EM & ACEP Update
June 2013

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”
MORE DUCT TAPE
We have a problem
Social Security, Medicare and Medicaid Will Consume Larger Percentage of GDP

Source: Government Accountability Office
U.S. Financial Condition and Fiscal Future Briefing, January 2008
Social Security and Medicare Cash Surpluses and Deficits (in constant 2008 dollars)

The Aging U.S. Population

Number of individuals age 65 or over (in millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>2007</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
<th>2040</th>
<th>2050</th>
<th>2060</th>
<th>2070</th>
<th>2080</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>38</td>
<td>40</td>
<td>54</td>
<td>70</td>
<td>77</td>
<td>81</td>
<td>87</td>
<td>93</td>
<td>97</td>
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</table>

Percentage of Population

<table>
<thead>
<tr>
<th>Year</th>
<th>2007</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
<th>2040</th>
<th>2050</th>
<th>2060</th>
<th>2070</th>
<th>2080</th>
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<tbody>
<tr>
<td>2007</td>
<td>12.4</td>
<td>12.7</td>
<td>15.8</td>
<td>19.1</td>
<td>20.5</td>
<td>20.8</td>
<td>21.4</td>
<td>22.2</td>
<td>22.7</td>
</tr>
</tbody>
</table>

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

Population by Single Year of Age and Sex: 2000

Source: U.S. Census Bureau, Decennial Census 1970

Source: U.S. Census Bureau, Decennial Census 2000
Population by Single Year of Age and Sex: 2030

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

Source: U.S. Census Bureau, Population Projections 2008
The U.S. health care system is the most expensive in the world.

International Infant Mortality Rates:* 2002

- Hong Kong: 2.3
- Sweden: 2.8
- Singapore: 2.9
- Finland: 3.0
- Japan: 3.0
- Spain: 3.4
- Norway: 3.5
- Austria: 4.1
- France: 4.1
- Czech Republic: 4.2
- Germany: 4.3
- Denmark: 4.4
- Switzerland: 4.5
- Italy: 4.7
- Northern Ireland: 4.7
- Belgium: 4.9
- Australia: 5.0
- Netherlands: 5.0
- Portugal: 5.0
- Ireland: 5.1
- England and Wales: 5.2
- Scotland: 5.3
- Canada: 5.4
- Israel**: 5.4
- Greece: 5.4
- New Zealand: 5.9
- Cuba: 6.2
- United States: 6.5
- Hungary: 7.0
- Poland: 7.5

*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

<table>
<thead>
<tr>
<th>Country</th>
<th>Expenditures</th>
</tr>
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<tbody>
<tr>
<td>Australia</td>
<td>$2,999</td>
</tr>
<tr>
<td>Austria</td>
<td>$3,606</td>
</tr>
<tr>
<td>Belgium</td>
<td>$3,488</td>
</tr>
<tr>
<td>Canada</td>
<td>$3,678</td>
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<tr>
<td>Denmark</td>
<td>$3,349</td>
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<tr>
<td>Finland</td>
<td>$2,668</td>
</tr>
<tr>
<td>France</td>
<td>$3,449</td>
</tr>
<tr>
<td>Germany</td>
<td>$3,371</td>
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<tr>
<td>Ireland</td>
<td>$3,082</td>
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<tr>
<td>Italy</td>
<td>$2,614</td>
</tr>
<tr>
<td>Japan</td>
<td>$2,474</td>
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<tr>
<td>Luxembourg</td>
<td>$4,303</td>
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<tr>
<td>Netherlands</td>
<td>$3,391</td>
</tr>
<tr>
<td>Norway</td>
<td>$4,250</td>
</tr>
<tr>
<td>Sweden</td>
<td>$3,202</td>
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<tr>
<td>Switzerland</td>
<td>$4,311</td>
</tr>
<tr>
<td>U.K.</td>
<td>$2,760</td>
</tr>
<tr>
<td>United States</td>
<td>$6,714</td>
</tr>
<tr>
<td>OECD Average</td>
<td>$2,824</td>
</tr>
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</table>

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
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)

20 percent = zero cost.

0% total cost

20% of people

Cost distribution of care (Working Americans)

10% total cost

70% of people

70 percent = 10 percent of the cost

Cost distribution of care (Working Americans)

1 percent = 30 percent of cost.

1% of people

30% total cost

Breakdown of National Healthcare Expenditures

Source: National Health Expenditure Accounts.
International Comparison of Spending on Health, 1980–2009

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

- United States
- Canada
- Germany
- France
- Australia
- United Kingdom

Total expenditures on health as percent of GDP

* PPP=Purchasing Power Parity.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 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.

OVERDIAGNOSED

MAKING PEOPLE SICK IN THE PURSUIT OF HEALTH

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

Age Counts of Current, Live Diplomates as of 11/18/2010

Age (Years) vs. Diplomates
Number of EM BC/100K
Number of ABEM diplomates

2030
The diagram shows the projected percentage of demand met from 2005 to 2040. The lines represent three scenarios:

- **Best Case** (solid line)
- **Worst Case** (dashed line)
- **Intermediate** (dotted line)

The graph indicates a steady increase in the percentage of demand met from 2019 to 2038, with the best case scenario reaching 100% by 2038, whereas the worst case scenario remains relatively flat. The intermediate case lies between the two extremes.

The y-axis represents the percentage of demand met, ranging from 0% to 100%, while the x-axis represents the years from 2005 to 2040.
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
Executive Summary

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

<table>
<thead>
<tr>
<th>Total expenses (billion)</th>
<th>Per person reporting an expense</th>
<th>Per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>People with an ER expense (million)</td>
<td>Mean expense per person</td>
</tr>
<tr>
<td>$48.3</td>
<td>35.8</td>
<td>$1,349</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Discharged</th>
<th>Admitted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>8.5%</td>
<td>1.5%-2.5%</td>
<td>10.0%-11.0%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>8.0%</td>
<td>1.5%-4.5%</td>
<td>9.5%-12.5%</td>
</tr>
<tr>
<td>Medicare</td>
<td>3.0%</td>
<td>2.5%-7.5%</td>
<td>5.5%-10.5%</td>
</tr>
<tr>
<td>All plans</td>
<td>7.0%</td>
<td>2.0%-4.0%</td>
<td>9.0%-11.0%</td>
</tr>
</tbody>
</table>
EDs Provide the Bulk of Acute Care to the Under-and-Uninsured

Active physicians (597,430)

Total acute visits (273 million)

Acute visits by underinsured – Medicaid or SCHIP (39 million)

Acute visits by the uninsured (24 million)

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
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
  – Dependents up to 26
  – Guaranteed issue and renewability
  – No pre-existing condition
  – Essential Health benefits
HOSPITAL EMERGENCY DEPARTMENTS

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

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.

Patient care services provided by Take Care Health Services SM, an independently owned professional corporation whose licensed healthcare professionals are not employed by or agents of Walgreen Co., or its subsidiaries, including Take Care Health Systems SM, LLC.
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May 16-19, 2013 | National Harbor, Maryland
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SHM provides premier educational resources to chart
The business of hospital medicine gives physician
SHM's QI initiatives are now based in SHM's Center for
Join over 10,000 hospitalists who are affecting the hospital

When Sepsis Strikes, Time Matters.
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
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

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

- Declared State-Based Exchange (17 states + DC)
- Planning for Partnership Exchange (7 states)
- Default to Federal Exchange (26 states)

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)

- Baseline State Spending, No ACA: $2,680
- New State Spending under ACA: $76
- New Federal Spending under ACA: $952
- Total New Medicaid Spending under ACA: $1,029 Billion

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

US Total Reduction in Uninsured: 48%

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

- Transactional Models
  - Dermatologists
  - Ophthalmologists
  - Dentists
  - Etc.

- Episodic Care Models
  - Orthopedics
  - CV surgery
  - General / specialty surgery

- Condition Care Models
  - Oncology
  - Diabetes
  - Asthma
  - Chronic/end-stage renal

Future: FFV

- Population Care Models
  - 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*

<table>
<thead>
<tr>
<th>Year</th>
<th>All Physicians</th>
<th>Primary Care Physicians</th>
</tr>
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<tbody>
<tr>
<td>2010</td>
<td>13,700</td>
<td>9,000</td>
</tr>
<tr>
<td>2015</td>
<td>62,900</td>
<td>29,800</td>
</tr>
<tr>
<td>2025</td>
<td>130,600</td>
<td>65,800</td>
</tr>
</tbody>
</table>

= All Physicians  = Primary Care Physicians
Center of the Hub

Multi-Stakeholder Collaboration

Specialist

Skilled Nursing Facility

Pain Center

Medical Home

Primary Care Physician

Emergency Department

Mental Health Agency

Housing Shelter

Urgent Care Center

Source: Greene J. "The Barriers"
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

Transforming the ED’s Role in Delivering Agile and Coordinated Care

Assuming a Proactive Stance to Managing Capacity Constraints

1. Fostering Collaborative Throughput
   - Criteria-Based Midtrack Acuity Segmentation
2. Escalating Housewide Capacity Protocol
   - Capacity-Dictated ICU Transfer Policy
3. Strategizing Observation Patient Management
   - Demand-Driven Observation Unit Sizing
   - Visibility-Enhanced Patient Cohorting
   - Abbreviated Patient Intake History
   - Front-Loaded Specialist Care Planning
   - Patient-Directed Observation Status Explanation

Succeeding in the Future by Bridging Patients to Resources

3. Hardwiring Continuity of Care
   - PCP-ED Automated Patient Handoff Note
   - SNF-ED Communication Transfer Tool
   - Dedicated Follow-Up Referral Specialist
   - Centralized ED Follow-Up Office
   - Geriatric-Focused Transition Planning

4. Managing High Utilizer Populations
   - Pain Management Accountability Escalation
   - Homeless Population Resource Link
   - Telepsych Consult Service
   - Personalized Post-Discharged Case Management
   - Contracted Outpatient Case Management
Patients are sicker

- 13% of Americans who are aged 65 and older in 2008, 35 million people
- 20% of Americans who are aged 65 and older in 2030, 70 million people

Comorbidity Breakdown of US Inpatient Admissions 2002-2016

- 4+ Chronic Diseases
- 1-3 Chronic Diseases
- No Chronic Disease
Safety, Operational, and Service Outcomes All at Risk

Hospital EDs Reporting Boarding of Admitted Patients for More than Two Hours\(^1\)

- 2008
- n=331
- No: 38.6%
- Yes: 61.4%

Mortality Increases with Patient Boarding Time

<table>
<thead>
<tr>
<th>Boarding Time</th>
<th>In-Hospital Mortality Rate</th>
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</thead>
<tbody>
<tr>
<td>&lt;2 Hours</td>
<td>2.5%</td>
</tr>
<tr>
<td>2-6 Hours</td>
<td>2.7%</td>
</tr>
<tr>
<td>6-12 Hours</td>
<td>3.9%</td>
</tr>
<tr>
<td>12-24 Hours</td>
<td>4.5%</td>
</tr>
<tr>
<td>24+ Hours</td>
<td>4.5%</td>
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</table>

Associated Consequences with Boarding

- Potential for compromised patient safety
- Decreased ED throughput
- Decreased patient and staff satisfaction
- Increased ED wait times, LWBS rates
Managing the Unfriendly Skies of Health Reform
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

- Patient
  - Self Care or Advice Line
    - Primary Care Physician
      - Urgent Care Clinic/Retail Clinic/Other
        - Emergency Department
          - Direct admission
            - Admitted to hospital (inpatient)
              - Transferred to another facility (e.g., hospital, nursing home)
                - Discharged home with outpatient follow-up
                  - Left against medical advice
          - Left without being seen
            - Returns
              - Repeat ED visits
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

<table>
<thead>
<tr>
<th>Category</th>
<th>ED</th>
<th>Referrals</th>
<th>Other</th>
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<tbody>
<tr>
<td>Elective/other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-elective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

% of inpatient hospital admissions
EDs

A vital portal for hospital admissions, especially of Medicare beneficiaries

Support PCPs by performing complex dx workups & handling after-hours demand

EPs are the main decision makers for half of all hospital admissions

Most non-emergent users believe they are ill, lack viable alternatives, or were sent by a provider

EDs may be playing a useful role in reducing preventable hospitalizations
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

North Carolina, South Carolina, Georgia

Michael Gerard, MD, FAAP, FACEP
ACEP Vice President
ACEP Board of Directors
<table>
<thead>
<tr>
<th>Good stuff</th>
<th>Controversial</th>
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<tbody>
<tr>
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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
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 physicians, patients, and caregivers to have conversations around the value of care. This encourages health care professionals to think about which treatments and procedures are most important for each patient's health and which may be unnecessary. 

NEWS FEED
RT @alikhan28: @acpinernists @abimfoundation @costsofcare @yalemed Engagement in high value care has to involve fun, diagnostic reasoning + costs #5GIM13
55 minutes ago
Good stuff

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

Active physicians (597,430)

Total acute visits (273 million)

Acute visits by underinsured – Medicaid or SCHIP (39 million)

Acute visits by the uninsured (24 million)

Pitts et al. *Health Affairs*, Sept 2010

Sponsor:

Rep Dent, Charles W. [PA-15]

(introduced 1/3/2013)
Cosponsors (45)
ACEP / EMPSF / KLAS
February 2013
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  99285  Procedural CPT® Code

SEARCH AGAIN
Browse Procedures by Category

ESTIMATED OUT-OF-POCKET COSTS

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Consumer Description</th>
<th>Est. Charge</th>
<th>Est. Reimbursement</th>
<th>Out-of-Pocket Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>99285</td>
<td>Emergency department visit</td>
<td>$711.14</td>
<td>$497.80</td>
<td>$213.34</td>
</tr>
</tbody>
</table>

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...

**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.

**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**.
Find Your Niche in Emergency Medicine
ACEP has 32 sections of membership >> join one today

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

THANKS TO ACEP MEMBERS
WE WERE $2 MILLION STRONG...
Because of you, we were able to invest more than $2 million in pro-emergency medicine candidates during the 2012 election cycle.
Your contributions give emergency physicians a voice on Capitol Hill and help shape the political landscape.
Contribute today at www.acep.org/NEMPAC

EM ACTION FUND™
Community-Oriented, Patient-Centered Care -- 24/7

Just 2% of the nation’s health care dollar is spent on emergency care.