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AT THE FOREFRONT
UChicago Medicine

A Multidisciplinary Approach to Reduce Patient Reliance on the Emergency Department

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Learning Objectives

- Describe the impact of a social medicine team model on individual patient outcomes and ED utilization.

- Explain the importance of a cohesive, interdisciplinary team model to the success of a social medicine intervention.

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Background

- The emergency department (ED) has become the American safety net.
- ED utilization is increasing and much of this is driven by social needs.

What are social needs?

- Housing instability
- Lack of transportation
- Food insecurity
- Unemployment
- Substance use
- Mental illness
- Language barriers/immigration status
- Child/elder care needs
- Etc.

Background

- ED overutilization leads to
  - crowding
  - long wait times
  - delays for sicker patients to receive care
  - increasing numbers of patients leaving before treatment completion

- Frequent ED users constitute a small proportion of patients but account for a disproportionate percentage of ED visits and spending[1]

- These patients often have a heavy burden of social needs.

1. Kanzaria HK, Niedzwiecki M, Cawley CL, Chapman C, Sabbagh SH, Riggs E, Chen AH, Martinez MX, Raven MC. Frequent Emergency Department Users: Focusing Solely On Medical Utilization Misses The Whole Person. Health Aff (Millwood). 2019 Nov;38(11):1866-1875. doi: 10.1377/hlthaff.2019.00082. PMID: 31682499.

The idea

- Design an intervention to address the social needs driving patients to visit the ED frequently
- Goals:

Improve the health and well being of the patients disproportionately relying on the ED

Decrease the burden on the ED by providing needed social services and support outside the ED

The ED Social Medicine Team

- Initial concept:
  - An interdisciplinary team capable of providing comprehensive services both in and out of the ED
  - Planned focus:
    - Patients with the highest number of ED visits
    - Patients identified to have high social needs by ED physicians or non-physician providers
    - Excluded sickle cell patients (dedicated team for this population)

Team members

- Social workers
- Case managers
- Patient advocates
- Behavioral health specialists
- Pharmacists
- an ED physician

Initial focus

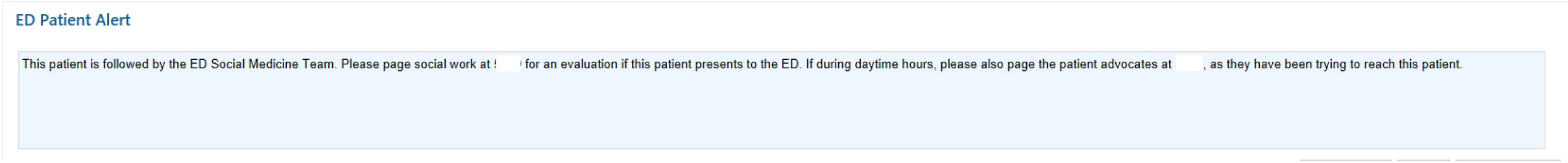
- Monthly data pull of the ten patients with the highest number of visits
- Patients referred by ED clinicians

- Monthly meetings to discuss individual patient cases and plan interventions
- Team members reach out by phone to patients to assess social needs and provide interventions

{2019}

Obstacles

- Many patients, especially those with complex social needs, were unable to be reached after ED discharge.
- A social needs assessment tool was developed to assist social work with in-person evaluations.
- Chart flags were developed to trigger a social work evaluation at the next ED visit.



Outcomes – First Two Years

- Total patients identified by team as frequent ED utilizers: **111**
  - On average, these frequent users visited the ED **6.49 times per month***
- Total patients referred to team: **~100**
- Social needs identified by team:

Patients with complete records (non-referrals)	**77**
Of which:	
Seeking primary or other outpatient care	54
Seeking shelter	44
Need transportation services	44
Exhibited behavioral health needs	42
Exhibited substance abuse disorder needs	29

*defined as the average number of visits during the month in which they were first identified as frequent utilizers

Trends emerged

Patients with an acute need such as a new medical problem or loss of transportation

Total patients: 61
Unable to contact/refused: 26

Patients with multiple complex and overlapping needs, such as homelessness, mental illness, and substance use

Total patients: 30
Unable to contact/refused: 21

Trends emerged

Patients with ar
need such as
medical probl
of transportati

Total patients: 6
Unable to contact

Around half of patients cannot be contacted or refuse assistance;
43% among those with acute needs

Patients with multiple
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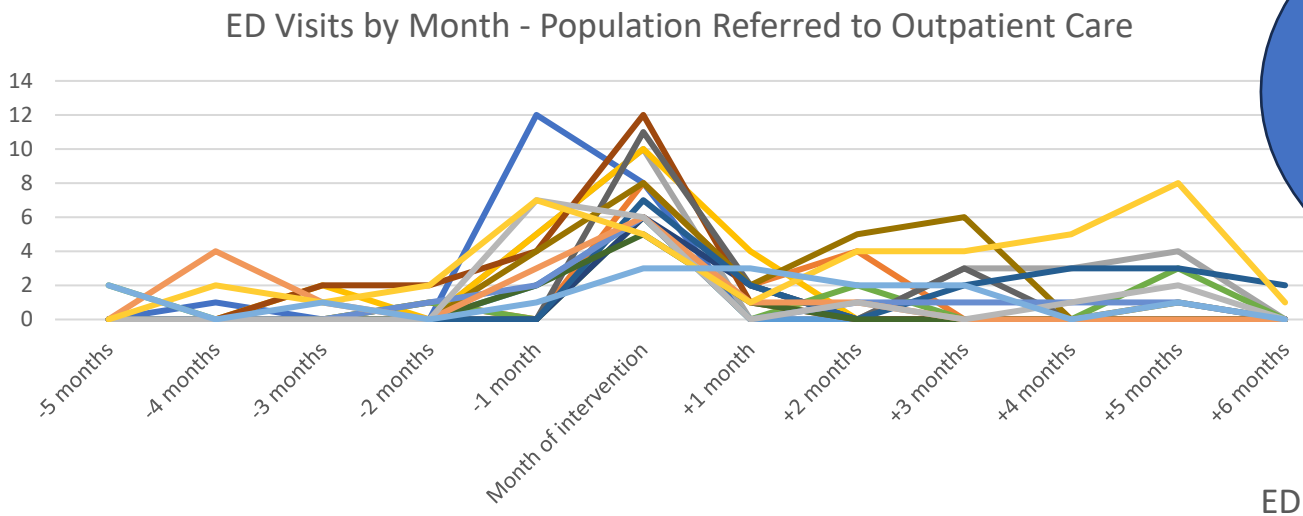
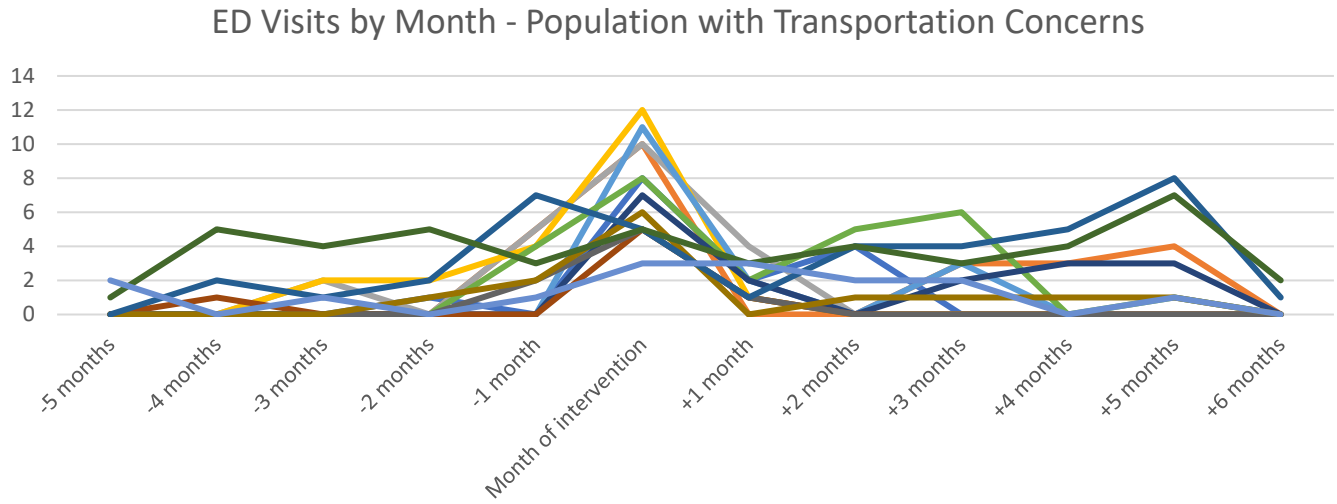
ontact/refused: 7

Patients with acute needs



38M with new epigastric pain thought to be GERD. Had 16 ED visits (plus more at other EDs) over 2 months. EDSMT* connected him to primary care and an expedited GI appointment, reassured him by phone. Has had 1 ED visit in the following 16 months.



*EDSMT: ED Social Medicine Team

Data source: University of Chicago Medicine

Patients with chronic needs

- Unable to place in shelter due to uncontrolled psychiatric illness and substance abuse
- Uninterested in the shelter system/declined assistance
- Prefer to seek care in the ED (e.g. outpatient paracentesis or dialysis arranged, patient declines and prefers the ED)

Evolution of the team mission

- Through discussion of individual patient needs, common threads emerged.
- Focus shifted from individual patient interventions to larger initiatives with broader impact.

Shelter placement

- **Problem identified**: many homeless patients were leaving prior to pickup for shelter placement
- **Interventions attempted**: providing food and a safe place to wait for shelter in the hospital lobby
- **Intervention:**
  - Partnership was developed with Salvation Army to directly transport appropriate patients to community service centers to await shelter placement.

Subsidized phone program

- **Problem identified**: Many patients with social needs are unable to be contacted after the ED visit to arrange services because they have no phone
- **Intervention:**
  - Partnership was developed with a free, wireless phone service to provide free, government-funded phones to qualifying patients

Mental health

- **Problem identified**: Many patients with anxiety have frequent ED visits for panic or anxiety
- **Intervention:**
  - Behavioral health developed a brief psychotherapeutic intervention to be administered in the ED at the conclusion of the visit
  - Resources put in place to connect these patients to ongoing mental health care.

Increasing immigrant/refugee population

- **Problem identified**: Increasing numbers of refugees visiting the ED with a variety of social needs (housing, food, legal services, infectious diseases, etc).
- **Intervention**:
  - A packet of resources was developed to assist ED staff in providing appropriate referrals to local social services.
  - Our team identified pathways to place patients with communicable diseases into isolation housing, and disseminated this information throughout the hospital

Impact of the team

- Positive impact on ED physicians, who feel they can offer support services to their patients that were not previously available
- Positive impact on patients followed by the team, who have been provided services
- Positive impact on other ED patients through averted unnecessary ED visits
- Strengthened partnerships throughout the hospital and has led to other collaborations and future projects

Future directions

- Further investigate options for patients with chronic complex needs, such as supportive housing or intensive treatment in partnership with psychiatry.
- Partnerships with local clinics/medical homes to coordinate services for frequent ED users.
- Understand outpatient referral needs and build additional infrastructure to support referrals for most utilized services (e.g., primary care, gynecology)

Lessons Learned

- Patients who frequently visit the ED often fall into two categories: acute and chronic ED users
- Individual patient interventions are very important but addressing the larger themes through development of partnerships or programs may have a larger impact
- Good record keeping from the beginning is key
  - Best practice of collecting info regarding the patients' needs, interventions & referrals provided by the team, as well as the use and impact of those referrals
    - Tracking usage and satisfaction is a great way to highlight the correlation between actions the team has taken with realized patient outcomes
  - Centralized data collection system with automated notifications for team members to follow-up with patients
- Must have someone coordinating the team's work to keep everyone on track

Key Takeaways

- This model is relevant to all EDs, as social determinants of health are a universal driver of ED overuse.
- Inclusion of members from all aspects of social service and care delivery, including people who work in the ED and in the ambulatory care setting, is key.
- Such a team must include navigators who can help connect patients to outpatient appointments and a set of resources for basic needs like transportation to appointments.
- Studying individual patient needs can lead to identification of larger themes that require more programmatic interventions.
- Develop a record keeping system and assign a person to coordinate activities and ensure records are up to date from the very beginning.

Questions?

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