UCHealth CENTRAL INSIDER

UNIVERSITY of COLORADO HEALTH

Volume 7 | Issue 18 | March 18, 2014

Decreased utilization among frequent ED, hospital users

Bridges to Care Helping to Close Primary Care Gap

By Tyler Smith

A federal grant program aimed at reducing unnecessary emergency department visits and hospitalizations among targeted patient populations in Aurora looks to be working.

Metro Community Provider Network (MCPN), a nonprofit organization that provides health care and educational services to the under-insured, is the recipient of the three-year, $4.2 million grant from the Centers for Medicare and Medicaid Innovation. University of Colorado Hospital is one of five organizations *(see box)* that has joined forces with MCPN to implement a model of care inspired by an approach developed in Camden, NJ known as "Hot Spotters."

Greg Misky, MD

Jennifer Wiler, MD

Roberta Capp, MD

The idea is based on data showing that small percentages of patients consume health care services disproportionately, often because of unmanaged chronic medical and mental health issues that lead to frequent ED visits and preventable hospital admissions. The Camden project identified two high-rise apartments as "hot spots" for residents with high utilization numbers. Connecting them to intensive community services and establishing them in medical homes that coordinated their care helped to drive down costs dramatically.

The MCPN program, called Bridges to Care, follows the same general approach, targeting residents of two Aurora zip codes, 80010 and 80011, who have had more than three hospital visits (either to the ED or an admission) in the previous six months. Enrollees receive an intensive eight-week intervention that includes care coordination, education, and mental health services. Aurora is the only one of four U.S. cities receiving the grants to integrate mental and behavioral health in its care delivery model.

Rising enrollment, falling costs. Halfway through the grant, which began the summer of 2012, the program is a little more than one-third of the way towards its goal of enrolling 900 patients. But it enrolled nearly 130 patients in just two months after UCH agreed to allow a Bridges to Care staffer in the ED to identify potential patients and inform them about the program on the spot, said Roberta Capp, MD, MHS, assistant professor of Emergency Medicine with the University of Colorado School of Medicine.

"It's a big step for University of Colorado Hospital to do this," Capp said. "The reach that the program has had has been immense. Both institutions are working together to serve patients."

The collaboration between UCH and Bridges to Care is straightforward, but it required some effort to implement. The patients who meet the inclusion criteria had to be identified so they could be flagged in the Epic electronic medical record. To do so, a Bridges to Care volunteer with a UCH affiliate badge takes a spot during regular business hours in the ED and works from a laptop that has read-only access to Epic.

When a patient with a flagged medical record arrives, the volunteer goes to an ED physician or nurse to ask permission to approach the

Continued

individual with information about the program and makes a note in the medical chart. If the patient agrees, the volunteer enrolls him or her in Bridges to Care and schedules an appointment with an MCPN nurse practitioner, Capp said.

During off hours, a prompt on the ED tracking board reminds nursing staff to ask the patient for permission to be contacted. If the patient agrees, nurses document the approval and put it in a work queue for the Bridges to Care staffer's next shift.

Data-gathering is still in the early stages, but there are indications that the program is helping to decrease utilization among the targeted population. Among 20 patients for whom the hospital compiled six months of pre- and post-intervention data, the total number of ED visits to UCH dropped from 56 to 36, while the total number of hospital admissions fell from 18 to 11. Nine of the 20 made no hospital visits in the six months after graduating from Bridges to Care.

Based on these preliminary numbers, Bridges to Care projects savings of roughly $2.7 million in ED visit charges and $2.1 million in hospitalization charges if the program meets its 900-patient enrollment goal. In addition, the program helped to transition patients from the Colorado Indigent Care Program to Medicaid, a key to ensuring they have a medical home to coordinate their care after graduation *(see accompanying story, this issue)*.

A helping hand. John Reid, vice president of fund development for MCPN, said pre-intervention data show that a small number of patients can account for as much as 70 percent of hospital costs rung up by the group, meaning even a modest shift in behavior could represent significant savings.

The Bridges to Care strategy centers on a health coach: a nurse practitioner who makes home visits to identify the patient's barriers to care, such as lack of transportation or money for medications, and finds ways to overcome them. The coaches help patients manage their health through diet, exercise, adherence to medication regimens and so on. Patients also get a mental health screening and interventions, if they are needed, from Aurora Mental Health.

"The biggest, most significant thing we have observed is the home visits have made a difference," Reid said. "People are less likely to go to the ED when their needs are being met by a nurse practitioner in the home setting. They develop trust when the information is shared with them in a manner they understand."

Reid also credited the hospital's tighter connection with MCPN for the signs of success. "There is now a continuum of care. People are not just discharged from the ED or the hospital. Before they leave, they are being managed."

A new model. "Our responsibility doesn't end with a discharge order," noted Greg Misky, MD, a hospitalist with UCH who is involved with the Bridges to Care initiative. "Ultimately, we should be handing off care to another provider, but the status quo hasn't worked. Coordination of care has been missing. Bridges to Care is not a hospital investment, but it does demonstrate that an institution like UCH can reach out and do better with its most vulnerable patient populations."

For UCH, Bridges to Care could help save money – the hospital's unreimbursed charity care totaled $371 million in charges in fiscal year 2013 – and free up ED and inpatient capacity, said Jennifer Wiler, MD, MBA, vice chair of Clinical Quality, Patient Safety and Process Improvement for the Department of Emergency Medicine. But the program is part of a broader shift from a fee-for-service reimbursement system to one that rewards clinical coordination and good patient outcomes.

"We're trying to decrease utilization, but we also want to make sure that patients utilize the health care system appropriately," Wiler said.

Wiler, Misky and Capp aim to expand the Bridges to Care concept to broader populations of patients. The three have made a proposal for a "sustained model" to the University of Colorado Health Board of Directors that envisions an interprofessional hospital team developing standardized care plans for patients who are now excluded from the Bridges to care program, Wiler said.

"If Bridges to Care does what we think it will do, we believe it will evolve beyond the current grant program," Misky said. "We're thinking ahead to the next steps."

Continued

Bridges to Care Community Partners

- Together Colorado
- University of Colorado Hospital
- Aurora Mental Health
- The Medical Center of Aurora
- Metro Community Provider Network
- Aurora Health Access