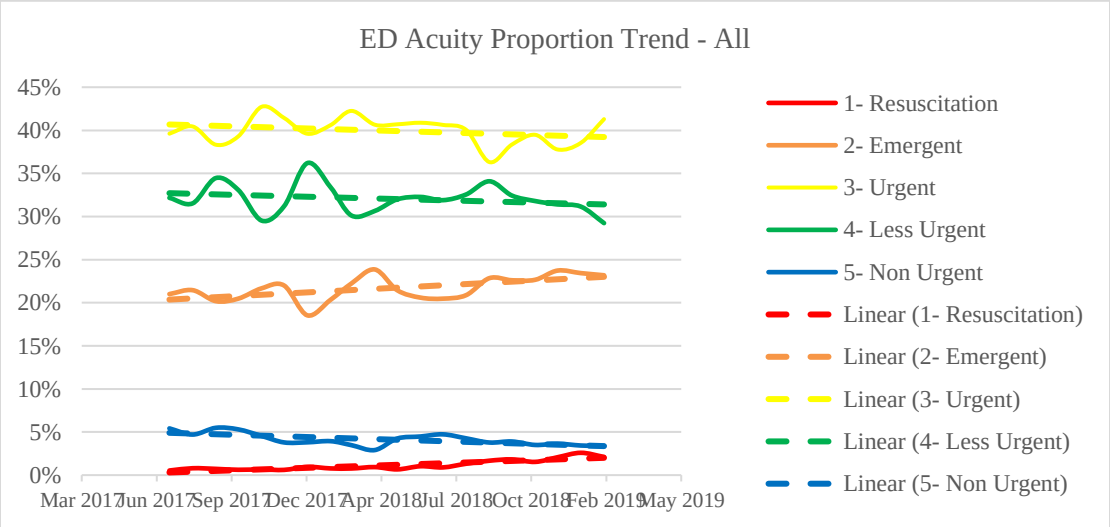
Outcomes Based Measures: ED utilization (risk-stratified)

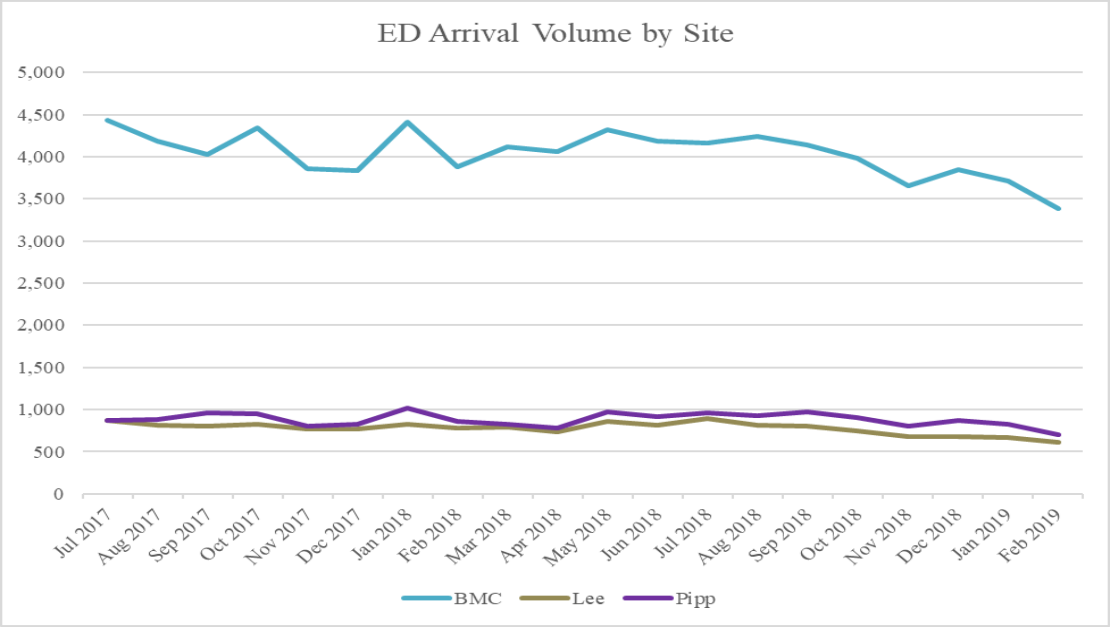
Process-Based Measures: % of patients with ED follow-up

% of patients enrolled in longitudinal care management

% of patients presenting in ED without a PCP, with successful follow-up PCP visit

What were the program results? Include qualitative data/graphs





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While seasonal fluctuation should be anticipated, the three-month period between December 2018 and February 2019 experienced a decrease of 9.8% ED Utilization for BMC, 17.7% for Lee, and 11.3% for Pipp when compared to the same period a year ago. BMC's acuity proportion of ED arrivals suggests that the two highest levels of severity (Resuscitation and Emergent) are increasing shares of utilization. Percentage of Urgent, Less Urgent, and Non-Urgent decreased. Approximately 15% of patients presenting in the ER without an established primary care provider attended a follow-up visit with a PCP to establish care. September 2018: 30% of patients with an ER visit received follow-up care within 7 days. July 2019: 44% of patients with an ER visit received follow-up care within 7 days. Longitudinal care management has increased from 0.5% to 1.06% of patients enrolled from Q218 to Q219.

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention? New tools created:
Symptom management guides to education patients on appropriate levels of care
Risk-stratification criteria for ER follow-up
ER follow-up letter mailed to patients

What are you proudest of regarding this submission? Why does this work matter?
This work is critical in improving the health of our population, reducing overall healthcare spend, and patient satisfaction. After many years of stagnant ER utilization, we are proud that this intervention is producing positive results and we are seeing a reduction in non-emergent ED utilization.

How will your organization use the funds if your submission wins?
Funding will be used to support the salary of the 2 additional population health coordinators and RN care coordinators added to support the additional work.