# Investing in high-touch care coordination to reduce emergency department revisits

HOLYOKE MEDICAL CENTER

Holyoke Medical Center (HMC) is a 198-bed facility with over 1,300 employees serving a population of over a half a million residents in western Massachusetts. In 2015, HMC received two grants from the Health Policy Commission. One, which amounted to $1.9 million, supported HMC's efforts to measurably improve outcomes for behavioral health patients in the emergency department (ED). A second grant of $2 million supported a capital project to build a Behavioral Health Unit within a new, larger emergency department.

## Challenge

Patients with behavioral health diagnoses wait three times longer than traditional ED patients for an inpatient bed, leading to extended periods of boarding, poorer outcomes for patients, and strains on ED operations.[1] They are also more likely to revisit the ED than other patients. As the number of patients seeking emergency care for behavioral health disorders increases,[2] the health care system, including EDs, must adapt to accommodate the needs of this growing patient population.

## Action

Holyoke Medical Center estimates that 67 percent of their medical population has a primary or secondary behavioral health diagnosis, and this population is becoming an ever-increasing share of all patients. With the goal of reducing 30-day ED revisits by 25 percent for patients with a behavioral health diagnosis, HMC deployed a behavioral health social work and assessment team in its ED to enhance care coordination, introduce targeted interventions to address patients' complex social issues, and increase information sharing across care providers.

The CHART grant made it possible to augment the existing behavioral health team in the ED for a total of 14 FTEs, including an advanced practice nurse (APRN) to manage medications, a medical doctor with a buprenorphine waiver who would help manage the patient's medical condition, four community health workers who served as patient navigators, one medical assistant, and three ED nurses. Importantly, the team's APRN was a psychiatric prescriber, meaning that she could offer "bridge" appointments to patients who were unable to get a timely appointment for psychiatric care but needed medication refills and monitoring to ensure full compliance with their treatment plan.

### What is CHART?

The project described in this case study was supported by a Community Hospital Acceleration, Revitalization and Transformation (CHART) Investment from the Commonwealth of Massachusetts Health Policy Commission (HPC). The CHART program made innovative investments in the Commonwealth's community hospitals with the goal of establishing a foundation for sustainable care delivery. CHART funds enabled the hospitals to develop new care models designed to help patients avoid costly acute care settings like the emergency department by assessing local needs, modifying services, and expanding relationships with medical, social, and behavioral health community organizations.

The team developed a flagging system in the electronic health record that would flag patients who entered the ED if they had been seen at HMC before and had a behavioral health diagnosis. The flag would trigger a visit from a member of the social work and assessment team, who would do a brief evaluation of the patient to

[1]Nicks, B.A. and Manthey, D.M. The impact of psychiatric patient boarding in emergency departments. Emerg Med Int. 2012; 2012: 360308. [2]Agency for Healthcare Research and Quality. Chartbook on Care Coordination. Measures of Care Coordination: Preventable Emergency Department Visits. May 2015. Rockville, MD: Agency for Healthcare Research and Quality. http://www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/carecoordination/care-coord-measures2.html. Accessed April 1, 2019.

determine what their needs were. From there, the team would develop a comprehensive care plan that included both follow-up for the patient's immediate health care needs as well any support the patient needed to meet basic needs such as food or housing. The care team also engaged the patient in a conversation about what they needed to avoid the ED and then made a plan to ensure that the patient got what they needed. In some cases, it was as simple as a regular phone call to check-in and help solve problems; in other cases, the patient navigators would visit patients at home to help them cope with difficult times. Post-discharge phone calls were made to all participants to identify any barriers to receiving follow-up care and to reinforce any discussions that happened while the patient was in the ED.

At the same time as HMC was pilot-testing this new process, the hospital also opened up the new emergency department in June 2017, which has a separate, specially-designed behavioral health pod. The new pod has six beds where behavioral health patients can be triaged and treated by a specialized behavioral health care team. The redesigned space helps decompress the ED by giving behavioral health patients their own area and was created with input from behavioral health patients.

## Outcomes

Over the course of the two-year grant, HMC was able to reduce 30-day revisits to the ED among their target population by 46.3 percent.[4] HMC has decided to maintain elements of the program as part of their MassHealth ACO offerings.

## Lessons learned

- Create care plans to facilitate coordination of treatment and services
- Reduce barriers by limiting the need for paperwork, appointment scheduling and diagnoses; focus instead on building relationships and trust
- Address social determinants of health and provide direct-care services to cover gaps
- Develop relationships with area service providers and when possible, use patient navigators to do warm handoffs

[3]Analysis from the Health Policy Commission, 2017.




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