EM & ACEP Update June 2013

Chapters

Sections

Committees

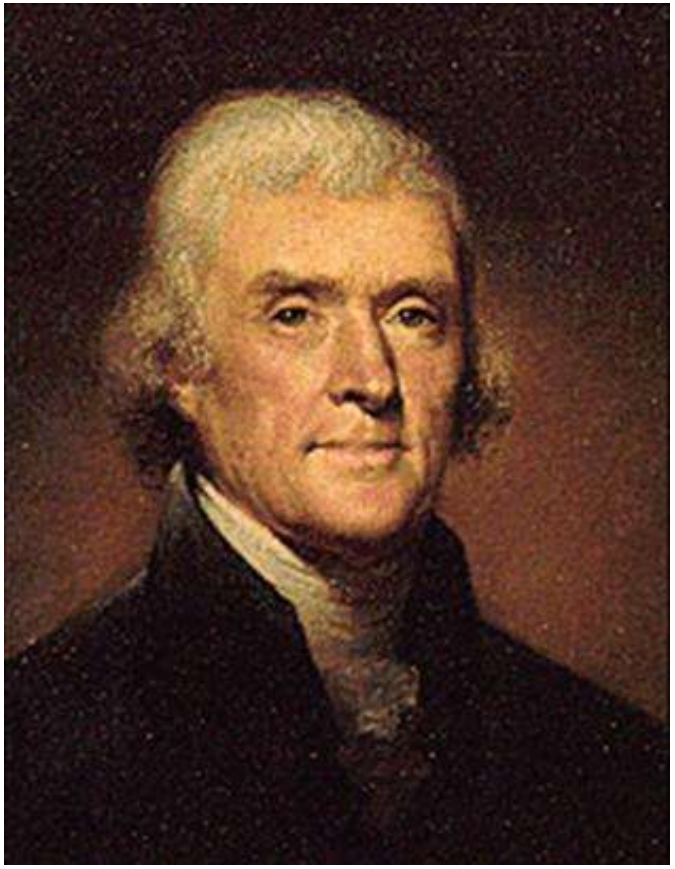
MEMBERS

North Carolina, South Carolina, Georgia

Michael Gerard, MD, FAAP, FACEP
ACEP Vice President
ACEP Board of Directors

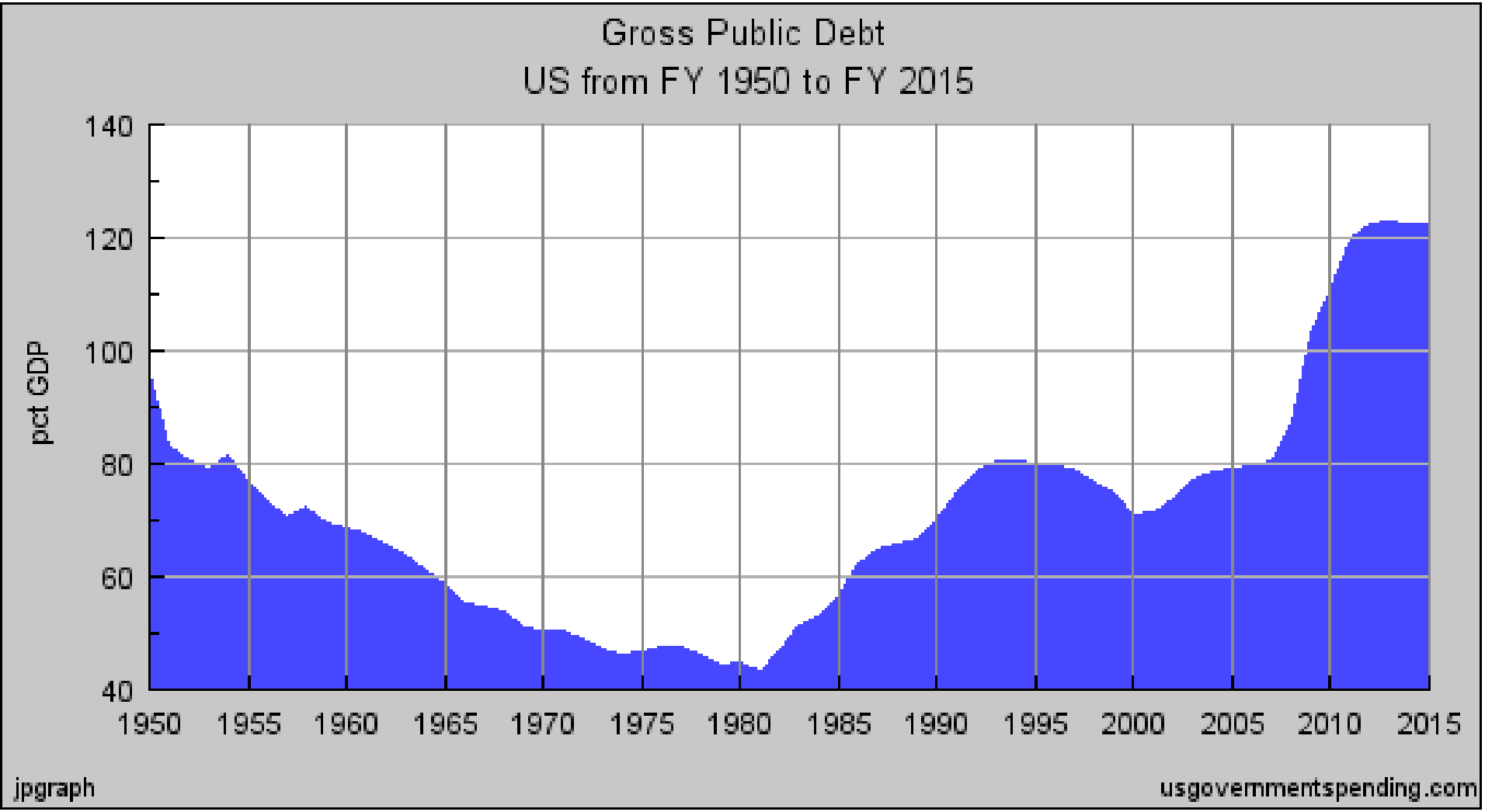
Thomas Jefferson

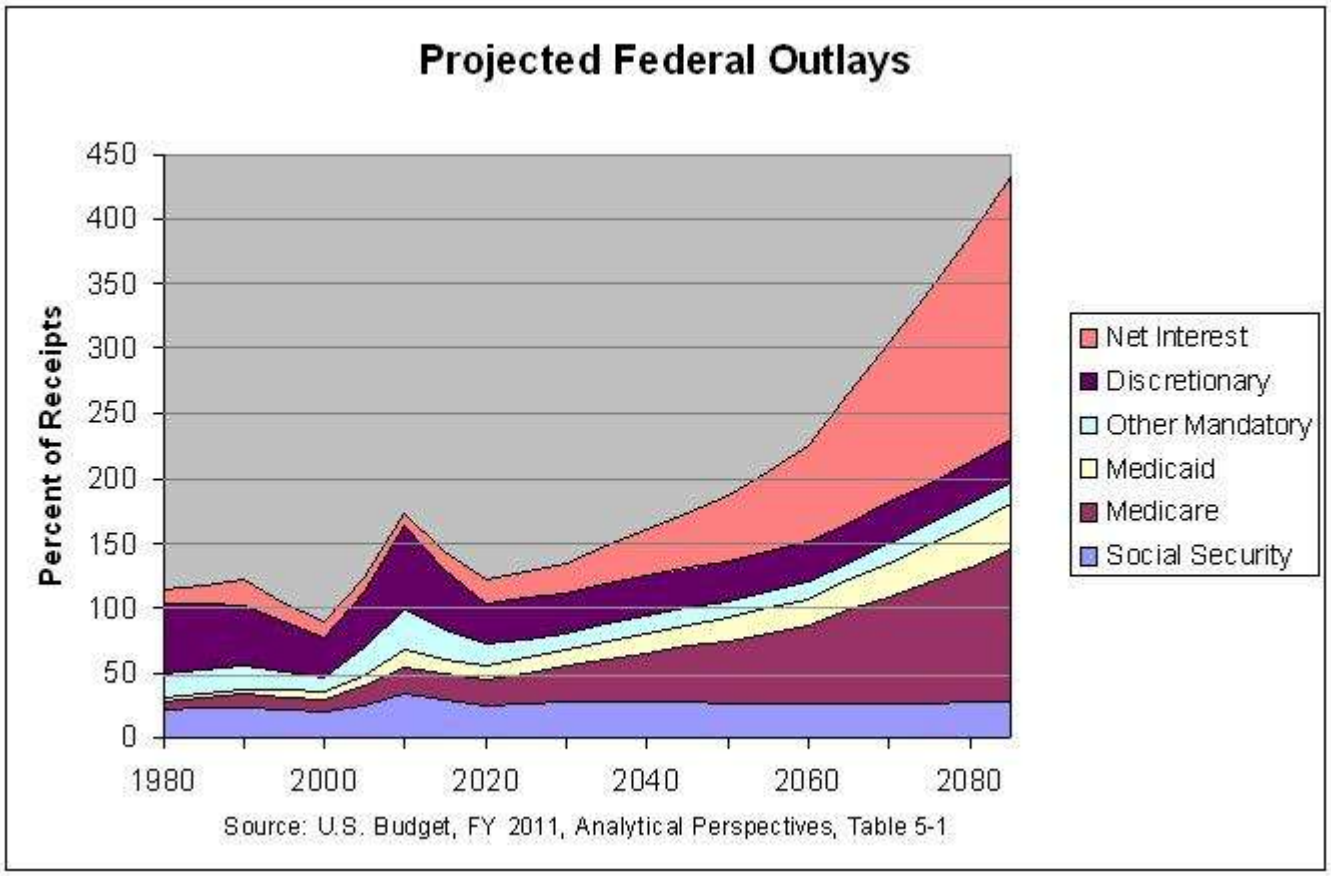
"Without health, there is no happiness"

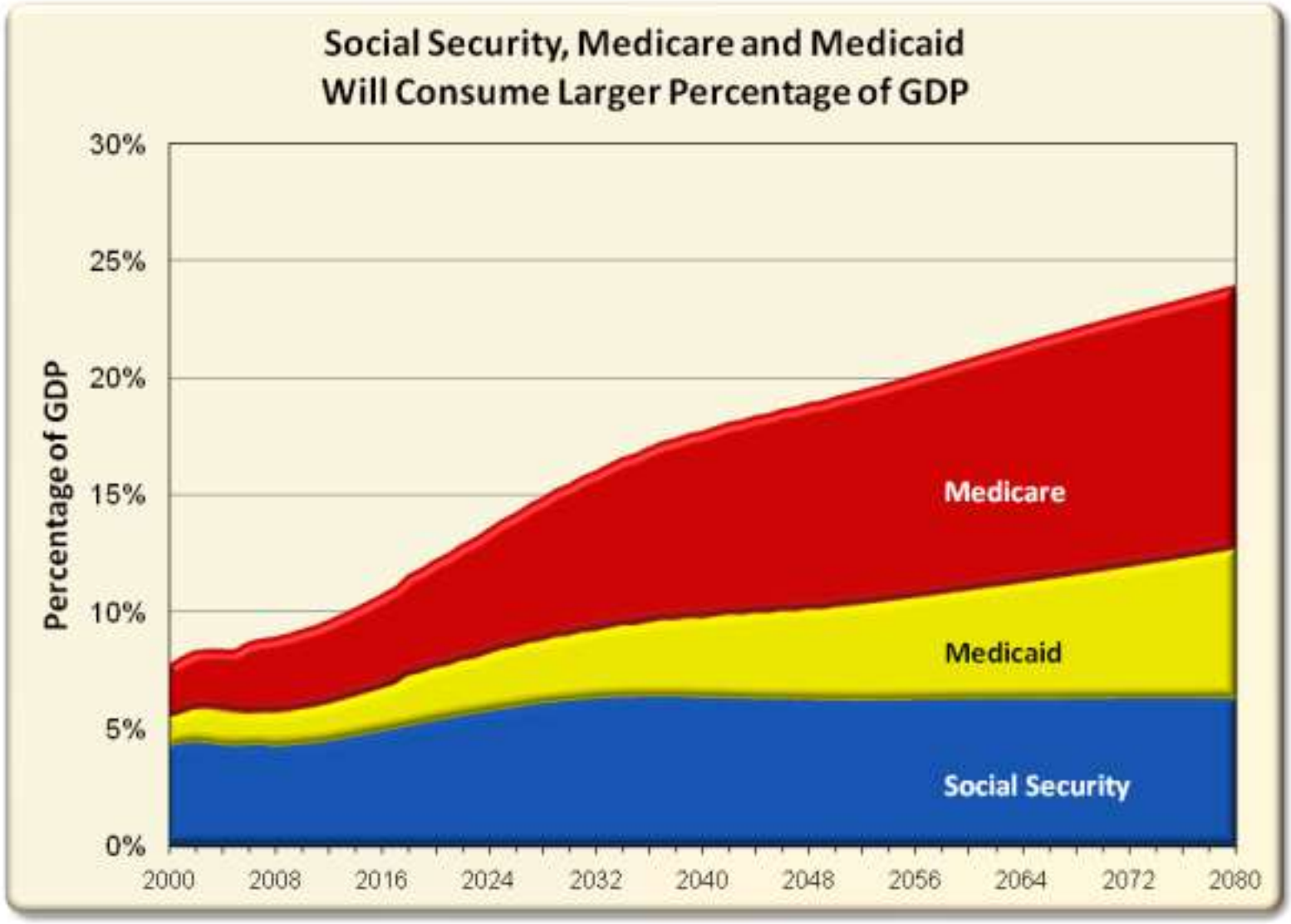



ECONOMY
MORE DUCT TAPE

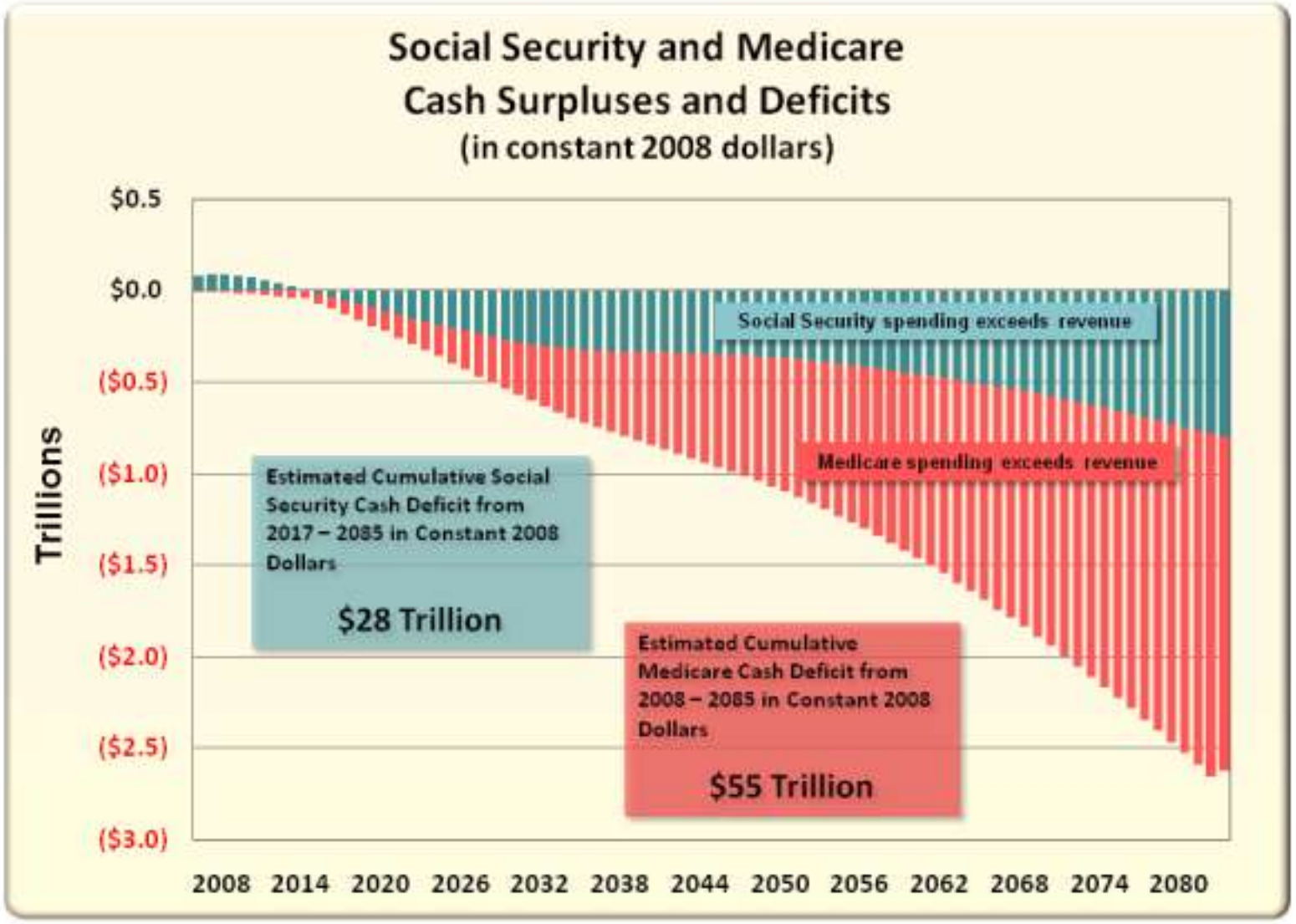
We have a problem




Projected Federal Outlays
Percent of Receipts
450
400
350
300
250
200
150
100
50
0
1980
2000
2020
2040
2060
2080
Net Interest
Discretionary
Other Mandatory
Medicaid
Medicare
Social Security
Source: U.S. Budget, FY 2011, Analytical Perspectives, Table 5-1

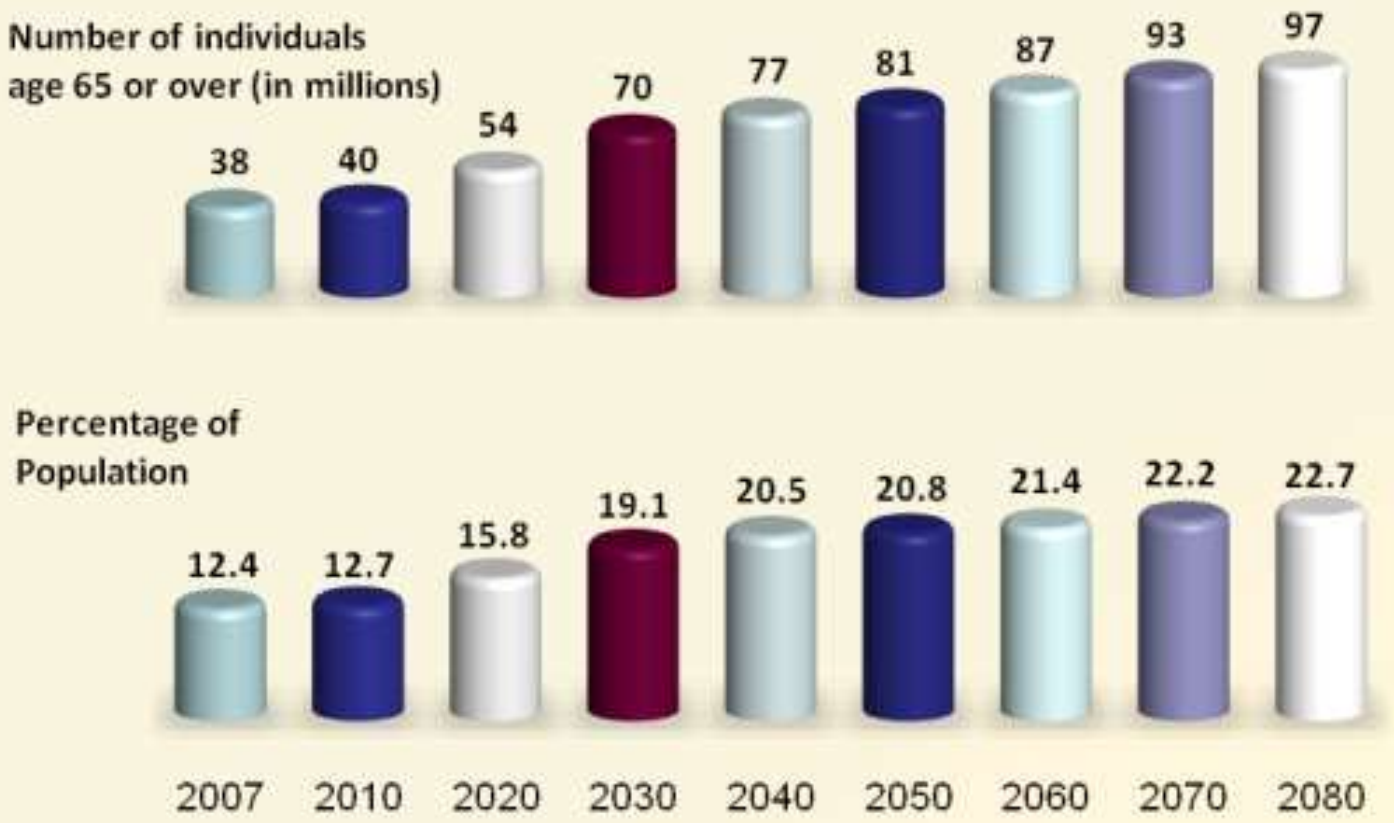


Source: Government Accountability Office
U.S. Financial Condition and Fiscal Future Briefing, January 2008

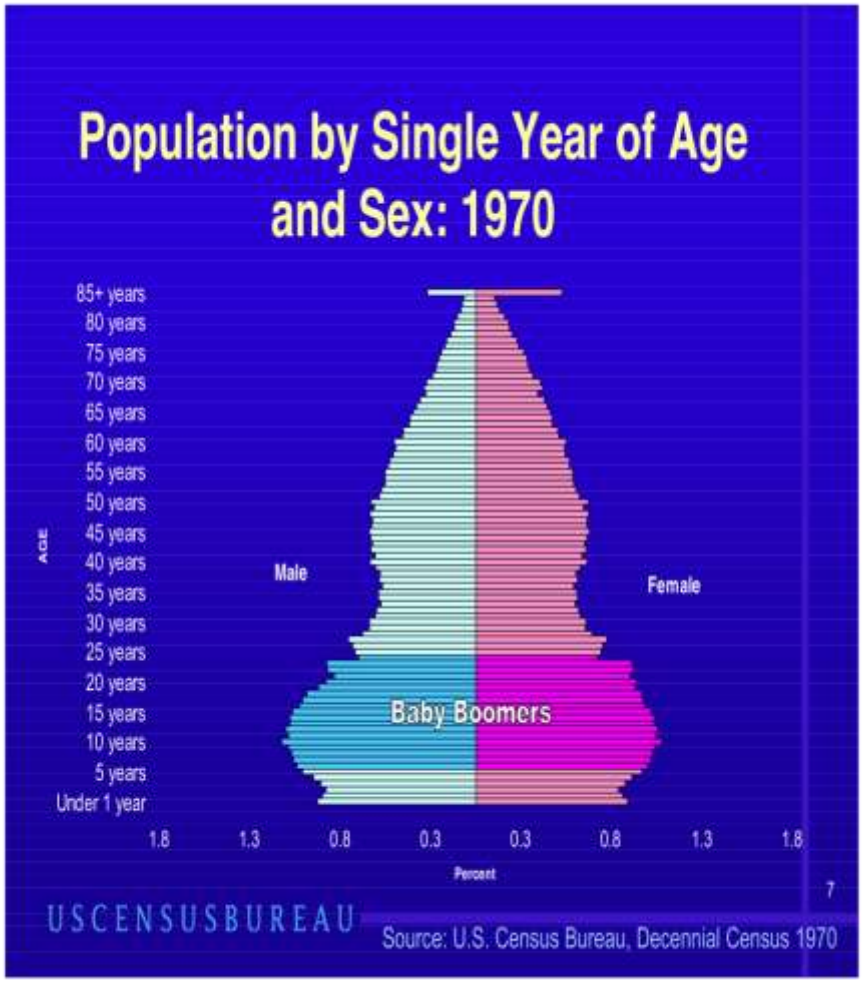


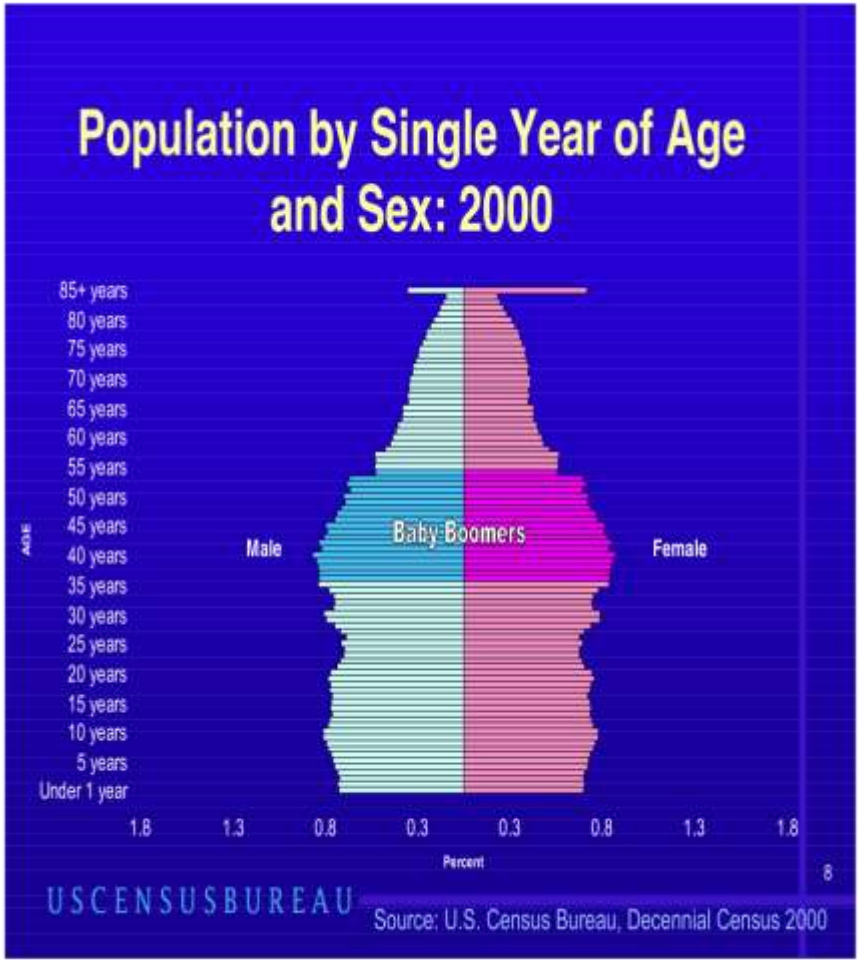
*Source: Government Accountability Office analysis of data from the Office of the Chief Actuary, Social Security Administration and Office of the Actuary, Centers for Medicare and Medicaid Services.**

The Aging U.S. Population

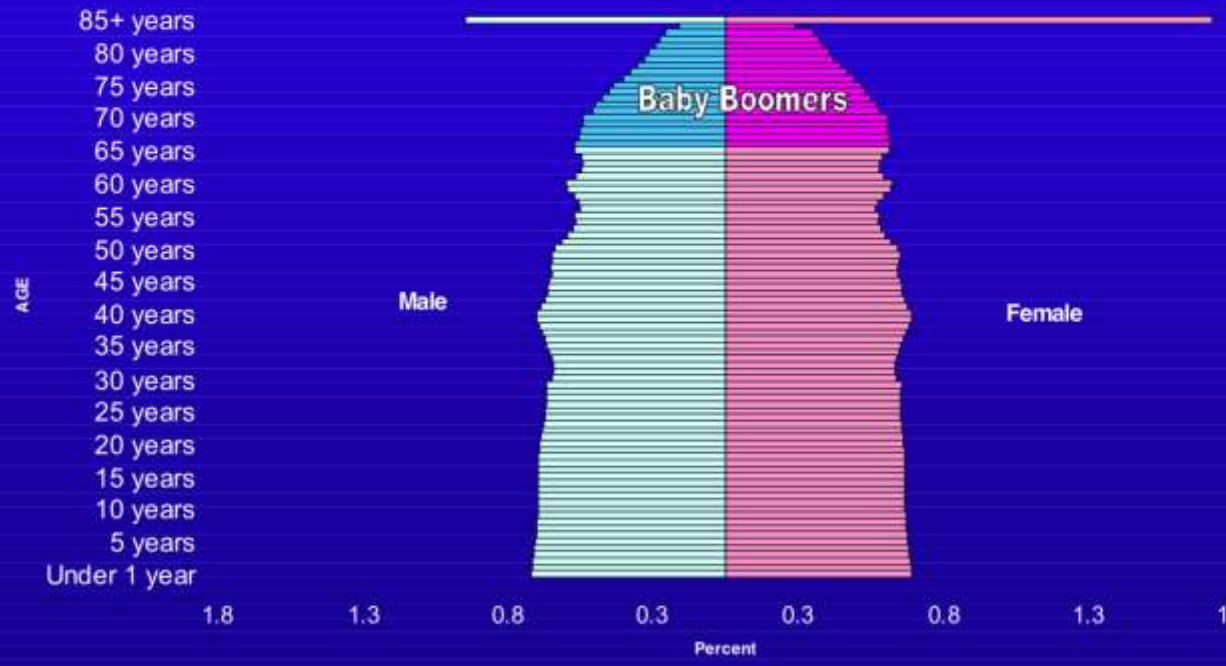


Source: U.S. Social Security Administration
2007 OASDI Trustees Report (April 2007), Table V.A.2


Population by Single Year of Age and Sex: 1970
85+ years
80 years
75 years
70 years
65 years
60 years
55 years
50 years
45 years
40 years
35 years
30 years
25 years
20 years
15 years
10 years
5 years
Under 1 year
AGE
Male
Female
Baby Boomers
1.8
1.3
0.8
0.3
0.3
0.8
1.3
1.8
Percent
7
USCENSUSBUREAU
Source: U.S. Census Bureau, Decennial Census 1970


Population by Single Year of Age and Sex: 2000
85+ years
80 years
75 years
70 years
65 years
60 years
55 years
50 years
45 years
40 years
35 years
30 years
25 years
20 years
15 years
10 years
5 years
Under 1 year
AGE
Male
Baby Boomers
Female
1.8
1.3
0.8
0.3
0.3
0.8
1.3
1.8
Percent
8
USCENSUSBUREAU
Source: U.S. Census Bureau, Decennial Census 2000

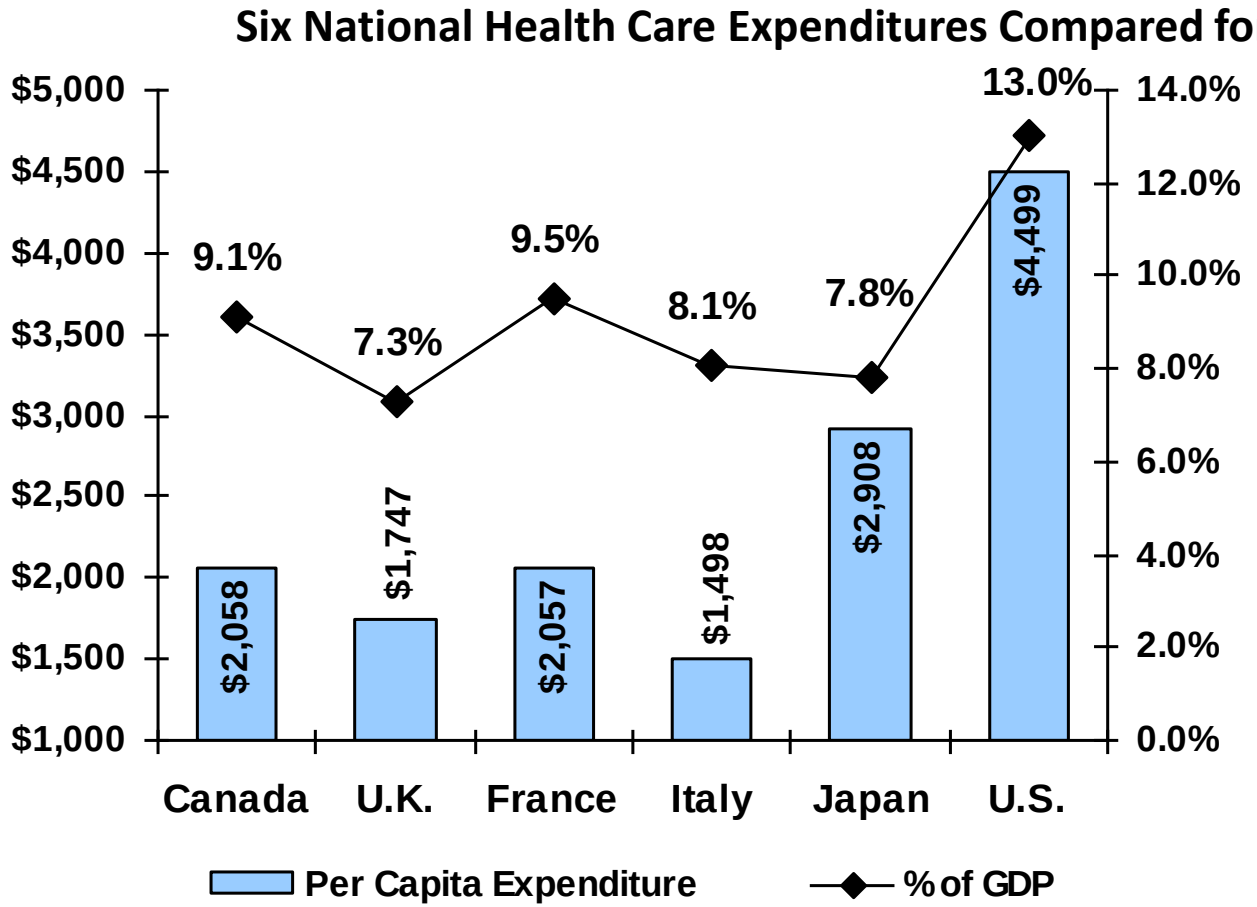
Population by Single Year of Age and Sex: 2030



USCENSUSBUREAU

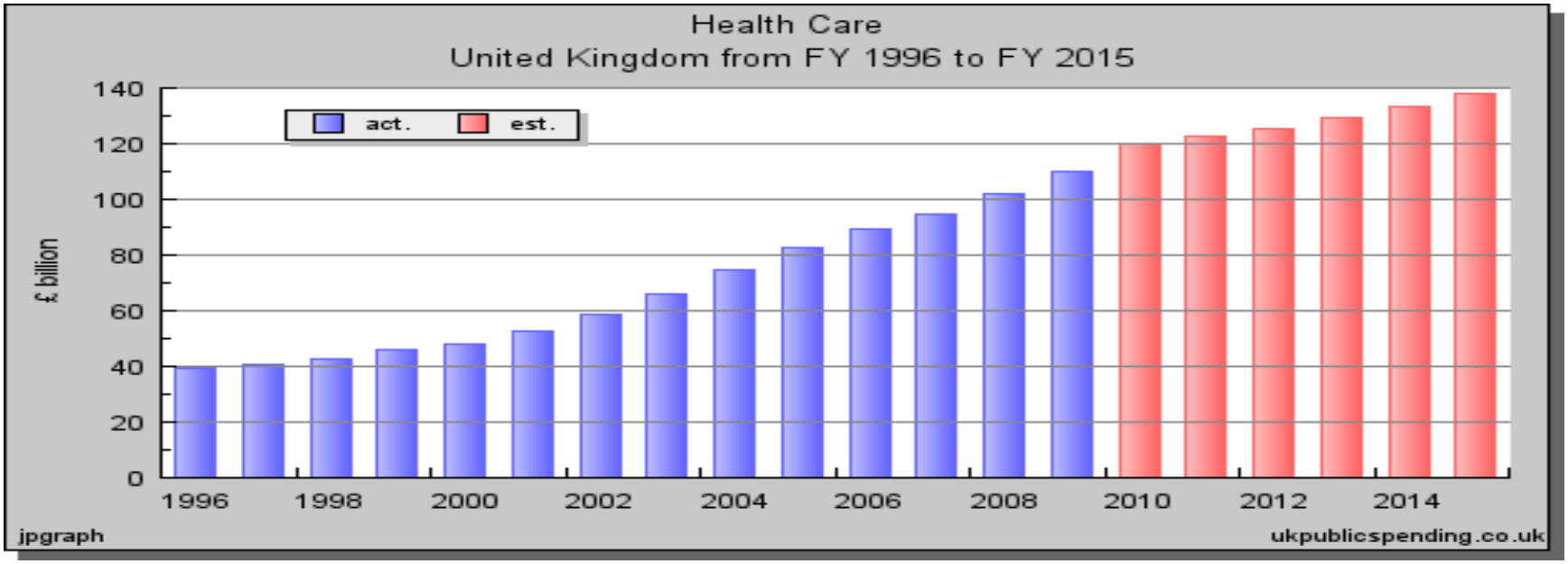
Source: U.S. Census Bureau, Population Projections 2008

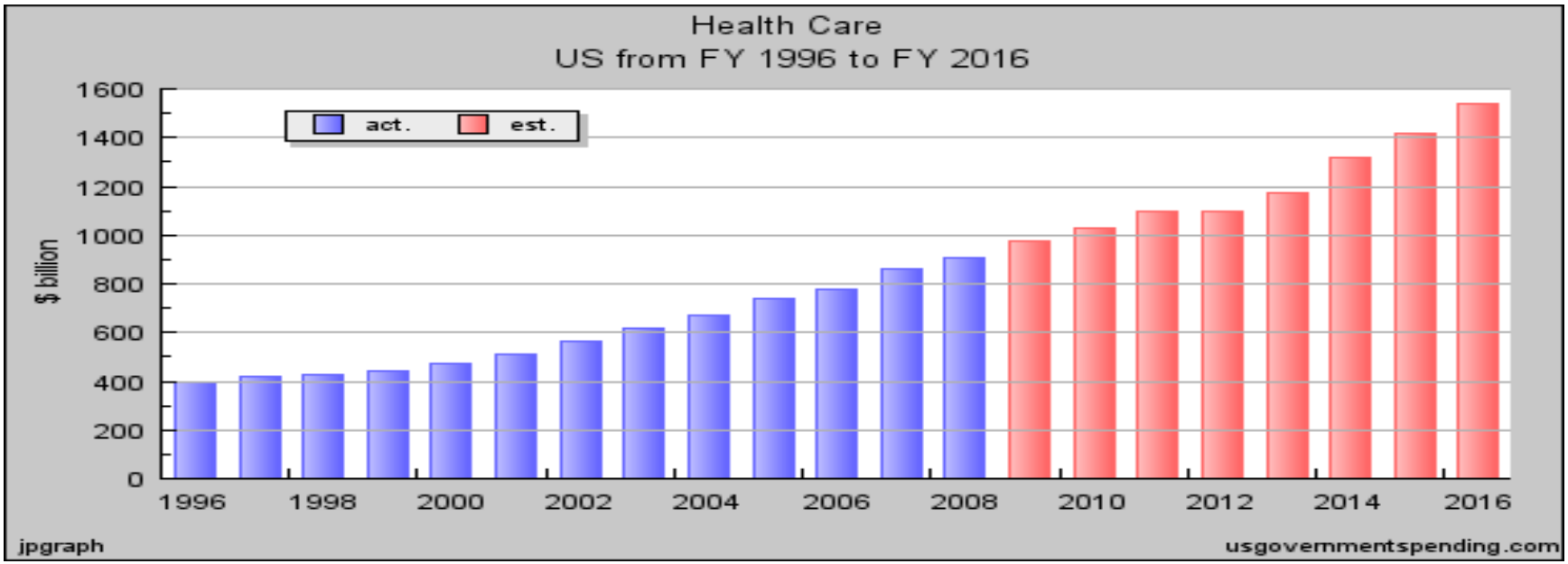
The U.S. health care system is the most expensive in the world.

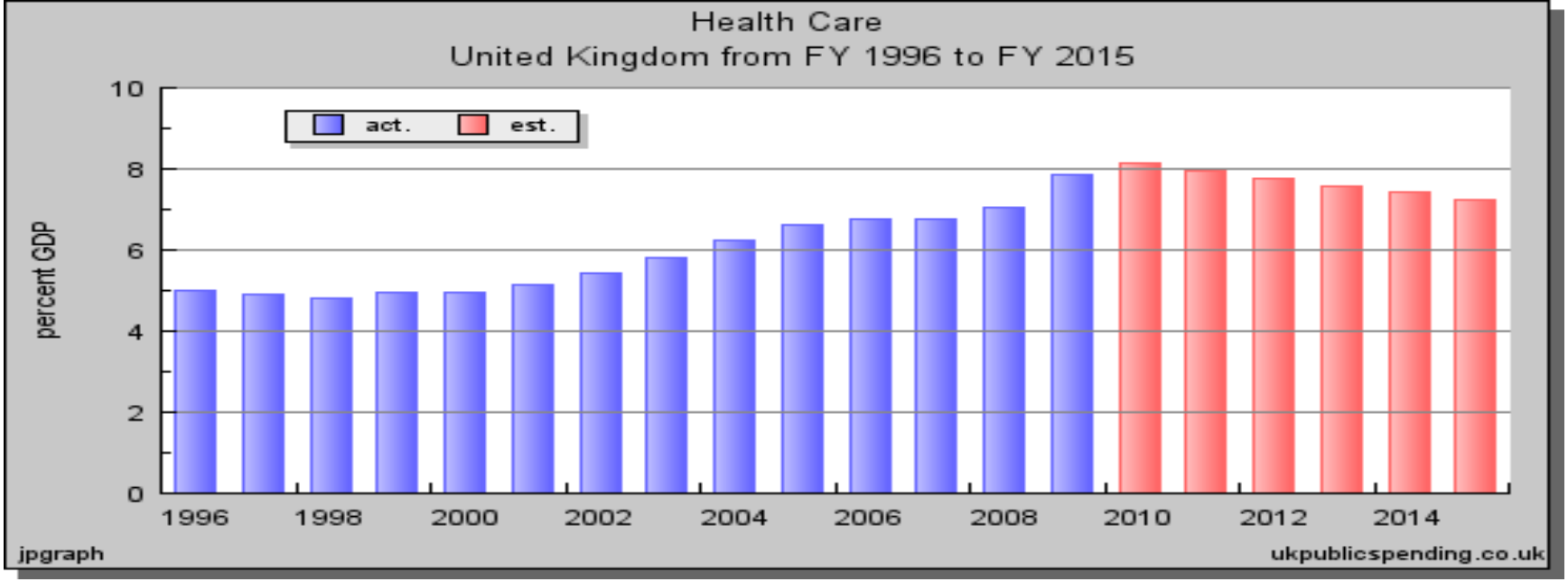


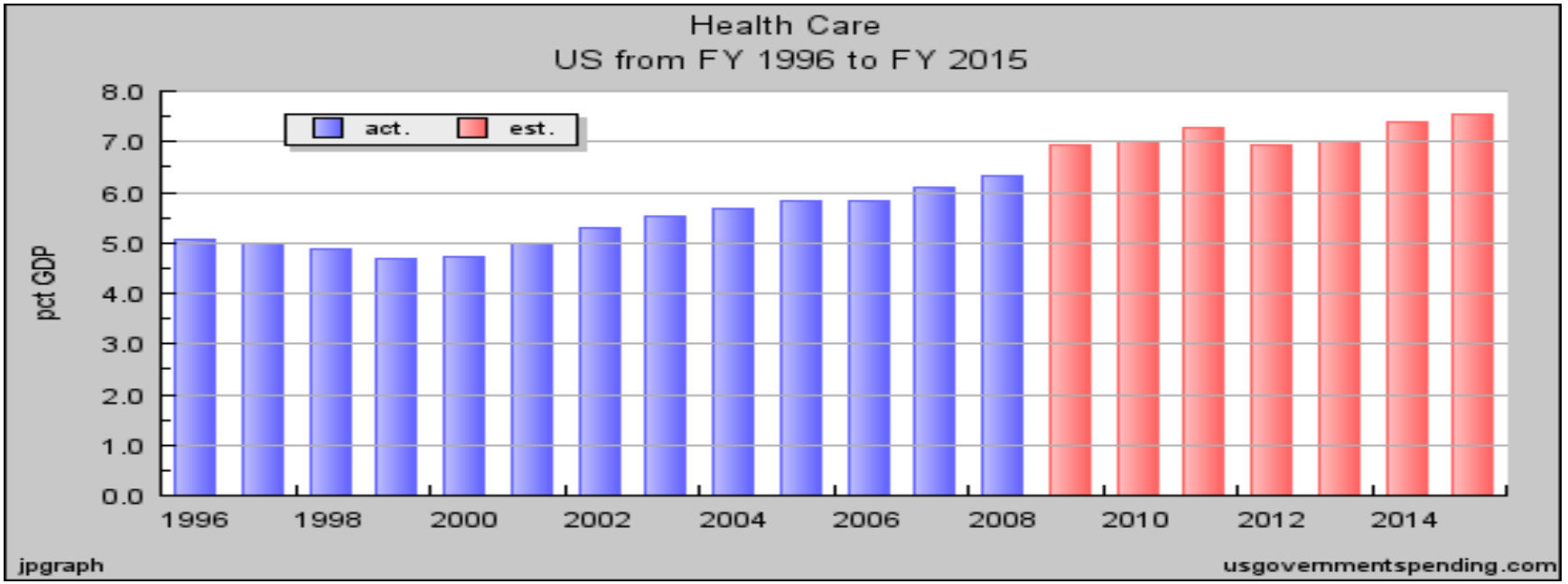
Total Expenditure on Health as percent of GDP

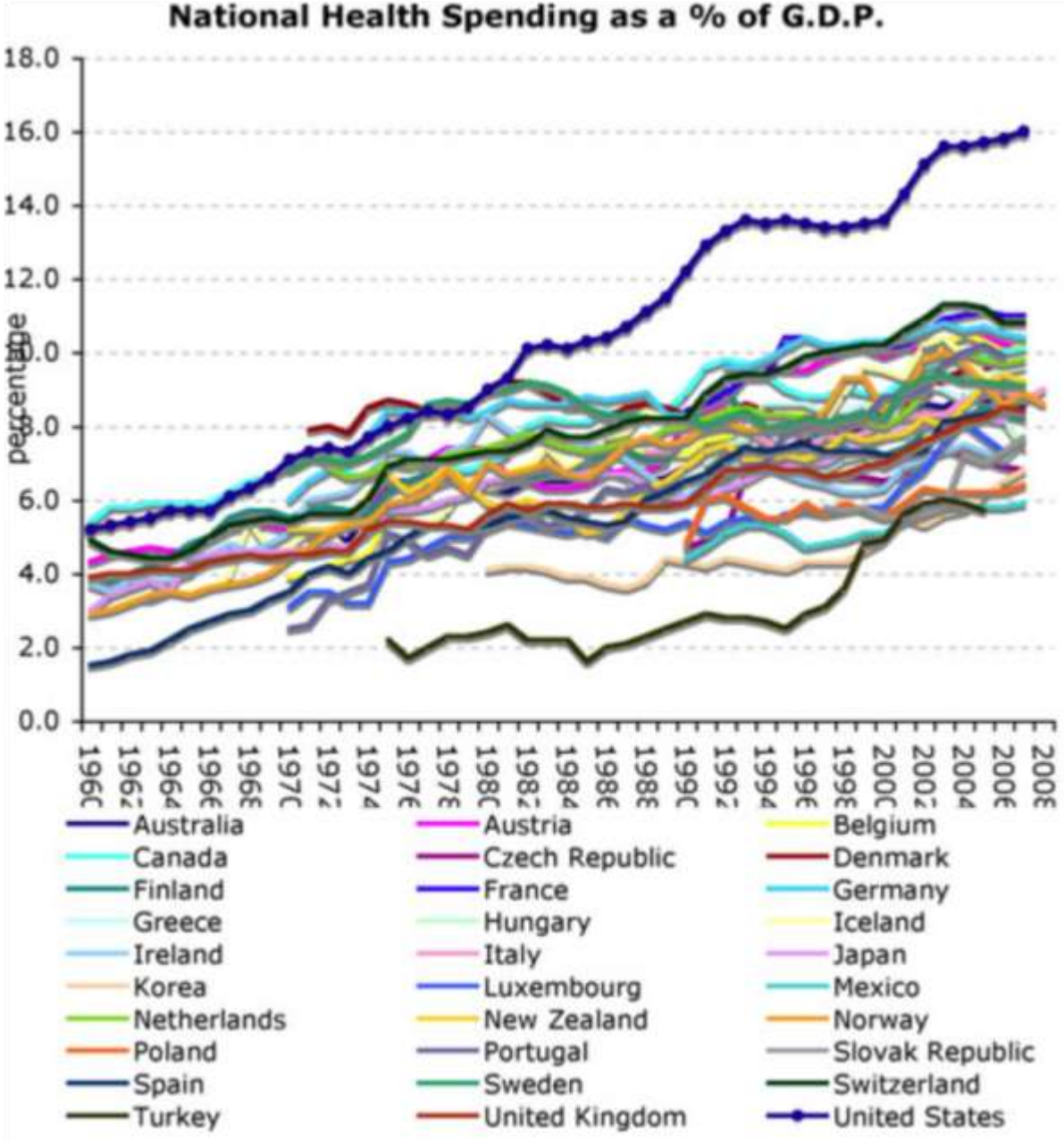
Source: World Health Organization data accessed 1/20/05 from WHO Web site: www.who.int/whr/2002/whr2002


Health Care
United Kingdom from FY 1996 to FY 2015
act.
est.
£ billion
0
20
40
60
80
100
120
140
1996
1998
2000
2002
2004
2006
2008
2010
2012
2014
jpgraph
ukpublicspending.co.uk

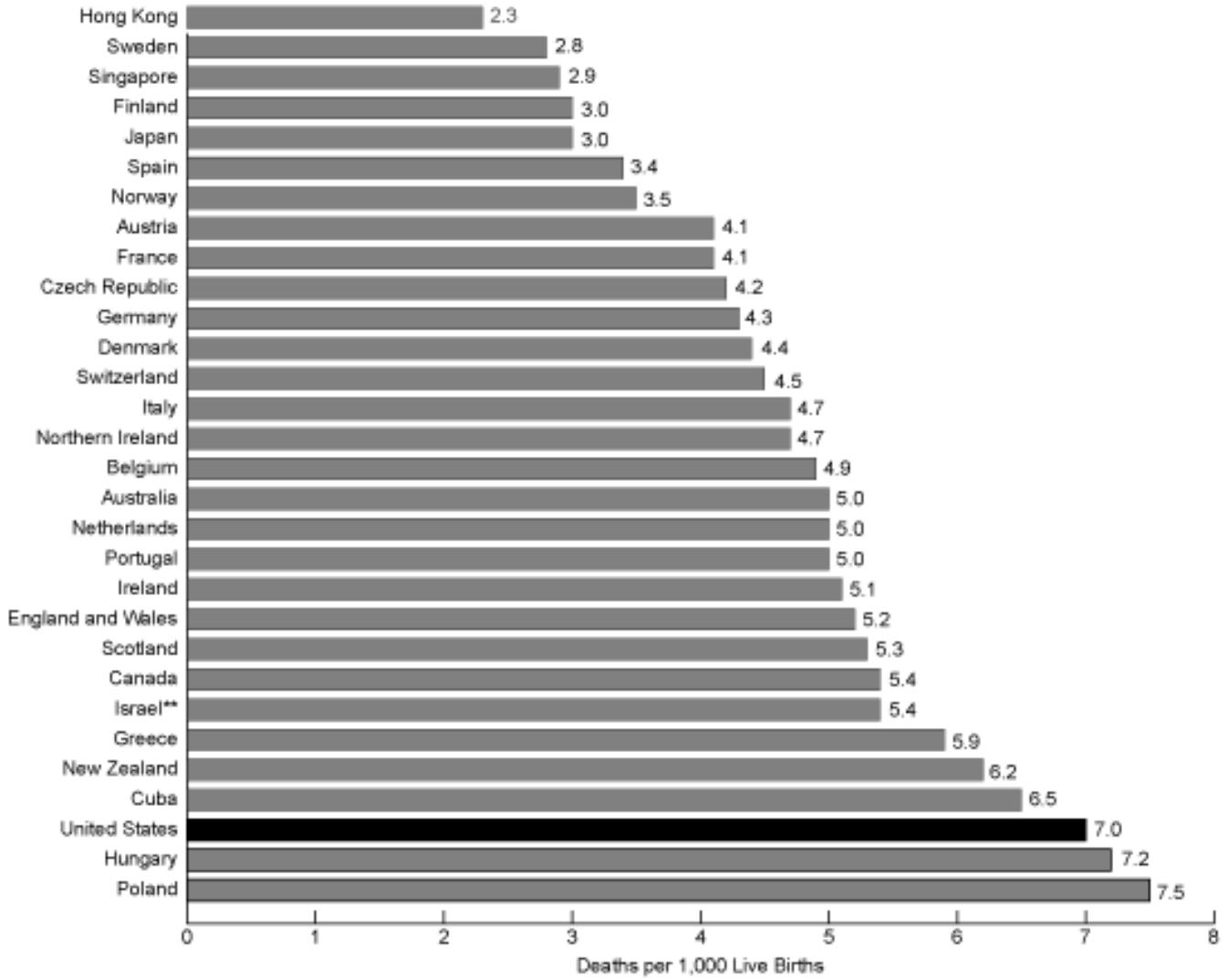

Health Care
US from FY 1996 to FY 2016
act.
est.
$ billion
0
200
400
600
800
1000
1200
1400
1600
1996
1998
2000
2002
2004
2006
2008
2010
2012
2014
2016
jpgraph
usgovernmentspending.com


Health Care
United Kingdom from FY 1996 to FY 2015
act.
est.
percent GDP
0
2
4
6
8
10
1996
1998
2000
2002
2004
2006
2008
2010
2012
2014
jpgraph
ukpublicspending.co.uk


Health Care
US from FY 1996 to FY 2015
act.
est.
pct GDP
0.0
1.0
2.0
3.0
4.0
5.0
6.0
7.0
8.0
1996
1998
2000
2002
2004
2006
2008
2010
2012
2014
jpgraph
usgovernmentspending.com

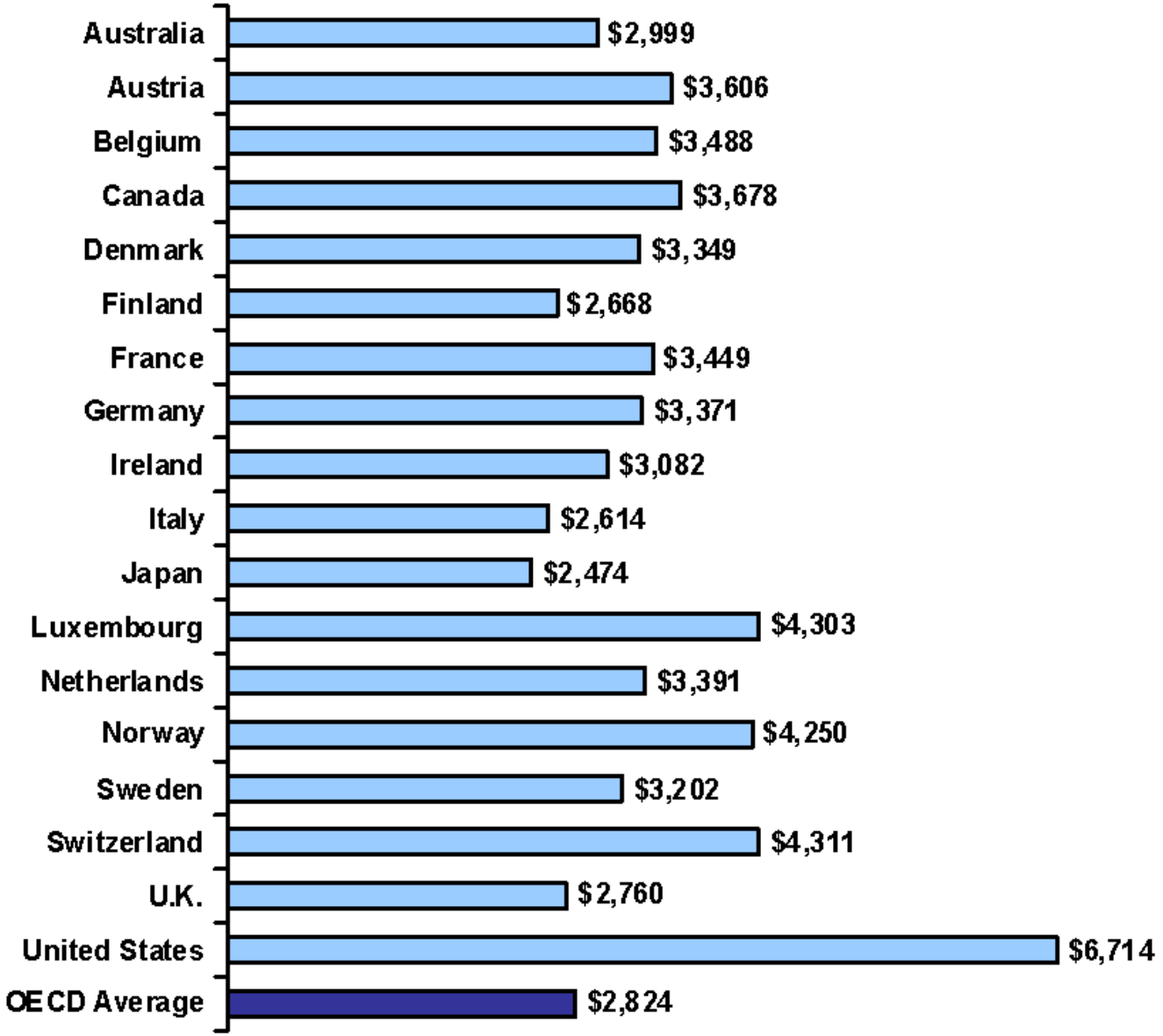

National Health Spending as a % of G.D.P.
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
percentage
Australia
Austria
Belgium
Canada
Czech Republic
Denmark
Finland
France
Germany
Greece
Hungary
Iceland
Ireland
Italy
Japan
Korea
Luxembourg
Mexico
Netherlands
New Zealand
Norway
Poland
Portugal
Slovak Republic
Spain
Sweden
Switzerland
Turkey
United Kingdom
United States

International Infant Mortality Rates:* 2002

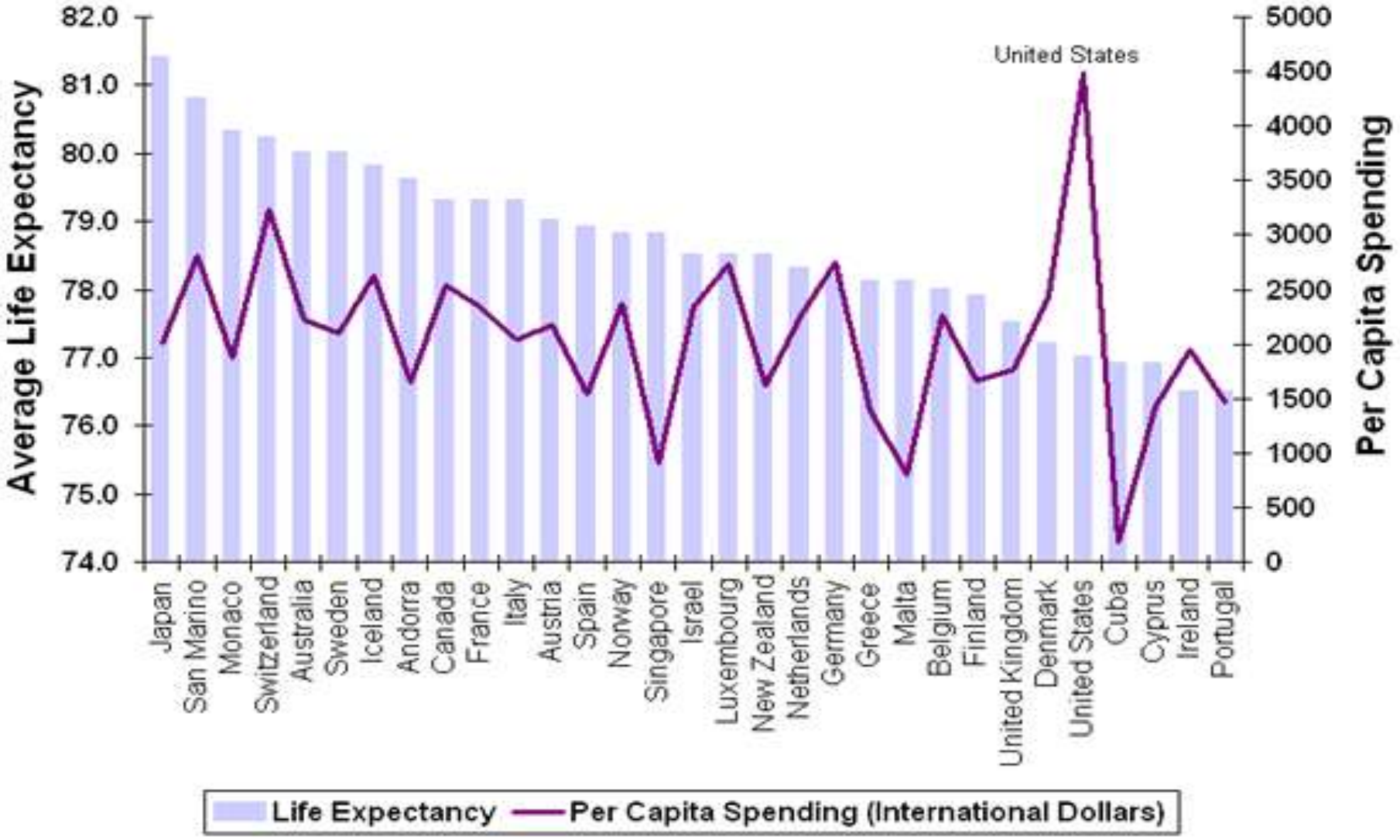


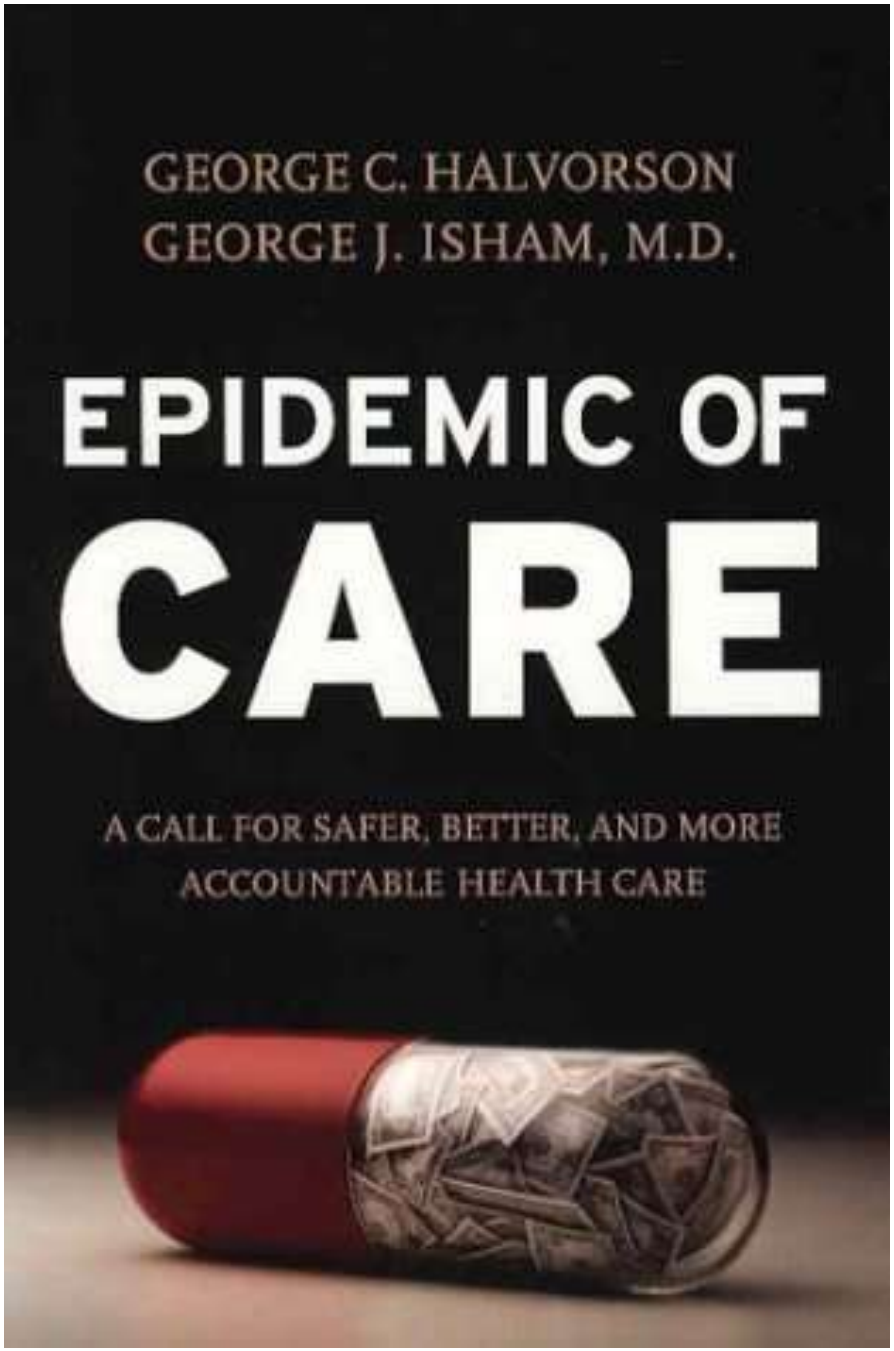
**Includes countries, territories, cities, or geographic areas with at least 1 million population and with "complete" counts of live births and infant deaths as indicated in the United Nations Demographic Yearbook. Some of the variation in infant mortality rates is due to differences among countries in distinguishing between fetal and infant deaths. **Includes data for East Jerusalem and Israeli residents in certain other territories under occupation by Israeli military forces since June 1967.*

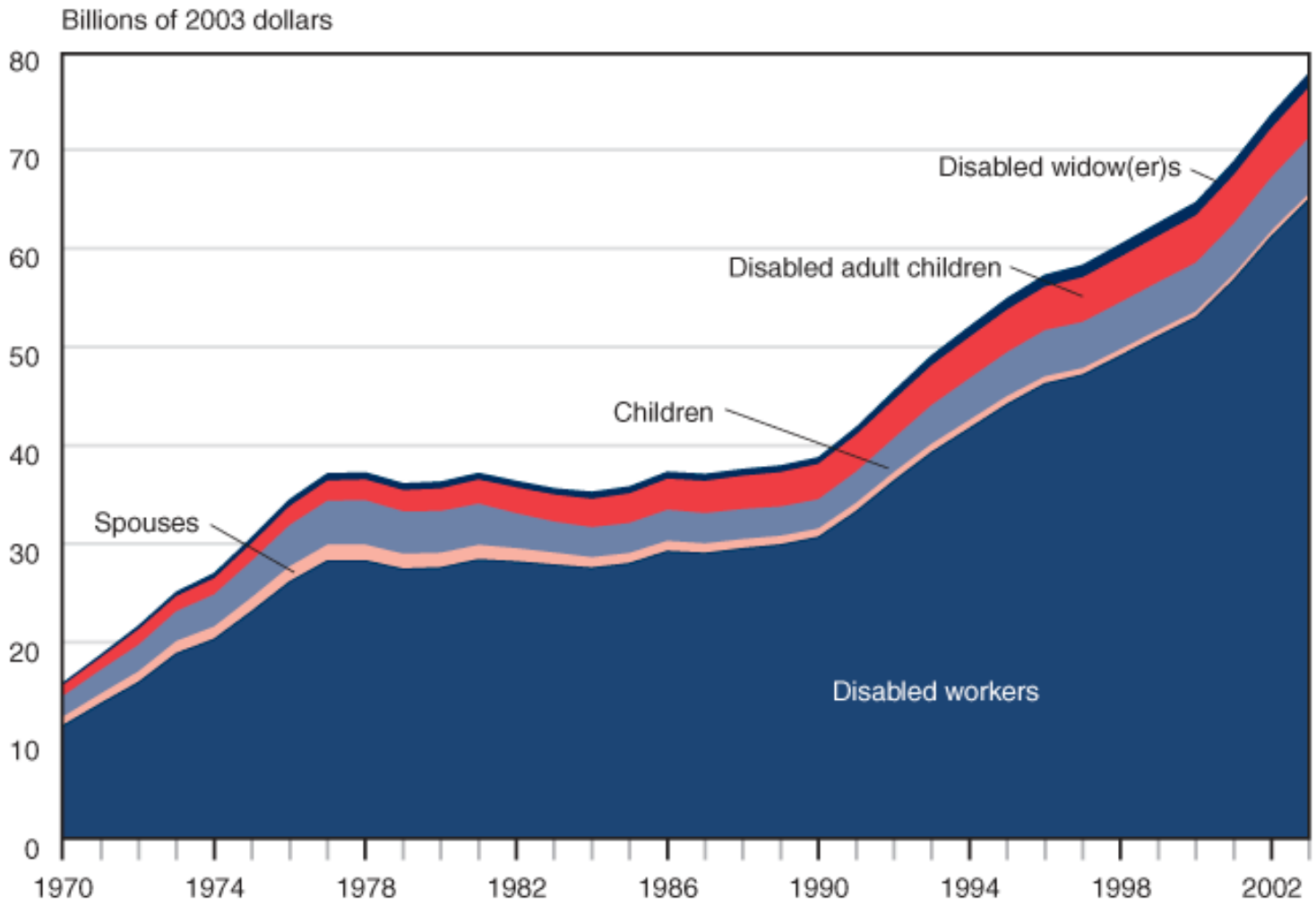
Figure 1.4. Total Health Expenditures Per Capita, U.S. and Selected Countries, 2006



Amounts in U.S.D. Source: Organisation for Economic Co-operation and Development, *OECD Health Data 2008*, updated August 26, 2008. http://www.oecd.org/health/healthdata.

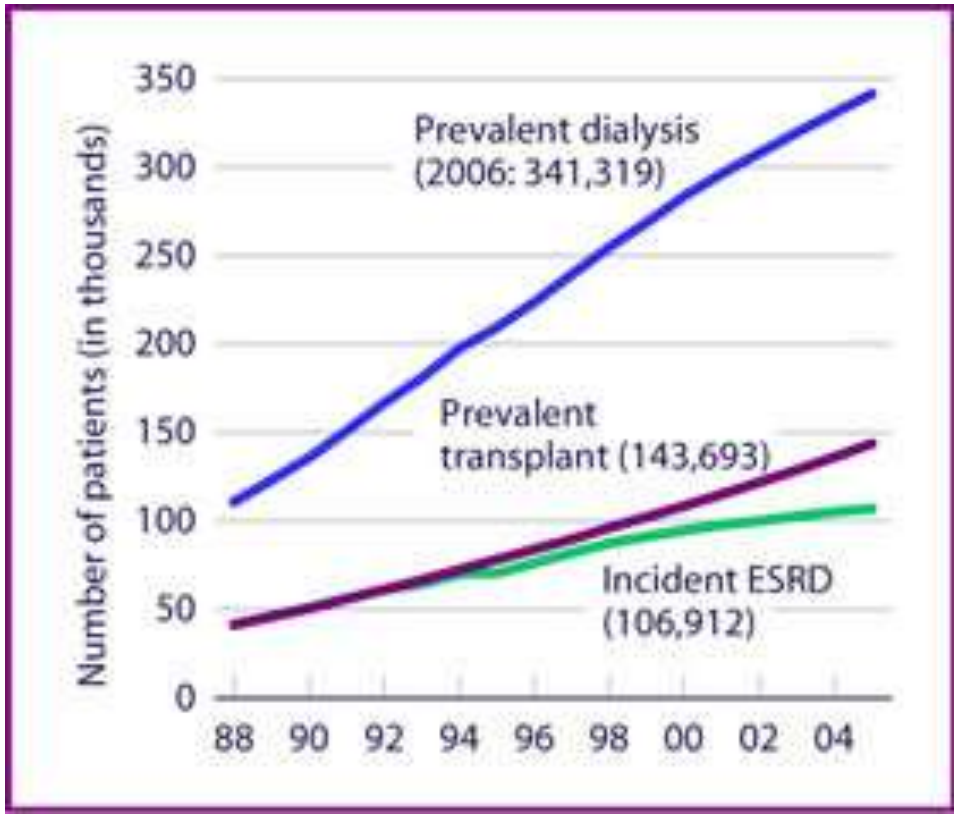

Average Life Expectancy
82.0
81.0
80.0
79.0
78.0
77.0
76.0
75.0
74.0
Per Capita Spending
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
United States
Japan
San Marino
Monaco
Switzerland
Australia
Sweden
Iceland
Andorra
Canada
France
Italy
Austria
Spain
Norway
Singapore
Israel
Luxembourg
New Zealand
Netherlands
Germany
Greece
Malta
Belgium
Finland
United Kingdom
Denmark
United States
Cuba
Cyprus
Ireland
Portugal
Life Expectancy
Per Capita Spending (International Dollars)


GEORGE C. HALVORSON
GEORGE J. ISHAM, M.D.
EPIDEMIC OF
CARE
A CALL FOR SAFER, BETTER, AND MORE
ACCOUNTABLE HEALTH CARE


Billions of 2003 dollars
80
70
60
50
40
30
20
10
0
1970
1974
1978
1982
1986
1990
1994
1998
2002
Disabled widow(er)s
Disabled adult children
Children
Spouses
Disabled workers

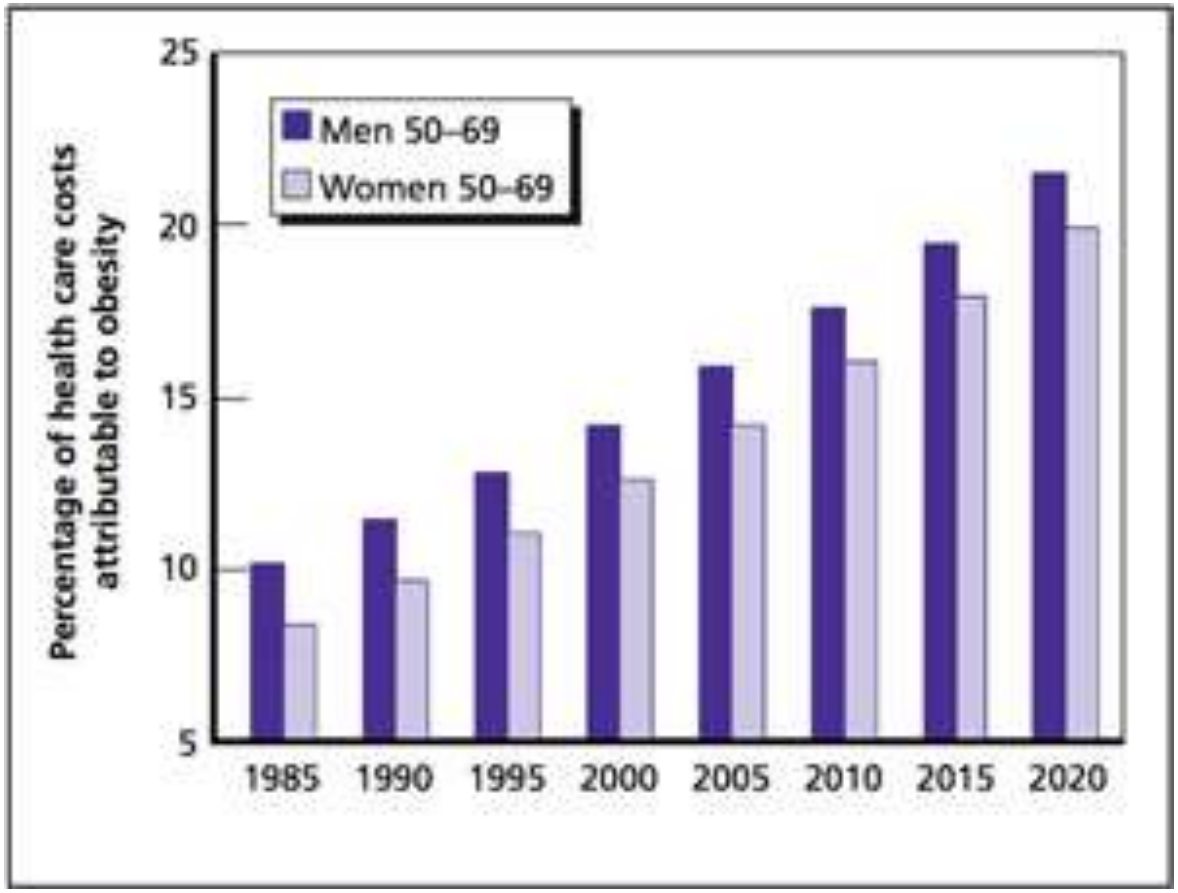
r

Chronic renal disease



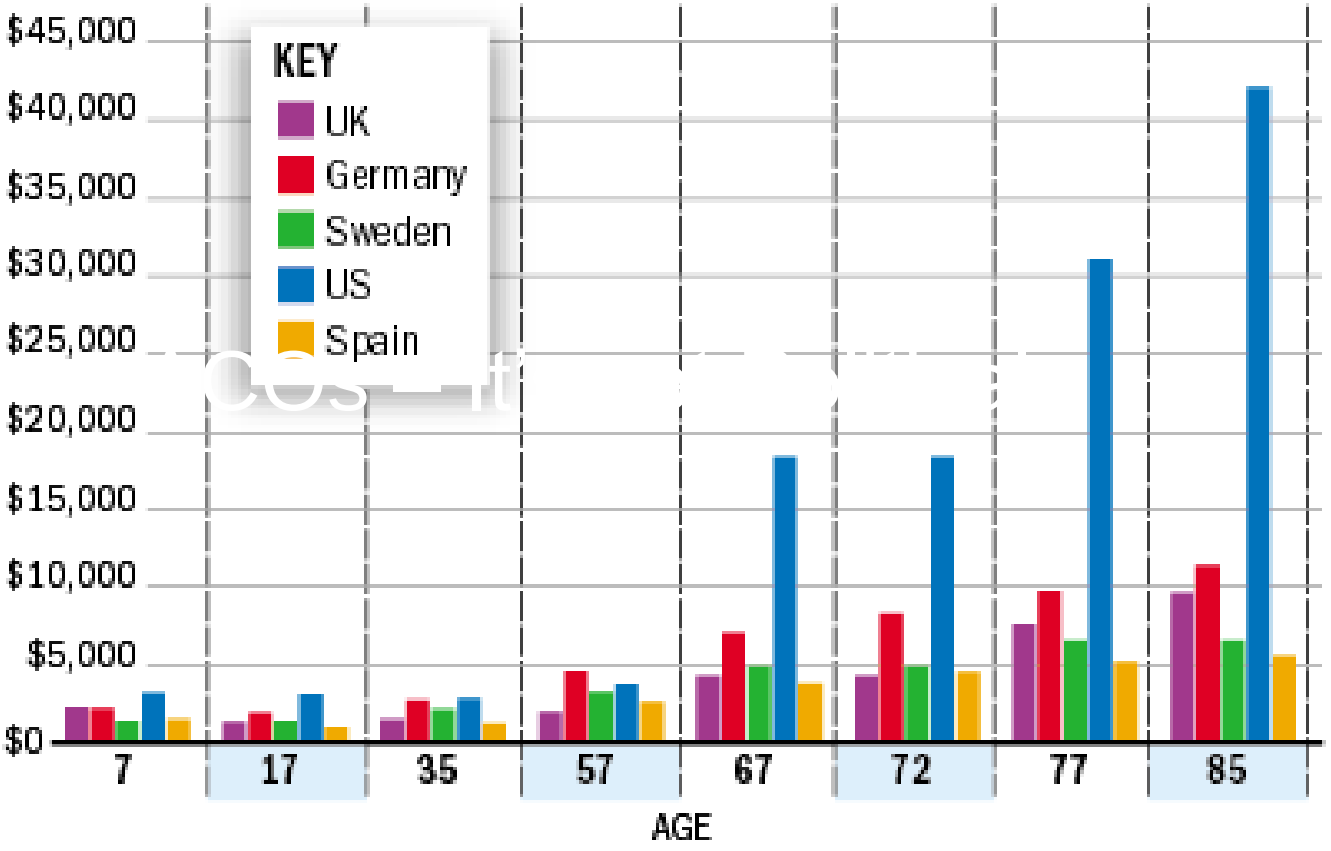
6.6% Medicare population has CKD, 1.2% ESRD
8.1% of MCMA population has CKD, 2.7% ESRD
19.4% of MC dollars on CKD, 8.2% on ESRD
Growing 2% per year

o


Men 50–69
Women 50–69
Percentage of health care costs attributable to obesity
25
20
15
10
5
1985
1990
1995
2000
2005
2010
2015
2020

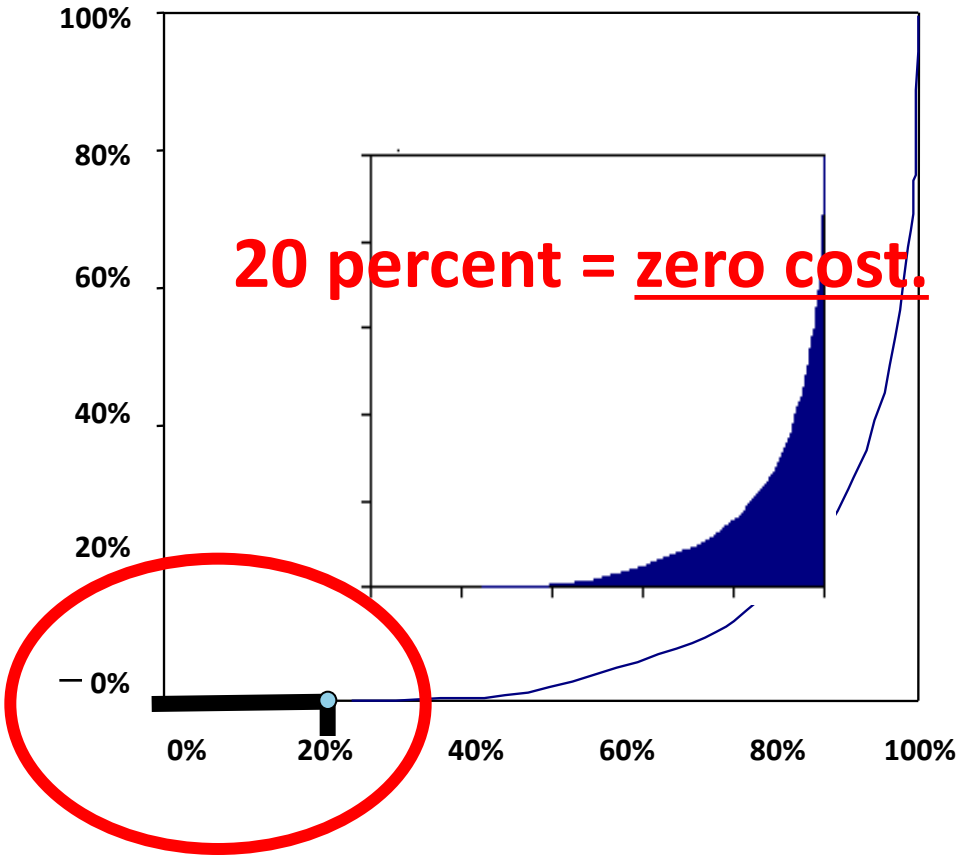
Health care costs: U.S. spends more for elderly

Annual per capita healthcare costs by age



Source: Paul Fischbeck, Carnegie Mellon University James Hilston/Post-Gazette

Cost distribution of care (Working Americans)

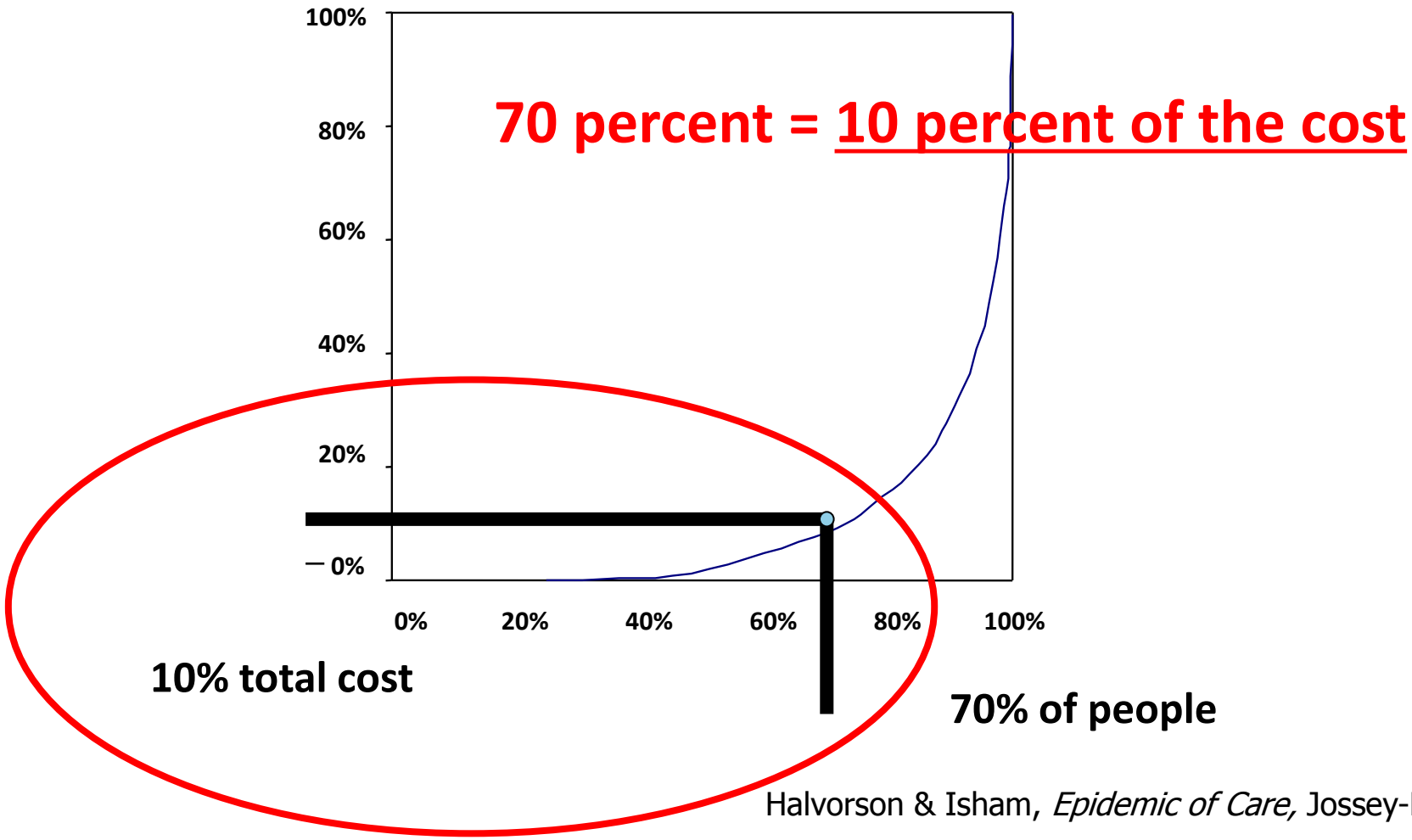


0% total cost

20% of people

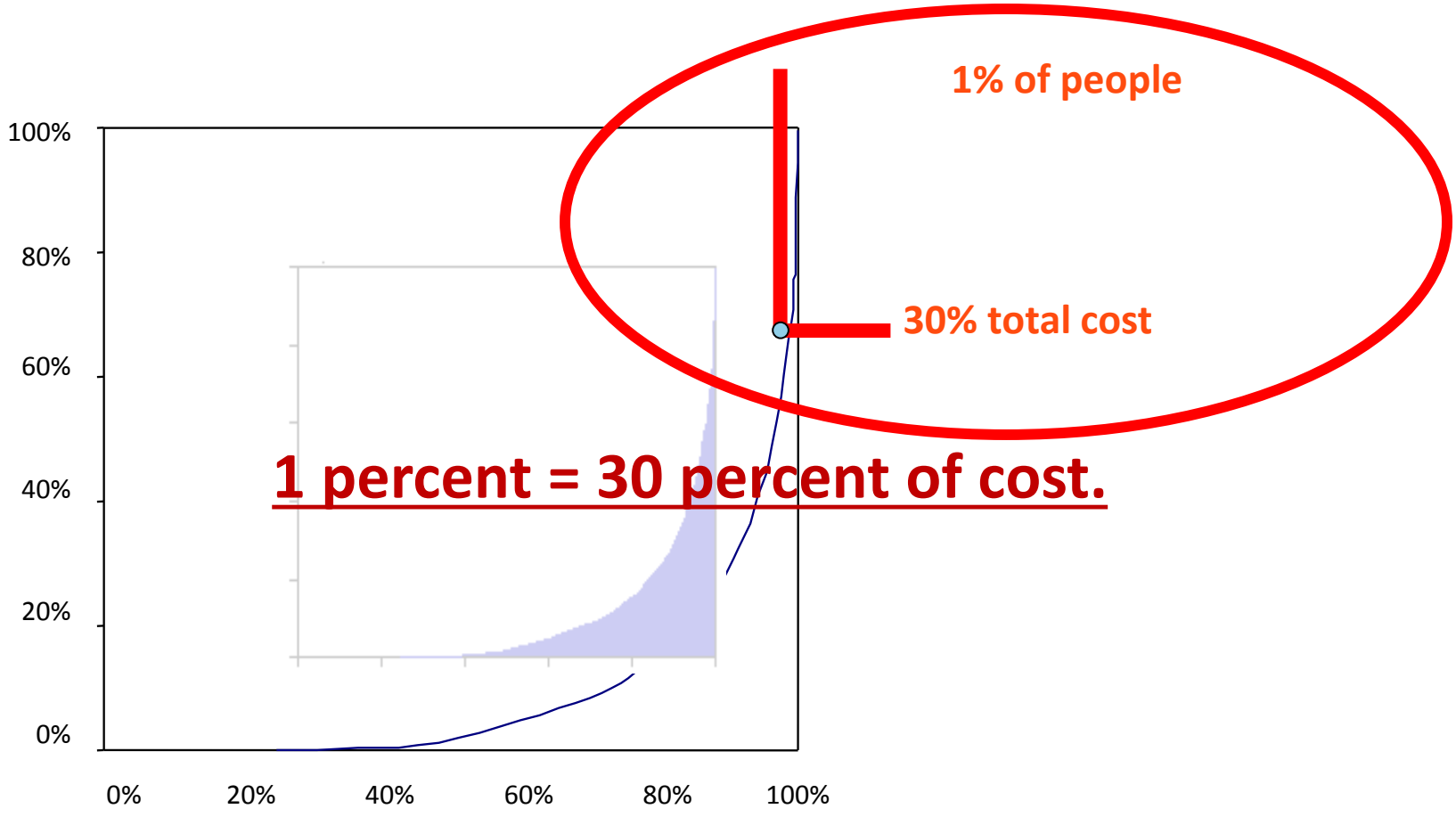
Halvorson & Isham, *Epidemic of Care,* Jossey-Bass: 2003

Cost distribution of care (Working Americans)

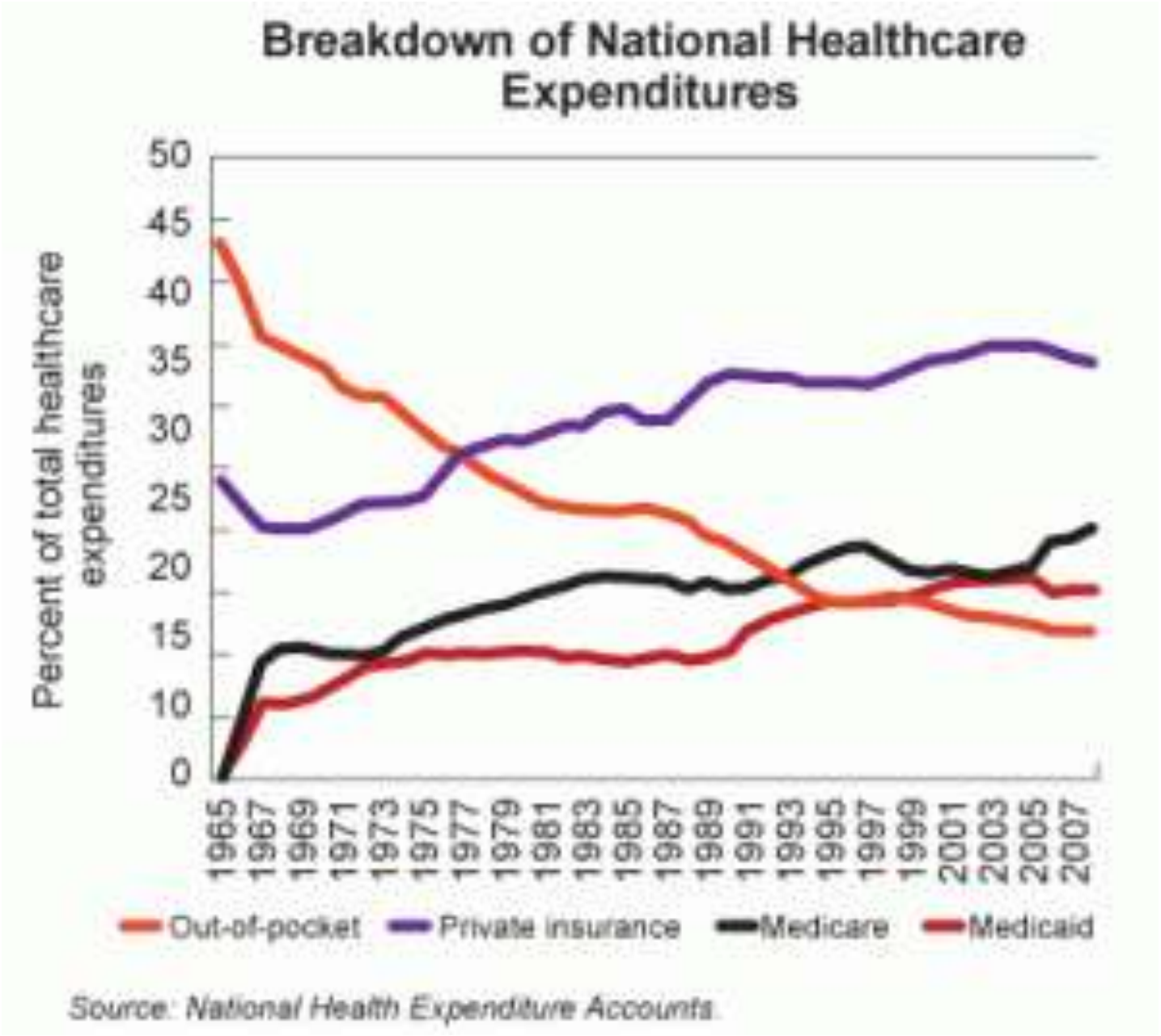


Halvorson & Isham, *Epidemic of Care,* Jossey-Bass: 2003

Cost distribution of care (Working Americans)

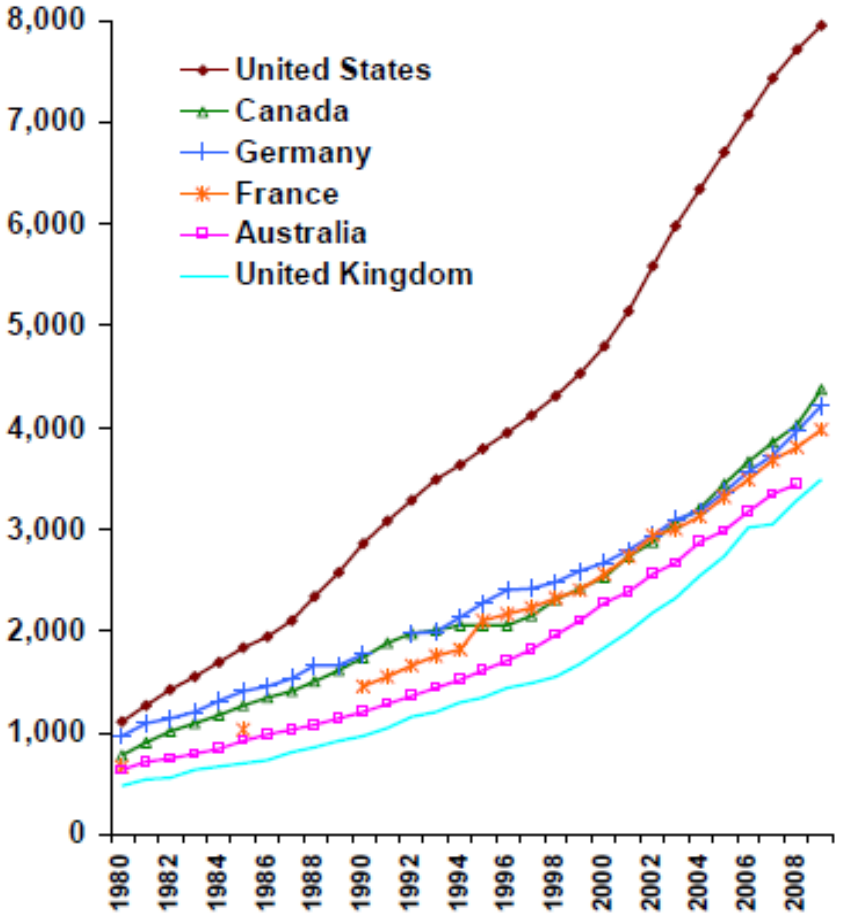


Halvorson & Isham, *Epidemic of Care,* Jossey-Bass: 2003

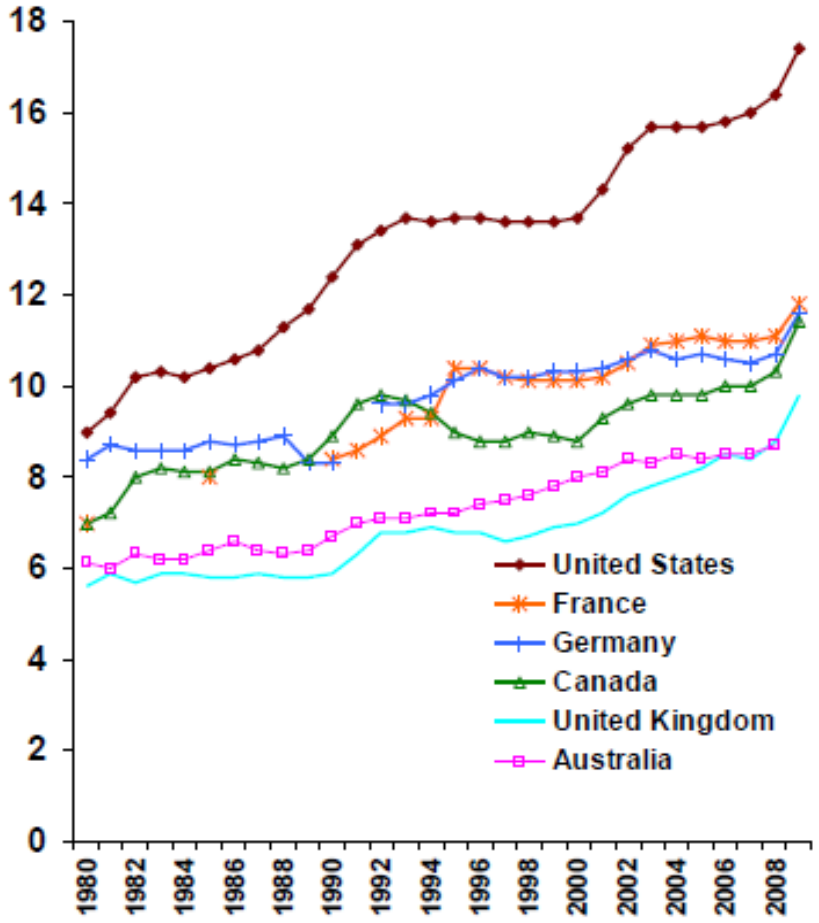

Breakdown of National Healthcare Expenditures
Percent of total healthcare expenditures
50
45
40
35
30
25
20
15
10
0
1965
1967
1969
1971
1973
1975
1977
1979
1981
1983
1985
1987
1989
1991
1993
1995
1997
1999
2001
2003
2005
2007
Out-of-pocket
Private insurance
Medicare
Medicaid
Source: National Health Expenditure Accounts

International Comparison of Spending on Health, 1980–2009

Average spending on health per capita ($US PPP*)

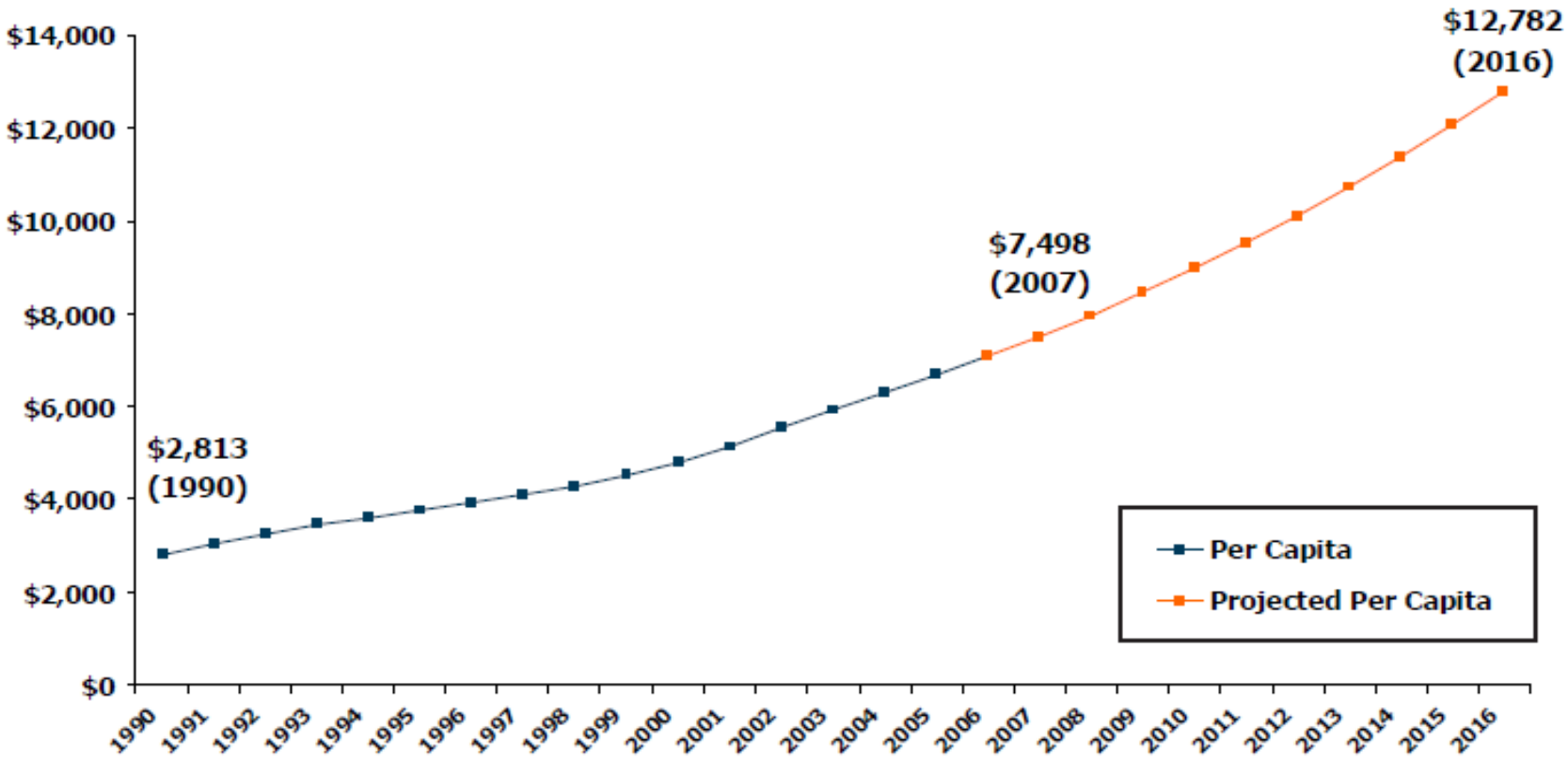


Total expenditures on health as percent of GDP



* PPP=Purchasing Power Parity.
Data: OECD Health Data 2011 (database), version 6/2011.

Exhibit 1: National Health Expenditures per Capita, 1990-2016



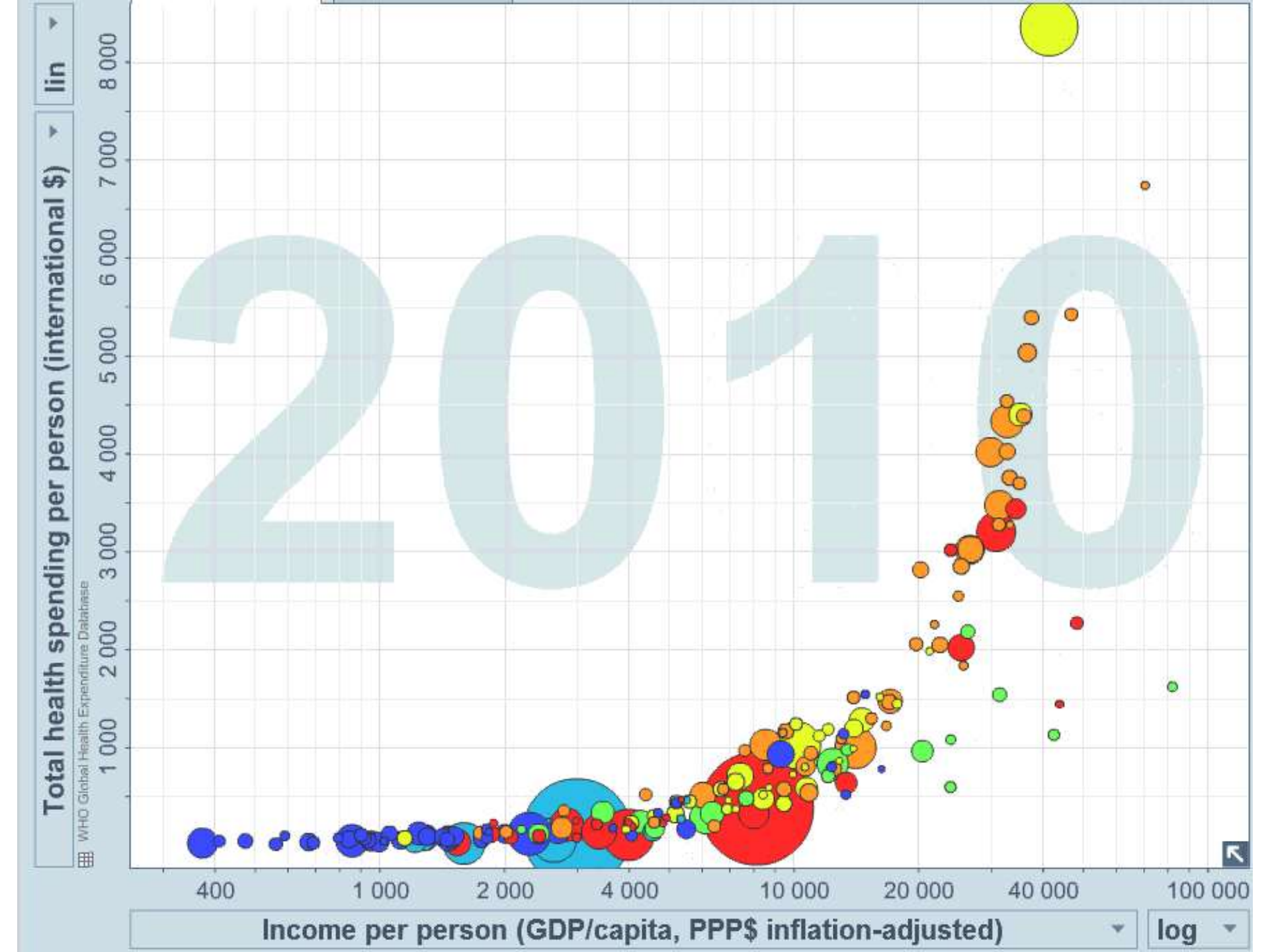
Note: Figures from 1990 through 2005 represent historical data; data from 2006-2016 are projected.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (Historical data from NHE summary including share of GDP, CY 1960-2005, file nhegdp05.zip; Projected data from NHE Projections 2006-2016, Forecast summary and selected tables, file proj2006.pdf).

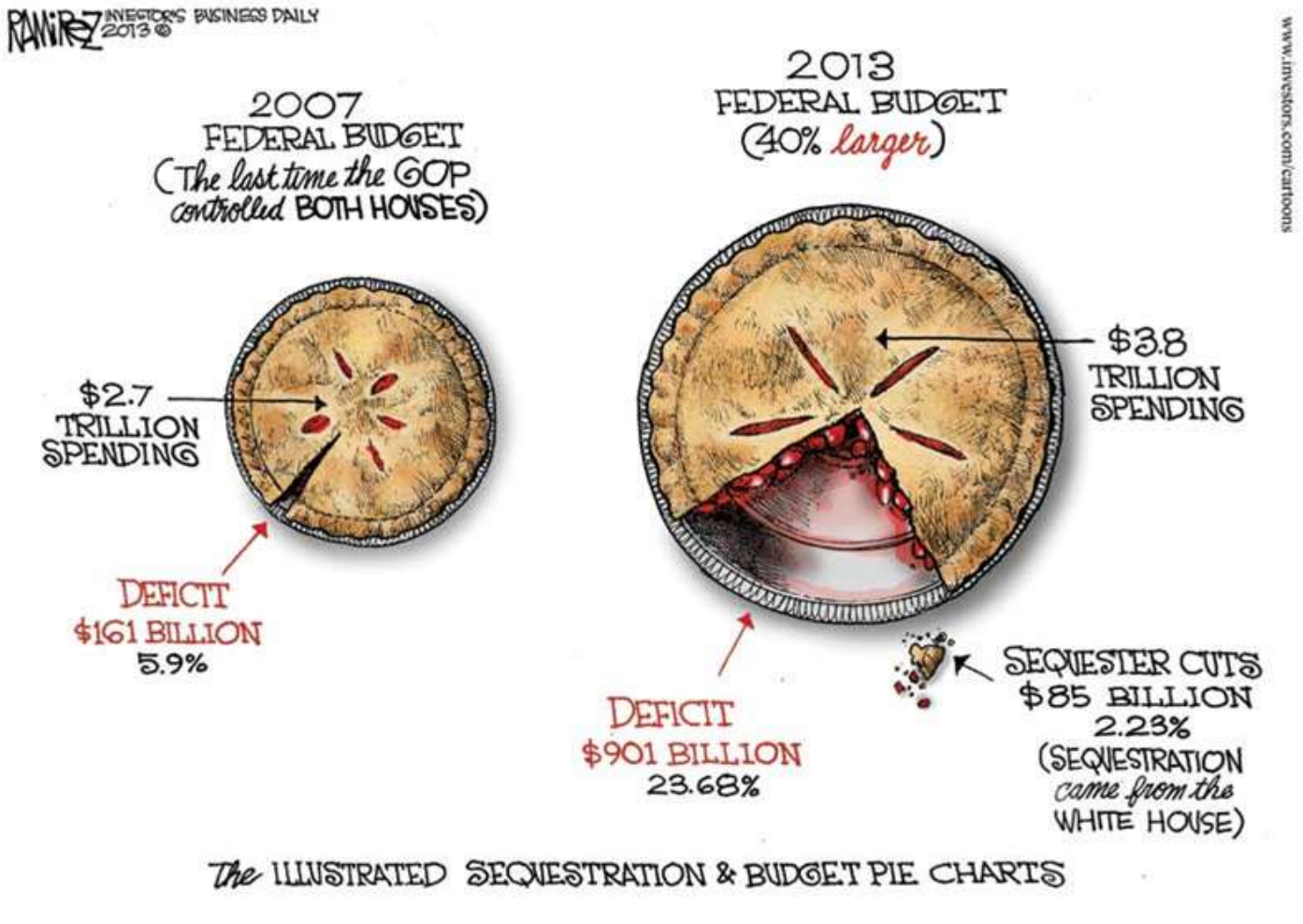
OVER-DIAGNOSED

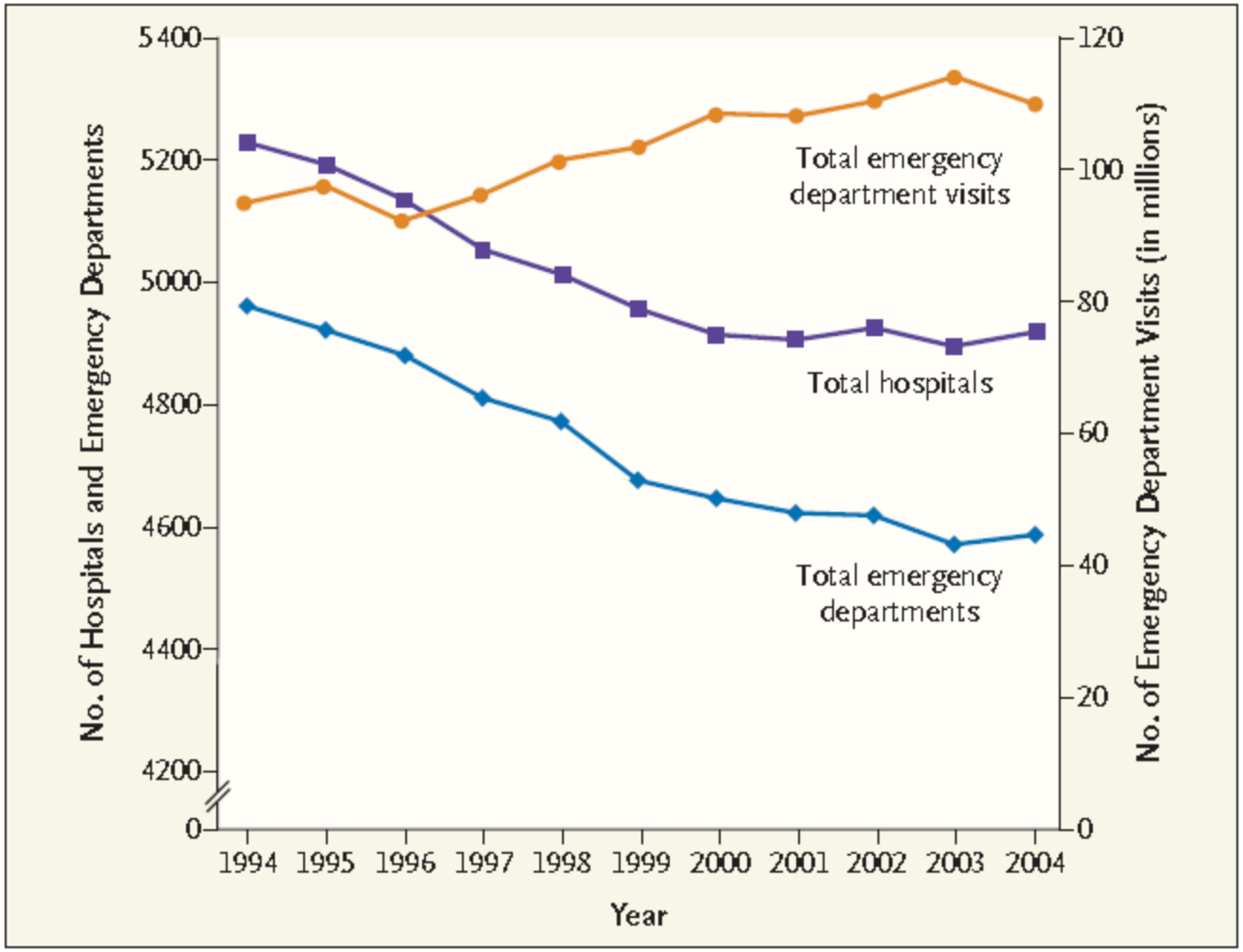
MAKING PEOPLE SICK IN THE PURSUIT OF HEALTH

DR. H. GILBERT WELCH,
DR. LISA M. SCHWARTZ, AND DR. STEVEN WOLOSHIN


Total health spending per person (international $)
lin
1 000
2 000
3 000
4 000
5 000
6 000
7 000
8 000
2010
WHO Global Health Expenditure Database
400
1 000
2 000
4 000
10 000
20 000
40 000
100 000
Income per person (GDP/capita, PPP$ inflation-adjusted)
log

Something Has to Give – Eventually?? (doesn't it?!)





Trends in Emergency Department Visits, Number of Hospitals, and Number of Emergency Departments in the United States, 1994–2004.

Visits to the emergency department represent about 10% of all outpatient visits in the United States. Data are from the National Health Policy Forum.

APRIL 15, 2013, 12:01 AM

Avoiding Emergency Rooms

By JANE E. BRODY

On a recent Sunday afternoon, a 75-year-old Philadelphia man with a fever of over 102 degrees was unable to reach his doctor. So his daughter took him to an emergency room, where the two sat for hours until he was examined by a physician who found no reason for the fever and decided to admit him overnight.

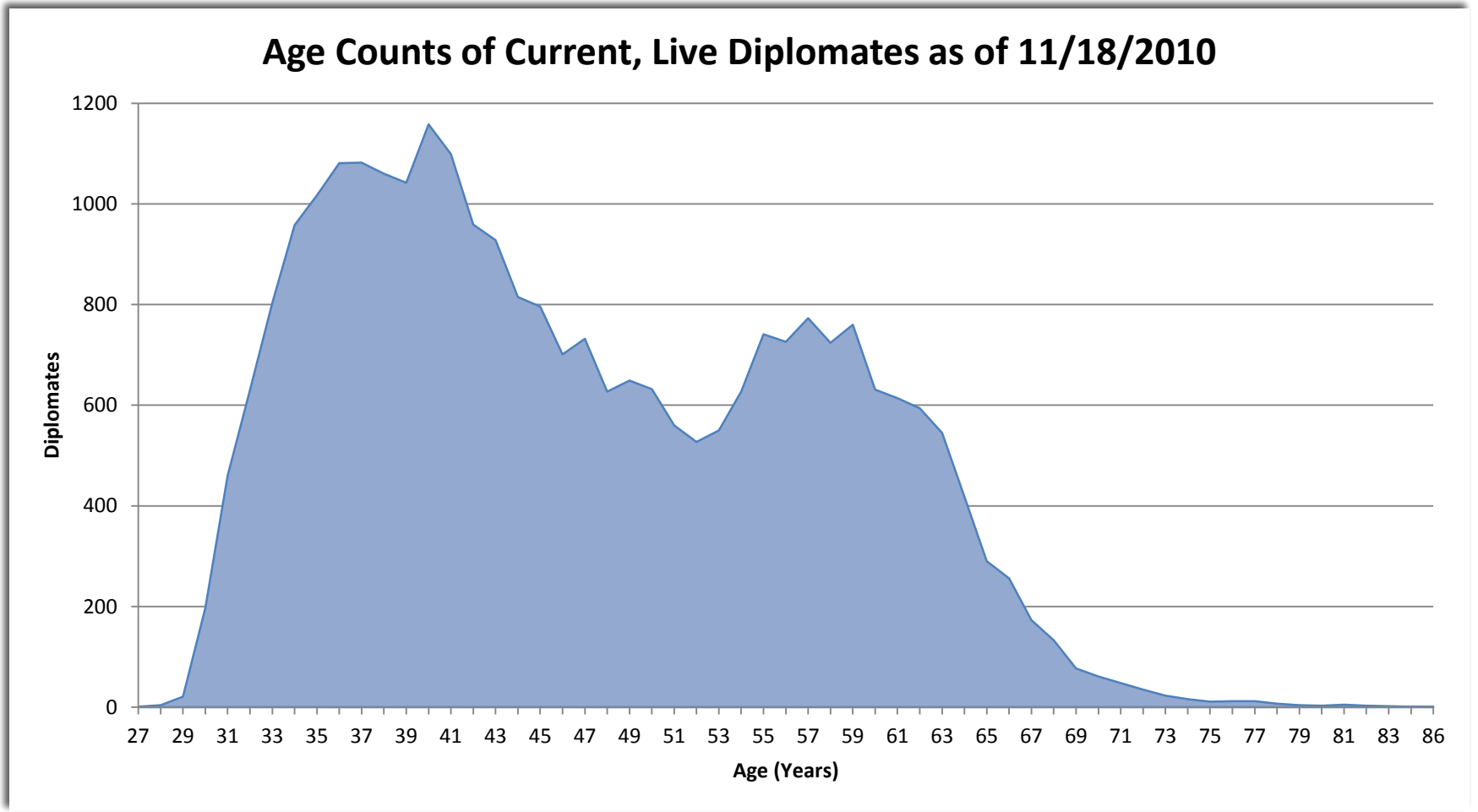
The man was given oxygen, a chest X-ray, a blood test and, finally, a urine test, which revealed a urinary tract infection. The problem was solved with a prescription for an antibiotic, but at a cost of thousands of dollars to Medicare.

Like so many other health issues seen in American emergency rooms, the man's infection was a common problem easily diagnosed and treated at a fraction of the cost by a primary care physician — if patients could reach their doctors when needed.

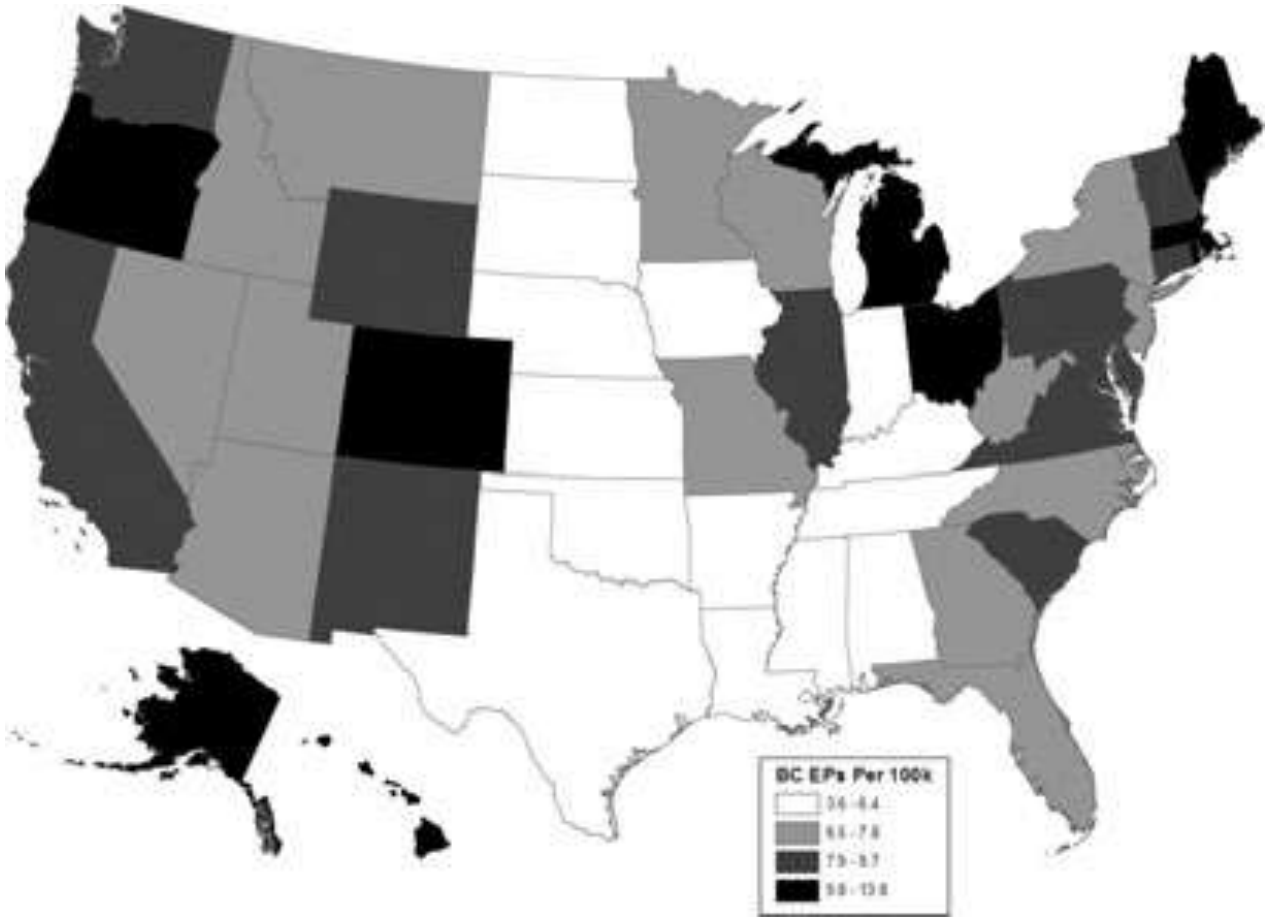
Workforce

- Aging practitioners
- Shortage of
  - Primary Care
  - General Surgeons
  - Emergency Physicians

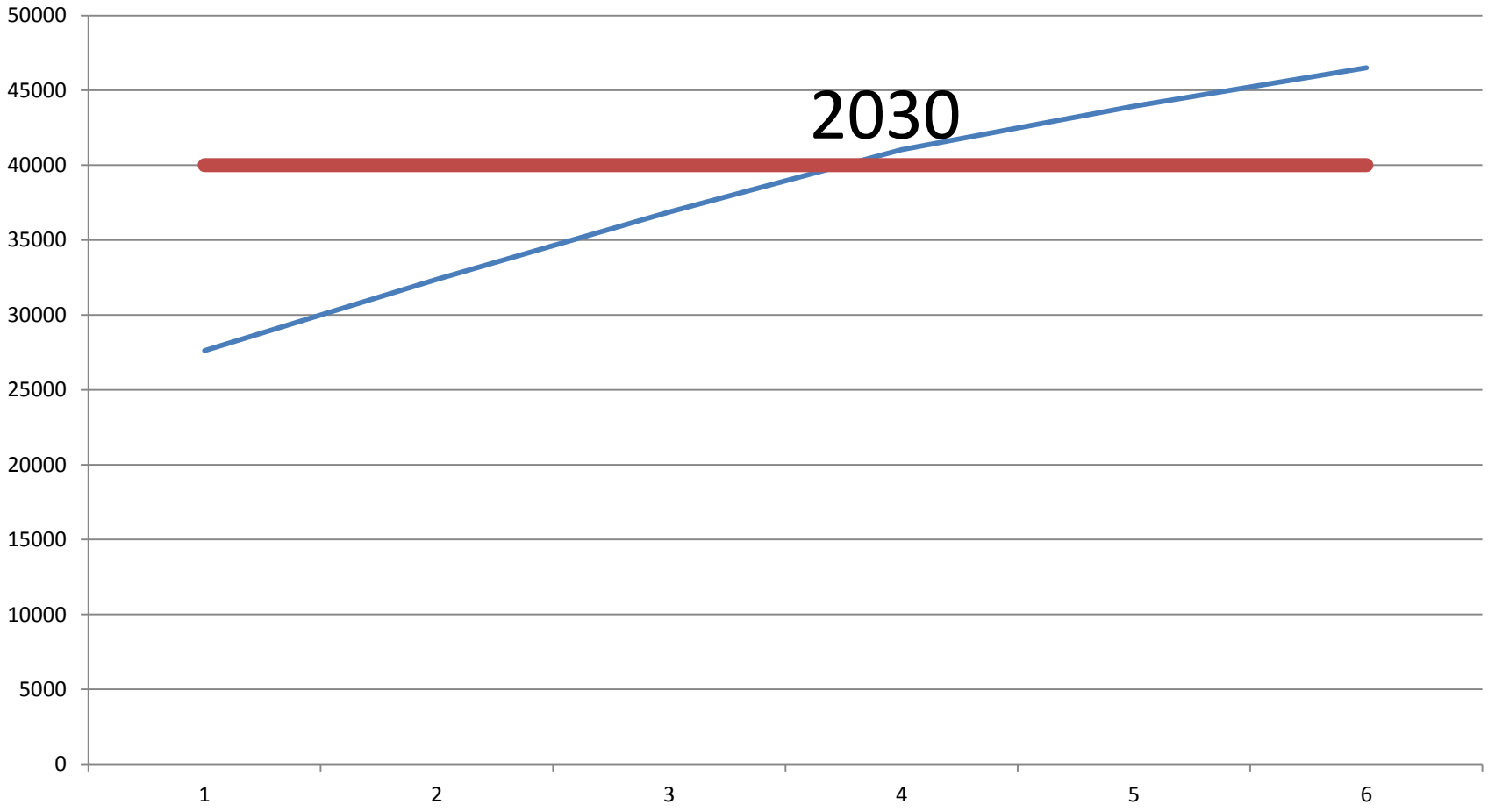
Age distribution of ABEM Diplomates



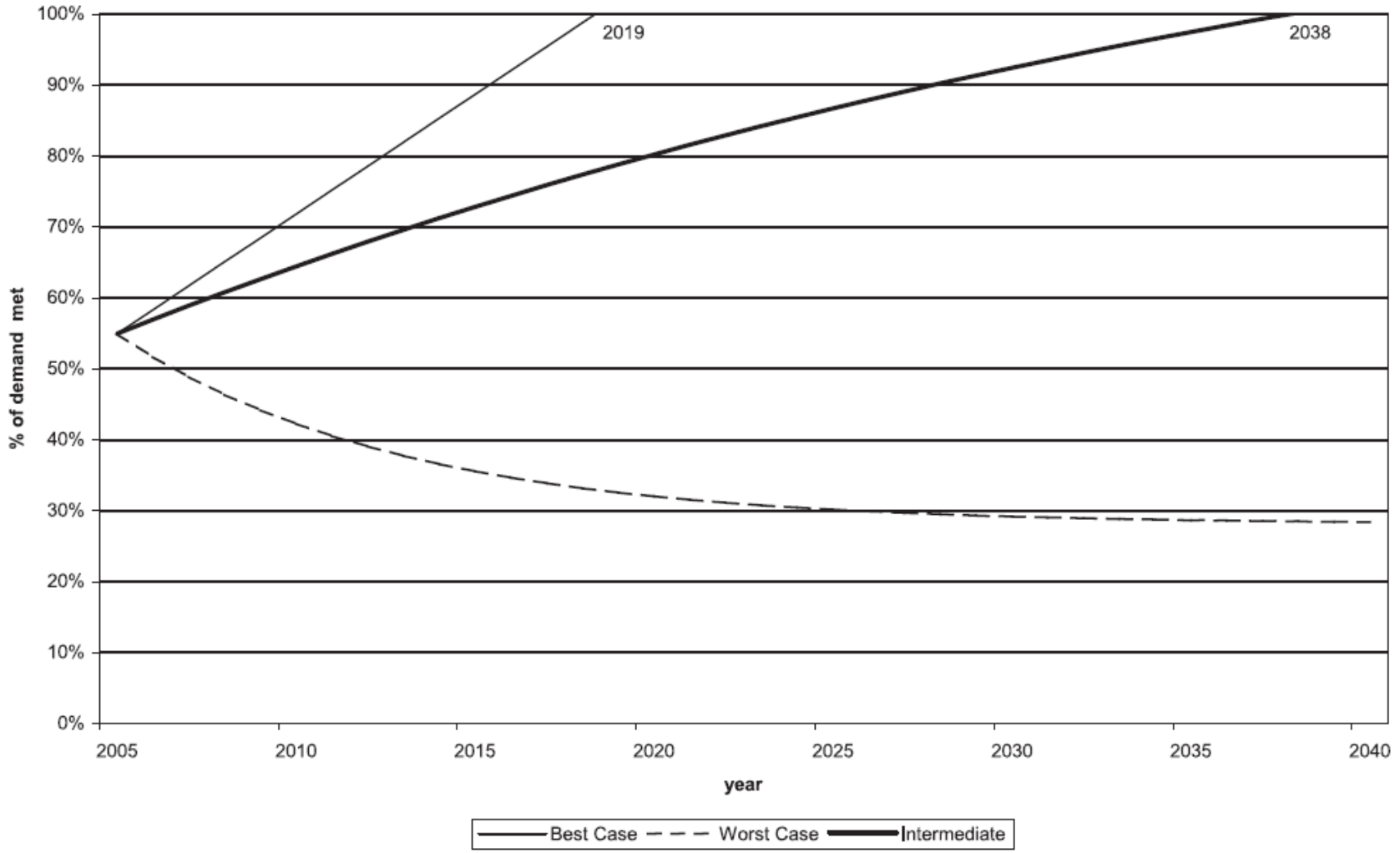
Number of EM BC/100K



Number of ABEM diplomates



Camargo *Acad Emerg Med* 2008



When 'Doctor' Doesn't Mean 'Physician'

By Matthew Weinstock
H&HN Assistant Managing Editor

April 25, 2013

Nurse practitioner leads the charge in performance improvement at a critical access hospital.

Steven Kelley's office is located next to the emergency department at Ellenville Regional Hospital.

"If I walk out and see someone sitting in the waiting room, I go over and ask what they are waiting for," says Kelley, CEO of the critical access hospital in upstate New York. "If the answer is anything other then they are waiting for a ride home, well, I want to know why."

For the most part, patients in Ellenville's ED are waiting for that ride. Over the course of the past few years, the hospital has cut the average ED length of stay from a mind-numbing three-plus hours to just 92 minutes, and that's in an ED where volume has grown from 7,000 visits in 2004 to 13,500.

"Everyone told me that our wait time was slightly better than average," Kelley says of that three-plus hours. "I think of average as mediocre. Being slightly better than mediocre? I don't think much of that."

Kelley exudes passion and confidence when he talks about the transformation at Ellenville. He

The National Report Card on the State of Emergency Medicine

Evaluating the Emergency Care Environment
State by State

ACEP Report Card
National Summary

EMBARGOED UNTIL 10:00 AM EST 12/9/08

Executive Summary

NATIONAL GRADE BY CATEGORY	
ACCESS TO EMERGENCY CARE	D-
QUALITY & PATIENT SAFETY ENVIRONMENT	C+
MEDICAL LIABILITY ENVIRONMENT	C-
PUBLIC HEALTH & INJURY PREVENTION	C
DISASTER PREPAREDNESS	C+
OVERALL	C-

The Report Card is designed to evaluate the conditions under which emergency care is delivered in the United States. It does not measure the quality of care provided in individual hospitals or by individual emergency providers – rather, it considers the legislative and regulatory environment, the existing infrastructure, and the available workforce that constitute the emergency care system we all rely upon every day.

The findings of the 2009 Report Card are sobering.

The overall grade for the United States is C-

The C- grade is the same as that reported in the 2006 Report Card. However, while the two editions are significantly different and not directly comparable, the 2009 Report Card provides a more extensive evaluation of the nation's emergency care system and confirms its tenuous condition. Individual state grades range from the highest, a B in Massachusetts, to the lowest, a D- in Arkansas.

National Grade *C-*

This low grade is particularly reflective of the poor score in *Access to Emergency Care (D–).*

- Boarding of patients in emergency departments and hospital crowding
- Lack of adequate access to on-call specialists
- Limited access to primary care services
- Shortages of emergency physicians and nurses
- Ambulance diversion
- Inadequate reimbursement from public and private insurers
- High rates of uninsured individuals

Just 2%
Public Education Campaign

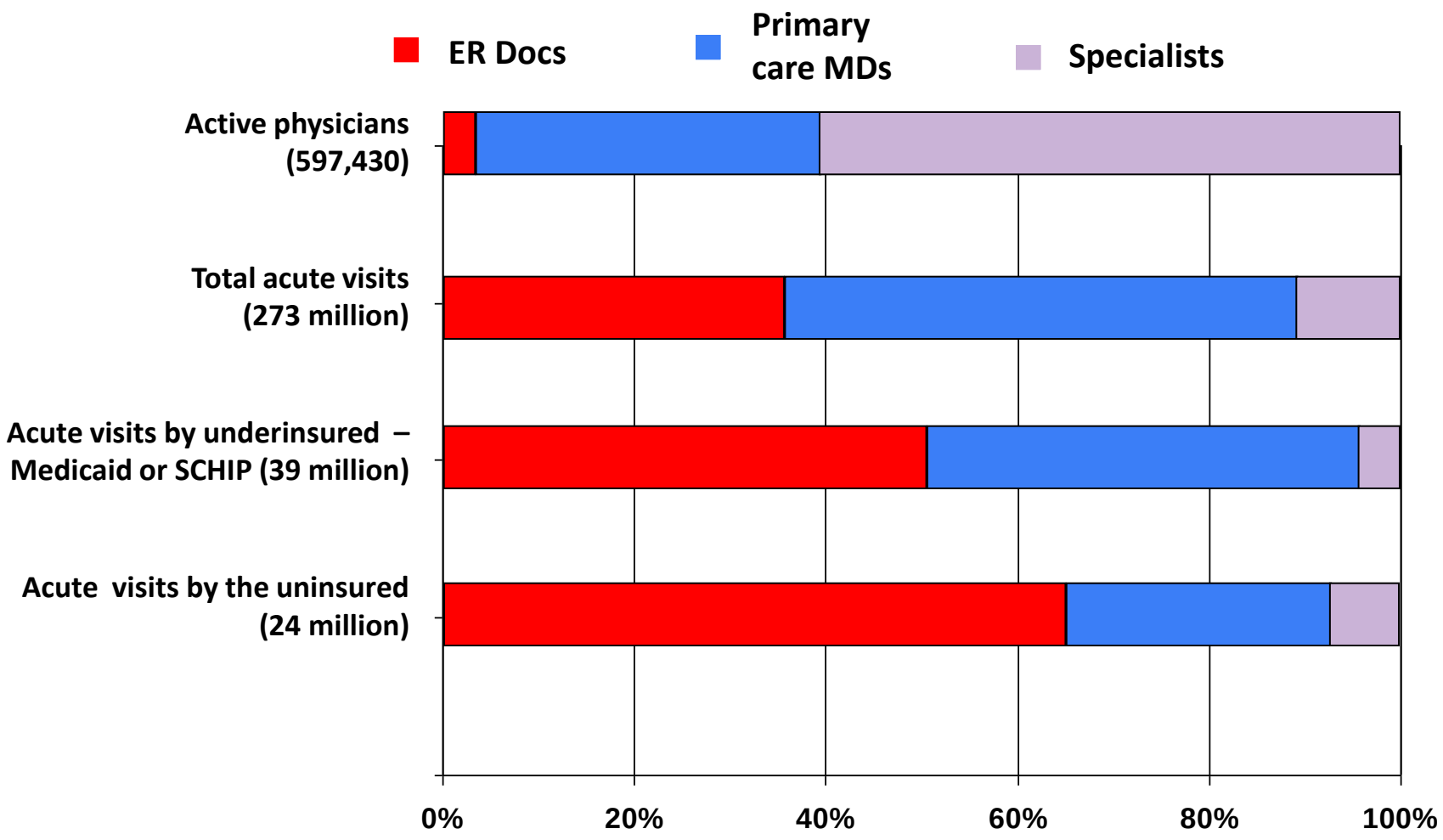
Table 1:
Expenses for emergency department services: 2010 Medical Expenditure Panel Survey[13,14]

	Per person reporting an expense		Per visit	
Total expenses (billion)	People with an ER expense (million)	Mean expense per person	Total ED visits (million)	Mean expense per visit
$48.3	35.8	$1,349	48.9	$969

Table 2:
ED expenditures for national private health insurer as percentage of healthcare spending* by plan type

Plan Type	Discharged	Admitted	Total
Commercial	8.5%	1.5%-2.5%	10.0%-11.0%
Medicaid	8.0%	1.5%-4.5%	9.5%-12.5%
Medicare	3.0%	2.5%-7.5%	5.5%-10.5%
All plans	7.0%	2.0%-4.0%	9.0%-11.0%

EDs Provide the Bulk of Acute Care to the Under-and-Uninsured



Pitts et al. *Health Affairs*, Sept 2010

FIRST: the BIG Picture

What is coming? Disaster or Salvation?

Krueger: Sequester Hits Harder, Earlier Than Expected

—Wall Street Journal, May 1, 2013

Global Economic Recovery to be ‘Slow and Bumpy’

—BBC News, April 28, 2013

U.S. Home Ownership Rate at Near 18-Year Low

—Financial Times, April 30, 2013

Health Care Reform

- The Health Care Reform law -- ACEP worked hard to get specific items included:
  - Prudent layperson language extended to group plans
  - No more “prior approval” needed
  - Expansion of research opportunities
  - Regionalization projects

Health Law Guarantees Protections For Emergency Room Visits

TOPICS: INSURANCE, HEALTH REFORM, DELIVERY OF CARE, HEALTH COSTS

By Maggie Mertens

13, 2010

When Kelly Arellanes fell off a horse and suffered a severe head injury in rural Arkansas, medics said she would need to be airlifted immediately to the nearest hospital—50 miles away in Fort Smith. There, emergency surgery saved her life – but at a cost.

The hospital wasn't in her insurance network, so she and her husband ended up with $20,000 in out-of-pocket expenses that they wouldn't have incurred at their network hospitals

new health overhaul mandates that insurers cannot pay less for emergency care in "out-of-network" hospitals and bars requirements for prior authorization for emergency treatment. (John Moore/Getty Images)

150 miles away in Little Rock.

Under the new health law, insurance companies must extend several new protections to patients who receive emergency care. One of the biggest guarantees: Patients who need emergency treatment will have their costs covered at the same rate, regardless of

Under the new federal rules, patients also can still pick their primary doctors or pediatricians, and prior approval requirements for emergency care will be prohibited

ACA Effects

- Insurance Reform
  - Mandate
  - Expand Medicaid eligibility
  - Insurance exchanges
  - Dependents up to 26
  - Guaranteed issue and renewability
  - No pre-existing condition
  - Essential Health benefits

United States Government Accountability Office

GAO

Report to the Chairman, Committee on Finance, U.S. Senate

April 2009

HOSPITAL EMERGENCY DEPARTMENTS

Crowding Continues to Occur, and Some Patients Wait Longer than Recommended Time Frames

GAO-09-347

Emergency Department Crowding: High-Impact Solutions

APRIL 2008

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

The Threats

- Employed physicians
- Greater number of government reimbursement
- Reduced reimbursement for emergency medicine

- More work, less pay
- Less opportunities

take care clinic™
at select Walgreens

You shouldn't be sick a moment longer than it takes to get well.

At Take Care Clinics, we know even minor health issues can cause major life hassles. So when you need convenient access to a qualified healthcare provider, just drop in. No appointments, no long waits. It's quality family healthcare built around you. Learn more

Find a clinic.
at select Walgreens

Need a flu shot? Just drop in.

Get what you need to stay happy and healthy this flu season.

Even minor health issues can be major life hassles.

Not feeling well? Drop into a nearby Take Care Clinic and one of our fully licensed board-certified Family Nurse Practitioners or Physician Assistants will see you.

- **We treat patients 18 months and older**
- **We're here 7 days a week, including weeknights**
- **No appointment necessary**
- **We welcome most insurance plans, too**
- **Conveniently located at select Walgreens**

Find a location closest to you.

shm Society of Hospital Medicine

Hospitalists. Transforming Healthcare. Revolutionizing Patient Care.

Log-in | Community | Career Center | QI Resource Rooms

QUESTIONS | CONTACT | SITE MAP

SEARCH >> GO

- About SHM
- Membership
- Education
- Quality Initiatives
- Practice Management
- Advocacy
- Events
- Publications
- News, Media & Blogs

Join SHM
Partner with SHM
SHM Store

SHM is committed to a culture of transparency with its industry partners.

Education and Meetings

SHM provides premier educational resources to chart

Practice Management

The business of hospital medicine gives physician

SHM's Center for Hospital Innovation & Improvement

SHM's QI Initiatives are now based in SHM's Center for

Membership

Join over 10,000 hospitalists who are affecting the hospital

A new vocabulary
A new world

- ACOs
- Value based purchasing
- Bundled payment
- Episodes of care
- IPAB
- Move from quantity to value
  - Quality/cost

Patient Centered Home

- Established panel of patients
- ‘Full’ care and coordination
- Rewards for quality care

- Reduced numbers of patients per provider
- Uncle Joe

2011

- Temporary reinsurance for retirees 55-65
- Further closure of doughnut hole
- Voluntary LTC insurance -$50/d
- PQRI bonus
- Funding community health centers

2012

- Fee imposed on drug manufacturers
- Accountable care organization discount
- Penalty for readmissions
- Value based purchasing for hospitals based on quality

2013

- Contribution limits to HSAs
- Physician quality reporting public
- Increase in MC taxes from 1.45% to 2.35%
- Payment bundling pilots

2014

- Mandate insurance or fine
- Medicaid expansion to 133% PL or $29,327 for family of 4
- No annual caps for coverage
- Insurance reform
- Federal subsidy to insureds
- Health insurance exchanges
- Value based modifiers

2015

- Independent payment board (IPAB)
- PQRI penalties

2016-7

- Sell insurance across states
- Excise tax on high cost plans

Solutions

- Prospective management of resources for next 20 years
- Telemedicine programs
- Expansion of EM opportunities
  - Transition of care
  - Expanded scope of practice paramedics

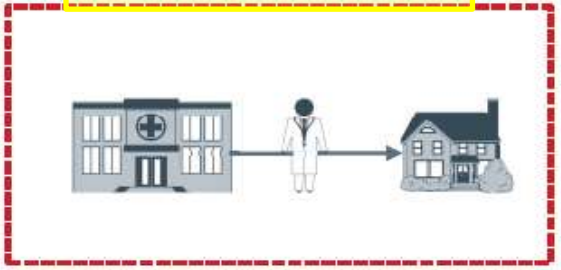
Your New Job

Looking Beyond the Four Walls

A New Approach to ED Care

ED Centric

Entire Continuum



Recognizing the Need for Integrated Care

"Many people go into emergency medicine to treat the super sick and to save lives. And then, they're done, and they go play golf. I think that's great, and that they've intervened successfully. But, a lot of patients are not there. They need more integrated care."

Emergency Medicine Physician at an Academic Medical Center in the South

"They want to work 12 hours a day and then never see their patients again. They want to do episodic-care. They're backwards."

CMO at Integrated Health System in the Northeast

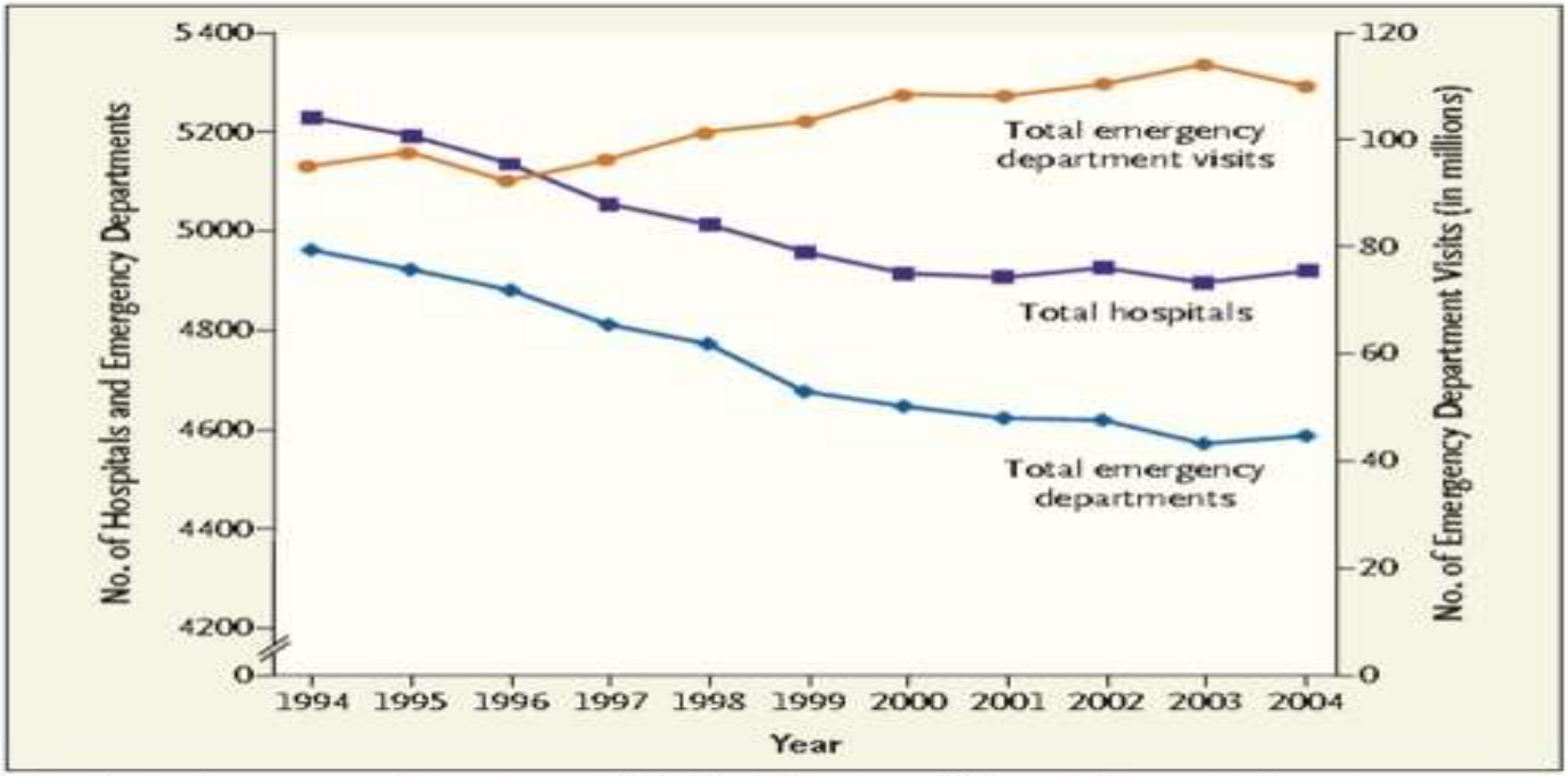
Source: Clinical Advisory Board interviews and analysis.

Advisory Board – [The ED as] "Hub of the Enterprise"

The Value of EM

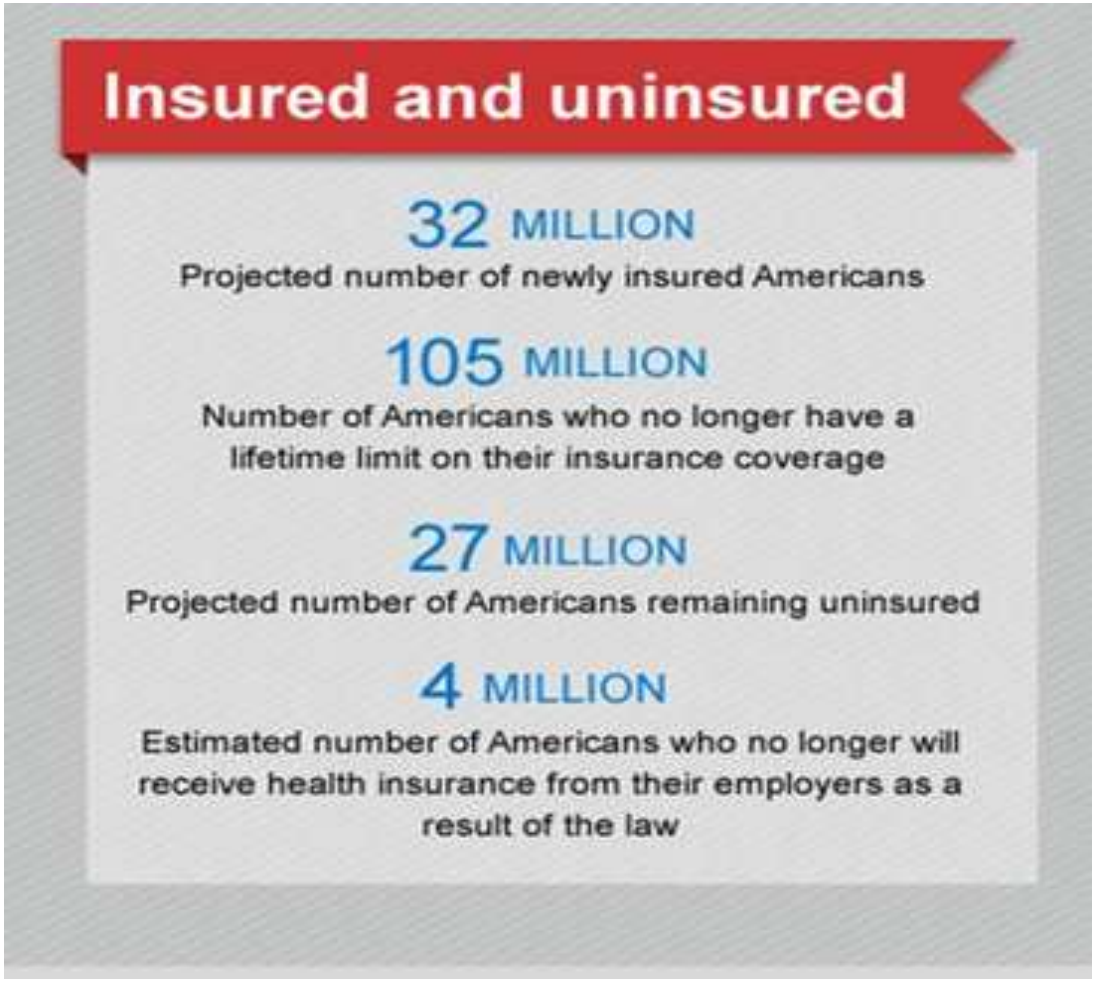
- Saving lives
- Control over hospital utilization
- Reduced employer costs
- Safety net

The Case for Emergency Medicine

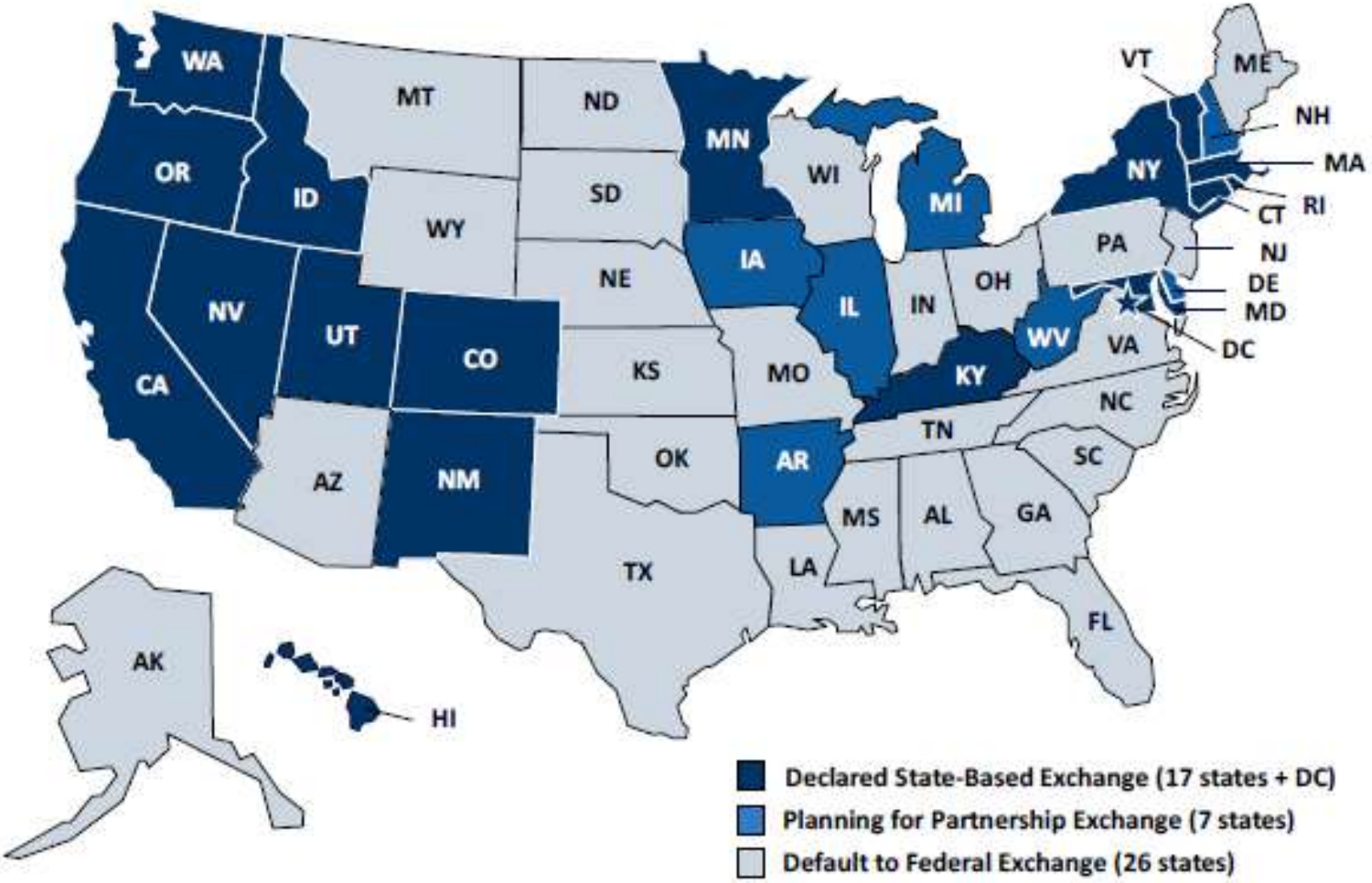


Trends in Emergency Department Visits, Number of Hospitals, and Number of Emergency Departments in the United States, 1994–2004.

Visits to the emergency department represent about 10% of all outpatient visits in the United States. Data are from the National Health Policy Forum.


Insured and uninsured
32 MILLION
Projected number of newly insured Americans
105 MILLION
Number of Americans who no longer have a lifetime limit on their insurance coverage
27 MILLION
Projected number of Americans remaining uninsured
4 MILLION
Estimated number of Americans who no longer will receive health insurance from their employers as a result of the law

State Decisions For Creating Health Insurance Exchanges



As of March 1, 2013

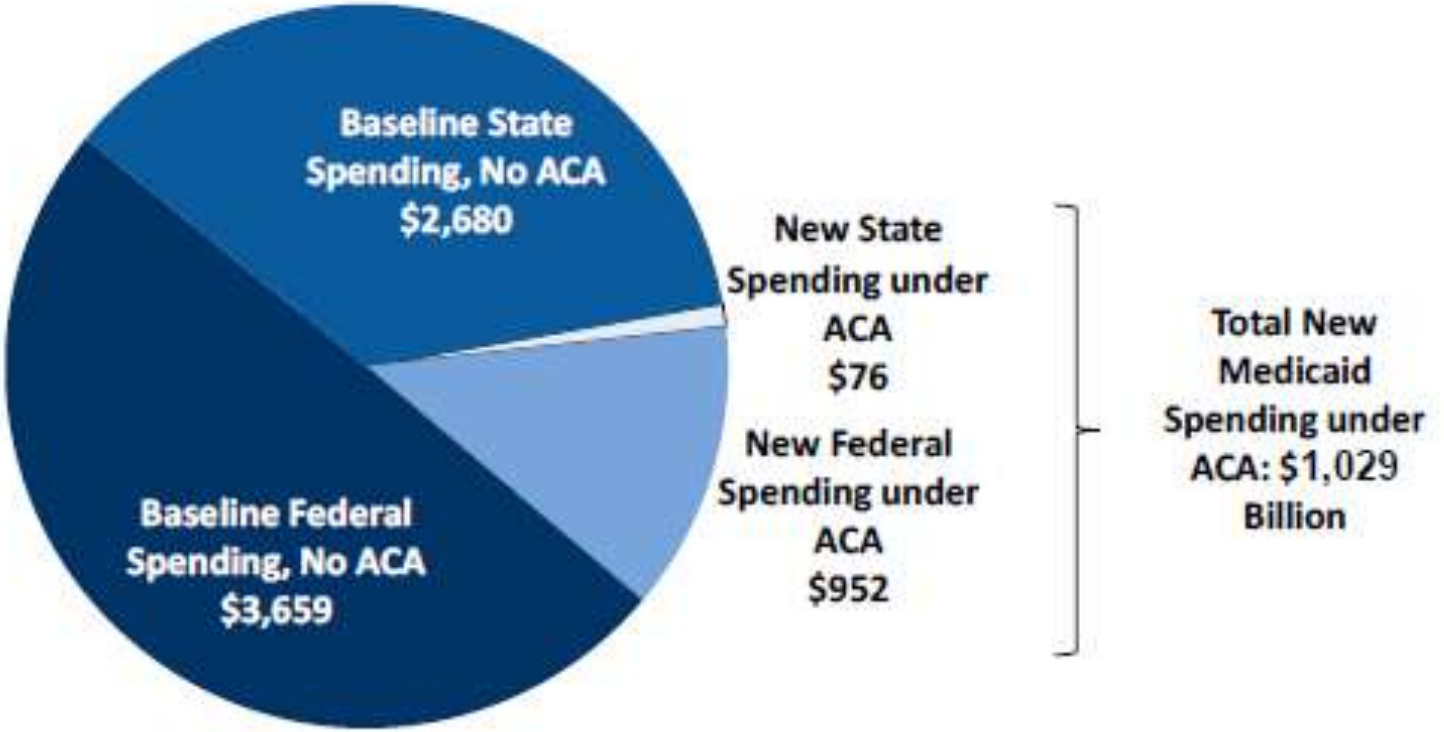
SOURCE: Data compiled through review of state legislation and other exchange documents by the Kaiser Family Foundation

Medicaid Expansion WILL happen. GOP Governors will gradually cave. All about $$

Figure 1

Total State and Federal Medicaid Spending Under ACA with All States Expanding Medicaid, 2013-2022

(billions)



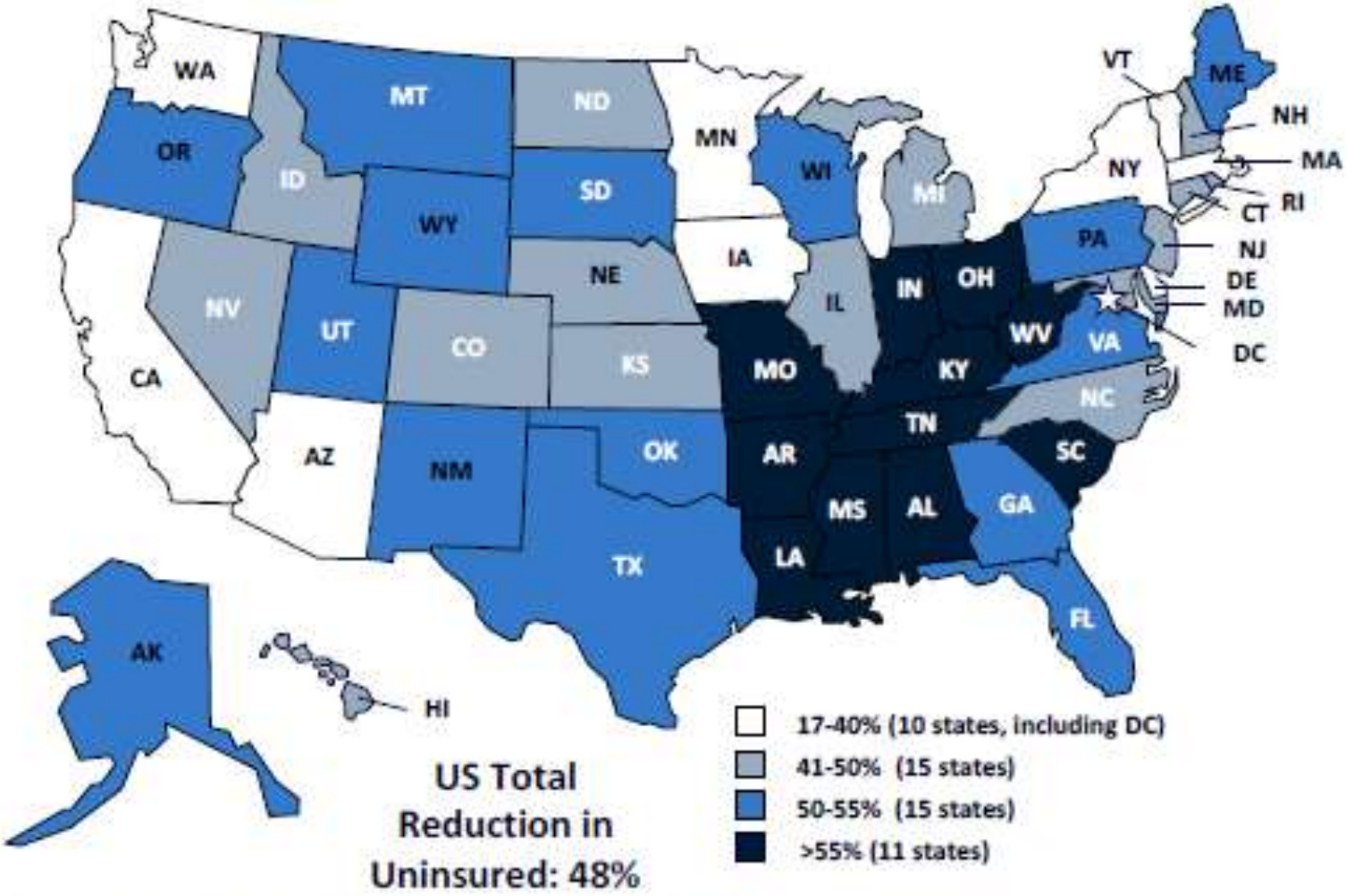
Total Medicaid Spending Over the Decade: $7,368 Billion

Note: Individual components may not sum to totals due to rounding.

Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2012.

Figure 2

Reduction in Number of Uninsured Under ACA with All States Expanding Medicaid, 2022



Note: Includes effects of the Medicaid expansion and other provisions in the ACA.
Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2012.

Value-Based Healthcare

Today: FFS | **Future: FFV**

Transactional Models	Episodic Care Models	Condition Care Models	Population Care Models
			
▪ Dermatologists ▪ Ophthalmologists ▪ Dentists ▪ Etc.	▪ Orthopedics ▪ CV surgery ▪ General / specialty surgery	▪ Oncology ▪ Diabetes ▪ Asthma ▪ Chronic/end-stage renal	Partial Population - Frail elder - High risk - Poly-chronic Full Population - Globally capitated models - Medicare shared savings ACO

Role of the ED

Not Coming to the ED by Choice, But by Necessity

Many PCPs Not Accepting Medicaid Patients, Shifting Burden to EDs

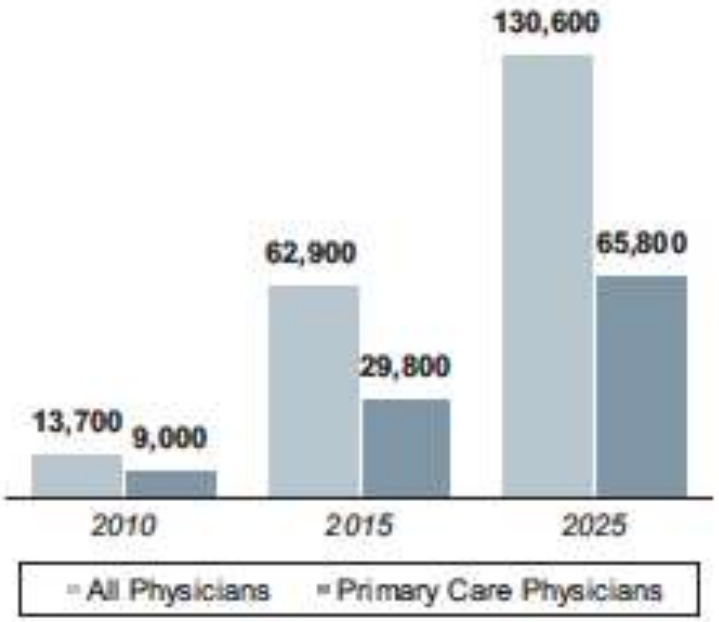
35% Percentage of all general practitioners not accepting new Medicaid patients

40% Percentage of all internists not accepting new Medicaid patients

97% Percentage of emergency physicians reporting regular, weekly treatment of Medicaid patients because they could not get an appointment with another physician

Future Looks Bleak

Projected Physician Shortages, 2010

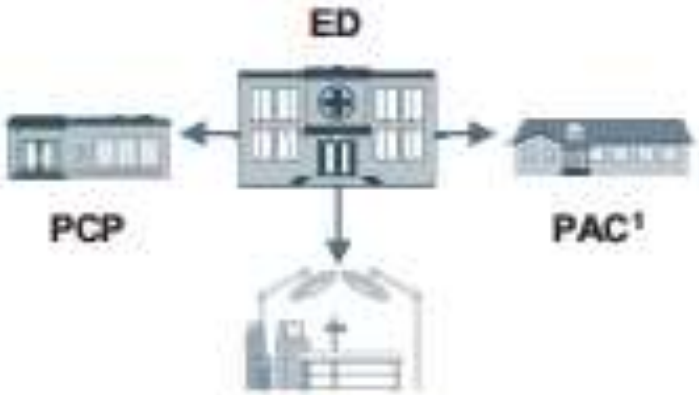


Center of the Hub

ED as an Island

- ED is focused primarily on efficiency and myopically concerned with acute care episode only
- ED and hospital at large view ED care as separate from larger care continuum

ED as a Bridge



- ED is intrinsically connected to entire health care enterprise and focused on items beyond efficiency
- ED collaborates to help prevent readmissions, avoid preventable admissions and promote care coordination

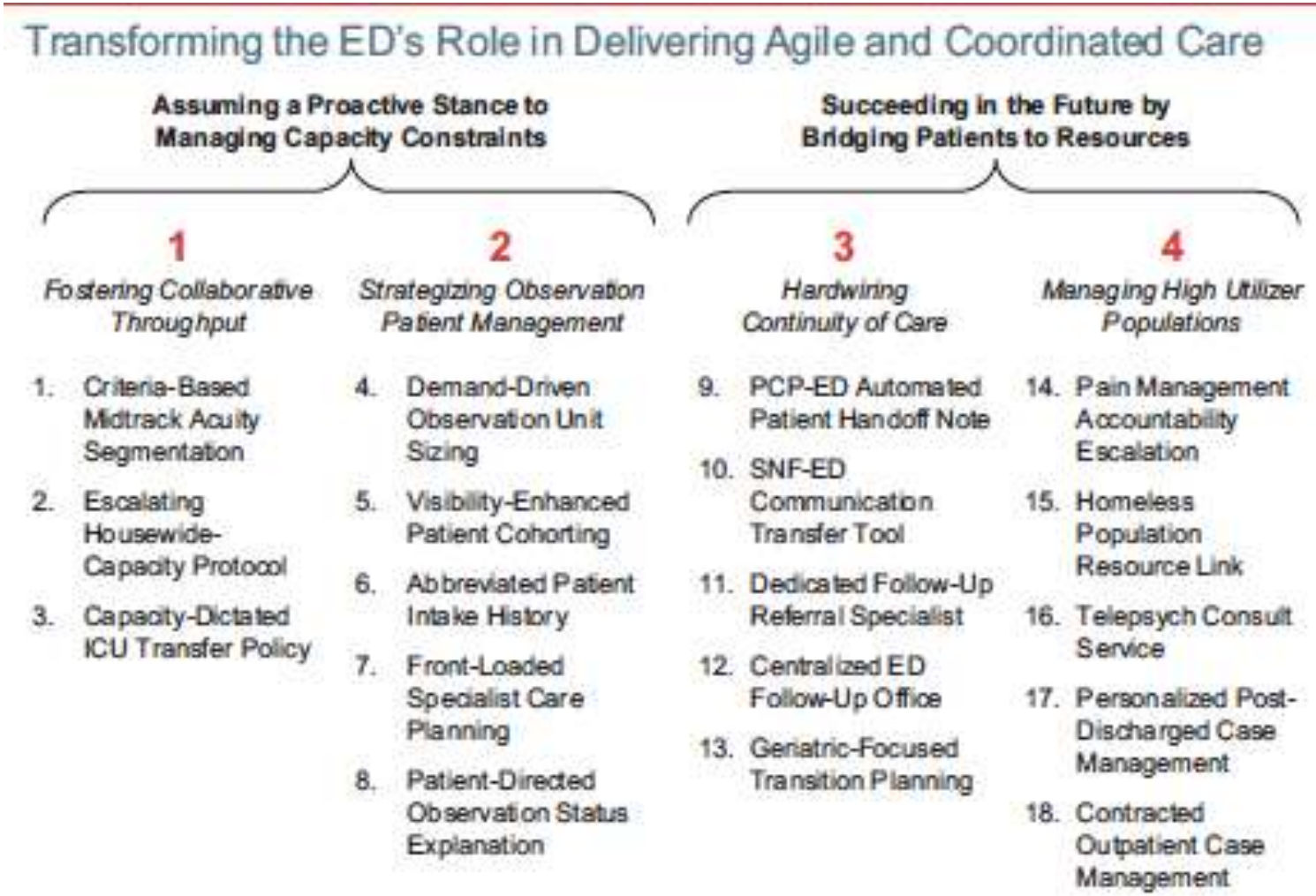
Transitions of Care

- Access to 130 million patients and nearly 130 million visitors
- ED as part of the medical neighborhood:
  - Prevention
  - Wellness
  - Disease Management
  - Palliative Care
  - Patient Hand-offs

Current Emergency Medicine Initiatives

- Observation Services
- Prevention of hospital acquired infections and procedural complications
- Readmission prevention
- Hospital length of stay issues
- Care management and homecare services
- End of life care
- Effective and efficient diagnostic testing

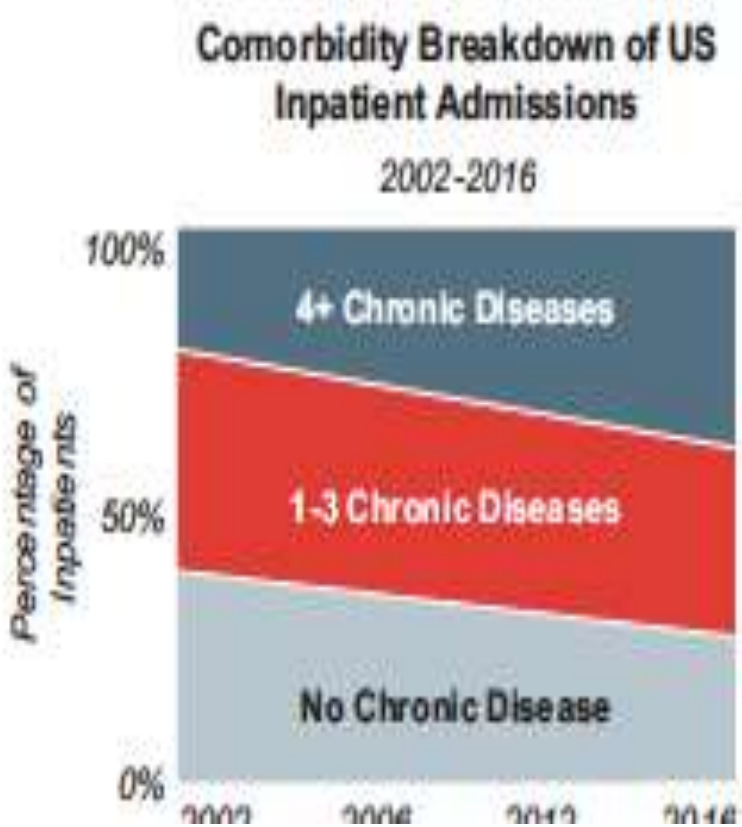
Care Coordination



Patients are sicker

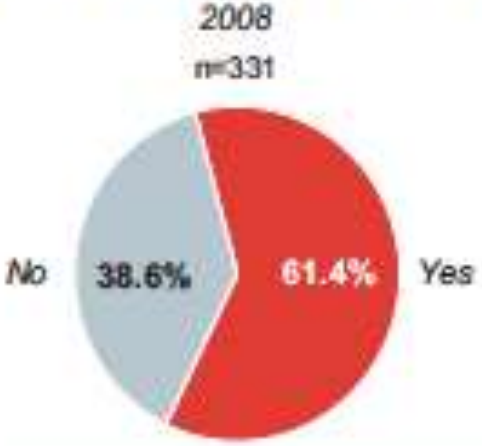
13% Americans who are aged 65 and older in 2008, 35 million people

20% Americans who are aged 65 and older in 2030, 70 million people



Safety, Operational, and Service Outcomes All at Risk

Hospital EDs Reporting Boarding of Admitted Patients for More than Two Hours[1]



Mortality Increases with Patient Boarding Time

In-Hospital Mortality Rate

Associated Consequences with Boarding

- Potential for compromised patient safety
- Decreased patient and staff satisfaction
- Decreased ED throughput
- Increased ED wait times, LWBS rates

Managing the Unfriendly Skies of Health Reform

RAND HEALTH

The Value of Emergency Medicine

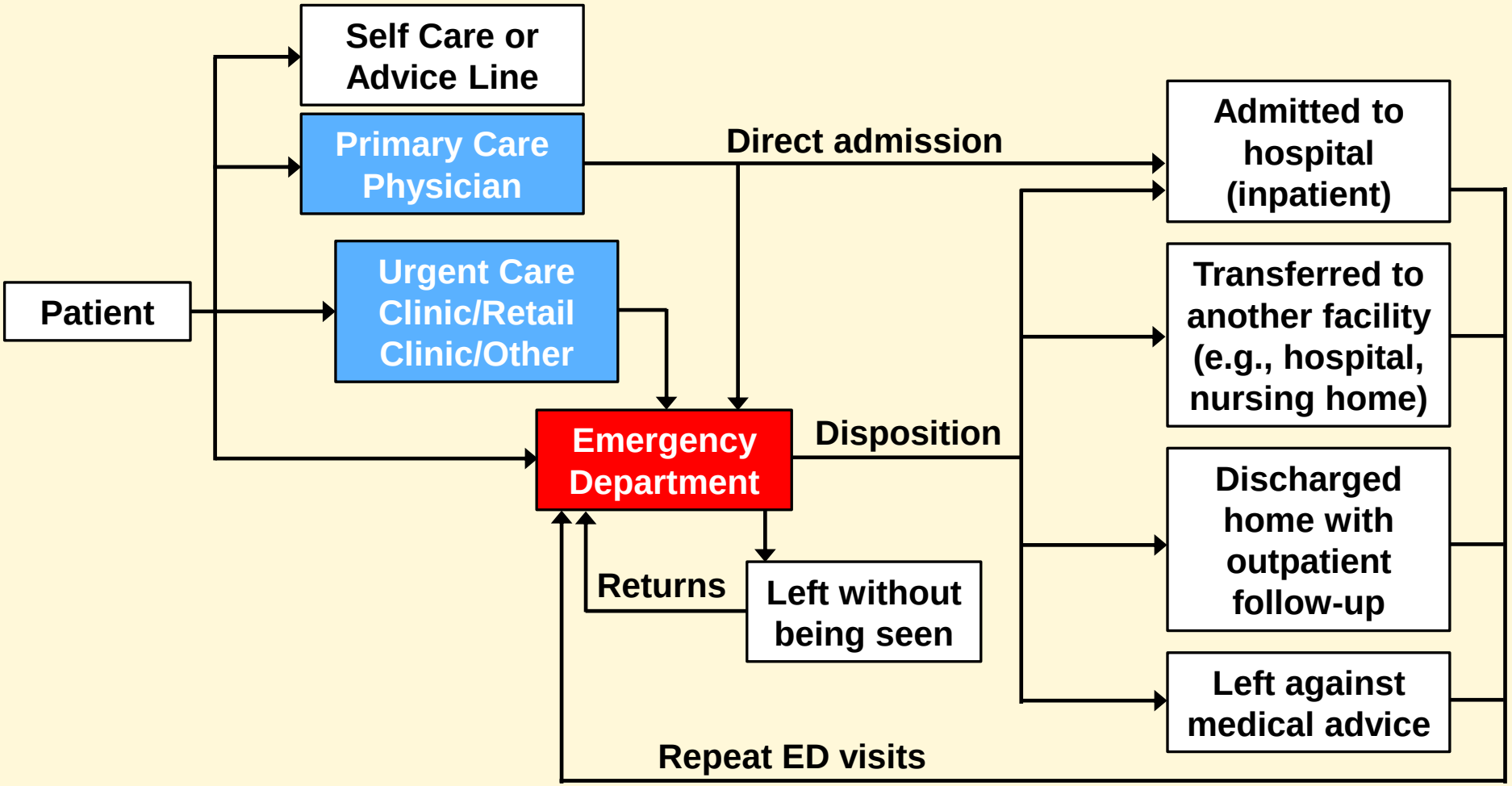
RAND Corporation

May 20, 2013

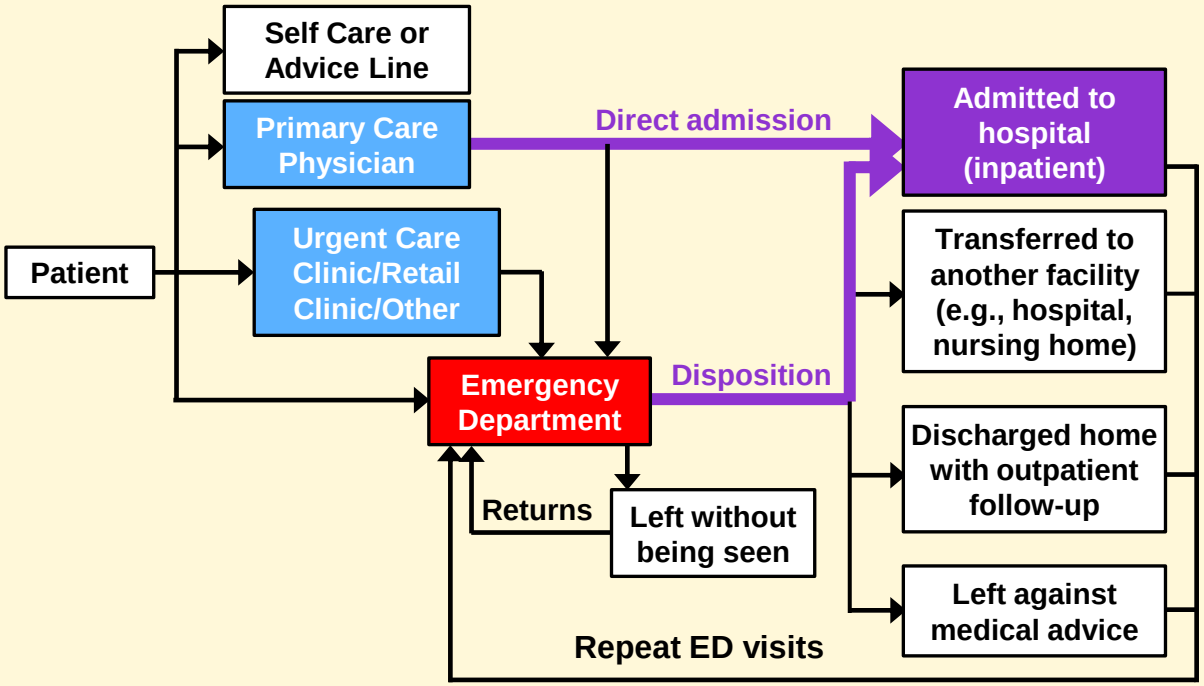
What Is RAND?

- **An independent, non-partisan, nonprofit research organization devoted to objective policy analysis**
- **Advisors to senior decision-makers in the U.S. and around the world**
- **A center for education and training**

Emergency Department Use

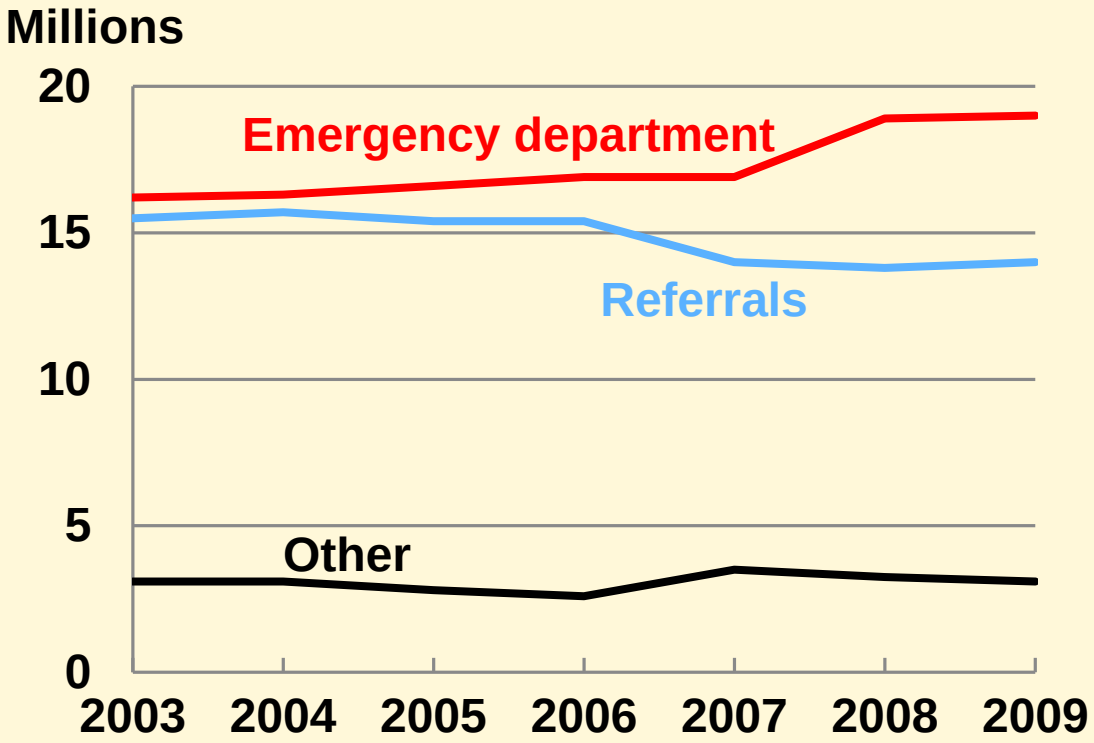


Entry Points for Non-elective Admissions



- What proportion of non-elective admissions enter hospitals through the ED
- How many admission decisions are made by EDs compared with other physicians?

EDs Account for Nearly All of the Recent Growth in Hospital Admissions

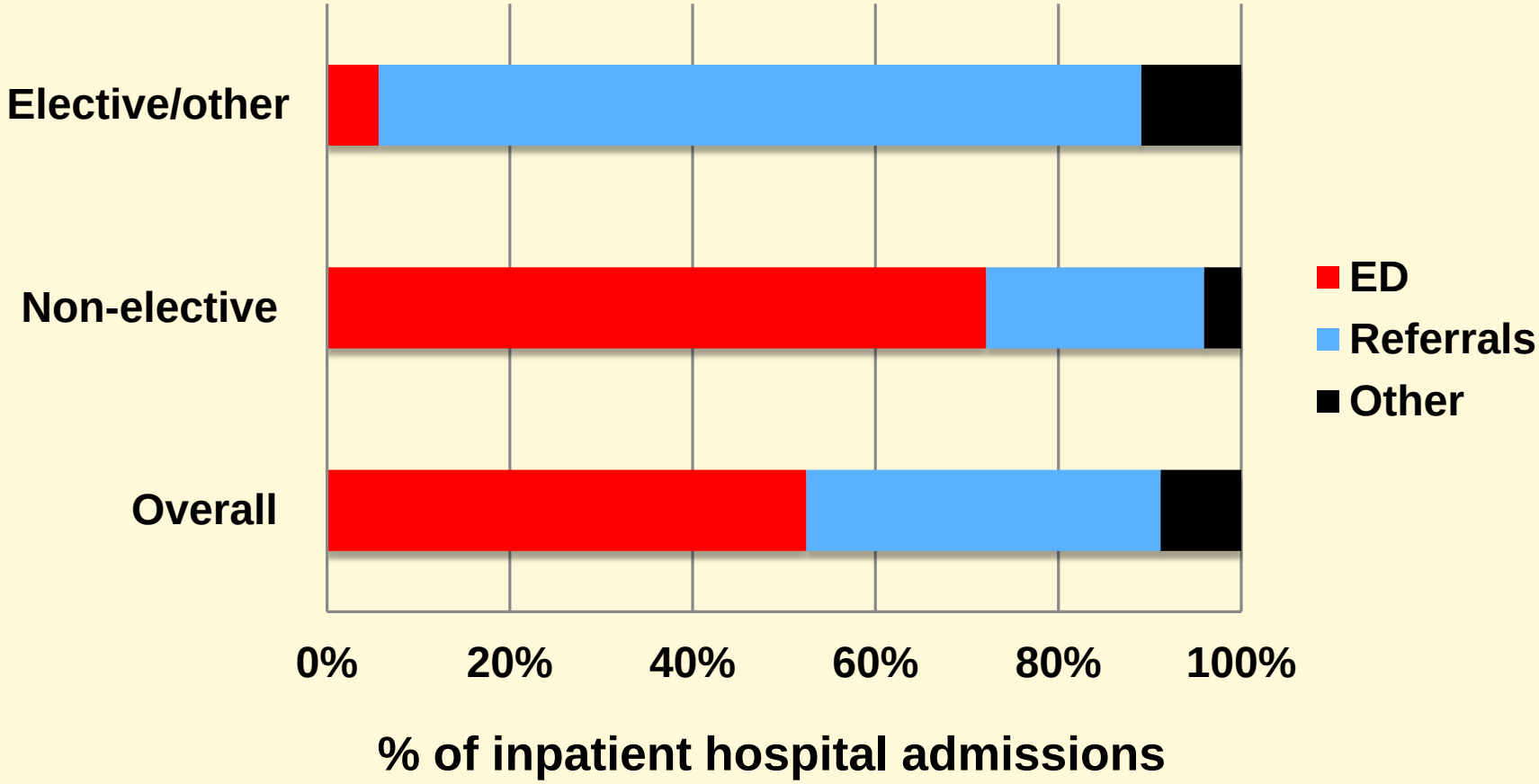


Between 2003 and 2009:

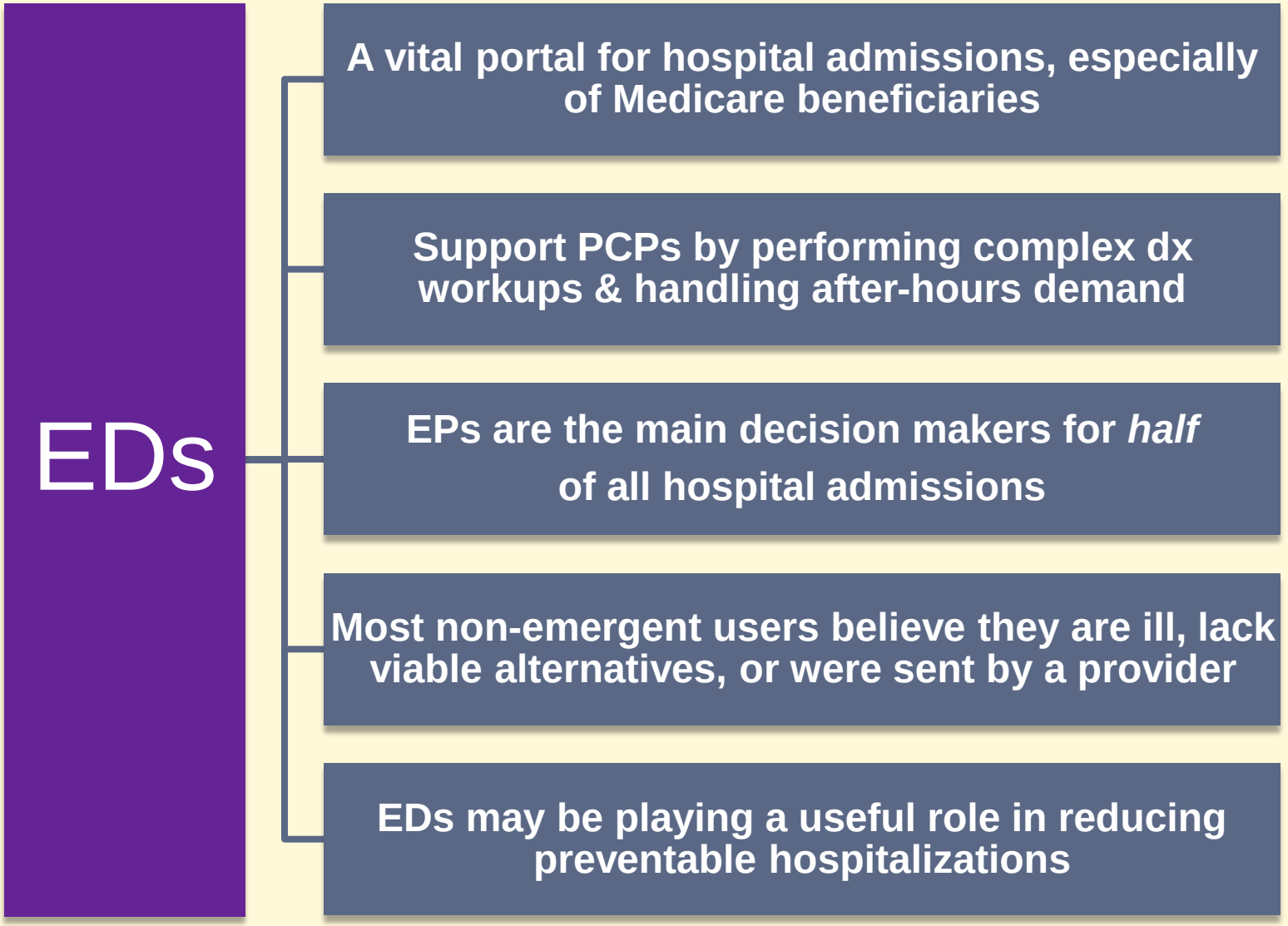
- Inpatient admissions (elective and non-elective) grew by about 4% (~34.7 million to 36.1 million)
- The US population grew by slightly less than 6%
- ED admissions accounted for nearly all of the growth in hospital admissions

Data Source: National Hospital Discharge Survey
Note: Excludes live births. Weighted counts with imputed values

In 2009, EDs Admitted Half of All U.S. Hospital Inpatients



The Bottom Line



Implications for Policy (1)

Hospital administrators, payers & policymakers should pay closer attention to the role EDs play in hospital admissions

Use of EDs as diagnostic centers warrants further research to determine if this is the most efficient way to evaluate patients with worrisome conditions

Efforts to reduce non-emergent use of EDs should focus on increasing affordable alternatives, rather than turning patients away

Implications for Policy (2)

EDs should be formally integrated into healthcare delivery systems--both inpatient and outpatient

Integration can be facilitated through:

- **more widespread adoption of interoperable and interconnected health information technology,**
- **greater use of care coordination and case management**
- **collaborative approaches to inter-professional practice**

EM & ACEP Update June 2013

Chapters

Sections

Committees

MEMBERS

North Carolina, South Carolina, Georgia

Michael Gerard, MD, FAAP, FACEP
ACEP Vice President
ACEP Board of Directors

Good stuff

- Value of EM
- HR 36: Healthcare Safety Enh. Act*
- Obs Units; 3 day stay
- McKesson FAST US Edit/Bundling*
- EMF Match Challenge*
- Meetings, eCME, cmeTracker
- Report Card

Controversial

- Firearm Injury Prevention
- Opioid Prescribing
- tPA Clinical Policy*
- Medicaid Expansion
- Choosing Wisely/Cost Effective Delivery Task Force*

Controversial

- Firearm Injury Prevention
- Opioid Prescribing
- tPA Clinical Policy*
- Medicaid Expansion
- Choosing Wisely/Cost Effective Delivery Task Force*

The ACEP and AAN partnered for simultaneous roll out of tPA policy: See March *Annals*

Evidence based; Inter-specialty, Inclusive of differing opinions, no company input, institutions need systems in place to maximize effectiveness and safety

Choosing Wisely®

An initiative of the ABIM Foundation

Partners
See Who Has Joined the Campaign

Watch a video of the February 21 Choosing Wisely® announcement and panel discussion.

How can physicians and patients have the important conversations necessary to ensure the right care is delivered at the right time? *Choosing Wisely®* aims to answer that question.

An initiative of the ABIM Foundation, *Choosing Wisely* is focused on encouraging

NEWS FEED

RT @alikhan28: @acpinternists @abimfoundation @costsofcare @yalemed Engagement in high value care has to involve fun, diagnostic reasoning + costs #SGIM13

Good stuff

- Value of EM
- HR 36: Hlthcare Safety Enh. Act*
- Obs Units; 3 day stay
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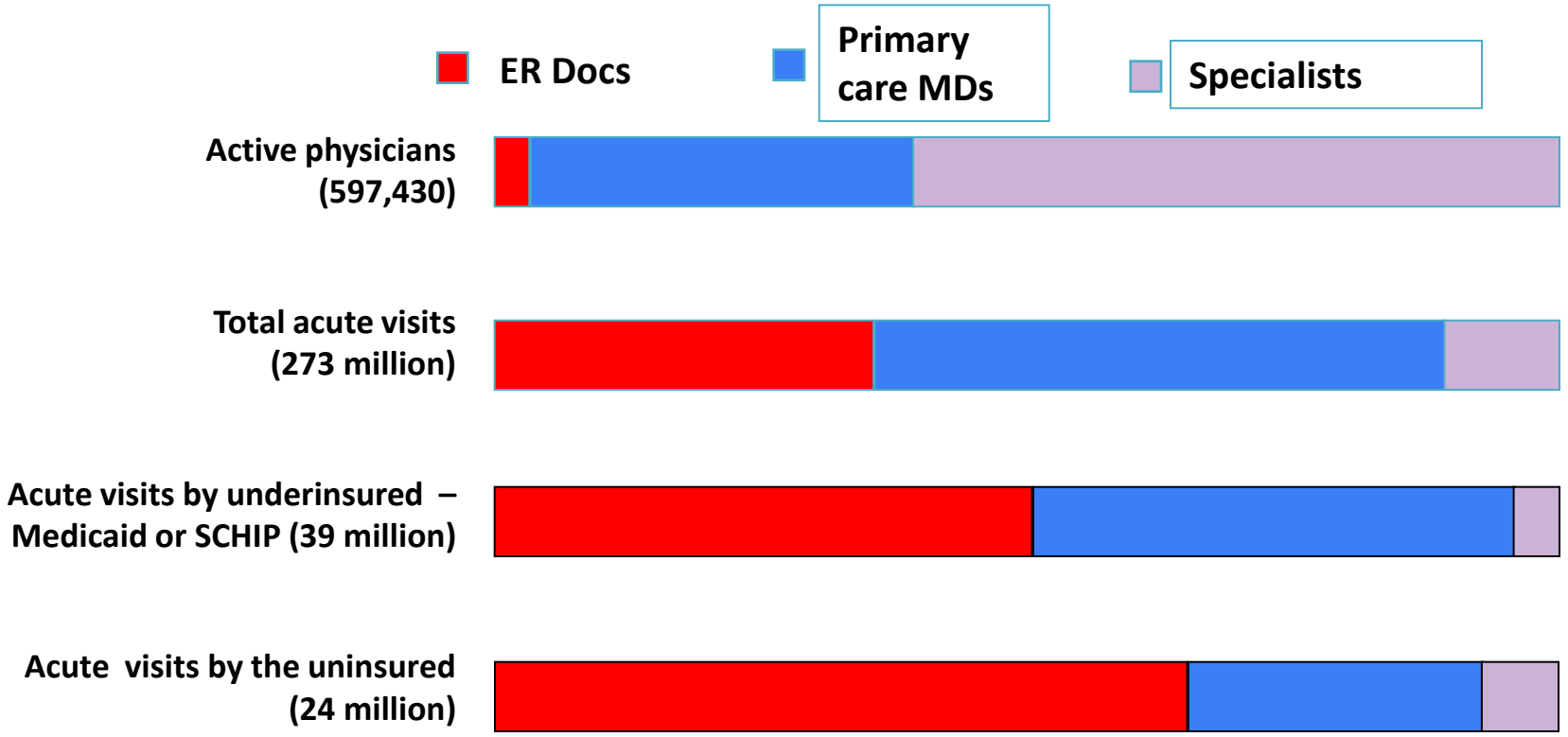
EDs Provide the Bulk of Acute Care to the Under- and Uninsured



Pitts et al. *Health Affairs*, Sept 2010

H.R.36: Health Care Safety Net Enhancement Act of 2013 Sponsor:

Rep Dent, Charles W. [PA-15]

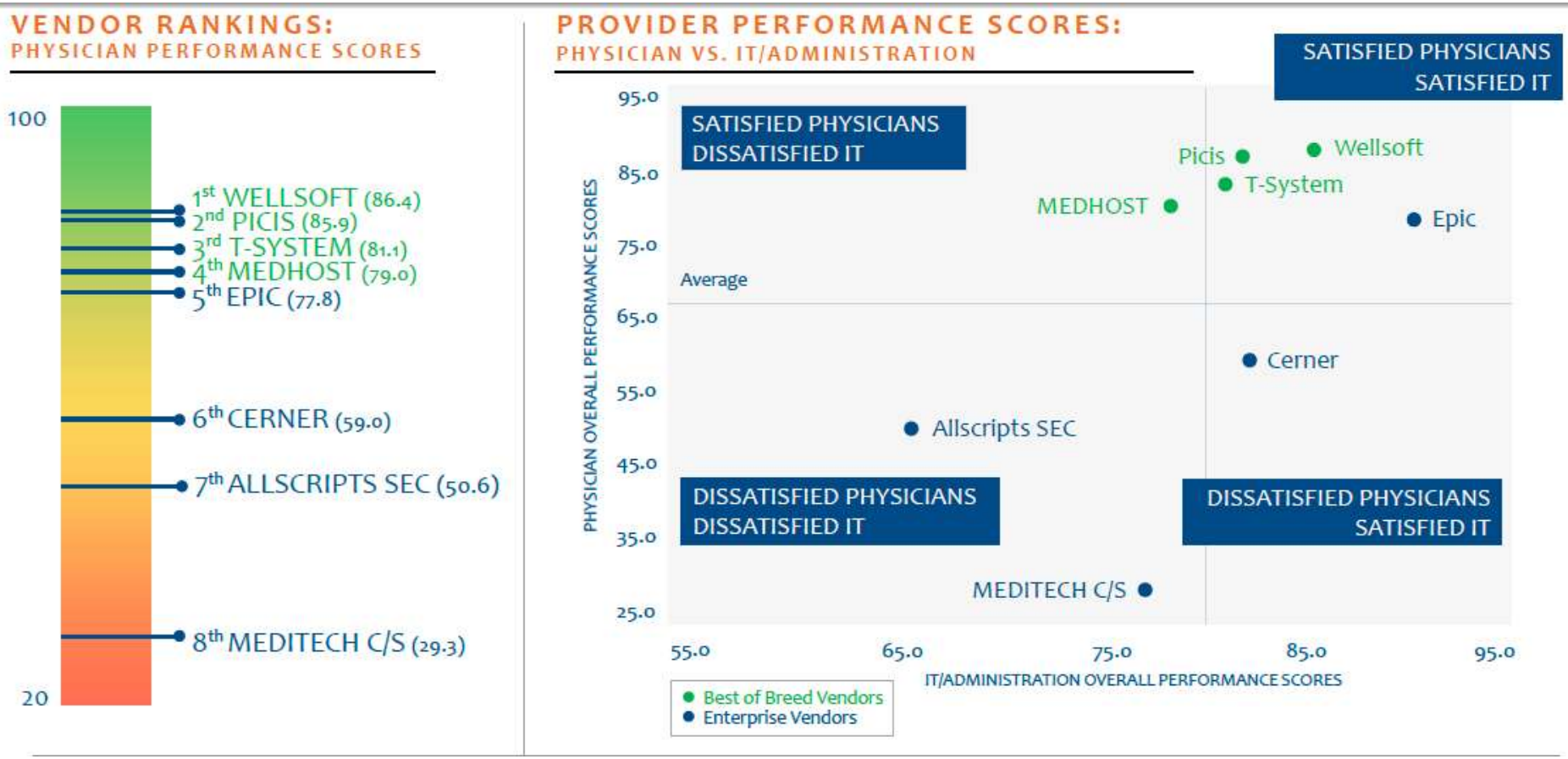
(introduced 1/3/2013)
Cosponsors (45)
Latest Major Action: 1/4/2013 Referred to House subcommittee. Status: Referred to the Subcommittee on Health.


EMRA


CORD
EM
Council of
Emergency Medicine
Residency Directors


Society of
Emergency Medicine
Physician Assistants

ACEP / EMPSF / KLAS
February 2013



What, me worry?

AMA Chair: Steve Stack
Chair of Associations: Dean Wilkerson
AAMC Journal: David Sklar
Report Card: Steve Epstein
Rand: Art Kellerman
RWJF: Peter Sokolove
NIH Fellow: Sandy Schneider

Numbers:
32,200; 130 million; 2%; 92%; 4.7%;
2 million
1 million
HR 36
1/31/14
VIII (Peer)

Wise choices: Finding value through a cost effective task force

ACEP Leadership met with the Society of hospitalist Medicine and the American Board of Internal Medicine Foundation in March:

- Discussed Choosing Wisely
- Ground rules for specialty submissions
- Need for Table of meeting
- Morph PR to real change, our attempts to score cost effective change with associated savings
- Protect individual treatment needs from denials secondary to overarching guidelines

AIUM Officially Recognizes ACEP Emergency Ultrasound Guidelines

ACEP action results in McKesson removing bundling edits from Ultrasound billing

MODIFY YOUR MEDICAL SEARCH

Location of Service or Procedure: 27610

Procedural CPT® Code: 99285

SEARCH AGAIN

Browse Procedures by Category

ESTIMATED OUT-OF-POCKET COSTS

PRINT

CPT Code	CPT Consumer Description	Est. Charge	Est. Reimbursement	Out-of-Pocket Cost
99285	Emergency department visit	$711.14	$497.80	$213.34

Estimated Out-of-Pocket Costs $213.34

Understanding Your Medical Cost Estimate

Adjusting Estimated Reimbursements

The Estimated Reimbursement amounts above are initially set to be 70% of the Estimated Charge. Click here to learn more about percentages and how they can factor into reimbursement.

If you find that your plan uses a different percentage in determining reimbursement amounts, you can adjust the level used in the estimates above using the slider below. When you adjust the percentage, the estimated charge amounts above may change, resulting in adjusted figures for the estimated reimbursement and out-of-pocket cost amounts on this page.

Adjust Percentage

50% 60% 70% 80% 90%

Click here to use our Advanced Charge Estimator

Reminder: Due to licensing requirements, you are limited to 20 searches per month. To help keep within those limits and avoid repeat searches, remember to print the results of your search for easy reference.

ABOUT THIS PAGE

It is important to understand that your actual costs may vary based upon factors specific to your provider and/or your plan. FAIR Health is not determining, developing or establishing an appropriate fee or reimbursement levels for any procedure or service. All of our estimates are being provided for informational purposes only. FAIR Health does not determine what is a "reasonable and customary" or UCR charge. That determination is made by your plan.

A Note on Office Visits

A Note on Treatments Involving Related Procedures

You can also learn more about provider and plan-related variables that may affect your costs by visiting the Understanding Your Medical Cost Estimate Page.

FAIR Health Worked closely with ACEP on re-write of this page…

Learn
Benefit Basics

- Alphabet Soup of Health Plans
- In-Network vs. Out-of-Network Care
- Cost-Sharing: Know What You May Owe
- **Emergency Care vs. Urgent Care**
  - What Are My Options?
  - How is Emergency Care Different from Urgent Care?
  - Your Action Plan: Get the Care You Need
- Out-of-Network Docs at In-Network Hospitals
- The Role of Medicare in Out-of-Network Reimbursement

EMERGENCY CARE VS. URGENT CARE

It can be frightening when a sudden illness or injury strikes, especially if your regular doctor is not available. You need to make a choice quickly about where to get the medical attention you need. But, it's also important to have all the facts before you seek care.

Emergency Care vs. Urgent Care

Introduction
What Are My Options? Emergency Rooms
What Are My Options? Urgent Care
How is Emergency Care Different From Urgent Care?
Your Action Plan: Get the Care You Need

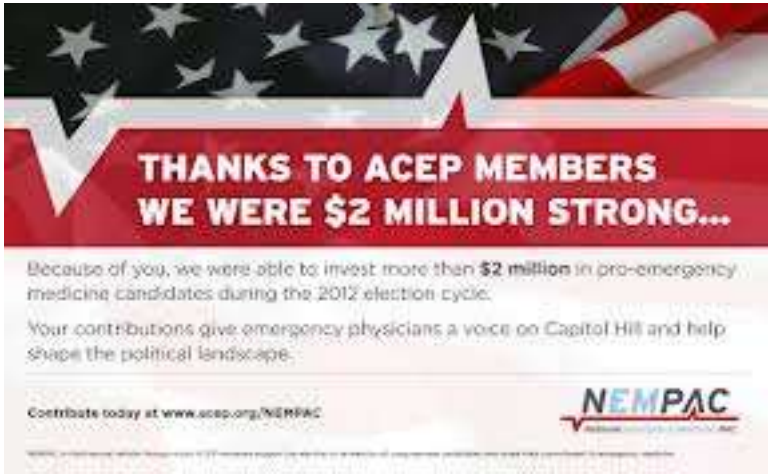
What Are My Options?

- **Emergency Rooms:** Emergency rooms are open 24 hours a day for potentially life-threatening emergencies. Many plans cover some portion of emergency care no matter where you are, even out of their network area. Once your condition is stable, you will generally be moved to an in-network provider for follow-up care. You may have an ER co-payment, co-insurance or deductible. You may also have an additional out-of-network charge. If you have questions about what constitutes an emergency, or about what emergency costs are covered, call your insurer.
- **Urgent Care Centers:** These centers have extended hours and are not equipped to deal with major medical traumas or conditions. They are intended to provide treatment for less serious conditions after regular office hours, or when your Primary Care Physician is not available. Your co-pay or co-insurance for an urgent care visit will often be lower than the co-pay or co-insurance for an ER visit. Urgent care centers may be attached to a hospital, or may be separate facilities. Most health plans include urgent care centers in their networks.

It's important to remember that most health plans will not pay for ER visits for what they consider to be non-emergency care. Most plans use what is called the "prudent layperson" rule to decide. This means that your condition is considered an emergency if the average person on the street, with an average knowledge of health and medicine, thinks that waiting to get care would be dangerous. If you visit the ER for non-emergency care, you could end up with high out-of-pocket costs.

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE



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