



# HEALTH POLICY ISSUE BRIEF

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## Recommendations for Acute Care Delivery and Payment Reform

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## **EXECUTIVE SUMMARY**

Several factors are driving health care providers and facilities, including acute care providers to shift away from prevalent fee-for-service (FFS) payments to value based payment models. Alternate payment models (APMs) are designed to support services that are not traditionally covered under FFS to lead to better coordination of care and higher value care delivery. A move from FFS to APMs requires careful consideration and promulgation of disruptive reforms that encourage more efficient use of existing services, better care coordination, and more effective and efficient acute care while preserving the core functions that acute care facilities provide in their communities. Examples of short-term delivery reforms that can support this transition are creating care plans for high risk patients to help address underlying needs and interoperable health technology to query health records during an acute care episode.

To support a movement away from FFS, a potential range of APMs can be utilized such as partially capitated payments, bundled payment for episodes of acute care, or global budgets with full capitation. These payments require that providers and organizations take on more accountability for the outcomes of their patients, giving them greater flexibility and the potential for higher net revenues from delivering care more efficiently, as well as financial risk if quality metrics are not met and overall cost growth is not slowed. In this paper, we describe several recommendations for moving away from FFS to APMs in acute and emergency care, specifically focused on increasing information sharing, changing payment to incentivize the right delivery reform, and patient engagement. Each category of recommendations presents a long term vision, with several short term implementation steps and examples to achieve this vision.

## **PART I: INTRODUCTION AND OVERVIEW**

The acute care system provides a broad range of unscheduled, urgent medical care for the ill and injured. Demands for acute care are borne out of the presence of patient pain and anxiety, and the need for immediate relief following an acute illness, exacerbation of a chronic disease, or trauma or disaster event. Acute care can be delivered in doctors' offices, community-health centers, hospital-based and freestanding emergency departments (EDs), hospitals, urgent care centers, and retail clinics, as well as through new methods such as telemedicine. Acute care is common: accounting for more than one third of all patient encounters<sup>1</sup>. [1] EDs admitted over 80% of unscheduled hospital admissions in 2009, an increase from 65% in 2000. [2] In addition, a large portion of U.S. health spending is attributed to acute care, with emergency medicine services accounting for 6% of Medicare Part B spending, which translates into \$2.3 billion dollars a year [3].

The vast majority of acute care payments occur on a fee-for-service (FFS) basis, where each service is paid individually, thus more volume or intensity leads to more revenue. Moreover, FFS does not currently reimburse many services that can improve health such as prevention, patient education and care coordination. New payment models are moving away from the FFS model with the aim to change the incentives for providers and facilities that deliver acute care services and create more higher-value approaches to improve the continuum of care.

In January 2015, the Department of Health and Human Services (HHS) announced the goal to move away from volume-based reimbursement toward value- and quality-based reimbursement, with a goal of tying 30% of traditional Medicare payments to alternative payment models (APMs) by the end of 2016, moving to 50% of payments by the close of 2018. [4] This goal was reinforced by Congress with the passage of the "Medicare Access and CHIP Reauthorization Act of 2015," which repealed the sustainable growth rate formula for physician payments, instead statutorily linking payments to performance measures and providing incentives for participation in APMs through the Merit-based Incentive Payment System (MIPS). [5]

Current APMs largely fail to address acute care services and tend to focus on improving management of chronic conditions to avoid the need for acute care altogether. Such initiatives like patient-centered medical homes (PCMH) and Accountable Care Organizations (ACOs) focus on primary care providers (PCP) or non-ED specialty providers who manage chronic diseases and population health. For the most part, these clinics and ACO arrangements have not actively engaged acute care providers. However, the acute care system, particularly EDs are a critical component of the care continuum that provide unique functions such as delivering around-the-clock care<sup>2</sup>, critical care, effective disaster response, in addition to complying with the federal mandate to see all regardless of the ability to pay. Thus, developing APMs for acute care requires a different approach than other medical specialties and settings. Payment models and delivery reforms must include and engage acute care providers and align with providers across the care continuum to develop synergistic models.

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<sup>1</sup> Pitts et al used two data sets to define acute care: National Ambulatory Medical Care Survey (NAMCS) and two subsamples of the National Hospital Ambulatory Medical Care Survey (NHAMCS) — outpatient department and emergency department. In NAMCS and the outpatient subsample of NHAMCS, visits were classified as acute if the major reason for this visit was "acute" or "chronic disease flare-up" or if "episode of care" was "initial". All visits in the emergency department NHAMCS subsample were considered acute.

<sup>2</sup> This includes seven day a week availability, as well as immediate access to specialty care services such as radiology and surgeons.

The goal of this paper is to describe what the ideal acute care system might look like and the specific, actionable next steps to achieve this vision. With input from our expert stakeholders (including participants from the American College of Emergency Physicians (ACEP) Quality and Payment Committee work group, completion of case studies[6-8], convening of expert roundtable, and other activities[9-11]) we present three sets of recommendations around three key areas of reform: critical information sharing, acute care delivery and payment reform, and patient engagement.

## PART II: VISION OF THE IDEAL SYSTEM

Ideally, we want to reduce inefficient use of acute care in a way that enables acute care providers to focus on their essential roles and provide excellent care to the most critical and complex ill and injured patients. The ideal system is committed to patient-centered care that is of the highest value to the patient and community. We advocate for disruptive but feasible reforms that encourage more efficient use of existing services, better care coordination, and more effective and efficient care for patients who are seen in facilities that deliver acute care, while preserving the core functions that acute care facilities provide in their communities.

There are three main ways to reduce acute care costs while improving outcomes:

1. Prevent avoidable acute health problems and the associated care from happening in the first place.
2. Create and expand patient-centered ways to deliver acute care.
3. Improve the efficiency of the acute care system itself through improvements that standardize the approaches to common conditions, and expand the role of acute care into new areas, specifically helping to manage demand and to better coordinate care with the patient’s personal physicians.

Table 1 illustrates some examples of interventions at in each of the above three categories that have shown some evidence of success.

**Table 1. Successful Strategies for Acute Care Delivery Innovation**

REFORM STRATEGIES	EXAMPLES
Prevent acute health problems	<ul style="list-style-type: none"> <li>• <b>Implement disease management programs.</b> Wellness programs, similar to those sponsored by payers and employers, decrease risk of developing costly and potentially preventable diseases. Removing volume from payments in primary care settings allow for increased clinical autonomy to provide valuable preventive services, like environmental remediation for asthmatics and smartphone technology with health applications for patients at high risk for diabetes.</li> <li>• <b>Identify frequent users of health care and create care plans.</b> Address underlying problems such as psychosocial needs and substance use.</li> <li>• <b>Focus on transitions of care.</b> Care managers work closely with acute care physicians to develop transition and follow-up processes to reduce future avoidable utilization and improve provider communication to improve health outcomes.</li> </ul>
Expand access to acute care services	<ul style="list-style-type: none"> <li>• <b>Offer patient-centered access options and extended office hours.</b> Continue to expand options like urgent care centers, retail clinics, expanded clinic hours, and telemedicine. PCMH-type settings offer extended office hours for increased primary care access.</li> <li>• <b>Operate 24/7 Call line.</b> Kaiser Permanente (KP) Southern California has a 24/7 call line, KP On Call, to reduce out-of-plan and ED utilization through advice for home management and same-day or next-day appointments.</li> <li>• <b>Educate all patients about appropriate use of acute care services.</b> Brochures are distributed and</li> </ul>

educational posters displayed that help patients choose the best place to go for health care and give providers a starting point for conversations.

Improved efficiency in the ED and other acute care settings

- **Incent patient callback program.** ED physicians at University of Maryland Upper Chesapeake Health System receive payments to call at least two of their discharged patients per shift to assist with follow-up and identify any barriers to improve risk management and patient safety.
- **Use comprehensive care clinic.** Targeted to complex, comorbid patients without a PCP to develop plans to assist patients with finding a primary care physician, and smoothly transitions to the outpatient care environment.
- **Utilize interoperable health information technology.** For example, Chesapeake Regional Information System for our Patients (CRISP), Maryland’s statewide health information exchange that allows ED physicians to query any patient to obtain records.
- **Create standardized workflow models.** Allows for rapid, accurate, and cost-effective diagnosis and service priorities, such as the University of Colorado’s clinical care pathway bundle.
- **Implement narcotic guidelines.** Washington States guidelines aim to reduce narcotic seeking behaviors through 17 recommendations and implemented a prescription monitoring program to help prevent drug seeking behavior.

Some of the examples in Table 1 may only require a simple reallocation of staff and resources. Others require some significant upfront capital infrastructure investment in staff, technology, facilities, and equipment, along with ongoing operational costs that are not currently reimbursed under FFS. A spectrum of payment reforms can help support both short-term investments, such as callback programs and care plans, as well as long-term transformations such as integrated health IT systems or establishing new healthcare clinics.

Emerging delivery and payment models such as PCMHs, ACOs, bundled payments, and capitated per-member, per-month payments (PMPM) aim to reduce the use of acute care services or shift the delivery of acute services from EDs to physician’s offices. As delivery reforms occurring outside of the acute care landscape continue to indirectly impact the demand and volume of acute care, non-volume based APMs will be critical in ensuring access to acute care services. With critical safety net and public health implications at stake, payment reforms affecting acute care must be carefully considered. For these to be successful, it is critical for acute care providers to be incorporated into the evolving population healthcare delivery infrastructure.

The challenge is that acute care does not neatly fit into today’s existing APMs. Thus, policy, payer, and provider leadership must be creative and thoughtful when developing and implementing new payment structures so that necessary and critical services are not diminished. However, existing APMs can help inform the development of acute care APMs, such as:

- **FFS with links to quality.** These supplemental payments can support quality metric reporting or reimburse for important services such as call-back programs or patient care-plan development. We suggest that these be a fixed payment, not a multiplier on fees (as this could increase FFS incentives and not offset the intended effect of the reform[12]). For example, physicians and hospitals could receive a bonus payment equal to the savings realized from avoiding costly hospitalizations or ED avoidable utilization.
- **Partial capitated payments.** Small per-person payments to a facility could pay for care coordination or support practice transformation. These payments could also be put towards hiring a social worker, case manager, or community health worker to support acute care physicians in coordination and patient education. An acute care facility could also receive a partially capitated payment to cover essential services to provide efficient care.

- **Bundled payment for episodes of acute care.** Providers or hospitals would receive a fixed reimbursement over a limited time period that would support a set of services for an acute disease presentation, such as congestive heart failure, chest pain, syncope, cellulitis, or acute asthma exacerbation.
- **Global budgets or full capitation.** This payment, possibly in the form of a PMPM, actually shifts provider revenue away from service-based reimbursement to person-based reimbursement. The provider receives a risk-adjusted fixed payment for a population of patients over a defined period. The acute care provider could be eligible for a portion of this payment to provide fully integrated acute care in partnership with other patient providers.

APMs have the promise to provide greater clinical autonomy, flexibility to provide services not reimbursed under FFS, and efficiency by better matching clinical and non-clinical tasks with the needed level of expertise. As payments shift from FFS towards bundled and capitated payments, organizations will be required to take on more accountability for the outcomes of their patients. This accountability will be offset with the potential for higher payments, as well as financial risk if quality outcomes and metrics are not met and overall cost growth is not slowed.

## PART III: RECOMMENDATIONS

To move from today's FFS system to novel APMs that support integration and delivery reform principles there will need to be a deliberate effort to break down traditional care silos. This will require developing local, regional, and state capacity to transform capabilities to be nimble, innovative and employ best practices to coordinate care and share information. A value-oriented acute care system can help ensure that patients are seamlessly transitioned back to their PCP after the acute care encounter or help those without a regular source of care by providing care coordination and resources to access the healthcare system beyond the ED.

In the recommendations that follow, we propose practical steps to achieve this goal by focusing on three categories: 1) critical information sharing, 2) delivery and payment reform; and 3) patient engagement. Each category of recommendations presents a long term vision, with several short term implementation steps to achieve this vision, with examples and geared to a specific stakeholder.

### Critical Information Sharing

**LONG-TERM VISION:** Health information technology (health IT) in acute care will align with Office of the National Coordinator's (ONC) broader goals of a "strong, flexible health IT ecosystem that can appropriately support transparency and decision-making, reduce redundancy, inform payment reform, and help to transform care into a model that enhances access and addresses health beyond the confines of the health care system." [13] Broad adoption of full health IT interoperability across providers and settings will be required to promote more personalized and safe care in acute care settings. Acute care physicians avoid duplicate care resulting in unnecessary resource use and have a comprehensive understanding of prior visits, testing, medications, procedures, and diagnoses. Health IT integration allows for complete integration of longitudinal care information. Acute care providers (and all treating physicians) have accurate and timely data in order to make clinical care decisions. Clinical data is accessible to all members of the clinical care team, especially primary care providers regarding patient unscheduled acute care visits. Information is communicated in an effective, easy-to-use manner (i.e. facilitated and displayed in a useful way). The electronic health record (EHR) is patient centered and portable. Moreover, payers work with governmental agencies to promote interoperability similar to the



adoption of health IT (with the understanding that these expenses have a long return on investment for both payers and to the health care system at large).

1. *Create a patient-level minimum essential dataset which is available and accessible to all providers.* This patient-centered minimum data set would be a first step toward interoperability between regional hospitals, clinics, and individual healthcare providers — essential to provide high quality acute care services. Information should include a basic problem list, current medications, allergies, test results, and recent health care encounters (visit reason and providers). This information could be updated by acute care and primary care providers via an interoperable EHR or accessible registry. This would be available to every physician who cares for patients in both hospital and ambulatory acute care settings. Incentives to facilities and providers to participate should be put in place as part of Meaningful Use Stage 2 and 3 and Merit-Based Incentive Payment System (MIPS). Valid process measures should be utilized to ensure vendors are working with local health entities to build the necessary interoperability. This minimum data set is critical not only to improve health care outcomes, but to incent the establishment of critical infrastructure from which future episode of acute care payments could be based. A potential hospital quality process measure could be validation if information was successfully received by a provider from a regional health insurance exchange.

Example: Washington State’s Emergency Department Information Exchange has three mandatory data elements: where was the patient last seen, chief complaint, and what services were performed. These have proven to be very valuable to help ED physicians provide better care in Washington State.[14] In another example, researchers identified seven domains that were essential in a disaster or public health emergency: identification, emergency contact, health care contact, health profile, past medical history, medication, major allergies/diet restrictions, and family information.[15] Colorado’s Regional Information Organizations (RIOs) have used legal contracting agreements to aid in the regulatory barriers around the Health Insurance Portability and Accountability Act (HIPAA). In another example, an AMA report suggested that a minimum data set would be included on a transportable device that could then be given to healthcare workers such as a Health Security Card (HSC), a credit card-sized device with a built-in chip that contains important personal health information. These cards can then be read via a handheld device. Disaster scenarios found that these cards allowed for faster triage and more effective utilization of resources. [16]

Who: CMS or ONC [or legislative action from Congress] to hospitals, for example through promulgating practical use-case electronic data standards and linking the reliable provision of such information to quality-related payments in MIPS or APMs.

2. *Partner with other providers and facilities to ensure interoperability of more detailed health information across communities.* Interoperable health information technology is vital to acute and non-acute providers’ ability to deliver cost-conscious care. While achieving the minimum essential data set is a good first step, having an expanded dataset with additional information would be more helpful and move the most clinically relevant data for acute care encounters into the care workflow. For high-cost users or patients with complicated illness, this information could also include physician notes, advanced directives, and a care plan that is designed by the patient’s personal physician and/or health system. This information should be accessible to the patient as well. Similar to the previous recommendation, financial penalties and rewards could be tied into Meaningful Use Stage 3 and MIPS as evidenced by the development of a clear and specific use case. This initiative should garner bipartisan support to improve quality of care, avoid unnecessary health care expenses, and benefit the patient. In addition, as prehospital care is part of the emergency care system and

therefore part of the healthcare system, the datasets linking pre-hospital care with hospital-based care should be integrated. HHS should work with the Department of Transportation to link the National EMS Information System (NEMIS) and the HHS data sets to better inform patient care and understand the continuum of care—from point of injury or illness till disposition. This will optimize outcomes, decrease costs, and increase value for the entire emergency care system.

Example: Maryland hospitals and ED's participate in Chesapeake Regional Information System for our Patients (CRISP), a statewide information system that provides easy access to information on prior visits and test results.[6] A second example is the Kaiser Permanente EHR, HealthConnect, which is accessible by every medical facility and provider in the Kaiser Permanente system. All KP California member's complete medical records are available for review by non-Kaiser Emergency Departments, 24 hour hours a day, by calling the Emergency Prospective Review Program.[17]

Who: HHS, hospitals, and providers

## Delivery and Payment Reform

**LONG-TERM VISION:** Emergency physicians and acute care specialists are able to coordinate care smoothly and quickly at the time when a patient is in acute need or crisis. Patient-centered systems are in place across the continuum of care to ensure that patients have their needs met. Care is optimized using care redesign strategies such as demand management, improved access for high-cost frequent users, and more longitudinal acute care through call-back systems. Facilities and providers are more effective in managing patients across time and space, rather than just focusing on a single acute care encounter. Payment is aligned with this care: providers and hospitals should be accountable for health outcomes of a population as payments are shifted away from FFS. Robust quality metrics tie efficiency and outcomes to financial incentives.

1. *Develop and test acute care specific payment model pilots through the Center for Medicare and Medicaid Innovation (CMMI) and private payer initiatives.* The testing of APMs should focus on delivery efficiencies in the acute care setting. The models should compensate and reward providers for the value they provide through the new and unmeasured services and delivery efficiencies, as well as take into account the time of day and day of week in payment differentials. CMMI should develop regionalized models of emergency care that includes the prehospital component of care, learning from the lessons of the department of Defense from the last decade. [18] Regionalized accountability among Emergency Medical Services (EMS), hospitals, and providers will achieve the optimal outcomes for patients suffering emergent conditions and allow non-emergent patients the opportunity to receive care in less expensive, appropriate settings. Value should be tracked through transparent, meaningful, and outcome-oriented quality measures, allowing providers to share in savings they can achieve across the continuum of care—prevention, management, and acute exacerbation. For example, acute care providers may need to act in a team-based consulting role to reduce future utilization of frequent users and payment should reflect that change. A variety of models, each shifting more payment toward population based health payments, should be considered.

Who: An active collaboration between CMS, private payers, hospitals, health systems, and acute care physicians and other providers

- a. **Paying for add-on services that improve value in acute care.** In the acute care setting, additional services such as care coordination with primary care/specialists, social work, case management, mental health, and palliative care may enhance downstream value greatly. A model could test a FFS modifier for specific add-on services. For example, emergency

physicians could be provided an acute care coordination Current Procedural Terminology (CPT) code, with incentives and accountability for keeping patients out of the hospital.

Example: United Healthcare’s High-Risk Case Management program has nurses who regularly call Medicare Advantage members who are at high risk of hospitalization. The program arranges for medical care, transportation, and assists the patient with a variety of social and environmental issues.[19] A similar program could be extended to acute care settings where considerable time investment is required to coordinate care.

- b. **Development and promulgation of criteria for a “Connected or Enhanced-ED” or acute episodic care facility (i.e. Urgent Care Center).** This model might use additional payments, like a small add-on capitated rate for the development of specific capacities and capabilities. These could include programs such as frequent user programs, call-back programs, clinical pathways, or other population health management services such as palliative care services. Over time, the payment might also be tied to achieving better population health results. These payments could be aligned with a “surgical home,” a concept similar to medical homes pushed by the American Nurse Association and American Society of Anesthesiologist that could promote shared decision making and continuity of care in a surgical setting. [20]

Example: One example of an ED that has developed these capacities and capabilities is the University of Maryland Upper Chesapeake Health System comprehensive care clinic that targets patients without a PCP, without insurance, or with high-risk follow-up that may cause patients (that was driven by payment reform in the state). ED physicians refer patients to the clinic for a visit or consultation. [6] Alternatively, the pilot could directly fund the development and sustainment of specific value-added systems.

- c. **Episodes of care for acute, unscheduled care.** This model would provide a single payment for an episodic visit, and focus on disease entities where efficiencies can be achieved through clinical pathways, such as pneumonia, urinary tract infection, cellulitis, back pain, and hyperglycemia. This pilot could also provide the guidance and evidence needed around patient attribution and payment distribution where there are multiple providers involved in the bundle (e.g. how acute care fits into surgical bundles).

Example: Arkansas has implemented a number of acute episodic bundles, including one for upper respiratory infection (non-specific, acute pharyngitis, and acute sinusitis).[21] From the initial visit at the physician’s office, clinic, ED, or other in-person setting, all services (labs, imaging, and medications) are included in a single retrospective bundled payment.

- d. **Global budgets with cross-subsidization between providers and facilities.** In this model, a group of providers and associated facilities would receive a global budget for a population, where each would share in the upside and (over time) the downside of the overall budget, using a shared savings model. Variables of interest would be patient attribution and payment distribution among providers, with special attention to acute care. In conjunction with the payment model, there would be shared governance to support coordination of care, for example through board memberships or joint management processes, and cross-subsidization is required between the providers and the facility. This would aim to support features of integrated care models like Kaiser outside of fully integrated systems.

Example: Maryland hospitals participate in the Global Budget Revenue (GBR) model, an all payer model that provides a fixed payment to hospitals for all hospital-based outpatient and inpatient care regardless of the number of patients treated or services

provided. In addition, hospitals must meet set targets for quality, safety, and patient experience. [6] Another example of integrated care is the Camden Coalition ACO in New Jersey that designed a case management intervention to address the needs of super users outside of the ED setting that saw significant cost savings while providing higher-quality care. [22]

2. *Expanding quality measure development related to effective acute care.* Cost and quality measures are increasingly utilized to adjust payments to providers, track the progress of innovation, and guide provider quality improvement. Currently, timeliness of care, a central domain to high quality care as defined by the Institute of Medicine, has been the primary focus of ED quality of care measures. While delivering timely care is important, it should not be the sole measure of care quality.[23] Measure developers should focus on and support the development of a broad variety of robust measures for acute care that reflect its unique features across all dimensions of the national quality strategy. Measures that should be included are patient access and safety; patient and family experience; whether the right care was delivered; how well coordinated it was; the outcomes of care delivered for specific conditions; measures of equity and disparities; and resource utilization measures that are actionable by providers. Measures should also capture situations where shared accountability with the primary care or other specialty provider are relevant as a means to incent providers to work together.

Example: Measures currently exist for conditions such as acute myocardial infarction, stroke, and sepsis. Additional measures need to be developed for both critical and non-critical conditions; whether care was coordinated (i.e. was the primary care provider notified and updated about the care delivered in the ED); efficient utilization of high-cost testing or hospital admission/ observation rates; and rates of misdiagnosis (eg. missed acute coronary syndrome, fractures, or patients with significant adverse events after post ED discharge). A measure to capitalize on the concept of shared accountability could address whether the rate of timely and successful handoffs from the ED to another provider (i.e. to an outpatient provider for a patient with a transient ischemic attack).

Who: CMS, NQF, private payers with input from emergency physician groups such as ACEP, or other physician and patient stakeholder groups

3. *Develop patient-centered systems to manage care across the continuum.* As acute care payments move away from visit and volume based FFS, the new payment flexibility should be used to improve management of patient demand for acute care through telemedicine, telephone, video chat, or asynchronous forms of communication such as text based follow up. Further, acute care physicians and specialists should develop and implement acute care specific pathways and protocols within and across settings. Standard pathways of care for patients with common conditions will improve efficiency by economically utilizing all team-members, improving outcomes, and decreasing workload. In addition, standardized pathways can be designed to be cost-effective, relying on rapid follow-up care or observation unit care rather than hospitalization for patients with moderately complex conditions (e.g. transient ischemic attack). As protocols are implemented providers, facilities, and organizations will need to utilize internal quality and scoring metrics to assess safety and other aspects of performance. These patient-centered systems could be financed through bonuses for additional capacity, or for portions of a PMPM to be shared with acute care physicians (see recommendation 1 for testing these financing mechanisms).

Example: The Kaiser Permanente (KP) medical group has a number of critical care pathways that allow clinicians to practice to the top of their license—spending more time with complicated patients whose presentation is difficult or otherwise requires greater attention. KP OnCall

provides advice to patients about where to seek medical care when they are ill and injured and is available 24/7, including access to patient records. [17] A second example is Upper Chesapeake hospital in Maryland that has developed a call-back system where ED physicians receive payment for calling back two patients per shift to assess whether the patient is recovering and to address outstanding clinical issues. In addition, Upper Chesapeake has a low-risk chest pain protocol that shunts eligible patients to an outpatient exercise treadmill stress tests instead of an observation or inpatient stay.[6]

Who: Hospitals, providers, public and private payers with input from patients

4. *Actively engage acute and emergency care providers in delivery and payment reform taskforces to enhance value.* Acute and emergency care providers should actively participate in delivery system improvements, and should be open to different ways of delivering care that may be more efficient, effective, and more patient-centered. National and state medical societies can play a critical role in coordinating efforts and disseminating information. Critical to these collaborations and the success of acute care programs is for parties to consider the entire continuum of care—prevention, management, and acute exacerbations—to work systematically with data to evaluate the impact of the intervention. This is especially important with respect to rural providers that may be the only provider for significant distances; large urban areas that may face large scale public health or disaster issues; and safety net providers who provide critical resources to those who have no other option for care.

Example: Many states have created health-professional advisory boards to assist government officials in implementing reforms that are conscious of possible disruptions in order to minimize unintended consequences. The Washington State American College of Emergency Physicians (WA-ACEP), the Washington State Medical Association, and the Washington State Hospital Association developed the “ER is for Emergencies” plan to better manage ED services and reduce over-utilization without dangerous denials of coverage and care.[24] The national ACEP organization also engages physicians and policy makers at the federal level.

Who: Acute and emergency physicians in collaboration with other partners

## Patient Engagement

**LONG-TERM VISION:** Patients have access to information about self-management of acute and chronic medical conditions, and specific information about when to seek medical care. When there are questions, health systems help by creating patient-centered advice lines staffed by medical personnel who have access to their information. With these tools, patients can be more confident and effective in managing their own health problems. The resulting reduced burden of acute care enables all patients who cannot manage their own conditions to access acute care at all times of the day or night, and providers deliver the most personalized care by having access to their records, prior test results, and care plans. For patient with chronic ongoing issues, there are services that actively manage ongoing needs that are integrated into the acute care system. For example, incorporating a community health worker or patient navigator into the care team can help extend the major role EDs play in connecting patients with community resources. Ideally in the long term, out-of-pocket costs (this includes costs related to high deductible insurance plans as well as out of network care) are fully transparent to both providers and patients. Providers can present price information, as well as quality data, so that patients can make informed decisions about their care plan and can predict the personal financial impact of these decisions, and can share in the savings from using less costly approaches to meet their health needs.

1. *Expand use of effective educational resources and tools for patient self-management.* Acute care providers should support and encourage effective patient decision-making about where and when to seek care. Educational tools for common acute care problems they might face and how to handle them should support these activities. While these approaches will be encouraged by provider payment reform, patient shared savings arrangements can be developed to support acute care providers to engage patients in prevention activities to prevent acute illness and chronic disease exacerbations.

Examples: Primary care practices in the Mayo Clinic provided parents with standardized education and prescribed pain-relieving ear drops to parents, with specific guidance on recognizing signs of serious illness. This intervention reduced ED visits for ear pain by 80%, urgent care visits by 40%, and primary care visits by 28%. There were no cases of serious complications of ear infections (mastoiditis) in this population.[25] As another example, Castlight Health’s platform that allows patients to see quality and costs data about providers in a consumer-friendly, personalized way. Employers have used these tools to enable patients to share in the savings when they use more efficient providers – and conversely, patients pay more when they use more costly ones. [26]

Who: CMS and private payers

2. *Support increased, around the clock access to acute care for patients.* Patients need the convenience of solving their health problem immediately. An APM could support expanded access to additional low-cost, acute care settings outside of hospitals either through telemedicine, open access to clinic appointments, extended hours, or urgent care centers. These services could enhance the patient experience and shift patients to lower cost, more longitudinally focused settings. To encourage patients to use these services, payers should design patient copays that encourage use of these alternatives (ensuring that there is access and transparency to the alternatives first).

Example: Evolution Health in Dallas utilizes a medical command center that provides 24/7 clinical support, including two-way video and remote vital sign monitoring services that relies heavily on the skill sets of non-physicians such as community-based paramedic and emergency medical technicians.[27] L.A. Care Health plan in Los Angeles County features an e-consulting program that streamlines and triages the referral process from primary care to specialty providers. This alleviates patients going to the ED to bypass long waits for specialty appointments.[28] Additionally, “treat and release” support may allow emergency medical services (EMS) to manage 911 calls in ways other than a transport to the ED. Researchers estimate about 34% of 911 calls may be managed outside of the ED, with a potential estimated savings of \$283-\$560 million per year. [29]

Who: CMS and private payers

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