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Study Shows Care Management for Low-Income Adults Reduces Inappropriate ED Utilization

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Published in February 2011 in *Medical Care*, a recent study found that care management for low-income adults reduced inappropriate emergency department (ED) utilization.

The study examined the impact of a care management program implemented for frequent users of hospital services at Kern Medical Center (KMC), a public safety net hospital situated in the third largest county in California. Provided under contract by COPE Health Solutions using their Care Transitions & Coordination[SM] model, the care management program was designed to be a low-cost intervention to provide patients with the tools and supportive services that enable them to take a more active role in their care. The Care Transitions & Coordination[SM] model is customizable to various populations based on payer type, with a focus on particular chronic conditions and other market segmentations, but generally includes the following components:

- **Goal creation and assistance in reaching goals:** Care managers work with patients to create and achieve care plan goals, ranging from applying for benefits and receiving stable housing to losing weight and receiving specialty care appointments.

Allen Miller, President & CEO of COPE Health Solutions with Chinyere Nwodim, Senior Project Manager (left) and the author (right)

- **Assistance with care navigation:** Care managers schedule appointments, follow-up on referrals, and help patients refill medications.
- **Arranging for support services:** Care managers make personal connections with staff at various agencies around the community and refer patients to appropriate services, including transportation resources, legal aid, homeless shelters, faith-based services, and substance abuse resources.
- **Care transitions:** Care managers meet with patients daily while they are admitted and work with discharge planners to assist patients in receiving recommended follow-up care and understanding discharge instructions.
- **Communication with providers:** Care managers serve as liaisons between patients and providers, accompanying them to appointments, creating and prioritizing problem lists, coaching patients about questions to ask, and sitting with patients after their visits to explain follow up instructions.

The analysis was conducted using KMC encounter data from August 2007 to January 2010 in order to assess the effect of care management on ED visits and inpatient admissions for the patients enrolled in the program. A comparison group was also included in the analysis. The two groups were similar in age and race/ethnicity, although the care managed group had more severe co-morbidities than the comparison group.

Results from the analysis demonstrated that care managed patients had a third lower risk of visiting the ED than the comparison group when potential differences between the two groups were controlled. After enrolling into the program, care managed patients experienced a significant reduction in ED visits, from 6.0 to 1.7 median ED visits per year. Further, annual ED costs decreased by an average of $671 per care managed patient. The effect of care management on inpatient utilization in this study was less clear. The care management group had slightly fewer inpatient admissions than the comparison group; however, the difference between the two groups was not found to be statistically significant. While care managed patients experienced fewer admissions, they accrued more bed days than the comparison group, suggesting a differential health status between the two groups.

Outside of KMC, the Care Transitions & Coordination[SM] model has been implemented successfully at several Los Angeles County hospitals, including a large urban-based hospital and a major academic medical center. More recently, the Care Transitions & Coordination[SM] program has been customized to manage not only Medi-Cal patients, but also Medicare patients, patients with dual Medi-Cal and Medicare eligibility (Medi-Medi), and patients with specific disease modalities such as congestive heart failure (CHF). In addition to decreasing inappropriate utilization of hospital services, Care Transitions & Coordination[SM] has helped strengthen the bond between patients and their health care network.

By connecting patients to appropriate primary care and social resources within their community, the care management program shows significant potential for its ability to reduce frequent emergency department use and costs among low-income adults. These findings may be particularly timely as the need to constrain health care spending becomes an escalating priority for policy makers. Highlighted by the recent passage of health reform, controlling health care costs is increasingly important for the sustainability of government health programs such as Medicaid. This study shows that care management strategies that empower patients to better manage their health can be a viable solution for curbing ED utilization and achieving cost savings.

Also contributing to this article were the following COPE Health Solutions employees:

- *Gloria Rodriguez, Project Manager*
- *Chinyere Nwodim, Senior Project Manager*
- *Dr. Sarita Mohanty, Chief Medical Officer*
- *Allen Miller, President and CEO.*

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Reference: Shah R, Chen C, O'Rourke S, Lee M, Mohanty SA, Abraham J. Evaluation of care management for the uninsured. Med Care. 2011 Feb;49(2):166-71. [Abstract]

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