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Take advantage of opportunities to reduce ED violence, recidivism among children and young adults

On-site community outreach workers can link victims of violence with needed resources

In the wake of the horrific massacre of young children by a disturbed gunman at Sandy Hook Elementary School in Newtown, CT, there has been a national discussion about what the country can do to curb such senseless acts of violence. While much of the focus has been on firearms legislation, there is also a renewed interest in steps that communities can take to prevent single instances of violence from becoming repetitive cycles

EXECUTIVE SUMMARY

There is evidence that ED-based interventions can make a difference in short-circuiting the cycle of violence that often impacts children and young adults. Since the Violence Intervention Advocacy Program was launched at Boston Medical Center in 2006, recidivism to the ED among gunshot victims is down by 30% and recidivism among stabbing victims is down by about one-half. At Denver Health Medical Center, the At Risk Intervention and Monitoring (AIM) project just launched in June, but thus far, none of the patients being followed in the program have reappeared in the ED with a violent injury.

- The U.S. Centers for Disease Control and Prevention reports that 700,000 people between the ages of 10 and 24 were treated in EDs for injuries caused by violence in 2009.
- To effectively intervene with victims of violence, experts recommend that EDs partner with community groups that have deep ties to the neighborhoods most impacted by violence.
- To avoid re-traumatizing victims of violence, health care personnel need to be trained in how to provide "trauma-informed care," a method of speaking to patients so that they feel empowered and safe.
- With young victims of violence, the biggest issues requiring attention are mental health, safety, and housing.

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in which physical and psychological damage is spread from victim to family to community in an ever-widening circle.

When violence is viewed in this way, it becomes clear that EDs are uniquely positioned to intervene in a way that can have lasting impact — not just on the victims of violence, who are often teenagers and young adults, but on the larger society as well.

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Statistics from the U.S. Centers for Disease Control and Prevention reveal the scope of the problem, as well the potential opportunity that EDs have to intervene: Roughly 700,000 people between the ages of 10 and 24 were treated in EDs for injuries caused by violence in 2009.

While meaningful intervention requires training, resources, and commitment, evidence is growing that ED-based efforts can produce measurable results in terms of violence reduction and reduced health care utilization.

Consider the experience of Boston Medical Center (BMC), which partnered with community activists to create the Violence Intervention Advocacy Program (VIAP) in 2006. "In our hospital, we see 72% of the penetrating trauma in Boston — the stabbings and shootings," explains **Thea James**, MD, an emergency physician at BMC and the director of VIAP. "There had been a resurgence of this violence in Boston, so the mayor came to our hospital and asked us to do something about it, and the city supported us with a grant."

The idea behind VIAP was to equip victims of violence with the services and support they need so that they could return to their communities and avoid repeat instances of violence. It was a tall order, but James observes that between 2007 and 2012, the program has reduced recidivism among gunshot wound victims by 30%, and recidivism among stabbing victims is down about half. In fact, the program has been so successful that the governor has asked BMC to disseminate the model to other hospitals in Massachusetts that see high numbers of shooting and stabbing victims, explains James.

Provide "trauma-informed care"

When the program began, it just consisted of James and two patient advocates that she hired from the community. However, the VIAP program has since evolved and expanded to include a program manager, who is a licensed clinical social worker, a family support coordinator, a data research manager, and two patient advocates, or, as some people call them, "interventionists," says James. "We also have another group of people we work with: the community response team. They provide mental health services for our clients."

The way the program works is whenever a victim of violence presents to the ED, the VIAP team is alerted to intervene. "Not every kid that we see is involved in negative behavior. Some people have

just been caught in the crossfire, but it is an opportunity to intervene no matter what background they have," explains James. "The first thing we do is develop a rapport with them and try to assess them for safety. We create a needs assessment for them in terms of what they are going to need throughout their [ED stay] or hospitalization and once they are discharged."

The VIAP team also immediately calls on the community response team to provide mental health services at the bedside. "We found out very early, during the first year of the program, that when one of these kids is injured, it not only affects them but everybody in proximity to them, so we also offer the mental health services to their siblings and their parents as well," says James, explaining that these services will continue after discharge as well.

Key to the VIAP approach is a specific method of talking with people that James refers to as "trauma-informed care." "You want to create an environment of safety and empowerment for the patients, and more than anything else, you want to avoid re-traumatizing them," she says.

This is important, says James, because people inadvertently re-traumatize victims of violence all the time, she says. "A lot of people think if you get stabbed or shot you must be a bad person, and sometimes they don't understand the manifestations of trauma."

For example, James says that when a nurse or physical therapist finds that a patient is apparently unwilling to do what is asked, and is instead lying on a bed with a sheet over his or her head, they may decide that the patient lacks respect or doesn't care about him- or herself or anyone else. However, this type of behavior can actually be a manifestation of trauma. "Oftentimes, when we have been up to intervene with this type of patient, when we look under the sheet, the kid is in a fetal position with tears streaming down his face," she says. "When kids are growing up in unsafe environments, one of the things they do to adjust to the environment is they become hyper-vigilant, and they sometimes become self-destructive."

The patient advocates have been specifically hired from these same communities so that they will have an understanding of what many of these patients are up against, says James. "We felt if we were going to provide services for these clients, the patient advocates needed to be able to understand and relate to them," she says.

Collaborate with community groups

Many victims of violence have deficits that are obvious. They may not be able to move an arm because they have been maimed in some way, or they may have visible scars, says James. "When they are young, say 14 or 15, they may not want to go to school anymore, so we have to address all those types of problems," she says.

James explains that the biggest issues are mental health, safety, and housing. "Many times, the parents don't want to live where they are living anymore, so we have to arrange for emergency housing," she says, noting that many also require education, life skills training, and job training. "We have developed connections with a lot of community-based organizations that provide various different types of services," she says. "We have one place that does weight-lifting, but it does a lot more than that. It also helps clients with life skills training, finding jobs, and teaching them how to do resumes."

Many of the people involved with these community organizations already know the patients who have presented to the ED with violence-related injuries because they have already been working in the higher-risk neighborhoods trying to prevent problems from erupting. "When someone gets injured and comes in, they can often provide us with more information about the person than we already know," says James. "It helps our advocates to be able to work with the patients and provide appropriate services. And because our advocates already live in these neighborhoods, they often know the patients, too."

Document the work performed

While VIAP is now firmly ingrained in the hospital, with funding support from several different sources, including the Boston Public Health Commission, the State Department of Health, the Boston Foundation, and the Robert Wood Johnson Foundation, staff education about trauma-informed care requires constant reinforcement. "People have no idea about how patients wind up in these [violent] predicaments, and they certainly don't know what causes the reactions that people have after they get in here," says James.

To make sure that providers and staff stay informed, James gives numerous presentations about trauma-informed care, but she would like to develop an educational program around the topic that she could take from unit to unit, and that

could be required of all new hospital employees. "It is important to disseminate this information," she says.

She also has advice to offer ED managers and providers who are interested in developing a VIAP-like program of their own. First, James has learned that it is important to adequately prepare hospital staff before moving forward with any changes. She did not do that when VIAP was first introduced, so it was a hard lesson.

"Our psych nurses in the ED are normally the people who serve as liaisons between the physicians and the family … and when our patient advocates came in and started doing some of that, a few people thought their jobs were being replaced," recalls James. "I didn't let them know that the patient advocates were coming and what their role was going to be. The roles are completely different, but I didn't prepare them."

There was also a negative reaction from some hospital staff members who thought the patient advocates were acting too much like social workers without a degree because the staff members didn't understand the peer-mentoring approach, explains James. "All of that stuff has long since been ironed out, but I could have easily oriented them about the program and avoided some of the issues that came up in the beginning," she says.

If you will be utilizing patient advocates from the community, James emphasizes that it is equally important to prepare them for the hospital environment, and to get them immediately accustomed to documenting their work. "From the very first client, have a data collection system in place to document everything," she says. Assembling a program database is very difficult when you get a late start, adds James.

Intervening in a meaningful way with the victims of violence is very hard work, acknowledges James. But she stresses that emergency settings are the ideal place to make a connection with these individuals. "The ED is the first point of contact," she says. "Every program is different, but we try to have a 100% capture rate. Very few people slip through here without coming into contact with us, so our level of accountability for our advocates is pretty steep. We are very serious that no one should come through here and not interface with us."

Establish whether there are risk factors

Denver Health Medical Center has also taken steps to intervene with young victims of violence who present to the ED through its At Risk Intervention and Monitoring (AIM) project, launched in June of 2012. As with BMC's program, AIM relies on a team of community outreach workers from Denver's Gang Rescue and Support Project to establish a rapport with patients who have been victimized by violence, link them with needed social services, and guide them toward less risky lifestyles and behaviors.

While the program is just getting started, there is already some evidence that the approach is having an impact on patients, explains **Sara Muramoto**, the program manager of AIM. "I did a brief measurement of the kids we are actively case managing … and none of them have come back to the hospital," she says, noting that recidivism in the ED is the primary metric she focuses on. "If they are coming in for a violent injury, they are going to be coming through the ED."

Currently, the outreach workers are only on-site in the ED between 11 p.m. on Saturday to 5 a.m. Sunday morning — the period when the ED receives the highest volume of violent injuries among the young people AIM targets, between the ages of 10 and 24. "We go room to room and talk to people. Even when someone does not appear to be at risk, we still go in and talk to them as long as they are in the target age range because one thing that a lot of people are unaware of in the city is victim assistance," explains Muramoto. "So even if it is a one-time visit, we will ask them how they are doing and find out what their needs are."

Once an AIM representative begins conversing with a patient, he or she can establish whether there is any gang involvement or other risk factors, says Muramoto. "What social factors brought them there that night? Are they in school? Do they feel safe going home? You try to address all of those things," she says. "But when we are not in the ED, it is up to the staff to call us."

Muramoto says she has had everyone from doctors and nurses to clerks and social workers call her about patients who have presented to the ED. "The entire hospital has my personal cell phone so they can reach me at any time," she says.

Don't expect quick results

The initial bedside interaction between an AIM outreach worker and a patient in the ED gets the process started, and there is always at least a follow-up call to the patient after discharge.

"Patients who are more at risk than others will definitely receive in-person contact, and those patients who are at very high risk will receive ongoing case management," explains Muramoto. "When patients are discharged from the ED, we always make sure that we get a phone number for them and usually an address as well because many times these patients are not very good at calling back."

While most patients indicate that they want help, many of them struggle to make changes in their lives, says Muramoto. "What is lacking for most of these people is a stable home," she says. "They don't have anyone who really cares for them, so once they start seeing that our outreach workers are going to be there consistently for them, we start to see a difference in their behaviors."

This kind of follow-up is labor-intensive and difficult, but even modest reductions in recidivism to the ED can result in huge cost savings to the hospital, although it takes time to reap the full benefits of violence prevention, says Muramoto. With the AIM program just reaching the one year mark, it is still too early to gauge any meaningful impact on recidivism or cost savings.

However, emergency providers are happy to have added resources when dealing with these often difficult cases. "These types of patients typically come in with their defenses up. They cuss at the staff, they're upset, and they're scared," says Muramoto, noting that it is difficult to show respect for someone who is yelling at you, especially when you are worried about your own personal safety. With their established ties to the community, the outreach workers can help to de-escalate these types of situations, she says.

Take advantage of training resources

One goal of the AIM program is to make sure that physicians and nurses pick up on signs that a patient may be at risk. "When you are in an inner city, safety-net hospital, almost all of the kids that come in fit the description to some extent, but I don't think our health care staff necessarily realize that all the time," observes Muramoto. "I would say about a third of the clients that I have been called in on were not in the ED for a violent injury. But when the physicians started talking with them, they realized there was something preventing these patients from living a normal life or taking care of themselves medically."

Muramoto provides ongoing training sessions to the medical staff about gang activity in the Denver area, and how to pick up on signs that there may be something beside a medical complaint that brought a patient to the ED. Nurses can earn continuing education credits for attending the sessions, and Muramoto is working on enabling physicians to earn continuing medical educational credits as well.

The community outreach workers also require training. They're not social workers, although many of them have received schooling in human services-related fields, says Muramoto. Before working one-on-one with patients, these workers typically follow a senior case manager in the hospital. Then they begin working in the community. As time goes on, the workers will have multiple opportunities to take advantage of training sessions on a multitude of topics, ranging from cultural competency and substance use to motivational interviewing and crisis intervention.

With the vast resources available through the hospital and the community, Muramoto says it is easy to arrange these training sessions. "We can get a psychiatrist to talk to us about mental health disorders, and we can get a SANE [sexual assault nurse examiner] nurse to talk about sexual assault or sexual abuse," she says. There is an ongoing learning curve of new breakout sessions dealing with such topics as how to treat post-traumatic stress syndrome and how to connect young victims of violence with mental health services. "That is usually the biggest obstacle," adds Muramoto.

The National Network of Hospital-based Violence Intervention Programs, which was formed by BMC and a handful of other programs in 2009, is a continuing source of new practices and ideas for training. "I do monthly calls with the group to discuss updates and find out about new ways that programs are running training sessions," says Muramoto. ***(See source box for contact information, p. 54.)***

Hospitals and EDs that are interested in establishing a violence prevention program should consider partnering with a community organization that already has deep ties to the neighborhoods most impacted by violence, advises Muramoto. "I wouldn't have known where to start on my own, but working with the [Gang Rescue and Support Project], I have been able to see what they do," she says.

There is no question that it is problematic to just have the community outreach workers in the

ED one night per week. "We have seen about 180 kids so far, and I have made the first contact on about 160 of them," acknowledges Muramoto. But she is working with the hospital to expand the program so that an outreach worker can be on site in the ED every evening. ■

SOURCES

• The National Network of Hospital-based Violence Intervention Programs, Philadelphia, PA. Website: www.nnhvip.org.
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Use split-flow approach to speed patients to needed care, eliminate inefficiencies and duplication

To customize split-flow model, involve front-line stakeholders from the start

For the past few years, the ED at St. Mary Medical Center in Langhorne, PA, has seen double-digit increases in patient volume. The surging demand has been difficult, to say the least. And by early 2012, administrators realized it was time for a change in course.

"What we needed to figure out was how we were going to see 70,000 patients a year in an ED that was built to see 52,000," explains **Charles Kunkle**, MSN, CEN, CCRN, BC-NA, the director of emergency, pediatric, and trauma services at St. Mary. "Truly, we were 18,000 patients above capacity, so we were really challenged."

After reviewing several different throughput models, the administrative team found what they were looking for in the split-flow approach, an evidence-based practice that relies heavily on queuing theory or line management principles to minimize wait times and expedite patients toward the type of care they need.

"It's not really about fixing the logistics of your institution. It's more about looking at the processes and how you can reduce wait times at each stage as the patients move along," says Kunkle. "How you implement split flow is specific to who you are and what challenges you face."

In the case of St. Mary's ED, the biggest challenge was limited space, coupled with surging demand. The percentage of patients being seen by a licensed practitioner within 15 minutes was hovering in the 60%-70% range, and this was impacting patient satisfaction.

"We did our research, went and visited some places [that had implemented the split-flow model], and then sat down with our operations improvement team and considered what we needed to do to make the model work for us," recalls Kunkle. "Then we created our own version of split flow, and that was the whole idea."

The results are impressive. In less than a year, the new model has enabled ED personnel to reduce door-to-physician times from an average of 47 minutes to 23.5 minutes, and overall length-of-stay in the ED for discharged patients has been slashed by 21 minutes. "Now, 99% of the time, people

EXECUTIVE SUMMARY

To address time and space challenges in the midst of surging demand, the ED at St. Mary Medical Center in Langhorne, PA, turned to the split-flow model, an evidence-based practice that relies heavily on the queuing theory to improve patient throughput. In less than one year, the approach has enabled administrators to reduce door-to-physician times from an average of 47 minutes to 23.5 minutes, and overall length-of-stay in the ED for discharged patients has been slashed by 21 minutes.
• Under the split-flow system implemented at St. Mary, an expedited triage/assessment process directs patients to prompt care, pediatric care, acute care, or an expedited treatment area (ETA) where patients will undergo further testing or procedures. This initial assessment typically takes about three minutes.
• Patients sent to the ETA remain there for no longer than 30 minutes. They may then be moved to a holding area while awaiting test results.
• Patients are constantly moving in the split-flow model, so it is important to pay close attention to handoffs. Patients will begin the process with one nurse and finish with another.

who walk in the door are seen by a nurse within 15 minutes," says Kunkle. And there is good reason to expect continued improvement in the coming months.

Get back to basics

By the time St. Mary began implementing the new model in April of 2012, there were already plans in the works for a major $22 million expansion of the ED — a development that would clearly alleviate St. Mary's space problems, but the ED's administrative team moved ahead with the new model anyway, hoping to become adept at a vastly changed workflow before moving into expanded quarters. "We were able to develop the new ED based on the feedback and experiences we had with the split-flow model we put in place," says Kunkle.

Under the new approach, the traditional triage process that used to take about 15 minutes was reduced to just a handful of questions that could be completed in three minutes. Kunkle acknowledges that the nursing staff at first balked at the notion that they could determine what kind of care patients needed without taking all their vital signs and going through the traditional routine, but he says it was a matter getting back to the basics.

Kunkle points out that you can tell a lot from a patient's radial pulse and skin temperature, and if you are talking to people, you can see how they are breathing and observe their skin color. "We really had to get those triage nurses back to the art of nursing," he says.

A more challenging aspect of this initial step was getting the nurses to carry out a mini registration process. "We did some specific training [on this aspect], and made sure we keyed in on the importance of identifying the patient appropriately," explains **Beverly Vanselous**, RN, CEN, a clinical lead in the ED at St. Mary.

It took some time for the nurses to become comfortable with carrying out the basic elements of registration , but the approach is working smoothly now. "Initially, I wasn't thinking real positively about having the nurses involved in registration, but the way it is laid out in our computer system, it really seems to work quite well, and we have had fewer issues that I thought we would," adds Vanselous.

During the initial assessment, the nurse determines whether a patient should be sent to prompt care, pediatric care, acute care, or an expedited treatment area (ETA). The prompt care area is for minor injuries or conditions; patients with conditions or illnesses that are severe enough that they are likely to be admitted will go to the acute care area; and patients who require additional blood work, imaging, or other tests will proceed to the ETA. These patients tend to be those classified under the Emergency Service Index as level 3, says Kunkle.

"The level 3 patients are the ones that really take the longest because they don't fit into any of those other categories," he says. "They could be sick or not, and they are often the patients who fall by the wayside."

Under St. Mary's split-flow model, patients spend no more than 30 minutes in the ETA. Kunkle likens the way this part of the ED operates to the way a pit crew works in a NASCAR road race. "When a patient is put in a room, he will have a nurse, a physician, a tech, and sometimes a physician assistant who will all come into that room at once," he says. "The physician asks the questions, and the nurses and the techs are listening so they don't have to repeat the same questions."

Scrutinize handoffs

One goal of the split-flow approach is to improve efficiency by enabling more tasks to be done at the same time, rather than in a linear manner, says Kunkle. What happens is the physician assesses the patient and orders whatever testing or procedures need to be completed, and then he or she moves on to the next patient, where the same process is repeated, he explains.

"The ETA is an area that is more labor-resource intensive because we only have 30 minutes from the time a patient arrives to get them assessed, get the initial set of vital signs recorded, and get tests and procedures ordered," says Kunkle. Then the patients are moved out of the ETA to make room for incoming patients, he says.

One thing for ED managers to keep in mind if they are considering the split-flow model: You will be moving patients a lot, says Kunkle. And he acknowledges that this aspect of the model did raise some concerns among administrators initially. "In traditional EDs, you find a seat and you stay there. You own it," he says. "We thought this would be a major issue for us, and that the patients would be upset."

With patient satisfaction gradually rising, such

concerns have eased. "In the old days, patients would sit and wait for us to see them and nothing would be happening," says Kunkle. "Now, because we are turning people over quickly [in the ETA] and moving them out, the patients may still be waiting, but they are waiting for their tests to come back, as opposed to waiting there idly with nothing being done."

However, the continued movement of patients from one area to another requires more handoffs than is typically the case. "One nurse isn't staying with a patient from the start to finish anymore, so you have to be careful because you don't have as much continuity," says Vanselous. "Communication is of the utmost importance because the patient is going to start with one nurse and finish with another, and any time you are doing a handoff, there is a chance for a communication breakdown, so we really work on that very hard to make sure information is shared from one nurse to another."

While handoffs require extra care, the approach enables charge nurses to spend more time on clinical intervention. "Before we implemented the new model, most of our time was taken up watching the waiting room and determining where patients would be placed," says Vanselous.

Now a pilot nurse takes charge of driving the flow of patients. "It frees us up a little bit to support the nursing staff at the bedside," says Vanselous. Further, split flow enables the ED to truly triage patients, she says.

"Before, it was more like we were doing data collection, and wherever there was a bed, we would put a patient," she says. "Now, the sickest patients will go over to the emergent side, and other patients we send through our expedited treatment area, and it is a little bit like a staging area."

With a variety of different pathways, the wait time to be seen is shorter. "It breaks that traffic jam," says Vanselous. "We are not just placing patients in a bed. We can get them seen and move them out to a holding area or waiting area, and it just gives us more flexibility."

Prepare for higher volume

Implementing the split-flow approach in a space-challenged ED hasn't been easy, but staff now have access to more room, as construction has been completed on the first phase of the new ED, which includes an 18-bed emergent area for the sickest patients. Phase two, which will encompass a brand new ETA and some additional waiting space, will also soon be opened. Phase three and phase four should be completed by September.

The new ED is being built to accommodate the split-flow model, so administrators are eager to have access to the new layout, but Kunkle emphasizes that it won't resolve all of the stress on the ED. There are still backlogs of patients being held in the ED while awaiting admission, so that will be the next issue to address on a hospital-wide basis, he says.

Kunkle's advice to other EDs that are struggling with the same issues is to involve as many stakeholders in the improvement process as possible. "We had everybody involved [in the operations improvement]," he explains. "We broke the process down into steps and figured out how we could make it better according to the principles of split flow."

Frontline staff representatives from nursing, pharmacy, radiology, and all of the other departments that work with the ED had a hand in structuring the process in a way they thought would work best. "The immediate engagement of staff helped to alleviate their anxiety because, oftentimes, when you come at people with major change that feels like it is being pushed from the top, it won't work," says Kunkle. "I was not a big believer in the operations improvement process, but I think it was invaluable time spent. Pulling each and every stakeholder into the room and getting their feedback, and then using their feedback, really did help us to implement this plan." ■

SOURCES

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For success with frequent ED utilizers, take steps to understand patient needs, connect them with appropriate resources

Robust effort requires time, effort, and a willingness to reach out to patients, providers

No one wants to see the ED used inappropriately, but it can be particularly frustrating when patients keep coming back with problems that never seem to get resolved. The reasons for such utilization patterns can vary, but what most repeat ED utilizers lack is any kind of consistency in their care, explains **Sandi McIntosh**, RN, the director of Emergency Services at St. Luke's Hospital in Cedar Rapids, IA. The hospital is a level 3 trauma facility that sees about 156 patients per day in the ED.

"If a patient comes into the ED five times, the likelihood that he or she will see the same provider each time is pretty slim," she explains. And the situation can become particularly complicated when the primary care provider (PCP) and any specialists the patient may be seeing are not in the loop when the patient presents to the ED.

Recognizing a clear opportunity to improve care for these patients while also reducing repetitive trips to the ED, in 2011 St. Luke's took advantage of a $50,000 grant that it received from Transamerica to develop its Consistent Care Program, an approach that routinely identifies frequent ED utilizers and attempts to connect them with the kind of care and resources they really need.

In just one year of operation, the program has reduced the number of ED visits among frequent utilizers by one-third and generated close to $1 million in savings for the hospital. As a result, the Consistent Care Program has now been made permanent at St. Luke's, and the Iowa Health System is thinking about expanding the approach to its other hospital facilities.

Establish care plans for frequent utilizers

Patients aged 18 and older are flagged for the program when they have visited the ED 12 times in 12 months. The names will come to light automatically through a computer-generated report that is created once a month, explains **Sallie Selfridge**, LBSW, the case manager for the Consistent Care Program. A committee, which includes Selfridge, as well as ED physicians and nurses, will then contact the identified patients and begin to develop care plans that take into consideration the reasons for previous ED visits, treatment received during these visits, and any information the committee is able to gather from other providers who have been involved with their care.

From this point forward, whenever one of these patients presents to the ED for care, the hospital's electronic medical record (EMR) system will immediately indicate that the patient is a participant in the Consistent Care Program, and there will be a link to the care plan that has been created for the individual. "On the tracking board in the ED, we have built a column that is just for this program, so when a patient comes in, there is a little suitcase [icon] that identifies him or her as being a participant in the program," says Selfridge.

If Selfridge is in the hospital when a program participant presents to the ED, she will go down to the department and meet with the patient. "This always involves interaction with the ED staff about what the visit is for, and then too, I

EXECUTIVE SUMMARY

Through its newly created Consistent Care Program, St. Luke's Hospital in Cedar Rapids, IA, has been able to significantly reduce ED utilization among patients who have been identified as having used the ED at least 12 times in the past year. Patients who meet program criteria are automatically identified once per month. A committee of social workers, nurses, and providers then creates care plans for these individuals, so that when they present to the ED, emergency providers will have a consistent road map to follow.

- In one year, the program has reduced the number ED visits among frequent utilizers by one-third, saving the hospital close to $1 million.
- Of the original 103 patients who were first identified for the program in January of 2012, only 10 patients still meet the criteria of visiting the ED 12 times in 12 months.
- Administrators say that key elements of the program are a case manager who can interact with the patients and their providers, a mechanism for flagging these patients when they present to the ED, and engaged providers.

will inform them about what I have learned from working with the patient," explains Selfridge. "If it is someone I have been working with for a while, chances are that I have had contact with their primary care physician, and if they have been working with any supporting community agencies, then I have had contact with them as well."

Interact with patients, providers

Many of the patients who participate in the program have complicated needs, and it can take considerable time and effort to get them stabilized. For example, Selfridge recalls the case of one woman who had uncontrolled migraine headache pain. "When I first started working with her, she had had about 14 ED visits in one month," she explains.

Selfridge first contacted the patient's PCP, who indicated that the woman should not receive narcotics for her migraine pain when she presents to the ED because they cause more severe rebound headaches. Selfridge then arranged for the woman to see a pain specialist.

"Once she got established with that physician, we worked with the pain specialist and her PCP to develop a care plan for when she comes into the ED during off hours," says Selfridge, noting that the patient was able to go to the hospital's outpatient infusion center for treatment during the day, but if she needed to be seen in the late evening or during the weekends, the ED needed a consistent plan for how to treat her.

"The patient was aware of the care plan, and it worked out great because everyone was on the same page," says Selfridge. The patient's ED visits gradually decreased throughout this process as the severity of her migraines lessened. And when the pain specialist she was seeing retired, Selfridge was able to transition the woman into a university-based program for migraine sufferers. "For the past three months, she has only had to visit the ED one time," adds Selfridge.

Another case involved a man who kept coming to the ED for care because he couldn't get in to see his PCP. "He had an outstanding bill at his PCP's office from a period during which he didn't have insurance," explains Selfridge. "The office wouldn't let him come back in to be seen until he paid that bill, so he was using the ED as an alternative."

Selfridge first tried to work with the PCP's office to come up with some sort of payment plan, but when that proved unsuccessful, she set the patient up with a new PCP. "He has called me a few times since then to tell me how great he feels and how well is doing," says Selfridge. "He really likes the new PCP, and she is the one who is coordinating his care and getting him in for the tests he needs."

Consider data, logistics

In most of the cases Selfridge has intervened with thus far, she has been able to reduce patient reliance on the ED. Out of the original 103 patients who were first identified for participation in the Consistent Care Program on January 1, 2012, she notes that only 10 patients still meet the criteria of having 12 visits in 12 months. For the time being, however, she is reluctant to remove any of the apparently stable patients from the program, even though about 10 new patients are added to the program each month.

"If we removed them from the program, or they graduated from the program, then they wouldn't be on my radar," explains Selfridge. "The concern is if their visits started to spike again, then we wouldn't know about it until they hit that 12-visits-in-12-months threshold again."

At this point, Selfridge says she would rather keep all the identified patients in the program, even if their medical and social needs have been stabilized. She also emphasizes that the intent of the program isn't to keep patients from utilizing the ED. "The intent is to have them come in if they have an emergency. Then let's look at their other medical needs and get them met in the most appropriate setting," she says.

McIntosh's advice to colleagues interested in developing a similar program is to take a good hard look at your data and analyze what your criteria for participation in the program should be.

COMING IN FUTURE MONTHS

- Using provider/staff feedback to drive improvement in the ED
- Placing a value on provider follow-up calls after discharge from ED
- The role texting can play in expediting care to stroke victims
- New perspectives on improving medication reconciliation

"Pulling data can sometimes be very difficult," she says. "Is it accurate? Also, what are the logistics of how you know that a patient should be in the program?"

Having a mechanism embedded in the EMR that automatically identifies patients who meet program criteria is important as well, explains McIntosh. And she emphasizes that you have to have your physicians, nurses, and social workers on board. "Ours were very engaged," she says. "If we didn't have that, I don't think the program would be successful." ■

SOURCES

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CNE/CME INSTRUCTIONS

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the evaluation is received, a credit letter will be sent to you. ■

CNE/CME OBJECTIVES

1. Apply new information about various approaches to ED management.
2. Discuss how developments in the regulatory arena apply to the ED setting.
3. Implement managerial procedures suggested by your peers in the publication. ■

CNE/CME QUESTIONS

1. According to **Thea James**, MD, what is the first thing VIAP does when it is alerted that a young victim of violence has presented to the ED?
A. call the police department
B. develop a rapport with the victim and try to assess him or her for safety
C. alert the parents and family members
D. all of the above

2. Also, according to James, what is the intention of "trauma-informed care?"
A. to make sure that providers know how to pick up on signs of abuse
B. to make sure that hospitals are equipped with added resources for victims of violence
C. to create an environment of safety and empowerment for patients
D. both A and B

3. According to **Sara Muramoto**, what seems to be lacking for most young victims of violence is:
A. a stable home
B. access to quality education
C. financial resources
D. engaged primary care providers

4. According to **Charles Kunkle**, MSN, CEN, CCRN, BC-NA, in the split-flow model being utilized at St. Mary Medical Center in Langhorne, PA, the expedited treatment area (ETA) typically sees patients who would be classified under the Emergency Service Index as:
A. level 3
B. levels 1 and 2
C. levels 4 and 5
D. level 5

5. According to **Beverly Vanselous**, RN, CEN, with the continuous movement of patients in the split-flow model, one thing administrators need to be very careful about is:
A. keeping close tabs on where patients are
B. patient handoffs
C. patient falls
D. keeping an eye on the waiting room

6. Patients older than the age of 18 are flagged for inclusion in the Consistent Care Program at St. Luke's Hospital in Cedar Rapids, IA, when:
A. they present to the ED 12 times in 12 months
B. they seek care in the ED for chronic care problems
C. they use the ED for non-urgent needs
D. they have mental health needs