Working to Reduce Admissions Program (WRAP)

"Do Something Different"

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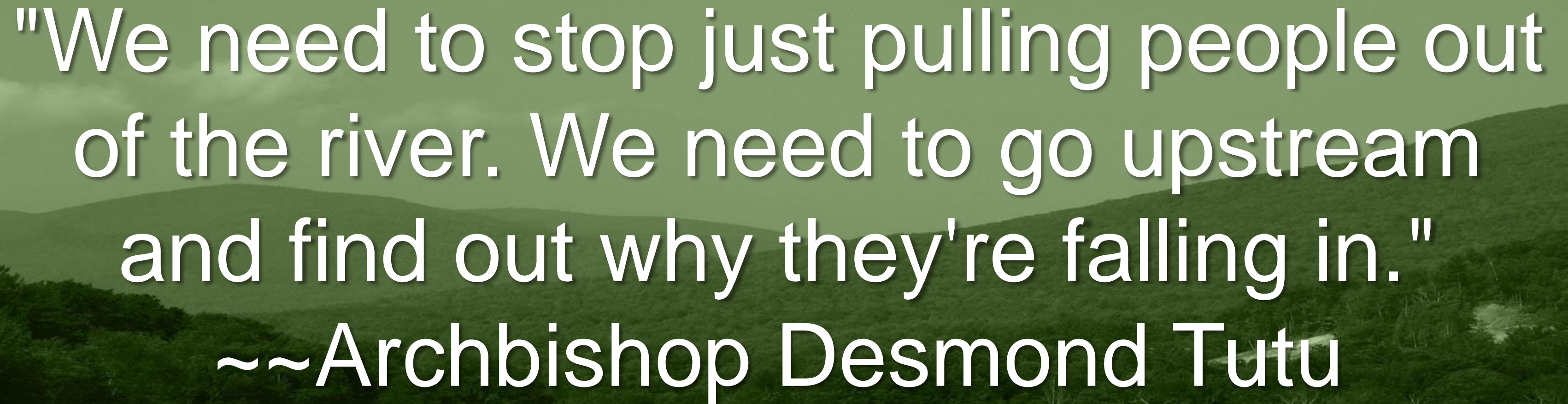

"We need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in."
~~Archbishop Desmond Tutu

Meet Joe

He's a frequent flyer

Non-compliant

We did everything last time, why is he back?!

WRAP: Why, What, and How?

High utilizers or super-utilizers, are patients with needs not well-met by the healthcare delivery system as it is currently designed (Ma et al., 2023).

- The system is designed for a different type of patient.

Innovative application of published evidence-based models and best practice is crucial to decreasing readmission rates and improving care (Labson, 2015).

- WRAP: Modeled on a Vizient Acceleration program designed for multi-visit patients.

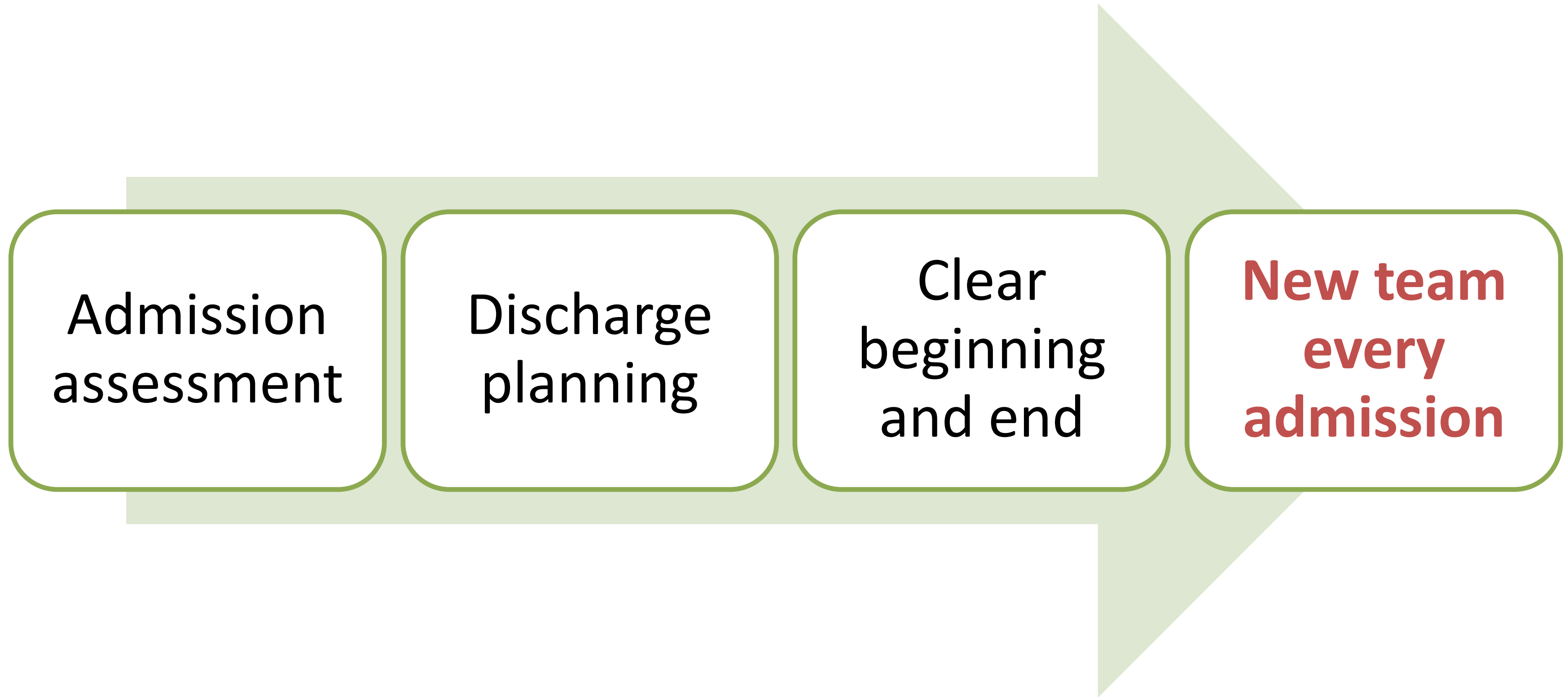
An interdisciplinary approach targeting several areas could substantially lower readmissions and hospital costs (Torisson et al., 2013).

- "WRAP"-around care with the patient and community.

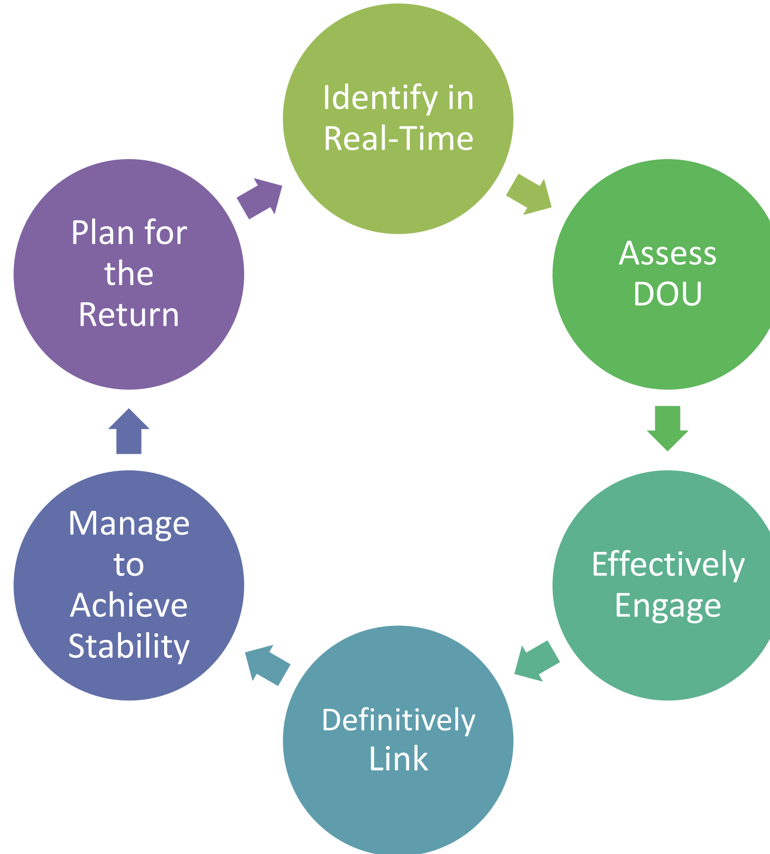
Drivers of Utilization

Re-admissions are a *symptom* of an unmet or inadequately addressed issue.

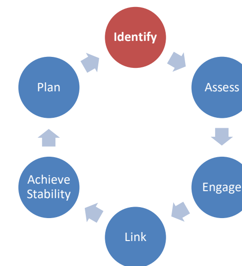
Typical Hospital-Based Care Pathway is Linear



WRAP Care Pathway is a Cycle



WRAP Criteria



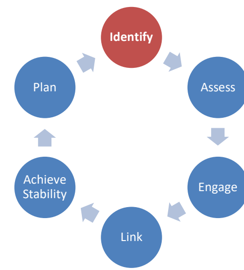
WRAP Inpatient

- 4 or more admissions in 365 days
- Excluding OB, Pediatrics, Psychiatry, Observation or Non-UVMMC stays, and planned admissions.

WRAP Community / ED

- 3 or more ED visits in 90 days to UVMMC ED only.
- Excluding OB, Pediatrics, ED to Hospital Admissions.

WRAP Criteria – Pharmacy Consult



WRAP Care Manager Pharmacy Screening

Is reason for this admission pharmacy related?

Yes

No

Patient on ≥ 10 medications
AND
has one of the following:

-Insulin dependent DM
-CHF
-COPD

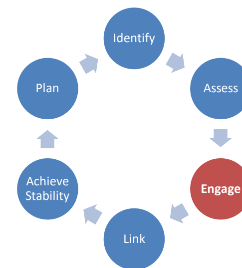
Yes

No

Pharmacy referral not indicated

Referral to WRAP Pharmacist

Drivers of Utilization



“NON-COMPLIANT” is NEVER a DOU

Medical

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

Behavioral Health

- Depression
- Trauma
- Anxiety
- Addiction
- Social Isolation

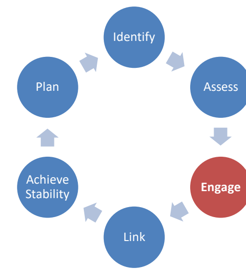
Systems

- Access to Care
- Fragmented Service Models
- Limited Capacity/Eligibility
- HIPAA Restrictions
- Poor Communication

Social

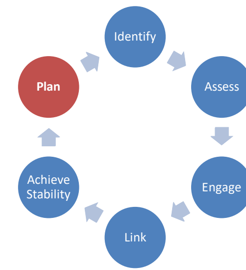
- Poverty
- Violence/Domestic Abuse
- Transportation
- Housing/level of support
- Bias and labeling

Pharmacy Interventions



Transitions of Care	Blister/bubble packs	Medication Access	Targeted counseling	Medication management
Medication reconciliation	Communicate RX changes to patient, pharmacy, PCP	Work with the patient to overcome DOUs	Encourage use of compliance aids	Deprescribing
Discharge follow up phone call	Ensure patient has necessary meds at discharge	Meds-to-Beds referrals	Advise on device techniques	Optimize chronic disease state management
Care coordination		Connect with community resources	Enhance health literacy	Create medication plans in alignment with GOC

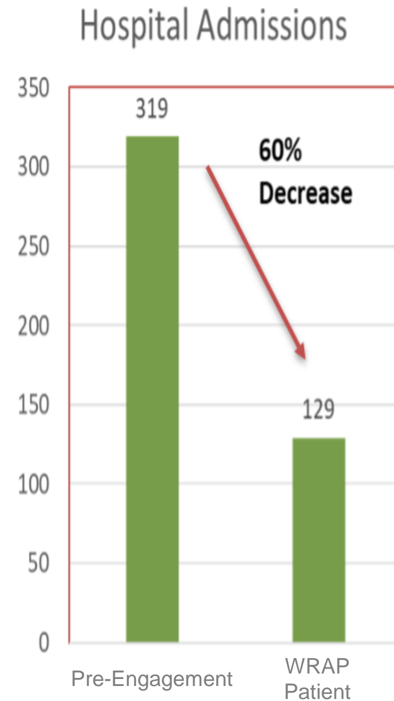
Essential Take-Aways

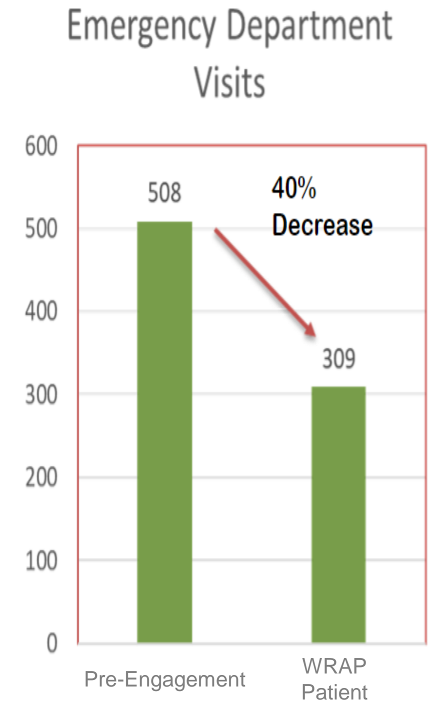


- Don't over-medicalize.
- Do a "deep dive."
- Ask "Why" 5 times: Curiosity is KEY
- Identify patient's health care "Buddy" (consistent connection)
- Remove barriers to access key supports
- Consider "outside the box" options
- Referrals do **NOT** work for this population.
- Warm handoff
- ED care plan

WRAP at UVMMC: Evaluation & Results*

- *Goal: Improve stability, whatever that looks like for that patient.*
- *Evaluation: Annual data review of engaged WRAP patients*
  - *Demographics, Drivers of Utilization, Inpatient and ED utilization rates, Length of Stay, and Revenue Impact.*
- *Results: Significant reduction in re-admission rates, LOS (-54%), and ED visits.*
- *Estimated Annual Savings:* ***$6.1 million***





** = based on 6-months data, annually*

Flip the Script

He seems really motivated to make a change.

Wow, it's been a lot longer this time!

I wonder what we can do differently this admission?

References

Labson, M. C. (2015). Innovative and successful approaches to improving care transitions from hospital to home. *Home Healthcare Nurse*, *Publish Ahead of Print*. https://doi.org/10.1097/nhh.0000000000000182

Ma, Z. B., Khatri, R. P., Buehler, G., Boutwell, A., & Tseng, K. (2023). Transforming care delivery and outcomes for Multivisit patients. *NEJM Catalyst*, *4*(7). https://doi.org/10.1056/cat.23.0073

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THANK YOU!