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The Abaris Group

The TAG Line

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Freestanding Emergency Departments

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Freestanding emergency departments (FED) are becoming more and more popular, as traditional hospital-based emergency care cannot satisfy the growing demand for prompt, efficient service in many communities.

The typical model involves a FED operating under the license of an acute-care hospital, but generally located several miles away. A hospital may operate a system of FEDs, to increase the range of care in the area or to act as a market maker for new service areas. Other models may have limited services, or more closely resemble more advanced urgent-care centers. Some but not all FEDs accept ambulances or are permitted by local policy to accept ambulance.

The Abaris Group estimates that there are approximately 75 to 100 FEDS in the country. Successful examples of freestanding emergency care centers include E-Care Urgent Care and St. Luke's centers in Texas, WakeMed Healthplex in North Carolina, and Henry Ford Hospital in Detroit.

Because emergency care is expensive to administer, FED are expected to do best in affluent areas, where people tend to have health insurance to cover the cost of treatment. However, successful examples have emerged throughout the country, regardless of the economic condition of the area.

A hospital might open a FED to establish a presence in a market before expanding to a full-sized hospital. A FED is a good means for "testing the water" in a new market. The FED can then be expanded into a full-scale hospital, remain as an ED, or be reduced to an urgent care clinic, depending on demand in the area. A good example of this approach is Alegent's Lakeside Hospital in Omaha that started as a FED.

Some advantages of FED include faster access to care for people who are located far from a main hospital, reduced wait time/length of stay, and increased efficiency, as FED tend to attract lower acuity patients, thus fewer are admitted and time is not wasted on "borders" waiting to be admitted to the hospital. Additionally, the atmosphere at a FED tends to be more relaxed than a high-paced, high-stress hospital-based ED.

Some FEDs face political pressure, as there is a fear that the freestanding facility will take paying customers away from safety-net hospitals. Experience has shown, however, that FEDs do not just attract patients from other EDs; they create new demand , as the promise of more efficient care attracts many people who otherwise would have sought care in a non-ED setting.

While no official data exists on the quality of care given by FED, certain FEDs have proven themselves capable in trials and some

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The Abaris Group announces the availability of a CD recording from the recent past Webinar:

"Medicare's New Rules for Outpatient, Emergency Department & Trauma Center Payments"

For more details and to purchase CD, visit: www.abarisgroup.com.

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

CDC Report on Staffing, Capacity, and Ambulance Diversion

On September 27, 2006 CDC released a report titled "Staffing, Capacity, and Ambulance Diversion in Emergency Departments: United States, 2003-04." This is the first national study to look at estimates of occupancy rates and their relationship with ambulance diversion practices.

The report looked at characteristics of the hospitals in which the EDs were located, characteristics and volume of the EDs, occupancy rates, staffing characteristics, and diversion hours, and how these criteria varied between metropolitan and non metropolitan areas.

Between 40 and 50 percent of EDs surveyed experienced overcrowding. This overcrowding was most concentrated in metropolitan areas, where 64 percent of EDs experienced crowding at some point during 2004.

Problems that lead to ED overcrowding include lack of treatment space, on-call specialists, and language translation services.

The report found that ambulance diversion was most often the result of a lack of inpatient beds and ED crowding, rather than staffing shortages and equipment failure. When an ED went on diversion, it typically remained on diversion for three to four hours.

Of the EDs surveyed for this study, 51.4 percent reported that they never went on diversion. Of those remaining, only 34.4 percent actually admitted to being on diversion at some time during the year.

Larger EDs tended to spend more time on diversion. The EDs with no diversion hours had the smallest mean bed size (138) and mean occupancy rate (60 percent), while those on diversion more than 20 percent of the time had the largest mean bed size (311) and mean occupancy rate (81 percent).

Eight percent of hospitals surveyed reported that they could not go on diversion, because of laws prohibiting turning away ambulances in their area.

The complete report can be found here.

Freestanding Emergency Departments (continued from page 1)

are operated by some of the leading hospital systems in the country, including Inova Fairfax in VA and the Carolinas in NC.

It is important for a FED to have the support of the local EMS authority.

Without receiving ambulance patients, a freestanding facility will not be treated like an ED in terms of Medicare/Medicaid and private insurance reimbursement. Additionally, in order to receive reimbursement at an ED, a FED must be identical to a hospital-based ED in terms of services offered, hours of operation, staff, licensing, and facilities. New Medicare compensation rules however permit freestanding EDs to be paid even if they do not operate 24 hours per day. For more information on these new payment rules and others visit www.abarisgroup.com.

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R. Adams Cowley Shock Trauma Center Plans $83 Million Upgrades

The R Adams Cowley Shock Trauma Center at the University of Maryland Medical Center is planning to spend $83 million on upgrades to better accommodate the increase in patient load that the center has been seeing recently.

Shock Trauma Center is the first free-standing trauma center of its kind, offering advanced trauma care in a freestanding facility. The Center has been an innovator in the field of trauma care, offering some of the most comprehensive services.

These upgrades, which will take place over the next five years, include expanding capacity from 84 beds to 108 beds, with the creation of an intensive care unit from 12 existing beds. $40 million will go towards upgrading health care technology systems and purchasing new medical equipment.

Officials state that a lack of physical space is limiting Shock Trauma Center's ability to treat its ever-increasing patient load.

Since it opened in 1989, Shock Trauma Center has been committed to treating as many patients as possible, a goal which has become increasingly difficult to meet as patient visits have increased from 2,000 annually in 1997 to 7,700 last year. These upgrades will help enable the center to provide state-of-the-art care to all who need it.

These upgrades will be funded by the University of Maryland Medical System, federal grants, and state support.

For more information, visit the Shock Trauma Center website or click here.

Hospital Improvements to Better Respond to Mass-Casualty Emergencies

A recent article in the *Wall Street Journal* looked at improvements that hospitals have made in terms of emergency/disaster preparedness since September 11, 2001. In the past five years, more than $4 billion in federal funds has been used to build up hospital, state, and local disaster preparedness. Many hospitals still face inadequate funding and poor coordination, but significant changes have been made at some hospitals to help make them better prepared to handle a mass-casualty emergency.

The article cites several hospitals that have taken great steps towards improving their emergency response preparedness.

New York Downtown Hospital expanded its emergency department capacity to double its original size. It also installed equipment, such as oxygen hook-ups, into the cafeteria so that it could be converted into another ED if extra space was needed during a large-scale emergency.

Swedish Medical Center in Seattle has begun running drills and tests so that emergency care providers will know how to handle a number of potential emergency disaster situations. In particular, they have run evacuation drills to practice removing patients in all conditions from the building in a safe, timely, and efficient manner.

East Jefferson General Hospital in New Orleans recognized that in an area prone to natural disaster, they should be prepared for such a disaster, with electronic medical records, food rations, backup generators, and staff security.

The changes made by these hospitals can serve as models for other hospitals, who should similarly make themselves more prepared to handle a mass-casualty emergency. Ever since September 11, 2001 and Hurricane Katrina, hospitals have been realizing that they must make changes to better prepare themselves for responding to disasters.

A summary of this article can be found at the American Trauma Society website.

Overuse of EDs is By Insured Patients

The California Health Care Foundation released a report looking at how insured patients are contributing to overcrowding of emergency departments in California.

The report identified two groups of insured individuals who were likely to be frequent users of EDs: chronically ill adults and individuals covered by Medi-Cal. Nearly half of these patients recognized that their visits to the ED could have been avoided. The report looks at the reasons why these individuals continue to visit emergency departments with non-urgent conditions.

The report identified the following four factors that lead people to visit the ED when it might otherwise have been avoidable:

- Lack of access to medical care outside of the ED: many ED patients felt that their problem could have been handled by a primary care physician, but visited the ED because they were unable to get an appointment with their primary care physician.
- Lack of advice from physicians on how to handle sudden medical conditions.
- Lack of alternatives to the ED: especially outside of normal business hours, many see no other alternative to visiting the emergency department.
- Positive attitudes towards EDs: many frequent ED visitors associate the ED with easy access to diagnostic testing, higher quality of care, easier access to specialists, convenience, and affordability, and trust that EDs offer the best possible care. Evidence actually suggests that because of overcrowding, the quality of care is not as high as it could be, and patients may actually have long waiting times, so it is not as convenient as they imagine.

The report goes on to offer possible ideas for reducing non-urgent ED visits, including expanding the network of community healthcare centers, making specialized respiratory and other equipment available in primary care settings, improving chronic disease management, creating financial penalties for choosing emergency department care, and extending hours of urgent care clinics.

The report can be viewed online at the California Health Care Foundation website.

ED Nurses Report High Job Satisfaction

Sixty-four percent of ED nurses reported that they are extremely satisfied with their jobs, despite the fact that 86 percent reported that they had been the victim of violence in the workplace in the past three years, according to a survey by the Emergency Nurses Association (ENA). Seventy-five percent of the 1,000 nurses surveyed said that they expect to remain in the nursing industry for at least ten more years.

ENA believes that increased funding for nurse training programs is needed to improve working conditions for ED nurses. Additionally, it supports the idea of a governing body to reform emergency care at the local, state, and federal levels.

For more information, visit the ENA website or click here.

SUNY Traffic Surveillance Study

SUNY Upstate Medical Center is taking part in a study using traffic surveillance cameras to observe motor vehicle crashes and rescue operations. Previous studies have found that emergency department staff members are better prepared to treat victims if they are able to view images of the crash site, rather than rely on descriptions of the injuries and accident site from emergency responders.

In this study, 20 closed-circuit cameras were set up to cover the major roadways in the area. These cameras will be monitored 24 hours a day by the Department of Transportation to assess traffic conditions. In the event that a motor vehicle accident occurs, the ED staff will be referred to the appropriate camera so that they can view the accident scene and assess the extent of damage before the victims arrive at the emergency department. By analyzing the scene of the accident, the staff can be better prepared to treat the patients when they arrive.

A description of the study was published in *Medical Devices & Surgical Technology Week*. A summary is available at the American Trauma Society website.

CMS Releases 2007 Outpatient Prospective Payment System and Physician Fee Schedule

Outpatient (ED & Trauma Center) Prospective Payment System

CMS released the 2007 outpatient prospective payment system (OPPS) final rule, with some very significant changes from the proposal released in August. CMS showed a willingness to listen to feedback from healthcare providers, and made changes accordingly.

The final rule differs from the proposal in that it does not include many of the proposed changes for facility E/M reporting and delayed until 2009 requirements for hospitals to report inpatient care quality data in order to qualify for the full outpatient rate update.

The 2007 OPPS final rule includes an increased list of services for which Medicare will make payments to ambulatory surgical centers in 2007 and includes a 3.4 percent update to Medicare payment rates.

Some of the most notable differences in this year's OPPS guidelines compared with previous years' are changes to the trauma codes. Providers will now receive additional payment when they report Trauma Response Team activation. CMS has acknowl-

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San Diego Healthcare Safety Net Report Released by The Abaris Group

The Abaris Group recently released a report analyzing San Diego County's Healthcare Safety Net. The study included a 20-year assessment of the county's healthcare safety net needs, as they relate to inpatient and outpatient hospital care, clinic visits, ED and trauma, primary and specialty care, physician requirements and funding requirements. The study involved input from a wide variety of county officials, healthcare providers, and members of the community.

An analysis of San Diego's strengths, weaknesses, opportunities, and threats was completed. The following are just some of the findings:

- Strengths: network of community clinics, county-wide collaborative groups, numerous groups that plan and deliver enhanced access to the safety net
- Weaknesses: increasing number of providers unwilling to serve the safety net, extremely limited access to specialty physician providers, lack of robust after-hour service at clinics
- Opportunities: identify and implement best practices, opportunity to bring greater coordination to the safety net, leveraging public funding
- Threats: aging population places greater strain on healthcare resources, increasing immigrant and refugee populations create cultural challenges to providing healthcare, increase in working uninsured, unfunded mandates

Key findings from the report:

- San Diego County has the second highest community clinic utilization rate (160 visits per 1,000 residents) in the state. This high utilization rate is likely due to the fact that San Diego County has a more extensive community clinic network than most.
- San Diego County has a relatively low ED utilization rate (225 visits per 1,000 residents) compared to California (275 visits per 1,000 residents) and the U.S. (370 visits per 1,000 residents).
- San Diego County's trauma utilization rate has increased from 2.9 in FY 1993 to 3.3 in FY 2005. San Diego County currently has one of the highest triage rates of any EMS region in the state, possibly because of local geographical and epidemiological factors.

The Abaris Group offered a series of recommendations to help San Diego County improve its healthcare safety net to better serve its residents. One important recommendation is for there be developed a county-wide coordination entity to study, implement and monitor key initiatives recommended in the report. This entity should develop a better means of accessing primary and specialty care for the safety net. Specifically, the community should adopt a method for hospitals and EDs to refer patients to county clinics. Additionally, the county should "quantify, trend and correct" the problem of transfers from ED and trauma centers to other facilities when they are unable to access an on-call physician specialist.

The complete report can be found on the Abaris Group website. For more information, contact Mike Williams, President, The Abaris Group.

2007 OPPS and Physician Fee Schedule (Continued)

edged that hospitals incur additional costs when critical care includes trauma activation, and is compensating hospitals accordingly.

Hospitals are expected to receive an overall average increase of 3.4 percent in Medicare OPPS payments compared with 2006, according to CMS estimates.

More information can be found on the CMS website.

Physician Fee Schedule

The 2007 Medicare Physician Fee Schedule places an emphasis on the physician-patient relationship. The new rule increases payments to physicians for time spent talking with Medicare beneficiaries about health care, by increasing the work component for the RVUs for face-to-face visits.

The new fee schedule also includes payment for more preventive services, particularly screening for various cancers and diseases.

CMS expects to make payments of $61.5 billion to more than 900,000 physicians, with a Conversion Factor of $35.9848 and a Work Adjuster of 10.1 percent.

Emergency medicine is expected to be one of only two specialties to have an increase in payments in 2007.

The 2007 Medicare Physician Fee Schedule is available online at www.cms.hhs.gov.

To learn more about the 2007 OPPS and Physician Fee Schedule and how it will affect your business, purchase a recording of the recent Webinar hosted by The Abaris Group. For more information or to purchase, visit www.abarisgroup.com.

Freestanding EDs (continued from page 2)

In some states, such as California, health care providers are experiencing difficulties in establishing FEDs because state Health and Safety legislation does not specifically allow for the licensing of these emergency care facilities or the use of the term "emergency" unless you are adjacent to a hospital. Here other alternatives to hospital-based emergency care have been explored, and changes to legislation proposed so that emergency services can be better available in underserved areas.

The concept of the FED is likely to be a powerful tool for alleviating the problems of overcrowding and lack of access to care so prevalent throughout our county, as successful models can be replicated and modified to meet the specific needs of an area.

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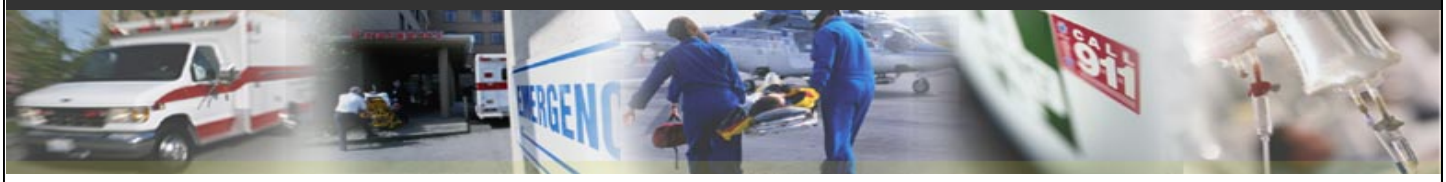

About Us

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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