colorado health INSTITUTE

Finding Consensus

Targeting Inappropriate Emergency Department Use in Colorado

APRIL 2016

Colorado health policy experts often point to reducing the use of unnecessary emergency department (ED) care as one way to address high health care expenditures and create more coordinated and streamlined care.

But the challenges to making this happen are complex.

The Colorado Health Institute (CHI) brought together a group of leading experts from insurance companies, hospital systems, nonprofit health plans, local health providers and academia on January 19 to discuss the problem, identify potential solutions and devise strategies to measure policy changes or other interventions.

Framing the Issue: Emergency Department (ED) Use in Colorado

ED use has emerged as a crucial health policy issue because cutting back on visits for nonemergencies supports the Triple Aim goals of reducing health expenditures, improving health care outcomes and increasing patient satisfaction.

One of five Coloradans (21.7 percent) visits the ED at least once annually, according to the 2015 Colorado Health Access Survey (CHAS).

Colorado actually does quite well compared with other states when it comes to ED use. Colorado has the 10th lowest volume of ED use, with 356 visits per 1,000 residents, compared with 423 visits per 1,000 people nationally.[1]

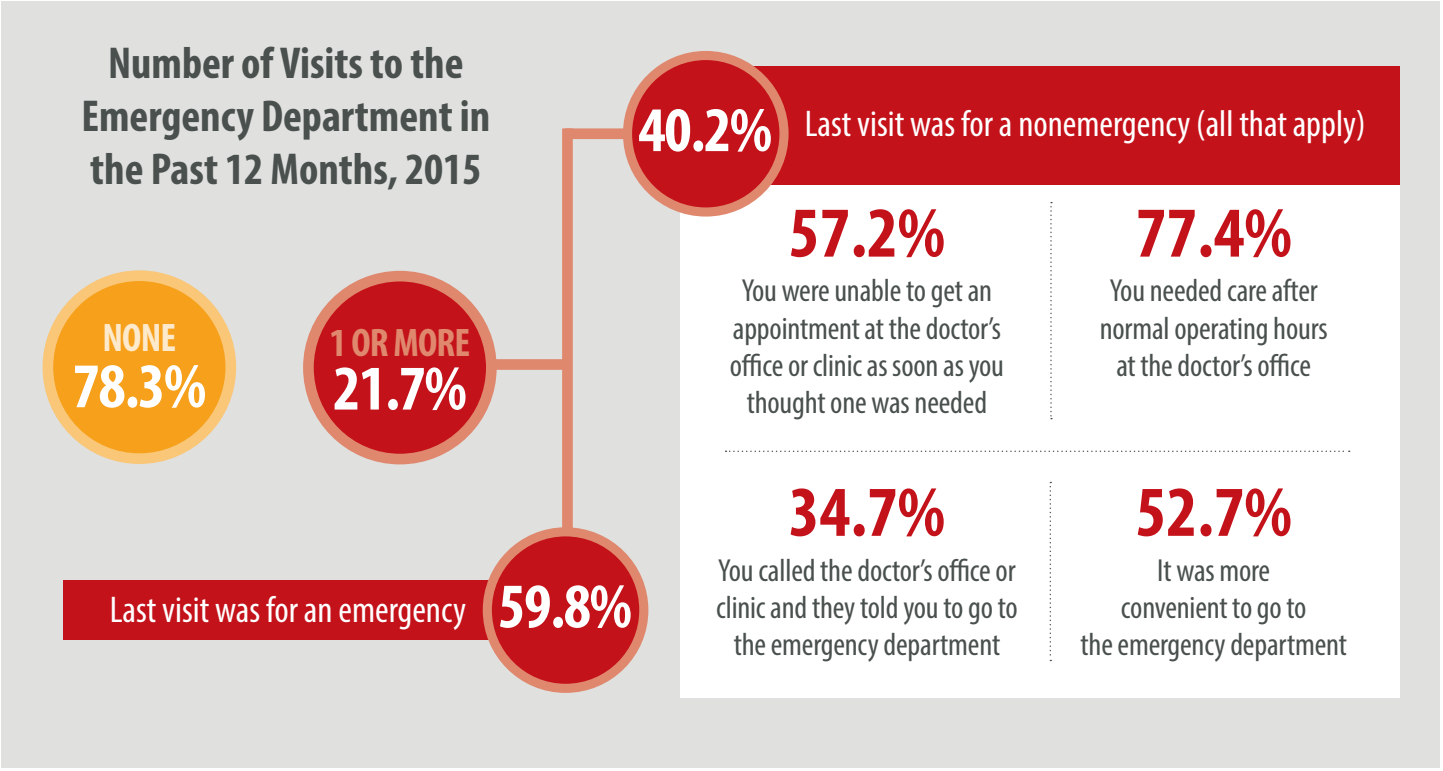
However, this overall standing masks important differences in ED use among populations within the state:

- While 21.7 percent of all Coloradans visited the ED in the past 12 months, the rate for Medicaid clients was 36.2 percent. That's more than double the rate of 17.0 percent for Coloradans with employer-sponsored insurance.

Panelists at the January 19 Discussion

- **Nancy Griffith**
  Director of Quality Improvement and Patient Safety
  Colorado Hospital Association
- **Janet Pogar**
  Regional Vice President
  Anthem Blue Cross and Blue Shield
- **Dr. Roberta Capp**
  Assistant Professor of Emergency Medicine
  University of Colorado School of Medicine
- **Gretchen McGinnis**
  Senior Vice President of Public Policy and Performance Improvement
  Colorado Access
- **Dr. Tracy Johnson**
  Director of Health Reform Initiatives
  Denver Health
- **Carol Bruce-Fritz**
  Chief Executive Officer
  Community Care of Central Colorado

Figure 1. Reasons for ED Use



- Of those who visited the ED, more than 40 percent say that they sought care for a nonemergency. (See Figure 1.)
- More than half of the people who went to the ED for a nonemergency said they did so for convenience.

Findings from the Panel: Five Themes

The discussion yielded many insights. CHI has organized them into five themes, detailing the panel discussion as well as opportunities for future analysis identified by panelists or audience members.

Theme 1: Medicaid Clients Have Few Reasons Not to Use the ED.

- What We Heard:
  - Gretchen McGinnis of Colorado Access, a nonprofit health plan and the operator of three of the seven Regional Care Collaborative Organizations (RCCOs) created by Colorado to care for Medicaid clients more efficiently, said there is no real disincentive to discourage ED use in the Medicaid benefit design. This is because Medicaid clients pay just $3 for non-emergency ED visits.
  - Many RCCOs are focusing on super-utilizers, Medicaid beneficiaries who often bounce from ED to ED for their health care. But McGinnis noted that these beneficiaries may require a lot of care management and may not be a population that can show much improvement in reducing total cost of care. "Many of these are folks that do not make significant changes or graduate from care management," she said.
- Opportunity for Further Analysis:
  - What are the subpopulations of ED users within the Medicaid population?
  - Would increasing cost-sharing for ED use among Medicaid beneficiaries discourage non-emergency ED use?
  - Are there policies that could be enacted to reward patients who call their primary care provider first before going to the ED?

Theme 2: Primary Care and Care Coordination Hold Promise in Reducing ED Use, But Take Time To Establish.

- What We Heard:
  - The panelists said nonemergency ED use often

is a symptom of health care system dysfunction. The ED is "filling the gap when people don't get what they need," said Dr. Roberta Capp, a physician and researcher.

- Connecting new patients to primary care takes time. It is common for the newly insured to experience a six-week wait to be connected to a primary care provider, said Janet Pogar of Anthem Blue Cross Blue Shield.

- Opportunity for Further Analysis:
  - Should preferred provider organization (PPO) plans, in which providers agree to provide services to members at a discounted fee, be required to connect all enrollees to an established primary care clinician?
  - Why and in what instances are Coloradans visiting the ED?
  - Are patients who reach out to the PCP first unable to get an appointment or are they being directed to the ED by their PCP?
  - How are new patients connected to care?
  - What has been the impact of patient-centered medical homes?

Theme 3: Consumer Education and Consumer Responsibility Are Key.

- What We Heard:
  - Health care literacy and health insurance literacy must be addressed. Carol Bruce Fritz, CEO of Community Care Central Colorado, which operates the Region 7 RCCO, said cultural norms sometimes point patients to the ED. Many people view the ED as the best place to "get good care and the latest technology," she said.
  - Health care providers want to engage in the work of reducing ED use because they are "very frustrated" by patients who bounce from one provider to another, said Dr. Tracy Johnson of Denver Health, the metro Denver region's primary safety net hospital.
- Opportunity for Further Analysis:
  - Can patient navigators, who steer patients through the care process and coach them on the appropriate place to get the care they need, play a bigger role in deterring nonemergency ED use?

Explaining EMTALA

EMTALA — the Emergency Medical Treatment and Labor Act — requires hospitals that offer emergency services to provide a medical screening examination or treatment for an emergency condition, regardless of whether the patient has the ability to pay. EMTALA requires that free-standing EDs that are affiliated with a hospital provide the same level of care as a traditional ED. Independent free-standing EDs, however, are not obligated to treat all patients and can redirect patients to other care settings.

Theme 4: The Proliferation of Freestanding EDs is Changing the Landscape.

- What We Heard:
  - The expansion of urgent care centers and free-standing EDs may be confusing patients. These facilities market their convenience, short wait times and walk-in availability as a contrast to primary care settings that require appointments and planning. It is important to understand patients' decision-making and how they choose where to seek care, said Nancy Griffith of the Colorado Hospital Association.
  - Most insurance companies and other payers believe they are legally required to compensate freestanding EDs for services to their enrollees, said Janet Pogar of Anthem.

- Opportunities for Further Analysis:
  - There is some interest among policymakers to require freestanding EDs to provide more information to potential users of their services. A bill introduced in the 2016 Colorado legislature would require freestanding EDs to have signs to differentiate them from urgent care centers. Other ideas include requiring freestanding EDs to explain the potential cost of services with patients prior to providing care.
  - Further analysis could monitor use of freestanding EDs and reasons why people seek care in these facilities. This analysis could measure the extent to which Coloradans are unknowingly seeking care in freestanding EDs when they believe they are in an urgent care setting.

Theme 5: The Economics of the ED Are Complex.

- What We Heard:
  - Reducing ED volume may not actually cut overall health care costs as much as anticipated because of the overhead expenses related to operating an ED.
  - Many hospitals have an inherent interest in keeping EDs running because they generate revenue and are typically profitable.
- Opportunities for Further Analysis:
  - Conduct a cost analysis to determine the financial implications of reducing ED volume.
  - Investigate the cost of treating patients with different types of insurance coverage in the ED.

Two research suggestions attracted a consensus from the group:

- A descriptive analysis of the status quo. This study would answer general questions such as who uses the ED and when and why they are most likely to go to the ED.
- An examination of discharge failures, which occur when a patient is readmitted to the ED within seven days of his or her last visit. Panelists agreed with Dr. Capp's assertion that readmissions within a week indicate that the system has failed to connect the patient with appropriate care.

End Notes

1 http://kff.org/other/state-indicator/emergency-room-visits-by-ownership/?state=co

The Colorado Health Institute is a trusted source of independent and objective health information, data and analysis for the state's health care leaders. The Colorado Health Institute is funded by the Caring for Colorado Foundation, Rose Community Foundation, The Colorado Trust and the Colorado Health Foundation.

303 E. 17th Ave., Suite 930, Denver, CO 80203 • 303.831.4200
coloradohealthinstitute.org