Quality Emergency Medicine:
What does it actually mean to the Stand Alone ER Patient?

By Steve Ohkravi, MD, MBA, CPE
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A Stand Alone ER, or any ER practice for that matter, needs to look at their core values as a healthcare institution and lay them out for all staff to see, to *learn from* and embrace as an *every day* behavior. It's a conscious decision for many healthcare professionals, but the very best ER practices start with a very basic commitment to continuing education…for every level of its staff. This process can be very humbling, as well. The Japanese call it, quite simply: *Kaizen*.

One key tenet of this principle is establishing a Continuous Quality Improvement (CQI) initiative, the process by which the practice leadership measures, analyzes and improves quality on a regular basis.

CQI teams identify areas in which there are opportunities to improve care, such as looking at:

1. The volume of cases handled;
2. How many of those cases are considered high-risk?
3. What is the patient *experience* as they move through the process of admission, examination, testing, and treatment?
4. *The Business of Medicine* also affects the patient's health care treatment experience: This is qualitative, too. Things like check out, billing, patient follow-up, etc. can take a perfectly good medical treatment and color the impact of the patient's experience of the practice, its professionalism and the practice's commitment to the *patient's well being*.

Other factors affect the *perception of quality care*: At such a high-impact moment when emergency medicine is required, out-of-house services such as collaboration with the patient's GP, a Specialist, and area hospitals also weigh into the mix of best ER practices to be vetted on an on-going basis.

Once the continuing education and the constant improvement foundation are built, the next quality care basic is for the practice leadership to ask the patient-centric question:

What barriers to a quality experience are there for my Stand Alone ER patients; those who have an accident or become unexpectedly (and, urgently) ill?

There are pressing functional matters that affect patients such as:

- Can transportation be easily arranged to and from the practice?
- Will they be there for my emergency, whatever the hour?
- Will I have issues with locating the right entrance for the practice during my emergency?
- How long will it take to see a Doctor?
- Can prescription fulfillment be coordinated for me?
- Will I have language barrier; is there a translator available…at any hour?
- Is the practice equipped with sophisticated on-site lab and testing equipment; are they properly staffed to operate and promptly read the results for my emergency?
- Pediatric and Geriatric healthcare has its own set of requirements; can they treat my kids or my elderly family members?

Other founding principles for a Quality ER Practice are:

- Emergency Room Medicine experience. There simply is no stronger qualification for quality care. A quality ER Practice provider has *tens of thousands of hours experience* collectively

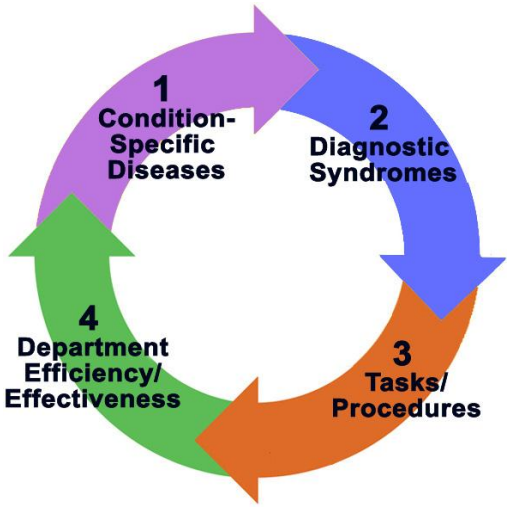
among their staff to account for the spot on response time necessary to succinctly practice emergency medicine. However, this qualification is also the essential foundation for the in-field management for ER Operations. I mention this because there is some debate[1] about "pre-care" in emergency situations. The Police, Fire Department, Emergency Medical Technicians come in contact with urgently ill patients simply by virtue of their numbers and by them being out on the street. These civil services are undeniably valuable and essential in emergency situations. They are also tempered, optimally, by collaboration those health care professionals experienced in practicing emergency medicine. Quality care and patient satisfaction is amplified by careful coordination and collaboration with these supporting resources. Emergency response and "pre-care" has a place in the equation.

- Telemedicine and Technology impacts Quality Care and outcomes. Never have medical professionals had more resources available as they do presently with Smart Phones and internet access to real time medical records. Specialist resources are available across town or across the county. Again, the careful coordination and collaboration of these resources puts healthcare information and therapy advice (specialist intervention) at the finger tips of ER professionals at a moments notice.

Another discussion matter of ER therapy quality care is the proper indication and usage of testing equipment. For instance, there has been some sensitivity about CT usage as it applies to adverse reactions[2]. The lowest radiation devices with comparatively high resolution (64-slice) optimize quality care and diagnosis, for the right indications and appropriate patients. *The best practices employ stringent Pathways and Guidelines for CT usage.*

All in all, quality emergency medicine really cannot, practically, be an idle promise. Much has been written about it, however in reality the basis in this premise goes back to very simple self preservation precepts: *"…Medical quality is defined as "the care health professionals would want to receive if they got sick."*[3] So, all health care professionals have a lot vested in this quest for quality. Though, how a practice's leadership goes about implementing this quest for quality makes all the difference between imparting good intentions or actually applying best practices as matter of professional behavior designed to achieve excellence every day.

With an interest to simplify the *Continuum for Quality Care,* the diagram to the right illustrates the path of "Operational Opportunity for Excellence."



At each of the four steps, there is a profound opportunity to critically evaluate best practices, apply those practices and —*most importantly* -- revisit those steps upon completion of the process. At this time, you can look at the outcomes and consider "how you may have done it better with the new learning gained from actually going though these steps."

It's the cycle of learning in this critical, Emergency Medicine process-oriented environment. In fact, this constant procedural evaluation process *in a non-punitive environment optimally promotes correction and increases patient safety*.[4]

In summary, there is a wide array of factors that lead to (and stage the environment for) quality emergency medicine.

We considered, above:

1. *CQI (Continuous Quality Improvement)*
2. *Collaboration and Cooperation with the greater community of caregivers*
3. *Eliminations of Barriers to Patient Care*
4. *ER Experience*
5. *Embracing Technology*
6. *Properly Prescribed Lab Work and Testing/Medical Imaging Procedures*
7. *Procedural Consistency*
8. *Constant Evaluation*

Certainly, the establishment of spot-on patient factors is of paramount importance in the examination process. Exemplary teamwork by all who come in contact with the patient is essential to a quality patient experience, outcomes and satisfaction.

When you add to this definitive recipe for Quality Emergency Care:

a) The highest level of ER staff communication skills, and
b) Detailed patient data/documentation systems…

All the ingredients effectively *work in combination* to deliver a quality emergency care experience.

Dr. Steve Ohkravi, MD, MBA, CPE is the founder of Emergency Medical Care located at 200 Chambers Street, Tribeca, NYC. A new facility has recently been added at 521 West 42nd Street in Midtown Manhattan. www.emcny.com

Dr. Ohkravi's deep credentials have made him the perfect candidate for creating and leading this novel Stand Alone ER facility--dedicated to the NYC communities that EMC serves. In his professional CV you'll find an uncanny blend of healthcare practice, process and work flow savvy, along with exceptional hospital, ER and business management skills. He is also a Six Sigma Black Belt. This convergence of skills formed EMCs best practices and Stand-Alone ER healthcare knowledge based on *practical, progressive, efficient, and compassionate emergency care principles.*

Citations:

1) http://en.wikipedia.org/wiki/Talk%3AEmergency_medicine
2) http://abcnews.go.com/Health/CancerPreventionAndTreatment/story?id=3927117&page=1
3) Graff, L., Stevens, C., Spaite, D. and Foody, J. (2002), Measuring and Improving Quality in Emergency Medicine. Academic Emergency Medicine, 9: 1091–1107. doi: 10.1197/aemj.9.11.1091
4) http://www.acep.org/content.aspx?id=26016