



NATIONAL ASSOCIATION OF
Community Health Centers

Emergency Department Care Coordination: Targeted Strategies to Improve Health Outcomes and Decrease Costs

Important Content Note:

This technical assistance resource was developed prior to the August 2017 release of the Health Center Compliance Manual by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). The BPHC Compliance Manual, issued August 2017, indicates where PINS, PALs and other program guidance are now superseded or subsumed by the BPHC Compliance Manual.

See:

<https://bphc.hrsa.gov/programrequirements/pdf/healthcentercompliancemanual.pdf>

February 2017

Background

The hospital-based emergency department (ED) has had a relatively short existence, originating just after World War II in response to round-the-clock need for access to emergency care specialists.¹ Today, EDs are a major component of the United States healthcare system, serving approximately 20% of the population annually.² ED utilization has increased at an extraordinary rate, with the number of ED visits increasing by 150% from 1994 to 2014.³

According to a report previously issued by NACHC⁴, at least one-third of all ED visits are “avoidable,” meaning non-emergency or ambulatory care sensitive, and therefore treatable in primary care settings.⁵ This inappropriate utilization of the ED is costly.⁶ It has been estimated that the average non-emergency visit to the ED is seven times more expensive than an average health center visit.⁷

There are many factors that contribute to the use of EDs. One factor commonly cited by patients is difficulty accessing outpatient primary care. In particular, it is often challenging to find providers willing to take new patients who are uninsured or enrolled in Medicaid.⁸

Health Insurance and ED Usage

Health insurance type has been associated with ED usage for adults, with the highest rates of use among adults with public health coverage, notably Medicaid, relative to adults who are uninsured or have private health insurance.⁹ According to a 2014 Information Bulletin issued by the Centers for Medicare and Medicaid Services (CMS), research suggests that the higher ED utilization by Medicaid beneficiaries may be in part due to unmet health needs and lack of access to appropriate settings.¹⁰ The Information Bulletin sets forth that “*efforts to reduce ED use should focus not merely on reducing the number of ED visits, but also on promoting continuous coverage for eligible individuals and improving access to appropriate care settings to better address the health needs of the population.*”¹¹

¹ Robert E. Suter, *Emergency Medicine in the United States: A Systemic Review*, 3 *WORLD J EMERG MED* 5, 5-6 (2012).

² Reasons for Emergency Room Use Among U.S. Adults Aged 18-64: National Health Interview Survey, 2013 and 2014, National Health Statistics Reports, Number 90 (February 18, 2016); citing National Center for Health Statistics. Health, United States, 2014: Table 80. Hyattsville, MD.

³ American Hospital Association Table 3.3: Emergency Department Visits, Emergency Department Visits per 1,000 Persons and Number of Emergency Departments, 1994 – 2014 (2016).

⁴ Lina Choudhry et al., *The Impact of Community Health Centers & Community-Affiliated Health Plans on Emergency Department Use*, National Association of Community Health Centers, Inc. (April 2007).

⁵ *The Impact of Community Health Centers & Community-Affiliated Health Plans on Emergency Department Use*, National Association of Community Health Centers, Inc. (April 2007).

⁶ U.S. Dep't of Health & Human Serv., Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey, Table 6: Emergency Room Services-Median and Mean Expenses per Person With Expense and Distribution of Expenses by Source of Payment: United States, 2013* (accessed Jul. 22, 2016).

⁷ U.S. GAO Report 11-414R, *Hospital Emergency Departments: Health Center Strategies That May Help Reduce Their Use* (April 11, 2011).

⁸ Letter from Debra A. Draper, United States Government Accountability Office to the Honorable Tom Harkin, United States Senate (Apr. 11, 2011), <http://www.gao.gov/assets/100/97416.pdf>.

⁹ Reasons for Emergency Room Use Among U.S. Adults Aged 18-64: National Health Interview Survey, 2013 and 2014, National Health Statistics Reports, Number 90 (February 18, 2016); citing Tang N, Stein J, Hsia RY, Maselli JH, Gonzales R. Trends and characteristics of US emergency department visits, 1997–2007. *JAMA* 304(6):664–70. 2010.

¹⁰ Centers for Medicare and Medicaid Services, Informational Bulletin, *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings* (January 16, 2014) <https://www.medicare.gov/Federal-Policy-Guidance/downloads/CIB-01-16-14.pdf>.

¹¹ Centers for Medicare and Medicaid Services, Center for Medicaid Services & CHIP Services, Informational Bulletin, *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings* (January 16, 2014).

Innovative Approaches to Incentivize Care Coordination

In response to the growing utilization of EDs to treat non-emergency health care conditions, particularly among Medicaid enrollees, as well as the high cost of preventable hospital readmissions, CMS and state Medicaid agencies are incentivizing hospitals to establish linkages with primary care providers. Through such linkages, patient care is managed in a more appropriate outpatient setting, resulting in a reduction in unnecessary and costly hospital care. For example, CMS's Readmissions Reduction Program, created under the Affordable Care Act, reduces payments for hospitals with higher than expected 30-day readmission rates for targeted clinical conditions such as heart attacks, heart failure, and pneumonia.¹²

In addition, Accountable Care Organizations (ACOs) typically provide financial incentives for participating providers, including hospitals and primary care providers, to coordinate care for a designated population. If certain quality performance standards are satisfied and expenditures are avoided, then the participating providers may be eligible to share such savings.

Health Centers as Essential Partners

As health centers, by mission and design, exist to provide comprehensive primary and preventive care to patients, regardless of their ability to pay, they have been identified as essential partners in these endeavors.

This brief is designed to assist health centers in exploring opportunities to collaborate with hospitals to reduce inappropriate ED utilization through linking individuals with the health center's patient-centered medical home model of care. This brief outlines strategies to achieve ED care coordination, summarizes important legal and policy issues, and provides case studies of health centers that have implemented successful ED care coordination programs.

"As beneficiaries gain coverage as a result of the Affordable Care Act, utilization of services across the health care system is likely to increase, and states and CMS share a strong interest in reducing unnecessary hospital emergency department usage."

– CMCS Informational Bulletin, Jan 16, 2014¹³

"Improving the performance of America's health system will require improving care for the patients who use it most: people with multiple chronic conditions that are often complicated by patients' limited ability to care for themselves independently and by their complex social needs. Focusing on this population makes sense for humanitarian, demographic, and financial reasons."

– Caring for High-Need, High-Cost Patients — An Urgent Priority,
New England Journal of Medicine, July 27, 2016¹⁴

¹² For more information, visit the Readmissions Reductions Program website at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>.

¹³ Centers for Medicare and Medicaid Services, Center for Medicaid Services & CHIP Services, Informational Bulletin, *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings* (January 16, 2014).

¹⁴ D. Blumenthal, B. Chernof, T. Fulmer et al., "Caring for High-Need, High-Cost Patients—An Urgent Priority," *New England Journal of Medicine*, published online July 27, 2016.

During his 2011 testimony to the Senate¹⁵, Jim McCrae, then Associate Administrator for Primary Health Care within HRSA, noted that research has shown:¹⁶

- Medicaid beneficiaries receiving care from a health center were less likely to be hospitalized.
- Medicaid beneficiaries receiving care from a health center were less likely to visit the emergency room inappropriately.
- Rural counties with a community health center site had 33% fewer uninsured emergency room/department visits per 10,000 uninsured population than those without a health center.

Strategies to Reduce Inappropriate ED Utilization

Health centers across the country are implementing a variety of different strategies to reduce inappropriate ED utilization. The most common five strategies listed below represent a broad spectrum of options, which are often mixed and matched based on available resources and local need.

1. Expanding access to outpatient primary care services through offering extended hours (weekends and evenings), open scheduling, and same day/walk-in appointments.
2. Educating patients regarding services available at the health center and the importance of managing chronic conditions in a primary care setting. The information can be disseminated broadly (*e.g.*, posters in the health center sites, public service announcements, etc.) and/or directly to the individual client (*e.g.*, letters, calls to patients while at the ED, in-person discussions post-ED visit, etc.).¹⁷
3. Establishing an interoperable health information exchange (HIE) system or other information sharing portal that informs the health center when its patient presents at the ED or is admitted. In addition, the health center and hospital often maintain interoperable electronic medical records systems that allow for the transmission of patient health information in a timely fashion.
4. Contacting health center patients (or individuals who indicate that they do not have a primary care provider) upon discharge from the ED to discuss the individual's health care needs and to make timely appointments for follow-up care at the health center. These interventions may occur in-person at the hospital or by telephone.
5. Establishing an ED diversion strategy whereby patients who present to the ED with a non-emergency medical condition are presented with the option to contemporaneously receive treatment at a health center site in close proximity to the ED (*e.g.*, on the hospital campus) as an alternative to being treated at the ED.¹⁸ The referral to the health center as an alternative to the ED is subject to patient freedom of choice.

¹⁵ Available online at: <http://www.hhs.gov/asl/testify/2011/05/t20110511a.html>.

¹⁶ United States. Senate. Committee on Health Education, Labor & Pensions, Subcommittee on Primary Health and Aging. *Efforts to Divert Non-Urgent ER Use to Alternate Providers, Focusing on Providing Better Care and Lower Costs*, May 11, 2011 (testimony by Jim McCrae, Associate Administrator for Primary Health Care, Health Resources and Services Administration).

¹⁷ Often, a care coordinator or community health worker is stationed at, or in close proximity to, the ED so that they may meet with the health center patient in-person.

¹⁸ Under an ED diversion strategy, the hospital retains responsibility for completing an EMTALA-compliant medical screening examination, as described below, prior to giving patients the opportunity to receive treatment at a health center site as an alternative to the ED.

Critical Considerations: The Emergency Medical Treatment and Labor Act (EMTALA)¹⁹

ED diversion strategies that include the referral of patients from the ED to a health center, as described under option #5 above, are often effective approaches to link patients with a primary care medical home and prevent inappropriate ED utilization. Prior to proceeding with such strategies, it is important to have a working understanding of the Emergency Medical Treatment and Labor Act (EMTALA) - a key federal law specifically applicable to ED care. An ED diversion strategy should not be implemented without having a clear process in place to ensure a hospital's EMTALA obligations are satisfied.

EMTALA was enacted in 1986 to ensure public access to emergency services, regardless of an individual's ability to pay, and applies to all Medicare-participating hospitals that operate an ED.²⁰ In relevant part, EMTALA requires hospitals with EDs to provide a medical screening examination to every individual who comes to the ED seeking examination or treatment for an emergency medical condition, including active labor.²¹

The medical screening examination must be appropriate to the individual's presenting signs and symptoms, as well as the capability and capacity of the hospital. Depending on the individual's presenting signs and symptoms, an appropriate medical screening examination can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures, such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or other diagnostic tests and procedures. The medical screening examination process is separate from triage, which entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the individual will be seen by a physician or other qualified medical personnel.

If an individual is determined to have an emergency medical condition, then the hospital is required to provide stabilizing treatment or appropriate transfer to another hospital. The hospital may not delay the examination or the treatment to inquire about the individual's insurance status or ability to pay. **If the medical screening exam is appropriate and does not reveal an emergency medical condition, then the hospital has satisfied its EMTALA obligation and has no further obligation to treat the individual.**

In the context of ED diversion strategies, there is no EMTALA exposure if the process to refer patients to a health center occurs *after* the hospital has determined, through an appropriate medical screening examination, that the individual does not have an emergency medical condition. Accordingly, EMTALA should not be perceived as a legal barrier for the referral of patients determined to have non-urgent health care needs appropriate for a primary care setting.

EMTALA may, however, raise important operational considerations. For example, if the ED clinicians conducting the medical screening examinations also provide the stabilizing treatment, then such individuals

¹⁹ Available at: <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/>.

²⁰ See 42 U.S. Code § 1395dd. The EMTALA regulations and CMS guidance are set forth <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/> (last visited September 2, 2016).

²¹ An "emergency medical condition" is defined as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs.

may be reluctant to interrupt the provision of care following the medical screening examination to discuss the opportunity to obtain services at a health center as an alternative to the ED.

Prior to establishing an ED diversion strategy, it is important for the health center and ED staff to collectively review and, as necessary, modify the hospital's EMTALA medical screening examination protocols to both ensure EMTALA compliance, while at the same time, breaking the habitual practice of providing primary care treatments through the ED staff.

CMS and State Initiatives to Reduce Inappropriate ED Utilization

In addition to understanding the EMTALA-related legal requirements and operational considerations, health centers and hospitals contemplating an ED care coordination strategy should become familiar with federal and state legislative initiatives to incentivize individuals to not seek ambulatory treatment at EDs.

In particular, the Deficit Reduction Act²² enacted in 2006 provides states with the option to amend their Medicaid State Plans to permit hospitals to impose enhanced cost sharing for non-emergency care furnished in an ED to certain Medicaid enrollees. In order for a hospital to charge the co-payment, it must first satisfy several conditions. In particular, following an EMTALA-compliant medical screening examination that determines the patient is presenting for a non-emergency visit, the hospital must provide the patient with the name and location of an **“alternate non-emergency services provider”** that is available, accessible, and can provide the needed services. The hospital must also provide a referral to coordinate scheduling of treatment provided by the alternate non-emergency services provider. **A “non-emergency services provider” is explicitly defined in the statute to include community health centers.**²³

The DRA also included \$50 million in grant funds available over a four-year period (FY 2006-2009) to support the establishment of alternate non-emergency services providers or networks of such providers. States were encouraged to apply for grant funds to implement projects that would:

- establish new community health centers;
- extend the hours of operation at existing clinics;
- educate beneficiaries about new services; and
- provide for electronic health information exchange between facilities for better coordination of care.

As shown in Figure 1, 20 states participated in the DRA Emergency Room Diversion Grant Program.

²² Available at: <https://www.gpo.gov/fdsys/pkg/PLAW-109publ171/html/PLAW-109publ171.htm>.

²³ 42 U.S.C. 1396o-1(e)(4)(b).

emergency conditions to utilize the health center as an alternate source of care. From a compliance standpoint, it is also advisable that the notice (or an accompanying referral slip or similar document) be transported with the patient and contain a representation by the hospital (*e.g.*, initialized checked box) that ensures that the patient being referred through the ED received an EMTALA-compliant medical screening examination and was deemed to not have an emergency medical condition.

Snapshot from the Field: Washington’s Innovative ER is for Emergencies Program

Rather than limit the number of ED visits across all hospitals, Washington State sought to improve management of ED conditions and address overutilization through establishing the “ER is for Emergencies” program in 2012. The program included the following “seven best practices”: HIE technology referred to as the Emergency Department Information Exchange (EDIE), patient education on appropriate ED use, identification of frequent users of the ED and prehospital care, development of patient care plans, implementation of narcotic guidelines, participation in prescription drug monitoring program, and use of feedback information.

In the first year of the program, Medicaid ED costs fell by nearly \$34 million through a reduction in ED visits. ED visits by Medicaid patients declined by nearly 10%, with rates of visits by high utilizers (5+ visits/year) declining by approximately 11%. For less serious conditions, the visit rate decreased by more than 14% over the year.²⁶

Case Studies

In order to highlight the experiences of health centers that have gone through the process of implementing an ED care coordination strategy, including the practicalities and nuances that can “make or break” the endeavor, we interviewed three different health centers. The following case studies illustrate the broad range of ED care coordination initiatives. In addition to summarizing their various strategies, the health centers describe the evolution of their project, as well as the successes and challenges encountered along the way.

Case Study #1:

Centro de Salud Esperanza

Esperanza Health Centers (Esperanza) cares for patients in some of the poorest communities in Chicago. Its mission is to improve patient health through high quality health care and wellness services for those who need it the most. Esperanza became an FQHC in 2005 and now operates three sites in Chicago’s Little Village and Chicago Lawn neighborhoods. As described in this case study, the impact Esperanza makes in its communities has significantly improved since it began participating in the Medical Home Network (MHN) ACO and experiencing the benefits of a value-based model.

The story begins with the inception of MHN, which is a formal provider collaborative established in 2009 by

²⁶ The Brookings Institution *Washington State Medicaid: Implementation and Impact of “ER is for Emergencies” Program*, (May 4, 2015), available at <https://www.brookings.edu/wp-content/uploads/2016/07/050415EmerMedCaseStudyWash.pdf>.

the Comer Family Foundation. The goal of MHN is to develop and implement provider-based solutions that improve the healthcare of Medicaid recipients in Chicago's south and southwest neighborhoods. MHN ACO, created in 2014, evolved from provider-led initiatives managed and supported by MHN.

MHN ACO is a limited liability company controlled and owned by its ten members, including seven FQHCs and three local hospitals. The ACO began as a pilot program, which the participating hospitals and FQHCs proposed to the Illinois Department of Healthcare and Family Services in 2012. The ACO has a contract with CountyCare, a Medicaid health plan sponsored by Cook County, and has roughly 80,000 attributed Medicaid patients.

MHN ACO was established to improve the health of Medicaid patients in Chicago by enhancing care coordination and quality, improving access, and reducing fragmentation and health costs. Reducing unnecessary ED visits and connecting patients with a health center medical home is central to the ACO's strategy. MHN and Esperanza share the same vision, values, and mission to improve health so it was a great partnership from the start. In fact, collaboration among all providers and partners has been key to the success of the ACO.

Currently, there are approximately 3,500 Medicaid patients assigned to Esperanza through the ACO, which accounts for 20% of Esperanza's total patient population. Some of these assigned Medicaid patients have not received primary care or other services from Esperanza, and often have significant health care needs and can be difficult to reach using traditional outreach efforts.

There are key features of the ACO that help Esperanza connect with its Medicaid patients and reduce unnecessary ED visits. In particular, a significant portion of the care coordination costs are paid up-front, which has enabled Esperanza to hire eleven care coordinators. Care coordination fees are paid on a per-member, per-month basis, and are then added into the medical cost of care calculations that eventually determine shared savings for the ACO.

As a participant in the ACO, Esperanza and its care coordinators have access to MHNConnect, the secure online portal provided by the ACO's management company, which links to the registration systems at numerous hospitals in the Chicago region. Through MHNConnect, Esperanza's care coordinators receive automatic, real-time alerts when one of its patients registers at a hospital ED or is admitted for inpatient care.

By leveraging technology, the ACO is fostering communication and collaboration between providers and hospitals and transforming the way care is delivered. This coordinated approach is designed to ensure that Esperanza's patients have better access to care. It's also about empowering patients to be more involved in their own health care.

The story of Robert Hernandez²⁷, one of the patient's at Esperanza, illustrates this approach and the benefits to Esperanza's patients. Robert had his first asthma attack two weeks after he was born and was rushed to the hospital. Over the next few years, visits to the ED became the norm for Robert and his mother, Vanessa. The attacks began to disrupt the family's life ... Vanessa almost lost her job and Robert missed too many days of school.

²⁷ The patient's name has been changed for purposes of this brief.

Meanwhile, Esperanza became a partner in the MHN and was assigned to be Robert's primary care medical home. During that same time MHNConnect, the secure portal, went live. Robert's medical history immediately appeared on the portal alerting his care team to his condition and history of frequent ED visits. This was a turning point in the boy's life. At Esperanza, Robert had a pediatrician who could provide preventative care and education to manage his condition and help avoid costly and unnecessary ED visits. A short time later, Robert had not suffered a single asthma attack.

Throughout Esperanza's health centers and in the communities it serves, Esperanza is seeing many examples like Robert where high-risk patients are flagged and given specialized care with very positive results. Esperanza's patients benefit from a team that coordinates their care and technology that connects patients and their providers to ensure they receive the right care across the health care system.

In addition to reducing unnecessary ED visits, the ACO also focuses on the importance of timely patient follow-up and successful care transitions. Experts estimate that 20% of U.S. hospitalization costs are due to readmissions within 30 days of discharge. Although hospitalizations are extremely costly for the healthcare system, they also highlight poorly executed transitions that negatively affect a patient's health.

Care transition programs are critical to reducing ED and inpatient visits and driving down costs. They can help patients address social barriers to getting healthy as well as receive the clinical care they need. The programs also provide better continuity of care as patients become more connected and engaged with their primary care providers. These programs are an important element to an effective value-based model.

To ensure the ACO is meeting its goals, the effectiveness of the ACO is continually evaluated. Through data analysis, the FQHCs and hospitals monitor their care coordination efforts and the impact on patients, health care use, and costs, including but not limited to ED utilization. ACO members agreed to share their data so each organization knows how the others are performing. Data shared includes metrics such as number of health risk assessments completed, rates of 7-day follow-up after inpatient or ED discharge, care plan completion rates, repeat hospitalizations and ED utilization, completion of transitions of care documents, and medical loss ratios. This "radical transparency" and trust among the ACO members fosters collaboration, creates healthy competition, and has been central to the ACO's success.

Successes, Challenges, Lessons Learned

The ACO is transforming the way health care is delivered to Medicaid patients in its communities. Patients feel empowered and are more involved in their own care. Overall, the ACO has had remarkable success reducing costs and generating shared savings. Esperanza has seen a material reduction in ED usage and hospital readmissions among its Medicaid patients. In the last year, Esperanza's care coordination efforts through the ACO netted significant shared savings revenue for the organization over and above fee for service and capitation payments, despite investments made in care coordination and technology.

The ACO information-sharing network platform has enabled Esperanza to provide personalized engagement efforts to its most clinically complex and costly patients, many of whom had historically slipped through the cracks. In addition, patients have said that they appreciate the care coordinators' individualized support and assistance addressing access barriers.

In terms of lessons learned, Esperanza cited the need to be proactive and to seek out other community

providers, including hospitals, that are willing, as a collective, to invest in creating the infrastructure necessary to form an effective ACO with sufficient economy of scale.

Esperanza recommended that health centers considering a value-based ED care coordination strategy directly approach their state Medicaid agency with a proposal, rather than wait for the state to take action. In addition, consider beginning as a pilot program and pursuing private donors. In Esperanza's case, private investment from the Comer Family Foundation, which was concerned about health care for the underserved, helped get the pilot project off the ground, which was an essential first step to establishing the ACO.

Case Study #2:

Carolina Health Centers

Carolina Health Centers (CHC) is an FQHC based in Greenwood, South Carolina. CHC, in close collaboration with Laurens County Memorial Hospital (LCMH), a campus of Greenville Health System located in Clinton, South Carolina, implemented an ED diversion strategy that included establishing a new CHC site directly adjacent to LCMH's ED. The new site, which is known as the Laurens County Community Care Center (the LC4), was established to offer individuals seeking primary care services at the LCMH ED an immediate, and directly accessible, alternative source for care. The ultimate goal of the creating the LC4 was to expand access to affordable primary care, thereby reducing the demand for primary care in the LCMH ED and improving health outcomes through more comprehensive health management. To accomplish these goals, CHC and LCMH identified the need to (1) educate the public about the importance of a primary care medical home; (2) enhance the patient's experience of care; and (3) redirect resources to optimize cost-effectiveness.

CHC and LCMH began planning their ED diversion strategy in 2008 in response to the high number of patients presenting to the ED with primary care needs. LCMH data indicated that nearly 75% of its ED visits were for conditions of the lowest severity, and suitable for an outpatient primary care setting. These non-emergency visits were spread out regularly during normal business hours, indicating that a general lack of primary care providers in the area (particularly those willing to accept Medicaid-enrolled or uninsured patients) was contributing to the inappropriate ED utilization.

CHC was awarded a competitive New Access Point grant to operate the LC4. In addition, CHC secured start-up funding from the State of South Carolina, capital support and a low cost lease from LCMH, and private funding. After extensive work by a joint implementation task force, the LC4 opened in 2012.

It was initially anticipated that the LC4 would predominantly serve patients who (1) presented to the ED; (2) were determined by hospital staff (after performing the required EMTALA screening) to have a non-emergency condition appropriate for LC4; (3) were counseled by ED staff about CHC and its co-located LC4 site, and then, if requested by the patient; (4) were referred to the LC4 for a walk-in appointment. This protocol proved challenging, with only a "trickle" of patients actually being referred to LC4 as an alternative to the ED. CHC determined that the ED staff often performed extensive diagnostic testing during intake, which resulted in the ED providers deciding to furnish the remaining treatment, including writing any necessary prescriptions. As a result, few ED patients with non-emergency conditions were choosing to

receive care at the LC4.

Another factor limiting the number of patients referred from the ED was the limited capacity at the LC4. Due to the identified lack of access to affordable primary care options in hospital's service area, the providers at the LC4 nearly reached full capacity with self-referred patients coming directly to the LC4 for primary care.

In response to these challenges, CHC hired a care coordinator and, in collaboration with LCHCS, amended the ED referral protocols and established a limited linkage to the LCHCS EHR system. From the collaboration's inception, there was agreement that a care coordinator was an essential position to facilitate the referral of patients to LC4, and to address socio-economic barriers that may prevent such individuals from appropriately using a primary care medical home. Under the updated approach, CHC is promptly notified if a patient presents to the ED with a non-emergency condition appropriate for the LC4. The CHC care coordinator then goes directly to the ED to speak with the individual in-person regarding the LC4's services. If the patient elects to receive care through the LC4, the CHC care coordinator arranges for immediate walk-in care.

It was originally anticipated that the CHC care coordinator assigned to the LC4 would work primarily with the ED staff to assist with access when patients were referred to the LC4. However, as soon as the LC4 began seeing patients, the care coordinator was contacted by the hospital's discharge planners seeking a source of follow-up care for inpatients being discharged without an established primary care medical home. A strong referral relationship developed whereby the CHC care coordinator walks to the hospital and meets in-person with the identified patients being discharged, arranges follow-up appointments, addresses access barriers the patient may have, and continues follow-up with the patient to ensure their full engagement with their primary care medical home.

Over the past year, an average of 37 patients per month were referred to the care coordinator prior to hospital discharge. An unexpected impact of the LC4 has been the reduction in the number of patients discharged without a primary care provider. In addition, LCMH recently reported that its hospital readmission rate is now one of the lowest in the state.

Today, the LC4 has extended hours during the week and is staffed with one family medicine physician and three mid-level providers. Nearly half of the LC4's appointments are reserved for same-day visits. In addition to serving walk-in patients and individuals referred from the ED, the LC4 also offers scheduled appointments. Though pediatric patients are seen at the LC4, many parents coming to LC4 choose to establish an ongoing relationship with one of the two CHC pediatricians at Hometown Pediatrics, a CHC pediatric medical home site located less than a mile from the LC4. The LC4 is a busy practice and having a CHC pediatric practice located nearby assists with expanding access.

CHC and LCMH are looking toward a possible "phase-two" of the LC4, which would establish an off-campus location for established patients and designate the on-campus LC4 site for ED-referrals, walk-ins, and same day episodic care.

Successes, Challenges, Lessons Learned

The creation of the LC4 and the subsequent efforts to fill the primary care shortage in Clinton have made a material impact, both in reducing inappropriate ED utilization and creating a healthier community. In particular, CHC's efforts have helped provide the education, care coordination, and chronic condition management necessary to break the cycle of inappropriate ED use for a significant number of former ED "super users." Another critical benefit for patients referred from the ED to the LC4 has been the ability for such patients to access affordable prescription medication through CHC's 340B pharmacy program. Such access has had a direct and substantial impact in improving patients' compliance with medical treatment protocols, which has resulted in improved health outcomes.

This collaboration has also proven effective in helping CHC and LCMH adjust to the changing health care marketplace, which continues to shift financial risk to providers – most notably the financial "penalties" for chronic hospital utilization arising through readmissions. For example, to accommodate for its lack of Medicaid expansion, South Carolina created the Healthy Outcomes Plan (HOP) which created financial risk for the hospital's Medicaid and Disproportionate Share Hospital (DSH) payments (as well as creating a primary care enhancement payment for primary care providers) to incentivize the identification of frequent ED users and other "high risk" patients and the establishment of medical homes for these individuals. The work done by CHC's care coordinator has proven to be highly successful in identifying these high-risk individuals and establishing CHC as their primary care home, with the added benefit of CHC receiving the cost-based FQHC primary care payment.

The most significant challenge has been the reluctance of ED providers to adopt the diversion strategy and provide patients with the option to receive care at the LC4. In addition, the LC4 payor mix includes a greater proportion of adult uninsured patients than was originally anticipated. Consequently, the original LC4 financial projections proved to be too optimistic. In retrospect, securing a greater commitment from LCMH to the financial model would have been beneficial. This commitment would most likely have been in the form of either ongoing financial support to CHC (e.g., a community benefit grant) to cover CHC's otherwise uncompensated costs resulting from its LC4 operations, and/or the establishment of more robust strategies to disincentivize post-EMTALA screening treatment efforts by ED providers for non-emergency conditions appropriate for the LC4's outpatient setting.

CHC has found that coordinated planning and communication among CHC and LCMH management, as well as key ED staff, have been critical to addressing challenges, achieving provider buy-in, and moving the project forward. CHC has also found that the close relationship with LCMH has laid the groundwork for obtaining the hospital's support for other beneficial collaborative initiatives.

CHC recommended that health centers pursuing an ED care coordination strategy implement mechanisms to measure the impact of the relationship. It is important that the parties can quantify the reduction in inappropriate ED visits and/or hospital admissions directly resulting from the health center's care coordination efforts. Such data is useful to monitor the initiative and is critical to securing additional funding support from the hospital, foundations, and local and state governments.

Case Study #3:

South Boston Community Health Center

The South Boston Community Health Center (SBCHC) is an FQHC that has served the community of South Boston since 1972. SBCHC currently has over 150 staff and conducts over 60,000 patient visits a year. In response to rising ED use by its patients, SBCHC began a concerted effort in 2008 to enhance its care coordination for SBCHC patients who visited local EDs. The specific goals of these efforts were to: (1) ensure timely follow-up of patients receiving care in the ED; (2) reduce preventable ED visits; (3) increase primary care visits; (4) engage patients in their care; and (5) identify complex cases needing enhanced care management (particularly SBCHC patients who were frequent ED users).

To facilitate care coordination, SBCHC restructured its care model by putting physicians, nurses, and mid-level staff into clinical care management teams. Each clinical team is assigned a distinct patient panel, with nurses serving as the lead care managers.

When a SBCHC patient is seen at one of the local EDs, SBCHC receives a notification (which is often transmitted electronically) and the ED typically provides SBCHC with an electronic copy of the patient's corresponding health record.²⁸ Within 24 hours of receipt, a member of the care management team reviews the patient's health record, documents a brief synopsis of the patient's condition and course of treatment, notes if the visit occurred during SBCHC's hours of operation, and assesses if the ED visit was preventable. The care management team then contacts the patient to discuss the patient's health status and assist with scheduling appropriate follow-up care. In addition, patients identified as having visited the ED for a non-emergency condition are sent a letter detailing SBCHC's services, hours of operation, and contact information. Additional outreach and education efforts are directed at SBCHC patients who have a history of frequent ED utilization or have complex health needs (e.g., substance abuse).

If a patient is admitted through the ED, the care management team regularly checks in with the patient while they are in the hospital. The care management team works closely with a hospital discharge coordinator to schedule follow-up appointments at SBCHC or, if necessary, home care is arranged. To ensure that the SBCHC primary care physician has the most up-to-date patient information, the care management team compares the patient's SBCHC medical record with the hospital's medical record, with a particular focus on ensuring that the SBCHC medical record includes the current medication list.

In addition to establishing the care management teams and the triage system, SBCHC expanded its scheduled hours of operation and implemented open-access scheduling. Open-access scheduling lets patients schedule non-emergency appointments on the same day. Patients are assigned appointment slots on a first-call, first-serve basis, yet the system allows for walk-ins and patients needing more immediate attention are given priority. Both efforts were implemented to provide more immediate and convenient access to primary care. SBCHC's open-access scheduling is a novelty among the outpatient primary care providers in SBCHC's service area, and has filled a significant service gap.

Another important component to SBCHC's efforts to reduce inappropriate ED utilization is the adoption of a triage system to assess walk-in patients' treatment needs. Under the triage protocols, when a patient presents to SBCHC without an appointment, they are promptly directed to a nurse from their care management team. Depending on the patient's condition, the nurse may either provide instructions on self-

²⁸ The level of access and integration of electronic health information with SBCHC varies amongst the different hospitals. For example, SBCHC shares an EHR system with one hospital which provides direct access to records, maintains "read-only" access with another, and relies on fax and telephonic communications with the remaining hospitals.

care, schedule a timely appointment with the patient's primary care provider, or direct the patient to a hospital for emergency or inpatient care. The triage system has reduced SBCHC patients' inappropriate utilization of the ED for non-emergency care, while promoting patient awareness and confidence in utilizing SBCHC as the initial (and primary) location when seeking non-emergency health services.

Successes, Challenges, Lessons Learned

SBCHC's ED care coordination strategy has achieved many of the desired goals. In evaluating the impact of its ED care coordination strategy, SBCHC showed: (1) a decrease in the percentage of ED visits that were ambulatory sensitive; (2) a decrease in the percentage of ED visits that were low acuity; (3) a decrease in the percentage of weekday work hour ED visits that were non-emergent; and (4) a decrease in the percentage of SBCHC patients who had three or more ED visits over the year.

There have also been challenges to overcome. Initially, the nurses were concerned that their care management duties – particularly responding to the frequent hospital notifications– would take too much time away from their existing duties. However, over time, these duties have become a normal part of their scope of practice and workflow.

Establishing the requisite information technology linkages with certain local hospitals has also been a significant and ongoing challenge. While SBCHC's close collaboration with Boston Medical Center and Tufts Medical Center has resulted in the creation of an electronic health record (EHR) interface that provides SBCHC with timely notifications and access to its patients' hospital records, this feedback loop is not as timely or effective with other hospitals. The ability to obtain hospital approval for information sharing is a frequent problem encountered by SBCHC, with the obstacle often arising from internal hospital policies and procedures, including those addressing patient consent.

In summary, SBCHC's concerted efforts to both enhance care coordination for SBCHC patients and implement an open-access scheduling system has resulted in significant clinical and operational achievements in reducing preventable ED visits by SBCHC patients and managing individual patients with chronic and complex conditions.

Top Ten Things to Consider Before Implementing an ED Care Coordination Initiative

1. **Review the Data.** It is essential to get a complete, objective picture of ED trends. Using data from the hospital, the State Medicaid agency, and/or managed care plans, identify who is using the ED, when they are using the ED, and why they are using the ED. Of key importance, evaluate whether individuals customarily present to the ED with conditions that can be more appropriately treated in a health center setting, and/or if coordinated and readily accessible primary care would improve care management and decrease the need for emergency care.
2. **Involve Providers.** Providers should participate in planning discussions and should play an integral role in structuring the ED care coordination protocols. Providers can look beyond the ED data to provide insights that may not be apparent in the black and white numbers. In addition, provider input and support helps to identify and resolve potential issues at the outset.

3. **Ask Patients.** Speak to and/or survey health center patients who have used the ED for non-emergency medical care. Inquire why they turned to the ED for non-emergency care (*e.g.*, health center is not open at convenient times, scheduling in advance is challenging, health center wait times are too long, health center's fees are too high, etc.). This patient feedback should inform the ED care coordination approach.
4. **Work with Community Stakeholders.** Coordinating efforts with other community stakeholders (*e.g.*, local primary care providers, specialists, and safety-net organizations) and seeking their expertise can smooth the implementation of ED care coordination projects, and may allow the health center and hospital to identify and leverage community resources.
5. **Consider Scope of Project.** Evaluate whether the ED care coordination initiative will require that the health center obtain approval from the Health Resources and Services Administration (HRSA) to modify its scope of project. Consider how HRSA's scope change approval process will impact the timeline to implement the ED care coordination strategy.²⁹
6. **Estimate Financial Impact.** Project the financial impact of the ED care coordination initiative. In calculating potential costs and revenue, consider that new patients referred through the ED may have complex and unmet health care needs and, in accordance with the medical home model of care, will likely use the health center for a spectrum of services. If the costs are projected to exceed the revenue, the health center must consider what financial resources (*e.g.*, donation from the collaborating hospital, the state/local government, and/or community foundations) are available to ensure a breakeven (or profitable) budget.³⁰ If the hospital or another health care entity agree to provide such financial support, it is essential to structure such donation in a manner that complies with federal and, as applicable, state anti-kickback laws. On the federal side, federally-funded health centers can seek protection through structuring the donation in accordance with the health center safe harbor to the federal anti-kickback statute.³¹
7. **Comply with HIPAA.**³² Effective ED care coordination strategies require timely and effective communication of patient health information. In addition to complying with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which permits the exchange of patient health information for treatment purposes (among others), it is critical to ensure that the electronic information exchange is consistent with the HIPAA Security Rule. Accordingly, experts should be consulted to establish the information technology infrastructure necessary to ensure the security of such information.
8. **Define the Referral Process.** If an ED care coordination program includes a diversion strategy (*e.g.*, referring patients from the hospital to the health center as an alternative to the ED), the parties should define, in detail and in writing, which clinical conditions are appropriate for referral to the health center. In addition to being deemed non-emergency, per the EMTALA screening

²⁹ Available at: <http://bphc.hrsa.gov/programrequirements/scope.html>.

³⁰ An ED care coordination initiative may include establishing a new health center site. A health center may add a new site to its scope or project through a competitive New Access Point grant or through a non-competitive "change in scope" (CIS) process. A CIS request must demonstrate that the expansion can be accomplished and sustained without additional Section 330 Health Center Program grant funds, and the health center must provide a break-even (worst case) scenario or the potential for generating additional revenue, as documented in the budget submitted with the CIS application.

³¹ See 42 CFR §1001.952(w). Available at: <http://www.cpc.org/cpca2013/assets/File/Health-Center-Information/FQHC-Safe-Harbor/2008-01-NACHCBriefonSafeHarbors.pdf>.

³² Available at: <http://www.hhs.gov/hipaa/>.

requirements described above, the parties may decide that presenting patients with the option for referral to the health center is only appropriate if a patient is determined by ED staff to have particular conditions of certain low acuity (*e.g.*, colds, flu, ear aches, etc.).

9. **Put it in Writing.** ED care coordination initiatives should not be established through handshake deals. Rather, the parties should execute an agreement that sets forth the parties' underlying goals, the particulars of the adopted ED care coordination strategy, the frequency with which the parties will meet, the dispute resolution process, the hospital's obligation to comply with EMTALA, the parties' agreement to comply with applicable laws and regulations, and the hospital's obligation to provide financial support (if applicable).
10. **Communicate and Expect Future Changes.** Ongoing communication between the health center and its hospital is critical to the long-term viability and continuing success of the ED care coordination initiative. It is important to commit time and resources to periodically reviewing the initiative to assess challenges and opportunities. It is customary for health centers and hospitals to revise their ED care coordination strategy at least once following implementation. Remaining flexible and open to change is essential.

COPYRIGHT - February 2017

National Association of Community Health Centers

Emergency Department Care Coordination:
Targeted Strategies to Improve Health Outcomes and Decrease Costs

Prepared By:



Feldesman Tucker Leifer Fidell LLP

Carrie Bill Riley

Michael Golde

Ty Kayam



National Association of Community Health Centers

1400 I Street, NW, Suite 910

Washington, DC 20005

For more information about this publication, please contact:

Kersten Burns Lausch

Deputy Director, State Affairs

klausch@nachc.org

202.296.3800

This publication was supported by a grant from Kaiser Permanente, Community Benefit. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of Kaiser Permanente.