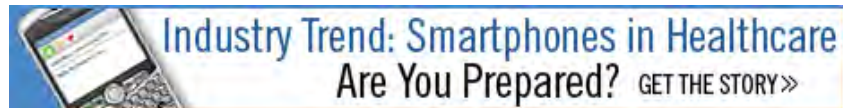


MEDICAL CALL CENTER NEWS

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December Clinical Update for Telephone Triage Nurses

The December 2011 *Clinical Update for Telephone Triage Nurses* from doctors Barton Schmitt, MD, and David Thompson, MD, contains two timely articles that address recent questions from many call center nurses. They are:

- The Neti Pot and Primary Amebic Meningoencephalitis
- Maximum Acetaminophen dosing

Download a [PDF file](#) of this issue; for more information, go to [Schmitt-Thompson Clinical Content](#).

Winter Weather Can Strain Your Heart

American Heart Association offers lifesaving tips

The snow and cold winter months can be very hard on people with potential or existing heart problems. Therefore, the American Heart Association is sharing some safe winter weather tips for your heart.

While you're outdoors in the cold weather, be aware that your heart is working harder. If you're not accustomed to physical activity, you should avoid sudden exertion, like lifting a heavy shovelful of snow. Even walking through heavy, wet snow or snowdrifts can strain a person's heart. To help make snow removal safer, the American Heart Association suggests:

- Give yourself a break.
- Don't eat a heavy meal prior to or soon after shoveling.
- Use a small shovel or consider a snow blower.
- Learn the heart attack warning signs and listen to your body. If you're not sure it's a heart attack, have it checked out anyway; minutes matter.
- Don't drink alcoholic beverages before or immediately after shoveling.
- Consult a doctor. If you have a medical condition, don't exercise on a regular basis, or are middle-aged or older, meet with your doctor prior to the first anticipated snowfall.
- Be aware of the dangers of hypothermia. Heart failure causes most deaths in hypothermia.

For more information, visit www.heart.org.

One-Third of Discharged Adults Are at Risk

One in three adult patients – aged twenty-one and older – discharged from a hospital to the community does not see a physician within thirty days of discharge, according to a new national study by the Center for Studying Health System Change (HSC) for the nonpartisan, nonprofit National Institute for Health Care Reform (NIHCR).

Even ninety days after discharge, 17.6 percent still had not seen a physician, nurse practitioner, or physician assistant. Many adults who do not see a physician after discharge are at high risk of readmission because of chronic conditions or physical activity limitations, according to the study, which used 2000-08 data from the nationally representative Medical Expenditure Panel Survey (MEPS) to estimate the prevalence of hospital readmissions for all causes – other than obstetrical care – for adults aged twenty-one and older.

About one in twelve adults (8.2 percent) aged twenty-one and older discharged from a hospital to the community was readmitted within thirty days and 32.9 percent were rehospitalized within one year of discharge.

Reducing avoidable hospital readmissions is viewed as a way to improve quality and cut unnecessary costs. While policy makers have targeted readmissions stemming from poor quality of care during an initial hospital stay, readmissions also can occur when patients don't receive appropriate follow-up care or ongoing outpatient management of other conditions.

Tips for Healthier Eating in 2012

The January issue of the *Harvard Women's Health Watch* offers twelve ways to break old dietary habits and build new ones. According to the article, nutrition research has shifted its focus in recent years from the risks and benefits of single nutrients to the health effects that come from the many interactions within and among nutrients in the foods we eat. The result is a better understanding of what makes up a healthy eating plan. Here are five of the twelve ways to improve the way you eat:

- 1. Pile on the vegetables and fruits:** Their high fiber, mineral, and vitamin content make fruits and vegetables a critical component of any healthy diet. They're also the source of beneficial plant chemicals not found in other foods or supplements.
- 2. Go for the good fats:** It's the type of fat that counts. Replacing saturated fat with polyunsaturated fat, including vegetable oils and omega-3 fatty acids (found in fish, seeds, nuts, and canola oil) and monounsaturated fat (avocados, olive oil, and canola oil), can help lower "bad" LDL cholesterol.
- 3. Rethink supplements:** It's best to get the vitamins and minerals you need from food rather than supplements. That can be difficult, especially when you are watching your calories. But it's not impossible. The key is choosing nutrient-rich foods like leafy green vegetables, low-fat yogurt, dried beans, whole grains, and salmon.
- 4. Dine mindfully:** Taking time to savor your food not only helps you enjoy it more, it also helps control your appetite. If you eat too quickly, your brain may not receive signals that your stomach is full. Put down your fork between bites and chew more slowly.
- 5. Eat breakfast:** The daily morning rush sometimes means that you skip breakfast. Don't. A healthy morning meal makes for smaller rises in blood sugar and insulin throughout the day, which can lower the risk of overeating and impulse snacking.

Read the full-length article "[12 for 2012: Twelve Tips for Healthier Eating.](#)"

Internet Service Improves Care for Newborns and the Chronically Ill

Premature infants often do better at home than in hospitals. The relationships with parents and siblings are more natural, and they run a lower risk of contracting contagious diseases than at the hospital. The chronically ill also benefit from being in their own homes. With the new Internet service developed and tested by Chalmers University of Technology, [Care@Distance](#), patients can be at home and at the same time get better follow-up and maintain a dialog with caring staff.

Anna Gund, who publicly defended her doctoral dissertation recently, has worked with the new Internet service [Care@Distance](#). It includes, for example, a website where the chronically ill, or parents of newborns that require more careful follow-up, regularly fill in measurement values and other data related to their state of health. Care workers thereby receive ongoing information about patients without having to be on-site.

“Similar systems are tested now and again, with positive outcomes, but it seems to be hard to make them part of routine care,” said Anna Gund. “We have developed a system based on the technology that is already used in most homes, and we believe that this can facilitate further dissemination.”

Addressing the U.S. Primary Care Workforce Shortage

Policy analysis examines state scope-of-practice laws and payment reforms to increase productivity as possible options to expand access to primary care services

While there's little debate about a growing primary care workforce shortage in the United States, it's less clear whether existing workforce policies – such as educational loan forgiveness or scholarships and higher payment rates – can boost the supply of practitioners quickly enough, according to a new policy analysis from the nonprofit, nonpartisan National Institute for Health Care Reform (NIHCR).

Written by researchers at the Center for Studying Health System Change (HSC), the policy analysis examines whether “policy makers may want to consider ways to increase the productivity of primary care providers and accelerate primary care workforce expansion by, for example, examining how changes in state scope-of-practice policies might increase the supply of nonphysician practitioners.”

According to the policy analysis, “most efforts to improve access to primary care services center on increasing the supply of practitioners through training, educational loan forgiveness, or scholarships, credentialing, and higher payment rates. The 2010 Patient Protection and Affordable Care Act includes many provisions promoting these strategies. While existing, longer-term efforts to boost the primary care workforce are necessary, they may be insufficient for some time because a meaningful increase in practitioners will take decades.”

Collectively, an estimated 400,000 practitioners, including physicians, advanced practice nurses (APNs), and physician assistants provide primary care in the United States. Most national studies indicate that the supply of primary care practitioners is growing, but not fast enough to keep pace with demand. The Health Resources and Services Administration (HRSA) estimates an additional 17,722 primary care practitioners are already needed in shortage areas across the country to meet a target of one provider for every 2,000 patients. Other research indicates that another 35,000 to 44,000 adult primary care providers may be needed by 2025 to care for the nation's aging population.

Seven Market Trends

By Jonathan D. Linkous

The telemedicine market is expansive, multifaceted, and growing. I have selected seven topics for brief comments and predictions as we start 2012:

1. Shifting away from reimbursement and CMS decision making: It's been the Holy Grail for telemedicine in America. But the rapid growth of managed care, Accountable Care Organizations, and medical homes are changing the way telemedicine services are paid and moving away from the fee-for-service model. One quarter of all Americans, 73 million patients, are now covered under a managed care health insurance program. With such shifts, the focus is gradually turning to local and regional healthcare decision makers.

2. Telemedicine as a standard of care: Medical images, x-rays, and the like have been viewed in digital form for forty years. Teleradiology is now so common that many hospitals no longer use the term "outsourcing radiology." It has become so common that providing 24/7 services by a radiologist, relying on teleradiology where needed, may be the first part of telemedicine to become a true standard of care. Such standards are included in state, federal, and Joint Commission requirements and serve a basis for court decisions on legal liability that hold hospitals accountable. It would not surprise me to see a legal suit decided on this basis; it has already been raised in a few cases.

3. Emergence of independent remote clinical enterprises: A relatively new market is the use of private firms of medical specialists to provide remote clinical consultations. A series of vendors have sprung up to do just that for stroke care, mental health, hospitalist and intensivist services, and dermatology. Some may be considered competitors to hospital-based telemedicine programs serving smaller clinics, while others may be contractors hired by the hospital. Look for mergers and expansions of such enterprises as the market starts to take off.

4. The rise of virtual medical centers: In October 2011, Mercy Hospitals announced that it would build a \$90 million virtual care center near its headquarters in Chesterfield, Missouri. The specialists will be located at one site and serve patients in outlying centers across the four states in which Mercy operates: Missouri, Kansas, Arkansas, and Oklahoma. On a smaller scale, intensivists at Inova Health System in Virginia are based out of a corporate office building and provide remote ICU services to 122 ICU beds throughout northern Virginia. Other health systems are looking closely at these developments and, if successful, will start on their own versions of virtual centers.

5. mHealth: This is still a sizzling subject and an important addition to the mix of technologies changing the way healthcare is delivered, along with other innovations such as social networking, "big data," and personalized medicine. In June 2010 I wrote that we were at the top of the hype cycle for mHealth. I was premature. Wild promises, naivety about the way healthcare is paid for and delivered, and investors throwing money at some "interesting" devices and services have continued. Mobile health apps are multiplying exponentially. No doubt there will be some upcoming market adjustments, but wireless technologies will continue to help redefine what we mean by telemedicine.

6. Programs versus networks for multisite telemedicine operations: Federal grants have helped to establish about 200 telemedicine programs linking multiple health centers throughout the country. Almost all have been based out of one large medical center, operating a hub-and-spoke program that allows the medical center to provide remote clinical and educational services to connected spokes. Such a design can expand a center's competitive footprint and increase referrals. An alternative approach connecting multiple centers, clinics, and offices based on a true network design is starting to gain favor. Such a network is typically financed by paid memberships from participating sites and grants rather than clinical services fees. Services can be delivered

from any site on the network to any other site. An early model is the Arizona Telemedicine Program, and the Ontario Telehealth Network is a classic model of this approach.

7. Multinationalization: Once confined largely to international charities serving underdeveloped nations and a few remote image-reading centers, telemedicine is poised to become a major source of international trade. Global investments in high-speed networks and emerging practice guidelines are providing the infrastructure. Issues such as licensure, payment mechanisms, trade protectionism, and cultural biases are but a few of the barriers in the way. However, the potential revenue from such services could have a significant effect on worldwide trade balances.

Jon Linkous is the chief executive officer of the [American Telemedicine Association](#) (ATA).

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Registered Nurse seeks Telephone Triage Employment – Based in Louisiana. 10+ years exp., w/ 2.5 yrs in Pediatric Telephone Triage. FT / PT. Flexible/Available any shift/holidays, etc. Resume and letters of reference available on request. Please contact Kimberly at 318-364-7600 or kimberlydurfee@yahoo.com.

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