High ED Utilization: Collaborating Across the Continuum

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Project Overview

- Per CMS, non-urgent emergency room visits compromise of 10% of all ED Visits

- Patients with higher utilizations of non-urgent/avoidable visits, tend to have poor mental and physical health and unmet social determinants of health

- In reviewing our systems non-urgent/avoidable emergency room visits, there were several commonly known patients on the list who had 30 or more visits within a calendar year

- Our goal was to collaborate with system care management teams to help reduce the number of non-urgent/avoidable emergency room visits

- Our teams worked with IAS to help us identify patients with 30 or more visits, which ultimately progressed to our current state of 20 or more non-urgent/avoidable emergency room visits
Atrium Health Care Management Teams

- AIM
- AMI Navigation
- BHI
- Neonatal Navigation
- LCI
- ACM
- CCPGM

Patient
Ambulatory Care Management

- ACM department developed in 2014 to help service patients of Atrium owned Primary Care Practices (Family and Internal Medicine) with poorly controlled diabetes

- In 2016, our team began to care manage patients with multiple chronic conditions from our Atrium owned Primary Care Practices

- During 2016, we began working to identify patients with 30 or more non-urgent/avoidable emergency room visits

- We hired an MSW to work specifically with this patient population

- We now have an MSW and Nurse Care Manager who work to with patients with 20 or more non-urgent/avoidable emergency room visits

- Both work closely with each facilities ED Care Managers and SW to work with these patients for needs
Community Care Partners

- Care Managers
- Behavioral Health
- Community Health Workers
- Pharmacists
- Patient Coordinators

TEAM BASED CARE

IT STARTS WITH YOU.
Tailored Approach to the Population:

- Dedicated RN/MSW care management team addressing the most challenging cases
- Case distribution across the team footprint
- Heightened accountability and report-outs based on recent utilization trends

- Retention of identified high utilizers beyond typical care management timeframe
- Collaborative interprofessional problem-solving
- Education of team to increase use of ED care plans and alerts
- "Cross-system" collaboration in appropriate cases
Community Care Bridge

Program Components

Population Health/Care Management for the uninsured utilizes a high-touch model. Targeted outreach by interdisciplinary team of RN, MSW, Peer Support, Community Health Worker (CHW), Financial Counselor. Wrap-around services include housing assistance, connection to community resources, linkage to primary care, BH & SU services, emotional support, & assistance with accessing insurance and disability.
Community Care Bridge

Foundational Elements

• Interdisciplinary team to intensively navigate complex uninsured patient care

• Personal touch moves patient through health system
  ▪ Face to face relationship is critical for success
  ▪ Intense and on-going follow-up for long term patient engagement

• Proactive care for the whole person, including supporting the medical plan of care:
  ▪ Tap into existing system and community resources

• Uncover barriers to failed outpatient management

• Empower patient self-management

• Link patient to a medical home, community resource needs, financial resources
Collective Goals and Work

• Overall goal was to reduce the number of times the cohort of patients entered the Emergency Room

• Through our work, we have been able to connect patients with family members, available community resources, and different care management teams in the community

• Built connections with Novant Health and Caromont Health for patients who utilized multiple ED Visits between systems

• Strengthened collaboration between Transition Clinic, Paramedicine Program, Mecklenburg County Medic, CMPD, and other Community Agencies

• Opens up resources for patients who need further assistance
Learned Lessons and Future State

• Multiple disciplines and skill levels were needed to address the needs of the patients – Transition Clinic and other local facilities

• Working with IAS to help determine our patient cohorts and for continuous updates on the current utilization of the patients

• **We have to be innovative!** All our work cannot be behind a desk and telephone!

• Developed a way to send a text to patients after they have discharged from an emergency room
High ED Utilization – ED Visits

Cohort changed from 30+ ED visits in 2016 to 20+ visits in 2018. 2017 was a 35% reduction in ED Utilizations. 2018 was a 40% reduction in ED Utilizations.
High ED Utilization – Billed Charges

In 2017, there was a $7 million reduction in ED Billed Charges. In 2018, there was a $16 million reduction in ED Billed Charges.
Questions?
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