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The TAG Line

Study Looks at the Use of Telepsychiatry in EDs

The Abaris Group recently conducted a study of emergency department telepsychiatry programs, with a focus on seven such programs currently in place in the United States. The study's findings were published in an article titled "Telepsychiatry in the Emergency Department: Overview and Case Studies." This project was funded by the California HealthCare Foundation, based in Oakland, California.

Although telepsychiatry is commonly used in clinics and correctional facilities, there are only eight known ED telepsychiatry programs. According to study's authors "ED telepsychiatry programs appear to provide quick and specialized care to patients with the risk of psychiatric emergencies and have the potential to assist in reducing crowding in EDs and lowering costs."

Telepsych visits usually last for between five and ten minutes, and often begin as soon as a request for the service is made. These visits are usually conducted using videoconferencing, although one program reported that they rely primarily on telephone and email, with videoconferencing used only when necessary.

Survey participants reported varying levels of utilization for their programs. The largest program sees nearly 6,700 telepsychiatry visits per year, while the smallest sees only six (which they attribute to a lack of acceptance of their program, not to a lack of need).

All of those surveyed believe that their programs are either "successful" or "very successful" in regards to medical benefits and access for mental health patients. Survey participants perceive high levels of satisfaction with their telepsych programs, rating

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Blog: Universal Coverage Does Not Reduce ED Visits

We are now learning that universal coverage does not necessarily mean reduced ED visits. The original postulate was that if all were insured, fewer people would need to go to an ED for primary care as they would have a traditional "medical home" environment and willing physician practitioners due to the patient's new "insured" status. Apparently, nothing could be further from the truth.

According to a relatively recent ACEP survey conducted in Massachusetts if ED physicians by the respected Harris Poll (October 2009), ED visits in states like Massachusetts with universal coverage (now reported to be close to 95 percent insured in that state) might not reduce ED visits which is true for Massachusetts, but rather the volume remains the same or ,worse yet, increases. In fact, ED physicians reported during the survey that ED "wait" times and even "boarding" stayed the same and may have increased in some facilities.

This might be shocking to some but the actual fact is that there still remains insufficient primary care doctors to treat this new group of insured patients. And evidence by the schools of medicine, there does not appear like there will fixes to this problem anytime soon. This will remain primarily "*an ED problem*".

What are your thoughts?

Mike Williams

Share your thoughts on The Abaris Group's blog, here.

Inside this issue:

Ask Abaris Column:

Dear Abaris

"My ED is starting to work on improving our processes that we control within the ED. Are there trends or recommendations you could make as a starting point?"

See page 4 for the answer.

Trauma Care is Cost Effective, Study Finds

A study recently published in *ACEP News* found that although care at a trauma center is more expensive than at a non-trauma center, it is cost effective.

For the study, researchers used the National Study for Cost and Outcomes in Trauma (NSCOT) database to analyze data for 5,043 severely injured adult trauma patients. The researchers sought to determine whether or not the additional cost of trauma care is cost effective, considering the cost per life saved, cost per life-year gained, and cost per quality-adjusted life-year (QALY) gained.

Researchers found that the additional cost of treatment at a trauma center over a non-trauma center was $36,319 per life year gained. This is well within the generally accepted threshold for cost-effectiveness of somewhere between $50,000 and $100,000 per life-year gain.

According to Dr. Mackersie, Professor of Surgery and Director of Trauma Services at San Francisco General Hospital, "It's one of the few studies estimating the value and cost effectiveness of providing trauma care...and provides data that are likely to be critical in our efforts to persuade legislators and the public to invest in trauma systems infrastructure."

More information about this study can be found in the December 2009 Issue of *ACEP News,* here.

Online Tools Allow Patients to Avoid Waiting in the ED

A number of hospitals throughout the country are posting average emergency department wait times on the internet, so that patients have some idea of how long they can expect to wait before they visit the ED. When wait times for multiple hospitals in a given area are available online, patients can choose where to go based on which ED has the shortest wait. Some hospitals post the number of patients currently waiting to be seen on their website, as well.

A few hospitals have taken this a step further, allowing patients to actually register online and "Skip the ER Waiting Room." This service offered by a company called InQuickER, allows patients to pay $24.99 to register for a place at the front of the line in a participating ED waiting room. A charge nurse reviews all online registrations, to be certain that the patient condition is not truly emergent, and an ambulance does not need to be sent.

Some experts, however, say that these efforts are simply marketing gimmicks, with potentially negative outcomes for patients. For example, there is concern that patients may choose to visit a further ED, with a shorter advertised wait time, when their condition is such that the delay is dangerous. Alternatively, patients may choose to forgo necessary care, having been scared off by a long wait time posted online.

"A better thing to work on is to find out what's jamming up your emergency department in the first place, get your patients on the floor, get them feeling better rather than working to post your times," said Sandra Schneider, MD, ACEP president elect.

Others feel that instead of posting wait times online, patients will generally report higher satisfaction if they are kept informed about their wait once they are at the ED.

More information about the use of online tools to keep patients informed can be found here.

Telepsych, continued

both patient and provider satisfaction as four out of five on average.

Five of the seven programs receive grant funds, with four relying heavily on these grants. Despite this reliance on outside funds, most survey participants believe that the telepsych programs can be financially sustainable, and that having state regulations that require telemedicine to be covered by insurance is essential for that sustainability.

Common roadblocks to establishing a telepsych program included high start-up costs, physician buy-in, concerns regarding quality of care in telemedicine, coordinating a vast network, and purchasing equipment. Additionally, many reported challenges with licensing and credentialing.

In addition to improving access to care for emergency mental health patients, for some of these programs there has been the benefit of increasing ED physicians' knowledge of mental health issues, because of their continued contact with the psychiatrists.

The complete report can be found at the California HealthCare Foundation's website, here.

Massachusetts Ban on Ambulance Diversion Proves to be a Success

Since the start of 2009, Massachusetts has banned the practice of ambulance diversion at all hospitals in the state. Massachusetts is the first state to issue such a ban.

Ambulance diversion was first eliminated in the city of Boston for a two week trial period. The trial in Boston was designed to test whether or not putting an end to diversion would significantly impact the efficiency of hospitals and EMS providers. The researchers were proven correct in their hypothesis that there is no actual benefit to diversion in terms of ED and EMS efficiency, as several measures of efficiency (including ED length of stay and time EMS spends at the hospital) either showed slight improvement or remained unchanged during the trial. Because of these results, the Massachusetts Department of Public Health decided to permanently ban diversion on a statewide level.

Public health officials recognized that ambulance diversion only provides temporary relief, because it does not address the problems that are causing the backup of patients in the ED. With the no-diversion policy, officials hope that healthcare providers will be forced to make improvements to address these underlying problems.

Since eliminating diversion, the average time patients spend in Massachusetts EDs has not worsened. While some hospitals are still experiencing long ED wait times, some have seen improvement.

For example, at Massachusetts General and Brigham and Women's hospitals in Boston, which together previously were responsible for most of the state's ambulance diversions, ED wait times have actually decreased. This is because the ban on diversion forced doctors and administrators to look at the underlying issues that lead to diversion, and find ways to solve these problems. Massachusetts General, for example, actually saw a 13 percent increase in ambulance traffic since diversion was banned, however the hospital was successfully able to make improvements to reduce ED wait times. ED ALOS has decreased at Massachusetts General, from about 5.5 to 3.5 hours for treat-and-release patients, and from ten to six or seven hours for admitted patients.

For more information about the effects of the state's ban on ambulance diversion, please click here.

LWBS may not increase risk for adverse events, study finds

Last year, *ACEP News* reported on a study that sought to determine if patients who leave an emergency department without being seen (LWBS) are more likely to suffer an adverse event than those who are treated and discharged home. The results showed that these patients do not suffer from more adverse events than other patients, suggesting that the problem of LWBS patients is an issue from a patient access standpoint, not patient safety.

Roughly 3.5 percent of visits studied were LWBS. These patients did not differ significantly from those who were treated and discharged in terms of demographics, socioeconomic status, and ED visits in the previous year. They also reported to the ED with similar chief complaints.

LWBS patients had a two percent increased risk of death or inpatient admission in the seven days following their initial ED visit, compared with discharged patients.

While the slight increased risk found in this study is statistically significant, researchers feel that it does not represent a clinically important difference. The authors feel that hospitals that routinely call LWBS patients to try to get them to come back in to the ED may be wasting their efforts, as there is little benefit to this practice from a patient safety standpoint. However, the authors caution that these results should not be used to justify turning patients away from the ED or intentionally limiting access.

More information on this study can be found here.

Upcoming 2010 ABARIS Webinars:

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Pathways to innovation *for the emergency and healthcare communities*

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The Abaris Group has been providing consulting services for more than 20 years.

We specialize in community health assessments, hospital and emergency department process improvement, trauma services, and emergency medical services.

Abaris provides health care consulting to clients on a wide range of topics including strategic planning, operational improvement, and financial enhancement to help them achieve their goals.

Ask Abaris - Ask a Question to One of Our Experts

Dear Abaris

"My ED is starting to work on improving our processes that we control within the ED. Are there trends or recommendations you could make as a starting point?"

TAG Response:

Good question. Yes we do see certain trends or areas within the ED that usually standout, those being the intake and the output of patients. In order to discuss these areas they will be broken down into three parts: intake, discharge home, and admits, over the next couple of issues.

PART ONE - INTAKE

Abaris defines intake as the time from when the patient arrives until a provider sees the patient. For the purpose of this discussion we will focus on the ambulatory patient, as most facilities have worked hard on processes that involve the EMS patient. Intake involves every step the patient takes from the time they walk in the door until a provider physically sees the patient; this involves greeting, triage and registration.

The key to each of these processes is to first evaluate whether each step in the current process adds value. Value means that it assists the team with making a disposition decision. The next question is whether each step is done by the right skill level, at the right time and in the right way. It is also very important to remember what triage means: it is French for sorting. Napoleon Bonaparte developed triage on the battle field for when the demand of patients was greater than the resources available. Thus if resources are available (treatment space & provider) the sorting step can be bypassed.

Does your triage nurse complete the medication reconciliation? In this case the medication reconciliation does not add value during the intake phase, thus it can be delayed until later in the patient's stay. Regarding the right skill mix, you might ask: do you have a nurse answering phones, entering orders or assisting visitors with finding their way? Yet there are patients waiting to see that nurse for the initial assessment. "Is it done in the right way" can mean do you use the technology you have to its fullest capability? Are you duplicating steps by manually writing and then entering into the computer?

The best methodology for assessing each of the intake processes is to develop a team from the staff that performs these functions for intake: nurses, techs, and registration, for example. As this team reviews the processes and develops new processes, keep in mind that the patient comes to see the provider (door-to-doc time), so ask yourself, if I was the patient, how would I want it?

If you have a healthcare question for one of our consultants, send an email with your question to:
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