Emergency Department Utilization Team
PCP Access Pilot

presented at PGIP Quarterly Meeting
Best Practices Session
September 9, 2011
SLSD ED Utilization Team

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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**


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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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
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 record launch date of all pilot program tools
- Engage in structured communication 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**
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
### 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>
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<tr>
<td>Total</td>
<td>12</td>
<td>32</td>
<td>100.0%</td>
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</table>

#### Self Reported Information

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Specialty (per BCN credentialing)</th>
<th>PCPs</th>
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<tbody>
<tr>
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<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>
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<tr>
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<td>Family Practice</td>
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<tr>
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<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 PCPs</th>
<th>Intervention PCPs</th>
<th>Total</th>
<th>% of All Control PCPs</th>
<th>% of All Intervention PCPs</th>
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</thead>
<tbody>
<tr>
<td>Solo PCP</td>
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<td>2</td>
<td>3</td>
<td>6.7%</td>
<td>11.8%</td>
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<tr>
<td>Urban Location</td>
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<td>3</td>
<td>7</td>
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<td>17.6%</td>
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<td>Suburban Location</td>
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<td>14</td>
<td>25</td>
<td>73.3%</td>
<td>82.4%</td>
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<td>Rural Location</td>
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<td>0</td>
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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 cohort assignment, outcomes were measured against these 4 months only (Sept – Dec)
  - Need to consider seasonality in ED visit patterns

- Intervention and control groups had PCP treatable ED visit rates measured only for Sept – Dec for years 2007-2010 to look for changes in trend
Outcome: Intervention v. Control

<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>
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</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>
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<td>2008</td>
<td>15</td>
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<td>25</td>
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<td>2009</td>
<td>15</td>
<td>11</td>
<td>16</td>
<td>25</td>
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<tr>
<td>2010</td>
<td>15</td>
<td>11</td>
<td>10</td>
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Intervention v. Control
(Ex. Intervention Test Site with Improving Annual Trend 2007-09)

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

Discussion

- Generalizability of the results of this pilot to settings other than OSP 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
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*
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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