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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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The Abaris Group Celebrates its 20th Year!

This year The Abaris Group celebrates its 20th year of providing its clients with expert healthcare consulting.

Over the years we have expanded our scope from trauma centers, to hospitals and hospital systems, to ambulance services, to county safety nets, to statewide diversion. All the while, maintaining our standard of high quality service to our clients.

This year will bring, among other things, a new TAG logo advertising our 20 years (see above), in addition to a complete overhaul of our TAG website. The new website will feature video clips, a blog to facilitate discussions on issues important to our clients and TAG Line readers, and a secure retail site.

Thank you for trusting us with your business needs. We hope to continue to provide innovative solutions for our clients in the healthcare industry.

Hospitals Struggle Over Recession Woes

It is virtually impossible to find an industry that has not been drastically affected by the recession, and unfortunately the healthcare industry is *not* one of them. Over the past six months, hospitals across the nation have been closing down departments, (psychiatric, pediatric and obstetric are the most common), and reducing the number of emergency department beds.

The number of paying patients and elective procedures are decreasing, while the number of uninsured is rising. Approximately 2/3 of hospitals saw a decline in elective procedures and admissions declined by 1/3 over six months.

Some hospitals, such as the UCLA Medical Center have even seen increases in emergency department visits of 25 percent over 6 months. The increase in cash-strapped individuals means that more patients are holding off on receiving medical care until they absolutely need it, which will likely lead to further increases in emergency visits.

These factors are hitting the healthcare industry, especially the emergency industry, with what some are calling a "triple whammy" of: (1) healthcare safety net seeing an increase in the uninsured; (2) employers scaling back coverage; (3) states seeking to further cut healthcare programs.

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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 3 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)

Cost Recovery for Fire Department Paramedic Programs

The current economy has had an impact on most of the nation's fire departments resulting in fire chiefs having to find areas of their budgets where they can cut costs. Another alternative to cutting the budget is to explore cost recovery opportunities. First response fees for paramedic level services with a corresponding paramedic membership program can generate revenues to offset some of the department's costs.

Property taxes are usually based on the cost to provide basic fire protection. Increasing taxes to pay for paramedic level services would be difficult in light of the public's opinion that they already pay too much in taxes. The implementation of paramedic first response fees and a paramedic membership program is an alternative revenue source to taxes for EMS and is considered a user fee.

In a recent study conducted by The Abaris Group, it was noted that several California cities have had these types of programs in place for many years generating significant revenues. The amount charged for first response ranged from $100 to $400 with some cities charging a higher fee for non-residents. One fire department supplements its budget by 25 percent from first response fees and a membership program. An analysis for a small southern California fire department (< 10,000 EMS runs/year) that is considering the implementation of a paramedic first response fee and a paramedic membership program, projected conservative revenues of up to $250,000 a year.

A paramedic membership program consists of an annual fee paid voluntarily by households and businesses that provides a waiver of the response fee charged by the fire department or insurance co-pay if insured. The incentive to join the program is to avoid out of pocket costs in the event they need paramedics. The original concept for this type of program was developed in the early 1980s by Chief Dennis Murphy and was called Fire-Med. In The Abaris Group study, membership fees ranged from $24 to $60 a year. The fees are commonly billed monthly on a local government utility bill.

The combination of a paramedic first response fee and a paramedic membership program can generate significant revenues back to a jurisdiction and is worthy of consideration.

If you would like to know more about alternative revenue sources for fire department, see our upcoming "white paper" on the subject soon to be published.

Author: Ken Riddle, Deputy Chief (Ret) and Senior Consultant at The Abaris Group

9-1-1 Frauds On The Rise

There appears to be an increase in a new form of 9-1-1 fraud that takes advantage of internet-based phone services. In some cases the fraudulent "prank" calls have led to the deployment of SWAT teams to scenes of gruesome crimes that did not occur. Due to the common deployment of SWAT teams for these calls, they are being referred to as "swatting" calls.

From his home in the small town of Mukilteo, WA, 18 year old Randal Ellis used an internet-based phone service for the hearing impaired to dial 9-1-1 and report a drug-fueled murder in Southern California. Because of his use of the internet he was able to mask his location and lead the 9-1-1 dispatchers to believe that he was calling from inside the home where the crime was occurring.

Believing that this was a legitimate emergency, 30 police officers, SWAT officers, ambulance and other emergency crews sped to the scene. SWAT teams stormed into the home as Mr. and Mrs. Bates and their two children were sleeping, and arrested the couple. Only after an interrogation and investigation of the home did the police realize that this was an elaborate hoax; a hoax that cost the agencies $14,700.

After weeks of further investigation the police arrested Ellis for the Southern California call as well as 184 other fraudulent calls, which landed him three years in prison.

Unfortunately, Ellis is not the only one who has exploited the weakness in the dispatch system. A number of arrests for these swatting calls have occurred in the past couple of years including:

- Eight in Dallas charged with 300 swatting calls
- Salinas, CA man victim of assault rifle charge
- Worcester, MA teenage hacker called in school bombings
- Hiawatha, IA business had numerous fake calls of workplace shooting

Roger Hixson at the 9-1-1 National Emergency Number Association has stated that "we're not able to cope with this well." Gary Allen, editor of Dispatch Monthly, confirmed this sentiment, stating that dispatchers are "totally at the mercy of the people who call."

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Decreasing Re-hospitalization

A recent study published in the Annals of Emergency Medicine found that implementing a structured discharge package can reduce re-hospitalization.

The study was performed at a large academic hospital and included 749 emergency department (ED) patients (mean age 50). The study implemented a discharge program where the participating patients were paired up with a "nurse discharge advocate" who arranged follow-up appointments, confirmed medication reconciliation, and educated the patient with an individualized instruction booklet that was also sent to the patient's primary care physician.

After the intervention, 370 (49 percent) of the patients had a lower rate of ED utilization. The researchers calculated that the total cost savings for the patients who received the information averaged $412. This calculation took into account actual hospitalization costs plus the estimated outpatient costs.

This study was limited by the fact that it was only conducted at one facility. Further tests will be required to prove more definitively that the intervention is globally effective.

The full article can be found in *Annals of Internal Medicine* 2009 Feb 3; 150:178.

9-1-1 "Swatting", *continued*

(Continued from page 2)

Due to the chronic low budget of dispatch services, especially in this recession, it is unlikely that they will be able to make sweeping changes in their security. However, Gary Allen offers some solutions, if and when funds permit: (1) upgrading dispatch center computers to show an internet caller's IP address (2) upgrading computers to identify calls from internet phone services and show name of service provider, which could cost upwards of $5,000.

Law enforcement officers are hoping that the arrests and considerable jail time applied to those committing "swatting" will deter others from committing the fraudulent act. Aside from determent and a costly upgrade to the dispatch systems, there is nothing to prevent more people from "swatting" in the future.

Other news reports of "swatting"

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 3 of 3

There are many steps EDs can take to improve their financial performance. Among these are charge master enhancements, coding management and improving billing and collections. Another somewhat novel form of improving the bottom line is to reduce or eliminate ambulance diversion.

The financial benefits of reducing diversion are apparent from the experiences of hospitals such as Ingalls Memorial Hospital, a 424-bed hospital in the Chicago suburb of Harvey, Illinois. An article in Healthcare Financial Management (HFM) described the success Ingalls has had reducing diversion by 79 percent through a series of initiatives to increase admissions. HFM reports that the hospital increased its inpatient revenue to 26 percent over budget.

Each ED has a unique mix of costs and revenues. When evaluating these, it is worth keeping in mind that the financial benefits of the ED may extend into other cost centers, that there may be additional insured patients wanting to utilize the ED, and as well there are many other strategies for improving financial performance, including not turning away patients with ambulance diversion. It has also been The Abaris Group's experience, after conducting in excess of 1,200 ED financial studies, that EDs tend to under charge for their services, do not have state-of-the-art registration tools, and lack other important revenue-cycle management practices to achieve success.

No ED should rely on historical presumptions or myths that may drive resource access. It has been The Abaris Group's experience that by conducting a special hospital study and evaluating charge masters, the entire revenue cycle and methods to make

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Some EMS Agencies Allow Charge Without Transport

San Joaquin County, located in California's Central Valley, recently began allowing emergency ambulance service providers to charge patients without providing transport. The ambulance providers are permitted to bill non-transported patients in two cases: (1) the patient receives one ore more advanced life support (ALS) procedures; (2) the patient is determined to be deceased by a base hospital physician following an ALS assessment.

The change occurred after a community ambulance manager wrote a letter to the County indicating significant losses from non-transport calls, between 10 and 20 percent. Medicare and Medicaid billing rules allow for some non-transport payments.

The state of Utah allows similar charges until 2006, when the state legislature passed a bill banning charges without transport. Crisp County in Georgia charges $50 for non-transport, some Colorado counties charge a base rate of $150 when procedures are provided; and Jackson County in Oregon recently defended their right to charge $267 for non-transport fees.

While this is not a new phenomenon, as the recession looms and as revenues reduce , ambulance providers and fire departments will likely be hunting for cost recovery opportunities and new sources of revenue. The Abaris Group expects to see more emergency providers appealing to the local EMSAs to implement non-transport fee policies to assist in this cost recovery effort.

Ask Abaris, *continued*

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improvements that often improve in EDs financial performance can be between 5 to 15 percent. Don't be a victim of these historical biases of your ED but attack the ED revenue work as a strategy where noting is sacred and develop your own customized ED financial performance improvement plan.

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.

University of Chicago ED To Begin Selecting Their Patients

In an attempt to cope with increases in volume, long waits, and costs, the University of Chicago's ED is restructuring its up front assessment process to selectively accept patients. The facility has not released specific changes, but has stated that it intends to create more physician and nurse evaluations at the front end of the patient process.

The hospital has struggled with increasing uninsured and Medicaid patients. The recession and months delayed reimbursements from Medicaid has exacerbated the issues. The facility calculated that ~40 percent of its 80,000 ED visits are cases that could be cared for at other lower cost sites such as clinics.

Patients that are triaged and have conditions that can be cared for at another facility will be educated about their options for care in the community. The patient, if able, provide their own transport, otherwise the facility will arrange for transport. Depending on the situation, the hospital will also schedule an appointment for the outgoing patient.

Up front assessments in this manner can be tricky and sometimes detrimental to the hospital and patient and potentially an Emergency Medical Treatment and Active Labor Act (EMTALA) violation. The correct policies and education must be in place to ensure that patients are properly evaluated prior to the decision to admit/discharge; otherwise, they risk sending severely ill patients home.

This is not the first attempt by a hospital to alter their up front assessment practices in this manner. Other hospitals across the country have tried this approach in the past and then ask for a deposit if the patient does not need the ED. This is usually confronting significant public backlash, only to return to more common triage operations.

The Chicago Tribune report can be found here.

Hospital Recession Woes, *continued*

(Continued from page 1)

Hospitals in California continue to find themselves in a particularly distressing bind, with the California Budget just recently approved and the state withholding Medicaid payments to providers. Previously hospitals would turn to borrowing until their Medicaid reimbursement arrived, but the credit freeze has made that prospect much more difficult.

In addition, many insured Californians have high deductible plans, and with less money to pay their deductible, some hospitals are seeing an increase in their uncollectible bills. North Bay's VacaValley and Fairfield hospitals in Northern California recently reported a $5 million increase in uncollectible bills over the past six months.

The recent passing of the economic stimulus plan, intending to pump billions into healthcare, is unlikely to provide significant relief for hospitals and ED. However, the reported $25 billion for subsidies under COBRA and the additional $87 billion in federal Medicaid funds may help the healthcare industry weather the storm.

The American Recovery & Reinvestment Act can be viewed here. The Los Angeles Times report can be viewed here.

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 these CDs and to register for future webinars, please visit: www.abarisgroup.com.

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ABARIS GROUP
CELEBRATING 20 YEARS OF INNOVATION
1989 - 2009

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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