POLICY ANALYSIS

Value-Based Emergency Management

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ABSTRACT

This article touches on the complex and decentralized network that is the US health care system and how important it is to include emergency management in this network. By aligning the overarching incentives of opposing health care organizations, emergency management can become resilient to up-and-coming changes in reimbursement, staffing, and network ownership. Coalitions must grasp the opportunity created by changes in value-based purchasing and impending Centers for Medicare and Medicaid Services emergency management rules to engage payers, physicians, and executives. Hope and faith in doing good is no longer enough for preparedness and health care coalitions; understanding how physicians are employed and health care is delivered and paid for is now necessary. Incentivizing preparedness through value-based compensation systems will become the new standard for emergency management. (*Disaster Med Public Health Preparedness*. 2016;10:158-160)

Key Words: health policy, quality of health care, decision making, organizational, health care economics and organizations, health care coalitions

Value-based payments in health care provide differential payment to providers based on the quality of care furnished compared to the cost of care. The payment method was devised to drive change and innovation. A similar model is appropriate for health care emergency management, which has been traditionally a cost-center and not judged on quality, and as a result has been devalued.

Since 2012 a major reorganization of public sector funding for health care emergency management has been underway as funding has shifted to management by health care coalitions. As health care coalitions are being reconceived and lose federal funding, new economic arrangements will be necessary. These arrangements should reflect how health care is organized. Large contract management groups offer some unique opportunities to health care preparedness planners and policy makers, such as:

- Education and professional development programs in place to train their physicians at their worksite as opposed to their employer. Regional coalitions or planners have an opportunity to engage these physician practice groups and bring local and coalition-specific training into their efforts.
- Hospitals and health systems can make adherence and participation in emergency preparedness efforts a required part of provider contracts with physician groups. Emergency preparedness standards and requirements would never be more than a small part of these contracts; their inclusion in any capacity could marshal attention to the issue and significantly increase participation.
- Payers, especially Medicare and Medicaid, can incorporate emergency preparedness into their value-based purchasing programs. Value-based purchasing has been shown to clearly motivate and move physician behavior in a number of areas such as reducing hospital-acquired infections and preventable errors.

Working with physician management companies is just one area where aligning incentives could increase the resilience of our emergency management.

The United States continues to face serious difficulties in developing a robust system of health care preparedness and response. These challenges are compounded by the underlying complexity of the US health care delivery system, which is less a system than a network of independent and interdependent institutions. The health care non-system (or infrastructure sector) is largely owned by private entities but is significantly funded by the publicly managed programs of the Centers for Medicare and Medicaid Services (CMS).[1] CMS programs were responsible for 30% of total health care funding in 2013, and under the Affordable Care Act, the eligibility criteria for these programs will be expanded.[1]

Health care is the largest single sector of the US economy, employing more than 17% of the population.[2] The sector will only grow and is predicted to account for one-third of the total increase in jobs through 2022.[3] Hospitals and their emergency rooms are shining beacons, attracting all parts of the community to their doors during all hours of the day.

The continuity of this sector is essential to the functioning of all American infrastructures during disasters. The business of health care adds complexity and has been changing more quickly than any of the models of emergency management. Health care networks are adding insurance plans, in some cases putting their credit rating at risk. This is not an environment in which cost centers like emergency management will thrive.

The passage of the Mental Health Parity and Addiction Equity Act (MHPAEA, 2008) and in 2010 the Affordable Care Act (ACA) is continuing to redefine the provision of health care through extension of insurance privileges.[4] The changes are focused on population health rather than reimbursement for tests and procedures, so called value-based payment programs. A value-based payment system differs from the current fee-for-service model in that reimbursement is focused on quality of health care and the monetary incentives for performing more services have been removed. By 2018, CMS will make 50% of its Medicare spending based on value-based programs, and insurers are now describing value-based programs as the "new norm."[5]

In the literature of hospital and health care preparedness, a focus on the business of health care, yet alone value-based payments, is hard to discern. The Pandemic and All Hazards Preparedness Act of 2006, Hurricane Katrina, the H1N1 pandemic, and Hurricane Sandy are the touchstones for federal funding of health care emergency management. The lack of attention to the economic drivers of the $3 trillion health care industry is an inherent weakness in the programs, policies, and practices of emergency management. Calculating the monetary cost of a disaster is under-researched, but examples exist like that of the Fraser Institute for Health and Risk Analytics model for the cost of disease outbreak.[6] More efforts will be needed to capture preparedness value in order for emergency management to be relevant to administrators.

In December 2013, CMS proposed new rules for emergency management designed to increase patient safety and a more "coordinated" response to disasters. These rules are primarily process focused (developing plans, policies, and procedures). Nonetheless, it is possible that not meeting these criteria will become the basis for penalizing facilities through a reduction in reimbursement rates. This shift represents an opportunity for emergency management to reframe the value it brings to the health care system by creating a direct link to the bottom line. At the same time, it also represents a threat, as many emergency managers don't currently have the ear of or the skills to speak in terms understood by executives.

A recurrent theme within emergency management is the quality of the engagement of executives in planning and preparedness. In 2013, the Centers for Disease Control and Prevention hosted a meeting entirely devoted to this issue. The common explanation: emergency managers are not addressing the concerns of executives. Executives are constantly surveyed, and they universally indicate other business drivers are more prominent than preparedness.[7]

Financial stability, patient care, and improving patient safety and quality in their organizations are the main focus of health care executives.[7] Many of these issues require more complex cultural change even than preparedness; however, all of them represent opportunities for emergency managers to provide daily contributions. The financial challenges stem most commonly from Medicaid, Medicare, and uncollectable debts from emergency departments.[7] For example, the provision of uncompensated care in the emergency room cost Parkland Hospital in Dallas $767 million in 2014.[8]

There is a compelling need to link the business of health care and the business of preparedness. For one, the entire federal funding of the Hospital Preparedness Program (once $646 million per year and in 2015 less than $250 million) expires in 2 years.[9] A superior reason is that preparedness could become a concern, interest, and service to the executives that direct health care. Getting executives energized about emergency management would allow more private money to supplement public resources.

The variety and complexity of the health care "system" is exemplified by the organizations responsible for providing risk and emergency management protection. Insurance companies, public health agencies, emergency medical services, private and public hospitals and health systems, health coalitions, physicians, vendors, and suppliers all operate with their own unique set of incentives, motivations, and goals. In many instances the motivations and goals of these institutions are at cross-purposes, such as the goals of payers (to cover their pool of enrollees at a high level of care with the best possible expense) and physicians and hospitals (to care for the individual patients in their care in the most effective manner while maximizing the financial interests of their stakeholders).

This underlying complexity and decentralization makes any effort that seeks to manage or unify these various independent and interdependent institutions, such as emergency preparedness, a major challenge. Market economic theorists argue a managerial approach is doomed to fail, indeed a complex adaptive system requires failure.[10]

Too often health care preparedness policy has approached this challenge with a false notion that the complexity of the health care delivery system should morph and adapt to the unique needs of preparedness. The designers of this policy believe that the underlying tension between contesting institutions will simply vanish because the goals of emergency management are noble and important. Rather than attempting to change the complex health care delivery system to fit a preset mold of preparedness, policy makers should

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work to analyze the strategies already in place and reorient those to advance preparedness and coordination.

The lack of engagement in health care preparedness by senior health care executives has been noted. Equally troubling is the lack of engagement and incentives among physicians with respect to preparedness issues, plans, and strategy. This lack of engagement is more pronounced and represents a more profound vulnerability even than that of health care executives.

Over the past decade the employment landscape for physicians has undergone a seismic shift. The days of independently practicing doctors is over. In today's landscape physicians are by and large falling into one of two employment categories: employed by hospitals or employed by large physician practice groups. The number of physicians employed by hospitals increased 34% between 2000 and 2010 and is likely to keep rising.[11] The strategies for engaging these hospital-employed physicians can be incorporated into the plans for engaging the hospitals.

Physicians employed by large physician practice groups require a different approach. Physician practice groups contract with hospitals to provide hospital-based physician services. In emergency medicine (outside of large academic medical centers), most emergency physicians are actually employed by these physician groups that have contracted with the hospital. One contract management group could provide emergency medicine physician coverage at 40% to 50% of hospitals in a small geographic area. Most health care preparedness strategists, planners, and policy makers do not acknowledge this economic arrangement. This represents an opportunity: health care coalitions and emergency managers now have a single entity to engage.

The purpose of this article is to start a dialogue about how to infuse an understanding of the business of health care into health care emergency management. Every day we see changes in reimbursement, staffing, and network ownership that constantly redefine the provision of clinical care. Similar dynamic change is not apparent in emergency management; the last event, rather than what is over the horizon, remains our focus.

The impending CMS emergency management rule, changes in value-based purchasing, and incentives for underwriting preparedness could have an entire set of recommendations. Coalitions must grasp the opportunity to engage payers, physician groups, and executives on their concerns. Preparedness and health care coalitions must move beyond being based on faith in doing good to demonstrating an understanding of how physicians are employed and health care is delivered and compensated. The same discussion should be had about ways that pay-for-performance programs for hospitals can be modified to incentivize preparedness.

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