Making an Impact

Review

Avoidable ED/K

- Reflects primary care access and care coordination
- ED care is more expensive than outpatient care
- High rates signal opportunities for improvement

Plan All Cause Readmissions

- Used to assess **care quality, coordination,** and **follow-up**
- discharge planning and transitional care
- Target high-risk patients for intervention
- Demonstrate impact of case management and home-based care

Avoidable ED (AED): Getting Upstream

Start small! Choose a subset of patients to focus on as you implement any changes. High ED utilizers are a smaller population with potential for big impact. Look at risk factors for potential high ED use

- Uncontrolled chronic or behavioral health conditions
- SDoH
- Polypharmacy

Understand your population

- Ensure you receive notification of ED visits
- Identify the reasons patients are using the ED

Be proactive

- Address the factors leading to potentially avoidable ED visits
- Monitor the impact of changes

Opportunities for Improvement : Common reasons for AED visits

Non-emergent AED

Access to care

- No PCP
- After-hours access
- Appointment availability
- Uninsured

Preventable Emergent AED

- Chronic care management
- Care coordination between providers

Making an Impact: Access to Care

No PCP / lack of PCP relationship

- Community Health Worker Campaign
- Right Care for You Brochure
- Mobile Health Unit
- Bridge Care Clinic

After-hours access

- Extended hours
- On- Call access

Patient education

- Where to go When you Need Care
- Insurance Card- Triage RN line

Appointment availability

- Extended Care Teams for Follow ups
  - Pharmacy, BH, Care Management
  - RN Visits and Flex Visits
  - Mobile Health Unit

Uninsured

- Community Health Workers
- Mobile health Unit
- Financial Assistance

Making an Impact: Care management and SDoH

- Follow up after ED Visit
  - Outreach after ED visit
- Chronic Care Management
  - Uncontrolled chronic conditions
- Care Coordination
  - Outreach to those with chronic conditions to coordinate labs, follow ups, referrals, etc.
- Community Health Workers/Social Workers
  - Address SDoH for more complex patients or those with multiple SDOH factors
- Referral to community resources
  - Care team directly refer patients to community resources
- Risk Stratification
  - Identify those with risk factors for high ED Utilization
- Patient Education
  - Self-management, where to go when you need care

Plan All Cause Readmissions(PCR): Getting Upstream

The type of data you receive on readmissions, and your ability to impact the performance on this measure may vary depending on the type and size of the health care entity you work for. There are ways to address readmissions in any health care setting.

Understand your population

- Ensure you can track readmissions
- Identify common readmission reasons

Be proactive

- Address the factors leading to Readmission within 30 days
- Monitor the impact of changes

Opportunities for Improvement : Common reasons for Readmissions

- Inadequate discharge planning /poor patient education
- No Follow Up with PCP
- No referral follow up
- Trouble understanding or receiving new medication regimens
- Poor self-management , or lack of support with care at home

Making an Impact: Preventing Readmissions

- Discharge planning
- Transitions of Care (TRC) measures improve performance on this measure
- Risk Stratification
- Readmissions Review council
- Engage with SNF and Home Health Partners
- TCM Visits -Bridge clinic
- Mobile Health

TRC measures
The TRC measure organizes patient care and follow-up activities after a hospital admission and discharge. There are four components that contribute to the TRC score, and each requires engagement from the PCP within a certain period of time, as listed below.

- Notification of Inpatient Admission (TRC–NIA)
- Receipt of Discharge Information (TRC–RDI)
- Patient Engagement After Inpatient Discharge (TRC–PED)
- Medication Reconciliation Post-Discharge (TRC–MRP)

Thank You to Laurel Avila and the Greater Health Now Team!

I have learned so much through the practice transformation work promoted by GHN. Working with this team has allowed us to implement many of the improvement activities I shared today.