The Chili Pepper Express Newsletter

January 31, 2011

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President's Corner

Brenda Cox
Chapter President
2010-2011

Happy New Year! Really! In July, I wished all chapter members good will for our new HFMA annual cycle.

Today, I am sending good will to all our members for a successful new calendar year! 2011 will bring changes and challenges our way. I am confident that abundant resources exist to help us turn any challenge into a great success!

While each of us continues to have our unique situation and challenges, we can all benefit from sharing our professionalism and knowledge through sharing our experiences and building new and stronger friendships through HFMA.

HFMA strives to be the leading resource for healthcare financial professionals at the state, region and local level. The national website is full of articles, seminars, and educational opportunities that support our profession. Our local Region 9 annual conference in New Orleans in November exposed attendees to best practices for RAC Audit responses, accounting techniques and leadership training.

Our local chapter educational offerings begin with the annual Healthcare Landscapes conference in San Antonio on January 28th. Road shows topics for denial management

and revenue cycle are scheduled throughout our chapter geography in February. This year's statewide conference is set in Austin on March 27-29th at the Driskill Hotel with speakers on topics that include legislative update, revenue cycle key performance indicators, employee benefit redesign and physician hospital alignment.

Along with all of these educational activities, the chapter offers opportunities to establish professional relationships through networking. These relationships have increased my knowledge and understanding of the profession as a whole.

Please use your membership to enhance your profession to better meet the changes and challenges of today that will become successes tomorrow. I hope to see you at one of these exciting meetings!

We are here to make your South Texas chapter an essential part of your successful career.

It is an honor to serve you,

Brenda Cox, FHFMA
South Texas President

Meeting Calendar

Mark your calendars **NOW** so you won't forget to attend STX HFMA's meetings during the upcoming year. Our scheduled meetings are:

Date	Meeting	Location
On demand access through February 26, 2011	Virtual Healthcare Conference	Online
February 9, 2011	Education Roadshow	San Marcos, TX
February 10, 2011	Education Roadshow	Uvalde, TX
February 16, 2011	Education Roadshow	Weslaco, TX
February 17, 2011	Education Roadshow	Laredo, TX
March 27-29, 2011	HFMA Texas State Conference 2011	Austin, TX
May 26-27, 2011	South Texas Chapter Annual Institute	South Padre Island, TX
June 26-29, 2011	2011 Annual National Institute	Orlando, FL

ANI: The Healthcare Finance Conference The 2011 ANI: The Healthcare Finance Conference will be held at the Gaylord Palms Resort and Convention Center, Orlando Florida from June 26-29, 2011.

Chapter Involvement Opportunities:
The South Texas Chapter Needs YOU!!

Attention members. Your Chapter desperately needs committed members to serve on key committees:

- **Sponsorship Committee**
  recruits sponsors and coordinates sponsorship activities
- **Certification Committee**
  teaches certification courses and proctors exams
- **Program Committee**
  develops agendas and recruits speakers for the Chapter's meetings
- **Newsletter Committee**
  drafts articles for the quarterly "Chili Pepper Express" newsletter
- **Membership Committee**
  recruits new members and manages social events for the membership

This is a great way to get involved, learn about the inner workings of the South Texas Chapter, make new friends, and position yourself to move up to a senior leadership position. Please contact any of the Chapter's Officers or Committee Chairs for more information. PLEASE VOLUNTEER TODAY!!!

HFMA Texas
State Conference 2011

March 27-29, 2011
The Driskill Hotel
Austin, Texas

Featured Speakers

Drayton McLane, Jr. is chairman of McLane Group, L.P., and chairman and CEO of the Houston Astros Baseball Club.The McLane Group, L.P., based in Temple, Texas, is still a family-owned holding company that consists of McLane International, Classic Foods, Leading Edge Brands, Lone Star Plastics, Inc., M-C McLane International, CSP (Convenience Store/Petroleum), Trade Magazine, and the Houston Astros Baseball Team. McLane Group's latest venture is McLane Advanced Technologies (MAT) which combines Drayton's family history and experience with a conglomerate of professionals from military and commercial backgrounds.

Mary Beth Briscoe is CFO of UAB University Hospital in Birmingham, Alabama and a former National Chair of HFMA. She has received the Follmer Bronze, Reeves Silver, Muncie Gold, and Medal of Honor merit awards. Ms. Briscoe, a Fellow of HFMA, a Fellow of The American College of Healthcare Executives, and a Certified Public Accountant, earned her BS degree in Accounting from the University of Alabama, Tuscaloosa, and her MBA from the University of Alabama at Birmingham.

Joel Allison is President and CEO of Baylor Health Care System in Dallas, Texas | Mr. Allison's career includes more than three decades in health care management. He has received numerous recognitions during his career for his outstanding leadership and commitment to the healthcare field. Mr. Allison received a bachelor's degree in journalism and religion from Baylor University in 1970 and a master's degree in health care administration from Trinity University in 1973. He is also a graduate of the Advanced Management Program at Harvard Business School.

For details and registration information visit www.hfmatexas.org

Comparing Active vs. Passive Management

Reprinted with permission from Lancaster Pollard's "The Capital Issue" at www.lancasterpollard.com.

Manager selection is an important part of constructing an institutional investment portfolio; however, before deciding on a specific investment manager, institutional investors must first decide whether to use active management or passive management. Given the proliferation of index strategies over the last 35 years, institutional investors have a number of passive investment strategies that are less costly than active management and cover nearly every market or asset class imaginable. Ideally, institutional investors should focus on using active management in those asset classes where active managers have consistently outperformed the index, while using passive management to gain cost effective exposure to asset classes in which active management has proved to be ineffective.

> Ideally, institutional investors should focus on using active management in those asset classes where active managers have consistently outperformed the index, while using passive management to gain cost effective exposure to asset classes in which active management has proved to be ineffective.

Research Parameters

To identify those asset classes in which active management is preferred over passive management, Lancaster Pollard Investment Advisory Group conducted a study of the historical performance of actively managed mutual funds within seven different asset classes. The use of mutual fund return data addresses two potential issues related to the analysis of manager performance, specifically fees and selection bias.

Mutual fund returns are reported net of fees, while separate account returns are typically reported to various databases gross of fees. Further, separate account investors pay different fees based on the size of their accounts, while every investor in a mutual fund pays the same fee, as defined by the fund's expense ratio. Therefore, it is difficult to generate net of fee performance for separate account managers. The cost associated with active management is an important consideration when analyzing the performance of active managers relative to the appropriate benchmark.

Selection bias occurs when a manager stops reporting performance to a database. This is most prevalent within separate account manager databases, to which reporting is voluntary, and typically happens after the investment manager has experienced a period of bad performance. Selection bias results in the worst performing managers being eliminated from the universe when they stop reporting performance, which artificially inflates the returns of that universe. Therefore, selection bias can cause active management to appear more effective relative to the index than is actually the case. Conversely, mutual funds are publicly traded vehicles, so managers cannot choose when to report performance. As a result, mutual fund universes typically have less selection bias relative to separate account databases.

The final issue addressed in designing the study was endpoint sensitivity, which is the risk that performance during the period is impacted by the beginning and ending points chosen for the analysis. For example, analyzing a single five-year period may show that a mutual fund outperformed the index; however, this performance might be largely attributable to a single quarter or year within that period when the mutual fund significantly outperformed. A better way to analyze performance is to utilize rolling periods, which allows for analysis over a number of periods and market environments, thereby reducing the impact of endpoint sensitivity.

The study utilized quarterly rolling five-year periods ending between June 30, 2000 and June 30, 2009. This period is be-

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Comparing Active vs. Passive Management

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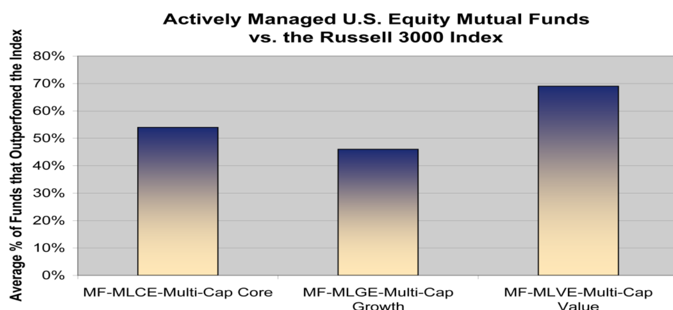
lieved to be sufficiently long enough to capture a manager's ability to generate alpha (returns over those expected from an index-tracking portfolio or other appropriate benchmark) while lessening the impact from a bad quarter or even bad year, both of which are bound to happen for all active investment managers. The first quarterly rolling five-year period was for the period ending June 30, 2000.

Active vs. Passive

Although active manager performance was analyzed in each of seven different asset classes, the most focus was placed on actively managed U.S. equity mutual funds due to the considerable active / passive debate within this asset class. Lancaster Pollard Investment Advisory Group compared the performance of actively managed U.S. equity mutual funds classified as multi cap core, growth, and value by Lipper to the performance of the Russell 3000 Index, which measures the performance of the largest 3,000 stocks in the U.S. Over the 37 quarterly rolling five-year periods ending June 30, 2000 to June 30, 2009, the study found that multi cap value mutual funds performed the best versus the Russell 3000 Index, with 69% of the funds outperforming the index on average during the 37 rolling five-year periods (see chart below).



Said another way, using historical data, there was almost a 70% chance of randomly selecting a multi cap value mutual fund that outperformed the Russell 3000 Index over any given five-year period between June 30, 2000 and June 30, 2009. Conversely, only about half of multi cap core and multi cap growth mutual funds outperformed the Russell 3000 Index on average during this period. Therefore, investors had no better than a 50% chance of randomly selecting a mutual fund in either one of these categories that outperformed the Russell 3000 Index over any given five-year period between June 30, 2000 and June 30, 2009.

Based on this analysis, Lancaster Pollard Investment Advisory Group believes a more efficient solution to constructing a U.S. equity portfolio would be to combine active management with passive management. For example, institutions could utilize an index fund that tracks the performance of the Russell 3000 Index, which would provide broad exposure to U.S. equities, including large cap and small cap stocks as well as growth and value stocks. This index fund could then be complemented with a multi cap value manager that has the freedom to select stocks without regard to market capitalization, while using its own definition of value rather than the definition of value according to Russell, Standard & Poor's, or some other index provider that constructs separate growth and value indices. The resulting U.S. equity portfolio, which would be more heavily weighted toward the index fund than the active fund, should reduce fees and should lead to a greater chance that the combined portfolio will outperform a broad-based U.S. equity index such as the Russell 3000 Index.

Conclusion

When it comes to manager selection, the decision to utilize active management or passive management is an important one, but these approaches need not be mutually exclusive. Rather, the use of active management or passive management is dependent upon the asset class as well as the institution's unique situation. This research has shown that active management is the most effective in certain asset classes, while passive management is more effective in other asset classes. A combination of active and passive management provides many investors with the best chance of outperforming their market benchmarks at the lowest cost possible.

Lancaster Pollard Investment Advisory Group helps nonprofit organizations identify their true risk tolerance and appropriately manage their portfolios. Contact them at (614) 224-8800 or visit www.chiefinvestmentofficer.com for more information.

Certification Program Changes

Dear HFMA Chapter Members,

As your Chapter President, I would like to share with you exciting information about HFMA's Certification Program. HFMA's Certified Healthcare Financial Professional (CHFP) program is now available online, allowing candidates the ability to purchase study materials and access online resources like the complimentary practice exam. The single examination is no longer proctored but can be taken at one of the several hundred sites with Castle Worldwide, HFMA's support partner.

Effective January 2011, the certification requirements are as follows:

- Successful completion of **one comprehensive certification examination designed for mid-level healthcare finance professionals**
- **Minimum of 3-5 years** of healthcare finance management experience

Current and active HFMA membership

SPECIAL OFFER: Apply for CHFP certification by March 31, 2011 and receive $100 off any HFMA product or service (excluding membership dues) of your choice. To take advantage of your discount, call the Member Services Center at (800) 252-4362, ext. 2 and provide discount code CHFPPROMO (members will need to have available their Castle Worldwide exam scheduling notice password and exam date to receive this discount). If you have questions, HFMA's Member Service Center will be happy to assist you at (800) 252-4362 ext 2 or memberservices@hfma.org.

Please forward this e-mail to colleagues and/or staff in your organization today! For more information, visit http://www.hfma.org/certification.

Thank you for your membership in HFMA. I look forward to seeing you at a future HFMA event.

Sincerely,

Brenda Cox, FHFMA

President, South Texas HFMA

Register Now for HFMA's 2011 ANI: The Healthcare Finance Conference

Join us in Orlando, Florida June 26-29, 2011 for a powerful line-up of best-practice sessions led by industry leaders and covering important topics such as Reform, Value, Clinical Transformation, Accountable Care, and Revenue Cycle. In addition, multiple networking opportunities and 27.5 CPEs ensure a valuable experience. **Learn more and register – early-bird pricing now available.**

Become CHFP Certified

HFMA's CHFP (Certified Healthcare Financial Professional) certification is intended for mid-level healthcare professionals with a minimum of 3-5 years experience. Becoming certified distinguishes you a leader as well as a role model in the healthcare finance community. Earning the CHFP credential enhances your credibility, supports your professional development, demonstrates a high level of commitment to the field, and validates your skills and knowledge.

The CHFP Certification Program is Online January 2011

We've made the process of certification more convenient. Beginning January 2011 the requirements to becoming CHFP certified are:

- Active regular or advanced HFMA membership*
- The title Manager and above or equivalent
- The successful completion of one comprehensive certification exam

Also new for 2011, CHFP preparation and study materials will now be available online.

To learn more about becoming certified, visit **www.hfma.org/certification.**

To review FAQs about the program changes, visit **www.hfma.org/certificationFAQ.**

*The two year HFMA membership requirement has been dropped

Education Roadshows

February 9-17, 2011

Speaker: **Benchmark Revenue Management**

4 Hours CPE Credit

Session I
How Many Denials Walking Do You Have? Using Your Denial Information Proactively

This session will begin by examining a few real-world patient access denials to understand how they are generally handled in a business office environment and to see the information regarding those denials is captured and used once the appeal has been generated. Because most business offices are doing quite a bit of research on a denial to make sure it is appealed correctly, then we should assume that such information can be used to avoid that same denial in the future, right? Wrong. Unfortunately, in very few hospitals is the information learned during denial processing ever delivered back to patient access in anything more than an anecdotal way. In this session, attendees will learn processes for capturing that information in a meaningful, trendable, reportable way. We will look at benchmarks for denials and understand which ones should be used to determine how a particular facility stacks up. In other words, where should YOUR target be? Finally, we'll revisit those same patient access denials we examined in the beginning and see how we could have used what we learned from our business office to handle this situation before these patients became "Denials Walking" in our facility.

Session II
Revenue Cycle - Connecting the Dots: Effective Communication and Optimization Across the Revenue Cycle

In this session, speakers will introduce some unique metrics that can be used to tie the revenue cycle together. The concept of what belongs in your definition of revenue cycle is explored. This session will show how data can be used to be the bad guy for all bad news in the revenue cycle. "People point fingers. Data informs." Once we get this notion across, it is much simpler for people to see how they might be able to work together without having to accuse one another of not delivering.

Denials Management / Revenue Cycle Communication and Optimization

Speakers

Lincoln Fish - VP Product Management, Benchmark Revenue Management

Ted Barduson - EVP of Sales and Business Development, Benchmark Revenue Management Cost $35 for both sessions (includes lunch)

San Marcos—February 9, 2011

Central Texas Medical Center

Uvalde—February 10, 2011

Uvalde Memorial Hospital

Weslaco—February 16, 2011

Knapp Medical Center

Laredo—February 17, 2011

Doctors Hospital of Laredo

Agenda

Registration: 9:30 - 10:00 am
Denials Management: 10:00 - 11:45 am
Lunch: 11:45 am - 12:15 pm
Revenue Cycle Communication & Optimization: 12:15 - 2:00 pm

These Sessions are generously sponsored by:

Central Texas Medical Center

Uvalde Memorial Hospital

Knapp Medical Center

Doctor's Hospital of Laredo

and

- **Benchmark Revenue Management**

The Growing Charity Challenge – Form 990 and Health Reform

By Steve Levin CEO, Connance

Providers have made great progress in expanding and developing financial counseling processes over the past several years. Unfortunately, a large number of patients are continuing to fall through the cracks. Many patients meriting financial assistance fail to participate in financial counseling and are instead declared to be bad-debt and sent to collections.

This situation, while disappointing, is taking on new concern with Form 990 filing obligations, in which hospital executives are required to declare the amount of charity they believe they missed by current processes and which ended up as bad-debt. This admission of process breakdown is in addition to documenting the various types of financial assistance delivered and scale of community benefit spending.

It is likely that community groups and consumer advocates will closely study the new information disclosed on the Form 990. They will use this information to form opinions with respect to how well not-for-profit hospitals are delivering on their community responsibilities.

Recently passed health reform legislation is also picking up on this issue, setting expectations for comprehensive financial assistance effort prior to any extraordinary collection activity. How this component of the legislation ultimately is converted into guidelines and operating standards remains to be seen; however, it is hard to imagine that the results will lessen the current anxieties. Similarly, it remains unclear what limits or restrictions the new Consumer Financial Protection Agency will impose.

Size of the Opportunity

Based on research done by Connance and PARO, it is common to find that 20-30% of a provider's bad-debt is from guarantors that would qualify for charity, but slipped through the cracks in the process. This is a meaningful percentage and is sure to attract attention when reported on Form 990.

Of course, the amount of missed charity for any individual hospital varies based on the local market, their specific financial assistance policies, and the financial counseling process in place. Poverty is a local phenomenon.

Root Causes of Missed Charity

Simply working harder under today's standard patient access and financial counseling processes is unlikely to overcome the missed charity issue. Structural challenges stand between many poor people participating in counseling and properly documenting their eligibility.

Consumers living in poverty have less education and higher illiteracy than the average household. While statistics on illiteracy and poverty are limited, the U.S. Department of Education estimates that, *on average*, 1 in 5 Americans are functionally illiterate. With this national average, a sizable share of the poor are very likely unable to fill in a basic charity application or even read a charity sign in the emergency room.

The Federal Reserve estimated that as many as 25% of those living in poverty lack access to traditional "banking" resources such as a savings or checking account.

People living in poverty often lack stable addresses, are immigrants, or are embarrassed by their situation and prefer to not participate in application processes and announce their plight.

The Federal Reserve estimated that as many as 25% of those living in poverty lack access to traditional "banking" resources such as a savings or checking account. This means they are unable to provide financial documentation and databases of such information will not have their information.

Poverty and Credit Scores

The relationship between poverty and credit scores is an interesting one.

It stands to reason that if people living in poverty lack traditional banking relationships they will also lack a credit score. However, the corollary is not true – just because one lacks a credit score does not mean they are poor. There are many reasons other than income that will cause an individual to lack a credit score. Consider the situations of students who are just entering the workforce, someone who is newly widowed or divorced, or recent immigrants.

Next, consider that credit scores are really not an income measure but a delinquency measure. They answer the

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The Growing Charity Challenge

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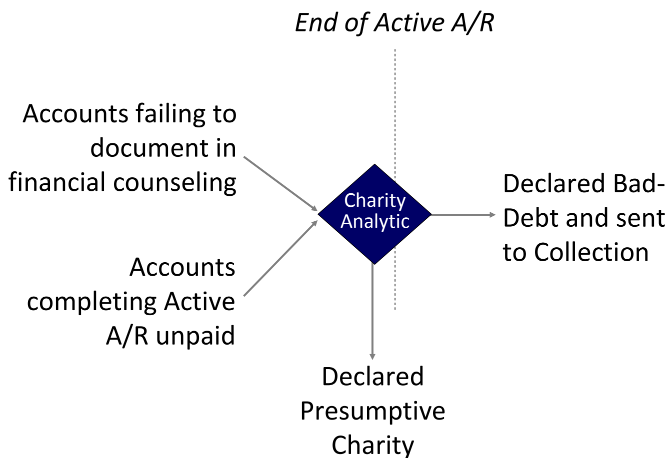
question "is this person likely to repay a new credit obligation?" Poverty is not a question of being overextended or spending more than you make. It is simply a question of income and household structure.

A common example of the difference between credit scores and poverty is an elderly patient living on a fixed income without any property. This patient will often have a bank account and a credit card, which they use sparingly or under tight control so as to never run up a bill they cannot afford. This patient will likely have a solid credit score, but also be eligible for poverty classification based on income. One can contrast this with a middle income consumer who has racked up large bills buying the latest electronics or being overextended on their mortgage. They probably have poor credit scores, but would not meet the charity test for low income.

Presumptive Charity Analytics Leading Solution



Presumptive charity analytics are the leading approach to addressing both day-to-day operational issues of missed charity and Form 990 disclosures. They are a type of predictive model built specifically for identifying accounts eligible for poverty classification. Presumptive charity analytics use publicly available information to predict whether or not that guarantor would have been approved for financial assistance had they participated in the process.

Providers are using predictive analytics to evaluate accounts that fail to document through standard financial counseling processes. Accounts are scored just prior to bad-debt assignment. Those qualifying for presumptive charity are reclassified as such and removed from the bad-debt placement file. Those failing to qualify are declared bad-debt and handled as such.

> Every account, including those that were missed by or failed to participate in financial counseling, are reviewed using a proactive, consistent and repeatable process.

Using a presumptive charity analytic in this fashion complements the existing financial counseling and patient access processes by addressing recognized breakdowns and barriers. Every account, including those that were missed by or failed to participate in financial counseling, are reviewed using a proactive, consistent and repeatable process.

This approach also provides a clear pathway for Form 990 submissions. Hospitals are able to reclassify significant bad-debts as presumptive charity, demonstrating a truer view of their community benefit. The estimate of missed charity ending up in bad- debt is reduced to the error rate of the model applied against bad-debt placements. In total, the institution is communicating a comprehensive and proactive effort to identify and aid needy patients, even those unable to speak up. This is clearly on point with newly passed federal health reform legislation.

In order to implement this approach, charity policies need to explicitly note that presumptive charity can be conferred based on a third-party analytic. Similarly, auditors should be apprised of the decision to implement a presumptive analytic. Their input should be incorporated into the process and policies.

Picking a Presumptive Charity Analytic

There are a range of presumptive charity analytics available to identify missed charity eligible accounts. In picking a model, consider the following elements:

Local calibration. Poverty is heavily weighted to local economic circumstances and socio-economic attributes. Better predictive models will be calibrated during implementation to the hospital's specific community.

How the model handles households without bank accounts and credit files. Credit based models may have challenges with this population. Socio-demographic models are often better able to handle households living in the cash economy.

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The Growing Charity Challenge

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Information required. Some models require a current address and guarantor social security number for scoring. Understanding differences in data requirements is important as it can have significant impact on Patient Access activities.

Portion of accounts a model cannot evaluate. Better models will have broader coverage, e.g. fewer accounts that are not able to be predicted or assessed. Some models cannot evaluate as many as 30% of self-pay accounts, while others will have issues with as few as 1-2%.

Sliding Scale Calibration. Models differ in the extent to which they can be tuned to a hospital's sliding-scale discount, e.g. the discount offered at different income thresholds.

Acceptance by IRS, Regulators and Other Organizations. With many different vendors offering models, understand the extent to which the model in question has been used in previous filings or been recommended as an effective solution.

Adopting a presumptive charity analytic is a straightforward, cost effective solution to a problem of significant public concern.

Few Simple Steps Solve Growing Issue

Analytics are commonly accessed through simple web-based applications and can be connected to a patient account system through secure file transfer. The system generates a file for scoring and sends it to the scoring website, much the same way patient accounting systems generate bad-debt placement files today. The web-based scoring system picks up the file, scores each account and sends back a response file. Your patient account system grabs the file and automatically reclassifies accounts based on the score.

Within just a few weeks of selecting a charity analytic an organization can be automatically reviewing accounts as they age out to bad-debt. In some instances it is also possible to review, at initiation, existing bad-debt inventory and execute a one-time financial adjustment for those identified as presumptive charity eligible.

Adopting a presumptive charity analytic is a straightforward, cost effective solution to a problem of significant public concern. It is additive to a great financial counseling and patient access program, closing the loop on patients missed in current routines, incapable of participating, or reluctant to make themselves visible. Your patients win and so does your organization.

About the Author

Steve Levin is CEO and co-founder of Connance. Contact him at slevin@connance.com or visit www.connance.com.

This article relies on material published in "a Form 990 Schedule H conundrum" by Shari Bailey, David Franklin and Keith Hearle, hfm magazine, April 2010. Shari Bailey is VP, Verité Healthcare Consulting, LLC; David Franklin is Chief Development Officer, Connance, Inc.; and Keith Hearle is President, Verité Healthcare Consulting, LLC.*-369-0344*.

HFMA's Online Membership Directory

Have you visited HFMA's Online Membership Directory lately? Log in at http://www.hfma.org/login/index.cfm.

When you select "HFMA Directory," not only can you search for members of your chapter, you can also search for all your HFMA colleagues by name, company, and location—regardless of chapter! Using an online directory instead of a printed directory ensures that you always have the most up-to-date contact information.

While accessing HFMA's Online Membership Directory, you can view your current contact information and make edits to your profile. You can also see products you have ordered, events you have registered for, your CPE credits, your Founders points, and more!

It's vital that HFMA has your correct information, so please take a moment to review your record now. By doing so, you'll ensure that HFMA continues to provide you with valuable information and insights that further your success.

The South Texas Chapter is now a LinkedIn Group! Under the direction of Christopher Snyder, the South Texas Chapter has begun a LinkedIn site to enhance member communication and serve as a resource for industry trends and issues. The guidelines for membership are shown below. Join now!

GUIDELINES

Mission Statement: provide HFMA South Texas Chapter members with an exclusive, professional site to exchange quality information without solicitation to gain knowledge of current industry trends and issues.

Eligibility to join site

- South Texas Chapter member (provider and vendor)
  - Vendors must be sponsor of chapter or Texas state-wide
- Non-member
  - Anyone employed by a provider that is in our geographic area
  - Vendors that sponsor chapter or Texas state-wide
- Industry experts that will provide quality information
- Keynote speaker candidates for conferences

No vendor solicitation of any kind

- Only sharing of quality ideas and articles pertaining to the latest healthcare industry trends and issues

No self-serving objectives

- Reoccurrence will result in being removed from site

Vendor campaigns to promote services will be held on a monthly basis

- Must be a chapter member and sponsor to be eligible

Editor's Alley

It is our goal to ensure that The Chili Pepper Express Newsletter continues to meet the needs of chapter membership by providing timely and relevant information to enhance your membership experience with the South Texas chapter of HFMA. If you have any comments or suggestions relating to any aspect of the newsletter (i.e. frequency, content, method of delivery, etc.) please let us know. Thanks.

Christopher Janik
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Newsletter Chair

Robert Husted
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Newsletter Committee

Reducing Emergency Department Volume—and Costs

One health network's solution to reducing non-emergency cases in the emergency department requires a change in culture—for patients and physicians.

Note: The following article originally appeared in the October 2010 issue of HFMA's Healthcare Cost Containment newsletter (www.hfma.org/hcc).

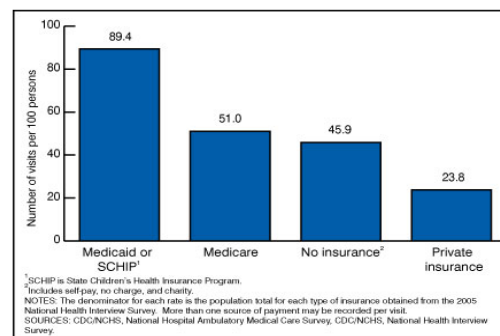
Like so many hospitals around the country, Presbyterian Hospital in Albuquerque, N.M., is facing a costly problem: Payers no longer want to pay emergency department (ED) prices for non-emergency care.

In July, the 453-bed hospital started a program aimed at reducing ED traffic by deferring such non-emergency cases like earaches and minor wounds to the hospital's primary care physicians. Currently, the hospital's ED gets about 180 visits a day; the goal is to reduce the number of ED visits by 10 to 15 percent, says Mark Stern, MD, medical director, Medical Management and Endcare Coordination, Presbyterian Healthcare Services, a network of eight hospitals in New Mexico.

Lisa Farrell, CFO for Presbyterian Health Plan, the network's integrated insurance plan, says the program should see savings beginning in 2011 amounting to $10 million to $15 million over the course of five years.

Called the "ER Navigator Program," the project has customer service representatives in the ED to set up appointments with the system's primary care physicians for non-emergency patients. All patients are first triaged by a nurse to determine the required level of care. Cases like earaches, sore throats, and lower-acuity upper respiratory infections in patients older than two years old are sent to a clinician, such as a nurse

Annual Rate of ED Visits by Expected Source of Payment, 2005



Source: Centers for Disease Control and Prevention.

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Reducing Emergency Department Volume—and Costs

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practitioner, who performs a screening and obtains a medical history. Cases that are non-emergent or non-urgent are sent to customer service representatives, called navigators, who then schedule an appointment for the patient to see a primary care physician within 12 to 24 hours; uninsured patients are connected to other care resources within the community.

ED No Longer a Safety Net

Slightly less than a month after its launch, the program had deferred about 60 ED patients to navigators, below the 18 to 24 ED patients per day hospital administrators had hoped to divert to primary care physicians, Stern says. He expects the number of deferred patients to increase as clinicians become more attuned to the parameters of the program.

One of the challenges in setting up the program was gaining buy-in from ED physicians, who were concerned that deferred patients wouldn't receive care, Stern says. However, because patients are given appointment to meet with primary care physicians, not just referred to these physicians, ED physicians have become more accepting of the program, he says. "What we're doing at Presbyterian is shifting paradigms from the emergency department being a safety net to a well-integrated system being a safety net," he says.

Stern says administrators will continue to refine the program as they meet with ED and primary care physicians to get updates and feedback on whether the program is working the way it was intended. Physicians will receive data on the number of patients who have been set up with care appointments, but who don't follow through with the visit, he says.

Program Costly at First

Reducing costs in the ED is part of Presbyterian Healthcare Service's systemwide medical cost optimization program, which was initiated in late 2009.

The goal of the program is to help patients access care in a setting that is more appropriate for their medical condition. "By treating patients with non-emergencies in a more appropriate venue than a high-cost acute care setting, we help to reduce healthcare costs overall for everyone," Farrell says.

However, Stern says the program is expected to cost money before it saves money. In many cases, the primary care visits set up by the navigators are not reimbursed. "This is probably something like a nine-month to two-year project" to change the behavior of patients and ED staff and to help patients understand the proper venue of care for non-emergency cases, he says.

Although physician buy-in was the priority, Farrell says administrators also made sure to seek support from federal regulators and advocacy groups, like Albuquerque Healthcare for the Homeless, before launching the program. The health network also implemented a comprehensive communications initiative with the community by giving media interviews, making public service announcements, and sending letters to previous ED patients, health plans, and their mem-

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Reducing Emergency Department Volume—and Costs

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bers explaining the program. "We really tried to make people aware of the program and what we're doing," she says.

Farrell adds that the health network has received no complaints about the program from regulatory agencies, and patients are accepting of the program as well. About one month into the program, just one patient left the ED angry about the deferral, Stern says. But the patient later came back to apologize—and make an appointment with a primary care physician.

"I think we're getting the results we anticipated," Stern says.

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Other Happenings:

"Other Happenings" is where we will list educational and networking opportunities in collaboration with other HFMA Chapters, primarily the Gulf Coast and Lone Star Chapters here in Texas. We will work in conjunction with the Newsletter Chairs from these Chapters to provide you with as many educational opportunities as possible.

Gulf Coast Chapter HFMA Events:

A full schedule of GCC events can be found at http://www.hfmatxgc.org/hfmacalendar.php.

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