

Reduction of Unnecessary Emergency Department Visits through targeted Patient Care Navigation for ED Overutilizers

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INTRODUCTION

Overutilizers of the emergency department (ED), defined as **anyone visiting the ED four or more times in twelve consecutive months**, consume a significant proportion of healthcare resources and make up approximately 21-28% of all ED visits in the United States. The significance of addressing the problem is both socioeconomic and financial. Healthcare dollar overspending, fragmented low-quality care, poor clinical outcomes for chronic disease, substance use disorders, and mental health conditions are all associated with unnecessary ED visits leading to ED Overutilization. Additionally, these factors are associated with a lack of resources available to the uninsured or those with public insurance.¹

Literature review indicates that a multidimensional approach to ED overutilization is most effective. Evidence-based interventions include standard work, early identification in the ED with an individualized care navigation program combining in-person hands-on approach with technology such as telehealth and an integrated electronic health record system.²

OBJECTIVES

GOAL

This DNP Quality Improvement project created and implemented an ED-initiated patient navigator program, the Advanced ED Care Management Program at the Atrium Health Cabarrus' three emergency care centers in the greater Charlotte metropolitan area.

AIMS

1. Developed a method of identifying ED overutilizers and connecting them with a patient navigation team to reduce ED overutilization.
2. Implemented and evaluated the patient navigation program.
3. Made recommendations for sustainability and scaling of the program within the healthcare system and beyond.

METHODS

Led by the Assistant Vice President of Emergency Services, the multidisciplinary Advanced ED Care Management team and ED Patient Nurse Navigator, a newly created role, developed a standardized post-discharge care plan to provide advanced care for ED patients identified as ED overutilizers.

Aim 1

Preliminary/Baseline Data: Adult ED overutilizers from October 1, 2022, thru January 31, 2023, were identified from the electronic medical record.

Inclusionary criteria: patients with **more than four ED visits in a rolling calendar year** that have public insurance or are uninsured

Exclusionary criteria: patients with a behavioral health condition as a primary factor for ED utilization, primarily housed in assisted living or skilled nursing facility, privately insured through a commercial insurer, or under 18.

The **ED Care Management Program Taskforce** consisting of key stakeholders *was engaged*.

Aim 2

ED Patient Navigator: role was developed: navigator was hired.

Participants: Using the baseline data, 30 identified overutilizers were enrolled in the first 30 days and were followed for the duration of the pilot. The Program included:

Application of the **AHRQ Re-engineered Discharge (Red) Toolkit** assessment to address patient needs, access barriers, and health-related social needs.

Care Plan and Intervention with in-network care resources and evidence-based primary interventions.

Virtual navigation follow-ups 7 days, 30 days

Cost, access, and utilization metrics, collected from Epic.

Program Evaluation consisted of 4, 5-point Likert scale questions, measuring key stakeholder perceived program effectiveness.

Results were evaluated using descriptive and bivariate statistics.

Aim 3

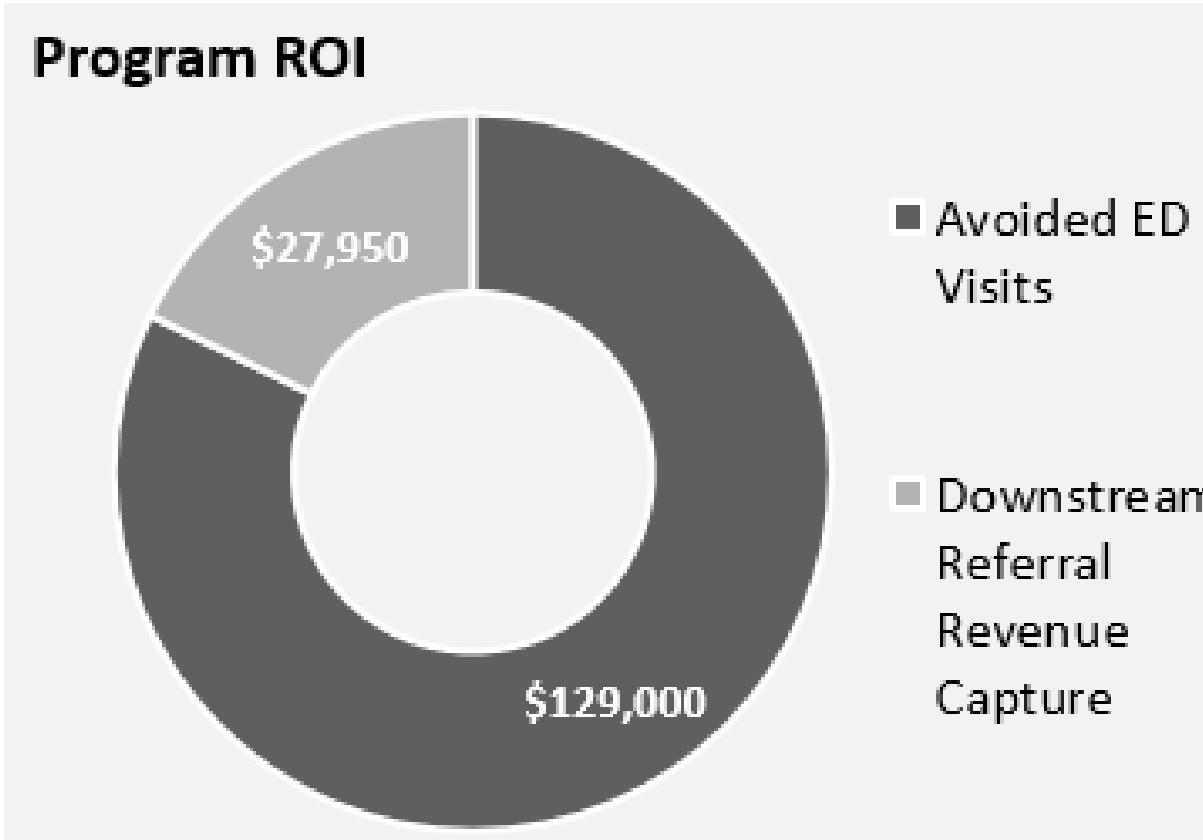
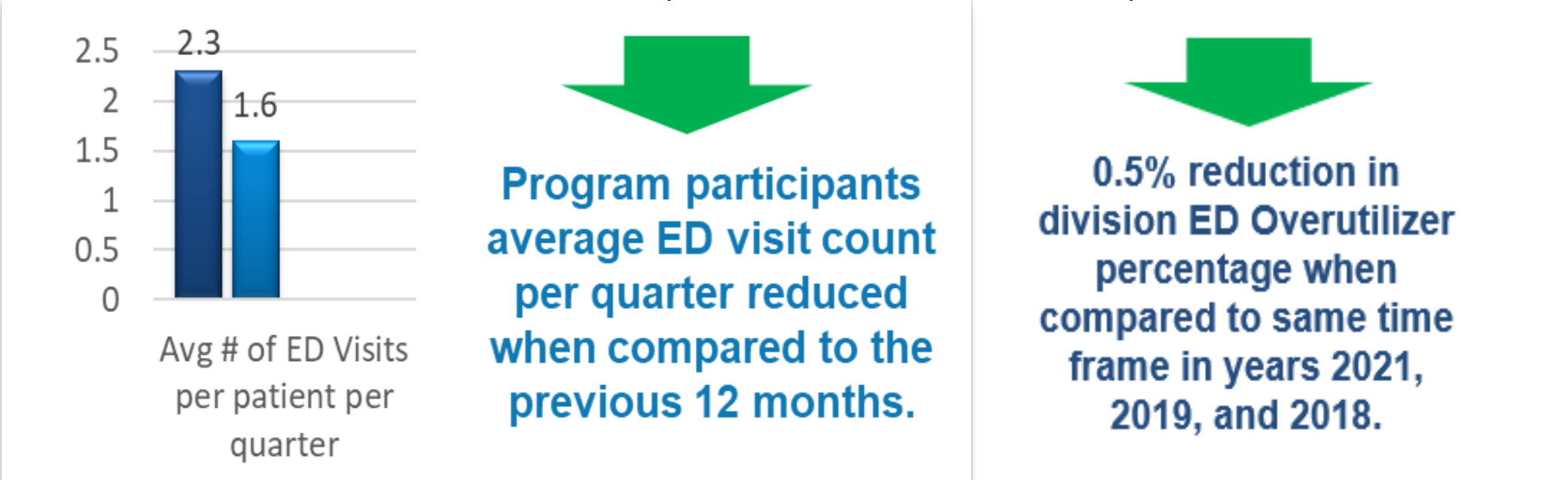
Findings will be presented to Executive Leadership in April 2023.

Recommend scaling the AECM Program throughout the healthcare enterprise, using a train the trainer education approach for navigators. As excess capacity is achieved, consider advanced care programming for specific populations, such as mental health conditions.

RESULTS

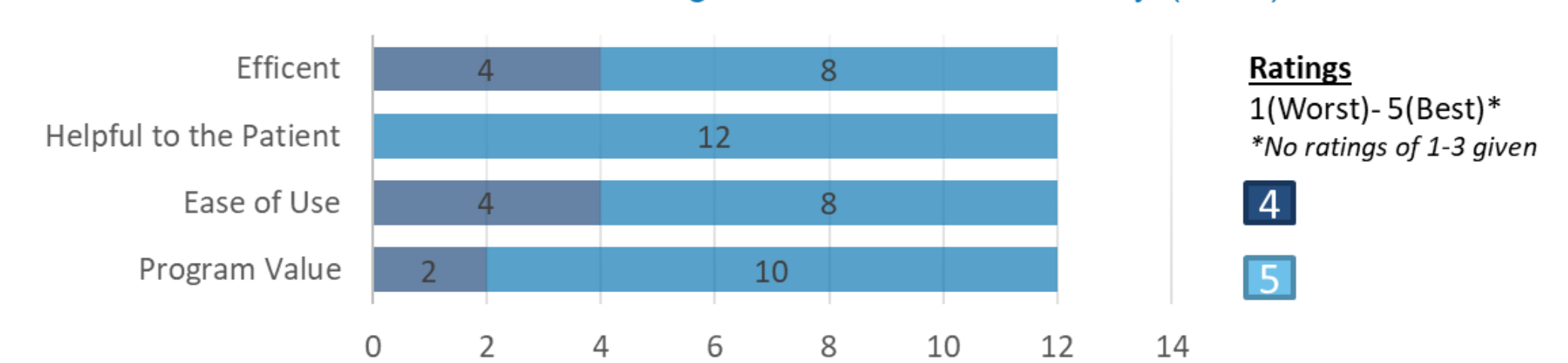
A chi-square test of independence was performed to examine a link between the program and the reduction of ED Overutilizer visits. *There is a significant relationship between the two variables: $X^2(1, N = 26) = 10.73, p = .03$

*Results should be interpreted with caution due to sample size.



43 Successful Referral Appointments made to System PCP or Specialists Office

Stakeholder Post Pilot Perceived Program Effectiveness Survey (n=12)



REFERENCES

1. Jacqueline LaPointe. (2019). *Avoidable Hospital ED Visits Cost Healthcare System \$32B Annually*. <https://revcycleintelligence.com/news/avoidable-hospital-ed-visits-cost-healthcare-system-32b-annually>.
2. Seaberg, D., Elseroad, S., Dumas, M., Mendiratta, S., Whittle, J., Hyatte, C., & Keys, J. (2017). Patient Navigation for Patients Frequently Visiting the Emergency Department: A Randomized, Controlled Trial. *Academic Emergency Medicine*, 24(11), 1327-1333. <https://10.1111/acem.13280>