These presenters have nothing to disclose

# What's New? Innovations in Emergency Medicine

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## Session Objectives

After this session, participants will be able to:

- Understand how others have dealt with key issues in their emergency departments
- Relate the pros, cons, and impact of the issues discussed

# Tele-medicine

The Case for Tele-Emergency Services: New research finds promise in tele-emergency system's ability to improve patient care in rural areas
*University of Iowa Newsroom, Released: 4-Feb-2014 10:25 AM EST*

Telemedicine Payments to Expand Under New Breed of ACOs
*Medscape Medical News, Robert Lowes, March 11, 2015*
Medicare will pay for services not only if the patient lives in a rural area, but also when the patient is at home

Telemedicine to Link Nursing Homes to the Emergency Department
*Urgent Matters: 2011 TelemedicineLinksNursingHomesED.pdf*
The Medical College of Georgia implemented a telemedicine program to conduct emergency physician evaluations before nursing home residents are unnecessarily sent to the emergency department.




# Tele-medicine

Telemedicine in Emergency Medicine
*ACEP Information Paper*

There are many current, and soon to be, uses for telemedicine, including remote consultation; nurse practitioners staffing rural emergency departments; the use of video telemedicine in ambulances by specially trained paramedics or nurse practitioners; a tertiary or quaternary EMS system; nationwide or worldwide consultation of specialists; remote telemedicine for disaster control; contracts with correctional facilities to provide medical care; expansion of teleradiology to telecardiology, teledermatology, psychiatric intervention, and pathologic consultation.

There is some concern that telemedicine may cut into emergency physician employment opportunities. It may decrease the demand for physicians to staff all sites of emergency care.

The barriers experienced are legal liability, lack of reimbursement of telemedicine by payers, acceptance by physicians and patients. The question also arises, will this technology increase or decrease costs?



# 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.





# Emergency Departments and Urgent Care Centers

## Race Is On to Profit From Rise of Urgent Care

*Julie Creswell , Wall Street Journal July 9, 2014*

One of the fastest-growing segments of American health care is urgent care, a common category of walk-in clinics with uncommon interest from Wall Street. Once derided as "Doc in a Box" medicine, urgent care has mushroomed into an estimated $14.5 billion business, as investors try to profit from the shifting landscape in health care.

Urgent care clinics have a crucial business advantage over traditional hospital emergency rooms in that they can cherry-pick patients. Most of these centers do not accept Medicaid and turn away the uninsured unless they pay upfront. Hospital E.R.s, by contrast, are legally obligated to treat everyone. The average charge to treat acute bronchitis at an urgent care center in 2012 was $122, compared with $814 at an emergency room, according to data on the website of CareFirst Blue Cross Blue Shield, which operates in Maryland, Northern Virginia and the District of Columbia. The price of treating a middle-ear infection was $100 versus nearly $500 in an E.R. Such cost differences matter not only to commercial insurers, but also to consumers with high-deductible health plans.

# 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.




# Emergency Departments and Urgent Care Centers

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

## Patients Choosing Emergency Department Care

*James Duncan, Medical Director Vermont Managed Care*

As a practicing emergency physician, I found that the article by Weinick et al. confirms my own observations about the numbers of emergency department patients who could be seen elsewhere. However, the study used diagnosis as the indicator for appropriate place(s) of service. Patients don't present with diagnoses, but rather with symptoms and complaints that may not be automatically characterizable as low-risk. I would wonder how many patients with respiratory infections presented with symptoms which they felt were serious or of great concern, such as shortness of breath, fever or chest pain -- symptoms which are generally viewed as appropriate ED problems. I also was impressed by the fact that antibiotic prescriptions were given to almost half the urgent care and retail clinic patients, arguably not indicated in a great number of them.



# 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.





# Collaboration between ED Physicians and Hospitalists

## Emergency Medicine and Hospital Medicine: A Call for Collaboration

*The Journal of Emergency Medicine, Pollack C. et.al. 2012;43(2):328-334.*

In most institutions there is little collaboration between emergency physicians and hospitalists, resulting in missed opportunities to improve the quality of care and reduce its cost. In this call to action, we challenge emergency physicians and hospitalists to work together to develop protocols for consistent, evidence-based, and expeditious care of patients admitted from the ED; to collaborate in the care of ED patients who can safely be discharged home; to pursue joint quality, hospital leadership, and cost-effectiveness projects; to work in partnership to assure adequate staffing of hospital-based specialists; and to cooperate in the professional, front-line assessment of clinically and fiscally driven policies aimed at assessing the appropriateness of hospital admissions and readmissions.

Hospital care is increasingly driven by emergency physicians and hospitalists. We envision a vital role for ongoing collaboration between them in achieving the goals of patient care, education, and quality and safety outcomes.



# 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.





# Treating the Chronic Pain Patient

## The Opioid-Free ED: Coming Soon to a Hospital Near You

*Fran Lowry, Medscape Medical News February 28, 2015*

The time has come to seriously explore the use of non-opioid analgesia for managing pain in the emergency department, said experts speaking at the American Academy of Emergency Medicine 21st Annual Scientific Assembly in Austin, Texas.
"Relying on opioids as the primary analgesics for moderate to severe pain is inadequate, unsafe, and costly," said Sergey Motov, MD, from Maimonides Medical Center in Brooklyn, New York.

"We have non-opioid analgesics that we can use for managing certain conditions in the emergency department, and the time has come to explore their use," Dr Motov told *Medscape Medical News*. "I'm not quite ready to say that we should just stop using opioids, period, because there are special situations and indications where nothing works better than opioids, but there are alternatives."