Volume 2, Issue 6 Nov/Dec 2005

The Abaris Group

The TAG Line

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The Hospitalist and the ED

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The specialty of hospitalist is a rapidly emerging one. The first hospitalist training program was not started until 1996, when the term was coined in a New England Journal of Medicine article by Robert Wachter, MD of UC San Francisco. The title was formalized in 1997 by the newly-formed National Association of Inpatient Physicians (NAIP,) and the first formal training program was started around that time at UCSF.

The main intent of a hospitalist program is to increase efficiencies and improve outcomes of hospitalized patients, which happens to cost less overall. Hospitalists round on selected inpatients regularly and so are able to make rapid decisions about treatment or discharge of patients that otherwise would have to wait for their primary care physician (PCP) to make late evening rounds. For example, if a PCP orders a CT scan after his morning rounds with the intent of discharge if the CT is negative, and the CT is done that morning and is negative, the patient would have to wait for the evening round of the PCP, at which point it would probably be too late for discharge and the length of stay has been increased by one day at costs of many hundreds of dollars. A hospitalist could have seen the patient immediately after the scan and discharged the patient that day. Managed care has been responsible for the growth of these programs, since emphasis has moved from "revenue enhancement" to "cost containment."

Hospitalists and the ED

The role of the hospitalist has rapidly expanded since this early focus, and the additional roles have a direct affect on the emergency department (ED), especially if planned as a team approach. Integration of the hospitalists and ED physicians in a team approach is one solid move to cost (time) efficiency in the ED which can, in turn ease the burden on an overcrowded ED.

The specific roles that hos-

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The Abaris Group continues:

Webinar Series on Improving ED and Trauma Services

The Abaris Group is continuing its Webinar series during 2006. Upcoming topics include:

- Freestanding EDs
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- Walk-in Assessment Centers
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Not All Trauma Centers Equal

According to a new report published in the October 2005 issue of the *Annals of Surgery*, patients treated at Level I trauma centers are more likely to survive than those treated at Level II trauma centers.

Dr. Demetrios Demetriades of the University of Southern California told Reuters Health, "Although it is the first study to show this difference, it is not an unexpected finding. Level I centers are academic facilities with stricter requirements and more resources."

Demetriades and his colleagues analyzed the outcomes of 12,254 trauma patients who had specific severe injuries and were treated at Level I or Level II trauma centers.

The researchers found that the overall mortality rate among patients treated at Level I trauma centers was 25.3 percent compared with 29.3 percent at level II trauma centers. After controlling for the severity of injuries, the mortality level at level I trauma centers was 20 percent lower than that of Level II trauma centers or all other centers.

The results "may have practical implications in the planning of trauma systems, triage of patients to trauma centers, and financial compensation of services according to level of accreditation," the team writes.

The study's abstract can be retrieved by visiting the Annals of Surgery website at www.annalsofsurgery.com.

(Annals of Surgery, 10/05)

The Hospitalist and the Emergency Department

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pitalists now often play are twofold. First, hospitalists are usually internists before gaining additional training to become a hospitalist. This means that in addition to the hospitalist duties, they can help fill the on-call list for the ED. Since they are in-house, this speeds up the throughput for those patients that require internal medicine consults in the ED.

Secondly, and more important, in addition to trying to discharge patients as soon as is safe, the hospitalists try to prevent admissions from occurring in the first place, or make sure that definitive testing takes place as soon as possible. Most admissions to the inpatient side generally come from the ED, so this is where most preventable admissions can be found.

This works to the advantage of the ED, especially if there is a separate ward contiguous with the ED for that care to take place. As every ED staff member knows, many of the backlogs in the ED occur because of patients waiting for an inpatient room, sometimes for hours or even days. This not only takes up ED beds, but ED staff time. ED nursing staff are used to having a physician available and tend to use physicians more frequently than do floor nurses, so not only are ED staff being used for what are technically inpatients, but the care is more time-consuming than if it were on the Med-Surg floor. Hospitalists and Med-Surg nurses can pick up these patients, take over the care and avoid duplicative H&Ps, lab work, and so forth, freeing up the ED staff for other waiting ED patients.

The key is to have a system for "who does what and when and how." It is helpful to have an idea of the hospitalist/ED physician connection to develop those guidelines as a team. Hospitalists and ED physicians have a number of things in common:

- ED physicians are trained in critical care but practice primarily episodic primary care, while hospitalists are trained in primary care but practice mainly critical inpatient care.

- Both hospitalists and ED physicians are hospital-based, but unlike anesthesiologists or pathologists, for example, both diagnose and treat patients

- Both hospitalists and ED physicians are generally in-house 24 hours per day. Some hospitals that can't justify a 24-hour hospitalist program have hired ED physicians that are board certified in both emergency and internal medicine, provided additional training in hospitalist care, and used them to augment a hospitalist program.

If your hospital has or is considering a hospitalist program, there should be clear plans, policies, procedures and protocols for optimal integration with the ED.

More information can be found at: The Hospitalist Movement: Ten Issues to Consider, by Dr. Robert M. Wachter, University of California, San Francisco

Just Released - The Abaris Group's

Ambulance Industry Report, 2005

This report is the fourth in a series of industry reports since 1999 that comprehensively analyze the private sector ambulance industry in the U.S. This 27-page report broadens its analysis of the evolution, key pressure points and success factors that affect the ambulance industry across the spectrum of provider types – private, public, volunteer and others. The report provides a detailed evaluation of the industry's two largest providers, as well as the latest trends of market share gain, contemporary delivery models and the "private vs. public" debate. Key financial performance and commentary of these two providers are provided.

Price: $340

For more information and to order, contact The Abaris Group at 888-EMS-0911 or email us at subscriptions@abarisgroup.com.

All four reports can be purchased by contacting The Abaris Group or visiting www.abarisgroup.com.

Doctors Urge Congress to Save Emergency Departments

A report released September 29 by the American College of Emergency Physicians shows that America's hospital emergency departments suffer from under-funding, overcrowding, and staffing challenges caused by rising costs of medical liability insurance. The report, entitled "State of Emergency: America's Emergency Departments in Critical Condition" reveals that in the past decade, the number of patients seeking emergency medical care increased 27 percent while the number of emergency departments decreased 15 percent. This trend has resulted in dramatic increases in patient volumes and wait times at remaining facilities. In fact, most of the nation's 4,000 hospital emergency departments report that they are operating at or beyond critical capacity.

That same month, almost 4,000 emergency physicians and nurses visited Capitol Hill urging Congress to "save emergency care" and to ensure that their patients continued to have access to lifesaving emergency medicine. The emergency medicine professionals praised the *Access to Emergency Medical Services Act of 2005* (H.R. 3875), introduced by Rep. Bart Gordon (D-TN) and Rep. Pete Sessions (R-TX), and urged Congress to pass it without delay.

Frederick C. Blum, MD, FACEP, president of the American College of Emergency Physicians remarked, "The U.S. health care system is collapsing, and nowhere is that more apparent than in our nation's emergency departments. Hurricane Katrina also made it clear—we must expand the "surge" capacity of our nation's hospitals."

Blum added, "Soaring health care costs, reduced hospital budgets, and an increasing dependence on emergency care mean that patients line the halls, waiting hours—sometimes days—to be transferred to inpatient hospital beds. This is a daily occurrence in many hospitals, and our patients can't wait any longer for Congress to act. That's why we applaud Rep. Sessions and Rep. Gordon for taking action and introducing much-needed legislation."

The Emergency Nurses Association voiced their concern for the future of medical care as well. "We are here on behalf of emergency nurses across the country who fight daily to provide optimal care in emergency departments that are overflowing with patients," said ENA President Patricia Kunz Howard, PhD, RN, CEN. "Today, we are moving to protect the rights of our patients and colleagues by urging our legislators to partner with us to secure the future of emergency patient care by endorsing initiatives that alleviate crowding and support emergency care as an essential public service."

The *Access to Emergency Services Act* recognizes that emergency medical care provides essential public services that should receive public funding, just as police and fire departments do. Specifically, the act would:

- Recognize hospital emergency departments as the backbone of the nation's health care safety net
- Provide hospitals with incentives to stop the boarding of admitted patients in emergency departments so that they can help end gridlock and save lives during natural disasters and acts of terrorism
- Extend liability protection to on-call specialists and emergency physicians who provide care mandated by the Emergency Medical Treatment and Active Labor Act, which ensures access to medical service regardless of ability to pay.

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Doctors Urge Congress

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"When you need an emergency room, you don't want to worry about it being crowded or underfunded or not having the staff it needs, but sadly, the challenges facing emergency departments mean that all of us might not be able to receive the care we need when we need it, said Rep. Bart Gordon (D-TN-6th District). "ER doctors are the heroes in America's hospitals, working under incredibly difficult conditions on patients who need critical attention Congress needs to step up and take action."

"More patients are seeking emergency care than ever before, but fewer emergency department resources are available," said Pete Sessions (R-TX, 32nd District). "A national investment is urgently needed to ensure that emergency departments can meet increasing demands. I think this legislation goes a long way toward that goal."

The original article and photos can be found at www.acep.org.

(ACEP, 9/05)

American Heart Association Updates CPR Guidelines

The American Heart Association recently announced November 29 "dramatic changes" to its CPR recommendations to make instructions "simpler and less intimidating to a passerby thrust into the role of rescuer," writes *USA Today.* According to the AP/Wall Street Journal, over 300,000 Americans die from cardiac arrest each year, and effective CPR doubles a person's chance of survival.

An international team of heart specialists reviewed several thousand studies on cardiac arrests and resuscitation. They concluded that CPR instructions were too difficult for the average person to follow. The new guidelines amend the focus of CPR instructions from mouth-to-mouth breathing to chest compressions.

The largest change, according to the Boston Globe, calls for rescuers to provide 30 chest compressions for every two breaths administered to a victim, as opposed to the previous recommendation of 15. In addition, the new recommendations tell EMS operators to provide instructions for chest compressions without any breaths since CPR often goes unadministered because bystanders "are reluctant to perform mouth-to-mouth resuscitation."

The recommendations are published in the journal *Circulation*.

(USA Today, 11/29)

U.S. Trauma Centers Ill-Prepared for Major Disasters

A November report published by the Associated Press concludes that trauma centers nationwide are facing major challenges to their ability to "quickly and adequately" handle major emergencies. The report cites continued funding problems and a growing U.S. population as contributors. Trauma center and ED workers estimate that facilities would be unable to provide sufficient care if a massive influenza epidemic or terrorist attack resulted in more than 20 or 30 patients with severe injuries or illnesses. Hospital officials often report that trauma care is a "money loser" because it requires constant specialist staffing and because many trauma patients are uninsured. These factors, according to industry experts, have caused some facilities to shut down their trauma units in recent years, increasing the burden on remaining operating centers.

At Atlanta-based Grady Memorial Hospital, the trauma patient volume has increased more than five percent each year due to a growing city population and the closing of nearby trauma centers, among other factors. Grady officials say that because the hospital's 100 ICU beds are "often completely filled", many patients are forced to wait in the ED for beds to open. Furthermore, reports Grady's chief of emergency medicine, the hospital expects to lose approximately $9 million to $10 million in 2005 and will require more government funding to expand its ICU and emergency capabilities. Officials at Detroit Receiving Hospital claim that increased state funding in the past two years has brought its trauma center back to "solid footing" after years of budget shortfalls. They remark that the unit is now able to handle multiple-trauma incidents "pretty well."

A copy of the report can be found at: The Mercury News

(AP/Mercury News, 11/6)

Legislative Updates

HRSA—EMS Program

Support is called for the passage of FY 2005 L-HHS-E Appropriations bill, HR 3010. While the Senate Subcommittee on Labor-HHS-Education Appropriations included $3.5 million in its version of HR 3010, the House failed to recognize the necessity of funding for the only federal source available to build trauma system infrastructure in the U.S. Trauma-EMS Program, which is administered by the Health Resources and Services Administration. This program was not included in the original L-HHS-E conference report (H. Rept. 109-130). Members of the American College of Surgeons, American Trauma Society, and Coalition for American Trauma Care have expressed that continued leadership is necessary in recognizing the importance of trauma care in saving lives.

(Letter to L-HHS-E Conferees, 12/5)

News Briefs

Kaiser Permanente awarded $7.6 million in grants to public hospitals and clinics in Northern Californina, reports the Woodland *Daily Democrat* (November 21). The grants were awarded to safety net clinics that provide health care to the uninsured and underinsured.

As part of its Safety Net Quality Improvement Partnership with clinics, hospitals, and public health departments, Kaiser awarded 47 grants, ranging from $50,000 to more than $500,000.

(Woodland *Daily Democrat,* 11/21)

Tobacco tax measures may compete on next year's California ballot, reports the *San Francisco Chronicle*. Two proposals aim to fund health programs by raising the cigarette tax by $1.50 per pack to generate $1.4 billion each year. The Tobacco Tax, Disease Prevention and Children's Health Insurance Act of 2006, would allocate 35 percent, or $450 million, of the funds to disease prevention and treatment programs for breast cancer, lung disease, strokes, and other illnesses. It would also appropriate $435 million for health care coverage for uninsured children and $270 million for anti-smoking programs.

A competing measure would use about 65 percent, or $906 million, of the funds for hospital emergency departments. Approximately 9%, or $126 million, would be budgeted for nursing education, with the same amount earmarked for smoking prevention programs. The remaining 17 percent would fund other programs, such as those for emergency physicians and breast cancer research.

(San Francisco Chronicle, 11/22)

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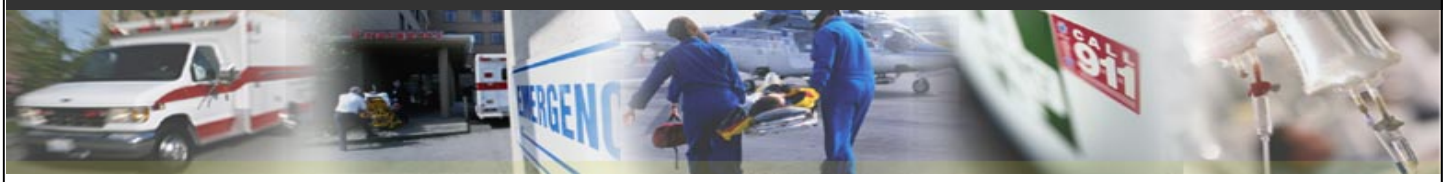

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The Abaris Group is a consulting firm that specializes in emergency and outpatient services. We provide clients with help on a wide range of topics, including strategic planning, operational improvement, and financial enhancement, to help them achieve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