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The Rural ED as a Flagship Service for the Hospital, Hospital System, and Community

Rural Emergency Care:
Stepping Up to the Challenge

April 26, 2013

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Agenda

- Health care *value*
- Transfer of *risk*
- ED performance improvement
- ED role in new care paradigms

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Today's Health Care Themes

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- Insurance coverage expansion
- Primary care emphasis
- Value-based purchasing
- New delivery systems
- Risk transfer to providers
- Reform is not just the Affordable Care Act!

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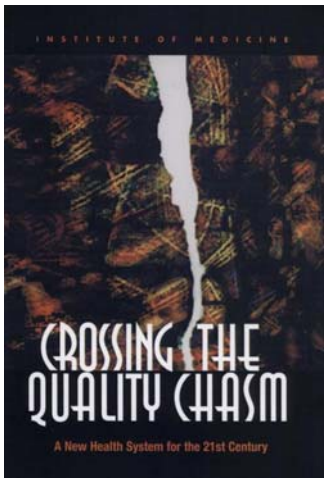
Value – IOM Six Aims

4

Health care should be:

- **Safe**
- **Effective**
- **Patient-Centered**
- **Timely**
- **Efficient**
- **Equitable**



Source: Corrigan, et al (eds.). *Crossing the Quality Chasm.* Committee on the Quality of Health Care in America. National Academies Press. Washington, DC. 2001.

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The Triple Aim

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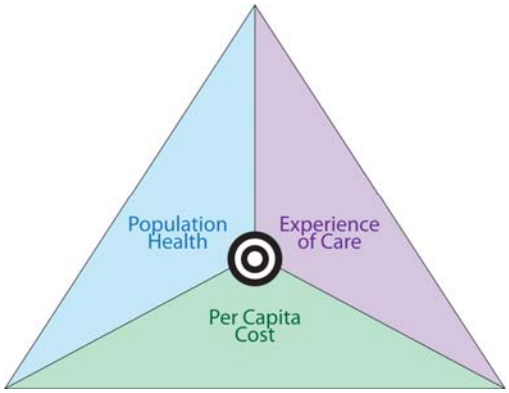

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Value Equation

6

$$\text{Value} = \frac{\text{Quality + Experience}}{\text{Cost}}$$

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

"Triple Aim"
- Better care
- Better health
- Lower cost

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The Value Conundrum

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You can always count on Americans to do the right thing – after they've tried everything else.

- Fee-for-service
- Capitation
- Market
- Single payer
- Self-police

- **Value-based Purchasing (VBP)?**
- **Accountable Care Organizations (ACOs)?**
- **Patient-Centered Medical Homes?**

Tyranny of Fee-for-Service

8

- Current measure of "success" is to maximize:
  - Office visits per day
  - Average daily inpatient census
  - Admissions from the ER
- Is this how you would identify a great physician or a world-class hospital?
- Can we design measures that reward industriousness, yet reflect why we went to medical school?

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Form Follows Finance

9

- How we deliver care depends on how we get paid for care
- Health care reform is changing both
- Fundamentally, reform involves a **transfer of risk** from payers to providers

Risk Assessment is Ubiquitous

10

- Risk is present when an outcome is uncertain or unpredictable
- Types of health care risk
  - Random
  - Insurance
  - Political
  - Medical Care
- Where/how can hospitals
  - **Influence or control risk**
  - **Reduce risk of harm**
  - **Optimize risk of benefit**

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Rural Risk?

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Random Risk

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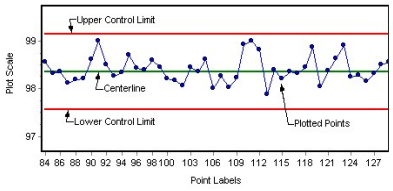
- Normal variation
- Rolling the dice
- Roulette v. poker
- No control, but important to recognize



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Insurance Risk

13

- Insurance risks
  - Demographic change
  - Technological innovations
  - Prior health status
  - Cost inflation
- Cost is the actuarial metric
- Minimal control, but predictable

Anthem · Aetna · UniCare · HUMANA · CIGNA · PacifiCare · UnitedHealthcare · Health Net

Political Risk

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- Rules, regulations, and legislation
- Profound impact on health care delivery and finance
- Modest control, often via advocacy avenues

American Hospital Association

AMA American Medical Association

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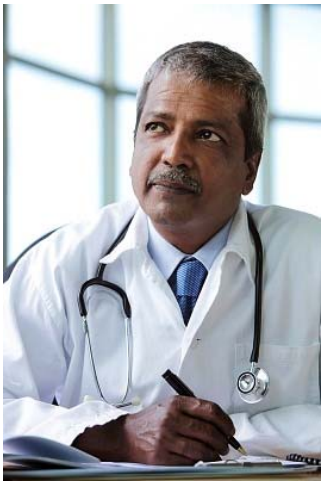
Medical Care Risk

15

- Medical care *variation*
  - Diagnostic accuracy
  - Care plan implementation
  - Guideline use compliance
  - Pharmaceutical choice
  - Procedural skill
  - Efficient resource use
- How our choices influence health care **value**
- Greatest control, how we deliver care



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The Risk of Inertia

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The Risk of Doing Nothing

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Rural ED as the Flagship

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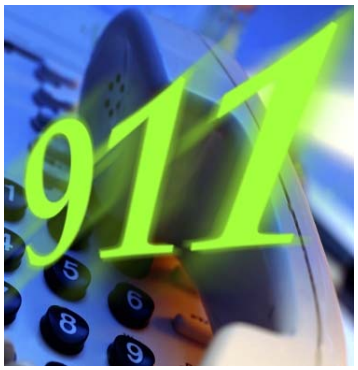
- Always "open" – 24/7
  - Life saving care
  - Public health surveillance
  - Safety net provider
- Most valued rural hospital service
- Provides a sense of safety and security for the community
- As important as we are, let's get our house in order
  - Let's look internal first, then external
  - A SWOT analysis!



Critical to the hospital
Critical to the community

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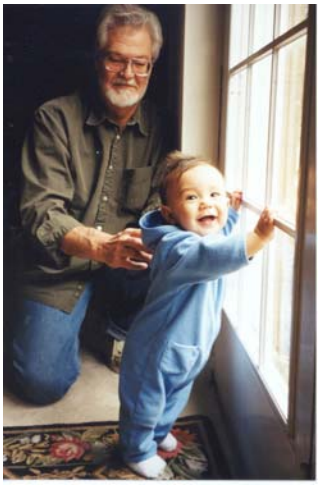
Front Door – Front Window

19

- 1st and lasting impressions of the hospital experience are made in the ED
- Patient experience is a critical ED performance measure
- Employee satisfaction often equals patient satisfaction



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ED Deserves Leader Attention

20

- Southwest Airlines makes employees a priority
- Employee/patient link
- *Attention* is the currency of leadership
- To do list
  - Dedicated clinical time for managers
  - Push decision-making down
  - Leadership rounds
  - Follow-up all explicit and implied commitments

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Serving the "Customer"

21

- Customer service can move market share
- A potential customer service nightmare
- We see 10x the number of inpatients
- To do list
  - Behavioral standards
  - Patient call back and satisfaction survey
  - Focus on improvement, not just benchmarks

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Not Necessarily the Money Pit

22

- High fixed costs impact revenue calculations
- Revenue, plus
  - Admissions
  - Ancillaries
- To do list
  - Document optimally
  - Reduce barriers for appropriate admissions
  - Treat the ED as a customer
  - Collect co-pays

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Driving the Liability Nitro Truck

23

- Perfect opportunity for disaster
  - The Law
  - Hospital policies
  - Medical liability
- To do list
  - Register, see, and treat all
  - Transfer policies
  - Contract to stipulate care in ED only
  - Admission protocols, not hand written orders
  - Bedside handoffs

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Making the Perfect Handoff

24

- Most error-prone process in health care
- Flash points
  - Waiting to see private MD
  - Between ED shifts
  - Admissions
  - Transfers
- To do list
  - All patients seen by ED doc
  - Bedside handoffs
  - Consistent communication (eg, SBAR)
  - Document the handoff

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Quality is Job One

25

- Quality is our mission
- Assess performance relative to Mission
- Quality not always self-evident
- To do list
  - Communicate results
  - Review every high risk, low frequency event
  - Measure variation
  - Don't assume a non-punitive environment

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Performance *Counts*

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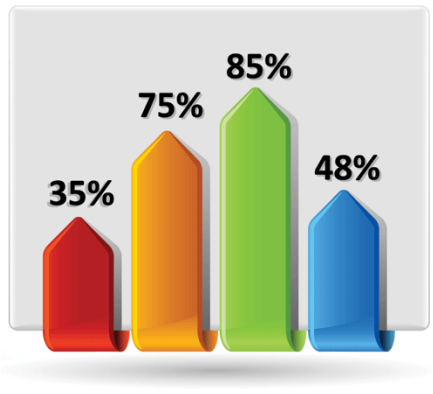
- Above average?
- Without measurement, we're managing by hunch
- Need to demonstrate performance
- Remember, reporting precedes P4P
- To do list
  - Measure performance: quality, service, and financials
  - Report to individual providers, board and staff



See Appendix for ED performance measures

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Variation = Risk = Opportunity

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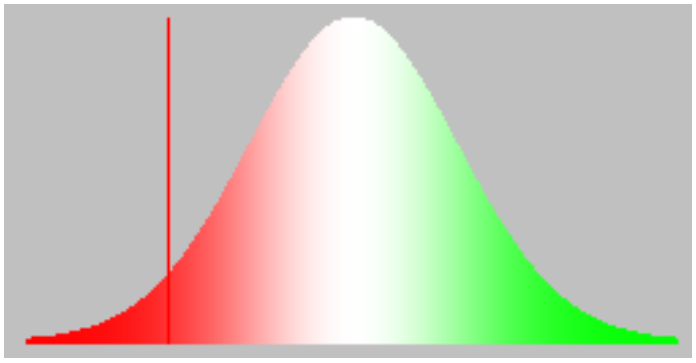

Variation suggests a risk for underperformance, but also an opportunity to excel

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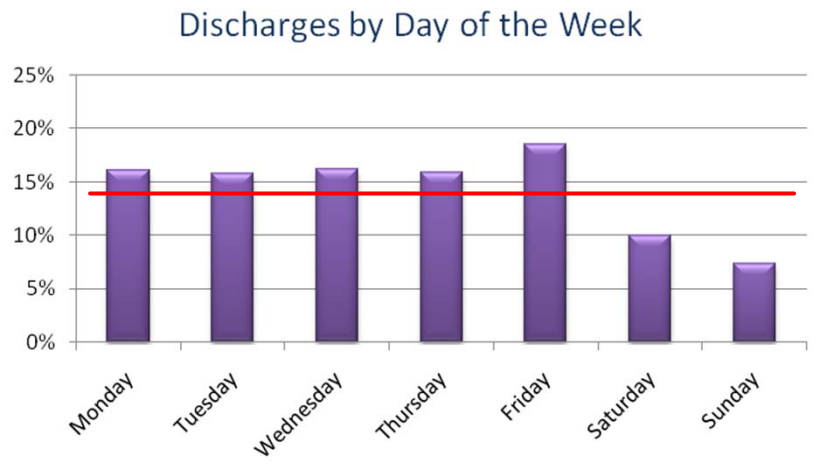
Variation – DC by Day of Week

28



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Variation – CT in Non-Trauma HA

29

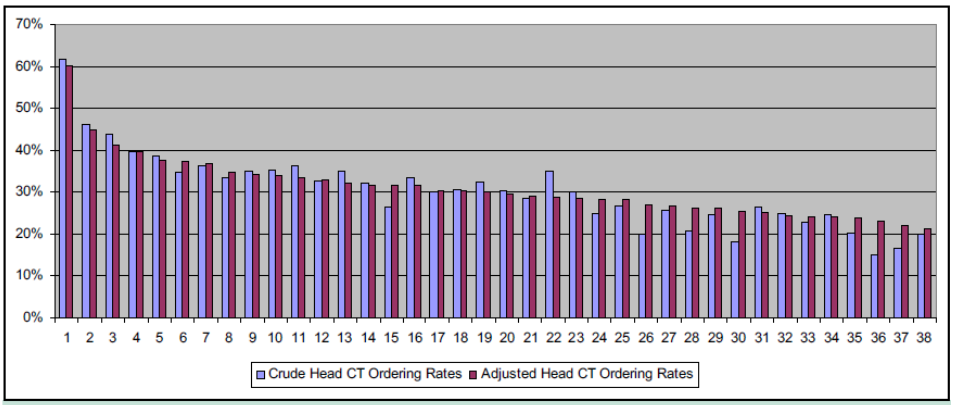

Figure 3 Crude and adjusted head CT ordering rates by physician in patients with atraumatic headache.

Source: Prevedello, LM, et al. Variation in use of head Computed Tomography by Emergency Physicians. *Am J Med.* April 2012.

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Drive Out (Most) Variation

30

- Best evidence is only the way we practice medicine
- Care <u>should</u> vary by unique *patient* needs, not by
  - Doctor or nurse
  - Day of week, or time of day
- Not cookbook medicine, many opportunities for
  - Clinical judgment
  - Thoughtful interactions
  - The "art" of medicine

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Our Own Demons

Nutting et al – small primary care practices are:

- Physician-centric
- A hindrance to meaningful communication between physicians
- Dominated by authoritarian leadership behavior
- Underserved by PAs/NPs cast into unimaginative roles

"Characteristics so ingrained in the primary care practice culture that they have become virtually invisible, along with their implications.

Source: Nutting, PA, Crabtree, BF, McDaniel, RR. Small primary care practices face four hurdles – including a physician-centric mindset – in becoming medical homes. Health Affairs. 31:11. November 2012.

Team-Based Care

- Fewer Chuck Yeagers, more John Glenns
- Fewer cowboys, more pit crews
- *Independence* is archaic
- ED Medicine is a *team sport*
- To do list
  - Make time and space for team building
  - Review, learn, improve together

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Physician Recruitment

- Desirable physician traits for future-oriented health care organizations
  - Team-oriented
  - Motivated by quality incentives
  - Technologically savvy
  - Evidenced-based approach
  - Comfortable working with PAs and NPs

Source: Survey of 200 health care employers and hospital systems by the Medicus Firm, 2012.

New World Realities

- Risk transfer to providers
  - Higher quality at lower cost
  - Doing what's needed, not more
- New business models
  - More primary care, less inpatient
  - Rewarding value, not just volume
- ACOs are the current poster child for value-based care

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Accountable Care Organizations

35

- A coordinated network of providers with shared responsibility for providing high quality and low cost care to their patients.*
- Couples risk-based provider payment with health care delivery system reform
- Payer shares savings with doctors and hospitals if high quality

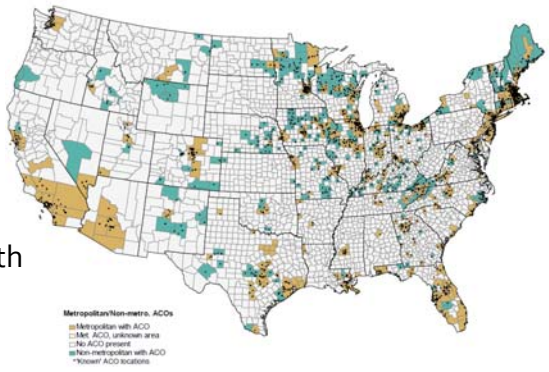
*Source: Robert Wood Johnson Foundation. Accountable Care Organizations: Testing Their Impact. 2012 Call for Proposals.

ACO Expansion

36

- ACOs in 15% of rural counties (38% of metro)
- 25-31 million patients receive care through an ACO
- ~**10%** of the population
- Remarkably quick growth for a new and complex form of payment and care delivery

County Medicare ACO Presence



Source: RUPRI Center for Rural Health Policy Analysis, 2013.
Niyum Gandhi and Richard Weil, The ACO Surprise, 2012.

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ACO Quality Measures

37

- 4 Domains
  - Patient/Caregiver Experience
  - Care Coordination and Safety
  - Preventive Health
  - At-Risk Population/Frail Elderly
- Commercial ACO Measures
  - Potentially avoidable ED visits
  - Generic dispensing rates
  - Ambulatory sensitive admissions

See Appendix for ED ACO measures

Source: Lynn Barr, CAReHIN

Cost Reduction Strategies

38

- Reduce ambulatory care sensitive admissions
- Reduce readmissions
- Reduce ED utilization
- **ED physicians will participate in the downside, so why not participate in the upside?**
- So… explore strategies to make the ED an integral part of a winning rural hospital!

Source: Lynn Barr, CAReHIN

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ED Care Strategies

39

- Care coordination process between ED and care management
- SBIRT (Screening, Brief Intervention and Referral to Treatment)
- Processes for behavioral health professional, care manager, and/or PCP referrals
- Place a care coordinator in the ED for peak hours?
- Get ED reps on ACO board

Source: Lynn Barr, CAReHIN

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ED Negotiation Options

40

- Payment for PCP appointment
- Payment for enrollment in care management program
- Payment for patient compliance
- Payment for PCP referral and beneficiary assignment
- Payments for preventive health activities

Source: Lynn Barr, CAReHIN

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ED Transformation

41

- How do we move toward value when our practice is primarily fee-for-service?
- One foot on the dock and the boat!
- But we can test the waters
  - Use Paul Nutting's insights to be introspective
  - Measure and share performance, then act on it
  - Make time and space for team building
  - Drive out variation; only the "best" evidence care
  - Actively engage in ACO planning – negotiate from strength

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What We're All About

42

- Community benefit
  - Essential service
  - Reduce government burden
  - Safety net provider
  - Safety and security
- To do list
  - Price transparency
  - Community education
  - Support local EMS
  - Human service needs
  - Document charity care

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The Relationship

43

- Interaction and information sharing is care
- Blessed to be trusted and invited into the most intimate parts of people's lives
- To do list
  - Every patient is the only patient
  - Nothing about me without me
  - Patient is the source of control
  - Transparency – "no secrets"

Collaboration and Value

44

- ACOs and other "programs" less important
- Collaboration that fosters health care value is key
- Future paradigm for success
- **Good medicine and good business**

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The Risk of Something New

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Healthy People and Places

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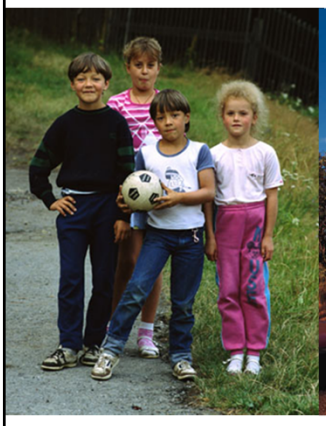

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Appendix

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ED Performance Measures

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- Median time ED arrival to discharge
- Median time ED arrival to diagnostic evaluation by provider
- Median time to fibrinolysis for STEMI patients
- % STEMI patients who receive fibrinolysis within 30'
- Median time to transfer for acute cardiac intervention
- % patients receiving ASA for suspected ACS
- Median time to ECG for chest pain patients
- % getting MRI for low back pain w/o conservative treatment
- % patients getting both contrast/no contrast abdominal CTs
- % patients getting both brain/sinus CTs

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ED Performance Measures

49

- % patients getting CTs for non-traumatic headache
- % patients left without being seen
- Median time to pain management for long bone fracture
- % patients getting CT results back within 45' with stroke
- Median time to PCI
- % patients receiving PCI within 90' of ED arrival
- % getting blood cult. prior to ATB for ICU pneumonia admits
- % pneumonia patients given appropriate antibiotics
- % patients considered for TPA in stroke
- Variety of patient satisfaction measures (CAHPS)

ED and Population Health

50

- % of patients with flu vaccine
- % of patients with pneumococcal vaccine
- % of females with mammogram within 2 years
- % of patients with appropriate colorectal cancer screen

ED can improve performance on these measures

Source: Lynn Barr, CAReHIN

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ED and Population Health

51

- % of patients queried for tobacco and % interventions
- % of patients screened for depression and % interventions
- % of pts with normal BMI or documented plan to address
- % of pts who have BP recorded within 2 years

ED can improve performance on these measures

Source: Lynn Barr, CAReHIN

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ED and Population Health

52

- % of pts queried for tobacco and % interventions
- % of pts screened for depression and % interventions
- % of pts with normal BMI or documented plan to address
- % of pts who have BP recorded within 2 years

ED can improve performance on these measures

Source: Lynn Barr, CAReHIN

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ED and Special Populations

53

- Hypertension (HTN): BP Control
- Ischemic Vascular Disease (IVD): LDL <100 mg/dl
- Ischemic Vascular Disease (IVD): Use of Aspirin
- Heart Failure: ACEI for LVSD

ED can improve performance on these measures

Source: Lynn Barr, CAReHIN

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ED Care Coordination

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- Readmissions
- Medication reconciliation
- Ambulatory Sensitive Conditions Admissions rate
- % of all physicians receiving EHR incentive payments
- % of patients screened for fall risk

ED can improve performance on these measures

Source: Lynn Barr, CAReHIN

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