Parkland

High Utilizer Program

Lisa Cross, Director of Post-Acute Services
Sheryl Mathew, Manager of Post-Acute Services
Nicole Bernard, Complex Case Social Worker

Program Goals

Program Goals

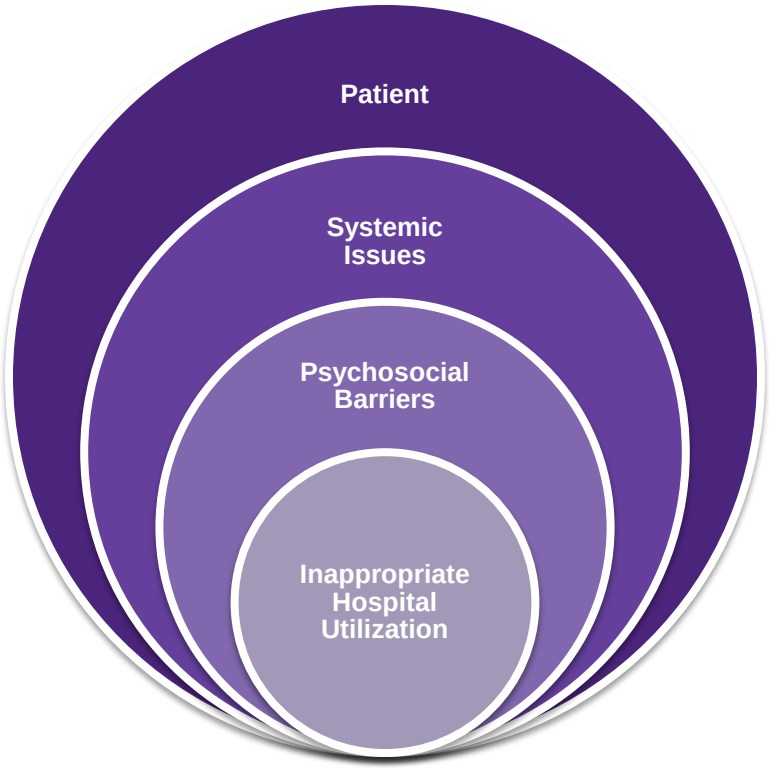
- Identify and begin implementing processes to intervene with patients who are identified as high utilizers of the ESD and provide appropriate resources
- Focus on long-term community interventions to decrease unnecessary visits to the ESD

High Utilizer Definition

- A high utilizer complex case can be identified as a patient who has greater than 10 emergency room encounters in 30 days for non-emergent needs

Program Tools

- High Utilizer – Complex Case Committee
- Complex Care Flag
- Post-Acute Follow-Up
- Community Coordination



Program Tools
High Utilizer – Complex Case Committee

- **Members**
  - Care Management/Post-Acute Services
  - Community Oriented Primary Care (COPC)
  - Dallas County Hospital Police Department
  - ESD Nursing
  - ESD Physicians
  - Ethics
  - Institutional Risk Management
  - Legal Affairs
  - Psychiatry
  - Parkland Financial Services
  - Homeless Outreach Medical Services (HOMES)

- **Bimonthly discussion of patient and system barriers resulting in creation of innovative interventions to create positive patient and system outcomes**

Program Tools
Complex Care Flag

- **The complex care flag has been created to ensure that the patients using the ESD/UCC at high volumes for non-emergent needs are flagged**

- **Real-time, standardized, interventions across disciplines**

Fall Risk

All Patient Flags

Flag Type	Author	Status
Fall Risk	[redacted]	Active
Fall Risk		
Complex Care	Abraham, Sheryl Rachel, LCSW	Active

Complex Care Plan

This plan is to help ensure that this patient, who has been flagged as complex due to High ESD utilization, receives a unified approach to care by all providers:

Physician: No specific intervention at this time

Nursing: No specific intervention at this time

Social Work: Re-direct patient's non-emergent psychosocial needs to Amelia Court HIV CM team.

Background Information:The patient is chronically homeless. The HIV CM team is working with Alexis of ASD for long-term housing at the Hillcrest House (ASD). referred to the Peer Recovery Navigator team to address his chronic alcohol abuse.

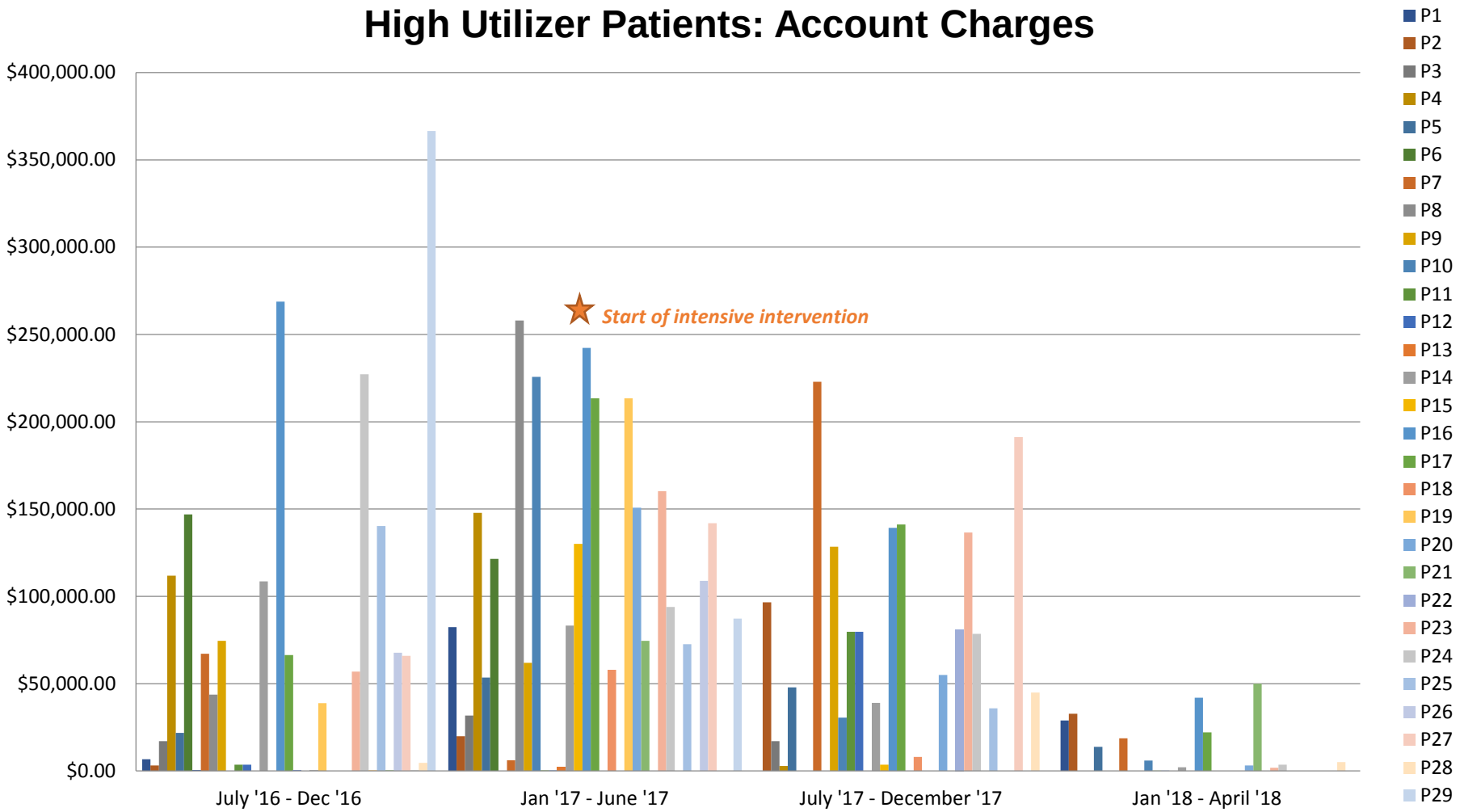
Post-Acute Follow-Up

- Face-to-face visits with patients who have transitioned to the community
- Warm handoff to partner community agencies

Community Collaboration

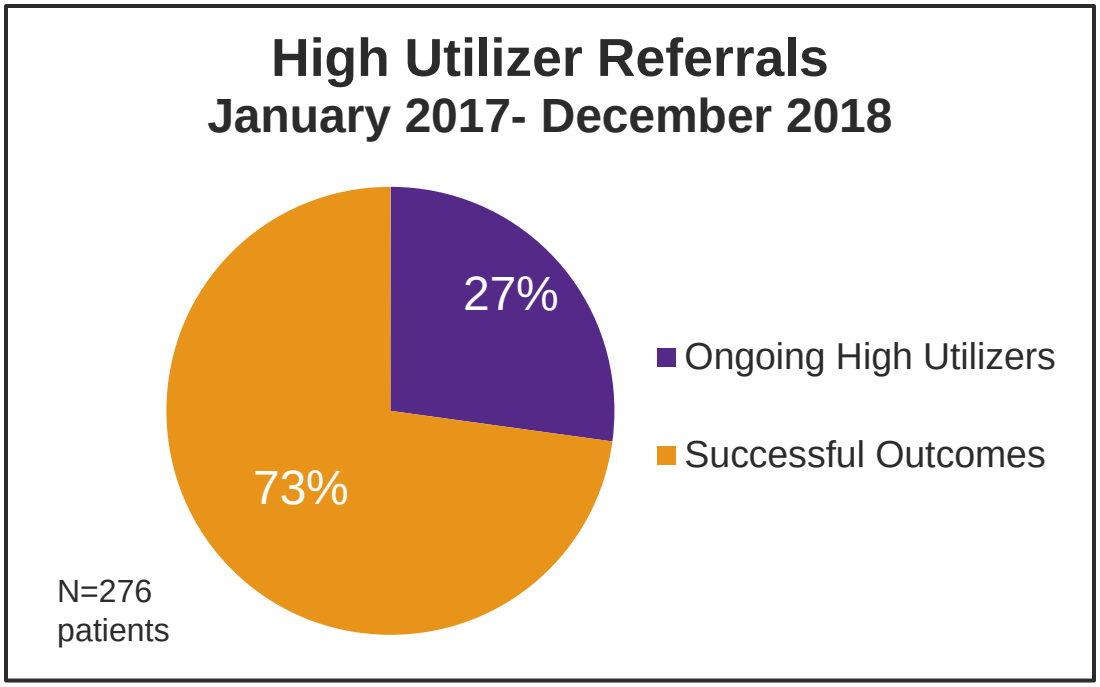
- Participation in community coalitions
- Relationship building and coordination with post-acute providers
- Goal is to provide uniform care at each portal of service access

Initial Outcomes



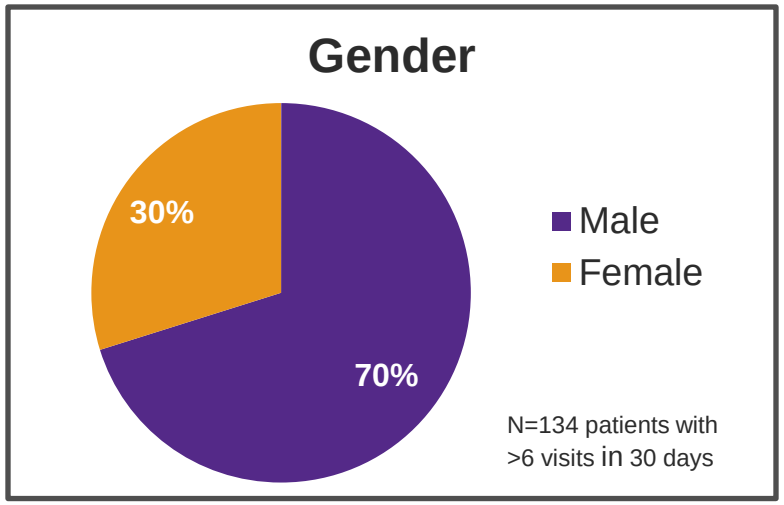
Overall Program Success

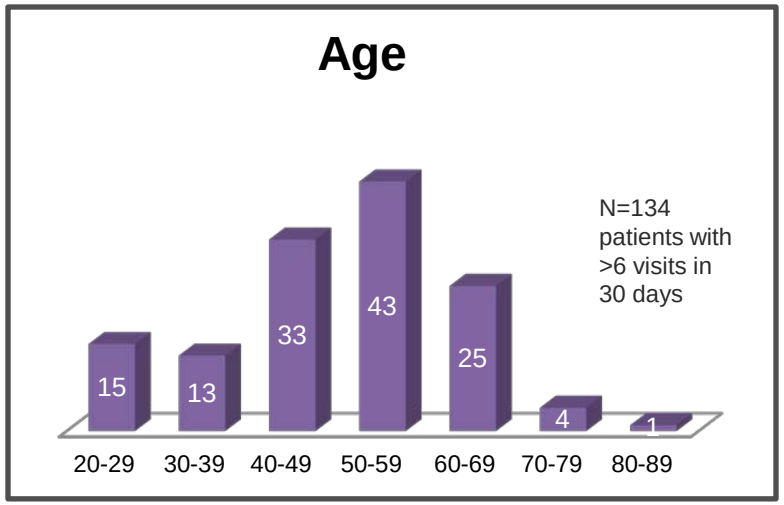
- **Total high utilizer referrals: 276**
- **Successful outcomes: 201**
  - **Patients with decreased utilization and successfully transitioned to the community for services to address psychosocial needs**
- **Ongoing referrals: 75**



Changing How We Look At Data

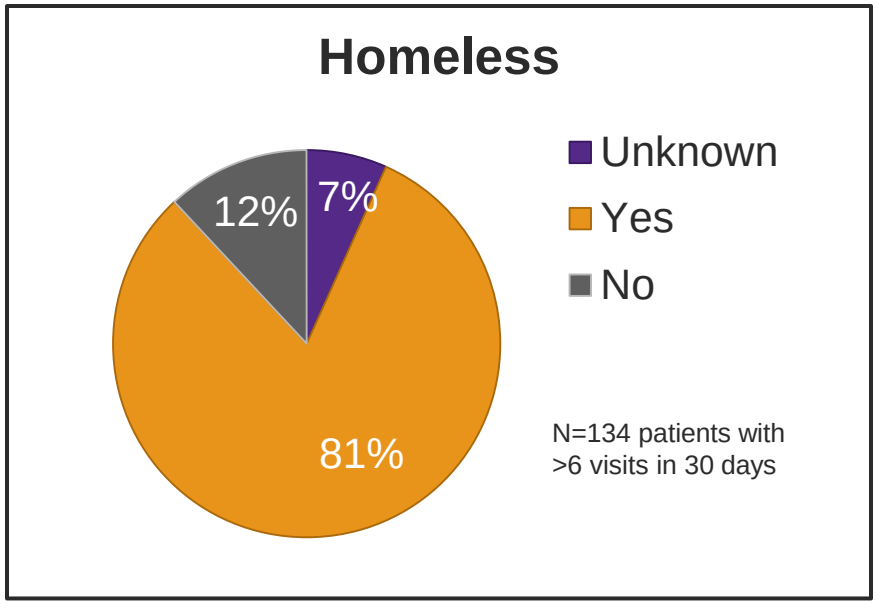
- Data excludes those whose primary presentation is for dialysis or psychiatric concerns
- High utilizer definition changed to those with 6 or more ED visits within last 30 days
- Analysis of high utilizer demographic data





Interventions

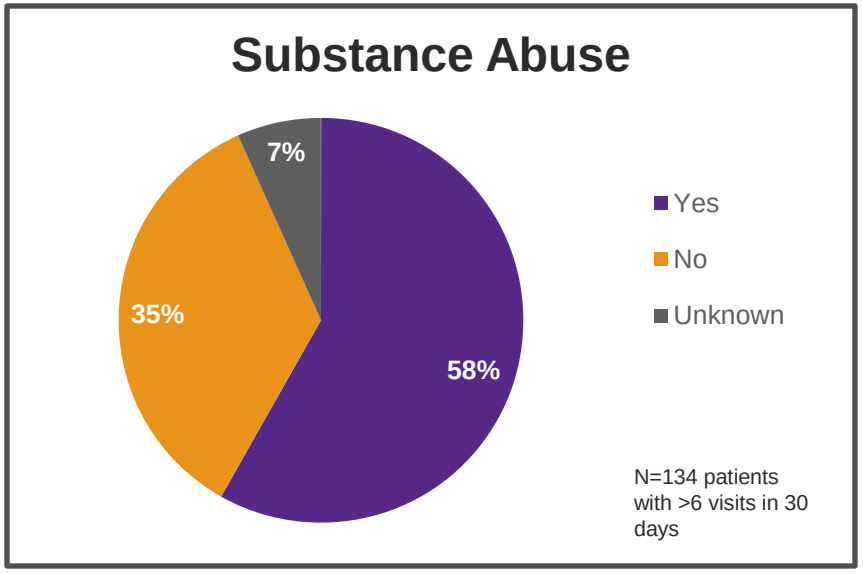
- **Lead bi-monthly huddles with care management staff interacting with high utilizers (ESD Homeless Social Workers, HOMES SW's, Lobby SW, Peer Recovery Navigators)**
- **Collaborate with community partners to determine if patient is utilizing community resources**

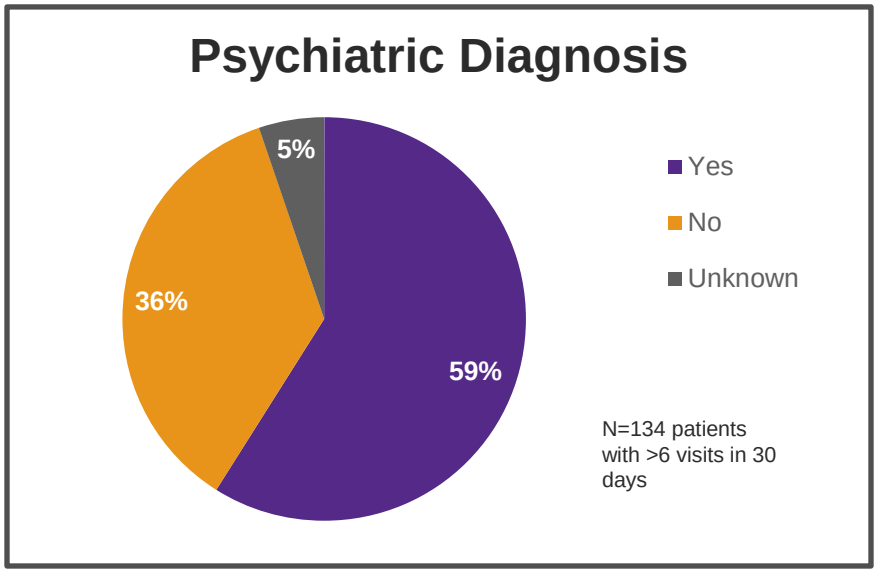


Psychiatric and Substance Abuse

Interventions

- Collaboration with psychiatric ESD and Mobile Crisis Outreach Team
- Coordination with community partners to determine patient utilization of community services
    - North Texas Behavioral Health Authority (NTBHA)
    - Metrocare
    - Substance abuse rehabilitation centers
- Referrals placed to Parkland peer recovery navigators

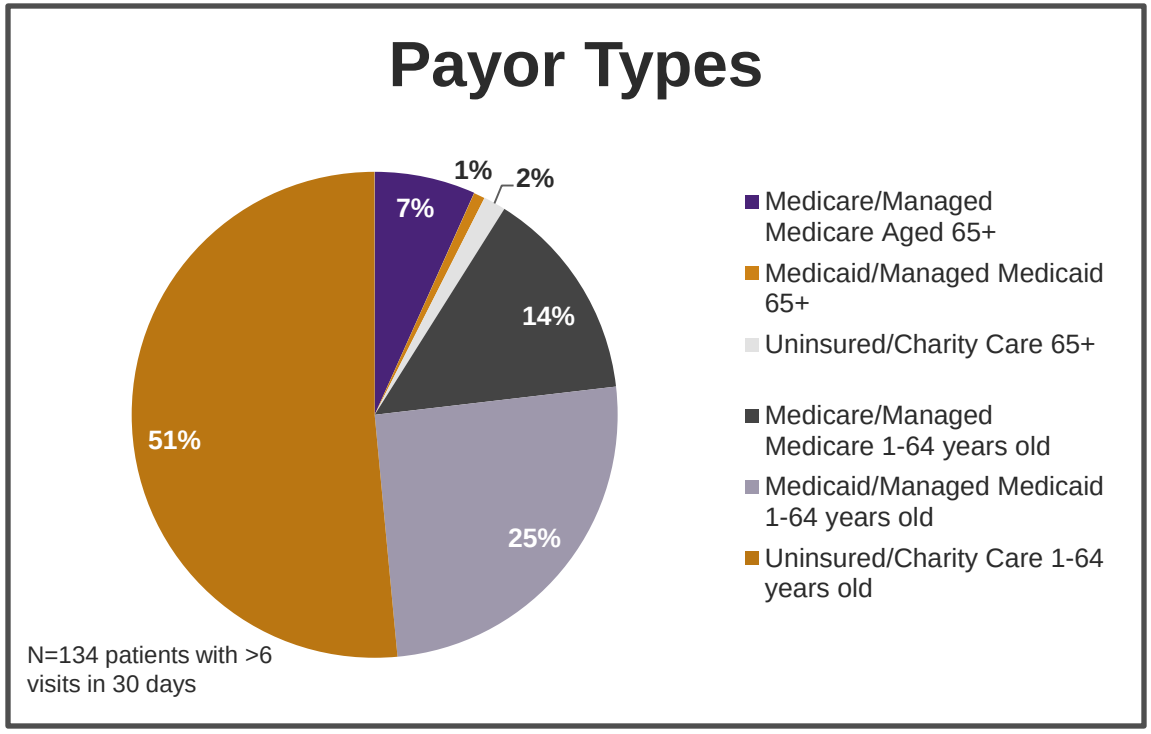




Payor Source

Interventions

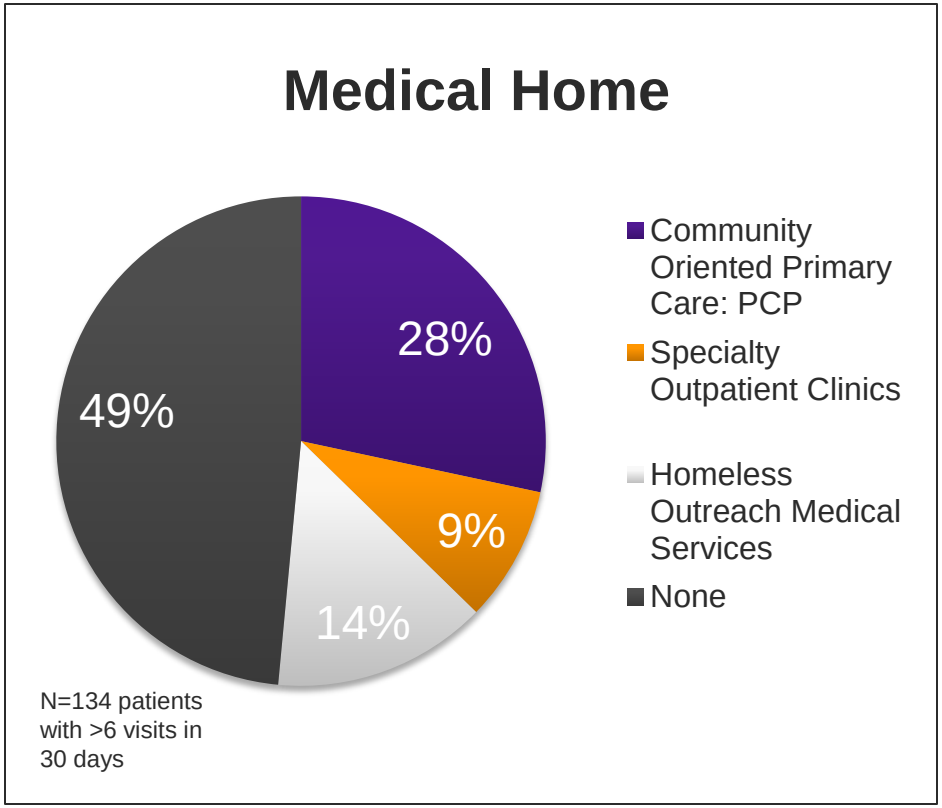
- Connecting those with Medicaid to their insurance case manager
- Refer patient to Parkland Financial Services to screen for eligible benefits (SSDI, Medicaid/Medicaid)



Medical Home

Interventions

- For those identified as connected with medical home in COPCs, refer to Value Based Care
- For those identified with medical home in specialty outpatient clinic, connect with clinic SW
- For those who utilize HOMES clinic, refer to Social Workers on mobile unit
- Peer Navigators attempt to engage patients in the community at shelter of origin
- For those identified with no medical home
  - Acute Response Clinic
  - Referrals to COPC
  - Partnership with City Square/Baylor Community PCP Clinic



Success Story – Ms. R

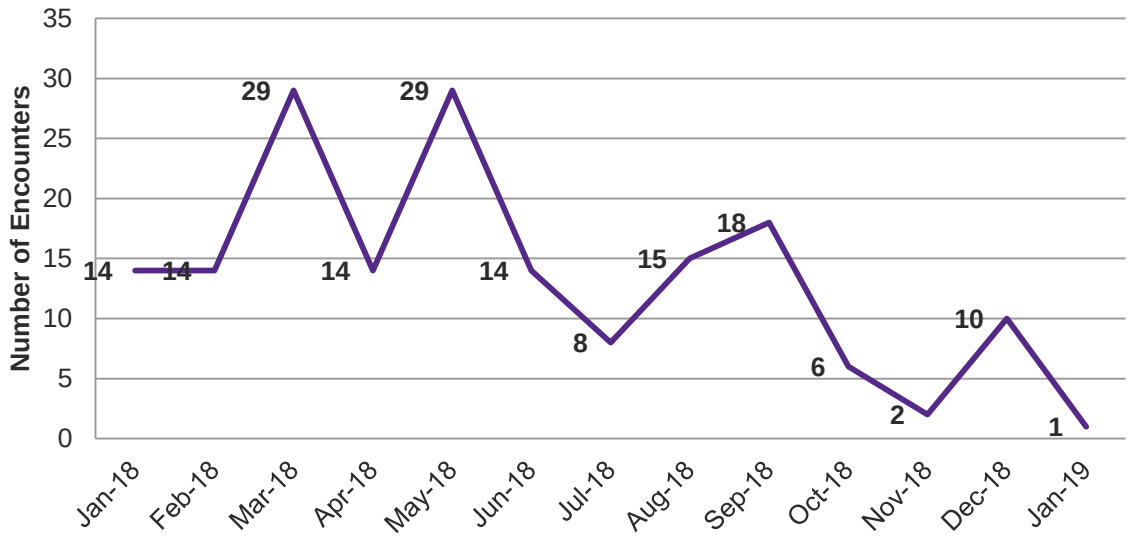
Medical/Psychiatric History

- 54 year old female
- Squamous cell carcinoma (in remission)
- Fibromyalgia
- Hypertension
- Bipolar disorder

Psychosocial Barriers

- Homeless
- Lack of social support
- Uninsured with no income
- Non-compliant with social work referrals
- Frequent lobby utilizer

ESD Encounters January 2018-January 2019



Intervention

- Care coordination across departments (main ESD; psychiatric ESD; care management/post-acute services)
- Referred and connected to Parkland COPC and established care with COPC social worker via Value-Based Care program
- Secondary gain reduced via split flow process in ESD
- Faith Health Initiative referral placed
- Secured a permanent placement for the patient at the Salvation Army homeless shelter
- Referred and connected with City Square case manager
- Referred to PFS for assistance with SSDI filing

Patient Outcome

- Patient established connections with multiple social service agencies in community and is obtaining assistance with permanent housing options
- Patient continues to utilize COPC clinic for medical needs and has continued engagement with COPC social worker via Value Based Care referral

Success Story – Mr. W

Medical/Psychiatric History

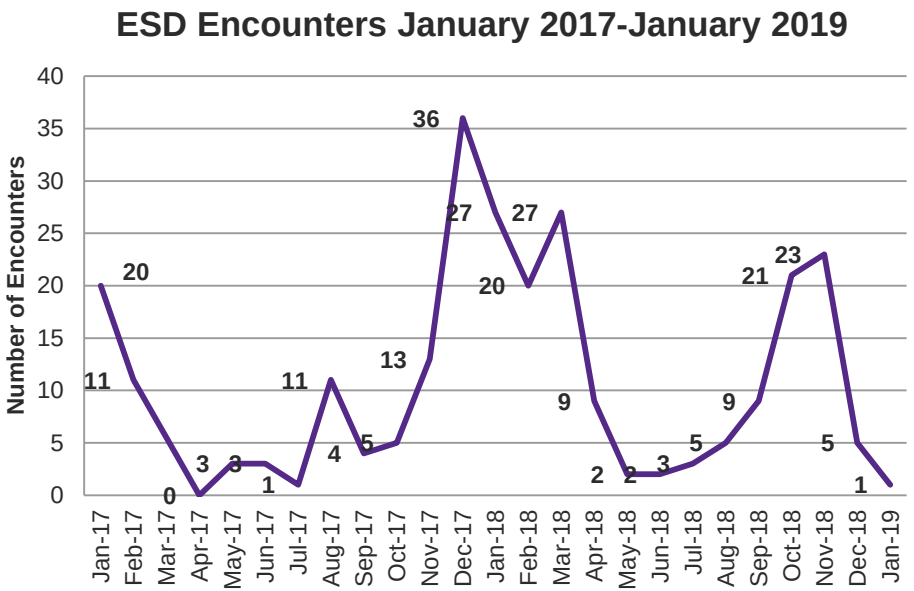
- 47 year old male
- Arthritis
- Schizophrenia

Psychosocial Barriers

- Greater than 2 year utilizer of ESD services
- Chronically homeless after relocating from Massachusetts
- Inability to identify/locate next of kin
- Capacity concerns
- Loss of funding and income

Intervention

- Care coordination across departments (main ESD; psychiatric ESD; care management/post-acute team) during each encounter
- Multiple attempts to engage patient with Salvation Army
- Referred to PFS for social security disability application assistance
- Parkland neurocognitive clinic referral secured and testing subsequently was conducted, resulting in a determination that patient does not have capacity



Patient Outcome

- Patient placed in a long-term care facility as SSI-pending
- Next of kin located and patient connected with family in Massachusetts
- Post-acute social worker continues to attempt family reunification while SSDI determination is pending

Barriers

- **Transient nature of patient population**
- **Access to community resources**
  - Affordable housing
  - Lack of emergency shelter beds
  - Mental health resources

Moving Forward

- **Further explore:**
  - Social determinants of health
  - Socially driven vs medically driven ESD encounters
  - Inpatient admissions, readmissions, and medical complexity of those identified as high utilizers
  - Redefining successful outcomes
- **Continued collaboration with DFW community partners**

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Laissez le bon ton roulet!

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Losing Your Mojo

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Losing Your Mojo

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Losing Your Mojo

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Losing Your Mojo

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Creating A Village, Finding Our Mojo

Lisa Cross, Director
Post-Acute Services

February 26, 2019

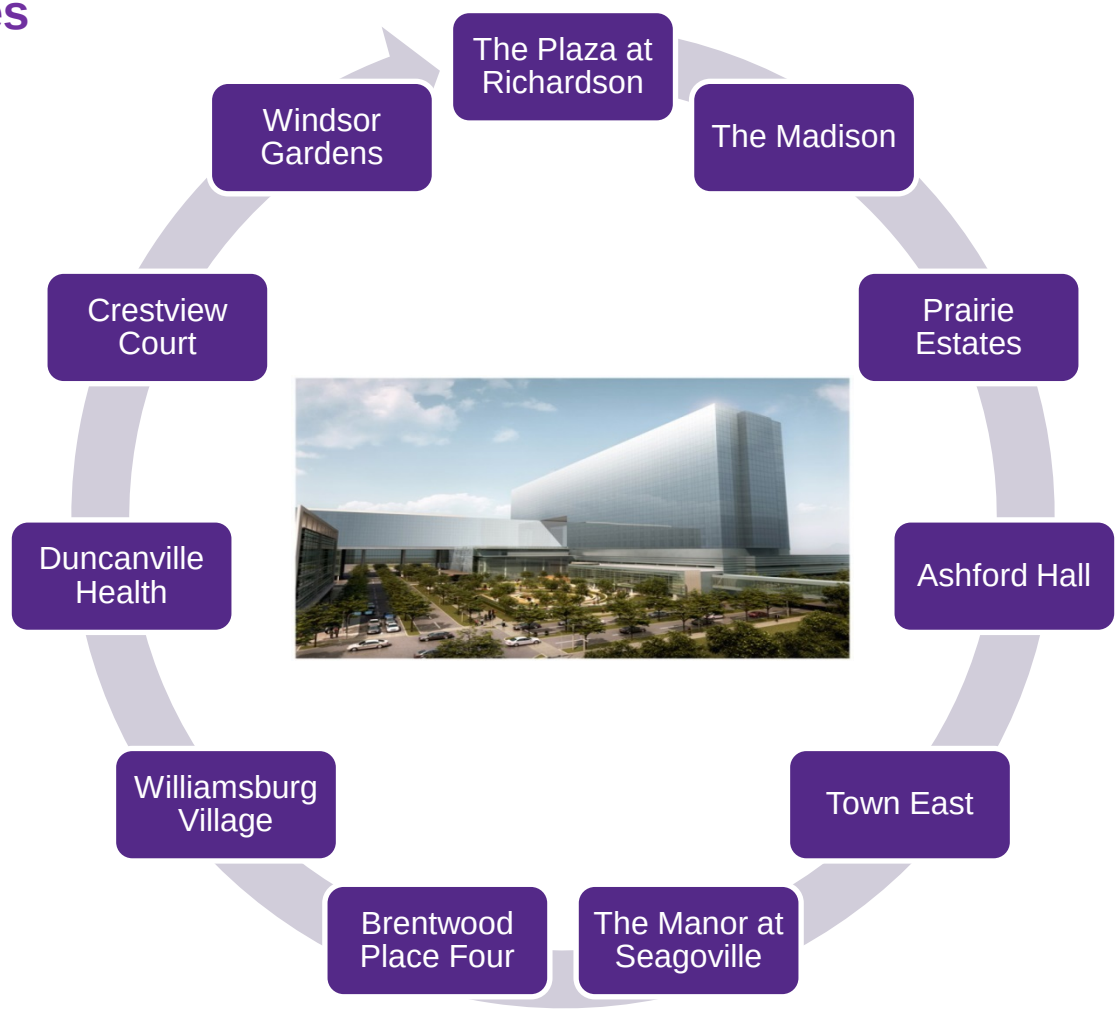
This is how the story begins …

- Sep 2015 – Minimum Payment Amounts Program (MPAP)
- Sep 2015 – Complex Cases
- Dec 2016 – Outpatient Clinics
- Jan 2017 – High Utilizer Program
- Apr 2017 – Nursing Home Expansion

Minimum Payment Amounts Program (MPAP)

- **Minimum Payments Amounts Program (MPAP) is a program which will provide a supplemental payment to eligible Nursing Facilities (NFs)**
- **Encourage linkages between hospitals and NFs to enable better continuity of care as recipients move between hospitals and NFs**
- **If approved, non-state government-owned nursing facilities could receive supplemental payments**
  - Payments based on the difference between the amount paid through fee-for-service Medicaid and the amount Medicare would have paid for those same services
- **A non-state government-owned entity is defined as a:**
  - Hospital authority
  - Hospital district
  - Health district, city or county
- **Program started March 2015**
- **Transitioned to QIPP in September 2017**

Twelve Facilities



Quality Incentive Payment Program (QIPP)

- **QIPP is designed to incentivize nursing facilities to improve quality and innovation in the provision of nursing facility services, using the Centers for Medicare and Medicaid Services (CMS) five-star rating system as its measure of success**

- **QIPP started September 1, 2017**

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Nursing Home Partnerships

MCM, INC.
Millennial Care Management, Inc.

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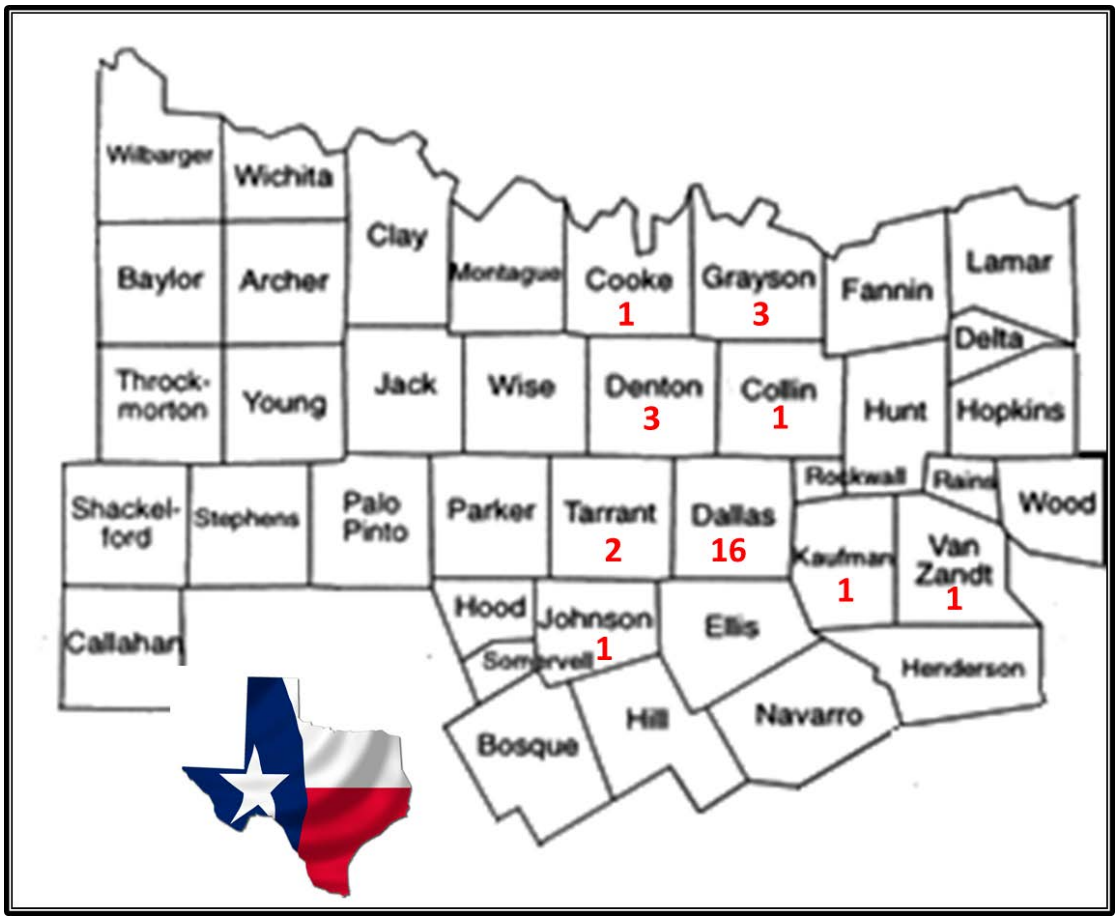
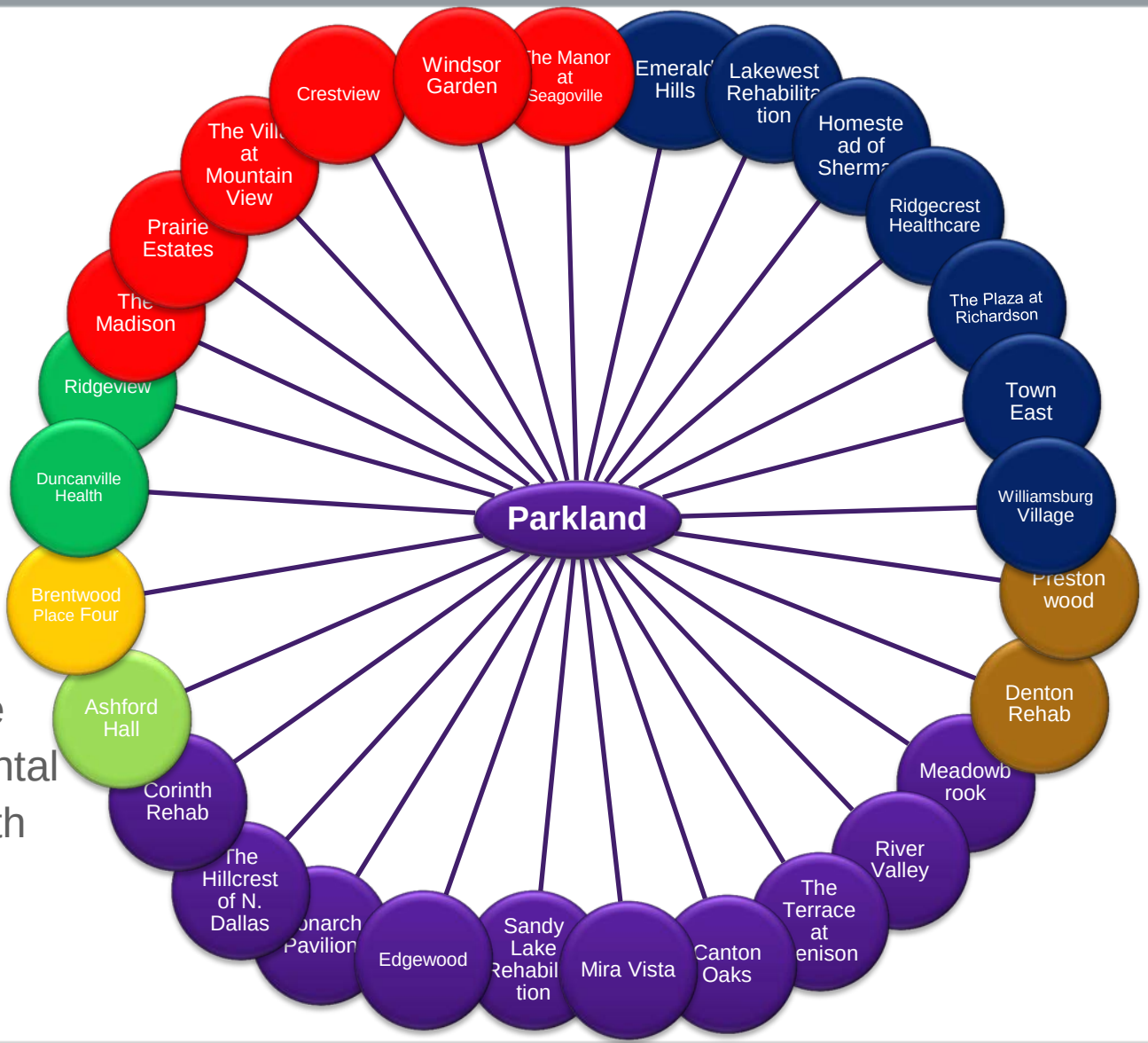
Facilities by Counties 2017

Nine Counties



Nursing Home Facilities



- Millennial
- Stonegate
- Fundamental
- Lion Health
- Oasis
- Nexion
- Cantex

Site Visits

- Conducted monthly
- Observe resident care and physical plant maintenance
- Collect other pertinent facility information:
  - Indigent care admissions, return-to-acute (RTA) readmission rates, staffing concerns, grievances, regulatory visits and quality reports

Nursing Home Action Plans

- Required monthly
- Address quality measures that are above State and/or Federal percentages

Support

- Complaint & Investigation Surveys
- Grievances
- Minimum Data Set (MDS)
- Infection Prevention
- Life Safety Code
- Quality Assurance Performance Improvement (QAPI)
- Educational Resources (Quarterly Nursing Home Sessions)

Hospital Oversight Performance Improvement Topics

Quarterly Nursing Home Sessions

January 2017	April 2017	July 2017	October 2017
Executive Rounds Marilyn Callies SVP, Transitional/Post-Acute Services	**Cost Report Preparation** Keri Disney-Story Director, Charge & Reimbursement Integrity	**Disaster Management** Chris Noah, Director, Disaster Mgt	**Leadership** Paul Rumsey, Chief Learning Officer
Sanction Screening Andrea Claire Internal Audit Manager	**QAPI** Beverly Hardy-Decuir VP, Quality & Clinical Effectiveness	**OPAT** Aurelia Schmalstieg, MD	**Social Services** Marcy Floyd LMSW, Manager Post-Acute
Physician Services Thomas Glodek, MD Physician Advisor	**Life Safety Code** Michael Radar Fire Marshal	**Customer Svc &Patient Relations** Miranda Bonds Director, Patient Relations	**Regulatory Requirements for LTC** Suzanna Sulfstede Director of LTC Ombusdman Care Senior Source
Patient Relations Miranda Bonds Director, Patient Relations	**Infection Prevention** Shannon Simmons Infection Preventionist	**Telemedicine** Meera Riner COO Nexion Health	
Partnerships in the Healthcare Community Lara Cline, RN, MSN, FNP Cantex CCN	**QIPP** Eddie Parades SVP Stonegate Senior Living		

Hospital Oversight
Performance Improvement Topics

Quarterly Nursing Home Sessions

January 2018	April 2018	July 2018	October 2018
Executive Rounds Marilyn Callies SVP, Transitional/Post-Acute Services Fred Cerise, CEO Mike Malaise, SVP Communications Katherine Yoder, VP Government Relations Saul Cordero, Chief Governance Officer **CMS – HHSC - PCCI** **Federal and State Regulations Overview** *Cancelled due to federal government shut down, rescheduled for April 2018.*	**Federal and State Regulations Overview** Theresa Bennett, RN, BSN, Technical Advisor Division of Survey and Certification **Texas Department of Health and Human Services Commission** Nicole McCown, Acting Regional Director **PCCI** Going Beyond Our Healthcare System into the Community Manjula Julka, MD, MBA/PCCI	**OIG Federal Audit** Lisa Cross Keri Disney-Story. Eddie Parades **Nursing Home Admissions and Hospital Discharges** Lisa Cross, Director of Post-Acute Services	**Federal and State Regulations Overview** Theresa Bennett, RN, BSN, Technical Advisor Division of Survey and Certification

Hospital Oversight Performance Improvement Topics

Quarterly Nursing Home Sessions

January 2019	April 2019	July 2019	October 2019
Quality Measures Joshua Cartwright, CQIA, CPHQ Healthcare Quality Improvement Specialist V TMF Health Quality Institute			

Indigent Care Program Statistics
April 2015 – August 2018

15,605 Hospital Bed Days Saved	
391 Patients Placed	
Description	**Total**
Long Term Placements (Total 52)	
Undocumented, abandoned by family	4
SSI Pending	48
Short Term, Non-Skilled Placements (Total 1)	
Hospice Services	1
Short Term, Skilled Placements (Total 282)	
Rehabilitation	
Unable to care for self post discharge	15
IV Antibiotic Therapy	
Drug abuse	166
Homeless	68
Special administration requirements	38
Non-compliance	6
Inability to self-administer	22
Specialized wound care	
Wound V.A.C.	12
Clinitron Bed	4
Complicated wounds	7

Initial Impressions from Community Stakeholders

Strategic Plan: 2017

- Created in 2016
- Strategic Priority #2: Implement a new “Parkland Culture” that engages all who serve here

Interview from November 2016

- Black hole
- Inaccessible to community
- Poor telephonic communications
- Free care for patients
- Untouchable
- Discharge medically unstable patients
- Don’t speak the same language

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Post-Acute Response

Creation of the Parkland Post-Acute Network (PPN)

Parkland Post-Acute Network Mission

To develop a care coordination model that successfully transitions complex case patients with chronic social, medical, and/or mental health conditions through a collaborative post-acute care network

Parkland Post-Acute Network Goals

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Reduce readmissions, length of stay, and wasted resources

Community Stakeholders

Improve the service delivery model between the hospital, post-acute providers and community

Home

Improve patient outcomes across the continuum of care

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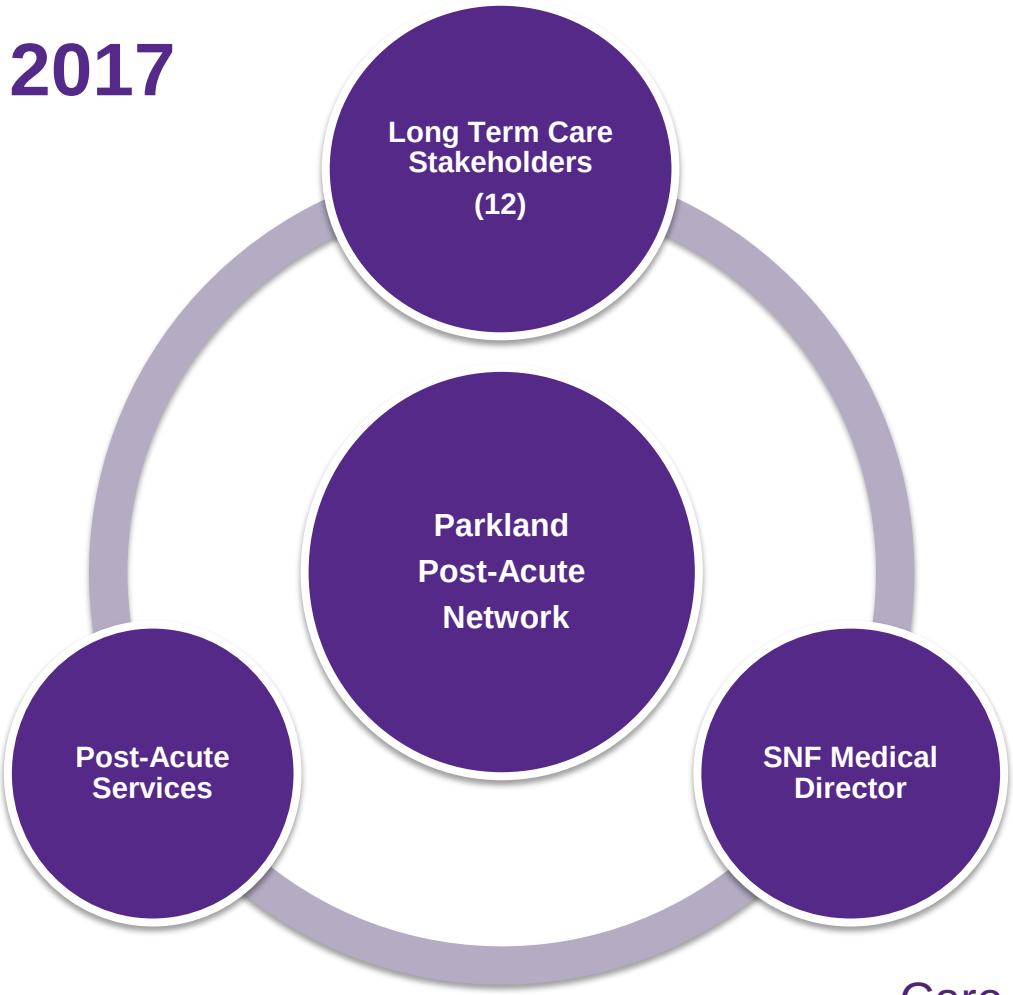
Parkland

February 2017



Care Coordination Model

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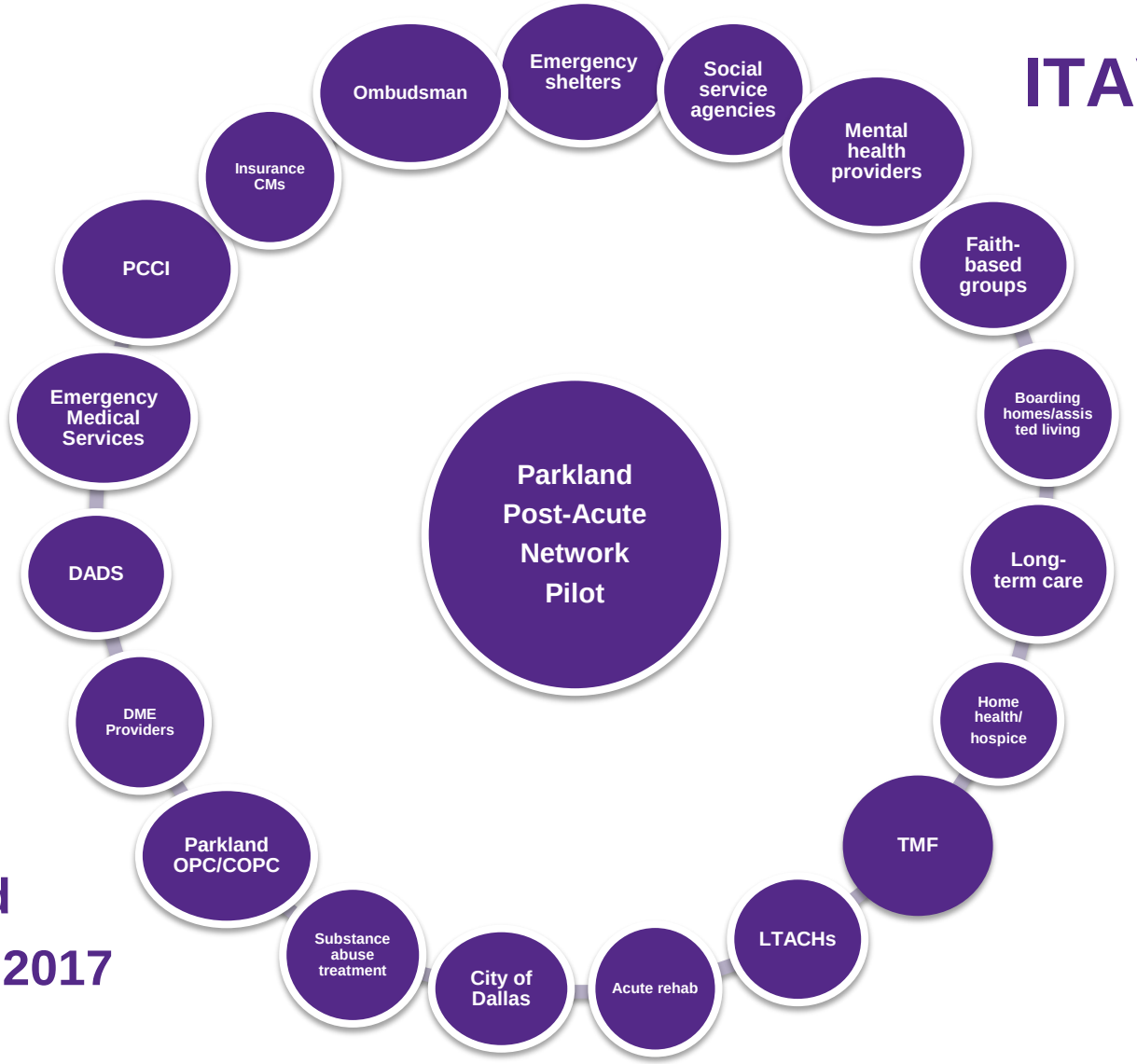
WHO STOLE MY MOJO?

Parkland

Care Coordination Model

Where Do We Start?

ITAV Pilot

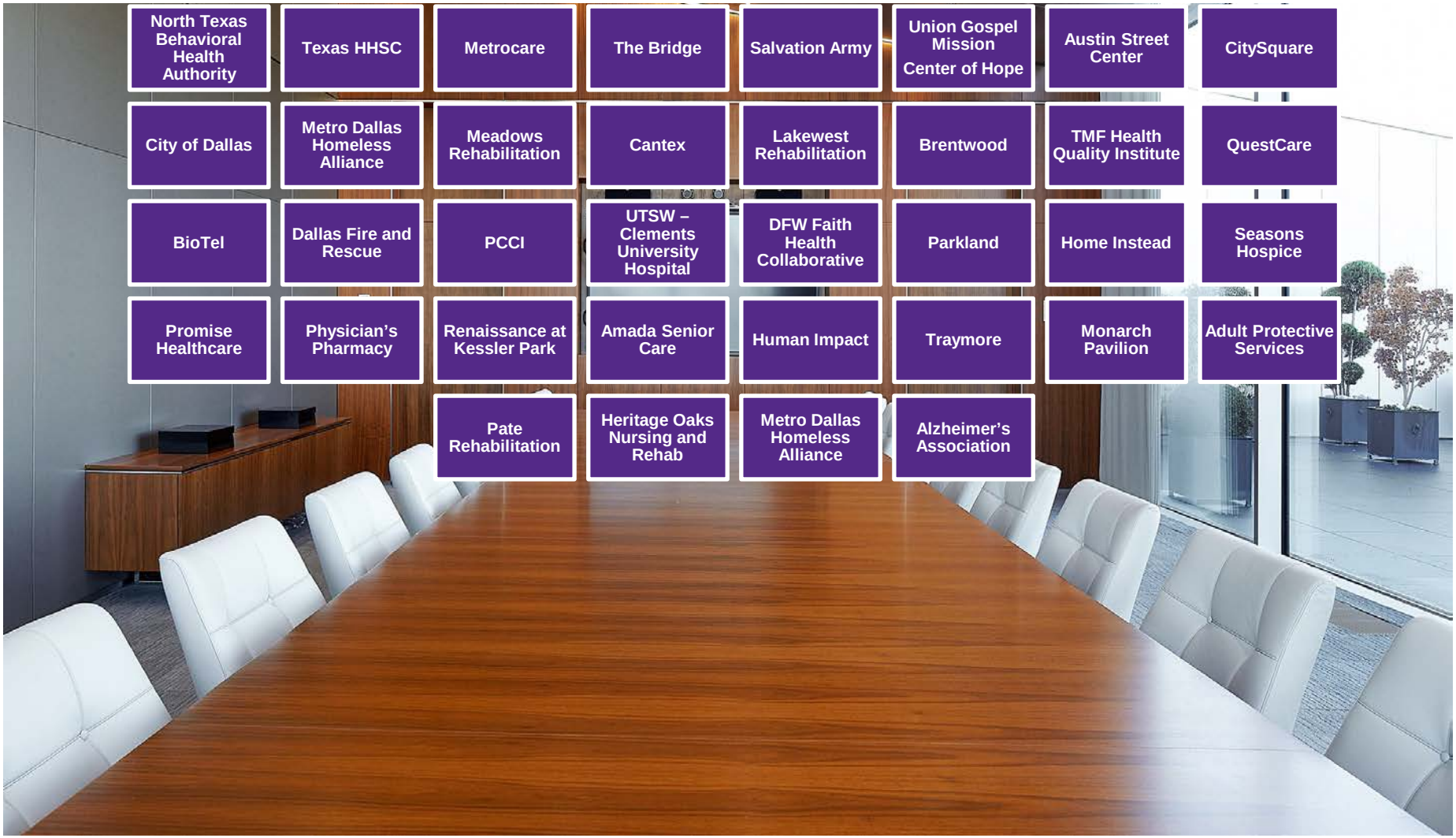


Established

September 2017

Initial Impressions of Village Partners

Bargaining Table



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So where do we go from here?

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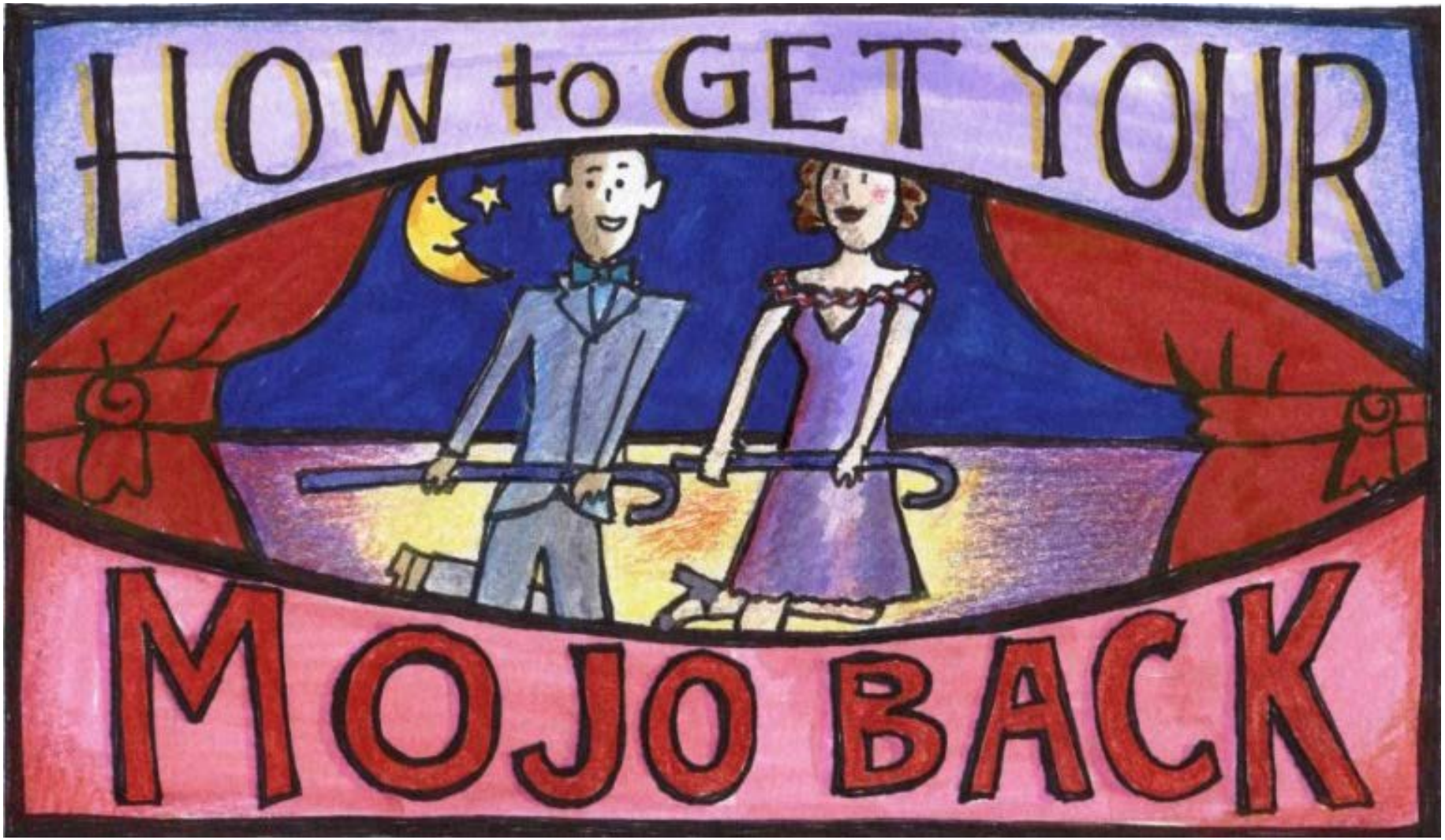

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Reconnect With Our Village
It's not a race, it's a journey!

Accept that the village starts with YOU

Remain open to new ideas and uncommon approaches

Understand our past failures without repeating them - "The shortcut is the long cut"

Resist a Band-Aid approach

Understand the root cause - Know the 5 WHYs

Engage in self-reflection… be a part of the solution, not the problem

Create, implement, evaluate, and re-evaluate the plan of movement

Expect the family to resume their roles and responsibilities then inspect that it happens

Be prepared … Understand the value of our households

Engage and rely on our village

Be relentless and supportive

Celebrate our successes!

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Thank you !

Parkland