



## Low-Tech Solutions for the High-Cost Problem of Emergency Department Overuse

The Greater Detroit Area Health Council (GDAHC) is heading a successful initiative to reduce avoidable emergency department (ED) visits as part of its work leading the *Aligning Forces for Quality* initiative (AF4Q) in Detroit.

In this work, GDAHC is working with Blue Care Network of Michigan, a statewide health maintenance organization, and Oakland Southfield Physicians (OSP), an independent practice association of more than 300 family and general practitioners, to implement simple, low-tech interventions across OSP practices to help patients understand their options when they encounter a medical issue after-hours.



To gain insights into the project's success, we sat down with Jenifer Hughes, an executive vice president of Administrative Network, Inc., which manages the daily operations for Oakland Southfield Physicians.

### Q What brought the problem of avoidable emergency department overuse to your attention and what made you decide to take it on?

*Jenifer:* Years ago, we joined a multi-stakeholder team led by GDAHC to look at avoidable ED use here in Southeast Michigan. The team includes ED managers, hospital systems, primary care practices, purchasers, health plans, and consumers. The team developed this pilot, which looks at enhancing access to primary care to help avoid primary care-sensitive ED visits. We explain these types of visits to our doctors as visits for conditions like upper respiratory infections or bronchitis that could've been safely treated in a primary care setting instead of an ED.

### Q Why do people end up in the ED instead of getting treated in primary care?

*Jenifer:* When we looked at the historical data, we saw that these visits were often related to benefit design and accessibility. For a working mom who couldn't take off work, there was no difference in copays or costs between waiting until she was done with work to take her child to the ED and taking time off work to see the pediatrician. But, we've certainly seen significant benefit design changes that discourage this choice or behavior.

It also has to do with accessibility and having purposeful conversations with patients to make sure they're aware of the urgent care facilities in their neighborhood. Often, patients say, "I don't want to bother the doctor," so one component of the pilot is getting the doctor to let them know, "It's not a bother, that's what I'm here for." Another part is finding those neighborhood urgent care centers and letting the patient know that, "If something happens, here's an option of an urgent care center."

#### *Aligning Forces for Quality*

AF4Q is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in 16 targeted communities across America. These briefs distill some of the key lessons learned by these regional alliances of providers, patients, and payers as they work to transform their local health care and provide models for national reform.

**Q Are there advantages to working with a multi-stakeholder group such as GDAHC when you're attacking a problem like this, versus taking it on yourself?**

*Jenifer:* Absolutely. It's critical, because it lets you understand the problem from the point of view of every stakeholder. For example, we learned about the rules and regulations that an emergency department is under from the person who runs the University of Michigan Health System Emergency Department. There were many things we learned that we didn't even know about.

**Q How did you develop these easy-to-implement, low-tech solutions?**

*Jenifer:* Sometimes it doesn't need to be glossy with a lot of bells and whistles. Common sense definitely entered the conversation with this pilot. We sat down, rolled up our sleeves, and worked with the multi-stakeholder team to develop a toolkit that incorporates strategic messaging and touch points to remind people in many different ways—not just an email, or a phone call, or a poster, or a letter. And we also let offices have ownership in it, involving them in customizing the toolkit.

During the initial pilot, our project manager visited the offices, got to know the office staff, and was the face of the project so they could feel comfortable reaching out to her to say, "We're feeling a little confused, and we don't understand, and this is what's happening here." We wanted to make sure they never felt as though they were left alone.

**Q A key part of the program seems to be making sure that patients understand that they can have access to care without going to the ED. Tell us about the communications that you've used.**

*Jenifer:* The first step is to ensure that every office establishes an access-to-care policy, from the receptionists to the physicians to the nurses to the medical assistants. Everyone involved needs to understand what access to care means and define it together. How quickly should the phone be answered? How do you handle clinical advice for a patient over the phone? Who can give that? How quickly can you see a patient? What do you do when you're notified of an ED or urgent care visit? You have to get everyone on the same page and sometimes that means pressing that reset button. Although everyone says they understand and follow access-to-care procedures, they all may have a different understanding, but that doesn't mean that they don't think it's important.

**Q So it's fairly common for many of these offices not to have a protocol in place?**

*Jenifer:* It's often an unwritten rule of "this is what we do." To make it purposeful, we asked our pilot project manager to sit with them, and say, "OK, let's write it out." We took on the writing burden, and incorporated their pieces into the template that's part of the toolkit. We did not leave our practices with an assignment to develop their policies on their own.

**Q How do practices reach out to patients? Do they make it part of a routine visit to make sure patients understand the after-hours practices and what to do?**

*Jenifer:* The toolkit offers a welcome packet for patients. We consider it a 'welcome packet' because even if patients aren't new to the practice, the information is new and helpful, including physician availability, office hours, and exactly what to do when faced with after-hours medical problems. We provide the practices with conversation scripts, which are bulleted talking points for medical assistants to use when taking the patients to an exam room. We provide telephone scripts for office staff who answer the phone and ask practices to consider a different after-hours telephone message. The welcome packet also includes a list of community-based urgent care centers with the phone number, name, address, and hours of operation.

We work with practices to help them understand that their idea of an emergency may be different from a patient's idea of an emergency. Some problems they think are not alarming can be a crisis to a patient.

**Q Can you tell us more about the scripts you give practices for their after-hours recorded messages?**

*Jenifer:* The script is based on an analysis by the University of Michigan Health System of what patients hear when they call a doctor after-hours, such as how much information they hear before hanging up. For example, we encourage offices to consider an after-hours message such as, “If you’re a patient and your problem is urgent and cannot wait until regular office hours, a doctor is always available to handle your urgent problem. Please call this telephone number for the doctor on call.” Rather than a message such as, “You’ve reached the office of Doctor X. If this is a life-threatening emergency, please proceed to the nearest emergency room or call 9-1-1.” Click, the patient hangs up because they think, “My problem is an emergency.”

**Q How do you ensure that the practices follow through and continue with the interventions?**

*Jenifer:* In our initial pilot, our project manager had monthly touch points with each practice. During the ramp-up phase, they worked a lot on developing materials, but later on, it became more like, ‘Hi! How are you doing? Do you have any questions? Any problems? It looks like your trend is going down, way to go! Keep up the good work!’

**Q What kind of feedback did you get from the doctors’ offices that were part of the pilot?**

*Jenifer:* Initially, they were concerned, asking, “Did I do something wrong? Am I really that bad?” And so we said, “No, we’re just excited to give you the opportunity to be part of this group. We noticed some things going in the wrong direction, and that’s not the kind of quality primary care practice we know that you are, so we want to assist you.” Once we got past the initial worry, they saw it as something helpful, not a burden.

**Q What advice would you give to another organization looking to take this on in their community?**

*Jenifer:* Understand that you can’t do it all. Be purposeful and thoughtful as to where you start. Get some quick wins, get some champions, and then turn on the spigot. You need to find at least one clinical or administrative champion. Sometimes all you need is that office manager, because she runs a tight ship and they listen to her, and if she tells them it’s a good idea, then it’s a good idea. You need to know the culture and the personalities of the office.

Once you have the champion, practices will start talking to each other and saying, “I want to do this too.” You start to get some of that healthy competition and dialogue across the offices.