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Reducing Inappropriate Emergency Room Use among Medicaid Recipients By Linking Them to a Regular Source of Care*

Improved collaborations between primary care providers and local hospitals, together with state Medicaid agencies, can significantly increase Medicaid beneficiaries' use of regular sources of care and therefore reduce inappropriate ER use substantially.

Collaborative partnerships, featuring a regular source of care; access to pharmaceuticals; assistance in navigating the health care system; education on illnesses; an emphasis on prevention; and continuity of care, hold significant potential to encourage the appropriate use of care and improve the health of Medicaid beneficiaries, while at the same time lowering Medicaid's costs.

*The ideas and opinions expressed in this document reflect the contributions of individual members of the Partnership. While every effort has been made to achieve consensus among all members, the ideas expressed in this document are not necessarily those of, nor are they endorsed by, any particular member organization(s) of the Partnership.

BACKGROUND

Americans are making increasing use of hospital Emergency Rooms (ERs), often for non-emergent – and even for routine – health care problems. According to data from the CDC's National Center for Health Statistics (NCHS), ER use has risen by almost 20 percent since 1990, to 110 million visits in 2002. This increased use has been linked to growth in the number of uninsured Americans, but is also closely tied to reduced access to a regular source of care, especially primary care providers. As many as 95% of all ER visits are treated and discharged, with no hospital inpatient admission. In the case of Medicaid, 90% of all ER visits result in discharge from the ER. Yet only 20% of ER visits are for emergent conditions, and at least 1/3 of all visits are for non-urgent health problems.

Almost 20 percent of all ER visits are made by Medicaid beneficiaries, who account for less than 15% of all U.S. residents. By contrast, only 12% of all ER visits are made by uninsured individuals, who make up nearly 15% of all U.S. residents. Medicaid spent an estimated \$8 billion for 22 million hospital ER visits in 2003.

Studies have shown that having a regular source of health care – often referred to as a 'medical home' or a 'health care home' – reduces ER use significantly, not only for healthy patients but also for those who are sicker and have greater health care needs.¹ Several states have undertaken initiatives designed to provide high quality, preventive, cost effective health care to the Medicaid population. Such approaches focus on providing primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. Many of these initiatives rely on primary care providers as the coordinators of care, to ensure access not only to medical, but also oral, behavioral, and pharmaceutical care, provided in a number of appropriate settings such as physicians' and dentists' offices, hospital outpatient clinics, school-based and school-linked clinics, community health centers, and health department and free clinics. In contrast to care provided in a medical or health care home, care provided through emergency departments, walk-in clinics, and other urgent-care facilities, though sometimes necessary, is more costly and often less effective. By reducing the inappropriate over-utilization of these care settings for the provision of primary care, including chronic disease management and episodic treatment regimens, medical and health care homes provide improved health outcomes at a reduced cost.

POTENTIAL SOLUTIONS

Improved collaborations between primary care providers and local hospitals, together with state Medicaid agencies, can significantly increase Medicaid beneficiaries' use of regular sources of care and therefore reduce ER use substantially.

- For example, a program in the Appalachian region of Kentucky has helped low-income people avoid the many "potholes" in the health care system by hiring and training "patient navigators" who help break down barriers to care for uninsured and underinsured rural families. Working as partners with safety net providers, social services, and other agencies, the program in its first three years helped more than 9,000 patients access services including primary health care, pharmaceuticals, dental, social, transportation and housing services, and education on disease management and prevention. **As a result, there has been a 95% reduction in heart disease-related emergency room visits, an 87% reduction in heart disease-related hospital visits, and a 20% reduction in the overall number of hospital inpatient days since the program was implemented.** By reducing clients' uncompensated hospital admissions and emergency room visits, the program has helped save the regional

¹ R. Rosenblatt, "The Canary in the Mine: Emergency Room Overcrowding and the U.S. Health Care System," presentation to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), December 2003.

hospital system alone about \$1.3 million. More importantly, disease case management has resulted in better health outcomes for patients.

- As another example of the benefits of a medical home, a Medicaid managed care plan in Ohio implemented a multi-faceted 'medical homes' initiative in 2003. Among other features, the plan established a 24-hour, 7-day Nurse Triage Line to engage in symptom-based triage and to direct enrollees to the appropriate care setting for their condition. **In the first 18 months of operation, the Nurse Triage Line alone was able to divert 58% of 13,000 callers away from the ER to a more appropriate level of care, resulting in a net savings of over \$1.7 million.**
- Other studies confirm the health and financial benefits of providing a regular source of care for underserved populations. Most recently, a study found that, 3 years after a newly-established community health center (CHC) began providing care in an Oklahoma community, uninsured visits to the local hospital ER decreased by almost 40%. **Even after 10 years, uninsured ER visits remained 25% lower than before the CHC was started, while total ER visits had almost doubled (98%), saving the hospital and uninsured patients almost \$14 million.**² The benefits of having a regular source of care accrue to Medicaid as well. For example, a recent study of Medicaid beneficiaries in 5 states found that those who received care at health centers were significantly less likely to be hospitalized or to visit hospital emergency rooms for ambulatory care sensitive conditions (ACSCs).³
- Examples of the cost effectiveness of early, preventive and consistent routine care also exist within the field of oral health where studies show that without access to regular preventive dental services, dental care for many children is postponed until symptoms, such as toothache and facial abscess, become so acute that care is sought in hospital emergency departments.⁴ **A three-year aggregate comparison of Medicaid reimbursement for inpatient emergency department treatment (\$6,498) versus preventive treatment (\$660) revealed that on average, the cost to manage symptoms related to dental care carries on an inpatient basis is approximately 10 times more than to provide dental care for these same patients in a dental office.**⁵

- RECOMMENDATIONS -

Collaborative partnerships, featuring a regular source of care; access to pharmaceuticals; assistance in navigating the health care system; education on illnesses, with an emphasis on prevention; and continuity of care, hold significant potential to encourage the appropriate use of care and improve the health of Medicaid beneficiaries, while at the same time lowering Medicaid's costs.

² Smith-Campbell, B, "Emergency Department and Community Health Center Visits and Costs in an Uninsured Population," *Journal of Nursing Scholarship* 37(1): 80-86 (March 2005)

³ Falik, M. et al, "Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers." *Medical Care* 39(6):551-56 (June 2001).

⁴ Pettinato Erika, Webb Michael, Seale N. Sue. "A comparison of Medicaid reimbursement for non-definitive pediatric dental treatment in the emergency room versus periodic preventive care". *Pediatric Dentistry* 2000: 22(6), pp.463-468.

⁵ Ibid.