ACAP
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ACAP Fact Sheet

Safety Net Health Plan Efforts to Reduce Avoidable Emergency Department Utilization

March 2014

Summary

Inappropriate, avoidable use of the emergency department (ED)[1] is an expensive indication of the opportunity to deliver better-coordinated, more comprehensive care. There are a multitude of reasons patients use the ED for conditions that could be treated, or prevented, in a different care setting: they range from convenience to unfamiliarity with the health care system to insufficient off-hour access to other types of providers. Safety Net Health Plans, along with the providers and hospitals in their provider networks, are implementing initiatives that address avoidable ED use.

This fact sheet outlines six efforts under way at Safety Net Health Plans across the country to reduce inappropriate and avoidable ED use. These initiatives cover a wide range of approaches, including expanded after-hours primary and urgent care options, care coordination and data sharing through health homes, identification and targeting of high-utilization members, health navigator programs, supporting post-discharge care transitions into the community, and implementing a streamlined and integrated care model.

Reducing Inappropriate Emergency Department Visits

Reducing inappropriate usage of the emergency department (ED) fits well into the broad "triple aim" of reducing costs, improving health outcomes, and improving the patient experience. For ambulatory care-sensitive conditions, care delivered in outpatient settings, such as a primary care provider's office, is less fragmented and significantly more cost-efficient than care delivered in the ED.

Inappropriate and avoidable ED utilization are complicated issues. Many consider inappropriate use of the ED to be primarily for non-urgent symptoms, such as a low-grade fever in an adult. But truly non-urgent concerns account for few ED visits for Medicaid beneficiaries and privately-insured individuals alike – 10 percent and 7 percent, respectively.[2] Patients make the decision to seek care in the ED based on their presenting symptoms which are often quite urgent, even if the ultimate discharge diagnosis did not warrant emergency intervention.[3] A patient with chest pain is right to seek emergency care because patients, and even providers, cannot easily or reliably distinguish heartburn from a heart attack without further testing.

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[1] This paper uses the terms "emergency department" (ED) and "emergency room" (ER) interchangeably.
[2] Sommers AS, Boukus ER, Carrier E. "Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are for Urgent or More Serious Symptoms." Center for Studying Health System Change, July 2012.
[3] Raven MC, Lowe RA, Maselli J, Hsia RY. Comparison of Presenting Complaint vs Discharge Diagnosis for Identifying "Nonemergency" Emergency Department Visits. *JAMA* 309(11): 1145-1153, 2013.

While the terms 'inappropriate' and 'avoidable' are often used interchangeably, avoidable ED use are visits for reasons that, though for urgent conditions, could have been treated in a physician's office or prevented with proper access to primary care. An asthma flare-up is a common example of an avoidable ED visit – though the condition is an emergency, in many cases it could have been prevented with proper care, education, and medication management. Medicaid health plans have made significant progress working with members and providers to better manage their conditions and avoid hospitalizations.[4]

Although the reasons for ED utilization are similar for Medicaid beneficiaries and privately insured patients, nonelderly Medicaid patients use EDs at significantly higher rates than privately insured patients.[5] Some of this difference is attributable to the higher burden and severity of illness and higher rates of disability among the Medicaid population. Barriers to timely primary care are associated with higher ED use, and Medicaid beneficiaries tend to face more barriers than privately insured patients.[6] Recent findings from a study in Oregon, coupled with qualitative interviews of beneficiaries who gained coverage through the Oregon lottery-style expansion, support the idea that individuals who are new to Medicaid often do not understand how to use their coverage and thus turn to the ED.[7,8] A 2012 study found that a recent change in health insurance status – both newly gained and recently lost coverage – was associated with greater ED use, while use fell for those continuously insured or uninsured.[9]

However, for some members, receiving care in an ED setting as opposed to a primary care setting may be more attractive for other reasons. An ED is effectively a 24-hour, full-service medical provider for which no appointment is required. These features may be particularly attractive to Medicaid beneficiaries who face barriers arranging childcare, time off work, and transportation for scheduled medical office visits.

The strong primary care provider networks and care management activities of Safety Net Health Plans are essential investments to reduce inappropriate and avoidable ED utilization. Additionally, the community-based nature of these health plans allows them to implement a variety of unique strategies, from expanding after-hours phone and primary care access to identifying patients with extremely high ED utilization for intensive case management activities, in an effort to further reduce avoidable ED use and improve utilization of care in appropriate settings.

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[4] Bindman AB, Chattopadhyay A, Osmond DH, Huen W, Bacchetti P. The Impact of Medicaid Managed Care on Hospitalizations for Ambulatory Care Sensitive Conditions. *Health Services Research* 40(1): 19-38, 2005.
[5] Sommers AS, Boukus ER, Carrier E. "Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are for Urgent or More Serious Symptoms." Center for Studying Health System Change, July 2012.
[6] Cheung PT, Wiler JL, Lowe RA, Ginde AA. National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries. *Annals of Emergency Medicine* 60(1): 4-10, 2012.
[7] Allen H, Wright BJ, Baicker K. New Medicaid Enrollees in Oregon Report Health Care Successes and Challenges. *Health Affairs* 33(2): 292-299, 2014.
[8] Taubman SL, Allen HL, Wright BJ, Baicker K, Finkelstein AN. Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment. *Science* 343(6168): 263-268, 2014.
[9] Ginde AA, Lowe RA, Wiler JL. Health Insurance Status Change and Emergency Department Use Among US Adults. *Archives of Internal Medicine* 172(8): 642-647, 2012.

Expand After-Hours Primary Care and Urgent Care

Driscoll Health Plan, which serves Medicaid and CHIP members in South Texas, has worked to ensure access to after-hours primary and urgent care as an alternative to the ED. The health plan has expanded its contracts with urgent care clinics. In the Hidalgo Service Area in Southwest Texas, almost all primary care practices are open until 8 p.m.; some stay open until midnight. There are also multiple after-hours clinics. These factors have likely contributed to the region having one of the lowest ED utilization rates in the state. Driscoll has encouraged providers in its Nueces Service Area in Southeast Texas to offer similar after-hours care availability.

The health plan also subsidized a new urgent care clinic in a region that had no pediatric urgent care options, and extended the hours of other urgent care clinics. These after-hours and urgent care clinics offer lower-cost alternatives to the emergency department for appropriate conditions, and often have a shorter wait time for health plan members with urgent but non-life threatening symptoms. Driscoll highlights after-hours care options prominently on its member Web site, and explains in plain language the difference between emergency and urgent care and how to obtain such care.

In addition to expanding after-hours access of non-ED care options, Driscoll Health Plan has implemented targeted home visits for specific populations that are prone to ED use, but whose utilization may be preventable with proper education and intervention. The plan has had great success with home visits for members with asthma who had an inpatient admission or ED visit, and has also seen improvements for members with substance use disorders after visits by social workers.

Improve Care Coordination through Health Homes and Data Sharing

Community Health Plan of Washington is a lead entity in Washington State's new Health Home program. The Health Homes are designed for high-cost Medicaid beneficiaries with complex conditions and high service needs and focus on comprehensive care management and coordination, including reducing avoidable ED use. While the program is in its infancy, comprehensive care management and supports for the most expensive, high-need beneficiaries have great promise for reducing avoidable ED utilization.

Washington State has also implemented a global data-sharing tool, the Emergency Department Information Exchange (EDIE). This tool, used extensively in the emerging Health Homes but available for all high-utilizing patients, is an ED care coordination service that enables providers across the state to develop, implement, and share care coordination strategies. EDIE allows care coordination guidelines, including prescriptions and services, to follow patients to all points of care. The system helps providers, payers, hospitals, and Care Coordination Organizations address the needs of high-utilizing patients. EDIE also supports customizable alerts for EDs and primary care providers when high-utilizing patients seek care in an ED.

EDIE allows consistent, collaborative care across all providers a patient sees. This care coordination, which would not be possible without the data-sharing EDIE allows, in turn better manages patients' conditions, reducing ED utilization for ambulatory care-sensitive conditions.

Identify and Target High-Utilizing Members for Intervention

The University of Arizona Health Plan has implemented a multi-tiered system with different levels of intervention for members depending on the frequency with which they use the ED for inappropriate or avoidable conditions, culminating with intensive case management for the highest-utilizing members.

The program begins by identifying members who use the ED for non-emergent diagnoses and, through automated and interactive telephonic outreach, reconnects them with primary care providers. This technique of connecting the patient with a primary care provider who will best meet their needs is quite successful for many members. If a member is identified as having a second ED visit for a non-emergent diagnosis within three months of their first visit, a case manager works with the member to clarify and better meet their needs.

For members the health plan identifies as ED "super-users" a very intensive case management plan is implemented. For those members assigned to a Patient Center Medical Home (PCMH), the health plan notifies the PCMH that outreach is required. Members not assigned to a PCMH are connected with a Behavioral Health Case Manager to perform the outreach.

For the population dually eligible for Medicaid and Medicare, the health plan has instituted a Health Together Care Partnership team that consists of a physician, a nurse practitioner, a nurse, a social worker and a community care worker. While their scope is not limited to members with high ED use, the team has achieved dramatic decreases in ED utilization for the dually eligible population.

The escalating levels of intervention for members with avoidable ED use recognize that the needs of and care management strategies effective for one member are not the same as those for another.

Implement a Health Navigator Program

Gold Coast Health Plan, a Safety Net Health Plan that serves Medicaid beneficiaries in California's Ventura County, implemented a Health Navigator pilot program in May 2013 to reduce ED visits among its members. The program is based on the Promotora Model, a longstanding program in Hispanic and Latino societies that uses lay health workers who are members of the target population to engage with their neighbors and act as liaisons between the health care system and their communities.[10] In the Gold Coast Health Plan program, Health Navigators have experience serving as peer health educators and understand the health clinic system. With this knowledge, they can effectively engage their fellow community members.

The goal of the health plan's Health Navigator Program is to reduce ED visits for preventable conditions among the Medicaid beneficiaries served by Gold Coast Health Plan. After an ED visit by one of the plan's members, a Health Navigator contacts the member to help renew the connection to his or her primary care provider. Health Navigators assist members with appointment scheduling and other social service needs, and educate beneficiaries about the importance of establishing and maintaining a relationship with their primary care provider.

[10] "Community Health Workers Evidence-Based Models Toolbox." Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services. August 2011. http://www.hrsa.gov/ruralhealth/pdf/chwtoolkit.pdf

Health Navigators also supply information about providers and clinics with after-hours service and conduct community presentations about appropriate ED use. Because Gold Coast Health Plan Health navigators are immersed in the communities that are home to the plan's members, they can effectively communicate to members the importance of building a relationship with one's primary care doctor and establishing a medical home for future health concerns to avoid preventable ED utilization.

Implement a Streamlined and Integrated Care Model

The **University of Pittsburgh Medical Center (UPMC) Health Plan**, which includes the Safety Net Health Plan **UMPC *for You***, has implemented a comprehensive program to reduce ED utilization among its members. The strategy focuses on providers, members, and hospitals to deliver streamlined and integrated care to reduce ED utilization.

At the provider level, UPMC Health Plan facilitates the identification and sharing of best practices among providers to help members achieve the correct level of care, including expanded hours and open access pilots. The health plan also incorporates a practice based care manager into practices that serve patients with high volumes of ED utilization, and partners with providers to develop specialized tactics and care plans for such high-use members.

UPMC Health Plan has embraced data collection, sharing, and analysis to better coordinate care. The plan keeps real-time data on its members' ED and outpatient utilization, including risk of readmission. This data is utilized to identify behaviors associated with inappropriate ED utilization. This assessment allows identification of high risk members for outreach by Patient Centered Medical Homes and Federally Qualified Health Centers (FQHCs).

The plan works to identify and engage members who fall in high-risk groups. One tactic involves assessments for behavioral health issues, drug and alcohol use, and depression to identify behaviors that lead to inappropriate and preventable ED utilization. As a result of these screenings and other data-driven programs, the plan has increased member referrals to health coaching programs and worked to connect members to community-based resources in their area. One example of this is the Cultivating Health for Success program, a shelter and medical care program for homeless members that the plan offers in collaboration with the local HUD agency, an urban inner-city primary care practice, and Community Human Services, a housing support agency. This program, while new, has shown great promise for cost savings and improvements in care delivery and coordination.

UPMC also works with hospitals to better integrate behavioral health care into existing hospital programs and connect members to their primary care provider or a specialist if they need a follow-up visit after leaving the hospital. In one pilot program, a Mobile Outreach Specialist is located in the ED and is available for face-to-face interactions with members and hospital staff in order to facilitate follow-up appointments and linkage to community services.

This comprehensive set of approaches works in a coordinated manner to improve how the health plan and health system interact at a provider, hospital, and a patient level. Through a diverse set of tactics UPMC's ED utilization reduction program works to create a new model of care continuum, delivering more streamlined and integrated care for its members.

Support Care Transitions from Acute and Inpatient Care into the Community

AmeriHealth Caritas, a national leader in health care solutions for those most in need, has developed a multipronged approach to reduce emergency room (ER) visits, including targeted education and support for care transitions from acute and inpatient care to the community. Hospital and ER utilization is an issue that affects all patients, especially those with certain characteristics including low health literacy that are often found in Medicaid beneficiaries. Efforts to strengthen self-management skills and improve care transitions back into the community can help prevent avoidable ER and inpatient utilization.

At AmeriHealth Caritas, the process begins when a new member joins the health plan. Through an initial health risk survey, AmeriHealth Caritas identifies new members at risk for high ER utilization and educates them about alternative sources of care. The plan works to assure such alternative care options are available and accessible, and maintains a 24-hour nurse advice line. Additionally, AmeriHealth Caritas conducts proactive outreach to members at risk for avoidable ER visits, including culturally competent education sessions for the mothers of infants.

If a member has an ER visit or hospital inpatient admission, the health plan implements a number of strategies to support the individual in their transition back to the community. The plan helps the member schedule follow-up appointments with a primary care provider or specialist and verifies that the member has transportation available. The plan also arranges and coordinates skilled or unskilled home care follow-up if needed, facilitates medication reconciliation and coordinates delivery of medications by a community pharmacy.

AmeriHealth Caritas' efforts to provide proactive education and ensure a member's transition from the hospital to home following an acute or inpatient care episode aim to reduce preventable ER use through comprehensive, coordinated care, and by proactively addressing issues that may arise.

Conclusion

Reducing inappropriate and avoidable ED utilization is a steeper challenge than it would seem on the surface. However, Safety Net Health Plans have developed programs aimed at reducing avoidable ED visits tailored to the unique needs of their members and communities. These programs are rooted in greater access, improved care coordination, better helping members to effectively use their insurance benefits, and mining data to find predictive indicators of inappropriate or avoidable ED visits.

The challenge will only become more daunting as Safety Net Health Plans integrate new members who have gained coverage through Medicaid expansions and the health insurance Marketplaces. Many of these new members will be insured for the first time. This poses a significant challenge for plans, as many new enrollees will not understand how to access their benefits, but also provides plans the opportunity to improve the health of their new members.

Safety Net Health Plans will continue to work with providers, state policy makers, and their members to deliver high-quality, efficient care and reduce inappropriate and avoidable ED use. Their programs will evolve over time to reflect new information provided by ongoing program analysis and new insights into the health and social needs of their members, as well as the capabilities of the providers and hospitals with which the plans work.