Improving Emergency Department Transitions of Care – Can It Help with ED Overcrowding?

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Who am I?

- 36 years in EM, 18 as Medical Director of Denver Health ED (Safety net, Level 1 Trauma, 3rd Service EMS)
- Past president of the DH medical Staff
- Past chair of ACEP Clinical Policies Committee
- Past chair of ACEP Quality and Patient Safety Committee
- 11 years experience in performance measure development
- Associate Professor, EM, University of Colorado SOM
U.S. emergency departments (ED) treat 130 million patient visits annually.

About 10% admitted, accounting for about 80% of all unscheduled hospital admissions.

ED visits are critical inflection points in a patient’s health trajectory.

Emergency care is costly but often preferred by patients.

Most transition efforts have focused on hospital discharges.

20% of Medicare hospital discharges are readmitted within 30 days, with half of the patients having not yet seen an outpatient doctor for follow-up.

Conventional wisdom: Better transitions into and out of the ED could result in more efficient resource utilization and a more seamless patient care experience.
What are “ED transitions of care?”

“Movement of patients between health care locations, providers, or different levels of care as their conditions and care needs change involving an emergency department as the receiving or sending location”
Examples of ED Transitions of Care

**INCOMING**
- Home
- Another ED / Hospital
- Specialist
- Medical Home / PCP
- Long Term Services & Support
- Prehospital
- Other episodic care
- Within ED
- Shelter
- Jail
- Other

**OUTGOING**
- Home
- Another ED / Hospital
- Long Term Services & Support
- Medical home / PCP
- Specialist
- With ED / Hospital
- Shelter
- Jail
- Other
Recognition of TOC as a Problem:

- The Joint Commission has publicly recognized that an inability to effectively transfer information and accountability is a primary factor in sentinel events.
- World Health Organization has made it a high priority for its patient safety initiatives.
- The Centers for Medicare & Medicaid Services has established a Community-based Care Transitions Program.
- The Accreditation Council for Graduate Medical Education has established effective communication during these transitions as a requirement of residency training.
Potential benefits of improving these transitions

- Improved person-centered care
- Increased value of care
- Reduced costs of care
- Improved efficiency of care
  - Reduced number of ED visits
  - Reduced duration for an ED visit
1. Improve communications during transitions between providers, patients, and caregivers.
2. Implement electronic medical records that include standardized medication reconciliation elements.
3. Establish points of accountability for sending and receiving care, particularly for hospitalists and nursing home providers.
4. Increase the use of case management and professional care coordination.
5. Expand the role of the pharmacist in transitions of care.

6. Implement payment systems that align incentives and include performance measures to encourage better transitions of care.

7. Develop performance measures to encourage better transitions of care.
13 recommendations:

1. Improve residency training and continuing professional development for emergency physicians on the importance of handoffs in effective transitions of care.

2. Enhance and promote training and education for all emergency department personnel regarding the importance of transitions of care and how to implement effective policies and procedures.

3. Assess provider performance, especially that of residents, with appropriate feedback, and provide training in communication skills as necessary.

4. Work with emergency department information system vendors to produce transition support tools.
5. Identify strategies that make handoffs successful, and use them to establish goals for emergency departments.

6. Identify the components of a minimum data set for all transitions.

7. Work with the Society of Hospital Medicine to hardwire the handoffs between the emergency department and the hospitalists.

8. Evaluate tools currently used to guide emergency department handoffs, identifying the assessment tool or guidelines used.

9. Develop a web-based toolkit that includes resources, assessment and support tools, and best practices.

11. Develop education resources on palliative care in the emergency department to enhance knowledge and increase the number of emergency department-based palliative care programs.

12. Seek funding for effective emergency department-based transition programs. Consider developing measures that quantify effective transitions.

13. Solicit research to determine the effectiveness of transitions of care programs on patient outcomes, especially related to emergency department revisits for the same condition and hospital readmissions.
1. Potentially unnecessary revisits due to poor information conveyance.
   * 8.2% of pts discharged from the ED will return within 3 days
   * 32% will visit a different institution
2. Unnecessarily repeated diagnostic studies due to flawed information flow.
NQF ED Quality of Transitions Project

- Funded by HHS Emergency Care Coordination Center (ECCC)
- Expert Panel:
  - 24 members, multi-disciplinary – 7 Emergency physicians
  - 5 NQF Staff
  - Rapid time frame: less than 12 months from soup to nuts
- Environmental scan of the literature: 47 relevant articles reviewed
- Scan for existing measures and measure concepts
  - Identify measurement gaps in TOC and develop measure concepts for these gaps
- Categorized and ranked measures and measure concepts
“Measure” vs “Measure Concept”

- **Measure**: a fully developed metric that includes detailed specifications and may have undergone scientific testing.

- **Measure Concept**: an idea for a measure that includes a description of the measure, including planned target and population, but has not undergone full specification or testing.
NQF Final Report:

Emergency Department Transitions of Care:
A Quality Measurement Framework
AUGUST 30, 2017

Available at:
Report Recommendations

1. EDs need to build infrastructure and linkages to support ED transitions that are patient centered.

2. Enhancements to health information technology (HIT) are needed to support high quality ED transitions in care.

3. New payment models may facilitate quality improvement in ED transitions and should be investigated.

4. A research agenda for further work in TOC is needed.
Recommendation #1  
**Infrastructure & Linkages**

* Investments in ED-based care managers, navigators, and social workers; referrals to community health workers and healthcare coaches.

* ED-based system for patients (e.g. phone access) where a provider is available to answer questions.

* Regular screening of patients who may be at high-risk for poor ED transitions in care, with a focus on unmet social service needs.

* Information on community resources, ensuring resources are available for patients.
Recommendation #2
Health Information Technology

- Health information exchanges should be viewed as a public good and supported by public funding or by payers.
- Sharing of key information elements important to ED transitions between clinical and non-clinical providers; support feedback about specific patients to promote a learning system.
- Integration of information from multiple sources (e.g., pharmacy data and prescription drug monitoring programs).
Recommendation #2 cont.

Health Information Technology

* Care team members to be contacted automatically when the patient arrives or departs the ED, e.g., ADT alert system.

* Shared decision making between providers and patients during transitions.

* Consider patient privacy concerns when sharing information between health care providers and community-based organizations.

* Systems to improve patient understanding, e.g., evolution of symptoms.
**Recommendation #3**

**New Payment Models**

- Global budgets to reward hospitals for coordinated care, e.g., investment in ED transitions.
- New reimbursement codes to support additional resources, e.g., observation units providing more intensive care coordination services.
- Primary care providers reimbursed for coordination efforts or follow-up not involving an in-person visit.
- Capitated payments to spur investments in improving ED transitions.
Recommendation #4
Research Agenda

* Taxonomies to support improved ED transitions:
  * Provider-to-provider communication
  * Provider-to-patient communication

* Research to understand which patients are at highest risk for poor transitions or poor outcomes.
  * Research to understand which interventions work best to improve transitions and outcomes
Recommendation #4 cont.

Research Agenda

* Identify and promulgate promising models for ED and community engagement including:
  * Community engagement with law enforcement, social services, housing, and other resources
  * Payer engagement
  * Linkages between community clinical providers and EDs
Measure / Measure Concept Compendium (Appendix C)

- 6 Existing Measures
- 25 Measure Concepts
- Measures/Measure Concepts Framework
  - Domains: 4
    - Provider Information Exchange: 2 subdomains
      - Key information elements and properties of transmission
      - Care coordination and feedback
    - Patient, Family, and Caregiver Information Exchange: 2 subdomains
      - Key information elements and properties of transmission
      - Effective communication and shared decision making
Measure / Measure Concept Compendium (Appendix C)

- **Engagement of the Broader Community**: 2 subdomains
  - Connection and alignment
  - Accessibility of services

- **Achievement of Outcomes**: 4 subdomains
  - Healthcare utilization & costs
  - Provider experience
  - Patient/family/caregiver experience
  - Follow-up and safety outcomes
* **Domain: Provider Information Exchange**
  
  **SUBDOMAIN: CARE COORDINATION AND FEEDBACK**

* 5 Existing Measure: Emergency Transfer Communication Measure: Percentage of patients transferred to another healthcare facility whose medical record documentation indicated that required information was communicated to the receiving facility prior to departure or within 60 minutes of transfer (NQF #0291):
  * Required information is communicated to the receiving facility prior to departure
  * Entire vital signs record is communicated
  * Medication information is communicated
  * Patient information is communicated
  * Physicians information is communicated
  * Nursing information is communicated
  * Procedures and test information is communicated

* 6 Concept: The proportion of patients managed by primary care physicians (or responsible specialist) who are frequent users of EDs (>=4 visits in a 12-month period) who have, (jointly when possible) created a care plan in collaboration with their primary care physician and ED (physician, nurse, PA, navigator, etc.)

* 7 Concept: A structural measure as to whether hospitals provide data to and facilitate a portal for providers to be able to view ED visits and other care delivered in outside hospitals and health systems

* 8 Concept: The proportion of EDs that have a system in place to provide feedback within referring providers for specific cases that may be useful for quality improvement
Measure / Measure Concept Prioritization (Appendix E)

- All 31 ranked as to
  - Importance
  - Feasibility

- Then ranked as potential for implementation:
  - Now
  - Mid-term
  - Future / Aspirational
Prioritization Findings: Now

Measures/measure concepts rated high in both importance and feasibility that can be implemented today (n = 5):

* Provider communication (EMS, ED, other facilities)
* Patient-centered communication and discharge activities
* Community resource information to support transitions
“Now”, In detail

* [concept] The proportion of EMS transports where a transition of care document and verbal report is provided to the ED at ED arrival

* [measure] Patient Specific Education Resources from Certified Electronic Health Record Technology (CEHRT) provided to Patient

* [concept] Documentation of the percentage of all patients/family/caregivers who are provided an ED based telephone number that is staffed 24/7, which they may use to clarify discharge instructions, medication questions, or follow up post-discharge from the ED
Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care): Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements (NQF #0649):

- Summary of major procedures and tests performed during ED visit, AND
- Principal clinical diagnosis at discharge which may include the presenting chief complaint, AND
- Patient instructions, AND
- Plan for follow-up care (OR statement that none required), including primary physician, other healthcare professional, or site designated for follow-up care, AND
- List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each
[concept] Collect and maintain information on available resources (to include social, community and any other available resource that may support a transition of care)
Prioritization Findings for Mid-Term

Measures/measure concepts of high importance and moderate feasibility that can be implemented in the mid-term (n = 19). [3 measures; 16 measure concepts]

* Care managers / coordinators / navigator services in ED
* Improved discharge instructions with considerations for language, social economic status, contact information
* Timeliness of information transfer to support high-risk transitions
* Provider and patient experience
Prioritization Findings for Future

Aspirational measures/measure concepts of high importance with low feasibility for future implementation (n = 6). [1 measure; 5 measure concepts]

* Reduction in duplicate testing
* Improved transitions for frequent ED users
* Bi-directional communication between clinical and community resources
* Shared care plan for frequent ED users
Unintended Consequences of Performance Measures in TOC:

- One-size-fits-all TOC performance measures
  - Pt with simple forearm lac vs chronic diabetic pt with COPD, angina and dementia
- Risks:
  - Decreased throughput
  - Increased costs: personnel, IT
  - Information overload
  - Difficulty in demonstrating improved patient care/patient satisfaction/provider satisfaction
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* So far, unfortunately, not much data.
* We hope so. (It is the right thing to do, if done intelligently)
* TOC performance measures may help, but they must be carefully crafted and implemented
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Selected Readings:


Thank you

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