Addressing the Care Gap

from the ED to Home

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Speakers

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Addressing the Care Gap

from the ED to Home

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Addressing the Care Gap from the ED to Home

Recognizing the Care Gap

- Health care's dilemma
- Defining the gap
- The unique vantage point of the Emergency Department
- Why is this still broken?

Enabling Transformation

- Changing our approach
- Care models
  - Non-clinical interventions
  - Clinical interventions
- Technology empowerment
- Payment models

A well-designed health care system

1. Disease prevention
2. Timely access to care
3. Appropriate deployment of resources
4. Mechanisms to ensure quality of care
5. Effective transitions of care
6. Surge capacity
7. Disaster preparedness and response

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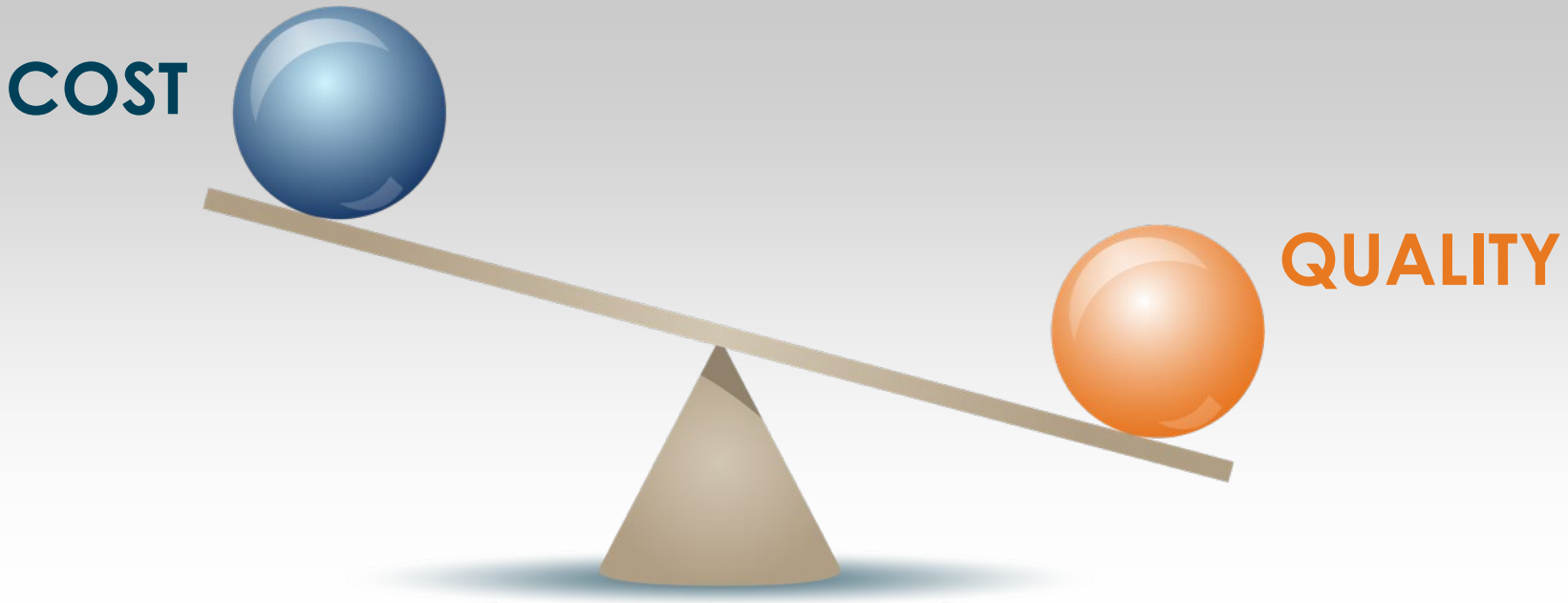
Health Care's Dilemma



The "Imbalance"

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Emergency Departments

Background

There are ~150,000,000 visits annually in the US

- Increasingly elderly
- Increasing acuity
- More co-morbidities per patient

Every hospital has an Emergency Department

EMTALA effectively guarantees access upon arrival

Emergency Departments

Emergency Departments regularly see large volumes of *high-focus* patients.

These patients often experience a significant gap in care after discharge from the ED.

Result: worse outcomes, higher costs, poor engagement, lower satisfaction.

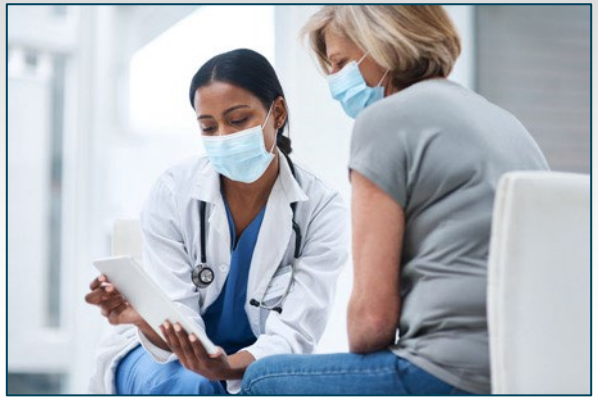
Solutions are possible, but *not* in the current paradigm

Our Patients

Patient #1
62-year-old male
CHF

Discharged Home

Patient #2
65-year-old female
HTN, hypothyroidism



Discharged Home

Patient #3
32-year-old male
History of PTSD and depression

Discharged Home

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The Gap

THE GAP
BEGINS WHEN:

the patient
leaves the ED

THE GAP
ENDS WHEN:

the patient
gets better or
fully engages in
follow-up care

WITHOUT CARE IN THE GAP

- Outcomes worsen
- Decreased trust and satisfaction
- Avoidable costs
- Increased demand and stress in the ED

IN THE GAP PATIENTS MUST:

- Understand and follow discharge instructions
- Fill new prescriptions
- Take medications differently
- Follow a new plan of care
- Obtain a follow-up appointment in a physician's office
- Gradually get better

WITH CARE IN THE GAP

- Better outcomes
- Increased patient satisfaction
- Decreased cost
- Improved quality of care
- Better performance in value-based models

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Polling Question

What do you think is the greatest difficulty for patients while they are in the Gap?

- Understand and follow discharge instructions
- Fill prescriptions or change medications
- Follow their new plan of care
- Find a primary care physician
- Obtain a follow-up appointment

The Evolution of the ED

Expanding Clinical Impact

- In-hospital code response

Partnering on Value and Cost

- Evidence-based utilization

Currently:

70% of a hospital's admissions come through the ED[1]

35-40% of patients that are discharged home have complex conditions[2]

EARLY

G

Estab

- D
- 24/7 staffing

- HAC documentation
- Rapid response teams
- Preventative screening (domestic abuse, etc.)
- Quality measures
- Operational measures

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[1] Emergency Department Benchmarking Alliance 2020

[2] "A Novel Approach to Identifying Targets for Cost Reduction in the Emergency Department," Annals of Emergency Medicine. 2012
Smulowitz, Peter B., MD, MPH; Honigman, Leah, MD; Landon, Bruce E., MD, MBA.

The ED's Unique Vantage Point

- All patients, all ages
- All medical conditions
- All insurance (or none)
- All socioeconomic conditions
- All reasons for accessing care

- First-hand experience with community's capabilities, resources, and weaknesses
- Interact with every element of:
  - The hospital
  - The medical staff
  - The community
- Accountable (and liable) for outcomes
- "Re-accountable" for failures of the system

Research

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High Focus Populations in the ED

Intermediate and Complex Conditions[2]

- **High focus clinical conditions comprise <u>31-57% of all ED visits</u>**
  - Approximately 10% of all health care costs.

- ***Reducing hospitalizations by 10-25% saves between <u>1 and 2.5% of all health care costs</u>.***
  - Much greater than savings from eliminating most "preventable" ED visits.

- **CHF**
- **COPD**
- **Diabetes**
- **UTI**
- **Chest pain**
- **Pneumonia**
- **Abdominal pain**

"Hospitals can generate significant cost efficiencies from addressing testing, treatment, and hospitalization patterns for intermediate and complex conditions."[2]

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[2] "A Novel Approach to Identifying Targets for Cost Reduction in the Emergency Department," Annals of Emergency Medicine. 2012
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Priorities and Processes

High acuity visits

> 40% of annual cost

Low acuity Visits

0.2%-1.5% of annual cost

Requires a programmatic approach:

- Provider communication
- Effective care transitions
- Effective coordination of care

Reduces waste, increases efficiency, and produces better outcomes.

Addressing Intermediate and Complex Conditions

"The contribution of ED care is different than primary care."[2]

Primary Care

- Prevention
- Wellness
- Risk factor modification
- Longitudinal care
- Minor acute care

Enhanced ED care

- Care navigation
- Low-acuity follow-up
- Telemedicine visits
- Compliance with treatment plans
- Bridge to primary care

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[2] "A Novel Approach to Identifying Targets for Cost Reduction in the Emergency Department," Annals of Emergency Medicine. 2012
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Data

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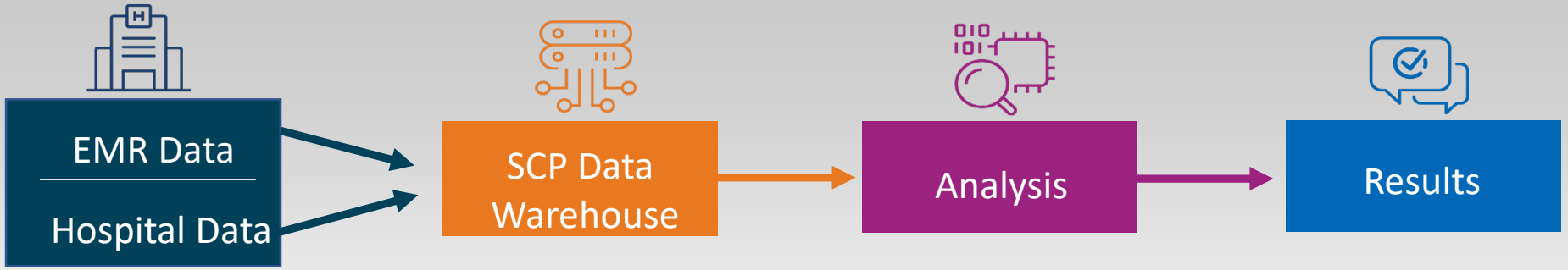
Data Analysis



> 1,000,000 encounters

- 300 emergency departments
- 30 states
- Pre-COVID

Discharged patients

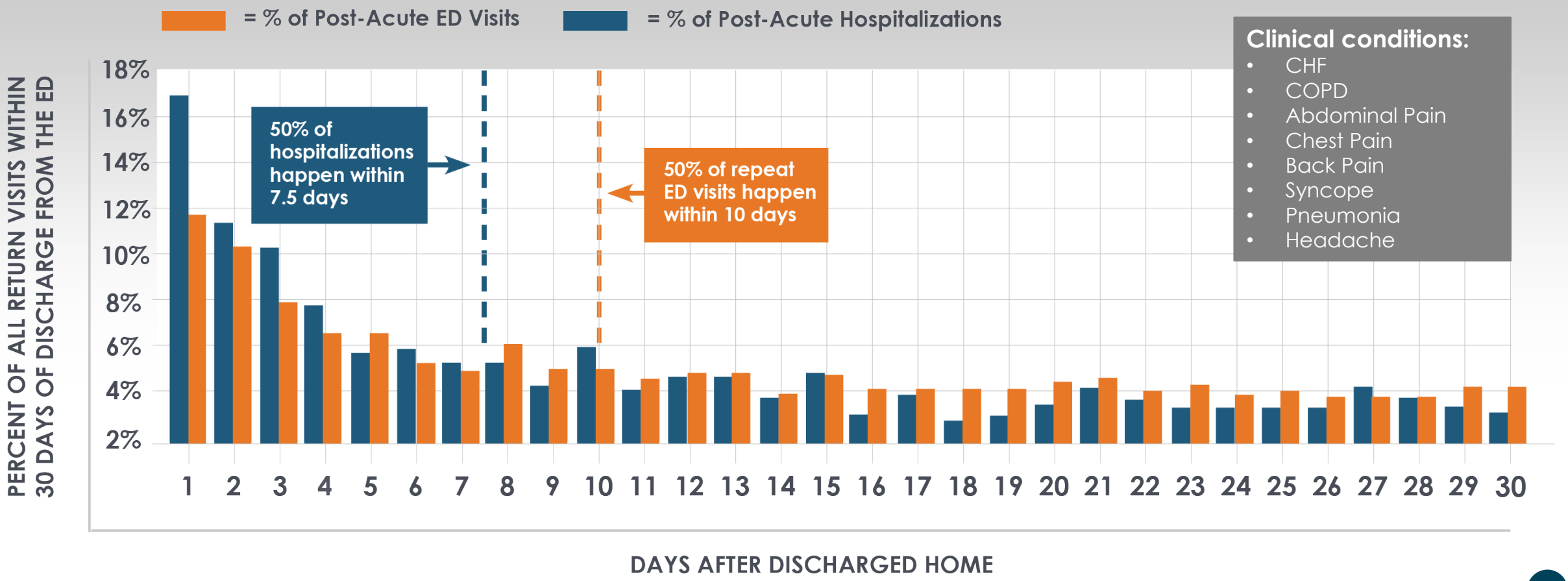
- Higher intensity, high focus clinical conditions
- **Assessed return visits for 30 days after an initial ED visit**

MODERATELY COMPLEX CONDITIONS DISCHARGED FROM THE EMERGENCY DEPARTMENT

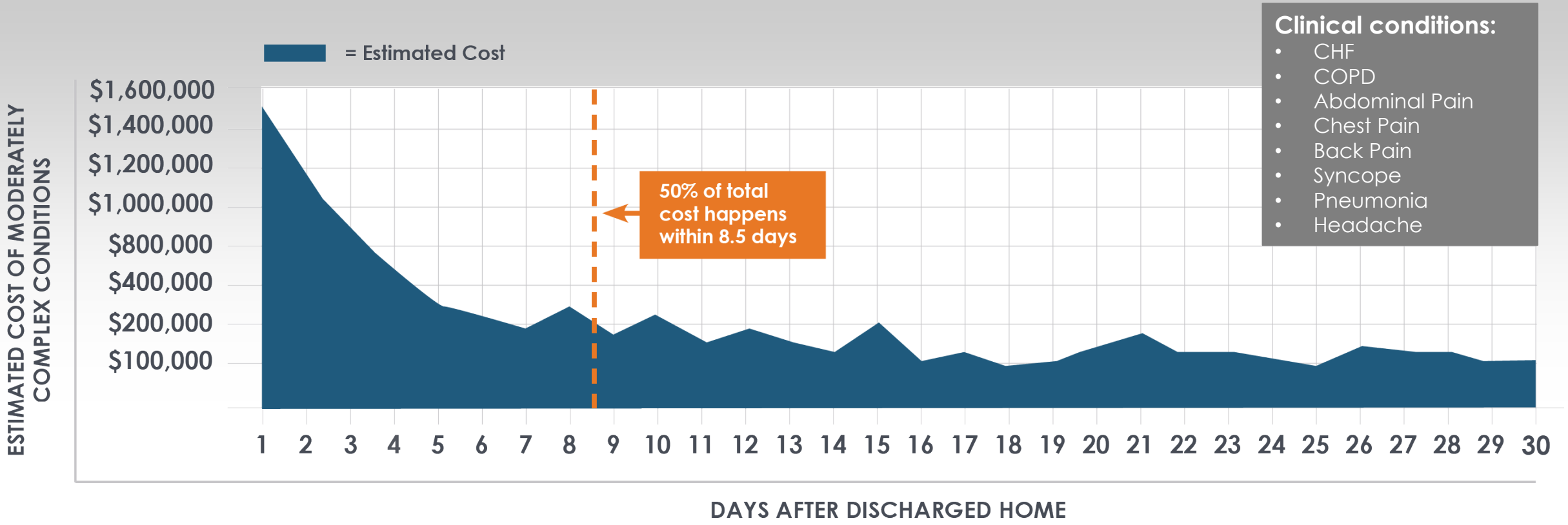
Clinical conditions:

- CHF
- COPD
- Abdominal Pain
- Chest Pain
- Back Pain
- Syncope
- Pneumonia
- Headache

MODERATELY COMPLEX CONDITIONS DISCHARGED FROM THE EMERGENCY DEPARTMENT



ESTIMATED COST FROM REPEAT ED VISITS AND HOSPITALIZATIONS FOR MODERATELY COMPLEX PATIENTS DISCHARGED FROM THE ED



Patients are most vulnerable in the first 7-10 days after leaving the emergency department.

50% of repeat hospitalizations occur within 7.5 days.

50% of repeat ED visits occur within 10 days.

50% of combined costs occur within 8.5 days.

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What happens?

Patients:

- Decreased satisfaction
- Poor outcomes
- Lower engagement
- Preventable utilization

Clinicians:

- Increased demand and stress in the ED
- Unsolvable situations
  - No new solutions on the second visit
- Decreased patient trust, more frustration, less satisfaction

Hospitals:

- Readmission penalties
- Decreased patient satisfaction
- Preventable acute care visits
- Increased mortality

Payors:

- High and variable costs of post-acute settings
- Costly return ED visits
- Avoidable hospitalizations
- Pressure on adequate networks and care coordination

The High Cost

$129 -$244 billion is wasted annually in health care spending.[3]

- Failed transitions of care
- Readmissions
- Poor care coordination
- Failed treatment follow-through
- Poor execution of best practices

3. Shrank, W. H. (2019, October 15). Waste in the US Health Care System. JAMA.

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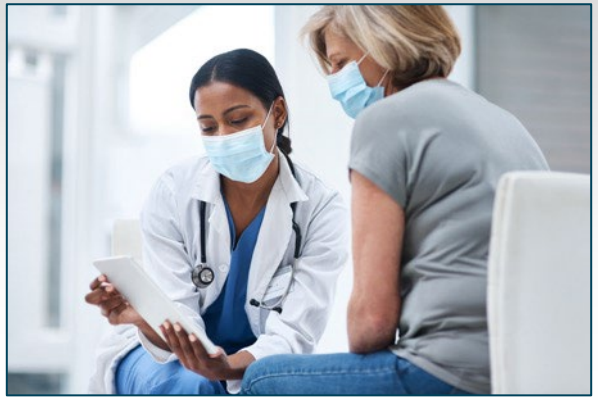
Patients in the Gap

Patient #1
62-year-old male
CHF

Hospitalized

Patient #2
65-year-old female
HTN, hypothryoidism



Returned to ED

Patient #3
32-year-old male
History of PTSD and depression

Returned to ED

Not for lack of trying…

Case managers

Payor outreach programs

ACO models

Home health

Patient-centered medical home

After hours clinics

Disease management protocols

Social workers

Call back systems

Acquiring primary care practices

Payment models

Consultants

Fragmented technology strategy

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“No matter how elegant the plans, you occasionally have to look at the results…”

- Winston Churchill

If you don’t like the results, change the approach.

Changing the Approach

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Polling Question

What do you think will make the greatest difference in bridging this Gap for patients?

- Non-clinical interventions (e.g., care navigation)
- Clinical interventions (e.g., telemedicine)
- Both clinical and non-clinical interventions

Changing the Approach

We need to change the approach to dramatically improve patient experience, quality, and outcomes.

Problems

- Timing
- Adrift patients
- Communication
- Payment

Solutions

- ED-initiated follow-up care
- Connected technology
- Financial alignment

ED-Initiated Follow-Up Care

Emergency physicians are uniquely qualified and positioned to ensure *timely* access to follow-up care, support, and navigation after an initial ED visit.

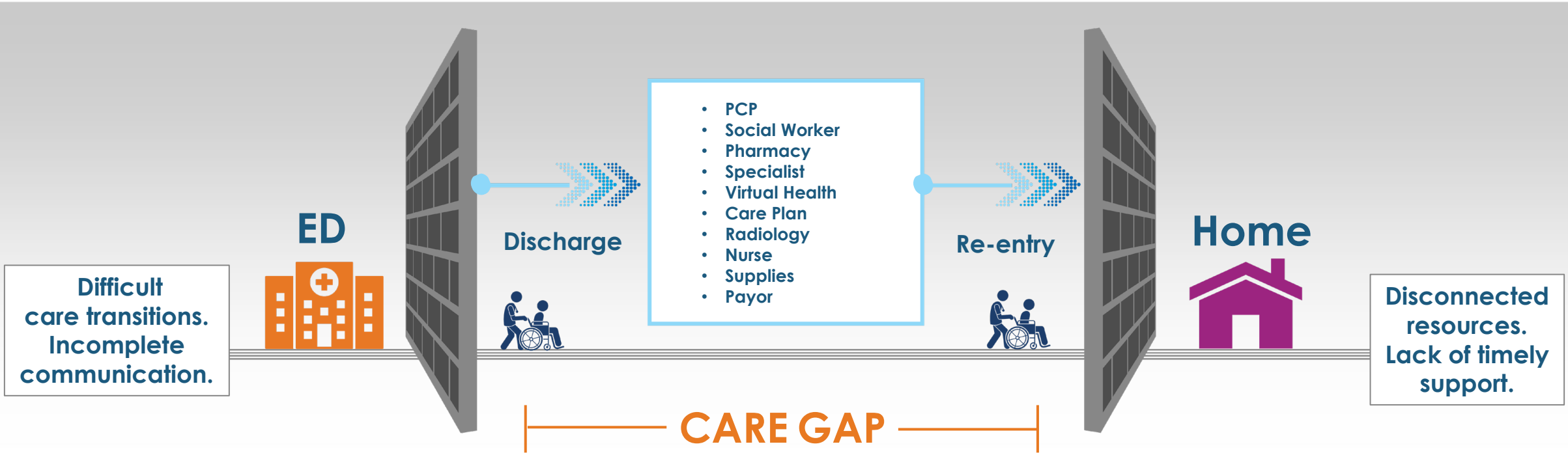
Non-clinical:

- Finding PCPs for patients without one
- Obtaining a timely appointment
- Supporting patients to understand and follow discharge instructions
- Encouraging patients to fill and take prescriptions

Clinical:

- Supporting ongoing care and a sustained patient relationship
- Providing low intensity clinical encounters with a physician, NP, or PA
- Bridging to longitudinal care
  - Primary care
  - Specialty care

Old Approach



New Approach

ED-led interventions:
- Prompt follow up
- Better navigation
- Consistent patient engagement
- Telemedicine support if needed
- Reduced hand offs

ED-initiated follow up care, support, and navigation.

Results:
- Increased satisfaction
- Fewer ED revisits
- Better outcomes
- Less cost
- Greater patient loyalty

ED

Discharge

Outreach on behalf of their ED clinician, within 24 hours of ED visit yields a **90% response rate** and sets up appropriate interventions to be much more effective.

Re-entry

Home

Digital Technology Capabilities

In the ED

Within current workflow, clinicians "tag" patients for additional follow-up according to predicted risk.

In the ED

Clinicians and the ED measure successful patient encounters and quality metrics based on extended accountability.

Care Coordination Platform

Automated systems sorts and prioritizes tagged patients for appropriate follow-up and outreach.

Digital Health Technology

Tech enabled processes leverage cost-effective, appropriate follow-up pathway based on individual needs and conditions.

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Value Based Progression

Aligning payment models with clinical objectives.

Pay-for-Performance:

- Allows bonus payments for higher-value care
- Typically aligns MIPS and HEDIS metrics and targets
- Can include resource utilization metrics

Pay-for-Performance Plus:

- Allows bonus payments for higher-value care
- Adds metrics which require additional post-discharge navigation or care coordination
- Improves outcomes with better engagement and follow-up care

Gain-Share

- Adds gain-sharing through targeted impact on overall utilization and cost
- Typically aimed at target conditions

Two-Sided Risk

- Establishes episode bundles with target pricing for initial triggering event plus 30-days of follow-up costs
- Share in upside and downside variances from target prices

Further Evolution: Gain-Sharing and Two-Sided Risk

The Acute Unscheduled Care Model (AUCM)

- First and only value-based framework that directly impacts emergency department care
- Episode-based model (clinical bundles)
  - Bundles include moderate-to-high intensity patients that are discharged from the emergency department
  - Bundles commonly have repeat ED visits or hospitalizations within 30 days of the index ED visit
  - Significant opportunity for improved outcomes and reduced cost
- "Target Price" includes the initial ED visit plus 30 days of post-acute care
- Mature model entails two-sided risk; other options possible
- Models being piloted and gradually adopted by various payors

Reimbursement vs ROI

Don't confuse one with the other.

Sources of ROI

- Patient satisfaction
- Lifetime value of a patient
- Quality outcomes
- Avoidable utilization

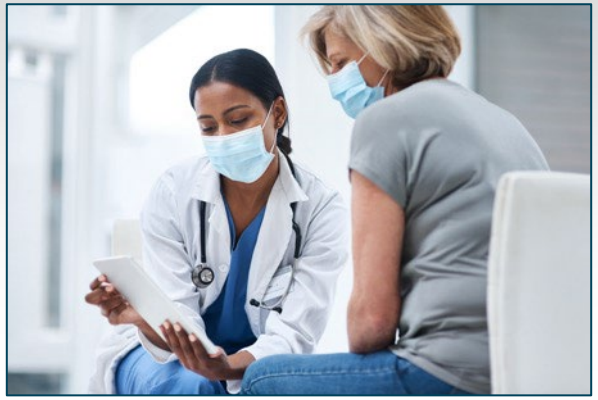
What Happens Next?

Patients *with Care* in the Gap

Patient #1
62-year-old male
CHF

Did not return to ED

Patient #2
65-year-old female
HTN, hypothyroidism



Did not return to ED

Patient #3
32-year-old male
History of PTSD and depression

Did not return to ED

Transformation takes courage

Confirm

a fundamental connection to our purpose.

We are committed to patient-centered healing and a system that works.

Choose

to take action.

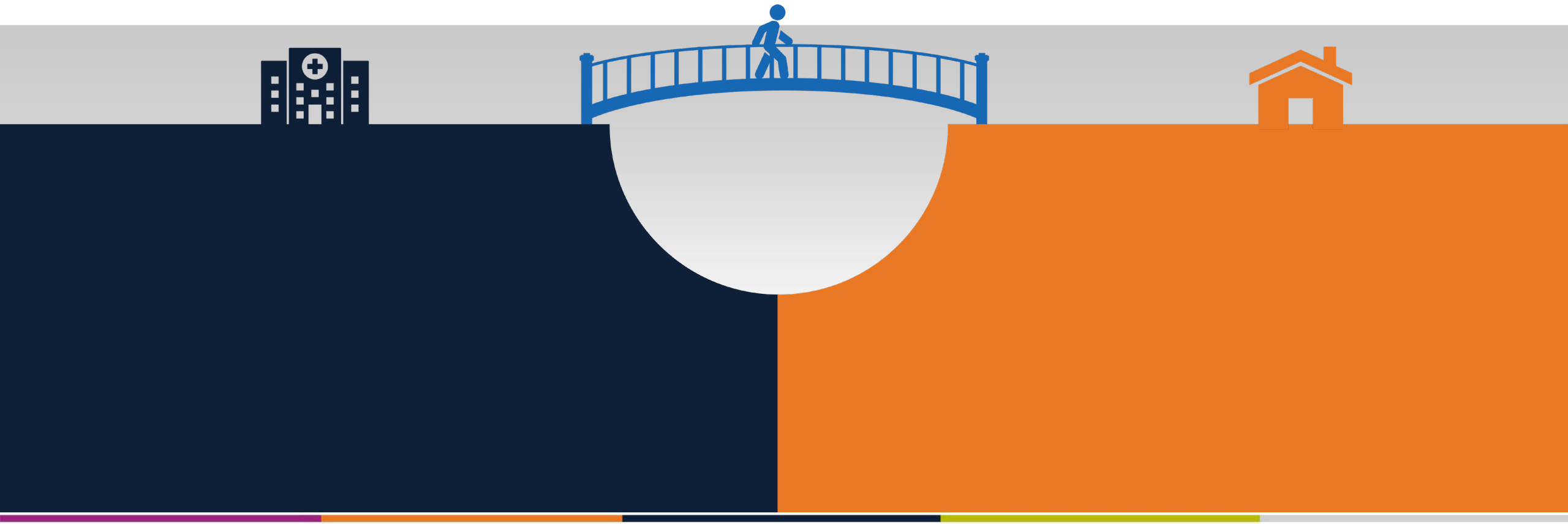
Use data to start the conversation. Empower with technology.

Embrace

a broader accountability for our patients and the health system.

Welcome new technology and emerging models.

Closing the Gap



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Questions

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