How to Create an ED To Medical Home Program

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In 2014, Savannah, Georgia's St. Joseph's/Candler Healthcare System and Armstrong State University (now Georgia Southern University, Armstrong Campus) provided pilot funds, undergraduate students as health coaches and graduate student interns to help create an an ED to Medical Home program at St. Joseph's Hospital. Administered by the mission services department, the program was designed to identify uninsured and underinsured patients, connect them with a medical home and thereby help them decrease unnecessary visits to the emergency department.

After initial success at St. Joseph's, the ED to Medical Home program then rolled out at Candler Hospital, also in Savannah. The program now is in its fourth year at St. Joseph's/Candler Healthcare System and has achieved a nearly 40 percent decrease in repeat emergency department visits by participating patients.

Student participation is a key program component. Each semester five or six students enroll in a patient advocacy course at Georgia Southern University and then work at the hospital for a minimum of two 4-hour shifts per week. A substantial part of the students' course grade consists of their weekly productivity and their effectiveness monitoring — the number of appropriate medical home appointments made and the achievement of effective patient outcomes.

St. Joseph's/Candler believes that with at least one academic partner and a dedicated mission service, other health care systems can create a similar low-cost, effective program to support and guide needy individuals towards a healthier life.

Reflecting on the program's beginnings and the health care system-academic partnership, we identified six essential components for creating a similar ED to Medical Home program.

1 **Establish program objectives and build a corresponding database.** At St. Joseph's/Candler, the global charge was to assist emergency department patients with non-urgent needs to establish a primary medical home and decrease their visits to the ED. Health system administrators and a professor from Georgia Southern University teamed up and divided the goal into measurable objectives or key performance indicators to be able to determine progress towards the global goal and see where to focus if objectives were not being met. The objectives (key performance indicators) are:

- A health coach (student or staff) will see at least 35 percent of qualified patients[1]
- Twenty-five percent of qualified patients will be referred to a primary care home
- Of the referred patients, at least 25 percent will keep their first medical home appointment
- Patients' repeat visits to the emergency department will decrease by at least 25 percent within the first year
- At least 25 percent of qualified patients' social determinant needs will be identified and met (this goal was added in Year 4)

With these measurable objectives in mind

and with the help of graduate student interns, we determined what data needed to be collected, then created patient forms and a database. Included in that information are: patient ID number, ED visit date and referral clinic location.

To create a similar program, we recommend also identifying your primary care home partner staff, as they can facilitate appointments while recognizing your objectives. We are fortunate to have two community health clinics as part of our hospital system, as well as two federally qualified health clinics eager to be core referral sites for identified patients.

Several graduate student interns built the initial database — which has proved successful for more than 6,500 patients — in Excel, Microsoft's spreadsheet software. Together, the student interns and student health coaches enhanced the structure and resolved problems as we found them, and as the database came together, staff and students worked on developing and revising patient forms.

We suggest seeking input from a variety of sources. Don't be shy! We used hospital executives and department heads, as well as staff health coaches and students. Make the patient forms as simple as possible, but make sure they collect the information you will need in order to assess your objectives.

We also suggest that you consider building the program's needs into the electronic medical record as early as possible, so that patient information and other data flow in to be captured and tracked there. That way, no one will have to spend extra time entering data into Excel. However, whatever database form you use, we recommend seeing patients at the same time the program is being built. We found that seeing patients and working on the database simultaneously helped us to discover quickly if there were any quirks or if there was a better way to collect the data we needed to track objectives.

Now, in the program's fourth year, we have successfully implemented a medical home module into the hospital's EMR. This module manages all aspects of patient tracking, from communication for appointments to tracking social determinants. The data then is transposed into the monthly monitoring of key performance indicators.

2 Hire, schedule and train staff and students. Having 24-hour staff coverage is ideal, but our pilot program began with a director, a graduate student intern in health administration and 10 undergraduate students serving three hours a week as health coaches. After one semester, we were able to add two staff health coaches on a 10-hours-per-week schedule. Today, the program has three full-time staff health coaches, about six student health coaches working eight hours per week and one graduate student intern.

Each student and staff health coach bring new insights and ideas, which can expand the program and allow it to reach patients at deeper levels. Examples: finding several new community services, creating patient-friendly brochures, introducing new funding sources and, at times, interpreting for patients who are more comfortable or fluent in languages other than English.

The qualifications for staff and student health coaches are similar, but not identical. We look for students who are motivated to help those in need, able to learn multiple tasks (such as how to find community services, how to use and maintain electronic health records, and interviewing techniques) and who can quickly grow and

Essential Components

1. Establish objectives and database
2. Hire, schedule and train
3. Visit and follow-up with patients
4. Prepare for students each semester
5. Monitor, monitor, monitor
6. Celebrate!

display self-confidence in front of patients and busy emergency department staff. Obviously, for young undergraduate students, it is expected that such skills need to be developed, but we also look for students who appear to have the ability and motivation to professionally grow in these areas.

Balancing patient needs and student schedules is a major challenge. Patients are in the emergency department at all hours, weekdays and weekends; most students have jobs and long classes, yet they need to be able to fit in two four-hour shifts during the week.

All participating students must complete required readings that include social determinants of health, roles of a patient advocate, patient coaching and communication styles, motivational interviewing and stages of behavioral change. Students must pass an online test and spend a full day in hospital training and role playing. Each student also receives a manual to use while working with patients. The manual details the processes and criteria for primary care homes and serves as a patient referral resource.

Our program is designed to follow each patient for six months. We have found that often it takes that much time to help a patient really connect with a primary care home.

Training continues with staff health coaches, who demonstrate how they work with patients and observe the students as they work with patients. Students are formally assessed at the midpoint and at the end of the semester. Things to keep in mind as you develop your program's training and scheduling:

- Know your hospital administration's level of commitment to the vision of the program, as this will serve you well as your staffing needs grow
- Be careful in creating student work schedules, as you'll have to live with them for an entire semester
- Try to arrange for some health coaching options outside the hospital for students who qualify for the program but can't coordinate their schedules. We have three community sites that want health coaches, so students have alternatives
- Since hospital training is a crucial component of the program, putting in the time up front to train staff and students will greatly affect productivity

3 **Visit and follow-up with patients.** The patient visit is the heart of the program and varies with the personality of each health coach. However, there are four steps that all health coaches — staff and students — must develop.

- First is organization — each health coach must have his or her resources organized and portable (notebook with brochures, charged phone in pocket, clinic schedule book, for example).
- Second is a developed sensitivity, because health coaches must target their time and efforts according to the patient's mindset. While they are in the emergency department, some patients just are not ready to set up a primary care appointment. If they seem interested in the idea, however, the health coach provides them with information on available primary care clinics and gives them a follow-up phone call the following week.
- Third is scheduling the appointment, which is critical. If the patient is receptive while in the emergency department, the health coach can help him or her set up a primary care appointment on the spot. All health coaches must provide at least one follow-up telephone call to remind the patient of the medical appointment and, if necessary, solve any logistical problems in getting to the clinic.
- Fourth is discussion. Health coaches learn to talk to patients about their personal situation and how to manage difficulties that might get in the way of keeping the primary care appointment. Based on needs the patient has revealed, the health coach might offer a one-day bus pass to help with transportation, for example, or provide brochures about resources for such social needs as child care, food or employment.

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six months in the event the student health coach completes the semester during a patient's follow-up time. Currently, slightly more than half — 51.47 percent — of our patients keep their appointments — a slow, steady improvement that our program has achieved.

An observation: After your program has started, we recommend you arrange for health coaches to get extra training in motivational interviewing skills, such as building a genuine rapport and partnership with patients, actively listening, using open-ended questions and using patient's own words to gently explore ambivalence and problem-solve together.

4 Prepare for students' success each semester. Student health coaches are a vital part of our program, so preparing them for success is crucial. Our program is unique in that all students must be part of a graded "patient advocacy" course and, if successful, they can take the course for up to three semesters. Similar programs use student volunteers, but we have tried it and found that students earning a grade are far more effective than volunteers, even at the graduate level.

The primary recommendations for this component are to keep students engaged in reflective learning as they work at the hospital. Providing them with weekly encouraging notes and questions helps students to process often very new and different worlds and challenges. Enthusiastically keeping communication open between the professor and student is paramount, as some will need a gentle push, and all will appreciate encouragement. Finally, hospital staff and professors need to support each other. There will be differences of opinion — staff expectations and academic expectations won't always match — but the students need to witness one team.

5 Monitor, monitor, monitor. Although seeing and working with patients is the most evident part of the program, careful behind-the-scenes monitoring is what keeps the program effective and constantly improving. We have added details to our reports that not only collect data but help us identify core patient needs.

Each morning, the senior health coach checks the previous evening's patients and creates a to-do list of "cold calls," that is, uninsured patients who visited the emergency department but didn't talk to a health coach. During the day, when the emergency department is slow, staff and student health coaches call patients to talk about helping them find a primary care home and to discuss any social needs that are barriers to their health and medical care.

The other daily monitoring requires checking the clinic appointments that health coaches have set up for the following day, then calling and gently reminding the patient about the appointment. It isn't unusual to discover that a patient has forgotten, or for some reason isn't going to keep the appointment. The health coach then discusses the patient's needs — transportation? child care? — and problem-solves in order to reschedule the appointment.

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Weekly monitoring includes checking on health coaches' patient contacts for accuracy and productivity, and checking on community primary care clinics for patient attendance rates. In the hurry of trying to see patients while they are in the emergency room, it's easy to forget to gather important information such as backup telephone numbers, household size, etc. The weekly checklist lets individual health coaches correct mistakes and add important information they might have missed.

6 Celebrate successes — staff and students. ED to Medical Home focuses on the neediest patients, who are often in great pain or distress. Working on connecting them to a medical home, as well as identifying and addressing their social service needs, can be difficult for professional staff, not to mention students, and like many mis-

sion programs, the effort many be understaffed by the hospital. This is all the more reason that the hospital and its university partners need to recognize and celebrate program successes.

At St. Joseph's/Candler, the hospital staff meet biweekly and often enjoy a spirited meal together. Also, they occasionally take a trip to visit clinics that are their partner medical homes and bring a thank-you of cookies and fruit trays. Most student health coaches visit one-on-one with their professor to discuss their cases, and all meet once a month to share their experiences. At the end of the semester, students may invite staff health coaches to the final class meeting, a refreshing gathering of excited participants eager to share their experiences and to hear each other's stories.

CONCLUSION

Several large metropolitan health care systems have undertaken programs to help low-income individuals get connected with community and primary care services and decrease their use of emergency departments. With much smaller pilot funding and a supportive mission services department, our program uses many of the same components, with the added twist of training university students and "employing" them as health care coaches for college credit. We believe our program can be effectively implemented in similarly sized hospitals in their aim to serve the most needy people within their communities.

The Catholic health ministry is committed to caring for poor and vulnerable persons, ensuring available and accessible health care for everyone, while minimizing administrative expenses. The authors welcome those interested in building their own program to use our work as a foundation as they further this ministry.

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NOTE

1. "Qualified" patients are defined as uninsured or covered by Medicaid, triage priority 3, 4 and 5 (less critical), and who have visited the ED four or more times in a two-year period.

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