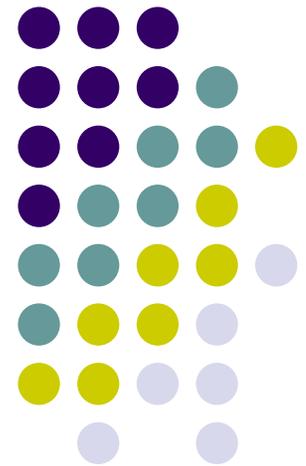


# MCO ER Issues

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FROM THE MCO  
PERSPECTIVE:





## ER Issues – Negative

- Services are never limited to a Medical Screening Exam because hospitals ED is afraid to send any patient away without a full assessment and treatment for fear of EMTALA violation and/or lawsuit
- All charges are excessive relative to actual cost of providing service
- Infrequent effort to coordinate care with PCP
- Excessive and inappropriate utilization of diagnostic testing and broad spectrum antibiotics
- Poor management of chronic pain patients



## ER Issues – Negative (cont'd)

- Ineffective management of “frequent fliers”
- Potentially dangerous for patients with true emergency situations when ER is backlogged with minor problems
- Patient safety issue with “frequent fliers” getting excessive radiation exposure
- Poor interventions and follow through for psychiatric and substance abuse services
- Every ER has a “fast track,” but none can bill an urgent care level of service



## ER Issues – Negative (cont'd)

- ER's often heavily marketed to the public - little effort to discourage inappropriate use of ER
- Fragmentation of care and medical record and loss of continuity of care with PCP when care is received in the ER leading to poorer quality of care
- Preventive services are missed when ER is used instead of PCP
- Infrequent effort to direct follow up care to a network provider or prescribe formulary drugs  
Patients are instructed to “Return to ER” for wound check, suture removal, packing removal, stress test (!)

# ER Issues – Negative (cont'd)



- Fast track/short turn around times encourage ER use
- Lack of walk in clinic services in many parts of the state
- No services for dental issues
- Potential for communicable diseases to be spread by long waits in crowded ER waiting rooms
- Lack of case management in ER to avoid social admissions (i.e. transportation home, obtaining DME, etc)



# ER Issues – Positive

- Best location for care of patients with truly emergent conditions for rapid diagnosis and immediate management
- Convenience from a transportation or distance point of view in many instances
- Certainty of being seen, albeit long wait potential
- Open 24/7 - No appointment necessary
- “Fast track” options often move the patient with minor issues in and out in an hour or less.



## ER Issues – Positive (cont'd)

- Convenience of “one stop shopping” with availability of testing which may be needed without another trip (e.g., X-ray if trauma; LE Doppler for r/o DVT)
- Allows PCPs to focus on their appointed patients with smoother and cost beneficial work day
- Treatments in EDs avert some IP admissions
- Pleasant social atmosphere is some EDs make for a positive patient wait experience
- Safe place for homeless members and members with violent home situations to seek refuge



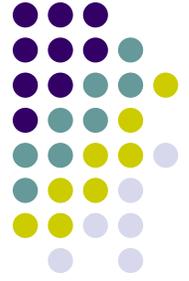
## Member issues – Negative

- Using ER for primary care services and missing preventative services
- Fragmentation of care with potential for excessive testing
- No consequences for misusing ER
- Go to ER during office hours
- Go to ER in the evening when they could have gone to the office in the day



## Member issues – Positive

- Immediate care for true emergencies
- Convenient hours with no appointments
- No need to miss work or school
- Practitioner does not know your history, and there is potential to obtain whatever you seek – prescriptions, testing - regardless of medical appropriateness



# Provider issues

- Utilize ER if they are having difficulty scheduling tests
- Place to have a rapid diagnostic evaluation completed

# Barriers to Change Hospital



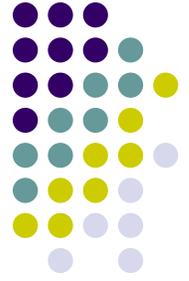
- ED visits provide source of admissions to the hospital
- EMTALA regulations require an evaluation – Medical Screening Exam
- Minor visits generate revenue to support high fixed costs of running an ED
- Community perception of the hospital is often based on ED experiences since more members of the community will contact ER than have an inpatient stay
- Profit center for the enterprise
- HSCRC charge setting structure

# Barriers to Change ED Provider



- Minor patients provide “downtime” from intensity of critical care
- Fear of malpractice if complete work up is not done
- Need to support strong patient satisfaction scores at some hospitals
- Fear of violating EMTALA regulations
- Generating profit for hospital provides “power” in hospital politics
- Provides income to ED providers
- No disincentives for over utilizing services and treatments

# Barriers to Change MCO



- PCP network can divert patients to ER taking pressure off network offices
- Can often avoid admission

# Barriers to Change Patient



- Breaking pattern which may have grown up with; if feeling bad, go to ED
- Perception that ED has better doctors with technology to support and therefore can do better job than PCP (TV shows don't focus on PCP practice as ER and House)
- Transportation issues; hospital likely on public transport line or ambulance will take you there if you call 911
- EDs open evenings and weekends; desire not to miss work
- Perception that ED doctors more likely to give what want: CT scans, Xrays, antibiotics, pain killers, etc.

# Barriers to Change

## Patient (cont'd)



- Perception that ED provider is more likely to provide an intervention, e.g., prescribe and antibiotic, and PCP is more likely to adopt a conservative, “wait and see” position and that intervention is the better quality care
- Don’t have a PCP with whom they have developed a trusting relationship
- Sensationalism about diseases as swine flu, anthrax by media enforcing need to be evaluated
- Poor health literacy regarding emergency vs. non-emergency situations
- Poor understanding of how to use afterhours resources like on call doctor at the PCP office or Urgent Care Centers
- Cultural variations on accessing health care services

# Barriers to Change Primary Care Provider



- Primary care limited work hours
- PCP may be assigned to a person who has never been to the office
- Medicaid patients often have so many co-morbidities that they need more office time and a more sophisticated system of care
- Poor financial incentives for PCPs to do acute care; would rather have all slots in schedule filled with established patient
- Avoid dealing with “difficult patients” by referring to ER