Session # F5

Primary Care Patients' in Family Medicine Integrated Care and Emergency Department Utilization

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CFHA Annual Conference
October 17-19, 2019 • Denver, Colorado

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

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Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

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Learning Objectives

At the conclusion of this session, the participant will be able to:

- Explore the relationship between ED utilization, behavioral health needs, and access to integrated behavioral health care.
- Discuss findings and implications of an economic analysis of ED utilization patterns before and after participant enrollment in an integrated behavioral health care program.
- Identify potential applications of care utilization findings to other primary care and/or specialty clinic settings.

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Bibliography / Reference

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Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

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Introduction: background info

- Utilization of the ED for chief complaints manageable at lower levels of care = lower cost-efficiency and lack of continuity (IOM, 2001).
- Behavioral health comorbidities frequently moderate the relationship between patient needs and ED utilization (ARHQ, 2016).
- Serrano et al., 2018, found PCBH model was associated with an 11.3% decrease ratio in ED visits to primary care encounters when compared to control

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Introduction: our model

- 2015: Implemented integrated behavioral health care (IBHC) model in a family medicine clinic (FMC)
  - Warm-handoffs
  - Brief BH intervention
  - Short-term BHP follow-ups.
- 4 full-time fully licensed BHPs, 1 BH intern (master's level), 1 BH fellow (doctoral), and 1 Behavioral Care representative covering FMC

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Methods: study population

Enrollment Criteria

- Enrolled in an IBHC program for at least one year
- Pt of FMC for ≥ 1 yr at enrollment
- ≥ 1 ED visit pre- or post-enrollment.

Participants (n=186):

- 79% female and 21% male
- 50% Non-Hispanic White, 46% African American; and 4% Other;
- 37% 18-44 years, 45% 45-64 years, and 18% ≥65 years.
- FMC patient panel = 58% Private, 20% Medicare, 14% Medicaid, 4% Self Pay and 3% Other.

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Methods: study design & procedures

- Used multiple regression analysis to explore correlation between IBHC enrollment and # of ED visits 1 yr +/– enrollment.
- Collected electronic health record data for participants enrolled in the IBHC.

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Methods

- **Our hypothesis:** By connecting patients with IBHC in their primary care clinic, we projected a change in ED utilization.

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Results

- Our preliminary analysis found that **enrollment in IBHC was not significantly associated with a decrease nor increase in ED utilization.**

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Discussion

- What do we do with **negative results**? Consider:
  - Dosing?
  - Primary diagnosis associated with ED visit (i.e., behavioral health- vs. physical health-related, chronic vs. acute)?
  - Case comparison between this IBHC program's and other program's effectiveness in lowering and/or offsetting costs.
- Next steps

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Why is this so tricky?

- Are we looking at the right group? Higher ED utilization among:
  - Older, female, high BH comorbidity, higher previous hospitalizations (Soril et al., 2016)
  - Younger, female, racial-ethnic minority, higher chronic disease burden, higher levels of poverty and unemployment, lower levels of education, Medicaid (Vinton et al., 2014)
  - Highly frequent users, substance use (Doupe et al., 2012)

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Why is this so tricky?

- How are we operationalizing our definitions?
  - Less frequent (1-6 visits annually)/frequent (7-17)/highly frequent (18+) (Doupe et al., 2012)
  - "Too frequent" – only if patient could have been better served in another setting. Consider:
    - Reason for visit
    - Are patients getting what they need? (Weber, 2012)

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Why is this so tricky?

- Are we measuring in the right way?
  - Ratio vs. total count. Highest ED utilization associated with higher outpatient utilization (Doupe et al., 2012; Vinton, et al., 2014) and higher mental health costs (Vinton, et al., 2014)

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Next steps

- **Better science > Better interventions**
- Challenge our bias as clinicians/researchers
- Base hypotheses on current literature
- Findings as a means to develop tailored interventions to keep people healthier.

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Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.

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Join us next year in Philadelphia, Pennsylvania! Thank you!