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Inside

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Identify best practices to improve patient flow in your ED

More than 80 EDs identify best practices for patient flow in national benchmarking study.

A 1998 Veteran's Hospital Administration (VHA) National Benchmarking Consortia Study surveyed more than 80 emergency departments (EDs) to identify best practices in patient flow management. "It's very helpful to be aware of benchmarking data to see what others tried, failed, or succeeded at," says **Michelle Myers, RN, MSN,** program manager for emergency and trauma services at Elmhurst Memorial Hospital (IL). "Administrators want to hear innovative ideas for improving patient flow along with hard data, since throughput times are closely linked with patient satisfaction scores."

The VHA study entailed two primary surveys. A data collection survey covered general practices in emergency services, while a second survey was completed on a patient sample for each ED to measure patient cycle times.

Having hard data can demonstrate that patient flow effects ED revenues, stresses Myers. "If patients are waiting too long for an x-ray to come back, they'll leave," she notes. "Show your administrator that 300 patients per year leave without being seen because wait times were too long, with an average charge of $280. They won't want to see those dollars walking out the door."

Benchmarking data can be used to compare efficiency with other EDs, which is a valuable negotiating tool, stresses Myers. "By using the data from the VHA study, we could compare our turnaround times to others," she says. "We can use it to justify our resources, in case our administrators want to cut x-ray techs or services that contribute to turnaround times. You can look at hospitals A, B, and C who didn't have those resources, and explain that our times could increase if they took away a tech in our radiology room."

Even EDs with efficient patient flow management can benefit from sharing information. "Our waiting times have been below the national average, but this was an opportunity to take a look at our practices and participate in benchmarking with other organizations," says **Tom Alinder, RN, BSN,** emergency medical services manager for United Hospital in Grand Forks, ND. "We were able to study the best practices of more than 80 EDs, which helped us to come up with strategies for improvement."

Here are some of the best practices in patient flow management identified by the study's participants. Some of the strategies are fairly common, but they all help save time in the ED.

Specimens transported via pneumatic tube system. "We have a tubing system that expedites our specimens so they go right down to a stat receiving specimen area. That is staffed 24 hours a day, so somebody is always there to collect a stat specimen," says Myers.

ED staff perform phlebotomy and EKGs. "Our ED nurses and techs draw blood, so we don't have to rely on a phlebotomist to come from another area in the hospital to do it," says Myers. "Even if you have a stat lab tech, you still have to wait for them to come to the ED. This way, when the patient comes in, we immediately start drawing blood."

At Methodist Hospital in Omaha, NE, all nurses and techs are certified in phlebotomy and EKG. "This had a significant impact on our flow times," reports **Pat Lenaghan, RN, MS, CEN,** service executive for emergency services. "Our door-to-EKG time went from 25 to about 10 minutes, and door-to-drug time for thrombolytics decreased from 40 to 29 minutes."

The ED's clinical nurse specialist sets up competency training for EKGs and phlebotomy. "We sent our nursing assistants through the same training that our phlebotomists go through, until they were competent," says Lenaghan. "We had to gain a lot of cooperation between the two departments to make that happen. For example, the cardiologists were supportive of getting our door-to-drug time below the national average, so they supported this."

A radiology department in the ED. "We have two x-ray areas, one for the fast track and one for the ED," says Myers. "The ED physicians do a wet reading, with a final reading by the radiologist in the ED. We also have a runner budgeted out of radiology who runs the films back and forth. Also, the radiology techs come and get our patients when we order an x-ray, so the staff does not have to bring patients to the x-ray rooms."

Good communication to resolve delays in ancillary services. "You need to have constant, ongoing communication with the directors of lab or radiology. We meet every two weeks so we can resolve any issues that come up regarding wait times," says Myers. "In many EDs, you leave messages at the other department and never get a call back for days."

One patient called to complain about the ED staff drawing blood. "She is a difficult stick and a frequent visitor in the ED, and let us know that she preferred the lab to come and draw blood instead of my staff," says Myers. "I made arrangements that the staff will contact a phlebotomist to draw this particular patient. If our staff is sticking this patient two or three times or the patient becomes upset, that could delay turnaround time and the patient will be dissatisfied."

Use of headphone cellular system. "We have purchased headphone sets for our registration staff, triage and charge nurses, so we have constant communication in trying to move patients faster," says Myers. "When a patient walks in the door, somebody can dial up and say, this patient has a laceration, where do you want them? Otherwise somebody would have to walk to the back. If you can't find the charge nurse, it looks like a chaotic, crazy scene. This way, the charge nurse can delegate where this patient should go."

Put extra carts in the hallway during peak volumes. "You can go on diversion and bypass but that doesn't stop the walk-ins, so you have to provide extra resources during busy times of the year. During the viral season, we get inundated, so we ask each shift to put an extra half-dozen carts in hallway for overflow if the beds are all taken," says Myers. "In order to move patients through the system, you don't want patients in the waiting room who need to be brought back."

Use of an incentivized oncall system. "If we have to hold a patient in the ED because the census is high on the inpatient side, we have an on-call list we use. There is an incentive plan for nurses who get called in, with an extra salary benefit to come in," says Myers. "It's better to pay the nurse time-and-a-half than have to transfer patients out because you don't have the space."

RN-initiated standing orders. "To facilitate ancillary tests, our triage protocols have standing orders for 30 standard diagnoses," says Lenaghan.

Use of nurse practitioners. "Our nurse practitioners see some patients independently and they see others collaboratively with physicians," says Lenaghan. "We have 2.6 FTEs [full time employees] from noon to midnight, and our patient satisfaction scores went

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up 8 percentage points after we started using them."

Use of a behavioral health consult. "We worked together with a psychiatric hospital and established a call list for licensed behavioral therapists. After the ED physician determines the patient may be at risk, the consult comes and does a more detailed assessment," says Lenaghan. "They decide whether to admit the patient to a behavioral health facility, make the arrangements to transfer, and do the placement."

As a result, patients are not in the ED as long. "Before we used behavioral consults, it took us five or six hours to make all it happen. The consults know who to call and how to document things, so it takes only two or three hours to get a patient placed now," says Lenaghan. "This is a big problem in EDs right now, because we are seeing payers decreasing benefits to behavioral health and less inpatient health benefits. So there are more patients coming to the ED."

Use data to justify increase in physician time. "The VHA benchmarking data on patients per physician hour showed that the average of all the 81 hospitals involved is 2.13 visits per MD hour," says **Ray Reidenbach,** business manager of patient care services for DCH Regional Medical Center in Tuscaloosa, AL. "We knew we couldn't afford to go to 2.13, but we wanted to make a significant improvement, so we created a goal of 3.5. Our starting point was 4.35, and we are now down to 3.05 visits per hour."

The benchmarking data convinced hospital administrators to renegotiate the ED contract for medical services, Reidenbach says. "Prior to the study, we didn't know where we fit with other hospitals. We were pretty far out of line with the average on that particular measure, so this gave us a guide to work toward. We then calculated the number of additional physician hours we'd need to get to 3.5 visits."

Reschedule staff to match patient flow. "We charted patient visits in the ED by hour of day so our medical director could reschedule physicians to better align our coverage to match the patient flow for peak hours," says Reidenbach. "By doing that, more physician hours are used in direct patient care which improves patient flow. Peak hours are charted on an ongoing basis and reported in monthly meetings."

Improvements in efficiency were more closely linked to rescheduling for peak hours than overall patient volume, notes Reidenbach. "We suspected that our visits per MD hour data were correlated to patient volumes, but we found that they were not. A lot of it had to do with redoing the physician schedules," he says.

Additional staff hours may only be needed during peak hours, stresses Myers. "Maybe you don't need extra FTEs during slow times, but you do need them during peak times such as summertime or viral seasons," she says. "Be creative in terms of how you staff your department, because you must be prepared for the unexpected," she says.

Use point of care testing. "We increased our use of i-stat point-of-care testing. For electrolytes, we started out at 42 minutes, with a goal of 26. We are now at less than 30," says Reidenbach. "We bought additional machines and trained the staff to use them. The lab did quality control to compare the lab sample and i-stat sample to make sure we were getting similar results. They were within a normal variance, so the lab was supportive."

Increase capacity of radiology. "We increased the capacity of radiology to service the ED by adding another x-ray room adjacent to the ED, upgrading the spiral CT scanner so it is one and one-half times the capacity we had before, and upgrading an MRI machine. We also increased the radiology staffing to handle those machines," says Reidenbach. "The radiology department had been manually keeping records of wait times and they were able to show significant reductions in delays for ED patients."

Bypass the ED for direct admits. "Physicians tend to send patients to the ED for direct admission even when it wasn't necessary, so we internally worked out how we could bypass the ED for those kinds of cases," says Reidenbach. "We educated primary care physicians and their office managers, so patients are routed through outpatient registration area. When they arrive, their escort is there to take them to the unit."

When the physician first calls, the bed control office alerts the nursing unit so when patient arrives ancillary tests have already been ordered, Reidenbach explains. "Our baseline was 334 minutes for direct admits through the ED. For the ones that bypass, [we're] looking at average of 15 minutes," he reports. "This was a way to provide an equal level of care without tying up the ED in volume."

A case manager for the ED. "Adding a case manager in the ED, as is traditionally done in ICU and med/surg, is a good way to ensure consistent care for patients," says **Eva Morris, RN,** unit manager for the ED at Lincoln General Hospital in Ruston, LA. "It can also prevent unnecessary visits to the ED that can back up patient flow. This reduces visits to the ED by clarifying instructions or explaining medication administration. Also, if a case manager knows a particular patient, [he or she] can help decide whether an ED visit is appropriate."

Link flow to satisfaction. "The first patient of every hour was our guinea pig patient which we used

in our survey. Every single piece of the treatment process was broken down by time," says Morris. "Then, this same patient filled out a detailed satisfaction survey. So we not only saw how we were doing with times, but also got the patient's opinion about how we did."

Streamline registration process. "By doing simultaneous triage and registration, we initiate treatment earlier to prevent delays," says Reidenbach. "It also allows the patient to realize the staff are caring for them immediately upon arrival. The second gain is that, when the patient is placed in a room 20 minutes after arrival, they may have x-rays already completed, so the physician can discuss findings and initiate treatment."

Track where patients are in the ED. "We developed a placement system for charts in the ED based upon where patients are with his or her treatment, so physicians and staff at first glance can tell what is going on with a patient in a particular room," says Alinder. "There are many automated systems out there to accomplish that, but they are extremely expensive, so we continue to do it manually."

In the central nurses station, four locations for charts indicate whether a patient is waiting to be seen, for lab and x-ray results, for admitting or consult physician, or for discharge. "We also have developed color coded clipboards to connotate the level of care the patient may require—red is critical, yellow is emergent, and green indicates non urgent. That allows the physicians, at first glance, to tell how many critical patients there are, so they can get a better grasp on their workload," says Alinder.

Registration staff report to ED. "Registration staff report to both the business office and the ED. That allows them to feel a part of the team, with an important role in the treatment process," says Reidenbach. "Their performance reviews are linked to their accuracy and timeliness of registration and their ability to work with patients. As a result, patient flow is impacted."

Use of patient flow algorithm. "We charted the entire process from the moment the patient arrives until they are discharged or admitted, with a detailed algorithm," says Reidenbach. *(See algorithm inserted with this issue.)*

Tracking delays in ancillary tests. "We worked with ancillary departments to document the time blood was drawn, when x-rays arrived, and when patients were brought back, on our nursing flow sheet," says Reidenbach. "That allows us to know what when we can expect the patient to return or lab results to be available."

Train ED nurses in triage. "We developed our own triage training tool, and also utilize components of the ENA triage training manuals. We outlined the roles and responsibility of triage and charge staff, and then have provided that education for staff nurses," says Reidenbach. "This way, if there is an influx of patients and a nurse needs assistance in triage, any staff nurse can help."

The triage training also helps when patients need to be retriaged. "We use different triage mechanisms throughout the care of any of our patients in the ED," Reidenbach explains. "If a patient suddenly becomes critically ill, any nurse can retriage that patient and determine the next level of care."

Abbreviate triage when physicians are available. "If there are only 2 or 3 patients and another patient comes to the ED, if you follow our normal triage practices, we would get the history and vital signs. But when there is a caregiver available, that process should be just to determine the level of care necessary. We do a briefer triage, have the patient registered and take them back to a room, instead of taking five or 10 minutes for triage and another two or three minutes for registration," Reidenbach explains. ■

Editor's Note: *For more information about the VHA National Benchmarking Consortia Study, entitled Emergency Services: Best Practices in Patient Flow Management, contact VHA Inc., 521 East Morehead Street, Suite 300, Charlotte, NC 28202. Telephone: (704) 378-2458. Fax: (704) 378-2415. E-mail: ccraig@vha.com. For a copy of the report on this project, please call VHA's member support services at 1-800-VHA-PLUS. The fee for the report is $195.*

ED *Spotlight on New Technologies*

Use of teddy bear nebulizers might make ED visits less stressful

Children are often apprehensive when in respiratory distress, and the use of a nebulizer can increase their anxiety. New Kid 0_2 aerosol and oxygen delivery systems shaped like teddy bears, in bright colors of yellow, orange, and green, are designed to calm children.

"Most kids will respond to the shape of a teddy bear because they probably have one at home. This is much less threatening than if you use a scary piece of medical equipment that looks like a big hose spewing vapor at them," says **Conrad Salinas, MD, FACEP,** chairman of the department of emergency medicine at San Bernardino County Medical Center (CA). "Instead of being apprehensive, they can hug the bear and not even realize they are getting medication."

Children are very nervous in this scenario, stresses **Diane Lomax, RN,** department administrator for emergency medicine at Kaiser Riverside Medical Center (CA). "Children who have respiratory problems and are unable to breathe effectively are very anxious," she notes. "Visits to the ED can be scary because we give medications and start IVs, so children are leery of any type of treatment we give them. If we can provide them with a cute little bear instead of a scary device, it's very beneficial for the child."

The teddy bears can impact the quality of care a child receives, Lomax says. "If the child is crying and moving [his or her] head back and forth, they are not getting a benefit from the mist," she explains. "They are already having difficulty breathing so you don't want to do anything that would increase their anxiety. If they are quieter and not fighting it, then you get a better result with the breathing treatment."

The bear-shaped nebulizers also have long-term benefits. "It helps physicians in the future, because the child will be apprehensive if a big mechanical device is thrust on them and they are held down," says Salinas.

The device also pleases parents, **Paula Sletten-Fenton, RN, MS, CEN,** ED manager Hemet Valley Medical Center (CA) says. "Parents of children we've given it to have very positive comments about it, because it makes the patient more willing to take the medication and distracts them. Parents would much rather have them use the bear than being held down because then the child develops a fear and doesn't want to come to the doctor again."

However, cost issues are a factor, since the nebulizers are $15.95 per unit. "We've got a fairly large asthma population, and these units are relatively expensive. The regular nebulizers cost under a dollar, so this is a difference of about $15. Therefore, we are very judicious about how we use them. Instead of using them on every asthma patient, we use them on children in distress," says Sletten-Fenton.

The parent can shed light on whether the child will become anxious with the nebulizer. "Ask the parent if the child has had a breathing treatment before. If so, how did they take it? If they indicate that the child hasn't done well in the past and has been very afraid, you know it's a good idea to use the bear," says Lomax.

Children take the teddy-bear shaped nebulizers home. "Parents like the idea of having the teddy bear to take home. The next time the child comes to the ED, the parents bring the bear with them so we can use it again," says Lomax. "We just hook it up, and a regular nebulizer fits right into the back of the bear. Also, some of these children have machines at home, so they can use it on their equipment at home."

The teddy bear nebulizers are a concept that reflects a trend, says Salinas. "It's an ingenious idea with many other applications," he says. "In the future, we [will be] looking at more surreptitious types of methods of delivering medications, especially to children." ■

Editor's Note: *For more information about Kid O_2's nebulizers, contact BLD Medical Products, 4450 Alpha Road, Dallas, TX 75244-4505. Telephone: (800) 872 9010. Fax: (972) 239 0310. World Wide Web: www.bldmedical.com*

Orientation of new physicians helps ensure smooth transition

Orientation of new physicians is often overlooked by ED directors, says **Dighton Packard, MD, FACEP,** medical director of the ED at Baylor Medical Center in Dallas, TX. "It's certainly an area that we can improve on. If you have a constant influx of new physicians every month, you probably have it down pat. But if you hire a new physician only every year or so, you probably don't have an orientation program set up," he notes. "Nurses have several weeks of orientation, but somehow we think doctors can do this an hour before their first shift."

Orientations are often poorly done, or not done at all, argues **Daniel J. Sullivan, MD, JD, FACEP,** chairman of the department of emergency medicine at Ingalls Memorial Hospital in Harvey, IL. "Most physicians pick up the day-to-day things fairly quickly, but there is no substitute for a good orientation," he stresses.

Here are some ways to improve orientation of new physicians:

Provide a manual. "It's a good idea to give new physicians a manual of answers to frequently asked questions," says **Tim McLean, DO, FACEP**, an ED

physician at Premier Healthcare, based in Dayton, OH. "That way, an employee can make notes to themselves as they go through and talk about the items with the ED director."

Give paid orientation shifts. This lends credence to the importance of the orientation process, says McLean. "This was a fairly significant debate for us, as to whether we should pay for orientation shifts or not," he recalls. "We consider it very important because, in all fairness, the physician is going to be working and seeing patients. Also, when we talk to new recruits, paid orientation is a good recruiting tool."

Have one person responsible for orientation issues. "There should be an administrative person who is, overall, responsible for orientation," says McLean. "That person ensures the ED director gets the checklist done, and that documentation is completed and sent back in a timely fashion. If not, it's a red flag, and the ED director gets a call from that person."

Start new physicians on the day shift. "We try not to put people on the night shift for the first few weeks, so people are around to answer any questions that come up," says McLean.

Allow enough time. "Generally, if the physician is new to the group and area, showing up an hour before the shift isn't going to cut it," says Packard. "Instead, ask them to spend an afternoon or morning with you when you are working, and stay connected at the hip. Physicians should spend a half-day actually observing, in addition to sitting down for an hour or two with the director."

A lot of scenarios will come up during that time, Packard notes. "The physician will have a chance to

Checklists: Important tools for a complete orientation

"If you seldomly orient people, you need a checklist to cover your bases. There are a variety of things that need to be covered," says **Dighton Packard, MD, FACEP,** medical director of the ED at Baylor Medical Center in Dallas, TX. *(See orientation checklist enclosed with this issue.)*

"Checklists are an important tool," says **Joel Stettner, MD, FACEP,** assistant chairman of the department of emergency medicine at Summit Medical Center in Oakland CA, and chairman of the emergency medicine group management section of ACEP. "This should include a list of items, such as how you get your meals in the hospital, what to do if an oncall physician refuses to come in, and patient management issues."

The following should be included in orientation:

Hospital policies and bylaws. "When you become a medical staff member, it's the hospital's responsibility to make sure you are familiar with their bylaws and policies and procedures, says Packard. "That is often delegated to the ED director, and, when a new doctor comes on board, they are handed a copy of the bylaws. But they are very seldom asked to sign that they've read it, which is the right thing to do," says Packard.

"You need to cover chart flow, patient flow, documentation, idiosyncrasies of your processes, how to order tests, how the results will come to you, who to refer cases to, what your call list is, and referral for outpatients that may be different than your call list," says Packard. "How do patients get admitted to hospital, do you have residents or trauma teams?"

Hospital bylaws can differ significantly, says Packard. "One hospital's bylaws may say that as a member of the medical staff, when you are on call, it is your responsibility to see that patient at least one time. Whereas other bylaws might not even speak to that," he notes.

If possible, a comprehensive presentation should be given. "We have five or six people who give an overview of the corporation, which is held at the corporate office," says **Tim MacLean, DO, FACEP,** an ED physician at Premier Healthcare Services, based in Dayton, OH. "A mini lecture series is also held in a single day, [including] COBRA, risk management, and documentation."

Differences in region. "You need to consider any significant change in environment, such as changing states or moving from a small rural to big urban facility," says Packard. "If somebody has only worked in Arkansas and they're now working in New York State, you need to orient them to the local laws. It's a different situation than if the physician has worked in New York all his life."

Hospital policy on writing of admission orders. A good orientation will alert physicians about appropriate admission order writing, says **Daniel J. Sullivan, MD, JD, FACEP,** chairman of the department of emergency medicine at Ingalls Memorial Hospital in Harvey, IL. "Physicians need to know the exact order writing climate in an institution," he stresses. "If they don't know what to write, critical patient care may be omitted. Also, it can lead to terrible communication problems and animosity between the ED doctors and primary care physicians."

ED physicians must understand legal risks of writing admission orders. "In recent years, in front of large

see how you interact with various people in the department. Problems you may not have thought about covering in orientation will come up and be taken care of."

Follow up. "A few weeks after a new doctor is there, you might ask them, did I prepare you for everything, or did you find something that you were unprepared for, was there anything that you were not expecting?" says Packard. "It's a good idea to give them your home number, and encourage them to beep you if they run into any problems."

Use the proctor system. "A lot of times, folks will come in with very little experience. So all our new physicians are proctored in the ED," says **Joel Stettner, MD, FACEP,** assistant chairman of the department of emergency medicine at Summit Medical Center, in Oakland CA, and chairman of the emergency medicine group management section of ACEP. "That way, they have the opportunity to deal with real life management situations with a new doctor who might not know their way around on-call lists, or the peculiarities of getting people admitted."

Summit Medical Center's ED has a formal process of proctoring. "During the first few shifts, the physician is always working with a more seasoned physician. The idea is not to look over their shoulder but to help with ongoing issues," Stettner explains. "This is a requirement for a defined length of time." A completed proctoring form is sent to the medical staff office before the physician is granted full privileges and is fully matriculated into the group, he adds.

'Shadow shifts' are extremely helpful for new physicians, says McLean. "Supervised shifts can help

groups of people, straw polls tell me that at least 50% of ED doctors are writing admission orders," says Sullivan. "However, writing orders does not increase exposure to liability. The more it looks like the ED doctor is responsible for admission care, the more likely it is that he or she will involved in a lawsuit related to the admission. The ED physician needs to understand that issue."

Policy for in-house resuscitations. This is a critical management issue that should be addressed during orientation, says Sullivan. "The range of responsibility should be very clear to new ED physicians," he emphasizes. "You must spell out exactly what is covered, [for example] resuscitations, deliveries, reading x-rays and EKGs, [or] pronouncing patient deaths?"

It should be explained that care to ED patients should not be compromised, says Sullivan. "There should be an express agreement that the ED physician cannot leave a critically ill patient in the ED," he says. "The ED physician should stay with the critically ill patient, and someone else called in to care for the in-house emergency."

Anything that is unique to your ED. "For example, we have disease reporting requirements that are a little different from other states," notes Stettner.

Individual hospital practices need to be explained, says Packard. "If you have a patient with hypertension that needs follow-up, in one hospital the patient will be sent to an oncall physician in internal medicine, but in another one that might be a strict no-no," he explains. "Instead, there might be a clinic, or a sub list of internists who take new cases."

Every ED handles things differently, says Packard. "You may have a particular way to report risk management incidents, or if a doctor has a problem with one of the medical staff physicians, maybe you handle it differently from most EDs," he explains.

Transfers. "Every hospital is different in terms of what kinds of cases your hospital cannot take care of and must be transferred, and where do they go," says Packard. "New physicians need to know what hospital they call for burns, pediatrics, and severe trauma cases."

EMTALA requirements. "Make sure physicians are thoroughly oriented in the requirements of EMTALA," says Stettner. "A new doctor who needs an ultrasound in the middle of the night needs to be told how to overcome resistance [from] radiologists."

Risk management concerns. "A new doctor might find himself involved in an incident that has potential risk. For example, there may be an untoward reaction to a drug where the physician might not have recognized an allergy and the patient deteriorates. That physician needs to know to report the incident early so the risk manager gets involved," says Stettner. "This is usually embarrassing to a doctor, but in fact you can get some support which can be very helpful in determining what follow-up steps to take."

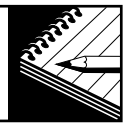
Billing. "Many of us are billing independently for our services," says Stettner. "New physicians may not understand how to identify, document, and accurately charge for their services. If a physician has policy statements to read, then [he or she] can absorb it at [his or her] own speed."

The group perspective. "A physician from another group or part of the country needs to understand what the new affiliation means. We have a new partner orientation program so a new physician gets oriented to the way our group operates," says Stettner. "That includes a series of presentations that address short- and long-term goals, culture, and management strategies. In addition, we give physicians a handout about the group's philosophy and guiding principles." ■

physicians prepare, by working with someone who's been there awhile," he explains.

Even experienced physicians may be thrown off by the idiosyncrasies of a new facility, notes Packard. "It's not the medical issues, since most physicians will be board eligible. Chest pain is chest pain no matter where you're at, but if you decide to admit it, how do you do it?" he says. "Who you call for admissions or refer people to can be overwhelming when you start at a new institution." he says. ■

GUEST COLUMN



ED compliance: Billing processes receive more attention

By Caral Edelberg

In late November, the Office of Inspector General (OIG) released it's long awaited Compliance Program Guidance for Third-Party Medical Billing Companies. This critical document provides the compliance expectations of the Federal Government with a "boilerplate" for all billing processes, whether performed by an outside contractor, within the medical practice, or by the hospital as a service provided to physicians. This compliance program, available for download on the HCFA website (http://www.dhhs.gov/progrog/oig.), provides a step-by-step approach to assuring the accuracy and legality of claims billed to payers.

The government has long been interested in increasing the monitoring efforts of the claims management industry as another layer of protection from fraudulent claims. The rapidly increasing complexities of coding and billing have far surpassed the reimbursement expertise of many physicians who, in ever-increasing numbers, are turning to professional vendors for assurances that the service is appropriately provided.

Until recently, billing vendors have enjoyed somewhat of a protection from sanctions that may be imposed on physicians' clients who break the law. Under carrier policy, the physician is ultimately responsible for all claims billed in his/her name. However, recent audit activities involving medical billing firms have proven that billing companies that knowingly process fraudulent claims can be held liable as well.

Benefits of a Compliance Program

A well-developed, well-managed compliance program provides safeguards for providers and billing managers by incorporating rules, regulations, and sound business practice into one comprehensive plan. The compliance effort formulates effective internal controls that can be used as the standard by which the billing staff and client physicians can be measured. Such controls are guaranteed to result in improved processes—from improved medical record documentation from physicians by or through more objective billing policies for clerical staff. By formulating sound, written policies, the collaboration, communication, and cooperation between providers and administrative staff is improved.

Employees, whether clerical or clinical, often voice concerns about confusing billing rules and poorly defined expectations. Generally, no employee wants to increase the risk of audit by making mistakes. Yet the ambiguity of today's billing rules, particularly the transitional documentation guidelines, the regulations governing billing for diagnostic interpretations, physician assistants, nurse practitioners, and teaching physicians, makes it nearly impossible to get a good, solid feeling of security on any front. This often holds true even with the clear, concise interpretations formulated by a cooperative effort between the billing company and the insurers.

A well-formulated compliance program provides some relief for these areas by providing those resources necessary to efficiently solve the problem for the providers and billing staff by assuring fast and accurate reaction to employee compliance concerns. Early detection and reporting of problems can be efficiently accomplished by outlining an effective communication process for all compliance concerns. For example, when a coder questions how to bill accurately for services provided by a resident assisting the attending physician in a teaching center, that information should be disseminated to all coders and catalogued in the coder policy and procedure manual to assure consistent and accurate coding of future teaching physician services.

Demonstrating commitment to quality performance of the billing process is an often stated but less often a proven component of billing system management these days. The difficulties and challenges are significant. However, the commitment must come from top management and trickle down through the organization for the mission to be realized. That places

increased responsibility and expectations on the management/administration staff to create an atmosphere of excellence—excellence that can often come at the expense of profit because of the extraordinary expense required to hire and retain competent staff and assure the "latest in technology" that the job requires. With their incomes declining, providers are looking for the "best price" with little knowledge of what is truly at stake when the job cannot be done correctly.

Billing agencies will also be expected to rely on their compliance efforts as a means of identifying and preventing the threat of criminal/unethical conduct by employees and clients. In essence, they will be expected to use their compliance efforts to monitor the activities of everyone associated with the billing effort. To many, this other, "watching" mentality is the most onerous responsibility advised by the OIG. Any methodology for encouraging official reporting of suspected problems, as well as managing investigational procedures, presents significant issues for most billing agencies who must now assure that the internal controls and management policies are in place to deal with this potential problem. Further, employment of sanctioned individuals should be avoided, and, if it is identified by the OIG, can be expected to have an adverse affect the outcome of investigations. As part of internal control measures, billing agencies should assure that there are no financial incentives for either clinical or clerical staff that would encourage upcoding or performance of unnecessary services.

Having established the importance of monitoring all individuals involved in the process, the OIG expects the outcome to be, in part, an improved relationship with the Medicare contractor as the billing company and the carrier work together to assure the reliability of the process. However, there is real concern that such an expectation will do much to erode the trust built between the billing agency and the client, which is a necessary component of building a strong, effective relationship.

Controlling the Risks for Billing of ED Claims

Emergency medicine's unique coding and billing challenges are, in part, brought about in no small way by payers' inability to view our issues apart from the "normal" office-based practice. This demands that we manage a higher level of risk. This is created by the types of patients the emergency physician and emergency nurse manage, and the lack of a simplified means of translating that service into documentation, codes, and charges. In identifying the major areas of risk in the medical billing process, the OIG has included numerous areas of specific concern to emergency medicine.

Billing for items and services not documented is the highest priority for most physicians and billers. Many physicians do not understand the significant constraints placed on coders who must follow the coding rules while attempting to convert poorly or illegibly documented services correctly into dollars. A justified national paranoia has infected most coders and severely affected his/her ability to "call it as they see it," regardless of his/her years of experience or what he/she can read "between the lines." "Assumption coding" has drawn the attention of the OIG. Coders and physicians alike are well advised to avoid the expectation that services not clearly documented can be coded. This demands a realistic approach to how documentation is ultimately interpreted for the coding process. The physician ultimately benefits when the coder minimizes the providers risk from the inevitable audit. However, providers and hospitals are recognizing the negative financial results when risks are over-minimizing by applying the most restrictive coding policies to those payers that have distinctly more liberal policies.

"Upcoding" is of considerable concern to the OIG and billing agencies alike. Upcoding should be a term that only applies to intentional "overcoding" of services. However, it has been liberally applied to those incidents where the subjective coding rules leave much open to interpretation—interpretation of the documentation requirements imposed on the physician; interpretation of the coding rules utilized by the coder; and interpretation of both of these by insurers with limited knowledge of coding applications for the emergency medicine environment where government regulations demand that everything must be considered an emergency until proven otherwise.

Coders should be required to obtain clarification from their providers when documentation is confusing or lacks adequate justification. Providers, in turn, should attempt to minimize the number of records requiring clarification, while welcoming the coders' attempt to code appropriately on their behalf.

Billing agencies can expect increased scrutiny of many components of the billing and coding process. For example, improper use of modifiers to obtain higher reimbursement will be monitored. Initially identified in the 1998 OIG Workplan, Medicare carriers have now been required to monitor the use of modifiers that result in higher payment. In emergency medicine, appropriate use of the -25 modifier should be outlined in each billing agency's internal coding practice policy to prevent audit and penalties for improper use.

The billing compliance plan should provide assurances that coding will not be performed without proper documentation of all physician and other professional services at the time coding is performed. Holding claims until all the information is obtained should be a mandate for the coding process. Shortcuts to the coding process that are achieved by coding incomplete records in order to speed-up the billing within a three- to five-day deadline is risky. It is not uncommon to find emergency department (ED) unit clerks assigning diagnosis codes from the chief complaint entered on the ED log in an attempt to "get the codes in before the bill drops," and it often results in improper and inaccurate diagnosis codes. With use of diagnosis codes now more critical for determining the need and payment for diagnostic tests and the general medical necessity for ED services, no ED coding should be performed on less than the final, legal medial record.

Other risky behaviors identified by the OIG involve more of the "business" of processing claims. These include the failure to resolve overpayments, a constant conflict between some providers and their billing agents—the providers want to hang on to refunds as long as possible to counteract diminishing income, and the billing agency must manage repeated requests for refund from irate patients. In addition, casual application of discounts and professional courtesy should be addressed as part of routine compliance and discontinued if the practice exists. Medicare prohibits writing-off balances for their beneficiaries and may frown on the practice altogether if discovered in an audit.

Computer systems will come under increased scrutiny, too, as governmental agencies evaluate the integrity of the billing process and the growing use of new software developed to streamline the coding process. But in doing so, the software encourages liberal interpretations of coding rules by coders.

Coding and Billing Training

Policy should be developed for each billing and coding process and should be consistently updated in a written policy and procedure manual. At the same time, training programs should be updated to reflect ongoing revisions to policy and regulations affecting the daily operations. At the same time, providers should be informed of any responsibilities that may effect the documentation of the services. Competency in any function is assured through practice during training and in "real-time" performance. Compliance demands that all providers and billing staff understand the rules and can successfully execute the process.

Selection and retention of knowledgeable staff is a key component of success and demands development and ongoing management of an effective training program relative to the tasks to be performed. For example, the staff responsible for posting payments do not need to be trained on documentation requirements at the level provided to the physicians! The OIG Compliance Plan includes the following components of a comprehensive training program that can be readily adapted to the emergency medicine environment. Each, in its own way, represents a body of knowledge and expertise necessary for successful application to the specialty of emergency medicine:

- **Knowledge of specific government and private payor reimbursement principles.** Coding and billing must take into account the variety of plans and rules applicable to each payer and provide assurance that employees follow each appropriately. Research of regulatory and policy issues should be the assigned task of knowledgeable individuals. Management should be expected to identify the necessary resources and assign responsibility for research of the issues relevant to emergency medicine.
- **Proper selection and sequencing of diagnoses.** In the practice of emergency medicine, the chief complaint and/or symptoms often take precedence over the final diagnosis in establishing medical necessity for ED care. Coders must first be proficient in general diagnosis coding principals and, to that knowledge, must apply the unique requirements necessary for successful coding in the emergency medicine environment.
- **Improper alterations to documentation.** Billing, coding, and professional staff should be aware of the legal restrictions on altering medical records. Physicians are permitted to provide addendums to medical records when necessary. However, physicians should exercise caution in routinely altering medical records to provide the necessary text to comply with documentation rules unless deemed medically necessary.
- **Submitting claim for physician services performed by non-physicians.** Specific rules have been formulated to determine when services performed by non-physicians may be billed to the Medicare program and other payers. Billing personnel should be proficient in interpreting documentation well enough to ascertain the differences. This would include nursing staff, physician assistants, nurse practitioners, and residents.
- **Proper documentation of services rendered, including correct coding rules.** Clinical and

billing staff should be able to recognize when documentation is deficient and code accordingly.

- **Duty to report misconduct.** More than any other component of the OIG Compliance Plan, this recommendation promises to be the most controversial. In essence, billing companies are encouraged to identify provider misconduct, advise providers to discontinue such activities if identified, and monitor to assure corrective action. If not corrected, the billing agency would be expected to either terminate the relationship with the client and/or report the inappropriate actions to the proper authorities. This recommendation from the OIG would supercede any confidentiality agreement generic to most contractual arrangements between providers and billing agencies. Misconduct by billing staff must also be dealt with quickly and, in severe cases where monetary overpayment from the government has occurred as a result of the offense, should be reported to the government for action.

Audits as the Cornerstone of Compliance

In order to demonstrate the importance of compliance to staff and providers as a company standard, a routine schedule of audits and quality assessment should be conducted and formally documented. To be effective, this program must function on multiple levels and involve the breadth of claims management. Often, outside auditors are required to provide an objective assessment of the coding and billing process. In addition, the management or compliance team should expect to conduct personal, on-site visits to each department to assess the daily process. Skills assessment may take the form of testing of billing and coding staff, surprise mock surveys, audits and investigations, examination of complaint logs, and interviews with management, operations, and coding. Tools for assessing the competence of staff may include questionnaires, review of personnel files for history of problems and documentation of corrective actions, review of written employee policies, policies and procedure for performing daily tasks, employee understanding, and use of resources and materials. Analysis of trends, along with longitudinal studies, are also a recommended as a means to identify deviations from established policies and documented norms.

Conducting Reviews of Provider and Billing Performance

As compliance audits must be relative to the task and area to be reviewed, reviewers must be qualified and experienced in order to adequately identify issues related to the subject matter. Reviewers would be expected to be objective and independent of line management and have access to existing audit and health care resources, relevant personnel and all relevant areas of operation in order to perform meaningful evaluations of competency. Following each routine evaluation, reviewers should be expected to provide written evaluative reports that specifically identify areas where corrective actions are needed.

Following scheduled internal reviews, management would be expected to take steps to correct any problems identified and revise policies and procedures, as applicable, to prevent future problems.

When Should I Develop My Compliance Program?

If you don't already have a compliance program you're way behind!! That's how important an organized compliance effort is. At the very least, it puts clients and staff on notice that following payer rules and performing each task with the maximum of care and competence is of paramount importance. It estab-

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lishes an expectation and provides the reassurance of its importance through routine evaluation. And it clearly states the corrective and disciplinary actions that will be taken when rules are broken.

Take some time, review the OIG's recommendations, and begin the process of safeguarding your business, whether it be billing or delivering emergency care. For a quick review, follow these steps:

- Designate a QA manager or compliance officer;
- Define policies and procedures through written manual;
- Educate and train staff and management;
- Communicate expectations;
- Audit and monitor outcome and process;
- Discipline when necessary; and
- Determine corrective actions. ■

Update on Access to Quality Care Act of 1999

ACEP supports the Access to Quality Care Act of 1999, the new managed care reform legislation introduced by Rep. Charlie Norwood (R-GA). "As emergency physicians, we strongly support provisions in the bill to protect patients from 'after the fact' claims denials of emergency care and prior authorization requirements that create barriers to care that can place the health of patients at serious risk," says **John Moorhead, MD, FACEP,** current president of ACEP. "ACEP is pleased to support this legislation, and we look forward to enactment of meaningful patient protections in the 106th Congress."

If passed, the bill would enact patient protection legislation that provides all Americans with coverage for emergency services consistent with the prudent layperson standard. This was adopted by Congress in 1997 as the standard for Medicare and Medicaid patients. ■

Readers are invited

Readers are invited to submit questions or comments on material seen in or relevant to ED Management. Send your questions to: Reader Questions, ED Management c/o American Health Consultants, P.O. Box 740059, Atlanta, GA 30374. Or, you can reach the editors and customer service personnel via the Internet by sending mail to: suzanne.zunic@medec.com. You can also visit our home page at http://www.ahcpub.com. We look forward to hearing from you. ■

CE objectives

After reading this issue of *ED Management*, the continuing education participant should be able to:

1. Discuss and apply new information about various approaches to ED management.
2. Explain developments in the regulatory arena and how they apply to the ED setting.
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication.