**We hope that your 2011 is off to a good start. So far, 2011 is "déjà vu all over again". It's January and we're waiting (again) for health care reform (reform). While we wait, we want to frame up three questions posed by the physician community in response to our November newsletter, entitled, 'Donuts, Diabetes and Dialysis".**

ALLEXIAN
GLOBAL HEALTH CARE ADVISORS

# New Lower Cost ER Option -- At What Cost?

Jan 2011
Issue 1 Volume 3

**This month we're responding to physicians' views of James' talk at the Sunday Times Health Care Conference and November's newsletter. Three questions emerged from their views:**

**1. Do lower skilled professionals compromise diagnosis and treatment?**

**2. Is a de-centralized approach to care at odds with the popular, centralized care model of ACOs?**

**3. Is there a place for new low cost consumer health care technologies when the physician is still ultimately accountable and liable for diagnosis and treatment?**

**This month we'll tackle question one. In subsequent newsletters we'll address questions two and three.**

**Some of our physician and provider clients took a contrary view to our comment in November's newsletter, "...by transforming care delivery from integrated, centralized delivery points utilizing high cost interventions supported by highly skilled professionals to more disintegrated, de-centralized points leveraging lower cost interventions and supported by lower skilled professionals."**

**The Flexner report in 1910 set out a national curriculum for teaching medicine in the US. Much of this curriculum is in use today. Physicians claimed that without rigorous training the people who were practicing medicine were ill equipped to make the appropriate diagnoses and treatments at that time. Physicians today say that without the appropriate training it's**

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**clearly almost impossible for a "physician extender" to have the knowledge necessary to manage and diagnose complex problems. The use of lower skilled professionals providing care, certainly at the initial stages of patient care management, often results in misdiagnoses and inappropriate treatment. Physican's will say that physician extenders are clearly quite capable of managing physician directed follow-up care, and can extend the physician's reach provided they don't overstep their mandate.**

**The pivot point in the last paragraph is "complex problems". Of course, physicians are correct in their views about first class training and experience. Does a skilled, high cost trauma physician, experienced in treating patients with complex problems (e.g. myocardial infarction) need to be on staff in an ER that treats non-life threatening emergencies such as sprains or lacerations? In a typical hospital-based ER the answer is yes but other models are emerging at lower cost and with good quality care.**

**Health care is following the same path as the information technology industry. In the 1950s you bought your computer from IBM. They sold you everything: hardware, software, network, operators, clean room, air conditioning, etc. Today you can go to Best Buy and purchase the monitor, mouse and motherboard separately. This is disintermediation and it's happening in health care. Staying with the ER example – the ER is the full service provider; the integrated, centralized, high cost treatment provider (IBM, in the information technology industry example). Today, a typical emergency room visit costs $4000, has an average wait time of 4hr 15min and for most, the patient experience is poor. ERs have to cope with an astonishing range of conditions, from the complex and life threatening to the mundane -- a stroke victim to a simple kitchen knife cut.**

**Could the ER function be transformed using a disintermediated, de-centralized point leveraging lower cost interventions? *Traditional views would say not, we disagree.* MedExpress, a multi-site urgent care company has developed a new ER model that disintermediates, de-centralizes and leverages lower cost interventions. MedExpress provides a different level of ER care than traditional hospitals. If you have a stroke you go to the ER with a stroke trauma unit. If you cut your finger in the kitchen, MedExpress provides an alternative treatment option. ER visits at MedExpress typically cost less than $1000, wait time is 40 minutes or less and patient satisfaction is high. These ER services do not treat complex problems like myocardial infarction and stroke but can treat less complicated issues in a lower cost setting: sprains, breaks, lacerations, muscle strains, burns, flu, bronchitis, pneumonia, asthma attacks and dehydration. The medical team is highly trained but operates at a lower cost given the less complex range of emergencies. This is in stark contrast to a full service ER where clinical staff must be able to treat a complete range of emergencies, from the complex to simple and maintain all the high cost equipment needed.**

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**This model works in ERs, why not elsewhere? High quality care at a much lower cost is now a reality.**

***We are experienced in performance improvement, strategy, M&A due diligence, interim management and technology planning and organizational change.***

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