



## Coordinating Care for Frequent Emergency Department Users

### WHY COORDINATED CARE?

The man seeking treatment at the Emergency Department (ED) of Providence St. Peter Hospital in Olympia, Wash., was already familiar to the physicians on duty—he had been there more than 40 times that year. Although on Medicaid, the man lacked a primary care provider and had uncontrolled diabetes. Clinical staff suspected he was manipulating his insulin use so that he would become nauseous enough to require narcotic pain medication.

That combination of medical challenges flagged the patient as a candidate for the hospital's Emergency Department Consistent Care Program (EDCCP), which offers a coordinated package of services to frequent and inappropriate ED users. Two years after being enrolled, that man's use of emergency services had dropped dramatically, to just eight visits a year, and hospital charges for his care had fallen from \$78,000 to \$7,500. In the third year, he made no emergency hospital visits at all.

Chalk up another success for a program that has tracked about 500 people since its launch in 2003 and is now being replicated in several other hospitals in the region.

*"The care we are offering is what they need, and this program will provide them with care and a level of coordination among providers that they literally will not get anywhere else."*

*Doug Busch, former EDCCP administrative coordinator*

### BUILDING THE PROGRAM

The Robert Wood Johnson Foundation (RWJF) Emergency Department Consistent Care Program was established under the Foundation's Access Initiative, which awarded grants to 18 sites participating in the *Covering Kids & Families* national program. **CHOICE Regional Health Network**, a nonprofit coalition of hospitals, community-based clinics and clinicians in five central/western Washington counties, was an Access Initiative grantee.

CHOICE and Providence St. Peter Hospital collaborated on the program design, which brings together a multidisciplinary team that includes physician and nursing care coordinators in the emergency department and health resource and administrative coordinators based at the CHOICE office in Olympia. Other partners include local primary care and social service providers, mental health and chemical dependency professionals and a Medicaid case management representative. "We have brought to the table a wide range of organizations that don't usually work together very closely," says Doug Busch, M.S.H.A., who was the program's first administrative coordinator.

In addition to RWJF funding, the Providence St. Peter Foundation supports care coordination by a registered nurse (RN).

The EDCCP has three primary goals:

- Reduce inappropriate use of the ED and the associated hospital costs
- Improve the health status of participating clients
- Increase the capacity and integration of safety-net services.

Clinicians in the ED identify candidates for the program, based on established criteria, such as frequency of visits and the nature of the health problems. Once patients are referred and accepted, the EDCCP team is guided by a Plan of Care, which is designed to coordinate clinical services, streamline access to pharmaceuticals and sometimes address other needs, such as public benefits, housing and food. With patient consent, these care plans are shared with participating community providers, including some 50 primary care physicians. (See [How the EDCCP Works](#) for more details.)

"The program has given doctors in the ED an easy, straightforward process for identifying and referring patients. Prior to this program, it was really frustrating as people came in again and again," says Kara Elliott, R.N., M.P.A., the current EDCCP administrative coordinator. "And doctors in primary care settings have a level of communication and coordination that wasn't there before. Together, we can provide a consistent message to the patient."

### **Inappropriate Use: ED Visits and Pain Medication**

The quest for pain medication plays a significant role in ED use, something the program designers had not initially anticipated. "We had not realized how much of the inappropriate use of the ED involved the inappropriate seeking of pain medication," acknowledges Busch. "We were

*"Chronic pain, drug addiction and lack of primary care are not issues the ED is designed or staffed to address, but they are an unfortunate and undeniable reality that EDCCP is helping to rectify."*

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unprepared for how thoroughly overwhelming these folks were in the pantheon of those who use the ED inappropriately."

As that became evident, the EDCCP team sought ways to control use of pain medications while ensuring patients had access to the right treatment. Mental health and chemical dependency experts were brought in to provide essential guidance.

"These patients have to hear everywhere 'no, you can't get the drugs you want, but yes, we can help you,'" says Busch. "Our process has been to literally run them to ground, close off every single avenue they have to get their fix inappropriately, and get them referred back to a single primary care provider, a single hospital and a single pharmacy where we can provide some structure and essentially get them so exhausted that they surrender to the care we are offering."

## **INTERVENTION REDUCES ED USE AND SAVES MONEY**

The model is reducing inappropriate use of the emergency department and lowering the associated hospital charges, according to an evaluation conducted by CHOICE staff. The evaluation, published in April 2010 and based on a 97-patient sample of EDCCP clients, found "a striking and consistent pattern of increasing ED visit rates that peak during the intervention year and then decline." Key findings:

- **Overall, ED visits fell by 55 percent, when comparing the year prior to the intervention (baseline) with the two years after it.** On average, clients made 10 ED visits during the baseline year and 4.5 visits in the post-intervention period. The reductions were greater among those with the highest usage—falling from 25 to 10 ED visits (a 60 percent reduction).
- **Hospital charges for ED use declined by 54 percent, or an annual average of \$9,371 per client** (falling from \$19,791 to \$8,652). That represents \$1.9 million in reduced charges for the full sample over two years.

*"In terms of satisfaction for clinicians, it is not only having a referral process, but seeing the improvements, seeing the reduction in visits by the people who are enrolled in the program."*

*Kara Elliott, EDCCP administrative coordinator*

The EDCCP team also conducted a small, preliminary survey of clinician satisfaction, and reported that more than 80 percent of primary care providers and ED nurses, and all of the responding ED physicians, said they had seen beneficial health changes among the program's clients.

In a further testament to the value of this program, the EDCCP program at Providence St. Peter Hospital earned the Mission Leadership Award from Providence Health and

Services, the five-state, 27-hospital nonprofit health system of which the hospital is a part.

## **FUTURE PLANS**

Elliott and Busch both believe the program can be widely replicated and sustained, especially within the CHOICE network. "Having a regional planning and coordinating agency makes it very easy for hospitals to participate. They don't have to start this up, they just have to get on the bandwagon," notes Busch. "People can build on what we have done and the way we have done it."

That is beginning to happen.

### **Expanding the Program**

Under Elliott's leadership, EDCCP is now in place at three other CHOICE facilities. Capital Medical Center is a partner in the Providence St. Peter Hospital initiative while Grays Harbor Hospital is tracking 130 patients and Providence Centralia Hospital is tracking about 40. A fourth program is in the planning stages at Mason General Hospital.

"The general process and interventions are the same, but each hospital has its own culture to meet its needs a bit more specifically," explains Elliott. In particular, the structure of the program might be influenced by the size of the hospital, its location in an urban or rural setting, and whether the emergency department or the primary care community takes the lead in organizing the collaborative effort.

Regardless of the approach, a common thread is the importance of a committed physician. "You are not going to build anything in health care without a physician champion," says Busch. "Lots of other things can slow you down—HIPAA compliance, an unenthusiastic manager of the ED—but won't kill it. If you don't have a doc, you are dead in the water." (HIPAA, short for the Health Insurance Portability and Accountability Act, is the federal law that guides medical privacy and protects individually identifiable health information.)

## **COLLECTING MORE DATA**

Refining data collection becomes more essential as the program expands. With a federal earmark for the first year's startup costs, CHOICE is introducing the Emergency Department Information Exchange, a Web-based data repository that identifies high users of ED services across participating hospitals. "We don't want to push people out of one ED into another so it is really important to have regional tracking and to distribute the plans of care so the same message can be conveyed at multiple facilities," Elliott emphasizes.

Gathering rigorous evidence of the program's benefit to client health is also on CHOICE's radar screen. "We have strong anecdotal evidence of improved health status, but we are very interested in some kind of well-developed clinical outcomes study to see whether we can verify that on a larger number of enrollees," says Busch.

### **Institutionalizing the Model**

EDCCP's demonstrated cost savings suggest an opportunity for sustainable funding. "Our contention is that if we are helping to reduce the cost of care in the community then the payers of care—the health plans, the public payers—ought to be assessing those savings and sharing those savings with the program," Busch insists.

At least one health plan is already on board. CHOICE is negotiating a contract with Molina Health Plan to enroll 130 members who are the highest users of ED care into EDCCP.

"We tell people this is not about cost containment, it is about quality improvement," says Busch. "The very best way to save money is to help people get better. If you want to reduce inappropriate visits to the ED, you focus on resolving their health problems, not on kicking people out."

The CHOICE approach is part of a larger shift that many believe needs to happen in medicine. "The program represents a culture change," says Elliott. "Doctors are used to working on their own to assess, create treatment plans and deliver care. Ours is much more of a group collaborative effort. We are strong believers in coordinated care and better care, not more care."

### **How the EDCCP Works**

Potential clients are identified either by Emergency Department clinical staff or by a provider who sees the patient after an ED visit.

The R.N. care coordinator *reviews* patient charts to determine eligibility, the physician coordinator officially refers eligible patients into the program, and the EDCCP team accepts patients to whom it can provide an appropriate level of intervention.

Patients are invited to participate voluntarily in the program, or enrolled involuntarily if they refuse. Typically, no more than 10 percent of patients agree to enroll. "The reality is that a lot of these people are trying to fly under the radar, they want to get

*"The program reduces staff frustration because they are no longer repeatedly treating frequent users whose needs cannot be met in the ED. The program frees ED staff to focus on emergent cases by providing an easy way to refer frequent inappropriate users into the program."*

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what they want and leave," said Elliott. "Some recognize they need help and enroll initially, some do so over time, but most are likely not to accept."

The physician coordinator develops a Plan of Care, in consultation with community providers if possible. If the client is a voluntary participant, the care plan is comprehensive, including community-based clinical care and social services. For involuntary clients, the plan structures only the care in the ED.

Privacy issues are rigorously considered and require a high degree of sensitivity to both HIPPA regulations and the stricter standards for sharing mental health and chemical dependency information, which require a signed release from every patient.

Clients who are also Medicaid enrollees are referred to the Medicaid Patient Review and Coordination program, which restricts them to one primary care provider, one pharmacy and one hospital. Providers may also be required to obtain prior authorization for certain prescriptions.

The CHOICE administrative coordinator enters client data into the Service Delivery Tracking Form, and the EDCCP team meets twice a month to review current cases and consider new referrals. The tracking form includes basic client demographics, ED utilization rates, and case notes on the client's clinical condition, including drug-seeking behavior, mental health diagnosis, chronic medical conditions and chronic pain issues.