Strategies to Improve Care for Patients With Complex Needs

Robert Mechanic
Institute for Accountable Care

NAACOS Fall Conference
September 30, 2021

Institute for Accountable Care

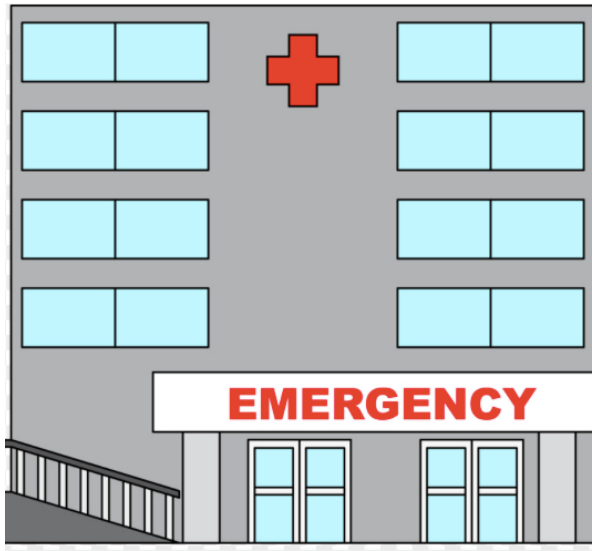
The NEW ENGLAND JOURNAL of MEDICINE

PERSPECTIVE | JAN 10, 2013

Post-Hospital Syndrome — An Acquired, Transient Condition of Generalized Risk

H.M. Krumholz | N Engl J Med 2013; 368:100-102

TO PROMOTE SUCCESSFUL RECOVERY AFTER A HOSPITALIZATION, health care professionals often focus on issues related to the acute illness that precipitated the hospitalization. Their disproportionate attention to the hospitalization's cause, however, may be misdirected. Patients who were recently hospitalized are not only recovering from their acute illness; they also experience a period of generalized risk for a range of adverse health events. Thus, their condition may be better characterized as a post-hospital syndrome, an acquired, transient period of vulnerability.


EMERGENCY


EMERGENCY


DISPENSARY


AMBULANCE

Today’s Panel

Matt Zavadasky, Medstar Mobile Health

Kevin Biese, MD, UNC Health System

Francis Balucan, MD, Vanderbilt Medical Center

ACO's & EMS

Transforming the Value Equation

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About MedStar…

- Governmental agency (PUM) serving Ft. Worth and 14 Suburban Cities
  - Metropolitan Area EMS Authority
  - 1,016,963 residents, 434 Sq. miles
  - Exclusive provider - emergency and non-emergency
- 168,000 responses annually
- 515 employees
- $52.5 million budget (FY 2021-22)
  - **No tax subsidy**
- Fully deployed Dynamic Resource Management
- Medical Control from 18-member Emergency Physician's Advisory Board (EPAB)
  - Physician Medical Directors from all emergency departments in service area + 7 Tarrant County Medical Society reps

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EMS Economics 1.0

- You call
- We haul
- That's all

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EMS Economics 1.0

- **Misaligned Incentives**
  - Only paid to transport
  - "EMS" is a ***transportation*** benefit
  - NOT a *medical benefit*
- **Downstream healthcare costs**
  - ED; admission?

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YEAR	% OF ED PATIENTS ARRIVING BY EMS	OVERALL ED ADMISSION RATE (%)	% OF EMS ARRIVALS WHO ARE ADMITTED	% OF WALK-IN PATIENTS ADMITTED
2013	17	16.5	39	12.5
2012	16	16.5	39	12.2
2011	17	17.6	42	12.6
2010	16	18.0	43	13.2
2009	16	17.3	43	12.4
2008	17	16.6	43	11.2
2007–2004	15	16.3	38	12.5

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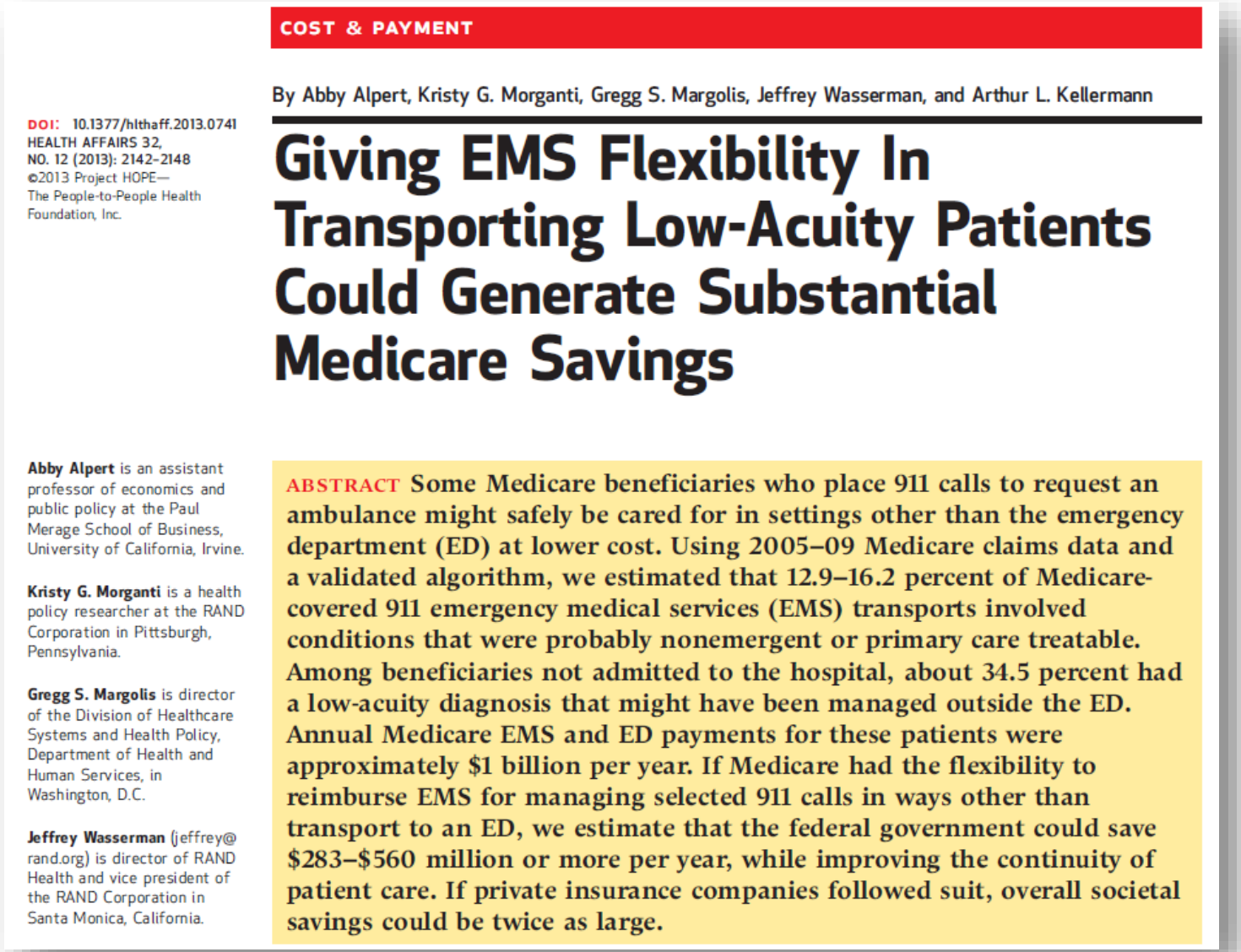
http://www.acepnow.com/article/emergency-medical-services-arrivals-admission-rates-emergency-department-analyzed/



COST & PAYMENT

By Abby Alpert, Kristy G. Morganti, Gregg S. Margolis, Jeffrey Wasserman, and Arthur L. Kellermann

DOI: 10.1377/hlthaff.2013.0741
HEALTH AFFAIRS 32,
NO. 12 (2013): 2142–2148

Giving EMS Flexibility In Transporting Low-Acuity Patients Could Generate Substantial Medicare Savings

Abby Alpert is an assistant professor of economics and public policy at the Paul Merage School of Business, University of California, Irvine.

Kristy G. Morganti is a health policy researcher at the RAND Corporation in Pittsburgh, Pennsylvania.

Gregg S. Margolis is director of the Division of Healthcare Systems and Health Policy, Department of Health and Human Services, in Washington, D.C.

Jeffrey Wasserman (jeffrey@rand.org) is director of RAND Health and vice president of the RAND Corporation in Santa Monica, California.

ABSTRACT Some Medicare beneficiaries who place 911 calls to request an ambulance might safely be cared for in settings other than the emergency department (ED) at lower cost. Using 2005–09 Medicare claims data and a validated algorithm, we estimated that 12.9–16.2 percent of Medicare-covered 911 emergency medical services (EMS) transports involved conditions that were probably nonemergent or primary care treatable. Among beneficiaries not admitted to the hospital, about 34.5 percent had a low-acuity diagnosis that might have been managed outside the ED. Annual Medicare EMS and ED payments for these patients were approximately $1 billion per year. If Medicare had the flexibility to reimburse EMS for managing selected 911 calls in ways other than transport to an ED, we estimate that the federal government could save $283–$560 million or more per year, while improving the continuity of patient care. If private insurance companies followed suit, overall societal savings could be twice as large.

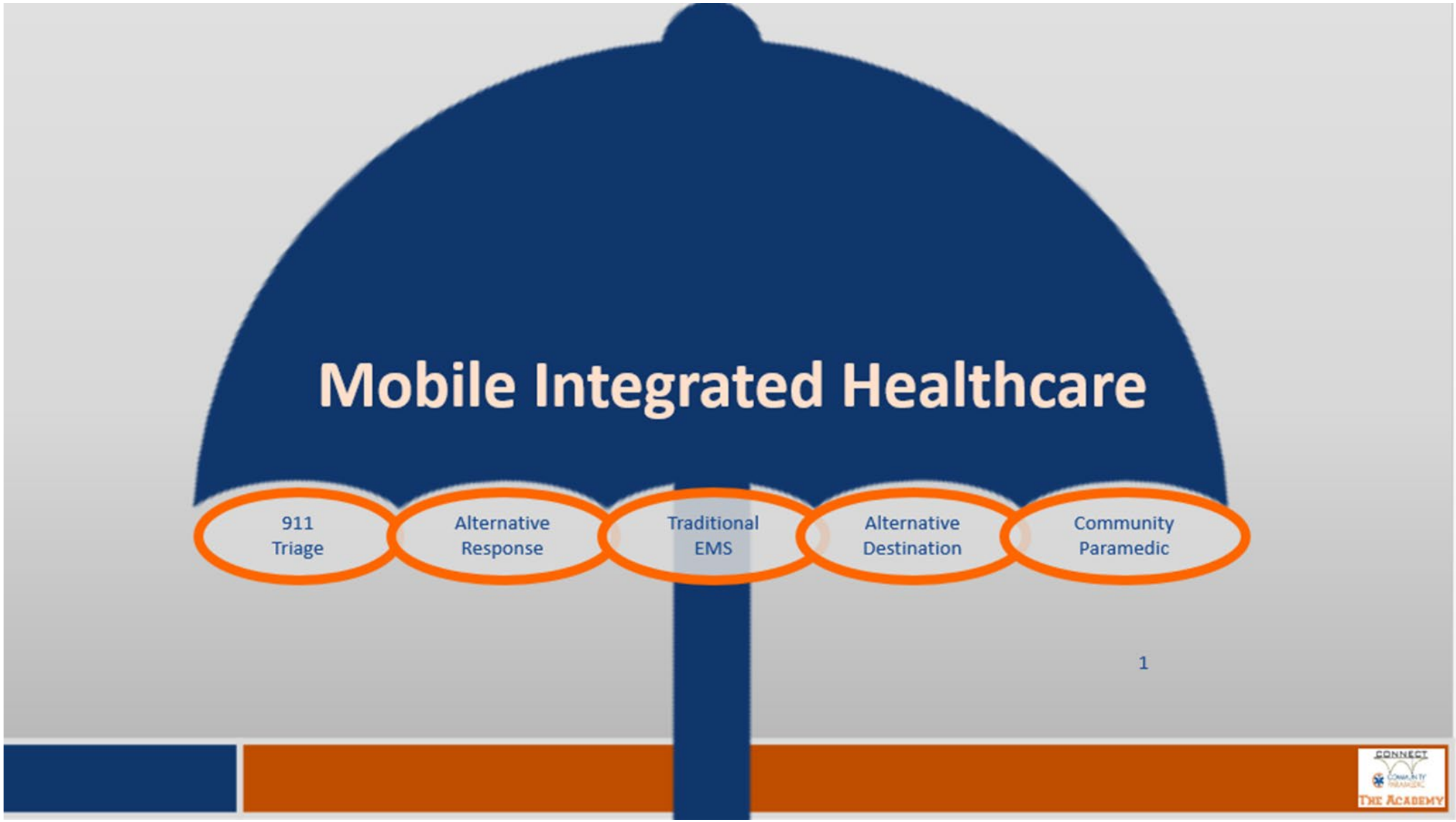
"EMS providers regularly encounter patients whose complaints might be better managed in settings outside the ED."

"Bringing patients unnecessarily to the ED places needless demands on an already overburdened system."

Conclusion

"Giving CMS the flexibility to reimburse EMS services for alternative handling of 911 callers could save Medicare $283–$560 million or more per year. If private third-party payers followed suit, the societal savings could be twice as large."

https://pubmed.ncbi.nlm.nih.gov/24301398/



Courtesy of Dan Swayze

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EMS Partnerships to Prevent ED Visits

- **High Utilizers**
  - Proactive EMS/MIH visits
  - ID/Address determinants of health that drive utilization
  - Education/compliance with care plans
  - Connect with PCP/PCMS
- **Admission/Readmission Prevention**
  - Patients at high-risk
  - Proactive EMS visits as above

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Expenditure Savings Analysis (1)

High Utilizer Program - All Referral Sources

Based on Medicare Rates

Analysis Dates: **October 1, 2013 - March 31, 2021**

Number of Patients Enrolled (2, 3): **884**

Ambulance Trip to ED Reduction: **-48.2%**

		Utilization Change	
Category	**Base**	**Avoided**	**Savings**
Ambulance Payment (4)	$419	6,034	($2,528,246)
ED Visits (5)	$969	3,496	($3,387,624)
Admissions (6)	$10,900	1,569	($17,102,100)
Total Expenditure Savings			**($23,017,970)**

Per Patient Enrolled	**HUG**
Expenditure Savings	**($26,038)**

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Patient Self-Assessment of Health Status (1)									
As of: 8/31/2021									
	High Utilizer Group			Admission/Readmission Avoidance			Obs Admit Avoidance		
	Enrollment	Graduation	Change	Enrollment	Graduation	Change	Enrollment	Graduation	Change
Sample Size	**309**			**764**			**72**		
Mobility (2)	2.29	2.51	9.7%	2.31	2.52	9.1%	2.40	2.56	7.0%
Self-Care (2)	2.55	2.73	6.8%	2.57	2.73	6.0%	2.67	2.78	4.3%
Perform Usual Activities (2)	2.26	2.60	**15.1%**	2.32	2.60	**11.7%**	2.47	2.55	3.1%
Pain and Discomfort (2)	2.01	2.36	**17.6%**	2.40	2.60	8.5%	2.21	2.35	6.4%
Axiety/Depression (2)	2.23	2.54	**13.7%**	2.50	2.73	9.0%	2.49	2.76	**10.8%**
Overall Health Status (3)	5.27	6.97	**32.1%**	5.55	7.10	**27.9%**	5.04	6.99	**38.7%**

Notes:

1. Average scores of pre and post enrollment data from EuroQol EQ-5D-3L Assessment Questionaire

2. Score 1 - 3 with 3 most favorable

3. Score 1 - 10 with 10 most favorable

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journal homepage: www.elsevier.com/locate/ajem

Brief Report

A pilot mobile integrated healthcare program for frequent utilizers of emergency department services

Vicki A. Nejtek, PhD [a,*], Subhash Aryal, PhD [b], Deepika Talari, MBBS, MPH [a], Hao Wang, MD, PhD [c], Liam O'Neill, PhD [b]

[a] University of North Texas Health Science Center, Fort Worth, TX, Texas College of Osteopathic Medicine, United States
[b] University of North Texas Health Science Center, School of Public Health, United States
[c] John Peter Smith Health Network, Emergency Department, Fort Worth, TX, United States

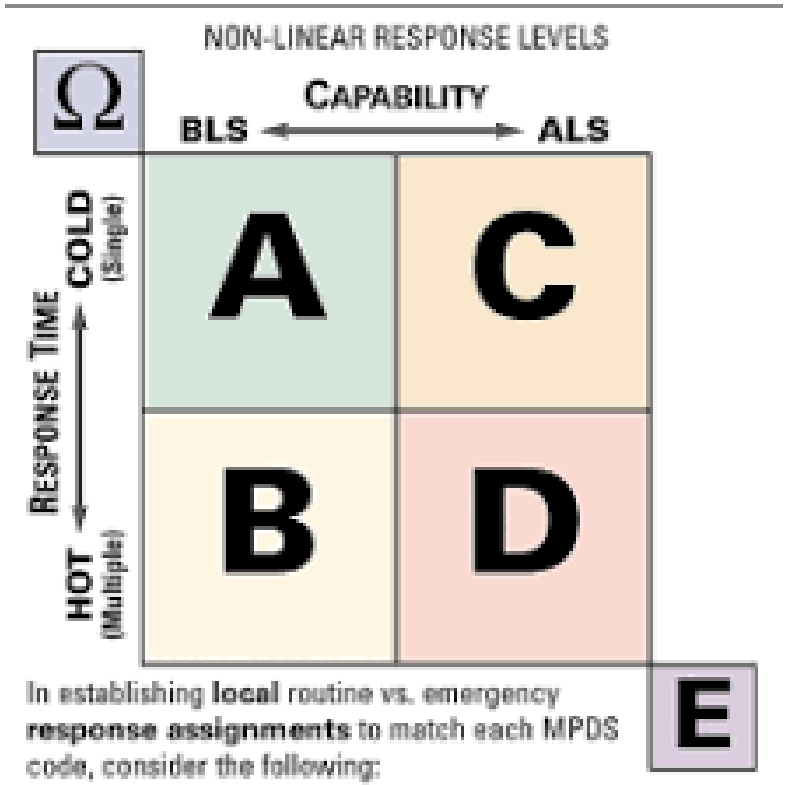
5. Conclusions

The results from this retrospective program evaluation suggest that MIH participation was associated with improved quality of life, fewer ED transports, fewer ED admissions, and reduced inpatient admissions. The MIH program may have potential to improve health outcomes in patients who are frequent ED users for non-emergent or emergent/primary care treatable conditions by teaching them how to proactively manage their health and adhere to therapeutic regimens.

Programmatic reasons for these improvements may also include psychosocial bonding with participants who received in-home care, health coaching, and the MIH team's 24/7 availability that provided them with immediate healthcare access.

EMS Partnerships to Prevent ED Visits

- **9-1-1 Triage**
  - Mitigate the potential response in the call center
    - Engage telehealth
    - Community paramedic response only
- **On-Scene Care Navigation**
  - ID eligible patients (ACO attributed)
  - Provider interface
    - On-scene or via telehealth
  - Treatment in Place
  - Transport to Alternate Destination
    - Urgent care, PCMH, etc.



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EMS Partnerships to Prevent ED Visits

- **Episodic visits request by ACO**
  - On-scene assessment to determine if ED visit is necessary
  - Partner w/telehealth provider
- **Hospital in the Home Partnership**
  - Episodic/scheduled visits in-between provider visits
- **Hospice/Home Health Partnerships**
  - 9-1-1 call?
    - Notification and on-scene care coordination w/follow-up by home health/hospice agency
  - Episodic EMS home visits requested by the home health/hospice agency
- **Observational ED Admission Avoidance**
  - ED 'discharges' the patient to EMS
  - EMS does 24 – 72-hour follow-up visits to assure safety
  - Assure follow-up care

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Utilization Outcome Summary **Through: August '21**

Home Health Partnership - Rollup

	#	%
Enrollments by Home Health Agency	**3556**	**100.0%**
9-1-1 calls by Enrolled Patients	2651	74.6%
9-1-1 Calls by Enrolled Patients with an MHP on-scene	1366	51.5%
ED Transports when MHP on Scene	1017	74.5%
Home Visits Requested by Agency	603	
ED Transports from home visits requested by Agency	40	6.6%

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Transforming the EMS Economic Model

- ***Response*** **fee vs.** ***transport*** **fee**
- **CPT codes for MIH services**
  - Single paramedic response
- **Shared Savings**
  - Total cost of care reduction
  - Case-rate reduction

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ET3 Model

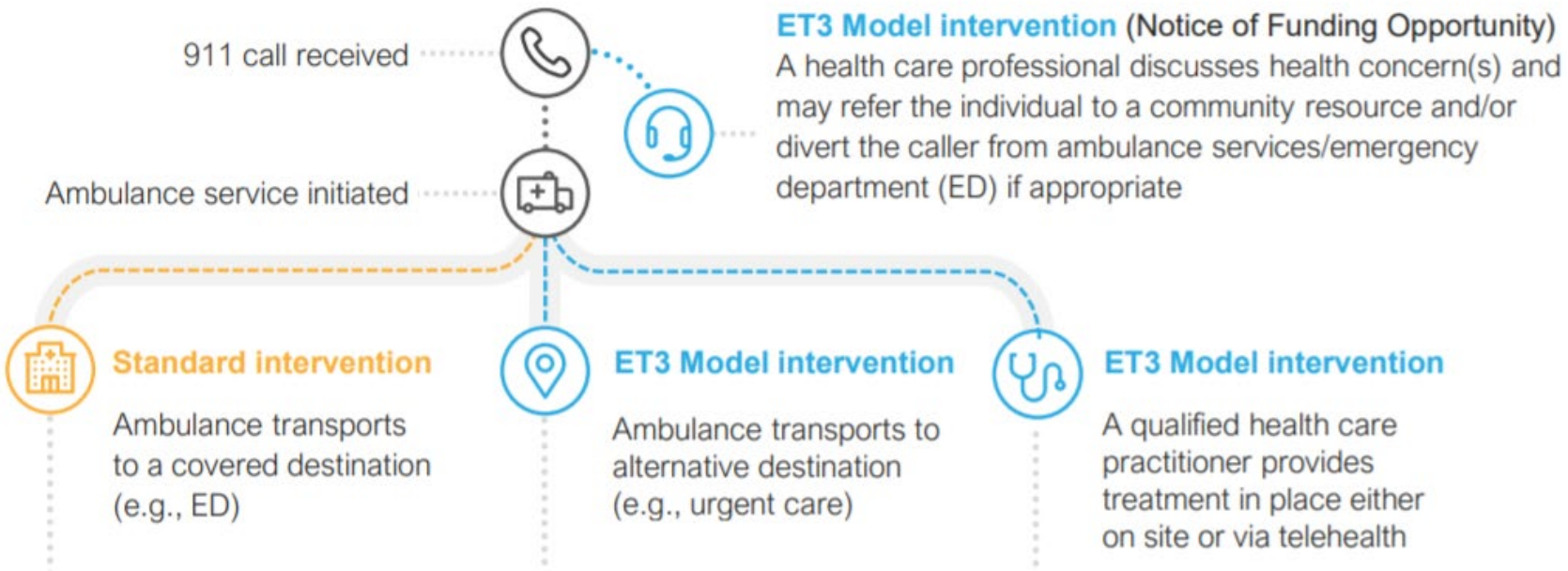
Emergency Triage, Treat, and Transport Model

CMS

The Emergency Triage, Treat, and Transport (ET3) Model is a **voluntary** 5-year CMS payment model that provides **greater flexibility** and new **payments** to ambulance care teams for Medicare beneficiaries.

ET3 Model Goals

• Encourage appropriate utilization of emergency medical services • Increase efficiency in the EMS system •
• Provide person-centered care at the most appropriate care level •



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Enhanced Services	Possible CPT Codes
9-1-1 Nurse Triage Services	**98967:** *Telephone assessment and management service provided by a qualified non-physician healthcare practitioner.*
Mobile Healthcare Paramedic Visit – Routine	**99349**: *Home visit for the evaluation and management of **an established patient**, which requires at least 2 of these 3 key components:* • *A detailed interval history;* • *A detailed examination;* • *Medical decision making of moderate complexity.* *Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.*

Mobile Healthcare Paramedic Visit – Episodic/Emergent	**99341**: *Home visit for the evaluation and management of **a new patient**, which requires these 3 key components:* • *A detailed history;* • *A detailed examination; and* • *Medical decision making of moderate complexity.* *Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.*

Enhanced Services	Possible CPT Codes
Ambulance Transport, Emergency, Alternate Destination	A0429 (modifier) • D: Diagnostic or therapeutic site other than P or H when these are used as origin codes • E: Residential, domiciliary, custodial facility • H: Hospital • N: Skilled nursing facility • P: Physician's office • R: Residence • S: Scene of accident or acute event

Examples:	HCPCS Code
9-1-1 Ambulance, Scene, Transport to Urgent Care	A0429 SD
9-1-1 Ambulance, Scene, Transport to Primary Care Clinic	A0429 SP
9-1-1 Ambulance, Home, Transport to Urgent Care	A0429 RD
9-1-1 Ambulance, Home, Refer to PCP, scheduled App't	A0998 RP

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Opportunities for ACO Partnerships with Geriatric Emergency Departments

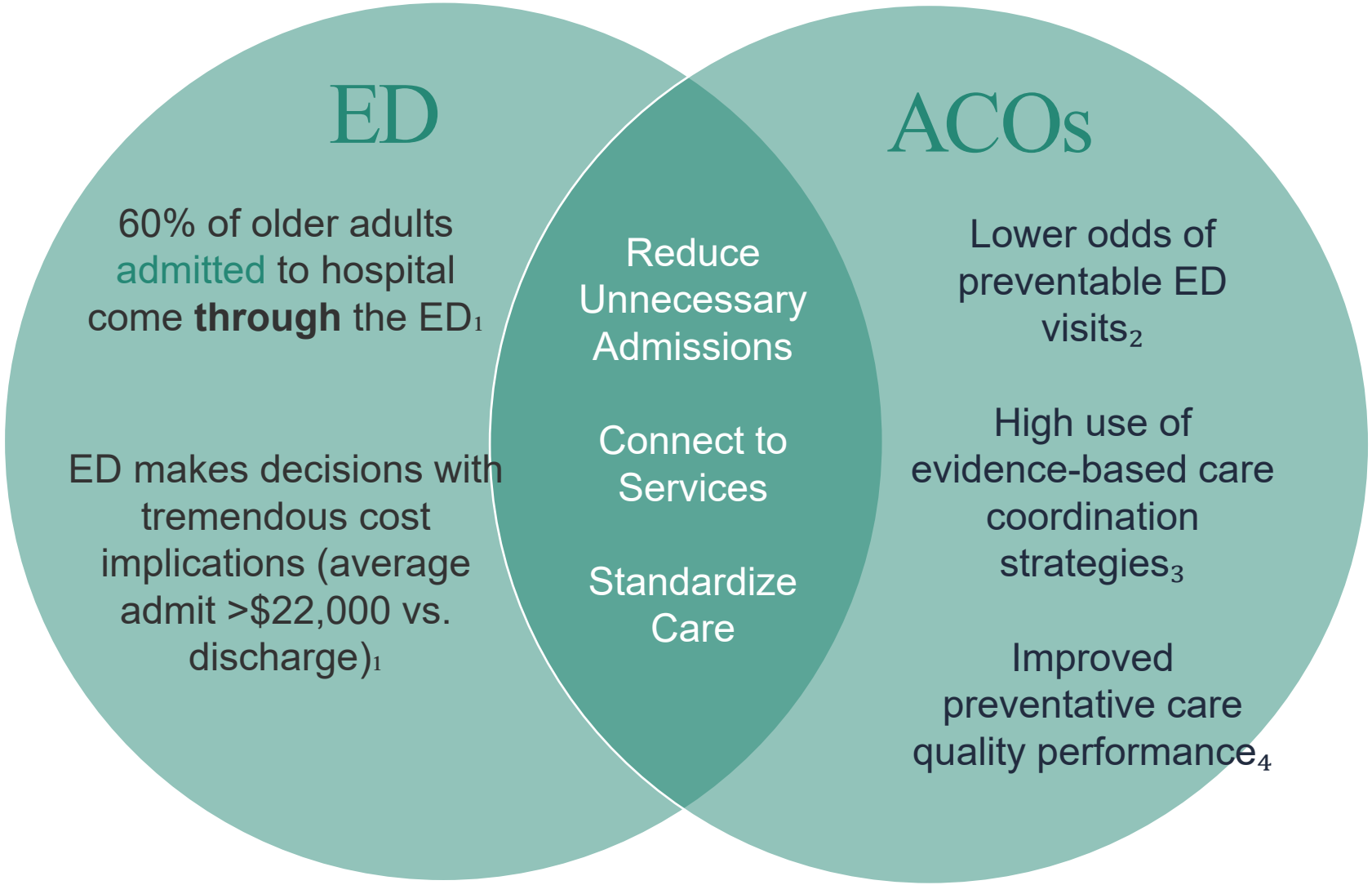
Dr. Kevin Biese
MD, MAT

Principal Investigator, Geriatric Emergency Department Collaborative

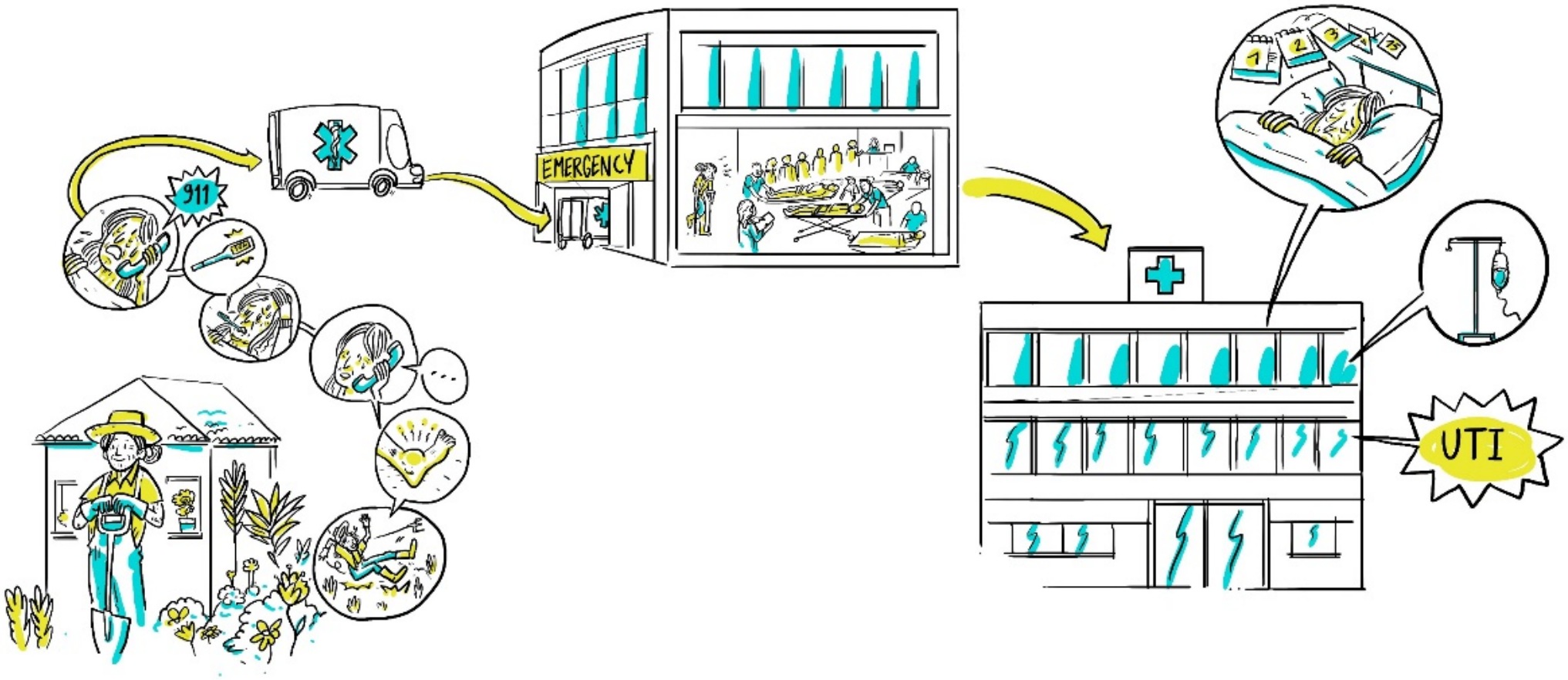
Chair, Geriatric Emergency Department Accreditation

GEDC

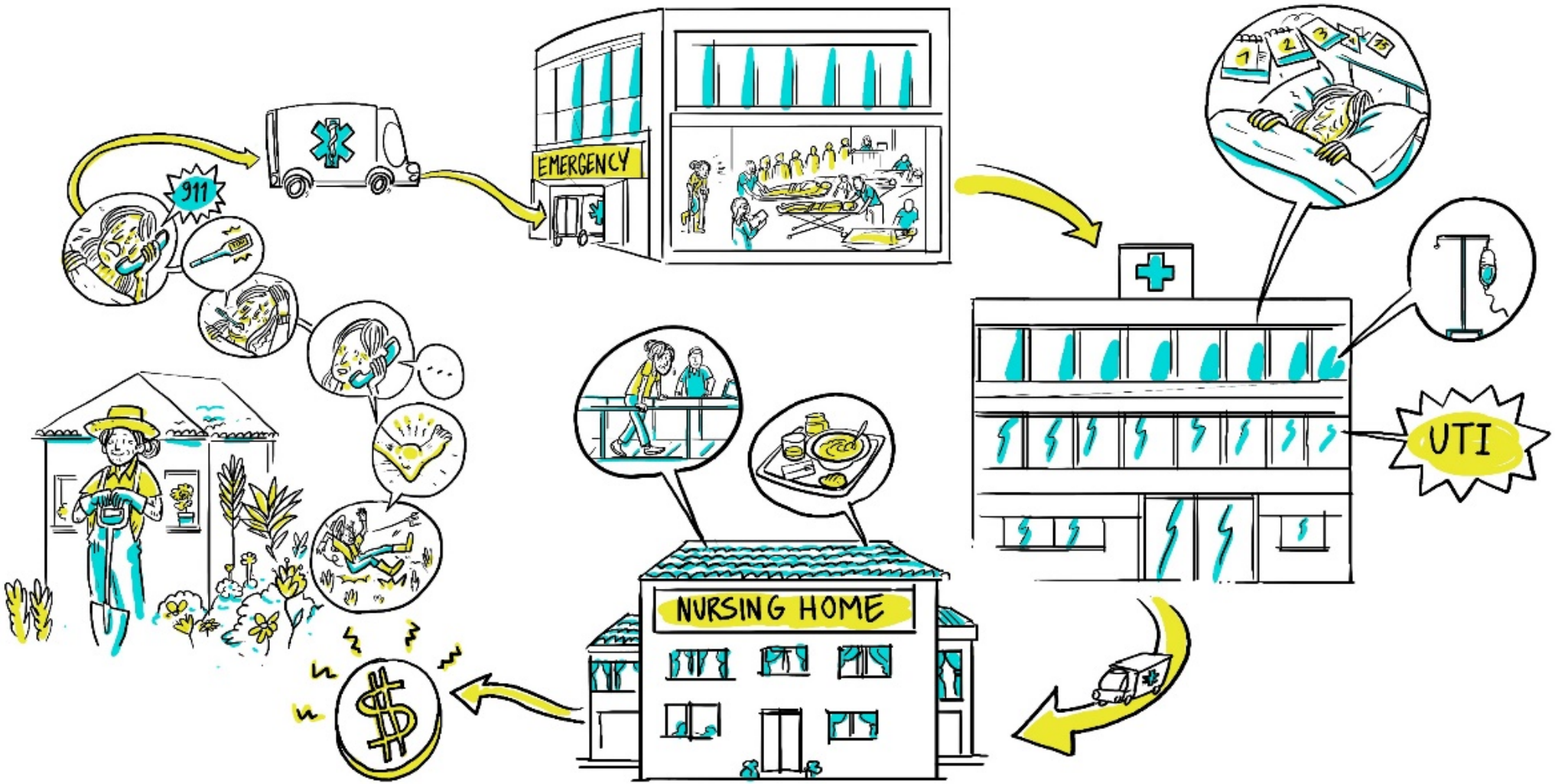
ACOs and GEDs can partner to improve the cost and care trajectory for older adults.



GEDC



GEDC



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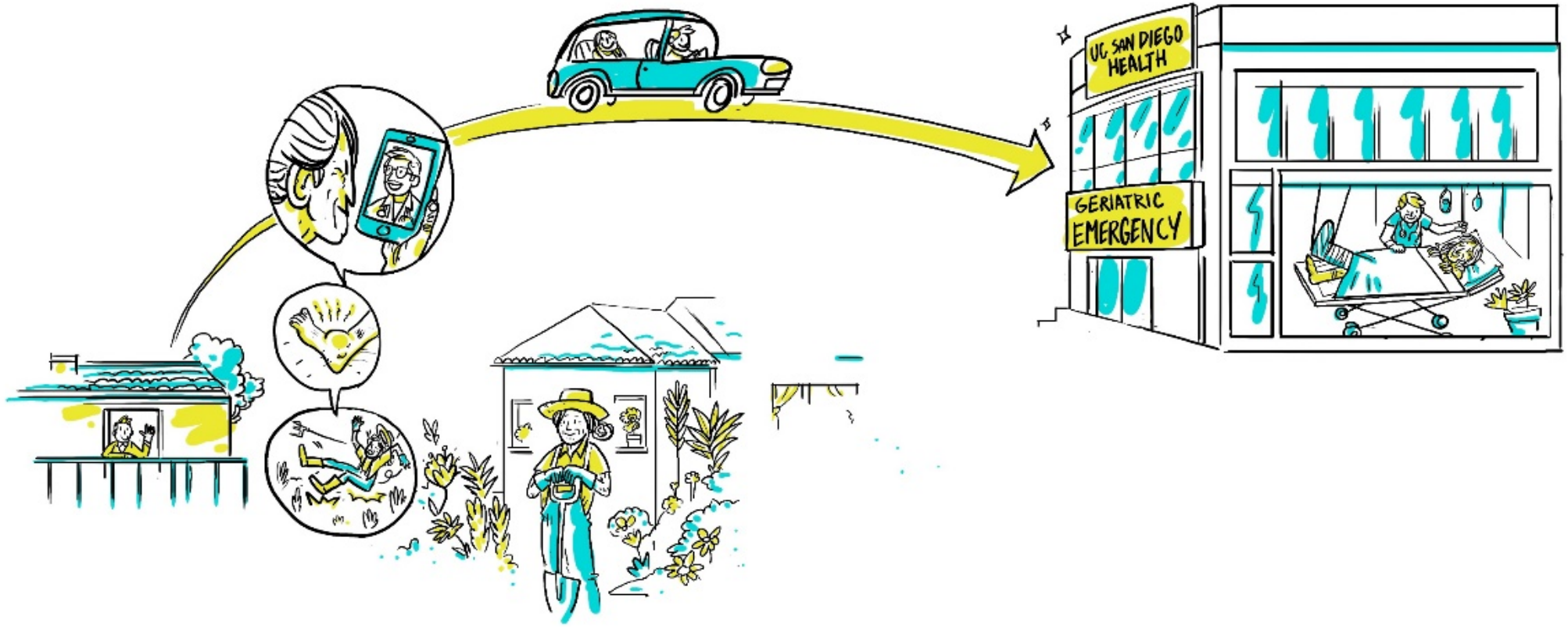
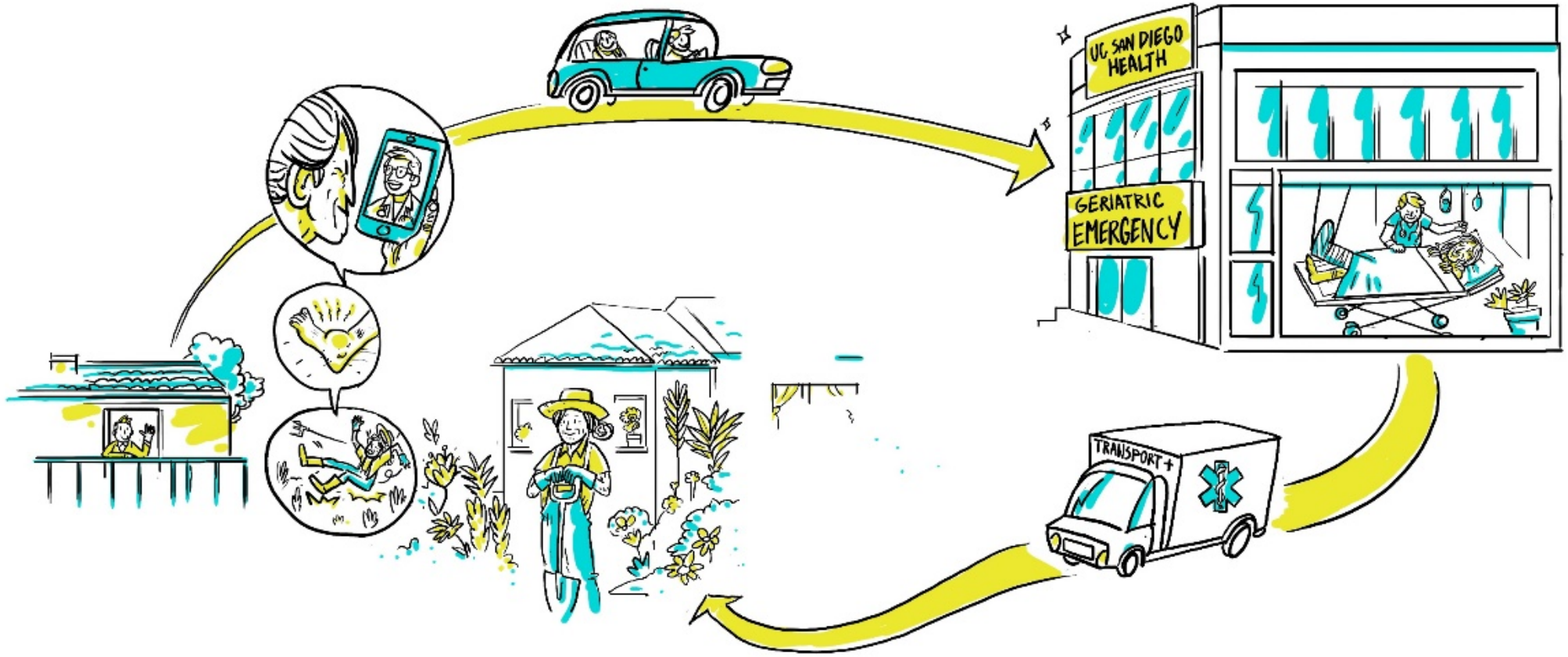


GEDC



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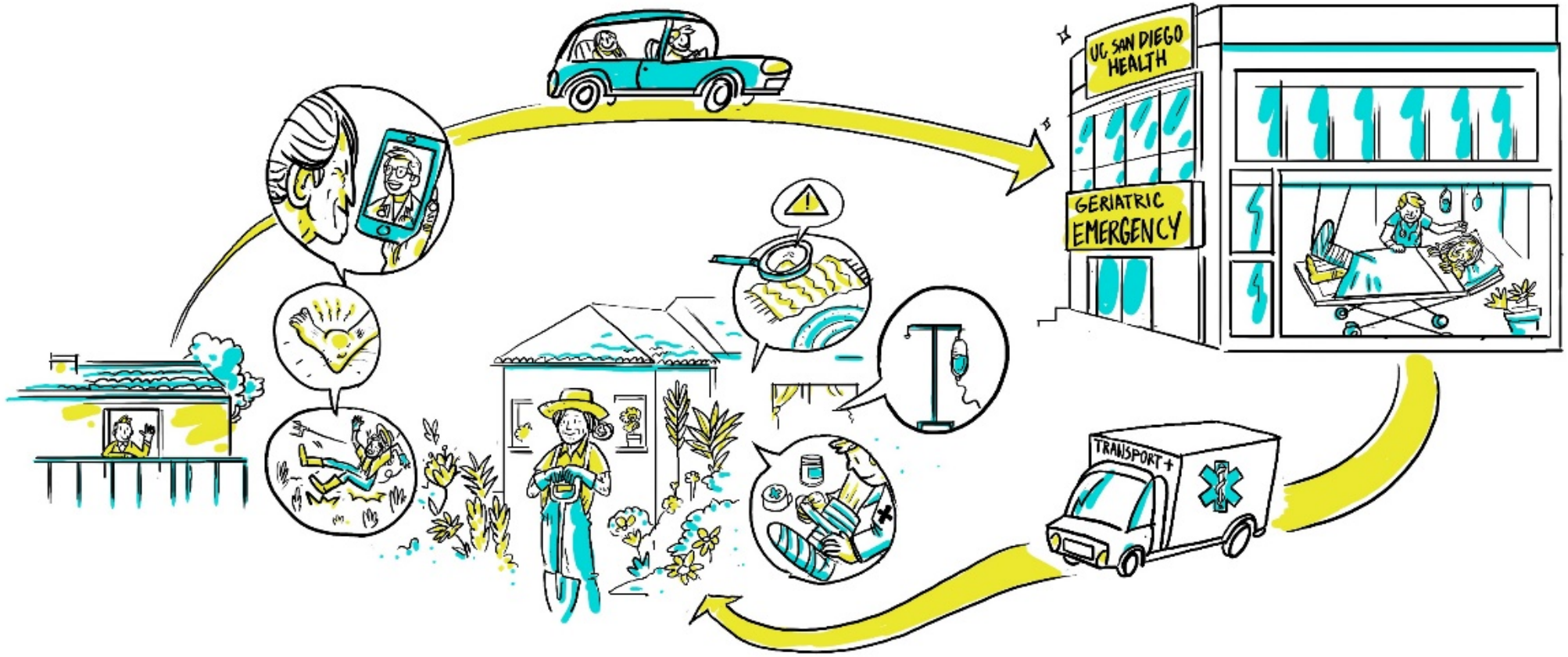
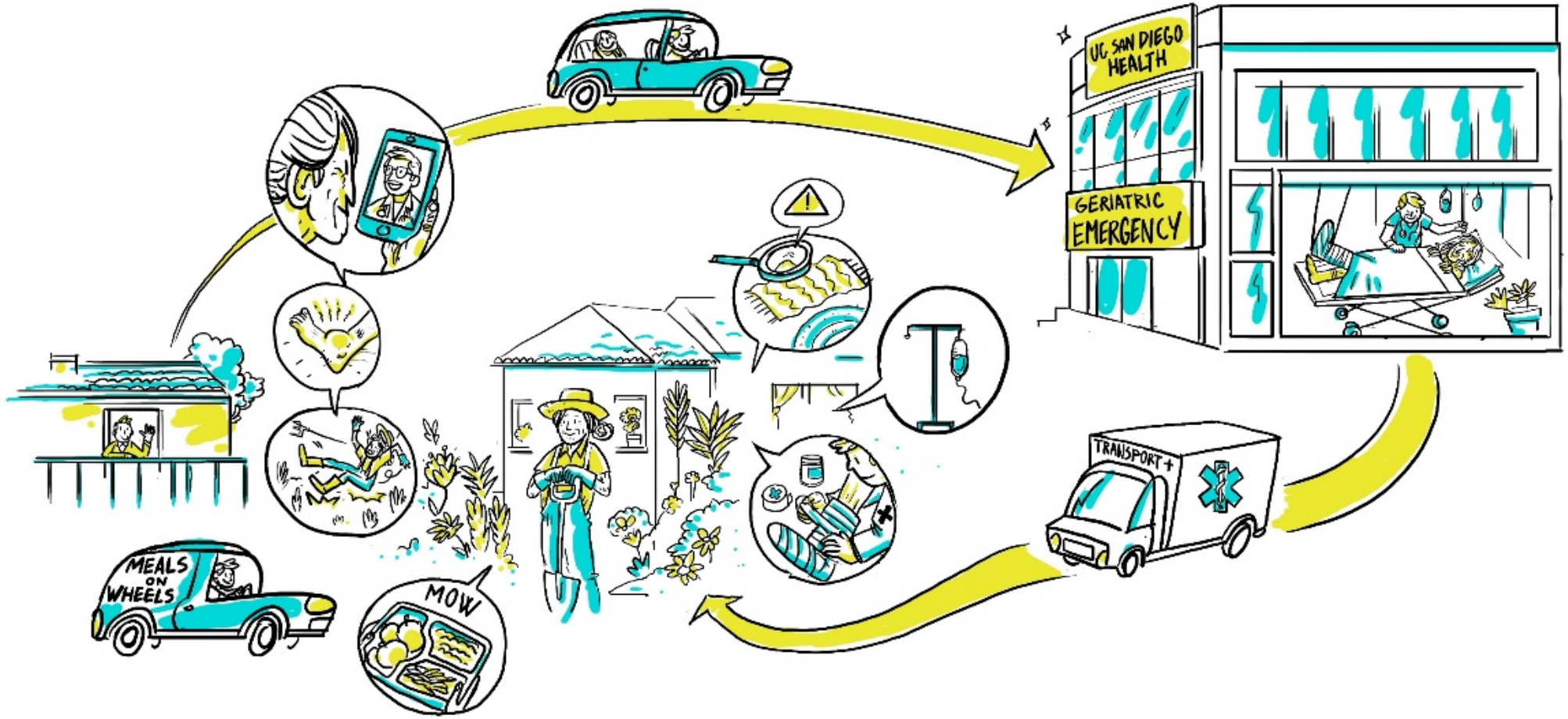
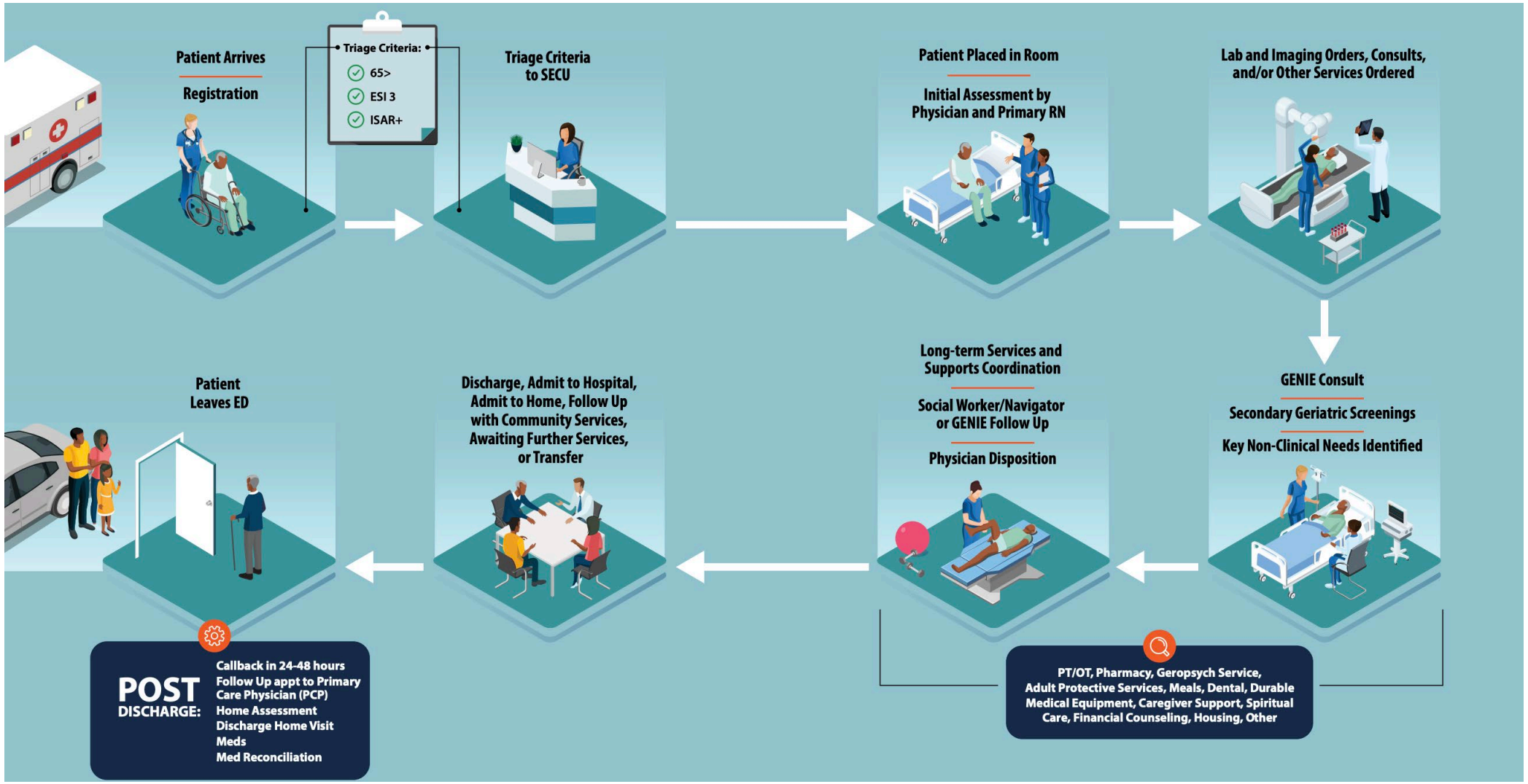


GEDC



GEDC

GEDs provide standardized and integrated care.



GEDC

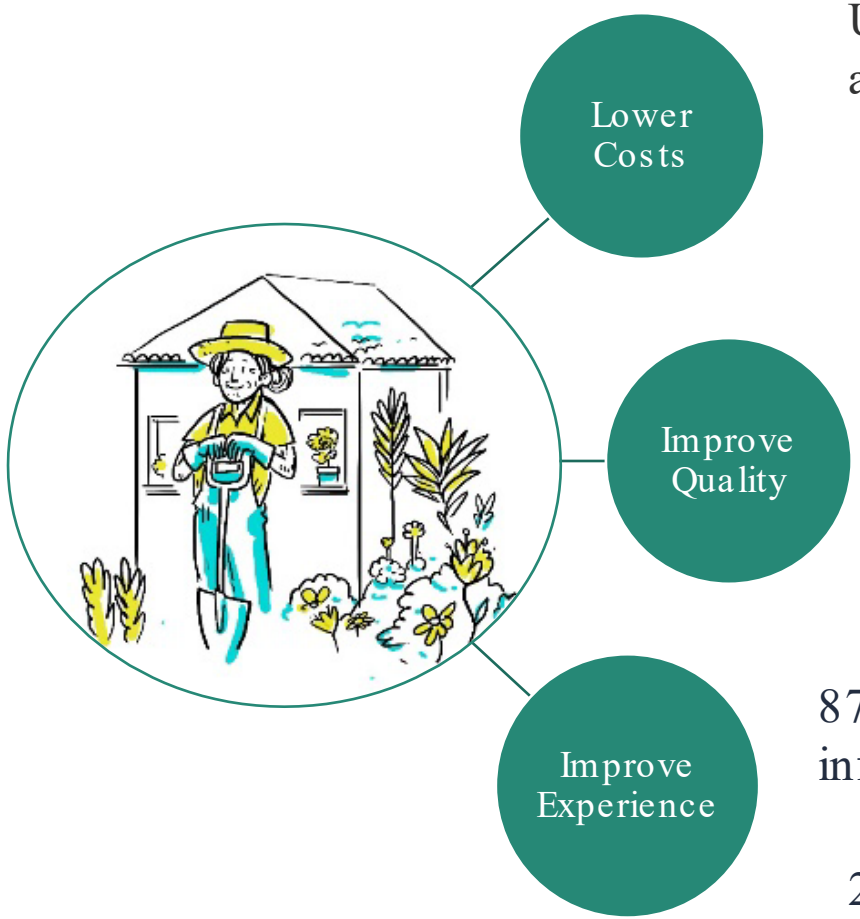
There are three levels of GED accreditation.

Each level has different staffing components.

ACEP Geriatric Emergency Department Accreditation

Staffing	Level 1	Level 2	Level 3
1 MD/DO with evidence of focused education for geriatric EM	✓		✓
1 RN with evidence of focused education for geriatric EM	✓		✓
Physician champion / Medical director	✓	✓	
Nurse case manager/transitional care nurse present > 56 hrs/week	✓	✓	
Interdisciplinary geriatric assessment team includes at least 2 roles		✓	
Interdisciplinary geriatric assessment team includes at least 4 roles	✓		
At least 1 executive / administrative sponsor supervising geriatric ED progra	✓	✓	
Patient advisor/patient council	✓		

GEDs and ACOs share similar goals.



Up to 16.5% reduced risk of hospital admission[5] and 17.3% of readmission[6]

$3,202 savings per Medicare beneficiary after 60 days[7]

Decreased odds of 30 and 60 day fall-related ED revisit with PT services[8]

87.3% satisfaction with the clarity of discharge information and perceived wellbeing[9]

21 studies showcasing improved experience across a variety of interventions[10]

ACO beneficiaries are seeking care at all 250 accredited GEDs.

477

- ACOs had 475,000 GED visits, representing 8.3% of total ED visits in 2019.

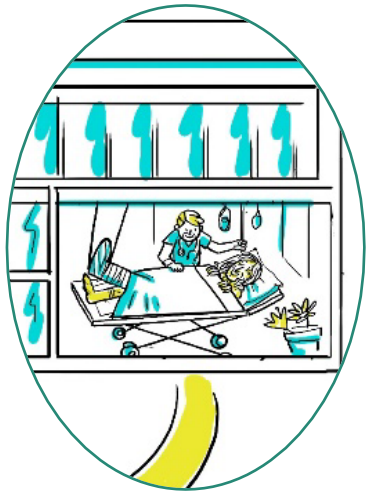
1.6x

- On average, ACO beneficiaries are visiting Emergency Departments at a GED accredited hospital multiple times.

103

- ACOs with at least 1,000 GED visits in 2019, representing 18% of total ED visits

Make the connection between your ACO and local GED.



Identify

Download the "Geriatric ED Accredited List" located at: https://www.acep.org/geda/

Determine

Determine GED lead physician by contacting Nicole Tidwell, GEDA program manager at: ntidwell@acep.org or Amber Hartwell, GEDA program coordinator at: ahartman@acep.org

Ask

What are your current QI projects? What services would you like to add?

Partner

How can we help identify our ACO patients at the beginning of their ED visit? Where can we partner on QI or population health projects?

EHR GED/ ACO Integration

Mechanism to alert GED physicians that they are treating an ACO beneficiary

Opportunities for ACO Partnerships with Geriatric Emergency Departments

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MD, MAT

Principal Investigator, Geriatric Emergency Department Collaborative

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GEDC

Generously supported by

GEDC

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VANDERBILT FAMILIAR FACES

Francis Balucan, MD, MBA

Medical Director, Vanderbilt Familiar Faces

VANDERBILT UNIVERSITY

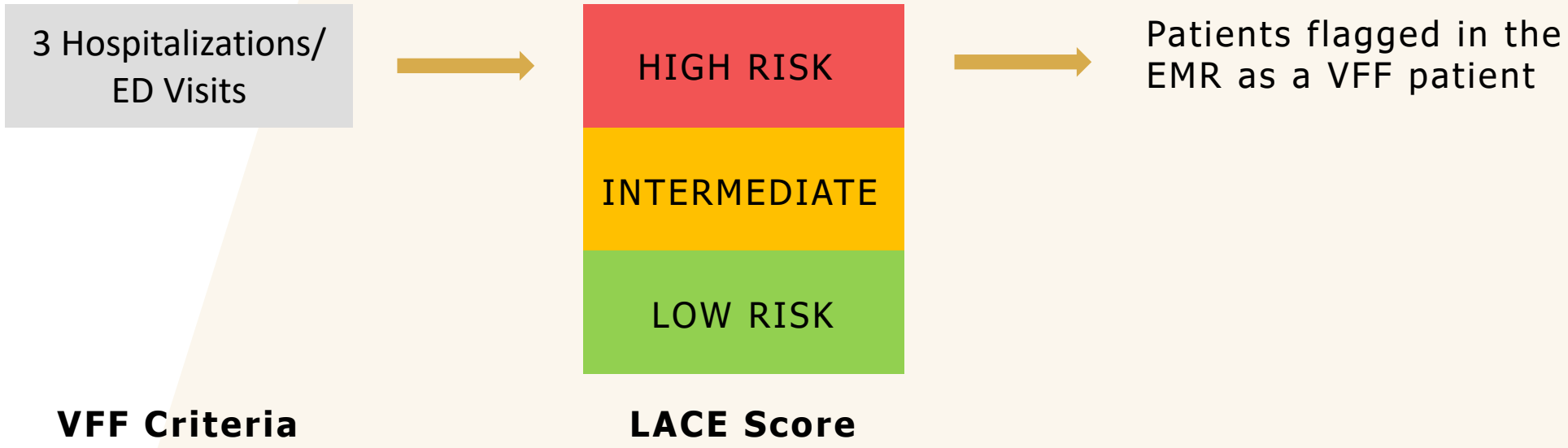
THE HIGH NEED HIGH-COST POPULATION

- Heterogeneous population
- <1% of all patients admitted in Vanderbilt, but accounts for 10% of admissions, and 15% of all charges
- Definitions are not standard:
  - High Cost over a specified time period.
  - Based on medical/social complexity based on diagnosis
- RCTs : Camden Trial; CHAMP Trial (Northwestern)

VANDERBILT UNIVERSITY

INTEGRATED PRACTICE UNIT FOR HIGH-NEED HIGH-COST PATIENTS

- VFF service takes care of high need high-cost population in Vanderbilt Medical Center
- Internally referred by staff, we but also have an algorithm that can screen patients who are admitted in the hospital.



VANDERBILT UNIVERSITY

THE VFF POPULATION

- 10% Uninsured, 40% Medicare, 20% Medicaid, 25% Commercial
- 523 patients, ~100 we are PCP, other patients we are the primary hospital provider.
- Age: ~10%: 20-30 y/o; **~60%: 30-65**, ~30% - 65 above.
- ALOS = 6.0 days vs. 5.2 Days for regular Medicine patients
- Contribution Margin = ~$-2K vs ~5K for medicine vs ~15K for surgical patients.

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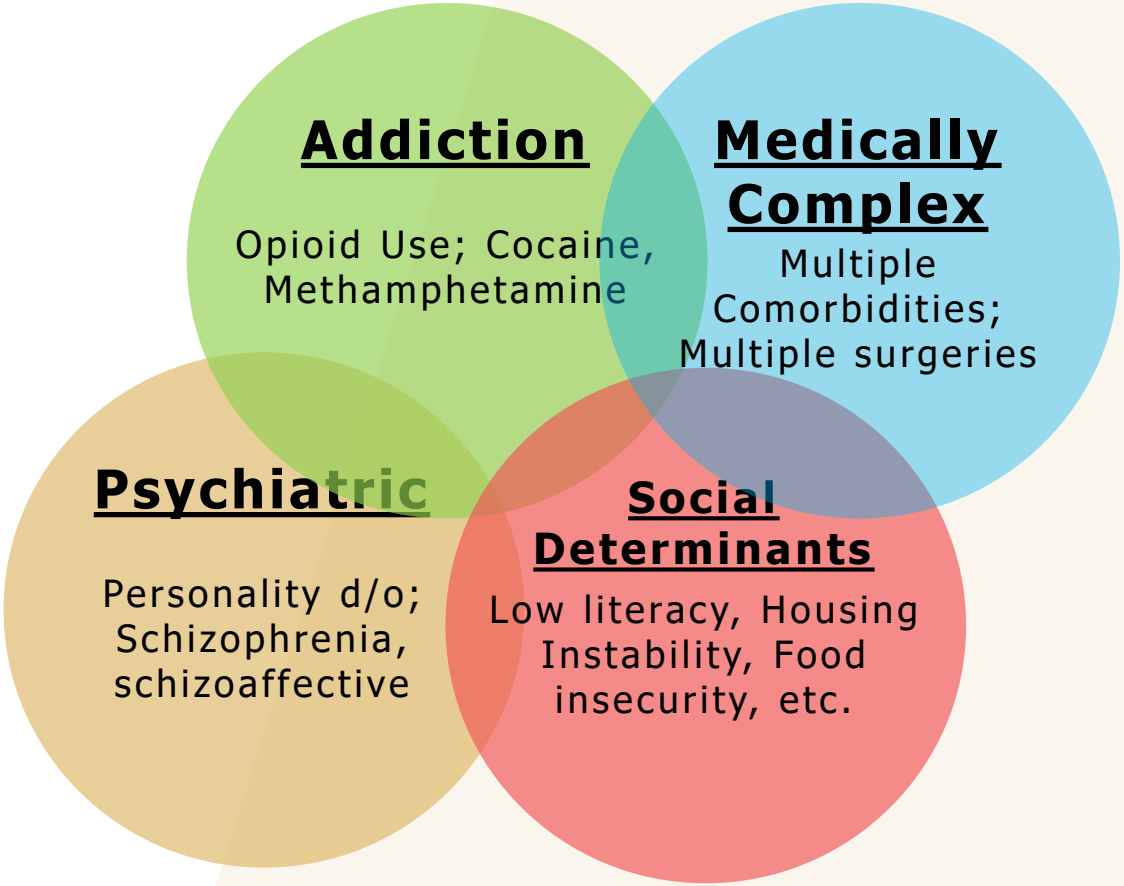
PATIENT PHENOTYPES



Complex interplay that changes over time = multiple visits

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DEFINITIONS OF SUCCESS

- Primary Outcome
  - Decrease readmissions, increase outpatient utilization
- Secondary Outcomes
  - Length of Stay, Early Discharges
- Redefining Success:
  - Focused group discussions for Patient Related Outcome Measures
  - Redefine timeline of success (heavy upfront investment, improvements take time to materialize)

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REDEFINING SUCCESS

Medically Complex

Multiple Comorbidities; Multiple surgeries

Earlier goals of care conversation. Earlier hospice referrals?

Social Determinants

Low literacy, Housing Instability, Food insecurity, etc.

Regular clinic visits
Screening and referral to resources.

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REDEFINING SUCCESS

Addiction

Opioid Use; Cocaine, Methamphetamine

Difficult to change pattern.
Referrals to Medication Assisted Treatment
Referrals to substance abuse treatment

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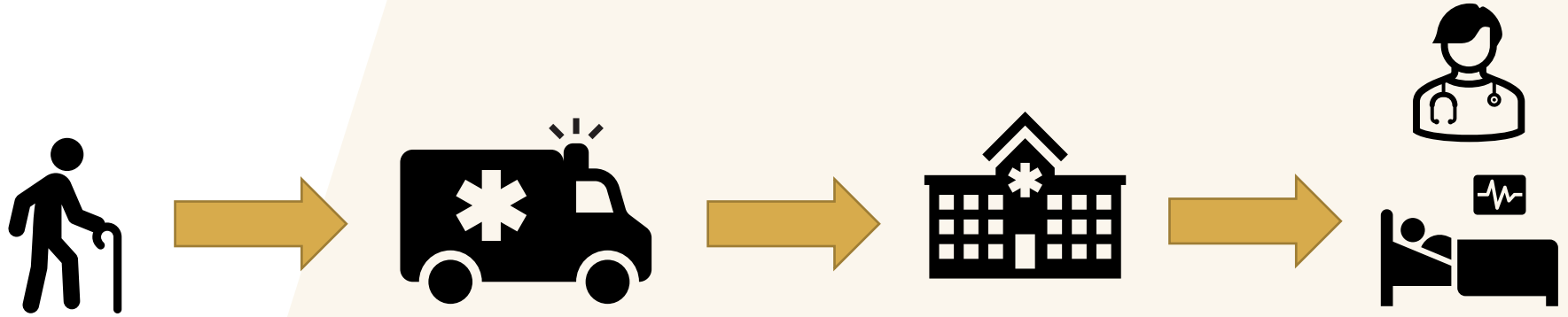
THE STATE BEFORE VFF



Patient feels sick

Calls EMS

Goes to ED

Admitted to different hospitalist teams

No consistency in plans;

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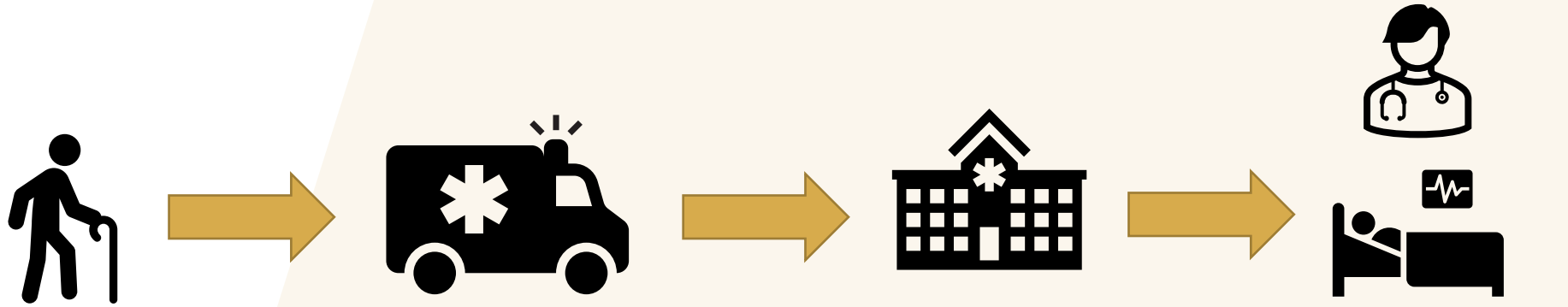
HOW WE FIT IN THE PICTURE



Patient feels sick

Calls EMS

Goes to ED

Admitted to VFF hospitalist team

Flag alerts teams that patient would go to VFF

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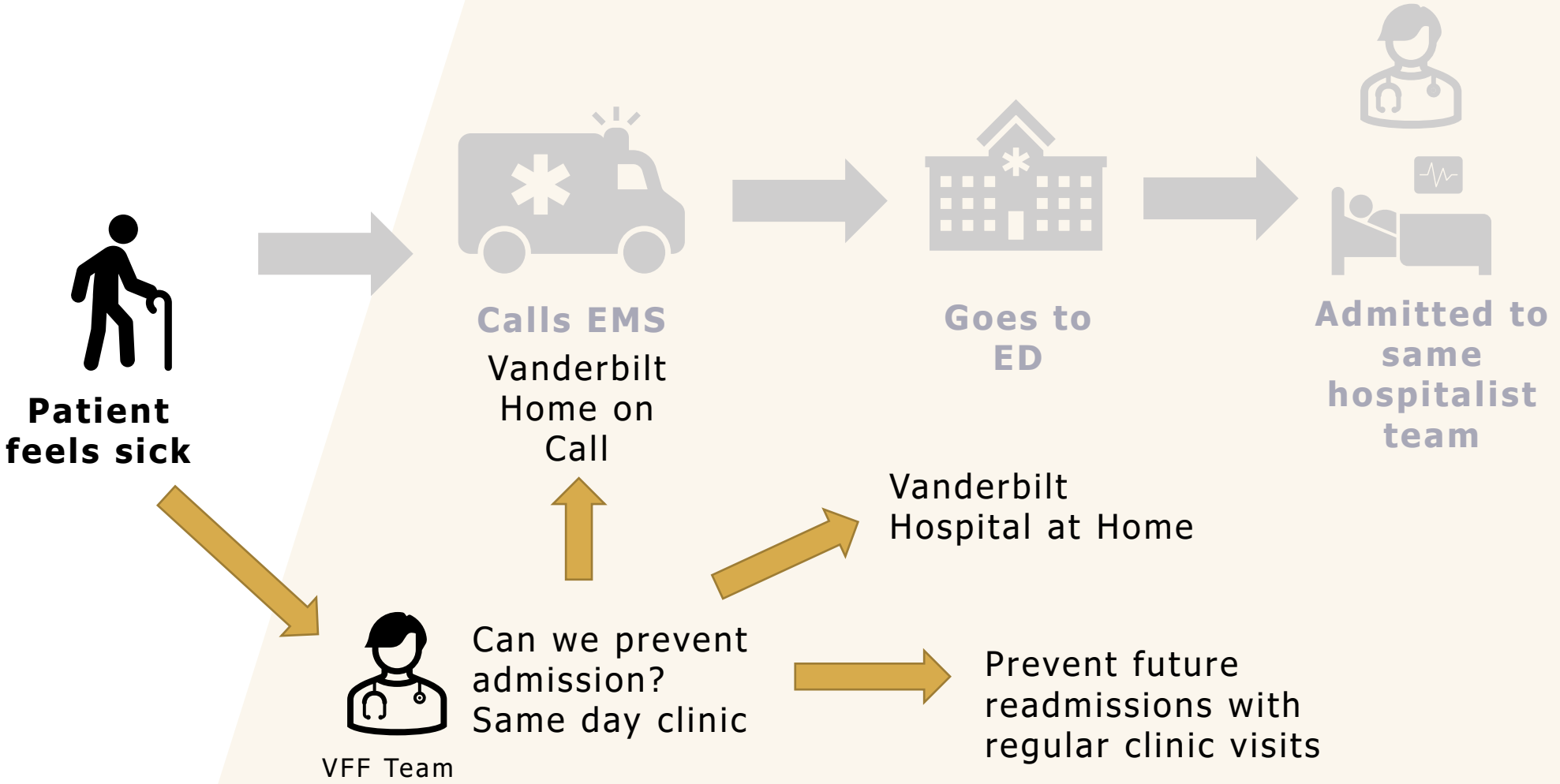
THE MISSION



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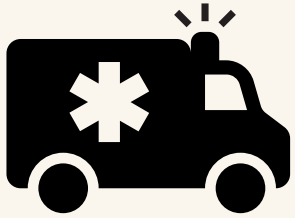
CHANGING PATTERNS TAKES TIME

Patient feels sick



Calls EMS

Vanderbilt Home on Call

Goes to ED

VFF Team

ED triages with VFF team

Admitted to VFF hospitalist team

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THE TEAM

- “Specializing” in medically and socially complex population
- Following patients longitudinally.
- ~5 FTEs spread around 4 Physicians and 2 APPs, seeing patients both inpatient and outpatient
- 1 Case Manager
- 1 Social Worker
- 1 Pharmacist
- 1 Nurse Program Manager, 1 LPN

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THE SERVICE

- **Inpatient Service**
  - Regular hospitalist service, physician + APP carrying ~20 patients.
  - ~12 are VFF patients, the rest are medically complex/socially complex patients.
- **Outpatient Service**
  - Monday-Friday in the afternoons.
  - Same Day Clinics/Post-Hospital Follow-ups/Regular Primary Care Clinic/Telehealth for VFF patients
  - Post-Hospital/ED Visits for General Medicine patients.
  - Provide transportation/bus passes to patients

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VFF OUTPATIENT SERVICES

- Medication Management (Bubble Pack)
- Social Determinants of Health Screening and Management
- Chronic Care Management
- Transportation
- Collaboration with Insurance for Community Health Workers to regularly visit patients.

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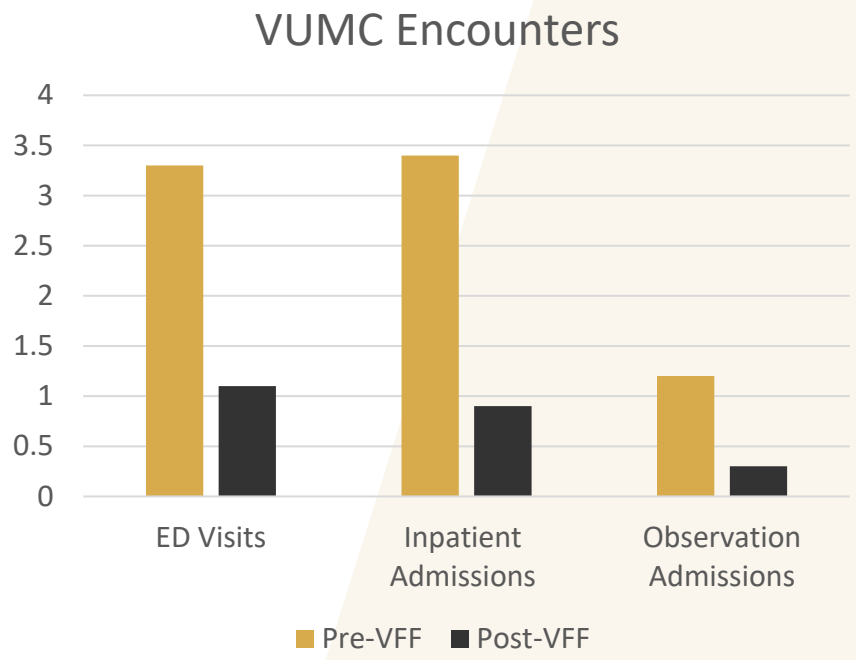
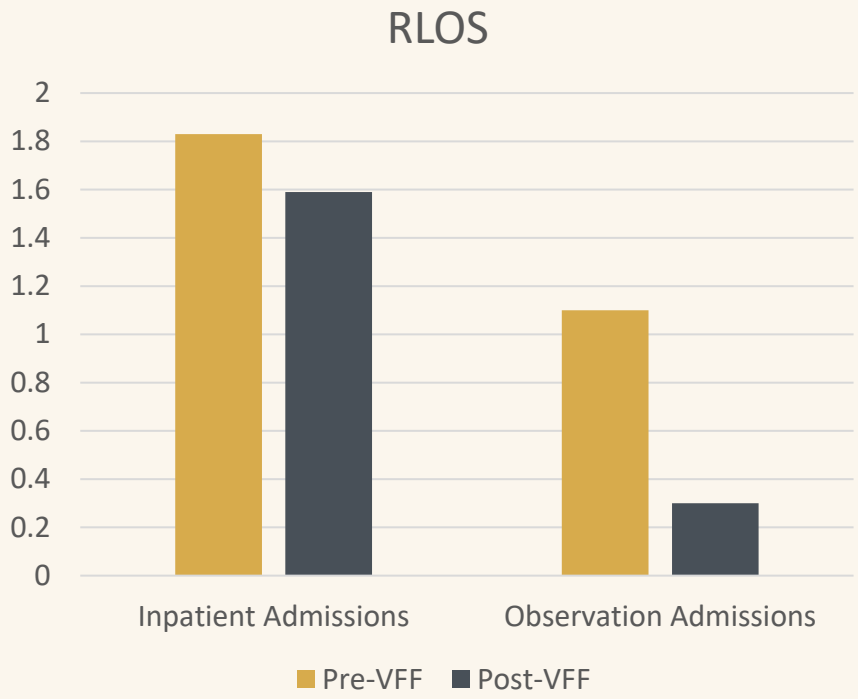
THE RESULTS





*Vanderbilt data only

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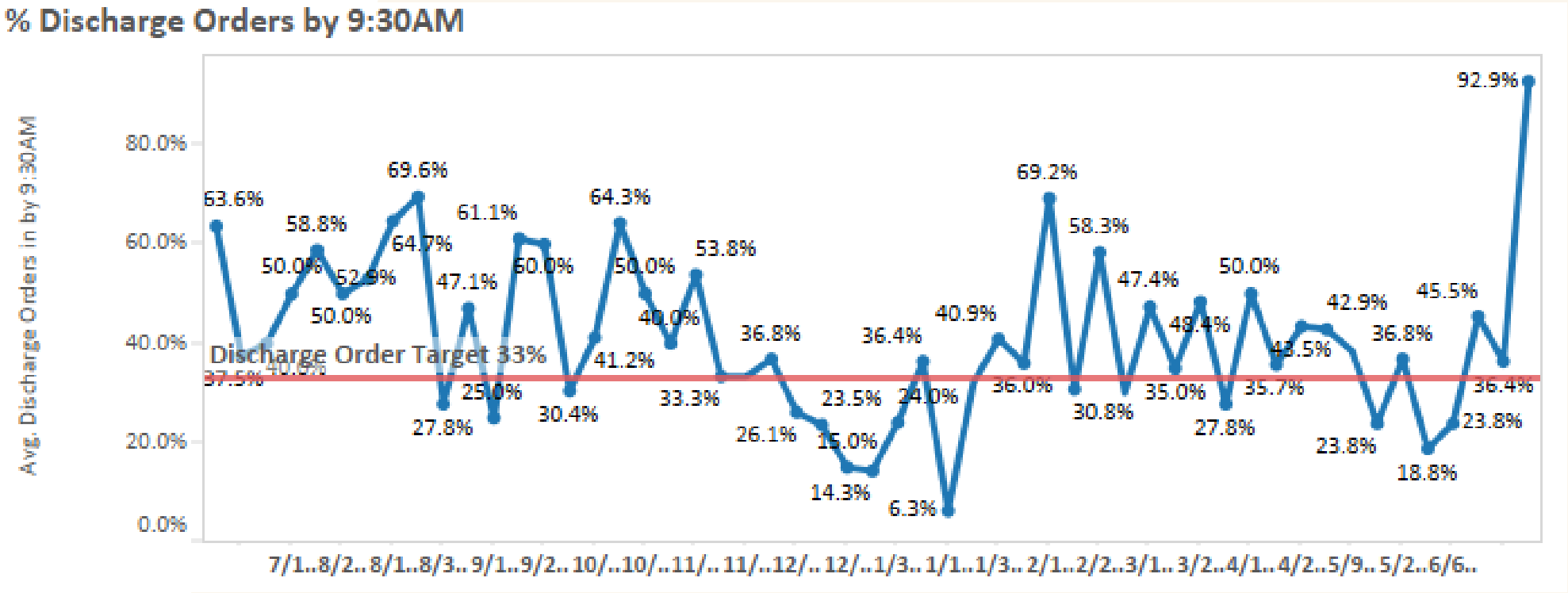
EARLY DISCHARGES



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CURRENT PARTNERSHIPS

- **United Healthcare Tennessee Medicaid**
  - Alternative Payment Model for High Need High Care patients to decrease all-Tennessee hospital utilization, and increase follow-ups with PCP
- **ESRD Collaboration**
  - Nephrology collaboration to similarly decrease all-Tennessee hospital utilization.
  - Telehealth during dialysis sessions.

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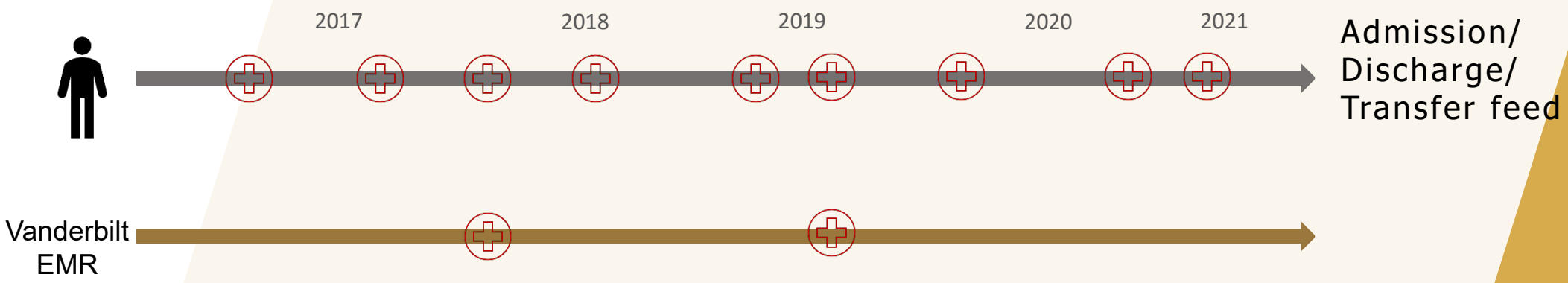
FUTURE GROWTH: ADT FEED INTEGRATION



Incorporate the ADT feed into risk scoring; and integrate into our workflow to see patients real-time when they get admitted to other hospitals.

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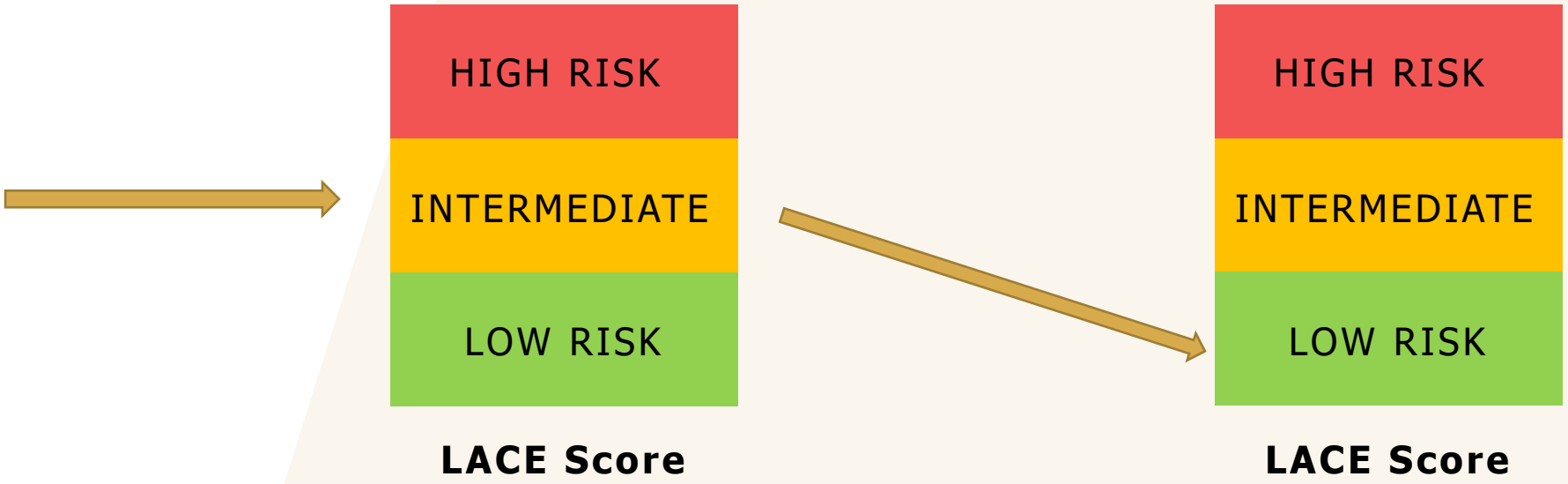
FUTURE GROWTH OF VFF: TARGET EARLY



Target intermediate risk patients before they become high risk.

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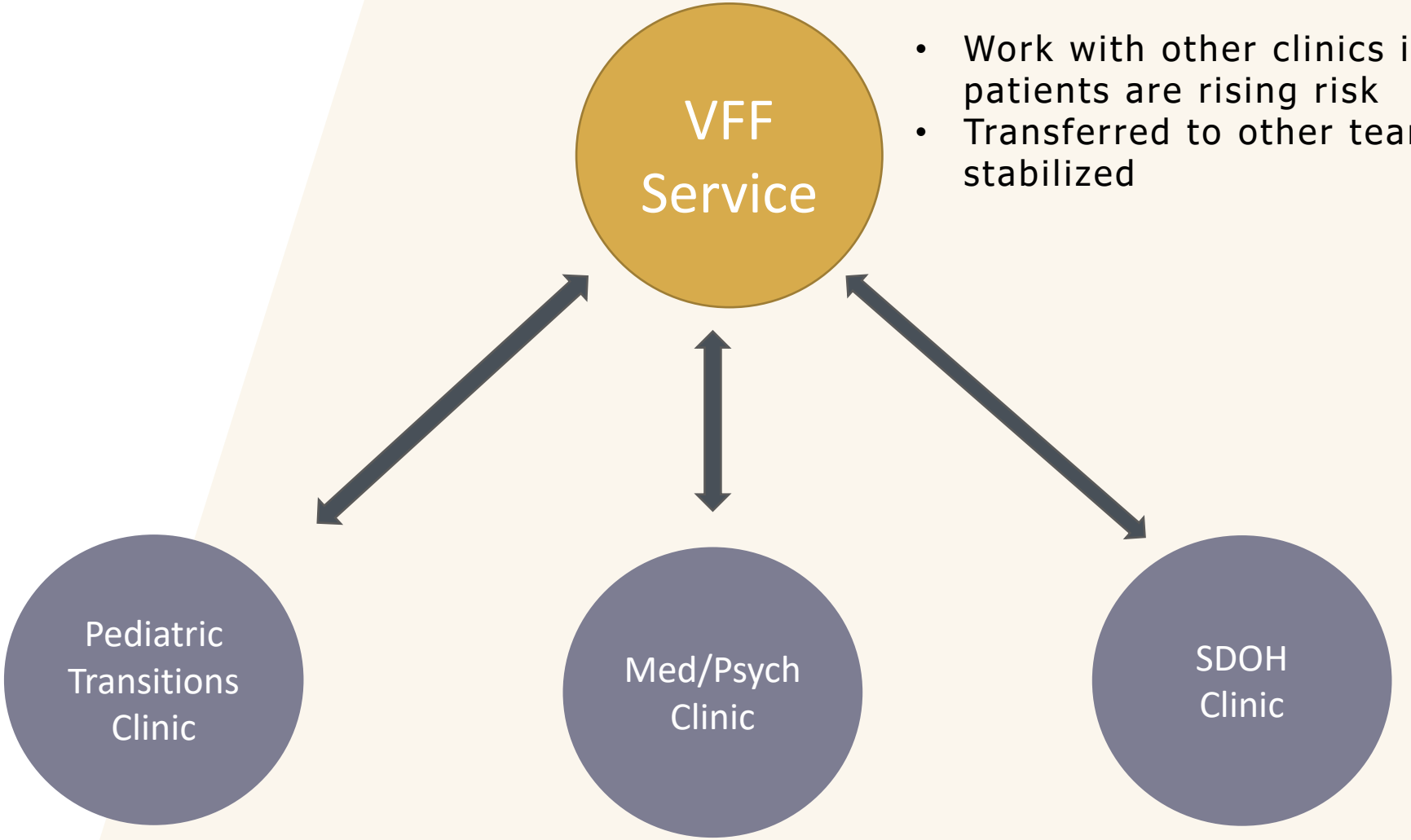
VISION FOR VFF



- Work with other clinics if patients are rising risk
- Transferred to other teams if stabilized

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