Abstract
High-risk patients who accumulate large number of emergency room visits are often called frequent flyers, or familiar faces. These high-risk individuals are significantly at risk for frequent readmission, poor health outcomes or even death (Cook, 2014). Vidant Medical Center’s Familiar Faces (FF) Program works with the most complex and vulnerable patients in our community with multiple medical, mental health and substance abuse conditions. In FY 13 Vidant Medical Center documented 1035 visits from the top 20 familiar faces in our ED. These top 20 patients evidenced total charges of $3.4 million with payment received for 19.19 % of charges.

Background
- Lack of focus and coordinated efforts to efficiently meet needs of familiar faces in ED
- Disjointed care with multiple disciplines operating in silos
- Lack of coordination between hospital, community, primary care providers and behavioral health services
- FY 13 1035 visits for top 20 familiar faces to VMC’s ED identified through data analysis
- Began data analysis, and monitoring cohorts of familiar faces

Goals
- Reduce overall number of ED visits and related charges for identified cohorts of familiar faces
- Reduce number of ED visits for identified cohorts of familiar faces during business hours (M-F, 8-5) when other resources, such as primary care provider offices, are available
- Increase coordination of care – linking of resources
- Improve patient reported quality of health
- Develop multidisciplinary care plans on identified familiar faces

Methods
- Enhanced collaboration with Community Care of North Carolina (CCNC). CCNC’s initiatives are geared toward decreasing non-urgent use of the ED by providing a standardized approach to network management of ED visits (CCNC, 2015).
- Developed and implemented Plan of Care (POC) for identified familiar faces including ED Pain Management Plans (Fig. 2)
- Leveraged electronic health record to enhance communication across the continuum: FY1 notification, and 30 Day Readmit Best Practice Alert
- Enhanced ED Case Management model (Fig.1)
- Held Bimonthly ED FF team meetings with key stakeholders:
  1. ED Social Workers
  2. Physicians
  3. CCNC
  4. Local Medical Entities/Behavioral Health Partners
  5. Primary Care Provider Teams
- Developed and implement Patient Engagement Survey (Fig.3)
- Shared electronic resource drive for care planning review

Vidant Medical Center ED Case Management Collaborative Care Model
- Current Resources: 6 SWs (5 MSW (2LCSW), 1 BSW) rotating shifts (8, 10, 12 hour shifts), coverage from 0700 – 0130.
- Consult based CM referrals:
  1. ED Familiar Faces – Best Practice Alert in EHR for notification 30 day readmissions
  2. Physician Referral Order
  3. Nursing Referral Order
  4. Patient Referral Request
- Case Management Discharge Planning/Psychosocial Assessment completed on all referrals
- Fast Track CM Screening/Triage:
  1. Trauma/Codes/Disaster
  2. CPS/APS
  3. Familiar Faces / 30 Day Readmissions
  4. BHDetox
- Structured Care Planning for ED Familiar Faces/Primary SW assigned to each familiar face

Results
The first Top 20 FF cohort from FY13 was followed for the next 12 months. Over the next year, VMC saw a 37% decrease in the number of total visits by these patients. The number of visits during routine office hours also fell – showing at 33% reduction. From this reduction in visits, the overall charges for our Top 20 FF group was reduced by 24%. The targeted goal of these metrics was to reduce usage by 25%, a goal that was met by 2 of the 3 metrics. In all three metrics, VMC improved outcomes for both the patients in the cohort and the hospital’s financial standing.

Future Implications
- Focus on ED pain management plans in collaboration with primary care providers and ED physician team
- Enhance information system capability with availability of plan of care documents in electronic health record
- Analyze Patient Engagement Survey data
- Expand model to all VH hospital EDs
- Leverage Faith Based Community for patient resources

References

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Fig. 1
Fig. 2
Fig. 3