Examining The Role of the Emergency Department in Reducing Readmissions

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Objectives

- How the ED can contribute to reducing readmissions
- Review of patient subsets
  - Superusers
  - Alcoholic
  - Homeless
  - Psychiatric
  - Elderly
- Analyze methods that can be used in the ED
What Can We Do?

- Before patient arrives
- During patient’s stay
- Hospital admissions
- After the patient is discharged
Before Patient Arrives
Analysis of Readmissions

- Review of frequent users
- Review of frequent readmissions by patient
  - By diagnoses
  - By MD
  - By admitting service or physician
ED Returns with Readmissions


- 23.8% returned to ED within 30 days
  - Older, men, English speaking
  - Associated with AMA (5% AMA vs. 2% not)
  - Non-specified chest pain

- 45.7% of these were readmitted
  - CHF highest rate 86.6%
  - Followed by diabetes, complications of device, sickle cell

Conclusion - Importance of collaboration with inpatient, post acute, community based care
Before Patient Arrives

Risk Factors for Readmission


- Patient types
  - African American
  - Underweight & weight loss
  - Cognitive function
  - Limited English proficiency

- Chronic disease
  - Depression, cancer, renal failure, CHF
  - Patients taking 6 or more medications
  - Prior hospitalization in past 6 months

- Lifestyle issues
  - Poor and Medicaid
  - Frequent ED patients
  - Homeless
Before Patient Arrives
Reduce Use

- Expand the walk-in and urgent care facilities.
- Determine which patients have used acute care 3 or more times in the past month.
- Call these patients to let them know about other resources and link them with health care, practitioners, case management, and disease management.
- Important role of social workers.
Inappropriate Admissions

- Legal and liability of sending patients home
- Secondary utilizes such as police, group homes, nursing homes and families
  - Send to acute care to resolve issues
- Lack of appropriate assessment
  - Difficulty in contacting PCP
  - Need for collateral information
  - Problem with obtaining old medical records
- Lack of outpatient resources
  - Housing
  - Medication
  - Care givers
Admission Criteria
Does the Patient Need to Be Admitted?

- Not always an easy decision
- Reliance on Interqual IS/SI criteria
- Use of admission criteria or guidelines for many conditions
  - Pneumonia, DVT, CHF, PID, asthma
- Alternatives to inpatient stay
One Day Readmissions

Examined ED readmissions with 1 day stays

- 12.1% of all patients
- CHF, COPD, prior hx of CHF
- 841 patients of 1207 admitted
- 12 died within 30 days
  - 3 had definitive F/U, 4 missed F/U appointment

Questions

- Is it due to premature hospital discharge?
- Was a one day admission necessary?
Alternatives to Inpatient Admission

- Observational care
- Psychiatric Patients
  - Acute psychiatric stabilization
  - Crisis respite
  - Day hospitals
  - Living room care
- Hospital at Home care
Discharge to Hospital at Home


- Have EPs, PCPs, and home care staff identify patients to benefit from receiving hospital-level care at home
- Physician visits, at least once daily, and 24-hour coverage
- Nursing visits, once or twice daily
- Telehealth nurses providing remote support
- Remote monitoring of key health indicators.
- $1,500 less than a comparable inpatient stay
For Admitted Patients
Acute Care’s Role

- Start patient in care management
  - Case management
  - Social work
  - Discharge planning
  - Pharmacy
  - Occupational and speech therapy
  - Nutritional service
- Identify patients that are at risk for readmission
ED Discharge

Set up follow up appointments

  - 62,746 COPD patients, 66.9% had PCP follow up
  - Patients who follow up visit reduced the risk of an ED visit and readmission

Begin case management

  - Involve social work and pharmacy
  - Set up home health services
  - Med reconciliation and F/U phone calls

Communicate with PCP

  - Hand off to primary care
For Discharged Patients
Acute Care’s Role

- Clear, detailed discharge plans tailored to patient, family, clinicians, case managers and payers
  - Teach self-care
  - Improved instructions and instruction process
  - Patient read back
  - Encourage self-management
- Telehealth technology to monitor at home
- Physician/nurse/social worker phone calls
- Assign a patient navigator
Value of Patient Navigator


- **Role of patient navigator**
  - Support and guidance throughout healthcare continuum
    - Coordinates appointments
    - Maintains communications
    - Arranges interpreter services
    - Arranges patient transportation
    - Facilitates linkages to follow up

- **Study of patient navigators**
  - 423 patient navigator and 513 in control
  - 12.1% were readmitted in patient navigator group and 13.6% in control group.
Super Users

- Demographic and utilization characteristics of patients who visit the ED 20 or more times per year.
- Retrospectively studied patients who visited a large, urban ED over a
- High-frequency ED users, contributing 1.1% of all visits.
- More likely to be 30–59 years of age (52%), insured (81%), and have at least one significant psychosocial cofactor (65%).
- Admission rate was 15
- High-frequency users are patients with significant psychiatric and social comorbidities.
Effective Interventions for Frequent ED Users


- Reviewed 11 studies
- Case management most often studied 7
- Demonstrated
  - Reduced ED use
  - Reduced cost
  - Reduced homelessness
Case Management


- Case management and homeless outreach to chronically homeless, alcohol-dependent, frequent emergency department (ED)

- The differences between intervention and prospective patients and retrospective controls were –12.1 for ED visits and –8.5 for inpatient days

- Eighteen participants accepted shelter; no controls were housed.

- Through intervention, ED use decreased and housing was achieved.
The **Medically Integrated Crisis Community Support (MICCS) Team**, was created in the Spring of 2014. It combines the typical range of interventions to stabilize a crisis with new interventions and methods. It mirrors the intensity of ED care, but seeks to move that level of care into community settings and transition brief, high-cost interventions into longer, engagement-oriented support episodes.
Interviews were conducted with 2578 homeless and marginally housed persons

40.4% of respondents had 1 or more emergency department encounters in the previous year;

7.9% exhibited high rates of use (more than 3 visits)

Factors associated with high use rates

- Less stable housing
- Victimization & arrests
- Physical and mental illness
- Substance abuse.

Targeted underlying risk factors among those exhibiting high rates of use.
Case management of chronically homeless, alcoholic persons

Compared intervention to controls

Reduced ED visits by 12.1 ED visits for 6 months

Reduced 8.5 inpatient days

18 participants intervention group accepted shelter

None in control group accepted housing
Patient Types - Alcoholic Sobering Center - Definition

- Facilities that provide a safe, supportive environment for mostly uninsured, homeless publically intoxicated persons to become sober.
- Alternative holding facility for patient who are intoxicated.
- Alternative to jail holding cell or ED.
- May go directly to sobering center by police, ambulance or center sponsored transport.
- May go to an ED first.
- May receive counseling and referrals.
Before Patient Arrives

Identification of Seniors at Risk Tools


- Use two tools to determine risk for readmission
- Identification of Senior at Risk (ISAR) and Triage Risk Stratification Tool (TRST)
  - ISAR
  - TRST
- Modest prediction of unplanned readmission after ED visit in patients over 75 years old
Triage Risk Screening Tool

1. History of cognitive impairment (poor recall or not oriented)
2. Difficulty walking / transferring or recent falls
3. Five or more medications
4. ED use in previous 30 days or hospitalization in previous 90 days
5. Lives alone and/or no available caregiver
6. ED staff professional recommendations:
   Nutrition / weight loss
   Incontinence
   Failure to cope
   Medication issues
   Sensory deficits
   Depression / low mood

If 2 or more factors identified, high risk
PLEASE ANSWER YES OR NO TO EACH OF THE FOLLOWING QUESTIONS

1. Have you needed help on a regular basis (from: home care, home nurse, relatives or others) prior to the illness that caused the hospitalization?

2. Have you needed more help (i.e. for personal care) than usual to be able to take care of yourself after the illness arose which caused the hospitalization?

3. Have you been hospitalized for one or more days during the last 6 months, not including visits to the Casualty Ward?

4. Is your vision usually good?

5. Do you usually have serious memory problems?

6. Do you use more than 3 different types of medicine a day?
Psychiatric Patient Admission Criteria

Does the Patient Need to Be Admitted?

- Not always an easy decision
- Use of admission criteria or guidelines for many conditions
  - Risk to self, Risk to others, Unable to care for self
- Improved assessment for admission
  - Telepsychiatry
  - Diversion programs
  - Suicide risk assessment
- Alternatives to inpatient stay
There were a total of 214 participants in the study:
- 106 medical and 108 were psychiatric
- Prescribed an average of between 2 to 6 meds/day

One significant difference between the two groups:
- Psychiatric pts. were more likely to get admitted (50%) than medical pts. (31%)
Crisis Triage Rating Scale

- Scores three categories 1-5
  - A. Dangerousness
  - B. Support system
  - C. Ability to cooperative

- Scoring
  - 9 or more – outpatient/crisis intervention
  - 8 or less - admit
Admission Criteria


- Decision support tool
- Criteria
  - Suicide potential
  - Danger to others
  - Severity of symptoms
- Predicted 73% of the admissions
Mobile Crisis Units and Telepsychiatry

**Mobile Crisis Units**


- Comparison of mobile unit to ED admission rate
- ED admitted 3x more than mobile units

**Telepsychiatry**


- High provider and patient satisfaction
- Wide variety of diagnosis, age and complaints
- Consultations, diagnostic assessment, medication management, family and patient psychotherapy
Determination of Suicide Risk Risk Myths

- All patients who want to harm themselves or others need admission
- Alcohol and substance intoxicated patients need admission even if they change their mind when they are not clinically intoxicated
- All teenagers with suicide gestures or thoughts need admission
- Maybe not
Can the Suicidal Patient Go Home


- Medical treatment not needed
- No prior suicidal attempt
- No actively suicidal
- Adult in house with good relationship
- Adult agrees to monitor
- Adult will move guns and medications
- Whom to contact for deterioration
- Follow up arranged
- Agreement to plan and recommendations
Observational Care

Appropriate use of OBS units for psychiatric patients

- Psychosis
- Suicidal
- Depressed
- Anxiety
- Alcohol and drug intoxication/withdrawal
- Social situation

Requirements

- Provides adequate stability and containment
- Availability of consultation liaison service
Crisis Stabilization Units


- Functions
  - Allows time for diagnostic clarity
  - Develop alternatives to admission
  - Respite function
  - Denies dependency needs

- Patient types
  - Schizophrenics
  - Personality disorder
  - Suicidality
  - Substance use disorders

- 41% of total patients seen
- May reduce admission by 70%
Long Acting Injectable Antipsychotics

- Long-acting injections (LAIs) of antipsychotic drugs were developed over 40 years ago in an attempt to improve the long-term treatment of schizophrenia.

- Haloperidol and fluphenazine

- Paliperidone, Risperdal, Olanzapine

- The use of these injections in first-episode psychosis and treatment-refractory schizophrenia
What Can We Do?

Before patient arrives
- Identify high risk patients

During patient’s stay
- Use admission criteria
- Limit inappropriate admissions

Hospital admissions
- Consider alternatives sites of care
- Start discharge process

After the patient is discharged
- Connect pt with out patient resources
What Can We Do?

- Use admission criteria
  - Avoid inappropriate admissions
- Admitted patients start processes
  - Care management, D/C planning, pharma
- Consider alternatives sites of care
  - Observation, home hospital, acute stabilization
- Identify high risk patients
  - Connect with additional services
- Discharged patients may need assistance
Patient Types

Psych Patients
- Look for deflection programs such as mobile crisis teams and law enforcement for those that do not need acute care
- Some patients can go home after evaluation with or without telepsychiatry

Alcoholic and Homeless
- Find housing
- Case Management

Elderly
- Identify those at highest risk
Contact Information

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