WRAP - Working to Reduce Admissions Program Model for Readmission Reduction

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THE University of Vermont HEALTH NETWORK

Abstract

- Reducing hospital readmissions is a longstanding goal for facilities across the nation. Hospitals and other health care facilities with high readmission rates experience a variety of negative impacts. They put unnecessary strain on health care resources and have low patient satisfaction scores. When patients experience high hospital readmission rates, also known as super users, it is often a result of unmet or inadequately addressed co-occurring medical, behavioral, and social needs. The WRAP Program was designed to meet the complex needs of patients experiencing high utilization of the acute care setting to achieve greater health and stability and to help patients stay out of the hospital and in their home environments. The program is designed to meet large and small organizational needs in addressing this complex population.

BIO

Lindsay Morse, MSN/NED, RN, ACM

University of Vermont Health Network Vice President, Care Management

Lindsay's career is marked by a solid commitment to enhancing healthcare delivery. With over two decades of nursing experience, she has been instrumental in leading care transformation initiatives. Her expertise spans improving care coordination, managing care transitions, and fostering hospital-community collaborations. At the UVM Health Network, Lindsay oversees utilization management, inpatient and outpatient case management teams, and programs focused on care transitions and community health improvement. Her background as a process improvement advocate and healthcare leader in various environments has equipped her with the knowledge to drive organizational capabilities that support population health management and community engagement. This aligns with her goal to reduce care fragmentation and enhance the quality-of-care coordination. Lindsay holds a Master's in Nursing Education and is an ACMA-RN. She is currently furthering her education by pursuing a Doctorate in Public Health, underscoring her dedication to advancing public health and healthcare leadership.

Objectives

Learning Objective 1

Define and identify how Drivers of Utilization (DOU) impact the most vulnerable and complex patients.

Learning Objective 2

Identify how to do something different in support of super user populations who are medically complex enough to require frequent admissions.

Learning Objective 3

Identify fundamental approaches through the WRAP methodology to high inpatient utilization of patients.

About UVM Health Network

- $2B billion Network
- 15,000+ employees
- 1500+ affiliated physicians (850 specialists/300+ primary care)
- Primary clinical partner of University of Vermont College of Medicine
- Six hospitals, anchored by tertiary/quaternary academic medical center, University of Vermont Medical Center
- 1,250 licensed beds
- Designated Rural Health System

The Why

Hospital/Healthcare Facilities

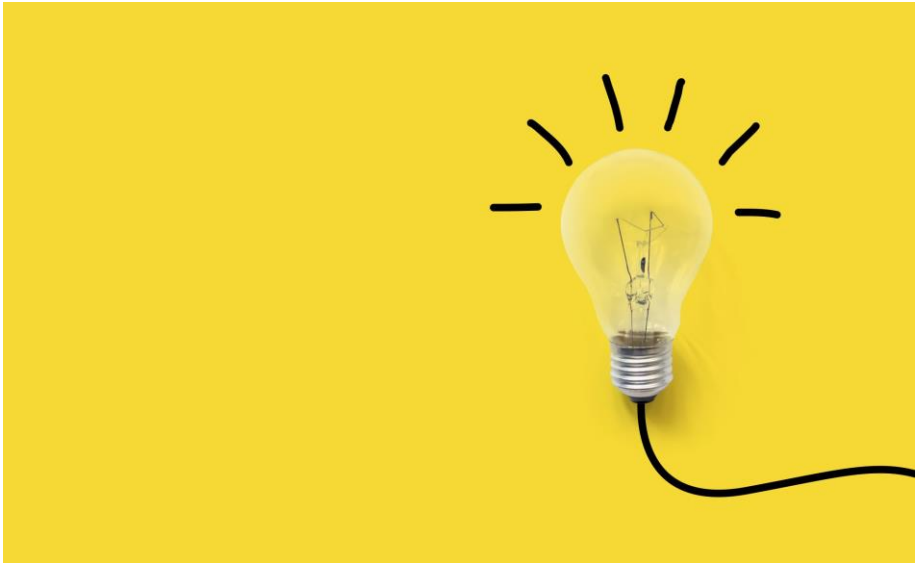
- Reducing hospital readmissions has been a longstanding goal for facilities across the nation. Hospitals and other healthcare facilities with high readmission rates experience a variety of negative impacts. **They put unnecessary strain on their care teams, time, and healthcare resources, and have low patient satisfaction scores** (Regis, 2022).

Patient/Family/Caregivers

- When patients experience high hospital readmission rates, also known as super users, it is often a result of unmet or inadequately addressed co-occurring medical, behavioral, and social needs.
  - Experience **lower quality** services
  - **Increased stigma**
  - Feelings of **Frustration and Fear**
  - **Less care** from providers
  - Increased guilt over seeking care

How it began

- The University of Vermont Medical Center's Transitions of Care Team
- Multi-Visit Patient (MVP) National Accelerated Network (*via Vizient*) led by Dr. Amy Boutwell
- Collective A-Ha Moment on the first MVP Accelerated Network Meeting
- **"Look to see what we did last time to discharge successfully....and do it again." –all of us**



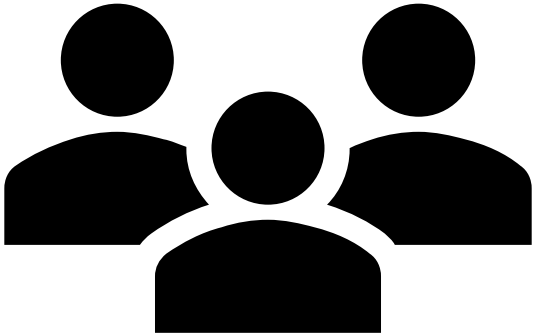
Now what…

- October 2018
  - 6 Month Pilot
  - UVMMC Inpatient Utilizers
  - Created Patient Identifier Reports
  - Ad-Hoc Inpatient Social Worker

- Identify
  - Patients who have four or more Inpatient admissions in the past 365 days
  - Daily list sent to the TOC team and the Pilot Case Manager with the admissions and their # of INPATIENT stays (and ER Visits for awareness in the past 30 and 365 days).
  - Excluded Pediatrics, Planned Admissions, and OB/GYN

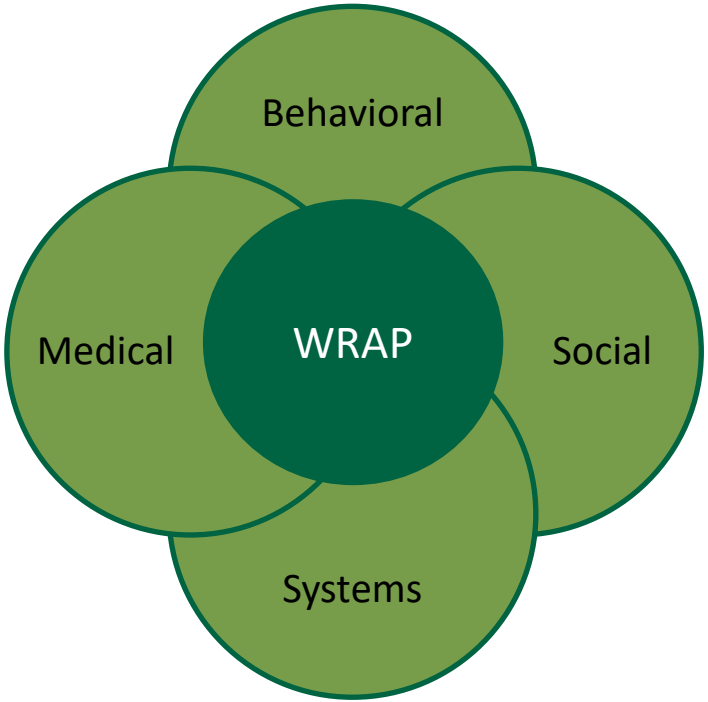
Inpatient WRAP Profile

- 53% Male, 47% Female
- 60% Over Age 65
- 91% White/Caucasian
- 49% Local to Burlington and greater area locations



Driver of Utilization (DOU)

- Most high-rate utilizers patients have co-occurring medical, behavioral, system, and social needs.
- 2019-2020
  - Developed DOU
  - Screenings
  - Pathways
  - Process Metrics

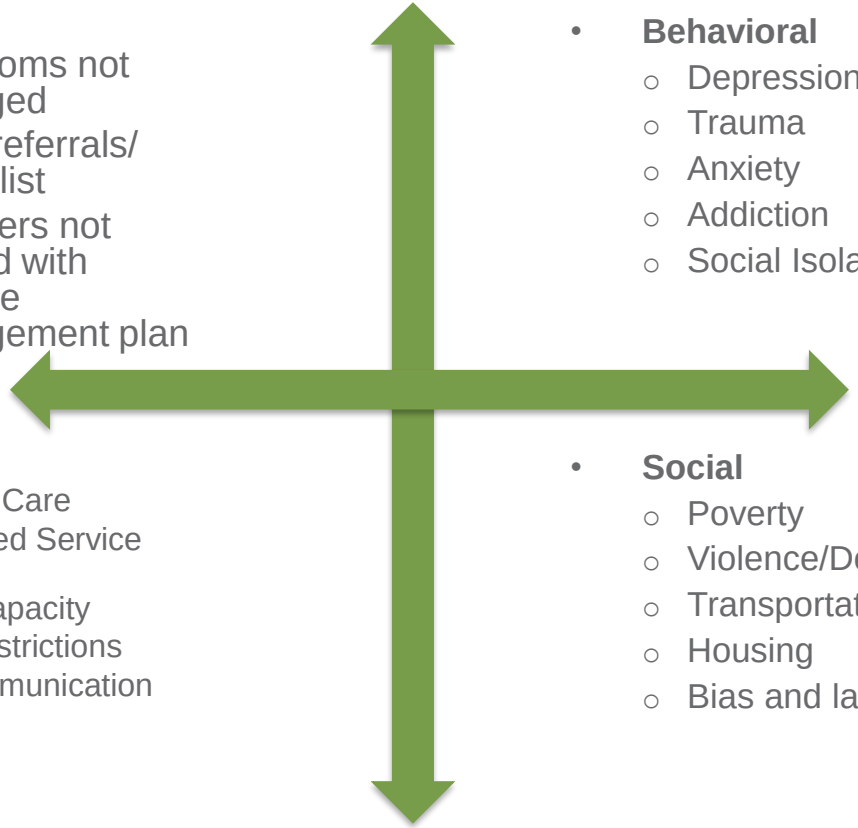


Drivers of Utilization (*examples*)

***** "NON-COMPLIANT" is NEVER a DOU*****

- **Medical**
  - Symptoms not managed
  - Need referrals/ specialist
  - Providers not aligned with disease management plan

- **Behavioral**
  - Depression
  - Trauma
  - Anxiety
  - Addiction
  - Social Isolation



- **Systems**
  - Access to Care
  - Fragmented Service Models
  - Limited Capacity
  - HIPPA Restrictions
  - Poor Communication

- **Social**
  - Poverty
  - Violence/Domestic Abuse
  - Transportation
  - Housing
  - Bias and labeling

Case Example: Patient Number One

- First ever interview
- Female Veteran
- End-Stage Lung Cancer
- 6th Inpatient Stay in 5 months
- Diagnosis: Shortness of Breath and low oxygen levels with chest pain

- **Be curious**
- **Look beyond doing the same thing**
- **Seek the Driver of Utilization**

Screenings/Actions

- Incorporated PatientPing (Admission, Discharge, Transfer (ADT) Feed)
- Implemented Screenings
  - Palliative (Active)
  - Smoking (Active)
  - Pharmacy (Active)
- Para-Medicine Program Connection and Engagement
- ETOH DOU Resources while Inpatient

Continued engagement and pathway creation:

- Heart Failure, *Geriatrics Pathways Collaboration, Med-Psych Pathway Collaboration ,ED Pathways (Plan for Return) Process*

DO SOMETHING DIFFERENT!!!!

Key Breakthrough: Screen with Palliative Care Tool

PALLIATIVE CARE SCREENING TOOL

Criteria – Please consider the following criteria when determining the palliative care score of this patient

1. *Basic Disease Process* (2 points each)

a. Cancer (Metastatic/Recurrent)
b. End stage renal disease on dialysis
c. Advanced COPD
d. Advanced cardiac disease- CHF with low ejection fraction
e. Stroke with severe functional deficits
d. Other life-limiting illness

2. *Other Disease Processes* (1 point each)

a. Liver disease
b. Moderate congestive heart failure
c. Moderate renal disease
d. Moderate COPD
e. uncontrolled diabetes

3. *Functional status of patient (Score as specified)*

Using ECOG Performance Status (Eastern Cooperative Oncology Group) / ECOG Grade Scale

Grade 0 - Fully Active, able to carry on all pre-disease activities without restriction. (Score 0)

Grade 1- Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work. (Score 0)

Grade 2- Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours. (Score 1)

Grade 3- Capable of only limited self-care; confined to bed or chair more than 50% of waking hours. (Score 2)

Grade 4- Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair. (Score 3)

4. *Other criteria to consider in screening (1 point EACH)*

The patient:

a. is not a candidate for curative therapy _____
b. has a life-limiting illness and chosen not to have life prolonging therapy _____
c. has unacceptable level of pain >24 hours _____
d. has uncontrolled symptoms (i.e. nausea, vomiting) _____
e. has uncontrolled psychosocial or spiritual issues _____
f. has frequent visits to the Emergency Department (>1 x mo for same diagnosis) _____
g. has more than one hospital admission for the same diagnosis in last 30 days _____
h. has prolonged length of stay without evidence of progress _____
i. has prolonged stay in ICU or transferred from ICU to ICU without evidence of progress _____
j. Is in an ICU setting with documented poor or futile prognosis _____

TOTAL SCORE _____

SCORING GUIDELINES:
TOTAL SCORE = 2 No intervention needed
TOTAL SCORE = 3 Observation only
TOTAL SCORE = 4 Consider Palliative Care Consult

- ✓ Screen every WRAP
- ✓ 4+ = pall care consult
- ✓ WRAP Team can place the consult
- ✓ Notice how many WRAPs screen +
  - Presence of serious illness
  - Limited functional status
  - Multiple visits
  - Poorly controlled symptoms

59% of WRAP patients are either engaged in the past 3 months with Palliative Team or screen positive for a Palliative Consult

Continued Evolution

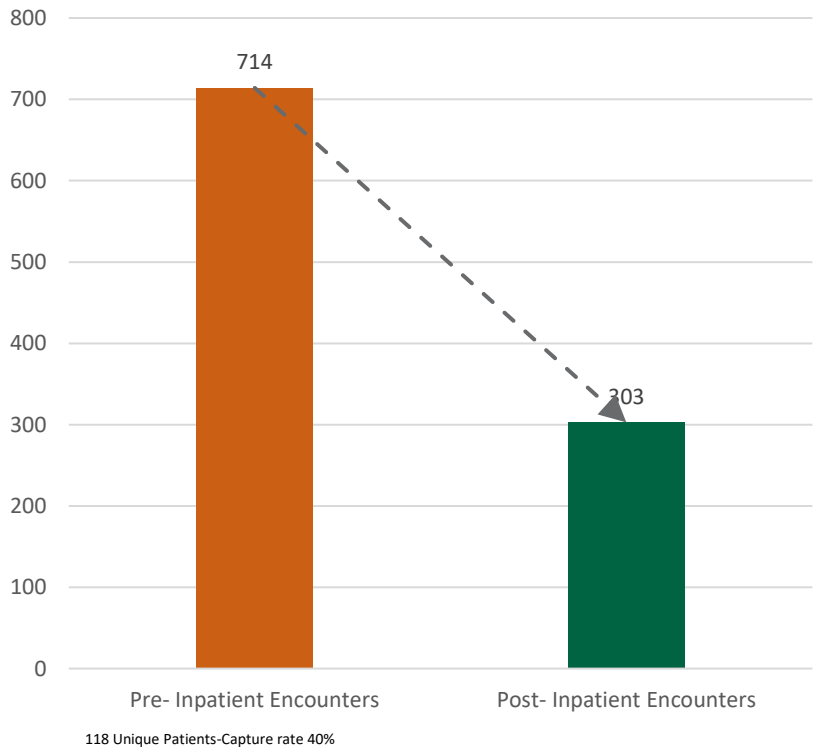
- Full Operational 1.5 FTE- WRAP Program Case Manager
- COVID-19
- Cyber Attack
- Dedicated Pharmacist
  - Cross Pollination with Heart Failure Pharmacist
- Outpatient PHSO- Integrated Care Management Stood Up

WRAP Pharmacy

Officially dedicated WRAP Pharmacist (started 9/29/21)

- The Need is High…
- 75% Screen Positive for needing WRAP Pharmacist
- Dedicated .05 FTE then increased to 1.0 FTE in 2022

Impact of Readmissions Inpatient



Overall, **58%** decrease in Inpatient Admissions

- 411 Decreased Readmissions
- Does not include deaths

54% Decrease in LOS for WRAPs Readmitted

Readmission Cost Savings:
Estimated: **$6.1 Million**

Results for CY2023 aligns with similar decrease over the past 3 years of program

Building Bridges

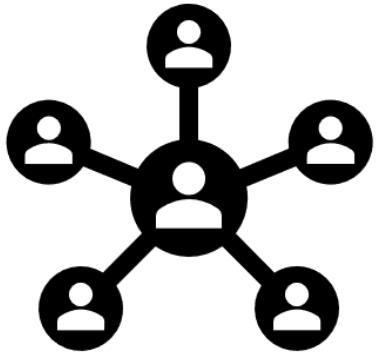
- Referrals do NOT work on this population
- Outpatient Integrated Care Management
- Community Partners (do something different)
- Planning for the Return
- Expand into the Emergency Department Utilization

Future

- Spread Emergency Department WRAP programing and resources to all UVMHN communities (NY and VT) by October 2024
- Program impact evaluation in collaboration with academic partners
- Begin preparations for Inpatient WRAP program spread to all sites of care in UVMHN for 2025

Multidisciplinary Team

- Kathrine Acus, LICSW, CCM
- Lisa Anderson, LICSW, CCM
- Angela Demasi, RN
- Jennifer Franzoni, LICSW, ACM, CCM
- Erica Garofalo, RN
- Joseph Goodrow, LMSW
- Amanda Kiruthi, LICSW, CCM
- Beth Reilly, RN
- Kimberly Jennett LMSW, CCM



Key Takeaways

- Super-users require us to “Do Something Different”
- There is a Driver of Utilization: Be curious, ask why
- “Non-Compliance” is NEVER a Driver of Utilization
- Referrals do NOT work
- Plan for the return
- Success is when the individual achieve stability (whatever that may look like)

Questions or Comments?

Thank you!

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Appendix

References

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