Ingham Health Plan Emergency Department Case Management Program

Ingham County Health Department Health Plan Management Services
Program Purpose/Description
May 2010

• To reduce non-emergency and inappropriate utilization of Emergency Department (ED) services by Ingham Health Plan (IHP) members

• To educate members regarding their health plan coverage

• To redirect members to their primary care provider (PCP) for services and coordination of health care
Process

- Establish program staffing & structure
- Select members to target
- Identify problems/opportunity for intervention
- Create plan to educate and redirect members
- Implement & monitor plan
- Collaborate with community partners
- Measure outcomes & effectiveness
- Continuous process improvement
## Top 10 Presenting Complaints 3/1/11 - 10/31/11

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain</td>
<td>407</td>
</tr>
<tr>
<td>Back Pain/Lumbago</td>
<td>289</td>
</tr>
<tr>
<td>Injury - single site</td>
<td>282</td>
</tr>
<tr>
<td>Dental Disorder</td>
<td>225</td>
</tr>
<tr>
<td>Alcohol Related</td>
<td>206</td>
</tr>
<tr>
<td>Chest Pain/Pressure</td>
<td>192</td>
</tr>
<tr>
<td>HA/migraine</td>
<td>182</td>
</tr>
<tr>
<td>Joint Pain</td>
<td>147</td>
</tr>
<tr>
<td>Pain in limb</td>
<td>130</td>
</tr>
<tr>
<td>SOB/DIB</td>
<td>108</td>
</tr>
</tbody>
</table>
Time of Visits

Percent of Total Visits by Time of Arrival
August 2011

- 8 am - 5 pm: 53% for Plan A, 51% for Plan B
- 5 pm - 9 pm: 17% for Plan A, 18% for Plan B
- 9 pm - Midnight: 15% for Plan A, 14% for Plan B
- Midnight - 8 am: 16% for Plan A, 17% for Plan B
Factors influencing ED use

- Health plan enrollment
- PCP access/availability
- Specialty & dental care access
- Health literacy
- Chronic pain & dental conditions
- Members seeking narcotics
Selection Process for CM Intervention

- Monitor & record all local ED visits
- Educate members accessing ED services by letter
- Members with 3+ ED visits in a quarter contacted by phone
- Other intervention on case by case basis
Staffing

- **HPMS Medical Services**
  - Coordinator
  - Nurse Case Manager(s)

- **HPMS Health Information & Claims Systems**: data management, programming & reports

- **HPMS Support Staff**: data entry, member & provider letters/notification
Data/Information Sources

• Registration information on members accessing ED services at Sparrow & McLaren received daily.
  ▫ Demographics
  ▫ Chief complaint (not discharge/billing diagnosis)

• Medical Claims Data via TPA (claims lag 30-60 days)

• McLaren & Sparrow ED Electronic Health Record – for detailed info re: visits

• Other Sources
  ▫ Michigan Automated Prescription System (MAPS)
  ▫ Pharmacy claims data via Pharmacy Benefit Manager
  ▫ HPMS Member Management System (MMS)
    • Demographics
    • Customer Service Notes, Correspondence
    • ED CM Module
  ▫ Recovery Center Census Reports
  ▫ ICHD Community Health Centers NextGen EPM/EHR
  ▫ Member information via telephone contact
Data Management

Tracking & Reporting

Excel spreadsheet May 2010 – February 2011
  Manual data entry and limited data manipulation

New module in HPMS Member Management System (MMS) March 2011 to current
  Additional fields for data capture
  Improved reporting capabilities
  More efficient use of Nurse CM time
  Ability to expand & develop
...need more influence over members seeking care in ED
Community Collaboration

**Hospital Partners**
McLaren Greater Lansing and Sparrow Health System
Clinical ED staff: Medical Directors, Physician Liaisons, Clinical Supervisors & Educators, Case Managers

**Community Mental Health**
Recovery Center – local sub-acute clinical detox unit
   SA Treatment & referral resource
   Addiction Prevention
   MH Services

**Ingham County Health Department**
Adult Dental Clinic
Community Health Centers
   Clinic staff
   Homeless Outreach
   Birch Center

**Contracted IHP Primary Care Providers**
Notification of assigned member use of ED
Notification if multiple prescribers of narcotics
IHP CM available to assist with PCP assignment, benefit determination & access to specialty care
Participation on PCP Subcommittee of Community Plan of Care Committee (CPOC)

**Individual Specialists**
MSU Department of Family Practice faculty
Michigan Pathways to Better Health
Community Plan of Care Committee

- Executive Director IHP
- Medical Director ICHD CHC/HPMS
- ED Physician/Liaison McLaren
- Patient Services Director McLaren
- Emergency Services Dept Mgr Sparrow
- Executive Medical Director Emergency Services Sparrow (outgoing & incoming)
- HPMS Medical Services Coordinator
- IHP Nurse Case Managers
Sparrow Medical Group
- Sparrow/MSU FP Residency Practice Site Director

McLaren Medical Group
- Manager McLaren Multi-Specialty Clinics
- DME McLaren Multi-Specialty Residents
- Director Patient Care Services McLaren

ICHD/HPMS
- Medical Director ICHD
- Medical Consultant HPMS
- HPMS Medical Services Coordinator
- ICHD CHC Adult Health/Inf Disease Nurse Practitioner

IHPC
- IHP Contracted PCPs – Clinic and Private Practices
- IHP Nurse Case Managers
PCP Subcommittee

- Overview of Community Plan of Care Committee
- ED utilization cause & effect / adverse outcomes
- Research overview - Introduction of Project Lazarus

Needs/Plan of Action

- Education for PCPs
- Standardized chronic pain protocol
- Member monitoring/protocol for abusers
- Legal considerations
- Access to pain management alternatives
- Incentives/support for PCPs caring for chronic pain
- Narcotics/IHP formulary
- Community comprehensive pain management clinic
Outcomes

“The conversation is not so much about the future for the community, but is the future itself.”

Peter Block, Community the Structure of Belonging.
Program Milestones

- Secured daily data for ED visits from both hospitals
- Gained access to both hospitals ED records via EHR
- Created member letters & resource sheets
- Developed ED CM module in HPMS Member Management System
- PCP notification of assigned member ED visits/bimonthly notification to all providers prescribing narcotics to a member with 4+ prescribers
- Access ICHD CHC schedules & medical records
- Improved access to dental care at ICHD Adult Dental Clinic
- Community Plan of Care Committee (CPOC) & PCP Subcommittee formed
- IHP Pharmacy & Medical Benefit changes
- CME Program for PCPs “Assessment of Chronic Pain in Primary Care”
Program Milestones FY 2013

• CPOC Guidelines for ED Treatment of Chronic Pain and Dental Pain developed & implemented at both hospitals Nov. 2012

• Collaboration with MI Pathways to Better Health

• CPOC PCP Subcommittee develops Primary Care Provider Tool Kit – CME Program in planning phase
Ingham Health Plan - Case Management Program
Dental Related ED Visits per Quarter

<table>
<thead>
<tr>
<th>Plan</th>
<th>Q1 2012</th>
<th>Q2 2012</th>
<th>Q3 2012</th>
<th>Q4 2012</th>
<th>Q1 2013</th>
<th>Q2 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10/1/11-12/31/11</td>
<td>1/1/12-3/31/12</td>
<td>4/1/12-6/30/12</td>
<td>7/1/12-9/30/12</td>
<td>10/1/12-12/31/12</td>
<td>1/1/13-3/31/13</td>
</tr>
<tr>
<td>A</td>
<td>10</td>
<td>13</td>
<td>11</td>
<td>14</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>B</td>
<td>53</td>
<td>56</td>
<td>77</td>
<td>70</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Grand Total</td>
<td>63</td>
<td>69</td>
<td>88</td>
<td>84</td>
<td>41</td>
<td>40</td>
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IHP CASE MANAGEMENT PROGRAM
DENTAL RELATED ED VISITS BY QUARTER
1/1/2012 TO 3/31/2013

Notes:
- New Dental Referral Form Implemented 4/1/12 at McLaren and Mid-May at Sparrow
- March 18, 2012 - Article featured in Lansing State Journal regarding people seeking treatment at EDs for Dental Problems
- ED Chronic Pain and Dental Pain Guidelines implemented by Sparrow and McLaren November 15, 2012 (Q1 2013)
IHP ED Case Management Program
% of Members with Repeat Dental Visits

Plan A
Plan B
Total
# IHP ED Case Management Program
## Pilot Project
### ED Visits by Diagnoses per Quarter

<table>
<thead>
<tr>
<th></th>
<th>Baseline 11/1/11 - 1/31/12</th>
<th>Follow-up 1 2/1/12 - 4/30/12</th>
<th>Follow-up 2 5/1/12 - 7/31/12</th>
<th>Follow-up 3 8/1/12 - 10/31/12</th>
<th>Follow-up 4 11/1/12 - 1/31/13</th>
<th>Follow-up 5 2/1/13 - 4/30/13</th>
<th>Follow-up 6 5/1/13 - 7/30/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain</td>
<td>18</td>
<td>10</td>
<td>12</td>
<td>15</td>
<td>7</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Back Pain/Lumbago</td>
<td>12</td>
<td>18</td>
<td>41</td>
<td>16</td>
<td>6</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td>Dental Disorder</td>
<td>21</td>
<td>23</td>
<td>24</td>
<td>14</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>HA/migraine</td>
<td>22</td>
<td>13</td>
<td>8</td>
<td>6</td>
<td>9</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Total Visits per Qtr</td>
<td>73</td>
<td>64</td>
<td>85</td>
<td>51</td>
<td>26</td>
<td>27</td>
<td>37</td>
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</tbody>
</table>

### Number of Visits by Diagnosis per Quarter

- **Abdominal Pain**
- **Back Pain/Lumbago**
- **Dental Disorder**
- **HA/migraine**
- **Total Visits per Qtr**

### Notes:

* April data is repeated in Follow-up Period 3 in order to have quarterly data follow normal FY quarters

ABW Open Enrollment occurred 4/1/13 - 4/30/13
<table>
<thead>
<tr>
<th>Plan A ER Services Expenditures</th>
<th>%</th>
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<tbody>
<tr>
<td>FY 2010</td>
<td>40.4</td>
</tr>
<tr>
<td>FY 2011</td>
<td>36.3</td>
</tr>
<tr>
<td>FY 2012</td>
<td>32.8</td>
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<tr>
<td>FY 2013</td>
<td>31.1</td>
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</table>

IHP ER Services Expenditures
# Program Summary & Potential

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Case Management can have a positive impact on individual members</td>
<td>PCP CME Program</td>
</tr>
<tr>
<td>ED CM does decrease costs and inappropriate ED use</td>
<td>Collaboration with Pathways CHWs for complex patients</td>
</tr>
<tr>
<td>Data management is a critical element of a program</td>
<td>Advocate for role of Nurse Case Managers and reimbursement</td>
</tr>
<tr>
<td>Clinical guidelines, research, and standards of care are foundational</td>
<td>Continued partnering with community</td>
</tr>
<tr>
<td>Education of health care providers/staff is essential</td>
<td>Improved access to Primary Care</td>
</tr>
<tr>
<td>It takes the entire health care community to effect change</td>
<td>Improved access to specialty care including Pain Management</td>
</tr>
<tr>
<td></td>
<td>Access to Complimentary Alternative Medicine treatment</td>
</tr>
<tr>
<td></td>
<td>Comprehensive community pain management clinic</td>
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</table>