URGENT Matters

# Urgent Matters Webinar Series

## Using Acute Care Plans to Improve Coordination Among ED High Utilizer Patients

2014 Emergency Care Innovation of Year Winners

May 5, 2015

GW | Office of Continuing Education in the Health Professions

# Information

Release Date: May 5, 2015
Termination Date: May 5, 2015

Hardware/Software Requirements

PC
Microsoft Windows 2000 SE or above. Internet Explorer (v5.5 or greater), or Firefox
Flash Player Plug-in (9.0 or later) Check your version here. Sound Card & Speakers
800 x 600 Minimum Monitor Resolution (1024 x 768 Recommended) Adobe Acrobat Reader*

MAC
MAC OS 10.2.8
Safari or Firefox
Flash Player Plug-in (9.0 or later) Check your version here. Sound Card & Speakers
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* Required to view printable (PDF) version of the lesson.

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# Information

Contact Information

**The George Washington University Office of Continuing Education in the Health Professions (CEHP)**

Email: cehp@gwu.edu

Phone: (202) 994-4285

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Theodore Benzer, MD, PhD (Speaker)
Beth Grabowski, MBA, MPH (Speaker)
Dawn Williamson, MSN (Speaker)
Jesse Pines, MD (Course Director)
Danielle Lazar (Staff)
Leticia Hall (Staff)

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# Commercial Support

This activity received no commercial support

# Asking Questions

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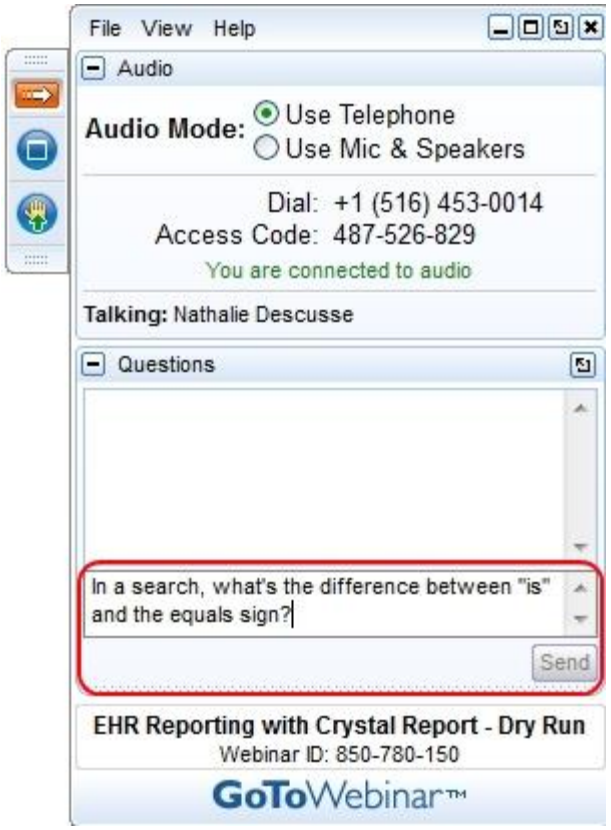
The question and answer period of the webinar will be interactive. We have scheduled approximately 10 minutes for questions at the end of the presentation. To submit a question, simply type your question in the designated area to the right hand column of the screen at any time during the webinar. If your question is not selected to be answered during the webinar, you can re-submit your question via email to info@urgentmatters.org.



# Speakers

## Theodore I. Benzer, MD, PhD, FACEP
### Department of Emergency Medicine, Massachusetts General Hospital

Dr. Theodore I. Benzer is an attending physician at the Massachusetts General Hospital Emergency Department. Since 2008, Dr. Benzer has been a member of the MGH Quality and Patient Safety Committee and Co-Chair of the MGH ED Quality and Safety Committee. He is the supervising physician of the Nurse Practitioners in the emergency department, responsible for clinical care assessment and ongoing education, and helped create the Nurse Practitioner model of care for the ED Observation Unit. In addition to his role as attending physician, Dr. Benzer is an Assistant Professor of Emergency Medicine at Harvard University.

## Dawn Williamson, RN, MSN, PMHCNS-BC, CARN-AP
### Addiction Specialist, Department of Emergency Medicine, Massachusetts General Hospital

Dawn Williamson is an Advanced Practice Nurse for Addictions Consultation in the Emergency Department at the Massachusetts General Hospital. Ms. Williamson responds to the treatment needs of both individuals and families with addiction and mental health issues in the emergency setting. As part of her responsibilities, she provides training and supervision of the clinical staff, develops and implements policies relating to patient care, and provides assistance with establishing treatment plans.

## Beth G. Grabowski, MBA, MPH
### Senior Administrative Manager, Quality, Analysis, and Process Improvement, Department of Emergency Medicine, Massachusetts General Hospital

Beth Grabowski is a Senior Administrative Manager of Quality, Analysis and Process Improvement at the Massachusetts General Hospital Emergency Department. Beth has over ten years of experience in project management, operations, and process improvement. She serves as Co-Chair of the MGH ED Quality and Safety Committee, where recent initiatives focused on improving safety of substance use disorder patients in the ED, enhancing the blood transfusion request process, optimizing the front-end screening process, and improving patient experience through better pain management, communication and privacy.

MASSACHUSETTS GENERAL HOSPITAL

# *Using Acute Care Plans to Improve Coordination Among ED High Utilizer Patients*

*Urgent Matters Webinar*

*Massachusetts General*

*Hospital May 5, 2015*

# *Agenda*

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- MGH Emergency Department Background
- Impetus for Innovation
- Acute Care Plan Implementation
- Results and Feedback
- Lessons Learned and Next Steps
- Questions

# *MGH Emergency Department Background*

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- MGH is a 999-bed medical center, located in the heart of Boston.
- The MGH ED is a large volume, high-acuity Level 1 Trauma Center, Level 1 Pediatric Trauma Center, and Level 1 Burn Center.
- The ED is staffed 24/7 by board certified emergency medicine attending physicians. Care is also provided by EM residents, RNs, NPs, and PAs.
- On an annual basis, we care for over 104,000 patient visits (287 daily), including over 13,000 pediatric visits and over 6,500 psychiatric visits.
- The ED footprint includes 40 monitored beds for acute and urgent patients, as well as a Fast Track area, Evaluation area, and 6 secured rooms for Acute Psychiatric Services.
- The ED also manages two Observation Units, totaling 32 additional beds.

*The mission of the Department of Emergency Medicine is to provide excellence in patient care 24/7 to all who present to the Emergency Department with acute illnesses and injuries; to create outstanding learning experiences for students, residents and practicing physicians and to train the next generation of Emergency Medicine leaders; to conduct high impact research in a variety of areas of EM and public health; and to provide service to the communities we serve, locally and around the globe.*

# *Impetus for Innovation*

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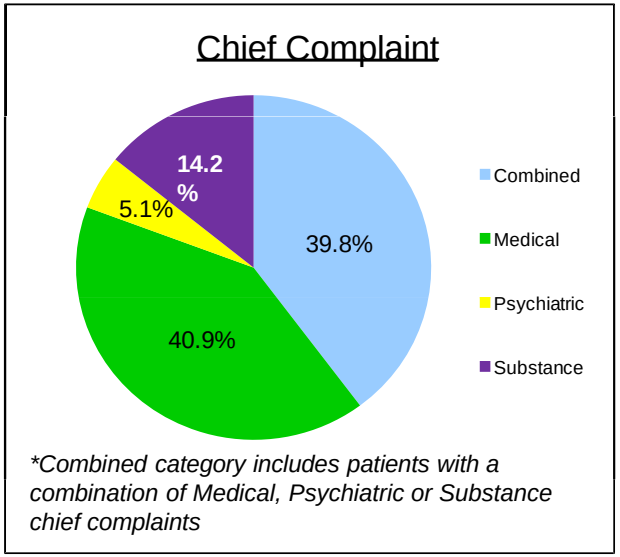
- ED overcrowding is a major concern.
- High utilizer patients, defined as having four or more ED visits per year, represent 4% of ED patients, 18% of ED visits and 21% of ED bed hours at our hospital.
  - These patients are often complex, with medical, psychiatric and social conditions
  - High utilizer patients often get a full work-up every time they visit the ED.
  - Despite a large number of homeless patients, the majority of these patients do have a primary care provider (PCP).
- Given the complex array of factors driving ED readmissions, it became evident that responding to just the chief complaint often did not address core issues and that interventions to decrease ED presentations must be broad and multifaceted.




- A multi-disciplinary team approach was necessary to address the complex issues driving the high utilization of emergency services.

**Goal:**
Reduce fragmentation and improve collaboration of care

# *Implementation of Acute Care Plans*

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- A multidisciplinary group of representatives from the ED, inpatient medical teams, case managers, social work, acute psychiatric consult service, and primary care providers collaborated on finding a solution.
  - Initially, a group of ED clinicians took on this issue as a quality assurance initiative. Data were gathered to aid in identifying care needs for patients that frequented the ED greater than ten times a year.
  - A team was assembled to develop and to communicate treatment plans for these patients. Initially, the group consisted of a Psychiatric Clinical Nurse Specialist, ED Social Workers and two ED Case Managers (CM).
  - This group quickly expanded to include representation from a variety of disciplines, including physicians, nurse practitioners, nurses, social workers, case managers, outreach workers, and administrators. Contact was also made with outpatient providers to provide collateral information and attempt to re-engage patients with their outpatient team.
- Acute Care Plans (ACPs) were created to address the lack of coordination among outpatient providers and ED providers, particularly for these complex patients.
  - Initially, these plans were developed for patients with the highest recent visits to the ED.
  - Plans were used to address who should be called when the patient arrives to the ED, steps to facilitate evaluation, medication recommendations and restrictions, specific protocols that should be followed, interventions that could be used to prevent admission, or issues that might impact a successful transition home.

# *Key Components of Acute Care Plans*

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- ACPs can be complicated and include all of these elements or be as simple a as phone number:
  - Name of patient, date & author
  - Ambulatory care team
  - Key specialists
  - Key care givers
  - Prescription issues
  - Pain management contract
  - Behavioral health
  - Substance abuse
  - Advanced care planning

- Key Points useful to ED clinicians at time of patient presentation:
  - Members of ambulatory care team to be called early during evaluation
  - Interventions to prevent admission or return to ED
  - Steps to facilitate evaluation and/or return home
  - Admit to specific service/floor Medication
  - recommendations/restrictions
  - Consults
  - Specific protocols that should be followed
  - Issues that might impact successful transition home

# *Example of Acute Care Plan*

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**Acute Care:**

**If patient presents for acute care, please consider:**

58 y/o homeless M with a hx of ETOH use d/o & a pattern of frequent visits to the MGH ED for alcohol intoxication and alcohol withdrawal. He was sec35, involuntary commitment for treatment of ETOH use disorder by the MGH ED treatment team. Since release he is waiting for housing via HUES (high utilizer's of emergency services) program. His case manager there is looking for him.

**Plan:**

- **Please contact pt's case manager from HUES to Home- Anne Hartwell 617-377-5770 to assist with him.**
- If unable to reach her pt can go to HUES program at Woods Haven Shelter at 72 Hamilton Ave Boston 617-533-7203 (available 24 hours a day) may send via taxi
- If respite is needed refer to Steven House for admission 846-654-1260. Pt is on a "fast track" list for admission for medical respite.

# *Acute Care Plan Development*

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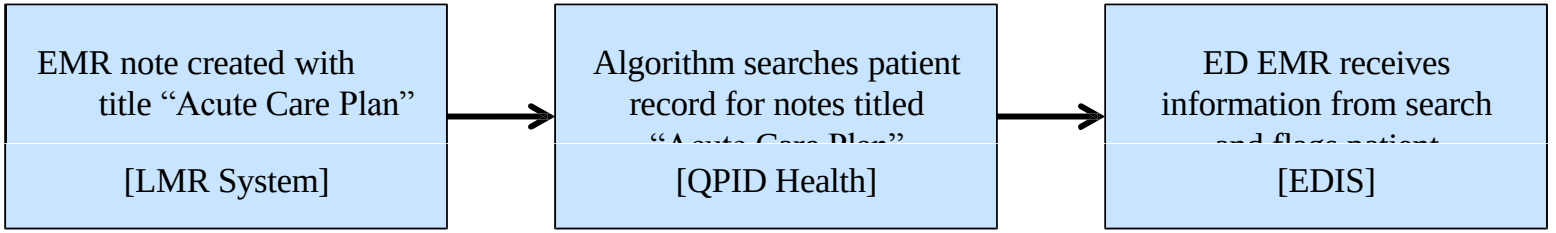
- In the electronic world, with so much information available to ED clinicians, there needed to be a way to flag the ACP and separate it from all of the other information in an electronic medical record.
- A solution was built within the electronic medical record (EMR) system due to its automated capabilities and ease of use:
  - The ACP note template was developed with standard fields giving guidance on a patient's treatment plan or disposition, along with a phone number of who to contact should the patient end up in the ED.
  - An algorithm was developed to search the patient record for notes titled "Acute Care Plan," which were created or updated within the last six months.
  - The outcome of this search sends information to the ED EMR system, automatically flagging the ACP when a patient arrives to the ED.



# *Acute Care Plans in ED EMR System*

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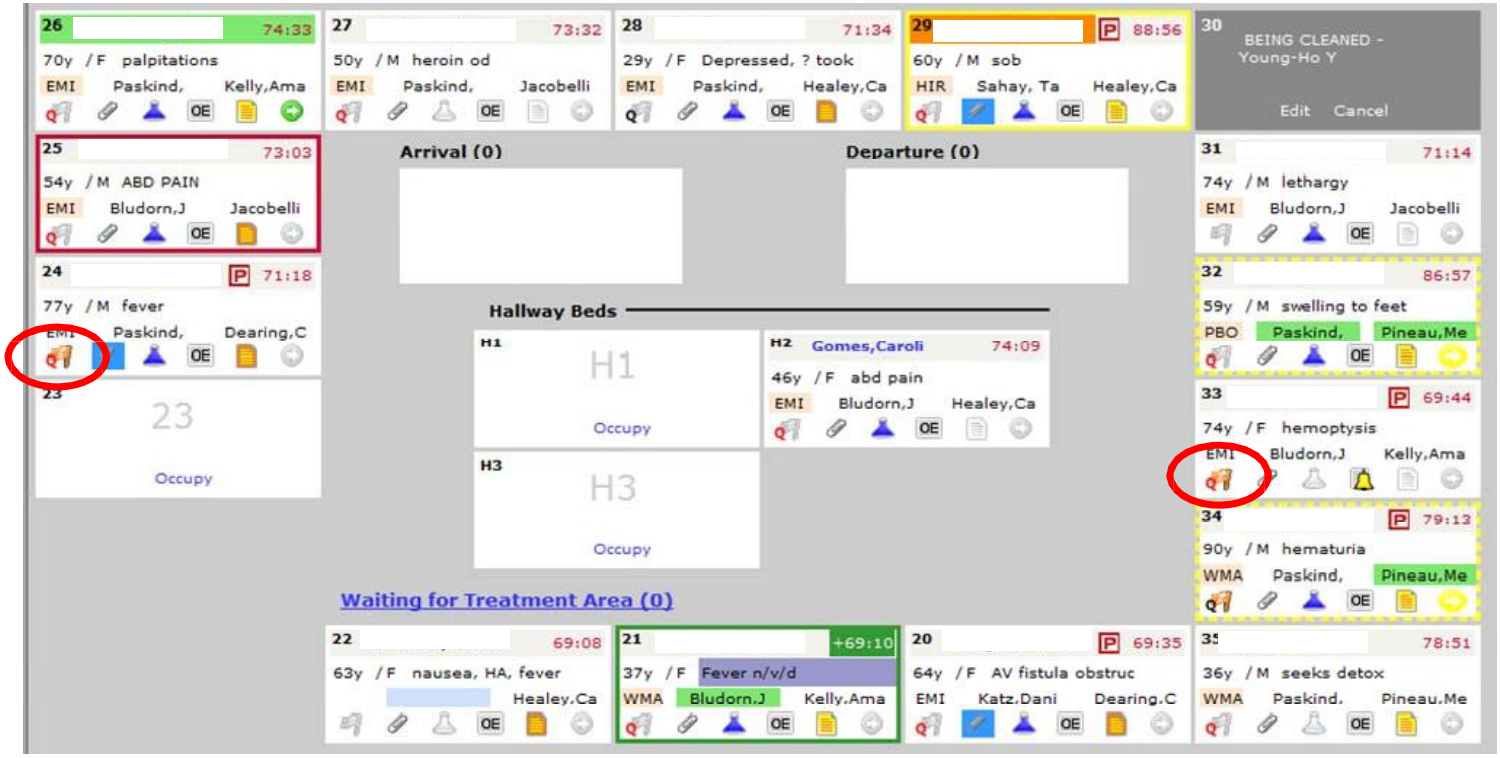
- When a patient with an ACP arrives to the ED, the electronic tracking system automatically initiates an orange referral flag.

**Example of patient tiles in ED Care Area:**



# *Acute Care Plans in ED EMR System*

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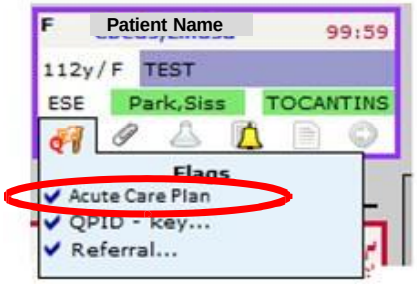
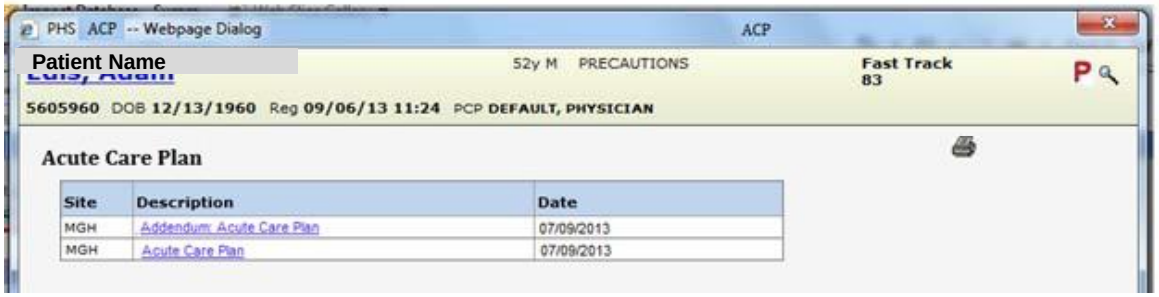
- When the orange flag is clicked, a dropdown shows important information about the patient, including the presence of an active ACP.
- This information displays on the patient tile as well as within the patient's chart.

**Patient Tile:**




- To review the information in an ACP, the user simply clicks on "Acute Care Plan" in the dropdown list. Any plans created or updated in the last six months will appear. A hyperlink directs the user to the ACP note.

**Active Acute Care Plans:**



# *Pilot Data*

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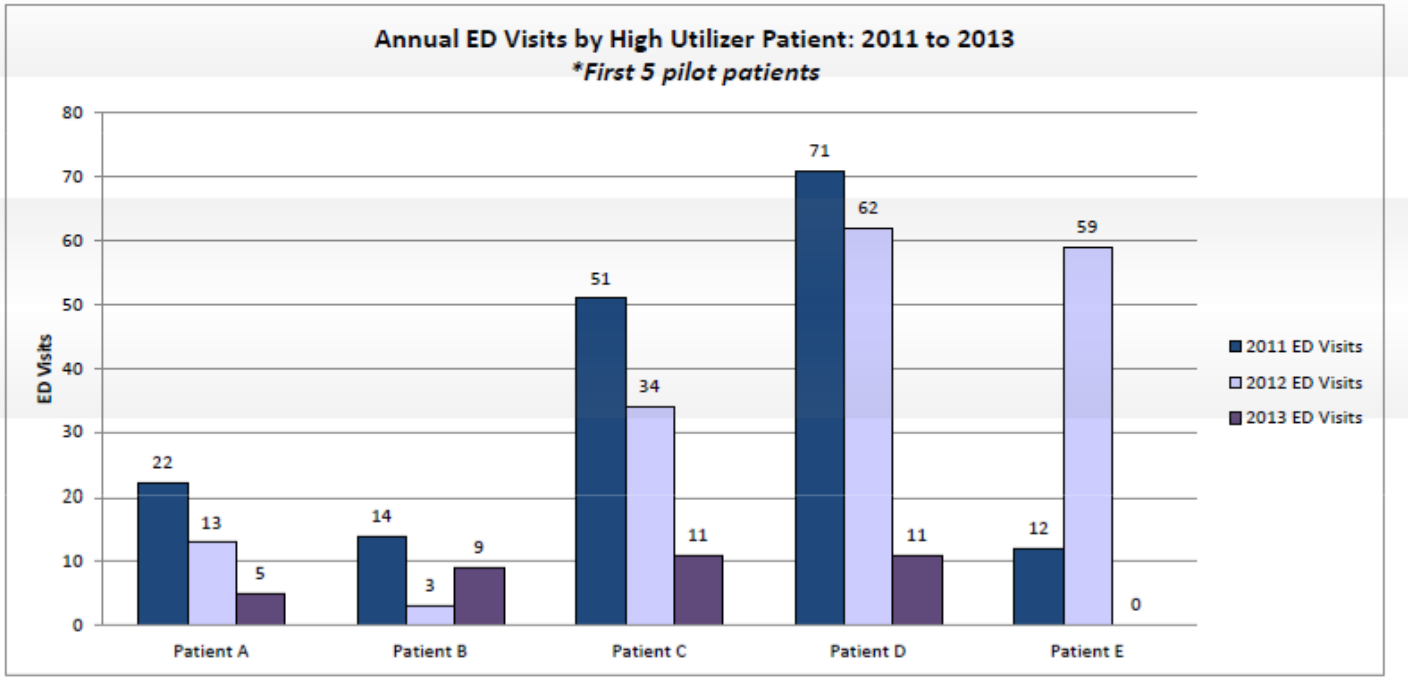
- Pilot ACPs were written for some of the highest ED utilizers. Initial data showed a large reduction in ED visits after implementation of an ACP. Through improved coordination of care, some of these patients ended up in psychiatric/addiction treatment, or even placement in a nursing home or assisted living facility.




- Since the pilot was considered successful, we continued to move forward encouraging ACPs for all ED high utilizers. This required coordination with PCPs, care managers, and other providers.

# *Impact of Acute Care Plans*

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- For the impact analysis, we looked at statistics 6 months prior to a patient's ACP and 6 months after implementation of the ACP. Patients who deceased during this timeframe were excluded from the analysis.
- At the time of initial analysis, there were 162 patients with ACPs, of which 103 were considered "active" and alive.
- Initial analysis showed many positive trends (see next two slides for details):
  - There was a decrease in ED visit volume among the high utilizer population with an ACP.
  - The number of hospital admissions also decreased pre- and post-implementation of an ACP.
  - These reductions in ED visits and hospital admissions have an associated positive impact on costs, and also offer additional bed capacity for new patients.
- Anecdotal feedback has been overly positive.

# *Impact of Acute Care Plans (continued)*

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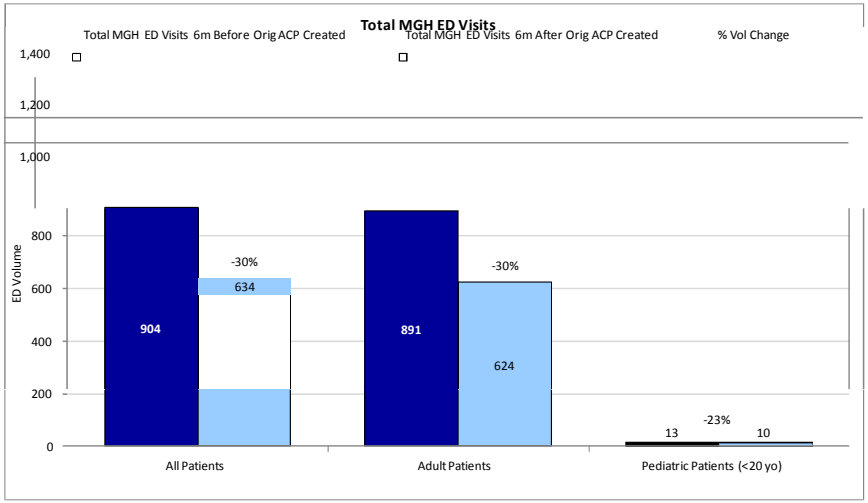
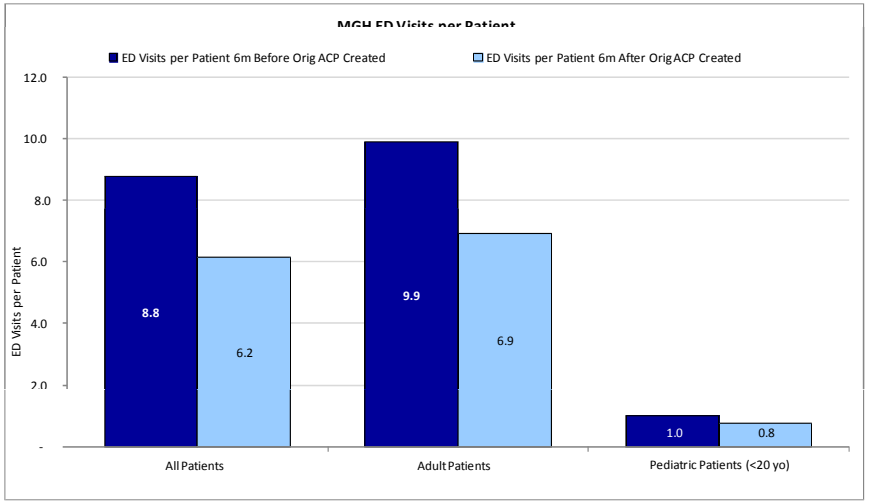
- There was a 30% decrease in ED visit volume among the high utilizer population with an ACP (net decrease of 270 visits).
- Approximately 65% of patients who had an ACP experienced a decrease in ED visit volume in the 6 months following the ACP.
- The average number of ED visits per patient decreased from 8.8 to 6.2.



# *Impact of Acute Care Plans (continued)*

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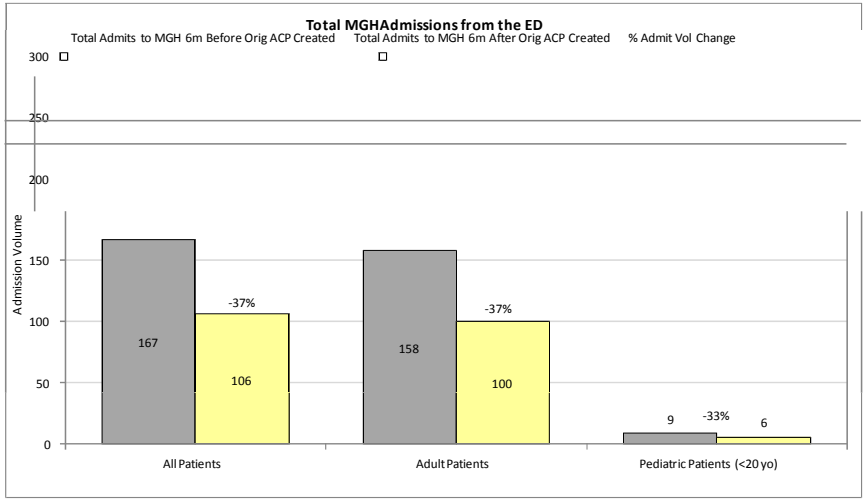
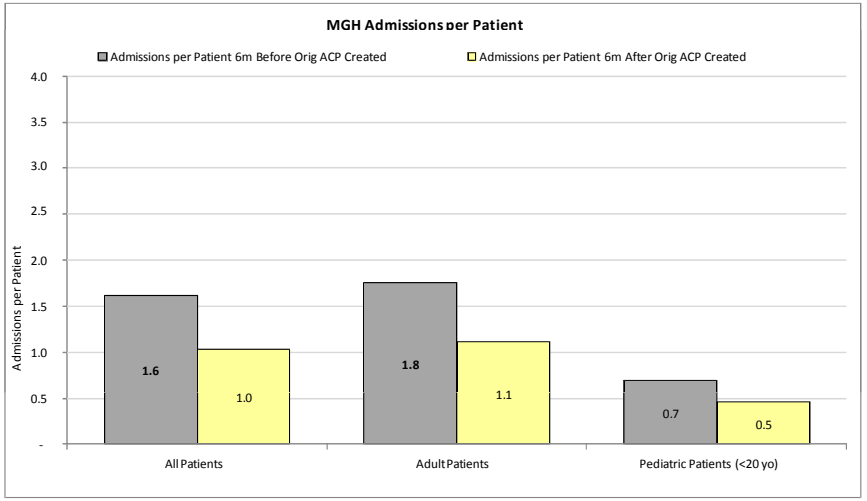
- The number of hospital admissions decreased by 37% for patients with an ACP (net decrease of 61 admissions).
- The overall admit rate among this population decreased from 18.5% to 16.7%.
- The average number of hospital admissions per patient decreased from 1.6 to 1.0.



# *Lessons Learned*

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- ACPs require buy-in from multiple partners across a system in order to be successful.
  - Relies on PCPs, case managers, etc. to create acute care plans and continue to update them when they approach 6 months. While there has been initial success with the tool, getting authors to update the ACP at the 6-month mark has been challenging.
- To date, the ACP tool has been used among providers within the system. However, many of the high utilizer patients have PCPs outside of the system.
  - We've made progress with some outside organizations, such as Healthcare for the Homeless, to create plans for their highest utilizer patients. However, this process requires more coordination.
- While there has been consensus that the information in the ACPs is extremely useful to ED providers, there are times where the information is not actionable during overnight hours and on weekends. We have attempted to address this issue through further education to providers when they create an ACP.
- Currently, we do not have a designated person to coordinate the Acute Care Plan process. Ideally, a case manager would be responsible for identifying high utilizer patients who do not have an ACP, communicate with the key providers to create an ACP, and interface with outside providers to get external ACPs into the system. This person could also help with education and take part in treatment planning meetings.

# *Sustainability and Next Steps*

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- Continue to monitor recidivism rates during our monthly ED quality assurance meeting. Through regular treatment planning meetings with internal and external providers, ACPs continue to be created.
- On the primary care side, a quality incentive measure was established to encourage PCPs with high utilizers to create and/or update an ACP. On the ED side, a similar quality incentive measure was established for EM physicians to continue reviewing ACPs.
- Expand ACPs to additional complex patient populations, such as transplant, palliative care, cyclic vomiting syndrome, autism spectrum disorder, etc.
- Work toward creating an automated message for authors of ACPs when the plans are approaching the 6-month mark. This message would remind providers to either update or discontinue the plan.
- Generate automated page to certain providers (ED addictions NP, recovery coaches, case managers, etc.) when their patients arrive to the ED.
- Continue to analyze the long-term impact of ACPs and calculate cost-savings.

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- QPID team

# *Questions?*

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Theodore I. Benzer, MD, PhD,
FACEP tbenzer@partners.org

Dawn Williamson, RN, MSN, PMHCNS-BC,
CARN-AP dwilliamson19@partners.org

Beth G. Grabowski, MBA,
MPH
bgrabowski@partners.org

# Thank You For Participating!

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