MidMichigan Collaborative Care Organization: Reduction of ED Utilization in MidMichigan Health Park Gladwin and Family Practice Center Alma

Contact Information

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Physician Organization Name: MidMichigan Collaborative Care Organization (MCCO)
Practice Name and Address:
MidMichigan Health Park Gladwin, 1105 East Cedar Avenue, Gladwin MI 48624
Family Practice Center Alma, 330 East Warwick Drive, Alma MI 48801
How many physicians in practice:
MidMichigan Health Park Gladwin: 4 Physicians
Family Practice Center Alma: 3 Physicians (additional: 1 APP and 12 Residents)

Description of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity):
MidMichigan Health Park Gladwin:
1 LPN Care Manager
1 Medical Assistant Patient Care Navigator
Clinical support: 2 RN, 1 LPN, 6 MA
Clerical support: 4 Patient Service Specialists

Family Practice Center Alma
1 RN Care Manager
1 Medical Assistant Patient Care Navigator
Clinical support: 1 LPN, 9 MA
Clerical support: 3 Patient Service Specialists

Category of Submission: Reduction in Emergency Department Utilization

Title of Submission: Use of Patient Care Navigators in the Care Management team to reduce admissions to the Emergency Department

When did the intervention start and end? The project began in Quarter 4 2018 in Gladwin and Alma and is still ongoing.

Goal of the Program/Intervention: (1-2 sentences):
A Patient Care Navigator (PCN) contacted high Emergency Department (ED) utilizers using Motivational Interviewing (MI) techniques to quickly gain a therapeutic relationship with the patient. Depending on specific diagnosis, the PCN would educate patients on the most appropriate location to receive care, identify and assist with obtaining resources, and support their care plan goals.

Who developed the program/intervention, and how? (2-4 sentences):
The program was developed by Director of Ambulatory Quality with MidMichigan Health's employed physician group and the Manager of Ambulatory Clinical Services. An interdepartmental A3 Process Improvement (PI) project was initiated to focus on frequent ED

presenters in the Gladwin and Gratiot (Alma) Emergency Departments. As the PCN was already aligned with the Care Management team for outreach to patients discharged from the hospital, it was logical to create workflow to reach out to frequent ED utilizers as well. Gladwin and Alma had MCCO's 2 highest ED rates/1000.

Description of the Program/Intervention (2-3 paragraphs):
Helping patients get their care in the right setting can save them time and expense, it supports care coordination and improves patient safety. An interdepartmental A3 PI team studied ED utilization and discovered a number of root causes for unnecessary ED use including: patient confusion on how and where to get the care they need, offices directing patients to the ED when other alternatives might have been available, patient transportation challenges, and patient risk factors such as behavioral health concerns.

The A3 PI team recommended specific counter measures to address some of these issues. Included in the project was an education campaign to help employees help patients know where to go for care, specific scripting for office staff to help in communication with patients, and using a PCN to reach out to frequent ED utilizers and ED utilizers with no primary care provider (PCP) to identify and address underlying causes of unnecessary ED use.

The PCN used the Epic ED utilization reports daily to identify patients who had been to the ED at least 3 times in the past 30 days or who had no PCP. She then called those patients and assessed psychosocial needs using a Social Determinants of Health (SDOH) survey, assisted with finding resources as identified in the SDOH survey, and supported appointment scheduling with Primary Care Physicians to address chronic conditions. If the patient did not have a PCP, the PCN called offices to facilitate establishing the patient with a PCP and scheduling an ED follow up appointment.

How were patients identified for the program/intervention? (1-2 paragraphs): The PCN used daily Epic ED utilization reports to identify patients. Parameters for selecting patients to contact included those with at least 3 ED visits over a 30 day period, or any patient with an ED visit and no PCP listed in Epic.

How was success measured? Please delineate whether metrics were process-based or outcome-based (2-3 paragraphs): Outcome-based success was measured using Patient Ping data. ED discharges were compared using baseline pre-intervention Q4 2017 discharges/1000 to post intervention Q42018 discharges/1000. Additionally, outcome-based success was measured by collecting anecdotal information from patients and ED providers

Process-based success was measured by completion of an ED Utilization Toolkit that included specific scripting for ambulatory office staff and the PCN. It also included a "Where to Go For Care" flyer. A Social Determinants of Health tool was also optimized and used in Epic to assist the PCN in identifying patient's barriers to appropriate care in the appropriate location.

What were the program results? Include qualitative data/graphs (2-3 paragraphs): Baseline Patient Ping ED Utilization: Alma FPC = 106/1,000 beneficiaries, Gladwin = 144/1,000 beneficiaries. Q4 2018 data after intervention of personalized patient contact by PCN, showed improvement: Alma FPC improved by 9.5% to 96/1,000 beneficiaries and Gladwin improved by 24.4% to 109/1,000 beneficiaries *(Appendix 1)*
The ED Utilization Toolkit was distributed to all PCP offices and also used by the PCN. *(Appendix 2, 3)* In addition to data supporting success of PCN intervention, the Alma Emergency Department and PCN had positive comments regarding the coordination of care. There was a specific example of a young girl with gastrointestinal issues, no insurance, no PCP, and no job. The PCN was able to get her established with a PCP and helped her complete an insurance application.

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention? (1-2 paragraphs):
The PCN went through comprehensive Motivational Interviewing training.
In addition, scripting was developed for the PCN's phone conversations with patients:

> "I see you were in the Emergency Department recently and I wanted to check to see how you are doing."
> "I see that prescriptions were ordered, were you able to pick them up? Do you have any questions or concerns with them?"
> "I also noticed that the ED wanted you to follow up with your primary care provider were you able to get that setup? (If you do not have a primary I do have a list of providers that are accepting patients that I am sure would be more than happy to help get you scheduled with for follow up care)"
> "Can I give you some information about how to figure out where to get care if your doctor's office is closed?"
> "Before we go, do you have any questions, concerns that I can help you with today? If anything comes up after our call, you can reach me at XXX-XXXX"

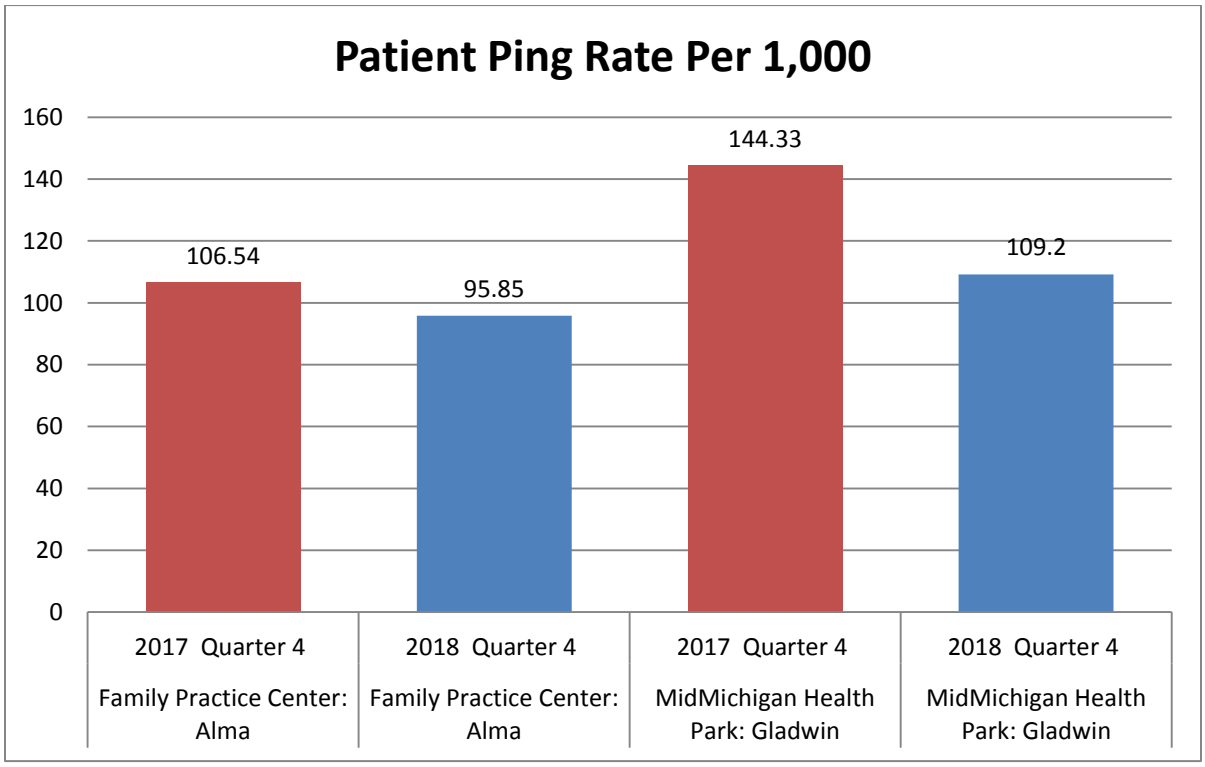
A SDOH tool *(Appendix 4)* was created and embedded into Epic and was used by the PCN during phone calls to patients to identify barriers to receiving care in the appropriate location.

What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs): MCCO has traditionally had high ED utilization rates, and developing a program that had such a positive patient impact and demonstrated significant improvement in ED utilization in just 2 practices is exciting. The project success was recognized by MidMichigan Health administration and they have approved hiring of 3 additional PCNs to continue reaching out to patients post ED discharge.

How will your organization use the funds if your submission wins? (1 paragraph): These funds will support Motivational Interviewing training of new PCNs as well as supporting hiring of an additional PCN. The ultimate goal is having a PCN as part of each practice unit's Care Management team.

Appendices:

Appendix 1: Patient Ping data



Appendix 2: Scripting for PCP Staff

Scripting: Encouraging PCS Visits to PCP rather than ED

Provider, Clinical Staff, and PSA Staff should use the following scripting to encourage all patients or caregivers to call the practice, when needs come up in between planned Primary Care visits.

"Your next regular checkup/planned appointment is _____. If you need us before then, please call. If you have urgent care needs during office hours call the practice or if you have urgent care needs when we are closed, there is always a provider on call to guide your care. You can get help whenever you need it."

"Sometimes medication or disease condition questions come up after we are closed, especially if you are feeling sick. If that happens, what would you do? Who would you call?
Let the Patient answer. Provide them with information on how to obtain care after the practice is closed; How to contact Provider on-call, *where to go for care* document, urgent care hours of operation.

"Could I share some information with you on what to do if urgent care is needed and we are closed?"
If they say yes, provide them with information on how to obtain care after the practice is closed; How to contact Provider on-call, *where to go for care* document, urgent care hours of operation.

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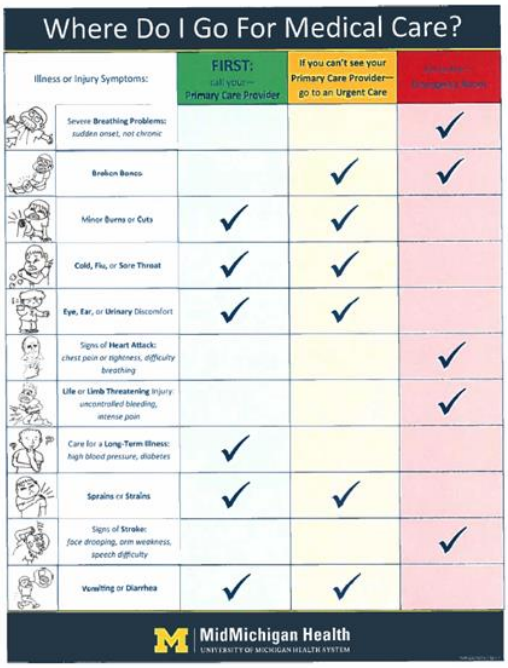
Appendix 3: ED Toolkit Flyers



"Where to go for Care" – MKG01079

Appendix 4: Social Determinants of Health Tool in Epic

		Yes / No
1.	Have you ever eaten less than you felt you should, in the last 12 months, because there wasn't enough money or food?	Yes / No
2.	In the last 12 months, has your utility company shut off your service for not paying your bills?	Yes / No
3.	Are you worried that in the next 2 months, you may not have stable housing?	Yes / No
4.	Do problems getting childcare make it difficult for you to work or study?	Yes / No
5.	In the last 12 months, have you needed to see a doctor, but could not because of cost?	Yes / No
6.	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	Yes / No
7.	Do you ever need help reading hospital materials?	Yes / No
8.	Are you afraid you might be hurt in your apartment building or house?	Yes / No
9.	I am lonely	Yes / No
10.	Are any of your needs urgent? For Example: I don't have any food, I don't have a place to sleep tonight.	Yes / No
11.	If you indicated yes to any boxes above, do we have your permission to refer you to other providers or community resources on your behalf?	Yes / No