The Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions Submitted by the American College of Emergency Physicians (ACEP)

Purpose

The purpose of the Environmental Scan research task is to provide current contextual information to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) related to the proposed model. This includes information about the submitting organization, the clinical condition or type of care addressed in the proposal, the relevance of the population, condition, and proposed model to Medicare, the relevant policy environment and the literature supporting or otherwise reflecting the potential implementation, and impact of the proposed model.

Methods

The Environmental Scan research task includes a search of grey literature, key documents, timely reports, peer-reviewed literature, and other related materials from targeted online and database (e.g. Pubmed) searches. Search terms included multiple Boolean (and/or/not) combinations of the following:

- acute care settings
- Acute Unscheduled Care Model (AUCM)
- Advanced Alternative Payment Model (APM) in emergency medicine American College of Emergency Physicians (ACEP)
- care coordination tools and services
- cost containment
- cost reduction
- discharge process
- emergency department (ED)
- emergency physicians
- emergency room (ER)
- hospital inpatient admissions or observation stays
- Postdischarge
- return ED visits
- shared decision making
- transition back to the outpatient provider
- unscheduled care

Submitting Organization

ACEP is a professional organization representing more than 31,000 emergency physicians. Membership is available for physicians who have completed an Accreditation Council for Graduate Medical Education (ACGME)-approved emergency medicine residency or an American Osteopathic Association (AOA)-approved emergency residency, obtained certification by another emergency medicine certifying body recognized by ACEP, or who have been practicing as an emergency physician since before 2000. ACEP, the headquarters of which is located in Irving, Texas, operates an office in Washington, DC. The *Annals of Emergency Medicine* is ACEP's official research publication.

ACEP displays a Rapid Integration of Care Toolkit on its website. This toolkit assists the practicing ED physician in managing a variety of transitions and coordination of care to and from the ED that includes information on transitions, including emergency medical services (EMS) to the ED, ED to ED Communication, ED to Inpatient providers, and ED to Community providers (ACEP, 2016b).

In addition to its toolkit, ACEP developed its Clinical Emergency Data Registry (CEDR) to monitor and report health care quality, which is stated to be in use in more than 800 EDs in the United States. The CEDR continues to evolve and is designated as a qualified clinical data registry (QCDR) with the Centers for Medicare & Medicaid Services (CMS) (CMS, 2016). Compared to the traditional Patient Quality Reporting System (PQRS), ACEP's CEDR is advantageous as it will support evidence-based shared decision

making and guideline-informed physician practices (ACEP, 2016a). The CEDR's de-identified aggregated data provides participating emergency physicians with feedback regarding individual and/or ED level performance based on a variety of process and outcome quality measures, benchmarked against peers at the regional and national levels. Emergency physicians may choose to report CEDR-specific measures, and receive credit for MIPS (Merit-based Incentive Payment System) reporting. ACEP CEDR supports certain QPP and non-QPP measures, eCQMs (electronic clinical quality measures), and QI (quality improvement) measures, as indicated on ACEP's website.

Background

Both inpatient hospitalizations and ED visits are expensive and often preventable aspects of health care. As inpatient and ED services are geared toward high acuity problems, hospitalizations and ED visits are also associated with poor quality of care for diseases and conditions that benefit from continuity of care and longer-term follow up. Thus, CMS and other payers have focused on reducing hospital admissions and ED visits across many programs and policies as well as across disease management approaches for common chronic conditions.

Inpatient Admissions from the ED

Despite the recognition that inpatient and ED care is often low value, Medicare accounts for more inpatient admissions from the ED than with any other payer (Morganti, Bauhoff, & Blanchard, 2013). Nearly 70 percent of hospital admissions for Medicare patients originate in the ED. From surveying emergency physicians in one study, 40 percent of admitted patients were identified as potential candidates for home-based care—furthermore, the majority of these patients stated a preference for receiving health care at home (Crowley, Stuck, Martinez, Wittgrove, Zeng, Brennan, et al., 2016). In ACEP's proposal, the submitters emphasized the crucial role of ED physicians in appropriately triaging patients who present to the ED with acute, unscheduled care needs. Recent studies confirm that ED decisionmaking and EDs in general are important determinants of admission to inpatient hospitals (Auerbach, Kripalani, Vasilevskis, Sehgal, Lindenauer, Metlay, et al., 2016; Schuur & Venkatesh, 2012). Although hospital readmissions have decreased with recent policy changes, including the Affordable Care Act (ACA), observation stays in the ED have increased somewhat—again suggesting an important and perhaps increasing role for ED physicians in the pre- and post-discharge care of patients (Zuckerman, Sheingold, Orav, Ruhter, & Epstein, 2016).

Beyond admissions and readmissions, EDs continue to play a role to address the unscheduled acute care needs for patients who do not have access to timely care from a primary care physician's (PCP's) office. Thus, some experts suggest that attempting to reduce the frequency of ED visits and admissions may not directly nor significantly reduce cost due to a high volume of visits from uninsured and/or under-resourced patients (Schuur & Venkatesh, 2012). In general, narrowly focusing on reducing ED utilization may missthe opportunity to collaborate with emergency physicians to reduce total cost of care (Harish, Miller, Pines, Zane, & Wiler, 2017).

Need for Improved Post-Hospital Discharge Care

Currently, hospitals are penalized for some readmissions within a specific time window—30 days for example— of a hospitalization, with at least 22 percent of discharges linked to 30-day revisits. The commonly used hospital quality metric regarding ED revisits are those that occur within a 72-hour time period, which are thought to be potentially preventable visits according to ACEP guidelines (Rising, Victor, Hollander, & Carr, 2014). There is, however, debate about the optimal timeframe in which to accurately examine ED revisits, as there is no empiric basis for 72 hours. Calculations performed by Rising and

colleagues (2014) proposed using nine days as the quality metric, the time frame during which most readmissions and revisits to the ED occur as opposed to 72 hours.

For both hospital and ED readmissions, many present to the ED with unscheduled care needs but without having had contact with a physician after discharge. Approximately half of Medicare beneficiaries who were readmitted within 30 days did not see a physician after discharge (Kripalani, LeFevre, Phillips, Williams, Basaviah, & Baker, 2007). A retrospective study conducted in 2015 found that 41 percent of Medicare beneficiaries returned to the ED within 30 days of an inpatient hospitalization (Brennan, Chan, Killeen, & Castillo, 2015). Additionally, only 20 percent of PCPs report consistent notification of their patients' discharge, and less than 33 percent report receiving discharge summaries within two weeks (Safety Net Medical Home Initiative, 2013). These data suggest that effective post-discharge care and communication of recently hospitalized patients is necessary to improve continuity of care and to prevent adverse events, including readmissions. Further evidence suggests that the earlier the post-discharge follow-up, the lower the likelihood of being readmitted (Hernandez, Greiner, Fonarow, Hammill, Heidenreich, Yancy, et al., 2010).

Adverse Events after Discharge

With the increased pressure to manage patients' health as an outpatient, or to discharge from the hospital or ED as soon as possible, the potential for adverse events increases. For example, research conducted at Harvard and Brigham and Women's Hospital found that, after analyzing a nationally representative of Medicare FFS beneficiaries (20%), more than 10,000 Medicare patients each year died within seven days after being discharged from EDs, despite having no reported previous life-limiting illness. While there is some variability across hospitals that may be attributed to the geographic and socioeconomic context of emergency care, findings suggest that hospitals with the highest rates of early death were also those with lower admission rates, and that slight increases in admission rates were related to a large decrease in risk. While data cannot determine whether admission would prevent deaths, it has been suggested that additional testing or monitoring could be beneficial to some patients (Obermeyer, Cohn, Wilson, Jena, & Cutler, 2017). Furthermore, Calder and colleagues (2015) conducted qualitative interviews of emergency physicians at the time of discharge and observed that these physicians were not successful in predicting adverse events after discharge among their patients.

Other Models

ACEP in its proposal discusses why the particular goals and outcomes are important and need to go beyond existing payment models, such as Comprehensive Care for Joint Replacement (CJR) and the Hospital-Acquired Condition (HAC) Reduction program, to directly target ED care. The current payment system of ED patient care reveals some concerns that lead to insufficient quality of care. Emergency physicians are not currently compensated for the time to develop a discharge plan and ensure its implementation. Moreover, emergency physicians have less time to see other ED patients when spending time arranging discharge. Last, current ED performance measures disproportionately focus on throughput (e.g., NQF measure 0495 for ED length of stay), and thus pressures emergency physicians to discharge patients as quickly as possible, in effect discouraging safe discharge practices.

According to Harish and colleagues, APMs will need to remove barriers to the payment of high-value services, such as communication and coordination between PCPs and emergency physicians, to improve patient care. For example, the University of Colorado's "Bridges to Care" program as a home-based model reduced ED visits by 43 percent and led to significant savings for payers. However, the services

offered in this model are not billable in the current FFS model. Physician-focused emergency medicine APMs need to address the following areas to improve delivery of care: (1) reducing avoidable admissions, (2) reducing downstream care and costs, and (3) reducing ED visit costs.

Two programs through CMS aim to reduce hospital admissions and, especially, readmissions. One value-based program entitled the "Hospital Readmissions Reduction (HRR) Program" provides financial incentives to hospitals to reduce readmissions for patients with acute myocardial infarction (AMI), heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), elective total hip and/or total knee replacement, and coronary artery bypass graft (CABG) surgery. CMS finalized its payment methodology to "calculate the hospital readmission payment adjustment factor" and to identify the "portion of the Inpatient Prospective Payment System (IPPS) payment used to calculate the readmission payment adjustment amount" (CMS, 2017a). CMS has also implemented a second value-based program entitled the Hospital-Acquired Condition (HAC) Reduction Program, which has saved Medicare approximately $350 million every year. The performance of hospitals within this program is based on the occurrence or prevention of the following five health care-acquired infections: Central Line-Associated Bloodstream Infection (CLABSI), Catheter-Associated Urinary Tract Infection (CAUTI), Surgical Site Infection (SSI), Methicillin-Resistant Staphylococcus Aureus (MRSA), and Clostridium Difficile (C. diff) (CMS, 2017b). Although both of these programs aim to reduce and prevent unnecessary hospitalizations, they do not address the role of the ED in managing these patients and improving their care.

Clinical Guidelines

Clinical guidelines and protocols developed by ACEP or others for ED care tend to apply to specific clinical conditions and do not outline protocols for when it is appropriate to admit versus discharge a patient more generally. These decisions need to be tailored instead to the clinical scenario, the patient, the home environment, as well as other mitigating factors that inform clinical judgement. However, it has been shown that in higher-acuity and complex ED cases ED physicians were more likely to make their discharge decision based on guidelines, defined as specific guidelines or by consulting literature (Calder, Arnason, Vaillancourt, Perry, Stiell, Forster, et al., 2015).

In summary, emergency physicians are not currently included in alternative or advanced alternative payment models although the emergency department is the setting where many of the critical decisions are made that affect health care costs and quality. Until access to primary care is more widely available at all hours, the ED is likely to continue as a setting for addressing unplanned needs for both acute and chronic conditions. Improved care coordination between inpatient, ED and primary care clinicians and improved follow up after discharge from both the ED and the hospital are necessary to limit unnecessary use of emergency services and improve outcomes. It remains unproven, however, whether ED physicians are ideally suited to address post-discharge needs and ensure care continuity and coordination. Accurate and timely use of data such as via use of CEDR and use of an integrated EHR is likely to improve health communication and outcomes both in and out of the ED. Furthermore , additional research is needed to understand who is most at risk of adverse events after discharge and for whom inpatient admission is truly necessary.

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PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

PRELIMINARY REVIEW TEAM (PRT)

CONFERENCE CALL WITH EMERGENCY ROOM PHYSICIAN EXPERT FOR THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS' (ACEP) PROPOSAL

Thursday, February 15, 2018

Noon

PRESENT:

TIMOTHY FERRIS, PTAC Committee Member
LEN NICHOLS, PhD, PTAC Committee Member
JEFFREY BAILET, MD, PTAC Committee Member

CARL BERDAHL, MD, MS, Office of the Assistant Secretary for Planning and Evaluation (ASPE)
SUSAN BOGASKY, ASPE
MARY ELLEN STAHLMAN, ASPE

ANJALI JAIN, MD, Social & Scientific Systems, Inc. (SSS)

ZACHARY F. MEISEL, MD, MDH, MSHP, Associate Professor, Department of Emergency Medicine; Director Center for Emergency Care Policy Research; Patient Safety Officer; Hospital of the University of Pennsylvania

P R O C E E D I N G S

[12:03 p.m.]

DR. FERRIS: Let's begin. What do you think?

DR. NICHOLS: There you go. Good question.

DR. MEISEL: Are you asking me? Zach?

DR. FERRIS: I am. I am.

DR. MEISEL: Okay, great.

Well, I really was interested and excited to look at this because I think it addressed some issues that have been bubbling to the surface in the world.

So I live -- just to introduce myself, I am faculty on Emergency Medicine. I am an emergency physician here at Penn. I also do -- I am a health services researcher and do a lot of work related to opioid prescribing but have over the years looked at utilization of health care and emergency care, particularly focused on pre-hospital, so ambulances and some of the downstream -- and focus on some of the downstream impact that results when different policies related to ambulance care and delivery of patients to hospitals changes.

So at a very high level, I think this is an exciting opportunity. I think emergency medicine has largely been left out of efforts to think about both coordinated care as well as efforts to think about -- on the physician side, on alternative payment models. Really, emergency medicine has just not really been part of the fix, and many, if not most of us, recognize that probably the most impactful decision that we make, both on our patients' lives as well as on the health care system and how it functions is this key decision about whether to admit or discharge a patient.

We are the gatekeepers for the vast majority of patients who are hospitalized in the United States. That decision is the hardest decision, honestly, that we make every day, and how to think about its impact and how to improve it, there's huge variations on admission that’s been -- that are baked into this report. And I think that's great that we're focusing on that piece.

And I ultimately think that both the health care system and emergency medicine in particular would benefit from including this key decision and their role into new ways of thinking

about coordinating care and alternative payment models.

DR. FERRIS: So can I just ask -- I'm having a little bit of phone trouble, and you're breaking up.

DR. MEISEL: Oh, I'm sorry.

DR. FERRIS: And I just wanted to know if I'm the only person that's having that trouble.

DR. NICHOLS: Sounds good to me, Tim.

DR. FERRIS: All right. I'm going to just, then, drop off for one second. I apologize, but I sort of was getting -- missing every third word.

DR. MEISEL: Okay. I can summarize, I said a lot, and I probably didn't say that much, but I'm happy to summarize what I just said in a more -- in a way that's a little bit more terse. So will you hang up and then see you in a second.

DR. FERRIS: Yeah. No, I think I got the content of what you were saying, and I think that's consistent. I think we should just dive right into the details because that's where we're -- I think we're with you exactly on your summary statements, but we're confused about the details and --

DR. MEISEL: Great.

DR. FERRIS: -- what to get into that.

So give me one minute. I'll be right back.

[Pause.]

DR. FERRIS: Hi. Tim back here, and now it seems clearer.

DR. MEISEL: This is Zach. Can you hear me better?

DR. FERRIS: Yep. Much better.

DR. MEISEL: Great.

DR. FERRIS: Thank you. Sorry for that.

And do we have Jeff yet?

[No response.]

DR. FERRIS: Okay.

MS. BOGASKY: I just wanted to mention that Mary Ellen and Carl joined us on the ASPE side.

DR. FERRIS: Okay, great. Okay.

DR. JAIN: And I'm here from SSS. Anjali Jain.

DR. FERRIS: Oh, great. Thanks.

DR. MEISEL: Hey, Anjali.

DR. FERRIS: Thank you for joining us.

DR. JAIN: Hey, Zach. How are you?

DR. MEISEL: Good.

DR. JAIN: Good, good.

DR. FERRIS: So I think we're all on the same page on the overview. The questions we have really get down into the details.

And I don't know. Len, am I -- or, Susan, do you have a process by which we ask questions? And I'll just throw one out, which is actually to go through Susan's document, which -- by the way, does Zach have that document?

DR. MEISEL: I only have the report.

DR. FERRIS: Okay. I guess I could see why there may be some reluctance to share anything that we've created with you.

DR. MEISEL: I understand that, but I'm happy to try to answer any specific questions that you may have, although I can't promise that I can speak with expertise on all of them.

DR. FERRIS: Yeah. No, I think that's -- I just want to be clear.

Susan, is this the highest and best use of this time?

MS. BOGASKY: So I think we can approach it however you think is best.

Tim, if you would like us to ask the general questions that are in the document, we

could do that. That works. You would like to do it by category? Whatever you think is best, we're happy to proceed.

DR. FERRIS: Yeah. Well, so let's -- let me just then quickly summarize where some of the details -- confirm with you that this is your understanding, and then we'll get to the questions.

So the proposal is for to use four high-volume ED conditions -- syncope, chest pain, abdominal pain, and altered mental status -- and the inflection of those is really based on the fact that there's incredible variability in the admission rates for those, and I think appropriately, they didn't include -- the plan is to increase the number of qualified conditions or presenting complaints, but that, in general, they'll stay below -- they will not include anything with greater than 90 percent inpatient admission rate. That makes total sense, right? Not much opportunity there.

DR. MEISEL: Yeah. No, and I agree.

And I think -- well, those are -- these are also four of the most common complaints that present to emergency medicine, emergency departments, abdominal pain being number one and

chest pain being number two. So I think they're good places to start.

I think that when framed around this concept of appropriateness, which is in the title, I worry a little bit because they're also conditions that have significantly high adverse events within the first 30 days of discharge. So despite the fact that they're variable doesn't mean that we need to push most of these patients into the outpatient setting after an ED visit.

DR. FERRIS: Right. Yeah.

The problem is that -- right -- just from a pathologic perspective -- and I'll use syncope as the example -- syncope could be the result of something completely benign in which a hospitalization is 100 percent wasted. It could also be the result of something very morbid, which creates a very high risk of mortality.

And the vast majority fall in the former category but an important subset fall in the latter category, and it is the ED physician's job to decide the likelihood of which category they fall into.

Is that the correct --

DR. MEISEL: That's fair, and there are

risk stratification tools. Syncope is an interesting -- each one of these brings together different clinical sort of trajectories. Syncope is an interesting one because -- so, for example, young patients who pass out or who they don't have a lot of comorbid conditions are -- almost always have benign syncope, whereas as you get older, you are more likely to have cardiac syncope. It becomes a much higher risk, but the risk stratification for those patients is often done in the sense that they're -- if, for example, they're worried that they had an arrhythmia, the decision to admit these patients is often for, quote, "observation," or for monitoring, telemetry monitoring, which had not been shown to actually reduce.

Even though -- even though they're at high risk for an adverse event, putting them in the hospital on a monitor hasn't necessarily been shown to reduce their overall morbidity.

Abdominal pain is an interesting one because most of these patients are no -- may present as undifferentiated abdominal pain, but often they get a very complete workup in the emergency department, which would include something

like a CAT scan, which often makes the diagnosis. And once the patient has a negative workup in the emergency department, their risk drops appreciably, and so an admission for abdominal pain after a full workup is a very different story than an admission prior to that.

Altered mental status is one that is almost always associated -- it's high risk, I would say, although -- and of these four is the one that I think a lot of people would worry about on the clinical side about trying to incentivize people to send these patients home. Even if it may not be framed that way, even if that's not what we're trying to do, people would push back, I think, on that.

And chest pain is just -- is probably the biggest nut to crack, because it's so common, and it's associated with so many admissions of which the benefit is variable.

DR. NICHOLS: So that was very helpful.

Tim, could I jump in on the risk adjustment question, if you don't mind?

DR. FERRIS: Sure.

DR. NICHOLS: And, Dr. Meisel, forgive me. I'm an economist, so I'll try to be brief.

I guess when you mention risk adjustment and in particular, the -- I'll call it bimodal nature of a syncope-type presentation, I was struck at the maps that the proposal includes showing the difference between the raw interquartile range of ED admissions versus the risk-adjusted.

In my economist opinion, the risk-adjusted variation is actually quite low, except for the upper Midwest.

DR. MEISEL: Yes. And when I saw the map, Len, I had the exact same response. I would like to know what the risk-adjusted interquartile range for ED discharge is because I can tell you, for example, that on the East Coast, syncope almost always gets -- if you decide not to discharge a patient, you will put that patient in an observation status, which doesn't count from a Medicare perspective as an admission, but they still don't go home.

So it would be interesting to know what the risk-adjusted IQR for ED discharge is or ED -- or the flip side, which would be ED admission plus ED observation because that's really -- from a clinical perspective, the question is not whether they go -- and Midwest is one place where patients

are -- where observation is used much less than on the coasts.

DR. NICHOLS: Well, that's a great hypothesis, which we'll pursue with our data gurus from SSS, but -- and with the admitters -- with the presenters.

DR. MEISEL: Yeah.

DR. NICHOLS: But I would also just like to pick up on that because your point about the complete workup usually ruling out an unnecessary admission for abdominal pain.

DR. MEISEL: Yep.

DR. NICHOLS: Is there a variation in the use of complete workup? Is that part of what's driving these --

DR. MEISEL: It's a good question. My sense is there may be some, but I don't think -- I think most patients that are being admitted to the hospital after -- for abdominal pain will get a complete workup.

Many patients which -- when I say complete workup, I'm meaning primarily bloodwork and CAT scan or something like that --

DR. NICHOLS: Yeah.

DR. MEISEL: -- some cross-sectional

imaging.

I would say that -- and I don't have the data at hand. I know that there's been some studies that have looked at variations in -- CAT scan use for abdominal pain in ERs over the years, and there is large variation, but my guess is that's not -- it's not that variation is not occurring within patients whom are being admitted because the decision for abdominal pain is often is whether or not the patient needs to go to the operating room --

DR. NICHOLS: Right.

DR. MEISEL: -- for acute appendicitis or a ruptured abdominal aortic aneurysm or something along those lines, and that's determined by imaging.

And so, again, when I saw this for abdominal, I almost thought that I'd be interested in knowing what the variation as well as the -- what the variation is for, abdominal pain, undifferentiated abdominal pain, or again, the flip side would be abdominal pain after complete emergency department evaluation because the variation may be a little -- may be less.

So, for example, a patient that has --

comes into the ER, has belly pain. You get a CAT scan. You do labs, there's -- it's normal, those tests. You've pretty much taken the life-threatening stuff off the table.

Yes, cardiac pain can sometimes present as abdominal pain. Yes, sometimes patients will declare themselves a few days later, but most of the patients are safe now from the perspective of their workup to go home.

The issue is if they're still in a lot of abdominal pain, can they go because their pain is controlled? And now I'm ranging into anecdotal territory because I don't know the data on this, but the patients that get admitted to the hospital or get put in observation after a full workup are usually ones with intractable abdominal pain, and they get admitted for pain control and maybe something called serial abdominal exams, which would be to make sure that you weren't missing something that was like an early appendicitis that blossomed -- that wouldn't show up on a CAT scan but blossomed a day later.

But again, these are very different than syncope where you're putting somebody in the hospital because you're worried about them having a

sudden life-threatening event 24 hours later. An abdominal pain patient is usually one that's had a full evaluation. You've taken the life-threatening events off the table, but you don't know how to dispo them.

And I think that's where the overall goal of this report comes in, because these are the types of patients that could benefit from improved coordinated care after discharge. They may be being admitted to the hospital because of the fact that they can't -- you don't know what to do with them. They're still in a lot of belly -- they still have a lot of belly pain. They don't have good follow-up. You can't see them the next day to make sure that they're getting better, even though you know that they're not going to die or have some major morbid event, but you're putting them in the hospital because it's the only way to keep eyes on them.

And so an alternative payment model that bakes in telemedicine or other ways to improve post-acute care coordination would benefit those patients a lot.

DR. NICHOLS: That's extremely helpful, Doctor, and I guess my only follow-up really has to

do with do you think it's possible or important that part of that reason for the existing variation in admission decisions is what I will call, for lack of a better term, the comfort level of the PCP? That is to say, an ED doc appropriately up on the literature and who knows exactly what should happen if I send them home may be perfectly comfortable sending them home, but the doc in the country is not, and they're scared. And they send them back. So that's what I'm trying to get at.

DR. MEISEL: Yeah.

DR. NICHOLS: Doesn't there have to be a full information set conveyed to the PCP as well as what's in the ED?

DR. MEISEL: Yeah. I think that's a good point.

I think more and more emergency physicians are solely responsible for that key decision, admission versus discharge, but in places where the PCP is closely connected to the provider and where the PCP may be the admitting doctor of record, their patient is in the ER. They got a workup, but they don't feel comfortable discharging -- they don't feel comfortable seeing them as an outpatient. They will put them in the hospital on

-- ask for the patient to be admitted under their care.

I would say the other flip side of what you mentioned, which is -- which I do think this proposal addresses, is the comfort level of the emergency doc who does not have a longitudinal relationship with the patient and are probably more likely to put patients in the hospital because they don't know them. They don't know if they're going to follow up. They don't know if they are reliable or if their family is reliable, if they have the side of the social safety net to be able to get to their doctor's appointment the next day.

And so for many of these patients, particularly for whom their social determinants are questionable, the emergency physician will err on the side of admission or observation, and that's probably where some of this variation comes in.

And that does -- and this proposal does speak to that, where if you can -- and I know this is true, and I believe this has been studied through qualitative and quantitative methods, which is if we could guarantee your Patient X could be seen the next day or could be seen by telemedicine the next day, or would you be more willing to

discharge them as opposed to admitting them in the hospital, and emergency physicians, by and large, say yes, at least for the patients that are lower risk or lower-medium – lower-to-moderate risk.

DR. NICHOLS: Very helpful.

Tim, I'll yield the floor back to you.

DR. FERRIS: Len, that's great and good for you to use our expert here on, one, the clinical side because I do -- you're so -- you walk the walk and talk the talk so well, Len, I sometimes forget you're not a doctor.

All right. So let's get in a little bit to the interface between these clinical concepts and the financial model, and I just want to say up front that we are not exactly sure, despite the being on the same page conceptually, what the financial model actually is here.

So the 7-day Medicare spending episode and the 30-day quality episode, those are well defined, and that the trigger event is the ED visit, so that starts the clock.

The issues that we had, one of this was -- and I'll go to the -- maybe the quality one first -- is it realistic -- let me put it this way -- to think about quality metrics that are disease-

specific in -- as a modifier to the payment in what they're proposing?

Do you see what I'm saying? There is a certain amount of complexity here, and they don't go into details about what the quality measures are. But we know that there are quality measures in these areas that ACEP has, and so we're trying to piece together some -- what we perceive as some vagueness in the reporting.

Can you just give us a handle on how realistic it is to actually put together the set of quality measures around these four conditions?

DR. MEISEL: So, yes. So let me think about this for a second. I'm flipping through to see if they -- did they specify any examples of quality? I remember there was a table that has -- here it is, Table 1. Right?

MS. BOGASKY: And I think there's also some measures that are specified in Table 2.

DR. MEISEL: Okay. So a return ED visit, I actually think of as very similar to a -- particularly when that leads to an observation stay or inpatient admission as a readmission -- the equivalent of readmission, right?

So I guess this gets to the question of

whether you think readmission, 7- or 30-day readmissions are good quality measures or not. It's always been an interesting -- it's always been interesting to those of us who sort of think about this stuff why you have to have been admitted to the hospital for the quality -- for the readmission clock to start counting when -- because for all the same reasons, coming back to the hospital and requiring more stuff after an ED visit sort of brings about a lot of the same questions and concerns, both on its face as well as probably when you dig deeper as well, so --

DR. FERRIS: So let me just test that. Let me just test a different way of saying that and see what you think.

DR. MEISEL: Yeah.

DR. FERRIS: So in the context of this proposal, one actually should expect a certain readmission rate, that a zero readmission rate is actually not the right readmission rate.

DR. MEISEL: Absolutely. In fact, I would say a lot of times, patients are told to come back if they're not feeling better.

DR. FERRIS: Right.

DR. MEISEL: Otherwise we would admit

everyone, right? And so if I trust you -- you've got the belly pain. It's not that bad, but it was really bad before, and your workup so far has been negative. But I'm a little worried. But you're a reasonable person. You live a block away from the hospital, and I know that you and your spouse will get you here if you start feeling worse. Then I will tell you to come back if you don't feel better, and I would expect you to come back, and want you to come back. And I wouldn’t want to --

DR. FERRIS: Right.

DR. MEISEL: But at some point, just like readmission, we expect some patients with heart failure to return after an inpatient stay, but what that number -- what the right number is -- it's not zero, but what it is, is also probably less than 50.

DR. FERRIS: Right.

DR. MEISEL: But probably the more the worse. Yeah.

DR. FERRIS: Here, we get into an issue that Len raised with risk adjustment, right? Because we're now down into conditions, that these are common in the ED, but they're still on a Pareto chart. They're not the majority of things that are

seen.

DR. MEISEL: They may be the majority of things.

DR. FERRIS: I think they are.

DR. MEISEL: Yes.

DR. FERRIS: Okay. So as a sum total --

DR. MEISEL: Yeah.

DR. FERRIS: -- these four are, but if you break them down individually, they're not, right?

DR. MEISEL: Well, abdominal pain is number one, and chest pain is number two. I don't know if they add -- individually, they're not the majority, but they are the numbers one and two reasons for emergency department visits nationally.

DR. FERRIS: Well, I'm just sort of getting into the science here of --

DR. MEISEL: Yeah.

DR. FERRIS: So say a quality measure is readmission for chest pain, you could expect month-to-month, year-to-year variation. So there's a signal-to-noise issue here that I don't know if we have the science, if the science is ready for this yet.

DR. BAILET: Tim?

DR. FERRIS: Yeah.

DR. BAILET: This is Jeff.

I thought -- I'm sorry. I've been listening --

DR. FERRIS: Yeah.

DR. BAILET: -- in for a bit, but I thought they were going to wash out this signal-to-noise or the variation by doing a baseline, because this activity is happening, right? Right now as we speak. Wouldn't that be the baseline and then the variation above and beyond that for --

DR. FERRIS: Yeah.

DR. BAILET: Right?

DR. FERRIS: And that’s -- I guess what I'm asking then is, is that sufficient? Or could secular trends or other just random variation -- on a year-to-year basis, would you expect over a year's experience, your chest pain revisit rate, readmission rate to the ED, be stable?

DR. MEISEL: Let me think about this.

I don't think that there has been -- so from a secular trend perspective, chest pain admissions have dropped over years for -- I think for two main reasons, one of which is the increase in observation, and the other is improved clinical decision rules that have allowed -- that have been

validated, that have allowed clinicians to use, for example, highly sensitive cardiac enzyme assays in the ER to basically risk-stratify patients in a way that is meaningful and that they can follow up and get different types of outpatient studies.

But would a -- so there probably are some trends in these conditions, particularly maybe chest pain, maybe less abdominal pain. But would that -- but those baselines would also readjust, right, from what I'm -- so I don't imagine that there would be significant year-to-year variation.

DR. FERRIS: Okay. That was my question.

DR. MEISEL: Yeah, yeah.

And I'm thinking about this for the first time right now, but just thinking about it -- there are other clinicians on the phone, right? Or am I the only one?

DR. FERRIS: You're talking to at least two.

MS. BOGASKY: Yes.

DR. FERRIS: And I know Len plays one on TV.

[Laughter.]

DR. MEISEL: Anjali, you're a clinician, sort of?

DR. JAIN: Yeah, I am. Yep.

DR. MEISEL: Yeah. Do you still see -- yeah.

DR. JAIN: Yes.

DR. MEISEL: I don't know. What do you guys -- I mean, I don't know. Am I -- does that make sense?

DR. JAIN: Yeah. To me, it does.

DR. MEISEL: It's such a numbers problem. It's numbers and is the variability in the intensity, or is variability in the risk on a year-to-year basis constant? And I just don't know the answer to that, but it sounds like you're comfortable that --

DR. JAIN: I think when there's new guidelines and things like that, that can change it.

DR. MEISEL: Yeah. Yeah, yeah.

DR. JAIN: But beyond that --

DR. FERRIS: I would also argue with the new CT scan that can get cardiac architecture in one heartbeat, and if that CT gets deployed across EDs, your chest pain admission rates are going to change. That whole complexion is going to change.

So there needs to be an opportunity with

technology or clinical advancement to go back in and reset these baselines. There's just too much movement year-to-year, not the underlying signal-to-noise of the clinical pictures and tools didn't change. But that's not the environment we live in, right?

DR. MEISEL: Yeah. I think that's right.

DR. FERRIS: So, Jeff, now that you're on the call, do you want to direct any questions to Dr. Meisel?

DR. BAILET: Well, I thought -- and again, I apologize for being late. I think that the concept of an alternative payment model for emergency medicine is brilliant and desperately needed.

I used to be on the provider side. I've been with the Blue Shield of California, a large health plan in the state, for a year, and one of our biggest expenditures and most challenging to actually influence is emergency medicine utilization.

And so having a partnership with the emergency medicine community is -- it's really a national need. So what I'm struggling with -- and it's already been commented upon -- is the actual

financial model. How do we actually -- What's the best way to reward the clinicians and the physicians for paying attention and managing these high-frequency reasons for presenting to the ED that is less complex?

Because I just feel that their proposed model is overly complex, and it may have to be. And that's really my question. Is there another way to get to the same place, meaning recognizing them for their efforts to focus on these very important things, but to have a financial model that is not so bloody complex?

And normally, I wouldn't ask this question because we as a PTAC committee are obligated to evaluate the proposals as they lay, but because Congress changed the language, we may have an opportunity -- and this is -- I've not shared this with my colleagues or the staff on the phone, but we may have an opportunity to provide some guidance to them to pursue potentially a different facet of financial recognition.

DR. MEISEL: Yeah. I mean, I would just echo that. I think that this is -- emergency physicians and emergency medicine have been hearing for years about sort of this overutilization,

inappropriate visits, inappropriate admissions, and, boy, is it -- you know, when you're in the weeds, is it difficult to try to kind of pull some of these things apart. There are better and better tools that allow us to risk-stratify patients, particularly with these conditions. And now there's an opportunity to actually try to both reward better decision-making and -- or more nuanced decision-making and put at risk sort of knee-jerk decision-making.

At the same time, I think -- and keeping people out of the ER or not, what Anthem is doing, which is not paying for patients who are determined after the fact to be inappropriate, is both problematic and would be addressed by potentially something like this.

DR. BAILET: So I don't know. Maybe I -- I don't know. I'd be interested in Len or Tim's perspective on my question. Is that not a worthwhile pursuit, or do we just need to stay and try and decipher their financial model and leave it alone?

DR. NICHOLS: So I think it's definitely, in this case, worth our consideration. I don't think it's the smartest use of our time with Doctor

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DR. MEISEL: Meisel.

DR. NICHOLS: Our consult here because, I mean, this is something we're going to have to wrestle with as a committee, and just to be clear, we're just the PRT.

DR. BAILET: Understood. Yeah.

DR. NICHOLS: But I think it's right -- it was in my mind, Jeff. You just said it, so I think it's right to raise it.

Anyway, I learned a lot. I think we've overstayed our welcome, but I'm happy to follow Tim's lead.

DR. FERRIS: Yeah. So I think this has been very helpful.

I guess -- I think we'll caucus a little bit among ourselves.

Do you have any questions for us?

DR. MEISEL: So --

DR. NICHOLS: Or anything we should have asked?

DR. MEISEL: So I can -- I made a few sort of high-level notes around -- that were things that, you know, if I had an opportunity to provide input directly to ACEP, you know, one of which I

think is around wording and title.

There may be a reason for calling it "Enhancing Appropriate Admissions," but, boy, is that a loaded term, "appropriate" and "inappropriate." And it raises the hackles of clinicians, as well as I think a lot of folks, because this is not necessarily about inappropriate or appropriate. This is about risk stratification and nuanced decision-making and how to actually build capacity to be able to help people feel more comfortable discharging patients for whom follow-up care is less clear.

DR. NICHOLS: Well, in the spirit of what our new legislative authority might be, Dr. Meisel, I would love it if you could send us whatever notes or comments you made. I don't know why we shouldn't -- couldn't take that under advisement and cite the source and say it ourselves if we think it's appropriate at the committee level.

DR. MEISEL: That's great.

I mean, there's even some -- been some nice editorials written about that terminology.

The only other thing -- I know we discussed it already -- is that -- that piqued my interest and wasn't really very well fleshed out

here was the abdominal pain category, which I do think is just qualitatively different than the others, although it's an important one because it's so common as a presentation.

But in terms of variation, what wasn't clear to me is where the variation lies in terms of pre- or post-workup and how does that -- variation for abdominal pain before a patient -- for all comers before they've gotten even a CAT scan is a very different ball of wax to me than somebody who gets evaluated, gets determined to have negative emergency department workup, but is admitted for other reasons. And is the variation there may be -- is probably important, but it's different than a chest pain or syncope, where the variation is about risk of a sudden life-threatening event.

Altered mental status, yeah. I'm not -- I think it's fine where it is, although it may be a challenge because there's so many clinical conditions that cause altered mental status that it's not really a distinct clinical entity. It's a presentation and a symptom, and what it means is hard for me to sort of wrap my brain around.

But those are my high-level questions and thoughts, and other than that, I'm excited about

the possibility of an alternative payment model, and I thought this was pretty well-sourced, well-documented, and the analysis seems relatively sophisticated, barring some of the questions that you guys have.

DR. FERRIS: Great. Great. Well, we'd love to see your notes on this, and so thank you very much. Great.

DR. MEISEL: I guess I'll just summarize some of my notes, and I'll forward them to Vanessa, who was my contact, and I guess maybe she can get them to you.

MS. BOGASKY: Yeah.

DR. FERRIS: Perfect. Thank you.

DR. NICHOLS: Thank you.

MS. STAHLMAN: So the transcriptionist can now stop transcribing, and the consultant can leave the call, and then the PRT members can stay on for the last part of the call.

Thank you.

MS. STAHLMAN: Thank you.

DR. JAIN: Thank you, Zach.

DR. MEISEL: Thank you. Take care.

DR. JAIN: Bye.

DR. BAILET: Bye, everyone.

[Whereupon, at 12:46 p.m., the conference call concluded.]