

Utah Health Status Update:

Evaluating Utah's Emergency Room Diversion Program

June 2010

Utah Department of Health

The Centers for Medicare and Medicaid Services awarded Utah an Emergency Room Diversion Grant (ERDG) in April 2008. Several states submitted proposals on how they would try to reduce the use of hospital emergency departments (ED) for non-emergent care. Utah's hypothesis was that Medicaid clients who have a primary care provider (PCP) as a regular place for care and information about urgent care clinics in their community are more likely to choose these instead of the ED. We used claims data from the Data Warehouse to identify fee-for-service and Select Access clients who had used the ED when the primary diagnosis was not on Medicaid's list of "Authorized Diagnoses for Emergency Department Reimbursement." We provided information and education to the Medicaid client about other options available to them because they are the initial decision maker about where to go for medical care. We helped clients find a PCP if they did not already have one and gave them a list of urgent care clinics throughout the state. We also developed a website that contains educational

Non-emergent Visit Comparison

Table 1. Non-emergent visit comparison between intervention (cases) and control groups

	N Clients	Percentage
Cases - 1 visit only	3,427	--
Cases - 2 visits	316	8%
Cases - 3 or more visits	98	3%
Case totals	3,841	11%
Controls - 1 visit only	375	--
Controls - 2 visits	67	14%
Controls - 3 or more visits	52	11%
Control totals	494	24%
Difference between controls and cases		13%
Reduction in repeat non-emergent ED visits after intervention		55%

and resource information, as well as up-to-date lists of the urgent care clinics (www.health.utah.gov/safetowait).

We named our program the Safe-to-Wait Project. A key component of the project is educating clients about when it is appropriate to go to the ED and when primary or urgent care providers will meet their medical needs.

Ask yourself - Is it Safe to Wait?

We told Medicaid clients to ask themselves a simple question, "Is it safe to wait?" Is it safe to wait a few hours or even to wait a day or more to be seen by a doctor? If it is, then a PCP is a good choice for care. This is the medical professional who knows you and your medical history. If it is safe to wait but you cannot schedule an appointment with your PCP, there are clinics in the community that see patients the same day, usually without an appointment. These urgent care clinics are often open later in the evening and on weekends. This is a great choice when your PCP is not available. When the answer is no, it is not safe to wait, then you should go to the nearest emergency medical facility.

The Medicaid clients included in this analysis had to meet certain qualifications. They had to have been Medicaid eligible at least two months pre- and two months post-intervention and have had claims in both the pre- and post- periods. Over 12,000 interventions were provided between October 1, 2008 and December 31, 2009. Of those who received interventions (cases), 3,841 met criteria to be included in the analysis of the effectiveness of the project. In the control group (controls), 494 people met criteria for analysis.

The data in Table 1 show that the percentage of cases who continued to use the ED for non-emergent care is 11% compared against 24% of controls who continued to do so. This 13% difference computes to a 55% reduction in non-emergent use of the ED for cases after



Is it Safe to Wait?



1-877-662-9651
www.health.utah.gov/safetowait

A Utah Department of Health
Project

intervention. Only 3% of cases used the ED for non-emergent care three times or more versus 11% of controls.

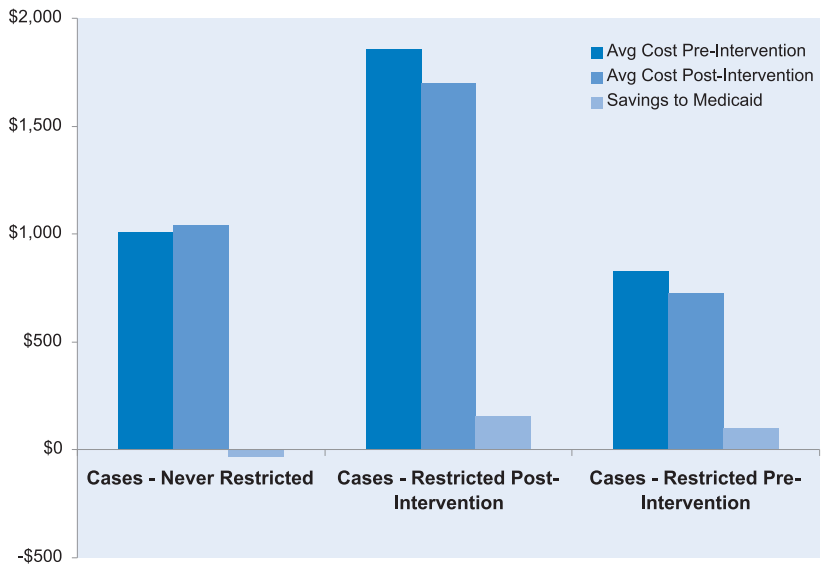
A large number of the over 12,000 Medicaid clients who received interventions met criteria to be enrolled in the Restriction Program where they are restricted to a PCP, urgent care clinic, and pharmacy. The goal of this program is to help clients establish and maintain an ongoing relationship with a PCP who coordinates and oversees all of their medical care. Sometimes when clients call their doctor's office for an immediate medical problem they will be referred to the ED. When this happens, we encourage clients to ask if an urgent care clinic would meet their medical need instead of going to the ED. The data in Figure 1 show the cost differences when a client is enrolled in the Restriction Program. As of March 2010, 285 people had been enrolled in the Restriction Program after being identified through the grant.

A Medicaid client seeking care can choose either the hospital ED or a less costly place for care. Because of Emergency Medical Treatment and Labor Act (EMTALA) laws, hospitals do not turn away patients seeking care at the ED. Until the hospital has definitively determined that an emergent medical condition does not exist, it must provide care. At this point the costs have already been incurred. When clients seek care at a hospital, there are facility charges from the hospital as well as the professional charges from the doctor who treats them. The professional charges are considered "a wash" because an office visit to a PCP or urgent care clinic is paid similarly to the ED visit. However, the facility charges are saved when clients choose to seek care at a place other than the hospital. When clients are told that as many as twelve people could get care from a PCP or urgent care clinic for what it costs for one person to be treated at the ED for a non-emergent medical problem, clients seem to better understand the importance of appropriate use of the ED.

The data indicate that it is a worthwhile endeavor to continue the Safe-to-Wait Project beyond the life of the grant. A client's decision making is influenced by the intervention demonstrated by a 55% reduction in repeat non-emergent ED visits for cases. The data also show that enrollment in the Restriction

Cost Differences

Figure 1. Cost differences for recipients per member per month post-intervention (cases) comparing those never restricted to those restricted before intervention and those restricted after intervention



	N Clients	Avg Cost Pre-	Avg Cost Post-	Savings to Medicaid
Cases - never restricted	2,727	\$1,010	\$1,044	-\$ 34
Cases - restricted post-intervention	84	\$1,856	\$1,700	\$156
Cases - restricted pre-intervention	7	\$ 827	\$ 728	\$ 99

Program reduces costs. Participants who are not enrolled in the Restriction Program show a small increase in their average costs whereas clients who are restricted show reductions in their average costs. Although only about 30% of the grant participants met criteria to be included in this analysis, similar cost savings would be expected per member per eligible month.

June 2010 Utah Health Status Update

For additional information about this topic, contact Nancy Cheeney, Bureau of Managed Health Care, Utah Department of Health, Box 143108, Salt Lake City, UT 84114-3108, (801) 538-6572, email: ncheeney@utah.gov, or the Office of Public Health Assessment, Utah Department of Health, Box 142101, Salt Lake City, UT 84114-2101, (801) 538-9191, email: chdata@utah.gov

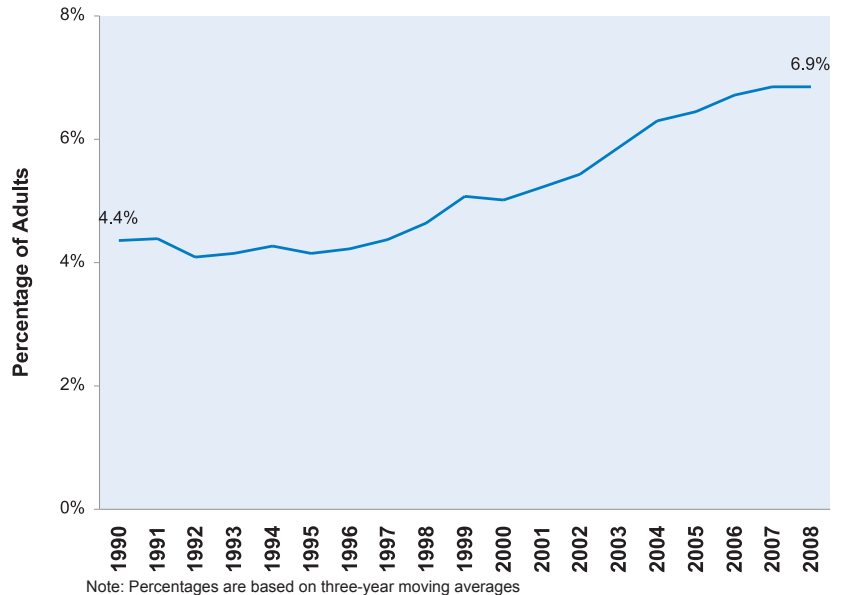
Breaking News, May 2010

Diabetes Prevalence and Costs for Utah

The percentage of adults diagnosed with diabetes has increased dramatically since 1990, rising from 4.4% to 6.9% (age-adjusted rates). Today, more than 120,000 Utah adults have been diagnosed with diabetes (Utah Behavioral Risk Factor Surveillance System [BRFSS] 2009). Another 45,000 Utah adults are estimated to have diabetes but are not yet diagnosed, bringing the total number of adults with diabetes (diagnosed and undiagnosed) closer to 165,000.

Diabetes is one of the most devastating and costly of all chronic diseases. National estimates from 2007 suggest that diabetes cost the nation \$174 billion in direct medical costs and lost productivity. However, this amount does not include costs associated with undiagnosed diabetes. Individuals can have diabetes for years without knowing it and may be diagnosed only after serious complications develop. The increased costs in medical care can begin eight years or more before a diagnosis. A study conducted by the Lewin Group (with Ingenix Research) found the cost for care and lost productivity for a person with undiagnosed diabetes averaged \$2,864 annually. In Utah, the costs for individuals with diagnosed diabetes are estimated to be one billion dollars a year. If the costs for adults with undiagnosed diabetes were also included, the estimated cost for diabetes in Utah would increase by as much as \$129 million every year.

Age-adjusted Percentages of Utah Adults Diagnosed With Diabetes, BRFSS, 1990–2008



Community Health Indicators Spotlight, May 2010

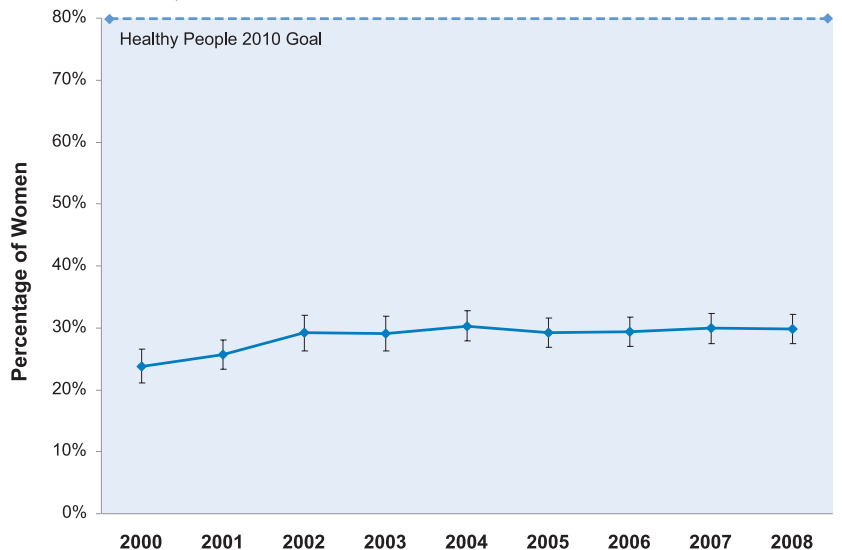
Multivitamin Use Before Pregnancy

All women who can become pregnant should take a multivitamin that contains folic acid to help prevent neural tube defects, or defects of the brain and spine. These defects form in the first 30 days of pregnancy; a time in which most women are unaware they are pregnant. Because of this early development, the Healthy People 2010 goal is for 80% of non-pregnant women to consume at least 400 mcg of folic acid each day.

The Utah Pregnancy Risk Assessment Monitoring System (PRAMS) asks women how many days a week they took a multivitamin/prenatal vitamin in the month before they became pregnant. Figure 1 shows the percentage of women who reported taking a multivitamin every day. Utah's rates fall drastically short of the national goal, with less than 30% of women reporting daily consumption.

Rates of daily intake were significantly lower among women who were Hispanic, of non-White race, unmarried, of younger ages, of lower education and income levels, uninsured, and who reported their pregnancy as unintended. A most concerning finding is that of the women who said they were trying to become pregnant, 37.2% were not taking any multivitamin. All women of reproductive age should be counseled on the importance of vitamin consumption.

Daily Multivitamin Consumption in the Month Before Pregnancy, Utah PRAMS, 2000–2008



Monthly Health Indicators Report

(Data Through April 2010)

Monthly Report of Notifiable Diseases, April 2010	Current Month # Cases	Current Month # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
Campylobacteriosis (Campylobacter)	21	17	68	66	1.0
Shiga toxin-producing Escherichia coli (E. coli)	0	4	0	11	0.0
Hepatitis A (infectious hepatitis)	0	0	3	5	0.6
Hepatitis B, acute infections (serum hepatitis)	0	2	0	6	0.0
Influenza†	Weekly updates at http://health.utah.gov/cpi/diseases/flu				
Measles (Rubeola, Hard Measles)	0	0	0	0	--
Meningococcal Disease	0	1	1	3	0.3
Norovirus	0	2	5	8	0.7
Pertussis (Whooping Cough)	19	29	116	139	0.8
Salmonellosis (Salmonella)	20	19	88	61	1.4
Shigellosis (Shigella)	3	2	10	9	1.1
Varicella (Chickenpox)	74	67	282	317	0.9
Viral and Aseptic Meningitis	0	3	0	9	0.0

Notifiable Diseases Reported Quarterly, 1st Qtr 2010	Current Quarter # Cases	Current Quarter # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
HIV	27	17	27	94	0.3
AIDS	12	14	12	42	0.3
Chlamydia	1,591	1,370	1,591	1,370	1.2
Gonorrhea	70	170	70	170	0.4
Tuberculosis	4	8	4	8	0.5

Program Enrollment for the Month of April 2010	Current Month	Previous Month	% Change ^s From Previous Month	1 Year Ago	% Change ^s From 1 Year Ago
Medicaid	213,550	213,145	+0.2%	191,114	+11.7%
PCN (Primary Care Network)	14,737	17,184	-14.2%	18,556	-20.6%
CHIP (Children's Health Ins. Plan)	40,865	41,845	-2.3%	38,687	+5.6%

Medicaid Expenditures (in Millions) for the Month of April 2010	Current Month	Expected/Budgeted for Month*	Fiscal YTD	Budgeted Fiscal YTD	Variance - over (under) budget
Capitated Mental Health	\$ 8.3	\$ 10.5	\$ 93.1	\$ 96.1	\$ (3.1)
Inpatient Hospital	\$ 22.9	\$ 26.0	\$ 205.5	\$ 180.4	\$ 25.1
Outpatient Hospital	\$ 9.0	\$ 9.5	\$ 92.1	\$ 86.8	\$ 5.3
Long Term Care	\$ 13.0	\$ 13.5	\$ 135.0	\$ 132.9	\$ 2.1
Pharmacy ^β	\$ 11.8	\$ 17.4	\$ 123.8	\$ 107.8	\$ 16.0
Physician/Osteo Services [‡]	\$ 6.9	\$ 6.7	\$ 69.2	\$ 61.2	\$ 8.1
TOTAL HCF MEDICAID	\$ 145.3	\$ 150.0	\$ 1,319.3	\$ 1,327.8	\$ (8.5)

Health Care System Measures	Number of Events	Rate per 100 Population	% Change ^s From Previous Year	Total Charges in Millions	% Change ^s From Previous Year
Overall Hospitalizations (2008)	279,504	9.4%	-2.7%	\$ 4,703.3	+10.3%
Non-maternity Hospitalizations (2008)	164,602	5.4%	-3.0%	\$ 3,924.7	+10.4%
Emergency Department Encounters (2008)	681,958	23.4%	-2.9%	\$ 879.5	+12.6%
Outpatient Surgery (2007)	296,596	10.5%	-5.7%	\$ 1,109.0	+8.6%

Annual Community Health Measures	Current Data Year	Population at Risk	Number Affected	Percent/Rate	% Change ^s From Previous Year
Overweight and Obesity (Adults 18+)	2009	1,939,721	1,125,900	58.0%	-0.2%
Cigarette Smoking (Adults 18+)	2009	1,939,721	188,600	9.7%	+4.4%
Influenza Immunization (Adults 65+)	2009	253,594	175,600	69.2%	-5.5%
Health Insurance Coverage (Uninsured)	2009	2,800,089	314,300	11.2%	+4.7%
Motor Vehicle Crash Injury Deaths	2008	2,781,954	268	9.6 / 100,000	-3.3%
Suicide Deaths	2008	2,781,954	384	13.8 / 100,000	+1.3%
Diabetes Prevalence (Adults 18+)	2009	1,939,721	123,200	6.3%	+4.1%
Coronary Heart Disease Deaths	2008	2,781,954	1,514	54.4 / 100,000	-4.0%
All Cancer Deaths	2008	2,781,954	2,478	89.1 / 100,000	-5.6%
Births to Adolescents (Ages 15-17)	2008	61,727	1,122	18.2 / 1,000	-2.0%
Early Prenatal Care	2008	55,605	43,997	79.1%	-0.4%
Infant Mortality	2008	55,605	264	4.7 / 1,000	-7.9%
Childhood Immunization (4:3:1:3:3:1)	2009	55,120	42,200	76.6%	+4.1%

† Influenza activity remains low in Utah. Influenza-like illness activity is below baseline statewide. As of May 12, 2010, 904 influenza-associated hospitalizations have been reported to the UDOH. More information can be found at <http://health.utah.gov/epi/diseases/flu>.

* % Change could be due to random variation.

‡ The Medicaid program service budget numbers by month are not available at this time.

β The Pharmacy Expenditure and Budget amount only includes the gross pharmacy costs. The Pharmacy Rebate and Pharmacy Part-D amounts are excluded from this line item.

‡ Medicaid payments reported under Physician/Osteo Services do not include enhanced physician payments.

Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance for West Nile virus has ended until the 2010 season.