NPO Best Practice – Reduction in ED Utilization

Contact Information

Submitter Name: Kris Elliott
Submitter Title: NPO Director of Quality
Submitter Email: kelliott@npoinc.org
Submitter Phone Number: 231-421-8505
Physician Organization Name: NPO
Practice Name: NPO
Practice Address: 125 Park Street, Ste 300 Traverse City, MI 49684
How many physicians in practice: N/A
Description of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity): N/A

Executive Summary (5-8 bullet points, must include summary of results)

- For the last few years, NPO has focused on a message to practices to drive down ED visits, thus decreasing inpatient admissions, readmissions, and thus, overall cost. NPO has been a lower ED utilizer when compared to other POs, but there was, and is, opportunity.
- There was initial pushback, as some practices felt that the patient's ED use was out of their control.
- NPO uses the PCMH-N model as the infrastructure for all work, and regarding ED visits, emphasized how specific domains, such as after hour call availability, when implemented, can help reduce ED visits. NPO educated and reinforced this message with practices.
- NPO promoted and provided tools that can aid in the reduction of ED visits: ADT and Medication Reconciliation, patient educational posters and Care Managers are examples.
- NPO believes that those at the practice know their patients and what works best for those patients. NPO uses PCMH User Group meetings, site visits, emails, Care Manager meetings, and other methods so that practices can share with and learn from one another.
- NPO ensured that success stories regarding use of all these tools were shared via these methods so that practices could learn from each other then test and tweak what would work in their practice. Practices sharing successes helps drive change, especially when each independent practice is slightly different.
- Practices now incorporate tools as soon as they are provided to continue to drive down ED utilization; those practices with Care Managers consider the Care Manager another tool in the toolbox and are using the Care Manager to further drive down reduce ED visits.
- From BCBSM Quarterly datasets (commercial), NPO rates, for adults and children, are:

	ED Utilization Rate per 1,000	PCS ED Utilization Rate per 1,000
2016	181.36	70.71
2017	172.74	66.9
2018	164.15	63.81

NPO's CMS MSSP ACOs also show reductions in ED utilization.

Category of Submission (see page 1): Reduction in ED Utilization
Title of Submission: NPO Best Practice – Reduction in ED Utilization

When did the intervention start and end? (1-2 sentences)

NPO has always focused on ED utilization, but in 2016 developed a consistent message: "If the patient does not go to the ED, then they are not admitted. If they aren't admitted, they can't be readmitted." This was

done recognizing that decreasing inpatient utilization, when appropriate, was NPO's most significant opportunity to reduce overall care costs.

Goal of the Program/Intervention: (1-2 sentences)
By keeping patients out of the ED, NPO practices can also reduce admissions, readmissions, and total cost of care. And of course, coordinated care with the PCP is much better for the patient ensuring no duplicate/unnecessary tests/procedures.

Who developed the program/intervention, and how? (2-4 sentences)
NPO staff in conjunction with Medical Leadership developed and continue to refine the message and the tools provided. It is the practices that then really refined how to use the tools, including the Care Manager. At PCMH User Group and Care Manager meetings, practice managers and Care Managers share what they have tried and how it worked. Others can ask questions, suggest revisions, and share their own learnings; in the end, each practice can then use a process that works for their own unique practice.

Description of the Program/Intervention (2-3 paragraphs):
NPO's ED utilization has always been low, which can make it difficult to continue to improve. In addition, many patients in the area live in areas where there is no UC, only a Hospital ED or Hospital Walk-In clinic with limited hours.

NPO practices, having already utilized after hours call and ADT to reduce ED visits, embraced the next tool in their arsenal, Care Managers, to further drive down ED utilization. At PCMH User Groups meetings and at Care Manager meetings, there was active conversation around these questions: How is your practice utilizing the Care Manager to reduce ED visits? Is that working? How could we modify that for our practice's situation?

A few months ago, when as part of its monthly PCMH request process, NPO asked practices to describe processes used to help reduce ED use, the attached document shows the responses from the practices. These are the practice managers' words, not NPO's. It is clear from the responses that the practices are committed not only to reducing ED utilization, but to utilizing the Care Manager to reduce ED utilization recognizing that the Care Manager can help address barriers and connecting patients with Community Resources.

How were patients identified for the program/intervention? (1-2 paragraphs)
The practices can identify patients using ADT messages. These ADT messages, delivered by NPO's HIE, in addition to the ADT message itself, have a summary listed which shows how many ED visits and inpatient admissions the patient has had in the last 6 months and 12 months. This helps the practice and Care Manager identify those patients with patterns of use.

Every quarter, NPO aggregates this ADT information into a practice report, using the previous 5 months of ADT messages, identifying high utilizer patients with 3 or more ADT/UC (hospital-based)/OBS/inpatient visits in that time period with one or more of those 3 occurring within the last two months. This narrows the patients down to those who have very recent activity showing high utilization of the hospital.

How was success measured? Please delineate whether metrics were process-based or outcome-based (2-3 paragraphs)
Every practice has anecdotes (stories) of success. It is those stories that they share with each other that help all learn from each other. Those stories help promote new initiatives. Without those initial stories of success, there is no momentum, no shared excitement, to push programs forward. So, one measure of success is being able to gather and share those stories – that the stories exist. Stories can be process and/or outcome-based. ED utilization metrics are outcome-based metrics.

What were the program results? Include qualitative data/graphs (2-3 paragraphs)

NPO monitors ED usage closely. From BCBSM Quarterly datasets (commercial), NPO rates, for adults and children, are:

	ED Utilization Rate per 1,000	PCS ED Utilization Rate per 1,000
2016	181.36	70.71
2017	172.74	66.9
2018	164.15	63.81

NPO's CMS MSSP ACOs also show reductions in ED utilization.

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention? (1-2 paragraphs)

The initial inclusion of the ADT ED and inpatient number of visits over 6 and 12 months on the ADT message was developed by NPO. Aggregating all ADT messages to identify, in near real-time high utilizers, is a report developed by NPO. Practices shared with each other how they were using Care Managers and refined their processes based on learnings from other practices.

What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs)

A few years ago, when NPO tried to talk to some practices about reducing ED Utilization, there was pushback that ED use was something that could not be managed or controlled – patients were going to use the ED regardless of any intervention. Now, practices not only understand the need to reduce inappropriate ED use, but eagerly use the tools, such as Care Managers, that they have available. And they understand that patients often have barriers that drive the patient to the ED, and that the Care Manager can assist with those barriers.

How will your organization use the funds if your submission wins? (1 paragraph) NPO currently, for practices new to Care Management, pays for a Care Manager in the practice for a few months until billings/incentives support the practice paying for the Care Manager itself. These funds would be used to continue that work expanding Care Management into more practices.

What are 2-3 examples of techniques the practice has used to decrease unnecessary ED utilization?

We use care management, we track adt, we have a provider available all times and we remind patients of that, we review usage reports and patients have access to our portal. We highlight and note for providers on reports and in chart when ED usage is an issue as well as scheduling with Care Manager when indicated by provider

We ask our patients to call here 1st so we can direct them to appropriate care (Us, Urgent Care in Charlevoix or ER)
We are annually discussing our relationship, extended hours, and phone call to us for direction when in doubt.
The Care Manager who is responsible for ER follow up and Hospital discharge shares conversation about relationship with practice team and utilizing us as a resource.
Care Management is a great lead for these frequent flyers. We invite these patients to speak with CM about Community Resources as well.

Care management: Identifies who needs that additional service to help them be confident in their care choices
ADT: Helps monitor who needs follow-up or has had an event the physician needs to address

- Education and Community Resource(s) connection by Care Manager
- Extended Office Hours (open on weekends, Saturday and Sunday)
- Education from phone nurse when making follow-up appointment from an Urgent Care visit or ER visit

We have signs posted in all rooms, at F.D. re: when to to to U.C. (green yellow red) E.R. or call office. We have C.M. who calls all pts seen in E.R. & educates on when to to to E.R. if necessary

Examples of techniques our practice uses to decrease ED utilization are:
With new patients we discuss that we are their medical home and to call us first. We have all patients sign a PCMH contract yearly which also addresses this.
High ED utilizers are referred to care management to discuss what barriers they have to seeking care with us.
We inform all new patients about our after hours triage nurse service, and remind current patients as needed.
We review ADT notices and follow up after ED visits and discuss future use of the ED as appropriate.

Care management capabilities- With TCM calls and ER follow up calls educating patients on proper ER use.
Provider availability 24 hours to help guide care- Educate patients about this at our New Patient Orientation and at check out.
Providers are doing quarterly home visits on patients that are not able to come into the office.
Nursing home team – rounding on several different Nursing Homes who care for our patients. Ensuring a smooth transition of care.

There are several ways we consistently work to reduce ED utilization. This year we are implementing care management into the Practice. Not only will the physicians refer patients to the Care Manager, but we also plan to have the Care Manager regularly review reports and ADT data to recommend patients for the program. We also educate our patients about the appropriate use for ED, UC, and the office. Our Providers are always available to patients after hours for questions and patients often contact them. We frequently accommodate “after hours” appointments.

What are 2-3 examples of techniques the practice has used to decrease unnecessary ED utilization?

Care Management department discusses contacting the office 24/7 regarding non-emergent health issues. They also hand out the ED vs Office magnets and information sheets to help educate patients. TOC (Also perform phone calls for follow up on ED visits) phone calls always go over the recommendation to call the office for non-emergent health issues before going to the ED. Providers and MA staff discuss with patients when they come in following an ED visit the recommendation to call the office for non-emergent health issues before going to the ED. We have ED vs office necessity flyers in our exam rooms.

Patient is reminded at yearly px/wellness visit, we are your patient centered medical home, call us for same day appointments, call us after hours to speak with a provider, and instructed how to contact the provider after hours, we want to keep you out of the ED if where you pay much more for care and very sick people are.

Care Management – Patients are called after ED visits to remind them of same day visits and after hour availability to a provider. The patients are offered CM service here for issues that may have taken them to the ED or to deter them from using the ED , teaching coping mechanisms to help self manage at home before going to the ED.

Patients are educated at yearly visits, by signage in the office, on our website and patient portal there is 24 hour access to their provider and how to contact them.

Patients are offered televisits after hours for visits if they are unable to come to the office during office hours. This is a visit that is “face to face” through our patient portal.

Patients are followed by Michigan ADT Initiative and contacted 24-48 hours after discharge from many facilities for a follow up visit with the provider or to be educated about calling practice first, same day appointments and 24 hour access to a provider and how to contact them.

One way we try to decrease ED utilization is having a dedicated nurse reach out to al pt's. She has a conversation with pt about PCMH and what that means and pt-provider expectations. (like to call us first before going to ED.)
Another way is having care managers reach out to pt's who have high ED utilization. Quarterly, we run reports and the care managers will call pt.'s and work to enroll them in care management with goals of decreasing utilization and working on chronic conditions.

One way we try to decrease ED utilization is having a dedicated nurse reach out to al pt's. She has a conversation with pt about PCMH and what that means and pt-provider expectations. (like to call us first before going to ED.)
Another way is having care managers reach out to pt's who have high ED utilization. Quarterly, we run reports and the care managers will call pt.'s and work to enroll them in care management with goals of decreasing utilization and working on chronic conditions.