

West Virginia Health Innovation Collaborative: Better Value Work Group

Emergency Department

High Utilizers/Multi-Visit Patients

11/18/15

Program Objectives

- **Guiding Principle:**

Ultimately, shift the care of multi visit patients from a crisis care model to a primary care model by providing more consistent and appropriate levels of care from an assigned medical home or medical neighborhood.

Program Objectives

- Identify high-utilizer Emergency Department patients
 - 12 and greater ED visits in 12 months (2014)
- Decrease the numbers of ED visits
- Improve satisfaction with the healthcare experience
- Decrease costs associated with frequent ED visits
- Use *CAPGate* to identify & track progress.

Participating PIHN Emergency Departments

PIHN Participating Hospitals	# ED high utilizer patients with 12 visits and greater in 2014
CAMC (Gen/Mem/WCH/TVH)	172 (Annual census 105,000)
Princeton Community Hospital	92 (Annual census 50,000)
Stonewall Jackson Memorial Hospital	22
Boone Memorial Hospital	14
Braxton County Memorial Hospital	10
Roane General Hospital	10
Webster Memorial Hospital	6
Pocahontas Memorial Hospital	4
Jackson General Hospital	0

The PIHN Experience: Who are our patients?

- Vulnerable, high risk patients with multiple chronic illnesses
 - Co-morbidities as well as non-clinical health issues
- Patients across the adult age span
- Those with or without an established Primary Care Provider/Patient Centered Medical Home (PCP/PCMH)
- Those who are insured by WV Medicaid

The PIHN Experience: Who are our patients?

- Those struggling with chronic illnesses including *but not limited to*:
 - Alcoholism
 - Substance abuse
 - Chronic pain
 - Behavioral health problems
 - Transient life style
 - Homelessness

The PIHN Experience

What makes them high utilizers?

- Reasons why they choose ED care rather than Patient Centered Medical Home?
 - Convenience of 24/7 care
 - Self-perceived emergency
 - Unreliable transportation
 - No PCP available to them
 - Non-compliance with medications and discharge instructions
 - Seeking opioid pain control

The PIHN Experience: Top 7 Clinical Diagnoses (CAMC Data)

- Abdominal pain
- Alcoholism
- Behavioral Health
- Substance abuse
- Back pain
- Headaches
- Dental caries

The PIHN Experience

Report of Correspondence: 172 patient calls (CAMC Data)

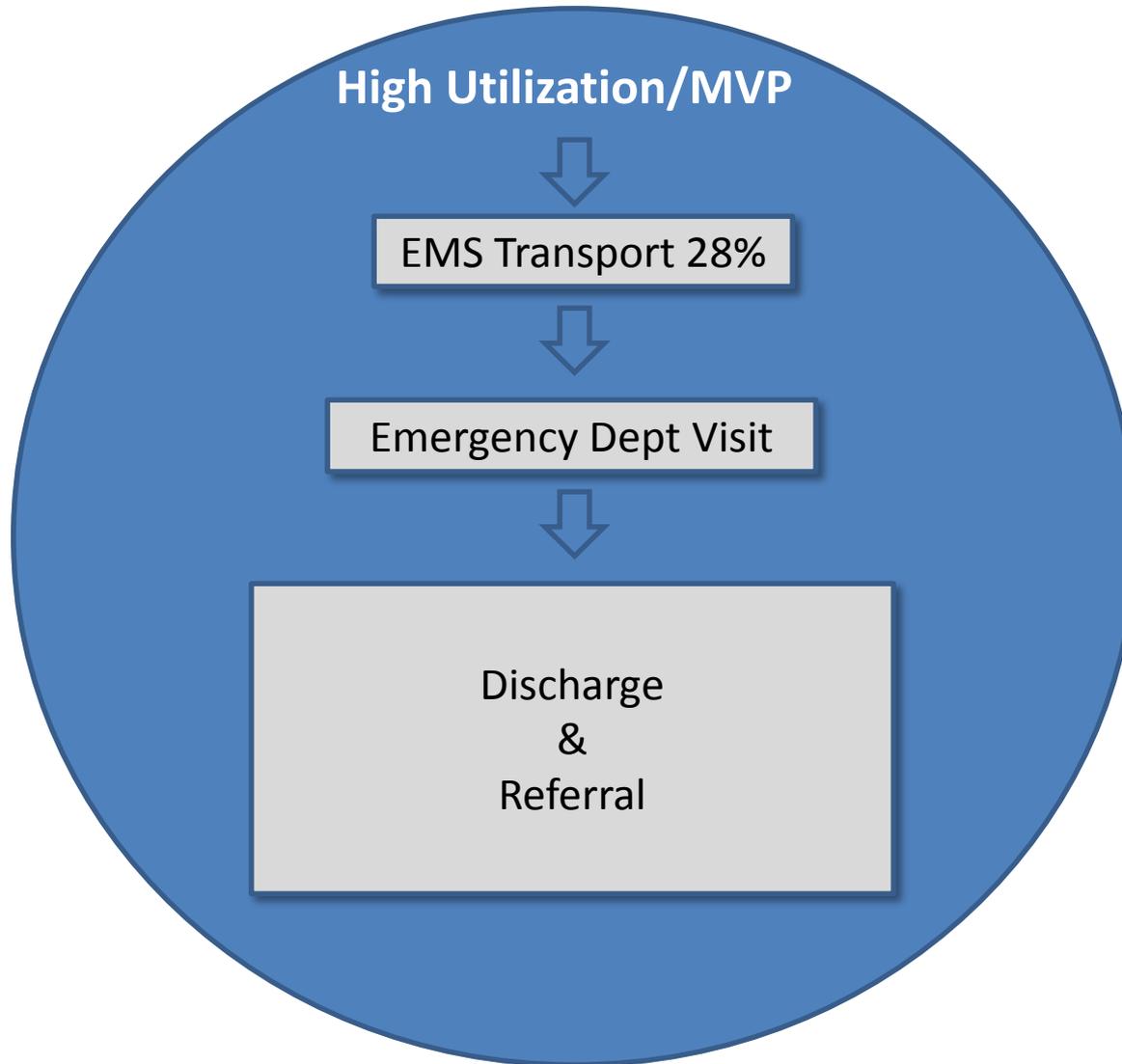
Response	Actual	Percentage
Referrals made	22	13%
Wrong number, No answer, Not in service	73	42%
Left message	39	23%
Established with PCP	24	14%
Other	14	8%

The PIHN Experience

Report of Correspondence: 100 mailed surveys (CAMC Data)

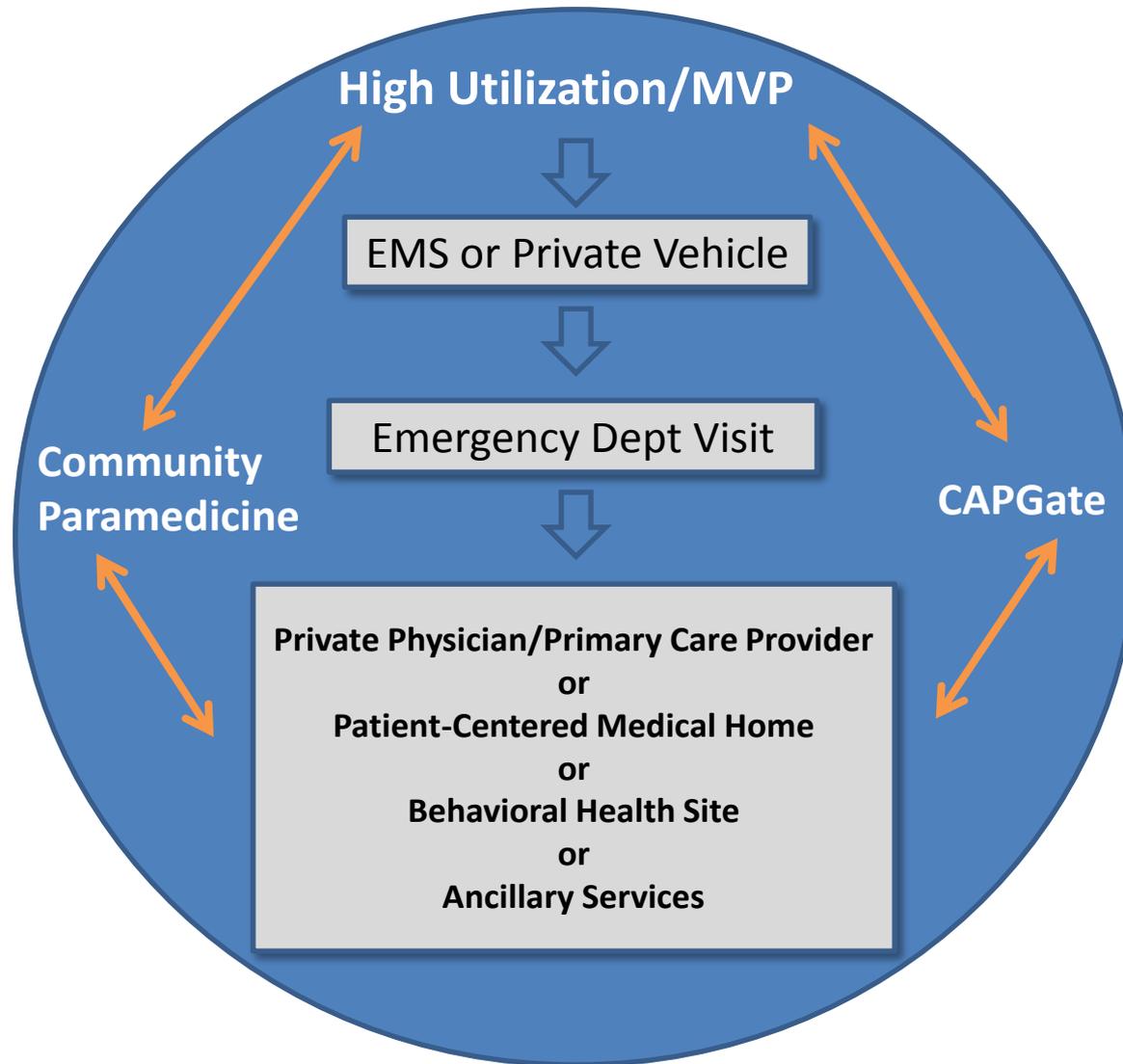
Response	Actual	Percentage
No Reply	89	89%
Return to sender	3	3%
Referral requested	7	7%
Do not contact	1	1%

The PIHN Experience - Common pathway to care



MVP = Multi Visit Patient (Criteria is 12 or greater visits/year)
EMS = Emergency Medical Services

The PIHN Experience - Preferred pathway to care



MVP = Multi Visit Patient (Criteria is 12 or greater visits/year)

EMS = Emergency Medical Services

CAPGate = Patient identification and tracking software

CAPGate

- Secure internet website
 - PIHN owned and developed
- Provides Secure data sharing between entities
- Can be managed through www.CAPgate.org
- Information sharing with participating clinics
- Data received within 24 hours of ED visit
- Completely customizable

CAPGate

- Enrollees are cross-referenced daily against hospital visit data
- Visit reports available to case manager
 - *Within 24 hours*
- Information is used by the clinic to quickly follow up after a hospital visit
- Access to information should lead to better care management and reducing ED visits

CAPGate: *Moving forward*

- Enrollment types available in CAPGate
 - Frail Elderly
 - MVP
 - CAP (private pay or uninsured)
 - Medicaid medical home

Also: diagnostic subgroups

CHF, Asthma, Diabetes, Hypertension

Care Management Project: Pilot

- Proposed pilot project with 30 high utilizer ED patients identified from CAMC/ED using CAPGate
- Primary Care Sites
 - Cabin Creek Health Center
 - Family Care Health Center
 - WV Health Right
- Project Duration: 6 months

Care Management Project: Pilot

- Outcome goals
 - Identify a group of 30 ED high utilizers/MVP
 - Establish each patient with Primary Care Provider (PCP) or Patient Centered Medical Home (PCMH)
 - Assist with specialty referrals
 - Track appointments (attended and missed)
 - Track ED visits
 - Track healthcare expenses

Care Management Project: Pilot

- Patient Engagement
 - Identify at-risk, high utilizer patient group
 - Reach out to each patient to participate
 - Schedule appoint with PCP & Case Manager
 - Determine patient's willingness to participate
 - By means of a structured interview, determine why the patient seeks frequent ED care rather than primary care services

Care Management Project: Pilot

- Complete Needs Assessment
 - Medical and nursing needs
 - Psychosocial needs
 - Informational needs and knowledge gaps related to health and appropriate use of ED and PCMH
 - Administer SF8

Care Management Project: Pilot

- Individualized care plan development
 - Collaborate for development of short and long term goals
 - Goals are agreed upon by patient and healthcare team

Care Management Project: Pilot

- Associated Service Components
 - Provide education related to medical and social programs available in the community
 - Provide assistance with care coordination of primary care and associated healthcare appointments
 - Psychiatric services
 - Pain management services
 - Medication reconciliation review
 - Single source opioid contract

Enhanced Care Committee

- Cynthia Persily, PhD – Chair
Highland Hospital
- Wallace Horn, MD
Princeton Community Hospital
- Barbara Lay
Pocahontas Memorial Hospital
- Barbara McKee
PIHN/CAMC
- John Moore
Bowles Rice
- Craig Robinson
Cabin Creek Health Systems
- Angie Settle, DNP
WV Health Right
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KCEAA
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Comments and Questions



Thank you!

