

# One-stop shop for care

*Hospital ERs seeing increase in patients, capital*

When Dr. Rich Zane arrived last year at the University of Colorado Hospital to become chair of its newly formed emergency medicine department, he found an emergency room built to handle 25,000 patients a year but was seeing 60,000.

Patients faced long wait times, satisfaction plummeted and many simply left without treatment. The ER was constantly on diversion. Like most hospitals, Zane said, it was operating under “a process that’s predicated on 1960s medicine and we’re practicing it in 2013.”

He set out to transform ER operations. Last month, the 467-bed hospital unveiled a re-envisioned emergency department. It has no wait. There’s no such thing as triage, and patients see a doctor as one of their first points of contact.

The Aurora-based hospital is the latest example of medical centers confronting the central paradox of today’s emergency-room care: more and more patients—and their primary-care doctors—are taking advantage of the emergency department’s ability to offer a 24/7, one-stop shop for all their ailments. And as they do, hospitals are seeing new opportunities to tap into that demand.

The change is being driven by a fundamental shift in how people inside the healthcare system are beginning to see the emergency department. An increasing number of office-based primary-care providers are concentrating solely on wellness and chronic-disease management. When they see patients with more urgent complaints, often requiring more sophisticated tests and procedures, they send them to the hospital.

This emerging practice pattern is challenging the conventional wisdom about emergency care—that high utilization is necessarily a bad thing. “Emergency departments have become a portal for patients to get care very quickly,” said Dr. Robert Norris, chief of emergency medicine at 477-bed Stanford (Calif.) Hospital & Clinics. “To be honest, I think that’s one of the real



advantages of emergency medicine.”

Last year, Silicon Valley’s leading academic medical center took a number of steps that would ultimately improve wait times and allow the hospital to see and attract more patients, even those with lower-acuity conditions. With Stanford’s reputation as a quaternary-care center, “the word was that you went other places for minor lacerations and ankle sprains,” Norris said. “And that always bothered me.”

Norris argued that the cost of delivering care in the ER is not more expensive than it would be in a doctor’s office. In fact, seeing lower-acuity complaints is actually an efficient use of fixed hospital resources, particularly staff and clinicians. “They’re there and they can see patients,” Norris said.

The changes are occurring at a time when the emergency department has been a consistent bright spot for hospitals in terms of volume, even as growth in inpatient admissions has stagnated. Hospitals now see new opportunities to be more involved at the point where patients are actually accessing the system since the ER has become the primary dri-

**More primary-care physicians are sending patients to emergency departments.**

ver of hospital admissions, which is where hospitals make the bulk of their revenue.

A study last week from RAND Health found that emergency departments are now responsible for about half of inpatient admissions, and accounted for all of the growth in admissions between 2003 and 2009. Direct referrals from physicians in the community, meanwhile, are on the downswing. The dramatic reversal means that even though hospitals admissions increased only 4% over the period—not even keeping pace with population growth—ER-related admissions jumped 17%.

The shift is driving hospitals to begin making significant investments in their ERs, a marked change from past practice. Dr. Andrew Agwunobi, who leads the hospital performance improvement practice at Berkeley Research Group, noted that hospitals traditionally did not invest much capital in the ER in the belief that it provided mostly uncompensated care. In addition, the under-



lying assumption was that delivery system reform would ultimately reduce the number of ER visits and steer patients toward lower-level care settings.

"What they found was that the financial health of the hospital was actually in jeopardy," Agwunobi said. "Most of the revenue of the hospital was actually coming from the emergency department."

After examining their revenue streams, hospital executives found that people showing up for nonurgent care actually did have insurance or other means to pay. What they didn't have was other options for treatment. "It is not only the uninsured and under-insured that use the ER—it is everyone," Agwunobi said. "The ER department provides 24/7 open access in a healthcare setting that very often has closed access."

Primary-care physicians are increasingly using the emergency room as a fallback. RAND researchers found that the increase in ER-related admissions coincided with a 10% decrease in direct admissions from doctors' offices and other outpatient settings.

"It's increasingly common for primary-care physicians to see themselves as dedicated to their own offices," said Dr. Wes Fields, an emergency medicine physician and a board member of CEP America, an acute-care management and staffing firm. "If a patient calls with chest pain or shortness of breath, they're not even going to think about working them up in their office. The same is true for minor trauma."

The good news in the RAND report was that increased ER use didn't necessarily drive up avoidable admissions. For instance, despite more patients showing up to the ER with chronic conditions such as asthma and heart failure, admissions for these conditions remained flat.

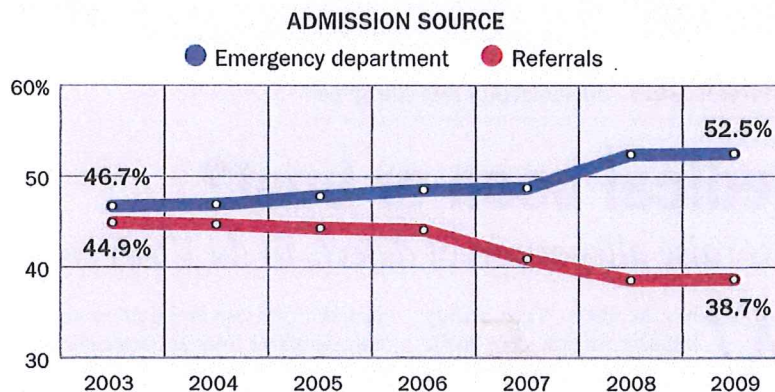
Moreover, the RAND study highlighted that even though emergency rooms account for 11% of all outpatient visits, they represent only 2% to 4% of annual healthcare expenditures. "You simply can't save enough money by trying to divert away low-acuity patients," Fields said. "There simply aren't that many of them. It doesn't make sense to treat those patients outside that hospital setting."

One thing that redesigned emergency departments have in common is that patients see a physician almost as soon as they walk in the door. Tests are ordered right away, and triage is a thing of the past. Physicians also work alongside a "scribe" who handles documentation.

The University of Colorado Hospital even has a 24-hour retail pharmacy so that patients can have a "productive waiting" experience, Zane said. Colorado's ER redesign was part of a larger \$400 million project to build a new 12-story inpatient tower—with the first floor

## MODERATING FORCE?

Amid flat admissions—a 4% increase as the population grew 5.7%—emergency departments accounted for a rising share of the total



Source: RAND Corp., "The Evolving Role of Emergency Departments in the United States"

MODERN HEALTHCARE GRAPHIC

largely dedicated to an ER that is now more than double the size of the old one.

Atlanta's 660-bed Grady Memorial Hospital is also in the midst of its own "eight-figure" project that will include an expansion and redesign of the emergency department. "It's a double-edged sword," said Dr. Leon Haley, chief of emergency medicine for the Grady Health System. "Everyone wants people not to come to the emergency department unless they have an emergency. We know that's not a reality."

The urban facility is still the major safety net hospital for the uninsured. But its emergency department has appeal for community physicians by speeding up the process of seeing specialists and getting test results. "It's relatively expedited (compared to) if you try to do the same thing in a primary-care setting," Haley said.

And sometimes it leads to admissions, the hospital's bread-and-butter. "When a patient exhibits serious symptoms, the ED can be the most direct and optimum way to take care of the patient and most convenient method of admission," said David Gans, a senior fellow at the Medical Group Management Association. It may even eliminate some costs. "For many, the current insurance system does not bill an ED visit if the patient is admitted, so there may be no additional cost to the consumer or the insurance company."

Another common theme among redesigned emergency rooms is larger observation units. Not every patient needs to be settled into an emergency department's most

valuable real estate: the monitored critical-care bed. "It's one of the most expensive beds in the hospital," said Dr. Bryan Gargano, associate chief of emergency medicine at Rochester (N.Y.) General Hospital. "It's your most valuable resource."

Rochester General first took a hard look at its emergency department four years ago. At the time, patients coming into the ER were waiting an average of 80 to 90 minutes to see a doctor, and a frustrated 4% to 5% left without being seen. The hospital first tried to tackle high volume and long wait times with a bigger space. But "it was pretty obvious that building a new space won't solve operational problems," Gargano said.

By mid-2010, the hospital had done away with the typical measures used to sort and process patients. It cut triage and fast track. It funneled every patient to a physician, nurse or technician immediately so that workups could begin right away. Despite a huge increase in volume—ER visits rose from 89,000 patients in 2009 to 119,837 last year—the median wait time fell to 19 minutes.

How? A 30% increase in productivity accompanied the increased focus on serving the immediate needs of its ER patients, Gargano said. <<

—with Ashok Selvam

**TAKEAWAY:** Physician referrals and insured walk-ins are **crowding** emergency rooms, which are now the leading source of hospital **admissions**.