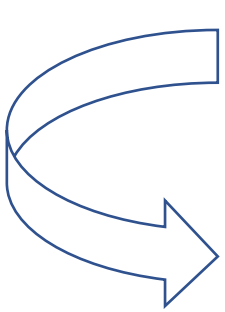
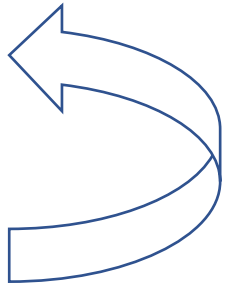
Return ED Visits



Return ED Visits

Admissions



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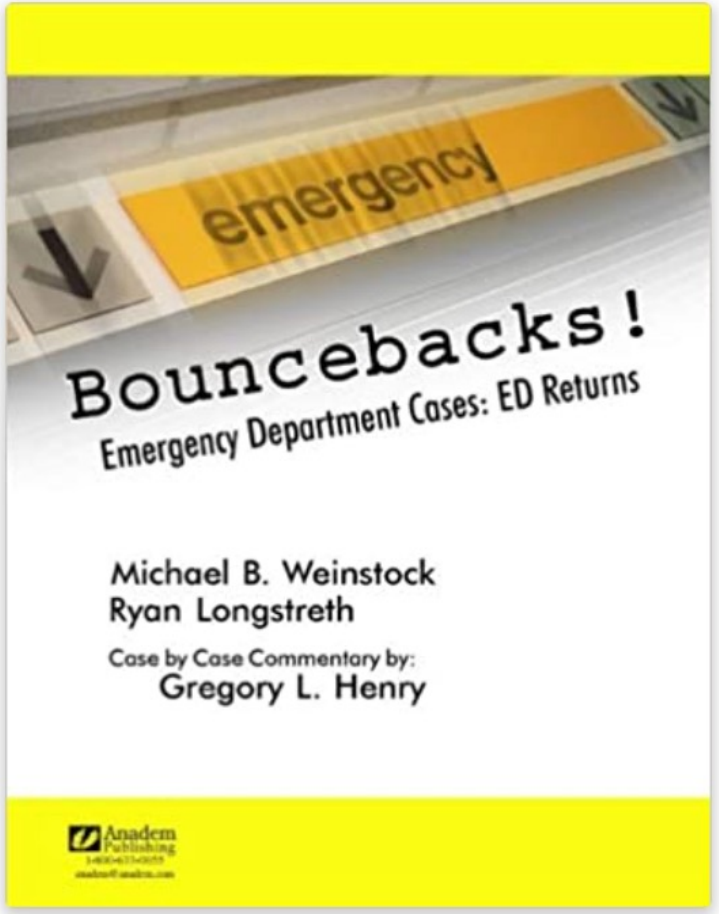
1. Understand the current literature re: Return ED Visits (RV) & Return ED Visits leading to Admission (RVA)

2. Framework to utilize RV for Education

3. Frameworks to utilize RVA for:
   - Quality & patient safety screening
   - Risk reduction

Unscheduled Return ED Visits (RV)



PHYSICIAN'S WEEKLY

Examining the Timing of ED Return Visits

May 11, 2015

In 2012, CMS implemented reimbursement penalties for hospitals with excessive inpatient readmissions for patients with several diagnoses. As a result, many interventions have been developed in an effort to reduce inpatient readmissions. Though there are currently no similar penalties for recurrent ED visits, there has been increasing attention on tracking and reducing 72-hour ED returns. "Return visits within an acute time period after ED discharge warrant a closer look to determine the reasons for the return and which visits may have been preventable," explains Kristin L. Rising, MD, MS. "We must use care in

Disclaimers

- RVs and RVA events do **NOT** equate to substandard ED care

- RVs may be intentional (e.g.: scheduled wound checks)
- RVAs may be desired (e.g.: shared decision-making or AMA)

What *is* the appropriate acute RV time period ?

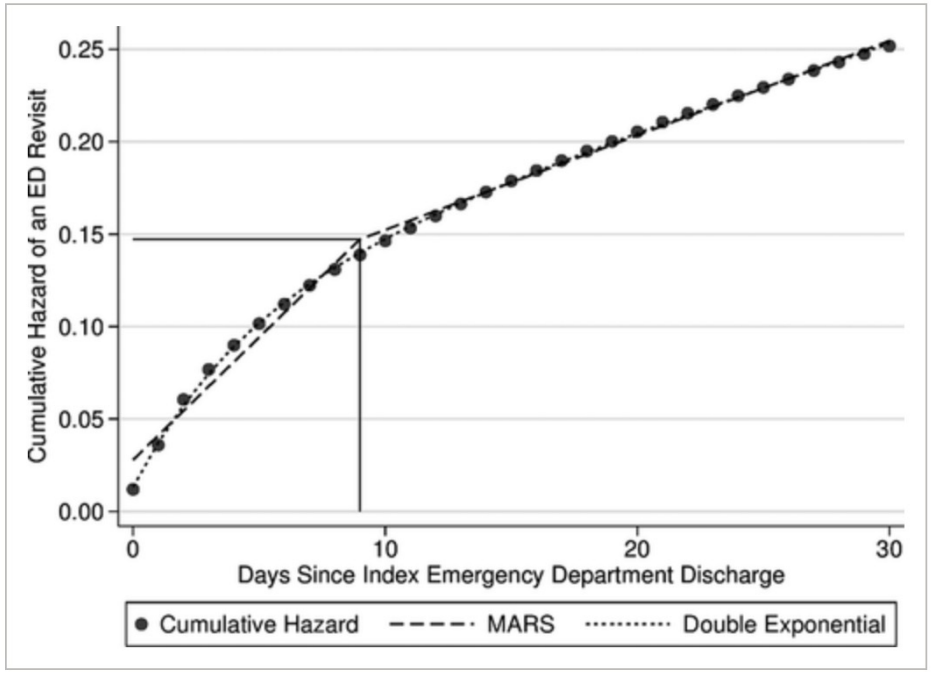
- 72 hour RV - expert opinion (0.4-7.5%*)
- 30 day RV - derivative of CMS readmissions (3 - 32%*)
- Other commonly studied: 48 hours, 7 day RV & RVA

*ranges due to data from single vs multi institutions vs statewide/national data sets

What *is* the quality of the data ?

- up to 30% of RV are to another (non-index visit) ED
- limits interpretation of studies not using state / federal data sets
- No current research exploring the difference between 2 cohorts

72 hours for a RV – is it good enough ?



Rising et al. **Patient returns to the emergency department: the time-to-return curve.** Acad Emerg Med. 2014

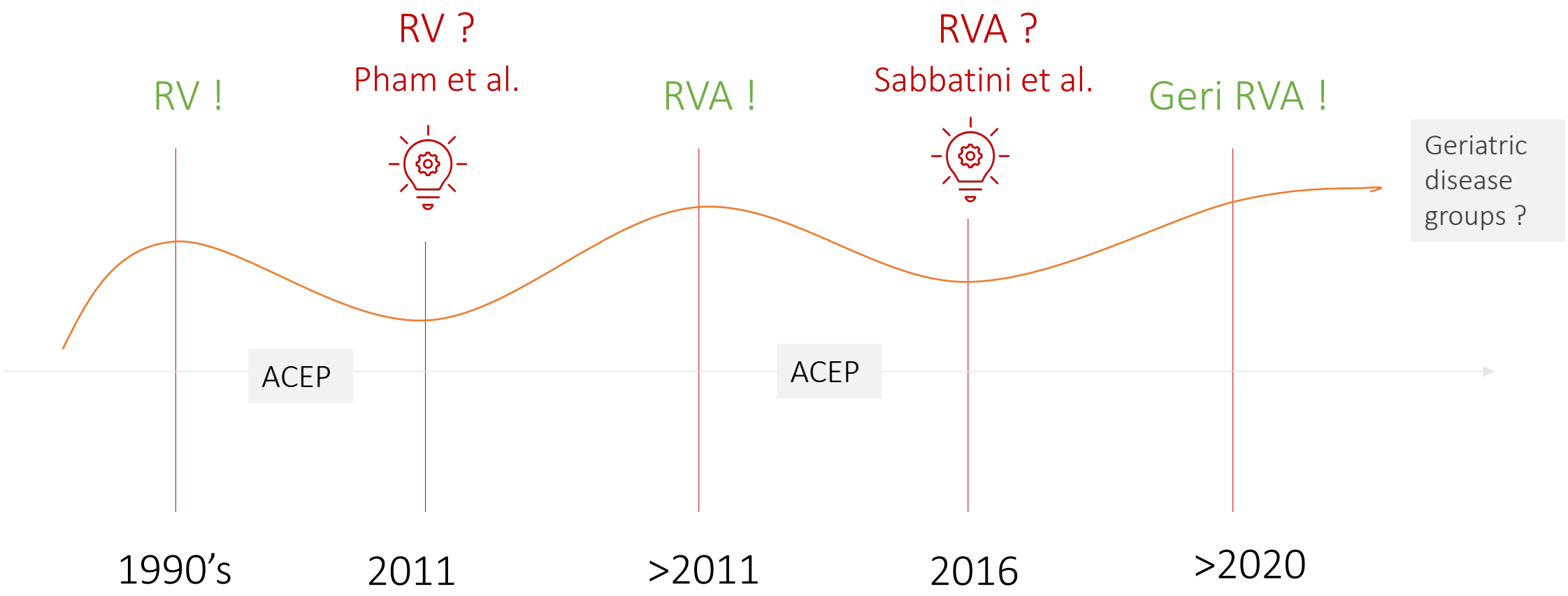
- Florida and Nebraska; Non-federal hospitals
- 1 year; 4,700,000 index ED discharges

- 7.5 % ED visits associated w 72hr RV
- 22% associated with 30 day return
- "Hinge point" at 9 days
  - Early return
    - 75% at 2.8 days
    - ~ 99% at 9 days
  - Late return
- 72 hr return visits – is it good enough?
  - ~ 75% of 9 day RV at 72 hrs

Factors that lead to RV

- Disease-based factors:
  - Disease progression
  - Recurrence of disease
  - Unforeseen therapeutic complications
- Patient-based factors:
  - Non-compliance with discharge plan
  - Age
  - Polypharmacy
  - Cognitive impairment
  - Non urgent medical needs / Overuse
- Physician-based factors*:
  - Diagnostic error
  - Therapeutic error
  - Inadequate discharge plan
  - Prognostic error
  - Premature discharge
- Healthcare system-based factors:
  - Lack of primary or specialty care availability

Knowledge Growth in RV



RV – A Good Quality Indicator ?

- Pierce et al.'s *Bounces* (1990) retrospective analysis of ED RV within 48 hours of index visit.
- Single site US study reported that while *patient-related factors* were responsible for the majority of RV, 18% were the result of *physician-related factors,* twice as likely to require admission.
- Other retrospective single site studies have found lower rates of quality issues, ranging from 7-12%*

*Studies did not include control group case reviews

RV – A Good Quality Indicator ?

- JC Pham et al. Seventy-two-hour returns may not be a good indicator of safety in the emergency department: a national study.

  US National Hospital Ambulatory Medical Care Survey data.

  Acad Emerg Med. 2011

  - Equivalent disease acuity to index visits
  - Equivalent admission rate to index visits
  - Equivalent resource utilization to index visits

RV Conceptual Framework:

- Most providers:
  - Orthopedic surgeon whose practice colleague saw all their post-op patients and rarely reported back their outcomes
  - *Outcome knowledge* helps refine judgement, skill and practice decisions long after formal training is completed
- ED physicians:
  - Episodic care + shift work
  - Disconnect between decisions and many patient's post-ED healthcare trajectories.

Enhance Tacit Clinical Knowledge Through Early Career RV Reviews

- 72 hr - 9 day: test your departments metrics
- Separate from formal professional performance evaluations
- Separate from formal QPS review processes

- First 6 months – 1 year of attending practice
- Send MRNs to provider
- Voluntary, non-judgmental, self-monitoring practice
- Leadership provide context, check-ins / open dialogue

What is the appropriate RVA time period?

- Most commonly studied: 48 hours, 72 hours, 7 day
- Frequency of 72 hour: Approx 1%

RVA - Good Quality Indicator?

- Quality issues frequency ranging between 3.5 - 32% of RVA cases*
- Variation due to variable interpretation of *physician error*
- Rapid disease progression vs. prognostic error
- *Diagnostic error* in the context of the ED care model

- Chartier LB et al. Improving Quality of Care Through a Mandatory Provincial Audit Program: Ontario's Emergency Department Return Visit Quality Program. Ann Emerg Med 2021*
- 12,000 chart reviews of 72 hour RVA and identified quality issues in 23.4% of cases

*Studies did not include control group case reviews

RVA - Good Quality Indicator?

- Sabbatini et al. In-Hospital Outcomes and Costs Among Patients Hospitalized During a Return Visit to the Emergency Department. JAMA. 2016

- Large multistate data set from the Healthcare Cost and Utilization Project
- Compared RVA to admissions on index visit:
  - Lower rates of in-hospital mortality, ICU admission, and costs
  - Inpatient lengths of stay were significantly higher.

RVA - Good Quality Indicator?

- Hiti EA, Tamim H, Makki M, et al. Characteristics and determinants of high-risk unscheduled return visits to the emergency department. Emergency Medicine Journal 2020
- Increased mortality, ICU admissions, need for surgical intervention and longer hospitalization
- Geriatric RVA
- 27% of older adults discharged from the ED: RV, hospitalization, or death at 3 months. Friedmann et al. **Early revisit, hospitalization , or death among older persons discharged from the ED.** Am J Emerg Med. 2001

RVA - Good Quality Indicator?

- US National Hospital Ambulatory Medical Care Survey data
  - Unpublished work

ED patients aged ≥65	Hospital Mortality	Admission to Critical Care Unit	Critical Care Unit Mortality
Admission to hospital at initial index ED visit	4.2%	18.9%	13.3%
RVA within 72 hrs	5.6%	21.6%	23.2%

Value of RVA Reviews

72 hour RVA Screening Reviews to Identify QPS Issues

- +/- formal QPS of 72 hour ICU-RVA
- Strategy should be department-specific: QPS leadership and/or frontline providers
- Opportunities for peer-based chart review process

EM leadership messaging is crucial:

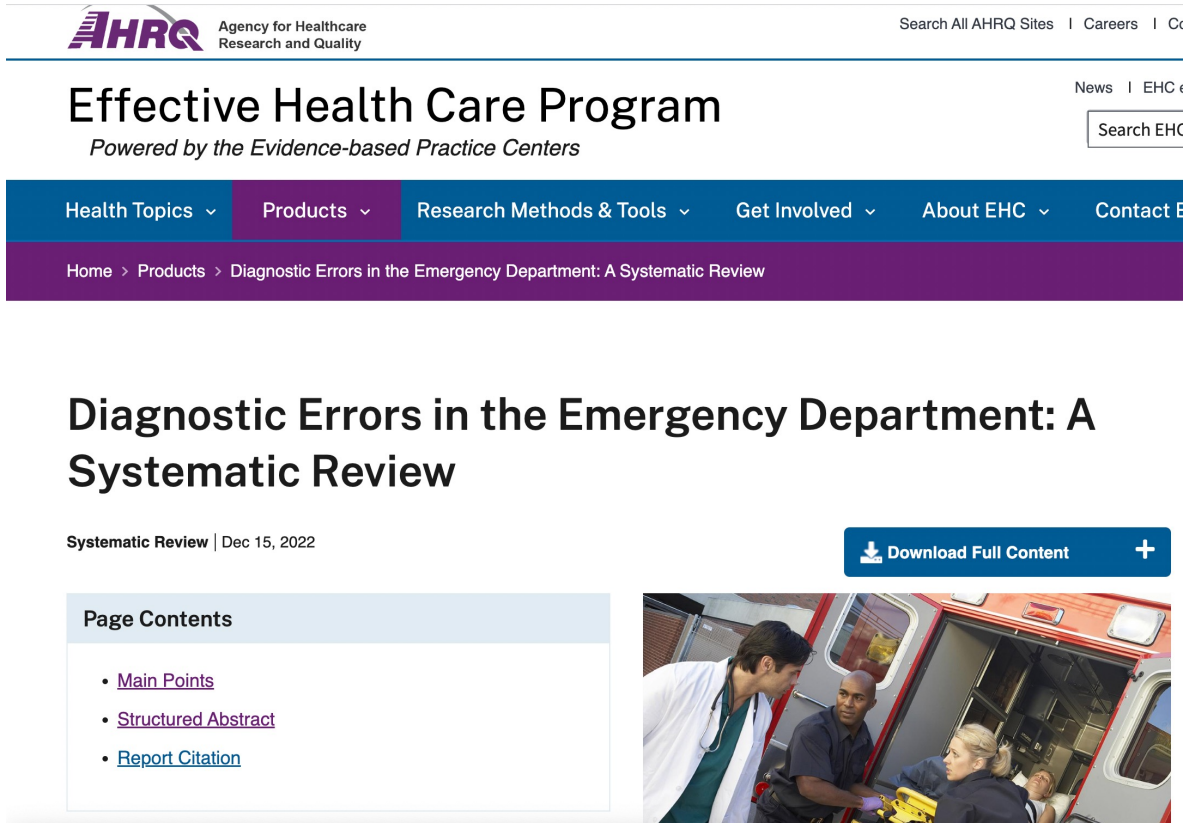
- Some cases will generate formal QPS reviews
- many RVA are the result of unforeseen disease progression, patient non-compliance, and shared decision making for trial home care
- avoid misperceptions of punitive scrutiny

Value of RVA Reviews

Disease specific look-back process, consider in…

- Stroke
- Myocardial infarction
- Aortic aneurysm and dissection
- Spinal cord compression and injury
- Venous thromboembolism
- Meningitis and encephalitis
- Sepsis
- Spinal and intracranial abscess
- Abdominal catastrophes

ED Diagnostic Error Controversy



.....Scalable solutions to enhance bedside diagnostic processes are needed, and these should target the most commonly misdiagnosed clinical presentations of key diseases causing serious harms.

ED Diagnostic Error Controversy

Multi-Organizational Letter Regarding AHRQ Report on Diagnostic Errors in the Emergency Department

December 14, 2022

As experts in emergency medicine, our organizations are committed to improving patient care in the practice of emergency medicine. Yet, we are deeply concerned about the recently released report and systematic review by Dr. David Newman-Toker, et. al., entitled *Diagnostic Errors in the Emergency Department: A Systematic Review*.[1] This work was conducted through an Evidence-Based Practice Center (EPC) as part of AHRQ's Effective Health Care Program. After reviewing the executive summary and initial draft, we believe that the report makes misleading, incomplete, and erroneous conclusions from the literature reviewed and conveys a tone that inaccurately characterizes and unnecessarily disparages the practice of emergency medicine (EM) in the United States (U.S.).

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Opportunity to Lead

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