

ED Performance Measures Into the Future

James J Augustine, MD

ED Performance Measures

- Based on the ED Benchmarking Alliance annual data survey.
- There are national databanks and group cohorts
- Data cohorts useful to develop community reports and comparison graphs
- Use data to predict future ED patient needs and performance
- Understand finances charges, collections, and costs

Challenges of Transparency, Safety, Quality and Effectiveness

- Problems started with EMTALA
- CMS on ED Quality: Pneumonia STEMI, ...
- CMS on Boarding Times
- **Current Definition**
 - Admit Decision to Departure Time
 - Time Interval beginning when “Admit Decision” is made until the actual departure time of the patient from the ED



CMS Hospital Compare Quality Measure for reported this year

Quality Reporting Challenge

- Defining and Reporting CMS metrics
- The "Decision to Admit" debate
 - CMS definition= admit order from the chart
 - *In the 1000 EDs there are 800 definitions*
- Within our industry: the least consistent metric?
 - RN work varies not by arrivals but by severity and how many patients are in the ED (Census and admit percent proxy)

The CDC Reports

decrease in the number of EDs. The visit increase was tied not only to provision of medical care to uninsured patients, but also to evening and weekend care of insured patients whose regular physicians were unavailable (3). There has been concern about increasing enrollment in Medicaid as an indicator of stress on the safety net system in which EDs play a major part (4). Data on ED visit rates, Medicaid and uninsured status of those using EDs, and the use of EDs for care in the evening and on weekends are presented in this report.

Methods

Data source

According to the Government Accountability Office (GAO), the main issue contributing to overcrowding of EDs has been delays in moving the sickest patients to inpatient beds (5). Admitted patients have often been boarded in EDs or hospital hallways for hours to days, resulting in overcrowding and diversion of incoming ambulances to other hospitals (6). IOM recommended adopting systems to even out the flow of patient admissions and implementing 23-hour observation units (3). This report presents data on boarding and systems to address patient flow.

On specialist availability, IOM found that approximately 75 percent of hospitals had difficulty providing consultants to take calls for emergencies. On pediatric care, IOM observed that most children received care in general EDs, rather than pediatric facilities with optimal expertise and equipment to handle their unique needs (3). Included in this report are data on visits involving on-call physicians and pediatric EDs.

In its 2009 National Report Card, ACEP rated emergency department quality of care, including patient safety with respect to a scoring system based on 15 quality indicators. Quality of care was rated as a C+ nationally, but individual state scores varied widely. Hospital crowding, ED boarding, ambulance diversion, and high rates of uninsured individuals were key issues impacting quality of care (7). Data from NHAMCS are used as a national standard for health care estimates in the HP-2010 objectives.

NHAMCS ED visit data have to establish baseline estimate objectives related to reducing for asthma and nonfatal dog injuries. The asthma object population into three age g identifies separate targets f in each group (8). This re data on visit rates for asth these age groups, for inju and for dog bites in parti

National Health Statistics Reports

Number 26 ■ August 6, 2010

National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary

by Richard Niska, M.D., M.P.H., F.A.C.E.P.; Farida Bhuiya, M.P.H.; and Jianmin Xu, M.S.; Division of Health Care Statistics

Abstract

Objective—This report presents data on U.S. emergency department (ED) visits in 2007, with statistics on hospital, patient, and visit characteristics.

Methods—Data are from the 2007 National Hospital Ambulatory Medical Care Survey, which uses a national probability sample of visits to emergency departments of nonfederal general and short-stay hospitals in the United States. Sample data were weighted to produce annual national estimates.

Results—In 2007, there were about 117 million ED visits in the United States. About 25 percent of visits were covered by Medicaid or the State Children's Health Insurance Program (SCHIP). About one-fifth of ED visits by children younger than 15 years of age were to pediatric EDs. There were 121 ED visits for asthma per 10,000 children under 5 years of age. The leading injury-related cause of ED visits was unintentional falls. Two percent of visits resulted in admission to an observation unit. Electronic medical records were used in 62 percent of EDs.

Keywords: boarding • electronic medical records • emergency department visits • overcrowding

Introduction

The National Hospital Ambulatory Medical Care Survey (NHAMCS) has been gathering, analyzing, and disseminating information about hospital outpatient and emergency departments (EDs) since 1992. NHAMCS and the National Ambulatory Medical Care Survey (NAMCS) are parts of the ambulatory component of the National Health Care Surveys, a family of surveys that measure health care utilization across various types of

providers. More information about the National Health Care Surveys can be found at the following website: <http://www.cdc.gov/nchs/nhcs.htm>.

NHAMCS and NAMCS data have been used in articles examining important topics of interest in public health and health services research. For a list of publications, see: <http://www.cdc.gov/nchs/data/ahcd/public9-4-2009.pdf>. In addition to the ED report, other reports highlight visits to outpatient departments (OPDs) (1) and

physician offices (2). Annual reports are available from: http://www.cdc.gov/nchs/ahcd/ahcd_reports.htm. Public-use data files are available from: http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm. Data from NHAMCS 2007 will also be available on CD-ROM. These and other products can be obtained from the National Center for Health Statistics (NCHS), Office of Information Services, Information Dissemination Staff at 1-800-232-4636, the Ambulatory and Hospital Care Statistics Branch at 301-458-4600, or by e-mail at CDICINFO@cdc.gov.

This 2007 report begins with a summary of major issues in emergency medicine as articulated by the Institute of Medicine (IOM), the American College of Emergency Physicians (ACEP), and the Healthy People 2010 (HP-2010) objectives of the U.S. Department of Health and Human Services. The report then highlights key data elements on EDs from NHAMCS that are relevant to those issues.

In 2006, IOM identified several key issues affecting U.S. emergency medicine, including overcrowding of EDs, lack of critical specialists to whom EDs could refer patients, and gaps in emergency pediatric care. On overcrowding, the IOM noted an increase in ED visits along with a

b or detoxification unit and the operating catheterization lab o separate items. large status now has me and transferred

dance
determination of is based on the onferrom establish the ally significant 'significance' possible icular variable s) of interest. gression ine the 0.05 level. such as 'y' or ificate that be to be

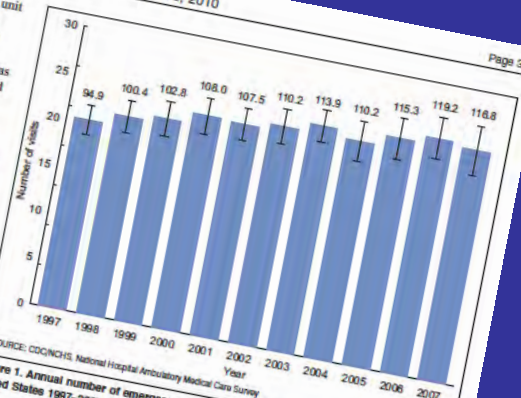


Figure 1. Annual number of emergency department visits (and 95% confidence intervals): United States 1997-2007

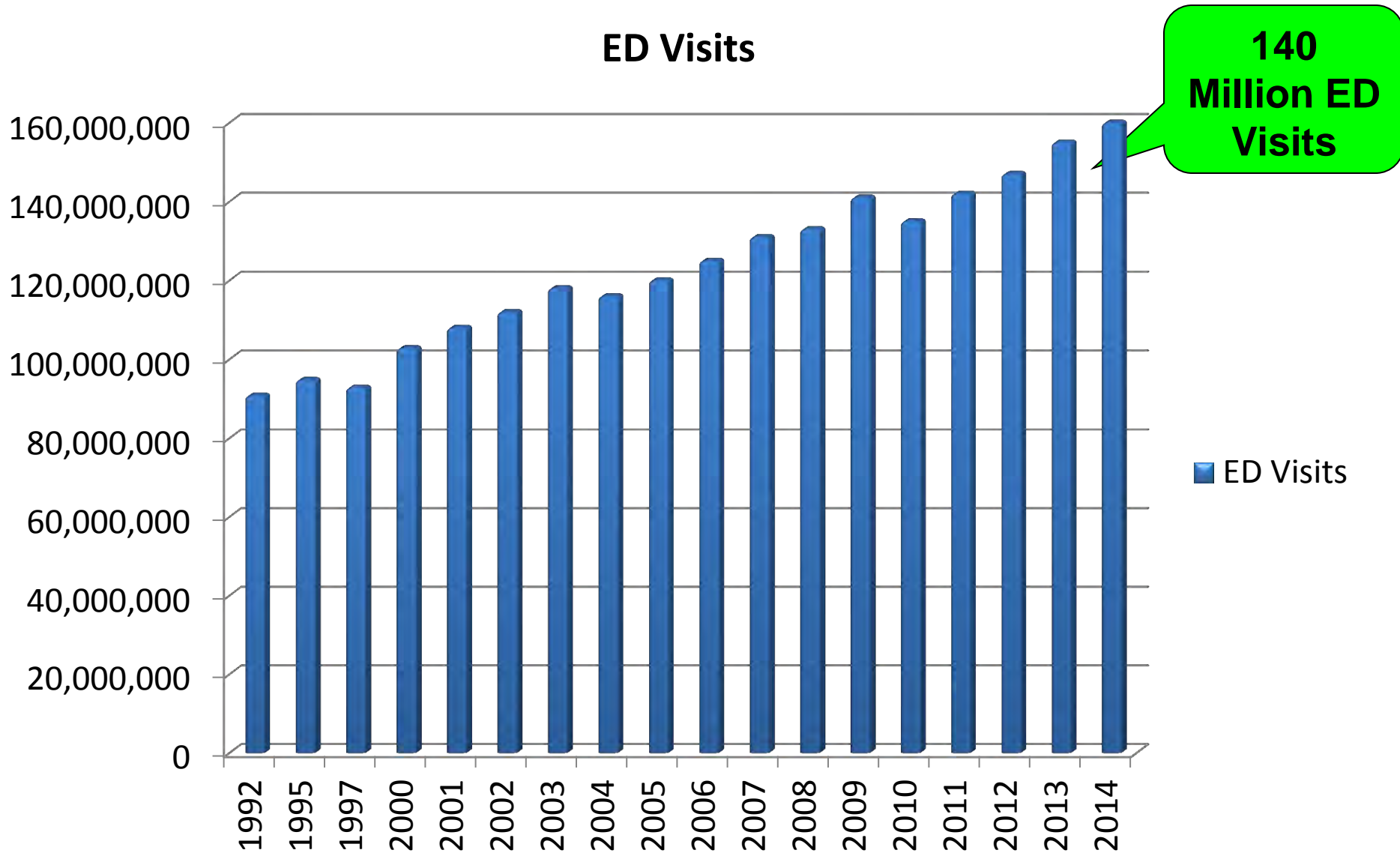
- Persons aged 75 years and over had an annual ED visit rate of 62.0 visits per 100 U.S. persons (Table 2).
- The visit rate for persons living in nursing homes was approximately four times higher than for those living in private residences, for the overall population and for persons aged 65 or over (data not shown). Nursing home residents accounted for about 2.3 million visits (Table 2).
- The visit rate for homeless persons was almost twice that of those living in private residences (71.8 compared with 35.9 visits per 100 persons). Homeless persons accounted for 542,000 visits (Table 2).
- Compared with the ED visit rate for white persons (35.9 visits per 100 U.S. white persons), the rate for black persons was more than double (74.6 visits per 100 U.S. black persons), and that for Asian persons was less than one-half (16.0 visits per 100 U.S. Asian persons) (Table 3).
- Private insurance was an expected source of payment for 39.0 percent of all ED visits (Table 6).
- Other sources of payment included Medicaid or SCHIP (25.2 percent) and Medicare (17.2 percent) (Table 6).
- Uninsured patients, defined as self-pay and no charge or charity, where no other payment source was reported, represented 15.3 percent of visits (Table 6).
- Patients were triaged as needing to be seen immediately at 4.5 percent of



NHAMCS Update

- Tables Published for 2010
- Volume down from 2009 (H1N1 year)
- Acuity Up
- Demographic trends continue:
more elderly, more medical

The CDC Data: Americans Vote With Their Feet



The ED NHAMCS: Payer Mix not Changing Much, except Medicare

<u>Payor Class</u>	<u>% of Visits</u>
Self Pay	15%
Medicare	18%
Medicaid	31%
Worker's Comp.	1.2%
Commercial	37%

The Patient Mix. Very Important and Unrecognized Issue

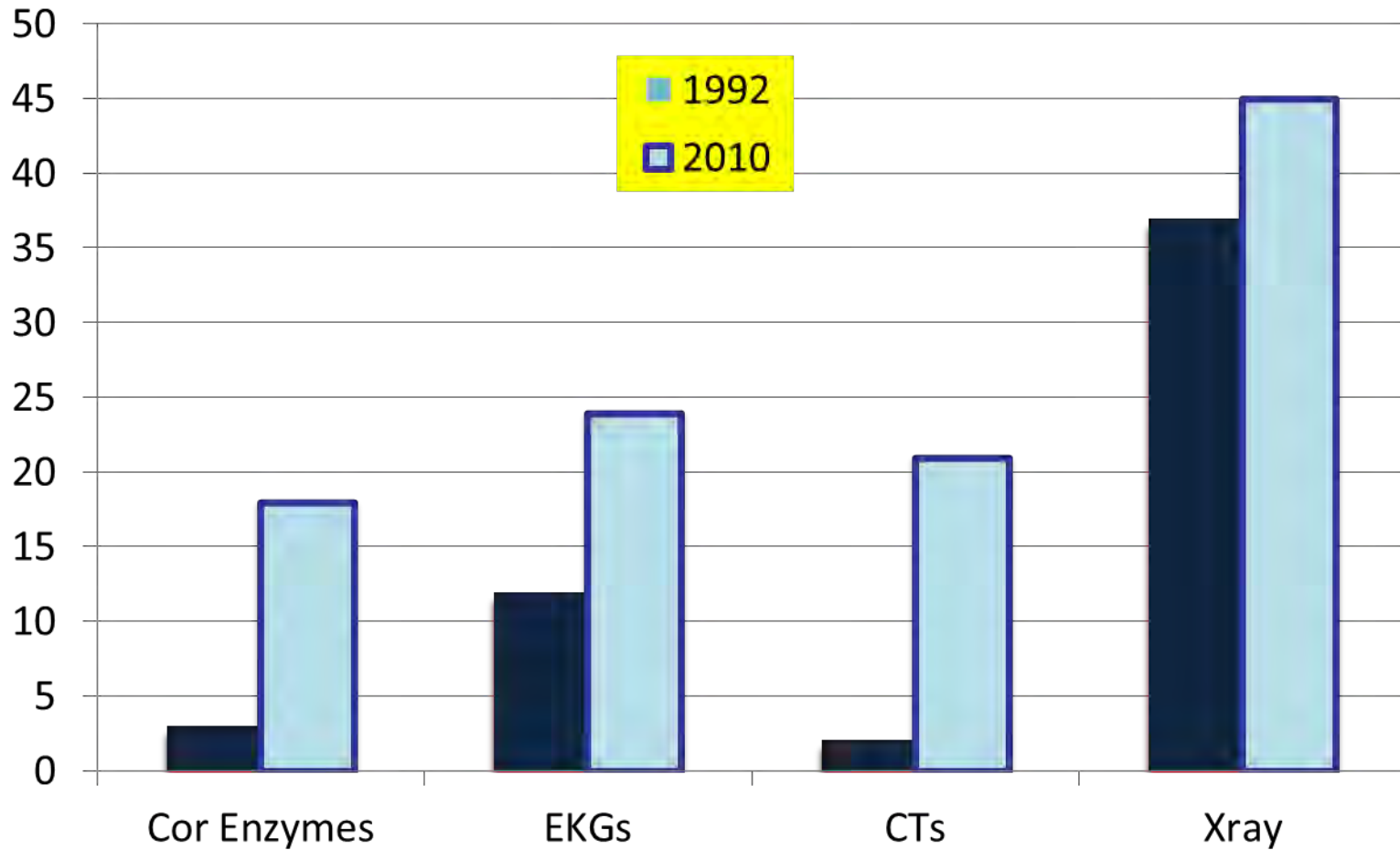


- The Burn, Trauma, Injury and Cardiac Arrest Issue
- What should we have known?
- When prevention works, more people are alive to get ill
- NHAMCS:
- 3% more pts per year
- Trauma population ages
- Highest injury rates are over age 75

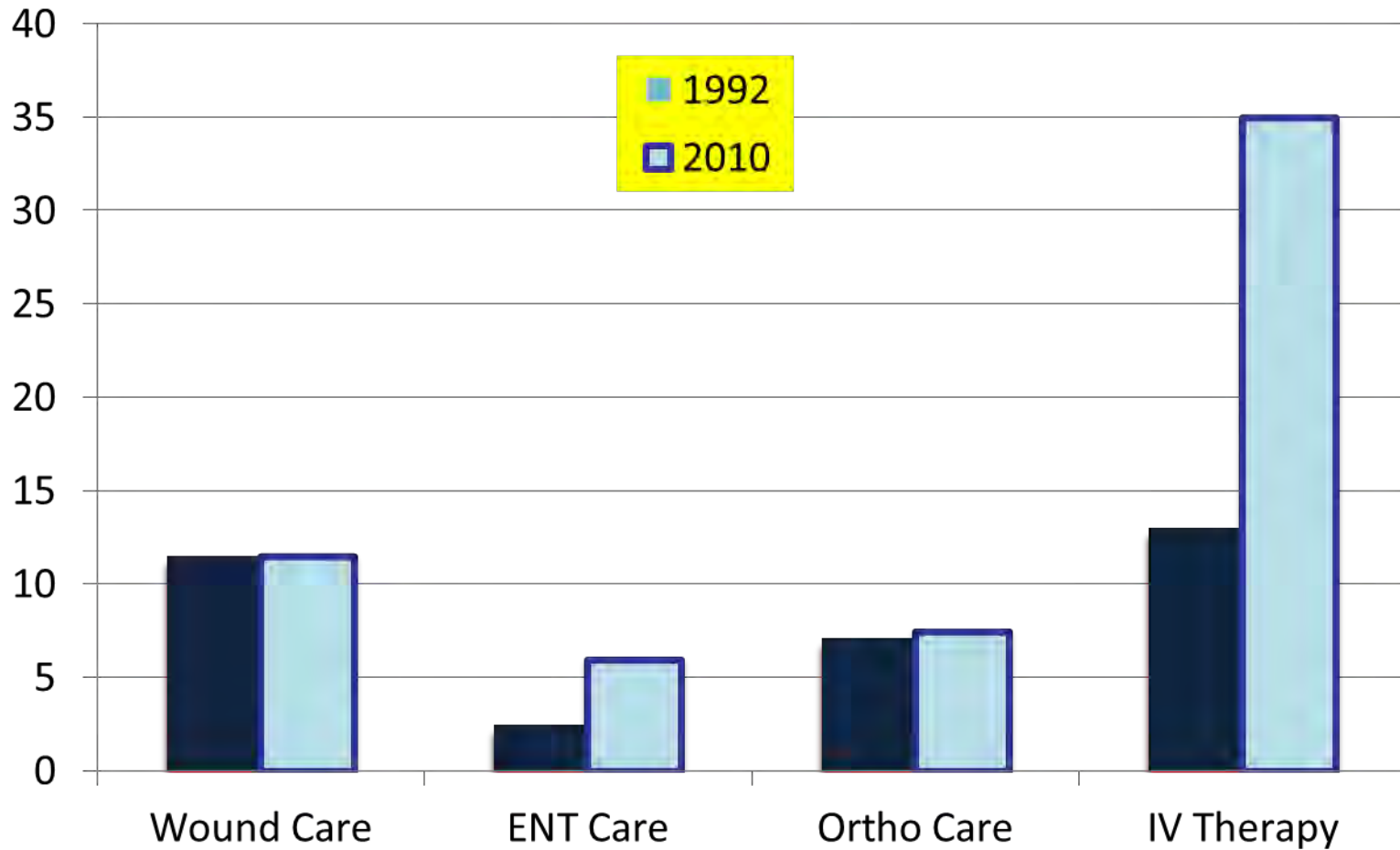
Our Patients: ED Utilization

- Extended Care Facility Residents are the Most Frequent ED User, with 3 m visits in 2010, 45% admission rate
- ECF Residents over 1000 Uses Per 1000 Persons
- Homeless (around 1000)
- Infants under age 1 (931)
- Medicaid
- Medicare
- Insured, Self Pay

ED Visits 1992 to 2010 Diagnostics

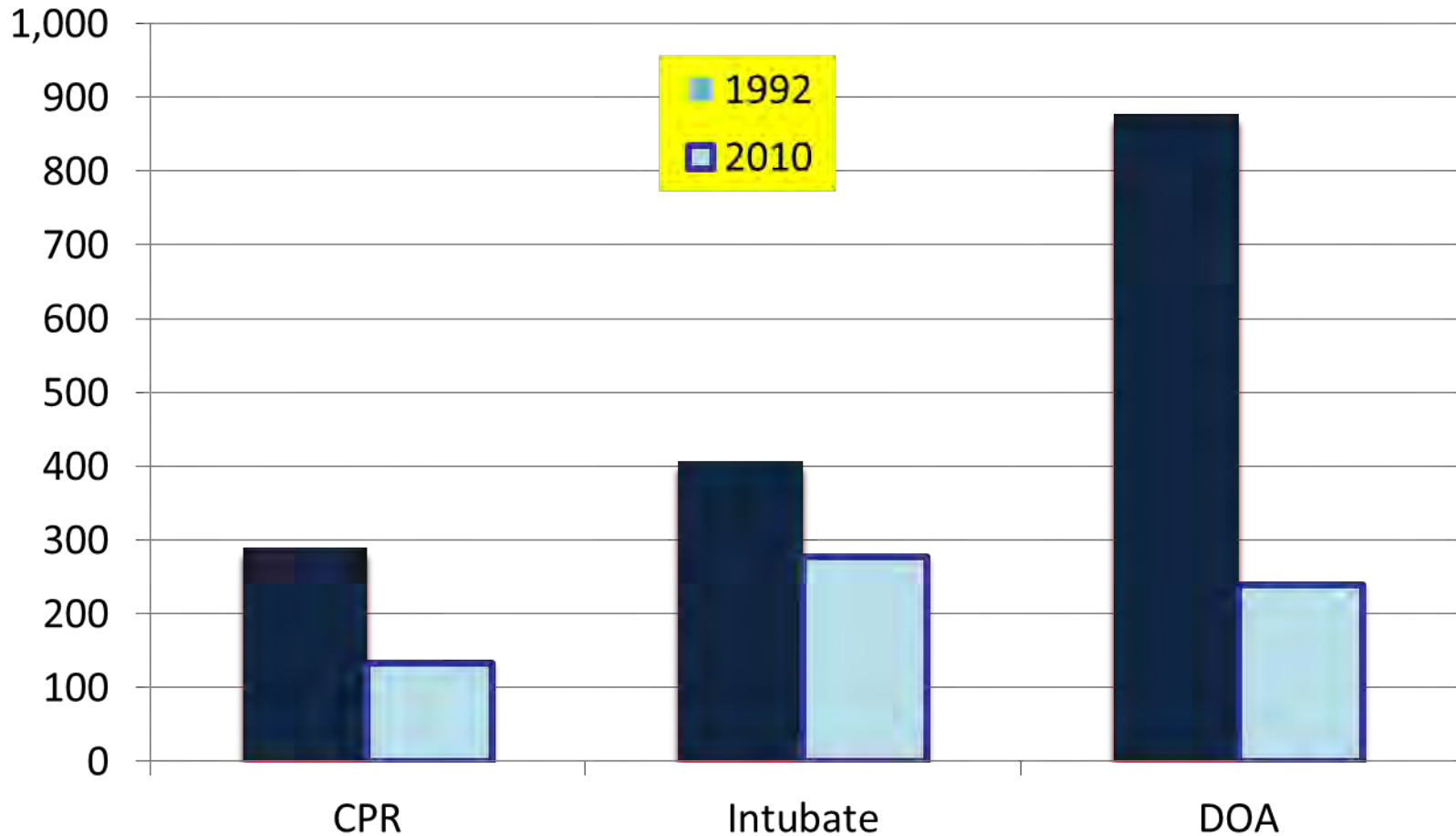


ED Visits 1992 to 2010 Therapeutics



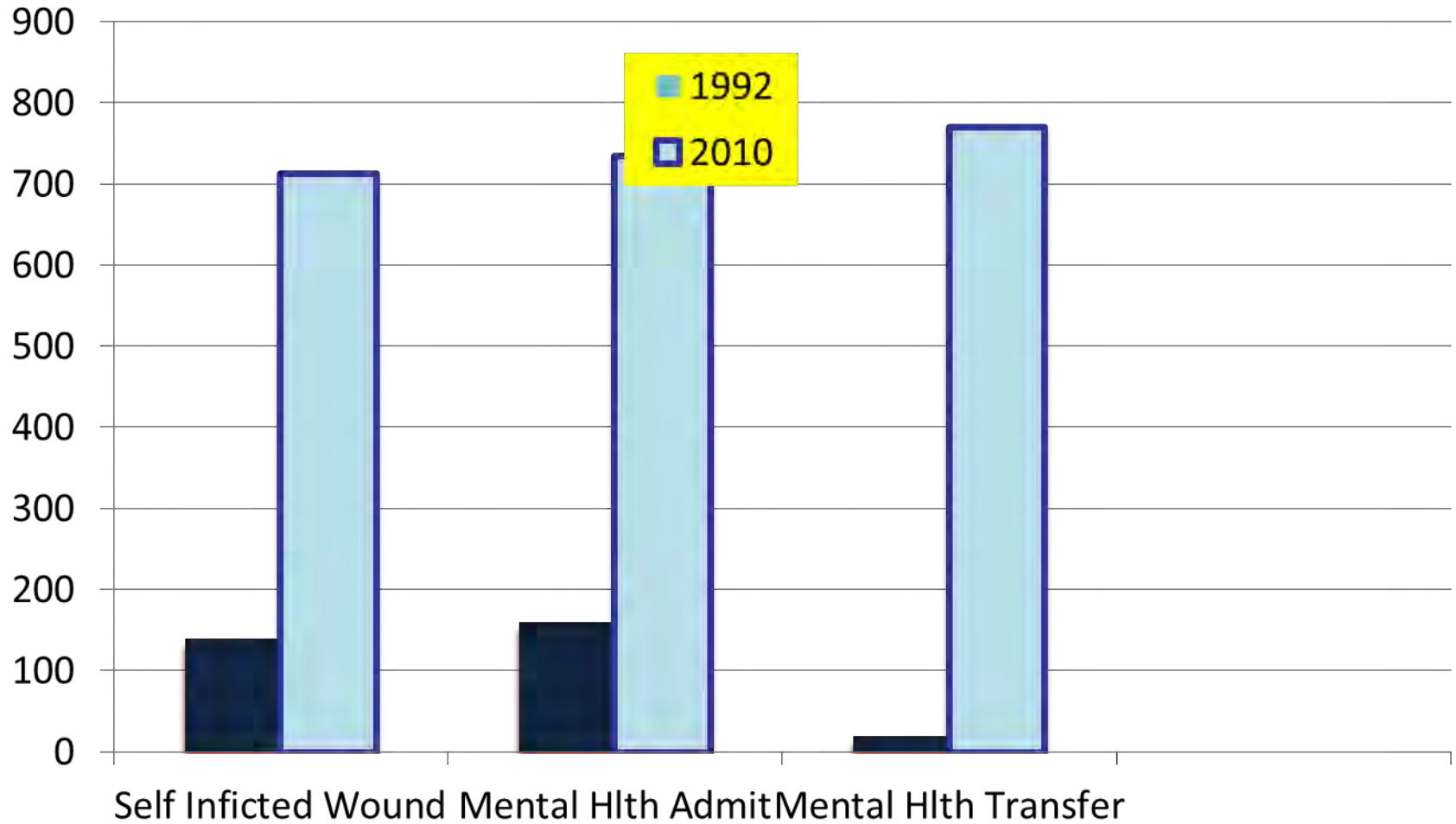
ED Visits 1992 to 2010

Critical Care



ED Visits 1992 to 2010

Mental Health



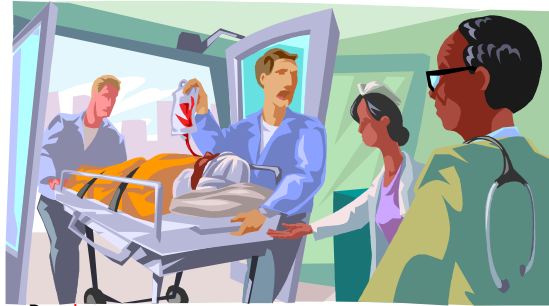
Patient Flow is Predictable

EMS



80/1000
Population

Emergency Department

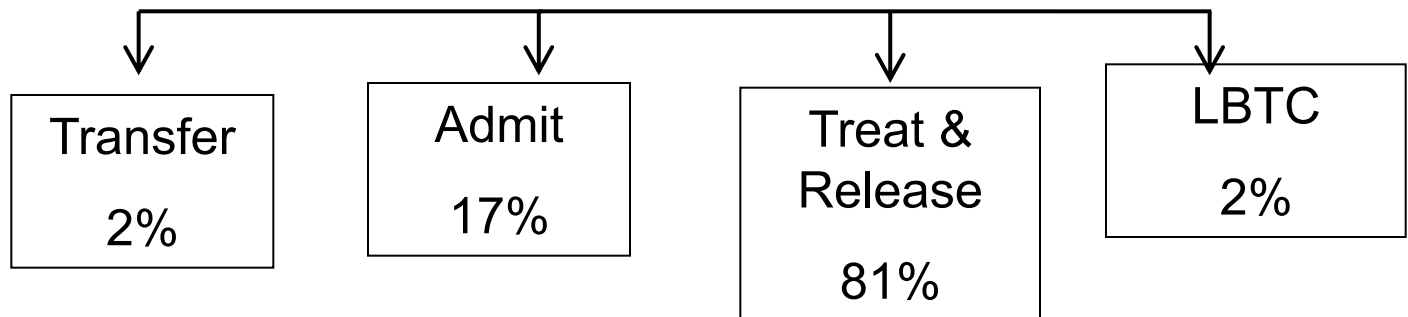


Total use 451 / 1000
Population
82% Walk-Ins
18% Arrival by EMS

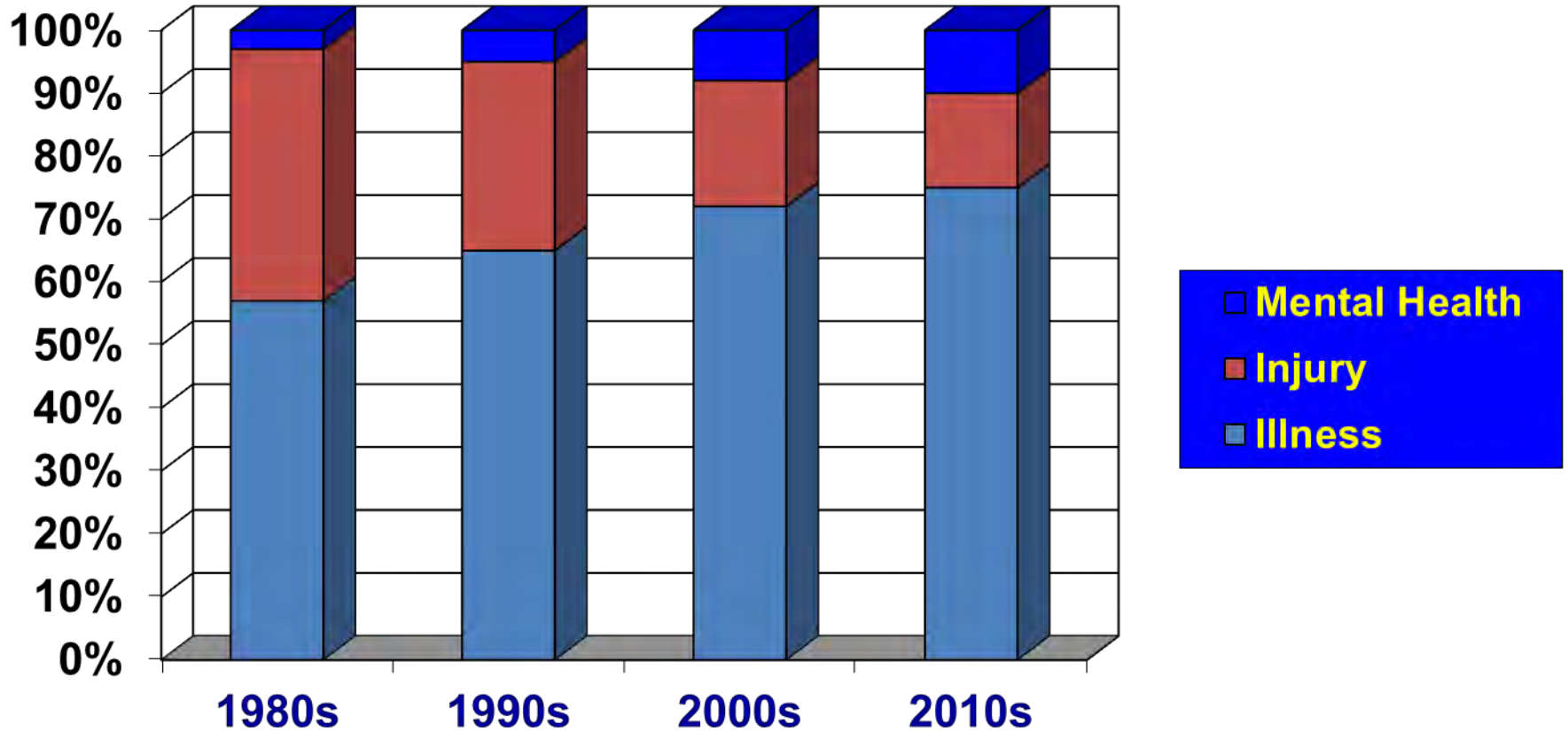
General Population



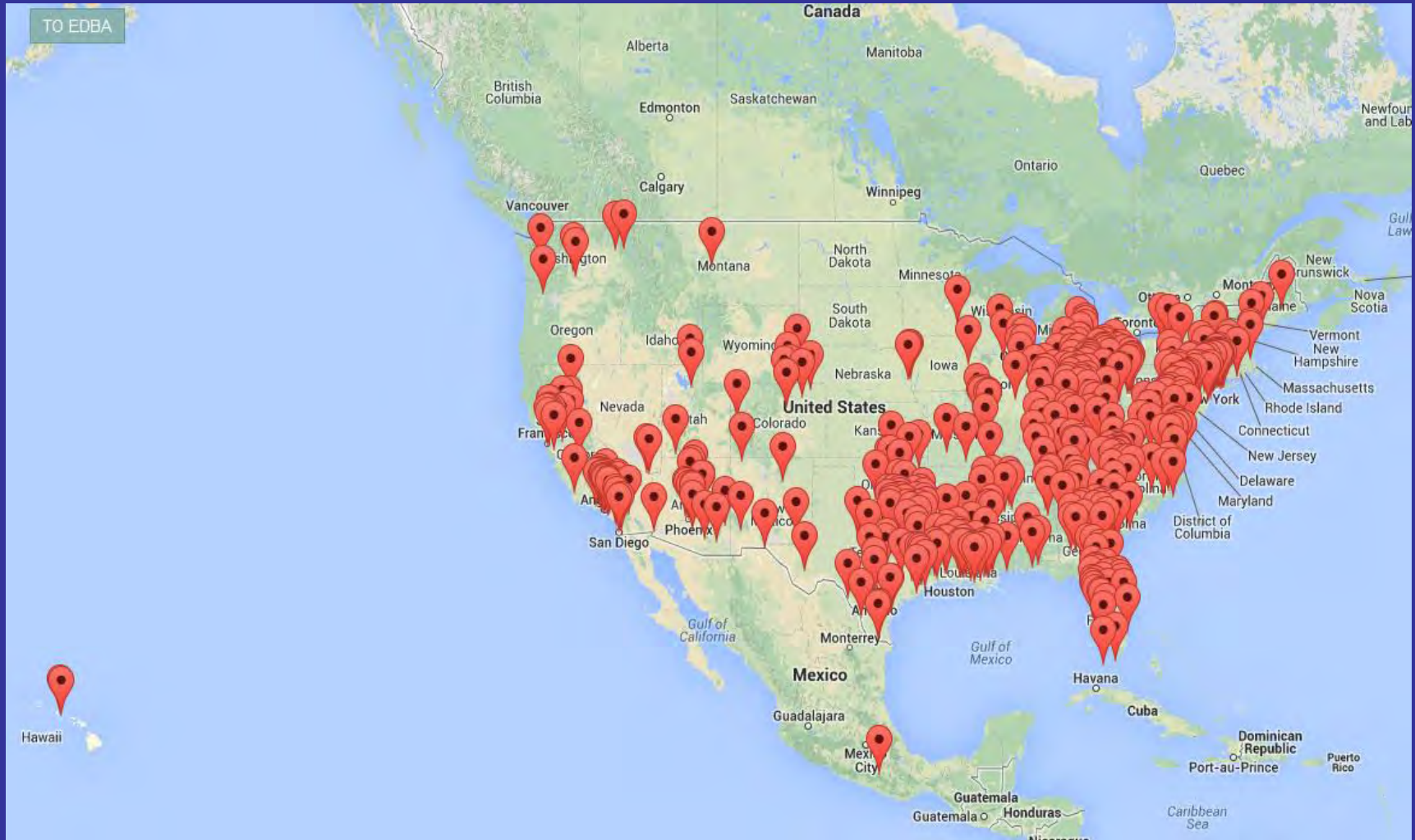
Walk-ins to ED
371 / 1000
Population



Changing ED Patient Mix



ED Benchmarking Alliance Network



Why EDDBA in 1994?

- No group that focuses on ED operations
- No group that is multidisciplinary
- No place to discuss problems and solutions
- Original members from Midwest, volumes around 100 PPD

EDBA Solutions

- Utilize and assist the CDC NHAMCS survey
- Produce good data source for ED leaders
- Don't put ACEP and ENA in untenable positions
- Find places to disseminate and publish
- Counteract "Street Legends"
- Identify Best Practices

ED Definitions and Performance Measures

Early Problem: No consistent definitions in the industry

EDBA Summit I hosted 2006 with all involved parties

EDBA Summit II hosted 2010, which also featured an AHRQ effort to improve ED intake systems

From the very public cases of "death in the waiting room"

EDBA Summit III will be hosted 2014 to further evolve performance measures

Emergency Department Performance Measures and Benchmarking Summit

Shari Welch, MD, James Augustine, MD, Carlos A. Camargo, Jr., MD, Charles Reese, MD

Abstract

The findings are presented of a consensus group created to address the standardization of performance measures for emergency medicine. This group, whose members have affiliations with most major organizations interested in emergency medicine performance, benchmarking and quality improvement, was tasked with standardizing definitions pertinent to emergency department performance measures, creating a set of general and operational measures, developing a comparison system for benchmarking and creating a plan for the dissemination of this information. The formation of this group, the problem statement, and the mission statement for the summit are all described, and the consensus document is presented.

ACADEMIC EMERGENCY MEDICINE 2006; 13:1074-1080 © 2006 by the Society for Academic Emergency Medicine

Keywords: quality improvement, benchmarking, ED operations, performance measures, process improvement

Emergency leaders increasingly are faced with challenges that go beyond the scope of traditional clinical medicine and department staffing. A thorough understanding of quality-improvement principles and benchmarking now is necessary for emergency department (ED) leaders to be successful in providing patient-centered care, improving customer satisfaction, and evaluating service initiatives. Providing state-of-the-art, evidence-based clinical care is not the only focus, and emergency physicians and nurses now are being asked also to provide safe, timely, efficient, and cost-effective care. The measures that allow emergency practitioners to gauge and measure their success in these areas are lacking, and even basic definitions have not been promulgated.

Outside agencies also are intensely interested in ED operations. With the potential for terrorist activity, pandemic flu, and natural disasters to create human casualties, government leaders are developing preparedness plans for communities. Those plans require forecasting of hospital surge capacity and ED capability. Communi-

ties have been made aware of diversion and rerouting of emergency medical services (EMS) patients, but there are no definitions for those activities. Further, these activities do not reliably predict the state of available resources for any individual ED or hospital. In addition, the Centers for Medicare and Medicaid Services (CMS) are interested in applying pay for performance (P4P) to organizations and physicians and in seeking definitions of adequate and outstanding performance. Without industry-driven standards in place that are developed by emergency-service leaders, CMS likely will develop its own definitions and indicators.

Although others have written about clinical quality measures,^{1,2} and indeed many of these parameters are being tracked via the regulatory requirements mentioned in the remainder of this section, the establishment of operational benchmarks for emergency medicine (EM) has been slower to evolve. The measurement of time intervals in the ED and the tracking of patients who leave before they are seen have become de facto markers for quality and efficiency in the literature,³⁻⁷ although no standardized definitions for these markers have been put forth or accepted.

There are three major reasons compelling emergency practitioners to standardize the language, terminology, and implementation of performance measures and benchmarking practices. These are as follows:

1. Regulatory burdens. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now is pursuing clinical quality improvement (QI) data in the form of Core Measures. Any facility that does not have in place the infrastructure to track these data risks its accreditation. These measures are likely to

From the LDS Hospital and University of Utah School of Medicine (SW), Salt Lake City, UT; Emory University (JA), Atlanta, GA; Massachusetts General Hospital (CAC), Boston, MA; and Christiana Care (CR), Wilmington, DE.

Individuals, agencies, and programs that contributed to the proceedings are listed in Appendix A.

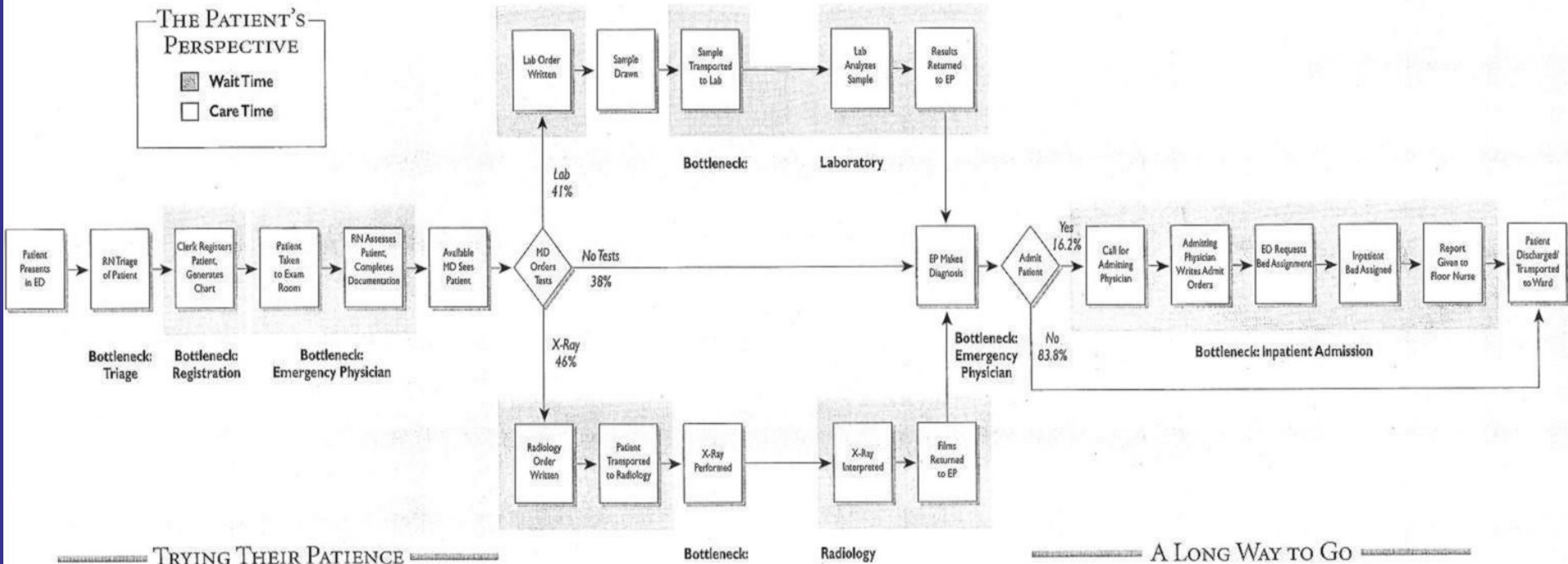
Received March 26, 2006; revision received May 16, 2006; accepted May 17, 2006.

Address for correspondence and reprints: Shari Welch, MD, Emergency Department, LDS Hospital-University of Utah School of Medicine, 8th Avenue and C Street, Salt Lake City, UT 84143. Fax: 801-947-5782; e-mail: sjwelch@networld.com.

The Clockwork ED

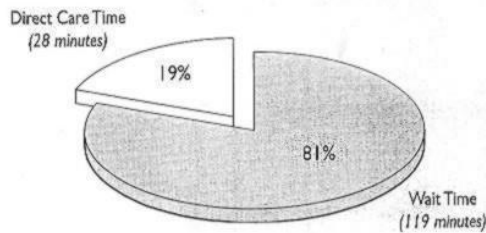
COMPLEX ED PROCESS

AWASH IN BOTTLENECKS



TRYING THEIR PATIENCE

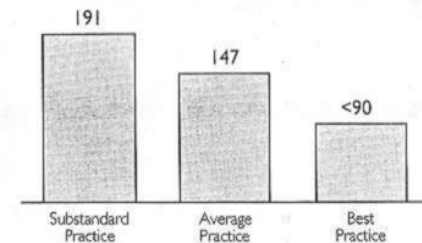
Breakdown of Typical ED Patient Stay



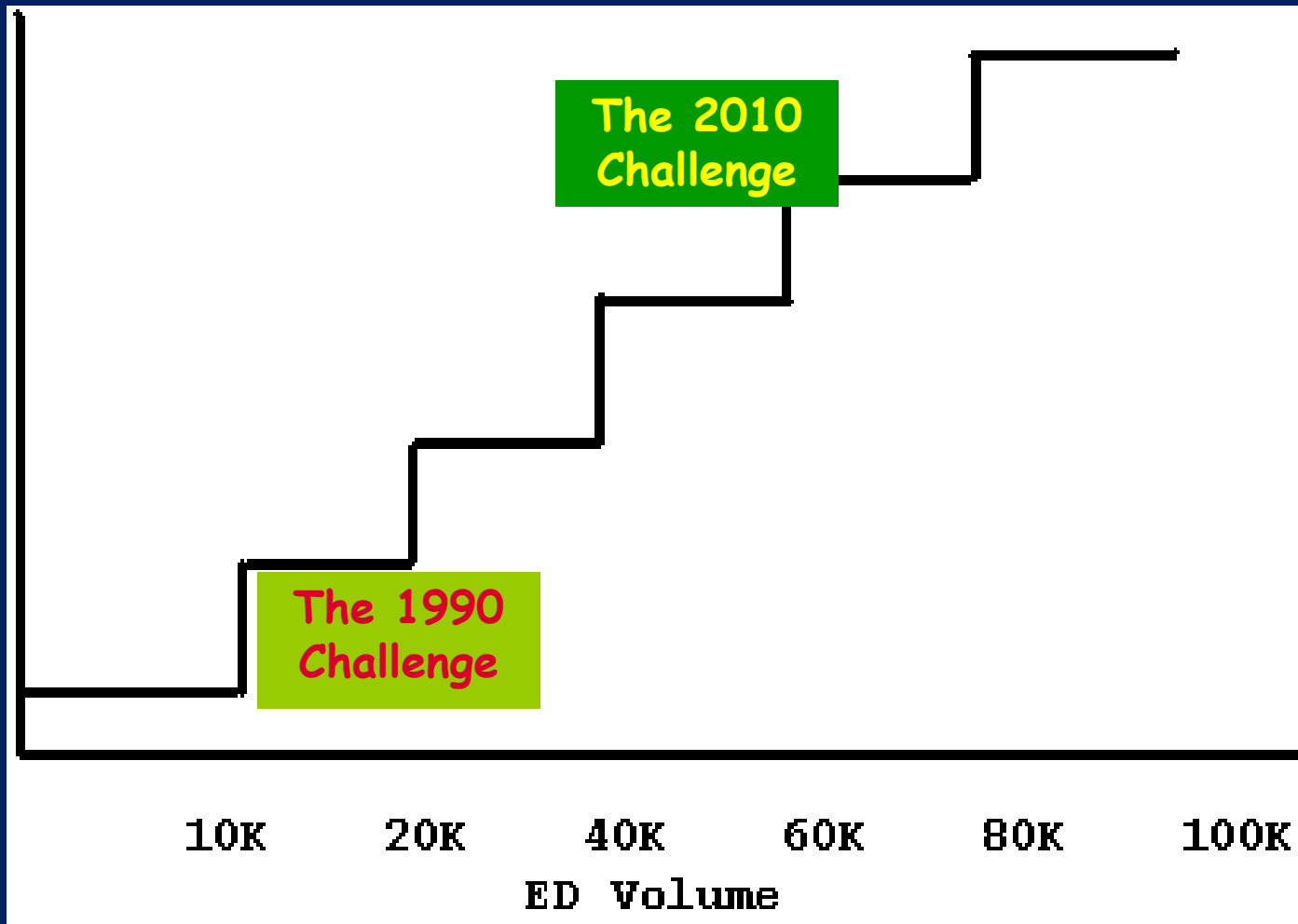
LOS = 147 minutes

A LONG WAY TO GO

ED ALOS, Minutes



An Early Observation: ED Process Depends on ED Volume



The EDBA Data Survey

The Cohorts

Super Centers	Over 100K	Over 275 PPD
Very Large	Over 80,000	Over 220 PPD
Large	60 - 80K	165 - 220
Medium	40 - 60K	110 - 165
Small	20 - 40K	55- 110
Micro	Under 20K	Under 55
Pediatric and Freestanding EDs	Any Volume	Any PPD

The EDBA Annual Data Survey

	Total Sites	Hi CPT Acuity	Peds %	Admit %	Transfer %	EMS Arrival	EMS Arrival Admit	Median LOS	LOS Treat & Release	LOS Fast Track	LOS Admit	LBT C	Door to Doc	EKG per 100	Xray per 100	CT per 100	MRI per 100	% Hosp Admits thru ED	Visits per Foot	Beds	Visits per Space	Admit Time
Total All EDs																						
2012 results	991	64%	21.2%	16.6%	2.0%	16%	40%	171	147	111	288	2.2%	32	26	48	20	1.0	68%	3.1	27	1,602	119
Over 100K EDs																						
2012 results	31	66%	22.3%	18.6%	0.8%	21%	39%	233	195	134	387	3.2%	49	31	43	19	1.1	67%	4.1	71	1,623	161
80 to 100K EDs																						
2012 results	42	69%	23.8%	20.3%	0.9%	18%	45%	219	185	117	363	3.4%	41	26	48	22	0.9	65%	3.4	53	1,720	165
60 to 80K EDs																						
2012 results	110	66%	20.6%	19.6%	1.2%	19%	42%	201	170	116	335	2.7%	39	31	50	24	1.8	65%	3.1	44	1,643	142
40 to 60K EDs																						
2012 results	207	67%	18.1%	19.4%	1.6%	19%	43%	187	160	113	303	2.5%	33	30	50	24	1.2	68%	3.4	31	1,671	121
20 to 40K EDs																						
2012 results	350	63%	22.1%	15.8%	1.9%	15%	38%	163	139	101	271	2.0%	30	23	48	19	0.8	68%	3.1	19	1,667	104
Under 20K EDs																						
2012 results	250	60%	22.7%	12.1%	3.3%	12%	35%	137	118	73	236	1.4%	24	20	44	16	0.3	71%	2.4	10	1,348	83
Pediatric EDs																						
2012 Results	31	50%	88.4%	10.5%	0.9%	8%	30%	146	130	100	260	1.3%	30	5	31	5	0.3	68%	4.0	23	1,924	95
Adult, Specialty EDs																						
2012 Results	31	70%	3.0%	24.7%	1.1%	23%	48%	241	199	129	359	3.4%	46	34	49	25	1.3	62%	3.2	38	1,420	179
Urgent Care, Freestanding EDs																						
2012 Results	52	52%	21.0%	8.4%	2.7%	8%	31%	114	107	53	250	1.0%	20	19	19	14	0.0	67%	2.4	12	1,510	93

EDBA Survey 2012

- 1026 EDs serving 40 million patients
- Increase volume and acuity
- CPOE about 80%
- Average ED broke 100 PPD (103 PPD)
- More trauma centers, mainly to serve the elderly injured patients on thinners
- Bed Utilization around 1600 visits per patient care space

EDBA Data 2012

- Better patient intake
- **New Team Triage systems over 25%**
- More use of Docs and MLPs in intake
- Fewer walkaways
- Matched to no high profile cases of dying in waiting room
- More arriving by EMS, and those patients getting admitted at same rate

EDBA Data 2012

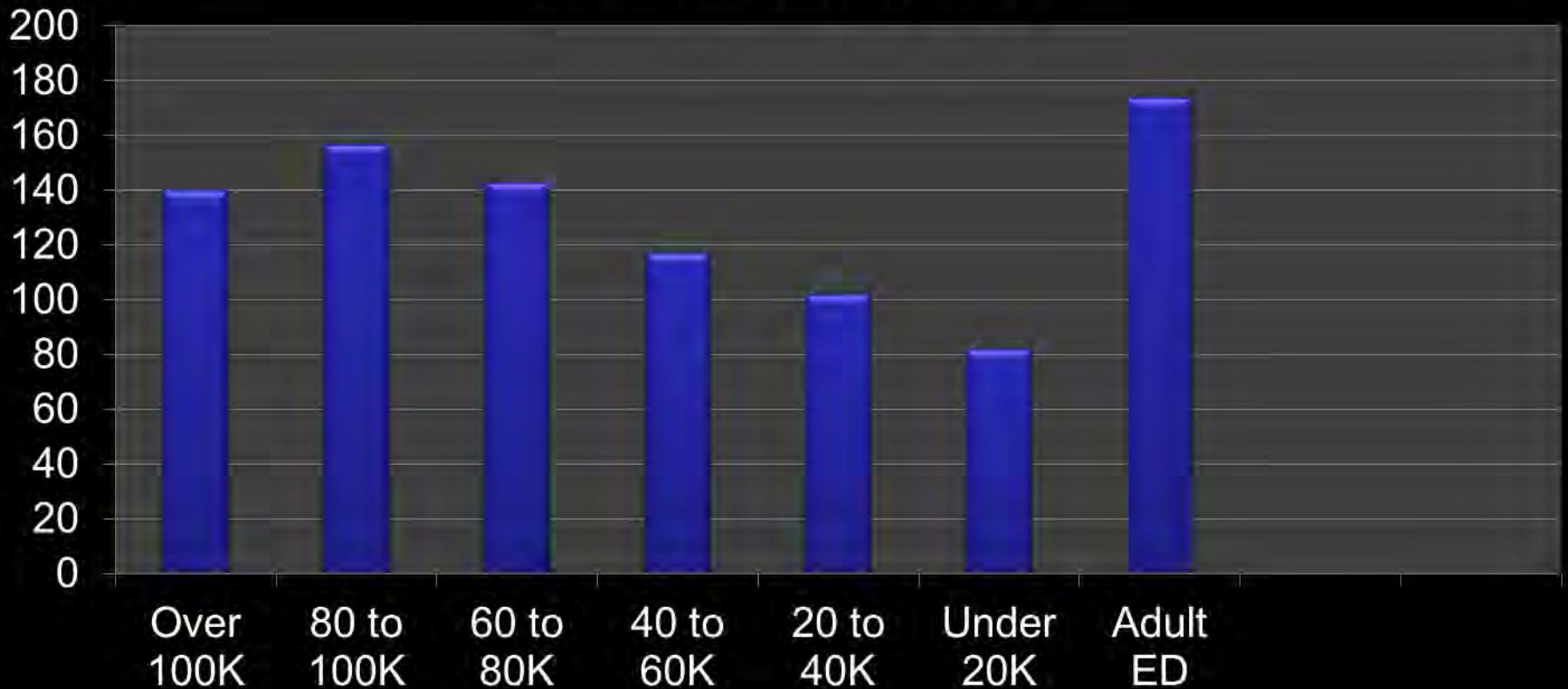
- More transfers. 1.9% of all patients, or 2.9 million a year. Half for mental health
- MRI now running about 1%
- Admits down for first time
- Boarding a burden
- First average boarding time number is 114 minutes, but very cohort dependent

Using the Data Your Site

	Total Sites	Hi CPT Acuity	Peds %	Admit %	Transfer %	EMS Arrival	EMS Arrival Admit	Median LOS	LOS Treat & Release	LOS Fast Track	LOS Admit	LBTC	Door to Doc	EKG per 100	Xray per 100	CT per 100	MRI per 100	% Hosp Admits thru ED	Visits per Foot	Beds	Visits per Space	Admit Time
Total All EDs																						
2012 results	1,026	64%	21.5%	16.6%	2.0%	16%	39%	171	147	111	288	2.2%	32	26	48	20	1.0	68%	3.1	27	1,597	119
Over 100K EDs																						
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80 to 100K EDs																						
2012 results	44	68%	23.2%	20.8%	0.8%	18%	45%	221	187	116	362	3.3%	41	27	48	22	0.9	64%	3.4	54	1,703	161
60 to 80K EDs																						
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40 to 60K EDs																						
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My Hospital	1	70%	12%	23%	2.0%	22%	47%	175	145	92	390	###	18	32	46	23	1.1	72%	3.5	32	1,750	205
20 to 40K EDs																						
2012 results	363	63%	22.3%	15.8%	1.9%	15%	38%	163	139	100	271	2.0%	31	24	48	19	0.8	69%	3.0	19	1,662	105
Under 20K EDs																						
2012 results	259	59%	23.1%	11.9%	3.4%	12%	35%	136	118	73	236	1.4%	24	20	44	16	0.3	71%	2.4	11	1,347	83
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Adult, Specialty EDs																						
2012 Results	33	70%	2.9%	25.4%	1.1%	23%	46%	242	200	126	356	3.4%	47	34	49	25	1.3	62%	3.1	39	1,403	175
Urgent Care, Freestanding EDs																						
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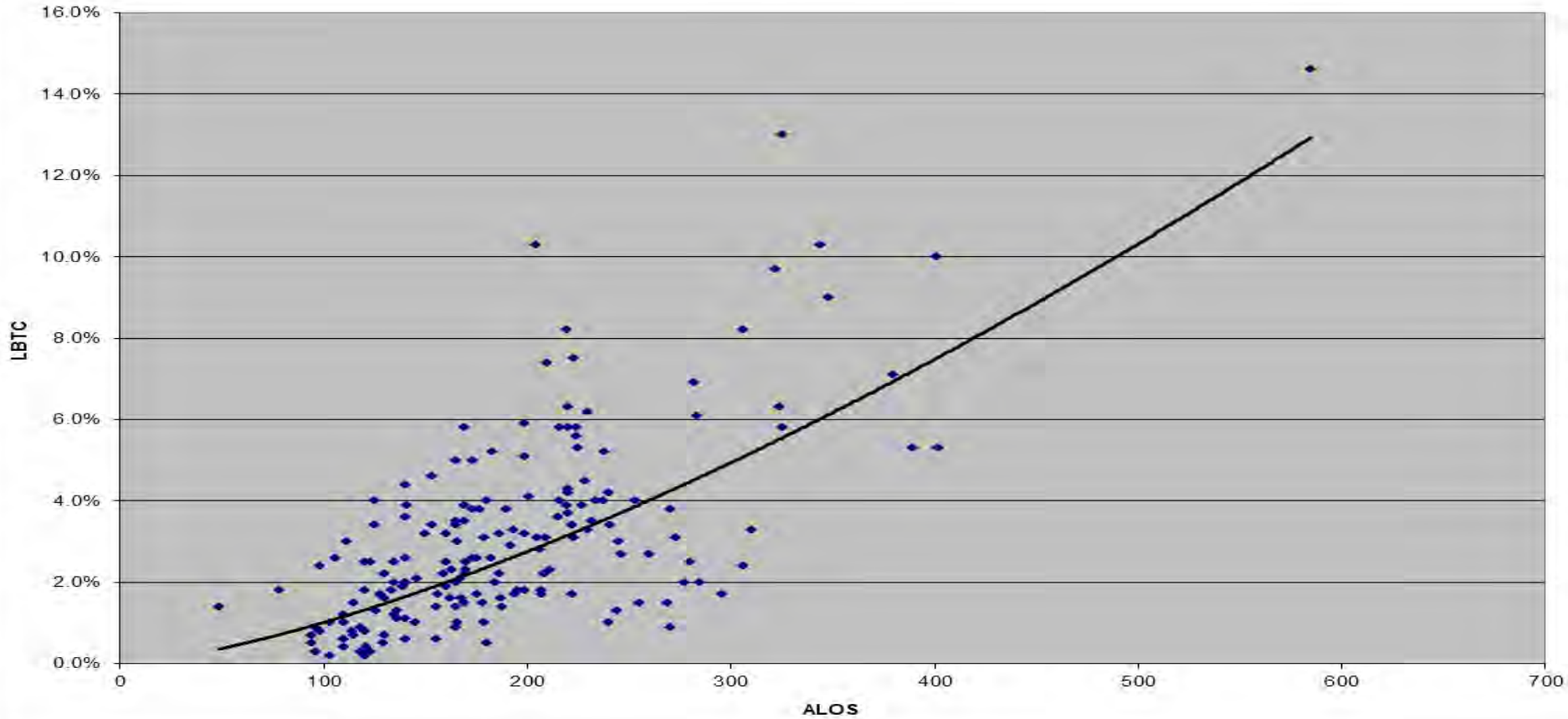
Admit Boarding Times

Median Boarding LOS



Length of Stay and LBTC

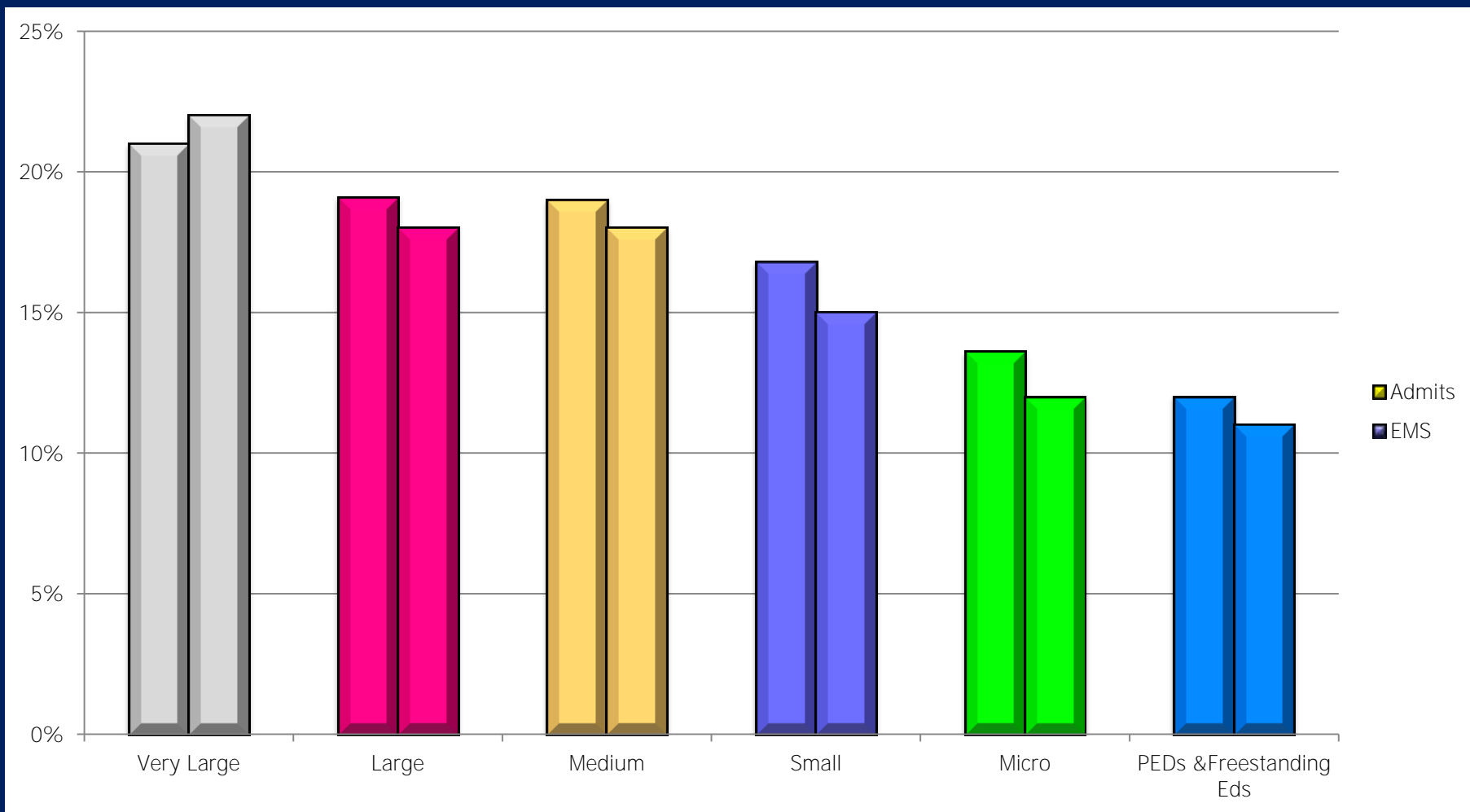
ALOS and Walkaway Rates



EMS Impact: 28M Transports

- 42% admitted
- Most Common Presentations:
 - Chest pain and heart disease
 - Short of breath
 - Contusions/blunt injury
 - Sprains of neck and back (MVA)
 - Syncope and seizures

Correlation of EMS Arrival and Admission



Important Trends even over only 9 years of Data

Year	EKG	Hospital Admits
2012	27	68%
2011	26	67%
2010	24	67%
2009	23	65%
2008	22	64%
2007	20	62%
2006	19	61%
2005	18	61%
2004	17	58%

Making the Data Valuable: A Day in our ED

130	Patients to be seen, although 3 want to leave
40	Will be in Fast Track
56	Will need Monitors
23	Will be Admitted 26% Of Patients in Main ED
6	Will have Dental Problem
991	Orders will be Entered in CPOE, or 7.6 per patient, and 21% of all orders Entered in the Hospital Today
25	Will Arrive by EMS

Economics 101:
Never Become
Perceived As An
Inappropriately
Expensive
Service

Money and Our Practice: MEPS Data

- Medical Expenditure Panel Survey (MEPS), a publicly available dataset available through the Agency for Healthcare Research and Quality (AHRQ). MEPS is an ongoing nationally representative survey which provides data on health care use and expenditures. MEPS is a large-scale survey of the U.S. non-institutionalized civilian population which uses a stratified, multistage probability sampling design
- <http://meps.ahrq.gov/mepsweb/>

- *For Years 2005 to 2010*

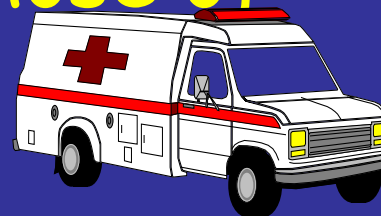
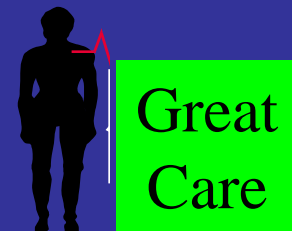
• Medicaid Total Charges \$2122	Total Payments \$553
• Uninsured Total Charges \$2040	Total Payments \$550
• Private Total Charges \$2178	Total Payments \$991
• Medicare Total Charges \$2500	Total Payments \$1000

Florida MEPS Data

- Count 7.1 m visits in 12 months to June 2012
- About half of Florida ER visits deemed "avoidable"
- \$3562 average charge for facility, physician, and ancillary services = \$25.6 B in charges
- Nationalize that data:
- 140m visits = \$498.7 B charges (T word)
- A 30% collection rate equals \$150 Billion

Unscheduled Care into the Future of US Healthcare

- Based on Patient Needs
- Unscheduled Care Coordination
- Integrated work with EMS
- Rapid diagnostics and Intervention
- Care changes timed with those of Medical Community



**EMS
Integrated**

A look Ahead: Serving Patients with Unscheduled Needs

Community-Based Health Care



Home
Care
Services



Extended
Care
Facility



Community
Mental Health



Ambulatory
Surgical



Primary
Care

The Unscheduled Care System

EMS ~ ED ~ Urgent Care ~ Ask-A-Nurse

Women's
Services

Diagnostic
Services

Clinical Decision
and
Observation
Services

Medical Patient
Hospitalist
Service

Surgical Centers
of
Excellence

Specialty
Services



Hospital-Based Health Care

The Unscheduled Care Options: Growing

EDs

Critical Access EDs

Freestanding

Stand Alone

Urgent Care

iTriage

Concierge Medicine

Boutique Medicine

Ultimately the same Two Tier System
present in all other countries

In what form will American EDs and EDPs Exist?

- How will we make the case for:
- Quality
- Safety
- Cost Effectiveness
- Partnerships
- Future Planning
- Prevention

Finding Market Solutions In the EDP Practice

- Value Pricing for All Acuties
- Reduced use of Expensive Solutions, like Admissions
- Cost Cutting and Quality Reporting
- Information Systems must Support Clinical Care

Leverage Points of EM

- High Productivity and Responsiveness to Patient and Community Needs
- Use Specialized Diagnostic Technology, Rapid Treatment, Access to all Available Community Services
- Ties to EMS
- Leader in Prevention
- Media Friendly Site & Staff

Accountable Provider Systems

- U.S. Government
- VA, Active Military, Department of Defense
- Facility Systems (Hospitals, ECF's)
- ACOs
- Integrated Systems

Marketing the ACO

Present

Price

Choice

Quality





Future

Quality

Choice

Price

The Service Report Card

- Finances
-  Staffing
-  Customer Satisfaction
-  Medical Care and Outcomes
-  Physician Profiles



Value Opportunities In Medical Care



- Find and Utilize Excess Capacity
- Restore Honesty in Pricing System
- Managed Healthcare and Unscheduled Care Episodes
- Appropriate Utilization and Pricing of Ancillary X-Rays, Labs

Evolving Role of the ED Physician



- Leader of Unscheduled Care System
- Improved Throughput of All Unscheduled Needs
- User of Enabling Technology (Tele_____)
- Reduced Care Variance, Aligned Incentives
- Refined Utilization of Expensive Resources, like inpatient care, palliative services
- New Activities, including two-tier health system

Consider Effects on the Practice

- New reality of medicine vs.. business
- Malpractice pressures
 - "That doctor was just trying to save money"
- Need for group consistency
- How will you provide transparency:
public reporting of your data

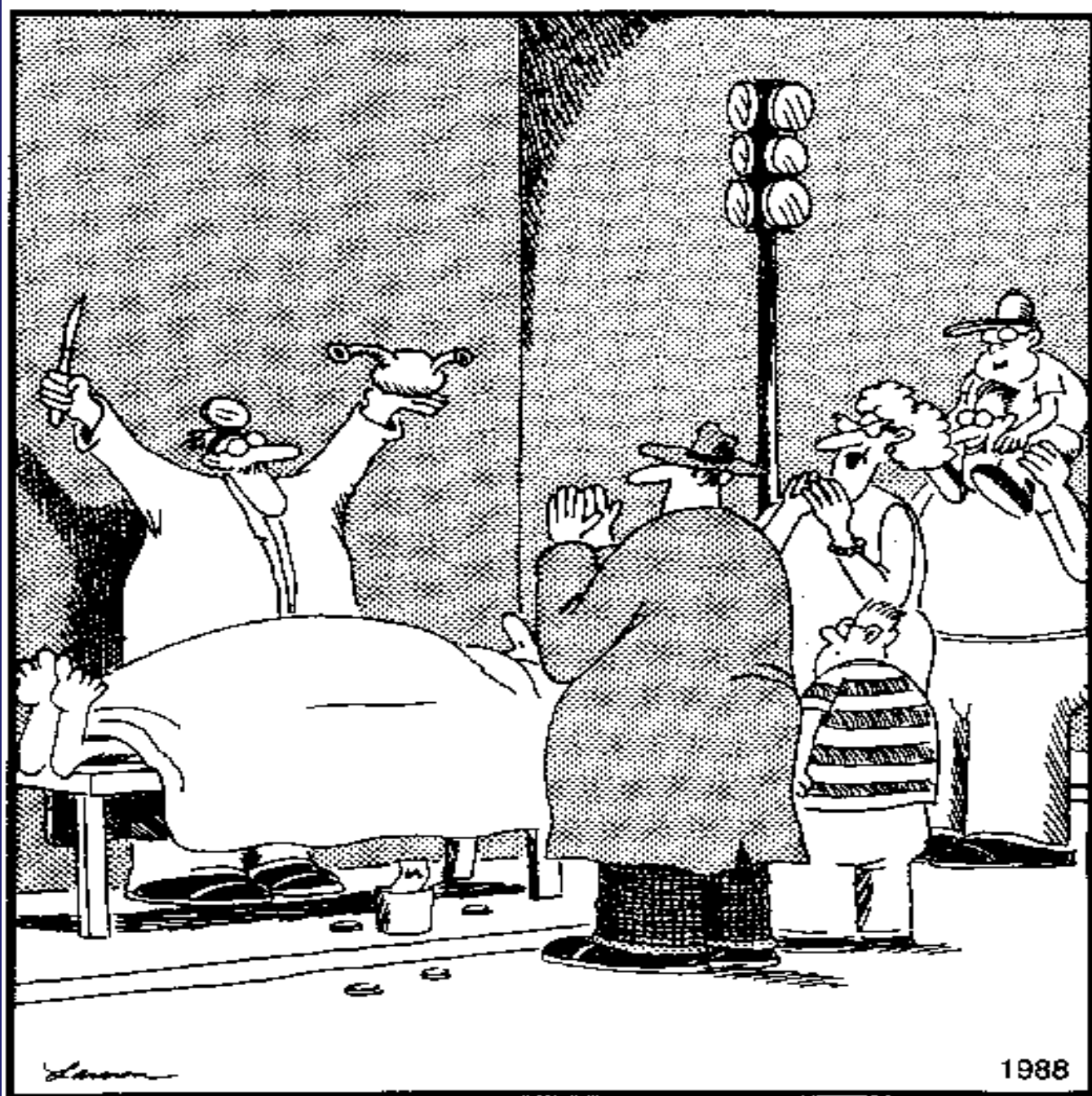
Identify The Opportunities



- Who Controls the Money and What do They Want?
- The Patients Want the Right Amount of Health Care for Return to, or Maintenance of Good Health and Avoid Premature Death
- Solutions are Developed at the Regional Level

Evaluating Contract Effectiveness

- How do You Get Paid?
- What is demand for patient satisfaction
- Do we get paid for prevention services?
- What are measurable clinical outcomes
- Who owns and reports data?
- How will EM participate on governing boards?



Street physicians

Finding Market Solutions In EM

- Manage Unscheduled Care
- Value Pricing for all Acuties
- Reduced Inpatient Utilization
 - Manage ECF Patients on site
- Utilize IT for Quality Improvement
- Manage Risk and Pay Appropriate
- Take Great Care of the Community

IEPC

- Please send me all data points for your ED
- Plan Forward with Hard Numbers
- Know, Understand your Numbers, Compare to Cohorts
- Make Sure all Staff Know Numbers
- Use Data to Drive Future across the Country
- Tell Your Story Effectively in Developing Designs, Process, Staff, Financing