Volume 4, Issue 5 November/December 2007

The Abaris Group

The TAG Line

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Urgent Care Centers Bridge the Gap Between Primary Care and Emergency Departments

A recent report published by the California HealthCare Foundation looked at growth and trends in Urgent Care Centers (UCCs) nationwide. Specifically, "No Appointment Needed: The Resurgence of Urgent Care Centers in the United States" addressed the following questions:

- What are UCCs?
- What services do UCCs provide?
- Who are UCC customers?
- How are UCCs reimbursed?
- Are UCCs really an alternative to emergency departments (EDs) for non-emergent conditions?
- Are UCCs regulated?

The report focuses on UCCs that are independently owned or part of chains of UCCs, rather than those owned by hospitals or multispecialty group practices.

There is no standard, generally-accepted definition of what a UCC is. In terms of services, UCCs tend to fall somewhere between the scope of a primary care physician and an ED. The Urgent Care Association of America (UCAOA) offers one definition of urgent care:

> Urgent care is defined as the delivery of ambulatory medical care outside of a hospital emergency department on a walk-in basis without a scheduled appointment. Urgent care centers treat many problems that can be seen in a primary care physician's office, but urgent care centers offer some services that are generally not available in primary care physician offices, for example: X-Ray facilities allow for treatment of minor fractures and foreign bodies, such as nail gun injuries. (www.ucaoa.org)

Although there is no standard scope-of-service, UCCs generally offer:

- Walk-in, unscheduled visits
- Extended evening or weekend hours (although typically not 24-hours per day, 7 days per week as offered by EDs)
- Expanded array of services compared to a typical pri-

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The Abaris Group announces its upcoming Webinar:

"Retail Healthcare—Free Standing EDs and Retail Centers"
January 16, 2008
10:00 - 11:30 am (PST)

Also planned for 2008:

1. So You Want to be a Consultant?
2. Choosing the Right ED Information System
3. Making a Business Case for Patient Throughput
4. How to Collect Patient Co-Pays in the ED
5. Designing the Ideal ED
6. Best of Breed Product Lines for Facilitating Patient Flow

Visit www.abarisgroup.com to purchase a recorded version of any of our previous Webinars, including Best Practice Approaches to ED and Inpatient Throughput, Optimizing Customer Service in the ED, Medicare's Fee Schedules for Trauma Centers and Emergency Departments, and many more.

For more details and to register, visit: www.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 or more Webinars.

Senate Bill Calls for $100 Million Grants for Trauma Centers

Senate Bill 2319, the National Trauma Center Stabilization Act of 2007, calls for the authorization of $100 million annually in grants to trauma centers, to help ensure that trauma centers are able to continue to provide necessary care throughout the country.

Specifically, this legislation will establish three programs to award grants to qualified public, non-profit, Indian Health Service, Indian tribal, and urban Indian trauma centers. These grants will help do the following:

- Defray uncompensated care costs
- Further the core missions; specifically regarding patient stabilization and transfer, trauma education and outreach, coordination with local and regional trauma systems, and essential personnel and other fixed costs
- Provide emergency relief to ensure the continued and future availability of services from trauma centers at risk of closing, or trauma centers which operate in an area in which another trauma center has closed

Preference for these grants will be given to those trauma centers which provide the greatest proportion of uncompensated care.

The bill was sponsored by Senator Patty Murray (WA), with co-sponsors Sen. Jeff Bingaman (NM), Sen. Saxby Chambliss (GA), Sen. Kay Bailey Hutchison (TX), and Sen. Johnny Isakson (GA). The sponsors recognized that trauma care is expensive, and trauma centers are often forced to cover the cost of care when patients are unable to pay for it. As a result, more than 19 trauma centers have closed since 2000, while others have been forced to downgrade services to a lower trauma designation level. These grants will help the most vulnerable trauma centers continue to provide important care to the communities which they serve.

The bill was introduced on November 7, and has not been acted on since it was referred to the Committee on Health, Education, Labor, and Pensions.

Capacity and Diversion Issues Vary by Type of Hospital, Survey Finds

According to the American Hospital Association's "The 2007 State of America's Hospitals—Taking the Pulse" report, nearly half (48 percent) of emergency departments (EDs) are at or over capacity. Capacity issues are most severe at teaching hospitals, with 27 percent reporting being at capacity, and 46 percent over. Rural hospitals tend to be the least strained by capacity, with only 20 percent at capacity and 11 percent over.

Percent of EDs At or Over Capacity by Type of Hospital

Type	At Capacity	Over Capacity
Urban	30%	35%
Rural	20%	11%
Teaching	27%	46%
Non-Teaching	24%	18%
All Hospitals	25%	22%

Source: American Hospital Association, "The 2007 State of America's Hospitals - Taking the Pulse."

The report also found that 36 percent of EDs reported being on diversion in the last year. Teaching hospitals had the greatest problem with diversion, as 68 percent of teaching hospitals were on diversion at some time during the last year. For comparison, only 30 percent of non-teaching hospitals were on diversion during that time period.

The most common factors contributing to ambulance diversion are a lack of staffed critical care beds (reported by 30 percent), overcrowding in the ED (29 percent), lack of general acute care beds (17 percent), and staff shortages (12 percent).

Primary Factors Contributing to Ambulance Diversion

Lack of Staffed Critical Care Beds	30%
ED Overcrowded	29%
Lack of General Acute Care Beds	17%
Staff Shortages	12%
Lack of Specialty Physician Coverage	7%
Lack of Psychiatric Beds	4%

Source: American Hospital Association, "The 2007 State of America's Hospitals - Taking the Pulse."

In addition to capacity and ambulance diversion, the report also looks at issues of workforce shortages, specialty coverage, and disaster preparedness. The report, which outlines the results of the AHA 2007 Survey of Hospital Leaders, can be downloaded from the AHA website.

Urgent Care Centers (*Continued from Page 1)*

mary care office (including radiology, point-of-care diagnostic testing, and the ability to repair lacerations or provide intravenous fluids)

UCCs concentrate on episodic care, rather than well care, immunizations, or long-term management for chronic conditions, which are the focus of primary care physicians.

A growing trend among UCCs is to offer on-site pharmacy services. Currently about one-third of UCCs offer some form of this service, known as point-of-care dispensing. They typically provide prepackaged medications in tamper-proof packages. This service increases customer satisfaction, as it is very convenient for patients to receive medication directly from the UCC.

One of the most important characteristics of UCCs is that they think of patients as consumers who are able to choose where they receive necessary health care services. As a result, UCCs tend to focus on customer service. They offer services such as online check-in and registration, or clearly list prices for services on their website.

Primary care physicians typically feel that a new UCC coming into their area will try to take patients away from them. However, many UCCs try to prove that this is not their intention. They desire to act as a complement, not competitor, to existing services. In fact, a UCC may work collaboratively with primary care physicians, providing after-hours care for regular patients of these physicians, and sending reports and records from a patient's visit back to his or her usual physician or refer patients back to these physicians for any necessary follow-up care.

Urgent care uses the same billing codes as primary care. There is also a flat rate code that may be used for urgent care. Under this code, UCCs are paid the same no matter what services they provide. Flat-rate billing may limit the services that a UCC offers, because it may not make financial sense to offer expanded services if they are not reimbursed at a higher rate for these services. Some UCCs have been able to negotiate with insurance providers for tiered charge systems or additional charges for certain procedures and services. Others have instituted a facility fee (similar to one used in an ED); however this concept is controversial as low costs are one of the main draws of a UCC.

An urgent care certification is offered for physicians by the American Board of Urgent Care Medicine; more than 900 physicians have passed the exam for this certification. However, this certification is not yet recognized by the American Board of Medical Specialties.

The complete report, which was prepared by Robin M. Weinick, Ph.D. and Renee M. Betancourt, B.A., can be found at the California HealthCare Foundation's website.

For more information on urgent care centers, visit the Urgent Care Association of America's website.

StatCom Surveys Patient Throughput, Capacity Challenges

The *2007 National Survey on Patient Throughput and Capacity Challenges*, published by StatCom, offers insight into patient throughput, bed occupancy, and length of stay issues at US healthcare facilities from the point-of-view of healthcare executives, including directors, nurses, and physicians.

Approximately 58 percent of the 225 survey respondents said that they do not have the ability to continuously track patients within their facility. The most common methods used to track patient throughput and manage beds are phone calls/voice messages and making information available on computer terminals, which are used by 67 percent and 63 percent of respondents, respectively. Other tools used include grease boards, digital displays, and registered mobile devices. Sixty percent of respondents reported that their facility does not have any bed management software or technology.

The survey also addressed the issues of bottlenecks in the patient flow process, how these bottlenecks impact overall length of stay, and what can be done to eliminate bottlenecks and reduce length of stay. Sixty percent of respondents reported that the discharge process was a common bottleneck in the flow process, and 58 percent said that there were frequent bottlenecks in critical care. The most commonly used methods for reducing length-of-stay are case management, used by 86 percent of respondents, and process improvement efforts, used by 76 percent.

Bed management is another important issue facing healthcare executives, as improper bed management can mean that beds are not cleaned in a timely manner or may remain empty unnecessarily for extended periods of time. Having a clear

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CMS Guidance on Emergency Capabilities, Patient Transfers, and Patient Parking

Earlier this year, CMS issued two memorandums relating to a hospital's emergency care capabilities, conditions of transfers, and patient parking at hospitals.

The memo issued on April 26 stated that according to Medicare's Conditions of Participation (CoP), all hospitals must be adequately prepared with policies and procedures to handle every patient's emergency needs, 24 hours a day, seven days a week. Additionally, hospitals must be prepared with procedures for situations in which a patient's needs might exceed the capabilities of the facility. This requirement applies to all hospitals, including those without an emergency department. This memo was issued in response to recent situations in which hospitals have called 9-1-1 to deal with patients' emergency conditions. CMS's memo reminds hospitals that calling 9-1-1 is not an appropriate substitute for the hospital having its own emergency evaluation and initial treatment capabilities.

On April 27, CMS informed hospitals that it is an EMTALA violation to condition the acceptance of a transfer patient on the use of a particular transport service. According to EMTALA regulations, "A participating hospital that has specialized capabilities...may not refuse to accept from a referring hospital...an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capability to treat the patient." Specifically, a hospital may not agree to accept a transfer patient only if that patient is sent by that hospital's own ambulance service. Transport arrangements are the responsibility of the physician sending the patient, not the receiving hospital.

The April 27 memo also addressed the issue of patient parking – the refusal of a hospital to accept the responsibility for a patient brought by ambulance for an extended period of time. In a previous memo regarding patient parking, CMS stated: "This practice may result in a violation of EMTALA." While many EMS providers interpreted this memo to mean that a hospital must in every situation immediately take custody of all individuals arriving at their ED by EMS transport, the April 27 memo clarifies that an instance in which a hospital does not immediately accept the care of a patient is *not* automatically an EMTALA violation. Instead the circumstances surrounding the event must be taken into account. However, if a hospital is unable to accept immediate control of a patient, they must still triage that patient immediately upon arrival to ensure that the patient is in stable condition, so that EMS staff can monitor the patient until the hospital is able to assume full responsibility.

These memos can be viewed at the CMS website.

"Provision for Emergency Services" memorandum

"Parking of EMS Patients" memorandum

StatCom Survey (continued)

view of bed occupancy is essential for ensuring efficient use of beds. Survey respondents reported using the following tools to determine bed occupancy:

- Bed huddles (38 percent)
- Electronic bed boards (38 percent)
- Manual bed boards (29 percent)
- Facility summaries (23 percent)
- Bed management dashboards (18 percent)
- Housekeeping reports (3 percent)

The complete report can be found on StatCom's website.

OIG Advises on Anti-Kickback Laws in Ambulance Contract

The Office of the Inspector General (OIG) recently issued an advisory opinion regarding a county's ambulance contract and federal anti-kickback laws.

Specifically, OIG looked at a specific situation in which a county has a contract with three private ambulance companies. The ambulance companies must absorb the costs of transporting uninsured arrestees, and must reimburse the county for their costs associated with providing administrative and emergency dispatch services. There was question as to whether or not this contract violates the federal anti-kickback statute, which states that it is a criminal offense to offer, pay, solicit, or receive any compensation to induce or reward referrals of items or services reimbursable by a federal healthcare program.

In this case, OIG ruled that there was no violation, but cautions that this opinion is only applicable to this particular situation, and has no meaning in any other case, no matter how similar a situation may be.

The complete advisory opinion is available here.

JEMS Survey Offers Insight into EMS Compensation, Workforce Issues Nationwide

The *JEMS 2007 Salary and Workplace Survey* is a 130-question online survey that looked at the topics of recruitment, talent management, diversity, benefits, on-the-job injuries, salaries, and retention and turnover in the EMS industry.

Altogether 247 surveys were completed by the 1,890 organizations who were invited to participate. Some key findings of the survey include:

- 69.2 percent of EMS organizations do not have anyone within their organization dedicated to recruitment; 10 percent use a professional recruiter from outside of EMS
- 67.9 percent said that their primary recruitment criteria is hiring "good" people; the remainder feel that experience and credentials are more important considerations for hiring
- 58.4 percent identify increasing diversity as an important strategic goal; 24.4 percent have made changes to their recruitment process to reflect that goal
- The most common on-the-job injuries are sprains, strains, and tears, accounting for 79.0 percent of injuries
- On average, the organizations participating in this survey lost 1,037 hours and 149 employee days due to injuries in 2006
- The employee turnover rate was 15.2 percent for full time employees, 23.2 percent for part-time employees, and 18.6 percent for volunteers in 2006; only 26.9 percent of organizations have an employee retention plan
- 57.6 percent of respondents think that there is a shortage of certified paramedics available to hire; 27.7 do not think that there is a shortage, but that there are more alternative employment options available for those paramedics

The top methods used by survey respondents to attract qualified employees were employee referral (34.6 percent), engaging EMS students from local certification programs (21.1 percent), posting job announcements on the agency's website (12.2 percent), distributing postings on mailing lists and list serves (4.2 percent), and posting on EMS job websites (3.0 percent). Only 2.5 percent of respondents reported using job sites such as monster.com or careerbuilder.com, and only a few advertise in national trade journals or at EMS conferences. There is some anecdotal evidence that suggests that national employee searches are not successful from a cost/benefit point-of-view.

The complete survey can be found at www.jems.com.

ABARIS GROUP *Innovative Solutions for the Emergency Care Field*

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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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