223 ER visits in 15 months? Time to change the system.

By Karen Garloch, CHARLOTTE OBSERVER, Oct. 20, 2016

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Four years ago, [Anita Schambach](https://www.communitycarenc.org/our-networks/) spent part of her weekend diving into computerized claims data for Medicaid patients, searching for the ones who racked up the highest emergency room bills in the Charlotte region.

She heads an agency that manages care for patients covered by Medicaid, the government health program for low-income and disabled people. She knew that ER visits here were higher than the state average.

She wondered why.

Here’s what she found: Of the 100 most frequent ER users in the database, No. 1 was a homeless alcoholic man who’d been to an ER 223 times in 15 months. In the same period, he had 150 x-rays or other scans, some obviously duplicative and needless.

The search confirmed Schambach’s suspicion that many of these patients didn’t have primary care doctors and were bouncing between health care systems.

Some patients came for medication refills or pregnancy tests – simple things that didn’t require an ER. Most – 86 of 100 – had a behavioral health problem, such as depression or bipolar disease, which could have been better treated in another setting.

Schambach found other patients who’d been discharged from one ER only to visit another across the street. One patient visited three ERs in a single day. ER visits tended to be higher on really hot or cold days, leading Schambach to conclude that some patients were just seeking shelter.

Armed with this research, she created the Emergency Department Innovation Team in July 2012 to help fix the problem.

Two years later, the change was dramatic.

From 2013 to 2014, emergency room use by Medicaid patients dropped by 17 percent in Mecklenburg, Union and Anson counties. That meant 29,590 fewer visits in the three-county network.

Because ER visits sometimes lead to unnecessary hospital stays, inpatient rates dropped as well – 5,873 fewer hospital stays.

‘This is amazing’

To achieve this turnabout, Schambach assembled representatives from health and social services agencies who often deal with Medicaid patients. They met monthly – and still do – to share resources.

She also dispatched her nurses and social workers to locate the highest-risk patients. They called, visited their homes, or tracked them down in the ER to help them get primary care doctors, take the right medicines and arrange for other necessities, such as meals, transportation and housing.

After two years, the greater Mecklenburg area’s rate of emergency room use was one of the lowest in the state.

“We were like ‘Wow. This is amazing,’ ” Schambach said.

Dr. Allen Dobson, CEO of [Community Care of North Carolina](https://www.communitycarenc.org/) – the umbrella group that includes Schambach’s office – said the ER project is an “example of how we’re moving the needle in a very big way on a very difficult population.”

States across the country have been copying CCNC’s system of getting the right care to Medicaid patients in the best and least costly settings. Earlier this year, CCNC received the first Hearst Health Prize, a national award that came with $100,000.

The prize recognized the agency’s model for managing the care of patients after they’re discharged from the hospital. “We don’t provide any (direct) care. We make care better,” Dobson said. “Incidentally, it saves money.…It’s really allowed us to do more with less.”

Coordinating care

Community Care of North Carolina was created in 2001 to manage the cost and quality of care for patients whose health care is paid for by Medicaid, which is funded by the state and federal governments.

It brought together networks of doctors, nurses, pharmacists and hospitals to coordinate care for the state’s 1.6 million Medicaid recipients. Patients were assigned to “medical homes” with primary care doctors to help manage chronic illnesses and reduce unnecessary emergency room use.

Within 72 hours of hospital discharge, patients who are at high risk for readmission are connected with CCNC staffers. Care managers or social workers visit the patients at home – or even before they leave the hospital – to review medicines, schedule follow-up appointments and arrange for meals or transportation.

Over the years, the program has been shown to improve quality of care and decrease costs. A 2015 report by the North Carolina state auditor estimated savings at 9 percent, a 3-to-1 return on investment for the Medicaid program.

Despite this, state lawmakers last year enacted legislation to reform Medicaid. Under this law, the state won’t continue its current contract with CCNC, leaving the program’s future uncertain.

The new law came about because legislators had grown frustrated by a string of Medicaid budget overruns from 2010 to 2013. But contrary to popular belief, Dobson said Medicaid costs “haven’t gone up a lick” even though enrollment grew by 17 percent.

An analysis by the actuarial firm Milliman Inc. estimated a net program savings of nearly a billion dollars from 2007 through 2010. A separate review by CCNC researchers showed that Medicaid spending dropped from $597 to $543 per person per month from 2010 to 2014.

Still, the legislature plans to change the way doctors and hospitals are paid for treating Medicaid patients. The state’s goal is to control costs and make the budget more predictable.

Instead of paying for each doctor’s visit or procedure, [the state will contract with insurers or groups of providers](http://www.charlotteobserver.com/living/health-family/article69505722.html) and pay them a flat rate for each Medicaid patient. The contracting groups will cover any cost overruns, giving them an incentive to provide effective care at the lowest cost.

It will be up to each contracting group whether to use the services of CCNC. “If I were them, I’d double down on everything we do, to get every bit of savings out there,” Dobson said. “.… Every time we save money, it goes back to the state.”

Spin-off project

In the Charlotte area, the idea behind CCNC has also been applied to uninsured patients, not just those covered by Medicaid.

Last year, Carolinas HealthCare System assigned social worker Julia Courchaine and nurse Johanna Wilson to a [pilot project](http://www.charlotteobserver.com/living/health-family/article76815332.html) called Community CareBridge.

In its first year, the project saved $285,000 on care that would have been provided for free, according to the hospital system. Emergency room visits dropped by a third.

Courchaine and Wilson started with 35 patients who were the most frequent users of the ER and hospital. Many didn’t speak English, had mental health problems and little education.

To track down the patients, the women sometimes had to be detectives. They took to the streets, knocking on doors. They met one person at the jail, another outside a strip club.

Some patients faced problems more urgent than health care – lack of jobs, housing and food.

“We start where the patient is and what they’re most concerned about,” Courchaine said. “We ask them, ‘What’s stressing you out the most?’.…When they’re ready, we start working on the health care goals.”

Wilson said she tries to “see the patient from their center.” If someone doesn’t feel safe at home or can’t sleep because of stress, she said, that affects health as much as high blood pressure.

One of the project’s more difficult patients has been Jose, 51, an immigrant from El Salvador who speaks only Spanish. When the project started, his diabetes and high blood pressure were out of control. He was nearly homeless, sleeping in a hammock in a relative’s home, and had been eating only avocados and cheese.

At a Carolinas HealthCare clinic, which offers medical care to low-income and uninsured patients on a sliding scale, Jose gets free doctor visits. Through churches and charities, Courchaine and Wilson pulled together a package of services, including meals, transportation and counseling for his mild depression and history of alcohol abuse.

In the first year of the project, most patients changed their behavior and stopped needing intensive followup. Jose is still being monitored and may never be able to take care of himself completely. “But his quality of life is certainly better,” Wilson said. “He told us he would be dead if he hadn’t met us.”

Read more here: http://www.charlotteobserver.com/living/health-family/karen-garloch/article109386677.html#storylink=cpy