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The Abaris Group

The TAG Line

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Physician-Owned Specialty Hospitals Fall Short of CMS Emergency Department Requirements

The Department of Health and Human Services Office of Inspector General recently published report looked at the extent to which physician-owned specialty hospitals are prepared to manage patients' medical emergencies. Although the Centers for Medicare and Medicaid Services (CMS) does not require hospitals to have EDs, there are several standards that must be met to ensure that hospitals are prepared to handle emergency situations. The study found that in general, physician-owned specialty hospitals are not well-equipped to handle medical emergencies.

The study looked at data from 109 physician-owned specialty hospitals. Fifty-five percent of these hospitals have an ED. Of those, more than half have only one ED bed, 17 percent have between two and five ED beds, 15 percent have between six and eight ED beds, and 8 percent have nine or ten beds.

CMS requires every participating hospital to maintain a written policy for how to handle a medical or traumatic emergency. While these policies may include using 9-1-1 service for patient transfers, hospitals are prohibited from relying on 9-1-1 to stabilize a patient's emergency condition. Thirty-four percent of hospitals examined in this study use 9-1-1 to obtain medical assistance to stabilize patients as part of their emergency response procedure, which is a violation of these CMS regulations.

The study found a number of shortcomings among physician-owned specialty hospitals in regards to staffing requirements. Seven of the hospitals included in this study failed to have an RN on duty at some point during the eight-day period sampled for the study. In fact, three of these hospitals failed to have an RN on duty for any shift during one of the eight sampled days, and

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Elderly Patients ED Visits Increase, Study Finds

A new study published in *Annals of Emergency Medicine* reports that between 1993 and 2003, the rate of ED visits for patients between 65 and 74 years in age increased 34 percent. At the same time, total ED visits increased by only 26 percent. If current trends continue, ED visits for patients between 65 and 74 years in age will reach an estimated 11.7 million in 2013, up from 6.4 million in 2003.

Researchers are concerned by this growth, as ED visits for older patients tend to last longer than visits for other age groups, and are more likely to require admission. Older patients also tend to utilize more resources while in the hospital. This growth in ED visits for older patients will put even more pressure on EDs and hospitals already struggling with overcrowding and capacity issues.

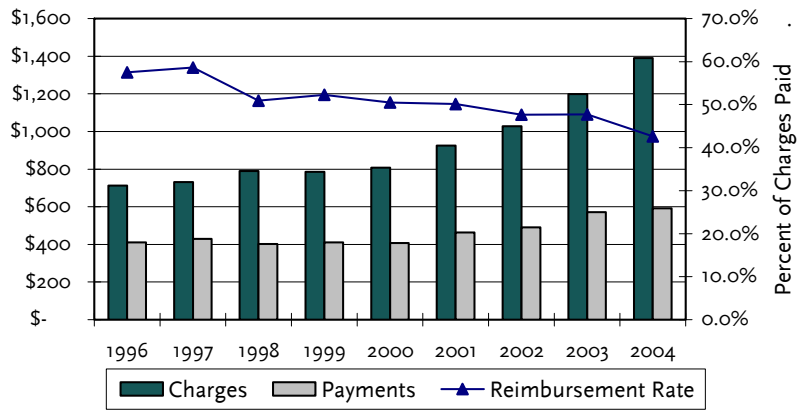
The study found that the severity of ED visits for this age group has not decreased along with this increase in visits, indicating that "older Americans are having more true emergencies, rather than increasingly visiting the ED for convenience or because of lack of access to non-emergency outpatient care."

For this study, researchers from the George Washington University Medical Center examined data from the Center for Disease Control and Prevention's National Hospital Ambulatory Medical Care Survey (NHAMCS). The study, titled "Increasing Rates of Emergency Department Visits for Elderly Patients in the United States, 1993 to 2003," was published in the December issue of *Annals of Emergency Medicine*. It is available here.

Reimbursement Rates for ED Visits Decreased 1996 to 2004

The percent of total charges paid for outpatient ED visits decreased from 1996 to 2004 for all major payers, according to a study published in *Annals of Emergency Medicine*. In 1996, approximately 57 percent of all outpatient ED charges were paid, decreasing to 42 percent in 2004. Actual payments did increase, however this increase was not as great as the corresponding increase in charges, resulting in a decrease in the reimbursement rate.

Mean Adjusted Charges and Payments
All Payers, 1996-2004



Overall, the proportion of ED charges paid decreased more among insured than uninsured patients. Average reimbursement rates did decrease for the uninsured as well; however the decrease was much less dramatic.

Researchers found that contrary to the common industry belief, the uninsured actually pay a higher portion of their ED charges than Medicaid pays. In 2004, uninsured patients paid 35 percent of their charges, while Medicaid paid only 33 percent of charges. For each year included in the study, private insurance paid the highest percentage of total changes, with an average reimbursement rate of 56 percent in 2004.

Declining reimbursement rates may be harmful to the financial viability of EDs, and may threaten their role as a major component of the nation's safety net.

For the study, researchers from UCSF and Stanford University examined Medical Expenditure Panel Survey data. They looked at charges and payments for 43,128 ED visits from 1996 to 2004 to determine the portion of charges actually paid for each major payer.

A complete report of the results from the study can be found at the *Annals of Emergency Medicine* website.

Specialty Hospitals *(continued from page 1)*

another failed to have an RN on duty during any shift during three of the eight sampled days. One hospital failed to have a physician either on call or on duty during at least one of the eight days. These are violations of Medicare requirements. Researchers found that these hospitals were most likely to fall short of staffing requirements on weekends.

The study concluded with the following recommendations to CMS:

- Create a system to identify and monitor physician-owned specialty hospitals on an on-going basis
- Come up with a means to ensure that hospitals meet the staffing requirements set forth by Medicare's Conditions of Participation that require an RN to be on duty 24-hours per day, 7 days per week, and a physician on-call if not onsite at all times
- Ensure that hospitals are capable of providing initial assessment and treatment of patient emergency situations that does not include using 9-1-1 as a substitute for their own ability to stabilize patients
- Require each hospital to include in their written policies relevant and specific information regarding the management of a medical emergency

To view the complete report, which includes CMS's response to the recommendations, click here.

Legislation Offers Temporary Relief to Physician Fee Schedule Decrease

The Medicare, Medicaid, and SCHIP Extension Act of 2007 increases the CMS Physician Fee Schedule Conversion Factor for the first six months of 2008. The Conversion Factor is scheduled to decrease by 10.1 percent this year; instead, as a result of this Act, the Conversion Factor will increase by 0.5 percent for dates of service beginning January 1 through June 30, 2008. For dates of service on and after July 1, 2008, the 10.1 percent decrease will take effect.

Additionally, the Act extends through June 30, 2008 a 5 percent bonus payment to physicians practicing in physician shortage areas, which otherwise would have expired. The legislation also extends the current work geographic index floor of 1.0 through June 30, 2008. The State Children's Health Insurance Program (SCHIP) is also extended by this Act, to provide states with the necessary funding to maintain their current enrollment through March 31, 2009.

The Act was signed into law by the President on December 29, 2007. To read the full text, please search for it at the Library of Congress website.

Report Calls for Better Communication, Coordination of Emergency Response

On February 4, 2008, the Joint Advisory Committee on Communications Capabilities of Emergency Medical and Public Health Care Facilities (JAC) released a report identifying the current lack of communication capability between EMS and health facilities, and issued recommendations on how to best address these shortcomings.

> "Too often today, EMS responders, doctors, and nurses must practice 21st century medicine with 20th century communications technology."

The report calls for the development of a comprehensive, systematic, and coordinated emergency communication system. JAC's recommendations involve all phases of emergency preparedness and response, from the receipt of 9-1-1 calls; EMS dispatch; onsite, transport, and hospital communications; interagency communications and coordination; treatment of victims; and identification of outbreaks.

EMS providers currently face communication problems when they transport patients across multiple jurisdictions, as neighboring regions may be using different and incompatible communication systems. This problem is worsened in a mass casualty event, when providers from multiple jurisdictions may be may called in to help but are unable to communicate with hospitals, trauma centers, and each other.

Some areas of the country have created communications systems linking public health agencies with hospitals, or establishing links between hospitals and other healthcare facilities. Some of these regions have gone so far as to create incident management systems, which will allow for a unified response to a major disaster or emergency. However, these efforts have not been wide-spread, and generally have not been designed to be compatible with one another or with federal disaster response systems.

The report calls for an interoperable broadband internet protocol (IP) based emergency communication network of networks. Past experi-

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Study Finds Increases, Disparity in Wait Times to See an Emergency Department Physician

From 1997 to 2004, average wait times to see a physician in the ED increased a total of 36 percent, or 4.1 percent per year, for all ED patients, according to a recent study published in *Health Affairs*.

For the study, researchers used data from the National Hospital Ambulatory Medical Care Survey (NHAMCS) to analyze recent trends in wait times to see physicians in EDs. The study focused on the following four questions:

1. Are wait times increasing?
2. How have wait times been changing for higher-acuity patients, specifically those with acute myocardial infarction (AMI) or who are triaged as "emergent"?
3. Can differences in these trends be found between patients of different race, ethnicity, or gender, or between patients visiting EDs that differ by type of ownership or location?
4. Does a patient's initial triage designation play a role in explaining differences in wait times among different demographic groups?

In 1997, the median wait time for all adult patients in the ED was 22 minutes. By 2004, this had increased to 30 minutes. For the subset of adult ED patients with AMI, the average wait times to see a physician increased even more substantially than for overall ED visits. In 1997 patients diagnosed with AMI waited a median of 8 minutes. This wait time increased 150 percent to 20 minutes in 2004.

These trends are particularly concerning because quality of care may decline along with longer waits, as many medical conditions benefit from the timely provision of care and rapid treatment. Additionally, longer waits may mean unnecessarily prolonged pain and suffering, patients leaving without being seen by a physician, and increased dissatisfaction with care.

Researchers found statistically significant differences in wait times among different racial and ethic groups. On average during the study period, white patients waited 24 minutes, black patients waited 31 minutes, and Hispanic patients waited 33 minutes. Females generally faced longer waits than males; the median wait time for a female in the ED during the study period was 26 minutes, compared with 25 minutes for a male. The researchers noted that these differences have not decreased over time, despite efforts to reduce disparities in health care.

A number of factors have likely contributed to increased waits in the ED. Among the factors identified by the study's authors are increased crowding of EDs because of the combined effect of growth in ED visits along with recent closings of EDs throughout the country; shortage of inpatient beds causing back-ups in transferring admitted patients from the ED to inpatient units; increasing incidence of uninsurance; the aging population; shortages of ED space, staffing, and support services; and difficulties in assuring patient follow-up care in non-ED settings.

The study also found that during this time period, the proportion of total ED visits which were classified as emergent decreased. In 1997, 26.9 percent of all ED visits were triaged as emergent; by 2004 only 15.2 percent of all visits were considered emergent. This suggests that people have been increasingly visiting the ED as an alternative to other sources of care, and that significant barriers may be hindering access to primary care services.

The study's authors identified several possible interventions that might help manage the growth in ED wait times, by addressing some of the main causes of these increased waits. These interventions include the following:

- Increase insurance coverage and access to primary care resources, which will mean greater access to alternative sources of care and less reliance on EDs
- Re-alignment of hospital resources to those services that are medically necessary (i.e. the ED) rather than more profitable services that are not medically necessary
- Increase the availability of ED space, staff, and specialty consultation services
- Make changes to the management of schedules for elective surgeries

The complete report is available for purchase at the *Health Affairs* website. To view an abstract of the report, click here.

JAC EMS Communication Report *(continued from page 3)*

ence has shown that during large-scale disasters when all other forms of communication have failed, internet-based systems stayed connected.

JAC offered the following recommendations for improving emergency communication systems:

1. Encourage interoperable broadband networks
2. Improve interoperability through better coordination between agencies
3. Enable consistent efforts through use of common standards and coordinated federal grant guidance
4. Advance capabilities through better network integration (including investing in new technologies and better coordination of existing systems)
5. Ensure that first responders, health care personnel, and patients have universal access to broadband services and applications by fostering a regulatory environment in which private sector companies build robust broadband networks and providing targeted funding

> "The best way to ensure access... in times of emergency is to build and support communications systems that link such institutions and support their use for the day-to-day delivery of healthcare."

The report also includes a description of current efforts made by the U.S. government to encourage enhanced emergency communication capabilities in EMS and public health.

Click here to download JAC's complete report to Congress.

EMS.gov Links the EMS Community to a Wealth of Industry Resources

A new website hosted by the National Highway Traffic Safety Administration, Office of Emergency Medical Service (OEMS) acts as a comprehensive portal to a wide variety of other websites and resources for EMS.

From EMS.gov you can find updates and background information on Federal EMS programs and initiatives, EMS education resources, and research and resources relating to EMS workforce issues.

The website also features breaking news from OEMS, as well as links to other EMS news agencies.

Visit www.EMS.gov to learn more.

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