Family Practice Associates: Emergency Department Follow-Up and Episodic Care Management Process

Rich Cheng, Family Practice Associates' care coordinator, calls all patients who visit the emergency department (ED) within a week of the ED visit and, ideally, within two business days. Mr. Cheng documents these calls and sends this documentation to the practice's primary care practitioners and nurses via the electronic health record (EHR), and also informs patients' care teams of any medication changes. During these ED follow-up calls, he works with patients to:

- **Coordinate Specialist Care:** Mr. Cheng helps patients arrange care with the specialist(s) they were instructed to follow up with at the time of ED discharge, ensuring that patients know where they need to go and whom they need to see.
- **Review Medication Changes:** He also reviews any medication changes made during the ED visit, such as new medications prescribed or dosages adjusted. Mr. Cheng also goes over patients' medication lists with them; checks whether patients have any barriers to obtaining their medications; and works to connect them with available resources, if needed. If patients have questions about their medications, he connects them with an available medical assistant. After the call, Mr. Cheng informs patients' care teams of any changes in medication via the EHR.
- **Provide Education:** Mr. Cheng talks to patients about when to use the ED and when to wait to see a primary care practitioner. He also explains the drawbacks of using the ED and makes sure patients know that the practice offers same- and next-day appointments and provides 24/7 on-call access. This information is also shared in a letter sent to patients who visit the ED. This information is also available on the patient portal, and in handouts available at the front desk.
- **Schedule a Follow-up Appointment:** After completing these processes, Mr. Cheng encourages patients to come into the office for a follow-up appointment and works with them to schedule this appointment. These appointments are typically scheduled for either the same day as the call or the following business day, with the goal of having an appointment scheduled no more than three days after the call. If transportation barriers are an issue, Mr. Cheng works with patients' county resources and connects them with transportation services.

In addition to making these calls, Mr. Cheng initiates the practice's episodic care management process for any patients who have visited the ED three or more times within one month. Patients who have visited the ED three or more times within one quarter also receive episodic care management if these visits were made for similar reasons. This care management process includes the following:

- **Notification and Chart Review:** Mr. Cheng uses the practice's EHR to alert the nursing staff about patients who have reached the three-visit threshold. Nurses receive these messages and review these patients' EHRs to determine why they visited the ED and learn more about their overall health.
- **Initial Conversation:** Patients are introduced to care management during their post-ED follow-up visits. At this time, nurses talk with patients about issues they are facing and any trouble they are having managing their diagnoses. Nurses also review these patients' ability to complete activities of daily living (ADLs), such as climbing stairs. In addition, nurses ask these patients if there are any resources, such as walkers, that would help them with ADLs. Patients who decline a follow-up visit receive a care management letter, sent either by mail or patient portal on the day they are identified.
- **Episodic Care Management:** Nurses work with identified patients to provide self-management support and help these patients set goals to reduce unnecessary ED utilization. In addition, nurses work to ensure these patients' health needs, as identified during the initial conversation, are met, including helping them obtain specialist referrals or connections to community resources when needed. If referrals are provided, practice staff help to coordinate these appointments; if resource needs are identified, Mr. Cheng helps patients obtain those resources, often through local organizations with which the practice has built relationships. Like specialist referrals, all resource referrals are documented in the EHR. Patients receiving care management are seen in the office more frequently than other patients, and nurses touch base with them by phone every one to three months, depending on patients' needs and wishes. Patients who continue to visit the ED after enrollment in episodic care management are transitioned into longitudinal care management, which they continue to receive until their primary care practitioners determine they can be graduated without experiencing health setbacks.