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The Abaris Group

The TAG Line

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Happy Holidays from The Abaris Group

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Empowering Your Emergency Department Team Members

By Trish Carlson, RN, BS, CEN

Trish Carlson, RN, BS, CEN, is a nationally-recognized speaker on improving ED throughput times and customer satisfaction, and has worked with The Abaris Group on various ED and inpatient process and flow improvement projects.

Over the past 25 years, emergency departments (EDs) have evolved into complex delivery systems with increasing use and high expectations. Many EDs have transitioned into multi-service line delivery systems which are known as Emergency Product Lines (EPLs). EPLs often encompass traditional acute care settings such as EDs, Urgent Care Clinics, Fast Tracks, Pediatric EDs, Clinical Decision Units, Rapid Admission Units, Psychiatric and Detox EDs, and Trauma Centers.

The challenge is to develop relevant and functional EPLs that have staff buy-in and accountability. Why can't today's line personnel be informed and educated regarding group processes, best practices, and benchmarks; mentored and given autonomy through vision sharing and boundary setting; and mentored by today's leaders to develop a more supportive structure to create, continually improve, and manage the complex EPL delivery system? The answer is they can.

A shared-governance model is truly worth the endeavor and may be one of the only ways to succeed in the rapidly changing environment we practice today.

In light of the expansion of services and flattening of the management model at most hospitals, success of these new EPLs is dependent upon the internal structure, shared vision and participation of all ED team members. The hierarchal form of top down management practiced several decades ago has been abandoned by most progressive management teams.

This new model of shared vision, shared goals and autonomy is not the "self-governance" model which seemed to often fail in the 1990s, but rather a model of "shared-governance" in which the vision "comes alive when everyone sees where his/her contribution makes a difference," as noted by author Ken

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Happy First Anniversary The TAG Line

Thank you to our subscribers for bringing The TAG Line to its first anniversary.

Empowering Your Emergency Department Team Members, *continued*

Key Parameters for ED Collaborative Practice Councils

Multidisciplinary
Empowered
Accountable
Core and Resource Team Members
Leadership Buy-in
Celebration and "Win" Tools

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Blanchard. This model of shared-governance lends itself well to the expansion of the EPL as it provides a methodology to move quickly through change while empowering team members to sustain changes and take ownership in their successes and accountability of goal shortcomings. Leaders must be willing to share information with all team members and replace traditional hierarchical management styles with empowered teams.

Successful shared-governance teams may require the establishment of core and resource team members. Core team member positions are present from start to finish, while resource team members are utilized on an as-needed basis. A core team member may be represented on the Collaborative Practice Council for the ED while resource team members may come from ancillary departments when projects involve those areas. In this model, it is important to always consider who the "stakeholders" are prior to addressing issues or changing initiatives. It is important that the resource team members are valued team members who can contribute much more than just their allotment of specific expertise. Supporting the Collaborative Practice Council are members from Operational Steering Committees who contribute to the ongoing success of each individual component of the EPL. For example, the Urgent Care Center or Fast Track may have its own operational steering committee. This model provides a helpful reporting structure with ownership, accountability and continuity for individual initiatives.

Additionally, this model provides a linkage for communication to all arms of the EPL as well as opportunities for feedback, input and stimulation of ideas for all providers. An often forgotten component in the "Collaborative Practice" management model is rewarding and recognizing participants. One excellent way to continually reward and recognize team members is to acknowledge ongoing participation to the team as a whole. Additional reward and celebration vehicles must be in place to reinforce short-term "wins" for teams and their members. Goal setting and milestone celebrations are essential to the continuous improvement process as well as for individual team sense of purpose and accomplishment.

The shared-governance leadership model helps EPLs. However, this model will only be successful and sustainable when recruitment and retention issues are taken seriously, non-clinical time is provided for team members, and emergency services administrators are willing to invest their time and talents in their staff, physicians and online leaders to move to the next level. This takes buy-in from senior administration. A shared-governance model is truly worth the endeavor and may be one of the only ways to succeed in the rapidly changing environment we practice today.

For additional information and a sample Collaborative Practice Council structure and membership policy, visit www.abarisgroup.com/resources.

URGENT Matters

Urgent Matters, the national initiative examining ED crowding and the healthcare safety net, is accepting applications from hospitals to participate in *Learning Network II*, a year-long collaborative to improve patient flow and reduce ED crowding. Building on the success of the previous collaborative, a new group of selected hospitals will receive consultation from experts, access best practices, measure patient flow, and learn with other leading hospitals in the country. Online applications are due Dec. 10, 2004. Visit urgentmatters.org for more details.

Urgent Matters is supported by a grant from The Robert Wood Johnson Foundation.

Conference Materials:

If you were unable to attend the Nov. 11-12 conference in Washington, D.C., *Perfecting Patient Flow: Proven Solutions to ED Crowding*, the PowerPoint presentations, audio recordings and additional tools and templates provided by conference presenters are available to download. Check urgentmatters.org to download and view materials.

Schwarzenegger Proposes Lowering Nurse-to-Patient Ratios

California Gov. Arnold Schwarzenegger's administration will delay expanding the state's nurse-to-patient ratio requirement set to go into effect Jan. 1, 2005, and to exempt EDs from the ratios entirely when they experience "unexpected surges" in patient volume.

According to a *Los Angeles Times* article (Nov. 5, 2004), Schwarzenegger's administration is considering revising the rules because of the financial burden that the new law has placed on hospitals.

Under the current law approved in 1999, there is a maximum number of patients that each nurse is allowed to care for at all times, based on the severity of the patients' illnesses. For example, each patient should have his or her own nurse in the operating room; whereas, one nurse can take care of six patients in a medical-surgical ward.

According to the California Healthcare Association, 85 percent of California hospitals are unable to meet nurse-to-patient ratios. On average, hospitals have 15 percent fewer nurses than needed to meet the ratios.

Hospital administrators complain about the costs of compliance. Nursing unions strongly support the law, saying that the state is "exaggerating the costs of hiring nurses."

Eleven hospitals have contributed their decisions to close or reduce services to the new nurse-to-patient ratios. Additionally, 68 hospitals have petitioned for more flexibility to deal with the ratios or asked the ratios to be waived because of the hospitals' positions as small, rural facilities.

California's Department of Health Services will likely hold a public hearing about the proposal in mid-January.

For breaking news, visit EMSNetwork.org.

Changes to Medicare Ambulance Fee Schedule

According to a November 15 Federal Register notice, the Centers for Medicare and Medicaid Services (CMS) has set the ambulance inflation factor at 3.3 percent and made no change to the conversion factor used to determine 2005 Medicare ambulance fee schedule rates. CMS estimates that there will be an average 3 percent increase in Medicare revenues for all ambulance suppliers and providers that furnish services to Medicare beneficiaries.

A transition to 100 percent payment under a fee schedule began in 2002, replacing the retrospective reasonable-cost payment system for providers and the reasonable-charge system for suppliers of ambulance services. During the transition period, the ambulance inflation factor is applied to both the fee schedule portion of the blended payment amount and to the reasonable charge or cost portion of the blended payment amount separately for each ambulance provider or supplier. These two amounts are combined to determine the total payment amount for each provider or supplier.

For additional information on the changes to the Medicare ambulance fee schedule, visit the CMS Web site at http://www.cms.hhs.gov/.

AMR and EmCare Sold to Canadian-based Onex

Onex Partners LP, an affiliate of Onex Corporation, will purchase American Medical Response (AMR) and EmCare from Laidlaw International, Inc. for $820 million (U.S.$) by the end of March 2005, in an announcement released in a recent press release. The Abaris Group received contact from AMR staff indicating that senior management at AMR will remain intact, including President and Chief Executive Officer William A. Sanger.

"AMR and EmCare represent two excellent platforms for growth in the emergency medical services industry. Both companies have industry–leading positions, significant and stable customer bases and an experienced management team led by William A. Sanger, CEO of AMR and EmCare," said Robert Le Blanc, an Onex Managing Director. "We believe that this investment will enable the management team to take advantage of future growth opportunities that will create shareholder, customer and patient value."

Onex has said that senior management at AMR and EmCare will also be investors and owners. According to a Denver Post article (Dec. 7, 2004), Sanger reported that AMR and EmCare have had double-digit growth in the past three years, producing about $1.6 billion in annual revenue. SEC filings show that AMR generated most of that, reporting a little more than $1 billion in revenue and $86.6 million in earnings before interest, taxes, depreciation and amortization in fiscal year 2004.

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Medicare Announces Payment Boosts and Policy Changes for Outpatient Services

Physicians and hospitals that provide outpatient services, including EDs, will receive higher payments in 2005 from the Medicare health insurance program. Payments for outpatient services at hospitals will rise by 3.3 percent to account for inflation, the Centers for Medicare and Medicaid Services (CMS) announced.

The final rule implements provisions required by the Medicare Modernization Act (MMA) of 2003 for preventative services in hospital outpatient departments. In addition to the new "Welcome to Medicare Physical" for new beneficiaries, the rule also increases payment rates to physicians and hospitals for screening examinations that Medicare already covers.

"The new rule makes it possible for people with Medicare coverage to obtain quality preventative and treatment services in hospital outpatient departments."

Mark B. McClellan, M.D., Ph.D.
CMS Administrator

The final rule reduces the maximum coinsurance rate for outpatient services to 45 percent of the total payment to the hospital in 2005, down from 50 percent in 2004. Under the Medicare law, the cap on coinsurance rates is to be reduced gradually until all services have a coinsurance rate of 20 percent of the total payment.

"The new rule makes it possible for people with Medicare coverage to obtain quality preventative and treatment services in hospital outpatient departments," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "The rule also will make it easier and faster for beneficiaries to receive state-of-the-art treatment."

Medicare beneficiaries will have greater access to preventative benefits, quicker access to new technologies and lower copayments for hospital outpatient services.

The expanded benefits and increased payments result from the MMA and are included in the 2005 Physician Fee Schedule rule, which will become effective January 1.

For additional information on the payment rates and policy changes for hospital outpatient services, visit the CMS Web site at http://www.cms.hhs.gov/.

California Funding for Emergency Care Fails

Voters failed to pass Proposition 67, a measure on the statewide November 2nd ballot to fund uncompensated emergency services. Seventy-two percent of voters opposed Proposition 67.

The initiative would have raised $550 million by adding a surcharge on residential telephones throughout the state. A majority of the funds would have been allocated to hospitals, physicians and clinics, and the remainder would have gone to first responders.

Proposition 67 faced strong opposition from telephone companies, which spent more than $6.5 million in the campaign. The measure also lacked a clear message to the public that the levy would have stabilized the emergency care system in the state.

AMR and EmCare Sold, *continued*

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Onex Partners LP, headquartered in New York, is a $2.2 billion private equity fund established by Onex Corporation. Onex Corporation is a diversified company with global operations in service, manufacturing and technology industries, and is one of Canada's largest companies, with $15 billion in annual sales and 80,000 employees. Onex holdings include Magellan Health Services, the leading provider of managed behavioral healthcare and insurance services in the United States.

The Laidlaw press release can be found at http://www.laidlaw.com/ and the Onex Corporation Web site at http://www.onexcorp.com/intro/default_template.asp.

The State of Trauma Centers

In an update to our last TAG Line newsletter, trauma centers throughout the country are facing increased pressure. The Los Angeles County Board of Supervisors voted to cut services at Martin Luther King Jr./Drew Medical Center's Level I trauma center on Dec. 1 and close it completely by Feb. 1, 2005. Recently, the Board has announced the approval of a Level II trauma center at California Hospital Medical Center in downtown Los Angeles which will provide coverage for 1,200 displaced trauma patients at MLK.

In the meantime, ambulances are no longer taking patients to San Jose Medical Center's (SJMC) ED as of Dec. 9 and thus the Level II trauma center will close as well. Although the interest to purchase SJMC has come and gone, hospital officials have proposed moving the trauma center to its nearby sister hospital, Regional Medical Center, a process that can take months.

In an effort to accommodate an expected annual increase of 800 trauma patients from SJMC, Stanford University Medical Center will hire additional staff members, add additional beds to their ED and reconfigure boundaries for its ambulance service area.

California's trauma system has had many changes throughout the years, depending on state funding and other sources to cover the financial gap. Leonard R. Inch from the Sierra-Sacramento Valley Emergency Medical Services Agency estimated an additional $600 million a year in funding is needed to maintain the current trauma system in California, which consists of 42 trauma centers. Some areas in California are without access to standardized trauma care. Counties, such as Ventura, have no trauma centers at all while others, such as Los Angeles County with 13, financially struggle to serve an excess of uninsured patients.

To view the Sierra-Sacramento Valley report recommendations, visit http://www.ssvems.com/.

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 abarisgroup.com or email subscriptions@abarisgroup.com.

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