

# Unique program aims to connect frequent ED utilizers with medical homes, resources to meet complex needs

*ED-based care coordinators facilitate access, coverage*

The ED at Sinai Hospital of Baltimore in Baltimore, MD, sees a fair number of patients who frequent the facility for primary care, mental health needs, and other services that emergency providers are not ideally suited to provide. It's a common problem in many EDs, but earlier this year, administrators at Sinai Hospital decided to investigate whether they could devise an intervention that would better meet the long-term needs of these frequent users while also preserving the ED's acute-care resources for patients who really need that level of care.

"We took a look through our own information system to see how many people visited the ED repeatedly," explains **William Jaquis**, MD, FACEP, the chief of emergency medicine at Sinai Hospital. "We decided to target a certain group of patients who were frequent utilizers of our services and just see what their needs were and why they were using us in the department."

The investigators concluded that many of the frequent ED utilizers had problems the ED could not adequately address, and that these patients really needed to be connected with other resources. However, making these linkages would require funding and a unique approach. Consequently, the hospital secured a first-year \$200,000 grant from the Maryland Community Health Resources Commission, an amount that will grow to \$800,000 over three

years. Further, the hospital partnered with HealthCare Access Maryland, a non-profit in the state, to pilot a new intervention dubbed the Access Health Program.

## Identify prospects

At the heart of the program are three care coordinators from HealthCare Access Maryland who are stationed in the ED over staggered shifts, so at least one of them is usually on hand to intervene with patients who meet the program's criteria for inclusion: they have visited the ED for primary or specialty

care four times in four months, and they have needs that the program can help with. "We have created a flag that basically notifies us that a person has been here recently, and it lets us dig a little bit deeper into the patient," observes Jaquis. "The care coordinators can see the information as well, and we can also notify them to let them know that this is a person who we feel could benefit from their services."

**Nakia Abrams**, MS, one of the ED-based care coordinators, says she typically receives referrals from the ED's care management coordinator, a social worker, or an emergency

## EXECUTIVE SUMMARY

Sinai Hospital of Baltimore in Baltimore, MD, is partnering with HealthCare Access Maryland, a non-profit organization in the state, to link patients who frequent the ED for care with medical homes and other resources that can better meet their medical and social needs. Under the Access Health Program, ED-based care coordinators intervene with patients who meet program criteria, linking them with medical homes and other resources that address their complex needs.

- The hospital has devised a flag to notify the ED when a frequent-utilizing patient presents in the department for care. Care coordinators then meet with these patients and get their consent to participate in the program.
- Within a week of the ED visit, care coordinators schedule a home visit with the patient to establish a care plan containing specific goals and a time frame to carry out these goals. Patients remain in the program for 90 days as care coordinators work to hand them off to longer-term resources.
- Many of the patients enrolled in the program have substance abuse and mental health problems. Patients are also often uninsured and/or homeless.
- Within two months of launching the program, care coordinators enrolled 74 patients, with the goal of eventually bringing that number to 200.

provider. “We are considered contractors with the hospital staff, and as contractors, we have access to the medical record database, so when a client is referred to us, we actually know the reason why he or she came into the ED, and we know their history,” she explains. “We can look at all of that information before we visit with them, and we can use it when we go to actually have a discussion with them about the types of programs or services we can probably help them with.”

Abrams tries to meet with the patients before they leave the triage area so that she can give them a little bit of information about the program. “We don’t dig into it too much at that point because we know that they are there because they don’t feel well or they are in pain,” she explains. “But we ask them if they are interested [in participating], and if they are, then they sign an agreement indicating that they agree to disclose their information and to follow up with us.”

Within a week of enrolling in the program, the care coordinator will schedule a home visit with the patient to conduct a complete assessment and devise a care plan that focuses on patient goals. “The purpose of the home visit is to identify any wrap-around services that we may need to include,” says Abrams. “For instance, if there is a situation where we see that the reason why a client continues to come to the ED is because there are things at home that cause an unhealthy environment, then we address that in the care plan.”

Abrams notes that she will discuss with patients how she will work with them to accomplish the stated goals in the care plan, what the various required steps will be, and what kind of time frame they can anticipate. What is also made clear is that the

patients will only be part of the Access Health Program for 90 days.

“Our program is short-term because the purpose is to connect the client with a longer-term resource,” says Abrams. “We want to gain that client’s trust so that we can get all of the information we need to make that connection.”

Within the three-month period, however, clients are encouraged to contact their care coordinators with any questions or concerns. “That is exactly what we are looking for – someone who is willing to share those feelings with us so that we can help them,” says Abrams. “The handoff [to the longer-term resource] is actually a slow process.”

At press time, the first patients to be enrolled in Access Health had not yet been in the program for 90 days, but some of them had already been connected with long-term resources, says Abrams. “We are still in the picture, though, because we want to make sure that before we close a case, the clients understand what they need to do,” she says.

## Partner with resource providers

Many of the patients targeted for the program have complicated needs that bring them to the ED, observes Jaquis. “They may have concomitant behavioral and somatic issues, they may be homeless, and they may not have insurance,” he says. “They may be identified as being on medication, but then aren’t compliant.”

Abrams explains that she commonly works with patients who have a substance abuse problem, and this is often coupled with a mental health issue. “That is a big problem in Baltimore, so we do get a lot of clients who are either seeking prescriptions

or they have substance abuse issues,” she says. “We partner with many mental health organizations in the city to connect these clients with a treatment service and get them into counseling for the mental health issues.”

Also, HealthCare Access Maryland has an entire department that is dedicated to homeless services outreach, adds Abrams. “We probably have eight or more clients who are homeless, and typically what we do is partner with the outreach program to [resolve the problem],” she explains. “If they are homeless and living with a relative or a friend, then we will try to find them permanent, stable housing.”

While issues such as homelessness and substance abuse come up often, the care coordinators also encounter patients with more unique circumstances. For instance, Abrams recalls one recent case that involved a man who was self-employed and uninsured, but he was very involved with fitness training, so he thought he was taking care of himself, she says.

“However, we discovered that he was over-utilizing vitamins and energy drinks, which brought him to the ED,” explains Abrams. “We needed to get him insurance right away because he required emergency surgery, so we were able to get that expedited within 48 hours.”

Abrams also linked the client up with a nutritionist and an internal medicine physician so that he could follow up on his care and receive expert guidance to prevent a similar situation from happening again. “Everything worked out for him,” she says.

While complex issues can be difficult to resolve in the emergency setting, patients can make progress when they are linked with appropriate support services. And even in the

program's early days, it is clear there is ample need for this kind of help. "The care coordinators have already had about 90 patients referred to them, and they have been able to discuss their programs and services with these patients," says Jaquis. "Seventy-four of those patients have agreed to continue with those services, and the care coordinators have already conducted 30 home visits."

A big part of the care coordinator's job involves getting patients plugged into a medical home and educating them about when they should call their primary care physician or a specialist rather than visiting the ED, explains Abrams. "We also want to make sure that when they have scheduled appointments for care, they follow up on getting required lab work completed and any other orders the physician discussed."

## Educate providers

Getting the emergency providers on board with the program was not difficult, but it did take some time to bring them up to speed on what types of patients are ideally suited to this type of approach and how the program works, explains Jaquis.

To help educate providers about the program, Access Health conducts weekly in-service sessions, typically during scheduled meetings or physician huddles. During these sessions, the care coordinators provide updates about the program and solicit input on any challenges the providers have faced with the program, explains Abrams. "We also check to see if there are any patients they didn't refer to us at the time of care, but now that they are thinking about it, may benefit from a follow-up post-discharge," she says. "We are doing all we can to educate the staff at Sinai, and a

referral can come from anyone in the hospital as long as the client meets the eligibility qualifications."

While providers have been largely open to the program, there have been some technical hurdles in getting the program up and running. "Our biggest challenge was connecting our data system to Sinai Hospital's data system," observes Abrams. "The two systems are not actually able to communicate, so as a result, our staff members have to document more than once, into more than one system."

Ultimately, Access Health staff members were able to work around the problem, but it is an issue that hospitals should consider if they are interested in setting up a similar approach, advises Abrams. "If it is possible to get your organization's data system to talk to the partnering facility's data system, that will save you a lot of time and energy," she says.

The goal is to eventually enroll 200 patients in the Access Health

Program, but Jaquis emphasizes that the focus of the program is not to get people out of the ED, but rather to connect them with appropriate care and coverage. He notes that the care coordinators have already been able to link 10 of the patients who were identified as being uninsured with insurance. "This program is helping people find pathways to care that provide a better long-term outcome for them," he explains. "We are very connected to outcome measures with this program. It will be good see within the next 6 to 12 months how we are doing." ■

## SOURCES

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## CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice.

## COMING IN FUTURE MONTHS

- Flu vaccinations: How to get everyone on board — or at least compliant
- Yet another reason to end the boarding of psychiatric patients in the ED
- Use improved communications skills to reduce misdiagnoses, enhance patient satisfaction
- The impact of ED closures on outcomes and other hospital EDs