Care Coordination Series, Season 1, Episode 1: Super Utilizers

Speaker 1 (00:03):

And for today's session, we are featuring a key readmission strategy to address super utilizers who are, you know, individuals who are, who frequently are in ED, need of critical services. I am going to turn it over to our guest speakers for today. So this is, I'd like to introduce Dr. Casey Grover, Dr. Reb Close, and Thomas Muir for Montage Health.

Speaker 2 (00:27):

So, you know, kind of where we start, um, is with definitions and, you know, we focus on the emergency department is we're off in the front door to the hospital, and usually people come through the emergency department if they get readmitted. And, uh, Reb and I both practice in the emergency department, as you heard. And Thomas, his, his efforts are focused on the emergency department as well. And really there's kind of three tiers of how many visits a, uh, a person makes a year. And what that tends to be the result of, uh, the definition of a frequent user of the emergency department is four or more emergency departments, Sorry, four or more emergency department visits a year. And it's broken down, like I said, into three tiers. You have the four to 10 visits a year, and I called these the system failures. The, my insurance doesn't cover anywhere else.

Speaker 2 (01:15):

The, I don't have a primary care physician. The, uh, my clinic was closed. Those are kind of the, the, the system isn't easily accessible to the person. Now, next up we have the 10 to 20 ED visits a year, and these tend to be the chronically ill congestive heart failure, diabetes, uh, chronic kidney disease. These are people who have multiple medical problems and are chronically sick. And then finally, we move to the 20 or more emergency department visits for per year. And this is where we focus most of our work, which are people with complex psychosocial problems, uh, homelessness, severe mental illness, uh, substance use, or all three together. Um, and this is, I think where you'll see we've had the most benefit in reducing ED visits and then the utilization of hospital services and admissions to the hospital. So what do these high utilizers do to the healthcare system?

Speaker 2 (02:09):

And the simplest way to think of it is there's only so much time that providers have, and there's only so many resources. For example, we only have one CT scanner for my emergency department. And the, the literature across, um, you know, the National Library of Medicine would really suggest that super utilizers contribute to crowding both in the ED and the hospital. They increase healthcare costs. And so, you know, the next question is, well, just how big of a problem is this and what are the kind of numerical effects on the system? And unfortunately, I can't really quantify it because each of us works in an individual hospitalized system. Sorry, an individual hospital system. So, do you have hospitals around you that those super utilizers may kind of share their visits between? So, we looked at a hundred and, uh, 58 patients that were identified as high utilizers, and we put them in a case management program, which we can discuss a little bit later.

Speaker 2 (03:05):

And we basically said, Okay, we're gonna give them a plan. They get these resources when they come to the ED, or we're not gonna do this, or we're not gonna repeat this study. What happens to their utilization of the ED inpatient and testing before and after? Um, they go into this case management program. So, you can see here from their one year prior to being in the case management program to one year after the case management program, their ED visits dropped, their inpatient admissions dropped, CT dropped, ultrasound dropped, X-ray, even lab

testing dropped. We dropped our ED length of stay and inpatient length of stay by 40%. That's a total of 180 bed days almost. And we reduced charges from these visits by 41%. So, we saved basically 5 million charges for kind of recurrent problems that we weren't really kind of providing meaningful care for in the emergency department because we were constantly doing the same thing every visit.

Speaker 2 (04:02):

And you know, you might be saying, Okay, well that's one hospital, that's one system. What about when you really kind of expand the breadth of, of, of studying this? And this was a study from academic emergency medicine in 2017, and this was a review of 31 different studies looking at high utilizers. And they really found that any intervention to decrease frequent visits, uh, to the emergency department was effective. And it, and it varied. Um, you know, it could be case management, it might be, might be medication guidelines. Uh, but the one that was most studied and most effective was case management. And again, I'll read the conclusion. Interventions targeting ED frequent users appear to decrease ED visits and may improve stable housing. And you might be asking, are the effects of case management durable? And the answer is yes. This was another study we did.

Speaker 2 (04:55):

We've had, as I see the longest kind of, uh, cohort of case management patients of anywhere. And we've published it. So we had, uh, let's see, we had, um, 199 patients that had been in case management for greater than six years. Most of these studies look at like a one year or a three year or six months. We looked at eight years. And what you can see is the visits per year dropped from 16 in the first year down to seven in the second year, and then it dropped to about three or two a year and it stayed there. And don't forget, the definition of frequent use of the emergency department is four visits a year. So we basically dropped these people from high utilizers to normal utilizers, and it's stayed. And that's probably multifactorial, right? It's not just our case management. Their condition could have gotten better, it could be regression to the mean, but if you want to know, does case management work on the long term? The answer is yes.

Speaker 3 (05:51):

So I think the question that I get asked the most is

Speaker 2 (05:54):

How do you, how do

Speaker 3 (05:55):

you start this? Where does it come from? And our program in particular was built out of need. And so as truly, it was kind of a night shift with one of my, um, evening nurses. And we were talking about the patients that were recurrently coming to the ER and we were providing absolutely no value, um, for that ER visit. And so that charge nurse and myself, we got together with our pharmacy, our chemical dependency specialist, our behavioral health teammates. Um, we pulled in our social work team as we built it because it was so critical to have their input. And every person in that room has, it's that multi-fact, multifactor, multidisciplinary team that is really important. And if you ask, you know, if you bring up a name, if they say, "Oh yeah, re was in the ER again," every person in that room has a reason that they are able to contribute to that care.

Speaker 3 (06:50):

And so really it is scheduling a meeting, setting some time and pulling the patient that everyone tends to know because they're seeing quite a bit. And everyone realizes that we're not, not impacting their health in a positive way by recurrent visits to the ER. And we talk about where can we provide better care, what is lacking for that

particular patient? How can we get them better, um, better managed in the system? And and truly it's just starting those conversations. And this program started as Casey mentioned, back in, uh, 2006 and we just had our monthly meeting last week. We meet every single month. We bring up our, um, computer software, um, our, um, EHR, EHR pulls up the highest, utilize the higher utilizers. It shows those as a list. Any patient, um, can be referred by someone in the healthcare system. So, any of my nurses can refer my physicians, anybody can refer someone. And we discuss these every single month with this multidisciplinary team.

Speaker 4 (07:54):

So the limitations, uh, that we've experienced or these high utilizers, they need more than just a, a friendly phone call from a, you know, well intentioned nurse or social worker. Um, you know, we have individuals that are suffering from addiction and mental health issues and complicated by mounting medical issues and often complicated by living in poverty or, you know, un being unsheltered, attempts of to coordinate care with these folks to, you know, been taking place for many years without success. And for some reason we, uh, you know, we kept sticking to only this approach, but for the most part, many of, many of these individuals, um, that, that, you know, that were, we're encountering. Um, and as mentioned were these the same folks that, that all these agencies, um, you know, first responders and social services agencies, the other hospitals, they, they all know these, these individuals, um, just as, as we do.

Speaker 4 (08:48):

So instead of trying to address, uh, these, these folks on our own, we, we've sought out help from these, these agencies, these other agencies to build, um, you know, to coordinate and to, um, and, uh, have a, have a collaboration. Um, you know, we're all working to help the same people, but we weren't communicating. So, um, you know, building, building these bridges to these other agencies and in, uh, addressing, addressing these, these folks together is, um, is, is vital. You know, when possible we, we go to their homes, uh, their or their encampment and favorite coffee shop or their bus stop, um, you know, just showing your face and letting them know that we're available and, and we care about their outcome. Um, you know, in meeting someone on their turf, uh, instead of our turf in the, in the emergency department, uh, where we have all the rules, we have all the power, um, it puts, it puts folks at ease.

Speaker 4 (09:37):

You know, um, I, um, I've been told many times from, from people that they can't believe someone from the ED showed up that they cared enough to show up, that they showed up at the bus stop, you know, or they showed up at their encampment at six in the morning, just taking the time to get to know these individuals and learning about their life and taking the time to build the rapport and finding out what is going on and, and, you know, hold their hand long enough for them to get on their feet and moving forward. You know, a lot of our folks, um, they might not have a phone. We've had people who have never had a cell phone before. The first cell phone they ever had was, was one that we purchased for them. Um, maybe they don't have transportation. Maybe they don't know how to use the bus.

Speaker 4 (10:14):

Um, you know, we're telling 'em, just get to this appointment. Well, I mean, you know, sometimes it takes, you know, for, for a lot of these folks, you know, they need more than just being, you know, given a, an appointment card and, and, uh, told, you know, to make sure they get to their appointment. Um, um, maybe they're too depressed or anxious to get anything done. Yeah, it's a delicate balance between enabling and empowering. Um, you know, but when you get them working as hard as you are to address these issues, then you're doing things right. The answer's not all about funding either. You can't simply throw money at these situations, but, you know,

it helps. But, um, um, you know, we, we, we need, you know, for the most part, we just need to help build people back up. So, and so it's a, it's a combination of things, community

Speaker 3 (10:55):

Partners that we brought to the table, not necessarily in 2006, but as we expanded some of the information we were using with our super utilizers and built that towards a, basically a safe prescribing or a safe medication initiative. And, and the point of this is there are a lot of people in the community that have a vested interest in the community. And so, you know, if you look here, we have our pharmacy represented. Um, we literally, I, I had a patient yesterday that was unable to get their meds. And so we figured out how to have that pharmacy deliver meds for the patient. Our local police department came up with a community action team and they brought additional partners that weren't even on the table. Um, Thomas, Thomas is central to this team, and we do, we not only within the walls of the hospital, but we've also now taken it to the street.

Speaker 3 (11:50):

And this is literally our police department led, um, similar initiatives saying, Okay, we've called on, you know, re three times this week, we've tried our interventions, Hey, everybody else on the team, how can we assist? And it just means because those lines of communication have been open that we can continue and we can build and expand on them. And so we do, we have a multidisciplinary outreach team, um, and Thomas is centered to this by focusing on our homeless issues and how we bring services to our community, so it becomes even bigger because it needs to be, and if you already have the relationships or at least the communication open, you can make that happen as well.

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