MICMT Annual Meeting
November 1, 2019

Topic Discussion Summary: Emergency Department Utilization

Barriers:

- Up to date data
- Hospital not directly admitting
- Urgent care billing in ED
- Patient see ED as easy and immediate care – convenience
- Patient unaware of how to see PCP in an emergency and not to access after hours
- Patient thinks it's an emergency
- Patient doesn't know PCP can treat condition for ED visit
- Patient doesn't understand impact of their visit on PCP/practice
- ED campaigns about "come see us" and short ED wait times
- Coding of visits – non-specificity. ED physicians need to be more specific
- Lack of collaboration between ED and practice. ED treats patient and doesn't educate them when they could/should have gone
- Revenue distinction – ED
- SNF to ED
- Police taking people to ED – this may not be avoidable due to legalities
- Can't reach patients to assess and prevent

Solutions:

- Incentivize/motivate patients to go to PCP
    - Reevaluate benefit structure
        - -0- co-pay for PCP office visit
        - High out of pocket cost for ED visit
- Access to PCP
- Establish relationship between patient and PCP
- More effective after hour phone messages
- Triaging patients appropriately - all hours of triage
- Patient orientation by the practice – BCBS capability
- Payers working on initiatives
- Call us first campaign

- Television, radio, billboard messages
    - If you step on a mousetrap, go to your PCP. If you step on a bear trap, go to the ED
- Sick Kits along with “no ED” message
- Population health navigator
- Stop light promotion – G-DAC
- Assess and treat anxiety in PCP office
- Collaborate with ED
- Ambulance/paramedics – divert ED visits
    - Whatever it takes grants
    - Muskegon – paramedics doing well visits
- Substance abuse pathway
- MAT collaboration with ED
- Behavior health collaboration with ED
- Prenatal health care available in ED – open part of the day