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Do Adult Medicaid Enrollees Prefer Going to their Primary Care Provider's Clinic rather than Emergency Department (ED) for Low Acuity Conditions?

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Abstract

Background—The rates of annual visits for adult Medicaid enrollees to the emergency department (ED) are increasing. Many programs throughout the country are focused on engaging patients in the use of their primary care providers (PCP) rather than the ED for low acuity conditions. It is unclear, however, the proportion of patients that are willing to utilize primary care services rather than the ED if they are given the choice.

Methods—Cross-sectional study of **adult Medicaid enrollees (18 years)** presenting to a large, urban, academic ED from June-August 2012 with a low acuity condition **was performed**. We excluded patients who did not have a PCP or active Medicaid insurance. Our primary goal was to determine the proportion of patients that prefer to use the ED, rather than their PCP clinic, if an appointment was immediately available. Our second goal was to understand why patients would prefer ED over PCP care.

Results—150 patients agreed to complete the survey, and 95 (63.3%) met our inclusion criteria. **Forty-three patients (45.3%)** stated preferring to use their PCPs rather than the ED if an appointment was available at that time. Thirteen (48.1%) cited that the ED had more technology or specialty care services available when compared with their PCP's clinic, 8 (15.4%) were in significant pain, and 6 (11.5%) felt the care they received in the ED was better than what they would receive in their PCP clinic.

Conclusions—Our study shows **that a little less than half** of adult Medicaid enrollees presenting to the ED with low acuity conditions would have preferred to use their PCP rather than the ED, if an appointment had been immediately available.

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Introduction

The rates of annual visits to the emergency department (ED) are increasing, beyond what can be predicted by population growth alone.^{1,2} Adults with Medicaid have contributed the most to this increase, with a high proportion of these visits for ambulatory care sensitive conditions.^{1,3} Although many of these Medicaid enrollees are quite ill and need to utilize the ED, others could be treated in a less expensive setting (i.e., primary care or urgent care clinic).⁴⁻⁶ Previous studies show that adult Medicaid enrollees are more likely to utilize the ED because of primary care access barriers (e.g., inability to get through on the telephone to get an appointment) when compared with privately insured patients.⁶⁻⁸

The implementation of the Affordable Care Act (ACA) added millions of newly Medicaid enrollees to the health care system.⁹ The ACA also ignited the development of Medicaid state-wide Accountable Care Organizations (ACOs) programs.¹⁰ These organizations align financial incentives with quality of care, by improving primary care utilization.¹⁰ It is unclear, however, the proportion of patients that are willing to utilize primary care services rather than the ED if they are given the choice. Understanding the patients' perspectives can help to illustrate the challenges associated with engaging patients in primary care.

In this study, we assessed adult Medicaid enrollees using the ED for low acuity complaints and their preference for ED versus primary care provider (PCP) use, if an appointment with the PCP had been immediately available. We further inquired about their reasons for this preference in an open-ended question.

Methods

This study was a cross-sectional study of adult Medicaid enrollees (≥ 18 years) presenting to a large, urban, academic medical center with an estimated annual volume of 100,000 ED visits. This ED is located in a small town with ~130,000 residents, with a quarter of its residents residing below federal poverty level. There are only two hospitals in the community, with our site study being the larger of the two. There are three major Federal Qualified Health Centers (FQHC) where most underserved patients utilize primary care services. We recruited study participants in the ED, during randomly selected blocks of time of 10 AM -3 PM and 3 PM- 8 PM (busiest hours of the ED), seven days a week, from June-August 2012. There was a total of 43 random blocks, of which 3 were weekend days. We identified Medicaid-insured adults presenting to the ED with low acuity conditions, defined as having an Estimated Severity Index (ESI) of 3, 4, or 5 through the electronic health record ED tracking board. We excluded patients who met criteria for other concurrent studies (opiate abuse, smoking cessation, alcohol dependence, flank pain). To include a diverse population of patients, we administered the surveys in either English or Spanish. The study was approved by the Yale University Institutional Review Board.

Two trained research assistants (a medical student and masters-level public health student) identified, approached, and consented participants, and they administered all surveys. Surveys were conducted in a private area within the ED and took ~ 20 minutes. The survey responses were combined with hospital claims data in order to confirm insurance status and

to calculate the number of ED visits in the previous 12 months. The survey questions focused on socio-demographic characteristics and clinical and health care utilization characteristics. To assess preference of PCP versus ED utilization, participants were asked: "Do you have a primary care provider?" For all patients who answered yes, a follow-up question was asked: "If you could get an appointment to see your primary care provider right now, would you prefer to get it at your PCP's office or in the ED?" If the patient said ED, they were asked why they chose the ED over their PCP in an open-ended question.

All data were stored using electronic web-based survey administration software (Qualtrics) and analyzed using SAS 9.3 (Cary, NC). Descriptive statistics was used to calculate the mean. Missing data were dropped from the analysis when representing less than five percent of the overall sample. Due to low cell numbers, a Fisher's exact test was used to test for differences in characteristics among patients who indicated a preference for using the ED over their PCP for **their current ED visit**. For the open-ended question, the study team reviewed all responses and combined them into broad descriptive categories. We collapsed some of the original survey response options and conducted further statistical testing. All data were tested at a significance level of $p < .05$.

Results

A total of 150 adult patients agreed to participate. We excluded 24 (16.0%) who did not have Medicaid insurance confirmed through our hospital billing claims data, 30 (20.0%) who did not identify a PCP, and 1 (0.67%) who did not complete the survey. Of the 95 (63.3%) eligible participants, the majority were female (71.6%) and middle age (31-49 years; 43.2%). **Forty-three patients (45.3%)** stated that they would have preferred to use their PCPs rather than the ED if an appointment had been available. Sixty-eight percent Black participants preferred to use the ED, while (17.9%) Black participants preferred to use their PCP ($p=0.10$). Contrary to that, 29.4% Hispanic participants preferred to use the ED, while 48.7% Hispanic participants preferred to use their PCP ($p=0.10$).

In total, 11 (11.6%) participants were not satisfied with their PCP. Of those 10 (19.2%) participants preferred to use the ED, while 1 (2.3%) preferred to use their PCP ($p<0.05$). Sixty-four (67.4%) participants had more than one chronic disease. Forty (76.9%) preferred to use the ED, while 24 (55.8%) preferred to use their PCP ($p<0.05$). Finally, 36 (37.9%) participants reported having either depression or anxiety. Of those 23 (44.2%) preferred using the ED, while 13 (30.2%) preferred using their PCP, although this difference was not statistically significant ($p=0.16$) (Table 1).

When examining the reasons for why patients preferred using the ED versus their PCP, 13 patients (48.1%) cited that the ED had more technology or specialty care services available when compared with their PCP's clinic, "***I wanted x-rays.***" **Eight** (15.4%) were in significant pain, "***pain is too bad.***" Six (11.5%) felt the care they received in the ED was better than what they would receive in their PCP clinic "the way my PCP treats patients is poor, different feeling in ***the ED.***" Four (7.7%) felt their condition was an emergency, "***this was an emergency.***" Four (7.7%) felt their PCP did not care about them, "***my PCP doesn't care about my situation.***" Three (5.8%) had no reason as to why they preferred the ED over

their PCP, “not sure, just more prone to using the emergency room.” Two (3.8%) were sent to the ED by their PCP “*My PCP sent me here*”.

Conclusions

Here, we found that a little more than half of adult Medicaid enrollees would have preferred to use the ED rather than their PCP if an appointment had been available immediately. A large number of these patients had one or more chronic disease and/or mental illness. Not surprisingly, most patients who were not satisfied with their PCP preferred ED over PCP care. Interestingly, however, a higher percentage of those with chronic diseases also preferred ED over PCP care. The most commonly cited reasons for ED care preference were access to technology (e.g., x-rays, MRI, CT scans, **laboratory testing**), “*ED has ultrasound and other tests I need*” and specialty care, “*needed a specialist*.”

Our study is unique in that we asked patients before their ED care was complete if they would be willing to see their PCP instead of an ED provider. In that context, we discovered **that a little** over half of patients would prefer to receive care in the ED rather than at their PCP's office due to the convenience, **access to technology and specialty care**. Patients with Medicaid suffer from poverty and often have transportation issues. A PCP might ask a patient to schedule an x-ray and a lab draw that requires multiple bus rides and significant travel time and money.⁷ Therefore, it is not surprising that many patients turn to the ED, a “one-stop-shop,” to get their health care needs addressed. From a patient's perspective, having all imaging and laboratory studies done in one place is likely more cost effective than going to a PCP clinic and having gone elsewhere to get further testing. Unfortunately, however, the ED does not provide ongoing chronic disease management and preventive care (e.g., diabetic foot checks, hemoglobin A1C checks) as they would receive in the primary care setting. In our study, many of the patients who prefer to use the ED over their PCP have one more chronic diseases.

A **little less than** half of patients reported that they would have preferred to use their PCP clinic over the ED. Our results suggest that almost half of adult Medicaid enrollees may benefit from services to help them breakdown health care access barriers and effectively utilize their primary care providers.¹¹ Successful examples of such services include ED-based programs where patient navigators, community health workers, or case managers help vulnerable populations utilize the primary care system more effectively.¹²⁻¹³ This type of work brings great value to Medicaid and potentially the health care system, as it will likely improve primary care utilization for chronic disease management and preventive services.^{11,13}

Our study has several limitations. We completed the surveys over a limited period (summer months) and at only one institution, potentially creating a sampling bias. Additionally, it is possible that the ESI system could have under-triaged or over-triaged some patients, and, therefore, some participants may not have been low acuity patients. However, only four patients perceived their chief complaint as requiring emergency care in our study. Furthermore, we asked all participants if they had a primary care provider and not primary care clinic. The responses might be biased, especially if they felt loyal towards their clinic,

but not a particular provider. Finally, we have a small sample of participants, and our study question was theoretical in that we were unable to offer patients an immediate PCP appointment. Nonetheless, this study provides important preliminary information about the adult Medicaid population and their views surrounding seeking ED care versus PCP care for low acuity conditions.

In summary, our study uncovered important information about adult Medicaid enrollees using the ED for low acuity conditions. A little less than half of the patients will likely benefit from intensive case management interventions to improve primary care utilization, chronic disease, and mental health management. The other half will require system-level changes such as wrap-around services at primary care clinics including x-rays, laboratory studies, and e-consults with specialty care. The combination of intensive case management interventions and ability to provide comprehensive “one-stop- shop” primary care services to Medicaid enrollees, will ultimately improve the effective use of primary care services. This primary care utilization will then, reduce avoidable ED visits and potentially preventable hospital admissions.

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Table 1

Demographic Characteristics of Medicaid Patients with a PCP who use the ED for low acuity complaints based on preference

Characteristic	Total (N=95)		Prefer PCP (N=43)		Prefer ED (N=52)		p-value
	f	(%)	f	%	f	%	
Gender							
Male	27	28.4%	12	27.9%	15	28.9%	0.17
Female	68	71.6%	31	72.1%	37	71.1%	
Age (years)							
18-30	31	32.6%	17	39.5%	14	26.9%	0.22
31-49	41	43.2%	19	44.2%	22	42.3%	
50-69	23	24.1%	7	16.3%	16	30.8%	
Race/Ethnicity							
White	26	28.9%	8	20.5%	18	35.3%	0.10
Black	22	24.4%	7	17.9%	15	28.8%	
Hispanic	34	37.8%	19	48.7%	15	29.4%	
Other	8	8.9%	5	12.8%	3	5.9%	
Level of education							
High school	52	57.8%	23	59.0%	29	56.9%	1.0
Some college	35	38.9%	15	38.4%	20	39.2%	
College or more	3	3.3%	1	2.6%	2	3.9%	
Employment status							
Employed	31	34.4%	13	33.3%	18	35.3%	0.50
Unemployed	11	12.2%	6	15.4%	5	9.8%	
Not in labor force	27	30%	9	23.1%	18	35.3%	
On disability	21	23.3%	11	28.2%	10	19.6%	
Monthly family income							
Less than \$800	15	16.7%	5	12.8%	10	19.6%	0.85
\$801 to \$1649	10	11.1%	5	12.8%	5	9.8%	
\$1650-5400+	10	11.1%	4	10.3%	6	11.7%	
Unsure/refused	55	61.1%	25	64.1%	30	58.8%	
Relationship Status							
Never Married	46	51.1%	21	53.8%	25	49.0%	0.90
Married	22	24.4%	8	20.5%	14	27.5%	
Separated/Divorced	18	20.0%	8	20.5%	10	19.6%	
Widowed	4	4.4%	2	5.1%	2	3.9%	
Lives in local area for:							
1 year	9	9.5%	7	16.3%	2	3.8%	0.22
2 to 5 years	10	10.5%	4	9.3%	6	11.5%	
6 years	61	64.2%	25	58.1%	36	69.2%	
Missing/Refused	15	15.8%	7	16.3%	8	15.4%	
Satisfied with PCP *							0.03

Characteristic	Total (N=95)		Prefer PCP (N=43)		Prefer ED (N=52)		<i>p</i> -value
	<i>f</i>	(%)	<i>f</i>	%	<i>f</i>	%	
Yes	74	77.9%	38	88.4%	36	69.2%	0.86
No	11	11.6%	1	2.3%	10	19.2%	
Missing	10	10.5%	4	9.3%	6	11.5%	
Perceived Health Status							
Excellent	15	16.1%	7	16.7%	8	15.7%	0.03
Good	47	50.5%	23	54.8%	24	47.1%	
Fair	21	22.6%	8	19.1%	13	25.5%	
Poor	10	10.7%	4	9.5%	6	11.8%	
Missing							
Health Conditions [*]							0.16
>=1 chronic disease	64	67.4%	24	55.8%	40	76.9%	
Mental illness							0.09
Depression/Anxiety	36	37.9%	13	30.2%	23	44.2%	
Regular Medication Use							0.18
Yes	63	69.2%	24	38.1%	39	76.5%	
No	28	30.8%	16	57.1%	12	23.5%	0.87
Symptom Duration							
< 1 week	59	62.8%	31	73.8%	28	53.8%	
1 to 4 weeks	11	11.7%	3	7.1%	8	15.4%	
1-12 months	6	6.4%	3	7.1%	3	5.8%	
> 12 months	18	19.1%	5	11.9%	13	25.0%	
Number of ED visits in previous 12 months							0.87
0-3 ED visits	58	61.7%	25	58.1%	33	64.7%	
4-18 ED visits	32	34.0%	16	37.2%	16	31.3%	
>18 ED visits	4	4.3%	2	4.7%	2	4.0%	

* indicated a *p* value <.05