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Executive in•sight™
JANUARY 2019

INSIGHTS AND INNOVATION FOR RURAL HOSPITALS AND PROVIDERS

Blind Spots

Part Two

Preventable Deaths: A Tragic Result of Low Admission Rates?

You face the same complex conditions as your larger urban neighbors down the road. But your decisions are more daunting because you deal with a razor-thin line between financial viability and closure.

My thoughts in recent issues of **in•sight**™ regarding blind spots and barriers to financial viability are based on my experiences of sitting in the same chair as you. I know what it's like dealing with patient care incidents, staffing and scheduling, and facing the awkward intersection of collections, paying payroll, and vendors.

PREVENTABLE DEATH – AN UNINTENDED RESULT OF TRYING TO SURVIVE FINANCIALLY

Wrestling with financial pressures and viability consumed more time than I had available—a horrible and stressful place. No time for quality. Only time to pay the bills. But as I have moved from operating hospitals to working directly with physicians, I have often guessed that there

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VOL 4.1

might be an adverse effect of low admission rates on patient care quality beyond the financial impact to the hospital. Do some patients suffer from undetected and untreated, low acuity medical conditions after discharge from the ED? Do these conditions become progressively worse?

THE BLIND SPOT

"Treat and Street" usually means diagnosing the most emergent condition, and referring all others to someone else for follow up, even though the ED is used for "non-emergent" primary care but held to the standards of "emergent". The window of time is short in which to assess, diagnose, treat, and dispose; and full of risk. Medical decisions focus on the most obvious and likely conditions of the most emergent patients. And medicine is very forgiving. However, "emerging" patient conditions can become progressively worse and may cost hundreds of times more when delayed, but not a high priority due to limitations of time.

One example of the problem of an "emerging" condition is CMS's focus on discouraging re-admissions after ED discharge. I understand the argument that a re-admission might suggest the provider(s) did not do a good job on the first visit, but I question a financial penalty. "Why was the patient treated incorrectly to start with?"

NEW INSIGHT

In the past, I had described patients in this condition as the "grey zone." Recently, I discovered a study that was conducted by the Departments of Emergency Medicine at Harvard Medical School and Brigham & Woman's Hospital, and the Departments of Health Care Policy and Economics, and published in BMJ, (formerly British Medical Journal) in 2016 that addresses the "grey zone". This study identified a surprising, totally unexpected relationship of higher rates of premature, preventable, and unnecessary deaths after visits to the ED of a hospital with low admission rates.

This is one of the only studies to date that I can find that addresses something so "unimportant" as the patient. This study looked at the incidence of early death from hospital EDs (within 7 days of discharge from the ED). The study included a large sample of 20% of all Medicare beneficiaries nationally that were discharged from EDs of all sizes to their home (domicile).

The study included only patients that were admitted to the ED from the local community, and discharged back to the community, and only those patients considered healthy and who would not be expected to die or have any adverse outcome at the time of discharge or soon thereafter. Rigorous statistical analyses were used to point to statistical cause and effect that eliminated subjective bias; and the report included patients ranked into tiers by inpatient admission rates, lowest rates to highest (with no regard to hospital size) and if the patient died within 7 days of discharge. Additionally, the study did not include:

- Nursing Home residents.
- Patients older than 90 years of age.
- Patients in Hospice or receiving any form of palliative care.
- Patients having a known life limiting illness or disease at the time of discharge, or during the prior year (e.g., myocardial infarction).
- Patients transferred from the subject ED to a higher level of service.

CONCLUSION

Hospitals with the lowest admission rates saw higher death rates in this healthy population than those with higher admission rates by a factor of 3.4 to 1. Why?

The effect of higher medical complexity was eliminated. These patients would be described as "healthy", and with no other reason to expect death within 7 days. These patients were the same as patients discharged from any ED of any size and had nothing to do with size or scope of services. If the incidence of death did not relate to admission rates, the death rate among this patient population in all hospitals–in all categories of admission rates–would be the same.

From our experience, we could reasonably expect that deaths were not because we didn't know to diagnose and treat. We could also reasonably expect that if the physician had more time in the ED to more fully understand the patient's condition, he/she or someone could have intervened earlier and reduced this frequency of death significantly. But this is not the traditional role of most EDs. We "stabilize and dispose". Low acuity discharges are someone else's problem.

Our internal analyses indicate that patients with these diagnoses are admitted with the same frequency as discharged home, suggesting that some are intercepted and attended to immediately and others are not. Thus, the "grey zone". Our experiences and analyses point to several likely root causes: traditional processes and workflow that are chaotic and limit sufficient assessment and diagnosis (all of which have evolved over many years without regard to either efficiency or effectiveness), physician competency and motivation, and absence of standards of care (both medical care, work flow, and customer service) that are suited to the local scope of services.

Could a design exist for a rural EM service that achieves the historic "emergent" goals and requirements, AND "emerging" conditions that prevent progression of acuity and cost, and less devastating physical and emotional impact on the patient within the framework of current regulation, billing requirements, and financial constraints? **HospitalMD** has done it, and it is available to you!

Our core competency addresses your dilemma. We understand these conflicting conditions and blind spots within the rural hospital setting, process improvement methods, and how to achieve improvement within the framework of current regulations.

We provide the system for treating patients more thoroughly and comprehensively in addition to accomplishing improved customer service goals such as ALOS. This enables us to make a more informed decision on whether they are admitted or not. By developing the right skill sets, we can help you keep more patients that would have been transferred. We are able to diagnose and treat them, rather than delay by sending them home.

Your expertise is operating your hospital. Our expertise is selecting and managing physicians, employing performance improvement methodologies, and enough experience in operating hospitals to align physicians with your goals and expectations. **We will guarantee your results.**

Please feel free to contact me with any questions or comments. You can reach me via **insight@hospitalmd.com** or at

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877.881.8783. Our goal is to help small community hospitals thrive!

Jim Burnette is the Founder and CEO of **HospitalMD**. Jim has worked in healthcare for more than 20 years. His mission is to strengthen small community hospitals across the nation and help them thrive in today's rapidly changing healthcare climate. Jim is a graduate of Georgia Tech and resides in Peachtree City, a small community right outside Atlanta.

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