

Emergency Department Use Associated With Primary Care Office Management

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Emergency department (ED) use as a substitute for primary care physician (PCP) acute minor episodic care has been an ongoing topic of interest in healthcare.^{1,2} One study that explored non-urgent visits to a pediatric emergency department demonstrated that 62.8% of visits were for parental convenience, and of the 45.4% of parents who did contact their PCP first, 72.6% were referred to the ED.³ Additionally, perceptions of PCP unavailability appear to be a reason why some patients do not attempt to contact their PCP prior to an ED visit. Another study also focused on pediatric emergency care revealed that ED visits for non-urgent conditions were *not* perceived as a significant enough breach in continuity of care by either PCPs or parents to warrant any concern, and discrepancies exist between PCP and parental perceptions of adequate PCP communication and access.⁴ Increased ED use is not solely due to the uninsured or those without a PCP, as is often perceived, and thus PCP office access affects everyone.⁵ When a problem is identified, our society tends to look for solutions involving innovative complex systems or expensive technology. Awards are not given for revisiting past, less technology-based solutions. The goal of this study is to demonstrate whether revisiting and focusing on simple PCP office management practices, and performing them well, has a meaningful impact on ED utilization for conditions that could have been treated in the PCP office setting.

Setting

The Greater Detroit Area Health Council (GDAHC)⁶ is a multi-stakeholder organization with the mission of driving collaborative improvements in healthcare quality, cost-effectiveness, and access to care across southeastern Michigan. GDAHC convened a multi-stakeholder team (payers, purchasers, consumers, and providers) to address ED utilization. An outcome of team deliberations was a goal of reducing ED visits for conditions when care likely could have been provided in the PCP office (PCP-treatable conditions) with interventions for improving PCP access.

Blue Care Network of Michigan (BCN) is a nonprofit, statewide health maintenance organization and wholly owned subsidiary of Blue Cross Blue Shield of Michigan (BCBSM). This study used BCN administrative data for commercial members only. The study time frame included the years

2007 to 2010, during which time total BCN commercial membership averaged about 500,000. BCN PCPs are charged with coordinating overall care for BCN members

Objectives: The goal of this pilot study is to demonstrate whether revisiting and focusing on simple and generally known primary care office management practices has a meaningful impact on emergency department (ED) utilization for conditions that likely could have been treated in the primary care office setting (primary care physician [PCP] treatable).

Study Design: Cohort study using health plan administrative data from 2007 to 2010 involving primary care physicians (PCPs) affiliated with both Blue Care Network of Michigan, a nonprofit health maintenance organization, and Oakland Southfield Physicians PC, a Metropolitan Detroit independent practice association. PCPs were assigned to cohorts according to pre-intervention increasing or decreasing temporal trends in annual ED visit rates for PCP-treatable conditions by 12-month continuously enrolled commercial members with the same emergency care copay.

Methods: A difference-in-difference approach measuring control and intervention PCPs for the same 4 months (September-December) during 3 years (2007-2009) pre-intervention, and the available same 4-month period post-intervention, to determine if the pilot was associated with decreased ED utilization for PCP-treatable conditions.

Results: A substantive reversal of a worsening 2007 to 2009 trend (peak of 49.2 visits per 1000 in 2009 decreased to 7.3 visits/1000 in 2010) in ED use for PCP-treatable conditions at intervention sites, with the 2010 rate also lower than control sites (23.8 visits per 1000) during the same post-intervention period.

Conclusions: Simple and effective practice management techniques, while generally known, require revisiting and focused attention by PCPs to limit rates of PCP-treatable ED visits.

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Take-Away Points

- There exist simple and largely known primary care office management techniques that may limit emergency department visits for conditions generally treatable in the primary care office setting.
- These techniques are not necessarily well understood or implemented properly by all primary care physicians (PCPs), and should be revisited.
- Clear direction, support, and follow-up from a larger organization with which a PCP is affiliated (eg, independent practice association [IPA] or accountable care organization [ACO]) may be necessary to achieve more consistent and effective use of these techniques within primary care practices.

and are generally affiliated with a primary care group (PCG). PCGs are not physician practice groups, but rather each PCG is a business entity composed of 1 or more physician practices and functions essentially like an independent practice association (IPA). The PCP practices belonging to a PCG may consist of physicians who are salaried, independent, or a mixture. Generally, each PCP (as opposed to the practice the PCP may belong to) has an individual contract with the PCG with which he or she is affiliated. PCGs vary as to the comprehensiveness and sophistication of their administrative structures in support of the financial goals of the PCG, and in their risk-sharing arrangements both with BCN and with their PCPs. Oakland Southfield Physicians PC (OSP) is an IPA that operates in Metropolitan Detroit and participates with BCN as a PCG. It consists of approximately 300 primary care physicians. OSP management (both physician and non-clinical) participated on the GDAHC multi-stakeholder team.

BCN and OSP collaborated on a pilot program to study implementation of the GDAHC team's recommendations for improving PCP access. These recommendations include adopting telephone triage processes and recorded messages that direct patients to the appropriate venue for care; establishing a strategy on how patients can obtain acute minor episodic care when the PCP is unavailable and communicating that strategy to patients; and implementing a scheduling strategy (eg, open-access scheduling) to support same- or next-day appointments including evenings and weekends. Pilot program activities included education of all intervention PCP offices on the initiative and sharing of program materials. Materials were customizable to specific offices (ie, new patient welcome letter and current patient brochure on use of the ED) and also included office procedures for access to care (ie, telephone triage, appointment scheduling, and patient follow-up after a known ED visit). A sample after-hours telephone script was provided, as well as recommendations on how to use the OSP monthly ED visit reports (supplied to OSP by major payers in the area using paid claims data). The launch date of all program tools was tracked and OSP engaged in structured communication with the intervention practice sites at frequent, established inter-

vals to support implementation of the program's recommendations and tools.

A summary of the OSP intervention site communication program is contained in **Table 1**. The sample materials, to be edited as appropriate for the actual circumstances of a specific practice, were provided to each intervention site and are contained within the **Appendix**.

METHODS

Defining PCP-Treatable Conditions

Different methods for identifying PCP-treatable conditions were evaluated and consensus reached by the GDAHC team, which included representation from primary care, emergency physicians, a major hospital system, and health plans. The final method was also shared with the GDAHC Data Users Group and adopted as part of its future plans for regional surveillance of ED use in the GDAHC service area.

The method chosen was a list of 1231 *International Classification of Diseases, Ninth Revision (ICD-9)* diagnosis codes compiled by BCN and used for various analyses and reports. The diagnosis codes used represent the primary *ICD-9* code on an emergency visit claim. Secondary, tertiary, etc, diagnosis codes that may (or may not) be present on a claim were not used to construct the list. The list contained elements of prior lists used by BCBSM and the list of codes contained within the Billings New York University algorithm, updated by using an Agency for Healthcare Research and Quality *ICD-9* diagnosis category grouper to aid in the process.^{7,8} Obstetric *ICD-9* codes were excluded, as were any codes not at least 50% of the time also present in BCN PCP office encounter data from a 12-month sample of PCP and emergency claims.

Behavioral health *ICD-9* codes were also excluded. Emergency department presentation of behavioral health issues falls into 2 main categories: overt and covert. Overt presentations include diagnoses such as suicide attempt or ideation, psychosis, drug overdose, and alcohol intoxication. Covert presentations include potentially serious physical complaints with a psychological root cause that may or may not reveal itself during the clinical encounter (eg, chest pain in a depressed person to gain attention from family, anxiety presenting as chest pain). While the overt presentations might be considered by some to be PCP preventable (perhaps ED visit avoidable had the PCP better managed a patient's substance abuse and/or psychological condition), such visits are not PCP office treatable, as the situation has escalated to a more severe manifestation making the emergency department the appropriate venue for evaluation. Patients with covert behav-

■ Table 1. Guide to Structured Communications by IPA With Primary Care Offices

New Patient Welcome Materials

Need to have a welcome letter or brochure that includes:

- Physician availability and office hours
- Instructions for what to do for urgent matters when the office is closed

Consider keeping copies around the office, including exam rooms, checkout window, and patient waiting area

Conversations

New patients get welcome letter/brochure

- Important to have regular, ongoing conversations with existing patients to reinforce/remind them of access information

Consider picking a week and making sure each patient seen during that week has a conversation with a staff member about this topic

Suggest patients add the practice's phone number to their cell phone contacts

Access to Care Policy

Needs to be in writing and approved by the physician

Hold staff meeting to review it together and make sure all staff are on the same page

Be sure it includes:

- How quickly will the phone be answered
- Handling clinical advice for patients
- Handling post-emergency department/urgent care visit notifications
- If there are too many to follow up on all, pick a disease and focus on those

After-Hours Telephone Script

Tone of voice matters: use a calm, relaxed, inviting tone

Start out explaining that a physician is always available if the patient cannot wait until the office opens

Be sure to include:

- How the physician is available
- What to do after regular hours

If the script must instruct patients to call 911 or go to the nearest emergency department, consider making this the last piece of information

General Points

Have frequent reminders and touch points

Build on your established and trusting relationship with the practice

IPA indicates independent practice association.

ioral health presentations would be less amenable to the PCP access maneuvers described in this pilot, as seeing their PCP may deprive them of the desired psychosocial dynamic that is part of the spectacle of emergency care itself (eg, ambulance transport). Anecdotally, PCPs express that they have little influence in regard to such covert emergency visits and holding them accountable for such visits is unfair. Therefore, behavioral health diagnosis codes were originally excluded to increase provider acceptance of the code list in regard to BCN reporting in general, and remained excluded for the purposes of this pilot program to eliminate the possibility of introducing any bias or detracting from acceptance of this analysis.

The list was edited by BCN staff, which included general emergency medicine, pediatric emergency medicine, inter-

nal medicine, and family physicians. The final list consists of ICD-9 diagnosis codes considered more likely than not for conditions that could be treated in the PCP office setting. The purpose of this type of tool is not for denying claims or making declarations about the appropriateness of a specific ED visit, but rather to follow trends in a population (eg, health plan, PCG- or PCP-affiliated members).

PCP Cohort Assignment and Composition

OSP PCPs were identified who had more than 100 BCN 12-month continuously enrolled commercial members in each of the 3 years from 2007 to 2009 to establish PCP “engagement” with BCN and OSP in general, with this threshold based on prior published BCN research.⁹ Engagement is

important to ensure that a PCP has a sufficient number of patients under a specific contractual arrangement to have interest in any associated initiatives or programs. Next, to compare “apples to apples,” members with the same benefit design in regard to an emergency care copay for all 12 months in any given year were identified. A member did not need to have the same benefit design or be a BCN member for all 3 years, but did need to be a BCN member with the same benefit design for all 12 months of any given year. A \$50 copay was the most prevalent in 2007 and 2008 for OSP-affiliated BCN members, and the second-most prevalent in 2009. The \$50 emergency copay members, of which 99.96% were also with the same PCP for 12 months of any given year, were linked to the OSP PCPs who met the overall engagement criterion. The engaged PCPs were required to have at least 30 such BCN members in each year (2007-2009) to be further considered for entry into either the intervention or control cohort. The count of BCN members who met criteria for study inclusion, by PCP, was used for rate calculations and the 30-member minimum reduces extreme results due to small denominators while leaving sufficient PCPs to evaluate for inclusion in the pilot.

ED visits for PCP-treatable conditions, as defined by the BCN ICD-9 code list, were tallied for \$50 copay members affiliated with BCN/OSP-engaged PCPs who also had at least 30 of the OSP-specific member subset in their BCN patient panel. These counts were then used to calculate ED visit rates, by year, for OSP PCPs that accounted for BCN/OSP engagement and member benefit design. The rates were then trended over 3 years to identify OSP PCPs with ED visit rates that were consistently worsening (yearly increase in utilization), consistently improving (yearly decrease in utilization), or that showed no consistent trend. In conjunction with OSP management, a demographically representative sample of PCPs was selected with a worsening trend for the intervention cohort, and PCPs with an improving or no trend as controls. GDAHC pilot program activities would not be implemented for an identified PCP alone if in a group practice, but rather for the entire office. Therefore, the initially identified intervention and control PCPs were labeled as index physicians and any other PCPs in an index physician’s practice were identified and included in the same cohort regardless of the ED utilization associated with the index PCP’s partner(s).

A total of 26 PCPs were included in the pilot, 15 at 6 practice sites as controls and 11 at 5 practice sites for program interventions. The specialty (as per BCN credential files) distribution of control PCPs was 8 family practice, 2 internal medicine, and 5 pediatric physicians. The intervention cohort consisted of 4 family practice, 1 internal medicine, and 6 pediatric physicians. Self-reported practice environment for the intervention cohort was 3 in urban and 8 in suburban lo-

cations, and controls were 4 urban and 11 suburban. One control and 2 intervention PCPs were in solo practice. By design, all 11 intervention physicians had an index PCP association with a worsening trend in ED use for PCP-treatable conditions; among controls, 12 had an index PCP association with an improving trend and 3 with no consistent trend.

Prior to this pilot some PCP sites were designated as BCBSM Patient Centered Medical Homes (PCMHs) and participated in the BCBSM Physician Group Incentive Program (PGIP). PCMH participation meant an office had a PCMH welcome letter with an access to care statement and had written a PCMH access to care policy, as defined by the PCMH program. Participants had a PCMH “start date” and these practices would have been integrating PCMH operational procedures prior to that date. PCPs within OSP specifically did not receive extra PGIP financial incentives in regard to ED utilization; therefore no differing financial incentive for OSP PCMH sites versus OSP non-PCMH sites existed. Of the 15 control PCPs, 6 (40%) had a PCMH start date of July 2009 and 4 (27%) July 2010. In regard to intervention PCPs, 4 (36%) had a PCMH start date of July 2009 and 3 (27%) July 2010.

Timeline

OSP PCP control and intervention practice identification, pre-implementation survey data collection, and intervention material creation were completed from June to July 2010. Survey data, which included PCP practice information, current office processes, and opinions, were collected by OSP management via telephonic interview. During August 2010 OSP introduced program materials to the intervention offices and tracked when specific program items were implemented. Intervention practices began utilizing program materials September 2010. Following 4 months (through December 31, 2010) and an additional 60 days for claims run-out (lag period to allow for submission of claims from providers), 2010 claims data were extracted and only the intervention practices resurveyed. PCP-treatable ED utilization from pre- and post-implementation was assessed for intervention PCPs, and compared with control PCPs, to determine if there were any substantive changes.

OUTCOMES

Pre-intervention Survey of All Practices

All study practices in control and intervention cohorts responded “yes” to the survey questions of: office staff utilizes a formal telephone triage process during office hours to evaluate if a patient has an acute clinical problem and to evaluate call urgency; after-hours calls are screened by an answering service

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Table 2. Pre-implementation Survey Results (Intervention and Control Practice Sites)

Survey Question	Question Type	Control (n = 15)	Intervention (n = 11)	Control Percent	Intervention Percent
Which best describes how external calls are managed during regular practice hours?	2 Options ^a	8	6	53.3%	54.5%
Does your office staff utilize a formal phone triage process during office hours to evaluate if the patient has an acute clinical problem?	Yes/No ^b	15	11	100.0%	100.0%
Does your office staff utilize a formal phone triage process during office hours to evaluate the urgency of the call?	Yes/No	15	11	100.0%	100.0%
Which best describes how after-hours calls are handled in your practice?	4 Options ^c	15	11	100.0%	100.0%
Do you have same-day or next-day appointments available in your office?	Yes/No	15	11	100.0%	100.0%
How are same-day or next-day appointments scheduled?	2 Options ^d	15	11	100.0%	100.0%
When a new patient first engages with your practice, does your office provide the name(s) of preferred urgent care center(s) in your area for minor episodic care when immediate care is deemed necessary by the patient but not available through your office?	Yes/No	14	7	93.3%	63.6%
When a new patient first engages with your practice, does your office provide instructions on the appropriate use of the emergency department?	Yes/No	12	7	80.0%	63.6%
Do you routinely use an electronic medical record?	Yes/No	8	0	53.3%	0.0%
Do you routinely use e-mail to interact with your patients?	Yes/No	6	0	40.0%	0.0%
Do you feel that your patients are likely to use the emergency department for non-emergency primary care treatable conditions, because your office is closed?	Yes/No	13	8	86.7%	72.7%
Do you feel that your patients are likely to use the emergency department for non-emergency primary care treatable conditions because they cannot schedule an office visit in the time frame they are seeking?	Yes/No	0	3	0.0%	27.3%

^aCount of responses to option: "Caller navigates a phone tree, such as an interactive voice response system or push-button system."
[Alternative response option: "Calls are answered directly by staff."]
^bFor yes/no questions, count of "yes" responses.
^cCount of responses to option: "Patient calls are screened by an answering service prior to speaking to a physician."
[Alternative response options: "Patient contacts you or a covering physician directly (direct dial number provided on answering machine)"; "A nurse answers the call and advises the patient on the physician's behalf"; "Patient receives a recorded message to go to the nearest emergency department if it is an emergency, or to call back during office hours if the caller does not feel it is an urgent or life threatening matter."]
^dCount of responses to option: "Practice offers 'open-access' scheduling."
[Alternative response option: "Non-scheduled slots are limited."]

before allowing a connection to a physician; same- or next-day appointments available; and practice offers "open-access" scheduling. Nearly all (93%) of control and a preponderance (64%) of intervention sites provided new patients with the name of a preferred urgent care center(s) for acute minor episodic care when immediate care was deemed necessary by the patient but not available from the PCP. A preponderance of both control (80%) and intervention (64%) practices also provided new patients with instructions on the appropriate use of the ED. Most control (87%) and intervention (73%) sites felt their patients were likely to use the ED for PCP-treatable conditions because the office was closed. None of

the control sites felt their patients were likely to use the ED because they could not schedule an office visit promptly, while a minority (27%) of intervention sites were of that opinion. E-mail was used to communicate with patients at 40% of control practices and at none of the intervention sites. Details are provided in **Table 2**.

Post-intervention Survey of Intervention Practices Only

All intervention sites made no change in regard to handling calls during regular business hours. A total of 27% changed how after-hours calls were handled, and 18% made

■ **Table 3.** Post-implementation Survey Results (Intervention Practice Sites Only)

Survey Question	Question Type	Intervention (n = 11)	Intervention Percent
Is your office staff still instituting a formal phone triage process during office hours to evaluate the urgency of a call?	Yes/No ^a	11	100.0%
Is a formal phone triage still in place during office hours to evaluate any signs or symptoms that prompted the patient to call, and with appropriate follow-up actions?	Yes/No	11	100.0%
Has a change occurred in after-hours calls and how they are handled in your practice?	Yes/No	3	27.3%
Did the office modify or change the availability of same-day or next-day appointments based upon the access to care policy?	Yes/No	2	18.2%
Did your office modify or change how same-day or next-day appointments are scheduled based upon the access to care policy?	Yes/No	2	18.2%
When a new/established patient engages with your practice, has your office been providing the patient welcome letter or brochure?	Yes/No	8	72.7%
Have you implemented an electronic medical record in the last 6 months?	Yes/No	1	9.1%
Has your office started using e-mail to interact with your patients?	Yes/No	0	0.0%
Given use of the tool kit (access to care policy, welcome letter, etc) do you feel that your patients are less likely to use the emergency department for non-emergency primary care–treatable conditions because your office is closed?	Yes/No	11	100.0%
Given use of the tool kit (access to care policy, welcome letter, etc) do you feel that your patients are less likely to use the emergency department for non-emergency primary care–treatable conditions because they cannot schedule an office visit in the time frame they are seeking?	Yes/No	11	100.0%
Do you believe that providing a follow-up letter or a phone call after an ED visit helped reduce patients' use of the emergency departments for non-emergency, primary care–treatable conditions?	Yes/No	8	72.7%
Overall, was the pilot a positive experience for your practice?	Yes/No	8	72.7%

^aFor yes/no questions, count of “yes” responses.
ED indicates emergency department.

changes in availability and scheduling of same- or next-day appointments. After the pilot, 73% of intervention PCPs supplied new patient information regarding ED utilization, a slight increase from the pre-intervention 64%. There was no change regarding the use of e-mail to interact with patients. All intervention sites felt the tools supplied by OSP made ED visits for PCP-treatable conditions less likely in regard to obtaining timely appointments and when the PCP office is closed. Most felt providing a follow-up letter or a telephone call after an ED visit helped reduce future use and also felt the pilot overall was a positive experience. Details are provided in **Table 3**.

Utilization Change

The measurement period to determine any change in temporal trend was short, only 4 months (September to December 2010). While annual trends 2007-2009 were used for PCP

cohort assignment, utilization outcomes for the last 4 months of 2010 were evaluated against the same 4 months in 2007 to 2009 to consider seasonality in ED visit patterns. Counts of PCPs, affiliated BCN members, and ED use for PCP-treatable conditions are noted in **Table 4**. The prevalence of the \$50 emergency care copay among OSP-affiliated members decreased over time, reducing eligible members to include in the 2010 assessment. The most prevalent copay in 2010 (\$100) was less prevalent in prior years. Of the members in **Table 4**, 99.94% were with the same PCP for all 12 months of a given year.

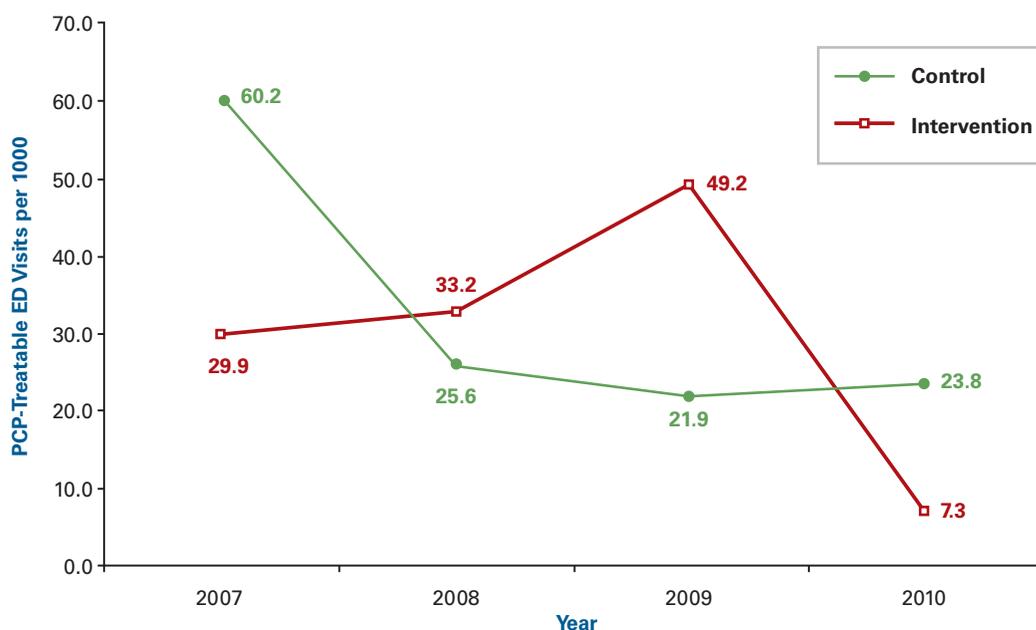
Intervention sites had increasing rates of ED use for PCP-treatable conditions, which peaked at 49.2 visits per 1000 in 2009, and decreased to 7.3 visits per 1000 when measured for the same 4-month period after the pilot began in 2010. This represents a substantive reversal of the prior 3-year trend and is also lower than the 23.8 visits per 1000 for control sites during the same 4-month period (**Figure**).

■ **Table 4.** Counts of PCPs, BCN Members, and ED Visits for PCP-Treatable Conditions

Year	Oakland Southfield Physicians, PC (OSP), Primary Care Physician Count		OSP-Affiliated BCN 12-Month Continuously Enrolled Commercial Members With \$50 Emergency Copay		PCP Treatable Emergency Visits September-December	
	Control	Intervention	Control	Intervention	Control	Intervention
2007	15	11	914	702	55	21
2008	15	11	975	722	25	24
2009	15	11	731	508	16	25
2010	15	11	421	273	10	2

BCN indicates Blue Care Network of Michigan; ED, emergency department; OSP, Oakland Southfield Physicians PC; PCP, primary care physician.

■ **Figure 1.** Emergency Department PCP-Treatable Visits per 1000, September to December



ED indicates emergency department; PCP, primary care physician.

DISCUSSION

The study design represents a difference-in-difference approach using 3 years of prior utilization to establish the temporal trend before the intervention. Cohorts of extremes (worst and best performing PCPs) were identified to make any change in trajectory as apparent as possible, as these data were too limited for formal statistical testing. The premise was that PCPs with an improving trend had, in the past, embarked upon a program of process improvement (specifics unknown) in regard to ED use for PCP-treatable conditions, while these data suggest that intervention sites were not addressing the issue effectively. Considering the small size of the study, control

and intervention cohorts were reasonably similar in regard to the distribution of practices and PCPs by PCP specialty and self-reported practice environment. The percentage of PCPs with PCMH participation, and dates of engagement with the PCMH program, were also reasonably balanced. Intervention PCPs, in aggregate, had ED visit rates for PCP-treatable conditions increasing steadily for 3 years before the pilot in 2010, with clear improvement after interventions were implemented, while the ongoing aggregate improvement for control PCPs moderated. As the distribution of PCMH-participating PCPs was largely balanced between the 2 cohorts, the positive impact at intervention sites suggests the pilot provided benefits beyond the PCMH/PGIP program alone, as no additional

financial incentives were attached to the GDAHC pilot, or the PCMH/PGIP program, for OSP PCPs in regard to ED use.

In the pre-implementation survey all control and intervention PCPs attested to already having a practice structure (telephone triage during office hours and appointment access processes) that should optimize PCP access and control ED use for PCP-treatable conditions. Both cohorts generally had new patient instructions regarding when to use an urgent care center as opposed to the ED, though this was more prevalent in the control group. The majority of PCP opinions in both cohorts felt patients went to the ED because the office was closed, yet most reported providing instructions to patients directing them to alternative sites of care (eg, urgent care). Hardly any PCPs felt their patients went to the ED for PCP-treatable conditions because of difficulty obtaining timely appointments. Pre-implementation survey responses indicated appropriate practice management in support of PCP access, yet PCPs with worsening trends were identified for this pilot. While the reasons for these discrepancies are beyond the scope of this study, possible causes include poor understanding of the office management techniques stated to be in place, good understanding but a less than enthusiastic implementation, or simply answering what was considered an appropriate response when interviewed by the IPA with which they were affiliated.

The OSP implementation methodology (Table 1) included regular practice contact, encouragement, and follow-up to maximize PCP practice focus and attention in regard to the pilot materials. How the intervention was implemented by OSP, and its well-established relationship with these practices, is likely a vital factor. Concepts alone, such as open-access scheduling, do not guarantee results.^{10,11} All sites claim to have embraced such practices before the pilot and, according to the survey responses, very little changed as a result of the pilot. Thus, it is not sufficient to merely have knowledge of methods for improving PCP access, but rather it is necessary to have the desire, or requirement, to also implement them well. The motivation could be financial (eg, a PCP financial risk arrangement), or could be related to it being made a priority by a larger organization with which the PCP is affiliated.

Clear direction, support, and follow-up from a larger organization with which a PCP is affiliated (eg, IPA or accountable care organization [ACO]) may be necessary to achieve more consistent and effective use of these basic techniques within primary care practices. A focus on the basics can be lost, or perhaps never properly understood, due to the constant clarion call of “innovation” from one stakeholder to another. Large health plan customers want to see something done to produce “new” savings, and an IPA or ACO may want

to impress a health plan to negotiate a better contractual arrangement. Policy makers, almost by definition, must be advocating changing something to support their political viability. At the individual practice level, physicians can only absorb and implement so much. While innovation is meant to push out the old in favor of newer and ostensibly more effective solutions, assessing whether thorough and proper implementation of the older and established methods has occurred should not be overlooked. The concept of thorough comparative effectiveness evaluations in healthcare should apply not only to therapeutic options but to the administrative aspects as well.

As a pilot, the number of practices and health plan members involved was small. Because practices had to agree to participate, a bias toward process improvement may have existed within the intervention cohort. It is unknown whether increased PCP access, increased urgent care use, or some of both offset the decreased ED visits for PCP-treatable conditions. The generalizability of these results is dependent on the prevalence of IPAs with infrastructure and influence among target PCPs similar in magnitude to OSP when addressing ED use among health maintenance organization members. Other issues to consider in regard to applicability elsewhere include member benefit design, existence and magnitude of financial incentives in regard to ED utilization, and existence of any real or perceived penalties for poor access (eg, being excluded from an IPA or ACO).

CONCLUSIONS

The interventions used in this pilot were not hi-tech, complex, or innovative, yet a substantive improvement was noted by revisiting and focusing on simple, standard practice management tools. Reducing PCP-treatable ED visits has to be important to the PCP, for whatever reason. In some circumstances other priorities appear to have superseded ED visits as an issue competing for the attention of primary care physicians.

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Authorship Information: Concept and design; analysis and interpretation of data; drafting of the manuscript; critical revision of the manuscript for important intellectual content; statistical analysis; administrative, technical; and supervision.

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REFERENCES

1. Pitts SR, Carrier ER, Rich EC, et al. Where Americans get acute care: increasingly, it's not at their doctor's office. *Health Aff.* 2010;29(9):1620.
2. Gindi RM, Cohen RA, Kirzinger WK. Emergency room use among adults aged 18–64: early release of estimates from the National Health Interview Survey, January–June 2011. National Center for Health Statistics. http://www.cdc.gov/nchs/data/nhis/earlyrelease/emergency_room_use_january-june_2011.pdf. Published May 2012. Accessed June 25, 2012.
3. Doobinin KA, Heidt-Davis PE, Gross TK, et al. Nonurgent pediatric emergency department visits: care-seeking behavior and parental knowledge of insurance. *Pediatr Emerg Care.* 2003;19(1):10-14.
4. Brousseau DC, Nimmer MR, Yunk NL, et al. Nonurgent emergency-department care: analysis of parent and primary physician perspectives. *Pediatrics.* 2011;127(2):e375-e381.
5. Weber EJ, Showstack JA, Hunt KA, et al. Are the uninsured responsible for the increase in emergency department visits in the United States? *Ann Emerg Med.* 2008;52(2):108-115.
6. Greater Detroit Area Health Council, Inc. GDAHC website. <http://www.gdac.org/>. Accessed June 25, 2012.
7. Billings J, Parikh N, Mijanovich T. Emergency department use: the New York Story. *Issue Brief (Commonw Fund).* 2000;(434):1-12.
8. Clinical Classifications Software (CCS) for ICD-9-CM. Healthcare Cost and Utilization Project (HCUP). Rockville, MD: Agency for Healthcare Research and Quality; March 2012. <http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp>. Accessed May 21, 2012.
9. Goodman RM. Relationship between primary care physician financial risk and member emergency department use in a commercial HMO population. *Am J Manag Care.* 2006;12(6):329-340.
10. Rohrer JE, Bernard M, Naessens J, et al. Impact of open-access scheduling on realized access. *Health Serv Manage Res.* 2007;20(2):134-139.
11. Kopach R, DeLaurentis P, Lawley M, et al. Effects of clinical characteristics on successful open access scheduling. *Health Care Manage Sci.* 2007;10(2):111-124. ■

■ **Appendix.** Sample Access to Care, Telephone, and Appointment Scheduling Policies

Entire care team needs to read and ensure adherence to this policy.

Office Telephone & Fax Number

Phone #: (xxx) xxx-xxxx

After hours #: (xxx) xxx-xxxx

Fax #: (xxx) xxx-xxxx

Regular Office Hours

Monday xx:xx AM- xx:xx PM

Tuesday xx:xx AM- xx:xx PM

Wednesday xx:xx AM- xx:xx PM

Thursday xx:xx AM- xx:xx PM

Friday xx:xx AM- xx:xx PM

Saturday xx:xx AM- xx:xx PM

Responding to Patient Inquiries

Ensure patients have telephone access 24/7. Answer all phone calls by the 3rd ring during office hours. Office hours are listed on answering machine. All patients have access to a physician or clinical decision maker 24 hours every day for the management of urgent and emergent conditions. Answering service is used when office is closed.

If a clinical phone call is answered by a non-clinical staff member, the staff member will:

1. Not answer clinical questions
2. Fill out a triage form/book to help the doctor assess the need and urgency of the patient's concerns
3. Inform the patient that the doctor will be with them shortly
4. Give the triage form/book to the medical assistant/healthcare provider who will then utilize office protocols to answer inquiry as soon as possible

Appointment Scheduling

Appointments will be scheduled to meet the request of the patient, including same-day access. Well care appointments may be made up to 3 months in advance. Sick appointments will be seen the same day.

Accommodate the patient whenever possible, it is the patient's choice. Encourage early morning appointments if scheduling for another day. If the patient insists on a later time, schedule the appointment as requested (patient's choice!). Try not to schedule any further than 2 weeks out, since the no-show rate rises after that length of time.

Follow-up with a reminder notice (letter or call) if the scheduled appointment is not during the current week. Be sure the patient knows what he or she is required to do and/or bring for the appointment:

1. Medication list or medications/devices
2. Self-monitoring tools/results form
3. Goal sheet
4. Completion of medical tests

Coordinate other specialist's appointments and/or diagnostic tests whenever possible. Usually the patient will schedule their own appointments. Required authorization/referral will be faxed to the specialist within a 24 hour period.

Follow Up Post Emergency Visit

Upon receipt of a patient emergency visit notice, physician reviews documentation and instructs staff to either place a follow-up call to the patient, schedule patient for an appointment or file notice in chart.

As part of this pilot your office is requested to consider:

1. Using a template letter (see sample) to communicate with patients after a primary care treatable emergency visit
2. Establish condition based follow-up program to actively address frequent emergency use eg, asthma – office will call patient or caregiver after every emergency visit to determine why needed and if any change to the care plan is necessary

SAMPLE WELCOME LETTER

[INSERT PRACTICE NAME]

YOUR PARTNER IN EXCELLENT HEALTH CARE

Address

City, State Zip Code

When you choose one of our primary care physicians, your health care becomes our responsibility and we work as hard for your health as you do. We all share that commitment, setting high standards for ourselves and the quality of our care and we deliver on that promise through caring, convenience and qualifications.

We will attempt to have you see your personal physician at each of your appointments. However, if he or she is not available, our physicians work as a team and use our electronic medical record system to provide coordinated care.

Combining services and programs is a growing trend for our practice to help our patients find multiple services at a single site. [Practice Name] proudly offers x-rays, ultrasounds, stress testing as well as in-house laboratory for patient convenience.

Scheduling Appointments

When you call the office, be sure to tell the receptionist the reason for your appointment so we can plan on a date and time that is most convenient for you. Appointments for physical exams and routine visits are always available and can be scheduled as needed. We know that illnesses are unexpected and we will gladly work around your schedule to bring you in for immediate care and attention.

Regular Office Hours

Telephone: (XXX) XXX-XXXX

Monday xx:xx AM- xx:xx PM

Tuesday xx:xx AM- xx:xx PM

Wednesday xx:xx AM- xx:xx PM

Thursday xx:xx AM- xx:xx PM

Friday xx:xx AM- xx:xx PM

Saturday xx:xx AM- xx:xx PM

Urgent Care Center

Telephone: (XXX) XXX-XXX

Name

Address

City, State Zip Code

Open Daily 7:00 AM – 11:00 PM

Extended Hours and After-Hours Emergencies

Health care emergencies can happen anytime. If you have an urgent problem and the office is closed, call us anyway at (XXX) XXX-XXXX. We're on call 24 hours a day. If you feel that you have a life-threatening emergency, call 911 or go straight to the nearest hospital emergency department. It is your responsibility to inform the practice regarding care with any other health care facilities and providers.

First Visit and Follow-Up Visits

On your visit, check in at the reception desk so your information can be reviewed for accuracy. You can help us serve you better by notifying the receptionist of any changes in name, address, telephone number or insurance coverage since the time of your last visit. Verifying this information at each visit will help ensure the accuracy of submitting your services to your insurance(s) company in a timely manner.

We try to follow our scheduled appointments as closely as possible. However, due to unavoidable circumstances or emergencies, a doctor may have to spend additional time with a patient who may have had an appointment prior to yours. This may result in a delay in seeing your doctor. We appreciate your patience and understanding in such circumstances.

Prescriptions and Refills

We proudly use electronic prescribing to improve prescription safety and efficiency. Prescriptions and refills are issued during regular office hours. Call your local pharmacy for all refill requests.

SAMPLE AFTER-HOURS TELEPHONE SCRIPT

It is important to make patients feel comfortable calling the doctor on call if they believe the matter is urgent and cannot wait until normal business hours. To support this you may wish to consider using after-hours language similar to:

“IF YOU ARE A PATIENT AND YOUR PROBLEM IS URGENT AND CANNOT WAIT UNTIL REGULAR OFFICE HOURS, A DOCTOR IS AVAILABLE TO HANDLE YOUR URGENT PROBLEM. PLEASE CALL XXX-XXX-XXXX FOR THE ANSWERING SERVICE WHO WILL CONTACT THE DOCTOR ON CALL.

FOR ALL OTHER NON URGENT REQUESTS PLEASE CALL DURING NORMAL BUSINESS HOURS. OUR OFFICE HOURS ARE...”

SAMPLE PATIENT FOLLOW-UP LETTER AFTER A PRIMARY CARE TREATABLE EMERGENCY VISIT

Dear _____:

Date: _____

According to our records, you recently sought care at an emergency room for a condition that could have been successfully managed by your primary care physician. It is important that you work through your primary care physician for non-emergency medical care.

Please contact our office to schedule an appointment. Regular appointments are important to managing your medical needs and ensuring your continued health.

Please take a few minutes to review the following guidelines for care:

Emergency Care: If you have an immediate and unforeseen injury or illness and the time needed to contact your physician may mean permanent damage to your health, you should seek treatment from the nearest emergency room or call 911 for assistance.

Other Care: Please call our office if your problems are urgent and cannot wait until regular office hours, a doctor is available to handle your urgent problem.

We hope this information is helpful.

Sincerely,

[insert physician or office name]