Coordinating resources to direct high utilizers to more optimal care settings

Effective provider and community partnerships for vulnerable patient populations

UK HealthCare

Lexington, Ky.

UK HealthCare collaborates with providers across the continuum to ensure that care is provided effectively, efficiently and appropriately to optimize the value of care to the patient. The hospital's busy emergency department, with more than 100 beds, reported 110,903 visits in 2018.

Background

Emergency department (ED) visits reached an all-time high of 142.6 million per year in 2016, according to the American Hospital Association. In 10 years, ED visits per 1,000 increased by 12 percent, rising from 395 in 2006 to 441 in 2016.[1] Studies have shown that many ED visits by frequent users are made for primary care or behavioral health reasons, in spite of value-based payment programs focused on decreasing avoidable ED visits.

Patients who are high utilizers of health care services—especially frequent ED visitors—pose a special challenge to UK HealthCare and other providers in Lexington, Ky. Many of these patients are homeless, have behavioral health needs or suffer from substance use disorder.

High utilization among vulnerable individuals was tracked over one year by the UK HealthCare post-acute care transitions team, revealing that 100 patients had used the ED 50 or more times within a six-month period. Some of these patients visited the ED four to seven times a day, because of a lack of shelter or personal support.

The number of ambulance runs was also on the rise in Lexington, with 11 ambulances making 48,238 calls in 2017.[2] Ambulance trip volume had increased 7.5 percent per year for three years running. An analysis showed that 8.9 percent

[1] Utilization and volume. In: American Hospital Association *TrendWatch Chartbook 2018*. Washington, DC: American Hospital Association; 2018:A-26. https://www.aha.org/system/files/2018-07/2018-chartbook-table-3-3.pdf. Accessed February 28, 2019.

[2] Combs M. Community paramedicine has ambulance runs down while paramedic morale is up. WKYT; September 10. 2018. https://www.wkyt.com/content/news/Ambulance-runs-down-while-paramedic-morale-is-up-Community-Paramedicine-492898331.html. Accessed February 28, 2019.

"Partnerships are like marriages. They require time, dedication and understanding. The more time you spend together the more differences in cultural and communication styles become apparent and impactful to the relationship. It is important to be open to other's opinions and thoughts, while keeping focus on the goals and ultimate outcomes."

Penny Gilbert, MBA, MSN, RN, NE-BE, CPHQ
Post-Acute Care/Transitions/Case Management, Enterprise Director
UK HealthCare

of these calls came from only 266 individuals, demonstrating how the system was stressed with overuse.

The group of high ED utilizers became the focus of a collaborative intended to track vulnerable patients after discharge and direct them to appropriate care settings and to resources that could help meet their basic physiological needs (including safe shelter and food). In addition to UK HealthCare, three Lexington-based groups were involved in the collaborative:

- **Community Paramedicine:** Sponsored by the Lexington Fire Department with funding support from the City of Lexington, this program enables paramedics to take a more comprehensive approach to care—including home visits—for patients who frequently call 911. In addition, paramedics and a dedicated Lexington City police officer assist homeless patients with obtaining medications, food and shelter.
- **Bluegrass Care Navigators:** This innovative organization provides individualized health coaching by registered nurses for patients at high risk for readmission, as well as a respite program for homeless patients being discharged from the acute care setting who are not ready to return to the street or a shelter. The respite service is a unique model in which patients are given a hotel room (with a contracted local hotel), food and health coaching. A separate home care service is provided if needed, and the organization supports the patients by providing transportation to medical appointments.
- **HealthFirst Bluegrass:** A Federally Qualified Health Center, this organization provides preventive services; pediatric care; women's health care; and pharmacy, mental and behavioral health, and dental services in multiple locations, often serving as a homeless patient's primary care provider when he or she is discharged from the hospital. Its community support services assist patients with removing barriers that prevent them from receiving and maintaining health care.

The Vulnerable Patient Collaborative launched with a combination of grant funding (Community Paramedicine and Bluegrass Care Navigators), U.S. Department of Health and Human Services funding (HealthFirst Bluegrass) and community donations. UK HealthCare budgets for indigent care each year and accepts donor funds for this type of care.

Objective

The UK HealthCare team focused on their "front door" to reduce unnecessary ED return visits by identifying high utilizers' needs and directing them to more effective resources. This focus was also designed to:

- Reduce 911 calls and nonemergency ambulance runs
- Decrease length of stay
- Increase use of community services
- Improve follow-up visits for care
- Locate housing and shelter options when needed

Initiative

The UK HealthCare team worked with staff from outpatient clinics that serve shelters, community-based care transition programs, mental and behavioral health and addiction health entities and paramedicine programs to ensure that vulnerable patients have support and services delivered in the most appropriate settings.

Before the initiative, the partners did not have direct or coordinated communication. To remedy this gap, business associate agreements were executed among all entities to encourage information sharing about how patients are flowing from one group to the next, care planning, and follow-up needs.

How to get started

If your organization wants to pursue a similar program, consider these steps:

1. Identify community partners and establish business agreements and metrics that benefit patients and all organizations.
2. Establish venues that encourage open and useful communication, including nonclinical notes from the streets or shelters.
3. Capture and report outcomes that attract sustained funding.

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The Vizient University Health System Consortium Vulnerable Patient Populations Network offers in-person and virtual opportunities to exchange knowledge and collaborate on common challenges and improvement strategies.

This allowed issues related to health and safety issues, such as whether a patient was living "on the streets," "in the home" or "in the shelters," to be communicated directly between clinics or EDs and the community partners.

The staff in the ED also wanted to more easily identify high utilizers so they could be connected with appropriate resources. Key fobs with HealthFirst contact information were given to all vulnerable HealthFirst patients living in homes or shelters to help staff easily identify them and direct them to follow-up care at a HealthFirst clinic. Similarly, homeless high utilizers were given rubber bracelets (a popular item suggested by paramedics) with HealthFirst information.

A handoff sheet based on the "situation, background, assessment, recommendation" (SBAR) communication system was developed by the UK HealthCare team to improve post-discharge communication.

While the patient is in the ED, the paramedicine program is often notified to provide discharge support. If patients are placed in the homeless respite program, Bluegrass Care Navigators fax the SBAR handoff sheet to the shelter and initiate a phone call to make the handoff.

Paramedics are notified about the patient's need for transport back to the shelter as well as follow-up visits to the clinic. Patients requiring transport from the ED to the shelters are covered by UK HealthCare's indigent fund. If the patient is homeless, paramedics perform follow-up on the street, if possible, and partner organizations are searched for housing options.

If a patient is deemed dangerous to himself or others, an adult protective services referral is made and the need for guardianship is assessed.

Meetings among the partners were held monthly, with open discussions on homelessness, access and complex care cases as well as regular data review. All members played an equal role and came to these meetings prepared to discuss how to identify patients and direct them to appropriate care settings.

Outcomes

All partners contributed to data collection, including paramedics for ambulance runs, UK HealthCare for inpatient and ED utilization, and the Bluegrass organizations for outpatient care and follow-up visits.

Results for 2018 are positive for patients and all partners:

- A 0.9 percent reduction in 911 calls has been reported, representing thousands of avoided ambulance runs.
- ED visits for high utilizers decreased by 19 percent.
- Observed-to-expected length of stay decreased from 1.4 before intervention to 0.94 after implementation.
- The time from discharge to follow-up shortened. While preintervention lag time for follow-up appointments had stretched to weeks and sometimes months, the opening of the HealthFirst Bluegrass Goodwin Clinic meant that patients could be seen in a few days or even the next day.
- As patients' health status improved, clinical resources were used less and reduced ED visits allowed for more effective ED throughput.

The partners also addressed the high utilizers' physiological and safety needs. For example, the collaborative sought and located permanent housing for four individuals in January 2019. For patients who have a fear of assault, UK HealthCare notifies the paramedic team and local police, if necessary. Individuals with ongoing health care needs are sometimes placed on housing lists first. To address high utilizers coming to the ED primarily for "a place to rest" or "safety," UK HealthCare works with the city homeless coalition to elevate the need for housing.

As the nation's largest member-driven health care performance improvement company, Vizient provides network-powered insights in the critical areas of clinical, operational, and supply chain performance and empowers members to deliver exceptional, cost-effective care.

Lessons learned

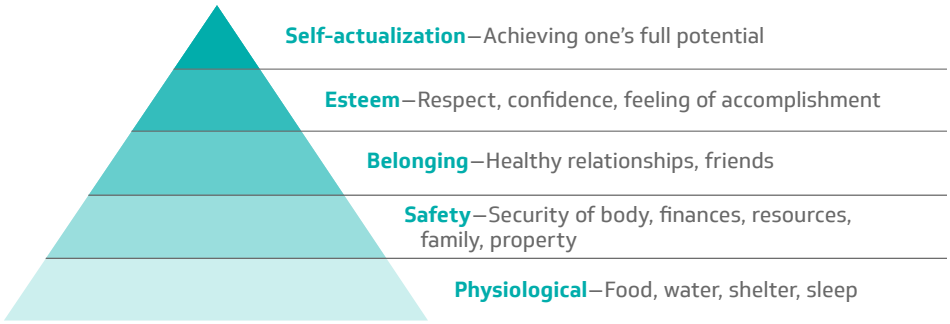
The willingness of various stakeholders to work together—always putting the patients' needs first—proved to be the real engine for this initiative.

Targeted data analysis helped the partners identify and prioritize the greatest needs and obtain buy-in from leadership to ensure an effective community partnership.

It was vital to understand how one change affected other programs and community residents.

While some earlier efforts jumped to the top of Maslow's hierarchy of needs (patients' self-actualization), the partners quickly recognized that the more basic physiological (food, water, shelter) and safety needs must be met first.

Maslow's hierarchy of needs



Source: Based on Maslow.[3]

The team also faced challenges, such as:

- Ensuring that all components of the initiative met legal requirements and were compliant with the Health Insurance Portability and Accountability Act (HIPAA)
- Understanding that each partner has its own culture and communication style, requiring focused attention and sensitivity to ensure smooth patient transitions and clear information exchanges
- Handling pushback from unexpected sources
- Searching for scarce housing, sometimes resorting to out-of-town or out-of-state placements

Future actions

With the initiative's initial success, more partners are joining the collaboration, including the local mental health facility (Eastern State Hospital), the Lexington police department and adult protective services through the state's Department for Community Based Services. The team is applying for a local grant that would expand funding to support other critical vulnerable populations in the area, including those released from the local detention center and state mental health center. The funding would support services like 90-day monitoring, personal money management and assistance with reconnecting to society by working with a community case manager.

Metrics are being used to build a clinical and financial model measuring the impact of interventions on health outcomes and cost of care.

To learn more, contact Shaifali Ray at shaifali.ray@vizientinc.com.

[3] Maslow AH. A theory of human motivation. *Psychol Rev.* 1943;50(4):370-396. doi:10.1037/h0054346.