# Inspector General Faults Specialty Hospital EDs

BY ALICIA AULT
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Physician-owned specialty hospitals are largely unprepared to handle emergencies and should be more closely tracked by the government to ensure that they comply with Medicare rules, according to a report from the Inspector General of the Department of Health and Human Services.

The IG's office reviewed written policies for managing medical emergencies, staffing schedules, and staffing policies for 8 days at 109 physician-owned facilities that were identified from a list provided by the Centers for Medicare and Medicaid Services. There are an unknown number of physician-owned specialty hospitals, according to the IG, which is urging the CMS to begin compiling a list.

Of the 109 hospitals surveyed, 66 were surgical, 23 were orthopedic, and 20 were cardiac. Eighteen of the cardiac hospitals had an emergency department; only 11 of the 23 orthopedic hospitals and 31 of the surgical hospitals had an ED. Thirty-three of the 109 hospitals were in Texas, 15 were in Louisiana, 9 in Oklahoma, 9 in Kansas, and 8 in South Dakota. The rest were spread across other states.

While half of the physician-owned hospitals surveyed had an emergency department, more than half of those EDs only had a single bed. Only 45% of the EDs had a physician on site at all times.

Ninety-three percent of the hospitals met Medicare staffing requirements: having a registered nurse on duty at all times and a physician on call at all times. Seven hospitals did not have an RN on duty and one did not have a physician on call or on duty on at least 1 of 8 days reviewed. Two-thirds of the hospitals told staff to call 911 in case of emergency.

While transferring a patient with an emergent problem to another hospital's ED is acceptable, it might be a violation of Medicare conditions of participation if a hospital uses 911 to obtain medical assistance to stabilize a patient, according to the IG. Thirty-seven of the 109 hospitals (34%) engaged in that practice, the IG reported.

A hospital also is not in compliance if it uses 911 as a substitute for providing services required by the conditions of Medicare participation, noted the IG.

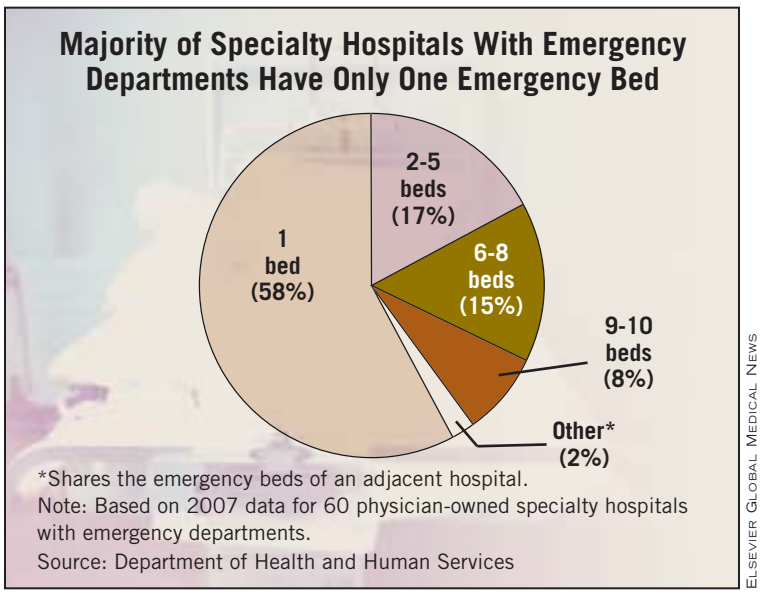
Almost 25% of the hospitals did not address in written policies the "appraisal of emergencies, initial treatment of emergencies, or referral and transfer of patients," according to the report.

The IG urged the CMS to enforce Medicare staffing requirements. Hospitals should also have information in their written policies on how to manage a medical emergency, said the IG.

The CMS issued a written response that was included in the IG's report. The agency said it agreed with the IG's recommendations and that it would examine current compliance through its routine hospital surveys. As many as 42% of the 109 hospitals would not have been subject to CMS oversight, however, according to the IG. Those facilities were instead accredited by the Joint Commission or the American Osteopathic Association.

Finally, the CMS said it would use its existing authority to require hospitals to have written policies and procedures on managing emergencies, but that it would also consider whether regulatory changes are needed to establish requirements for equipment and staff qualifications.

The report was requested by the Senate Finance Committee, whose leaders—Sen. Chuck Grassley (R-Iowa) and Sen. Max Baucus (D-Mont.)—have a history of seeking restrictions on physician-owned specialty hospitals, and have successfully implemented moratoriums on new facilities.




Elsevier Global Medical News

These senators will likely introduce a new proposal to rein in specialty hospitals this spring, Molly Sandvig, executive director of Physician Hospitals of America, said in an interview.

Ms. Sandvig said that her organization—which represents 108 physician-owned facilities—believed that all hospitals should meet Medicare conditions of participation. However, not every hospital should have an emergency department, she said.

Both the American Hospital Association and the Federation of American Hospitals pounced on the report, saying that it shows physician-owned facilities are a threat to patient safety.

"The report illustrates yet another reason why Congress needs to take action in the best interests of patients and ban physician self-referral to new limited-service hospitals they own and operate," AHA Executive Vice President Rick Pollack said in a statement. ■

# Physician Resistance to EMRs Still Persists

BY GREG MUIRHEAD
*Contributing Writer*

MAUI, HAWAII — Physicians are needlessly resisting the inevitability of electronic medical records, according to Dr. Martin J. Bergman.

As of 2005, about 23% of office-based physicians used electronic medical records (EMRs), said Dr. Bergman, citing statistics from the Centers for Disease Control and Prevention's National Center for Health Statistics that were reported in 2006. In contrast, almost 80% of office-based physicians used billing software, he added.

Reasons for resistance include complaints that EMRs are difficult to complete, interrupt the office flow, and take too much time to administer and review, said Dr. Bergman, chief of rheumatology at Taylor Hospital, Ridley Park, Pa.

The first obstacle is cost, he noted. EMR software can run $5,000 to more than $30,000. Still, the better software does not necessarily cost more. Once EMRs are established in the practice, physicians can expect significant savings, especially on transcription fees.

Twelve years ago, Dr. Bergman said he was paying just under $20,000 a year for transcriptions. "I no longer use a transcriptionist. Over 12 years, I've saved close to $250,000" on those fees alone.

However, there is a "steep learning curve" in getting used to using EMRs; it takes about 3 months to become familiar enough with the software that it no longer slows the physician's practice. But after that, he said, "your productivity doubles."

Dr. Bergman pointed out that physicians can use EMRs to track metrics—measures of patients' progress—which is difficult to do with paper files. Metrics can quickly help gauge the success of the practice, and the news is not always good. "Until you start doing metrics, you think you are doing better than you are," he said.

Benefits of EMRs include:

► **An increase in productivity.** Dr. Bergman observed that, now, paper records slow him down. EMRs give him instant access to entire histories, including lab tests and drugs used.

► **Easy creation of referral letters.** Print them by pressing a couple of buttons, and upon leaving the computer, he said, "I'm done when I'm done."

► **A tool for research.** Patient data can be graphed to show results of treatment over time, which provides a good source of private practice research.

► **Access to databases.** Data extracted from the database can readily be shared with existing databases.

Patient data typically collected in an EMR include demographic information, active and comorbid diagnoses, current and formerly used medications, lab reports, DAS28 findings, both physician and patient global scores, and patient-reported measures such as pain, functionality, fatigue, and tender and swollen joint counts, Dr. Bergman said during his presentation at a symposium sponsored by Excellence in Rheumatology Education.

EMR software offers two basic options: template or database software. The choice might depend on whether the physician is in a solo or group practice.

The solo dermatologist will be better served by database software, which is flexible and can be altered on the fly to fit special information-gathering needs. But a group practice or hospital will more likely want template software, which requires all users to fill in the same kinds of information in the same format.

Dr. Bergman said although he has been using EMR software from Stat Systems for 12 years, he is not a spokesman for nor an owner of the company. ■

# *E-Prescribing Standards Proposed for Medicare*

The Health and Human Services department has proposed federal e-prescribing standards to be used for Medicare participating physicians, pharmacists, and software vendors.

E-prescribing is not required for participation in the Medicare Part D drug benefit, but under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003—the law that established the benefit—drug plans, physicians, and pharmacists who use electronic prescribing are required to meet the HHS standards.

Some organizations have pushed for required e-prescribing for Medicare participation. The Pharmaceutical Care Management Association (PCMA), which represents pharmacy benefit managers, is spearheading the effort. The organization launched a print and broadcast ad campaign in November that called for adoption of e-prescribing by 2010—the same deadline set by the Institute of Medicine in a report on reducing adverse drug reactions that was issued in July 2006.

The American Health Information Community has also urged the HHS to require e-prescribing for Medicare.

The American Medical Association and other groups oppose a mandate. "From a practical side, a mandate would be premature," Stacey Swartz, Pharm.D., senior director of pharmacy affairs at the National Community Pharmacists Association, said in an interview. "We can see the benefits of it, but we can't ignore that there are costs involved."

The final e-prescribing standards should be issued by April 1.

**—Alicia Ault**