Prepared for the Foundation of the American College of Healthcare Executives

Session 104AB
Reducing ED Recidivism: A Necessary Population Health Strategy

Presented by:
Trent E. Gordon, FACHE
Marianne D. Araujo, PhD, FACHE
Roseanne C. Niese

AmericanCollege *of*
HealthcareExecutives
for leaders who care

Reducing ED Recidivism:

A Necessary Population Health Strategy

2016 CONGRESS ON HEALTHCARE LEADERSHIP
MARCH 14–17, 2016
HYATT REGENCY CHICAGO
LEADING WELL

Presenters

- Marianne Araujo, PhD, RN, FACHE
  - Chief Nurse Executive
- Trent Gordon, MS, FACHE
  - Vice President, Strategic Planning
- Roseanne C. Niese, MBA, RN, NE-BC
  - Director, Emergency Services and Medical / Surgical

Learning Objectives

- Gain knowledge to implement individual care plans in an emergency room setting.
- Learner will learn to decrease cost of care by decreasing recidivism and redundant tests.

Agenda

- About Us
- Why be concerned about ED visits?
- ED recidivists to Good Shepherd
  - Integration with ED EMR
  - Integrated care plans
  - Overall success

ABOUT ADVOCATE HEALTH AND ADVOCATE GOOD SHEPHERD HOSPTIAL

Advocate Health Care

- Named among the nation's Top 5 largest health systems by Truven Analytics.
- Largest health system in Illinois and one of the largest health care providers in the Midwest.
- Operates more than 250 sites of care
  - 12 hospitals that encompass
    - 11 acute care hospitals and 1 critical access hospital
  - The state's largest integrated children's network
  - 5 Level I trauma centers
  - 2 Level II trauma centers
  - One of the area's largest home health care companies
  - One of the region's largest medical groups.

Advocate Good Shepherd Hospital

Advocate Health Care – Embracing Risk

- A number of commercial ACO contracts as well as an MSSP ACO
- Largest number of attributed lives in ACO contracts in the country – 700k+ lives (Modern Healthcare 2013 and 2014)
- Very intentional population health approach
- Moving more into risk contracts

Advocate Good Shepherd Hospital

Community-Based

- Barrington, Illinois (NW Chicago suburbs)
- 176 Beds
- 34,000 ED Visits
- 11,000+ Inpatient Admissions
- 7,000+ Procedures
- Level 2 Trauma

Certifications/Awards:

- DNV ISO 9001 Certified
- ANCC MAGNET
- 2012-2015 ENA Lantern Award
- 2013 Richard L. Doyle Award
- Commission on Cancer Outstanding Achievement Award
- DNV Primary Stroke Center Program
- Diabetic Certification
- Truven Top 50 Cardiovascular Hospital (2 times)
- EDAP
- SCPC Accredited Chest Pain Center
- SCPC Accredited Atrial Fibrillation Center
- National Accreditation Program Breast Centers

WHY BE CONCERNED ABOUT ED VISITS?

Newly Insured Status Doesn't Deter Use

- Studies (Oregon, Massachusetts) show that newly insured continue to visit ED for their primary care
- Under risk-based contracts hospitals responsible for their care

You're seeing these patients now and more may be on the way!!!

Low Cost Approach to High Cost Patients

- Creative approach to known patients that addresses patient behavior at the site of care and in a planned, inclusive way
- Not a bricks and mortar approach of setting up new sites
- Not an improved-access approach that may potentially increase costs

Costly Visits

- 136.4M visits annually
  - $1,316 average charge for an outpatient ED visit
  - $145 office visit
  - $1,171 difference
- 41% of outpatient ED visits could have been handled in a PCP office
- These visits cause longer wait times for appropriate patients
- These visits can slow down throughput, which is publicly measured and reported

Source: Truven Health Analytics

Realities of High Recidivism

One of the most important negative impacts on patients who have a high ED recidivism is that the care they do receive is potentially:

Inconsistent **and/or not** High-Quality Care

Advocate Good Shepherd Hospital

Realities of High Recidivism

With each ED visit:

- Lack of communication
  - The plan of care and treatment can greatly differ from visit to visit even if the symptom presentation is the same
  - Differing goals
- Inconsistent Continuous Care
  - Using the ED as THE primary care
  - Additional costs to using the ED as primary care
  - Not promoting healthy outcomes

Advocate Good Shepherd Hospital

Realities of High Recidivism

Costs and Over-Utilization of Resources

- Duplication of Diagnostic Exams
  - Labs
  - CT Scans
- Readmissions
- Reimbursement

Advocate Good Shepherd Hospital

Focus on the Vital Few

The Henry J. Kaiser Family Foundation (2007) reported that "frequent ED users comprise only 1% of the study population but are responsible for close to 18% of total Emergency Department visits and close to 16% of Emergency Department expenditures."

Advocate Good Shepherd Hospital

OUR STORY

What Change Innovation Can Do!

- Magnet Conference in 2010
  - Staff driven project
  - Leadership sustains
  - Organization supports
- Over the course of 2 years, we
  - Reduced ED Recidivism 87% in the first year
  - Realized a projected health care cost savings of about $2.3 million by the second year

Advocate Good Shepherd Hospital

Initiation Reasons

- Dissatisfaction
  - ED physician frustrations
  - Patient satisfaction concerns
  - Decreased associate morale
- Inconsistent and fragmented care
  - Not addressing the real needs of patients
  - No continuity of care
  - Patient Fatigue Syndrome
- Health Care Reform
  - Readmissions
  - Reimbursement concerns

Advocate Good Shepherd Hospital

Why a Care Planning Team?

- Involvement of patient, family, staff, and primary care physician in the development and implementation of appropriate patient treatment plans for ED patients is very powerful.
- The team can regain a sense of control and have a clear direction.
- Studies have shown an increasing popularity with involving inter-disciplinary teams within the ED that are dedicated to design and implement individualized plans of care that deliver high quality continuity of care.
- Individual attention to managing patients with high recidivism rates has been shown to both reduce ED use and improve the symptoms of patients with chronic conditions.

Advocate Good Shepherd Hospital

Change Our Thinking

Within the total population of patients who seek care in Emergency Departments is a subset of patients who misuse or abuse the services of the Emergency Department (ED).

We asked ourselves - why is this?

Advocate Good Shepherd Hospital

Change Your Thinking

- Do these patients have access to any other type of health care beyond the ED?
- Is the ED the only place where they know to receive health care services?
- What drives these patients to continue to return to our Emergency Departments?
- Not all patients who overuse the ED intend to misuse or abuse the ED. They are seeking care out of desperation.

Advocate Good Shepherd Hospital

How Advocate Good Shepherd Tackled Recidivism

- Developed an interdisciplinary team
- Created Individualized Plans of Care
  - Family included
  - Other medical professionals within and outside Advocate
- Accessed resources

Individual Care Planning Fundamentals

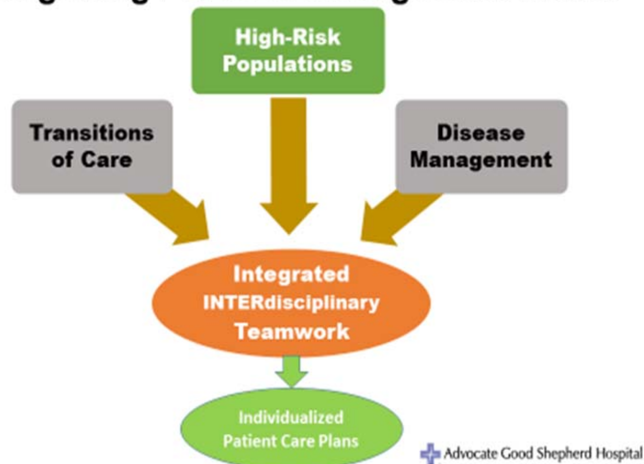
- Provide consistent high quality, patient-centered care with each ED visit.
- Reduce recidivism rates.
- Manage healthcare costs.
- Empower patients to become active participants in their own healthcare by providing tools and alternatives to promote healthy lifestyles.
- Partner with patient's healthcare providers to create individualized plans of care.

Changing Paradigms: What Do We Need To Do Differently?
Enterprise Care Management (ECM)

FROM…	TO…
Silo case management	Enterprise care management
Episodes of care	Coordination of care
Discharges	Transitions
Utilization Management	Right care, right place, right time
Caring for the sick	Keeping people well
Production (volume)	Performance (value)

Advocate Good Shepherd Hospital

Integrating ED Care Management Model



ICP Program – Foundation Structure

(Individualized Care Plans)

1. Identify the Patient Population
2. ED Recidivism and Readmissions
3. Team Membership and Meeting Schedule
4. Creating a Vision and Charter
5. Create Operational Guidelines
6. Develop Exclusion & Inclusion Criteria
7. Enrollment & Referrals of Patients
8. Creating Visual Triggers – Transparency in Communication
9. Reporting Structure
10. Gaining Organizational & Leadership Support
11. Compliance w/ HIPAA, Legal, Risk, HIM….
12. Data Collection

Individualized Care Plan Patient Types

- Narcotic Recidivist
- Chronic medical conditions
- Special Needs
- Social Issues
- Mental Health Concerns

Synergy

The ED Care Manager and the Social Worker Dyad

- **Care Manager/Social Worker** assesses the patient/family need.
- **Care Manager/Social Worker** tag-teams medical, psycho-social, behavioral, and/or substance abuse issues.
- **Partnership** with patients and families to involve them in the individualized plan care.

Advocate Good Shepherd Hospital

Team Membership

- Core Inter-Disciplinary Team
  - ED Physicians
  - ED RNs
  - ED Leadership
  - ED Nurse Care Managers
  - ED Social Worker
  - ED RN/Pediatric Liaison
  - Oncology Nurse Navigator
  - Chaplain
- Ad Hoc Team Members
  - Inpatient Nursing Team
  - PCPs and Specialists (pain, radiologist,...)
  - Inpatient Social Workers
  - Inpatient and Outpatient Care Managers
  - Hospice/Palliative Care
  - Community Resources
  - Pre-hospital

Advocate Good Shepherd Hospital

Creating Alignment: ICP Team Vision

- Our purpose is to re-instate control of the patient's condition back to the patient by creating a degree of wellness that allows the person to function at her highest contributing level.
- The patient is an active member of the team and often the driver of the plan in conjunction with the people who know the patient the best: his family, significant others, and his physician(s).

By planning and creating options and choices, the plan is Patient-Driven and Inclusive.

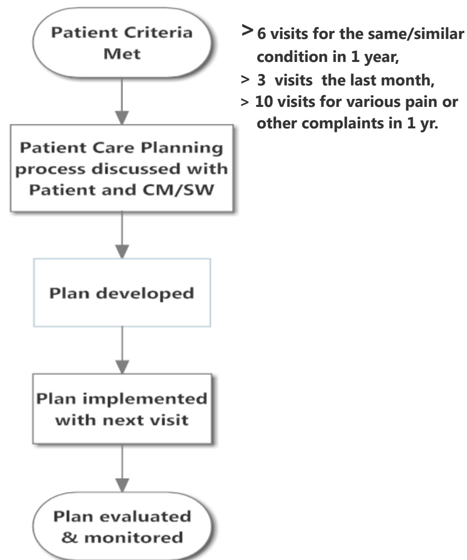
Advocate Good Shepherd Hospital

ICP Format

- Inter-disciplinary ED Care Plan Team
- Under direction of an ED MD
- Engagement & empowerment of ED staff
- Provides the tools for the patient to ultimately take responsibility for her own health/wellness
- Care Plans are the essence of Care Management

Advocate Good Shepherd Hospital

ICP Process



> 6 visits for the same/similar condition in 1 year,
> 3 visits the last month,
> 10 visits for various pain or other complaints in 1 yr.

Individualized Care Planning Design

- Staff and physicians can both refer/recommend patients
- Scheduled monthly ICP meetings
  - Ongoing work throughout the month
- Case presentation and review
  - Criteria met?
- Create a plan of care
  - Simple versus Complex
  - Formal Care Conferences

Advocate Good Shepherd Hospital

Patient Enrollment: Inclusion & Exclusion Criteria

1. Visit trends
2. Evidence on the Illinois Prescription Monitoring Program website (https://ilpmp.org) of inappropriately obtaining opioid prescriptions
3. Other questionable behavior that can be well-documented
4. Other special needs patients such as those with LVADs, hemophilia, et al.

Advocate Good Shepherd Hospital

Automated EMR Visual Trigger

Patient Name

Patient Name

ICP Format

- Title / Type of Plan
- Patient Name
- Date of Birth
- Medical Record Number
- Primary Care Physician
- Specialty Physicians
- Direction of Care
- Safety Section
- Treatment / Medication Protocols
- Pertinent Medical History
- Psychosocial History Section

Advocate Good Shepherd Hospital

ICP Format

Jane Doe Emergency Department Care Plan

DOB 01/01/51

MR# 123456789 **New POA – John Doe 555-555-5555 (son)

Initiation Date: (5/19/11) REVISED 11/28/12 / Revised 6/1/13 / Revised 8/30/13 / Revise10/30/13 Revised 3/28/14 / Revised 9/1/14 11/25/14. Updated 12/12/2014 rmm. Updated 12/17/2014 RMM. Updated 5/25/15 dm Updated 6/23/15 STC

NEW INITIATIVE: PAGE (THROUGH OPERATOR) CHAPLAIN SAM MARTINEZ IMMEDIATELY UPON ARRIVAL
It doesn't matter what time or day – * help to manage ED visit / family

- **ED Care Manager should always see patient with every visit**
- **ED Social Worker must see patient with every visit to encourage psychiatry evaluation and follow up**
- **As of 5/25/15 – Unable to secure care by an Illinois based pain physician – continuing to follow with Dr. Rudin in Wisconsin**

PCP: Local physicians: Dr. C PCP/ Dr. W (managing mediport May 2015) / Dr. H / Dr. B
University of Chicago –Gastroenterologists: Dr. A and Dr. E – 555-555-5555
Pain Management Dr. Q – 555-555-5555 Hematology Dr. Z 555-555-5555 Dr.X, Neurology.
Hopice: Was being treated through xxxxx discharged 1/1/11 – Dr. T and ARNP Jane.

- Centegra Inpatient admissions 2013 = 13 times
- Multiple admissions to St. Alexius, GSHP, and primary facility U of C.
  Dr. B contact Dr. B and is writing prescriptions for pain medicines. Pt sees Dr. Bl every week.

Approved Emergency Department Pain Management Protocol as Recommended by *Dr.B* (*5/24/13 Letter of direction and 5/22/13 Care Conference) cancelled -*
Dr.B will not call us back to update the pain medication plan. 5/25/15

NEW UPDATED per Dr. EDMD and ICP team– Communicated with PT on 5/25/15

- When Patients pain flares are not managed by home medication regimens, she can be safely managed with the following. Patient is sufficiently tolerant to opioids and should be able to handle this dosage without difficulty.
  - Administer 1-2mg Dilaudid.
  - Benadryl dosing should not exceed 50mg.
    - If pain is still not managed, contact Dr. R she is the PCP as of 5/15

If Laura's pain is not managed with the above The ED MD will make a decision based on clinical need if admission is warranted or if can be managed safely at home.

Problem List:

1. Whipple procedure (2012) (Pancrectomy)
2. Splenectomy
3. Successful Islet Cell Transplant (2012)
4. Recurrent Sepsis events (2011, 2012, and 2013) from *central line sources*
5. DVT and Pulmonary Embolus (2012 and 2013) from *central line sources*
6. Venous Thrombosis in Brain 2014
7. Von Willabrand's Disease – variant not yet defined as of June 2013 (still needs final follow up)
8. Chronic Abdominal Pain - Pain is 8/10 at best, 9/10 at worst
   a. (3) Celiac Nerve Blocks performed in past
9. Chronic malabsorption and diarrhea
   a. TPN infusion
10. Episodic Orthostatic hypotension vs Dehydration
11. Recurrent lower leg cellulitis (6/13)
12. Laura has been verified to be **ABSENT** of any addiction issues (per Dr.B)
13. April 2015 EKG shows Long QT syndrome – methadone stopped – will follow with cardiologist
14. Pseudoseizures

Continued……….

Emergency Department Direction of care for symptoms unrelated to usual abdominal pain or feelings of dehydration or hypotension

- Work pt up in the same manner as for any other patient.
- There is no risk of hospital induced anemia, even when there have been recent phlebotomy draws. If he needs lab work, it may be done without concern.
- PT has a very complex medical history and has suffered multiple episodes of complications from PICC lines (sepsis, DVT, and PE). We need to anticipate for these potential events as they have been recurrent.

Continued……

Direction of Care:

- Interdisciplinary Care Conference held 5/22/13 that included both health care providers from University of Chicago, Advocate Good Shepherd, and pt's father. Updated care plan based on care conference discussion and recommendations
- Staff must recognize that there is much anxiety, anger, and mistrust projected towards health care team members based on patient's and family's long history of seeking treatment for health issues.
- ED Care Managers to see patient with every visit
- Psych social worker to be involved with every visit
  - Reach out to Hospice– consult and collaborate for both patient and family support
  - Health Psychology Referral is recommended to develop further coping skills for pain and disability.
- Contact Dr.s AB and C with each visit for any questions and or further direction of care.
- Dr. should be contacted with every ED visit to ensure the local MD connection
- Dr. should be the only one who is managing her narcotic prescriptions.
- **pt's feelings of dehydration may actually be caused by episodic orthostatic hypotension.** Past BUN and Creatinine lab values have been consistently within normal. If he presents with these symptoms, **go ahead and administer one liter of normal saline (0.9NS) during the course of her ED visit to help mitigate these symptoms.**

ICP Format (inpatient plan not shown)

Psycho-social Support

(IMPERATIVE THIS IS NOT SHARED with patients father <u>Per Patient Request</u>)

- Chaplain Sam Martinez has set up an excellent rapport with patient. ICP team concerned over continued weight loss, recurrent sepsis events, and continued degradation of health. Since 5/22/13 Care Conference, there has been no follow up for mental health as discussed. Sam has been able to work with pt who wants to speak to a psychologist but does not want father to know or be involved. Patient is concerned about not thier own health but the relationship with son and the impactof failing health has on son.
- Inpatient social work placed contact to psychologist 8/30/13 to begin
- Offer Chaplain Sam Martinez visit with every ED visit– patient has a strong Catholic faith
- Dr. EDMD shared with the Care Planning Team her concerns over nutrition –has not been consistently using the TPN at home and has been skipping infusions a few days at a time.

Medication List as of May 2015

	Medication	Dose	Amount	Frequency
1.	Cholecalciferol(Vit. D)	1000U	(1) TAB	Q Day
2.	Diphenydramine	25mg	(2) Caps	Q 6 hours PRN
3.	Cymbalta (Duloxetine)	60mg	(1) Tab	Q morning
4.	Multivitamins		(1) Tab	Q morning
5.	Bactroban	2%		Apply PRN
6.	Zofran	4mg	(1) Tab	Q 8 hours PRN
7.	Pancrelipase (Viokase 16)	60/16/60 MU	(3) Tabs	3x Daily at mealtimes
8.	Protonix	40mg	(1) Tab	Q Day
9.	Compazine	10mg	(1) Tab	Daily at bedtime PRN
10.	Topamax	200mg	(1) Tab	Q Day in the morning
11.	Retin-A Cream	1%		Apply to face Q NOC
12.	Coumadin	10mg	(1) Tab	Q day
13.	Lovenox new since	44mg	SQ	
14.	Keppra Elixer	500mg	po	
15.	Hydromorphone (Dilaudid)	4mg (1mg/1ml)	4 ml	Q12 hours

<u>Central Line / PICC Line Issues</u>

- Every PICC line and Mediport placed and or replaced in 2012 and 2013 has ended with a sepsis event or a DVT / PE event. (Currently, 4/30/15 – pt has PICC line).
- Consult placed with PICC RN to evaluate home care process – concern as to why so many sepsis events – 8/13 re-education occurred and evaluation by PICC RN.
- 10/30/13 – Dr. EDMD shared that the organisms causing repeated sepsis events are due to the patient's own well water. Patient had shared with Dr.EDMD that they are installing an ultraviolet light system in the home to mitigate the organism growth.
- Additionally, Dr. EDMD stated there is a health care compliance concern –has not reached out to any of her physicians for (3) days when she began to experience rigor, chills, and fever, despite being discharged very recently with sepsis again (10)

Why:

- We need to provide a good thorough medical screening.
- Review History.
- Because of her complexity, when there are questions or concerns, always reach out to one of her physicians.

ED care plan Revised 12/20/14

Interdisciplinary conference 12/20/14 w/ Dr Onwuta and APN, Tracy per I/P Care Plan Team

Inpatient Plan

- Dr Onwuta/NP Tracy to manage patient's pain regimen at the start of each admission to GSH and throughout discharge (per the request of hospitalists Dr Rao, and Dr Kapoor)
- Dr Onwuta to contact UW pain specialist, Dr Rudin, (608) 263-8639 to advise regarding patients GSH plan of care
- **Patient is not to receive parental administration of IV narcotic pain medications,** with the exception **of** emergent situations, or at the direction of Dr Onwuta/ NP Tracy
- **Pt to receive PO pain medication such as Dilaudid - GSHP now stocks the oral Dilaudid suspension**
- Verify current medication list and reconcile with the Illinois Prescription Drug Monitoring program
- Jan Bevilacqua to follow up, and collaborate with Season's Hospice regarding patients home palliative care program
- Barb Koenig to follow up with referral to pain psychologist, Ken Lofland (847) 920-4644
- Emergency Department plan of care to align with the above inpatient guidelines
- Barb Koenig to finalize inpatient plan of care

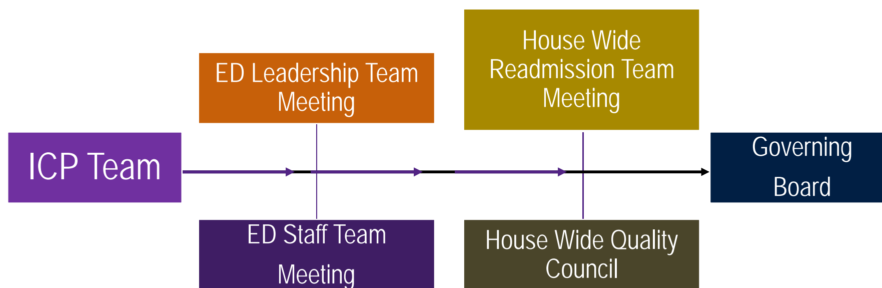
Dr. Leskovac will discuss with Dr. Barry Rosen and team will arrange to discuss further with Dr.'s Kapoor, Rao and Galezia.

1/23/14 Pt states Dr Rudin, UW pain specialist is off the case, and is only seeing MD from Seasons hospice for pain management, pt states she is seeing pain psychologist Ken Lofland.

2/12/14—pt is no longer with seasons hospice. Dr. Ruden is outpatient pain management . Dr Ruden and Dr. Onwuta should talk if pt is admitted.

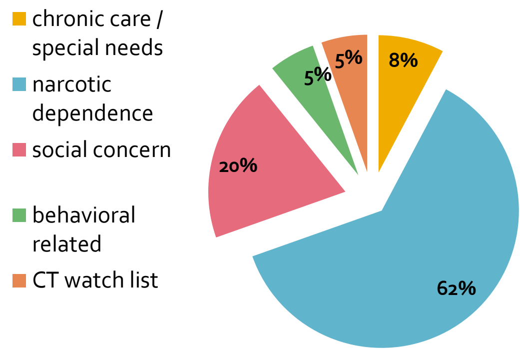
When admitted inpatient – if medically stable, try to get patient a psych evaluation. Non compliant with following up with Dr. Vedak as promised. Dr. Vedak is familiar with the family. Social work and Care Management to follow up with Dr. Vedak appointments.

Reporting Structure



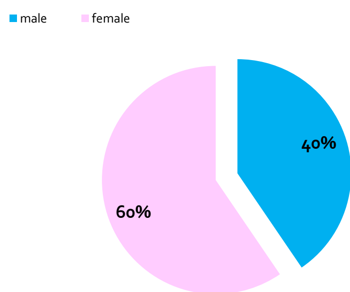
Advocate Good Shepherd Hospital

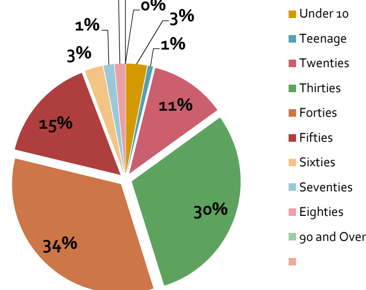
Identify Your Patient Population



Advocate Good Shepherd Hospital

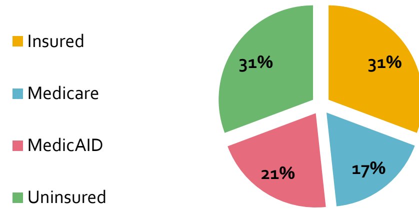
Enrolled Patient Demographics

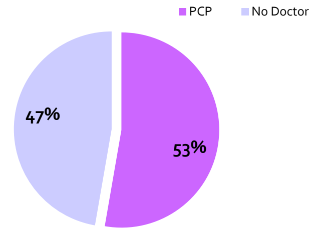




Advocate Good Shepherd Hospital

Enrolled Patient Demographics

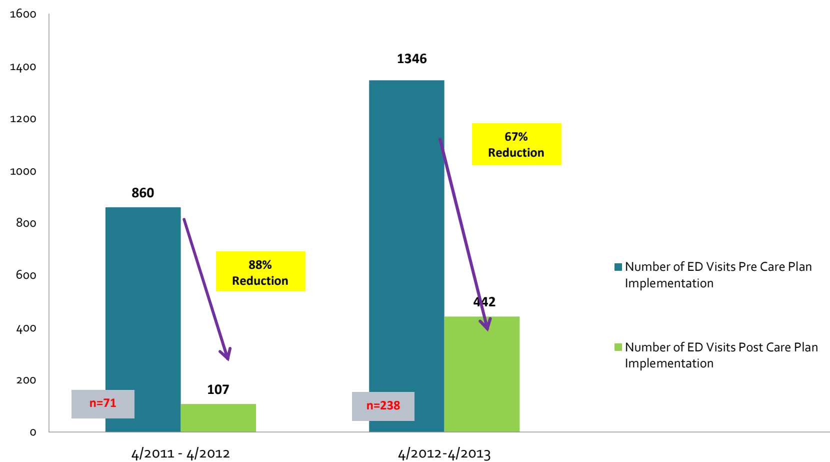




Advocate Good Shepherd Hospital

Positive Impact Seen

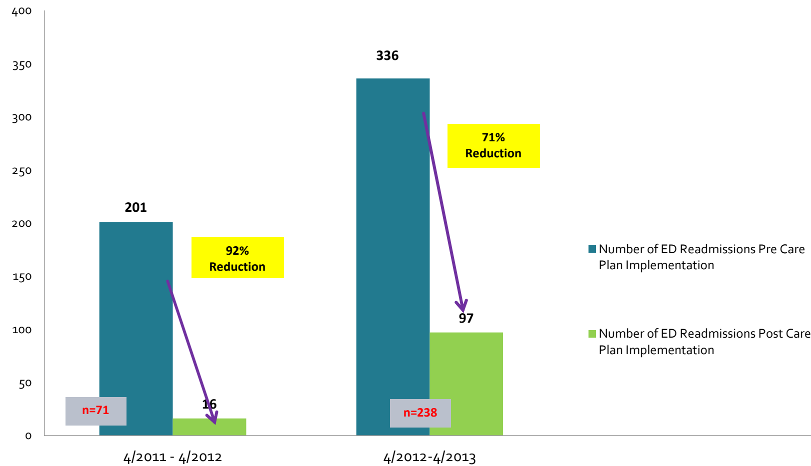
ED Recidivism Reduction as seen in Combined Demographic ICP Groups Yearly Trend



Advocate Good Shepherd Hospital

Positive Impact Seen

ED Readmissions Reduction as seen in Combined Demographic ICP Groups Yearly Trend



Advocate Good Shepherd Hospital

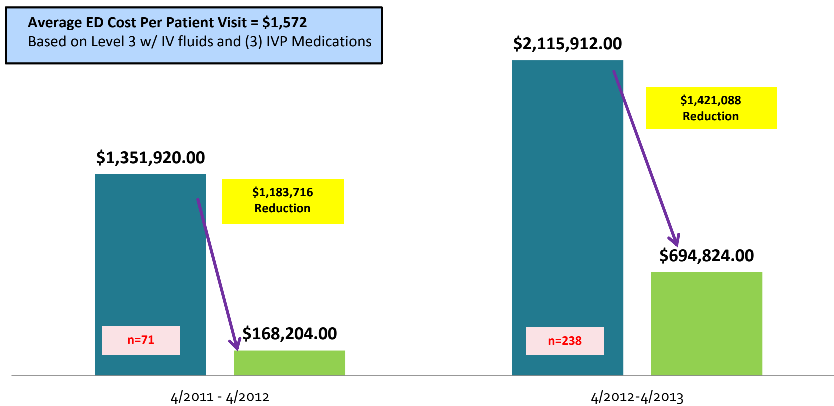
2016 CONGRESS ON HEALTHCARE LEADERSHIP

45

Cost Analysis on ED Recidivism

ED Recidivism Estimated Cost Reductions Yearly Trend for Combined Demographic ICP Groups

ED Visit Costs Pre Care Planning Implentation   ED Visit Costs Pre Care Planning Implementation

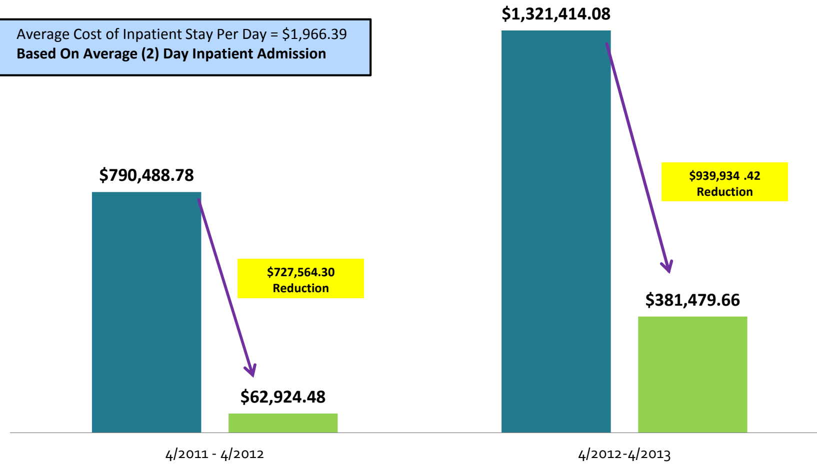


Advocate Good Shepherd Hospital

2016 CONGRESS ON HEALTHCARE LEADERSHIP

46

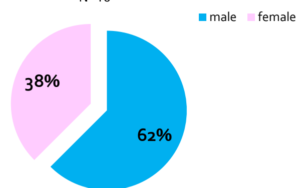
Cost Analysis on ED Readmissions



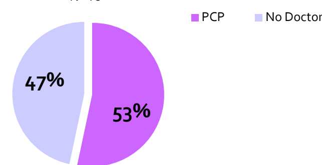
Advocate Good Shepherd Hospital

Social Concerns Demographic ICP Group

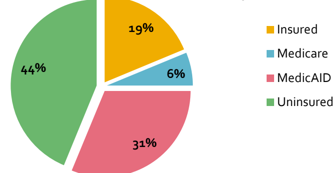
Male/Female Distribution for Social Concerns
N=16



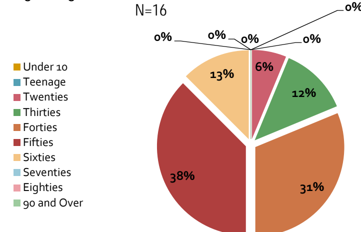
Physician Distribution for Social Concerns
N=16



Insurance Distribution for Social Concerns
N=16

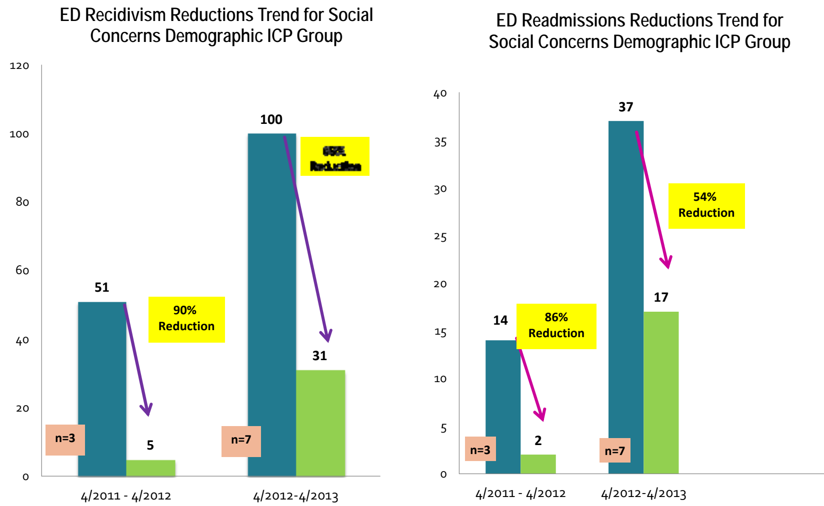


Age Range Distribution for Social Concerns
N=16



Advocate Good Shepherd Hospital

Social Concerns ICP Group

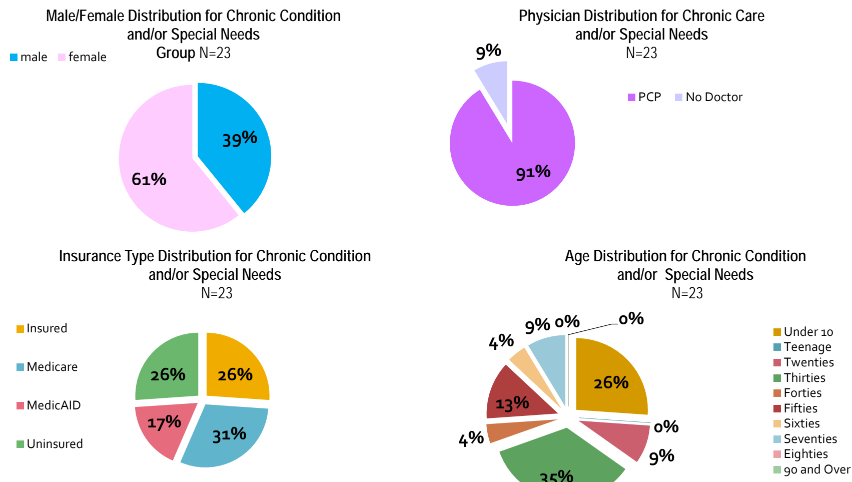


Advocate Good Shepherd Hospital

2016 CONGRESS ON HEALTHCARE LEADERSHIP

49

Chronic Condition/Special Needs Group



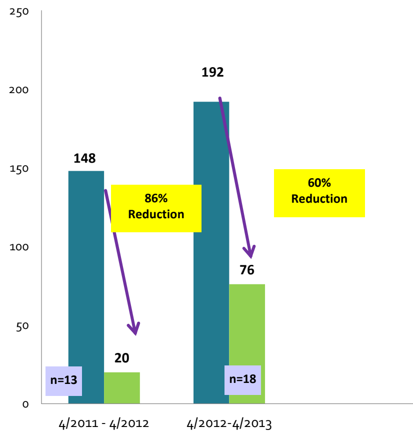
Advocate Good Shepherd Hospital

2016 CONGRESS ON HEALTHCARE LEADERSHIP

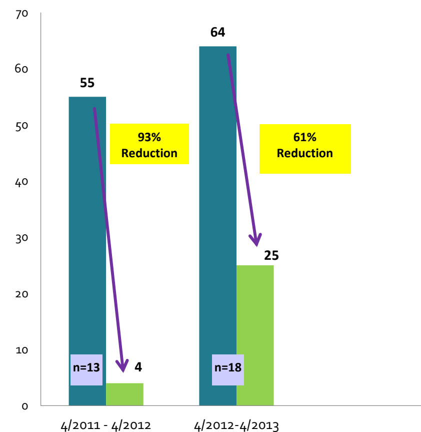
50

Chronic Conditions/Special Needs ICP

ED Recidivism Reduction Yearly Trend for Chronic Condition and/or Special Needs Demographic ICP Group



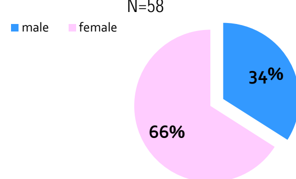
ED Readmissions Reduction Yearly Trend for Chronic Condition and/or Special Needs Demographic ICP Group



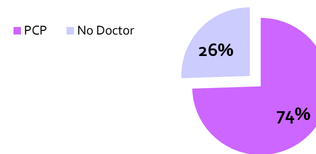
Advocate Good Shepherd Hospital

Behavioral-Related Demographic Group

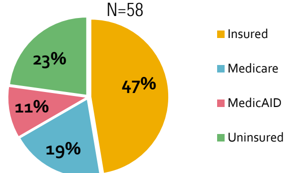
Male/Female Distribution for Behavioral-Related Issues
N=58



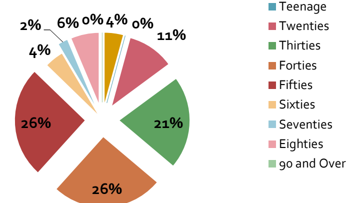
Physician Distribution for Behavioral-Related Issues
N=58



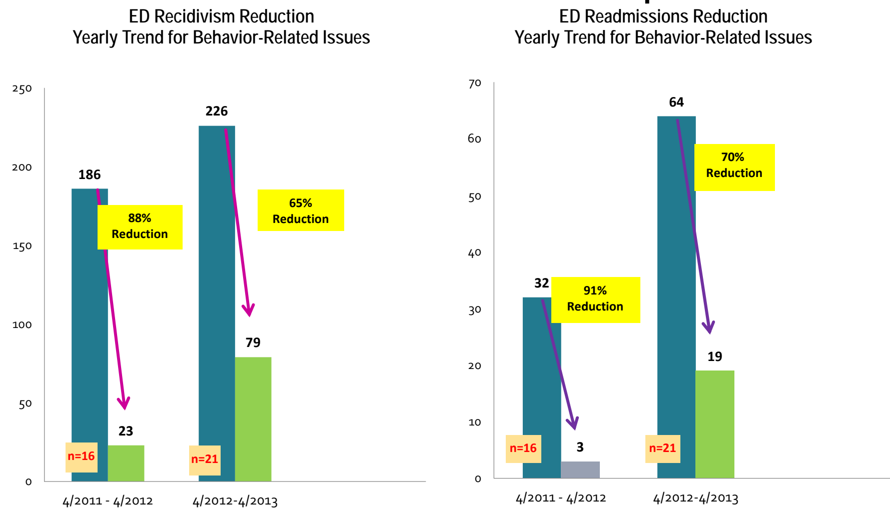
Insurance Type Distribution for Behavioral-Related Issues
N=58

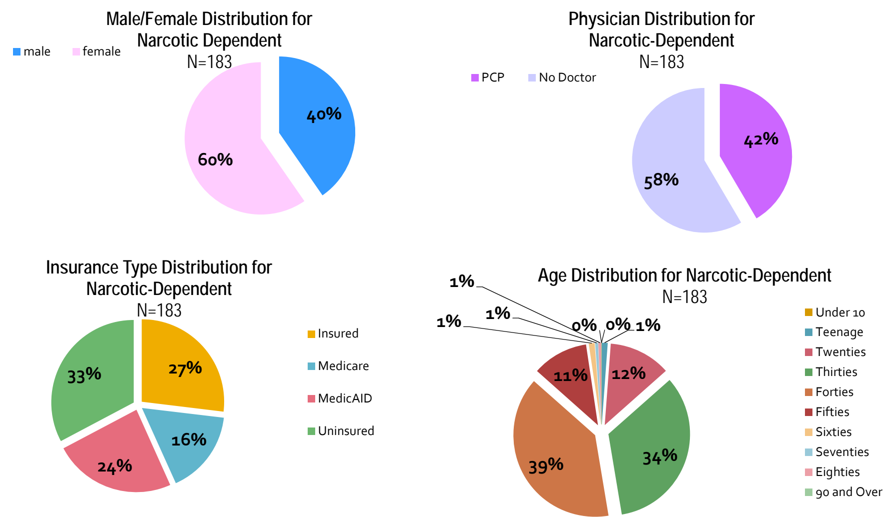


Age Distribution for Behavior-Related Issues
N=58



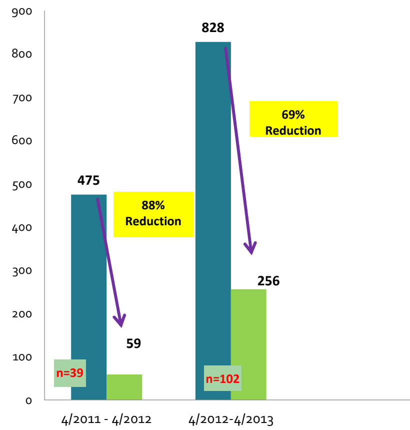
Advocate Good Shepherd Hospital


Behavioral-Related ICP Group
ED Recidivism Reduction
Yearly Trend for Behavior-Related Issues
250
200
150
100
50
0
186
88% Reduction
23
n=16
226
65% Reduction
79
n=21
4/2011 - 4/2012
4/2012-4/2013
ED Readmissions Reduction
Yearly Trend for Behavior-Related Issues
70
60
50
40
30
20
10
0
32
91% Reduction
3
n=16
64
70% Reduction
19
n=21
4/2011 - 4/2012
4/2012-4/2013
Advocate Good Shepherd Hospital
2016 CONGRESS ON HEALTHCARE LEADERSHIP
53

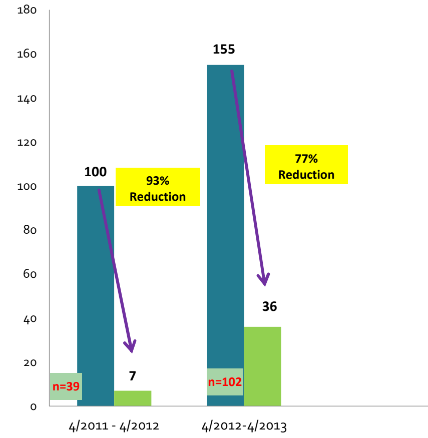

Narcotic-Dependent Demographic Group
Male/Female Distribution for
Narcotic Dependent
N=183
male
female
40%
60%
Physician Distribution for
Narcotic-Dependent
N=183
PCP
No Doctor
42%
58%
Insurance Type Distribution for
Narcotic-Dependent
N=183
Insured
Medicare
MedicAID
Uninsured
27%
16%
24%
33%
Age Distribution for Narcotic-Dependent
N=183
Under 10
Teenage
Twenties
Thirties
Forties
Fifties
Sixties
Seventies
Eighties
90 and Over
1%
1%
1%
0%
0%
1%
12%
34%
39%
11%
Advocate Good Shepherd Hospital
2016 CONGRESS ON HEALTHCARE LEADERSHIP
54

Narcotic-Dependent ICP Group

ED Recidivism Reduction Yearly Trend for Narcotic-Dependent Demographic ICP Group



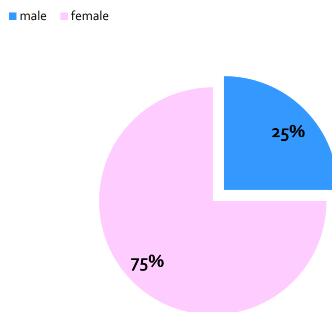
ED Readmissions Reduction Yearly Trend for Narcotic-Dependent Demographic ICP Group



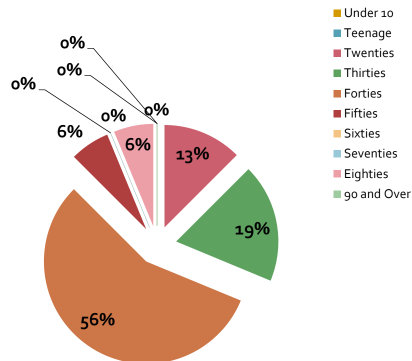
Advocate Good Shepherd Hospital

CT Scan Watch List Demographic ICP

Male/Female Distribution for CT Scan Watch List Demographic ICP Group 4/2013 N=12

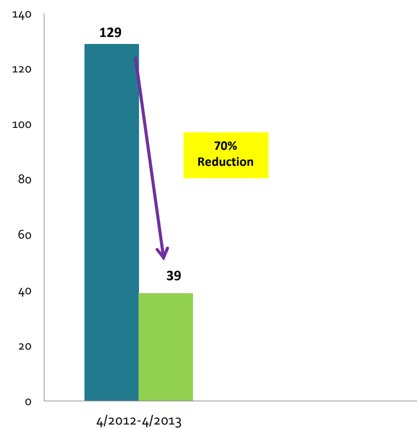


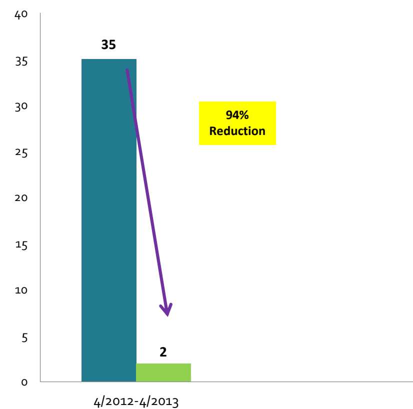
Age Distribution for CT Scan Watch List Demographic ICP Group 4/2013 N=12



Advocate Good Shepherd Hospital

CT Scan Watch List: Visit Reductions





Advocate Good Shepherd Hospital

2016 CONGRESS ON HEALTHCARE LEADERSHIP 57

Further ICP Enhancements

1. **Newly implemented visual icon trigger across system**
   Each ED and Urgent Care Center can now see icon on tracking board
2. **Offering workshops to our other Advocate Hospital EDs**
3. **Added *"Abuse and Neglect"* care plan group**
4. **Full integration of ICP within the EMR**
   System-wide access to patient care plans site-to-site

Advocate Good Shepherd Hospital

2016 CONGRESS ON HEALTHCARE LEADERSHIP 58

ICP Development: A Viable Option for Everyone

- Educating Patients
- Empowering Staff
- Linkage with Social Workers / Care Managers
- Partnering with Physicians
- Bridging Services to the Community
- Mitigating Addiction and Abuse
- Reduction of Costs
- Reduction of Readmissions
- Enhancing Patient and Associate Safety

THANK YOU!

QUESTIONS?

Marianne D. Araujo, Ph.D., MSN, FACHE

- Marianne is a graduate of Mount Sinai Hospital School of Nursing and earned both her BSN and MSN from DePaul University, Chicago. She earned her PhD in Organizational Development and Change from Benedictine University in Lisle, Illinois. She has been with Advocate Health Care as CNE at Advocate Good Shepherd Hospital for over six years and was previously in multiple hospital leadership roles at the University of Chicago, Mercy Hospital in Chicago, and others both in Illinois and Michigan. Marianne has a broad base of experience in both operations and effecting change and has served as CEO, COO, and CNE. As a consultant she worked with Ernst & Young and then led her own international consulting services. Marianne has served on several editorial boards including Nursing Management and Nurse.com, as well as on other health boards.
- Contact information:

- Advocate Health Care
- Marianne.Araujo@advocatehealth.com
- 847-842-4015

Trent Gordon, MS, FACHE

- Trent earned both his BA and MS at Trinity University in San Antonio, Texas, and has been a Fellow in ACHE since 2005. He has been with Advocate Health Care for over nine years and was previously with Evanston Northwestern Healthcare for eight years, where he oversaw the operations, academics, and research of the Department of Obstetrics and Gynecology. He has published ten peer-reviewed articles and served in leadership positions in Society for Healthcare Strategy and Market Development and other health care boards. He has also served on a variety of editorial boards, including the Journal of Healthcare Management and Frontiers of Health Service Management.

- Contact information:

- Advocate Health Care
- Trent.Gordon@advocatehealth.com
- 847-842-4259

Roseanne Niese, MBA, RN, NE-BC

- Roseanne earned her primary nursing education from St. Anthony School of Nursing. Roseanne received her BSN from Rockford College in Rockford, IL, and her MBA from DeVry's Keller School of Management. She has been with Advocate for 25 years working in various clinical areas and advancing leadership positions. She has been the Director of the ER for over 15 years and is currently responsible for Medical Surgical Nursing. Roseanne was awarded the 2008 Nursing Spectrum Nurse of the Year Award for Leadership, and led Good Shepherd's achievement of the Nursing Lantern Award in 2012 for Emergency Nursing. In collaboration with Physician Leadership, she led the redesign of the patient / work flow of the ER. By designing a split flow process, the ER staff reduced length of stay by over 20 minutes and improved Press Ganey Patient Satisfaction for the last nine months to the 80th%ile.

- Contact information:
- Advocate Health Care
- Roseanne.Niese@advocatehealth.com
- 847-842-4275

Bibliography/References

- Peppe, E., Mays, J., Chang H., Becker, E., & DiJulio, B. (2007, October). Characteristics of Frequent Emergency Department Users. (Actuarial Research Corporation and The Henry J. Kaiser Family Foundation Research Brief #7696). Retrieved from https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7696.pdf
- Truven Health Analytics, Inc. (2013, March) Avoidable Emergency Department Usage Analysis. (EMP #201209) Retrieved from: http://averytelehealth.com/wp-content/uploads/2013/03/Avoidable-Emergency-Department-Usage-Analysis-Truven-Health-Analytics.pdf
- Taubman SL. Medicaid increases emergency-department use: evidence from Oregon's Health Insurance Experiment. Science 2014 Jan 17;343(6168):263-8.

American College of Healthcare Executives
Disclosure of Relevant Financial Relationships
By Faculty and Planners of Continuing Education Activities

It is the policy of the American College of Healthcare Executives (ACHE) to ensure balance, independence, objectivity and scientific rigor in all of its directly sponsored or jointly sponsored Continuing Education (CE) activities. The intention of this policy is to identify potential conflicts of interest, facilitate resolution according to protocols, and ensure that disclosure is provided to participants prior to the beginning of the activity so that learners may formulate their own judgments as to the objectivity of the activity. Failure to disclose is grounds for dismissal as a faculty member or planner.

All individuals in a position to influence and/or control the content of ACHE directly and jointly sponsored CE activities must disclose to ACHE and subsequently to learners that the individual has either no relevant financial relationships or the nature of the financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in the CE activities.

Conflict of Interest: Circumstances create a conflict of interest when an individual has received financial benefits in any amount from a commercial interest within the past 12 months and that individual is in a position to affect the content of CE regarding products or services of commercial interest.

Commercial Interest: A commercial interest is considered any entity producing, marketing, re-selling, or distributing goods or services.

Financial Relationships: A financial interest is established by payments for various activities to the individual, the individual's spouse or partner by proprietary companies related to the content of a CE program. Examples of payments that constitute financial interests include grants or research support, employment, consultation, speaking or teaching activities, or royalties for companies. Financial interest also includes owning stock or options in any amount in these types of companies.

Name: Roseanne C. Niese
Event Title: 2016 Congress on Healthcare Leadership
Program Title: Reducing ED Recidivism: A Necessary Population Health Strategy (104A and 104B)
Relationship: **Faculty**

Do you or any immediate family member have a financial relationship or interest (currently or within the past 12 months) with a proprietary entity? **No**

If **Yes,** please indicate the individual, organization and he nature of the financial relationship below.

Do you intend to discuss an unapproved/investigative use of a commercial product/device? If yes, please disclosure such references to the learner in the educational activity. **No**

I will adhere to the ACHE policy on Conflict of Interest Disclosure. I will uphold the ACHE standard to insure that balance, independence, objectivity and scientific rigor are maintained in the planning and presentation of this CE activity.

Roseanne C. Niese — Signature

December 31, 2015 — Date

American College of Healthcare Executives
Disclosure of Relevant Financial Relationships
By Faculty and Planners of Continuing Education Activities

It is the policy of the American College of Healthcare Executives (ACHE) to ensure balance, independence, objectivity and scientific rigor in all of its directly sponsored or jointly sponsored Continuing Education (CE) activities. The intention of this policy is to identify potential conflicts of interest, facilitate resolution according to protocols, and ensure that disclosure is provided to participants prior to the beginning of the activity so that learners may formulate their own judgments as to the objectivity of the activity. Failure to disclose is grounds for dismissal as a faculty member or planner.

All individuals in a position to influence and/or control the content of ACHE directly and jointly sponsored CE activities must disclose to ACHE and subsequently to learners that the individual has either no relevant financial relationships or the nature of the financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in the CE activities.

Conflict of Interest: Circumstances create a conflict of interest when an individual has received financial benefits in any amount from a commercial interest within the past 12 months and that individual is in a position to affect the content of CE regarding products or services of commercial interest.

Commercial Interest: A commercial interest is considered any entity producing, marketing, re-selling, or distributing goods or services.

Financial Relationships: A financial interest is established by payments for various activities to the individual, the individual's spouse or partner by proprietary companies related to the content of a CE program. Examples of payments that constitute financial interests include grants or research support, employment, consultation, speaking or teaching activities, or royalties for companies. Financial interest also includes owning stock or options in any amount in these types of companies.

Name: Trent E. Gordon, FACHE
Event Title: 2016 Congress on Healthcare Leadership
Program Title: Reducing ED Recidivism: A Necessary Population Health Strategy (104A and 104B)
Relationship: **Faculty**

Do you or any immediate family member have a financial relationship or interest (currently or within the past 12 months) with a proprietary entity? **No**

If **Yes,** please indicate the individual, organization and he nature of the financial relationship below.

Do you intend to discuss an unapproved/investigative use of a commercial product/device? If yes, please disclosure such references to the learner in the educational activity. **No**

I will adhere to the ACHE policy on Conflict of Interest Disclosure. I will uphold the ACHE standard to insure that balance, independence, objectivity and scientific rigor are maintained in the planning and presentation of this CE activity.

TRENT GORDON
Signature

October 09, 2015
Date

American College of Healthcare Executives
Disclosure of Relevant Financial Relationships
By Faculty and Planners of Continuing Education Activities

It is the policy of the American College of Healthcare Executives (ACHE) to ensure balance, independence, objectivity and scientific rigor in all of its directly sponsored or jointly sponsored Continuing Education (CE) activities. The intention of this policy is to identify potential conflicts of interest, facilitate resolution according to protocols, and ensure that disclosure is provided to participants prior to the beginning of the activity so that learners may formulate their own judgments as to the objectivity of the activity. Failure to disclose is grounds for dismissal as a faculty member or planner.

All individuals in a position to influence and/or control the content of ACHE directly and jointly sponsored CE activities must disclose to ACHE and subsequently to learners that the individual has either no relevant financial relationships or the nature of the financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in the CE activities.

Conflict of Interest: Circumstances create a conflict of interest when an individual has received financial benefits in any amount from a commercial interest within the past 12 months and that individual is in a position to affect the content of CE regarding products or services of commercial interest.

Commercial Interest: A commercial interest is considered any entity producing, marketing, re-selling, or distributing goods or services.

Financial Relationships: A financial interest is established by payments for various activities to the individual, the individual's spouse or partner by proprietary companies related to the content of a CE program. Examples of payments that constitute financial interests include grants or research support, employment, consultation, speaking or teaching activities, or royalties for companies. Financial interest also includes owning stock or options in any amount in these types of companies.

Name: Marianne D. Araujo, PhD, FACHE
Event Title: 2016 Congress on Healthcare Leadership
Program Title: Reducing ED Recidivism: A Necessary Population Health Strategy (104A and 104B)
Relationship: **Faculty**

Do you or any immediate family member have a financial relationship or interest (currently or within the past 12 months) with a proprietary entity? **No**

If **Yes,** please indicate the individual, organization and he nature of the financial relationship below.

Do you intend to discuss an unapproved/investigative use of a commercial product/device? If yes, please disclosure such references to the learner in the educational activity. **No**

I will adhere to the ACHE policy on Conflict of Interest Disclosure. I will uphold the ACHE standard to insure that balance, independence, objectivity and scientific rigor are maintained in the planning and presentation of this CE activity.

Marianne Araujo, PhD, RN — January 15, 2016

Signature — Date