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Technology will have major impact on shaping future EDs, say the experts

Shift seen toward treating sicker patients, as retail clinics grow

Peering accurately years into the future requires a crystal ball that no one possesses, so how do you prepare? Observers of emergency medicine share common visions in several key areas. They are certain that technology will have an enormous impact and that EDs might come closer to their original mission of treating only the sickest patients.

"In the ED of the future, let's say a patient comes in who has been treated in your ED or system before," offers **Linda Laskowski-Jones**, RN, MS, ACNS-BC, CCRN, CEN, vice president of emergency, trauma, and aeromedical services, Christiana Care Health System in Wilmington, DE. "They will have some ability to self-triage to the lower or higher acuity side."

For lower-acuity cases, she explains, patients will be able to use self-registration kiosks. On the higher acuity side, Laskowski-Jones says, they will still require personnel to assess and initiate treatment. "I can see them using some kind of biometric authentication devices like palm vein scanning or retinal scanning, where there is basically a biometric link to a previous encounter in the hospital, and the patient has an actual medical record number," she adds.

Recently, says Laskowski-Jones, she had a glimpse into the technology of tomorrow. "I saw a mattress cover, which you can put on either a stretcher or a bed, that automatically monitors the heart and respiration — with no need for leaders or for the patient to remove their clothes," she shares." This technology, called

ED Management marks its 20th anniversary

With this issue, *ED Management* celebrates its 20th anniversary. We've marked the occasion by taking a look back at the past 20 years and a look ahead to the next 20. We've assembled an impressive group of experts to identify the key trends, point out the lessons we hope we've learned, and share thoughts on what lies ahead. We appreciate your readership and hope you will enjoy this special anniversary coverage! ■

IN THIS ISSUE

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the LifeBed, from Hoana Medical, of Honolulu, "takes any bed or stretcher and turns it into a call bell," Laskowski-Jones explains. "If the patient tries to get out of bed, a voice will tell them to get back in." **(The product is in the demonstration stage, so no price has been established. For more information, see the resource box on p. 3.)**

An added benefit, she says, is that the cover can be used with patients on hallway stretchers. "We have these stretcher patients we're worried about, but if we do not solve our intake problems, we can at least provide safety for unexpected surges," Laskowski-Jones offers. **(Before we get to this bright future, EDs will face several years of hardship. See the story on p. 3.)**

Thom A. Mayer, MD, FACEP, president and CEO of Best Practices, an emergency medicine, pediatric emergency medicine, and physician leadership management firm based in Fairfax, VA, agrees with Laskowski-Jones on the importance of information technology, but warns of the dangers it presents. "Anything that puts you closer to a patient is good thing; anything that puts you farther away is a bad thing," Mayer says. Short-term, information technology could be devastating to ED, he says. "All of a sudden, the doctors are sitting in front of computers and not patients," Mayer says.

The future, he says, will require the creation of a new position in the ED. "Doctors will not interface with computers, but with scribes, who are better at working with computers," Mayer envisions. These would be pre-law students, pre-nursing students, or paramedics. "We truly need to keep doctors away from computers," he insists. Nurses also will have scribes, he says. "Why should we take these highly trained people and sit them in front of a computer?"

Long-term future is bright

While the short-term challenges will be significant, Mayer does see a brighter future that includes technology. "We will have patient ID cards, which will contain all of their medical information, and they will be updated with each encounter," he says. "Providers will

Executive Summary

Technology can be a tremendous aid to any ED, if it is used properly, and it will have a growing role over the next 20 years.

- You might wish to enlist the help of pre-nursing or pre-law students to serve as "scribes," so that your doctors and nurses can spend less time at the computer and more time with patients.
- Be prepared for an increasingly informed patient population, many of whom may have gone online and have already "diagnosed" themselves.
- Stay on top of new technology that might improve care and safety, such as the "life stretcher," a mattress cover that automatically reads patients' vitals.

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have universal access to that information through a centralized system."

This information, Mayer says, will improve the predictability of emergency care. "Not only will we have what our intuition tells us when things are out of whack, but an IT system that says, for example, that this patient has been in the ED for chest pain three times," he explains. **(For more on the anticipated increase in critical care patients, see the story, below.)**

Technology already has begun to affect the way patients interact with providers, adds **Denise King**, RN, president of the Emergency Nurses Association. They are going to become more responsible; the good news, she says, is that patients also will be more responsible about providing more complete and accurate information about their medical history and their current medications.

Already, the increased responsibility of patients is apparent, King says. "They come in today to the ED much more educated than they were 20 years ago," she says. Patients go on the Internet; they diagnose themselves, King says, and then "come in and tell you what they want." ■

Sources/Resource

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EDs will focus on critical care

The EDs of the futures will look "far more like critical care centers," predicts **Thom A. Mayer**, MD, FACEP, president and CEO of Best Practices an emergency medicine, pediatric emergency medicine, and physician leadership management firm based in Fairfax, VA.

"Even small ones will be geared toward taking care of really sick patients," he says. This care will be enabled by the advent of assistants to help physicians with computerized documentation, he says.

"We will spend our time really as physicians and not as modified clerks or techs," Mayer says. "ED shifts will be much more intense, and we will generate much more revenue per hour because we will see more patients."

Accordingly, he says, ED physicians will only be able work six- or eight-hour shifts because of the increased intensity, "but it will be extraordinarily more satisfying."

Denise King, RN, president of the Emergency Nurses Association, sees a shift in delivery of care that fits in with Mayer's prediction. "The trend of retail clinics is a huge shift in our society, and it will continue, bringing health care much more to the community," King says. "I estimate that between 40% and 50% of patients seen in EDs do not need be seen there and could be seen in retail clinics."

King also sees a shift in the individuals who actually provide the care. "Traditionally, that has always been the physician, but we've seen change creeping in through the use of nurse practitioners and physician assistants," she says. "We see it more and more in the ED setting."

The retail clinics often are run by nurse practitioners, who King says are certainly qualified. "As there are not enough doctors, there is a good possibility they'll be even more active in the ED, but that depends on what happens in areas outside of the ED," she says. If the retail clinics can drain off that 40%-50%, King says, "they can leave the EDs with truly the sickest of the sick." ■

Things may get worse before they get better

While the long-term future for emergency medicine is bright, ED managers and their staffs will see some tough times in the short term, predicts **Thom Mayer**, MD, FACEP, president and CEO of Best Practices, an emergency medicine, pediatric emergency medicine, and physician leadership management firm

based in Fairfax, VA.

"There will be a period of four or five years of very difficult times for hospitals in general, with massive unemployment, and an increasing load of medically disenfranchised folks," he says. "But once that wave breaks, once hospitals get back into the black, we'll see an increase in freestanding EDs, where hospitals can get their presence in the midst of strategic segments of the community, i.e., paying patients."

"Over time, administrators will realize EDs are not loss leaders — even with tough economic times, we are still money makers," Mayer says. "We'll see more of a true focus on the economics of emergency medicine and fact that EDs do make money, and there will be a massive increase in the focus on flow." ■

Executive Summary

The most important events in the past 20 years have not only changed the face of emergency medicine; they still are affecting the way ED managers must operate their departments.

- The Emergency Medical Treatment and Labor Act (EMTALA), perhaps the most impactful event of all, has been a major contributing factor in the ongoing lack of specialists willing to take ED call.
- EDs face continued chronic underfunding due to misperception that most of the patients they treat do not really require emergency care.
- As a result of dramatic advances in emergency care, many patients are living longer. However, they are developing chronic conditions that bring them back to the ED on a regular basis.

EMTALA most impactful change in past two decades

Boarding, reduced safety unintended consequences

A lot can happen in 20 years, and certainly a lot has happened in the practice of emergency medicine — both good and bad. But experts seem to agree that no single event has had more impact on the field than the passage of the Emergency Medical Treatment and Labor Act (EMTALA).

"EMTALA is an unfunded mandate, and we have borne the brunt of it," says **Nicholas Jouriles**, MD, FACEP, president of the American College of Emergency Physicians (ACEP). "ED physicians provide more than $150,000 each of free care per year — magnitudes more than any other specialty."

That's because EDs often have no choice but to treat patients under EMTALA, while specialists often do have a choice, he says. "We've seen patients suffer because of that," Jouriles says. "It's one of the reasons we've seen more boarding, along with more likely complications, longer lengths of stay, and more patient deaths."

Robert Bitterman, MD, FACEP, president of Bitterman Health Law Consulting Group in Harbor Springs, MI, agrees. "EMTALA gave a lot of people access to care, but there are no primary care physicians anymore," he notes. "Specialists are cutting back, specifically not to take care of ED patients."

In many cases, he notes, those specialists are changing their privileges. Some neurosurgeons, for example, are reclassifying themselves as spine surgeons "so as to not have to be associated with all the other neurosurgery stuff that has much higher liability," he says. At some point, Bitterman predicts, the situation will hit home in a very public way. "Some senator's daughter is going to be transferred 90 miles with head bleed, and she is going to die," he says.

James J. Augustine, MD, FACEP, director of clinical operations at Emergency Medicine Physicians, an emergency physician partnership group in Canton, OH, cites another governmental action as a major development of the past 20 years. "There was a 1994 GAO [Government Accounting Office] report that said at least half of the patients in EDs could receive care elsewhere and, to this day, government leaders talk about the ED as the most expensive site of care where people do not need to be," he says. "Probably no single document has been more damaging to our industry than that."

That's because politicians, community health departments, and hospital boards decided that if most of those patients did not belong in the ED, there was no reason to expand EDs because that would just "invite" more of these patients to show up, he says. "That's resulted in a pattern of chronic underfunding," Augustine says. ■

Great strides made in patient care

Despite the challenges of overcrowding, underfunding, and staff shortages, experts say emergency medicine has made great progress in the last 20 years.

"The last 20 years have brought us great success in the delivery of care, as well as hard lessons about what

Sources

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excellence and virtuous care will reward us with in the ED," says **James J. Augustine**, MD, FACEP, director of clinical operations at Emergency Medicine Physicians, an emergency physician partnership group in Canton, OH. "We should revel in the fact that we deliver excellent care and prevent premature death in people from all etiologies."

In the past 20 years, "we have built great systems for preventing people from dying prematurely of injuries or acute medical events," Augustine says. "And, we have developed an excellent reputation in the community for what emergency care can do." Accordingly, Augustine says, there are a lot of people alive after suffering one of the "big three" — trauma, burns, and cardiac arrest — who in the past did not survive. "But when people don't die prematurely, they live, and they have to come back into the ED on a regular basis, particularly people who have cardiovascular problems," Augustine notes.

The emergency medicine community also has made great advances in political advocacy, says **Nicholas Jouriles**, MD, FACEP, president of the American College of Emergency Physicians (ACEP). "With ACEP leading the way, we've been able to become a force within the national arena," he says. "We have 'branded' the names emergency medicine and ACEP, we have lots of people lobbying for us, and we have our own bills before Congress."

As an example, Jouriles notes, 10 years ago, "we were able to pass the 'prudent layperson' interpretation of emergency care, and we are called on frequently by *The Wall Street Journal* and *The New York Times* to offer our opinion." ■

EDs must learn from past to solve nagging problems

Many problems identified years ago still exist

Experts in emergency medicine often have correctly identified key challenges over the past 20 years; unfortunately, they have not been as adept at addressing them, say observers. However, the lessons learned at least point the way to future improvement, they add.

"We've learned that indentured servitude will not work; you can't force people to provide care," says **Robert Bitterman**, MD, FACEP, president of Bitterman Health Law Consulting Group, Harbor Springs, MI, referring to the Emergency Medical Treatment and Labor Act (EMTALA) and the ongoing problem of finding specialists to take call. "With unfunded mandates, you end up with patients dying, or not getting care on a timely basis, or not having access to care," he says.

What Bitterman hopes will happen is a "swinging of the pendulum." For example, "It could be as simple as providing some form of liability protection," he says, noting that the state of Florida has put a hard cap on liability for EMTALA-related patients.

"People look at EDs as public facilities, and if they are looked at that way, they should be treated that way," he says. "If you can't sue police, firemen, or other public officials, you shouldn't be able to sue an emergency physician." Bitterman says he understands the need for funding to compensate for patients without insurance, "but you can't threaten the livelihood of the physician."

There has been a failure to recognize that people did not want to wait out front in the ED, says **James J. Augustine**, MD, FACEP, director of clinical operations

Executive Summary

ED experts say that we can learn from the key developments of the past 20 years to help improve the way EDs operate in the future. Here are a few suggestions for adapting to the challenges that have arisen:

- Develop physician leadership of the triage process to reduce lengthy delays on the front end of the care process.
- Support modification in liability legislation to lighten the burden placed on EDs by the Emergency Medical Treatment and Labor Act (EMTALA).
- Design new EDs or expansions to accommodate the needs of elderly patients, who will comprise a much larger segment of the patient population.

at Emergency Medicine Physicians, an emergency physician partnership group in Canton, OH. "In the last three years, the emergency system has suffered tremendously because of widely disseminated information about people left to die in the waiting room," he says. "It is absolutely essential to cut out that lengthy front-end process so we do not have people performing triage functions facing criminal actions."

The best way to accomplish that step is to develop physician leadership of the greeting process, he says. "Physician in triage and other programs with a variety of names are critical elements to get patients into the system rapidly, address acute medical needs, and to move them more quickly through the ED so beds are available for the next groups of patients," notes Augustine.

Overuse of telemetry?

Augustine also cites "failure to recognizing that preventing death from care at age 50 results in many more people 60, 70, and 80 years old coming to the ED with medical events that result in them needing telemetry beds." That lack of planning or ability to identify outcomes "has created more difficulty in running EDs and to others misinterpreting outcomes, leading some to say we overuse telemetry," he says.

His solution? "We should prepare by building EDs that can provides the services for this changing population," he says. "That includes an intake area that sees them rapidly and allows the physician to begin directing their care very early on." This change also might require more people "to simply help move them around the department," adds Augustine.

In addition, "We should build EDs with beds and other accommodations that are comfortable for people who are older and more frail, and in many cases not able to rest as comfortably on cots with 1-inch mattresses," he says. So, Augustine explains, in choosing bed design, ED managers should consider thicker and more comfortable mattresses and rail systems that will allow an older patient greater ability to move and to care for themselves. ■

Mental health system adds to ED burden

Among the key challenges that have developed in the past 20 years — and have not yet been addressed — is the failure of the community's mental health system, according to **James J. Augustine**, MD, FACEP, director of clinical operations at Emergency Medicine Physicians, an emergency physician partnership group in Canton, OH.

"We have a large number of patients now in the ED who have mental health or chemical dependency needs, and no plan to find alternate sources or sites of care for that group of patients," he reports. "So, as an industry, we have essentially accepted the burden of caring for the mental health needs of the community even though our physical structures and the personnel we hire have not been set up to manage that group of patients."

The ED community has to recognize and address this problem, he says. "We have to come out and say this [community] failure has unloaded these patients on us and our medically trained staff and beds are not the right place for these people to be," Augustine says. "We should use that approach as the emergency leaders and uniformly say this compromises the care of the acute medical and trauma patients who don't have another place to go."

The burden ultimately should fall on the leaders of the community mental health effort, he says. "They are the ones that, acting with the support of the hospitals and emergency providers, can go to the bigger community and say their mental health system needs be funded," says Augustine. "In places where that has occurred and appropriate tax levies and other support systems have been developed, the community emergency mental health system is intact and that group of patients is not a burden on EDs." ■

Economy predicted to put more pressure on EDs

Reduced revenues anticipated, slowdown continues

Emergency medicine experts say the lagging economy is putting additional pressure on EDs that are already stretched to the limit, and that ED managers can look forward to even greater demand from patients while financial woes will lead to staff cuts, further exacerbating the situation.

"In the short or long term, it will increase our census; most EDs are seeing substantial growth," says **Charles L. Reese IV**, MD, FACEP, chair, Department of Emergency Medicine, Christiana Care Health System, Newark, DE. "And to the extent that people are out of jobs, do not have insurance, lose benefits, and get sicker, it's just going to drive our censuses higher in both low- and high-acuity populations." **Caral Edelberg**, CPC, CCS-P, CHC, of Edelberg Compliance Associates, Baton Rouge, LA, says, "In a

Executive Summary

There is nothing that you, as an ED manager, can do to improve the nation's economy, but knowing what to expect will enable you to make more informed decisions about department operations. Here is what the experts say you should expect:

- Your patient census is likely to increase as more people become unemployed and lose their health insurance.
- It will be more important than ever to improve documentation where possible, assure correct coding and billing, perform internal audits and self-disclose overpayments before Medicare/Medicaid identify them.
- As hospital revenues drop, expect to see a 'substantial' impact on your ability to compensate ED physicians. **(For more on ED manager salaries, see the *ED Management* 2008 Salary Survey results enclosed in this issue.)**

nutshell, unless the economy improves, we will see more uninsured patients and higher ED acuity as folks wait longer for care with fewer alternatives for finding it," says "RAC [recovery audit contractor] audits and recoveries mean practices will be paying money back to Medicare and Medicaid while income is down due to patient inability to pay."

All in all, she says, EDs will need to tighten up, improve documentation where possible, assure correct coding and billing, perform internal audits, and self-disclose overpayments before Medicare/Medicaid identify them.

Funds are 'drying up'

Hospitals are being severely affected by recession, says **Mike Williams**, president of The Abaris Group, a Walnut Creek, CA-based health care consulting firm specializing in emergency services. "Capital markets for hospitals have completely dried up," he says. "I know one CEO who went to 20 lending agencies and they all told him no — and this is one of the richest counties in California and one of the richest hospitals." That means fundraising for more wings or departments is drying up, says Williams, adding, "We will see layoffs."

The American College of Emergency Physicians is equally concerned. In a prepared statement in October 2008, then-president **Linda Lawrence**, MD, noted, "The emergency department provides an essential health care safety net for everyone, and this role becomes even more important as the country goes through difficult financial times and faces physician shortages. When people lose their jobs or their health insurance, they go without preventive care and necessary medications, and depend on emergency physicians to treat them when their illnesses turn critical."

There is no question that in New York EDs will be heavily affected, says **Steven J. Davidson**, MD, MBA, FACEP, chairman, Department of Emergency Medicine, Maimonides Medical Center, Brooklyn, NY. "Whatever we get for Medicaid patients, we get from the hospital and the governor is talking about a $15 billion budget gap," he says. "When you work it all through, this is going to translate to perhaps a 10% reduction on the hospital side of things."

Davidson says that translates into a "substantial" impact on the ability to compensate emergency physicians, who, he says, already tend to be compensated at lower levels than other areas of the country because New York is a desirable place to live. "This will have an impact on my capacity, for example, to support my 35 attending ED physicians," says Davidson. But the effects, he adds, are everywhere. "There are going to be layoffs in the hospitals, and certainly the capital resources are going to be affected," he predicts, adding, however, that there will be winners and losers.

The only good news, notes Reese, is that "if I had to pick a job to be secure in, it's us. There's plenty of job security, but it will be a tougher environment for everyone in medicine." ■

Sources

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You may have to wait for that new equipment

The ongoing recession means that many ED managers should restrain their excitement about the new equipment they were anticipating. "Hospitals often manage their capital equipment by financing it through leasing; for example, GE [General Electric] is a big seller of imaging equipment and does financing leases for the equipment," explains **Steven J. Davidson**, MD, MBA, FACEP, chairman, Department of Emergency Medicine, Maimonides Medical Center, Brooklyn, NY. "Given my reading of the tea leaves, I'd say GE has less cash to finance equipment than it had a year ago."

Davidson says he already has heard from colleagues all over New York City that capital equipment acquisition is entirely on an emergency basis, so people who have been anticipating upgrades will be disappointed. "For example, there was a lot of excitement over the last 12-16 months about cardiac CT imaging for coronary artery disease, and some hospitals were planning installation of the 64 detector scanners," he notes. "I'd bet that people are not going to spend that $1.5 million on those devices so quickly." ■

'Strenuous' times seen For ED managers

The current economic crisis is creating "strenuous times for ED leaders because all prudence will be necessary," notes **Steven J. Davidson**, MD, MBA, FACEP, chairman, Department of Emergency Medicine, Maimonides Medical Center, Brooklyn, NY. "They are going to be challenged to be creative in finding ways to do things," he says.

For example, Davidson notes, his nurse manager is pregnant and soon will be going out on leave. The assistant nurse manager position has been available for awhile. "I'm still struggling to get that position approved and there's no certainty I'll get it," he says.

Davidson notes that his ED does about 98,000 visits a year, and that he has over 80 nurses. "The director of nursing is going to be down to a single assistant nurse manager and a number of unionized nursing work force team leaders who can't do any discipline or evaluation," he notes. "That puts more of a burden on the leadership that remains in place." ■

Experts unsure that the new administration will help EDs

Little relief expected for overcrowding

The natural excitement and optimism that normally accompany the transition to a new administration are not universally shared by ED experts, judging by their comments to *ED Management.* While they offer their good wishes to the new Obama team, they feel it may be missing the boat in terms of the issues that directly affect ED operations.

"Even if the next administration somehow finds the money, the initiative, and the political energy to create more health care coverage for everyone, they'll try to send people to their primary care physicians, but there are not enough to go around and there won't be for years unless we change the education system and incentives, so they will still come to us," predicts **Charles L. Reese IV**, MD, FACEP, chair, Department of Emergency Medicine, Christiana Care Health System, Newark, DE. "The thing is in both scenarios, we are probably going to be paid less per patient than we are now."

Tough years predicted

Gregory Henry, MD, FACEP, vice president of risk management, Emergency Physicians Medical Group, Ann Arbor, MI, says, "I wish the new president well — principally not for his sake; but for mine, my children's, and my grandchildren's." However, there's no reason to believe that former Sen. Tom Daschle, the designated new Secretary of Health and Human Services, has any knowledge of broader health care issues, Henry says. By that statement, says Henry, he means an understanding

Executive Summary

"Change" may have come to America, but to hear the experts tell it, that doesn't mean that ED managers will get any of the change they are seeking. Here is their best guess at what the new administration will mean for you:

- Even if health care reform is implemented, it will not do much, if anything, to lessen the burden of overcrowding.
- Rationing may be one of the potential solutions to underfunding and growing shortage of providers.
- Malpractice reform is unlikely under the new administration.

of the root cause of our current situation.

"Without understanding what the Germans and Singaporese and British are doing, we can't move forward," he says. "They actually put up intelligent limits to care; it's called health care rationing." The American people want access, quality, and quantity of care without any limitations, Henry says, "and that cannot be." In addition, he says, we must adopt a realistic approach to futile efforts to prolong life. "To believe for one second there are no hard choices out there is not to understand where we are," he says.

Reese agrees with Henry on rationing. "It will be nice to have more patients with insurance [as President-elect Obama proposes]; but in the long run, there will be a drift toward more socialized medicine," he says, adding that rationing is the next logical step. "You mandate all this care, give everyone insurance, and you won't have enough money to pay for it all, so some de facto rationing will occur," he predicts. The bottom line, says Reese, is this: "I expect the Democratic Party to be more sensitive to our mission but less to economics, and completely unsympathetic to malpractice reform — and that makes it a very tough environment for everybody."

But **Steven J. Davidson**, MD, MBA, FACEP, chairman, Department of Emergency Medicine, Maimonides Medical Center, Brooklyn, NY, is extremely optimistic. "Based on the campaign I saw run this fellow run, he's really going back to first-leadership principles and trying to operate with some integrity," he says. Davidson also has a decidedly different opinion on Daschle than Henry. "He has apparently been going to school in health care for the last umpteen years, and that can only be a good thing," he says. ■

Rationing: The 800-lb. gorilla in the room

Will the new Obama administration successfully address emergency medicine's most pressing problems? Some are not hopeful.

"During the campaign, nobody talked about it," says **Gregory Henry**, MD, FACEP, vice president of risk management, Emergency Physicians Medical Group, Ann Arbor, MI.

"It," explains Henry, is the rationing of care. "We're filling our beds with patients who need huge amounts of work-up, who no one wants to admit, and we cannot come to a final agreement on what happens to them," he says. "Grandma has pneumonia, is demented, and has COPD [chronic obstructive pulmonary disease]. What are you prepared to do for her?" There are no answers forthcoming, he says, "because nobody wants to carry on this discussion publicly."

And yet, Henry continues, it must be discussed because it only is getting worse. "The single largest change in the last 30 years is who populates the ED," he says. "Because of things like seatbelts and improved care dynamics, we are seeing far fewer trauma patients."

Most ED patients, Henry says, are "nursing home types" at the end of their lives. "They require huge amounts of therapy and spend long times in the department, but it's OK to die in a nursing home," he says. "If someone is demented and is going downhill, and if we have nothing to truly offer them, why do you send them to the ED?"

Rationing, however, is not a popular concept, and it certainly is a dangerous political issue. "It takes somebody with some guts to say this or that will not be provided, and it needs be done on an across-the-board basis, because no individual doctor can be put in the position of denying anyone health care," Henry concludes. ■

Standards endorsed to boost efficiency, quality

They're voluntary, but CMS could adopt many

The National Quality Forum (NQF) has endorsed 10 national voluntary consensus standards for hospital-based ED care, with the goal of reducing overcrowding,

Executive Summary

While the new ED standards endorsed by the National Quality Forum are voluntary, many, if not all, of them eventually could be adopted by the Centers for Medicare & Medicaid Services (CMS). They already are eligible for public reporting. They also indicate ways in which ED quality of care can be improved.

- Review the measures and begin to plan for their measurement and utilization in their own departments, in anticipation of CMS adoption.
- Pay particular attention to some new clinical measures that help monitor quality: bundling, documenting wait time, and weight in kilograms for children.
- The measures will enable you to get a sense of your department's baseline, particularly with throughput.

National Voluntary Consensus Standards for Hospital-Based ED Care

- Median time from ED arrival to ED departure for admitted ED patients
- Median time from ED arrival to ED departure for discharged ED patients
- Admit decision time to ED departure time for admitted patients
- Door-to-provider time
- Left without being seen (LWBS)
- Severe sepsis and septic shock: Management bundle
- Confirmation of endotracheal tube placement
- Pregnancy test for female abdominal pain patients
- Anticoagulation for acute pulmonary embolus patients
- Pediatric weight in kilograms

Source: National Quality Forum, Washington, DC.

decreasing patient wait time, and improving quality of care. Although the standards are voluntary, experts predict that many, if not most, of the standards ultimately will be adopted by the Centers for Medicare & Medicaid Services (CMS). **(See list of measures, above.)**

Possibility of implementation

While CMS often ends up adopting standards endorsed by NQF, the likelihood is even greater in this case because CMS actually requested that NQF implement the process that led to this action. "I don't know the answer, but since this was requested and funded by CMS, these are the types of standards they are seeking and there is a much higher likelihood," says **Helen Burstin**, MD, MPH, NQF's senior vice president of performance measures.

Being endorsed by NQF means those standards have gone through a rigorous process of review. Their approval stamp is important to groups such as CMS that are looking to use measures that have gone through this type of process, says **John Moorhead**, MD, professor of emergency medicine at Oregon Health & Science University, Portland. Moorhead co-chaired NQF's steering committee on hospital-based ED care. "In fact, CMS had submitted some measures to NQF for review, so we anticipate that those will be adopted, and hopefully all of them will," he says. **(For advice on how ED managers should plan for these likely adoptions, see story on p. 11.)**

"We were able to establish some new clinical measures we think will be helpful to ED physicians as they monitor quality: bundling, documenting wait time, weight in kilograms for kids," says Moorhead. He thinks this will be the beginning of improved reporting on throughput that will more clearly tell the story on crowding in the ED. "Putting some numbers to it will help tell the story to the public, the health care industry, and practicing ED physicians and nurses," he notes.

Understanding factors such as time from arrival to discharge and admit decision time gives providers a broad view of ED care, says Burstin. It also will help the ED in working closely with and coordinating care with other hospitals, she says. "The clinical measures get at high-risk activity like placing endotracheal tubes and ensures we are always looking to document medication for kids based on weight in kilograms," Burstin adds. ■

Sources

For more information on the new ED standards from National Quality Form, contact:

- **Helen Burstin**, MD, MPH, Senior Vice President of Performance Measures, National Quality Forum, Washington, DC. Phone: (202) 783-1300. Fax: (202) 783-3434.
- **John Moorhead**, MD, Professor of Emergency Medicine, Oregon Health & Science University, Portland. Phone: (503) 494-7551.

COMING IN FUTURE MONTHS

- ■ Key to patient satisfaction gains in the ED
- ■ How one community solved the emergency mental health problem
- ■ Florida ED writes success story with new discharge unit
- ■ How to get your left-without-treatment rate below 1%

Don't wait for CMS move, EDs are told

With the likelihood that the Centers for Medicare & Medicaid Services (CMS) will adopt some or all of the 10 national voluntary consensus standards for hospital-based ED care recently endorsed by the National Quality Forum (NQF), experts advise ED managers to begin preparing now to be in compliance. Besides, they argue, the new measures will help them improve the efficiency and quality of their departments.

"ED managers should respond to these measures through their own local performance improvement programs, review these measures, and begin to follow them in their own institutions — and be on the lookout for groups like CMS to include them, perhaps as soon as 2010," advises **John Moorhead**, MD, professor of emergency medicine at Oregon Health & Science University, Portland. Moorhead co-chairs NQF's steering committee on hospital-based ED care. "These measures are not the be-all and end-all, but they are important steps in terms of our long-term goal of ED quality improvement," he says.

Those are good measures that ED managers can begin using now to get a sense of their baseline, particularly with throughput, says **Helen Burstin**, MD, MPH, NQF's senior vice president of performance measures. They are measures they can use to compare with other hospital EDs and learn from them, Burstin says. "In addition, because NQF has endorsed them, they are now eligible to be used for public reporting, so it's important to get to understand them in advance of CMS potentially using them as part of their outpatient public reporting requirements."

Moorhead says he hopes that in the long run, these measures will not present an additional burden of documentation for EDs. "We hope over a period of time one set of reporting is generated to meet the need of all these programs [i.e., CMS, The Joint Commission], and there is an attempt to minimize the burden on doctors, nurses and department in terms of the reporting process," he says. ■

CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity with the **March** issue, you must complete the evaluation form provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CNE/CME objectives

1. **Apply** new information about various approaches to ED management.
2. **Discuss** how developments in the regulatory arena apply to the ED setting.
3. **Implement** managerial procedures suggested by your peers in the publication. ■

CNE/CME *questions*

19. According to Thom A. Mayer, MD, FACEP, president and CEO, Best Practices, in the future, doctors and nurses will not document directly into computers, but rather will use individuals called scribes. Those scribes might be:
A. pre-law students.
B. pre-nursing students.
C. paramedics.
D. All of the above

20. According to James J. Augustine, MD, FACEP, director of clinical operations, Emergency Medicine Physicians, elderly patients are returning to the ED for additional visits on a regular basis, particularly those who suffer from:
A. diabetes.
B. cardiovascular disease.
C. Alzheimer's.
D. chronic obstructive pulmonary disease.

21. According to Robert Bitterman, MD, FACEP, president, Bitterman Health Law Consulting Group, one "simple" solution to the ongoing problem of finding specialists to take call would be:
A. to create a hard cap on liability for patients under EMTALA.
B. to repeal EMTALA.
C. to prohibit specialists from changing privileges.
D. to raise the stipends offered for taking ED call.

22. According to Steven J. Davidson, MD, MBA, FACEP, chairman, Department of Emergency Medicine, Maimonides Medical Center, the weak

economy will:

A. make it harder for EDs to buy or lease new equipment.
B. bring more uninsured patients to the ED.
C. require ED managers to be more creative with the assignment of staff responsibilities.
D. All of the above

23. According to Gregory Henry, MD, FACEP, vice president of risk management, Emergency Physicians Medical Group, a pressing issue for EDs that the incoming administration has yet to address is:

A. uninsured patients.
B. call panels.
C. rationing.
D. staff shortages.

24. According to Helen Burstin, MD, MPH, senior vice president of performance measures, National Quality Forum (NQF), Medicare is even more likely than usual to adopt the 10 new voluntary standards endorsed by NQF because:

A. they address pediatric patient safety.
B. CMS requested and funded the underlying research.
C. they can be used as the basis of performance improvement projects.
D. they address throughput.

CNE/CME answers

19. D; 20. B; 21. A; 22. D; 23. C; 24. B.

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Salaries of ED managers stop climbing, as hospitals respond to financial pressures

It was too good to last. In the 2007 *ED Management* Salary Survey, we noted that hospital administrators were reacting to the realities of supply and demand and showing a willingness to be more generous with salary increases. As 2008 unfolded, however, and as our 2008 *EDM* Salary Survey illustrates, a shortage of available talent was not enough to keep those salaries rising significantly. Experts predict that as the economic downturn takes hold, even that shortage of talent may be short-lived.

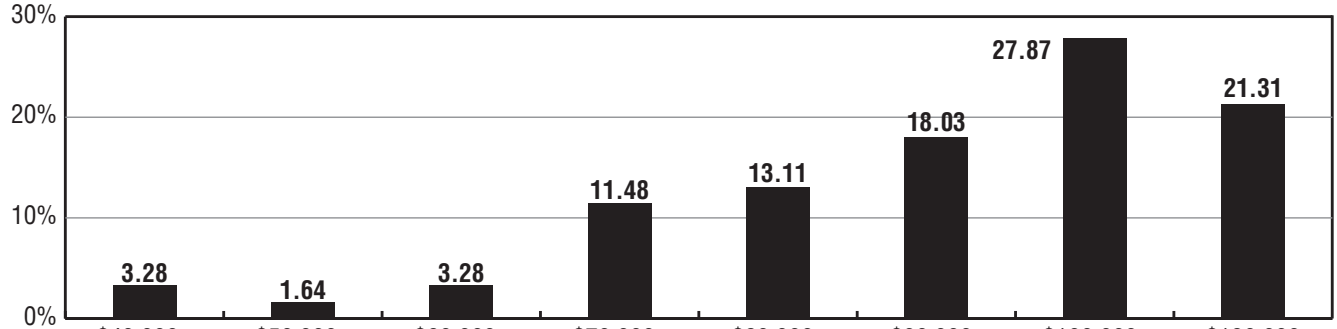
Compared to the 2007 *EDM* Salary Survey results, there was not a dramatic increase in the number of managers in the highest income levels. For example, in 2007, 21.05% were in the $90,000-$99,999 range, compared with 18.03% in the current survey. Those between $100,000 and $129,000 increased slightly, from 25% to 27.87%. There was a more significant jump in those making $130,000 or more, from 17.11% to 21.31%. **(See chart on salary changes, below.)** In terms of increases, the vast majority saw a 1%-3% increase (49.18% in 2008, 50.65% in 2007) or a 4%-6% increase (27.87% in 2008, 29.87% in 2007). There was a jump in the number of respondents who said they received a 7%-10% increase (6.56% in 2008 vs. 3.9% in 2007), but that is not statistically significant given the percentage and the sample size. **(See chart, p. 2.)**

For the 2008 report, 880 surveys were disseminated. There were 61 responses, for a response rate of 7%.

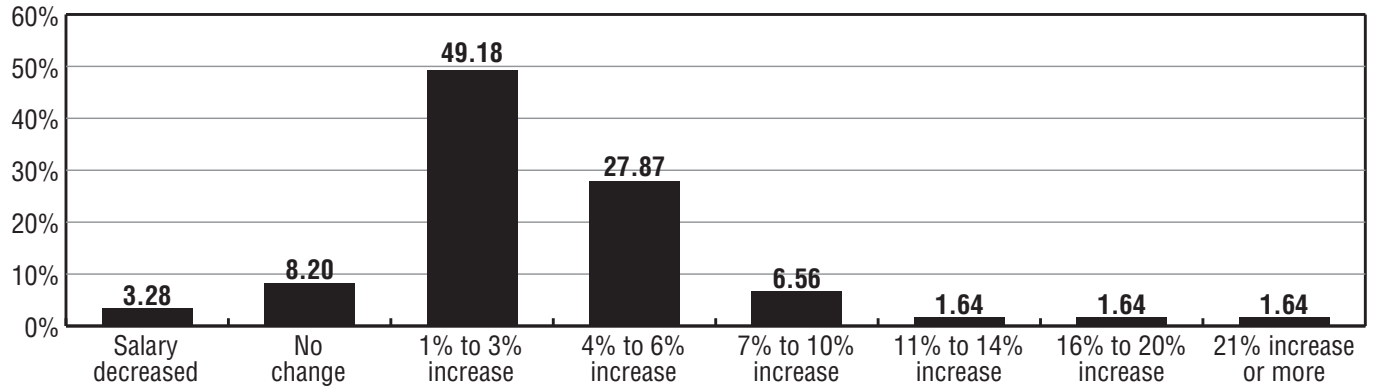
Don't blame it all on the economy

The reason for a slowdown in the rate of salary

What is Your Annual Gross Income from Your Primary Health Care Position?



In the Last Year, How Has Your Salary Changed?



increases is not as simple as "the economy," notes **Diana S. Contino**, RN, MBA, FAEN, senior manager, health care, with McLean, VA-based BearningPoint Management & Technology Consultants, which provides management and technology consulting services.

"I do think there will be continued downward pressures on [nurse manager] salaries due to reimbursement decreases from 'never events,' and revenue repayments from the recovery audit contractors [RAC]," she says.

Impact from less money

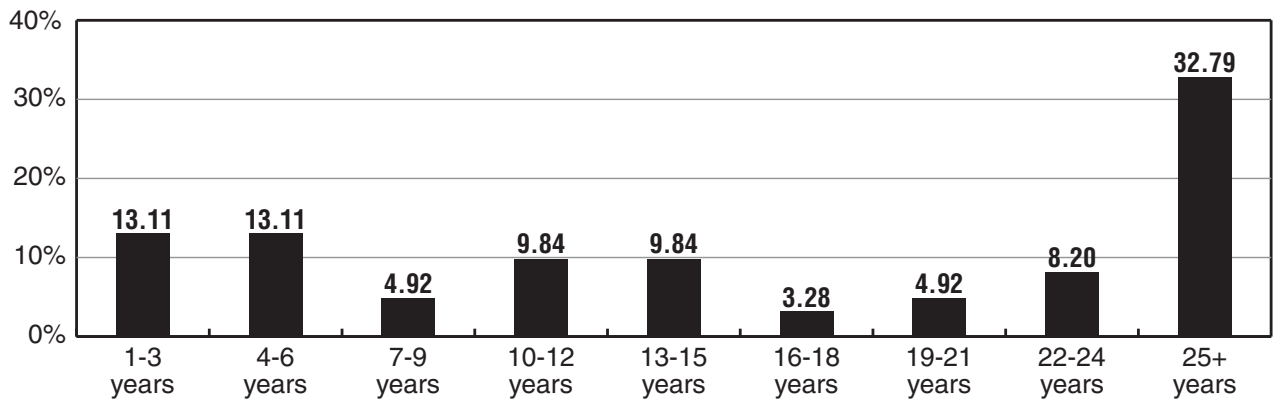
EDs have the same problems the rest of the world is having: There's less money available, says **Michael D. Bishop**, MD, president and CEO of Unity Physician Group, a Bloomington, IN, firm that staffs hospital EDs in Indiana and Kentucky and owns and operates urgent care centers in Indiana. He also is a spokesman for the American College of Emergency Physicians. "We are not necessarily seeing huge increases in volume, but we *are* seeing a decrease in collectibles," Bishop says.

When he talks to his physician managers, they tell Bishop that their income has dropped or stayed the same, although it varies depending on the busyness of the ED. "A lot of times hospitals will kick in some money for medical directors [from nonemployee physician groups], but my experience is they never kick in enough to cover all the costs," Bishop says. "They want to pay for five to 10 hours a week, and the guys end up working 20-30 hours a week in larger hospitals, going to meetings and so forth," he explains.

As for ED physician groups, salaries are fixed or going down "because there's not as much money in the system," he says. "Reimbursements are going down, and it's getting to be a real tough business."

There clearly is a difference in what drives

How Long Have You Worked in Your Present Field?



compensation for ED managers who are physician employees, compared with those who are not, adds **Mike Williams**, president of The Abaris Group, a Walnut Creek, CA-based health care consulting firm specializing in emergency services. He notes that about 30% of EDs are staffed by employees, while 70% are contractors or partners in a medical group. "They are typically compensated differently; for example, I expect a modest increase in salaries for contract ED physicians," Williams says.

As for employees, that compensation is driven by how the hospital is doing, he says. "Hospitals are not in a position to offer larger salaries to anybody."

Other factors involved

The economy alone does not explain what's happening with ED manager salaries, Williams says.

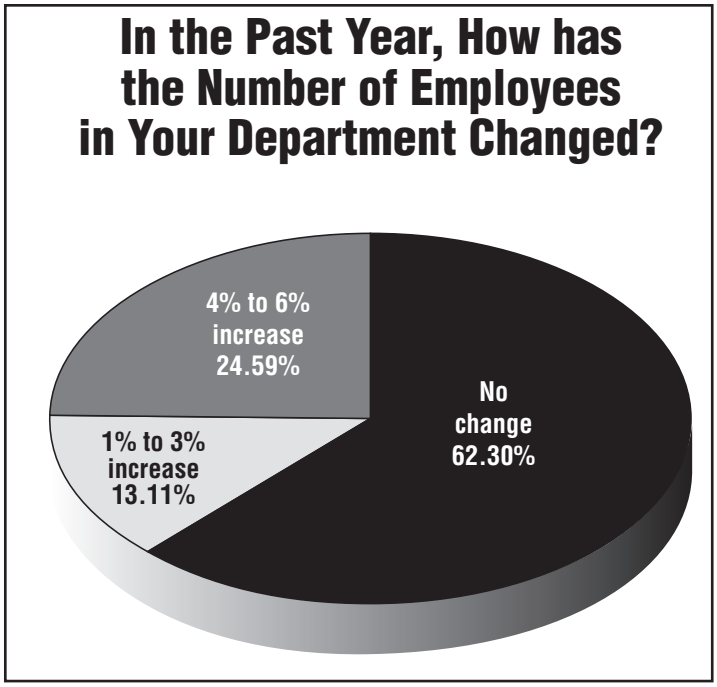
"We see some compression of salaries, but the market is booming with open positions, so that tells us what's driving this market may not be entirely compensation but it may be the lack of inventory [of managers]," he says. Williams says he asked one of his nurse leaders to explain the situation, and says she thought that as older nurse managers move on, they are replaced with younger ones who don't command salaries quite as high. **(See chart on years in the field, p. 2.)**

However, Contino says, "The competition for some open management positions may increase slightly, mainly due to layoffs in other industries, and potentially nurses returning to work." In general, she adds, "I don't see salaries increasing much in the next few years."

Contino adds that no one yet knows what the reduction in reimbursement due to "never events" will be, "but hospitals won't continue to get reimbursed for errors and mistakes, so there is significant pressure to improve processes and care delivery accuracy," she says. **(For more information on "never events," see "CMS wants to double list of conditions for which it will not pay a higher rate," *ED Management*, July 2008, p. 73.)**

In addition, Contino says, salaries alone do not tell the whole story. "It's true that any time the economy is depressed, nurses go back to work, work more hours, or take a higher position such as management because it pays a higher base salary," she says. "However, there are still hospitals and/or departments where managers will not make as much as staff who do a lot of overtime."

This difference is linked to a trend Contino says is common among a lot of nurse managers. "One of the questions we ask when we see high turnover of managers is whether they are getting support, both organizationally and structurally," she says. "What are their job responsibilities, and how are they aligned to their pay?" Prospective managers, Contino advises, should always inquire about pay rates and alignment with roles, responsibilities, and support systems.



Ironically, improving the nurse manager's ability to be successful in a management job has in some cases exerted downward pressure on salaries, says Contino. Positions with fewer direct reports may have a slightly lower pay scale. "There were quite a few vacancies in areas where one manager [director] supervises multiple departments. As a strategy to fill these open positions, chief nurse executives have made job realignments, and some managers who were managing two departments may now be overseeing just one," she says.

That doesn't mean that their jobs have actually become easier, Contino contends. "The job is becoming more complex because of recruitment and retention challenges, dealing with electronic medical records and other new technology, and with patient populations that are often more complex; you have a myriad of issues." Still, she concedes, this consolidation "makes it tougher to push for that higher salary."

An important consideration

Of course for many individuals, financial compensation is not the be-all and end-all of job satisfaction, and that's an important consideration when it comes to retention, says Williams. "The literature has shown that ineffective bosses can have a huge impact on a nurse's decision to quit, and that can impact nurse managers,"

he says. "In the younger age group, they are more about lifestyle, wanting to go to a sane place, where their skills are reinforced and their excellent service is compensated well, but where they also get nondollar compensation in the form of recognition."

Like all human beings, at some point we want our positive behavior to be reinforced, he says. "The hottest thing in hospitals is rounding, where you round with your staff," Williams shares.

"The manager carries 3x5 cards, asks people how things are going, and as soon as they say something, their manager writes it down to show important the comment is to them." This type of reinforcement is important to retention, which, he notes, "becomes increasingly important as you want to dip down into your staff to get managers — and as those openings increase."

Almost all the hospitals that Bishop is familiar with are employing patient satisfaction and quality measure incentives, especially those that CMS is promoting through the Physician Quality Reporting Initiative.

Other forms of compensation drop

In recent years, ED managers could look forward to supplementing their salaries by earning performance bonuses. While that opportunity will continue, say the experts, they might not be quite as lucrative.

"Performance bonuses and other nonsalaried compensation for hospital EDs may be declining," says Williams. "The only exception may be those hospitals that are unionized or where unions are gaining strength."

However, he says, performance incentives will continue. "More and more contract groups are working on incentives, and there may be more dollars to be made," notes Williams. As for the metrics most commonly used, "door-to-doc time is huge," he says. "Total turnaround is also common, and some groups measure errors." Many groups are putting providers at the door, which can improve door-to-doc times dramatically, he adds. "I've seen the left-without-being-seen number drop to 0.5%, and customer service ratings go sky high," Williams says.

Some sites pay nurse managers performance bonuses, but there definitely will be a decrease, Contino predicts. That's because most facilities only give out bonuses if the organization is meeting a certain profit margin, "and profits will likely be declining," she adds.

As for metrics, Contino continues, "Some hospitals base it on a balanced scorecard, looking at hospital-wide performance and goals." In those cases, she explains, the manager may have a percentage of their bonus tied to employee satisfaction, another to patient satisfaction, another to financial performance and productivity, and still another to their operational metrics. Those metrics might include documentation standards or projects they are implementing on time and on budget. In other sites, she says, bonuses might be based just on productivity and financial performance; if you are on budget, you will get your bonus. "Some bonuses are as small as a few thousand dollars, while some can be as much as $20,000 to $30,000," she says. They also can be affected favorably if you are a director over multiple departments, Contino adds.

Getting docs to assume more risk

There are more payment plans or payment systems that are involving RVUs (relative value units) or productivity and patient satisfaction, says Bishop, "and all of that is now being figured into any kind of bonus structures."

What's more, he adds, "even if the hospital doesn't subsidize the ED, it may require those kinds of things for people to maintain their contracts."

Almost all the hospitals that Bishop is familiar with are employing patient satisfaction and quality measure incentives, especially those that the Centers for Medicare & Medicaid Services (CMS) is promoting through the Physician Quality Reporting Initiative (PQRI), Bishop says. "But it's not because the hospitals are anxious to part with more money, he explains. "They're becoming much more common because the hospitals want doctors or groups to have some risk."

This is all related to the economy, he explains. "As the economy worsens, the hospitals want to put everyone else at risk as well," Bishop says. "While this does not involve huge sums of money — maybe $5,000 a quarter or something in that range — there could be a potential for compensation to actually go down, depending on how the deal is set."

So, for example, consider a situation in which there is a total of $100,000 at risk ($25,000 per quarter), a set amount for patient satisfaction, a set amount for core measures, and so forth. The group sets up their pay for doctors based on the assumption they will get the entire bonus, "and all of a sudden, their patient satisfaction scores are not appropriate, then basically they not going to get it all," says Bishop.

Some managers would look at that as a pay cut. "We try to look at the bonus as 'found money,'" says Bishop, "And if everybody does a good job, we get a bonus." ■