

OVERVIEW

The Emergency Department to Medical Home Program (EDMH) has worked since 2007 to decrease avoidable ED visits, reduce duplicative ED tests and procedures, and connect or reconnect high-risk patients 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.**

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.**

2023 PROGRAM EXPANSION

As the health care delivery landscape shifts and patient needs and utilization patterns change, **the program is expanding the number of participating referring and receiving organizations** to ensure residents get timely, clinically appropriate and acceptable access to a variety of health care services.

Moving forward, the EDMH Program will be renamed the **Connect to Care Program** to reflect this expansion in scope.

Referral best practices will also be shared to increase referral show rate. This includes patient education on the importance of a medical home, offering patient choice, pre-appointment outreach, and assistance with transportation barriers.



PARTICIPATING MEMBERS

Current partners:

- All Milwaukee emergency departments (referring)
- Milwaukee Health Department (referring)
- Health system mobile health (referring)
- All FQHCs and large safety-net clinics (receiving)

Future referral partners:

- Inpatient hospitals
- Mobile health units
- Community-based lead testing clinics
- Health department clinics
- Community paramedics

Future receiving clinic partners:

- Milwaukee County Behavioral Health Services Access Clinics
- Additional dental clinics
- Medication-Assisted Treatment providers

GOALS

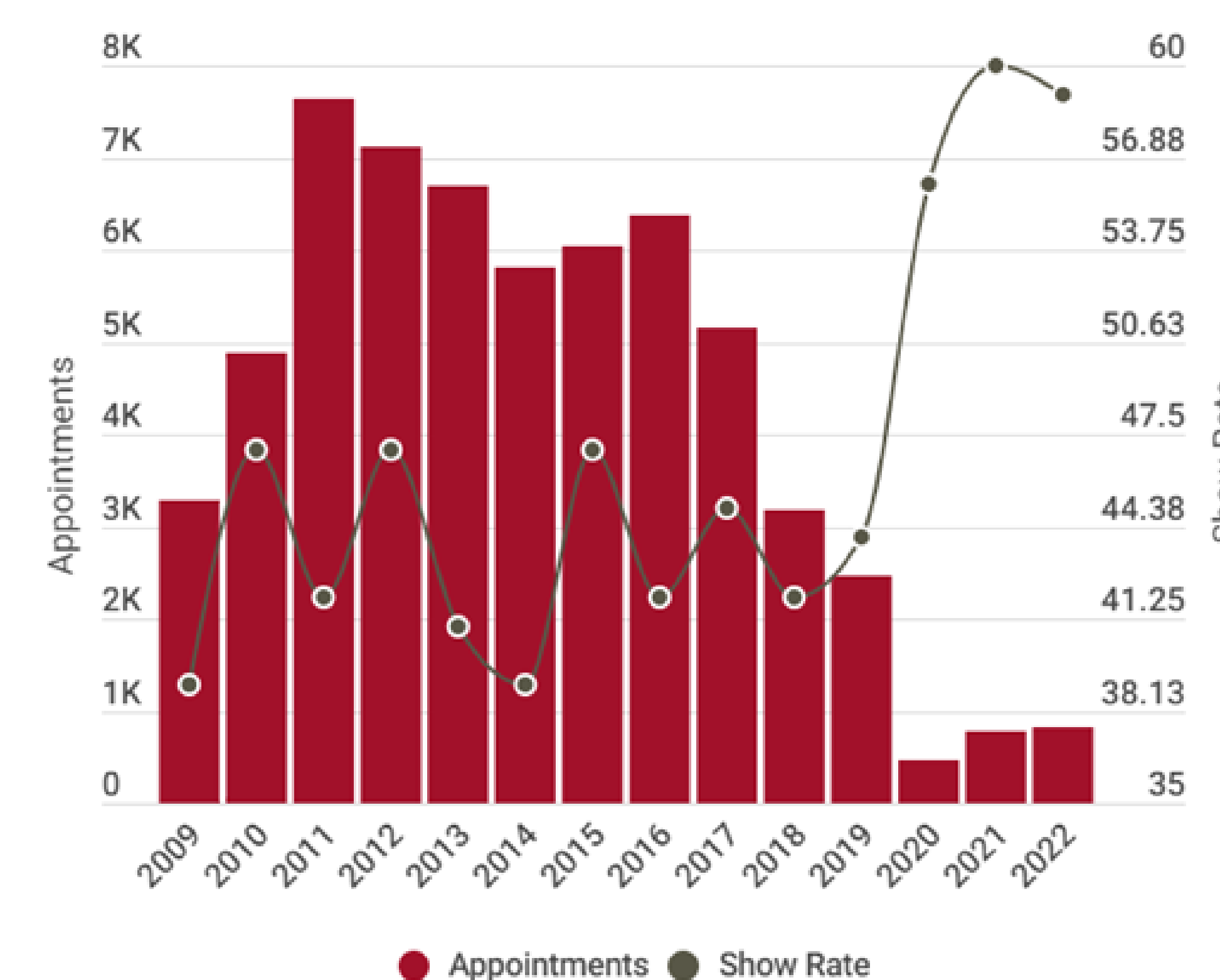
Connect or reconnect residents to health homes to improve health outcomes.

TARGET POPULATIONS

- People with chronic and infectious disease
- Women of child-bearing age
- People with mental health and SUD issues
- People with oral health issues
- Other at-risk populations (aging, children, disabled)
- Target zip codes to drive equity
- Unestablished patients motivated to establish a health home

OUTCOMES

Connect to Care Show Rate and Referrals by Year



CURRENT PARTICIPATING CLINICS

