Primary Care Physicians Driving Transformation in Emergency Department Utilization

PCP Access Pilot

November 2011
Executive Summary

- A key to reducing emergency visits for primary care treatable conditions is *not* new or revolutionary

- Can be summed up by the proverb “where there’s a will, there’s a way” (along with appropriate tools)
  - The right tools are necessary, but not sufficient

- Reducing emergency visits for primary care treatable conditions has to be *important to the primary care physician* (PCP)
  - Could be for financial reasons (e.g. a PCP financial risk arrangement)
  - Or, because it has been unequivocally labeled as a priority over others by a larger organization to which the PCP belongs or participates with, and the PCP values that relationship

  - Competing priorities may have superseded emergency visits as an issue in regard to physician practice/Physician Organization resources
Executive Summary

- Encourage the adoption of specific activities to decrease emergency department use for PCP treatable conditions
  - **Develop** relationship-based interaction with offices
  - **Assist** offices in the development or enhancement of access to care standards - answering the question:
    - How accessible are we to our patients?
  - **Provide** communication templates the offices may use with patients and mutually agree on how these will be used
  - **Commit** to measure and interact with cohort of offices based on rate of ED use for PCP treatable conditions
  - Establish **frequent and repetitive** contact focused on specific activities related to ED use for PCP treatable conditions
Part I

BACKGROUND
GDAHC Emergency Department Utilization Team

- Emergency Department (ED) utilization identified by purchasers as a high priority issue during GDAHC SLSD 2007 strategic planning

- Revised scope of work (March 2009): develop recommendations to stakeholders for interventions to reduce ED utilization
  - Primary Objective: Reduce ED visits for Primary Care Physician (PCP) treatable conditions in Southeast Michigan

- Recommended interventions organized into categories, which included the category of *improve PCP access*


Blue Care Network (BCN) Survey: Emergency services utilization appears to be a substitute for PCP acute episodic care

- Member perception of PCP unavailability (after normal business hours) appears to be the primary reason the member did not attempt to contact the PCP prior to an emergency visit
- Majority of members with PCP treatable diagnoses would prefer to see their PCP, but typically were directed to the emergency department either by the PCP or an after hours message
- Published study* of “nonurgent” visits to a pediatric emergency department demonstrates the same theme
  - 62.8% of ED visits were for parental convenience
  - Of the 45.4% of parents who contacted their PCP, 72.6% were referred to the ED

PCP Access Pilot

- BCN and Oakland Southfield Physicians (OSP) agreed to work on a PCP access pilot
  - To study an actual implementation of SLSD ED Utilization Team recommendations for improving PCP access
    - Adopt phone triage processes and recorded messages that direct patients to appropriate provider
    - Establish strategy for acute minor episodic care when PCP is unavailable and communicate strategy to patients
    - Implement scheduling strategy to support same day appointments including evenings and weekends
  - Measure PCP treatable ED utilization before and after
  - Assess any barriers to implementation
OSP PCP Access Pilot Program Activities

- Educate all intervention cohort offices on the SLSD initiative
- Developed custom office-based tools
  - Customized (to the specific office) a new patient welcome letter and current patient brochure
  - Policy/procedure documentation
    - Develop or update office procedures
      - Access to care, telephone triaging and appointment scheduling
      - Patient follow-up after office receives notice of an ED visit
    - Recommend and also provide an after hours telephone script
    - Recommendations on how to use OSP Monthly ED visit reports
- Implement and track launch date of all pilot program tools
- Engage in structured communication with the intervention offices at established intervals to support implementation of interventions
PCP Access Pilot Timeline

- **June – July 2010**
  - Identified PCP practice sites for control and intervention cohorts
  - Collected survey data from identified sites
  - Created intervention materials

- **August 2010**
  - OSP introduced program materials to offices
  - OSP began working with offices and tracked when specific program items were implemented

- **September – December 2010**
  - Intervention office sites utilized program materials

- **January – May 2011**
  - 60 day claims run out period
  - Extraction of all data fields necessary
  - Data organization & analysis

- **June 2011 - Reporting of results**
Part II

METHODS
Intervention and Control Groups

- Created a process to evaluate OSP PCPs for inclusion in intervention and control groups
- Identified *index* PCPs for each cohort
  - Pilot program activities would not be implemented at the PCP level, but rather for each index PCP’s entire office, including other PCPs (if not a solo practice)
- PCPs associated with each index PCP were identified and labeled with the same study inclusion characteristics as the index PCP
Index PCP Identification Process

- Identified PCPs with > 100 BCN 12-month continuous commercial members in each of the 3 years 2007-09
  - To establish PCPs "engaged" with BCN in general
    - PCP has sufficient BCN membership to have an interest in BCN specific programs
    - 100 member threshold based on prior published research at BCN*

- Identified specific commercial members with the same certificate of coverage in regard to emergency copay for all 12 months in 2007, 2008 and 2009
  - Member did not need to have the same benefit for all 3 years, just for all 12 months of any given year
  - $50 copay was the most prevalent in 2007 and 2008. It was second most prevalent OSP copay amount in 2009
  - For trending purposes and to compare "apples to apples" as much as possible, focused only on members with a $50 copay for all 12 months in a given year (2007-09)

Index PCP Identification Process

- Connected the $50 copay members back to the "engaged' OSP PCPs
  - Excluded PCPs that did not have at least 30 such members in each year 2007, 08 and 09
    - To establish a denominator population to use for rate calculations
    - 30 member minimum reduces extreme results due to a small denominator while still leaving some PCPs to include

- BCN PCP treatable ICD-9 diagnosis list previously supplied to SLSD used to identify likely PCP treatable visits among treat and release emergency cases in each of the 3 years for study members assigned to study PCPs

- Used this count of cases to get potential pilot PCPs’ treatable ED visits/1000 for each year that also accounted for overall BCN enrollment with a PCP and member benefit design
Index PCP Identification Process

- Tended OSP PCPs over the 3 years to identify PCPs on PCP treatable ED visits/1000
  - Getting worse over time (increasing utilization rate)
  - Getting better over time (decreasing utilization rate)
  - No clear trend over time

- In conjunction with OSP leadership selected a representative sample of
  - OSP index PCPs with a trend of getting worse (n=5) for the intervention group
  - OSP index PCPs with an improving (n=5) or no trend (n=2) for control (no intervention)
  - Also placed one index PCP with a trend of getting better in the intervention group as a test case
Data Considerations

- Also strove for, as best possible, some balance between intervention and control groups on demographic and other characteristics
  - Practice location: urban vs. suburban
  - Mix of specialty: internal medicine, family practice and pediatrics
  - Involvement with BCBSM Patient Centered Medical Home (PCMH) and Physician Group Incentive Plan (PGIP)
Index PCP Population

- While total index PCP count was 13 (6 intervention and 7 control), total PCPs in the pilot including index PCP practice associates was 33
  - A PCP identified as a partner by OSP with a control index PCP (ID #8) was excluded from the analysis as had no BCN members
  - An intervention index PCP (ID #47) identified separately for the pilot using BCN address data from a time prior to the pilot, was actually in the same practice as another intervention index PCP as of the pilot
    - PCP ID #47 merged into PCP ID #44 practice site data
- Final count was 6 different intervention sites and 6 different control sites with a total of 32 PCPs (index and practice associates)
Surveys

- Initial survey of pilot (intervention and control) PCPs to ascertain added information on PCP
  - Demographics
  - Office processes in place before pilot interventions
  - Opinions

- Post pilot survey of intervention PCPs
  - Changes in office processes during pilot
  - Experience with the pilot
Member Copay

- $50 copay prevalence among OSP assigned members was lower in the year of the pilot reducing eligible members on whom to base measurements of post intervention utilization.

- Highest prevalence copay ($100) in 2010 was less prevalent in the prior years on which intervention and control PCP identification were based.

- No perfect choice in a dynamic environment.

<table>
<thead>
<tr>
<th>Emergency Copay</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>6.5%</td>
<td>4.6%</td>
<td>3.1%</td>
<td>1.5%</td>
</tr>
<tr>
<td>$20</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.1%</td>
</tr>
<tr>
<td>$25</td>
<td>6.1%</td>
<td>5.4%</td>
<td>4.8%</td>
<td>4.8%</td>
</tr>
<tr>
<td>$50</td>
<td>54.7%</td>
<td>42.9%</td>
<td>33.2%</td>
<td>24.7%</td>
</tr>
<tr>
<td>$53</td>
<td>0.0%</td>
<td>0.0%</td>
<td>3.4%</td>
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<tr>
<td>$75</td>
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<td>19.1%</td>
<td>15.1%</td>
<td>13.1%</td>
</tr>
<tr>
<td>$100</td>
<td>9.9%</td>
<td>27.6%</td>
<td>39.3%</td>
<td>47.3%</td>
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<td>0.0%</td>
<td>0.9%</td>
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<tr>
<td>$150</td>
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<td>0.3%</td>
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<td>5.2%</td>
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<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Count of Members

- Count of members used in index PCP identification and also in post intervention assessment
- While count of members decreased who met inclusion criteria in more recent years, control and intervention member counts remained nearly equivalent

<table>
<thead>
<tr>
<th>$50 Copay 12 Member Month Members of Study PCPs</th>
<th>Control</th>
<th>Intervention</th>
<th>Total</th>
<th>Control % of Members</th>
<th>Intervention % of Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007 Study Members</td>
<td>914</td>
<td>887</td>
<td>1,801</td>
<td>50.7%</td>
<td>49.3%</td>
</tr>
<tr>
<td>2008 Study Members</td>
<td>975</td>
<td>923</td>
<td>1,898</td>
<td>51.4%</td>
<td>48.6%</td>
</tr>
<tr>
<td>2009 Study Members</td>
<td>731</td>
<td>689</td>
<td>1,420</td>
<td>51.5%</td>
<td>48.5%</td>
</tr>
<tr>
<td>2010 Study Members</td>
<td>421</td>
<td>395</td>
<td>816</td>
<td>51.6%</td>
<td>48.4%</td>
</tr>
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</table>
PCP Demographics

<table>
<thead>
<tr>
<th>Cohort</th>
<th># of Practices</th>
<th>PCPs</th>
<th>% of PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>6</td>
<td>15</td>
<td>46.9%</td>
</tr>
<tr>
<td>Intervention</td>
<td>6</td>
<td>17</td>
<td>53.1%</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>32</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Specialty (per BCN credentialing)</th>
<th>PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>Family Practice</td>
<td>8</td>
</tr>
<tr>
<td>Control</td>
<td>Internal Medicine</td>
<td>2</td>
</tr>
<tr>
<td>Control</td>
<td>Pediatrics</td>
<td>5</td>
</tr>
<tr>
<td>Intervention</td>
<td>Family Practice</td>
<td>4</td>
</tr>
<tr>
<td>Intervention</td>
<td>Internal Medicine</td>
<td>1</td>
</tr>
<tr>
<td>Intervention</td>
<td>Pediatrics</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self Reported Information</th>
<th>Control</th>
<th>Intervention</th>
<th>% of All</th>
<th>% of All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCPs</td>
<td>PCPs</td>
<td>Control</td>
<td>Intervention</td>
</tr>
<tr>
<td>Solo PCP</td>
<td>1</td>
<td>2</td>
<td>6.7%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Urban Location</td>
<td>4</td>
<td>3</td>
<td>26.7%</td>
<td>17.6%</td>
</tr>
<tr>
<td>Suburban Location</td>
<td>11</td>
<td>14</td>
<td>73.3%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Rural Location</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
ED Utilization for PCP Treatable Conditions

- Count of all study PCPs (index and practice partners) based on 2007-2009 annual trend of ED visits for PCP treatable conditions used to identify the index PCPs
  - Improving trend means lower (decreasing) visit rate
  - Worsening trend means higher (increasing) visit rate

- The one test intervention site with an improving trend was comprised of the index PCP and 5 associates

<table>
<thead>
<tr>
<th>2007-09 Annual Trend: Based on Index PCP</th>
<th>Control PCPs at Index Sites</th>
<th>Intervention PCPs at Index Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreasing Visits</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>No Trend in Visits</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Increasing Visits</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>17</td>
</tr>
</tbody>
</table>
Self Reported Practice Characteristics  
*(Pre-Intervention Survey)*

- All study practices responded “yes” to the following survey questions
  - Office staff utilizes a formal phone triage process during office hours to evaluate if the patient has an acute clinical problem
  - Office staff utilize a formal phone triage process during office hours to evaluate the urgency of the call
  - Patient calls are screened by an answering service prior to speaking to a physician
  - Same day or next day appointments available
  - Practice offers “open access” scheduling

<table>
<thead>
<tr>
<th>Practice Characteristic (self reported survey data)</th>
<th>Control PCPs</th>
<th>Intervention PCPs</th>
<th>Total</th>
<th>% of All Control PCPs</th>
<th>% of All Intervention PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone triage during office hours for acute clinical problems</td>
<td>15</td>
<td>17</td>
<td>32</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Phone triage during office hours to evaluate call urgency</td>
<td>15</td>
<td>17</td>
<td>32</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>After hours calls screened by answering service</td>
<td>15</td>
<td>17</td>
<td>32</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Same day or next day appointments available</td>
<td>15</td>
<td>17</td>
<td>32</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Practice offers “open access” scheduling</td>
<td>15</td>
<td>17</td>
<td>32</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Self Reported Practice Characteristics
(Pre-Intervention Survey)

- Study practices that responded “yes” to the following survey questions as noted in the table below
  - Patient callers initially must navigate a phone tree, such as an interactive voice response system or push-button system
  - When a new patient first engages the PCP’s practice, the office provides
    - Name of preferred urgent care center(s) in the area for minor episodic care when immediate care is deemed necessary by the patient but not available through the PCP’s office
    - Instructions on the appropriate use of the emergency department

<table>
<thead>
<tr>
<th>Practice Characteristic (self reported survey data)</th>
<th>Control PCPs</th>
<th>Intervention PCPs</th>
<th>Total</th>
<th>% of All Control PCPs</th>
<th>% of All Intervention PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caller navigates a phone tree</td>
<td>8</td>
<td>12</td>
<td>20</td>
<td>53.3%</td>
<td>70.6%</td>
</tr>
<tr>
<td>New patients get list of preferred urgent care centers</td>
<td>14</td>
<td>13</td>
<td>27</td>
<td>93.3%</td>
<td>76.5%</td>
</tr>
<tr>
<td>New patients get instructions on appropriate ED use</td>
<td>12</td>
<td>13</td>
<td>25</td>
<td>80.0%</td>
<td>76.5%</td>
</tr>
</tbody>
</table>
Self Reported Practice Characteristics
(Pre-Intervention Survey)

- Study practices that responded “yes” to the following survey questions as noted in the table below
  - Routine use of an electronic medical record
  - Routine use of e-mail to interact with patients

<table>
<thead>
<tr>
<th>Practice Characteristic (self reported survey data)</th>
<th>Control PCPs</th>
<th>Intervention PCPs</th>
<th>Total</th>
<th>% of All Control PCPs</th>
<th>% of All Intervention PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routinely use an EMR</td>
<td>8</td>
<td>0</td>
<td>8</td>
<td>53.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Routinely use e-mail with patients</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>40.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
PCP Opinions  
*(Pre-Intervention Survey)*

- Study practices that responded “yes” to the following survey questions as noted in the table below
  - Do you feel that your patients are likely to use the Emergency Department for non-emergency primary care treatable conditions, because your office is closed?
  - Do you feel that your patients are likely to use the Emergency Department for non-emergency primary care treatable conditions because they cannot schedule an office visit in the time frame they are seeking?

<table>
<thead>
<tr>
<th>Practice Opinion</th>
<th>Control PCPs</th>
<th>Intervention PCPs</th>
<th>Total</th>
<th>% of All Control PCPs</th>
<th>% of All Intervention PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED use because PCP is closed</td>
<td>13</td>
<td>14</td>
<td>27</td>
<td>86.7%</td>
<td>82.4%</td>
</tr>
<tr>
<td>ED use because cannot get appointment</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>0.0%</td>
<td>17.6%</td>
</tr>
</tbody>
</table>
PCP Pre-Intervention Survey Summary

- Considering small size of the study, control and intervention cohorts reasonably similar on demographic characteristics
  - Count of practices and PCPs
  - Specialty of PCPs
  - Practice location (urban vs. suburban)

- All sites in both control and intervention groups attested to already having 4 practice characteristics that, in theory, should optimize PCP access and control ED use for PCP treatable conditions
  - Phone triage during office hours for acute clinical problems
  - Phone triage during office hours to evaluate call urgency
  - Same day or next day appointments available
  - Practice offers “open access” scheduling
PCP Pre-Intervention Survey Summary

- PCPs in both cohorts largely already had new patient instructions on urgent care and emergency department use
  - Slightly more prevalent in the control group
- Use of phone trees for incoming calls was common
  - More prevalent in the intervention group
- About half the control group PCPs used an EMR and email on a routine basis
  - No intervention PCP sites used an EMR or email to interact with patients
PCP Pre-Intervention Survey Summary

- PCP practice site opinions
  - Majority in both cohorts felt that patients went to the ED because PCP office was closed
    - Yet, most everyone reported instructions for patients directing them to appropriate sites of care (e.g. urgent care)
  - Hardly anyone felt it was because patients could not get timely appointments
    - Responses stated all had appropriate office processes, yet PCPs with worsening trends were identified for this pilot

- How could this be?
  - Incomplete understanding of optimal office processes
  - Implementation of processes not as robust as perceived or not considered a priority in regard to ED utilization
Blue Cross Blue Shield of Michigan
Patient Centered Medical Homes

- Prior to this pilot some PCP sites were designated as BCBSM Patient Centered Medical Homes (PCMH) and participated in the Physician Group Incentive Program (PGIP)

- These BCBSM programs are potential confounders when looking at pilot program data

<table>
<thead>
<tr>
<th>Cohort</th>
<th>PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>15</td>
</tr>
<tr>
<td>Intervention</td>
<td>17</td>
</tr>
<tr>
<td>PCMH Start</td>
<td></td>
</tr>
<tr>
<td>7-2009</td>
<td>6</td>
</tr>
<tr>
<td>7-2010</td>
<td>4</td>
</tr>
<tr>
<td>Paneled</td>
<td>4</td>
</tr>
<tr>
<td>7-2010</td>
<td>9</td>
</tr>
</tbody>
</table>
Blue Cross Blue Shield of Michigan
Patient Centered Medical Homes

What did BCBSM PCMH participation mean for OSP PCP sites?

- Office had PCMH welcome letter with access to care statement included, as defined by the PCMH program
- Office had written PCMH access to care policy, as defined by PCMH program
- PCMH start date is date received BCBSM designation or actively enrolled in the OSP PCMH program for nomination
  - Site would have started integrating operational practices prior to that date

BCBSM PCMH PCPs within OSP did not receive extra PGIP financial incentives for ED utilization performance

While no differing financial incentives existed for OSP PCMH sites versus OSP non-PCMH sites, PCMH sites did have certain PCP access policy and procedures as delineated by the PCMH program
Part III

OUTCOMES
Results: Data Considerations

- Pilot implementation and subsequent measurement period was short, only 4 months (September – December 2010)

- While annual trends 2007-2009 were used for pilot PCP identification, outcomes were measured against these 4 months only
  
  - Need to consider seasonality in ED visit patterns

- Intervention and control groups had PCP treatable ED visit rates measured only for these 4 months 2007-2010 to look for changes in trend
### Outcome: Intervention v. Control

- **Excludes** from the intervention group the one practice site with an improving annual trend 2007-2009

<table>
<thead>
<tr>
<th>Year</th>
<th>PCP Count</th>
<th>PCP Treatable ED Visits</th>
<th>$50 Copay Members</th>
<th>Visits/1000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Control</td>
<td>Intervention</td>
<td>Control</td>
<td>Intervention</td>
</tr>
<tr>
<td>2007</td>
<td>15</td>
<td>11</td>
<td>55</td>
<td>21</td>
</tr>
<tr>
<td>2008</td>
<td>15</td>
<td>11</td>
<td>25</td>
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<td>2009</td>
<td>15</td>
<td>11</td>
<td>16</td>
<td>25</td>
</tr>
<tr>
<td>2010</td>
<td>15</td>
<td>11</td>
<td>10</td>
<td>2</td>
</tr>
</tbody>
</table>

Clear improvement seen in intervention cohort in 2010 while controls had relatively steady utilization.
Did GDAHC Pilot Matter at PCMH Sites?

- Looked only at pilot sites that were a PCMH designated site as of 7/2009
  - Longest amount of PCMH participation
  - Intervention and controls were the same on initial survey responses for all office demographic and processes except:
    - All the controls used an EMR and e-mail, while none of the intervention sites did
    - Controls were all suburban and intervention sites were mostly urban locations
    - One intervention site was a solo PCP, and that site did not use a caller phone tree

- Also looked at pilot sites that have never been PCMH designated, neither as of 7/2009 nor as of 7/2010
  - Intervention and controls were the same on initial survey responses for all office demographic and processes except:
    - No control or intervention PCPs used e-mail or an EMR
    - No intervention PCP gave instructions in regard to urgent care centers or appropriate ED use to new patients, while controls mostly did
    - Intervention PCPs mostly used caller phone trees, while only some controls did
    - Controls were nearly split between suburban and urban locations, while intervention sites were all suburban
    - One solo PCP in the intervention group and one solo PCP among controls
Outcome: Intervention v. Control
Only PCMH Sites as of 7/2009

<table>
<thead>
<tr>
<th>Year</th>
<th>PCP Count</th>
<th>PCP Treatable ED Visits</th>
<th>$50 Copay Members</th>
<th>Visits/1000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Control</td>
<td>Intervention</td>
<td>Control</td>
<td>Intervention</td>
</tr>
<tr>
<td>2007</td>
<td>6</td>
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<td>9</td>
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<td>2008</td>
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<td>2010</td>
<td>6</td>
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<td>0</td>
</tr>
</tbody>
</table>

Improvement seen in intervention cohort in 2010 while controls experienced slight upward trend. Zero intervention use in 2010 likely due to small sample size. The message is a decrease in rate.
Outcome: Intervention v. Control
Never a PCMH Site

Improvement seen in intervention cohort in 2010 while controls steady. Zero intervention use in 2010 likely due to small sample size. The message is a decrease in rate.
Did GDAHC Pilot Matter at PCMH Sites?

- Patterns largely the same regardless if looking at all PCPs, just PCMH designated PCPs or just those PCPs not PCMH designated

- Intervention sites had lower utilization levels in 2010 compared to controls (overall and also regardless if PCMH or not) during those same 4 months

- Suggests SLSD/OSP pilot program provided additional benefit over PCMH alone
  - No additional financial incentives attached to SLSD pilot program for OSP PCPs
  - No additional financial incentives attached to PCMH for OSP PCPs in regard to ED use
Outcome: Intervention Site with Improving Annual Trend 2007-2009

- Site actually had a worsening trend 2007-2009 when assessing Sept-Dec months only, and improved with the pilot program

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<td>Intervention</td>
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<td>29.9</td>
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<td>2009</td>
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<tr>
<td>2010</td>
<td>6</td>
<td>4</td>
<td>122</td>
<td>32.8</td>
</tr>
</tbody>
</table>
Site is a 6 person pediatric suburban practice

While doing well on an overall annual basis, appears to have derived a benefit from the SLSD pilot during the 4 month period which exhibited worsening performance over the years

- Worsening performance Sept-Dec 2007-2009 was not assessed for when choosing this PCP/practice site, as exact time frame for intervention was not finalized at that point

This site became PCMH designated 7/2010

- Thus exposure to PCMH may be confounding, but seems unlikely in light of other PCMH v. non-PCMH pilot analysis data
Outcome: Urban Sites Only

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<tr>
<td>2010</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

Urban sites alone followed the same pattern as other subgroups. Zero intervention use in 2010 likely due to small sample size. The message is a decrease in rate.
Outcome: Urban Sites Only

- Urban locations present in both control and intervention cohorts

- When looking at urban locations alone
  - Sites with an improving trend existed to qualify as controls
  - Intervention urban PCPs appeared to also benefit and have an improvement in utilization that followed overall patterns

- While urban sites did have higher rates of ED use for PCP treatable conditions than suburban at both intervention and control sites, being located in an urban setting does not appear to alone preclude practice activities that impact utilization rates in a positive manner
Post Intervention Survey Results of Intervention Sites Only

- All sites retained their phone triage processes (no changes)
  - Urgency of calls
  - Clinical evaluation of calls

- Only 18% of intervention PCPs were affected by a change in how after hour calls were handled
  - No changes for all others

- Only 12% of intervention PCPs were affected by a change in availability and process for same/next day appointments
  - No changes for all others
Post Intervention Survey Results of Intervention Sites Only

- 82.4% of intervention PCPs were supplying new patient welcome letters or brochures in relation to ED utilization
  - Slight increase from pre-intervention 76.5%
- 6% of intervention PCPs were involved with a new EMR during the pilot (0% had an EMR before)
- No change (0%) in the use of e-mail to interact with patients
Post Intervention Survey Results of Intervention Sites Only

- All intervention sites felt the tools supplied by OSP made ED visits for PCP treatable conditions less likely in regard to:
  - Obtaining timely appointments
  - When the PCP office is closed

- Most felt providing a follow-up letter or a phone call after an ED visit for a PCP treatable condition helped reduce future use

- Most felt the pilot was overall a positive experience
DISCUSSION
Discussion

- OSP implementation methodology
  - Included regular practice contact, encouragement and follow-up in regard to SLSD specific ED use pilot materials

- Very little apparent change in PCP practice processes as a result of the pilot, as per post intervention survey

- Practices agreed to participate, thus a potential bias towards process improvement already present at the intervention sites
  - Sites also aware were being monitored by OSP

- It is unknown whether increased PCP access or increased urgent care visits (or some of both) were the offset for decreased ED visits for PCP treatable conditions
Discussion

- How the intervention was implemented by OSP and PCP office characteristics, and not just the pilot materials and concepts themselves, are likely vital factors to success
  
  - Concepts alone, such as open access scheduling, do not guarantee results (references below)
    
    - All sites claim to have embraced such practices before the implementation, and very little seemed to change in regard to processes as a result of the pilot (self reported survey data)
  
  - The right tools are necessary, but not sufficient


Discussion

Recent study done to better understand parental decisions to seek care for their children and physician perceptions of parents' decisions to seek non-urgent emergency department care*

- In-depth interviews of 26 parents of children and 20 primary care physicians of the same children presenting for non-urgent care at a children's hospital emergency department
- Four main themes emerged:
  - Immediate reassurance that their children are safe from harm is critical to parents' decisions
  - Primary care offices lack specific tests and treatments that parents and physicians believe may be necessary, regardless of whether they are actually needed
  - Discrepancies exist between physician and parent perceptions of adequate communication and access
  - Non-urgent emergency-department visits are not perceived as a significant enough breach in continuity of care by physicians and parents to warrant any concern

Study conclusion: neither parents nor primary care physicians saw non-urgent emergency-department visits as a significant enough problem to warrant any change in physician care practices or parent care-seeking behavior

Discussion

- It is not just the tools, it is the will to use them

- If decreased ED use for PCP treatable conditions is considered a quality outcome (care rendered by the provider who knows the patient best), and using Donabedian’s* paradigm of quality assessment
  - PCP office infrastructure *and these pilot tools* are structural in nature
  - The implementation (i.e. oversight, regular OSP interaction and emphasizing the importance of the initiative) is the process, not the scheduling and phone activities themselves
  - Outcome is the decrease in PCP treatable ED visits

Discussion

- Scaling of these results to the wider GDAHC geographic area of interest depends on
  - Prevalence of OSP-like levels of primary care group/IPA infrastructure, support and influence among target PCPs
  - PCP desire for practice performance improvement
    - Existence and magnitude of financial incentives in regard to ED utilization specifically
    - Existence of any real or perceived penalties (e.g. being excluded from a Physician Organization or Accountable Care Organization if fail to implement)
    - Aware of being part of a program and being directly evaluated on outcomes
  - Other confounding elements not considered in this pilot
Part V

CONCLUSION
Conclusion

- Goal of the Pilot was to determine if the GDAHC intervention, as implemented by OSP, is likely worth disseminating on a more widespread basis.

- This is a pilot with a small number of PCPs, different practice sites and study members, as well as a short evaluation time frame.
  - However, the available evidence does support dissemination.

- The real message is *not* new or revolutionary.
  - Can be summed up by the proverb “where there’s a will, there’s a way”
    - Along with appropriate tools
  - Reducing PCP treatable ED visits has to be *important to the PCP*, for whatever reason.

- *Over time, this message appears to have been lost, or other priorities have superseded ED visits as an issue in the competition for physician practice/Physician Organization resources.*
Conclusion

- This GDAHC Pilot experience should be shared as part of the Cost Quality initiative among Physician Organizations
  - Web based materials (the tools) made available for all
  - Regional opportunities
    - PGIP meetings as an ED utilization best-practice
    - Michigan State Medical Society/Michigan Osteopathic Association conferences
    - Michigan Primary Care Consortium
  - National opportunities
    - Robert Wood Johnson Foundation *Aligning Forces for Quality* Communities
    - Chartered Value Exchange (CVE) Communities
    - Network Regional Health Improvement collaborative
Conclusion

Encourage the adoption of specific activities to decrease ED use for PCP treatable conditions

- Develop relationship-based interaction with offices
- Assist offices in the development or enhancement of access to care standards - answering the question:
  - How accessible are we to our patients?
- Provide communication templates the offices may use with patients and mutually agree on how these will be used
- Commit to measure and interact with cohort of offices based on rate of ED use for PCP treatable conditions
- Establish frequent and repetitive contact focused on specific activities related to ED use for PCP treatable conditions
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