The Gap:
Why We Should Care

The opportunity and the imperative for hospitals and health systems

TOGETHER, WE HEAL I Volume 1, Issue 2

scp-health.com

By Randy Pilgrim, MD, FACEP, FAAFP

Introduction

The Emergency Department sits at the nexus of hospital-based care and the outpatient world. It continues to serve as a "front door" for the hospital, but it also occupies a vantage point that provides unique insights into the health of the surrounding community. From this vantage point, we can see clearly an unaddressed "Care Gap" that is costing the health care system dearly. The Gap produces worse outcomes for patients despite higher costs, loss of market share for hospitals, and suboptimal performance in value-based plans.

The negative effects of this Care Gap impact payors, employers, clinicians, and patients. Each of these groups has a stake in seeing that the Care Gap is addressed.

Last year, SCP Health identified and described this Care Gap in a white paper, "**From Insights to Interventions: Using the unique vantage point of the emergency department to drive transformation.**" This paper identified significant populations regularly receiving care in our nation's emergency departments that require transformative approaches. Shortly, I will lay out in greater detail how we in health care can do a better job of predicting the Gap, closing the Gap, and delivering care and coordination to the patients most at risk in the Gap.

In this series, entitled "**Together, We Heal**", we will cover:

- **Predicting high risk patients:** how to predict which patients are likely to fall through the Gap, leading to avoidable ED visits, re-hospitalizations, and higher costs for employers and patients
- **Post-discharge transitions:** best practices for optimizing outcomes after discharge from the ED
- **Clinical interventions:** strategies for post-discharge touchpoints, including bridges to primary care, behavioral health, telehealth, and home care solutions
- **Non-clinical interventions:** wayfinding and practical instruction for patients on appointment setting, filling prescriptions, and adherence to treatment plans
- **Health equity:** the role of health equity before, during, and after the Gap, and how differences can affect outcomes

By addressing these topics and more, clinical and operational health care leaders can begin to overcome critical shortcomings in our health system and prepare for further transformation.

This is a time of fast-paced change, with stressors all around. These recent difficult years have shown that we can band together in time of crisis—but innovation and change are necessary if we are to build (and lead) a functioning system that is sustainable into the future.

What is the Care Gap?

The Care Gap starts when a patient leaves the hospital, and ends when they either get better or fully engage in meaningful follow-up care (such as primary care, an appropriate specialist, or an outpatient facility).

In order to better understand this Gap, SCP analyzed more than a million patient encounters during the 2019 calendar year. We reviewed patients discharged from approximately 300 emergency departments. We assessed patients with high-focus conditions for 30 days aft er their initial emergency department visit.

We wanted to know which patients were at risk for either a re-visit to the ED or a subsequent hospitalization, and when those visits were most likely to occur. In the course of this analysis, we discovered that, in the 30 days following an initial ED visit.

THE GAP ***BEGINS*** WHEN:

the patient leaves the ED

THE GAP ***ENDS*** WHEN:

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

WITHOUT CARE IN THE GAP

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

IN THE GAP PATIENTS MUST:

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

WITH CARE IN THE GAP

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

SOLUTIONS IN THE GAP

Care Navigation - Supporting Care

- Finding PCPs for patients without one
- Encouraging patients to follow discharge instructions
- Encouraging patients to fill and take prescriptions

Clinical Care - Delivering Care

- Support ongoing care
- Provide low intensity clinical encounters with a physician, NP, or PA
- Bridges to longitudinal care – primary and specialty care

The Care Gap is this 7-10-day window of high risk for patients.
As we know from clinical and practical experience, this is the time after the ED visit or hospital discharge where patients are not yet fully improved, but must fill new prescriptions, take medications differently, follow a new care plan, and obtain a follow-up appointment. As practicing emergency physicians, we know that many return ED visits and re-hospitalizations are necessary. We also know that many are preventable with reasonable, straightforward interventions. However, our health care system does not readily support or provide such solutions.

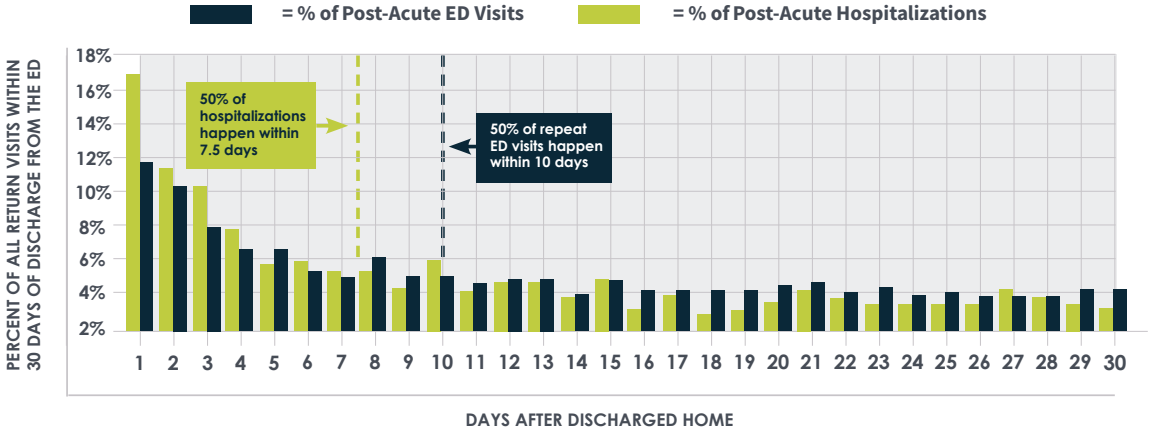
This is the Care Gap.

50% of hospitalizations occurred within **7.5 days** after ED discharge

50% of repeat ED visits occurred within **10 days** after ED discharge

50% of these costs occur within **8.5 days** after ED discharge

Figure A: MODERATELY COMPLEX CONDITIONS DISCHARGED HOME



The Impact of Not Addressing the Gap

In 2018, there were 40.4 ED visits for every 100 persons in an average community. For the Medicare population, that number is 45 visits per 100 persons.[1] Most of these visits are not preventable. However, many will either return to the ED unnecessarily or be re-hospitalized because of gaps in care. The effect of these gaps is far-reaching. It includes hospitals, health systems, employers, clinicians, and of course, patients.

The Gap Impacts
- Patients
- Clinicians
- Hospitals
- Payors
- Employers

The Impact on Hospitals and Health Systems

Hospitals and health systems recognize four significant benefits by addressing care in the gap:

1. Better quality of care across the continuum
2. Retained or newly gained market share
3. Increased patient satisfaction
4. Financial benefits in risk-based models

Unfortunately, many health systems struggle to effectively connect with the post-acute care system in their community. A report from Deloitte[2] quoted a physician executive for a health system: "Post-acute care looks like an archipelago of little islands with no bridges. Consumers are at a loss about which island to approach, with poor transportation and communication options."[3]

Deloitte interviewed 36 health care executives representing 10 large systems and found that many leaders only have a "very rudimentary" understanding of the post-acute care providers in their area and the differences between them, giving little thought to where patients end up after they are discharged. Considering the outsized role that post-acute care plays in driving both cost and ultimate outcomes, this is significant and concerning.

> **"Post-acute care looks like an archipelago of little islands with no bridges."**
>
> - Health system executive

Significant Variation in Post-Acute Care Spending

The post-acute care world is highly fragmented and siloed, making better care coordination an even more difficult challenge. Many large health systems refer to multiple post-acute providers. According to the Deloitte interviews, the number can reach upwards of 30 in some markets.

A major retrospective analysis of 3,246 hospitalizations followed by post-acute care engagements found that the risk of re-hospitalization varied significantly between facilities, and that the variation could be traced to specific risk factors. Hospital readmissions from post-acute care (PAC) facilities is also associated with higher mortality rates, the authors concluded.[4] Similarly, the Healthcare Cost and Utilization Project (HCUP) found the best performing Skilled Nursing Facilities (SNFs) had an average Medicare length-of-stay of less than 24 days, but low-performing SNFs have an average of more than 34 days. Additionally, 30-day readmissions can reach as high as 22 percent from some post-acute care facilities, as compared to a national average readmissions rate of 17 percent.[5]

Our analysis on the Care Gap shows there is low-hanging fruit and reason for hope. Health systems can focus on high impact populations and begin to reduce the number of patients who fall through the cracks. Doing so will benefit patients, reduce costs, and support long-term objectives througout the health care system.

The Impact on Employers and Individuals

Every year, human resource department leaders examine their company spending on employee health insurance and nearly every year that spend goes up. Similarly, the cost for individuals and families has also been increasing every year for decades.

According to a gold standard annual report on employer health benefits, undertaken each year by Kaiser Family Foundation, annual premiums for employer-sponsored health coverage reached $22,221 in 2021, up from $15,073 a decade ago. The share of that cost paid by workers has also continued to rise, from a $4,129 average annual contribution in 2011 up to $5,969 in 2021.[6]

Those increases also continue to outpace both inflation and wages by significant margins.[7] And outpacing everything are deductibles, which have risen 92 percent. For employer-based plans, the average deductible now stands at $1,669, up from $991 a decade ago.

While there are many contributing causes for the increasing cost of health insurance, we know that hospitals and physician services together account for a large proportion of U.S. spending on health care. Health System Tracker estimated that hospitals and physician services accounted for 51% of health care spending in 2019.[8] Addressing Care in the Gap offers the possibility of reducing overall spending by impacting the most significant domains of cost in health care.

Efforts to contain these costs have been multidimensional, even resulting in some dramatic ventures, such as employers that actually pay their employees to travel internationally for major surgeries rather than pay for the cost of those procedures at U.S. hospitals, or self-funding unions that have directly contracted with providers to set up locations with incentives for their members to use those dedicated facilities. While laudable, there are much more compelling and immediate solutions at hand.

For large numbers of high intensity patients, the first 7-10 days after an initial ED visit offers an opportunity to reduce avoidable ED visits and hospitalizations, and increase satisfaction. Additional care coordination and clinical support after hospital stays or visits to the ED is compelling indeed.

The Impact on Payors

In the course of my work with health plans, I often hear complaints about avoidable costs, perceived or otherwise. I hear frequently about potentially avoidable low-acuity ED visits. But I hear far less frequently about more impacting issues.

SCP's internal data repeatedly shows that low-acuity visits usually comprise less than 1% of an emergency department's annual patient volume, and less than 0.2% of its annual cost. Conversely, the moderately complex conditions noted in Figure A comprise 35% of the annual volume, over 40% of the annual cost, and contribute to a vast majority of repeat ED visits and subsequent hospitalizations.

Focusing on higher complexity visits offers exponentially more opportunity. These are the patients that are higher acuity, who rely on the emergency department for stabilization of acute or chronic conditions, and require more solutions in the Gap than our current system provides. With solutions in the Gap, costs will decrease, satisfaction increases, and outcomes improve. Most of these solutions need to be in the immediate post-acute period (after an initial ED visit).

Low-acuity visits:

- <1% of annual patient volume
- <0.2% of annual cost

Moderately complex visits:

- 35% of annual patient volume
- >40% of annual cost

Health plans (both commercial and governmental) are important partners when it comes to addressing the challenge of Care in the Gap. In "An All-Payer View of Hospital Discharge to Post-Acute Care," Dr. Wen Tian used the 2013 National Inpatient Sample to estimate the percentage and share of costs for the nearly 8 million patients discharged to post-acute care settings each year. These 8 million patients account for 22.3 percent of all hospital discharges.

Not surprisingly, a huge proportion of patients (approximately three quarters) discharged to post-acute care settings are Medicare beneficiaries. The proportion is higher for SNFs (84.9%) and long-term care hospitals (76.2%) and somewhat lower for inpatient rehabilitation facilities (68.7%) and home health agencies (64.6%).[9]

But how hospitals and health systems choose where to discharge, and what coordination is provided, if any, remains opaque and unconnected to patient outcomes. Dr. Tian wrote: "Discharges to PAC often are driven by the availability of specific types of settings and by financial incentives that are not always aligned with clinical needs and may not be cost-effective."

And, in a telling passage from the Deloitte report, its authors note the ambivalence of health plans about what happens post-discharge. "Most health plans we spoke with believe that their medical management approaches are reasonably effective at controlling costs and quality for their Medicare Advantage populations and any further responsibility for improving post-acute care cost and quality falls to health systems." However: "Other health plans take a more active role in post-acute care performance by developing new clinical models and analytically-driven decision-making tools."[10]

Health plans that take a more active role and provide solutions for Care in the Gap will see increased member satisfaction, realize a competitive advantage by empowering their members to do well, and will excel in a world increasingly impacted by value-based models of care.

The Impact on Clinicians

I wrote extensively on the implications of the Care Gap for clinicians in "**From Insights to Interventions.**"

First, taking responsibility for what happens after a patient leaves our care is highly consistent with a patient-centered mission. In the emergency department, our core mission is to treat the sick and injured regardless of the patient's race, class, gender, or ability to pay. The ED is the nation's clinical safety net, and it is natural to embrace the fact that this also includes what happens to patients after they leave our care.

Second, by addressing the Care Gap we reduce unnecessary or avoidable visits. This impacts key elements of cost during a time of severe stress on ED and hospital capacity, where reducing avoidable visits can have a material effect on the ability of clinicians to focus on what is absolutely necessary. Ultimately, no emergency physician enters the specialty with a mission of caring for patients who don't really need to be there. By expanding our attention to the Care Gap, we support clinicians in working at the top of their license, and optimize the impact of first-contact care.

Finally, fixing the problems in the Care Gap is critical to keeping clinicians out of "unsolvable situations." Think of an ED clogged with behavioral health patients who cannot be placed in either inpatient or outpatient facilities. Problems like this take a considerable toll not only on patients and families, but also on clinician morale, as they struggle to deal with the fallout from system failures outside the hospital.

Conclusion

It is no small task ahead of us. Pre-pandemic data already alerted us to the opportunity for positive change that can come from addressing this critical Gap in post-discharge care. The pandemic has not only added new challenges and stresses but as importantly, has amplified our focus on weaknesses that were already present.

What happens in the Gap is critically important. For the sake of patients, clinicians, employers, and payors, and for the overall health of our system, we must be agents of transformation. We must invest in the continuum of our patients' journey and advocate for change. And we must meaningfully incorporate the emergency department as a critical element of solution-making.

Anything less will yield the same system we have today. What we have today is entirely unacceptable for our patients and unsustainable for our health care system. Our system is begging for innovative solutions. **We must deliver.**

This year, SCP will release several additional resources that focus on how to address these challenges, examining the issue both from the perspective of different service lines and different stages in the patient journey, inside and outside of the hospital. The pressure to do better is immense—but so is the opportunity.

References:

1 "NAMCS/NHAMCS – Ambulatory Health Care Data Homepage" Centers for Disease Control and Prevention, 16 July 2021
2 Deloitte — "Viewing post-acute care in a new light: Strategies to drive value."
3 https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-post-acute-care-innovation-report.pdf
4 Journal of Post-Acute and Long-Term Care Medicine — "Hospital Readmission from Post-Acute Care Facilities: Risk Factors, Timing, and Outcomes, 20 December 2015
5 https://www.hcup-us.ahrq.gov/reports/statbriefs/sb199-Readmissions-Payer-Age.jsp
6 https://www.kff.org/health-costs/report/2021-employer-health-benefits-survey/ and https://www.kff.org/report-section/ehbs-2021-summary-of-findings/attachment/figure-a-38/
7 https://www.kff.org/health-costs/press-release/average-family-premiums-rose-4-this-year-to-top-22000/
8 https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/
9 https://www.hcup-us.ahrq.gov/reports/statbriefs/sb205-Hospital-Discharge-Postacute-Care.jsp
10 https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-post-acute-care-innovation-report.pdf