

The Rural ED as a Flagship Service for the Hospital, Hospital System, and Community

Rural Emergency Care:
Stepping Up to the Challenge
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Agenda

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- Health care *value*
- Transfer of *risk*
- ED performance improvement
- ED role in new care paradigms



Today's Health Care Themes

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- Insurance coverage expansion
- Primary care emphasis
- Value-based purchasing
- New delivery systems
- Risk transfer to providers
- Reform is not just the Affordable Care Act!



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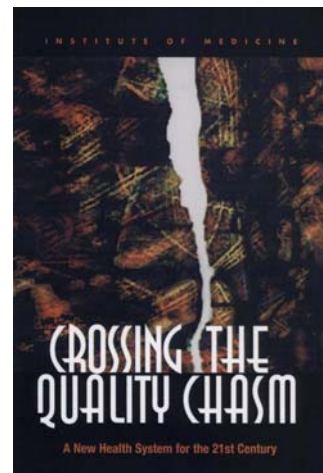


Value – IOM Six Aims

4

Health care should be:

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable



Source: Corrigan, et al (eds.). *Crossing the Quality Chasm*. Committee on the Quality of Health Care in America. National Academies Press. Washington, DC. 2001.






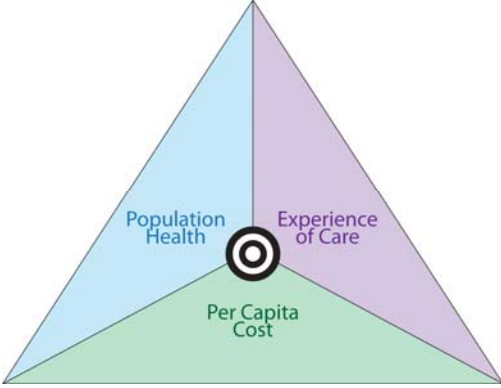


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The Triple Aim

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Value Equation

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$$\text{Value} = \frac{\text{Quality} + \text{Experience}}{\text{Cost}}$$

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

"Triple Aim"

- Better care
- Better health
- Lower cost



The Value Conundrum

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You can always count on Americans to do the right thing – after they've tried everything else.

- Fee-for-service
- Capitation
- Market
- Single payer
- Self-police
- **Value-based Purchasing (VBP)?**
- **Accountable Care Organizations (ACOs)?**
- **Patient-Centered Medical Homes?**



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Tyranny of Fee-for-Service

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- Current measure of "success" is to maximize:
 - Office visits per day
 - Average daily inpatient census
 - Admissions from the ER
- Is this how you would identify a great physician or a world-class hospital?
- Can we design measures that reward industriousness, yet reflect why we went to medical school?



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Form Follows Finance

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- How we deliver care depends on how we get paid for care
- Health care reform is changing both
- Fundamentally, reform involves a **transfer of risk** from payers to providers



Risk Assessment is Ubiquitous

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- Risk is present when an outcome is uncertain or unpredictable
- Types of health care risk
 - Random
 - Insurance
 - Political
 - Medical Care
- Where/how can hospitals
 - Influence or control risk
 - **Reduce risk of harm**
 - **Optimize risk of benefit**



Rural Risk?

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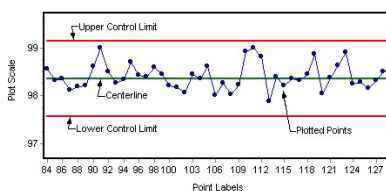
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Random Risk

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- Normal variation
- Rolling the dice
- Roulette v. poker
- No control, but important to recognize



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Insurance Risk

13

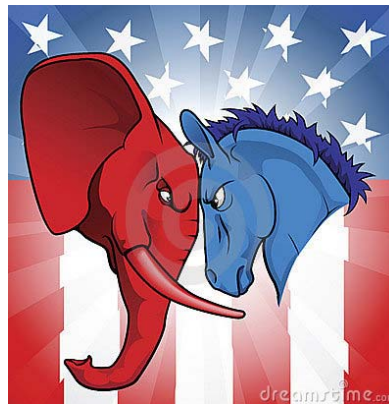
- Insurance risks
 - Demographic change
 - Technological innovations
 - Prior health status
 - Cost inflation
- Cost is the actuarial metric
- Minimal control, but predictable



Political Risk

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- Rules, regulations, and legislation
- Profound impact on health care delivery and finance
- Modest control, often via advocacy avenues



Medical Care Risk

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- Medical care *variation*
 - Diagnostic accuracy
 - Care plan implementation
 - Guideline use compliance
 - Pharmaceutical choice
 - Procedural skill
 - Efficient resource use
- How our choices influence health care **value**
- Greatest control, how we deliver care



The Risk of Inertia

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Because
we've ALWAYS
done it that way!

The Risk of Doing Nothing

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"We've considered every potential risk except the risks of avoiding all risks."



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Rural ED as the Flagship

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- Always "open" – 24/7
 - Life saving care
 - Public health surveillance
 - Safety net provider
- Most valued rural hospital service
- Provides a sense of safety and security for the community
- As important as we are, let's get our house in order
 - Let's look internal first, then external
 - A SWOT analysis!



Critical to the hospital
Critical to the community



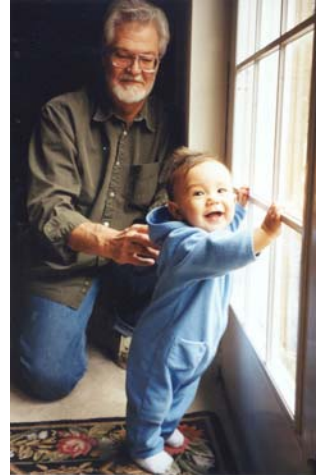
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Front Door – Front Window

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- 1st and lasting impressions of the hospital experience are made in the ED
- Patient experience is a critical ED performance measure
- Employee satisfaction often equals patient satisfaction



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ED Deserves Leader Attention

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- Southwest Airlines makes employees a priority
- Employee/patient link
- *Attention* is the currency of leadership
- To do list
 - Dedicated clinical time for managers
 - Push decision-making down
 - Leadership rounds
 - Follow-up all explicit and implied commitments



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Serving the "Customer"

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- Customer service can move market share
- A potential customer service nightmare
- We see 10x the number of inpatients
- To do list
 - Behavioral standards
 - Patient call back and satisfaction survey
 - Focus on improvement, not just benchmarks



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Not Necessarily the Money Pit

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- High fixed costs impact revenue calculations
- Revenue, plus
 - Admissions
 - Ancillaries
- To do list
 - Document optimally
 - Reduce barriers for appropriate admissions
 - Treat the ED as a customer
 - Collect co-pays



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Driving the Liability Nitro Truck

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- Perfect opportunity for disaster
 - The Law
 - Hospital policies
 - Medical liability
- To do list
 - Register, see, and treat all
 - Transfer policies
 - Contract to stipulate care in ED only
 - Admission protocols, not hand written orders
 - Bedside handoffs



Making the Perfect Handoff

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- Most error-prone process in health care
- Flash points
 - Waiting to see private MD
 - Between ED shifts
 - Admissions
 - Transfers
- To do list
 - All patients seen by ED doc
 - Bedside handoffs
 - Consistent communication (eg, SBAR)
 - Document the handoff



Quality is Job One

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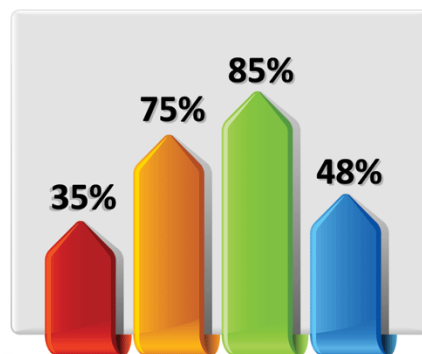
- Quality is our mission
- Assess performance relative to Mission
- Quality not always self-evident
- To do list
 - Communicate results
 - Review every high risk, low frequency event
 - Measure variation
 - Don't assume a non-punitive environment



Performance Counts

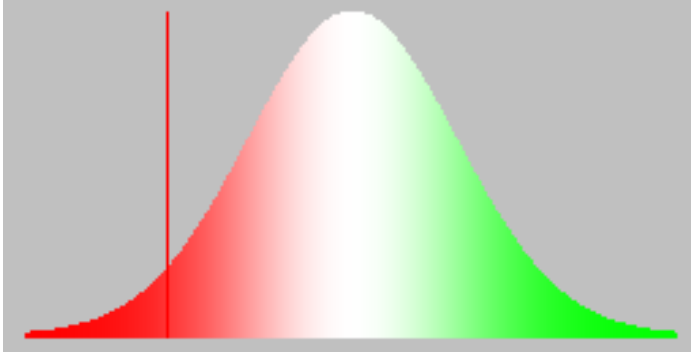
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- Above average?
- Without measurement, we're managing by hunch
- Need to demonstrate performance
- Remember, reporting precedes P4P
- To do list
 - Measure performance: quality, service, and financials
 - Report to individual providers, board and staff






See Appendix for ED performance measures

Variation = Risk = Opportunity 27

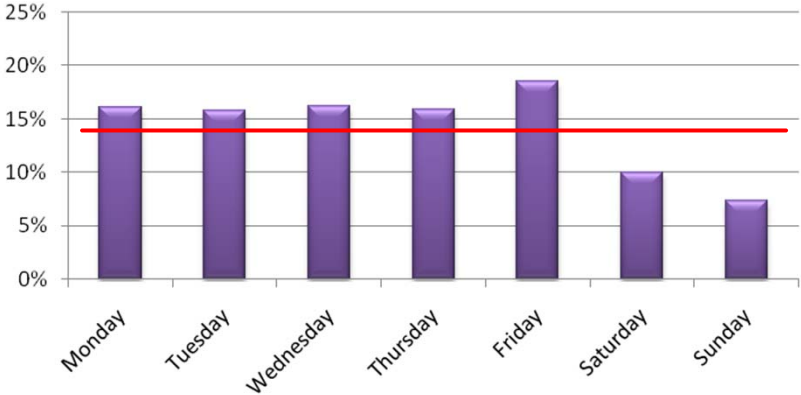


Variation suggests a risk for underperformance,
but also an opportunity to excel




  

Variation – DC by Day of Week 28

Discharges by Day of the Week



| Day of the Week | Discharges (%) |
|-----------------|----------------|
| Monday | 16% |
| Tuesday | 16% |
| Wednesday | 16% |
| Thursday | 16% |
| Friday | 18% |
| Saturday | 10% |
| Sunday | 7% |

Variation – CT in Non-Trauma HA

29

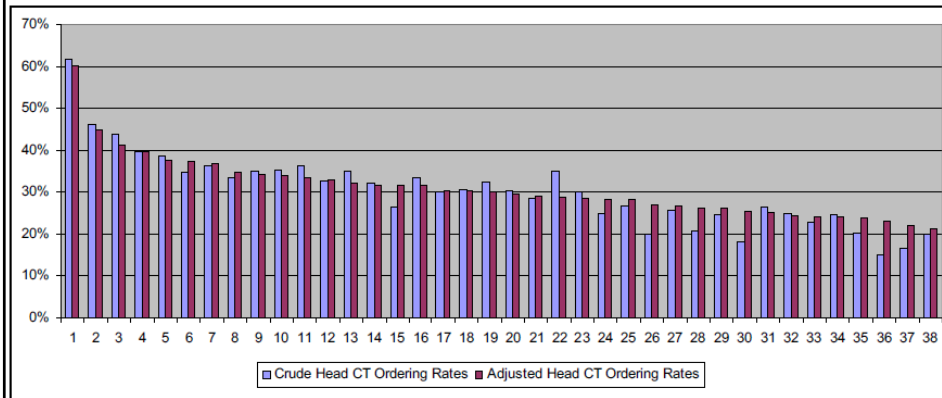


Figure 3 Crude and adjusted head CT ordering rates by physician in patients with atraumatic headache.

Source: Prevedello, LM, et al. Variation in use of head Computed Tomography by Emergency Physicians. *Am J Med.* April 2012.



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Drive Out (Most) Variation

30

- Best evidence is only the way we practice medicine
- Care should vary by unique *patient* needs, not by
 - Doctor or nurse
 - Day of week, or time of day
- Not cookbook medicine, many opportunities for
 - Clinical judgment
 - Thoughtful interactions
 - The "art" of medicine



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Our Own Demons

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Nutting et al – small primary care practices are:

- Physician-centric
- A hindrance to meaningful communication between physicians
- Dominated by authoritarian leadership behavior
- Underserved by PAs/NPs cast into unimaginative roles



"Characteristics so ingrained in the primary care practice culture that they have become virtually invisible, along with their implications."

Source: Nutting, PA, Crabtree, BF, McDaniel, RR. Small primary care practices face four hurdles – including a physician-centric mindset – in becoming medical homes. Health Affairs. 31:11. November 2012.



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Team-Based Care

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- Fewer Chuck Yeagers, more John Glens
- Fewer cowboys, more pit crews
- *Independence* is archaic
- ED Medicine is a *team sport*
- To do list
 - Make time and space for team building
 - Review, learn, improve together



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Physician Recruitment

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- Desirable physician traits for future-oriented health care organizations
 - Team-oriented
 - Motivated by quality incentives
 - Technologically savvy
 - Evidenced-based approach
 - Comfortable working with PAs and NPs



Source: Survey of 200 health care employers and hospital systems by the Medicus Firm, 2012.



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New World Realities

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- Risk transfer to providers
 - Higher quality at lower cost
 - Doing what's needed, not more
- New business models
 - More primary care, less inpatient
 - Rewarding value, not just volume
- ACOs are the current poster child for value-based care



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Accountable Care Organizations

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- A coordinated network of providers with shared responsibility for providing high quality and low cost care to their patients.*
- Couples risk-based provider payment with health care delivery system reform
- Payer shares savings with doctors and hospitals if high quality



*Source: Robert Wood Johnson Foundation. Accountable Care Organizations: Testing Their Impact. 2012 Call for Proposals.



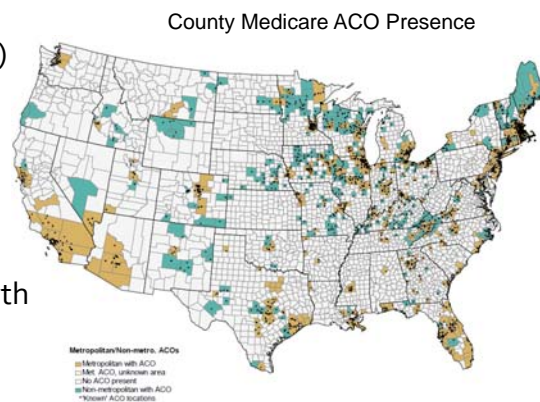
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ACO Expansion

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- ACOs in 15% of rural counties (38% of metro)
- 25-31 million patients receive care through an ACO
- ~10% of the population
- Remarkably quick growth for a new and complex form of payment and care delivery



Source: RUPRI Center for Rural Health Policy Analysis, 2013.
Niyum Gandhi and Richard Weil, The ACO Surprise, 2012.



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ACO Quality Measures

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- 4 Domains
 - Patient/Caregiver Experience
 - Care Coordination and Safety
 - Preventive Health
 - At-Risk Population/Frail Elderly
- Commercial ACO Measures
 - Potentially avoidable ED visits
 - Generic dispensing rates
 - Ambulatory sensitive admissions



See Appendix for ED ACO measures

Source: Lynn Barr, CAREHIN



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Cost Reduction Strategies

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- Reduce ambulatory care sensitive admissions
- Reduce readmissions
- Reduce ED utilization
- **ED physicians will participate in the downside, so why not participate in the upside?**
- So... explore strategies to make the ED an integral part of a winning rural hospital!



Source: Lynn Barr, CAREHIN



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ED Care Strategies

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- Care coordination process between ED and care management
- SBIRT (Screening, Brief Intervention and Referral to Treatment)
- Processes for behavioral health professional, care manager, and/or PCP referrals
- Place a care coordinator in the ED for peak hours?
- Get ED reps on ACO board



Source: Lynn Barr, CAREHIN



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ED Negotiation Options

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- Payment for PCP appointment
- Payment for enrollment in care management program
- Payment for patient compliance
- Payment for PCP referral and beneficiary assignment
- Payments for preventive health activities



Source: Lynn Barr, CAREHIN



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ED Transformation

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- How do we move toward value when our practice is primarily fee-for-service?
- One foot on the dock and the boat!
- But we can test the waters
 - Use Paul Nutting's insights to be introspective
 - Measure and share performance, then act on it
 - Make time and space for team building
 - Drive out variation; only the "best" evidence care
 - Actively engage in ACO planning – negotiate from strength



What We're All About

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- Community benefit
 - Essential service
 - Reduce government burden
 - Safety net provider
 - Safety and security
- To do list
 - Price transparency
 - Community education
 - Support local EMS
 - Human service needs
 - Document charity care



The Relationship

43

- Interaction and information sharing is care
- Blessed to be trusted and invited into the most intimate parts of people's lives
- To do list
 - Every patient is the only patient
 - Nothing about me without me
 - Patient is the source of control
 - Transparency – “no secrets”



Collaboration and Value

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- ACOs and other “programs” less important
- Collaboration that fosters health care value is key
- Future paradigm for success
- **Good medicine and good business**



The Risk of Something New

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Healthy People and Places

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Appendix

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ED Performance Measures

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- Median time ED arrival to discharge
- Median time ED arrival to diagnostic evaluation by provider
- Median time to fibrinolysis for STEMI patients
- % STEMI patients who receive fibrinolysis within 30'
- Median time to transfer for acute cardiac intervention
- % patients receiving ASA for suspected ACS
- Median time to ECG for chest pain patients
- % getting MRI for low back pain w/o conservative treatment
- % patients getting both contrast/no contrast abdominal CTs
- % patients getting both brain/sinus CTs



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ED Performance Measures

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- % patients getting CTs for non-traumatic headache
- % patients left without being seen
- Median time to pain management for long bone fracture
- % patients getting CT results back within 45' with stroke
- Median time to PCI
- % patients receiving PCI within 90' of ED arrival
- % getting blood cult. prior to ATB for ICU pneumonia admits
- % pneumonia patients given appropriate antibiotics
- % patients considered for TPA in stroke
- Variety of patient satisfaction measures (CAHPS)



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ED and Population Health

50

- % of patients with flu vaccine
- % of patients with pneumococcal vaccine
- % of females with mammogram within 2 years
- % of patients with appropriate colorectal cancer screen



ED can improve performance on these measures

Source: Lynn Barr, CAREHIN



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ED and Population Health

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- % of patients queried for tobacco and % interventions
- % of patients screened for depression and % interventions
- % of pts with normal BMI or documented plan to address
- % of pts who have BP recorded within 2 years

ED can improve performance on these measures



Source: Lynn Barr, CAREHIN



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ED and Population Health

52

- % of pts queried for tobacco and % interventions
- % of pts screened for depression and % interventions
- % of pts with normal BMI or documented plan to address
- % of pts who have BP recorded within 2 years

ED can improve performance on these measures



Source: Lynn Barr, CAREHIN



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ED and Special Populations

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- Hypertension (HTN): BP Control
- Ischemic Vascular Disease (IVD): LDL <100 mg/dl
- Ischemic Vascular Disease (IVD): Use of Aspirin
- Heart Failure: ACEI for LVSD



ED can improve performance on these measures

Source: Lynn Barr, CAREHIN



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ED Care Coordination

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- Readmissions
- Medication reconciliation
- Ambulatory Sensitive Conditions Admissions rate
- % of all physicians receiving EHR incentive payments
- % of patients screened for fall risk



ED can improve performance on these measures

Source: Lynn Barr, CAREHIN



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