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The Abaris Group

The TAG Line

The Abaris Group | *Innovative Solutions for the Emergency Care Field*
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Inside this issue:

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Massachusetts To Become The First "No Diversion" State

In a letter sent to the CEOs of Massachusetts acute care hospitals on July 3, Paul Dreyer, director of Massachusetts Health Safety and Quality, detailed the state's new policy banning hospital ambulance diversion. The letter describes the state's intention to require hospitals to remain open to patients at all times, *except* when the emergency department's (ED) status is "code black". The term "code black" is used to describe an internal emergency in the ED that can result from fires, chemical or other contamination, or flooding.

The state regulation, which will go into effect January 1, 2009, also made an exception for instances in which "advisory's" or "notifications of status" from the hospital, were reported to EMS systems. This would apply to circumstances in which a hospital does not have CT or neurosurgery staff available and would notify the transporting ambulance, which would then decide whether to reroute the patient.

In August, to test their readiness for the no-diversion policy, Boston hospitals agreed to stop ED closures for two weeks. Evaluation afterward determined that there was no resulting increase in patient turnaround times or patient boarding. Some hospitals, such as Massachusetts General who had some of the most diversion hours in the state last year, will have a difficult time adjusting by January. But, the majority of Massachusetts stakeholders agree that allowing hospitals to rely on diversion ignores the heart of the problem and that the new state policy will force them to make much needed operational adjustments.

Dr. O'Leary, former president of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) disagrees with the critical nature of rising

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Upcoming Webinars:

Optimizing ED Design for the Future
Tuesday November 4, 2008
10:00am—11:30pm PST

According to HealthCare Financial Management, 51 percent of all hospitals are building new or re-designing their old ED. This webinar will look at ED design from the standpoint of poor design methodologies and design flaws as well as model design processes.

Medicare's 2009 ED and Trauma Center Rules
November 2008—TBD

This is the third annual webinar on the impact and strategies for adopting the new fee schedule.

For more details and to register, visit: www.abarisgroup.com. Educate your entire staff for one low cost. Pay only **$295** per site for one Webinar or learn about our special discounts when you purchase two or more Webinars.

Ask Abaris Column:

This new section of our newsletter will publish one question from a TAG Line reader, to be answered by one of our senior healthcare consultants. Send an email with your question to: askabaris@abarisgroup.com

In This Issue:
Dear Mike Williams,

Mike, I have heard you say that it is a myth that EDs loose money, is that true and why?
- Hospital CFO – California Hospital

(See page 3 for the answer)

Hospital Death Rates Go Public

On August 20th the Centers for Medicare and Medicaid Services (CMS) released mortality estimates for all U.S. hospitals for the past two years. Now anyone with the internet can go to hospitalcompare.hhs.gov and compare mortality rates for common life-threatening conditions, as well as over two dozen quality measures. Among these measures are the percentage of patients that receive appropriate care, the outcome, and patient satisfaction surveys.

> **"We're in an era of change at last."**
>
> -Donald Berwick, CEO, Institute for Healthcare Improvement (IHI)

While executives at hospitals such as Lehigh Valley in Allentown, PA, concur with the CMS report of their low mortality rates, others like Danville Regional in Virginia are less than pleased with CMS. Danville's CEO Michael Moore claims that the numbers do not account for the poverty and lack of education in the region.

The estimates were derived from deaths among 35 million Medicare beneficiaries that occurred within 30 days of hospital admission. The analysts also factored in patient mix and expected mortality rates with the hospital's population. The current approach is slightly different from the one that the CMS took in the 1990s, when they attempted to release total hospital mortality rates.

The Institute for Healthcare Improvement's (IHI's) CEO Donald Berwick, praised the release of this data as evidence that "we're in an era of change at last." Critics claim that the analysis is overly conservative, causing only a few hospitals to stand out as better or worse than the national average, while the rest fall in the middle.

The Leapfrog group has begun crafting their own hospital rating system, aiming to create a more distinct comparison for employers to utilize.

To read the USA Today article, click here.

Ambulance Medicare Rate Boost

The Medicare Improvements for Patients and Providers Act that was passed by Congress on July 9, 2008 not only prevented rate decreases for physicians, but also *increased* ambulance reimbursement rates. The bill provides a 3% increase for rural transports and 2% for all other transports, and is retroactive to July 1, 2008.

The rate increases are a much needed respite, especially for smaller ambulance companies, though the opinion of many in the industry is that the rates are still too low. The American Ambulance Association (AAA) had lobbied Congress for a 5% rate increase, but according to the Government Accountability Office (GAO), that is still far below the necessary amount to reduce the 6% gap in reimbursement rates vs. average cost of transports.

CMS estimated that overall the rate increase will accumulate an additional $170 million in revenue for ambulance companies.

AAA Senior Vice President for Government Affairs Tristan North commented that "This will provide some relief until the end of next year, " when the Medicare rate boost for super rural ambulance services expires.

The AAA has hopes that new legislation will secure a permanent Medicare rate increase for ambulances in 2009.

Source: EMS Insider, August 2008. "Congress Provides Medicare Ambulance Rate Boost – 'Physician bill' includes 2% urban & 3% rural increase"

For additional information on CMS ambulance provider rules, visit the CMS Ambulance Services Center website.

CMS Changes Position on Proposed EMTALA Rule

The Centers for Medicare and Medicaid Services (CMS) made a last minute change to the 2009 proposed inpatient prospective payment rules. The August Federal Register release of proposed rules would have expanded hospital obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA) by requiring specialty hospitals to accept transfer patients who had been admitted to another hospital.

EMS attorney Doug Wolfberg said the proposal would have been "inconsistent with the 'bright line' rule" adopted by the CMS in 2003, stating that a hospital's EMTALA obligations ended when it admitted the patient.

For more information on EMTALA visit, the CMS EMTALA website.

Visit www.abarisgroup.com for details on The Abaris Group's upcoming Webinar on the 2009 CMS changes and how they will affect you and your organization. Additionally, audio CDs of a recent Webinar on EMTALA rules are available for purchase.

"No Diversion", *continued*

(Continued from page 1)

diversions. Dr. O'Leary stated in the New York Times that diversion has historically surged and then recovered, and that there needed to be more proof that there is a trend.

At the end of Paul Dreyers' letter to the Mass. CEOs, was a list of sources to consult for quality improvement and patient flow efforts.

Click here for the Boston Globe's news report and here for the Dept. of Public Health's letter to Mass. hospital executives.

Ask Abaris

Welcome to the new TAG Line column where our senior consultants answer your questions

Reader's Question:

Mike Williams,

I have heard you say that it is a myth that EDs loose money, is that true and why?

- Hospital CFO – California Hospital

TAG Response:

(This will be the first of a three-part story on the myths of EDs loosing money)

The emergency departments (ED) environment has many challenges not the least of which being driven by assumptions that limit the availability of resources within a hospital. More profitable programs tend to have a higher priority for expenditures and achieve more resources. However, there are many myths that fuel ED financial assumptions.

For example, EDs are often viewed as money losers with increasing volumes of uninsured patients. The historical studies that demonstrate the lack of financial viability of EDs hinge on accounting methodology. Using state data based on traditional accounting methods, the California Medical Association (CMA) has released three reports, which list the losses of EDs throughout California. A press release from CMA's most recent report, published in February 2003, reported that in California "hospitals lose an average of $71 for every patient who receives care in emergency departments." Interestingly, this most recent study shows that every ED in the state (approximately 450) lost money during that year of the report.

However, EDs may not be a financial burden after all. Two recent studies argue that EDs actually make a positive contribution to hospitals' overall economic viability. Another finds that it is patients with private insurance who are driving ED volume increases.

Researchers from the University of Southern California (USC) argue in two papers that traditional hospital accounting have, in the past, underestimated the financial contribution made by EDs as while hospitals lost money on ED outpatients, the ED contributed to profitability overall through inpatient admissions.

(Continued on next page)

Healthcare Executives Report Poor Patient Flow At Their Facilities

A survey of over 200 U.S. healthcare executives revealed that 89 percent believe that their facility has poor patient flow, and only 56 percent of healthcare facilities have implemented patient flow systems. The majority of executives report utilizing a combination of old and new technologies, including: computer data; phone and voice messages; grease boards; digital displays; and mobile devices. When compared with 2007, the respondents reported increased use of each of these technologies.

The study conducted by StatCom surveyed 237 healthcare executives, 59 percent of which were C-level execs and vice presidents and 19 percent were directors.

When asked what the root of the patient flow problem was, two-thirds of the executives responded that poor communication was the cause. Other root causes mentioned were ineffective scheduling, lack of beds, lack of staff, and poor centralized knowledge of patient status.

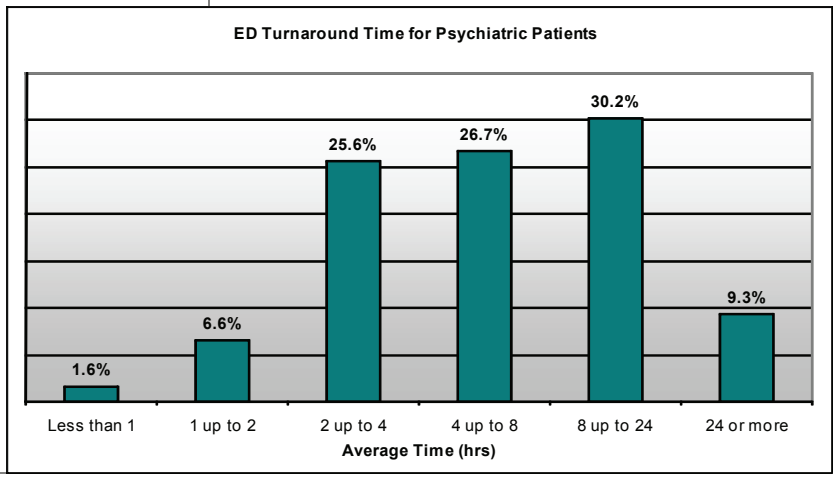
Despite the fact that 43 percent of healthcare facilities do not yet have a patient flow system, 55 percent of execs believe that implementing one would result in the greatest improvement in patient

Growing Problem With Boarding of Psychiatric Patients

According to a survey conducted by the American College of Emergency Physicians (ACEP), the boarding of psychiatric patients in emergency departments (EDs) is growing. The study found that 79 percent of EDs are boarding psychiatric patients and that 30.2 percent of them are in the ED from between eight to twenty-four hours *after* the decision to admit.

ACEP reported that the replacement of regional inpatient psychiatric hospitals in the 1950s to outpatient and community services has reduced the number of resources for psychiatric patients to utilize. This has in turn resulted in an increasing number of psychiatric patients visiting EDs for treatment. The surveyed medical directors appear to agree, with 85 percent of respondents believing that "wait times for all patients in the ED would improve if there were better psychiatric services available."

For a summary of ACEPs survey results, click here.



Ask Abaris, *continued*

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The USC authors, Melnick, et al., found that traditional accounting methods do not credit the ED with inpatient net revenue from ED patients who are admitted. That distinction was found to be important because although the authors calculate that hospitals lost an average of $84 for each outpatient treated in a California ED between 1990 and 2001, they made $1,220 for each of the patients who was admitted (about 1 in 7). Trauma centers were not included in the analysis.

I will have more to this answer in our next newsletter.

If you have a healthcare question for one of our consultants, send an email with your question to: askabaris@abarisgroup.com

About The Consultant:

Mike Williams
President, The Abaris Group

Mike is the president of The Abaris Group, a firm that specializes in ED and inpatient program patient flow and capacity building strategies. He has personally conducted greater than 350 hospital studies on improving performance, productivity and market share. He is a recognized expert on healthcare performance, benchmarking and financing.

Patient Flow, *continued*

throughput. Three-quarters of executives reported that their facility has patient flow committees and that they have yielded the greatest results in both case and bed management. In terms of patient tracking, healthcare executives appear to be most interested in implementing bar-coding, (62 percent).

The results of the study can be found at http://www.statcom.com/survey/national-survey-2008.aspx

Recent Webinars:

Audio CDs Now Available For:

Optimizing ED & Trauma Center Payments

Are EDs and Trauma centers doomed to be classic hospital money losers or are they simply *designed* to lose money?

On August 19th, The Abaris Group conducted a Webinar that described how to enhance fee schedules, optimize co-pays and bill all unique payer sources *within the context of the new Medicare hospital outpatient fee schedule policies.*

For more details on purchasing this cd and to register for future webinars, please visit: www.abarisgroup.com.

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The Abaris Group is a consulting firm that specializes in emergency and outpatient services. We provide clients with help on a wide range of topics, including strategic planning, operational improvement, and financial enhancement, to help them achieve their goals.

We pride ourselves on delivering value to our clients in the form of quality recommendations and strategies that work. To achieve this, we conduct detailed analyses, blending insight and experience from all spectrums of the healthcare and emergency care fields to meet our client's unique needs.

Whether it is evaluation of new programs, studies of existing ones or assistance with implementation, we will extend this superior level of service to you and your organization.

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