

# TRENDS & Ideas

LAW

## COBRA's Scope Broadens

Indigent patients and emergency department patients are no longer the only persons protected by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Designed to prevent patient dumping, COBRA stipulates that hospital emergency patients and women in active labor must be medically screened and stabilized before they can be transferred. But recent court rulings and amendments to

available ancillary service.”

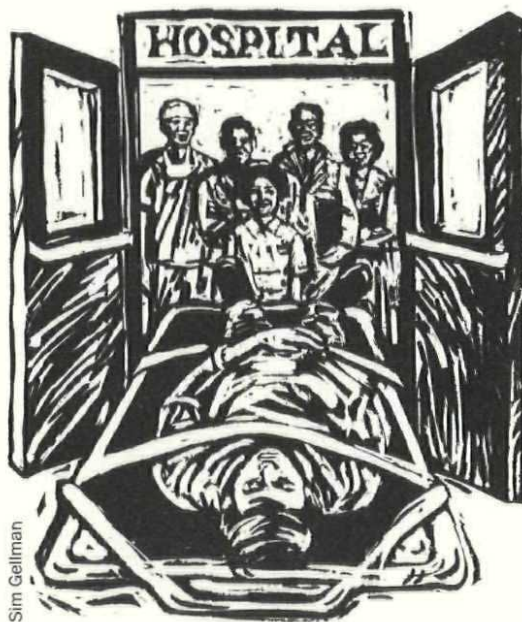
In one case a court ruled that a hospital improperly transferred a patient who was released after five days and was never in the emergency department (ED). And in October the U.S. Seventh Circuit Court of Appeals ruled that the family of an infant who died could (under COBRA) sue the hospital that routed the child to another facility when its pediatric intensive care unit

notes McCormick. And now a facility that specializes in a certain technology must accept transfers of patients it is capable of treating. Before, only receiving hospitals that had given express approval were required to accept transfers, writes McCormick.

These amendments to COBRA leave a host of questions, questions that could be answered if the regulations required to accompany the law were in place. “Legal experts say vague legislative language and a lack of interpretive regulations have left the Emergency Medical Treatment and Active Labor Act open to broad judicial interpretation,” reports McCormick.

Sidney Wolfe, MD, director of Public Citizen's Health Research Group, believes this lack of regulation simply frustrates COBRA enforcement. “It is an outrage to allow the amount of dumping that is going on to continue unchallenged because of the lack of regulation,” asserts Wolfe.

Michael Astrue, former general counsel for the Health and Human Services Department, believes regulations are nearing release. He explains that the regulations will show that COBRA protects “all persons who attempt to gain access to the hospital for emergency care”—including those not admitted through an ED.



Sim Gellman

the law have broadened the definition of a medical screening. “Under current interpretations,” writes Brian McCormick in *American Medical News*, “a violation may occur any time an emergency doctor fails to use an

was full.

Amendments to COBRA have also broadened the law's scope. For example, the standard for violations has been changed to simple negligence from “knowing and willful” negligence,



PHYSICIANS

## Self-Referral and Use of Services

California physicians who own testing or treatment facilities to which they refer patients are increasing the costs and rates of use in the state's workers' compensation system, according to Alex Swedlow and colleagues. The researchers compared the costs and usage rates of these physicians (the self-referral group) with those of physicians who refer patients to independent facilities (the independent-referral group). They looked at referrals for physical therapy, psychiatric evaluation, and magnetic resonance imaging (MRI) between October 1990 and June 1991.

Although the physical therapy cost per case was about 10 percent less for the self-referral group, the small difference “is more than offset by the dramatically greater frequency [2.3 times] with which self-referring providers initiate physical therapy,” the authors report in the *New England Journal of Medicine*.

Swedlow et al. did find a greater difference in cost per case for psychiatric evaluations. The self-referral group's cost per case was 26 percent higher than that of the independent-referral group.

The rate of referral and the cost per MRI scan were similar for both groups; however, 38 percent of scans the self-referral group requested were deemed inappropriate, compared with 28 percent for the independent-referral group, write Swedlow et al.

What could all this cost the California workers' compensation system? The state would pay considerably more for every 1,000 workers referred by the self-referral group versus the independent-referral group: \$143,672 more for physical therapy, \$672,000 more for psychiatric evaluation, and \$89,456 more for MRI scans.

## Identifying "Best Practices"

Many top-performing ambulatory care providers challenge conventional wisdom by registering patients on the day of surgery and by making preoperative screening visits an option rather than a requirement, according to a study conducted by Dallas-based Arthur Andersen. Such procedures—which the study terms "best practices"—can cut in half the time between patients' arrival at a facility and the beginning of their surgery, minimizing inconvenience and increasing productivity.

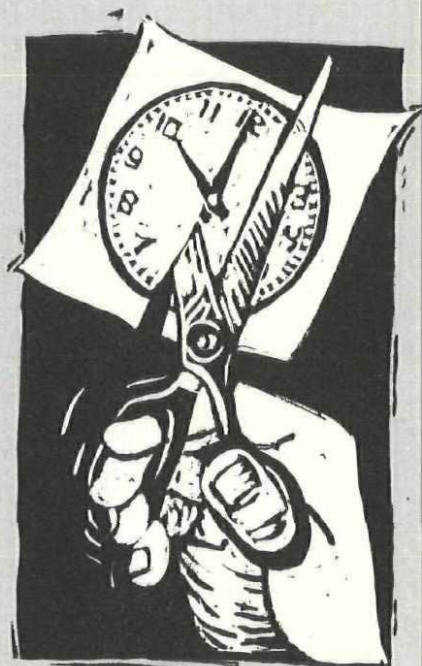
The study defines a "best practice" as "simply the best way to do a process." According to the report, the rapid growth of ambulatory care and the complexity of handling outpatient cases have made it necessary to determine which practices promote higher-quality service and greater patient satisfaction.

The study focused on processes basic to ambulatory surgery, including scheduling and registration, surgery and recovery, human resource management, and physician relations. Study team members, who interviewed representatives from facilities to identify typical practices, found that 71 percent of the best-performing facilities use automatic scheduling, compared with 56 percent of other respondents. Best performers also make the scheduler an important staff position and educate the physician office staff on what information is needed when scheduling a surgical case.

A number of "best practices" help make surgery more efficient and effective. Top performers regularly have experienced staff assemble case packs the day before surgery to reduce errors, and they ensure that necessary equipment is scheduled at the same time as the surgery. In addition, they often dedicate a core group of anesthesiologists to the ambulatory surgery unit.

Successful facilities also cross-train staff to handle a variety of situations. For example, nurses rotate through preoperative and postoperative duty. And "all best performers utilized some form of team building and concluded that effective managers must empower their staff by gaining their input and involving them in carrying out important decisions," the Andersen study reports.

The best healthcare facilities also stress team alliances with physicians. They educate physicians in patient screening processes; regularly survey doctors on their concerns and then react promptly; and ensure that the medical director is on-site most of the time to assist in decision making and to facilitate communications between various specialists, physicians, and managers.



## AGING

### Divergent Prospects

Although demographers and public policymakers agree that increased life spans will have major social and economic implications, experts differ about how fast the elderly population will grow.

Reporting for the *New York Times*, Gina Kolata notes a number of researchers believe that Census Bureau projections for the growth of the nation's elderly population are far too low. While the bureau predicts there will be

18.7 million persons aged 85 years or older in 2080, Duke University demographer Dr. James Vaupel, for example, thinks the number will be closer to 72 million.

The discrepancy is the result of different assumptions about the nature of aging. Whereas the Census Bureau assumes life spans have a natural average limit of about 85 years, Vaupel and other researchers predict dramatic increases in life expectancy in the next century—with no biological cap to how long people can live. Such a trend would have a major impact on retirement, Social Security funds, and pensions, Kolata points out.

The very old are already the fastest-growing segment of the U.S. population. And elderly men are more likely than women to live with a spouse or family and to be economically independent,

according to another *Times* article. Felicity Barringer reports that a Census Bureau study conducted by demographer Cynthia M. Tauber uncovered a number of gender-related trends of concern to social health and welfare planners.

"The differences between older men and women include differences in education, differences in occupation, presence in the work force, having pensions in their own name," said Tauber. Her report noted that, although women tend to

live longer than men, more of them are poor and need help with basic activities of daily living. Women also tend to require more expensive healthcare. "Elderly women are likely to have long-term, chronic disabling diseases, while men tend to develop relatively short-term fatal diseases," the report noted.

