American College of Emergency Physicians®
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2016 Town Hall Meeting
Friday, October 14, 2016
Mandalay Bay Convention Resort
Mandalay Bay Ballroom
12:45 pm – 2:15 pm

Alternate Delivery Models and Their Impact on Emergency Medicine

Moderator: Marco Coppola, DO, FACEP

Discussants: Paolo Coppola, MD, FACEP
Hartmut Gross, MD, FACEP
Howard Mell, MD, FACEP
Gerad Troutman, MD, FACEP

Description: The landscape of emergency medicine continues to change at a rapid rate. Long gone are the days of a basement, back hall area treating accident patients brought by hearses and staffed by interns. Four "emerging" disciplines are now prevalent and are "facts of life" in emergency medicine: urgent care, telemedicine, mobile integrated healthcare, and freestanding EDs. Will these four areas augment emergency care or are they set to collide? How will they impact emergency department visits and reimbursement? Will they make our lives easier or more complicated?

Presentations:

1. Freestanding Emergency Centers – Dr. Troutman
2. Mobile Integrated Healthcare/Community Paramedicine – Dr. Mell
3. Telemedicine – Dr. Gross
4. Urgent Care – Dr. Paolo Coppola

Summary Report:

After a welcome by Vice Speaker Dr. John McManus, Dr. Marco Coppola, as moderator, introduced the assigned topic concept of each of the panelists.

Dr. Gerald Troutman, MD, FACEP speaking on Freestanding Emergency Centers (FECs), gave an overview of the development and business model of the industry. He emphasized that FECs bring patient care into the community for easier access. Because independent FECs are designed and run by emergency physicians, everything is optimized to providing emergency care and allows the emergency physician to control their workplace environment. He listed the top ten diagnoses treated in the FEC, demonstrating that they are real emergency departments. Because in Texas, Medicare does not recognize FECs as an ED nor a viable entity, FECs cannot bill for services rendered to Medicare patients. However, the rules and regulations governing FECs in Texas have EMTALA-like language in that they are required to provide care for all presenting patients regardless of their financial ability and the penalties for not doing so are harsher, including losing your license to practice medicine.

When asked why FECs are only built in affluent areas of town, Dr. Troutman explained like with any other business, they are located where they can prosper.

Dr. Howie Mell presented on community paramedicine. He noted that there are successful community paramedicine programs, but they are mostly pilot projects that are supplemented by grants. Unfortunately, they may not prosper without that extra funding. Paramedics are often providing primary care in the home setting, especially for senior citizens. Many patients seen by community paramedics also qualify for home health nurses. Perhaps the better community paramedicine model would be as a public health and public works program rather than billing individuals

for that care. The challenges are how and where this will fit into the healthcare payment scheme, and that each state would have to pass legislation guiding community paramedicine practice and funding.

When asked what would have to change in the legislative landscape to support paramedicine, Dr. Mell answered that you would have to overcome specific EMS and trauma systems regulations in each state.

Dr. Hartmut Gross presented on telemedicine, summarizing the history of telemedicine. Evolution continues with improving technology, such as telemedicine carts. He outlined several current applications for EM telemedicine scenarios, such as cruise ships, nursing homes, and FEC specialist consults. While it was agreed that telemedicine can save healthcare costs, the amount of the savings is uncertain.

There are telemedicine impediments such as licensing, state regulations, transparency, reimbursement, and physician resistance. Telemedicine is not intended as stand-alone care, but rather it supports other healthcare processes.

When asked how telemedicine will impact ED care and reimbursement, Dr. Gross provided statistics from United Health Care and Kaiser Permanente that showed that the practice of telemedicine is significant and growing. Last year, 10 million patients received telemedicine services. Rural clinics may have only an advance practice provider on site with telemedicine support.

Dr. Paolo Coppola presented on Urgent Care Centers. He described how emergency physicians who worked in the ED moved to urgent care practices for more favorable working conditions. Urgent care is an established fact of the medical continuum. According to the Urgent Care Association of American benchmarking survey, there were 6,950 urgent care centers in 2015, seeing 120 million patients, and generating $12.7 billion in revenue; although more data are needed to truly capture the patient population trends. Urgent care centers are owned by hospitals, physicians, and corporations. Urgent care centers are primarily seeing patients that would have been seen in a fast track area of a hospital ED.

When asked if he agreed that urgent care centers need more regulatory oversight, Dr, Coppola answered that in general it is better if government stays out of the practice of medicine.

Following the panelist presentations, Dr. Coppola asked questions that were texted to him for the audience. Councilors were also invited to ask questions from the microphones. The balance of the allotted time was filled by a spirited exchange between those asking questions and the answers from the Panelists.

Audience Comments/Questions

- Kaiser uses community paramedics for high ED utilizers. It works well with a geriatric population.
- In Texas, there is similar EMTALA language in its FEC rules but the penalties are stricter. It is Medicare that does not recognize the FECs rather than the FECs refusal to take Medicare. In NY, the Urgent Care's accept Medicare and some managed Medicaid.
- Patient satisfaction is the focus of FECs. Patients languish at hospitals and are seen quickly in FECs.
- Increased opportunities will result in more jobs
- Residents need to learn about using telemedicine because it is a different approach, a more sterile environment where you don't lay hands on the patient.
- Only 11 % of FEC visits are later admitted.
- TX, RI and CO are the only states where physicians can own an Independent FEC.
- Boarding and overcrowding in FECs and Urgent Care facilities are avoided because we control it, we can add additional providers when it is needed to control patient flow in our facility.

Following summary remarks by Dr. Marco Coppola, the session adjourned at 2:18 p.m.

Special thanks to Cynthia Singh, MS, and David McKenzie, CAE, for their assistance in developing this report.