UCH INSIDER

UNIVERSITY of COLORADO HEALTH

Volume 6 | Issue 9 | through November 6, 2012

Grant targets frequent ED, hospital utilizers

UCH a Hot Spot for "Hot Spotters"

By Tyler Smith

Aurora is one of four U.S. cities to receive a multimillion-dollar federal grant aimed at finding new models of care delivery for patients who frequently use the hospital. The aims: coordinate care, increase efficiency, improve health and thereby reduce costs to hospitals and to the health care system.

The grant recipient, Metro Community Provider Network (MCPN), a nonprofit organization that provides health care and educational services to the underinsured, will receive $4.2 million over three years from the Centers for Medicare and Medicaid Innovation, which in turn received the funds from the Affordable Care Act.

University of Colorado Hospital, which handles tens of thousands of visits from uninsured and underinsured patients in its crowded ED each year, is a partner in the effort, which was inspired by an initiative developed in Camden, NJ, dubbed *"Hot Spotters."*

30 percent by 1 percent. In an exhaustive review of medical records, family physician Jeffrey Brenner found that one percent of about 100,000 Camden residents using medical services were responsible for 30 percent of total costs. Brenner identified two high-rise apartments whose residents had unusually high numbers of costly ED admissions and hospitalizations.

Aiming to reduce utilization and improve patients' health, Brenner developed partnerships with community organizations and providers and created a system to funnel patients to primary and behavioral health care and social services. The approach significantly reduced the number of ED visits and hospitalizations in the targeted group and saved hundreds of thousands of dollars in the process.

Following the Camden model, MCPN has joined forces with Aurora Mental Health; Aurora Health Access, an organization of providers, community agencies and residents developing ways to improve health care coverage and delivery; and Together Colorado, a congregation-based community-organizing group. The goal is to create a web of primary-care resources as an alternative to expensive, fragmented emergency care.

Numbers of ED Visits, July 1, 2010 to June 30, 2011 by Aurora Zip Code*

ZIP CODE	TOTAL CASES	% OF CASES
80010	1,669	36%
80011	1,511	33%
80012	479	10%
80013	270	6%
80014	213	5%
80015	94	2%
80016	23	0%
80017	270	6%
80018	29	1%
80019	8	0%
80040	13	0%
80041	15	0%
80042	8	0%
80044	5	0%
80045	17	0%
80047	11	0%
Grand Total	4,635	100%

* Numbers are for those patients who made at least five ED visits during the period.
Source: University of Colorado Hospital and Aurora Health Access.

The numbers of Aurora residents who made five or more visits to UCH's Emergency Department during a one-year period. Residents in two Aurora zip codes, 80010 and 80011, accounted or nearly 70 percent of all the visits.

Two zips. In contrast to the densely populated Camden, the Hot Spotter focus in the geographically spread-out Aurora will be neighborhoods in two zip codes, 80010 and 80011, said Heather Logan, director of accountable care for MCPN. The two zip codes are roughly bounded on the west by Yosemite Street, the east by Tower Road, the north by Smith Road and the south by Mississippi Avenue.

The hospital is itself a hot spot: between July 1, 2010 and June 30, 2011 patients in the two targeted zip codes accounted for 58 percent of all visits of Aurora residents to UCH's frequently crowded ED, according to data supplied by the hospital to Aurora Health Access.

Continued

In addition, some 650 patients from the two zip codes made at least five ED visits to UCH during that one-year period. They accounted for more than 4,600 total visits, nearly 70 percent of all visits made by Aurora residents seen in the ED five times or more during that time.

Logan said in the first year, MCPN aims to identify 150 patients residing in those areas who have high numbers of ED visits and hospitalizations, multiple medications or a combination thereof. Many of these patients, she added, have complex psycho-social needs that must be addressed. The three-year enrollment goal is 900.

By the beginning of 2013, MCPN is to begin tracking patients and collecting and reporting on a wide variety of data, including hospital and ED costs; numbers of encounters with providers; primary and secondary diagnoses; comorbidities; patient satisfaction, and more.

The organization is working with an ad-hoc Hot Spotters group of UCH physicians and staff to identify patients that fit the profile and create a process for referring them to the MCPN network.

The Hot Spotter approach offers an opportunity for the hospital to channel at-risk patients from the ED to better coordinated community care, said Greg Misky, MD, a hospitalist at UCH and member of the informal group.

> *"The model makes good sense if it's done right and efficiently," he said. The hospital plans to help MCPN by using its Epic electronic medical record to flag frequent hospital users from the two zip codes and then having staff connect the patients to MCPN providers for further assessment."*

Web of providers. While much has been made recently of the importance of connecting underserved patients to primary care physicians, Misky said the Hot Spotter model is "not a physician, or hospital-based solution." Rather, the hub of the approach is a "clinical care coordinator" whose job it is to connect patients and their caregivers with community services, coordinate their care and to help them get to appointments, understand their medications, provide support for psycho-social issues and overcome other barriers to medical care, he explained.

"If we align patients with potential resources, everyone wins," Misky said. "If the approach is done right, we won't just funnel patients to a primary care physician but to [a network of] medical providers. But we need somebody to help implement the plan."

The long-term goal is not only to improve patients' health, but also to help them and their caregivers manage and make good decisions about their own health care needs. One important key to that, Logan said, is getting the clinical care coordinator to the hospital as soon as the patient is admitted.

Greg Misky, MD, a hospitalist at UCH. Misky and Emergency Medicine physicians Jean Abbott and Jennifer Wiler are among an ad-hoc "Hot Spotters" group at the hospital.

At the bedside or in an exam room, she explained, a care coordinator would triage the patient and determine his or her needs: medical treatment, social support, mental health services or assistance with substance-abuse issues, for example.

Depending on the patient's mix of medical and social needs, nurse practitioners, health coaches and social workers in the MCPN network would pair up to develop an individualized care plan and provide regular home visits.

Possible twin wins. Abbott and Misky said the concept requires front-end engagement from UCH, but it dovetails with key organizational goals, namely decreasing volume pressure on

Continued

the ED and forging strong connections with community providers. The latter is one of the aims of the ACT I (Accountability, Clinical Transformation and Improvement) initiative launched last year by UCH, the CU School of Medicine and University Physicians, Inc.

The hospital benefits from building links to MCPN and other community resources, argued Jean Abbott, MD, professor emerita with CU's Department of Emergency Services and a member of the Hot Spotters group at UCH.

"The question is how do we coordinate to make transitions of care more efficient," Abbott said. "This grant allows funding to hire providers to do focused managed care and impact the health of patients globally and efficiently. That's better care from a business point of view as well as from a medical care perspective."

Complex care. In fact, Abbott said, the population of patients targeted by the grant demands a coordinated approach to care. In a previous study, she showed that more than 60 percent of frequent ED users had a chronic or end-stage medical condition, while nearly 40 percent had a diagnosed psychiatric condition, often in conjunction with significant chronic medical disease. About one in five had a history of either alcoholism or drug abuse.

Jean Abbott, MD, has studied patients who are frequent ED visitors.

"Patients with chronic conditions and their families struggle, and those with psychiatric conditions are most stressed by chronic disease," she said. "Patients have to have their mental health needs met if they are going to manage their medical disease well."

There are plenty of "hard fixes" to resolve if the Hot Spotter model is to work, Abbott conceded, including shortages of mental health and primary care providers and funding for specialist support. Challenges to the expansion of Medicaid and the unaddressed issue of how or if to provide insurance coverage to 20 million undocumented workers pose additional dilemmas.

But the present era of shrinking resources, reimbursement and hospital bed shortages makes alternative approaches like Hot Spotters potentially viable for hospitals and other providers, Misky said.

"We don't want patients to use the ED for primary care, and in fact most patients don't want to go to the ED," he said. "An option to get them into a clinic with follow-up and transitional care is a save for the hospital because it frees up beds."