# EMERGENCY DEPARTMENT TO MEDICAL HOME PROGRAM

All too often, individuals who are uninsured or underinsured use the emergency department (ED) to access primary care or other ambulatory services. Each year, nearly half of all emergency department visits in Milwaukee County are classified as non-emergencies*, with about 65% being visits of Medicaid and uninsured individuals.

The **Emergency Department to Medical Home Program (EDMH)** has worked since 2007 to decrease avoidable ED visits and related hospitalizations, reduce duplicative ED tests and procedures, and connect high-risk individuals with health homes and other health resources, including behavioral health and dental care.

This community-wide health improvement initiative, involving eight adult EDs and more than 20 safety-net clinics, uses standard transition care management processes, aided by health information technology, to schedule patients with appropriate follow-up health care services prior to ED discharge.

Since 2009, ED case managers have scheduled **more than 60,000 appointments** with area safety-net clinics for pregnant women, individuals with chronic medical conditions, and frequent ED users.

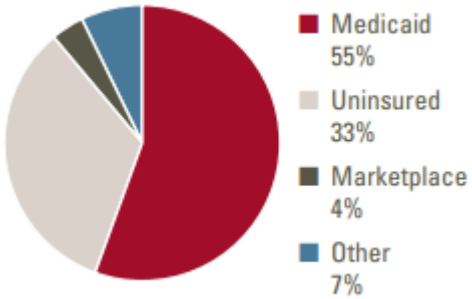
A study conducted by the Center for Urban Population Health demonstrated a **44% reduction in subsequent ED visits** for those patients who kept their scheduled primary care appointment.

**As defined by NYU ED Algorithm*

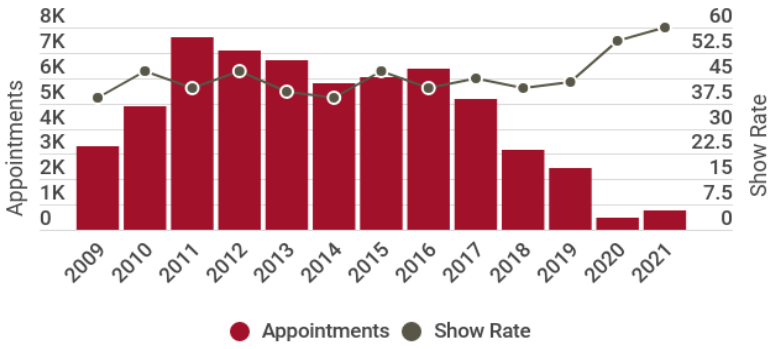
## GOALS

- Decrease avoidable ED visits and related hospitalizations
- Decrease duplicative ED tests and procedures
- Connect Medicaid and uninsured ED patients with medical homes and/or other health resources

## EDMH REFERRALS TO COMMUNITY HEALTH CENTERS



## EDMH Appointments and Show Rate
2009-2021




# TARGET POPULATION

Medicaid and uninsured patients with select diagnoses:

- **Pregnant Women**
- **Chronic Conditions:** Asthma, COPD, Diabetes, Hypertension, HIV/AIDS, Chronic Seizures
- **Oral Health Conditions**
- **Behavioral Health Conditions**
- **Frequent ED Visitors**
- **Patients Not Connected to Primary Care**

# EDMH PROCESS

The community-wide ED care coordination process is used in eight adult Milwaukee County EDs and more than 20 primary care, dental, and behavioral health safety-net clinics.

- ED staff identify patients in the target population, provide patient education about the importance of a health home, and **schedule appointments** with patient input for follow-up care.
- Care managers at safety-net clinics contact patients before the appointment to welcome them, **address barriers to attendance**, and reinforce the importance of a health home.
- Providers leverage **WISHIN and Epic** to improve health information exchange to enhance clinical decision-making and transition care management across health systems and safety-net clinics.
- **MyHealthDirect,** a web-based appointment scheduling platform, allows clinics to post open appointments and ED case managers to schedule an appointment while the patient is in the ED with patient input on preference for location and time.
- More **intensive ED transition care coordination** models are being piloted for frequent users with complex health and social needs.
- Improved **navigation to social services** from the ED, including housing and transportation are also being piloted.

# PARTICIPATING ORGANIZATIONS

### Health Systems

- Ascension Wisconsin
  - Columbia St. Mary's Hospital
  - St. Francis Hospital
  - St. Joseph Hospital
- Advocate Aurora Health
  - St. Luke's Medical Center
  - St. Luke's South Shore
  - Sinai Medical Center
  - West Allis Medical Center
- Froedtert & the Medical College of Wisconsin
  - Froedtert Hospital

### Safety-Net Clinics

- Gerald L. Ignace Indian Health Center, Inc.
- Milwaukee Health Services, Inc.
- Outreach Community Health Centers
- Progressive Community Health Centers
- Sixteenth Street Community Health Centers
- Other free and community clinics
- Oral and behavioral health clinics

### State of Wisconsin Department of Health Services

### Medicaid Managed Care Organizations

### Wisconsin Statewide Health Information Network / PatientPing
Health Information Exchange

### MyHealthDirect
Web-based Appointment Scheduling Tool

# HEALTH EQUITY

Low-income and people of color are disproportionately uninsured or underinsured and experience barriers to accessing regular, appropriate care. As such, the EDMH program is a vehicle to address racial and healthy equity, connect individuals to culturally relevant health homes, and reduce health disparities.

*"Getting people the right care at the right place at the right time is critical to long-term health — particularly for people with chronic conditions who need ongoing management. This program makes the linkage from the ED to primary medical homes easy for the patients and providers, leading to positive outcomes for all stakeholders."* ***Robert Marrs, MS Director of Operations Aurora Family Service***