ED Visits: Proposed Definition and Suggestions for D2D 4.0

Purpose of an ED visit indicator

Measuring ED visit volume is intended to support teams in diverting a proportion of visits that could be managed within primary care settings or preventing the need for emergency care in the first place.

Background

Ontario (and Canada) have high ED visit rates. Part of the rationale for investment in primary care is to reduce ED visits. MOHLTC has signalled an intent to include ED visits in the renewed contract with FHTs in the future.

There are several approaches to tracking Emergency Department visits including "ED visits Best Managed Elsewhere", "less urgent ED visits – CTAS 4-5" and patient self-report of ED visits, among others. There are limitations with each of these definitions. This document describes an approach to measuring ED visits that balances these limitations. It also includes suggestions regarding inclusion of the indicator in D2D 4.0 based on the clinical consultation process.

Proposed Indicator Definition

Low acuity ED visits (ie CTAS 4 or 5), possibly broken down to show visit volume between 8 am and 5 pm (specific end points to be confirmed in consultation with ICES).

Suggestions regarding inclusion in D2D 4.0

Include as an indicator "of interest to external stakeholders": Members have persistent concerns about how actionable an ED visit indicator is, almost independent of definition. Members agree that they are able and willing to do things to help their patients find ways to address their concerns without going to the ED. And they also feel that there are so many other factors contributing to ED visits that a specific focus on measuring and reducing ED visits is not the best way to improve quality in primary care in the current healthcare system. However, members are interested in monitoring ED visit rates to continue to inform conversations with external partners who they recognize have very high levels of interest in this indicator.

Consider reporting only for hospitals with high ED volume: In recognition of the perverse financial incentives for small hospitals to maintain ED visit volumes to ensure financial viability of their emergency department services, members suggest tracking ED visit volumes only for primary care providers associated with hospitals for whom volume is less of a financial sustainability issue.

Consider reporting CHANGE in ED visit volume over time: Misclassification of ED visits as "primary care sensitive" remains an issue in spite of a plethora of algorithms to resolve the problem. To minimize the impact of this, teams might consider measuring *change in ED visits over time*, rather than focussing on the actual number of visits. Either way, targets for measurement need to consider that only a

proportion (approximately one third, by a variety of estimates) of CTAS 4/5 visits are amenable to primary care intervention.

Equip teams with drill-down access to data: Regardless of the definition used, teams will only be able to intervene if they know which of their patients are visiting the ED. Better access to timely, patient-specific data will help teams coordinate care for patients with multiple visits or provide more support for patients with mental health issues for whom the ED is far better than any other help they feel comfortable seeking.

Provide supports to help teams intervene to avoid ED visits: Members agree that, independent of any definition, it would be useful to put more energy and resources into specific activities to help patients avoid the ED. These activities range from clinician training to access to diagnostic equipment and public and provider education (see Appendix B).

Rationale for proposed definition

Highlights of input from broad-ranging consultation over the past year to inform the proposed definition include the following (see Appendix A for more complete details of the input):

- The issues most commonly identified with measuring ED visit rates are not so much about the definition as they are about the difficulty in making a difference in ED visit volume.
- The proposed definition aligns with many existing reporting standards.
- More refined definitions of primary-care sensitive ED visits are still considered to over-estimate the number of visits that primary care providers could prevent. The most restrictive definition (Eg ED visits Best Managed Elsewhere) is considered to accurately identify preventable ED visits but identifies so few (eg 3%) that even complete success in addressing it will not have much impact on overall ED volume.
- No definition (whether it aligns with existing report or accurately identifies primary care sensitive visits or not) will address the underlying issues regarding policy, system design and patient choice that counter the effect of efforts to reduce ED visit reduction.

Appendix A: Summary of Input from consultation activities

Analysis of CTAS 4/5 data (SEPTMEBER 2015)

Preamble: CTAS 4 or 5 visit data for the entire province were extracted from the Intellihealth data repository (of the MOHLTC) for April 2014 and analyzed to describe reasons and timing of visits.

Summary of CTAS 4/5 visit data

The analysis showed that the most common reasons for visits only account for about 6% of all CTAS 4 or 5 visits. This means, that it is not possible to target a particular set of conditions or complaints to make much of a difference in overall ED visit volume. This is, incidentally, one of the challenges with using the ED visits Best Managed Elsewhere indicator. Although there is solid consensus that these visits indeed could be managed elsewhere, they account for 3% of ED visits overall. Focusing on them does not represent much potential benefit to the system. The analysis also showed that the majority (ie about 60%) of CTAS 4 or 5 visits occur during the daytime (ie 8 am to 5 pm).

Evaluation of Formal algorithms for primary care sensitive ED visits (OCTOBER 2015)

Preamble: Two formal algorithms to identify ED visits that could potentially be managed in primary care were applied to the CTAS 4/5 data extracted from Intellihealth (see above).

Summary of results

The New York and Alberta algorithms both estimated that about one third of CTAS 4 or 5 visits were potentially manageable in primary care. However, there was not complete overlap in the cases, suggesting that even with the refinements in the identification of cases that might be managed in primary care, there is still room for interpretation.

	Background	Results
New York	probability that a visit is "primary care treatable", based on diagnosis	37% of CTAS 4/5 visits are Primary Care Treatable or non-emergent
Alberta	classification of conditions as "family practice sensitive"	31% of CTAS 4/5 visits are Family Practice Sensitive

Local team-level study of "avoidable" ED visits (OCTOBER 2015)

Preamble: One team undertook a chart review of ED visits as part of an internal project examining options to reduce ED visits.

Summary of results

- A group of physicians completed a manual chart review for 75 ED visits which were assumed to be low acuity (even though no CTAS data was available) because 97% were not admitted
- 37% of visits could have been managed in the team
- Many visits were in the daytime (42% between 0800-1600) and on week-days (67% of visits)
- The majority of patients visiting the ED (78%) did not contact the FHT prior to going to the ED

Clinical consultation (JULY 2015 – JAN 2016)

Preamble: Individual and group consultations were held with approx. 30 physicians to gather input on a revised definition for this indicator.

Summary of Input:

- Include CTAS 4/5 visits made during office hours
- Due to policies regarding hospital ED funding, physician remuneration and patient choices, not nearly all ED visits made after-hours are "avoidable", regardless of CTAS score.
- Exclude "unavoidable" visits, although it was acknowledged that defining what was "avoidable" remained a challenge
- ED visits "best managed elsewhere" (ED BME) was one option but this definition was rejected these visits make up only about 3% of all ED visits
- Consider alternative measures. For example, instead of tracking ED visits, track contact with FHT before ED visit, although there was not consensus on whether these visits should or should not be excluded from the indicator
- Strategies to help reduce ED visits (e.g. patient education and accountability, improved access to lab services after-hours) must be implemented at the same time as ED visit rate reporting.

AFHTO conference "Family Feud" (OCTOBER 2015)

Preamble: AFHTO hosted a Family Feud between family physicians and Emergency physicians to identify opportunities for primary care providers to intervene to reduce the need for ED visits.

Summary of discussions

Following discussion of a series of cases, the participants identified some changes that could have an impact on ED visit volumes.

- ***Changes at the Patient Level***
    - There is a need for more targeted patient education activities to reduce ED visits
    - E.g. to combat public perception that "if you want to be seen today, you should go to the emergency department.
    - Suggestion: have office staff call to remind patients that physician has 'X' number of spots per day for advanced access
- ***Changes at the model and/or System Level (i.e. AFHTO, MOHLTC)***
    - Work with partners to get timely information flow from hospital to primary care
    - Advocate for resolution of policy and system issues that incent higher ED visit volume, independent of access to and quality of primary care
- ***Changes at the Physician Level***
    - Consider offering house call services to help keep patients at home
    - Improve physician education around diagnoses that are commonly sent to the emergency when they could be managed in primary care (e.g. cellulitis)
    - Educate physicians to educate patients more consistently about primary care sensitive conditions

Membership-wide vote (NOVEMBER 2015)

Preamble: AFHTO members were asked to vote on plans for including this indicator in subsequent iterations of D2D.

Summary of Results:

- 85% of respondents agree D2D should include an ED visit measure but some think it is a SYSTEM measure therefore not appropriate as a primary care measure.
- 71% agree the definition should include all CTAS 4/5 visits. However, 45% want to include only those in the daylight hours and 51% want to include only those that are "primary care sensitive".
- Comments from members include the following:
    - Lack of real-time data makes it impossible to do anything about ED visits. Primary care doesn't even get data in time for performance measurement and QI.
    - Patients can choose to go to ED, independent of availability of primary care so therefore primary care should not be measured on ED visits.
    - When the ED is the after-hours service, it is not possible nor desirable to reduce ED visits.
    - There are policy drivers that incent higher volume ED visits to keep hospital ED operational, maintain sufficiently attractive physician remuneration and avoid "access bonus" penalties.
    - Emergency department and family doctors do not always agree on what is primary care sensitive and give conflicting advice to patients

MOHLTC Discussion regarding new FHT contract (January 2016):

Preamble: AFHTO discussed this indicator with MOHLTC in the context of proposing indicators for inclusion in the new FHT contract.

Summary of input

MOHLTC's priority is to reduce ED visits and are likely to include a measure of ED visits in the new FHT contract. They considered AFHTO's position that

- Additional resources are needed to help primary care teams put in place some of the strategies identified to help reduce ED visits (see family feud notes above)
- Policy drivers that incent higher volume ED visits to keep emergency departments operational, as well as penalties to physician access bonuses for walk-in visits, must be addressed.

Appendix B: Enablers to reduce ED visits

Access to data and reporting

Team, group and individual physician-level performance on this indicator are available for all Ontario primary care providers (regardless of model of care) from Primary Care Practice Reports via HQO portal.

Additional tools and more timely access to patient-specific data (eg e-notifications) are needed to support improvements within teams.

Targets for performance need to reflect the observation that probably no more than one third of CTAS 4 or 5 visits are currently possible to divert to primary care providers.

Attention to policy drivers for ED visits:

Credible attention to the perverse policy drivers of ED visits is crucial to ensure engagement of primary care providers with this indicator.

Clinical resources and provider supports

Access to EKG equipment and interpretive support could help some teams manage patients who might otherwise visit the ED.

Decision-support tools (similar to Ottawa ankle rules) for issues like cellulitis or other indications for IV antibiotics, Bells palsy and perinatal care might increase confidence of providers in managing patients who might otherwise visit the ED.

Patient education

Central (ie provincial-level) delivery of patient education to counter the long-standing perception that primary care is not available after hours might influence patient choice about going to the ED.

Team-level patient and provider education via messages from receptionists and team voice-mail about the options available for after-hours care such as evening appointments, home visits, phone support etc might influence patient choice about going to the ED.