Emergency Department (ED) Diversion Programs from the Inside-Out: Understanding Care Management Challenges in the ED and Opportunities for Home Infusion Provider Collaboration

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I hold a Masters of Social Work and am licensed in the State of MD as an LCSW-C. The ideas proposed in this training are uniquely my own. When necessary appropriate credit and recognition are provided to the cited sources. I do not have any personal prior or existing financial relationships or with any of the companies represented here. The primary purpose and intent of this presentation is educationally based and does not seek to promote any one provider or their respective products and services over another. Finally I will not be discussing any off-label or investigational drug or product during this training.
Training Objectives

This training seeks to provide attendees with pertinent information on:

• The *Big Picture* changes and challenges that influence and impact ED functioning
• The new and uncharted frontier of ED diversion programs
• Patient populations of greatest interest to ED Care Management Staff
• Organizational challenges related to emergency patient care
• Areas of opportunity for home infusion providers and developing partnerships that matter
Identifying the Challenges of Today and the Future
Let’s begin with why you are here...

You are most likely here because you want to partner with a given hospital organization’s ED to:

• Generate new business and in turn new revenue opportunities
• Show the value-added scope of services that your company has at hand
• Demonstrate your company’s capacity to be an industry leader in this new business frontier
Let’s continue with why I am here ...

I am here to give you an insider’s view on how the ED functions (and doesn’t function) and to provide timely and relevant information on:

• What hospitals and their ED programs really care about
• How decisions to admit are actually made
• How ED programs are inevitably at the mercy of policy and programmatic trends
• How we all need to look at this aspect of healthcare with thoughtful critique and fresh eyes
Understanding the Emergency Department from the Outside In

The major impetus for healthcare change and for a seemingly hyper-fixation on the ED especially falls into three primary cost-related domains:

• Healthcare reform as it applies to payment and provision of quality care
• The cost of health care is eclipsing GDP
• Radical shifts within the US population – particularly the aging population

The overarching theme through all of this is that we collectively need to create a strategy for managing cost while still managing and providing quality care.
Understanding the Emergency Department from the Outside In

*RAC, probes, financial penalties, oh my*

We inhabit a healthcare system that is increasingly highlighting the importance of:

- Responsibility
- Reportability
- Accountability
Understanding the Emergency Department from the Outside In

The Emergency Department system also inhabits a healthcare world that is profoundly impacted by:

- Payer source protocols
- Organizational fragmentation
- An unwavering mass workload
- Restricted social and financial resources
- Incremental and dynamic shifts in state and federal policy
Understanding the Emergency Department from the Outside In

Key Point: It is critical to realize that the ED does not exist in a vacuum – it is part of innumerable larger systems. All of these systems come into play in coordination of patient care.
The Myth About Entry into the Acute Care World

Prevention of patient admissions and readmissions does **not** begin and end with this line.
The Long Path to the ED and to Acute Care System

Key Point: The ED is one of the few organizational domains that has limited to no control over its own patient referral base. Patients accessing care from the ED are often directed to go there by external providers.
The Long Path to the ED and to Acute Care System

This is the true beginning point on the path to the Acute Care system
Key Point: Decision making concerning patient admissions changes with increased patient volume and in tandem with physician habits. Care Management staff’s ability to influence decision making concerning admissions is highly connected with the level of trust allocated by their peers and prior history of patient successes.
The Decision to Admit

The decision to admit a patient to the hospital is not consistently made based on patients meeting the *acute care criteria*. Far too often it is made for the wrong reasons:

- Lack of knowledge about alternative outpatient clinical interventions
- Patient *bottle-necking*, patient surges
- The ease of admitting vs. labor-intensive problem solving
- Diagnostic based resource restriction
- Patients lacking health insurance
- Fear of liability and medical malpractice
The Decision to Admit

• It is worth noting that concerns about incurring a liability/medical malpractice weigh heavily on decision making concerning patient care.

• When partnering with emergency departments, it is highly recommended that you anticipate this concern and build contractual language into your relationship with your client.

• When Physicians and Care Management staff feel confident around this point they are more likely to endorse alternative clinical interventions.
Patients of Interest to ED Care Management Staff

ED Care Management staff are charged with being the *gate-keepers* to acute care. They are also tasked with identifying and intervening with the *High Risk/Frequent Flyer* patient population. These are patients who have been:

- Admitted within the last 30 days
- Diagnosed with chronic illness (i.e. diabetes, CHF etc.)
- Prescribed with 5 or more medications
- Identified with active psychosocial risks (i.e. uninsured, homeless, vulnerable etc.)
- Identified as non-compliant with outpatient care
Patients of Interest to ED Care Management Staff

In light of the recent economic downturn, hospital emergency departments all over the country are seeing surges in the uninsured population. This is largely due to:

• Increased unemployment and loss of benefits
• The shrinking social welfare system
• Delaying routine treatment because of cost
• Lack of being able to pay for recommended medication

Key point: Most hospital systems either lack or have a fragmented protocol for how to manage the uninsured population. Hospitals are caught between the ethical requirement to treat while absorbing the cost of care for the uninsured.
Hospital systems are hybrid organizations that serve a plurality of functions within a given community. As a consequence they are often:

- Supplementing an ever shrinking social welfare system
- Tasked with coordinating care that is also based upon resolution of social problems
- Balancing fiscal survival with the ethical need to treat
- Continually evolving in concert with larger healthcare policy

Therefore creating partnerships and solutions that matter mandates that providers are in tune with these larger system challenges.
Developing Solutions and Partnerships that Matter
Assessing Your Organizational Partnerships and Current Standing

Before you begin you need to know where you stand

Given that ED diversion programs are a new domain, it is critical to begin this process by assessing your organizational partnerships. Which type of relationship does your business have with its hospital partners?

**LEVEL 1: Transactional**
- Provision of basic services; generation of sales volume

**LEVEL 2: Integrative**
- Access to decision makers; provision of more complex services

**LEVEL 3: Strategic**
- Full fledged business partner; can contribute to decision making process; Relied upon as a resource
Assessing Your Organizational Partnerships and Current Standing

The basic element that enables partnerships to grow with hospital systems is **trust**. Ways that organizations can demonstrate trustworthiness include:

- Building patient centered business practices
- Mutual sharing of financial risk
- Profit sharing
- Modifying business practices to mimic patient flow
- Simplification of access to services
The Old and New World

In the new emerging world of healthcare, hospital payment will be contingent upon production of effective clinical outcomes and not by volume. Therefore hospitals will need to create programs that are:

• Based on quality
• Aimed at preventing readmissions
• Taking into account the whole patient

*This will be a shift in conceptualizing patient care from an episode of illness to a total illness event. Additional understanding of your client’s reimbursement shifts will help to anticipate their business priorities.*
The Big Picture for Every Patient

A broad sweeping review of this system, of its current and future states will inform your organization as to how to strategically position itself. It suggests that programs and clinical interventions should be based upon:

• Population trends
• Disease management
• Resource gaps

All of these macro elements come into fruition in emergent care and are exacerbated because of the crisis elements that facilitate patient access to care.
ED Diversion Programs of Today

The truth is current ED diversion program models say very little about how to meet today’s care management challenges. The ED, unlike the acute care hospital, has experienced minimal:

- Innovation
- Process change
- Process improvement

*Identifying the need will identify areas for innovation.*
Mapping Out the Need

Creating real and viable ED diversion programs is really more about:

- Finding the need and supplementing the gaps
- Building plans on population trends rather than patient cases
- Anticipating contingencies always
- Rapid problem solving

*The best provider will cease to be the best if they cannot process requests and orders with speed and quality.*
# Mapping Out the Need

Patient populations most likely to present with complex dispositions in Emergent Care:

- Elderly
- Chronically ill
- History of non-compliance
- Uninsured
- Disabled
- Language/communication barriers

## Workflow

- **Peak patient hours:** 11am - on
- **Spikes in Surges:** Friday-Sunday

## Demand

- **Patient admit triage and disposition within 2 hours**
- **Increasing mgmt of complex patients and uninsured**

## Resource Gaps

- **Physician Education**
- **Process gaps – PICC nurses, X-rays, staffing**
- ***Resource gaps facilitate admissions***

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*Time of day yields length of stay*

*Bottlenecking disrupts the entire system*
The Shifting Insurance Landscape

Within the next 10 years, it is projected that not only will the population landscape shift but the insurance mix will also shift under and after healthcare reform. The payer mix is expected to be:

- **7%** Uninsured
- **13%** Medicare
- **35%** Commercial
- **45%** Medicaid

Source US Census Bureau available at https://www.census.gov

Creating ED diversion programs will be just as much about negotiating with hospitals as it will with payer sources.

Management of uninsured patients remains a challenge as these patients present an unpredictable expense to hospitals.

Creation of preferred provider relationships that include cost sharing terms for ED patients can be a mutually beneficial value-added offer.
Pre and Post Acute Care Partners

“The success of health reform hinges on hiring 30,000 primary care physicians by 2015” ~ Washington Post

What is also necessary is to empower PCPS with the knowledge about how to keep patients well in the first place.

Targeting and partnering with PCPs in hospital catchment areas can build revenue for infusion providers, can build natural business partnerships with CTPs, and respond to healthcare trends.

Two significant and **untapped** healthcare trends that will increasingly relate to ED Diversion programs will be:

- **Care Transitions Programs (CTPs)**
  - Programs essentially owned by a hospital system that are tasked with patient education, linking patients to PCPs and prevention of readmissions

- **Primary Care Physicians (PCPs)**
  - These are the doctors that are tasked with **solving every healthcare woe**

*Because these are untapped territories there is prime opportunity for how these areas are developed in terms of partnerships. Private industry especially could play a significant role in terms of what ED diversion health care models can be developed.*
Securing Your Market

ED care management and ED diversion programs are not in the business of disrupting patient and PCP connections with external providers (i.e. home care, home infusion etc.). The challenge for the infusion provider will be to:

• Secure their respective external market
• To make patient connections with their service transparent
• Produce processes to expedite patient care safely

*If a patient comes to the ED with a home care agency they will leave with the same agency. This relationship would only be disrupted if the agency was too slow to respond to disposition needs.*

*The most valuable resource in the ED is time.*
One of the primary ways to demonstrate value to ED program is through resource sharing. Consider thinking about or posing these questions to hospital contacts. Could my company support your hospital through:

- Insertion of PICC lines
- Provision of x-ray services to confirm PICC line placement
- Administering the first dose of antibiotics in the ED to ensure a safe transfer home
- Utilizing our knowledge of organism sensitivities and lab results to expedite a care plan
- Establishing an infusion base close to the hospital campus to streamline patient care
- Partnering with consulting infectious disease specialists

Demonstrating Value Through Synergy

- In the world of the ED patient volume is key as is segmenting out patients that can be treated and discharged.
- With volume increase, resource restriction increases.
- When volume grows and resources diminish, the risk for unnecessary admissions rises because of the need to decrease patient volume.
The Long Path to the ED and to Acute Care System

Proactively creating partnerships with external providers is what builds revenue sources, what expedites patient care and what creates value.
Now that I have overloaded your cart, do you have any questions?
Thank you for your time and attention!

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