

Free Standing EDs

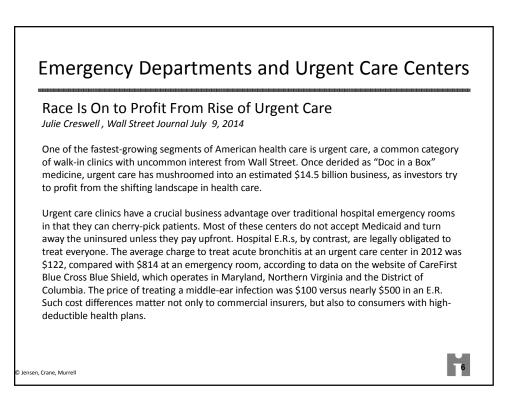
Freestanding emergency department growth creates backlash American Medical News (amednews.com) Sue Ter Maat - Posted April 29, 2013

The number of facilities is on the rise due to pressures from increased health care demand. With growth has come a backlash over freestanding EDs charging, or attempting to charge, a facility fee, as a hospital ED would. Facility fees are charges that hospitals collect from insurers for operating EDs and cover the cost of running the departments. Some insurers have sued freestanding emergency departments over their use of the facility fee, which can run about \$1,500 per patient.

Urgent care centers also have viewed freestanding emergency departments as a competitive threat. Few states have passed legislation requiring freestanding emergency centers that don't accept Medicare and Medicaid to conform to EMTALA standards on accepting all patients.

Proponents of freestanding EDs say these departments provide services that patients want in their communities, while critics say they will increase health care costs at a time when lowering them is paramount.

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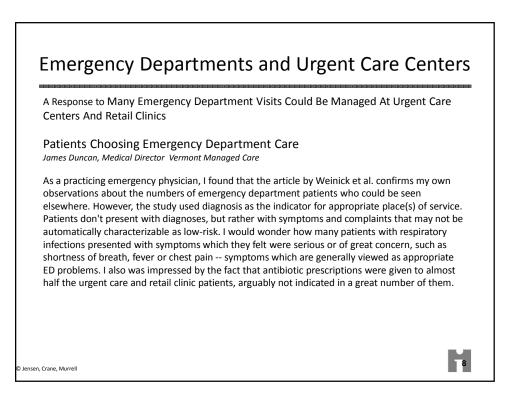


Emergency Departments and Urgent Care Centers

Many Emergency Department Visits Could Be Managed At Urgent Care Centers And Retail Clinics

Robin M. Weinick, Rachel M. Burns, and Ateev Mehrotra, Health Affairs September 2010

Americans seek a large amount of nonemergency care in emergency departments, where they often encounter long waits to be seen. Urgent care centers and retail clinics have emerged as alternatives to the emergency department for nonemergency care. We estimate that 13.7–27.1 percent of all emergency department visits could take place at one of these alternative sites, with a potential cost savings of approximately \$4.4 billion annually. The primary conditions that could be treated at these sites include minor acute illnesses, strains, and fractures. There is some evidence that patients can safely direct themselves to these alternative sites. However, more research is needed to ensure that care of equivalent quality is provided at urgent care centers and retail clinics compared to emergency departments.

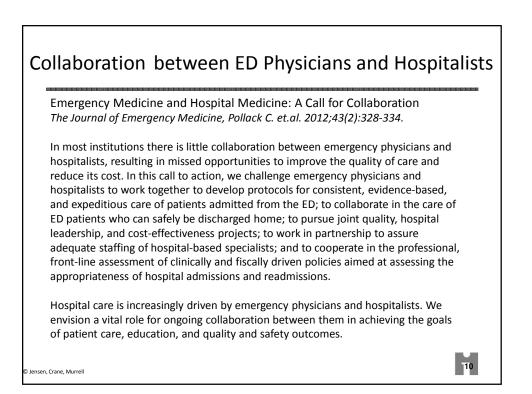


Collaboration between ED Physicians and Hospitalists

Emergency Medicine and Hospitalist Collaboration The Hospitalist, Casey Quinlan November 13, 2014

(From a podcast featuring Dr. Ken Epstein, chief medical officer for Hospitalist Consultants, a division of ECI Healthcare Partners; and Dr. Ken Heinrich, regional director with ECI Healthcare Partners and chief medical officer for emergency services for the ECI Advisory Group, discussing their ongoing work helping emergency physicians and hospitalists form collaborative teams.)

The focus for emergency physicians, says Dr. Heinrich, is triage and disposition. Differing incentives for hospitalists and emergency physicians can cause stress between the groups, and dialogue is needed to defray the tension, he notes. Dr. Epstein says he thinks that collaboration can be an effective tactic against becoming a "30 day readmission rule" statistic. Shared metrics, developed in partnership, can also improve patient care, he adds.



Reducing Hospital Readmissions

Reducing hospital readmissions from the emergency department *Myles Riner, MD, KevinMD.com July 6, 2014*

All of the focus that CMS is putting on hospital readmissions via the Readmission Reduction Program, and the financial penalties that readmissions can generate, is causing hospital administrators to look to the emergency department and emergency physicians to intervene and resolve the issues that interrupt recovery for post-hospitalization patients.

Jordan Rao in the *Incidental Economist* notes that "readmissions are down ... to what extent can that be explained by an increase in ED visits that don't result in an admission. Certainly, aggressive ED intervention or observation care can fend-off the need for inpatient readmission but preventing readmissions in this way does not necessarily imply better care.

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