

# ED UTILIZATION BY UNINSURED AND MEDICAID PATIENTS AFTER AVAILABILITY OF TELEPHONE TRIAGE

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**Problem:** For emergency departments experiencing crowding and a high percentage of patients leaving without being seen, a telephone triage service can provide other care options for low-acuity patients.

**Methods:** A nonexperimental pre- and postintervention comparative design was used to measure ED visit volumes from Medicaid and uninsured patients presenting with a low-acuity health care problem. Visit volumes for the 12 months before and 12 months after the initiation of telephone triage were compared.

**Results:** The overall low-acuity visit volume increased in the first 12 months of telephone triage availability. However, the

proportion of low-acuity Medicaid and uninsured patients seeking ED care decreased. For the first 12 months of operation, telephone triage received 10,055 calls. Sixty percent of the calls (N = 6086) were from uninsured and Medicaid patients. More than 43% of the calls resulted in a self-care decision.

**Implications for Practice:** A telephone triage service may help decrease ED crowding by communicating other care options to patients with low-acuity health problems.

**Key words:** Telephone triage; Emergency department; Crowding; Medicaid; Uninsured; Utilization

Medicaid and uninsured patients are more likely than insured patients to seek ED care for low-acuity health problems and therefore are over-represented in the low-acuity visit volumes.<sup>1</sup> These data underscore a local pattern of underinsured patients utilizing the emergency department as a substitute for primary care. Influenced partly by Medicaid reimbursement, 31% of physicians in Texas do not accept new Medicaid patients.<sup>2</sup> Utilization of the emergency department for low-acuity health issues adds to crowded emergency depart-

ments, generates emergent care delays, and increases health care costs.<sup>1</sup>

The telephone triage service is a mechanism used in many countries to help guide health care decisions over a telephone. Several studies have found that callers comply with the advice given<sup>3</sup> and that the service decreases health care provider workloads.<sup>4</sup> In addition, the service is associated with high patient satisfaction scores.<sup>5</sup> A synthesis study of telephone triage services from 1999 to 2008 found evidence of decreased ED utilization and could be considered a safe alternative for low-acuity health care issues.<sup>6</sup> Further, telephone triage has been credited with a 14% decrease in ED utilization.<sup>7</sup>

Telephone triage is a timely contemporary intervention because evidence is conflicting about the effects of health care reform on ED use. Comparing the National Health Interview Survey before and after the 2006 Massachusetts health care reform revealed an increase in the intention to use primary care and a matching decrease in the intent to utilize the emergency department.<sup>8</sup> This finding inferred that access to insurance could decrease ED utilization. However, another Massachusetts study found no reliable conclusion that access to health insurance or primary care decreased ED utilization for asthma and upper respiratory illnesses.<sup>9</sup> An additional synthesis review including the Massachusetts health care reform efforts indicated that the expansion of insurance coverage may actually increase ED crowding.<sup>10</sup>

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## Local Problem

This practice improvement initiative took place at a 420-bed academic medical center that is designated as a level I trauma center by the state of Texas. The medical center had just completed an expansion of the emergency department, growing from 40 to 58 beds. Even with the expansion, crowded conditions continued because of the volume of visits. Data for this emergency department revealed that 71% of the low-acuity visits were made by uninsured or Medicaid patients. The telephone triage service was implemented in an attempt to decrease this low-acuity demand.

## Significance

The Patient Protection and Affordable Care Act<sup>11</sup> instructed states to expand Medicaid through a change in the income qualification levels. However, expanding the number of Medicaid recipients who are more likely to seek care in the emergency department may contribute to the current volume-related problems.<sup>1</sup> In recognition of crowding and its impact on patient care, the Center for Medicare and Medicaid Services is now developing patient flow throughput measures. The intent of the measurement is to withhold reimbursement from hospitals that are unable to achieve patient flow targets.<sup>12</sup> If telephone triage can decrease ED utilization for low-acuity problems, it will be a contributing factor in resolving crowded conditions, decreasing patient flow demands, and decreasing health care costs.

## Intended Improvement

The aim of this practice improvement evaluation was to determine if there is a decrease in ED utilization of low-acuity health care problems in the local uninsured and Medicaid patient populations 1 year after implementation of a telephone triage service. Low acuity is defined as a final billing code of level 4 (semiurgent) or level 5 (nonurgent). The telephone triage service was implemented to reduce the number of patients seeking ED care for low-acuity problems. The focus was on the uninsured and Medicaid patients because they represented 71% of the low-acuity volume.

## Methods

The Institutional Review Board determined that their review of this study was not required.

## IMPLEMENTATION OF TELEPHONE TRIAGE

The telephone triage software company with the preferred physician-directed algorithms was selected. Staff were hired, and on April 30, 2013, a telephone triage service center was set up to receive telephone triage calls 24 hours per day, 7 days a week. The initial staff consisted of a department director, 4 registered nurses (RNs) working 12-hour shifts (4.2 full-time equivalent positions), and 2 on-call RNs as contingency staff. This staffing pattern only accommodated 2 telephone triage callers at a time when the director was present. Before the first year was over, another RN was added to the evening hours to accommodate peak daily call volume.

## MARKETING

Prior to initiation of the telephone triage service, the marketing department for the hospital mailed refrigerator magnets to the uninsured and Medicaid patients who had visited the emergency center in 2012 and were coded as either nonurgent or semiurgent at the time of their visit. The refrigerator magnet marketed the telephone triage phone number and an offer to help with health care decisions. In the first few months of operation, the telephone triage staff also marketed the service through neighborhood events, radio ads, television interviews, and newspaper ads and by placing flyers in churches, as well as community-owned buildings. Further, they networked with local clinics and found some who were willing to provide standing appointments to be filled with telephone triage callers.

## DATA COLLECTION

The data collected and analyzed from the telephone triage service were caller ZIP codes, monthly call volumes, and the health insurance category of the caller. ED visit data were analyzed for level of care and visit volumes.

After the first year of operation, the telephone triage call volume was sorted by ZIP codes. We then collected the visit volume of low-acuity ED visits for the 10 ZIP codes with the most calls from May 1, 2013, to April 30, 2014. The low-acuity ED visit volume was then collected for the same ZIP codes for the period of May 1, 2012, to April 30, 2013 (12 months prior to opening). The visit data were then filtered to look specifically at the uninsured and Medicaid patient groups to determine visit volume differences for the two 12-month periods.

Relative risk was used as the statistical test to determine if the proportional changes in visit volumes were significantly different between the 2 time frames. Relative risk

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