NEW MODELS TO CONTROL ESCALATING HOSPITAL-RELATED COSTS

The cost of carerelated to hospital admissions, readmissions, and emergency room visits is now front and center in the national conversation. In 2011, (the most recent published statistics), the aggregate cost for nearly 39 million hospital stays totaled $387 billion. Inpatient hospital services constitute the largest share of total healthcare spending in the United States. In addition to providing direct medical care, services provided by hospitals to patients, include: room and board, ancillary charges, services of resident physicians, inpatient pharmacy, hospital-based nursing home and home health care, and all other services. As health care costs continue to rise and the population ages, we need to be increasingly concerned about the growing burden of hospital-based care expenses.

Equally concerning are ER visits. Emergency care represents about 4% of all health care spending in the United States. On average, expenses for emergency department visits are higher than for visits to physician offices or other outpatient settings. Between 2000 and 2010, the mean expense for emergency department visits that did not result in a hospital admission increased by 77%. Unnecessary ER visits for minor conditions—colds, headaches, and feverish babies, minor cuts and bruises —that could be handled more cheaply in doctors' offices or an outpatient clinic have also been much discussed and debated because they cost the health system several billion dollars annually.

Peter Orszag, the Director of the Federal Office of Management and Budget, says that about $700 billion, or 5% of the U.S. gross domestic product, is wasted on unnecessary care, such as extra costs related to medical errors, defensive medicine, and just plain fraud. He contends that: "If we could only convince patients to take their stubbed toes to urgent-care clinics or primary-care offices instead of the ER, we could save a load and help fix this whole health care fiasco."

Obviously there is some truth to this statement. However, the reality is that most visits are defensible, and it is difficult to distinguish among patients who come to the ER to determine who genuinely needs

critical care. A study of almost 35,000 patient visits to emergency departments across the country, indicate that in only 6% of cases, the patient was discharged and could have been treated in a doctor's office. In nearly 90% of the other, more urgent cases, patients came to the emergency room with similar complaints, like abdominal discomfort, chest pain or fever, as the 10% who ended up in surgery or intensive care. The other 80% who were treated and sent home, did have a serious condition that needed to be addressed.

There are some innovative programs being piloted in various part of the country to treat patients more effectively in the home, help them remain stable, and out of the hospital and the ER.

EasCare, a mobile, integrated healthcare provider and one of New England's largest health transportation companies has aligned with Commonwealth Care Alliance, a not-for-profit care delivery system for Medicare and Medicaid beneficiaries. Together EasCare and Commonwealth Care Alliance are piloting a program to send paramedics into homes to treat patients with complex medical conditions. The purpose is to avoid sending them to the hospital whenever possible.

This innovative program called Community Paramedics enables the paramedics to access an individual's health record from the patient's primary care physician, visit the home, take labs, administer IVs, evaluate respiratory issues, assess blood sugar levels, manage hypertension, treat nausea and vomiting symptoms, treat for infection, minor wounds, injuries from falls, and problems associated with chronic disease, and provide 24/7 phone assistance between visits. These paramedics are trained, certified healthcare providers, who can administer advanced life support as well as basic care services. Their training includes hundreds of hours of classroom and clinical work in the hospital and on ambulances. They must have a state license to practice.

A Minnesota health care provider, North Memorial Health System, is doing much the same thing, among patients who have a record of frequently visiting the ER (nine or more times a year). Paramedics

help these patients manage their chronic conditions and address problems so that they can be controlled in the home.

In Boise Idaho, there is a pilot program where paramedics are assigned high-risk patients who have recently been released from the hospital. The paramedics visit the patient within 48 hours of their release and follow-up with them for a month, to insure that they are taking their medications and following the release instructions issued by the hospital physicians. The paramedics not only focus on the patient, but on conditions in the home that might cause the patient to fall or otherwise have an emergency. The program is in its second year and has been successful.

Another program, at SUNY Upstate Medical University in New York, involves social worker visits to the home to ensure that patients schedule an appointment with their primary care physician following a hospital stay. According to a two-year study, this program has helped reduce readmissions by more than 50%.

With pressure on hospital staff to send people home sooner than they used to, helping patients through the difficult transition from hospital to home has become critical. Early reports indicate that those who are followed by a social worker, paramedic, nurse, or other healthcare worker have fewer post-discharge complications, and subsequent readmissions, because their issues are caught early and treated effectively,before they become serious and more costly.