WHITEPAPER

How ACOs can Benefit from ED Optimization

The Centers for Medicare & Medicaid Services (CMS), together with the Office of the National Coordinator for Health Information Technology (ONC), has recently updated established standards[1] that electronic health records (EHRs) must meet in order to qualify for the Medicare Promoting Interoperability Program.

These standards seek to improve care collaboration by requiring Certified Electronic Health Record Technology (CEHRT) and include criteria for security, confidentiality, and interoperability.

With the CMS/ONC standards, health care providers need to be able to store data electronically in a structured format that allows care teams to easily retrieve and share appropriate patient data to improve overall patient care.

ACOs and Interoperability

For ACOs and other organizations with an emphasis on accountability and value-based care, meeting these regulations is key to ensuring patients are receiving the best care possible.

In addition, maintaining these CMS/ONC standards helps ensure that organizations are protected from unnecessary penalties in a value-based care program and are able to maintain a high quality of care through improved care collaboration.

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When navigating so many different care teams and providers, it can be difficult to know where to start care coordination efforts. CMS released a toolkit[2] to help ACOs care for the following five beneficiary groups:

- Patients who receive emergent care in the emergency department (ED)
- Patients who require treatment in a skilled nursing facility (SNF)
- Patients who have recently been discharged home after a hospital or ED visit
- Patients who have been diagnosed with a chronic condition
- Patients who have conditions affected by social determinants of health

Basics: What Is an ACO?

ACOs, or accountable care organizations, are a group of participants who assume collective responsibility for the care provided to a specific population, such as Medicare, Medicaid, or a commercial insurer.

In these groups, hospitals, health centers, primary care practices, and others work together to care for patients using a value-based care (VBC) model that compares the cost of service against traditional fee-for-service (FFS) rates.

Regardless of the beneficiary group, ED optimization can be the starting ground for helping these patients—especially those at high risk—experience streamlined care and better outcomes. As ACOs learn to optimize ED utilization and collaboration for these different core groups, patients will receive a better quality of care at a lower cost.

Caring for Patients Who Receive Emergent Care in the ED

Coordinating emergency care through established guidelines and shared histories sets the foundation for better long-term patient outcomes and fewer readmissions.

As the frontline of the healthcare world, the ED is often the first stop for patients at high risk with complex needs. In fact, the American College of Emergency Physicians (ACEP) describes the ED as the "safety net"[1] of the US healthcare system, serving three roles:

- Fulfilling the mandate of the Emergency Medical Treatment and Labor Act (EMTALA)
- Providing around-the-clock, unscheduled care
- Providing constant readiness for disasters and emerging pathogens

This makes the ED an integral part of improving the quality and coordination of care. And because 70 percent of hospital admissions are processed in the emergency department, collaborating with EDs to avoid unnecessary utilization can help save ACOs money.

Optimization Through Better Follow-up

Columbia Medical Associates (CMA), now a part of Kaiser Permanente, is a provider practice[3] in Washington participating in the MSSP program as an ACO. It turned to ED optimization to facilitate better care management and help meet patient needs.

CMA started by implementing care collaboration technology that notified primary care providers when a patient presented at the ED. Able to track their patients, staff could then support them through transitions of care post-discharge by setting follow-up appointments and providing education—through online resources and in-person consultations—on better avenues of care for patients who had presented unnecessarily to the ED. These care settings were also more equipped to help patients manage their care long-term.

With better patient tracking, the practice was able to help patients transitioning from the ED to post-acute care and prevent future avoidable ED use. After one year of collaboration, metrics showed:

- A 15 percent reduction in ED utilization
- A 7 percent reduction in avoidable ED admissions
- A 16 percent increase in patient satisfaction

Ultimately, these changes meant a $6.5 million reduction in care costs and lower patient copays.

Optimization Through Redirection

Patient redirection has helped providers inside and out of ACOs reduce unnecessary ED admissions and connect patients with better-suited, and more affordable, care upfront—before they're ever admitted for inpatient care.

ER is for Emergencies Outcomes

With Collective's platform, the ER for Emergencies program has been able to break down barriers between providers and streamline collaboration. In the first year, Medicaid ED costs in Washington state decreased by nearly $34 million, due to a reduction in the following:[16]

- *9.9% reduction* in overall ED Medicaid visits
- *10.7% reduction* in ED visits among frequent utilizers
- *14.2% reduction* in low-acuity ED visits
- *24% reduction* in narcotic prescriptions from the ED

Being able to send patients where they need to go starts with better care collaboration. Washington State Medicaid launched the "ER is for Emergencies"[4] program—powered by Collective Medical's care collaboration platform—designed to connect hospitals across the state to quickly identify patients with patterns of high utilization and determine the best way to get them appropriate care.

ACOs can collaborate on a smaller level by connecting hospitals and providers in and out of the ACO to help identify patients with patterns of high utilization and create care guidelines that direct them to the most appropriate source of care from the moment they present at the ED.

Optimization Through Better in-ED Care

One study[5] published by ACEP in conjunction with the Massachusetts General Hospital suggests that 42 to 100 percent of tests performed in the emergency department are repeated and unnecessary. This redundancy resulted in over $600K of unnecessary spending in one year for a sample of 200 patients. Looking at the hospital as a whole, this means hundreds of millions of dollars in unnecessary spending.

Optimizing ED workflows by integrating care guidelines and histories into patient care gives ED providers the information they need to help the patient—while reducing unnecessary testing. This not only lowers the cost of care for ACOs, but allows patients to receive more timely and efficient care, and lessens ED wait times so that more patients can receive care more quickly.

Caring for Patients Who Require Treatment in a Skilled Nursing Facility

In an ideal world, patients in the ED will have the opportunity to be placed in inpatient care before being discharged to a skilled nursing facility. However, occasionally a patient frequenting the ED with low acuity conditions may be redirected to a SNF for more appropriate care rather than being admitted to inpatient care. In these cases, optimizing ED practices to properly prepare both patients and providers for patient discharge can help ACOs improve those difficult ED to SNF care transitions for better overall outcomes.

Smooth transitions start with seamless communication. Just as an ED physician benefits from a patient history, when ED staff take the time to share key patient information with the SNFs and case managers who will be helping the patient post-discharge, the facility and staff can prepare appropriately before they receive the patient. This could mean providing a special room for patients who have behavioral health concerns and require a quieter location, or informing SNF staff of any triggers that could cause the patient to become aggressive or non-compliant.

With collaborative care networks like Collective Medical, ED physicians can send critical patient information to the appropriate skilled nursing facility, simplifying communication and giving the patient a better chance at a successful transition. Conversely, if the patient were to leave the SNF and return to the ED, ED physicians would quickly be able to see the patient's care history, including the SNF and associated case manager, and connect with them directly to determine the next best steps for care. This could mean redirecting the patient back to the SNF—avoiding costly readmissions—or admitting the patient for necessary acute care and coordinating with the SNF on appropriate care post-discharge.

Reducing Revenue Loss Through Improved Readmissions

Avoidable readmissions cost Medicare an average of $1 billion[6] a year. In reducing these readmissions through better ED-SNF collaboration, ACOs can avoid loss of money from unreimbursed care and qualify for certain "bonus" reimbursements from CMS by achieving top-notch readmissions scores.

Marquis/Consonus Company, a network of post-acute care providers, reduced readmissions 60 percent[7] across three facilities by collaborating with hospitals on patient readmissions. Using Collective's care collaboration platform, the facilities have real-time visibility into patient activity across care settings—including the ED—enabling timely follow up any time a patient is observed, admitted, transferred, or discharged. This in turn, has helped Marquis meet key CMS requirements and qualify for $115K in reimbursements.

Caring for Patients Who Have Been Discharged Home After a Hospital or ED Visit

More than 40 percent[8] of Medicare patients receive post-acute care post-hospital discharge, with 39 percent of those patients receiving home-based health care instead of receiving care in a SNF.

For ACOs looking to control care costs without compromising on patient outcomes, home healthcare can be an effective option—saving an average of $5,385[8] in care and $4,514 in Medicare payments per patient, compared to SNF care. But without the right safeguards in place, these savings can be forfeited to costly ED readmissions that could have been prevented.

Hospital to Home: Controlling Transitions of Care

With the financial penalties enforced by Medicare's Hospital Readmissions Reduction Program, many ACOs are scrambling to find ways to help patients post-discharge have a successful transition home.

Implementing better practices between ED and home through home healthcare can help these patients receive the rehabilitative and preventative care they need while minimizing hospital readmissions. According to one recent study[9], patients utilizing home health services within 14 days of hospital discharge are 25 percent less likely to be readmitted to the hospital within 30 days. In addition, for patients who go from acute care to post-acute facility care to a home health program have a reduced risk of hospital readmission.

Bon Secours Mercy Health (BSMH) is one of the largest Catholic healthcare systems in the US with a number of MSSP ACOs. To better care for its large patient population, BSMH relies on its strong home health care program, COPE, to help patients transition to home-based care smoothly while avoiding unnecessary hospital admissions and readmissions.

The program brings together physicians, social workers, nurse practitioners, registered nurses, dietitians, and pharmacists from across the medical neighborhood to collaborate on home-based care plans for patients. These plans are then shared through a common platform, allowing each key player access to a uniform plan of care.

By making home healthcare a collaborative effort, BSMH has been able to reduce readmission rates for high-risk serious illness patients by 23 percent. For patients with medium-risk, readmission rates were reduced by 27 percent.

Hospital to Home: Controlling Transitions of Care

Ideally, patients who are discharged from hospital to home won't have to return to the ED. However, one study conducted by the University of Rochester School of Nursing suggests that 11.5 percent[10] of patients admitted into a home healthcare program post-hospital discharge return to the hospital within 48 hours. With hospital readmissions costing more than $41 billion[11] a year, finding a better way to coordinate patient care between hospital and home is crucial to controlling healthcare costs for ACOs.

The CMS toolkit suggests stationing a case manager within the ED to help catch patients presenting at the hospital, intervene, and redirect them to the most appropriate care setting—before they're readmitted to the ED. This not only minimizes the high cost of readmissions but ensures that the patient is getting the best care possible at the right acuity level for his or her condition.

When a patient is readmitted to the hospital, optimizing that visit can help make sure the extra cost is not in vain. Letting home health providers know when their patients are in the ED allows case managers to reach out to and coordinate with ED staff for a smoother patient visit and eventual transition back home.

Housecall Providers[12], a CareOregon facility, understood this and had staff regularly call on patients to track them as they moved between hospitals. By tracking these patients, Housecall Providers was able to meet the established quality metrics set forth by Medicare's Independence at Home (IAH) home health program and provide quicker patient follow-up.

Still, the process of calling each hospital to try and find patients was tedious and time consuming.

Soon, case managers at Housecall Providers began using Collective's real-time notification technology to receive notifications about patient activity—including hospital visits. This not only allowed them to follow-up with their patient faster, but prevented patients from falling through the cracks if a case worker was not able to follow up with a hospital before the patient was discharged.

Housecall Provider Outcomes

With the notifications, patients received the follow-up care they needed post-readmission discharge more quickly, making it less likely that they would need to be readmitted in the future. This not only saved Housecall Providers from unnecessary spending, **but helped the organization meet key Medicare metrics and save Medicare $1.8 million in care costs.** Housecall Providers received 80 percent of those savings, totaling $1.2 million in its initial year.

Caring for Patients Who Have Been Diagnosed With a Chronic Condition

For those with chronic conditions, a visit to the ED can become routine. In 2017, nearly 60 percent[13] of all ED visits were for patients with one or more chronic conditions—resulting in $8.3 billion in spending. Of those visits, it's estimated that 4.3 million, or 18 percent, were avoidable.

Illnesses such as asthma, COPD, hypertension, heart failure, diabetes, and mental or behavioral health conditions can cause patients who don't know where to turn to seek treatment in the ED—when specialized treatment could have been given at a lower-acuity level. Maximizing what happens during an ED visit becomes key when connecting the patient with the most effective care for fewer readmissions later on.

In one Idaho-based ACO, an ED was experiencing a high-volume of patients with chronic conditions. Of these patients, many could have received the necessary treatment through a visit to a primary care provider or appropriate specialist.

Coordinating Better Outcomes

A patient with Crohn's disease was frequenting the ED with a bowel obstruction. Because she was in the ED multiple times a week, the ED physicians helped her schedule a colon resection. She had the surgery, but soon after was back in the ED again.

When ED physicians examined this woman's care history, they noticed a pattern of substance use as well. The next time the woman presented, they spoke with her about her use of narcotics, and explained that they wanted a way to treat her existing illnesses—without contributing to her addiction. The staff developed new care guidelines, and once off the narcotics, the woman was able to receive the care she needed and follow her prescribed post-op instructions.

To help reduce unnecessary ED utilization and better care for these patients, ED staff began using the Collective platform to track patient patterns and identify the real reasons these patients were returning to the hospital over and over again. Physicians then met monthly with local care providers, including primary, psychiatric, and EMS care teams to determine the best plan of action for helping these patients get the needed—and appropriate—care for their conditions.

The care guidelines were housed in the Collective platform and delivered in real time to providers when these patients presented at the ED. With a more complete knowledge of the patient needs, ED providers could refer these patients to the correct care avenues, improving outcomes and saving the ACO almost $1 million in care costs within the first eight months of implementation.

Caring for Patients Who Have Conditions Affected by Social Determinants of Health

The Center for Disease Control and Prevention defines social determinants of health (SDOH) as conditions in the places where people live, work, and play that affect health. Poverty, lack of education, unstable housing, and other SDOH are estimated to be responsible for up to 80 percent[14] of a patient's health outcome.

Still, these factors are largely overlooked in the ED because they can be difficult to discern when a provider is unfamiliar with the patient. With the ED providing more than 50 percent of acute care for uninsured populations, ED physicians need a way to better identify and address SDOH for their patients. More complete care histories can provide stronger insight into ED utilization patterns that could give way to possible SDOH. The following table shows possible scenarios where ED physicians can use patient histories to identify and help address hidden SDOH:

Homelessness or unstable living conditions

A patient regularly presents in EDs with complaints that require workup, but the patient is content once roomed.

Provide a list of shelters or other housing resources with the discharge instructions, and watch patient for signs of disease that have homelessness as a main risk factor.

Food insecurity, low income, or econonic insecurity

A patient presents frequently with minor complaints and requests multiple servings of food for him/herself and family during the visit.

Refer to a social worker for supplemental nurtition assistance programs, provide a list of food banks with discharge instructions, and prescribe (if needed) generic versions of medication and prescriptions that are provided at low cost.

Low literacy, lack of education

A patient fails to follow discharge instructions and returns to the hospital with complications that could have been prevented by following care instructions.

Ensure discharge instructions are written at a low literacy level, and verbally talk through discharge instructions. Ask questions for comprehension and have the patient reiterate the instructions to you before leaving the hospital.

Abusive home life, unsafe neighborhood, other exposure to violence, and possible mental illness

A patient presents at the hospital with a knife wound. The patient history shows similar visits with wounds that caused both severe internal and external bleeding.

Work with social and community resources to report violence and implement necessary interventions. Connect with suicide prevention organizations (if neccesary) and assign to case manager for further behavioral care.

One health plan in Washington worked to better identify social determinants of health through collaborating care between hospital and home through the use of a case manager.

Knowing that case managers hold a unique role—working closely with patients and functioning as the eyes and ears of physicians into SDOH—the plan relied on case managers to help address patient SDOH and improve patient outcomes. Case managers worked in partnership with housing authorities to provide affordable housing options for those with low incomes, and shelter for those who were homeless. In addition, they helped qualified patients apply for Supplemental Security Income and worked with community immigration resources to establish care opportunities for those unable or afraid to receive appropriate healthcare due to lack of proper immigration documentation, insurance, or an inability to speak the language.

When patients are able to receive the food, shelter, protection, and healthcare they need, their reliance on the ED is reduced, care costs are lowered, and patient outcomes improve. By optimizing ED communication within the ACO, ED physicians and staff will be able to not only identify potential SDOH through access to patient histories but coordinate with the appropriate case manager to help address these SDOH.

About Collective Medical

Collective Medical provides the nation's largest and most effective network for care collaboration. Our risk-adjusted event notification and care collaboration platform spans across all points of care—including emergency departments, hospitals, payers, behavioral and physical ambulatory, and post-acute settings. This technology integrates seamlessly with existing workflows and allows providers to identify and support at-risk patients in real time—avoiding preventable admissions and utilization and providing better care.

Learn more at collectivemedical.com

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