

Appropriate Emergency Department Utilization: Accountable Care Act and Beyond

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NCIOM Safety Net Work Group

- Action items presented are an initial draft
- Please write down questions and discussion topics and save for the end
- Collaboration with this WG and other stakeholders is greatly appreciated
- At the end of the day, it is all about maintaining access to high quality cost effective healthcare

Emergency Departments provide the healthcare safety net for millions of Americans

- Only 2% of healthcare costs are generated by 150 million annual ED visits
- 75% of the acute care provided in the country is provided in ED's
- ED's remain the most efficient health care location to evaluate a patient with the onset of a problem with acute symptoms

Emergency Departments are unique in providing an essential community service in providing our medical safety net

- Only 8 percent of emergency patients have nonurgent medical conditions (per 2008 CDC report).
- Emergency departments have a federal mandate to treat everyone, regardless of ability to pay.
- Two-thirds of emergency visits occur after business hours, when doctors' offices are closed.
- America has a growing elderly population; most have chronic health problems and require an increasing amount of emergency care.

Emergency Care provisions in ACA

- Continue to evolve
- No EMTALA changes have been proposed
- Coverage for ED care/services is a required for all health plans offered on the exchange
- Medical liability reform is not addressed

Sec. 5502: Medicare Federally Qualified Health Center Improvements

- Monitor the development of a prospective payment system for FQHCs, working with CMS and HRSA, foster coordination and communication between FQHCs and ACEP/emergency departments to improve appropriate flow of patients from emergency departments to FQHCs, and vice versa.

Sec. 1202: Payments to Primary Care Physicians

- Expand program that requires states to pay primary care physicians for Medicaid services at Medicare rates.
- Essential to preserving access for Medicaid patients to primary care providers

The 800 lb. Guerilla: EMTALA

- *EMTALA definition of an Emergency Medical Condition (EMC):*
- "A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in --
placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part,
- Or "With respect to a pregnant woman who is having contractions --that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or her unborn child."

EMTALA considerations

- Hospital obligated to provide MSE to determine if an EMC exists
- Care must be continued until the patient is “stable” (stable is poorly defined, and represents a continuum)
- Up to a \$50,000 fine for each violation
- Encourages unchecked ED utilization (and sometimes abuse)



NCCEP Response to ACA and North Carolina budget crisis

- Initiated meetings with Secretary Cansler; NCCEP has been invited to help develop models to maintain access for Medicaid patients while reducing costs
- Formation of NCCEP Access to Care Committee (ATCC)
- Proposed House budget: no provider cuts, but CCNC charged with cutting 80 million in costs.....(or else?)

ATCC SBAR Report

- **S**ituation
- **B**ackground
- **A**ssessment
- **R**ecommendations

Entire SBAR is in your handout; will address some of the key components as follows

Background

- NC faces a 3 billion budget deficit in 2011. Most providers (including ED providers) took a 9% cut in Medicaid reimbursement rates in 2010 and face an even greater reduction in 2011. Many Medicaid recipients are forced to turn to the ED for primary care services, and this trend will greatly increase when/if provider reimbursement is further reduced as many more providers will no longer be able to afford to treat Medicaid patients in their practices. Health care delivery as mandated by PPACA is projected to increase the number of Medicaid patients in NC ~600,000 by 2014. NC is projected to have a declining number of PCP's over the next decade.

Assessment

- The healthcare environment for the practicing EM physician continues to deteriorate in NC. ACEP's Report Card on the State of Emergency Medicine gave NC an "F" for the professional liability climate. Multiple factors make it increasingly problematic to retain and recruit highly qualified EM physicians. Many groups have placed a moratorium on hiring additional physicians due to increasing overhead and declining reimbursement. Emergency departments remain the most cost and time effective place for the medical screening exams (MSE) for most of the possible undifferentiated emergency medical conditions (EMC's) that acutely ill and injured patients have.
- (See additional assessment points on the handout.)

Recommendations

- Medicaid reimbursement for EM services should be restored to the levels paid early in 2010 and needs to be maintained at a level that will ensure the ongoing EM safety net our EM physicians provide for the residents of NC.
- To ensure the broadest ongoing participation of primary care practitioners (PCPs) in the state, primary care office codes (99201-99215) need to be preserved at current levels. Failure to do so will result in the termination of many PCPs from Medicaid, leaving many of the underserved of NC few places to go to meet their primary care needs. Preserving existing reimbursement for all specialty office visit codes (99201-99215) will also serve to ensure ongoing access of Medicaid patients for specialty office care.

Recommendations (cont.)

- Access to the NC Medicaid Portal needs to be fully implemented and utilized in all our ED's. The clinical information available in Portal needs to be expanded this year to include results of recent evaluations for the same or similar patient presentations to greatly reduce the current high frequency of duplicating expensive evaluations (especially imaging). Alternatively, EDP's could contact healthcare professional gatekeepers who have full access to the clinical information available in Portal to relay to EDP's. It is essential to maximally utilize and develop Portal access to reduce utilization and cost for NC Medicaid beneficiaries. Access to imaging studies and/or their reports will save millions of dollars annually through the marked reduction of ordering duplicative studies. Access to an enhanced Portal clinical database would save additional millions annually due to reduction in duplicative evaluation and management services.

Recommendations (cont.)

- Another Portal functionality that could result in the savings of additional millions of dollars will involve identifying chronic pain patients who have high ED utilization and coordinating their care to reduce ED visits, redundant imaging, and overuse of prescription drugs. Most importantly, this will result in greatly improved mental and physical health for these patients as the parenteral use and prescribing of controlled substances will decrease for this patient population.

Recommendations (cont.)

- Another related recommendation is for NC DHHS to consider identifying the top 1% of those with the highest utilization of Medicaid resources, and assign caseworkers to respond to all unscheduled healthcare visits in real time to assess the need for that service (EMTALA concerns acknowledged).

Recommendations (cont.)

- Alternative networks of health care need to be further developed for patients for whom an EMC does not exist, or needs prompt follow up once an EMC has been stabilized. Increased access to primary care practices, urgent care centers, and FQHC's should be utilized for all patients needing prompt follow up after being seen and stabilized in an ED or for those who have been determined that not EMC exists after having a MSE performed.

Recommendations (cont.)

- Work to establish legislation/regulations that will find reasonable locations outside the ED for all patients with mental health conditions needing further mental health evaluation after they have been medically stabilized/cleared in an ED.
- All stakeholders need to work collaboratively to bring about substantive liability reform for all providers who provide EMTALA mandated care.

Recommendations (cont.)

- States (including NC) should not continue to absorb the unfunded mandate of EMTALA as dictated by the federal government. States as well as their medical societies and professional organizations need to work collaboratively to bring about EMTALA reform.

Access to Care Committee

- Proposed initial action plan (draft)
- Endorsed by NCCEP BOD
- Has not yet been presented to DHHS

Goal

- Identify categories of patients who might present to an ED for treatment who could be more appropriately treated in another health care setting. All patients who do present to an ED will need to have a MSE performed to ensure that an EMC does not exist.

Identification of Appropriate Patient Groups

- Initially, 3 groups of patients selected:
- Dental Complaints: The vast majority of these patients do not have an EMC, and more appropriately need care from a dentist or other oral health professional.
- Chronic Pain Complaints: The vast majority of these patients present with complaints such as “I am out of my pain medicine” or “chronic back (knee, etc.) pain”. These patients are most appropriately managed by a pain clinic or pain caseworker.

Identification of Appropriate Patient Groups (cont.)

- Behavioral Health Complaints: These patients are often brought to the ED by law enforcement personnel, where they will often be boarded for extended periods of time (sometimes many days), even if they have not harmed themselves and are in no need of EMC. Other behavioral health patients who do have an EMC and are usually quickly medically stabilized are also often boarded for extended periods of time while awaiting transfer to an appropriate behavioral health facility.

Procedures for bypassing the ED, eliminating the need for a MSE

- Dental Complaints: Communities and hospitals need to further establish oral care clinics that can see patients with dental complaints at least 6 days a week. The availability of these dental clinics needs to be widely publicized in the community, media, and in health care settings. Same day or next day appointments need to be advertised. This should allow many patients to self-select their dental needs to the clinic rather than the ED.
- Chronic Pain Complaints: Health plans need to set up hot lines and caseworkers to field calls from these patients, and advise them of alternatives to meet their needs other than the ED.

Procedures for bypassing the ED, eliminating the need for a MSE

- Behavioral Health Complaints: Law enforcement policies need to be further implemented such that patients who have behavioral health issues that do not need to be evaluated for a EMC are not brought to the ED by law enforcement officers, but are transported to the designated LMA or other BH facility as appropriate in that community. Specifically, patients that are suicidal or homicidal but do not have an EMC need to be transported directly to a local BH facility and not brought to an ED.

Procedures to expedite care in the ED

- NC DHHS should consider pursuing a limited EMTALA waiver from the federal government for a well defined group of patients such as these. Ensuring access to prompt care would be a necessity to obtaining such a waiver on a trial basis.
- In the event that a limited EMTALA waiver was not granted, written protocols could be developed by hospitals and key health plans (like Medicaid) that would provide hospital ED personnel with the knowledge necessary to decide which patients may have an EMC (and need to be evaluated by a provider), as well as those that do not have an EMC and can be referred to another place of care for prompt care.

• Procedures to expedite care in the ED (cont.)

- Dental Complaints: Those not having an EMC would be referred to the local dental clinic for same day or next day treatment.
- Chronic Pain Complaints: Those not having an EMC would be triaged by the chronic pain hot line or caseworker for prompt treatment.

Procedures to expedite care in the ED (cont.)

- Behavioral Health Complaints: Those not having an EMC would be transported by law enforcement to the appropriate LMA (or other appropriate acute BH evaluation site). Those with an EMC will have had appropriate LMA arrangements made simultaneous with the MSE and will be transported to the LMA as soon as the MSE is complete. Hospitals with delayed access to having onsite evaluations done by BH professionals should develop telemedicine resources to ensure that unnecessary (and expensive) boarding of BH patients in EDs does not continue.

Utilization of the Medicaid Portal and other Resources

- NC hospitals, ED's, and ED providers all need to gain access to the Portal as soon as possible this year.
- Portal functionality should be expanded as quickly as possible to facilitate the appropriate review of all recent visits, imaging performed, and medication lists and prescribing history.
- Medicaid and other health plan caseworkers should be available 24/7/365 to ED providers to help coordinate the care of the patients who have the highest health care utilization.

NCCEP EMTALA Reform initiative

- Task force was created at the BOD meeting on 4/20/2011 to evaluate introducing an ACEP Council Resolution seeking EMTALA reform
- Other stakeholder groups (NCMS, EMRA, other states) will be approached to seek broad consensus and sponsorship

Final thoughts

- ACO's, bundled payments, and other evolving models will force healthcare facilities to develop lower cost clinics
- Will see more and more extended hour urgent care and community based clinics on hospital campuses in close proximity to ED's
- Hospital based providers (operating under the hospital's tax ID and Medicare numbers) will allow EMTALA mandated MSE's to be provided outside the ED (acknowledging that this is very **logistically** and medical-legally challenging)
- This draft is a starting point, and initiatives like this need to provide a catalyst for the most appropriate cost effective high quality care for our patients

Questions and Discussion



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