International comparisons of selected service lines in seven health systems

ANNEX 5 – REVIEW OF SERVICE LINES: ACCIDENT & EMERGENCY

Evidence Report

October 27th, 2014

Executive summary for A&E

- Accident and Emergency departments (generally known as emergency departments (ED) or emergency rooms (ER) abroad) can take **significantly different forms internationally**.
  - Germany and Sweden have historically had a different approach to A&E than the UK. Emergency departments are manned by specialist from around the hospital, rather than having dedicated emergency medicine doctors. Both countries are now moving towards emergency medicine as its own specialty, and staffing a specialised A&E department, but the systems remain considerably different from the UK model
- Similar to the NHS, in many regions **almost all acute hospitals have a 24/7 A&E department**
  - In Ontario, the Netherlands and Sweden nearly all acute hospitals have a 24/7 A&E department
  - In Victoria, almost all public as well as some private hospitals provide 24/7 A&E services
  - In Arkansas, public policy and incentives support and encourage the provision of one or more A&Es in every locality; though they may be staffed by on-call physicians
- **Most countries are following the UK 4 hour target** as it is recognised that there is a benefit to adding in a time constraint.
  - Victoria and Ontario both have **set the achievement target lower**, at 75% and 90% respectively, compared to 95% in England. Moreover, neither system actually meets their target, and especially in Victoria there are few consequences to this
  - In Stockholm the county monitors performance on the 4 hour target but this is **not nationally mandated**
- In **Germany the pre-hospital care** delivered by doctors through the ambulance service plays an important part in emergency medicine.
  - There is a strong focus on treating people on site, and ambulances are staffed by consultants to provide direct care
  - The term emergency medicine has been used primarily in the pre-hospital setting
- In the **Netherlands, gate keeping by the GP** plays a major role in low A&E attendances
  - 40% of patients is referred to A&E by their GP (compared to 5% in England)
  - In the future the share of patients referred by GP is set to increase further, with the establishment of GP posts at the hospital, and with financial incentives to keep patients out of A&E
- While timely access to emergency care is an often quoted concern, **only some regions have implications around minimum travel times**
  - In the Netherlands, minimum travel times are mandated by law: every patient must be able to reach a hospital within 45min from calling for an ambulance.
  - In Arkansas critical access regulations provide financial support for hospitals that are 15-35 miles (or a 45 minute drive) from the next nearest provider, and an A&E-type service is available in even the smallest localities
- Many regions have **out-of-hospital emergency services** similar to the minor injury units and walk-in clinics in England
  - In the Netherlands, GP posts, providing out-of-hours primary care. Many are located at or near many hospital A&E sites to provide an alternative to the A&E
  - In Sweden there exist sub-acute centres, located at community hospitals or in health centres, which provide emergency care in the evening and on weekends
  - In Victoria private urgent care centres are being created to provide an alternative to the long waiting times in A&E

A&E – NHS core standards

NHS standards setting bodies

- Department of Health, A&E clinical quality indicators
- College of Emergency Medicine
- Royal College of Surgeons

Core NHS standards[1]

Access

- **Patient spending more than 4hrs in A&E department <5%**
- Patient waiting more than 15 minutes for initial assessment <5%
- Median time to treatment ≤60min
- EDs are open 24 hours a day, 7 days a week
- A patient for whom an emergency surgical assessment is required will receive the same within 30 minutes of referral being made in the case of a life- or limb threatening emergency, and within 60 minutes for a routine emergency referral

Input

- **Presence of a senior ED doctor (ST4 or above) as a clinical decision maker 24/7**
- Presence of up-to-date facilities for resuscitation, emergency care and ambulatory care
- Support from Critical Care, Acute Medicine, laboratory services and diagnostic imaging
- Presence of a Clinical Decision Unit (CDU)/ observation ward
- 24/7 access to x-rays, ultrasound and computed tomography (CT)
- **Availability of a surgeon at ST3 level or above, or a trust doctor with equivalent ability (ie MRCS with ATLSR provider status)**
- **24/7 emergency operating facilities available, on site, capable of being accessed and staffed to allow the timely management surgical emergencies**

Process

- A patient for whom an emergency surgical assessment is required will receive it within 30 minutes of referral being made in the case of a life- or limb threatening emergency, and within 60 min for a routine emergency
- **Clinical handover from ambulance should happen within 15min, 30 min to the ambulance leaving hospital**

Outcomes

- Patients that are an unplanned re-attendance within 7 days ≤5%
- Patients leaving the departments without being seen <5%

Critical standards

		Level achieved
1	**Patient spending more than 4hrs in A&E department <5%**	4.6% (95.4% of patients leave within 4 hours)[3]
2	**Presence of a senior ED doctor (ST4 or above) as a clinical decision maker 24/7**	Not available
3	**Availability of a surgeon at ST3 level or above, or a trust doctor with equivalent ability**	Not available
4	**24/7 emergency operating facilities available, on site**	Not available
5	**15 min ambulance handovers**	Not available

1 College of Emergency Medicine – The Way Ahead 2008-2012; Workforce recommendations, 2012; Royal College of Surgeons – Standards for unscheduled surgical care, 2011; 2 Provisional Accident & Emergency Quality Indicators, HSCIC; 3 A&E weekly sitreps, 2014-14 so far, HSCIC

A&E – International standards

Standard topic	Standard specifics						
	England	**Victoria**	**Ontario**	**Netherlands**	**Germany**	**Stockholm**	**Arkansas**
Total time to departure	Less than 5% takes longer than 4hrs	Less than 25% has a length of stay over 4hrs	9 out of 10 patients with minor conditions spent <4hrs, complex <8hrs	No guideline	No guideline	Less than 29-21% has a length of stay >4hrs for patients <80yo	No guideline
ED doctor presence	24/7 presence of a senior ED doctor (>ST4) as a clinical decision maker	FACEM doctor: 16x7 on-site, 24/7 available (L4), 16x7 (L3), on-call 24/7 (L2)	No guideline	Presence of an IC experiences (not qualified) doctor required	N/A	N/A	Arrangements like on-call roster required to ensure physician availability for all
Operating facilities	Availability of a surgeon >ST3; 24/7 emergency operating facilities on site	Dedicated facilities to manage emergency presentations	No guideline	No guideline	N/A	N/A	Trauma/cardiac rooms for emergency procedures/ surgery shall be provided
Ambulance handover time	15 minutes to handover, 30 to ambulance leaving	15min transfer, 25 to completion	30 min offload, 90% of cases	No guideline	No guideline	No guideline	No guideline
No NHS equivalent:							
Time to triage	No target	Triage should occur at arrival	10 – 15 min after arrival	No guideline	No guideline	No guideline	No guideline
Maximum travel time	No guideline	No guideline	No guideline	45 min call to arrival time	No guideline	No guideline	No guideline

N/A: A&E departments in Germany and Sweden are staffed by consultants from the wards; as described later

A&E – Comparison of standards

Stricter target than NHS
Same target than NHS
More lenient target than NHS
No target

	England	Victoria	Ontario	Netherlands	Germany	Sweden	Arkansas	NHS strict?
Total time to departure	95% <4hrs	75% <4hrs	90% <4hrs	✗	✗	71-79% <4hrs	✗	
ED doctor presence	24/7	16x7	✗	✓	n/a	n/a	On call	
Operating facilities	24/7	✓	✗	✗	n/a	n/a	✓	
Ambulance handover time	15 min/30 min	15 min/25 min	30 min	✗	✗	✗	✗	
Time to triage	✗	At arrival	15 min	✗	✗	✗	✗	
Maximum travel time	✗	✗	✗	45 min	✗	✗	✗	

Note: Targets based on second highest care level where applicable, or lowest standard where a range is given

A&E – Reasoning behind the critical standards

Standard topic	Why critical?
Total time to departure	▪ The 4 hour A&E target is widely reported in England and seen as a measure of hospital quality ▪ Many countries report performance but few meet their stated target ▪ Smaller hospitals with lower volumes may struggle more to deal with variations in attendance rates and peak times
ED doctor presence	▪ There are not enough consultants to enable every hospital to meet the workforce standard and the smaller more remote hospitals particularly struggle to recruit emergency care consultants and trainees
Operating facilities	▪ The availability of operating facilities (as well as surgeons) during out-of-hours requires additional investment which can be difficult for smaller hospitals, where lower volumes do not warrant these investments
Ambulance handover time	▪ Ambulance handovers are reported on and seen as an indication on quality ▪ Rapid handovers require instant availability of personnel which may be difficult for smaller hospitals to guarantee
No NHS equivalent:	
Time to triage	▪ Smaller hospitals may struggle to recruit specialist nurses who are trained to do triage ▪ Timely triage requires a flexible workforce to respond to spikes in demand
Maximum travel time	▪ In more rural areas it may be more difficult to meet the time and distance standards set, which mainly affects smaller hospitals

SOURCE: Research team's analysis on why these standards are critical

A&E – Sources for standards

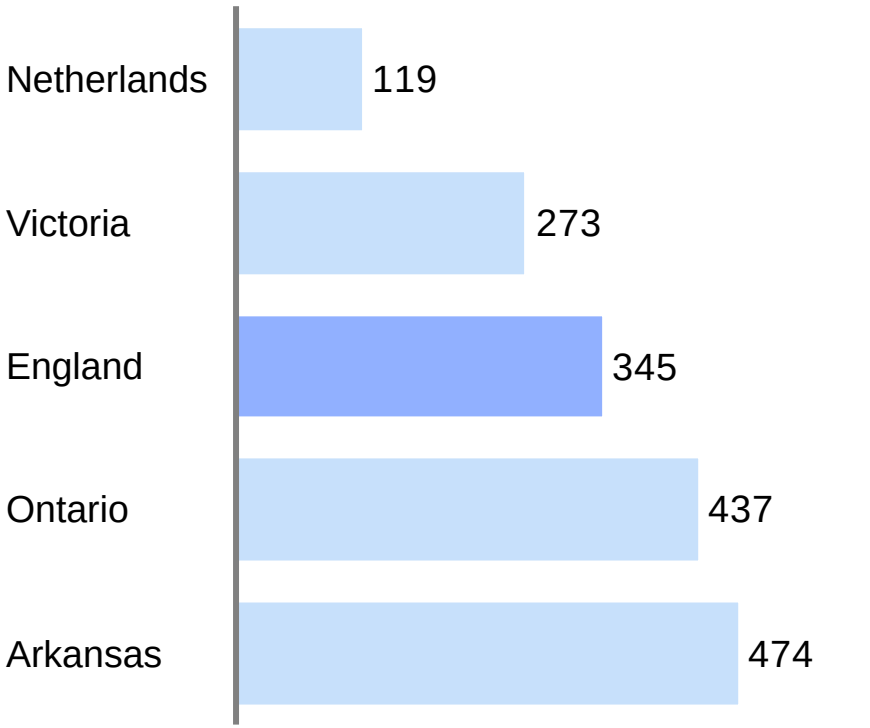
	Sources for standards
England	▪ College of Emergency Medicine – The Way Ahead 2008-2012 & Workforce recommendations, 2012 ▪ Royal College of Surgeons – Standards for unscheduled surgical care, 2011 ▪ Department of Health – Ambulance handover delays, 2012
Victoria	▪ Australasian College for Emergency Medicine – Statement on the Delineation of Emergency Departments, 2012 ▪ Victoria Government – Guidelines for ambulance presentations in the emergency department, 2007 ▪ Department of Health Victoria – Specifics for Victorian Health Services Performance Data, 2012
Ontario	▪ Ministry of Health and Long Term Care – Hospital Emergency Departments Audit 2010 ▪ Canadian Association of Emergency Physicians – CTAS Implementation Guidelines
The Netherlands	▪ Inspectie voor de Gezondheidszorg - Ziekenhuizen goed op weg met implementatie normen voor afdelingen spoedeisende hulp 2012 ▪ Nederlandse Vereniging Spoedeisende Hulp Verpleegkundigen – Richtlijn Triage op de SEH
Germany	▪ N/A
Sweden	▪ Genomlysning av Stockholms fem stora akutmottagningar, Slutrapportering Oktober 2013
Arkansas	▪ Arkansas Department of Health – Rules And Regulations For Hospitals And Related Institutions In Arkansas 2007

A&E – Standard setting context

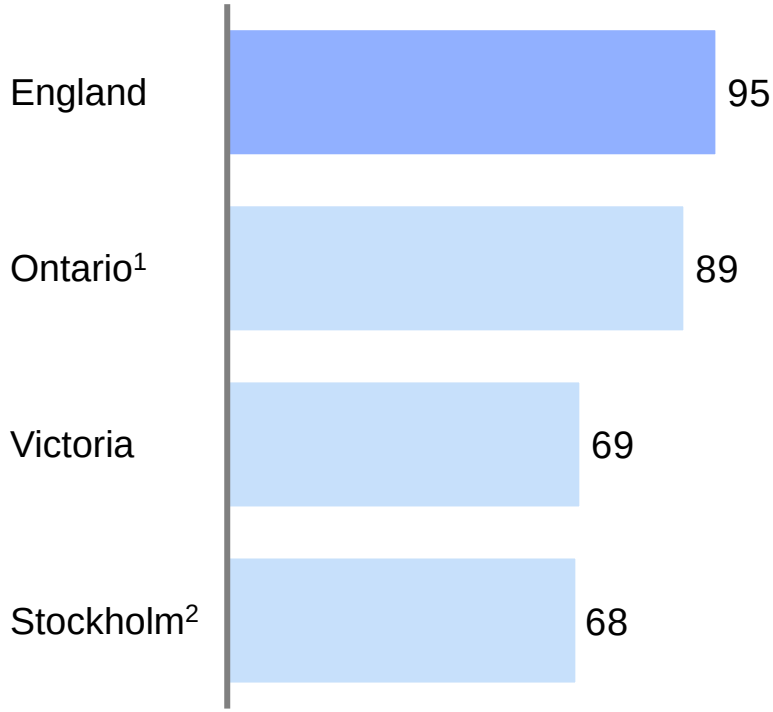
	Standard setting context
England	▪ The four hour wait and other time targets are monitored and published by the NHS ▪ The College of Emergency Medicine's The Way Ahead lays out standards for all emergency care delivered in hospitals ▪ There exists no national monitoring against those standards, but local programmes like London Quality Standards do report their performance based on the College's recommendations
Victoria	▪ The Australasian College for Emergency Medicine has published guidelines on the delineation of emergency departments (see appendix) as well as on triage implementation ▪ The 'Better faster emergency care' report published by the DoH contains a range of recommendations to innovate emergency care departments ▪ The DoH reports on waiting times as part of performance
Ontario	▪ The Department of Health for Ontario, as well as the Canada Ministry, report on waiting times in emergency rooms ▪ The Canadian Association of Emergency Physicians has published triage guidelines (CATS) ▪ The 2010 Annual Report of the Office of the Auditor General of Ontario reviews ED performance compared to standards
Netherlands	▪ The Law Access to Healthcare Institutions (WTZi) outlines minimal travel times of 45 minutes, which has been references by the Ministry as a potential restriction to reconfiguration ▪ The Dutch Association of Urgent Care Nurses (Nederlandse Vereniging Spoedeisende Hulp Verpleegkundige) have set guidelines for triage ▪ The Ministry of Health, through the Inspection for Healthcare, reviews performance of A&E departments in a national audit
Germany	▪ The German Association of Emergency Physicians (BAND) is an umbrella organization for emergency physician organisations ▪ The German Interdisciplinary Association of Critical Care Medicine (DIVI), is an association of many medical professional organisations and focuses on intensive care medicine and emergency medicine ▪ There is no or little guidance or monitoring of A&E departments (as far as they exist)
Sweden	▪ The Swedish Society for Emergency Medicine (SWeSEM) was established in 1999, and is involved in the training and standards for EM doctors ▪ There are no specific guidelines or waiting time targets for A&E
Arkansas	▪ The State Health Department sets "Rules and Regulations for Hospitals and Related Institutions in Arkansas" which hospitals have to comply with to get certification ▪ There is no other monitoring of standards

The number of A&E visits in England are average compared to international systems but the waiting time is low

Number of A&E visits per 1,000 population[a]



Percentage of people leaving A&E within 4hrs[b]

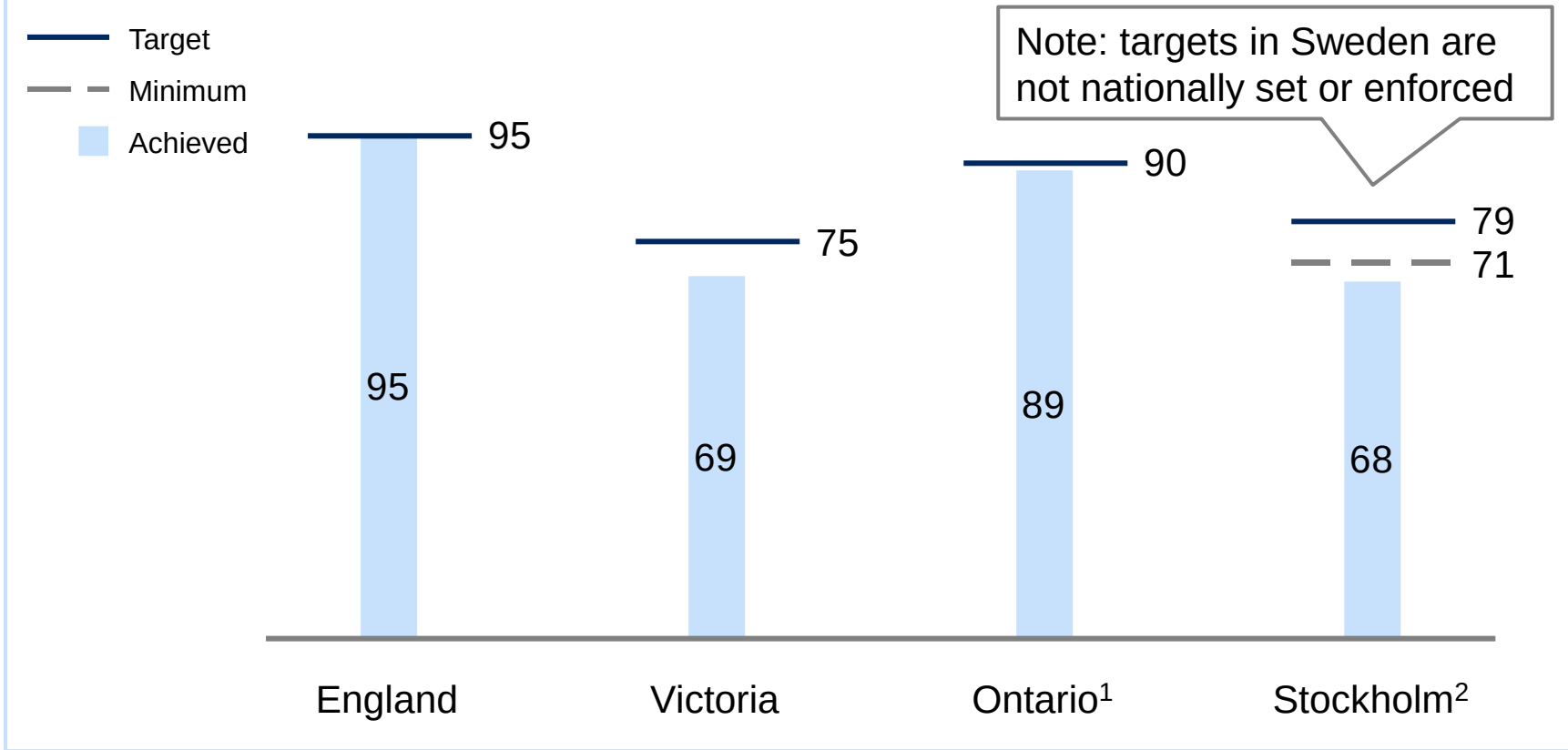


Note: A&E attendance numbers come from different sources and may therefore use different definitions
1 Patients with minor or uncomplicated conditions (that require less time for treatment, diagnosis, or observation): defined as low-acuity patients at CTAS 4 and 5 who have not been admitted to an inpatient bed. There is an 8 hour target for patients with high-acuity patients with complex conditions that require more time for treatment, diagnosis, or admission to a hospital bed: defined as patients at all CTAS levels who have been admitted to an inpatient bed, and patients at CTAS 1, 2, and 3 who have not been admitted to an inpatient bed.
2 Patients under 80 years old only

SOURCE: a: HSCIC, Performance.health.vic.gov.au, Nationaal Kompas Volksgezondheid, Hospital Emergency Department Audit MoH Ontario, Kaiser Family Foundation State Health Facts; b: HSCIC, www.ontariowaittimes.com, performance.health.vic.gov.au; Genomlysning av Stockholms fem stora akutmottagningar, Stockholm County Council, 2013

England has the toughest standard for A&E waits, but is closest to achieving the target

% of A&E length of stays <4hrs



1 Minor or uncomplicated conditions only
2 Patients under 80 years old only

SOURCE: HSCIC, www.ontariowaittimes.com, performance.health.vic.gov.au; Genomlysning av Stockholms fem stora akutmottagningar, Stockholm County Council, 2013

A&E in the Netherlands

Service line definition

- The existence of emergency medicine as a specialty in the Netherlands is relatively new
- Recently three levels of A&E have been introduced: Basic A&Es, profile A&Es and university centre or complete A&Es
- While the A&E departments are 'open' (i.e. everyone going to an A&E will be treated, 24/7), 40% of patients come referred via the GP (compared to 5% in England)
- Basic A&Es do not need to be open 24/7, they are determined in collaboration with surrounding hospitals

Service delivery model

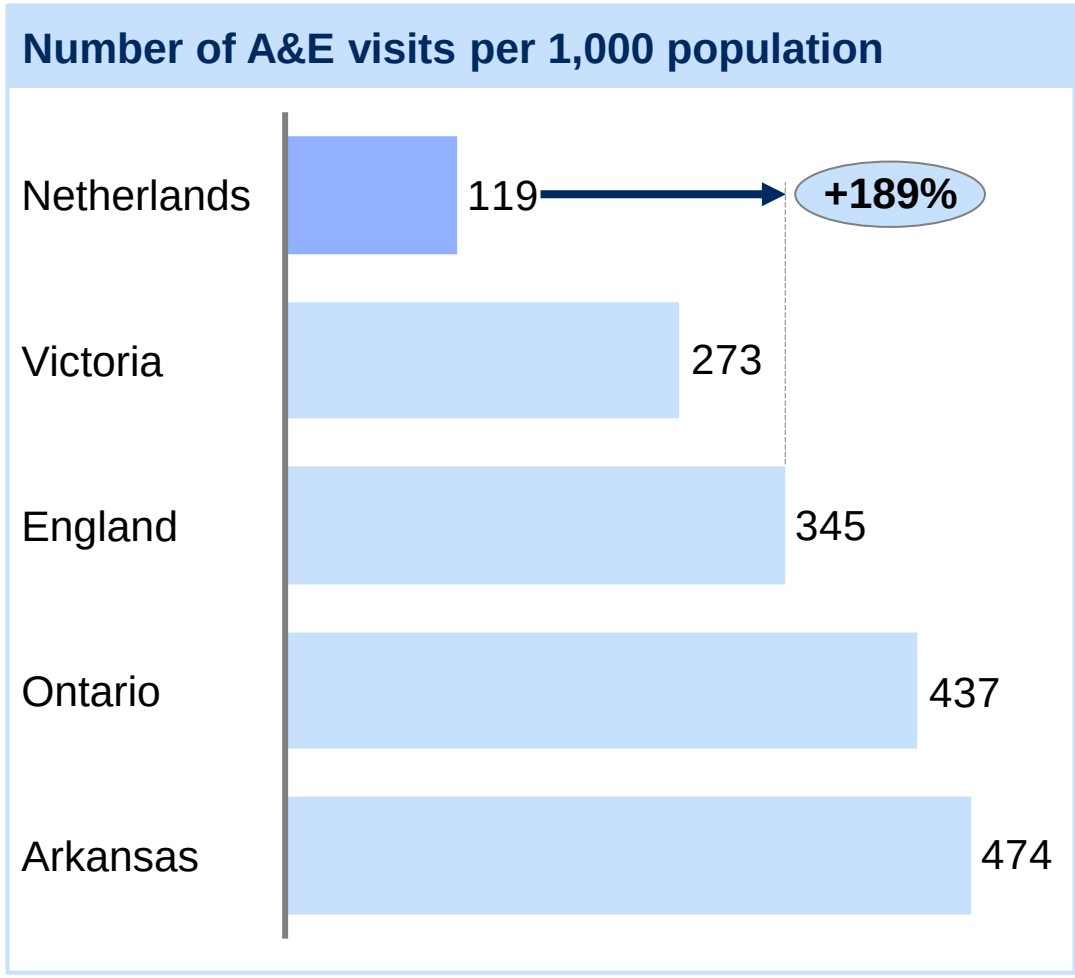
- Currently there is no centralisation of A&E care
  - In the Netherlands there are 98 (95%) hospitals with A&E departments
  - Insurers have discussed plans to close a number of A&Es and centralise care
- Financial incentives are being developed to further reduce A&E visits
  - The MoH is looking for other ways to reduce unnecessary A&E care
  - Currently, the €360 'own risk', a compulsory deductible, includes A&E care but excludes GP services, thus incentivising the use of a GP
  - A recent proposal required patients attending A&E without GP referral to pay €50, but this has been discarded as unlawful
  - It has now been suggested that formally insurers do not need to cover patients going to the A&E without a referral from the GP, if it turns out care was not required
- Many hospitals collaborate with GP posts to provide emergency care
  - Patient requiring out of hours acute care can go to regional GP posts
  - Collaboration between these GP posts and A&Es is encouraged – currently 76 out of 105 hospitals have a GP post
  - The aim is that patients are seen by a GP before going to the A&E, reducing the number of unnecessary cases
- GP post receive subsidies for covering rural areas
  - For each person living in a rural area (defined as outside a town with more than 70,000 people), a EUR 2.78 (GBP 2.20) subsidy is received by the GP post in addition to the normal capitated payment of EUR 11 per person per year

Comparison to NHS

- Like in England, many acute providers have an A&E department
- In the Netherlands, GPs are a gate keeper, with a large part of A&E attendances being referred by the GP
- In addition, Dutch hospitals work together with GPs to provide out of hour GP services next to the A&E

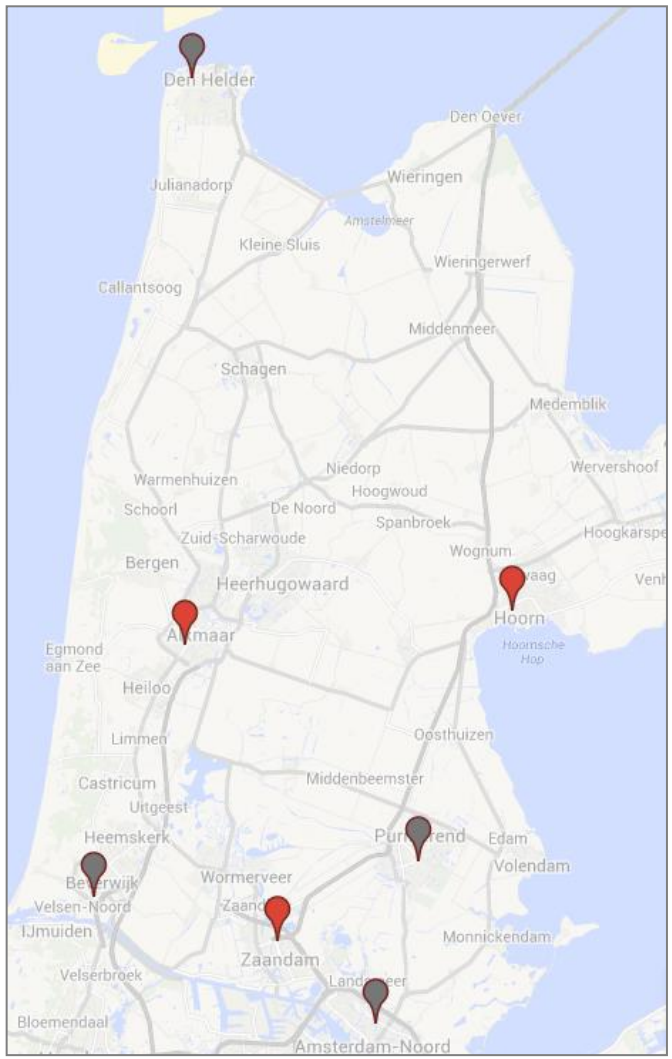
SOURCE: Gezondheidsraad: De basis moet goed, 2012

The Netherlands has significantly lower rates of A&E attendances



SOURCE: HSCIC, Performance.health.vic.gov.au, Nationaal Kompas Volksgezondheid, Hospital Emergency Department Audit MoH Ontario, Kaiser Family Foundation State Health Facts

Reconfiguration plans of the insurers to close A&E departments are being met with strong resistance



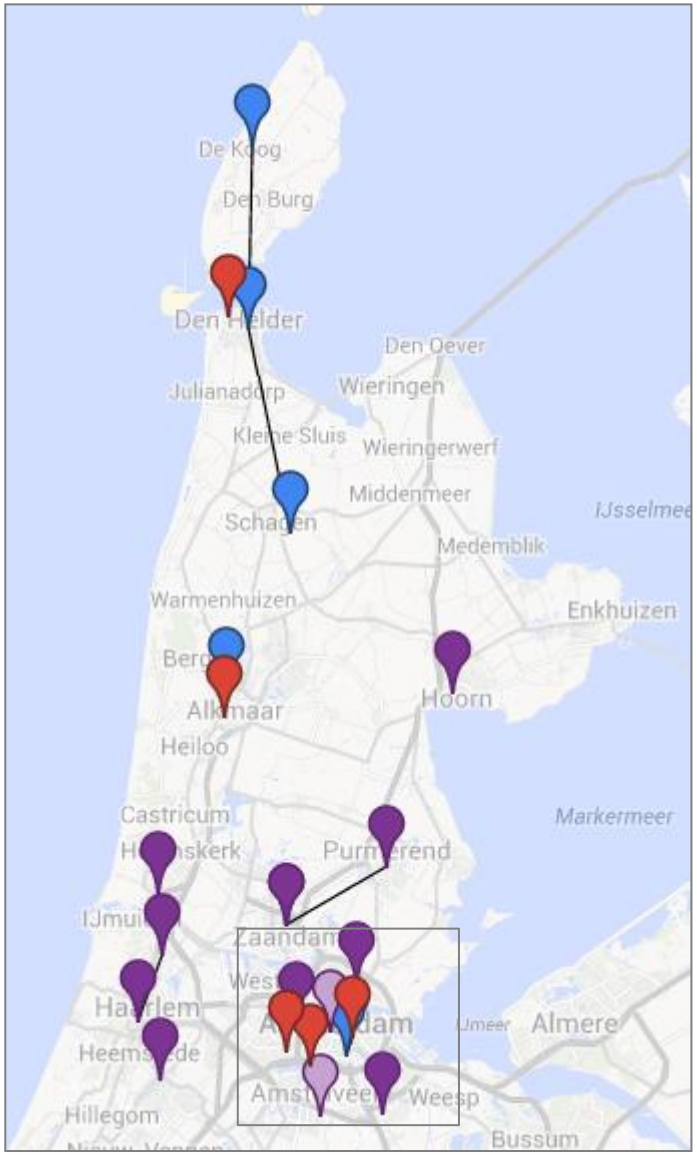
- The Healthcare Insurers Netherlands (ZN) has announced plans to reconfigure emergency departments and close a number of A&Es[1]
  - North of the Noordzee Canal in Holland, 4 out of 7 A&Es are earmarked for closured
  - The ZN is also looking to define the different levels of A&E further and configure care around them
- The Minister of Health has reiterated the importance of the 45 minute access target but is not planning on intervening if this target is met
- Research by a news outlet has shown that 47 out of 105 A&E could close while maintaining national coverage of the 45 minute target[2]
- The plans have been met with a lot of resistance, from hospitals as well as patient organisations and local communities

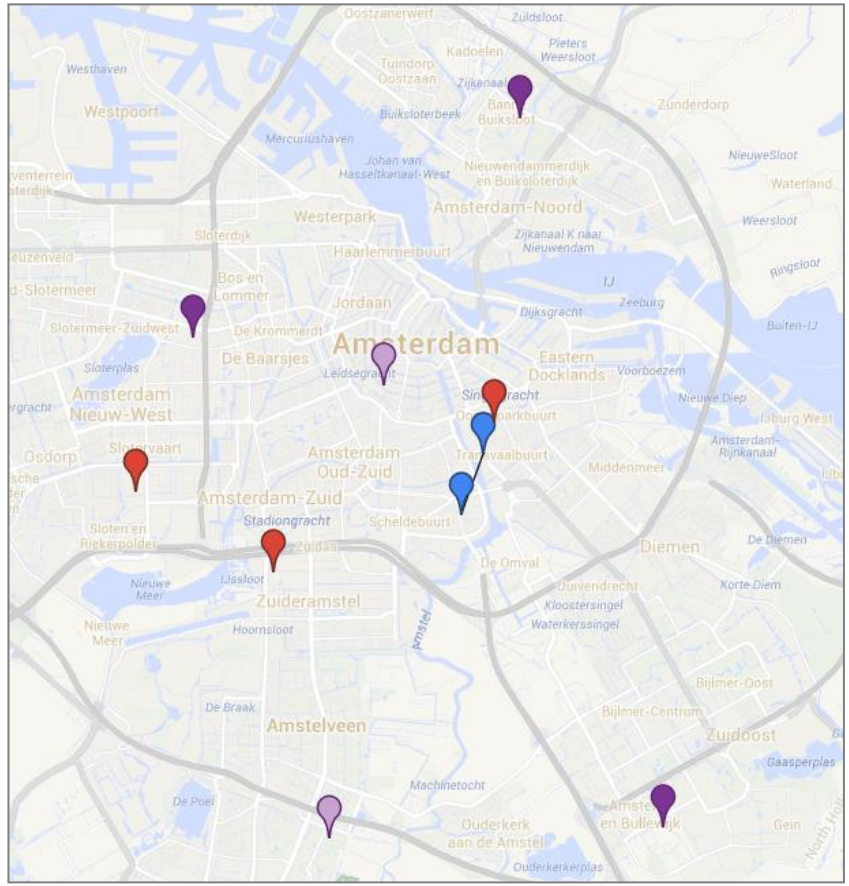
A&E to remain open

A&E to close

SOURCE:1. Zorgvisie: Beroertezorg Noord-Holland: van 18 naar 6 ziekenhuizen, Feb 2014; 2. NOS Helft spoedeisende hulp kan dicht, 2011

Most hospitals have a GP post in their hospital or nearby





- GP post
- A&E only
- GP post + A&E
- GP post instead of A&E
- Roster agreements

SOURCE: Nationale Atlas Volksgezondheid

GP posts in the Netherlands provide a significant part of emergency care

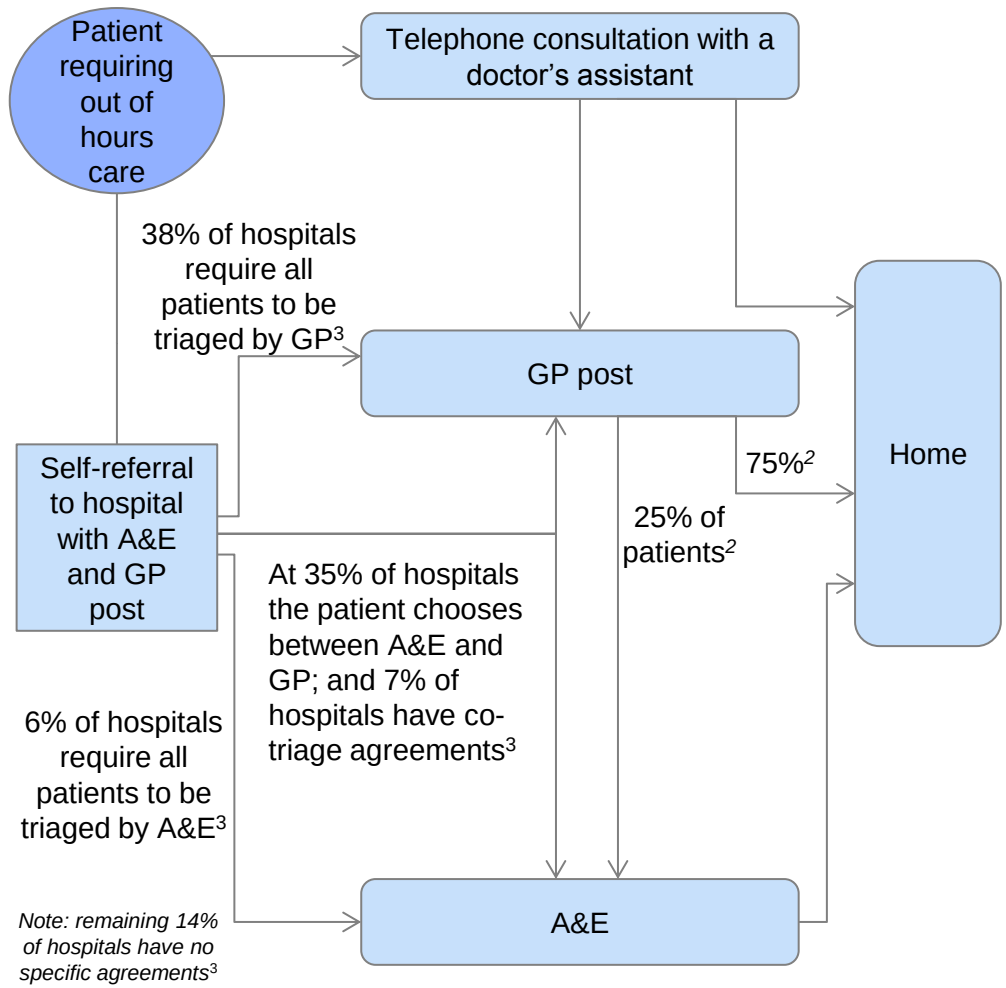
What are GP posts?

- At GP posts (Huisartsenposten) GPs provide out-of-hours emergency care[1]
  - 5pm – 8am on weekdays
  - 5pm Friday – 8am on weekends
  - 8am – 8am on bank holidays
- A telephone consultation with a doctor's assistant is required to get an appointment
- Cost for treatment at the GP posts are significantly lower than A&E visits
  - The average GP post visits is €100, compared to €50 for normal GP services[2]

How will they evolve?

- Collaboration between GPs and hospitals is a major component of the Ministries approach to reduce acute care cost
- Financial incentives are being discussed and developed to steer patients and to encourage collaboration between providers

How does it work



SOURCE: 1. Huisartsenposten Amsterdam; 2. Giesen, P.: Substitutie zelfverwijzers SEH naar HAP; 3. Vereniging Huisartsenposten Nederland: Samenwerking huisartsenposten en spoedeisende hulp (SEH) -Inventarisatie van huidige situatie

A&E in Ontario

Service line definition

- Most acute hospitals operate a 24/7 Emergency Department 365 days/year
- Ontario there are 160 hospital EDs (mean catchment size ~84,000)

Service delivery model

- In Ontario, almost all providers have some A&E provision, though the levels of care provided vary

- Community Health Centres function as walk in clinics and are available in many major cities but are often under-utilized – and EDs routinely ask patients to return to the ED for follow-up care rather than referring them their GP or walk in clinic: for example for antibiotics, wound check, or lab results etc

- Financial incentives are being used to improve ED performance
  - Since 2009, Ontario pay-for-results hospitals have been required to measure patient satisfaction and waiting time targets in EDs
  - Hospitals are rewarded for meeting specific emergency-department wait-time-reduction targets set by the Ministry; however, of the 23 hospitals that received Year 1 funding, only three were able to meet the Ministry's targets
  - Some of the EMS (Emergency Medical Services, providing air and land ambulance services) receive funding from the Ministry of Health and Long-Term Care specifically targeted to help reduce emergency-department wait times

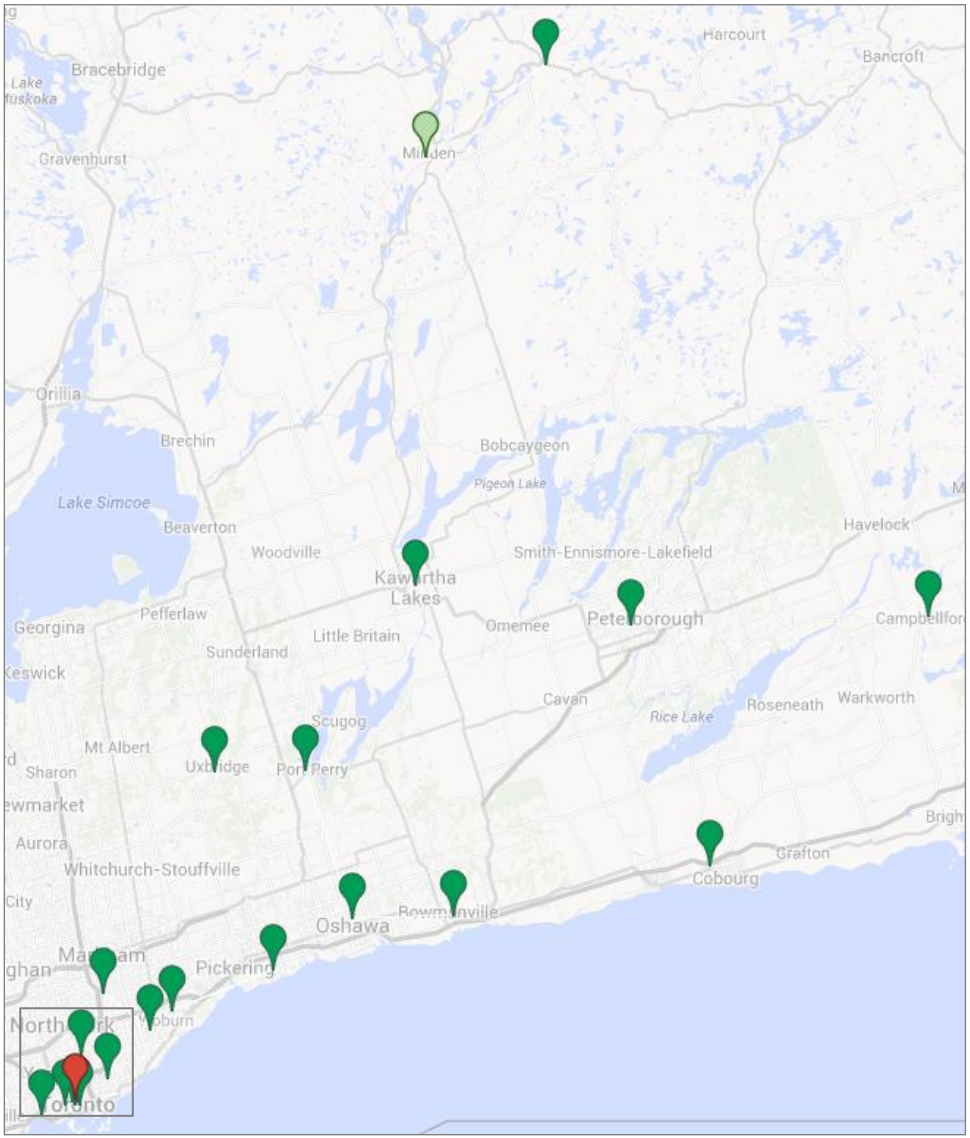
- The Canadian ED Triage and Acuity Scale (CTAS) is used in urban and rural EDs
  - CTAS has five levels, with 55% of cases in the three most severe levels
  - CTAS guidelines recommend that all patients be triaged within 10 to 15min

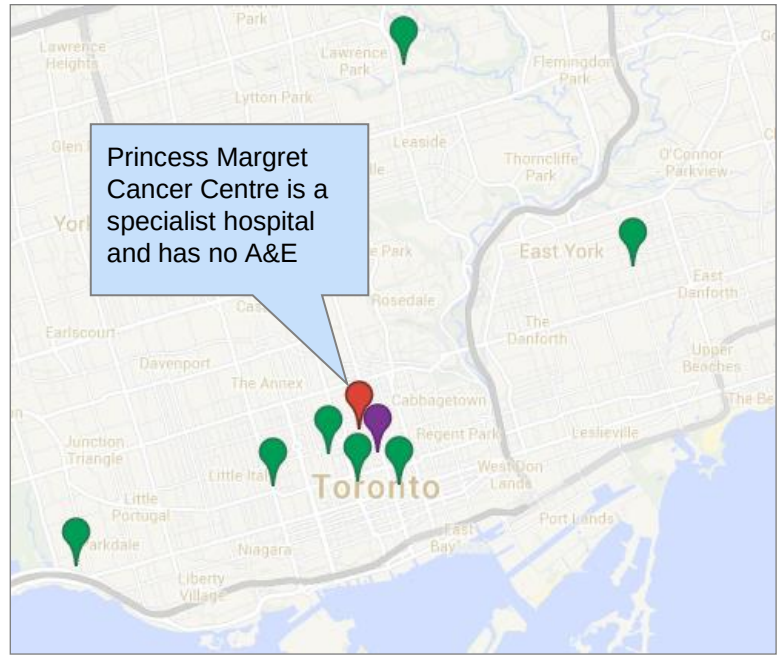
Comparison to NHS

- Emergency Departments in Ontario are much more varied in terms of size and range of services available than their NHS counterparts – though there is no standardised tiering of service levels
- Community Health Centres play a role in providing unscheduled urgent care. However – as with the NHS – these are often under-utilised

SOURCE: Ontario ED audit; Ontario Department of Health

Almost all providers have some level of A&E provision through stroke, trauma, burns and other specialist services are more centralised[1]





- Toronto EMS provides a combined air and land ambulance service across the region with protocols to ensure transfer to the most appropriate setting which may not be the nearest Emergency Room
- No single standardised level of Emergency Room provision and services available may vary by provider

- 24/7 Emergency Room
- 24/7 emergency services, staffed by on-call GPs, nurses, radiographer
- Paediatric A&E (dedicated paediatric A&E departments also available at St Joseph's Health Centre and Toronto East General Hospital)
- No A&E

1 Except for stroke, trauma and other specialist networks are not covered in this document
SOURCE: Central Toronto LHIN; Central East LHIN; hospital websites and Annual Reports

A&E in Sweden

Service line definition

- Emergency care in Sweden is provided by larger hospitals with EDs. Urgent and Primary Care is provided by hospital based walk-in clinics, or by general practitioners in the regional clinics
- Emergency medicine officially did not become a subspecialty in Sweden until 2006

Service delivery model

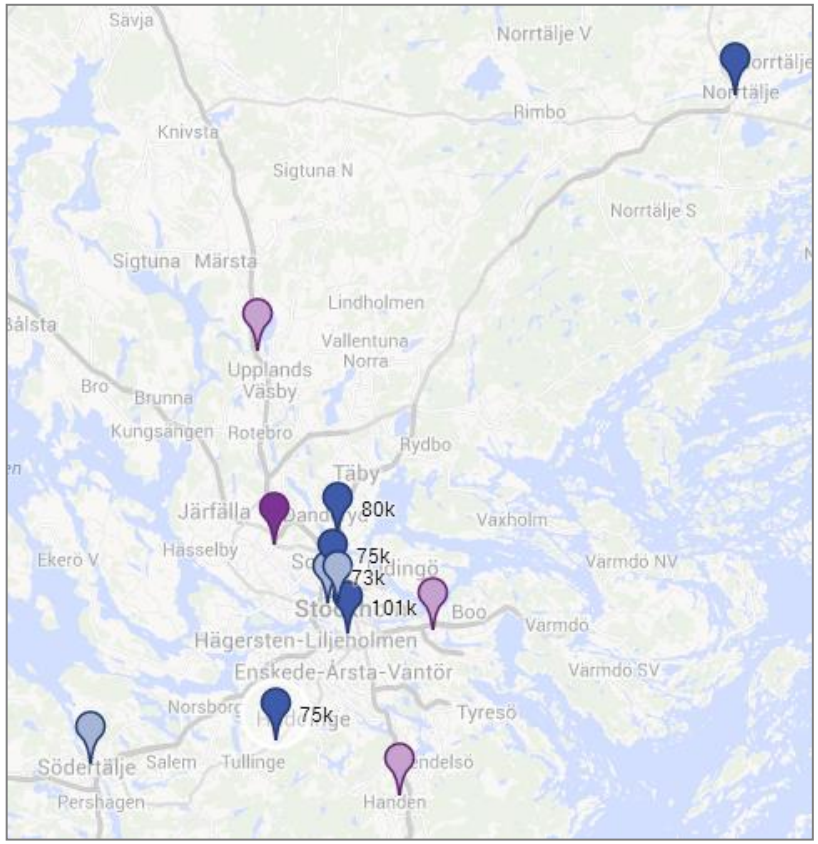
- Emergency care as a specialty is still in its infancy, but EDs are now starting to be populated by designated doctors working only there
  - Historically EDs were staffed by specialists from other wards
  - In recent years the number of specialists in emergency medicine is increasing
- Some EDs have a short term ward that treats patients from all specialties
  - Access to and use of hospital beds in the emergency department (AVA) differs greatly among hospitals, where some emergency rooms have a large number of AVA locations available, others have no AVA places[1]
- A large network of local acute hospitals and clinics called närakut ("proximity acute") provide emergency services for non-life threating conditions
  - Most are open until 10 pm every day including weekends
  - They are co-located in community hospitals, near larger hospitals or in health centres
- Ambulance services provide advanced pre-hospital care
  - For calls that are triaged as critical, mobile coronary care cars may be dispatched to the scene allowing a registered nurse to deliver advanced care
  - From 2014, Stockholm has an intensive care ambulance (size of a bus) with the capacity to take an entire team, with ECMO-treatment and PETS

Comparison to NHS

- The A&E model like the NHS's does not exist as such in Sweden, where emergency medicine is only recently recognised as a specialty
- Sweden is still moving towards the English model of an emergency department staffed by emergency specialists
- A significant proportion of emergency care is provided out of hospital by public and private sub-acute centres, similar to the NHS's minor injuries units and walk-in centres

SOURCE: Swedish National Board of Health and Welfare, Södersjukhuset.se, 1. Stockholm Country Council: Genomlysning av Stockholms fem stora akutmottagningar, Slutrapportering, 2013;

All hospitals in Stockholm Country have an A&E, and the community hospitals have sub-acute centres



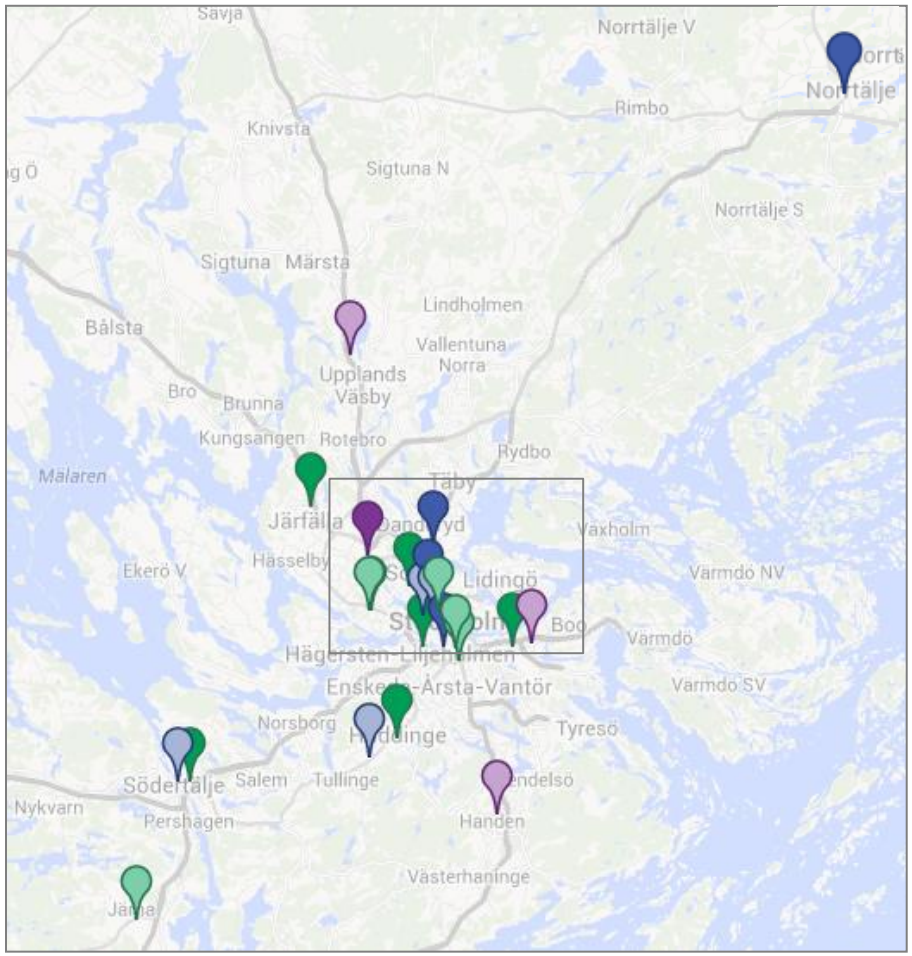
- A&E with paediatric services
- A&E without (explicit) paediatric services
- Sub-acute centre[1] with paediatric services
- Sub-acute centre[1] without (explicit) paediatric services

\# A&E attendances per year

1 Närakut

SOURCE: Stockholm Country Council: Genomlysning av Stockholms fem stora akutmottagningar, Slutrapportering, 2013; hospital websites; www.1177.se

In addition to hospital based emergency care, there are a large number of sub-acute centres at community health centres



- Sub-acute centres provide non-life threatening emergency care, such as simple fractures or allergic reactions
- In 2012, there were 300k visits to lower tier acute services like sub-acute centres, compared to 490k A&E visits[1]
- Sub-acute centres at community health centres are open from 8am to 10pm every day, with some centres opening at 5pm on weekdays to provide only out-of-hours care[2]

- A&E with paediatric services
- A&E without (explicit) paediatric services
- Sub-acute centre with paediatrics
- Sub-acute centre without paediatrics
- Public sub-acute centre at health centre
- Private sub-acute centre at health centre

SOURCE: Hospital websites; 1. Stockholm Country Council: Genomlysning av Stockholms fem stora akutmottagningar, Slutrapportering, 2013; 2. www.1177.se;

A&E in Germany

Service line definition

- Hospital-based EM in Germany differs significantly from the Anglo-American model
- Historically, there have been separately staffed “emergency admission areas” (Notfallaufnahme) within individual hospitals for many specialisms
- In the past decade, many hospitals have created “centralized emergency departments” (Zentrale Notaufnahme (ZNAs))

Service delivery model

- Germany has a long tradition of having physicians deliver prehospital emergency care, and traditionally the terms “emergency physician” (Notarzt) and “emergency medicine” (Notfallmedizin) have referred exclusively to the prehospital setting

- Numerous German hospitals have started to introduce ZNAs
  - They are often staffed by internists, surgeons and other specialists
  - The German Society for Interdisciplinary emergency Medicine (DGINA) has developed a training for EM doctors, pushing for recognition of EM as its own specialty
  - However German Society of Surgery and the German Society of Internal Medicine argue that the introduction of hospital-based emergency physicians are neither necessary nor cost-effective

Comparison to NHS

- The German model for A&E care is very different from the NHS
  - Each specialty has its own emergency room
  - Central A&E departments are only recently being introduced
  - These central A&Es are still staffed by specialists from around the hospital, rather than specialised emergency medicine physicians

SOURCE: Expert interviews (conducted by research team); DGINA

A&E services in Arkansas - Introduction

Service line definition

- EMTALA (Emergency Treatment and Active Labor Act) regulations define an emergency condition as “a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."

Service delivery model

- All CMS-reimbursed – which effectively means all - acute medical/surgical hospitals with an Emergency Department (ED) are required to provide a basic 24/7 emergency service under EMTALA regulations to all patients, regardless of insurance status or ability to pay. The only acute hospitals exempt from this provision are elective only centres (e.g. Ambulatory Surgical Centers). ~80% of the acute hospitals in Arkansas (covered in this document) operate an accredited ED.
- Emergency services may be staffed by on-site or on-call physicians and emergency response times are not explicitly specified, though a hospital using an on-call model must have maximum time-to-site targets and processes supporting these targets in place
- The level of service required under EMTALA regulations, are assessment, stabilisation, and treatment or transfer (when clinically appropriate/safe). For many smaller Critical Access hospitals, transfer will be the default option for most acutely ill patients.
- Critical access regulations provide financial support for hospitals that are 15-35 miles (or a 45 minute drive) from the next nearest provider, and in practice exceptions to these regulations (whereby local politicians can designate a hospital as Critical Access even if it does not meet these regulations) mean that an A&E-type service is available in even the smallest localities

Comparison to NHS

- The model of A&E provision is very different to the NHS
- Public policy and incentives support and encourage the provision of one or more A&Es in every locality – though EMTALA was designed to ensure that uninsured patients were not turned away/ transferred without treatment
- Smaller A&Es provide an assess, stabilise and transfer model which may be of interest in some parts of the NHS – and is different from our Urgent Care Centre model – but it is unlikely to offer any efficiencies compared to the NHS model

SOURCE: Rules and Regulations for Free-Standing Birthing Centers, and Rules and Regulations for Hospitals and Related Institutions in Arkansas 2007, Arkansas Department of Health (http://www.healthy.arkansas.gov/aboutADH/Pages/RulesRegulations.aspx)

A&E in Victoria, Australia

Service line definition

- EDs are split into 4 levels of increasing capability
- There are 38 metropolitan and rural hospitals in Victoria with a designated emergency department. Of these, almost all (37) provide a staffed 24-hour emergency service[1]
- There are six private hospitals offering a staffed 24-hour emergency department[1]
- There are also 50 urgent care centres and 28 primary injury services in rural hospitals[1]

Service delivery model

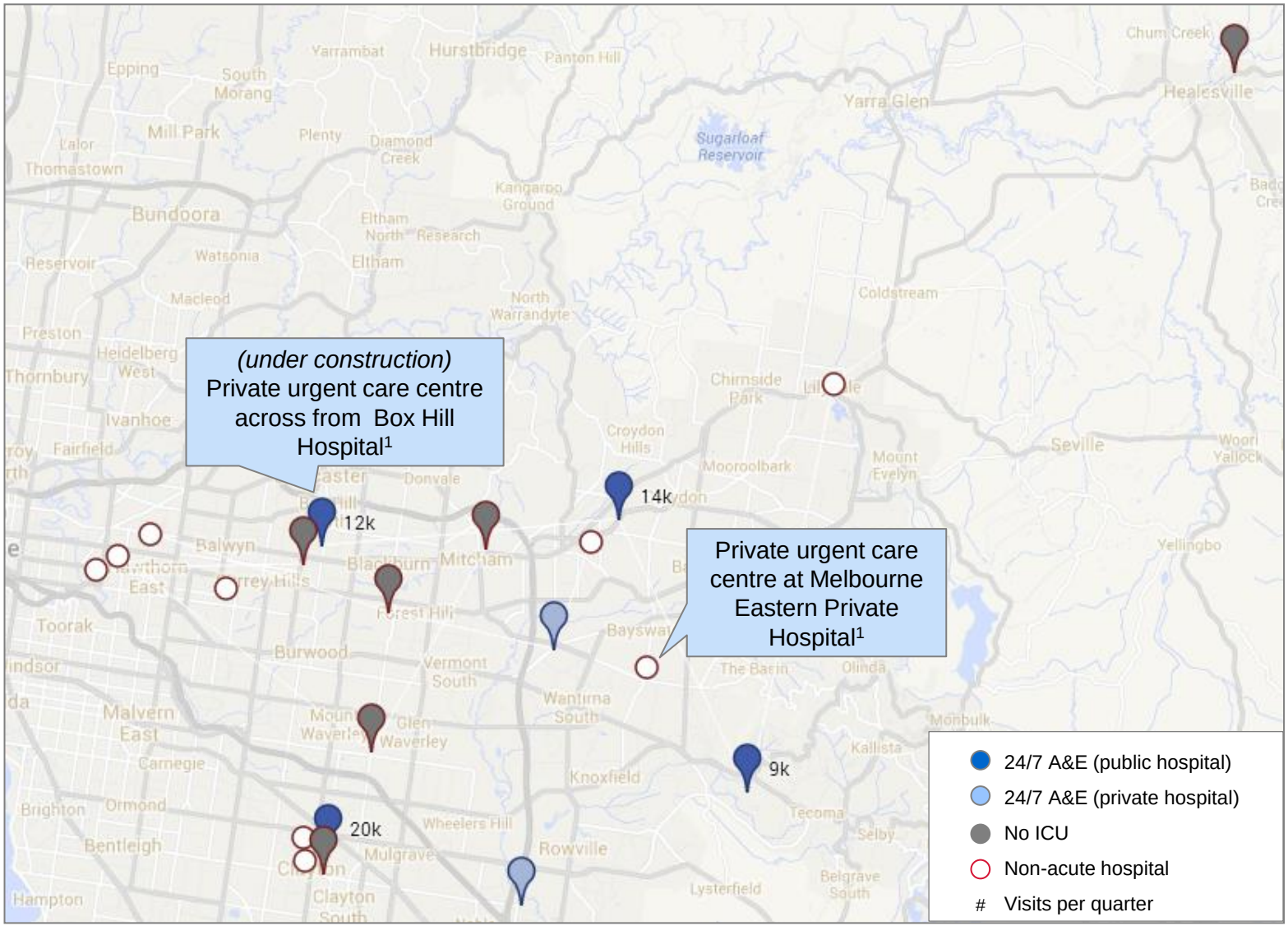
- From 2013/14 on, Eds are included in the Activity-Based Funding[2]
  - The National Health Reform Agreement (NHRA) required that ABF (Activity Based Funding) be introduced for emergency department care from 1 July 2012
  - Before, patients that got admitted from the ED where covered under the admission's DRG payment, and for non-admitted patients hospitals received a Non-admitted Emergency Services Grant
  - Going forward, EDs will be reimbursed based on Urgency Related Groups (URG), regardless of whether the patient gets admitted or not
- Victoria has a 4 hours A&E standard similar to the NHS, but their target percentage and actual performance is low – with very little consequences
- A triage system is used in EDs in Victoria and standards are set accordingly
  - All patients presenting in ED in Victoria (and Australia) are triaged by accredited nurses, using the Australasian Triage Scale (ATS)
  - Time to treatment targets are set by triage category
    - Waiting times for the 6 categories vary from immediately to 120 minutes[3]
- Private urgent care centres are offering an alternative to A&E
  - Groups of doctors are opening private centres for patients with non-life threatening injuries, where they are treated within an hour for a $150 (£80) fee[4]

Comparison to NHS

- Most larger acute hospitals have an A&E which is open 24/7, like in the NHS
- The Australian system has a number of private players also providing emergency care, in the form of private hospital A&Es and private urgent care centres
- Victoria uses the 4 hour standard like the NHS, but the target is set at 75% and performance is even lower

SOURCE: 1. Victoria Department of Health: Better faster emergency care, 2007; 2. Victoria Department of Health: Fact Sheet: Emergency Department Care funding under National Health Reform; 3. Australasian College for Emergency Medicine: Guidelines On The Implementation Of The Australasian Triage Scale In Emergency Department; 4. http://www.theage.com.au/victoria/150-buys-urgent-care-20120229-1u3je.html

A combination of public and private hospitals provide 24/7 emergency care in the Eastern Met region



SOURCE: Emergency department total attendances, Victoria Department of Health; hospital websites;
1. http://www.ekeraurgentcare.com.au/