How Integrated Clinical Services and Technologies are Making Healthcare Work Better

EmCare®

Making Health Care Work Better.™

YOUR PRESENTERS

Kirk Jensen, MD, MBA, FACEP

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Executive Vice President, EmCare

W. Mark Hamm, MBA

Chief Executive Officer

EmCare Hospital Medicine

OUTLINE

Proposed format:
2:00-2:03 EDT Intro the call and housekeeping (Becker's)
2:03-2:05 Brief bios of the presenters

2:05-2:35 Dr. Jensen: Benefits of hospital-wide integration
- Fostering a culture of integration & collaboration across departments
- Medical leadership and alignment with hospital goals
- Improved throughput reduces cost, improves patient satisfaction
- Critical success factors for successfully integrating clinical operations

2:35-2:40 Mark describes example of EM and HM integration
- Impact of ED boarding & implications for lost revenue
- Process supporting early discharge from inpatient unit

2:40-2:50 Mark: Innovations & case studies
- Integrated clinical technology to support clinical integration across service lines
- Improved communications leads to improved flow, better care and better financial metrics
- Experience of StoneCrest and other customers

2:50-3:00 Q&A.

Our Goals and Objectives

Outline the **benefits** of hospital-wide integration

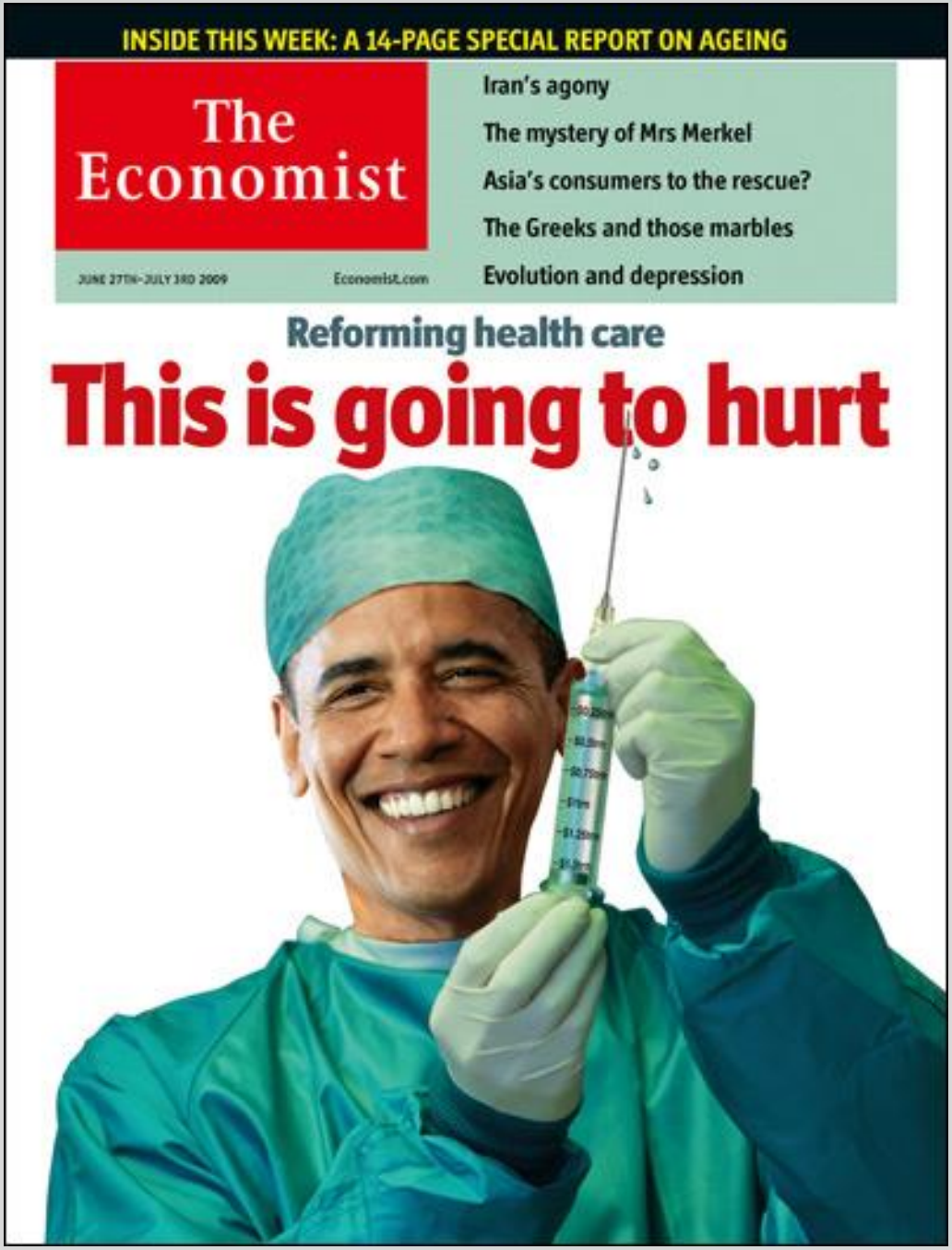
Illustrate how **Emergency Medicine** and **Hospitalist Medicine** clinicians can work effectively together

Discuss **integration**, **innovation** and **selected case studies**

A **healthcare system that works** for your patients, your healthcare team, and for you…

There are differing views of health care reform…

The impact and uncertainty of health care reform tops the list of more than one healthcare professional…

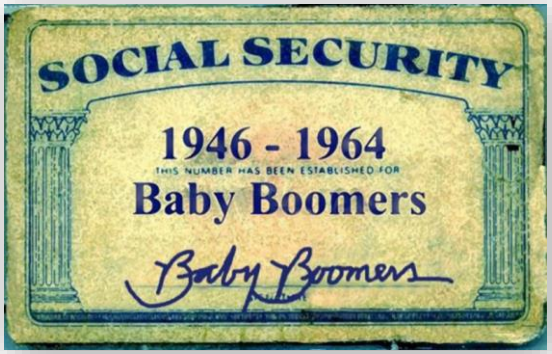


The Future is Now-The Baby Boomers are Here…

Demographic growth is driven by the elderly:

The 65 and older age cohort will experience a 28% growth in the next decade

- One baby-boomer turns 50 every 18 seconds and one baby-boomer turns 60 every 7 seconds (10,000 a day)
- This will continue for the next 18 years



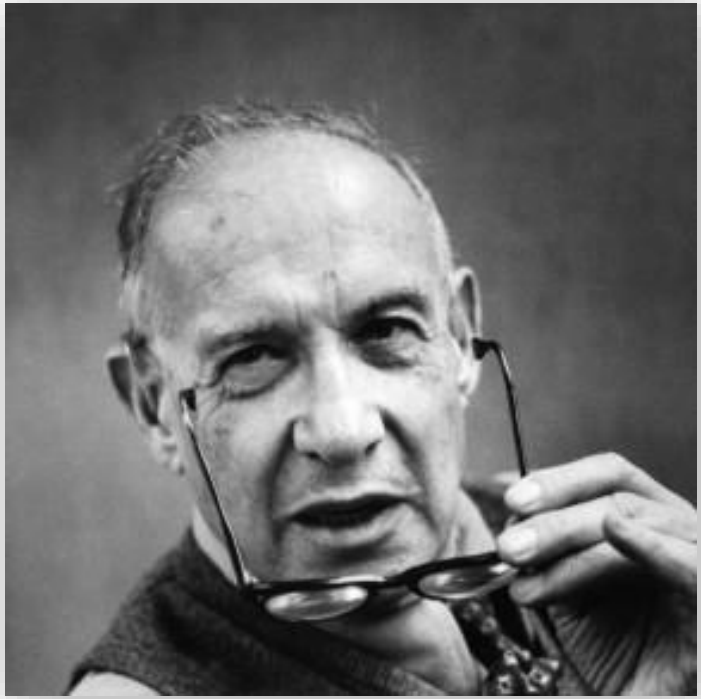
This cohort will comprise 15% of the total population by 2016

A higher proportion of patients in this cohort, in comparison to other age groups, are triaged with an emergent condition

One-quarter of Medicare beneficiaries have five or more chronic conditions, sees an average of 13 physicians per year, and fills 50 prescriptions per year…

Peter Drucker's Observations on Hospitals and Healthcare

"The ***hospital*** is altogether the ***most complex*** human organization ever devised."



TJC and Hospital-Wide Patient Flow

2005 -TJC and the Hospital-Wide Patient Flow Committee:

JCR Leadership Standard LD.3.10.10

- The leaders develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital.
- Effective for all accredited [illegible] uary 1, 2005

The Joint Commission

2013 - The Joint Commission says "Boarding in the ED requires a hospital-wide solution."*

***As reported in ACEP NEWS**– January 14, 2013

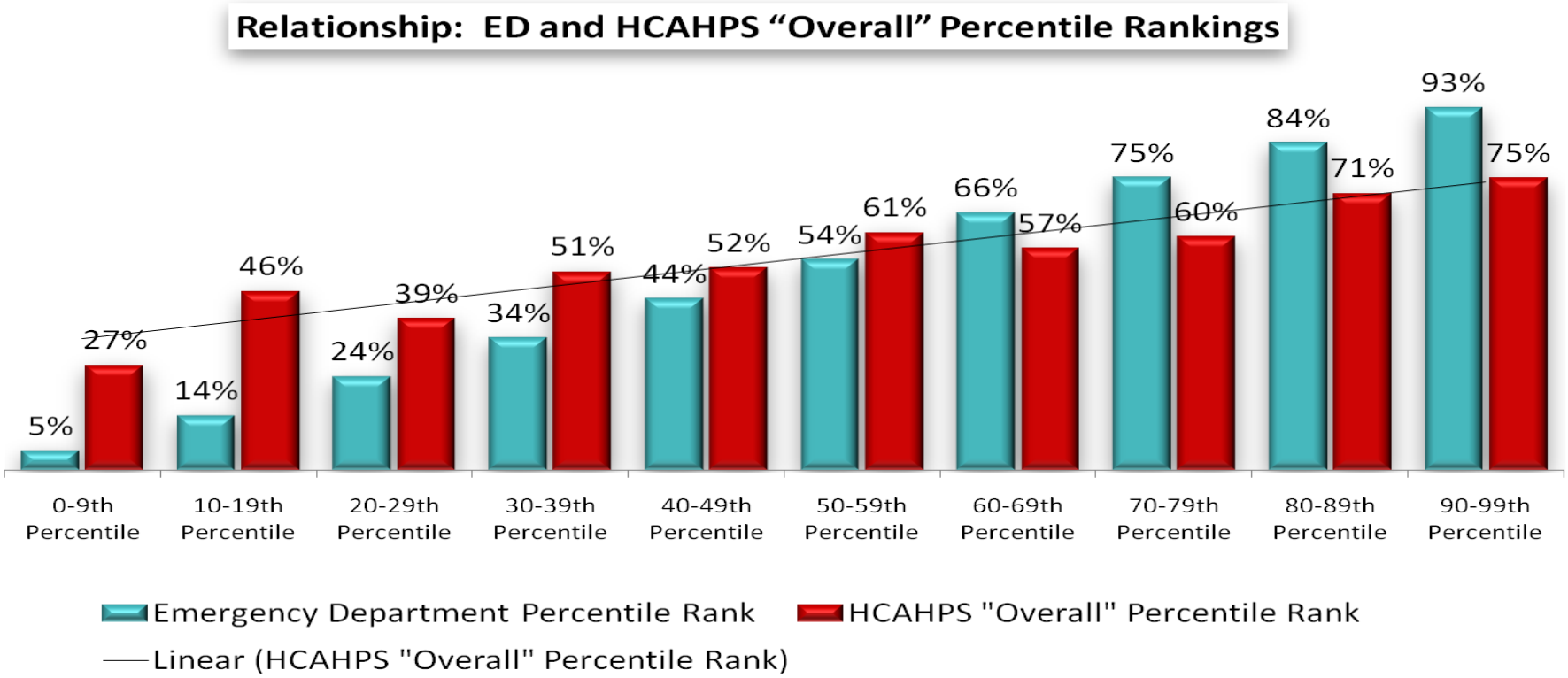
- Performance standards put into effect Jan 1, 2013 require hospital leaders – namely the chief executive officer, medical staff and other senior hospital managers – to set specific goals to:
  - Improve patient flow
  - Ensure availability of patient beds
  - Maintain proper throughput in labs, ORs, inpatient units, telemetry, radiology and post-anesthesia care units

"We want to make sure that organizations are looking at patient flow hospital-wide, even if the manifestation of a flow problem seems to be in the emergency room." ~ Lynne Bergero, The Joint Commission

Hospital-Wide Patient Flow and the Emergency Department

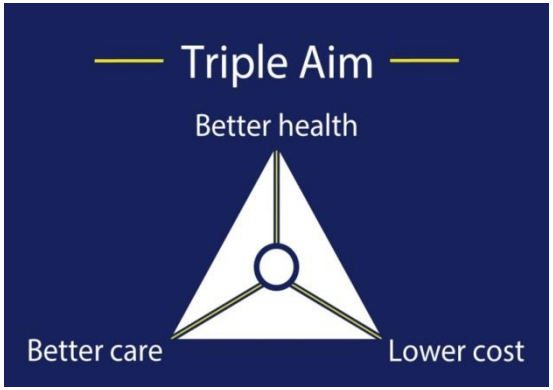
- Nearly half of the EDs in the U.S. report operating at or above capacity
- Approximately 500,000 ambulances are diverted each year away from the closest hospital
- 9 out of 10 hospitals report "boarding patients" in the ED while waiting for inpatient beds

As a Hospital's ED Percentile Ranking Increases, So Does Its HCAHPS "Overall" Percentile Ranking*



***Courtesy of a Studer Group analysis**

The Triple Aim



Improving care, improving health, reducing costs

"Improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

The integrator's role includes at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration."

Preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an "integrator") that accepts responsibility for all three aims for that population.

Health Affairs 27, no. 3 (208) 759-769
10.1377/hlthaff.27.3.759Trendwatch

Hospital-Wide Patient Flow

Poor patient flow has a negative impact on overall hospital performance, slowing throughput and decreasing capacity.

The negative impact of inefficient patient flow is often felt most in the emergency department, where movement, flexibility and efficiency are critical.

Poor collaboration, strained communication, silo mentalities, and differing incentives contribute to fragmented relationships between emergency medicine and hospital medicine physicians.

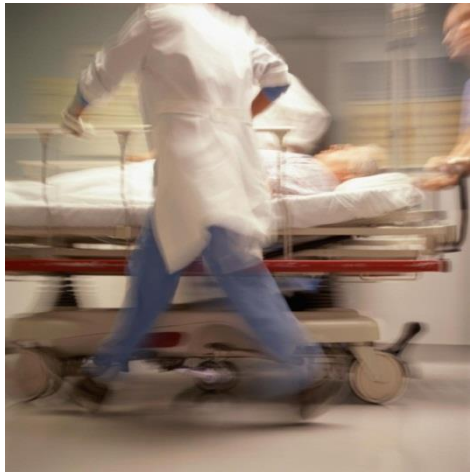
A primary culprit is **physician communication and hand-offs** at admission — moving patients from the emergency department to the inpatient units.

Major Patient Flow Drivers

Emergency Department Efficiency and Effectiveness

- The emergency department (E.D.) is the front door of the hospital. It addresses the urgent and acute care needs of patients.
- For many patients, the E.D. is only the first phase of their hospital experience.
- Approximately 50% of inpatient admissions come from the E.D
- In the E.D., efficiency and productivity are critical. Seconds count.
- Improving E.D. throughput has a distinct impact on success.
- Redesign efforts should focus on staffing, triage, registration and other patient-centered care factors.

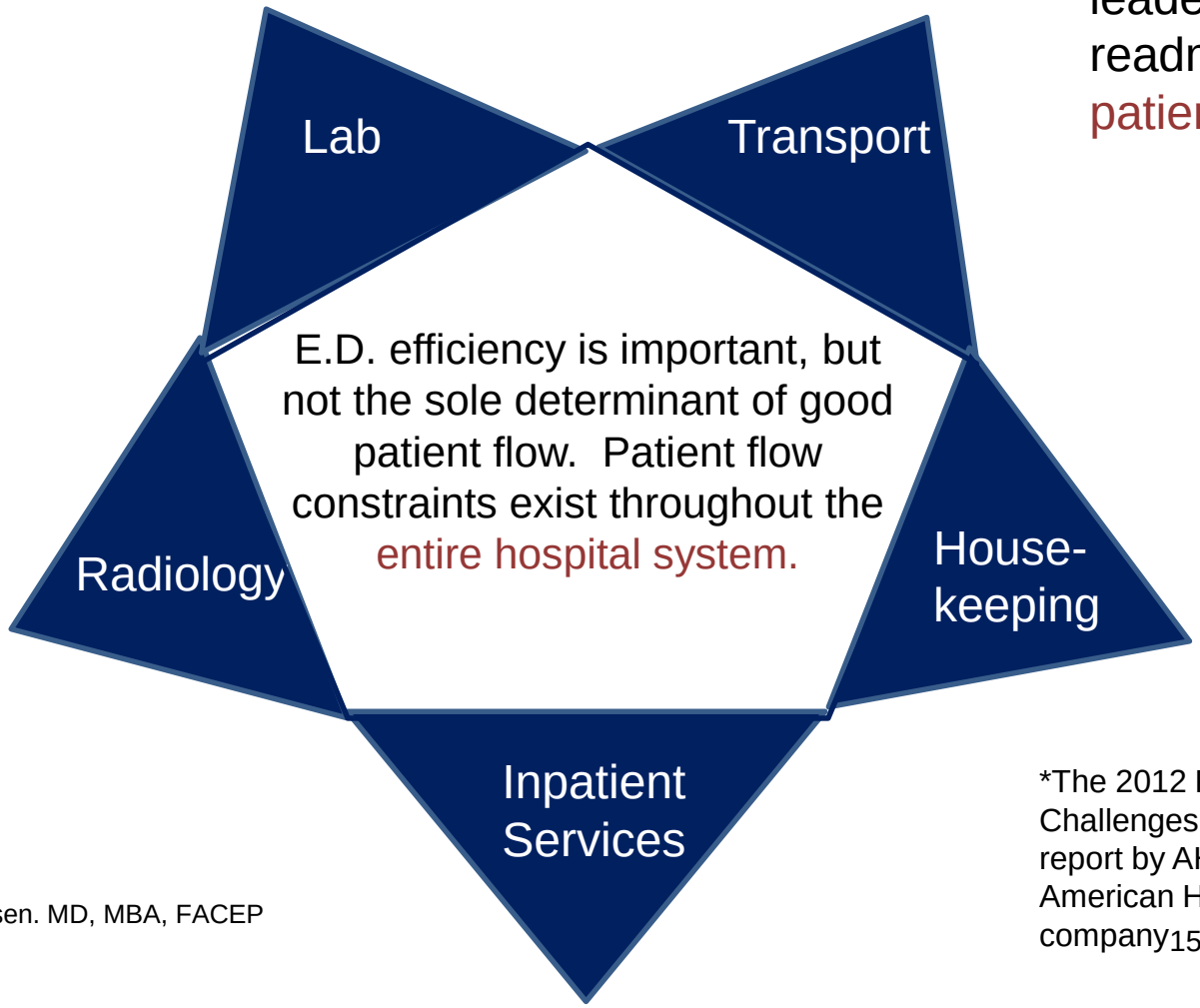
The Centers for Medicare & Medicaid Services (CMS) goals for 2013 and 2014 include measures to record improvement in E.D. efficiency and throughput times.



Major Patient Flow Drivers

Hospital System Efficiency and Effectiveness

The top three areas of concern for hospital leaders are HCAHPS, readmissions and poor patient flow.*



*The 2012 Patient Flow Challenges Assessment (PFCA) report by AHA Solutions, an American Hospital Association company

Poor Patient Flow Issues

Hospitals with patient flow issues demonstrate:

A culture allowing physicians and staff to work in silos instead of focusing on a broader picture of patient-centered care.

Divergent perspectives and priorities of the emergency medicine and hospital medicine physicians causing inefficiencies, communication breakdowns and slow patient hand-offs.

Inpatients ready for discharge filling hospital beds into the late afternoon, blocking admissions from the emergency department.

The average time to move the admitted patient from the emergency department to the inpatient unit was commonly 3½ hours or more
(E.D. boarding time).

*The 2012 Patient Flow Challenges Assessment (PFCA) report by AHA Solutions, an American Hospital Association company

Foundation of Patient Flow Improvements

Improving patient flow often takes a complete refocus of the hospital organization on…

- Process
- Critical bottlenecks
- Teamwork
- Hand-offs and
- Clinical leadership

…crucial elements that lead to "**culture change**."

Expert facilitation of changes to **both processes and culture** is a key element in bringing about improved overall efficiency and effectiveness.

Contributions to Patient Flow By Specialty

Significant flow and service efficiencies plus improved clinical outcomes can be achieved through the combined efforts of both services.

Emergency Medicine

- Effective triage
- Professional, organized communication
- Lean thinking and patient-centered processes
- A continuous focus on improving flow and the patient experience

Hospital Medicine

- Patient rounding throughout the day
- Foresight and planning
- Observing and understanding a patient's needs
- Arranging appropriate services and assistance
- Managing the patient experience and creating a positive care environment

Hospital Medicine Physicians - Hospitalists

As Quarterbacks

Hospital medicine physicians, or hospitalists, direct care for patients requiring hospital inpatient services.

The hospitalist can serve as **quarterback** of the patient care team, teaming up with multiple players:

- E.D. physicians and personnel
- Primary care physicians
- Specialists
- Nursing staff
- Case managers
- Laboratory staff
- Radiology personnel
- Patients
- Family members
- Program coordinators
- Home care agencies
- Long term acute care hospitals
- Rehab facilities
- Nursing homes

As many hospitals move to a model of 24-hour laboratory, radiology and other essential services, the advantages of 24-hour hospitalist services will likely become more dramatic.

Hospital Medicine Physicians - Hospitalists

Impact and Advantages

The impact of the hospital medicine group on HCAHPS scores is hefty because hospitalists provide the majority of clinical care for admitted patients.

As a hospital-based practice, hospitalists are positioned to effectively manage and facilitate hospital admissions and discharges.

Therefore, from a patient flow perspective, hospitalists have come to play major roles in improving flow efficiency, satisfaction and cost (McHugh et al, 2011).

Value-based Success

Key Ingredients

1. Uniting E.D. and hospitalist services around shared goals and operations
2. Optimizing patient throughput via system-wide collaboration and integration
3. Focusing on providing quality patient-centered care

INTEGRATION

Leadership and Culture Change

Behind virtually every successful, patient-centered E.D. is great leadership, a culture of service excellence and operational efficiency.

Healthcare providers almost invariably support processes that improve patient care.

When **leadership** can manage from a clinically and operationally integrated E.D. and hospitalist model, it can break down problematic silos, collaboratively addressing the availability of inpatient / ICU beds, spikes in arrival, diagnostic turnaround times and more.

After all, helping others is the reason so many nurses and physicians go into healthcare.

Clinical Integration

The Solution

Today's focus on efficiency, cost effectiveness and quality has put coordination and collaboration at center stage.

Foreword thinking healthcare organizations are realizing that integration of services and care requires a holistic approach.

That's why many visionary healthcare organizations are pursuing a strategic path toward **operational integration**.

Ultimately, the solution has been found in an **integrated approach** to emergency medicine and hospital medicine in order to improve communication, collaboration and performance…

Clinical Integration
Operational *and* Technical Components

Integration includes behaviors, activities and tools to achieve, sustain and accelerate exceptional **clinical, operational and financial outcomes**.

Even with existing integrated groups, turning a historically disjointed system into a well-oiled machine will be facilitated by applying the right tools.

Shared technology and structural improvements can improve communication and efficiency.

Shared operational tools can improve clarity, flow, hand-offs, communication and more.

The **benefits of integration** and alignment include cost reduction, revenue enhancement, CMS-imposed penalty reduction, and increased satisfaction of all parties involved.

Clinical Integration

Fast Track to Flow Improvement

Integration of the emergency and hospital medicine practices on **all levels** - clinical, operational, technical, financial, etc. - quickly and profoundly impacts the hospital by:

- Improving patient flow,
- Optimizing care and efficiency,
- Improving the patient experience, and
- Generating related value.

For the hospital, improvements in efficiency, faster bed turns in the E.D., the opportunity for incremental admissions and decreases in patients leaving the E.D. without treatment provides opportunities for new revenue, with synergies that lead to a better bottom line.

Door-to-Discharge: Ideally a seamless network of patient care, handoffs, and transitions

DOOR

Patient seen in ED by a physician

COLLABORATE

ED and Hospitalist physicians collaborate during the admission process

HOSPITALIST CARE

Hospitalist physician oversees patient's care during inpatient stay.

DISCHARGE

Patient discharged by Hospitalist

Improving Patient Flow

Key Strategies

It's one thing to have processes in place that improve efficiency. But, flow is equally thwarted if there are no inpatient beds available when needed. Countless variables impacting bed availability are beyond the control of either the emergency physician or hospitalist. Still, it helps to be aware of initiatives and programs available to a hospital for addressing areas that can be managed.

EmCare offers valuable support to the hospital for a number of strategies to improve both patient flow and the patient experience, such as:

- Accommodating discharge strategy planning within the first 24 hours.
- Supporting the hospital's "11 a.m. Discharge" program or other focus on timely discharge.
- Starting Off Right Discharge planning typically begins the moment the patient is admitted.
- Hospitalists who collaborate with case managers can be instrumental in helping to successfully transition the patient to the next stage of appropriate care.

Improving Patient Flow

Key Strategies Continued

- Participating in programs such as "early rounding" on inpatients or "rounding with a multidisciplinary team."
- Assisting with initiatives such as "day of discharge" conferences or, preferably, "next day discharge" conferences to identify patients who may be ready to go home.
- Providing expertise in setting up a discharge lounge.
- Supporting the use of nurse practitioners and physician assistants in accordance with the hospital's bylaws and state laws.
- Investigating new concepts in hospital medicine such as ways to overcome inefficient routines, for example, rounding on discharges first and taking more time with sicker patients later as medically prudent.
- Providing educational programs customized and facilitated by clinical services experts.
- Designing and implementing an effective hospitalist orientation process

(Quinn, 2011).

Integration Changes Everything

EmCare's Door-to-Discharge

EmCare's Door-to-Discharge integrated hospitalist/ED service (D2D) expedites care by moving patients more efficiently from the ED to treatment to testing and a quicker discharge, leading to:

- Faster admission
- Less E.D. boarding time
- More E.D. capacity
- Less wait time in the E.D.
- Less ambulance diversion

In addition to patient benefits, the D2D model delivered significant financial benefits to hospitals previously experiencing even minor challenges with LWBS, LPT and LPMSE rates. Hospitals utilizing EmCare's D2D with RAP&GO software experience a nearly *12% improvement in E.D. volume*.

EmCare processes are designed to drive greater:

- Efficiency and cost savings
- Potential new hospital revenue
- Positive perception of care
- Improved quality of care

Clinical Integration
Powering through Software

EmCare's proprietary Rapid Admission Process and Gap Orders™ (RAP&GO™) evidence-based software supports EmCare's D2D service.

RAP&GO™ leverages technology to improve patient flow by organizing, automating and expediting the process of moving the patient from the ED to the floor; in short, ***hardwiring*** the LEAN process.

RAP&GO™ helps organize and facilitate communication not only between physicians, but throughout all hospital departments.

All entities associated with coordinating a hospital admission and moving patients more rapidly through the admission process benefit from RAP&GO…including patients.

"From the first day I used **RAP&GO™**, I loved it! All the calls back and forth are eliminated. No more 'Let me call you back…,' where sometimes 30, 40 or 50 minutes would pass before you heard back. We can now stay ahead on beds as everyone who needs the message gets the message … at the same time."

~ Quote from the House Supervisor of a hospital using RAP&GO™

Integration Changes Everything

The Industry Blueprint for Success

Integration changes everything:

Communication, collaboration, patient flow, patient perception of care… *and the bottom line.*

With this insight, EmCare has developed the industry blueprint for success.

EmCare's Door-to-Discharge program with RAP&GO™ evidence-based software tackles the outdated silos and the rigidities of complex and cumbersome systems, and delivers improved quality, safety and service.

Door-to-Discharge with RAP&GO™ :

- Addresses throughput and efficiency with lean and rapid process redesign
- Provides leadership to bring all departments together on a patient centered mission
- Integrates the emergency medicine and hospital medicine physician team
- Creates efficiencies in length of stay and implements an inpatient early rounding and discharge program
- Supports the process with software to improve communication, accuracy, confidence and efficiency
- Supports growth in E.D. volume / performance and the potential for new revenue generated by decreasing boarding time and opening up E.D. beds

CONCERNS OF HEALTHCARE LEADERS

2013 | 2014 | 2015

60%

expect ED operating margin to decrease

75%

identified ED-to-Inpatient BIGGEST bottleneck

9 out of 10

expect ED volumes to increase

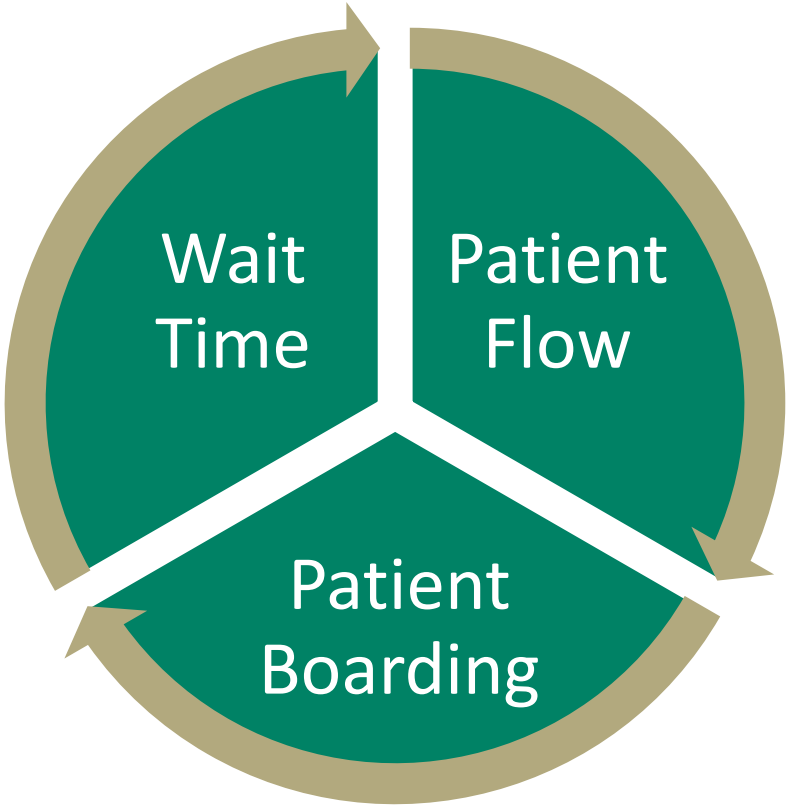
40

million newly insured patients from ACA using the ED

TOP CHALLENGES

Most healthcare leaders say that patient flow, wait time and patient boarding are their biggest ED challenges.

The ED only flows as well as the hospital flows.



THE COST – IT ADDS UP

1.9 million

In 2007, 1.9 million people – representing 2% of all E.D. visits – left the E.D. before being seen. These walk-outs represent significant lost revenue for hospitals.

$1,086

A 2006 study found that each hour of ambulance diversion was associated with $1,086 in foregone hospital revenues.

$9,000

A recent study showed that a 1-hour reduction in E.D. boarding time would result in over $9,000 of additional revenue by reducing ambulance diversion and patients who left without being seen.

Source: Ambulance Diversion: Economic and Policy Considerations , 14 July 2006 Robert M. Williams *Annals of Emergency Medicine* December 2006 (Vol. 48, Issue 6, Pages 711-712) Retrieved from http://www.annemergmed.com/article/S0196-0644(06)00621-4/abstract April 29, 2014.

ILLUSTRATION OF POTENTIAL FINANCIAL BENEFIT TO XYZ HOSPITAL

Assumptions:

Projected Reduction in LPSME Based Upon Actual D2D Results: 24%
(15 facilities with D2D program; year-over-year comparison)

Projected Increase in ER Volume Based Upon Actual D2D Results: 10%
(15 facilities with D2D program; year-over-year comparison)

Projected Increase in Hospitalist Program Encounters
Based Upon Actual D2D Results: 5%
(15 facilities with D2D program; year-over-year comparison; the admissions increase is driven by increased ER volume - the total admission rate of ER patients under the D2D model is generally unchanged or slightly less than historical admission rate prior to D2D implementation)

* Potential New Hospital Revenue is representative of a decrease in LWOT/LPMSE rates and/or improved bed availability which in turn contributes to an increase in E.D. volume. An increase in E.D. volume may result in improved revenue for the hospital through charges for the additional patients in the E.D. Historical data suggests that admission rates under the D2D program remain essentially flat compared to the time period immediately prior to implementation of the D2D program. Thus, thus the additional E.D. volume would result in additional admissions and potential increased revenue for the hospital.

ILLUSTRATION OF POTENTIAL FINANCIAL BENEFIT TO XYZ HOSPITAL

Financial Illustration:

Current ED Volume:		40,000		
Projected Annual ED Volume Increase from improved flow:	10%	Assumption		4,000
Hospital Revenue per ED case			x $	1,000
Total Potential Hospital Revenue from Increased ED Volume:			**$**	**4,000,000**
Potential New ED patients per day due to improved flow	***11***			
Potential Additional Annual Admissions From ED Volume Increase Assuming	16.0%	Admission Rate		640
Historical Medical Cases Composition Rate				
Revenue from Medical Cases at $7,500/case	70%	448	$	3,360,000
Historical Surgical Cases Composition Rate				
Revenue from Surgical Cases at $15,000/case	20%	128	$	1,920,000
Historical Cardiac Cases Composition Rate				
Revenue from Cardiac Cases at $12,000/case	10%	64	$	768,000
Total Potential Hospital Revenue from Additional Admissions:			**$**	**6,048,000**
Potential New Admissions per day due to improved flow	***2***			
Potential Additional Annual Hospital Revenue			**$**	**10,048,000**

* Potential New Hospital Revenue is representative of a decrease in LWOT/LPMSE rates and/or improved bed availability which in turn contributes to an increase in E.D. volume. An increase in E.D. volume may result in improved revenue for the hospital through charges for the additional patients in the E.D. Historical data suggests that admission rates under the D2D program remain essentially flat compared to the time period immediately prior to implementation of the D2D program. Thus, thus the additional E.D. volume would result in additional admissions and potential increased revenue for the hospital.

VALUE-BASED PURCHASING

The Hospital Value-Based Purchasing (VBP) Program is a Centers for Medicare & Medicaid Services (CMS) initiative that rewards acute-care hospitals with incentive payments for the quality of care they provide to people.

CMS bases hospital performance on an approved set of measures and dimensions, grouped into specific quality domains.

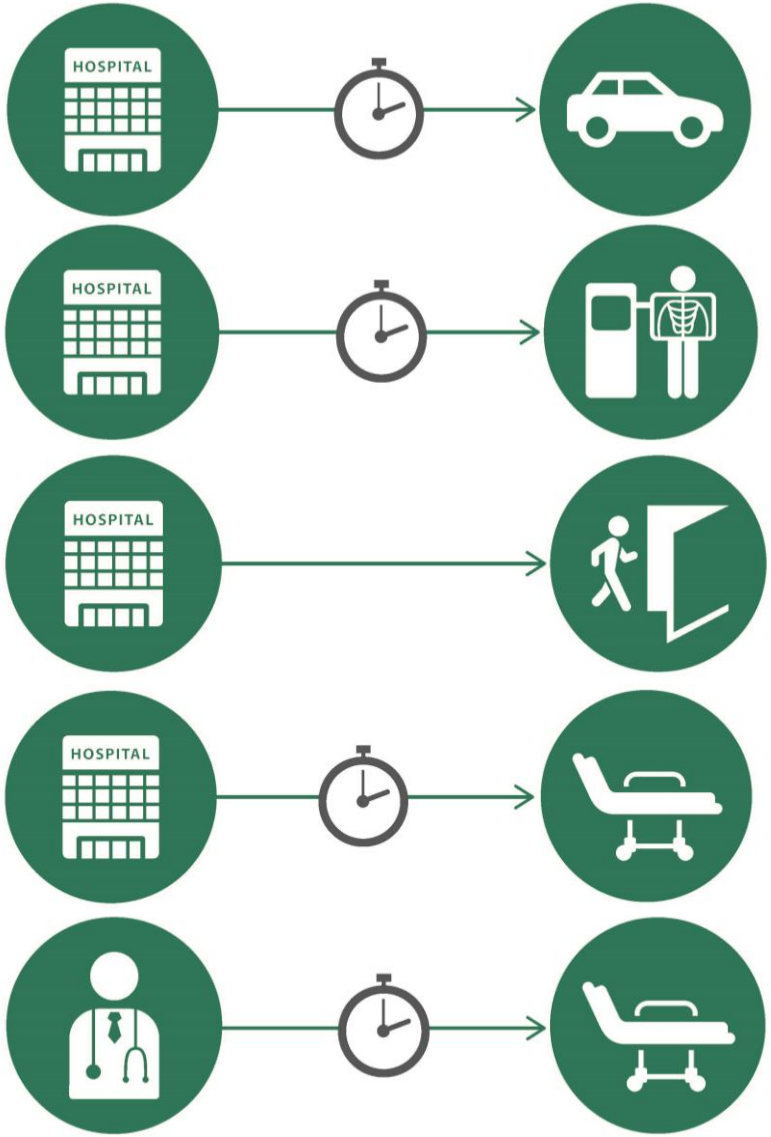
WEIGHTED VALUE OF EACH DOMAIN, FY 2013 – 2015

Domain	FY 2013 Weight	FY 2014 Weight	FY 2015 Weight
Clinical Process of Care	70%	45%	20%
Patient Experience of Care	30%	30%	30%
Outcome	N/A	25%	30%
Efficiency	N/A	N/A	20%

Source: Medicare Learning Network. (2013, March). *MLN Products ICN 907664 March 2013.* Retrieved from CMS.gov: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf

HOSPITAL REPORTING OF ED MEASURES TO CMS

1. **Median time ED arrival to ED departure - for discharged patients (CY 2013)**
2. **Door-to-diagnostic (CY 2013)**
3. **Left without being seen (CY 2013)**
4. **Median time ED arrival to ED departure - for admitted patients (FY 2014)**
5. **Median time admit decision to ED departure - for admitted patients (FY 2014)**



EMERGENCY MEDICINE PHYSICIANS AND HOSPITALISTS

YIN AND YANG…

ED Physician

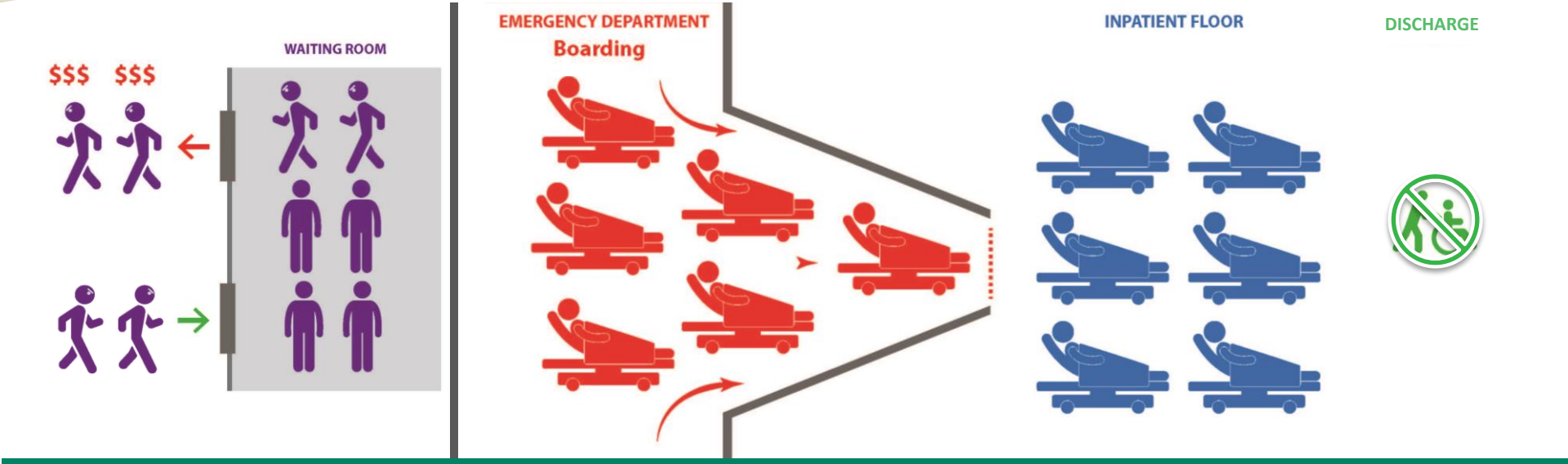
- Acute condition
- Stabilize and transport
- Thinks of the big picture
- Diagnose, treat and discharge
- Move fast and make critical decisions quickly

- **LOS measured in MINUTES**

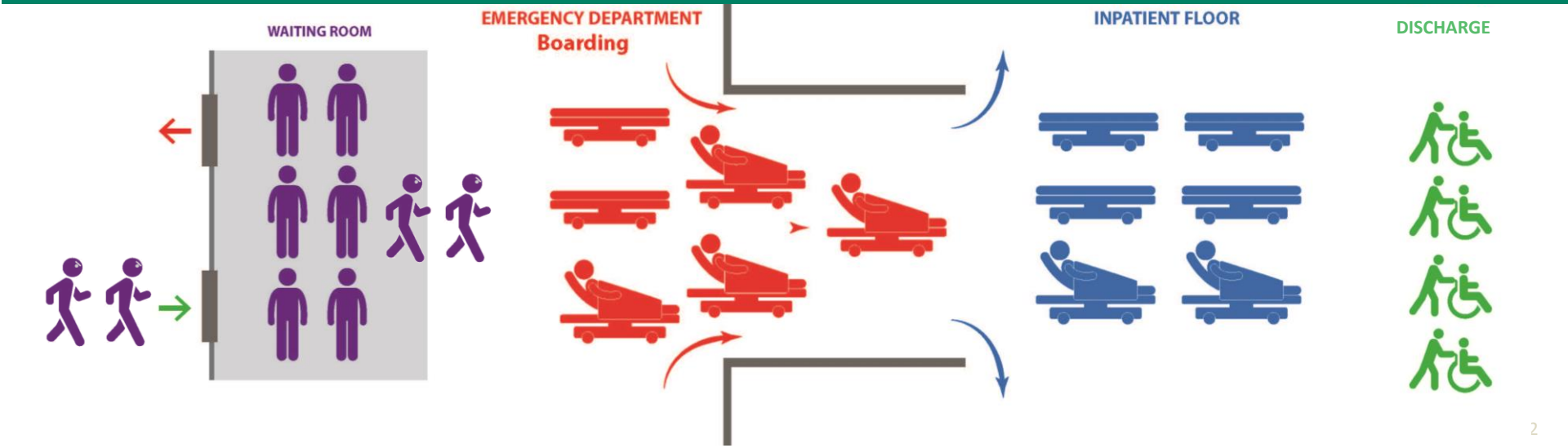
HM Physician

- Evaluates all the details
- All conditions and comorbidities
- Treat, educate and prevent recurrence
- Has time to explore options with patients and caregivers
- Methodical decision making
- **LOS measured in DAYS**

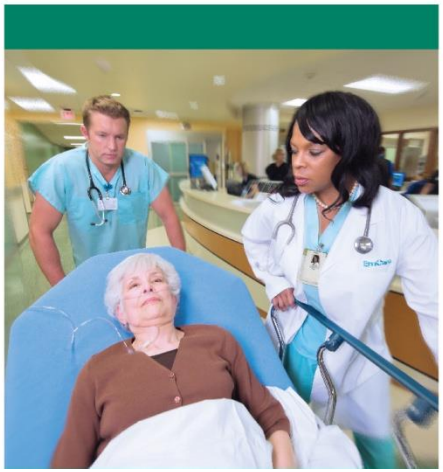
BOARDING AND BOTTLENECKS



SMOOTH PATIENT FLOW



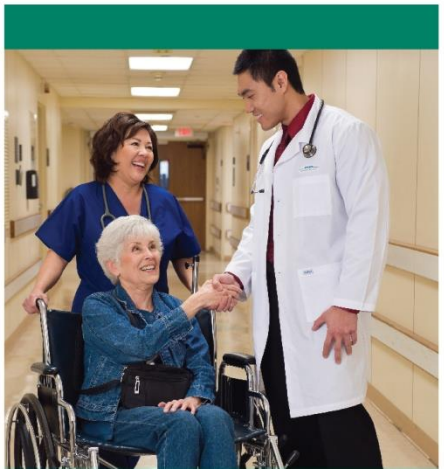
ALIGNMENT, CLINICAL INTEGRATION, AND TECHNOLOGY



Lean Emergency Department

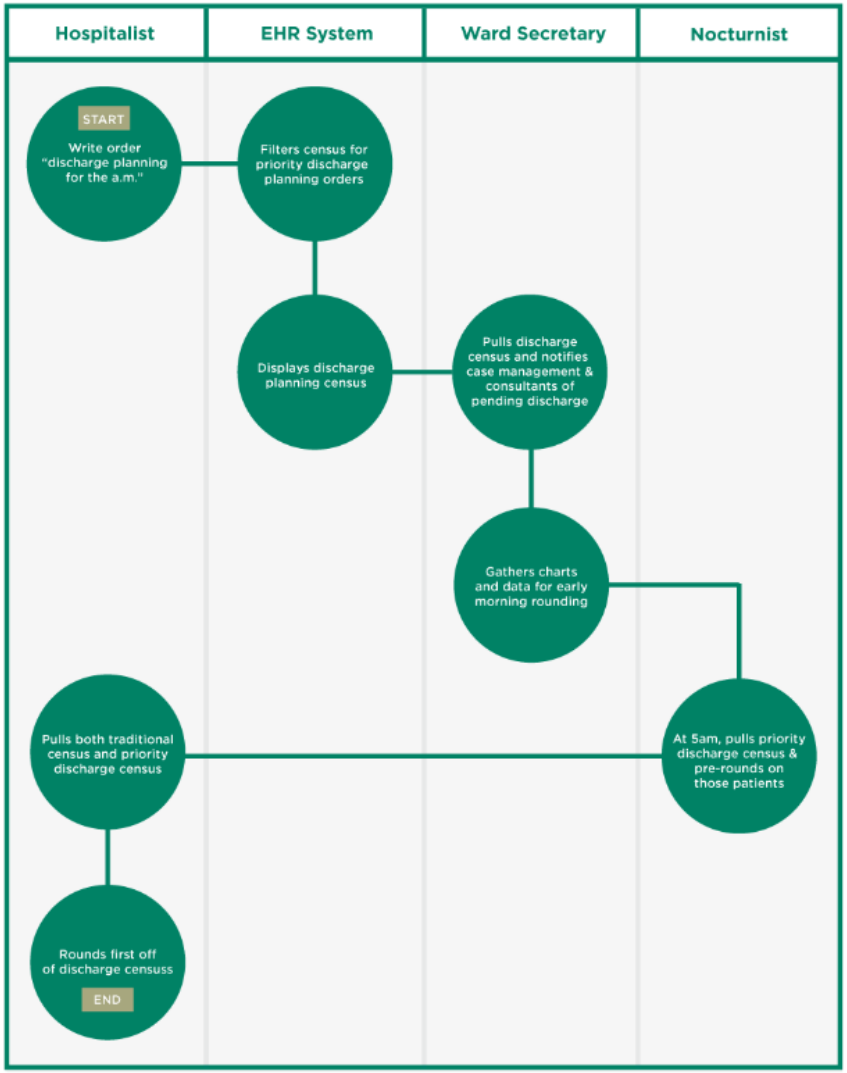
Collaboration and Efficient Inpatient Admission

Efficient Inpatient Services



Discharge by 11am

Priority Discharge Frees Up Inpatient Capacity



Technology Facilitates Communication and Process Efficiency

CMO/Rx Diagnostic Report × | Welcome to Net Conferenc ×

https://cmorx.com/ccAssist/ccReport.cfm

Apps | Stephensaccess | EMSC Portal | EmCare WebMail | Concur Solutions | Enterprise BI Portal | Login :: Edge Web H | HughesNet Login Info | Other Bookmarks

CMO/Rx | Inpatients | Diagnostics | Utilization | Search | Hospital | SuperUser | Logout

Demo Hospital

530.11, Reflux esophagitis (10)

+ Gastric Reflux Therapy

CONSTIPATION: POA The patient is on treatment for constipation. Look for the following:

564.00, UNSPECIFIED CONSTIPATION (10)
564.02, OUTLET DYSFUNCTION CONSTIPATION (10)
564.09, OTHER CONSTIPATION (10)

+ Constipation Therapy

HYPONATREMIA: POA The patient has HYPONATREMIA with a Na < 135. Info

276.1, HYPOSMOLALITY AND/OR HYPONATREMIA CC (10)
253.6, SIADH (OTHER DISORDERS OF NEUROHYPOPHYSIS) CC Info (10)

- SODIUM
  - Fri Oct 25, 2013
    134.0

LEUKOCYTOSIS: POA The patient has a WBC > 12. The patient is on antibiotics which supports an infection (Septicemia). Info

038.9, Unspecified septicemia MCC (10)
038.8, Other specified septicemias MCC (10)
038.49, Other septicemia due to gram-negative organisms MCC (10)
288.60, Leukocytosis, unspecified (10)
995.90, Systemic inflammatory response syndrome, unspecified CC Info Defn:SIRS (10)
995.91, Systemic inflammatory response syndrome due to infectious process without organ dysfunction Defn:SIRS (10)
995.93, Systemic inflammatory response syndrome due to noninfectious process without acute organ dysfunction CC Info Defn:SIRS (10)
995.94, Systemic inflammatory response syndrome due to noninfectious process WITH acute organ dysfunction MCC Info Defn:SIRS (10)

Clinical Integration extends into the community

RAPID ADMISSION PROCESS

RAP&GO (Rapid Admission Process and Gap Orders) software, an internet-based set of orders with predefined protocols, helps expedite patient admits from the emergency department.

"…created by doctors to help hospitals achieve outstanding CMS time measures for patient admission from the ED…"

Link

https://rapgotraining2.emcare.com

Staff - RAP&GO

File Edit View Favorites Tools Help

Work... KM P... Proj... FAST... My C... prem... Mate... RTI ... sale... EmCa... Prin... Cont... Mark... Page Safety Tools

RAP & GO

My Home Log Out Logged on as:

Patient Info

ZZTEST, MARK Search

Sex: M **DOB:** 5/3/59 **MR#:** 900730 **Acct#:** 176822005

Patient Stability

- ○ Yes ◉ No Sustained pulse rate > 120
- ○ Yes ◉ No SBP < 90
- ○ Yes ◉ No Respiratory rate > 29

Imaging Findings

- [x] CT shows Diverticiculitis or CT will be ordered within 24 hours

Physical Exam

- [ ] LLQ abdominal pain or tenderness
- [x] Persistant vomiting
- [ ] Inadequate oral intake

Results & Disposition

Diverticulitis

Disposition:

Meets criteria for admission.

Continue Cancel

100%

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STEP ONE:
COMPLETE ONLINE FORM BASED ON PATIENT DIAGNOSIS

Complete checklist based on patient's condition.

Patient Info

ZZTEST, MARK Search

Sex: M **DOB:** 5/3/59 **MR#:** 900730 **Acct#:** 176822005

Patient Stability

- Yes ◉ No Sustained pulse rate > 120
- Yes ◉ No SBP < 90
- Yes ◉ No Respiratory rate > 29

Results and Disposition created based on checklist.

Results & Disposition

Diverticulitis

Disposition:

Meets criteria for admission.

✓ Continue × Cancel

STEP TWO:
GENERATE GAP ORDERS (GO)

GENERATE GAP ORDERS

Gap Orders (GO)
generated based on
Rapid Admission Process (RAP)

https://rapgotraining2.emcare.com

Staff - RAP&GO

File Edit View Favorites Tools Help

Work... KM P... Proj... FAST... My C... prem... Mate... RTI ... sale... EmCa... Prin... Cont... Mark... Page Safety Tools

RAP & GO

My Home Log Out Logged on as: Amanda Simmons

Summary

Age/Sex: 55 year old Male

Diagnosis: Diverticulitis

Disposition: Meets criteria for admission.

Disposition Criteria:

- No - Sustained pulse rate > 120
- Yes - CT shows Diverticiculitis or CT will be ordered within 24 hours
- Yes - Persistant vomiting
- No - SBP < 90
- No - Respiratory rate > 29

Patient

ZZTEST, MARK

Sex: M

DOB: 05/03/1959

MR #: 900730

Account #: 176822005

Hospitalist

Dr Jane Hospitalist2

ED Room #

2

Special Requirements

Sitter

Add

Fall Risk/Near Nursing Station
Sitter

Admit type

(•) Inpatient ( ) Observation

Bed Type

(•) Med Surg
( ) ICU
( ) Telemetry

Hospitalist Action

Notify Hospitalist | Hospitalist Accepted | Hospitalist Accepted, Notify Bed Control | Hospitalist Declined | Hospitalist Hold | Cancel

100%

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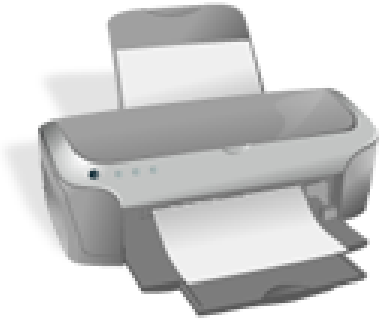
5/12/2014

STEP THREE:
HAND OVER PATIENT TO HOSPITALIST



Gap Orders generated.

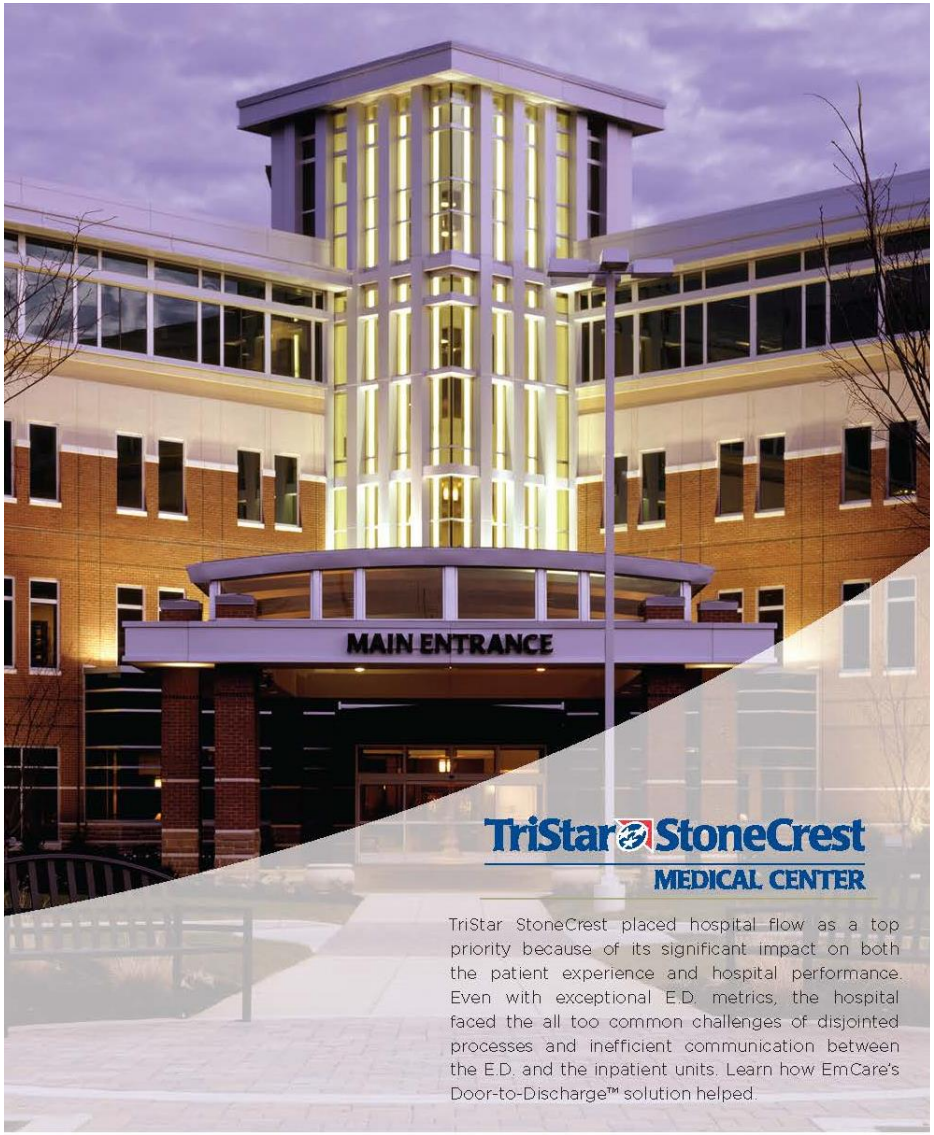
Print and sign Gap Orders.

ED Physician hands over patient to Hospitalist with defined orders and protocols.

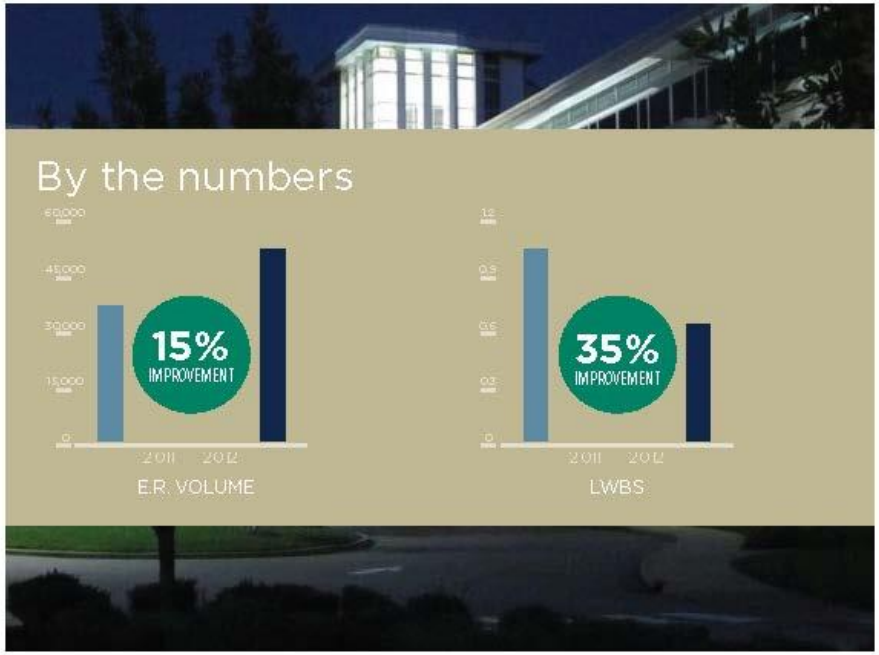
PATIENT IMMEDIATELY MOVED FROM ED TO FLOOR

Hospitalist Does Not See Patient In ED

TRISTAR STONECREST MEDICAL CENTER



TriStar StoneCrest placed hospital flow as a top priority because of its significant impact on both the patient experience and hospital performance. Even with exceptional E.D. metrics, the hospital faced the all too common challenges of disjointed processes and inefficient communication between the E.D. and the inpatient units. Learn how EmCare's Door-to-Discharge™ solution helped.



Results

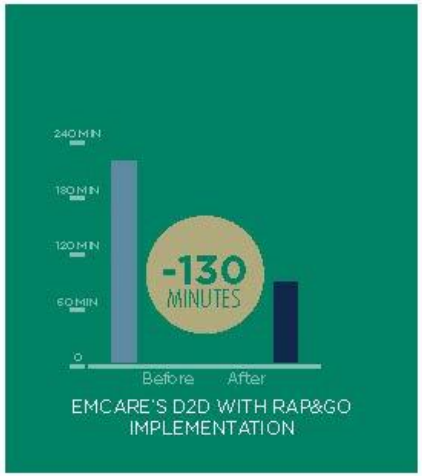
The before and after results from EmCare's D2D with RAP&GO were outstanding:

Disposition to admission (boarding time) dropped from approximately 210 minutes to 80 minutes almost immediately.

Additional metric improvements:

- LWBS decreased from 0.99% to 0.64%

Reduced boarding time in the E.D. meant more patients could be seen in the E.D and patient volume increased from 38,940 to 46,043.



TriStar StoneCrest
MEDICAL CENTER

Before and After with RAP&GO

Decreased "ER boarding time" by nearly 2 ½ hours

Before Rapid Admission Process

ED → Floor

>3 ½ Hours (210 minutes)

After Rapid Admission Process

ED → Floor

<80 Minutes

Q&A

Emcare.com/integratedservices

How Integrated Clinical Services and Technology are Making Healthcare Work Better

Thank You!

Presenters:

Kirk Jensen, MD, MBA, FACEP
Chief Medical Officer
Best Practices, Inc
Executive Vice President, EmCare

Mark Hamm
CEO
EmCare Hospital Medicine

For more information, call 877.416.8079.

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