The Acute Care Management Model

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Disclosures

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- Board of Directors, Emergency Medicine Foundation
- Editorial Board, Annals of Emergency Medicine
- Health Policy Advisor, Emergency Medicine Health Policy Scholar Program

** Mention of any private sector products are not an endorsement**
Mission: To lead the US Government’s efforts to create an emergency care system that is:

1. patient- and community-centered,
2. integrated into the broader healthcare system,
3. high quality, and
4. prepared to respond in times of public health emergencies.
• …establish a (new) lead agency for emergency and trauma care
• …primary programmatic responsibility for the full continuum of emergency medical services and emergency and trauma care for adults and children
• …including medical 9-1-1 and emergency medical dispatch, prehospital EMS, and hospital based emergency and trauma care
• …develop evidence-based categorization systems for EMS, emergency departments, and trauma centers based on … capabilities
• …establish a demonstration program … to promote coordinated, regionalized, and accountable emergency care systems…
Emergency Care Coordination Center (ECCC) 2009

IOM Reports
2006

HSPD-21
2007

• USG wide advisory panel

• Purpose:
  – Identify national issues related to emergent & acute care
  – Identify opportunities for synergistic efforts across the USG to improve emergent & acute care
  – Serve as an advisory board to the ECCC

• Members include representatives with emergency care portfolios from:
  – US Department of Defense
  – US Department of Health and Human Services
    • HRSA, CMS, NIH, SAMHSA, AHRQ, ONC, OASH
  – US Department of Homeland Security
  – US Department of Transportation
  – US Department of Veterans Affairs
Reimagining emergency medicine: How to integrate care for the acutely ill and injured

Full Event
Mark B. McClellan and Jesse M. Pines

Reimagining emergency medicine: How to integrate care for the acutely ill and injured - Part 2
Mark B. McClellan and Jesse M. Pines
Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

Sylvia M. Burwell
Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

- **Historical Performance**
  - **2011**: 0% FFS linked to quality, 68% All Medicare FFS, 0% Alternative payment models
  - **2014**: ~20% FFS linked to quality, >80% All Medicare FFS, 0% Alternative payment models
  - **2016**: 30% FFS linked to quality, 85% All Medicare FFS, 0% Alternative payment models
  - **2018**: 50% FFS linked to quality, 90% All Medicare FFS, 0% Alternative payment models

- **Goals**
  - **2016**: 0% FFS linked to quality, 50% All Medicare FFS, 0% Alternative payment models
  - **2018**: 0% FFS linked to quality, 90% All Medicare FFS, 0% Alternative payment models
# Payment Taxonomy Framework

<table>
<thead>
<tr>
<th>Description</th>
<th>Category 1: Fee for Service—No Link to Quality</th>
<th>Category 2: Fee for Service—Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
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<tbody>
<tr>
<td><strong>Payments are based on volume of services and not linked to quality or efficiency</strong></td>
<td>Payments are based on volume of services and not linked to quality or efficiency.</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery.</td>
<td>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk.</td>
<td>Payment is not directly triggered by service delivery, so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. &gt;1 yr).</td>
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<tr>
<th>Medicare FFS</th>
<th>• Limited in Medicare fee-for-service</th>
<th>• Hospital value-based purchasing</th>
<th>• Accountable care organizations</th>
<th>• Eligible Pioneer accountable care organizations in years 3-5</th>
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<tbody>
<tr>
<td>• Majority of Medicare payments now are linked to quality</td>
<td>• Physician Value-Based Modifier</td>
<td>• Medical homes</td>
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<td></td>
<td>• Readmissions/Hospital Acquired Condition Reduction Program</td>
<td>• Bundled payments</td>
<td>• Comprehensive primary care initiative</td>
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<td>• Comprehensive ESRD</td>
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<td>• Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
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Patient Prioritization in Seeking Sick Care

- **Acuity/Severity/Concern**
- **Cost and Convenience**
- **Capabilities and Quality (Outcomes/Reputation)**
Increasing Transparency of Hospital Acute Care Capabilities

Solicitation Number: 14-100-SOL-00011
Agency: Department of Health and Human Services
Office: Office of the Secretary
Location: Acquisitions Management, Contracts, & Grants (AMCG)
“The Emergency Care Coordination Center of the US Department of Health & Human Services has been charged by the federal government with examining regionalization models of emergency care. An initial step toward de facto regionalization could be categorization of emergency facilities.”
Acute Care Management Model

Solicitation Number: 14-100-SOL-00012
Agency: Department of Health and Human Services
Office: Office of the Secretary
Location: Acquisitions Management, Contracts, & Grants (AMCG)

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Solicitation Number: 14-100-SOL-00012  Notice Type: Combined Synopsis/Solicitation

Synopsis:
Added: Aug 01, 2014 12:28 pm  Modified: Aug 12, 2014 5:03 pm

Amendment 0001 provides answers to the questions submitted for Acute Care Management Model Solicitation 14-100-SOL-00012.
“Lost in the public debate over implementation of health care reform is a meaningful conversation about managing the challenge of acute unscheduled care—a responsibility that must be shared between primary and emergency care.”

“One side stresses bolstering the patient-centered medical home and therefore primary care access to avoid emergency department (ED) visits, whereas the other side underscores the accessibility of ED care and the vital services provided.”

“...the public is lost in the middle...”
• “In summary, we find that patients come back to the ED because they are anxious about symptoms, unsure of what else to do, and have lost trust in the health care system’s interest in serving as their advocates. They see options as limited to calling a provider in the hope of a timely appointment or coming back to sit in the waiting room until they can be treated again in the ED. We suggest that to deliver patient-centered care, the medical community must learn to better meet patients when and where they want.”
Accountable Health Communities — Addressing Social Needs through Medicare and Medicaid

Dawn E. Alley, Ph.D., Chisara N. Asomugha, M.D., Patrick H. Conway, M.D., and Darshak M. Sanghavi, M.D.

For decades, experts have described a profound imbalance between public funding of acute medical care and investments in upstream social and environmental determinants of health. By some estimates, more than 95% of the trillion dollars spent on health care in the United States each year funds direct medical services, even though 60% of preventable deaths are rooted in modifiable behaviors and exposures that occur in the community.1

Most clinicians are familiar with the stories behind these statistics: the child with asthma whose substandard housing triggers repeated emergency department visits; the patient with repeated visits for severe abdominal pain caused by her violent home life; the older adult with diabetes forced to choose between paying for heat and buying groceries. But in our current system, patients' health-related social needs frequently remain undetected and unaddressed. Despite calls for obtaining an expanded social history at the point of care,2 most health care systems lack the infrastructure and incentives to develop comprehensive, systematic screening-and-referral protocols and relationships with the array of community service providers that would be required to address their patients' health-related social needs.

If the rate of preventable hospitalizations among residents of low-income neighborhoods could be reduced to the level among residents of high-income neighborhoods, there would be 500,000 fewer hospitalizations per year.3 As health systems are increasingly being held accountable for health outcomes and reducing the cost of care, they need tools and interventions that address patient and community factors contributing to excess utilization. Effective partnerships among medical care, social services, public health, and community-based organizations could improve population health outcomes, but developing sustainable payment models to support such partnerships has proved challenging.4

Some encouraging innovations

Track 1 Awareness – Increase beneficiary awareness of available community services through information dissemination and referral

Track 2 Assistance – Provide community service navigation services to assist high-risk beneficiaries with accessing services

Track 3 Alignment – Encourage partner alignment to ensure that community services are available and responsive to the needs of the beneficiaries
Key Questions

• Emergency care is currently framed as primarily for life and limb threats.
  – Is this consistent with the perception/utilization patterns of the general public?
  – Is this patient-centered?

• The general policy community is very interested in avoiding ED use.
  – What are the key drivers of this interest? (fragmentation, cost, etc.)

• Quality measurement for emergency care is limited.
  – What is the future of quality measurement for acute and unscheduled care? (bundles, population based, care coordination)

• Emergency and acute care is not fully integrated into advanced payment models/delivery system reform.
  – What can be done to integrate emergent and acute care into emerging delivery system models? (Accountable Care Organizations, Accountable Health Communities, etc.)
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