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Regionalizing Emergency Care Systems to Serve Accountable Care Organizations

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- Patients often encounter multiple professionals across different settings
 - Limited access to medical records
 - Poor communication between providers
 - Poor care coordination
 - Faulty transitions between settings



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- Local delivery systems of physicians and the hospitals where they work or admit their patients
 - “Extended hospital medical staff”
 - Foster shared accountability among providers
 - Support development of shared EHRs
 - Improve quality and affordability
- Existing Accountable Care Organizations
 - MD-Hospital Practice Networks (Academic Centers)
 - Integrated Delivery Systems (Mayo, Intermountain Health)



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- Rational for Regionalization
 - Improve Outcomes
 - Improve Efficiency
 - Reduce Waste
- Regionalized for
 - Major Trauma
 - Stroke
 - Sick Pediatric Patients
 - ?? Accountable Care Organizations??



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- Why Regionalize to Accountable Care Organizations?
- Consider the following scenarios...



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- An eighty year old man with vomiting and confusion brought by EMS to Elsewhere General Hospital, medical records unavailable, workup reveals UTI, pt Rx with IVF, returns to baseline MS and is discharged on Cipro
 - Pt returns one week later with UGI bleed and INR=10 resulting from an interaction between Cipro and Coumadin



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- **An eighty year old man with vomiting and confusion Brought by EMS to Elsewhere General Hospital, medical records unavailable, workup reveals UTI, pt Rx with IVF, returns to baseline MS and is discharged on Cipro**
 - **Pt returns one week later with UGI bleed and INR=10 resulting from an interaction between Cipro and Coumadin**
- **Brought by EMS to Accountable General Hospital records show pt on Coumadin**



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- A fifty year old female with chest pressure brought by EMS to Elsewhere GH, records unavailable, pt is anxious, PE nm, ECG NS-changes, Trop nm, admitted overnight, recurrent CP, cardiac cath nm



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- A fifty year old female brought by EMS to Elsewhere GH, records unavailable, pt is anxious, PE nm, ECG NS-changes, Trop nm, admitted overnight, recurrent CP, cardiac cath nm
- Brought by EMS to Accountable GH
 - medical record shows multiple visits for CP
 - Pt had normal ETT 6 mo ago
 - Pt had normal cardiac cath 3 mo ago
 - Pt reassured, d/c with PCP follow-up



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- A forty-five year old with cough and SOB brought by EMS to Elsewhere GH, CXR shows LLL infiltrate, CBC reveals HCT 30%. ED MD prescribes antibiotics and advises patient to follow-up with PCP for evaluation of anemia
 - Pt presents 1-yr later with wt loss/fatigue, Dx with stage III colon CA. Pt has surgery to remove tumor/nodes followed by both chemo & radiation Rx

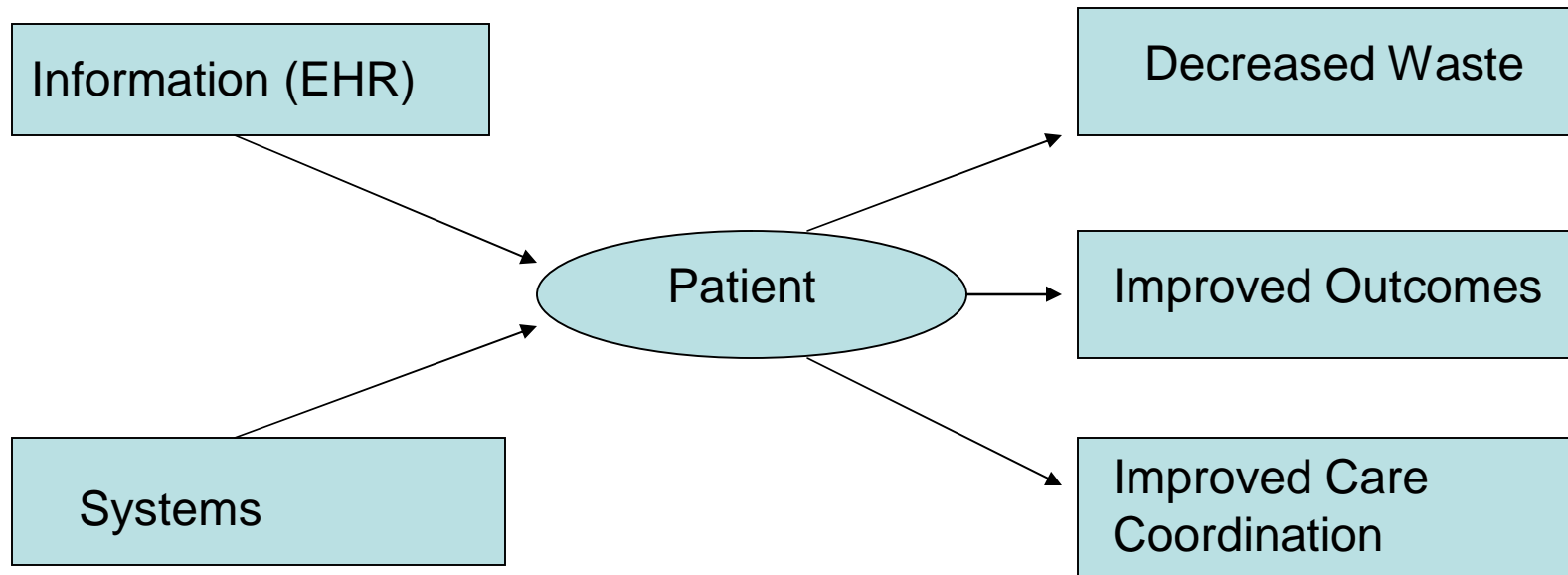


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 - Pt presents 1-yr later with wt loss/fatigue, Dx with stage III colon CA. Pt has surgery to remove tumor/nodes followed by both chemo and radiation therapy
- Brought by EMS to Accountable GH. ED MD notes anemia, sends priority message to PCP
 - Pts colonoscopy reveals stage I colon CA that is removed. No additional treatment is required.



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- Why are we not Regionalizing to Accountable Care Organizations?
- Consider the following case study...



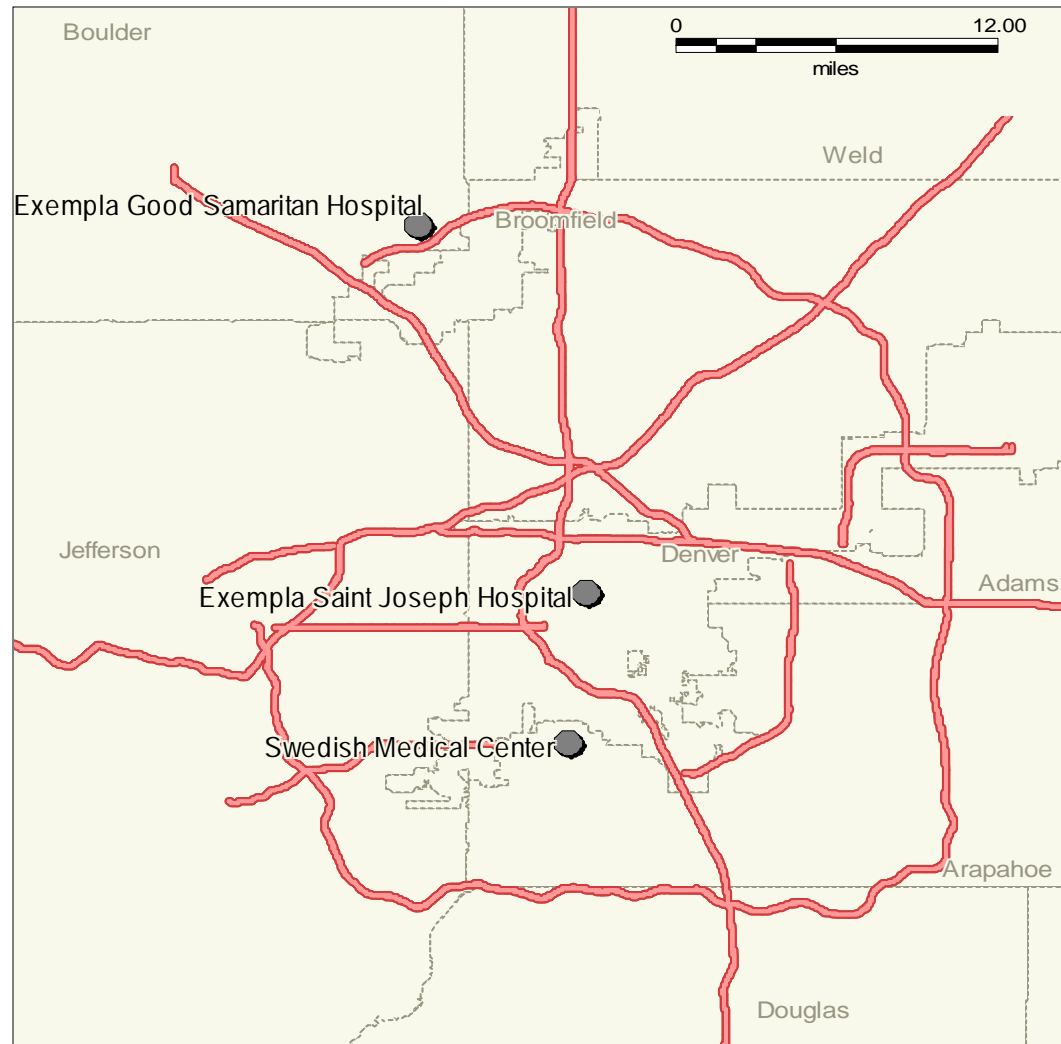
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- Almost 3 million residents
- 19 Hospitals
- Over 50 Ambulance Transport Agencies
- Destination Policies are geographically based, not patient-centered
- Fragmented system does not support dynamic positioning of ambulances
- Patients routinely taken to Elsewhere
General Hospital



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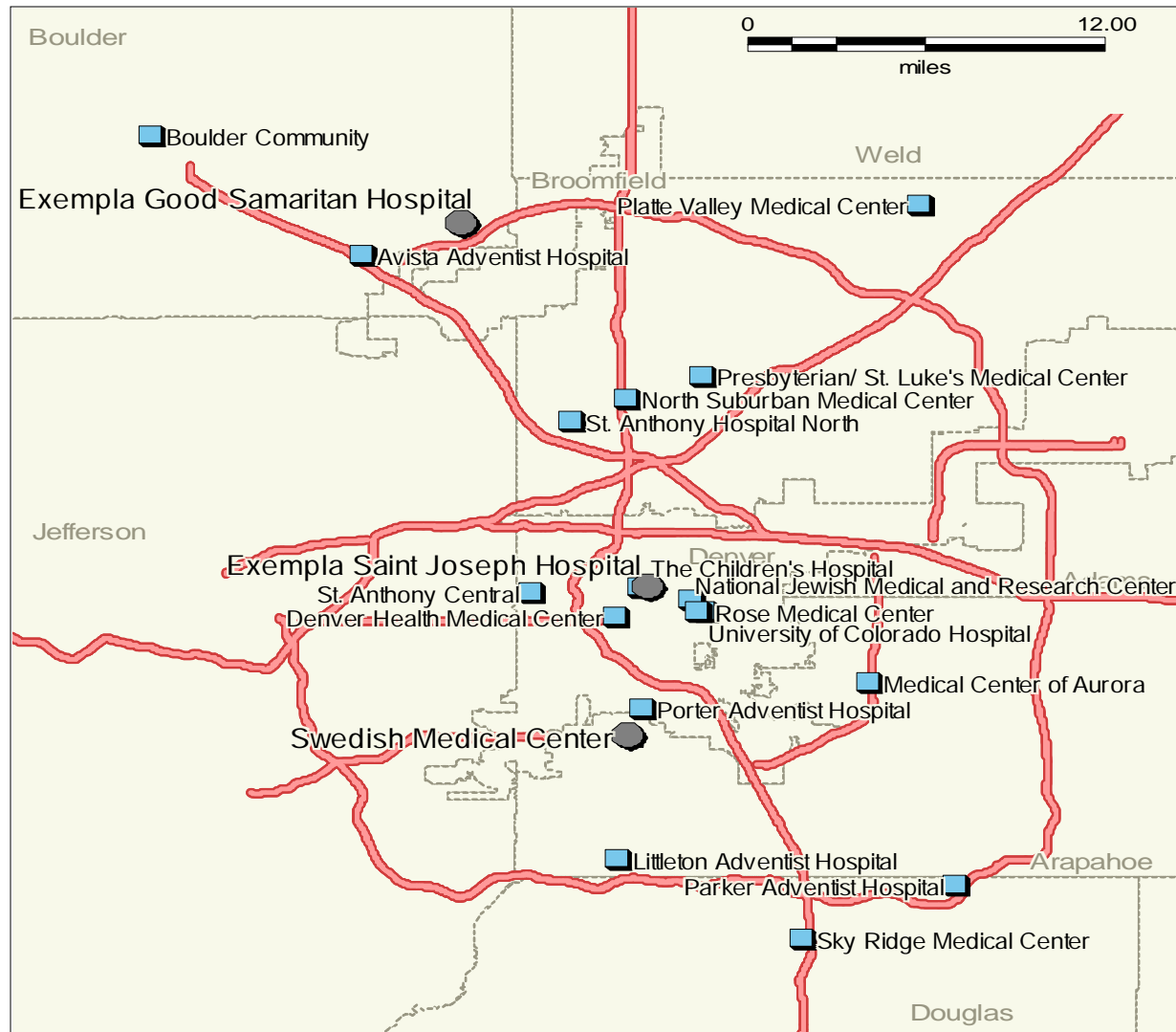
Denver Metro Area KPCO Core Hospitals





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Denver Metro Area – All Hospitals





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- Cultural Factors
- Transport Distances/Limited Coverage Areas
- Financial Incentives



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- Regionalizing emergency care systems to Accountable Care Organizations
 - Improve health outcomes
 - Improve efficiency
 - Reduce waste
- However, in the current fragmented healthcare system there are significant barriers to achieving this goal