

SEVEN STEPS

TO IMPROVE THE

FINANCIAL HEALTH

OF YOUR ED

A Phase 2 Consulting White Paper



Is your ED in need of critical care?

Seven Steps to Improve the Financial Health of your ED

OVERVIEW

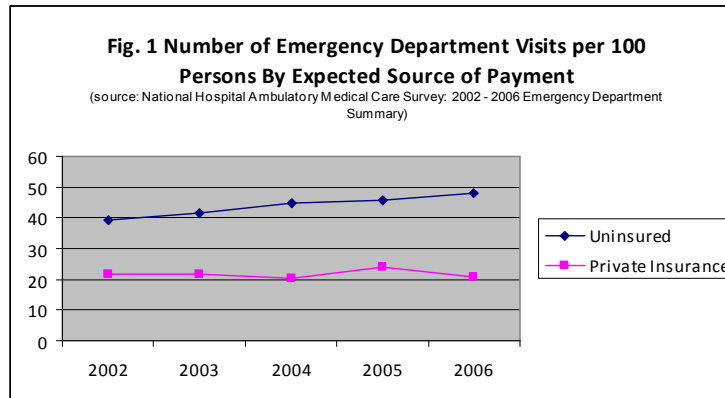
Emergency care providers face many opposing forces that impact both their ability to provide quality care and to maximize financial performance in the Emergency Department (ED). From ED overcrowding to increasing patient volumes, these trends are not likely to change in the near future. Over the past decade, the average wait time for emergency room patients to see a physician has grown from about 38 minutes to almost an hour, according to recently released statistics from the CDC.¹ Since the passage of the Emergency Medical Treatment and Active Labor Act (EMTALA) additional financial pressures have been placed on the ED. In response, some hospitals have chosen to close their ED even though there is increasing demand for emergency care. On the other hand, some hospitals have chosen to accommodate more patients by increasing capacity in the ED, which often exacerbates the problem if process improvements to address efficient patient throughput and increase inpatient capacity are not performed.

There are seven key initiatives that can improve the financial health of the ED. Efficiently and effectively developing these processes, while maintaining compliance with EMTALA regulations, will improve the likelihood for success. In addition to this, ultimate success is contingent upon developing and maintaining strong leadership both within and outside of the department. A financially successful emergency department must have empowered leaders who employ an ED strategy with clear vision and actionable goals to push the organization to continued success. The ED strategy must plan for and manage the interdependencies with other departments, which are critical to overall performance.

1. Drive Registration Quality and Patient Financial Responsibility – Dot the I’s and Cross the T’s

Improving patient registration and financial counseling functions is the first step toward improving the financial health of your ED. Significant revenue related problems originate early on, at the time when the hospital is collecting and verifying patient information during registration. Additionally, ED visit rates for patients without insurance continue to grow and are now twice that of those with private insurance (Figure 1).

It is essential that patient registration processes support and confirm that accurate and complete demographic information is collected and that financial expectations are communicated. Communicating financial responsibility for private insurance patients is as important as for uninsured patients. As private insurance co-payments and deductibles rise, patient awareness must be elevated so they understand their financial responsibility and establish their most appropriate plan and method for payment.



There are many different models for patient registration, ranging from traditional registration to bedside registration to hybrid quick registration models. Regardless of the model, all share common goals:

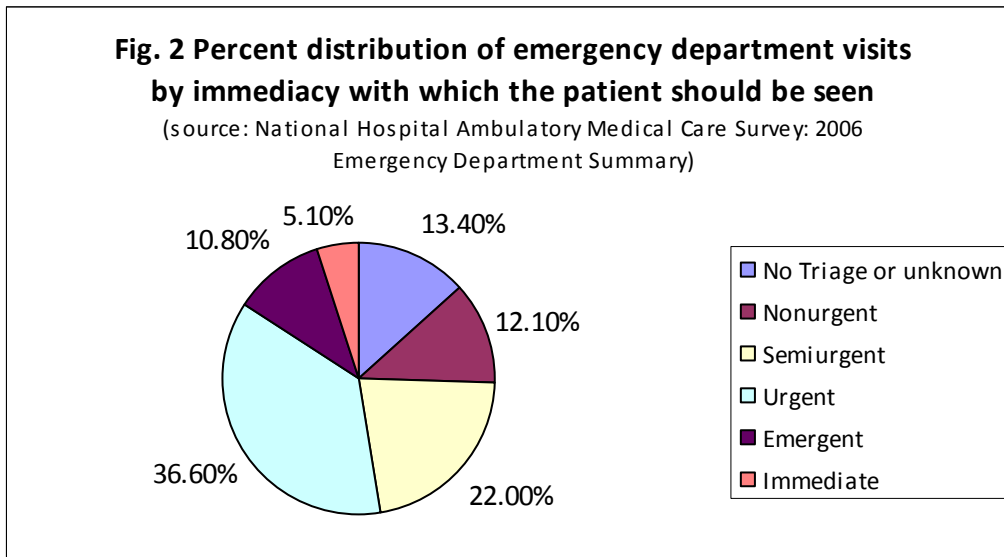
- Capture as much patient information as possible and get the patient access to an appropriate provider as soon as possible.
- Quickly determine if the patient already has a medical record on file. Creating a duplicate medical record not only wastes valuable time, but it can also impact the patient's safety.
- Verify insurance and information for all patients to reduce denied claims and lost revenue.
- Inform patients of their payment responsibility, in accordance with EMTALA regulations. All co-pays and deductibles should be identified and collected as part of registration (and definitely prior to discharge), if the patient is able.
- Refer patients without insurance or with high deductibles to a financial counselor. Financial counselors should provide payment and assistance options and perform tasks such as Medicaid Eligibility screening.
- Provide additional financial counseling at discharge via a discharge desk. For patients who have received counseling up front, the financial counselor can confirm the patient's understanding of financial responsibility and answer any new questions.

2. Initiate a "Right Care" Program – The Right Care, The Right Location, The Right Practice

Implementation of a "right care" program can have a significant impact on the health of the emergency department. The term right care refers to providing the right care at the right location, with the right practice.

In right care programs, medical screening occurs at the time of triage and is a process to screen patients for true medical emergencies. As Figure 2 shows, a large number of patients visiting EDs are not urgent. Under a right care program, patients who are not emergent are provided non-emergent health care options that include financial counseling and education on the proper use of the ED. Patients with non-emergent health issues are referred to a registrar for alternative health care options and locations.

The primary goal of a right care program is for the ED to be used as originally intended; for the treatment of injuries and illnesses that threaten lives. As a result, overall patient care will improve as providers are able to focus on the patients who need the care most.



Another option is to provide an urgent care process with a dedicated treatment space for patients with a lower level of acuity. This would free space to treat patients who present with more acute problems. Without these “right care” options, patients with non-emergent needs typically wait the longest and require the least amount of time for treatment, which leads to great dissatisfaction.

3. Tackle Throughput - The Need for Speed

Efficient throughput is a critical step to achieving maximum financial health for your ED. Long wait times not only are a safety issue, but they are a major contributor to patient dissatisfaction. Additionally, overcrowding can take a toll on staff. While congestion is often caused by slow turnover of rooms in the ED, often the ED is holding or boarding patients who are admitted because of slow bed turnover on med/surg units and in the ICU.

Emergency department information systems (EDIS) not only capture data to measure throughput in real-time dashboards and reports, but also provide a dynamic intuitive visual presentation of this information for clinicians. Improving hospital efficiency and patient flow requires an understanding of how the current patient flow can be modified to best support the desired practices. Assessing normal clinical flow and exceptions includes triage process overview, registration process and the identification of special cases, such as psychiatric, obstetric and trauma. Ascertaining their specific flow is the required first step to re-engineer and streamline processes that can reduce patient wait times, which in turn can help reduce overcrowding and ease overburdened EDs.² By utilizing an EDIS several key processes can be actualized that can improve throughput:

- **Effective triage is a key factor in ensuring efficient patient throughput.** Appropriate staffing of the triage function can greatly enhance throughput. An experienced nurse trained in triage should be attending to this function at all times. During traditionally high volume times of day, having a physician assigned to triage or having additional triage nurses may also eliminate bottlenecks and reduce patient wait time. Under any triage process, it is important to have rating systems in place that will accurately prioritize

patients within five minutes. Protocols such as the Emergency Severity Index (ESI) should be implemented to ensure patients are prioritized by severity and resource needs.

- **Create and empower a bed manager position.** Quick triage can't be effective if beds are not available. Many hospitals have been successful using bed managers who are responsible solely for patient flow by closely tracking bed availability and coordinating timely outflow from the ED.
- **Develop discharge waiting areas.** Moving patients to discharge waiting areas can make beds available sooner. A waiting area can also ensure patients get directed to a financial counselor prior to discharge.
- **Improve ancillary management integration.** An effective ED is completely dependent upon other hospital functions. Improving integration with ancillary departments such as the lab, radiology, pharmacy and other departments is critical. Diagnostic tests should be flagged as being for the ED and receive quick turnaround time by the lab. Additionally, clinical pathways should be created and used to quickly order a range of diagnostic tests based on initial assessment of patient condition. This can save time in patient evaluation and treatment.
- **Develop 24-hour rapid admit teams.** Nurses may also be tasked on a 24-hour rapid admit nursing team that works around the clock to complete nursing assessments and paperwork needed to move patients to the appropriate inpatient unit. This can free beds faster in the ED.
- **Review and adjust staffing levels to account for variations.** In addition to improving throughput via the rapid admit team, overall staffing levels should be shifted based on historical patient flow data. Time of day, day of week, population served, and other factors should all be carefully analyzed and linked to staffing of not only nurses and physicians in the ED, but ancillary departments as well. Additionally, the use of specialized staff like hospitalists and intensivists can be valuable in reducing inpatient length of stay, which can have a trickle-down effect and improve throughput in the ED.
- **Link the goal of throughput to metrics programs.** Finally, the goal of throughput must be "top-of-mind" with all ED staff. Clear goals should be set for patient throughput, and metrics should be tracked and closely tied to staff incentive plans.

4. Better Manage Patient Disposition – Your Gateway to the Hospital

Appropriate patient disposition is another critical success factor for an Emergency Department. The emergency department is increasingly becoming the 'front door' to the hospital. In 2006, over 50% of hospital admissions entered through the ED door.³ The average hospital inpatient Length of Stay (LOS) is continuing to decrease, further enhancing the importance of getting the patient admission status and appropriate codes assigned efficiently and correctly. Capturing the correct data at the time of the ED encounter will ensure that the proper admission status is established at the time of admission, as well as being in line with quality measurement programs.

The financial benefit of accurate patient disposition is largely a byproduct of accurate clinical documentation. Utilization of technology solutions can capture the necessary documentation associated with the disposition and facilitate appropriate patient disposition.

The ED should consider the following:

- Use observation stays appropriately. CMS identifies failure to do so as one of the major reasons why patients are admitted for medically unnecessary one-day hospital stays.
- Make decision support software available to assist ED physicians in determining if an observation or inpatient stay is most appropriate.
- Invite someone from utilization management to talk with the ED managers and physicians about medical necessity admission criteria. Have them explain what tools and criteria the hospital uses to validate medical necessity for observation and inpatient admissions.
- If there is a problem with admission denials from the ED, ask about the feasibility of basing a case manager in the ED to implement an admissions review process prior to the admission.
- Make sure physicians document the full clinical picture of patients' severity of illness in the ED. This includes any social conditions, co-morbidities and debilities that affect the decision to admit.
- Document why the patient is being admitted to the hospital. It is also helpful to document why it is not safe to discharge the patient home; identify the risks.
- Clearly document physician orders to "admit to inpatient" or "place patient in outpatient observation." Be aware that an order for "admit to observation" can be confused with an inpatient admit. Likewise, an order for "admit to short stay" may be interpreted as "admit to observation" by some individuals and "admit to inpatient" by others.
- Ask Patient Financial Services for information and feedback on any ED admits that become problematic short inpatient stays.

5. Enhance Coding/Clinical Documentation – Get More Bang for Your Buck

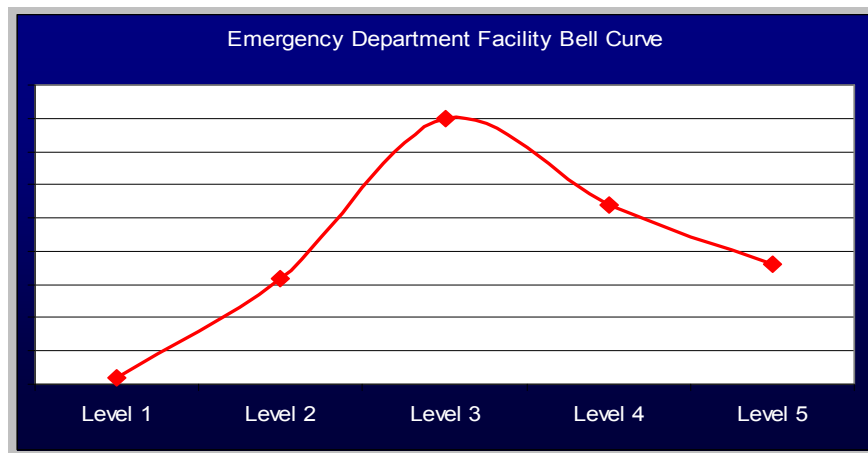
It is no surprise that successful management of Emergency Department Charging / Coding is a challenge for emergency departments across the country. Often declared the "black hole" of the hospital revenue stream, the ED faces numerous challenges. Private pay patients, resource intensive services, chaotic work environments, and documentation challenges are just a few of the obstacles for ED Management.

There are two separate revenue streams for the Emergency Department – Facility Revenue and Professional Revenue. Facility Revenue is owned by the hospital A/R, while Professional Revenue is dependent on the ED physician contract or employment status. Each of these revenue streams are driven by two very different sets of regulations and, hence, documentation rules.

In August of 2001, the Centers for Medicare and Medicaid Services (CMS) implemented Ambulatory Payment Classifications (APC) in response to congress' request to create an Outpatient Prospective Payment System (OPPS) per the balanced budget act of 1997. Prior to APCs, hospitals would report costs, and then were paid a percentage of those costs. With the implementation of APCs, hospitals were to get paid a fixed amount regardless of costs for outpatient services. Furthermore, CMS stated a hospital should follow its own system for assigning different Evaluation and Management (E/M) levels to Emergency Department encounters. The implementation of APCs left hospitals across the country scrambling for a method to assign emergency department E/M levels while providing only minimal guidelines. The response by hospitals was the creation of a paper tool for calculating the E/M level based on a point system. The paper tool posed many challenges to

hospitals, all of which contributed to a negative impact on hospital revenue and the overall state of Emergency Department Management. With the emergence of Emergency Department systems for tracking and documentation, it is clear that automating the process of Emergency Department Level (E/M) assignment and procedure charge capture is a win for everyone.

The assignment of E/M Visit Levels for Emergency Department facilities when graphed should reveal a “bell curve” distribution, which implies that a system of consistent E/M Level assignment is in place. Although the “Bell Curve” can arguably be affected by patient population, acuity, etc., it still serves today as a visual tool for measuring the accuracy of hospital E/M Level assignment. The graph below represents a “typical” Emergency Department Bell Curve.



The following facility revenue check list is important for ED management to consider when evaluating the financial health of the emergency department:

- Is Facility E/M Level Charging consistent across patient populations and reflective of Emergency Department Resource Utilization?
- Do your E/M Levels produce a bell curve?
- Do your Paper Charge tickets often result in undercharging of E/M Levels, therefore not consistent with or reflective of resource utilization? Are they often lost, or unidentifiable?
- Does nursing documentation support the E/M Level Charge?
- Does your nursing staff think an E/M Level should be reflective of “how sick is the patient ” vs. what type of resources were needed to assess, treat, and diagnose the patient in the Emergency Department?
- Do your nurses understand the recent changes to IV Infusion and Injection Charges?
- Are you missing reimbursable charges due to lack of documentation?

ED Physicians are compensated according to the CPT (Current Procedural Terminology) system, copyrighted by the AMA. This system is how Emergency Physicians get paid for evaluation and management services (direct patient care). Many Emergency Physicians are not familiar with the inpatient payment system known as ICD-9. This system, the International Classification of Diseases, has unfamiliar rules that dictate how much hospitals get paid. These coding rules are not generally taught to Emergency Physicians and, therefore, they have little insight into what documentation accurately describes patient complexity when using the ICD-9 system. The clinical documentation provided leading to CPT evaluation and management codes equates to Relative Value Units (RVUs) that may become the physician's paycheck if their compensation is based on productivity. This same documentation often does not support hospital payment, and therefore, patients admitted from the ED are often under-coded. This is because of the lack of documentation necessary to describe the services within the ICD-9 system. The link between Emergency Physician practice and hospital payment has recently become a bigger challenge, and regulatory changes have increased the importance of Emergency Physician documentation.

Regulatory Changes Driving the Need for Improved Emergency Physician Documentation:

- Recovery Audit Contractors (RAC) - Reduce Medicare's improper payments through efficient detection and collection of overpayments and the implementation of actions that will prevent future improper payments.
- Present on Admission (POA) - The avoidance of payment for medical conditions that were acquired by a Medicare beneficiary during an inpatient hospital stay.
- Medicare Severity Adjusted DRGs (MS-DRGs) - DRG system is how physician documentation is turned into codes that determine eventual hospital payment.

Improving documentation can help ensure that clinician documentation supports the appropriate Evaluation and Management (E/M) codes, which can be linked directly to accurate billing, charge capture, and revenue generation. By utilizing technology to automate clinical documentation and coding processes, healthcare facilities can more accurately align services with resources utilized. If the ED coding is more reflective of actual resource consumption, organizations are better positioned to drive overall compliance and financial health within the ED.

Fortunately, tools are available to ensure clinical documentation is thorough and facility charges are captured.

- **Use coding documentation management systems.** Coding documentation management systems can be utilized by nursing to address specific problems, track and capture charges for supplies and procedures, update the charge master and document the time spent with a patient. Nursing documentation is critical in determining the E/M codes.
- **Refer to quick coding guidelines.** Quick coding templates and guidelines should be readily available and used by providers for common medical conditions. This can help ensure all appropriate charges are captured and are not missed.
- **Leverage reporting to monitor process.** Coding systems can provide valuable reports to allow hospital management to review coder accuracy, practice patterns, coding production, and capture supply and testing charges.
- **Streamline dictation via templates.** Utilizing dictation templates in conjunction with the documentation management system can help doctors meet documentation guidelines, improve legibility, eliminate medication errors, and help nursing facilitate the speedy delivery of care.

- **Deploy professional coding tools.** The information systems not only help physicians auto-populate coding and documentation, but they also assist the professional coders by helping them identify the exact description, the extent of the procedure, and who ultimately performed the procedure for coding purposes. The coders can then go back to a physician if there is a question on coding.

6. Enforce Charge Description Master (CDM) – The Rosetta Stone of Healthcare Coding

The CDM or “charge master” is a hospital-specific comprehensive listing of the items that can be billed by the hospital. It provides the direct link between services provided and the generation of claims and billings. Facilitating proper charge capture via an accurate charge master is key to the financial health of the emergency department.

- **Develop and enforce charge master policies and procedures.** It is imperative that charge master policies and procedures are in place to provide guidance for all staff involved in documenting, coding, or monitoring charges.
- **Frequently revisit and revise charge master.** It is important to review and maintain the charge description master on a regular basis for accuracy, inactive line items, additions and price effectiveness. Professional Charge Master reviews performed by trained individuals can ensure that the CDM reflects the latest CMS guidelines, revenue is maximized and that facility coding policies and procedures are reflected in the chargemaster. Key elements to review a hospital charge master include: invalid or inaccurate CPT/HCPCS codes, invalid or inaccurate revenue center codes, inadequately defined procedures and tests, appropriateness of bundled CPT/HCPCS codes, and validity of service.

7. Remember: Quality is King

Quality is a theme that runs throughout every emergency department process. Not only does providing high quality care lead to higher patient satisfaction, but with new CMS guidelines, quality will begin to impact the bottom line as pay-for-performance measurement is expanded.

Drivers of continuous quality improvement initiatives in the ED include staff satisfaction/retention, error reduction, and patient care. Improving quality in the emergency department requires the development and utilization of important ED metrics. Some of the key metrics include:

- Hours ED department is on divert monthly/annually
- ED elopements
 - ⇒ Patients left without being seen (LWBS)
 - ⇒ Patients left against medical advice (AMA)
- Ancillary turnaround time
- Fast-track volume
- Holding hours for patient admitted
- Patient satisfaction

These metrics can be reported in a “dashboard” format that gives quick access to a visual representation of historical and current ED performance. The systems used by the organization will be critical to obtaining and reporting on these necessary quality metrics. The successful ED will not only report on the metrics, but it will also closely tie these measurements to staff performance goals and evaluations. As pay-for-performance initiatives expand and more data is gathered on the relationship between automation and enhanced patient care, pay-for-performance programs will get a boost. As the model shifts to reimbursement for better outcomes, the ROI for emergency department information systems will be further strengthened.

CONCLUSION

How can you improve the financial health of your ED? There is not one magic bullet that will solve the myriad of issues. But if the hospital and ED leadership make operational and financial improvement a strategic imperative, the chance of success improves. And if leadership aligns resources and goals along the seven steps, there is even greater chance of success.

- Create “best in class” patient registration and financial counseling processes to capture accurate patient information and communicate financial responsibility as early as possible after patient presentation.
- Shift patients to a continuum of treatment options to provide the right care at the right place and at the right time.
- Make throughput a “top-of-mind” goal with staff throughout the ED and empower people to improve patient flow whenever possible.
- Improve the accuracy of clinical documentation by providing physicians with the information system tools and training needed to help them accurately document patient condition at disposition.
- Provide coding systems and tools to help physicians and financial departments maximize accuracy and optimize revenue capture through right coding.
- Review the charge master regularly and enforce processes. Don’t just set it and forget it.
- Put in place measures and processes to capture important quality metrics.

There is no one answer. However, following these seven steps will put your ED on the path to improved quality and financial health when given organization-wide attention and focus.

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Mr. Dazley has worked in the health care industry since 1990 in various capacities including office of the U.S. Surgeon General, managed care operations, finance, administration, and consulting. Prior to joining Phase 2 Consulting, he worked as a senior health care consultant for Ernst & Young in Los Angeles. During that time, he gained experience in strategic repositioning, mergers and acquisitions, financial modeling, and business process improvement. Mr. Dazley has participated in numerous strategic planning and financial turnaround engagements for health systems throughout the country and currently leads Phase 2 Consulting's revenue cycle team. Mr. Dazley received his M.B.A./H.S.A. from the University of Utah. He is fluent in Spanish and is also a participating member of the Health Care Financial Management Association.

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Mr. Gee has over 20 years experience in senior level planning and strategy positions in the health care industry. He has orchestrated strategy for organizations ranging from a leading for-profit health care system in Texas to a prominent not-for-profit hospital in the Northwest. Mr. Gee is a noted author and health industry thought leader on the subject of market-driven strategies for hospitals and health systems. He has been writing about, and lecturing on consumer-oriented models, such as service line management. His most recent book, *Service Line Success: Eight Essential Rules*, represents the author's eighth professional book. In addition to his books, Mr. Gee has written over 150 articles on innovative and progressive strategy in every major publication in the healthcare industry.

Mr. Gee is also a frequent speaker at national healthcare forums on topics ranging from competing against niche providers to new business development strategy. Prior to joining Phase 2 Consulting, Mr. Gee served as the senior vice president of strategic planning for the St. David's Healthcare Partnership in Austin, Texas, a position he held for over 11 years. Mr. Gee brings an atypical perspective to health care, having started his career in manufacturing/consumer goods with The Quaker Oats Company in marketing and new product development. He holds a Bachelor of Science Degree and Masters Degree in Business Administration from Brigham Young University in Provo, Utah. He is a recipient of *Modern Healthcare's* "Up and Comer's Award."

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Mr. Burt joined Phase 2 Consulting in April 2008. He has a strong record of leading and delivering results on a broad range of consulting projects. Expertise includes strategic planning, process redesign, and revenue cycle. His experience spans the healthcare continuum and includes working with leading hospital networks, managed care organizations, academic medical centers, and government healthcare entities. Prior to Joining Phase 2 Consulting, Mr. Burt worked at PricewaterhouseCoopers and Ernst & Young in their healthcare consulting practices. Mr. Burt received his Masters Degree in Health Policy and Management from Emory University.

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