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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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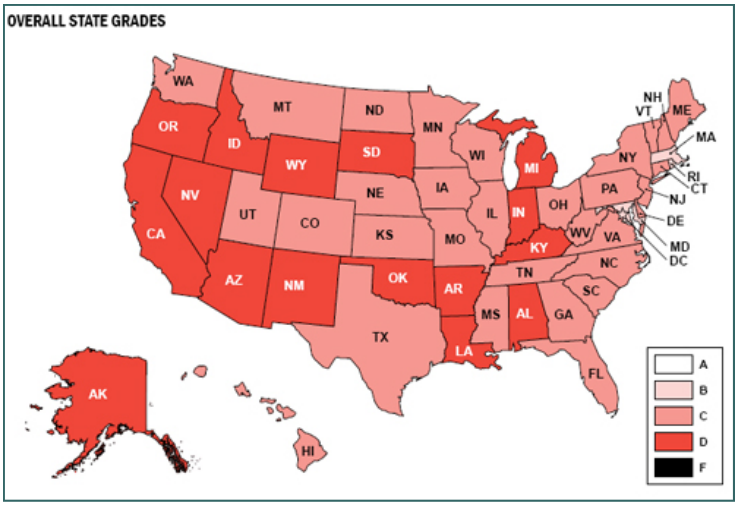
HAPPY HOLIDAYS FROM THE ABARIS GROUP TEAM!

Annual Emergency Medicine Report Card Gives Nation a C-



The American College of Emergency Physicians (ACEP) recently released the 2009 edition of their annual report card of the state of emergency medicine in the nation. The final grade, which is the result a 116 objective measures, is a C- for the nation. There were a number of states with a D grade, but Arkansas was noted by ACEP as the lowest/worst grade. However, Massachusetts, Rhode Island, and the District of Columbia were among the top with a B grade.

The 116 objectives were derived from data gathered by the Centers for Disease Control and Prevention (CDC), Highway Traffic Safety Administration (HTSA), Centers for Medicare and Medicaid Services (CMS), and the American Medical Association, (AMA). These objectives were divided into 5 categories that have varying weights on the overall score: Access to Emergency Care, Quality & Patient Safety; Medical Liability; Public Health & Injury Prevention; and Disaster Preparedness.

Upcoming Webinars:

Stay tuned for the 2009 Webinar schedule.

View the Products section of our website for CDs of previous 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:
Part 2 of 3:
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)

Emergency Services Report Card, *continued*

Access to emergency care had the greatest weight in the overall score (30%) and was given the lowest grade nationwide.

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While this report may come as a shock to the general public, those in the healthcare industry are not surprised. A study administered by ACEP in 2007 revealed that out of 1,500 emergency physicians polled, 80% had "significant concerns about the crowded conditions in emergency departments." Other polls have indicated similar feelings among those in the industry.

So, what is Massachusetts doing right? According to ACEP, their trauma registry, stroke system, STEMI system have strong performance. In addition, the state's implementation of the universal health insurance mandate drastically reduced the uninsured, (and therefore improving patient access). Also the state's decision to become a "no diversion" state boosted their score on the report card.

What is Arkansas doing wrong? It is currently the only state in the nation without a Level I or Level II Trauma center, and only 12.6% of the state's population lives within 60 minutes of a trauma center. The state also has a shortage of specialty physicians and an uninsurance rate of 22.1%, (the national average is 17.2%).

In addition, ACEP notes that Arkansas has no patient tracking system, no mandatory quality reporting requirement, and a low percentage of hospitals utilizing electronic health records or computer order entry systems.

Many of the states are already in the process of implementing new systems and regulations that improve on the categories in the report; however, ACEP also provides their own suggestions, some of which are shown below:

1) Alleviate boarding in emergency departments and hospital crowding
2) Enact federal and state medical liability reforms
3) Increase support for the nation's healthcare safety net
4) Develop greater coordination of emergency services.
5) Increase the use of systems, standards, and information technologies to track and enhance the quality and patient safety environment

For ACEP's full report including individual state scores, click here (on the

Hospitalists Managing Emergency Department Throughput

An interventional study at Johns Hopkins Bayview Medical Center was able to reduce throughput times by 98 minutes and total diversion hours by ~33 percent, despite an 8.8% increase in visits.

The study evaluated the hospital's throughput and diversion times over a four month period before and after implementing a quality improvement initiative, called "active bed management." This program required hospitalists to rotate to the position of "bed management hospitalist" where they were responsible for assessing and coordinating the bed capacity in the ICU, cardiac, pulmonary, and general medicine units.

The bed management hospitalist also makes triage determinations by consulting the admitting physicians over the phone (and in person if deemed necessary). A "bed director" supports the bed management hospitalist by activating additional resources when prompted by the bed management hospitalist.

As a result of the intervention, despite an increase in patient volume, the throughput for admitted patients decreased by 98 minutes. Throughput for patients not admitted did not change. The diversion hours decreased by 6% for "yellow alerts" and 27% for "red alerts". (Yellow and red alerts are categories of diversion designated by the Maryland Institute for Emergency Medical Services Systems).

Decreases of this proportion can be extremely important not only for patient safety and quality of care, but also to cut back on lost revenue. Previous studies have shown that it can cost the hospital $1086 to $8889 per hour of diversion.

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California Bans "Balance Billing" for Non-Contracted ED Patients

Beginning October 15, 2008, California's Department of Managed Health Care (DMHC) eliminated the ability for physicians to balance bill for emergency department patients. When physicians provide care for a patient covered by insurance payers with which the physicians are not contracted, they typically utilize balance billing to make up the difference between what the insurer paid and the amount of billed charges.

The DMHC has stated that patients normally billed in this manner can now only be billed for their co-pays and deductibles. If a physician wishes to recover the difference they must make an appeal to the insurer.

This new regulation has the potential to significantly reduce physician revenues in addition to giving insurers a gateway to further reduce reimbursements. However, it does provide more protection for patients from being caught with a large medical bill after a visit to the emergency department.

In November, the California Medical Association took the case to the California Superior Court on the basis that the DMHC did not have the authority to regulate physician billing in this manner, but in December the regulation was upheld by the court.

Bed Management Hospitalists, *continued*

(Continued from page 2)

Although researchers commented that the program is "not inexpensive," they concluded that reducing the lost revenue from diversions compensated for the costs.

This study was only performed at one hospital and thus may not yield the same results at other institutions.

The report can be found (for purchase) on the Annals of Internal Medicine website.

Howell, E; Bessman, E; Kravet, S; Kolodner, K; Marshall R; Wright, S. "Active Bed Management by Hospitalists and Emergency Department Throughput." Annals of Internal Medicine, 149, 2008.

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:

The myth of EDs as "money-losers," Part 2 of 3

As I mentioned in the past newsletter there are a number of published articles that claim the EDs are not money losers at all. In the USC article mentioned in the last newsletter, the authors found that "hospitals with EDs derive an economic benefit from maintaining their EDs and even expanding ED capacity if the expanded capacity leads to an increase in hospital admissions." This finding was consistent with their other studies finding that although there is often a common complaint that the number of EDs is dropping in the US, at least in California, ED capacity has indeed expanded over 1990-2001. Incidentally, the authors also found that traditional accounting methods underreport true ED costs because they do not include ED-related costs booked in other cost centers. These higher costs are reflected in the net revenue figures shown above.

Commentaries were published alongside the second Melnick, et al., paper. Among the criticisms were that statewide profitability does not mean that some hospitals are not struggling and that the environment has changed since 2001 due to rapidly increasing costs.

Among the costs reported to be increasing is the cost to treat uninsured patients. However, it is mostly privately insured patients who drove the 16 percent increase in ED visits between 1996-97 and 2000-01, according to a recent study published by the Center for Studying Health System Change. The number of privately insured visits increased by

(Continued on next page)

Hospitals Display Emergency Room Wait Times Online

For the past 4 years, Mountain States Health Alliance (MSHA) in Tennessee has been posting their hospital's wait times online. While a seemingly small gesture, a number of patients have reportedly enjoyed being able to choose which hospital to visit. In April 2008, the Scottsdale Healthcare system in Arizona initiated a similar program for three of their hospitals in the Phoenix area.

Genesis Health system in Iowa has chosen to post the wait times at all of its urgent care centers, which has reduced the number of phone calls from 40-50 per day about wait times to 10 per day.

According to Ken Croken, Vice President of Corporate Communications and Marketing at Genesis, the ED patients that are forced to wait are the nonemergent patients. EDs can experience a rush of heart attack or stroke patients, which will drastically increase the wait times at a hospital. While in contrast, urgent cares operate on a first come first serve basis, so the wait times are less subject to large fluctuations.

Other hospitals have chosen to post wait times to gather data for patient quality and provider accountability, in addition to providing a vehicle for increased patient satisfaction.

This and other marketing strategies can serve as an additional tool for hospitals to mitigate hospital overcrowding and improve patient care.

Rough Year For Emergency Medical Services

Advances in the quality of the EMS industry are being clouded by a number of truly unfortunate incidents. Recent reports are indicating that 2008 will be the deadliest year for medical helicopter crashes, with 28 dead so far. Investigations have shown that all of these accidents occurred during dangerous flying conditions, when other aircraft were grounded. This year has also seen its fair share of ambulance and fire engine crashes, involving injuries and deaths.

These incidents put to the forefront the issue of weighing the safety of the patient versus the safety of the crews. The ambulance and fire crews are relied upon to transport the patient safely to the hospital. When that does not consistently occur, then the operations should be re-evaluated.

Another recent report of the EMS industry has revealed a disturbing statistic, in which 129 paramedics have been accused of sex-related crimes (on and off duty) in the last 18 months. A number of these cases involve the paramedic molesting a patient in the back of the ambulance during transport.

Though the number of cases appear small compared with the nearly 900,000 EMTs and Paramedics in the industry, they are cases which should not be tolerated at any number.

As the year ends, it is a good time for leaders in the healthcare industry to learn from these incidents and evaluate their operations to ensure that they are doing all they can to prevent them.

Ask Abaris, *continued*

(Continued from page 3)

24.3 percent over the period, compared to an increase of 10.3 percent among the uninsured, which would indicate a marginal change toward more insured patients. It is worth noting from the study that although volume increases have been larger among insured patients, "uninsured Americans increasingly rely on emergency departments because of decreased access to other sources of primary medical care."

In the next edition of our newsletter, I will tell some of our most successful strategies in getting EDs to make money.

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.

Statewide Hospital Availability System

Arkansas state officials have initiated a statewide EMS reporting system which will allow hospital and EMS workers to determine whether a hospital has available rooms and specialists, in real time. This means that, once fully implemented, a paramedic in the field who has a stroke patient, for example, will be better able to determine which hospital to transport to based on the availability of a specialist.

This is a positive first step for Arkansas, who is currently the only state with no trauma centers or trauma system.

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?

Medicare's 2009 Changes for EDs and Trauma Centers

In November, the CMS released the final changes for the 2009 outpatient fee schedule for Emergency Departments and Trauma Centers. This Webinar evaluates the impact and strategies for adapting to the changes.

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

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About Us

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.

For more information, visit www.abarisgroup.com or email subscriptions@abarisgroup.com.

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