A grantee of the Robert Wood Johnson Foundation

Using Hospital Admission, Discharge, and Transfer Data to Coordinate Care: Lessons from Tennessee and Washington

September 6, 2018

STATE Health & Value STRATEGIES
Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation
About State Health Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University’s Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.
Agenda

Tennessee: Care Coordination Tool

Washington: *ER is for Emergencies*

Discussion
ADTs are the most actionable real-time electronic information in health care today

<table>
<thead>
<tr>
<th>ADT uses</th>
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<tr>
<td>• Increase primary care follow up from ED and inpatient visits</td>
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<tr>
<td>• Help primary care and behavioral health providers find hard-to-reach patients</td>
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<tr>
<td>• Facilitate patient education on appropriate ED use</td>
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<td>• Increase access to patients’ care history</td>
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Tennessee Providers see the benefit of ADT

• “We’ve been able to really monitor the ADT feeds and recently noticed we had a consumer that went 18 times for a hospitalization or ED visit over 90 days. That was eye opening for us.” – Andrea Westerfield, Mental Health Co-op

• “We had a patient we’d been treating since 1993 for schizophrenia. When we started receiving admission, discharge and transfer feeds from the hospitals, we discovered that she would come to our office and then immediately head to the ER for treatment of her physical health conditions. This was a real opportunity for us to improve care.” – Pam Womack, CEO, Mental Health Co-op

• “It is not uncommon for one of our patients to discharge from the hospital and not understand what the next step would be in having their condition addressed. We utilize the information from the ADT export as well as the ADT summary to help our patients stay on track post discharge [...]It is very helpful to have the name of the physician (at the hospital), and the admit diagnosis so we can link our members to resources and additional follow up appointments. We also utilize the ability to pull ADT history, to identify patterns of hospitalizations for our patients. This allows us to build supports for the member that would reduce the need for rehospitalization for a condition that can be safely and appropriately addressed here at our office.” – Victoria Allen, LifeCare

Two minute video of Tennessee providers talking about ADT at: https://youtu.be/9Em69pakIfY
In 2015 and 2016, MCO reps and consultants met with all Tennessee hospitals to ask them to send ADT data. This is what they heard:

- [Lack of trust]
- [Lack of technical expertise]
- [Lack of priority]
- [Lack of 2-way benefit]

Sometimes we were talking to the wrong person.
TennCare and the Tennessee Hospital Association (THA) have a history of working together to solve problems. In 2017, we worked together to get agreement with all hospitals to share ADTs.

- Technical expertise through Audacious Inquiry (Ai)
- Priority created by THA Board (agreement to timeline)
- Hospitals can use data on readmission
- Long-term trusting partnership

THA was able to connect to the right person

TennCare also tied hospital pool payments to submitting ADT data.
Over the past year, Tennessee has connected most hospitals in the state
Providers receiving ADT information

Patient-Centered Medical Home (PCMH): 67 primary care organizations caring for 450,000 TennCare members at over 300 sites throughout the State.

Tennessee Health Link: a health home program providing care coordination for 65,000 TennCare members with significant behavioral health needs with 22 behavioral health providers at over 100 sites throughout Tennessee.
TennCare ADT Data Flow
A multi-payer shared care coordination tool allows primary care providers to implement better care coordination in their offices.

**Care Coordination Tool Functions**

- Allows practices to view their attributed member panel
- Real time admissions, discharges, and transfers (ADT feeds) and follow-up tracking
- Patient risk scores
- Generates and displays gaps-in-care based on quality measures and tracks completion of activities
- Displays claims – including pharmacy
CCT Screenshot: Landing Page
## CCT Screenshot: ADT Tab

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>DOB</th>
<th>Altruista ID</th>
<th>Health Plan</th>
<th>Risk Score</th>
<th>Load Date</th>
<th>Admit Date</th>
<th>Facility Name</th>
<th>Event Type</th>
<th>Discharge Date</th>
<th>Next Activity</th>
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<tbody>
<tr>
<td>EDWARDS</td>
<td>MARCUS</td>
<td>09/12/1951</td>
<td>32063789495</td>
<td>TN Select</td>
<td>0</td>
<td>09/29/2017</td>
<td>08/02/2017 00:00:00</td>
<td>Henry County Medical Center</td>
<td>A02: Transfer a Patient</td>
<td>N/A</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Load Date</th>
<th>Admit Date</th>
<th>Facility Name</th>
<th>Event Type</th>
<th>Discharge Date</th>
<th>Next Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/29/2017</td>
<td>08/02/2017 00:00:00</td>
<td>Henry County Medical Center</td>
<td>A01: Admit / Visit Notification</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>09/29/2017</td>
<td>08/02/2017 00:00:00</td>
<td>Henry County Medical Center</td>
<td>A03: Discharge/End Visit</td>
<td>08/05/2017</td>
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<td>09/29/2017</td>
<td>07/26/2017 00:00:00</td>
<td>Henry County Medical Center</td>
<td>A01: Admit / Visit Notification</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
This is the actual coded diagnoses TennCare receives in the DG1 segment of the HL7. This is a diagnosis someone entered in the EMR at the time of visit.
CCT Screenshot: Member Panels and Risk Scores

- Within the My Members tab, CCT users can:
  - View information about their attributed members for each MCO
  - View the member’s risk information at a glance and stratify members by risk or disease
CCT Screenshot: More Population Health Tools

CCT users can easily stratify their population by risk score and by disease state.
CCT Screenshot: Gaps in Care

- CCT users can view Gaps in Care for all of their attributed members. These Gaps are closed based on weekly claims data loads and HEDIS-like rules.
Thank you
Brooks.Daverman@tn.gov
Background

• Some patients visiting emergency departments could be treated effectively in a less costly setting

• There are evidence-based practices that can reduce low-acuity emergency room visits, coordinate care, and save health care dollars
Creating the Partnership: Government

• In 2012, the Legislature passed House Bill 2127.

• Requires all Washington hospitals to implement seven best practices.
Creating the Partnership: Coordinated Care

- Washington State Hospital Association
- Washington State Medical Association
- Washington Chapter of the American College of Emergency Physicians
- Washington State Health Care Authority
Power of a Statewide Goal

• Standard policies in every hospital
  - No patient shopping for a different physician
• Safe Table Learning Collaboratives to share best practices
• Friendly competition towards a shared goal
Seven Best Practices

1. Track emergency department visits to avoid ED “shopping”
2. Implement patient education
3. Institute an extensive case management program
4. Reduce inappropriate ED visits by collaborative use of prompt visits to primary care physicians
5. Implement narcotic guidelines to discourage narcotic-seeking behavior
6. Track data on patients prescribed controlled substances
7. Track progress of the plan to make sure steps are working
Project Impact

• 98 hospitals now sharing emergency room information electronically

• 97 hospitals developed and use a standardized care plan format, providing consistent care no matter where a patient goes

• Expansion of care coordination efforts to all frequently utilizers, regardless of payer

• Instant notification of Primary Care Providers
Results

• Reduced ED Visits by 9.9%
• Reduced number of visits by frequent clients by 10.7%
• Reduced visits resulting in a narcotic prescription by 24%
• Reduced low-acuity visits by 14.2%
• High utilizers can generate multiple patient care plans, collaborative decision making as to management
  • Top 25 utilizers of EDs in WA have 1-7 clinical care guidelines
Results cont.

• Using ED metrics for non-critical access hospitals
  • ER is for Emergencies (adult and pediatric hospitals with emergency rooms only):
    – Percent of Patients with Five or More Visits to the Emergency Room at the same facility with a Care Guideline

• Using information on high risk groups/high utilizers to target interventions

• Adding claims data to enhance clinical information at the point of care
Targeted Education Campaign

ED Patient Education Pilot

• 8 WA state pediatric providers
• 50 total families
• Most common clinical problems:
  • Accidents (head injury, broken bones)
  • Ear infection/pain
  • Cough/Croup
  • Sore Throat
• Most common reasons families went to ED:
  • Felt they were in an emergency situation
  • Necessary emergency visit/referred to ED
  • Didn’t know about PCP’s clinic hours
• Most common times of day for ED use:
  • 6pm-9pm
  • 9pm-midnight
  • 9am to noon
Key to Successful State Initiatives

• Evidence-based
• Measurable
• Achievable benchmark, possible for everyone to succeed with commitment and hard work
• Clear positive outcomes
• Strong partnerships
Ongoing Barriers to Care

• Mental Health
  Among high utilizers of ER services, 80% have mental health issues

• Access to Dental Care
  Restoration of adult dental for Medicaid Patients

• Access to Primary Care
  Expanded medical health homes
Other Information

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Q&A
Thank You!

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