Healthy Capital District Initiative

Emergency Department Use and Planning

Department of Health Presentation
April 1, 2010
Quality care in the appropriate setting at the right cost
State Support for Emergency Departments

- DoH assessment of ER data
- CON approvals and reductions in PQI admissions
- Promoting more regional health planning
- Changes in Medicaid reimbursement
- Medical Home
- HEAL initiatives
New York Leads the Nation in Medicaid Inpatient Hospital Spending

- New York ranks #4 on per enrollee inpatient hospital spending and spends almost twice the national average.

Source: CMS, 2008 Statistical Supplement Table 13.3 and 13.26
Despite High Spending, New York Performs Poorly on Key Quality Indicators

**State Scorecard on Health System Performance**

<table>
<thead>
<tr>
<th>Care Measure</th>
<th>2009 Scorecard</th>
<th>2007 Scorecard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall National Ranking</td>
<td>21</td>
<td>27</td>
</tr>
<tr>
<td><strong>Access:</strong> Insurance coverage &amp; indicators of access and affordability of care.</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td><strong>Prevention &amp; Treatment</strong> Effective care, coordinated care, and patient-centered care.</td>
<td>22</td>
<td>32</td>
</tr>
<tr>
<td><strong>Healthy Lives</strong> Measures of long &amp; healthy lives, including rates of smoking and obesity.</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td><strong>Avoidable Hospital Use &amp; Costs</strong> Care that may have been prevented or reduced with appropriate care as well as Medicare costs and annual private insurance premiums.</td>
<td>50</td>
<td>42</td>
</tr>
<tr>
<td><strong>Equity</strong> Performance associated with income level, type of insurance, or race/ethnicity.</td>
<td>11</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: The Commonwealth Fund
Problems in the ED

- **Symptoms**
  - Overcrowding
  - Questionable admissions
  - Decreased patient safety

- **Reasons**
  - Access to primary care, particularly for special populations
  - Physical design of ED

- **Response**
  - Improved hospital through-put/observation beds
  - Expanded access to community based care
DoH Fact Finding: ER Overcrowding
ED Overcrowding

- Recognition of the growing problem
- Periodic regional surveillance when issues were identified
- Respond to complaints about poor care
ED Overcrowding Panel

- Convened Dec 13, 2006

- Stakeholders include:
  - ED Physicians
  - Directors of Nursing
  - Hospital Associations
  - OMH
ED Overcrowding Panel

- What are the factors?
- Who do we need to engage?
- What steps do we take to affect change?
- What data do we need?
- How do we collect the data?
HERDS Survey

☐ Collecting ED census data via HERDS

☐ 3 times/week
  ■ Monday, Wednesday, Friday

☐ Collecting
  ■ Number of admitted patients waiting for an inpatient bed over 24 hours
  ■ Number of days with over 30 patients waiting
ED Surveys

- On-site surveys process to collect facts
- Non-regulatory
- Used HERDS data to formulate the list
  - Frequent outlier
  - Geographic distribution
  - Sustained levels of overcrowded situations
- Unannounced
- Conducted 5 surveys to date
ED Surveys

- Comprehensive review of hospital system, not just ED
  - ED Directors
  - Administration
  - Housekeeping
  - Bed czar (if used)
- Appropriate level of inpatient admission
- EMS wait times
Variation

- Not ED Problem

- Issues are statewide

- Variation in what hospitals are doing to combat problem
Best Practices

- Centralized bed monitoring systems
  - Especially effective if combined with transportation and housekeeping efforts
  - 1-2 times daily bed meetings with participants from all affected departments
  - All have access to the system for monitoring

- Decreased door to doc time
  - Nurse/doctor triage team
Best Practices

- Notification/involvement of administration during peak periods
- ID of a “trigger” that accelerates services during overcrowding; eg discharge services, environmental, bed management, etc
- Dedicated ancillary services to the ED
- Patient satisfaction surveys
DoH Certificate of Need Process
Certificate of Need Review
Nonurgent ED Utilization

- Consistent with causal factors identified by HCDI
  - Poor service selection by patients
  - Preventable conditions
Change in Focus

- Community-centric versus Institution-centric
  - Community Service Plans & Community Health Assessments (Rochester example)
  - PQI Data

- Broadened view of acute care projects
  - ER specific
  - M/S related
## Enhanced ED Analysis

<table>
<thead>
<tr>
<th>Previous Criteria</th>
<th>Current Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Visits per square foot</td>
<td>• Types of visits and treatment bays</td>
</tr>
<tr>
<td>• Annual visits per treatment bay</td>
<td>• Utilization trends</td>
</tr>
</tbody>
</table>

- Enhanced ED Analysis
- Previous Criteria
  - Visits per square foot
  - Annual visits per treatment bay
- Current Criteria
  - Types of visits and treatment bays
  - Utilization trends
Non-ER Projects

- PQI analysis
- Relationship/affiliation with other providers
- Acuity levels
- Primary Care initiatives
- Payor Mix
ER Design

- Flex-capability
- Surge and Preparedness
- Security Considerations
- Function and throughput
Financial Reform and Incentives
Medicaid Inpatient Spending Per Enrollee Significantly Exceeds National Averages; Spending on Physician Care Has Lagged

Source: CMS, 2008 Statistical Supplement Table 13.26
Medicaid Hospital Reimbursement Reform

Inpatient
- Base Year Update/Severity Adjusted DRGs (12/1/09)
- Psychiatric Severity Per-Diems (in process)
- Cost Report Simplification (in process)

Outpatient
- APGs (12/1/08)
- Medical Home (in process)
- Primary Care Enhancements (implemented/in process)
- Reimburse Physician Service separate from Hospital Rate (in process)

Indigent Care
- 10% of Payments Based on Uninsured Units (4/1/09)
- Overall Transparency (ongoing)
New York has Invested over $600M in Medicaid for in Ambulatory Care

<table>
<thead>
<tr>
<th>(Gross $ in Millions)</th>
<th>Approved in SFY 08/09 Budget (Full Annual)</th>
<th>Additional Funding Approved in SFY 09/10 Budget (Full Annual)</th>
<th>Total Investment SFY 10/11 (Full Annual)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Programs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>$178.0</td>
<td>$92.0</td>
<td>$270.0</td>
</tr>
<tr>
<td>Ambulatory Surgery</td>
<td>$88.0</td>
<td>$92.0</td>
<td>$180.0</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$40.0</td>
<td>$0.0</td>
<td>$40.0</td>
</tr>
<tr>
<td>Freestanding Programs</td>
<td></td>
<td>$12.5</td>
<td>$50.0</td>
</tr>
<tr>
<td>Primary Care Investments</td>
<td></td>
<td>$38.0</td>
<td>$128.1</td>
</tr>
<tr>
<td>Asthma and Diabetes Education (08/09 Enacted)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded &quot;After Hours&quot; Access (08/09 Enacted)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Social Worker Counseling (08/09 Enacted)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Smoking Cessation (08/09 Enacted)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Nurse Family Partnership (08/09 Enacted)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Cardiac Rehabilitation (09/10 Enacted)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>SBIRT (09/10 Enacted)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Smoking Cessation (09/10 Enacted)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Primary Care Standards/Medical Home (09/10 Enacted)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Adirondack Medical Home (09/10 Enacted)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Physicians</td>
<td>$120.0</td>
<td>$68.0</td>
<td>$188.0</td>
</tr>
<tr>
<td>Mental Hygiene Enhancements</td>
<td></td>
<td>$2.7</td>
<td>$2.7</td>
</tr>
<tr>
<td>Detoxification Services Reform</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$348.5</strong></td>
<td><strong>$290.3</strong></td>
<td><strong>$638.8</strong></td>
</tr>
</tbody>
</table>
Impact of Investment: Hospital Clinic Rates Up 55%
Impacts of Investment: Payments to Physicians and Practitioners Up 80% Still not at Medicare Levels

Note: Calculations include fee schedule enhancements only. These do not include the following primary care enhancements: (1) asthma and diabetes education; (2) expanded ‘after hours’ access; (3) smoking cessation; and (4) medical home enhancements.
Impact of Investment: Hospital ED Rates Up 48%
2010-11 Rate Reform Proposals

-- Reducing PPRs (Potentially Preventable Readmissions)

- Total Annual Cost (2007) of PPRs $813M for 70,294 readmissions, $665M (82%) for persons with MH/SA diagnoses

-- Restructuring Indigent Care and DSH

-- Investment in Doctors Across New York Phase II ($3.8M, full annual)

- Additional 100 slots: 50 for Physician Loan Repayment and 50 for Physician Practice Support
Medical Home Initiative

- New York Medicaid to adopt medical home standards that are consistent with those of the National Committee for Quality Assurance's (NCQA) Physician Practice Connections® - Patient-Centered Medical Home Program (PPC-PCMH™).

  - The PPC-PCMH™ is a model of care that seeks to strengthen the physician-patient relationship by promoting improved access, coordinated care, and enhanced patient/family engagement.

  - A medical home also emphasizes enhanced care through open scheduling, expanded hours, and communication between patients, providers and staff.
Medical Home Incentive Payments

- Upon federal approval, office-based practitioners (physicians and registered nurse practitioners) and Article 28 clinics recognized by NCQA's PPC-PCMH™ will receive additional payment for primary care services provided to Medicaid beneficiaries.

- Payment will be made through Medicaid fee-for-service rates and by health plans for clients enrolled in Medicaid Managed Care or Family Health Plus.

- There will be three levels of incentive payments for fee-for-service providers. Evaluation and Management (or Preventive Medicine codes) will be eligible for an enhanced payment, commensurate with the level of NCQA recognition received by the provider.

- Fee-for-service add-on incentive payment amounts for providers achieving patient-centered medical home recognition are as follows:

<table>
<thead>
<tr>
<th>Setting</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article 28 clinics</td>
<td>$5.50</td>
<td>$11.25</td>
<td>$16.75</td>
</tr>
<tr>
<td>Office-based practitioners*</td>
<td>$7.00</td>
<td>$14.25</td>
<td>$21.25</td>
</tr>
</tbody>
</table>

- A majority of providers participating in Medicaid managed care, will also receive three levels of payment but as a 'care management' fee paid as a per member per month (vs. adding to a visit fee). There is some flexibility but DoH has encouraged payment levels close to $2/4/6 per member per month depending on level.
Healthcare Efficiency and Affordability Law for New Yorkers (HEAL-NY)

- Established by Chapter 43 of the Laws of 2004 (amended in 2006 and 2009) to invest up to $1 billion in state resources over 4 fiscal years;

- Provides “match” to Federal F-SHRP funds to invest in:
  - Health information technology
  - Restructuring of healthcare services
  - Support for hospitals to transition to the new Medicaid FFS rates
  - Capital access initiatives, including PCDC

- Sources of funding for HEAL-NY included Personal Income Tax state supported bond funding issued by DASNY and state capital appropriations
HEAL Awards Phases 1 through 14 as of January 2010

<table>
<thead>
<tr>
<th>HEAL Phase</th>
<th>Eligible Projects</th>
<th>Total Amount (in Millions)</th>
<th>Awards Announced</th>
<th>Number of Awards</th>
<th>Talking Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Health IT</td>
<td>$53</td>
<td>May-06</td>
<td>26</td>
<td>The first round of Health IT grant projects. Funds interconnect for multiple providers on a regional basis.</td>
</tr>
<tr>
<td>2</td>
<td>Capital Restructuring</td>
<td>$268</td>
<td>Nov-06</td>
<td>53</td>
<td>The first round of capital restructuring grants. These projects were reviewed, scored and announced before the commission mandates were published.</td>
</tr>
<tr>
<td>3</td>
<td>Health IT</td>
<td>$53</td>
<td>Canceled 8/07</td>
<td>0</td>
<td>This was an extension of Phase 1 in concept. This round was canceled under The Health Department's Office of Health Information Technology and Transformation. Phase 3 funds were rolled into Phase 5.</td>
</tr>
<tr>
<td>4</td>
<td>Implementation of Berger Commission Mandates</td>
<td>$550</td>
<td>Four Rounds 1) 9/28/07 2) 1/1708 3) 3/27/2008 4) 9/30/08</td>
<td>49</td>
<td>This Phase limited the eligible applicant pool to the facilities which were identified in the Commission's Report which became mandated activities. Grants were negotiated with the help of the Berger team with an emphasis on financial need and compliance with the mandate.</td>
</tr>
<tr>
<td>5</td>
<td>Health IT</td>
<td>$106</td>
<td>Apr-08</td>
<td>21</td>
<td>This phase is the launch of the new statewide Health IT initiative. Goals include the building of a statewide health information network (SHINY) using regional health information organizations (RHIOs) and local health collaborations (CHITAs). Contracts are managed directly by OHITT.</td>
</tr>
<tr>
<td>6</td>
<td>Expanding Primary Care</td>
<td>$100</td>
<td>Sep-08</td>
<td>79</td>
<td>This phase is to enhance and expand primary care services in the community. It includes a range of eligible applicants and only allows $20 million to directly be awarded to hospitals.</td>
</tr>
</tbody>
</table>
## HEAL Phases 1-14 (continued)

<table>
<thead>
<tr>
<th>HEAL Phase</th>
<th>Eligible Projects</th>
<th>Total Amount (in Millions)</th>
<th>Awards Announced</th>
<th>Number of Awards</th>
<th>Talking Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Capital Restructuring (Round #2)</td>
<td>$150</td>
<td>Sep-08</td>
<td>26</td>
<td>This is to fund Berger Coverage Partners and Berger “Look-alikes”. Primary support to closures and mergers which were not identified in the Berger Commission’s final report.</td>
</tr>
<tr>
<td>8</td>
<td>RHCF Rightsizing</td>
<td>$30</td>
<td>Sep-08</td>
<td>10</td>
<td>Grants to Nursing Homes to support activities which result in the reduction of RHCF beds and expands community based services. Complies with 2818 Section 3.</td>
</tr>
<tr>
<td>9</td>
<td>Planning</td>
<td>$8</td>
<td>Feb-09</td>
<td>19</td>
<td>Local Healthcare Planning Grants - This includes $1M for the Finger Lakes HSA</td>
</tr>
<tr>
<td>10</td>
<td>Health IT</td>
<td>$100</td>
<td>Sep-09</td>
<td>11</td>
<td>The goal of this phase is to improve care coordination and management through a patient centered medical home model supported by an interoperable health information infrastructure. Includes funding for the New York eHealth Collaborative.</td>
</tr>
<tr>
<td>11</td>
<td>Capital Restructuring (Round #3)</td>
<td>$174</td>
<td>Sep-09</td>
<td>25</td>
<td>This phase is to assist hospitals to voluntarily downsize, consolidate services and initiate changes in governance or merge for operational efficiencies.</td>
</tr>
<tr>
<td>12</td>
<td>Alternative Long Care Initiatives</td>
<td>$172</td>
<td>Sep-09</td>
<td>19</td>
<td>The goal of this phase is to assist communities in developing viable alternatives to RHCF care for long term care populations while downsizing RHCF beds.</td>
</tr>
</tbody>
</table>
HEAL Phases 1-14 (continued)

<table>
<thead>
<tr>
<th>HEAL Phase</th>
<th>Eligible Projects</th>
<th>Total Amount (in Millions)</th>
<th>Awards Announced</th>
<th>Number of Awards</th>
<th>Talking Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Expanding Access in Queens - Round #1</td>
<td>$16</td>
<td>Feb-09</td>
<td>8</td>
<td>These were emergency grants awarded to increase access in Queens responding to the healthcare need due to the closure of St. John's Queens and Mary Immaculate Hospitals and St. Dominic's Health Center.</td>
</tr>
<tr>
<td>14</td>
<td>Expanding Access in Queens - Round #2</td>
<td>$30</td>
<td>Sep-09</td>
<td>12</td>
<td>This phase is for additional funds to hospitals and D&amp;TCs for projects that meet distinct health care needs in the borough of Queens.</td>
</tr>
<tr>
<td>14</td>
<td>Individual Facility Awards</td>
<td>$105</td>
<td>Sep-09</td>
<td>14</td>
<td>This block of discretionary awards were made to help address specific problems and issues experienced by various facilities across NYS. Some funds were used to complete pending Berger mandated changes and in addition, five awards were made to</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(Total dollars excludes Phase #3)</td>
<td>$ 1,862</td>
<td></td>
<td>372</td>
<td><strong>Total HEAL Projects</strong></td>
</tr>
</tbody>
</table>
Healthcare Efficiency and Affordability Law (HEAL)

In addition to HEAL 9 (Local Planning grants), HEAL 10 supported $60 m for 9 Patient Centered Medical Home Model IT projects throughout the State.

Projects include the following elements:

- Improve the coordination and management of care across the full continuum of care for a target patient population through a Patient Centered Medical Home (PCMH) model supported by the implementation and effective use of interoperable health IT.

- Identify a target patient population with a chronic disease or high risk/high cost diagnosis and support a PCMH through which the care of the target patient population will be coordinated and managed.

- Include a Community Health Information Technology Adoption Collaboration (CHITA) responsible for promoting and supporting implementation of interoperable EHRs and other health IT tools and ensuring their effective adoption and use to support the PCMH model.
Discussion:
Capital Region Data
## 2008 PQI Admissions and Patient Days at Capital District Hospitals

<table>
<thead>
<tr>
<th></th>
<th>Statewide</th>
<th>Ellis</th>
<th>Albany Medical Center</th>
<th>Albany Memorial</th>
<th>St Peter's</th>
<th>Seton – St. Mary's</th>
<th>Samaritan</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQI Admissions (Adults)</td>
<td>259,538</td>
<td>2,159</td>
<td>1,520</td>
<td>785</td>
<td>2,197</td>
<td>1,231</td>
<td>1,141</td>
</tr>
<tr>
<td>… as % of Med-Surg Adults</td>
<td>15%</td>
<td>15%</td>
<td>7%</td>
<td>16%</td>
<td>13%</td>
<td>20%</td>
<td>22%</td>
</tr>
<tr>
<td>PQI Patient-Days (Adults)</td>
<td>1,450,985</td>
<td>11,355</td>
<td>9,030</td>
<td>4,162</td>
<td>13,564</td>
<td>6,599</td>
<td>6,350</td>
</tr>
<tr>
<td>… as % of Med-Surg Adults</td>
<td>14%</td>
<td>15%</td>
<td>7%</td>
<td>18%</td>
<td>13%</td>
<td>21%</td>
<td>22%</td>
</tr>
<tr>
<td>Average Length of Stay (PQI's)</td>
<td>5.6</td>
<td>5.3</td>
<td>5.9</td>
<td>5.3</td>
<td>6.2</td>
<td>5.4</td>
<td>5.6</td>
</tr>
</tbody>
</table>
Treated and Released ED Visits: 2007

### Data Table

<table>
<thead>
<tr>
<th>Hospital</th>
<th>NOT Emergency</th>
<th>PC-Treatable Emergency</th>
<th>ED Required - Avoidable</th>
<th>ED Required NOT Avoidable</th>
<th>Injury, Substance, Mental Health</th>
<th>Unclassified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany Medical Center</td>
<td>18%</td>
<td>19%</td>
<td>7%</td>
<td>9%</td>
<td>29%</td>
<td>2%</td>
</tr>
<tr>
<td>Albany Memorial</td>
<td>21%</td>
<td>19%</td>
<td>5%</td>
<td>10%</td>
<td>34%</td>
<td>2%</td>
</tr>
<tr>
<td>St. Peter's</td>
<td>20%</td>
<td>21%</td>
<td>5%</td>
<td>12%</td>
<td>29%</td>
<td>2%</td>
</tr>
<tr>
<td>Seton - St. Mary's</td>
<td>20%</td>
<td>21%</td>
<td>6%</td>
<td>9%</td>
<td>30%</td>
<td>1%</td>
</tr>
<tr>
<td>Samaritan</td>
<td>20%</td>
<td>19%</td>
<td>5%</td>
<td>9%</td>
<td>30%</td>
<td>1%</td>
</tr>
<tr>
<td>Ellis (incl. St. Clare’s)</td>
<td>16%</td>
<td>20%</td>
<td>5%</td>
<td>12%</td>
<td>31%</td>
<td>3%</td>
</tr>
</tbody>
</table>