



## Life at EPRP—The Emergency Prospective Review Program

### Abstract

The Emergency Prospective Review Program (EPRP), a part of Kaiser Permanente (KP), has responsibility for KP Health Plan members who present to non-KP emergency departments. By telephone, EPRP helps non-KP physicians who care for these patients. Then EPRP expedites the safe return of these patients to the KP system. EPRP serves more than six million KP and Group Health Cooperative members throughout California and part of Washington State.

This article outlines EPRP's history, current operating statistics, and day-to-day function. The author also describes some of his personal experience while working at the EPRP office, located in Pasadena.

### Introduction

A patient at a remote community hospital in Northern California has a rupturing abdominal aortic aneurysm and must be rushed to a larger medical center for emergency surgery. A woman visiting Guam has medical complications during the second trimester of pregnancy; the doctors on Guam believe that the woman needs treatment at a more advanced hospital than exists on the island. A man with emphysema who is vacationing in the mountains has an acute exacerbation when a forest fire occurs nearby. The physician treating this patient at a small hospital wants him transferred out of the smoky area immediately.

What do these three people have in common? The answer is that all are Kaiser Permanente (KP) Health Plan members who have benefited from KP's Emergency Prospective Review Program (EPRP). EPRP, where I work periodically, has responsibility for KP Health Plan members who present to non-KP emergency departments. By telephone, EPRP helps non-KP emergency physicians who care for these patients. Then EPRP expedites the safe return of these patients to the KP system.

### History of EPRP

EPRP is the brainchild of Jeffrey Selevan, MD, Assistant Medical Director, Operations, who formerly worked as a Southern California Permanente Medical Group (SCPMG) emergency physician. In the early

1980s, Dr Selevan recognized the opportunity to improve the quality of care received by KP members in non-KP emergency departments while conserving KP resources spent on non-KP services. Dr Selevan realized that non-KP physicians treating these patients lacked access to existing clinical information and that many expensive claims for outside services began when KP members made non-KP emergency department visits.

Under EPRP, Dr Selevan created a program in which outside providers are expected to contact EPRP soon after the initial medical evaluation of the patient and stabilization of the patient's condition. As emphasized by the program's name, EPRP and non-KP health care providers jointly review these cases prospectively or concurrently. In addition to this timely, coordinated review, EPRP offers non-KP physicians real-time access to existing clinical information about the patient. These EPRP activities assist in the care of KP members at non-KP facilities and expedite the members' safe return to the KP system. In this way, EPRP also enhances continuity of care provided to KP Health Plan members.

### Expansion to Northern California

EPRP originally served only Southern California, and physician staffing consisted entirely of SCPMG emergency physicians. When Northern California joined the program in 1997, emergency physicians in The

Permanente Medical Group (TPMG) had the opportunity to participate. Dr Selevan felt that having Northern California physicians participate would increase acceptance of EPRP throughout Northern California and would provide valuable input to the other EPRP staff members.

Dr Selevan and Dr John Shohfi (Regional Coordinating Chief of EPRP, SCPMG) recruited an original group of about 40 TPMG physicians, many of whom remain active in the program. Dr Chip Rath became Regional Coordinator for TPMG. EPRP is structured to include three physician shifts daily; EPRP allots one 24-hour shift to TPMG. The TPMG physician typically flies down in the morning from Northern California and returns home after work the next day.

### Current Statistics

EPRP began in 1989 and served only the San Diego area. Now EPRP encompasses all of California and part of Washington State. Two or three physicians and six or seven nurses are on duty at any time to answer incoming calls about California and Washington KP members. All the physicians and nurses who manage EPRP cases have extensive emergency department experience.

EPRP is responsible for well over six million plan members. EPRP occupies 1000 square feet at Walnut Center in Pasadena, employs 39 people on a full-time basis, and handles almost 90,000 cases per year. The program has an annual budget of \$5.3 million. Twenty-four hours per day EPRP is able to supply a wide range of clinical information about any California KP member and about many members of the Group Health Cooperative. This material includes:

- History and physical examinations
- Discharge summaries
- Consultations
- Medications
- Allergies
- Immunizations
- Laboratory results



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- Radiology reports
- Electrocardiograms (ECGs)
- Cardiac catheterization reports.

Also important to the success of EPRP are the Critical Care Transport (CCT) and Allied Intensivists Network (AIN) programs. In CCT, a physician or nurse accompanies the patient in an ambulance to a KP facility. CCT has performed more than 34,000 safe interfacility transfers since 1989. A case-control study compared more than 3200 matched pairs of cardiac patients with patients who were not transported and found no increase in adverse outcomes for the patients transported at this high level of care.<sup>1</sup>

KP created the AIN program in 1998 to provide an alternative to direct admission to non-KP hospitals for some patients. Through AIN, EPRP dispatches to the non-KP emergency department a non-KP physician with privileges at the non-KP hospital. The AIN physician evaluates the patient and assumes responsibility for care, which includes possible discharge, transfer, or admission to the non-KP hospital. Both CCT and AIN began in Southern California but have since been expanded to parts of Northern California as these programs proved effective. CCT also operates in the Seattle area.

### Overview of an EPRP Case

How does an EPRP case work (Figure 1)? Things typically start with a call to the EPRP 800-number from the non-KP emergency de-



Emergency Prospective Review Program (EPRP) staff member responds to initial calls, recording patient data and entering case in computer tracking system and determining disposition of a simple case.

partment. EPRP has asked the non-KP emergency departments to notify EPRP only after the Medical Screening Examination and stabilization of the patient. This sequence ensures the patient's safety and satisfies legal requirements, including those encouraged and monitored by national regulatory agencies and the California Chapter of the American College of Emergency Physicians (CAL/ACEP) to protect patients without placing undue burden on health maintenance organizations.<sup>2,3</sup>

An EPRP nurse answers all initial calls, records demographic and preliminary medical data about the patient, and enters the case into EPRP's computer tracking system. The EPRP nurse may independently handle simple cases resulting in discharge of the patient from the non-KP emergency department.

In any more complex situation, an EPRP physician takes over as soon as the treating

physician at the outside hospital is ready to discuss the case with an EPRP doctor. At this point, several possibilities exist:

- Discharge patient from the non-KP emergency department
- Further evaluate or treat patient at the non-KP emergency department
- Admit patient to the non-KP hospital
- Transfer patient to a KP (includes KP-affiliated) facility
- Transfer patient to another non-KP facility.

Within this framework, further variations are possible. For example, the non-KP physician may agree to a transfer only if a physician accompanies the patient, an arrangement that EPRP may be able to provide. In other cases, EPRP calls for an AIN physician to go to the non-KP hospital and assume care of the patient.

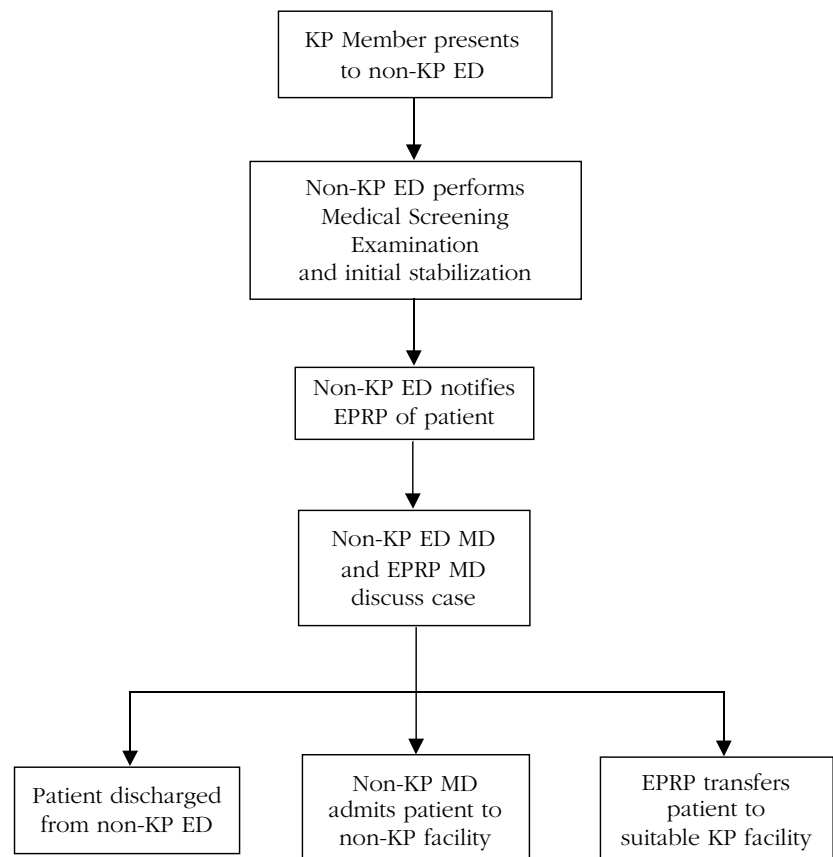


Figure 1. Summary Overview of Emergency Prospective Review Program (EPRP) Program.

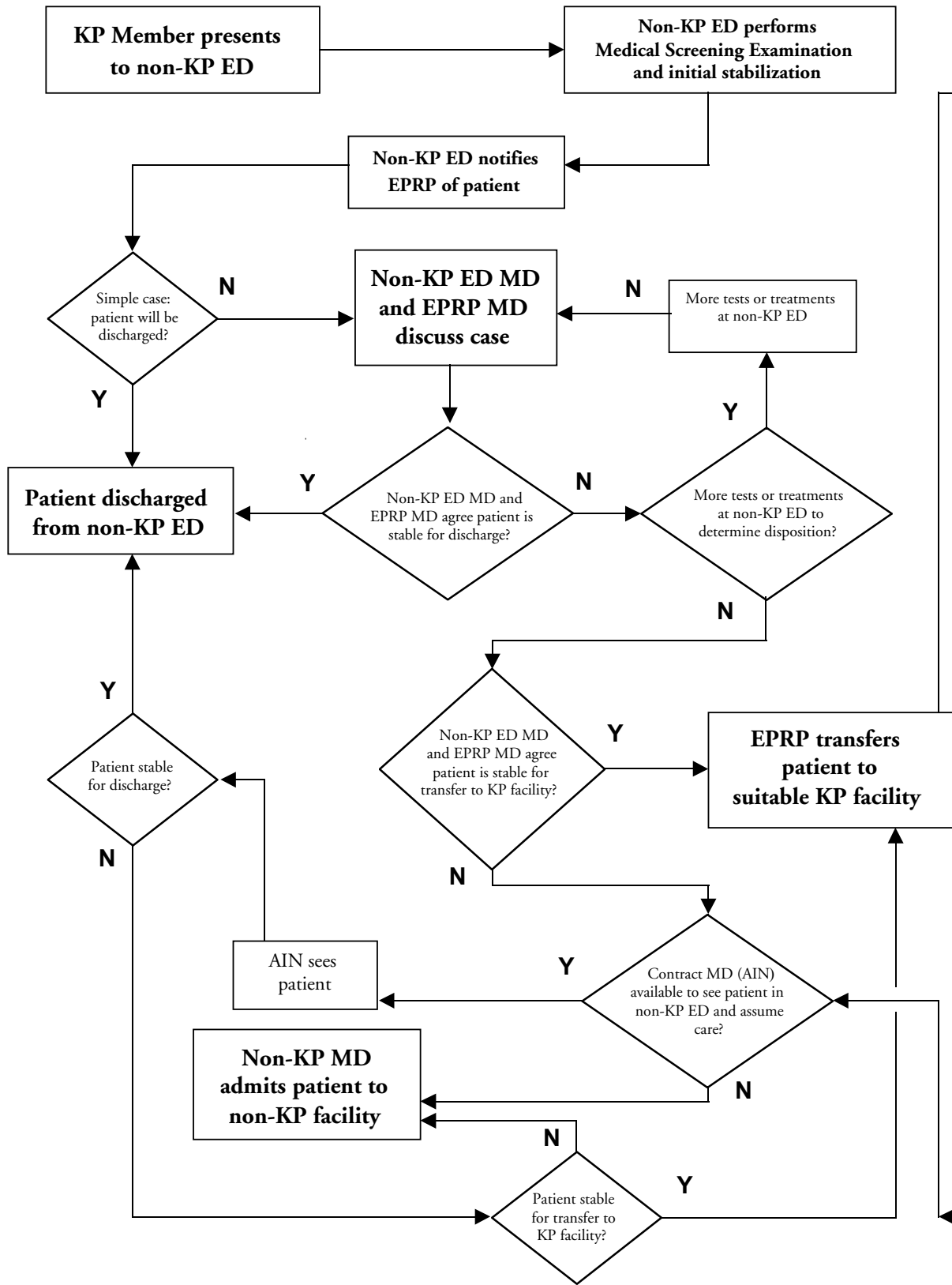
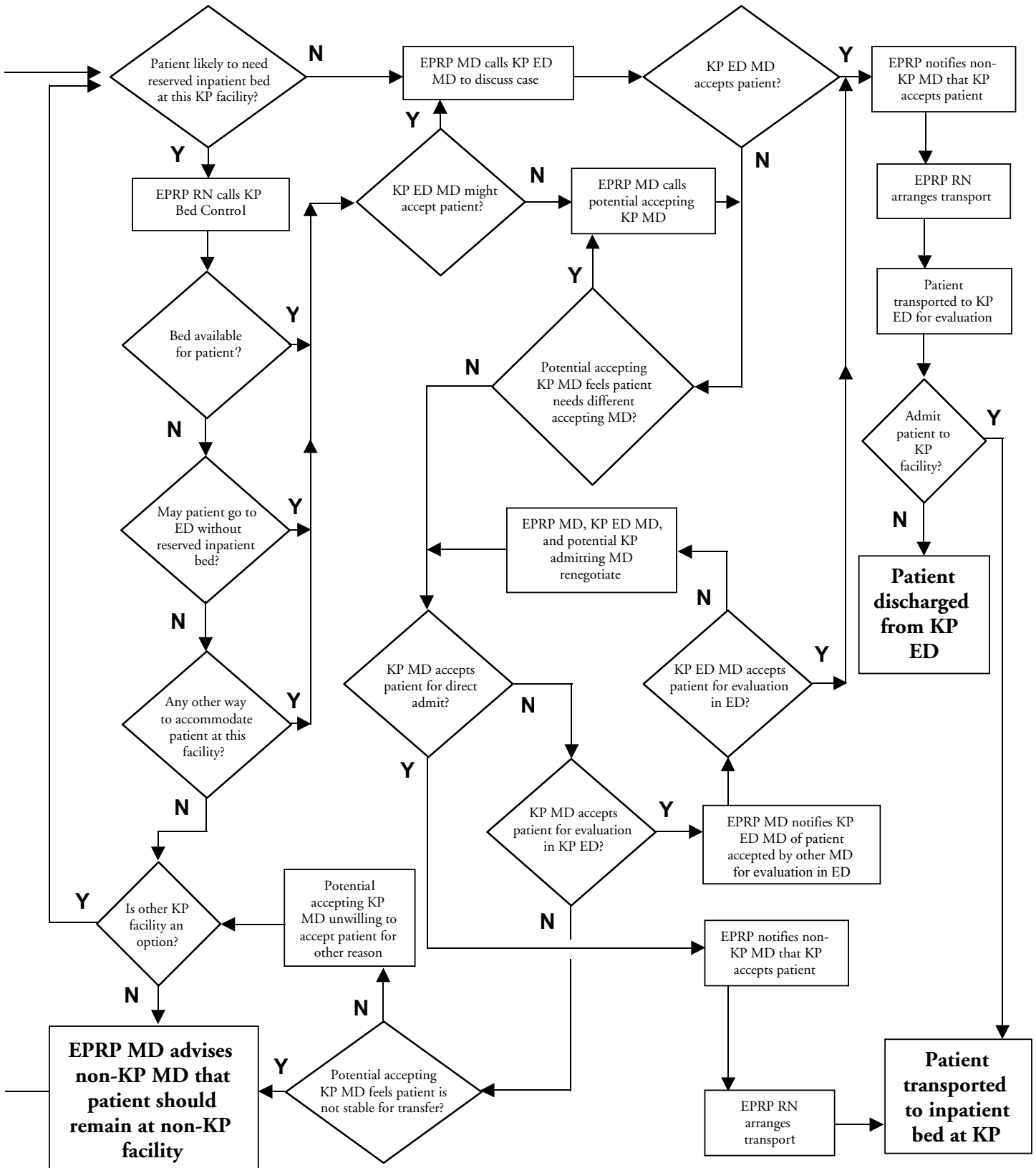


Figure 2. Decision flow chart shows EPRP transfer process: decision whether or not to admit patient from non-KP facility; location of bed and receiving KP or KP-affiliated physician to receive patient. AIN = Allied Intensivists Network.





EPRP physician takes over more complex case for discussion with non-Kaiser Permanente treating physician.

EPRP staff members have several ways to help a non-KP physician:

- Discuss clinical information about the patient from available records
- Fax ECGs or other requested material
- Make direct contact with the patient's regular physician
- Provide phone numbers for patients to use in arranging follow-up care
- Leave messages for KP physicians about their patients' non-KP visits
- Make a follow-up appointment for the patient at a KP facility.

Discussions with the non-KP emergency physicians tend to be collegial and knowledgeable. Both sides wish to assure good and prompt care for the patient while obeying all relevant laws concerning transfer of patients between facilities.

Once the non-KP and EPRP physicians agree that transfer of the patient to a KP facility is appropriate, EPRP must make it happen. We identify the likely level of care the patient will need if admitted, begin a search among nearby KP facilities for that type of bed, and secure approval of a receiving physician. Sometimes the whole process is as simple as a single phone call to a KP emergency physician, who may say, "Fine, send the patient." But the experience often requires multiple calls and numerous pages among EPRP, bed control staff, nursing supervisors, and one or more KP physicians (Figure 2). Sometimes we must repeat the process at a second or even third

KP facility; for example, the right bed or the right consultant may not be available. Or a potential receiving physician may ask the non-KP emergency department to perform one or more additional tests to ensure that the patient's condition is stable before any transfer takes place.

Finally, EPRP must arrange the transport itself. This process may entail delay if the required level of ambulance (eg, CCT) is not readily available. Meanwhile, as time passes, the non-KP emergency department will be calling back, wondering what is taking so long, and urging faster disposition of the case.

### My Personal Experience at EPRP

Staffing the phones at EPRP once per month provides a nice break from my usual routine of seeing patients in the KP Vallejo emergency department. I arise in the East Bay at 7 am, arrive at Oakland International Airport by 9 am, and board the one-hour flight to Burbank. After a 20-minute cab ride to Pasadena, I'm usually just in time to start the 24-hour shift. During the course of a recent slower-than-average stint there, I spoke to a total of 83 physicians regarding 49 patients. Much as in an actual ED, the work pace can be highly irregular: In the busiest two-hour period, I made and received a total of 26 phone calls; in the slowest two-hour period, I had only six.

In the case of the man whose aortic aneurysm ruptured, I received a desperate call late one evening from a general surgeon at a small community hospital in Willets, California. The patient was hypotensive, and the surgeon and his facility were unable to care for such a sick patient; could we find a vascular surgeon immediately? I quickly called the KP Santa Rosa facility and reached Marvin Palmer, MD, in the emergency department. He said he would try to contact the vascular surgeon on call and would let me know as soon as possible. Within a few minutes, Dr Palmer returned; yes, he reported, the vascular surgeon had said to send the patient right away. We rapidly arranged air transportation and flew the patient to Santa Rosa. The patient had surgery

that night. After a long and difficult recovery, he survived to leave the hospital.

The woman in midpregnancy had gone to Guam because of a family crisis; while she was on the island, her blood pressure rose dangerously. The doctors on Guam began treatment but called EPRP to request transfer. The EPRP staff agreed and contacted KP perinatologists in Hawaii to see if they would accept the case, which they did. EPRP then spoke to a company that provides air ambulance services. The company said they would transport the patient for \$150,000! Kathy Mitts, MD, the physician handling the case at EPRP, felt this price was outrageous and tried to make other arrangements. She found that Continental Airlines would take the patient the next morning on a scheduled flight to Honolulu if we would purchase first-class seats to accommodate the patient, a doctor, and a nurse. The patient could receive whatever intravenous medications she needed en route. This option was entirely acceptable to the patient and to her treating physicians on Guam. The transfer occurred uneventfully for a total cost under \$10,000.

The man with exacerbation of chronic lung disease during smoky conditions in the mountains presented a different problem. The doctor called from the scene to demand immediate transfer at night by air, saying that the patient would only worsen while in that area. However, the patient's current condition was actually stable, and the treatment he had received so far was appropriate. After conversations with the internist at the patient's home KP facility, we decided that subjecting the patient to a rushed and potentially hazardous air transport was unnecessary. The patient stayed at the non-KP facility overnight and was later transferred under better conditions.

### The Challenges of the Job

What are the tough parts of working at EPRP? Sometimes the physician at a non-KP facility unreasonably insists that a patient be directly admitted to that facility although we believe we could safely transfer the patient to a KP facility. Or a potential

receiving physician at KP may throw up roadblocks to a transfer. There's no getting around the fact that for a Permanente physician on duty in the emergency department or taking admissions, a call from EPRP invariably means more work. Thus, the inclination to say "No" may be strong. At other times, when I must call a colleague who I already know is very busy, I regret having to ask, "Can you take one more patient?"

Even harder are cases of patients whose condition is highly unstable, for example, the man with the aneurysm. The physician on the scene understandably has great anxiety and pleads for rapid transfer of the patient. Every moment of delay then feels endless.



EPRP staff members celebrating successful disposition of another case.

Finally, frustrations arise when our carefully constructed plan to repatriate a patient—an arrangement involving perhaps a dozen or more phone calls and several hours of work—falls apart because of a last-minute glitch. Much of the challenge of the job is to anticipate and forestall all the obstacles and pitfalls that a given case presents.

### A Look to the Future

EPRP has several current goals:

- Further enhance computer hardware and software.
- Expand the CCT physician and AIN programs in Northern California.
- Improve quality of care provided to KP Health Plan members seen in non-KP emergency departments.
- Maintain a high level of patient satisfaction.

All these goals require considerable cooperation among many parties, including physicians and administrators in the non-KP hospitals as well as in the KP organization.

EPRP is already a success story. According to Loren Johnson, MD, President of CAL/ACEP, "EPRP continues to be America's foremost example of a well-managed emer-

gency poststabilization case management program" (written communication, July 21, 2001). Nonetheless, we expect to deliver even more benefits to KP patients and to the KP organization. EPRP will continue to refine its role in providing quality patient care to our Health Plan members. ❖

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### References

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## Trapped in a Dark Fate

Humanity is not simply trapped in a dark fate. People can be attracted by new ways of ordering their lives, as well as driven by the recognition of what will happen if they do not change.

For the Common Good: Redirecting the Economy Toward Community, the Environment, and a Sustainable Future, *Herman E Daly and John B Cobb*