AVOID THE ED? NOT ON YOUR LIFE!

Converting the Emergency Department into a Strategic Asset for Your Hospital

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TODAY'S AGENGA:

Avoid the ED? Not on your Life!

Objectives

1. Describe the essential role of emergency departments in the patient care continuum
2. Discuss how to leverage the ED as a strategic asset
3. Explore examples of EDs that have been successful at enhancing value in innovative ways
4. Provide tangible actions and concrete steps that will leverage the value of your ED over time

YOUR HEALTH CARE SYSTEM

Addressing the Challenges

- Effective transition from volume to value
  - Accommodate variabilities in timing and overall impact
  - Preparing for alternative payment mechanisms
- Cost-effective, longitudinal patient care
- Patient engagement
- “Market disruptors”:
  - New entrants, retail medicine, telemedicine, non-traditional competitors
- Increasing demand for pricing transparency

YOUR HEALTH CARE SYSTEM

Addressing the Challenges

At the local level, hospitals must:

- Maintain or increase desirable market share
- Respond to value-based payment mechanisms
- Optimize the performance of all assets to create value
    - Especially fixed assets (like the emergency department)
- Accommodate reduced involvement of community physicians
    - Increased burden for unscheduled care, complex care, and hospitalized patients
- Provide for cost-effective transitions of care that insure quality

Today's Theme:
The Emergency Department:

- **Increasingly identified as a *strategic asset* for hospital-based care**
- **Must be:**
  - Effective in today's environment
  - Right-sized for the future
  - Optimized for health care value in both
- **Can be leveraged to address significant issues for hospitals and health systems**

COMMON PERCEPTION:

"The Emergency Department is a Problem"

THE ED "PROBLEM"?

The perception that the ED is "bad" is based on . . .

- **"Overuse of the ED costs the U.S. $38 billion annually…."**
- **Growth in ED visits has continued "almost unabated"**
    - ~44 million visits in 1968; ~140M annual visits in recent years…
    - Growth outpaces population increases*
- **A large proportion of ED visits seem "avoidable"**
- **The average cost of an ED visit (over $2,000) is ~40% more than most people spend on monthly rent . . .**

*Overview of Emergency Department Visits in the United States, 2011

KEY DISTINCTION

Necessary Evil or Strategic Asset?

(Un)-Necessary Service

- Not optional
- Cost > value
- Costs must be offset elsewhere
- Outcomes are no better
- Not advantageous
- Not unique

Strategic Asset

- **Increases Value**
  - **Improves efficiency**
  - **Reduces waste**
  - **Improves outcomes**
- **Reduces overall cost**
- **Valued by key stakeholders**
- **Creates competitive advantages**
- ***Not optional*!**

PREVENTABLE & SUBSTITUTABLE ED VISITS?

Are estimates accurate and actionable?

- **Can we prevent ED visits?**
  - Need a better "system"
- **EMTALA mandate & prudent layperson standard**
- **ED alternatives**
  - Retail clinics do not reduce ED visits[1]
  - DTC Telemedicine does not reduce ED visits[2]
- **Focus on intermediate / complex conditions[3]**

[1]Martsolf 2016
[2]Uscher-Pines 2017
[3]Smulowitz 2015

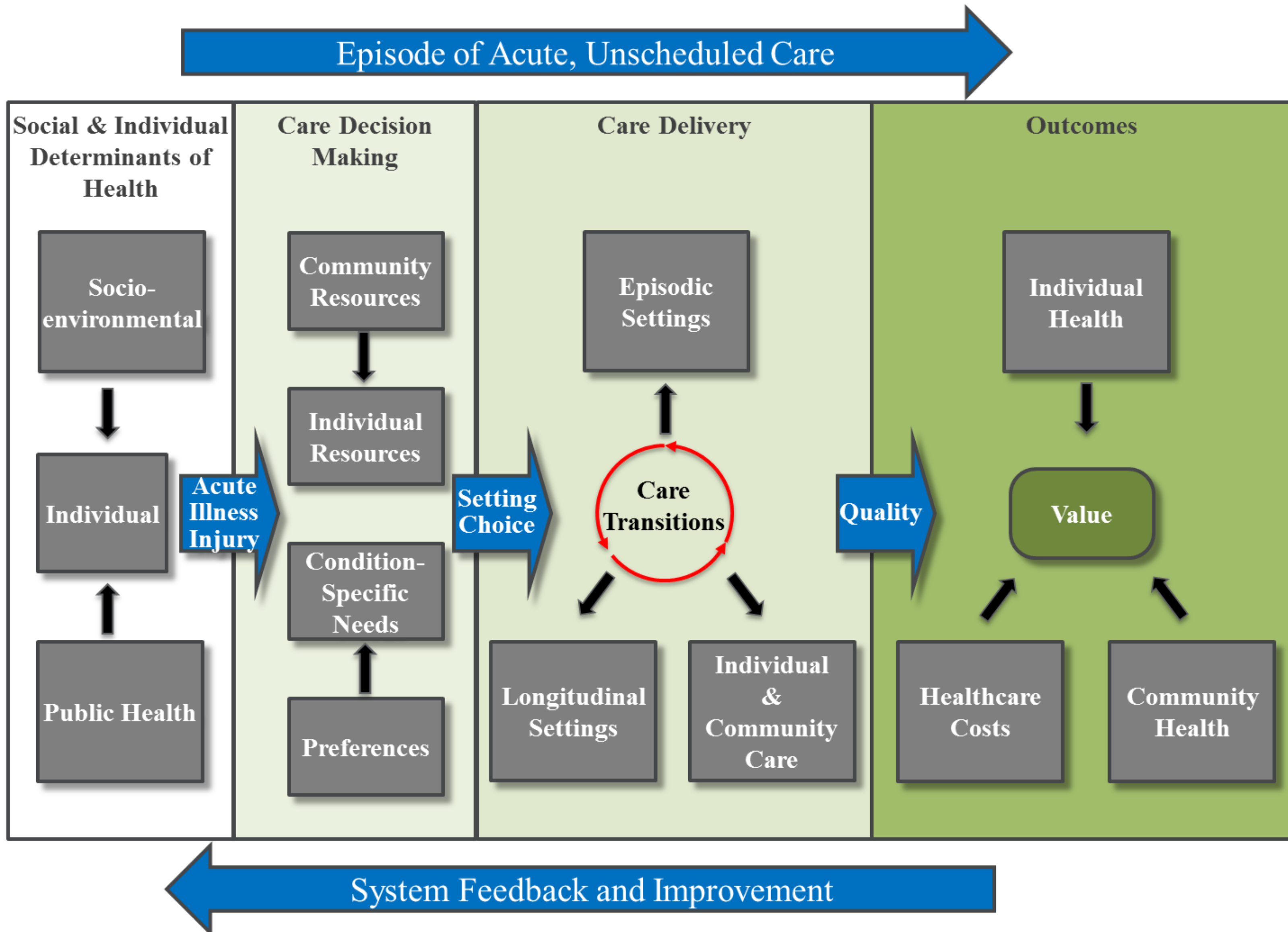
WHY ER VISITS FOR NON-EMERGENCIES AREN'T GOING AWAY

"You can't teach economics lessons to patients when they don't feel well. So let's improve the system."

THE WALL STREET JOURNAL.

By PAUL S. AUERBACH
Sept. 25, 2015

CONCEPTUAL MODEL



THE EMERGENCY DEPARTMENT

Why the ED as a strategic asset?

- Lots of people
- Sick people
- High focus populations
- Frequent interface with rest of the health care system
- Important things get started there
- Decisions that matter get *made* there
- Increasing dependence on the ED by community physicians
- All payor types use the ED
- Single hub for introducing and managing change
- You have to have one
- It's always open
- Market share and revenue driver for the hospital

THE EMERGENCY DEPARTMENT

Why the ED as a strategic asset?

- **Lots of people**
  - Over 140 million visits per year in the US
- **Sick people**
  - 50-70% of hospital admissions come through the ED
- **High focus populations**
  - High percentages of admissions are CHF, COPD, pneumonia, AMI, etc.
  - 75-80% of admissions are "intermediate and complex chronic conditions" (high focus populations)*
- **Frequent interface with rest of the health care system**
  - Hospitalists, specialists, primary care, post-acute care, ancillary departments

* "A Novel Approach to Identifying Targets for Cost Reduction in the Emergency Department."
Smulowitz, Peter B., et. al.
Health Policy/Concepts, Annals of Emergency Medicine. 2012

THE EMERGENCY DEPARTMENT
Why the ED as a strategic asset?

- **Decisions that *matter* get made in the ED**
  - Admit or not?
  - Advanced imaging or not?
- **All payor types use the ED**
  - Usually ¼ each: Medicare, Medicaid, Commercial, and self-pay
- **Single hub for introducing and managing change**
  - Prioritization and implementation of initiatives
  - Flexibility for rapid-cycle adjustments

THE EMERGENCY DEPARTMENT

(and by the way…)

- **You have to have one**
  - High fixed cost, yet essentially required
- **It's always open**
  - 24/7 availability
  - Significant difference versus office-based providers
- **Market share and revenue driver for hospital**

"RIGHT-SIZING" THE ED

The Work Starts Here:

1. **The ED itself**
   - Foundations and fundamentals
2. **Right-sizing key interfaces**
   - Admissions
   - Near-admissions
3. **Right-sizing patient care after the ED encounter**
   - Transitions of care
   - Patient care follow up
   - Health information systems
4. **Right-sizing utilization of the ED**
   - Best use of the health care system
   - Consider other settings --> focus on value

The Emergency Department as a Value-Driven Asset

Coming Soon: Beyond the "Four Walls"

Before the ED Visit
- Assist employees/employers with optimal site of care for certain illnesses or injuries
- Assist patients with access to office-based care
- Coordinate care with health plans
- Manage care-seeking behavior
- Direct patients to best site of care

KEY DRIVERS OF CHANGE
- Value-based purchasing
- Novel payment mechanisms
- Cost management imperatives
- Fragmentation of care
- Insufficient access to primary care
- Emergency department crowding
- Overall reductions in revenue per patient

Expanded ED functions

Recent Changes
- Two-midnight rule compliance
- Readmission prevention
- Quality measure compliance
- HCAHPS (and ED-CAHPS) performance
- Certification & regulatory standards
- Documentation for hospital-acquired conditions
- Care transition management

After the ED Visit
(For post-ED patients with high-cost conditions)
- Telemonitoring
- Primary care integration
- Patient engagement strategies
- After-care visits
- Care management
- Assistance with palliative care
- Disease management
- Medication monitoring

Core ED Functions

Foundations
- Acute treatment of sick & injured
- Treatment of time-sensitive conditions
- Rapid diagnostic center
- EMS direction and coordination
- Disaster preparedness & response
- Safety-net care

Evolving Care
- Treatment of intermediate conditions
- Treatment of complex chronic conditions

ED-Focused Outcomes → Key Hospital Outcomes → Coordination & Continuity

Value-Driven Health System

© 2014

ED Assessment Tool available at: ed-assessment.schumachergroup.com

INTERMEDIATE & COMPLEX CONDITIONS

Changing the Approach

- Hospital admissions account for approximately 31% of health care costs
- Over half of hospital admissions come through the ED (50-68%)
- Intermediate and complex conditions:
  - CHF, COPD, Diabetes, UTI, pneumonia, abdominal pain, chest pain, etc.
  - 31-57% of all ED visits
  - 75-80% of admissions from the ED
- Hospitals can generate significant cost-efficiencies by addressing testing, treatment, and hospitalization patterns for intermediate and complex conditions
  - Reducing hospitalization in this group by 10-25% saves 1.0-2.5% of all health care costs ($28B - $70B annually)

"A Novel Approach to Identifying Targets for Cost Reduction in the Emergency Department."
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RIGHT-SIZING EMERGENCY CARE

Moderately Complex Patients/Chronic Conditions

- **Examples:**
  - Complex chronic conditions:
    - Congestive heart failure
    - COPD
    - Diabetic complications
  - Acute presentations:
    - Pneumonia
    - Abdominal pain
    - Atypical chest pain
- **Opportunities:**
  - Agreed-upon care pathways
  - Create alternative hospital-based resources:
    - ED observation units
    - Dedicated rapid treatment units
    - Hospitalist or specialist consultation with in ED
    - Consistently utilize mechanisms that deliver value & efficiency
  - Ensure seamless coordination of care
  - Plan for timely follow-up

RIGHT-SIZING EMERGENCY CARE

Moderately Complex Patients/Chronic Conditions

- **Time-based throughput goals should be a secondary priority**
- **Highest priorities:**
  - Diagnostic precision; coordination; effective care
- **Solutions require time, adequate resources & space**
- **Work with the community**
- **Example:** ***Mass General Care Coordination Program***
- **Example:** ***University of Pittsburgh Substance Use / Psych***

PRACTICAL ALTERNATIVES TO HOSPITAL INPATIENT STATUS

Solution	Objective
Rapid Decision Units	Rapid disposition with high diagnostic specificity
Rapid Treatment Units	Rapid-cycle treatment; reduced down time & reduced cost of care
Hospitalist Consultation in the ED	Early and accurate determination of optimal patient status and disposition (inpatient/ Obs/ SNF/home-based, etc.)
ED Observation Unit	Hospital-based short stay (in the ED) with less in-hospital transitions of care
Hospital Observation Status	Hospitalized care for less than 2 midnights

ALTERNATIVES TO INPATIENT ADMISSION

Must Address

- **Inclusion and exclusion criteria**
- **Agreed-upon clinical pathways**
- **Revenue and provider reimbursement**
- **Informed patient choice**
- **Clear metrics and outcome measures**
  - Clinical
  - Operational
  - Financial
- **Example: UCSD Admission at Home Program**

OUTSIDE THE FOUR WALLS

Preparing for the Future

OUTSIDE THE FOUR WALLS

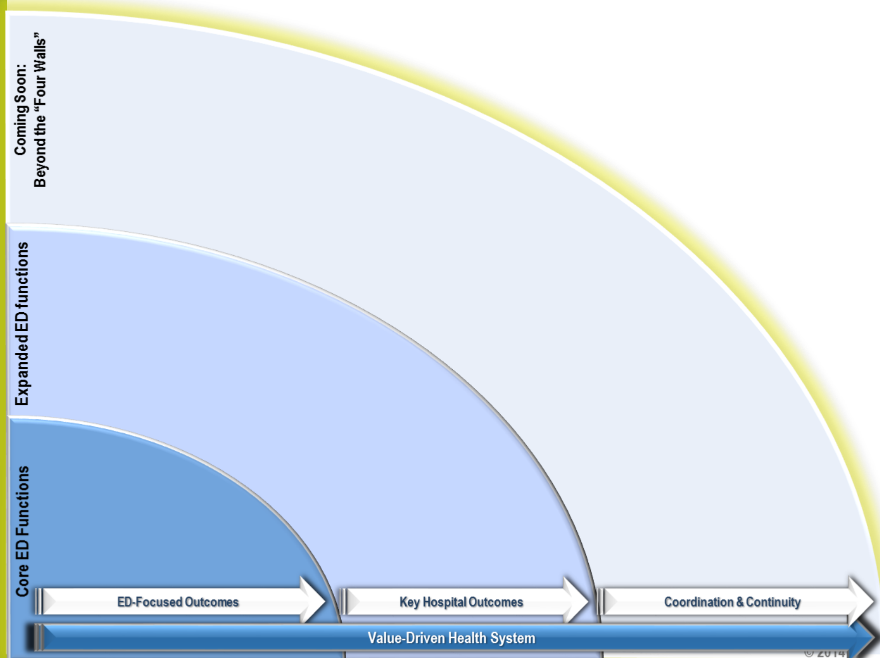
Right-Sizing Patient Care Before the ED Visit

- **Assist with optimal site of care**
- **Assist patients with access to office-based care**
- **Coordinate care with health plans**
- **Manage care-seeking behavior**

OUTSIDE THE FOUR WALLS

Right-Sizing Patient Care After the ED Visit

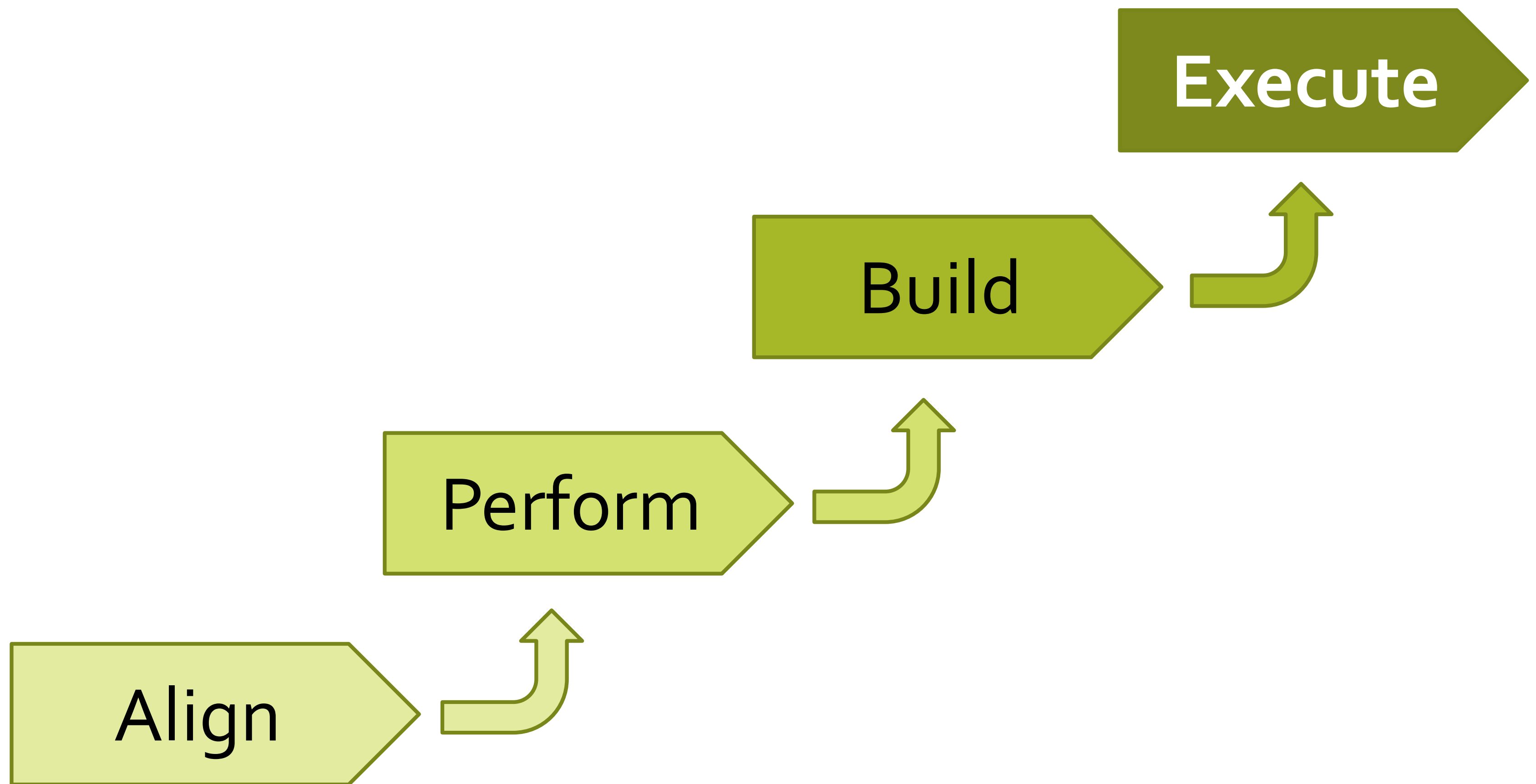
- **Appropriate transitions of care**
  - **Post-acute strategies**
- **Case and disease management**
- **Primary care accessibility**
- **Palliative care**
- **Telemedicine**



THINGS TO DO **NOW**

THINGS TO DO NOW

Framework



"If you don't know where you're going, any road will get you there"

THINGS TO DO NOW

Short Term

Align	Define success (with ED Director and management group) (define what, and by when)
Perform	Routine ED rounds Routine monthly meetings Routine departmental performance reviews
Build	Reporting tools Standard meeting agenda ED Director and provider relationships ED Nursing relationships
Execute	All the above Data flow to support reporting Acknowledge successes and highlight opportunities Problem-solve *together*

THINGS TO DO NOW

Medium Term

Align	Consider re-contracting (ED group or individual providers) • Include performance incentives
Perform	Perform versus aligned objectives, this time with dollars attached Continue all "short term" disciplines
Build	New clinical pathways Observation units Post-acute care options
Execute	Insure that the above options are • Functional • Utilized • Deliver ROI

THINGS TO DO NOW

Longer Term

Align	Insure that payor contracts are aligned with Hospital & ED Goals • Upside & downside risk • Performance period versus payment period
Perform	Insure appropriate performance versus metrics, measures and dollars
Build	Transparent reporting mechanisms for providers Routine cadence of performance reviews Continue all "short term" and "medium term" disciplines
Execute	Accordingly!

RIGHT-SIZING EMERGENCY CARE

Challenges & Obstacles:

- **Regulation and legislation**
  - EMTALA, prudent layperson standard
- **Patient choice and convenience**
  - 24/7 availability
  - "One-stop shop"
- **ED facility fee**
  - Often 3-4 times professional fee, but
  - Revenue for hospitals
  - Cost for patients and payors
- **Hard-wired perceptions of the ED**
  - Reality or not. . .

TAKE HOME POINTS

RIGHT-SIZING EMERGENCY CARE

The ED is an important hub for managing population health

- **Leverage the ED's position**
- **ED can be a key setting for:**
  - Preventing admissions
  - Connecting patients to primary care
- **Must embrace the role of the ED**
  - Patients *will* end up in the ED
    - Higher acuity, high cost, high impact patients
    - Even low acuity patients
- **Need strong connections**
  - For hospitalized patients
  - Ambulatory care transitions

RIGHT-SIZING EMERGENCY CARE

Changing health care policies

- **ACA**
  - Insurance expansions
    - Medicaid
    - Other
  - Payment reforms
- **MACRA**
  - MIPS/APMS
- **Effect of ACA Repeal / Replace?**

RIGHT-SIZING EMERGENCY CARE

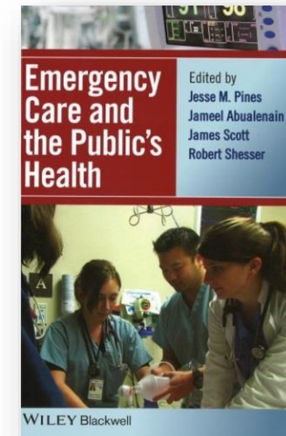
The “safety net” function must be recognized & accommodated.

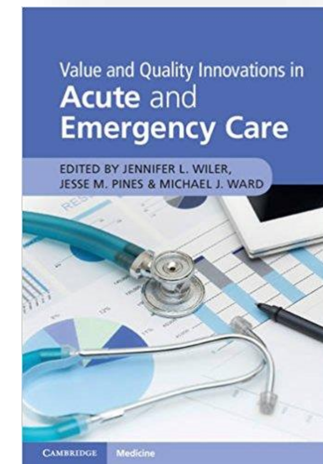
- Most communities and delivery systems will continue to struggle with availability and access to primary care.
- EMTALA requirements and the prudent layperson standard will continue to force cost-shifting.
  - Lower reimbursing payers do not cover the cost of care.
- Comparing the cost of ED care with other settings is difficult.
  - Health care safety net comes at a cost.
  - Standby and surge capacity comes at a cost.
  - Capability for treating a large range of conditions comes at a cost.
- *Reinforces the need to leverage the ED’s fixed costs.*

QUESTIONS

ADDITIONAL RESOURCES

- **Emergency Care and the Public's Health**
  - Edited by Dr. Jesse Pines
- **Value and Quality Innovations in Acute and Emergency Care**
  - Edited by Dr. Jesse Pines
- **Modern Healthcare Perspectives:**
  - Right-Sizing the Emergency Department in Health Care Reform
    - www.schumacherclinical.com/ed-assessment
  - ED Rapid Assessment Tool
    - ed-assessment.schumacherclinical.com





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