Volume 4, Issue 1 Jan/Feb 2007

The Abaris Group

The TAG Line

The Abaris Group | *Innovative Solutions for the Emergency Care Field*
700 Ygnacio Valley Rd, Ste. 270 | Walnut Creek, CA 94596
888.EMS.0911 | www.abarisgroup.com

Inside this issue:

Find *The TAG Line* and much more at www.abarisgroup.com.

To subscribe, email subscriptions@abarisgroup.com.

For breaking news, visit EMSNetwork.org.

Retail Clinics

Kathleen Hurley
Research Assistant, The Abaris Group

Retail clinics have been a growing trend since the first QuickMedx (later named MinuteClinic) opened in Minneapolis in 2000. The California Healthcare Foundation recently released a report titled "Health Care in the Express Lane: The Emergence of Retail Clinics," which describes the history and potential of these clinics.

Retail clinics, located in grocery stores, discount stores, and pharmacies, offer fast, convenient care for a range of low-acuity conditions, such as strep throat, ear infections, bronchitis, and pink eye, in addition to performing screenings and administering vaccines. On average, a visit to a retail clinic costs between $40 and $70 and lasts about 15 minutes. Retail clinics are able to provide lower cost care because of lower overhead, less expensive staff, no billing, and limited scope of service. According to research done by Health Partners, a MinuteClinic visit is on average 15 percent less expensive than a visit to a physician's office or an urgent care center.

Most retail clinics are staffed by nurse practitioners (NPs), with physicians available for consult by phone. Although some states' regulations require physician oversight of NPs some or all of the time, 22 states do not require any physician oversight of NPs.

Many retailers are welcoming in-store clinics, seeing the potential for increased profit. Retailers expect that these clinics will attract new customers to their facility, thus increasing

sales on prescriptions, over-the-counter purchases, and other areas of the store. Additionally, some retailers see an opportunity to decrease the costs associated with providing healthcare to their employees.

Retail clinics initially did not accept insurance, because the expense of filing claims would have made it impossible to continue to provide low-cost health care. Now, however, approximately 40 percent of retail clinics accept insurance,

Continued on Page 3

The Abaris Group announces 2007 Webinars:

- "Hot Topics in Emergency Care" (free webinar)
- "New Medicare ED and Trauma Center Revenue Opportunities"
- "Best Practice Approaches to ED and Inpatient Throughput"
- "So You Want to be a Consultant"
- "Retail Healthcare — Free Standing EDs and Retail Centers"

Dates and times to be announced soon

For more details and to register, visit abarisgroup.com. Educate your entire staff for one low cost. Pay only **$295** per site for one Webinar or learn about our special discounts when you purchase two Webinars.

If you've missed any of our previous popular Webinars, visit www.abarisgroup.com to purchase a recorded version on CD.

Mobile Trauma Center to Bring Care to Disaster Scenes

Hackensack University Medical Center received $3.2 million in federal funds to produce a mobile emergency trauma unit. The unit will have an operating room and seven critical-care beds, and will be staffed with a surgical team, nurses, and therapists.

The vehicle is ideal for large-scale catastrophes and terrorist attacks. In such an event, the hospital will be able to go to the scene of the disaster, so that victims will not need to take an ambulance to reach care. This reduces the time to treatment, which can help save lives in a mass-casualty event.

In addition to the operating room and beds, the expandable unit will have digital X-ray technology, a portable field laboratory, a small pharmacy, and a telemetric medicine system. Before expanding, the unit is approximately the size of a FedEx truck, allowing it to easily move through traffic and debris in a disaster situation.

Hackensack's unit will be the first of its kind. The need for such a unit was evident when the Federal Emergency Management Agency's large mobile trauma unit was too bulky to reach the places where it was needed following Hurricane Katrina.

The mobile trauma unit will be operated by Hackensack University Medical Center's disaster preparedness team, who are specially trained to handle mass casualties and large-scale disasters.

For more information, click here.

Primary Care Home Initiative Redirects Improper ED Users

St. Louis Integrated Health Network, a nonprofit organization, and IBM have teamed together to help reroute patients who improperly use emergency department (ED) services for primary care through an initiative called the Primary Care Home Initiative.

IBM is developing the technology, which involves building a Network Master Patient Index. This index will electronically track those patients who regularly go to the ED for primary care, and redirect them to primary care physicians for future care. The Integrated Health Network estimates that currently 37 percent of visits at local EDs are for conditions that can be treated in a primary care setting.

The Integrated Health Network identified seven EDs that have the greatest need of these services, and plans to install the tracking technology in these facilities. Those EDs selected include SSM St. Mary's Health Center, SSM DePaul Health Center, SSM Cardinal Glennon Children's Medical Center, Saint Louis University Hospital, Barnes-Jewish Hospital, Christian Northeast Hospital and St. Louis Children's Hospital.

The initiative is expected to cost between $4 and $5 million, but will result in great savings for businesses, insurance payers, and hospitals, as the cost of an average visit to a primary care physician is $120, compared with $560 for an average visit to the ED. Hospitals will see the majority of the savings, especially those that provide care for many uninsured and Medicaid patients who visit the ED for routine care.

This initiative will also help improve the quality of care, as primary care physicians can provide better follow-up care.

For more information, click here.

Funding For Undocumented Immigrant Care Remains Unused

In the first nine months of a federal program to give funding to hospitals, physicians and EMS providers for providing emergency care to undocumented immigrants, only 15 percent of the $1 billion has been claimed. Federal officials do not understand why these funds are not being utilized.

An article in the Official Newsletter of the Emergency Nurses Association identified several possible reasons that these federal funds go unclaimed. The following are some of the reasons cited:

- Time consuming paperwork: The amount of money they will receive may not be worth the cost of hiring someone to do the paperwork.
- The federal government calculates costs differently, and reimburses at a much lower rate than hospitals charge.
- Moral issue: by asking immigration status, hospitals may deter patients from seeking needed medical care. Even though the government says it will not give data to immigration officials, some individuals may be afraid to seek medical help.

Federal officials are hoping to find answers to why these funds remain unclaimed, and hope that they will be better used in the remaining two years of the program.

For more information on this source of funding, click here.

Shortage of On-Call Specialists Hurt Trauma Centers Around the Country

Trauma centers in Oregon are having trouble maintaining adequate levels of service because of difficulty in providing 24-hour specialty service. A survey by Oregon Health & Science University emergency medicine researcher John McConnell found that nearly half of emergency departments in Oregon could not continue to provide 24-hour service in at least one medical specialty from 2004 to 2005. This problem arises from a shortage of specialists willing to provide trauma care in many of the state's EDs.

This problem is not unique to Oregon. Throughout the nation, EDs and trauma centers are having trouble finding specialists willing to be on call, especially during night and weekend hours.

Seven of Oregon's hospitals have had to lower their trauma designation because they were unable to provide the necessary staffing to maintain service at their current level. In fact, Oregon is considering adding a fifth, lower trauma designation, because even level IV standards are too high for many.

A number of factors contribute to the challenge of maintaining on-call specialists. In addition to an overall shortage of specialists in many regions, more and more surgeons are practicing outside of hospitals to avoid being on call. As an increasing amount of patients either lack health insurance or are covered by Medicare and Medicaid, physicians are not being fully paid for the care they provide. Dr. John Moorhead, an OHSU emergency doctor, explained that it is difficult to ask these specialists to provide emergency care, as they may not receive payment for the care they provide yet may be sued by the same patients.

Hospitals have to pay stipends to keep specialists on call; however there is no mechanism to receive reimbursement from private or public insurers for this expense, which can be up to several thousand dollars per occasion.

The complete findings from this survey can be found in the *Annals of Emergency Medicine*, or a summary can be found here.

Retail Clinics (continued from page 1)

as special contracts with insurance companies make sure that these clinics will be fully reimbursed. Recognizing that a visit to a retail clinic is a less expensive alternative to an ED or primary care physician, some insurance companies are even eliminating the co-pay to encourage their policyholders to visit a retail clinic for a minor illness.

So far most retail clinics have been successful in wealthy, suburban areas. Although when not covered by insurance, a visit to a retail clinic might cost slightly more than a typical co-pay at a physician's office, some insured individuals are willing to pay more for fast, convenient care. In fact, according to the California Healthcare Foundation's report, 70 to 80 percent of patients visiting the three Wellness Express clinics had insurance, but chose to pay out-of-pocket for the convenience of the visit. Retail Clinics also have the potential to do well in urban areas, where the uninsured have no cheaper alternative.

Retail clinics differ from one another in terms of scope of service, physician involvement, and physical layout. The American Academy of Family Physicians identified several desirable characteristics for a retail clinic, keeping the patient's best interest in mind. These include having a well-defined and limited scope of service, having strong connections to physician practices in the community to encourage continuity of care, a procedure for referring patients to a physician when the patient requires treatment outside of the clinic's scope of service, use of an electronic health record system, and clearly defined evidence-based treatment procedures. (AAFP News Now, "AAFP Defines Ideal Retail Health Clinics," (1/3/06).

Click here to view the recent report on retail clinics published by the California Healthcare Foundation.

PDA Technology Brings Medical Libraries to the Field

New software allows medical practitioners to have access to a library of medical information wherever they are. The software, created by Skyscape, allows individuals to download medical data, medical journals, and volumes of reference material to a PDA, creating a mobile library.

The software has been popular with nurses and paramedics, particularly with those stationed in Iraq. It provides a practical alternative to bulky textbooks.

Reference data can be downloaded using Skyscape's software anytime an internet connection is available. It can then be saved to the PDA for easy access, even when an internet connection is not available.

Other similar products and technologies exist, however Skyscape controls about 90 percent of the market. It has over 625,000 users, and is partnered with 45 medical journals.

More information can be found by clicking here or at www.skyscape.com.

ED Co-Pay Decreases Visits

A study published in Health Services Research in October looked it the effects of a co-payment for health care on emergency department visits. The study, based on research conducted by Kaiser Permanente of Northern California, is the largest ever to look at such effects. It looked at ED visits for more than two million commercially-insured individuals and 250,000 covered by Medicare.

The study found that as the required co-payment increased, the rate of ED visits decreased substantially, while there was no significant increase in the rates of hospitalization, intensive care admission, and other unfavorable clinical events, and no increase in deaths.

For those with commercial insurance, ED visits decreased by 12 to 23 percent, depending on the co-pay, compared with no co-pay. Hospital admissions also decreased, with no change in ICU admissions or mortality rates. The results were less substantial for individuals covered by Medicare, but they also saw a decrease in ED visits.

For more information, visit www.medicalnewstoday.com

NEJM Myocardial Infarction Study

The New England Journal of Medicine published a report regarding treatment for patients with ST-segment elevation myocardial infarction. The study, titled "Strategies for Reducing the Door-to Balloon Time in Acute Myocardial Infarction," looked for best practices in a survey of 365 hospitals nationwide.

The study found that only about 35 percent of hospitals achieve the recommended average door-to-balloon time of 90 minutes for percutaneous coronary intervention (PCI). The authors identified six strategies that are most effective for reducing the door-to-balloon time. These include:

- Have emergency medicine physicians activate the catheterization laboratory
- Have a single call to a central page operator activate the laboratory
- Have the emergency department activate the catheterization laboratory while the patient is en route to the hospital
- Expect staff to arrive in the catheterization laboratory within 20 minutes of being paged
- Always have an attending cardiologist on site
- Have emergency department and catheterization laboratory staff use real-time data feedback

These strategies require only minor changes to a hospitals response procedure and cost relatively little to implement, yet have proven to be very effective at improving patient outcomes.

The study can be found at http://content.nejm.org.

Physician On-Call Survey

In July Sullivan, Cotter and Associates, Inc. released the results of its second annual physician on-call pay survey. The survey looked at 109 healthcare organizations, 78 percent of which provide on-call pay to some or all of their physicians required to be on call.

The survey found the following results:

- Trauma centers paid higher on-call rates than non-trauma centers
- 24 percent of trauma centers, and 13 percent of non-trauma centers have had to shut down service due to lack of on-call physician service
- Neurosurgery, orthopedic surgery, and trauma surgery received the highest on-call pay
- There appears to be a relationship between the likelihood of being called to work and the on-call rate paid

To encourage physicians to be on call, some hospitals are offering a guaranteed level of payment for service, a subsidy for malpractice when called in, fee for service payments for uninsured patients, hourly rates when called in, and payment based on work Relative Value Units when called in.

A copy of the 2006 Physician On-Call Pay Survey is available for purchase at www.sullivancotter.com.
Click here for more information.

Last Minute Change to the CMS Physician Fee Schedule

The 2007 Medicare Physician Fee Schedule Final Rule released in November 2006 called for a five percent decrease in payments to physicians in most specialties, as determined by the Medicare Sustainable Growth Rate payment formula. HR611, The Tax Relief and Health Care Act of 2006, signed into law in the last month of 2006, included a one-year delay in these scheduled fee cuts in Medicare's fee schedule for physicians.

HR611 froze physician payments at the 2006 rate, with a conversion factor of 37.8975. Some physicians will actually receive an increase in pay because of updates to codes in the 2007 Physician Fee Schedule, and a 1.5 percent bonus if quality reporting requirements are met.

In recent years, the SGR has called for decreases in payments to physicians, but short-term legislative actions have prevented these decreases from taking place. Unless the SGR is changed, physicians can expect to see a five to ten percent decrease in pay in 2008. The Medicare Payment Advisory Commission is considering replacing the SGR system. One possibility being considered is replacing the SGR with a system of performance-based payments and bonuses.

To view the updated Physician Fee Schedule, please visit the Centers for Medicare and Medicaid Services website by clicking here.

Study on Firefighter Line-of-Duty Deaths

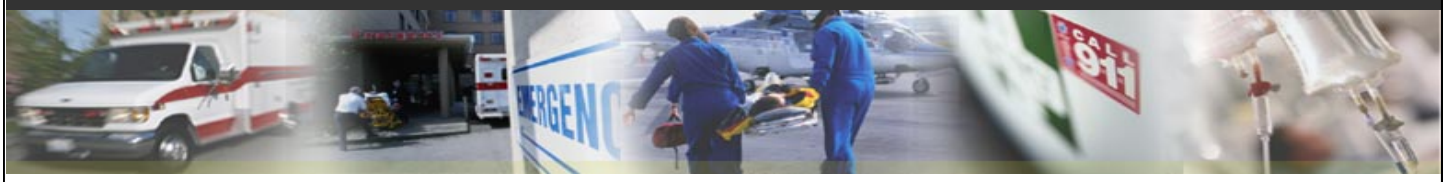
The United States Fire Administration and the International Association of Fire Fighters released a report in September of 2006 that looked at the main causes of firefighter line-of-duty deaths.

Researchers looked at the factors contributing to 644 line-of-duty deaths between the years of 2000 and 2005. Analysis of the data found that health/fitness/wellness factors were responsible for 53.88 percent of these deaths. Other significant factors included personal protective equipment (responsible for 19.41 percent of deaths) and human error (19.1 percent).

Each year approximately 100 firefighters are killed in the line of duty. The study found that the majority of these deaths are preventable. The report includes recommendations for risk management practices, which the authors hope will help reduce the incidence of firefighter line-on-duty deaths.

The complete report can be downloaded here.

ABARIS GROUP *Innovative Solutions for the Emergency Care Field*



About Us

The Abaris Group is a consulting firm that specializes in emergency and outpatient services. We provide clients with help on a wide range of topics, including strategic planning, operational improvement, and financial enhancement, to help them achieve their goals.

We pride ourselves on delivering value to our clients in the form of quality recommendations and strategies that work. To achieve this, we conduct detailed analyses, blending insight and experience from all spectrums of the healthcare and emergency care fields to meet our client's unique needs.

Whether it is evaluation of new programs, studies of existing ones or assistance with implementation, we will extend this superior level of service to you and your organization.

For more information, visit www.abarisgroup.com or email subscriptions@abarisgroup.com.

Contact Us

The Abaris Group
700 Ygnacio Valley Rd, Ste 270
Walnut Creek, CA 94596
Phone: (888) EMS-0911
Fax: (925) 946-0911
Email: subscriptions@abarisgroup.com

www.abarisgroup.com

Subscriptions:

Would you or someone you know like to subscribe to updates when new newsletters are released?
To subscribe, simply email subscriptions@abarisgroup.com with your email address and the word *subscribe*.