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The Economic Impact of Delivering ED Health Care

THE SURGICALIST: A NEW CONCEPT IN ON-CALL CARE

Your emergency department can turn away no one that is the reality of , but what is being done to soften the economic impact.

Welcome to the Clinician's Roundtable. I am your host, Dr. Shira Johnson, and joining us today to discuss the economic impact of delivering ED care is Dr. John McConnell, who has his PhD from Stanford University, but he is also an Associate Professor of Emergency Medicine at Oregon Health And Science University. He has been working on a committee formed by The Institute of Medicine to solve the on-call crisis in Palm Beach County. His research is focused on emergency and trauma care, behavior and health sciences, and health policy.

DR. SHIRA JOHNSON:

Dr. McConnell welcome to ReachMD.

DR. JOHN MCCONNELL:

Thank you, nice to be here.

DR. SHIRA JOHNSON:

First of all what is your role in department of emergency medicine and how did you get there? There is not too many people who study economics that work in the ER.

DR. JOHN MCCONNELL:

Right, I am sort of an odd bird. Our emergency department at Oregon Health & Science University has a research group and I am an economist as part of this group and so I do research and look for grants to do research and some of my research is on emergency care and that turned out to be a good place to go. There is a lot of interest in health economics and not many people have focussed on emergency care service of nice fit for me after graduate school.

DR. SHIRA JOHNSON:

And you are very timely doing this right now, right?

DR. JOHN MCCONNELL:

Yeah, I have lot of interest in health economics in general and especially the uninsured and how they relate to emergency care.

DR. SHIRA JOHNSON:

Now emergency departments in America have had the same economic crisis that American's face. In fact they may have been facing it longer with budget cuts what are some of the strategies that you have explored to solving the problem of subspecialty coverage.

DR. JOHN MCCONNELL:

In other sort of may be 5 ways that hospitals are sort of dealing with this. You know one is just to go without call and that unfortunately is happening so we know that lot of hospitals are dropping 24/7 coverage for some other hospitals and in Oregon it has been a large number. It has been over a third of hospitals that have done that. The second strategy is to pay stipend so you pay physicians receive 1000 or 2000 dollars a night to agree to carry beeper and be on-call. Third is to guarantee pay for physicians say at a medicare rate for any patient they see, who is uninsured so that the physicians know that they are getting paid. A more sort of recent shift is to employ physicians or specialists like a hospitalist model, but employing surgeons instead of primary care physician. And then other things that are being used here and there are some more frequent hiring of local attendant physicians to come in and cover call gaps and then in some cases interest in regionalization.

DR. SHIRA JOHNSON:

Now surgicalists come in. They are paid by the hospital stipend correct, and they are on their on-call.

DR. JOHN MCCONNELL:

Yes.

DR. SHIRA JOHNSON:

And then they see patients that need surgeons emergently correct.

DR. JOHN MCCONNELL:

Yes.

DR. SHIRA JOHNSON:

Is it cost effective to higher surgicalists?

DR. JOHN MCCONNELL:

Yes, it's a good question. I think it depends on the hospital size and how many patients they see and how many surgeons they have to employ, but in some ways its becoming more cost effective because of these other changes and so you could imagine that say 3 years ago hospital might look may be lets say well, I can hire 3 surgeons for a million dollars, but if I higher them I am only going to bring an extra 700,000 dollars in terms of the revenue that I could capture from those physician services, so I will be losing 300, 000 dollars and so I wouldn't do that, but today you know the option might be to do that and lose 300,000 dollars or to not do that, but still end up losing 500,000 dollars that should be paying in stipends and so I think what hospitals are seeing is well may be I make money or I break even, but its better than not having that money and paying out these stipends.

DR. SHIRA JOHNSON:

You worked on a committee out of Palm Beach County to solve their on-call crisis. Can you tell us something about that project?

DR. JOHN MCCONNELL:

That was a couple of years ago and that was sort of one of the early canary in the coalmine places where this is becoming a real issue. When Palm Beach turned I didn't realize that still I went down there, but this is one of the richest counties in the US and perhaps the richest county in the US. This is where Donald Trump has one of his famous houses and it's a nice place and near there the focus was people were looking for lot of different solutions and nobody really sort of proposed a surgicalist model or at least not widely. The focus then was really to try to see if you could regionalize call and it seems to make sense. You know, you would think in an urban area may be you don't need a hand surgeon to be on-call at every single hospital every night of the week, so may be you can find a way for 1 hand surgeon group at 1 hospital to take call for the whole region and so that was the emphasis that's we talked about. There was a lot of money put into there sort of, you know, money used sort of form committee and buy consultants and things like that, but it never really got of the ground. I think that kind of there is a lot of challenges there, but it is sort of speaks to some with difficulty of regionalization that this was an area with a lot of money, a lot of focus, but they still couldn't make it work.

DR. SHIRA JOHNSON:

You have part time ED coverage, some nights you have hand surgery or OB/GYN some nights you don't and you are a guide, who has worked in the ED that's when you get stuck because you are not on they don't have anybody covering that service and you are placed in a position that many of us have been in we have to try to transfer that patient who may or may not have funding to another facility, who probably doesn't want to accept them. It's not safe for the patient, it's challenging for the doctor, and mistakes get made and people get sued.

DR. JOHN MCCONNELL:

Yes, I am an economist, so I do not work clinically, but I work with people who do and it's a real headache. It's been really hard for them, I mean, you know, I hear these horror stories of them being on the phone for hours trying to locate a particular specialist to take care of the patient and it can be very difficult.

DR. SHIRA JOHNSON:

You applied this solution in Oregon and did it work there.

DR. JOHN MCCONNELL:

I can't take credit for applying any solutions here, but I can tell you what Oregon has done and what they have done is sort of use a blend of these things. In some cases hospitals have gone without coverage and some cases they have done stipends. The trend has generally been to move away from stipends, towards guaranteed pay, towards employing physicians and I think it's working, but it's amazing how quickly this is changing. It's a very dynamic situation and so you know it's working, I don't if it's hit equilibrium yet.

DR. SHIRA JOHNSON:

So what are some of the other issues you have worked on with Oregon policy makers where you think may be your work has made a difference? What could we learn from you have already researched and been through.

DR. JOHN MCCONNELL:

Well, you know, I do some work on emergency department care and then some sort of general policy care. One project that I just worked on was looking at medicaid clients beneficiaries and Oregon was 1 of the first states to see if they could cut the cost of Medicaid by imposing copayments on some other medicaid enrollees and so we have good data actually with some good economic research on how the patients with commercial insurance respond to copayments and generally they use less services and it reduces the cost of care, but we hadn't really seen much research on what that looks like for very poor, very sick people, who might be on Medicaid and so this is sort of interesting study because the copayments work that's a good way to save money if they don't than that's useful and what we found was that the medicaid clients who had these copayments put on them they pay pullback service, they use less services just like commercial patients, but when they went they were sicker so they had fewer visits, but when they went their visits were more expensive and they had more inpatient admissions and so in the end the economic gain from fewer visits was offset by more expensive care when they needed it with some sort of disturbing suggestion so some good evidence the copayments weren't good there.

DR. SHIRA JOHNSON:

If you are just tuning in, you are listening to the Clinician's Round Table. I am your host, Dr. Shira Johnson, and joining me to discuss managing the economic impact of ER medicine is Dr. John McConnell.

So, with all that's going on today with loss treating economy, how is the current economic crisis going to effect physicians, emergency departments, and health care across the board given the challenges we have already had?

DR. JOHN MCCONNELL:

In general, it is sort of help for the sort of think about where we are going in the economy without thinking too much about the health care and I think the best guess looking at economist to do more of this macro economic policy prediction. You know I think we are looking at pretty severe recessions sort of like something that we had in 1982 and this has been a long time since we have had anything that

bad, so I think it is going to be difficult and in 2009 is not going to be great, 2010 is going to be probably little bit better, but not great and I think by 2011 may be things will come around if our sort of current policies work.

DR. SHIRA JOHNSON:

Now, because you are an economist we are hanging on your every word.

DR. JOHN MCCONNELL:

Right, right.

DR. SHIRA JOHNSON:

So, everybody listening to this want your overall forecast probably as well as they want you specific ED forecast?

DR. JOHN MCCONNELL:

Well the usual caveat applied to economist looking into the future there that seems to me to be kind of a reasonable scenario so if people want to use that as a bench mark I think that's, you know to me, that seems to be reasonable. So what is that mean for physicians well. I think in the short run you are not going to see a lot of changes, but may be over the next year you can expect that there is going to be more unemployment, which means that people are going to come off employer covered insurance, there is going to be more uninsured that are seeking care through the hospital, Medicaid roles will probably go up. We will probably see more of medicaid patients coming into the hospital or your practice, but you know the shift from commercial payment to medicaid payment. You may see more medicaid patients, but they are going to be paying less. So I think that's probably what you are going to

see. We are already hearing sort of locally that there are some shifts away from elective surgery that people seem to be putting that off so you know I think it is going to affect medical practice. On the other hand, there are other industries that are sort of more susceptible to changes in economic fluctuations, so you know, medical care is generally pretty steady relative to other industries.

DR. SHIRA JOHNSON:

So they are putting off elective surgery and we are seeing that already?

DR. JOHN MCCONNELL:

Yes.

DR. SHIRA JOHNSON:

The patients are going to be sicker coming into the hospital because they may avoid seeking care if care is going to cost them.

DR. JOHN MCCONNELL:

You may see some of that as well.

DR. SHIRA JOHNSON:

And the other interesting thing is with COBRA. We know that employer have to provide COBRA for not sure of the days, but certainly number of months after terminating employment, but COBRA which isn't

often spoke about is outrageously expensive and many patients are not able to continue coverage at those rates because you are paying the employer half and the employee half correct?

DR. JOHN MCCONNELL:

Yes, that's right.

DR. SHIRA JOHNSON:

And we don't have solutions for those built into our system and as you said jobs are being terminated.

DR. JOHN MCCONNELL:

Right.

DR. SHIRA JOHNSON:

At our county hospital in Miami, the ED was always a revolving door for the un and the under insured. Is this an issue that again needs to be addressed in a more aggressive manner than we have in the past because even when time were good, we still had this problem because the people come here without healthcare and they are from other countries and they need it urgently?

DR. JOHN MCCONNELL:

Yeah, I mean, this is sort of the system that we have and, you know, I think that we saw some of dramatic version of that here in Oregon when we had a medicaid contraction in 2003, and this is

another project I worked on, but we saw a contraction medicaid program that put about 100,000 people out of 400,000 and the total medicaid population took them off and put them into the uninsured rank. So we tracked what happened to emergency departments across the state and what we saw was a average increase in uninsured patients going to emergency department by over 30% with even higher increases when you broke it down to some specific diagnosis so lot more people coming in with mental health issues and substance abuse issues and thinks like that. So, we know from that experience that, you know as people become more insured that emergency department is where they go.

DR. SHIRA JOHNSON:

And I heard that whereas previously we know that many mental health benefits and many substance abuse issues are not covered under insurance even if you have good working insurance, so they are not covered to a great degree and if you have anymore knowledge of this please correct me, but I believe they said 2010 the health care plans are going to be required to cover substance abuse and mental health need for the patients.

DR. JOHN MCCONNELL:

Yes, that's a sort of a very strange interesting part of the emergency financial rescue plan that was just passed. So that was a 700 billion dollar plan with a few other weird things in there.

DR. SHIRA JOHNSON:

This look tacked on.

DR. JOHN MCCONNELL:

This was tacked on so there was a mental health parity thing that had been always floated around the

house and senate and sort of made it up to a certain levels, but never quite passed and so that passed a lot. States had sort of parity laws for some of their fully insured groups, but because of the way that federal laws effect whether or not plan is self insured and self funded, it didn't affect all of the commercial groups. But yes starting in 2010 there will be mental health parity for everybody with some small exceptions according to small group employer plans, but should be pretty widespread.

DR. SHIRA JOHNSON:

Thank you very much John.

DR. JOHN MCCONNELL:

Thank you.

DR. SHIRA JOHNSON:

I would like to thank my guest Dr. John McConnell for joining us to discuss the econimic impact of delivering ED health care. For complete program guide and podcast visit www.reachmd.com, and thank you as always for listening.

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