INSTITUTE FOR BEHAVIORAL HEALTHCARE IMPROVEMENT

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Webinar Series on Innovation and Re-Design of Systems of Behavioral Health Care
March 23, 2011
3:00 PM
With Roger Resar, MD of IHI

IBHI

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Objectives

Participants will be able to

- describe how ED visit categorizations of avoidable, non-emergent, and non-urgent impact approaches to improvement;
- discuss the importance of the patient perspective in determining which ED visits may be avoidable;
- explain the importance of both non-medical and medical solutions in reducing ED visits and in working with community coalitions.

Fact or Fiction?

- All emergent ED visits are necessary.
- Primary care accessibility is a major contributor to avoidable ED visits.
- Lack of or inadequate health insurance is a major reason for recent increases in ED utilization.
- Major cost savings can result from focusing on “frequent fliers”.

The US Perspective

- Number of emergency room visits increased 20% in a decade (96 to 115 million)
- Avoidable visits increased from 9.7% to 13.9%
- 50% of all visits are non-emergent or avoidable
- Cost for an ED visit is 2 to 5 times greater than receiving the same care in alternative settings

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Necessary Visits

- Determination of necessity:
  - Retrospective
  - Made by providers and payors
  - No patient input
  - Typically only considers alternative medical interventions in determining degrees of "avoidable" and "emergent"
    - Social and health/wellness issues excluded

ED Use Classification

(New York University)

- **Non-emergent** - The patient's initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical care was not required within 12 hours;
- **Emergent/Primary Care Treatable** - Based on information in the record, treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting. The complaint did not require continuous observation, and no procedures were performed or resources used that are not available in a primary care setting (e.g., CAT scan or certain lab tests);
- **Emergent - ED Care Needed - Preventable/Avoidable** - Emergency department care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.); and
- **Emergent - ED Care Needed - Not Preventable/Avoidable** - Emergency department care was required and ambulatory care treatment could not have prevented the condition (e.g., trauma, appendicitis, myocardial infarction, etc.).

Case Study

Young, single mother with an infant who will not stop crying at 3:00 AM. With no family or other support, in desperation she brings the infant to the ED.

How would this visit be classified?

Was this an *avoidable visit?*

- Were there alternative solutions for her?
- Did she know of them?
- Were they accessible to her?

She deemed the ED was the best and perhaps the *only* choice at the time – to her it was unavoidable.

Fact or Fiction?

Primary care accessibility is a major contributor to avoidable ED visits.

Lack of or inadequate health insurance is a major reason for recent increases in ED utilization.

Major cost savings can result from focusing on “frequent fliers”.

Facts

- Increased utilization of the ED appears across *all* payer categories and includes significant numbers of patients with insurance or an assigned primary care physician.
- Similar increases in ED visits in other Western countries, such as the United Kingdom, where primary care is routinely provided and available to all, suggest that the issue is more complicated.

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Charging Back To GPs The Costs Of Inappropriate Use Of A&E Services By Their Patients Is An Unworkable Idea, Says GP Leader, UK

DH figures show that in 2006-07 there were 3.7 million patient visits to walk-in centers and minor injury units which did not result in admission. Of those visits, 1.7 million did not result in any treatment, yet still cost £58m

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Considerations

- Current financial reimbursement structures create an incentive for hospitals to treat patients in the ED:
  - Significant source for use of internal imaging and laboratory services.
- Hospital-initiated efforts to reduce ED utilization tend to focus on visits that are financially undesirable.

More hospitals begin advertising wait times for their ERs, emphasizing that the target patients aren't the true emergency cases

Modern Healthcare
By Joe Carlson
Posted: November 1, 2010 - 12:01 am ET

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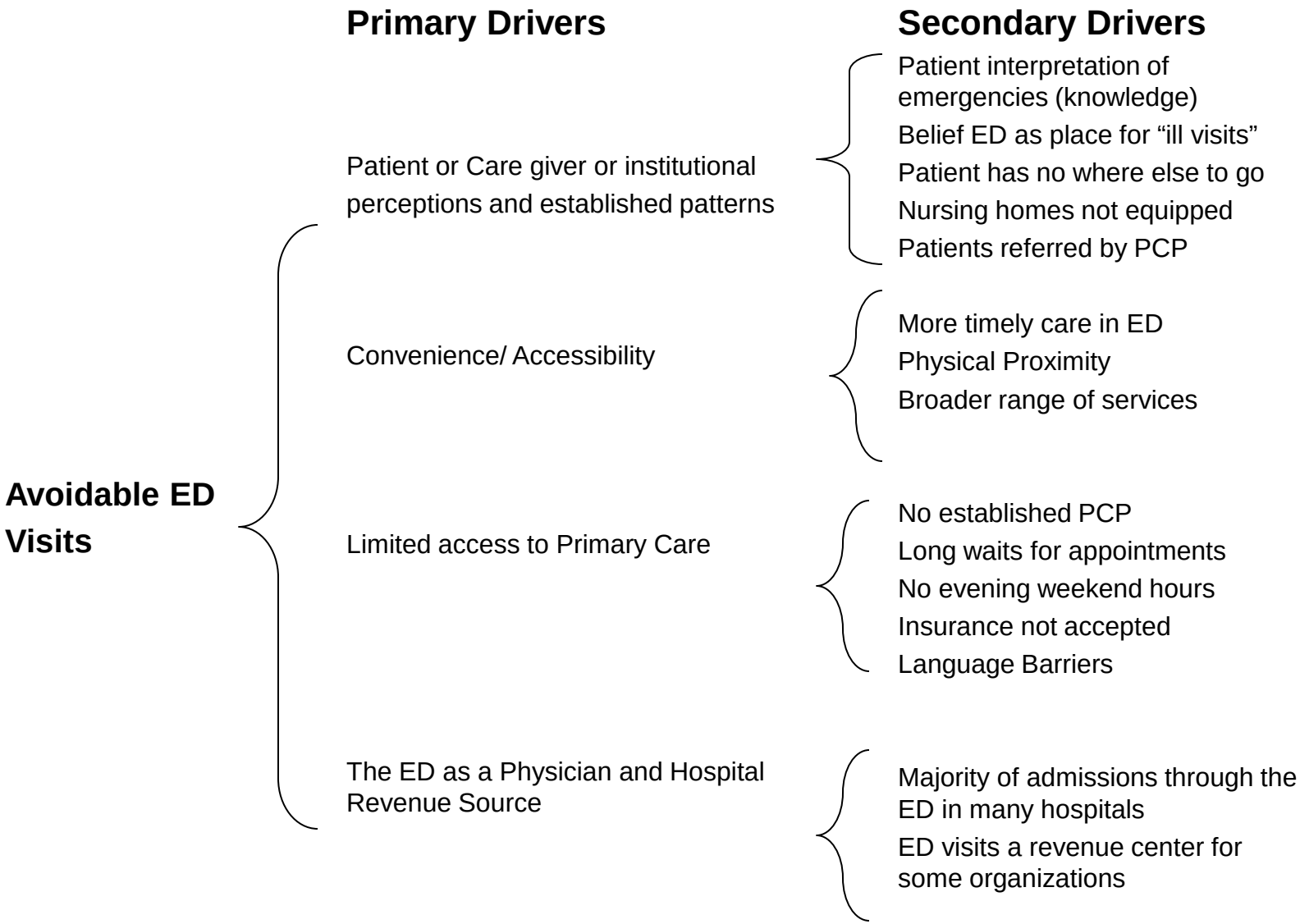
IHI Initial Work (2008)

- Partnership with New England Healthcare Institute:
  - Extensive literature review
  - Interviews with key individuals and organizations
- Internal Research & Development:
  - Driver diagram connected to interviews allowing a better understanding of the topic
  - Strategies accumulated and connected with literature
  - Political considerations and business case issues integrated with strategies

Avoidable ED Visits Driver Diagram



The IHI Prototype Initiative

- May 2009 – January 2010
- Eight US and two Canadian teams
- High-level coalitions included:
  - a state Medicaid agency
  - several small Independent Practice Associations
  - health plans
  - existing community coalitions

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Initial Learning

- Avoidable visits concept balances the problem from the point of view of the patient and the care system.
- Political considerations need to be connected with specific segments of the population (one size does not fit all).
- The business case will be segment dependent and most likely be at the population level.
- Focus on reduction of avoidable ED use (i.e. prior to arrival) and not ED crowding, management or patient flow (after arrival)

Coalitions

- Temporary alliances of distinct parties, persons, or states for joint action – should include any relevant community resources, whether medical or not.
- Such coalitions are needed when a single organization cannot achieve the necessary changes or improvements alone and there are compelling reasons for other organizations to participate in change efforts.

Key Concepts for Prototyping Initiative

- Start with a high-level coalition of community organizations.
- Identify a high-volume patient stream that could benefit from interventions to reduce ED visits.
- Design specific interventions for each patient stream, based on patient interviews – including non-medical resources.
- Enhance the community coalition by adding members who can provide or support specific interventions for the selected patient stream.
- Test strategies using the Model for Improvement with emphasis on rapid-cycle testing.

IHI Framework

Mission	High Level Coalitions	Identification of patient streams	Refined Coalitions based on Strategies	Reducing Avoidable ED Visits
High level population groupings	Necessary for funding grants and business plans	Data collection on patients (Uncover key defects in the healthcare/community resources)	Strategies based on data collection may require additional partners	Refined coalition establishes aims, measures initial design, concepts

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Patient Streams

- A reasonably homogeneous population with
  - enough ED visit volume to warrant intervention
  - characteristics that allow for easy identification for measurement
- Examples of patient streams include:
  - school-age children with asthma
  - adults with diabetes,
  - dialysis patients
  - cancer patients with pain

Patient Interviews

Strategy: interview 5 patients from the stream to learn from a few and apply the knowledge to a larger population.

- When did you first start having problems?
- When did you realize you might need medical attention?
- When did you decide to go to the ED?

Lessons from Interviews

- Decision to seek care in the ED often results from symptoms or circumstances that develop over time.
- Issues were discovered that had not been previously known, such as
  - retail pharmacists directing people to the ED;
  - patients reporting that their symptoms had started days earlier and they had taken no action.

Prototyping Lessons

- High-level coalitions need to function as overall management teams for multiple patient streams.
- Patient streams need to be reasonably homogeneous to attract community resources.
- Patient streams need significant volume and the ability to be measured to sustain the improvement work.
- Patient interviews were vital in designing strategies.
- Improvement teams should comprise both medical and non-medical participants to achieve the richness and robustness needed in the improvement strategies.
- Small tests of change are preferable to complex designs.

Perhaps the most critical result of the prototyping work is that *the dialogue has changed*.

Conclusions

- Most if not all ED visits are potentially avoidable.
- Community coalitions appear to be best aligned to work on reducing ED visits because a population focus is more likely to integrate the medical and social solutions.
- Sustainable reductions in avoidable ED visits will only occur when the patient perspective is understood.

Policy Implications

1- Health and health care needs cannot and should not depend on the ED as a long-term solution, as this lacks continuity and ignores needed social solutions.

2- The time and expense of implementing medical solutions without including social considerations are wasteful. Even when such interventions achieve some success, they are not useful in sustaining long-term improvements because the precise causes for ED visits have been neither investigated nor addressed.

Policy Implications

3- Focusing on underinsured and uninsured patients with high-frequency, high-cost ED visits supports the business case for hospitals; however, without working on other patient segments (streams) meaningful reductions in visits will not occur.

4- Funding community coalitions makes sense because this aligns incentives around provision of both medical and social solutions. However, this work should not be funded unless the patient perspective is clearly integrated into the proposal.

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Publication

Rethinking Emergency Department Visits
Roger K. Resar, MD
Frances A. Griffin, MPA, RRT

Journal of Ambulatory Care Management
Vol. 33, No. 4, pp. 290–295
October-December 2010
http://www.nursingcenter.com/library/JournalArticle.asp?Article_ID=1064639

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Bringing Rethinking to Behavioral Health

- Avoiding ED use would be a great benefit for BH
- Behavioral Health clients often have few choices
- Better systems of care require thinking differently
- Listening to the consumer is the best place to start
- The IHI project opened a new approach
- Many behavioral ED visits can be avoided
- Central East Local Health Improvement Network (Ontario Canada) recognized the opportunity

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Background

- 8% to 12% of ED visits are behavioral health diagnosis
- Up to 50% have behavioral health issue
- Few efforts have been made to reduce ED visits
- Behavioral health consumers create issues for EDs due to lack of understanding and lack of care practices

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Changing the System

- Community organization can change practice
- Steps to reducing ED use
  - Identify likely types of consumers to serve
  - Develop community connections
  - Work with hospitals to identify consumers
  - Educate community providers
  - Establish police and other community knowledge and support

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Case Study CELHIN

- Central East Local Health Improvement Network Ontario part of IHI Prototyping
  - Created a broad team of community and hospital staff
  - Interviewed consumers
  - Identified community providers as alternatives
  - Built community network
  - Worked to divert potential ED use
  - Measure unplanned readmissions w/in 30 days

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Key Decisions for CELHIN

- “Jumping right in” approach (instead of study it to death)
- Try it - on a small scale- rather than expect to get major new funding to make it possible
- Include consumers as full partners in the team
- Developed a team approach
- Create a learning environment
- Include funders as facilitators of improvement
- Use small tests of change to build understanding and acceptance

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Conclusions

- Most behavioral health ED visits are a result of a breakdown in community systems of care.
- Diversion requires planning and action beyond the usual level of cooperation
- The IHI prototype approach can work well but requires a dedicated supporting network
- Directly involving the consumer is crucial

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Conclusions -continued

- Some key service providers are used to turning consumers over to the ED
- Breaking this expectation is a challenge
- Funders should be key participants in supporting the systems redesign
- Community coalitions are essential in most places
- Other lessons from the project are also important

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Perhaps the most critical result of the prototyping work is that *the dialogue has changed*.

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Questions and Comments

Raise a hand or enter a question or comment in chat.

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About IBHI: IBHI is a charitable organization formed in 2006 dedicated exclusively to improving the quality and outcome of mental and substance use (behavioral) health care.

Our **AIM: Create a national learning organization and movement to invite organizations out of their silos. Bring people together to translate a passion for quality improvement into sustained action that dramatically improves behavioral health care outcomes.**

To learn more about translating a passion for quality Improvement check out our web page www.ibhi.net IBHI is a national organization: Home Office – Albany New York

COMING IBHI Webinar Programs

- **April 6, 2011, 3:00 PM - 4:00 PM EDT - Using Peer Counselors in the ED to improve Patient and Staff experience - Steve Miccio, Executive Director, People, Inc.** Steve Miccio and his organization are devoted to assuring that the patient and family's voice is effectively heard and recognized by the behavioral healthcare system. He will share innovations in the use of peer counselors to make ED care more effective, hospital diversion programs and ways to sustain relationships to avoid acute care.

- **April 20, 2011**A **3:00 PM - 4:00 PM EDT**- Adapting and Implementing New Strategies for Patient Centered Care - Transforming Care where we meet our clients in Behavioral Health, Alden (Joe) Doolittle and Julie Kelly, MSW, MPH Program Chief, Mental Heath Psychiatry Contra Costa Regional Medical Center, Martinez, CA.

  A multi-faceted method, involving QI, Re-design, "lean" methods and successful approaches to engage front-line staff to make and hold major improvements in care will be reviewed. A case study from the Contra Costa Medical Center, in Northern California will be described involving major system re-design within the hospital and with community resources. Opportunities to apply the approach in collaborative learning. Alden (Joe) Doolittle is Co-Director of IBHI, and brings solid experience in Quality Management and Consulting to his role. He was the Improvement Advisor for IBHI's recent Emergency Room Collaborative. Julie Kelly, MSW, MPH, and was a 2010 NAPH Fellow.

- **Hold the Date: Our third webinar series, Innovation and Re-Design to More Fully Integrate Primary Care and Behavioral Health, begins May 25, 2011.**

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