# CONNECT TO CARE PROGRAM

## (FORMERLY EMERGENCY DEPARTMENT TO MEDICAL HOME)

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. All too often, individuals who are uninsured or underinsured use the emergency department (ED) to access primary care or other ambulatory services.

Since 2007, the **Connect to Care Program** has worked to decrease avoidable ED visits and related hospitalizations, reduce duplicative 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 health system emergency departments, mobile teams, inpatient units, Milwaukee County health departments and fire departments, use standard transition care management processes, aided by health information technology, to schedule patients with appropriate follow-up health care services at one of the participating clinics.

Since 2009, **more than 60,000 appointments** have been scheduled at area safety-net clinics for individuals without an established medical home, pregnant women, individuals with chronic medical conditions, and/or frequent ED users.

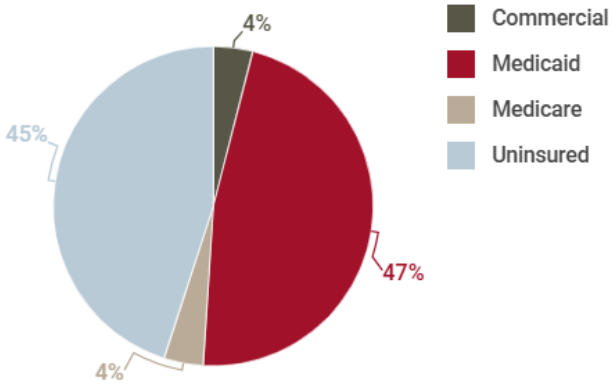
A study conducted by the Center for Urban Population Health demonstrated a **44% reduction in subsequent ED visits** for those patients who kept their scheduled primary care appointment.

**As defined by NYU ED Algorithm*

## GOALS

- Connect high-risk individuals with medical homes and/or other health resources
- Decrease avoidable emergency department visits and related hospitalizations
- Decrease duplicative tests and procedures
- Improve patient experience and compliance with discharge plans and medical recommendations

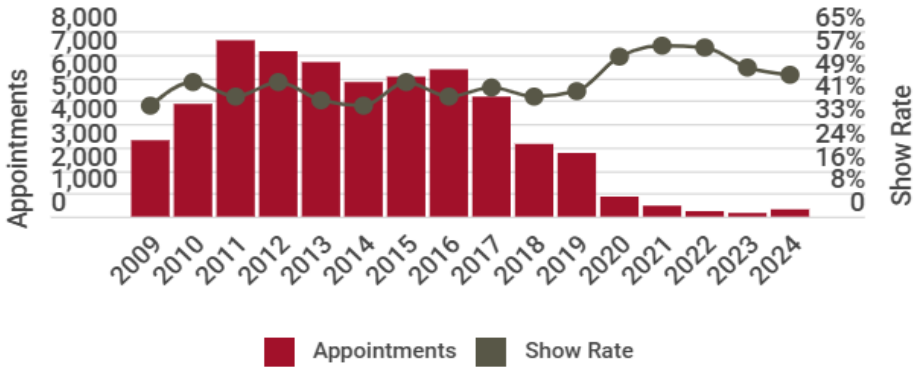
### Connect to Care Appointments (2017-2024 Q3)




MILWAUKEE HEALTH CARE PARTNERSHIP

mkehcp.org | 400 W. River Woods Parkway | Milwaukee, WI 53212 | 414-585-4923

## Connect to Care Appointments and Show Rate
(2009-2024)




# CONNECT TO CARE PROCESS

The community-wide connect to care process is implemented in more than 20 scheduling sites and a dozen receiving clinics sites.

- Staff in the emergency department, inpatient unit, or community setting identify patients in the target population, provide patient education about the importance of a health home, and **schedule appointments** 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.
- **Experian-Patient Schedule,** a web-based appointment scheduling platform, allows clinics to post open appointments for staff to review with the patient and choose a location, date and time that works best for the patient.
- Receiving clinic staff are notified that an appointment has been scheduled at their site and will follow the clinic registration process.

# TARGET POPULATION

- People without established primary care/medical homes
- Pregnant women
- People with chronic conditions
- Frequent emergency room visitors
- People with frequent hospitalizations

# PARTICIPATING ORGANIZATIONS

**Scheduling Organizations**

- Ascension Wisconsin
- Aurora Health Care
- Froedtert Health
- Milwaukee area Health Departments
- Milwaukee area Fire Departments

**Receiving 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
- Milwaukee area Free and Community clinics
- Behavioral and mental health clinics

**Experian**

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 Connect to Care 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***