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

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

<table>
<thead>
<tr>
<th>Fall Risk</th>
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**All Patient Flags**

<table>
<thead>
<tr>
<th>Flag Type</th>
<th>Author</th>
<th>Status</th>
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<tr>
<td>Fall Risk</td>
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<tr>
<td>Complex Care</td>
<td>Abraham, Sheryl Rachel, LCSW</td>
<td>Active</td>
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- 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
High Utilizer Patients: Account Charges

Start of intensive intervention
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

High Utilizer Referrals
January 2017- December 2018

- 73% Successful Outcomes
- 27% Ongoing High Utilizers

N=276 patients
• 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

Gender

- Male
- Female

N=134 patients with >6 visits in 30 days

Age

- 20-29: 15
- 30-39: 13
- 40-49: 33
- 50-59: 43
- 60-69: 25
- 70-79: 4
- 80-89: 1

N=134 patients with >6 visits in 30 days
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

Homelessness

N=134 patients with >6 visits in 30 days

- 81% Yes
- 12% Unknown
- 7% No
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

**Substance Abuse**

- Yes: 35%
- No: 58%
- Unknown: 7%

N=134 patients with >6 visits in 30 days

**Psychiatric Diagnosis**

- Yes: 36%
- No: 59%
- Unknown: 5%

N=134 patients with >6 visits in 30 days
Interventions

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

N=134 patients with >6 visits in 30 days
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

Medical Home

- Community Oriented Primary Care: PCP
- Specialty Outpatient Clinics
- Homeless Outreach Medical Services
- None

N=134 patients with >6 visits in 30 days
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

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

ESD Encounters January 2018-January 2019

Number of Encounters

- Jan-18: 14
- Feb-18: 14
- Mar-18: 14
- Apr-18: 29
- May-18: 29
- Jun-18: 14
- Jul-18: 8
- Aug-18: 15
- Sep-18: 18
- Oct-18: 6
- Nov-18: 2
- Dec-18: 10
- Jan-19: 1
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
• **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**
Welcome to NEW ORLEANS
How’s Ya Mama and ’Em?

Laissez le bon ton roulet!
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 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

- Windsor Gardens
- The Plaza at Richardson
- The Madison
- Crestview Court
- Prairie Estates
- Duncanville Health
- Ashford Hall
- Williamsburg Village
- Town East
- Brentwood Place Four
- The Manor at Seagoville
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.
Nine Counties
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)
## Quarterly Nursing Home Sessions

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

- **Leadership**
- **Social Services**
- **Regulatory Requirements for LTC**

The table includes sessions and topics for each quarter, along with the names and roles of the presenters.
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| **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 |
## Quarterly Nursing Home Sessions

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<td><strong>Quality Measures</strong></td>
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<td>Joshua Cartwright, CQIA, CPHQ</td>
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<td>Healthcare Quality Improvement Specialist V</td>
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<td>TMF Health Quality Institute</td>
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</table>
### Indigent Care Program Statistics
April 2015 – August 2018

#### 15,605 Hospital Bed Days Saved

#### 391 Patients Placed

<table>
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<tr>
<th>Description</th>
<th>Total</th>
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<tbody>
<tr>
<td><strong>Long Term Placements (Total 52)</strong></td>
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<td>Undocumented, abandoned by family</td>
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<td>SSI Pending</td>
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<td><strong>Short Term, Non-Skilled Placements (Total 1)</strong></td>
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<td>Hospice Services</td>
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<td><strong>Short Term, Skilled Placements (Total 282)</strong></td>
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<td>Rehabilitation</td>
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<td>Unable to care for self post discharge</td>
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<td><strong>IV Antibiotic Therapy</strong></td>
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<td>Drug abuse</td>
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<tr>
<td>Homeless</td>
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<td>Special administration requirements</td>
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<td>Non-compliance</td>
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<td>Inability to self-administer</td>
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<td><strong>Specialized wound care</strong></td>
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<td>Wound V.A.C.</td>
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<td>Clinitron Bed</td>
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<tr>
<td>Complicated wounds</td>
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</tbody>
</table>
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
CHANGE YOUR MINDSET
Creation of the Parkland Post-Acute Network (PPN)
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

Parkland
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
a goal without a plan is just a wish

- Antoine de Saint Exupéry
February 2017

Care Coordination Model

- Long Term Care Stakeholders (12)
- Parkland Post-Acute Network
- Post-Acute Services
- SNF Medical Director

Plan

[Diagram showing the relationships between Long Term Care Stakeholders, Parkland Post-Acute Network, Post-Acute Services, and SNF Medical Director]
WHO STOLE MY MOJO?
Care Coordination Model

It Takes a Village
Where Do We Start?

ITAV Pilot

Established
September 2017
Band – Aid approach
Duplication of services
No community or individual follow-up
Operating in silos
Resistance to change
Agency-centric approach
<table>
<thead>
<tr>
<th>North Texas Behavioral Health Authority</th>
<th>Texas HHSC</th>
<th>Metrocare</th>
<th>The Bridge</th>
<th>Salvation Army</th>
<th>Austin Street Center</th>
<th>CitySquare</th>
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<td>City of Dallas</td>
<td>Metro Dallas Homeless Alliance</td>
<td>Meadows Rehabilitation</td>
<td>Cantex</td>
<td>Lakewest Rehabilitation</td>
<td>Brentwood</td>
<td>TMF Health Quality Institute</td>
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<tr>
<td>BioTel</td>
<td>Dallas Fire and Rescue</td>
<td>PCCI</td>
<td>UTSW – Clements University Hospital</td>
<td>DFW Faith Health Collaborative</td>
<td>Parkland</td>
<td>Home Instead</td>
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<td>Physician’s Pharmacy</td>
<td>Renaissance at Kessler Park</td>
<td>Amada Senior Care</td>
<td>Human Impact</td>
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MAKE things Happen
So where do we go from here?
HOW to GET YOUR MOJO BACK
Set Goals
BIG & small
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!
Thank you!

Alone we can do so little; together we can do so much.

Helen Keller