

OKLAHOMA EMERGENCY DEPARTMENT UTILIZATION

EXECUTIVE SUMMARY

AUGUST 24, 2016

Government Human Services Consulting

Introduction and Background

In 2014, The Oklahoma Health Care Authority (OHCA) contracted with Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, to conduct a multi-year analysis of one of the key drivers of health care cost, emergency department (ED) utilization. In November 2015, Mercer submitted the report “Oklahoma Emergency Department Utilization.” The report included a description of the OHCA program, development of an OHCA definition of “inappropriate” ED utilization, statistical analysis of ED utilization, summary of low-acuity non-emergent (LANE) ED utilization, geospatial analysis of ED utilization and LANE for July 2012 through December 2013 and analysis of eight state approaches to managing ED utilization.

As described in the 2015 report, EDs have become the front door to health care for many Americans, and often, ED visits are for non-urgent — and even routine — health care problems. According to Cheung et al., the probability that an individual will seek care at the ED increases if there are barriers to timely care in other settings.¹ The Medicaid and Children’s Health Insurance Program (CHIP) Payment and Access Commission (MACPAC) states that “...approximately one third of adult and 13 percent of child enrollees have reported barriers to finding a doctor or delays in getting needed care.”² The costs of these low-acuity ED visits can be more than triple the cost of treatment in a primary or urgent care setting. Nationally, the estimates of waste in the health care system related to unnecessary ED visits totaled approximately \$14 billion in 2010, not including replacement costs had services been delivered in a more appropriate setting. However, to put spending for ED visits in perspective, the MACPAC estimated that spending on ED visits represented only about 4% of the overall Medicaid spend in 2011.³ In Oklahoma’s SoonerCare program ED services accounted for approximately \$144 million for state fiscal year 2013 (SFY13), \$148 million for state fiscal year 2014 (SFY14) and \$150 million for state fiscal year 2015 (SFY15), approximately 5% each year of the State’s total Medicaid spend.

It has been, and continues to be, the OHCA’s mission “...to responsibly purchase state and federally funded health care in the most efficient and comprehensive manner possible; and to analyze and recommend strategies for optimizing the accessibility and quality of health care; and to cultivate relationships to improve the health outcomes of Oklahomans”. To that end the OHCA is seeking to fully understand a critical component of their SoonerCare program expense. They are committed to engaging data analytic models to quantify the issues, identify drivers, implement refinements to existing initiatives, identify new strategies to more appropriately manage inappropriate ED utilization, and to develop member-centric, coordinated, efficient and effective systems of care for the most vulnerable Oklahomans.

¹ Chueng, P.T., Wiler, W.L., and. Ginde, A.A. “Changes in Barriers to Primary Care and Emergency Department Utilization”. 2011 Archives of Internal Medicine 171, no. 15: 1319 – 1320.

² Medicaid and CHIP Payment and Access Commission, MACStats, Tables 24 – 27, March 2014, available at <https://www.macpac.gov/publication/macstats-archive/>, accessed 28 June 2015.

³ Medicaid and CHIP Payment and Access Commission, MACFacts, “Revisiting Emergency Department Use in Medicaid,” July 2014, available at <https://www.macpac.gov/publication/mac-facts-revisiting-emergency-department-use-in-medicaid/>, accessed 29 July 2015.

During year one of the project, the Mercer team gained a strong foundational knowledge of the OHCA Medicaid program. This included gaining a comprehensive understanding of the SoonerCare program including the populations covered under each of the different delivery models, the various population health management programs and the specific activities and interventions developed to address inappropriate ED utilization. Based on direction from the OHCA, during year two of the project Mercer was able to refine the analytic approach to provide a picture of ED utilization for those populations and topics of most interest to the OHCA over SFY13 (July 1, 2012–June 30, 2013), SFY14 (July 1, 2013–June 30, 2014) and SFY15 (July 1, 2014–June 30, 2015). This executive summary presents key findings from Mercer's August 24, 2016 Oklahoma Emergency Department Utilization report. The full report: includes a detailed description of the Oklahoma Medicaid population and SoonerCare programs; provides detailed statistical analysis of SoonerCare ED utilization over three SFYs; shares a description and results of Mercer's low-acuity non-emergent (LANE) methodology over three SFYs.

Oklahoma Medicaid Program and Initiatives

SoonerCare, Oklahoma's Medicaid program, provides coverage through a wide variety of health care benefits and innovative programs to a diverse population of adults and children, often considered to be the most vulnerable citizens in the State. To accomplish its goal, the OHCA utilizes two different health care delivery models and a variety of programs and initiatives through which it administers the various benefit packages.

SoonerCare Traditional

In this "traditional" fee-for-service (FFS) payment model, SoonerCare Traditional enrollees receive a comprehensive medical benefit plan and can access services from contracted SoonerCare providers; enrollees are not required to select a primary care provider (PCP). SoonerCare Traditional provides coverage for members who are institutionalized, in state or tribal custody, covered under a commercial health maintenance organization (HMO), enrolled under one of the Home and Community-Based Services (HCBS) waivers or dually eligible for both Medicare and Medicaid services; approximately 31% of SoonerCare Traditional enrollees are dual eligible.

SoonerCare Choice

SoonerCare Choice provides a managed care option typically referred to as "enhanced" primary care case management (PCCM) more commonly known as the patient-centered medical home (PCMH) model. The PCMH model is centered on enrollees selecting a PCP who is responsible for providing a medical home for the member. The SoonerCare Choice model provides Medicaid benefits to over 70% of all SoonerCare enrollees.

Other SoonerCare Programs

The OHCA operates a number of other programs that offer either limited benefits or premium assistance to qualifying individuals including those who are currently receiving home and community-based services.

- Sooner Plan (family planning services and contraceptive products).
- Soon-to-be-Sooners (pregnancy-related medical services).
- SoonerCare Supplemental (dual eligibles).
- Insure Oklahoma Employer-Sponsored Insurance (ESI) (premium assistance for small businesses).
- Insure Oklahoma Individual Plan (basic health services for uninsured adults).

SoonerCare Initiatives

Over the past seven years, the OHCA has implemented initiatives that can be classified as population care management and PCP practice transformation; these initiatives are not mutually exclusive to each other. The purpose of these initiatives includes engagement of SoonerCare enrollees in active health care decision-making, including choosing where to receive health care services and developing self-management skills to support ongoing efforts to manage individual chronic conditions; the delivery system initiatives additionally focus on quality of care and expanding program access.

- The care management unit focuses on individuals with complex or high-risk health care needs such as high-risk pregnancies, medically complex newborns, children and adults; women undergoing breast or cervical cancer treatment and individuals with repeated ED visits.
- The OHCA's Health Management Program (HMP) and their Chronic Care Unit (CCU) engage members through methods such as individual telephonic support and embedding health coaches and facilitators in larger volume primary care practices.
- Patient Centered Medical Home (PCMH) members are aligned with a PCP who is responsible for meeting strict access and quality of care standards. PCMH providers are paid a monthly care management fee based on the number of quality standards met. Exhibit 1 provides information on the success of the PCMH model.
- Health Access Network (HAN) provider systems are community-based, integrated networks intended to advance program access, quality and cost-effectiveness goals by offering greater care coordination support to affiliated PCMH providers.

Exhibit 1: Medical Homes and Inappropriate ED Utilization

Recent research indicates that medical home models can curb inappropriate ED utilization 5-8%.

Defining the Issue

As part of the year one project, Mercer was asked to help the OHCA document a definition of “inappropriate” ED utilization and identify how the definition may differ from the provider’s perspective. Mercer’s approach to this task included conducting telephonic interviews with various stakeholders including the OHCA staff members, community primary care physicians, hospital representatives and ED physicians. The result was development and use of the term Primary Care Treatable/Low-Acuity Non Emergent (PCT/LANE) ED utilization.⁴ This term will be used in the discussion of the OHCA population analysis results.

Throughout the remainder of this executive summary, ED utilization that is often referred to as “inappropriate”, “unnecessary”, “avoidable” or “preventable” will be referred to as primary care treatable and/or low-acuity non-emergent. Primary care treatable and/or low-acuity

⁴ Primary Care Treatable/Low-Acuity Non Emergent: SoonerCare member ED visits for low-acuity conditions, as well as primary care treatable and/or low-acuity non-emergent conditions that, with evidence based and consistent outpatient management may not have deteriorated to the point of necessitating a SoonerCare member ED visit. Examples of low-acuity conditions include cough, diaper rash, urinary tract infections, and sore throat. Examples of primary care treatable ambulatory care sensitive conditions include asthma, diabetes, and hypertension.

non-emergent can be defined as those ED visits by SoonerCare members for low-acuity conditions that may not have deteriorated to the point of necessitating a SoonerCare member ED visit with evidence based and consistent outpatient management.

Statistical Analysis of ED utilization in Oklahoma

The OHCA shared member eligibility, provider and member claims data files with Mercer for the three years under review (2012–2015). The data were parsed, analyzed and are presented by SFY: SFYs begin July 1 of each year and end on June 30 of the following calendar year. The OHCA eligibility system allows member assignment in multiple aid categories in one month. For purposes of analysis, a hierarchy was provided by the OHCA to assign one aid category for each month of eligibility. For each month of eligibility with a PCMH selection, a member was categorized as SoonerCare Choice, otherwise the member was categorized as SoonerCare Traditional. Given that a member could change membership in SoonerCare programs during the SFY, each member was placed into a single combination of the eligibility fields based on the program in which they were enrolled during the majority of their enrollment for that SFY. For example, if a member was in SoonerCare Traditional for eight months, but SoonerCare Choice for three months, they were categorized as a SoonerCare Traditional member for that SFY for purposes of statistical analysis.

From the member claims files, ED visits were counted per member, and paid claims were summed to calculate total visits and ED per member per month (PMPM) dollars paid during the study period. The primary diagnosis code for each ED visit was captured from the member claims file. Members were categorized as “frequent ED users” if they had four or more ED visits in the SFY being analyzed. An ED visit was defined as someone who was treated and released; or an individual who had an ED visit but was not subsequently admitted to the hospital.

Mercer conducted descriptive, univariate and multivariate statistical analyses. As a first step in the analysis, Mercer conducted descriptive statistical analyses. Data were summarized for the entire SoonerCare population, SoonerCare Choice, SoonerCare Traditional and members with at least one ED visit during the study period. ED utilization rates per 1,000 member months were calculated as the number of ED visits divided by the number of member months, multiplied by 1,000. Complete tables of statistical analyses are presented in the comprehensive report.⁵

SoonerCare Demographics

Over the course of the three years of data Mercer analyzed, the demographic characteristics of the SoonerCare population, which is just over one million members, remained fairly stable. As of SFY15, more than 61% of the SoonerCare population was under the age of 21, female and Caucasian; across the three years of data there was some variance in the racial distribution of the population and an increase in the number of individuals who declined to select a racial category. The percentage of pregnant members remained consistent at 5% across all three SFYs analyzed.

In SFY15 there was a decrease in the total SoonerCare population and there was a slight shift in the distribution of membership between the SoonerCare Choice and SoonerCare Traditional populations. One key item when considering this decrease in total SoonerCare population was the change in approach to passive enrollment. Historically SoonerCare enrollment was

⁵ The full statistical analysis can be found in the Mercer report, Oklahoma Emergency Department Utilization: July 2016 through June 2015, August 24, 2016.

passively renewed when their income and other criteria were met. For example, in December 2013 approximately 25,355 applications were renewed via the passive renewal process. As of July 2014 the passive renewal process was suspended. This may account for some of the decrease in the total enrollment for SFY15. In SFY13 the population was split with 61.5% in SoonerCare Choice and 38.5% in SoonerCare Traditional. In SFY14 the percentage in SoonerCare Choice increased to 62.2% but in SFY15 the percentage of the population in SoonerCare Choice decreased to 58.0%. There were 38,495 more people in the SoonerCare Traditional population in SFY15 than in SFY14, a shift of more than four percentage points. This shift is interesting in that the largest shift in the distribution by age in the SoonerCare population was a 1.3 percentage point decrease in the number of members age 21–64.

The population in the majority of the aid categories that were analyzed was very stable across the three SFYs. The exceptions were the Family Planning, Insure Oklahoma and temporary assistance to needy families (TANF) aid categories. Over the three years Family Planning decreased from 7.4% in SFY13 of the SoonerCare population to 5.9% in SFY15, Insure Oklahoma also decreased from 4.2% in SFY13 to 2.6% in SFY15. In contrast the TANF population increased from 68.5% in SFY13 to 69.3% in SFY14, up to 71.3% in SFY15. The SoonerCare population has been geographically stable and fairly evenly split, between rural (approximately 46%) and urban (approximately 53%) areas across the three SFYs.

ED Utilization Descriptive Analyses

Various statistical analyses were conducted to study the relationship between member demographics and ED utilization. Consistent with previous ED utilization analysis conducted for the SoonerCare population, members with higher rates of ED utilization were female and infants or those over 21 years of age. As could be anticipated, those in the aged, blind and disabled (ABD) aid category and several of the ABD waivers had far higher ED utilization rates than any other aid category. It should be noted that the ABD waiver populations are small relative to the general population, so these rates should be considered with that caveat in mind. The six most frequent ED diagnoses were consistent across all three SFYs for the SoonerCare population, the top four were consistent for the SoonerCare Choice population and the top five were consistent for the SoonerCare Traditional population.

Across the three SFYs analyzed for the SoonerCare population the rate of ED utilization per 1,000 member months (MM) decreased each year. In SFY13 the rate was 68.9/1,000 MM, in SFY14 the rate was 65.0/1,000 MM, and in SFY15 the rate was 63.6/1,000 MM. While there was a decrease from SFY13 to SFY14 in the rate of ED utilization for the SoonerCare Choice population, there was a slight increase from SFY14 (68.0/1,000 MM) to SFY15 (68.9/1,000 MM). The rate of ED utilization per 1,000 MM decreased each SFY for the SoonerCare Traditional population from 62.0/1,000 MM in SFY13 to 59.7/1,000 MM in SFY14 to 55.8/1,000 MM in SFY15. The rate also decreased each year for members in both the rural and urban locations.

The SoonerCare population on the whole had decreased ED utilization per 1,000 MMs across all three SFYs. The rates of ED utilization per 1,000 MM in the SoonerCare Choice population showed variability across time and demographic groups. The exception to this is that the rate decreased each SFY for those members in the age group 21–64, from 139.6/1,000 MM in SFY13 to 129.9/1,000 MM in SFY14 to 127.2/1,000 MM in SFY15. The SoonerCare Traditional population demographic groups across time showed consistent decreases in the rate of ED

utilization per 1,000 MMs. The exception being some variability across the three years in the rate for those ages 21–64 and 65+.

Low-Acuity Non-Emergent (LANE) ED Utilization Methodology

Mercer developed an analytical process specifically to identify and quantify the impact of low-acuity non-emergent (LANE) ED usage. The LANE analysis provides a systematic and evidenced-based approach for evaluating trends and patterns of ED utilization. The analysis is underpinned by extensive health services research with additional input from an expert panel including ED physicians, state Medicaid chief medical officers and other clinical providers with Medicaid and managed care experience.

Low-acuity non-emergent visits are determined by diagnosis (ICD-9) and evaluation and management codes. Mercer has identified 701 ICD-9 codes related to conditions that can be considered low-acuity and non-emergent that have the potential to be considered LANE conditions. Evaluation and management (E&M) codes that are used for visits to the ED include 99281, 99282, 99283, 99284 and 99285. For purposes of Mercer’s LANE analysis, ED visits coded 99281, 99282 or 99283 (lower level of clinical complexity) are considered “potentially preventable”. Visits with an E&M procedure code of 99284 or 99285 (higher level of clinical complexity) are not included in the analysis of ED visits considered “potentially preventable”. These conditions are of high severity, may pose an immediate significant threat to life or physiologic function and require urgent evaluation by the physician or other health care professional. Conditions meeting these criteria are not considered potentially preventable.

The following is a description of LANE results grouped by SoonerCare Choice and SoonerCare Traditional populations. All tables and graphs prepared for the LANE analysis are presented in the comprehensive report.

Identification and Stratification of ED Visits

Mercer’s LANE analysis began with the identification of all ED visits within the study period. For this project, Mercer reviewed records of SoonerCare members’ ED visits for each SFY being analyzed (SFY13, SFY14 and SFY15). In order to quantify the comprehensive cost of an ED visit, Mercer aggregated all claims for the same member, at the same facility with the same date of service. The total ED visits and total ED dollars for each SFY are as follows (see Table 1 below):

Table 1: Total ED visits and total ED dollars

Program	SFY13 Total ED Visits	SFY14 Total ED Visits	SFY15 Total ED Visits	SFY13 Total ED Dollars	SFY14 Total ED Dollars	SFY15 Total ED Dollars
SoonerCare Choice	429,745	439,574	432,494	\$105,905,674	\$115,512,357	\$118,106,328
SoonerCare Traditional	240,468	211,646	216,515	\$ 38,572,877	\$ 32,314,511	\$ 31,743,703

After all ED visits were identified and claims for an individual visit were aggregated, the medical diagnoses available on the visit record were compared to Mercer’s list of LANE diagnoses. The LANE diagnoses were categorized as “low-acuity non-emergent” based on the clinical severity of the condition that drove the member to the ED. Mercer reviewed all available diagnosis information for each ED claim and identified the subset of visits with a diagnosis on the list. For the SoonerCare Choice population, 71.7% of ED visits and 64.9% of ED expenditures in SFY13, 70.8% of ED visits and 63.7% of ED expenditures in SFY14, 69.8% of ED visits and 63.2% of

ED expenditures in SFY15 were categorized as LANE. For the SoonerCare Traditional population, 49.9% of ED visits and 52.5% of ED expenditures in SFY13, 46.7% of ED visits and 49.8% of ED expenditures in SFY14, 46.6% of ED visits and 51.0% of ED expenditures in SFY15.

Mercer recognizes the significant challenges of influencing member behavior in a Medicaid population, as well as variation in clinical interpretations of the term “preventable”. As a result, each diagnosis in the LANE analysis is assigned a unique percentage which represents the portion of visits with that diagnosis code that could either be redirected to a more appropriate setting or avoided entirely. These percentages are applied to the observed utilization by diagnosis code to quantify the “potentially preventable” ED utilization. Mercer also considers the input of the attending physician through the procedure code information attached to the claim. Cases that are indicated as having the highest level of medical complexity (99284 or 99285) are not considered “potentially preventable”. Based on the severity these conditions require urgent evaluation in an emergency department setting and are not considered low-acuity non-emergent.

The SoonerCare ED utilization quantified as potentially preventable for overall ED utilization for each SFY follows (see Table 2 below).

Table 2: Potentially Preventable ED visits and Potentially Preventable Dollars

	SFY13 Total Potentially Preventable ED Visits	SFY14 Total Potentially Preventable ED Visits	SFY15 Total Potentially Preventable ED Visits
SoonerCare Choice	103,619	103,574	98,567
SoonerCare Traditional	39,313	31,285	30,785
	SFY13 Total Potentially Preventable Visits as % of Total ED Visits	SFY14 Total Potentially Preventable Visits as % of Total ED Visits	SFY15 Total Potentially Preventable Visits as % of Total ED Visits
SoonerCare Choice	24.1%	23.6%	22.8%
SoonerCare Traditional	16.3%	14.8%	14.2%
	SFY13 Total Potentially Preventable Dollars	SFY14 Total Potentially Preventable Dollars	SFY15 Total Potentially Preventable Dollars
SoonerCare Choice	\$15,049,008	\$15,543,084	\$14,867,864
SoonerCare Traditional	\$ 4,085,503	\$ 3,031,739	\$ 2,886,767
	SFY13 Total Potentially Preventable Dollars as % of Total ED Dollars	SFY14 Total Potentially Preventable Dollars as % of Total ED Dollars	SFY15 Total Potentially Preventable Dollars as % of Total ED Dollars
SoonerCare Choice	14.2%	13.5%	12.6%
SoonerCare Traditional	10.6%	9.4%	9.1%

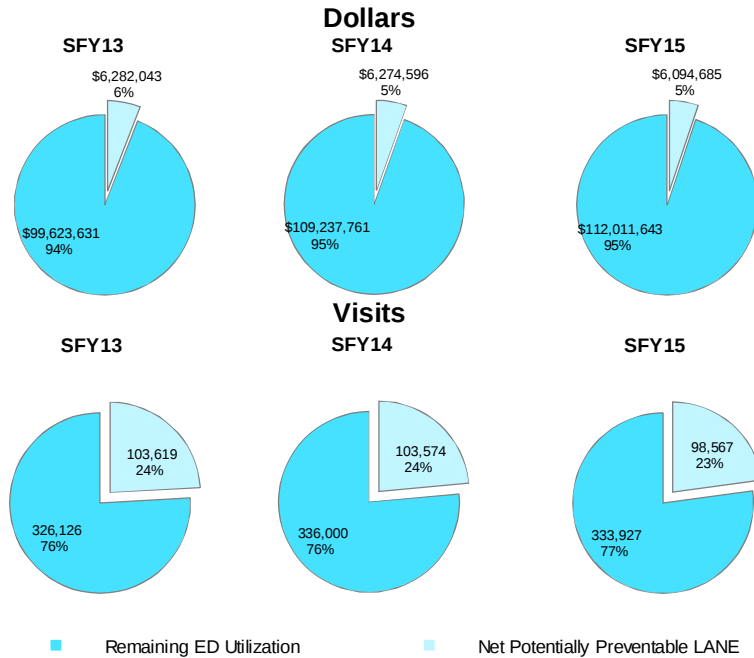
While many ED visits could have been avoided entirely, the final step of Mercer’s LANE analysis was to consider the costs of providing care in a more clinically appropriate and financially efficient setting. Mercer summarized the cost of physician office visits during the study period to quantify the cost of comparable visits to a primary care office, clinic, or specialist. The average

cost per office visit for SoonerCare Traditional and SoonerCare Choice are included below (see Table 3 below). The difference in average costs appeared to be based on underlying fees, rather than variation in the severity of cases. These unit costs were counted for each of the visits shown above as “potentially preventable”, which reduced the potential savings. For those individuals that incurred more than four LANE visits during the study period, Mercer only provided for four physician cost off-sets in the calculation. The net potentially preventable ED utilization after physician unit cost off-sets were considered follows.

Table 3: Low-Acuity Non-Emergent (LANE) Analysis Results

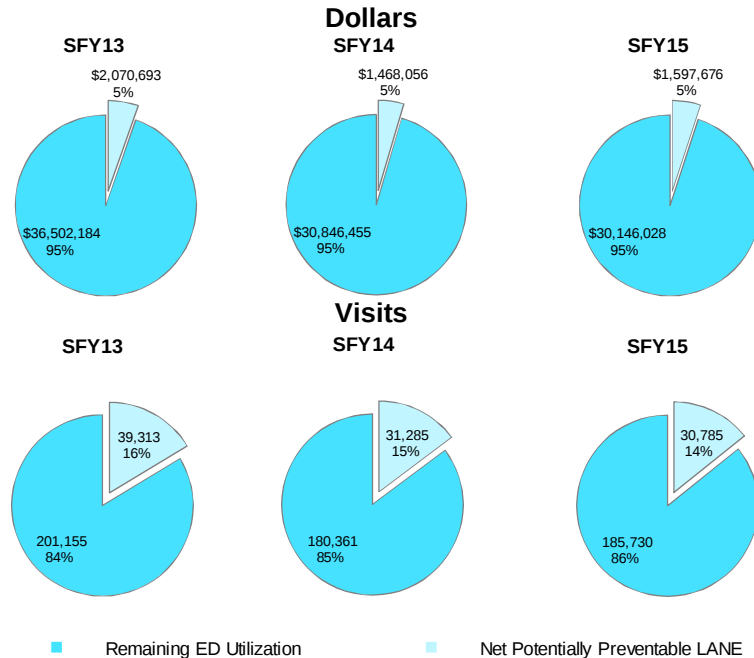
	SFY13 Total Potentially Preventable Dollars	SFY14 Total Potentially Preventable Dollars	SFY15 Total Potentially Preventable Dollars
SoonerCare Choice	\$15,049,008	\$15,543,084	\$14,867,864
SoonerCare Traditional	\$ 243,201	\$ 236,122	\$ 208,366
	SFY13 Net Potentially Preventable LANE Dollars	SFY14 Net Potentially Preventable LANE Dollars	SFY15 Net Potentially Preventable LANE Dollars
SoonerCare Choice	\$6,282,043	\$6,274,596	\$6,094,685
SoonerCare Traditional	\$ 72,018	\$ 73,087	\$ 77,314
	SFY13 Total Equivalent Provider Office Costs	SFY14 Total Equivalent Provider Office Costs	SFY15 Total Equivalent Provider Office Costs
SoonerCare Choice	\$8,766,965	\$9,268,488	\$8,773,179
SoonerCare Traditional	\$ 171,183	\$ 163,035	\$ 131,052
	SFY13 Average Provider Office Visit Cost	SFY14 Average Provider Office Visit Cost	SFY15 Average Provider Office Visit Cost
SoonerCare Choice	\$91.39	\$96.66	\$95.78
SoonerCare Traditional	\$55.64	\$54.76	\$45.64
	SFY13 Net Potentially Preventable Percent of LANE Dollars	SFY14 Net Potentially Preventable Percent of LANE Dollars	SFY15 Net Potentially Preventable Percent of LANE Dollars
SoonerCare Choice	5.9%	5.4%	5.2%
SoonerCare Traditional	1.7%	1.6%	1.8%

Exhibit 2: SoonerCare Choice Low-Acuity Non-Emergent (LANE) Analysis Results
Source: Oklahoma Health Care Authority Medicaid Management Information System, July 1, 2012–June 30, 2015



1. All ED visits with a primary diagnosis on the list of 701 codes are identified as LANE. Mercer applies a specific percentage to each diagnosis code to adjust the LANE dollars and visits to the "Potentially Preventable LANE" subset of ED visits.

Exhibit 3: SoonerCare Traditional Low-Acuity Non-Emergent (LANE) Analysis Results
Source: Oklahoma Health Care Authority Medicaid Management Information System, July 1, 2012–June 30, 2015

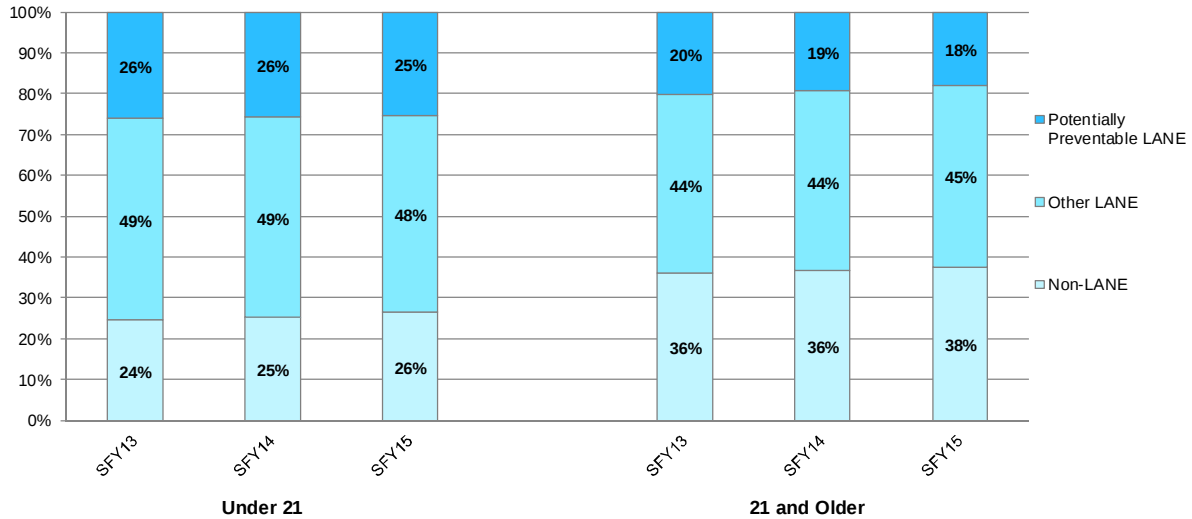


1. All ED visits with a primary diagnosis on the list of 701 codes are identified as LANE. Mercer applies a specific percentage to each diagnosis code to adjust the LANE dollars and visits to the "Potentially Preventable LANE" subset of ED visits.

As noted earlier, more than 60% of the total Medicaid population is under 21 years of age. In the SoonerCare Choice population under 21, the percentage is even higher at 75%. In the SoonerCare Traditional population, approximately 33% of the population is under the age of 21. The graphs below (Exhibit 4 and Exhibit 5) show a comparison of LANE utilization for members who are under 21 years of age and those 21 and older for the SoonerCare Choice and the SoonerCare Traditional populations.

Exhibit 4: SoonerCare Choice Low Acuity Non-Emergent (LANE) Visit Statistics by Age Group

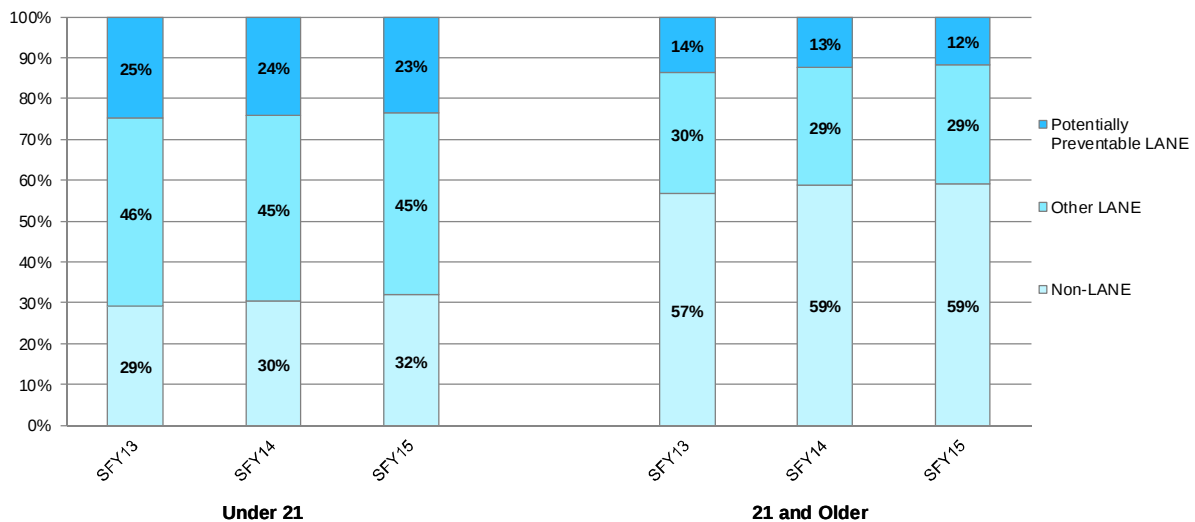
Source: Oklahoma Health Care Authority Medicaid Management Information System, July 2012–June 2015



1. All ED visits with a primary diagnosis on the list of 701 codes are identified as LANE. Mercer applies a specific percentage to each diagnosis code to adjust the LANE dollars and visits to the "Potentially Preventable LANE" subset of ED visits.

Exhibit 5: SoonerCare Traditional Low Acuity Non-Emergent (LANE) Visit Statistics by Age Group

Source: Oklahoma Health Care Authority Medicaid Management Information System, July 2012–June 2015



1. All ED visits with a primary diagnosis on the list of 701 codes are identified as LANE. Mercer applies a specific percentage to each diagnosis code to adjust the LANE dollars and visits to the "Potentially Preventable LANE" subset of ED visits.

Conclusion

Social determinants of health, that is the conditions in which people are born, grow, live, work and age, are significant contributing factors to ED utilization. For example, some health services research indicates that individuals with limited english proficiency engage less frequently with primary care and utilize the ED more frequently.⁶ Other factors that influence ED utilization patterns may include access to transportation, habituation, convenience and direct to consumer marketing (re: advertising ED wait times). Innovative models such as accountable care organizations that meet both ambulatory and inpatient care needs are designed in part to serve those with the most challenging social determinants of health. One of the keys is making ambulatory care more convenient and coordinating access to care. By design, accountable care organizations should also enhance communication between ambulatory care and ED providers to facilitate consistent care plans across various healthcare settings.

As the data analysis in the preceding section has shown, PCT/LANE ED utilization, while consuming more dollars than desired, has decreased since July 2012. Whether this finding is a trend or a result of other external factors, remains to be seen in subsequent evaluation years. Appropriate caution should be taken given that this evaluation focuses on only one component of the delivery system, ED utilization, and does not provide a more global view of how all the OHCA services are fitting together, for example primary and preventive care or case management. Additional statistical analysis of ED utilization trends and intervention implementation may provide insight.

Lower PCT/LANE utilization may be a positive outcome, but should be viewed in the context of whether primary care services have increased and whether evidenced based care and prevention outcomes have improved. Given the current physician shortage in rural, underserved areas it raises questions when fewer people are accessing the ED for less severe needs (PCT/LANE visits). Consideration for the possibility that individuals are either not seeking or not receiving adequate prevention and wellness services resulting in, what appears to be more appropriate ED utilization, only because the severity of the condition is such that it warrants more significant treatment, up to and including an inpatient admission.

The state of Oklahoma is not alone in the challenges it faces managing ED utilization. This is a multifaceted issue facing all states and delivery systems including FFS and capitated managed care. There are multiple stakeholders, sometimes with competing interests and needs. As evidenced in Oklahoma's health management and care management programs, there is no one technique that works for all members. There is not one approach that fits all, no silver bullet.

⁶ Njeru, J.W., St. Sauver, J.L., Jacobson, D.J., Ebbert, J.O., Takahashi, P.Y., Fan, C., and Wieland, M.L. "Emergency Department and Inpatient Health Care Utilization Among Patients Who Require Interpreter Services". BMC Health Services Research (2015) 15:214



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