Low Acuity Emergency Department Visits

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Goals and Objectives

- Identify and quantify low acuity ED visits
- Analyze challenges associated with low acuity ED visits
- Assess the impact of these visits on the health care system
- Strategize a plan for managing low acuity health care visits
ESI at SZ *90,391 FY17
Seasonal Variation in Low Acuity ED visits

![Seasonal Variation in Low Acuity ED visits graph]

The graph shows the number of low acuity ED visits from May 2017 to April 2018. The x-axis represents the months from May 2017 to April 2018, while the y-axis represents the number of visits ranging from 0 to 3500. The visits show a general trend of increasing from May to late autumn, peaking in January and February, and then decreasing sharply in March and April.
Why?

• Lack of appropriate alternatives
• Parental over-estimations of disease severity
• Convenience

Hospital’s Role in Encouraging Low Acuity ED Visits
Implications of ED overuse for Low Acuity Visits

Individual Health Effects
- Low Acuity Patient
- High Acuity Patient

Population Health Effects
- Financial Effects
- Institutional Effects
- Cultural Effects
What are the implications for ED overuse on low acuity patients?

**Individual Health Effects**
- Low Acuity Patient
- High Acuity Patient

**Population Health Effects**
- Financial Effects
- Institutional Effects
- Cultural Effects
Individual Health Effects of Low Acuity ED Visits

- Lack of connection to a primary care provider
- Poor communication and trust with health care providers
  - All leading to poor chronic care management
- Lack of exposure to resources of primary care
  - Screening tools for development, mental health, ACEs, SDH
  - Preventive care lab screenings: anemia, lead, etc.
  - Reach Out and Read
- Missed opportunities for vaccination
What are the implications for ED overuse on high acuity patients?

Individual Health Effects
- Low Acuity Patient
- High Acuity Patient

Population Health Effects
- Financial Effects
- Institutional Effects
- Cultural Effects
Mechanisms for Delay of High Acuity Patient Care in the Setting of High Volume of Low Acuity ED Patients
Implications of ED overuse for Low Acuity Visits

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Health Finance Effects of ED overuse

• Costs to system of ED visits that receive lower or no reimbursement

• Costs to system of care rendered in a more expensive setting
  • Urgent Care median payment $76.90
  • ED median payment $186.20

• Potential duplication of care with fragmented health care delivery
Cost

• Transitioning lowest severity of illness patients to Urgent Care could save Medicaid $50 million a year.

• Transitioning all non-emergent care away from the ED saves $4 billion annually

Weinick RM, Burns RM, Mehrotra A. Many emergency department visits could be managed at urgent care centers and retail clinics. Health Aff (Millwood). 2010;29(9):1630–6.

Montalbano, A, Rodean J, Kangas J et al. Urgent Care and Emergency Department Visits in the the pediatric Medicaid Populaiton. Pediatrics 2016; 137
Implications of ED overuse for Low Acuity Visits

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Measures Reported to CMS

• LOS
• LWBS
• Median time from admission to patient arrival in inpatient bed
How CMS Improves Quality Measures

• Medicare cuts payments by 1 percent for hospitals that fall in the worst-performing quartile.

• In 2018, 751 hospitals will have their Medicare payments reduced

• Academic medical centers and hospitals that serve poorer and sicker patient populations are disproportionally penalized
Implications of ED overuse for Low Acuity Visits

Individual Health Effects
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- Institutional Effects
- Cultural Effects
Population Cultural Effects of ED overuse

• Culture of care that is disconnected from primary care

• Disproportionate decrease in access to preventive services for vulnerable pediatric populations

• Leads to increased disparities in care and outcomes
Strategies to Reduce ED Visits

High Risk Programs

Low Acuity Programs

- Primary Care Linkage
- ED Diversion
- Financial Penalties
Primary Care Linkage

• In adult patient’s identification of a PCP did not correspond to reduced low acuity ED visits
  • Most Low acuity ED patients can identify a PCP and do not attempt to reach them prior to coming to ED

• Primary Care linkage does improve Primary Care follow up in adult patients presenting for low acuity visits
  • Patients walked over from ED to PCP

• No Pediatric data, but most patients do identify PCPs and this doesn’t seem to help
Enhancing Existing Primary Care Linkage

• Systems level supports
  • Empanelling patients to providers
  • Call center that directs patients to visit with their PCP
  • Renewed focus on hospitality
  • Utilizing technology to engage patients and provide quicker access to care

• Provider level supports
  • Flag providers when their patient is seen in ED

• Patient level supports
  • Transportation
  • Education
ED Diversion via EMS Non-transport

- Vulnerable patients groups (include children) are more represented in the non-conveyance population

- Within 24 h–48 h after non-conveyance, 2.5%–6.1% of the general patients represent to EMS, and 4.6–19.0% present themselves at the ED.

- A limited amount of non-conveyance guidelines or protocols

- Concerns about patient safety related to non-conveyance

RIGHT CARE, RIGHT NOW

Right Care, Right Now is the District's program specifically focused on connecting you with the most appropriate health care. Managed by DC Fire and Emergency Medical Services (DC EMS), our goal is to improve your health outcomes and preserve resources for patients with life threatening injuries and illnesses.

Callers to 911 with non-emergency injuries or illnesses will still receive treatment, but that may not involve an ambulance. Not sure when to call 911?

WHEN TO CALL 911:
- Trouble breathing or unable to breathe
- Symptoms of a heart attack
- Fainting or dizziness
- Bleeding that will not stop
- Severe or persistent vomiting
- Sudden, severe pain anywhere in the body
- Serious medical emergencies that you believe are life threatening or may become life threatening

WHEN NOT TO CALL 911:
- You need transportation to a doctor's appointment
- Getting a scraped knee bandaged
- Needing a prescription to be filled
- For a sprained or twisted ankle
- For transportation to another area of the city
- Whenever the injury is not life threatening

For more information, visit www.fems.dc.gov or text: DC RIGHTCARE to 468311
Safety and Medical legal Concerns about EMS Non-Conveyance

The ten-year malpractice experience of a large urban EMS system

The "No-Patient" Run: 2,698 Patients Evaluated but Not Transported by Paramedics
Financial Penalties

• No pediatric data

• 5 studies implementing co-payment, all adult studies
  • Largest Kaiser study showed decrease low acuity visits with increasing co-payments (1$-100)
  • Medicare studies showed no difference in low acuity visits with co-pays of $2-$8
  • Oregon had a $50 co-pay and that did reduce visits

• Concern that imposing penalties could lead to delays in needed care, particularly for low-income populations
Low Acuity Programs

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- ED Diversion
- Financial Penalties
Thank you!

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