United States Falls Short in Emergency Care

BY DENISE NAPOLI

WASHINGTON — The United States gets a C– in support of emergency care, according to a report by the American College of Emergency Physicians.

Among the states, Massachusetts scored the highest, B, and Arkansas the lowest, D–.

After Massachusetts, the highest overall grades were received by the District of Columbia (B–), Rhode Island (B–), Maryland (B–), and Nebraska (C+). After Arkansas, the lowest overall grades went to Oregon (D), Nevada (D), New Mexico (D), and Oklahoma (D).

The report card does not measure the quality of care in individual hospitals or by individual emergency providers, but "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," according to an executive summary released at a press briefing.

Two years in the making, it is the second such report issued by ACEP since 2006. Its committee, made up of 14 physicians and ACEP regional heads, drew on unpublished medical reports, as well as data from the Centers for Disease Control and Prevention, the National Highway Traffic Safety Administration, the Centers for Medicare and Medicaid Services, the American Medical Association, other physician associations, and a survey of state health officials.

The report reviewed five major categories affecting care and weighed them according to their importance to the overall delivery of emergency services: access to care (30%); the quality and patient safety environment (20%); the medical liability environment (20%); public health and injury prevention legislation (15%); and disaster preparedness (15%), a new category that was not included in the original 2006 report card.

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"It has been 7 years since 9/11, but we have only achieved a C+" nationally on disaster preparedness, Dr. Stephen Epstein said.

The nation's overall C– reflects an especially low grade in the access-to-care category: a D–, according to the report. That's due primarily to the combined effect of an aging population and a simultaneous shortage of emergency departments and emergency care workers.

"While national data for hospital crowding, emergency department patient boarding, ambulance diversions, and shortages of on-call specialists are available, there is a critical lack of detailed and state-specific data related to these and other major emergency care access issues," the report stated. "Collection and analysis of such data should be a priority for states as they work to address these issues and ensure adequate access to care."

Nationally, the areas receiving the highest grades (C+) were in the quality and patient safety environment category, which "has benefited from extensive efforts to continually improve the quality of care provided," according to the report, and in the disaster preparedness category.

The report card outlined eight recommendations to improve the nation's overall grade:

1. Alleviate boarding in emergency departments and hospital crowding, identified in surveys and studies as one of the top concerns of emergency physicians. It's a problem with simple, "high-impact" solutions—such as coordinating inpatient discharge times and moving patients to beds as soon as they are admitted.

2. Pass the Access to Emergency Medical Services Act, also known as the Access Act. Among other things, the proposed federal legislation calls for the CMS to collect data on boarding for the purpose of developing new standards and guidelines.

3. Enact federal and state medical liability reforms, primarily those that help retain physicians and ensure access to specialists nationwide.

4. Increase federal funding and support of disaster preparedness. "It has been 7 years since 9/11, but we have only achieved a C+" nationally, Dr. Stephen Epstein, chair of the task force and an emergency physician at Harvard Beth Israel Deaconess Medical Center in Boston, said at the press briefing. "Surely, America can do better."

5. Increase support for the nation's health care "safety net." "Federal policies must be enacted to reimburse hospitals for uncompensated emergency and trauma care," the report states. "In addition, federal and state policies must address the growing rates of uninsured adults and children in our nation," who often end up in the care of emergency physicians.

6. Foster greater coordination of emergency services.

7. Maximize the use of information technologies to track and enhance the quality and patient safety environment, and to ensure that health care workers are properly trained.

8. Strengthen emergency departments through national reform. Ensure that emergency department reform is not left out of other national efforts.

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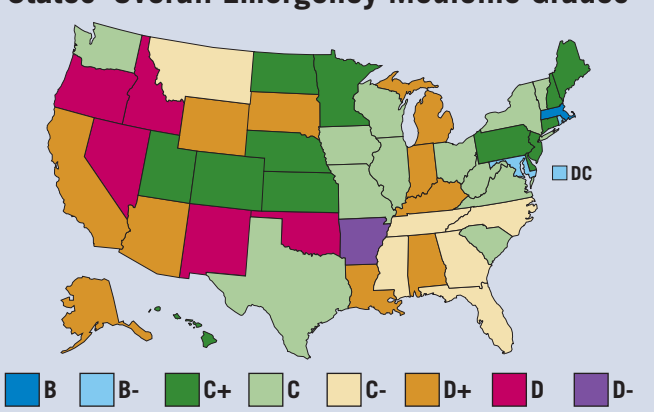
The report, which ACEP plans to reissue every 3 years, is available at www.acep.org/reportcard.

States' Overall Emergency Medicine Grades



Note: Overall grades based on access to care, quality and patient safety environment, medical liability environment, public health and injury prevention legislation, and disaster preparedness.
Source: American College of Emergency Physicians

ELSEVIER GLOBAL MEDICAL NEWS

Duplicate Testing Common in Study of CHD Patients

BY DOUG BRUNK

SAN DIEGO — Over the past year, Bridget A. Stewart and her associates at Children's Hospital Boston had a hunch that duplicate testing was going on among adults with congenital heart disease who were evaluated at Children's Hospital and subsequently admitted to nearby Brigham and Women's Hospital.

"If a patient is seen at Children's Hospital and then goes immediately over to the Brigham for admission, does that admitting resident realize that you just drew a full set of labs or that you just did an EKG, or does that resident reorder everything?" Ms. Stewart, administrative director of the hospital's cardiology department, said in an interview.

She and her associates conducted a retrospective study of 86 adult congenital heart patients admitted to Brigham and Women's Hospital after postcatheterization, a postclinic visit, or a post–emergency department visit at Children's Hospital Boston between Jan. 1, 2006, and Dec. 31, 2007. Each hospital has a separate electronic medical record system.

Clinicians were surprised to see that some of the duplicate testing 'was not clinically indicated.'

MS. STEWART

The researchers found that 28 (32%) of the 86 patients underwent some form of duplicate testing. Of these 28 cases, 18 (64%) were deemed non–clinically relevant by two independent reviewers.

The duplicate testing, the largest source of which derived from patients who originated in the clinic at Children's Hospital Boston, resulted in $1,800 in reimbursements, based on the Medicare fee schedule.

Cardiology clinicians at Children's Hospital Boston were surprised, because "they try to mitigate duplication through communication. …The dollar value was relatively small, but they were surprised to see that 18 patients had duplication testing that was not clinically indicated," Ms. Stewart said during a poster session at the annual conference of the Medical Group Management Association.

If the researchers followed adult congenital heart disease patients who live in Florida or Arizona for the winter months after being followed in Boston, "we'd find a lot of duplicate testing," she added.

One solution is to develop a national integrated EMR system such as that of the Department of Veterans Affairs. "All of their computer health records are integrated," she said. "I think that's what we need to do across America."

One study limitation was the fact that physicians' intentions in ordering the duplicate tests were unknown. "I do not know if he looked for results in the EMR prior to ordering testing, if he ordered it to have testing results in the institution's EMR, if there was some undocumented change in patient status that we did not pick up, or if he did not trust the data from the referring facility," said Ms. Stewart, who had no conflicts to disclose. ■