White Paper

From Insights to Interventions

Using the unique vantage point of the emergency department to drive transformation.

By Randy Pilgrim, MD, FACEP, FAAFP

SCP HEALTH
TOGETHER, WE HEAL

Author's Notes

Dr. Randy Pilgrim provides executive oversight and direction for SCP Health's clinical operations across all service lines. He is responsible for empowering and creating sustainable systems that provide clinical excellence, minimize risk, and deliver key results for patients.

Dr. Pilgrim completed medical school and residency at the University of Minnesota. He has been in Emergency Medicine practice and leadership roles for over 30 years. He is regularly involved with health policy issues at state and national levels and continues to advise the evolving role of Emergency Medicine in healthcare delivery systems of the future. A former actuary with Northwestern National Life, his analytical and business experiences combine with clinical and operational knowledge to balance patient care demands, clinicians' needs, and key business considerations.

During four terms as Board Chairman of EDPMA (Emergency Department Practice Management Association), he represented members that impact over half of the 150 million annual ED visits in the United States, advocating for state, federal, and public policy issues that affect the health of patients and the sustainability of the health care system. He co-chairs the Task Force on Alternative Payment Models for the American College of Emergency Physicians (ACEP) and leads EDPMA's Federal Health Policy Committee. He has lectured with the Institute of Medicine's dissemination workshop series, "Hospital-Based Emergency Care, At the Breaking Point."

As faculty for ACEP's Scientific Assembly and ED Director Academy, Dr. Pilgrim speaks on a variety of topics related to Emergency Medicine and healthcare reform and has twice been honored as a Speaker of the Year.

Contributors:

Dr. Pilgrim and SCP Health would like to thank the following for their contributions to this work:

Rich D'Amaro
Rob Reilly
Dr. Stephen Nichols
Lisa Fry
Emily Middour
Meghan Connell
Marc Roth
Charlie Nguyen
Emily Harrison
Maura Nelson
Russell Max Simon

Table of Contents

Introduction

Patient #1: 62-year-old male
A 62-year-old male with congestive heart failure comes to the ED: emergency conditions are ruled out and the patient is discharged, but prompt physician follow-up is required.

Patient #2: 65-year-old female
A 65-year-old woman with hypertension, hypothyroidism, and increasing fatigue: ED physician adjusts medications, recommends repeat labs and a PCP visit within a week.

Patient #3: 39-year-old male
History of PTSD and depression: prescription written, follow-up recommended with mental health provider & treatment clinic.

I've been working with emergency departments (EDs) across the country for almost 30 years: different cities, different sizes, in small community hospitals and busy urban ones, nonprofit, for-profit, and academic. Patient scenarios like these are commonplace — and those who care for these patients know that what happens next is often a failure in the system: an inability to obtain follow up, a repeat ED visit, an avoidable hospitalization, a fight with the insurance company. Each time, my reaction is the same: "Thank goodness the ED is here for them, but there is so much more we can do."

We need to do more, but not more of the same. We need something transformative. Maybe not revolutionary, but *significantly* different, or this longstanding pattern will continue and more likely, get worse. These patterns are unfortunate for our patients, and the very health of our health care system is suffering. The result is unsustainable cost and further erosion in clinical outcomes.

The Emergency Department's Unique Viewpoint

A significant number of patients seek care in the ED not because they are acutely sick or injured, but as a direct result of problems in the health care system itself.

- Lack of resources
- Lack of patient engagement
- Poor access to other physicians
- Poor transitions of care
- Ineffective patient teaching

A 2019 study published in JAMA[1] estimated that factors including lack of care coordination, failures of care delivery, and poor execution of best practices account for anywhere between $129 billion to $244 billion in wasted health care spending per year.

Amid these problems however, there is opportunity. In the health care system we have today, the ED has a unique vantage point for detecting what is right and what is wrong in the very health system it serves.

Yet we are more than passive observers. The ED has frequent contact with significant patient populations. This combination of direct observation, clinical accountability, and the realities encountered during patient-by-patient problem-solving gives the emergency physician not just insight but opportunity and most importantly, a responsibility.

We must ask ourselves: what does this unique vantage point mean for clinical outcomes, the stewardship of resources, and the sustainability of our health care system? What does the ED's unique insight ask us to change, as we work toward the future we need?

Those questions are the subject of this paper. In the sections below I will trace the ED's evolution from "accident response" to increasing levels of system responsibility and accountability and suggest why that evolution has occurred. With data gleaned from within the ED, I will show examples of what this unique vantage point can tell us about the highest risk, highest cost patients, and what can be done better. I will review other vantage points within the health care system, including their strengths and limitations. And finally, I will suggest how this country's 24/7/365, EMTALA-governed emergency departments may be better utilized as strategic assets within the health care system itself.

The consistent, repeated issues that occur in a local health care system are not unlike clinical conditions. They can be diagnosed. They have treatments. Some even have cures. ***The ED can uniquely advise changes. But most importantly, the ED can actively participate in transformation.***

1. Expanding Hospital Partnership & Clinical Accountability

From the earliest days of emergency departments as "accident response" centers, hospitals and health systems have turned to the ED for expanded roles outside of its core function.

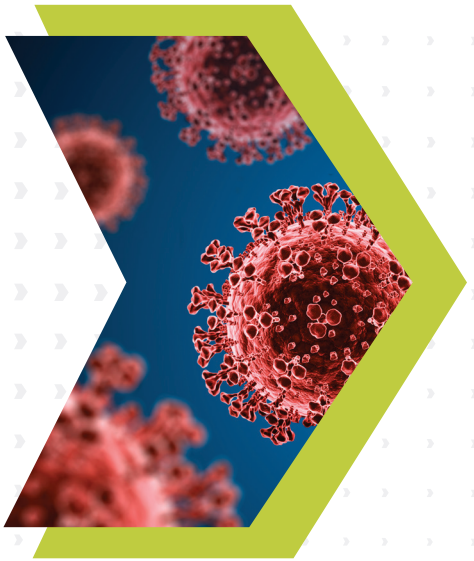
> **After EMTALA was enacted, the wisdom of placing increased responsibility into the hands of the emergency department became more and more apparent. The reason was simple, but not fully appreciated: no other clinical resource provided 24/7/365 access to health care that was essentially required by law, where physicians regularly interfaced with every segment of hospital-based care.**

Hospitals thus turned to the emergency department for an increasing array of acute unscheduled care needs, including key service and performance measures reflected in the inpatient environment.

The Evolution of the Emergency Department

At each stage in the evolution of the ED's role, hospitals and health systems have surveyed the landscape of strategic assets at their disposal and found that the ED was a natural partner. None of these additional roles were part of a grand plan to leverage the ED's unique vantage point as an interface for the system's most pressing problems. Yet, taken as a whole, it's clear this evolution happened and has been sustained, for good reason.

COVID as a Catalyst



In June of 2020, I and two of my colleagues at SCP Health (SCP) presented a webinar titled *COVID-19 as a Catalyst: Rebuilding the House While Preparing for the Future*.[2] The theme was drawn in part from Henry Kissinger's famous quote:

> ***"The historic challenge for leaders is to manage the crisis while building for the future."***

Whether we wanted it or not, 2020 was a year that forced clinicians and health care leaders at nearly every level to do as Kissinger suggested. We faced a crisis unprecedented in our lifetime. Across all our sites, patient volume in emergency departments declined by 50 percent within six weeks. Ambulatory patients virtually disappeared overnight — beginning on March 13, the day a national emergency was declared due to COVID-19.

Our core prediction was that COVID-19 would catalyze much-needed solutions that had good reasons to progress, but previously languished without regulatory and legislative solutions or without the support of an aligned payment model. That prediction has thus far turned out to be correct. We highlighted five such trends:

1. **Growing use of telemedicine**
2. **Transition of volume to urgent care**
3. **Increasing utilization of non-physician resources**
4. **Payment changes supporting additional models of care**
5. **Increasing focus on social determinants of health**

All five of these COVID-accelerated trends support cost-effective solutions that can be utilized by emergency departments, inside and outside the four walls of the ED. None of these trends obviate the core requirement for high quality emergency care. But all of these trends are required to address "Care in the Gap," which I will discuss later in this paper.

2. The Turning Point & Evolution of the ED's Vantage Point

In 1986, Congress made a fateful decision to clamp down on a practice known as "patient dumping." Hospital emergency departments were denying care to patients with a medical need but insufficient means of payment, and "dumping" them to a different hospital, making them someone else's economic problem. Truly, this was abhorrent. The law passed in response to this practice was named the Emergency Medical Treatment and Active Labor Act, now known ubiquitously as EMTALA.

The immediate consequence was that hospitals could no longer shift patients who needed care somewhere else. The law created a legal responsibility to see, assess, and stabilize these patients within the capabilities of that institution. This much is well understood. Yet the long-term consequences of EMTALA are still not fully appreciated.

As Dr. Robert Bitterman wrote in ACEP Now in 2018[3], EMTALA "forever changed the practice of Emergency Medicine." In essence, Bitterman noted, "the law created a federal right to emergency care for anyone in the United States."

But the law did more than that. The law required that patients be assessed and stabilized within the capabilities of the hospital simply because they presented there. This not only made the ED a safe place to receive medical attention, it made emergency departments the nation's 24/7 safety net. After EMTALA, patients had access to health care without an appointment, and with no other requirement.

From that point forward, the onus was on the ED to assess and stabilize patients. In effect, it made the emergency department clinically, legally, and—by virtue of our professional vows—ethically accountable for patients, simply because they arrived. All this happens irrespective of the reason the patient decided to seek care.

The core mission of an ED—to provide for the acute treatment of sick and injured patients—was alive and well. Over time, emergency departments became a point of confluence in the health care system for patients. Motivations for care-seeking behavior are many and diffuse, but often include difficulties accessing appropriate primary care, following treatment plans, and understanding medication schedules. Fueled by EMTALA then, the ED became a place where multiple challenges in a health care system were revealed, and where some challenges found refuge.

Already a gateway between the outpatient setting and inpatient care, the ED increasingly became a nexus where a variety of care-seeking motivations converged.

It was now a 24/7 entry point for those who perceived a need to see a doctor. This happened irrespective of the patient's economic or insurance status, their level of engagement with the medical system, the ability to care for their medical condition at home, or health care literacy.

The ED as a Beneficial Resource for Hospitals

Meanwhile, despite the considerable economic challenges that resulted from unfunded and under-funded patient populations, other forces worked to position the ED differently. Hospitals recognized the value of the ED as a "front door" to their suite of health care services. They endeavored to give patients rapid access to doctors (reduced waiting times), better experience of care (patient satisfaction), and better outcomes (quality measures). Hospitals advertised not only the ED itself, but real-time "door-to-doctor" times on websites and highway billboards. Over time, hospitals were required to report certain performance measures publicly, further spotlighting the ED as one of the hospital's most important interfaces with the community.

The ED went from a reluctant after-thought to a 24/7/365 access point with few or no barriers, including:

- Patients of all ages, all health conditions, all manner of insurance (or non-insurance), and all levels of health literacy.
- All had rapid access to a continuously improving clinical service, with publicly reported measures of effectiveness.
- Regulatory and certification bodies scrutinized the ED just as focally as any other element of the hospital, further driving high-quality processes and outcomes.

Meanwhile, emergency medicine matured as a clinical specialty. The number of residents graduating from accredited EM residencies dramatically increased. Community physicians increasingly referred their complex patients and potential admissions to the emergency department, rather than seeing them in the office.[4] And although a minority of hospital admissions originated in the ED initially, **today an average of 70% of the hospital's inpatients are admitted through the emergency department.**[5]

Large data sets note the considerable rise in community utilization of the ED in health care systems, and an increasing use by high-focus populations. For example, in 2018, there were 40.4 ED visits annually for every 100 persons in an average community. However, for the Medicare population, every 100 persons yielded 45 ED visits each year.[6]

Furthermore, from 2011-2017, the number of Medicare patients presenting to emergency departments increased by 14%. During the same time period the number of Medicare patients presenting to physician offices increased by only 4%.[7]

From every angle, the ED's role, responsibility, and function in the health care community was becoming increasingly vital.

The ED's Current Strengths & Unique Vantage Point

As the ED's role continues to evolve, hospital leaders are well-advised to optimize the value of significant patient-motivated contact, concentrated in a focal hub with few barriers to access. To be relevant, further evolution must address the billions of dollars lost in inefficiences and sub-optimal outcomes in our health care system. The ED has a good foundation to date. Why will it continue?

The ED's vantage point stands out for four core reasons:

- **Access & trust.** The ED has access to a high volume of patients and a large number of sick, high focus patients. In the U.S., ~4,500 emergency departments see approximately 150 million patient visits in the U.S. each year, and 70-80% of hospital admissions are intermediate and complex conditions.[6,8] These patients voluntarily arrive at the ED's doorstep wanting to receive care, and in general, trusting the clinicians they see to provide it.
- **High touch interface.** The ED frequently interacts with nearly every other part of the health care system, including the other departments within the hospital they serve, as well as outpatient clinics, primary care physicians, specialists, social workers, and payors.
- **Care initiation & pathway designation.** The patient journey - or its current chapter - often begins in the ED. With good clinical decisions, the patient is stabilized and just as importantly, sent down an accurately chosen, cost-effective pathway. Getting this right and making it happen avoids inefficiencies, poor outcomes, wasted resources, and frustration.
- **Used by all payors.** Since the hospital is essentially required to have an ED, all payors rely on it for their patients. And, with the passage of the No Surprises Act in the waning days of 2020, additional provisions will exist to ensure that payors and providers come to agreement over the terms of those engagements.

> **To summarize, emergency departments see a high volume of patients, regularly interacts with a high volume of very sick patients, and interface with nearly every other part of the health care system.**

Alternative Vantage Points

The ED has both a unique perspective - hard to come by - and an opportunity for important change. Still, other parts of the health care system also have unique perspectives. Like those in the ED, others may feel a desire and responsibility to extend their role to meet our collective challenges. These perspectives are worth examining:

Payors

If there is one constituency in health care with obvious incentives to reduce costs, it is payors, including both governmental and commercial health plans. Payors have a hybrid relationship with clinical providers: at times antagonistic, using their market power to reduce reimbursement rates or seeking to deny coverage; and at other times a partner in alternative payment systems, seeking to transition a portion of risk and reimbursement into value-based payment systems.

Payors should be a leading contender, aside from emergency departments, for an expanded role in addressing the challenges of care coordination and care delivery discussed above. Yet payors are also at a severe disadvantage in at least three respects:

- **Payors do not see patients.** While payors may purport to have visibility into and insight about the health of their customers, there is only so much a coded chart and a request for reimbursement can tell you about the true challenges facing patients. Payors are not the patient's doctor. They do not see patients, and while many individuals who work for payors are highly skilled and knowledgeable (and some are physicians themselves), their role is substantially different than that of a patient's clinician.
- **Payors lack trust.** Patients generally want to hear from their insurance company only when they will be paying for all or a substantial part of their health care costs. A payor's primary interaction with their members are usually transactional and revolve around payment and the structure of their benefits.
- **Payors do not see the uninsured.** Whereas emergency departments have an EMTALA-driven requirement to see everyone, those who are uninsured are not the payor's concern. In the emergency department, the uninsured population ranges widely, but is typically 25-35% of all patients.[6]

Primary care physicians

Primary care physicians (PCPs) are the oft-mentioned missing link in American health care. For more than a decade, leading voices in the health care industry have pointed to primary care as the solution to the challenges of uncoordinated care, access to care, and some aspects of care delivery.

The problem with turning to primary care is that there remains a long-standing lack of access (or timely access)—a challenge no one has solved despite many, many efforts. Market forces, lower pay than other specialties, and downward reimbursement pressures all contribute—and, unlike emergency care, there is no EMTALA analog (no requirement to deliver timely access on demand).

Additionally, like payors, PCPs have limited visibility into those patients who lack health insurance, as well as those who, for whatever reason, will only seek health care in acute unscheduled situations. These are crucial deficits when it comes to addressing the challenges of rising costs, unnecessary hospital admissions, and chronic care for target patient populations.

Despite the remarkable commitment and mission-driven efforts of many primary care physicians, there is reason to believe that this problem will persist. A study of the physician workforce[9] published in 2020 by Human Resources for Health indicated that, "Only in the most optimistic supply and demand scenarios would the nation have an adequate supply [of primary care physicians] to meet demand in the year 2020." Transformative solutions are in order.

Other Vantage Points

There are many other groups and constituencies within the health care system that are seeking solutions in this regard. None have as strong a claim to being able to solve these challenges as the groups mentioned above. But they are worth acknowledging:

- **Social workers.** Social workers and case management professionals play a crucial role in addressing social determinants of health. They are important partners when it comes to addressing substance abuse, mental and developmental disabilities, and other challenging instances of longitudinal care. Yet these professionals only have responsibility for certain patient segments, usually those assigned to their care, and have more limited visibility into, and accountability for other aspects of the health care system.

- **Health care consultants.** The health care industry is full of knowledgeable, experienced professionals that apply their skills to chronic challenges. Yet, consultants have a secondary and supporting role versus those who must deal with challenges directly. There is no substitute for the insights gained by having primary clinical and operational accountability for patient care.

- **Technologies.** New technology, especially telemedicine, will play a crucial role in the health care delivery and coordination of the future. As new investments pour into the health care system, technology that enables Hospital at Home programs, real-time care coordination, and monitoring and tracking, among others, will be vital tools. Yet this technology must ultimately support the cognitive work and clinical judgements of clinicians and will not soon replace significant segments of that work.

3. Identifying & Understanding the Care Gap

A crucial advantage of the unique perspective offered by the emergency department is its ability to analyze, identify, and ultimately manage crucial gaps in care.

For many physicians, the course of care after discharge has not been a particular focus. This has changed over time, with the advent of episode-based models like BPCI for hospital medicine and CJR for orthopedics, and with other pressures, such as hospital-based penalties for all-cause readmissions. Continued pressure on better outcomes and cost efficiencies will require broader engagement and even more change.

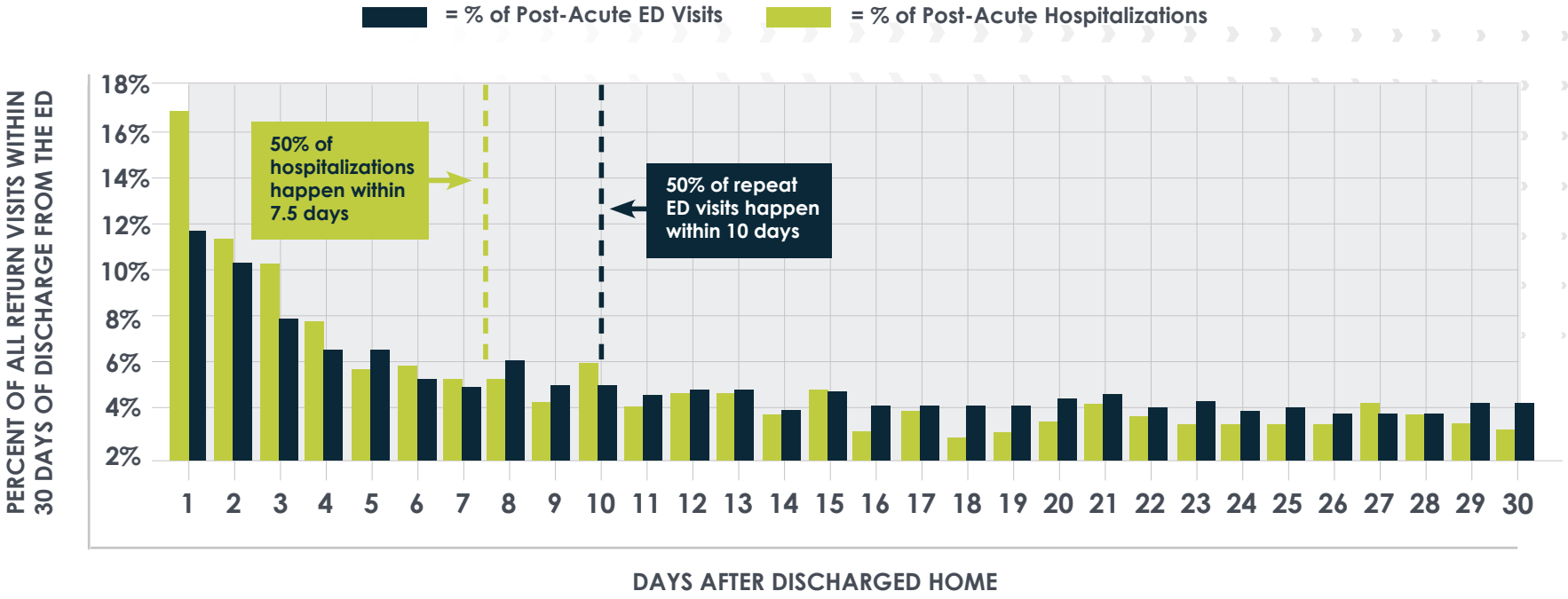
Perhaps the biggest opportunity for change lies within a critical "Care Gap."

> **The "Care Gap" begins when a patient leaves the hospital and ends when the patient either gets better or fully engages in meaningful follow-up care.**

Post-Acute Admissions and Repeat ED Visits: Care in the Gap

SCP conducted analyses of more than 1,000,000 patient encounters during the 2019 calendar year, reviewing patients discharged from approximately 300 emergency departments. We assessed patients with high-focus clinical conditions for 30 days after an initial emergency department visit. Subsequent hospitalizations and ED re-visits were identified, including the frequency and timing of those events. (Hospitalizations and repeat ED visits are a common focus because of the relatively high cost, and because some are avoidable during the post-acute period). As with other examples discussed in this paper, the ED's access to this kind of data makes it uniquely positioned to address issues that are identified.

Figure A: MODERATELY COMPLEX CONDITIONS DISCHARGED HOME



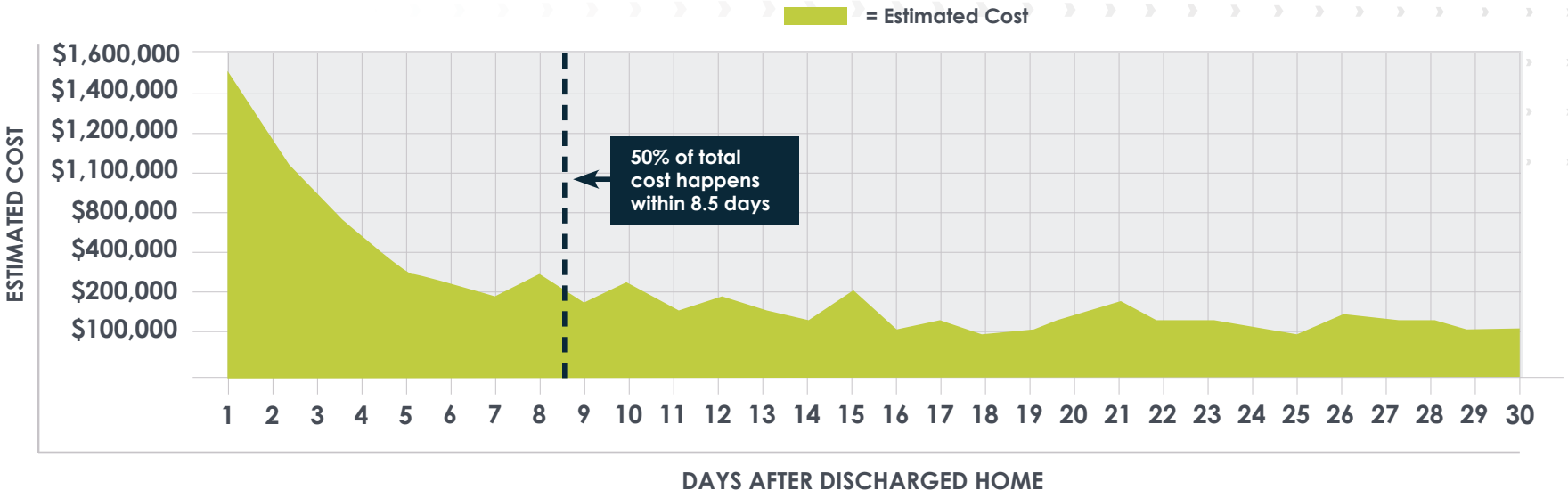
The results are significant.
For patients that had a subsequent hospitalization, 50% occurred in the first 7.5 days after an ED visit.
For patients that had a subsequent ED visit, 50% of those occurred in the first 10 days after an ED visit.

The data shows that for key clinical conditions there is, in essence, a 7–10-day window of high risk for patients who were subsequently hospitalized or returned to the ED. As we know from clinical and practical experience, this is the very time frame where patients are not yet fully improved, and need to get their prescription filled, take medications differently, follow their new care plan, and obtain a follow up appointment. This is the very time where patients are most vulnerable–and 50% of those repeat events occur in this window.

The Cost of Post-Acute Admissions and Repeat ED Visits

After identifying the frequency and timing of admissions and repeat ED visits in the 30 days after an initial ED visit, we worked with selected payors to identify the cost of those events. Actual costs will differ by payor. A representative cost profile is indicated in FIGURE B.

Figure B: ESTIMATED COST DUE TO REPEAT ED VISITS AND HOSPITALIZATIONS FOR MODERATELY COMPLEX PATIENTS DISCHARGED FROM THE ED



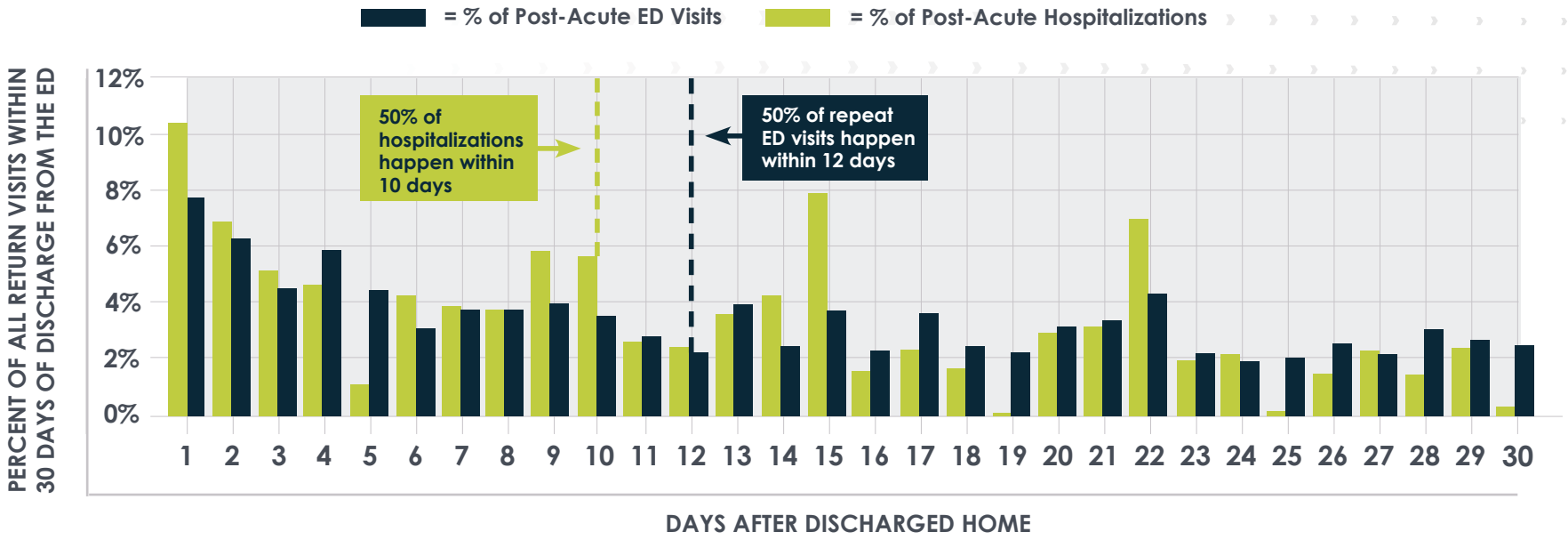
The intuitions and experience of ED physicians related to shortcomings in care within the community is supported by the data. There is a golden window in the immediate post-acute time frame. Fifty percent of the key post-acute cost events occur in the first 7.5-10 days after an initial ED visit for key conditions, and these events drive substantial cost in the 30-day post-acute period. Some of these events are avoidable.

Knowing when and where these episodes and costs occur informs prioritization, timing, and intensity of intervention. Not all these events are preventable; some are necessary for appropriate patient care. In fact, some ED visits are valuable and necessary because the patient is stabilized again, at about a tenth of the cost of another hospitalization. In general, however, preventing hospitalizations and repeat ED visits is satisfying to patients, improves performance in value-based models of care, and promotes better outcomes.

Bundle-Specific Analysis

The prior analysis relates to seven high-intensity clinical presentations that together, account for 25-35% of a typical ED's volume. Our clinical experience shows that different clinical conditions act differently in the post-acute timeframe and therefore, post-acute interventions can be customized by condition. For example, Figure C shows the frequency and timing of hospitalizations and repeat ED visits after an initial ED visit for chest pain. Hospitalizations occur either very soon (which may be less avoidable), or in "spikes" near post-acute days 15 and 22. Proactive post-acute interventions can be targeted accordingly.

Figure C: POST-ACUTE ENCOUNTERS FOR CHEST PAIN BUNDLE



The profile of post-acute hospitalizations and repeat ED visits for heart failure patients show a different pattern over the ensuing 30 days, consistent with exacerbations of this chronic disease. These patients benefit from more frequent contact throughout the entire 30-day period, until the patient meaningfully engages with primary care or a cardiologist. The profiles for headache and back pain are unique, owing to the more acute presentation, followed by an indolent post-acute course.

During the "Care Gap," data should guide the frequency and intensity of post-acute interventions, which should be matched with the clinical condition to optimize outcomes and address preventable episodes of care. Understanding the timing and frequency characteristics for high-focus diagnostic bundles can support an effective coordination plan that helps these patients get the right level of care in the right setting. Coordinating that care with the emergency physician that initiated the entire sequence results in greater efficiencies and more thoughtful use of resources.

Patient Examples

Patient #1: 62-year-old male

A 62-year-old male has congestive heart failure (CHF) following a myocardial infarction five years ago. He is seen twice a year by his cardiologist and quarterly by his primary care physician. He takes four medications regularly. He is usually stable, but occasionally has episodes of shortness of breath. He tries to manage but is often "on the edge." After calling both of his physicians' offices, he follows the instructions on the recorded messages, and comes to the emergency department.

What happened in the ED and afterward:
The emergency physician performs a history, physical, EKG and labs, administers a diuretic, and observes him over several hours. Emergent conditions were ruled out and he is feeling better. He was discharged home with with a diagnosis of a mild exacerbation of chronic CHF. Follow up within 2-3 days was strongly recommended – sooner if worse.

Unfortunately, the patient was unable to get an appointment with his primary care doctor for longitudinal management. Concerned, he returned to the ED in four days, and because timely specialist follow-up was not available either, he was hospitalized in observation status.

What this visit reveals about the health of the health care system:
In this example, the patient lives in a community with a relatively high incidence of CHF. The emergency department sees 100 patients a day, with an average of 25 admissions, 8-10 of which are CHF patients. Almost all the hospital's CHF admissions come through the ED.

The community's busy primary care physicians and cardiologists have trouble accommodating the frequent need for prompt follow up from this patient population. Noting this, the hospital implemented new interventions, including dedicated case management, disease management, and patient education. These options showed some promise, but all were hampered by the lack of 24/7 availability, the need for more frequent intervention, variable patient engagement, and high demand. Given the frequent contact of this significant CHF population with the ED, leaders considered ways to optimize the ED's role in the health care community.

The hospital reviewed recent patient experiences, which showed a substantial opportunity for CHF patients to receive next-day assistance in obtaining a timely follow up visit, telephone follow-up, interval guidance from an emergency clinician via telemedicine, and occasionally, remote monitoring with physician oversight. With augmented staff, the emergency physicians filled gaps in home-based care, creating a necessary bridge to primary care. Preventable ED visits and hospitalizations were reduced, and patient engagement, satisfaction, and outcomes were improved.

Patient #2:
65-year-old female

A 65-year-old female presents with weakness and fatigue for the past three weeks. She has a medical history of hypertension, hypothyroidism and other minor conditions, and takes four medications routinely. She came to the emergency department because she was concerned about the duration of her symptoms and was unable to get an appointment with her primary care doctor.

What happened in the ED and afterward:
Clinicians conducted a thorough evaluation (history, physical exam, tests) which showed no emergent condition, but did show mild abnormalities on laboratory tests. The emergency physician adjusted one of her medications, recommended close follow-up with her primary care physician, and repeat lab tests within a week for ongoing monitoring. Unfortunately, her insurance denied payment for the labs, and she had difficulty adjusting her medications. Her doctor couldn't see her for another month. She returns to the ED 10 days later feeling worse.

What this visit reveals about the health of the health care system:
This is a common scenario. The patient needed primary care attention but could not access even her own physician in a timely manner, so she presented to the emergency department, which is available 24/7 without an appointment. The ED physician—as required—evaluated her for the presence or absence of an emergency medical condition. Finding none, the ED physician was able to discharge her home with some adjustments and reassurance, but with clear needs for timely follow-up.

This patient is in "The Gap." The ED physician acted appropriately. However, the patient was discharged into the same system that led her to come to the ED in the first place: a system where she still has trouble accessing primary care. In this case, the referral for repeat labs in a week was also denied. Eventually, her health care condition will be addressed, but she needs "Care in the Gap." She needs assistance accessing her primary care physician, and needs near-term coaching and low acuity follow-up. If the "Care Gap" is not bridged, she may return to the emergency department again, and repeat the cycle, or eventually, require an otherwise avoidable hospitalization.

Patient #3: 39-year-old male

A 39-year-old male with a history of post-traumatic stress disorder and depression comes to the ED with concerns about side-effects from his medications. He also relates ongoing symptoms from his mental health conditions that affect his ability to function at home and at work. He does not have a consistent mental health provider.

What happened in the ED and afterward:
The emergency physician conducted a history, physical exam, medication review, and suicide risk evaluation. All were consistent with known diagnoses and there was little risk of suicide, but there were significant enough side effects to change his medications. The patient was counseled, and a new prescription was given, with recommendations to find a mental health provider in an outpatient clinic.

What this visit reveals about the health of the health care system:
The emergency department is often a landing zone for unaddressed issues in our health care system. Mental illnesses are common in the U.S., with over 50 million adults affected.[10] Approximately one in eight visits to emergency departments involve mental and substance use disorders, and the rate of visits is increasing.[11] While mental health issues are appropriately screened and stabilized in the ED, long-term management or inpatient treatment may not be available, and some patients are boarded in the ED for days or weeks, awaiting inpatient placement. Many of these ED visits are entirely avoidable with consistent use of appropriate outpatient care.

Our nation's mental health crisis is well known. The lack of resources are well documented, and solutions have been elusive for years. Alone, the ED cannot solve the larger issues of funding, availability of inpatient services, or address social issues that are frequently present. This requires more than "Care in the Gap."

However, given the high frequency of contact with this important population, the ED can play a key role in deploying future solutions. The ED can connect patients with appropriate resources including mental health professionals, pharmacy services, and increasingly, telemedicine consultations. The nation's mental health crisis is significant indeed. Leveraging the frequent in-person contact the ED already has with these patients represents yet another important opportunity for our health care system.

4. Implications
(So What, and Now What?)

Given the challenges facing hospitals and health systems today, all health care leaders must actively leverage every resource and capability of every clinical service line, optimizing and driving value–especially existing services with a high degree of untapped potential.

This paper suggests that emergency departments have much more than observations, intuitions, and data. They have a unique opportunity (if not a responsibility) to address longstanding challenges facing health care communities.

The issues are usually clear. The answers require that we step out of our current paradigm, design solutions, support them with resources and a solid plan, and back them up with sustainable financial models.

Change always starts with first steps, and there are many options. What are a few to consider?

- **Helping Patients Navigate Effectively**
- **Delivering Care in the Gap: The Bridge to Primary Care**
- **The Acute Unscheduled Care Model (AUCM)**

Helping Patients Navigate Effectively

Only 7% of U.S. health care organizations report fully coordinating care between hospital, post-acute, and home settings. A majority of patients don't understand or follow their discharge instructions. And $25 - $45 billion in health care spending is wasted as a result.[12-15]

Addressing "Care in the Gap" as described above will demand more effective transitions of care, starting with basic health care navigation, with escalation to nurses or physicians as needed. Previous attempts to provide better discharge planning have typically failed because the EDs don't have the tools or resources to succeed, and are not sufficiently accountable for the consequences of the discharge plan (they are accountable for creating the plan, but not for its results).

In the future, the expanded role of the ED (and its extended team), must shoulder a more comprehensive transition:

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

Delivering Care in the Gap:
The Bridge to Primary Care

This option connects patients with a clinician who addresses "Care in the Gap" with a new, but less intensive encounter than the one they experienced in the emergency department. A physician, NP, or PA provides one of several options as appropriate, for example:

- **Telemedicine visit**
- **Home visit**
- **Medication review and adjustment**
- **Return to ED if needed**

These lower acuity visits support ongoing care, address straightforward clinical issues, prevent unnecessary escalation and bounce-backs, and transition the patient to primary care or an appropriate specialist. They also "right-size" the ED, reserving its use for more acute and complex patients, as originally intended.

The Acute Unscheduled Care Model (AUCM)

The ACEP-proposed Acute Unscheduled Care Model[16-17] is an alternative payment model under consideration by The Center for Medicare and Medicaid Innovation (CMMI).
This alternative payment model extends clinical and economic accountability for a qualifying emergency care visit to a full 30 days after that initial ED visit.

The reason I spent much of my recent career working with emergency medicine colleagues to develop this model and submit it to CMS is that it provides additional resources to support interventions addressing observations like those above, concurrent with the professional accountability inherent in a value-based model. For high cost and higher acuity patients—those most vulnerable to adverse events after leaving the ED—the model extends the ED's opportunity and accountability past the initial ED encounter. This model addresses "Care in the Gap."

The AUCM proposes financial rewards (or penalties) for clinical bundles related to care coordination and delivery, including:

- **Safe discharge options**
- **Coordination and management of post-discharge services**
- **Avoidance of post-ED adverse events and readmissions**

The model provides additional resources that support these efforts (telemedicine, coordination of care, home interventions). Under our current system, these are not available to emergency physicians, limiting our ability to make an impact.

Some of these goals are addressed by forward-thinking health systems, but if this model or a similar one is elected by an ED group, it significantly enhances the contributions of those practices to value-based objectives (click here for more about the AUCM[18]). In a world where the ED is often seen as a liability or a risk to succeeding in value-based models, the AUCM model is the first (and only) model that embraces the unique insights, connections, influence, and interventions that are possible from the ED. Rather than a threat, the ED becomes an accountable part of the solution and therefore, a catalyst for change.

I believe the AUCM will be a key model in the near future for Medicare patients. Additionally, there is already considerable interest from commercial health plans, hospitals, and health systems, all of which are seeking better clinical and economic alignment with key provider groups.

Conclusion

In recent years, the Emergency Department's role has evolved substantially. The ED treats the acutely sick and injured, serves as a significant interface between outpatient and inpatient care, and serves as the nation's health care safety net. This produces a unique vantage point, key insights, and data-driven conclusions that address many of the most vexing problems in health care.

Health care leaders – all of whom are experiencing tremendous challenges in today's environment – are well advised to embrace these observations, formulate new pathways, and drive transformation.

In the months during and after the worst of the COVID-19 pandemic, I heard from many colleagues that even amid this unprecedented global emergency they felt a profound disconnect from their profession. This feeling had its origins before the pandemic, alienating them from their original motivation for becoming a healer. Moral injury. Burnout. Endless bureaucratic requirements. Productivity measurements. Onerous legislation with broad consequences. It all amounted to a growing sense of estrangement, a feeling that physicians no longer had control over their clinical mission, and more importantly, could no longer connect with it.

COVID-19 stressed our imperfect system to its breaking point. Some of my colleagues are trying to get out of medicine, retire early, reduce their workload, or transition to other careers. While I respect these thoughts, I don't believe the answer is to disconnect further from our purpose. The answer is to meaningfully and newly engage with our purpose. Engaging in the long work of shaping the environment in which we practice, investing more in our patients' journey, and advocating for meaningful change is critical.

We can't do this alone, and transformation is never easy. But it may be more painful to carry the insights we have without putting those insights to work. We must engage patiently, with a deep sense of belief that what we do matters. What we know makes a difference, and we *can* be agents of transformation.

Emergency medicine's unique position in the health care world creates both a responsibility and an opportunity.

The responsibility is to embrace broader accountability for our patients and for the health system that we ourselves will one day inherit.

The opportunity is to recapture a fundamental connection to our healing purpose.

The opportunity is here.
The choice is ours.

References

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

2 Pilgrim, R., Fry , L., & Nichols, S. (2020, May 4). COVID-19 as a Catalyst: Rebuilding the house while preparing for the future. SCP Health

3 Bitterman, Robert A. "EMTALA: The Law That Forever Changed the Practice of EM ." ACEP Now, 25 Sept. 2018

4 Gonzalez Morganti, Kristy, Sebastian Bauhoff, Janice C. Blanchard, Mahshid Abir, Neema Iyer, Alexandria Smith, Joseph Vesely, Edward N. Okeke, and Arthur L. Kellermann, The Evolving Role of Emergency Departments in the United States, Santa Monica, Calif.: RAND Corporation, RR-280-ACEP, 2013. As of July 12, 2021

5 Augustine, James J. "Latest Data Reveal the ED's Role as Hospital Admission Gatekeeper." ACEP Now, 20 Dec. 2019

6 "NAMCS/NHAMCS - Ambulatory Health Care Data Homepage." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 16 July 2021

7 MEDPAC "Options for Slowing the Growth of Medicare Fee-for-Service Spending for Emergency Department Services." The Medicare Payment Advisory Commission, June 2019

8 Smulowitz PB, Honigman L, Landon BE. A novel approach to identifying targets for cost reduction in the emergency department. Ann Emerg Med. 2013;61(3):293-300. doi:10.1016/j.annemergmed.2012.05.042

9 Zhang, X., Lin, D., Pforsich, H., & Lin, V. W. (2020, February 6). Physician workforce in the United states of AMERICA: Forecasting nationwide shortages. Human Resources for Health

10 Mental health by the numbers. NAMI. (2021, March)

11 Weiss AJ (Truven Health Analytics), Barrett ML (M.L. Barrett, Inc.), Heslin KC (AHRQ), Stocks C (AHRQ). Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006-2013. HCUP Statistical Brief #216. December 2016. Agency for Health care Research and Quality, Rockville, MD.

12 Compton-Phillips, A., & Mohta, N. (2016, November 10). Care Redesign SURVEY: Strengthening the Post-Acute Care Connection. NEJM Catalyst

13 Cheney, C. (2015, December 14). How Postacute Care is Evolving. HealthLeaders Media

14 Figueroa, J. F., Feyman, Y., Zhou, X., & Maddox, K. J. (2018, October 1). Hospital-level care coordination strategies associated with better patient experience. BMJ Quality & Safety

15 Hastings, S. N., Barrett, A., Weinberger, M., Oddone, E. Z., Ragsdale, L., Hocker, M., & Schmader, K. E. (2011, March). Older patients' understanding of emergency department discharge information and its relationship with adverse outcomes. Journal of Patient Safety.

16 Baehr, A., Nedza, S., Bettinger, J., Vaskas, H. M., Pilgrim, R., & Wiler, J. (2019, December 3). Enhancing Appropriate Admissions: An Advanced Alternative Payment Model for Emergency Physicians. Annals of Emergency Medicine

17 Wooster, L. (2018, June 12). Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions A Physician-Focused Payment Model (PFPM) for Emergency Medicine. Washington D.C. ; American College of Emergency Physicians

18 "Acute Unscheduled Care Model." ACEP

SCP HEALTH

TOGETHER, WE HEAL