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Health systems turn to stand-alone EDs to handle surges in demand, bids for market share

Some stand-alone facilities offer both emergency and urgent care

With demand for ED beds surging as the nation's demographics, health care needs, and finances continue to change, a number of health systems across the country are opening stand-alone EDs — freestanding centers that are staffed by emergency physicians and deliver emergency care, but are not attached to a main campus or hospital facility. In some cases, these stand-alone EDs are meeting a clear community need for emergency care in underserved areas, while in others, they are helping established health systems expand their market share or decompress hospital-based EDs that are overrun with patients.

Regardless of the primary motivation for establishing a stand-alone ED, the number of such facilities is growing rapidly, according to the American Hospital Association. And consumers clearly like the convenience of these new centers, although pioneers with this concept stress that community edu-

EXECUTIVE SUMMARY

Stand-alone emergency departments are cropping up across the country as health systems endeavor to manage increased demand for emergency care, while hospital-based facilities are declining. Some health systems are also using the strategy to enhance their market share or to establish a footprint in a fast-growing area.

• Humility of Mary Health Partners based in Youngstown, OH, has established stand-alone EDs to gain market share in fast-growing areas, as well as to meet the needs of under-served areas.

• Ridgeview Medical Center in Waconia, MN, opened a stand-alone ED facility 10 miles away that also offers urgent care. One triage process determines whether patients will be siphoned to urgent care or emergency care areas. Urgent care patients typically offer lower reimbursement rates.

• Ridgeview administrators worked with area hospital providers to remove barriers or disincentives that might prevent patients from accessing care at the health system's stand-alone ED.

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cation is critical to helping the public understand the difference between "urgent" and "emergency" care.

Establish a footprint

Humility of Mary Health Partners (HMHP), a Youngstown, OH-based health system that includes three hospital campuses, first began operating a stand-alone ED in Andover, OH, when it came along with the purchase of a hospital in the late 1980s, explains **Genie Aubel**, President, St. Elizabeth Boardman Health Center (SEBHC) in Boardman, OH. "The [stand-alone] ED delivers needed care to a rural area that is about 50 miles from the health system's main campus," says Aubel. "That one we inherited, and it has run well."

However, in 2001, the health system decided to open another stand-alone ED for more strategic reasons, says Aubel. "We wanted to build a new hospital [in Boardman, OH], about 10 or 15 miles south of our main tertiary center hospital, but we wanted to get in the area first before other [providers] — to get ourselves a footprint before building a hospital, so we put a [stand-alone] ED there," she says.

The effort began modestly with a modular unit that featured nine emergency care beds, but Aubel explains that it drew people to the area and got them used to coming to the property for emergency care.

Three years after the opening of the modular unit, a permanent ED was constructed on the property. "At this point, we already had a good volume of patients coming in," says Aubel. "People were used to our service line, and the facility was already break-even."

The permanent ED functioned as a stand-alone facility until the new hospital was constructed and opened on the site four years ago. "We were down in this market for six or seven years with an off-campus-based ED that was not attached to a hospital until 2007," says Aubel. "It was a phased-in strategy that helped us step into this market."

Consider demographics

While the stand-alone ED in Boardman was just a stepping stone to a new hospital, the health system had plans for another stand-alone ED, which it opened in Austintown, OH, in November of 2004. "That ED continues to be separate [from a hospital], and in our minds, it will always be separate," explains Aubel, although she says the strategy in opening the Austintown facility was also to increase market share.

Further, deciding where to locate the stand-alone EDs had everything to do with demographic studies that assessed where populations were moving and what facilities people were using for care. "Boardman, which is where we built the hospital, is the fastest growing area [in our region]. Austintown, which is where our non-hospital ED is located, is where the second largest growing population is," says Aubel.

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"It was a strategy to increase the feeders into our facilities, as opposed to patients going to other hospitals," she says. "And it was also a strategy to decompress some of our hospital-based EDs. Nationally, hospital-based EDs are overcrowded, so [the Austintown ED] gave people another option that was about 10 miles away, and that was extremely well-received."

When the Austintown facility first opened, it had nine beds, and administrators calculated that it needed to treat 30 patients per day to break even. The facility met that goal within six months, says Aubel, noting that the facility has since been expanded to 15 beds. "Now we're seeing 85 patients per day, and we have had days where we see more than 100 patients."

Get EMS providers on board

There is a lot more involved with making a stand-alone ED successful than just finding a strategic location, stresses Aubel. You also have to work with the EMS squads in the area to make sure they understand the capabilities of the stand-alone ED, and when patients have needs that can more appropriately be addressed at the hospital-based ED.

"The relationship with EMS is really key. We hosted breakfasts and luncheons to sit them down and let them know what we were doing and to get their input," says Aubel. "We have meetings with them throughout the year, we celebrate their EMS week, and we really try to be hand-in-glove with them."

For example, EMS providers understand that trauma cases, heart attacks, and any case that is likely to require hospital admission should go to a hospital-based ED, but the stand-alone ED also has the flexibility and resources to accept any patient, explains **Janet Divelbiss**, RN, BSN, CEN, the director of emergency nursing services for both SEBHC and the St. Elizabeth Emergency and Diagnostic Center in Austintown.

"Patient preference is number one in the state of Ohio, so if the patient says he wants to go to Austintown, the EMS provider will take him there," explains Divelbiss. Similarly, if the hospital is on diversion, or a patient headed for the main campus has an airway issue or some other problem that requires immediate attention, the Austintown facility will assist. "We have an ED physician, but no specialty services at Austintown," says Divelbiss. "So the ED physician will talk to [clinicians at the main campus], and then we'll send the patient straight to the main ED to be cared for there."

The health system has what Divelbiss refers to as a mobile ICU to transport patients to the main campus, and she indicates that this is one of the main reasons for the stand-alone ED's success. "We can get an MI [myocardial infarction] in and out of our facility in 25 minutes, and straight to the cath lab at the main hospital," she says. "We also have priority for beds when our patients are waiting for beds at the main hospital."

What this means, in practice, is if there are two critical patients, one at the Austintown facility and one on the main campus, the patient from the Austintown ED will receive priority for a bed because the patient in the hospital-based ED already has access to a blood bank, anesthesia, surgeons, and all the other specialty services that are available on the main campus, says Aubel. *(Also, see Management Tip: Prioritize team cohesiveness over flexible staffing, p. 101.)*

Educate the community

Getting the EMS squads in the area up to speed on the Austintown ED's capabilities was a relatively simple matter because of their expertise and familiarity with emergency procedures. A much more difficult task was educating the community about how they should most appropriately use the stand-alone ED facility, and what the difference is between emergency care and urgent care, explains Aubel. "Our system does operate urgent care facilities in another country," she says. "To try and reeducate the community on what is appropriate for urgent care or, in this case, what is appropriate for a non-campus-based ED is very difficult no matter how you try and do it."

The health system sent representatives to speak with community groups, sent out news releases, used direct mail, and spoke to local media in their attempts to educate the community in advance of the opening of the Austintown ED, and some of these activities are ongoing. However, they still get patients who think they are coming to an urgent care facility, and are unpleasantly surprised by their co-pays, which are at the same ED-based rate that the hospital-based ED uses.

"We use the same triage system that all the hospitals in our system use, but we do get a lot more of the lower acuity patients at Austintown," explains Divelbiss, estimating that roughly 60% of the patients that come to the Austintown ED are [Emergency Severity Index graded] 3s, 4s, and 5s, whereas 40% of the patients who go to the hospital-based EDs fall into these categories.

This failure to understand the different reimbursement rates between ED care and urgent care can lead to some patient dissatisfaction, but for the most part, patients seem to prefer the stand-alone ED, says Aubel. "There is no question that we have pulled patients out of the main hospital-based ED, and that we have pulled patients from our competition, which was the strategy," she says.

Further, the Austintown facility sees 150 patients per month who have never before registered at an HMHP facility, the average door-to-doc time is under 30 minutes, and patient satisfaction for 2010 was at 90%, says Divelbiss.

"We would seriously consider opening other [stand-alone EDs]," adds Aubel. "We don't have current plans put to paper, but we would seriously consider it because this has been successful for us."

Try ED plus urgent care

A newer entry to the stand-alone ED field is Two Twelve Medical Center in Chaska, MN. The center, which opened on February 1 of this year, is owned and operated by Ridgeview Medical Center, which is about 10 miles away in Waconia, MN. The hospital has an attached ED too, but it represents too far a drive for many in the rapidly growing region to the south of Ridgeview, say hospital administrators.

"We believe there are enough [hospital] beds around this area, but there wasn't enough access to emergent or urgent care, so we looked at this model in other areas, and felt like it would be a good fit for the community," explains **Mike Phelps**, MBA, Chief Administrative Officer, Ridgeview Medical Center.

Like the stand-alone ED facilities operated by Humility of Mary Health Partners in Ohio, Two Twelve Medical Center is open 24/7, but unlike those facilities, Two-Twelve offers both urgent and emergency care. All patients who are walking into the facility check in at the front desk and will then be triaged, explains **Ben Nielsen**, MHA, the executive director of the new facility. "The triage nurse will do the appropriate assessment, and at that point, he or she will make a decision on what path the patient will go through — whether it is urgent care or emergency care," he says. "If a [designated urgent care] patient gets to the back and sees the physician, and the needs are more critical, then we could flip the urgent care patient to an emergency care patient."

Patients siphoned toward the urgent care pathway will be reimbursed at a lower rate than patients who require emergency care, explains Phelps. "It is something unique. We haven't seen any other combined urgent care-freestanding ED facilities, but we had the desire to compete with some of the [walk-in] clinics and other retail-oriented urgent care centers around," he says. "We wanted to have a model that not only competed, but also has better traction because it is not just open 8 to 10 hours a day like most urgent care facilities. It is open 24 hours a day."

Work with other hospitals

Another advantage to the approach is that the health system not only owns the stand-alone Two Twelve facility, it also owns the ambulance service. "We serve 700 square miles with ambulance service," says Phelps. "That has allowed us the comfort of having a relationship where we could know that we can transport a patient at any given time."

Further, administrators have worked with other local community hospitals throughout the large service area to eliminate any obstacles or negative incentives that might prevent patients from using the Two Twelve facility for care. "We work with those hospitals to find ways to directly admit to their floors so that patients don't have to go back through the EDs at the hospitals they are transferred to, generating more bills," says Phelps.

In addition, since the health system owns the ambulance service, administrators decided not to bill any of these hospitals for the transfer of patients to those facilities. "We don't want that to be a barrier to patients coming here, so we just do that service for free."

Two Twelve administrators are tracking metrics, but say the facility has not been open long enough to report meaningful data as of yet. However, they say patients are providing positive feedback on their experiences with the facility, and Ridgeview's hospital-based ED has seen volumes eased by about 10%.

Phelps acknowledges that turning many ED visits into lower-cost urgent care visits represents a financial hit to the health system, but he believes that lowering the cost of care will ultimately pay off for everyone involved. "We see it as a big benefit to commercial payers, to patients, to Medicare, and I think it could be a model for the future." ■

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Management Tip

Prioritize team cohesiveness over flexible staffing

For hospitals that operate more than one ED, it can be tempting to share clinicians and staff between the various facilities, but **Genie Aubel**, president, St. Elizabeth Boardman Health Center in Boardman, OH, suggests that greater benefits may come by enabling people to work within their own core groups. "You want to keep one team working together because the team knows how it operates," she says. "You want the concept of a team." ■

Get ready for new scrutiny of cell phone-, tablet-based medical apps

At long last, FDA issues draft guidance on what to expect

The Food and Drug Administration (FDA) has made it clear that cell phone applications that aid in clinical decision-making or act as medical devices will soon be subject to the strictest Class II and Class III regulations. The news comes in the form of long-awaited draft guidance issued by the agency in July, and it puts clinicians and ED managers on notice that they need to insure that any relevant phone or computer tablet applications that are used in their care settings are properly FDA-approved.

"It is incredibly significant, and a very big step that was needed from the FDA," observes **Zachary Bujnoch,** senior health care industry analyst in the San Antonio, TX, office of Frost & Sullivan, a global consulting firm. He explains that up until now, applications that essentially transform cell phones into functioning electrocardiograms, for example, have been largely unregulated. "Now there is guidance out there that says that this type of application is a medical device," adds Bujnoch.

The draft guidance may leave some clinicians still wondering whether their cell phone- or tablet-based applications are subject to more rigorous FDA regulations, but it provides a long list of specific applications that would fall under the more rigorous regulatory oversight, including:

- Apps that attach EKG/ECG leads to a mobile platform to collect/analyze/monitor EKG/ECG signals;
- Apps that connect wirelessly to a blood glucose tester to display, calculate, trend, convert, or download results to a PDA;
- Apps that act as a blood glucose meter by using an attachment to a mobile platform;
- Apps that use the mobile platform with or without a microphone to act as an electronic stethoscope to amplify heart, lung, blood vessel, enteral, and other body sounds;
- Apps that use a mobile platform to upload electroencephalograph (EEG) recordings and automatically detect seizures;
- Apps that use pictures and sound to diagnose conditions by comparing to previously determined diagnoses of images, symptoms, sounds, or other physiological measurements;
- Apps that use a mobile platform in determining blood donor eligibility prior to collection of blood or blood components.

(To see the full list of examples, review the FDA's draft guidance here: http://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/UCM263366.pdf)

In brief, if a tablet or cell phone application assists you in making a clinical decision, then you need to make sure the software you are using is FDA approved, explains Bujnoch, but he acknowledges that there are still many applications that are not specifically mentioned in the document. What is clear, however, is that regulators are trying to draw a line between mobile applications that pertain to wellness and are not subject to stricter regulation, and applications that are used for clinical decision-making and, therefore, must be subject to the higher regulatory standards, adds Bujnoch.

The FDA is accepting input on the draft guidance, and may not formalize these standards until next year, but Bujnoch believes the document already has

some teeth. "It is really going to put the squeeze on a lot of [mobile application] companies that don't have their regulatory act together," he says.

Further, he advises ED providers to familiarize themselves with the draft guidance, as well as what types of mobile applications are used in their care settings. "This is an area where things are going to change, and you need to be aware of it," he says. ■

SOURCE

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Turn to staff for dramatic improvement in wait times, productivity

Volunteer team members weed out inefficiencies

When it's typical for patients to wait four hours or more to see an emergency physician, and your leave-without-being-seen (LWBS) rate is pushing 10%, you know it's time to rethink the whole process. And these were the grim realities facing the ED at Baylor Medical Center in Garland, TX, as recently as two years ago, explains **Steve Arze**, MD, the medical director of the ED.

"We had hit the point where our waiting times had just become too long to be safe," he says. "While there are certainly places in the nation where the wait times are longer, we were not in a place that we felt was appropriate for our patients."

Taking a closer look at the problem, administrators quickly realized the issue was hardly inadequate staffing levels. "As patients would pile up in our waiting room, there were doctors who were not seeing patients and nurses who were not seeing patients," says Arze. Instead, what was gumming up the process was a triage plan that was packed with too many unnecessary steps. "There is no reason to wait to see a triage nurse, for instance, if there are plenty of beds open in the area where patients need to go," adds Arze.

The ED managers could have re-engineered the process themselves but, instead, they handed the problem to a cross-section of ED staff who volunteered to put the patient-flow process under a microscope and identify inefficiencies, explains **Brennan Bryant**, RN, MSN, MSHCAD, the hospital's director of emergency services.

"They developed solutions to the bottlenecks," says Bryant, and the results have been stunning. The average length-of-stay (LOS) for patients discharged from the ED has decreased by 36 minutes, and the average LOS for admitted patients has decreased by 91 minutes. "In essence, we have added 11 beds without really changing anything other than the process flow through the ED," adds Bryant. "It's phenomenal."

Take a team approach

To get the volunteer team started, management collected detailed time metrics on every portion of the patient-flow process from arrival to triage to the total LOS, explains Bryant. "We mined that data and presented it to them so they could basically brainstorm around what [changes] they felt would deliver the most bang for their buck," he says.

The team pored over the data and came up with 33 processes and efficiencies that could be improved; then the challenge was to whittle that list down to a workable group of changes based on frequency of occurrence and the impact on overall LOS, adds Bryant.

For example, the group streamlined the triage

EXECUTIVE SUMMARY

Baylor Medical Center in Garland, TX, has been able to drastically reduce ED wait times, as well as the LWBS rate by streamlining the triage process and implementing a staff-driven improvement effort aimed at identifying inefficiencies and replacing them with solutions that work. The result is 11 beds of added capacity just from changes in patient flow.

- A cross section of volunteers from the ED staff reviewed metrics and devised solutions that they felt would work best to boost efficiency and eliminate bottlenecks.
- Solutions included letting low-acuity patients move themselves between care settings, freeing the charge nurse from patient care duties so that he or she could oversee patient flow, and empowering physician-nurse teams to see patients more quickly.
- ED managers say leadership is important, but letting staff drive the improvement process is key to their success.

process so that patients are now asked a minimal number of questions — just enough to ensure that they proceed to the most appropriate area for care, which is either a location designated for lower acuity complaints or the main ED, explains Arze. "A full triage, including extensive histories about what happened to the patient, why they are there, what type of medicines they are on, and who their physicians are — all of that can be done later and does not need to be obtained before the patients are connected with a physician," he says. "The triage really becomes a quick screen to determine what area the patient needs to go to, and then a primary nurse gets the remainder of the information about that patient at a later point."

Another change to the process is that physicians no longer have to wait until a chart is generated by a nurse before they see the patient, says Arze. "We have a team approach in that either of them can go on independently to see the patient."

If the physician sees the patient first, he or she will go ahead and take the history and issue orders without waiting for the nurse. This enables the team to see several people at a time rather than waiting for each patient to come through the process in a sequential manner, explains Arze.

Let low-acuity patients travel solo

Looking beyond triage, the volunteer team realized that efficiencies could be gained by enabling lower-acuity patients to travel from one point of care to the next on their own rather than being escorted by staff. To facilitate this "standard conveyance" model, the staff developed signage on the walls and floors so that patients could be easily directed to the right place, explains Bryant. "For patients headed to radiology, for example, we have these little bones on the floors. The patients are taken to where the bones start, and then they are told to follow the bones down the hall, turn to the right, and have a seat in the chairs where someone from radiology will pick them up," says Bryant.

A computerized tracking system lets ED staff know where patients are throughout their ED stay, adds Bryant. There are more than 40 computer monitors in the ED so that a monitor is available about every 10 feet to let staff see where a patient is on his or her journey, he explains. "They can see whether labs have been ordered, drawn, or returned, and the same thing for radiology and other procedures," adds Bryant.

Some job responsibilities have been realigned as well. For example, in the past, the charge nurse would typically take care of some of the sickest patients and assist staff when they became overloaded, says Bryant. "The team found that we had lost that high-level vision of what is going on in the whole ED … so they rewrote the job description of the charge nurse to pull [this person] out of direct patient care and put him or her back where the position needs to be, which is as kind of the traffic cop of the ED," says Bryant. "That has worked very well."

The volunteer team also observed that roughly 46% of the ED's volume was being handled in seven rooms that make up the rapid medical evaluation area, but these rooms were under-staffed, so they adjusted the staffing matrix to better support this area, says Bryant. However, as they addressed staffing for the lower-acuity patients, they found that this change also lessened LOS times for the more acute patients. "For patients admitted to the hospital, LOS in the ED was decreased by 91 minutes," adds Bryant.

Much of this improvement can be explained by the snowball effect that having success can create, suggests Bryant. "Once the team started to see results from the process changes that they had envisioned, it became kind of a self-fulfilling process," he says. "Success breeds success, and when the turnaround times began to rapidly go down, everybody realized that working together as a cohesive unit and actually bringing the patient into the care team really helps to effect change."

Look for boost in productivity

Any type of change is likely to prompt questions or even skepticism when people are used to doing things a particular way, but Arze stresses that in this case, there wasn't much grumbling. "On the physician side, we were able to increase the number of shifts that we had because our productivity increased so much," he says, noting that the revenue to pay for these shifts came from capturing paying patients who previously left without being seen. The LWBS rate has dropped from 10% to 2% since the improvement process began, adds Arze.

The improvements are also evident in the brand new ED that the hospital constructed about six months after the improvement process began. "We now use less space than we used to in our old ED to see the same number of patients," says Arze. "It's just purely because of the improvements in efficiency that we have achieved. Patients don't linger in our beds for a long time because we are able

to move them through quickly. That has enabled us to essentially reduce the number of beds that we have to have operational at any one time." ■

Management Tip

Empower staff to find and implement solutions

If you want to see substantial improvement in one or more of your ED metrics, consider turning the task over to the people who actually do the work, advises **Brennan Bryant**, RN, MSN, MSHCAD, the director of emergency services at Baylor Medical Center in Garland, TX.

"The most important thing is for the leadership team to put aside preconceived notions of what will work, and really trust in the bedside staff," he says. "The people who do the work day-by-day have the solutions, but often times they haven't been empowered to enact them."

While it is critical to loosen your control over the process, you do need to continually check with staff for progress reports as they are working on projects, and you need to celebrate their wins, stresses Bryant. "However, resist the urge to micromanage or steer the boat in the direction you think it should go."

Bryant contends this type of staff-driven approach fueled dramatic decreases in both wait times and the leave-without-being-seen rate in the ED at Baylor Medical Center at Garland. "I think that is why our [improvement] efforts have been so successful and why they will continue to be successful," he says. "They are staff-driven, not leadership-mandated." ■

SOURCES

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Survey: ED physicians report burnout, desire help for dealing with frequent users

Detroit approach identifies frequent users, connects them with resources

It's no secret that emergency medicine providers are frustrated by patients who inappropriately come to the ED for primary care, pharmaceuticals, and help with a wide range of social issues. However, a new survey suggests that ED physicians are experiencing burnout from dealing with these frequent users, and a majority of respondents would like to see their health systems develop programs or strategies for more effectively managing these types of patients.

The 18-question survey, which was conducted by the Henry Ford Health System in Detroit, MI, was sent to a random sampling of 1,500 ED physicians across the country between July and October of 2010. A total of 418 physicians returned the anonymous survey, representing every state except Alaska. Among the survey findings:

• 59% of physicians said they have less empathy for frequent users than other patients;
• 77% of physicians said they held bias against frequent users;
• 82% of physicians said they feel some level of burnout from frequent users;
• 91% of physicians reported that frequent users pose challenges for the ED.

EXECUTIVE SUMMARY

A new survey conducted by Henry Ford Health System in Detroit, MI, suggests that a high percentage of ED physicians feel burned out from treating patients who repeatedly use the ED inappropriately for primary care, pharmaceuticals, and a wide range of social issues. Further, only about 30% of hospitals have programs in place to better manage these patients.

- Three-quarters of the ED physicians surveyed said they held bias against frequent users of the ED, and 59% said they have less empathy for these patients than for other patients.
- Henry Ford Health System has a program that identifies frequent ED users through its electronic medical record, and takes steps to connect these patients with more appropriate care and assistance.
- Experts point out that while there may be no current financial incentives for developing programs to address inappropriate ED use, that could soon change with health reforms pushing for more cost-effective care.

Jennifer Peltzer-Jones, RN, PsyD, a clinical psychologist in the ED at Henry Ford Hospital, which led the survey, says these findings suggest that health systems need to take a much closer look at the issue and come up with solutions. "When an overwhelming [percentage] of physicians say they have burnout, and that they are having issues with feeling empathy for frequent users … then I think ED managers need to implement some type of program, not just for patient care, but also for physician care," she says. "We found that only 30% of EDs have a program [for managing frequent users]," she says. "We expected to find many more places that had programs."

In fact, one of the reasons for doing the survey was to find out how other health systems were managing this patient population. However, programs designed to manage or assist with frequent ED users were so scarce that researchers had little to compare, she says. What's more, a number of respondents provided comments on the survey, noting their need for added resources. "Many physicians stated that their hospitals needed a program to help them, and that these patients are a source of daily frustration," adds Peltzer-Jones.

Researchers did not measure or analyze the impact of these results on patient care. That will require future studies, says Peltzer-Jones.

Identify frequent users

The Henry Ford Health System has had a program to manage frequent ED users since 2004. Called Community Resources for ED Overuse (CREDO), the program identifies frequent users through the health system's electronic medical record. A multidisciplinary team meets twice a month to plan care for these patients, explains Peltzer-Jones, who co-directs the program with an attending physician in the ED.

"We do a comprehensive review of each patient's medical record to see what kinds of things are going wrong with the patient and why he or she keeps coming in," explains Peltzer-Jones. "We have patients who come to the ED more than 60 times a year, and this is not just because they don't have a family physician."

For example, many of these patients are homeless or suffer from mental health issues; others have transportation difficulties that prevent them from accessing care in a more appropriate setting, says Peltzer-Jones. With support from case managers and social workers, the CREDO program attempts to connect these patients with community resources that can address these needs.

"We are not in the ED 24/7, but the program is, and it can be easily accessed through the electronic medical record. We also have patients identified at triage so that they are [picked up by the program] as soon as they walk in the door," adds Peltzer-Jones. "It is a very comprehensive approach, and the results may not happen immediately, but we are often seeing these patients over the course of several years."

For example, substance abuse problems often require time and effort to get resolved, stresses Peltzer-Jones, noting that in these cases, trained staff will engage in consistent motivational interviews in the hope that they will be there when patients are ready to stop.

While payers favor programs that keep high utilizers out of the ED, there is not necessarily a financial upside for hospitals, which may, in fact, be losing ED revenue as a result. However, Peltzer-Jones stresses that health care reform may alter the financial incentives that are currently in place. "If Medicare is going to cut back on paying for readmissions to the hospital, the next down-river possibility could be cutting back on recidivism in the ED," she says. "Why pay for someone to be in the ED three times a week?"

Regardless of the financial picture, however, Peltzer-Jones stresses that more effectively managing these patients is the right thing to do for patients as well as providers. "When patients keep coming back to the ED, clearly there is a bigger picture we need to look at." ■

SOURCE

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ED Coding Update

ED frequent flyers and the impact on payment for medically necessary services

[This quarterly column is written by ***Caral Edelberg****, CPC, CPMA, CAC, CCS-P, CHC, President of Edelberg Compliance Associates, Baton Rouge, LA.]*

With our economy in shambles, and July unemployment at 9.2% nationally — just short of the all-time high of 10.81% and way off the mark of the all-time low of 3.31% — fewer and fewer ED patients are insured, and it's a significant challenge to manage the resulting uptick in ED visits. Looking at current ED coding and billing audit activity, it seems apparent that payers for those ED patients with insurance are looking closely at medical necessity for the ED visit and focusing on pre-existing conditions to deny or reduce ED payment. Unless the documentation supports the need for the patient's visit, payment for claims may be reduced or denied altogether. It is a common misconception that frequent flyers are abusers of the ED. However, with no other means of healthcare, EDs have become the nation's primary care source for many patients.

How we define ED "frequent flyers" varies from one study to another. The Henry Ford study defined frequent users as patients who visit the ED at least 10 times per year. Excerpts from the *Annals of Emergency Medicine* indicate that frequent users are those ED patients who are seen four or more times per year. A South Carolina Public Health Institute study defined frequent ED users as patients who visit an ED five or more times per year.

Clearly, there is a significant disparity between how frequent users are defined. However, much of the information that is available indicates that these patients are frequent users because they are in poor physical or behavioral health and lack health care alternatives to the ED.

In 2006, the *Annals of Emergency Medicine* study determined that "the majority of adults who use the ED frequently (4+ times per year) have insurance and a usual source of care but are more likely than less frequent users to be in poor health and to require medical attention. The February 2011 South Carolina study referenced patients with private insurance as the largest and most quickly growing group of ED users and, yet, according to the national Bureau of Statistics, South Carolina has one of the highest jobless rates in the United States (10.5%), as well as in South Carolina's history. Therefore, it would appear that the majority of our repeat customers have insurance and require our services.

What is medical necessity as it relates to an ED visit? An emergency condition and prudent layperson are defined as, "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment of bodily functions; or (iii) serious dysfunction of any bodily organ or part." Payer interpretations of "serious," however, vary, and can make it difficult to support marginally documented ED visits.

Payers generally use the nature of the presenting problem (NOPP) and details relating to medical decision-making to determine whether or not services are medically necessary. Templated documentation systems often prompt high-level history and physical examinations to prevent loss of important details, but are not often used to defend medical necessity unless a number of pertinent positives and negatives are documented. Conflicting documentation (history of present illness [HPI] patient with "shortness of breath and wheezing;" respiratory review of symptoms [ROS] "negative;" respiratory pulmonary embolism [PE] "negative" or not documented) complicates the audit appeal process when medical necessity is the issue under review.

Payers are increasing their review of medical necessity and using deficient documentation to deny claims. Documenting detailed information about the problems patients are experiencing and what is done about them will support medical necessity, particularly for those patients with chronic conditions or low severity NOPPs that, upon investigation, are determined to be more significant problems.

The correlation between a detailed NOPP, strong HPI, differential diagnoses, orders, details about the ED course, and disposition of your patient can protect your revenue in an audit. If you are not using a templated system, use an outline to remind you of what needs to be addressed to support the services you provide. Most important, remember that your charts will be judged by an outsider, not someone familiar with your facility, your handwriting, and your unique abbreviations. Emergency medicine providers should remember to document clear and concise notes and use documentation to support clinical justification for the patient's decision to come to the emergency department for these medically necessary services.

Nature of Presenting Problem (NOPP): Be sure to capture the patient's complete discussion of what brings him or her to the ED. Add some of

his or her own words and don't summarize with clinical terminology: *Mr. Jones presents today with a chief complaint of generalized fatigue, dizziness, lethargy, and problems concentrating*. "I just don't feel right and my legs are weak and my head spins when I get up. I am afraid I will fall. I can't remember when this started but I feel like I'm getting worse."

History of Present Illness (HPI): The history of present illness, as well as medical decision making are significant indicators of medical necessity and are used by payers to determine the appropriateness of the ED visit. Each element of the HPI is important. For each patient, consider and record, as indicated, the location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem.

Differential Diagnoses: Differential diagnoses help to define the problems that are being considered, support the orders for further study or medications, and help other providers, coders, and auditors to understand the significance of the emergency physician's work plan. As long as they are relevant, differential diagnoses are a significant element of medical necessity.

Orders: Physician orders are used to score the complexity of each ED case. Orders for, and interpretations of, diagnostic studies, type and route of medications, comfort measures, and patient monitoring are significant indicators of the complexities of the patient's condition that are being managed during the ED visit.

Overall ED Course: Include a discussion of your thoughts about patients who present with routine complaints, as they are determined to be more significant following study and observation. Think RISK FACTORS and correlate them to the work you are doing to rule out a more significant problem.

Disposition: "I am admitting this patient for further study of _____;" "We will observe the patient's condition and administer _____ for a period of _____ and monitor the results to assure that _____ is resolving or _____ is not present;" "I will discharge this patient and request that he/she schedule an appoint with Dr. Orthopedist for further examination and stabilization of the fracture within 3 days;" " I am transferring this (urgent care)patient to the emergency department for additional care," "I am transferring this patient to the heart center for _____ and have stabilized for transfer."

If you are audited for medical necessity problems, review your records and appeal each case individually with a narrative to support each of the elements discussed here. Many appeals are successful when a payer better understands the elements of emergency care. Although many payer auditors are unaware of Prudent Layperson and EMTALA, medical necessity is supported by documenting the patient's needs and the rationale for the important services we provide. ■

COMING IN FUTURE MONTHS

- EDs become early beneficiaries of health information exchanges
- Patient safety takes center stage in new hospital initiatives
- Strategies to ease tensions, avoid confrontation in emergency settings
- Universal truths about patient flow

CNE/CME INSTRUCTIONS

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the evaluation is received, a credit letter will be sent to you. ■

CNE/CME OBJECTIVES

1. Apply new information about various approaches to ED management.
2. Discuss how developments in the regulatory arena apply to the ED setting.
3. Implement managerial procedures suggested by your peers in the publication. ■

CNE/CME QUESTIONS

1. Why are health care systems across the country turning to stand-alone EDs?
A. to provide care to under-served areas
B. to decompress traditional hospital-based facilities
C. to obtain increased market share
D. all of the above

2. Why is community education important when establishing a stand-alone ED?
A. Patients don't like to use stand-alone EDs.
B. Patients often don't understand the difference between stand-alone EDs and urgent care centers.
C. Patients ask too many questions when they come in for care.
D. There is a difference in the reimbursement formula for care that is received at a stand-alone ED vs. a traditional hospital-based ED.

3. What type of cell phone and tablet applications are coming under increasing scrutiny by the Food and Drug Administration?
A. applications that are used to gather registration information
B. applications that are used for wellness purposes
C. applications that aid in clinical decision-making or act as medical devices
D. applications that are used for provider-patient communications

4. How do ED staff at Baylor Medical Center at Garland, TX, direct lower-acuity patients to the next care setting?
A. They escort patients to the next point of care.
B. The use signage on the walls and floors.
C. They give patients maps with floor plans.
D. They provide detailed verbal instructions.

5. Why did staff in the ED at Baylor Medical Center at Garland, TX, rewrite the job description for the charge nurse so that this person would no longer engage in direct patient care?
A. They felt they had lost the high-level vision of what is going on in the ED.
B. The physician-nurse teams felt the charge nurse was interfering with their decision-making.
C. The ED was regularly running short on supplies.
D. ED volume had decreased.

6. How does the "Community Resources for ED Overuse" (CREDO) program identify patients who overuse the ED?
A. ED physicians are responsible for referring patients to the program.
B. Program coordinators interview patients.
C. It uses the health system's medical record.
D. The health system's billing office flags these patients.

ED ACCREDITATION UPDATE

Covering Compliance with The Joint Commission Standards

The Joint Commission readies new performance standard for ORYX measures, set to begin January 1, 2012

New accreditation standard puts teeth behind reporting requirement

Most accredited hospitals have been reporting ORYX performance data to the Joint Commission (JC) on a monthly basis since 2002. But beginning on January 1, 2012, the JC is putting teeth behind these measures, requiring an 85% compliance rate on a single composite rate, reflecting all accountability measures, in order to meet accreditation standards.

"This is really the first time the Joint Commission will be implementing a standard directly addressing performance on the reported measures," explains **Stephen Schmaltz**, PhD, the JC's associate director in the Center for Data Management and Analysis, Division for Healthcare Quality Evaluation. The new standard does not apply to critical access hospitals.

EXECUTIVE SUMMARY

Beginning January 1, 2012, most accredited hospitals will be required to meet an 85% compliance rate on a composite figure reflecting 22 of the ORYX accountability measures. This marks the first time the Joint Commission will require hospitals to meet a specific standard of performance on these measures for accreditation.

- For most hospitals, the composite rate will be based on data from the third and fourth quarters of 2010 and the first and second quarters of 2011.
- The JC plans to eventually raise the compliance standard to 90% and to periodically add additional accountability measures.
- The JC has established the "Core Measures Solutions Exchange," an online tool that accredited hospitals can use to learn from each other about strategies that can help them improve their performance.

Schmaltz emphasizes that how individual hospitals are performing on these measures should not come as any surprise because the JC has been providing regular feedback on their ORYX performance data and how they compare against other hospitals nationally. Further, at the end of this year, the JC will begin providing to hospitals the overall composite measure that they will be judged by, so they will see it before the standard goes into effect, adds Schmaltz.

The composite rate will be calculated using the most recent four quarters of data that is available at the time a hospital is surveyed. "For most organizations we will be looking at the third and fourth quarters of 2010 and the first and second quarters of 2011," stresses **Sharon Sprenger**, RHIA, CPHQ, MPA, senior advisor, Measurement Outreach, Division of Quality Measurement and Research. "But keep in mind that it will be a rolling four quarters going forward, so it may vary a little bit from hospital to hospital depending on when they are surveyed."

The composite measure is derived by taking the sum of all numerator counts of a hospital's accountability measures from all measure sets, and dividing that by the sum of all the denominator counts from the same accountability measures.

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Accountability Measures

Heart Attack Care

Aspirin at arrival
Aspirin prescribed at discharge
ACEI or ARB for LVSD
Beta-blocker prescribed at discharge
Fibrinolytic therapy received within 30 minutes of hospital arrival
Primary PCI received within 90 minutes of hospital arrival

Heart Failure Care

ACEI or ARB for LVSD

Pneumonia Care

Pneumococcal vaccination
Blood cultures performed in the ED prior to initial antibiotic received in hospital
Initial antibiotic selection for CAP in immunocompetent patient
(derived by combining PN-6a and PN-6b)
Initial antibiotic selection for CAP in immunocompetent ICU patient
Initial antibiotic selection for CAP in immunocompetent non-ICU patient
Influenza vaccination

Surgical Care

Prophylactic antibiotic received within one hour prior to surgical incision
Prophylactic antibiotic selection for surgical patients
Prophylactic antibiotics discontinued within 24 hours after surgery end time
Cardiac surgery patients with controlled 6 a.m. postoperative blood glucose
Surgery patients with appropriate hair removal
Surgery patients on beta-block therapy prior to arrival who received a beta-blocker during the perioperative period
Surgery patients with recommended venous thromboembolism prophylaxis ordered
Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery

Children's Asthma Care

Relievers for inpatient asthma
Systemic corticosteroids for inpatient asthma
Home management plan of care given to patient/caregiver

Source: The Joint Commission, Oakbrook Terrace, IL

Standards will rise

The current accountability measures pertain to care that is provided to patients that have experienced heart attacks, heart failure, and pneumonia. In addition, there are measures related to surgical care and to the care of children with asthma. (**See Accountability Measures on p. 2.**) "We believe that these are the measures that have the greatest positive

impact on patient outcomes when hospitals demonstrate improvement," explains Sprenger. "We have come to realize that only certain measures should be used for purposes of public reporting, accreditation, and pay for performance."

Sprenger notes that the JC selected these measures based on four criteria, including:

- strong scientific evidence that compliance results in improved outcomes;
- a close linkage between the process and an outcome;
- ability to accurately assess or measure the process of care;
- the process of care is associated with minimal unintended adverse effects.

In 2010, the JC began to comb through its data to determine which measures met the threshold for being accountability measures, says Sprenger, noting that the accrediting agency began with four measure sets that it has in common with the Centers for Medicare and Medicaid Services (CMS) and one measure set that the JC collects that CMS posts on its Hospital Compare website. "We identified or reviewed 28 measures, 22 of which we felt met the accountability criteria," she says. "Then we identified six measures we labeled as non-accountability measures, which we believe are more suitable for secondary uses."

The non-accountability measures include providing smoking cessation advice to patients with heart attacks, heart failure, and pneumonia; providing antibiotics to patients with pneumonia within six hours of arrival to the hospital; and providing discharge instructions and LVS function assessments to patients with heart failure.

The JC fully intends to add more accountability measures to the mix soon, but these data points will be collected for 12 months before they are calculated in the composite measure. The agency also intends to gradually inch up the compliance standard for accreditation. "We anticipate moving that up to a 90% threshold eventually," says Schmaltz. In 2010, the JC reports that 98% of hospitals met an 80% compliance rate and 92% met a 90% compliance rate.

Share best practices

As of January 1, 2012, hospitals that fail to meet the 85% compliance rate for the accountability measures at the time of their survey will receive a requirement for improvement (RFI) in their accreditation report, and they will have an opportunity to address the problem, explains Sprenger. To assist these organizations and any accredited hospitals that are striving to improve their performance on these measures, the JC launched a "Core Measures Solutions Exchange," an online tool that enables hospitals to share their success stories and offer up strategies that have proven to be effective.

"We are really trying to facilitate dialogue between hospitals so that they can help each other learn," says Sprenger. "They can search for solutions, post comments, rate the usefulness [of a strategy], and note if they think a particular solution is transferable to another organization."

The solutions can be searched by measure so if a hospital is having difficulty with a particular measure, administrators can pull up that measure to see what organizations have done to improve their performance in this area, adds Schmaltz. The online exchange is only available to accredited organizations to review. ■

Higher-level certification available to hospitals that that meet more rigorous standards in caring for patients with heart failure

Program recognizes emergency services as key component of HF care

Hospitals that want to distinguish themselves as centers of excellence in the care of heart failure (HF) have a new avenue to pursue. On July 1, the Oakbrook Terrace, IL-based Joint Commission (JC) launched its Disease-Specific Care Advanced Certification Program in Heart Failure. The program, which is being offered in collaboration with the American Heart Association (AHA), incorporates additional clinically-specific requirements over and above the core framework of requirements for Disease-Specific Care Certification, explains **Jean Range**, MS, RN, CPHQ, executive director, Disease-Specific Care Certification, at the JC.

The July launch of the program actually represents phase two of an initiative that began in 2009 with the requirement that hospitals participate in the AHA's Get-With-The-Guidelines program, adds Range. To be eligible for the higher-level HF certification program, hospitals must have demonstrated bronze-level achievement in the AHA's program, consisting of 85% compliance on the quality measures

in that program, she says. In addition, the hospital's HF program must include either a hospital-based and hospital-owned outpatient HF clinic, or it must have a collaborative relationship with cardiology practices.

"We are very excited about the fact that we have been able to incorporate additional requirements into this program relating to transitions of care and care coordination," says Range, noting that these areas tie into specific requirements mentioned in the Affordable Care Act that seek to prevent avoidable readmissions related to HF.

"From our point of view, emergency services are a key component of HF care in hospitals because this is where many of these patients are presenting," says Range. "EDs are playing an active role in identifying patients at increased risk for readmissions, and when patients are not admitted, actually coordinating their care."

Recognize symptoms, implement guidelines

A key focus area for on-site evaluators tasked with observing whether hospitals qualify for advanced certification will be reviewing whether ED physicians are making the appropriate diagnosis, says Range. This is important because it is not always evident that a patient is suffering from HF, but being able to recognize the signs and symptoms of the disease is critical to implementing effective care interventions. "The expert panel that we used to come up with our requirements for the program talked extensively about this," says Range. "The first line of care that is so important to these patients is going to be the ED."

EXECUTIVE SUMMARY

The Oakbrook Terrace, IL-based Joint Commission has unveiled a new Disease-Specific Care Advanced Certification Program in Heart Failure. The program, which launched on July 1, recognizes hospitals that meet additional clinically-specific requirements over and above core framework requirements.

- To be eligible for the programs, hospitals must have received bronze-level achievement in the American Heart Association's Get-With-The-Guidelines program, and they must either have a hospital-based and hospital-owned outpatient HF clinic, or collaborate with cardiology practices.
- The program includes new requirements that focus on care transitions and care coordination.
- The JC says that hospitals often have a tough time ensuring that clinical guidelines are not just adopted, but also implemented.

Evaluators will also be looking for evidence that clinical practice guidelines for HF are in place and actually embedded in the care processes. The program has integrated the "2009 Focused Update: American College of Cardiology/American Heart Association Guidelines for the Diagnosis and Treatment of Heart Failure in Adults." However, making sure that best practices are actually being used is a tall order for many organizations.

"The most frequently cited standard for certification relates to the consistent implementation of clinical practice guidelines," says **M.J. Hempel**, MPH, MBA, senior associate director, Disease-Specific Care Certification at the JC. "Guidelines and protocols and standing orders are adopted by organizations, but sometimes they are not implemented, [resulting in non-compliance.]"

Achieving adherence to disease-specific guidelines can be particularly challenging in the ED where providers are dealing with all different types of patients in a fast-paced setting. Range says this is one of the reasons why the JC always advises organizations that are contemplating certification for any disease state to secure the endorsement and support of the senior executive leadership as well as the senior executive clinical leadership. "This is very complex. There are so many different stakeholders and details that have to be reinforced constantly that it just turns out to be the most challenging aspect of certification," she says.

Quality is top priority

Currently, hospitals interested in pursuing advanced certification can expect to pay about $5,000 per year for the two-year certification period, says Range. This covers the expenses associated with the on-site reviews that will take place at the beginning of the process, and annual fees. While the program may, indeed, ultimately save hospitals revenue, Range emphasizes that what prompted the JC to develop the program was a drive to improve quality.

"We were very interested in the section of the Affordable Care Act that focuses on HF readmissions, and once we spoke with expert panel members, they confirmed that this is a big issue," she says. "We think the timeliness of this program is closely aligned with the focus that all hospitals are placing on this issue." ■

Editor's note: For more information on the Joint Commission's new Disease-Specific Care Advanced Certification Program in Heart Failure, contact program administrators at: dscinfo@jointcommission.org.