Primary Care Physicians Driving Transformation in Emergency Department Utilization

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GDAHC ED Utilization Team

Bruce Carl, MD
UAW Retiree Medical Benefit Trust

David Donigian, MD
Molina Healthcare

James Fox, MD
Michigan College of Emergency Physicians

Richard Frank, MD
Healthplus

Jerry Frankel, DO
Oakland Southfield Physicians

Robert Goodman, DO* (Team Chair)
Blue Care Network

Jennifer Holmes, RN*
University of Michigan Health

Jeni Hughes*
Oakland Southfield Physicians

George Kipa, MD*
Blue Cross Blue Shield of Michigan

Jamie Kopiczko*
Oakland Southfield Physicians

Bruce Niebylski, MD
Priority Health

Alina Pabin
Blue Cross Blue Shield of Michigan

Ara Rafaelian
Blue Cross Blue Shield of Michigan

Sanford Vieder, DO
Botsford Hospital

Ed Wolking*
Detroit Regional Chamber

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Sheri Moore – UMHS Emergency Department, LEAN Coach
Joanne Gutowsky – CJ Systems, Inc., LEAN Coach

Lisa Mason* – GDAHC Staff

***PCP Pilot Team Members**

GDAHC Emergency Department Utilization Team

- Identified by purchasers as a high priority issue during GDAHC SLSD 2007 strategic planning
- Scope of work (March 2009): Develop recommendations for interventions to reduce Emergency Department (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***

S. R. Pitts, E. R. Carrier, E. C. Rich, A. L. Kellermann. Where Americans Get Acute Care: Increasingly, It's Not At Their Doctor's Office. Health Affairs, 2010; 29 (9): 1620 DOI: 10.1377/hlthaff.2009.1026

Weber EJ, Showstack JA, Hunt KA, Colby DC, Grimes B, Bacchetti P, Callaham ML. Are the uninsured responsible for the increase in emergency department visits in the United States? Ann Emerg Med. 2008 Aug;52(2):108-15. Epub 2008 Apr 14.

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BCN Survey of Members with PCP Treatable ED Visits
(2004 Survey Based on 2001-2002 Claims Data)

- 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

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*Doobinin KA, Heidt-Davis PE, Gross TK, Isaacman DJ. Nonurgent pediatric emergency department visits: care-seeking behavior and parental knowledge of insurance. Pediatr Emerg Care. 2003;19:10-14.

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PCP Access Pilot

- BCN and Oakland Southfield Physicians (OSP) agreed to work on a PCP access pilot
- 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
- Pilot will
  - Measure PCP treatable ED utilization before and after
  - Assess any barriers to implementation

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OSP PCP Access Pilot Program Activities

- Educate all intervention cohort offices on the initiative
- Developed custom office-based tools
  - A new patient welcome letter and current patient brochure
  - Develop or update policy/procedure documentation
  - Recommend after hours telephone script
  - How to use OSP ED visit reports
- Implement and track launch date of all pilot program tools
- Engage in structured communication at established intervals to support implementation of interventions

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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

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Intervention and Control Groups

- Created a process to evaluate OSP PCPs
- Identified index PCPs for each cohort
  - The worst historical performance trend for the pilot intervention
  - The best historical performance trend to serve as controls
- Pilot program activities implemented for PCP's entire office, so would include any associates
- PCPs associated with each index PCP were identified and labeled with the same study inclusion characteristics

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PCP Demographics

Cohort	# of Practices	PCPs	% of PCPs
Control	6	15	46.9%
Intervention	6	17	53.1%
Total	12	32	100.0%

Cohort	Specialty (per BCN credentialing)	PCPs
Control	Family Practice	8
Control	Internal Medicine	2
Control	Pediatrics	5
Intervention	Family Practice	4
Intervention	Internal Medicine	1
Intervention	Pediatrics	12
	Total	32

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Self Reported Information	Control PCPs	Intervention PCPs	Total	% of All Control PCPs	% of All Intervention PCPs
Solo PCP	1	2	3	6.7%	11.8%
Urban Location	4	3	7	26.7%	17.6%
Suburban Location	11	14	25	73.3%	82.4%
Rural Location	0	0	0	0.0%	0.0%

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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

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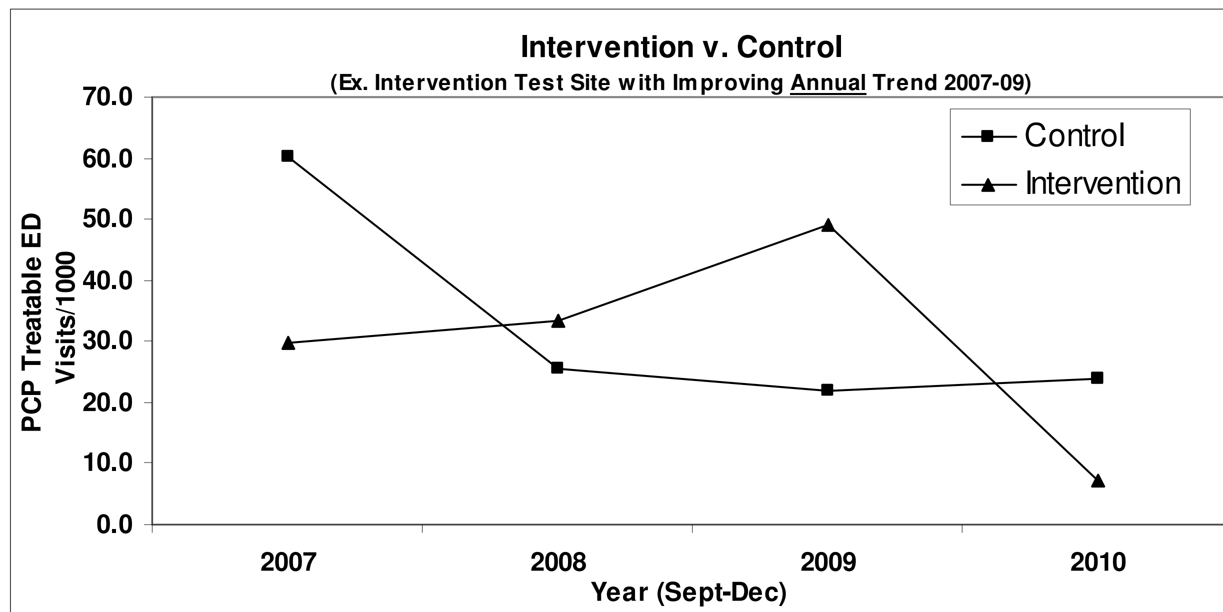
Outcome: Intervention v. Control

Year	PCP Count		PCP Treatable ED Visits		$50 Copay Members		Visits/1000	
	Control	Intervention	Control	Intervention	Control	Intervention	Control	Intervention
2007	15	11	55	21	914	702	60.2	29.9
2008	15	11	25	24	975	722	25.6	33.2
2009	15	11	16	25	731	508	21.9	49.2
2010	15	11	10	2	421	273	23.8	7.3



Clear improvement seen in intervention cohort in 2010 while controls had relatively steady utilization.

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Discussion

- Pilot Methodology = Regular Practice Contact + Encouragement + Follow-up
- Very little apparent change in PCP practice processes as a result of the pilot (pre and post pilot surveys)
- Sites were aware of being monitored
- Unknown whether increased PCP access and/or increased urgent care visits were the offset for lower ED visits for PCP treatable conditions

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Discussion

- Recent study* with in-depth interviews of parents who sought non-urgent emergency care at a children's hospital, and their PCPs
  - Neither parents nor PCPs saw non-urgent emergency department visits as a significant enough problem to warrant any change in physician care practices or parent care-seeking behavior
- Vital factors to success = Type of intervention + Pilot materials
- It is not just the tools, it is the will to use them

*Brousseau DC, Nimmer MR, Yunk NL, Nattinger AB, Greer A. **Nonurgent emergency-department care: analysis of parent and primary physician perspectives**. Pediatrics; 2011 Feb;127(2):e375-81

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Discussion

- Scaling of these results to the wider GDAHC geographic area of interest depends on:
  - Prevalence of similar level of infrastructure, support and influence among target PCPs as present within OSP
  - PCP's desire for practice performance improvement

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Conclusion

- 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***

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Conclusion

- 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

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Contacts for Additional Information

- **Robert Goodman, DO**

  Blue Care Network

  rgoodman@bcbsm.com

  248-799-6312

- **Jeni Hughes**

  Oakland Southfield Physicians

  jeni@aniosp.com

  248-357-4048

- **Lisa Mason**

  Greater Detroit Area Health Council

  lmason@gdahc.org

  313-596-0811

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