"SLOW THE FLOW"

A COMMUNITY PROGRAM AIMED AT ADDRESSING PRESCRIPTION DRUG ABUSE AND OVERUTILIZATION OF THE EMERGENCY DEPARTMENT

Alliance Consistent Care Program of South Eastern Washington

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OBJECTIVES

- Understand the need for Emergency Department care coordination in order to address ED over utilization and prescription drug misuse
- Learn about a CDC sponsored clinical trial and program for over-utilizers of the ED in Washington State
- Identify ways to implement an ED care coordination project in your area
- Understand how the implementation of an Emergency Department care coordination project can reduce the incidence of prescription drug and emergency department misuse while improving access to coordinated health care
- Learn the role Medicaid policy has in driving better coordinated emergency department care in Washington State.

WHAT IS THE CONSISTENT CARE PROGRAM?

- A community program to reduce
  - Inappropriate ED visits
  - Prescription drug abuse and overdose deaths
- Identifies and coordinates care for patients that over utilize the ED at four hospitals-KRMC, KGH, LMC and PMH
  - One coordinated and shared system
- Methods:
  - Coordinate care with primary care physician
  - Develop ED Care Guidelines for each patient that is accessible by emergency physicians
  - Provide individualized patient-centered case management

WHAT WE KNOW…

- Patients frequent multiple EDs for many reasons, including: pain, multiple chronic diseases, mental illness, chemical dependency issues
- Many patients have multiple providers
- Most have concurrent mental health diagnoses
- Many report chronic pain
- Some have a primary care physician
- Most have one hospital they prefer to frequent, many visit several
- Most are not forthcoming with information
- Most commonly have Medicaid, Medicare, or no insurance
- There is a lack of systems in place to coordinate care between ED's and multiple providers
- Lack of education exists regarding alternatives to the ED
- There is a high incidence of prescription drug abuse and deaths

CHALLENGES TO ADDRESSING EMERGENCY ROOM USE

- Prescription Drug Abuse
- Access to Coordinated Care
- Mental Illness and Substance Abuse
- Vulnerable populations

PRESCRIPTION DRUG ABUSE

- Amount of opioid medications sold in the US has quadrupled since 1999.
- In 2007, Washington state opioid overdose rate exceeded the nation's rate at 8.2 per 100,000 to 4.6 per 100,000
- Cost of prescription opioid abuse reached $55.7 billion in 2007
- In 2009, 500,000 emergency room visits were attributed to pain and prescription related complaints
- Now America's fastest growing drug problem!

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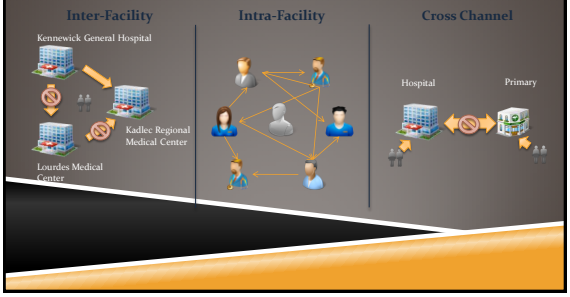
CROSS-DOMAIN COMMUNICATION IS DIFFICULT



LACK OF COORDINATED CARE

- Many patients frequent numerous hospital ED's
  - Lack of communication between ED's
- Lack of consistent communication between hospital ED's and assigned Primary Care Providers (PCPs).
- Patients are not forthcoming with medical information
  - Leading to duplication in diagnostic studies- Radiation overexposure
  - Medication overprescribing
  - Barrier to communication with care providers

MENTAL ILLNESS AND EMERGENCY ROOM USE

- Majority (estimated at around 90%) of our clients have underlying MH needs
- Estimated that 53% of patients with drug use disorders have co-occurring mental illness
- Complicates the treatment of pain
  - opioid abuse is as high as 32% in patients being treated for pain
  - Pain potentiates depression, anxiety and other symptoms of mental illness
- Presence of mental illness compromises patient's ability to engage in coordinated care
- Lack of communication between behavioral health providers and medical providers

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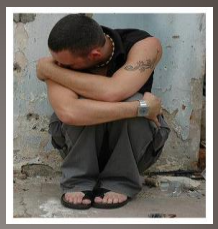
SUBSTANCE ABUSE AND EMERGENCY ROOM USE

- Many patients have poly-substance abuse
- High number of ER visits related to medical clearance visits
- Need for standardization of protocols
- Access to timely CD services



VULNERABLE POPULATIONS

- Dual Diagnosis Clients
  - Co-occurring disorders in many of the clients in the program
  - Require high levels of care coordination
- Medicaid
  - More overdose deaths in the Washington state among Medicaid clients 30.8 (per 100,000) Medicaid vs. 4.0 (per 100,000) non-Medicaid—More than 7 times the rate
- Children
  - In 2008, 13.8 million people aged 12 and over used opioid medication in a non-medical way—kids are getting a hold of opioids out of our medicine cabinets!
  - Far too many drug-exposed babies born annually
  - Pregnant women-opioid dependency

CORE PRINCIPLES OF CONSISTENT CARE

- Do what is best for the patient- not punitive
- Identify the driving force behind ED use
- Coordinate care among providers and hospitals
- Keep the primary care provider in control
- Assist in resource identification and application
- Provide skills and tools for patients to treat themselves
- Prevent prescription overmedication, abuse and death
- Address community gaps leading to higher ED utilization

COMPONENTS OF CONSISTENT CARE

- Community Collaboration
  - Hospitals working together
  - Care Guidelines Committee
  - Organizational points of contact, "go to people"
- Prescription Monitoring Program
  - Patient specific controlled-substance tracking
  - Habitual access and use by ED providers and CM staff
- Emergency Department Information Exchange (EDIE)
  - Communication among treating hospital ED's and PCPs
  - Database for Case Management tracking
  - Patient Centered Care Plan development
- Case Management
  - Proactive and available outside the emergency department
  - Skilled in addressing BH/CD issues
  - Patient-Centered
  - One Team across all hospitals

COMMUNITY COLLABORATION

- Hospitals working together
  - Held meetings with key leadership in Case Management, Health Information Technology, Compliance/Privacy and Emergency Department
  - Community effort
- Care Guidelines Committee
  - Identified experts and organizations in the community vested in decreasing inappropriate ED use
  - Create an opportunity to collaborate
- Target and communicate with key "go to" people in clinics, hospitals, urgent cares, and community organizations

CARE GUIDELINES COMMITTEE

- Mental Health & Chemical Dependency
  - Crisis Response, Detox, Lourdes Counseling Center, community providers
- Hospital Case Management & Emergency Physicians
  - KRMC, KGH, LMC, PMH
- Public Health
  - "Safe Moms Safe Babies" (BFHD)
- Community Resources
  - Aging and Long Term Care (ALTC)
  - Child Protective Services (CPS)
- Pastoral Care
- Pharmacist
- Consistent Care Program Staff
  - Medical Director- Dr. Darin Neven
- Primary Care

PRESCRIPTION MONITORING PROGRAM (PMP)

- Controls prescription misuse by providing practitioners prescription histories
  - Changes the clinical management in 41% of the cases
- Access to PMP for ED providers and ED Case Management staff
- Promote the use of PMP for other providers; dental, pain management specialists, PCP
- Ability to use PMP to assess provider prescribing behavior and identify areas of improvement/education

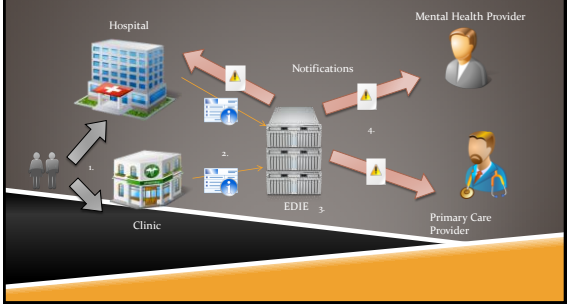
EXECUTIVE OFFICE OF THE PRESIDENT OF THE UNITED STATES. (2011). *EPIDEMIC: RESPONDING TO AMERICA'S PRESCRIPTION DRUG ABUSE CRISIS* [POLICY REPORT].

EMERGENCY DEPARTMENT INFORMATION EXCHANGE (EDIE)

Collective Medical Technologies

- Internet delivered tool that facilitates communication across hospitals and care providers
  - 2.5M ED visits going through EDIE (98%)
- Ability to identify high users across all service areas
- Creates a mechanism to "re-insert" the PCP as the center of care through automated notifications
- Allows the automated delivery of individualized care guidelines to the treating ED 24/7
- Notifications automatically trigger the delivery of Case Management services at the time of the ED visit
- HIPAA Compliant

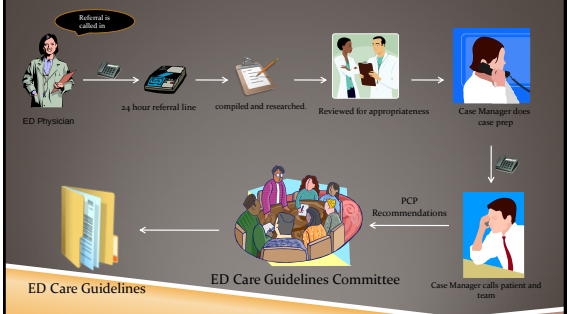
HOW EDIE NOTIFICATIONS WORK



CASE MANAGEMENT

- Patient-Centered
  - Establish PCM for every client
- Face to Face
- Care Guideline development
- Promote clinical coordination
- Proactive Case Management
  - Chemical Dependency
  - Behavioral Health
  - Community resource needs
  - Alternative plans and education to the use of the ED

DEVELOPMENT OF THE CARE GUIDELINES



CARE GUIDELINES

- **ED Visit Summary:** A table of all ED visits made by the patient in the metropolitan area for the past two years.
- **Primary Care Provider:** A statement identifying the patient's primary care provider/clinic name including the phone number.
- **Opioid Recommendation:** A recommendation from the Care Guidelines Committee regarding administering or prescribing opioids in the ED when objective findings to substantiate complaints of pain are absent
- **Chronic Pain Medication:** A statement identifying if the patient has entered into an opioid agreement with their provider or is receiving a scheduled supply of controlled substances

CARE GUIDELINES

- **Past Medical History:** A compilation of diagnoses listed on medical records, summary of other pertinent psychosocial history factors obtained from hospital medical records including overdose history
- **Security Summary:** Statements regarding the security risk of the patient to ED staff and describing patterns of dangerous behavior demonstrated on prior visits
- **Referrals:** A statement regarding the referrals recommended by the Care Guidelines Committee such as chemical dependency evaluation, psychiatric evaluation, or physical therapy evaluation
- **CT Scan Statement:** A statement summarizing number of CT scans the patient has received in the last year

WHAT DOES A NOTIFICATION LOOK LIKE?

- Patient Identifier
- Notification Reason
- Patient PRC Alert
  - PRC Contact Information
  - PRC Providers
- Other Providers
- Care Guidelines
  - PCP Guidelines
  - ED Guidelines
  - Other Notes


The Emergency Department Information Exchange
Technology Leadership in Care Coordination
DOE, JOHN Q
Patient is on Washington PRC
Provider
PRC type Phone
Service Dates
Care providers on record:
KEVENM JOHNSON MD
Primary Care
Current
From PCP
Refer back to PCP for management of all chronic conditions.
Care Guidelines
Restrict use of opioids in ED to only obvious trauma or severe medical issues.
Establish clearly that no opiates or benzodiazepines will be given for chronic conditions.
History
Psych Issues: BIPOLAR DISORDER, SCHIZOPHRENIA
Miscellaneous
Please do not provide this report to patient or representative except though the Medical Records Department.
Other Notes:

WHAT DOES A NOTIFICATION LOOK LIKE?

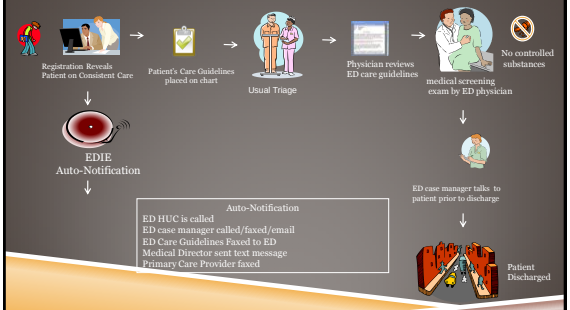
- 3 Month Visit List
  - Date / Time
  - Location
  - Diagnoses
- 12 Month Visit List
  - Visit Counts
  - Non Emergent Visits*
  - Facilities
- Narcotic Prescriptions (In Work)
- PDMP Data (Pilot in Progress)

* Non emergent visits as indicated by HCA NE Dx List

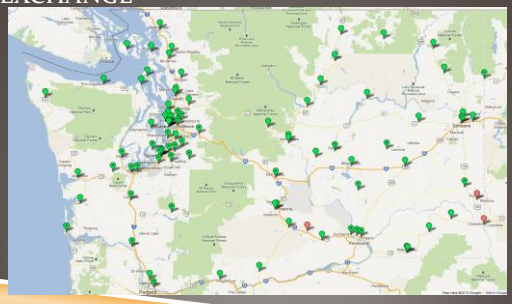
WHAT DOES EDIE LOOK LIKE?

- Patient / Visit Summary Section
- Care Guideline Section
- Investigation Section

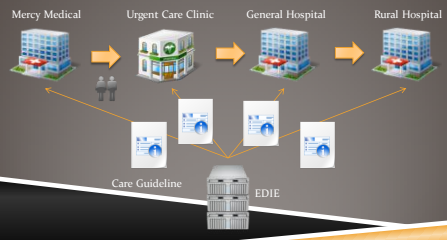
ED VISIT PROCESS



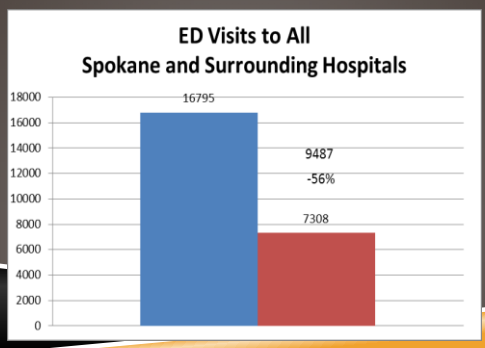
EDIE IMPLEMENTATION- STATEWIDE EXCHANGE



CONSISTENT & COORDINATED CARE



RESULTS



n=540 patients (enrolled from 2006-2011)

ED CARE COORDINATION STUDY (CDC)

- Began in September, 2011- two year study
  - No informed consent required
  - Focus on prescription drug abuse and preventing overdose deaths
- 165 Participants randomized into the TAU (control) and CCare (treatment) groups
  - Screened for those patients with > 50% visits related to pain complaints
- All payer sources- Medicaid, Medicare, Commercial and uninsured
- Collecting data
  - Prescribing behavior- PMP and hospital data
  - ED visit utilization- EDIE
  - Financial indicators- hospital data

ALTERNATIVE TO A NO-PAYMENT POLICY

- History of no-payment policy
- Adopted in April 11, 2012
  - WSMA, WSHA and WA-ACEP
- Attestation by June 15, 2012
- Adoption of practices by October 1, 2012
- Reporting by January 15, 2013

"SEVEN BEST PRACTICES"

- Adoption of an Electronic Health Information system
- Patient Education
- Narcotic Guidelines
- Prescription Monitoring
- Feedback Reporting
- Patient Review and Coordination (PRC) Client Lists and Notifications
- PRC Care Plans and PCP Access

PROGRAM FUNDING

- Health Plans
  - Financial savings
  - Contractual arrangement for enrollment based on acuity
- Hospitals
  - Coordinated Effort
  - Financial
    - Reduction of uninsured visits
    - Manage state spending/Medicaid legislation
    - Commercial Insurance- Manage ED costs
- Not for Profit Organization- Benefits community
  - Health Access Fund

WHAT WE'VE LEARNED

- Just communicating with each other and having access to EDIE information has made huge impact
- Mental health care is key-improving patient access and adherence
- We need to learn how better to communicate with the vulnerable- better skills in the ED around patient engagement and motivation for change
  - Beginning to access training for staff
- We need around the clock or late hours access to Urgent Care
  - Community health access team is working to address this
- We need timely access to primary care appointments- Patients have PCP's, they just can't get into them
  - Establish relationships to open up slots for patients within our program
  - Identify complex patients that need regularly scheduled appointments

WHAT'S NEXT..

- Reductions in the use of the ED for medical clearance visits
- Streamlining the care of patients with dental issues
- Closer working relationships with EMS and local dispatch centers
- Collaboration on a statewide basis
  - Standard care planning
  - Transparent outcomes for identification of best-practices

FINAL THOUGHTS

- It's important to "slow the flow" of controlled substances – people are dying!
- Communication and collaboration with community stakeholders is critical- get to know your neighbors!
- Over-utilization of the emergency room is a symptom of underlying disease, whether that is poor primary care access or prescription drug abuse, use your assessment skills and create a treatment plan.
- It can't be fixed overnight ...but you can go a long way in a short amount of time!

QUESTIONS?

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