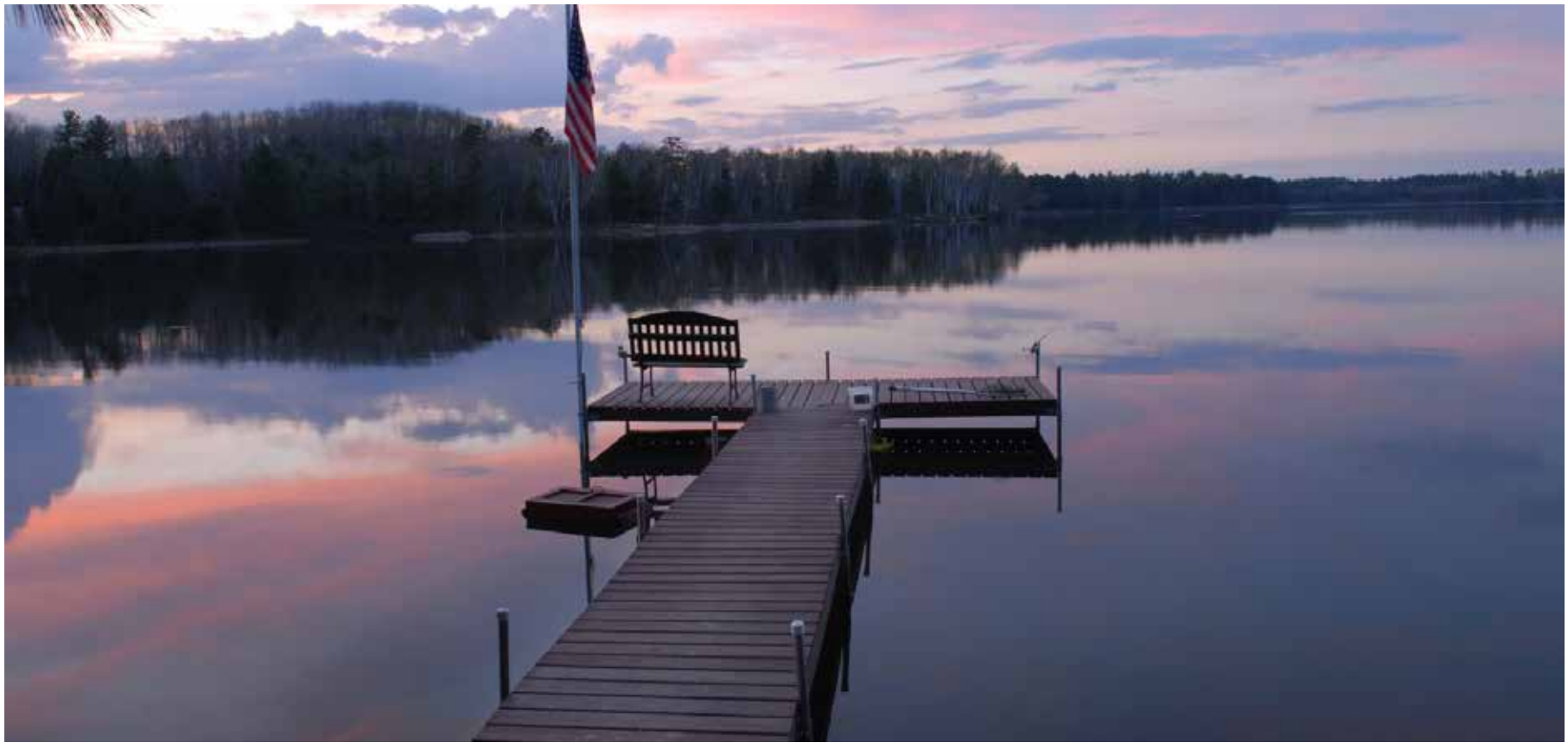
Small Tests of Change Grow to Big Results in Reduction of ED Overuse

Heightened awareness of growing problems in the medically underserved population—such as fragmented and duplicative care, poor access to care, and a lack of care coordination—helped spark Milwaukee County's five health care systems to join forces to address these pressing issues.

The health systems created the Milwaukee Health Care Partnership in 2007, and the organization has since grown to include the area's four federally qualified health centers, the Medical College of Wisconsin, and state and local government health agencies. The Wisconsin Collaborative for Healthcare Quality, the Aligning Forces for Quality (AF4Q) Alliance in that state, is a collaborating partner.

"There was a leap of faith that by working together we could improve care for underserved populations and achieve better outcomes and better health care at a lower cost," said Joy R. Tapper, the partnership's executive director.

A major catalyst for the partnership's creation was overuse of hospital emergency departments (EDs) for primary care and ambulatory sensitive conditions among the uninsured and Medicaid populations. In 2011, 47 percent of ED visits in Milwaukee County were classified as non-emergencies. Medicaid and uninsured patients accounted for 67 percent of those visits.



One of the partnership's first projects was the ED Care Coordination Initiative. It has three goals: decrease avoidable ED visit and related hospitalizations, reduce avoidable and duplicative tests and procedures, and connect high-risk ED users with medical homes.
The project targets people without health insurance or on Medicaid who lack a medical home and are pregnant, are frequent ED users, or have at least one of five chronic conditions: asthma, chronic obstructive pulmonary disease, diabetes, hypertension, or HIV/AIDS. The partnership settled on these categories because these patient groups could benefit most from gaining a medical home, Tapper said.

The initiative features an ED-to-medical-home transition care management process through which case managers at the county's eight adult EDs identify patients in the target population, provide printed and face-to-face patient education, schedule primary care appointments, and make referrals to one of the health centers, which then serves as the patient's medical home.

Getting the various stakeholders on the same page to create a common program was no easy task, said both Tapper and Betty Ragalie, the initiative's project manager. Some of the health systems already were exploring different strategies to address avoidable ED visits. So the partnership created an ED care coordination steering committee that includes ED medical directors and care managers, Medicaid managed care personnel, and representatives from the safety net clinics. Together, they diagnosed the situation, learned about each other's efforts, and looked at best practices in the community and nationally to develop their unified approach.

The initiative benefited greatly by the concurrent development of the Wisconsin Health Information Exchange, for which the five health systems provided some funding. AF4Q, through its funding from the Robert Wood Johnson Foundation, also provided some health information technology grant money to the Wisconsin Department of Health Services on behalf of the partnership's ED Care Coordination Initiative.

The information exchange gives ED providers and case managers information on patients' ED, ambulatory, and inpatient utilization history across the Milwaukee delivery system. The health information exchange (HIE) gives physicians and other providers the information that can guide clinical decisions and care coordination. For example, the record could show a patient just had an MRI—knowledge that could prevent a physician from repeating the scan. Also, if a patient sought treatment at one ED in the morning and then visited another ED later in the day for the same reason, providers would see that in the electronic record. For care coordination purposes, the system allows providers and case managers to identify a patient's primary care provider and share information regarding the ED visit and recommended plan of care.

It also helps guide case managers' decision making by showing, for example, whether a patient is in the target population or has a pattern of ED use. The HIE also flags frequent ED users—patients who have visited an ED four or more times in a year—so that case managers can provide coaching regarding the importance of continuity of care and the benefits of a medical home.

The HIE now is being expanded into the health centers. "Already the first clinic is finding it gives them information about which of their patient groups is going to the ED most frequently and learned that it's asthma, behavioral health, and pain," Ragalie said. "That information is

really allowing them to look at their patient management strategies."

Another technology that is instrumental in the initiative is a web-based, electronic scheduling tool called MyHealthDIRECT. It allows the community health centers to post open appointment slots so ED case managers can schedule a medical home appointment while the patient is still in the emergency department. Appointments in MyHealthDIRECT automatically are populated in the HIE. The five health systems entered a community contract with MyHealthDIRECT.

The product allows case managers to select a medical home for the patient using such criteria as the health center's proximity to the patient, physician specialty, such as internal medicine or OB/GYN, and patient preferences, such as the provider's language or gender. The case managers print out an appointment confirmation sheet that gives the patient all of the necessary information. Patients also receive a fact sheet on the community health center and are offered other support to ensure they keep the appointment.

After an appointment is made, a health center intake coordinator reaches out to the patient, provides information about the center, encourages the patient to keep the appointment, and follows up if he or she doesn't show.

In 2011, the initiative resulted in Milwaukee EDs scheduling 7,600 appointments with safety net clinics for Medicaid and uninsured patients. Forty-two percent of patients kept their initial appointments, and about 45 percent returned for a second appointment within six months.

> "There was a leap of faith that by working together we could improve care for underserved populations and achieve better outcomes and better health care at a lower cost."

The partnership now is testing a way to use information technology to compare patients' ED and inpatient utilization before their referral to a medical home with their utilization after the referral, Ragalie said.

The ED initiative has faced several challenges over the years. One has been "trying to adopt common processes and maintain constancy of purpose and consistency of application across multiple providers and organizations that are very dynamic and where there is considerable turnover of personnel and multiple competing priorities," Tapper said. Having a strong commitment from the organizations' CEOs and chief medical officers has helped to address the issue and reinforce the importance of these collaborative efforts. Additionally, the initiative's steering committee, with representation of all the stakeholders, is instrumental in keeping everyone on the same page. It's also vital to have a project manager to keep track of all the initiative's moving pieces and measure progress, Tapper added.

Although it's important to have standard implementation of core processes and patient referral criteria, it's okay to have some variation among the EDs and health clinics. For example, the initiative's approach was to identify ED case managers' roles and responsibilities but then to respect the health systems' role in determining exactly how to staff them.

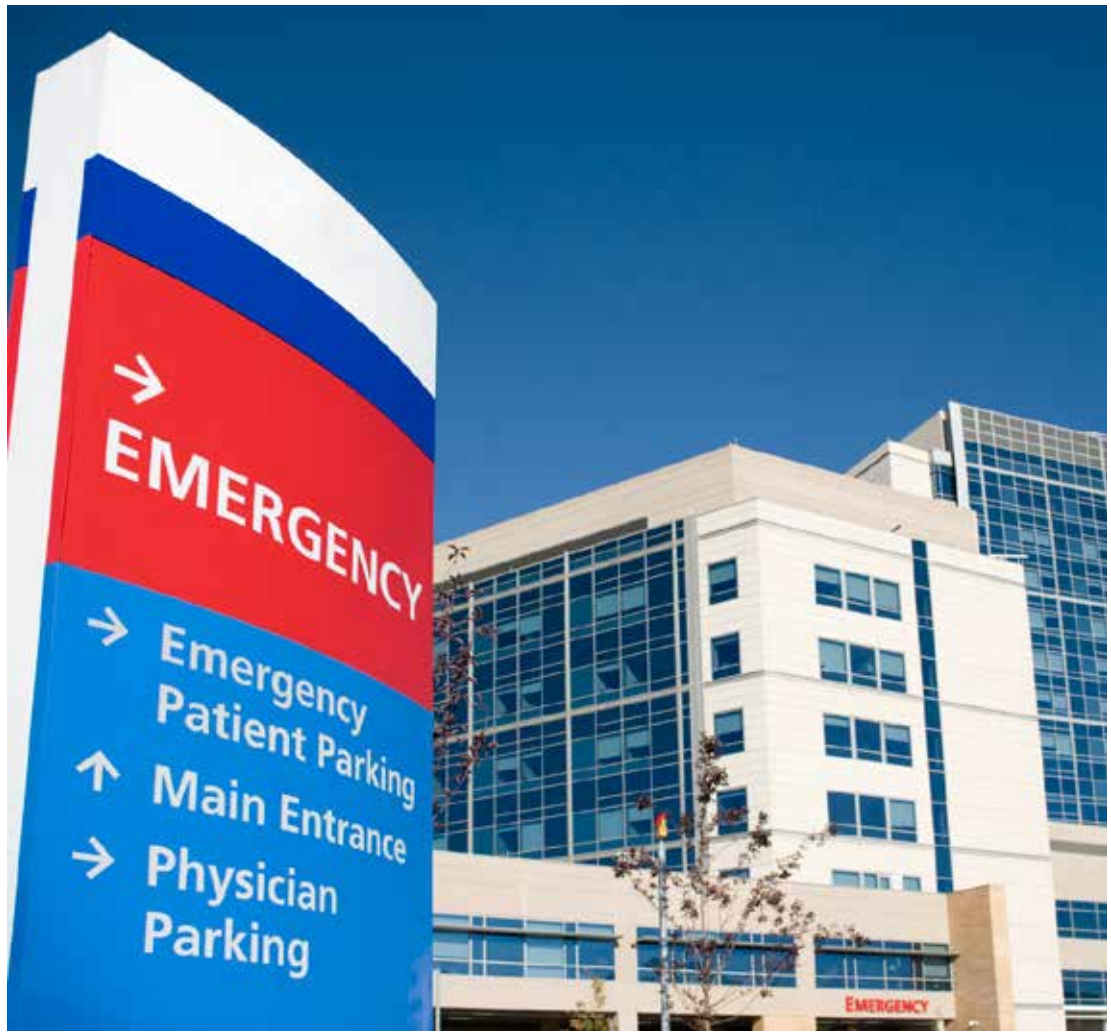
Another major challenge has been "the multiple variables and confounding factors that result in people using the ED for primary care purposes," Tapper said. One of the biggest factors is insufficient primary care capacity for uninsured and Medicaid patients. So in 2008, the partnership commissioned a primary care access study. It showed that 10 Milwaukee ZIP codes with the highest rate of poverty generated 60 percent of avoidable ED visits. Tellingly, those 10 ZIP codes also have the lowest concentration of primary care providers in the community.

The study spurred the partnership to invest in building primary care capacity. The health systems have contributed $1.7 million a year to subsidize medical homes in the health centers, and each system sponsors other safety net clinics' capacity, Tapper said. The partnership also is trying to expand the number of community health centers.

To make primary care available when patients in the target population need it, all of the health centers expanded their after-hours and weekend appointments. The partnership learned valuable lessons for its ED Care Coordination Initiative through its participation in the Institute for Healthcare Improvement's Reducing Avoidable Emergency Department Visits Prototyping Project. One lesson was to start small with pilot projects and then build from there, Ragalie said. The initiative wasn't implemented all at once and continues to progress in stages.

Another tactic the Milwaukee initiative learned from the IHI project is to involve patients in developing and improving processes, Ragalie said. For example, in a recent effort to evaluate the primary care appointment confirmation sheet, the ED case managers and health center intake coordinators interviewed a small number of patients about whether the information was clear, if the patients would change anything, and whether it helped them keep their appointments.

The ED Care Coordination Initiative continues to act as a catalyst for new partnership projects. For example, in working to improve primary care access to decrease ED overuse, the partnership has recognized that specialty access for the uninsured also is a significant issue. So now it's in the early stages of creating a model for specialty access for the uninsured, Ragalie said. "Connecting ED patients with medical homes is one issue, and it's connected intimately with all of the other coverage, access, and care coordination initiatives of the partnership."



Lessons Learned

- Focus on a well-defined population. The ED Care Coordination Initiative targets people who would benefit most from gaining a medical home: patients without health insurance or on Medicaid who are pregnant, are frequent ED users, or have at least one of five chronic conditions.
- Conduct small tests of change and get patient feedback. The entire ED Care Coordination Initiative wasn't launched overnight. At each step of the way, pilot projects were conducted to test change, and patient input often was sought.
- Strong support from participating organizations' leaders is essential to get multiple providers to adopt common processes and maintain constancy of purpose and consistency of application. Also, a project manager is necessary to keep tabs on all the moving pieces.
- Multiple factors contribute to medically underserved patients' use of EDs for primary care. No one solution is going to address all of them, so project organizers must be willing to adapt.