

CMS May Adopt Throughput Measures to Deter ED Boarding

By **Lola Butcher**

If the federal government adopts emergency department throughput measures for its quality reporting programs as expected, hospital administrators may be motivated to help solve ED crowding and diversion.

“The misconception is that low-acuity and uninsured patients are piling into emergency departments and driving crowding,” said Dennis M. Beck, MD, the chair of the American College of Emergency Physicians’ Quality and Performance Committee. “The truth is that easing congestion upstairs, appropriate discharge planning, bed planning, and staffing can reduce boarding time issues.”

For the first time, the Centers for Medicare and Medicaid Services is considering ED throughput measures for two quality reporting programs. If those measures are adopted, hospitals will have a financial incentive to track and report the measures. Both reporting programs support CMS’ future vision of paying hospitals for value rather than volume of services, making it likely that hospitals will eventually have a financial incentive to hit certain performance levels for ED throughput. (The CMS measure specifications can be found on *EMN*’s web site at <http://bit.ly/EMNmeasures>.)

In its proposed rule for “meaningful use” of electronic health records, CMS proposed that hospitals electronically submit several quality measures to qualify for an incentive in 2011-2012, including:

- Median time from ED arrival to ED departure for admitted patients.
- Median time from admit decision time to ED departure for admitted patients.
- Median time from ED arrival to ED departure for patients who are discharged from the ED.

Hospitals that comply with the so-called “meaningful use” criteria, including quality reporting, will receive \$2 million from CMS in addition to an amount that reflects the hospital’s number of discharges and proportion of Medicare patients.

Separately, CMS has identified two of the measures — ED arrival to departure time for admitted patients and time from admit decision to ED departure — for possible inclusion in its Reporting Hospital Quality Data for Annual Payment Update (RHQ-DAPU) program beginning in fiscal 2011. Hospitals that do not participate in that program are subject to a



Suzanne Stone-Griffith

two percent cut in their annual Medicare inflation update; more than 95 percent of hospitals report these measures.

Dr. Beck said when hospitals see money attached to ED throughput measures, administrators will start focusing new attention on ED crowding, which in turn will force them to recognize that ED crowding is actually a hospital throughput problem. “What I think the measures will do is shine a light on the accountability of the system to deal with crowding and boarding as opposed to just emergency physicians,” Dr. Beck said.

The measures being considered by CMS are among 10 ED measures endorsed by the National Quality Forum in 2009. (See Dr. Shari Welch’s September *EMN* column for the entire list: <http://bit.ly/PerfMeasures>.) The NQF’s steering committee for emergency care measures was chaired by Suzanne Stone-Griffith, RN, MSN, the assistant vice president for quality at the Hospital Corporation of America, and John C. Moorhead, MD, a professor of emergency medicine at Oregon Health and Science University School of Medicine. Ms. Stone-Griffith also chairs the emergency crowding committee of the Emergency Nurses Association, and Dr. Moorhead is a past president of ACEP.

Angela Franklin, ACEP’s director of quality and health information technology, said most emergency physicians are more than ready for the throughput measures to be reported. “Many of our members say it’s a significant step in the right direction in terms of being able to address the boarding problem, which studies have shown is the primary contributor to crowding,” she said. “The question I get most frequently is ‘why isn’t a timing element attached?’”

The reason: It may be too soon.



Dr. Dennis Beck

“Until this point, facilities having been defining and tracking these data according to their own definitions,” Ms. Stone-Griffith said. “How do we compare apples and oranges? And for that matter, which is better or more meaningful to the patient outcomes?”

Until a large volume of ED throughput data are collected using standard definitions and then analyzed, no consensus will be reached about appropriate time thresholds for ED throughput, she said. When is an arrival-to-departure time for admitted patients too long, for example? When does boarding negatively affect the patient?


Many physicians have said if hospitals were held to ED throughput standards, chronic boarding and diversion problems would be addressed by top administrators. It worked in England, where total turnaround time for ED patients must be four hours or less. The same happened within the HCA system after its hospitals started internally reporting ED holding statistics on a monthly basis, Ms. Stone-Griffith said. In 2008, HCA hospitals began tracking the number of patients boarded for 60 minutes or more after an admit decision, the amount of time they were boarded, and why they were held in the ED. Those data helped hospital leaders outside the ED recognize the need for an inpatient bed management initiative that has dramatically reduced ED crowding problems, she said.

If CMS adopts the NQF-endorsed measures, all EDs will start measuring ED throughput in the same way. This will allow researchers to analyze the relationship between length of ED stay and patient outcomes, and eventually will lead to the development of throughput standards.

The development of ED throughput

standards will be challenging because EDs treat such a wide range of patients. The NQF steering committee recommends stratifying the measurement of “median time ED arrival to ED departure for patients who are admitted to the hospital” by:

- A global score for all ED patients who are admitted.
- Psychiatric patients who may have longer waiting times because of their needs.
- Patients formally admitted to observation.
- All others (including non-psychiatric populations, those not transferred, and those not being observed).

“The global score is too broad to be meaningful so you need to cull out certain subsets,” Dr. Beck said. 

Comments about this article?
Write to *EMN* at emn@lww.com.

Click and Connect! Access the links in this article by reading it on www.EM-News.com

In Brief

EP Appointed Chair of ABMS

John McCabe, MD, was appointed the 33rd chair of the American Board of Medical Specialties, which oversees the certification of physician specialists.

Dr. McCabe joined ABMS in 1999, and most recently served as its vice chairman. He has been a member of the American Board of Emergency Medicine since 1996, and has held all offices within that organization, including president of the board from 2004 to 2005.

Dr. McCabe, a professor of emergency medicine at the State University of New York (SUNY) Upstate Medical University in Syracuse, was instrumental in developing the university’s department of emergency medicine and its residency program. He also is the CEO and senior vice president for hospital affairs at the hospital and a past president of the American College of Emergency Physicians.

The ABMS board consists of 31 voting directors, one for each of its 24 member boards, three public members, and the ABMS officers. ABMS has been overseeing physician certification in the United States for more than 75 years. 