Emergency Medicine

Transitions of Care

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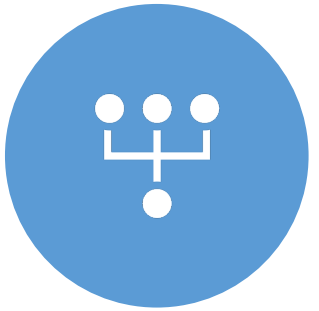
Goals

UNDERSTAND THE VALUE OF ED TRANSITIONS OF CARE

UNDERSTAND THE CURRENT LITERATURE ON ED CARE TRANSITIONS INTERVENTIONS

FRAMEWORK OF POST-ED RISK REQUIRED FOR ED FOLLOW UP CENTER



MANAGING SUPER-HIGH UTILIZERS & OTHER INTERVENTION CONCEPTS

The unpopular end of the ED conveyor belt ?

Care Transition Interventions

Contents lists available at ScienceDirect

American Journal of Emergency Medicine

journal homepage: www.elsevier.com/locate/ajem

Optimizing emergency department care transitions to outpatient settings: A systematic review and meta-analysis

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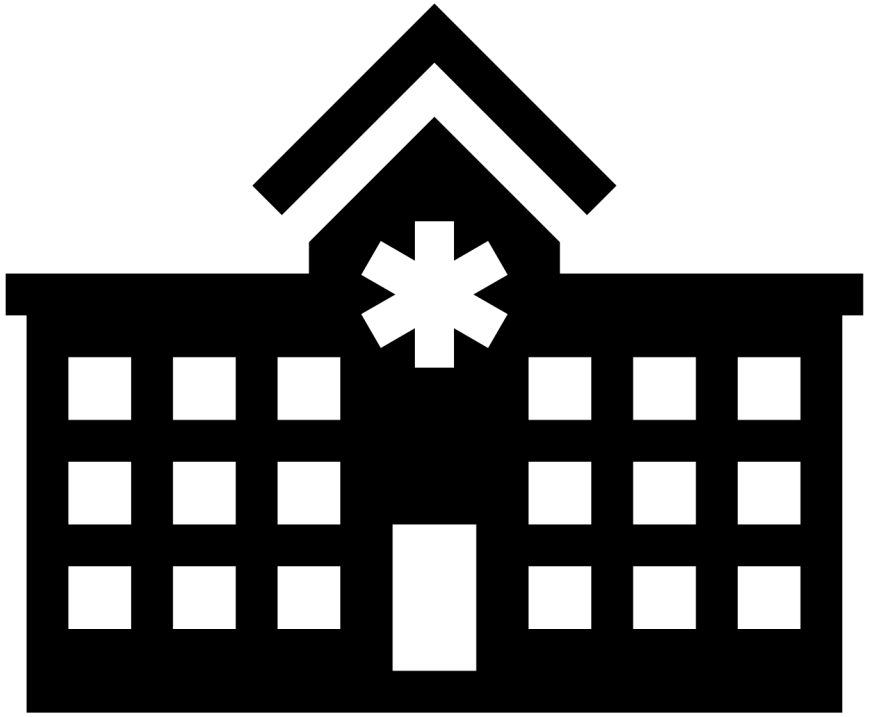
- ED-based CTIs
- 42 articles that met inclusion criteria. Pooling data from 20 studies.
- Included CTIs in all three functions of care continuity: information, communication and coordination.

- Increase in outpatient follow-up, compared to routine care
- No significant effect on ED revisits or hospital admission after ED discharge when compared to routine care.

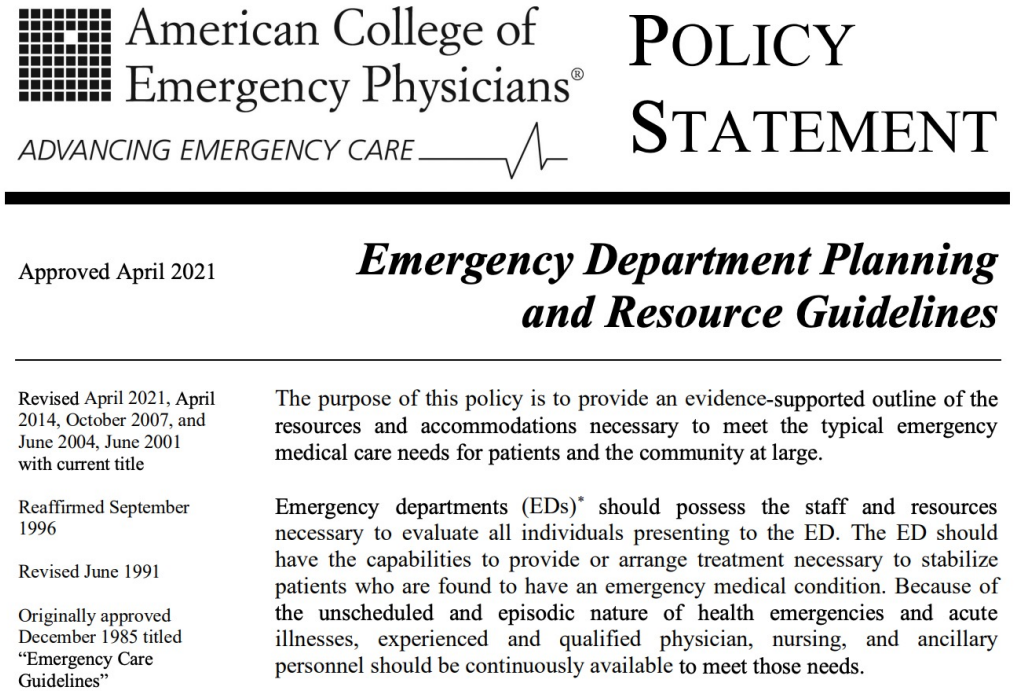
Care Transition Interventions



- ED Discharge Process

- Portal
- Patient navigation
- Social work / care coordination
- Post-ED clinician call-backs

Discharge Instructions - ACEP



American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved April 2021

Emergency Department Planning and Resource Guidelines

Revised April 2021, April 2014, October 2007, and June 2004, June 2001 with current title

Reaffirmed September 1996

Revised June 1991

Originally approved December 1985 titled "Emergency Care Guidelines"

The purpose of this policy is to provide an evidence-supported outline of the resources and accommodations necessary to meet the typical emergency medical care needs for patients and the community at large.

Emergency departments (EDs)* should possess the staff and resources necessary to evaluate all individuals presenting to the ED. The ED should have the capabilities to provide or arrange treatment necessary to stabilize patients who are found to have an emergency medical condition. Because of the unscheduled and episodic nature of health emergencies and acute illnesses, experienced and qualified physician, nursing, and ancillary personnel should be continuously available to meet those needs.

- Transfer of care should be coordinated by the ED physician and the ED nurse
- All patients discharged or transferred from an ED should have specific, printed, or legibly written aftercare instructions.
- It should also be confirmed that the patient is reasonably able to read and understand these instructions.

Discharge Instructions - SAEM

1. Summarize the evaluation and treatment that was performed, diagnostic test results, and medications administered.
    - Explain any outstanding test results that need follow-up.
2. Post-ED treatment plan
3. Plan for follow-up care.
    - Specify with whom the patient should follow up and in how many days follow-up should occur.
    - If needed, provide the appropriate specialty clinic phone number for the patient.
4. Reasons to return to the emergency department.

Discharge Instructions - SAEM

- Care must be taken in choosing the proper wording for a discharge diagnosis.
- A patient's definitive diagnosis is sometimes not known at the time of discharge from the emergency department.

Discharge Instructions - SAEM

- Language
- Language level
- Medical Jargon

- 50% of the adult US population have low health literacy and may have difficulty understanding health-related information provided by a physician, including written discharge instructions (Ruddell, 2006).
- Approx. 1 in 5 adults cannot read the front page of a newspaper (Ruddell, 2006).

Discharge Instructions

- Important **patient factors** in ED discharge efficacy:
  - Emotional state
  - Education
  - Memory
  - Ability to access portal

- Verbal instructions: deficient patient comprehension on diagnosis, care plans, return needs
- Written + verbal instruction > verbal alone

- Video content: enhance patient engagement, comprehension

EHR Portal / PHR Use

- The 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act encourages: meaningful use of electronic health records (EHRs) to further the quality of care received by patients.
- Personal Health Records have interactive functionality: ordering prescriptions, scheduling appointments, secure messaging, remote patient monitoring
- Patient online access to EHRs via PHR portals in 93% US hospitals

EHR Portal / PHR Use

- Research : digital communication incorporated into post-ED care can improve patient satisfaction, return ED visits and care quality.
- Research: PHRs demonstrate improved medication adherence, disease management, patient–provider communication, and satisfaction with care
- Variable patient engagement with PHRs, including large racial/ethnic disparities.

PHR Push vs Text

- Barriers to account creation / activation / initial navigation
- Requires new downloads to maintain push notification
- Requires data plan
- Cell / Cell service changes

PHR Push vs Text

Text messaging:

- high consumer interface familiarity – wide adoption and low expense
- 98% open rate
- response rate **double** that of email, phone, or social media
- does not require updates & changes in number infrequent
- lower data plan requirement

- May require institutional legal approval re: HIPPA

Patient Navigation

- Increased return visits associated with **barriers to obtaining timely appointments or accessing outpatient care**
- Includes lack of insurance or transportation
- Post ED adherence to appointments +/- 50%
- Adherence with follow-up after ED discharge *may* reduce ED return visits

Patient Navigation

- Most studies demonstrate *higher* outpatient appointment adherence if the appointment was made in the ED rather than simply providing a clinic number to contact.

- *Some* ED Patient Navigator programs (CHWs) have demonstrated:
  - increased outpt appointment adherence
  - Increased patient satisfaction
  - reduced ED return visits (as long as 24 months after intervention)
  - reduced overall healthcare costs
  - reduced hospitalizations

Social Services / Care Coordination

- Improve the quality of ED care transitions?

- Katz EB, Carrier ER, Umscheid CA, Pines JM. Comparative effectiveness of care coordination interventions in the emergency department: a systematic review. Ann Emerg Med, 2012

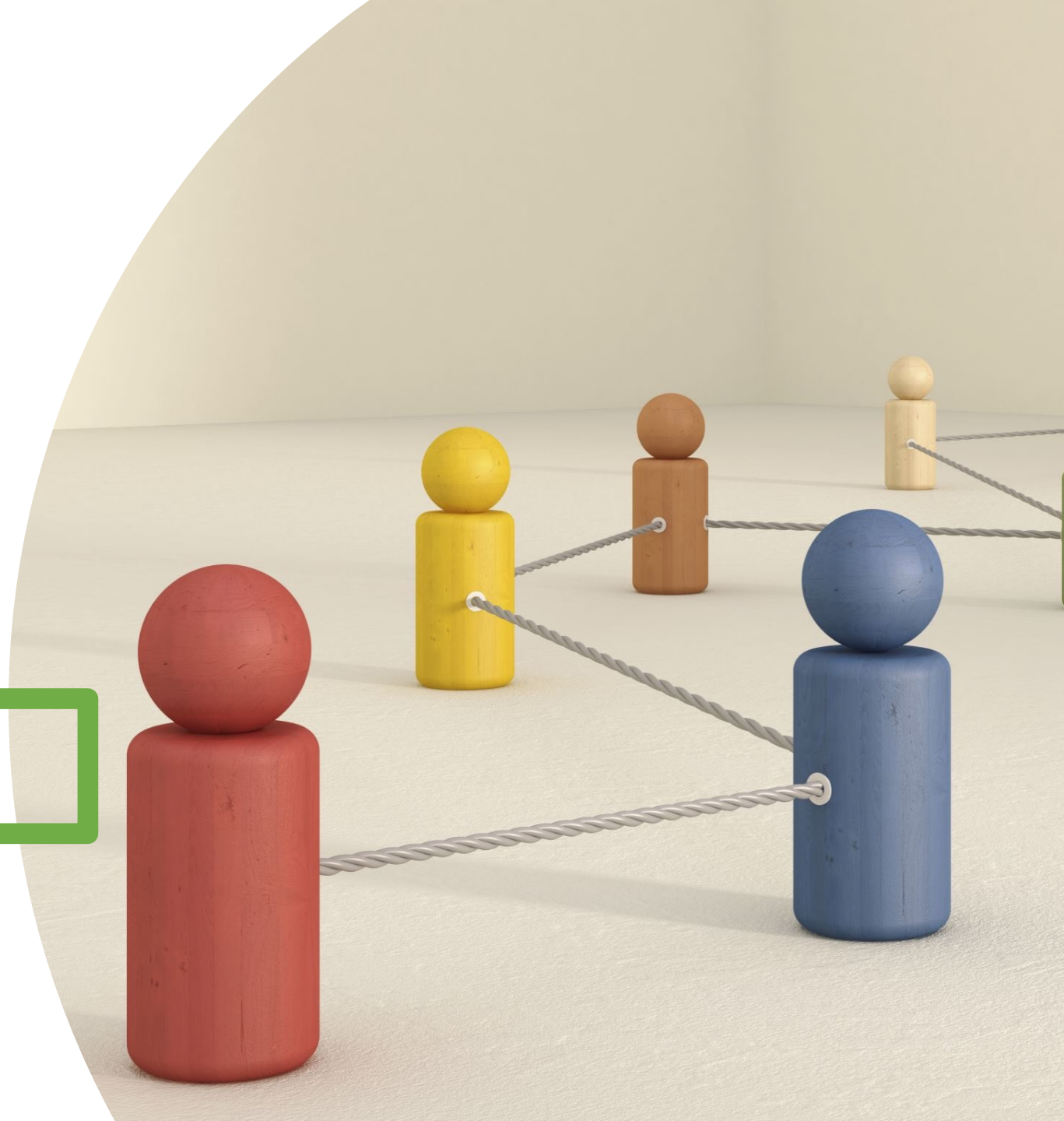
  - Randomized studies have showed *variable* impact in improving
    - Follow-up rates
    - Repeat ED visits

  - ….suggest focus on quality of interventions chosen….

Social Services / Care Coordination

Recommend strategic use in partnership w hospital :

- Better to reduce low acuity admissions?
- Better to reduce denials?
- Focused disease groups (e.g.: Sickle Cell Patients)?
- Super-high utilizers?



ED Telephone Callbacks

- Improve patient satisfaction……? selection bias ?
- Additional questions answered: approx 50% of patients request clarification about their discharge instructions during ED telephone callback
- Can improve adherence with follow-up appointments - either through direct scheduling of appointments or reinforcing the importance of adherence

ED Telephone Callbacks

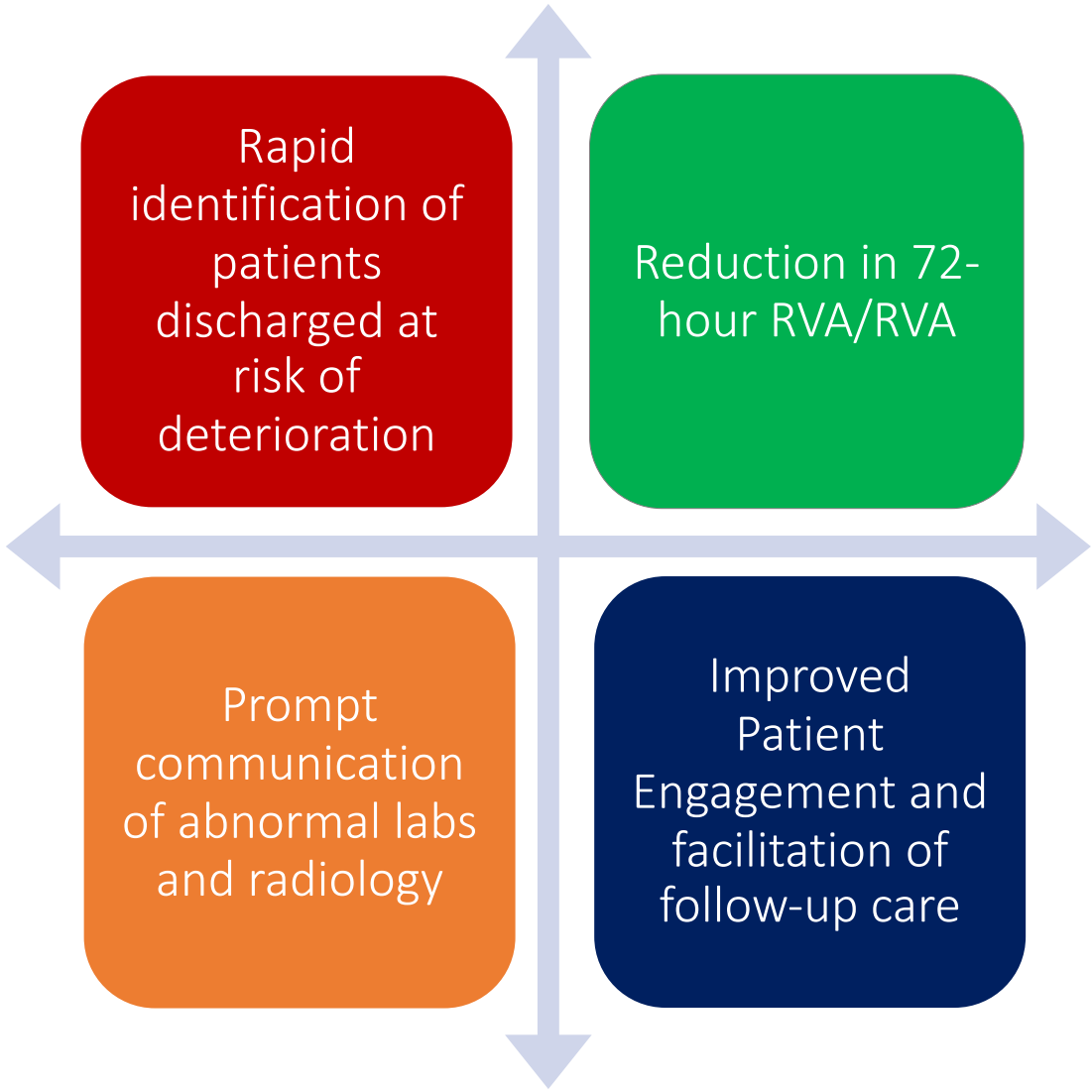
- Does **not** impact ED return in elderly in randomized control trials

- A scripted call from a nurse showed **no** benefits on health services utilization and discharge plan adherence by older patients after ED discharge

- Is texting better?
- Is telemedicine the future….can this be billed?
  - CTP
  - VUC

How to build
an
ED Follow-up Center

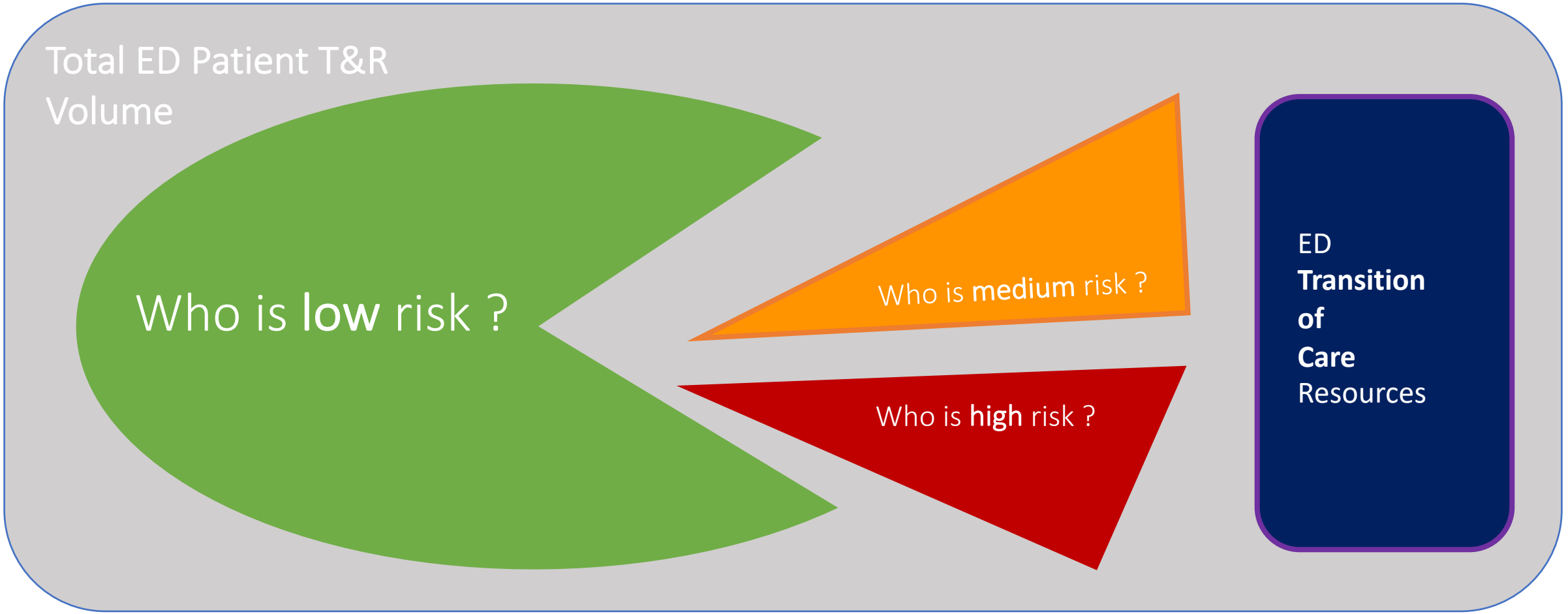
Optimize Quality and Safety of ED Care



Defining Post-ED Risk

- Appropriate risk stratification of T&R patients
- Appropriate utilization of ED resources

Defining Post-ED Risk



Defining Post-ED Risk

Who is low risk ?

Do they need ***any*** transitions of care resources ?

Who is medium risk ?

Utilization of which transitions of care resources reduce their risk ?

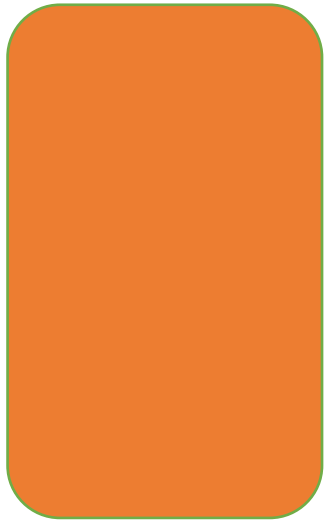
Who is high risk ?

What is the best way to ensure they receive ***optimal*** post-ED resources ?

Who is **low** risk ?

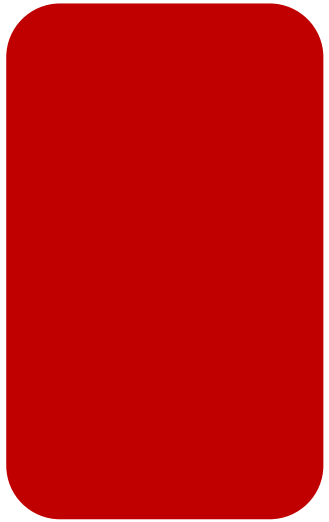
- Young
- Low comorbidity burden
- Without pending results on discharge
- Insured
- Not socially vulnerable
- Did not AMA / LABS

Who is **medium** risk ?



- 27% of older adults discharged from the ED: RV, hospitalization, or death at 3 months. Friedmann et al. Early revisit, hospitalization, or death among older persons discharged from the ED. Am J Emerg Med. 2001
- Abnormal vital signs in ED
- New Projects
- Chest Pain / Neurological / Infectious discharged patients
- Uninsured / Socially Vulnerable
- AMA / LABS

Who is **high** risk ?



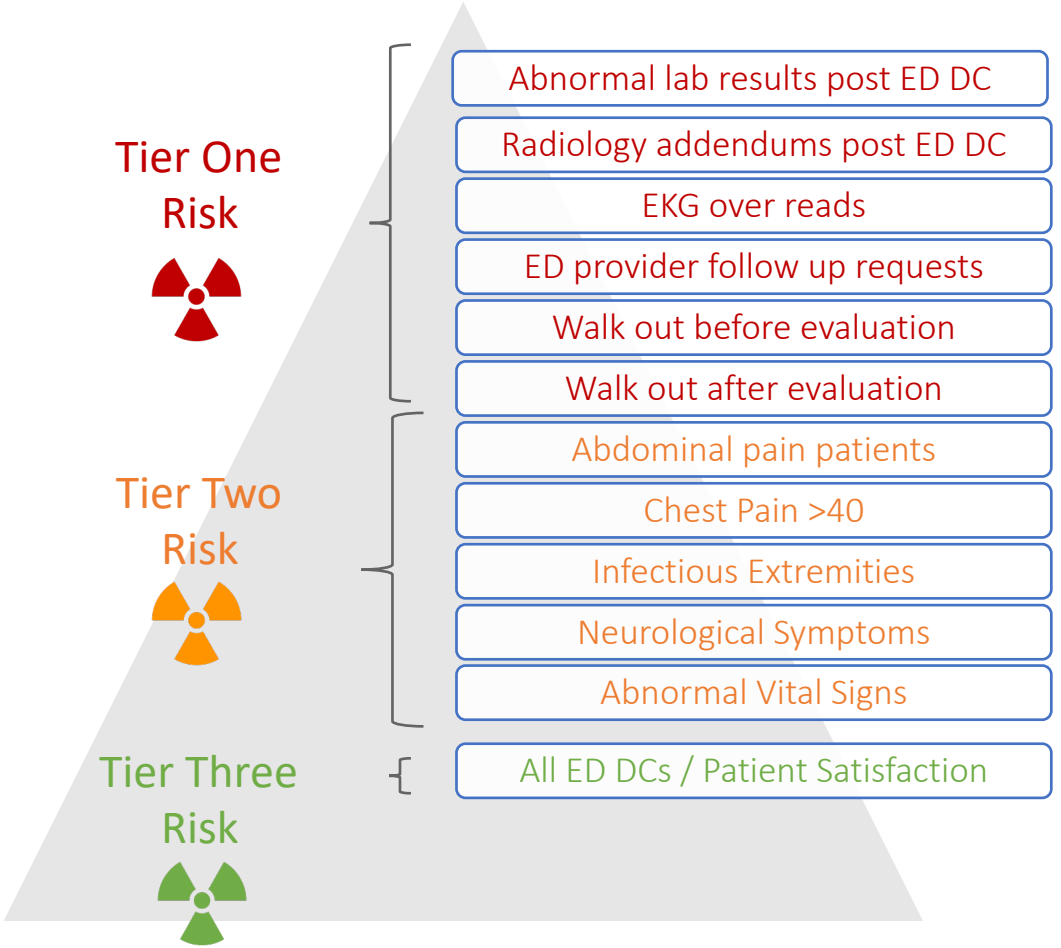
- Abnormal lab results post ED DC
- Radiology addendums post ED DC
- EKG over reads
- ED provider follow-up requests
- Walk out before evaluation
- +/- Walk out after evaluation
- Consider Epic order

Optimize Quality and Safety of ED Care

Intensity of Resources

Provider Callbacks
Vs
Telehealth Encounters

RN Callbacks



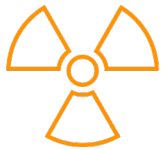
+/- Review of new projects

Optimize Patient Expereince

- Additional touch point post discharge, shown to improve satisfaction

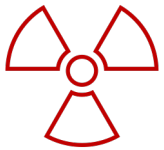
- Collect data on ways to improve ED experience

‘Superusers’, ‘High Utilizers’ and ‘Super-high Utilizers’



High Utilizers (HU)

- definitions vary
- 3-5 ED visits / year ?



Super-High Utilizers (SHU):

- Conceptually different to HUs
- >5 ED visits / year ?

Should we be looking at # admissions ?

Super-High Users 

Associated with:

- high chronic disease burden
- substance abuse
- psychiatric disorders

Multidisciplinary SHU Interventions have been shown to:

- reduce ED visits
- reduce hospital admissions
- reduce healthcare resource expenditure (estimated $38 billion a year in healthcare spending and up to 50% of the ED care Medicaid costs)
- improve patient satisfaction
- improve quality of life

Super-High User Program 

- Use metrics (ED utilization, admissions)
- Also take front-line referrals

- Partner with IM, Social Work, Psychiatry

- Consider EHR-based early notification systems

- Start small (12 cases/year)
- Monthly meetings

Telehealth Services

- Reduce low acuity admissions
- Consider leveraging Paramedics
- Hospital at home concept e.g.: CHF

Visiting Nurse Services

- Reduce low acuity admissions
- Leverage patients' insurance
- Hospital at home concept e.g.: IV Abx