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The Abaris Group

The TAG Line

The Abaris Group | *Innovative Solutions for the Emergency Care Field*
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CMS Releases Proposed 2009 Medicare Outpatient and Ambulatory Surgery Center Payment Updates

On July 3, 2008 the Centers for Medicare and Medicaid Services released the proposed rules for Medicare payments of Outpatient and Ambulatory Surgery Centers for 2009.

The proposed changes include a 3% annual inflation update for payment rates for facilities that meet the quality reporting requirements, and a 1% inflation update for those facilities that do not meet the quality requirements. Along with the initial seven quality measurements, the proposal includes four additional measurements covering imaging efficiency.

The CMS has also added 18 potential quality measures to the hospital-acquired conditions (HAC) list, bringing the total to 26.

The additions to the provisions are worrying many in the ED community who feel that some conditions are not completely preventable and therefore hospitals will be unjustly penalized. Urinary tract infections (UTIs) are often cited as a fairly common incidence during catheterizations due to a number of causes that may not necessarily be related to a mistake of the provider.

Another part of the proposal intends to change the way Medicare pays for imaging services. If the proposal is approved, CMS would provide a single payment for "multiple services of a particular type (i.e. multiple CT scans) performed in a single hospital session." This includes other imaging procedures such as MRIs and Ultrasounds as well. This would likely hurt reimbursement for places with critical patients such as trauma centers that frequently do 3 to 4 image exams on each patient.

Type B EDs will also be affected. The provisions will create four new APCs that will pay Type B EDs based on claims data. The most intensive ED visits will have a single APC code for both Type A and B EDs.

Some believe that these provisions are another step towards a "non-pay for non-performance" system, where preventable events are not reimbursable and/or reduced. Several hospitals no longer charge for these events, Mas-

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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 redesigning 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.

NEW to The TAG Line:

Ask Abaris
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 Abaris,

What alternatives exist to provide specialty coverage for our Emergency Department and Trauma Center patients?
– Hospital Representative *in Connecticut*

(See page 3 for the answer)

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CDC/NCHS Release 2006 US Emergency Department Visits Data

On August 6th, the CDC and the National Center for Health Statistics (NCHS) released the latest Emergency Department visit data for US hospitals. The report summarizes the CDC's findings regarding hospital utilization, patient characteristics, payment sources, and more.

The CDC found that "In the last decade, the increasing frequency of ED visits has coincided with decreasing numbers of EDs and decreasing numbers of inpatient beds." Specifically, hospital ED visits in 2006 had increased to 119.2 million, (3.4% increase from 2005), while the number of EDs dropped from 4,019 to 3,833. Of the 119.2 million visits, 15.3 million (12.8%) were admitted to the hospital.

Private insurance surpassed other expected payment sources in 2006, accounting for 39.7% of ED visits. This was followed by Medicaid/SCHIP (25.5%), Medicare (17.3%) and the uninsured (17.4%). In the last decade, the proportion of private insurance payments in the ED has continued to grow as the uninsured proportion remains relatively the same. This implies that there is an increasing proportion of private payers utilizing emergency departments.

The throughput evaluation indicated that:

- 61.8% of ED visits, the patient waited less than 1 hour, (median 31mins).
- Median patient care time was 2.6 hours.
- 2% of ED visits left without being seen
- 1.3% of ED visits left against medical advice

Nearly two-thirds of visits were after normal business hours. The hospitals reached peak occupancy at 7pm and peak volumes in the summer and winter.

> "In the last decade, the increasing frequency of ED visits has coincided with decreasing numbers of EDs and decreasing numbers of inpatient beds."
> — CDC

Complications of medical and surgical procedures accounted for 2.5% of injury visits, while adverse effects to medication were 1.8% of injury visits. The number of visits related to adverse effects of medical treatment totaled 1.9 million.

These updated results further emphasize the extent with which EDs are being used in America. Hospitals should use this data to prepare for continued increases in visit numbers by creating more efficient processes and optimizing billing procedures. In addition, with more pressure from CMS and other insurers linking reimbursement to quality and outcomes, hospitals must become more proactive in improving quality measures.

The above mentioned CDC report along with ambulatory and OPD data can be found here.

Marin County Safety Net Project

The Abaris Group is completing its final revisions of the one and a half year long Marin County Safety Net project. The project involved a comprehensive look at healthcare services in Marin, with a focus on the safety net. Community input was obtained through one-on-one interviews, focus groups, and Town Hall meetings. The end goal was to provide a 20 year needs assessment of the healthcare safety net services in Marin County.

TAG found that population changes towards more Hispanic persons and persons aged 65 and older will increase the number of uninsured and those on Medicare and Medicaid. Those factors combined with the changing landscape of healthcare in the state and the nation result in an uncertain future for the safety net.

As of the time of the study, the analysis indicated that current capacity meets current demand. Marin County is below capacity for its inpatient bed and operating room occupancy and also currently has adequate ED capacity (though they will need to add 4 ED treatment stations by 2010). Their acute psychiatric bed capacity is the lowest in the region, which is a cause for concern amidst reports of individuals being outsourced to adjacent counties.

The safety net capacity is likely to continue to meet the demands up until 2025 given that the county compensates for future changes in the healthcare environment.

The Abaris Group concluded with recommendations for ensuring the sustainability of the safety net, including:

- Vision & Plan (a collaborative with performance dashboards)
- Best & Promising Practices (target prevention, leverage volunteerism)
- Reduction of Waste & Waiting (re-engineer patient experience)
- Mental Health Assessment (further analysis of access and delivery)

The draft report states that the county is at a turning point where they can ensure the sustainability of their safety net and the county hospital, (MGH). The county has already begun developing a central medical services complex and is in the process of transitioning sustainable control of MGH.

For more detailed information on the Safety Net project including the draft final report, please visit our website.

Clinical Trial to Help Improve Severe Trauma Survival Rates

The Orange County Resuscitation Outcomes Consortium (ROC) will begin a clinical study aimed at treating severe traumatic injuries in EMS settings. Study participants will administer hypertonic saline solution to trauma patients as part of the treatment procedure. Previous clinical studies have proven to compensate for blood loss more effectively, reduce inflammation, (especially with brain trauma), and improve survival outcomes.

The clinical study is part of a collaborative NIH study to improve survival from cardiac arrest and severe trauma. The study is involving EMS agencies, public safety agencies, regional hospitals, community healthcare institutions, and medical centers in 11 regions of the US over a three-year period.

Accidents are the fourth leading cause of death in the US and the cause of 43,000 American deaths per year in motor vehicle accidents alone. Improving the trauma and cardiac arrest treatment procedures could save thousands of lives per year.

For more information visit the NIH website or search for the study at clinicaltrials.gov

Medicare Updates, *continued*

(Continued from page 1)

sachusetts is proposing to link the events to accreditation, and some payers are jumping on as well. Proponents of the provisions argue that they are necessary as incentives for hospitals to increase the quality of care.

The CMS Press Release, titled "CMS Proposes Quality Improvements and Other Changes for Hospital Outpatient and Ambulatory Surgical Center Services for 2009" can be found here.

Further detail also available in the Federal Register, updated July 18, 2008. Click here for pdf. (Note: the file is quite large and may take a five minutes or more to download, depending on your internet connection).

Ask Abaris

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

Reader's Question:

Dear Abaris,

What alternatives exist to provide specialty coverage for our emergency department and trauma center patients?

-Hospital representative in Connecticut

TAG Response:

Many clients are finding that the ED on-call commitment for physicians is less about a stipend and more about their lifestyle. It is more common today for physicians to strike a balance between work and home. A recent report stated new physicians work about 25 percent less than their more senior peers. This supports that it is not all about working any longer. Nationally, there is predicted to be a physician shortage of at least 85,000 by the year 2025. This fact, combined with a more balanced lifestyle, require new ways of ensuring physician coverage to emergency departments.

ED physicians have been using mid-level practitioners for years with excellent results. They can triage patients, order tests, and even begin treatment on their own. When a case is more complex, the Nurse Practitioner (NP) or Physician Assistant (PA) refers it to an ED physician. This concept has been adapted to the specialty medicines, such as pediatric neurosurgery, which has limited specialists available in many communities. For example, the NP at Children's Hospital in Oakland is activated with the trauma team, performs the initial triage, and coordinates with neurosurgeon. The NP also handles follow-up visits for many patients. This allows the one pediatric neurosurgeon to focus his expertise on the most acute cases.

Hospitalist programs have proven effective at reducing inpatient length of stays. The Abaris Group is recommending similar programs for orthopedic and general surgery where the burden of ED/trauma call is too great an impact on the surgeon's private practice. Orthopedic or surgical hospitalists are dedicated to on-call coverage and do not manage a separate private practice. The patients that they treat in the hospital are typically seen in a clinic by the special hospitalist or possibly an NP or PA, if the demand is high enough. Some hybrid models have been implemented that use private groups and hospitalists to cover the on-call burden. One example would be two surgical hospitalists covering the administrative and clinical needs of a trauma center during the days, while the existing general surgical group covers the nights. Other hospitals are using two orthopedic hospitalists to cover 20 days a month and private orthopedic group coverage for the remaining days.

Finally, CMS is currently considering "community call arrangement" coverage as acceptable under existing EMTALA rules. This would allow one hospital in a

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Adoption of Patient Tracking Systems Among Emergency Rooms in California

In July, the California HealthCare Foundation published a study that looked at the extent to which California hospitals are utilizing ED information systems (EDIS). For the study, The Abaris Group conducted a survey focused on the features of EDIS that were being utilized, barriers that the hospitals encounter, as well as best practices.

The results indicated that 69% of the hospitals surveyed have some type of EDIS. Of those hospitals, 29% of those use Meditech and 6% use Epic, McKesson, Logicare, or Eclipsys. Half of the surveyed hospitals with EDIS also link their EDIS to their inpatient tracking system.

Real-time ancillary information was cited as the most commonly used function of the EDIS, followed by data reporting and patient order entry. The majority of EDIS users also reported capturing billable charges.

The primary implementation challenges faced were addressing integration capabilities, thorough training, research and testing prior to implementation, and having a system that is not customized to the ED. Post implementation, respondents stated that if they could change anything about their EDIS, they would prefer a faster system, better tracking of throughput times, increased integration and increased user-friendliness.

Overall users were satisfied with the ED tracking systems. Users were most satisfied with its quality of discharge instructions and increased HIPPA compliance. They were most disappointed with its ability to integrate with physiological equipment and other systems in general.

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Return of Tourniquets in Prehospital Care?

A recent study conducted by the Journal of Emergency Medical Services attempted to evaluate the costs/benefits of civilian tourniquet use. The researchers evaluated documents from a number of sources regarding patients that were admitted to the Boston Medical Center ED from 1999 to 2006. Each of the patients had penetrating extremity wounds and had a prehospital tourniquet applied to the extremity.

Only one patient died, but was pulseless at the scene of the incident. The rest of the patients were discharged from BMC, retained complete neurological function of the extremity and vascular repairs were patent post-operatively. Despite the small sample size (14), there is an indication that tourniquet use may be more beneficial than current methods.

The researchers also evaluated historical data on tourniquet use in civilian and military settings. To date there are limited studies of tourniquet use in civilian settings, though anecdotal evidence from the military indicate that they increase the survival rate with minimal side effects. The military has proven their commitment to tourniquet use in the field by requiring all troops in Afghanistan to carry a Combat Application Tourniquet (CAT).

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Ask Abaris, *continued*

region to be "designated as the on-call facility for a specific time period or for a specific service, or both." Unstable patients needing the specialty care could be transferred to this facility, but only within that region and specific transfer agreements would have to be established and renewed annually. To understand all of the details, consider purchasing our June 2008 webinar- *ED Physician On-Call Crisis* at http://abarisgroup.com/index.cfm?area=products.

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

About The Consultant:

Bill Bullard
Senior Consultant

Bill has 20 years of experience in emergency services including both public and private agencies. He put himself through college as an EMT and later joined the startup team of BayStar Medical Services, a division of Laidlaw/MedTrans, as the Director of Business Development.

Bill joined The Abaris Group in May 2005. His experience ranges from system analysis and strategic planning to proposal development and innovative contracting with EMS providers, hospitals, and health plans throughout Northern California.

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The authors concluded that when prehospital tourniquets are appropriately applied, they can safely and effectively control life-threatening bleeding from a penetrating extremity injury. They encouraged more detailed study and further stated that tourniquet policy should be re-evaluated in favor of using the procedure more routinely in a prehospital setting.

Further detail regarding this study can be found at the JEMS website.

Patient Tracking Systems in California, *continued*

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The three best practices that emerged from the study were:

- Improved patient tracking
- Improved patient throughput
- Better tracking of laboratory/ radiology status and results

The hospitals without EDIS reported lack of funds as the primary reason for not implementing the system, yet they believed that it would improve efficiency, productivity, and quality. Interestingly, none of the hospitals with EDIS reported being extremely satisfied with their system's ability to improve those functions.

There was no correlation between large or small hospitals and having an EDIS, nor was there any correlation between licensed beds and having an EDIS. However, hospitals with larger EDs and ED visits tended to have tracking systems. The Abaris Group concluded that from both revenue and risk management perspectives, some form of patient tracking system can be beneficial. If the implementation of the EDIS is performed as a multi-disciplinary approach it is likely that the organization will maximize their returns.

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.

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.

ABARIS GROUP *Innovative Solutions for the Emergency Care Field*

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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