



**RPCC**

*Regional Primary Care Coalition*

# **Moving from Emergency Rooms to Medical Homes**

*A Survey of Emergency Department Utilization Programs in  
Montgomery County Maryland and the District of Columbia*

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## ***Abstract***

*The Metropolitan Washington region—which encompasses Northern Virginia, DC, Montgomery County, and Prince George’s County—is a region, like many others, where too many people rely on hospital emergency rooms to obtain their health services. Noting these trends, two of the region’s primary care associations have developed and implemented Emergency Department(ED)-Diversion Programs to reduce unnecessary use of emergency rooms and link people to appropriate medical homes.*

*The Primary Care Coalition (PCC) of Montgomery County, Maryland, and the District of Columbia Primary Care Association (DCPCA), have started projects to reduce reliance on emergency rooms for low income populations (who are often uninsured, especially in Maryland\*). The emergency room, as its name directly implies, is for emergencies—not for the treatment and management of chronic illnesses and especially not for any type of preventive care. Thus, not only are emergency room medical services expensive, but they do little to help improve health status and certainly don’t prevent health conditions from forming in the first place. The models PCC and DCPCA have used represent promising practices that might be helpful throughout the region and nationally. With the uncertainty of the economic environment, many new, previously employed people are finding themselves without health insurance for the first time and are turning to emergency rooms for their care, making these diversion programs increasingly important. These programs provide a vehicle for helping this new population become aware of the potential services available to them through the safety net system.*

[\*] DC has a high rate of insurance, even among low income populations. Department of Health Triple Aim presentation, September 1, 2009.

The state of the American health care system - in terms of cost, coverage, quality and access – is one of the most pervasive topics of discussion nationally. On the heels of an economic recession, the United States has had to critically reevaluate some of its largest expenditures and as such, the trillion dollar health care system has been a major focus as the country seeks to rebuild and strengthen the economy. Congressional Budget estimates on the costs of medical services in this country confirm that expenditures for services offered in the emergency departments of hospitals are among the most expensive places to receive care. But this is not new. In the early 90’s, President Bill Clinton called the emergency department “the most expensive place of all.”<sup>1</sup> The *Journal Medical Care* also noted the costliness of emergency room care years ago—estimating in 1996 that ER services in some places were up to three times more expensive than the same services delivered in the primary care setting<sup>2</sup>.

### **Innovative Programs**

Individual states are also looking at the rising costs of emergency room services and searching for innovative ways to cut down on avoidable use. Washington Post writer Peter Slevin’s July 2009 article *If Not the Emergency Room, Then What?* discusses a project being chartered by the Urban Health Initiative and University of Chicago. Eric Whitaker, the lead physician and public health specialist on by physician and public health specialist on the project, and other project coordinators emphasize that “many emergency room patients have ailments that could be treated

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<sup>1</sup>[Is the Emergency Room More Expensive than the Doctor’s Office?](http://www.slate.com/id/2221153/?obref=obinsite) Juliet Lapidos, June 23, 2009.

<sup>2</sup>[Is the Emergency Room More Expensive than the Doctor’s Office?](http://www.slate.com/id/2221153/?obref=obinsite) Juliet Lapidos, June 23, 2009 .

effectively in clinics or in smaller hospitals that are eager for business<sup>3</sup>". Thus, this Chicago based project seeks to "improve health and reduce reliance on emergency rooms by encouraging 'medical homes'---a clinic or doctor's office where patients can turn for routine needs and chronic conditions<sup>4</sup>". While rumors abound speculating that overutilization of emergency rooms has forced hospitals to begin "dumping" (diverting) some of their poorest patients from the ED to save money, project coordinators insist this is not the case. They have employed a "patient advocate" to bear major responsibility for the success of the initiative, with the primary job of "redirecting patients who do not need urgent care". The patient advocate is stationed in the emergency room and answers the emergency department's incoming calls, redirecting patients who do not need immediate attention to the appropriate resources. Semeca Johnson, one of the Initiative's patient advocates, reported redirecting 15 patients one day; some who were connected with local doctors, and other's given future appointments.

While this multi-stakeholder Initiative is arguably one of the most robust programs of its kind in the US, it is certainly not the only existing example of programs started by States wrestling with the problem and cost of emergency room misuse. In Houston Texas, for example, the "Save our ERs" Coalition was commissioned in 2001 to address the issue of inappropriate use of the emergency room by many uninsured and Medicaid non-emergent patients "to whom EDs [were] substitutes for more appropriate, yet frequently unavailable, community-based primary care."<sup>5</sup> The Texas Coalition concluded that without a full restructuring of health care services, including

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<sup>3</sup> *If Not the Emergency Room, Then What?* Washington Post. Peter Slevin. <http://www.washingtonpost.com/wp-dyn/content/article/2009/07/24/AR2009072403717.html>. July 25, 2009

<sup>4</sup> Description of project provided by Yale University Professor Harlan M. Krumholz. *If Not the Emergency Room, Then What?* Washington Post. Peter Slevin. <http://www.washingtonpost.com/wp-dyn/content/article/2009/07/24/AR2009072403717.html>. July 25, 2009

<sup>5</sup> "Envisioning the Delivery of Health Care Service to Uninsured Patients in Harris County". Executive Summary prepared by The Lewin Group, Inc for the Save Our ERs Coalition. 2002.

the redirection of inappropriate users outside of the ER, the already decaying emergency system would collapse. In Kentucky, the HealthPoint Family Care organization began a patient navigator pilot program in an attempt to move patients from “primary care in [the] ED to a medical/dental home”. Patients using the ED for non emergency situations more than four times a year were flagged and referred to primary care providers in an effort to reduce hospital overcrowding and improve patient health by funneling them into medical homes<sup>6</sup>.

### **Regional Efforts**

Similarly, in the Metropolitan DC region—a region encompassing Northern Virginia, the District of Columbia, and Montgomery and Prince George’s Counties in Maryland—two primary care associations have piloted projects to help address the underlying causes of inappropriate use of emergency rooms and move patients into medical homes. The Primary Care Coalition (PCC) of Montgomery County and the District of Columbia Primary Care Association (DCPCA) have started projects to reduce reliance on emergency rooms for low income, largely uninsured populations,<sup>7</sup> but for reasons that span far beyond high emergency room costs. The emergency room, as its name directly implies, is for emergencies—not for the treatment and management of chronic illnesses and especially not for any type of preventive care. Not only are emergency room medical services pricey, but they also do little to help improve health status and certainly don’t prevent health conditions from forming in the first place.

In the fall of 2009, the PCC convened a Health Reform Symposium—bringing together county and state stakeholders, national experts, clinic and hospital representatives, and representatives

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<sup>6</sup> “There’s no place like home: Moving from primary care in ED to a medical/dental home”. PowerPoint presentation delivered by Caroline Braden of HealthPoint Family Care. October 22, 2009.

<sup>7</sup> DC has a high rate of insurance, even among low income populations. Department of Health Triple Aim presentation, September 1, 2009.

from the Department of Health and Human Services, among others— and participants agreed that there needs to be a shift away from thinking of healthcare solely in dollars and cents and towards thinking of healthcare in terms of the value that it adds. Misuse of emergency departments, for one reason or another, adds no value to the health of the population and as such, needs to be aggressively targeted. PCC and DCPCA’s diversion projects are similar in their realization of the problem; focus on connecting non-emergent patients with primary care providers and medical homes; and use of partnerships outside of their coalitions to prosper the mission of their programs, but there are differences. A close examination of the diversion programs of these two primary care coalitions—one approaching its 3<sup>rd</sup> year in practice, and the other coming to a close—can help inform work to be started in other places around the Metropolitan DC region and can help others learn how to mitigate the high costs and negative health effects of emergency department overutilization.

### **Primary Care Coalition of Montgomery County: ED-MC Connect**

PCC is a member of the Institute for Health Improvement’s Triple Aim Initiative—a project being tested both nationally and internationally by health plans, public health departments, integrated delivery systems, safety net providers and other teams—which focuses on three components: improving population health, enhancing patient experience, and reducing/controlling per capita costs; collectively called the [Triple Aim](#). PCC’s Emergency Department-Montgomery Cares Connect project (ED-MC Connect<sup>8</sup>) was proposed as their Triple Aim focus project in 2007, with the initial goal of developing a coordinated referral

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<sup>8</sup> PCC’s Montgomery Cares program serves over 21,000 low income, uninsured adults in Montgomery through partnerships with numerous clinics and hospitals in the area. For additional information, visit [www.primarycarecoalition.org](http://www.primarycarecoalition.org)

system between PCC Community HealthLink clinics<sup>9</sup> and Emergency Departments in Montgomery County hospitals. In a September 2009 conversation with Maria Triantis, Director of PCC's Center for Health Improvement and ED-MC Connect Program Manager, Triantis retraced the intellectual framework she'd developed nearly two years prior. The aim of ED-MC Connect was to, in her words, "create a bidirectional health information exchange of an integrated and coordinated referral system."<sup>10</sup>

The preliminary project aim was supported by the findings of the Maryland Health Care Commission (MHCC) in their January 2007 report, *Use of Maryland Hospital Emergency Departments: An Update and Recommended Strategies to Address Crowding*.<sup>11</sup> Among other findings, MHCC reported an 18% increase in ED visits between 2000-2004 (compared to a nationwide increase of 9%) and of those visits, persons who reported having no health insurance accounted for the most visits. Over 30% of all ED visits in the County in 2005 were deemed non-emergent/emergent but primary care treatable ("avoidable"),<sup>12</sup> which was also an increase from earlier years. In addition to evidence from this report, PCC reviewed local quantitative data on ED utilization patterns provided by the Health Service Cost Review Commission (HSCRC). The datasets revealed that in FY2008, the approximately 100,000 low income, uninsured residents of Montgomery County<sup>13</sup> incurred over \$5.5million in avoidable ED charges. The cost was even more staggering for Medicaid recipients (some 60,000 Montgomery County residents), who in

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<sup>9</sup> [PCC Community HealthLink Clinics](#)

<sup>10</sup> Conversation between Maria Triantis and Brittany Stanley, September 30, 2009.

<sup>11</sup> Access the full report:

[http://mhcc.maryland.gov/hospital\\_services/acute/emergencyroom/ed\\_crowding\\_122006\\_report.pdf](http://mhcc.maryland.gov/hospital_services/acute/emergencyroom/ed_crowding_122006_report.pdf)

<sup>12</sup> The NYU Algorithm provides state and county level data on ED visits not resulting in admission to the hospital. The four major categories are non-emergent care, emergent PC treatable, emergent PC preventable, and Emergent not preventable. Non-emergent, emergent PC treatable and emergent PC preventable can be combined and collectively "avoidable" visits.

<sup>13</sup> Montgomery County epidemiologists have settled on this rough estimate for the number of low income (250%FPL), uninsured residents in the County based on 2005 Small Area Health Insurance Estimate (SAHIE) figures.

FY2008 incurred over \$12 million in “avoidable” ED charges. 2005-2007 HSCRC data show that ED utilization trends for avoidable visits in Montgomery County are consistent, which comes in stark contrast to the vast expansion of safety net clinics in the County. In fact, through the work of PCC and its Community HealthLink Clinics, there was a 100% expansion of safety net clinics for adults from 2005-2008. While in 2005 there were 6 clinics for low income uninsured Montgomery County residents (serving little over 8,000 patients), by 2008 there were over 16,000 patients being seen in 10 safety net clinics across the County. Evidently, access to care was not the driving force behind avoidable ED visits.

ED-MC Connect was not only concerned with redirecting hospital flows of patients with non-emergent needs. It also sought to “improve access to primary care for Montgomery Cares eligible patients with no medical home<sup>14</sup>”. For patients already established in Montgomery Cares (i.e., people who technically already had a medical home), PCC sought to reduce their unnecessary utilization of the emergency room by reemphasizing a relationship with the primary care provided through its partner clinics. In addition, PCC sought to improve health information exchange (HIE) between emergency departments and clinics to spur care continuity for discharged patients and to link ED inappropriate cases among MC patients to the proper clinics.

To achieve these goals, PCC initially targeted one Montgomery County hospital—Montgomery General—and one Community HealthLink Clinic<sup>15</sup>—Proyecto Salud—and linked them to the Montgomery Cares health care delivery system. In 2005 alone, Montgomery General had close to 3,000 non-emergent ED visits by uninsured patients. As part of the ED-MC connect

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<sup>14</sup> From PCC’s Triple Aim prototyping presentation.

<sup>15</sup> Information on the Montgomery County Community HealthLink Clinics, which work with the County’s Department of Health and Human Services to provide primary and specialty care, is available at <http://www.primarycarecoalition.org/?q=communityhealthlinkclinics>

demonstration pilot, PCC established the HIE tool necessary to provide patients with efficient, continued care outside of the emergency department<sup>16</sup>.

ED-MC grew into the ED-PC Connect Pilot when the Centers for Medicaid and Medicare Strategies (CMS) granted \$700,000 to PCC for an expanded 2 year project. This scale up of the ED-MC Connect demonstration pilot—this time called ED-PC connect (Emergency Department-Primary Care Connect)—set the following goals:

1. *Establish an ED-PC Connect Steering Committee comprised of 5 county hospitals, 6 Montgomery Cares clinics, and the Montgomery County Department of Health and Human Services (MCDHHS).*
2. *Create a link enabling the hospital's emergency department and the patient's medical home to exchange medical/health records and information electronically.*
3. *Establish an enrollment program for ED discharged patients into a medical home (be it Medicaid, Montgomery Cares, or some other safety net)*
4. *Collect and evaluate patient's experiences with health care to try and parse out the reasons why people improperly use the ED*
5. *Implement small tests of change<sup>17</sup> to help patients navigate the health care system<sup>18</sup>*

To begin the ED-PC Connect project, a patient stream was identified: low income (250% FPL), uninsured adults and children seen in the Emergency Department (PCC's target enterprise). The ED-PC Connect project aligns seamlessly with the Triple Aim framework—in fact PCC is an active participant in an ED Prototyping Community with other teams across the country trying to understand why people go to the emergency room for non emergencies and create programs to circumvent this flow of patients into the appropriate clinics and/or social services<sup>19, 20</sup>.”

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<sup>16</sup> Taken from “Reducing Avoidable ED Visits--Prototyping Community, June 2009 Meeting” by PCC.

<sup>17</sup> Model of improvement, Institute for Health Improvement

<sup>18</sup> These goals were taken from August 4, 2009 Team Update presentation by Maria Triantis to PCC's Triple Aim core group.

ED-PC Connect has experienced successes in three main areas: the establishment of a Steering Committee; implementation of integrated referral system from the emergency department into Montgomery Cares Clinics; and the establishment of an enrollment program for ED discharged patients into medical homes.<sup>21</sup> At present, the Steering Committee is comprised of representatives from the Community HealthLink Clinics, County Hospitals, the Department of Health and Human Services and the other partnering organizations that were involved in that mission as well. The referral system from partner emergency departments to Community HealthLink clinics was facilitated by the implementation of standard referral forms in the hospitals. Participating hospitals and clinics continue to meet to strengthen the referral processes between them.

A Care Coordination Unit (CCU) will provide a more robust screening process for discharged patients to ensure that they are placed into the appropriate medical home. As of December 2009, a patient navigator has been trained in referral policies and procedures at the Washington Adventist Hospital and six patients received clinic visits in the process.

Picking up on the importance of the patient's perspective in the project, ED-PC Connect also collects qualitative data on inappropriate ED use. Two focus groups of recruited ED-discharged

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<sup>19</sup> In a recent face to face conference in Chicago, the PCC ED Prototyping Team met with other North American Triple Aim teams to discuss progress to date and share some best practices. PCC's team has recently begun a project with patients discharged from the Montgomery General Hospital Emergency Department. Through patient interviews, the team has learned that many discharged patients elected to obtain medical services at the hospital because of "lack of other medical options" (*Reducing Avoidable ED Visits: Prototyping Community October 2009 Meeting*). To this stream of discharged patients, the team introduced an intervention of a patient navigator in August of 2009. The navigator contacts patients either in the emergency department (face to face interaction) or by phone and discusses with them the possibility of making an appointment with Proyecto Salud (a PCC Community HealthLink Clinic). The team learned that even with a patient's number and an available slot for an appointment in a medical home, that there were still barriers to setting up a patient-medical home relationship. However, preliminary results from the teams' work show an increase both in the percent of patients the navigator is able to contact using hospitals referrals and the percent of patients contacted by the navigator who actually make clinic visits.

<sup>21</sup> Montgomery County Community HealthLink Clinics.  
<http://www.primarycarecoalition.org/?q=communityhealthlinkclinics>

patients (one conducted in English and the other in Spanish) met in July 2009. Group members were asked about their experiences in the emergency department and many agreed that they went to the ED because: they had a problem that was in need of immediate care; they didn't have insurance or a medical home to go to; they were referred by a primary care clinic to go to the hospital where full diagnostic tests could be performed; they needed the flexibility of a 24-hour hospital due to their own schedules. The overwhelming consensus from the focus groups was that there is a need for “increased community awareness about the local safety net clinics<sup>22</sup>”, many of which have expanded hours, equipment to perform some diagnostics, and take low income, uninsured patients<sup>23</sup>.

### **DCPCA ED Diversion Project**

The District of Columbia's Primary Care Coalition devised its Emergency Department project on the heels of numerous assessments of the growing costs of ED use in DC, particularly *Access and Quality in D.C.: Shifting Trends*—a report concluding that 60% of DC Healthcare Alliance patients using the ED received non-emergent care that could and should have been provided by a primary care physician<sup>24</sup>. The report estimated that DC spends over \$100 million dollars on hospital admissions that are avoidable. DCPCA, like PCC, has an expansive network of community Health Center Members that it works with who operate safety net clinics around the District. Through the Medical Homes DC Capital Grants project started in May 2005,<sup>25</sup> there has been major expansion of clinic space and infrastructure funded and supported by the work of DCPCA.

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<sup>22</sup> Emergency Room Diversion Grants: Quarterly progress Report 2 of 8

<sup>23</sup> Emergency Room Diversion Grants: Quarterly progress Report 2 of 8

<sup>24</sup> Lurie, Blanchard, and Mandelberg: *Access and Quality in D.C.: Shifting Trends*. 2006 health Data Update, presented at the 2006 DC Primary Care Association Annual Meeting (October 19,2006).

<sup>25</sup> See [Medical Homes DC](#) section of the RPCC website for more information on this DCPCA project.

The DCPCA Emergency Room Diversion Pilot Program placed Community Health Workers<sup>26</sup> (CHWs) over several months in the Emergency Room of one hospital—Providence—“ ... in the hope of connecting patients with non-urgent care needs to medical homes and social services outside the hospital setting.<sup>27</sup>” The program sought to improve the health of DC residents by making a connection between patients and a continued source of primary care. Community Health Workers act as “liaisons between health/social services and community members [to] build individual and community capacity through outreach programs such as community education, informal counseling, social support, and advocacy<sup>28</sup>.” CHWs are rigorously recruited and trained by DCPCA staff in order to receive proper certification. CHWs’ responsibilities and functions span outside of this ED Diversion Program, but one of their principle duties involves connecting patients to a medical home<sup>29</sup>.

The program was also part of a larger effort to try and change the behaviors of DC residents so that they could be equipped with the tools they needed to be accountable for their own health, according to Eric Vicks, the Association’s Senior Community Relations Manager. Vicks explained that DCPCA’s commitment to educating people about their right to quality healthcare was furthered through this project because Community Health Workers are able to interface with people in need and point them in the direction of the appropriate resources.

As Vicks pointed out, many people who use the emergency room for non-emergent reasons do not feel comfortable in a primary care setting. They don’t feel they know how to talk to their

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<sup>26</sup> Community Health Workers are apart of a larger DCPCA program for Workforce Development. More information on the CHW program is available on the DCPCA website: <http://dc pca.org/index.php/Community-Health-Workers-8-2007.html>

<sup>27</sup> DCPCA ER Diversion Pilot Program. <http://dc pca.org/index.php/ER-Diversion-Pilot-Project-8-2007.html>

<sup>28</sup> CHW Workforce Development Program One-Pager (not just published to DCPCA website)

<sup>29</sup> For more information on Community Health Workers, and the Workforce grant DCPCA and other partners just received, visit the RPCC website at <http://regionalprimarycare.org/new-topics.aspx#three>

providers, or are unsure of how to navigate the system—the numbers to call, the services that they have rights to, how they can get services without insurance, etc. These doubts stand as large barriers to their participation in the safety net network, no matter how expansive it has become in DC.

Unlike the findings from the focus group conducted by PCC, DCPCA’s preliminary pilot attributed primary care provider appointment unavailability to over-utilization of the emergency department. In addition, ER users assumed that they would receive the best quality care in the hospital setting. From February 2008 to January 2010, DCPCA positioned Community Health Workers in Providence Hospital’s Emergency Room. From 9am-8pm, the CHWs worked with patients and served as navigators between them and the appropriate medical services. CHWs did not provide any type of medical evaluation or triaging services to patients, although this is a commonly held fear among opponents of ER Diversion programs. These opponents fear that CHWs will discourage or redirect patients with real emergencies from the emergency room. On the contrary, DCPCA’s CHWs saw patients after they’d received a physician’s evaluation and in no way made assessments on what care was necessary or who should provide it.

The CHWs collected information from patients about why they chose to use the Emergency Room over a primary care facility. They also offered to make a connection between the patient and a medical home (including booking appointments or finding new primary care providers if the patient already has one) and followed up after the patient leaves to ensure a successful linkage has been established with the primary care physician. CHWs also made recommendations about other resources available to the patients. For example, there is an “on-call nurse line” at Providence Hospital (and in many hospitals across the country) where nurses speak to patients that call in about the troubles they are experiencing and what steps they might

want to take before (or in lieu of) coming to the hospital. The CHWs positioned at Providence asked patients “did you call the on-call or ‘ask a nurse’ number provided by your MCO?” and they found that few non-emergent ED users had ever used these services. The CHWs also refer patients to appropriate social services upon assessment. DCPCA’s project formally ended in January 2010, but there are important learnings from it—including the difficulty of finding hospitals willing to participate in programs of this nature (and consequently have reduced revenue), and the misconceptions about care offered in primary care vs. hospital settings.

### **Lessons Learned**

Both PCC and DCPCA face a perplexing problem: expansion of access to safety net clinics alone doesn’t seem to reduce avoidable ED visits. Therefore, utilization of the emergency room for non-emergent issues is costly, an inefficient way of providing quality care, and can be prevented, but not solely through programs to expand access to safety net clinics. Instead, programs that try to link ED patients up with medical homes like the work at PCC and DCPCA seem to be promising efforts toward lowering avoidable ED visits. However, programs centered in Emergency Rooms are not sufficient. As Vicks predicted Diversion Program[s] will not be enough to encourage patients to go to safety net clinics for non-emergent needs. He suggests, and PCC’s ED Prototyping team agrees, that the community will be the place where intervention is most plausible. Vicks suggests that education needs to take place outside of the ED setting and well before someone has already visited the ED for a non-emergent need. Education could take many forms, perhaps written materials explaining appropriate use of the emergency department, or even a new marketing of hospitals that doesn’t make them seem like the best place to receive primary care.

For more information on each Coalition's diversion program, contact Maria Triantis ([maria\\_triantis@primarycarecoalition.org](mailto:maria_triantis@primarycarecoalition.org)) of PCC or Eric Vicks ([evicks@dcpcpa.org](mailto:evicks@dcpcpa.org)) of DCPCA.