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Civitas 2024

How the Emergency Department Care Coordination (EDCC) Program Turbo Charged Care Collaboration in Virginia

FROM NUMBERS TO KNOWLEDGE
VHI
VIRGINIA HEALTH INFORMATION

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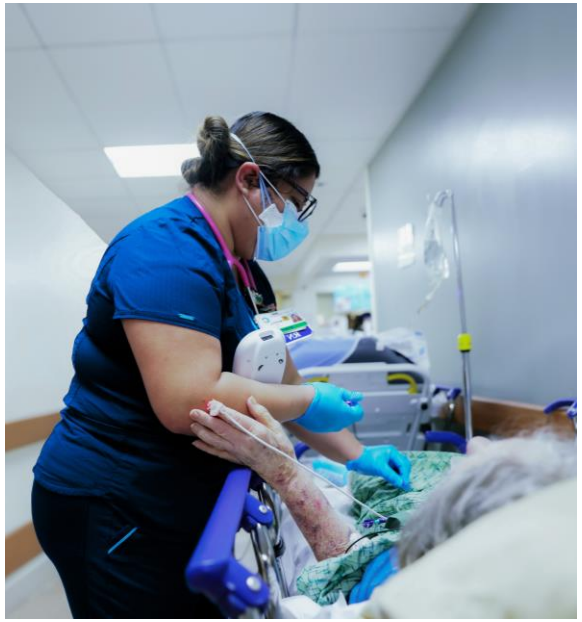
Key Takeaways

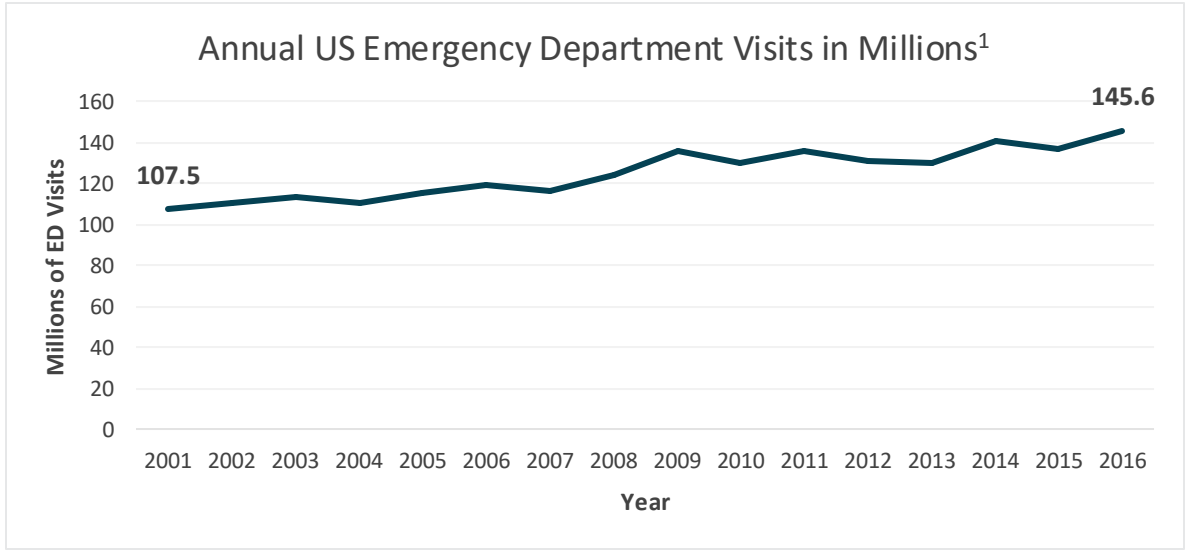
1. Virginia's approach to build a statewide program designed for a specific use case — overutilization of the emergency department (ED) — before expanding more broadly has been successful

2. Virginia Health Information's (VHI) state relationships plus tailored technology from PointClickCare built a system that address the needs of Virginia's stakeholders

3. Usage of the EDCC technology has been consistently correlated with 25%+ reductions in ED visits by high utilizers

Background





Where healthcare challenges find solutions

PATIENTS | OPERATIONS | CARE DELIVERY | PAYMENT

CARE DELIVERY

February 07, 2019 12:00 AM

Unnecessary ED visits from chronically ill patients cost $8.3 billion

MARIA CASTELLUCCI

TWEET SHARE SHARE EMAIL

About 30% of emergency department visits among patients with common chronic conditions are potentially unnecessary, leading to $8.3 billion in additional costs for the industry, according to a new analysis.

The report, released Thursday by Premier, found that six common chronic conditions accounted for 60% of 24 million ED visits in 2017; out of that 60%, about a third of those visits—or 4.3 million—were likely preventable and could be treated in a less expensive outpatient setting.

Problem: Overutilization of the ED Due to Low Care Coordination

Searching for Solutions

ER is for Emergencies

Addressing through Legislation

The 2017 Virginia General Assembly established the Emergency Department Care Coordination (EDCC) Program within the Virginia Department of Health (VDH) to provide a single, statewide technology solution that **connects all hospital emergency departments in the Commonwealth to facilitate real-time communication and collaboration** among physicians, other healthcare providers, and other clinical and care management personnel for patients receiving services in hospital emergency departments for the purpose of improving the quality of patient care services (re: § 32.1-372).

Where VHI Comes In

VHI is an independent, nonprofit, 501(c)(3) organization established in 1993 to administer Virginia healthcare data collection, reporting, and exchange programs.

Why VHI?

- Deep local knowledge of data systems, relevant policy, and key stakeholders
- Vendor and partnership network — VHI knows the right partners throughout the industry and can provide greater ease of procurement
- Strong reputation of unbiased decision making — both political and industry specific

Where PointClickCare Comes in

Largest care collaboration network in the U.S., outcomes focused, and a trusted partner

3,600+
Ambulatory

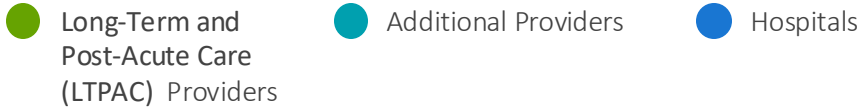
27,000+
Long-Term and Post-Acute Care Providers

350+
Risk-Bearing Provider Organizations

70+
State and Government Agencies

Every
Major U.S. Health Plan

2,800+
Hospitals



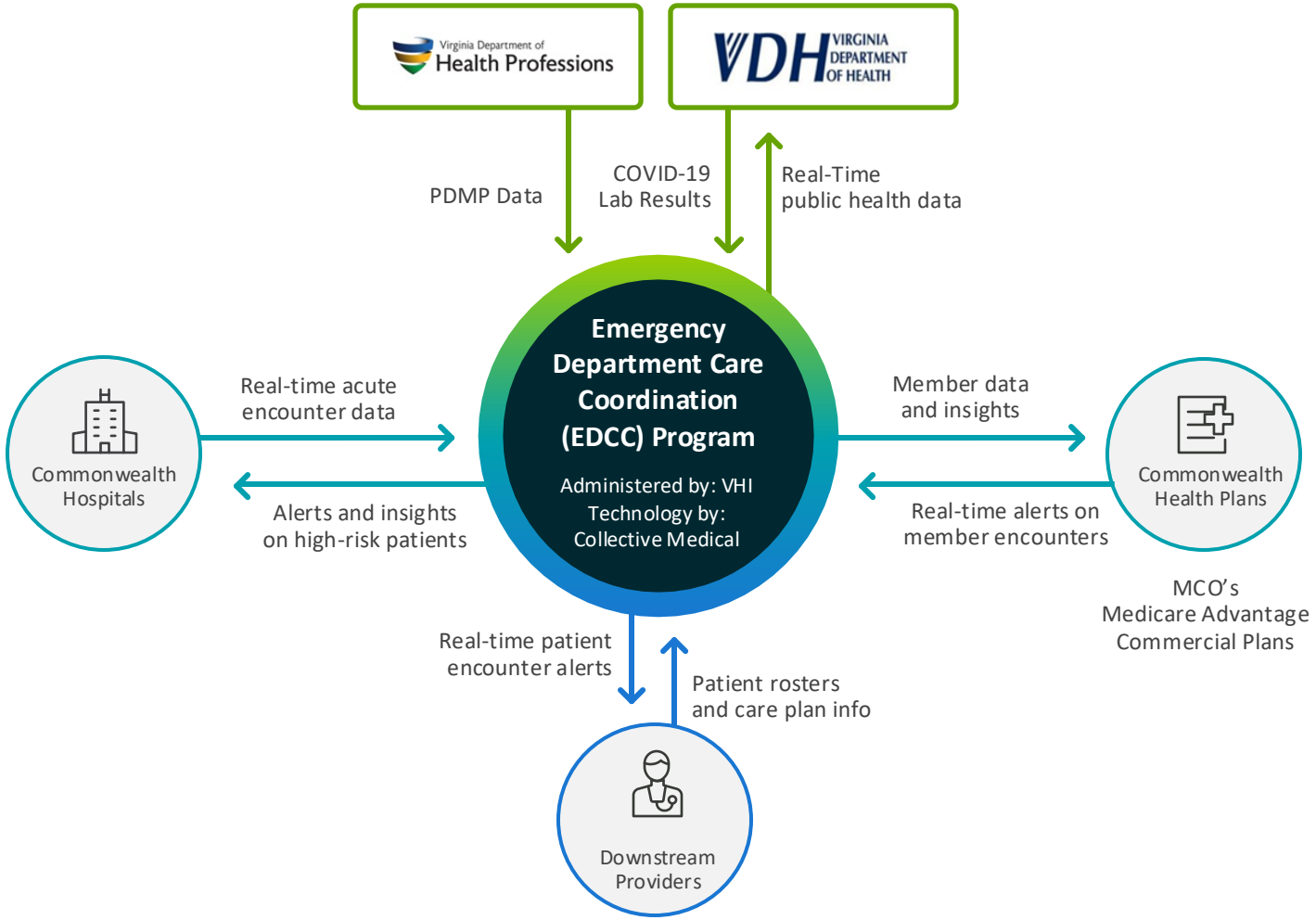
Time to Get to Work

By June 2018 all had to be connected:

- ✓ All hospital emergency departments
- ✓ All Medicaid Managed Care Organizations (MCOs)
- ✓ Integrate with Prescription Monitoring Program (PMP) data
- ✓ Integrate advance healthcare directive registry data

And by June 2019:

- ✓ All State Employee Health Plans, Medicare, and Commercial plans operating in Virginia (excluding ERISA)
- ✓ On-board downstream providers including primary care provider (PCP), Community Services Boards (CSBs), Federally Qualified Health Centers (FQHCs), skilled nursing facilities (SNF), post-acute, social workers, specialty care, behavioral health, and long-term care



Solutions

Scope of Solution through PointClickCare

Emergency Department Optimization

For all Virginia emergency departments

Health Plan, Risk Bearing Entity and Clinic Portals

For all health plans and available to other Treatment, Payment, and Healthcare Operations (TPO) entities such as ACOs, PCPs, FQHCs, behavioral health (BH) clinics, Clinics, clinics, and Emergency Medical Services (EMS), Post-acute

Program Specific Enhancement Areas

Mental health, SUD, public health, maternal health, MDRO

How Does the EDCC Program Work?

Patient Has a Hospital Encounter

Care Team Notified if Patient Meets Criteria

Real-Time Notification Sent

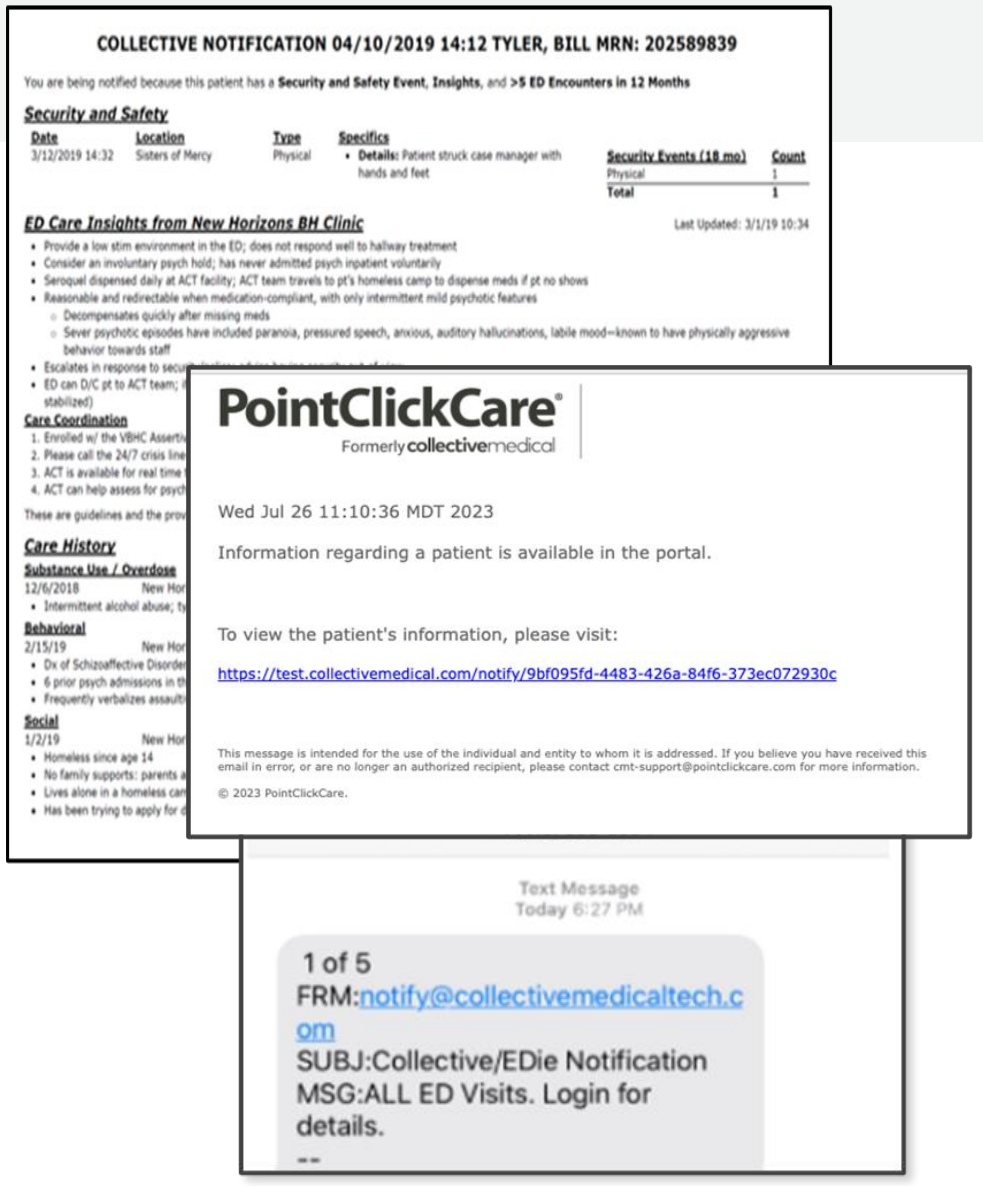
Care Team Member Logs into Portal

Staff receives notification and logs into the portal to learn more about the patient and take appropriate action.

What Criteria Results in a Notification?

Core Criteria
High Utilizing Patients 5+ ED encounters within 12 months
Rising Risk 3+ ED encounters within 90 days
Prescription Monitoring Program (Narx Scores)
Safety and Security Events
Care Insights
SNF Encounters
Advanced Directives
MDRO Lab Results
Substance Exposed Infants (SEI)

BH/SUD Criteria: History Of…
ED Visit with Mental/ Behavioral Health Diagnosis
ED Visit with Suicidal Ideation, Suicide Attempt and/or Self Harm
ED Visit with Opioid Overdose
ED Visit with Alcohol Abuse
ED Visit with Opioid Use Disorder



Supporting Public Health: Candida auris Cases Are on the Rise

EDCC Program surfaced 1,370 facility encounters where C. auris was present

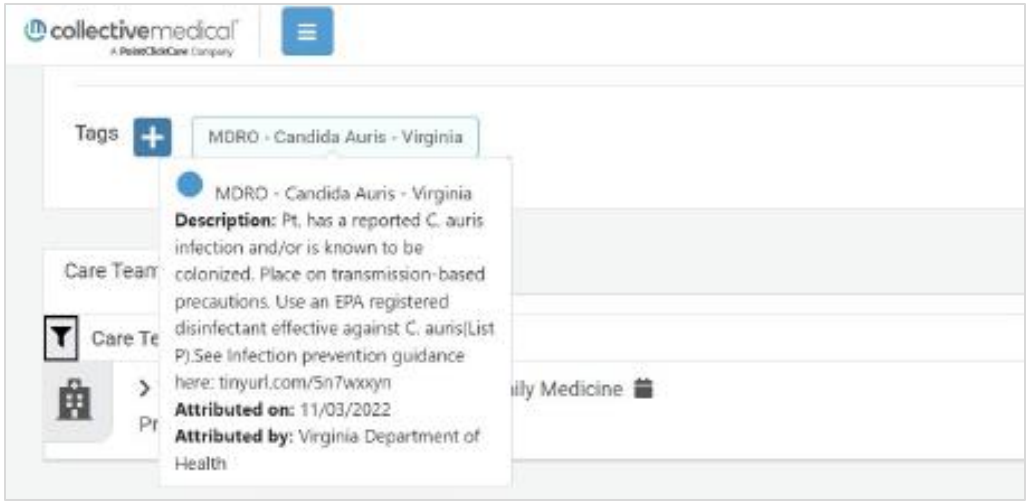
Sept 2022- June 2024

C. auris is an emerging fungus that presents a serious global health threat. It is often resistant to antifungal drugs used to treat Candida infections, is difficult to identify with standard laboratory methods, and can cause outbreaks in healthcare settings that have resulted in high mortality rates.

- Deadly
- Difficult to identify
- Moves through air and contact
- Hard to clean
- Persists in hospitals and long-term, post-acute facilities
- Resistant to treatment
- Reported cases confirmed by state Public Health

A plate with a strain of *Candida auris* fungal organisms. Credit: CDC

Supporting Public Health: Multi Drug Resistant Organisms (MDRO)



VDH VIRGINIA DEPARTMENT OF HEALTH

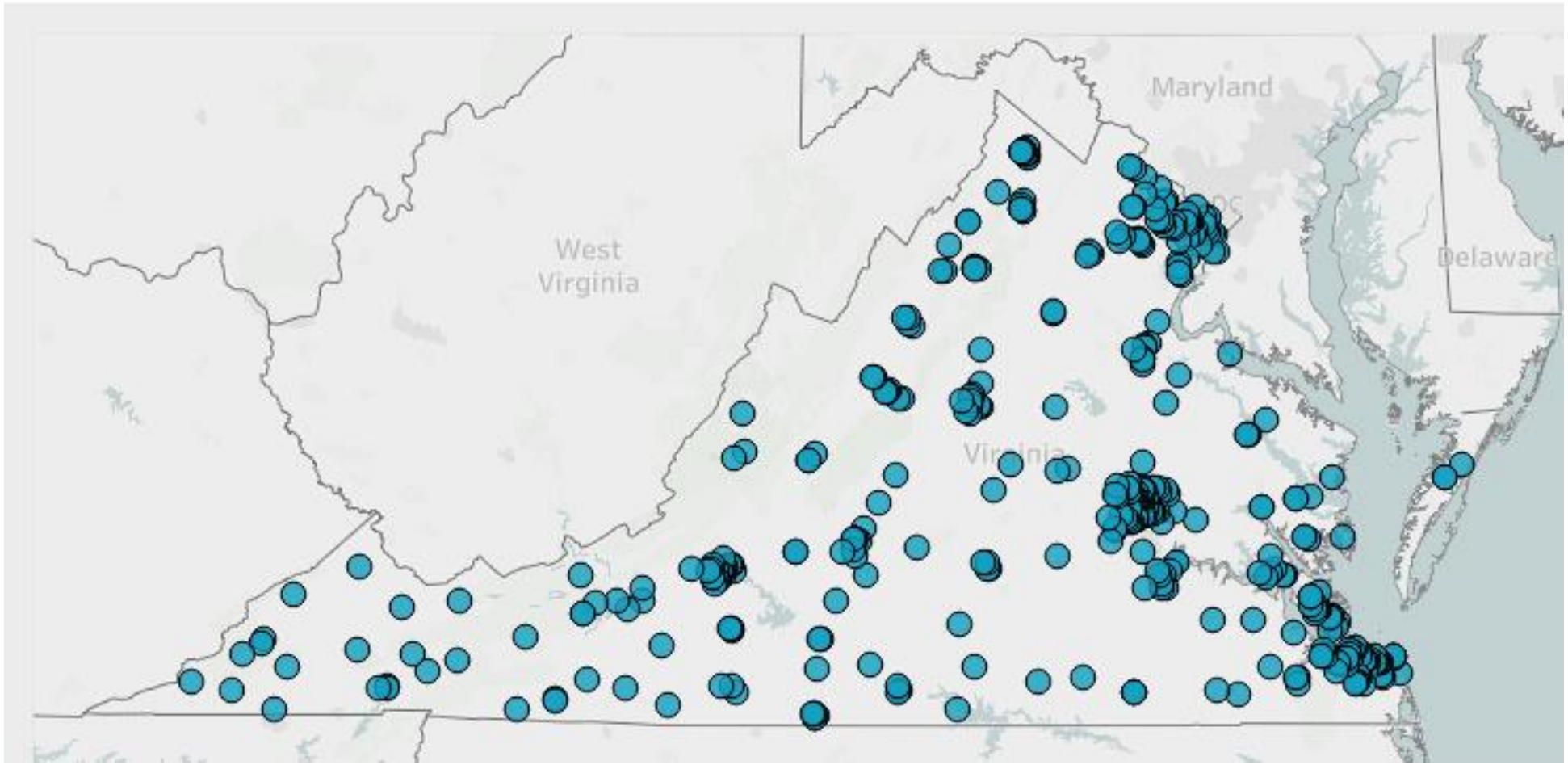
MDRO Flags: linking the EDCC Program data with health department labs

The goal of the alert is to leverage existing technology to aid in communication of patients/residents infected or colonized with MDROs when discharged to downstream facilities so the following can occur:

- Patient/resident placed in the appropriate transmission-based precautions to prevent further spread
- Help inform the optimal antimicrobial therapy regimen, if deemed necessary by the patient care team

Network Effect

Network Growth



What is an EDCC Care Collaborative?

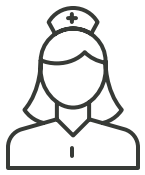
Meet virtually with other providers participating in the EDCC program

Establish community standards for complex patient care management and care planning

Share ideas with other program participants on ways to use the EDCC in your workflow

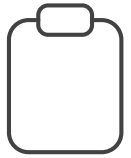
Identify opportunities to improve care collaboration in Virginia

Who Attends?



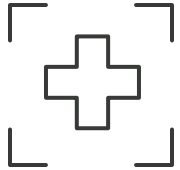
Nurses

Community Providers

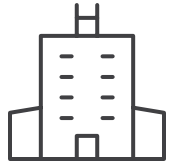


Administration

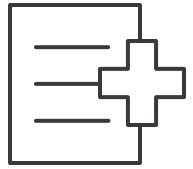
Health Plans



EDCC Participants



Hospital Staff



Post-Acute Providers

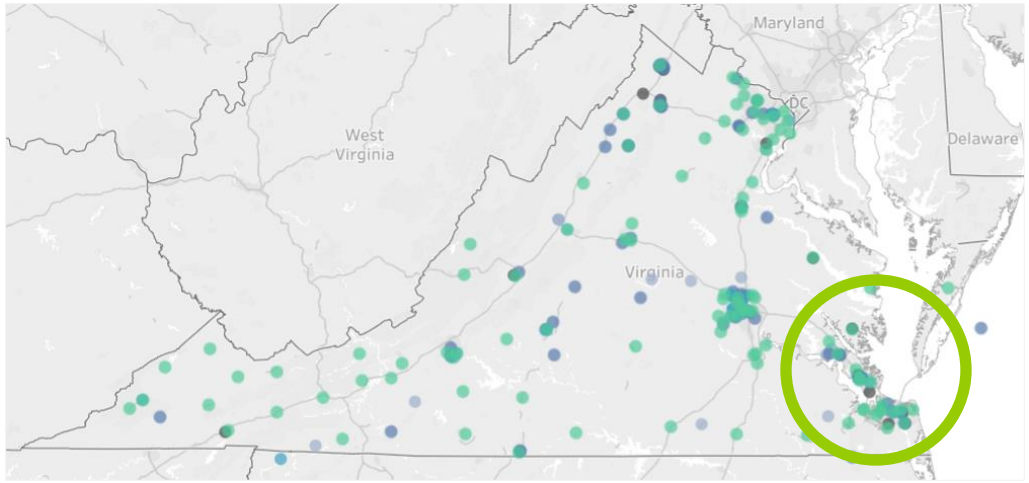
Local Engagement: EDCC Tidewater Collaborative

Goals:

- Develop standardized approach to implement EDCC technology
- Develop best practice standards of care for multi-visit patients throughout all local health systems
- Improve communication, collaboration, and care planning efforts between health systems, post-acute providers, and community entities

Key Deliverables:

- Formalize care plan strategies to decrease readmissions
- Standardize templates for all health-systems and plans to utilize for insight and care recommendations



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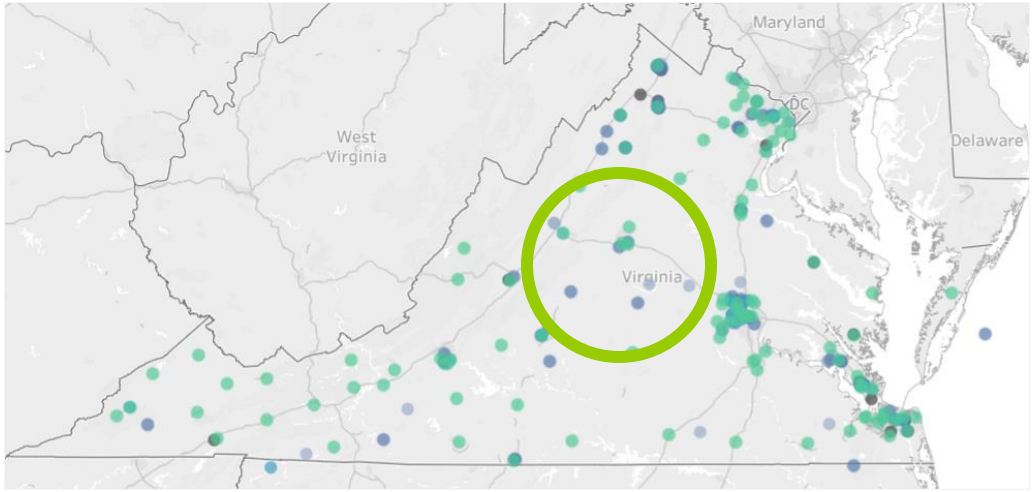
RIVERSIDE Health System

Local Engagement: EDCC Central Regional Collaborative



UVA Health Population Health

Augusta Health

regionten community services board

Sentara

Overview:

- UVA Medicine Home Program, initiated the creation of a central region collaborative in 2024.
- The Medicine HOME Program, a highly engaged user of the EDCC, was in replicating the success of the Tidewater Regional Collaborative.

Key Deliverables:

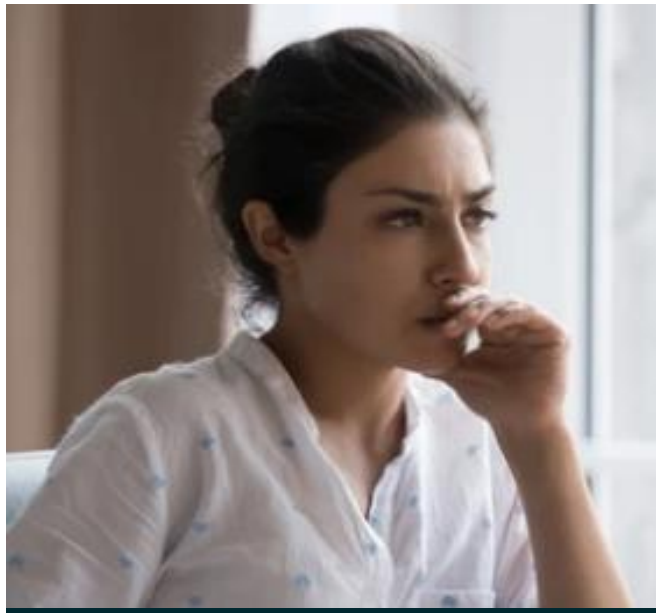
- First goal is to develop relationships between clinicians in the region to improve patient outcomes and reduce utilization
- Currently developing metrics, goals, and a charter
- Increasing awareness and utilization of the EDCC across the region and nodes of care

Impact and Outcomes

Family Insights: Achieving Better Care Coordination with the EDCC

- **Family Insights Virginia based clinics support families and individuals with treatments for a diverse spectrum of mental health needs**
- **Complete Care Model**: Family Insights' value-based model integrates physical, mental, and social health for holistic care
- **EDCC Integration**: Real-time alerts through the EDCC program allow timely interventions, improving care coordination and reducing unnecessary ER visits
- **Impactful Results**:
  - 25% reduction in ER visits
  - 35% reduction in hospitalizations
  - 32% decrease in inpatient behavioral health use
- **Real-World Example**: Identified a patient making multiple ER visits for sinusitis and facial pain, which were linked to untreated dental abscesses and anxiety. By coordinating care for a daytime visit with a dentist, we addressed both physical and mental health needs, reducing unnecessary ER visits.

Patient With Multiple Chronic Conditions and Undiagnosed Conditions Becomes a High ED Utilizer



Laura

Anthem BlueCross BlueShield

History

- Laura, a 41-year-old, has complex care needs and multiple chronic conditions*
- She also has a history of opioid dependency
- Due to the nature of her needs and undiagnosed conditions, her care plan has become quite extensive and includes recurring visits to multiple specialists, frequent outpatient treatments, and effective/appropriate pain management

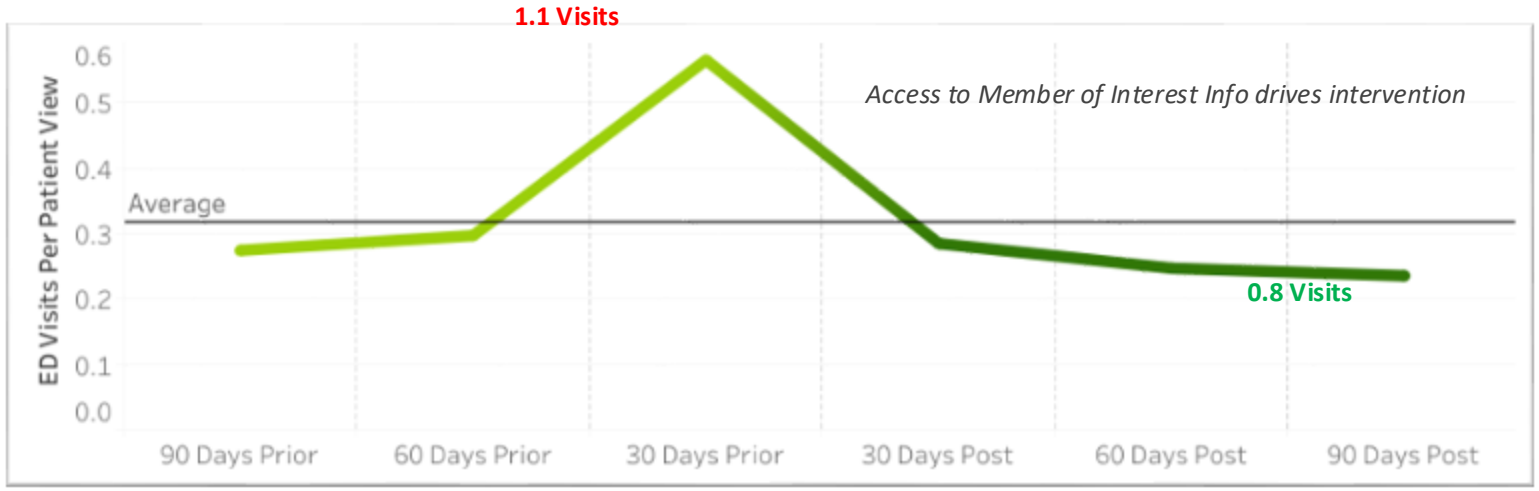
Success:

- Health plan contributed a care insight to ensure the ED has visibility into available benefits
- Hospital care manager authored a detailed care plan to support Laura's needs and shared the plan via care insights.
- Laura also has her primary care provider and 10+ care team member contacts available within the PCC Portal to ensure she is guided to the right next step in her care path
- Her ED utilization has decreased as a result of the cross collaboration of health plans and providers

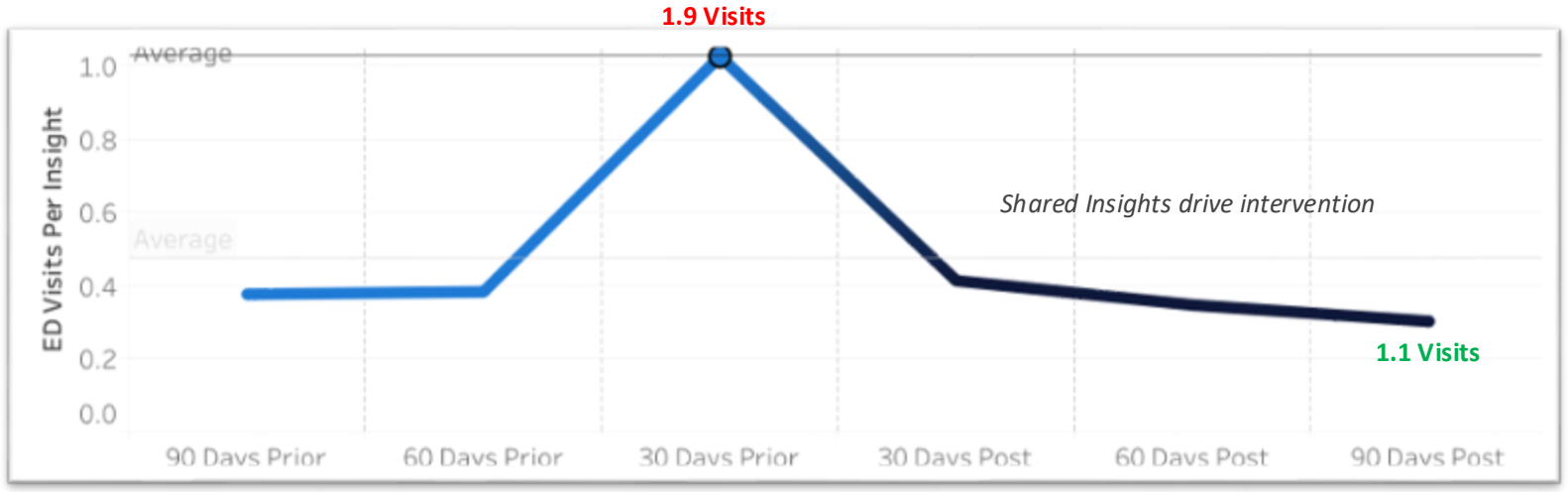
Driving Outcomes: Member Views by Health Plans Have a Direct Impact on Reducing ED Utilization

27%

Reduction in ED utilization in YTD 2024



Driving Outcomes: Care Insights Contributed by Health Plans Have a Direct Impact on Reducing ED Utilization



42%

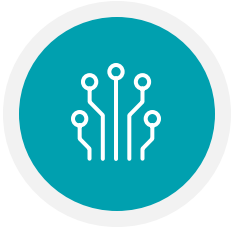
Reduction in ED utilization in YTD 2024

Road Ahead

Legislation Updates

EDCC Program		Smart Chart
Receives real-time patient visit information form, and shares such information with, **every hospital emergency department** in the Commonwealth	=	Receives real-time patient visit information form and shares such information with, **every hospital** in the Commonwealth
Provides…care management personnel with **care coordination plans and discharge and other treatment and care coordination information**…	=	Provides…care management personnel with **care coordination plans, lab results, images, and discharge and other treatment and care coordination information…**

Where Do We Go From Here?

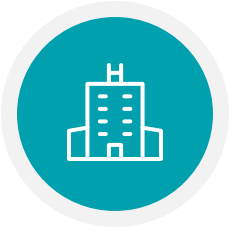


Additional Data Sources

Additional data sources beyond ADT including labs, imaging, CCDs, and claims

Ambulatory Connectivity

Growing the network of active users that are part of a patient's care team is vital to expanding the program's success



SMART on FHIR

Allows for integrated access to hospitals, expands usage, and allows more insights into usage patterns.

Q&A

Thank you!

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