SoonerCare Choice ER Utilization Reduction Program

State Fiscal Year 2012

July 2011 – June 2012

This Presentation

- Brief description of the ER utilization reduction program
- Descriptive data from SFY 2012 about demographics, costs, visits, visit characteristics.
- Phase 1 of an ongoing formative evaluation of the SoonerCare Choice ER Reduction program.

This Presentation

- Present and briefly discuss findings regarding emergency room use and user characteristics from published literature.
- Briefly discuss plans for continuing efforts to refine and perfect OHCA ER program, which will be phase 2 of this ongoing formative evaluation of the ER reduction program.
- Interested in audience comments, questions, suggestions regarding phase 2.

Purpose of the ER Reduction Program

- To educate members on the appropriate use of visits to the emergency room.
- To educate providers on the emergency room visit history of their patients and to advocate for outreach to the patients.
- To insure the most efficient and effective use of SoonerCare funds.

ER Reduction Program

- Focus is on SoonerCare Choice members
- This is one of several OHCA programs that aim to increase quality of care and reduce unnecessary costs.
- SoonerCare Choice membership criteria
  - Qualify for SoonerCare (Oklahoma Medicaid)*
  - Do not qualify for Medicare
  - Do not reside in an institution
  - Not receiving SoonerCare services via home and community-based waiver program
  - Not in state or tribal custody
  - Not in a health maintenance organization
- ***Patient-Centered Medical Home***

* Membership criteria are found on the OHCA web site: http://www.okhca.org

Patient-Centered Medical Home Principles

- Patient care is:
  - Accessible
  - Continuous
  - Comprehensive
  - Family-Centered
  - Coordinated
  - Compassionate
  - Culturally Sensitive

Patient-Centered Medical Home*

- Three "Tiers"
  - Tier 1 – Entry-Level
  - Tier 2 - Advanced
  - Tier 3 – Optimal

* http://okhca.org/providers.aspx?id=8470&menu=74&parts=8482_10165&terms=medical%20home%20tier%201

Case Management

- Patient-Centered Medical Home is designed to provide case management at the provider level.
- Case Management is also a major theme in OHCA member programs.

Brief History of the ER Reduction Program

- In January of 2005, thanks to additional funding from the tobacco tax, the payment for emergency room (ER) visits was increased from a flat rate of $50 to the same payment rate for all other E & M codes.
- In July of 2004, prior to the expected increase in ER expenditures, the Oklahoma Health Care Authority (OHCA) designed and implemented a Quality Initiative (QI) program to encourage appropriate ER use.

Unnecessary ER Visits?

- EMTALA (Emergency Medical Treatment and Labor Act of 1986) basically guarantees treatment in an ER to anyone.
- ER treatment is more costly than treatment for the same condition by a PCP; one source estimates that an ER visit average cost is $1,316 versus $145 for an office visit.[1]
- Not all ER visits are true emergencies; estimates vary, but according to one study[2] 41.3% of ER visits were non-emergent, 33.5% emergent but treatable by PCP, 7.3% emergent but preventable had the PCP been visited, and only 17.9% were truly emergent.
- ER costs are rising[3].

Unnecessary ER Visits?

- Having and using a primary care provider results in better quality of care, especially if the patient is a member of a Patient-Centered Medical Home[4].
- HB2842 (2006) directed the Health Care Authority to continue its ER-related efforts.

ER Program Evolution

- Since the inception of the ER program in July of 2004, OHCA has pursued continuous quality improvement.
- There have been pilot projects and modifications over the years, but the basics have not changed.
  - Member intervention procedures
  - Provider intervention procedures
- The current version was revised April 2013.

Member Interventions

- 45 days after the end of a calendar year quarter, the MMIS claims warehouse is queried to identify members with 2, 3, 4 – 14, or 15 ER visits for that quarter.
- Restricted to members who had a PCP at the time of the visits & currently have a PCP.
- A letter which varies according to ER visit range (2, 3 & 4-14) is sent to each SC Choice member identified. The letter is stratified based on Adult - 21 and older and Child – 20 and younger.

Member Interventions

- Letter for the 4-14 group requests that member contact Member Services for education according to ER guidelines.
- The 2 & 3 visit letters are informational letters requiring no response.
- Appropriate members (depending on the reason for the ER visit) are referred to Care Management/Behavioral Health.

Persistent Member Interventions

- For members identified as persistent with **15 or more ER visits in a quarter.**
  - Attempts to contact member begin, and efforts are entered in a call tracking log.
  - Referred to be considered for pharmacy lock-in.
  - Member PCP information is researched & current PCP is contacted and case discussed.
  - Continued high utilization will be referred to legal for investigation.

- A letter is generated to the PCPs of all identified SoonerCare Choice members.
- The letter includes the ER date of service, facility, and first three diagnoses billed on the claim.
- Dedicated Provider Services Education Specialist responds to & documents all resulting PCP inquiries, in response to the letter, in Call Tracking.
- Identified appropriate members are referred to Care Management/Behavioral Health.
- In addition, hospital outreach is done as needed.

Provider Interventions Persistent Members *

- Dedicated Provider Services Education Specialist immediately conducts outreach calls to all persistent members' PCPs. Staff discuss the following with PCPs:
  - The ER reduction initiative by all departments involved: Care Management, Provider Services, Member Services, Health Management, and Behavioral Health.
  - The PCP's perspective of the member's ER usage and the utilization of the PCP's office.

* 15 or more ER visits in a quarter.

Provider Interventions Persistent Members

- The member's utilization of office hours, office visits and appointment history.
- The availability of urgent care office visits and protocol to obtain, i.e. triage nurse.
- Review member's chronic illnesses, pharmacy history, and specialty history.
- Educate PCP on resources, i.e. SoonerCare Choice training, Care Management referral form, Pharmacy Lock-in, Provider Services phone number and availability.

Provider Interventions Persistent Members

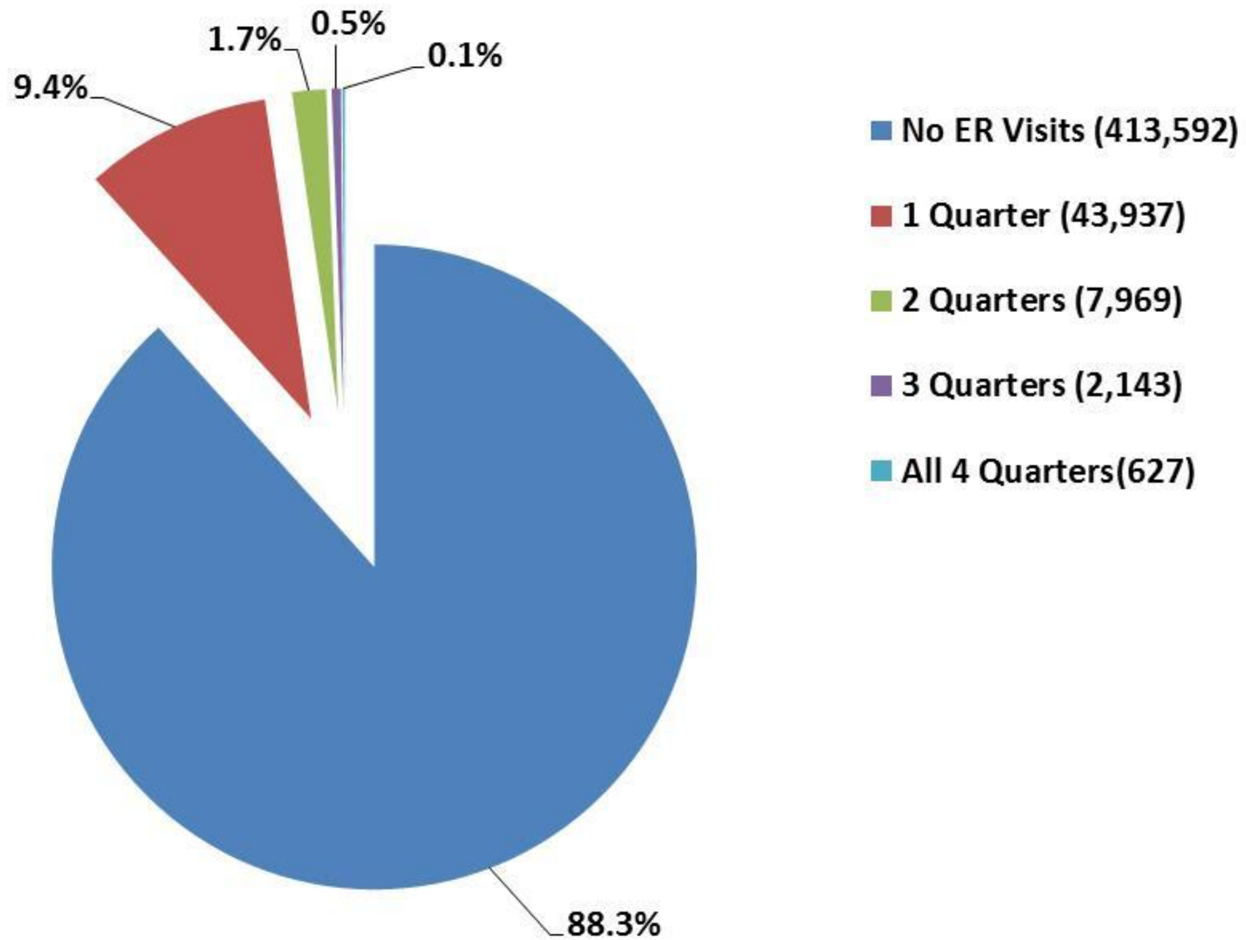
- Explain specialty referral protocol and assistance with available specialists.
- Review ER provider profile letter from Quality Assurance: stats, billing, and questions.
- Explain member outreach for education opportunity, refer to provider ER letter.
- Closing comments and suggestions from provider.

Data & Analyses

- MMIS claims data for SFY 2012 for the SoonerCare Choice ER reduction program extracted from the MMIS claims warehouse using Business Objects.
- ER visit data plus selected data for non-ER visits for the same members.
- Descriptive data developed using Microsoft Access and Excel.

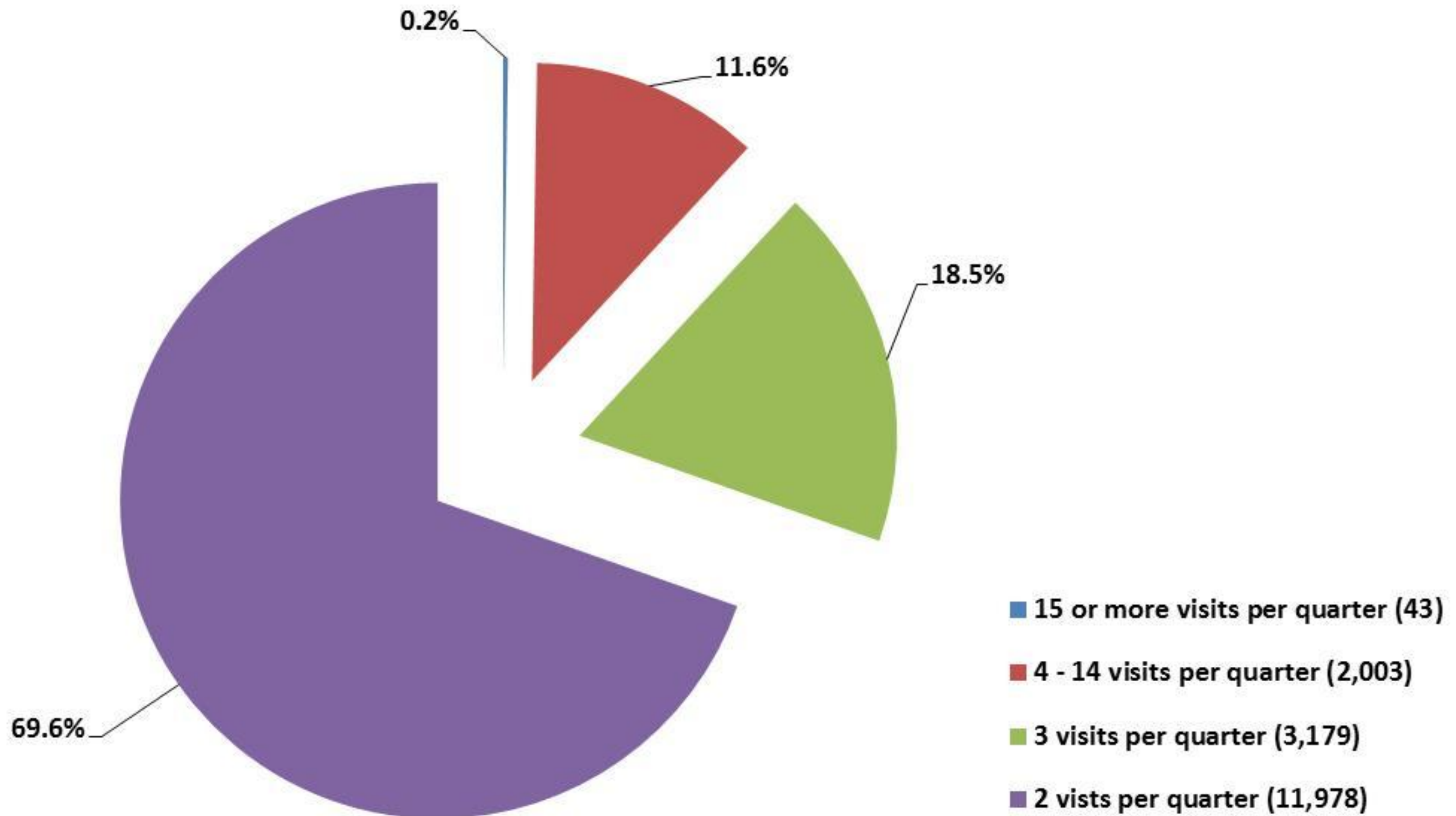
SFY 2012 Frequent ER Visitors

- The average SoonerCare Choice membership in SFY 2012 was 468,268.
- 413,592 of these members did not have 2 or more ER visits in any quarter in SFY 2012.
- A total of 54, 676 members had 2 or more ER visits in 1 or more quarters.
- 627 members were present in all 4 quarters.
- 2,143 members were present in 3 quarters.
- 7,969 members were present in 2 quarters.
- 43,937 members were present in only 1 quarter.


Average Frequent ER Visitors by Quarter SFY 2012
1.7%
0.5%
0.1%
9.4%
88.3%
No ER Visits (413,592)
1 Quarter (43,937)
2 Quarters (7,969)
3 Quarters (2,143)
All 4 Quarters(627)

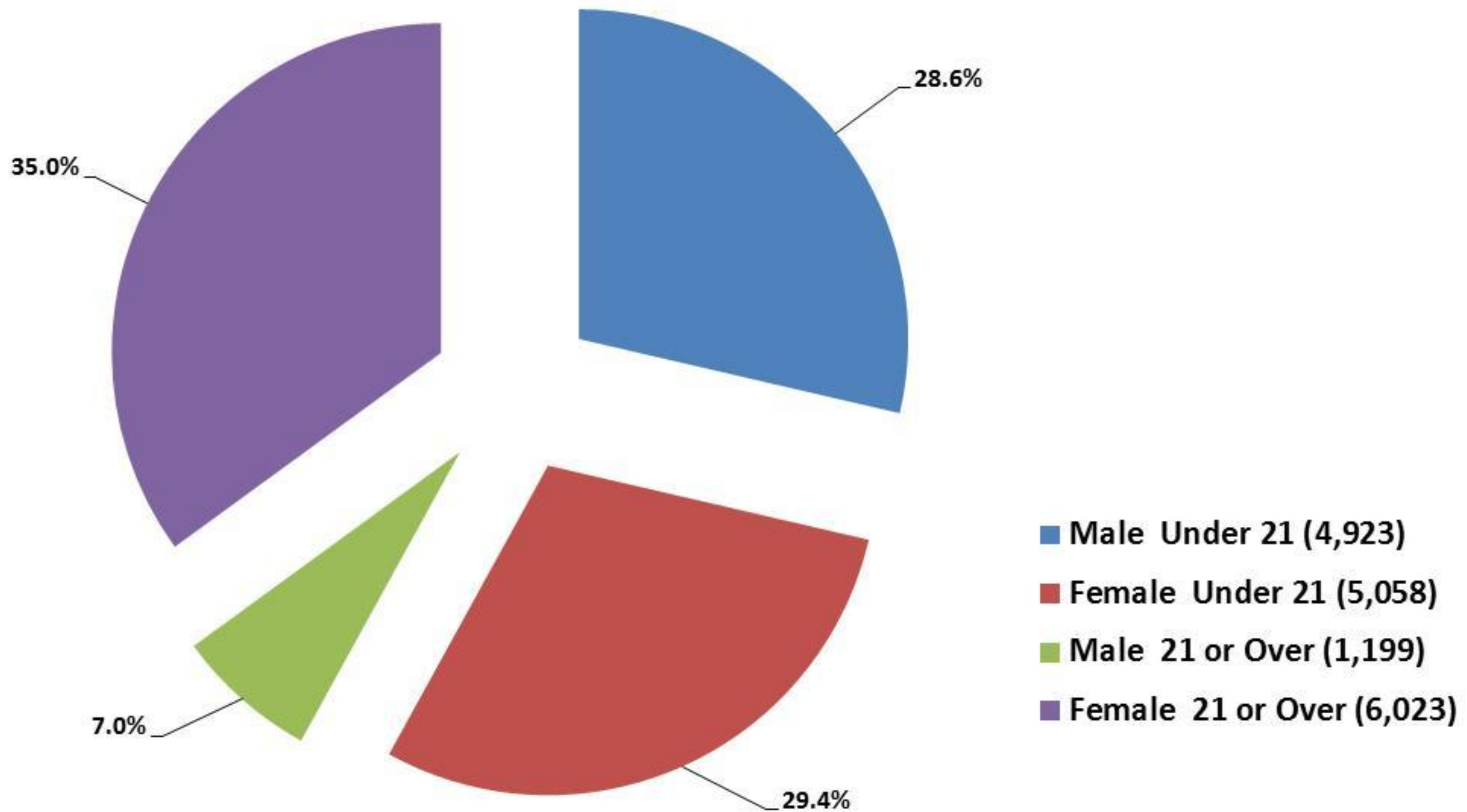
SFY 2012 Visits by Visit Count

- For all of SFY 2012 there was an average of 17,203 visits per quarter.
- The 2 visit average per quarter was 11,978
- The 3 visit average per quarter was 3,179
- The 4 – 14 visit average per quarter was 2,003
- And the 15 or more visit average per quarter was 43.


Average Quarterly Number & Percent of Members with 2 or More ER Visits
0.2%
11.6%
18.5%
69.6%
15 or more visits per quarter (43)
4 - 14 visits per quarter (2,003)
3 visits per quarter (3,179)
2 vists per quarter (11,978)

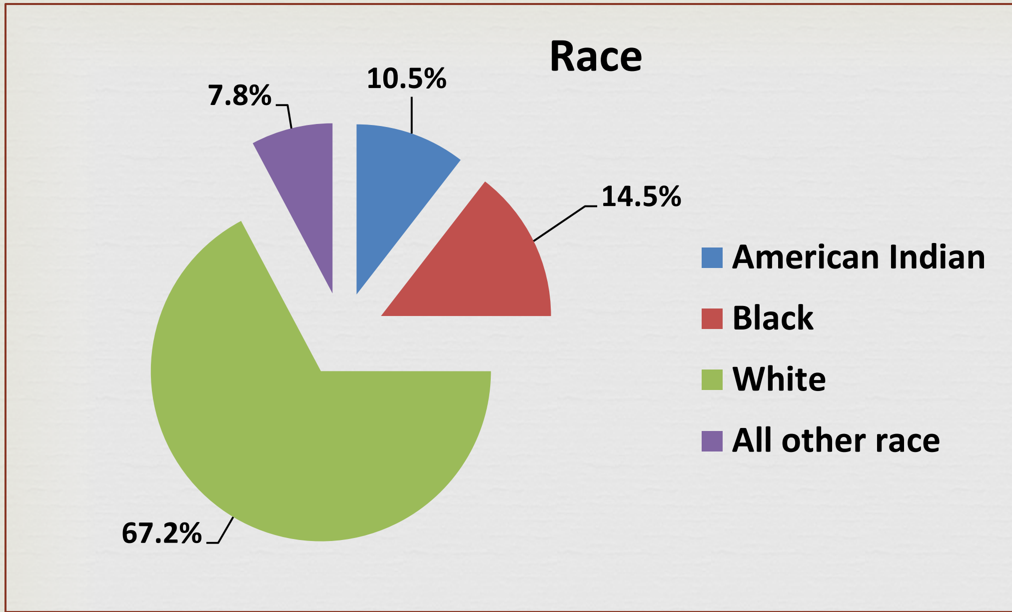
Demographics
Age & Sex

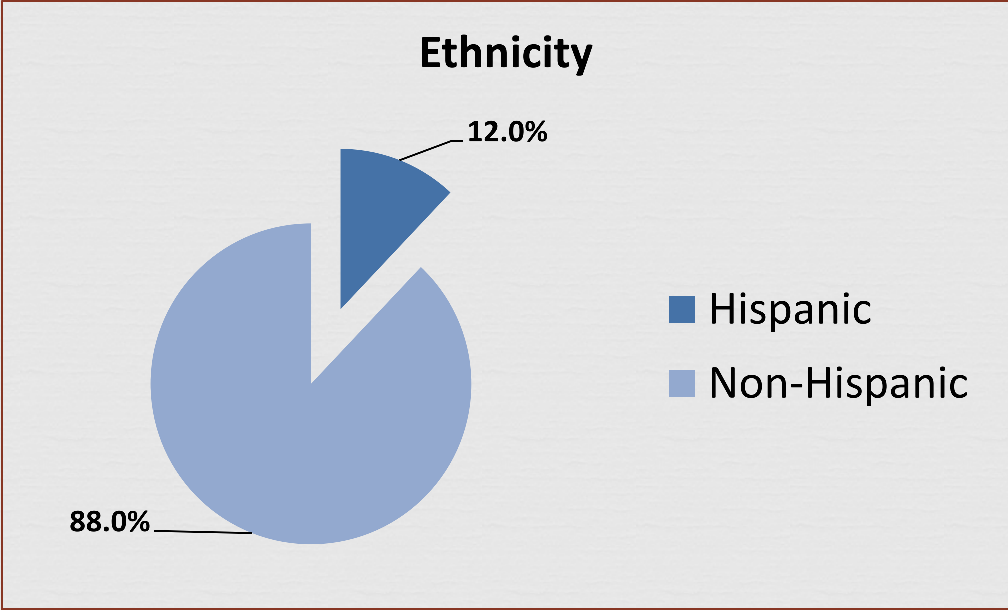
- As an average per quarter
  - There were 9,981 children under 21
    - 4,923 were Male
    - 5,058 were Female
  - There were 7,222 adults 21 and over
    - 1,199 were Male
    - 6,023 were Female


Average Quarterly Age & Sex Demographics
28.6%
35.0%
7.0%
29.4%
Male Under 21 (4,923)
Female Under 21 (5,058)
Male 21 or Over (1,199)
Female 21 or Over (6,023)

Demographics
Race & Ethnicity

- As an average by the quarter, persons describing themselves as:
  - White averaged 11,564
  - Black or African American averaged 2,498
  - American Indian averaged 1805
- As an average by the quarter, persons describing themselves as:
  - Hispanic averaged 2,068
  - Non-Hispanic averaged 15136


Race
10.5%
7.8%
14.5%
67.2%
American Indian
Black
White
All other race


Ethnicity
12.0%
88.0%
Hispanic
Non-Hispanic

SFY2012 High and Low ER Charges

	Q1	Q2	Q3	Q4
Total of All Visit Charges for the Quarter	$8,306,662.77	$8,445,688.73	$8,033,641.43	$9,099,483.63
Total number of Visit Total Charges (by ICN group) for the Quarter	43,298	43,641	45,402	46,305
Average Cost per Claim (by ICN group sum) for the Quarter	$191.85	$193.53	$176.94	$196.51
Smallest Visit Total Charge for the Quarter	$15.22	$14.01	$14.24	$4.12
Diagnosis Code associated with the Smallest Visit Total Charge	5990 - Urinary tract infection, site not specified.	30720 - Tic disorder, unspecified.	462 – Acute pharyngitis.	8748 – Open wound of other and unspecified parts of neck, without mention of complication.
Highest Visit Total Charge for the Quarter	$7,410.48	$7,049.81	$6,773.96	$7,218.45
Diagnosis Code Associated With the Highest Visit Total Charge	V5331 - Fitting and adjustment of cardiac pacemaker.	41401 - Coronary atherosclerosis of native coronary artery.	41401 - Coronary atherosclerosis of native coronary artery.	41401 - Coronary atherosclerosis of native coronary artery.

SFY2012 Frequent 1st Diagnoses

Diagnosis	Totals SFY 2012		Averages per Quarter SFY 2012	
	Visits	Dollars*	Visits	Dollars*
78900 - Abdominal pain, unspecified site	4638	$1,272,933.19	1159.5	$318,233.30
5990 - Urinary tract infection, site not specified	3757	$848,028.24	939.25	$212,007.06
78650 - Chest pain, unspecified	1867	$755,498.76	466.75	$188,874.69
7840 - Headache	3262	$745,396.15	815.5	$186,349.04
78659 - Other chest pain	1656	$694,778.23	414	$173,694.56
3829 - Unspecified otitis media	7373	$773,344.03	1843.25	$193,336.01
4659 - Acute upper respiratory infections of unspecified site	7868	$910,806.55	1967	$227,701.64
78909 - Abdominal pain, other specified site	1664	$471,080.83	416	$117,770.21
4660 - Acute bronchitis	1741	$358,867.77	435.25	$89,716.94
78060 - Fever, unspecified	3455	$524,579.46	863.75	$131,144.87
64893 - Other current conditions classifiable elsewhere of the mother, antepartum condition or complication	2634	$555,732.13	658.5	$138,933.03
462 - Acute pharyngitis	4106	$474,398.46	1026.5	$118,599.62
34690 - Migraine, unspecified, without mention of intractablemigraine without mention of status migrainosus	1934	$396,385.88	483.5	$99,096.47
5589 - Other and unspecified noninfectious gastroenteritis and colitis	1953	$386,372.93	488.25	$96,593.23
49392 - Asthma, unspecified type, with (acute) exacerbation	2212	$431,977.85	553	$107,994.46
78703 - Vomiting alone	2166	$370,322.70	541.5	$92,580.68
78701 - Nausea with vomiting	1487	$309,720.09	371.75	$77,430.02

* The dollar value depicted is the sum of all charges for that visit where the diagnosis was as shown.

Evaluation & Management

- Evaluation and management (E&M) codes reflect the complexity of the treatment needed from the simplest (99281) to the most complex (99285).
- The following reflects the pattern and costs of E&M coding for SFY 2012.

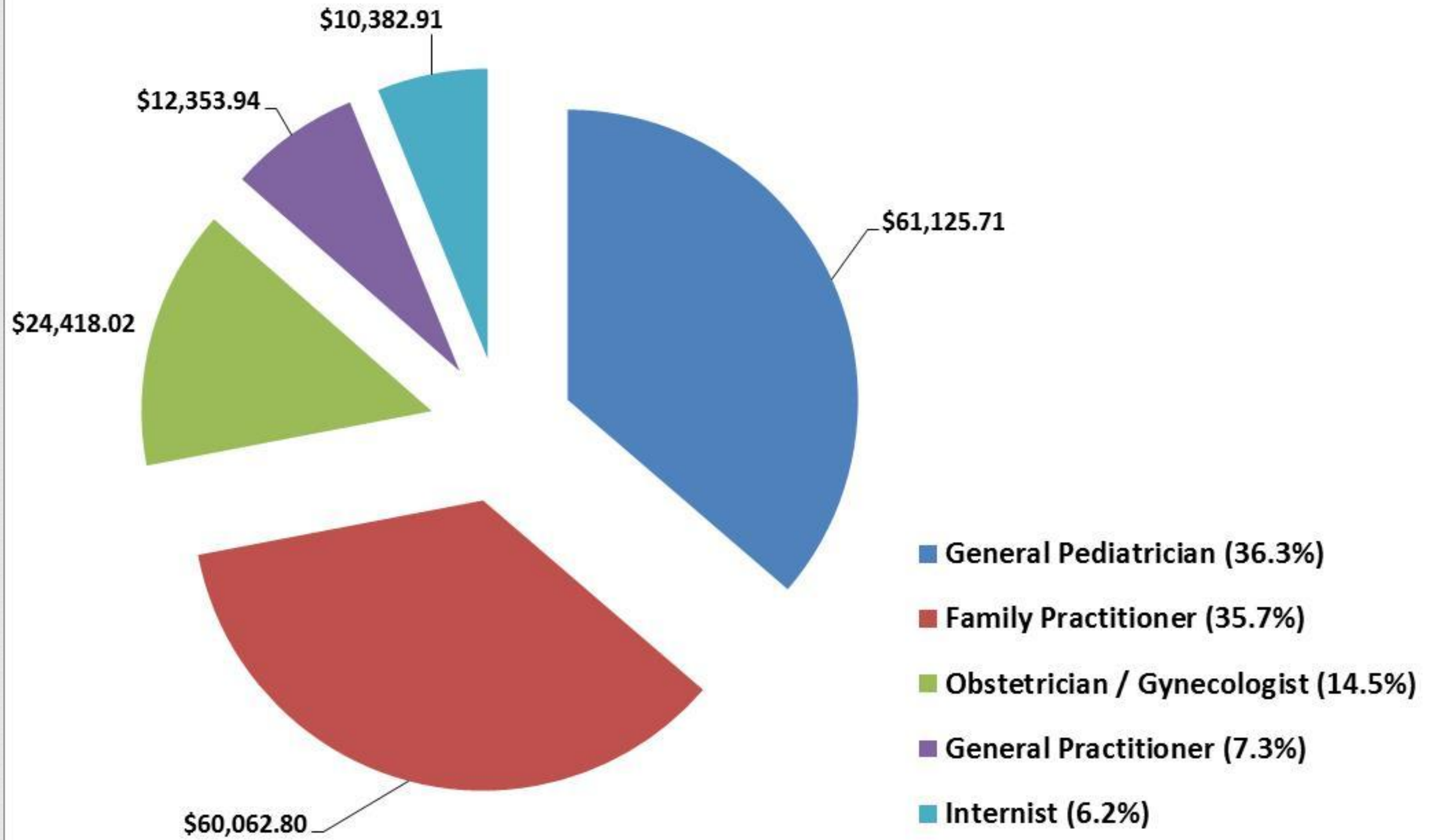
E & M Code	Visits	Reimbursements
99281	8,620	$384,099.03
99282	46,418	$3,451,717.44
99283	79,006	$9,435,142.34
99284	34,232	$6,480,430.49
99285	9,941	$2,783,120.48

Some Observations from the Published Literature

- A small percentage of frequent ER users account for a large percent of ER visits[5,6]
  - They tend to be chronically ill, either physically or mentally or both
  - They tend to use not just the ER, but also considerable other healthcare benefits and services.

Non-ER Physician Claims – Top 5

Top 5 SFY 2012 Physician Specialty	Total Claims SFY 2012	Total Cost SFY 2012	Average Claims per Quarter	Average Cost per Quarter
345 - General Pediatrician	9322	$244,502.82	2330.5	$61,125.71
316 - Family Practitioner	12161	$240,251.20	3040.25	$60,062.80
328 - Obstetrician/Gynecologist	413	$97,672.09	103.25	$24,418.02
318 - General Practitioner	1879	$49,415.74	469.75	$12,353.94
322 - Internist	1327	$41,531.65	331.75	$10,382.91


Top 5 Average Quarterly Non-ER Charges
$10,382.91
$12,353.94
$61,125.71
$24,418.02
$60,062.80
General Pediatrician (36.3%)
Family Practitioner (35.7%)
Obstetrician / Gynecologist (14.5%)
General Practitioner (7.3%)
Internist (6.2%)

More Observations from the Published Literature

- We do not as yet have standard widely-accepted definitions or clear-cut descriptions [6,7]
  - What constitutes "frequent use"
  - Subgroups
    - Demographics
    - Degree and type of illnesses
    - Access to other medical care
    - Utilization patterns
  - This makes it difficult to collate research and reach conclusions.

More Observations from the Published Literature

- Case management seems to be the most prevalent approach to limiting inappropriate ER use, and it also appears to be the most effective[8].
- Case management is a major part of OHCA programs.

Future Plans

- The Health Care Authority and the Primary Care Health Policy Division of the University of Oklahoma Health Sciences Center Department of Family Medicine are working together to determine the various reasons for unnecessary ER visits and to design cost-effective and efficient programs to reduce unnecessary ER visits.

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