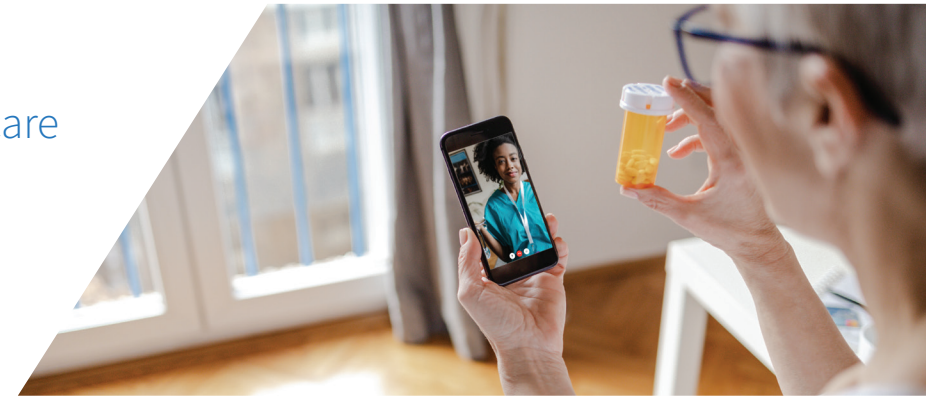
Changing the approach to follow-up support after ED discharge

Utilizing technology to enhance care coordination and improve your bottom line



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Introduction

Each year in the U.S., our emergency departments (ED) provide 150 million patient visits, discharging approximately 75-80 percent of those patients back to their homes. What happens next? The answer to that question has profound implications for health systems, patients, and our country's health care system as a whole.

We have known for years of the myriad problems facing patients after they are discharged from an episode of care in the ED. These patients, often having just experienced one of the worst days in their lives, must then understand and follow discharge instructions, sometimes fill new prescriptions or take existing medications differently, follow a new plan of care, obtain a follow-up appointment in a physician's office, and, of course, focus on their recovery.

In practice, many of these tasks fall through the cracks. Last year, SCP Health's Enterprise Chief Medical Officer, Dr. Randy Pilgrim, published a paper that not only further clarified the cost of this "Care Gap," but identified a window of opportunity in which cost-effective action can be taken to address it.

But only if we change what we are doing currently. To continue on the current path is to fail in our mission to care for patients. Without interventions, patient outcomes will only worsen.

This paper will outline a new approach to support patients after ED discharge, including enabling people-driven services with the use of technology tools to effectively communicate with patients and provide more timely support as they transition to follow-up services.

Emergency medicine clinicians are often frustrated by their patients' repeat visits to the ED, but with the right approach, we can turn this challenge into an opportunity—one that the country's emergency departments are uniquely positioned to address – leading the way to meaningful change for the better.

Change Must Start Somewhere

Assessing the Costs of the Care Gap

In 2013, physicians Peter Smulowitz, Leah Honigman, and Bruce Landon[1] sought to classify the country's emergency visits into broad categories of severity. The purpose was to better understand both what percentage of ED capacity was being appropriately utilized and to identify the highest potential for cost savings.

They found that patients with "high focus clinical conditions" comprised approximately 31 - 57 percent of all ED visits. These conditions included CHF, COPD, diabetes, UTIs, chest pain, pneumonia, and abdominal pain. Together, these conditions, including their subsequent care needs after discharge, account for 10 percent of all U.S. health care costs.

In their paper, the authors estimated that perhaps 10 - 25 percent of subsequent hospitalizations in this group could be avoided—saving between 1 and 2.5 percent of all health care costs. In today's value-based care environment, those are potentially avoidable costs that we simply cannot afford to ignore.

The High Cost of Poor Transitions

$129 - $244 billion

is wasted annually from:

- Failed transitions of care
- Readmissions
- Poor care coordination
- Failed treatment follow-through
- Poor execution of best practices

The Post-ED Discharge Window of Opportunity

In 2021, SCP released an analysis of its own claims data of more than 1 million patient encounters discharged from approximately 300 emergency departments. Publishing the results in *From Insights to Interventions: Using the unique vantage point of the emergency department to drive transformation*, Dr. Pilgrim identified a crucial 7-10 day window of opportunity in which interventions improving communication with clinicians and providing care coordination and transitions can have the most impact.

According to the analysis, of the patients who bounce back to the ED within 30 days:

- **50% of bouncebacks resulting in subsequent hospitalizations occur within 7.5 days**
- **50% of repeat ED visits occur within 10 days**
- **50% of combined costs happen within 8.5 days**

It is during these vulnerable periods that we must take a new approach to post-ED discharge care and coordination.

Without care:

- Outcomes worsen
- Decreased trust and satisfaction
- Avoidable costs
- Increased demand
- Stress in the ED

With care:

- Better outcomes
- Increased patient satisfaction
- Decreased cost
- Improved quality of care
- Better performance in value-based models

The ED's Unique Vantage Point

We know many well-intentioned efforts in many corners of the health care industry have already attempted to address these gaps. However, the emergency department's care team is uniquely positioned to expand its role in this area.

Since its inception nearly half a century ago, the role of the emergency department care team has continuously matured its role to meet hospital needs. From providing in-hospital code responses and assisting with precipitous deliveries to partnering with health systems on HCAHPS performance, and, most recently, to addressing readmissions prevention and leading evidence-based utilization programs, the emergency department continues to mature as a resource for the hospitals and health systems in which they serve. Today, we must again mature and evolve to meet a critical need.

The ED is uniquely positioned to serve these high-focus patients. The ED sees all patients, of all ages, with all conditions, regardless of whether they have private or public health insurance or none at all. The clinicians in the ED are already professionally, clinically, and medico-legally accountable for the outcomes of their patients. The clear next step is to use this unique vantage point to begin to close the care gap that can occur immediately after discharge.

Changing the Approach

A new approach to the problem of Care in the Gap will include three parts:

- ED-initiated follow-up support and care coordination
- Connected, multi-channel technology
- Financial alignment

ED-Initiated Follow-up Care

ED clinicians already have an intimate relationship with their patients. Emergency medicine clinicians are trusted, they're present at a teachable moment with patients, and we have found patients respond at high rates to the last physician who cared for them.

By initiating care in the ED, we're not waiting for charts to be coded, or for diagnoses codes to be assigned. We're acting based on the needs identified during that initial patient encounter. We find when integrating patient navigators and virtual health clinicians as part of an extended, hybrid, ED care team, following up within 24-48 hours of discharge, 7 days a week, we see a response rate as high as 90 percent among those patients targeted for real-time intervention outreach. This is an extraordinary response rate—and it primarily happens because we are acting efficiently and communicating effectively on behalf of the clinician who just cared for the patient in the ED.

The clinical and non-clinical interventions the extended ED care team can undertake in the first critical 7-10 days are not intended to replace primary care physicians (PCP). Yet the ED team can take a proactive role in helping to find PCPs for patients who don't have one, as well as ensuring they have a timely appointment. If patients do not have a PCP or one cannot be found, the extended ED clinical care team can support patients after discharge with low-intensity clinical encounters such as a telemedicine visit, or help connect care to a specialist.

This approach is careful to utilize clinical resources when needed, escalating to nurse practitioners (NPs), physician assistants (PAs), or physicians, when necessary, while using patient navigators for non-clinical support.

In the old approach:

- Patients have difficult care transitions
- Communication is disjointed or incomplete
- Multiple barriers exist for patients to access their PCP or other specialty care
- There is a lack of timely support

In the new approach, ED-led interventions lead to:

- Prompt follow-up
- Better navigation
- Consistent patient engagement
- Telemedicine support if needed
- Reduced hand offs

The benefits of these interventions include increased patient satisfaction, fewer ED bounce backs, better outcomes, less cost, and greater patient loyalty to the health system.

Multi-Channel Technology

Changing the approach to post-ED discharge support and care coordination entails utilizing a collaborative care team, working within a connected platform to create a comprehensive care experience. We must strive to support every discharged patient with the appropriate level of follow-up support and care, aligned to their needs and risk levels.

By combining experience in emergency, hospital, and virtual health medicine with proprietary multi-channel communication technology we can connect patients with evidence-based best practices, programs, and resources that match their predicted risk level or needs. Technology platforms can deploy a combination of live phone calls, interactive voice response (IVR), and text, video, and remote monitoring to support communication and care coordination, depending on the anticipated needs of individual patients – aligning more costly interventions with higher-risk patients.

An optimal platform has fully developed workflows for care transitions, readmissions management based on individual needs, and communications. To ensure optimal communications and follow-up, the platform would be designed to leverage technology combined with the human touch of non-clinical coordinators, NPs, RNs, and medical assistants, involving them as soon as they are needed.

Finally, the platform should create real-time actionable data from patient communications in order to close the loop on clinical and service opportunities. This would include generating a rich dataset used for analytics and reporting in support of the hospital's strategic priorities.

By using technology for rapid cycle patient engagement, we can shorten or even eliminate the care gap, while also addressing priorities related to outcomes and quality, patient loyalty and satisfaction, and compliance with value-based care programs.

Patient Examples

To make the full impact of this new approach real, it is helpful to look at three characteristic examples of patients who may be helped by it—or fall through the cracks without it.

Patient #1: A 62-year-old male with congestive heart failure. Five years ago, he had a myocardial infarction. He has a cardiologist he sees twice a year and a PCP he sees four times a year, and he is on four medications. Lately, he has had increasing shortness of breath. It hasn't curtailed his activities of daily living, but he knows it feels different. His attempts to see his cardiologist and PCP were unsuccessful, so he presents to the ED.

Patient #2: A 65-year-old female with hypertension and hypothyroidism. She also has a PCP and is on four medications. She's been feeling gradually worse over the last three weeks, and she is getting concerned. She hasn't been able to access her PCP, so she too comes to the ED.

Patient #3: Finally, consider a 32-year-old male, a war veteran with a history of PTSD and depression. A previous physician had given prescriptions based on those diagnoses, but at this point, he is having a mental health crisis and has also presented to the ED.

All three of these patients are highly typical. In the old paradigm, all three would likely be seen, stabilized, screened for emergencies, given adjustments in their current treatment, be discharged home, and told to follow up with their current PCP or to locate one. They would all officially enter the "Care Gap," which begins when a patient leaves the emergency department and ends when the patient gets better or fully engages in their follow-up care.

In the new approach, all three of these patients get support, ensuring they don't bounce back because of a poor transition of care:

Patient 1, the 62-year-old with CHF, would be connected with a patient navigator who would check on him the next day. He could also receive an electronic home monitoring system, while a telemedicine physician would stand available to review those metrics and do weekly visits until the patient is able to connect with his cardiologist.

Patient 2, the 65-year-old with hypertension and hyperthyroidism, would also have immediate contact from a patient navigator. She would be given access to a nurse line that offered guidance on medications for simple things to do or not do that are within the nurse's license. Telemedicine visits are also available, so she can access a follow-up visit with a physician if timely access to her PCP is still not available.

Patient 3, the 32-year-old war veteran, would have a virtual visit with a telePsychiatrist arranged. The telePsychiatrist would review medication, address side effects, adjust prescriptions, and help the patient adjust to the new care plan. Meanwhile, the care team would send frequent text messages to check in and offer escalation options as needed until the care navigation team could arrange a long-term outpatient solution for him.

With care in the gap, none of the above patients need to bounce back to the emergency department with short-term exacerbations—improving outcomes, reducing cost, and increasing patient satisfaction.

Financial Alignment

Staffing resources related to the ED are already stretched thin, and finances are stressed. In order to be successful, these additional interventions must have funding mechanisms. There are multiple payment models and/or funding mechanisms and ROI sources that could be leveraged to support these programs.

The first is pay-for-performance payment models with health plans and other payors —already a familiar model from primary care which often makes it a good starting point for value-based partnerships with health plans. These programs reward the best, evidence-based care while patients are in the ED to ensure they are discharged with their best foot forward. This care aligns with programs like MIPS and HEDIS metrics and with programs that aim to ensure appropriate resource utilization.

Additionally, hospitals and their ED clinical teams can pursue gain-sharing agreements with health plans which target overall utilization and cost, often emphasizing support for certain high-focus conditions. This provides the compensation needed for the extended ED care team to provide additional follow-up support for patients after discharge, helping to ensure that unnecessary care gaps are addressed proactively.

These reimbursement models take time to develop. Yet, a value-based reimbursement model need not be in place in order to realize an ROI on the above changes. ROI comes in several forms:

- Improved clinical outcomes and quality results
- Additional bonuses from readmissions and HCAHPS results
- Better fee-for-service reimbursement through ACOs and payor negotiation
- Optimal clinician utilization
- Increased clinician satisfaction and retention
- Downstream opportunities for reimbursement on additional physician and ancillary services
- Returns related to patient acquisition, retention, and improved reputation

There are numerous mechanisms already in place that allow a return on the investments required to close important gaps in care after an initial ED visit, but deploying them effectively relies on sustainable funding and an efficient, comprehensive approach.

Conclusion

Many of the solutions above have been deployed in one way or another previously. The challenge is not coming up with new solutions; the ones we have are correct. The challenge is to deploy all the building blocks – multi-channel communications, clinical and non-clinical interventions, intensive outreach in the right mix and alignment, based on the needs and preferences of patients – and enable them with technology and financial models, making a sustainable and increasingly efficient and effective solution. A solution, originating with the ED team and extending into the community post-discharge, that is tech-enabled, but ultimately, people-powered.

The new approach to post-ED discharge care and coordination works for patients, works for clinicians, and works for the hospitals. Patients get better outcomes, timely follow-up, and less confusion about their care plans. Clinicians can take an active role in being able to reduce unnecessary bounce backs, thereby creating increased ED capacity and reducing risk. And hospitals and health systems will see improved quality of care across the continuum. They will retain or gain market share, see increased patient satisfaction, and perform better in value-based models.

Innovation in health care today is not always about coming up with something brand new, but using the resources we already have with a different approach to get better results. As long as we remain committed to our purpose of delivering better care to patients, in a more sustainable way, we can be confident our innovations are on the right track.

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