



The Abaris Group

The TAG Line

The Abaris Group | Innovative Solutions for the Emergency Care Field
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Getting the “Pulse” on Emergency Departments

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On July 27 Press Ganey released its annual Emergency Department (ED) Pulse Report, which provides an overview of characteristics of ED visits throughout the country in 2006. For the study, Press Ganey surveyed approximately 1.5 million patients at 1,500 EDs nationwide during the course of the year, and gained an understanding of the quality of care provided in EDs from a patient’s perspective. In particular, the ED Pulse Report looks at the relationship between length of time spent in the ED and overall patient satisfaction.

The survey found that patient satisfaction varies greatly by metropolitan area, hospital size, patient age, and other demographic characteristics. Overall, patient satisfaction increased from 2003 to 2006.

Nationwide, average length of stay (ALOS) in the ED was four hours, up from 3.7 hours in 2005. ALOS varied greatly by state as well as by size of the ED. EDs which saw fewer than 20,000 patients annually had an ALOS

of 3.1 hours; those which saw greater than 40,000 patients each year had an ALOS of 4.4 hours. Overall, ALOS increased by about 30 minutes for each additional 10,000 patients seen in the ED.

Press Ganey found that patient satisfaction decreased substantially after a patient’s length of stay reached two hours. Another factor that can influence a patient’s satisfaction is the annual patient volume seen in the ED. Satisfaction tends to be greatest in lower-volume EDs, which Press Ganey attributes to the fact that each patient in a lower-volume ED is competing with fewer other patients for medical attention.

Even with long waits, there are some things that an ED can do to improve patient satisfaction. The first is to keep patients well informed about delays. Simply updating a patient from time to time

about his or her status makes a huge difference in terms of overall satisfaction. Press Ganey found that even with wait times of upwards of four hours, patients who were kept well informed about delays reported higher levels of satisfaction than patients who had

shorter waits, but who were not kept informed about delays. Also, creating a

comfortable waiting area in the ED increases overall patient satisfaction. Patients who faced long waits in comfortable waiting rooms were substantially more satisfied than patients who waited in an uncomfortable waiting room, even if the patients in the less-comfortable waiting area had shorter wait times.

The ED Pulse Report is one of the series of 2007 reports published by Press Ganey, including the Hospital Pulse Report, the Physician’s Office and Outpatient Pulse Report, and the Physician Check-Up Report. Each of these reports can be found on Press Ganey’s [web-site](http://www.pressganey.com).

Longest Length of Stay by State:

1. Utah—381 minutes
2. Nevada—358 minutes
3. Arizona—337 minutes
4. Virginia—283 minutes
5. Kansas—279 minutes

Shortest Length of Stay by State:

1. South Dakota—158 minutes
2. Idaho—159 minutes
3. Iowa—167 minutes
4. Nebraska—172 minutes
5. North Dakota—175 minutes

Is Primary Care Coming back to Paramedics?

A new pilot program is being developed in two states which will help provide primary and preventative services in rural communities where these services have not previously been available. This comes after a long absence of such pilot programs that occurred in the US during the 1980s and 90s.

This program is based on an existing community Canadian paramedic program on the remote islands of Long and Brier, off the coast of Nova Scotia. The program was started because it was not feasible to station a physician on these small islands, yet the communities had unmet primary healthcare needs. To help address these needs, local paramedics received additional training in order to expand their services. They began administering flu shots, performing blood pressure and glucose checks, conducting home assessments, providing wound care, performing blood draws, monitoring medication compliance, administering antibiotics, assessing urine specimens, changing dressings, and removing sutures and staples.



A study by Dalhousie University in Halifax, Nova Scotia found that the community paramedic program has decreased costs for patients, travel time to receive healthcare services, and rates of hospitalization.

A collaborative of rural health providers, EMS providers, and academic organizations in Minnesota and Nebraska obtained federal grant funding to help get the pilot program started. The project is being led by Gary Wingrove, director of government affairs for the Mayo Clinic's ambulance service in Minnesota, and Dennis Berens, director of the Nebraska Office of Rural Health.

The collaborative is working to create a community paramedicine bachelor's degree program, combining elements from the Minnesota Community Health Worker college certificate program with the Nova Scotia community paramedic modules. The degree program will provide participants with a strong background in EMS, public health, and mental health. The collaborative plans to eventually spread this degree program to different regions, so that community paramedicine providers can offer consistent, research-based care throughout the country.

Project developers also think that the concept of community paramedicine could potentially be modified to help ease hospital overcrowding in urban areas.

For more information about the pilot program, click [here](#). To find out more about Nova Scotia's experience with community paramedics, click [here](#).

New Surge and Capacity Funding Grant Announcement

On August 7, 2007 the Office of Preparedness and Emergency Operations announced a competitive grant program offering up to \$25 million for emergency preparedness programs. The grant, titled the 2007 Healthcare Facilities Emergency Care Partnership Program, will provide funding for up to three collaborative projects.

The focus of these projects should correspond with the grant's missions, which is to improve hospital surge capacity, emergency care system capacity, and community and hospital preparedness for healthcare emergencies. The hope is to improve the nation's ability to respond to public health emergencies by improving the emergency care system. Specifically, the grant seeks innovative projects that can be replicated throughout the country.

Grants will be given to collaborative groups consisting of each of the following entities:

- One or more hospitals, at least one of which is a designated trauma center;
- One or more local health care facilities, including clinics, health centers, primary care facilities, mental health centers, or nursing homes; and
- One or more political subdivisions

In particular, the Office of Preparedness and Emergency Operations hopes that this project will facilitate "developing and strengthening relationships between and among partnership entities engaged in the provision of emergency care, traditional first response agencies, public health and other response partners prior to disasters and emergencies, so that during and after these kinds of events, response and recovery activities happen in an expedited, coordinated manner." They hope to encourage healthcare facilities to collaborate with other facilities belonging to different healthcare systems, in order to facilitate cooperation between competing entities for the purpose of emergency preparedness.

Grant applications were received by September 7, 2007. As of this time, recipients have not yet been selected.

For more information about this grant program, please click [here](#).

Misunderstanding HIPAA puts Emergency Care Providers at Risk

The Health Insurance Portability and Accountability Act (HIPAA) contains a number of regulations designed to protect patients' privacy, among other regulations. In particular, the Privacy Rule, put into effect on April 14, 2003, limits the use and disclosure of Protected Health Information (PHI). Certain PHI may not be shared without the patient's written consent, except for treatment, payment, or healthcare operations purposes. HIPAA is frequently misunderstood, with many healthcare providers citing HIPAA as their reason for refusing to share information that they are allowed or even required to share, because they do not understand the law.

A recent article in the *Journal of Emergency Medical Services* discussed hypothetical scenarios in which healthcare providers refused to share a patient's diagnoses or test results with EMS providers despite the fact that the EMS providers were at risk from exposure to the patient's disease or condition. The reason given for not sharing the information was that releasing such details would be a violation of HIPAA privacy laws.

In fact, the Ryan White Law says that in cases where an EMS employee is exposed to a communicable disease, the medical facility to which the patient is transported is legally required to provide the patient's test results to the designated officer for infection control, who in turn is obligated to inform the EMS employee of the results.



Not only is releasing information in these cases not necessarily a violation of HIPAA, failure to release such information may actually violate OSHA regulations, under the Bloodborne Pathogens Standard. The Bloodborne Pathogens Standard says that in the event of an exposure incident, the employer is required to obtain the test results for the source individual, and must make sure that the EMS employee involved in the exposure incident receives these test results. In such situations, the OSHA regulation meant to protect the health of the EMS personnel supersedes HIPAA regulations relating to patient privacy.

On July 3, *The New York Times* published an article titled "Keeping Patients' Details Private, Even From Kin," which discusses this same issue of misunderstanding HIPAA. The article describes situations where patient information could legally have been released, but healthcare providers withheld the information, most often out of ignorance of the privacy rule. The author of the article recognizes that HIPAA is a complex law, however something must be done to stop providers from blindly using HIPAA without attempting to understand when it is or is not applicable.

To learn more about HIPAA, visit the HIPAA [website](#) from the Department of Health and Human Services.

Please click [here](#) to read the *JEMS* article.

The New York Times article is available for purchase at *The New York Times* [website](#).

Self-Serve Kiosks to Improve ED Triage

Parkland Hospital in Dallas, Texas has implemented a new system to speed up registration in its ED, by allowing patients to check in themselves at touch-screen kiosks upon arrival. Prior to this new system, patients would often be waiting up to two hours to check-in at this crowded ED which sees upwards of 146,000 visits annually.

Patients identify their symptoms by selecting the areas where they feel pain or discomfort on a diagram of the human body. They then answer questions in either English or Spanish regarding the nature of their visit.

Data entered into these kiosks are automatically transferred to the ED's main computer system, where it can be reviewed and monitored by ED nurses. If a patient enters information to suggest that he or she might be in an urgent condition, a nurse will immediately identify this and attend to that patient. Parkland's managers feel that this method will enable staff to more easily identify those patients in the most urgent condition, through a more efficient triage process. Ultimately they expect this innovation to lead to shorter wait times and increased patient satisfaction.



Parkland Hospital purchased these kiosks, which are called MediKiosks, through a grant given to the Parkland Health and Hospital System from the University of Texas Southwestern Medical Center. The kiosks were purchased from Galvanon, a company that specializes in the use of technology to streamline patient interactions and improve patient throughput.

For more information on Parkland Hospital's new MediKiosks, please click [here](#).

For more information on Galvanon's MediKiosks, please visit their [website](#).



The Abaris Group Announces: The 2007 Webinar Series

Join us for our new series of Webinars. These 90-minute interactive presentations led by industry leaders will provide participants with valuable knowledge on topics important to the field of Emergency Medicine.

Upcoming Webinars:

- I. Retail Health Care - Freestanding EDs and Retail Centers - September 25, 2007, 9:00-10:30 a.m. PST
- II. New Medicare Revenue Opportunities for EDs and Trauma Centers - October 4, 2007, 10:30 a.m.-noon PST
- III. Best Practice Approaches to ED and Inpatient Throughput - October 31, 2007, 10:00-11:30 a.m. PST
- IV. Optimizing Customer Service in the ED - November 14, 2007, 8:00-9:30 a.m. PST

Educate your entire staff for one low cost. Pay only **\$295** per site for one Webinar or learn about our special discounts when you register for two or more Webinars.

For more information or to register, visit www.abarisgroup.com or call (888) 367-0911.

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

Only Abdominal Compression CPR?

A new method of cardiopulmonary resuscitation (CPR) is thought to be more effective than traditional CPR. The new method, developed by Leslie Geddes, a biomedical engineer at Purdue University, increases blood flow through the heart by 25 percent compared to traditional CPR.

The new CPR, called "only rhythmic abdominal compression" CPR (OAC-CPR), involves pushing on the abdomen rather than the chest. This method reduces risks associated with the tradition method of CPR, particularly the risk of breaking ribs if you push too hard on the chest, but not being effective if you don't push hard enough, and the risk of transferring infectious diseases through the mouth-to-mouth component. Many people are unwilling to perform CPR on a stranger because of the risk of infectious disease.

OAC-CPR eliminates the need for mouth-to-mouth resuscitation, because the act of pushing on the abdomen moves the diaphragm toward the head, which expels air from the lungs. The resulting release of force causes the individual to inhale invol-

untarily.

Additionally, with traditional chest compressions, blood sometimes flows in the wrong direction, which brings de-oxygenated blood back to the heart. Research shows that abdominal compressions force blood to flow in the proper direction.

Researchers at Purdue compared OAC-CPR with standard CPR, using the American Heart Association's standards of pushing with 100 pounds of pressure 100 times per minute. Although Geddes says that OAC-CPR does not require as much pressure or the same frequency, researchers chose to follow the AHA standards for consistency and to avoid criticism of their study. The findings showed that the OAC-CPR caused 25 percent more blood to flow through the heart muscle, and eliminated any retrograde flow in the coronary arteries.

This method has not been approved for use.

More information on OAC-CPR can be found [here](#).

"FIRE" Fire Fighter Tracking System Using RFI Technology

The University of California, Berkeley has developed a tracking system to improve the safety of firefighters working in burning buildings. The wireless system will be able to pinpoint the location of firefighters in any building equipped with the technology.

The system, called Fire Information and Rescue Equipment (FIRE), is made up of two components: SmokeNet and FireEye.

SmokeNet is a wireless network that allows sensor devices to register and report changes in the environment to firefighters. The sensors will alert a fire-

fighter if conditions become unsafe. The sensors can be installed in smoke detectors, on ceilings, or in door jams. Additionally, each firefighters' air tank will be equipped with a sensor, which communicates a unique ID number to the sensors located in the building, thus establishing the location of the individual firefighters. This information is then sent to the chiefs' or incident commanders' PC, which updates the locations on a diagram of the building. This system can be used in any building in which the sensors have been installed.

The second component, FireEye, is an

LCD screen the size of a postage stamp which is installed inside a firefighter's helmet. The screen displays the location of each firefighter on a floor plan of the building.

The need for such a system was recognized during the rescue efforts of 9/11, when rescue workers were unable to communicate with one another because of incompatible two-way radios. It is important for rescue commanders to know the location of the firefighters, so that they can make informed tactical decisions.

For more information about the FIRE system, please click [here](#).



Proposed Legislation Relating to Emergency Medical Care

Congress is currently considering two bills relating to emergency medical care. Both bills address some of the recommendations made in the Institute of Medicine's *The Future of Emergency Care* report.

Improving Emergency Medical Care and Response Act
S. 1873 and H.R. 3173

This proposed legislation calls for a demonstration program looking at the formation of a regionalized, accountable emergency care system. Specifically, such a system will be designed, implemented, and evaluated in four regions of the country. The idea behind this legislation is that emergency medical care can potentially benefit from a regionalized, coordinated system of care, however little is known about the most effective and efficient way to set up such a sys-

tem. If passed, the legislation will ensure that response teams, medical personnel, and emergency departments will have necessary communication tools to aid in emergencies, including streamlined communications systems and real time data tools. Supporters of the legislation believe that the results of this demonstration project will ultimately lead to improvements in medical service delivery, which in turn will result in enhanced patient outcomes.

Access to Emergency Medical Services Act of 2007
S. 1003 and H.R. 882

This proposed legislation calls for examination of all factors that may negatively impact the delivery of care in emergency departments in the United States. A national bipartisan commission on access to emergency medical services will study

these factors, specifically looking at overcrowded conditions, diversion, and other barriers to prompt access to care. The Senate bill calls for a working group to establish standards relating to ambulance diversion and patient boarding, and to come up with guidelines and incentives to facilitate with the implementation of these standards. The House bill would require hospitals to report data on patient boarding to the Department of Health and Human Services.

The above bills have been referred to the relevant House and Senate committees, but have not been acted on since reaching these committees.

For additional information on the above bills, please visit the Library of Congress [website](#).



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.

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