# Aligning your Emergency Department with your Hospital's Priorities

*How to embrace and leverage your ED as a value-driven asset*

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TOGETHER, WE HEAL

As a healthcare leader, you face a spectrum of complex issues: rising costs, declining reimbursement, more requirements, new technology, the transition from volume to value, alternative payment models, changing health needs in your community, and optimizing transitions of care. All these and more contribute to your regular challenge of balancing quality, satisfaction, and cost.

What you may not realize is this: your emergency department can play a pivotal role in managing these issues, driving value, and enabling your facility or system to thrive amidst the chaos.

Emergency departments are often cast in a relatively negative light. EDs can be considered by healthcare leaders—perhaps you included—as expensive, overcrowded, complex, and avoidable.

Consider this alternate view: The ED is a centrally-placed, necessary, and potentially strategic asset that can be leveraged to create significant value. When aligned with your hospital priorities, it can be a powerful, central hub for improving efficiency, reducing waste, and improving outcomes.

**In this white paper, we outline the changing role of the ED, opportunities to leverage it, and provide actionable strategies that hospital leaders can employ to align their ED with hospital priorities.**

# WHAT'S THE EVIDENCE?

- **Across the U.S. each year, 42% of people visit emergency departments.**[1]
  Often a patient's visit to the ED is their only exposure to a hospital or health system.

- **50-70% of hospital admissions come through the ED.**[2]
  The majority of these admissions are for patients who are acutely ill and require an inpatient stay in order to diagnose and manage their condition. There are also patients admitted who are subsequently discharged within 24 hours. This raises the question – could those patients be managed differently in order to avoid a 24-hour admission/short stay?

- **Large numbers of patients with high-focus conditions regularly visit the ED (CHF, COPD, acute MI, etc.) offering an opportunity to optimize their management, disposition, and transitions of care.**[3]
  Patients with chronic conditions often require hospitalization to stabilize their conditions but many could be managed in the ED and through post-acute care services – providing the patient an opportunity to better manage their care in their home environment.

- **The ED frequently interfaces with the full spectrum of the medical staff (inpatient units, community providers, ancillary services).**[2]
  The ED is a central, pivotal hub with lots of connections inside and outside the four walls of the hospital.

- **The Emergency Department is a safety net in the U.S. healthcare system. Patients and community providers alike rely on EDs to offer acute, unscheduled care and rapid diagnosis outside of primary care office hours - regardless of the patient's insurance status.**
  Patients, providers and communities need care when and how they need it. Each part of the healthcare system plays a vital role in the overall ecosystem. The ED is no different.

1 https://www.cdc.gov/nchs/fastats/emergency-department.htm
2 http://www.rand.org/pubs/research_reports/RR280.html
3 Ann Emerg Med. 2013 Mar;61(3):293-300. Doi: 10.1016/j.annemergmed.2012.05.042.
Epub 2012 Jul 13. A Novel Approach to identifying targets for cost reduction in the emergency department. Smulowitz PB1, Honigman L, Landon BE



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# THE EMERGENCY DEPARTMENT:
# STRATEGIC ASSET OR NECESSARY EVIL?

The Emergency Department truly is your facility's front door, and it significantly impacts patient perception and satisfaction. To leverage your ED as a strategic asset, it's crucial to recognize and embrace its influence, breadth of services, and impact on your community and patient population. In fact, ignoring the ED's potential role in your overall strategy may actually be a critical mistake.

## (UN)-NECESSARY SERVICE

- NOT OPTIONAL
- PERCEIVED AS EXPENSIVE
- COSTS MUST BE ABSORBED
- OUTCOMES SAME OR NO BETTER
- NOT UNIQUE OR ADVANTAGEOUS

## STRATEGIC ASSET

- INCREASES VALUE
  - Improves efficiency
  - Reduces waste
  - Improves outcomes
- REDUCES OVERALL SYSTEM COST
- VALUED BY OTHER STAKEHOLDERS
- CREATES COMPETITIVE ADVANTAGES
- NOT OPTIONAL

# "RIGHT-SIZING" THE ED
## THE WORK STARTS HERE



1. **THE ED ITSELF**
   - Foundations and fundamentals
2. **RIGHT-SIZING KEY INTERFACES**
   - Admissions
   - Near-admissions
3. **RIGHT-SIZING PATIENT CARE AFTER THE ED ENCOUNTER**
   - Transition of care
   - Patient care follow up
   - Health information systems

# 1. THE ED ITSELF
## OPTIMIZING ED FOUNDATIONS AND FUNDAMENTALS


Right-sizing your ED requires examination and optimization of three key areas: foundations and fundamentals, admissions and near-admissions, and post-encounter care. A shaky foundation threatens all that is built upon it. Before refinements or new processes can be implemented, it's crucial to work with your ED director and management group (if applicable) to identify any weakness in your foundation.

**The ED's Core Functions include:**

1. Safety–net care – 24/7 access
2. Acute treatment of sick and injured patients
3. Rapid diagnosis
4. Direction and coordination with EMS services
5. Disaster preparedness and response

**To optimize the core functions of your ED, fundamentals need to be addressed first. Key fundamentals to examine and optimize include:**

- Space and equipment
- Staffing providers and support teams
- Effective leadership
- Quality care for acute treatment of sick and injured (protocols, core measures, etc.)
- Efficient treatment of time-sensitive conditions (stroke, trauma, etc.)
- Efficient interface with lab and radiology
- Effective EMS direction and coordination
- Disaster response plans

If these aren't working smoothly, start here. Once your fundamentals are solid, you are on firm footing and ready to innovate and enhance your ED's functions.

# 2. RIGHT-SIZING KEY INTERFACES:
## INNOVATIVE OPPORTUNITIES TO LEVERAGE YOUR ED

Work with ED leadership to closely review how well the ED's current operations align with hospital priorities, define what success looks like, and decide when you want to achieve it.

With aligned expectations, goals, and an agreed upon timeline, the real work can begin. To maintain momentum toward achieving goals, schedule monthly meetings with ED leadership – utilize a standard agenda to check in on performance, acknowledge successes and highlight opportunities. Problem-solve together.

Delivering on your ED's baseline responsibilities (providing quality, efficient care for sick and injured patients) shouldn't be minimized, but it doesn't represent the complete value your ED can deliver in an evolving environment. The real opportunities include using the ED as a triage vehicle for care transitions outside of the ED, and enhancing the ED's role with stabilization and treatment of the large number of patients with intermediate and complex chronic conditions.

**Admissions: Leverage key interfaces within the hospital**

Since essentially all ED patients are transitioned to another setting (inpatient, SNF, home, etc.), the ED's involvement in patient transitions is critical. However, optimizing these transitions to deliver a better patient experience, quality outcomes, care consistency, and cost efficiency is often overlooked in service of avoiding the ED altogether. This is a missed opportunity.

Consider this: over half of hospital admissions come through the ED. **31-51%** of visits to the ED are related to intermediate and complex conditions, which account for **75-80%** of a hospital's admissions from the ED[3]. So, why not leverage the ED for these key conditions, to:

- **Optimize inpatient length of stay and efficient use of bed capacity?**
- **Generate cost efficiencies by testing, treating, and analyzing hospitalization patterns for patients with intermediate and complex conditions?**

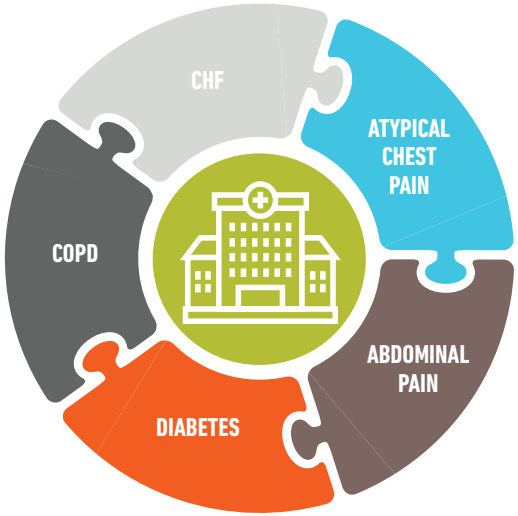
Essentially, your ED can function as a host for a very brief, "mini-hospitalization," allowing for focused diagnostic time and a much more targeted set of treatments, ultimately shortening a hospital stay by enhancing diagnostic specificity and allowing time for initial treatment effect. For increasing numbers of hospitals, this alternative is compelling: it may avoid an observation stay and reduce the cost of care for hospitals that are economically at risk.

**Near-admissions: Moderately complex patients and chronic conditions**

As ED visits increase and availability of inpatient hospital beds simultaneously decrease, hospitals and EDs face overcrowding and escalating healthcare costs. In many cases, admissions through the ED are avoidable – and many are not reimbursable due to changes in inpatient criteria.

How is a hospital to handle this challenge? The solution is not about avoiding appropriate inpatient admissions but rather to address those patients who are being admitted but are requiring an inpatient stay of 24 hours or less. For many moderately complex patients and/or patients with chronic conditions, the ED could be part of the solution. With adequate monitoring, testing, and treatment time in the ED, the needs of these patients could be accommodated and an inpatient admission or observation stay avoided.

Taking more time to monitor a patient in the ED may seem counter-intuitive in the setting of time-based throughput goals. However, by temporarily suspending time-based goals for certain patients, the ED can deliver better diagnostic precision, better care coordination, better and more targeted care. Ultimately, the ED can achieve more efficiency, more focused care and better inpatient resource utilization.




Moderately complex chronic conditions such as congestive heart failure, COPD, diabetic complications, and acute presentations such as pneumonia, abdominal pain, and atypical chest pain are prime opportunity areas to find cost efficiencies, reduce avoidable admissions, and enhance transitions of care to benefit the hospital and patient.

3 Ann Emerg Med. 2013 Mar;61(3):293-300. Doi: 10.1016/j.annemergmed.2012.05.042. Epub 2012 Jul 13. A Novel Approach to identifying targets for cost reduction in the emergency department. Smulowitz PB1, Honigman L, Landon BE

**Practical alternatives to observation status and inpatient admission**

A typical hospitalization is 8-10 times more expensive than a typical Level 5 ED visit that is discharged home[4]. For those moderately ill patients discussed on the previous page, there are other alternatives and your clinical leaders and/or management group can help.

## STEP 1

Look at acceptable alternatives to hospitalization. Be innovative and open-minded.

## STEP 2

Identify or create agreed-upon care pathways for specific diagnosis or patient populations.

## STEP 3

Identify alternative hospital-based resources for patients with these conditions in the ED.

Practical alternatives to hospital inpatient status benefit the ED, the hospital, and the patient. These alternatives may include:

- Rapid Decision Units
- Hospitalist Consultation in the ED
- Rapid Treatment Units
- ED Observation Units

4 http://www.rand.org/pubs/research_reports/RR280.html



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## PRACTICAL ALTERNATIVES TO HOSPITAL INPATIENT STATUS

| SOLUTION | OBJECTIVE |
|---|---|
| **Rapid Decision Units** | Rapid disposition with high diagnostic specificity |
| **Rapid Treatment Units** | Rapid-cycle treatment; reduced down time and reduced cost of care |
| **Hosptalist Consultation in the ED** | Early and accurate determination of optimal patient status and disposition (inpatient / Observation / SNF / home-based care, etc.) |
| **ED Observation Unit** | Hospital-based short stay (in the ED) with less in-hospital transitions of care |
| **Hospital Observation Status** | Hospitalized care for less than 2 midnights |

Each of these alternatives provides a home for patients to receive focused monitoring, diagnostic testing, therapy, and ongoing assessment to determine whether he or she will require further treatment as an inpatient, or be safely discharged from the ED.

Many patients – especially those with straightforward diagnoses and clear treatment plans – could benefit from a short, ED physician-managed stay in the ED. For example, an ED physician could evaluate and treat a patient with low-risk chest pain in an observation unit and the patient could receive a stress test or other workup before being discharged home. For those patients who would likely spend 24 hours or less in the hospital, this approach would decrease in-hospital transitions, provide an alternative to traditional inpatient admission, and meaningfully augment the emergency department episode of care while decreasing overall cost.

# Case Study:

**Hospital A serves a community with a high prevalence of congestive heart failure (CHF).**

- The ED sees approximately 70 patients a day, admitting an average of 21 patients/day – 7 of which are patients with CHF
- Hospital data indicates that almost all CHF admissions are admitted to the hospital through the ED

**Hospital A recently executed 2 value-based contracts which could significantly reduce inpatient revenue and put pressure on controlling cost. The hospital considered several options, including dedicated case management, disease management, patient education, and additional primary care involvement. Each option had potential, but all were hampered by:**

- The lack of 24/7 availability
- The need for more uniform clinical management
- Variable patient engagement
- Concerns about spotty execution

**Given the significant role of the ED regarding the management of this population, hospital leaders considered several new and innovative approaches:**

- A review of admissions from the ED identified an opportunity to stabilize patients with CHF in the ED with same-day discharge to home
- Further review showed that many ED visits might have been avoided using more frequent home-based monitoring and interval guidance for discharged patients

**After careful planning, hospital and ED leadership implemented a Rapid Assessment and Treatment Unit for CHF:**

- Phase I:  Dedicated space, cross-trained personnel, and agreed-upon clinical pathways
- Phase II:  Addition of tele-monitoring for early intervention (paid for by the health plans), and coordinated alerts to primary care providers

**Hospital A was able to manage the costs in line with revenue for this population. Patient engagement, satisfaction, and overall quality improved.**

This Case Study is a clear example of how an innovative strategy, collaboration of clinical leaders, planning, and execution can enable better patient outcomes, shorten length of stay, lower inpatient admission rates, and save time for providers by concentrating a dedicated group of clinicians in a specified location to care for a specific patient population.

# 3. RIGHT-SIZING PATIENT CARE AFTER THE ED ENCOUNTER:
## IMPROVE POST-DISCHARGE CARE TRANSITIONS

Historically, patients who visit the Emergency Department are either admitted to the hospital for further treatment, or in a large majority of cases, are discharged to home. As we explored in the previous section on in-hospital transitions, routine disposition options are beginning to expand beyond "discharge" and "admit," and the ED can be a pivotal center for deploying these new solutions.

**With the introduction and refinement of "inpatient criteria," many patients who were routinely hospitalized several years ago are now being discharged home to care for themselves. The practice of sending "sick" patients home has outpaced the development of systems to support them outside the hospital. Chronically ill patients often do not get better at home and return to the ED, and in some cases, their condition worsens to the point that they require hospitalization. This dilemma is not desirable for the patient, the provider, the hospital, or the payor.**

As a hospital leader, you can reduce healthcare costs, and improve the patient's overall experience of care by facilitating expedited access to home health care services or other post-acute settings for patients being discharged from the ED. Not to mention, implementing a post-acute care discharge strategy will help your facility thrive in the shift from "volume" to "value," helping you participate in advanced payment systems that reward care coordination and superior outcomes.

To implement a post-acute care discharge strategy in your ED, we recommend providing an in-ED home health assessment for high-risk patients who are being discharged to home. Typically these patients do not meet criteria for an inpatient admission but may be too sick to recover safely at home without additional home-based support and resources. Conducting an expedited assessment of patients prior to discharge from the ED will help identify issues and gaps in care that can be addressed while the patient safely recovers in the comfort of their home environment.

Creating a 24/7 call center or in-house resource focused on coordinating post-acute care for patients being discharged to home will go a long way to meeting the needs (and hours) of the ED. Your clinical leaders and your ED group can help.

## CONCLUSION

Patients seek out an emergency department because they know they can depend on it when they are sick and injured. Because of this relationship, the ED is in a unique position to extend its ability to impact patients beyond the four walls of the hospital. If the ED and ED providers embrace their role in post-acute care, they can play a valuable role in improving patient outcomes, improving quality of care, improving patient safety, increasing patient satisfaction, potentially avoiding admissions or observation stays, and reducing ED re-visits and re-admissions.

There is significant, often unrecognized potential to generate financial, quality, and strategic value using the ED as a foundation, while also expanding its reach. This is especially true as more hospitals enter payor contracts which emphasize alternative payment models and greater compensation for enhanced value (and greater penalties for low-value services). To align your ED with your hospital priorities, you must be clear on what those priorities are, and constantly consider how the ED can help you achieve them. To succeed, you must also consider how you can ensure that your ED has the fundamental resources it needs to succeed: great leadership and an engaged team with the ability, capacity, and strategic thinking to help you address your goals.

By optimizing its traditional functions and actively engaging in its role as a transition way-point for post-acute care, the ED can function as a secondary hub for managing population health. In doing so, you will reduce waste, optimize efficiency, and improve outcomes.

This white paper, and the strategies and solutions contained herein, come courtesy of SCP Health, one of the largest providers of physician staffing and management services to healthcare facilities in the United States.

Special thanks to Dr. Randy Pilgrim, FACEP, SCP Health Enterprise Chief Medical Officer

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