

Milwaukee Health Care Partnership **CONNECT TO CARE PROGRAM**

In Milwaukee County, a significant share of emergency department (ED) visits are for conditions that could be safely addressed in primary or preventative care settings. Milwaukee County experiences preventable ED visits at a rate of 3,056 per 100,000 residents, approximately 40% higher than the Wisconsin average, underscoring a significant gap in access to timely appropriate care. These visits are disproportionately made by individuals who are uninsured, underinsured, or lack connection to a medical home.

The **Connect to Care Program** is a community-wide care coordination initiative designed to address these gaps by connecting individuals to appropriate, ongoing care.

The program operates through a coordinated, cross-organizational network that includes emergency departments, inpatient units, mobile outreach teams, health departments, and fire departments. Using standardized care transition processes and shared scheduling technology, the program identifies individuals at the point of care, largely in ED hospital settings, and facilitates in-the-moment connections to primary care and other services before discharge.

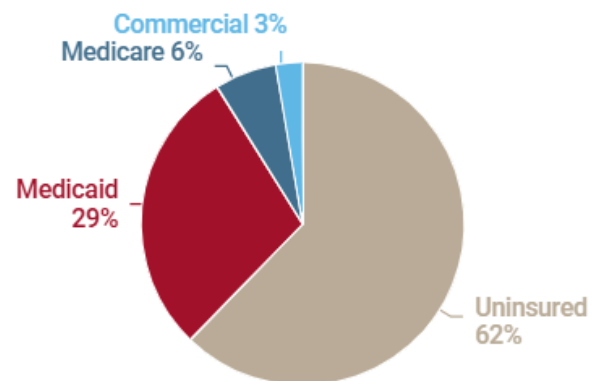
Since 2009, **60,994 appointments** have been scheduled for individuals without an established medical home or for other needed services.

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

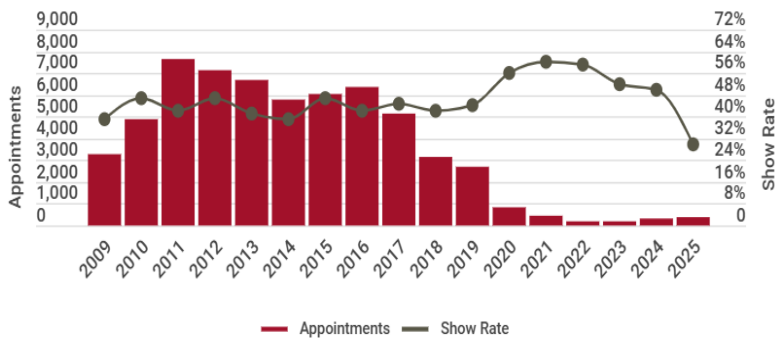
GOALS

- 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 by Coverage Status, 2020-2025



Connect to Care Appointments, 2009-2025



RETENTION AND COVERAGE OUTCOMES

A targeted analysis of 341 patients connected to medical homes through the Connect to Care Program showed that approximately 50% remained engaged with ongoing appointments, alongside a substantial reduction in uninsured rates among this group.

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 ThedaCare
- 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
- Muslim Community Health Center
- 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 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