Volume 6, Issue 4 July/August 2009

ABARIS GROUP
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The Abaris Group

The TAG Line

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Abaris' California ED Diversion Report Released

With support from the California HealthCare Foundation (CHCF) based in Oakland, CA, The Abaris Group conducted the California ED Diversion Project, which analyzed ED and emergency medical services (EMS) diversion in all 31 local EMS regions in California. In addition, The Abaris Group inventoried best practices and invited a sample of EDs and local EMS agencies to participate in a collaborative to reduce diversion in their region.

The nearly one year collaborative phase involved four regions and 11 hospitals. Each hospital assigned a project sponsor and two champions and submitted a data collection plan for key performance indicators (KPIs). In addition, the participants engaged in monthly coaching calls and three summits.

During this collaborative phase, from September 2007 to June 2008, total diversion hours dropped by 39.8 percent, while ED volume and ED admissions increased by 12.1 percent and 22.7 percent respectively. In addition, the participants were able to improve on a number of KPIs.

This study resulted in the first statewide reporting of diversion hours, EMS

CMS Proposes *Increasing* Medicare Hospital OPPS 2.1 Percent and *Decreasing* MPFS 21.5 Percent

On July 1st and 13th the Centers for Medicare and Medicaid Services (CMS) released the proposed changes for the Hospital Outpatient Prospective Payment System (OPPS), including EDs, and the Medicare Physician Fee Schedule (MPFS) for the 2010 calendar year.

Hospital Outpatient Prospective Payment System

While the CMS initially indicated that there would be a 1.9 percent increase in reimbursement rates for hospital OPPS, on July 9th they released a correction, announcing that there would be a 2.1 percent increase. The proposal includes measures to allow hospitals to bill for outpatient pulmonary and cardiac rehabilitation services and permits rural hospitals to bill for kidney disease education for Stage IV beneficiaries. Emergency Departments (EDs) will see an increase of 2 to 2.5 percent for Level 1-3 and Level 5 visits and a 3-5 percent increase for Level 4 and Critical Care visits.

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Upcoming Webinars:

Coming this Fall —

CMS Proposed Changes to Medicare Hospital Outpatient Compensation and Physician Fee Schedule for CY2010: a look at the proposed changes and how they will affect hospitals, EDs, and physicians.

Self-Pay Collection Strategies: this Webinar will look at self-pay accounts and identify strategies to collect payments from them.

The Abaris Group will notify you of the dates and times of these Webinars.

Ask Abaris Column:

This 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

Most Retail Clinics Are Located In Affluent Areas

A recent study published in the *Archives of Internal Medicine* has revealed that the majority of retail clinics are located in affluent areas. The researchers mapped the locations of 930 retail clinics nationwide and evaluated their locations using the 2000 US Census and the Health Resources and Services Administration's 2008 health data. The researchers then compared census tracts that had retail clinics with those that had no retail clinics.

The results were:

- 18 states had no retail clinics and 17 states had 25 or more clinics.
- 13 percent of retail clinics are in underserved communities
- 18.5 percent of retail clinics are near non-white populations
- The home-owner rate in communities surrounding clinics is 65 percent.
- Areas with clinics have a median income of $58,544
- Areas with clinics have a poverty rate of 7 percent

The researchers also noted that one-third of the chain stores that operate retail clinics are located in medically underserved areas. If those stores were to open a retail clinic, the medical access in those areas could potentially improve.

Although some proponents of retail clinics have touted their potential to provide greater access to affordable healthcare for the underserved communities, others claim that this was not the intention of such clinics. A statement from the Convenient Care Association (CCA) stated that, "the convenient care industry was never devised as a safety net."

Despite these assertions, the fact that retail clinics provide greater access, lower cost healthcare, and a potential to reduce ED visits, lead one to question why the clinics have not expanded into underserved communities.

The study can be found here.

The HealthLeaders article can be found here.

CMS Proposed Changes, *continued*

CMS Percent Change in Medicare Hospital Compensation for ED Charges, 2009 vs. 2010 (proposed)

HCPCS	Description	Percent
99281	Level 1 Emergency Visit	1.9%
99282	Level 2 Emergency Visit	2.6%
99283	Level 3 Emergency Visit	2.6%
99284	Level 4 Emergency Visit	3.4%
99285	Level 5 Emergency Visit	2.1%
99291	Critical Care, First Hour	4.8%
G0390	Trauma Activation	-14.1%

Source: CMS, Proposed 2010 OPPS, Released July 1, 2009

CMS Percent Change in Medicare ED Physician Charges, 2009 vs. 2010 (proposed)

HCPCS	Description	Percent
99281	Level 1 Emergency Visit	-15.9%
99282	Level 2 Emergency Visit	-15.7%
99283	Level 3 Emergency Visit	-18.7%
99284	Level 4 Emergency Visit	-18.8%
99285	Level 5 Emergency Visit	-20.3%
99291	Critical Care, 1st Hr	-18.0%
99292	Critical Care, Each Add'l 1/2 Hr.	-18.0%

Source: CMS, 2010 Proposed Physician Fee Schedule, Released July 13, 2009

Also, the CMS proposes to increase the ties between payment and quality in a number of ways. One, by reducing payment to non-participating hospitals for the Hospital Outpatient Department Quality Reporting Program (HOP QDRP) to two percent less than the CY2010 rate. Two, to implement a new validation requirement to ensure accurate reporting of the quality measures; however, this would not be effect hospitals until FY2012. Three, the proposal includes 16 new quality measures for future OPPS updates, including ED throughput, overuse/appropriate use, and health information technology.

Medicare Physician Fee Schedule

Although the CMS and Congress have taken steps in the past few years to avert a reduction in the MPFS rates, the CMS is currently projecting a CY2010 rate reduction of -21.5 percent. There will be a slight increase in emergency physician relative value units (RVUs), but due to a decrease in the conversion factor, payments for ED visits will decrease under the proposed rule. For emergency visits (CPT codes 99281-99285, 99291) there will be a 17.9 percent average decrease (15 percent for Levels 1 & 2, 18 percent for Levels 3 & 4, 20 percent for Level 5, and 18 percent for Critical Care).

In addition, the CMS has proposed to stop payment for consultation codes and require that consultative services be paid as an E/M service. The CMS will also maintain the 2 percent bonus for physicians who participate in the Physician Quality Reporting Initiative. Other notable proposed changes are: the refining of practice expenses (i.e. "removing physician-administered drugs from the definition of 'physician services"); malpractice cost evaluation; and revised time estimates for complex imaging machines.

The CMS will accept comments for both the proposed OPPS and MPFS until August 31st and will publish the final changes on November 1, 2009.

The CMS Proposed CY2010 Hospital OPPS can be found here.

The CMS Proposed CY2010 Physician Fee Schedule can be found here.

Hospitals Consider Putting Federally Qualified Health Centers Inside Their EDs

Frustrated by the continual in-flow of uncompensated care visits to the ED, Detroit's hospital systems are debating whether to implant federally qualified health centers (FQHCs) inside their EDs. FQHCs are clinics that provide primary care to medically underserved communities.

In 2008, charity care in Wayne County (where Detroit is located) reached $700 million and statewide it reached $2 billion. The executives at the Detroit hospitals hope to curb these costs by diverting patients to the FQHC instead of treating them in the ED. They argue that treating a patient in the ED will cost an average of $500, whereas an FQHC visit will be approximately $40 for a visit. Since FQHCs are typically reimbursed by Medicaid at the full cost of the visit, there may be an additional advantage. Aside from the financial benefits, shifting some patients to the FQHC could reduce overcrowding in the ED and increase quality of care by sending the patients to the appropriate department.

However, not everyone is supportive of the idea, and are concerned that the hospitals may violate EMTALA and also may not treat patients equally in such a design. The supporters of the idea counter that each patient entering the ED would be triaged and cared for in the appropriate setting regardless of their payment ability. They assert that only the low acuity patients would be directed to the FQHC.

At this time, the hospitals are still debating the project and whether they will move forward with it.

Further information regarding this article can be found in the September 2009 issue of *ED Management*.

CA ED Diversion, *continued*

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transports and the analysis of why some communities seem to handle diversion better than others. It also provided a demonstration of the benefits of a collaborative approach between EMSAs and hospitals.

In addition to the report, there is also a section of the project's web site dedicated to resources that address the diversion issue. Here one can find best practices and tools that are being used to help reduce diversion.

For more information on the collaborative, the report, or the toolkit, visit CAEDDiversionproject.com.

You can also read the corresponding CHCF Issue Brief, Reducing Ambulance Diversion in California: Strategies and Best Practices.

Ambulances Make Non-Emergent House-Calls

MedStar, an ambulance provider in Fort Worth, TX is concerned over the 'frequent flyers' that its ambulances routinely transport to the areas EDs. So-called 'frequent flyers' are patients who visit the ED numerous times per year. In 2008, 21 'frequent flyers' were transported 812 times, with approximately a dozen who were transported at least 40 times, and one patient that was transported 127 times. Altogether, these transports amounted to a bill of $900,000, of which MedStar has only recovered $150,000.

The extent of the costs and the number of transports has led MedStar to begin a community health program in August 2009. Under this program, MedStar's paramedics will begin routine medical visits to the 'frequent flyers' in an attempt to prevent future 911 use for non-emergency care. Patients who would like to participate, must enroll for the program. The program is expected to cost MedStar $500,000.

This article may be viewed here.

Ambulance Laptops Linked To Hospital Medical Records

Wishard Health Services (WHS) in Indiana recently linked 25 ambulance laptops with the hospital's records. With this new link, the ambulance staff can now review a patient's medical history, blood type, and prescriptions from the field. WHS is a not-for-profit healthcare system in Indianapolis that owns and operates the EMR-linked ambulances.

This program is anticipated to not only save critical minutes in retrieving patient information, but also provide the medic with more accurate information via the patient's medical records rather than relying on a friend or family member to fill in the blanks.

The health system has spent $6million on the project, which was mostly funded by the Urban Area Security Initiative.

Further information can be found here.

Most California Hospitals Will Not Meet Seismic Retrofit Deadline

The California Hospital Association (CHA) reported in July that 64 percent of California hospitals will not meet the states 2013 or 2015 seismic retrofit deadlines. The legislation, passed in 1994, requires that all California hospitals meet new seismic standards by 2013 or 2015. The RAND Corporation estimates that the costs for this mandate will reach $110 billion.

Although approximately 50 percent of hospitals may be able to take advantage of the seismic reclassification under the HAZUS program, which moves their seismic mandate to 2030, there are still a number of hospitals that will not meet the original deadline or qualify for the postponement. This may lead to state forced closures of California hospitals.

The CHA reported that due to the states' financial struggles, many hospitals are unable to start/ continue their transition toward compliance with the mandate. Some specific struggles mentioned included: limited access to capital; increased cost of borrowing; increase in uncompensated care; decrease in both admissions and elective care.

The CHA report can be found here.

A history and description of the California Seismic Safety law can be found here.

The Health and Safety Code can be found here.

The RAND study can be found here.

Death Rates Following Hospitalization For Heart Attack Decreases

According to a study published in the August issue of the *Journal of the American Medical Association (JAMA)*, hospital 30-day mortality rates decreased significantly for patients suffering a heart attack. In addition, the variation in mortality between hospitals decreased.

The study evaluated 3.2 million discharges between 1995 and 2006 for Medicare patients in non-federal hospitals. The results were that:

- 30-day mortality rates for heart attack decreased from 18.9 percent to 16.1 percent
- In-hospital mortality rates for heart attack decreased from 14.6 percent to 10.1 percent.
- 30-day mortality rates for all other conditions decreased from 9.0 percent to 8.6 percent

Although the cause of such decreases have not been determined, the study indicates a positive step towards improved patient care and may reflect a success in quality improvement initiatives.

The JAMA report can be found here.

Some EDs Unprepared For Recent H1N1 Outbreak

According to a report in the latest issue of *ED Management*, some EDs were unprepared for the sudden surge in patients during the H1N1 outbreak. Hospitals were already experiencing increases in EDs visits as a result of the recession, so the sudden influx of H1N1 patients overwhelmed many hospitals.

To date, there have been 8,843 hospitalizations and 556 deaths in the US associated with the H1N1 virus. The Centers for Disease Control and Prevention (CDC) is predicting that this Fall as many as 40 percent of Americans may be affected by the virus. Hospitals should heed the warning of the recent outbreak and ensure that there are programs/ procedures in place that account for the potential surge.

CDC updates on H1N1 can be found here.

First Nationwide Study of Homeless Patients in EDs

A recent study by West Virginia University evaluated the characteristics of the homeless population that visit EDs across the nation. The study evaluated insurance status, ambulance transport, admission rate, and acuity level, among other factors, and compared those with ED patients who are not homeless.

The study concluded that one-third of homeless patients arrive at an ED by ambulance and cost a total of $67 million. In addition, although homeless patients are more likely to have more diagnostic tests than other ED patients, their acuity level and admission rates were similar to non-homeless patients. Two-thirds of homeless ED patients were white and three-quarters were male.

The researchers utilized data from the National Center for Health Statistics (NCHS) 2005 National Hospital Ambulatory Medical Care Survey.

The WVU news release can be found 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?

Optimizing and ED's Design for the Future

Many lessons are known about optimizing the ED design for the future and those mistakes that have been made are also now well known. This webinar will look ED design from the standpoint of poor design methodologies and design flaws as well as model design processes and their design.

For more details on purchasing these CDs 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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