Patients with Persistently High Emergency Department Use in Co-Located Substance Use, Medical, and Psychiatric Care Setting

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Background

Little is known about the care needs of patients who have persistently high emergency department (ED) utilization: 10+ visits in consecutive years. Many individuals with chronic ED visits also have substance use disorders (SUD). At University of Maryland Medical Center's (UMMC) ED, of 43 patients with 20+ ED visits/year 70% had SUD.

Our SUD outpatient clinic University of Maryland Addiction Programs at 1001 (*1001 UMAP*) co-locates medical and psychiatric care, providing a unique capacity to enhance care for patients with SUD and persistently high ED use. As outpatient and ED collaborators, we seek to understand experiences and needs of this patient population to improve care. We pursued the following objectives in our quality improvement (QI) study.

Objectives

1. To identify and describe patients with persistently high ED use.
2. To qualitatively explore patients' experiences and considerations in seeking healthcare.
3. To gain insights for quality improvement interventions to optimize primary care and ED utilization for people with persistently high ED use.

Methods

We identified patients who had an encounter at*1001 UMAP* and quantified their ED utilization from 2021-2023 by a review of our health information exchange (CRISP) and electronic health records. We performed descriptive analysis of healthcare utilization and demographics among participants over a two consecutive 12-month periods.

To explore what led patients to choose ED care vs. primary care, as well as patient experience of care in both settings, we sought to interview a sample of 20 active *1001UMAP* patients. We enrolled 12 patients for semi-structured interviews and quantified 10 years of their ED/hospital visits.

We applied rapid qualitative analysis with two reviewers of transcripts and audio files to identify codes, established corresponding patterns and themes applying descriptive qualitative and content analysis to initially describe phenomena. This study was deemed non-human subjects research for quality improvement purposes by University of Maryland, Baltimore IRB.

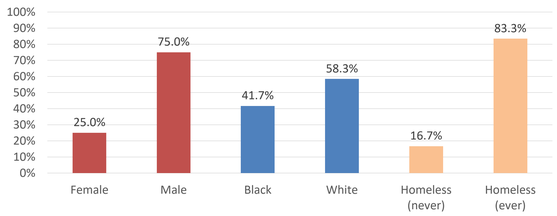

Figure 1. Demographics and Hospitalizations 2013-2023 for Select *1001 UMAP* Patients (n=12)

Preliminary Quantitative Results

Of 418 UMMC ED/*1001 UMAP* patients, most (62%) had <4 ED visits; 98 (23%) had high use =>10 visits in only one year, and 59 (14%) had high use in two consecutive years.

Of the 12 interview patients with 10+ ED visits in consecutive years, most were male, white, aged 29-60 years (mean= 45.4 (SD=10.9), median= 43) and had experienced homelessness (see Figure 1). They had a total of 1512 ED and hospital visits from January 2013-October 2023, ranging from 0-140 visits, mean 10.5 (SD 13.6), median 5.4 visits/year (see Figure 2).

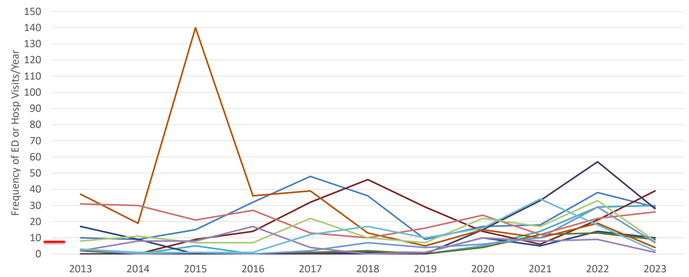

Figure 2. Emergency Department and Hospitalizations 2013-2023 for individual *1001 UMAP* Patients with Persistent High ED Utilization (n=12)

Preliminary Qualitative Results

Influence of Social Needs and Addiction on Healthcare Seeking

Most participants reported sentiments like IN1 quote below, that addiction and social living conditions did not influence how they sought healthcare. In descriptive analysis, these were important factors for some patients, see below.

Social Needs

Housing: *No, I'm me - whether I'm living in a mansion or whether I'm living on a sidewalk.*-IN1

A lot of times I was homeless, and it was cold out, I would go there just to have somewhere to be warm and they let me sit in the waiting room because of the weather. -IN2

There's flies and dirt and it's no water; it's almost impossible to keep your stuff clean.-IN9

Food: *I don't eat like the way I'm supposed to-I eat a lot of junk food.* -IN5

I'm at that shelter, I cannot eat that stuff, [the food] it play a very important role on my diet, with diabetes. -IN4

Social Isolation. *Pretty much every day of the week, so I'm alone and pretty much all the time. And that's a big problem too, because it ain't like I have them there with me and I can talk to them.* - IN12

Addiction

Well, as far as using…I don't go out buying drugs…not in years.-IN12

It does it definitely does. Any addict, if they're gonna go to the emergency room they're gonna get dosed before they go because they know they're gonna be waiting and we know that if we don't get our medicine we will be going into withdrawal. -IN1

You know the movie Groundhog Day, it's like the same day over and over again?

…and like they say that's like what insanity is; and it's true- but it's so difficult like especially when you're with somebody else-- to just like change one of those little things like out of your day because you're so used to it, you're complacent. -IN9

Consideration for Emergency Care Visits

For most respondents, proximity, accessibility, and need for immediate advanced medical attention influenced care seeking. Some participants chose hospitals by the wait times experienced, or by the treatment received from staff. Most did NOT want to keep going to the E.D.

Location

Proximity to where you are that's probably it, proximity. IN1

What's close, near at the time, and that's the hospital that's I'm familiar with. IN3

Is it within walking distance? IN2, IN5

Serious medical situation

When I go to the hospital, I'm gonna need hospitalization. IN1

Only time I go to hospital is if I fall out. IN4

when it just got to the point where I couldn't deal with it on my own anymore. IN12

Like if you can't breathe you have to go to the hospital for sure. IN5

Hospital/ED waiting time

How long will I will be waiting in the waiting room. IN1

I broke my neck I sat there for 14 hours before [they] see me. IN2

If I if I go to the door and see like 30 people in the waiting room, I'm gonna turn back around. IN13

Hospital/ED staff attitudes

The attitudes of the people at the hospital. At hospital [x] they usually didn't treat you like terrible.. it's just other emergency rooms…they treat you like a junkie. IN1

When they're like 'you're on methadone and you can't get that' (pain medicine). IN6

Because nobody want to keep going to the ER constantly. You know what I mean? IN13

Consideration for Primary Care Visits

Many participants felt that primary care offered easier and familiar care and emphasized the benefit of an ongoing, trusting, and caring relationship. Some participants felt that primary care couldn't offer them convenient access, or they didn't know what was available in outpatient care.

Pros:

It's a lot easier to call and schedule an appointment.-IN1

With my primary, we have a relationship; she's like my second mother. -IN3

I'm tired of sitting in hospitals, I'd rather just have primary care….just go sooner rather than brushing it under the rug. -IN1

We have a rapport. I've been around him long enough and I trust him -IN2

They've been awesome here; this place has been oasis for me….somewhere to go feel safe; someone talks to you like a human being. -IN10

Cons

It {crisis} always happened in the middle of the night or early morning. So it's hard to go to my primary at that time. -IN7

I'm not really aware of what you can come here [primary] for, like no one ever told me. -IN12

They (primary) don't have any openings sometimes…but it's perfect for me because I don't want to see him…all you're doing (in primary care) is refilling my medications anyway. -IN13

I've really never considered that (going to primary more often) ..something to think about. -IN6

Conclusion

We are still analyzing data and conducting chart reviews. In general, patients feel that the hospital/ED is the best and only place to go when they feel their conditions are serious. Patients have limited understanding about outpatient services, about some of their health conditions, and about how addictions and social conditions may be contributing to their health and healthcare. We are learning about patient preferences in ED care (accessible, fair treatment) and outpatient care (not as convenient, services unknown). Limitations: This QI project does not have the rigor and resources of a research study and findings may not be generalizable. However, with patients and healthcare colleagues, we are contributing new insights to inform care for patients with SUD who have persistently high ED use.