



SPOTLIGHT

Hospital participation in clinical trials linked to improved outcomes

Patients with non-ST-segment elevation acute coronary syndrome treated at hospitals that participate in clinical trials receive better care and have a lower risk of in-hospital mortality than patients treated at facilities that do not participate in clinical trials, according to a study in this week's *Archives of Internal Medicine*.

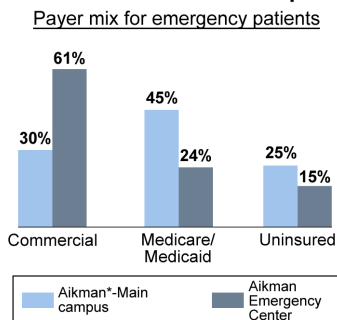
See story #1

RESEARCH HIGHLIGHT

A healthy infusion of well-insured patients

Urban hospitals with satellite EDs in more affluent suburbs are seeing their payer mix improve, in terms of both ED patients and the downstream inpatient admission generated by the freestanding facility. While the net impact on a hospital's payer mix is likely to be small, stand-alone EDs enable the hospital to grow volumes in more lucrative service areas. To learn more, please see the Innovations Center's *Freestanding ED: New Models of Urgent and Emergent Care Beyond the Hospital*.

Satellite ED attracts affluent patients



* Aikman Health Center (pseudonym) -- a 500-bed academic medical center in the south that opened a stand-alone ED in a wealthy, fast-growing community in 2004

Source: Innovations Center interviews

THIS DAY IN BRIEF

Practice arrangements, not income, affect physician charity care provision

Physicians whose practice income declines significantly are more likely to stop accepting Medicaid patients, although income has little effect on physicians' decisions to provide charity care, according to a new study from the Center for Studying Health System Change.

See story #2

Supreme Court upholds policy allowing employers to reduce retiree benefits

The Supreme Court yesterday upheld a federal policy that allows employers to reduce health insurance benefits for retirees who turn 65 and become eligible for Medicare, the *Los Angeles Times* reports.

See story #3

Umbilical cord blood increasingly used as alternative to bone marrow

Umbilical cord blood is emerging as an alternative to bone marrow for treating cancer patients needing a new blood supply and for the treatment of at least 50 other diseases such as sickle cell anemia and Tay-Sachs disease, the *Houston Chronicle* reports.

See story #4

FROM THE ADVISORY BOARD

Enhancing accuracy of bed demand analyses and forecasts

Through use of the new online Bed Demand Forecasting Tool, hospitals can now access sophisticated analyses and forecasts of inpatient bed demand down to the individual unit level based on institution-specific data inputs.

See story #5

NAMES IN THE NEWS

Children's Hospital Boston (#8) ■ Duke University (N.C.) (#1) ■ Harvard School of Medicine (Mass.) (#8)
Le Bonheur Children's Medical Center (Tenn.) (#7) ■ Louisiana State University (#7) ■ Pepin Heart Hospital (Fla.) (#7)
Tulane University (La.) (#7) ■ University Community Hospital (Fla.) (#7) ■ University of Texas M.D. Anderson Cancer Center (#4)



Advisory Board Daily Briefing Contents

Tuesday, March 25, 2008

Today's Headlines

- 1 Hospitals:** Participation in clinical trials linked to improved outcomes
- 2 Physicians:** Practice arrangements, not income, affect charity care provision
- 3 Supreme Court:** Upholds policy allowing employers to reduce retiree benefits
- 4 Umbilical cord blood:** Increasingly used as alternative to bone marrow

From the Advisory Board

- 5** Enhancing accuracy of bed demand analyses and forecasts
- 6** Advanced analytics for nursing executives profiled at AONE

Regional Round-up

- 7 Around the nation:** Bite-sized hospital and health industry news

Endnotes

- 8 Et cetera:** Boston hospital launches toilet training school for children

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► Today's Headlines

1 Hospital participation in clinical trials linked to improved outcomes

Patients with non-ST-segment elevation acute coronary syndrome treated at hospitals that participate in clinical trials receive better care and have a lower risk of in-hospital mortality than patients treated at facilities that do not participate in clinical trials, according to a study in this week's *Archives of Internal Medicine* that is expected to "assuage some of the concerns related to the possible opportunity costs and potential downsides" of clinical trial participation. Hypothesizing that the "same elements required for hospitals to participate in trials" could lead to improved care processes and patient outcomes, researchers from the University of Alberta in Canada and **Duke University** analyzed outcomes for 174,062 patients with non-ST-segment elevation acute coronary syndrome treated at 494 U.S. hospitals between 2001 and 2006. After analyzing the data based on the treating hospital's level of clinical trial participation, the researchers determined that in-hospital mortality was 3.5% at hospitals with strong clinical trial participation compared with 4.4% at hospitals with some trial participation, and 5.9% at facilities that did not participate in clinical trials. The researchers note that even after adjusting for hospital characteristics such as revascularization capacity, academic teaching hospital status, and geographic region, the results still suggest "a significant trend toward reduced mortality with increasing participation in clinical trials." In addition, participation in clinical trials was associated with greater adherence to **American College of Cardiology/American Heart Association** treatment guidelines, with high-participation hospitals scoring 81.1% compared with just 76.9% among hospitals with no clinical trial participation on measures such as appropriate medication prescribing practices, length of stay, and health promotion interventions.

Recognizing the common perception among patients and hospitals administrators that clinical trial participation may "detract from quality care," the researchers conclude that there is "no downside for [institutional] participation in clinical trials," and add that they are important to medical progress. Moreover, the researchers say it is "disturbing" that 30% of the hospitals examined did not have a single patient enrolled in a clinical trial related to acute coronary syndrome and that fewer than 3% of patients receiving care at all of the hospitals participating in the study were enrolled in a clinical trial. Saying that the difference in mortality between the no-enrollment and high-enrollment hospitals is "larger than the difference between bare metal stents and [drug-coated] stents," the researchers suggest that future studies examine whether the trial participation effect applies to patients with non-cardiovascular conditions (Majumdar et al., *Archives of Internal Medicine*, 3/24 [subscription required]; Gever, *MedPage Today*, 3/24; *HealthDay*, 3/24).

2 Practice arrangements, not income, affect physician charity care provision

Physicians whose practice income significantly declines are more likely to stop accepting Medicaid patients, although income has little effect on physicians' decisions to provide charity care, according to a new study from the **Center for Studying Health System Change** (HSC) that sought to shed light on a 10-year decline in the proportion of physicians providing charity care and accepting Medicaid patients. For the study, researchers selected a combined panel sample of 15,966 physician surveys from four rounds of the nationally representative Community Tracking Study Physician Survey conducted in 1996-97, 1998-99, 2000-01, and 2004-05. Seeking to examine physician decisions to stop or start providing care to uninsured or Medicaid patients, the researchers developed baseline values of the variables using the first survey in the panel and determined changes in each panel's characteristics by comparing responses in each panel's baseline (T1) and follow-up (T2) surveys. Contrary to expectations, the researchers did not find that changes in physicians' practice income "were significantly associated

with their decision to stop providing charity care.” Additionally, there were virtually no differences in physicians’ decisions to start accepting Medicaid patients as a result of income changes, although physicians who experienced large decreases in income were more likely to stop accepting Medicaid patients. However, the study found that changes in physician practice arrangements were “more strongly associated” with decisions to start or stop providing charity care. Specifically, physicians who shifted from being owners of solo or small-group practices to being employees of larger groups were more likely to drop charity care patients and begin accepting Medicaid patients—likely because larger groups are less affected by high administrative costs per Medicaid patient and sometimes receive greater reimbursements for these patients. Additionally, larger organizations may have fixed policies governing care of the uninsured. Physicians who switched from being employees of large groups to owners of solo or small practices, however, were more likely to drop Medicaid patients and accept charity care patients, the study found.

Contending that many physicians’ shift to working in larger practices helped decrease physicians’ charity care provision across the last decade, the researchers suggest that the decline in accepting Medicaid patients would have been even greater without this shift in practice arrangements, because these larger practices are more likely to accept Medicaid patients. Additionally, the researchers say that the results imply that physicians moving to different types of practice settings treat charity and Medicaid patients “as substitutes rather than as similar types of patients,” which will contribute to future declines in charity care provided to the uninsured in physicians’ primary practices. Even if a continued shift to larger practices increases the acceptance of Medicaid patients, such care likely will be concentrated into fewer settings, leading researchers to conclude that policymakers should “[raise] Medicaid reimbursement rates and [subsidize] organizations that encourage private physicians to provide charity care” (Cunningham/Hadley, HSC [report](#), 3/20 [subscription required]; [AHA News](#), 3/21).

3 Supreme Court upholds policy allowing employers to reduce retiree benefits

The Supreme Court yesterday upheld a federal policy that allows employers to reduce health insurance benefits for retirees who turn 65 and become eligible for Medicare, the *Los Angeles Times* reports. In a one-line order, the justices turned away a legal challenge from the AARP arguing that the policy violated federal law prohibiting age discrimination, ending an eight-year legal dispute that began when retired county workers in Erie, Pa. won a ruling from the U.S. appeals court in Philadelphia in 2000 barring officials from reducing their health benefits when they reached the age of 65. After careful analysis, however, the Equal Employment Opportunity Commission (EEOC) concluded in 2003 that the “all-or-nothing benefits rule” would create an incentive for employers to cut—not raise—retiree benefits and decided instead to permit employers to coordinate benefits with Medicare under a “narrow” exception to the anti-age-bias law. In 2005, the AARP—the nation’s leading senior citizen’s lobby—sued to strike down the EEOC exemption but lost in a U.S. court of appeals decision last June.

Commenting on the Supreme Court’s decision, the AARP says it “clears the way for employers to discriminate by reducing or terminating benefits for older retirees simply because they’ve turned 65 years old.” The group’s senior vice president contends that the court’s decision is part of a larger problem which could be solved if Congress passed comprehensive health care reform legislation. Advocates for employers and labor unions, meanwhile, applauded the outcome, saying it will instead encourage employers to maintain health coverage for all retirees. According to the director of collective bargaining for the National Education Association, a law requiring employers to provide identical benefits for pre- and post-Medicare-eligible retirees “would be the erosion of post-retirement health care benefits for all” (Savage, [Times](#), 3/25 [registration required]).

4 Umbilical cord blood increasingly used as alternative to bone marrow

Umbilical cord blood is emerging as an alternative to bone marrow for treating cancer patients needing a new blood supply and for the treatment of at least 50 other diseases such as sickle cell anemia and Tay-Sachs disease, the *Houston Chronicle* reports. Although bone-marrow transplants remain more common than cord-blood transplants—which were first performed in 1988—the number of cord-blood transplants performed worldwide has more than tripled to 14,000 across the last few years. Additionally, there are now 52 cord-blood banks in the world, and some transplant centers only use cord blood. Noting that more than 6,000 Americans each year are unable to find suitable bone marrow donations despite the availability of 7 million registered donors, the National Marrow Donor Program says the number of unmatched patients is partially due to differences in gene frequencies among certain ethnic and racial groups and low donations from minorities. Cord blood makes matching easier, since only four of six genes particular genes required to match in the donor and patient in bone marrow transplants need to match for the cord blood transplants, the *Chronicle* reports. Efforts are underway to increase cord blood donation from minorities, including a campaign at the **University of Texas M.D. Anderson Cancer Center**, which has increased cord blood donation in minorities to more than 70% from 50% in 2005. While cord blood provides more flexibility in matching donors, cord blood provides fewer stem cells, resulting in a longer engraftment process—up to a month with a cord blood transplant versus a typical two and a half weeks for patients undergoing a bone marrow transplant. Saying that “cord blood possibly could eventually replace bone marrow,” the chairman of M.D. Anderson’s department of stem cell transplantation and cellular therapy notes that researchers at the facility are trying to expand the number of stem cells per cord-blood unit to achieve an engraftment time of 10 days or less (Ackerman, *Chronicle*, 3/24).

► From the Advisory Board

5 Enhancing accuracy of bed demand analyses and forecasts

Given the importance of future trends in bed demand to today’s strategic planning efforts, the Innovations Center has launched its new online Bed Demand Forecasting Tool, to allow members to access and customize sophisticated analyses and forecasts of inpatient bed demand down to the individual unit level. The easy-to-use model is based on institution-specific data inputs on existing bed resources, current patient stays, and expected growth.

With a step-by-step roadmap, the tool walks members through the bed demand forecasting process, providing options to customize such critical definitions as inpatient units and service lines to better align the results with individual institutions’ internal structures. Scenario and sensitivity analyses at various levels are also available directly within the tool.

For more information

For more information about the Bed Demand Forecasting Tool and to initiate use of the tool, click [here](#).

6 Advanced analytics for nursing executives profiled at AONE

The Advisory Board will be showcasing its full portfolio of solutions for assisting nurse executives with improving nursing performance at the upcoming AONE annual conference in Seattle, Wash., on April 25 to April 29 at booth 729. We will be profiling our nursing technology offerings, including updates from the Advisory Board's workforce management tool, OptiLink, as well as the root cause analysis capabilities of our Nursing Compass program.

In addition to our data and analytic solutions, we will also be presenting work from the Nursing Executive Center, the Advisory Board Nursing Leadership Academies, and H*Works consulting. Advisory Board representatives will be on hand to answer questions during all exhibition hours.

For more information

If you are interested in learning how the Advisory Board's nursing portfolio can impact performance at your institution, or to schedule time to speak with a representative at the conference, please contact Chelsea Fleckenstine at 202-266-5710 or fleckenc@advisory.com.

► Regional Round-up

7 Around the nation: Bite-sized hospital and health industry news



- **California:** Saying reimbursements from the state's health insurance program are not enough to cover the costs of providing care, California physicians are increasingly dropping or refusing to accept new Medi-Cal patients, and more will likely follow as a result of a 10% cut in physician fees approved by the state Legislature earlier this year and scheduled to take effect this summer, the *Los Angeles Times* reports. The Medi-Cal program serves about 6.7 million poor, disabled, and elderly residents who already struggle to obtain timely physician appointments and often turn to EDs for care or forgo care all together, experts say. In response to growing concerns, San Francisco Mayor Gavin Newsom (D) is expected to announce today that some local governments and healthcare providers plan to file suit to eliminate the scheduled cut in physician fees (Halper, *Times*, 3/24 [registration required]).
- **Florida: University Community Hospital (UCH)** in Tampa plans to use the projected proceeds from a \$95 million bond issue to fund several projects, including a \$15 million ED expansion that would roughly double the number of treatment rooms to 66. Additionally, UCH is planning a \$10 million surgical floor expansion on its Carrollwood campus that would add three ORs and three ICU beds to the facility's six OR and six ICU beds. About \$35 million, meanwhile, will be used to incorporate digital technology already in place at **Pepin Heart Hospital** throughout the UCH-Fletcher and UCH-Carrollwood campuses. Roughly \$21 million will be used to construct a long-term acute care facility in Connerton Commerce Park, and the remaining funds will be used for issuance costs and a debt service reserve fund (Manning, *Tampa Bay Business Journal*, 3/21 [registration required]).
- **Louisiana:** Half of the 246 medical students graduating from **Louisiana State University's** (LSU) medical schools in New Orleans and Shreveport will stay in Louisiana to complete their residencies—"an encouraging sign" for health care in the state, since "most doctors practice where they complete their residencies," the New Orleans *Times-Picayune* reports.

Because LSU's medical schools only enroll state residents, the institution's retention rates "are thought to provide a glimpse of the state's medical future." At LSU's New Orleans campus, 49.3% of graduates will stay in state—marking a 4% increase from last year—while the Shreveport campus reported a 2% drop in retention, from 53% last year to 51% this year. **Tulane University**—which accepts out-of-state students—reported that 24 of its 156 medical students will continue their training in the state (Pope, [Times-Picayune](#), 3/21).

- **Ohio:** Five years after the state Legislature imposed malpractice caps, Ohio continues to lose obstetricians. An AP analysis of state Medical Board data indicates that Ohio had 1,327 physicians listing OB/GYN as their primary specialty in 2007, a 5% decrease from 2002. Supporters of the malpractice limits—which cap most jury awards for pain and suffering in medical malpractice cases at \$350,000, but permit up to \$1 million in cases involving multiple victims—had argued that large jury awards were driving up insurance rates and causing some physicians to leave. The Ohio State Medical Association says, however, that malpractice rates are still too high for OB/GYNs and physicians practicing other high-risk specialties (Welsh-Huggins, [AP/Akron Beacon Journal](#), 3/24).
- **Tennessee: Le Bonheur Children's Medical Center** has opened a \$1.6 million cardiovascular ICU, a step officials say is part of its push to become one of the nation's top 10 pediatric hospitals. The five-bed facility is roughly 2,600 square feet and has private patient rooms large enough to accommodate family members. Additionally, Le Bonheur is running a \$327 million capital campaign to build a new hospital on the site of the former Memphis Mental Health Institute on Poplar, where the center would expand the cardiovascular ICU to 10 beds (Sells, [Memphis Business Journal](#), 3/21 [registration required]).

► Endnotes

8 Et cetera

Toilet terrors: Boston hospital launches toilet training school for children

Recognizing that toilet training can often become a "power struggle" between children and their parents, **Children's Hospital Boston** launched a Toilet Training School program for children of potty-training age, CNN reports. As part of the six-week program, a nurse practitioner (NP) at Children's meets with roughly six children once per week, and uses books, music, and art to help them overcome their fear of using the toilet. In addition to encouraging positive reinforcements and simple rewards—such as extra playtime—the NP asks the children to set small and realistic goals for themselves, such as sitting on the toilet for five minutes. Separately, a psychologist and instructor at **Harvard School of Medicine** advises parents who often come in "feeling extremely discouraged [and] isolated," urging them to try different tactics with their children. According to CNN, the Children's program has graduated roughly 450 children across the past years. Commenting on the program, one parent notes that the group sessions allowed her to vent her frustrations with other parents having similar potty-training problems, joking "it was like going to Betty Ford."

—Fortin, [CNN.com](#), 3/17